HOUSEKEEPING

SESSION DETAILS

| AGENDA: Measuring and monitoring the Key Population Programme outputs and outcomes at National and Global Level | Date – 4th April 2023			
Meeting chair: Tim Sladden and Clemens Benedikt		11:00 – 12:30 (CEST)	16:00 – 17:30 (CEST)
Time	Session	Facilitators / Speakers	Facilitators / Speakers
5 min	**Opening remarks** Welcome Objectives of the meeting	Tim Sladden	Clemens Benedikt
25 min	**Global Overview:** This will include sharing of the 2025 global targets in relation to key population programme and reflections around approaches to measure outputs and outcomes for Key Population programmes Investment in robust monitoring and evaluation systems including available evidence to plan and improve programmes including funding requests Need for programme data triangulation to improve programming and overview of the new monitoring and evaluation toolkit developed by UNAIDS	Keith Sabin, UNAIDS Amrita Rao, JHU Kate Rucinski, JHU	Keith Sabin, UNAIDS Amrita Rao, JHU Kate Rucinski, JHU
2.5 min	**Priority (interactive)** Why would you prioritize monitoring and evaluating Key Population programmes in your country?	Mentimeter	Mentimeter
25 min	**Practical approaches to implementing a monitoring and evaluation system to monitor progress of KP programme** Country presenters will share how the specific country has developed practical strategies led by the government to measure and monitor KP programmes.	Keshab Deuba and Neeti Sedhain, Nepal Dr. Peter Mudioppe, Uganda	Dr. Jebet Boit, Kenya Dr. Ketevan Stvilia, Georgia
25 min	**Programmatic Key Population Community Led Monitoring (CLM) approach and practices** Presenter(s) from KP-led organisations and networks will share their successful efforts and practices in leading community led monitoring processes	Shahnaz, Tais Plus Viet Trinh, Light House	Aniedi Akpan, DHRAN Sean Regg, Transbantu
2.5 min	**Reflections (interactive)** *What is the most important action you will take to strengthen the monitoring and evaluation of key population programme in your country?*	Mentimeter	Mentimeter
5 min	**Closure** Summary of actions and next steps	Tim Sladden	Clemens Benedikt

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OBJECTIVES

- Create a safe space for frank discussion how to accelerate programmes

- Facilitate peer-to-peer/country-to-country exchange of experiences in programme development, implementation, monitoring, evaluation and community engagement;

- Receive updates on global policy, latest guidance, implementation tools and financing opportunities

OPENING REMARKS

Clemens Benedikt
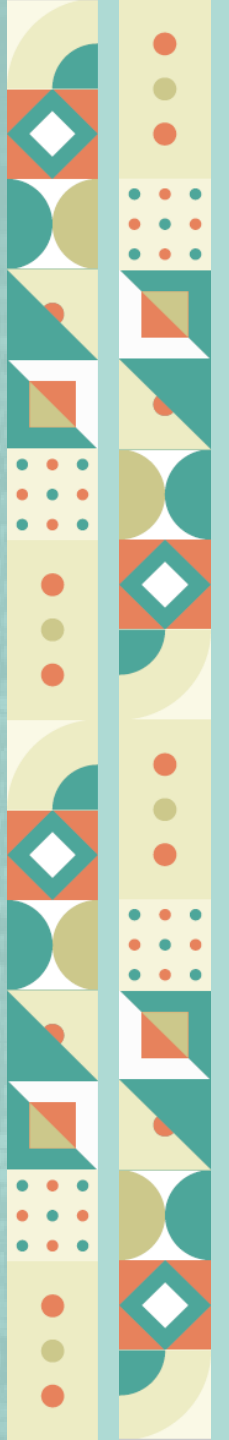
GLOBAL OVERVIEW

Keith Sabin, UNAIDS

Amrita Rao, JHU

Kate Rucinski, JHU

ENDING AIDS BY 2030

KEITH SABIN

Ending AIDS by 2030: it cannot happen unless we prioritize key populations

Keith Sabin, UNAIDS Data for Impact practice

Global Ambitions

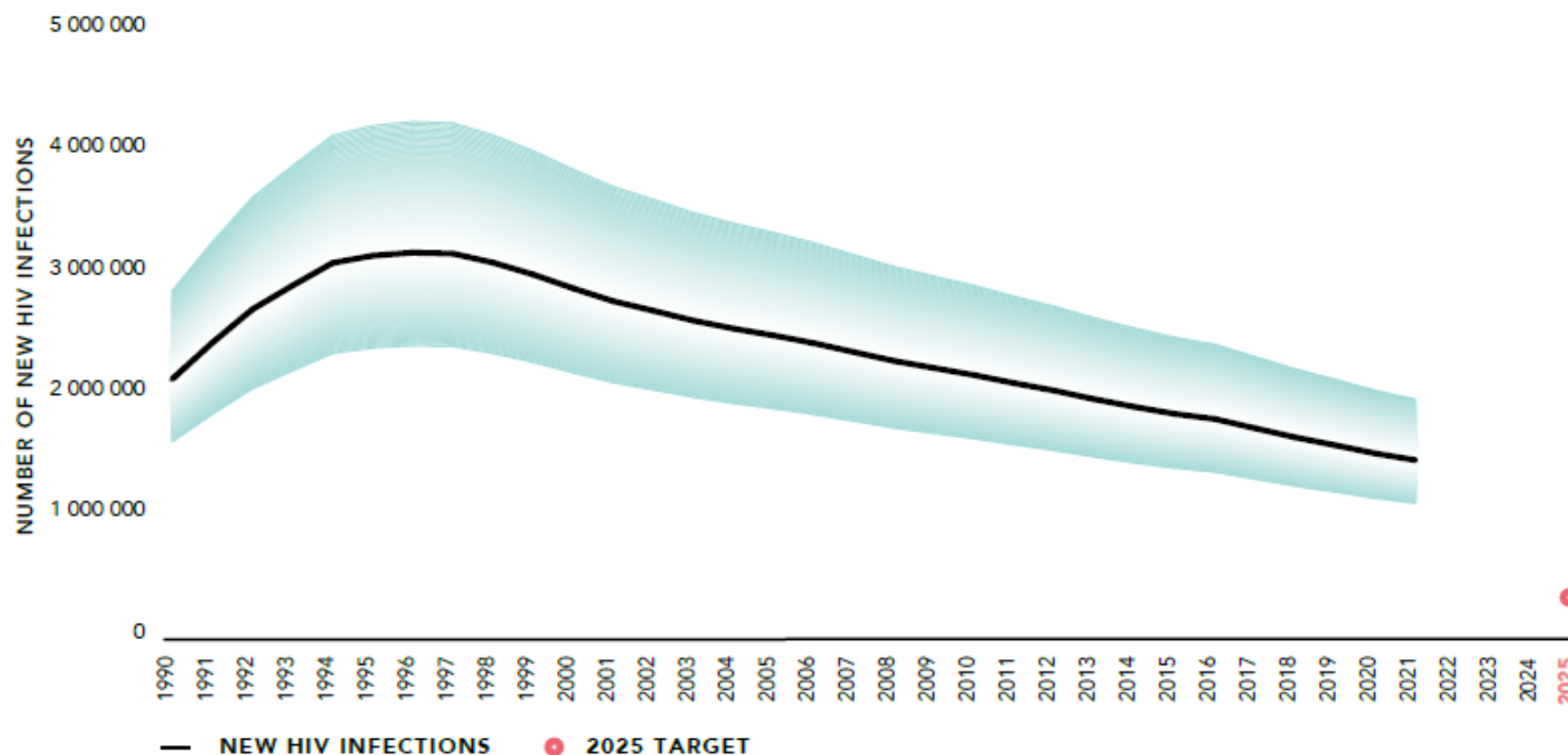**Human Rights**

Ethics & Morality

Equality

Public Health approach
Targets: *can we achieve without some groups?*
=> utilitarian approach

Rights approach
Targets: *Apply to all possible groups?*
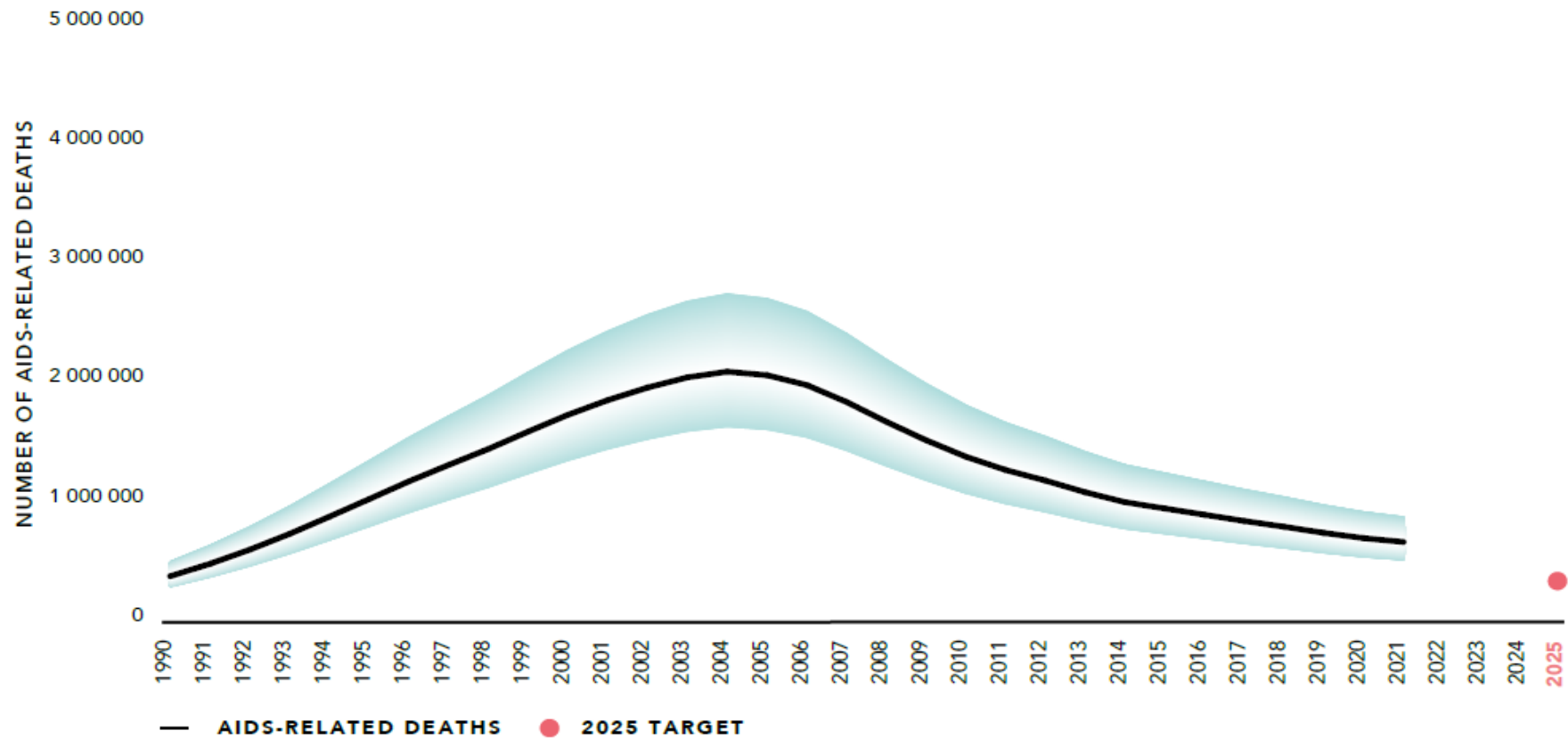*=> Equity approach*

Number of new HIV infections, global, 1990–2021, and 2025 target
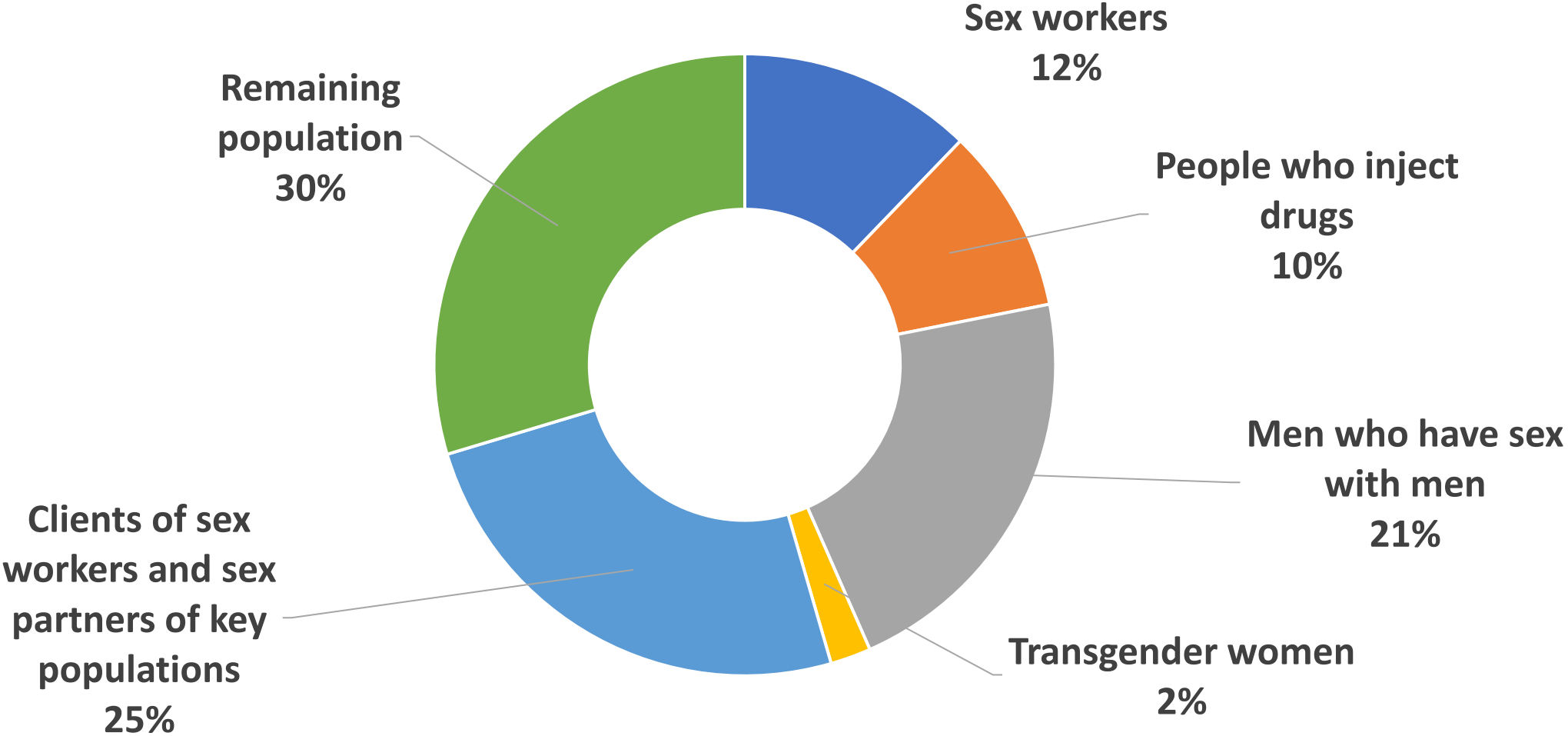

Source: UNAIDS epidemiological estimates, 2022 (https://aidsinfo.unaids.org/).

Number of AIDS-related deaths, global, 1990–2021, and 2025 target

Source: UNAIDS epidemiological estimates, 2022 (https://aidsinfo.unaids.org/).

Distribution of acquisition of HIV infection by population, global, 2021

Sex workers
12%

People who inject drugs
10%

Men who have sex with men
21%

Transgender women
2%

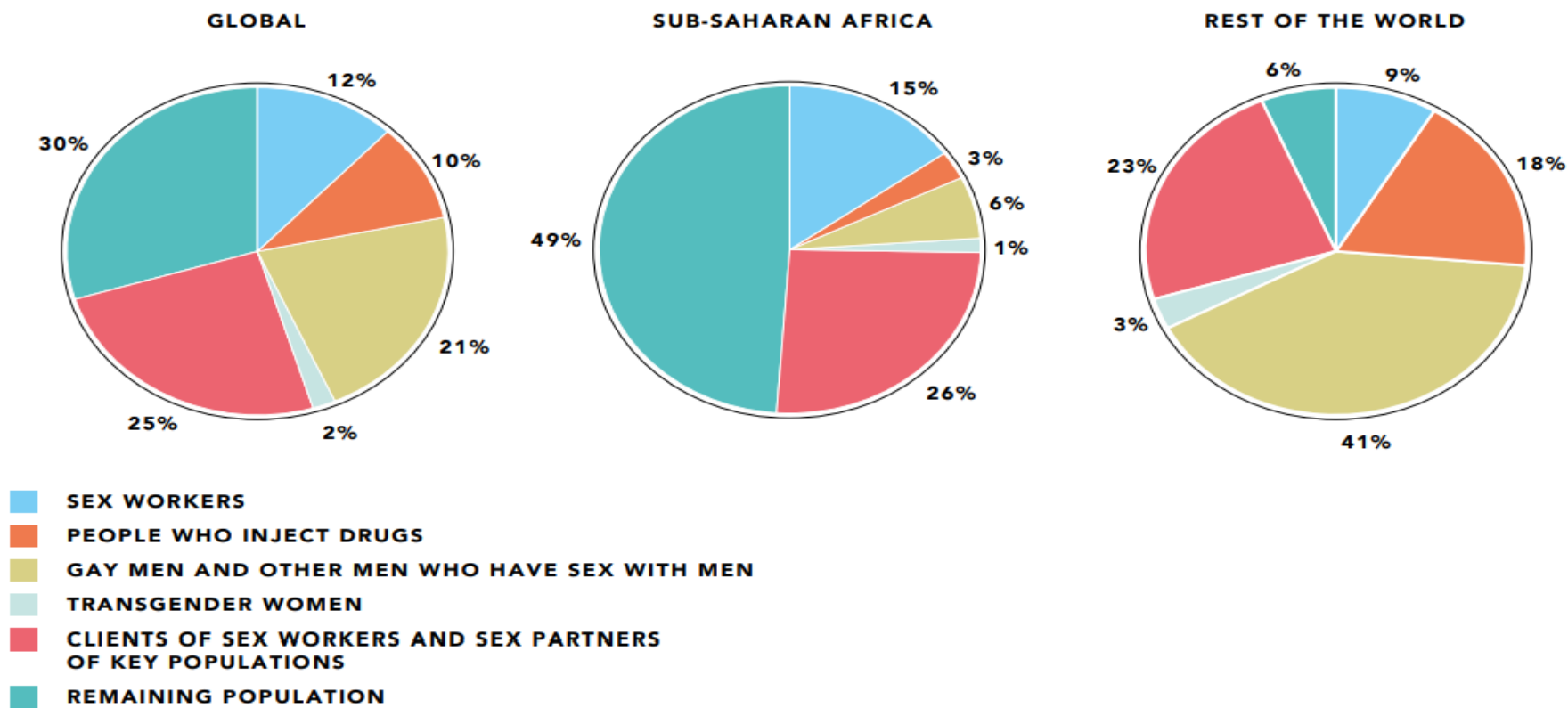Clients of sex workers and sex partners of key populations
25%

Remaining population
30%

Sustainable Development Goal Indicator 3.3.1

Number of new HIV infections. The number of new HIV infections per 1,000 uninfected population, by sex, age and *key populations* as defined as the number of new HIV infections per 1000 person-years among the uninfected population.

