



Differentiated Service Delivery for Key Populations

Virtual Meeting: August 25-26 and 30-31, 2021

Experiences with Community-Led Monitoring of KP Programs in Sierra Leone

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HIV Learning Network
The CQUIN Project for Differentiated Service Delivery



HIV and KP in Sierra Leone

Overall adult HIV prevalence = 1.7% (DHS 2019)

Spectrum estimate: 80,000 PLHIV in Sierra Leone (UNAIDS July 2020)

No recent KP size estimates, but IBBS study is underway – new data expected soon

Key Population Groups	KP size estimates (2013)	Estimated HIV prevalence amongst KP (2019)
Female sex workers	240,000	6.7%
Gay men and other MSM	20,000	14%
Transgender people	3,400	15.3%
People who inject drugs	1,500	8.5%

Source for KP size estimates = UNAIDS Fact Sheet 2020

Scope of KP Program in Sierra Leone

- Hotspot Mapping
- Drop-in-Centres (DIC) - HIV testing, HIV Self Test, PrEP, Safe Haven for GBV victims
 - DIC soon to provide comprehensive services including HIV care/ART, STI
 - KP also receive HIV services at MOHS facilities; however, they are not classified and documented as KP at these facilities so no monitoring/reporting specific to KP or tailored services for KP are provided
- Peer Education/Community Outreach/Peer Navigator
 - Linkage to care
 - Support retention in care
- Harm reduction (PWID)
- Data collection, analysis and reporting
- Ongoing IBBS study which will help change programming approach

Community-Led Monitoring (CLM)

- **Community-Led Monitoring** is an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups or other community entities.
- Recipients of care collect and analyze quantitative and qualitative data on the availability, accessibility, acceptability, affordability and appropriateness of HIV services.
- To back up the quantitative data, interviews and focus group discussions are held with recipients of care and health care workers.
- Advocacy based on the evidence and observations gathered is an essential outcome of community-led monitoring initiatives.
- In Sierra Leone, CLM is implemented by implemented by the network of HIV Positives in Sierra Leone (NETHIPS)

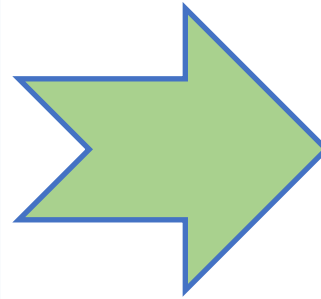
CLM Data Collection Process

Quantitative Data

- ITPC tool used by volunteers to collect data from service registers at health facilities
- Data collected on monthly basis

Qualitative Data

- ITPC tools used by volunteers to collect data or conduct interviews for RoC and HCW
- Recordings are captured with tablets
- Key points are captured in the worksheet and transcribed in Word



