



**DIFFERENTIATED  
CARE**

# WORKSHOP REPORT

5-7 February 2018 - Cape Town, South Africa

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## **GLOBAL WORKSHOP ON DIFFERENTIATED SERVICE DELIVERY FOR KEY POPULATIONS:**

*Sharing success stories, showcasing hidden gems, strategizing next steps*

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## ACRONYMS

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<b>ART</b>	Antiretroviral therapy
<b>BMGF</b>	Bill & Melinda Gates Foundation
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CeSHHAR</b>	Centre for Sexual Health and HIV AIDS Research (Zimbabwe)
<b>CSO</b>	Community service organization
<b>CBO</b>	Community-based organization
<b>DSD</b>	Differentiated service delivery
<b>FAIR</b>	Family AIDS Initiative Response (Kenya)
<b>KP</b>	Key population
<b>IAS</b>	International AIDS Society
<b>MSF</b>	Médécins Sans Frontières
<b>MSM</b>	Men who have sex with men
<b>NCD</b>	Non-communicable disease
<b>PWID</b>	People who inject drugs
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>SWEAT</b>	Sex Workers Education & Advocacy Taskforce
<b>TASO</b>	The AIDS Support Organization (Uganda)
<b>GF</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization



Setting the ground rules of the workshop.

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# OVERVIEW OF WORKSHOP

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## BACKGROUND

The “Global Workshop on Differentiated Service Delivery for Key Populations” brought together nearly 50 participants from 20 countries to discuss the current state of service delivery for key populations over three days in Cape Town, South Africa. The following is a summary of discussions at the workshop and its recommendations.

Differentiated service delivery (DSD) [1] is increasingly being included within national HIV guidelines, but considerable work remains to be done to ensure that all people have access to differentiated services. With partners and with funding from the Bill & Melinda Gates Foundation (BMGF), the International AIDS Society (IAS) has led the development of a Decision Framework series. The Decision Framework series is designed to support the scale up of DSD by providing operational guidance on how to implement differentiated service delivery across the HIV care cascade and for specific populations. [A Decision Framework for antiretroviral therapy delivery](#) provides guidance on how to implement differentiated ART delivery, and [A Decision Framework for differentiated antiretroviral therapy delivery for children, adolescents and pregnant and breastfeeding women](#) draws purposeful attention to these specific populations.

Key populations, including men who have sex with men (MSM), people who inject drugs (PWID), sex workers and transgender people, are disproportionately affected by HIV and often underrepresented in HIV testing and treatment programmes. A series of global activities over the past two years has been convened in recognition that specific populations, including key populations, have inadvertently been excluded from differentiated service delivery approaches.

## PURPOSE

The purpose of the workshop was to inform the content, scope and best practices that should be included in a Decision Framework for differentiated care key populations, a document that will guide programme managers on how to implement differentiated service delivery models in their contexts.

## OBJECTIVES

The workshop objectives were:

- To increase understanding on how organizations from around the world are delivering care to key populations
- To collaboratively identify what strategies affect the effectiveness and efficiency of DSD for key populations
- To improve global consensus on means of supporting scale up of DSD for key populations.

These activities include:

**NOVEMBER 2016** – The World Health Organization (WHO) hosted a [global consultation](#) on how to extend DSD to specific populations, including key populations.

**JULY 2017** – WHO, along with the Centers for Disease Control and Prevention (CDC), President’s Emergency Plan for AIDS Relief (PEPFAR), United States Agency for International Development (USAID) and the IAS, published [Key considerations for differentiated ART delivery for specific populations](#), recognizing that DSD could benefit specific populations, including key populations.

**OCTOBER 2017** – WHO, in collaboration with the IAS, published a call for programme examples to collect good-practice programme examples of differentiated ART initiation and delivery to key populations.

**FEBRUARY 2018** – The IAS convened the [“Global Workshop on Differentiated Service Delivery for Key Populations”](#) to inform the content, scope and best practices that should be included in a Decision Framework for key populations.

## STRATEGIES

Strategies used in the workshop covered a variety of aspects, including:

- Discovering best-practice examples of DSD from across the care continuum for key populations
- Debating if and how to leverage momentum for DSD to support improving the quality of care for key populations
- Discussing how each group of stakeholders can work collaboratively to move the DSD agenda for key populations forward
- Determining the key enablers of supporting scale up of DSD for key populations
- Drafting a priority list of strategic next steps.

## FORMAT

The workshop agenda was designed to maximize interaction and participation while providing a focus on showcasing, sharing and strategizing. It included a variety of participatory methodologies to maximize interaction between participants.

During the first and second showcase sessions, participants were divided into three groups and the presenters rotated from room to room, each giving their presentation three times. Fireside chats (one-on-one interviews) and a panel format were used for the sharing part of the workshop.

Strategizing sessions were undertaken each afternoon of the first two days. Here, participants were divided into three groups: policy; providers; and peers. There was also time on the agenda to listen and learn from key population representatives, to hear about the vital role of peer providers, to participate in a debate and to engage in moderated discussions. See Appendix 1: Workshop agenda.

## PARTICIPANTS

Workshop participants came from a wide spectrum of persons working on or supporting the area of differentiated care. Nearly 50 participants representing 20 countries took part in the three-day workshop. Participation and interaction was vibrant.