Distribution of acquisition of new HIV infections by population, global, sub-Saharan Africa and rest of the world, 2021

GLOBAL

- 12%
- 10%
- 21%
- 2%
- 25%
- 30%

SUB-SAHARAN AFRICA

- 15%
- 3%
- 6%
- 1%
- 26%
- 49%

REST OF THE WORLD

- 6%
- 9%
- 18%
- 41%
- 3%
- 23%

Legend:
- **SEX WORKERS**
- **PEOPLE WHO INJECT DRUGS**
- **GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN**
- **TRANSGENDER WOMEN**
- **CLIENTS OF SEX WORKERS AND SEX PARTNERS OF KEY POPULATIONS**
- **REMAINING POPULATION**

Source: UNAIDS special analysis, 2022 (see Annex on Methods).

Note: Due to variations in the availability of data from one year to the next, we do not provide trends in this distribution. See Annex on Methods for a description of the calculation.

Relative risk of acquisition of HIV infection by population, global, 2021

Bar chart — Relative Risk:
- Transgender women: 14
- Gay men and other men who…: 28
- People who inject drugs: 35
- Female sex workers: 30

X-axis: Relative Risk (0, 10, 20, 30, 40)

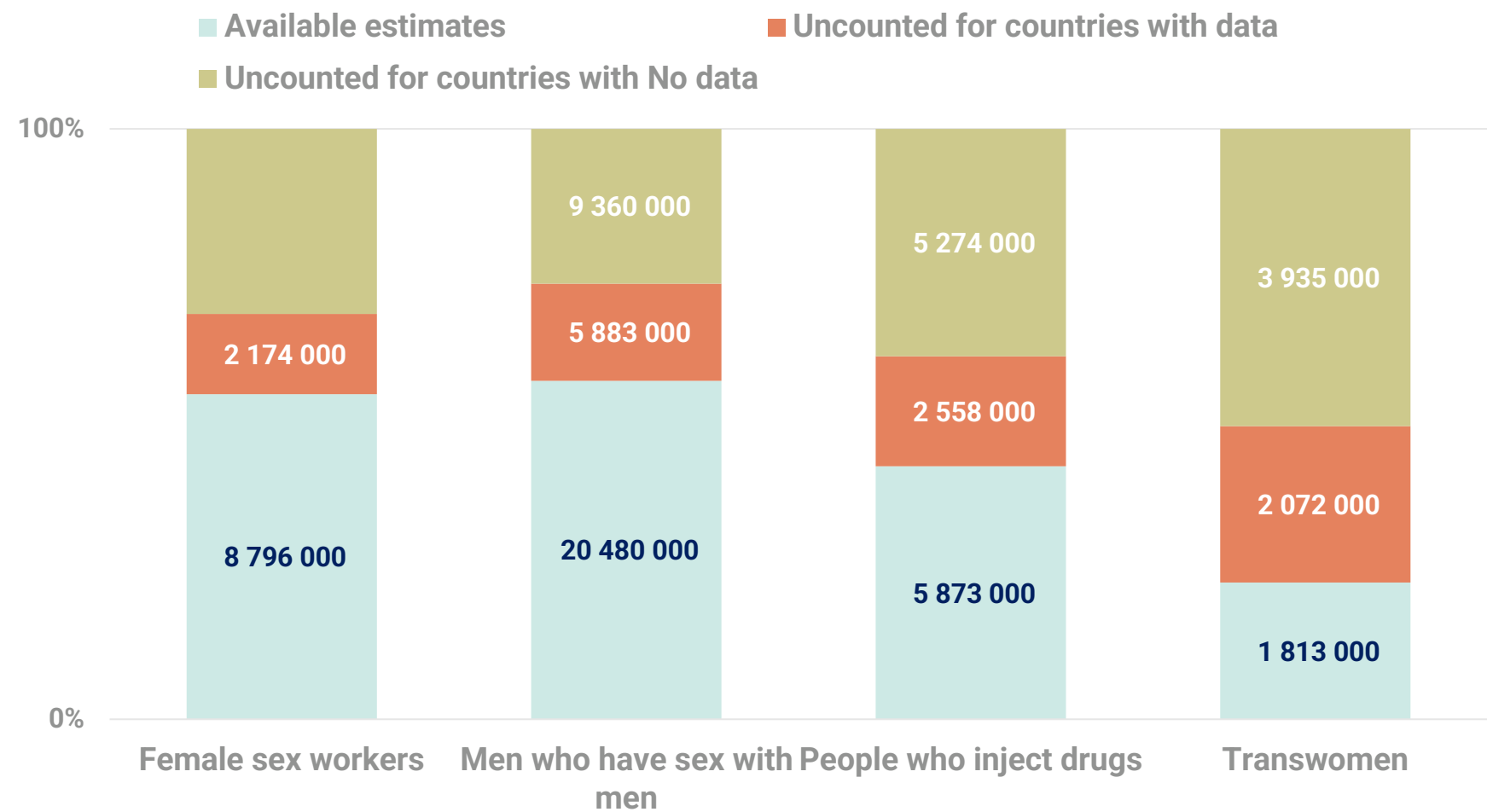Risk compared to remaining population of same gender identity

UNAIDS special analysis, 2022

Percentage change in HIV incidence among key populations, global, 2010–2019
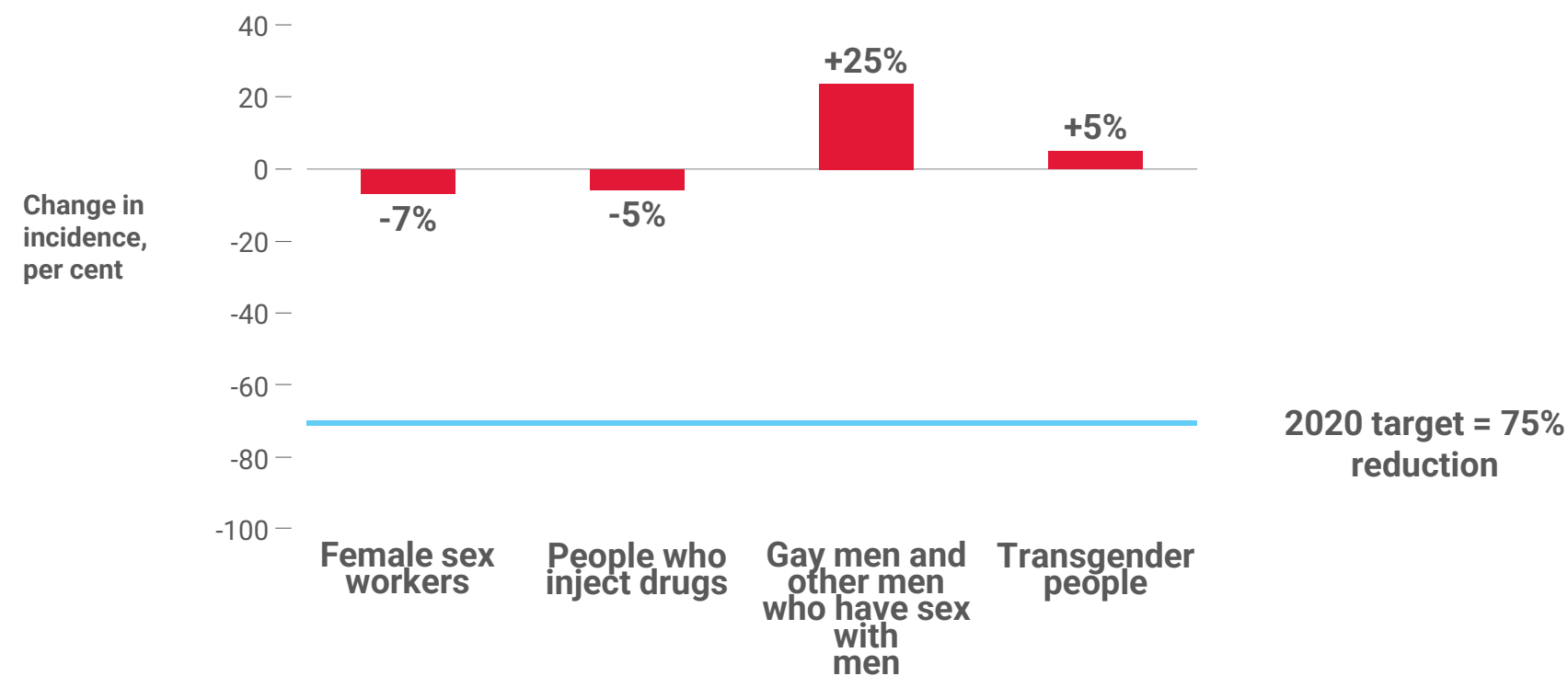
Source: UNAIDS special analysis of available key population data, 2020.

Gap between country-reported key population size estimates and extrapolated sizes, global, 2020

Legend:
- Available estimates
- Uncounted for countries with data
- Uncounted for countries with No data

Female sex workers
- Available estimates: 8 796 000
- Uncounted for countries with data: 2 174 000

Men who have sex with men
- Available estimates: 20 480 000
- Uncounted for countries with data: 5 883 000
- Uncounted for countries with No data: 9 360 000

People who inject drugs
- Available estimates: 5 873 000
- Uncounted for countries with data: 2 558 000
- Uncounted for countries with No data: 5 274 000

Transwomen
- Available estimates: 1 813 000
- Uncounted for countries with data: 2 072 000
- Uncounted for countries with No data: 3 935 000

Targets thresholds for 2025

	Criterion	Very high	High	Moderate and low
Sex workers	National adult (15–49 years) HIV prevalence	>3%	>0.3%	<0.3%
Prisoners	National adult (15–49 years) HIV prevalence	>10%	>1%	<1%
Gay men and other men who have sex with men	UNAIDS analysis by country/region	Proportion of populations estimated to have incidence >3%	Proportion of populations estimated to have incidence 0.3–3%	Proportion of populations estimated to have incidence <0.3%
Transgender people	Mirrors gay men and other men who have sex with men in absence of data	Proportion of populations estimated to have incidence >3%	Proportion of populations estimated to have incidence 0.3–3%	Proportion of populations estimated to have incidence <0.3%
People who inject drugs	UNAIDS analysis by country/region	Low needle–syringe programme and opioid substitution therapy coverage	Some needle–syringe programme; some opioid substitution therapy	High needle–syringe programme coverage with adequate needles and syringes per person who injects drugs; opioid substitution therapy available

Targets for 2025

KEY POPULATIONS	Sex workers	Gay men and other men who have sex with men	People who inject drugs	Transgender people	Prisoners and others in closed settings
Condoms/lubricant use at last sex by those not taking PrEP with a non-regular partner whose HIV viral load status is not known to be undetectable (includes those who are known to be HIV-negative)	--	95%	95%	95%	--
Condom/lubricant use at last sex with a client or non-regular partner	90%	--	--	--	90%
PrEP use (by risk category) ■ Very high ■ High ■ Moderate and low	80% 15% 0%	50% 15% 0%	15% 5% 0%	50% 15% 0%	15% 5% 0%

Estimates of HIV-free key populations for ≈160 countries

Country	WB_Class	Max Estimated Med Risk	Est Med risk as % of PSE	Est High risk	Min Estimated High risk	Max Estimated High risk	Est high risk as % of PSE
Ghana	Lower middle income	28592	21%	71559	59761	82506	61%
Guinea	Low income	1162	57%	479	393	609	28%
Guinea-Bissau	Low income	5211	55%	3263	2627	3938	41%
Haiti	Low income	45171	58%	17111	14094	22075	25%

Translating Coverage Targets to Numbers: 2025

Population	Population Size (Millions)	Coverage Target	Target (Millions)
FSW	11.9	9.4%	1.1
MSM	30.0	14.0%	4.2
Transgender	5.3	15.8%	0.8
PWID	12.3	5.3%	0.6
Prisoners	10.4	1.4%	0.1
AGYW	532	0.1%	0.4
ABYM	571	0.02%	0.1
Adults 25+ with multiple partners	163	0.3%	0.5
Total	1336	0.6%	8.0

*Coverage target is weighted average across all countries and population risk groups.

Number of people who received pre-exposure prophylaxis (PrEP) at least once during the reporting period, by region, 2017–2021
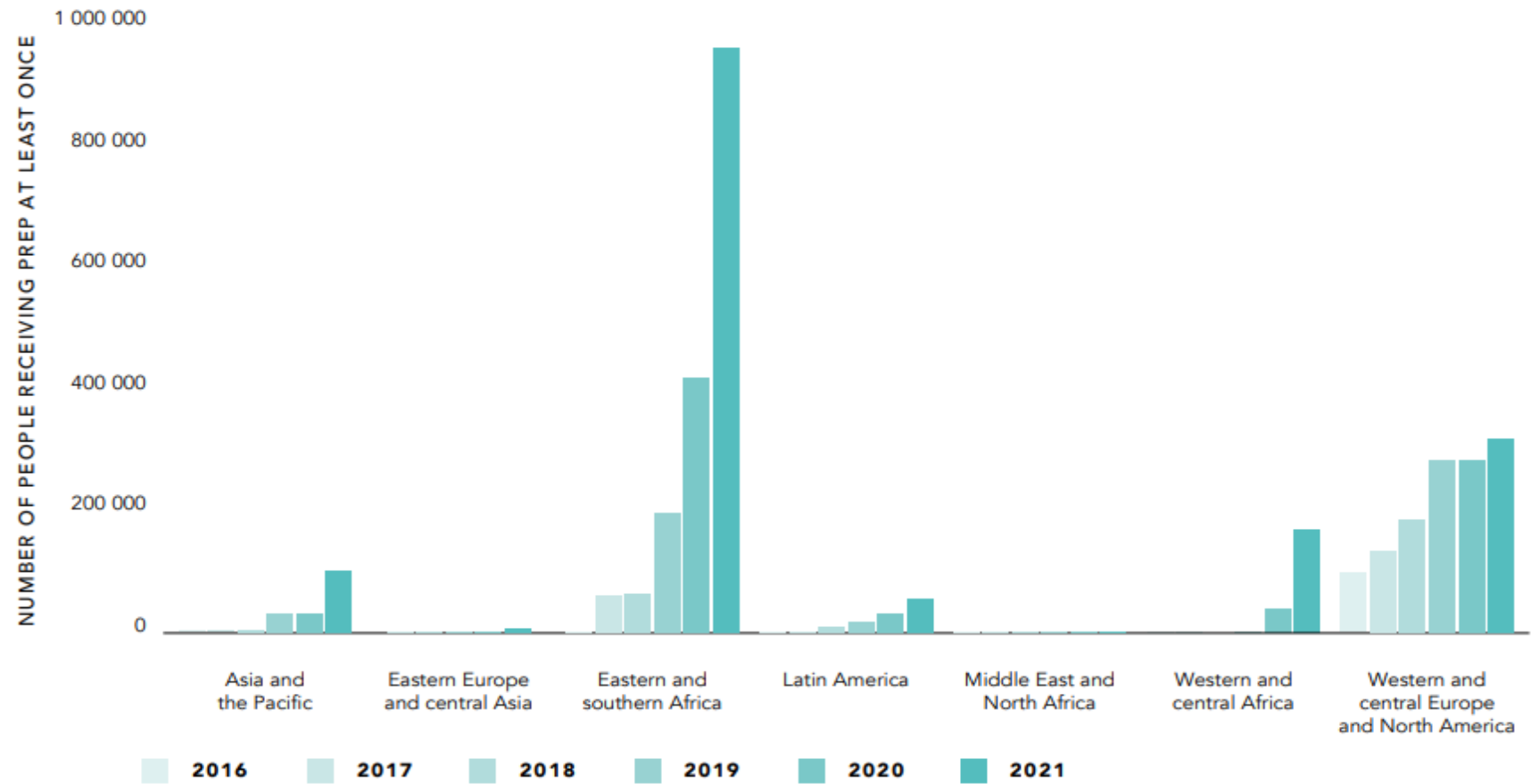
Source: UNAIDS Global AIDS Monitoring, 2022 (https://aidsinfo.unaids.org/).

Number of people who received pre-exposure prophylaxis (PrEP) at least once during the reporting period, by region, 2021, and 2025 target

Source: UNAIDS Global AIDS Monitoring, 2022 (https://aidsinfounaids.org/).
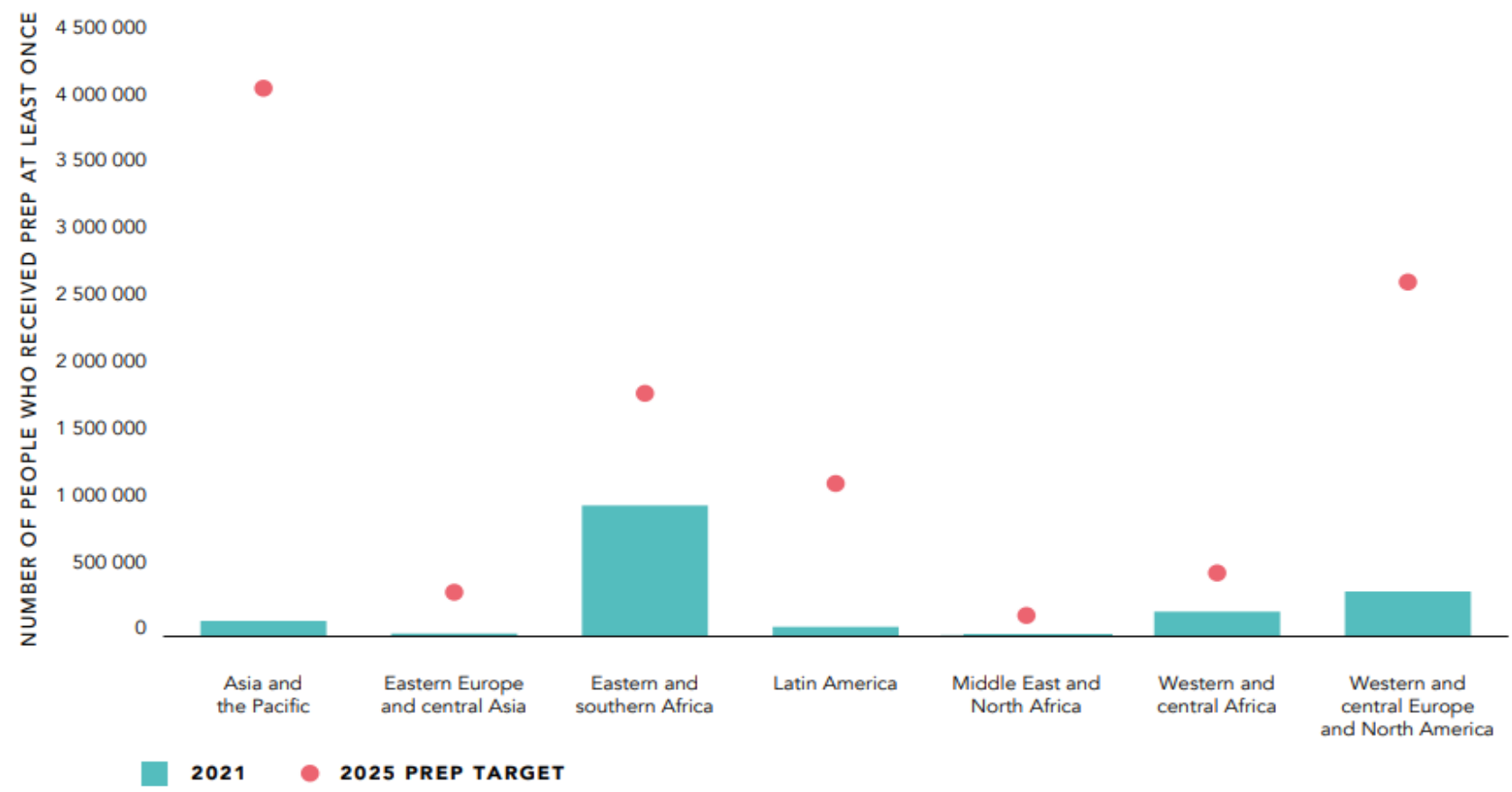
Gap to achieve the combination prevention targets among key populations, by intervention and region, 2017–2021

