Stockholm Evaluation Unit

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EVALUATION OF THE MSF-OCB CORRIDOR PROGRAMS FOR KEY POPULATIONS

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CONTENTS

Cover photo: Health education street theatre troupe in action, Beira, Mozambique (photo: R Bedell)

ACRONYMS

aOR	Adjusted Odds Ratio
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CE	Community Educator (peer educator)
CHAM	Christian Health Association of Malawi
CHREAA	Centre for Human Rights Education, Advice & Assistance (Malawi)
CHW	Community Health Worker
CO	Clinical Officer
CSW	Commercial Sex Worker
DH	District Hospital
DPS	Direcção Provincial de Saúde = Provincial Directorate of Health, Mozambique
FGD	Focus Group Discussion
FP	Family Planning
FSW	Female Sex Worker
FU	Follow-Up
GBV	Gender-Based Violence
HBV sAg	Hepatitis B Surface Antigen
HC	Health Centre
HF	Health Facility
HIV DA	HIV Diagnostic Assistant (also HDA)
HR	Human Resources
HTC	HIV Testing & Counseling
ICRH	International Centre for Reproductive Health
IPV	Intimate Partner Violence
KP	Key Population(s): sex workers, MSM, people who inject drugs
LAMBDA	The Mozambican Association for the Defense of Sexual Minorities
LTFU	Lost to Follow-up
MoH	Ministry of Health
MSM	Men who have Sex with Men
MULEIDE	Women's Association for Law & Development, Mozambique
MW	Midwife
NAC	National AIDS Commission
NGO	Non-governmental Organization
OC	Oral Contraceptive
OPD	Outpatient Department
OR	Operations Research
PE	Peer Educator

PEP	Post-exposure Prophylaxis
PMTCT	Prevention of Mother-to-child Transmission
PrEP	Pre-exposure Prophylaxis
RIC	Retention in Care (alternately: retained in care)
SGBV	Sexual & Gender-based Violence
SOP	Standard Operating Procedure
SRH	Sexual & Reproductive Health
STI	Sexually Transmitted Infection
SV	Sexual Violence
SW	Sex Worker
SWEAT	Sex Worker Education and Advocacy Taskforce
SWPE	Sex Worker Peer Educator
ToP	Termination of Pregnancy
TSW	Transactional Sex Worker
TVIC	Trauma- and Violence-informed Care
Q3M	Every 3 Months
VDRL	Venereal Disease Research Laboratory: non-treponemal antibody test for syphilis
VIA	Visual Inspection with Acetic acid (cervical cancer screening)
VL	Viral Load (HIV, unless otherwise qualified)
WHO	World Health Organization

EXECUTIVE SUMMARY

Since 2014, MSF has been implementing health programs for key populations (KP) mainly along a major transport corridor running through Mozambique and Malawi. Programs serving KP were developed in Beira, Tete (Mozambique), and in Mwanza, Zalewa, Nsanje and Dedza (Malawi). Some programs cover large geographic areas (Tete, Nsanje), while others are focussed on an urban/peri-urban setting (Beira, Mwanza, Zalewa, Dedza). The nature of the collaboration with the relevant Ministry of Health varies and different models of care have evolved at various locations, mainly aimed at reaching commercial sex workers (CSW) and transactional sex workers (TSW) and, in one location, men who have sex with men (MSM).

This evaluation was conceived to evaluate each program individually, and then to look at all programs comparatively in order to discern which interventions were most effective in reaching the objectives set forth – which were largely concerned with HIV prevention, diagnosis, and treatment, given the inordinately high prevalence HIV infection among SW, as well as with other common issues in sexual and reproductive health. Furthermore, our intention was to consider the sum of the MSF experience in these programs to infer an optimal model of care that responds best to the health needs of KP.

A detailed evaluation matrix was developed to fully explore several aspects of each of appropriateness (from the perspectives of KP members), effectiveness (in terms of health-related objectives), and connectedness (including capacity-building, replicability, and sustainability of programs). The planning process was informed by extensive documentation and 19 key informant interviews. A month was spent in Malawi and Mozambique undertaking rapid assessments of all programs, involving site visits to 5 of 6 sites, extraction of quantitative data, focus group discussions and informal interviews with beneficiaries, and interviews with 88 key informants (MSF project personnel and representatives of other agencies working with KP).

FINDINGS

Appropriateness. All programs engaged with CSW very effectively in program design and intervention, although TSW have had less input. There has been no specific engagement with youth for design or implementation of youth-focussed programming, and not all subgroups of MSM have been considered or consulted in MSM program development. SW-friendly care is the norm in MSF services for KP, and while there has been some progress in ministry of health (MoH) settings, more work is needed therein. Sexual and gender-based violence (SGBV) is a major issue faced by most SW and, although MSF responds medically and connects victims to legal support, social and psychological support is lacking and no comprehensive advocacy strategy to address sexual violence (SV) exists. Gaps include care for children of SW; some overtly KP-focussed services are too stigmatizing for some TSW or MSM.

Effectiveness. All programs recruited well, dependent primarily on the number of sex worker peer educator (SWPE) staff. Retention was less likely for younger women, often more likely with a new HIV+ diagnosis (in Tete). Beira had somewhat better early retention (i.e. after the 1st and 2nd visits) whereas Tete had better retention for SW having at least 3 visits; the reasons for these differences are unclear, but they may be related to different demographics and TSW/CSW mix. In Tete, Zimbabwean women stay in the program most, based on retention in care (RIC). Re-testing is at least 6-monthly everywhere, with a minority getting 3-monthly re-testing. Unfortunately, HIV incidence is extremely high among SW in all programs – in the range of 25-35 times the general population HIV incidence in Mozambique and Malawi. Among active HIV+ SW, ART coverage runs 74-85%. Viral load coverage is poor everywhere. PEP is under-utilized due to stigma and confusion; PrEP would be of interest but has not been available outside of a study enrolment. Contraception coverage has been <50% at all sites – but with no data on unmet need. Termination of pregnancy (ToP) is available in Mozambique, but access is often limited by late diagnosis of pregnancy. Violence reduction has resulted from sensitization of the police, who have been the main perpetrators.

Connectedness. SWPE are the centrepiece of all the programs, and their capacities can be optimized through standardized training and mentorship; counsellors support SWPE to reach their health educator potential. Their outreach activities must be NGO or CBO-provided. MSF clinical officers (COs) are part of some programs, often allowing 1-stop (or nearly 1-stop) KP services of high quality, but most SW issues concern sexual and reproductive health (SRH) or antiretroviral therapy (ART) and can usually be dealt with by a nurse. Engagement with MoH will transfer skills for KP services more effectively if it is done through structural mentorship than via parallel service provision. Sex Worker-Friendly Training and SWPE navigation of SW to MoH services can shift attitudes and improve quality of care. According to the National Aids Commission (NAC), *Linkages* is the preferred national model for KP services in Malawi, and it relies on MoH clinicians.

CONCLUSIONS

All programs have engaged respectfully and effectively with KP members both as program personnel and as beneficiaries. In every program, KP members have gained capacities, respect from others, and self-respect, in the processes of outreach and health care. In every program KP personnel and beneficiaries have collectively had their lives enhanced by the support that MSF has given, and by their often-voiced perception that MSF values them as persons. These facts underlie the enormous potential for improvements that we discuss in this evaluation.

SWs are vulnerable to harm, including HIV-related harms, physical and psychological trauma, and death due to SGBV. Response to this harm has been impaired by a lack of recognition (normalization), a lack of comprehensive strategy to address violence, and a lack of capacity to provide psychological support. Risk can be altered through regular interventions with the police and other key actors. Attitude change among health care personnel is also fostered by Sex Worker-Friendly Training and rapport-building over time. Advocacy by MSF on decriminalization, rights, antidiscrimination measures, stigma reduction, and violence prevention and response has taken place, at times fruitfully – but has been inconsistent.

Programming for SW-involved youth (<18) does not fully acknowledge sexual exploitation (as understood in the UN Convention on the Rights of the Child); SRH services for sexually exploited youth should be provided within general youth programs.

SWPEs are limited by lack of a standardized training curriculum, mentorship plan, and continuing education and training plan, trauma- and violence-informed counselling and care.

Current programs have less appeal to more stigmatized groups including many TSW, MSM, and trans women, so enrolment of these KP is likely suboptimal. More general approaches (e.g. presenting services as 'women's SRH' or 'men's health') offer more appealing, less stigmatizing modes of contact.

HIV incidence is extremely high among SW, indicating that condom-based HIV prevention is insufficient. PrEP has been available to only a small fraction of potentially interested KP members despite being recommended in WHO guidelines, mainly due to MoH-imposed limits; long-acting injectable PrEP would be better still but needs advocacy, piloting and evaluation. PEP should be offered whenever HIV exposure is judged to have occurred without regard to circumstances.

An optimal model of care is led by NGO/CBO-affiliated peer workers, adapted to specific KP characteristics, with easy access to outreach services provided by peers and counsellors; navigating clients to clinical services (health facilities or decentralized sites) by training peers, and structural mentorship of MoH nurses, midwives and clinical officers, will optimize the quality of care provided to SW (and their children) and MSM.

KEY RECOMMENDATIONS

⇒ Recommendation 1: Define a comprehensive strategy, including advocacy, to tackle the prevention, early intervention against, and treatment of violence against sex workers, including individual, community, health sector, and other structural interventions, including decriminalization of sex work.

⇒ Recommendation 2: Define a comprehensive strategy to meet the needs of young people engaged in sex work. This strategy must adhere to the UN Convention on the Rights of the Child and identify the under 18-youth exchanging sexual services for money or other resources as sexually exploited youth.

⇒ Recommendation 3: Standardize the SWPE orientation, education and training (including updating) particularly on the topics of SGBV, health promotion, SRH and HIV treatment access. Define the scope of practice and enhance the role of SWPE in liaison with MoH staff.

⇒ Recommendation 4: Develop a more comprehensive model of care to address the needs of diverse sub-groups of MSM and of TSW, and engage representatives from these sub-groups during this development process.

⇒ Recommendation 5: Advocate, pilot and evaluate to maximize the availability of oral PrEP (in accordance with WHO guidelines) and of new injectable, and/or other long-acting forms of PrEP. In the absence of PrEP, maximize the correct application of PEP.

INTRODUCTION

This evaluation concerns programs initiated by MSF OCB in 2014 to respond to the disproportionate risk of HIV infection and its consequences among particular key populations (KP) along an industrial transport corridor running through Mozambique and Malawi – specifically at Beira, Tete Town and Moatize, Mwanza, Zalewa and Dedza. While not on the corridor per se, a KP-focussed program initiated in 2013 in Nsanje District of southern Malawi is also included. The locations of these sites are shown on the map below. `

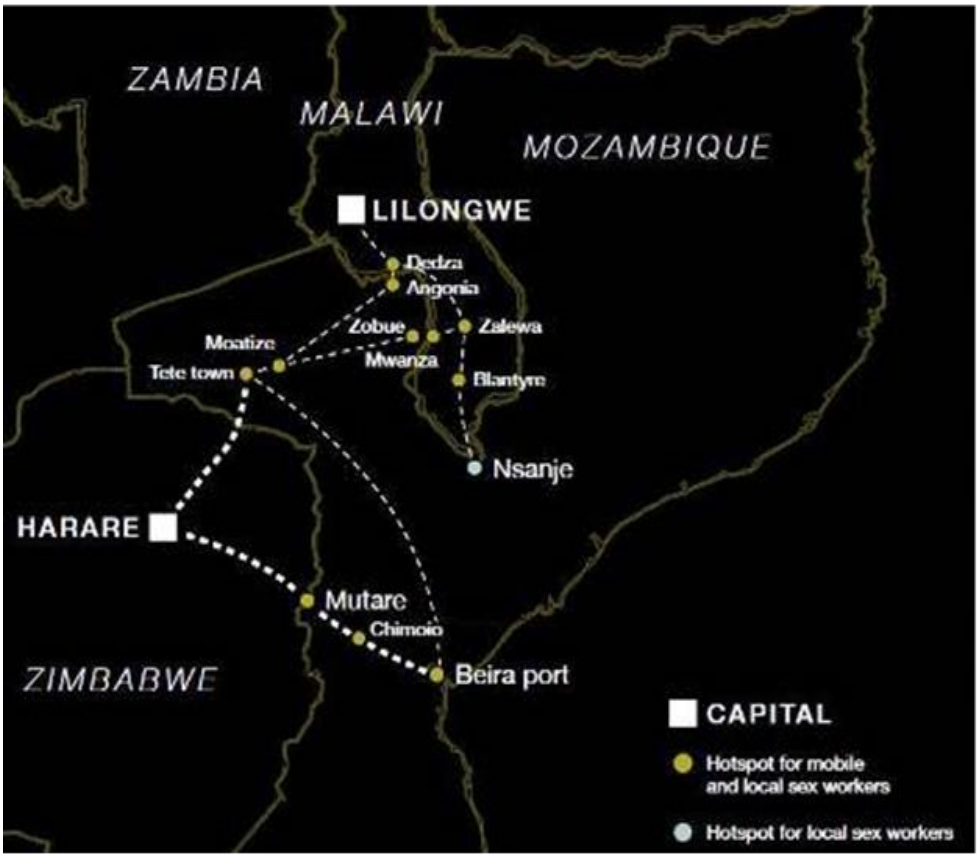

Figure 1. (from Moz_Corridor_PresentationARO2017_2016OCT_final.ppt).

Most of the programs are primarily concerned with women involved in sex work (also known as sex workers, SW) and only one site (Beira) has a distinct program for men who have sex with men (MSM). Female SW in Malawi are predominantly Malawian, but in Mozambique SW are Mozambican, Zimbabwean and Malawian; MSM in Beira are 98% Mozambican. The heightened risk of HIV inherent in sex work and for all MSM occurs against a backdrop of major HIV epidemics in all 3 countries. The table below summarizes some key data to characterize the state of the HIV epidemics in each country (from UNAIDS 2017 report), shows the relative overall performance of the HIV treatment programs, and illustrates a ≥50% drop in HIV incidence in all 3 countries between 2010 and 2016.

Table 1. HIV Data (UNAIDS 2017 report)

	% HIV+ know status	% ALL** HIV+ on ART	HIV Incidence* 2010	HIV incidence* 2016
Mozambique	61	54	7.95	3.63
Malawi	70	66	4.54	2.29
Zimbabwe	75	75	6.48	3.03

**per 1000 population*

***denominator includes estimate of HIV+ who do not know status*

Although we expect the situation for SW and MSM to be somewhat different, these data suggest that the risk of HIV transmission from male clients of SW is likely to have diminished over time. Since this is the main driver of HIV acquisition by SW, we would expect that HIV incidence among SW may be falling too. This is the epidemiological backdrop against which the MSF projects have been implemented.

PROJECT BACKGROUND

The initial concept of the Corridor Project was to focus on health challenges associated with mobility including but not limited to HIV, beginning with KP (sex workers and long-distance truck drivers). The project design included several points for programming along the corridor because it was well understood that the issue of mobility was the major obstacle to engagement, particularly with SW needing HIV prevention, diagnosis, treatment initiation, and adherence support. Various mechanisms were attempted in the early years of the project to create smooth cross-border continuity of care, and to create project-wide unique identifiers that would permit multiple points of contact with individual SW. Over time the Corridor Project became more HIV-centric and it became clear that SW mobility was more variable than had been understood, and that many SW came from or left for locations where MSF had no presence. By 2016 these original linkage ambitions were being set aside, and in mid-2017 the Corridor Project formally ended, although the same work continued as a thematically-linked group of independent KP programs.

All of the programs have sought to develop an adapted model of care for KP, particularly SW. Program developers at different sites made different choices as to how to organize outreach activities and clinical care. Collaboration with the local Ministry of Health services has differed from program to program, and even from site to site within some programs. Program objectives resonate with WHO health sector recommendations for KP and with 5 critical enablers related to (i) laws, policies, and practices, (ii) antidiscrimination measures and laws, (iii) access to acceptable health care, (iv) community empowerment, and (v) violence prevention and response (most recently articulated in the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Care and Treatment for Key Populations: 2016 Update). An annotated list of the recommendations relevant to these programs and this evaluation is provided in Annex IX.

Table 2. Organization of KP services at Corridor Sites. Differences between services are underlined.

Corridor Site	Community Outreach Services[1]	Community Clinical Services[2]	Health Facility Clinical Services[3]
Zalewa, Mwanza, Dedza	MSF SWPE, Counsellor	(No community clinical services; SWPE navigate SW to HF as needed)	MSF CO (KP) MoH Nurse, MW (KP 1-Stop clinic; weekdays)
Nsanje	MSF SWPE, Counsellor (no HTC outside clinic sessions)	MSF SWPE, Nurse, MW, Counsellor MoH Nurse, HIV DA (KP-specific clinics: Q 2- 4 weeks per site + some home visits)	MoH Nurse, MW, CO (general clinics: OPD, ART, FP; weekdays)
Tete	MSF SWPE, Counsellor	MSF SWPE, Nurse, MW, Counsellor, Lab tech (Weekdays; weekly visits per site + home visits)	MoH Nurse, MW, CO (General clinics: OPD, ART, FP; weekdays)
Beira	MSF SWPE, MSM PE, Counsellor	MSF SWPE, Nurse, MW (Weekdays; site visit schedule + home visits)	MSF CO (KP), MW (KP) (KP-specific services at 1 HC & MSF office; weekdays)

1 Community Outreach Services: Health education, HTC, condom education/distribution, STI symptom screen, TB symptom screen, PEP starter pack, Emergency contraception/STI prophylaxis, PrEP continuation (where offered), pregnancy test, VDRL, HBsAg screen, EAC

2 Community Clinical Services: all the above plus STI treatment (syndromic & periodic presumptive), ART initiation and follow-up, PEP, Family Planning methods, VL, HBV immunization, HCV screen (Beira)

3 Health Facility Clinical Services: the above plus, VIA, general medical consultation and (in the case of Mozambique) ToP or ToP referral.

EVALUATION SCOPE

The goal of this evaluation is to assess the appropriateness, effectiveness and connectedness of each model of care being implemented, individually and comparatively. From this we wish to draw inferences as to the optimal model of care for KP, particularly for SW regarding whom MSF has the largest amount of information and program experience.

Each program is associated with the standard set of MSF documents defining its context, objectives, expected results, activities, indicators, and data sources, including a logical framework for project management. These are updated periodically to accommodate contextual changes or new plans. It is impractical to reproduce all of the logical frameworks for each program here; the **evaluation matrix** captures the common goals of each of the KP programs found in each logical framework. Each program was evaluated with specific reference to this evaluation matrix (found in Annex IV) versus each individual program logical framework. In order to describe the scope of this evaluation, a brief summary of the evaluation matrix is provided below.

Table 3. Evaluation Matrix Summary

Evaluation Question	Related Questions
APPROPRIATENESS	
EQ1. Is the intervention appropriate from the perception of the target population?	What information was gathered from intended beneficiaries in the project design? What information was gathered on user perceptions during project implementation?
EQ2. Is the strategy appropriate in order to achieve the objectives?	How do sites of service provision influence recruitment of KP into care and treatment? How were burdens affecting KP services addressed? How does style and quality of service influence acceptability and retention in care? Who are the service providers and how are peers involved? How are staff trained? Is engagement with KP culturally appropriate, non-discriminatory, and tailored to unique contextual features?
EQ3. What are the differences in strategy between settings?	How do site-to-site variations in recruitment and retention relate to the service model? How do other aspects of program performance relate? What languages are services provided in? What gaps in service exist? What individual and organizational factors contribute to them? How do they affect loss to follow-up?
EFFECTIVENESS	
EQ4. To what extent have the objectives been achieved?	How well are KP members recruited and retained in care? Are there patterns to loss to follow-up? What proportion of KP contacted knows their HIV status, initiates ART and has suppressed VL? What is the uptake of PEP and PrEP? What is the incidence of unintended pregnancies? What has been done to address violence prevention?
EQ5. What are the reasons for achievement or non-achievement of the objectives?	What are the proportional contributions of recruitment, retention and quality of treatment?

EQ6. What can be done to make the project more effective?	How can recruitment and retention be optimized? How can acceptability and accessibility be optimized? What can be done to enhance service quality and completeness?
CONNECTEDNESS	
EQ7. What local capacities and resources have been identified and how does the project connect with these?	How does the project liaise with the MoH and other providers related to KP needs? What has been done to enhance local capacities? How involved are experiential people in program development and implementation? How does program design accord with international consensus guidelines on KP engagement?
EQ8. How transferable or replicable is the project?	How could local organizations or peer groups be involved in a sustainable model of care? What ongoing education and training would be needed to support them?
EQ9. Will the project be sustainable?	How aware and involved is the MoH in KP services? What are the human and material resource implications of KP services provision?

For the purpose of the evaluation, we defined sex work as the consensual, adult exchange of sexual services for money or other resources. Sexual services refer to any real or simulated explicit sexual conduct or acts that may or may not include direct physical contact. Sexual exploitation is defined as any person under the age of 18 who has engaged in trading or exchanging sex or sexual activities with an adult for money or other resources including food, shelter, transportation, protection, or other basics of life. Trafficking is not the same as sex work or sexual exploitation, although it may occur in the case of exploitation of youth or with sex workers who are forced by a third party into sex work activities.

We purposefully did not engage in the debates concerning the agent-victim binary that plagues sex work research, policy and programming. These debates make little contribution to the provision of services to key populations and rarely consider the complexity of agency as enacted within a nexus of opportunities and constraints. Nor do these debates usually contribute to the overwhelming evidence that supports decriminalization of sex work as essential to sex workers' health and safety and to the prevention of STIs, HIV, and workplace violence, and their deleterious effects. The attached bibliography (in Annex III) includes detailed resources for those readers wishing for additional information.

METHODOLOGY

Evaluators (2) were provided with an archive of 300 project documents from which the history, objectives, and outcomes of the various projects could be understood. These included standard quarterly reports containing data on program performance and challenges. A unique quantitative review of the period 2014-2017 was also available. Nineteen key informants (KI) from within MSF (including several individuals who had worked at Corridor Project sites in the past) were interviewed regarding the history of the project and the details of the evaluation plan. A detailed evaluation matrix was elaborated. The 29-day field visit phase of the evaluation began on 19 May 2018 in Blantyre, Malawi, and continued to Zalewa and Mwanza (where MSF staff – including SWPE staff – from Dedza were also interviewed), Lilongwe, Blantyre (a 2nd time), and then on 31 May to Tete, Mozambique. From there, evaluators continued to Beira and Maputo where the field visit concluded on 16 June 2018. At all sites KI both from within MSF and from several key agencies (such as MoH, NGO, and/or international donors) were interviewed. Additionally, at program activity sites MSF peer employees, other MSF team members, and (for sites other than Dedza) beneficiaries were interviewed or participated in focus group discussions. Sites of outreach activities and clinical care were visited to observe the MSF programs in real-time practice. After the field visit, additional data extracted by project epidemiologists (which had been discussed in the field) was further examined and interpreted in relation to the evaluation matrix. A detailed chronology of the field visit is provided, as is a complete list of key informants interviewed (see Annex II).

LIMITATIONS

All project epidemiologists that we contacted (past and present) cautioned us that data quality was variable and that some data were unreliable, particularly prior to 2017. Certain data were felt to be more reliable (e.g. HIV test results) than others (e.g. TB screening). Circumstances and project activities evolved over the life span of each program, with attendant data collection and reporting changes; it was not always possible to find comparable data for the same period in different programs. The 2014-2017 Corridor Project quantitative analysis (M Zhang) is the only existing multi-site analysis using the same metrics across all projects (except Nsanje which was not included in that analysis). Some sections of that analysis (e.g. retention in care) do not allow distinction between early program performance and current program performance, potentially obscuring important changes over time.

One of the ambitions for this evaluation was a comparative evaluation of effectiveness, pointing to factors in program execution that influenced effectiveness. Although the table of effectiveness measures that is presented allows some direct comparisons, the differences between programs are usually small and most likely attributable to differences in the density and demographics of sex workers in each of the programs, and to human resources, all of which varied from program to program, and over calendar years. There was no way to attribute relatively small differences in program performance to model of care per se. On the contrary, issues that emerged as crucially important in all programs provided the strongest guidance as to program design.

Because of the geographical variation in project sites and the amount of time required for travel between programs and to visit sites within a program, the evaluators spent only 1-3 weekdays visiting each program (except Dedza which was not visited). Although detailed information was obtained in each site visit, additional time would have permitted more nuanced observations, more examination of data collection and reliability, more thorough examination of specific clinical issues (e.g. TB screening could not be reviewed), and clarification of the unique context of each site. Furthermore, the field visit schedule afforded little time for transcription of field notes or synthesis of information between rapid reviews of 6 programs. In retrospect, this was an insufficient time frame for such an ambitious evaluation, despite the evaluators both voluntarily working beyond the terms of the agreed contract.

FINDINGS

This section of the report follows the format of the evaluation matrix with an emphasis on comparative statements to highlight what is distinctive about a particular program, or to remark on common phenomena shared by most or all programs. These findings related to SW programs; the MSM program in Beira has no comparator programs. It should be noted that Zalewa, Mwanza and Dedza (Z/M/D) all operate with essentially the same model of care. Variations in performance between these 3 programs are noted in the program description and the Annexes on Appropriateness and Effectiveness, but they are unlikely to be related to the model of care. The Dedza program is newer and smaller than the others and readers should be cautioned against over-interpreting data from that program.

APPROPRIATENESS

EQ1 concerns appropriateness from **the perspective of the target population of KP**

The perspectives of the target population of commercial sex workers (**CSW**) were integral to the development, implementation and revisions to the program across all sites and programs, as evidenced by the comprehensive needs assessments that included focus group discussions with KP, mapping exercises to identify hotspots for engagement with beneficiaries, and existing data about the HIV- and SRH-related health needs of KP within the respective countries. Additionally, the SW programs are responsive to shifting needs based on informal feedback from the SWPE and CSW beneficiaries. Transactional sex worker (**TSW**) input was limited. The limitation of input from women engaged in transactional sex is influential for the challenges in recruitment and retention of the TSW (discussed in EQ2 and EQ3 and Effectiveness). **Youth** were also less engaged in program design and implementation, except in sites Tete and Beira that included younger SWPE within the cadre and integrated their experiences into the program recruitment strategies (see EQ2).

The **MSM** program in Beira has also not benefitted from the same degree of beneficiary input into program design to enhance the acceptability and attractiveness of the MSM program that CSW programs have had. In particular, it was noted that recommendations from the ANOVA Rapid Assessment and the limited input from LAMBDA were overlooked (see Appropriateness Annex and Connectedness discussion for further details). There is a need for engagement with non-transgender MSM, gay men, and men who do not identify within the LGBTQ communities but have sex with men, in order to refine acceptability and attractiveness of the MSM program for diverse sub-groups of MSM.

