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# DIFFER

## FINAL PUBLISHABLE SUMMARY REPORT

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## Executive Summary

The DIFFER project piloted and tested an intervention package to improve access to and uptake of HIV and sexual and reproductive health (SRH) services among female sex workers (FSW) in four cities: Mysore in Karnataka State, India; Mombasa in Kenya; Tete in Mozambique; and Durban in South-Africa. The hypothesis was that the best results are achieved by a 'diagonal' approach, combining services targeted at FSW (vertical) with improving access to the general health services (horizontal). It applied a mixed-methods implementation research design based on a framework for health systems research. In a first phase, a thorough situational analysis was done by reviewing national strategic documents; interviewing key policy makers, health managers, service providers, and service users; conducting audits at relevant health facilities; holding focus group discussions with FSW; and measuring key indicators through a cross-sectional survey with FSW. The results were triangulated to inform the design of a comprehensive site-specific intervention that was then implemented for at least 18 months. Simultaneously, the capacity of the FSW communities at the African sites was strengthened through a south-south exchange from the Indian site.

We assessed the effect of the intervention on the uptake of services, empowerment, equity and acceptability by FSW. To that purpose, we conducted a second cross-sectional survey and compared the results to the baseline, we held a second round of FSW focus-group discussions and analysed the available service statistics. The feasibility, adequacy and sustainability of the interventions were assessed through interviews or group discussions with policy makers, managers, service providers and, where relevant, service users, and the cost of the interventions was analysed. To ensure translation into policy, appropriate mechanisms were established to engage the community and key stakeholders at each step of the process.

In each of the cities, an increase in service uptake was achieved. In **Mysore**, Ashodaya Samithi, a sex worker-led organization, had an already well-mobilized FSW community and high coverage of HIV/STI services at baseline. Further increase was mostly achieved by integrating other SRH services, such as cervical cancer screening and family planning, with the HIV/STI services at the Ashodaya clinic and the HIV care centre of a charitable hospital. Ashodaya's next step will be advocacy at the local and national levels to support the scale up of integrated SRH and HIV/STI services across the state and country. At baseline, **Durban** had the least well-developed interventions targeting FSW and the lowest service uptake. Great advances were achieved by successfully facilitating a collaborative effort between a government clinic and two non-governmental organisations, combining peer education and clinical outreach with enhanced access through health systems navigators. These successes opened the door to advocacy at the policy level and scaling up of some intervention components. In **Mombasa**, increase of uptake was mostly achieved by strengthening peer outreach and the use of FSW-specific drop-in clinics. Piloted systems to improve linkage with and use of public health facilities were less successful. In **Tete**, not all activities identified as necessary to improve access to care could be implemented due to government policy and lack of resources. Nevertheless, progress was made mostly by strengthening peer outreach and targeted mobile clinics. Approaches to improve access to public health facilities, such as the appointment of key population focal points, were highly appreciated but started too late to demonstrate a measureable effect. The future of an essential component of the intervention, a clinic targeting key populations, is uncertain because of low government endorsement. Sustainability of the targeted interventions is threatened by a high dependence on short-term external funding.

The equity analysis indicated that overall some improvements were observed in the use of SRH services among the most vulnerable sex workers in all sites, but particularly in Tete. The findings from the analysis of baseline and end-line empowerment data suggests some improvements in FSW empowerment indicators in all sites. An analysis of the cost of the Mysore and Durban interventions suggested that they were cost effective in both sites, and likely to be sustainable.

The level of community mobilisation was low in all three African cities, at baseline. The south-south exchange was successful in enhancing the capacity of the FSW, and the main lessons learned were that (1) it is key to have a community-to-community (C2C) connection; (2) C2C must go beyond trainings and workshops; (3) endorsement by intermediaries is required for meaningful access to the community; (4) C2C capacity building is bi-directional; and (5) proper logistics planning and documentation is important.

## Acronyms

AIDS	Acquired immune-deficiency syndrome
ANC	Antenatal care
APHIA	AIDS, Population and Health Integrated Assistance
ART	Antiretroviral therapy
CAB	Community Advisory Board
CBO	Community-based organisation
CHP	Centre for Health Policy
CSS	Cross-sectional survey
DIFFER	Diagonal interventions to fast-forward enhanced reproductive health
DIC	Drop-in clinic
EC	Emergency contraception
FGD	Focus group discussion
FP	Family planning
FPAI	Family Planning Association of India
FSW	Female sex workers
GPW	General population women
HCN	Health Care Navigators
HCP	Health care providers
HSN	Health Systems Navigators
HTS	HIV testing services
HIV	Human immune-deficiency virus
ICAAP	International Congress on AIDS in Asia and the Pacific Region
ICASA	International Conference on AIDS and STIs in Africa
ICRH	International Centre for Reproductive Health
ICTC	Integrated Counselling and Testing Center
IEC	Information, education and communication
INT\$	International dollar
KZN	Kwa-Zulu Natal
MatCH	Maternal Adolescent and Child Health
MSM	Men-having-sex-with-men
MoH	Ministry of Health
NACO	National AIDS Control Organisation
NASCOP	National AIDS & STI Control Programme
NGO	Non-governmental organisation
NHM	National Health Mission
OB/GYN	Obstetrics/Gynaecology
PAB	Policy Advisory Board
PAC	Post-abortion care
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PPTCT	Prevention of parent-to-child transmission

PrEP	Pre-exposure prophylaxis
RDS	Respondent-driven sampling
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infections
TB	Tuberculosis
TI	Targeted intervention
TOP	Termination of pregnancy
UCL	University College London
UG	Universiteit Gent (Ghent University)
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VIA	Visual inspection with acetic acid
WHO	World Health Organization

# 1 Project Context and Objectives

## 1.1 Rationale

The large majority of women in developing countries still lack access to even the most basic sexual and reproductive health (SRH) services. Reproductive and sexual ill health accounts for a large proportion of the global burden of ill health for women. This proportion is even higher in marginalised populations, such as female sex workers (FSW)<sup>1</sup> who face increased risks because of limited access to health services, increased exposure to infection, general poor health, and the considerable effects of living in poverty. It is well documented that sex work remains a potent driver of HIV/STI transmission, but surprisingly few reproductive health services are directed towards sex workers in high-burden countries. Although a large body of evidence has shown that a few relatively simple interventions with sex workers, if implemented at sufficient scale, can interrupt transmission and help reverse the course of HIV epidemics, these kinds of interventions have been largely neglected in sub-Saharan African (SSA) countries with the highest burden of HIV.

Improving women's sexual and reproductive health requires innovative strategies to maximise potential synergies between components of care. Most adverse reproductive health outcomes stem from unintended pregnancy, and acquisition and transmission of reproductive tract infections. Although proven solutions exist, their implementation has been fragmented, with limited population impact, and little access for populations most at risk, such as sex workers. Integration of SRH services is key to achieving universal access to reproductive health. However, with weakened health systems and an HIV pandemic, the way forward is uncertain. The essential package of services and models for delivering them at high coverage in resource-limited settings are unclear.

To address this, we implemented a '*diagonal*' strategy, incorporating both '*horizontal*' health systems strengthening and more targeted '*vertical*' approaches. Horizontal reproductive health services are those that are normally available to the general population and provided as standard care through a wide network of Primary Health Care (PHC) facilities, linked to district hospitals. Such services can reach large numbers of women, while vertical programmes often target specific high-risk populations who have high level of need, but are difficult to reach through a horizontal approach. In many countries many of these vertical services are NGO-run, with low coverage and have inadequate links with the rest of the health system.

The aim of the DIFFER project was improved SRH services through identifying best practices in delivering a combined package of interventions for general population women and female sex workers. The project helped to define packages of SRH services and models for delivery that met the needs of all women and impact positively on their health.

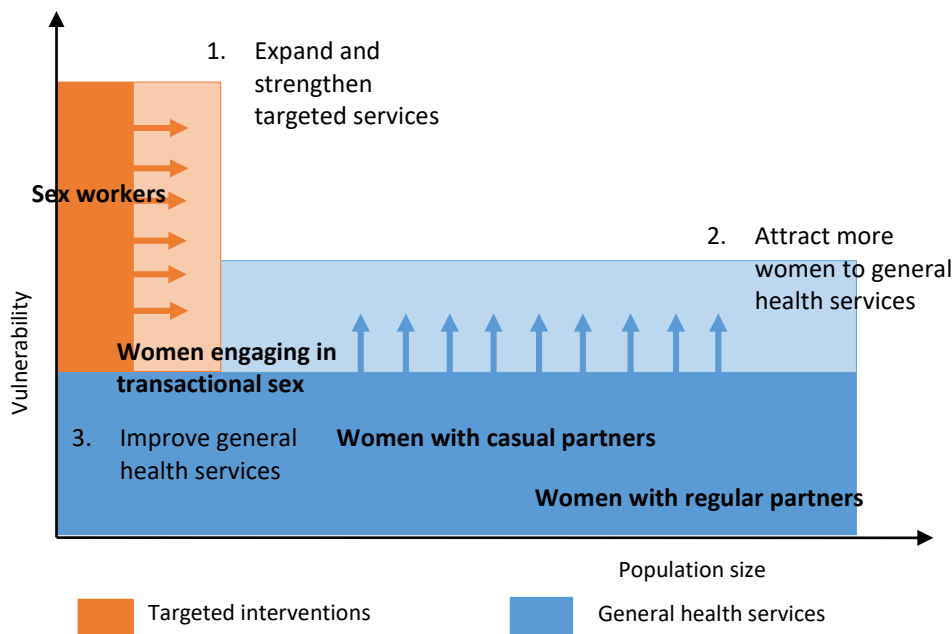
## 1.2 Concept

The DIFFER project was based on the hypothesis that combining vertical SRH interventions, such as services targeted to FSW, with horizontal health systems strengthening by integrating a broader range of SRH services within existing health facilities, is synergistic, feasible, and likely to be more effective and cost-effective than providing them separately. In particular, the research activities intended to build capacity to implement interventions for FSW, utilising the best practice experiences of partners in Mysore and Kolkata, India (Ashodaya and DMSC Sonagachi) where successful interventions for FSW had been brought to scale. These were to be applied and adapted to 3 research sites in SSA -- Kenya, Mozambique, and South Africa --focusing on integrated SRH care delivery to two populations of women: 1) FSW, and 2) women in the 'general population' who attend public health facilities, many of whom are also at high risk for poor SRH outcomes. These 2 populations have extensive overlap, with many of the 'general population' practicing some form of transactional sex, and many women who repeatedly enter and exit sex work, or are part-time sex workers.

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<sup>1</sup> In our study we defined female sex workers as women who receive money or goods in exchange for sexual services, either regularly or occasionally. The eligibility criteria to be included as a participant in the different research components was 'having received money or gifts for sex at least three times in the last six months'.

DIFFER focused on two channels for delivering improved SRH services; (1) through public facilities at district or primary level where women are already receiving some services, such as FP and HIV counselling and testing (HCT), and (2) through interventions designed with and for FSW in the communities where they work, through outreach and special mobile or satellite clinics. The latter services are referred to as Targeted Interventions (TI). This bidirectional or 'diagonal' approach proposed builds on the strengths of both horizontal and vertical programming for maximum impact, as illustrated in the figure below.



The study wanted to explore possible ways of improving SRH services overall; attracting more women to SRH services through outreach and by improving provider attitudes; and strengthening targeted interventions. The study was investigating ways of strengthening health systems and service delivery, rather than trying to establish the efficacy of already proven clinical interventions. There are much data on the effectiveness of condoms use in sex work settings, for example, this project aims to examine how best to implement such interventions. The project had a deliberate focus on ensuring community mobilisation of FSW and their full participation in the design assessment and implementation of study activities. FSW were to be supported by the research process in creating and promoting a supportive social environment for improved SRH. Additionally, there was a major focus on involvement of other community stakeholders and policymakers. This aimed to increase uptake of study findings and to ensure that study results contribute practically to sustainable services in this and similar settings. Moreover, the research included strong south-south collaboration, for the first time bringing the rich experience and successes of innovative, scaled-up sex worker-led interventions from the DMSC Sonagachi, Ashodaya and Avahan projects for adaptation to the African setting.

### 1.3 Objectives

#### *General objective of the research:*

The general objective was to improve SRH for all women by expanding and strengthening SRH services, and providing and testing targeted interventions for FSW in the context of existing health systems.

#### *Specific scientific and technical objectives:*

1. To assess the feasibility and practicability of integrating a combination of new SRH services into existing services for general population women;
2. To assess the feasibility and practicability of linking and/or integrating services for FSW into existing services for the general population, within district or Primary Health Centre (PHC) level facilities and at community drop-in centres;

3. To assess the feasibility and practicability of participatory processes involving FSW, local service delivery partners and the general population in design and delivery of improved SRH services for FSW;
4. To design packages of SRH care interventions which are feasible, appropriate, sustainable, effective, scalable and tailored to the conditions of each study site, to improve SRH among FSW and the general population;
5. To implement and evaluate site-specific packages of improved SRH services delivered at facilities, at TI sites (mobile/satellite clinics for FSW), and within the community by peer educators (PE);
6. To evaluate effectiveness of 21 months of strengthened services by conducting a cross-country assessment of the determinants of improved SRH services and outcomes pre- and post-intervention;
7. To measure cost-effectiveness and equity of improved SRH care for, and empowerment of FSW;
8. To engage policymakers from the outset in planning, implementing, evaluating and expanding the project;
9. To inform SRH policy and service delivery guidelines development that serves the needs of the general population and vulnerable groups such as FSW, thus aiming to improve reproductive health and health equity.

#### 1.4 Package of SRH services

The project focused on those SRH risks for which FSW are most vulnerable and for which access to preventive and curative services needs most improved. Therefore, it did not include safe motherhood services such as antenatal, obstetric or postnatal care. The priority services to be addressed by the project were:

1. Contraception, including emergency contraception
2. STI care
3. HIV testing services, and links to care, support and ART
4. Prevention of cervical pre-cancer (screening, treatment, follow-up)
5. Gender-based violence services
6. Peri-pregnancy counselling (pre-conception, pregnancy testing, unwanted pregnancy counselling, TOP where legal, and post-abortion care)
7. Male and female condom and lubricant promotion and distribution

In addition, FSW were to be informed and sensitized, mainly through peer outreach.

The final choice of the package of services was to be done based on the information gathered from the policy and situation analyses at each site, taking into account the legal context, making the best use of available resources and meeting the local needs.



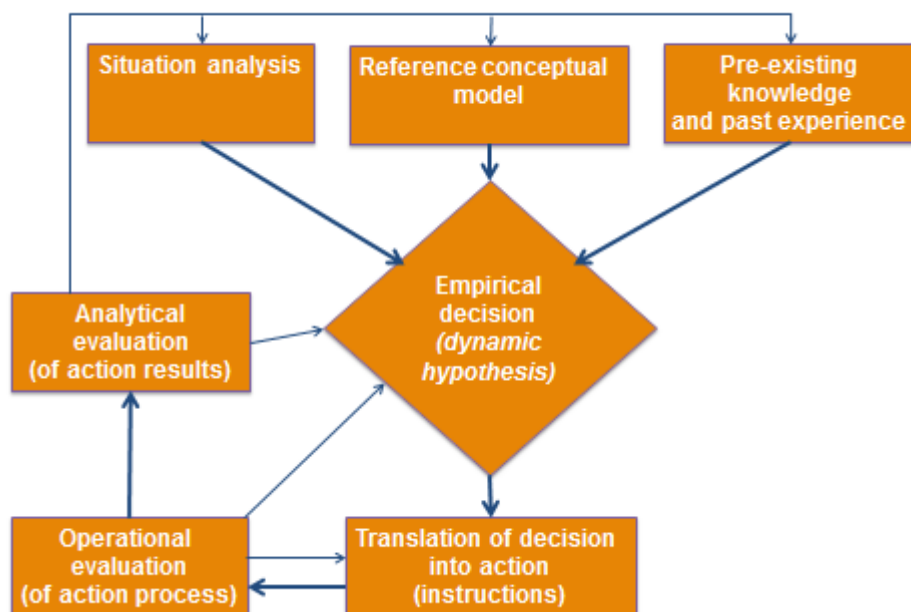
## 2 Main Science & Technology results

### 2.1 Study design and methods

#### 2.1.1 Overall study design

The study was designed as a set of case studies, with the 'case' being a well-defined geographical area where sex work is common. These were, the city of Mysore in Karnataka state, India; the city of Mombasa in Kenya; the neighbouring cities of Tete and Moatize in Mozambique; and the city centre of Durban in South Africa.

The project applied a methodological framework for health systems research, as shown in the diagram below<sup>2</sup>.



During the initial phase of the project, a broad situational analysis was conducted that gathered information on the SRH policy environment and on the current availability and use of SRH services by women in general and FSW in particular. The information was used, in combination with the pre-existing knowledge, to inform the development of a generic package of interventions that outlined the priority areas to be addressed and listed the interventions that needed to be implemented in order to improve access to and use of key SRH services by FSW, and this in a context of expanding and strengthening SRH services in general. The generic package divided the intervention in three components: 1. Interventions specifically targeted at FSW (TI); 2. Strengthening of general SRH services; and 3. Strengthening of linkages between both. The DIFFER partner in each of the 4 countries adapted, in close collaboration with the FSW community and local stakeholders, the package to their context and developed a country-specific intervention action plan. These plans were then implemented, and after at least 18 months the performance of the intervention package was evaluated.

#### 2.1.2 Study methods

A convergent parallel mixed-methods design was applied, combining qualitative and quantitative research techniques, in both the baseline analysis and the final evaluation.

For the baseline analysis these were:

1. A policy analysis, comprising a desk literature and document review, and key informant interviews
2. Health facility assessments, comprising:

<sup>2</sup> Grodos D & Mercenier P (2000) Health systems research: a clearer methodology for a more effective action, in Studies in Health Service Organisation and Policy. Antwerp, Belgium: Institute of Tropical Medicine.

- Health manager interview
  - Inventory checklist
  - Provider interviews
  - Client exit interviews
  - Cost analysis
3. An analysis of available service statistics
  4. FSW focus group discussions
  5. A cross-sectional survey among at least 400 FSW

For the final evaluation, the choice of the research components was site-specific and in line with the intervention package that had been implemented. At all sites, it comprised:

1. A repetition of the cross-sectional survey among at least 400 FSW
2. FSW focus group discussions
3. An analysis of the service statistics that had been collected during the intervention
4. An analysis of the process measures that had been collected during the intervention
5. Analysis of the intervention costs
6. Key informants' feedback through either individual interviews or group discussions

At certain sites additional research components were added, such as health facility assessments, service provider interviews, or interviews of SRH users at general health facilities.

The cross-sectional surveys aimed to collect quantitative data on FSWs' use of SRH services, exposure to peer outreach, FSWs' appreciation of the availability of services, level of empowerment, and some information on the cost of SRH services from the users' perspective. A respondent-driven sampling approach, statistically adjusting for the selection bias of snowball sampling, was used to improve the inclusion of hard-to-reach FSW. The results of the final survey were compared to the baseline and assessed for statistical significant changes in key indicators.

The focus group discussions explored the FSWs' perceptions and appreciation of the package of interventions that was implemented at each site. FSW were asked if they judged the current availability, accessibility and quality of the services satisfactory and what were the main changes in comparison to the pre-intervention period.

All SRH care routine data available from the health facilities that were involved in the intervention, and all available routine data recorded during the provision of community outreach services, were collected for comparison with the baseline data and analyses of trends in SRH care use.

All process information collected during the implementation of the intervention package was analysed to assess to what extent the intervention had been implemented as planned and what barriers were encountered.

Intervention costs were collected prospectively throughout the implementation of the intervention package using a standardised costing tool developed by UCL in consultation with the research teams in the four sites.

Key informants, such as local and national policy and decision makers, health managers and community representatives, were asked their appreciation of the intervention package, in regards to feasibility, acceptability to service providers and managers, alignment and coherence with national legislation, policies, strategies and guidelines, and short- and long-term sustainability.

In the final evaluation, a mixed-methods analysis was done to formulate integrated responses to the following research questions, in line with the study's objectives:

1. What was the main effect of the intervention on the uptake of SRH services by FSW? (*effectiveness*)
2. Was the intervention feasible/ practicable to implement? (*feasibility*)
3. Was the intervention adequately responding to the needs, in accordance with national policies and guidelines, and acceptable to beneficiaries, providers, health managers and policy makers? (*appropriateness/relevance*)
4. What was the cost of the intervention and was it cost-effective? (*cost-effectiveness*)

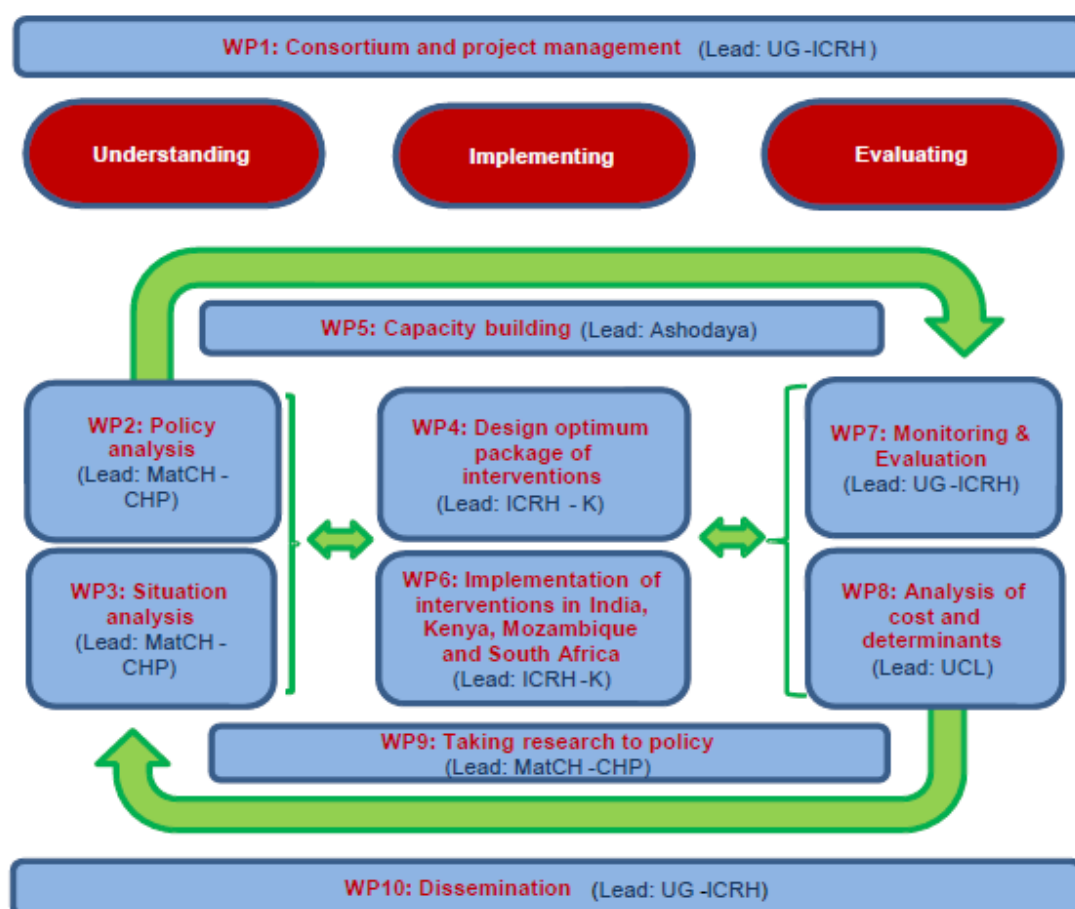
5. Is the intervention financially and institutionally sustainable on a long-term, and can it be rolled out on a larger scale? (*sustainability/replicability*)
6. Did the intervention reach all FSW sub-populations and did it empower the FSW population? (*equity*)

### 2.1.3 Ethical considerations

The study applied the ethical standards and guidelines necessary to protect participants from any risks or burdens. Written informed consent was obtained of all participants of the different study components. In India, Kenya and South Africa all participants were 18 years or older. In Mozambique, 15-17 years old FSW were also eligible for participation in the cross-sectional surveys as emancipated minors, as is custom in the country. Confidentiality was guaranteed through the use of non-identifying survey codes and keeping all collected information locked or protected. Reimbursements were only given to cover extra costs, such as for transportation. The country-specific study protocols for the baseline analysis and the final evaluation were approved by the responsible ethical boards in each country (the University of Witwatersrand's Human Research Ethics Committee in South Africa, the National Committee of Bioethics for Health in Mozambique, the KNH/UoN Ethics and Research Committee in Kenya, and the Asha Kirana Institutional Ethics Committee in India). In South Africa and Kenya, in addition, approval was obtained for the implementation of the intervention package. Ethical approval was also given by the ethical board of the coordinating partner, for the DIFFER project overall and for the baseline analysis (the Commission for Medical Ethics of the University Hospital Ghent).

### 2.1.4 Organisational structure

The project was divided into 10 work packages, in each of which one of the consortium partners took the lead:



## 2.2 Results by study site

### 2.2.1 Mysore, India

#### 2.2.1.1 Study setting

Mysore City, the setting for the DIFFER project, is located in Mysore District, Karnataka State, in south India.

Ashodaya Samithi (Ashodaya) is a sex worker-led organization in Mysore, formed out of the aspirations of female, male, and transgendered sex workers. Since 2004, Ashodaya has been implementing HIV prevention programs with support from *Avahan*, the HIV/AIDS initiative of the Bill and Melinda Gates Foundation. The drop-in-centre and static and outreach clinics were initiated under *Avahan* and continue to be supported by the government HIV prevention program. Ashodaya also operates a Government Integrated Counselling and Testing Center (ICTC) and has strong linkages with the government run ART facility. In 2011, when DIFFER was launched, Ashodaya was implementing government-funded targeted interventions in four districts and had a total membership of 5,000 sex workers, with 1,826 FSW members in Mysore City. Sex work in Mysore has transitioned from operating in more visible street-based settings to mainly occurring in more hidden home-based locations. Over the years, Ashodaya has built strong relations with important stakeholders, including local police, government, non-government agencies, academic institutions, legal authorities and policymakers at the district, state, and national levels.

#### 2.2.1.2 Situation at baseline

##### *Methods*

The baseline situational assessment was conducted from October 2012-March 2013. The assessment drew data from: (1) 9 key informant interviews with policymakers and heads of programs; (2) a desk review of HIV/STI and SRH policies; (3) 3 facility audits that looked at statistics and costing tools; (4) 150 health facility exit interviews with general population women (GPW); (5) 21 in-depth interviews with community leaders and 7 in-depth interviews with key stakeholders; (6) 6 focus group discussions (FGD) among 66 FSW and (7) a baseline cross-sectional survey (CSS) among 458 FSW. Respondent-driven sampling (RDS) design was used to recruit the FSW participants for CSS and convenience sample was used for qualitative interviews and FGD. Eight seeds each went on to recruit 5 participants in the 1st wave and each of them had to recruit 3 each. A total of 3 waves were undertaken to achieve the desired sample size.

##### *Key findings*

In India, the government HIV program is managed vertically through the National AIDS Control Organisation (NACO) and then implemented through State AIDS Control Societies (SACS). In Mysore, Ashodaya has been providing targeted intervention (TI) services since 2004 including: HIV prevention, community mobilisation, condom distribution, STI identification and treatment, creating an enabling environment for sex workers, and HIV screening and care. The existing TI programs do not allow Ashodaya to provide any SRH services, other than HIV prevention and care, to the community. Policy documents on SRH services do not mention needs or services for specialized populations like FSW. There is no operational manual, either through NACO or the National Health Program, on how to integrate SRH and HIV services for FSW. Many community members felt that the attitude of health care providers, a restrictive legal framework for FSW, their lack of social or legal status and lack of focus on the marginalised community made it difficult for FSW to access SRH services.

The CSS documented the median age of FSW as 35. Condom use by FSW, across all type of clients, was reported to be high (97.4% during last sex with occasional clients, 93.3% with regular clients), and was 69.9% with non-paying partners. FSW had a mean of 2 clients a day. About a third of the FSW (34.8%) experienced symptoms of an STI in the last 12 months. A total of 95.2% reported to have ever had an HIV test and of those, 8.0% reported to be HIV-positive. HIV prevalence, as measured by the national testing algorithm, was 15.0%. Only 13.6% of FSW reported to have undergone cervical cancer screening. Sterilisation was common, with 84.5% of FSW reporting sterilization. Use of emergency contraception (EC) was low with only 2.4% of FSW having ever taken it. A total of 8.0% of FSW had an abortion in the last 5 years. Sexual violence in the last 12 months was reported by 7.1% of FSW.

Client exit interviews among GPW reported a median age of 26. Most (91.3%) GPW had never used a condom and among those who did, only 8% used a condom at last sex. Around 36% of GPW experienced an STI in the last 12 months. A total of 10.7% reported to have ever had an HIV test, however none reported to be HIV-positive. Only 3.3% of GPW had ever been tested for cervical cancer. Around 20.7% of GPW were sterilised and 24.7% reported using family planning methods (including sterilisation) at the time of interview, but 95% had never heard of EC. No GPW reported experiencing violence during the last 12 months.

#### *Challenges encountered while conducting baseline assessment:*

The team encountered few challenges during the baseline. The study was conducted at a time when sex work operation in Mysore was changing from street based to more hidden home based. This made the process of identification of seeds more time consuming. This was mainly because the right seeds were identified to cover all the hidden networks. Care had to be taken to ensure that the sex work environment was not disturbed. As the nature of sex work was changing, many FSW were not willing to come to the office for interviews. Therefore, appropriate venues had to be identified ensuring confidentiality of the participants. However, since the researchers and mobilisers were also from the community, it was easy to convince the participants to take part in the survey. The long questionnaire, some of the terminologies, sexual behaviour related questions with a time frame of longer than a week, created discomfort and also resulted in recall bias by the participants. This discomfort was overcome by adhering to the ethics of research (no coercion). Moreover, the intensive training provided to the community researchers helped them to put the participants at ease.

#### *Overall gaps identified and key recommendations from situation analysis:*

For FSW in Mysore, TI services are available through Ashodaya. Condom use and education through outreach continues to be high. However, gaps in the availability of SRH services were identified, including: screening and follow-up for cervical cancer; education and availability of family planning options (promoting condoms as family planning methods, injectable, pills) and abortion related services; services for victims of sexual and gender-based violence (SGBV); a need to further strengthen the existing HIV referral services; and a need to reduce stigma and discrimination at public hospital settings. For GPW, Mysore district public hospitals are well equipped to provide SRH and HIV services. However, the situation analysis documented that Asha Kirana, a highly rated HIV care centre, does not provide any SRH services. Therefore, there was a need to integrate SRH services (cervical cancer screening, family planning services) for GPW (primarily HIV-positive) at Asha Kirana. At the government hospitals, the main gap identified related to strengthening referral services for HIV-positive members and addressing the stigma and discrimination experienced by FSW and HIV+ patients.

### **2.2.1.3 Intervention**

#### *Intervention process*

The Ashodaya DIFFER team had extensive consultations with the community members and the Ashodaya Board to identify their priority issues. As a sex worker organization, the Ashodaya board (comprised only of sex workers) determined that, like in other projects, their philosophy and principles would govern DIFFER. These included: maintaining a flexible project approach in order to work effectively with a rapidly changing sex work environment; prioritizing the needs of FSW; focusing on the service gaps identified; moving towards comprehensive delivery of an integrated package of services; and collaborating with the most effective partners (e.g. Family Planning Association of India (FPAI), Asha Kirana Hospital).

Once the priority issues were identified, the team (including community and non-community staff) developed mechanisms to provide those services and to determine which services Ashodaya would provide directly and which would require accompanied referral. The community's primary interests were in cervical cancer screening and family planning services. It was decided that DIFFER services would be built onto Ashodaya's well-established community mobilization/HIV/STI prevention model. In order to establish linkages and integrated services with government and private sectors, conducting *strategic advocacy* at the state and district level was also prioritized. This approach helped to ensure government involvement and ownership in DIFFER from the beginning.

#### *Key intervention components and activities:*

Based on the identified gaps and priorities, the intervention was provided at three places:

## **A. Ashodaya Clinic:**

The Ashodaya intervention was implemented from October 2013 through September 2016 for a total of 36 months. The intervention had 5 key components:

### **1. Strengthen existing community mobilisation and peer outreach**

The primary task was to continue to build on existing TI services and to strengthen outreach & clinic services, including continuing: the Ashodaya Drop-In Centre, a safe meeting place for community members; Ashodaya membership drives to encourage group identity and provide opportunities for addressing common problems by meeting on a regular basis (weekly or more); to encourage the use of the TI clinic; to strengthen network-based outreach through on-going peer and outreach worker trainings; and to promote condoms and distribute them along with relevant health messages/education.

### **2. Strengthen and expand existing STI/HIV services**

The goal was to strengthen existing STI/HIV services and to add SRH services. This approach was called “TI Plus”. The TI included quarterly routine clinic visits for genital/speculum exam; counselling on condom use; periodic preventive treatment for first time visits or for those with > 6 month interval between visits; syphilis screening and HIV testing (every 6 months); and tracking/follow-up of all HIV-positive women by Ashodaya for ART services and prevention of parent-to-child transmission (PPTCT). Building on this, DIFFER focused on expanding TI services to include SRH services. Below are descriptions of the TI Plus services added:

#### **• Cervical cancer Screening**

- Ashodaya Clinic doctor and 3 other select doctors trained in VIA screening
- Clinic staff and peer educators trained about cervical cancer and the importance of screening
- All clients screened annually using VIA - accompanied referral to OB/GYN services as required for follow-up of suspected cases
- Advocacy at government level for regular cancer screening (based on clinic data)
- Training of counsellors on importance of screening for cervical cancer
- Preparing simple talking points for counsellors (messaging)

#### **• Pregnancy Follow-up (see section on FP Services)**

- TI clinic staff guaranteed antenatal visits, delivery, post-partum care and family planning follow-up for all pregnant FSW, as well as accompanied referrals to government facilities
- Enhanced coverage and tracking of all HIV-positive pregnant women in collaboration with government PPTCT program and Ashraya (Ashodaya’s HIV-Positive Women’s Group)
- Training of counsellors, peer educators, outreach workers and developing messages

### **3. Provide Family Planning, EC and abortion services**

Prior to DIFFER, the Ashodaya TI was not addressing any of the community’s family planning needs. After extensive discussions, it was decided to provide family planning services through outreach, the clinic, and accompanied referrals. Specific activities included partnering with FPAI to provide training to 83 peer educators and FSW and men-having-sex-with-men (MSM) Outreach Workers and 22 counsellors, ANM at Ashodaya clinic and counsellors at government and private hospitals. Ashodaya obtained oral contraceptives from FPAI and from the District Health Officer’s office. These were provided free of cost to the community. Ashodaya also purchased Depo-Provera and misoprostol at a reduced cost from FPAI and provided them at the same price to the community. The doctor at Ashodaya Clinic was trained in the use of Misoprostol for the medical termination of pregnancy. All other abortion-related services were referred through accompanied referral to FPAI and government centres.

### **4. Strengthen and expand Ashodaya’s linkages/referral system**

The referral system in Ashodaya’s TI mainly focussed on referring HIV-positive FSW to the District Hospital ART centre and to Asha Kirana. Through DIFFER, the existing accompanied referral system was strengthened, including developing a triplicate printed referral format with a procedure for written feedback and a referral monitoring system. A cadre of trained and empowered community Health Care Navigators (HCN) was developed to provide assistance to patients at government health care facilities. Regular meetings between the Ashodaya-DIFFER team and government health officials were held on the progress of TI Plus services.

## **5. Address sexual and gender based violence (SGBV)**

Ashodaya has worked for years to address incidents of violence, stigma, and discrimination faced by FSW. Through DIFFER, SGBV activities included: raising awareness on the prevalence of SGBV among the community; developing SGBV counselling and risk assessment guidelines; identifying resources for referral and support; training TI, government & private facility counsellors on addressing SGBV; training peer counsellors to provide support to community members; continuing Ashodaya's community-led crisis response system; and providing counselling to victims of SGBV and referral as required.

### **B. Asha Kirana Hospital**

Ashodaya has supported a Well Women's Clinic at Asha Kirana, a local hospital providing services to the HIV-positive community. This partnership arose out of an identified need for SRH services for HIV-positive women. The clinic was initiated from November 2013 and continued through September 2016. Following consultation with decision makers and informally with clients, Asha Kirana began offering cervical cancer screening using VIA and follow-up; STI screening and treatment; family planning services; emergency contraception; and addressing victims of SGBV. Ashodaya provided training to the physician and counsellors on the above mentioned areas. Monthly meetings were scheduled with the physician and counsellors and Ashodaya team to address any challenges.

### **C. Government Hospital**

The main challenge identified at the government hospital was the stigma and discrimination faced by the community when accessing services. In order to address that, Ashodaya developed a system of Health Care Navigators (HCN) who were strategically placed in various departments in the government hospitals (HIV testing and counselling centres, ART centres, ANC, etc). HCNs were members of the community who were trained to provide assistance in navigating the complex hospital system, addressing any instances of stigma and discrimination, and working with the hospital staff as needed.

#### **2.2.1.4 Key results and lessons learned**

Qualitative methods used in the final evaluation included 10 key informant interviews with stakeholders at the district, state, and national level and 8 focus group discussions with FSW. An end-line CSS was done with 415 FSW participants following the same RDS methods. Service statistics from clinic and outreach data from 2013-2016 and intervention costs were also considered.

The key results of the DIFFER project can be classified broadly under three categories: (1) increased coverage and SRH/HIV service utilisation; (2) appropriateness, feasibility, and practicability of this model; and (3) other important effects of the intervention.

In interpreting the results, it is important to remember that community empowerment and ownership is the core of Ashodaya's work. Therefore, the DIFFER project was developed to address community-identified service gaps in a way that the community would like them addressed. Upon extensive community consultations, Ashodaya decided to provide all SRH services in addition to its TI services at their clinic. Thus, Ashodaya moved from a vertical HIV/STI intervention to an integrated SRH/HIV intervention. This resulted in more FSW seeking SRH/HIV/STI services at the Ashodaya clinic (general health care: 81% vs. 26% at baseline; contraception: 19.4% vs. 0% at baseline; cervical cancer screening: 100% vs. 40% at baseline). Integrating SRH services for HIV-positive women at Asha Kirana also documented high identification of cervical cancer, increased STI detection, and uptake of family planning services. These services are rarely offered to HIV-positive women and were therefore highly appreciated by the policymakers and healthcare providers. Services provided by the HCN for clients (not only for Ashodaya members but also for other clients) and assistance provided to the government health care staff were highly appreciated by the government health care providers and FSW who felt the *"invaluable support of the HCN"* in reducing stigma and discrimination. Almost all FSW who were part of DIFFER felt that this project gave them a feeling of *"being treated as women and not just people selling sex"* as their reproductive health needs were looked after. In addition to this, the system for accompanied referrals (when services were not available at Ashodaya) reduced lost to follow-up for ART and resulted in 100% linking of HIV positive cases to ART centre.



Ashodaya's flexible approach to work with a rapidly changing sex work environment helped in maintaining saturated coverage. While mapping data in early 2014 documented 1,557 FSW working in Mysore, DIFFER was able to reach 1,605 FSW over 3 years. On average 1,363 (85%) FSW were met at least once in 15 days. There was a clear increase among FSW seeking services at Ashodaya under DIFFER.

Stakeholders' felt that the DIFFER model of service delivery was feasible and practical to adopt and implement. The stakeholders interviewed throughout the evaluation commended the way Ashodaya was able to integrate the services, deliver them, and document the processes. They felt that this was the first time Ashodaya had documented "*how to integrate*" services effectively. Many stakeholders commented that the on-going engagement of Ashodaya with district and state level authorities, coupled with field visits by the policymakers, led to greater ownership of this project among stakeholders. Many stakeholders felt that this model is highly reliable and sustainable and can be scaled-up across the State. Importantly, one state-level stakeholder mentioned that this is the right time to advocate for this model: "*KSAPS (Karnataka State AIDS Prevention Society) should advocate with NACO (National AIDS Control Organization) to integrate SRH and HIV program .....Send us your proposal, we will take it up.....*" The project articulated a critical mode of "*strategic advocacy*" that focused on emphasising simplicity, building on existing projects, targeting people who have influence on the decision making structure, and inviting observation and participation of the stakeholders that resulted in a sense of ownership among state functionaries.

Some key challenges faced during the implementation of DIFFER included the changing landscape of sex work over the past 5 years, with a shift away from street-based towards home-based solicitation, making the population less visible and more difficult to reach. This was overcome by ensuring close contact with the community and recruiting the right peer educators who have influence on these FSW. Furthermore, policies around HIV and SRH services are developed at the central level. Bringing any change in the public sector at the local level is a challenge since the policies and directives have to come from the centre. Frequent changes in government policymakers and health managers also makes it difficult to sustain any changes. On-going strategic advocacy was key to overcome this challenge.

Despite these challenges, DIFFER was successful. The key lessons learned from the intervention include the need to:

- Prioritize the needs of the community and deliver services in community-identified ways that maximize service utilization
- Demonstrate flexibility in responding to a rapidly changing sex work environment
- Deliver SRH and HIV/STI services in an integrated manner to mobilize the community and increase community participation
- Provide SRH services to HIV-positive women to help detect and treat cervical cancer in early stages
- Advocate with different Ministries to ensure the availability of comprehensive SRH services and other supports

#### 2.2.1.5 Conclusion

Ashodaya Samithi had an already well-mobilized FSW community of over 8,000 sex workers in 5 districts of Karnataka. Findings from DIFFER support incorporating SRH services into the existing HIV/STI TI services. Further work should focus on continuing to improve access to cervical cancer screening services and treatment, as well as advocacy at the local and national levels to support the scale up of SRH and HIV/STI services in an integrated way across the state and country.

### 2.2.2 Mombasa, Kenya

#### 2.2.2.1 Study setting

In Kenya the DIFFER Project was implemented in Mombasa County, in the Coast region. The Mombasa County (Mombasa and Kilindini Districts) is situated in the South-Eastern part of Coast Province, and is the smallest of the six counties in the province. The county covers an area of 229.6 Km<sup>2</sup> with an estimated population of 939,370 (486,924 males and 452,446 females) (Kenya Population Census, 2009).



The county is a busy container port and a popular destination for domestic tourism. As Kenya's major sea port on the Indian Ocean, conditions in Mombasa favour active sex work networks. Thousands of sailors, truck drivers and associated workers pass through the port each year, creating demand for sex work that is readily met by local women with limited economic opportunities. The resultant multi-cultural environment initiates varying behaviour and sexual practices.

The current FSW population is estimated to be 11,667 according to NASCOP reports from a study conducted in 2014. At baseline, the FSW population in Mombasa was estimated to be around 18,000 (out of an estimated 43,469 self-identified female sex workers in the Coast province) but with seasonal variations due to tourism (APHIA II/ICRH Enumeration report, March 2010). A study conducted in 2005 measuring impact of peer education among sex workers found that HIV prevalence in the sex worker population was around 30%, syphilis was 2%, gonorrhoea 1% and bacterial vaginosis 46%. Unwanted pregnancies were reported to be 27% in a cohort study conducted among Mombasa sex workers in 2008.

#### 2.2.2.2 Situation at baseline

The DIFFER situation analysis in Kenya was implemented by ICRH-K in the four divisions of the Mombasa County namely: Island, Likoni, Changamwe and Kisauni. The health facility assessment included the three drop-in clinics (DICs) operated by ICRH-K and that provide services to FSW, and four public health facilities. These are spread over the four divisions: Chaani Health Centre for Changamwe division; Kisauni DIC and Kisauni health centre for Kisauni division, Island DIC and Tudor district hospital for Island division, and Likoni DIC and Likoni Sub-district hospital for Likoni division.

