

Ensuring Efforts to Scale up, Strengthen and Sustain HIV Responses:
Scaling up HIV Prevention for Key Populations, Adolescents and Young Adults:
Developing a Differentiated Service Delivery Approach

Hosted by the Joep Lange Institute

10–11 April 2018
Amsterdam, the Netherlands

What's in this meeting report

Section 1 provides:

- An **introduction of the overall initiative**
- Background analysis as to the **rationale for the meeting**: lagging progress in HIV prevention and insufficient access by key populations
- Overview of the **state of HIV prevention worldwide**
- Overview of **prevention interventions** that are considered most **valuable and effective**, tools that are in the **pipeline**, and what is generally needed in all contexts for combination prevention coverage

Section 2 **summarizes some prevention-related challenges** discussed at the meeting, both in terms of 'failures' overall and challenges more directly relevant for service providers.

Section 3 summarizes **examples of efforts to reach key populations through differentiated approaches** in context including Kenya, Thailand, Indonesia, West Africa, Caribbean islands and Uganda.

Section 4 offers information and observations about some **issues to keep in mind when designing and implementing prevention for key populations**

Section 5 discusses some **issues associated with key populations and HIV prevention that might need further analysis and work** to bolster clarity and guidance.

Section 6 includes a set of **recommendations aimed at moving forward practical discussions and decision-making** around primary prevention, key populations and differentiated service delivery (DSD) in overall HIV responses.

1. Introduction and Overview

1.1. About the overall initiative

Ensuring Efforts to Scale up, Strengthen and Sustain HIV Responses is an initiative launched in April 2017 by the Joep Lange Institute. The initiative's overall objectives are to

describe challenges to meeting current HIV targets and articulate an approach for the HIV response that takes sharp aim at:

- reducing the number of new HIV infections, with a focus on key populations, adolescents and young adults;
- streamlining and improving service delivery to sustain the overall quality of treatment;
- efficiently targeting the use of resources; and
- building new and more sustainable approaches for funding.

A total of seven consultations anchored the initiative's agenda. A comprehensive report and findings from those meetings will be launched at the International AIDS Conference in Amsterdam, July 2018. That report will be preceded and accompanied by additional work products to highlight research, communications and advocacy needs and strategies.

Three of the seven meetings were larger-scale, bringing together at least 35 participants from across a range of sectors—including government, donor, research/science, multilateral and technical agencies, and civil society. One of those three, held in September 2017, centred on the potential impact of reduced funding for HIV on countries' efforts and ability to scale up their responses and how limited resources can best be used effectively and responsibly. The second meeting, held in October 2017, considered approaches and strategies to make responses more efficient, with an emphasis on differentiated service delivery (DSD) and HIV prevention efforts for highly vulnerable populations. A third large-scale meeting, on innovative financing options and opportunities, took place in February 2018.

The 10–11 April 2018 meeting, **Scaling up HIV prevention for key populations, adolescents and young adults: developing a differentiated service delivery approach**, was the last of four additional meetings that further contributed to the overall process. This meeting was one of three planned and organized to respond to priority areas of more intensive work, as identified by participants at the first two larger meetings. The first of these three side meetings, on HIV incidence measurement, was held in January 2018. The second, in February 2018, was a workshop discussing reporting mechanisms that can help to promote increased funding and other resources to communities. The seventh contributing meeting, held in mid-March 2018 and organized by the Joep Lange Institute (JLI) and the World Health Organization (WHO), focused on strategies and advocacy to address growing rates of HIV drug resistance.

Presentations from each of these meetings will be available through a dedicated page on the JLI website. Exceptions may include situations in which presenters have asked not to make their presentations publicly available for one reason or another.

1.2 Rationale for the meeting: lagging prevention progress

The UNAIDS Fast-Track agenda has galvanized countries to scale up their HIV responses to meet the 90-90-90 targets. Treatment has received priority attention and resourcing in most countries, with efforts focusing on testing and antiretroviral therapy (ART) initiation. Yet even as numbers of those on ART continue to climb, insufficient progress has been made globally in reducing new infections to reach control of the epidemic.

Achieving epidemic control cannot be accomplished without steep and steady narrowing of the gap between all people living with HIV and all of those on effective treatment. However, despite the powerful impact of treatment as a means of preventing HIV transmission; treatment, on its own, will not be able to lower HIV incidence to the levels needed for epidemic control. The

inadequate progress in reducing HIV incidence also represents a failure to reach, support and meet the needs of key populations, who in most contexts are highly vulnerable and ‘left behind’ not only in HIV responses but in a wide range of health, social and development areas.

Revitalizing and improving primary prevention, especially for key populations, is an essential component of successful responses that has been largely neglected in the Fast-Track era.

Similarly, the large population of adolescents and young adults in many high prevalence countries poses a significant risk of increasing HIV infection rates. The recent PHIA surveys from a number of countries in sub-Saharan Africa show that adolescents and young adults are often unaware of their HIV status and, if HIV-positive, often not linked to care and treatment and have suboptimal ART adherence and high treatment failure.

The April 2018 meeting in Amsterdam centred on identifying strategies and approaches to reverse these trends, including through consideration of differentiated service delivery (DSD) in prevention programming and interventions. Ultimately, however, the meeting focused primarily on the needs of key populations, with the acknowledgment that additional discussions are needed to address adolescents and young adults from the general population,

For the purposes of the meeting, the term ‘key populations’ was assumed to include gay men and other men who have sex with men (MSM), people who inject drugs, sex workers, transgender people and people in prisons and other closed settings. Other highly vulnerable populations from a prevention perspective include intimate partners of members of key populations, migrants, and adolescents and young women. In many contexts, targeted prevention services have been or should be designed for them as well.

1.3 Where we are now: the state of prevention worldwide

Recent data from UNAIDS underscore the lagging global HIV prevention efforts overall, and among KPs specifically. For example:

- More than 2 million people worldwide were newly infected with HIV last year. That number has been more or less the same for each of the past several years, and new figures to be reported by UNAIDS in July 2018 will show only a small decline from the previous years. ***As a result, the core 2020 Fast-Track prevention target—to lower annual new infections to 500,000 that year—is off track by a wide margin.*** This ongoing plateau in new infections is attributed to poor results among adolescents and adults. Annual new infections among children have continued to decline sharply, largely due to the success of prevention of mother-to-child transmission (PMTCT) programming.
- Although weak prevention results are evident everywhere, regional differences persist. Of note is that annual new infections are increasing in some places where epidemics are highly concentrated among key populations, including Eastern Europe and Central Asia.
- Nearly half (45%) of the 2 million new infections in the most recent year were among key populations and their intimate partners.
- Coverage with proven prevention tools, services and effective interventions remains low. Among the examples:

- The number of condoms available Africa covers only about half the current theoretical need
- Uptake of pre-exposure prophylaxis (PrEP) is less than 5% of the global target
- Almost half (43%) of countries with injecting drug use do not have any needle/syringe or opioid substitution programmes. This is one reason that less than 1% of people who inject drugs live in an area where this is sufficient coverage of a full suite of harm reduction services, including substitution therapy, syringe exchange, and drug treatment programs that are needed for adequate combination prevention.
- Only about 38% of people living with HIV are virally suppressed, well below the level needed to reach the 90-90-90 targets.

Many of these figures and trends indicate that meeting prevention targets for key populations will become increasingly more difficult to achieve because key populations are almost always harder to reach with information and services. ~~In addition, reaching~~ Reaching key populations, especially young key population groups, adolescents and young adults, particularly those who are members of key population groups, will require new strategies for raising HIV awareness and engagement in health services. Other important factors are **lack of political leadership and commitment to prevention and key population programming**, which contributes to the lack of inadequate investments in such work (including for communities), and numerous **environmental and structural barriers**. Among the most problematic are policies that criminalize or discriminate because of behaviours including sex work, drug use and same gender sex, and lack of critical documentation that matches a person's gender (important for many transgender individuals). Research indicates that removing such barriers can have a noticeable impact on HIV transmission and reduce HIV programming costs over time. For examples, studies have shown that making sex work safer (e.g., by decriminalizing it) could lead to a greater reduction in transmission than providing ART to HIV-positive sex workers¹.

Few environments come with as much HIV and TB risk as prisons. Worldwide, some 30 million people enter and leave prisons every year. Many have risk behaviours going in (e.g., injecting drug use) and many more risk factors and threats exist inside (e.g., rape, violence, and unsterile tattooing and drug injection). Outbreaks of HIV in prison are common; often, they are linked with high rates of TB and hepatitis C. The main obstacle is inequity in access to prevention and treatment services for HIV for those incarcerated, including access to condoms. Another main problem is the continuity of care (for HIV, TB hepatitis and drug dependence) between prisons and the community.

1.4 Combination prevention: what works, what is in the pipeline, and what should be provided

Combination prevention includes an integrated variety of biomedical, behavioural and structural interventions. The amount and type of data showing value and efficacy for each intervention differs, with some (especially many behavioural and structural ones) having been evaluated less frequently in general. However, each intervention should not be viewed as stand alone but each contributes to prevention. Behavioral and structural interventions are an essential component of treatment and PrEP delivery.

1. ¹ *Global epidemiology of HIV among female sex workers: influence of structural determinants*, Shannon, Kate et al., The Lancet , Volume 385 , Issue 9962 , 55 - 71

A recently published systematic review of some 2,000 primary prevention studies found particularly strong evidence and efficacy for PrEP and voluntary medical male circumcision (VMMC).² Condoms and clean needles were also seen as being effective. The study's authors concluded that evidence was less clear regarding efficacy for demand side interventions and interventions to promote the use of or adherence to prevention tools.

One notable conclusion based on reviewing a range of studies related to topical and oral PrEP is that **efficacy is directly proportional to adherence**. This finding is not surprising overall, and neither is the observation that different populations and programmes have different challenges with adherence. For example, although older women tend to have significant reduction in HIV incidence in studies of topical PrEP (e.g., dapivirine ring), the impact has been minimal among younger women, who are also at higher risk and can have greater challenges with adherence. Variations in adherence challenges highlight the importance of tailoring adherence support interventions to the discrete needs of clients to the fullest extent possible.

Studies and evaluations are regularly ongoing of potential new biomedical tools to be included in combination prevention programming and approach, as per what might be suitable and acceptable to individual clients. Some are long-lasting agents for HIV prevention, including implants and long-acting injectable ARVs. Cabotegravir (CAB), an analogue of dolutegravir (DTG), appears to be well-suited as long-acting in suspension. It is currently being studied in two separate large trials, one of which includes about 4,500 MSM and transgender individuals. As with most other biomedical interventions, adherence is vital for the individual's personal health as well as more broadly should drug resistance ensue and be transmitted to others.

Behavioural interventions for prevention of HIV acquisition are intended to decrease risk behaviours, increase protective behaviours, and increase uptake of and adherence to biomedical products. A comprehensive package would include, among other things, peer-based interventions, socio-economic interventions, and information, education and communications (IEC). One area receiving substantial new attention, including in pilot projects and studies, is mHealth. For example, Prepmate comprises a multi-faceted approach to supporting individuals initiated on PrEP, including Web-based and text reminders to take the drugs and opportunities to partner online and support adherence.