DQA/Quality Assurance

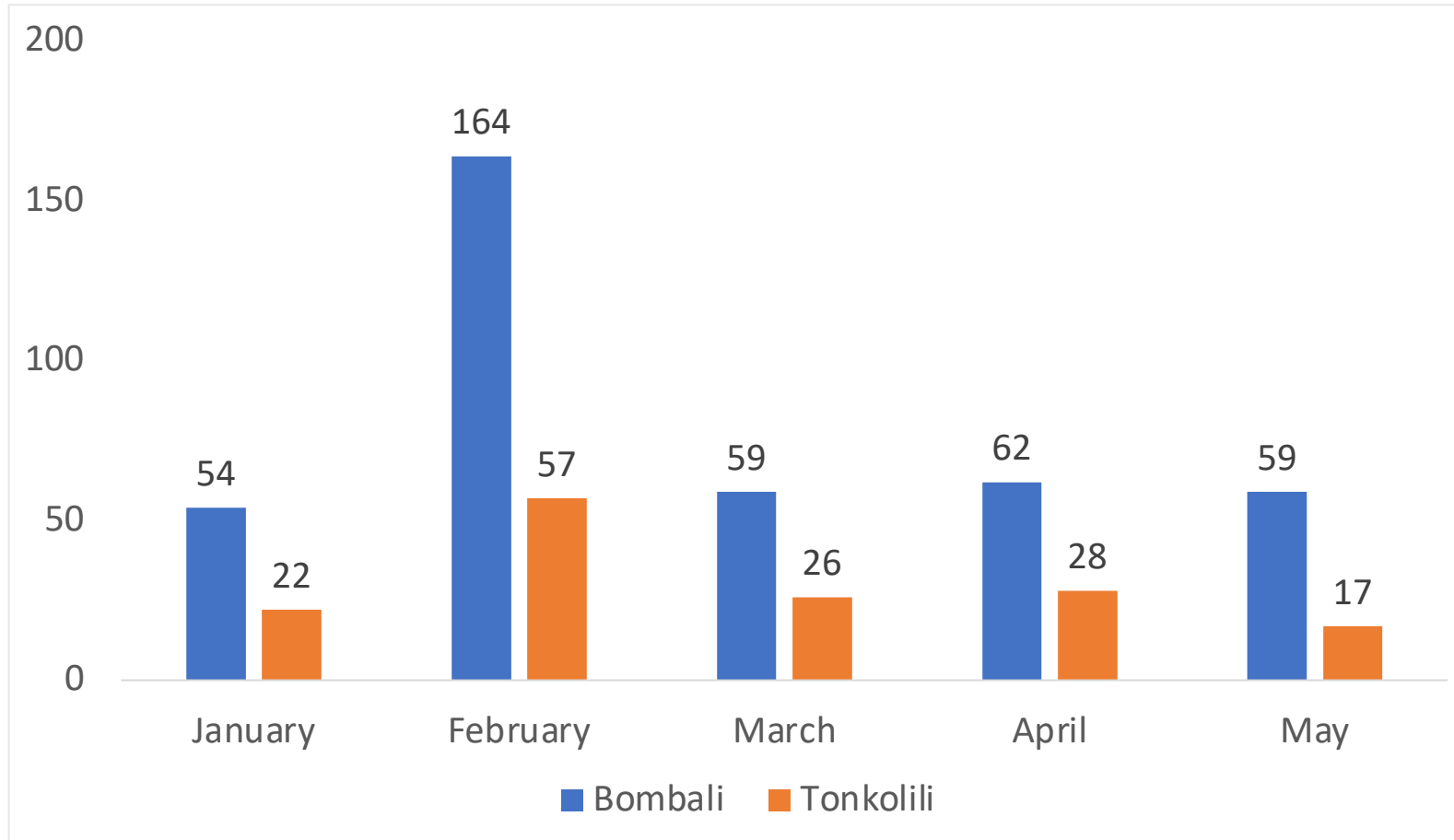
- District Supervisors receive and review field reports
- Project officer conducts follow up visit to health facility to address issues with data
- CLM Focal Point organizes quarterly review meeting with project team and HCW to verify correctness of data
- Community Consultative Group (CCG) receives report, validates and advise on advocacy issues

CLM in Sierra Leone

- NETHIPS signed MoU with National AIDS Control Programme for data collection at public health facilities.
 - Wide range of data is collected, including ART initiation [same day vs. not] and retention, MMD, viral load testing and suppression, CD4 coverage, stock out [drugs & duration, equipment, supplies & duration], TB, COVID-19, etc.
 - Cannot monitor KP specifically due to lack of classification/documentation
- Also conducting CLM at Drop-in Centres for KP
 - Collecting data on intimate partner violence, HIV testing, PrEP
 - Will collect data on ART initiation and retention, viral load testing and suppression
- CLM findings are shared with key partners including government
 - Evidenced informed advocacy based on CLM findings