The situation analysis was conducted in order to build an understanding of the scope and quality of existing SRH services, information about utilization and barriers to utilization and on the unmet and overlapping needs of women in the general population and of FSW. Research activities focused especially on examining the nature, characteristics and extent of commercial and informal sex work, in terms of health risks to women and ways to mitigate these risks through improved SRH services or policy reform. Qualitative methods included key informant interviews with policy actors, senior health workers and community informants, and FGDs with female sex workers. Quantitative methods comprised of an inventory of facilities, costing of services, individual provider and client-exit interviews, and a cross-sectional survey of FSW. Using these methods the study sought to identify potential ways of improving access to SRH care and the feasibility of introducing and integrating new interventions to improve existing services, address unmet needs and better align targeted, vertical services with general, horizontal services. Table 1 shows the number of interviews conducted for each group.

**Table 1: Situation analysis activities undertaken at the Mombasa Site**

Study component	Planned total	Completed
<b>1. Health Facility components (all quantitative)</b>		
• Facility audits/observation (one per facility)	4	4
• Health statistics from registers (one per facility)	4	4
• Health provider interviews	25	26
• Client exit interviews (25 per facility)	100	100
• Costing tool	4	3
<b>2. Policy components</b>		
• KII interviews with policy makers (qualitative)	Up to 15	13
• Documentary review on SRH services targeted by DIFFER	Open	Done
<b>3. FSW components</b>		
• KII interviews with providers of FSW services (qualitative)	20	21*
• FGDs with FSWs (qualitative)	4	4
• Cross Sectional Survey (CSS) - quantitative	400	400

### *Challenges encountered during the situation analysis*

The key informant interviews were delayed because the locations where the key informants were was a distance apart, some were in Mombasa and other were in Nairobi. The appointments were made via the phone call and sometimes the interviews appointments had to be rescheduled.

The CSS faced some challenges with some of the recruitment chains dying out rapidly selected and new seeds had to be selected to allow reaching the targeted 400 interviews.

### *Key conclusions of the baseline situational analysis, major gaps identified to be addressed by the intervention*

Some of the major gaps in provision of SRH services identified during were:

- Family planning was offered in all facilities but with intermittent stock-outs. E.g. Female condoms and lubricants are mostly unavailable in government facilities. The integration of FP was still minimal so one just gets FP from the FP clinic. The most common methods were injectable, oral contraceptives, condoms and emergency contraceptive pills. Stock-outs of supplies, provider attitudes and skills was identified as a major problem.
- FP was only offered 1-2 times weekly in the DICs and 5 days a week in the health facilities.
- Accordingly STI care was available 1-2 days/week in the DICs and 5 - 7 days a week in the health facilities. Stock outs of treatment medications was a problem with resulting use of ineffective self-treatment.
- HIV care and treatment services are available through vertical donor funded programmes. Stock outs of testing supplies and lack of staff training are some of the issues identified.
- Cancer and cervical cancer services are available at most primary health care (PHC); services focuses on VIA/VILLI for screening These services are mainly offered as an in-reach service by NGOs in the health centres. Lack of training and equipment are some of the reasons cervical cancer is not routinely offered.
- Peri-pregnancy/fertility counselling are not routinely available; pregnancy testing is done if indicated (missed menses); as TOP is illegal no data were available on abortion counselling. Post abortion care (PAC) is provided. Women opt for backstreet abortion then attend health facility for PAC.
- Condoms are supplied through the national AIDS control program for prevention and with donor funding; promotion strategy exists but lack of adequate supplies, especially female condoms was an issue.
- SGBV – good national policy exists but societal norms and lengthy court procedures, and police harassment hamper implementation, resulting in alternative community resolution which disadvantages women. There are few GBVRCs and insufficient trained staff; limited hours make access difficult for FSW, who lack of confidence in services. 17 of 26 providers interviewed had seen patients with SGBV complaints. Counselling is offered with referral to provincial hospital or to police.
- Targeted interventions take place through ICRH-K and APHIA Plus projects with approximately 200 peer educators covering 4-5000 SWs. They focus on advocacy, community sensitization and holding public events. These services are useful but sustainability always questioned.
- Integration – Condom promotion and family planning are integrated into HIV care and treatment. Lack of training, equipment, time, infrastructure, medications and rigid staffing patterns are among the barriers to further integration of other services.
- Stigma is a major reason FSW avoid getting SRH services from public health facilities.
- Long queues and time for opening facility is inconveniencing access to services for SWs.
- FSW referral to essential services barely takes place possibly due to unavailability of commodities and/or unwillingness by FSW to visit a facility they are unfamiliar with because of potential backlash.
- Lack of basic equipment e.g speculums, examination tables. Drugs and supplies stock outs

#### **2.2.2.3 Intervention**

The development of the intervention included all stakeholders in the health sector, Mombasa county government local authority and the community representation. These involved the Policy advisory board (PAB) members and the community advisory board (CAB) members. The members for the PAB and CAB are drawn

from the community sex worker representation and from the policy actors, health care fraternity, local administration, non-governmental organizations respectively. It was opted that DIFFER would focus on Likoni and Changamwe divisions, and thereby complement a similar intervention that had been initiated, in the context of another project, in the two other divisions.

#### *Activities undertaken*

##### **Peer outreach and community mobilization**

The Intervention started with the training of the peer educators who would reach out to their FSW peers. The 5 day training was conducted using the NASCOP curricula. The peer educators reached their peers with information on reproductive health, promoted and distributed condom and lubes, referred them for services to the Drop in Centre and also to the primary health care facilities.

##### **Targeted Clinical services**

The seven targeted SRH services (see section 1.4) were offered at the Likoni DIC. All services were included, although that because of abortion being illegal in Kenya, this service was not offered. Patients could only receive post abortion care. The DIC was opened 6 days a week.

##### **General health services**

The referral of female sex workers to the government health facilities was done from the DIC by the Clinician and also the peer educators would do it at the community level. Most of the services referred included family planning methods that were not available maybe due to stock outs and also linkage to care for those who were HIV infected.

##### **Training**

From the situational analysis, it emerged that most of the Health care providers (HCPs) were not trained on offering sexual reproductive health services to the sex worker population. Five day training was conducted to the HCPs after which quarterly meetings were done as a follow up to find out from them about the implementation of the training.

During the project implementation there was also engagement of the community advisory board and Policy advisory board. They gave their input as the project progress was presented to them.

#### **2.2.2.4 Key results and lessons learned**

The final evaluation of the intervention was done in the period October 2015 – April 2016. Qualitative methods included key informant interviews with the policy actors and selected members of the PAB and CAB, FGD with female sex workers and peer educators, and semi-structured in-depth interviews with the health care providers. Quantitative methods involved conducting a second CSS with FSW using respondent driven sampling and exit interviews with women accessing sexual reproductive health services at the health facilities.

The team successfully conducted the interviews as per the table 2 shown below

Activities	Study Participants	Target Sample Size	Total conducted
Cross-sectional Survey Exit Interviews	FSWs	400	407 Interviews done
FGDs	FSW-peer educators & FSW peers	6	2 Peer Educators FGDs and 4 FSW FGDS done
KIIs	Policy makers/project managers	15-20	5
Semi-structured interviews	Health care providers	16	10
Exit interviews	Women attending SRH services	100	101

### *Challenges encountered*

- It was very difficult to get the selected policy makers. Some gave the research assistants the appointments that they never honoured at all.
- Most of the HCPs were too busy to set appointments for the interviews, the interviewers had to do several call backs and in some cases they had to go to the HCP's home.
- Some of the DIFFER trained HCP were not in the facilities, they had either been transferred to other departments of the county or moved out of Mombasa
- Some of the FGD were initially not conducted since the quorum hadn't been reached and therefore had to be rescheduled.

### *Responses to the main research questions*

*Feasibility.* Termination of pregnancy is illegal in Kenya and could therefore not be integrated in the package of offered services. The designed intervention package was successfully implemented, although not to its full extent because of the limited amount of resources available. For example, the number of peer educators was insufficient to achieve full coverage.

*Effectiveness.* Uptake of services increased between baseline and end-line, in particular HIV testing (from 71% tested in the past 6 months to 88%) and to a lesser extent contraception, STI care, cervical cancer screening and female condom use. The increase was mostly due to a greater attendance of the FSW-targeted DICs. Important barriers in visiting public health facilities, such as long waiting times, being asked bribes, frequent stock-outs and bad reception, persists, and FSW prefer targeted clinics. Out of fear of being stigmatized, most FSW do still not disclose to be a FSW when visiting public health facilities, which hampers appropriate care. Also the DICs are confronted with frequent stock-outs. Coverage of peer outreach increased, but is still insufficient. Little effect was seen on community mobilisation.

*Adequacy.* The tested intervention was aligned with the national policies and fully endorsed by policy makers, health managers, service providers and beneficiaries. FSW were greatly satisfied with the availability of services. Gaps insufficiently addressed by the intervention included more mobile clinics and a stronger involvement of FSWs' regular partners.

*Sustainability and replicability.* Making public health services more FSW-friendly is considered sustainable because requiring little additional resources, and could possibly be replicated nation-wide. The targeted interventions, both community-based and health facility-based, are however heavily dependent on short-term, project-based external funding and the presence of non-governmental actors, and are therefore financially and institutionally not sustainable.

### **2.2.2.5 Conclusion**

The DIFFER project was feasible and practical during its execution, the access of sexual and reproductive health services among the sex workers improved greatly. However there were challenges in involving the various stakeholders in the implementation. Some of the challenges were beyond what the project could support such as stock outs of family planning commodities. The linkage system can be further monitored with a continuous engagement of the health care providers ensuring that they have all been trained and a follow up on feedback on application of the training. The sustainability of the project can be possible with the county financial availability at the county health department. The DIFFER intervention can be replicated elsewhere and it is important to have continuous engagement with the stakeholders in working together to find solutions where possible.

## **2.2.3 Tete, Mozambique**

### **2.2.3.1 Study setting**

The DIFFER intervention was implemented in Tete Province, Mozambique, in the area covering the adjoining cities of Tete and Moatize. The province is intersected by a major transport route connecting Malawi to Zimbabwe and the port of Beira, and over the past decade there has been a rapidly growing mining industry, attracting travellers, migrant workers and sex workers. The Tete-Moatize area has a total population of

approximately 250,000 people. An accurate estimation of the number of female sex workers in the area is not available: A mapping and enumeration exercise conducted by ICRH in 2008 counted approximately 4000 women, likely to be an over-estimate; while recent USAID estimates are 1100 women. The FSW population in Tete-Moatize is characterised by a strong presence of women from neighbouring countries, in particular Zimbabwe. FSW meet clients in various settings including on the street, in bars and their residences. The DIFFER intervention focused on identified hotspots with a high concentration of FSW activity.

Health services in Tete-Moatize are mostly provided by the government. First-line health services are provided in primary health care centres. Some second-line services are provided in larger health centres, but primarily at the provincial hospital. For the DIFFER intervention, 4 of the 8 health centres in the project area were selected to be included in the project. These are the Carbomoc Health centre in Moatize, and the health centres Number 2, 3 and 4 in Tete City.

An intervention targeting FSW and truck drivers has been ongoing in Moatize since 2002. This intervention comprises a 'Night Clinic' that operates on week days from 4:00 PM to 10:00 PM. It is operated jointly by ICRH-Mozambique and the District Health Services with financial support from the international donor community. The government contributes by providing routine drugs and medical supplies and making health staff available against over-time payment. The private sector (mining industry) participated through a public-private agreement with the construction of new premises. At baseline, the clinic offered family planning, HIV testing and counselling, STI care, free condoms, IEC and SGBV services.

#### 2.2.3.2 Situation at baseline

In Mozambique, the baseline situational analysis was carried out between October 2012 and April 2014. Data was collected through: a cross-sectional survey with 311 FSW; 3 focus-group discussions with Mozambican and Zimbabwean sex workers; health facility audits and the collection of health statistics from 6 public health facilities, one private clinic and the Moatize night clinic; interviews with 19 SRH care providers; exit interviews with 99 SRH care users; interviews of 12 key informants; and a review of all national HIV/SRH strategic documents. The CSS also included a biomedical component with the collection of samples for HIV testing.

Key challenges faced in carrying out the situational analysis included:

- Delays in obtaining ethical approval for the study protocol;
- Recruitment of sufficient FSW to meet the target sample size for the CSS, in particular Mozambican FSW.
- Identification of experienced researchers in Tete to conduct the focus-group discussions.

Key findings of the situational analysis included:

- There existed national guidelines for most HIV/SRH care services, but none provided guidance for care adapted to the needs of FSW, although that the MoH had initiated the process of establishing guidelines for attendance of key populations at their facilities
- Policy makers had different views on the best approach for providing services to FSWs - integrated in the general health services or through parallel services for key populations - and there existed no national strategy
- The most important provider of HIV/SRH services in the study area was the government. Most basic services were sufficiently available, with the exception of certain family planning methods, cervical cancer screening, services for victims of sexual and gender-based violence, and termination of pregnancy
- The public facilities faced serious limitations in term of space, staff, equipment, regular supplies and adequate provider practices
- The Night Clinic offered a limited range of services and had a low geographical coverage
- Private clinics offered only a few services, at commercial price
- The use of non-barrier contraception (71%), STI care (78%), 6-monthly HIV testing (51%), HIV care (83%), SGBV care (48%) and cervical cancer screening (0%), was still too low
- FSW expressed dissatisfaction with the public health services, as a result of being asked for bribes, being badly attended by some care providers, stigmatisation and breaches of confidentiality. The service most lacking was said to be TOP.

### 2.2.3.3 Intervention

The intervention development process was led by ICRH-M with technical support from ICRH/UG. First, a causal analysis workshop was convened with all key and strategic stakeholders, to share the findings from the situational analysis, except the CSS, and to solicit input and buy-in, and a draft intervention package was developed. After the results of the CSS became available, a PAB meeting was held to review the intervention package, which was then finalised.

The key components of the intervention were:

- Mapping & enumeration of FSW and hotspots in Tete-Moatize, with strong participation of the FSW community, in order to ensure adequate targeting of outreach services and to increase ownership by FSW.
- Peer-led outreach and community mobilization: Increase of peer educators from 15 to 30 to increase coverage; training of peer educators to provide a package of SRH IEC, condom/lubricant provision, and referrals to health services; encourage development of FSW association; provide safe space for FSW to meet.
- Targeted clinical services at night clinics: Open second night clinic in Tete city, and expand package of services to include IEC; male and female condom/lubricant provision; HTS; HIV care, STI care and syphilis screening; family planning, including implants and EC; post abortion care; SGBV screening and referrals; and also couple counselling and regular check-up consultations with FSW
- Improve FSW access to general SRH services: Make 4 public health facilities more FSW-friendly through providing sensitisation and training workshops with providers, identification of focal points in each health facility, joint supervision with health authorities.
- Linkages/ referral systems: Regular meetings between focal points and FSW community to monitor progress; establishment of referral and counter-referral system between peer educators, night clinic and public health facilities; tracking of defaulters by peer educators.