Many of these interventions are included within one or more categories of interventions that comprise a comprehensive prevention package for key populations, as recommended by the World Health Organization (WHO) and other entities (see Figure 1 below). WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, revised in 2016, exemplifies the reality that there is no lack of options and guidance for prevention.

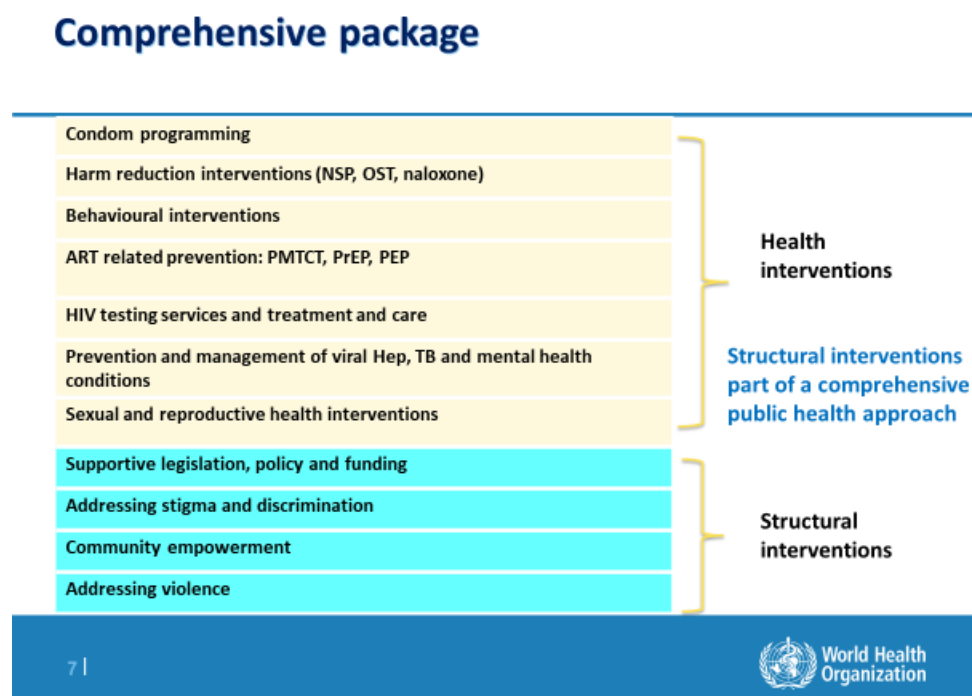
The main overarching impetus should be to improve delivery and implementation. This would include not only making tools and interventions available more widely and consistently, but also building political support for increased financing and addressing structural barriers to support and allow communities to play their critical roles.

The HIV prevention cascade illustrated in Figure 2 below offers an example of how interventions and approaches might be considered from the point of view of demand, supply and adherence. Thinking about what is wanted, needed and available from this perspective might help to

² Krishnaratne S, et al. Interventions to strengthen the HIV prevention cascade: a systematic review of reviews. *Lancet HIV*. 2016 Jul;3(7):e307-17.

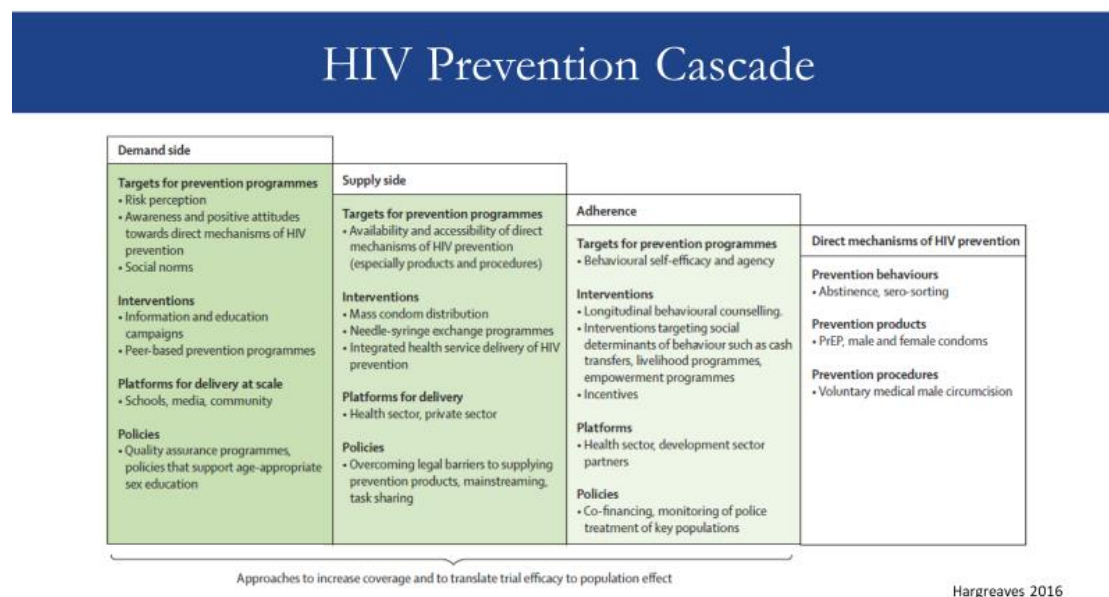
determine what is necessary and relevant for targeted and prioritized services in different contexts.

Figure 1. WHO comprehensive package of services for key populations³



³ WHO (2016). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. www.who.int/hiv/pub/guidelines/keypopulations-2016/en/

Figure 2. Suggested categorization and components of HIV prevention work⁴



⁴ Hargreaves JR, et al. The HIV prevention cascade: integrating theories of epidemiological, behavioural, and social science into programme design and monitoring. *Lancet HIV*. 2016 Jul;3(7):e318-22. doi: 10.1016/S2352-3018(16)30063-7.