EQ2 addresses the degree to which **the strategy (i.e. model of care) is appropriate** to enable achieving the objectives of the Corridor Project and includes issues of recruitment and burdens for the KP in attending for services

Outreach strategies, mobile clinics in Nsanje, Tete and Beira, and static clinics (all but Nsanje) were considered highly acceptable, safe, and attractive for many of the beneficiaries and important for achieving Corridor Project Objectives. SWPE established credibility and trust with the MSF program, the mobile clinics reduced burden for attendance to care and the static clinics were SW-friendly, which enhanced their attendance to care. Static clinics in Beira (MoH and MSF) were not perceived as consistently MSM-friendly, due to stigma associated with MSM and the discrimination experienced by both MoH and MSF staff. The use of advocates within the Beira MoH clinic was helping to tackle acceptability of the MoH clinic for MSM by assisting with attendance to MSF staff that were MSM friendly. The location of services and the number of staff were not distributed equally among the program sites. Tete had a large number of staff that enabled significant recruitment of mainly CSW in concentrated clusters. Beira also had a large number of staff (mainly in the last 2 years) yielding increased enrolment, but recruiting TSW and MSM appears more labour-intensive than for CSW. Nsanje had the most extensive geographical coverage and the staff were limited in the frequency with which they could visit hotspots. There was no specific MSF static clinic in Nsanje (see EQ3). Confidentiality was maintained to the best of the staff's ability. **All cadres of staff** are able to deliver SW-friendly services that foster recruitment and attendance to care (see Effectiveness EQ 4 and EQ5 on enrolment data). SWPE are an essential part of the team and provide continuing support and education to the non-experiential staff on the needs of the beneficiaries and what SW-friendly service includes. There is variation in the preparation of SWPE in that there seems to be minimal standardized orientation or education concerning their roles.

Strategies for the **recruitment and retention of youth** into the existing models of care were problematic. Overall, attempts to recruit youth were situated within the sex worker KP programs and identified as a sub-group of sex workers. The United Nations Convention on the Rights of the Child states that youth 18 years and younger who are engaged in trading sexual services for money or resources are considered to be sexually exploited (see Annex X for details on this Convention). Sexual exploitation among youth is associated with significant negative health and health behaviour

outcomes including self-harm, suicide, and high levels of other forms of violence and victimization. Additionally, sexual exploitation and the consequential trauma that youth experience have proven deleterious effects for brain and cognitive development and emotional/behavioural regulation, compromising their ability to achieve many developmental milestones necessary for optimal health and well-being. Recognition of sexual exploitation versus sex work has significant implications for MSF program format and strategy. First, programs responding to the needs of sexually exploited youth must incorporate strategies for prevention of, and mitigation of harms from, sexual exploitation as much as is feasible or possible. It also requires appropriate reporting and referral, treatment and follow-up. Recognizing that sexual initiation under the age of 18 is quite common in both countries as is the commercialization of sex for adults and youth, and that engaging in sexual service exchanges among youth is somewhat normalized, significant advocacy is required for prevention efforts and for effective programs to provide care for those who are sexually exploited. In the interim, a distinct MSF model of care that is youth-specific, such as youth clinics that are for the general population but have specific resources for those who are sexually exploited, would be beneficial. The clinics would require linkages and supports for sexually exploited youth including psychological support, STI and HIV testing and treatment, age appropriate education for self-care and protective behaviours, and working with relevant ministry-funded services to prevent further exploitation (Saewyc & Edinburgh, 2010).

Burdens for target population to access services were identified and not uniform across sites. Availability of MSF staff was a concern in Nsanje due to the vast geographical coverage area, seasonal flooding, and relatively small number of staff. However, the Nsanje team addressed this through the use of extensive mobilization strategies to ensure that they were able to attend to large numbers of women when they visited a site. The upcoming closure of Tete contributed to significant stress and concern for beneficiaries. Tete staff are working diligently to develop strategies for handover of outreach activities, including formal collaboration with ICRH (and their local implementation partners) who also have KP as a priority for service provision (although they offer no decentralized clinical services, just outreach). All MSF programs will eventually close and further evaluation of the lessons learned in the closure of the Tete site is warranted, including effective communication with beneficiaries concerning alternative sites of care and linkages and referrals with other services prior to closure.

SGBV services were an additional burden that affected attendance with MSF services. MSF has the capacity to respond to physical health needs of an assault including PEP, testing, and treatment. However, MSF provides minimal care to reduce the social and psychological effects of an assault (physical or sexual). There are referrals to support reporting to the police in all sites, but these are received with varying degrees of competency or respect. There are no formalized violence prevention initiatives provided within the model of care. The data on incidence and prevalence of reported violent assaults is insufficient for adequate analysis. Anecdotally, from the perspectives of beneficiaries and MSF staff, violence is a leading concern among the KP. National-level advocacy in partnership with Muleide is ongoing in Mozambique, demonstrating positive benefits of reduced police violence against sex workers, according to program beneficiaries and MSF SWPEs. Muleide also provides rights training to beneficiaries and legal support in the event of an assault in Beira. There are also activities in all sites to work with police to improve reporting of violence. Although various sites are engaged in advocacy and support in various ways to address SGBV, a formalized advocacy strategy for prevention, early intervention and treatment for violence against sex workers is currently not part of any of the MSF models of care.

EQ3 discusses the **difference in strategies between sites**

Variations in strategies between sites were **associated with KP characteristics**. In Tete, and to a lesser extent Beira, recruitment and retention of non-nationals - particularly women from Zimbabwe - was high. SWPE provided services in varied languages to engage nationals and non-nationals within these locations. Also, counsellor, nurses and COs provided translation in non-nationals' health passports to enable communication at MoH static clinics. Nsanje was considerably different from all other sites. Unlike the other Malawi 'one stop clinic' sites, there is no daily sex worker clinic in Nsanje, but rather a schedule of either two weekly or monthly static or outreach clinics thereby limiting recruitment and retention. Nsanje is the only program that currently holds adolescent-specific clinics, although addressing youth needs have been identified at each site. The model of youth care as noted above is, however, not congruent with models of care that reflect the UN Convention of the Rights of the Child. Models of youth care that include crisis management, intense clinical services, educational supports, mental health services, life skills training and housing assistance have been shown to be effective in reducing the traumatic impact of sexual exploitation. While the full range of services is likely beyond MSF's scope of service delivery, youth could benefit from crisis management; SRH services that are youth-specific; and referrals to existing, available, longer-term social and health supports. Tete and Beira differ from other sites as they have mobile clinics and Beira offers the only current night outreach program (although Tete offered night services for 3 years previously). Other sites have offered night programs, but safety concerns contributed to closure in Nsanje, and other sites did not have adequate uptake by KP. Nsanje and Beira also

have a different approach to identifying KP. Beira holds clinics for the general population to avoid outing sex workers or MSM; they find 'snowballing' effective in expanding contact with other MSM. In Nsanje, many activities are defined under the umbrella of women's health services to avoid outing sex workers and to also make the services more user-friendly for transactional sex workers who either do not identify with doing sex work or fear being outed.

Beneficiaries identified **gaps in services** with relevance for recruitment and retention in care. SWs specifically identified a need for a package of services that provided care for their children, in recognition that many women engaged in sex workers are also mothers. Inclusion of children could increase retention if women are able to attend to care for themselves and their children simultaneously. MSM identified the need for a more holistic package of care that is not limited to their sexual activities as MSM and covers men's overall health more generally. Gaps in social and psychological support were identified by both KP groups. Other issues were raised by beneficiaries that are reflective of the larger social and economic context in which many of the KPs live: severe poverty, including food insecurity, and sexism, for example. While identifying KP groups as targeted populations for care has many benefits including KP-friendly services and program funding, there is a significant need for holistic models of care that recognize the complexity of beneficiaries lives inclusive of their multiple and competing needs and roles in the context of their everyday lives. Additionally, the label of sex worker was not an identifying 'label' accepted by all people engaged in exchange of sexual services for money or other goods, especially those involved in transactional sex work. It is also a highly-stigmatizing label. Situating programs in women's and men's health programs may help to address degrees of attractiveness to KP members who do not self-identify with the categorical labels afforded by SW or MSM.

A more detailed program-by-program review of Appropriateness is provided in Annex VI.

EFFECTIVENESS

EQ4 concerns Findings; EQ5 concerns Reasons for Findings and is addressed in Conclusions; EQ6 is addressed in Recommendations

All programs have the **capacity to recruit** SW (range 148-433 per semester) with variability attributable primarily to the number of SWPE working in the program, which was greatest for Tete and smallest for Zalewa and Dedza. This also reflects the relative size of the SW population in each area, and the proportion of CSW who are generally considered more accessible (compared to TSW or MSM). There was no significant variation in mode of SW recruitment from program to program, although Tete program made good use of 10-15 SW peer mobilizers (non-employees, but paid monthly cash incentives and transport costs) to identify new sex workers.

Retention in care (RIC) appears low in the 2014-2017 analysis (M Zheng): of all SW contacted 33-63% (median ~50%) had more than one visit (2014-2017) with subsequent LTFU of 21-43% after every succeeding visit. This is consistent with the high mobility of SW but variations observed may relate to the demographics of the SW population, as well as to program characteristics. Beira program had the highest RIC with 63% of SW having a 2nd visit, and 65-68% retained after each of the 4 next successive visits, but Tete had the highest RIC after at least 3 visits (72-84%). There is no clear programmatic difference to explain this variation. (Program indicators vary but all focus on retention of HIV+ KP members aiming at 80-90% at 6 months; 60% at 12 months).

Program data drawn from 2017 shows that short term RIC (typically defined as 'seen within the preceding 6 months') gives a somewhat different picture: In Z/M/D it was 35-60%, Nsanje 31-48%, Tete 67%, Beira 55%, but some of the differences fall apart on closer scrutiny: Dedza was a young program in 2017 with a relatively less mobile population (60%); Nsanje has infrequent clinics making it common for SW to attend health facilities independently (31%); Tete reports retention of those seen in the preceding quarter, not retention of those ever enrolled – hence the higher figure (67%).

Attrition was examined by stratifying SW with one visit only versus those with 2 or more visits:

Among SW in Malawi, younger age (<25) was associated with more attrition: they were 43% more likely to have only 1 visit than 2 or more visits. This difference was negligible among women ≥25. Younger women are more likely to be HIV uninfected.

In Tete, Mozambique, SW are Mozambican, Zimbabwean and Malawian (predominantly). Younger SW (<24) of all 3 ethnicities were roughly equally likely to be seen only once versus 2 or more times.

Among SW with a diagnosis of HIV infection (new or previous) at the time of enrolment, women of all ethnicities appeared more likely to be have 2 or more visits (or less likely to have only one visit) when compared to women with a

new HIV negative result, or unknown HIV status. The overall impression is that women with a HIV+ diagnosis in Tete were somewhat more likely to be seen 2 or more times (or less likely to be LTFU after 1 visit), as illustrated below.

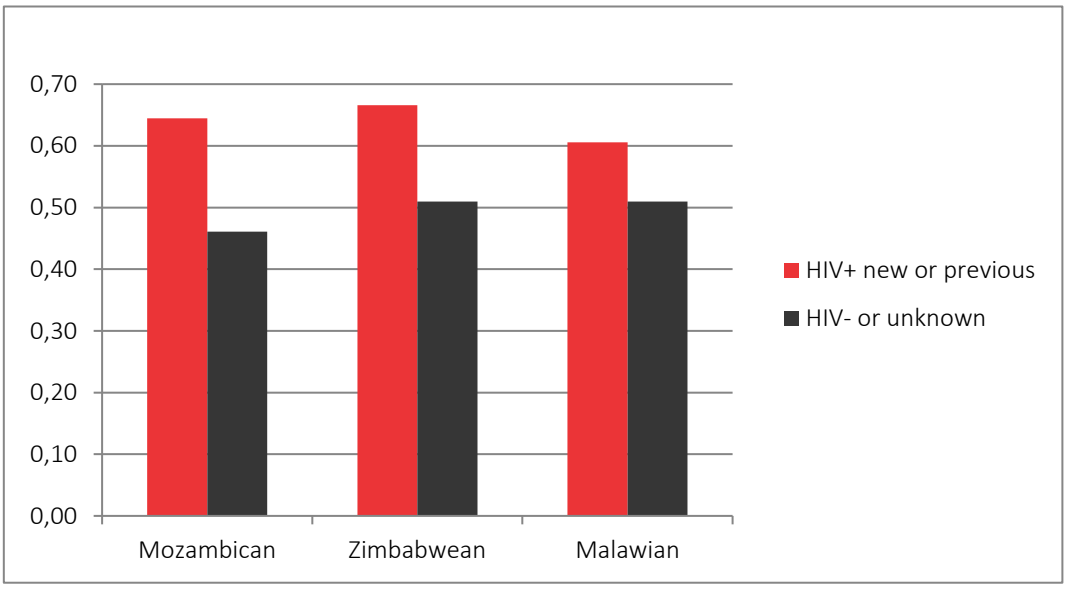

Figure 2: Proportion (%) of Tete SW seen 2 or more times, stratified by HIV status and Nationality

RIC (inverse attrition) appears related to SW nationality in Tete: while 38% of SW every encountered in Tete are Zimbabwean, 47% of SW RIC (6 months) are Zimbabwean, the most strongly represented nationality in the program.

In Beira, the majority of SW ever encountered are Mozambican (75%), with this nationality forming a slightly greater proportion (79%) of those RIC (6 months). The others are almost all Zimbabwean SW. There is a large number of TSW in Beira, residing permanently in the region.

HIV testing of newly-enrolled SW is accomplished with generally high efficacy. This was assessed by looking at the proportion of SW with HIV 'status unknown' after enrolment. In Z/M/D this was 2.2%. 3.0 %, N/A; in Nsanje 4.2%; in Tete 16%, 24% & 23% among Mozambican, Zimbabwean & Malawian women, respectively, with only 1 visit – but 4.4%, 7.1% & 7.3% among women with 2 or more visits, respectively. In Beira, after enrolment it was 3.9% and 3.8% for Mozambican and Zimbabwean SW, respectively, but this typically included a next-day follow-up visit. (All programs use the indicator: ≥90% of persons know their HIV status, which accords with UNAIDS '1st 90').

HIV re-testing of HIV negative SW is an indicator of the quality of follow-up. The 2014-2018 analysis looked at re-testing rates using the WHO standard of 6 monthly re-testing (MSF usually specifies 3 monthly re-testing, but that analysis was not available). By Q3 2016, all programs except Nsanje exceeded the number of re-tests expected; all showed considerable improvement over earlier quarters. Exactly comparable data were not available for Nsanje but program data (Q1-Q4 2017) showed that re-testing in the next quarter (i.e. an average of 3 months) after a negative HIV test varied from 27-35%. 6-month re-test figures for Nsanje would likely be higher but not 100%. (All programs currently use the indicator '50% of HIV negative re-tested in next quarter', which equates to a 3-6 month inter-test interval).

HIV incidence among SW is estimated based on subjects for whom person-time was available. While there is variation in the HIV incidence rates presented for each program, independent estimations using project data all yield estimates in the *same order of magnitude* – suggesting that the range of the estimates is likely to be correct. HIV incidence among SW is staggeringly high – in Malawi it varied from 79-121 cases per 1000 person-years (about 35 times the general population HIV incidence), and in Mozambique it usually varied between 88-102 cases per 1000 person-years (about 25 times the general population HIV incidence).

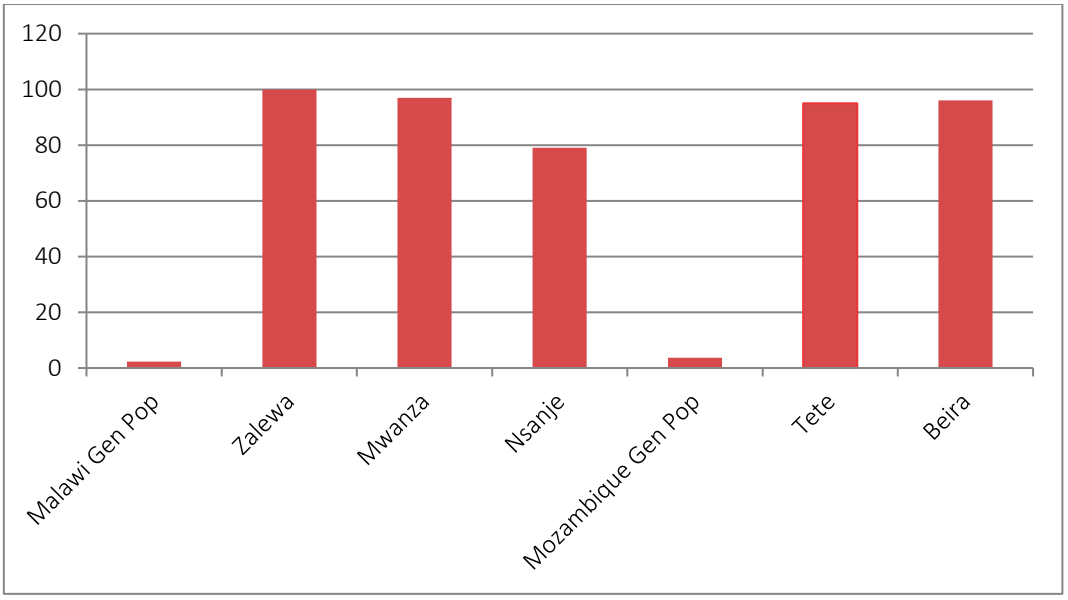

Figure 3. SW estimated HIV Incidence per 1000 person-years

Coverage of ART among HIV+ SW is reported for the active cohort (seen within the past 6 months) since it is understood that ART use cannot be monitored among women LTFU. ART coverage (data from 2017 quarterly reports) for Z/M/D was 81-83%; 85% for Nsanje; 85% for Tete and 74% for Beira. (All programs refer to an indicator of ≥90% of HIV+ initiated on ART, in accordance with the UNAIDS '2nd 90').

Viral load coverage is far below target in all programs, even looking at the proportion of ART patients with a single VL measurement (some projects have an MSF standard of Q6 monthly VL, others have a MoH standard of 6, 24, 48… monthly VL). In Z/M (D – no data) 2017 data showed that 34% of SW on ART for ≥6 months had a VL available (89% suppressed <1000 copies/mL); in Nsanje an estimated 43% of SW on ART had a VL available (76% suppressed); in Tete (2014-2017 overall) 10% of SW on ART had VL (56% suppressed); in Beira 2017 data show 31% of all KP had VL (61% suppressed). These coverage rates are too low to expect that the VL values represent each program in an unbiased manner; however, the low viral suppression in the Mozambique programs is notable (and may partly reflect baseline antiretroviral drug resistance in the general population). MSF personnel suggest that these suboptimal results reflect a combination of limited patient understanding of the value of VL measurement, plus technical and motivational issues within the respective MoH. (All programs are aware of the UNAIDS indicator: ≥90% of ART patients with viral suppression, but since that is not yet demonstrable they have focussed on VL coverage indicators of 80% or greater).

PEP, insofar as the MSF data represent its application, has been used much less than expected: 2017 data show 0-23 prescriptions for PEP per quarter across all programs. MSF provides PEP for condom failure, whereas MoH provides it only for sexual assault; SW may directly attend MoH facilities for PEP – MSF would have no record of that in Nsanje or Tete programs, but SW would likely see the MSF CO in Z/M/D or in Beira. Z/M (not D) and Nsanje have recently begun to allow SWPE to initiate a starter pack for PEP on weekends (or after hours) when the MSF CO (Z/M) is unavailable, but this change is too recent to be reflected in the data.

PrEP (oral TDF) has only been offered during a study in Tete and Beira; acceptability among SW and MSM was > 70%, 290 persons were recruited into the study but there was substantial LTFU within 3 months; by June 2018 RIC was 36% - attributed mainly to mobility and sometimes to a subjective sense of decreased risk (no sero-conversions). This is similar to what was seen in a South African study where 22% of SW that initiated PrEP were seen at 12 months (Eakle R et al). There is very little useful evidence regarding improved PrEP adherence among SW.

Contraception. Family planning coverage (methods other than condoms) for SW in Z/M/D varied from 36%-45% from Q1 to Q4 2017; (no such data for Nsanje); FP coverage among SW in Tete varied from 36%-44% from Q1 to Q4 2017; in Beira coverage was 24%-28% from Q1 to Q3 2017; there has been a substantial enhancement of SRH services in Beira since these data were collected.

ToP services are variably available in Mozambique. Tete has 0-4 requests per quarter in 2017; Beira had 24 requests total in Q1-3 2017 but now has enhanced access to ToP (currently 9-12 per month). (Total need has not been estimated so there is no reference indicator). The demand for ToP has been underestimated due to insuficient knowledge of its availability and insuficient familiarity among health care workers with the procedure, but this implies at least some unmet need for contraception. Many women present with pregnancy >12 weeks gestation, implying some unmet need

for early pregnancy testing (linked with health education). Late presentation may also occur when women have had to travel from other districts that lacked any ToP services, or in situations where the father withdrew support.

Prevention of violence against SW. In Z/M/D, the human rights advocacy and support group CHREAA has coached SW (particularly in Mwanza, where there is a cohesive, autonomous 52-member section of the Sex Workers Alliance) to reduce risk by negotiating payment before the sexual service is provided (a strategy that has been empirically demonstrated to be effective; see Manning E, Bungay V).

In Beira, some sub-groups of sex workers have worked collaboratively to share information about violent clients so that they can be avoided by others. MSF programs have not been a part of building that capacity among SW at Beira or any other site.

Programs that have conducted sensitization workshops with the police have noted clear benefit, with an anecdotally reported reduction in incidents of harassment, theft, or violence; this has been the experience in Dedza, Tete and Beira. Despite some reported improvement regarding police conduct, all programs report violence by clients and police as substantial problems that are inadequately addressed due to stigma, discrimination and the normalization of GBV.

Discrimination, mistreatment or exclusion from health care services are forms of structural violence: all programs have positive experiences with Sex Worker-Friendly Training for MoH personnel, and SWPE and SW in all programs report improvement in the attitudes and practices of MoH personnel at health facilities.

Navigation of SW to health facilities by SWPE has established familiarity and working rapport with MoH personnel over time; SWPE indicate that this is the most important reason for shifts in attitudes and behaviour toward SW in MoH facilities.

A more detailed program-by-program review of Effectiveness is presented in Annex VII.

CONNECTEDNESS

EQ7 concerns engagement with **local capacities and resources**

SW peer educators form the essential core of each of the programs reviewed. SW have variable levels of literacy and education, but uniformly high levels of motivation. Some programs provided 1-3 days of initial training on outreach activities, but this did not appear to be consistent within any program: most training was on-the-job by counsellors and/or nurses depending on the program; where COs were part of the team they participated in didactic training, but not in a structured way (Z/M/D). Structured (at least weekly) supervisory contact was offered to SWPE and counsellors, sometimes with an emphasis on debriefing (Tete) and sometimes with an emphasis on didactic learning (Beira). Supervisory contact was less frequent (monthly meeting plus contact during clinics) in Nsanje, as MSF human resources were fewer. Overall, engagement with SW peers corresponds well with international guidelines.

The major institutional partner in each program is the MoH. As described above, SW-MoH interactions have benefitted from Sex Worker-Friendly Training packages, although some sites have only ever had one such training. The programs currently illustrate 2 major modes of interaction with the MoH: Z/M/D and Beira each have a dedicated MSF CO for KP working within a MoH facility, which ensures a minimum quality of care, and typically bypasses the usual queue for outpatient care. In these programs, there appears to be no formal process to enhance the quality of MoH COs to care for KP patients, except for separate SRH services in Beira where there is structural mentorship of MoH midwives by MSF midwives. Programs in Nsanje and Tete provide some decentralized clinical care (FP, STI treatment) but largely rely on referral to MoH outpatient services for most clinical care. There is also no structural process for enhancing MoH capacity to care for KP in these programs.

Other partners substantially enriched the SW and SWPE experience due to their greater recognition of SW beyond the disease-specific (HIV) perspective: Z/M/D had productive interactions with a human rights organization, and progressive violence reduction through sensitization of the police; Tete had productive violence prevention through police sensitization plus legal support for SW; Beira had a formal partnership with a women's rights organization, and with a national LGBTQ organization, and reported reduction in police harassment of SW after a sensitization workshop.

EQ8 concerns **replicability**

Each program has a functional model of SW outreach based on SWPE. There is no likelihood that the MoH can take these services on, or any indication that they aspire to do so (at the time of this evaluation) despite the fact that HIV prevention programs for sex workers have demonstrated cost-effectiveness in a variety of contexts, including various sub-Saharan African countries (Wilson D). **Outreach activities for SW** require NGO or CBO presence to fund and staff these activities. None of the SW populations served by the MSF programs has demonstrated sufficient organizational capacity to operate SW outreach services autonomously, even in Mwanza where the most promising grassroots SW alliance group exists.

Although an NGO superstructure is required to manage SWPE outreach activities, the large number of SW interested in working as SWPE has resulted in the human resources advantage of opportunities to select highly effective, motivated SWPE staff who are paid modest salaries (compared to formally qualified personnel).

There are **other models for SW programs**, in particular Linkages, the Malawi version of the USAID-funded global program for KP. They consider their Malawi program their most successful KP program and, crucially, the National AIDS Commission of Malawi considers this a strong model for KP services in Malawi. Linkages is based on several years of experience in KP programming, is also based heavily on engagement of SWPE for outreach activities, and has a well-defined supervisory cascade that fosters high coverage (although retention is likely overestimated). This model relies on MoH clinical services in existing facilities, although the possibility of (other) NGO provision of some decentralized clinical services is not excluded. Local variations like this are possible. (We did not evaluate this program, but our impression is that it is effective).

Replicability requires a **consistent definition of the SWPE** core knowledge and 'scope of practice'. It is natural that more experienced, better organized and more adaptive SWPE may be interested in and capable of upgrading their knowledge and skills (seen most clearly in Beira); this too should be standardized so that program managers know what can be expected of an SWPE and what standard her performance should be judged against. The SWPE whom we met appeared to have good understanding of their roles at all sites, although the initial preparation and ongoing training and education appear inconsistent from program to program. There are recurrent areas of difficulty in the practice of the SWPE: the most important of which is how to understand and teach about sexual violence, an area undoubtedly made more difficult by the almost certainty that every SWPE has her own history of traumatic experience related to violence - sexual and/or gender-based. There is difficulty surrounding the implementation PEP, partly due to an insufficiently clear policy within MSF. These issues will be further discussed later in the report.

