4

Service Delivery
Approaches

Community mobilization
and structural interventions

2 Stigma,
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4 Service Delivery
Approaches

Approaches to improving
the continuum of HIV and
STI prevention, diagnosis,
treatment and care

What's in this chapter?

This chapter explains:

- how to deliver clinical services appropriately (Section 4.2)
- how to design and implement trans-specific behavioural interventions, and how to adapt other HIV programmes for trans populations (Section 4.3)
- trans-specific condom and lubricant programming (Section 4.4)
- community empowerment and engagement (Section 4.5)
- how to create and maximize use of safe spaces (Section 4.6)
- how to use information and communication technology for programming (Section 4.7).

The chapter also includes a list of resources and further reading (Section 4.9).

4.1 Introduction

The comprehensive package of interventions presented in this tool includes health interventions common to all trans individuals and specific to trans women. Most of these interventions are the same HIV prevention, diagnosis, treatment and care interventions as for the general population. Chapter 3 discusses the particular health concerns of trans populations and how these are addressed though clinical health-care services. However, there are often complex challenges and barriers to implementation and delivery of these services. Some of these challenges relate to the multiple concurrent factors that impact the health of trans populations, including psychosocial stressors, substance use, violence and victimization, discrimination, familial rejection, social isolation and economic hardship (see Chapter 2 for further information). Other challenges relate to the scarcity of clinical services designed specifically for trans people which could serve as models for service delivery. It is therefore often necessary to adapt behavioural interventions designed for the general population or other key populations in order to meet the unique needs of trans individuals. Programme adaptations must be executed with particular attention to the needs of the trans community[1] to ensure that services are truly appropriate, accessible and acceptable to them, as well as affordable and equitable.

Programmes need to address these challenges and barriers to provide sustainable HIV services for diagnosis, linkage, retention and adherence. Multicomponent interventions are required to respond to these complex interacting factors. In addition to sexual-health services, it is important to provide linkages to substance use treatment, psychosocial care, housing, legal and educational services. It is equally important to publicize these services at the community level in order to reach trans individuals who may feel disconnected from general health-care services within mainstream public-health systems.

This chapter presents some of these challenges and discusses approaches to overcoming them, especially by engaging the community in the delivery of services. By linking clinical services to formal and informal community-led activities, it is possible to expand the reach of HIV prevention programmes to individuals who are marginalized and underserved.

It is critical that trans community members are involved in every aspect of programme design and implementation to ensure that strategies are relevant and meaningful to them. This is particularly important when the implementing organization[2] is not trans-led or does not have significant trans representation on its staff. There is no "one size fits all" approach, but the general principles described in this section can be universally applied.

HIV prevention, diagnosis, treatment and care interventions are more effective and sustainable when conducted within an empowerment framework. This enables trans individuals and communities to address structural constraints to health, human rights and well-being; make social,

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1   In most contexts in this tool, "community" refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to trans people, "community-led interventions" are interventions led by trans people, and "community members" are trans people.

2   An implementing organization is an organization delivering an intervention to trans people with a client-centred approach. It may be a governmental, non-governmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a non-governmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

economic and behavioural changes; and improve access to health services. Meaningful participation of, and partnership with, community-led organizations and networks in the planning, implementation, monitoring and evaluation of activities is fundamental to improving HIV service provision for trans people.

Trans-led and trans-focused groups, activities and services foster a sense of community, belonging and validation. Whenever possible, hiring from within the trans community sends a powerful message of affirmation. Trans people should be trained and hired to provide professional health services and training. Having trans people deliver services fosters a sense of trust within trans communities.

4.2 Clinical approaches

Different programme models can be used to provide a comprehensive continuum of HIV prevention, diagnosis, treatment and care to trans persons, depending on the context, location, estimated number of clients and available resources (see Table 4.1). It is important to consider that there is limited data on clinic-based interventions designed for trans individuals and communities compared with community-based programmes. However, establishing strong links between clinics and the communities they serve is paramount. In this objective, some approaches for trans populations may be adapted from models used to meet the needs of other key populations (see Section 4.3.2).

Table 4.1 Models of clinical service delivery sites and approaches

TYPE OF CLINIC	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Standalone NGO/CBO clinic	• Full-time services in fixed location, often run by an NGO or CBO; ideal where there is a high concentration of trans people (over 500) • Dedicated staff required	• Technically efficient • May be community driven/managed • Comprehensive services may be provided; mix of clinical and educational interventions is possible • Flexible to address needs of trans people • Greater possibility for hiring trans staff, hosting trans-led health promotion programmes/activities on site • Possibility of linking to safe space (drop-in centre)[3]	• May be costly if few trans people access the clinic • In countries where only a doctor is permitted to administer hormone therapy, staffing this service may be expensive. • Possibility of stigma associated with clinic • May be difficult to sustain

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3   A safe space (drop-in centre) is a place where trans people may gather to relax, meet other community members and hold social events, meetings or training. For more information, see Section 4.6.

TYPE OF CLINIC	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Outreach/mobile clinic • can be NGO- or government-run	• Satellite or "pop-up" clinics (fixed location) or mobile vans • Part-time clinics • Operate at fixed time in fixed locations • Ideal for reaching hard-to-reach trans people and for providing services to smaller numbers of trans people • Dedicated staff or volunteers	• Satellite or "pop-up" clinics providing a select menu of services can be set up in any location and can operate effectively in small spaces, i.e. small retail spaces in shopping plazas, private rooms inside community centres • Cost-effective for reaching hard-to-reach trans people and for providing services to smaller numbers of trans people • Greater accessibility • Can increase visibility of HIV testing services, thereby normalizing testing and reducing stigma	• Provision of comprehensive services for trans people may not be possible • Quality of services may be variable • Only accessible at specific times
Private-sector clinic	• Services provided by private practitioners who develop rapport with trans community and who are acceptable to the community	• Acceptable to trans people • Confidential • Sustainable	• Comprehensive services may not be provided (e.g. educational and counselling services) • Consistent monitoring and reporting may not be possible • May not be affordable for all
Government-owned clinic/public health department	• Government clinics, including STI clinics and integrated HIV clinics	• Sustainable • Provision of technically efficient services if staff are well trained and facilities are available	• May not be acceptable and accessible to trans people • Links to CBOs services, including the ability to track referrals, may not exist • Real or perceived concerns regarding discrimination, lack of confidentiality
Hybrid partnership model of CBO working directly with government staff	• Government clinic with CBO staff working onsite, or government operated clinic within a community space • Could be fixed site or mobile	• Strong links between national programme and community-led organization possible	• Government staff need to work outside their comfort zone • Restrictions on funding may limit the number of services offered along the continuum of care
Public–private Partnerships	• Managed by private-sector entity using public funding	• Funding may be more secure but it may be subject to government procurement policies • May fill gap in service delivery in remote locations or where infrastructure is not well developed	• Dependent upon private-sector entity, i.e. corporation that has established business in a specific location and has vested interests in improving local health services • Clinics are only sustained as long as the private company is in operation

4.2.1 Creating an appropriate clinical services environment

Training clinical and support staff

In order to reduce the likelihood that trans people receive substandard care, health-care workers and other staff of facilities providing health care must be trained and sensitized about trans persons and their health needs. Health-care workers frequently report that other staff will stigmatize

them if they demonstrate compassion for trans and sexual-minority clients. For this reason, training staff at all levels—from the waiting room to the exam room—empowers them to engage with all clients respectfully. This is known as trans cultural competency (Box 4.1) Adequate training will reduce stigma and discrimination and increase knowledge of trans health at every point along the HIV continuum.

Box 4.1

Ensuring trans cultural competency

Trans cultural competency is a set of skills that enables trans and non-trans individuals to work together effectively. Trans cultural competency is broadly defined as the ability to communicate and demonstrate a respectful understanding of trans people as unique individuals, on their own terms, according to their chosen gender identity,[4] preferred gender pronouns, and self-identified sexual orientation. Beyond basic etiquette, this includes understanding that trans people, like all people, identify across a spectrum of gender and sexual orientation, and do not conform to a universal standard of physical transition,[5] psychological traits, or lived experiences.

Organizations can make a commitment to trans cultural competency by providing mandatory trainings for all staff, including trans individuals on staff. The ideal scenario for trans-cultural competency trainings is to create a system that ensures all employees receive the same information in an ongoing manner. It is critical to include all staff, from community outreach workers[6] to administrative support staff, in such trainings. This ensures that each staff member whom a trans client or programme participant will encounter from the moment they walk into a clinic or service-delivery site is equipped with knowledge and understanding to address them respectfully and guarantee they receive the highest quality of care and attention.

"LGBTI" is now a common term that combines lesbian, bisexual, gay, trans and intersex people in a single category. However, it is often applied to programmes that in fact serve only one or some of these populations. When community organizations and service-providers apply the "LGBTI" label, it should be a truthful indication which implies that their programmes and services really are inclusive of all. As trans people have been widely excluded from lesbian, gay, bisexual and intersex spaces, LGBTI should only be applied where trans people are actively engaged as programme leaders, participants and beneficiaries.

