

BRIDGING THE GAPS

Health and rights for key populations

ENGAGING AND REACHING OUT TO UNDERSERVED KEY POPULATIONS



Lessons learnt and best practices from the Bridging the Gaps programme



BRIDGING THE GAPS

Health and rights  for key populations



The Bridging the Gaps programme addresses the human rights violations and challenges faced by sex workers, people who use drugs, and lesbian, gay, bisexual, and transgender (LGBT) people, in accessing HIV and other essential health services. The Bridging the Gaps programme works with more than 90 local partner organisations which collaborate with four Dutch non-governmental organisations: Aids Fonds, AIDS Foundation East-West (AFEW), COC Netherlands, and Mainline, and with five global networks: the Global Network of People Living with HIV (GNP+), the International Network of People who Use Drugs (INPUD), the International Treatment Preparedness Coalition (ITPC), the Global Forum of MSM and HIV (MSMGF), and the Global Network of Sex Work Projects (NSWP).

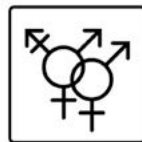
3 KEY POPULATIONS:



SEX WORKERS



PEOPLE WHO USE DRUGS



LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

1 MISSION:

OUR MISSION IS TO ACHIEVE UNIVERSAL ACCESS TO HIV/STI PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATIONS

BRIDGING  THE GAPS

BY LINKING:

COMMUNITY WORK WITH GLOBAL ADVOCACY

3 KEY POPULATIONS

HUMAN RIGHTS AND HEALTH

ABOUT THIS DOCUMENT

It is widely acknowledged that marginalised populations are the most vulnerable to HIV, but there is little consensus on how to engage them. Outreach is a frequently used method, and is recommended by the WHO as a vital addition to interventions within the healthcare system.

This document describes good practices and the lessons learnt from local partner organisations of the Bridging the Gaps programme, regarding how they have engaged and reached out to underserved key populations. These good practices and the lessons learnt were identified in programme documents from 2012-2015, and in operational research conducted in 2014 and 2015 in Kenya, Kyrgyzstan, Ukraine and Vietnam. Operational (or implementation) research aims to improve programmes. It seeks to find out how to optimise programme inputs (e.g. personnel, supplies) and processes (e.g. training, supervision, promotion of services)¹. A total of 767 people participated in the studies (see table 1). This included members of key populations, and key informants from local partner organisations, civil society organisations, service providers (healthcare workers, outreach workers, peer educators), national and international NGOs, and Ministries of Health.

THE PURPOSE OF THIS DOCUMENT

This document describes good practices, the main lessons learnt and general principles that have been associated with successfully engaging and reaching out to key populations. In addition, it provides references for readers who would like to explore the subject in more depth (see Relevant links and resources).

WHO IS THIS DOCUMENT FOR?

This document is aimed at civil society organisations who want to learn more about outreach for key populations. The information it contains can be useful for community leaders, implementers, technical support providers and programme officers of SRHR and HIV/AIDS programmes for key populations, particularly at local partners of the Bridging the Gaps programme.

| Research respondents | People who use drugs | Sex workers | LGBT (including MSM) | Key informants | Total |
|----------------------|----------------------|-------------|----------------------|----------------|------------|
| Country case study | | | | | |
| Kenya | 28 | 39 | 28 | 34 | 129 |
| Kyrgyzstan* | 151 | 149 | 136 | 14 | 450 |
| Ukraine | 85 | NA | NA | 18 | 103 |
| Vietnam | NA | 85 | NA | NA | 85 |
| TOTAL | 264 | 273 | 164 | 66 | 767 |

* In the Kyrgyzstan country case study, 436 respondents filled in a survey, and with 91 respondents in-depth interviews were held. The other country case studies conducted in-depth interviews.

Table 1. Overview of operational research respondents

¹ WHO and Global Fund (2008). Guide to Operational Research in programs supported by the Global Fund.

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KEY TERMS USED IN THIS DOCUMENT

Key populations In the Bridging the Gaps programme, key populations are sex workers, lesbian, gay, bisexual and transgender (LGBT) people, including men who have sex with men (MSM), and people who use drugs (PWUD).

Outreach Any activity, ranging from community-led peer education to mobile health or other services, that aims to reach out to vulnerable groups who would otherwise not access information or services.

Services In the Bridging the Gaps programme, services include health, legal, information and social services. Health services are HIV prevention, treatment, care and support, and also services related to sexual reproductive health, tuberculosis, viral hepatitis and harm reduction services. Depending on the local context, vocational, psychosocial and legal care may also be provided.

Self-stigma and double stigma with self-stigma we refer to internal stigma, or internalised shame, blame, hopelessness, guilt, and fear of discrimination, not actual stigma by society. With double stigma, we refer to the stigma people may face that arises from more than one particular undesirable attribute, such as HIV, or association with a particular group or behaviour (e.g. homosexuality, using drugs, selling sex).