Many participants came from local community-based organizations (CBOs) representing or working with a variety of key populations, including gay and other men who have sex with men, sex workers, trans women and people who inject drugs. Several people represented government health services providing services for key populations and/or working with key population CBOs. Several international agencies that support work on differentiated care were represented. See Appendix 2: List of participants.



All workshop attendees were active participants.

# WORKSHOP PROCESS HIGHLIGHTS

## INTRODUCTION

IAS President Linda-Gail Bekker, who lives in South Africa, opened the workshop and welcomed participants. She noted the importance of the workshop in terms of access and quality services for “those left behind”. She emphasized the vital need to address inequities in the quest for universal access, saying that we need “tailored, affordable, effective and efficient” responses.

Anna Grimsrud, the primary workshop organizer for the IAS, introduced participants to what she referred to as a “different format”, stressing that this was not a meeting but a workshop. She walked the participants through the agenda, outlining tasks over the three days. Those present then participated in an icebreaker exercise as a way of meeting each other. Kevin Osborne, the IAS Director of HIV Programmes and Advocacy, elicited ground rules for the workshop and challenged the group to come back with creative ways to save water as the host community of Cape Town is suffering a severe drought.

Anna laid out the key aspects of DSD. It is: client centred; data driven; uses outsourcing; and uses peer delivery as a means of inclusion for those left behind.

As an introduction to DSD, Tom Ellman from *Medécins Sans Frontières (MSF)* showed a video of the *GOALKEEPERS* series, outlining the situation and the need for DSD. He noted that we often “think we know it all”. He added that we need to take a closer look at home, listen to patients, trust the perceptions of target populations and adapt accordingly. Effective DSD, he said, takes this approach. It is best, he said, to work from the bottom up – using simplified and often de-medicalized means to ensure that excluded people get access to health services and treatment.

Representatives of key populations gave opening remarks about “Responding to the realities of key populations”. They outlined many aspects of key population (KP) exclusion from accessing quality health services due to situations such as: an already overburdened health system being unwelcoming to KPs and medical professionals being reluctant to treat members of key populations; legal issues, such as criminalization of sex work, homosexuality and drug use; law enforcement (drug enforcement, police, judiciary, etc.) impeding access to treatment; pervasive stigma, discrimination and violence towards KPs; and KPs who, outside urban areas, remain hidden and reluctant to access potentially hostile services.

They noted that differentiated service delivery is necessary and often provides the “best way to provide care” in difficult circumstances. It is important, one panellist said, to continue to advocate and work towards integration in existing services and “not take the government off the hook” in the process. The speakers pointed out that creating alternative services often requires strategic partnerships with health facilities and other organizations; they should be tailored to local needs and consider sustainability. Trust in partnerships is vital for success.



Alberta Komba from Jhpiego (Tanzania) completes the opening icebreaker



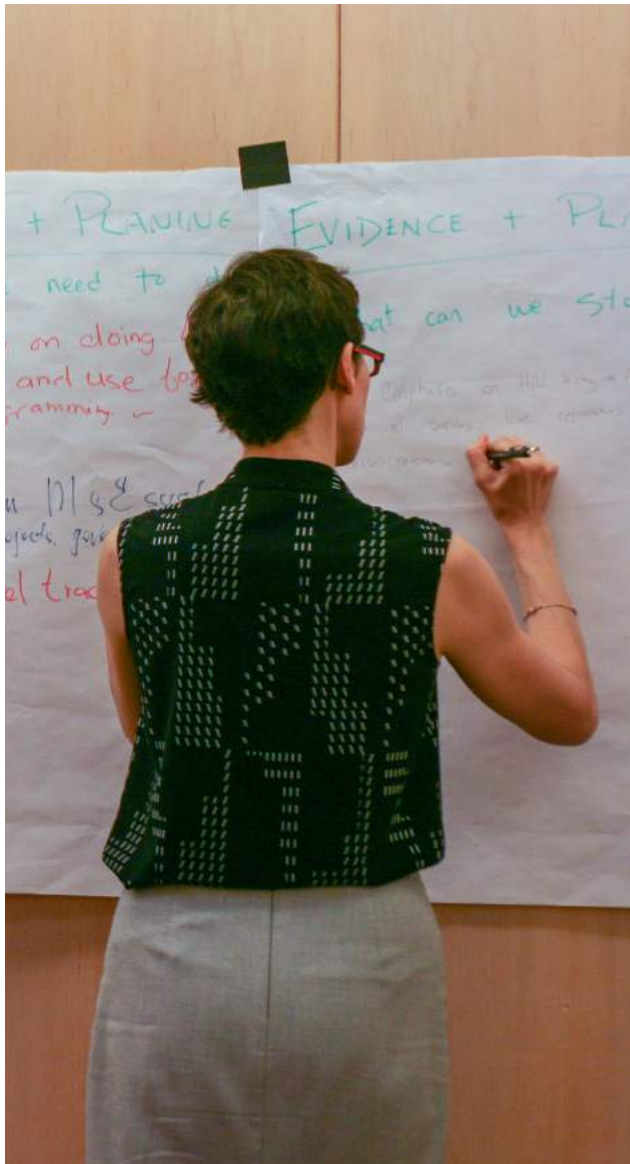
Kim Green, from PATH, gives her opening remarks in a debate on integration of services.