EASTERN AND SOUTHERN AFRICA
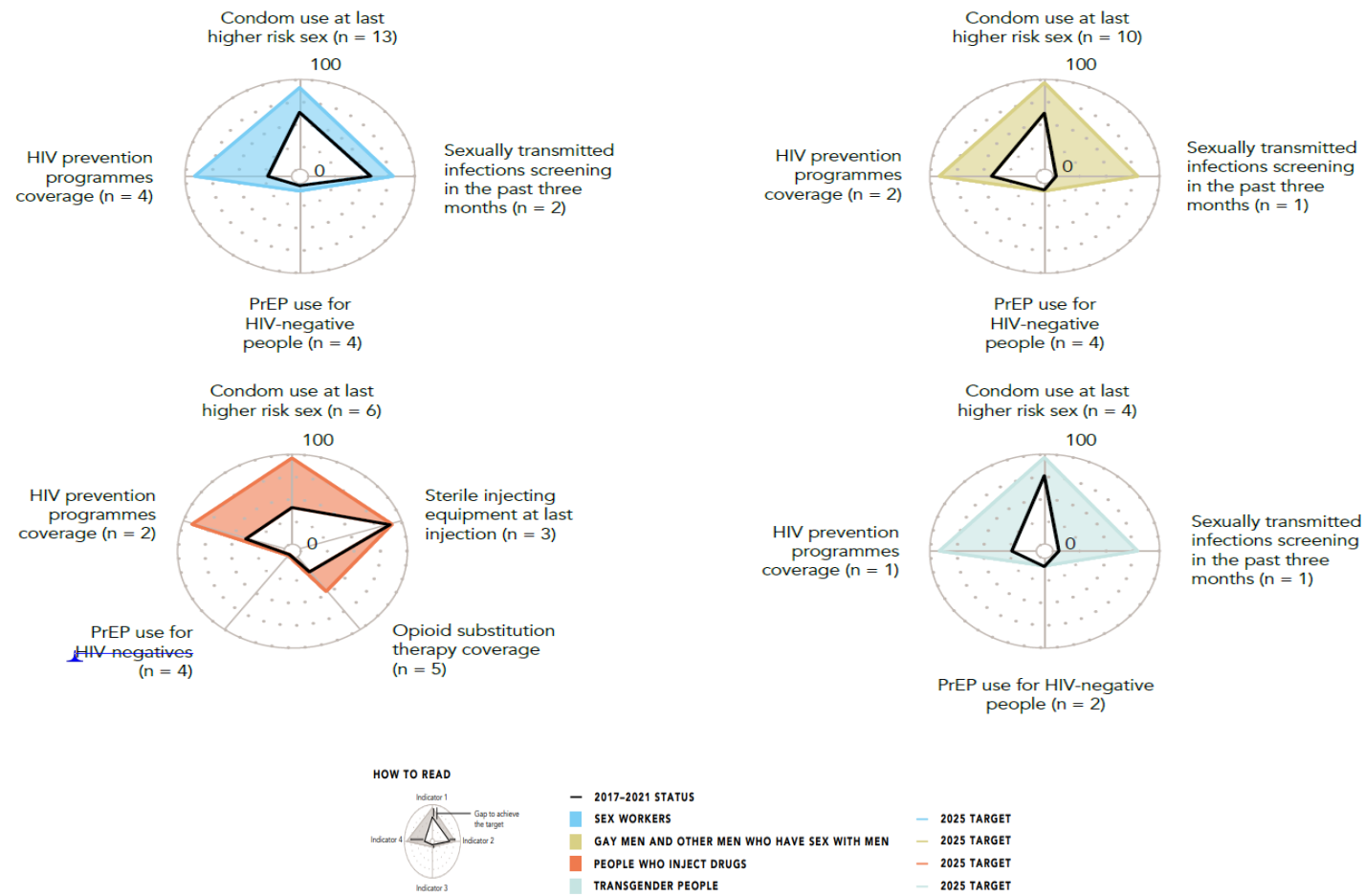
USE OF ROUTINE DATA TO ANSWER PROGRAM-RELEVANT QUESTIONS

KATE RUCINSKI & AMRITA RAO

OUTLINE

Routinely collected program data

- What is routinely collected data?
- Challenges and opportunities
- Developing questions of impact

Example analyses using program data

1. Patterns of PrEP use among FSW and AGYW in South Africa
2. Impact of implementation strategies on PrEP persistence among FSW and AGYW in South Africa
3. Extrapolation of population size estimates for FSW and MSM in Namibia

ROUTINELY COLLECTED DATA

Routinely collected data (Nicholls et al. 2018)

- Data collected for purposes other than research or without specific research questions developed prior to collection

- These data can support **1) clinical management** of patients or service users, and/or **2) monitoring and evaluation** of program activities

Examples

- Clinical information from health records
- Health administrative data (e.g. claims or receipts of payment)
- Program registers
- Epidemiologic Surveillance Systems

Process of data collection and capture

Clinical encounter between professional nurse/nurse counselor and the client (initiation or follow-up visit)

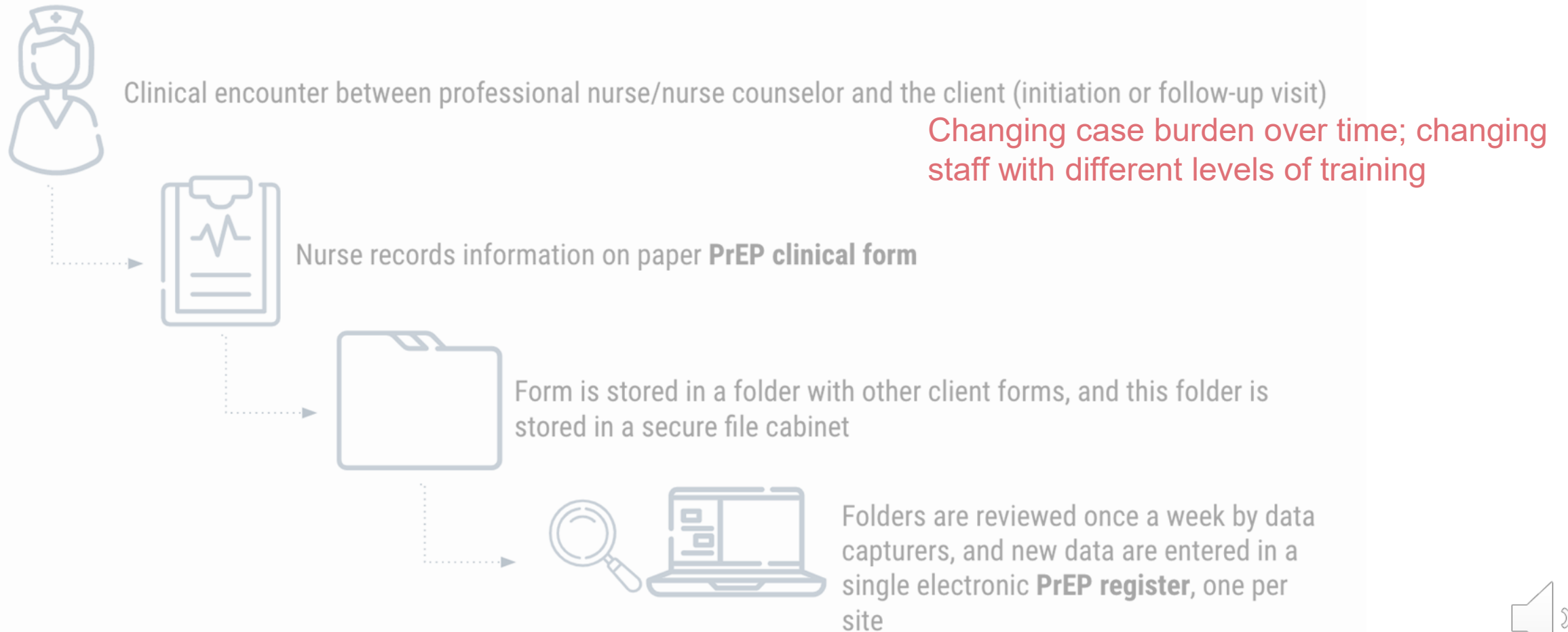Nurse records information on paper **PrEP clinical form**

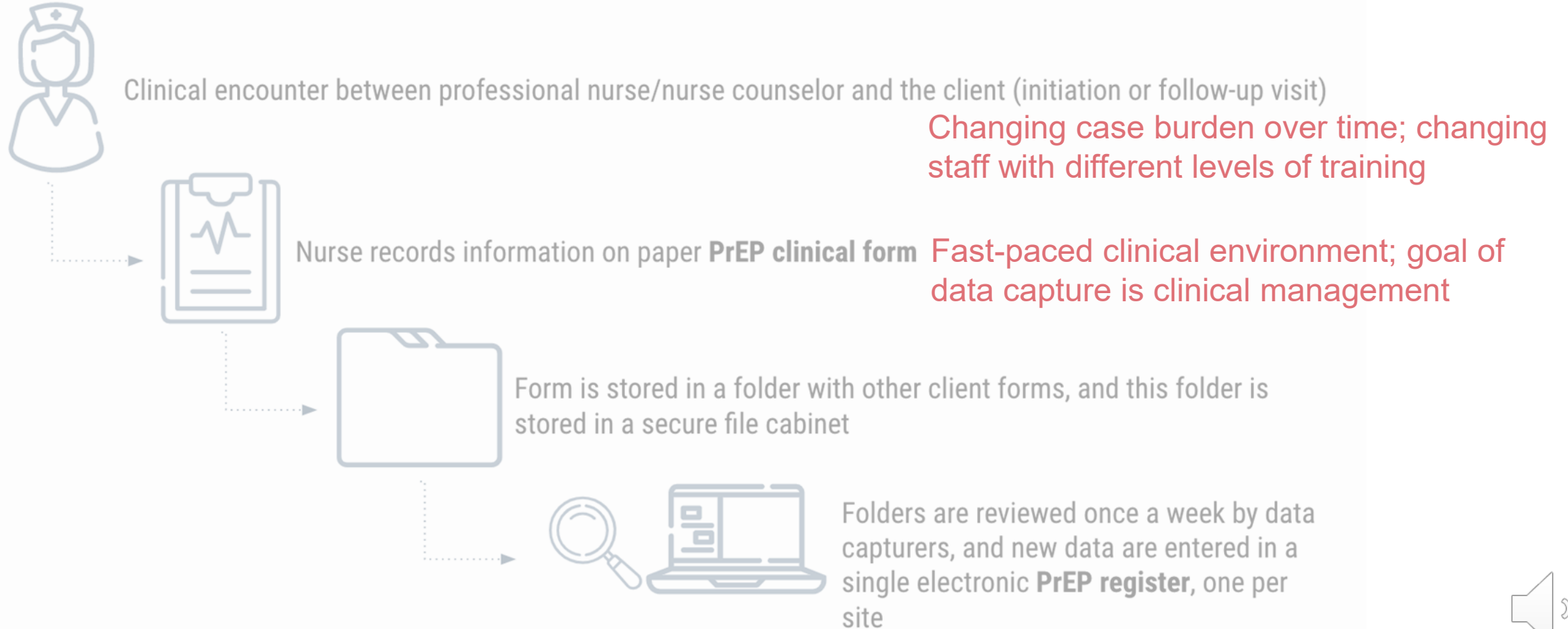Form is stored in a folder with other client forms, and this folder is stored in a secure file cabinet

Folders are reviewed once a week by data capturers, and new data are entered in a single electronic **PrEP register**, one per site

Process of data collection and capture

Clinical encounter between professional nurse/nurse counselor and the client (initiation or follow-up visit)

Changing case burden over time; changing staff with different levels of training

Nurse records information on paper **PrEP clinical form**

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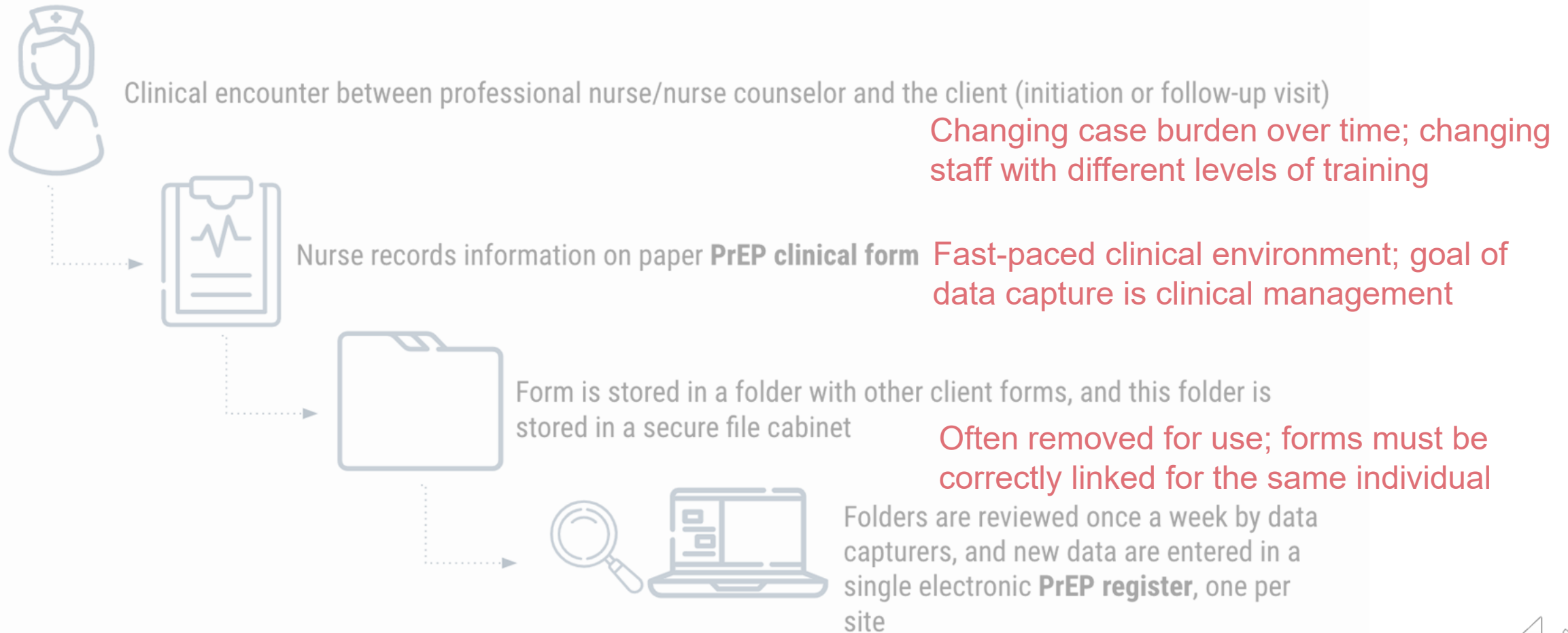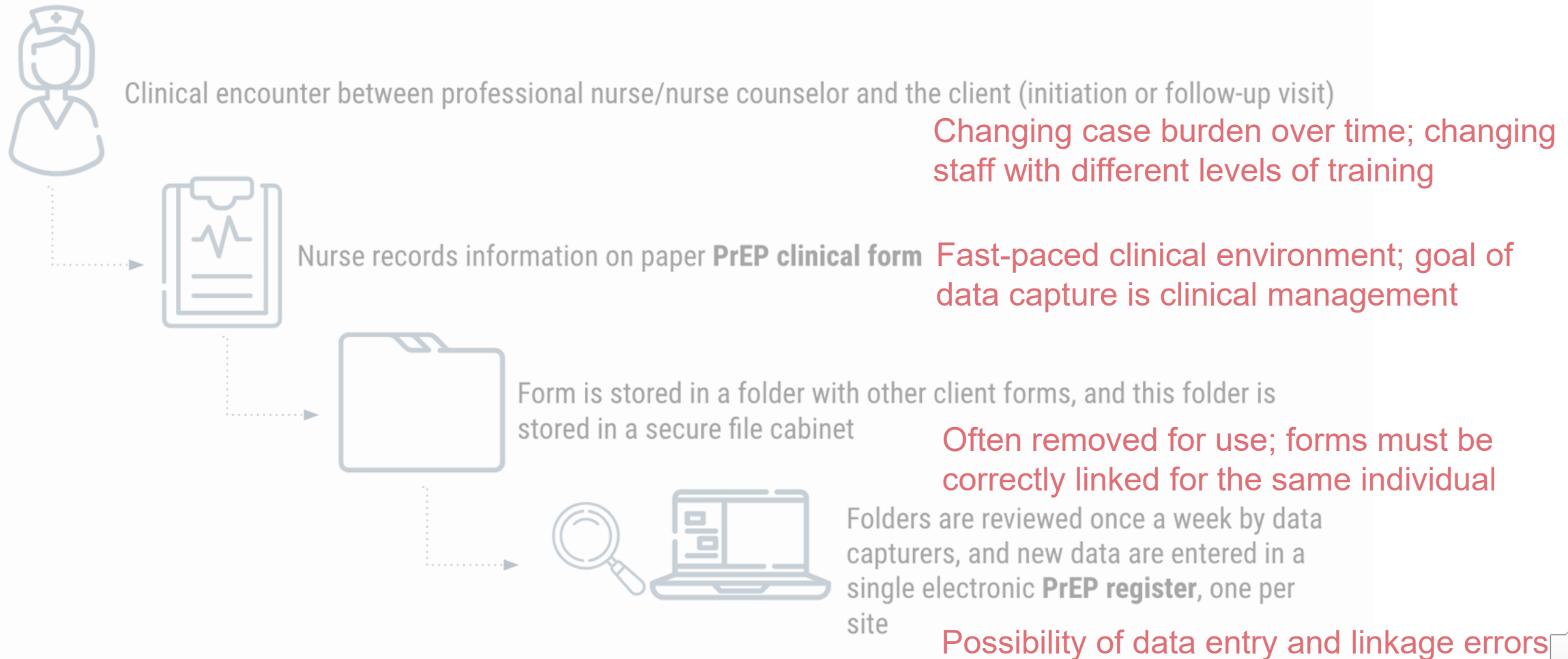
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Possibility of data entry and linkage errors

Using program data: challenges and opportunities

Challenges
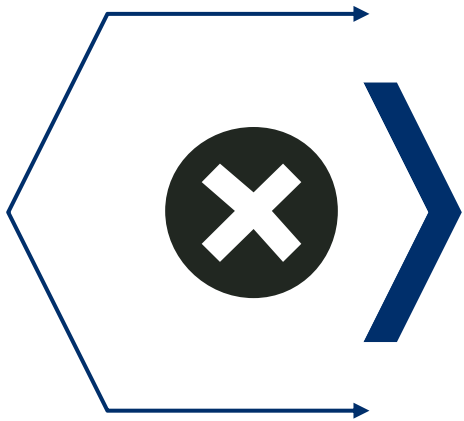
- Often incomplete or messy
- Challenging to access and obtain individual-level data
- Difficulty linking individuals over time (switching to different clinics, moved out of the area)
- Competing priorities to data collection

Opportunities
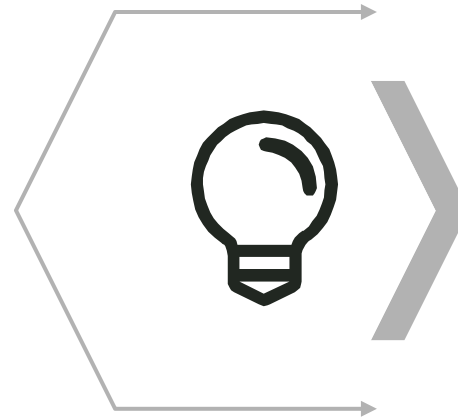
- Data from real-world setting
- Already being collected, so does not involve additional person power or data collection costs
- Can help in studying much larger groups of people
- Answer questions that would otherwise be unethical or too expensive to study

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Development of questions of impact: a partnership

- Create research-practice partnerships or develop research capacity in-house

- Questions developed should be responsive to program needs and gaps in knowledge
  - Demand for services
  - Available resources
  - Implementation
  - Identification of hotspots (geographic, by population group, etc.)

- Continuous feedback from on the ground service providers about findings and adaptation

Opportunity for impact

- Add rigor in evaluation of existing systems

- Answer program-relevant questions, while improving and strengthening systems

  o   How data are **captured**

  o   How data are **managed**

  o   How data are **used**

CASE STUDY EXAMPLES USING PROGRAM DATA

01

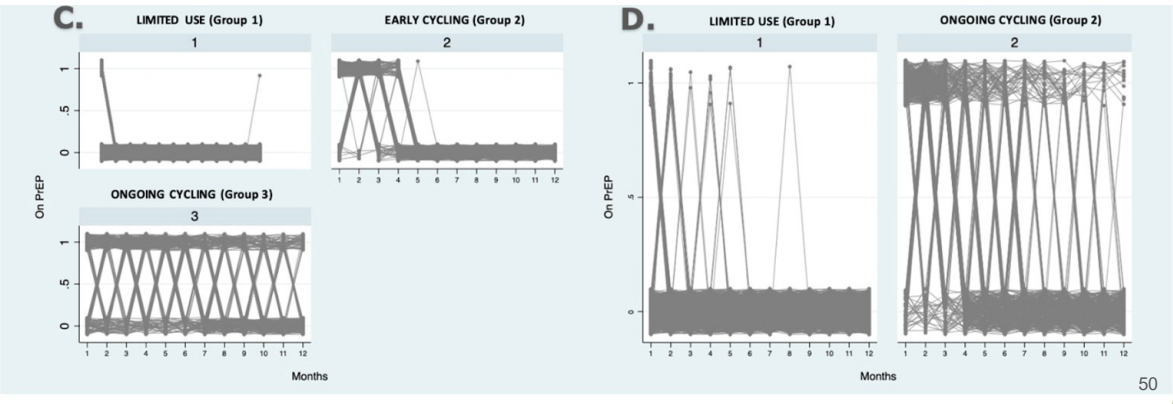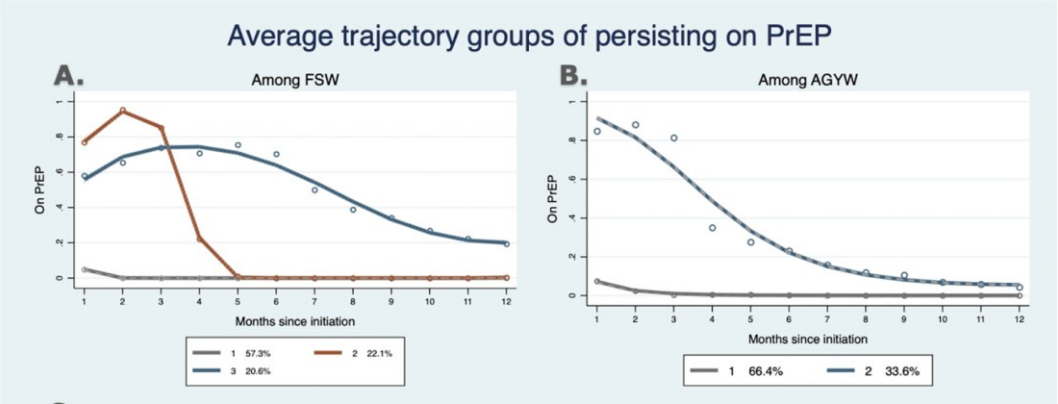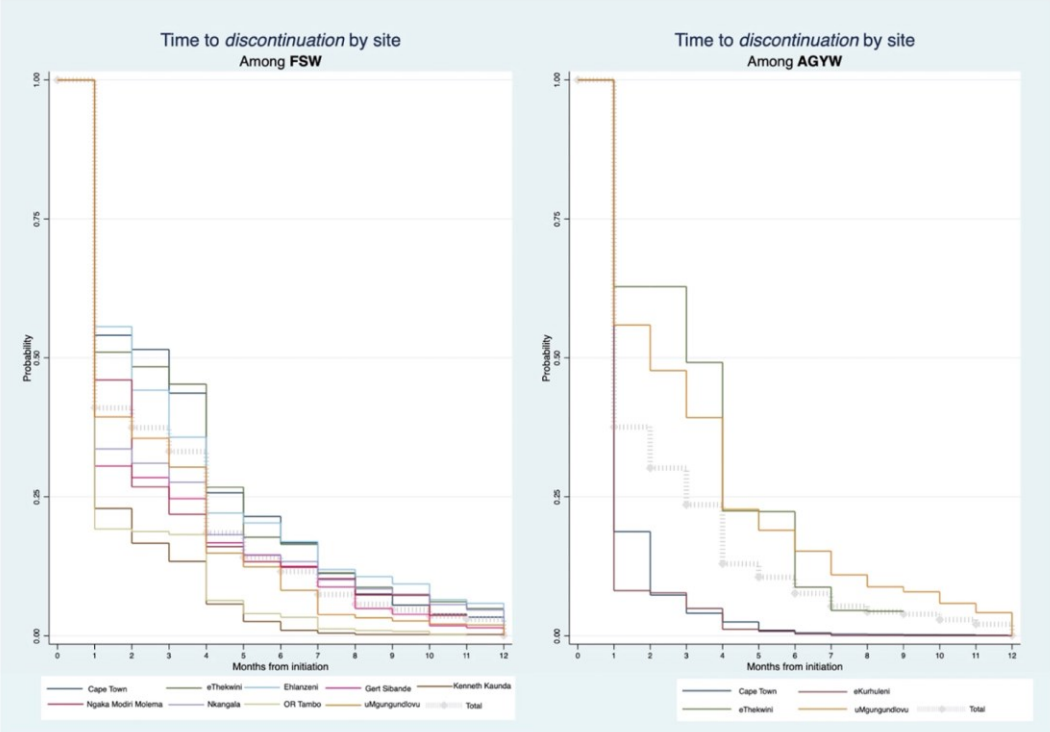Examine patterns of PrEP initiation, discontinuation, re-initiation, and cycling among FSW and AGYW who initiated PrEP in South Africa

Research – practice partnership

TB HIV Care and Johns Hopkins University

- Longstanding research-practice partnership between TB HIV Care and JHU
- Data were reviewed together and questions were developed to be responsive to program needs and gaps in knowledge
- Adding methodologic rigor to the evaluation and understanding of existing systems

Study population

- FSW only
- AGYW only
- Both
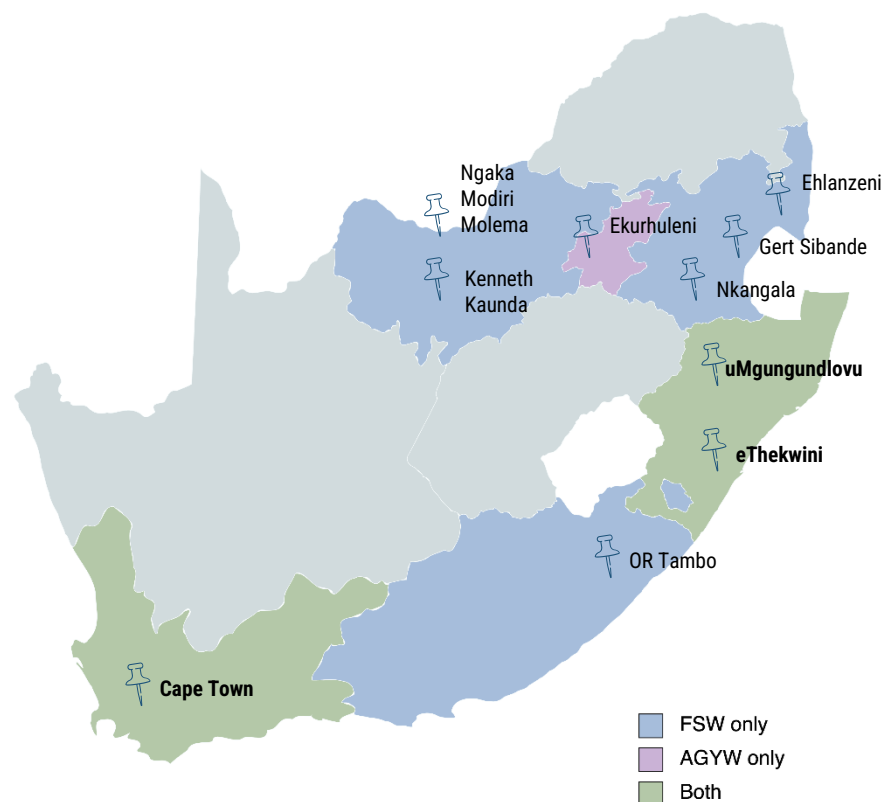
Female sex workers and adolescent girls and young women receiving prevention services through TB HIV Care

Women would have been eligible if they were accessing other prevention services (testing for pregnancy or STIs; family planning) and were HIV negative

Multiple TB HIV Care Sites across 6 provinces

FSW: June 2016 - August 2021

AGYW: May 2018 - September 2020

01) Examine patterns of PrEP initiation, discontinuation, re-initiation, and cycling among FSW and AGYW who initiated PrEP
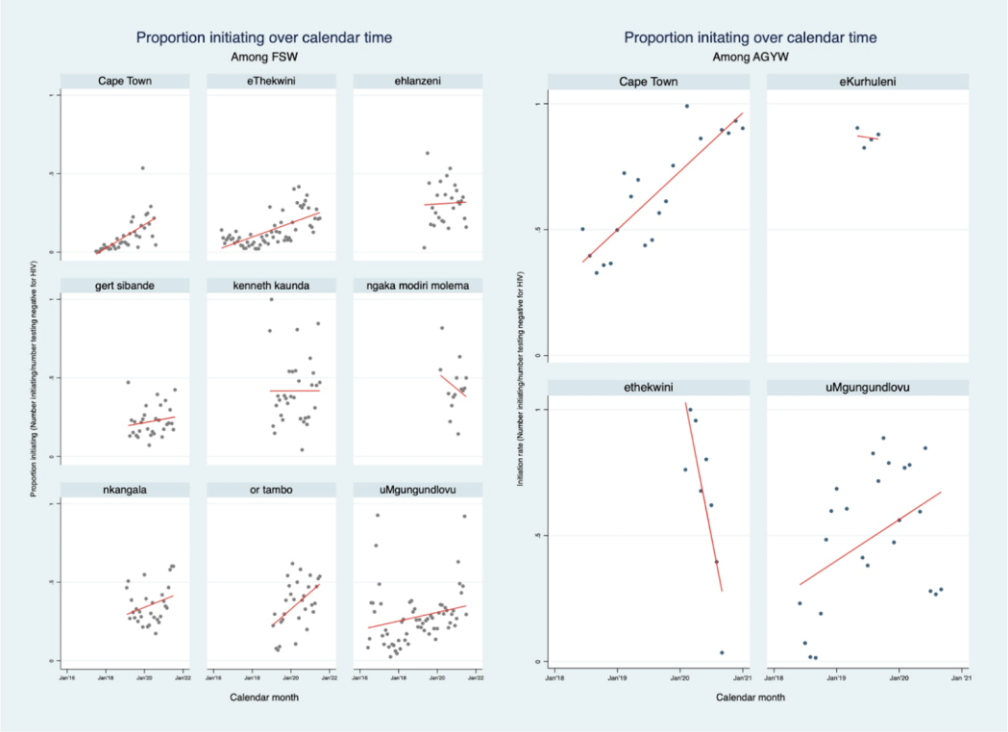
ANALYSIS

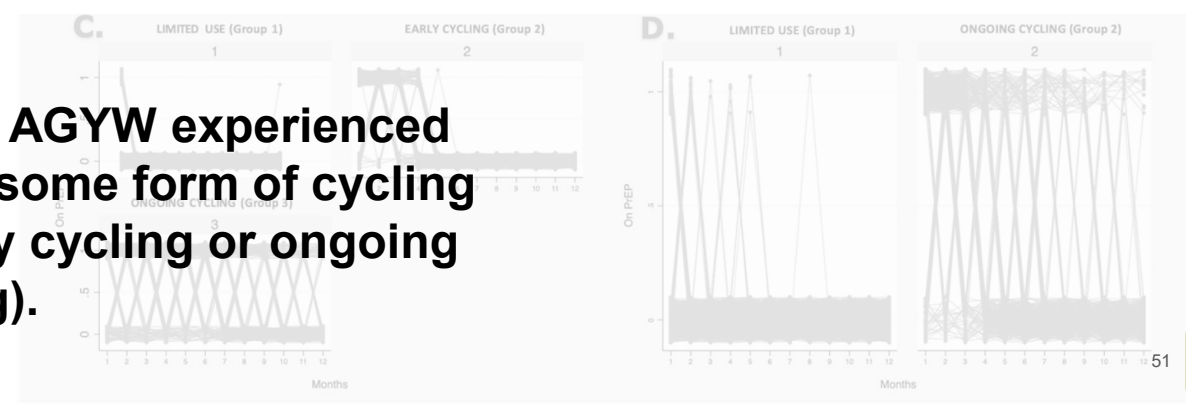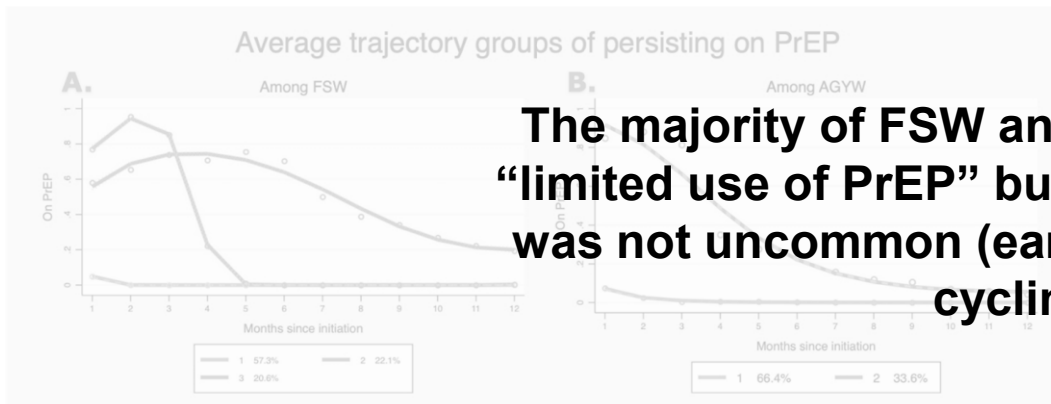|		
Plotted the monthly proportion of eligible HIV negative encounters who initiated PrEP over **calendar time**	✓	Initiation (monthly)
Estimated time to PrEP discontinuation and plotted Kaplan-Meier survival curves	✗	Discontinuation
Estimated time to re-initiation and plotted cumulative incidence using complement of KM curves	✓	Re-initiation
Group-based trajectory modeling	⟲	Cycling

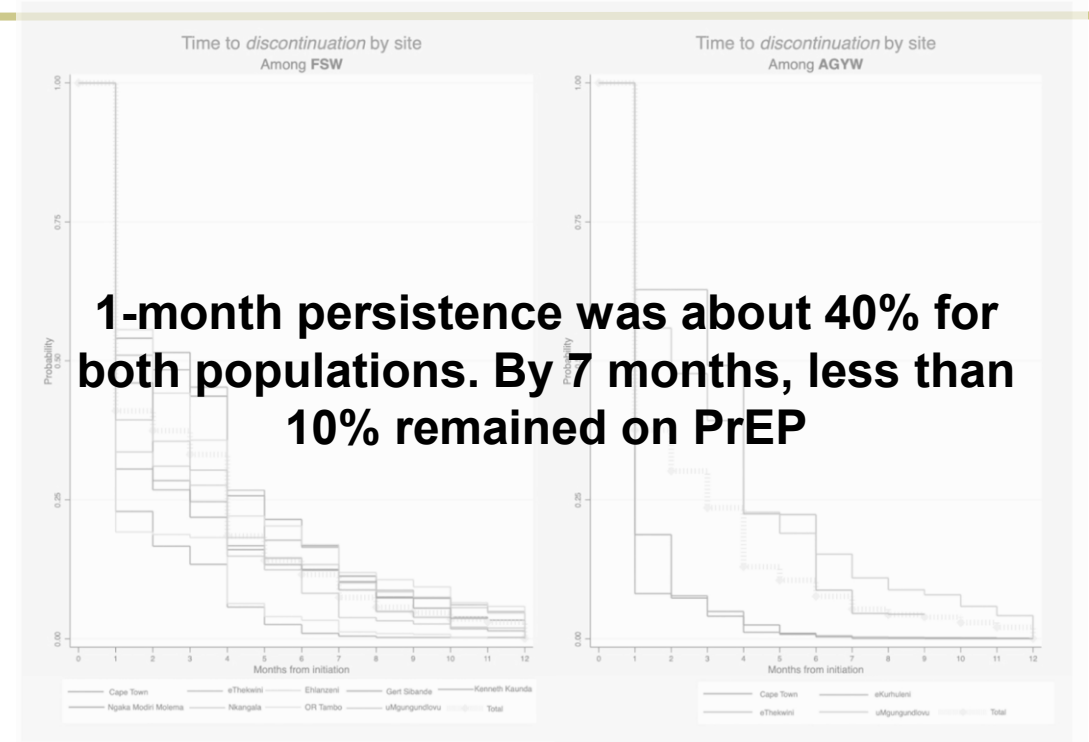**RESULTS**

01) Examine patterns of PrEP initiation, discontinuation, re-initiation, and cycling among FSW and AGYW who initiated PrEP
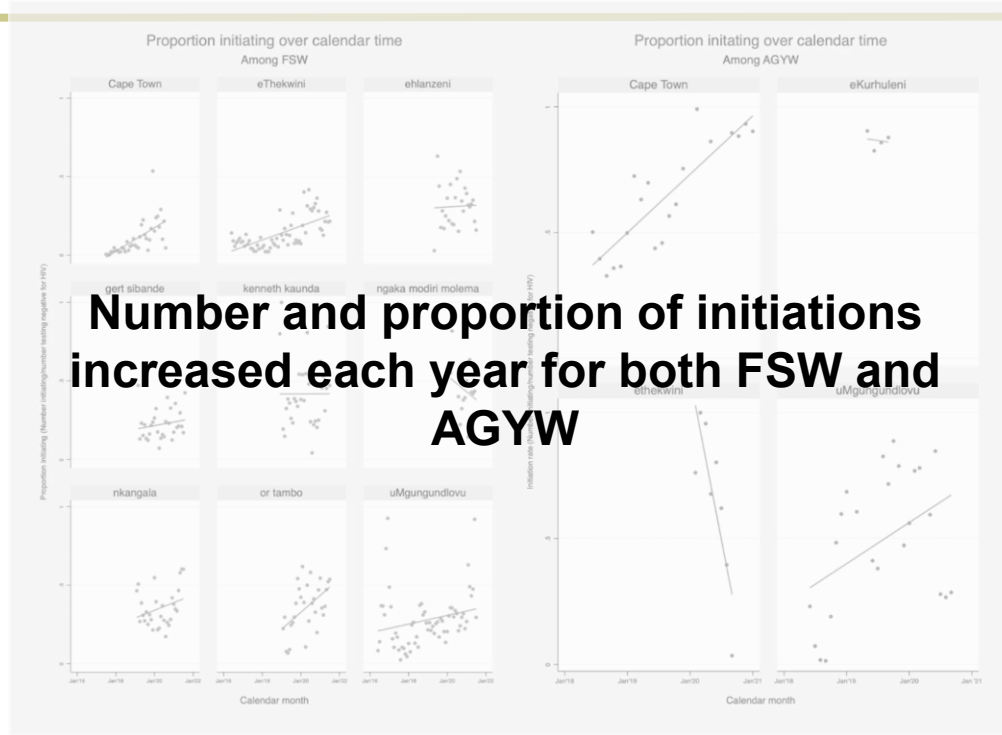

Number and proportion of initiations increased each year for both FSW and AGYW

1-month persistence was about 40% for both populations. By 7 months, less than 10% remained on PrEP

The majority of FSW and AGYW experienced "limited use of PrEP" but some form of cycling was not uncommon (early cycling or ongoing cycling).

