"Enhancing KP Intervention: Taking Stock and Moving Forward"

2nd Key Population Regional Meeting

27 – 29 October 2015, Lomé, Togo

REPORT

Table of contents

List of acronyms

AFAZ	Association des Femmes Amazones
AGALES	Human Rights Association created by the late Joel Nana
AIDS	Acquired Immune Deficiency Syndrome
ALCO	Abidjan-Lagos Corridor Organization
AMSHER	African Men for Sexual Health and Rights
ANCS	Alliance Nationale de lutte contre le Sida
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBAC	Community-Based ART Clinics
CBO	Community-Based Officer
CI	Côte d'Ivoire
CNLS-IST	National Commission to fight AIDS and STI
COP	Chief of Party
DBS	Dried blood spots
DCM	Deputy Chief of Mission of the U.S. Embassy
DIC	Drop-in-Center
E4D	Evidence for Development
ECOWAS	Economic Community of West African States
EMTCT	Elimination of Mother-to-child Transmission of HIV
FAMME (NGO)	Forces in Action for the Well-Being of Mother and Child
FHI 360	Family Health International
FSW	Female Sex Worker
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTC	HIV Testing and Counseling
IBTCI	International Business and Technical Consultants Incorporated
JAIDS	Journal of AIDS
KP	Key Population
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MARPs	Most-at-Risk Populations
mHealth4KP	Mobile Health for Key Populations
MoH	Ministry of Health
MSM	Men Who Have Sex with Men
MSMIT	MSM Implementation Toolkit
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
PACTE-VIH	HIV/AIDS prevention and care project in West Africa
PE	Peer Educator
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-child Transmission of HIV
PrEP	Pre-Exposure Prophylaxis
PSI	Population Service International
PWID	People who inject drugs
RST	Regional Support Team
SHiPS	Strengthening HIV Prevention Services
SMS	Short Message Service
SNT	Social Network Testing
SPO	Senior Program Officer

STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities, Threats
TB	Tuberculosis
TWG	Technical Working Group
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
USA or US	United States of America
USAID	United States Agency for International Development
VAD	Home-based visit
VAH	Facility-based visit
VL	Viral Load
WA	West Africa
WAHO	West African Health Organization
WB	World Bank
WCA	West and Central Africa
WHO	World Health Organization

INTRODUCTION

In West and Central Africa, the prevalence of HIV among the general population remains low, with 12 of 24 countries reporting a national HIV prevalence of less than 2 percent. However, the prevalence among key populations (KP) in the region is between 3 and 30 times higher than the general population. Ending the HIV epidemic in West and Central Africa requires that programs and policies take an innovative and targeted approach that emphasizes access to services for those populations, and that best programmatic practices are shared, replicated and scaled.

There is therefore the need to establish a strong coalition and appropriate strategies to confront programmatic challenges necessary to advance the HIV response in West and Central Africa. Collaboration and cooperation must be promoted on issues requiring collective actions to advance the fight against HIV in West and Central Africa. The workshop was therefore in response to key recommendations from the May 2014 regional KP meeting that called for the establishment of annual technical forums on KP in the region to share experiences and learn from others.

Meeting objectives

To discuss with key regional and country stakeholders the latest experiences in KP programming and research, identify promising practices, regional strategies or innovative steps to advance HIV prevention, treatment and control in the West and Central Africa region.

Specifically, the meeting sought to achieve the following:

- Experience-sharing: Bring together experts in KP programming to share experiences.
- Participatory exchange: Allow for a participatory and constructive exchange and interaction between stakeholders and participants from within and outside West and Central Africa.
- Lessons learnt: Draw lessons from successes and challenges from the various projects presented.
- Networking: Create a network for the various participating actors/stakeholders to allow for future collaborations.
- Best practices: Disseminate best practices among countries regarding KP programming.

Attendance

The meeting was attended by 138 delegates from 16 countries including: South Africa, Benin, Burkina Faso, Cameroon, Cote d'Ivoire, USA, Gambia (The), Ghana, Guinea, Guinea- Bissau, Mali, Niger, Nigeria, Senegal, Switzerland and Togo.

Also present were representatives from government and civil society groups from countries in the West and Central Africa region, regional institutions such as the West Africa Health Organization, Abidjan-Lagos Corridor Organization, donors and development partners including UNAIDS, The Global Fund, the World bank Group and vulnerable population organizations

The list of participants is attached to this report as Annex 3.

OPENING CEREMONY

The high table: L to R: Dr. Virginie Ettiegne-Traore (PACTE-VIH), Dr. Carlos Brito (OOAS), Ms Dana Banks (US Embassy), Prof Gado Napo-Koura (MOH), Prof Vincent Pitche (SP/CNLS), Dr. Leopold Zekeng (UNAIDS) & Dr Sylvain Parent (Global Fund)

The Secretary General of the Ministry of Health and Social Welfare of Togo, Professor Gado Napo-Koura and the Deputy Chief of Mission (DCM) of the U.S. Embassy, Togo, Mrs Dana Banks officiated at the opening ceremony of the 2nd Key Populations Regional Meeting.

Other officials present included Prof Vincent Palokinam Pitche, the National Coordinator of Togo AIDS Commission (CNLS-IST), Dr. Leopold Zekeng, the Deputy Director of the UNAIDS Regional Support Team for West and Central Africa, Dr. Carlos Brito, the Director of the Department for Disease & Epidemic Control at the West African Health Organization (WAHO) and Dr. Virginie Ettiegne-Traore, the Chief of Party (COP) of the HIV/AIDS prevention and care project in West Africa (PACTE-VIH).

Welcome remarks by Prof Vincent Palokinam Pitche, the National Coordinator of Togo AIDS Commission (CNLS-IST):

Three major points marked his presentation:

- He began by calling on all present to observe a minute of silence in memory of activist Joel Nana.
- He then welcomed all participants and thanked the American Government, colleagues from the AIDS Commission of countries represented, and the PACTE-VIH team for their active participation.
- He ended with a brief reminder of the objectives of the Dakar declaration and emphasized the need to draw inspiration from practices that have worked elsewhere.

Speech Dr. Leopold Zekeng, the Deputy Director, UNAIDS Regional Support Team for West and Central Africa:

Ensuing points highlighted the need to work together to wipe out AIDS by 2030. To achieve this, Dr. Zekeng prescribed the following four factors:

- Political will on the part of Presidents so that KP actions can be enshrined in strategic policies;
- Domestic funding for the implementation of these programs
- Collaboration to ensure information exchange
- An enabling social and political environment to end stigma against KP.

"We must work together to bring an end to AIDS by 2030." - Dr. Leopold Zekeng

Speech by Dr. Carlos Brito, the Director of the Department for Disease & Epidemic Control at WAHO:

Dr. Brito lauded progress made in the fight against AIDS from 2009 to 2015. This progress is noticeable in the reduction of the infection rate and increase in service coverage for prevention and treatment among the general population thanks to the joint efforts of the government and

civil society stakeholders. However, to deal with persistent difficulties, he made the following recommendations:

- Direct efforts towards key populations among whom HIV prevalence rate is five times high otherwise there is a risk that effort made toward the general population will decline;
- Discuss KP program implementation and identify promising practices that would facilitate KP access to services in order to support the commitment of authorities to fight against HIV among KPs;
- The speaker concluded his presentation by reiterating ECOWAS readiness to take the workshop recommendations into consideration.

"ECOWAS will take into consideration the recommendations from this workshop." - Dr. Carlos Brito

Speech by Mrs. Dana Banks, DCM of the U.S. Embassy, Togo:

- She thanked the Government of Togo for accepting to host this workshop and actively participating in its opening ceremony. She then summarized the efforts made by the American Government to fight against HIV, especially among KPs. She concluded with the declaration that the American Government has resolved to continue supporting the fight against AIDS until the objective of an AIDS-free generation by 2030 is attained.