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4   Gender identity is a person's internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

5   Transition refers to the process transgender people undergo to live authentically in their gender identity. This may involve changes to outward appearance, clothing, mannerisms or to the name someone uses in everyday interactions. These types of changes are sometimes called "social transitions". Transitioning may also involve medical steps that help to align a person's anatomy with their gender identity. These steps are sometimes called "medical transition" and can include feminizing or masculinizing hormone therapy, soft tissue fillers or surgeries. However, transition is not defined by medical steps taken or not taken.

6   A community outreach worker is a trans person who conducts outreach to other trans people, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or simply "outreach workers"). Community outreach workers may also be known by other terms, such as "peer educators". However, the terms "peer" or "community" should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Box 4.2

A checklist for trans-competent care

Trans-competent care means providing services, especially health-care services, to trans people in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination.

Further aspects of trans-competent care include:

- free or affordable services—clinical, counselling, training/workshops
- both fixed-site and outreach/mobile services—mobile care-providers and community outreach workers
- "one-stop-shop" service catering holistically for a range of health and social needs, e.g.:
  - fully equipped—all equipment and no stock-outs of commodities
  - range of services: sexual and reproductive health, HIV and STIs, drugs and alcohol, psychosocial care and support
  - point-of-care testing or quick referral for fast turnaround of results
  - counselling on all issues of concern including housing, finance, legal issues
  - healthy lifestyle promotion (diet, nutrition, exercise)
- flexible opening hours, e.g. including evening/weekends
- no appointments/short waiting times, with adequate clinic staff to ensure quick service
- service signage/branding, posters, brochures and photographs, and other visual elements that acknowledge and are relevant to trans people's lives
- "Charter of Service" for clients, clearly displayed
- confidential services:
  - private counselling and clinical examination rooms
  - providers/staff only informed on a "need to know" basis
  - young trans clients welcomed without need for parental/guardian consent[7]
  - locked storage of all client notes/records
- choice of service-providers including:
  - trans, male and female staff for gender-sensitive care
  - clinical staff, counsellors, health educators, social workers, community outreach workers
  - trans peer navigators to help clients access, understand and navigate services (see Section 4.2.2)
- relaxed consultations, with time to clearly explain issues
- voluntary procedures clearly explained for informed decision-making by clients:
  - referral for further specialist care, as required and with client consent
  - list of trans-competent resources available within the area
- provision of information, education and communication materials, e.g. brochures, posters, DVDs, presentations on different topics
- provision of condoms and lubricants by providers and via dispensers, including outdoors for after-hours accessibility.

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7   Young trans people are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young transgender people: a technical brief* (Geneva: World Health Organization; 2015) .

Organizations of trans people are essential partners in delivering comprehensive training on human sexuality and gender expression.[8] They also can facilitate interaction with members of communities with diverse gender identities and expressions, thereby generating greater understanding of their emotional health and social needs. Where formal trans-led organizations do not exist, information about sexual health and where to access clinical and social support services can be disseminated through informal networks of peers. In addition to training, health service centres need policies and practices to prevent discrimination. Follow-up and supportive supervision should complement training in order to detect challenges early, ensure onsite support is provided, and work to solve problems collaboratively. Health-care workers have a professional obligation to care for and treat people impartially, equitably and ethically.

Box 4.3

Case example: Approaches to training health-care workers in the Caribbean

The USAID-funded Health Policy Project has developed a training manual for health-care workers, piloted in the Dominican Republic, Jamaica and Barbados, to strengthen their capacity to provide high-quality, stigma-free health services for trans persons.

The manual, *Transforming care: tools to understand and meet the health needs of transgender people in the Latin America and the Caribbean*, contains six half-day sessions on the following topics:

- gender identity and sexual diversity
- transphobia[9] and stigma
- health needs
- trans people and HIV
- deeper understanding of trans people's lives
- planning the way forward.

The manual was developed in response to a lack of training for health-care providers on trans health in the Caribbean. Providers work in environments where there are high levels of stigma and discrimination against trans persons, which creates significant barriers in their access to health services. The training provides tools to implement in their own settings to improve knowledge and reduce stigma and discrimination. In the three countries where this training was piloted, it was well received and was acknowledged to fill an important gap to improve the quality of health care for trans persons.

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8 Gender expression is a person's ways of communicating masculinity and/or femininity externally through their physical appearance (including clothing, hair styles and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns.

9 Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people. For more information, see Chapter 2.

Using appropriate language

Just as images can have a strong impact in creating environments that are welcoming and affirming for trans individuals, language used in clinical environments is just as powerful. It is critical to ensure that all client intake forms, clinical documents and health information literature includes gender-neutral or gender-inclusive language wherever appropriate. For example, on client intake forms that require individuals to indicate their sex and gender there must be separate questions for "sex at birth" and "gender". It is also important to ask individuals to indicate their preferred gender pronoun, and for all clinic staff and community health workers to be trained to ask for preferred gender pronouns and to use them accordingly.

In health facilities where electronic medical records are maintained, the information that can be recorded should not be limited in ways that prevent clients from receiving accurate and competent health services. If electronic medical records "auto-populate" anatomy, exams and recommendations according to the gender assigned at birth, this limits the ability to accurately and efficiently provide and document care. For instance, a person who was assigned male at birth, takes estrogen, had breast augmentation surgery, but has not had a legal name and gender marker change to match their female appearance will be registered in an electronic health record as a male. This registration does not allow health-care workers to accurately address the individual using their preferred name and gender or provide appropriate medical care for the anatomy that is present. See Figure 4.1 for an example of a gender-inclusive intake form.

Ensuring client safety and confidentiality

Trans people are less likely to access health services if they cannot do so safely. It is important to ensure that at every point of health-service delivery trans people feel safe and that their information is kept confidential. All staff (administrative, community health workers, nurses, doctors, lab technicians and management) should be trained, monitored and evaluated for their compliance with safety and confidentiality procedures and laws. If health records cannot be secured sufficiently to ensure that the client's information is confidential, health-care workers may consider developing special codes (e.g. unique identifier codes) to document the information adequately but protect it from being accessed for non-medical reasons. (See Chapters 2 and 5 for legal and programme management methods of addressing safety and confidentiality issues.) If possible, a system should be in place for people to anonymously report problems. Efforts should be made to ensure that trans people are not targeted or harassed by police, security personnel or others when entering or exiting the clinic. In particularly hostile climates, mobile rather than fixed service-delivery centres or safe spaces (drop-in centres) may be a safer alternative (see Table 4.1).

Figure 4.1 Example of gender-inclusive intake form for clinics and social-service agencies

NOTE: These are suggested questions—this does not represent a complete intake form.

Legal name: Name I prefer to be called (if different):

Preferred pronoun?

❑ She/her ❑ He/his ❑ They/their ❑ Other _____

Gender: Check as many as are appropriate:

[An alternative is to leave a blank line next to Gender, to be completed by the client as desired]

❑ Female ❑ Male ❑ Transgender
❑ Transmale/Transman/Female to Male ❑ Transfemale/Transwoman/Male to Female
❑ Genderqueer/Gender non-conforming ❑ Other _____

Sex assigned at birth

❑ Female ❑ Male ❑ Other _____

Are your current sexual partners ❑ Female ❑ Male ❑ Transgender

❑ Transmale/Transman/Female to Male ❑ Transfemale/Transwoman/Male to Female
❑ Genderqueer/Gender non-conforming ❑ Other _____

In the past, have your sexual partners been ❑ Female ❑ Male ❑ Transgender

❑ Transmale/Transman/Female to Male ❑ Transfemale/Transwoman/Male to Female
❑ Genderqueer/Gender non-conforming ❑ Other _____

Current relationship status
[An alternative is to leave a blank line next to current relationship status]

❑ Single ❑ Married ❑ Domestic Partnership/Civil Union ❑ Partnered
❑ Involved with multiple partners
❑ Separated from spouse/partner ❑ Divorced/permanently separated from spouse/partner
❑ Other _____

Children in home

❑ No children in home ❑ My own children live with me/us ❑ My spouse's or partner's
children live with me/us ❑ Shared custody with ex-spouse or partner

Sexual orientation/identity

❑ Bisexual ❑ Gay ❑ Heterosexual/Straight ❑ Lesbian ❑ Queer

❑ Other _____ ❑ Not Sure

Are there any questions you have or information you would like with respect to starting a family?
❑ Yes   ❑ No   ❑ Don't know

Do you have any concerns related to your gender identity/expression or your sex of assignment?
❑ Yes   ❑ No   ❑ Don't know

Do you currently use or have you used hormones (e.g., testosterone, estrogen etc.)?
❑ Yes   ❑ No   ❑ Don't know

Do you need any information about hormone therapy?
❑ Yes   ❑ No   ❑ Don't know

Source: Based in part on Deutsch, M.B., et al., Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. Journal of the American Medical Informatics Association. 2013;20(4)700–703.

