



# Innovative HIV Prevention Practices and Programmes for Long Distance Truck Drivers and Sex Workers: Global Lessons and Opportunities in the SADC Region



Health outreach

## Introduction

HIV prevalence is disproportionately high among sex workers (SW) and long distance truck drivers (LDTD) compared to the general population, both globally and in the Southern African region.<sup>1</sup> A recent HIV sero-prevalence survey by the World Health Organization (WHO) at three border sites in Southern Africa found HIV prevalence rates of 53% among SW and 26% among LDTD.<sup>2</sup> The vulnerability of these populations is fuelled by high levels of mobility; stigma and discrimination; poor access to HIV, sexually transmitted infection (STI), tuberculosis (TB), and other essential health services; and limited coordination by service providers along the transport corridors.<sup>3</sup> This situation leaves behind key priority populations, and if not addressed, will continue to be a source of HIV transmission and pose challenges to case detection, retention in care and management of both communicable and non-communicable diseases.

## Objective

Southern African Development Community (SADC) Member States are committed to the identification, adoption and implementation of evidence-based best practices, harmonization of standards, and revitalization of prevention strategies to achieve the UNAIDS 90-90-90 goals for an AIDS-free generation.

1 WHO (2011). Preventing HIV in sex work settings in sub-Saharan Africa.

2 WHO (2014). Repeated HIV Sero-Behavioral Survey Among Sex Workers and Long Distance Truck Drivers in 3 Border Sites in the SADC Region.

3 Ibid.

However, the region will not be able to reach these targets unless it applies an inclusive approach targeting marginalized populations such as SW and LDTD. This fact sheet describes innovative HIV prevention practices and programmes for LDTD and SW globally and identifies opportunities for scaling up services to these target groups in the SADC region.

## Transport routes in SADC



## A Global Model of Innovative Practice: Avahan—The India AIDS Initiative

Jointly implemented by the Bill & Melinda Gates Foundation and the Government of India from 2003 to 2014, Avahan reduced HIV transmission in the general population by rapidly scaling up HIV prevention services to reach 80% of high-risk and bridge population groups in six high prevalence states.<sup>4</sup> Participants were highly diverse in terms of culture and religion, and the states constitute a large geographic area and population size (300 million).<sup>5</sup> Avahan established a model for successfully scaling up combination HIV prevention programming to meet the complex and varied needs of key populations that many countries find challenging.<sup>6</sup> This model has been commended by the WHO and USAID as replicable in other contexts, including Southern Africa.

Avahan targeted SW, their clients (including LDTD<sup>7</sup>), men who have sex with men (MSM), transgender persons, and injecting drug users (IDU) along major trucking routes. The project applied a combination prevention approach which incorporated behavioural and biomedical risk reduction strategies as well as structural interventions to address the social, economic, and political barriers to programme implementation.

Core programme elements included: mass media and peer-led community outreach to promote behaviour change; clinical services to treat STIs other than HIV (with referral to HIV and TB treatment services); primary health care; commodity distribution (promoting and distributing free condoms for SW and needle/syringe exchange for IDUs); community mobilization and capacity building to ensure community ownership of the programme; and research and advocacy to reduce structural barriers, such as stigma and discrimination, police harassment, and violence.

### Critical Success Factors of Avahan

**Data driven approach to programme design, monitoring, and implementation:** Avahan analysed national epidemiology and sexual behavioural data, which highlighted that 82 districts in six of India's 28 states contributed 83% of all HIV infections in the country. The project used population size estimates and community mapping at district and sub-district levels to estimate the number of high-risk groups, map sexual networks, and identify hotspots in the community. This enabled programme managers to identify priority target groups, service needs, and the location of services.

4 Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Nagaland, and Manipur.

5 Avahan—The India AIDS Initiative (2008). "The business of HIV prevention at scale." New Delhi: Bill & Melinda Gates Foundation.

6 Rau, B. (2011). "The Avahan-India AIDS Initiative. Promising approaches to combination HIV prevention programming in concentrated epidemics."

7 LDTDs accounted for approximately 10% to 12% of clients of female SW.

The population size estimates also established a denominator for setting targets for scale up, measuring progress, and facilitated appropriate resource allocation. At the community level, peer educators conducted individual risk assessments with clients, identified their specific health needs, and planned weekly community outreach activities.