## SHOWCASE SESSIONS

The workshop had three showcase sessions where participants were given a chance to explain their services, successes and challenges.

The first session brought together six examples of DSD systems for different KP target populations, from: Anova Health; Sex Workers Education & Advocacy Taskforce (SWEAT) and OUT Well-Being in South Africa; the Prevention Department at the Thai Red Cross AIDS Research Centre and SISTERS Foundation in Thailand; the Sauti Project led by Jhiego with USAID support in Tanzania; and Project Sunrise run by FHI 360 and CDC in India. Around the globe, participants pointed to high prevalence rates for KPs, but low linkage to services and high loss to follow up.

The second showcase session focused on two examples of DSD with a policy perspective from WHO, Swaziland and Jamaica.



All delegates participated in the breakout group work sessions.

Following an overview presentation from WHO, speakers from each country included a representative of the national ministry of health and a representative of a KP CBO that works collaboratively with the ministry of health.

Highlights of the session included the need for a policy framework for collaboration so that governments are better able to support CBO endeavours and provide for task shifting and outsourcing.

Collaboration between the two sectors facilitates decentralized service delivery. Consultation with target populations and collaboration in training and sensitization were identified as essential strategies.

In order to change this, the presenters suggested several strategies that show promise:

- Bring the medicine to the people, and use CBOs as part of the supply chain mechanism.
- Doctors need to hear from communities so that communities are “put into the driver’s seat”. This includes consulting with communities and using both providers and peers in training communities and/or health service providers.
- Dealing with mistrust and building trust is essential. It takes time to establish a reputation and vigilance to keep it.
- Different models for low- and medium-density (small town and rural) KP populations are needed that maintain confidentiality and provide comprehensive care.
- A phased (and/or tiered) approach often works best. Develop this over time, consolidate and document, and expand.
- Peers are vital to the process, but they often need training on HIV, rights, options of services available, treatment literacy, etc.
- In hostile environments, strategic partnerships, creative approaches and care with language are imperative.

The third showcase, on Day 3, brought together participants from MOLI in Burundi, John Snow International in Ghana, the Centre for Sexual Health and HIV AIDS Research (CeSHHAR) in Zimbabwe, The AIDS Support Organization (TASO) in Uganda, STAR-STAR in Macedonia, J-FLAG in Jamaica, and the Family AIDS Initiative Response (FAIR) in Kenya.

Case studies were presented, outlining successful strategies. Some examples:

- Community client-led antiretroviral treatment (ART) delivery systems can work very effectively and efficiently by widening outreach, providing opportunities for adherence support and lessening the demands on overburdened health providers.
- Nurses and peers working together help link clients with health services.
- Using drop-in centres run by peers as an ART delivery point works effectively when combined with comprehensive training.
- Training of peers and health providers alike should be a combination of competency and sensitivity training. It should also consider the importance of confidentiality and monitoring.
- Providing training for peers and health providers is important to deal with internalized stigma, as well as experienced stigma and discrimination.
- Trained peers can effectively undertake a combination of tasks, including linking to services, community mobilization and empowerment, and lay paralegal and child protection services.
- Social justice and paralegal organizations can be resilient partners in HIV training and service delivery.
- Social media can be an effective tool in social mobilization, as well as in data collection.
- Working in hostile social environment often takes intense interpersonal advocacy with health delivery and law enforcement partners.



Kate Thomson (Switzerland) speaks with Ken Morrison (Mexico) and Gautam Yadav (India).

## SHARING SESSIONS: FIRESIDE CHATS

One Day 1, Kevin Osborne from the IAS interviewed Gina Dallabetta, Senior Program Officer for Integrated Delivery at the Bill & Melinda Gates Foundation. Gina reflected on history and the current situation of HIV-related service delivery.

With the advent of effective ART, she noted, focus on prevention has been reduced, and in the process, key populations have been left behind. When asked about lessons over time, she used the example of Avahan to note the centrality of having solid “data for decision making” and functional supervision systems in partnerships.

On Day 2, Ken Morrison (Mexico) and Gautam Yadav (India) interviewed Kate Thompson, Head of Community, Rights and Gender at the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF).

Kate was diagnosed with HIV in 1987. She spoke about how she did not see any women living with HIV around her and, despite close friendship networks with HIV-positive gay men, she felt very isolated. She said she had to take a lead in shaping the response and supporting communities of women living with HIV as other were doing so. Over time, she, along with a few other colleagues, became heard and respected through the UK-based Positively Women organization and subsequently the International Community of Women Living with HIV. For the past 17 years, she has been working with global agencies (United Nations and the GF).

When asked about lessons, she explained that community empowerment has been effective in so many ways, but that it often starts on a very small scale. What has changed over time? “There has been lots of progress, lots of change – especially in relation to treatment access, but so much has stayed the same,” she said, pointing to legal, gender-related and social barriers that impede access to prevention, treatment and support.

When asked about the GF, Kate remarked that it is a partner to the community, and, like other global partners, pushing in the same direction with a person-centred, gender-responsive and human rights agenda that places an important focus on scaling up community-led responses as a critical element of broader systems for health.”



