



DIFFERENTIATED SERVICE DELIVERY FOR HIV:

A DECISION FRAMEWORK FOR DIFFERENTIATED ANTIRETROVIRAL THERAPY DELIVERY FOR KEY POPULATIONS

The last mile to universal access


It's time to *deliver* differently.



Differentiated service delivery:

- Making ART delivery client centred
- Relevant for all people living with HIV including key populations

It's time to *deliver* differently.



A Decision Framework for differentiated antiretroviral therapy delivery for key populations draws purposeful attention to the specific populations of men who have sex with men, transgender people, people who inject drugs and sex workers. The concepts presented here are applicable to a global audience.

This is the third of the Decision Framework series – a vital step towards the 90-90-90 targets.

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ABBREVIATIONS

ANC	Antenatal care	NACO	National AIDS Control Organization (India)
ART	Antiretroviral therapy	NGO	Non-governmental organization
ARV	Antiretroviral	OI	Opportunistic infection
CBO	Community-based organization	OST	Opioid substitution therapy
CCLAD	Community client-led ART distribution (Uganda)	PEP	Post-exposure prophylaxis
CDDPs	Community drug distribution points (Uganda)	PEPFAR	President's Emergency Plan for AIDS Relief (US)
CSO	Civil society organization	PLHIV	People living with HIV
CD4	Cluster of differentiation 4	PrEP	Pre-exposure prophylaxis
CDC	Centers for Disease Control and Prevention	RSAT	Rainbow Sky Association Thailand
CHW	Community health worker	STI	Sexually transmitted infection
DIC	Drop-in centre	SWING	Bangkok and Songkhla, Service Workers IN Group Foundation
DSD	Differentiated service delivery	TASO	The AIDS Treatment Organization (Uganda)
GFTAM	Global Fund for TB, AIDS and Malaria	TB	Tuberculosis
HCV	Hepatitis C virus	VL	Viral load
IAS	International AIDS Society	UNAIDS	Joint United Nations Programme on HIV/AIDS
KP	Key population	USAID	United States Agency for International Development
KPLHS	Key Population-led Health Services (Thailand)	WHO	World Health Organization
LINKAGES	Continuum of HIV Services for Key Populations Affected by HIV project		
M&E	Monitoring and evaluation		

“Involving key population communities and organizations as partners and leaders in implementing health services is an evidence-informed approach to improving the quality and acceptability of services.”

– World Health Organization

COMMON CHALLENGES: WHY IT'S TIME TO DELIVER DIFFERENTLY



CLIENT PERSPECTIVE



They treat me like someone from another planet. So my name and address does not match my identify card. That's no excuse for the way I'm treated. The doctor does not understand the use of hormones and HIV. Why should I bother even coming? I am better off looking after myself.

I don't understand. What does he want or need? What do I call him/her? I'm confused. I really don't even know where to start with a physical examination. We have no training on gender and sexuality.



I have to move around a lot as there are different places where I can find work at different times of the year. It's frustrating that I have to go to my clinic for ART refills and that they'll only give me one month of medication at a time.

Our guidelines only allow us to give one month of ART. This is really difficult for our clients who tell us they are going to travel. Could we not give longer refills?



HEALTHCARE WORKER PERSPECTIVE

I work during the night and then get some rest while my children are at school. Going to the ART clinic in the morning is really difficult and there's no way I can afford the private clinic.

Why should we run our clinic later in the afternoon? We are so busy. We know there are sex workers in the local community, but why can't they come during the normal clinic hours?



I've just found out that I'm living with HIV and am scared to share my status. If I go to the clinic, won't everyone know that I'm positive? I'm really afraid to tell my partner about my test result.

I've heard that there are high rates of gender-based violence in my community, but how can I help? I'm just one person.



EXECUTIVE SUMMARY

There is good news in the fight against HIV. Antiretroviral therapy (ART) is keeping people alive, healthy and living longer. Pre-exposure prophylaxis (PrEP) is helping prevent new infections. A record 20.9 million people are on ART meaning, for the first time, more than half of all people living with HIV are on treatment¹.

But there are gaps. Key populations (KPs) are disproportionately affected by HIV, but are underrepresented in HIV testing and treatment programmes^{2,3}. Global data shows that the HIV prevalence among key populations, including men who have sex with men people who inject drugs, sex workers and transgender people, is substantially higher than it is among the general population⁴. Analyses from 2017 highlight that 80% of new HIV infections outside of sub-Saharan Africa occur among key populations and their sexual partners⁴. Even in high-prevalence countries in sub-Saharan Africa, key populations are disproportionately affected, with 25% of new infections occurring among this group. Further, key populations have low access to treatment and face specific challenges in remaining on treatment compared with the general population⁵⁻⁸. These are populations that have been left behind in the fight against HIV.

The concerns from a district HIV manager and a member of a key population shown opposite, highlight some of the challenges being faced as we continue to scale up access to HIV care and treatment. The vulnerabilities of key populations result in their being disproportionately affected by HIV in all countries and settings. These disproportionate risks are related to issues common among members of these populations, such as specific legal and social inequities that increase their vulnerability. Key populations are often socially isolated and subjected to social rejection, stigma and self-stigma, discrimination and criminalization. Many live in fear of violence, and too often, they are excluded or self-excluded from accessing health services. Annex 1 includes a list of key reference documents about HIV care for key populations⁹⁻¹².



I do not understand the high prevalence of HIV among key populations or the effects of stigma and discrimination on health outcomes for these individuals.

Learn more about **Andrew**, a district ART manager, on page 4



I am afraid to go to my local HIV clinic for fear that someone will see me – either a potential client or someone from my family.

Learn more about **Namrata**, a female sex worker, on page 4

Differentiated service delivery (DSD) provides an opportunity to reconsider how the healthcare system can adapt to ensure that previously underserved populations receive client-centred care. Key populations must be part of the response if we are to attain the 90-90-90 goals set out: 90% of persons living with HIV know their status; 90% of them access treatment; and 90% of those on treatment achieve viral suppression, and move forward to the 95-95-95 targets by 2030.

“Differentiated ART delivery can address inequities in the access of key populations to HIV treatment services by developing new ART delivery models that meet the specific needs of key populations and reach marginalized, criminalized and stigmatized groups. Differentiated ART delivery can also enable key population communities to be more involved in HIV treatment and care.”

– World Health Organization

Use of the term “key populations”

The Decision Framework for key populations purposefully focuses on four groups:

- Men who have sex with men
- People who inject drugs
- Sex workers
- Transgender people.

In this document, for ease of use, the acronym KP will be used when referring to these four groups.

While other groups, such as migrants and fishermen, are also at increased vulnerability to HIV, they are not subject to criminalization in the same way as the four key populations we address here. While the World Health Organization (WHO) and UNAIDS also include prisoners and people in closed settings among key population groups, this document does not address this group as they have different needs related to the delivery of healthcare³.

Some KP individuals are part of more than one key population. For example, some men who have sex with men and some transgender people may also engage in sex work and/or inject drugs.

ART delivery models that are tailored, accepting, affordable, effective and efficient are needed for key populations. These approaches to health care delivery must go hand-in-hand with addressing social, structural, policy and cultural barriers to services for key populations. When we, as agents of public health, reach out and successfully include the excluded, we will have reached another level in creating health systems that work to achieve universal access. While published data on key populations is often lacking, ART programmes need to respond directly to relevant local contexts and the challenges faced by key populations. “Treatment for all” will only be accomplished if we move into communities and, listen to the needs and preferences of our key population clients, adapting our service strategies accordingly.

Two key interventions that apply to all key populations are reconsidering the “who” and “where” of ART delivery (further discussed in Part 5, The building blocks). Peers as partners and peers as providers provides a new and effective means of filling a human resource gap, but with people who provide legitimate access and understanding of the specific key population. Utilizing existing community infrastructure, such as drop-in centres as sites for clinical consultations and ART delivery, may also reduce the barriers associated with attending routine public services.

This framework will outline the methodology for identifying specific challenges, deciding what DSD models may solve these challenges and how to systematically adapt or build a differentiated model of ART delivery for a specific key population.

DSD, sometimes known as differentiated care, is about client-centred health responses. DSD involves adapting services along a continuum from prevention to treatment, inclusive of diagnoses, care and support. This decision framework is one of four DSD decision frameworks aimed to support decision making by health managers within ministries of health. The other three frameworks focus on differentiated ART delivery for clinically stable adults and for children, adolescents, pregnant and breastfeeding women and on differentiated HIV testing services.

Key populations can benefit from access to differentiated ART delivery and should not be excluded based on their drug use, occupation, gender identity or sexual orientation.

In addition, where possible, services should be decentralized to settings, such as drop-in centres, to facilitate access to treatment.

Key population peers should be actively engaged in the delivery of HIV and ART services.



I really like attending my drop-in centre. I wish I could also get my ART refills there.

PREFACE

Background to the Decision Framework Series

The first *Decision Framework for ART delivery* was released in July 2016 and set the background and principles of DSD for clinically stable clients using the principles of the elements and building blocks¹⁴. The framework provides guidance on which elements of DSD should be prioritized for implementation and how to build a given model.

Moving beyond clinically stable adult clients, the second in the series, the *Decision Framework for differentiated ART delivery for children, adolescents and pregnant and breastfeeding women*, was developed and launched in 2017¹⁵.

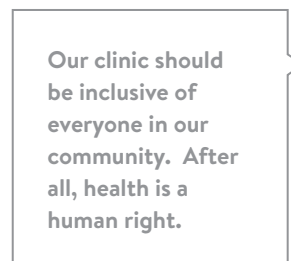
This framework, the third in the series, provides guidance on how to prioritize a DSD approach for key populations with a focus on differentiated ART delivery. This Decision Framework was developed based on an analysis of current best-practice models and from the outcomes of a “Global workshop on DSD for key populations” that brought together almost 50 participants from 20 countries.

A fourth Decision Framework focusing on differentiated HIV testing services, to be released in late 2018, includes examples of how HIV testing service delivery models may be adapted for key populations.

Key populations can also benefit from access to differentiated ART delivery

Key populations, often excluded from accessing health services, should also benefit from DSD, including differentiated ART delivery. The main focus of the first Decision Framework was to describe ART delivery models for clinically stable adults. At the time, this is where the majority of evidence was available and initially reflected the largest possible gains for both clients and the health system. Key populations who are stable should also benefit from any differentiated ART delivery models that are implemented for the general population. As countries have formulated DSD policies, there has been a louder call for guidance on how specific populations can also benefit from differentiated ART delivery and how to adapt or build models for these populations.

DSD offers the opportunity both to simplify care for those doing well on treatment and to provide adapted care for those who struggle to initiate ART and remain in care with a suppressed viral load due to access barriers. A *Decision Framework for differentiated antiretroviral therapy delivery for key populations* is focused on providing alternative avenues for key populations to access health services. It builds on the evidence and recommendations provided by the World Health Organization (WHO)^{3,16} and the Key Considerations¹³ to develop a systematic approach to building effective models of ART delivery for key populations.



How to read the Decision Framework for key populations

A *Decision Framework for differentiated antiretroviral therapy delivery for key populations* sets out a comprehensive understanding of differentiated ART delivery and a step-by-step approach to planning provision of ART services for key populations and how to adapt or build differentiated ART delivery models. The examples and case studies provided specifically focus on key populations.

The Key Considerations¹³ and the WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations outline “what” should be implemented. This Decision Framework focuses on “how” to operationalize delivery of ART services.

If you are new to DSD, to the Decision Framework series or to working with key populations, read from Part 1.

If you have experience in DSD or have read the earlier Decision Frameworks, but are less familiar with key populations, pay close attention to Parts 1, 4 and 6.

It takes up a lot of my day when I have to go and get my ART from the clinic. They also suggested joining a support group but the other members don't really understand my challenges. I wonder if I could form a group with my men who have sex with men friends who also need ART.



I know there are female sex workers and men who have sex with men coming to our clinic but I'm not sure my staff know how to deliver the sexual health services they need as well as their ART. I think we should try to integrate these services.

Objectives of the Decision Framework for key populations

The objectives of the *Decision Framework for ART delivery for key populations* are to provide:

- A **background** to the principles of DSD and differentiated ART delivery and how they relate to key populations
- **Examples** of differentiated ART delivery for key populations that demonstrate the use of the elements (Part 3) and building blocks (Part 5)
- **Guidance** on how to adapt or build a differentiated ART delivery model for specific key populations.

A *Decision Framework for differentiated antiretroviral therapy delivery for key populations* is aimed at both national and district HIV programme managers and, where appropriate, implementing partners, donors and other organizations supporting national HIV programmes, including civil society and key population community-based organizations.

