Session 8: Plenary Session: Differentiated Treatment Models for KPs
Questions and Answers

1. It's a good presentation and good information how we going to be given the handout
   Response: Thank you very much. All presentations and recorded versions of the presentations are available on the ICAP website.

2. In Monitoring and Evaluation, how do we take care of data on TB screening especially when there is MMD implementation or Community delivery of ARVs by Lay workers
   Response: "Thanks for this question. This is relevant for all people who are accessing DSD for HIV treatment (not specifically just for key populations). Critically - people living with HIV should have a good understanding of HIV treatment and lifelong adherence. This treatment literacy should also include an understanding of TB symptoms and they should be reassured they can access the health services if and when they need (not just on their HIV date). In other words, people should know when to access care if they have TB symptoms. Further, when ART refills are provided outside of health facilities, TB screening can be incorporated into the collection of ART refills. In addition, we want to ensure people have the psychosocial support they need and know who to contact if they have questions."

3. Can you share the challenges encountered in relation to the scale-up the DSD uptake among KPs?
   Response: Thanks for the question. One big barrier has been access - we need to emphasize that people who are members of key populations are eligible for DSD for HIV treatment (they should not be excluded just because they are part of a key population). Another consideration is what DSD looks like for a given key population in their context. For example, decentralization will depend on levels of stigma and criminalization, and as Tisha also highlighted, specific key population members may require additional services (or integration) such as screening and treatment for STIs, family planning, etc. and so we want to consider their health needs (not just their HIV status) when providing services.

4. hi Moses, thank you for your input on Community Pharmacy ART Delivery. is there a cost to the client for receiving the service from the private pharmacy outlets? or do these outlets receive some funding support from Epic ?
   Response:

5. For Moses - what are the challenges encountered in implementation of Private pharmacy DSD model? What is the experience like so far and what are the prerequisites for the successful implementation?
   Response:

6. "Great presentations. Congratulations. Why not start discussing about decentralization of services (including prevention commodities, e.g., condoms, lubricants and oral contraceptives) and not only decentralization of drug dispensation."
   Response: Absolutely! You raise a great point which is that many of the other services and commodities required could be decentralized as well.

7. Are there any specific criteria used in the selection of Private pharmacies for the implementation of these interventions?

Response: Great question. Before selecting pharmacies, we worked with MOH, pharmacy councils, pharmaceutical associations, and treatment partners to assess pharmacies to ensure that they met the standards to meet. For example registered and in good standing, had the space for confidential counselling, had reporting systems, storage and were willing to serve clients. So in 6 countries we did this assessment and identified those that were eligible. conducted training and then selected the ones that could dispense ART.

8. And these private pharmacies incentivised to implement.?

   Response:

9. '@ Moses. How does the private Pharmacy ART delivery respond to the needs of privacy and confidentiality ? are the drugs provided openly just as it is done for commercial clients who patronise them to buy medicines ?

   Response:

10. '@ Moses; one of the DDD for KPs is Private pharmacies where Kps are located and they take the ART drugs in the selected Private pharmacy but returned to The Health facility for Clinical services; But since the KPs are returned to the Health facility for clinical services why the private pharmacy is selected?

    Response:

11. Pascal can you please list some of the stigma reduction strategy used for KPs?

    Response:

12. To Moses, can you please share the ART dispensation assessment tool for private pharmacies if possible?

    Response:

13. Are there any tools for collect data on SGBV and stigma and discrimination?

    Response: Au Sénégal ya les outils de collecte de données basée sur les droits humains et le traitement mis en place par l'observatoire communautaires sur le traitement du Vih pour les pvvih et pop clés

    In Senegal there are data collection tools based on human rights and treatment set up by the community observatory on the treatment of HIV for key pvvih and pop

14. To DDD Presenter: What mechanism are in place to promote rational drug use at private pharmacies, in this case how to prevent misuse of ARV drugs?

    Response:

15. What is DIC activities?

    Response: DIC = Drop-in centre

16. What was the experience with data collection and reporting from the ART distributing private pharmacies?

Response: In some countries, we have used an App to help private pharmacies and health facilities share information real time. Here is a link to how the App works in Nigeria https://youtu.be/LJVI3dJzCt4

17. Did EPIC establish MoU with Pharmacy board (on the private pharmacies distributing ART) and which other organisations supported the process? Were the workers in the private pharmacies provided some form of insentives for the ART distribution?
    Response: YES! Good point. Tripartite MOUs were signed between MOH, private pharmacies and sites. This MOU articulates the terms and responsibilities for each party.

18. What was the acceptance among the KPs on the ART pick-ups from the private pharmacies?
    Response:

19. Are any groups considering use of Self-collected Dried blood spot for their participants for VL testing? (https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-021-06110-x)
    Response: This could help alleviate viral load gaps but might not close the gaps enough because of upstream factors. Under EpiC, we have also worked with private labs to add to the laboratory capacity. In Botswana we work a private lab chain. This model has shown promise and shortenned the TAT. We are considering engaging more countries to see if private labs can play a role

20. How are the VL test results delivered to the KPs and what is being done for those with unsuppressed VL?
    Response: