# Linking Key Populations to Post-Test Services in Uganda

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# Outline

- Overview of key population needs and approaches to service delivery in Uganda
- Drop-in center (DIC) model of service delivery
- Post-test linkage approaches and outcomes
- Recent contextual challenges and impact on services

# Key Populations in Uganda

Key populations (KP) include sex workers, men who have sex with men (MSM), transgender persons, people in prison or incarcerated settings and people who inject drugs (PWID)

| Key Population Group | HIV Prevalence |
|---|---|
| Sex workers | 26%-55% |
| MSM | 4%-10% |
| Transgender persons | 5%-25% |
| People in prison or incarcerated settings | Male 11.1%<br>Female 21.1%[1] |
| PWID | 3%-14%[2] |

[1] Prisons survey 2022
[2] Crane Survey 2023 (Integrated Bio-behavioural Survey)

# Context of Service Provision for Key Populations

- Drug use, sex work and same sex relationships are criminalized
- However, non-discriminatory delivery of KP-friendly services has been prioritized in the National Health Policy and the National HIV Strategic Plan since 2011.
- Health sector policies and materials were revised, and new guidelines developed to guide and address KP issues, e.g., HTS, ART, DSD, DIC, Harm Reduction.
- Uganda's Anti-Homosexuality Act (AHA) in 2023 threatened HIV service delivery for KP groups, especially MSM and transgender people.

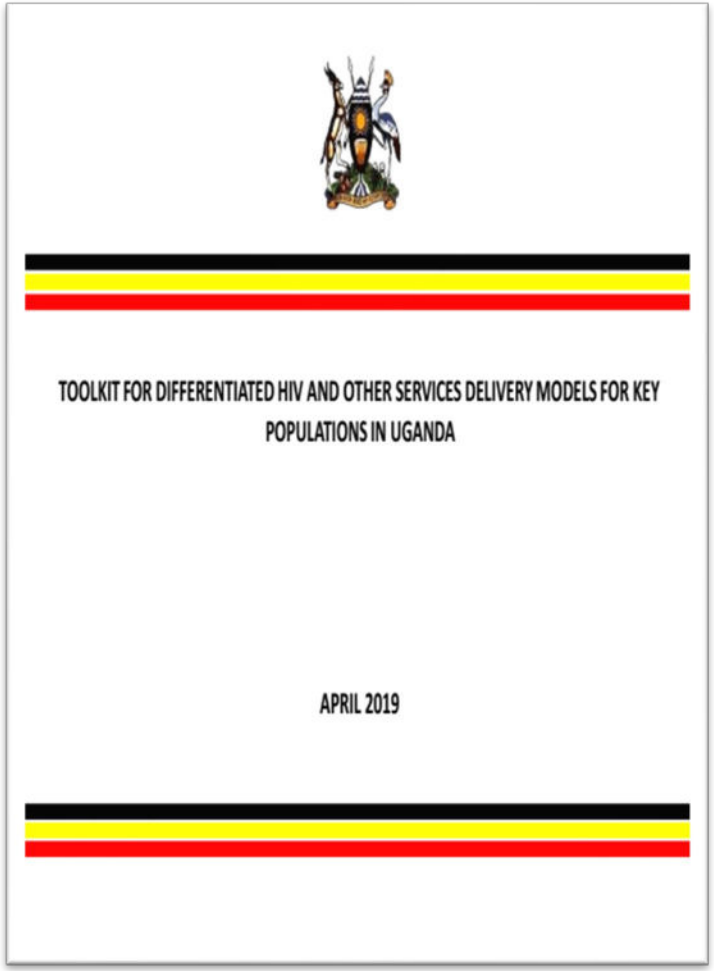
# Approach to Service Delivery for Key Populations

KP programming in Uganda at different levels:

- **National level** – multisectoral coordination led by Uganda AIDS Commission
- **Sectoral level** – the AIDS Control Program at MoH leads the public health response. MoH prioritizes provision of services with biomedical and behavioral interventions
- **District level** – MoH ensures efficient and effective implementation through district health teams, supported by civil society organizations (CSO) and implementing partners
- **Community level** – CSO, community-based organizations, networks and peer mechanisms support mobilization, service delivery/uptake and advocacy