An online knowledge repository (www.differentiatedservicedelivery.org) supports the Decision Framework for key populations. It is the “go-to” resource for DSD and includes global and national guidance, best-practice service delivery models with their associated implementation tools, and related resources.



PART 1

INTRODUCTION

WHAT IS DIFFERENTIATED SERVICE DELIVERY FOR HIV?

DSD is a client-centred approach that simplifies and adapts HIV services across the HIV care cascade to reflect the needs and preferences of various groups of people vulnerable to or living with HIV, while reducing unnecessary burdens on the health system¹⁷. By providing DSD, barriers to HIV service access are reduced and the health system can refocus resources to those most in need.

Differentiated service delivery is also referred to as differentiated care.

DSD is aimed at enhancing the quality of the client experience, putting the client at the centre of service delivery, while ensuring that the health system is functioning in both a medically accountable and efficient manner. To meet the diversity of needs for key populations and people living with HIV (PLHIV), WHO recommends a differentiated approach to service delivery¹⁶. Within a public health framework, one may consider the needs of a population group according to three elements (Part 3): the specific client population; the context in which he/she lives and seeks care (for example, urban or rural, low- or high-burden setting); and their clinical characteristics.

WHY DO WE NEED TO DIFFERENTIATE SERVICE DELIVERY FOR KEY POPULATIONS?

Improve access and quality of services

Key populations who have been socially isolated often do not have confidence in health services and fear being stigmatized, discriminated against or, in some cases, reported to authorities. By differentiating service delivery for key populations, inequities in access to health services across a spectrum of HIV prevention, testing, care and treatment services may be addressed¹⁸ along with improving the quality of the comprehensive medical package offered³.

By decentralizing ART delivery to the community (for example, to drop-in centres) access to HIV services for key populations may be enhanced.

There are several successful examples of DSD for key populations. The community response from key population organizations provides some of the earliest examples of DSD. They include prevention outreach services run by community-based organizations (CBOs), key population initiatives for testing and linking to health services, support groups for key populations living with HIV and drop-in centres (DICs) offering services, such as prevention information and commodities, STI treatment, OST and referral services¹⁹. Building on these successes, incorporating the lessons learned from pilot programmes into approaches supported by the ministry of health may support further scale up of quality DSD.

Improve access

DSD for key populations first and foremost means improving access to health services for key populations. Because of high levels of criminalization, stigma and discrimination, coupled in many instances with high levels of violence, many persons from key populations are reluctant to use public health services. In addition, social marginalization, poverty and exclusion from insurance and social security results in poor access to ART. Using the building blocks of DSD to adapt how ART is delivered may overcome some of the barriers to accessing ART and support integration of such services within ministry of health facilities.

Improve quality of care

Through the lens of specific key populations, adapting and building DSD models can lead to earlier diagnosis, linkage to prevention and treatment and improved treatment outcomes. Further, the integration of the appropriate comprehensive package with ART can improve the quality of care and outcomes for the client.

While long-term health efficiencies and sustainability must be kept in mind, local contexts, local health systems and the level of criminalization, stigma, discrimination and violence will determine how to reach otherwise excluded key populations. It is important that key populations are able to access services relevant and critical to their needs, when they need. NGO and community initiatives should aim to complement services provided by the government, ideally working together to provide a sustainable service.

Sensitize healthcare workers on specific needs

Many health professionals are hesitant to treat persons from key populations because of preconceived prejudices or unfamiliarity with sexual and gender diversity, sex work, anal health or drug use. DSD can help create systems to identify medical staff who are more expert, friendly or open to being trained on how to treat key populations. There are some areas that will require specific medical expertise (for example, hormonal use and ART interactions amongst transgender people) along with consideration of ethical issues involved in engaging with key population communities. What is better for the client will in turn be better for the provider, ultimately improving health system efficiencies and overall health outcomes.

Support “treat all” and reaching 90-90-90

Worldwide, nearly 38 million people are living with HIV and 20.9 million people are receiving ART⁴. With the implementation of the WHO 2015 recommendation to “treat all” HIV-positive individuals with ART²⁰, health systems, often already under extreme pressure due to lack of human and financial resources, are being forced to re-examine how ART care is delivered. While progress in treatment coverage has been extraordinary over the past five years, it is time to make a concerted effort to treat the marginalized and excluded people who are disproportionately affected by HIV but underrepresented in HIV testing and treatment programmes. A renewed focus to ensure better adherence and linkages to health services among key populations is required.

WHAT ARE THE CORE PRINCIPLES OF DSD?

Providing client-centred care

A core principle for differentiating service delivery for ART is to identify and address specific barriers identified by clients and to empower them to better manage their health with the support of the health system, including community-based services. WHO highlights the need for client-centred care to improve the quality of HIV services (Box 1)¹⁶.

WHO Guidelines

Box 1: WHO recommendations for client-centred care¹⁶

“HIV programmes should: provide people-centred care that is focused and organized around the health needs, preferences and expectations of people and communities, upholding individual dignity and respect, especially for vulnerable populations, and engage and support people and families to play an active role in their own care by informed decision-making.”

Engaging peers in the delivery of HIV services, including ART delivery should be a priority in the design of differentiated service delivery models for key populations.

Reducing stigma and discrimination and respecting human rights

Criminalization, stigma and discrimination can be the biggest obstacle for key populations accessing health services. Through community engagement and empowerment, DSD can increase demand for providing stigma-free services and initiate work with health facility partners to reduce stigma and discrimination through sensitization and training on needs of key populations. It is vital to keep in mind the safety and security of key populations, especially in areas where they are criminalized or subject to violence.

Recognizing the importance of communities and peers as providers

A Decision Framework for differentiated antiretroviral therapy delivery for key populations seeks to highlight how ART delivery models can take a community approach when considering ART delivery options for key populations and their partners. Networks representing key populations are critical partners in creating demand for services and addressing barriers to access. Provision of services by lay providers is recommended by WHO³ and the role of peers in delivering services and influencing behaviour is also recognized within the “who” building block when designing any DSD model (Part 5). Health and rights literacy should also be incorporated as key components to develop resilient communities.

Including psychosocial support

The importance of psychosocial support, both from healthcare workers, communities and peers, is of particular significance to key populations. Many communities have care or support groups provided through CBOs and/or linked to healthcare facilities. While one-on-one adherence counselling is an important part of ART initiation and ongoing adherence counselling, the type and frequency of psychosocial support should be appropriate to the needs and wishes of the client. This may include support from social peers in a group and/or individuals or from trained peers or counsellors. Just as PLHIV in DSD models can access services outside of scheduled visits, psychosocial support can similarly be accessed and should be available at the frequency desired by the KP client.

WHO Guidelines

Box 2: WHO recommendation on HIV treatment and care²

Key populations living with HIV should have the same access to antiretroviral therapy and to ART management as other populations.

WHAT IS DIFFERENTIATED ART DELIVERY?

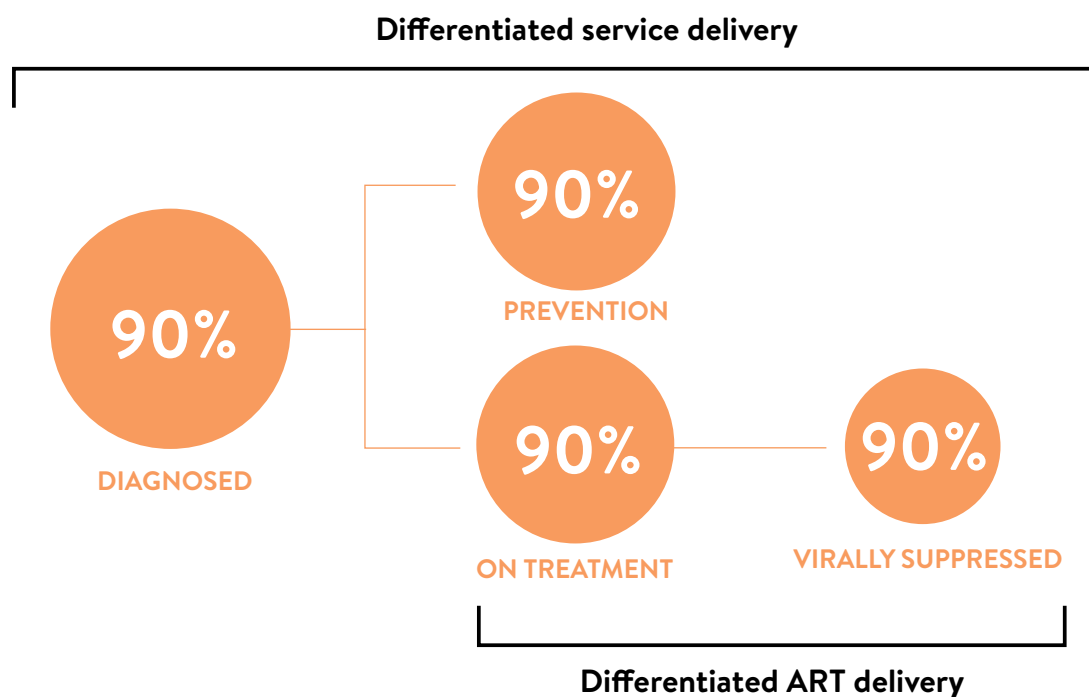
Differentiated ART delivery is a component of differentiated HIV care or service delivery

DSD applies across the HIV continuum, from prevention to viral suppression, and across all three of the 90-90-90

targets²¹. Differentiated ART delivery is a component of DSD (Figure 1).

Differentiated ART delivery is not just for clinically stable adult clients. The principles may be applied across all populations, including key populations, and for clients who may, for a period, require more intensive clinical follow up.

Figure 1: Differentiated service delivery is applicable across the HIV care continuum



DSD applies across the HIV care continuum including linkage to prevention. This Decision Framework focuses on ART delivery for key populations.



Learn more about Andrew

Andrew is a medical doctor who is now a district ART manager in a district that is composed of a couple of small towns and otherwise more rural communities. At a national meeting, he learned about key populations and the situation they face in terms of burden of disease, criminalization, exclusion from health services and the effects of stigma and discrimination on health-seeking behaviour. He understood that this was a great challenge in a rural community where key populations were discriminated against and were often hidden. He went home not knowing where to start.

Learn more about Namrata

Namrata is a sex worker and supports her elderly mother and her two small children. She was recently diagnosed with HIV, but fears going to her local HIV clinic for a number of reasons. She does not want to be seen entering the clinic by family members, neighbours or potential clients. In her work, she moves around, working in different towns.



Learn more about Juan

Juan has sex with men and found out his HIV status only because he was very ill and was hospitalized. The hospital referred him to an HIV clinic, but he is afraid to approach the clinic because of threats of violence or verbal abuse. He sticks to himself and has few friends – none of them know his sexual orientation.

Learn more about Chantal

Chantal is a transgender woman who runs her own small business and manages to make enough money to support her elderly parents. She was treated very rudely at the local HIV clinic and, although she is HIV positive, she refuses to go back.



Learn more about Ian

Ian is a young person who injects intravenous drugs and has had trouble keeping a steady job because of recurring, sometimes serious, health issues over the years. He has just been diagnosed as HIV positive. He has been on ART for only a few months, but is having trouble coping, as he needs to go to one place for his clinical consultations and ART supply, and another for his opiod substitution therapy.

DIFFERENTIATED ART DELIVERY IS FOR EVERYONE

Differentiated ART delivery is client-centred and responds to the needs of clients who are clinically stable and those requiring more intensive medical follow up²².

If a client is clinically stable, they should have access to differentiated ART delivery models with less frequent clinical visits and longer ART refills. Therefore, providing access to differentiated ART delivery for clinically stable clients requires establishing criteria for clinical stability. Most definitions of “stable” include a minimum duration on ART and a measure of adherence or treatment success. Box 3 outlines the WHO criteria for clinically stable clients. A number of countries, during the development of country-specific operational guidance, have already adapted this definition. **Importantly, the Key Considerations¹³ suggest that the criteria for KPs should match the same criteria as for other adult clinically stable clients/patients** (see Box 3). This will enable simplified implementation for specific populations.

For clients with advanced HIV disease (defined as having a CD4 cell count <200 cells/mm³ and/or

Key Considerations

Box 3: Criteria for defining clinically stable clients

Received ART for at least one year; no adverse drug reactions that require regular monitoring; no current illnesses (including conditions such as malnutrition in children, mental health conditions or postpartum depression); a good understanding of lifelong adherence; and evidence of treatment success (two consecutive viral load measurements below 1,000 copies/mL, rising CD4 cell counts or CD4 counts above 200 cells/mm³).

Stage 3 or 4 disease), more intensive follow up and a package of interventions should be implemented to reduce morbidity and mortality in this vulnerable group²².

FOUR GENERAL MODELS OF DIFFERENTIATED ART DELIVERY

Differentiating ART delivery requires that there is a choice of service delivery models from which the client may choose. The option chosen by the client may change over time to reflect changes in needs or preferences. The majority of documented differentiated ART delivery models can be categorized into four models. For clinically stable clients, including key populations, all of these models should always specify the frequency of clinical consultations and the frequency of receiving ART refills.

- In **healthcare worker-managed group models**, clients receive their ART refills in a group that is managed by either a professional or a lay provider. Healthcare worker-managed groups meet within and/or outside of healthcare facilities, for example, in key population drop-in centres (DICs).
- In **client-managed group models**, clients receive their ART refills in a group that is managed and run by clients themselves, in this case key population groups (for example, female sex worker community-client led distribution, or CCLAD, in Uganda, page 27). Generally, client-managed groups meet outside of healthcare facilities.
- In **facility-based individual models**, on an ART refill visit, clients can bypass clinical staff and/or adherence support and proceed directly for their medication refill, most often directly from the dispensing point (Integration of ART delivery into KP services in Haiti, page 31).
- In **out-of-facility individual models**, clients receive some or all of their ART refills, clinical consultations and psychosocial support outside of healthcare facilities. These models include mobile outreach, services decentralized to key population drop-in centres, community pharmacies or home delivery of ART (Key Population-Led Health Services in Thailand, pages 21 and 29, and community-based services for people who inject drugs in India, page 25).



PART 2

THE FIVE-STEP APPROACH TO DIFFERENTIATED ART DELIVERY FOR KEY POPULATIONS

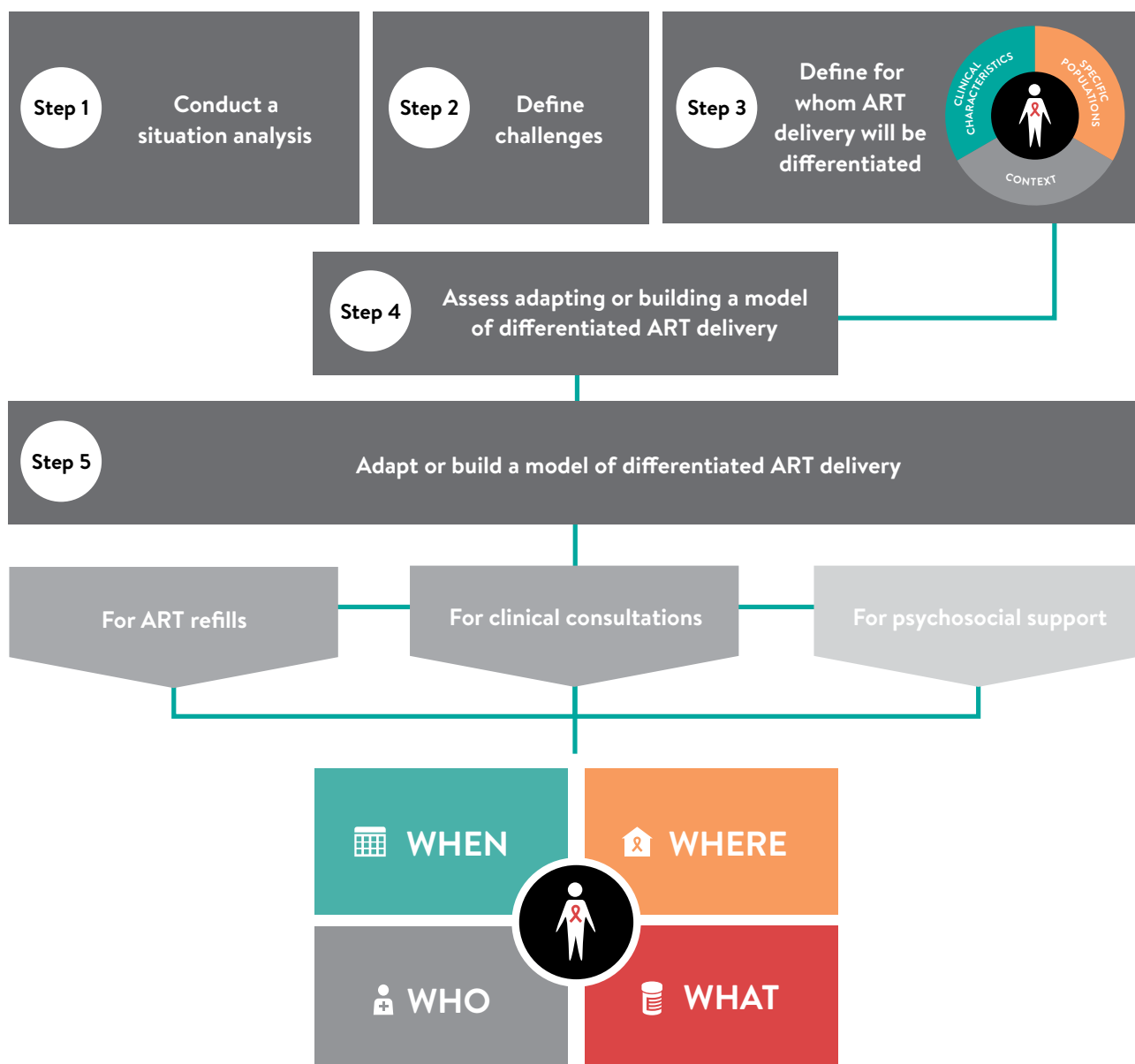
THE FIVE-STEP APPROACH

To develop differentiated ART delivery models for key populations, a situation analysis both at national and local levels is needed. Where feasible, policy guidance should be developed at the national level. In countries where criminalization of sex work, drug use or consensual same-sex behaviour impedes setting up or maintaining DSD for key populations, alternative approaches may be necessary.

The five-step approach guides ministries of health, health agencies and civil society organizations (CSOs) providing

key population services in planning how to differentiate ART delivery (Figure 2). While this outlines the approach for key populations, the five-step process can also be undertaken simultaneously for other populations and for services across the cascade. To support this process, a number of annexes are available for download at www.differentiatedservicedelivery.org/Resources/DecisionFrameworkOnlineAnnexes or <http://bit.ly/2sVehV5>. See Annex 1 for a full list of the annexes available online.

Figure 2: Five-step approach to differentiated ART delivery for key populations



STEP 1 – CONDUCT A SITUATION ANALYSIS

It is important to have an understanding of how HIV services are currently provided for key populations and their outcomes, as well as the existing policies that support or obstruct differentiating ART delivery for specific key populations. An example of a survey performed to map DSD at the national level (Annex 2), along with the survey tools used, can be found online at <http://bit.ly/2sVehV5>.

For key populations, there are often gaps in the available data. Formative work should be done to engage with key populations and key populations living with HIV to understand the barriers to services. Lack of available data for key populations should not, however, be used as a reason to delay service provision. Data collection should be done in parallel to implementation.

1.1 Assess the perspectives of key population PLHIV and healthcare workers

DSD is fundamentally client centred. Speaking with a range of key population members, both those who are HIV positive and HIV negative, is critical for ensuring that service delivery models are designed appropriately to meet their needs and expectations. As such, this includes actively involving them in the planning, delivery and monitoring of differentiated ART delivery. Data on the perspectives of key population members may be obtained through clinic exit surveys, focus group discussions and/or individual interviews. Often these will need to be performed in the community at sites where a particular key population is known to meet and should be done in partnership with key population networks

and organizations. It is important to ensure meaningful participation of both current and potential clients.

Healthcare workers, including lay providers and clinical staff, should also be consulted in order to address their challenges in providing key population services. A sample questionnaire that can be used to assess the perspectives of key populations and healthcare workers and can be found in Annex 2 and online at <http://bit.ly/2sVehV5>.

1.2 Assess the data

National-level data should be reviewed to provide an overview of the estimated number of key populations, the HIV prevalence in each key population and a mapping of where key populations may be found. In many cases, there may not be accurate population size estimates for key populations – but this should not impede service provision. Collection of data about key populations through routine patient monitoring systems is not recommended and the sensitivity of any data collected and mapping exercise should be respected. Visit <http://www.who.int/hiv/pub/guidelines/person-centred-hiv-monitoring-guidelines/en/> for more details.

1.3 Assess the policies

A comparison of national-level policies with current WHO service delivery recommendations¹⁶ and Key Considerations¹³ should be undertaken. Policies should be reviewed in alignment with the building blocks (Part 5) and to support differentiated ART delivery in general. A template for assessing the relevant policies, online Annex 2, for differentiating ART delivery for specific populations can be found at <http://bit.ly/2sVehV5>.



Remember Andrew?

With a community leader, district ART manager Andrew, brought together a few supportive health professionals from two clinics with representatives of three local NGOs who worked with sex workers and men who have sex with men. They agreed to collaborate and devised a plan in which the NGO would support peers as navigators to discreetly help key populations access the health services. The staff in the clinics would also be trained in sexual diversity health needs in order to provide more friendly and tailored services for key populations.

In the case of key populations, it is imperative to assess current legislation and policies that may either support or negatively impact the rights and health of key populations. WHO has outlined an audit of these legal issues (see Annex 3), which should be conducted with “participation of government, civil society and community-led networks, and organizations of key populations”²⁴.

1.4 Assess the current models of ART delivery and who is providing services to key populations

An initial mapping of existing key population services should be made in order to identify what may be adapted to integrate differentiated ART delivery. Secondly a mapping of existing differentiated ART delivery models that may also be scaled up or adapted to meet the needs of another key population.

At the district level, for each site, data should be collated describing service provision based on the elements (Part 3) and the building blocks (Part 5), and it should consider how clinical, refill and psychosocial visits are provided. An example of a checklist that you can use to perform this assessment can be found in Annex 2 and online at <http://bit.ly/2sVehV5>.

Examples of differentiated ART delivery for key populations are outlined in Parts 3 and 5. The mapping may be carried out through a combination of a desk review of existing published literature and local country and partner activity reports, a survey of district ART coordinators and implementing partners, and selected site visits. It is

important to map not only current delivery models for ART, but also whether the respective comprehensive medical package is provided and whether services are standalone or integrated within a ministry ART or outpatients’ department clinic. It is also important to know whether facilities have an appointment and tracing system, and whether specific days are allocated to serving key populations.

It is also essential to document whether the services for clinical HIV care, the comprehensive medical package and psychosocial support are provided through public, private or NGO-supported services to aid future planning. Existing key population support groups may be leveraged to include ART delivery and provide psychosocial support.

Case study 2:

Government and key populations working collaboratively, Ghana

In Ghana, HIV services for key populations were provided by a NGO in collaboration with the Ministry of Health. HIV services were provided at drop-in centres but did not include ART delivery. In 2017, as part of the strategic development of an operational manual for all HIV services, the Ghana National AIDS Control Program worked together with NGOs and representatives of key populations to include specific recommendations on ART delivery for key populations including providing ART refills from drop-in centres. The manual is available at <https://bit.ly/2NrcSOc>

Case study 1:

Assessing female sex workers and healthcare worker perceptions of ART services for key populations, South Africa

In Durban, South Africa, in depth interviews were carried out with sex workers, clinic staff and local stakeholder such as police, brothel managers and implementing partners to assess whether female sex workers would prefer decentralized ART services²⁷. Decentralizing care was seen to be beneficial as it would decrease transport costs, reduce time spent at the clinic and had the potential to address sex-work related stigma and inadvertent HIV disclosure. In particular, mobile services were felt to be discrete and perceived to facilitate improved tracing of clients.

Case study 3:

Engaging key populations to provide sensitivity training to healthcare workers, Jamaica

In Jamaica, the high HIV prevalence rate among men who have sex with men and the high level of violence and discrimination levelled at men who have sex with men creates challenges for quality HIV care. A KP-led organization collaborated with government trainers to train and sensitize healthcare providers and facility staff on the effects of stigma and discrimination on health and health-seeking behaviour, as well as gender, sexuality and diversity, legal awareness and working with local communities. The CSO, in collaboration with the ministry of health, led the process from curriculum design and training to community monitoring.

STEP 2 – DEFINE CHALLENGES

Based on Step 1, the challenges that can be addressed through differentiated ART delivery should be identified. At this stage, it is important to engage strategic stakeholders, including representatives of the health system, supporting implementing partners, policy makers and networks of key population PLHIV. Ideally this should be done in a broader context of developing an overall approach to differentiated service delivery with a subgroup focusing on key populations. In some cases, given the level of stigma, discrimination and violence, this workshop might have to be a discreet encounter with stakeholder allies.

The meeting should be aimed at achieving the following objectives:

- a. Sensitize ART coordinators and implementing partners on the background and core principles of differentiated ART delivery and relevance for key populations.
- b. Present the outcomes of the national-level review relating to specific key populations.
- c. Provide an opportunity for stakeholders including current providers of key population services to present existing examples of DSD implemented for adults and specific populations (if any) in their settings, including psychosocial interventions provided and utilized by specific populations.
- d. Summarize the findings from consultations with key populations living with HIV, representatives of key population organizations and healthcare workers.
- e. Engage stakeholders in a plan for local/district strategy analysis for KP service delivery.

STEP 3 – DEFINE FOR WHOM ART DELIVERY WILL BE DIFFERENTIATED

With a clear understanding of the needs for specific key populations, the current service delivery programme and policies in place, you are ready to proceed with prioritizing differentiated ART delivery for one or more of the specific key populations. Using the programme data inputs from key

population PLHIV and understanding the policies in place, you can determine the challenges faced by KP clients and by the health system. Based on the challenges, you can work out which populations should be prioritized to receive differentiated ART delivery.

Case study 4:

Expanding services to reach people who inject drugs and men who have sex with men, South Africa

OUT Well-being is an NGO clinic in South Africa that works closely with the health sector. It began by offering services to men who have sex with men and recognizing the unmet needs of people who inject drugs, including them in its service delivery model. Working with people who inject drugs, the clinic was recently integrated into the public health network as a KP clinic. It has close partnerships with government, universities and funders. The ART delivery model that it uses is facility based with an outreach component involving peers in service delivery. The clinic uses outreach nurses working closely with KP peer counsellors/educators. The distribution system of ART is from nurses to peers to clients. The clinic notes that one of its successful strategies is good retention rates on ART and being well known for providing quality services at the key population hotspots. The project has seen high retention rates and high rates of viral suppression among people who inject drugs, and has provided ART refills in the community hotspots as a result.

STEP 4 – ASSESS ADAPTING OR BUILDING A MODEL OF DIFFERENTIATED ART DELIVERY

There may already be existing health centres or community based facilities (for example, drop-in centres) that are providing peer support and other HIV services for key populations. Where these interventions and programmes are already in place, they could be adapted to include differentiated ART delivery. Part 4 will guide you through assessing whether to adapt or build a model of ART delivery.

Your district may already have implemented a differentiated ART delivery model/s for stable adult clients. If so, before building a new ART delivery model for key populations, assess whether an already implemented model could be leveraged to meet the needs of the specific key population. Where a model is already understood, implemented and functioning within the health system, minor adaptations may be easier to undertake than implementing a new model.

Case study 5:

Using optional drop-in centres to provide comprehensive services, Kenya

In Kenya, a CSO uses drop-in-centres (DICs) as a safe space to provide services, including HIV testing, STI screening and treatment, prevention commodity distribution and cervical cancer screening. People who test HIV positive are directed to nearby ministry of health facilities. ART distribution for stable clients is arranged via the DIC. The DIC nurse also provides services in the evenings and on weekends.

STEP 5 – ADAPT OR BUILD A MODEL OF DIFFERENTIATED ART DELIVERY

Adapting or building a model of differentiated ART delivery for KPs based on your data and policies can be carried out using a building-block approach considering the “when” (time of day and service frequency), “where” (service location), “who” (service provider) and “what” (package of care) for ART refills, clinical consultations and psychosocial support.

After this five-step process has been completed, it will be necessary to discuss at a district and/or facility level the specific model mechanics (such as drug supply, human resource allocation, relevant adaptations of M&E materials). Visit <http://bit.ly/2sVehV5> and download online Annex 2, which outlines the “how” or model mechanics after selecting a model of differentiated ART delivery. A clear plan for implementation and to assess the impact of the model will be required.

Case study 6:

Same-day ART initiation in community-based settings, Tanzania

In Tanzania, ICAP at Columbia University is implementing a CDC PEPFAR-funded community-based HIV prevention intervention, known locally as the “FIKIA” project (Fikia means “to reach” in Swahili). The project engages volunteers from KP groups (men who have sex with men, female sex workers, and people who inject drugs) to create demand for HIV testing and support linkage to HIV prevention and care services. Peer volunteers conduct community outreach to identify potential beneficiaries, conduct screening for TB, STI, and HIV risk, and escort beneficiaries to community testing locations. ICAP organizes community testing with medical services (including HIV testing and ART initiation services) provided by HCWs from government health facilities. Testing modalities vary from large events with multiple tents, venue-based (e.g. at a truck stop or guesthouse), in cars, and via teams carrying supplies in a backpack who travel on foot to the client’s preferred location and time (“backpack” HCWs). Clients who test positive undergo a clinical screening and receive a two-week starter pack of ART at the point of diagnosis in the community. These clients are supported with an escorted follow-up visit to their preferred health facility by a peer volunteer within two weeks of initiating ART. Where immediate community ART initiation is not available, clients are escorted by peers to the nearest care and treatment facility.

PART 3

WHAT ARE THE THREE ELEMENTS?

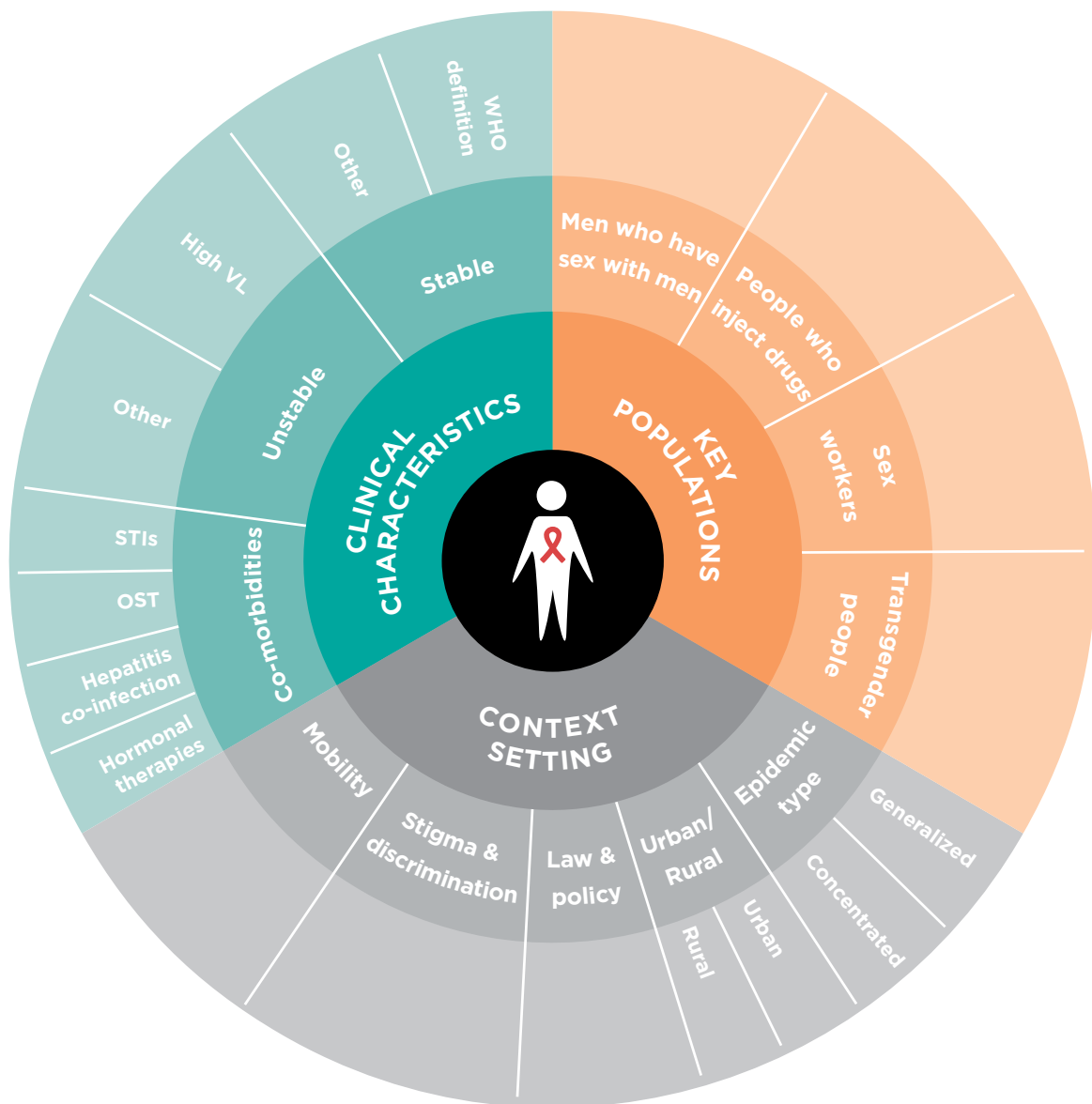


THE THREE ELEMENTS

In order to provide client-centred care, the following three elements for any client should be considered: the specific key population(s) being considered; their clinical characteristics; and their social and geographic context (Figure 3). This will allow you to adapt or build appropriate

models of ART delivery using the building blocks described in Part 5. In this part, we consider each of these specific key population groups, as well as their clinical characteristics and their context, as presented in Figure 3.

Figure 3: The three elements for key populations



HOW DO WE DIFFERENTIATE BASED ON CLINICAL CHARACTERISTICS?

Key population members can be defined as clinically stable regarding their HIV or as requiring more intensive medical care because they may have an unsuppressed viral load or present with another HIV-related co-infection, including TB, STIs and viral hepatitis. They also may present with specific clinical characteristics related to their related behaviour. Some clinical presentations, such as mental health issues, may be more common across all key populations; others, such as recurrent skin abscesses or withdrawal symptoms, may be specific to one key population, such as people who inject drugs.

Table 1 outlines some examples of the clinical characteristics that should be considered when designing a differentiated model of ART delivery for key populations. Management of these clinical conditions should ideally be provided as a one-stop service with their HIV care. Where this is not feasible, communication between service providers should be strengthened to ensure that medication interactions do not occur and that consistent health messages are provided to the client.

Table 1: Clinical characteristics to consider with key populations

All key populations	<ul style="list-style-type: none"> Viral load suppressed or unsuppressed Opportunistic infections, including TB Mental health (e.g., depression and anxiety, alcohol or drug dependence) Physical and sexual violence Sexual health, including STIs and contraception
People who inject drugs	<ul style="list-style-type: none"> Treatment of substance dependence (OST and ART interactions) Hepatitis B & C Skin infections Management of withdrawal symptoms Overdose
Sex workers	<ul style="list-style-type: none"> Sexually transmitted infections Reproductive health needs
Men who have sex with men	<ul style="list-style-type: none"> Sexually transmitted infections Anal health
Transgender people	<ul style="list-style-type: none"> Sexually transmitted infections Hormonal therapies Anal health

HOW DO WE DIFFERENTIATE BASED ON THE SPECIFIC KEY POPULATION?

ART delivery should be differentiated by considering the challenges of each specific population. As differentiated ART delivery is being designed and implemented, special attention should be given to address the common challenges faced (Table 2) rather than seeing them as barriers to implementation.

While there are challenges common to all key populations, each specific key population group will require a unique and

comprehensive package of healthcare services to address their particular needs and overcome challenges. However, the potential for an individual to require the comprehensive medical package aligned to more than one specific key population should be recognized when designing services. For example, illicit drug use may be more common among sex workers and may need to be integrated into a comprehensive service.

