

# HONING THE ENHANCED PEER OUTREACH APPROACH TO INCREASE HIV TESTING YIELD AMONG KEY POPULATIONS IN SENEGAL

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## CONTEXT

In October 2018, Senegal began implementing the West African PEPFAR program model, which focuses on prevention, care, and treatment among key populations as the primary means to control the HIV epidemic. The USAID-funded Neema project (2016–2021), led by IntraHealth International, supported the National AIDS Control Program (CNLS) and the Division for the Fight Against Infectious Disease (DLSI) in the coordination, implementation, and monitoring of the model in selected sites. Neema implemented the Enhanced Peer Outreach Approach (EPOA) to improve HIV case finding among men who have sex with men (MSM) and female sex workers (FSWs) in each site. This technical brief outlines the adaptations made over the course of five EPOA campaigns, which led to an increase in HIV testing yield from 12% to 24% over five quarters.

## METHODOLOGY

The EPOA is led by mediators who recruit members of their communities as peer mobilizers to identify and motivate peers in their social and sexual networks to get tested for HIV. It is based on four key components:

- The use of referral chain networks
- The offer of prevention and screening services to clients
- Performance-based incentives
- Linking clients who screen HIV-positive into treatment.

**Enhanced Peer Outreach Approach (EPOA):** EPOA is led by peer outreach workers, who engage key population members to encourage peers in their own social and sexual networks to be tested for HIV in an effort to identify new HIV-positive cases.

Implementing EPOA involved three groups: community actors, facility-based care and treatment teams, and Neema project staff. Figure 1 describes the community actors' roles.

Implementation of EPOA took place through a series of 4-to-6-week campaigns entailing the following steps:

- Train outreach mediators on EPOA standard operating procedures and management tools (enrollment sheets, coupons, tracking sheets).
- Outreach mediators and providers recruit peer mobilizers under the supervision of support teams. Selection criteria include: member of

**Figure 1: Profiles and roles of community actors**

OUTREACH MEDIATOR	PEER MOBILIZER	CLIENT	ON-SITE MEDIATOR
<ul style="list-style-type: none"> <li>• Linked to the project; salaried</li> <li>• Trained on HIV testing &amp; counseling, EPOA and communications</li> <li>• Educates, advises, and connects clients to services</li> <li>• Identifies, guides, and supervises peer mobilizers</li> <li>• Screens and refers clients and transmits data to supervisor</li> </ul>	<ul style="list-style-type: none"> <li>• Recruited and oriented by outreach mediator</li> <li>• Linked to the project</li> <li>• Incentive-based</li> <li>• Identifies at-risk members of their social and sexual network and gives them a referral coupon</li> </ul>	<ul style="list-style-type: none"> <li>• Contacted by a peer mobilizer and motivated to be screened</li> <li>• Referred to screening</li> <li>• Gives a coupon to the on-site mediator or social worker</li> <li>• Has the opportunity to become a peer mobilizer</li> </ul>	<ul style="list-style-type: none"> <li>• Linked to the project; trained employee</li> <li>• Provides linkage to care, motivates and supports client, helps with adherence</li> <li>• Follows-up with appointments and the community</li> </ul>

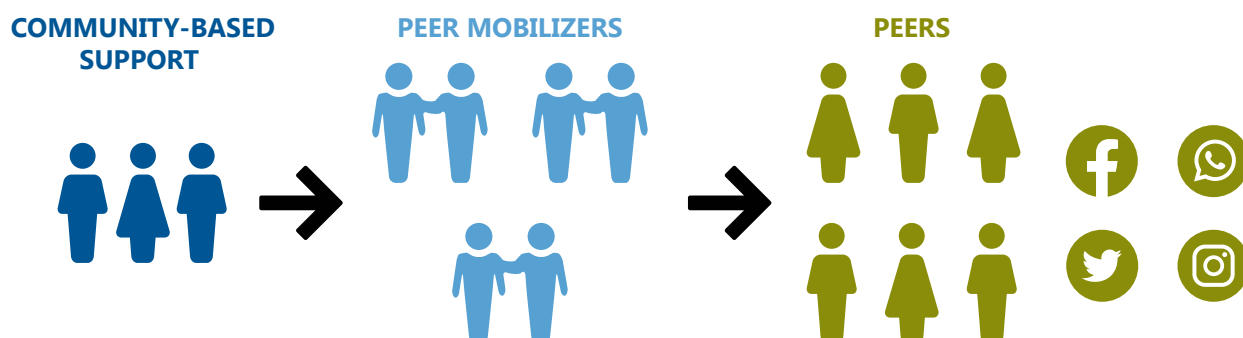
a key population, willing to participate, have access to a network (virtual or physical), and have the capacity to communicate about HIV testing and care.