Service integration

WHO recommends integrating HIV services with a range of other relevant clinical services, such as those for TB, viral hepatitis, maternal and child health, sexual and reproductive health services and drug dependence treatment. Integration of services makes it easier to provide comprehensive and consistent care and makes service accessible. It allows individuals to take care of their various health needs at the same time and in the same location. Integration of services involves not only providing related services in a single setting but also systems to share information and provide referrals across settings and among providers.

Collaboration between programmes at every level of the health system is important to the success of HIV and other related health and social services. Aspects of coordination that need consideration include mobilizing and allocating resources; training, mentoring and supervising health workers; procuring and managing drugs and other medical supplies; and monitoring and evaluation. A key goal of programme planning is to create delivery systems that best facilitate access.

Box 4.4

Case example: Clinical service integration in the USA

The Transgender Family Programme at the Community Healthcare Network clinics in New York City was established in 2004 to improve access to HIV prevention and linkages to primary health care. To understand how best to integrate comprehensive trans services into a community health clinic, the Network undertook community mapping, consultations and forums and learning from similar programmes. The programme asked clients to form a Client Advisory Board to help guide integration and implementation of services for the trans community.

Integrated services include trans care, HIV testing services (HTS), medical case management, support for treatment adherence, STI screening and treatment, prevention interventions and psychosocial and nutritional services. In addition, the programme provides risk reduction counselling, support groups, outreach, bilingual educational workshops and referrals to legal and social services.

Over 750 people have received trans-specific services. Identified benefits of integrated trans services include:

- greater sensitivity to and long-term acceptance of this population in the wider community;
- improved accessibility through convenient location of services; the provision of trans care is no longer a specialty but an integral part of primary care across the network of 12 centres;
- flexible hours as a result of larger capacity;
- increased access to a range of in-house support services.

In addition, in-depth evaluation has found significant decreases in sex work, needle-sharing and unregulated hormone injections, and increased likelihood of regular condom use.

www.chnnyc.org/services/transgender-lgbt

The majority of programmes providing health services to trans people focus on HIV and other STIs. However, trans people should receive the same high-quality health services as non-trans people for all of their health needs. Programmes should work to provide a full range of health and social services. It is important that case management strategies link participants to health clinics and HIV testing and to other programmes for legal advocacy and social support. Psychosocial services should ideally be available to provide individual, group, and family sessions for trans persons who have psychosocial needs.

Using trans-specific health services as a point of entry for HIV care

The threat and actual experience of stigma, discrimination, violence and oppression create significant barriers for trans people to access health services. In order to make services more accessible, trans-specific health issues beyond HIV can be used as a point of entry. These services could be offered at the health site or via referral to known and trusted facilities. At a minimum, information and education on trans-specific health issues should be provided, such as:

- hormone access and hormone therapy
- hormone level monitoring and assessing of hormone–medication reactions (see Chapter 3, Section 3.3.9)
- gender-identity and psychosocial counselling and support
- support groups focused on transitioning and developing networks of support
- hair removal
- male and female chest reconstruction surgery, sex reassignment surgery, and other gender-affirming[10] surgeries and procedures.

Health-care workers can use client visits for any of the above concerns as opportunities to discuss co-existing issues that may impact their health care for both trans-specific and general needs. Many of these concerns may not be directly related to health but nonetheless impact a client's ability to seek and adhere to adequate health care. These concerns commonly include:

- employment
- housing
- family and social acceptance
- legal gender recognition and identity documents
- HIV-related care
- STI services
- sexual and reproductive health care
- feminization/masculinization process
- sex work
- substance use and dependence
- violence (intimate partner, intrafamilial, domestic, institutional, structural etc.).

Health-care workers should use these opportunities to treat clients for other health issues they may be experiencing or refer them to other competent health-care workers if necessary.

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10 Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity.

Box 4.5

Case example: Delivering trans-focused HIV prevention and treatment services in India

By recruiting trans people in its Shadows and Light Project as peer supporters, the Family Planning Association of India was better able to assess trans people's needs when improving access to sexual-health and HIV services. In several locations, clinics engaged health-care providers who were sensitive to the needs of trans clients, provided hormone care, information about gender transition, laser (hair removal) services, and referrals for gender-affirming surgeries. Making use of these destigmatized services, which trans people identified as the most important to them, led to increased uptake of screening and treatment for STIs (including hepatitis and syphilis), and HIV testing, diagnosis, treatment and care.

www.fpaindia.org

Box 4.6

Case example: Raising trans awareness among health-care workers in Central America

From 2011 through 2013, AIDSTAR-One (AIDS Support and Technical Assistance Resources, Sector I, Task Order 1) implemented a series of activities targeting trans women, health-care workers, and Ministry of Health authorities in Central America. In all, 916 trans women and 109 health-care workers participated in assessments of trans health needs and the attitudes of health-care workers in the region. The results contributed to the development of a health-care worker certification, which included a three-day training, supportive supervision visits, and sensitization session in the workplace. Participating health-care workers obtained a basic knowledge about fundamental aspects of sexual health and how to address trans people's needs in a positive and respectful way. The trained health-care workers then returned to their health service centres and facilitated sensitizing activities with their peers. In El Salvador alone, a total of 42 trained health-care workers conducted sensitization sessions in 28 health facilities.

Trans women were trained as data collectors and incorporated into the assessment team. They also co-facilitated the training of health-care workers. Engaging trans persons to fulfil these important and visible roles—and paying them to do so—not only strengthened their technical capacities, but also allowed them to engage with health-care workers as professionals and peers, thus dispelling myths and negative beliefs about trans women, their capacity and their behaviour. This engagement also increased the visibility of trans persons within their own societies, identifying them as key actors in national and regional actions that affect their own well-being and interests.

4.2.2 Peer navigators

In order to reduce loss along the HIV prevention, diagnosis, treatment and care continuum (see Chapter 3, Figure 3.1), trained peer navigators can act as important mentors and guides for their peers to access and adhere to a programme. Peer navigators are community outreach workers who are knowledgeable about existing local treatment and care resources for people who are HIV positive. They may be living with HIV themselves and have first-hand experience of seeking and accessing services. Peer navigators guide new HIV programme clients from HIV counselling and testing at community-based sites to clinics which provide diagnostic screening and HIV treatment and care services. This is critical not only in contexts where all who test positive are required to register with a government clinic or hospital for ART (most treatment sites are government-run), but also for supporting case management more broadly.

Peer navigators can serve as liaisons between the public, private and community sectors. They should be aware of mobile clinics, and clinics with flexible times or after-hours services and with trans-competent staff. Peer navigators may accompany or trans individuals to providers, building upon systems of formal referrals. A strong peer navigation programme can strengthen linkages to additional services like counselling, psychosocial and legal support and ensure that clients are supported along the continuum of testing, treatment and care.

Peer navigators can have an especially important role at service-delivery sites which are not community-led. They can greet individuals when they arrive and explain the client intake process, including completing medical and client history forms etc. Where fear of judgement, discrimination and maltreatment is a major barrier for trans individuals in seeking HIV and STI services, peer navigators can answer questions and alleviate any anxiety clients may have about the clinical encounter. In this role, peer navigators are more than merely a "friendly face" for trans individuals within health clinics. They are community health professionals who are integral members of a clinic staff. Peer navigators are essential to linking communities and clinics.

Because of peer navigators' central role in the implementation of key population programming, an investment in their professional development is also an investment in the broader network of trans individuals participating in service delivery across the HIV prevention, diagnosis, treatment and care continuum. When peer navigators are institutionally supported with continued training, career mentoring and ongoing opportunities to increase their reach, they are able to serve as linking agents in decentralized HIV service delivery models. They can also be key leads in stigma and discrimination work, monitoring and reporting, as well as becoming leaders and experts in referrals, prevention, care and support and treatment literacy.

4.3 Social and behavioural interventions

Social and behavioural interventions are interventions that operate at the societal, community, organizational or individual level to change behaviours in a way that positively impacts health. Social and community-level behavioural interventions seek to change structures and norms that influence individual behaviours, while individual-level behavioural interventions aim to address an individual's sources of risks. For HIV prevention, individual-level interventions often include one-on-one risk reduction counselling focused on routine sexual-history taking, client-centred counselling on protective strategies such as use of condoms and lubricant, sero-adaptive strategies,

pre-exposure prophylaxis (PrEP), sexual practice related to relative risk (insertive versus receptive anal sex, oral sex versus anal sex etc.), importance of health-seeking behaviours and the benefits of HIV treatment, and skills-building on negotiation with partners. See Chapter 3, Section 3.3.4 for additional information about harm reduction counselling and promotion in clinical settings.

Box 4.7

Case example: Behavioural interventions through community-led education in the USA

The Healthy Divas programme is a behavioural intervention to address the HIV care needs of trans women living with HIV in San Francisco. The programme helps them build skills to cope with transphobia and HIV stigma, become active and collaborative in their treatment planning, and proactively address challenges to adherence and in their relationships with providers.