### 2.2.3.4 Key results and lessons learned

The intervention was gradually implemented from mid-2014 onwards. The final evaluation was conducted in the period October 2015-June 2016. It comprised a second CSS with 404 FSW; 6 FGD with Mozambican and Zimbabwean FSW; interviews with 16 key informants; facility audits at the 4 public health centres where FSW-friendly services were introduced and the Night Clinic; an analysis of the monitored process and the available service statistics; interviews with the 4 FSW focal point and 2 group discussions with Mozambican and Zimbabwean peer educators. A mixed-methods analysis was performed to formulate answers to the project's research questions.

In regards to *feasibility*, it had not been possible to implement the intervention package exactly as it had been designed. In particular the planned expansion of the scope and range of the peer outreach and targeted clinical services was not fully achieved. This was mostly because the available resources were by far insufficient to implement such a comprehensive and extensive package of interventions. Nevertheless, most of the planned intervention components were judged to be feasible by the consulted policy makers, health managers, and providers, if the necessary resources were made available. Legally, it had not been possible to include TOP among the package of offered services, but Mozambique has meanwhile legalised TOP and it should be feasible to offer this service in the future.

The intervention in its whole was considered *adequate* and responding to a real need according to all stakeholders. Peer outreach and community mobilisation was endorsed and considered aligned with the national health policies, although that the government has not yet developed a strategy or guidelines for it. Having parallel clinical services for key populations, be it through outreach or standalone clinics, such as the Night Clinic, is however no longer endorsed by the government. The strategy chosen is to make selected public health facilities key population-friendly, as was done by the project at 4 facilities. The concept of the focal points was therefore well appreciated. Non-governmental stakeholders, and also local government officials, are less opposed to parallel services.



The targeted interventions, both community-based as clinic-based, are currently financially not sustainable because depending on short-term project funding, and without perspectives of long-term funding by the government, the international community or from other sources. Institutional sustainability of interventions to improve access to HIV and SRH commodities and services for FSW is challenged by the high dependency on the technical and managerial support of external partners. The intervention as such cannot be *replicated* at national scale, but some components, such as the focal points, the linkage systems and the peer outreach model, could.

Because the intervention package was only partially and lately piloted, the overall effect on the *uptake* of HIV/SRH services by FSW was only moderate, although that substantial and significant advances were achieved in for example regular HIV testing (from 57% tested in the past 6 months to 77%) and cervical cancer screening (from 0% to 26% ever screened). SRH care seeking at public health facilities and the Night Clinic did not appear to have substantially increased, but a relatively higher proportion of FSW were receiving care from outreach services.

The mapping exercise provided better insight into the characterisation of sex work in Tete, and formed the basis of introducing a new peer education approach, copied from the Avahan experience, involving each peer educator being responsible for a set number of FSW. It was successfully introduced and greatly improved the peer outreach, although that still only a relative small number of FSW are being reached.

FSW were at end-line overall very satisfied with the *availability* of contraceptive services, STI care, HIV testing services, HIV care and, to a lesser extent, male condoms. Services whose availability were said to have improved since baseline included HIV testing, mainly because of the mobile outreach, cervical cancer screening and peer outreach. Commodities or services for which the availability is still not ideal include the female condom, lubricants, services for victims of violence and particularly TOP. A large proportion of, mostly foreign, FSW seeks HIV care outside the Tete-Moatize area, mostly in their area of origin, and many face problems getting their ARVs replenished.

Persisting *barriers* at the public health facilities were the habit of asking bribes and the long waiting lines. Cost was a barrier for (informal) TOP and for some contraceptives and STI drugs when there is a stock-out at the public health facilities or the Night Clinic. Despite that the presence of the focal points was said to have diminished bad reception at public health facilities, FSW, and in particular Zimbabwean FSW, declared that they are still often badly received and sometimes refused a service, by certain providers. FSW therefor suggested to expand the opening hours and scope of services at the Night Clinic, to include ART, cervical cancer screening and TOP.

Intervention components that at this stage could be replicated on a national scale include the newly introduced peer outreach model, the concept of focal points, the linkages systems and the community mobilisation activities.

#### **2.2.3.5 Conclusion**

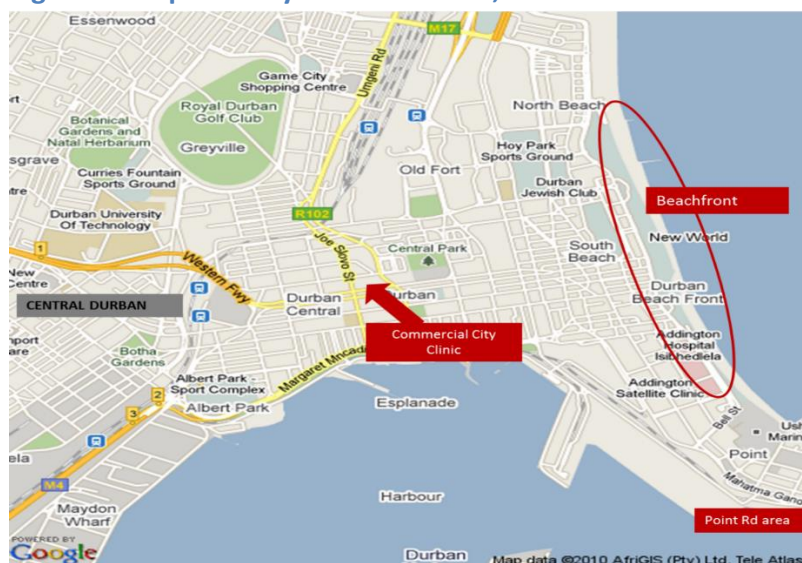
The DIFFER project successfully tested some new interventions to further improve access and uptake of SRH commodities and services by FSW in Tete/Moatize. Uptake of services, in particular HIV testing and cervical cancer screening, improved, but the overall effect was moderate because the available resources had been insufficient to implement the complete intervention package and some intervention components started late in the project. The greatest effect was caused by the initiated outreach services. Some intervention components, such as the new peer outreach model, the community mobilisation, having key population-focal points at public health facilities, and the linkage systems could be further developed and scaled-up. The future of stand-alone clinics for specific key populations is uncertain in Mozambique, and there is a need to thoroughly evaluate the effect of the alternative proposed by the government, namely making the public services more key population-friendly.

## 2.2.4 Durban, South Africa

### 2.2.4.1 Study setting

The research activities in South Africa were conducted in central Durban, a coastal city in KwaZulu-Natal (KZN), one of South Africa's nine provinces, and home to roughly 20% of the country's population. Durban – the largest city in the province – had an estimated population of 3.4 million in 2007 (Statistics SA, Community Survey 2007). The city is the busiest container port on the continent and a popular destination for domestic tourism. As Africa's major port on the Indian Ocean, conditions in Durban favour active sex worker networks. The DIFFER project was run from three study sites located in the downtown area adjacent to the port/harbour (see Figure 1), where there is a known concentration of sex worker activity.

Figure 1: Map of study sites in Durban, South Africa



#### Commercial City Clinic

Commercial City is a Department of Health (DoH) facility located in the heart of Durban's commercial district. It is a popular clinic, with a client load of 6000-7000 per month. It offers a range of SRH services, including: family planning, pap smears, STI care, HTS, and referrals for pregnancy tests, TOP and sterilisation. On-site CD4 testing is done, with ART initiation if eligible. It is also an 'adolescent friendly' site, as determined by national standards. Open Monday to Saturday, the clinic is staffed by professional nurses and nursing assistants, with a doctor available two afternoons a week for complicated cases.

#### NGO sites

**Lifeline Durban** hosts a drop-in centre, part of the Ithubalethu Project, which aims to educate, train and equip FSW with valuable life skills by offering them face-to-face counselling, HTS and CD4 testing facilities. The project also hosts various prevention programmes and a 15 week personal skills development training which focuses on developing FSWS' skills in order to attain alternative employment. This initiative is now in its 16th year and is supported by multiple stakeholders and donors including the Department of Justice and the Department of Social Welfare. **Sisonke** is the National Sex Worker Movement of South Africa, run by sex workers for sex workers and is a non-profit organisation which aims to unite sex workers in order to improve living and working conditions and to fight for equal access to human rights. Sisonke provides information to sex workers on accessing social services, such as health care, and working with the police and legal system. The group offers workshops on sexual health, leadership and human rights and advocates for the decriminalization of sex work.

### 2.2.4.2 Situation at baseline

Although MatCH-Research has worked with FSW populations at different times in the past, in 2011 there were very limited targeted interventions for sex workers in Durban. In South Africa all aspects related to sex work, the sale, procurement, act of having sex for financial gain, profiting from or assisting with the sale of sexual



services are criminalised. Studies conducted after the baseline but before the intervention provided a snapshot of the situation in 2012-2013. A rapid size estimation, conducted in 2012, estimated that the metropolitan centre of Durban hosts 28% of South Africa's sex worker population, an estimated 3000 – 6300 sex workers. The majority of sex workers are female with less than 5% male and 4% transgender sex workers. Of South Africa's nine provinces, KwaZulu-Natal has consistently recorded the highest HIV prevalence and sex workers based in this province are at an elevated risk for HIV acquisition and transmission. Additionally, the incidence of adults treated for a STI in 2008-9 in the Durban eThekweni district (6.7%/year) was higher than in all other metro areas in the country and the national average (4.6%).

The specific objectives of the baseline situational analyses in Durban were:

- To gain an understanding of the current scope, quality, coverage, cost and utilisation rate of existing SRH services;
- To assess capacity building needs among health providers and what is needed in order to address these gaps;
- To collect essential data on the opportunities for introducing new services and service delivery models, in order to inform development of the interventions to be implemented latter in the study;
- To assess the nature and extent of existing community participation in SRH, and the most urgent unmet SRH needs of women;
- To build support and buy-in for the project within the district, sub-district and municipal health service structures.

The quality of the seven focus services (see section 1.4) was assessed through a combination of health facility assessments, structured interviews with providers, and client exit interviews. Investigating service utilisation at the study clinics allowed us to establish a clear baseline prior to implementation of new interventions. Key informant interviews were also conducted to explore the inter-locking and overlapping sub-systems that influence integration of SRH services; the inherent complexities and variations of health systems that account for present functioning of SRH services and that present opportunities for improving service delivery. The outcome of this activity was a comprehensive policy analysis, including identification of opportunities for altering such policies.

*Challenges at baseline:* Although the situational analysis was successfully completed, the main challenge encountered was an underestimation of the time required to plan, obtain approval and implement all data collection components of the situational analysis, resulting in delays. Delays receiving ethics approval created a knock on effect for all activities in all the sites. Another challenge was to correctly judge the need and timing of FSW mapping and enumeration exercises. Initially, it had been planned to include mapping and enumeration as a part of the situational analysis, but later it was decided that it would be integrated at the beginning of the intervention.

*Key findings:* Durban had a higher HIV prevalence, incidence of STI syndromes, incidence of unwanted pregnancies and occurrence of sexual violence in relation to the other DIFFER study sites at baseline. More than 10% of sex workers in Durban reported not having used a condom the last time they had sex with a client and condom use with new, unknown clients was higher than with regular clients. The contraceptive method mix was largely dominated by condoms as the sole contraceptive method by the majority of FSW in Durban (67%). HIV prevalence was estimated at 65% and while the majority of FSW had ever tested for HIV, less than half had tested within the last 6 months. Of those FSW who knew their HIV positive status, less than half were accessing treatment or care. Female sex workers demonstrated a high reliance on public health facilities for the majority of their sexual and reproductive health service needs.

#### **2.2.4.3 Intervention**

Based on the situational analysis, an intervention package was designed with the highest likelihood of sustainability and acceptability within the current healthcare system, and able to continue with little or no support from the research team after project completion. The DIFFER intervention comprised of three core components:

1. **Comprehensive and integrated high-quality SRH services within healthcare facilities;** by implementing facility based interventions and integrated services.
2. Inclusive high-quality SRH services for FSW through enhancing existing and implementing new **targeted interventions** (TIs).
3. Finally, establishing **a linked combination of services for FSW and general population women** by forming and reinforcing linkages between the sex worker community, general population, targeted interventions and health facilities; in order to increase accessibility and acceptability for women and FSW.

The intervention was implemented from October 2014 – March 2016, and consisted of the following activities:

1. A site validation mapping to identify the geographical locations where sex work is negotiated or takes place and gather data on operational characteristics of the female sex worker population in our site.
2. Establishing Health Systems Navigators (HSN) at the partnering health facility. Navigators functioned as an interface between patients and health care providers in underserved communities as well as provided much needed information regarding the various services offered at healthcare facilities. Navigators also took on an expanded role that involved conducting health promotion and talks in the facility as well as outreach at a community level in conjunction with study partners.
3. Integrate sexual and reproductive health services at facility-level. The intervention aimed to provide SRH information to women accessing services, in the healthcare facility catchment area and to FSW through outreach, through the dissemination of relevant IEC materials on safer sex practices and services offered at the facility. This was also achieved by distributing ‘SRH packs’, which included: IEC materials/ pamphlets/ posters/ information on SRH and HIV services, home pregnancy test-kits, male and female condoms, lubricants and menstrual cups and additional commodities based on need. HIV testing was offered to FSWs every 6 months through referral to public sector and NGO testing services. FP clients who do not know their HIV status were offered routine HIV counselling and testing. SRH providers were trained in FP counselling and available/approved methods within their scope of practice including a focus on myths and new FP guidelines and policy (such as the launch of the subdermal implant contraceptive method, which occurred during the intervention period). Providers also received sensitisation training.
4. For the targeted intervention component, MatCH-Research partnered with three organisations to foster sex worker empowerment, primarily by (a) supporting the establishment of a Durban branch of Sisonke, and addressing structural conditions that increase sex workers’ vulnerability to HIV, especially within brothels, as well as supporting “creative spaces” which were conducted and owned by FSW community members; (b) access to HTS and condoms through community and healthcare facility based outreach; (c) reducing HIV transmission efficiency, primarily through facilitating access to ART, STI and TB services, and medical male circumcision for male and transgender sex workers, and male clients in Durban; (d) public sector SRH services with outreach and linkages to existing TIs driven by peers, in order to improve coordination and two-way referrals between CBO/NGO-run TIs and public SRH services.

#### 2.2.4.4 Key results and lessons learned

The primary goal of the evaluation was to assess the impact of the intervention on access and uptake of the selected HIV and SRH services; to explore changes in the proportion of FSW who reported participating in sex worker targeted interventions or being in contact with a peer providing outreach services, and changes in accessing integrated SRH/HIV services by FSW and the general female population. The evaluation focused on two service delivery channels targeted at different populations: (1) ‘general population’ health facilities where women, including FSW, are already receiving some services, such as family planning and HIV testing services; and (2) targeted interventions for FSW in the communities where they work, including outreach.