The **education and training of PE** needs to be both didactic (information and knowledge-based) on one hand, and practical and field-based on the other. The programs all adhere in some manner to didactic learning, but there is inconsistency in the mentorship provided during the course of the work day, during outreach activities such as health education sessions, and during home visits. Periodic assessment forms (for SWPE and counsellors) exist but emphasize health education topics, and the ability to interact sensitively with SW. Although this information is vital (although we could not assess how effectively they were used for feedback), they do not include mental health screening or support, or recognizing symptoms and signs of serious medical illness indicating the need for prompt clinical assessment. SWPE are not clinically qualified, so they need to be trained on basic skills in recognizing ill persons (knowledge & skills), and there needs to be systematic supervision and debriefing about who has been seen (supervision & mentorship). We were not charged with the evaluation of SWPE, but these comments are based on direct observation in the field.

EQ9 concerns **sustainability**

Sustainability can only be discussed sensibly by relating a program, with particular characteristics, to its context – since there will be variables external to the MSF program per se that will influence sustainability.

It is evident that **USAID (and other external) funding** plays a crucial role in supporting the HIV-related programs of the MoH in both Malawi and Mozambique, manifested as direct funding for HIV-related medicines, technical assistance and funding of USAID-implementing organizations (such as FHI360). According to UNAIDS, Malawi relies on external funding for 97% of HIV prevention activities and 98% of HIV treatment activities; the figures for Mozambique are 94% and 98%, respectively.[1] Since budgetary constraints still limit the options for enhancement of KP-specific services, any reduction in USAID funding would be disastrous, since the viability of the KP-focussed programs relies on the viability of the general HIV programs.

The **MoH in Malawi and Mozambique** have both created and disseminated guidelines for health services for KP, thus recognizing the distinctive needs of KP. Neither has any intention of providing outreach services (with the exception of

[1] http://hivfinancial.unaids.org/hivfinancialdashboards.html

Nsanje) beyond condom supplies (although these are unlikely to meet SW demand in Malawi; in Mozambique supply may be adequate but distribution can be problematic). Neither has any plan to dedicate specific providers to routinely provide KP services in health facilities; some generalist providers have had training on the KP guidelines but they see KP patients interspersed with the general population. Dedicated KP clinicians are provided by MSF and allowed to use MoH outpatient workspace because they also see general ART clinic patients, thus providing the MoH with an extra free CO. Without NGO involvement, this is not sustainable in its current form. It may not be necessary to provide a CO for KP clinics: all COs that we interviewed remarked that the majority of SW visits concerned relatively straightforward SRH issues, or ART. An appropriately-trained nurse could deal with the most common of these needs, including ART and VIA, referring to a CO or MD if he/she encountered a SW patient with a problem outside his/her competencies.

One serious concern about current arrangements wherein an MSF CO has been added as the KP clinician is that knowledge and skills are not transferred, so there is no preparation for a **post-MSF KP program** – there is even a vacuum effect, as the other clinicians see fewer KP and gain less of their own experience. This is undoubtedly unsustainable.

Programs that send SW to **attend existing MoH services** (Tete most prominently, and Nsanje) both provide limited decentralized clinical services. But for the full range of SRH needs, some or all ART needs, any non-SRH medical problem, and any child health issues, the SW is required to attend MoH (or sometimes CHAM, in Malawi) health facilities. SWPE navigation is used effectively in conjunction with many, but not all, SW visits to HF. The program in Nsanje does have the participation of MoH staff (nurse, HIV diagnostic assistant) in decentralized clinics, and the Tete program previously had some MoH clinical staff involved in such clinics (but this was not part of the model of care during our program review). As they do not rely on HF-based clinical staff, these programs are potentially easier to sustain, and certainly correspond more with other NGO programs serving KP - none of which provide extra clinicians in HF.

A program-by-program review of Connectedness is provided in Annex VII.

SUMMARY OF KEY FINDINGS

- Sex worker perspectives (particularly CSW) have been well-considered in the design and continuing operation of all programs; there has been less input from TSW, and youth have not been particularly engaged in program design or implementation. MSM program development has not fully considered the range of subgroups of MSM, each with unique identities and needs.

- The models of care all work well for CSW, whereas TSW often require more discretion and privacy and may reject the label of 'sex worker'. MSM are also very sensitive to stigma and being 'outed', as such KP-focused programs or services at health facilities may be too risky for them.

- There are no program streams aimed at youth that are fully congruent with the UN Convention on the Rights of the Child (Annex X), although a Concept Note on sex work-involved youth in the Malawi programs outlines a thoughtful premise for development of youth-oriented services. Youth-focused programming aimed at the general population should also care for sexually exploited youth (<18) as this can lessen stigma and potentially increase access.

- There is insufficient recognition of SWs as mothers; SW programs do not acknowledge motherhood or provide services for the children of SWs.

- There is no comprehensive advocacy strategy to prevent, mitigate, or respond to sexual violence, and there is insufficient training and capacity to offer psychological support to victims of violence.

- Recruitment of SWs is similar in all programs; the volume of recruitment depends mainly on the number of SWPE in the program, and facilitation by peer navigators liaising with them. Age distributions show that Malawian sex workers are younger in Malawi than in Mozambique; Mozambican SWs are the youngest in Mozambique; Zimbabwean SWs are the oldest, Malawians intermediate between these.

- Retention is influenced primarily by the high mobility of the population, but women <24 in Malawi are less likely to be seen more than once, regardless of HIV test results. In Tete, Mozambique, women of all ethnicities are more likely to be seen more than once if they are given a new HIV+ diagnosis on enrolment. In Tete, Zimbabwean SWs were more likely than other nationalities to remain in care.

- Overall, about half of SW encountered are seen more than once, so the first (often only) visit is a very important opportunity to inform the SW of her status, and to advise on next steps (even if she follows up elsewhere).

- HIV testing of recruited SW is effective and should continue to be a priority at the time of enrolment. Re-testing is reasonably complete using a 6-month standard for re-testing, but does not meet Q3M re-testing goals.

- HIV incidence is extremely high among SW – at 25-35 times the average HIV incidence rates in Mozambique and Malawi: this indicates that condom-based prevention is inadequate HIV prevention for SW, and demonstrates the urgent need for more effective prevention such as PrEP.

- ART is generally well-applied to the HIV+ population retained in care; all HIV+ women should be informed of the options for obtaining ART over the short and long term, and assisted with whatever documentation they need to facilitate this (language appropriate to the MoH concerned).

- PEP policy and hence PEP implementation is insufficient to yield appropriate levels of use. It is already clear that the solution is PrEP; but in the absence of its availability, and the adherence issues posed by oral PrEP, the PEP SOP is unclear.

- Contraceptive coverage is <50% in all programs, sometimes much lower, but we have little basis to understand current unmet contraceptive needs.

- Violence prevention has resulted from sensitization workshops with the police – the prime perpetrators of SGBV against SW. Even a single intervention improved the situation, although it did not eliminate the problem.

- Structural violence manifesting in exclusion or abuse from health care personnel has been effectively reduced through a combination of Sex Worker-Friendly Training, and building rapport over time through the mediation of SWPE accompanying SW to health facilities.

- NGO or CBO programs are essential to support SWPE outreach activities.

- Clinical service provision by NGO-funded staff in health facilities will not be sustainable with MoH resources alone and will not transfer knowledge and skills to MoH providers if not enabled to do so by structural changes; nor will it be sustainable until NGO presence is designed to be a transitional phase only, not a permanent program feature.

- Malawi has a well-developed KP program (Linkages) operating in 3 large population centres and 6 districts, which offers a viable alternative, supported by NAC and the MoH in its current form.

- SWPE, counsellors and other program staff need standardized training and continuing development of knowledge and skills, including on-the-job direct mentorship.

- Programs for SW have difficulties with SGBV, partly related to (i) variations in conceptual understanding of SV and rights, (ii) variable understanding the social construction of SGBV, (iii) the absence of a programmatic approach to trauma among SW and SWPE, and (iv) the normalization of SGBV in both countries.

CONCLUSIONS

1. **All programs have engaged respectfully and effectively with KP members** both as program personnel and as beneficiaries. In every program, KP members have gained capacities, respect from others, and self-respect, in the processes of outreach and health care. In every program KP personnel and beneficiaries have collectively had their lives enhanced by the support that MSF has given, and by their often-voiced perception that MSF values them as persons. These facts underlie the enormous potential for improvements that we discuss in this evaluation.

2. **SWs are at continual risk of harm**, including HIV-related harms[2], physical and psychological trauma and death due to sexual and gender-based violence – it is the core vulnerability that must be addressed. Response to violence is impaired by lack of recognition (normalization), lack of comprehensive strategy to address it, and lack of capacity to provide psycho-social support.
    a. Actions by SWs, SWPEs and civil society actors (NGOs, CBOs) can alter the risk of violence through interventions with the police, and likely with other actors (e.g. bar or lodge owners) and this should be systematic and regular.
    b. Attitude change among health care personnel can be improved through the combination of sensitization workshops (Sex Worker-Friendly Training) and rapport-building over time though collegial interactions between SWPEs, SW patients and health care personnel.
    c. Progress by MSF on the critical enablers of SW well-being – those being laws & policies (including decriminalization), reducing stigma & discrimination, community empowerment, and preventing violence (see WHO 2016 guidelines) – has been limited by the absence of a comprehensive national, regional and local strategy for advocacy on those issues.

3. **Existing youth programming is modelled on adult programs for CSWs but needs to acknowledge sexual exploitation**; SRH services for sexually exploited youth should be provided within general youth programs, not CSW programs. This requires much more substantial integration with existing youth services.

4. **SWPEs have variable knowledge and skills and need a standardized pre-employment training curriculum**, mentorship plan and continuing education and training plan; this should include additional specialized training for specific subgroups (of SW or MSM); training must include trauma- and violence-informed counselling and care (and psychosocial staff care for SWPEs).

5. **Programs are well-adapted to CSW but have more limited appeal to more stigmatized groups** including many TSW, MSM, and trans women, so enrolment of these KP is likely suboptimal. More general approaches (e.g. presenting services as 'women's SRH' or 'men's health') offer more appealing, less stigmatizing modes of contact. Effective engagement with each KP subgroup will be optimized when SWPE /MSMPE profiles mirror the variety of SW /MSM subgroups in the community; this also includes issues basic issues like language and age range.

6. **HIV incidence among SW is extremely high, indicating that condom-based HIV prevention is inadequate in these contexts**. PrEP has been available to only a small fraction of potentially interested KP members and should be provided (as recommended in WHO guidelines) to all interested, at risk persons (the majority of SW and MSM) as it is preferable to continuous or frequently repeated PEP; long-acting injectable PrEP would be better still but needs advocacy, piloting, and evaluation - all of which MSF could do. Where PrEP is not available, PEP should be offered whenever HIV exposure is judged to have occurred without regard to circumstance (it is ethically unacceptable to withhold effective HIV prevention when risk has been determined because of disapproval over the circumstances).

[2] A study of intimate partner violence (IPV) among HIV-infected sex workers in Zambia found that participants who reported IPV has significantly reduced odds of engagement in HIV care (aOR 0.48) and of ART initiation (aOR 0.40) (Oldenburg CT et al).

IMPLICATIONS FOR THE MODEL OF CARE

The conclusions above (and recommendations below) already refer to elements of the model of care, but there are other points which either recognize good practices that are already in place or indicate other features which should be included. The following is a list of the essential features of the optimal model of care, with reasoning and/or supporting evidence provided where necessary (see also Annex IX, where points relevant to MOC are highlighted in relation to the WHO-recommended Package of Care):

- Outreach activities are designed and implemented so as to prioritize peer engagement, with emphasis on representing the TSW, MSM, and trans women subgroups. The number of peers engaged in program activity will govern enrolment and the capacity for navigation.
- Gatekeepers – such as bar owners – are engaged and encouraged to cooperate within the model of care.
    - A recent systematic review of social network and HIV risk behaviours in female sex workers affirmed that gatekeepers as well as peers have a key role in social networks of SW and can influence HIV risk behaviours and condom use (Shushtari ZJ et al).
- Peer involvement is provided via NGO/CBO programs focused on KP (MoH provision of non-clinical outreach services is untenable); appropriate funding mechanisms are supported and secured.
- SWPE are supported with standardized initial and continuing training, mentorship, and psychological support; trauma-informed counselling services are included therein.
- Violence is addressed using a comprehensive and multi-sectoral approach to prevention, early intervention, and treatment.
- Health care personnel are systematically sensitized to address stigma, discrimination, and mistreatment in health care settings.
- Services to sex-work involved youth (<18 years) are provided primarily within general youth health programs, supported by collaboration with existing youth service providers. These services focus on the psychosocial development of SW-involved youth (this being an essential distinction from adult-oriented SW programs).
    - FGD by MSF Malawi suggest that psychosocial support is important for youth, and services for those involved in sex work should be given within general youth services. There is evidence to support these assertions: a needs assessment in Zimbabwe looked at young women who sell sex in 6 cities; they were a heterogeneous group that did not work with or attend the same services as adult sex workers (Chiyaka T et al).
- Priority is given to HIV status determination at first contact, with a clear message about where and how to obtain ART.
    - Venue based (hotspot) outreach delivered HIV education- such as are already provided by MSF programs- increased the odds of having had HIV testing within the last 6 months among FSW, MSM, and transgender women in Malawi and Angola (Herce ME et al).
- Frequent re-testing (every 3 months) is strongly encouraged and adequately provisioned for.
    - Re-testing provides an opportunity for early diagnosis and treatment of HIV, and for discussion of other health issues.
    - More frequent re-testing will be required for PrEP follow-up as its availability expands.
- ART provision or facilitation is prioritized for HIV+ SW and MSM; ideally, SWPE should offer navigation to all.
    - ART intervention is crucial for SW health, PMTCT, and reduction of HIV transmission.
- Contraceptive interventions and FP are provided on the basis of intensive needs assessments.
    - Contraceptive needs currently exceed coverage, but a comprehensive effort to determine needs and to commence FP could address this issue.
    - The majority of SW across all programs chose long-acting methods (Depo-Provera or implants).

- A recent interventional study conducted in Durban, Tete and Mombasa tested a combination of vertical, targeted SRH interventions for FSW, with improved access to general health services. In Tete and Mombasa, the very substantial increases in service uptake were almost entirely due to a greater uptake of targeted services – such as MSF is providing now (Lafort Y et al).

- Pathways to health care for the children of SW — developed with their particular needs in mind – are clearly signposted and maintained as a priority.
  - The children of SW have specific health needs, and are particularly vulnerable to sexual exploitation – which must be prevented.
  - This issue was highlighted in a field note published in AIDS (Sept 2018) where vertical HIV transmission risk was also noted (Ficht, AL et al).

- Tension between the development of KP-specific clinical services (including outreach clinical services) and the adoption of a similar model or care by the relevant MoH is (ideally) well resolved.
  - Outreach or KP-dedicated *clinical services* are undoubtedly more appealing to SW and MSM, particularly those who are more visibly identified as KP group members: firstly, *they* reduce barriers to access; additionally, their quality of service (specificity of care, attitudes of care providers) is invariably better.
  - The MoH of Malawi and Mozambique demonstrate little interest to systematically provide and resource decentralized or facility-based KP-specific *clinical services* (such as MSF is providing in all the programs evaluated, albeit in a variety of ways as described in Annex V).
  - There are 2 strategies that could help resolve this tension: (1) involve the MoH directly in providing KP-specific services, at least in health facilities, but ideally also in some outreach clinical activities, and/or (2) identify NGO partners – which will already be essential for peer-led non-clinical outreach services – where it may be possible to build capacity for clinical outreach services, or at least to enhance the quality of lay (including peer) providers in preparing and guiding KP members (patients) towards suitable clinical services (likely health facility-based).

- Formal health care services are provided at existing MoH health facilities, or in decentralized locations involving MoH personnel (appropriately-trained nurses). Quality of care is enhanced with structural mentorship (by NGO health care personnel) and by navigation of patients by SWPE to MoH-provided services when appropriate.

- Structural mentorship is provided by MSF staff to MoH health service workers with/alongside whom they work. This structural mentorship is to be understood by all parties as a temporary and transitional arrangement, involving a gradual shift in responsibility building up to MSF's eventual exit, which is foreseen from initiation by all parties involved in the collaboration.

- Program evolutions in Malawi are substantially modeled on the LINKAGES Malawi program, which is accepted by the NAC as the national reference standard for SW programs in that country, and which already covers a substantially greater SW population that MSF programs.
  - This is not to say that LINKAGES is comprehensively superior to the MSF KP service model, but it is likely more sustainable since it does not employ parallel clinical service providers, and MSF has already decided to terminate its KP programs in Malawi in 2019.

RECOMMENDATIONS

⇒ Recommendation 1: Define a comprehensive strategy, including advocacy, to tackle the prevention, early intervention against, and treatment of violence against sex workers, including individual, community, health sector, and other structural interventions, including decriminalization of sex work.

⇒ Recommendation 2: Define a comprehensive strategy to meet the needs of young people engaged in sex work. This strategy must adhere to the UN Convention on the Rights of the Child and identify the under 18-youth exchanging sexual services for money or other resources as sexually exploited youth.

⇒ Recommendation 3: Standardize the SWPE orientation, education and training (including updating) particularly on the topics of SGBV, health promotion, SRH and HIV treatment access. Define the scope of practice and enhance the role of SWPE in liaison with MoH staff.

⇒ Recommendation 4: Develop a more comprehensive model of care to address the needs of diverse sub-groups of MSM and of TSW, and engage representatives from these sub-groups during this development process.

⇒ Recommendation 5: Advocate, pilot and evaluate to maximize the availability of oral PrEP (in accordance with WHO guidelines) and of new injectable, and/or other long-acting forms of PrEP. In the absence of PrEP, maximize the correct application of PEP.

ADDITIONAL SUGGESTIONS: IMPLEMENTATION OF THE RECOMMENDATIONS

1. **Define a comprehensive strategy, including advocacy, to tackle the prevention, early intervention against, and treatment of violence against sex workers, including individual, community, health sector, and other structural interventions, including decriminalization of sex work.**
    a. Coaching on individual strategies to reduce risk of violence.
        i. All sex work venues involve alcohol for clients, but it is also frequently consumed by SW. A study of FSW in Tanzania found that frequent intoxication during sex work was associated with increased odds of GBV, and reduced odds of consistent condom use with clients (Leddy AM et al).
        ii. For programmatic inferences, see also "Ecologies of security: On the everyday security tactics of female sex workers in Nairobi, Kenya" (Lorway R et al).
    b. Group strategies to intervene in situations of escalating risk or violence.
    c. Sex Worker-Friendly Training for health care workers (MoH, NGO), bar & lodge owners, and community leaders (ideally, responsibility will be shared by multiple stakeholders – this should be considered an essential program element where SW are involved, rather than something optional, and its essential nature should be acknowledged with sufficient funding).
    d. Sex worker-friendly sensitization workshops with police departments; establishment of standing liaison mechanism for problem resolution.
    e. Advocacy for SW rights; legal support for victims of harassment or violence.
    f. Participation on national (and regional) working groups and advocacy platforms, including those relating to decriminalization of SW and MSM.
    g. Trauma-informed mental health services, including staff mental health care for SWPE.** This needs more expert input, but will encompass training on avoidance of re-traumatization by care givers, and social support that builds on any grassroots efforts, and creates safe spaces (e.g. non-workplace) for gathering. This recommendation is supported by the following:
        i. A survey among female SW in Soweto, South Africa, found that 69% had symptoms of severe depression and 40% had PTSD (33% had comorbid PTSD and depression) (Coetzee et al).
        ii. In contrast, a survey of SW in Lilongwe, Malawi, found the prevalence of depression was 8% (although 49% were experiencing mild depression); prevalence of PTSD was 8% (MacLean SA et al).
        iii. These studies of incidence/prevalence must be interpreted cautiously in light of growing evidence that violence and trauma frequency, severity, and length of time over life span have been shown to correlate significantly with depression and PTSD; women experiencing more frequent and severe violence over longer periods of time show much more severe health problems, including PTSD, than those with experiences of lesser severity and of shorter duration (Davies L et al. 2015).

h. Develop a framework for monitoring and evaluation of the recommendations 1a – 1g. Take cues from the WHO guidelines for KP (2016), particularly Section 5 (pages 84-105) on Critical Enablers, where law and policy, stigma and discrimination, community empowerment, and violence are all considered. The enabling steps recommended here form the basis for the qualitative indicators a program should use in monitoring progress on the implementation of a comprehensive approach.[3,4]

2. **Define a comprehensive strategy to meet the needs of young people engaged in sex work. This strategy must adhere to the UN Convention on the Rights of the Child and identify the under 18-youth exchanging sexual services for money or other resources as sexually exploited youth** (see Annex X for details on the Convention).
   a. Clarify existing national policies and strategies concerning sexual exploitation.
   b. Undertake a regional assessment of existing youth services and develop effective strategies to liaise with these services.
   c. Develop youth-friendly services with the involvement of youth, including safe spaces that youth can attend.[5]
   d. Expand youth-peer cadre to support recruitment of peers.
   e. Provide training to MSF staff on youth development and the effects of sexual exploitation on development, health behaviours and health outcomes.
   f. Incorporate crisis management into existing youth-specific services.
   g. Tailor education materials that are age-appropriate and youth-friendly.

3. **Standardize the SWPE orientation, education and training (including updating) particularly on the topics of SGBV, health promotion, SRH and HIV treatment access. Define the scope of practice and enhance the role of SWPE in liaison with MoH staff.**
   a. Define the basic knowledge and skills that all SWPE must have.
   b. Train SWPE on the contents of the 'package of care' to bolster their ability to act as health advocates when navigating an SW to health services.
   c. Provide training on SGBV that includes a comprehensive definition of trauma, which recognizes trauma as the experience and response to overwhelmingly negative events or series of events, including interpersonal violence.
   d. Provide psychological support for SWPE and systematic debriefing opportunities.

4. **Develop a more comprehensive model of care to address the needs of diverse sub-groups of MSM and of TSW, and engage representatives from these sub-groups during this development process.**
   a. Recognize differences in identity, behaviour, and needs among subgroups of MSM, particularly trans women versus cis men, sex work-involved versus not sex-work involved, out versus not out (regarding sexual or gender identity, and/or involvement in sex work).
   b. Adapt service design to meet the needs for privacy, and avoid stigma, among transactional sex workers who cannot disclose to family or community, or who do not see themselves as sex workers (incorporate peer input from each subgroup regarding approaches such as e.g. home visits, or men's or women's health clinics that are not overtly for SW or MSM).
   c. Translate the gender and sexual subcultural differences into different program approaches, considering the role of social media tools, and closer cooperation with existing groups to bolster sustainability (and clarify MSF's stance on conditions for grants to national NGO- or CBO-collaborators).
   d. Adapt services to adopt a sex-positive versus sex work-friendly specific approach. Sex positive approaches recognize and affirm that sexuality is an important part of life. Sex positive approaches are concerned with promoting positive experiences for people, rather than solely working to prevent negative experiences. Sex-positive approaches also acknowledge and tackle the various concerns and risks associated with sexuality without reinforcing fear, shame, or taboo of people's sexuality and gender inequality.
   e. Provide sex positive training for all MSF staff involved in KP programs and services tailored to individual staff needs (e.g. clinician and peer staff should have sex positive approaches to discussing sex, taking sexual

[3] The recommendation to support SW community empowerment was highlighted in a major review on developing and delivering HIV programs for SW (Wilson D).

[4] Also of interest, a study from Tanzania examining organically formed savings groups among female SW found that savings groups promoted individual agency to reduce sexual risk behaviours and fostered community empowerment among FSW (Mantsios A et al).

[5] This is consistent with a recommendation from the evaluation of the South African national sex worker program: "As a high priority, provide training and/or mentorship for under-18 sex workers on HIV, gender, sexuality, life skills and rights. This should be provided in a separate setting, style and with different emphasis from older participants." (Sex Worker Education & Advocacy Taskforce).

health histories; drivers and administrative staff should have sex positive approaches to be gender and sexuality-affirming as opposed to discriminatory or fearful).

f. Recognize that sex work involvement and other behaviours are not uniform among sex workers. Sex workers' agency is a process situated within historical, structural and social contexts. Their capacities to engage in specific actions (e.g. condom use, adherence to ARVs) are therefore dependent on specific and variable contexts that can serve to constrain or support their options.

5. **Advocate, pilot and evaluate to maximize the availability of oral PrEP (in accordance with WHO guidelines) and of new injectable, and/or other long-acting forms of PrEP. In the absence of PrEP, maximize the correct application of PEP.**
    a. Liaise nationally with MoH and implementing partners to meet conditions for implementation of PrEP as program or operations research.
    b. Engage with relevant MSF bodies (e.g. MSF Access Campaign) to advocate for early access to injectable PrEP.
    c. If PrEP is not available and continuous PEP is being offered, consideration could be given to 2-agent PEP (e.g. Tenofovir-Emtricitabine) as it will be more easily tolerated, and less costly. While internationally, including WHO, all major PEP guidelines have moved to 3-agent regimens, in the past 2-agent regimens were an option. Admittedly, a 2-agent regimen may select for HIV drug resistance mutations if a person takes it while already HIV-infected (and this is even more likely if there is transmitted HIV drug resistance in the population – a concern we have in Mozambique particularly). The likelihood of that scenario could be reduced by obliging patients to have frequent HIV re-testing (at least monthly) as a condition for renewal of their PEP prescription.

ADDITIONAL RECOMMENDATIONS

The following recommendations concern aspects of project implementation; they are complementary to the 5 main recommendations made in the preceding section.

6. **When working to develop a new model of care for adoption by the Ministry to Health, ensure that MSF staff provide structural mentorship to MoH health service workers with/alongside whom they work.** This structural mentorship is to be understood by all parties as a temporary and transitional arrangement, involving a gradual shift in responsibility building up to MSF's eventual exit, which is foreseen from initiation by all parties involved in the collaboration.
    a. Negotiate the shared objectives for the collaboration, including the time frame.
    b. Identify the contributions of each party (human and material resources).
    c. Clarify the specific mode(s) of cooperation in patient care.
    d. Agree on the metrics for (i) quality of care, and (ii) maturation of the collaboration towards completion.