Healthy Divas consists of six individual counselling sessions with a community facilitator and one group workshop, which take place over a three-month period. Each individual session is standardized: the facilitator uses a detailed manual specifying session content, procedures, exercises and activities. The manual helps the facilitator tailor this content to the participant's unique circumstances and address their particular concerns (such as transition, or substance use). The sessions also develop the individual's communication, coping and self-advocacy skills through role-playing, behaviour rehearsal or practice exercises. Workshop topics are generated by the participants and are also tailored to address their concerns while capitalizing on a supportive group process in which participants can share experiences and brainstorm solutions.

Healthy Divas was adapted from an existing programme for people living with HIV by members of a trans community advisory board and project staff, who re-wrote the content to reflect the priorities and values of the people to be served. The intervention was piloted with members of the trans community, and their feedback on both the structure and content of the intervention was incorporated into the next iteration. Programme participants are recruited through service-providers, clinics, community-based organizations, word of mouth, direct outreach and social networks. The programme is currently government-funded, and participants receive monetary incentives for participating. Feedback is gathered at the end of each session and at the end of the whole intervention for incorporation into the next round.

4.3.1 Designing trans-specific behavioural interventions

While programmes can be successfully adapted to serve immediate community needs, programmes that are wholly designed to meet the specific needs and concerns of trans people are likely to be more effective. Such programmes, whether at the community, national or regional level, are ideally designed, led and implemented by trans people themselves. Trans HIV and STI programmes, similar to other HIV interventions, are based on the principles and best practices of social and behaviour change communication (SBCC). The foundational principles guide programme design and can be used as a roadmap to link trans individuals with clinical services and other resources. One tool for developing high-quality SBCC is the P Process, a framework originally developed at the Johns

Hopkins Bloomberg School of Public Health in the USA (Figure 4.2). Each step in the P Process is based upon the principles of community participation and capacity-strengthening as requirements for effective social and behaviour change.

Figure 4.2 Steps in the P Process[11]
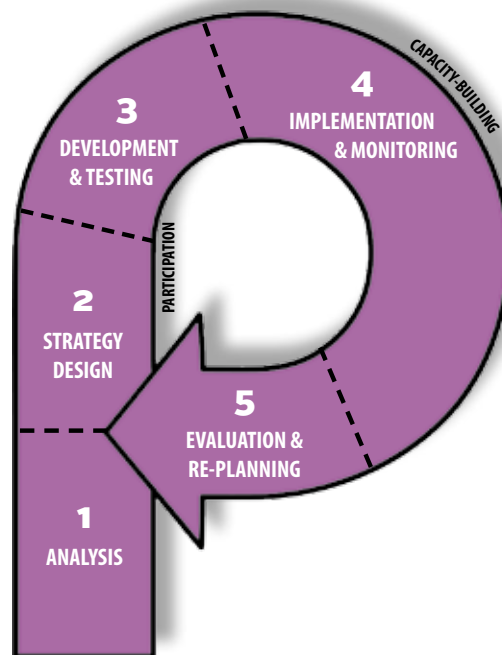
Step 1 Analysis

Conducting a situation or environmental analysis and an audience and communication analysis is the first step to developing a tailored programme. However, when a programme is being developed in a context where local trans experiences are already documented and where there is sufficient baseline health data or knowledge of trans health priorities, the initial analysis does not need to be lengthy. A situation analysis can be done by reviewing existing health and demographic data, and any information that exists relating to the aspect of HIV programming that the given intervention seeks to address. Situation and environmental analyses can include: a list of factors that prevent and enable the desired behaviour change; a clear and brief problem statement that sums up the issue(s) that the programme will address; and a clear and specific description of the target population who are the intended beneficiaries of the programme.

Where there is little or no data on the local trans population, formative research will be required to establish the baseline of the targeted population's health status and needs (see Community Mapping in Section 4.5.1).

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11 *Source:* The Health Communication Partnership. The New Process: Steps in Strategic Communication; 2003. http://www.who.int/immunization/hpv/communicate/the_new_p_process_jhuccp_2003.pdf https://www.k4health.org/toolkits/hcp/strategic-approach.

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Audience and communication analyses should assess the knowledge, attitudes and behaviour of intended participants. This analysis will also look at the communication and training needs of the intended participants, including community preferences for media sources, social media and social communication. Finally, the programme should conduct a participation analysis to identify stakeholders in trans health within the targeted area.

Step 2 Strategy design

Strategy design begins by outlining *programme objectives* that are "SMART": Specific, Measurable, Appropriate, Realistic, and Time-Bound. Next, the strategy design process *determines the model(s) of behaviour change* that best fit the intervention and uses the selected models to explain how and why the programme will improve health behaviour among trans people. A third step in the strategy design process is to *decide the channels of communication* (i.e. social media, interpersonal communication, group settings, mass media) that will most easily reach and change the behaviour of the specific trans population. Once SMART objectives, behaviour change models, and channels of communication have been decided, an intended output of the strategy design stage is the development of an implementation plan and work schedule that has benchmarks at regular intervals to gauge progress.

Step 3 Development and testing

This step involves gathering, creating and adapting the tools and materials that will be needed, including guidelines and toolkits, facilitation manuals for conducting workshops or discussion groups, manuals for peer counselling, or HIV and STI messages for media circulation. New materials developed for the programme, or existing materials adapted for it, must be clearly designed to address a specific aspect of the behavioural model. Before implementation, all materials should be pre-tested with the exact segment of the trans population that will be reached in order to evaluate the materials for cultural competency, accuracy, and to ensure they are tailored to local languages and socio-cultural norms.

Step 4 Implementation and monitoring

The implementation and monitoring stage puts all of the planning that occurs in the first three steps into action. At this stage, trainings should take place for managers, outreach workers and any key partners involved in implementation. Once key personnel have been trained, they will implement the programme with regular supportive supervision to ensure ongoing quality.

As implementation progresses, key participants can be mobilized to share information and results among other organizations and agencies within the network of allies and programme partners. Throughout the period of implementation, programme monitoring should occur to ensure consistency and quality of outputs and gauge milestones in achieving stated intervention goals. For additional information and resources on programme monitoring and evaluation, see Chapter 5.

Step 5 Evaluation and re-planning

Evaluation of any intervention determines how well it has met its objectives. For behavioural interventions, evaluation can identify how and why a programme was able to change behaviour, and in some cases, determine the overall impact on disease transmission of changing those behaviours. In the P-Process framework, evaluation includes measurement of outcomes and impact assessments, dissemination of programme evaluation results, and programme revision or redesign.

4.3.2 Adapting behavioural interventions developed for other populations

There is an immediate need for HIV prevention among trans populations. However, in many settings, no evidence-informed HIV prevention programmes specifically designed for trans women have been rigorously designed and evaluated. Many programmes must therefore be adapted from those designed to serve other populations, particularly men who have sex with men. When HIV prevention programmes for men who have sex with men are expanded to include services for trans women, they must be evaluated and adapted in order to adequately accommodate trans participants and clients.

Systematic adaptation can increase the cultural relevance of an evidence-based intervention. Interventions that lack cultural relevance to a subpopulation's unique needs and preferences will likely falter in achieving the desired outcomes.

To adapt a programme, community-led organizations must: (a) conduct a community needs assessment; (b) create a method for community involvement that works best for the organization; (c) hire appropriate staff if needed; (d) attend the original intervention training; (e) become familiar with the adaptation process; (f) develop a method of systematically creating changes to the curriculum and activities; (g) pre-test specific activities; (h) adapt the evaluation forms; and (i) pilot the adaptation.

One organization explains the process it followed to adapt an HIV prevention curriculum for trans youth: "We started by having everyone that was part of the [adaptation] team review the original curriculum and write down their own ideas of what they liked about it, what they thought should stay the same, what they thought should change, what they thought was missing. We then spent several meetings brainstorming key issues for trans youth. Then … we would sort of synthesize that down [to] what we thought were the really key issues in terms of health outcomes and HIV prevention for trans youth, then we talked about okay, so how do we make sure these key points are in this curriculum?" By engaging community members in each stage of planning, and conducting a thorough needs assessment, this organization was able to strategically plan a programme that directly addressed the priorities and preferences of its intended beneficiaries.

4.4 Condom and lubricant programming

2014 Key Populations Consolidated Guidelines[12]

The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs. *(p.26)*

Members of key populations, including people living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options. *(p.81)*

TRANSGENDER PEOPLE

Condoms and condom-compatible lubricants are recommended for anal sex. *(p.27)*

Adequate provision of lubricants for transgender women and transgender men who have sex with men needs emphasis. *(p.27)*

Promoting condom and lubricant knowledge and use through non-judgemental, sex-positive and medically accurate communication at the individual, group and community level is essential to successful programmes with trans individuals. Condom and lubricant behaviour change communication strategies should be designed with the primary goal of motivating individuals to understand and take charge of their sexual and reproductive health. For additional information about the use and efficacy of condoms and lubricants for sexual health, see Chapter 3, Section 3.3.1.