**Planning programmes for scale:** Avahan set ambitious targets for scale up, aiming to reach 80% of high-risk groups with a comprehensive package of HIV prevention services. As the project was rolled out simultaneously in all states, Avahan defined a core minimum package and program and established an effective management model. This defined a set of basic technical and managerial standards to guide service delivery and management systems, promoting consistent high quality services, training, and monitoring, while giving local partners the flexibility to customize activities based on local needs.

**Community empowerment:** Community empowerment facilitated individual and collective ownership of the programme to achieve HIV outcomes and address social and structural barriers to health and human rights.<sup>8</sup> Through Avahan, SW and other key populations participated in all aspects of programme design, implementation and evaluation. For example, they monitored the appropriateness and quality of services through clinic committees and other structures.

**Expanded role of peer educators:** Peer educators led the mapping of hotspots and sexual networks in their communities, and played a key role in mobilising their peers. Peer educators played an important role in the development of community-based organizations (CBOs) and SW networks.

**Structural interventions:** Avahan helped to create an enabling legal and social environment for HIV prevention. A key finding from the community mapping exercise was that female SW and MSM experience

8 Blanchard, A. K., H. L. Mohan, et al. (2013). "Community mobilization, empowerment and HIV prevention among female sex workers in south India." *BMC Public Health* 13(1): 234.



Community dialogue with sex workers under the Avahan project

violence at the hands of the police and gangs.<sup>9</sup> In health care settings, MSM and SW faced stigma and discrimination from staff who often denied them services. Fearful of this treatment, many simply did not access basic health care. Avahan introduced sensitivity training for police and health workers, and encouraged SW to proactively confront police who try to intimidate or marginalize them.

This approach empowered them to have greater control over their own sexual health and wellbeing, which was one of Avahan's goals. Avahan also introduced a peer-led and NGO-supported rapid response/crisis intervention service, with lawyers responding to reports of violence by police or gangs or domestic violence within 24 hours. Negotiations were conducted at police stations, sometimes with senior officers, to resolve these issues.

**Sustainability:** In phase 1 (December 2003 to April 2009), Avahan focused on establishing systems for maximum coverage of key populations with prevention services, while phase 2 (May 2009 to July 2014) concentrated on building the capacity of government, NGOs and community networks for an effective and smooth staged transfer of the programme. Project approaches such as participatory site assessment, community participation and empowerment, clinic

<sup>9</sup> For example, women carrying condoms were suspected of being SW and forced to pay bribes to avoid arrest or coerced into providing sexual favours.

branding and colour-coded STI kits, redefined the way health programs were implemented in the country. Many of these approaches were later adopted by the National AIDS Control Organisation.

**Achievements:** Avahan scaled up HIV prevention services to more than 80% of the high-risk target groups in priority districts. By the end of phase 1, Avahan partners had reached more than 220,000 SW with monthly HIV prevention services, as well as 80,000 high-risk MSM and transgender persons, 18,000 IDUs, and 5 million men working in the trucking industry. Avahan increased consistent condom use among key populations, improved health seeking behaviour, reduced STI rates, and created a safer work environment for SWs. Avahan ultimately had a population-level effect on HIV incidence, averting an estimated 100,178 new HIV infections between 2003 and 2008. The reduction in HIV prevalence in the general population due to Avahan varied among states, ranging from 2.4% in Maharashtra to 12.7% in Karnataka.<sup>10</sup>

**For more information, visit:** [www.gatesfoundation.org/](http://www.gatesfoundation.org/) or [www.fhi360.org/projects/avahan-%E2%80%94-india-aids-initiative](http://www.fhi360.org/projects/avahan-%E2%80%94-india-aids-initiative)

<sup>10</sup> A greater intensity of Avahan activities, as measured by the amount of grant funds per population with HIV, was significantly associated with lower HIV prevalence in three states.

## Models of Good Practices in the SADC Region

Several innovative programmes for key and priority populations in the SADC region present opportunities for collaboration and scaling up services.

### REGIONAL NETWORKS

#### Africa Sex Worker Alliance (ASWA)

ASWA is the Pan African Alliance of sex worker-led groups based in Nairobi, Kenya. Formed in 2009, ASWA's vision is to see a world where sex work is recognized as work in Africa, and where the health and human rights of all SW living and working in Africa are protected. Through networking, strategic partnerships, advocacy, capacity building, and resource mobilization, ASWA empowers and advocates for the health and human rights of female, male, and transgender SW, including those living with HIV and using drugs. ASWA has 84 member organizations, nine of which are in the SADC region. ASWA is part of the Global Network of Sex Work Projects, and is a key implementing partner for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) KP REACH project and the AIDS Fond Hands Off! Project.<sup>11</sup>

**For more information, visit:** <http://aswaalliance.org>

<sup>11</sup> ASWA. (2014). "About ASWA." Retrieved 26/10/2015, 2014, from <http://aswaalliance.org/about/>.

#### Federation Eastern and Southern African Road Transport Associations (FESARTA)

FESARTA is a regional road transport association, representing 16 National Road Transport Associations (NRTAs) in East and Southern Africa. FESARTA adds value to its NRTA members through information dissemination, advocacy and solving cross-border problems along the region's transport corridors. It further aims to improve the efficiency of transport in the region, lower transport costs and reduce poverty. The *Harmonised Cross Border Road Transport Regulations and Standards* address driver health and wellness.

**For more information, visit:** [www.fesarta.org](http://www.fesarta.org)

### REGIONAL INITIATIVES

#### Regional Minimum Standards and Brand for HIV and other Health Services along the Road Transport Corridors in the SADC Region (RMSB)

In response to the HIV high prevalence rates among SW and LDTD in the region, the SADC Secretariat developed Regional Minimum Standards and Brand for HIV and other Health Services along the Road Transport Corridors in the SADC Region (RMSB).



The RMSB, approved by the SADC Health Ministers in November 2015, harmonize prevention services, treatment and care for HIV, TB, STIs, sexual and reproductive health, occupational health and non-communicable diseases for LDTR, SW and local communities throughout the region's transport corridors, beginning at existing SADC Cross Border Initiative roadside wellness centres. The RMSB complement existing services, and define the roles and responsibilities of key stakeholders including government, regional and national transport federations, SW associations, trucking companies, and NGOs in the implementation of the standards. The RMSB create a platform for regional and national partnerships and collaboration to enhance the quality and reach of prevention and treatment services to these populations.<sup>1</sup>

**For more information, visit:** [www.sadc.int](http://www.sadc.int)

## Hands Off! Project

Hands Off! is a five-year project (2015-2019) to prevent HIV and reduce violence against SWs. Implemented by Aids Fonds of the Netherlands, the project takes a multi-pronged approach to improve the living and working conditions for SW by involving regional partners (ASWA, COC Netherlands, North Star Alliance), SW, police, law enforcement, and service providers in five SADC countries.<sup>2</sup> The project uses police sensitization, rapid response methods, and SW protection systems as intervention strategies. It gathers data to advocate for SW rights, and litigates in support of victims of violence. The project has a strong capacity building component that focuses on SW and SW-led organizations in the region. Ongoing research guides programme design and assesses the effectiveness of strategies.

**Achievements:** The project, which is in its start-up phase, has initiated the development of a regional manual for police sensitization, lobbying and advocacy for SW rights, safety and human rights. AIDS Fonds recently completed a baseline needs assessment, which involved 2,300 survey interviews, 120 in-depth interviews, and 40 focus group discussions in the five project countries, and will be used to guide program design and implementation.

**For more information, visit:** [www.aidsfonds.nl/about/organisation](http://www.aidsfonds.nl/about/organisation)

## HIVOS KP REACH project

In July 2015, the Global Fund awarded \$11.4 million to a consortium focusing on key populations most affected by HIV in Southern Africa. The three-year, seven-country Key Populations – Representation, Evidence and Attitude Change for Health Impact project (KP REACH), is managed by HIVOS in partnership with regional key population organisations. The goal of KP REACH is to reduce HIV and TB infections and deaths through improved access to prevention, testing, and treatment

services. A key focus of the grant is on key population community systems strengthening. The project will engage existing networks of key populations in the region as sub-recipients, strengthening these networks; improving data collection, knowledge management and innovation; and helping scale up and replicate best practices. KP REACH will also address stigma and discrimination, using targeted messaging and innovative approaches to change mindsets and promote social change.