- Outreach mediators orient peer mobilizers with the support of community supervisors.
- Peer mobilizers distribute coupons to key populations.
- Outreach mediators screen clients who present a coupon at the community level, health facilities, mobile clinics, or through venue-based outreach strategies.
- Clients who test positive for HIV are put on ARVs at health facilities or mobile clinics.
- Performance monitoring and coordination conducted through supervision and weekly meetings.
- Data managed through validation, checking consistency, and entering data into the electronic HIV case notification system (SENCAS) and the EPOA tracker module.
- Ongoing evaluation of the EPOA campaign at the site and central level.

The referral chain begins when a peer mobilizer is contacted at hotspots or other public or private locations where key populations congregate in small or large groups. Some MSM mediators used social networks and web platforms (e.g., Grindr, Instagram, Facebook) in the last two campaigns of 2020 because of COVID-19 restrictions on in-person gatherings.

Peer mobilizers are financially incentivized, based on performance, up to 2500 F CFA (or about \$4) per individual referred. In addition, they are given prevention and communication materials (e.g., condoms, lubricants, T-shirts). Payment is made at the end of each week after counting individuals who were screened and verified based on the eligibility criteria. Confirmatory testing of positive clients is performed in health facilities or at mobile clinics based on the client's choice. Clients visiting the mobile clinics also benefit from care and treatment for sexually transmitted infections and other care as needed.

**Figure 2: Referral chain networks between community-based support (CBS), peer mobilizers, and peers**



**Table 1: Plan for each campaign**

Key elements of the campaign	Q1 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q4 FY21
# of weeks	6 weeks	6 weeks	6 weeks	6 weeks	4 weeks
# of sites*	4 sites	4 sites	3 sites	12 sites	9 sites
# coupons distributed	10 coupons/peer mobilizer	10 coupons/peer mobilizer	10 coupons/peer mobilizer	10 coupons/peer mobilizer	3 coupons/peer mobilizer
Key modifications made	1st campaign for all sites; training of providers, community workers, and peer mobilizers	Improved selection process of peer mobilizers		New campaign for new PEPFAR sites	Fewer coupons per peer mobilizer

\*Sud, Pikine, Mbour (all campaigns); Ziguinchor (Q120, Q320, Q421); Nord, Mbao, Keur Massar, Thies, Kaolack (Q121, Q421); Saint Louis, Sedhiou, Kolda, Bignona (Q121). After expansion to 13 sites in Q121 (Ziguinchor was not included in the campaign), only 9 sites were chosen for Q421 on the basis of their previous performance and potential to find key populations. Other strategies for key population case finding were developed for sites not selected for EPOA campaigns.

**Table 2: Analysis of the results from the five EPOA campaigns**

	Q1 FY20	Q3 FY20	Q4 FY20	Q1FY21	Q4 FY21
# peer mobilizers	84	87	70	251	196
# coupons/peer mobilizer	12	9	9	11	3
% coupons returned	88%	86%	87%	71%	71%
% key populations tested	84%	98%	98%	90%	103%
# of key populations tested/peer mobilizer	9	8	8	7	3
Yield	12%	15%	14%	8%	24%
Linkage	99%	94%	101%	94%	87%
# HIV-positive	86	99	76	143	118

## RESULTS

Neema conducted five EPOA campaigns in Fiscal Year (FY) 20-FY21, or September 2020–August 2021. Table 1 captures the details of each campaign and Table 2 the overall results.

