

1. In countries where sex work is criminalized KPs are mostly reserved from mentioning their target group. What are these countries experiences with strong M & E?
Responses: It really varies greatly by the experience of the community members with the service providers. Where there is trust, and where the police are not waiting outside, we see people being more forthcoming. WHO does not recommend insisting on disclosure, that it is important to protect the well-being of the participants.

Strong M&E does not overcome strong stigma and discrimination.

In addition, in some countries we have also used other acceptable terms to describe the key populations. For instance, in one country we were not allowed to use the terms female sex workers (FSWs) and men who have sex with men (MSM). Working with staff at the ministry of health we instead used the terms “females at risk” and “men at risk” in place of FSWs and MSM.

2. For the second presenter: What is the best approach? To have a specific health information system to collect and report KP data or to integrate it into the general HIV information systems, and have KP as a disaggregation?
Response: As shows in Shem's presentation this begins with strong national leadership and coordination and the development of standardized tools which used by all organizations providing services to KPs. Regular analysis of data and feedback to implementing partners is also important.
3. What may have caused the relatively low uptake of PrEP among the FSW - you stated only 43% of FWS who consented to be referred for PrEP were actually initiated on PrEP?
Response: The reasons varied. The most important issue though was readiness (or lack of) for PrEP.

4. As you know KPs are mobile by there working nature, when to do impact evaluation? if it is difficult to get at the end of the project
Responses: It is important to set your evaluation criteria in advance. The population is often very fluid in the community. If the intervention is for the community, you can measure impact on the community even though some proportion of the population has changed. If the intervention is for individuals, you might want some way to find them again, even if they have left that geographic community.

In addition, projects should also regularly update their data on the number of KP in the target areas and the location of the sites where KPs can be found. Given the mobility and frequent turnovers, especially among FSWs, projects may want to utilize their routinely collected data to measure changes in reach, coverage, and risk behaviors among KPs at regular intervals rather than wait until the project has ended.

5. Question sur la stratégie pour gerer la mobilité élevée de KP pour garantir la fiabilité de rapportage?
Response: Ce sera bon à faire une petite enquête sure la mobilité, si c'est possible à dècrir les caracteristiques des gens qui vont et viennes. C'est toujours une question dificile à gerer.

Question on the strategy to manage the high mobility of KP to guarantee the reliability of reporting?

Response: It will be good to do a little mobility survey, if it is possible to describe the characteristics of the people who come and go. It is always a difficult question to deal with.

6. What are the estimates for PWUDs in the year 2018 for Kenya? Size estimates, not HIV prevalence.

Response: Kenya reported 16,000 PWID in 2019.

7. Avons-nous une approche coût-efficacité pour les rencontres en ligne?

Réponse : Pour les HSH, oui, il y a quelques exemples de FHI360, et Terrence Higgens Trust au Grande Bretagne. Ca marche dans les regions où il y a beaucoup des useurs de "dating apps."

Do we have a cost-effective approach to online dating?

Response: For MSM, yes, there are a few examples of FHI360, and Terrence Higgens Trust in Great Britain. It works in areas where there are a lot of dating apps users.

8. What are the mapping process you have gone through for PWID? By whom? where? how?

Response: We use programmatic mapping approach in estimating the size of Key populations. This process involves peer educators, drawn from the various locations where PWID interventions are implemented

9. Pour Shem; Ce code unique est-il accompagné par l'identité du client quand on sait que ce dernier peut avoir plusieurs identités ?Aussi qui encode ?

Réponse : Il est encodé par le partenaire de mise en œuvre et les variables utilisées masquent l'identité d'un individu

For Shem; Is this unique code accompanied by the identity of the client when we know that the latter can have several identities? Also who encodes?

Response: It's encoded by the implementing partner and the variables used hides the identity of an individual

10. Aimeriez-vous partager avec nous les outils de collecte des données afin de capitaliser les éléments importants?

Réponse : Oui, je les ai partagés avec les organisateurs de la réunion et les outils et conseils seront affichés sur le site Web de la réunion dans la section « ressources ».

Would you like to share with us the data collection tools in order to capitalize on the important elements?

Response: Yes, I have shared these with the meeting organizers and the tools and guidance will be posted on the meeting website under the "resources" section.

11. Is the UIC also used by the government/ public health facilities in Kenya or its only used by IPs?

Response: In Kenya, the KP program is a donor funded program and used by IPs. However, we have some drop-in centers integrated within the government facilities and funded by donors. The UIC is also used in this setting

12. To the Kenya presenter: How do you avoid double or even triple reporting since the unique identifier is not really based on an individual but rather the IP or even county. Can't a KP seek services and be registered under several counties and/or IPs?