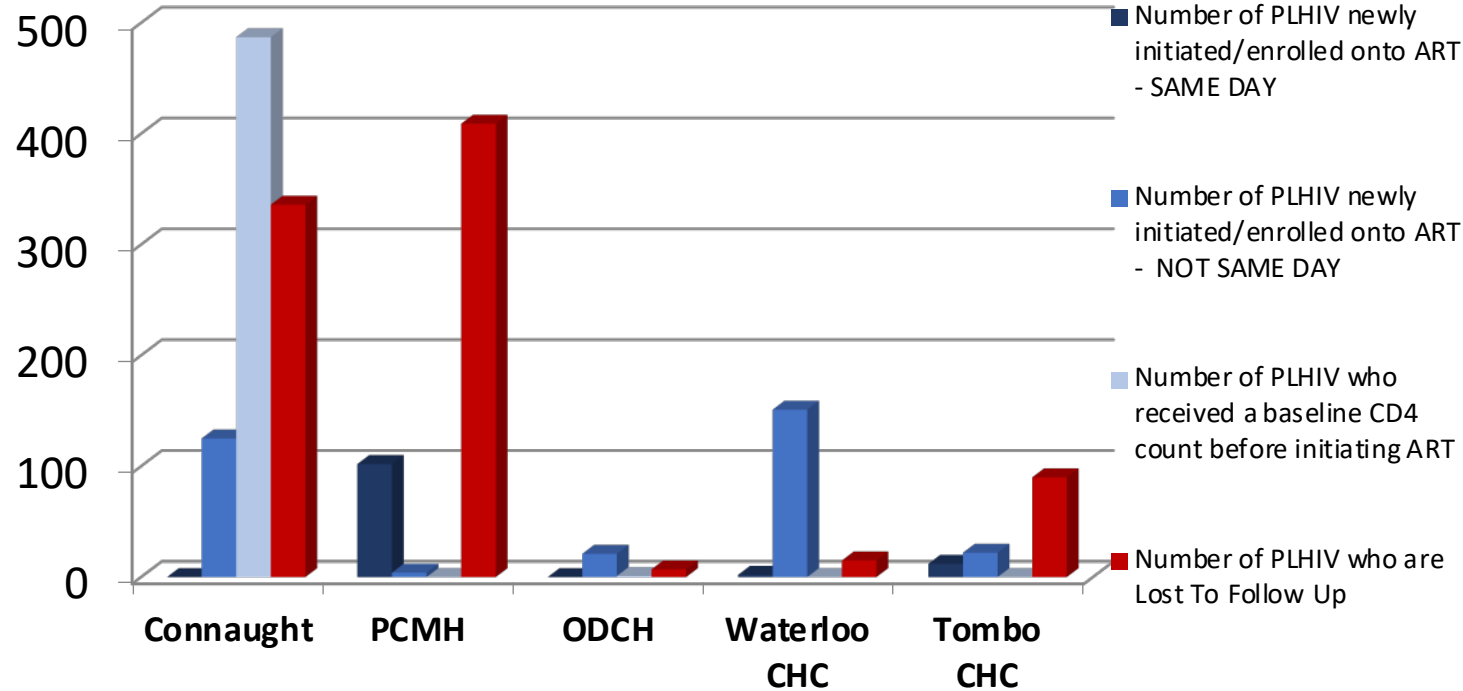
Example of CLM data from DIC

Number of incidents of IPV among female sex workers, January-May 2021



Example of CLM data from public facilities

ART enrollment, baseline CD4, and LTFU, September –December, 2020



'Our clients are afraid to come because their immunity is already compromised. They fear getting COVID-19'

HCW Connaught, 7th Dec. 2020

Lessons Learned

Important to engage in evidenced informed advocacy;
some issues identified through CLM:

- High level of intimate partner violence and other gender-based violence registered among FSW population
- Unavailability of data on Key Populations in MOHS facilities – DIC now encouraged to provide services for Key Populations. CLM is collecting routine data at DIC on HIV testing, PREP, etc.
- Stock out of ARV – Data collected on type of drugs, facility, period of stock out, etc. (led to prompt distribution, loan of drugs from neighboring countries, etc.)
- Unavailability of Viral Load and EID testing
- DSD services – that led to DSD policy and implementation

Lessons Learned Contd.

Evidence informed advocacy:

- Provides opportunity for recipients of care and key populations to work together with relevant stakeholders to improve access to quality, uninterrupted HIV services
- Enhances constructive dialogue between service users and service providers for improved service quality
- Ensures trust and ownership of the process

Key Challenges

- High level of stigma at public health facilities – health facilities not KP friendly
- Unfriendly legal environment – anti-KP laws
- DIC are not yet equipped to provide comprehensive KP services (ART, STI and other treatment)
- Safe havens for people affected by intimate partner violence (IPV)/gender based violence (GBV) not fully functional
- Stock out of HIV drugs and other commodities is a major challenge that affects service uptake

The End

