Stockholm Evaluation Unit

MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

EVALUATION OF THE MSF-OCB CORRIDOR PROGRAMS FOR KEY POPULATIONS

OCTOBER 2018

This publication was produced at the request of MSF OCB, under the management of the Stockholm Evaluation Unit. It was prepared independently by Richard Bedell and Victoria Bungay.

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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.

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