Box 1. Global HIV Prevention Coalition

The Global HIV Prevention Coalition, launched in 2017, includes a 10-point action plan (the HIV prevention 2020 road map) that aims to accelerate HIV prevention at country level. As noted by UNAIDS at its release in October of last year, “The road map identifies factors that have hindered progress, such as gaps in political leadership, punitive laws, a lack of services accessible to young people and a lack of HIV prevention services in humanitarian settings. It also highlights the importance of community engagement as advocates, to ensure service delivery and for accountability.”

The road map includes a 100-day plan to address the first four activities, which are related to targets, key policy impediments and changes, and national prevention leadership. The four initial activities are:

1. Conduct a strategic assessment of key prevention needs and identify policy and programme barriers to progress
2. Develop or revise national targets and road maps for HIV prevention 2020
3. Make institutional changes to enhance HIV prevention leadership, oversight and management
4. Introduce the necessary legal and policy changes to create an enabling environment for prevention programmes

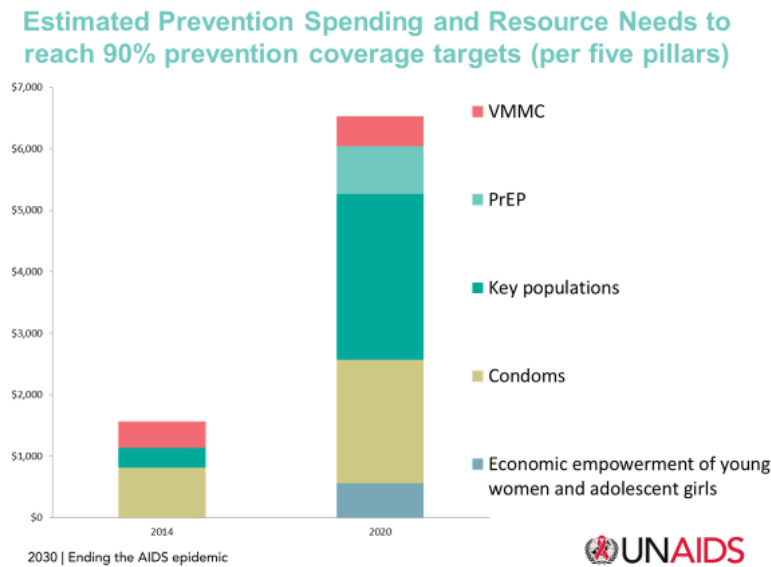
New prevention-related energy and action have subsequently occurred in many countries. More extensive community-based monitoring for prevention is one component needed for the coalition to be put in place correctly. ***A notable consideration regarding the road map overall is that there is no new money to put in place the action plan.***

2. Challenges to Prevention in General and Key Populations Specifically

This section summarizes some specific prevention-related challenges mentioned during the April meeting. They are of two kinds: prevention ‘failures’ or weaknesses in general, and challenges more directly relevant for providers implementing services for key populations.

(A) Money is one of the biggest obstacles. **HIV prevention lacks adequate financial investments.** UNAIDS modelling, illustrated in Figure 3 below, shows a large gap between what was invested in several effective prevention areas globally in 2014 and investment needs for 2020.

Figure 3. Prevention Spending Gap, UNAIDS calculations and modelling



One reason for such gaps is that prevention is underprioritized across HIV responses. As a result, prevention spending remains far lower in most contexts than the recommended 25% of HIV spending, which is the minimum level called for in the ‘quarter for prevention’ drive spearheaded in recent years by advocates and within the Fast Track strategy.

The poor prevention results and prevention funding shortfalls are both the cause and effect of **insufficiently extensive and financed civil society work**. Comprehensive and effective prevention for key populations requires strong community-based organisations (CBOs) and other non-governmental organisations (NGOs) to deliver, especially because government-run services have limited access to (or deliberately ignore or exclude) key populations in many cases. Yet the role of communities often is not recognized, which makes it more difficult for them to get money for prevention or any other HIV activities.

Funding also lags because primary prevention is **undervalued in critical areas such as country programming and applications to the Global Fund**. ‘Low asks’ for prevention result from, among other things, strong pressure and advocacy around treatment scale-up. In contrast, key populations and others most likely to be advocating for prevention funding tend to have weaker or non-existent voices at the table when decisions are made at country level and elsewhere on HIV funding and prioritization.

Absorption is another funding-related challenge. Across Global Fund grants, for example, an estimated 30% of money targeted for prevention is not spent. The reasons vary by context and may be related to management or supply chain issues or a range of inefficiencies across health systems. Regardless of the reasons, such poor absorption points to a need to help countries improve their ability to spend all their Global Fund and other monies efficiently and effectively (e.g., by using opportunities to reprogramme as needed).

(B) Funders usually base decisions and priorities on indicators and other measures of impact.

But much prevention work, including work by CBOs to reach and support key populations, is difficult to measure when blunt quantitative indicators predominate, such as the number of condoms distributed or number of people who are tested. As a result, many critical prevention efforts are unrecognized or unattributable, and thus not funded. Many donors and other partners do not fully acknowledge or respect what it takes for CBOs and other civil society groups to work in hostile environments. Little recognition or funding is therefore made available to cover the often lengthy yet crucial process of gaining confidence of key populations and working closely with individuals to get to the point of successfully offering condoms, clean needles and other services from HIV and STI screening to legal support.

Much of the additional work done by CBOs focuses on reducing or overcoming structural barriers, such as advocating for decriminalizing sex and drug use, and addressing discrimination and stigma, and ensuring meaningful involvement of key populations in program development and oversight. These are often necessary steps to improve the reach, scope and scale of prevention efforts. Such work often serves as the main or only entry point to all HIV and other health services for key populations. Also needed for effective combination prevention among key populations are programmes and interventions that address underlying factors to risky behaviour and seek to improve an individual's overall health and life, such as building self-esteem. Yet such work also can be difficult to measure, which is one reason there is little interest in investing in it sufficiently.