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02

Evaluate the impact of implementation strategies on PrEP persistence among FSW and AGYW served by TB HIV Care

02) Evaluate the impact of implementation strategies on PrEP persistence among FSW and AGYW served by TB HIV Care

OUTCOME

PrEP persistence at one month
Whether or not a client returned to pick up her PrEP refill at one-month following initiation

Data at the individual level were **aggregated to produce monthly site-specific counts** of the number of women who picked up their 1-month PrEP refills and counts of the number of women who initiated PrEP in the prior month (who would be expected to pick up a PrEP refill)

02) Evaluate the impact of implementation strategies on PrEP persistence among FSW and AGYW served by TB HIV Care

STRATEGIES

- **WhatsApp support groups**: groups of PrEP users where members can discuss successes and challenges in using PrEP

- **Clinical mentoring for providers**: weekly meetings conducted with PrEP providers, led by a nurse clinician or clinical trainer to review best practices for PrEP provision
- **Mobile van PrEP provision**: decentralized delivery of PrEP in the community using a TB HIV Care mobile van

- **SMS PrEP refill reminder**: text messages sent one week before and one day before scheduled refill
- **Generic SMS support**: text messages of support sent once a week designed to empower and promote self efficacy
- **Loyalty rewards program:** incentives in the form of airtime (credit used to make calls, send texts, or access the internet) for initiating and returning for PrEP visits
- **Case management approach**: Nurse clinicians and assigned case managers provide dedicated follow-up of PrEP users to support and guide with HIV prevention care

We evaluated the independent impact of...

1) clinical mentoring for providers

2) SMS refill reminders and support texts

3) case management approach, and

4) loyalty rewards program

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_1 + \beta_3 X_2 + \beta_4 X_3 + \beta_5 X_4 + \beta_6 (COVID) + offset(person\ time)$$

Where X1 represents clinical mentoring for providers, X2 represents SMS PrEP refill reminders and support texts, X3 represents the case management approach, and X4 represents the loyalty rewards program

02) Among FSW

Cape Town · **Ehlanzeni** · **eThekwini** · **Gert Sibande** · **Kenneth Kaunda** · **Ngaka Modiri Molema** · **Nkangala** · **OR Tambo** · **uMgungundlovu**

1-month persistence

Calendar time by month, June 2016-April 2021

- Loyalty Rewards Program
- SMS PrEP refill reminders and support texts
- Clinical mentoring for providers
- Case management
- Shaded region represents a pause in the Loyalty Rewards Program
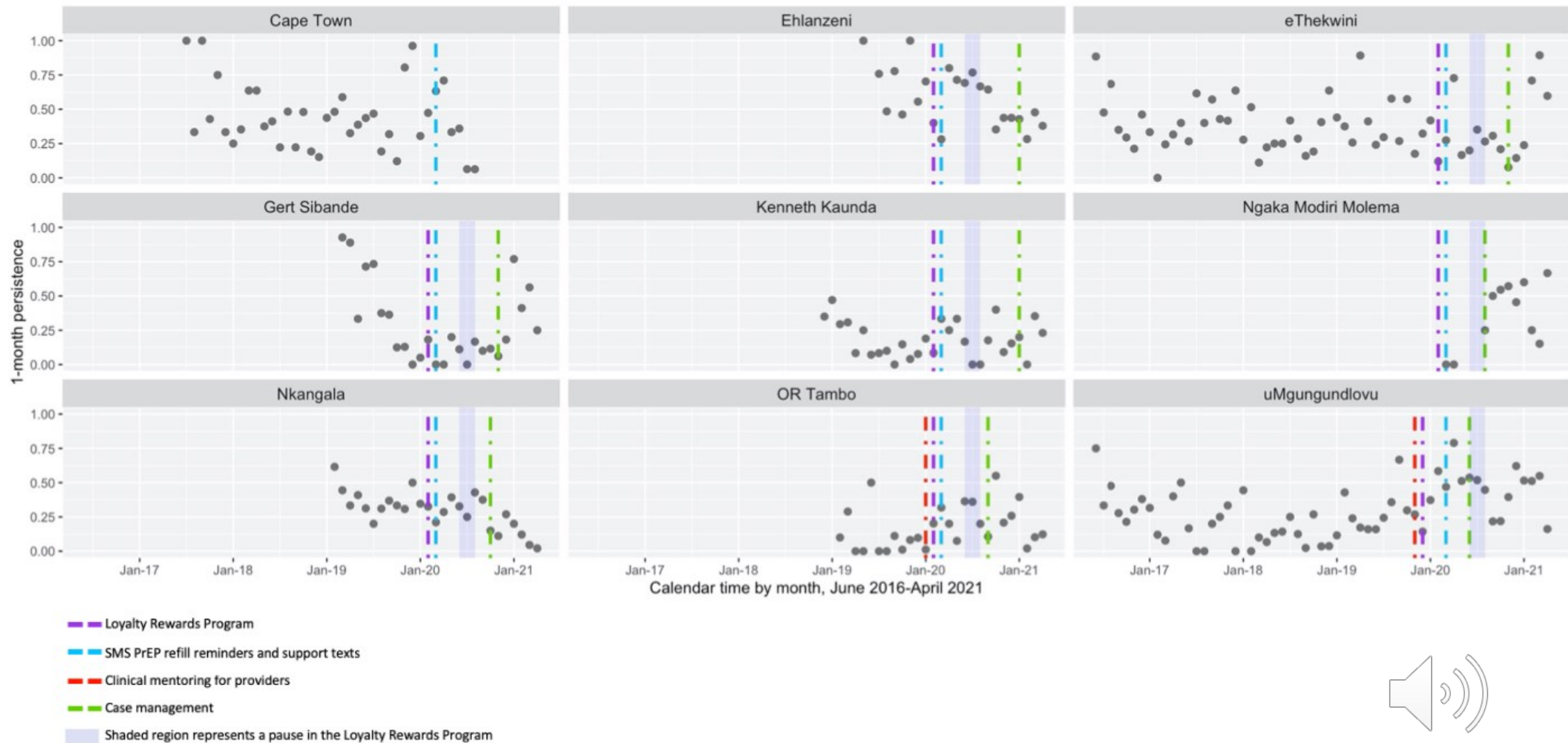
02) Among FSW

Introduction of **clinical mentoring for providers** was associated with a **12%** increase in 1-month persistence (95% CI: 1.03, 1.23).

Introduction of **SMS support and refill reminders** was associated with a **33%** increase in 1-month persistence (95% CI: 1.18, 1.50).

Introduction of **the case management approach** was not associated with any increase in 1-month persistence (95% CI: 0.92, 1.13).

Introduction of **the loyalty rewards program** was associated with a **26%** decrease in 1-month persistence (95% CI: 0.67, 0.82).

03

Extrapolation of population size estimates for FSW and MSM in Namibia

03) A lack of reliable population size estimates (PSE) for key populations contributes to gaps in knowledge across the HIV cascade

- Size estimates are among most volatile, unreliable estimates in HIV public health

- Nonexistent in rural, remote areas and/or settings with most unmet needs

- Small area estimation can help fill in gaps

Program data are typically excluded from small area estimation approaches

Areas with Population Size Estimates

Areas without Population Size Estimates

2%	→	2%
3%	→	3%
5%	→	5%
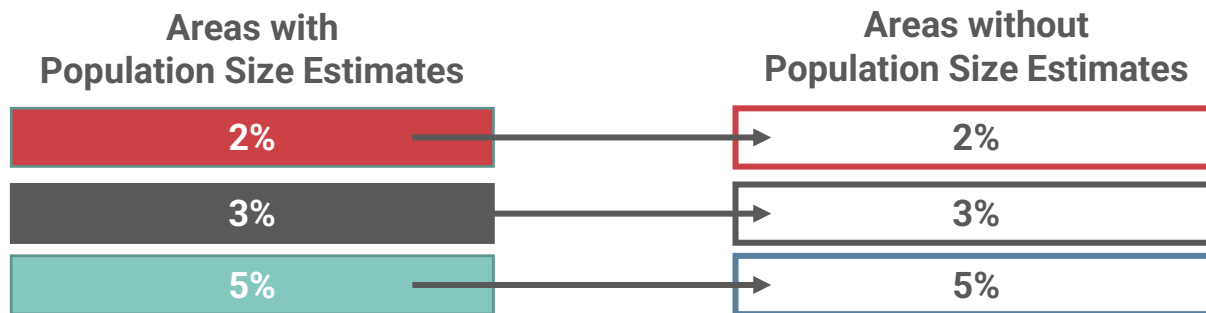
03) In Namibia, differences in PSEs exist within and across regions for FSW and MSM

Table 1. Direct Estimates (2012-2014, 2019), n (95% CI), by Key Population and Region*

KP	Region	Direct Estimation Method						
		Mapping	Key Informant Interview	Unique Object Multiplier	Wisdom of the Crowds	Literature Review	Stakeholder Consensus	SS-PSE
FSW	Zambezi	284 (142-426)	300 (50-4300)	5299 (3500-8575)	300 (100-1000)	84 (47-251)	800 (380-2000)	674 (318-2426)
	Ohangwena	158 (79-237)	100 (30-800)	1494 (1249-1822)	500 (300-1000)	85 (47-254)	900 (775-2750)	900 (775-2750)
	Erongo	322 (161-483)	330 (200-1000)	2352 (1597-4557)	700 (200-2000)	241 (134-723)	900 (825-1500)	1057 (576-3369)
	Khomas	528 (264-792)	100 (50-1700)	5240 (3373-11706)	600 (200-1500)	1582 (1055-2110)	3000 (1800-3400)	2196 (1651-2382)
MSM	Karas	282 (141-423)	1132 (200-2948)	1714 (1292-2359)	100 (40-400)	84 (24-138)	500 (300-650)	-
	Oshana	78 (39-117)	2000 (250-5184)	3538 (2379-5632)	150 (50-500)	157 (45-259)	500 (350-800)	-
	Erongo	488 (244-732)	100 (70-300)	2982 (2013-5808)	70 (40-250)	427 (122-701)	610 (475-658)	670 (410-1610)
	Khomas	460 (230-690)	300 (100-1600)	2229 (1699-3240)	400 (no bounds available)	1207 (345-1983)	2416 (850-4000)	2210 (382-10410)

*Data collected between 2012-2014 and 2019[18,19]

Source: Loeb et al. (in prep)

03) Program data may be used to "ground truth" for key populations

- Quarterly data provided by community-based HIV service providers can approximate the number of individuals engaging with HIV programs

- While imperfect, can cumulatively function as a lower bound for PSEs in districts or regions where services are being provided

How can we systemize the integration of program data in small area estimation approaches?

03) Triangulating multiple PSEs using prior beliefs via a consensus-estimation approach

- Triangulator (formerly Consensus Estimator) developed by Dr. Ian Fellows et al. (https://epiapps.com/shiny/app_direct/shinyproxy_combine_estimates/)

- Leverages known information about the distribution of each population to inform a singular estimate for each region

- Weights each direct estimate based on user-defined confidence (e.g., multiplier methods may be more rigorous than wisdom of the crowd methods)

EPIAPPS

THE TRIANGULATOR

The Triangulator is a Shiny user interface designed to help derive consensus estimates of a population quantity (e.g. a population size, a proportion, a mean, etc.) from multiple empirical estimates. Stakeholders may add additional information regarding the methodological quality of the studies and prior knowledge of the metric. Triangulated estimates are statistically defensible, reproducible and openly inspectable.

LAUNCH APPLICATION

Authors: Ian E. Fellows and Carl Corcoran

Github: https://github.com/fellstat/triangulator

03) Weighting PSEs based on quality of study implementation and prior beliefs

- PSE methods ranked by level of confidence (0-100)

- Internal "tests" explored varying levels of confidence to calculate triangulated PSEs for each region

- Prior beliefs for the distribution of the derived size estimates were defined based on quarterly program data

Supplemental Table 1. Example Determination of Confidence Values, FSW in Zambezi

Method	Design Confidence		
	Test 1	Test 2	Test 3
Mapping	75	75	85
Key Informant Interview	55	60	65
Unique Object Multiplier	85	85	95
Wisdom of the Crowd	40	40	50
Literature Review	60	60	70
Stakeholder Consensus	65	60	75
SS-PSE	90	90	99.9
	Results from Consensus Estimator Tool		
	Test 1	Test 2	Test 3
Median (SD)	429.29 (90.91)	425.34 (92.66)	367.62 (66.58)

03) Changes in extrapolated PSE proportions after including program data

Table 2. Absolute and Proportion Estimate Differences in FSW Extrapolated Estimates Before and After the Integration of Programmatic Data

FSW

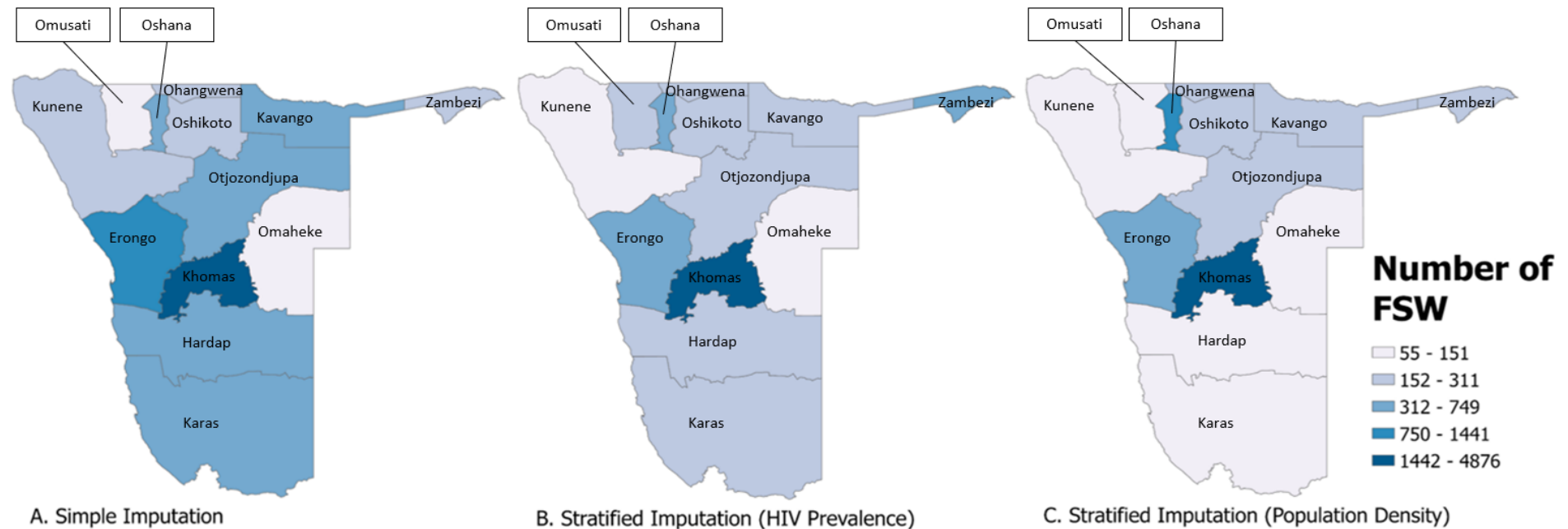| Stratified Imputation	Simple Imputation		Stratified Imputation, HIV Prevalence		Stratified Imputation, Population Density	
	Pre-Programmatic Data Proportion	Post-Programmatic Data Proportion	Pre-Programmatic Data Proportion	Post-Programmatic Data Proportion	Pre-Programmatic Data Proportion	Post-Programmatic Data Proportion
Greater than Median	0.019	0.028	0.026	0.040	0.011	0.034
Less than/Equal to Median			0.014	0.012	0.028	0.010

Table 3. Absolute and Proportion Estimate Differences in MSM Extrapolated Estimates Before and After the Integration of Programmatic Data

MSM

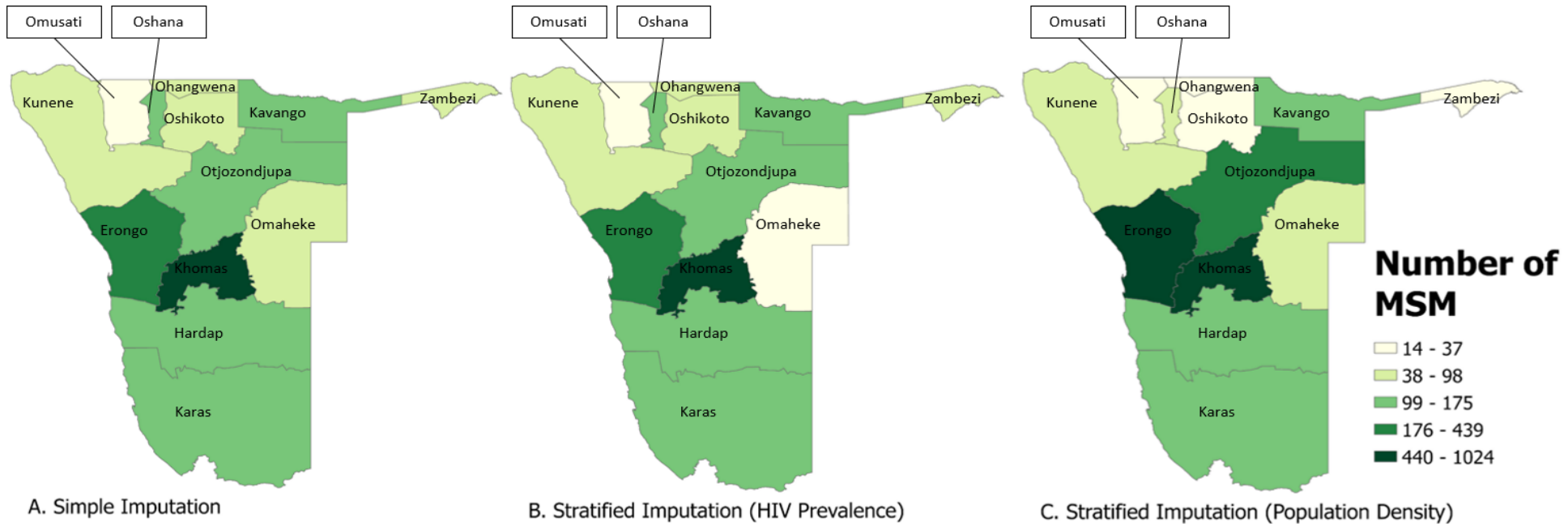| If Stratified Imputation	Simple Imputation		Stratified Imputation, HIV Prevalence		Stratified Imputation, Population Density	
	Pre-Programmatic Data Proportion	Post-Programmatic Data Proportion	Pre-Programmatic Data Proportion	Post-Programmatic Data Proportion	Pre-Programmatic Data Proportion	Post-Programmatic Data Proportion
Greater than Median	0.015	0.0075	0.021	0.008	0.014	0.0045
Less than/Equal to Median			0.013	0.007	0.015	0.010

Source: Loeb et al. (in prep)

03) Among FSW

Extrapolated national estimates ranged from 4777 to 13148, comprising **1.5% to 3.6%** of **women ages 15-49**

A. Simple Imputation

B. Stratified Imputation (HIV Prevalence)

C. Stratified Imputation (Population Density)

Number of FSW
- 55 - 151
- 152 - 311
- 312 - 749
- 750 - 1441
- 1442 - 4876

Source: Loeb et al. (in prep)

03) Among FSW

Extrapolated national estimates ranged from 4611 to 10171, comprising **0.7%-1.5% of men ages 15-49**

A. Simple Imputation

B. Stratified Imputation (HIV Prevalence)

C. Stratified Imputation (Population Density)

Number of MSM

- 14 - 37
- 38 - 98
- 99 - 175
- 176 - 439
- 440 - 1024

Source: Loeb et al. (in prep)

03) Summary of implications

- Using SAE approaches, we combined epidemiologic and program data to generate subnational size estimates for key populations in Namibia

- The inclusion of program data increased the proportion of FSW in high-density/high HIV prevalence regions and decreased the proportion of MSM in all regions

- Future work is needed to determine how best to include program data in KP size estimation studies, ultimately bridging research with practice to support a more comprehensive HIV response.

DISCUSSION

Program data present an opportunity for:

- Collaboration

- Repurposing existing data and analyses and infusing additional methodologic rigor

- Shedding light on program-relevant questions

Questions?

Kate Rucinski rucinski@jhu.edu
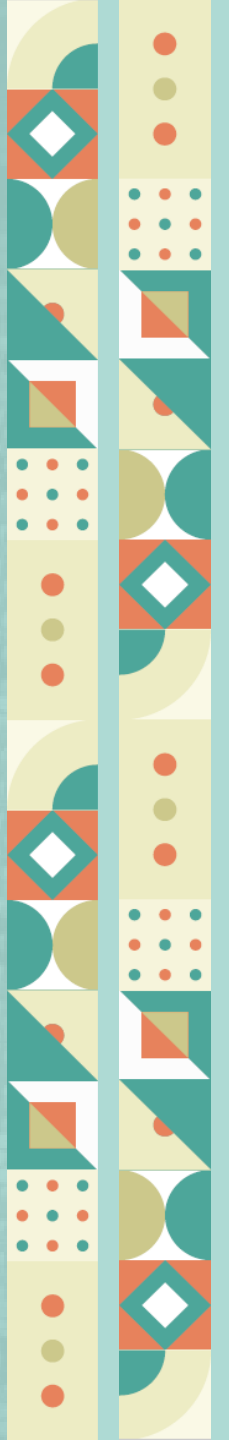
Amrita Rao arao24@jhu.edu

WITH THANKS
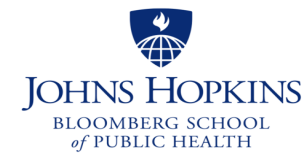
PRIORTY

Mentimeter
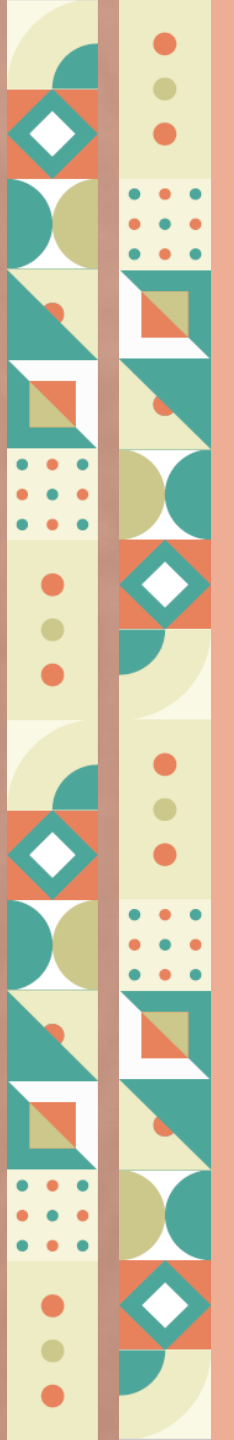
PRACTICAL APPROACHES TO IMPLEMENTING A MONITORING & EVALUATION SYSTE TO MONITOR PROGRESS OF KP PROGRAMME

Dr Jebet Boit, Kenya

Dr Ketevan Stvilia, Ekaterine Ruadze and Maka Gogia, Georgia

PRACTICAL APPROACHES TO IMPLEMENTING A MONITORING AND EVALUATION SYSTEM TO MONITOR PROGRESS OF KP PROGRAM
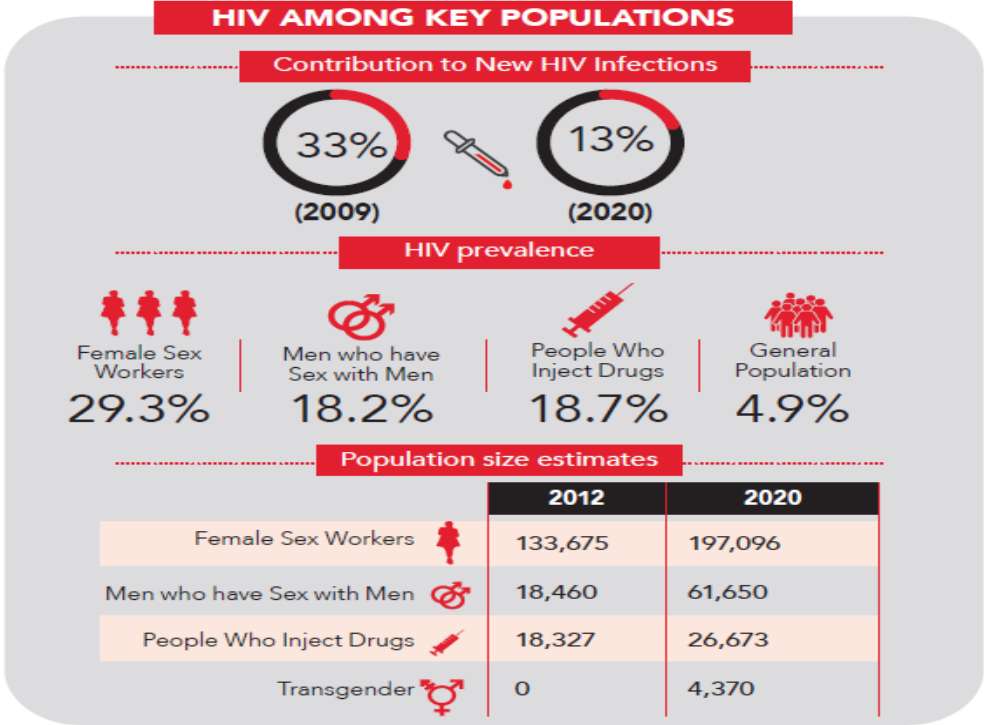
DR JEBET BOIT

The Key Population Program: at a Glance

- Led by Ministry of Health (MOH) - NASCOP and NSDCC since 2008, provides strategic direction, technical support and coordination, and evidence; sets standards; mobilises resources, and establishes an enabling environment

- Technical Support Unit implemented by UoM established to support scale-up of interventions in 2012

- Funding through MOH, PEPFAR, GFATM, and other funders to 95 implementing partners (IPs) in 37/47 counties

- MOH leadership instills confidence in IPs to implement a prevention programme for KPs, though sex work, same sex relationship and drug possession and use are criminalized in Kenya
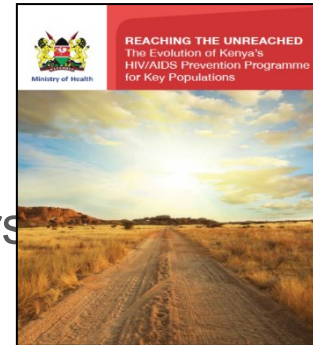
Role of Key Populations in Kenya

- Kenya Modes of Transmission study (2008) identified key populations as groups disproportionately affected by HIV, contributing to 33% of all new infections. However, the current national data shows a reduction to 13%.

- IBBS results (2010), showed a higher burden of HIV among key populations, prevalence 3–5 times higher than the general population

- Current data illustration

HIV AMONG KEY POPULATIONS

Contribution to New HIV Infections

33% (2009) → 13% (2020)

HIV prevalence

Female Sex Workers	Men who have Sex with Men	People Who Inject Drugs	General Population
29.3%	18.2%	18.7%	4.9%

Population size estimates

	2012	2020
Female Sex Workers	133,675	197,096
Men who have Sex with Men	18,460	61,650
People Who Inject Drugs	18,327	26,673
Transgender	0	4,370

Mapping and Size estimation

- Mapping and size estimation conducted in 2012 and repeated in 2018-2020. Virtual mapping conducted in 2019 to estimate the population size of MSM who meet partners in virtual spaces.

- Used the data to determine denominators and targets and develop a scale up plan.

- Used the evidence to develop guidelines to reach the unreached like virtual MSM, young key populations
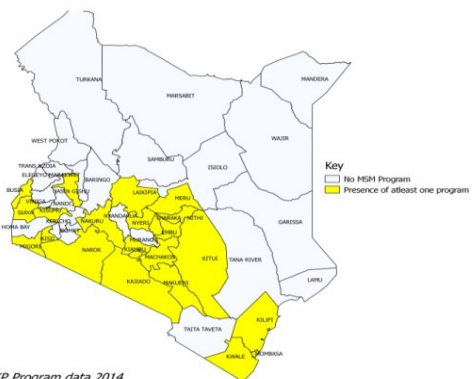
ESTIMATES
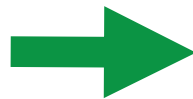
IMPLEMENTATION

County Estimates of Men Who have Sex With Men

County Distribution of MSM Programs

Key
- No MSM Program
- Presence of atleast one program

Source: NASCOP KP Program data,2014

EVIDENCE BRIEF   September 2018

Ministry of Health

VIRTUAL MAPPING

Harnessing online social networks to reach men who have sex with men in Kenya

Number of MSM who used virtual sites by county

KISUMU	MOMBASA	KIAMBU
1567	1469	3635

Routine program monitoring – development of national tools
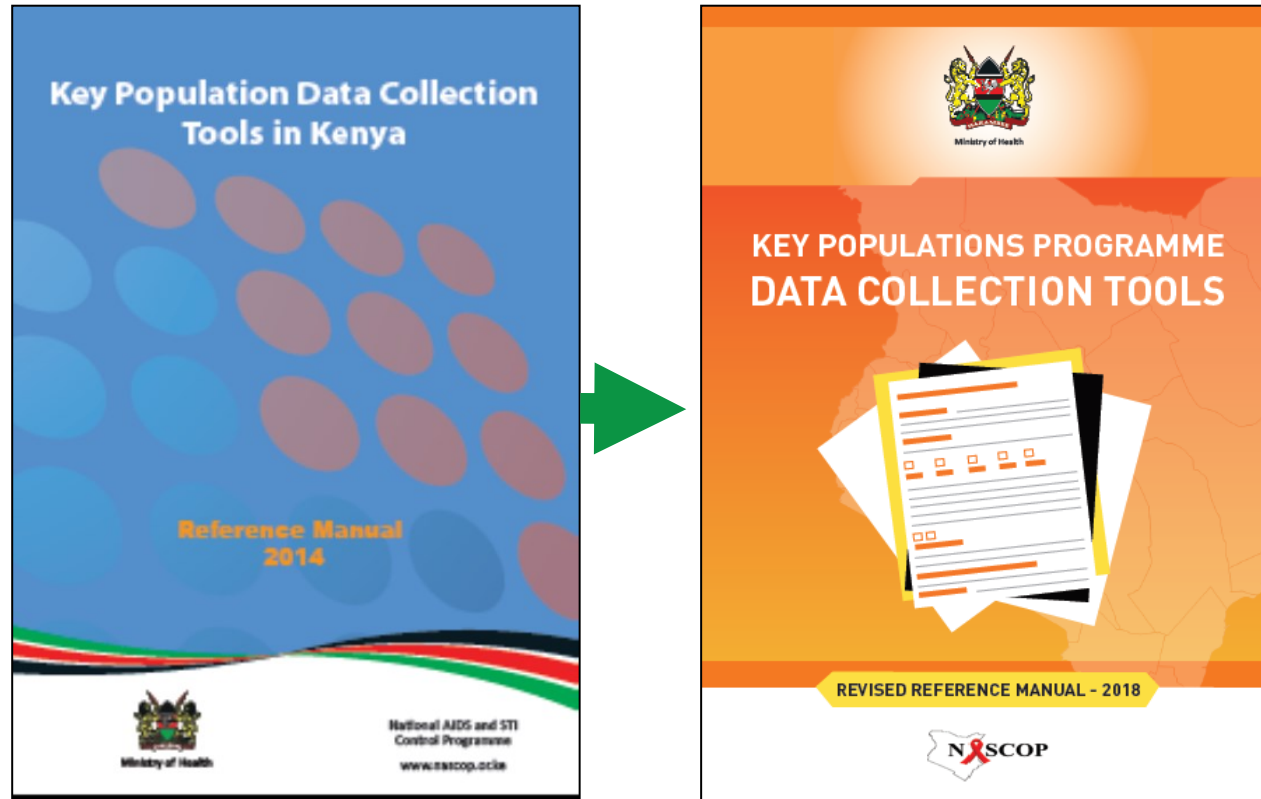
Mapping of Implementing Partners
- NASCOP mapped all the KP implementing partners in the country in 2012

Development of Reporting Tools
- Developed a set of KP reporting tools in 2014 partnership with
  - o Members of key populations
  - o Donor agencies
  - o Implementing partners
  - o Tools were revised in 2018

Output
- 22 data collection tools
- Monthly and quarterly tools
- High reporting since 2014

Routine Program Monitoring – capacity strengthening

Series of Trainings Conducted

- Definition of indicators and variables
- Responsibility of various staff cadres in tool completion
- Periodicity of filling the tools

Quality of Reporting Checked

- Desk review on receipt of reports
- Regular RDQA
- Analysis and sharing of data to the IPs and County and national managers
- Presentation of data in TWG and COE

Routine Monitoring: Unique Identifier Code
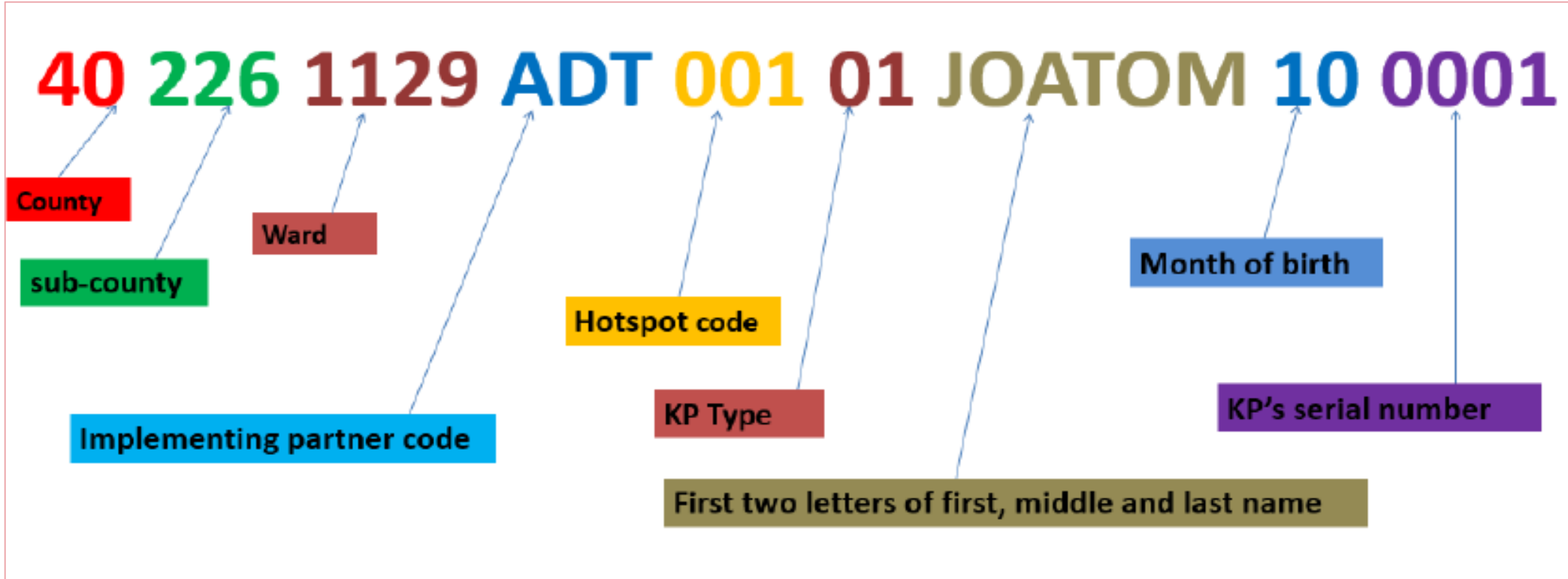
Source: UIC guidance note, NASCOP

Routine monitoring - One National Reporting System

Reporting through Kenya Health Information System (KHIS) – MOH 731plus
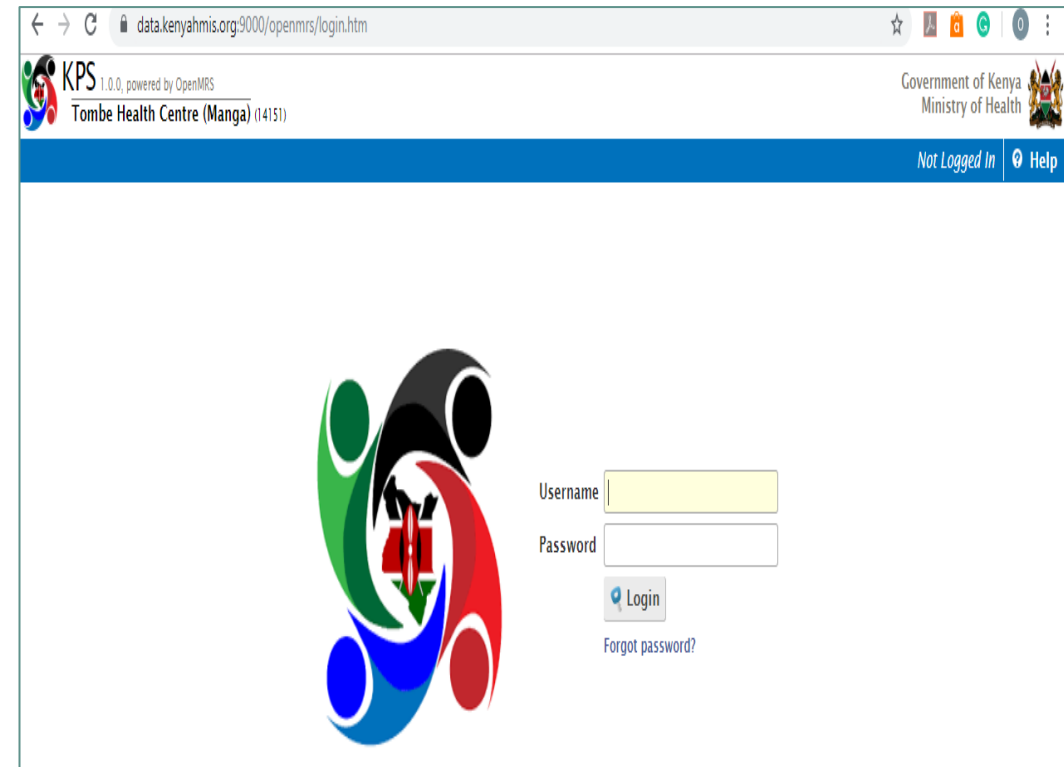
Data Management: Kenya Electronic Medical Record System (Kenya EMR)

Routine monitoring - One National Reporting System

- All implementing partners (421 reporting unit) enter the KP program performance data on a monthly basis using MOH 731plus form

- The filled form is submitted to the county CHRIO who enter the data into the KHIS

- The data is analysed at county and national level to monitor program progress and performance

- Implementers who use the EMR system for data entry can automatically generate the reports using MOH 731 plus

Analysis and Information Use:
Hotspot Levels to IP level to sub national and national level by sub population
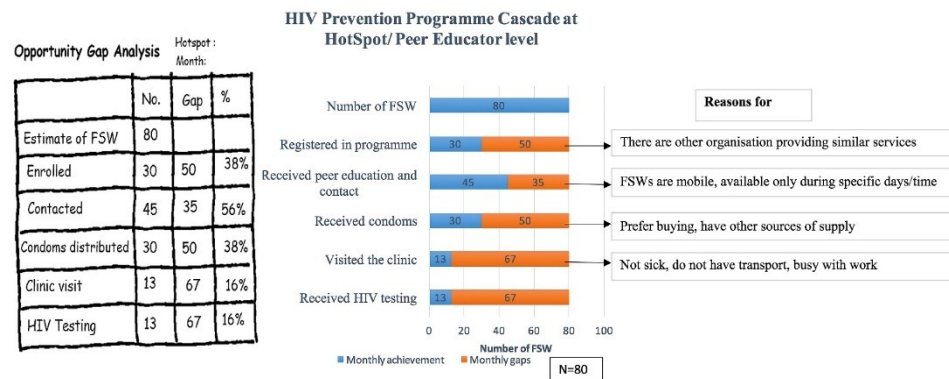
Analysis at hot spot level

Opportunity Gap Analysis — Hotspot: Month:

	No.	Gap	%
Estimate of FSW	80		
Enrolled	30	50	38%
Contacted	45	35	56%
Condoms distributed	30	50	38%
Clinic visit	13	67	16%
HIV Testing	13	67	16%

HIV Prevention Programme Cascade at HotSpot/Peer Educator level

Reasons for:
- There are other organisation providing similar services
- FSWs are mobile, available only during specific days/time
- Prefer buying, have other sources of supply
- Not sick, do not have transport, busy with work

Figure 3: HIV Prevention Programme Cascade for Implementation Partner at Hot Spot level, Learning Site, Nairobi

Prevention cascade Q3 2022

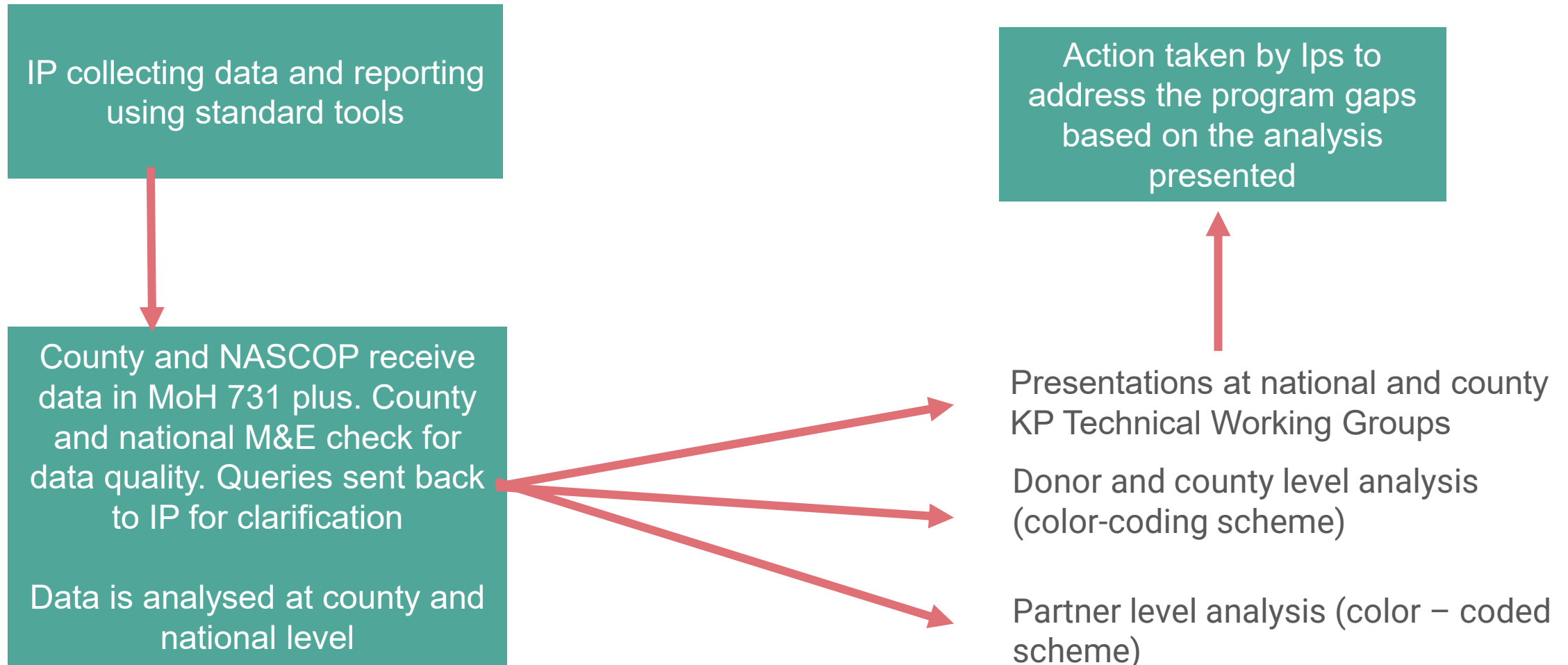### National/Sub national analysis and presentation
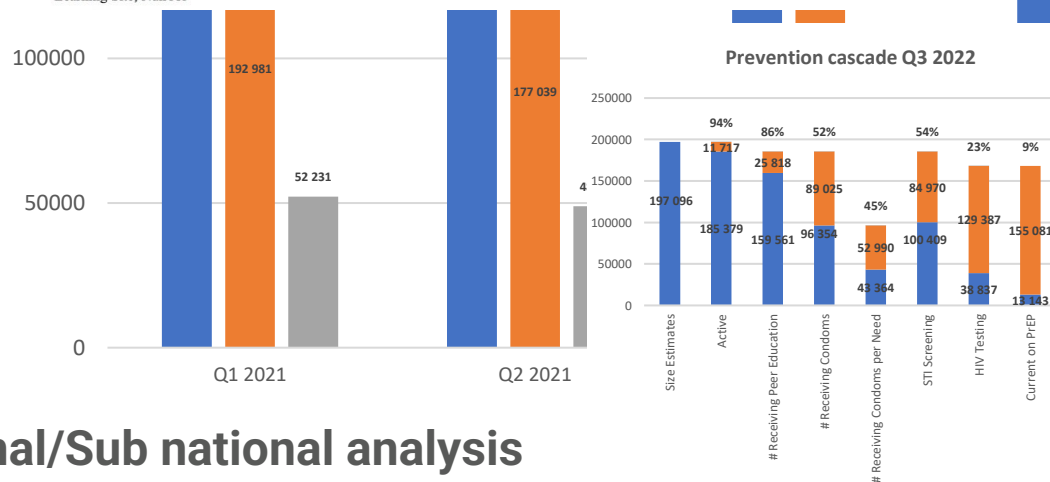
Implementing Partner-level analysis: color coded based on reporting

County	Subcounty	dice_name	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Kiambu	Kiambaa Sub County	DICE Karuri Health Centre MAT	100	100	100	100	100	100	100	100	100	100
Kilifi	Malindi Sub County	DICE Malindi MAT	100	100	100	100	100	100	100	100	100	100
Kisumu	Kisumu Central Sub County	DICE MAT JOOTRH	100	100	100	100	100	100	100	100	100	100
Kwale	Matuga Sub County	DICE Kwale MAT Kombani	100	100	100	100	100	0	100	100	100	100
Mombasa	Nyali Sub County	DICE Kisauni MAT	100	100	100	100	100	100	100	100	100	100
Nairobi	Mathare Sub County	DICE Mathare MAT	100	100	100	100	100	100	100	100	100	100
Nairobi	Starehe Sub County	DICE Ngara MAT	100	100	100	100	100	100	100	100	100	0
	COUNTY		**100**	**100**	**100**	**100**	**100**	**86**	**100**	**100**	**100**	**86**

- Help identify national, sub national, implementation partner and hotspot level gaps and opportunities for each sub population
- Informs development of strategies to address gaps
- Prioritizes counties and IPs for technical support

Routine Monitoring System:
National Reporting and Feedback Framework

IP collecting data and reporting using standard tools

County and NASCOP receive data in MoH 731 plus. County and national M&E check for data quality. Queries sent back to IP for clarification

Data is analysed at county and national level

Action taken by Ips to address the program gaps based on the analysis presented

Presentations at national and county KP Technical Working Groups

Donor and county level analysis (color-coding scheme)

Partner level analysis (color − coded scheme)

Outcome measurement

- The national program conduct IBBS to measure outcomes. IBBS was conducted in 2010-11. The 2nd one will take place in 2023.

- The KP program also conducts annual surveys to measure outcomes using Polling Booth Survey Methods

- This data is used to understand programme outcomes like condom use, PrEP use or prevalence of violence at the population level

- Monitoring data and survey data is used to develop prevention and treatment cascades at subpopulation and county levels to understand programme gaps and develop strategies to address the gaps
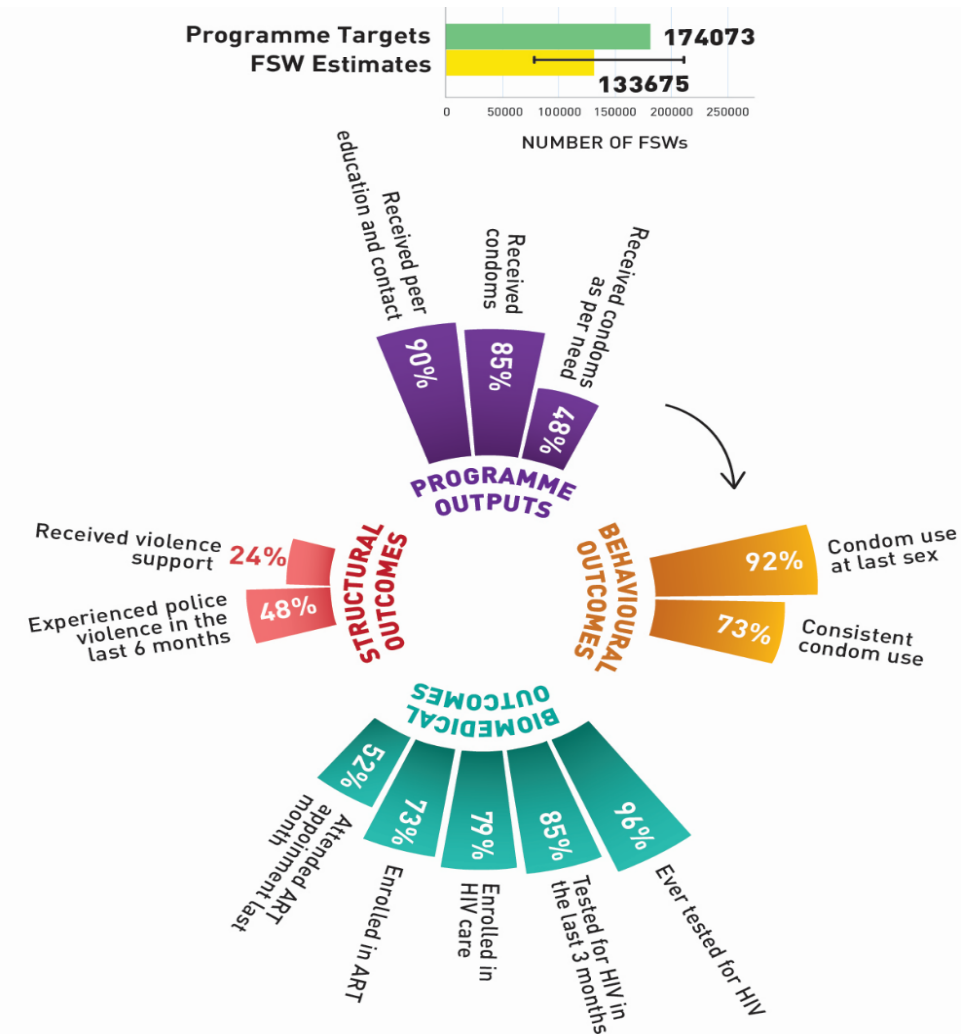
Figure 1:
HIV Prevention Programme Cascade for FSW at National Level

Coordination and Management
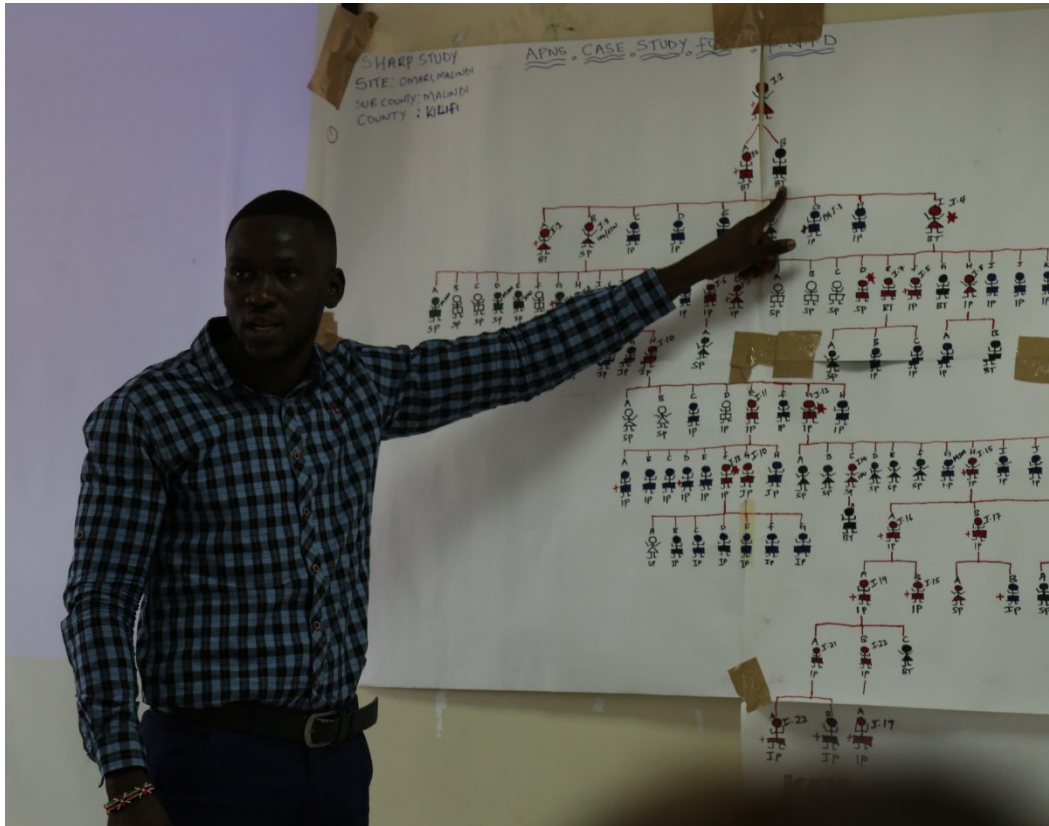
- At the national level, a M&E sub-committee has been formed to coordinate the monitoring and evaluation issues.

- Chaired by NASCOP, member representation is drawn from:

  - o Donor agencies

  - o Members of key populations

  - o Implementing partners

  - o The Sub Committee reports to the national KP TWG

  - o The sub committee supports technical decisions related to reporting tools and guidelines, analysis of data, development of protocols etc.
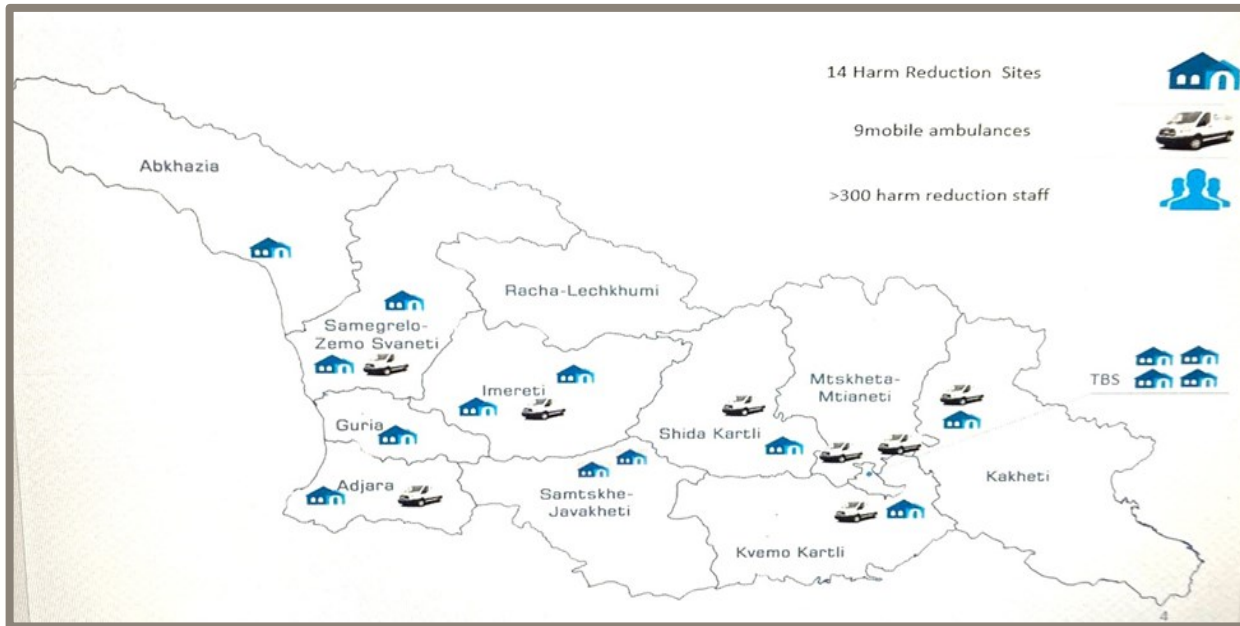
Georgia

- Population 3,7 M
- Estimated number of PWID: 52,500 (=2% of adult population)
- Georgia is located on important route of drug traffic from Afghanistan and Central Asia to Europe

The first BSS was conducted in 2007 in Georgia
The last BSS before BSS Lite was conducted in 2017-2018

International donors' support is decreasing in EECA region
State allocations covers critical diagnostic and treatment services, but not research
Simplified, quality and affordable methodologies have to be developed

Objectives of the BSS-Lite pilot

To test the feasibility of the methodology and protocol

- To measure HIV and HCV prevalence among PWID

- To assess HIV risk behaviour

- To measure access to HIV testing, prevention, and treatment services among PWID

- To generate evidence for advocacy, policy-making and programming

Comparison of IBBS & BSS-Lite methodologies

	BSS-Lite (2021)	Standard IBBS (2022)
	2000	2005
	6 weeks	12 weeks
	The same 7 major cities	The same 7 major cities
	Harm reduction service providers	Non-service providers
	• Consecutive recruitment at NSP sites & mobile outreach • Snowball recruitment (3-5 coupons)	• Respondent driven sampling (3 coupons)
	37 questions (focus on core indicators)	182 questions (+10 questions for network size)
	• Questionnaire on tablet devices + paper • Administered by trusted VCT consultants and outreach workers at office & during mobile outreach	• Paper based questionnaire • Administered by external interviewers
	<20 minutes	> 45 min
	USD 75,000	USD192,300

Study cycle

Short questionnaire – **less time required for the analysis and report writing**

In the regions (6 sites) **regular BSS also using the same HR sites**

Both on HR sites and in Mobile Ambulatories **trained personnel could conduct RDT and collect samples for RNA testing**
As HR sites are the implementing organizations of the State HIV Program they were able to use RDTs procured through the State Program – **cost saving**

HR staff has collected 15 digit unique identifier codes from the participants and they were reported as covered with HIV testing through the state program – **Achieving testing targets and getting additional income for the organization**