# DSD Key Population Toolkit

- Minimum package of differentiated HIV prevention, care and treatment services
- DSD approaches for HTS, linkages, prevention services and ART services
- DSD services packages for people who use drugs, sex workers, MSM and transgender persons
- DSD services for mobile KP



# Most At Risk Population Initiative (MARPI)

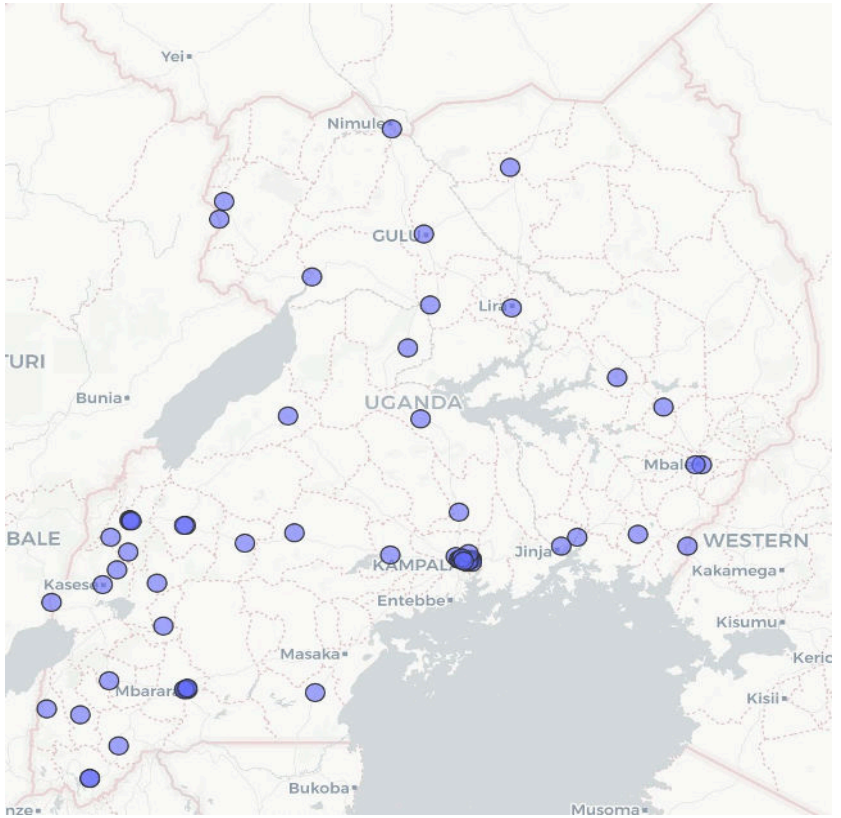
- The MARPI model is a strategy aimed at addressing the specific needs of KP.
- Implementing targeted interventions tailored to needs of specific KP
    - Interventions include outreach programs, peer education, condom distribution, harm reduction services, and provision of HTS, PrEP/PEP, ART, TB services, mental health services etc.
- MARPI Clinics –established in Government hospitals and operated by CSO supported by Global Fund (GF) and PEPFAR grants mainly
- MARPI Clinics operate drop-in centers (DICs) that are also located within government hospitals

# MARPI Model Key Components

- Active involvement and participation of KP in the design, implementation, and evaluation of HIV services through peer networks
- Addressing stigma, discrimination, and human rights violations
- Reduce barriers to accessing HIV services and empower individuals to seek care without fear of judgment or reprisal
- Engaging communities to build trust, identify barriers to accessing services, and tailor interventions to meet the unique needs of each population
- Monitoring and evaluating the effectiveness of HIV services for KP
- DIC at community-based facilities where KP can access a range of services in a non-judgmental and supportive environment

# Drop-in Centres and One-Stop-Shop Approach

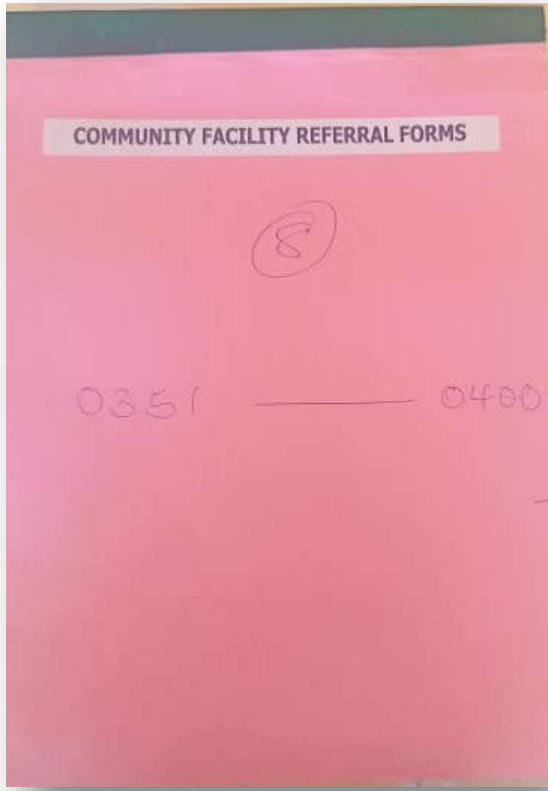
- Close to 100 DICs across the country
- Supported by:
  - Implementing partners
  - CSOs
  - Municipal councils
- DICs can be:
  - Co-located (established in facilities)
  - Stand-alone (established in communities where KP are concentrated)
- Services offered:
  - Health services
  - Recreational and socio-economic activities
  - Distribution of health commodities



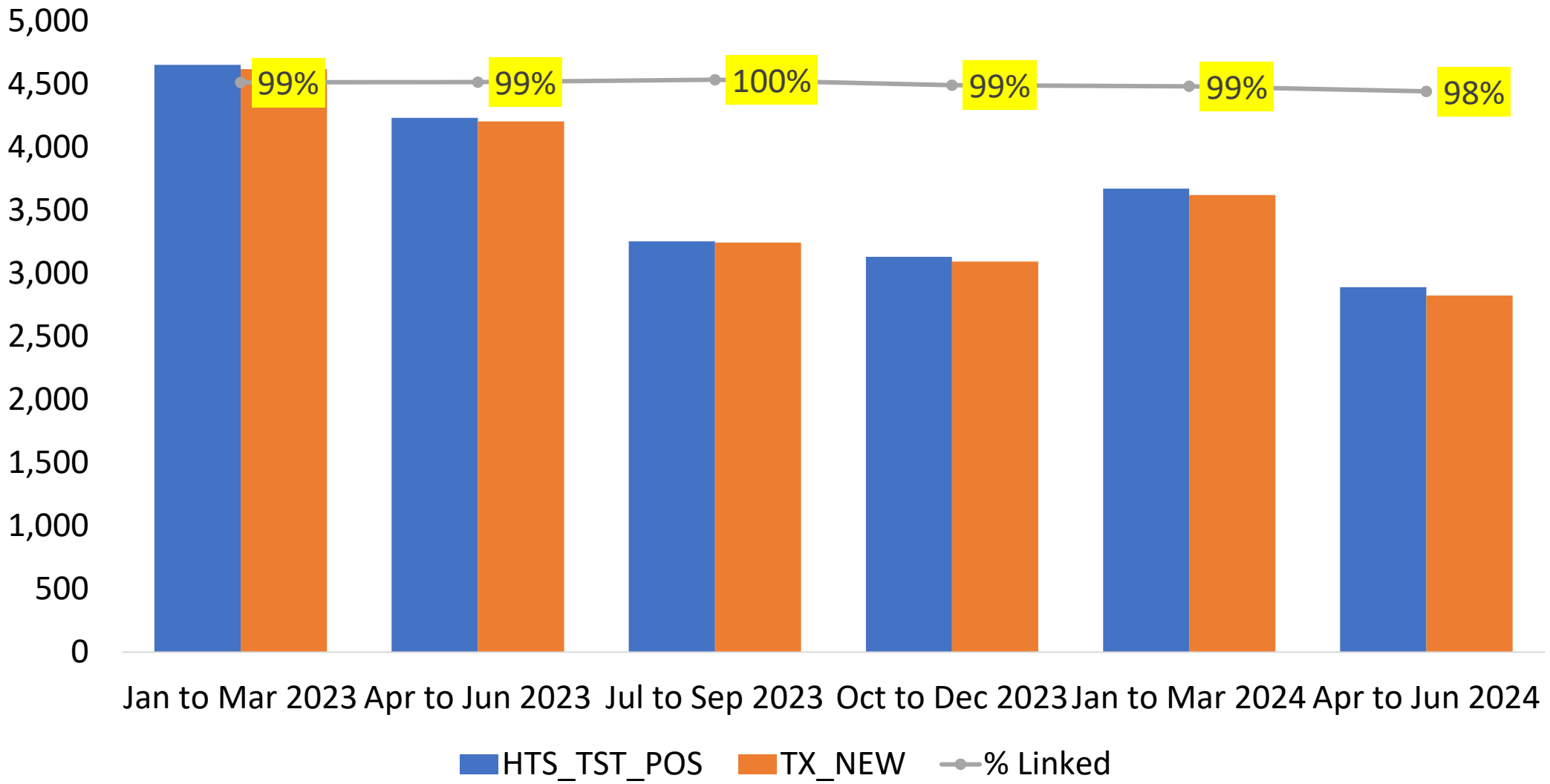

**Distribution of DICs by region**

# Approach to Post-Test Linkage to Services

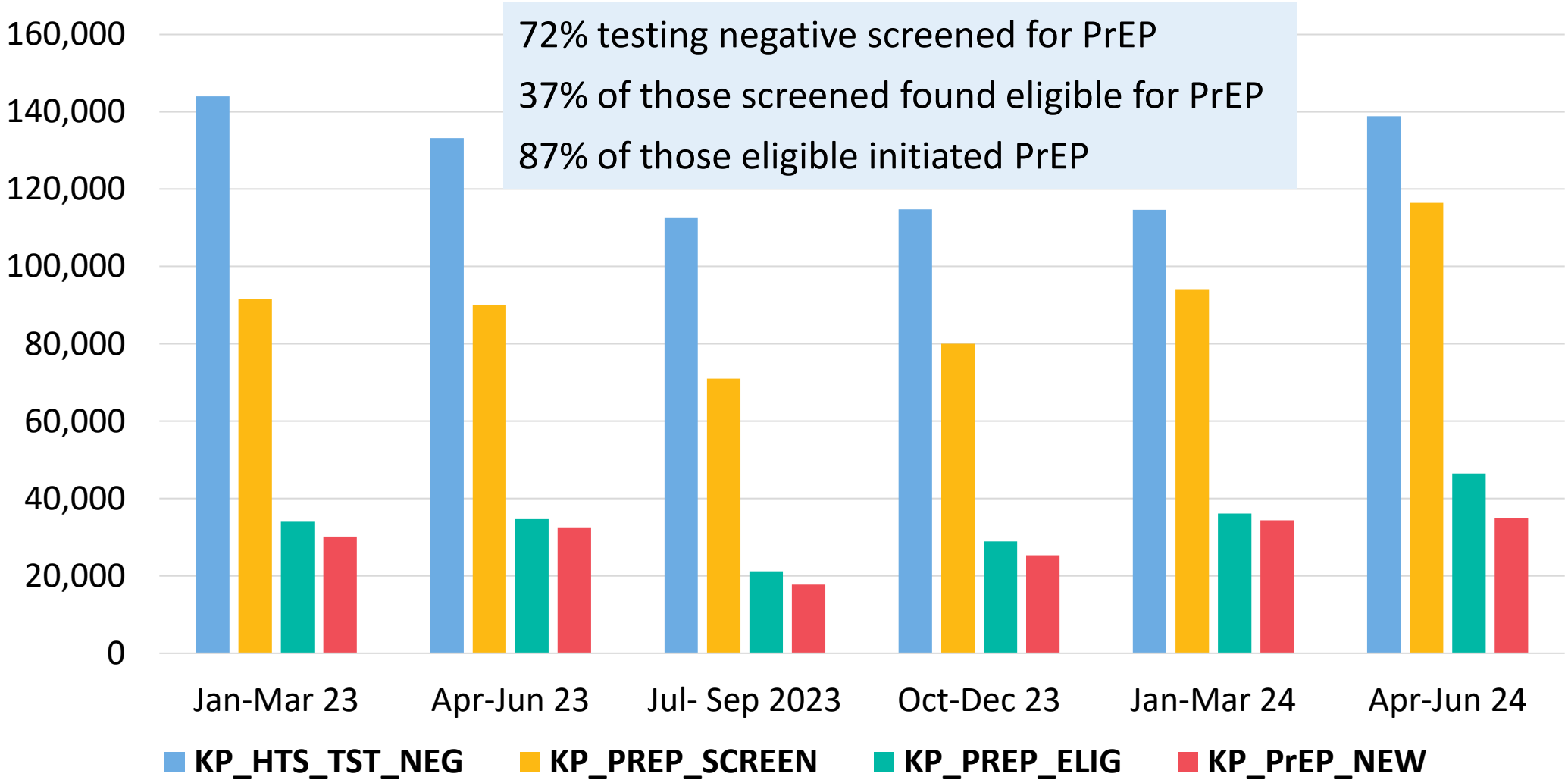
- **Clients tested at DIC:** Services/commodities like condoms, lubricants, injecting needles refills are offered immediately
- **Clients tested in hotspots:** Referral and linkage forms are filled, linking a client to a DIC or health facility offering the desired services. Where necessary contacts of the focal person of the facility is given to the client
- **Health education:** Offered on various HIV prevention methods, including condom use, PrEP, and safe sex practices. Schedule follow-up appointments to reinforce education and ensure ongoing support.
- Efforts are made to ascertain if a client reached locations using phone calls. A copy of the referral form is kept at the DIC and a copy taken to health facility receiving a client.
- For all clients testing positive for HIV, ART is initiated immediately