Tanya Shewchuk from the BMGF responds to questions during the discussion with funders session.

## SHARING SESSIONS: PANEL DISCUSSIONS

On Day 2, a panel of programme managers shone the spotlight on strategies that work. Chris Akolo from the USAID LINKAGES Project related the experience of the many projects that LINKAGES supports. He noted that DSD can be used across the prevention-care-treatment cascade. He emphasized the importance of peer-led approaches, as well as the key role of drop-in centres as antiretroviral distribution points. Clinical support services supported by ministries of health are effectively delivered in drop-in centres with weekly timeframes with clinicians and/or nurses. Many of the CSOs supported by LINKAGES have test and referral experience to which DSD is an add-on that has shown remarkable results in uptake of services.

Kim Green, the HIV/TB/NCD Program Director and Chief of Party for the USAID/PATH Healthy Markets project, Vietnam, recounted the DSD experiences and lessons of USAID/PATH in Vietnam. She explained that early in the programme, PATH recognized that “one size does not fit all” and began to pilot new approaches in HIV service delivery using KP-led CSOs. She said that sustainability is a constant challenge and that in response CSOs are registering as “social enterprises”, opening the door for possible private sector and government financing. She also pointed to the value of online apps for greater outreach, information dissemination, booking services and data collection. In a few sites, pre-exposure prophylaxis is now being offered to key populations. She said that in terms of prevention, project staff work closely with KPs to change to positive aspirational messages.

Tom Ellman recounted his organization’s adapting of alternative models for service delivery based on extensive experience in conflict zones: how to get services to excluded, invisible and mobile populations. Peer delivery, “the community essence of delivery” in politically hostile settings, requires peer champions and sensitized staff. It also requires that peers participate in the design, as well as rollout, of interventions. He added that peers can be used successfully across the prevention-treatment cascade as outreach workers, referral agents, paralegal support and service delivery personnel where task shifting becomes an integral part of the differentiation. He also noted the importance of addressing corollary issues for key populations, including disease progression, mental health, addiction and reproductive health.

Keerti Gedela from Dean Street Clinic in London highlighted its successes and challenges in responding to KPs, primarily gay and other MSM, in an overburdened health system. She pointed to the need to bring services closer to the target population. Creative use of technologies, such as a self-administered sexual history and videos, as part of the pre-test counselling process is making a difference in efficiencies and in response rates. Dean Street Clinic, over time, designed special services for particular subpopulations of MSM, such as sex workers and men using drugs in conjunction with sex (chemsex), as well as trans women.



Group work stimulated discussion on the importance of peer providers.



Chris Akolo discusses key findings from the LINKAGES programme.

## DEBATE

To integrate or not: that is the question. Kim Green from the Healthy Markets project sparred in a spirited debate with Albert Komba, Chief of Party, Sauti Project, USAID/PEPFAR HIV Combination Prevention Project for Key and Vulnerable Populations, Tanzania. Kim said that integration is “a continuum ... like building a ship while sailing”, but for sustainability and effectiveness, it is the best option. Albert said that in hostile environments, integration is not an option – working around government services and policies in a parallel fashion is essential. While both arguments were cogently laid out, it was noted that effectiveness must be measured with efficiency and sustainability. Service delivery systems must be gauged against what is going to work. What is effective to get people on to HIV treatment if they are HIV positive?

Discussants and participants stood on the speakers’ box to add their comments to the debate. One remarked that the discussions of a parallel model notwithstanding, changes in existing services are needed, that “science can help to simplify a complex world”. Another said that “the problem with parallel services is the willingness to fund them”.

The moderator summed up the discussion, pointing out that this was not an either/or discussion, but a process. Local contexts, local health systems and the level of stigma and violence will determine how to reach otherwise excluded key populations. Integration is the goal but, in many contexts, introduction of differentiated services is a necessary step to get there.



Pascal Macharia (Kenya), Keerti Gedela (UK), Sakhumzi Mose (South Africa) and Tendayi Mharadze (Zimbabwe) debate from the soapbox.

## MODERATED DISCUSSIONS

A group discussion on “The power of peers” brought together participants from Thailand, Uganda, Vietnam and Zimbabwe. They discussed not only the vital role that peers play in testing, counselling and linking to health services, but also the need to change the way we perceive, train and use peers. Peers can be an integral part of the ART supply chain, key facilitators of social mobilization, adherence counsellors, case managers, data collectors, providers of training and technical assistance to healthcare workers, and advocates that raise community concerns. Local contexts determine the right fit. Community leadership is imperative. Overcoming government resistance to KP programmes requires better data and documentation of success stories.

The second moderated discussion revolved around funds, fundraising and funding realities with representatives from PEPFAR, the CDC, the GF and the Bill & Melinda Gates Foundation. Speakers acknowledged how valuable the workshop was in terms of hearing about KP experiences in service delivery. They noted the need for better evidence and data to make the case for DSD that goes beyond yield (albeit recognizing that this is an important indicator) and requires asking and listening intently to KPs, as well as the need for improved documentation to be used in advocacy. It was described as “stories presented in a compelling way”.