Condom and lubricant programming should reflect a rights-based approach to sexual health that honours and protects individual choice and bodily autonomy. Effective programming recognizes the full spectrum of human sexuality, sexual orientations and gender identities and is grounded in respect for each individual's sexuality.

Sex-positive approaches to behaviour change communication are likely to be most effective. Sex-positive messaging emphasizes pleasurable, romantic and enjoyable aspects of sexual expression, removes the stigma around condoms and lubricants, and associates condoms and lubricants with the broader realm of healthy sexuality and sexual expression.

A variety of opportunities exist to promote condoms and lubricants among trans individuals, including individual, community and mass-media strategies. Condoms and lubricants may be promoted via one-to-one counselling, interpersonal communications, group activities, television, the Internet and social media. Condoms and lubricants should be available and promoted in health centres frequented by trans individuals (i.e. clinics) as well as in community spaces frequented by them (i.e. drop-in centres, entertainment venues etc.).

It is important that government condom and lubricant distribution programmes actively involve organizations of trans individuals and civil-society organizations in condom and lubricant supply forecasting, market segmentation, condom and lubricant distribution and product promotion.

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12 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

Procurement of condoms and lubricants should follow internationally established quality assurance mechanisms. In addition, empowering organizations of trans individuals to play an active role in awareness-raising and in distributing condoms and lubricant to communities is essential to increase their accessibility and use at the community level. With direct access to the population being served, organizations of trans individuals are key distribution points for condom and lubricants, providing condom and lubricants in safe spaces (drop-in centres), through community outreach workers and as part of other health services.

It is useful for marketers and distributors of condoms to engage trans populations to design and distribute a variety of condoms and lubricant that meet the specific needs of trans women and men. Male condoms may not be acceptable for some trans women, nor female condoms for some trans men. Trans communities need to be engaged from the start in the design and marketing of condoms and lubricant, and in planning, mapping and implementing their distribution.

4.5 Community-led outreach

> ### 2014 Key Populations Consolidated Guidelines
>
> Community-based approaches to service delivery can increase accessibility and acceptability for key populations. Outreach, mobile services, drop-in centres and venue-based approaches are useful for reaching those with limited access to, or underserved by, formal health facilities. These approaches allow for more efficient referrals between the community and health facilities, and support collaboration across all sectors engaged in health promotion. Community-based programmes can also refer to programmes that are led and delivered by members of the key population community. *(p.117)*
>
> Community-led organizations can play important roles in reaching key populations, engaging with them, linking them to services and providing ongoing care and support. *(p.116)*
>
> Community-led organizations play a crucial role in delivering services that best meet the needs of key populations. *(p.129)*

Community-led approaches are an essential link between the community and HIV prevention, diagnosis, treatment and care services. They empower trans people to draw on their first-hand knowledge of vulnerability and risk to problem-solve with members of their community, strengthening access to services, and making HIV prevention, diagnosis, treatment and care viable.

A community outreach worker is a trans person who conducts outreach to other trans people. Trained community members with direct experience of many of the factors that elevate risk for HIV and other STIs can discuss personal stories and address intimate issues with candour and empathy. With formal training in health education (see Section 4.5.1) community outreach workers can link others to clinical and community-based or community-led services.

Community-led approaches involve building the capacity of a community-led organization to assess the needs of the community, design high-quality services based on identified needs (starting with

the most essential) and roll out these services progressively as the capabilities of the organization grow. In most localities, the social-political context, HIV incidence and risk behaviours among trans people will shape how services are designed. In more tolerant settings (for example, some urban areas), community-led organizations may be able to be more visible about their work and hold public events and group outreach sessions. In much of the world, community-led organizations must operate very discreetly to provide outreach, HTS and referrals to comprehensive care services. (For more information on organizational capacity-building of community-led organizations, see Chapter 1, Section 1.4.)

Most trans community-led organizations initially build their outreach work around one-on-one and group education activities, with referrals to safe spaces (drop-in centres) where available (Section 4.6), or to trans-competent public or private health-care providers. Some trans people may prefer to receive information online or through social media (see Section 4.7). On the other hand, one-on-one or group approaches can be particularly effective for people who are illiterate. In contexts where trans people are marginalized or disconnected from organizations and services, formal and informal support groups can foster a sense of community and alleviate social isolation and its attendant risks. Support groups, including informal social gatherings that are exclusive to trans-people, can help individuals to process trauma, understand their shared experiences and be empowered to engage in safer sexual practices. Individual counselling can also help in this regard.

Promoting sexual health and HIV prevention, diagnosis, treatment and care must extend far beyond clinical settings to be effective. In order to reach the greatest number of individuals who can potentially benefit from programmes, it is essential to bring information and services to places where trans people gather socially. Physical and virtual spaces frequented by trans individuals can be entry points for developing relevant, accessible and sustainable programmes. Sexual-health promotion in non-clinical settings is the most effective means of reaching individuals who are most disconnected from mainstream health services and therefore at greatest risk for HIV and other STIs.

Community-based entry points are often different for trans women, trans men and young trans people. Determining where those spaces are, and how they can best be used as sites for sexual-health education, peer counselling, condom and lubricant promotion and other HIV programming can therefore only be done with the meaningful participation of community members themselves. Recruiting and retaining trans people as community outreach workers ensures that programmes are not only established in the right locations, but also that they are responsive to the changing preferences and priorities of their beneficiaries.

Community outreach workers are uniquely positioned to address the complex interaction between stigma, trauma, social stressors and behavioural risk among other members of their communities. It is important for community outreach workers to address these psychosocial stressors and provide resources to help with them (see also Chapter 3, Section 3.3.10).

Community outreach workers' understanding of, and personal investment in, the welfare of their community are as essential to the success of an intervention as the services they offer. Therefore, they must be respected and engaged meaningfully. Community outreach workers are not volunteers. They should be remunerated for their work at a rate comparable to that of other staff, and should have the opportunity to progress to permanent paid positions in the implementing organization.

The following section presents steps in developing community-led outreach that can be used by programme managers of an implementing organization that does not yet benefit from an established community-led outreach approach.

Box 4.8

Case example: Community-led outreach and empowerment in the Dominican Republic

As in many other countries, Dominican trans women are disproportionately represented among sex workers, and face the converging risk factors of police abuse and harassment, limited education and economic opportunities, and discrimination within the public health-care system. Since 2004, La Comunidad de Trans-Travestis Trabajadoras Sexuales Dominicana (COTRAVETD) has worked to eliminate stigma, discrimination and marginalization of trans sex workers throughout the Dominican Republic.

Although free HIV testing is readily available, many trans women report that they do not access any other routine health services due to the criminalization of sex work and systemic discrimination of both trans women and sex workers. For those who test positive for HIV, high-quality treatment and care is not easily or regularly attainable. In order to bridge this gap, COTRAVETD developed a programme tailored to trans women sex workers in Santiago and Santo Domingo. The programme recruits and trains community health educators to go beyond distributing condoms and lubricant and information on testing. The educators also address health and well-being from a human-rights perspective and educate their peers about their legal rights to be free of discrimination in health-care settings and how to take action against police abuse. COTRAVETD also dispatches a mobile clinic to provide basic primary health care, STI and HIV testing. A central component of the programme is the referral system to a clinic offering a trans health programme that provides primary care, hormone therapy and transition counselling. To date, they have reached approximately 1,300 trans women through community outreach,[13] with a staff of eight trained community outreach workers in the field.

cotravetd.blogspot.co.uk

4.5.1 Implementing community-led outreach

There are several steps to establishing an effective community-led outreach programme:

A. Map the community and design outreach strategies with community members fully engaged in each stage of the process. This includes mapping virtual spaces used by trans communities, i.e. popular social media platforms and websites.

B. Engage and train community outreach workers, or online community outreach workers.

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13 Community outreach is outreach to trans people in order to provide services such as education, commodities and other forms of support. Wherever possible, outreach is best done by empowered and trained community members, i.e. trans people (referred to in this tool as community outreach workers). However, non-trans people can also be effective outreach workers, especially in contexts where community members are not yet sufficiently empowered to do outreach.

C. Implement and manage outreach, including website banner ads and social media promotion.
D. Foster leadership opportunities for community outreach workers.

A. Map the community and design outreach strategies

Understanding where trans people are and how to reach them is essential. This starts with population size estimation and programmatic mapping. Population size estimation may be conducted at a regional or national level when a programme is established, but it may involve members of local trans communities and other organizations or individuals with knowledge of local communities. This process is described in Chapter 5, Section 5.3.1.

Mapping is a process to identify more precisely the number of trans people in a more localized area, as well as any places where they gather, and services that already exist that they make use of. Mapping involves the programme team, trans people and other people at locations where trans people gather. Once mapping focuses on locations within a coverage area, the participation of community members is needed to help assess the availability and quality of services and characteristics of the environment, as well as the relative risks and vulnerabilities of individual trans people.