### CAMPAIGN 1

During the first EPOA campaign, there was significant variability in performance among the sites. Sud performed the highest (17% yield and 98% linkage) compared to Ziguinchor (0% positive cases and thus no one linked). Overall, we observed high rates of return of coupons (87%), good performance in terms of yield among people tested (12% overall and 17% for MSM), and high linkage to treatment (99%). This was in large part due to having a contact person for cases as well as the financial incentives for peer mobilizers at the facility and community levels. The low performance in Ziguinchor was largely due to management issues and challenges recruiting good peer mobilizers. However, we also noted several other challenges including low overall yield among FSWs (4%).

**Strengths:** Overall, there was strong commitment and collaboration among actors at different levels, including between community actors and health workers. Our regular meetings and supervision enabled coordination and reliable oversight and we maintained strong data quality control mechanisms.

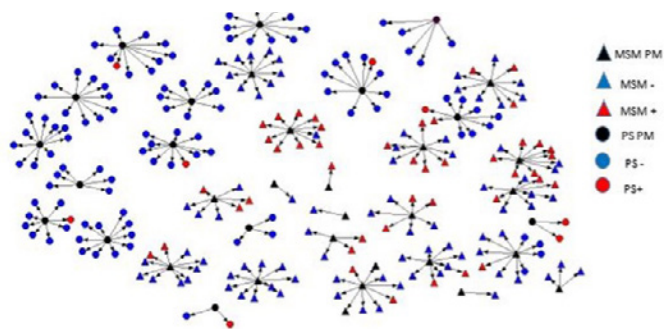
**Weaknesses:** Guidance from some outreach mediators was insufficient due to the reluctance of peer mobilizers to accept the participation of community supervisors, delayed payment of peer mobilizers at sites, and lack of funds for data bundles for peer mobilizers.

Figures 3 and 4 visualize results from the first EPOA campaign, showing MSM who referred the most positive cases (red triangles or squares).

### CAMPAIGNS 2 & 3

The second and third campaigns occurred during the COVID-19 pandemic, which allowed Neema to adapt the EPOA strategy to add awareness and protection measures against COVID-19 into the provision of HIV services and use phone and social

**Figure 3: Example visualization of the EPOA results for the first campaign**



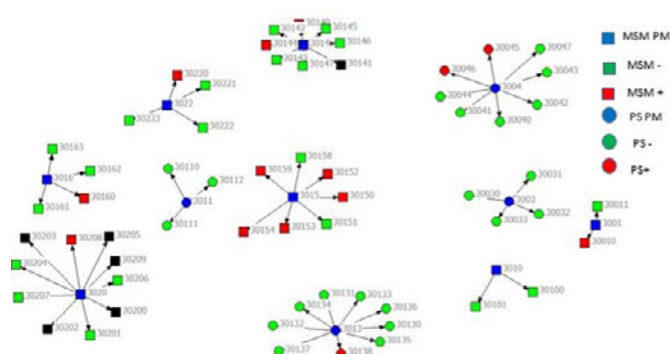
networks (e.g., Facebook, WhatsApp) to expedite referral and testing at the community and facility level. Neema reorganized working hours at facilities to ensure the continuity of services, especially during the state of emergency and 6 pm curfew.

The second and third campaigns showed similar results as the first campaign in terms of coupons returned (87%). However, there was an improvement in testing acceptance—up to 98% in both campaigns among key populations returning with a coupon. This may be indicative of better targeting of peers by peer mobilizers or improved counseling among outreach mediators and health workers because they better understood and implemented the EPOA campaign. The yields of the second and third campaigns were higher at 14% and 15% compared to the first campaign at 12%.

**Strengths:** Debriefing meetings allowed for quick adjustments such as the use of online social networks and modifying work hours. Strong team commitment and leadership demonstrated the collaboration of community actors with site providers, and the motivation of actors beyond working hours. The commitment of the care and treatment teams resulted in the mobilization of the site teams throughout the campaign in search of recent cases not yet confirmed and their availability to confirm these clients outside the campaign structure or during non-working hours and days.

