Session 1 Questions and Answers

What is the cause of increased mortality among men compared to women living with HIV/AIDS? Are there effective strategies for case identification among them?

Response: Increased mortality for men compared to women is in part due to a 'service gap' for men (vs. a 'rights gap' for women). The 'rights gap' also often applies to men who have sex w men, men who are sex workers, and men who use drugs.

If prevention is effective why there a shortage of financing for it? What advocacy is being done?

Response: Agree this has been underfunded! The new Global AIDS Strategy costing calls for increases in funding here, to match the unmet needs. There are also a couple of things to note on Prevention funding: much of the monies spent on HIV prevention in 2018 (30-40%) were spent on activities that are not part of the key evidence-based 'prevention pillars'--this amounts to billions of dollars being spent for sub-optimal or sometimes no effect. Also, even as PEPFAR and Global Fund need to invest more in prevention, it's important to note that the vast majority of prevention funding, especially for key populations, is funded by international sources. Commitment to prevention funding including for KP really needs to increase nationally as well.

For trans people, while aspects relating to their identities are not criminalized, they are disproportionally targeted by laws criminalizing homosexuality. How is transgender criminalization defined in the slides?

Response: trans criminalization is defined by criminalization or prosecution specifically targeting trans people. It's not only criminalization …even better than non-criminalization are "protective laws" that explicitly grant equal rights and protect against discrimination.

Comment atteindre l'obhectif de réduction de la stigmatisation et discrimination à moins de 10% des pays alors qu'il ya encore plus de 130 pays concernés dès lors que nous proche du jalon (2025). Des réflexions dévraient être menées pour cette cible qui reste pour moi trop ambucieuse.

How can we achieve the objective of reducing stigma and discrimination to less than 10% of countries when there are still more than 130 countries concerned and we are close to the milestone (2025). Reflections should be conducted for this target which remains for me too ambiguous.

Response:

The presentations have shown 65% of new HIV infections occur among key population, is there a factor that implementers should focus on? Is COVID-19 a contributing factor?

Response: While the 65% is based on 2020 data, so does include "COVID times" this seems more of disproportionate impact of HIV on KP as well as failure to make as much progress for KP as we are for non-KP populations.

How can NACP Liberia and other GOL Agencies provide services for MSM when our Penal Code criminalizes same sex relationship?

Response: Great question. Our colleagues from Zimbabwe and Tanzania have recorded presentations on this topic - they are on the meeting website here: This will also be the topic of several of the meeting sessions - especially session 7 and session 9a, but I think this will come up in many contexts throughout this meeting.

Are there surveys or studies that can inform on KP who are both MSM and SW or MSM and PWID?

Response: Keith Sabin from UNAIDS is presenting later in the conference, and he would be a great resource for more details on this. Of course, there is intersectionality between these designations... these are poorly captured in large studies, but we can gain insights from more specific and targeted studies including the IBBS and newer methodologies

In Kenya, people under the age of 18 and below, the government does not create awareness to people like those. It has come to my attention that many people who are getting infected are below the age of 18. How can this be solved?

Response:

Will these inequalities towards men in programing which is now resulting in more men dying from AIDS result into another crisis and what can we do to make sure that men do not suffer as current key population in our various countries?

Response:

Quel sera le niveau d'implication des des KP dans les PSD au niveau de chaque pays vu que des différences sont significatives dans le suivi de ces personnes qui ont du mal à avoir accès aux soins de qualité.

What will be the level of involvement of the KP in the DSD at the level of each country given that there are significant differences in the follow-up of these people who have difficulty in having access to quality care?

Response:

Looking at the information on distribution of HIV infection by population, globally and SSA from the last presenter, while we note 61% of HIV infections are from other populaitons in SSA (and only 39 fromKP), I wonder how much are the structural barriers in this region (SSA) affects the surveillances among KP?

Response: Great point! We will have two sessions tomorrow on M&E of KP services (session 4 and session 6a) and I think this point will be discussed in more detail.

Aujourd'hui peut-on avoir un rapport harmonisé sur l'impact des DSD pour chaque pays et au niveau global afin d'apprécier l'impact des actions réalisées depuis un peu longtemps?

Can we now have a harmonized report on the impact of DSDs for each country and at the global level in order to assess the impact of actions carried out for a little while?

Response:

The presentation focused on sex workers, but what about their customers?

Response:

Can you briefly describe? Societal enablers 10-10-10 targets the first 10% target which says Less than 10% of countries have punitive legal and policy environments that deny or limit access to services. Does it mean that all countries should remove social and legal impediments towards an enabling environment limiting access or utilization of HIV services?

Response:

What are the challenges/barriers for a full implementation of the 2016th political declaration to ensure that KP led organizations are really playing a relevant role in terms of programs implementations?

Response: The challenging political environment for KP that members here referenced in your survey is definitely a challenge--and we would note that the global 'temperature' on this is very difficult. In the political declaration negotiation itself, it really took a lot of work of member states working together (led by Namibia and Australia) to KEEP even the language/naming of KP in the declaration, and to keep the community-led language as well. In part what helped is the understanding that we cannot end AIDS without addressing and serving KP, and for community-led clarifying that increasing attention to this does not eliminate the responsibility of the govt/duty-bearers to deliver for ALL their citizens including KP.

Related to the challenging of capturing Key Population data, what are the barriers? Won't collecting data in forms be a possible tool of discrimination for Key Populations?

Response:

For Zimbabwe: you said you started the approach of treat All within the ministry but how? Where did it start? what made you start? Other ministries or your parliament don't agree on KP and your laws do criminalize KPs right? And yet there are other country guidelines that mentions KPs but when it comes to creating specific KP group everything is denied so what do you do on that?

Response:

How do MOH programs capture data specific to KP groups when other leaders don't want to see the word transgender, MSM, SW etc.??

Response:

For Zimbabwe: What process did you use to get different national key population estimates for planning and implementation?

Response:

How have countries/governments integrated KPs in social protection programs during COVID-19?

Response: