Session 5: Differentiated Testing & Linkage for KPs
Questions and Answers

1. quelle est la place de l'autotest dans la strategie actuelle? et comment faire le linkage
   what is the place of the self-test in the current strategy? and how to link
   Response: L'autotest du VIH peut être mis en œuvre dans une gamme de stratégies différentes, dans les établissements, les approches communautaires, le réseau social et une partie du test de référence. Étant donné que tous les HIVST réactifs nécessitent des tests supplémentaires pour fournir un diagnostic positif, les programmes s'appuieront sur les interventions et les services de liaison existants une fois que les personnes auront reçu un diagnostic de VIH. Des stratégies supplémentaires pour améliorer le lien avec les soins peuvent inclure des interventions rationalisées, l'amélioration de la qualité, la navigation et le conseil entre pairs, le passage à un algorithme de confirmation davantage basé sur les TDR, le TAR à domicile, les incitations des prestataires. Nous avons vu de nombreux programmes également utiles à la sensibilisation communautaire (virtuelle et en personne) pour également aider à mobiliser et à faciliter les liens

   HIV self-testing can be implemented in a range of different strategies, in facilities, community-based approaches, social network and part of index testing. Since all reactive HIVST require further testing to provide a positive diagnosis, programmes will be relying on existing linkage interventions and services once people are diagnosed with HIV. Additional strategies to enhance linkage to care can include streamlined interventions, quality improvement, peer navigation and counselling, moving to more RDT-based confirmatory algorithm, home-based ART, provider-incentives. We've seen many programmes also useful community outreach (virtual and in-person) to also help mobilize and facilitate linkage.

2. How can we address the equity and sustainability gaps in term of key population HIV services especially when the intervention are led by other organization
   Response: This a broader challenge that requires programmes to ensure equity and KP-led programmes are targets and priorities for programmes. Partnership is important, as well as advocacy. It maybe useful to highlight the evidence to other organizations, as well as working with stakeholders to ensure these priorities are included in larger national HIV strategies and goals.

3. How are other countries dealing with issues of Index testing among KPs, In Kenya this was stopped, when KPs raised issues including bridge of partner confidentiality
   Response: It is really important to consult with KP groups in country on how to implement and message on index testing. We've seen many different models, that through this consultation and coordination, have benefited. Social network based approaches are another tool that should be considered as well, as it provides a broader criteria and includes HIV+/HIV- KP and those that are social contacts, in additional to sexual and drug injecting partners.

4. Is there guidance on M&E for self-testing, particularly related to verification of linkage to care when HIVST is the entry point? Thank you
   Response: Yes, we have guidance on HIVST M&E. I'm happy to share with you details - so email me johnsonc@who.int. When it comes to measuring linkage, this is not something that routine programmes can do using individual data. Programmes use triangulation - looking at HIVST distribution, HTS positivity and ART initiations in catchment areas and among priority groups to

assess. HTS log-books can be used, but it needs to be noted these generally under-estimate the people who self-tested and were confirmed HIV+ and linked. So important to use this data along with other information to understand programme impact.

5. May I know some examples of provider incentives for HIVST in KPs?
   Response: Here is one recent trial paper that might be of interest: https://gh.bmj.com/content/6/Suppl_4/e003866 . It is not specific to KP, but general community-based HIVST implementation. Any linkage intervention design for KP programmes should be discussed with community.

6. Will be glad if you can explain a little more the recommendation to move away from Western blotting test and what is the rational for this? Thank you
   Response: Absolutely. We recommended this because evidence showed EIA/RDT-based algorithms performed as well or better than WB-based algorithms, and were also more prefered (especially by KP) and significantly shortened the time between testing and return of results (and many more people who get missed and did not receive results). It was also noted that PrEP would be seriously hindered by WB, because of the lags in turn around time and window period of risk. Our policy brief is here: https://www.who.int/publications-detail-redirect/WHO-CDS-HIV-19.30

7. Regarding SNS, how do you manage the possibility of perverse incentives related to the coupons driving recruitment? Thank you
   Response: Thanks for this question. We encourage countries to keep the value of the incentives quite low...about 1.5 USD.

8. Please would you comment on the availability & supply of HIV self testing kits/HIV ST kits?
   Response: There are 4 WHO PQ HIVST products, and products available for procurement range from $1.50-2.00. We've seen substantial scale-up, but the need for HIVST is large and we need greater investment from countries and donors.