**Weaknesses:** A weakness in the return of coupons was noted throughout the campaigns due to the fact that peer mobilizers were not able to distribute coupons to people at high risk, suggesting a flaw in how peer mobilizers themselves were identified and recruited. This situation was most often due to a lack of adherence to the criteria for the recruitment of peer mobilizers by mediators. In many of the locations, the recommended solution was to assist mediators in recruitment using pre-defined criteria,

**Figure 4: Visualization of the results of the first campaign in Pikine**



to organize formative supervision, and to monitor coupon distribution activities. At some health facilities, stockouts in lab reagents (Multisure and SD Bioline) and supplies to confirm positive cases was a challenge. To remedy this, the support of the DLSI was requested to deliver reagents, which led to a quick resolution.

## CAMPAIGN 4

During the fourth six-week EPOA campaign, which also occurred during the COVID-19 pandemic, the overall rate of return of coupons distributed was 71%. Although the overall yield was quite low (8%) and average among MSM (10%), an acceptable yield of 5% was recorded among FSWs despite the decline in prevalence among FSWs at the national level. The ART initiation rate for all key population categories and for MSM stayed the same (94%). Of the positive cases, 99% came from community screening.

**Strengths:** Good coordination, timely data entry, supervision of peer mobilizers for quality data collection and risk evaluation, and the discovery of new networks of key populations were noted as strengths.

**Weaknesses:** Challenges during the fourth campaign included finding hidden FSWs, an insufficient number of peer mobilizers especially among FSWs, capacity gaps in knowledge among mediators, stockouts, low desire of key populations to become peer mobilizers, and restrictive measures such as curfews due to COVID-19 that slowed down the performance of mediators.

**Figure 5: EPOA enrollment form**

EPOA ENROLLMENT FORM					
Structure Name: _____		Date: _____			
Name of Mediator: _____					
STEP 1: IDENTIFICATION	YES	NO	STEP 3: REFERENCE	YES	NO
Q1. Have you had sex in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Were you referred for HIV testing?	<input type="checkbox"/>	<input type="checkbox"/>
Q2. Have you had sex in exchange for goods or money in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Were you referred by a peer mobilizer (PM)?	<input type="checkbox"/>	<input type="checkbox"/>
MSM: Q3. When was the last time you had sex with a man?			If yes, the PM's name: _____ If yes, the PM code (on the reference coupon): _____/_____/_____/_____		
STEP 2: HIV RISK ASSESSMENT	YES	NO	STEP 4: RECORD	YES	NO
Did you use a condom during the last time you had sexual intercourse?	Yes = 0	No = 2	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ Relationship with the Peer Mobilizer: <input type="checkbox"/> Friend <input type="checkbox"/> Sexual partner <input type="checkbox"/> Other <input type="checkbox"/> Refused to respond How many other KP do you know? _____		
MSM: Have you had more than one partner in the last 3 months? SW: Do you have more than 5 clients per week?	Yes = 2	No = 0	Have you ever benefited from HIV services (HIV testing, ART)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used alcohol/drugs before sex in the last 3 months?	Yes = 1	No = 0	Eligibility for screening (see eligibility criteria below) if yes, follow the screening circuit	<input type="checkbox"/>	<input type="checkbox"/>
Have you been forced to have sex in the last 3 months?	Yes = 3	No = 0	STEP 5: PEER MOBILIZER	YES	NON
Have you been tested for HIV in the last 2 months?	Yes = 0	No = 2	Do you want to become a PM and distribute referral coupons? (Explain the strategy before)	<input type="checkbox"/>	<input type="checkbox"/>
Score total	/_____/10		How many coupons can you distribute?		
			How many coupons have been issued?		

**Eligibility Criteria:**

- Be a SW (female respondent who answered yes to Q1 & Q2) or MSM (male respondent who answered yes to Q1, and gave a period in Q3)
- Be at high risk of HIV transmission (score greater than or equal to 4)
- Not having benefited from the services of the Niema project

## CAMPAIGN 5

During the fifth campaign, the coupon return rate remained relatively low at 71%; however, over 100% of key populations were tested. The yield for the fifth campaign was the highest, at 24%, allowing the identification of 118 positive cases. This was due in part to increasing the eligibility score to be tested from 4 to 5 out of 10 risk criteria (see Figure 5). Analysis of the results from four sites over time (Sud, Pikine, Mbour, and Ziguinchor) shows increasing campaign effectiveness thanks to decreasing the number of coupons distributed

