Key Populations Priorities

Supporting Key Populations/Priority Populations with Prevention & Treatment Services"

Where are we now and what is working well

Where are we now?

- We note progress as well as challenges and opportunities for improvement of KP/PP services

What is working well?

- Community engagement of KPs is yielding results. It's going quite well in some areas of Uganda e.g., Central, Rwenzori, West Nile
- KP organizations doing well in mobilizing fellow KPs to access HIV services
- Community Scorecard -- continue to use it's valuable to capture issues raised re: service delivery
- Policy is an area of progress we now have SOPs for KP and other guidelines for service delivery to KP/PP as well as training curricula in different stages of development
- In access to services we have several modalities:
  - DICE
  - outreaches happening
  - KPIF serving KP organization
  - KP sitting on advocacy committees at high level as well as at local levels
  - KP organizations to implement KP community interventions

Major Challenges and Ideas for Solutions from Work Group:

Inmates and TGs

- **Prisoners have big challenges with ART retention:** Prisoner transfers between prisons is streamlined, but on release, prisoner transfer to health services on re-entering the community is a problem, related to prisoners not disclosing the community they intend to go to on release .
- **Suggested solution for prisoners:** Sensitize prisoners on importance of continuity of their medication and when they don't confirm the community where they intend to go post release can have an effective referral to HF on release. Idea - have the prisoners avail the Prison medical services for picking their ART meds, as prisons serve community in their catchment areas
- Prison information system is "not there" **A solution might be**: SMS/text could provide linkage between Prisons and the community level health system when prisoners are released. A centralized system
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- **Lack of understanding about transgender orientation has an effect on quality of ART care & clinical monitoring:** For example, trans women don't get the right care and treatment…..need to train health workers in providing C&Tx to transgender women

ART initiation and Follow Up

Need to address Issues of follow up and ART retention - Suggested solutions:

- Do Root Cause Analyses, conduct focus groups to identify underlying factors
- Strengthen health provider training
- Provide facilitation to outreach workers to improve service provision and outcomes
- Encourage health facilities to hold flexible working hours (such as "after work" hours)
- Strengthen the DICEs, including DICE support groups
- SMS/text reminders
- Stronger side effect counseling
- Peer support and home visits
- With Unique Identifiers any KP referral would be easier to track, even Prisoners

Solutions proposed for Viral Load Suppression issues in KPs

- Need to better understand causal factors…especially for the mobile KPs
- U=U messaging to promote how one's health is reliant on another's -- a unifying message is: "adherence is protective to us all"
- Quality committees/panels of users to provide feedback on the services
- Why did only 7% pick their ARVs when DSDM was offered?
- PLHIV KPs fear to be seen in their groups to be taking ARVs.

Solution:

- Clear messaging and continuous counseling, either from a health provider or a confidant/mentor.
- Provide trainings to newly enrolled clients on ART to empower the individual to manage his/her own treatment procedure.

Discontinuation/Disengagement on PrEP Possible solution

Discontinuation/Disengagement on PrEP -- Possible solutions:

- Less information available for keeping clients on PrEP (as compared to ART).
- Increase treatment literacy by making info available to KPs and forming a network for sharing PrEP info/knowledge amongst KPs-
- PrEP packaging currently identical to ARVs - solution: change packaging
- Mass communications re: PrEP have not been clear or always understandable to potential users Solution: improve messaging
- Do Root Cause Analysis to pinpoint why beneficiaries sometime disengage from PrEP
- Need better approaches for follow up and engaging w/PrEP clients

Case finding - Suggested solutions to address causal factors:

- Integrate Enhanced Peer Outreach Approach(EPOA) to increase positivity yield
- To increase the number of peer navigators/peer facilitators to identify more cases and KP with unmet need -- provide better remuneration & recruit
- **Recent refinement of Population Size Estimates can help us to find new cases:** capacity of CSOs has not been strong in KP/PP populations in size estimation, or in mapping and surveillance to improve data. **Solution:** Recent week modeling/PSE estimates can refine the way forward .
- **ICT:** how does it come in for messaging to find KPs/PPs? 1st do we have clear and understandable messages for KPs? We need to agree what messages work and share them online or in other communications channels, teach peers and KP mentors on how to deliver the messages
- Intergrade KPSE size estimates and the USAID programmatic hot spots mapping and size estimates to reach new unidentified KPs.