(C) **Perverse incentives** limit recognition of the impact of prevention programming. For example, there is **little reward or recognition for keeping people negative**, which is the core objective of prevention work. Instead, a PEPFAR-influenced emphasis on yield in HIV testing has directed attention, work and resources to HIV case finding.

(D) **The overall HIV response both globally and at country level has become increasingly biomedicalized in recent years**. Such an approach can limit effectiveness of a primary prevention frame because it undervalues other necessary components, including behavioural interventions and mobilization work. The repercussions have been especially severe for work and funding targeting key populations.

While pills are important, they are not enough on their own. Without structural support—e.g., through behavioural work such as adherence support, breaking down barriers and monitoring and reporting stock-outs—pills are taken less consistently and by fewer people. With poorer adherence, biomedical interventions for HIV become less effective. This is true for both treatment and prevention.

(E) **Setting up prevention and other services targeting key populations can be extremely political**, with health ministries and other government structures often unwilling or reluctant to fund, support, develop or implement them. This challenge could remain a major concern as governments focus on universal health coverage (UHC). For example, some governments are making the case that targeted services for key populations are not necessary as UHC expands because they will be folded into generalized programmes. This negates the need for services that specifically cater to key populations, who are distrustful of government systems and often reluctant to engage in health services.

(F) Stigma, repressive legal regimes, and numerous social factors can be barriers to **identification and disclosure**. Reaching many key population individuals is especially difficult when they do not identify as being a member of one or more of the highly vulnerable groups and/or do not disclose behaviours to health care workers or others. Most therefore do not seek

out or access targeted programmes for key populations even if welcoming, stigma-free community-based services are available. In Jamaica, for example, an estimated one-third of all men who regularly or occasionally have sex with other men do not identify as MSM. Reducing HIV transmission among the overall MSM population is much more difficult as a result.

(G) **Peer educators** can be critical for implementation of prevention services for key populations. Often, though, their roles and those of outreach workers are not recognized or valued, including by governments as cadres in health systems. This means that in many settings, those who are directly in field and responsible for providing the bulk of prevention services are not considered part of a health team, nor are they paid adequately for their efforts. Failure to value and incorporate the work of peer educators represents a barrier to scaling up prevention services.

3. Defining and positioning Differentiated Service Delivery in HIV prevention

One meeting participant observed, “If you ask 100 people what DSD is, you’ll have 100 definitions.” This observation underscores the difficulty in determining whether, how, and to what extent combination prevention programming for key populations (or in general) can or should be designed and delivered. The use of DSD approaches in care and treatment may be easier to define based whether patients are “stable” or “unstable” according to a country’s guidelines. Efforts to achieve a common understanding of DSD for prevention might include further consideration and analysis of the following observations, among others:

- ***The goal of DSD: costs, efficiency or better care?*** Defining DSD means agreeing on its objective. As initially conceived, DSD for HIV was about developing varied approaches to service delivery that would better meet the needs of clients, rather than providing a “one size fits all” approach. However, DSD is increasingly now presented as a way to save money or to improve the efficiency of health services. Efficiency might end up cutting costs, but that is not the primary goal. In the long-term, sustaining improved patient outcomes is the most reliable way to save resources.
- ***‘Client-centred care’ may be another term for DSD.*** Conceptualizing DSD this way might help to remove the technical, biomedical-sounding terminology that obscures the main focus on making sure that services are available to meet an individual’s various needs at different times and places in life, and are set up and delivered in ways that make them likely to be successful.
- ***Differentiation should be thought of beyond just services.*** A first step should be to understand the enabling activities and support needed to make such services have full value. In other words, before deciding what services to offer, it is important to segment clients by age, risk factors and behaviour, identity, preferences and environment, among other things. For example, effective and acceptable prevention services for a 50-year-old differ from those for a 15-year-old. A young gay man whose family has rejected him needs different things than one from an accepting and supportive family or environment.
- ***There is a large piece of overall prevention work that is not related to the health system.*** Thus, differentiation in the context of primary prevention for key populations and others should be thought of in a broader sense. Many young MSM, for example, do not see themselves as sick or at risk of being sick. They do not want to be associated with HIV. New thinking is needed as to the type of interventions that can help prevent

them from getting HIV. Such interventions may not be “HIV-specific”, but include HIV and other health issues within a broader effort for improved socialization, mobilization and quality of life.

- ***Differentiation might not be the right strategy for primary prevention, which instead could benefit from a non-differentiation approach at the base.*** This might mean having a core set of prevention programmes and interventions integrated within UHC. DSD would then come on top of the core, including in areas such as case management. Through more thorough integration, partners and stakeholders can collaboratively determine which partner(s) might deliver the services best—government, CBOs, private sector, self-directed individual care, etc.

Important questions remain about whether or how a cost-saving approach can be utilized to revitalize primary prevention in ways that make it more successful, either in the short or longer term. At the same time, if DSD is intended to work as a modality of social cohesion and to improve lives, what does that mean in practice in terms of the financial and other resources needed to introduce and sustain highly granular services targeting key populations?

One possible way to square the situation might be to acknowledge that although the ‘better care’ DSD guidance for key populations might not be cheaper in the short term, it might be in the long term. That is because spending more upfront to provide more effective prevention services would be a good investment to reduce need for ART and other services for key populations living with HIV.