Speakers noted the need for funders to develop better mechanisms to support innovative DSD programming, measurement and documentation of DSD, and to enable better sustainability. In the discussion, the vital role of funders was highlighted in helping governments and communities support DSD in areas such as: social contracting; task shifting; supply chain options; transition planning; accountability; and capacity of CBOs to absorb and effectively use funds.

In the question period, a participant stated, “It is hard to have help from a country that does not recognize your existence.”

## STORY HOUR

Two young men told their own personal history of how and why they got involved in the response to HIV. Touchingly personal, they told very different yet strikingly similar stories of personal fear and fright as teenagers, and the evolution – much of it around HIV testing – to community activism, advocacy and eventually service delivery.

As one put it, “I waited seven days for my test result, the longest week of my life.” Both told how they arrived at the realization that there were other people like them who needed help; one then chose to an activist and one chose to be a peer educator. “Now we raise our own voice,” one declared. “We are not hiding anymore.”



Oksana Bryzhovata, Thitiyanun Doi Nakpor (SISTERS, Thailand) and Ajamia Makawa (CeSHHAR, Zimbabwe) during “The power of peers” session.

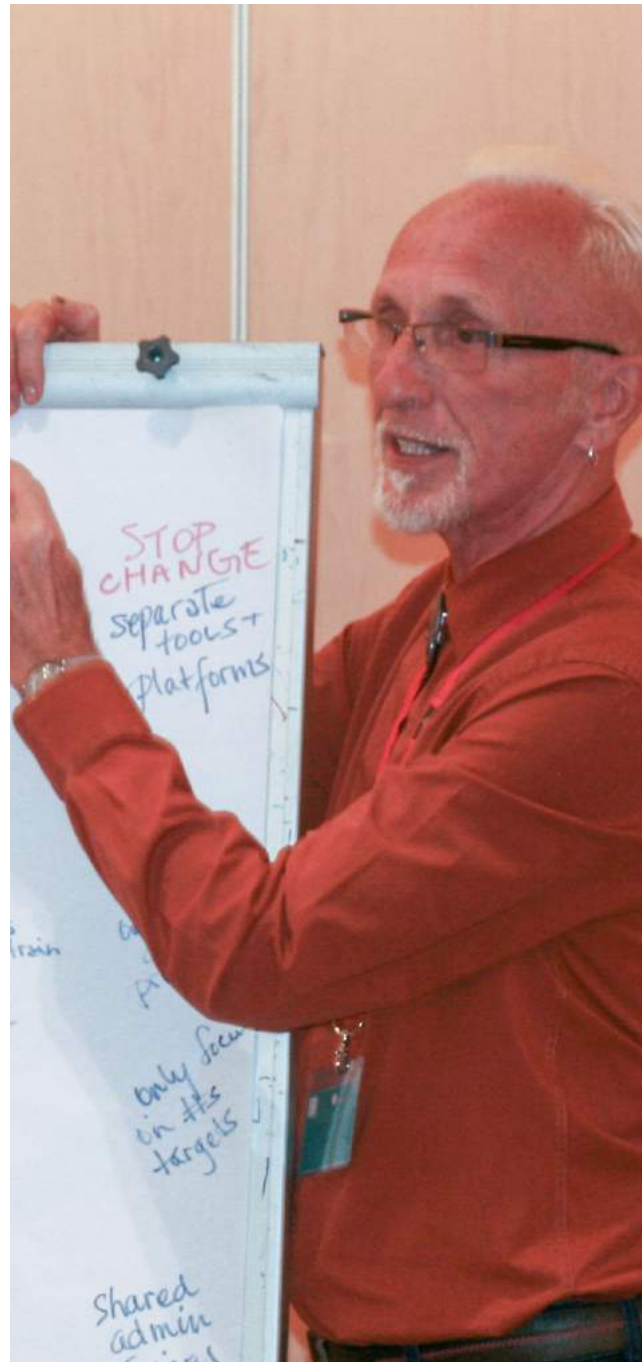
## STRATEGIZING SESSIONS

Over two days, three groups had moderated discussions exploring their personal and organizational experiences and looking at strategies that are needed and have shown signs of success. The workshop participants were divided into three groups: peers; providers; and policy people. Groups discussed strategies in two sessions over two days. On the third day, they reported on the key strategies that they recommended.

### PEERS

The Peers group outlined five priority strategies for DSD:

1. DSD for KPs should address not only the complete spectrum of prevention, care and treatment for HIV, but also comprehensive health needs of key populations (for example, mental health, hormonal therapy, economic independence, other SRH services and co-morbidity issues).
2. Community-led research, documentation of successes and community-driven data for decision making are important.
3. Social media should be better used to reach marginalized populations (information on sexual health, orientation to services, making appointments, collecting data, anonymous social support, etc.). Data protection must be taken into account, especially in hostile environments.
4. KPs should be involved in service provider training and sensitization (personalized touch).
5. Focus on capacity building for peer educators and support group leaders in more than just HIV care (for example, advocacy, rights and responses, innovative fundraising, sustainability models, and data collection and analysis).