The steps for local consultations to inform mapping are:

*   Engage a core group of trans individuals to participate in mapping. They should have detailed knowledge of where trans people gather and meet, often referred to as "hot spots".
*   Work with the core group to develop maps that identify these hot spots (such as bus stations, clubs, parks, saunas and other hook-up spots).
*   With the core group, identify and build rapport with "key informants" in these locations, such as trans individuals, bar owners and managers of sex workers. Through group discussions with the key informants, arrive at consensus estimates of the number of trans individuals at each location.
*   Work with local stakeholders to identify and map service-delivery points for core elements of the comprehensive service package, including condoms and lubricants, prevention and STI services, HTS, and clinics for treatment and care.
*   Plan services, using the information from the key informant meetings. In order to maximize access to services, clinics and drop-in centres should be located near the areas with the greatest density of trans individuals and operate at the most convenient times for them. The maps can also be used for planning structural interventions against stigma and discrimination, including violence.
*   Through the key informants, meet and build rapport with additional trans people who could become community outreach workers.

Box 4.9

Case example: Trans women make the case for integrated service delivery in Peru

The Peruvian Ministry of Health is developing a Focus Plan to reduce the high rates of HIV and other STIs among trans women. One of the first activities was to map trans communities. Trans women were identified and trained to develop and manage the mapping. They then went to all the places where trans women work, live and socialize and were able to produce a cohesive and comprehensive map of the health services they need and when and where to deliver them. This informed the subsequent mobile service delivery with an emphasis on community action and the engagement of trans women to ensure that services are relevant. The implementation of the mapping demonstrated that when this type of research is done by trans women, they are more likely to obtain the necessary information and evidence to develop the programme.

Ultimately, the trans women produced more than just a map of their community's needs. They shaped the technical norms for providing integrated services to trans women nationwide. Even though this started out in response to HIV, they realized they could not make an impact in that epidemic without providing integrated services, with an emphasis on primary care and requiring the state-funded health system to deliver trans-competent care.

B. Engage and train community outreach workers

Engaging community outreach workers

In the initial stages of a programme, selecting community outreach workers may be an informal process. Implementing organizations may invite trans people who have been involved in the initial mapping and planning stages to remain involved in the new programme as community outreach workers, or to identify other trans people with the potential to fulfil this role. In either case, the selection criteria listed in Box 4.10 can be considered. It is also important to observe the rapport between trans people involved in mapping and other members of their community.

As the programme matures, a more structured process for selecting new community outreach workers may be adopted:

- A community advisory group and programme staff, including current community outreach workers, define the criteria for new community outreach workers, identify potential community outreach workers, contact them to see if they are willing to serve and conduct a basic interview with them. The candidates are ranked based on the criteria listed in Box 4.10.

- The candidates are asked to take part in a social network mapping exercise, facilitated by outreach coordinators, to determine the size of their social networks of trans people.

- Current community outreach workers consult with the potential community outreach worker's contacts to see whether the candidate would be acceptable to them as a community outreach worker.

- Based on the interviews, social network mapping and consultations, the community advisory group selects the appropriate number of new community outreach workers.

- The community advisory group discusses methods for monitoring community outreach workers' performance. This can be through formal performance reviews or through informal feedback processes such as regular "check-in" meetings. Community members should be able to contact the project if they have any issues related to the community outreach worker. It is important that community outreach workers not only meet programme targets, but do so with the highest quality and skill.

Community outreach workers from subgroups at higher risk should be engaged to do outreach to their peers. This includes those engaged currently or formally engaged in sex work or injecting drug use.

Box 4.10

Suggested selection criteria for a community outreach worker

- active in the community with time to do outreach
- committed to the goals and objectives of the programme
- knowledgeable about the local context and setting
- accepted by the community
- accountable to the community as well as to the programme
- respectful of all communities of trans people
- able to maintain confidentiality
- good listening, communication and interpersonal skills
- self-confident and with potential for leadership
- potential to be a strong role model for the behaviour promoted by the programme
- willing to learn and experiment in the field
- committed to being available to other trans people if they experience violence or an emergency.

Programmes that conduct outreach through social media may also choose outreach workers based on their profile as opinion leaders within social networks and other criteria such as age, class or local sexual and gender identities that will enable them to reach distinct subgroups for the programme.

Training community outreach workers

Training curricula should be interactive. The strength of community outreach workers in bringing their own experience and initiative to their work should be emphasized. This means that training may be most effective when facilitated by trainers who are themselves trans people. Basic training for all new staff must include competency in understanding gender and sexual diversity, regardless of how the new staff themselves identify.

Training should take place regularly and may be done at several levels:

- basic training at the beginning of engagement in the programme
- advanced training sessions at least quarterly to build knowledge and skills and to reinforce positive examples of outstanding outreach
- informal mentoring by an outreach supervisor to support community outreach workers (daily)
- group discussions and mentoring with community outreach workers (weekly).

Basic training may include:

- interpersonal communication skills to build confidence and individual agency (the choice, control and power to act for oneself). This includes learning to apply tact, discretion, active listening skills, being non-judgemental and maintaining confidentiality
- awareness of gender and sexual diversity, including the basic physical and psychological stages of human sexual development
- knowledge of a range of trans issues, both health- and non-health-related
- condom gap analysis, condom negotiation, lubricants, and training on how many condoms outreach workers should take to meet their outreach needs
- social network mapping
- monitoring of programme reach
- making prevention and care referrals
- using micro-planning tools, record-keeping
- STI symptoms and disease processes, referrals and treatment of STIs, HIV and TB
- promotion of voluntary HTS
- identifying and discussing violence, providing psychosocial support
- community mobilization.

Advanced training may include:

- advanced communication and counselling skills
- leadership skills
- dealing with stigma, discrimination and harassment
- legal literacy, negotiating with police and calling upon the community for support
- violence screening and crisis intervention
- counselling for drug and alcohol use
- creating links to other services (e.g. sexual health, HIV and HTS, and other health services)
- helping people navigate systems for social benefits, e.g. health insurance, unemployment insurance etc.
- care and support through individual and group peer counselling, including for trans people living with HIV
- use of programme data to better target outreach services
- interacting with the media to promote a positive image of the community (but note the importance of maintaining the safety of trans people whose identity is revealed through media interviews and other coverage).

C. Manage outreach

Outreach happens at two levels: the community outreach worker manages their own outreach to trans people; and programme staff supervise and support the community outreach workers.

The community outreach worker uses a prevention and case management approach for each trans person, consisting of several steps that are re-assessed and repeated, as circumstances require.

- Assess the range of needs of the individual, using a standardized tool (see "Micro-planning" below).
- Develop a plan of action with the individual based on needs that can be addressed.
- Provide commodities, information and counselling to address the beneficiary's needs.
- Facilitate referrals to other services, as needed.
- Follow up referrals with support and information, as needed.
- Re-assess and evaluate the needs of the individual on a regular basis.

Micro-planning

Micro-planning gives community outreach workers the responsibility and authority to manage their own work. In this approach, community outreach workers use their knowledge of the community, and the information they record during their contacts with trans people, to prioritize and manage outreach.

Community outreach workers are trained to use tools to capture data on the vulnerability and risk of each individual they serve, and the services they deliver. Micro-planning tools are designed to be user-friendly, e.g. they are pictorial and can be used by people with low literacy skills. They may be adapted so that routine monitoring can be reported using a mobile phone, in addition to recording data on paper.

Community outreach workers record data at each encounter with the individual trans person, and aggregate them onto a weekly or monthly reporting form (unless the data have already been submitted electronically), with the assistance of a supervisor if necessary. Some of the aggregated information may be reported by the programme according to regional or national reporting requirements, but its primary purpose is to enable community outreach workers to analyse their outreach efforts and plan their outreach according to the most urgent needs of the trans people they are serving (e.g. those with the highest risk or vulnerability, or those who have not been met for a significant period of time). The community outreach worker may do this planning in the context of weekly review sessions with the supervisor.

Supervising and supporting outreach

An outreach supervisor has the responsibility to train, motivate and monitor the work of 5–20 community outreach workers. The role may be filled by a community outreach worker who has progressed into this supervisory role or by an NGO staff member until community outreach workers are trained. The outreach supervisor observes community outreach workers in their day-to-day outreach work, reviews their data on components of the service package (number of one-to-one contacts, group contacts, referrals or accompanied visits, condoms and lubricant distributed etc.), and may input the data into a computerized management information system if there is no dedicated data entry officer. The supervisor has weekly meetings with their group of community outreach workers,

usually at the safe space (drop-in centre), to discuss high-priority individuals and any problems the community outreach workers may be encountering, and to provide informal training.

Remunerating community outreach workers

Community outreach workers should always be remunerated for their work. However, paying community outreach workers for each individual they persuade to come to the clinic or drop-in centre for services—rather than providing a fixed salary or stipend—may distort demand and lead to coercion. In addition to fixed remuneration, effective incentives and evaluation-based recognition can include phone credit, non-monetary gifts and leadership opportunities that are not linked directly to the number of trans people who are brought to the programme. Offering the chance to participate in national or international trainings and meetings, where possible, may also be an effective way of recognizing outstanding community outreach workers.