The following working definition of DSD was proposed to guide all future discussions. It aims to prioritize the three competing objectives summarized in Section 5:

- DSD is first and foremost a way off providing client-centred services that are tailored to meet the needs of individuals. It is about improving access.
- A second goal is related to value: improving the efficiency of service delivery in a broad sense. This could include health systems but also drug-delivery systems, community systems, etc.
- A third goal is to cut costs, with an emphasis on considering longer-term costs as well as short-term ones.

4. Examples of Differentiated Efforts to Reach Key Populations

Programming and approaches that are or could be characterized as DSD for key populations have been implemented in numerous places. Most include multiple prevention components and are intended to help address some of the challenges to more effective, sustained and comprehensive prevention services for key populations.

This section summarizes some observations from meeting participants about DSD-related efforts in several contexts, including discussions of work done by CSOs and CBOs as well as by technical providers implementing PEPFAR initiatives. These snapshots illustrate what is being done to try to increase services to key populations. Collectively, they present a set of context-specific efforts, opportunities and challenges to reach more key populations with HIV

prevention, screening and referral services in particular. The extent to which combination prevention is offered to key populations varies by initiative and context.

Kenya

Nairobi-based LVCT Health is one of the country's largest civil society providers of HIV services. It implements one of the country's major key population prevention programmes, which includes an essential package of services. LVCT's approach to DSD for key populations and prevention has been to add on to this basic package, and to deliver this expanded set of services in a wide range of ways to make them more accessible and acceptable to current and potential new clients.

For example, LVCT uses a peer-led approach for outreach. Most outreach services are non-clinical, such as referring clients to relevant and friendly clinical services such as referring or accompanying people to the methadone clinic.. But as part of its DSD efforts, LVCT has added on some clinical services to its outreach work so it can directly deliver HIV screening and PrEP education and awareness, among other things. Nurses, HIV testing counsellors and other trained personnel accompany peers on outreach to provide such services.

LVCT also differentiates by other factors, including age and location. It has set up drop-in centres specifically for key population members younger than 19, for example, and has begun offering specialized psychosocial support services following a request by some young clients. The organization's DSD approach also has prompted it to focus on service location and convenience such as extended working hours or home delivery of condoms. Steps taken in response have included providing services at night at MSM hot spots and paying for a room in a bar to provide clinical services for sex workers, who can stop by between clients.

Evidence and observations to date indicate improvements stemming from DSD approaches, including in PrEP uptake and adherence and higher levels of viral suppression among MSM and female sex workers.

Thailand

PEPFAR's LINKAGES Thailand programme is being implemented by FHI 360. It is a cascade-centred model that focuses primarily on MSM and transgender individuals in nine provinces, mostly in urban environments. Partners are mainly community-based implementers.

The initiative uses outreach workers to recruit clients from communities, often by snowball referrals. A guiding idea is to differentiate clients based on needs and priorities while also utilizing a wraparound services model.

All differentiation decisions are based on extensive gathering and analysis of data, including from social networks, for adaptive programme management. The information helps to target outreach. Examples of differentiation include the following:

- For maintenance clients (not in immediate need for referral to clinical or other services), a goal is behaviour change counselling and promotion of healthy behaviours.
- Clients who have taken an HIV test are grouped by result, with those testing negative evaluated for risk (and thus PrEP recommendation). Further differentiation among those who are HIV-positive is based on factors such as evaluation of whether a client is ready for ART initiation immediately and contraindications such as TB.

- Differentiation in messaging includes considering how to tailor prevention and positive health-seeking behaviour to individual clients based on their specific needs.

Extensive evaluation has not been undertaken yet because the programme is relatively new. Some indications of impact are emerging, including uptake of treatment at one anonymous clinic surging from 8% of those testing positive in one quarter's results to 70% in the subsequent quarter after it introduced same-day ART initiation. No information is yet available as to adherence or retention.

Indonesia

FHI 360 also is implementing the LINKAGES programme in Indonesia, where eight key population-led CSOs and 50 hospitals and clinics are being supported. Most outreach work is done in Jakarta.

Through the programme, differentiated outreach, testing and treatment services are being offered for MSM, sex workers, people who inject drugs, transgender women, intimate partners of key populations and some other targeted populations such as TB clients. A main differentiation strategy in the outreach context is based on considerations of how clients like to get service (or, 'differentiated preferences'). Three options are largely used: assistance (with service navigation and counselling; facilitated (e.g., by an opinion leader) and centered on risk assessment and referral; and client-controlled.

One major obstacle to scaling up the program extensively is that Indonesia is an increasingly discriminating environment for most key populations due to rising social and political conservatism fuelled by religious leaders and groups. Many important differentiated service elements for prevention and treatment also are not in place or cannot be offered to scale, including PrEP, self-testing, condoms and lubricants, community-based HIV screening or ART distribution, and viral load for monitoring.

The programme uses a range of different strategies to identify clients, which is difficult and complicated for key populations in most contexts including Indonesia. For example, a cadre called community-based supporters (CBS) do some mapping that is introduced to database tools to help programme managers determine who is being reached, where they are, and what kind of needs they have. Another data-gathering strategy is density mapping based on anonymized data from MSM dating apps. This approach consists of using information on where people were online when accessing such apps to give some indication of geographical areas where outreach workers might find more clients. Concerns about client privacy and confidentiality were raised by meeting participants with regards to tracking the whereabouts of people whose behaviour is considered illegal.

Caribbean islands

The Caribbean Vulnerable Communities Coalition (CVC) is seeking to strengthen and improve the efforts of CBOs in six small islands, the Organisation of Eastern Caribbean States (OECS), to reach and support key populations. The environment is complicated and difficult, with challenges including severe development and humanitarian shocks (e.g., from hurricanes in 2017); criminalizing regimes for MSM, sex workers and people who use drugs; stigma, discrimination and concerns about confidentiality; and limited data on key populations, with available HIV information also often not disaggregated by populations.