**For more information, visit:** [www.hivos.nl](http://www.hivos.nl)

**Key populations** are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. KPs include (but are not limited to) 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people. People in prisons and other closed settings are included also because of the often high levels of incarceration of the other groups and the increased risk behaviours and lack of HIV services in these settings. The KPs are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic. (WHO, 2014)

**Vulnerable populations** are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. (WHO, 2014)

## ILO Corridor Economic Empowerment & HIV Project (CEEP)

The International Labour Organization (ILO), with support from the Swedish International Development Agency, initiated CEEP in six East and Southern African countries in 2011 to empower SWs and vulnerable women living along selected transport corridors through personal development and by increasing the availability of economic services and opportunities. The project aims to reduce their vulnerability, mitigate the impact of HIV and AIDS, and enable women to address the challenges that arise in their local contexts.

**Achievements:** Since 2011, CEEP's technical assistance reached more than 164,603 stakeholders and policy makers, and resulted in national policies and programmes incorporating economic empowerment and gender equality in their HIV risk reduction programmes. CEEP supported 70 business support structures and co-operatives in six countries by training 386 trainers in economic strengthening who in turn trained 10,970 community members in business management, gender equality, and HIV and AIDS. Beneficiaries continue to

<sup>1</sup> SADC (2015). Regional Minimum Standards and Brand for HIV and other Health Services along the Road Transport Corridors in the SADC Region

<sup>2</sup> Botswana, Mozambique, Namibia, South Africa, and Swaziland

support each other to develop business plans. The 2014 project assessment estimated that CEEP supported nearly 9,000 businesses and resulted in the creation of 11,554 jobs. An Innovation Fund enabled vulnerable groups to access funding through co-operatives and business groups. Beneficiaries reported improvements in their socio-economic status and personal lives, as well as changing attitudes toward gender roles and violence. The project increased participants' HIV knowledge, with 56% of beneficiaries adopting risk reduction strategies in the last six months compared to 8% of the control group.<sup>3</sup>

**For more information, visit:** [www.ilo.org/addisababa/technical-cooperation/WCMS\\_315603/lang-en/index.htm](http://www.ilo.org/addisababa/technical-cooperation/WCMS_315603/lang-en/index.htm)

### SADC HIV and AIDS Cross Border Initiative (CBI)

The CBI, funded by the Global Fund, supports the 12 inland SADC countries to reduce HIV infections and manage the impact of HIV on mobile populations, including LDTD and SW, through a network of 32 mobile primary health care clinics at border posts across the region.

**Achievements:** In phase 1, 11 wellness centres were established to provide HCT, treatment of STIs, and condom distribution services. Phase 2 activities focus on the rapid scale up of the number of wellness centres and the transitioning of established sites to Member States. All CBI wellness sites comply with country health protocols, quality assurance, and reporting requirements, enabling Member States to track the services provided.

**For more information, visit:** [www.sadc.int](http://www.sadc.int)



A North Star Alliance Roadside Wellness Centre in Musina, a border between South Africa and Zimbabwe

### North Star Alliance

One of the sub-recipients of the SADC CBI, North Star Alliance is a non-profit, public-private partnership that brings quality and sustainable health services to people with increased health risks, such as LDTD and SW, and communities with limited or no access to medical

services. The organization's network of 34 roadside health clinics at major truck stops, border crossings, and transit towns in East, Southern, and West Africa enables beneficiaries to access essential health services at multiple points along the transport corridors. The majority of sites are open late, tailored to the hours of the target populations.

**Achievements:** In 2014, North Star Alliance reached an estimated 229,224 truck drivers and other mobile workers with educational and health services. To increase the number and frequency of truck drivers accessing health services, the organization introduced Star Driver, a loyalty programme which combines traditional clinical and public health services with non-medical benefits, such as professional development, and activities directed at boosting a sense of community and increased self-esteem. North Star Alliance uses COMETS, an electronic health passport system with ORTEC to capture and track patient-specific data among clinics to ensure continuity of care and monitoring services. North Star Alliance partnered with the Foundation for Professional Development to map health, social, and support service providers along transport corridors and border areas in Southern and Eastern Africa. The resulting web-based Medical Services Directory is a geographic information system allowing mobile populations to access up to date information on the location of the closest health facility. North Star Alliance is also collaborating with the Wits Reproductive Health Institute to pilot the feasibility of providing ART services to LDTD and SW in five sites in three countries through its clinic network.<sup>4</sup>

**For more information, visit:** [www.northstar-alliance.org/](http://www.northstar-alliance.org/)

### Walvis Bay Corridor Group

The Walvis Bay Corridor Group (WBCG) is also a sub-recipient of the SADC CBI. It started in 2003 as an HIV and AIDS workplace initiative for the road freight and logistics industry in Namibia to promote HIV and STI awareness among LDTD, SW, and cross border communities. WBCG has evolved into a dynamic public-private partnership providing holistic health and wellness services for both communicable and non-communicable diseases, as well as primary health services to partners in the trucking and allied industries through a range of mobile wellness clinics and fixed wellness centres.