9. Great presentation on SNS; How do we deal with concerns that incentives in SNS may be perceived negatively as if we are paying people to access services; How can we best communicate that these incentives are for peer mobilisers (performance based) and not necessarily payment to those accessing testing?
   Response: the incentives are used to support KP to access the HTS site....this can be a transportation voucher or another small token that appreciates that the KP must go to a site to access testing. We suggest small incentives for the person who refers the network member and a small payment for the person who goes to the testing site

10. Aimeriez-vous partager avec nous les outils de collecte des données afin de capitaliser les éléments importants?
    Would you like to share with us the data collection tools in order to capitalize on the important elements?
    Response: It is important to ensure that the data collection tools do not vary from those being used in the national HIV program, such as screening tools for PrEP, ART and IPV. This is important to ensure standardization, and KP programming is nested within the overall national HIV program.

11. Any reports of IPV documented as result of SNS?
    Response: I have not heard of any IPV resulting from SNS. In fact, because SNS can be used as an alternative to index testing, some MSM like the SNS approach because it does not suggest that the person who gives the coupon is a sexual partner. It can be within the social network.

    In the systematic review, informing the WHO-guidelines, there were no reports of IPV.

12. How do you ensure that KPs mobilised for HTS virtually are linked to care when positive?
    Response: It's important virtual services plan and end-to-end strategy for mobilization, testing delivery and linkage. If an individual is mobilized virtually, they may test in a community or clinic setting and therefore could be linked from there. If they are self-testing, all reactive results need further testing and confirmation by a trained provider in a community or clinical setting. So the focus would be providing information on where to get the support for further testing, outreach and follow-up to support that linkage. WHO recommends streamlined interventions like case management, partner services, staff training, co-location of services, quality improvement, peer navigators (including counselling).

13. To Trista Bingham - you indicated that monitoring of the SNS should monitor yield to ensure it is working effectively. I understand it is a method to get individuals who have never engaged with services. In the case of KPs, would not the % never tested before also be a metric of success regardliness of HIV status?
    Response: Yes, that would be a great indicator to track.

14. What approach can one deploy to maintain the 5 "Cs" of HTS with SNS?
    Response: we engage both HIV positive and HIV negative KP in SNS so that the status of participants is not a given. I can answer more later.

15. Trista, thank you very much for the exciting intro to social network approach. Many stakeholders and partners express misgivings about the use of incentives to support testing. Could you talk a little about the rationale for incentives, immediate and distal benefits, and considerations for effective use of incentives? Thank you!
    Response: for those concerned about incentive, it's important to think of these as very small tokens to encourage KP to participants to be part of the program. KP members are the best ones to recommend a what that monetary or non-monetary reward looks like.

16. Please how do you build partnership with HCW to organize joint outreach activities ? especially during moonlight and weekend activities in a context where HCW do not work during these hours.
    Response: Thanks Oscar: These are coordinated by facility incharge and sometimes care and treatment center incharge to ensure the roaster is accommodate the scheduled event even in the community during off hours and public days

17. Comment faire ce depistage par les reseaux sociaux
    How to do this screening by social networks
    Response: La Session 10 prévu pour le Mardi 31 Aout vas se concentrer davantage sur l'utilisation des interventions virtuelles notamment l'usage des réseaux sociaux tout au long de la cascade du VIH

Session 10 scheduled for Tuesday August 31st will focus more on the use of virtual interventions including the use of social networks throughout the HIV cascade

18. What has been done for having successful linkage to ART among KP tested HIV positive under the FKIA project?
    Response: Jirina, I am going to connect you to Macdonald via email, so he can share some lessons learned …

19. Are there any legal age consent for KP implications (for those who are minors) under the SNS program?
    Response: SNS programs don't require showing proof of age to participate. It is best to follow national age of consent for testing guidelines.

20. Thanks to all presenters. My question would be what is the demarcation between the Index testing and the HIV testing through SNS?
    Response: These are often linked. The main difference I would articulate is that index testing is where providers assisted PLHIV to contact their partners, and follow-up with biological children, so they can receive HTS. SNS is really focused on KP and can include HIV- and HIV+ social, sexual and drug injecting partners. The SNS approach can be one-wave or multiple-waves to go further and further into these networks.

21. Where fragile stakeholder commitment on KP programs exist, how can the country programme improve on putting the people at the centre of the response?
    Response: It is important, as has been the case in Zambia, to build collaboration and stakeholder buy-in. Sometimes this takes time, but it is the only way of ensuring sustainable and effective implementation of KP programming. In Zambia, this has been done through the formation of a national KP technical working group, hosted by the National AIDS Council, and chaired by the Zambian Ministry of Health.

22. Is there global standard for M&E to measure behavioral change for female sex workers?
    Response: One of the ways that behavioral change is measured is through periodic integrated bio-behavioral surveys (IBBS). Please refer to the WHO/UNAIDS guidance on implementation of IBBS.

23. For SNS - I note the incentive of about 1.5 USD but how are programs addressing the different sub-KP types - where 1.5 USD wont incentivize - think high end hotel SW; Older (30+) full time employed MSM. Those are some of the populations not yet reached by our services.
    Response: Good questions. I would ask these two groups what would motivate them to participate.