ABBREVIATIONS

| | |
|-------------|---|
| AIDS | Acquired immune deficiency syndrome |
| CBO | Community based organisation |
| HIV | Human immunodeficiency virus |
| LGBT | Lesbian, gay, bisexual and transgender people |
| MSM | Men who have sex with men |
| NGO | Non-governmental organisation |
| PWUD | People who use drugs |
| SRHR | Sexual and reproductive health rights |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| WHO | World Health Organization |

WHY OUTREACH IS VITAL IN THE HIV AND AIDS RESPONSE

GOAL: WORKING TOWARDS UNIVERSAL ACCESS TO SERVICES FOR KEY POPULATIONS

While many countries have scaled up HIV testing in health clinics, civil society representatives have called for more community friendly approaches, focusing on key populations who often do not attend clinics.

WHAT IS OUTREACH?

Outreach aims to contact key populations in the communities where they live and work, and to give them the information and means to reduce the risks of acquiring HIV infection related to their specific risk behaviours. Outreach programmes can differ regarding:

- Type of outreach worker: peers, current or former sex workers and drug users, volunteers, social workers and health professionals.
- Venue or location where outreach takes place: streets, bars, railway stations, motorways, crack houses, store fronts, markets, slums.
- Services provided: i.e. information, materials, medical supplies, testing, referrals.

Reaching out to underserved key populations is an important strategy for working towards universal access to health services and the fulfilment of rights. Research has shown that people are more likely to make use of community- and peer-led education and services². The WHO recommends community-based HIV testing and counselling linked to prevention, care and treatment services, in addition to provider-initiated testing and counselling. Community-led organisations can play a crucial role in meaningfully engaging key populations, linking them to services and providing ongoing care and support. Peer outreach workers can provide valuable services while linking community and health services³.

While key populations are most affected by HIV, it is stigma and discrimination in society and the healthcare system, fuelled by criminalisation of their behaviours, sexual orientation and gender identity, that often force them to hide, and causes them to be poorly reached and underserved by interventions and services. In many countries, key populations which include people living with HIV face social exclusion. This can also exclude them

from STI/HIV prevention, treatment, care and support⁴. Bridging the Gaps aims to increase their access to and uptake of services by providing accessible, affordable and acceptable services, and by reaching out to them in various ways.

“ The outreach worker is a bridge between medical institutions, human rights organisations, social services and people from the community. I wouldn't be able to approach these institutions myself without an outreach worker... ”

– LGBT person, Kyrgyzstan



² Greenall, M. (2013). Community Systems Strengthening and Key Populations: A Policy Discussion Paper for the Global Forum on MSM and HIV.

³ WHO (2014). "HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Consolidated Guidelines, July 2014".

⁴ UNAIDS (2014). "90-90-90 An Ambitious Treatment Target to Help End the AIDS Epidemic" Rep. No. JC2684. Geneva. Joint United Nations Programme on HIV/AIDS (UNAIDS).

MAXIMISING THE QUALITY OF OUTREACH

PRACTICAL STEPS FOR ENGAGING UNDERSERVED POPULATIONS

In this document we use case examples to give a detailed description of lessons learnt, divided in practical steps in line with the decision-making, planning and monitoring processes advised by the WHO⁵:

A. Understanding the situation

- Step 1. Identifying the underserved key population(s)
- Step 2. Analysing the context and needs

B. Planning and implementing the response

- Step 3. Identifying the right strategy to engage underserved key populations
- Step 4. Selecting and supporting outreach workers

C. Monitoring and evaluation

STEP 1: IDENTIFYING THE UNDERSERVED KEY POPULATION(S)

Which group of people is the least engaged in STI/HIV prevention, treatment, care and support, depends on the context and, it often concerns specific sub-groups. Regularly identifying the population(s) currently not being engaged or currently not accessing or utilising services is therefore essential. Underserved subgroups of key populations often include:

- Transgender people
- Home-based or internet-based sex workers
- Young key populations, including street children
- Key populations in detention
- Overlapping key populations, such as lesbian, gay, bisexual and transgender people who sell sex, and sex workers who use drugs.