Response: Thank you for your question. The unique identifier is tied to an individual. In the event that a KP seeks services from another IP, there is a tool which is used to ascertain if they are enrolled somewhere else. Once this is established, they will not be enrolled by that program

13. Bonjour merci pour l'exposition clair ma question est par rapport aux données spécifiques des pops clés ou même de la priorités de leurs programmes ne va pas renforcer les désagréments par rapport a leurs besoins et l'accès de leur santé adaptée aux besoins dans les pays qui sont prêts à s'affronter a ses cibles

Response: C'est bien possible que des questions dans une enquête peut empêcher la participation des gens. Mais, pour la plupart, nous rassemblons les données d'usage des programmes, pas beaucoup des questions sur leur comportement. On espère que on les empêche pas.

Hello, thank you for the clear exposition, my question is par rapport to the specific data of the key pops or even the priorities of their programs will not reinforce the inconvenience par rapport to their needs and the access of their health adapted to the needs in the countries who are ready to face their targets

Response: It is quite possible that questions in a survey may prevent people from participating. But, for the most part, we collect data on the use of programs, not a lot of questions about their behavior. We hope that we do not prevent them.

14. For Sierra Leone, Considering the different locations for testing (DIC) and treatment (health facilities), are there challenges with linkage to care for those tested at the DIC?

Response: At the moment, the Peer Navigators have as part of their terms of reference to support clients to be linked to care. Of course, there are challenges with that arrangement which was also highlighted in my presentation. KPs can fall through the cracks with such arrangements, including delay in time to access services and cost for transportation to and from the health facility. We are working with NACP to have these challenges ameliorated by providing comprehensive care in the DICs once we start the implementation of the Global Fund NMF 3 grant.

15. On Community-led Monitoring, how does the team manage to secure support from the Government to validate the findings and respond to the findings/recommendations.

Response: The focus of Community-Led Monitoring is to collect credible data that everyone will trust. For that reason, data quality checks are done at every stage of the data collection process. This makes it easier for government to trust the findings. Government is also represented in the Steering Committee known as the Community Consultative Group (CCG) with three members – National AIDS Secretariat (NAS), National AIDS Control Programme (NACP) and the District Health Management Team (DHMT). This committee receives, discusses, and validates the report. In short, the government is involved at the data collection stage (health facility register is our source document) and validation stage (CCG).

16. For Mr. Songo: Are there any strategies put in place to reduce stigma and discrimination of the KPs in their families and workplaces?

Response: The PLHIV stigma index 2.0 was conducted in 2020 in Sierra Leone, and it has recommendations for different categories of people including KPs. In the Global Fund grant (NFM 3), there are specific stigma reduction activities for KPs targeting different stakeholders including their families, religious leaders, the police, Parliamentarians, etc.

17. @ Sierra Leone. Kindly give examples who the volunteers who collect Quantitative data are

Response: The volunteers are KPs and Recipients of Care (PLHIV).

18. Question for NETHIPS: What information do you collect through CLM that is not collected by partners through routine monitoring (like 90-90-90 data). Can you share few examples? Thanks

Response: We collect data on HIV services focusing on the 5As – Availability, Accessibility, Acceptability, Affordability and Appropriateness. For example, on availability: *How often do you need to return to the clinic to pick up your refill? At your last refill, for how many months did you receive ARV? At your last refill, were all the ARVs in your regimen available?*

19. Pour la Sierra Leone, l'Etat a-t-il pris des mesures pour la réduction de la stigmatisation?

For Sierra Leone, has the state taken steps to reduce stigma?

Response: Lots of effort is made to reduce stigma but we need to do more. A legal environment assessment was conducted by UNDP in collaboration with the government and civil society organizations. The implementation of the recommendations will contribute to stigma reduction. A PLHIV stigma index study 2.0 was conducted in 2020 and there are recommendations for stigma reduction

20. Thanks, Sierra Leone, for details. Am concerned about CLM indicators, they are not different from facility indicators. One would want to see indicators that monitor community efforts at improving those facility indicators. What are the CSOs doing to improve loss to follow up, test and treat among others. Those are the indicators CLM should track

Responses: As much as we look at indicators that the health facility also considers, we go beyond collecting routine data. We also collect data on service availability, accessibility, acceptability, affordability, and appropriateness. For this, we directly engage recipients of care. At activity implementation level, efforts are made to bring lost to follow up to care and support retention efforts. CLM capture data on ART initiation (same day or not), loss to follow up, viral suppression, etc.