24. Great Presentations so far.....How can we use incentivized SNS better? Should we prioritize it for events driven mobilization, For new hot spots, New locations, New sub populations that are harder to reach like Young KPs, Trans, Female drug users and use NON incentivized SNS for normal programming for purposes of sustainability? Whats your take
    Response: Thanks Helgar, these are great recommendations. In Vietnam, a country I support, the team has started using SNS for PrEP scale up specifically. I think this is another untapped approach to expand the usefulness of SNS for KP.

As long as PEPFAR is paying for these testing programs, I think KP programs should use the monetary and non-monetary incentives to find as many undiagnosed KP as possible, as soon as possible.

25. What are the challenges you encountered in implementation of HIVST in KPs, especially in terms of confirmation of HIV status and linkage?
Response: We have seen some challenges with HIVST distribution among FSW and this can be for various reasons (1) highly mobile, (2) have good access to other HTS, (3) Many FSW living with HIV already know their status and HIVST use may be retesting, (4) Outreach for peer educators may not be acceptable or desirable in all settings. Overall - I think programmes can be well-positioned to address challenges and improve programming by working with KP groups. Special attention and consultation with sex workers would be an area of focus.

26. Thank you Macdonald, 1. Which HIV self test ditribution approached(Assisted Vs Un assisted) you integrated in SNT? 2. How do you confirm the actual test of peer with HIVST if unassisted approach is used? 3. If Tanzania is using both HIVST kit distribution modalities, Which HIVST distribution modalities you presented as test kit return rate is as high as 100%? 4. If your HIVST cascade presentation included unassisted approach, what strategies used to support clients return this much high % test kit?
Response: yes we are having both assisted and un assisted approach, and all integrated in SNT........the presence of the toll free number and contact information at kits as well the 7days follow for every kit distributed has been very useful

27. Qual é o valor de insentivo monetario ?
What is the monetary incentive value?
Response: 1.5 USD for referring network member and 1.5 USD for testing

28. SNS incentives attract known positives where there is no system like finger print at national level? What is the experience in this regards? As peers and KP beneficiaries have low income, re-testing for the incentives is common and this affect the linkage and retention.
Response: Some countries have used fingerprint code to reduce duplication of participation.

29. Does creating a separate investment agency for KP not lead to duplication of duties by agencies. This is applied to Nigeria where we have agencies that are involved in health sector response and multisectoral response to HIV/AIDS?
Response: Different countries may use different approaches. However, what is important is to ensure collaboration and engagement by all stakeholders engaged in HIV programming regardless of the target population groups.

30. In Liberia, when the index client has been identified, index testing must be offer, if the index client consent to index testing. they will identify their contacts and discuss with the HCP or tester how these clients will be refer; contract, dual, provider etc. from this point. if they refused to consent when index testing is offered, that is the end until they can consent in further engagement
Response: All index testing needs to be voluntary. We have seen evidence that not everyone newly diagnosed with HIV is immediately ready to have a discussion about index testing. So follow-up discussions are needed, providers need to be sensitive and support clients with this as a process.

31. Despite same place testing and linkage is challenging among KPs in DICs? Is there any strategy for the high linkages?
Response: Yes, additional to other strategy but we rely much to linkage case management will be presented in session 6b please be there

32. How often was the hotspot mapping done?
Response: There is no time framework or frequency attached to hotspot mapping. This has to be an integral part of on-going community-based programming. This ensures that the list of hotpots in a given locality of constantly updated to inform mobilization and interventions.

Response 2: The hot spot mapping is data driven, we analyze data in weekly and monthly bases to have a timely understands of the KP dynamics. Further analysis and decision is made in monthly bases so in a quarter at least three times re-mapping of the hotspots is done.

33. Thanks for this success, could you tell us the initiation rate on treatment and retention at 6 and 12 months
Response: In the Zambian KP program, the initiation rate has been above 95%. However, retention has tended to drop by 15% at 6 months and 20-30% at 12 months. Poor retention tends to be highest among FSW due to high mobility as they frequently move from one area to another where their services could be in high demand.

Response 2: For the case of FIKIA project, the same day ART initiation (within 14days from date of diagnosis) is 96%, though these remained un ART initiated clients are further linked to care through the linkage case management and later on are ART initiated. We previously observed the drop down of the retention rate to 88% after 3months post ART initiation and was realized much psychological support and close guidance to clients in navigation of the all treatment barriers till 6months post ART initiation till viral load suppression is achieved. Therefore, we programmatically started the extended linkage case management from 3months to 6months support by PLHIV peers (refer to session 6b presentation). The extended LCM has shown success the 6months retention is 93.5% and observed increase the viral suppression after the first VL testing. 12months retention rate will be assessed on the end of the September.