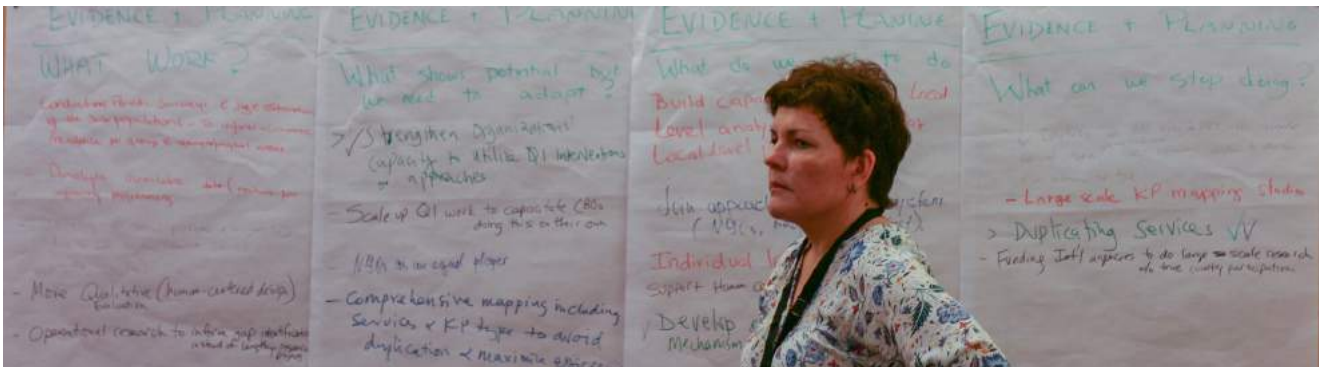


Co-facilitator Ken Morrison discusses ideas with the Peers group.

Other areas of discussion included: the vital importance of peer support and the potential key role of peers in service delivery; the need to share tools and platforms for social mobilization, monitoring and communication; the need for comprehensive approaches to the whole person and his/her health; measurement beyond yield and target numbers; and the central need for better data and documentation.



Sherika Anderson from the Jamaican Ministry of Health listens to the discussion.



Olga Gvozdetska from the Ukraine stands alongside the brainstorming done by the Policy group.

## PROVIDERS

The Providers group pointed to three central themes in priority strategies:

1. Training of “providers”
2. Knowing your target population
3. Recognition of the value added by peers and community organizations.

In relation to training of providers, Providers noted:

- The valuable use of modular techniques, as well as experiential learning using coaching and mentoring
- The intrinsic value of using peers in the training process
- Ensuring that all personnel have sensitive attitudes to KPs, as well as an openness to drugs and sexual health. Personnel include everyone at the health facility – from security guards to receptionist, janitors and clinical staff.
- Encouraging accreditation for peer providers and training of all cadres in health centres
- Reinforcing the notion of “peers as providers”.

In relation to knowing your population, the group said that the process of “taking stock”, of diagnosing local context and KP needs, is vital. Members highlighted mechanisms to dialogue with communities, to ask and to listen. The point was made that one can provide services, concurrently gather data, and adapt along the way.

The group added that better use of techniques, such as unique identifiers, will help better track service use. It also noted that research techniques, such as snowballing, are effectively used to locate hard-to-reach populations and get them linked to services.

In relation to the recognition of the value of peers and CSOs, it stressed the importance of challenging policies that prevent or impede community delivery of care and task shifting. Group members commented that peers are not a homogenous group and that we need to define what it is that peers do in order to better inform normative guidance.

Collaborations will improve with less vertical organizational charts and more dialogue with clients. We need to better document successful models of community service delivery and share with providers and decision makers. Better use of technology to track and document will help with this process.

Provider champions should be harnessed in advocacy for DSD. There should be more sharing of tools and models, more time to debrief with key population providers, and more creative use of existing platforms (closed Facebook or WhatsApp groups). The group ended with questions, such as how to balance minimum standards of care and systematization with flexible models adapting to population needs.

## POLICY

The Policy group reported back on three areas:

1. Evidence and planning
2. Resource mobilization
3. Political will

In the area of evidence and planning, group members indicated that data is available but not always known, aggregated or analysed. They suggested that local data be used more effectively for advocacy and planning. In the process, we need to better distil learning and create compelling messages.

The group emphasized the need for one streamlined monitoring and evaluation framework (tools and benchmarks) for country KP programmes. It is time, members said, to stop emphasizing only yield and to cut down on duplication.

In the area of resource mobilization, the group prioritized several strategies, including:

- Taking pilots that work to scale
- Advocating for more public-private partnerships, social contracting and social enterprising for CSOs
- Adding a business approach of performance-based service provision
- Reducing inefficiencies by improving leadership and coordination.

In the area of political will, the group recommended that global agencies work with governments in leveraging and co-financing DSD for key populations.



Virginia Macdonald (left) and Tanya Shewchuk (right) report back from the Policy group.



**InFocus**

*Collaboration That Works*

# WORKSHOP OUTCOMES

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## MAJOR EMERGING THEMES

The emerging themes from the “Global Workshop on Differentiated Service Delivery for Key Populations” included:

- **Social exclusion impedes access by key populations to health services around the world.**
- **Differentiated service delivery should be expanded to reach more key populations.**

Models for ART delivery can effectively be built by expanding existing outreach and/or testing services.

Social isolation is a result of rejection and fear. Providing and using opportunities for subpopulation exchange is vital (telephone technology, social media and drop-in centres).