7. **Reconsider program monitoring and evaluation in light of some recurrent theoretical and practical issues.**
    a. We cannot attribute epidemiological change solely to an MSF intervention: MSF programs for SW are very unlikely to be the only service providers for many beneficiaries, due in part to mobility, to the scope and availability of MSF services, to stigma and confidentiality concerns, among others.
    b. Quantifiable indicators are only well chosen — and will only yield meaningful information — when contextualized within a nuanced understanding gleaned through qualitative assessment of the complexity of individual, social and structural factors influencing behaviour. Sexual behaviour, sex work, and HIV are all tremendously influenced by a myriad of intimate psychological and cultural issues that defy complete quantification.
    c. There are important differences between indicators for program management, and indicators that describe the epidemiological or health service situation, particularly when point (a) applies. The former are usually process indicators that monitor services provided (e.g. HIV testing, ART initiation). The latter describe a health status (e.g. HIV prevalence) or health event (e.g. HIV incidence).

ANNEXES

ANNEX I: TERMS OF REFERENCE

MEDICAL HUMANITARIAN CONTEXT

Mozambique is one of the worst HIV/AIDS affected countries in Southern Africa. It has an estimated HIV prevalence of 11.5%, with higher rates in urban centres, southern provinces and among women. In Tete province the prevalence is estimated to be 5,2% overall[6] but in Tete City, near to the coal mining area and a major hub along the eastern transport corridor it is 19% (INSIDA, 2010). In Malawi, the national HIV prevalence for sex workers aged 15-49 years is estimated at 71% (Chizimba and Malera, 2011).

Mining, trade and mobility provides work opportunity for a large population of resident and migrant sex workers. They are at far higher risk of HIV than the general population due to the nature of their work, stigma and discrimination, and the difficulties they experience in negotiating safe sex (Shannon et al., 2014).

In this area many SW are migrant, often coming illegally from Zimbabwe and other neighbouring countries, further increasing their risks and complicating access to prevention and care services (Incerti, 2013).

In January 2014 Médecins Sans Frontières opened the 'Corridor Project' aiming to improve access to HIV/STI diagnosis, prevention, and treatment among this key mobile population and to map mobility and continuity of care along the transport corridor.

The project has six main sites, each covering populations of between 300-1000 sex workers in urban and semi-rural environments in Malawi and Mozambique. In Mozambique, **Beira port** and **Tete** are on the transport corridor highway towards Blantyre. Malawi includes three small sites along a 200km stretch from Blantyre to the border: **Zalewa**, **Mwanza** on the border, **Dedza** on the way to Lilongwe and **Nsanje** towards the south from Blantyre. The site in Nsanje district (in southern Malawi) is not on the corridor but is included within the frame of the evaluation as it responds to similar population needs and with similar approaches. Each project is a sub-component of a larger HIV/TB program with specific teams of between 10 – 40 staff (expatriate, national and peer workers).

It is likely that most of these project sites will be handed over in the coming 1-2 years.

REASON FOR EVALUATION / RATIONALE

This project is an opportunity for institutional learning on how MSF can work with Sex Workers and MSM. At the same time, the end of project cycle (partly in 2018 and partly in 2019), is an adequate time to reflect on the achievements; on project areas which may require programmatic amendments and on main lines of its handover process.

A regional workshop with the respective Health Authorities is foreseen in early 2018 and it is expected that this evaluation will provide us with an appreciation of current models of care as developed during the course of this project and recommendations to go forward that can be shared during the workshop.

OVERALL OBJECTIVE and PURPOSE

The evaluation aims to assess and compare each of the projects in terms of their effectiveness in achieving their objectives, the appropriateness of their adopted strategies, and their prospective continuity of care provided. It is requested that each project is initially evaluated individually, in preparation for the comparative analysis. Specifically:

1. To describe, assess and compare the effectiveness and appropriateness of the different models of care MSF developed in the different sites (for SWs, their clients and MSM), providing recommendations to improve the existing project and identifying the lessons learnt for future similar projects.[7]

[6] INSIDA 2015.

[7] Specific attention to be given to the peer-led approaches; outreach versus facility-based support; dynamics between peers, non-peer MSF staff, and beneficiaries; advocacy and activism; research; and routine elements including PREP, PEP and SRH, mobility and monitoring (of HIV-negative and positive SW and in both outreach and facility sites).

2. To inform the wider debate on how to optimally approach the different groups of people engaged in risky sexual behaviours (CSW, transactional sex, MSM...) in the Southern African region within a specific setting and between different settings/countries.

3. Finally, provide an early assessment of the prospective sustainability of the care provided by MSF, to inform and guide the gradual handover planning to MoH and/ or other partners.

EVALUATION QUESTIONS

NOTE: The following evaluation criteria/questions are proposed, however it will be necessary for the evaluation team to develop these according to the inception phase, keeping in mind the above objective(s):

APPROPRIATENESS:

- *Is the intervention appropriate according to the perception of the target population?*
- *Is the strategy appropriate in order to achieve the objectives?*
- *Appreciate the differences between the strategies for each setting. Analyse the underlying assumptions which lead to these differences and provide recommendations for the future.*

EFFECTIVENESS:

- *To what extent are the agreed objectives being achieved?*
- *What were reasons for achievement or non-achievement of objectives?*
- *What can be done to make the intervention more effective?*

CONNECTEDNESS:

- *What local capacities and resources have been identified? How does the project currently connect with these?*
- *How sustainable & replicable are the results of MSF work? Currently, what is the overall likelihood of continuity of the care / the proposed model of care provided by MSF after its planned departure? What measures are necessary to maximise this likelihood?*

EXPECTED RESULTS

- Written report (20-30 pages) as per SEU standard responding to this ToR with specific attention to:
    - SWOT analysis of different approaches,
    - Key conclusions to inform the debate on optimal strategies/approaches for engaging with these group (to be discussed at regional workshop)
    - Concise and practical recommendations[8] to:
        - Improve the overall effectiveness of the existing projects
        - Maximise the likelihood for an eventual sustainable handover of care
    - Lessons Learned for comparable interventions
- Written report short version (snapshot) for dissemination
- Presentation to MSF field team and HQ team
- Presentation to beneficiaries and/or other stakeholders including MoH

TOOLS AND METHODOLOGY PROPOSED

- Review and analysis of project documents including outputs from routine monitoring and specific research
- Interviews/Focus Group Discussion with MSF key-team members at HQ and field levels
- Interviews/Focus Group Discussion with key stakeholders including authorities, academic partners, local & international partner NGOs, etc.
- Interviews/Focus Group Discussion with patients/former patients

[8] Maximum of 5 key recommendations to be routinely followed up.

- Observation of activities in the field
- Comparison with existing literature/similar projects in other contexts

RECOMMENDED DOCUMENTATION

- Mozambique and Malawi project documents
- Quarterly reports
- Quantitative and qualitative research reports and publications
- Latest national policies of each country
- Strategic documents of other partners
- Monitoring and evaluating tools
- Forms and files
- HP tools and education material.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	1 or 2
Timing of the evaluation	September-November 2017
Required amount of time (Days);	
• For preparation (Days)	4
• For field visits (Days)	25
• For additional/follow-up interviews (Days)	2
• For data analysis (Days)	3
• For writing up report (Days)	5
• For presentation of results (Days)	1
Total time required (Days)	40

Notes:

- Movement between project sites may require from 3 to 7 hours by car. In order to ensure an effective use of time, a detailed and coordinated planning for the field visit should be agreed in advance.
- Translator may be needed in Mozambique, and facilitated by MSF

PROFILE /REQUIREMENTS: EVALUATOR(S)

- Social Science and/or Medical and/or Epidemiology background
- Experience in working and evaluating projects with KPs (MSM & Sex Workers)
- Experience in HIV/AIDS programming and evaluation (evaluating MSF projects as asset)
- Demonstrable evaluation competency
- Language requirements: English (Fluent), Portuguese or Spanish will be an asset

ANNEX II: LIST OF INTERVIEWEES

Table 4. People interviewed during the Preliminary Phase

Name	Project Position/Role
Kristel Eerdekens	Deputy Operations Coordinator Cell 5
Mira Jimenez	Medical Officer Cell 5
Tom Ellman	Director SAMU
Gilles van Cutsem	HIV TB Advisor SAMU
Lucy O'Connell	Key Populations Focal Point SAMU
Ilse Casteels	Malawi HoM
Reinaldo Ortuno	Malawi MedCo
Altynay Shigayeva	Malawi Epidemiologist/M&E Malawi (former)
Julia Jung	Malawi Corridor Project Coordinator
Patrick Mangochi	Malawi Dep MedCo
Caroline Rose	Mozambique HoM
Gianluca Ferrario	Mozambique Medco (former)
Ruggero Giuliani	Mozambique MedCo (former)
Anna Torrens	Mozambique Epidemiologist M&E
Ivan Pulido Tarkino	Operational Research Coordinator
Francesca Zuccaro	Corridor Project Field Coordinator (former)
Amaury Gregoire	HoM (former)
Mei Wenzhang	Epidemiologist; data cleaner
Daniel Remartinez	Mozambique MedCo (former)

Table 5. People interviewed during the Evidence Collection Phase

Name	Project Position/Role	Location
MALAWI		
MSF Mission Coordination, Malawi		
Ilse Casteels	Malawi HoM	Blantyre
Reinaldo Ortuno	Malawi MedCo	Blantyre
Patrick Mangochi	Malawi Deputy Medco	Blantyre
Ester Orban	Malawi KP EPI (current)	Blantyre
Julia Jung	Malawi Corridor FCo	Blantyre
Brian	Malawi Health Policy Advisor	Lilongwe
MSF Corridor Project, Malawi		
Agnes	Patient Support Officer (PSO)	Zalewa
Cecilia	Community Health Worker (CHW)/Peer Educator (PE)	Zalewa
Mfane	CHW/PE	Zalewa
George	Clinical Officer (CO)	Zalewa
FSW group (10)	SW program beneficiaries	Zalewa
Bertha	Patient Support Officer (PSO)	Mwanza
Vellece	Patient Support Officer (PSO)	Mwanza
Jamilla	CHW/PE	Mwanza
Hanna	CHW/PE	Mwanza
Agnes	CHWPE	Mwanza
Prince	Clinical Officer (CO)	Mwanza
FSW groups	SW program beneficiaries	Mwanza
Joan	Patient Support Officer (PSO)	Dedza*
Alice	CHW/PE	Dedza*
Ndaziona	CHW/PE	Dedza*
Phavarious	Clinical Officer (CO)	Dedza*

Chrissie	Nurse, Team Leader	Nsanje
Patrick	Counsellor/ Educator	Nsanje
Marta	CHW/PE	Nsanje
Amina	CHW/PE	Nsanje
Ivy	CHW/PE	Nsanje
Joyce	CHW/PE (there were 7 SWPE in total)	Nsanje
FSW group	SW program beneficiaries	Nsanje
Others (MoH, NGOs, professional associations, donors), Malawi		
Raphael Pirningu	MoH DHO Mwanza (former)	Blantyre
Shawn Aldridge	National Aids Commission (NAC)	Lilongwe
Melchiade Ruberintwari	LINKAGES/ FHI 360	Lilongwe (Skype)
Noah Johnson	PEPFAR Coordinator	Lilongwe
Nicole Buono	CDC	Lilongwe
Libby Brennan	USAID HIV/AIDS Deputy Team Leader	Lilongwe
Leo Dymon	Evangelical Lutheran Development Service (ELDS)	Mwanza
MOZAMBIQUE		
MSF Mission Coordination, Mozambique		
Caroline Rose	Mozambique HoM	Maputo
Joana Borges	Mozambique Advocacy	Maputo
Ana Torrens	Mozambique Epidemiologist	Maputo
Jessie Kurnurkar	Tete Field Coordinator	Tete
Nadia Duarte Marini	Tete Patient Support	Tete
Liina Haldna	Tete Project Epi	Tete (Skype)
Gabriele	Beira field coordinator	Beira
Kathleen Leroy	Beira PCS (former)	DRC (Skype)
Maura	Beira PCS	Beira
Lena	Beira Midwife	Beira
Augusto	Beira MD/ Advocacy	Beira
Alessandra	Beira HR	Beira
Cindy Zahnd	Beira Project Epi	Beira
MOH Authorities and Staff, Mozambique		
Dra Noella	MOH - HIV prevention director (prev. KP respons.)	Maputo
Dra Jessica	MOH - KP Responsible	Maputo
Dr Alex Bertil	Public Health Dept., Sofala Province (DPS)	Tete
Dra Natalia	Director, Munhava Health Centre	Beira
Dr Sahal	Medical Quality Assurance, Munhava HC	Beira
Dra Graciana	Public Health Director, Sofala Province (DPS)	Beira
Dra Cesaria	District Clinical Services Director	Beira
MSF Corridor Project & Staff, Mozambique		
Evelize	Nurse Supervisor Tete	Tete
Stella	Tete Patient Support Supervisor (PSS)	Tete
Humberto Jassitine	Advocacy Tete	Tete
Candida	Counsellor Tete	Tete
Francisca	Counsellor Tete	Tete
Arminda	Counsellor Tete	Tete
Marta	CHW/PE	Tete
Didja	CHW/PE	Tete
Celsa	CHW/PE	Tete
FSW groups	SW program beneficiaries	Tete
Nordino Mulieca	Data Manager Beira	Beira
Jose Beirao	Operational Research Coordinator	Beira
Sebastiana	Beira Patient Support Supervisor (PSS)	Beira
Farisai Gamariel	Beira Patient Support Officer (PSO)/ OR Assistant	Beira

Jianne	Counsellor Beira	Beira
Carlistos	Counsellor Beira	Beira
Teodora	Community Educator/PE	Beira
Marialita	CHW/PE	Beira
Laura	Community Educator/PE	Beira
FSW informal discussions	SW program beneficiaries	Beira
Matunha	Counsellor	Beira
Bertrao	Counsellor	Beira
Neilinho	Community Educator/PE	Beira
Constantino	Community Educator/PE	Beira
Manuel	Community Educator/PE	Beira
Felipe	CHW/PE	Beira
Tinasha	CHW/PE based at Munhava HC	Beira
MSM SW (4)	MSM program beneficiaries	Beira
Others (NGOs, professional associations, donors), Mozambique		
Júlio Calengo	LIGA	Tete
Dr Alex Lucas	ICRH	Tete
Dr Bila [check]	FHI 360	Tete
Mateus Manuel	Kupulumussana (HIV-focused CBO)	Tete
Eunice Samuel	Muleide officer	Beira
Rosita (Mickey) Beola	Prov. Dir. LAMBDA (LGBTQ association)	Beira
Roberto Paulo	HIV focal person – LAMBDA national office	Maputo
Frederic Rocuts	FHI 360	Maputo
Jacqueline	USAID PEPFAR Dir	Maputo
N Gaspar	USAID-PEPFAR Prevention TA	Maputo
P Simbine	USAID PEPFAR KP TA	Maputo
Carla Matos	GFATM	Maputo

** Dedza program personnel were interviewed in Mwanza.*

Brackets in the left margin indicate people interviewed together as a group.

This list does not include conversations with beneficiaries taking place during site visits to observe outreach activities or clinical care – these took place for all programs except Dedza.

ANNEX III: INFORMATION SOURCES

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Table 7. Itinerary of evaluators, 16 May 2018 – 16 June 2018

Key

KII = Key Informant Interviews FGD = focus group discussion

SV = Site Visit B = beneficiaries

Date	Location	Activity	KI Organization
16 May	Vancouver-Amsterdam	Transit	-
17 May	Amsterdam-Nairobi	Transit	-
18 May	Nairobi-Blantyre	KII	MoH Mwanza (ex)
19 May	Blantyre	Unscheduled	
20 May	Blantyre	KII	MSF
21 May	Blantyre	KII	MSF
22 May	Blantyre-Zalewa-Mwanza	Transit (2); KII; SV; FGD	MSF Zalewa, B
23 May	Mwanza	KII; SV; FGD	MSF Mwanza, ELDS, B
24 May	Mwanza-Dedza	KII; FGD; transit	MSF Mwanza & Dedza
25 May	Dedza-Lilongwe	Transit; KII	MSF, NAC, USAID
26 May	Lilongwe-Blantyre	Transit	-
27 May	Blantyre	Unscheduled	-
28 May	Blantyre-Nsanje	Transit; KII/FGD	MSF
29 May	Nsanje	KII, SV	MSF, B
30 May	Nsanje-Blantyre	KII, SV; transit	MSF, B
31 May	Blantyre-Tete	KII; debrief; transit	Linkages/FHI360, MSF
1 June	Tete	KII; SV; FGD	MSF, B
2 June	Tete	SV/FGD	B
3 June	Tete	Unscheduled	-
4 June	Tete	KII; FGD; SV	Kupulumussana, B, MSF
5 June	Tete	KII; SV	DPS, ICRH, FHI360, Liga, MSF
6 June	Tete-Beira	Transit	-
7 June	Beira	KII, SV, FGD	MSF, DPS Munhava HC, B
8 June	Beira	KII, SV, FGD	MSF, Muleide, Lambda, B
9 June	Beira	Unscheduled	-
10 June	Beira	Unscheduled	-
11 June	Beira	KII, SV, FGD	MSF, B
12 June	Beira-JNB-Maputo	KI interviews; transit	DPS Beira
13 June	Maputo	KI interviews	MSF, DPS, FHI360
14 June	Maputo	KI interviews	PEPFAR, GFATM, Lambda, MSF
15 June	Maputo-Nairobi	Debrief; transit	MSF
16 June	Nairobi-Paris-Vancouver	Transit	-

ANNEX IV: DETAILED EVALUATION MATRIX

Evaluation Question	Judgement Criteria	Indicators	Data Sources
APPROPRIATENESS			
EQ1. Is the intervention appropriate according to the perception of the target population?	What information was gathered from intended beneficiaries regarding their perceived needs and preferences for HIV-related (and SRH) services?	Consultation with KP peers, peer involvement in project design and peer in service provision, patient centred care models	Review of exploratory reports, historical documentation regarding project set up; interviews with field and coordination staff involved in design and set up
	What information on user perceptions was gathered during the course of service provision since project inception?	Peer-initiated adaptations in service scope, location, hours; structural involvement of peers and structured opportunities for feedback	Discussions with KP peer educators, counsellors, KP beneficiaries & project personnel, coordinators
EQ2. Is the strategy appropriate in order to achieve the objectives?	How do the sites of service provision (accessibility, visibility, privacy, safety) influence recruitment of key group members into care and treatment?	Direct (attendance) and indirect (verbal endorsements) of acceptability of service sites	Enrolment and retention data; interviews with KP group members
	What if any burdens for target population in attending these services were identified? And how were these addressed? [This may include support around legal issues, involvement of community health workers with shared life experiences, the use of outreach as a strategy to build trust and foster engagement]	Presence of non-standard modes of care provision: extended hours, mobile or workplace services, outreach and/or door-to-door services; support for referral Visible KP peers involved in service provision Advocacy to improve legal protections, support after SGBV	Interviews with MSF advocacy personnel to explore activities associated with protections for KP (e.g. guideline and policy development and implementation) Review of documents and/or reports on models of care and referral services Observations and interviews with peers (as described above) Interviews with non-MSF funders and/or implementation partners concerned with KP services (if possible)
	How does the style and quality of service (including characteristics and behaviours of service providers) influence acceptability of services and retention in care?	Enrolment & retention in care figures according to model of care, and care provider(s); for HIV negative and HIV positive KP group members	Program enrolment & retention figures by site; data on linkage to outside (MoH) services, RIC at MoH-provided services (pending data availability)
	Who are the service providers?	Role of peers in service provision;	KP group members, PE, SW, MSM

Evaluation Question	Judgement Criteria	Indicators	Data Sources
	How engaged are peers? What preparation and training do service providers undergo to engage with the target population (e.g. training in trauma informed care, cultural sensitivity)?	interaction with other cadres of providers Preparatory process for PE and counsellor, patient supporter Peer retention figures Continuing professional development opportunities and attendance figures Roles of non-peer service providers, KP-specific training including that related to stigma & discrimination	Project personnel responsible for recruitment, training, mentorship, supervision Non-peer service providers (NGO and MoH) Training documents Interviews with SWEAT trainers Job descriptions for Peer Educators, Counsellors Professional development protocols/guidelines (if available)
	Is engagement with the target population culturally appropriate for the diverse settings and sub-groups within the target population? Is it non-discriminatory and welcoming with regard to ethnic or religious subgroups, MSM, trans people or other sub-groups? Is the intervention tailored to the uniqueness of the local context of each setting?	Availability of services that are respectful of persons from sexual and/or gender minorities; what is the approach to stigma and discrimination re: KP? Attention to privacy & confidentiality around health information and around sexual behaviour and/or involvement in SW	Interviews with beneficiaries, KP group members, care providers (peer and non-peer) Clinical practice guidelines and/or protocols concerning patient confidentiality/privacy Resource materials and/or training for staff on the provision of non-judgmental care Observations of clinical service sites to assess how welcoming the environments are
EQ3. Appreciate the differences between strategies for each setting. Analyse the underlying assumptions which lead to these differences and provide recommendations for the future.	What do site-to-site variations in recruitment and retention suggest about the importance of locations, style, range and quality of services provided? Are there particular aspects that are associated with significantly better (or poorer) program performance?	Enrolment volume and retention by site and model of care, including package of care offered, and provider characteristics Consider both HIV+ and HIV-	Program quarterly and other existing reports, plus some specific data extraction (by project epidemiologists) from existing databases Reports on models of care, site visits and discussion with project personnel on evolution to current model of care
	What languages are services provided in?	Availability of services in	Site visits, interviews with project personnel

Evaluation Question	Judgement Criteria	Indicators	Data Sources
	▯ Are these appropriate to the population in each setting? ▯ When necessary, are translation services provided?	languages spoken by KP being served	
	Are there site-to-site variations in services that attend to the diversity of factors associated with infection susceptibility among the various sub-groups within the target population (e.g. sexually transmitted infections, reproductive health, and violence prevention/intervention)? ▯ How do variations in support services relate to program performance? 1. What gaps are there in the support services? 2. What individual (e.g. provider performance) and organizational (e.g. program protocols and policies, capacity to offer diverse services) factors contribute to gaps in services? 3. How do these gaps affect attrition in attendance for care?	Availability of STI screening or diagnostics, and treatment; evidence of effectiveness of STI treatment Availability of pregnancy testing, a variety of FP methods (appropriate to client preferences) Support for victims of SGBV: emotional support, medical care including STI treatment, contraception, PEP; support with police/ legal issues Accessibility (spatial, temporal) of each of these services	Project reports Site visits, interviews with peer staff and with KP group members
EFFECTIVENESS			
EQ4. To what extent have the defined objectives been achieved?	How well are key group members retained in care over time? ▯ Is there as specific pattern to attrition within and across sites (e.g. frequency of visits; beneficiary characteristics; pattern in clinical services offered/provided)? ▯ What accounts for attrition? [What can be learned from people who have left the program?]; what accounts for retention?	Retention/attrition data, in relation to beneficiary and health service characteristics, including model of care	Retention in care (including on ART for HIV+, and followed & re-tested for HIV-) stratified by age, nationality, HIV status, site of service, semester/year of program Interviews with beneficiaries who have left the program (if feasible)

Evaluation Question	Judgement Criteria	Indicators	Data Sources
	What are the proportions of key group beneficiaries who: □ Know their HIV status (known HIV-positive or, if HIV-negative, tested within the past 3 months)? □ Have initiated ART (and what proportion is retained on ART over time)? □ Have HIV viral load <1000 copies/ml (over time)?	Project indicators for HIV status knowledge (>95%) Re-test data (proportion, inter-test interval) Proportion new HIV+ initiating ART Proportion previous HIV+ on ART Proportion on ART 6 months or more with VL <1000	Project reports + selected additional data extraction from existing databases
	What has been the uptake of PEP and of PREP analysed by service site & type, demographic characteristics, co-morbidities, etc., and what has been the measured effectiveness of each?	Criteria and SOP for offer of PEP/ PrEP Adherence to SOP/offer for each; acceptance rates for each; adherence to PEP or PrEP	Preliminary PrEP Research data Program data on PEP use Discussions with KP, peers re: acceptability, concerns with each
	What is the incidence of unintended pregnancies among women enrolled in the program?	FP provision coverage, acceptability and TOP request	Project reports, KP interviews
	Have sex workers' capacities for violence prevention been enhanced?	Condom negotiation with clients Payment receipt and negotiation for sexual services Police reported violence figures (if available) (*Note: this does not infer that sex workers are responsible for preventing violence but that their capacities to advocate for their safety are enhanced through skills in safely negotiating services, condoms use and payment with clients*)	Health promotion tools and resources used by peer educators Observations with peer educators and counsellors engaging with sex workers to build capacity for negotiating with clients Key informant interviews with peer educators and counsellors and sex workers
EQ5. What were reasons for	What are the proportional contributions of	Cascade of care by model of care, and	Project reports, databases

Evaluation Question	Judgement Criteria	Indicators	Data Sources
achievement or non-achievement of objectives?	recruitment, retention and quality of treatment (as reflected in coverage of testing, treatment and treatment effectiveness, among others)?	beneficiary/patient characteristics Estimates of HIV incidence where data permits	
EQ6. What can be done to make the project more effective?	a. Optimizing recruitment (enrolment) in the program implies a focus on acceptability and accessibility b. Accessibility and acceptability also implies a focus on the feasibility of the program for the target population: what can be done to reduce the burden on beneficiaries to attend to care? c. Retention is likely to depend more on service quality, therapeutic relationships and addressing co-existing issues that may compromise treatment effectiveness	Identify variables (patient, service) associated with above or below average enrolment Investigate the association between retention in care and KP member characteristics Define what is typically accomplished with a one-time contact, and with a 2-visit contact history – consider	Project reports; site visits, observation of details of models of care Characterize patient groups with reference to HIV prevalence (and incidence if available) among non-KP members in same region Discuss with beneficiaries and peers how mobility influences retention in care Explore how stigma & discrimination affect access to care, continuity of care
CONNECTEDNESS			
EQ7. What local capacities and resources have been identified? How does the project currently connect with these?	a. How does the project (MSF) liaise with the Ministry of Health and other formal and informal, not-for-profit and for-profit providers to facilitate access to services not provided directly? b. How does the project specifically build upon local capacities to provide non-judgemental, low threshold services to people engaged in illegal activities and experience substantial stigma? ▯ How engaged are experiential people (e.g. sex workers, MSM) in program development and implementation? ▯ How does project design accord with existing international consensus	Systematic and structural training and mentorship have taken place Local staff, particularly peer KP group members function in roles that include service design and implementation decision making Action taken to enhance the capacity of MoH providers – including re: non-discrimination with regard to KP members …and of other NGO providers	Recruitment and training information in project descriptions and reports Discussions and interviews with KP peers and project personnel

Evaluation Question	Judgement Criteria	Indicators	Data Sources
	guidelines on successful engagement with this key population?	Contact and collaboration with local, national and international organizations of KP members	
EQ8. What activities/processes are necessary for transferring the project to other geographical and functional areas? [Replicability]	How might local NGO and/or key group member peer organizations involve themselves in a sustainable model of care? □ What are the ongoing educational requirements to support the capacities of staff and peers in providing these services?	Definition of model of care, minimum package, peer-led project development available Training package for staff and peers related to KP – including attitudinal considerations (stigma, discrimination) Presence of funders with interest in services for KP	Project reports, comparative analysis of effectiveness per site and model of care Peer interviews re training and support needs
EQ9. Will the project be sustainable? [Continuity]	How informed is the Ministry of Health regarding the aims and accomplishments of the project? □ What would be the budgetary and staffing implications should the MoH consider providing these services?	Define MoH capacities and aspirations with regard to KP services Define services that should be NGO provided and identify HR needs and training needs for a minimum package of KP care Look for potential NGO/CBO partners for ongoing KP service provision	Discussion with project personnel, site visits, discussions with KP group members, other NGOs and service organizations, and MoH

ANNEX V: PROGRAM SERVICE DESCRIPTIONS

Annex V (1): Site reviews of Zalewa, Mwanza, Dedza

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
COMMUNITY-BASED SERVICES		
Daytime outreach services 5 weekdays per week on a recurrent schedule to cover key hotspots • Health education, including SGBV • Condom education/ distribution • STI symptom screen • PEP starter pack [Z, M] • Emergency contraception, STI prophylaxis MSF Counsellor (only) provides: • HTC, initial and repeat Q3M • VDRL/Syphilis rapid test • HBV sAg • Pregnancy test • EAC There was a range in the number of hotspots visited by outreach teams within each program (e.g. Dedza: 46 hotspots; visited 3-4 per day)	Hotspot leader: focal SW for each hotspot (unpaid) liaises with MSF team MSF-employed SWPE: • 2 Zalewa, • 4 Mwanza • 2 Dedza MSF Counsellors • 1 Zalewa • 2 Mwanza • 1 Dedza Drivers • 1 Zalewa • 1 Mwanza, also used private rental • 0 Dedza; private rental	SWPE are called CHW in these programs Health education is conducted for small groups, and on 1:1 basis (more suitable for TSW) Outreach includes specific follow-up of women needing repeat HIV testing, or VL In [M] (only) SW Alliance (54 members including 2 MSF SWPE; not a formalized group) working together to provide peer support, limited social support to other SW
Evening outreach & mobile testing in SW hotspots	No longer offered	Previously offered [M] but appeared to decrease health-seeking behaviour and attendance at SW Clinic, therefore discontinued
Daytime mobile clinic events	Not available	No decentralized clinical services offered
MSF Office	Health services not provided Data officer (1 shared) Logistic Support officer (1) [M]	No perceived need for this as SW have dedicated CO at HF
Community-health facility linkage	Peer Educator navigation: MSF SWPE accompanies SW to hospital or HC Referral note	SWPE also accompanies after SGBV

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
HEALTH FACILITY SERVICES		
MSF 1-Stop SW Clinics • Zalewa HC • Mwanza DH • Dedza DH 5 weekdays per week • HTC • VL (same day: GeneXpert) • STI treatment, syphilis treatment • FP • PPT of STI • PEP initiation or continuation • ART initiation/ continuation • HBV immunization • Cervical cancer screening*	MSF CO working in: • ART clinic room (Mwanza, Dedza) • HC consultation room (Zalewa) GeneXpert for HIV VL (technology & reagents provided by MSF) *VIA for cervical cancer screening requires certification; patients are referred to a certified MoH provider if the MSF CO is not certified	SW patients have relative priority to see MSF CO, but CO also sees other patients (ART clinic patients [M, D]; general outpatients [Z]) MSF CO [Z] sees average 12 SW/day (range 6-20); Medical Assistant at [Z] OPD sees ~200 patients/day Overall, Sex Worker-Friendly Training improved attitudes, service quality, acceptance by frontline staff for SW at MoH HF (all sites) but SW still face critical attitudes, e.g. refusal if PEP requested more than once [M]; a Concept Note and FGDs reflect preparation for youth-focussed services
Approach to SGBV • MSF CO provides medical support • Legal support and training on risk reduction from CHREAA • Victim Support Unit (Police Station) • In [D] only, Police held workshop with 40 SW to hear their experiences • SW Alliance has provided workshops on SW rights [M]	• MSF SWPE ad hoc • MSF CO ad hoc • MSF Counsellor trained on 'case management' for SGBV (but not psychosocial care) CHREAA trained SW in [M] only to take pre-payment for services as a strategy to decrease risk of violence; minimal anti-violence training elsewhere	Overall, harassment by police has decreased but is still a problem [M][Z]; specific intervention only in [D] with some perceived benefit (reduction); no documented measures of police violence Some magistrates compound abuse of SW by declaring their work illegal (it is not criminal in Malawi); difficulty in progressing to criminal charges against perpetrator due to stigma and discrimination MSF counsellors express need for more SGBV-related training; [Z] needs specific training in what constitutes SGBM suggest working with bar/lodge/rest house owners to prevent/ respond to SGBV
Approach to MSM	No program activity	

Annex V (2): Site Review of Nsanje

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
COMMUNITY-BASED SERVICES		
Daytime outreach services 5 weekdays per week • Health education • Condom education/ distribution • FU HTC and VL reminders & mobilization for clinics • ART adherence counseling (but not EAC) • PEP starter pack • Referrals STI treatment, TB screening	Peer mobilizers (unpaid volunteers), rotate monthly in each area; work with SWPE SWPE (CHW) each work in their home area	SWPE are known as CHW in this program, since this is less stigmatizing 125 hotspots throughout the district No community-level HTC outside of periodic clinic sessions (as detailed below)
Evening outreach & mobile testing in SW hotspots [currently suspended]	Team as noted below	These were effective with 50-60 SW visits per session (6-9 PM); had to be suspended because of community panic over 'blood suckers' myth
Daytime periodic clinic events Aiming to provide low barrier contact with TSW and CSW A. <u>Outreach SW Clinics</u> (Trinity, Marka, Bangula*) Monthly • Health Education • STI symptom screen & Rx • HTC, initial and repeat Q3M • PEP • VDRL • HBV sAg; immunization (sAg neg) • VL specimen collection • Periodic presumptive treatment of STI • Condom education/distribution • ART initiation and FU* • Referred to MoH for cervical cancer screening B. <u>Static SW Clinics</u> (Nsanje District Hospital, Ndamera HC) Twice monthly, monthly, respectively • Services as above, except • Referred to MoH for ART, VL, cervical cancer screening C. <u>Adolescent girls/ young women's clinics</u> (Nsanje DH, Bangula,Trinity) Monthly • Accept ages 12-20 involved in transactional or commercial sex (exploited youth and young SW) • HTC, HIV prevention, FP	• MSF SWPE - 7 • MSF Counsellor - 1 • MSF Nurse - 1 • MoH Nurse (ART provider) - 1 • MoH HIV Diagnostic Assistant** MSF provides ARV buffer stock **H.D.A. funded by *Partners in Hope* (part of a District-wide program)	*At Bangula, ART is provided via SWPE navigation to Kalemba Community Hospital ART clinic ~50 SW visits per outreach clinic ~35 SW visits per static clinic PrEP is not available SW Community ART Group (CAG) pilot: 4 groups constituted Jan-Jul 2017; District ART Coordinator wants evaluation prior to further expansion Seasonal clinics are offered on an *ad hoc* basis if there is an influx of workers related to fishing, a harvest, or other economic activity creating a market for more sex work Engagement with TSW higher in some locations; barriers to TSW engagement is being 'outed' as doing sex work; TSW do not self-identify as CSW Sexually exploited youth and young SW are often missed in services; work with young girls to help recruit other girls
MSF Office	Not provided	

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
Community-health facility linkage	SWPE accompanies SW to HF for ART, STI treatment, PEP, after SGBV Referral note	SWPE sometimes make home visits to house-bound SW, escort to HF if necessary
HEALTH FACILITY SERVICES		
Nsanje District Hospital (MOH), Kalemba Community Hospital (CHAM), Ndamera HC, Bangula HC, Trinity Hospital (CHAM) (OPDs, ART clinics) 5 weekdays per week • HTC • VL • STI treatment, syphilis treatment • PPT of STI • PEP • Cervical cancer screening (VIA)	MSF supports ARV buffers stock, but no fixed HR in MoH health facilities	Only 1 Sex Worker-Friendly Training in 2016 (repeat planned for 2017 was postponed); some improvement in MoH personnel attitudes after 2016 training Obstacles to cervical cancer screening include: • Lack of transport to HF • Lack of sterile instruments or medical materials for VIA
Approach to SGBV • SW education on SGBV • MoH 1-Stop SV Clinic at Nsanje DH • Victim Support Unit at Police Station	SGBV education to SW by MSF team MoH CO at 1-Stop SV clinic often absent VSU staffed daytime Monday-Friday	SGBV is poorly understood; infrequently requested topic for health education No Police sensitization training; VSU staff are unlikely to implicate police colleagues Often harass SW with 'Rogue and vagabond' law (even though this has been successfully challenged in court)
Approach to MSM	No program activity	

Annex V (3): Site review of Tete

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
COMMUNITY-BASED SERVICES		
Daytime outreach services Door to Door visits FU plus new contacts in same compound 5 weekdays per week • Health education: SRH, SGBV • HTC, initial and repeat Q3M • Condom education/ distribution • STI symptom screen • TB symptom screen • PEP starter pack • PrEP continuation (study cohort only)	Peer Mobilizers in each neighbourhood identify newly arrived SW: • 10-15 PM (MSF incentive) • 5 SWPE (MSF employed) for Tete & Moatize	SWPE with counsellor sees 15-18 SW per day; typically sees 9-10 new SW per week; only 1 Mozambican SWPE Team aims for weekly visit to each hotspot
Night outreach & mobile testing in SW hotspots	Not offered	Previously offered; discontinued since no advantage noted

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
Daytime mobile clinic events Weekly in each neighbourhood All services as above, plus: • Pregnancy test • VDRL • HBV sAg; immunization (sAg neg) Providing MSF Nurse is present: • VL & CD4 count • STI treatment • Periodic presumptive treatment of STI • Referral for ToP	Large mobile van, 2 private consultation spaces & 1 lab consultation space MSF nurse, counsellor, SWPE, lab technologist, (+ driver) GeneXpert (HIV VL) technology Pima (CD4 count) technology	Mobile clinic and team make weekly rounds to regular locations for SW residing and/or working in each hotspot Mobile Clinic volume: 50-60 SW visits (summer) to 20-30 SW visits (winter)
MSF Office • Clinic for SW • PrEP follow-up only	• MSF Nurse • Consultation room • MSF counsellor • 1 SWPE	Referral to MoH for ToP Counsellor & SWPE also do community follow-up for PrEP
Community-health facility linkage	Peer Educator navigation: MSF Peer Navigator from neighbourhood accompanies SW to HC Referral note for HC clinician	
HEALTH FACILITY SERVICES		
MoH HC OPD, ART clinic 5 weekdays per week • VL • STI treatment, syphilis treatment • PEP • ToP • FP • STI treatment • Cervical cancer screening	No MSF human resources MSF trained health personnel MSF supports buffer stocks of ARVs & other medications, some medical materials	
Approach to SGBV • SW education on rights (including printed materials) • Sensitization workshop for Police • Individualized case support • MOU with LIGA not renewed as LIGA interest in taking cases to court; not active in sex worker training	MoH has Centre for Violence Against Women (CAI), but focus is domestic violence rather than SV MSF conducted SGBV training Created set of (4) forms for documentation, medical care, advocacy MSF has collaboration with the *Mozambican Bar Association* for individual SV case support	Police awareness & conduct much improved after intervention; SW awareness of rights has increased over time Printed materials on SV also available for SW in Tete High level advocacy supported by wife of Governor of Tete Province Challenge remains in that before women can proceed with a full criminal complaint against an offender (i.e. police officer) they receive an offer of payment (in exchange for dropping charges) which they

PROGRAM COMPONENT	RESOURCES	OBSERVATIONS / NOTES
		accept as a survival mechanism because of the severe poverty

Annex V (4): Site review of Beira

PROGRAM COMPONENT	RESOURCES	COMMENTS
COMMUNITY-BASED SERVICES		
Daytime outreach services Home FU visits 5 weekdays per week • Health education • Condom education/ distribution • STI symptom screen • PEP • PrEP (study cohort only) • HTC, initial and repeat Q3M • VDRL • HBV sAg; immunization (sAg neg) • VL specimen collection • Periodic presumptive treatment of STI (when N present)	2 SW teams, 1 MSM team; each: • Supervisor/Team Leader • Peer educator • Community educator (peer) • Counsellor • Nurse or Midwife (planned) • Vehicles (1 per team) • Bicycles (for CE) • (PE + CE + counsellors = 20 in 2016; = 25 in 2017)	No specific youth outreach but youth are not excluded; educational content includes sex worker rights 2 groups (of ~15) 'catorzinhas' (young adolescent girls) have been followed; working on strategies to increase catorzinhas engagement
Night outreach & mobile testing in SW hotspots Open to general population but aiming to contact cis- and trans-female CSW and MSM including MSM CSW 1 evening each week (Friday) • Recruitment & enrolment • Condom education/distribution • Health Education • HTC & other services as above also available	HR as above Multi-person vehicle with consultation space	Services will expand with the presence of a Nurse (planned)
Daytime mobile clinic events Open to general population but aiming to provide low barrier contact with TSW and MSM Currently 4 events per month • Recruitment & enrolment • HTC • Health Education • Condom education/distribution	HR as above Multi-person vehicles for transport of team, materials Tents & canopies	Approximately 25% of beneficiaries are KP members; events attract youth Clinical services (treatments or prescriptions) not provided in current format

PROGRAM COMPONENT	RESOURCES	COMMENTS
MSF Office Clinic for SW or MSM • PrEP follow-up • Other services as above • ToP	MSF CO MSF MW	Monday – Friday (hours not specified)
Community-health facility linkage	Peer Educator navigation: MSF SW Peer Navigator (1) at HC MSM Peer Navigator (1) at HC Referral note	
HEALTH FACILITY SERVICES		
Munhava HC OPD, ART Clinic 5 weekdays per week • HTC • VL • STI treatment, syphilis treatment • PPT of STI • PEP • HCV testing	MSF SW Peer Navigator (1) at registration MSF CO (1) for KP MSF support for physical improvements of MHC; buffer stocks of medicines, medical materials	CO sees average ~8 KP patients/day, plus ~25 general population ART clinic patients
Munhava HC SRH Clinic (general population & KP) 5 weekdays per week • Enhanced service quality • FP • STI treatment • Cervical cancer screening • Breast exam • ToP	MSF midwives (2) + MoH midwives (2) MSF provided 'Exploring Values & Attitudes' (EVA) training to all MSF and some MoH staff	Midwives see KP and non-KP patients/clients per day. Peer navigator can help navigate women to receiving ToP services and other reproductive health services
Approach to SGBV • SW education on rights (including printed materials) • Sensitization workshop for Police • Individualized case support • *Muleide* also supports women with alternate income generation	Formal collaboration with *Muleide* (Women's Rights Organization): Advocate (1) seconded to MSF	Police awareness & conduct much improved after intervention; collaboration with MSF was problematic initially as MSF wanted women as witnesses to sexual violence; SW awareness of rights has increased over time
Approach to MSM • Collaboration on health education, HIV prevention, access to HIV treatment	Informal collaboration with *Lambda* (Mozambican association to promote human rights for LGBT persons)	Lambda risks losing any USAID-associated funding if it formally collaborates with an organization offering or facilitating ToP; MSM encompasses both men who have sex with men and people who self-identify as transgender, although the needs and risks may be different

ANNEX VI: DETAILED PROGRAM-BY-PROGRAM REVIEW OF APPROPRIATENESS

The following is a detailed, program-specific assessment of the evaluation criterion Appropriateness. Each of the core evaluation questions is addressed. Definitions of cultural appropriateness/safety and trauma- and violence-informed care are provided throughout the Zalewa, Mwanza and Dedza discussion. These definitions formed the basis for the evaluation of these elements in each model of care.

1. Zalewa, Mwanza, Dedza

Needs of the KP and KP input into models of care: The intervention was based on needs assessments in each site that entailed focus group discussions with KP, mapping exercises, and existing data on HIV-related health needs in particular. During field visits, beneficiaries express uniformly positive opinions of the range of services (community-based, SWPE delivered), mode of delivery (locations, timing, frequency, promptness) and respectfulness they are afforded.

The outreach teams (SWPE and Counsellors) are in constant interaction with beneficiaries and continue to engage with them about whether the services are meeting their needs, including identification of new hotspots, being open and receptive to meeting beneficiaries at acceptable locations, and addressing new issues that arise, including SGBV.

Appropriateness of strategies for recruitment and engagement in care: Recruitment takes place at KP residences/homes, communities and their places of work (which may also be their home). The recruitment strategies maximize the likelihood of enrolment. Mobilization by SWPE is an essential component. Additional steps have been taken to ensure privacy for particularly sensitive groups such as women on ART, young women <18, some TSW who fear disclosure of their involvement in sex work to friends, family and other community members ('being outed'). For example, discussions about HIV status, testing and ART happen most often during private, one-on-one counselling sessions with the counsellor, taking place regularly after a health education session by the SWPE. Regarding young women engaged in sex work, a well-referenced Concept Note lays out the relevant issues with reference to the Convention on the Rights of the Child; focus group discussions have taken place to understand the experiences of young women involved in sex work, their perceptions of STI/HIV/pregnancy risk and prevention, and their ideas about learning and health service needs. There are plans for Teen Clubs for young women sex workers.

Burden for beneficiaries: There is some burden for the target population concerning attending the services and there is a gap in the ability to respond to the issues that the beneficiaries are experiencing. The main area of concern is the insufficient legal support, including local case management and higher-level advocacy for violence prevention and intervention. There are oversights in violence intervention and prevention in that the models of care only address the physical consequences of sexual assault (e.g. PEP) while only minimal psychological support is offered. The gaps in psychological support are important as the link between violence and PTSD is well substantiated. Additionally, although there are some activities aimed at addressing violence perpetrated by police, there is a general gap in advocacy to tackle this issue on a larger scale. The evidence demonstrating the correlation between HIV risk and violence against women is extensive, but this correlation is not fully developed within the MSF models of care. The specific burden is that women report wanting psychological and legal support when experiencing physical, sexual, or economic violence, and may engage with MSF in hopes of receiving some support — but this support is not available through the MSF program.

Privacy and confidentiality burden was a non-issue for beneficiaries. KP expressed no concerns about SWPE having intimate knowledge about beneficiaries' health and social concerns. The relationships with SWPE and the accompaniments and supports provided by SWPE were instrumental in reducing burdens for accessibility to MSF services and the intimate knowledge about the KP health and social concerns was seen as important to help the SWPE facilitate counselling interactions. SWPE outreach activities were non-threatening and non-judgemental in that beneficiaries could determine the level of engagement with the program, which in turn fostered their trust in the program and supported attendance to care.

***Style and quality of the models for retention in care*:** Issues of retention in care (RIC) were documented (see Effectiveness discussion). The retention issues, however, were complex. Analysis of enrolment shows high interest in MSF services, whereas low figures for RIC are multifactorial and reflect high mobility (particularly among younger SW), service provision by multiple actors other than MSF, and deliberate obfuscation of identity in order to maintain privacy (due to stigma around sex work and/or HIV).

Service provider capacity: The three sites had similar team composition of CO, SWPE, and Counsellors. Each cadre is discussed individually.

SWPE: Preparation of SWPE was variable in quality for a variety of reasons. There is no standardized/defined curriculum within MSF for this cadre. For example, some had 3-day formal training [D] offered with support of SWEAT, others

learned on the job [Z]; some had prior training on major SRH topics, and a few had prior advocacy training [D, M]. Although everyone understood stigma associated with sex work, there was limited understanding about how to respond and support KP members to build self-confidence and self-esteem and avoid internalizing the stigma experienced. The ability to respond to reduce the likelihood of internalized stigma is essential. Internalized stigma among SW has been shown to detrimentally affect their health behaviours, including unprotected sex, substance use, and increased susceptibility to violence and its deleterious effects (Bungay & Guta, 2018; Ziao & Bungay, 2018; Scambler, 2008). The primary education needs identified in consultation with the SWPE were: (i) SGBV training – what is it and how to respond (i.e. trauma-informed care); (ii) family planning methods. There were variations in what people knew across sites but the SGBV training was identified in all sites. SWPE have minimal turnover as they value their leadership role in the SW community highly, in addition to the salary support (calculated to equate to roughly 3 days of sex work income per week).

Counsellors/Educators: There were diverse titles that have different job descriptions, but overall the counsellors and educators operated in similar ways. This cadre requires formal education in counselling, psychology, or social work and certification in HTC and EAC. All were comfortable within their scope of responsibilities although the ability to take a leadership and mentorship role with the SWPE varied to some extent among the sites contributing to variations in the support received by SWPE from the Counsellors/Educators. This impacted the SWPE capacity to respond to issues of violence and queries by KP about ART access or Family Planning methods.

COs: Each site had a CO within their model of care. The COs either had experience working with KP members prior to joining MSF or had taken sensitivity training to provide non-judgemental health care to beneficiaries. In some sites (e.g. [D]), additional learning opportunities to provide a full range of SRH services such as cervical cancer screening was noted. However, the COs were knowledgeable and able to do referrals to support beneficiaries accessing this service within the MoH.

MoH Personnel: All sites have relationships with MoH staff and COs often work closely with MoH. MoH personnel have, according to SWPE and SW, benefitted from Sex Worker-Friendly Training in that all locations report overall improved quality of care by MoH providers. The effect of this training has not been optimized as it has not been given frequently enough in any of the MSF program locations. Role modelling of non-discriminatory behaviour by MSF staff has reportedly been an even more powerful stimulus to changing attitudes and behaviour among MoH staff.

Dedza offers a one-stop clinic; Zalewa has done so for 1 month, and Mwanza refers for FP and VIA. In each case these are centrally located, fixed sites. Issues of referral are not problematic because of the positive collegial relationships with MoH staff and Sex Worker-Friendly Training. No team members however had any training in trauma and violence informed care. Trauma and violence informed care (TVIC) involves operating from the recognition that people impacted by social inequities, particularly stigma often experience multiple forms of violence; the structural conditions of their lives place them at risk for more interpersonal violence and they experience significant challenges in accessing supports to improve their safety. TVIC approaches are not necessarily trauma therapy but an approach that aims to mitigate the potential harms and traumatizing effects of seeking health care by creating a safe environment (Browne et al. 2015; Forde-Gilboe et al. 2009). TVIC training ensures sensitivity to the effects of violence and teaches providers how to provide care in ways that is not-traumatizing for individuals affected by violence. Violence against sex workers is a pervasive problem and it was obvious in the site visits that physical violence was a frequent occurrence for the beneficiaries. Although services were SW-friendly through cultural appropriateness, the oversight in TVIC training was observed in how providers approached issues of violence and, in some instances, an insensitivity to the triggering nature of questions or probes about beneficiaries' experiences of violence. Additionally, all staff reported an educational need to learn more about SGBV, and this could be inclusive of TVIC approaches to care.

Cultural Appropriateness: The goal of culturally appropriate services is to ensure that all people feel respected and socially and physically safe when they interact with health services and providers, and that the strengths of people's identities and communities are recognized and built upon (Browne et al., 2015). The COs had sensitivity training concerning working with KP members that supported SW-friendly services. SWPE provided ongoing daily understandings to other cadres of service providers concerning norms of behaviour and practice within KP communities that was well received by non-experiential staff. The majority of the SW served in Malawi are from Malawi, and there were shared cultural and spiritual understandings among the service providers and the beneficiaries that facilitated communications in appropriate and respectful ways.

Differences in Strategies for Each Setting: Variations in the model of care are subtle in Mwanza, Dedza and Zalewa, and are highlighted throughout. The assumptions underlying the program at each site, and strategies for recruitment and retention, are virtually identical, as are SW-friendly approaches and the role that each of the cadres play in delivering services to the beneficiaries. The subtle differences involve infrastructure support to perform their work, and non-

standardized preparation for the SWPEs. One issue that influenced how different teams engage with and recruit SW was the use of assigned MSF vehicles. The lack of an assigned transport vehicle and reports of restrictions on how much private transport could be used in Dedza may be contributing to challenges in recruitment of SW if the team is restricted in geographical movement. This issue warrants further exploration and analysis.

2. Nsanje

As noted previously, Nsanje had only recently (within the previous few months) come under the coordination of the Corridor Project, although KP-focused activities have taken place since 2013. Activities are underway to support the integration of this site into the Corridor Project. As the underlying assumptions and SW-friendly approach are similar, this Annex speaks only to the differences between Nsanje and the other Malawi sites. The actual model of service delivery and staff complements are detailed in the Effectives Annex, thus specific elements of appropriateness based on the evaluation criteria, are highlighted here.

Needs of the KP and KP input into models of care: The needs of the SW communities within Nsanje District were well considered in the development of the program. Geographical mapping was undertaken to understand where beneficiaries are working as SWs, as was an assessment of current services in those settings. An assessment was also carried out to understand the seasonal mobility within the district that is associated with agriculture and flooding. The SWPEs work directly within their home communities as the program covers a significant geographical area where road conditions are variable and can be limited by flooding. The SWPE were instrumental in helping to shape the program by teaching the team about the context of commercial sex work in diverse communities. They helped the other cadres to understand that Nsanje has a significant number of TSWs who do not identify as sex workers, but who are engaged in sex work to supplement their income and resources from other small businesses that they run. They were key to informing recruitment strategies to support TSW engagement with the program without being outed.

Appropriateness of strategies for recruitment and engagement in care: SWPE live and work in their home communities. They collaborate with mobilizers to do health promotion to recruit women to attend mobile clinics that rotate through diverse communities. The SWPE provide detailed information to both CSW and TSW and the recruitment is much more discreet than in the other sites. The program is more positioned as a women's wellness program versus KP-specific within communities generally, although the fact that it is KP-friendly is communicated in one-on-one recruitment efforts. The SWPE know who is engaged in SW and can perform this type of targeted recruitment, which is essential to maintain privacy and confidentiality, especially for the TSW. Youth-specific strategies are under development, including a youth clinic. Youth mobilizers are recruited in some communities with helping to recruit and engage young girls in the program. The engagement in services in group education and one-on-one sessions with counsellors is similar, except that there is a nurse to support more comprehensive delivery of services in the outreach clinics (e.g. Family Planning, vaccination, and other general health concerns that beneficiaries may experience).