**Achievements:** In 2014, WBCG tested more than 7,497 individuals for HIV. Of the 1,514 LDTD who tested for HIV, 67 tested HIV positive (4%), a slight decrease from 2013, when 409 or 6.9% tested HIV-positive. All HIV-positive clients were referred to HIV treatment, care and support services. WBCG also tested 935 SWs, of which 67 tested HIV positive (7%).

**For more information, visit:** [www.wbcg.com.na/](http://www.wbcg.com.na/)

3 ILO. (2015). "Corridor Economic Empowerment Project Case Studies." from [http://www.ilo.org/addisababa/technical-cooperation/WCMS\\_315603/lang-en/index.htm](http://www.ilo.org/addisababa/technical-cooperation/WCMS_315603/lang-en/index.htm)

4 North Star Alliance. (2015). "Our Model." from <http://www.northstar-alliance.org/our-model/>



## COUNTRY INITIATIVES

### Red Umbrella Project

The Red Umbrella Project (2013-2016), funded by the Global Fund, is the first national-level programme in South Africa to provide comprehensive HIV prevention, care, and support services to SW. The Networking HIV, AIDS Community of South Africa (NACOSA)<sup>1</sup> is the Principal Recipient for the project, with the Sex Workers Education and Advocacy Taskforce (SWEAT) as the lead implementing partner providing training, coordination, quality assurance, and monitoring and evaluation (M&E) support to partners. The Red Umbrella project model is similar to Avahan and aligned with global guidelines for implementing programmes for SW developed by WHO, UNFPA, UNAIDS, NSWP, and the World Bank in 2013. Key components of the project include: structural interventions; community empowerment and community led-services; capacitating NGO sub-recipients to provide SW-focused services; sensitization training for police and health workers; training for peers and site coordinators; support to the Sisonke Sex Worker Movement; and support to the South African National AIDS Council (SANAC) Sex Work Sector.

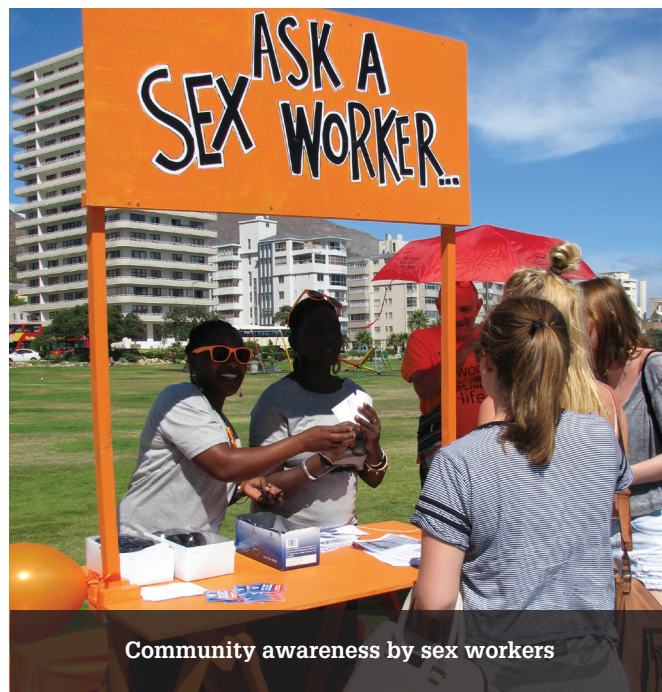
**Achievements:** The first national knowledge, attitude, and behaviour survey and population size estimate study among SW was conducted in 2013; a follow-up survey is planned for 2016 to assess the impact of the project. Partnerships have been established with 18 NGOs in 74 sites to expand services for SWs in all nine South African provinces. Since 2013, the project trained 56 site coordinators and 469 SW peer educators who provide comprehensive HIV prevention, treatment, care, and violence prevention services to approximately 37,000 SW per quarter. They also trained 109 SW as paralegals, called human rights defenders, who educate peers on their legal and human rights and provide paralegal support in cases of human rights violations. To increase condom use among sex workers and their clients, the project introduced branded pink condoms and strawberry flavoured lubricants distributed by peer educators.