Selection of service sites

Data analyses

Training of service site staff

Field work at harm reduction sites and through mobile ambulatories

Development of online database and dashboard

NSP site personnel had **experience of conducting PDI** (peer driven intervention) and it was easy to train them on BSS Lite steps

Enrollment time 5-6 weeks instead of 4 weeks (due to COVID 19 new wave)
On some days there was a large surge of participants, staff had to stay after working hours, but as they were incentivized, they didn't complain

Refusal rate was <5% as **the most of participants knew and trusted the study team**

Study **steps were not much different from the standard** NSP service provision except of the questionnaire, but it was made short

91

Electronic database and online dashboard

Online entry for questionnaire - https://www.veed.io/view/5561c110-fe4e-4676-8f73-688ba8996b0e?aspect-ratio/Landscape&category=Media

Online monitoring - Quality of data entry; Control over the progress of the Study

Recruitment methods for BSS Lite

All Study participants (N=2000)

Service Center, (29%)
Snowball, (47%)
Mobile outreach, (24%)
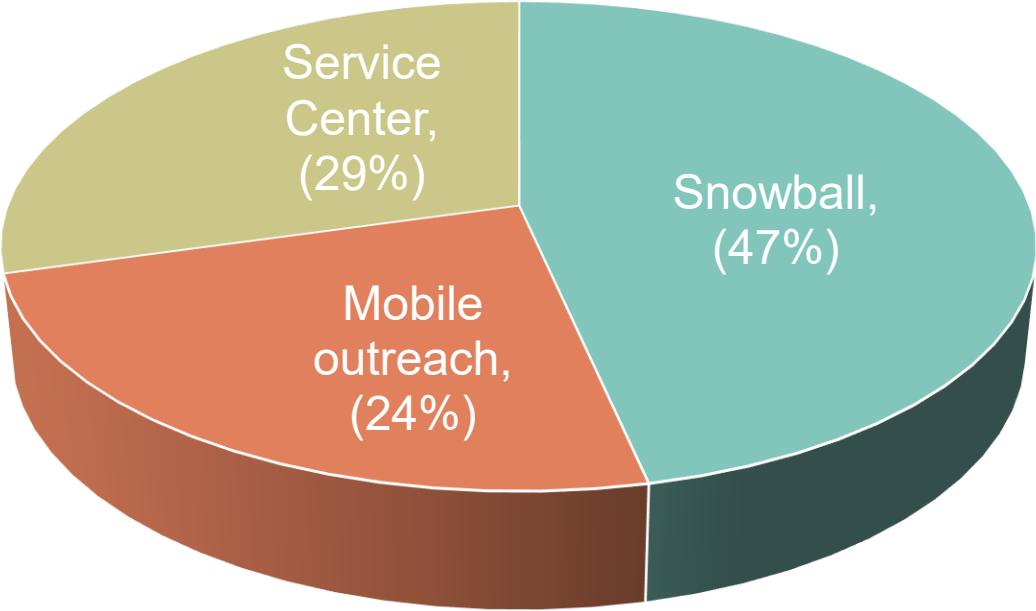
New Clients of NSP
(N=658, 33% of all participants)
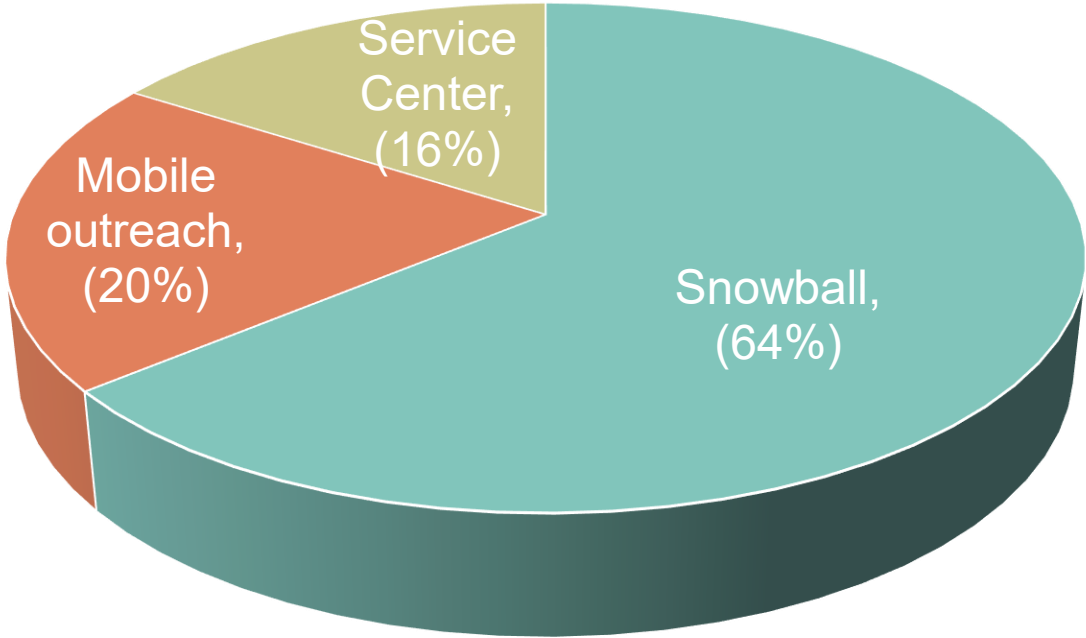
Service Center, (16%)
Mobile outreach, (20%)
Snowball, (64%)

Comparison of BSS-Lite & IBBS (2022) results

	BBS-lite (2021)			IBBS (2022)
	Clients (N=658)	Non-clients (N=1,342)	Total (N=2,000)	Total (N=2005)
Client of harm reduction service*	-	-	67.1%	60.4%
Participated in 2021 BBS-lite	-	-	-	4.0%
Median age	44 years	39 years	43 years	44 years
Female	2.6%	2.6%	2.6%	1.4%
Drug last injected:				
Heroin/Sirets	29.5%	27.9%	28.5%	30.1%
Methadone/Subutex/Suboxone	63.8%	60.6%	62.9%	54.1%
Amphetamine/Methamphetamine	7.3%	5.5%	6.7%	5.6%
Overdose in the last 12 months	7.7%	5.0%	6.8%	10.1%
Used sterile needle-syringe last injection	83.4%	77.7%	81.5%	78.7%**
Condom use during last sex	48.4%	34.5%	39.6%	38.7%

* For BBS-lite defined as those participants who were registered clients of harm reduction service
   For IBBS defined as those who reported having received needles-syringes from NSP in last 12 months
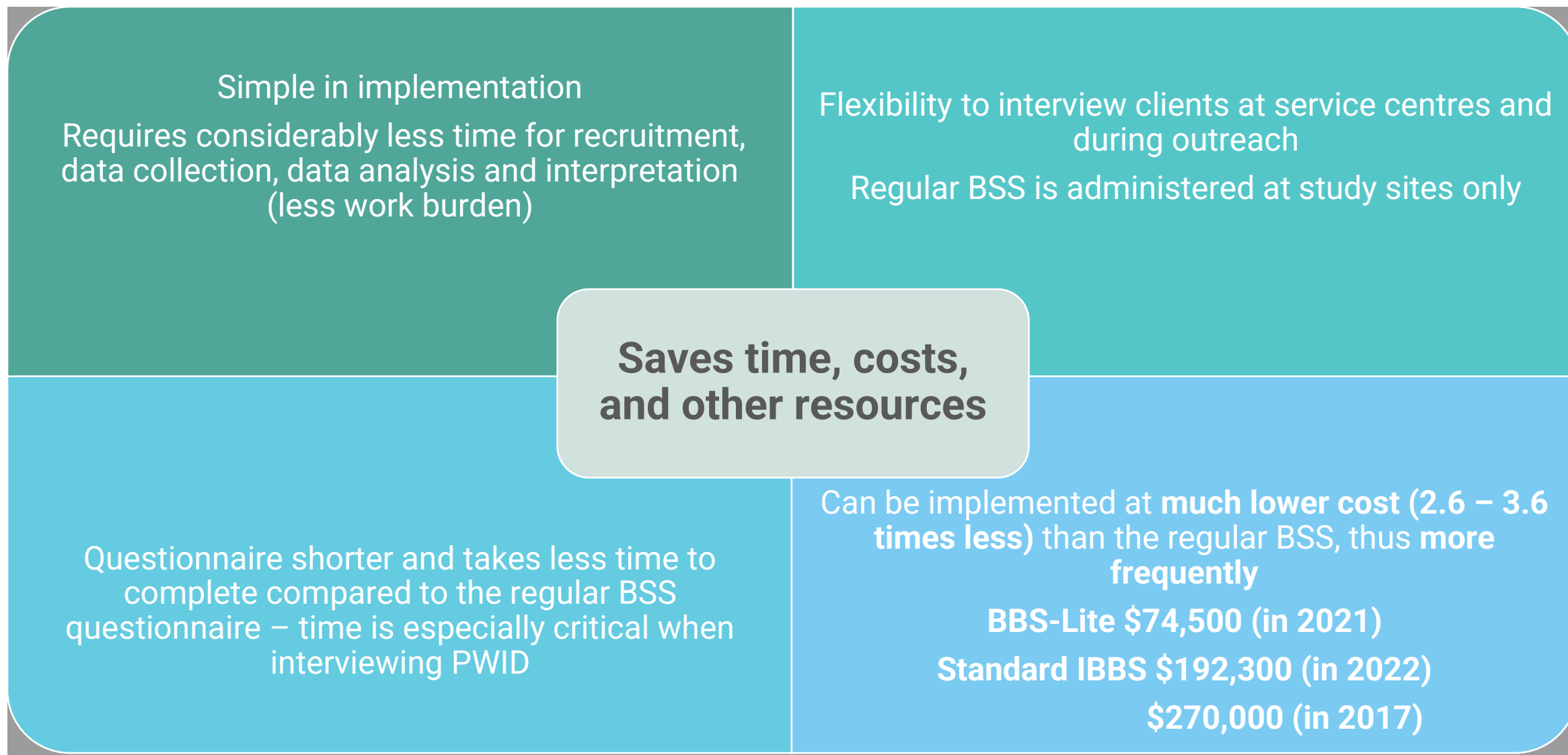** People who never re-used injection equipment

Comparison of BSS-Lite & IBBS (2022) results

	BBS-lite (2021)			IBBS (2022)
	Clients (N=658)	Non-clients (N=1,342)	Total (N=2,000)	Total (N=2005)
Received needles-syringes from NSP in last 3 months	86.7%	3.2%	59%	60.4%
Received OAMT in last 12 months	67.3%	56.5%	64.3%	21.7%
Tested for HIV in the last 12 months	60.9%	36.3%	69.3%	37.5%
HIV positive	1.4%	1.2%	1.4%	0.9%
HIV positive who knew status	100% (19/19)	87.5%*(7/8)	96.2%*	98%
HIV positive on ART	100% (19/19)	75%* (6/8)	92.5%*	Not available
Anti-HCV positive	63.8%	41.6%	56.5%	58.1%
HCV RNA positive	14.7%	14.7%	14.7%	24.1%

*   One individual Refused to answer

Lessons learned from BSS-Lite pilot (1)

Simple in implementation
Requires considerably less time for recruitment, data collection, data analysis and interpretation (less work burden)

Flexibility to interview clients at service centres and during outreach
Regular BSS is administered at study sites only

Saves time, costs, and other resources

Questionnaire shorter and takes less time to complete compared to the regular BSS questionnaire – time is especially critical when interviewing PWID

Can be implemented at **much lower cost (2.6 − 3.6 times less)** than the regular BSS, thus **more frequently**
BBS-Lite $74,500 (in 2021)
Standard IBBS $192,300 (in 2022)
$270,000 (in 2017)

Lessons learned from BSS-Lite pilot (2)

Allows for frequent tracking of PWID for risk behaviour, access and utilization of the harm reduction, testing and treatment services **(uses the same indicators as regular BSS for comparison)**

Methodology was able to produce data that were useful for programming and decision making

Smart methodology gives other possibilities

Participants felt comfortable with the harm reduction service staff interviewing them and happy with short questionnaire

Outreach and snowball allowed recruitment of new, hidden or lost to follow up PWID, who otherwise would not come to harm reduction programs

As samples are collected, they **can be tested on other infections**, we tested for Covid-19, self-reported vaccination coverage was 46%

Depending on the Testing outcomes participants were linked to HR services, confirmation testing, treatment and care

Screening on:
- HIV
- HCV
- HBV
- Syphilis
- TB
- COVID-19

Risk Counselling,

Provision of injecting paraphernalia

PoC Diagnostics

Medical Consultation

Consultation of Psychologist

Linkage to HIV and HBV (80 cases of chronic HBV was identified) Care and to OAT programme

Specialized clinics

Low Threshold program

HCV RNA diagnostic and treatment at HR sites

214 (73% of all RNA positives) PWID with active HCV were linked to care

Use of BSS-Lite Results for Program/service planning

Information was generated on types of drugs injected and injection frequency	• Helps to tailor harm reduction counseling to the needs of the community • To improve planning of centralized procurement of injecting equipment
★ Prevalent unprotected sex (>60%) among PWID ★ 17.3% reported re-using own syringes	• relevant updates were introduced in the risk reduction counselling instruction for outreach workers to improve safe sex counselling/promote condom use and reduce re-use of own syringes
65.4% of PWID reported using naloxone distributed by the program to prevent overdose related death	• Important evidence is provided in support of distribution of naloxone through the Needle and Syringe Program
≈ 60% PWID uses both, NSP&OAMT services	• Discussion was initiated to integrate NSP in OAMT or place new vending machines for distribution of injecting equipment near to OAMT clinics
>80% of PWID reported getting clean syringes from pharmacies	• Place more vending machines at pharmacies, or come up with a new effective intervention that can be integrated in pharmacy chains

Trust and data ownership

Community Trust
- Trust is especially important for PWID community we can assume that PWID's responses were more honest to the questions asked by the NSP staff

Trusting the results
- Communities have greater trust in the results of studies conducted by the community organizations

Data Ownership
- Communities learning how to use research data to modify services, to use research as catalytic tool, think of potential future research questions

You can reach us at:

stviliak@gmail.com
e.ruadze@ncdc.ge
and marine_gogia@yahoo.com

THANK YOU!

CONTENT

Drug Harm Reduction
Advocacy Network(DHRAN)

BACKGROUND

- Funded by the Global Fund (GF) through the Community Rights and Gender Strategic Initiative (CRG SI)

- Led by the Drug User Network (DHRAN)

- Used to Monitor the GF-funded Needle and Syringe program (NSP) in the 3 Pilot States

- Monitoring targeted at Community and Facility Level
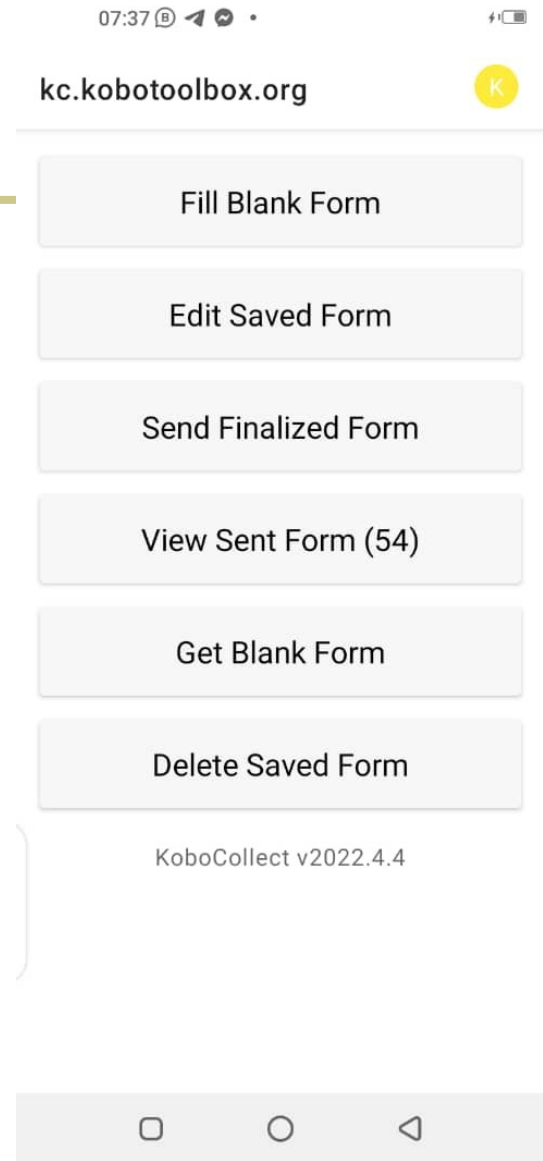
- Indicators developed by Community Members

PURPOSE

- Monitor quality of NSP service provision.

- Monitor access of community members (People who Inject Drugs) to the services

- Monitor acceptability of the NSP service

- Monitor compliance with NSP implementation standard

- Monitor stock-outs of commodities

- Serves to understand community needs

DEVELOPING CLM FRAMEWORK

- Meeting with Drug User community leaders to define Indicators

- Contracting of Consultant to develop CLM Framework and refining Indicators

- Review of Framework/Indicators by Community leaders

- Coding on online data collection platforms

- Training of data collectors

- Piloting of CLM/Review/Implementation of CLM

07:37

kc.kobotoolbox.org

Fill Blank Form

Edit Saved Form

Send Finalized Form

View Sent Form (54)

Get Blank Form

Delete Saved Form

KoboCollect v2022.4.4

IMPLEMENTATION LEVELS

1. Facility Level

    a. Data Collected: Quantitative data

    b. Mode of collection: Interview

2. Community Level

    a. Data Collected:

        i. Quantitative data

        ii. Qualitative Data

    b. Mode of Collection:

        i. Interview

        ii. 5 Focal Group discussions (10 persons/FGD)

ADVOCACY USING CLM DATA

Advocacy and dissemination of CLM reports exists at:

1. Technical Working Groups periodic meetings
2. Coordination Meetings
3. Global fund country implementing partners structure (PR & SR)
4. Visitation to relevant institution

CHALLENGES

1. Resistance by facilities to CLM
2. Limited understanding of Indicators for development of questionnaire.
3. Limited knowledge of data analysis among community-led organizations
4. Limited funding for community-led data collection
5. Perceived conflict of interest from community-led organizations leading community-led Monitoring.
6. Disagreement of stakeholders on report of CLM
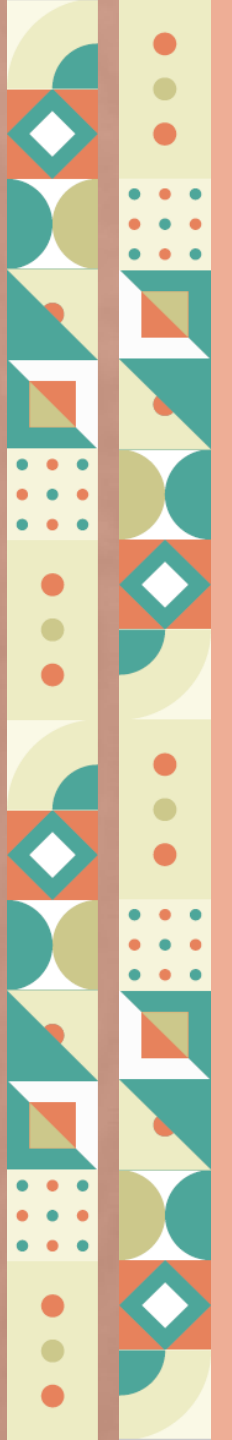
IMPROVING CLM

1. Improvement of capacity of Key Populations on CLM

2. Institution of CLM as an integral part of program implementation for KPs.

3. Establishment of advocacy platforms for real time resolution of issues raised/noticed during CLM

4. Improved funding for data collection for CLM

5. Advocacy with facilities for acceptance of CLM

THANK YOU

REFLECTIONS

Mentimeter

CLOSURE

Clemens Benedikt