Burden for beneficiaries: As in other sites, there is some burden for the target population concerning attending the services, and there is a gap in the ability to respond to the issues that the beneficiaries are reporting. Issues raised by beneficiaries that differed from other sites included the need for MSF to also be able to provide children's health care, the infrequency of outreach visits by the nurse, and the significant burden of travel to attend to the MoH facilities (e.g. 10 km walk). The distance to a MoH clinic and the need for children's health care compounded one another. SGBV, while identified as a significant issue by the MSF staff, was *not* raised among the beneficiaries, even with probing. MSF local staff reported that violence against women is normalized and education and advocacy for women was needed.

Privacy and confidentiality burden was an important issue for some beneficiaries, especially TSWs. The positioning of the program as women's health helped to address these concerns.

Style and quality of the models for retention in care: Issues of retention in care (RIC) were documented (see Effectiveness discussion) and are similar to the other Malawi sites. Retention was more problematic in some instances because of the vast geographical area MSF was covering and MSF's inability to get to a site frequently enough. Frequency of MSF service availability was further influenced by the terrain, flooding, and the distance for the most northern areas. The MSF staff were however very creative in using time and travel effectively and worked diligently to provide consistent service to as many areas as possible.

Service provider capacity: Unlike the other Malawi sites, Nsanje did not have a CO but does have a nurse midwife (usually 2). The other providers were counsellors and SWPE and their roles were consistent with the other Malawi sites.

SWPE: Similar education needs to the other sites were identified and there was again a range in preparation. The SWPE were the largest complement for Malawi with a staff of 7, a fact associated with the geography covered in Nsanje. The

SWPE received an orientation and provided health promotion sessions and materials regularly (e.g. condoms, PEP) in their communities. They worked out of their own homes and were essential for mobilization when the nurse and counsellor were coming to run a clinic. The difference for this team is that they often worked separately from other SWPE although they did come together to meet monthly and strategize to optimize their work in their home communities.

Counsellors/Educators: This role is new in Nsanje and is not well developed to maximize use of the training. To help address issues of role clarity and to maximize the effectiveness of this role, the counsellor was scheduled to spend time with the team in Mwanza to learn more about the role of the counsellor in this model of care.

COs: No CO at this site.

Nurse midwife: The nurse was very well-versed in all aspects of SRH and primary care. Their role was quite comprehensive and ranged from treating stomach ailments to working with MoH to dispense ART, STI syndromic management, and family planning. There was also a level of statistical proficiency in trying to determine the population characteristics for beneficiaries attending care, as well as documenting falsely elevated LTFU (observed when beneficiaries shift to attending MoH facilities independently).

MoH Personnel: One MoH nurse accompanies the MSF nurse when doing an outreach clinic and is responsible for dispensing medications. MoH personnel were SW-friendly, but many had not received Sex Worker-Friendly Training. The MoH nurse attending during the site visit was new and was received on-the-job training and mentorship from the MSF nurse. This is a common occurrence, although there is little guidance documentation for providing such an orientation. This lack of standardization or documentation may eventually contribute to inconsistencies in how MSF and MoH nurses work together.

Cultural Appropriateness: The MSF staff are primarily staff from the Nsanje district, which has distinct norms around sex work that are perhaps more discriminatory than other Malawi site locations. Also, as noted previously, there is a substantial element of TSW in this district. While TSW is evident in all sites, there is a notable presence of this in Nsanje. The issues of providing support to TSW where they feel safe to share information about their sexual practices and partners so that health education and care can occur were particularly evident. The SWPE, counsellor, and nurse midwife demonstrated significant understanding of the sensitivity of the issues for TSW and were able to provide care in physically and emotionally safe spaces (i.e. they did not use language of transactional sex work when talking with beneficiaries, but instead focused on safer sex practices, family planning, etc. as important parts of health and well-being). The ability to avoid terms that women would see as disparaging to their identity was critical for recruitment and engagement.

3. Tete

Needs of the KP and KP input into models of care: The intervention was based on needs assessments in each site that entailed focus group discussions with KP, mapping exercises, and existing data on HIV-related health needs in particular. During field visits, beneficiaries express uniformly positive opinions of the range of services (community-based, SWPE delivered), mode of delivery (locations, timing, frequency, promptness) and respectfulness they are afforded.

The outreach teams (SWPE and Counsellors) are in constant interaction with beneficiaries and continue to engage with them about whether the services meet their needs, including identification of new hotspots, being open and receptive to meeting beneficiaries at acceptable locations, and addressing new issues that arise, including SGBV. In Tete it is estimated that approximately 70% of CSWs are from countries other than Mozambique, and the Tete MSF team is able to understand and respond to the diverse needs of a highly mobile group of sex workers who often travel every 1-3 months to their home countries.

The difference within Tete compared to the other sites is that project closure was announced and is underway. The beneficiaries expressed that they had minimal input into that decision and were dismayed that MSF would no longer be offering a KP care program in the city. Phrases such as “sex workers are going to die” and “nobody asked us about this” were common. There was not a clear understanding of where they would go for services, and improvements could be made by engaging SWPE and beneficiaries in discussions about sustainability/connectedness (see Connectedness evaluation details).

Appropriateness of strategies for recruitment and engagement in care: Recruitment takes place in KP residences/homes, communities and their places of work (which may also be their home). Unlike other sites, Tete has community mobilizers that rotate on a monthly basis. Mobilization by SWPE and community mobilizers is an essential component to maximize the likelihood of enrolment. Additional steps have been taken to ensure privacy for particularly sensitive groups (such

as women on ART, young women <18, some TSW who fear disclosure of their involvement in sex work to friends, family and other community members ('being outed'). For example, discussions about HIV status, testing and ART happen most often during private, one-on-one counselling sessions with the counsellor who regularly meet one-on-one after a health education session by the SWPE. There is a definite need to expand services tailored to young girls and young adults. The young girls are often TSW and need targeted strategies to make services youth-friendly. The majority of younger girls and women are from Mozambique and SWPE and beneficiaries noted a need to increase the cadre of SWPE from Mozambique, particularly young women.

Burden for beneficiaries: There is some burden for the target population concerning attending the services The greatest burden identified by beneficiaries, as noted above, is the planned closure of the MSF program in this province. As with all sites, there was a significant concern about insufficient legal support, including local case management and higher-level advocacy for violence prevention and intervention. There are oversights in violence intervention and prevention in that the models of care only address the physical consequences of sexual assault (e.g. PEP) and there is minimal psychological support offered. The gaps in psychological support are important as detailed in the Malawi summaries. The issues remain consistent across sites in the entire program. The primary burden for many beneficiaries was the fear that MSF's imminent departure from Tete being public knowledge would led to an escalation in police violence. MSF is working with the Mozambican Bar Association to try and respond to this, and have a direct referral to the MoH centre for violence against women for legal support.

Privacy and confidentiality burden was a non-issue for beneficiaries. KP expressed no concerns about SWPE having intimate knowledge about beneficiaries' health and social concerns. The relationships with SWPE and the accompaniments and supports provided by SWPE were instrumental in reducing burdens for accessibility to MSF services, and the intimate knowledge about the KP health and social concerns was seen as important to help the SWPE facilitate counselling interactions. SWPE outreach activities were non-threatening and non-judgemental in that beneficiaries could determine the level of engagement with the program, which in turn fostered their trust in the program and supported attendance to care.

Style and quality of the models for retention in care: Issues of retention in care (RIC) were documented (see Effectiveness discussion). The retention issues, however, were complex. Analysis of enrolment shows high interest in MSF services, whereas low figures for RIC are multifactorial and reflect high mobility (particularly among younger SW), service provision by multiple actors other than MSF, and deliberate obfuscation of identity in order to maintain privacy (due to stigma around sex work and/or HIV). The fact that the services were free was a significant advantage for beneficiaries. The use of the mobile outreach was seen as highly valuable and appropriate as the beneficiaries did not need to attend an MoH clinic where their sex work involvement might be outed in public, thereby threatening their safety and increasing risk of harassment and violence.

Service provider capacity: Tete has a team composition of SWPE, SW Mobilizers, Counsellors and nursing staff. Each cadre is discussed individually. There is also a mobile clinic staffed by a nurse and laboratory technician that rotates through the various hotspots (see Annex XX Program Site Reviews for more details on service delivery model).

Mobilizers: These are women identified by SWPE to help mobilize women in communities to engage with MSF KP services. They are well known in communities where they live and work, and are also known to police who are SW-friendly. This helps beneficiaries' report crimes committed against them, although beneficiaries are often reticent to file a complaint/report. They are not salaried but receive a small stipend and work closely with the SWPE.

SWPE: Preparation of SWPE was variable in quality for a variety of reasons. Some had been engaged with MSF for a long period of time and others for less time. The importance of experiential learning in the role was noted as essential to developing competence and confidence in their roles. The beneficiaries reported that the SWPE were approachable and understood their issues. As with the other sites, there is a formal job description, but the training and orientation seems non-standardized for this cadre. The primary education needs identified in consultation with the SWPE, counsellors and Field Co were: SGBV training – what is it and how to respond (i.e. TVIC); and to reduce the normalization of violence against sex workers. In particular, there is a need for documentation and education to support SWPE and counsellors to complete documentation about reported violence by beneficiaries. SWPE have minimal turnover as they value their leadership role in the SW community highly, in addition to the salary support (calculated to equate to roughly 3 days of sex work income per week).

Counsellors: This cadre requires formal education in counselling, psychology or social work and certification in HTC and EAC. All were comfortable within their scope of responsibilities, although the ability to take a leadership and mentorship role with the SWPE varied to some extent among the sites, contributing to variations in the support received by SWPE from the counsellors. This impacted the SWPE capacity to respond to issues of violence and queries by KP about ART access or Family Planning methods.

COs: No CO at this site.

MoH Personnel: Challenging relationships with MoH were noted (see Effectiveness and Connectedness). Beneficiaries report preferring MSF programs. Sex Worker-Friendly Training has been provided in some areas within a 'train the trainer' model but this has not been sustained within MoH clinics that beneficiaries attend.

No team members had any training in trauma and violence informed care.

Cultural Appropriateness: Overall, the services were reported by beneficiaries to be SW-friendly and this was substantiated throughout the site visits. SWPE and the educators provided ongoing daily understandings to other cadres of service providers concerning norms of behaviour and practice within KP communities that was well received by non-experiential staff. The majority of the SW served were not from Mozambique. The MSF teams provide services in an array of languages spoken by the diverse groups of beneficiaries. The SWPE are also from diverse countries of origin that represent beneficiaries' country of origin, thereby drawing on experiential knowledge of being in the country as a foreigner including navigating lack of legal status in Mozambique, visas, ART, and other health services.

4. Beira

Beira is the only site with two distinct KP programs, one providing services to sex workers and the other specifically aimed at men who have sex with men (MSM). The separation of those programs with a supervisor for each group is still relatively new. Beira is also the most urban site within the Corridor KP Project (see Annex site reviews; evaluation Effectiveness for further details) and this provides a unique context in the sense of population density, night activities of the MSF teams, and the diversity of sex work working locations and living conditions.

Needs of the KP and KP input into models of care:

SW KP: The intervention with the sex worker KP was based on needs assessments in each site that entailed focus group discussions with KP, mapping exercises, and existing data on HIV-related health, needs in particular. During field visits, beneficiaries express uniformly positive opinions of the range of services (community-based, SWPE delivered), mode of delivery (locations, timing, frequency, promptness), and respectfulness they are afforded. Currently, the Beira program is undergoing revision based on the needs of diverse KP (sex work and MSM). The revisions include feedback from beneficiaries, needs assessment, and evaluation of existing program information within the site led by the Field Co. The input and feedback from the outreach teams (SWPE and Counsellors) are instrumental in program revision as they have the most comprehensive understanding of the experiences of beneficiaries within the diverse hotspots.

MSM KP: The MSM program was initially conceptualized in 2015 based on recognition within MSF and in feedback with beneficiaries that the sex work strategy would not be able to meet the needs of the MSM groups. During this time, LAMBDA peer educators were consulted and began to work with MSF to help shape outreach activities. The degree of involvement of beneficiaries in planning the MSM program appears somewhat limited, compared to the sex work KP programs. However, MSF has supported MSM peers and staff to help design the program. Currently, MSF is working to develop more effective strategies for engaging MSM in services and consequently seek their input into the design of services. Research activities facilitated by the supervisor have explored the challenges MSM in Beira face accessing MSF services. How to integrate this information into program revision is still under development. Additionally, there is a need for greater input of transgender people, particularly those engaged in sex work, to have input into how they are categorized within the service model (e.g. MSM versus an individual KP group versus integration with SW-specific models of care) and how services are tailored to them.

Appropriateness of strategies for recruitment and engagement in care: Recruitment takes place at KP residences/homes, communities, and their places of work for both CSW and MSM. There is also an active street recruitment strategy that occurs at night that combines a mobile clinic and health education and promotion activities delivered by SWPE. The street recruitment activities are aimed at reaching the largest possible number of beneficiaries, and the condom demonstration activities were highly appropriate for engaging particularly young men with the MSF team. The use of humour by staff to help people learn how to use a condom effectively, and to have youth demonstrate how to use it as a strategy to receive condoms, was well received. This strategy also supported MSF team members to 'check in' with beneficiaries known to them who had yet to engage more fully with the program, or to do follow up for those with whom they had existing relationships. The recruitment strategies maximize the likelihood of enrolment for KP. Mobilization by SWPE is an essential component for sex workers and greater attention to MSM peers is warranted to maximize MSM recruitment.

There are several additional recruitment challenges for MSM beneficiaries that warrant attention. MSF is not consistently viewed by beneficiaries as an MSM-friendly service and it is reported that some beneficiaries experienced

discrimination when attending the MSF clinic office, particularly by non-clinicians who were MSF staff. MSM are also reluctant to attend for care within the Munhava clinic due to stigma associated with MSM activities and fear of discriminatory interactions with health care providers. Although same sex relations are legal in Mozambique, there is still significant stigma socially and within health services, which contributes to men's reluctance to engage in care. Recruitment within the project has been slowly improving with word of mouth among beneficiaries deemed by the team as the most effective, current recruitment strategy and this was reinforced through interviews with beneficiaries. The message traveling by word of mouth is that the MSF outreach teams are safe and that the MSF clinics are safe spaces to attend for care. There is still reluctance to attend for care within the Munhava clinic. The outreach team members are also 'spreading the word' that a navigator hired by MSF is situated within the Munhava clinic and can help facilitate access to services. The navigator gets a referral from the outreach team, and once the beneficiary presents themselves to the clinic, they can help navigate towards MSM- and SW-friendly services by the MSF CO and counsellors (see Effectiveness discussion for further details on patient flow and services within the clinics).

There are several topics for further exploration that warrant attention concerning appropriate recruitment strategies to engage MSM. According to its representatives, LAMBDA is perceived as a safe space for MSM and trans people. LAMBDA expressed interest in exploring new collaborative strategies with MSF, but as a not-for-profit they raised issues of being reimbursed for their role in assisting MSF to aid in maximizing recruitment strategies for diverse groups of MSM. The feasibility of engaging in a formal relationship with LAMBDA, perhaps entailing financial support for the organization, may require further attention to maximize integration of their services and expertise to recruit and engage MSM people into care.

Additionally, a consultation by ANOVA Health Institute, a South Africa-based organization focused on HIV among MSM, took place in August 2016 and generated a report (Health4Men AFRICA Rapid Assessment report on MSM services offered by Médecins Sans Frontières, Beira, Mozambique) with specific recommendations, particularly concerning the need for MSF to "brand" their MSM services and advertise them in diverse platforms, including social media. They also highlighted the need for a men's health clinic that could potentially be integrated into Munhava health centre. Unfortunately, ANOVA will lose its USAID funding effective 30 Sept 2018, so plans for further involvement in the Beira MSM program were cancelled.

Burden for beneficiaries: There is some burden for the target populations concerning attending the services. Attendance to care is influenced by other health issues that the beneficiaries might be experiencing (e.g. severe gastroenteritis) that can limit beneficiaries' mobility or visibility to the SWPE and the MSM peers and counsellors. Other burdens to attendance have to do with visibility, once they are known by other community members who are not sex workers or as MSM. Sex worker beneficiaries specifically report harassment and discrimination by other people when they are publicly visible including at MoH clinics or when they are seen with MSF staff. MSM report being discriminated against within health centres. MSF is very aware of the stigma of sex work and MSM and have worked to provide information and testing opportunities for the general population, in areas where they also have working knowledge that beneficiaries within both KP groups are part of that community. Many beneficiaries do not want to be identified as SW or MSM and the Beira team works hard to avoid outing people.

As with all sites, there was a significant concern about legal support for **sex worker beneficiaries**, including local case management and higher-level advocacy for violence prevention and intervention. There are oversights in violence intervention and prevention in that the models of care only address the physical consequences of sexual assault (e.g. PEP) and there is minimal psychological support offered. The gaps in psychological support are important, as violence and prolonged abuse can have devastating effects for people's mental health (i.e. depression, PTSD, anger management challenges) and well-being, and contribute to less safe behaviours in HIV prevention. There were also burdens for **MSM beneficiaries** concerned with being exposed to potential discrimination which can contribute to unmet health needs and avoidance of health services. Transgender persons experience significant discrimination, according to the beneficiaries and MSF teams. LAMBDA offers some psychological support, but these services are not fully integrated within the MSF program. There is also a need for advocacy for anti-discriminatory health services both within MSF and the MoH services.

Privacy and confidentiality burden was a non-issue for sex worker beneficiaries. KP expressed no concerns about SWPE having intimate knowledge about beneficiaries' health and social concerns. The relationships with SWPE and the accompaniments and supports provided by SWPE were instrumental in reducing burdens for accessibility to MSF services, and the intimate knowledge about the KP health and social concerns was seen as important to help the SWPE facilitate counselling interactions. SWPE outreach activities were non-threatening and non-judgemental in that beneficiaries could determine the level of engagement with the program, which in turn fostered their trust in the program and supported attendance to care.

Privacy remains a significant issue for MSM, particularly non-transgender MSM. The MSF team recognized that strategies to protect the identities of men having sex with other men who do not identify as gay or transgender was a priority and are currently working on a strategy to determine how to best engage with men to ensure they are not outed as having same sex relations (e.g. outreach at work sites during the day).

Style and quality of the models for retention in care: Issues of retention in care (RIC) were documented (see effectiveness discussion). The retention issues, however, were complex. Analysis of enrolment shows high interest in MSF services among SW, whereas low figures for RIC are multifactorial and reflect high mobility (particularly among younger SW), service provision by multiple actors other than MSF, and deliberate obfuscation of identity in order to maintain privacy (due to stigma around sex work and/or HIV). The fact that the services were free was a significant advantage for beneficiaries.

Both MSM and SW beneficiaries noted that follow-up by peer educators (PE) and peer counsellors (PC) was very important to review information about medication and to do appropriate referrals to the Munhava clinic and MSF staff situated within that clinic. There were some variations in the referral process for beneficiaries between the MSM and SW PE. Both cadres had similar strategies for follow-up (e.g. a list generated each week concerning which beneficiaries they would follow up with – see Effectiveness discussion). However, anecdotal data supports that the SWPE were more likely to respond to a range of health needs beyond SRH or HIV and support referral for care services for health concerns. There were no documented protocols for responding to urgent health concerns within either KP program and as such some health needs could go unmet and/or there could be the possibility of retention issues. Further work is warranted to assess the complex issue of responding to health needs outside of the scope of the MSF KP program.

The Munhava clinic navigators were viewed by beneficiaries as critical for engagement and retention in care. The referral process from the outreach teams to the navigators helped to ensure timely attention to the KP beneficiaries who attended the clinic and helped to circumvent stigmatizing interactions with MoH providers.

Service provider capacity: Beira SW program has a team composition of SWPE, Counsellors, Educators, COs and nursing staff. The MSM program has the same composition, and the COs are shared within each program. The nurses are also all midwives and their role primarily focuses on SRH with women. Each cadre is discussed individually. There is also a mobile clinic staffed by counsellors that rotates through the various SW hotspots and neighbourhoods situated within the city where beneficiaries are known to live. The night clinics that target both KP groups are also staffed by a nurse, and plans are underway to hire an MSM-specific nurse. Mobile testing sites that are supported by significant mobilization by SWPE, MSM PE and the addition of live street theatre that tackles issues affecting KP health including violence, family planning, HIV, etc. (see Annex site reviews for more details on service delivery model) were also important, and the cadres of staff engaging in these clinics were well-versed in recruitment to the testing 'tents' (portable tents that provided privacy and 1-1 encounters between counsellors and beneficiaries).

SWPE: Preparation of SWPE was variable in quality for a variety of reasons. Some had been engaged with MSF for a long period of time (since program inception) and others for less time (a few months). The importance of experiential learning in the role was noted as essential to developing competence and confidence in their roles. The beneficiaries reported that the SWPE were approachable and understood their issues. As with the other sites, there is a formal job description, but the training and orientation seems non-standardized for this cadre. The primary education needs identified in consultation with the SWPE, counsellors and Field Co were: SGBV training – what is it and how to respond (i.e. TVIC), and to reduce the normalization of violence against sex workers. Beira is more advanced than other sites in responding to violence through their work with Muleide, and the SWPE regularly do referrals and accompany beneficiaries for consultation with Muleide. SWPE have minimal turnover as they value their leadership role in the SW community highly, in addition to the salary support.

Community Educators: Similarly to Tete, some of the Community Educators had started out as SWPE or MSM PE (thus all are experiential) and over time had returned to school and received additional training to become educators. Within both the MSM and SW KP programs, the community educators receive referrals from the PE and engage in follow-up with beneficiaries to explore fit with MSF program and their interest in engagement. They are knowledgeable about the package of care offered by MSF and able to answer questions and make referrals to the counsellors.

Counsellors: This cadre requires formal education in counselling, psychology or social work and certification in HTC and EAC. All were comfortable within their scope of responsibilities, although the ability to take a leadership and mentorship role with the SWPE varied to some extent among the sites, contributing to variations in the support received by SWPE from the counsellors. This impacted the SWPE capacity to respond to issues of violence and queries by KP about ART access or Family Planning methods. The counsellors reported that they had minimal experience working with MSM or how best to support MSM-friendly services. This is a significant learning need for this cadre (see cultural appropriateness discussion for further details).

COs: Based exclusively at Munhava HC; not involved in outreach activities or decentralized clinical services. The CO is the focal point for KP patients at this HC, and a SWPE or MSM PE navigates KP patients to the CO. He provides KP-friendly care and has benefitted from mentorship from MSM, but has not had formal training on work with KP. The CO prioritizes KP patients, but sees general ART clinic patients as well (since the volume of KP patients is currently only ~8 per day).

Nurse midwives: There is an MSF nurse situated within Munhava HC offering a full range of SRH services. They see general public as well as KP. They are fundamental to offering ToP services and are involved in training the MoH staff in ToP. Although unrestricted ToP is legal for pregnancy less than 12 weeks, many women still experience barriers, and the midwives are particularly effective in ToP counseling and support during and after the procedure.

MoH Personnel: MSF has clinic space in Munhava HC (see Beira site review Annex, evaluation Effectiveness and Connectedness documentation). The insertion of an MSF navigator based at the site facilitates beneficiaries' access and referral to MSF or MoH staff as appropriate. Beneficiaries report receiving appropriate care with MoH personnel but do have a preference for the MSF program. Sex Worker-Friendly Training has been provided in some areas within a 'train the trainer' model but this has not been sustained. Nurses work closely with MoH staff for the SRH services and provide mentorship in SW-friendly service provision and training in essential SRH services.

No team members had any training in trauma and violence informed care.

Cultural Appropriateness: Overall, the services were reported by sex work beneficiaries to be SW-friendly, and this was substantiated throughout the site visits. SWPE and the educators provided ongoing daily understandings to other cadres of service providers concerning norms of behaviour and practice within KP communities that was well received by non-experiential staff. Unlike Tete, the majority of the SW served were from Mozambique with many also from Zimbabwe and fewer from Malawi. The MSF team provides services in an array of languages spoken by the beneficiaries. The SWPE are also from diverse countries of origin that represent beneficiaries' countries of origin, thereby drawing on experiential knowledge of being in the country as a foreigner including navigating visas, ART, and other health services.

As noted previously, there is a growing need identified by beneficiaries and members of the MSF service provision team for MSM-specific services that respond to the needs of the diverse groups of men who may be categorized as MSM. Currently, many services appear to be targeting a very important and vulnerable group of transgender persons. This is very important, and there is a level of understanding about the norms and practices among many of the transgender beneficiaries. However, there are some gaps in understanding concerning norms about diverse sub-groups of MSM, such as men who identify as gay, men who identify as heterosexual but also engage in sex with men, and other sub-groups. There are some assumptions about behaviour patterns or modes of dress that are somewhat stereotypical views of how a man who has sex with other men acts or speaks. The MSF MSM team including the outreach peers and counsellors identified a need for further training in MSM-friendly services that capture diversity of this broad category that defines a sexual behaviour more so than specific cultural norms. This education is vitally important and strategic planning is underway about how best to respond to the learning needs of the team to best respond to the diversity of beneficiaries. MSF has also begun recruiting MSM staff as counsellors, and there are plans underway to hire a man who is a nurse, who is ideally MSM.

ANNEX VII: DETAILED PROGRAM-BY-PROGRAM REVIEW OF EFFECTIVENESS

Table 6. Achievement of objectives

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
RECRUITMENT (unit: average number of persons per semester)[1]				
Results	[Z] 148 [M] 269 [D] 190*	281 → 133	433	170 → 295
Comments	*Based on only 2 semesters. HIV+ prevalence highest in first year of programs compared to later years (observed for all age strata).	133 data from Q1/2 2017 downward change begins Q4 2016. HIV+ prevalence highest in first year of program compared to later years (observed for all age strata).	This program encounters an ethnic mixture of Mozambican, Zimbabwean and Malawian women with distinctive age distributions for each.[2]	295 data from Q1 2016 onward; correlates with substantial addition of new activities, consolidation of existing activities.[3]
Target	Not specified	Not specified	Not specified	244[4]

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
RETENTION (unit: percent of person)[1]				
Results	% with 2nd visit: [Z] 33 [M] 51		% with 2nd visit: 53 % with 3rd visit among those with 2nd visit: 50	% with 2nd visit: 63
			% retained after each of next 3 successive visits: 72-79	
	% retained after each of next 4 successive visits: [Z] 57-70 [M] 44-54			% retained after each of next 4 successive visits: 65-68
	% seen ≤ 6 months (range Q1 to Q4 2017): [Z] 40-50% [M] 35-41% [D] 60-100%[5]		% seen ≤ 6 months (Q4 2016 to Q1 2017): 67	
		% of ever-enrolled SW had a visit in the preceding 6 months 48 (Q4 2016 data) 31 (Q2 2017 data)		% of ever-enrolled, since Q2 2014, seen within preceding 6 months (Q2 2017 data): 55
Comments	(D] insufficient data	Q2 2017 data likely to be underestimated.[6] Retention by successive visits is not available for Nsanje.		[7]
Target	≥90% at 6 months (Specified for active HIV+ on ART)[8]	>80% at 6 months (Specified for HIV+ on ART)[9]	>60% at 12 months (For all beneficiaries)[10]	Not specified[11]

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
PATTERNS of ATTRITION				
Results	Younger age is associated with greater likelihood of a single visit only;[12,13] note that 75% of SW are <30 years of age. HIV status on enrolment: HIV+ new diagnosis 64% 1 visit HIV+ ART pre-enrolment 44% 1 visit HIV+ self-report 71% 1 visit HIV- at enrolment 56% 1 visit		When data on contact with SW is disaggregated to '1 visit only' and '2 or more visits' Women with a new or previous HIV+ diagnosis appear less likely to be seen only once compared to women who are HIV negative, or HIV status unknown. [14] Women from Zimbabwe were more likely to remain in care than Mozambican or Malawian women: comparing fraction of Tete SW ever seen, to fraction of those seen in past 6 months: Zim SW 38% / 47% Moz SW 28% / 23% Mal SW 35% / 30%	Beira SW are Mozambican or Zimbabwean (few others) 75% of SW ever seen are Mozambican, 79% of those RIC (last 6 months) are Mozambican (thus 25% and 21%, respectively, are Zimbabwean). Somewhat more Mozambican SW are RIC (55%) than Zimbabwean SW RIC (45%); many Mozambican SW are TSW residing in Beira.
Comment	This contrasts with Tete where women with new diagnosis HIV+ appeared less likely to be seen only once.	Malawi data for all sites; not disaggregated for Nsanje.		
Target	There are no standard indicators for patterns of attrition.			

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
KNOWLEDGE OF HIV STATUS (unit: percent of person)				
Results	% after enrolment with HIV *status unknown* (Q1 2016-Q1 2018): [Z] 2.2 [M] 3.0 [D] n/a	% after enrolment with HIV *status unknown* (Q1 2016-Q1 2018): 4.2	% after enrolment with HIV *status unknown* (database to May 2018): Mozambican only 1 visit: 16, 2 or more visits: 4.4 Zimbabwean only 1 visit: 24 2 or mote visits: 7.1 Malawian only 1 visit: 23 2 or more visits: 7.3	% after enrolment with HIV *status unknown* (database to April 2018): Among women Mozambican: 3.9 Zimbabwean: 3.8 Among MSM* 2.7
Comment				*98% are Mozambican.
Target	≥90% tested[15]	>90% tested[16]	Not specified[18] Default would be >90% (UNAIDS 90-90-90)	>90%[18]

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
RETESTING HIV NEGATIVE (units: ratio of actual/expected and percentage of person)				
Retesting HIV negative	'actual'/'expected' ratio from Q3 2016 onward[19] >1.0	% retested within 6 months (Q4 2016): 27 % retested within 3 months (Q4 2016): 10 % retested in average of 3 months (Q1-Q4 2017): 27-35	'actual'/'expected' ratio from Q3 2016[19] >1.0	'actual'/'expected' ratio from Q3 2016 onward[19] >1.0
Comment	Using 6 monthly retesting for HIV-persons (WHO standard) as the reference standard for 'expected' # of HIV tests all sites. This was a notable improvement over earlier semesters.		Using 6 monthly retesting for HIV-persons (WHO standard) as the reference standard for 'expected' # of HIV tests all sites.	Using 6 monthly retesting for HIV-persons (WHO standard) as the reference standard for 'expected' # of HIV tests all sites.
Target	>50% retested of those testing negative in preceding quarter.[20]	>50% retested of those testing negative in preceding quarter.[20]	>50% retested of those testing negative in preceding quarter.[22]	>50% retested of those testing negative in preceding quarter.[23]
HIV INCIDENCE (unit: number of persons per 1000 person-years)				
Results	(SW ARO 2018 Joburg): [Z] 82 [M] 79 (2014-2017 Corridor Report): [Z] 121 [M] 116	(SW ARO 2018 Joburg): 79	(Q1 2016-Q1 2017 compiled reports, Tete): 102 (Q4 2016) 132 (Q1 2017) (2014-2017 Corridor Report): 88	(2014-2017 Corridor Report): 96
Comment			Data from compiled reports in Tete, based only on subjects for whom person-time was available.[24]	
Target	2.29[25]	2.29[25]	3.63[26]	3.63[26]

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
INITIATION of ART & CONTINUATION (unit: percentage of person)				
Results	% of all HIV+ (new diagnoses and previously known) on ART (2014-2017 overall): [Z] 43 [M] 61 [D] 69 % of HIV+ SW on ART (Q3/Q4 2017): [Z] 82 [M] 81 [D] 83	% of eligible HIV+ newly initiated on ART (Q1/Q2 2017): 64 (among those seen within preceding 6 months): 85	% of all HIV+ (new diagnoses and previously known) on ART (2014-2017 overall): 44 % of HIV+ SW on ART (Q3 2017): 85	% of all HIV+ (new diagnoses and previously known) on ART (2014-2017 overall): 63 % of HIV+ SW on ART (Q3 2017): 74
Comment	Over the period Q1 2016-Q1 2018 there is no discernible trend in the proportion of all HIV+ on ART (includes those LTFU).			Overall ART coverage for all HIV+ (new diagnoses and previously known). Numbers for MSM are very small so a useful proportion cannot be generated from the data.
Target	≥90%	≥90%	≥90% >50% within same quarter that HIV+ status known	≥90%

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
VIRAL LOAD (unit: number of measurement and percentage of person)[27]				
Viral load <1000 copies/mL (= suppressed/ WHO)	(overall 2014-2017) [Z] 74 VL (40% of ART patients); 85% suppressed [M] 42 VL (10% of ART patients); 93% suppressed [D] 31 VL (11% of ART patients); 90% suppressed Q4 2017 (Z & M only): 148 VL (34% of ART ≥6 months); 89% suppressed	(Q2 2017)[28] 139 VL (43%* of SW ART patients); 76% suppressed	(overall 2014-2017) 66 VL (10% of ART patients); 56% suppressed	(overall 2014-2017): 33 VL (9% of ART patients) 82% suppressed (Q3 2017): 51 VL (31% of all KP on ART); 61% suppressed
Comment		*likely an overestimate, even using the MoH standard of VL at 6, 24, 48 months etc. after ART initiation.	Very low coverage of VL. Very unlikely that these 66 VL measurements represent an unbiased sample of all patients on ART.	Coverage figure based on VL within ART patients active within preceding 12 months; MSF standard is 6 monthly VL in this project; these VL measurement are unlikely to represent an unbiased sample.
Target	≥90% Default: ≥90% on ART have VL <1000[29]	≥90% Default: ≥90% on ART have VL <1000[29]	>80% of active HIV+ have VL measurement Default ≥90% on ART have VL <1000[29]	≥80% KP have VL measurement Default ≥90% on ART have VL <1000[29]

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
PEP (unit: number of persons)				
PEP	(Q3 2017) 19 referred 17 received (Q4 2017) 23 referred 23 received	(Q1 2017) 7 prescriptions (Q2 2017) 0 prescription (Q1 2018) 1 prescription	(Q3 2017) 3 prescriptions	(Q1 2016 to Q1 2017) 0-16 prescriptions per quarter
Comment	Combined data from all 3 sites.	Note that PEP may be obtained directly at MoH health facilities (for SV only) and this is not reflected in these figures.	Note that PEP may be obtained directly at MoH health facilities (for SV only) and this is not reflected in these figures.	Note that PEP may be obtained directly at MoH health facilities (for SV only) and this is not reflected in these figures.
Target	No standard indicator for coverage (total need has not been estimated so there is no denominator). Some projects monitor service quality (indicator: provision within 72 hours of need). Completion of PEP is not monitored.[30]			
PrEP				
Results	Not available	Not available	Q2 2016-Q3 2017 (Tete & Beira combined): 290 enrolment >70% acceptability substantial LTFU in first 3 months after enrolment; 36% retention in study (June 2018) attributed to mobility; high adherence to Q3M HIV retesting among RIC participants	
Comment			Available via study enrolment (will not be continued).	Available via study enrolment (duration uncertain).
Target	No standard indicator. Using the estimate of 70% acceptability (from study in Beira & Tete) the denominator for coverage would be 70% of clients retained in care; would be complemented by adherence indicator (e.g. >95% doses taken), and an effectiveness indicator (seroconversion rate).			

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
UNINTENDED PREGNANCIES				
Unintended pregnancies	% SW using FP (besides condoms): Q1 2017: 36 Q2 2017: 43 Q3 2017: 45 Q4 2017: 45 [31]	Prescriptions for OC or Depo-Provera (Q2 2017): 94 (Q3 2017) 71	% SW using FP (besides condoms): Q1 2017: 36 Q2 2017: 40 Q3 2017: 38 Q4 2017: 44 ToP requests (2017): 0-4 requests per quarter Emergency contraception (2017): 24-46 per quarter	% SW using FP Q1/Q2 2017: 24 Q3 2017: 28 Q1/Q2 2017: 11 requests 8 eligible by gestation 6 linked 5 completed Q3 2017: 13 eligible requests 12 linked
Comment		Comparable data are not available for this site. Regarding prescription numbers, this program has 306 SW seen in the preceding 6 months, as of Q2 2017.	Risk of pregnancy can be somewhat inferred by uptake of emergency contraception. Data about emergency contraception is calculated not counting PEP recipients for whom this is included.[31]	In 2018 there are substantially enhanced SRH services at Munhava HC, including ToP (9-12 performed per month (June 2018).
Target	>60% using FP (assume in addition to condoms)	FP target not specified.	>60% use dual protection (=condoms + other FP method). No standard ToP indicators. [32,33]	>60% use dual protection (=condoms + other FP method). No standard ToP indicators.

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
VIOLENCE PREVENTION				
Results	[M] SW already arrange pre-payment for services. Effective sensitization on SV for police.	No SV-specific initiatives for violence prevention.	Effective sensitization of police with high-level advocacy from local leaders.	Effective sensitization of police on SV. Effective engagement of women's rights advocacy group for education, advocacy and specific case support.
Comments	Other sites do not advocate for pre-payment agreement systematically. Sensitization for police already somewhat effective in reducing SV, particularly in [D] where police initiated discussion with SW.		Perceptible reduction in incidence of police-related SV.	
Target	No standard indicators exist.[34]			

Table 7. Reasons for achievement or non-achievement of objectives. Relative contributions to:

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
Recruitment	Limited only by human resources (# of SWPE, counselors).	Limited by human resources and the large geographic scale of the project.	Enhanced by multiple points of service provision and an effective outreach cascade.	(SW) Related to SWPE HR but somewhat impeded by a relatively inefficient enrolment process and variable effectiveness in the outreach team members. (MSM) Inefficient for those not involved in sex work.
Retention	Influenced mostly by mobility rather than service type.	Limited by relatively infrequent outreach clinics and the need for independent access to MoH facilities.	Limited by mobility but optimized by regular (weekly) outreach in most areas.	(SW) Supported by structured follow-up but limited by mobility of SW. (MSM) Unable to comment.
Quality Of Care	Perceived by SW as high (dedicated MSF clinician).	Limited to HF only and is limited by distance/ transport + MoH HR and material constraints.	Perceived by SW as high for outreach activities, but limited at HF by HR constraints.	(SW) Perceived by SW as high (dedicated MSF clinician). (MSM) Unable to comment.
Overall		Overall the project is substantially under-resourced for its aims.		

Table 8. Enhancing project effectiveness

Criterion	Settings			
	Zalewa, Mwanza, Dedza	Nsanje	Tete	Beira
Recruitment, Ease of access	More SWPE & counselors.	More SWPE & counselors Increase frequency of outreach clinics (HR and logistics dependent).	NA	Streamline enrolment process; SWPE to maximize independent work. Revise MSM recruitment strategies, making distinct plans for sex work-involved and other MSM.
Retention	NA	Increase SWPE FU and navigation to MoH services.	Enhance SW friendly approach at HF Enhance SWPE navigation & liaison at HF.	(SW) Enhance linkage to HF-based services, to human rights and legal services. (MSM) Enhance linkages to advocacy, human rights resources.
Quality of care	• Maximize utility of first (often only) contact: HIV test and specific advice on next step(s) • Intensify follow-up plans particularly for younger <25 women • Enhanced follow-up for HIV+ not on ART to maximize initiation • Address large VL backlog; consider 'Campaign' style events to catch up • PEP is under-utilized; rationalize PEP policy and SOP (see discussion) and re-train all personnel & SWPE on it • Continue advocacy and early adoption of PrEP, & introduction of injectable PrEP • Make FP inquiries routine & systematic by SWPE; offer pregnancy testing often and by SWPE • In Mozambique, navigate ToP referrals with SW • Many SW do not recognize SV: education and strategizing among SW to recognize SV, reduce risk, respond to perceived risk, and obtain immediate assistance to limit harms, & obtain necessary care • Systematically organize multi-stakeholder sensitization of police on SV; include bar and hotel/lodge owners to reduce risk, optimize response to limit harms			

Notes:

1. Recruitment & Retention data all sites except Nsanje: Corridor Report 2014-2017, Meiwen Zhang (Dec 2017). Recruitment & Retention data Nsanje: Nsanje Quarterly Report, Q2 2017.
2. Tete program has the most ethnically diverse SW population among the sites considered here; the figure below illustrates the age distribution for women contacted 1 or more times, illustrating that Mozambican women predominate in younger strata, Zimbabwean women predominate in older strata, and Malawian women

predominate in the middle strata; overall approximately 75% of SW contacted are <30 years old. Data extracted for this evaluation by Tete Project Epidemiologist, May 2018.

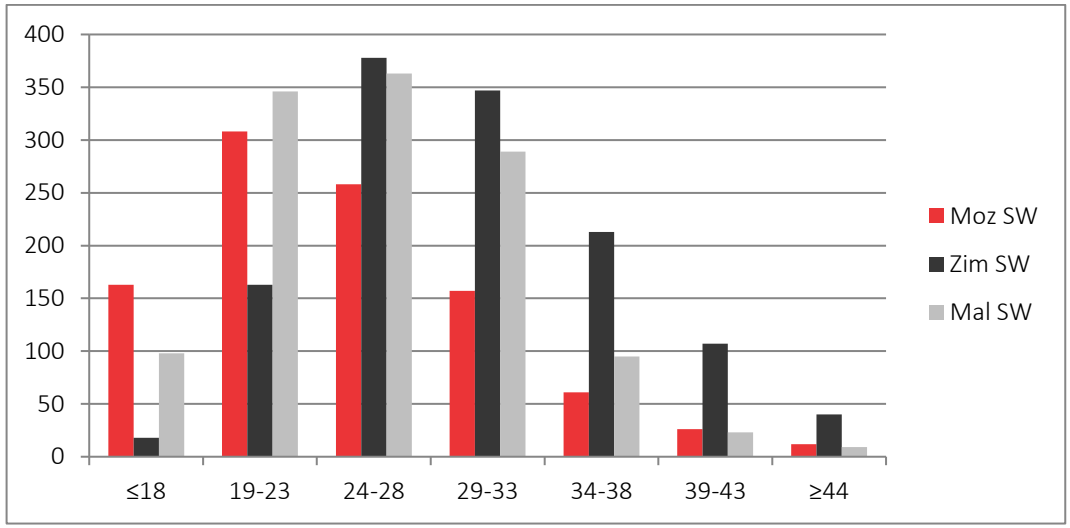

Figure 4. Number of SW contacted in Tete program, by age and ethnicity (2014-2017)

3. Source: Project Document – Beira, reference MZ1 35 (3 Oct 2016).
4. Source: Beira 2017 Project Description.
5. Dedza site began activities in Q3 2016 and Q1 2017 was the first quarterly report with an analysis of ≤ 6 months retention (reported as 100%); according to the Dedza team, the SW population is predominantly local and even women who are mobile tend to return to Dedza frequently; retention fell in subsequent quarterly analyses to 80% in Q2 2017 and 60% in Q4 2017, thus approaching figures seen in Mwanza and Zalewa. Sources: Corridor Project Malawi – Quarterly monitoring narrative reports Q1, Q2, Q3-4 2017.
6. Retention, Nsanje: because MSF clinics are held only monthly in most locations (except NDH which is 2-weekly) patients will often attend their nearest MoH health facility independently of MSF; this may appear as LTFU in MSF records whereas the patient is not LTFU but rather obtaining care and treatment without MSF involvement. There is anecdotal data from Trinity outreach clinic to illustrate this phenomenon: data from Sept 2017 showed that of 52 patients with MSF ART records only 18 had up to date MSF follow-up, whereas 30 others were found in Baobab EMR on ART and up to date despite appearing as LTFU in MSF records (another 4 were LTFU by MSF and not found in Baobab EMR, although they may possibly have been re-registered for ART with a different ART number). Source: Personal communication with Nsanje SW Team Leader/Nurse (Chrissie); data collected in Dec 2017.
7. Corridor Beira Quarterly Report, Q2 2017.
8. Source: Corridor Project Malawi, Q4 2017 Report.
9. Source: LF_Nsanje_2018 ER 7 SW.
10. Source: Tete Q1 2017 Final.
11. Source: 2017_MOZ_Beira_PD_Final.

12. Malawi data disaggregated to show the age-stratified number of SW seen once only versus 2 or more times (exclusive categories) show that younger women (< 25) are more likely to be seen only once, and older women (≥ 25) are about equally likely to be seen 2 or more times:

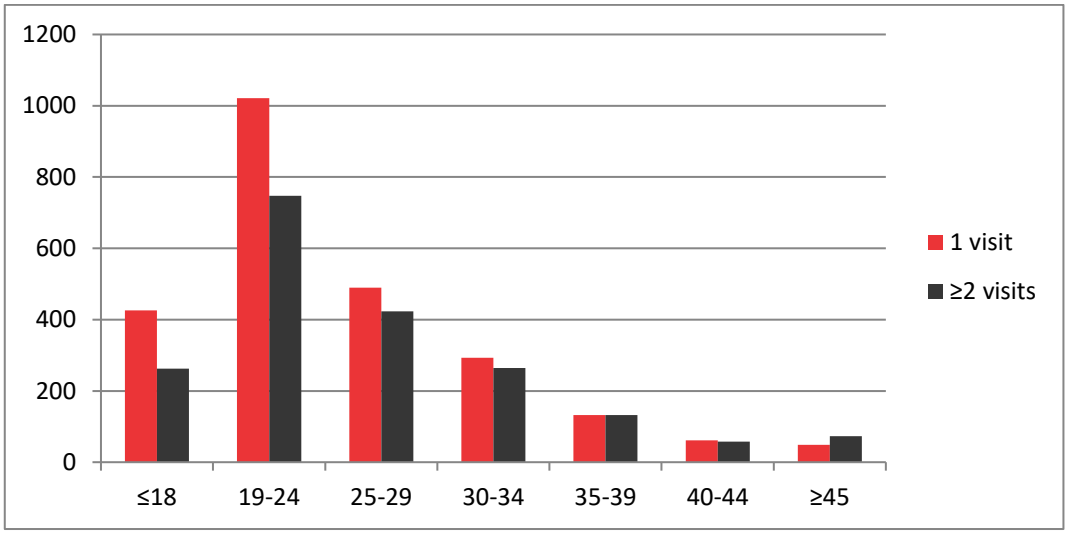

Figure 5: Volume of Malawian SW seen stratified by age, and whether seen once only, or 2 or more times

13. With regard to attrition, Malawi data (reanalyzed for this evaluation) showed that, overall, 56% of all SW contacted had a single encounter (visit); women with a new HIV+ diagnosis on that visit were somewhat more likely to have a single encounter (64%). As the age-stratified analysis in point 9 shows, this was driven mostly by the behavior of women under 25. Note the contrast with what was seen in Tete, Mozambique (next point), although the figures for younger Malawian SW (<24) are less different than for all other SW.
14. Tete project data was disaggregated by number of visits (1 visit vs 2 or more visits), age and HIV status (known +, new +, new -, unknown) and the 3 major ethnicities seen in the program. Figure 6 below illustrates that women with a new or previous HIV+ diagnosis were less likely in most age strata and among all ethnicities to have only 1 visit (less attrition), compared to women in the other categories combined (higher attrition). Data extracted for this evaluation by Tete Project Epidemiologist.

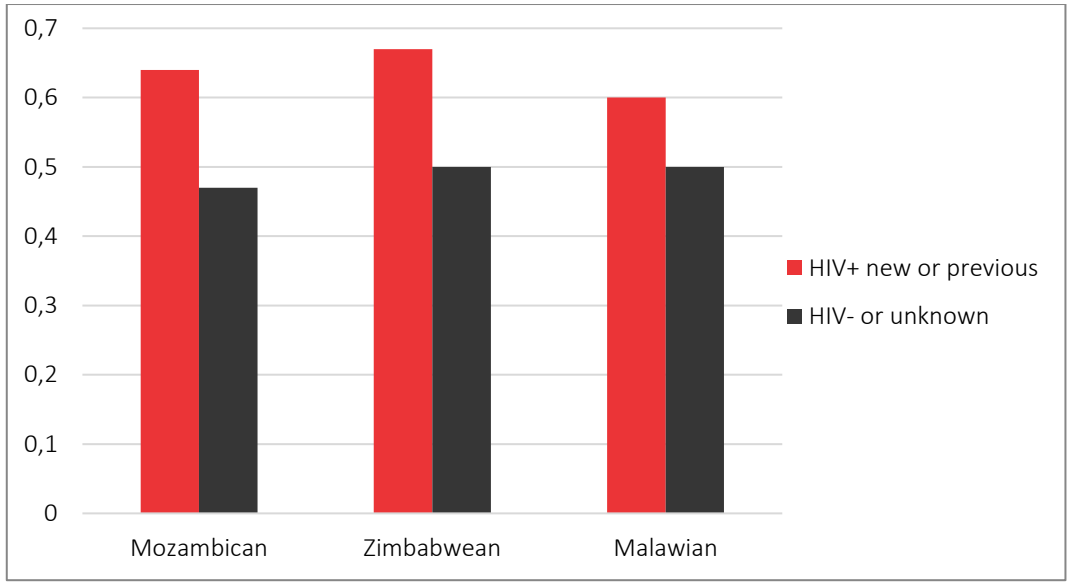

Figure 6. Proportion of Tete SW seen 2 or more times (compared to once only), by HIV status & nationality

15. Source: Q3-Q4 2017 Corridor Malawi.
16. Source: LF_Nsanje_2018 ER 7 SW.
17. Source: Tete Logframe 2017.
18. Source: 2017_MOZ_Beira_PD Final.
19. HIV retesting data for all sites except Nsanje District, Malawi, is taken from the analysis of M Zhang, covering 2014-2017 (Dec 2017).
20. Source: Corridor Project Malawi Q4 2017.
21. Source: Not specified but implied in Q1 and Q2 2017 reports.
22. Source: Tete Q1 2017 Final.
23. Source: 2017 MOZ Beira PD Final.
24. Compiled 2017 Quarterly Reports, Tete, Mozambique.
25. Source: UNAIDS 2016 figure for Malawi; not disaggregated by sex, age or KP status.
26. Source: UNAIDS 2016 figure for Mozambique; not disaggregated by sex, age or KP status.
27. A criterion of 90% suppression (VL <1000 copies/mL) implies that the product of VL coverage and VL suppression is at least 90%, OR that ART patients are sampled in an unbiased manner to estimate VL suppression among the entire group of ART patients; these projects have not randomly selected ART patients for VL measurement so (i) their VL coverage does not represent an unbiased sample, and (ii) the proportion of patients with VL <1000 copies/mL cannot reasonably be generalized to all ART patients in the respective program.
28. Nsanje SW VL data were taken from Q2 2017 Quarterly Report; the % with suppressed VL is provided in that report however the estimate of 43% of ART patients with VL (coverage) was not provided but was estimated by taking the cumulative figure for 'HIV+ on ART' from Q4 2016 (since the first VL is due only after 6 months on ART). This figure is based on a single VL per individual and thus is likely to be an overestimate as some ART patients (e.g., after high VL, or in program >2 years) were eligible for >1 VL measurement over the life span of the program. VL data for other sites was taken from the 2014-2017 report of M Zhang.

29. Source: UNAIDS 90-90-90.
30. An estimate of PEP need (number of instances for which PEP is technically indicated based on risk assessment, per time interval) would entail estimating the frequency of intercourse which is unprotected (for any reason), or involves condom failure – we have no such denominator. For example, if a SW has 10 clients per day and works 6 days per week, in one quarter (13 weeks) she has 780 sexual contacts. If one contact per quarter (0.13 percent of all contacts) entails a risk of HIV exposure she should be eligible for PEP, so all HIV negative women like her would request PEP at least once per quarter. Even if she has only one potential HIV exposure per 6 months, half of the HIV negative cohort should be eligible for PEP per quarter. PEP requests are obviously a very small fraction of this volume. PEP completion (adherence to the 28-day course) has not been reported by any project but is known to be poor (completion of regimen by 57% of general population, but by only 40% of sexual violence victims; WHO Fact Sheet: PEP to prevent HIV infection, December 2014).
31. Unwanted pregnancies: not all SW pregnancies are unwanted; risk of pregnancy can only be inferred from existing data on FP uptake, ToP uptake (if available), and emergency contraception uptake.
    a. Data from Tete program for 2017 showed little uptake of ToP (this is available only via referral to MoH health facilities); although most quarters in 2017 showed uptake of emergency contraception 24-46 cases, Q2 showed 118 – this appears to be an outlier.
    b. Current ToP estimate in Beira (personal communication, MSF midwife; 7 June 2018).
32. Although there are no standard ToP coverage indicators (because there is no accurate denominator) the quality of access could be partially assessed by monitoring the availability of early pregnancy testing, and the proportion of ToP requests that is made at <12 weeks gestation.
33. We have no program data on motherhood among SW. One of the common myths about SW is that they are mostly single and do not wish to become pregnant. Depending on the country studied, 50-80% of SW had at least 1 child. (Strathdee S et al, Lancet 2015).
34. Indicators for violence prevention could potentially be derived from the '5 Critical Enablers' described in the WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for Key Populations, 2016 Update. Specifically,
    (#2) Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations; (systematic local and national advocacy and dialogue)
    (#4) Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations (strategies for safety in the context of sex work)
    (#5) Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice. (local and national advocacy, dialogue, legal support).

ANNEX VIII: DETAILED PROGRAM-BY-PROGRAM REVIEW OF CONNECTEDNESS

1. Zalewa, Mwanza, Dedza

Statements below apply to all 3 sites unless otherwise specified by [Z], [M] or [D]; Dedza program personnel were interviewed but the site was not visited.

Engagement of experiential people: 2 [Z]/ 4* [M]/ 2 [D] capable SWPE (identified as CHW in these programs) comprise the essential link to the SW population; they interviewed for the jobs when the positions were advertised, attracting a large number of applicants. Frontline activities could only be expanded significantly with more SWPE.

(*1 on maternity leave at the time of this evaluation; not interviewed)

Enhancement of local capacities: in addition to the SWPEs, 1 [Z]/ 2 [M]/ 1 [D] local trained counsellor(s) and 1 CO per site ([Z] with prior KP program experience) and a team driver ([Z], [M]) all reflect a friendly, non-judgemental attitude in their interactions with SWPE and with SW beneficiaries. [Z] Even the driver talks informally to curious women about what the team is doing and corrects misconceptions about the program; he also talks to men about safe sex.

[Z] One SWPE had internal MSF training at another KP program site (Nsanje), the other trained on the job here. [M] [D] SWPE had brief internal MSF preparation and/or were trained on the job here.

Written and pictorial teaching materials are used, and the (trained) counsellor is the person most responsible for mentorship and continuing education for the SWPE, although the CO (team leader) also contributes. These programs have (i) a comprehensive checklist for (quarterly) assessment of each counsellor, adapted from published source materials on supervision in health programs, (ii) a more simplified (suggested monthly) supervisory form for assessment of the counsellor, and (iii) a form for assessment of SWPE (CHW) during a group health education session (to be completed at least once quarterly) which was adapted from a NAC SW training course in 2016.

Collaboration with MoH & other providers: [Z] MoH provides a consultation room at Zalewa HC in which the MSF-employed CO works on weekdays; CO works closely with the MoH MA (the only other clinician) although KP patients are seen by the MA in the general OPD (when the MSF CO is absent).

[M] [D] MoH provides a consultation room located within the ART clinic at the District Hospital [M] [D] in which the MSF-employed CO works on weekdays; [M] [D] CO works closely with the MoH staff working in the adjacent ART (and other) clinics. The MSF CO sees general population ART patients interspersed with KP patients throughout the day. This KP clinic provides multiple services related to HIV care and ART, and most [Z][D] or some [M] SRH services but refers internally to MoH providers for FP and for cervical cancer screening (VIA) – [M] located within the same building at MDH thus posing minimal inconvenience. Other MoH providers do not appear to substitute for the MSF KP CO if he is unavailable. HIV care is bolstered by provision, for KP patients on ART, of GeneXpert VL (same day result) provided by MSF.

[M] Other community partners supporting SW include CHREAA (legal and victim support, but also coaching to demand pre-payment for services as a strategy for violence reduction), SW Alliance (a 54-member SW peer-led group providing social support, fellowship and health education), and the Victim Support Unit of the Police Department (there having been an overall improvement in conduct, with less harassment or violence towards SW).

[D] Dedza is distinguished by the proactive attitude and behaviour of the police with regard to interactions with sex workers. The police initiated a meeting to share experiences and perspectives with SW; the police aimed to decrease fear of police and affirmed the total unacceptability of harassment or sexual violence by policemen; the police asked that SW keep their young children in locations separate from their places of work. Overall, complaints by SW about the police have decreased noticeably.

Accordance with international consensus guidelines: These 3 programs generally follow the WHO (2016) recommendations on health sector interventions for KP, although the spectrum of mental health services - in particular in relation to violence - is underdeveloped. The Global Network of Sex Work Projects (2017) issued recommendations on the meaningful involvement of sex workers in the development of health services aimed at them. The programs overall accord with the locally-implementable recommendations (except that in Mwanza an alliance of sex workers exists which has not been supported by MSF); others (such as decriminalization of sex work, legal protections, and labour rights for sex workers) imply sustained national-level advocacy efforts in which MSF does not consistently engage.

Replicability of this model of care: [All] The small, high-functioning and cohesive team at each site, with well-defined roles are points in favor of replicability. The 1-stop [Z] [D] (or close to 1-stop [M]) KP-specific clinic is very popular with

KP beneficiaries, a factor likely to optimize retention (although this cannot in itself overcome the high mobility inherent in sex work involved women). The CO role is the one that is probably not sustainable outside a well-resourced NGO (discussed further below). [D] The Dedza team felt that resource limits (e.g. STI drug stock outs, lack of dedicated transportation for the entire day) compromise their capacity to expand coverage of the KP that they could otherwise provide.

Capacity building needs: [All] SWPE are motivated to have further training, and they could benefit from further formalized training in addition to continued on-the-job mentorship. The team needs a policy, SOP, and specific training on (i) SV and (ii) engagement with youth. In order to accomplish this, the SWPE in particular need psychosocial support that recognizes their personal trauma histories in relation to sexual violence. Beneficiaries themselves also need trauma-informed psychosocial support. Although the supervisory checklists for counsellor and SWPE performance (mentioned above) are likely to be useful in assessing counsellors and SWPE with regard to knowledge and ability to interact empathetically and effectively with SW, they do not address mental health nor address prompts to referral – i.e. how to help SWPE (or counsellors) recognize an ill person and/or one who needs clinical assessment. We do not expect SWPE to make clinical judgments per se, but they probably can be trained to encourage and facilitate clinical assessment when significant symptoms of illness are expressed or elicited in conversation.

[D] The Dedza CO and counsellor also cited needs for continuing education, updating on new national guidelines (HTS, ART, STI treatment) since their knowledge informs the quality and correctness of their work, and of the health information that SWPE are disseminating in the course of their outreach work.

MoH approach to KP: Historically, women involved in SW have been subject to derision, discrimination and poor treatment at MoH health facilities. Training on 'SW-Friendly Services' has made a palpable improvement in the way SW are dealt with, according to the MSF SWPE and to SW beneficiaries, although the latter still strongly prefer to see the MSF CO [Z] [M], but [D] SW will also attend the MoH CO for ART or STI treatments. [M] Some MoH personnel are still uncooperative with e.g. repeated PEP requests from KP, but some others will also prioritize KP patients to avoid a missed opportunity (should the SW fail to wait).

Human & material resource needs: The outreach activities essential to this KP program cannot be provided by the MoH and thus demand some form of NGO or CBO involvement.

The MSF CO can only be justified if he/she is seeing other general population patients too. [Z] At the MoH HC there is typically not a CO on staff, and if one were on staff he/she would not be expected to prioritize 9-12 KP patients per day (while the MA down the hall sees 200 outpatients per day). [All] As currently designed, the project does not actually require a CO: almost all health issues that SW present with are SRH- (or ART-) related, and an appropriately trained nurse could provide them. This could preserve program autonomy at a considerably lower cost, particularly if the nurse was available for other patients (other than those identifying as KP) with SRH needs, thus maximizing utility to the MoH. The CO role is possibly sustainable if there is optimal use of this position for related SRH and ART issues among general population patients as well as KP.

2. Nsanje

Engagement of experiential people: 7 SWPE (known as CHW) are employed, each originating from the area in which she works. Each SWPE liaises with area-specific SW mobilizers (unpaid, rotating responsibility among a local group) who assist with condom distribution, and with mobilizing for attendance at SW clinics.

Enhancement of local capacities: MSF provided 3-day training for SWPE after employment but there is no regular formalized training; all would like to have further training in addition to that provided by the MSF nurse and counsellor on the job. Most SWPE would like to provide HTC, but this is pending the creation of a simplified national training curriculum.

Collaboration with MoH & other providers: Sex Worker-Friendly Training has helped improve the acceptability and quality of treatment of SW at MoH health facilities. MoH nurses and HIV diagnostic assistants participate directly in MSF-led outreach and static KP clinics – an MoH-certified ART provider must be present to include ART in the range of services provided. MSF refers to MoH for cervical cancer screening (VIA) but this is variably compromised by equipment shortages and patient transport difficulties. Partners in Hope (NGO) support the MoH with HTC services in HC and have piloted oral self-testing for HIV; there may be potential for enhanced KP-focussed HTC to complement (or replace) what MSF does in this regard.

Of note there has been no Sex Worker-Friendly Training or any other sensitization training for police in Nsanje, who remain the principal group responsible for harassment and violence against SW.

Accordance with international consensus guidelines: The program generally follows the WHO (2016) recommendations on health sector interventions for KP, although the spectrum of mental health services - in particular in relation to violence - is underdeveloped. The Global Network of Sex Work Projects (2017) issued recommendations on the meaningful involvement of sex workers in the development of health services aimed at them. The programs accord with the locally-implementable recommendations, but others (such as decriminalization of sex work, legal protections, and labour rights for sex workers) imply sustained national-level advocacy efforts in which MSF does not consistently engage.

Replicability of this model of care: This program requires modification in one of 2 directions. In its current form it is markedly under-resourced for its ambitions and its geographic scale. While increasing resources could address this by increasing the frequency of contact in each clinic setting, it will also make the program less likely to be transferable due to higher costs. If the program objectives were modified to adapt to the context – for example, by emphasizing initial recruitment for MSF with the aim of maximal liaison with MoH services, including ART continuation — it could be more feasible to continue with similar resource inputs. Trying to maintain a predominant role in FU of SW beneficiaries with current resources in a large district with far-flung service points is unlikely to be very successful.

Capacity building needs: SWPE and counsellor (of which there should be more than 1 — ideally 2 or 3 based on the number of SWPE) need regular continuing education on the range of SRH topics including cervical cancer screening, and sexual violence and psychosocial support related to SV. It is assumed that the Nsanje project now has the same assessment forms for counsellor and SWPE that were noted above for Zalewa/Mwanz/Dedza, given that there is now unified coordination in Malawi.

A multi-stakeholder sensitization workshop with police is a must. These have proven effective in other Malawian program sites and the need for change in police conduct is great in Nsanje. Others like community leaders and village head men should be included or trained in separate sessions.

MoH approach to KP: The single Sex Worker-Friendly Training that took place in 2016 was considered successful, but it needs repeating and should be repeated regularly to reinforce messages and sensitize personnel newly arrived since the last training.

Human & material resource needs: The human resource limitations for KP services are obvious – too few nurses and counsellors limit the amount of concurrent activity. The alternative would be to drastically rethink the goals of the project so that they better match the limited number of MSF personnel dedicated to KP services. There are distinct logistical requirements (transport daily, out-of-town accommodations occasionally) for this program in its current form; these are probably not sustainable outside a well-resourced NGO. The alternative may be to mentor distant service sites less intensively with more independent operation and close collaboration with MoH (or CHAM) health facilities in such areas.

3. Tete

Engagement of experiential people: This program is distinguished by the fact that its creation was directly related to a request from Zimbabwean SW working in the area. The team currently employs 5 SWPE (1 died recently, so only 4 are currently present); only 1 is Mozambican (the others are Zimbabwean). Historically, there were usually 10-15 in the team (SWPE plus counsellors). Each SWPE has a designated area in which they connect with a group of (usually) 10-15 peer mobilizers. The SWPE have in most cases worked for years in the program and are highly skilled and effective.

Enhancement of local capacities: MSF has provided most of the training for SWPE and for counsellors (who are predominantly lay counsellors), including on-the-job continuing education and mentorship by the MSF psychosocial team leader and the team nursing supervisor.

This program has made the greatest progress in discussing, educating on, intervening on, and documenting sexual violence. Consequently, team members have more knowledge and capacity, and the project as a system supports them.

Given its long history in Tete, this project has some exceptionally knowledgeable and skilled staff in influential leadership positions. When planning to end a project it would be ideal to actively support the placement of highly skilled and knowledgeable staff members in other KP-related organizations.

Collaboration with MoH & other providers: The project provides some decentralized medical services, but others (notably ART, cervical cancer screening, ToP, and most non-SRH related health care) require attendance at an MoH (DPS) health facility. This has improved over the life of the program, and this is attributed to Sex Worker-Friendly Training, but also

importantly to increasing rapport with SWPE who often act as navigators for SW at health facilities. This collegial contact has increased respect for SWPE and SW patients over time as familiarity has grown.

This KP has benefited from an effective sensitization process coordinated by MSF which focussed on police mistreatment, harassment, and violence against SW. High-level support within the police department was bolstered by high-level political support to generate marked improvement, according to SW interviewed in Tete. MSF also has a formal collaboration with the Mozambican Bar Association to provide legal support in assault cases, typically involving policemen.

Accordance with international consensus guidelines: The program generally follows the WHO (2016) recommendations on health sector interventions for KP, although the spectrum of mental health services - in particular in relation to violence - is underdeveloped. The Global Network of Sex Work Projects (2017) issued recommendations on the meaningful involvement of sex workers in the development of health services aimed at them. The programs accord with the locally-implementable recommendations, but others (such as decriminalization of sex work, legal protections, and labour rights for sex workers) imply sustained national-level advocacy efforts in which MSF does not consistently engage.

Replicability of this model of care: This program has used its considerable resources to provide high quality services in a large number of sites. It is already clear that some aspects are too costly to be taken on by another NGO or by the MoH. That should not distract us from questioning how essential some of the service features really are, in terms of meaningful health endpoints. The large mobile clinic van, for example, certainly announces MSF's arrival in a neighbourhood, but it may not be necessary to provide the outreach and decentralized medical care that MSF provides. Whatever one's opinion, it is already clear that no NGO nor the MoH plans to provide decentralized medical care (as distinct from outreach services like HTC, condom distribution, STI screening, etc. which must be decentralized) in Tete as MSF has done. The convenience and secondary benefits (like health education opportunities) may be lost, but SW already had to attend health facilities for ART, for most non-SRH medical problems, and for their children's medical care – since MSF could not address those needs directly.

Undoubtedly one of the most valuable aspects of the MSF service was the high-quality outreach provided by the experienced and effective SWPE and counsellors, since they were a reliable presence and were well-resourced by MSF to meet basic needs for SW (e.g. enough condoms – which means work can continue with at least some risk mitigation). Stable SW beneficiaries in particular developed a trusting relationship with the SWPE, and by extension with MSF. This can be replicated, but it demands a recognition of the inherent value of the MSF approach to outreach, with coaching and support (materially and emotionally) for SWPE and counsellors, and sufficiently frequent contact (weekly) with other team members and with beneficiaries to meet needs and maintain relationships.

Capacity building needs: Work with the designated handover partner, ICRH, to capture the essential elements of MSF KP outreach, including how the team is supervised and supported. This is the best hope for the existing ICRH SWPE and any SWPE transferred from MSF to succeed in their work.

Emphasize the elements of the KP package of care so that SWPE are optimized for the role of navigation of SW to health facilities; this has the potential to maximize the services that MoH can (and should) provide.

MoH approach to KP: There is now a national KP guideline — disseminated after a long delay, but nonetheless an essential reference to the accepted standard of care for KP. It can be used at all levels from coordinators to SWPE to prompt provision of all components of the package of care. The MoH will not be involved in decentralized medical services, so the focus must be on sensitization of MoH personnel, and supporting KP-relevant training needs.

Human & material resource needs: SWPE and counsellors are essential elements of the KP program and we already understand that all medical services will be MoH-provided in future. Expensive elements like the large MSF van are not affordable for any other NGO. Decentralized mobile HIV viral load is valuable, particularly in the Mozambican context where prolonged treatment on a failing regimen has been observed, and where viral suppression is likely suboptimal. This should not distract from the more pressing problem of enhancing VL capacity at health facilities for all ART patients. Major emphasis should be placed on enhancing the quality (and if possible, number) of SWPE since they provide services to KP that no other cadre can duplicate; they can also play a unique role in navigation to health facilities.

4. Beira

Engagement of experiential people: [SW] Outreach teams (2) consist of 2 types of SWPE known as Peer Educators who, with demonstrated aptitude and experience, may be promoted to Community Educators; both are MSF trained, but the latter has more knowledge & skills, often including HTC.

[MSM] Outreach team (1) consist of MSM PE and MSM CE, and a team leader who is MSM (and also involved in operations research for the project).

Enhancement of local capacities: [SW] MSF has trained the PE and CE in the team, and offers some community education on HIV prevention, testing and treatment. MSF has recently upgraded SRH services at Munhava HC aimed at the general population but also serving SW – this entails side-by-side collaboration between MoH midwives and MSF midwives. A special package of training on ToP – called 'Exploring Values & Attitudes' (EVA) – was provided for MSF and MoH personnel. In the KP clinic the MSF CO sees KP patients, but other MoH COs generally do not – there appears to be no systematic knowledge transfer to MoH staff here.

[MSM] MSF originally worked with PE provided by Lambda, but subsequently trained their own PE and CE.

Collaboration with MoH & other providers: [SW & MSM] MoH at Munhava HC provides a consultation room for the MSF KP CO, contingent on him seeing general population ART clinic patients (~25 per day) when not seeing KP patients (~8 per day); as noted above, the SRH clinic also serves SW, including for ToP. MSF also provides medicines and medical materials and has undertaken building improvements or renovations.

[SW] There is formal engagement with a national women's rights organization (MULEIDE), with one of their advocacy and legal aid persons seconded to MSF.

[MSM] There is a national LGBTQ organization (Lambda) with whom MSF has collaborated ad hoc on mainly health educational events, but there was no formal input from Lambda per se into the form of the MSM program. (The MSM team leader is a member of Lambda but he did not represent an organizational policy or approach). The collaboration with Lambda is aimed at health education for MSM but not at building capacity within Lambda, although Lambda would like more support on technical issues regarding e.g. HIV treatment or PrEP.

Accordance with international consensus guidelines: The program generally follows the WHO (2016) recommendations on health sector interventions for KP, although the spectrum of mental health services — in particular in relation to violence — is underdeveloped, and non-discriminatory services for MSM are limited. The Global Network of Sex Work Projects (2017) issued recommendations on the meaningful involvement of sex workers in the development of health services aimed at them. The programs accord with the locally-implementable recommendations, but others (such as decriminalization of sex work, legal protections, and labour rights for sex workers) imply sustained national-level advocacy efforts in which MSF does not consistently engage.

Replicability of this model of care: [SW] The current model of care is in evolution at the time of the evaluation. Optimizing performance requires independent functioning of outreach team members to maximize the number of contacts per day – which currently appears modest [6-10 per day per team]. SWs reputedly appreciate the follow-up that MSF provides and the dedicated service provider (CO) and HC-based peer navigator decrease the barrivenesser to attendance at the HC. There are currently at least 3 different types of outreach activities and evaluation criteria for each should be clearly defined as the format of each matures. The HC-based services for KP by MSF are essentially parallel services but should ideally be provided by some MoH providers in order to effect knowledge transfer – and attitudinal shifts.

[MSM] The current model of care began as an add-on to the sex worker program. There are at least 2 very distinct populations with different needs: (1) MSM or Trans women (biological males identifying as female) presenting as female and selling sex to men, often encountered in the same environments as (cis) female SW, (2) non-sex work involved MSM (gay or bisexual) presenting as men but not out regarding sexual orientation, and not typically found in SW hotspots. The program currently reaches population (1) because they are visible, but it has limited means of reaching population (2) apart from word of mouth in MSM networks. It is likely that population (2) will often not be interested in contact with an organization that marks their sexuality publicly. Therefore, a very different approach is needed to recruit and serve this population. This should not be an MSF-branded program given the time-limited MSF presence.

Capacity building needs: [SW] Continue coaching on SW rights and educate on SGBV recognition, prevention, and response; counsellors and SWPE need training on TVIC. We did not see checklists for performance assessment of counsellors or SWPE (see section on Zalewa/Mwanza/Dedza). We recommend, in addition to knowledge of key health content, and empathic approaches to conversation and counseling, that some attention be paid to prompts for clinical assessment – i.e. how to help SWPE/MSMPE (or counsellors) recognize an ill person and/or one who needs clinical

assessment. We do not expect SWPE to make clinical judgments per se, but they probably can be trained to encourage and facilitate clinical assessment when significant symptoms of illness are expressed or elicited in conversation.

[MSM] Incorporate the advice of Lambda and other regional LGBTQ groups (e.g. Anova, South Africa) with regard to program design. Develop an acceptable social media approach that is compatible with MSF policies. Develop a 'Men's Health' approach that is widely accessible and non-stigmatizing.

MoH approach to KP: [SW and MSM] Although there is a national guideline that defines KP services, there is no plan to offer specialized KP services in health facilities. The current arrangement offloads KP services from MoH at Munhava HC and does not enhance MoH provider capacity (except for SRH services).

Human & material resource needs: [SW and MSM] A mentorship arrangement could entail the MoH CO seeing some KP patients with the MSF CO, and/or equipping PE or CE to act as patient advocates during health facility visits to ensure that the necessary services are provided and to support patients in asking for and obtaining them. It is unlikely that, post-MSF presence, the MoH will dedicate a CO to serving KP members. MSF is obligated to prepare for that arrangement. Printed wall charts, desk top flip charts, and other pictorial materials can support the CO and other team members in providing health services and health education to KP patients.

[MSM] Expertise in social media will be necessary to develop a larger MSM program.

ANNEX IX: WHO RECOMMENDATIONS FOR KP HEALTH SECTOR INTERVENTIONS - ANNOTATED

This is a selection of the recommendations that are relevant to these programs and this evaluation; points related to people who inject drugs have been omitted. Text from the WHO guidelines is numbered as in the source document and presented in brackets; the evaluators have added additional comments relevant to implementation of the recommendations, with the most important elements underlined for emphasis.

Taken from: WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Care and Treatment for Key Populations: 2016 Update

Health sector interventions	Included in current MSF minimum package
«1. The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).» Comment by evaluators: Best distributed to SW at no cost by SWPE with NGO/CBO affiliation; number of condoms distributed must match consumption (which for SW is much higher than for general population) so MoH unlikely to meet needs; if NGO cannot provide sufficiently at no cost, best alternative would be bulk purchase to minimize unit cost.	✓
«2. Oral pre-exposure prophylaxis (PrEP) containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for key populations at substantial risk of HIV infection as part of combination HIV prevention approaches.» Comment by evaluators: This is not freely available in Malawi or Mozambique, although the situation is in flux. This links to a major point on advocacy by NGOs for new, injectable PrEP, but oral TDF-containing PrEP can still be used effectively by at least a minority about 35%) of SW. Follow-up HTC is crucially important as breakthrough HIV infections will rapidly select for TDF resistance if PrEP is continued after infection.	
«3. Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.» Comment by evaluators: This can be made maximally accessible by equipping SWPE with starter kits, but successful implementation also requires addressing the stigma associated with HIV medications which is likely a factor in under-utilization of PEP. With NGO involvement, MoH providers need sensitization around the frequency of risky exposures for SW and the likelihood of repeated requests (in the absence of PrEP availability).	✓
«9. Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.» Comment by evaluators: This is an essential NGO/CBO activity; it should happen on the initial contact with a SW and she should be given clear advice on the next step (initiate ART, restart ART, re-test in 3-6 months, PrEP offer if available).	✓
«10. Key populations living with HIV should have the same access to antiretroviral therapy (ART) and to ART management as other populations.» Comment by evaluators: While MoH should provide this service, SWPE play an important role in education of SW patients and navigation to health services to support linkage.	

«11. All pregnant women from key populations should have the same access to services for prevention of mother-to-child transmission (PMTCT) and follow the same recommendations as women in other populations.» Comment by evaluators: see previous comment.	
«12. Key populations should have the same access to tuberculosis (TB) prevention, screening and treatment services as other populations at risk of or living with HIV.» Comment by evaluators: TB screening is inconsistently performed but could be a more effective SWPE activity after re-training; preventive TB treatment (for HIV+ SW) is unrealistic except for highly motivated, non-mobile persons; treatment referral and completion will benefit from navigation by SWPE.	✓
«13. Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.» Comment by evaluators**:** Hepatitis B screening & vaccination has been used as a point of (NGO/CBO) access to KP, apart from its intrinsic value; it demands resources that most NGO/CBOs do not have, particularly for decentralized services, so health system linkage is more feasible.	
*«14. Routine screening and management of mental health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from co-counseling for HIV and depression to appropriate medical therapies.»** Comment by evaluators: Counselling beyond that which is HIV-related is poorly available mainly due to lack of personnel trained in mental health, and/or in trauma- and violence-informed care (TVIC). This is ideally a service that NGO/CBOs should provide because they have the access to and trust of SW in need, and because MoH services are unlikely to have sufficient resources to provide such services.	
«15. Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.» Comment by evaluators: SWPE affiliated with NGO/CBOs already provide screening but specific treatment requires consultation with a nurse, medical assistant or clinical officer – this should be a low-barrier service but, in the absence of decentralized clinical services, linkage to a health facility is required.	✓
«16. People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options.» Comment by evaluators: SWPE and counsellors can provide information on contraceptive choices in the community such that consultations at health facilities are more focussed and quicker.	✓
«17. Abortion laws and services should protect the health and human rights of all women, including those from key populations.» Comment by evaluators: Abortion is legal Mozambique but access can be enhanced through education and navigation. Access will be optimized if pregnancy testing is early (<12 weeks gestation) as ToP is medically and administratively simpler then.	
«18. It is important to offer cervical cancer screening to all women from key populations.» Comment by evaluators: This will usually require referral to MoH services but can be optimized by (i) direct NGO provision of service by a certified provider, or (ii) support to the MoH (materials & equipment) if availability is compromised.	
«19. It is important that all women from key populations have the same support and access to services related to conception and pregnancy care, as women from other groups.» Comment by evaluators: Apart from pregnancy diagnosis, which should be provided by NGOs, navigation to MoH services should be the norm.	

** The evaluators would like to draw special attention to this point and emphasise its pertinence to the projects.*

ANNEX X: THE UN CONVENTION ON THE RIGHTS OF THE CHILD IN RELATION TO SEXUAL EXPLOITATION OF YOUTH

We have recommended that programs targeting youth involved in sex work take an approach with more explicit acknowledgement that, for persons under the age of 18 years involvement in transactional sex, from the perspective of the Convention on the Rights of the Child, defined as sexual exploitation. One hundred and ninety-six countries are states parties to this convention, including Malawi and Mozambique.

The full text of the Convention can be found at https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

The articles most directly relevant to our recommendation are:

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Comments:

These commitments are, we recognize, very difficult to implement in resource-limited contexts where early sexual debut is commonplace. We are *not* suggesting a primarily legal or punitive approach to contraventions of these principles. There is a place for advocacy, both locally and nationally, on the protection of children from abuse and exploitation, but this demands considerable cultural sensitivity and considerable information gathering at community and household levels beforehand.

We are suggesting a child-centred approach that emphasizes health, the well-being of the developing personality, and freedom from harmful coercion. The approach to sex-work involved youth cannot be focussed only on HIV and SRH concerns without programmatic consideration of the particular vulnerabilities of youth.

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