CVC has used onward granting and other methods to try to bridge a funding gap for civil society that has persisted since Global Fund resources diminished. The issue of disclosure, discussed in Section 2 above, is widespread in the OECS, thereby reducing access to health care by key populations in the region.

West Africa

An initiative known as Frontiers has been launched in nine countries in the region to bring innovation in delivering prevention and treatment. CSOs are undertaking the work, which aims to introduce and expand approaches such as ‘one-stop shops’ for prevention, testing, and treatment in mobile clinics and other non-traditional settings. Such efforts are considered vital to increase engagement with key populations.

Self-testing is being evaluated through a pilot programme in two cities in Senegal. Early results indicate good results in terms of acceptance and interest, and in return for HIV-related information. Implementers in Senegal are also seeking to make the environment safer for key populations and more conducive for their ability to obtain HIV and broader health services. This effort has included engaging with parliamentarians and hosting workshops with Muslim religious leaders on key populations and HIV. Such conversations have already shown some promising results, including a ‘gentleman’s agreement’ that the civil society-led programme targeting key populations will not be stopped as long as engagement continues.

CBOs and other community groups are also exploring ways to address legal barriers, both in terms of criminalized behaviours and age of consent policies for HIV testing and ART uptake. These and other efforts, such as engaging with families to help create safer environments for key populations, are considered necessary from a human rights perspective as well.

Uganda

In Uganda, the Ministry of Health in June 2017 released national implementation guidelines for DSD models for HIV prevention, care and treatment. The models refer to three different provision methods, one facility-based and two community-based (‘out of facility’). Key populations have been provided with services by many organisations offering PrEP, VMSC, risk assessment, referrals and linkages.

Unstable and complex clients are prioritized for facility-based care, with stable ones eligible for both facility- and community-based service delivery. Differentiation examples include stable clients being able to participate in community ART pick-up schemes that reduce the frequency of clinic visits. HIV testing can now be accessed and provided by CBOs and other civil society groups through outreach services and at clients’ homes.

5. Designing and Implementing Prevention for Key Populations: Some Issues to Keep in Mind

The examples summarized in Section 4 indicate that a differentiated approach might offer useful opportunities to provide key populations with more effective prevention information and services. Carefully segmented models might be needed, including to reach high-risk groups in diverse contexts such as members of the armed forces, construction workers and individuals who do not self-identify (and thus will not respond to peer linkage and outreach).

In general, revitalizing primary prevention to better meet the needs of key populations and other vulnerable groups, such as adolescents and young women, requires consideration of issues such as the following (all of which were discussed at the April meeting):

Flexibility in identification and affinity. Prevention programmes and models should be adapted to meet clients' own needs and lifestyles. This is at the core of most assumptions about differentiation. In developing flexible options and approaches for key populations, it will be important to keep in mind that many individuals have changing and multiple multiple behaviours and identities, including at different times in their lives. For example, a woman might sell sex worker, inject drugs and a mother—all at the same time, or each separately over time.

As noted in the discussion about the disclosure challenges in Section 2, there is often a difference between identity and behaviour. Shifting away from rigid ideas of identity, affinity and affiliation recognizes that each person also will opt to receive services in ways that respond to their personal context as well as the larger context in which they live. Some might prefer a CBO-centred model, some a health system model, and some a self-service model, for example. Versions of all three will need to be available to reach the largest share of any key population in any context.

Further flexibility is needed to respond to the fact that, for example, some people who regularly do sex work may not identify as a sex worker, and thus services targeting sex workers may not interest or appeal to them. Reaching transgender people with HIV prevention will be more effective if primary care and transition related care are offered. Reaching some MSM might best be done by offering HIV services at facilities and through programmes that do not segment for gay men, such as a 'men's clinic'. Similarly, a young gay man might not consider HIV to be something of relevance to his life and thus would not find HIV-focused outreach to be relevant. For some members of key population groups, creating safe spaces and opportunities for socialization may be a higher priority need than HIV-specific services, which, instead could be incorporated into broader socialization efforts.

All these examples underscore the importance of actively engaging with clients to find out what is working and what should be changed or abandoned.

Communities are indispensable. Prevention for key populations cannot be improved, expanded or sustained usefully without the involvement and leadership of CBOs and other civil society groups. Key populations continue to be systematically excluded from or discriminated against in many health systems, and thus CSOs may often be the only way they have access to any existing health infrastructure or services. Similarly, community-base services may be the only services that key populations trust to understand their needs and provide them with respect. This reality can and should be highlighted in all global, regional and local discussions, including through the HIV Prevention Coalition. For prevention to work better, the response should be to get more money and other support to them, especially in the most politically and socially hostile places.

Front-line services ideally should provide a standard minimum level of coverage that is relevant for key populations. In practice this means that although 'boutique' services for a key population such as transgender people might exist, government clinics that are often the entry point into health and wellness should have the capacity and ability to offer basic services for key populations and information and resources on hand to provide relevant referrals. Assuring a minimal level of coverage of this sort is important for sustainability.

Data can be a double-edged sword. Extensive and granular data, collected regularly and in real time, can help service providers and programmers become more targeted in their efforts. Concerns about confidentiality and clients' privacy deserve close attention, however, including in regard to how and why data is collected. Also, rich and extensive data is of little value if CBOs and other partners do not know how or why to use it.

Capacity can also be a double-edged sword. CBOs and other CSOs require sufficient human and financial resources to operate effectively. Many struggle to find donors able or willing to fund core administrative costs or advocacy work, the former of which is critical to their survival and the latter critical to their clients' survival. Onerous donor reporting and implementation expectations often make it difficult to meet conditions of project-specific funding.