"The U.S. government will continue to support the fight against AIDS until the objective of AIDS-free generation by 2030 is attained." - Mrs. Dana Banks

Official opening of the workshop, by Professor Gado Napo-Koura, the Secretary General of the Ministry of Health and Social Welfare of Togo:

The Secretary General declared that:

- KPs are part of the priorities in Togo; reason why the country shall, here and now, sign the Dakar declaration in order to help all stakeholders improve their interventions. – *Togo publicly signed its commitment at the opening of this meeting, in the presence of the American Government, UNAIDS, and all participants to this workshop.*
- The Togolese Secretary General at the Ministry of Health and Social Welfare then declared open the second Key Populations Meeting under the theme: ***"Enhancing KP Intervention: Taking Stock and Moving Forward."***

After the official opening of the workshop, Togo proceeded with the signing of the Dakar declaration.

Prof Vincent Pitche (SP/CNLS) showing the signed Dakar Declaration

MEETING PROCEEDINGS

The meeting was organized in five (5) sessions during which presentations were made in plenary.

DAY 1:

SESSION 1: CURRENT SITUATION KEY POPULATION

Dynamics of HIV among Key Populations in West and Central Africa: Epidemiology, programs and policy – by Dr Leopold Zekeng

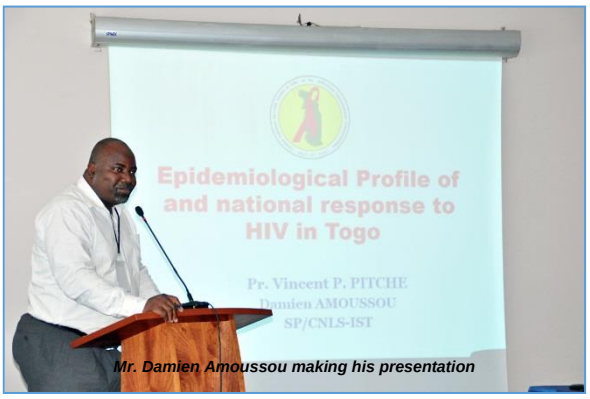
This presentation revealed the current situation of HIV prevalence in West and Central Africa. According to 2014 data, HIV prevalence among the general population was 2.3%. Meanwhile, it stood at 16.5% among female sex workers (FSW), 17% among men who have sex with men (MSM), and 6.7% among people who inject drugs (PWID). It is, therefore, evident that the prevalence rate among key populations is markedly higher than among the general population. Moreover, the use of condoms among key populations is still an issue. 2014 data show that in the last 12 months, 77.2% of FSW used condoms as opposed to 56.2% among MSM, and 43.3% among PWID. The situation is worsened by a low HIV testing rate among these key populations whose data varies between 69.7% (FSW), 45.2% (MSM), and 22% (PWID).

Strengthening the evidence base and KP monitoring systems and promoting the generation of strategic information to improve KP programming and inform key stakeholders and decision makers.

Nigeria, Cameroon, the Democratic Republic of Congo, Chad, and Cote d'Ivoire represent close to 80% of the disease burden as they all, put together, host the greatest number of PLHIV and new infections. One of the lessons learned during this presentation is the nature in which the disease is diversified given that the sub-region and countries host more than just one epidemic. Moreover, HIV is the first cause of mortality among the youths from 15 to 24 years. As for key populations, available data show a higher rate than among the general population. In an effort to obtain updated data, UNAIDS sponsored a study to determine the prevalence rate in 24 countries. In spite of the political and judicial environment that criminalizes prostitution and homosexuality in most West and Central African States, some major programs targeting key populations were implemented in most of the countries of the region. However, to eradicate the HIV epidemic by 2030, UNAIDS made the following recommendations:

- The "Fast-Track" Strategy which focuses on the innovative objective; go faster, track down, and find pockets of infected persons and place them under rapid treatment;
- To implement the Fast-Track Strategy, it will be necessary to set up a "Strategic Regional Group" which will rely on the following seven pillars: access to services, human rights, strategic information, relations/governance, funding, information sharing, and knowledge management;
- It was equally suggested to update KP data to replace that of 2005.