Populations excluded from health services often need alternatives for access. This can best be ascertained by knowing your target population’s perceptions and preferences.

The workshop highlighted some best-practice examples from around the world, specifically examples of differentiated ART delivery. Through various discussions, DSD models of ART delivery should consider alternative criteria to expand access. Currently, stable clients who have good adherence are eligible, and so those with no opportunistic infections and evidence of treatment success (for example, suppressed viral load and increasing CD4) are being enrolled. We are missing the vulnerable KPs for whom DSD will be most beneficial.

DSD should be expanded to include prevention services – at the moment, most are limited to care and treatment.

- **Although creating integrated services and universal access is a long-term goal, in existing circumstances, differentiated service delivery is necessary for many communities around the globe if we want to reach universal access.**

Peers are a vital link into communities. They should be trained, accredited and positioned in relation to health services. Efficient and effective systems for ART delivery can build on existing key population structures for testing and prevention, as well as organizations working on social justice, community research and advocacy.

Alternative methodologies for training (such as mentoring and coaching) can be effectively employed and there should be better recognition of the power of “peers as providers”.

Political commitment should be built to recognize and support DSD structures for key populations. This requires good local data for decision making, successful models for consideration, and mechanisms to support innovation and scale up.

- **Data is important, but it’s not just about data.**

Communities should be equipped to collect and utilize data both for programmatic purposes and to highlight their contributions and successes to potential funders.

Data is one component of documenting successes and it can be an illustrative way to share stories.

Advances in technology and increased access to mobile phones should be leveraged to collect data, report back and expand community monitoring.



Thitiyanun Doi Nakpor (left) and Leigh Ann van der Merwe (right) draft their key take-home messages from the workshop.

## NEXT STEPS

### 1. Workshop report

- The IAS will coordinate and issue a report to participants in March.
- After a period of receiving comments, it will be posted on the differentiated care website.

### 2. A Decision Framework for differentiated antiretroviral therapy delivery for key populations

- The IAS will coordinate production of a Decision Framework for key populations.
- It will launch the framework at the International AIDS Conference in Amsterdam in July 2018.

### 3. Website

- Site: <http://www.differentiatedcare.org> / [www.differentiatedservicedelivery.org](http://www.differentiatedservicedelivery.org)
- Participants were encouraged to use the website to share tools, research reports and effective models.

### 4. International AIDS Conference

- It takes place in Amsterdam in July 2018.
- The IAS is committed to launching the Decision Framework and pushing for opportunities to discuss and present successful models for differentiated care.

Participants expressed their appreciation to the organizers. Some of their comments:

***“Being with colleagues doing similar work was a real eye-opener.”***

***“I thought I knew it all, but I got a lot of information here that I can use to help my community.”***



Participants from the Peer group celebrate a successful workshop.

# APPENDIX 1: AGENDA

## DAY 1 – MONDAY, 5 FEBRUARY

Time	Session	Chairs & speakers	Venue
07h30-08h30	REGISTRATION & WELCOME		
08h30-9h30	INTRODUCTION TO THE WORKSHOP		Plenary room
09h30-10h00	BACKGROUND TO DIFFERENTIATED SERVICE DELIVERY		Plenary room
10h00-10h30	RESPONDING TO THE REALITIES OF KEY POPULATIONS		Plenary room
10h30-11h00	Coffee		
11h00-12h30	<p><b>SHOWCASE, PART 1</b></p> <p><b>A</b> Johan Meyer – South Africa (OUT Wellbeing), Jayne Arnott – South Africa (SWEAT)</p> <p><b>B</b> Reshmie Ramautarsing – Thailand (Thai Red Cross), Thitiyanun Doi Nakpor – Thailand (SISTERS), Albert Komba – Tanzania (Sauti)</p> <p><b>C</b> Aditya Singh &amp; Sampath Kumar – India (FHI360, Project Sunrise), Kevin Rebe – South Africa (ANOVA)</p> <p><b>Chairs (Turquoise room):</b> Annette Verster &amp; Leigh Ann van der Merwe</p> <p><b>Chairs (Orange room):</b> Henry Nagai &amp; Olga Gvozdetska</p> <p><b>Chairs (Grey room):</b> Gregory Brighton Kata &amp; Trista Bingham</p>		
		<b>A</b> Turquoise name tag	Turquoise room
		<b>B</b> Orange name tag	Orange room
		<b>C</b> Grey name tag	Grey room
		<b>B</b> Turquoise name tag	Turquoise room
		<b>C</b> Orange name tag	Orange room
		<b>A</b> Grey name tag	Grey room
		<b>C</b> Turquoise name tag	Turquoise room
		<b>A</b> Orange name tag	Orange room
<b>B</b> Grey name tag	Grey room		
12h30-13h30	Lunch		
13h30-14h00	<p><b>SHARE PART 1</b></p> <p>Fireside chat – Progress and pitfalls</p>	<p>Interviewers - Kevin Osborne (IAS) &amp; Pascal Macharia (HOYMAS)</p> <p>Discussant - Gina Dallabetta (BMGF)</p>	Plenary room
14h00-15h30	<p><b>STRATEGIZE PART 1 (Group work)</b></p> <ul style="list-style-type: none"> <li>• <b>Policy</b> – black lanyard</li> <li>• <b>Provider</b> – blue lanyard</li> <li>• <b>Peers</b> – red lanyard</li> </ul>	Providers (Facilitators: Chris Akolo & Anna Grimsrud)	Turquoise room
		Peers (Facilitators: Kevin Osborne & Ken Morrison)	Orange room
		Policy (Facilitators: Virginia Macdonald & Tanya Shewchuk)	Grey room
15h30-16h00	Coffee		
16h00-17h00	WALKING DEBRIEF		All rooms