Table 4.2 Remuneration/compensation for community outreach workers

RESOURCE SPENT BY COMMUNITY OUTREACH WORKER	REMUNERATION	RATIONALE
Time on outreach (includes time for travel, meeting with trans people, reporting, planning further outreach)	Fixed periodic payment	Agree upon a rate that is acceptable to community outreach workers and feasible for programme sustainability. If possible, rates should be set consistently across state and national programmes.
Time on extra training	Stipend	Programmes should recognize that community outreach workers may have other work and personal obligations that cannot be fulfilled when they are in training.
Travelling between venues, for referrals, training etc.	Bus, train, taxi charges, as required	It is usually most efficient to map travel routes and fix travel allowances for groups of community outreach workers.
Mobile phone airtime	Mobile phone airtime (predetermined is usually best)	Whether using text messages or limited talk time, community outreach workers should be remunerated for on-the-job phone use.
Mobile phone batteries	Chargers, access to power and safe charging	Community outreach workers need their phones for outreach, and phone battery chargers should be made available at agreed-upon charging locations.

D. Foster leadership opportunities

Experienced community outreach workers improve the effectiveness of outreach and provide leadership in their community beyond programme services. It is important that programmes adopt an approach from the beginning that allows community outreach workers to grow as leaders. Programmes do this not only by showing respect and appreciation to community outreach workers, but also by:

• providing support through training, mentoring, constructive feedback and remuneration;

• offering opportunities for them to learn new skills and apply their experience in expanded ways through the programme and in their communities, so that they and other trans people are empowered;

• developing individual promotion plans, whether it be within the implementing organization (higher-salaried jobs within the organization) or with opportunities that the community outreach worker may want to pursue in other organizations.

Training and mentoring of community outreach workers should focus not only on outreach, but also on strengthening their leadership. Community outreach workers with leadership skills are more likely to use critical thinking and take the initiative to reach greater numbers of trans individuals. They may also support the programme in other important areas including:

- **Advocacy:** Trans community outreach workers are uniquely positioned to advocate and mobilize ground-level support to counter barriers such as police harassment, discrimination, stigma and violence. They may initially need support in this role from staff of the implementing organization who are not themselves trans people, but staff should be sensitive to the need to reinforce the community outreach worker as a leader for their community, only stepping in when needed.

- **Programme monitoring:** With experience and support, community outreach workers can participate in monitoring the programme and improving its quality. This develops naturally from the approach taken with micro-planning, where community outreach workers assume responsibility for recording, analysing and acting on data about the trans people to whom they provide services. Community outreach workers who collect monitoring data should also be provided with tools to analyse them (as with micro-planning) and the authority to make decisions based on the information collected. They should also be supported in monitoring aspects of the intervention that the community considers important, such as trends in the service quality of referral clinics. Report-back methods can be through in-person meetings, or by entering tracking information into simple web-based databases.

- **Programme management and leadership:** Community outreach workers can train and mentor other community outreach workers, and may assume other roles in a programme. As programmes mature, community outreach workers naturally seek advancement as leaders, and jobs once done by implementing organization staff may be done by trans people who began as community outreach workers. Outreach supervisors will generally work as full-time staff with a salary commensurate for implementing organization staff in similar positions—these positions will often be staffed by members of the trans community.

4.5.2 Building coalitions and alliances

In most contexts, trans-specific programming has only been recently developed, and resources and infrastructure may be limited. Forming coalitions with existing organizations and local public-health departments that provide similar services to other key populations is therefore essential. Building alliances with non-trans organizations can create opportunities to promote improved policies and practices in HIV prevention, diagnosis, treatment and care into existing public and private systems. Alliances with non-trans organizations such as civil-society organizations, non-governmental organizations (NGOs), community associations or unions representing gays, lesbians, bisexuals or sex workers can enable trans communities to widen their pool of resources. Partnerships with health departments and clinics, colleges and universities, and private businesses can help trans organizations meet the needs of their constituents while generating powerful shifts in mainstreaming and destigmatizing trans individuals and their unique health concerns.

Box 4.11

Case example: Reaching trans people in Mexico

Clinica Especializada Condesa in Mexico City offers a model for successfully providing services to hard-to-reach key populations in a large urban area. The clinic was originally planned as a centre for STIs and HIV care, but has expanded to include psychosocial counselling services, referrals to social services and care for victims of sexual violence. The clinic also provides outreach to people in prisons and is engaged in community-based health promotion.

A comprehensive care centre expressly for trans individuals has been established as a separate component of the clinic, complemented by a community outreach programme to link trans individuals to the services. The passage of a gender recognition law in Mexico City in 2009, and amendments to the city's health law in 2014 recognizing trans individuals as a distinct population with particular health concerns, helped to create an enabling environment for the centre's work. All services are provided at no cost to more than 1,000 female and male trans clients, in an environment that promotes compassion, equality, and respect for all trans individuals.

Although HIV prevalence among trans women who receive services at the clinic is 41%, the majority of clients in the new trans health centre seek clinical services for medical transitioning, and not initially for HIV-related care. Self-medication with hormones is common within this population, often leading to medical complications and sometimes to hospitalization. Clients come at the invitation of outreach workers, or via word of mouth from other users, because of promotion in the print and electronic media, or because they are already receiving other care at Clinica Condesa.

After a mental-health assessment, clients are referred to the clinic´s endocrinology unit for an assessment to initiate hormone therapy. HIV tests are offered as part of the routine lab work. Persons with positive results are linked to HIV treatment and care services. Hormone treatment is initiated once the HIV positive individual's viral load is undetectable, barring secondary health conditions. In this way, the centre serves as a gateway to public health services that normally would be difficult to access due to stigma and discrimination from some providers.

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4.6 Safe spaces

The term "safe spaces" is widely used throughout HIV prevention programming among key populations. In trans communities, safe spaces are any location where trans individuals can gather in a place where they feel secure and are able to freely express themselves. Safe spaces can also be online (virtual) locations (see Section 4.7), but this section addresses physical safe spaces, also known as drop-in centres, which can be:

- a place where community members may discuss programmes with programme managers to improve services
- a venue for psychosocial services and support, based on community demand
- a place to provide information on events and activities relevant to the community (not just programme-related information)

- a place to strengthen community empowerment by discussing discrimination and stigma against the community and planning a response
- a distribution point for condoms and lubricants
- a place for community outreach workers to review their work and plan outreach
- a place for community trainings (of community outreach workers, but also of other trans individuals, e.g. in violence response, power analysis)
- any location where trans individuals gather to share common interests. These spaces can range from private businesses such as salons to retail outlets that are owned or patronized by trans individuals, or any other space in a community where people regularly gather.

In many contexts, safe spaces are important as they provide the only opportunity for trans people to freely express themselves in their preferred gender. In places where criminalization and hostile social environments restrict individuals from dressing and acting according to their preferred gender, safe spaces can be used as a place for people to change clothing, do their hair and alter their gender presentation in a way that is comfortable and authentic for them. Some programmes have established social gatherings for a few hours a week in private rooms of bars and restaurants, and in community centres (see Box 4.12). For some, these short gatherings may be the only time they are able to be themselves openly. Providing an affirming and secure environment, even briefly, for that opportunity can have an extremely positive impact for participants regardless of their stage of transition.

Safe spaces may be located close to programme-operated STI clinics, or even in the same building. There are practical advantages to co-locating safe spaces with clinics, such as the convenience of dealing with just one landlord, and the closer links between community activities and programme services. Nevertheless, it is important to ensure that safe spaces remain a distinct community area. In some contexts, it may be important to separate an implementing organization's office from the safe space and to ensure that community leaders have clear responsibility for managing activities at the safe space.

Box 4.12

Case example: Social safe spaces in South Africa

T-Junction gatherings began in 2004, when there were no formal trans-led organizations in South Africa, as a way to bring trans people and their partners together to socialize without experiencing prejudice or stigmatization. The meetings provided a private and affirming environment where people could experiment with new ways of presenting themselves, especially those who were not fully out as trans and did not change their appearance in public.

T-Junctions were initially potluck gatherings held once a month at the home of a trans community member. In order to include people from more diverse socio-economic backgrounds and from communities of colour, facilitators would drive participants from different suburbs to and from the gatherings. Financial support under Gender DynamiX, a trans-led organization based in Capetown, made it possible to expand the programme and increase average attendance from 5 to 20 people.

In 2010 T-junction collaborated with the Triangle Project, another organization that held monthly support group meetings. The project's support group would meet for two hours on Saturdays, facilitated by a trained counselling professional. Half an hour after the group dispersed, T-Junction would start at a nearby restaurant. Attendees of each programme were encouraged to participate in the other one as well. After some initial success, the collaboration faced financial challenges to cover costs of the T-Junction venue and assist participants with transport costs. Additionally, since the T-Junction began as an exclusively social activity, later efforts to engage participants in more structured thematic discussions around health-care issues were not appealing. However, as the gatherings continued, an increasing number of trans individuals who had previously been socially disconnected from each other developed a sense of community and began to participate in both the support group and in T-Junction's social activities. This caused a substantial trans community to coalesce and made it possible to carry trans issues into other mainstream spaces.