**Semi-structured interviews** were conducted with health care providers at each of the study facilities (Commercial city clinic and Lifeline), to gather data on current knowledge, practices and attitudes in SRH service provision, and to assess their capacity building needs. **Structured interviews with female clients** were held with women who had completed a visit and received one of the following services: STI; FP; HIV testing, counselling and care; cervical cancer; SGBV; or TOP and who were willing to participate. **Focus group**

**discussions-** participants were recruited through Lifeline's existing sex worker outreach programme. Interested FSW who were in contact with health systems navigators, Sisonke peers and Lifeline peer outreach workers during the course of their outreach work, could participate.

*Uptake of HIV/SRH services and commodities by FSW:* The cross sectional survey measured largely positive results in the provision and access of HIV/SRH services and commodities. Condom use remained stable between the baseline and end-line surveys and overall contraception use increased, with a more diverse method mix and less reliance on condoms as the sole contraceptive method. Testing for HIV increased substantially, as well as the frequency of HIV testing. Of those who had tested positive, more FSW reported accessing HIV care and ART. Care seeking for STI symptoms also increased and when calculating the same composite index for use of HIV services as at baseline, we noted a substantial and significant increase in this area, and an even greater increase in this index when calculated for the use of other SRH services.

In the focus group discussion, male condoms, HTS and TB testing were the most frequently accessed services, further confirming that awareness of HIV risk is higher among FSWs than at baseline - as is willingness to take active steps to prevent HIV and other STIs. FGD participants emphasised why they saw repeat HCT as necessary and demonstrated fewer perceptions of 'fear of a positive result'. Although improvements were seen in HIV/SRH provision, FSWs in the focus groups did outline unmet needs (or services they would like to access), these included: gynaecological services (including cervical cancer screening), ARV services, CD4 tests and trauma counselling. Although these services were listed as frequently accessed in the CSS, FSWs in the FGDs explained that while they *could* access these services, they did not sufficiently address their needs or access itself was at times erratic.

*Place where FSW seek care:* No big changes were seen in the locations where FSW most commonly reported to seek HIV/SRH commodities and services between the two surveys. Condoms were relatively more procured from peer educators. Public health facilities continued to be by far the main source of care for most HIV/SRH services (not surprising given the South African health system model), although that more FSW received care from outreach services than at baseline.

*Effect on reducing stigma and discrimination of FSW/ empowering FSW:* No substantial change was seen in the proportion of FSW reporting disclosing that they are a FSW when visiting a public health facility. Most FSW found that they were not treated differently from other users at public health facilities, however, migrant sex workers in the FGDs reported many barriers to healthcare access within the healthcare facilities, including stigma. In terms of empowerment, peer assistance was highly valued by FSWs in the FGDs as this interaction served to foster a sense of community, which some felt was currently lacking among sex workers. Participants were virtually unanimous in their support for targeted outreach to be delivered by peers, who were believed to hold a common understanding of the lives of SWs and consequently, implicitly recognize what their health needs were.

*Effect on HIV/SRH service provision for women in the general population:* The health systems navigators had assisted a third of the general population woman interviewed during an exit interview at the health facility site for the study evaluation. Of these over 80% found the health systems navigators useful. In addition, outreach conducted by the health facility for FSW also assisted general population women at the outreach site (sites which were determined as "high HIV transmission areas" by the South African Department of Health), over 2000 general population women who did not identify themselves as FSW were assisted through outreach in a variety of services including HIV testing, STI diagnosis and treatment, cervical cancer screening and condom provision.

The intervention was feasible to implement as planned with few barriers experienced. The intervention was able to adapt to changing circumstances in the public health landscape in South Africa, through regular communication with intervention stakeholders. The intervention harmonised with national policies and strategies, some of which drew on preliminary findings from DIFFER to inform their development. Buy-in by national and local policy makers was achieved with great success and contributed largely to the success of the intervention. Health managers and service providers were constantly engaged for the duration of the study and intervention, and the different components of the intervention were found acceptable by them.

Preliminary findings from the cost analysis conducted by UCL found that the intervention in Durban was financially viable, and certain aspects of the intervention have been adopted by study stakeholders following the conclusion of the study. The DIFFER project continues to engage with the Department of Health, as they look to adopt certain aspects of the intervention.

#### 2.2.4.5 Conclusion

The project sought not only to test a diagonal model of interventions but also to facilitate the integration of NGOs into the public sector. The model demonstrated that by working together and pooling resources these groups were able to improve confidentiality in public health-care settings, strengthen their monitoring systems, facilitate access to the FSW through NGOs and establish two way linkages between the public health facility and the NGOs. NGOs successfully educated FSW about their rights to access to health-care. The intervention allowed the public health services to engage directly with high risk groups such as FSW through outreach. The intervention assisted both horizontal and targeted services to work together to focus attention and resources on the needs of FSW, pioneer and test new approaches to improving access to health services for FSW. The intervention was complimentary, using the strengths of each partner. For example, NGOs generally have more expertise in working at the community level and can train and capacitate health care providers in the public sector, and the public sector have skills that allows them to provide healthcare services and health promotion beyond condom promotion and information sharing. These successes opened the door to advocacy at the policy level. Interventions that support effective HIV prevention methods, and are tailored and delivered to FSW could reduce the epidemic in the longer term; therefore efforts to prevent HIV transmission among FSW and reduce discrimination among HIV positive FSW should be prioritised.

### 2.3 Capacity building through South-South exchange

The overall goal of Work Package 5 was for Ashodaya, a sex worker collective with extensive experience in community led Targeted Intervention for HIV/AIDS prevention, to build the capacity of DIFFER partners, FSW community members and the staff of organizations:

- To implement an integrated SRH package through south-south collaboration of FSW community members
- To enhance community empowerment as a means for improved SRH services in Targeted Interventions.
- To build capacity of all partners to integrate and strengthen SRH interventions in the context of Targeted Interventions among FSW

#### SUMMARY OF ACTIVITIES

To implement the DIFFER project multiple approaches and activities were utilized by the Ashodaya Team. They included:

- 1) Conduct an initial *needs assessment* for capacity building
  - Different methods were deployed to understand the needs for capacity building, which included findings from the situation assessment, field visits, interaction with the community and team at each site etc.
- 2) Develop a *capacity building curriculum*
  - Develop a draft curriculum with the findings from #1 and share the draft with all partners
  - Based on the feedback, the topics and methods were finalized
  - It was agreed that the curriculum will be dynamic and context specific and the broad goal will be to increase community mobilization, engagement and ownership in the DIFFER project.
- 3) Conduct a *capacity building workshop*
  - The original DIFFER design was to have one workshop in Mysore, India, but based on the demand and needs identified, four workshops were held in India (with similar content)
- 4) Conduct relevant *thematic workshops*
  - In addition to the workshops in Mysore, based on the need, thematic workshops were conducted in each site

- Topics included community mobilization, increasing self-esteem, community led outreach etc.
- 5) Provide *in-country hand-holding and support*
- Each country was visited at least 3 times to provide on-site support.
- 6) Conduct regular in-country assessment of community engagement and progression using a DIFFER *Community Progression Tool*.
- Orientation on this tool was done during the first visit and community assessed themselves in each of the 4 critical areas (outreach, clinical services, enabling environment and community mobilization) having 5 questions. Each question had 6 options (statements), with numbers that range from 0-5.
  - This tool allowed the community participating in this assessment to identify their own situation as well as to become aware of the type of situations that might be possible
  - It allowed the team to ascribe a quantitative number to the local team's progress towards community involvement in HIV/AIDS/SRH.
- 7) Evaluate the effectiveness of the capacity building activities undertaken by Ashodaya
- Participatory workshop was conducted in May 2016 to: understand the effectiveness of Ashodaya's support, identify effective and ineffective strategies used and to conduct a community progression exercise.
  - Ashodaya's approaches were highly appreciated by all FSW and many said that workshop in Mysore was "life changing."
  - Ashodaya's support was termed "invaluable" to them.

#### CHALLENGES

There were three primary challenges encountered during the implementation of WP5.

- ❖ Limited time available for proposed number of visits and difficulties of procuring Visas
- ❖ Ensuring availability of DIFFER staff & sex-worker leaders during the visits
- ❖ Addressing policy issues while working in the field.
- ❖ Meeting the divergent needs of the "project" versus those of the community

#### MAIN ACHIEVEMENTS

- Increased understanding of all participants about the key components of a community led targeted intervention
- Community mobilization among sex workers in these sites is in its early stages - Community members have started taking care of their peers and seeing the "power of uniting."
- DIFFER staff members see the potential of the community to help themselves when offered the necessary support
- Importance of community friendly preventive and clinical services understood by sex worker community leaders
- With the help of tools and strategies shared with them, the communities at these sites have started handling problems (e.g. harassment from police etc.) by themselves.
- Community members beginning to find their own voices and solutions to issues important to them

**Table 3: Summary of Community Progression from Kenya, Mozambique and South Africa**

<b>KENYA</b>		
	<b>July 2014</b>	<b>May 2016</b>
<b>Outreach</b>	<b>13</b>	<b>16</b>
<b>Clinical Services</b>	<b>12</b>	<b>21</b>
<b>Enabling Environment</b>	<b>4</b>	<b>16</b>
<b>Community Mobilization</b>	<b>12</b>	<b>16</b>

<b>SOUTH AFRICA</b>		
	<b>March 2015</b>	<b>May 2016</b>
<b>Outreach</b>	<b>13</b>	<b>25</b>
<b>Clinical Services</b>	<b>11</b>	<b>24</b>
<b>Enabling Environment</b>	<b>14</b>	<b>16</b>
<b>Community Mobilization</b>	<b>9</b>	<b>10</b>
<b>MOZAMBIQUE</b>		
	<b>Oct 2014</b>	<b>May 2016</b>
<b>Outreach</b>	<b>10</b>	<b>16</b>
<b>Clinical Services</b>	<b>11</b>	<b>21</b>
<b>Enabling Environment</b>	<b>4</b>	<b>16</b>
<b>Community Mobilization</b>	<b>8</b>	<b>15</b>

**Scoring Key:**

<b>0 to 6</b>
<b>7 to 13</b>
<b>14 to 20</b>
<b>21 to 25</b>

## LESSONS LEARNED

Serving as the Capacity Building lead partner for the DIFFER project has been an enormous honor for Ashodaya. Below are just a few of the “lessons learned” during the course of this exciting project:

- ❖ Community to community (C2C) connection is key
- ❖ C2C must to go beyond “training/workshop”
- ❖ Leadership endorsement is required for meaningful access to the community
- ❖ Community to community capacity building is bi-directional.
- ❖ Proper logistics planning and documentation is important for such projects

## 2.4 Cost, empowerment and vulnerability

### 2.4.1 Intervention package costs

We estimated the total and incremental costs of the DIFFER intervention packages in two sites<sup>3</sup> from the provider perspective, collecting data from health care providers, through key informant interviews and from project accounts. The costing process followed an ingredients approach. During the situation analysis/baseline phase of the project we undertook a detailed exploration of the baseline costs of existing service delivery in each site. This exploratory baseline phase asked; What services are currently being offered? By whom? At what cost? This enabled us to quantify what was added by the intervention packages and at what cost. All baseline data were collected retrospectively from health care providers using a standardized tool. Baseline cost data were received from the South Africa and India sites.

The costs of the various DIFFER intervention packages developed and implemented in each site were then collected prospectively, using a standardised costing tool developed in consultation with the research teams in the four sites. The tool differentiates/measures main interventions components in each site, resources used for each component (i.e. staff, materials, overhead/joint, training costs, capital/equipment). The tool also collected information on donated resources (either in the form of volunteer time or donated materials such as condoms) and their estimated market values. Provider costs are calculated for increases in primary care use only. Costs resulting from possible subsequent increases in tertiary care demand are not included in these

<sup>3</sup> Collection of cost data in Mozambique and Kenya was not completed as resources were focused on the effective design, implementation and evaluation of the intervention packages in each site. The rationalizing of activities was necessary due to higher than expected turnover of experienced staff.



analyses as these increases could be confounded by a wider range of societal and systemic factors. Intervention costs were estimated for the India and South Africa sites<sup>4</sup>.

The intervention cost data collected from India and South Africa were compiled, and total and average annual costs were estimated for each site. Intervention costs in each site were adjusted for inflation using the Consumer Price Index (CPI) for India and South Africa, and converted to International Dollars. Considering the differences in the content and scope of the DIFFER intervention packages in each site, we present the results separately here and do not recommend direct comparison of the cost effectiveness analyses for these two very different interventions.

**Table 4: Total, average annual and unit cost of the DIFFER intervention in India and South Africa (2016 INT\$)**

Site	Total project costs	Average annual costs	Start-up costs	Implementation costs	Total sex workers covered	Cost per sex worker covered	Average annual cost per sex worker covered
India	1,606,166	560,725	52,416	1,553,750	1605	1001	349
South Africa	387,540	232,895	29,470	358,070	3,500	111	67

\* Time horizon for costing in India and South Africa was 30 and 18 months, respectively.

\*\* The total cost in India included only recurrent costs.

#### 2.4.1.1 Cost of India' intervention package

As mentioned in detail in section 2.2.1.3, the DIFFER intervention package in Mysore consisted of five main components including; strengthening existing community mobilisation and peer outreach, strengthening and expanding existing STI/HIV services, providing individualised Family Planning, emergency contraception and abortion services, strengthening and expanding Ashodaya's linkages/referral system, and addressing sexual and gender based violence (SGBV). Although, the intervention package was implemented for 36 months, commencing in October 2013 the time horizon for the costing is 30 months in order to be consistent with the time period of programme evaluation and with the evaluation data collection in Mysore in March 2016. The total and average annual program costs of implementing Ashodaya's comprehensive and individualised intervention package were INT\$ 1,606,166 and INT\$ 560,725, respectively. A total of 1605 FSWs were covered by the intervention in Mysore, resulting in a cost per sex worker covered and average annual cost per sex worker covered of INT\$ 1001 and INT\$349, respectively.

#### 2.4.1.2 Cost of South Africa's intervention package

As mentioned in detail in section 2.2.4.3, the DIFFER intervention package in Durban, comprised three core components: integrating high-quality SRH services within healthcare facilities, enhancing existing and implementing new targeted interventions (TIs), and forming and reinforcing linkages between the sex worker community, general population, targeted interventions and health facilities. The intervention package was implemented and evaluated over a period of 18 months from October 2014 – March 2016. This is the same time horizon used for the costing. The total project/program cost of implementing MatCH's intervention package in Durban was INT\$ 387,540. Including costs to the health system or government providers resulting from stimulated demand for care results in an estimated total cost of INT\$ 411,239. Similarly, the average annual cost to the project was INT\$ 232,895 and INT\$ 256,594 when project and provider costs are included. The project cost per sex worker covered and average annual project cost per sex worker covered are INT\$ 111 (INT\$ 117 including provider costs) and INT\$ 67 (INT\$ 73 including provider costs), respectively.