34. These KP projects are able to track linkage to care and VL suppression. Are there any insights / recommendations for a national program to be able to report the 95-95-95 for key population subtypes per the new UNAIDS recommendations given the stigma issues, data protections, etc.
Response: This should be the ultimate goal, of ensuring that VL coverage and suppression data is collected and disaggregated by population type. This is important in order to inform targeted interventions. Unfortunately, very few countries have national M & E systems that collect and report such information.

35. Dr Maurice, is your office open for collaboration, it would be nice to reach out for a Learning and Exchange call, I missed your Contact Details
Response: Maurice Musheke, PhD
Head – KPIF Program
Centre for Infectious Disease Research in Zambia Lusaka, Zambia
maurice.musheke@cidrz.org

36. Thanks - High end hotel-based SW want over $100 - for linking with 6, thus our hesitancy. But thanks for the presentation.
Response: Right, I would feel very uncomfortable using incentives more than 5 USD. Maybe ask if there are non-monetary incentives that would of interest to the high-end SW?

37. @Mahiti. In the context where UID is not implemented, how do you track KPs to ensure those register in facilities are really the ones referred to. Which tools is used?
Response:
    a. For Newly HIV POS identified clients: All the clients are linked to care and treatment and provided with UIC at the community testing point, per National guideline we are allowed to initiate the ART per national protocol. For those not ART initiated are always linked to case management and attached to expert client for follow up and escort referral to facility is always encouraged per client consent and flexibility.

    b. For other services beyond care and treatment: All our community KP peers are equipped with digitalized tablets to assist in standardized screening as well reporting. The tablets automatically generate the UIC but in additional to this, every KP paper-based map is taken it include all necessary information which will always tally at any point of the interview unless the KP client decide to lie in some of the occasion), these information are always stored in the client's file at facility level. Also, the FIKIA project are KP peer led interventions hence majority of the KP reached and tested are already in contact with KP peer before the testing events or linked to other service therefore a peer is a key person for service sensitization, linkage and as well verification process. The verification process is done in weekly, monthly, and quarterly bases as the KP are very dynamic to avoid re-testers and other recounting of the KP reached and provided with different services.

38. To last presenter: HIV positivity among KPs in Tanzania is very high for all KP sub-populations (20-50%). This looks one of the highest testing yield. Would you explain to us the approaches/methods the project employed to identify high risk KPs?
Response: The use of the SNS is very effective in reach high-risk, undiagnosed KPs. However, what is key is to also ensure that the KP program has from the outset identified the right "seeds" to facilitate the identification and mobilization of high-risk undiagnosed KPs. Second, it is also important to constantly monitor the recruitment tree to ensure that only those networks generating high yields are retained during SNS implementation.

    Response 2: HIV positivity among KPs in Tanzania ranges from 5-34%, the highest yield of above 20% is always when the index testing is the dominant modality of the testing. But still using of the different targeted testing strategies such as double risk screening to client by a peer and then HCW improve the standard and quality of screening

39. Bonjour bonne presenta una. Ma question est a Maurice penser vous que la mobilité des pops clés est liée au covid et pas aux contexte de l'environnement défavorable je pense qje au contraire le COVID-19 a permis au pop
Réponse : COVID-19 a eu deux effets profonds. L'une est qu'elle a rendu certains KP immobiles, notamment en cas de confinement, compromettant ainsi l'accès aux soins. D'autre part, COVID-19 a également rendu KP mobile car la fermeture des hotpots où KP rencontre ses clients a obligé KP à toujours être mobile que ce soit dans un district ou à l'extérieur d'un district à la recherche de hotspots où leurs services sont toujours très demandés. Dans certains cas, en

particulier pour les KP transitoires, COVID-19 a également forcé KP à retourner dans leurs villes d'origine.

Hello good presentation. My question is for Maurice: do you think that the mobility of key pops is linked to covid and not to the context of the unfavorable environment? I think that, on the contrary, COVID-19 has enabled people to stay in one place.
Response: COVID-19 has had two profound effects. One is that it has made some KP immobile, especially in cases of lockdown, thus undermining access to care. On the other hand, COVID-19 has also made KP mobile because closure of hotpots where KP meet their clients has forced KP to always be mobile whether within a district or outside a district in search of hotspots where their services are still on high demand. In some instances, especially for transient KP, COVID-19 has also forced KP to go back to their original hometowns.

40. Dr Maurice how do you face KP high mobility please?
Response: Tracking KP has always been a challenge. In our program, the recruitment of Peer Promoters, who are KP themselves has helped keep track of the whereabouts of the KP. Second, the KPIF program in Zambia implements KP support groups, whose aim is not just to improve adherence to treatment but to also facilitate retention in care.