# Linkage to ART



# Linkage to PrEP



# Uganda's Anti-Homosexuality Act 2023 and Potential Impact on Service Delivery

- The AHA assented on 26th May 2023 and affected KP service delivery
- KP driven away from services uptake points
- KP grappled with the violence and anxiety as a repercussion of this law
- Healthcare workers feared offering services to MSM and transgender people, as interaction could be regarded as promoting homosexuality
- Proven models such as peer models were ineffective because of fear to identifying as an LGBTQI peer
- Commodities such as lubricants were considered evidence of promoting homosexuality

# AHA Response and Adaptation Strategy

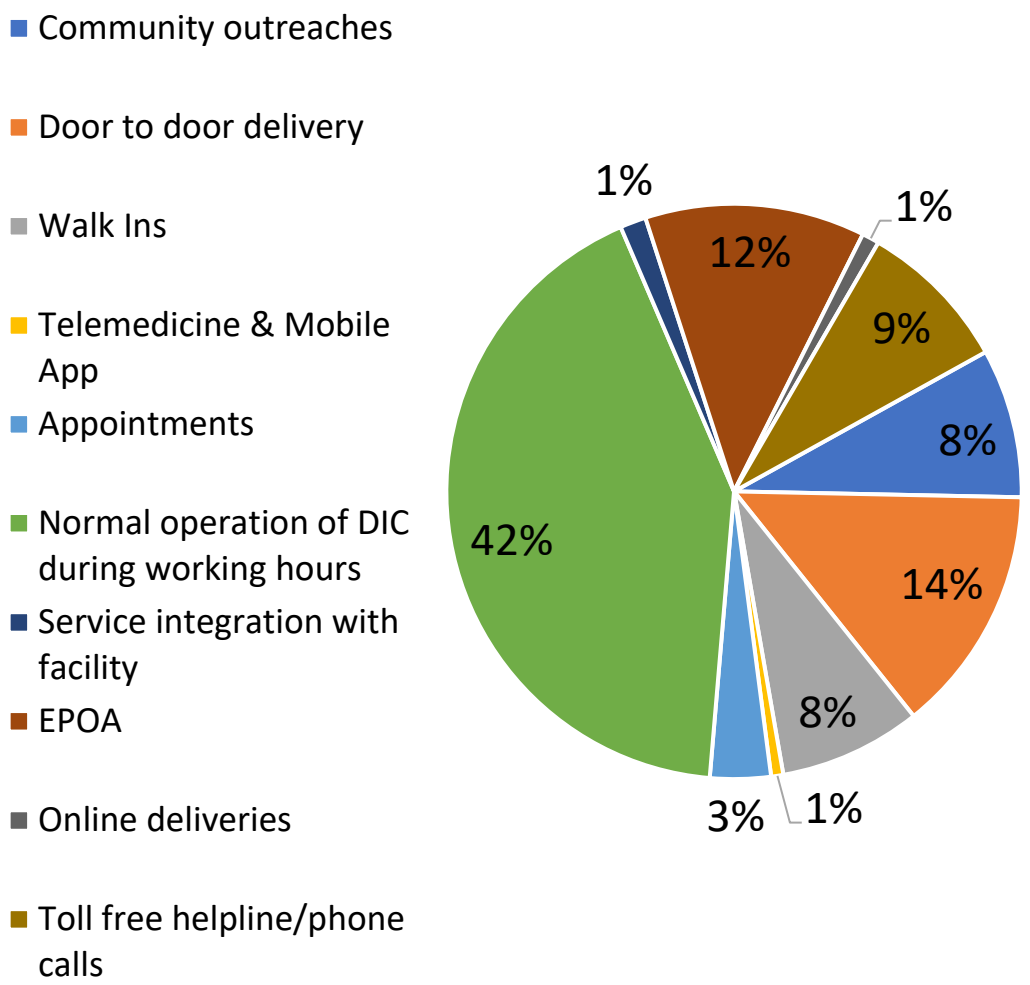
- National Task Force formed with MoH, IPs and communities
- Assessment of both community and health facility DIC and adaptation strategy developed to guide service delivery
- PEPFAR-supported projects stopped data disaggregation and reporting data with personal identifying information
- Supported KP to relocate from hostile environment to safe places (GF & PEPFAR)
- Training of healthcare workers to provide services and sensitizing law enforcement agents and local leaders, on the need for service provision

# AHA Response and Adaptation Strategy - 2

- Weekly review meetings to inform KP programming and services implementation
- Set up a surveillance unit with a hotline to monitor incidences of human rights abuse and violence.
- Training on physical and digital security for DICs, use of digital applications for data security
- All the participating organizations drafted security plans

# DIC Coping Strategies

- More than half of DICs (58%) scaled down operations
- LGBT+ DICs affected most with some temporary closures and reporting was also perceived as risky.
- Service delivery continued at affected DICs through:
  - Door-to-door deliveries
  - Telemedicine through online apps
  - Service integration
  - Outreaches for FSW DICs
  - Some walk-ins for old clients through appointments and phone reminders. *e.g., "Friends of Friends Model"* whereby a friend invites another friend in need of services, after the inviter has assessed the security situation



# Lessons Learned

- Different KP groups have unique needs and barriers.
- Training health facility staff to understand and respect the cultural contexts of KP fosters trust and improves service uptake.
- Maintaining strict confidentiality is essential to build trust with KP who may fear stigma and discrimination.
- Offering consistent and reliable services helps to establish the DIC as a trustworthy and dependable resource.
- Involving peer educators who are part of the KP community can significantly enhance engagement and trust. Peers can share personal experiences and relate to the challenges faced by clients.

# Lessons Learned - 2

- Providing a range of services under one roof, including mental health support, substance use counseling, and reproductive health services, addresses the comprehensive needs of clients and encourages them to stay engaged
- Ensuring that DICs are located in areas that are easily accessible to KP is vital. This might include extended hours or mobile services to reach those who cannot visit during regular hours
- Collaborating with community-based organizations, advocacy groups, and other stakeholders helps to create a supportive network for KPs.
- Empowering clients with knowledge about their health and rights enables them to take control of their health decisions.

# Next Steps

- Differentiated services delivery including internet-based platforms, especially for young and hidden KPs
- Strengthen the MARPI model for services delivery to reach more KP
- Continue capacity building for KP-led organizations
- Roll out revised KP-friendly service delivery guidelines for healthcare workers
- Passive surveillance of incidences of violence and human rights abuses
- Uphold KP data confidentiality and privacy
- Engagement of law enforcement agents

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# Thank You!