**Table 3: Results from Pikine**

	Q1 FY20		Q3 FY20		Q4 FY20		Q1 FY21		Q4 FY21	
	Pikine	Total	Pikine	Total	Pikine	Total	Pikine	Total	Pikine	Total
# peer mobilizers	29	84	29	87	20	70	29	251	23	196
# coupons/peer mobilizer	11	12	9	9	9	9	10	11	5	3
% coupons returned	93%	88%	95%	86%	93%	87%	98%	71%	88%	71%
% key populations tested	100%	84%	98%	98%	98%	98%	102%	90%	99%	103%
# key populations tested/peer mobilizer	10	9	9	8	8	8	10	7	5	3
Yield	7%	12%	9%	15%	17%	14%	11%	8%	30%	24%
Linkage	100%	99%	96%	94%	100%	101%	97%	94%	100%	87%
# HIV-positive	20	86	23	99	29	75	33	143	33	118

among the peer mobilizers from 12 to 3. This led to an overall positive progression of yield (11% to 23%), which was particularly significant among MSM (27%). This was due in part to retaining high performing peer mobilizers.

In taking a closer look at Pikine (Table 3), we can see an even higher increase in yield from 7% to 30%.

**Strengths:** Specific targets were attributed to each site for MSM and FSWs based on hotspot mapping and virtual weekly monitoring at site level enabled course correction.

**Weaknesses:** The length of the campaign was cut short due to the end of the project, slow transfer of funds at community level, and a lack of supplies needed for testing.

## LESSONS LEARNED

- The results confirm a **high concentration of the epidemic among young hidden MSM**. However, they also highlight the need to develop strategies to recruit older MSM, which obtained the highest yield, as they may not respond as well to younger peer mobilizers.
- **Ownership of the EPOA** by health actors (districts, regions, and central level) was critical in achieving the results.
- The implementation of EPOA requires **good preparation** and the **availability of financial, material, and human resources**. Participatory planning with the development of action plans at all levels is important for smooth running campaigns.

- Respecting the **selection criteria for peer mobilizers** and maintaining high performing mobilizers contributes to the success of EPOA campaigns.
- **Reducing the number of coupons** and **increasing the eligibility score** for inclusion in the EPOA campaign increased the yield.
- The **adaptation of work schedules** by the support teams during the campaign facilitated the confirmation of reactive cases and the initiation of ARVs.
- The **use of mobile clinics and networks** (WhatsApp, Facebook) during the campaign made it possible to overcome challenges due to restrictions because of COVID-19.
- Central level **data quality audits** helped correct malfunctions and improve the quality of the use of data management tools.
- Make a specific action plan for identifying underground FSWs and hidden networks
- Follow-up confirmed cases not yet put on ARVs at the health center
- Make more use of online networks (e.g., Facebook, WhatsApp) for the referral of key populations

## RECOMMENDATIONS

- Provide peer mobilizers with communication credit
- Ensure compliance with the selection criteria for mobilizing peers
- Involve health care providers in the selection of peer mobilizers from key populations living with HIV who may not be part of networks (e.g., VIPs/local authorities who are MSM)
- Support the guidance of peer mobilizers by community supervisors through individual interviews
- Organize two meetings per week for the coordination of the campaign
- Strengthen the frequency of mobile clinic outreach in the sites during the campaign
- Check regularly for unconfirmed reactive cases and do not wait for the end of the campaign
- Strengthen the use of the enrollment form among FSWs to increase performance
- Identify strategies to encourage certain key populations to become peer mobilizers

## CONCLUSION

Overall, the EPOA campaigns made it possible to reach hidden key populations, specifically MSM, and significantly contributed to an increased yield. They also raised awareness among key populations who were not usually reached by traditional prevention activities. The two most important factors in improving the yield were reducing the number of coupons the peer mobilizers distributed from 10 to 3 (which encouraged more selective and efficient testing and was more cost effective) and increasing the eligibility score for the risk evaluation for testing, which facilitated better and more efficient targeting of the most at-risk key populations.

## CONTACT

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