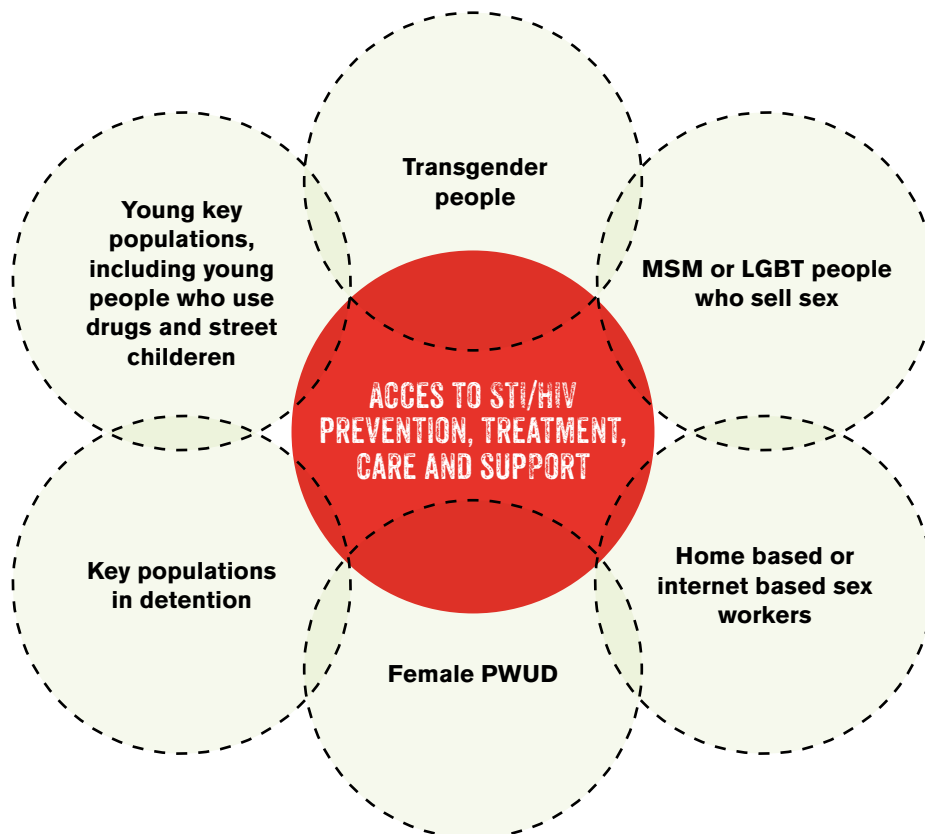


Figure 1. Examples of underserved key populations

Initial contact can best be established through peers, community leaders or gatewatchers. Making enough time to build a relationship and creating trust are crucial. Mapping social networks, meeting locations and meeting times can increase insights into how to engage and serve these populations. See the example described below.

EXAMPLE A. REGULAR LOCATION MAPPING AND UTILISING SOCIAL NETWORKS

Operational research done in Kenya⁶ indicated the need to regularly map locations and utilise social networks.

Location mapping is a community-based activity that counts the number of people belonging to a key population within defined zones. In Kenya, it has been used to locate the different places where sex workers are active, to understand the dynamics of sex workers' movements and to identify underserved groups. A programme report⁷ confirmed the need for regular re-mapping, as precisely where sex workers are active depends on business activity along the truckers' corridors. Every April, for instance, sex workers move towards areas where wheat harvesting takes place. On the basis of this, we strongly recommend conducting re-mapping regularly, perhaps even on a monthly basis, to identify new locations and watch the movement patterns of particular groups. Although this aspect of key populations can be challenging, it also provides an opportunity for peer educators to spread information on services and introducing safe practices to underserved people at the new location. Community-based services might benefit from increasing the number of outreach workers or exploring new ways to do outreach. A promising method utilising social networks is based on respondent-driven sampling, a strategy that has proved to be an efficient method for engaging marginalised populations in research⁸. Evidence from another study shows that this kind of mapping increases the accessibility of healthcare services to sex workers because they trust their peers and therefore also the information they are given about where and when to access the services. After peer educators have been trained to do outreach, they visit new locations to provide services or pass on knowledge about services to sex workers⁹. Peer-led outreach has several advantages, regarding knowledge, contacts and language. Peers are familiar with certain terms, trends and needs. The resourcefulness of this approach is demonstrated by the fact that peer outreach workers make use of already existing social networks to recruit and educate their peers. Because of their 'insider' status, they are also effective in identifying and addressing any myths and misinformation that may circulate within networks¹⁰.

DID YOU KNOW?

A social network analysis of collaboration dynamics within Bridging the Gaps partner organisations showed that specific people or small organisations may be reaching populations not being reached by bigger organisations. It is therefore crucial that key population organisations collaborate more closely and utilise each other's social networks, to engage underserved populations with a comprehensive package of services¹¹.

HELPFUL RESOURCES

WHO

Guidelines on estimating the size of populations most at risk to HIV. Geneva, WHO, 2010.

UNAIDS

Information and resources on epidemiology, country progress reports and response tools. Including an online database with information on key population characteristics per country.

Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J. Brozek, I., Hughes, C. (2014). Reaching the hard-to-reach: a systematic review for improving health and medical research with socially disadvantaged groups. BMC Medical Research Methodology 2014, 14:42

5 WHO (2014). "HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Consolidated Guidelines, July 2014".

6 Igonya, E. K., & Echoka, E. (2015). Reaching key populations and improving their access to HIV services in Kenya: Lessons from the Bridging the Gaps programme. See www.hivgaps.org

7 Aids Fonds (2015). Bridging the Gaps: Narrative mid-year report on sex workers in Uganda, Vietnam and an East Africa truckers' corridor.

8 Johnston, L.G. & Sabin, K. (2010). Sampling hard-to-reach populations with respondent driven sampling. Methodological Innovations Online. 5(2) 38-48.