**For more information, visit:** [www.nacosa.org.za](http://www.nacosa.org.za)

<sup>1</sup> NACOSA is a national civil society network of organizations working in HIV, AIDS, TB, and related social development fields. With more than 1,400 members, NACOSA works to build healthy communities through capacity development, networking, and promoting dialogue.



SWEAT campaign to decriminalise sex work in South Africa



Community awareness by sex workers

### Sex Workers Education and Advocacy Taskforce (SWEAT)

SWEAT, South Africa's leading sex worker human rights organization has a reputation for effective advocacy and lobbying for sex worker rights both in South Africa and the SADC region. SWEAT collaborates closely with SANAC to raise awareness of SW human rights and improve access to services for sex workers. SWEAT hosts Sisonke, the national SW movement that is led by SW. SWEAT's SW peer educators and leaders conduct outreaches at sex work locations and facilitate risk reduction workshops and support groups for SW (including adherence support for HIV-positive clients). SWEAT also facilitates drama groups to deliver behaviour change messages and manages a 24-hour national helpline for SW by SW that provides human rights support, including addressing violence and police abuse. SWEAT advocates for law reform, including decriminalization of sex work.<sup>2</sup>

**Achievements:** SWEAT trained SW peer educators for the Red Umbrella Project and sensitised 2,408 health care workers, and other service providers such as social workers from more than 90 institutions regarding SW needs and rights. SWEAT co-hosted the first National Sex Work Symposium, involving 200 practitioners, policy makers and sex workers in 2014 which resulted in the development of South Africa's National Operational Plan for Sex Workers. SWEAT established and mentored the African Sex Workers Alliance and facilitated the establishment of a national coalition for the decriminalisation of sex work (the Asijiki Coalition), and is a partner in the Hands Off! project to reduce violence against sex workers.

**For more information, visit:** <http://sweat.org.za>

<sup>2</sup> SWEAT. (2015). "Who we are." from <http://www.sweat.org.za/who-we-are/>

## Corridor Empowerment Project (CEP)

CEP, also known as Trucking Wellness, was established in 2006 in partnership with the South African National Bargaining Council of the Road Freight Industry. Trucking Wellness provides comprehensive primary health care to an entire industry through a national network of 22 strategically placed Roadside Wellness Centres at truck stops along national routes in South Africa. Basic screening, diagnosis and treatment services are provided, as well as on-site health screening at the company level, Wellness Programme presentations to unions and employers, peer education training to road freight industry personnel and SW, and support for revision and implementation of workplace HIV policies.

**Achievements:** CEP provides comprehensive HIV and other health services to an average of 3,000 LDTR, SW, and community members per year. Any person testing HIV-positive is referred to Care Works, which facilitates enrolment in care: either private treatment in the case of an industry employee, or to state/NGO treatment partners. More than 3,000 industry employees are currently enrolled in private treatment funded by the road freight industry and managed by Care Works, with an 80% adherence rate. Wellness centres are linked via an internet-based real-time computer system to provide a tailored and continuous level of care.

*For more information: <http://coremp.co.za/>*

## Disseminating Avahan Lessons in South Africa Project (DALSA)

With support from the Bill & Melinda Gates Foundation, the DALSA project (2011-2015), managed by FHI360, focused on strengthening the capacity of provincial and national institutions in South Africa to effectively manage, scale up, monitor, and evaluate HIV prevention, care, and treatment interventions for key populations. Activities were concentrated primarily in the Kwa-Zulu Natal province, with additional support at the national level.

**Achievements:** DALSA supported the NDoH and SANAC to develop the Operational Guidelines for HIV, STIs and TB Programs for Key Populations in South Africa and the SANAC National Sex Work Sector Plan. The project also supported the revision of NDoH High Transmission Areas guidelines, scaled up HIV services to key populations in HTA areas from 41 to 77 sites; mapped HIV risks at selected trucking sites; mentored and coached primary health care facilities to integrate services to key populations and assisted the Department of transport to improve HIV and TB programming in the transport sector.