**DAY 2 – TUESDAY, 6 FEBRUARY**

Time	Session	Speakers	Venue
08h30-09h00	<b>SUMMARY OF DAY 1</b>		Plenary room
09h00-10h00	<b>SHOWCASE, PART 2</b> <b>Policy perspectives</b>  Chair – Keerti Gedela	Annette Verster & Virginia Macdonald (WHO)  Swaziland – Sindy Matse (Swaziland National AIDS Programme) & Zandile Grace Dlamini (FLAS)  Jamaica – Sherika Anderson (Ministry of Health, Jamaica) & Jaevion Nelson (Equality for All Foundation)	Plenary room
10h00-11h00	<b>DEBATE</b> <b>To integrate or not integrate: that is the question.</b>  Chair: Ken Morrison	Lead 1 – Kim Green (PATH)  Lead 2 – Albert Komba, Sauti	Plenary room
11h00-11h30	Coffee		
11h30-12h30	<b>SHARE, PART 2</b> <b>Shining a spotlight on strategies that work</b>  Chair - Reshmie Ramautarsing (Thai Red Cross)	Chris Akolo (LINKAGES)  Kim Green (PATH)  Tom Ellman (MSF)  Keerti Gedela (Dean Street Clinic)	Plenary room
12h30-13h30	Lunch		
13h30-15h00	<b>STRATEGIZE, PART 2</b> <b>(Group work)</b>  • <b>Policy</b> – black lanyard • <b>Provider</b> – blue lanyard • <b>Peers</b> – red lanyard	Providers (Facilitators: Chris Akolo & Anna Grimsrud)	Turquoise room
		Peers (Facilitators: Kevin Osborne & Ken Morrison)	Orange room
		Policy (Facilitators: Virginia Macdonald & Tanya Shewchuk)	Grey room
13h30-14h00	<b>SHARE, PART 3</b> <b>Fireside chat - Rights and responses</b>	Chair – Ken Morrison & Gautam Yadav (Husafar Trust)  Discussant – Kate Thomson (Global Fund)	Plenary
15h30-16h00	Coffee		
16h00-16h45	<b>STORY HOUR</b> <b>Personal examples of success stories</b>  Chair – Tanya Shewchuk (BMGF)	Gautam Yadav (Husafar Trust), Doan Thanh Tung (Lighthouse Social Enterprise)	Plenary
16h45-17h00	<b>SOAPBOX DEBRIEF</b>		Plenary

**DAY 3 – WEDNESDAY, 7 FEBRUARY**

Time	Session	Chairs & speakers	Venue
07h30-08h30	<b>REGISTRATION &amp; WELCOME</b>		
11h00-12h30	<b>SHOWCASE, PART 3</b> <b>A</b> Irwin Iradukunda – Burundi (MALI), Henry Nagai – Ghana (JSI) <b>B</b> Tendayi Mharadze – Zimbabwe (CeSHHAR), Lazarus Oucul – Uganda (TASO), Borche Manev Bozinov – Macedonia (STAR STAR) <b>C</b> Jaevison Nelson – Jamaica (J-FLAG), Marion Awiti – Kenya (FAIR)	Chairs – same as Day 1	
		<b>A</b> Turquoise name tag	Turquoise room
		<b>B</b> Orange name tag	Orange room
		<b>C</b> Grey name tag	Grey room
		<b>B</b> Turquoise name tag	Turquoise room
		<b>C</b> Orange name tag	Orange room
		<b>A</b> Grey name tag	Grey room
		<b>C</b> Turquoise name tag	Turquoise room
		<b>A</b> Orange name tag	Orange room
		<b>B</b> Grey name tag	Grey room
12h30-13h30	Coffee		
13h30-14h00	<b>MODERATED DISCUSSION</b> The power of peers Chair: Oksana Bryzhovata, (All Ukrainian)	Doan Thanh Tung (Lighthouse Social Enterprise, Vietnam), Edith Ssenyonga (TASO, Uganda), Thitiyanun Doi Nakpor (SISTERS, Thailand), Ajamia Makawa (CeSHHAR, Zimbabwe)	Plenary room
11h30-12h30	<b>MODERATED DISCUSSION</b> Funding realities Chair – Kevin Rebe (ANOVA)	Discussants – Trista Bingham (CDC), Kate Thompson (Global Fund), Gina Dallabetta (BMGF)	Plenary room
12h30-13h30	Coffee		
13h30-15h00	<b>STRATEGIZE PART 3</b>		
	Group work		As per day 1 & 2
	Self reflections		All
	Closing comments		Plenary

## APPENDIX 2: LIST OF PARTICIPANTS

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Delegates listen to presenters during a showcase session.



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