Togo epidemiology and response to the Epidemic – by Prof Vincent Pitche and Mr. Damien Amoussou, Deputy National Coordinator of CNLS-IST



Mr. Damien Amoussou making his presentation

This presentation outlined the epidemiological situation of Togo with a 2.5% prevalence rate among the general population. This prevalence rate varies in the urban area (3.5%) as opposed to 1.6% in the rural area. It has also been observed that the epidemic more prevalent among females (3.1%) than males (1.6%). Regarding key populations, the prevalence rate stood at 13.1% among SW and 20.4% among before the implementation of the 2012-2015National Strategic Plan (NSP). Similarly, a study conducted in 2011 by the National AIDS Control Program (NACP) shows a 5.5% prevalence rate among injectable drug users. In response to the epidemic, the country intensified and extended interventions targeting vulnerable groups by undertaking to prevent mother to child transmission (PMTCT) through a wider treatment using antiretroviral (ARV).

Meantime, several normative documents were developed and projects and programs implemented with the involvement of target groups. The national response was designed following an agreement on activities notably; a definition of the service package to be offered, the continuum of care strategy, advocacy for an enabling environment, setting up a national observatory to handle discrimination against and criminalization of PLHIV and KPs. Thanks to these efforts, the prevalence rate among FSW dropped from 20% in 2005 to 11.70% in 2015. Among MSM, it dropped to 13% in 2015, against 26% in 2007. Lessons learned from Togo include: the development of consensual strategic documents through the contribution of KP resource persons, and the consensual definition of the service package for KPs.

Nonetheless, based on available data, the following strong recommendations were made:

- Take a moment to reflect, pool information, define a source from which data can be documented; given that data on KP is usually patchy and therefore cannot be disaggregated according to sexual orientation;
- Hence, Prof. Pitche's appeal for UNAIDS to urgently update available information.

SESSION 2: STATUS OF RECOMMENDATIONS FROM LAST MEETING

WAHO engagement: Dakar Declaration and KP regional TWG – by Carlos Brito

Dr. Carlos Brito explaining WAHO engagement

This presentation revealed that the HIV prevalence in ECOWAS member states is very heterogeneous. It is less than 1% in Niger, Cape Verde, Senegal, Mali, and Liberia; between 1 and 3% in Burkina Faso, Ghana, Guinea, Sierra Leone, Togo, and Benin; and in Cote d'Ivoire, Guinea Bissau, and Nigeria, prevalence rate is above 3%. This situation portrays the heterogeneous inter and intra-country nature of the epidemic. It is, therefore, necessary to act in line with these parameters.

However, it was also revealed that significant progress has been recorded in the fight against the epidemic such as a reduction in the regional infection rate from 2.0% to 1.6% among youths

between 15-49 years, a 15% reduction in the number of new infections; an increase in the coverage of anti-retroviral treatment (ART) services which increased from 50 to 79%. The fight against HIV witnessed major strides among the general population but such was not the case among KPs. Within the ECOWAS region, the prevalence among KP is as follows: between 5.6 to 39% for FSW; 6 to 37% among MSM and 3.5 to 9% among PWID. Meanwhile, regarding the fight against the epidemic among KPs, the social, political, and legal environment in most of these countries do not ease KP access to prevention and care, although that is a prerequisite if HIV has to be contained within the region. This makes reducing the HIV epidemic among KPs a challenge, if the best indicator must be the reduction in the prevalence rate among KPs in the region, given the unfavorable political, social, and legal context. It is within this backdrop that a regional consultation on HIV and KP was held in Dakar in 2015, and brought together all senior government officials of the countries of the region.