**For more information, visit: [www.fhi360.org/projects/disseminating-avahan-lessons-south-africa-dalsa](http://www.fhi360.org/projects/disseminating-avahan-lessons-south-africa-dalsa)**

## Botswana ART Test and Treat Approach for Key Populations

Based on evidence of antiretroviral (ART) drugs preventing HIV transmission,<sup>3</sup> in 2014 the Government of Botswana, its Ministry of Health (MoH), and US Government partners began one of the first test and treat programmes<sup>4</sup> for key populations in the region. The Botswana Key Populations Program pilot, implemented by Management Sciences for Health (MSH), provided high quality, effective, and accessible services to SW and MSM. The programme incorporated community outreach and peer education, community mobilization, and clinical services including ART. The programme sought to immediately enrol all female SW who tested HIV-positive on ART to reduce their viral load, leading to improved health and a reduction in HIV transmission.

**Achievements:** MSH and its partners developed standard operating procedures to guide comprehensive services for key populations. The project reached more than 4,100 SW and MSM with targeted HIV prevention messages, distributed more than 1.6 million condoms, and tested over 750 individuals for HIV. Of the 3,478 FSWs reached with HIV prevention messages, 606 were tested for HIV and received their results, and 171 tested positive for HIV. Although the “test and treat strategy” implemented by the project requires that all 171 HIV-positive individuals be placed on ART regardless of CD4 count, only 24 were enrolled in treatment. Nearly 25% of these clients were non-citizens and were therefore not supported by the Botswana national antiretroviral drug supply system. Sixty-five percent of the HIV-positive Botswana has CD4 counts above 350 and were reluctant to start ART, citing previous MoH messages that advised starting when CD4 fell below 350. Remedial strategies instituted to improve programme performance include: tightening the referral system between community and clinical partners; strengthening partnership to enforce mutual accountability for shared goals; “moonlight” (evening) delivery of services when clients are available; and re-orientation of peer educators on the ultimate goals of the programme to better support clients to access the entire range of key prevention services, and adhere to treatment for their own health and that of their clients.

**For more information, visit: [www.hivsharespace.net/node/2993](http://www.hivsharespace.net/node/2993)**

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3 Cohen, M. S., Y. Q. Chen, et al. (2011). “Prevention of HIV-1 infection with early antiretroviral therapy.” *New England journal of medicine* 365(6): 493-505  
4 Smith, M. K., K. A. Powers, et al. (2012). “HIV treatment as prevention: the utility and limitations of ecological observation.” *PLoS Med* 9(7): e1001260

## Conclusion

The Avahan project in India provides useful lessons for rapidly scaling up services to key populations in the SADC region. Success factors include: using data to effectively plan and monitor project implementation; successfully combining a mix of behavioural and biomedical interventions with community mobilization and advocacy to address the structural drivers of the epidemic for more effective health outcomes; the benefits of working with multiple partners within an agreed-upon framework; and the need for effective programme management and flexibility to review and align programme objectives and approaches to local realities.

This review has also highlighted several innovative initiatives in the SADC region that provide accessible, quality health services to LDTD, SW, and other mobile populations. Many of these programmes also address structural factors that increase these populations' vulnerability to HIV and other STIs and hamper their access to essential health services and commodities. The challenges in serving these key populations are many and include preventing duplication of effort, creating an enabling legal and policy framework and effectively coordinating and supporting CSOs and other partners to scale up such initiatives to reach those most in need.

While providing evidence of good practices, it should be noted that there is a need to strengthen and improve the quality and reach of these interventions to these target groups. The SADC Regional Minimum Standards and Brand for HIV and Other Health Services along the

Road Transport Corridors in the SADC Region can be a key guiding document for the harmonization of HIV and other health services along transport corridors in the region.

## Resources

UNAIDS, The Gap Report. Geneva: UNAIDS, 2014.

WHO, Implementing Comprehensive HIV/STI Programmes with Sex Workers Practical Approaches from Collaborative Interventions, 2013.

The President's Emergency Plan for AIDS, Technical Considerations provided by PEPFAR Technical Working Groups for 2015 Country Operational Plans and Regional Operational Plans Global Fund, Key Population Action plan 2014-2017, 2014.

HEARD, Human rights and the HIV response report Eastern and Southern Africa Region.

Lancet Series, HIV and Sex Workers, July 23, 2014  
<http://www.thelancet.com/series/hiv-and-sex-workers>

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