4.6.1 Steps in establishing safe spaces

Community consultation and mapping: A consultation provides guidance on where to locate the safe space, services to be provided, staffing and service hours. Services should be available when trans individuals most need them.

Location: The choice of location should take into consideration not only its accessibility to trans individuals but also its visibility to the public and the response from the wider (non-trans) community. Care must be taken to ensure that the space is safe from intrusion by outsiders and the police.

Lease agreements and landlords: Maintaining a fixed location for the safe space is important to prevent disruption of services. The lease drawn up with the landlord should clearly state the duration of the agreement and clarify the hours and nature of use.

Infrastructure and safety: The safe space will ideally have at least two rooms: one that can be used for one-on-one meetings or counselling, and one for community activities. The safe space should be equipped with basic equipment to handle fires and other emergencies.

Designing the space: The space should be both functional and inviting. Meeting tables and chairs may be kept to one side unless in use; couches or mattresses to sit on can make the room comfortable. Walls may be painted or decorated with art made by the community.

4.6.2 Operating safe spaces

Management: The programme should provide resources for the space. To ensure that the community feels ownership, trans individuals should have the lead role in decisions about the space and its management.

Service promotion: To ensure trans individuals are aware of the safe space and its services, it can be promoted through flyers, SMS messages and community networking.

Ground rules: These should be formulated by those using the space so that they understand what behaviour is acceptable, e.g. with regard to noise levels (this is also important so as not to disturb any neighbours) as well as drug and alcohol use.

Relationships with neighbours: The safe space managers, including the community, should make plans to manage relationships with neighbours and those in the wider community. In contexts where there are concerns about interaction between police and trans community members, the sponsoring organization or individuals overseeing the safe space should assess the policing environment in the area where the safe space is located. Where there are reported incidents of police violence or harassment (e.g. arbitrary stopping and searching of trans women on allegations of sex work, or confiscating condoms and lubricants and using them as evidence of sex work), tracking and monitoring systems may ensure the security of individuals using the safe space. For more information on documenting stigma, discrimination and violence, see Chapter 2, Sections 2.3.1 and 2.3.2.

Programme use: Growing implementing organizations may want to use the safe space for other programme activities or as offices; efforts should be made to ensure that this does not happen or that such activities are kept to a minimum. The safe space should remain open to members of the community to use informally, even if the programme is using it.

Sustainability: Safe spaces can be made financially sustainable when managed by the community. For example, programmes requiring a location can rent or negotiate for use of space on a limited basis, or during set meeting times. In some locations, trans community members generate extra income by renting their own private or commercial space to programmes.

4.7 Information and communication technology

Harnessing information and communication technologies (ICT) that are already being used by trans individuals can broaden outreach efforts and be instrumental in scaling up HIV services. Social media, SMS messaging and other ICT platforms are used by increasing numbers of people, and online spaces in particular have the power to draw together individuals from all socio-economic levels and demographic groups. The anonymity offered by virtual spaces makes users feel safer in discussing intimate topics openly, such as their sexuality, transitioning concerns and personal relationships, without fear of judgement or discrimination.

Community outreach workers are able to provide health information and HIV prevention, diagnosis, treatment and care in clinic-based and community-based programmes. Many of these "frontline" health-promotion activities can also be taken online in order to reach wider audiences and generate meaningful dialogue among supportive peers. Common platforms for trans-led ICT programmes include social media such as Facebook, Twitter, Instagram, independent blog pages and websites, podcasts, and dating and hook-up websites and smartphone applications.

While disseminating medically accurate information, individuals can also connect with each other to share experiences and seek emotional support. ICT interventions should link the virtual to the physical, i.e. they should enable linkages to HCT, treatment, care and support; referrals to STI services; and referrals to psychosocial and other health services.

ICT can be used for the full continuum of HIV prevention, diagnosis, treatment and care, and can be a tool for programme research, design, mapping and analysis as outlined in the "P Process" (Section 4.3.1). It is important to note that while the use of ICT platforms, and social media in particular, in HIV prevention programming for men who have sex with men is widely documented, ICT programming by and for trans communities is only just beginning to grow. Although many of the publication, dissemination, and live-chat strategies used by organizations of men who have sex with men can be adapted for trans communities, the nature and preference of online social media must meet the needs and interests of trans people. Trans community members who are involved in programme mapping, design, implementation and monitoring can determine the platform that will best reach their own community and generate the most positive responses.

4.7.1 Social media and social isolation

Social media can expand programmatic reach to individuals who may otherwise not access trans-specific health information, but it should not replace all face-to-face interactions. As one community outreach worker in El Salvador explains: "These are communication methods that bring with them some risk, such as people having a lot of online friends that they don't know in person, so they are still strangers, really. This can give a false expectation in people who lack self-esteem and who have trouble interacting with others in public for fear of discrimination because of their appearance or gender expression. It can sometimes give people a false sense of security. When people feel isolated and lonely, they can easily trust people who they shouldn't or may be more likely to engage in unsafe behaviour." While ICT can provide important information, emotional support provided face-to-face in a community setting is equally or more important for many individuals.

Box 4.13

Case example: Online sexual-health promotion in Thailand

Sexperts! is an online community-led outreach and support platform for trans sexual-health promotion. A "Sexpert" is a trans woman trained as a community health educator. Sexperts provide HIV, sexual-health and legal rights education in non-threatening, anonymous virtual environments. They not only address standard HIV prevention and treatment questions, but also engage community members in discussions around sex, relationships and body issues that come with transitioning and self-acceptance in one's chosen gender identity.

Sexperts! uses a Facebook group page as the main communication platform and for facilitating live chats. Any member who logs on can discuss any issue related to their sexual health and well-being with a community health educator. Since Thai trans women are typically frequent users of social media, Sexperts! maximizes the captive audience and advertises its page on other trans- and LGBTI-related social media pages. Compared to traditional peer support workshops and online peer education, this approach allows more intensive communication between community health educators and community members.

A priority for Sexperts is to openly acknowledge the pleasure of having sex. A Sexpert understands that causing a person to feel guilty about their sexual practices will sacrifice an opportunity to discuss safer sex and personal risk of HIV.

Thai Lady Boyz Sexperts! Facebook community page allows community members to chat live and anonymously with peer counsellors.

Sexperts receive training and supervision from Thai Lady Boyz and partner organizations. They are required to stay up to date with news relating to trans health. The community health educators are also equipped with authoritative sources to quickly look up information for Facebook page members upon request, and are able to provide resources to individual community members when needed. Their communications are monitored by a programme manager.

4.7.2 Quality assurance and online safety

Good-practice standards for online programmes and outreach efforts using smartphone applications ensure the safety and privacy of members and participants. Many online programmes prefer platforms such as Facebook Group pages, such as the Sexperts! profiled in Box 4.13, or independent blog pages that require users to subscribe for membership and that are monitored by group administrators. Such monitored sites can control who has access to content and who is able to engage in live chats with either community outreach workers or other community members. Consistent monitoring by community outreach workers trained in HIV prevention and sexual-health promotion is critical to ensure the accuracy and integrity of any information presented. This is particularly important where social media pages are used as they may be easily subject to unwanted advertising and unsolicited posts from outside the intended audiences. Since it is not possible to verify the identity of online community members with total accuracy, it is especially important to take safety measures when designing and implementing any form of ICT programme.

Social media pages that include live chats with community outreach workers should be moderated by community members who serve as site administrators. This can be done by only accepting members who can access the website by referral or request. Content must also be consistently monitored to ensure that members are not "trolling" to collect information about other people's identity or to gather content without permission.

Steps to ensuring online safety include:
- Personal information such as addresses and phone numbers must never be shared.
- When using social media platforms to connect with other individuals for dating or other personal reasons, exercise great caution when sharing any personal information. When meeting in person with someone through an online connection, always meet in a public place and inform a trusted friend about the time and location of the meeting.
- Precautions must be taken to restrict announcements about safe space (drop-in centre) gatherings, or other social events that are for trans community members only to social media pages that have restricted access to members only.

4.8 Conclusion

As this chapter and the case examples throughout it highlight, programmes across diverse regions have successfully forged links between clinics and communities, using innovative approaches to common strategies. In doing so, they have achieved measurable improvements in the health of local trans populations and offer models for promising practices that may be replicated in similar resource-limited regions. Providing effective HIV prevention, diagnosis, treatment and care for trans populations not only requires trans competency in clinical and community-based programmes, but depends upon strong links between programmes across all sectors. As discussed in Chapter 3, strengthening health systems through improved training and service integration enables providers to better meet the comprehensive health needs of trans individuals. At the same time, these services must be brought together with greater efforts to bring health information and services to individuals where they are, beyond clinical settings.

4.9 Resources and further reading

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