9 Ruisendaal, E. (2015). Integrating healthcare services for sex workers. A qualitative study in Uganda, Kenya and Vietnam. See www.hivgaps.org

10 Murray, H. (2015). "Just because we are using doesn't mean that we can't do anything, that we can't do something for ourselves". An exploration of best practices of meaningful peer involvement within a harm reduction context with substance users from GHB, MSM, and IDU drug use settings. See www.hivgaps.org

11 De Vries, D., Brenman, N., Tang, J. (2015). Effective Collaboration in Partnerships for Health and Human Rights: Lessons Learnt from Bridging the Gaps. Lessons learnt and best practices in the Bridging the Gaps programme on working in collaboration.

STEP 2: ANALYSING THE CONTEXT AND NEEDS

After identifying the most underserved groups, the next step is to assess the various barriers and enablers for accessing services in the local context, as illustrated in figure 2:

- 1. Personal level** (including family and friends); e.g. low risk perception, other high priorities, lack of resources or support to seek services, fear for stigma and discrimination from healthcare providers and community members, and risk behaviours. People from key populations often engage in more than one high-risk behaviour (e.g. sex work and injecting drugs). This can increase their vulnerability, but also poses extra barriers to accessing services: for example internal stigma, double stigma.
- 2. Health system and other sectors** (including resources, capacities and behaviours of healthcare professionals, law enforcement staff and community members); availability of services suiting their needs, health promotion and/or outreach.
- 3. The community and society** (including general population, community leaders and the national government); stigma, discrimination, violence, and legal barriers, e.g. need to show identification.

¹² See www.hivgaps.org for more information on needs assessments and baselines of Bridging the Gaps.

¹³ Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J. Brozek, I., Hughes, C. (2014). Reaching the hard-to-reach: a systematic review for improving health and medical research with socially disadvantaged groups. BMC Medical Research Methodology 2014, 14:42.

EXAMPLES OF HOW TO ENGAGE KEY POPULATIONS IN RESEARCH

Although it is vital to analyse characteristics and needs of the key population, marginalised groups are often underrepresented in assessments and research. It is particularly challenging when marginalised individuals are criminalised or do not identify themselves with a key population. Despite these challenges, Bridging the Gaps partner organisations have successfully conducted needs assessments among key populations¹². The methods for sampling that are used to engage marginalised groups in research might also be applicable for more effective outreach to new groups. Frequently used methods to recruit stigmatised groups into research are snowball/social network or respondent-driven recruitment, venue-based time-location sampling, targeted sampling, capture-recapture, and adaptive sampling. Which type of recruitment works best depends on the specific population and the context. We therefore recommend close collaboration with community leaders or gatewatchers, and planning for higher costs and extended timeframes¹³. Because contexts continuously change, it is important to regularly engage key populations to re-assess the context, needs and barriers.