- **HIV Testing Yield for KP is lower** -- in some instances -- than for Ugandan general population, need to identify causal factors for this
- Most SW organizations deal with adult sex workers, not children SWs--how can we link these younger SW to DREAMS or OVC projects as a way to rehabilitate them?
- HIV Prevention and case finding in **Children of KPs** is a very serious **concern, as is children in sex work. Suggestion:** Find ways to include them in DREAMS program or OVC programs
- **PWID:** lacking NSP sometimes have to share needles - solution ask GFATM to provide needles & syringes [NB. The GFATM is already procuring for NSP programs in many PEPFAR countries]
- **PWUD:** Lots of attention given on injecting, should we expand programming to PWUD (non-injecting)?

To address legal issues, violations of human rights that affect KP case finding, strike a balance between structural solutions and health interventions in 2020. Suggested interventions:

- Combine Health advocacy with promoting respect, legal & human rights
- Direct legal aid service provision for those experiencing a violation
- Have reporting mechanisms for KPs/peers to report on, and a means of follow up
- Provide training to police, drug enforcement authorities as well as the KPs themselves in understanding their rights and identifying and reporting human rights violations
- In cases of arbitrary arrest/detention of persons on ART, assist with getting access to medications when arrested/detained. Police don't have ARVs on hand. Solution: stock police stations with ARTs /Train paralegals to provide basic information and to support KPs in detention.
- Need programming that would streamline those interventions

Continue to have community dialogues with leaders and religious leaders. For example, last year's Symposium for KPs planned in Uganda was stopped need high level advocacy and intervention whereby such spaces to speak on issues affecting KP

Apart from Gender Diversity trainings what other interventions to we need to address the Stigma Index findings? Suggested solutions:

1

Reduce Stigma & Discrimination within the community as well as with providers and leaders by improving enabling environment, so that duty bearers, stakeholders and KPs informed and empowered re: their rights

2

Support trans-gender networks and operations so that they can effectively work on their own issues

3

Integrate mental health and socioeconomic empowerment into health service delivery

4

Encourage media to not stigmatize KPs - sensitize journalists/media and raise their awareness of stigmatizing reporting

STIs and Lubrication procurements

Who will pay for STI treatment is still a big question unanswered. The STI treatment drugs currently used are not registered (Cipla?) MoH does not have enough STI meds,

Integrate HIV services with FP services and STI tx especially for FSW,

Provide Treatment for STIs as incentive to retain patients/client on treatment and PrEP.

Issues with Lubricants identified: Lubricants are being imported to Uganda by PEPFAR and (GFATM also would support?). Problem with color changing once sachet is open…Solution could be education/messaging/fliers on how to use the commodity..Supply chain can assist with the right quantities and size of containers (eg sachet vs. bottle).

Enhancing DICEs

- DICs serve populations that vary widely, for example, variations in age and KP/PP group
- Currently we lack standards & Guidelines for DICs Solution: create these
- A possible role expansion of DICE?
- The **issue identified** is that most KP community groups are informal - need organizational/operational structures/safe spaces that would enable them to address issues, discuss as a community and work in an office or safe space for consultations beyond health.

Possible Solution:

- Consult the CSOs as they understand the different needs of different KP groups
- Have a space beyond the role of DIC-- possibly a chance to implement their own funds. Hoimas in Kenya has both a DICe that also has that function as an Office & point of health service/medication delivery. Have DICes become more effective/efficient and have them serve multiple purposes and services for the populations they are serving. Facilitate DICs to perform that work.