Table 2: Challenges and potential solutions through differentiated ART delivery for key populations

Challenges	Potential solutions through differentiated ART
Common across all key populations	
<ul style="list-style-type: none"> • Levels of stigma and discrimination in health services • Stigma and discrimination in broader communities • Gender-based violence • No funding or political support for KP programming • Violence, including law enforcement harassment and arrest • Legal status, including possible criminalization of same-sex behaviour, drug use and sex work. 	<ul style="list-style-type: none"> • Sensitization and training of healthcare professionals and facility staff • Opportunity for introducing peer support in group models or individual models, such as peer navigators and outreach workers • Creative discreet services advertised by word of mouth or social media • Confidentiality, safety and trust • Working with law enforcement • Investment in effective adapted programming for KPs • Advocate for funding and political support (even tacit support) • Monitoring and documenting human rights violations
Men who have sex with men	
<ul style="list-style-type: none"> • Fear of outing in community or family 	<ul style="list-style-type: none"> • ART delivery and psychosocial support in group or by a peer • Network of peers • Network of DSD providers for men who have sex with men
Sex workers	
<ul style="list-style-type: none"> • Timing of public ART services not convenient • Fear of outing in community or to family, including fear of losing work • Migration, movement 	<ul style="list-style-type: none"> • Adaptation of time of clinic according to sex worker needs • Integration of sexual and reproductive health, including family planning into HIV services • Network of peers • Network of DSD providers for sex workers
Transgender people	
<ul style="list-style-type: none"> • Transition care, including hormone treatment and potential interaction with ART • Legal identity different from physical appearance 	<ul style="list-style-type: none"> • Training on providing transition care, including hormone therapy and potential interactions with ART • Sensitivity and training around gender, sexuality and diversity
People who inject drugs	
<ul style="list-style-type: none"> • Drug use and, if on OST, potential interactions 	<ul style="list-style-type: none"> • Combine with OST in clinical settings or NSP in community settings (CBO, outreach, DICs, etc.) • Peer counselling and orientation

HOW DO WE DIFFERENTIATE BASED ON CONTEXT?

For each key population, services may need to be differentiated in different ways depending on the numbers of the key population present and whether the setting is urban or rural. Where numbers are not high enough to support a standalone service, key population members should still be able to access existing service delivery models available for the general population.

The political or legal framework, such as criminalization of same-sex relationships, selling sex, drug use and/or the level of social acceptance and rejection of particular KPs, is also an essential contextual issue to consider when

designing differentiated service delivery models. Where needed, legal support may also be integrated within the KP service. Finally, the additional contextual factor relevant to many KPs is their mobility, with many moving to a particular location for defined periods (for example, sex workers moving to construction locations) and for some moving to new areas where they will not be identified for fear of discrimination and potential violence. Adapting ART delivery services to the mobile nature of key population's lifestyles is an important consideration in differentiating ART delivery for key populations.

Case study 7:

Providing differentiated services in areas that have a low density of female sex workers, South Africa

In South Africa, a CSO works closely with health facilities in predominantly small towns and rural areas by employing part-time sex worker peer outreach workers and a peer coordinator. Peers visit people in their homes, do weekly night-time outreach and are involved in the training of healthcare providers and performing allocated clinic tasks to support healthcare workers. They are reaching more than 500 sex workers monthly and are able to follow up on challenges along all steps of the prevention-to-treatment cascade.

Case study 8:

Providing paralegal services within health services, Burundi

In Burundi, a CSO that focuses on human rights violations expanded its reach to include HIV services. It provides outreach services that include linkages to care, as well as treatment and legal literacy. The use of drop-in centres has been instrumental in ART delivery and psychosocial support. Peer educators and outreach workers foster social empowerment. They use social media and telephone technology to monitor situations that also allows for emergency response for arbitrary arrests and mistreatment.

Case study 9:

Providing services for female sex workers and men who have sex with men in a challenging political context, Tanzania

The Sauti project is a community-based HIV prevention and treatment initiative for men who have sex with men and female sex workers that includes positive health, dignity and prevention, the active involvement of PLHIV in the response and family planning services. It works within an atmosphere of persistent stigma and discrimination and unfriendly services for KPs.

The project includes access to a core package of tailored, quality, community and client-centred services, including combination prevention (biomedical, behavioural and structural). The implementation of the project was undertaken in phases and included the standardization of materials, competencies and procedures such as training, training aides and monitoring tools. Vital aspects of the project have been strategic partnerships and the involvement of PLHIV in health service delivery. KPs were integrally involved in mapping, consultation, planning, implementation and monitoring. The innovative use of social media and data dashboards has been a key aspect of its success. The project recently added PrEP and self-testing to its services.

CRITICAL ENABLERS

Practical guidance documents on how to implement comprehensive programming for key populations have been developed for men who have sex with men¹¹, people who inject drugs⁹, sex workers¹¹ and transgender people¹⁰.

WHO also provides recommendations on the critical enablers that should be addressed when developing any service for key populations. Figure 4 outlines these critical enablers².

Figure 4: WHO Critical enablers to improve access to HIV services for key populations²

CRITICAL ENABLERS
Laws and policies
Moving towards decriminalizing the behaviour of key populations Age of consent to services Recognition of transgender people in the law Access to justice and legal support for key populations
Stigma and discrimination
Anti-stigma, antidiscrimination and protective policies Provision of “key populations friendly services” Training and sensitization of health workers
Community empowerment
Programme led by key population organizations Meaningful participation
Violence against key populations
Prevention of violence against key populations Support for persons experiencing violence

Case study 10:

Female sex worker peer educators, Zimbabwe

In Zimbabwe, a programme was set up in 2009 to use female sex worker peer educators to mobilize and empower sex workers and help link them to health services. They provide a variety of services, including STI management, condom distribution, HIV testing, referrals for ART and PrEP and adherence support. Their training includes paralegal training and child protection services. Data is collected electronically using unique identifiers.

Case study 11:

Rights and services for sex workers, Macedonia

In Macedonia, a sex worker-led organization, originally set up as a rights organization, mobilizes community members to participate in service delivery. The group provides outreach testing and counselling services with a mobile van in collaboration with the ministry of health. It provides navigation to health services where facility workers have been trained and sensitized. Trust in services has increased over time. The group also advocates with partners for DSD and other services for sex workers.



PART 4

ASSESS WHETHER TO ADAPT OR BUILD A MODEL OF DIFFERENTIATED ART DELIVERY

ADAPT OR BUILD

Before building a new model of differentiated ART delivery, it is crucial to first ask two questions to assess if there are existing programmes that could be adapted and leveraged to support differentiated ART delivery for key populations.

Question 1: Is there an existing HIV or health intervention being delivered for key populations that could be adapted?

Before developing a new model of differentiated ART delivery, it is crucial to assess who is currently providing services to key populations. In many instances, there may be existing community-based organizations

(CBOs) who are offering HIV, health or psychosocial interventions. Leveraging these existing programmes to include include for example distribution of ART refills could support less frequent visits at the health facility.

Case study 12:

Expansion of KP drop-in centres for men who have sex with men and sex workers to include ART initiation and distribution through LINKAGES, Kenya¹⁹

In Kenya, the USAID-funded LINKAGES programme supports the provision of services in 16 counties for female sex workers, men who have sex with men and male sex workers. Recently, drop-in centres (DICs) offering psychosocial support, HIV prevention and testing services have expanded to include rapid initiation and ART delivery to their clients. Since October 2017, Family AIDS Initiative Response, an NGO serving female sex workers in Nakuru and Narok counties, has a clinician who comes to the DICs to support ART initiation and delivery on specific days, supporting more than 50 female sex workers on treatment.

The ministry of health has recently accredited an additional four DICs for female sex workers, men who have sex with men and male sex workers to provide ART. Uptake at these facilities is expected to increase rapidly; 118 female sex workers and 115 men who have sex with men and male sex workers already access ART through the DICs.

Case study 13:

Providing holistic sexual health and wellness for men who have sex with men, South Africa

In South Africa, a Men4Health project provides facility-based services, including prevention and treatment. It is estimated that 50% of all direct services are non-HIV related (STI assessments, mental health visits, distribution of prevention commodities and information education communication materials). It began with one site and has now expanded to have services in every province. Services include PrEP and treatment for hepatitis C virus ART delivery is through a clinic-based system with flexible pick-up times, an example of a facility-based individual model. Thorough training and ensuring quality services has meant that the brand is accepted in the community and that the levels of community trust are high.

Question 2: Is there an existing differentiated ART delivery model that could be adapted?

As HIV service delivery becomes increasingly differentiated, ART delivery models for specific populations may already have been planned and implemented. When considering a specific key population, different clinical characteristics or a changing context, an important step is to assess whether one or more of the existing models could be adapted to meet the needs of that population instead of building a new model.

Where a model is already understood, implemented and functioning within the health system, adaptations, minor or major, are often easier to undertake than implementing a new model. Also, there may be peer support, peer testing and linking or psychosocial interventions that could be adapted to include ART delivery.

With key populations, social issues related to stigma and discrimination must be taken into consideration in adapting existing models. It may require rigorous sensitization and training, as well as an ongoing system to ensure ongoing training where the workforce may be regularly changing.

Where an appropriate model exists for adaptation, the model building blocks – “when”, “where” and by “who” the service will be provided, and any changes to the package of care (the “what”) should be used systematically to adapt the model mechanics to the new population (See Part 5).

Case study 14:

Adaptation of community client-led ART delivery, Uganda

In Uganda, The AIDS Treatment Organization (TASO) has been facilitating differentiated ART delivery for adults for more than 10 years. It has set up a number of out-of-facility community sites, known as community drug distribution points (CDDPs). It followed this by setting up another group model of ART delivery in the community, known as CCLADs or community client-led ART distribution. Recently, female sex workers at a CDDP began advocating for an female sex worker-led CCLAD.

WHEN IS IT APPROPRIATE TO BUILD A NEW ART DELIVERY MODEL FOR KEY POPULATIONS?

Where there is no model that may be adapted, then a new differentiated ART delivery model may need to be developed. Part 5 will guide you through this building process.

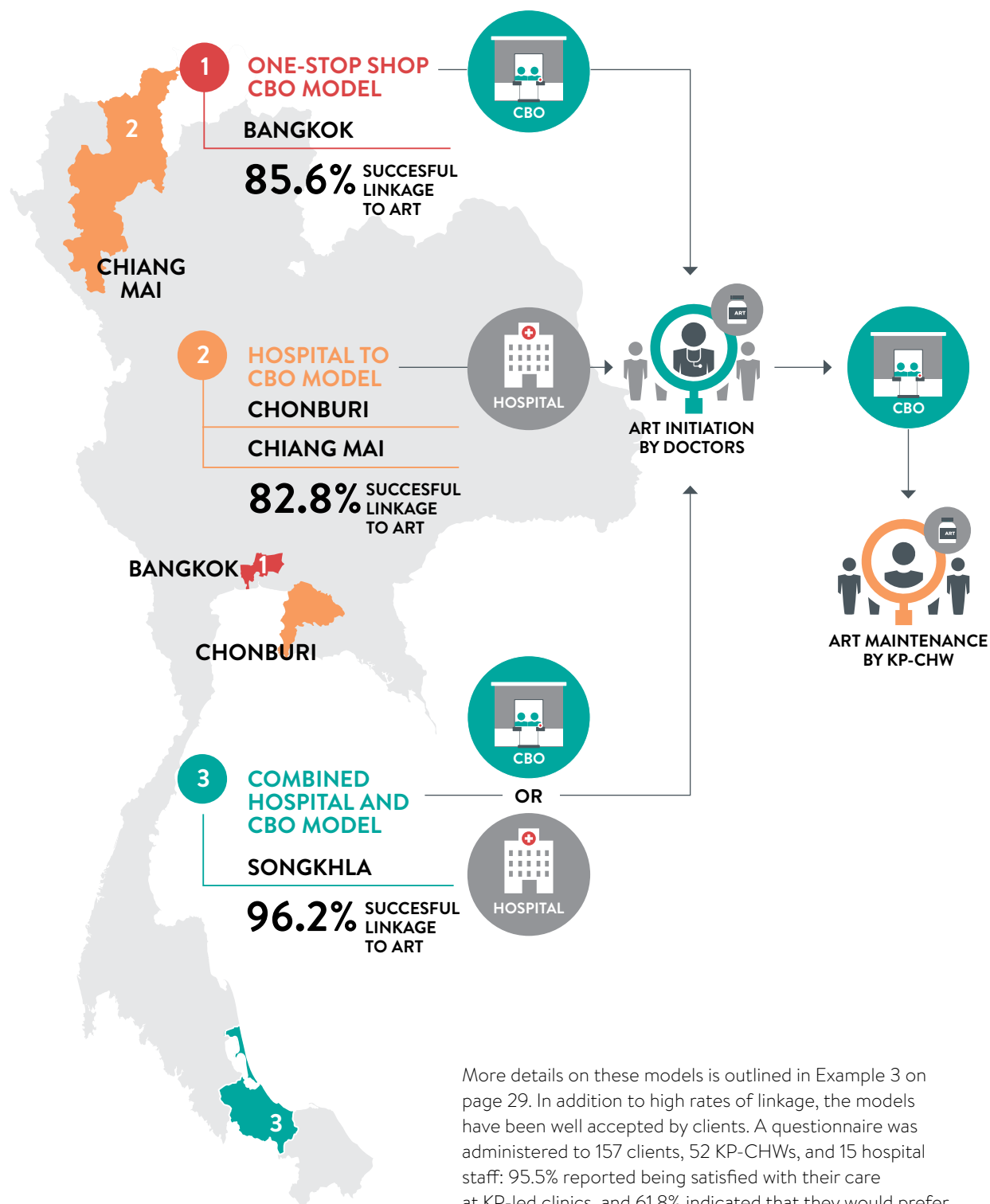
Case study 15:

Key Population-Led Health Services, Thailand

The Key Population-Led Health Services (KPLHS) Model is funded by USAID/PEPFAR through the LINKAGES Program implemented by FHI 360, and has been piloted in four provinces in Thailand. Differentiated HIV services are provided to improve HIV service uptake among men who have sex with men, male sex workers, transgender women and transgender women sex workers. These services are tailored to meet the needs of the specific population along the cascade: reach, recruit, test, treat, prevention and retain.