In addition, in EpiC and LINKAGES we worked with the programme managers and technical team to identify a set of questions they would like to answer in order to improve the quality of the programs. Based on this a standard set of graphics were developed to display the data in a format that is easily understood by them. These slides are updated regularly (at least monthly) and shared with program managers.

21. Given the heightened risk related to KP data, please describe the ethical considerations when setting up a HMIS. Thank you

Response: The best approach is to take preventative steps to prevent unauthorized access to the project data that can lead to either to identification of the individual KPs or places where they are usually reached with services

22. Thank you very much for your response what we face to see individual level impact is after they have gaining different behavior change services like peer education, outreach services,

counseling, etc. They change their geographic address for searching better business places and change their phone number for their security. So it is difficult to get what behavior changes come after the program. In some case and place they are mobile in a month base

Responses (from question 4 above): It is important to set your evaluation criteria in advance. The population is often very fluid in the community. If the intervention is for the community, you can measure impact on the community even though some proportion of the population has changed. If the intervention is for individuals, you might want some way to find them again, even if they have left that geographic community.

In addition, projects should also regularly update their data on the number of KP in the target areas and the location of the sites where KPs can be found. Given the mobility and frequent turnovers, especially among FSWs, projects may want to utilize their routinely collected data to measure changes in reach, coverage, and risk behaviors among KPs at regular intervals rather than wait until the project has ended.

23. A minha questão vai para o Keith, gostava de ouvir sobre a cobertura de carga viral, para as populações chave gostava de ouvir na sua experiência.

Resposta: Em geral, temos poucos dados sobre a supressão da carga viral (VLS) especificamente de populações-chave. Esses dados que vimos vêm de pesquisas que puderam incluir um teste VLS em seu orçamento. Ocasionalmente, vemos relatos de centros clínicos com números de uma determinada população com supressão viral, mas raramente vemos isso combinado com o número de pessoas recebendo TARV ou que conhecem seu estado. Este continua sendo um dos indicadores mais críticos que não conseguimos medir com frequência. Os desafios são a combinação do custo adicionado a uma pesquisa e a capacidade de perguntar e coletar com segurança a “adesão” da população-chave em ambientes clínicos onde o estigma e a discriminação são comuns na sociedade. Por enquanto, a OMS continua a não recomendar a coleta do status da população-chave em registros clínicos se não for clinicamente relevante e onde possa representar um dano potencial para o cliente.

My question goes to Keith, I would like to hear about viral load coverage, for key populations I would like to hear about his experience.

Response: In general, we have few data on viral load suppression (VLS) specifically from key populations. Those data we have seen come from surveys which have been able to include a VLS test in their budget. Occasionally, we see reports from clinical sites with numbers of a particular population with viral suppression, but we rarely see this combined with numbers of people receiving ART or who know their status. This remains one of the most critical indicators that we have been unable to measure with any frequency. The challenges are combination of cost added to a survey, and the ability to safely ask and collect key population “membership” in clinical settings where stigma and discrimination are common in the society. For the now, WHO continues to not recommend collecting key population status in clinical records if it is not clinically relevant and where it might present a potential harm to the client.

24. CLM seems to be a robust approach as you explained but why do you have to sign an MOU with government instead of advocating it to be part of the national M&E System?

Response: We can only have access to the health facility registers when permitted. In this regard, signing an MOU with the National AIDS Control Programme allowed us to collect data at all government health facilities across. We are advocating for some of the data to be part of the national M&E system.

25. Comme les lois sont répressives comment vous faites pour mettre en œuvre les interventions commentaires et collecter les données mbaïe boye Sénégal

Réponse : Dans certains pays, nous avons également utilisé d'autres termes acceptables pour décrire les populations clés. Par exemple, dans un pays, nous n'étions pas autorisés à utiliser les termes professionnelles du sexe (FSW) et hommes ayant des rapports sexuels avec des hommes (HSH). En collaboration avec le personnel du ministère de la Santé, nous avons plutôt utilisé les termes « femmes à risque » et « hommes à risque » à la place de FSW et HSH.

As the laws are repressive, how do you go about implementing comments and collecting data

Response: In some countries we have also used other acceptable terms to describe the key populations. For instance, in one country we were not allowed to use the terms female sex workers (FSWs) and men who have sex with men (MSM). Working with staff at the ministry of health we instead used the terms “females at risk” and “men at risk” in place of FSWs and MSM.