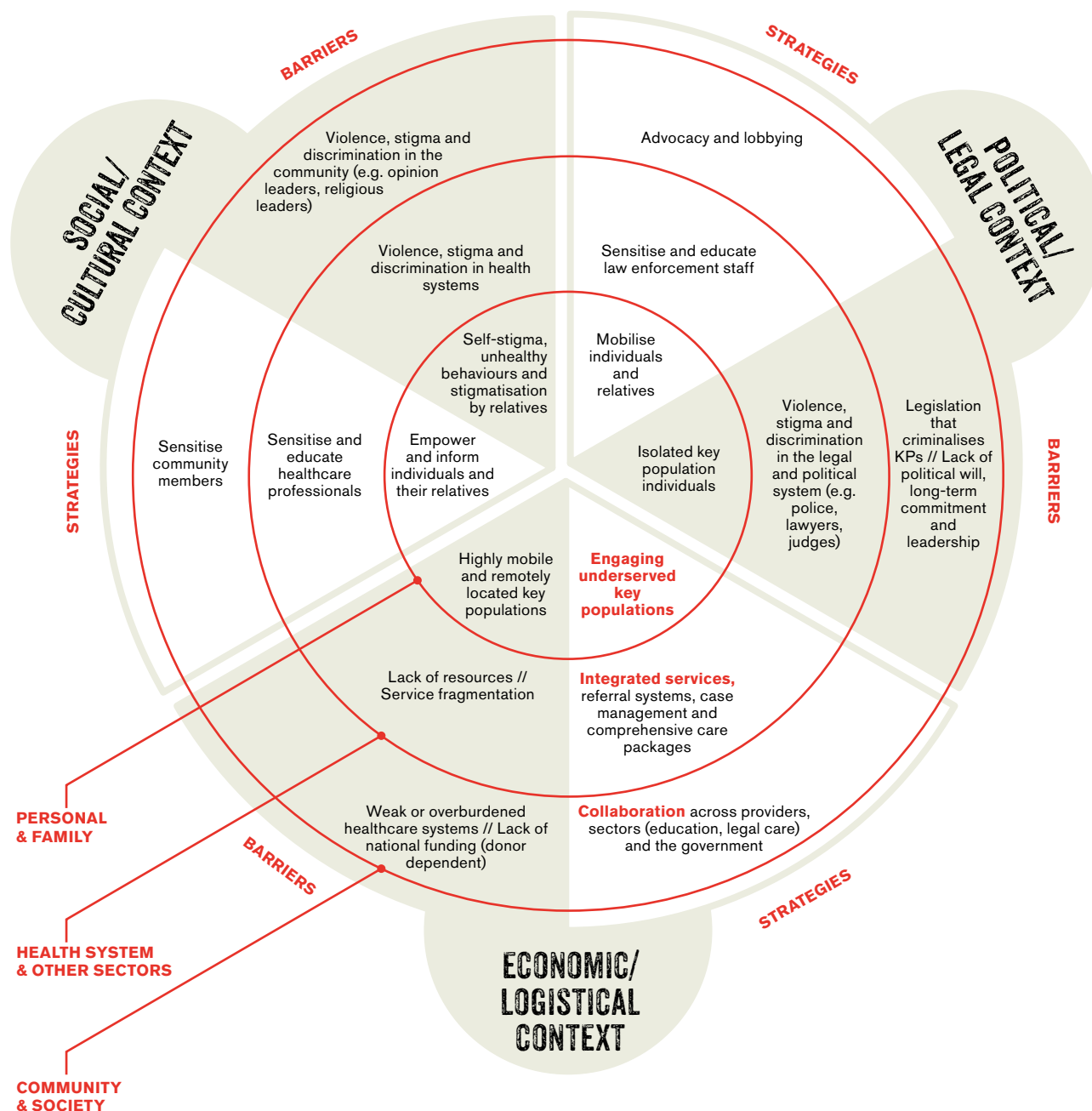


Figure 2. Integrated services – barriers and strategies

STEP 3: IDENTIFYING THE RIGHT STRATEGY TO ENGAGE UNDERSERVED KEY POPULATIONS

At this step, based on the analysis of needs, enablers and barriers, you determine which strategies are the most appropriate and effective to engage underserved key populations and to increase their access to STI/HIV prevention, treatment, care and support. If the analysis shows that outreach would be the most effective or most promising solution, you need to determine which type of outreach is needed and how to organise it.

Questions to answer when planning the right outreach strategy:

1. **Who is the ideal outreach worker:** professional or peer? Same sex/age? In the case of people who use drugs, can current users conduct outreach? Should they be paid or volunteers?
2. **Where should the outreach be done?** Where can the most underserved groups be best found and approached: online, in their homes, in meeting, dealing or working locations, or in detention centres?
3. **When is the best time to conduct outreach?** When are the specific key populations available and approachable?

4. Which services are needed?

- a. Providing **information** to increase knowledge about the availability of services. This can include risk reduction information, provided by peer educators or professionals, or using written materials through text messages, or online platforms.
- b. Providing **support** to enable and motivate underserved key populations to utilise services. This can include fostering self-confidence and reducing self-stigma, as well as provide case management, follow-up support and accompaniment to services after referral.
- c. Provide **mobile services**, via professionals, outreach workers, or peers. This can include:
 - Mobile and rapid testing, self-test kits, emergency services, treatment for common illnesses
 - Materials: condoms, bleach, clean needles and syringes, sterile water and alcohol swabs, collection of used injecting equipment
 - Referrals to drug-dependence treatment, abscess management, HIV testing and counselling, treatment of sexually transmitted infections, treatment of HIV/AIDS-related illnesses, psychosocial support
 - Shelter and food¹⁴.

OUTREACH STRATEGIES

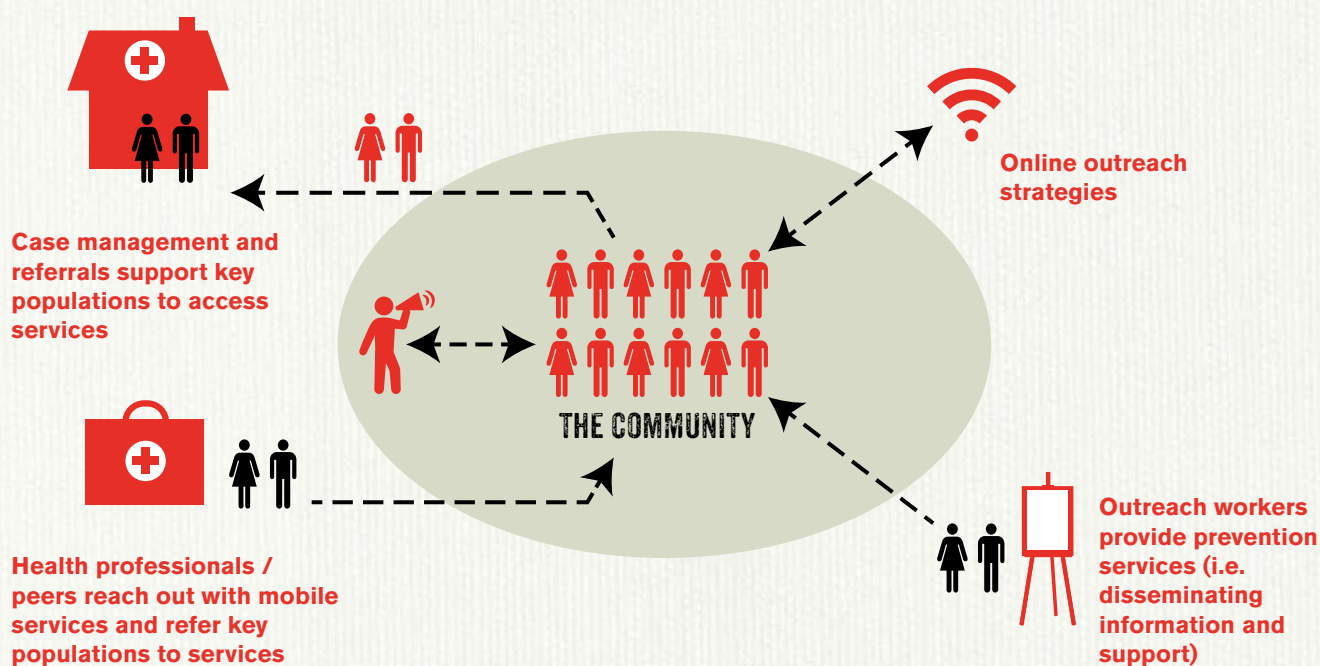


Figure 3. Various outreach strategies

EXAMPLE B. REACHING YOUNG PEOPLE WHO USE DRUGS IN UKRAINE

In Ukraine, Aids Foundation East West (AFEW) engages young people who use drugs through a variety of mechanisms; referrals from detention centres or schools, or volunteering opportunities. Operational research¹⁵. Identified gaps in the current programme, for example, the need for outreach for children and youth living on the streets. Outreach teams, which consisted of social workers, psychologists and medical personnel, should also include representatives of street children and adolescents. Two good practices observed in the operational research were street children projects funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria in Ukraine: a mobile team reaching out to street children, and a peer-driven intervention that involves street children bringing others for interviews and services. Money rewards are paid for each interview with a client, and also for every three clients the child has brought to the project. These types of interventions require plenty of resources. However, they can be highly effective for reaching adolescent PWUDs who live on the streets with prevention services.

EXAMPLE C. MOBILE SERVICES FOR LGBT PEOPLE IN TAJIKISTAN

Our partner in Tajikistan, LGBT organisation 'Equal Opportunities', has improved the quality of the STI/HIV prevention services they offer by introducing outreach counselling. In addition to providing professional advice and support on health issues, mobile clinics are now used for HIV and STI testing. This model allowed Equal Opportunities to improve the quality of services provided and to almost double the number of community members reached during the first six months of 2015. In Tajikistan, NGOs were previously not allowed to provide this kind of service. As a consequence, many members of the LGBT community, including men who have sex with men, did not get tested for HIV and STIs, because they did not want to go to a state-run AIDS centre out of fear of being stigmatised and discriminated and/or forcefully outed by homophobic and transphobic medical staff. Now that Equal Opportunities and other NGOs have started to do HIV and STI testing themselves via mobile clinics, working with trained healthcare professionals, more LGBT are making use of these services, knowing that the medical staff working in the mobile clinics are sensitised about LGBT and will behave professionally¹⁶.

DID YOU KNOW?

Population Services International (PSI), a global NGO, is rolling out oral-swab HIV self-test kits to key populations in Malawi, Zambia, and Zimbabwe¹⁷.

Pathfinder, an international NGO promoting sexual and reproductive health, succeeded in engaging a large number of ethnic minority populations in the Central Highlands and Northern Mountains regions of Vietnam using text messages. This project will be expanded to engage people who inject drugs and MSM¹⁸.

14 WHO, UNAIDS, UNODC (2004). Evidence for action on HIV/AIDS and injecting drug use Policy Brief: reduction of HIV transmission through outreach.

15 Maksymenko, K., & Shebardina, A. (2014). Better access to services for adolescents who use drugs in Ukraine: Lessons from the Bridging the Gaps programme. See www.hivgaps.org

16 Aids Fonds (2015). Bridging the Gaps: Narrative mid-year report on LGBT.

17 See for more information

18 See for more information

STEP 4: SELECTING AND SUPPORTING OUTREACH WORKERS

It is important that you plan for adoption and implementation of the outreach strategy by answering the following questions:

- a. **Who is best suited to conduct the outreach work?** What are the characteristics an outreach worker needs to possess, and what are the selection criteria for recruiting outreach workers?
- b. **What type of training and support** should always be provided so that they can implement the outreach strategy well?

EXAMPLE D. CHARACTERISTICS OF THE IDEAL OUTREACH WORKER IN KYRGYZSTAN

Bridging the Gaps partners AFEW Kyrgyzstan and Labrys jointly conducted operational research in Kyrgyzstan¹⁹. Based on 440 interviews with key population members, the study highlights the crucial role of outreach workers and provides recommendations for improving outreach work to engage underserved key populations more effectively. According to the respondents, the ideal outreach worker has the following characteristics:

1. Is a member of the community and knows the specific needs of the key population.
2. Has strong social and communication skills to build trust, identify needs, and expand their own network.