Figure 5 highlights the three models that were designed with CBOs to support retention among clinically stable ART clients. Clients were eligible for ART maintenance through KPLHS if they were clinically stable defined as having been on ART for more than one year, with evidence of suppressed viral load (defined as two consecutive HIVRNA results <50 copies/mL), CD4 count >200 cells/mm³, no current adverse drug reactions or opportunistic infections, no co-morbidities that need regular medical follow up, and a good understanding of lifelong adherence.

Figure 5: KPLHS models of differentiated ART delivery



More details on these models is outlined in Example 3 on page 29. In addition to high rates of linkage, the models have been well accepted by clients. A questionnaire was administered to 157 clients, 52 KP-CHWs, and 15 hospital staff: 95.5% reported being satisfied with their care at KP-led clinics, and 61.8% indicated that they would prefer ART maintenance to happen at KP-led clinics. A positive attitude towards differentiated ART delivery was reported by 82.7% of 52 KP-CHW and 86.7% of the 15 hospital staff.



PART 5

ADAPT OR BUILD DIFFERENTIATED ART DELIVERY FOR KEY POPULATIONS

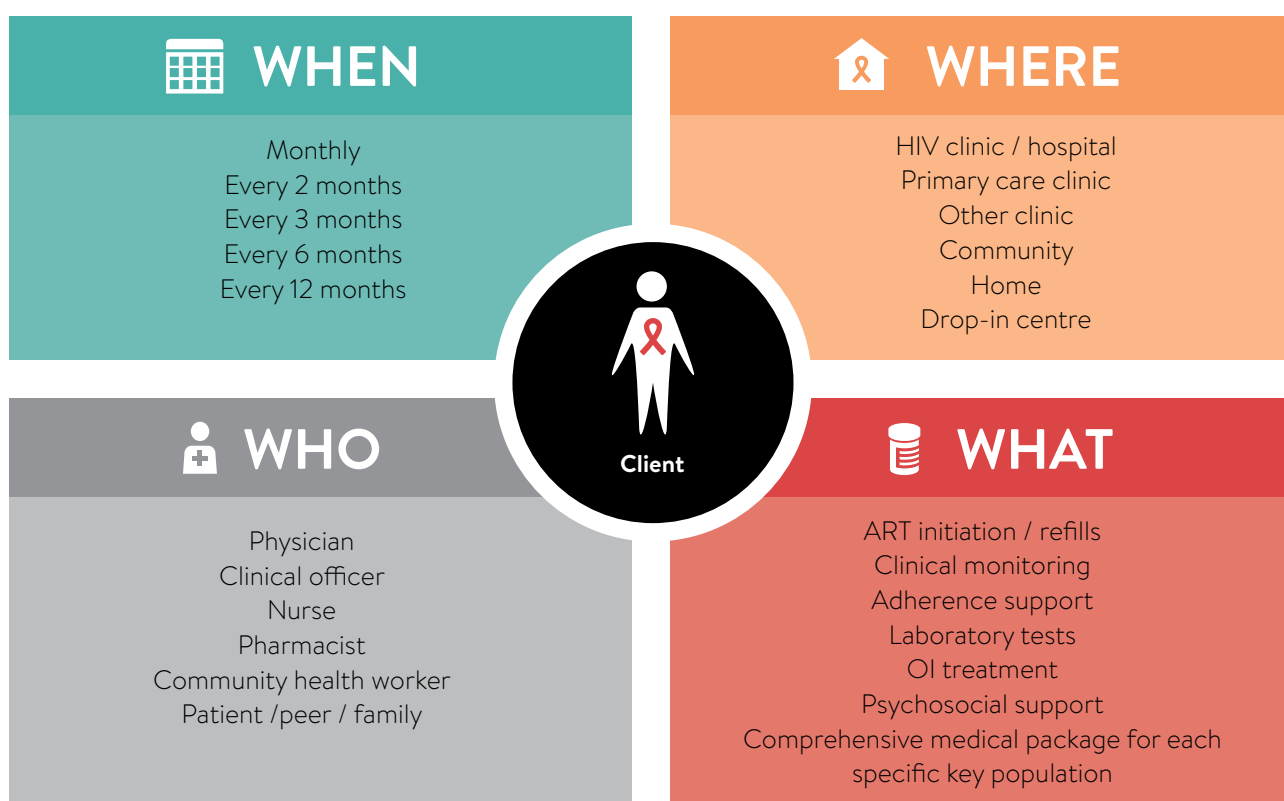
THE BUILDING BLOCKS

This section presents the four building blocks of differentiated service delivery and highlights the relevant WHO guidelines² and Key Considerations¹³ that support their use. Examples from existing differentiated models of ART delivery for specific key populations are also described. Key take-home messages related to each KP are presented. We also see our characters, Namrata, Juan, Chantal and

Ian, thinking about how their lives could be improved if the building blocks of their ART delivery were differentiated.

The building blocks are the foundation of any model of service delivery. Where is care provided (location)? Who is providing care (service provider/peer)? When is care provided (time of visit and visit frequency)? What care is provided (service package)? See Figure 6.

Figure 6: The building blocks of differentiated ART delivery for key populations



Separate building blocks may be needed for clinical consultations, ART refills and psychosocial support

The building blocks for clinical consultations, ART refills and psychosocial support may be different –clients may require more frequent psychosocial support than clinical review and some services may be more readily decentralised. Clients who are clinically stable may require a clinical consultation every 6-12 months while collecting ART refills in a simplified model more frequently (for example, 3-6 monthly). In addition, for key populations, there is a need to provide different components of the comprehensive medical package and psychosocial support.

Specific key populations, regardless of clinical stability, may be subject to isolation and social rejection and benefit from additional psychosocial support. This support may be

provided through support groups or networks (including virtual platforms) of key population PLHIV, one-on-one adherence counselling with healthcare workers or lay providers or, in some cases, home visits by lay providers.

In all models of differentiated ART delivery, the client is at the centre. It is up to the district health manager to work with healthcare workers and clients to determine the “where”, “who”, “when” and “what” building blocks of the differentiated model of care that respond to the key population and community’s most urgent needs. The stakeholders must balance the goal of improving client outcomes with the ability to make the most efficient use of the available health system and community resources.



“WHERE” is ART provided?

Decentralizing services closer to home

For many key population clients, physical access to ART remains a challenge. The time and travel costs of getting to the clinic, long waiting times and persistent issues of stigma remain barriers to retention and sustained viral suppression. Decentralizing HIV care, including for key populations, means taking the services closer to the client’s home, either to a facility closer to home or, ideally, to some place within or near the client’s community, such as a drop-in centre or key population hot spot. This strategy can reduce both the burden on clients and relieve congestion at centralized sites. Decentralization may be feasible for ART refills and psychosocial support, while clinical consultations may be most appropriately provided at health facilities.

How far to decentralize varies according to context

Many members of key populations want to have the assurance of discreet service delivery, privacy and confidentiality. Issues of criminalization, stigma and discrimination must be evaluated when determining where clinical consultations and ART refills are provided. In rural areas, decentralization can reduce the difficulty and cost of travel, shorten waiting times and provide safer, discreet and more accessible healthcare options. However, the client should always have the choice of where they would like to receive their care.

In addition, due to the specialized nature of some of the comprehensive medical package required, it may not be appropriate to decentralize all services to all sites within a district. Often there is a higher burden of KPs in a particular geographical location, which should guide where services are prioritized.

Integration of services

Ideally the comprehensive medical package for each key population group should be provided as a “one-stop-shop” service. This prevents miscommunication between services and should prevent drug interactions. Where this one-stop service is provided is an operational/strategic decision. Services for key population members may be integrated within an existing ART clinic, as a standalone clinic within an existing health facility, or standalone in a community-based or mobile facility.

However, there are instances where integration may not be the best choice for the client. For example, a KP client already receiving their ART delivery through a group may prefer to continue in this model while accessing the other



WHO Guidelines

Box 4: Recommendations on decentralization

Decentralization of HIV treatment and care should be considered as a way to increase access and improve retention in care:

- Initiation of ART in hospital with maintenance of ART in peripheral health facilities
- Initiation and maintenance of ART in peripheral health facilities
- Initiation of ART at peripheral health facilities with maintenance at the community level.

elements of their medical care at a separate specialized service. Integrating HIV and other health services into one facility-based programme may or may not be seen as a positive change. Consistent with the principles of differentiated service delivery, clients should be given the choice of where to access both ART and the components of the comprehensive medical package.

Case study 16:

Decentralization of HIV care for men who have sex with men in Guatemala City

HIV care for men who have sex with men in Guatemala City was provided at central hospital sites. In 2017, ART delivery was tailored for men who have sex with men and offered at three decentralized sites, two run by an NGO and one run by the MoH. Of the 276 men who have sex with men who were offered the option to decentralize their care closer to home, 47% accepted. The majority preferred to attend the NGO-run clinic. At the end of study follow up, among those at the NGO-run clinic, 98% were retained in care. Median duration of the decentralized visits was 30 minutes compared to 4-5 hours at the centralized clinic. Over 90% of participants across the three clinics considered the care they received to be “excellent”.

Example 1:

Community-based ART delivery for people who inject drugs, India

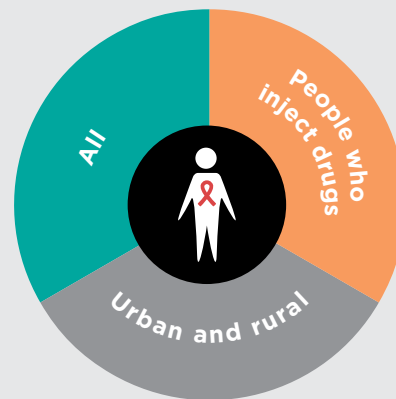
Overview

Injecting drug use is the primary driver of the HIV epidemic in the northeast region of India. India's National AIDS Control Organization (NACO) implements targeted interventions: peer-led, community-level prevention programmes for key populations, which are operated by NGOs. Project Sunrise, implemented by the CDC and FHI360 in collaboration with NACO, supports these programmes in selected districts by providing a package of services to people who inject drugs, including harm reduction, STI screening and linkage to HIV testing and ART centres. Project Sunrise employs field mentors to network with the community, NGO outreach teams and service providers to deliver services to people who inject drugs.

After India's adoption of "treat all" in 2017, the project implemented a strategy to support ART initiation among registered KP PLHIV care organizations and improve access to ART by providing refills at services offering OST.

Field mentors have been employed to network with the community, NGO outreach teams and service providers to reach people who inject drugs. Project Sunrise is an example of out-of-facility individual model of ART delivery.

The three elements of Project Sunrise



The building blocks of the delivery of Project Sunrise's services, India

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	Monthly	6 monthly	Monthly, as required
WHERE	Community sites providing OST	ART centres	Community sites providing OST
WHO	Peer field mentors for outreach Clinical staff for ART dispensation	Clinicians	Peer mentors
WHAT	Navigation, needle and syringe programme, condoms, counselling, HIV screening, ART dispensing, OST	Clinical assessment Laboratory examinations	Psychosocial support

Over six months, preliminary results show that field mentors reached 1,123 PLHIV, navigated 444 PLHIV to ART centres and documented ART initiation in 396 PLHIV. To further

enhance ART initiation among KPs, Project Sunrise recently initiated pilots involving co-location of ART dispensation at three intervention sites providing OST.

WHERE: Key Considerations

Box 5: Location of visits¹³

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHERE	CBOs Primary healthcare Hospitals	Hospitals Primary healthcare CBOs OST clinics*	CBOs OST* Phone hotlines

*For people who inject drugs



“WHO” is providing differentiated ART delivery?

The importance of task sharing

ART delivery for key populations may be provided by doctors, clinical officers, nurses, lay providers and peers. In settings with human resource constraints, a wider range of task sharing may be appropriate. Assessing the regulatory frameworks that may support or block appropriate task sharing, including the role of KP peers, is an important part of the situation analysis. Box 6 outlines WHO’s recommendation on task sharing and Box 7 outlines the role of peers as providers.

Healthcare workers

WHO recommends task sharing among healthcare workers to provide clinical consultations and ART refills, and this approach should be considered in the provision of KP services. In some settings, the same healthcare worker who delivers ART may be able to deliver other clinical services (where possible, this should be the goal); however, in other settings, a different clinician with specialist training may have to implement this (e.g. OST). Provision of the comprehensive medical package may also mean that key populations require more frequent interactions with a medically trained healthcare provider.

Healthcare workers should also be trained to provide psychosocial support and to screen for and treat or refer clients presenting with mental health conditions.



WHO Guidelines

Box 6: Recommendations on task shifting and task sharing^{3,16}

Trained and supervised lay providers can distribute ART to adults, adolescents and children living with HIV.


- Trained non-physician clinicians, midwives and nurses can initiate first-line ART.
- Trained non-physician clinicians, midwives and nurses can maintain ART.
- Trained and supervised community health workers can dispense ART between regular clinical visits.

The role of key population peers

The role of peers in the provision of ART services for all key populations has been shown to improve retention and adherence to ART. Key population peers may be engaged in ART delivery models to support distribution of ART (by facilitating group refill models at the facility or in the community; or delivering ART to community ART groups with the client’s consent), provide psychosocial support and trace clients who have missed appointments. In addition to supporting treatment literacy and adherence to ART, engaging peers allows clients to address, with someone with shared experiences, the challenges of stigma, discrimination and related legal and social barriers key populations face.

WHO: Key Considerations

Box 7: Provider of key populations services

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
 WHO	Lay providers, peers, outreach workers, healthcare workers	Nurses, midwives, clinical officers, doctors	Social workers, lay providers, peer navigators, outreach workers, healthcare workers



Chantal thinks: I really appreciate the support I receive from the peer counsellor when I collect my ART refills at the drop-in centre. She understands the challenges that I have faced.

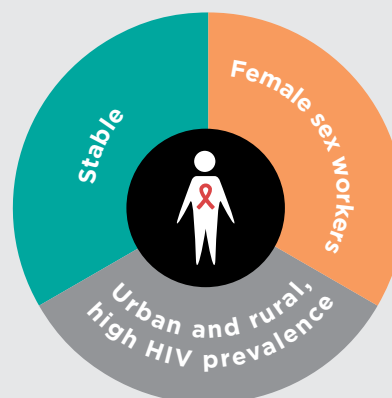
Example 2:

Female-sex worker led ART delivery, Uganda

Overview

In Uganda, The AIDS Support Organization (TASO) has been providing differentiated ART delivery for more than 10 years. ART distribution was first decentralized to community drug distribution points (CDDPs). In 2017, a group of female sex workers advocated for female sex worker-led community client-led ART delivery (CCLAD), a model that was similar to one developed for adult stable clients in the communities. A CCLAD includes grouping sex workers from a geographical area into a peer support group of five to ten members. The group selects a peer leader who is responsible for collecting 3-monthly ART refills from the nearest CDDP. The peer leader then distributes the refills to the CCLAD members at the agreed venue, documents the distribution and monitors the treatment among her peers. The female sex worker-led CCLAD is an example of a client-led group model of ART delivery.

The three elements for female sex worker CCLADs



The building blocks of CCLADs for sex workers, Uganda

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	Every two months, 6 times/year Flexible service hours, decided by the group	Semi-annually (2 times/year)	At each clinical visit; within the group at each refill Additional support as required
WHERE	Community: community drug distribution point (CDDP)	Primary care clinic	Community
WHO	Group-nominated female sex worker peer leader distributes pre-packed ART	Doctor or clinical officer	Group-nominated female sex worker peer leader
WHAT	ART refill distribution, peer psychosocial support, peer adherence monitoring, psychosocial support	Nutrition monitoring, adherence measurement, TB screening, STI screening, OI examinations if any, lab investigation (VL and CD4), weight monitoring, mental health screening, dosage adjustment as required	Peer psychosocial support

Between October 2016 and June 2017, a behaviour change campaign reached more than 7,000 female sex workers. A total of 5,775 HIV tests were completed and 525 people living with HIV were identified (positivity rate = 9.1%). Of those identified as HIV positive, 81.5% (n=428) were linked to

care and 23.6% of those linked to care were initiated on ART (n=124). Over the same period, a cumulative number of 215 female sex workers were in care, with 89.8% on ART, of which 90.9% were virally suppressed. To date, all the 24 female sex workers in the four CCLADs are virally suppressed.

“WHEN” is ART delivered?

Extending or adapting service hours

In most resource-limited settings, ART is available to be collected only during clinic hours. Consideration must be given to availability of key population members, confidentiality and trust. Alignment with visits by family members should apply to key population members with children and others in their support network. Having special evenings or weekends for key populations may be appropriate in some cases.

Adapting the timing of services is a simple way to address access issues for specific key population clients. For example, providing refills for sex workers in the early evening will allow them to miss less work.

Reducing the frequency of ART refills and clinical visits

Reducing the frequency of visits is an efficient way of alleviating the burden on both the client and healthcare system. A key principle, linking all models of differentiated ART delivery, is separating “refill-only” visits from visits that require clinical and/or laboratory assessment. If stable clients can be seen six monthly, then for the intervening period,

the client should be able to limit their interactions with the health system to obtaining their resupply of medication (the maximum agreed refill duration should ideally be 3-6 months) and accessing desired psychosocial support. For key populations, there may be a need for additional clinical visits to provide the comprehensive medical package (for example, OST for people dependent on opioids and sterile needles and syringes for people who inject drugs). ART refill may be provided through one of the four common refill models described or an adaptation of those. Clients do not need to have a clinical interaction during a refill visit.

Utilizing the maximum duration of ART refills

Depending on local regulations, the appropriate authority (for example, national, district or facility) should inform healthcare workers about the maximum duration that an ART refill can be given (1 month, 3 months, 6 months, etc.) and whether there are any special circumstances. Special circumstances may include holidays or if the client is moving to another location for a period to seek work. This guidance will determine the frequency of a key population client’s visits to collect refills.

Frequency of psychosocial support

The frequency of psychosocial support should be appropriate to the key population client’s needs. Adherence counselling is an important part of both ART initiation and an unstable client’s package of care. However, ongoing adherence counselling may not be necessary for some stable key population clients and may place an undue burden on clients, lay providers and the healthcare system. Adherence and retention has been shown to improve when clients have access to peer support either individually or as part of a peer support group²⁵.


WHO Guidelines¹⁶

Box 8: Recommendations on frequency of visits

- Less frequent clinical visits (3-6 months) are recommended for people stable on ART.
- Less frequent medication pick-ups (3-6 months) are recommended for people stable on ART.

WHEN: Key Considerations

Box 9: Frequency of visits for key populations who are clinically stable on ART¹³

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
 WHEN	Every 3-6 months	6-12 months for ART Dependant on needs for comprehensive medical package	Every 1-6 months

Example 3:

Key population organization-led ART delivery for transgender women, Thailand

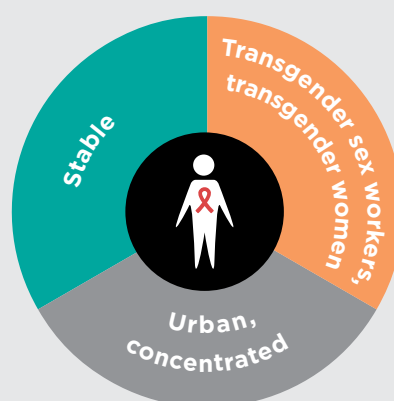
Overview

In Thailand, health service delivery models were designed to improve HIV service uptake among transgender women and men who have sex with men, and address the challenges of low rates of linkage to care and high rates of loss to follow up. In this example, details of ART maintenance for transgender women are described. Clients were eligible for ART maintenance through KP-LHS if they were clinically stable as defined in case study 15 on pages 20-21.

Three models of differentiated ART delivery were developed in collaboration with CBOs (see page 21). In the “one-stop shop CBO model”, doctors go to KP-led CBOs to support ART initiation. Once clinically stable, KP-CHWs provide support to clients for ART maintenance. In the “hospital to CBO model”, CBO staff accompanies clients to their provincial ART network hospitals for initiation and then once clinically stable, clients are referred to KP-CHWs at their CBOs for ART maintenance. In the “combined hospital to CBO model”, treatment initiation and maintenance can

occur at the hospitals, as well as at the CBO, depending upon clients’ preferences. The models are examples of out-of-facility individual models of ART delivery (see page 5).

The three elements of KP-led ART delivery



The building blocks of differentiated ART delivery for transgender women through KP-LHS , Thailand*

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	Monthly or every three months During regular business hours for doctor led visits, additionally during evenings and/or weekends for KP-CHW led visits	Every three months During regular business hours for doctor led visits, additionally during evenings and/or weekends for KP-CHW led visits	Every three months, or as needed During regular business hours for doctor led visits, additionally during evenings and/or weekends for KP-CHW led visits
WHERE	Alternately hospital and CBOs, or all visits at the CBO, depending on client preference and local circumstances	Alternately hospital and CBOs, or all visits at the CBO, depending on client preference and local circumstances	Alternately hospital and CBOs, or all visits at the CBO, depending on client preference and local circumstances
WHO	Alternately doctors and KP-CHWs	Alternately doctors and KP-CHWs	Care and support officers (CSOs)
WHAT	Doctors: ART rescripts, clinical consultation KP-CHWs: ART refills, comprehensive health check, adherence check and counselling, and referral to doctor as needed	Doctors: ART rescripts, clinical consultation KP-CHWs: comprehensive health check, adherence check and counselling, and referral to a doctor as needed	CSOs: psychosocial support, safe sex counselling and referral for additional counselling if needed

Between May 2015 and October 2016, 784 TGW were tested for HIV, 83 (10.6%) were HIV-positive and 68 (81.9%) started ART. Viral suppression was achieved by 46 of 50 clients (92%) in care at month 6. By March 2018, 19 of 50 patients on ART were stable, 16 were still in follow up and were

offered ART maintenance by KP-community health workers (KP-CHW) at KP-led clinics. Ten (62.5%) TGW agreed to be seen by KP-CHWs, while six (37.5%) preferred to receive ART maintenance elsewhere. No adherence or clinical concerns that warranted referral back to hospitals have occurred so far.

*The KPLHS model is funded by USAID/PEPFAR through the LINKAGES program implemented by FHI360, and is delivered through the following CBOs: Rainbow Sky Association Rainbow Sky Association Thailand (RSAT) in Bangkok and Songkhla, Service Workers IN Group Foundation (SWING) in Bangkok and Chonburi, SISTERS in Chonburi, and Caremat and M-plus in Chiang Mai.



“WHAT” services should be offered?

Key population clients need clinical, ART refill and psychosocial support visits

Once defined as stable, the client still requires the following types of visits. These may be provided separately or, depending on frequency, combined:

- ART and drug refill visits
- Clinical visits, including
 - Laboratory investigations where needed
 - Comprehensive key population specific medical package and other specific health issues
- Psychosocial support, including adherence support, and support to address legal barriers.

Clinical visits should assess the success of ART treatment through taking history and clinical examination and review of viral load monitoring tests. It is the frequency of these visits that change once clients are defined as clinically stable. Key populations may require more psychosocial support than other populations and this may be the only reason for specific visits.

Key populations may require additional services


In addition to the services related to HIV, all key populations should receive the evidence based comprehensive package outlined by WHO³ (see Annex 4). The frequency of these medical services may be required more or less often than the clinical HIV review, but where both are needed, ideally the client should receive them in the same clinic, on the same day and from the same healthcare worker.

The importance of effective referral systems from ART refill and psychosocial service providers

Where ART refill visits and/or peer support are provided separately, it is essential to have a referral system between the lay providers who manage the ART refill or psychosocial support and providers of clinical care. With less frequent clinical contact, lay providers have more responsibility for providing screening and referral. Screening can be informal, based on the lay provider or key population client’s own assessment of well-being, or more formal, utilizing a structured symptom and/or adherence tool. Confidentiality is imperative.

WHAT: Key Considerations

Box 10: Package of care¹³

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
 WHAT	ART refill Referral check Adherence check Prevention	Clinical consultation Laboratory tests Rescript Prevention Comprehensive services	Peer support Legal support Responding to violence Social interventions Psychological interventions

Ian thinks: I now access OST at a community centre with the support of a nurse. I can also get my ART at the community centre and it works so much better to get everything I need in one place.