### 2.4.2 Empowering sex workers

These analyses explored whether the DIFFER interventions empowered FSWs to better protect their sexual and reproductive health. We measured empowerment using different questions/indicators, reflecting both empowerment in the context of sex work and general individual self-assessed empowerment. Across all sites,

<sup>4</sup> As before, while every effort was made to collect these data in all sites, collection of cost data in Mozambique and Kenya was not completed as resources were focused on the effective design, implementation and evaluation of the intervention packages in each site.

at both baseline and end-line, we collected indicators of empowerment in the context of sex work as measured by the questions; “Who usually decides about condom use?”, “Have you ever refused a client because of condom use refusal?” and “During the past 3 months have you ever participated in a group, organisation, network or association that defends the rights of FSW?” We also used an adapted version of the questionnaire designed by the Oxford Poverty & Human Development Initiative (OPHDI), for collecting multi-dimensional empowerment in India (at baseline and end-line), Kenya (at baseline) and South Africa (at end-line). In addition to the OPHDI questionnaire, we used a set of questions developed by Ashodaya Samithi to measure empowerment in the sex worker community in the Indian context.

The findings from the analysis of baseline and end-line empowerment data suggests some improvements in FSW empowerment indicators in the context of sex work in all sites.

### 2.4.3 Equity impact of DIFFER

The equity impact of the DIFFER intervention was assessed using data collected in the baseline and end-line cross-sectional surveys in all four sites. The equity impact analysis aimed to assess whether DIFFER succeeded in reaching the most vulnerable FSWs, or whether access to SRH improved among the most vulnerable. To identify the most vulnerable, a vulnerability index was created for respondents in each site using the following indicators: age at first sex for money or gift, number of sexual partners/acts, numbers of unwanted pregnancies, experience of abortions or miscarriage, experience of sexual violence and having other income sources. Using this index, all FSWs were categorised as either ‘least vulnerable’ or ‘most vulnerable’ and the incidence of STI symptoms and health seeking behaviour/utilisation of SRH services was compared between the two groups at baseline and end-line.

The results showed that at both baseline and end-line, an average of 46% of FSWs were classified as ‘most vulnerable’ across sites (Table 5). The results further showed that at baseline, the most vulnerable FSWs generally reported more STI symptoms, particularly in Kenya and South Africa, while at end-line the prevalence of these symptoms among the most vulnerable decreased in all sites. The findings also indicate some improvement in the use of SRH services among the most vulnerable sex workers in all sites, particularly in Mozambique, where uptake of HIV testing, screening for cervical cancer and contact with peer educators significantly improved at end-line (Table 6).

**Table 5: Proportion of the most vulnerable sex workers in the four sites**

Study site	Baseline % most vulnerable	End-line % most vulnerable	P-value
India	46.07	40.72	0.099
Kenya	48.99	48.69	0.933
Mozambique	40.00	49.63	<b>0.010</b>
South Africa	49.22	47.93	0.720
<b>Average</b>	<b>46.07</b>	<b>46.74</b>	N/A

**Table 6: Health seeking behaviour among the most vulnerable FSWs in Mozambique**

STI symptoms and Health seeking behaviour indicators	Baseline				End-line				% change
	N	% Most vulnerable	% Least vulnerable	P value	N	% Most vulnerable	% Least vulnerable	P value	
Vaginal discharge	310	54.84	53.23	NS	403	47.00	41.38	NS	-7.8*
Sore or ulcer	310	7.26	8.60	NS	403	22.00	24.14	NS	14.7**
Sought advice or treatment for STIs	172	74.29	80.39	NS	208	89.81	92.00	NS	15.5**
Difficulty getting care	121	8.33	19.18	NS	310	14.19	15.48	NS	5.9
Testing for cervical cancer	-	-	-	-	380	29.02	18.72	<0.05	N/A
Contraception use	310	73.39	67.74	NS	440	80.09	82.65	NS	6.7*
Emergency contraception	306	14.63	12.57	NS	387	12.24	10.99	NS	-2.4



STI symptoms and Health seeking behaviour indicators	Baseline				End-line				% change
	N	% Most vulnerable	% Least vulnerable	P value	N	% Most vulnerable	% Least vulnerable	P value	
Contact with peer educators	265	55.96	44.87	NS	403	64.50	51.72	<0.01	8.5*
Ever tested for HIV	310	92.74	88.71	NS	403	99.50	94.58	<0.01	6.8**

\* P-value <0.05

\*\* P-value <0.01

## 2.5 Involving policy makers and the community

This work package aimed to ensure the full participation and involvement of the local and national health authorities and policymakers in the research project to develop, implement and evaluate a strategy to bridge the gap between research and health policy and service delivery guidelines. From the onset of the project, the African and Indian partners have worked to promote the participation and involvement of the local and national health authorities and policymakers in the research project to bridge the gap between research and health policy and service delivery guidelines, and to improve local ownership. One of the most fundamental tasks related to the successful completion of study activities depends on 'gaining access' to gatekeepers, stakeholders, community leaders and members. Although successful and beneficial the process of 'gaining access' has been a time consuming and difficult activity in all of the DIFFER sites. In order to secure buy-in and partnerships with these groups a process consultation model has been used and site mapping exercises secured access to SW networks. This model was utilised in partnership with key stakeholders during the design and implementation of the study interventions and emphasized collaboration between the groups involved and rather than focusing on the content of problems alone. This model underscored the importance of solving problems in collaboration and using pooled resources, ensuring that both the DIFFER project and identified stakeholders were both equally involved in diagnosing and solving problems. The four fieldwork sites attained endorsements from authorities such as their Departments of health and local ethics boards in the preliminary stages of the project. Once ethics approval was attained the partners gradually phased in their entry into the FSW community and the key stakeholders working with the community as well as Departments and ministries of health who are strong influencers of policy that directly affect SWs. Through forums such as stakeholder meetings or similar platforms that facilitate open dialogues, information sharing and cooperative engagement. Throughout the study the four fieldwork sites have responded receptively to stakeholders input, concerns and requests.

To further encourage cooperation an approach of prolonged engagement was adopted. After presenting the situational analyses results and proposed intervention the research team invited feedback from all stakeholders and community members. As stakeholders are, arguably the most, familiar with the culture of the organization or community, the ultimate decision about which intervention activities to include or which were most suitable, rested with the stakeholders and FSW community members. Input and feedback from stakeholders served to enhance the researchers understanding of which aspects of the intervention proved to be effective within these settings. To foster sustainability the partners engaged in reciprocal relationships with stakeholders, to ensure that they learn from the experiences of implementing the intervention and through their engagement with the project, enhance their own problem-solving skills. In this way, this intervention model aimed to also to equip the stakeholders with relevant skills so that future problems can be handled effectively without the assistance of the research/ study staff.

Fora used to engage stakeholders were organised at each of the research sites, a local policy advisory board or equivalent mechanism that met at least once a year and community advisory boards that met once a month. The PABs include political stakeholders (including community-level), scientific experts and health managers and the CABs comprised of members and representatives of the FSW community and the community at large. An approach of 'Comprehensive Participatory Planning and Evaluation' was adopted. Stakeholders' workshops, namely, a causal analysis stakeholders' workshop was conducted at the start of the project and a participatory evaluation workshop at the end of the project. Apart from involving stakeholders through these formal meetings, stakeholders were at each site also directly involved by the project implementation.

## 3 Potential impact and main dissemination activities

### 3.1 Potential impact

#### 3.1.1 Mysore, India

Ashodaya, a sex workers' organization, has successfully implemented the DIFFER project. Through this project, sexual and reproductive health (SRH) and HIV services are provided in an integrated manner to the female sex workers in Mysore and to HIV positive women from the general population who sought services from Asha Kirana, a private HIV care hospital.

Service uptake by the community was very high. The challenge Ashodaya encountered was more related to the government system. The SRH and HIV services are provided at State level by two different departments. SRH services are implemented by the National Health Mission (NHM) and the HIV program by the Karnataka State AIDS Preventions Society through support from the National AIDS Control Organization. The challenge lies in getting the two government agencies to come together as they are currently running parallel programs. Dialogue with the NACO and NHM programs is ongoing in order to push for the inclusion of certain indicators into their programs.

Ashodaya is continuing to influence the national government through the members of PAB (equivalent), Ashodaya's selected social champions and through the All India Network of Sex Workers (AINSW). In addition to this, Ashodaya is continuing its "strategic advocacy" with the State and District level authorities as an ongoing effort to ensure impact at the policy level. The policy makers are very hopeful as the design of the National AIDS Control Program (NACP) Phase V will begin soon.

Specifically, Ashodaya's DIFFER intervention showed impact by:

1. Combining SRH & HIV services, which led to increased utilization of services.
2. Ashodaya's clinical data shows that those most at risk for infections are seeking services.
3. District Government officials are aware of the DIFFER model and believe it to be feasible and scalable, as well as provided a template for "how to" integrate HIV/SRH services.
4. District government officials are now aware of high rates of early cervical cancer among female sex workers and women living with HIV.
5. The District Hospital authorities have accepted the role that the Health Care Navigators (HCN) play in various departments (ART centre, ICTC, ObGyn etc.) and would like to institutionalise it.
6. Ashodaya's system of follow-up for ART adherence has been highly appreciated and the system of accompanied referral to be scaled up in the district.

#### 3.1.2 Mombasa, Kenya

During and before the DIFFER project, there was continuous engagement of the community advisory board (CAB) and Policy advisory board (PAB). The members drawn from the were sex worker representation for the CAB and the PAB comprised of the policy actors, health care fraternity, local administration, non-governmental organizations respectively. There were 4 meeting with the PAB and quarterly meetings with the CAB in the 18 months of DIFFER project implementation. The project progress was presented to them and they in turn gave their input on various ways to ensure that the findings translated into policy. One of the recommendations from the team was that all the health care providers at the government health facility need to be trained on offering non stigmatising services to the health care providers. Monitoring this activity would be supported by the heads at the facilities and continually getting feedback from the sex worker community on how they have been served. On linkages of the services, they mentioned on having a system to check on the whether the referral slips reach the facility and these can be made effective by having a health care navigator to link the sex workers to the providers at the facility. These recommendations could be taken up when ICRHK is implementing the LINKAGES project in collaboration with FHI 360 supported by PEPFAR funding.

Plans are underway to continue with the dissemination to the national and international level. The next meeting targeted is the University of Nairobi/ Manitoba collaborators meeting held every year in January in Nairobi.

Publishable papers are to be written from the data collected from both quantitative and qualitative; that is the cross sectional survey data with female sex workers, client exit interviews with women attending reproductive health services, focus group discussions with female sex workers and peer educators and in-depth interviews with health care providers.

### *3.1.3 Tete, Mozambique*

In order to facilitate translation of findings into policy, various measures were taken to promote full participation and involvement of the local and national health authorities and policymakers in the research project, including participation in the national-level key populations working group, close involvement of provincial and district health departments in project planning and implementation (information sharing, regular updates and discussions, involvement in study as co-investigator), contribution to development of national guidelines on services for key populations, and coordination meetings with other implementing partners to share information/experiences. Regular meetings were held with key stakeholders (provincial/district health departments) and sex workers themselves, a PAB was set up at provincial level, and a Community Advisory Board was set up in Moatize. Results of the situation analysis and baseline survey were shared with key stakeholders at national and provincial level. It was not possible to present the final evaluation results to stakeholders before the end of the project due to lack of time, however the findings will be presented at meetings at national and provincial level, to share and discuss findings and their implications.

Impacts of the DIFFER project are expected at various levels:

- At individual level, FSW in Tete are expected to have benefited from increased access to appropriate SRH information and services, and therefore improved health outcomes
- At population level, FSW in Tete are now better organised, and the community is more empowered and knowledgeable and therefore better able to defend their rights. It is also expected that stigma and discrimination of FSW in Tete is reduced, and services more adequate for this group, creating a more enabling environment. Findings will continue to be used to contribute to national level advocacy work to create enabling environment for working with key populations and FSW in particular.
- At a programme level, there will be uptake of learning from the DIFFER project in a new project started at end of project funding by USAID – both in Tete where ICRH continues to implement interventions developed under DIFFER, and through influencing other consortium members working in 7 other provinces across the country.
- At policy level, DIFFER findings will be used to contribute to the development of guidelines and a training package for key population peer education being developed by the National AIDS Council, as well as to ongoing discussions at the Ministry of Health and with partners regarding the most effective approaches for reaching key populations, in particular FSW but also applying lessons and experiences to other groups where relevant such as MSM.
- In terms of research, DIFFER findings are forming the basis of discussion regarding potential new areas of research in relation to SRH of FSW in Mozambique.

### *3.1.4 Durban, South Africa*

MatCH Research has participated in national consultations since 2012 through these meetings study staff have been able to disseminate findings from the situational analysis and present potential intervention plans as well as receive feedback and input into the project activities and progress. MatCH Research have also contributed to the national strategic guideline documents for working with key populations and the national strategic plan for working with sex workers (2012 -2016 and 2016-2019). The situational analysis findings have been presented at provincial and national fora. Many of the stakeholders that were engaged with are also trusted gatekeepers within the FSW community and work with the FSW community. With the support of these gatekeepers a greater sense of trust within the community has been nurtured and promoted; permitting to assess the feasibility and practicability of participatory processes involving FSW and local partners in both the design of the DIFFER intervention and eventual delivery of improved SRH services for FSW. During the study

policy briefs were drafted for Work package two (Policy analyses) and each site plans to draft site specific policy briefs as part of their dissemination activities.

Study staff held a final dissemination workshop with the community and stakeholders in order to discuss maintaining the sustainability of aspects of the DIFFER intervention, such as the creative space events which were run by the FSW community. Future studies were also discussed with the community, such as the potential use of Pre-Exposure Prophylaxis (PrEP) among FSWs. Stakeholders who had attended the monthly stakeholder meetings throughout the intervention were present at the community feedback dissemination event. Other notable members who attended this meeting included the District HIV/AIDS programme manager from the South African Department of Health, and a member of the study Scientific Advisory Board. This was to encourage dialogue between the community, stakeholders and researchers regarding the findings of the study, and to maintain links which were established between the FSW community and the stakeholders who were to continue working with the community following study closure.

At the dissemination meeting the sustainability of the intervention was discussed with key informants. Since the intervention ended in March 2016 a sex worker committee was formed, with sex worker ambassadors from each site and monthly creative space meetings have been coordinated by them. The numbers attending these meetings have increased since the intervention has ended and Sisonke continues catering for these events. Brothel managers and SWs have continued to request services from Commercial City Clinic who continue with their brothel based outreach. However not as consistently as the outreach that was conducted with the FSW peers. Discussions have begun with the Department of Health to adopt the peer model which is in line with the National strategic plan to provide services to female sex workers in South Africa (2016 -2019).