Yet at the same time, assumptions that CBOs do not have sufficient capacity often are used to justify decisions not to fund them, or to do so in a limited manner. Thus, CBOs are denied access to funding based on capacity constraints at the same time that their capacity is constrained by burdensome donor requirements. This irrational and convoluted situation complicates and retards efforts to achieve the shared goals of providing prevention and other services as efficiently and extensively as possible.

Integration with and within UHC is both a priority and a necessity. The push and drive for UHC has made it a top health goal in many countries. How UHC is conceptualized and what it consists of will vary by context, but there are signs in some places that it is being interpreted narrowly as health insurance only or primarily to cover treatment. All essential components of an HIV response, including primary prevention and CBOs, must be included in the UHC umbrella. Evidence-informed advocacy can help make the case that UHC cannot be achieved in any country without them.

The value of safe spaces. Stigma and discrimination around key populations and HIV remain widespread, a deep-rooted social challenge that continues to restrict access to welcoming and secure services. Many key populations can benefit from more, and more accessible, safe spaces where they can get a full a range of health and social services and support.

Prevention in a PEPFAR world. PEPFAR-funded programmes such as LINKAGES focus on case finding and global ART uptake, which means the motivation is toward testing. A tension therefore exists between the need for PEPFAR-supported CBOs and other partners (including governments) to meet the PEPFAR mandate and the importance to the overall response in providing effective prevention services to key populations and others. Getting this balance 'right' is a complicated yet fundamental imperative.

6. Clarity and Guidance: Issues Requiring Further Analysis and Work

Service providers, programme designers, policy makers and advocates all could benefit from more clarity on some issues associated with HIV prevention and key populations. Summarized below are among the areas in which Amsterdam meeting participants suggested that additional work and analysis is needed.

Access should be the guiding principle of all prevention work, and thus of any DSD-related efforts. Issues around (and impediments to) access to prevention, testing and treatment services for key populations are different from the general population. Among the most important considerations is where key populations can go to get quality, respectful and

safe services. All efforts to define and introduce DSD for key populations therefore must be based on increasing and improving access.

Population-size estimates. Reliable data and information is lacking on key populations in many contexts, thereby reducing confidence in existing estimates and restricting the ability to design and plan interventions. Given the difficulties and expense of estimating population sizes, how important and useful is it to focus or increase efforts to obtain better numbers?

One school of thought is that size estimates are still useful in countries where governments are in denial about key populations. More reliable estimates could perhaps help to convince such governments of the need to have special services for one or more key populations. Another idea is that more energy, funding and time should be spent on immediately and comprehensively expanding services and support to key populations that can be reached now. If such services are good and acceptable, they may attract more clients and thus offer opportunities to scale up prevention more quickly even in the absence of data.

6. Recommendations

Meeting participants proposed a series of recommendations aimed at moving forward practical discussions and decision-making around primary prevention, key populations and DSD in overall HIV responses. Some of them are summarized below.

(A) Earmarked funding should be made available for CBOs to develop prevention interventions.

(B) Best-practice guidance and case studies should be prepared to promote the formalizing, professionalizing and standardizing of the role of peer educators and other peer providers. Such guidance might include, for example, how to define a peer educator, what they should and should not be asked or permitted to do, a code of ethics that covers them and their affiliated organizations, and the type of adaptations that might be needed in certain contexts (e.g., highly criminalizing ones).

(C) Advocacy around community systems strengthening (CSS) should be revived. This is important because any strategy or initiative around DSD requires CBOs and other civil society groups being able leverage expertise and synergies more effectively and extensively. This can only be successful when communities are strengthened, including in areas such as programmatic and financial management.

(D) Increased opportunities should be created for collaboration between CBOs and authorities at both local and national levels. This is necessary for several reasons. For one, it could address the fact that good and effective experiences in service delivery by civil society groups often are not formalized or taken forward. Even standard complementary prevention and treatment services provided by CBOs are not always incorporated into national systems and thus supported on an ongoing basis. Increased and regular collaboration is also essential for the overall quality and reach of HIV responses as governments continue to take on more funding responsibility.

For any response to be effective, particularly in regard to serving key populations, CBOs will need to be involved extensively and continuously. Mechanisms such as social contracting will facilitate government funding of civil society groups to undertake vital prevention services that national or local governments are unable or unwilling to provide.

(E) In all countries and contexts, UHC should be approached and implemented broadly so that combination prevention for HIV is included. Space for prevention and most other HIV services, including treatment, is non-existent or limited when UHC is solely or mostly about insurance coverage.

There is urgency to this recommendation. Many countries that are seeking to scale up insurance schemes as part of UHC work are not including HIV services in the package of services covered because doing so would bankrupt the schemes. Coordinated advocacy across a wide range of health and human rights groups is needed to ensure that UHC is interpreted in a way that leads to access to all for the health services they need.

(F) Targets and indicators should be developed to gauge impact in keeping people negative. Such indicators would give CBOs and other entities providing prevention services more opportunities to highlight and prove the value of their work. One way to approach concerns about developing a 'hard' indicator for such work might be to assess testing results over time. An organization's impact could be indicated by its ability to support a client to stay negative at each six-month testing period, for example.

(G) A specialized fund should be developed to ease donors' ability to fund broad-scale social justice work around a key populations platform that is not solely about HIV. An integrated human rights initiative of this sort might be particularly appealing in the UHC and Sustainable Development Goals (SDGs) agenda. The Robert Carr civil society Networks Fund could be a model.

(H) Donors should be more flexible when working with civil society groups in programme design and implementation. Flexibility in this sense refers to issues such as what donors are willing to fund (e.g., their current reluctance to support core funding); the expectations of reporting mechanisms (e.g., their rigidity and extensive paperwork); and length of grants and agreement, as most implementers consider multi-year arrangements to be better for clients and organizational sustainability.