Example 4:

Integration of ART delivery into KP services, Haiti

Overview

To improve access to and support for uptake of HIV prevention, testing, treatment and care for men who have sex with men and female sex workers, the LINKAGES project in Haiti integrated ART delivery within nine pre-existing KP-focused service delivery sites in October 2016. Previously, those who tested HIV positive at one of the centres or during mobile testing were referred to public and private ART facilities. At each KP-focused facility, the healthcare team includes medical doctors, nurses, lab technicians, a psychologist, pharmacist and social workers. Staff also undergo training on the provision of KP-friendly services to ensure that KPs are able to access existing services without fear of stigma and discrimination¹⁹.

The three elements of integrated ART at key population service delivery sites



The building blocks of differentiated ART through integration into key population focused sites, Haiti

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	Every two to three months	Every three months During regular business hours for doctor led visits, additionally during evenings and/or weekends for KP-CHW led visits	Every two to three months More frequently if required
WHERE	KP-focused service delivery site Community/home	KP-focused service delivery site	KP-focused service delivery site Community/home
WHO	Multidisciplinary team including peers	Multidisciplinary team	Multidisciplinary team including peers
WHAT	ART refill, peer support, safe space	ART rescripts, clinical consultation, comprehensive health check	Psychosocial support, referral for additional counselling if needed, safe space

Following the introduction of ART provision at these nine sites, dramatic improvements have been observed in linkage to care and rates of ART initiation. At the three sites supporting men who have sex with men, ART initiation has increased from 18% to over 70% and in one quarter reaching 94%. In the six sites supporting female sex workers, ART initiation has increased from 17% to above 90% in the most recent quarter¹⁹.

Peer navigators are now an integral part of not just psychosocial support but also responsible for delivery of ART. Clients can request community or home-based ART refills from peer navigators if they have challenges in visiting the sites due to distance or busy schedules.

CONCLUSION



CONCLUSION

Key populations often encounter barriers to accessing HIV services. The principles of DSD and differentiated ART delivery should be expanded to improve outcomes for key populations while reducing unnecessary burdens on healthcare workers and the health system. DSD should be based on the local context and be sensitive to the needs of local specific key populations.

Specific services for key populations have already been differentiated with data indicating a positive impact on ART outcomes. Documenting such strategies with the outcomes and challenges is critical for decision makers to make future investments in DSD for key populations and for ministries of health to make such services sustainable.

Differentiated ART delivery for key populations should not be limited to clients who are clinically stable. DSD can be a way of increasing access to HIV services for key populations and then offering choices for service delivery models based on clinical needs and individual preferences. A differentiated service delivery approach should also be applied across the care continuum – with differentiated approaches to prevention (for example, delivery of PrEP), testing, linkage, ART initiation and care.

DSD for key populations should ensure existing differentiated ART models are accessed by key populations and look for opportunities to adapt existing key population services to include ART delivery.

The where and who of differentiated ART delivery are particularly important to address, through decentralization of ART delivery to the community and the inclusion of peers in service delivery.

This framework is best used in parallel with the Key Considerations and the *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Tools and best practices are available at www.differentiatedservicedelivery.org. We welcome your feedback.

Please email us at dsd@iasociety.org and visit www.differentiatedservicedelivery.org for more details.

With differentiated ART delivery for key populations ...



Andrew worked successfully with NGOs and key population representatives to implement a training plan to better utilize peer navigators. Access to services for key populations has improved in his district.



Namrata takes turns with a peer network of fellow sex workers to collect ART refills for each other. She is happy as she only needs to visit the clinic for clinical consultations and her viral load is undetectable.



Juan now receives his ART refills at the drop-in centre. He is receiving training to be a peer counsellor.



Ian receives his ART and OST at the same place and has not had any major health issues since his care has been integrated.

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ANNEXES



ANNEX 1:

Key reference documents on key populations and HIV

World Health Organization. *Policy brief: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, 2016 update. Geneva, Switzerland: World Health Organization; 2017. <http://www.who.int/hiv/pub/toolkits/keypopulations-2016-update/en/>

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ANNEX 2:

Online annexes available to support implementation

Available at <http://bit.ly/2sVehV5>

- Online Key Populations Annex 1: Template for mapping common examples of differentiated ART delivery at a national level
- Online Key Populations Annex 2: Facility-level questionnaire for baseline assessment of differentiated ART delivery
- Online Key Populations Annex 3: Using participatory mapping to assess service catchment and coverage. Guidance from the Iringa participatory mapping exercise.
- Online Key Populations Annex 4: Programmatic mapping readiness assessment for use with key populations

ANNEX 3:

Audit of current legislation and policy checklist²⁴

Adapted from “Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key population”. 2015.

1. Does current legislation and policy include any of the following, which may negatively impact key populations and efforts to address HIV?
1.1 Laws criminalizing behaviours of key populations, including: sex acts between consenting adults of the same gender; anal sex between consenting adults; involvement in sex work by consenting adults; “cross dressing” or “gender impersonation”; drug use or possession of drugs for personal use
1.2 Legislation defining homosexual and heterosexual ages of consent as not equal
1.3 Laws or policing practices criminalizing or preventing the distribution of condoms or information on condom use and safe sex
1.4 Laws criminalizing the carrying of condoms; or policing practices where carrying condoms can be used as evidence of sex work (if sex work is illegal)
1.5 Laws or policing practices criminalizing or preventing the distribution of injecting equipment and information on safer injecting practices
1.6 Laws or policies making provision for mandatory HIV testing of key populations
1.7 Laws or policies making provision of mandatory testing in prisons or for the segregation of prisoners living with HIV
2. Does current legislation and policy include any of the following, which are supportive of the rights of key populations and efforts to address HIV?
2.1 The National HIV Strategy, which specifically addresses key populations
2.2 Laws that protect against human rights violations and discrimination (generally – not specific to HIV or key populations)
2.3 Laws that protect against human rights violations and discrimination on the basis of sexual orientation, gender identity, engagement in sex work or drug use
2.4 Legislation that requires people in prisons and other closed settings have access to healthcare of equal standard as that available in the community
2.5 Laws that recognize sex work as work
2.6 Laws that criminalize all forms of exploitation and victimization, consistent with international law
2.7 Laws that regulate occupational health and safety conditions to protect sex workers and their clients
2.8 Regulations allowing transgender people to easily change their names officially and to acquire legal recognition and identification acknowledging their chosen gender identity
2.9 Laws that unambiguously support the provision of maintenance opioid substitution therapy and needle and syringe programmes

Comments:

The items listed in this checklist can be used as a guide when conducting an audit of current legislation and policy to identify laws and policies that might either support or negatively affect the rights, health or welfare of men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers or transgender people. An audit of this kind should be undertaken with the participation of government, civil society and community-led networks, and organizations of key populations.

ANNEX 4:

Summary of WHO recommendations concerning key populations health sector interventions³

HIV prevention	<ul style="list-style-type: none">• Correct and consistent use of condoms• PrEP offered to KPs with substantial risk of acquiring HIV• PEP offered after potential exposure to HIV• Voluntary male medical circumcision in high-prevalence settings for men who have sex with women
Harm reduction	<ul style="list-style-type: none">• All people who inject drugs should have access to sterile injecting equipment• Access to OST• Access to evidence-based intervention• Emergency management of overdose
HIV testing and counselling	<ul style="list-style-type: none">• Routine offering of voluntary testing and counselling in clinical and community settings
HIV treatment and care	<ul style="list-style-type: none">• KPs should have the same access to and management of ART as other adults• Pregnant KPs living with HIV should have access to ART
Prevention and management of co-infections and co-morbidities	<ul style="list-style-type: none">• Access to TB screening, diagnosis and treatment• Access to viral hepatitis B and C screening diagnosis and treatment• Routine screening and management of mental health disorders (depression, psychological stress, etc.)
Sexual and reproductive health	<ul style="list-style-type: none">• Screening, diagnosis and treatment of STIs• Full pleasurable sex lives, including a range of reproductive options• Options and services for termination of harmful pregnancies• Cervical cancer screening for female KP• Access to conception and pregnancy care for female KP

SPECIAL THANKS

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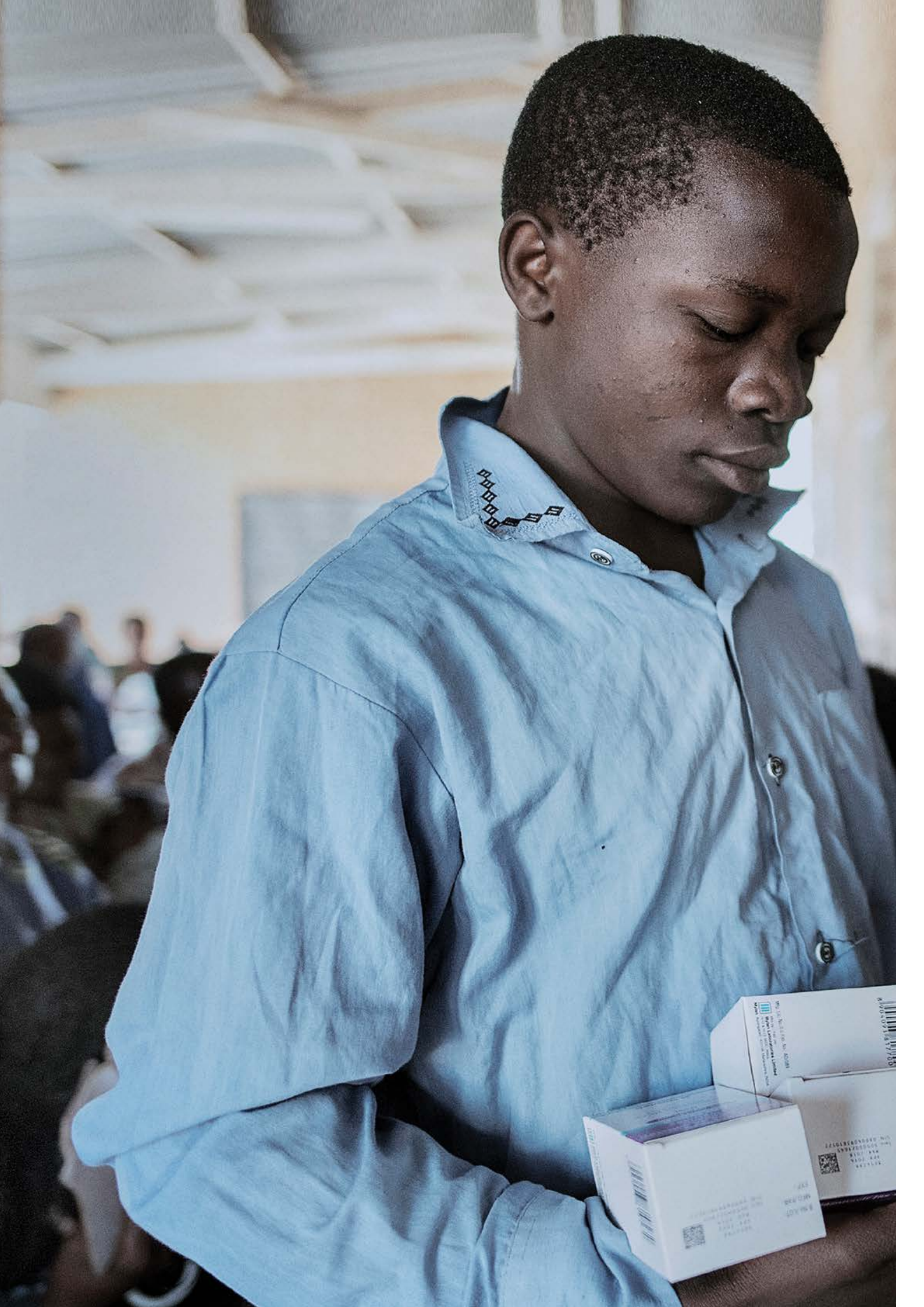
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Follow these characters as they find solutions to common challenges in HIV care

I do not understand the high prevalence of HIV among key populations or the effects of stigma and discrimination on health outcomes for these individuals.



Andrew, a district ART manager

I want to be able to get all my health needs met in one place.



Ian, a person who injects drugs

No one at the clinic is able to address my needs.



Chantal, a transgender woman

I don't know how to disclose my HIV status or tell my friends about my sexual identity.



Juan, a man who has sex with men

I am afraid to go to my local HIV clinic for fear that someone will see me – either a potential client or someone from my family.



Namrata, a female sex worker