### 3.1.5 International impact

In addition to the impact at the level of the four countries where the project was implemented, the DIFFER project will provide a valuable contribution to the knowledge about how best to combine different components of SRH services in different settings, similar to ours, to achieve better SRH outcomes for women, especially those with most need.

While there is a large amount of evidence on what SRH services FSW need, knowledge on how best to deliver these services and how to ensure a correct availability, accessibility and uptake of these services, is still very limited. The DIFFER project tested four different context-specific interventions, each combining NGO-led activities specifically targeting FSW, with strengthening linkages and access to general, public, health services. Most of the lessons learned are context-specific, but some can be extrapolated to a broader scale and inform policy development at an international level. For example, the findings of the project will greatly contribute to the discussion of what the role of governments is in delivering services to key populations, such as sex workers, and if it is justified to have services operated by non-governmental actors in parallel to the public services. Our study will provide evidence that can be used in advocating for long-term and sustained funding of those activities that have shown to be feasible, adequate, have a reasonable cost and enhance uptake of services among FSW. Another example are the lessons learned from the south-south exchange between India and Africa, that can inform other such mechanisms of south-south capacity building.

To ensure that these lessons learned are disseminated at international level, and have an impact on policy making, the project will present the findings as much as possible through fora such as international conferences and meetings, and scientific publications, as described below, and share infographics and other materials with relevant international agencies, such as WHO, UNAIDS, USAID, among others.

## 3.2 Main dissemination activities

### 3.2.1 Dissemination strategy

At the beginning of the project, a dissemination strategy was discussed among the consortium partners. This resulted in a document entitled '*DIFFER Guidelines on ownership and dissemination of foreground generated by the project*'. It described who had ownership of the data to be generated by the project, and the rules for sharing and disseminating these data. It also included a dissemination plan of the data and information to be gathered by the baseline situational and policy analysis. Different means of dissemination were proposed,

such as reports and slide presentations for local distribution, scientific publications and presentations at local, regional and international conferences. The responsibilities of each consortium partner in the dissemination of the results were defined, and a Publication Committee was established comprising of one representative, usual the Principal Investigator, of each consortium partner. The role of the committee was to oversee and approve the international dissemination process and arbiter in case of conflict. The procedures for the submission of scientific publications and conference abstracts, including criteria for authorship, were described. The procedures were regularly evaluated and updated as needed. A second document, presenting the revised procedures and entitled '*DIFFER Dissemination Strategy*', was developed in 2014.

### 3.2.2 Public relation tools

Also at the beginning of the project, the coordinator developed some materials presenting the DIFFER project, that could be adapted by each partner to their local context. These included a DIFFER leaflet, a DIFFER factsheet, a DIFFER poster and a DIFFER slide presentation. A DIFFER logo and a standardised template for reports and documents were designed, and a website developed that presented key information about the project, project news, project documents available to the public and contact details (<http://differproject.eu>). It also comprised a members area where consortium partners could exchange internal documents. To inform external partners about the progress of the DIFFER project, a periodic Newsletter was distributed. In total five Newsletters will have been distributed, one after each PMT meeting.

### 3.2.3 Presentations at international conferences

Each consortium partner identified appropriate conferences where key results from the baseline situational analysis could be presented. The main conference identified was the 20<sup>th</sup> International AIDS Conference, held in Melbourne in July 2014, that was attended by five of the six consortium partners and where one oral and 6 poster presentations were presented. ICRH-Kenya presented results through two posters presentations at the 17<sup>th</sup> International Conference on AIDS and STIs in Africa (ICASA), held in December 2013 in Cape Town; Ashodaya presented two posters at the 11<sup>th</sup> International Congress on AIDS in Asia and the Pacific Region (ICAAP), held in November 2013 in Bangkok; and UCL made an oral presentation at the 11<sup>th</sup> World Congress in Health Economics, in July 2015, in Milan. Match-Research presented additional results, through two poster presentations, in July 2016, at the 21<sup>st</sup> International AIDS Conference in Durban. Table 7 provides an overview of all conference presentations.

Table 7: Presentations at international conferences

Title	Lead author	Conference	Type	Date
India needs integrated policy for SRH and HIV service delivery for FSW and women in general population	Ashodaya	11 <sup>th</sup> ICAAP	Poster	November 2013
Sexual and reproductive health care for female sex workers: the need of the hour	Ashodaya	11 <sup>th</sup> ICAAP	Poster	November 2013
The community health worker touch in access to health: findings from prevention with positives study in Mombasa, Kenya	ICRH-Kenya	17 <sup>th</sup> ICASA	Poster	December 2013
Media coverage of the determinants of HIV infection among women in Kenya: content analysis of the 'Daily Nation' and 'Standard' newspapers for January-December 2005	ICRH-Kenya	17 <sup>th</sup> ICASA	Poster	December 2013
Condoms for contraception: Patterns of contraceptive use among female sex workers in eThekweni South Africa	Match-Research	20 <sup>th</sup> International AIDS Conference	Oral	July 2014
The occurrence of sexual and reproductive health problems among female sex workers: A comparison between 3 cities in India, Kenya and South Africa.	UG-ICRH	20 <sup>th</sup> International AIDS Conference	Poster	July 2014



Title	Lead author	Conference	Type	Date
Access to and satisfaction with general health and specific sexual and reproductive health services among FSW in India, Kenya and South Africa	UG-ICRH	20 <sup>th</sup> International AIDS Conference	Poster	July 2014
Where do female sex workers seek sexual and reproductive health care? A comparison between 3 cities in India, Kenya and South Africa.	UG-ICRH	20 <sup>th</sup> International AIDS Conference	Poster	July 2014
Condom Use and Access Amongst Female Sex Workers in eThekweni District, KwaZulu-Natal	Match-Research	20 <sup>th</sup> International AIDS Conference	Poster	July 2014
Evaluating respondent driven sampling as a method to access and map female sex workers in Durban, South Africa	Match-Research	20 <sup>th</sup> International AIDS Conference	Poster	July 2014
Condoms, Condoms and More Condoms: Expanding Family Planning Choices for Female Sex Workers in India	Ashodaya	20 <sup>th</sup> International AIDS Conference	Poster	July 2014
Measuring empowerment among female sex workers in India, Kenya, Mozambique and South Africa	UCL	11th World Congress in Health Economics	Oral	July 2015
High co-occurring STI and HIV prevalence and the poor treatment cascade among Female sex workers in Durban, South Africa.	Match-Research	21 <sup>st</sup> International AIDS Conference	Poster	July 2016
“Nobody helps because I am a sex worker”: Sex workers’ barriers to healthcare seeking and experiences in the South African context.	Match-Research	21 <sup>st</sup> International AIDS Conference	Poster	July 2016

### 3.2.4 Scientific publications

Findings of the baseline policy analysis, led by CHP, were used in four publications during 2013-2014. ICRH-UGent took the lead in publishing the results of a comparative analysis of the four baseline cross-sectional surveys, resulting in two publications in 2016, and one still under review. ICRH-UGent was the principal investigator of the Mozambique situational analysis, under another agreement, and therefore took also the lead in the publications of these results. Two articles were published in 2016. UCL published results of the baseline cost analysis in 2015. The articles are presented in table 8.

**Table 8: Scientific publications**

Title	Lead author	Journal	Status
Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services	CHP	Journal of the International AIDS Society	Published, March 2013
Human rights abuses and collective resilience among sex workers in four African countries: a qualitative study	CHP	Global Health	Published July 2013
Community empowerment and involvement of female sex workers in health interventions in Africa: a systematic review	CHP	Global Health	Published June 2014
Facility-based service delivery models for female sex workers in Africa: a systematic review	CHP	Global Health	Published June 2014
Inequity in costs of seeking sexual and reproductive health services in India and Kenya	UCL	Int J Equity Health	Published, Sept 2015
Are HIV and reproductive health services adapted to the needs of female sex workers? Results of a policy and situational analysis in Tete, Mozambique	UG-ICRH	BMC Health Services Research	Published July 2016
Barriers to HIV and sexual and reproductive health care for female sex workers in Tete, Mozambique: Results from a cross-sectional survey and focus group discussions	UG-ICRH	BMC Public Health	Published July 2016

HIV prevention and care seeking behaviour among female sex workers in four cities in India, Kenya, Mozambique and South Africa	UG-ICRH	Tropical Medicine & International Health	Published August 2016
Where do female sex workers seek HIV and reproductive health care and what motivates these choices? A survey in 4 cities in India, Kenya, Mozambique and South Africa	UG-ICRH	Plos One	Published August 2016
The use of sexual and reproductive health services by female sex workers is context-specific: Results from a cross-sectional survey in India, Kenya, Mozambique and South Africa	UG-ICRH	Reproductive Health	Under Review

### 3.2.5 Local and regional dissemination

In addition to the above, each partner used various occasions and opportunities to disseminate their findings locally. Results from the different project phases were continuously shared with policy makers and other key stakeholders during the mechanisms that were developed to interact with these (see sections 2.5 and 3.1). Other local dissemination activities are described below, per site.

#### *Mysore, India*

Ashodaya worked with a team of community members and technical experts, to organize and carry out local and broader dissemination of DIFFER project activities and findings. These included (1) a DIFFER Study Briefing and Mysore Baseline Report; (2) video documentation on DIFFER Capacity Building Workshop; (3) dissemination with the All India Network of Sex Workers (AINSW); (4) presentations at regional and international meetings, listed in the table below.

Date and Place	Meeting	Organiser
October 2014, Kuala Lumpur, Malaysia	Cooperation Fund for fighting HIV/AIDS in Asia and the Pacific regional conference	Asian Development Bank (ADB)
March 2015, Geneva, Switzerland	Advocating for PrEP in priority population Determining the scope of recommendations for PrEP used by women	WHO and UNAIDS
May 2015, Jakarta, Indonesia	South to South collaboration- Field visit to Jakarta by a team of Policy makers, UN representatives and Ashodaya Academy Director	UNAIDS
July 2015, Cambodia	NSWP capacity building workshop on the Global Fund, human rights and gender	Network of Sex Workers Project (NSWP)- Funded by Global Fund
December 2015, Bangkok, Thailand	Meeting on available evidence, tools and promising practices on preventive violence against women and girls through social norms change	UNWOMEN, UNFPA, Australian AID and Korean Women Development Institute (KWDI)
April 2016, New Delhi, India	Technical Resource Group for FSW at NACO	NACO
April 2016, New Delhi, India	65th CCM Meeting	India CCM
June 2016, Jakarta, Indonesia	Community to Community Capacity Building (India Mission to Indonesia)	UNAIDS India & UNAIDS, Indonesia
July 2016, New Delhi, India	AINSW Board Meeting	AINSW
August 2016, Chennai, India	TI meeting	CFAR & CF
August 2016, New Delhi, India	66th CCM Meeting	India CCM

### *Mombasa, Kenya*

ICRH-Kenya developed a project factsheet, and presented the project at various local meetings such as the University of Nairobi / Manitoba collaborators meetings and Key population Technical Working Group meetings. A final dissemination workshop was held with the PAB and the CAB members in September 2016.

### *Tete, Mozambique*

The results of the different components of the baseline situational and policy analysis were summarised in two different reports in Portuguese, one presenting the findings of the health facility-level assessments, and one presenting the findings of the cross-sectional survey and focus group discussions, and these reports were widely distributed in-country. The key results were also presented with power-point presentations in two phases. In June 2013, the results of the policy analysis and health facility-level assessments were presented to and discussed, first with local stakeholders in Tete, and then with national stakeholders in Maputo. Additional dissemination meetings were organised in October 2014 to a broader audience, one with in addition to the health authorities, also the police and influential community members, and a second with the FSW community. The results of the CSS and FGD were presented in January 2015, again first at local and then at national level.

### *Durban, South Africa*

DIFFER staff members presented results from the situational analysis and the DIFFER intervention in a number of different scientific fora. The most important are summarized in the table below.

Date	Meeting
April 2013	Key Population Stakeholder Meeting
March 2014	District AIDS Council (DAC) and Provincial key populations meeting
April 2014	KZN Department of Health PEPFAR & non PEPFAR partners workshop
May 2014	District AIDS Council (DAC) Civil Society meeting for Key Populations
July 2014	South African National AIDS Council eThekweni meeting
August 2014	District AIDS Council (DAC) Strategic planning meeting
September 2014	HSRC consultative workshop
September 2014	Wits Faculty of Health Sciences Biennial Research Day 2014
January 2015	36 <sup>th</sup> Annual Conference of the South African Association of Campus Health Services - SAACHS (DUT and UKZN) invited speaker "DIFFER"
March 2015	Invited to present DIFFER situational analysis findings at Massachusetts General Hospital
March 2015	District AIDS Council Meeting
July 2015	SA AIDS Conference [DIFFER situational analysis FGD findings]
September 2015	UKZN, Public Health. Invited speaker "An overview of the DIFFER project"
September 2015	District AIDS Council Strategic planning meeting
September 2016	WITS University Biennial Research Day (poster & oral presentations)

A final workshop was held in August 2016 with all stakeholders to present the preliminary end-line results. This also included a workshop with the community to discuss maintaining the sustainability of aspects of the DIFFER intervention and possibilities for future studies.

### **3.2.6 Final DIFFER symposium**

At the end of the project, in September 2016, a 2-days final symposium was organized in Brussels, Belgium. Each of the six consortium partners presented the final results of the project to each other; to the Scientific Advisory Board members; to a number of selected policy makers, stakeholders, and representatives of the FSW community from each of the countries where the research was done; to international policy makers in the field of sexual and reproductive health and rights or FSW interventions, such as WHO, UNAIDS and USAID; and to the funding agencies (the EC and the Flemish government). A total of 43 people participated. The results, lessons learned, and the next steps for a possible replication of some of the intervention components on a larger scale were discussed.



### *3.2.7 Future dissemination plans*

The analysis of the data collected during the final evaluation was only completed in September 2016, and it was therefore not possible for all partners to hold the final in-country dissemination workshops within the project's period. In Mysore, discussions are underway to plan a final evaluation workshop. The workshop was originally planned for September 2016, but was rescheduled due to the difficulty scheduling with Government representatives. The timing is good to advocate with the National AIDS Council (NACO) and National Health Mission (NHM) as they are currently revising their strategies. In Tete, the team plans to present findings to stakeholders at provincial/local level, such as, the District and provincial Health authorities, relevant non-governmental agencies conducting activities with key populations, peer educators and lay counsellors, health facility focal points and the police.

At the end of the project the consortium partners agreed, during the final PMT meeting, a strategy for the dissemination of the results of the final evaluation. Each partner will make a suggestion of the article(s) they would like to take the lead in, and of abstracts they intend to submit to conferences. Each partner should take the lead in at least one publication. A table was sent around to facilitate the process. The procedures for article and abstract submission were slightly changed to smoothen the process. In addition, an Info-graphic will be developed with the key results/ lessons learned from the project, and shared with WHO and other international partners.