3. Has counselling skills and maintains long-term contact.
4. Has knowledge of the system, laws and regulations, as well as the local organisation, and is able to explain this well.
5. Is kind, supportive, motivating, friendly and open. Provides a sense of safety, but does not enter into any relationships with clients, particularly financial ones.
6. Is professional:
 - Handles information about clients with complete confidentiality.
 - Manages time well, and knows when to contact group leaders instead of individuals (particularly while undertaking outreach with sex workers).
 - Maintains distance and is impartial, while also being adequately responsive, and is careful about making and keeping promises.

TRAINING AND SUPPORT FOR OUTREACH WORKERS

Various reports have stressed that programmes working with peer outreach workers should ensure regular training, mentoring and supervision, as well as adequate wages and/or other appropriate incentives. Involvement in the organisations and safety measures are also important aspects to take into account.



EXAMPLE E. TRAINING AND SUPPORT FOR SEX WORKER CBOS IN VIETNAM

In Vietnam, the Bridging the Gaps local partner organisation Supporting Community Development Initiative (SCDI) initiates the development of community based organisations (CBO). SCDI identifies potential community leaders who could become peer outreach workers and provides them with training and space for sex workers to gather. The peer outreach workers are often active or former sex workers. They are best suited to reach out to their own community since they truly understand the daily life and work of sex workers. This helps them to gain the trust of the group and they can then begin to offer information, training, counselling and support to the CBO participants.

Outreach workers often adopt a 'snowball effect' strategy, using their social network. This starts by reaching out to sex workers they know themselves, asking these people to reach out to their own friends. Slowly, the network builds up and the group size increases. They also recruit participants during their working hours on the streets and in public parks. The people they find are invited to take part in informal small gatherings with other sex workers and in training sessions on safe sex practices, health and rights issues. Outreach workers also provide one-on-one advice on available resources and emergency services, and often accompany sex workers to appointments with trusted health professionals. They are paid for their work, but many continue to work as sex workers too.

The SCDI provides training courses for the peer outreach workers on:

1. Knowledge about health (HIV transmission, prevention and treatment, harm reduction, condom negotiation), legal issues, and interventions for sex workers.
2. Relevant services in their locality and how to access them.
3. Basic skills for counselling, teamwork, facilitating group meetings, public speaking, data collection and administration for accessing services. This training also plays a role in group bonding and building trust.

Operational research conducted by SCDI in 2015 showed that the approach is highly promising in identifying, approaching, assisting, and, eventually, empowering vulnerable and isolated sex workers, including young, handicapped and older individuals. Research findings indicate that sex workers see the benefits of CBO participation as:

- Network, support, and information. For example, cell phone calls to CBO leaders and other members in a dangerous situation occur frequently and are a very effective way to get support.
- Enhanced feelings of empowerment, self-esteem and self-confidence, which has contributed to sex workers' ability to negotiate safer sex with clients and to protect each other in case of an emergency.
- Access to non-judgemental healthcare practitioners²⁰.

19 Madybaeva, D., Karipova, A., & Yanchinov, Engaging under-served key populations in Kyrgyzstan: What works? A study in Kyrgyzstan with sex workers, people who inject drugs and lesbian, gay, bisexual and transgender people. See www.hivgaps.org

20 Bélanger, D., Huong, N. H., Giang, K. T. H., & Oanh, K. T. H. (2015). Promoting safe sex and empowerment among sex workers in Vietnam: Lessons from the Bridging the Gaps programme. See www.hivgaps.org

EXAMPLE F. COMMUNITY-LED OUTREACH FOR PEOPLE WHO USE DRUGS IN KENYA

Muslim Education & Welfare Association (MEWA), our partner organisation in Kenya, provides outreach for people who use drugs. They build peer counsellors' skills so that they can 'graduate' as outreach workers. According to operational research conducted, this strategy is a promising practice for engaging people who use drugs²¹.

MEWA implements the following steps:

1. People who visit the residential drug treatment centre for harm reduction programmes are supported during their gradual reintegration into society for a period of one year.
2. These clients are given more and more responsibilities as peer educators: escorting other clients for treatment and conducting community dialogue. One of their roles is establishing and maintaining interpersonal relations, linked to support groups as ambassadors for change, while family members provide moral support. This peer outreach model provides a basis for personal development.
3. Feedback on the clients is collected regularly from family members, other peer counsellors, community members and organisation staff.
4. Clients are recruited to become outreach workers if the performance evaluation is positive.
5. Outreach workers are given different kinds of training and supportive supervision to strengthen their skills, self-confidence and motivation. The training includes: motivational interviewing, counselling, management of street-based illnesses, outreach work, HIV/TB awareness, and entrepreneurship skills.

One of the key success factors of MEWA's approach is that the peer outreach workers are actively engaged in programme development and budgeting. "Most of the ideas they generate are put into action. They own the programme and can represent the organisation at community and regional level." The outreach workers are paid and work eight hours a day. The organisation does not have high turnover rates.

SAFETY TIP

It is important to have safety measures in place when working with outreach workers, as the environment where underserved key populations live or work can be unsafe. Safety measures will vary per location and key population, but some general principles apply²².

Safety Tips

- Know the 'gatekeepers'.
- Never work alone.
- Let people know who you are.
- Don't dress to impress and or carry too many personal items.
- Be consistent, trustworthy and ethical.
- Don't get lulled into complacency.
- Show extra caution in isolated areas and know when to back off.
- Don't give out personal phone numbers or talk about personal things.
- Use basic de-escalation techniques when confronted by angry or aggressive community members.

HELPFUL RESOURCES

1. U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau Special Projects of National Significance Program (2013). Training Manual: Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care.
2. Ermolaeva I, Rybina N. (2014). Guide for outreach workers in teaching harm reduction strategies for working with IDU/ Bishkek, AFEW.
3. Klimenko M & Kostenko S. (2014). Guide for outreach work among MSM/LGBT groups in the Kyrgyz Republic. Bishkek/ The Global Fund to Fight AIDS, Tuberculosis & Malaria.

21 Igonya, E. K., & Echoka, E. (2015). Reaching key populations and improving their access to HIV services in Kenya: Lessons from the Bridging the Gaps programme. See www.hivgaps.org

22 NCFY. (2007). Safety's the Rule for Street Outreach Workers.

STEP 5. ONGOING MONITORING AND EVALUATION (M&E)

The success of interventions that aim to engage key populations is measured not only by effectiveness, but also by the quality of the process itself: that is the degree to which key populations are engaged and the process and mechanisms of their engagement²⁵.

Outreach, peer-led or not, should be continuously monitored to ensure its quality and effectiveness. Client satisfaction, process evaluations and regular evaluations are needed. Both clients and outreach workers should be closely involved, to plan for further improvements in implementation, as well as in training and support for the outreach workers.

MORE INFORMATION?

- Consolidated HIV monitoring and evaluation guidelines. Geneva, WHO, in preparation.
- Rapid assessment and response adaptation guide on HIV and men who have sex with men (MSM-RAR). Geneva, WHO, 2002.
- The rapid assessment and response guide on psychoactive substance use and sexual risk behaviour (SEX-RAR). Geneva, WHO, 2002.
- Rapid assessment and response adaptation guide for work with especially vulnerable young people. Geneva, WHO, 2004.



CONCLUSION

Outreach plays a vital, often lifesaving role for underserved key populations, especially in contexts where an enabling environment is hindered by many structural and cultural factors. This document describes five steps that can guide organisations in planning outreach services to reach and engage these populations. Activities related to these steps depend on the context, populations and organisations involved. The steps are not a one-size-fits-all model for successful outreach but do offer lessons learnt and tips to organisations. Engaging communities must play a central role in all these steps. Key populations need to be engaged and consulted to identify what, when and how they want to access services. It is crucial to assess specific characteristics and needs: in a setting where people trust healthcare professionals more than their peers, community-led mobile services would not work, and vice versa. Training and support for outreach workers should be carefully planned together with the outreach workers, to ensure the quality of the outreach services.

Programmes that do not engage key populations in planning, implementation, and monitoring and evaluation are not likely to increase access to services. We hope that by sharing our lessons learnt from operational research, and other Bridging the Gaps programme documentation, we contribute to building a knowledge base of what works best to pave the road to achieving universal access to sustainable services for key populations.

MORE INFORMATION?

If you have any questions about this document, please use the contact form available on www.hivgaps.org. More Bridging the Gaps programme information and resources can be accessed here as well.



RELEVANT LINKS AND RESOURCES

TECHNICAL BRIEFS AND GLOBAL STRATEGIES

WHO (2011). Outreach services as a strategy to increase access to health workers in remote and rural areas.

UNAIDS (2012). HIV and outreach programmes with men who have sex with men in the Middle East and North Africa

From a process of raising awareness to a process of commitment.

WHO (2014). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations

In this new consolidated guidelines document on HIV prevention, diagnosis, treatment and care for key populations, the World Health Organization brings together all existing guidance relevant to five key populations – men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people – and updates selected guidance and recommendations.

WHO and NSWP (2013). The Sex Worker and HIV Implementation Tool (SWIT)

This tool offers practical advice on implementing HIV and STI programmes for and with sex workers.

WHO and MSMGF (2015). Men Who have Sex with Men Implementation Tool (MSMIT)

This tool offers practical advice on implementing HIV and STI programmes for and with MSM.

TECHNICAL TOOLS

U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau Special Projects of National Significance Program (2013). Training Manual: Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care.

USAID (2009).

Outreach Worker's Handbook. This handbook is a practical tool, with sections that can be applied to different fields of outreach work as well, for example the sections on interpersonal communication, tips on how to conduct promotional activities in groups and a self-assessment form for outreach workers to reflect about their performance.

OTHER DOCUMENTS IN THE BRIDGING THE GAPS SERIES

Engaging And Reaching Out To Underserved Key Populations is part of a series on key population programming. Other topics include:

Integrated Services for Key Populations

Lessons learnt and best practices from the Bridging the Gaps programme.

Effective Collaboration in Partnerships for Health and Human Rights

Lessons learnt and best practices in the Bridging the Gaps programme on working in collaboration.

MORE INFORMATION?

The studies conducted in Kenya, Kyrgyzstan, Ukraine and Vietnam will be published on www.hivgaps.org

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