A regional thematic working group was, therefore, constituted to provide technical support to national and regional initiatives as part of the specific KP HIV response. A text was signed by senior government officials of the countries, a clear sign of their commitment to fight against HIV among KPs. The following recommendations were made by the thematic working group to States of the Region:

- Invest in programs targeting stigma reduction;
- Increase community service offers for KPs;
- Integrate KP specific needs into efforts geared towards strengthening the health system;
- Increase access to strategic information.

To this end, there is the need to combine public health interest with public interest defense, notably by improving dialogue with public interest advocacy agents.

It is in this light that the West African Health Organization (WAHO) in its 2016 workplan took the commitment to provide technical and financial support to countries for the implementation of interventions to improve the understanding of the courts (prosecuting attorneys, public prosecutors and state prosecutors) and the Ministry of Interior (Police) on the stakes in the fight against HIV among KPs.

Therefore, one of the major activities conducted within ECOWAS was the Forum on best practices in HIV and the KP aimed at disseminating promising practices, regional strategies, and innovative approaches that encourage HIV prevention, care and control in ECOWAS countries.

At the end of this presentation, discussions revealed that given the task ahead, this working platform may not be enough because there is real need to coordinate and stimulate this platform daily. Thus, it was highly recommended that a working group with a program officer, scientists, and technical partners be set up especially in Central Africa, as WAHO is not enough.

However, one of the lessons learned from this discussion was the prospect to adopt a public health code under the auspices of WAHO. It should be noted that WAHO expressed the interest to do so on condition that it was going to begin by holding structured discussions with states, notably with their Justice and Interior Ministries.

"WAHO has planned in its 2016 workplan, to provide technical and financial support to countries for the implementation of interventions to improve the understanding of the courts (prosecuting attorneys, public prosecutors and state prosecutors) and the Ministry of Interior (Police) on the stakes of the fight against HIV among KPs."

FSW implementation science TA package (Cameroon, Togo, Burkina Faso) – by Elisabeth Mziray

Mrs Elizabeth Mziray making her presentation

This presentation highlighted the investment strategies of donors (World Bank, UNAIDS and USAID) in the countries for the fight against the epidemic among KPs. The strategy is founded on a leitmotiv, considered as the basis for a successful intervention which is: *"the right interventions for the right people in the right place at the right time, delivered in a sustainable way with high demand and consistent use"*.

This sentence summarizes the strategy guiding the investment choices of donors. Thus, concretely, efforts will target populations that benefit from these programs notably the development of a mapping that prioritizes intervention sites by selecting and recruiting civil society organizations, identifying hotspots, recruiting community intervention agents (peer educators, mobilizing agents, etc.), developing micro plans at the local level for the provision of communication services and condom distribution. Interventions would comprise behavioral, biomedical, and structural aspects.

Thus, the World Bank, USAID and UNAIDS entered into a partnership to support programs to upgrade interventions among sex workers (SW). The goal of this partnership is to provide technical support to improve the scale, efficiency, roll-out, targeting, coverage, quality and measurement of the impact of HIV services for SWs

Key elements shall consist in undertaking assessments to select countries in which gaps and opportunities have been identified, integrating by informing through rapid assessments, develop regional training groups that involve KPs and promoting experience and knowledge sharing through South-South collaboration. It is evident from ongoing programs in countries selected that implementation is done at varied levels and quality; the typology of "sex worker" is equally ever changing; there are lapses in strategic information; there is no minimum prevention and intervention package for KPs and even when there is one, it is obsolete; there is an important need to harmonize indicators and standardize routine tools; coordinating national interventions among key populations is still a major challenge and there are shortcomings in the effective implementation of programs.

However, the World Bank, UNAIDS and USAID partnership is currently supporting programs in several countries in West and Central Africa notably in Cameroon, Cote d'Ivoire, Senegal, Niger, Togo, and Gabon as well as regional training in West and Central Africa.

Regarding the mobilization of domestic resources, the Indian example is a lesson for countries to follow. In 2003, India had a 90% dependence on external funding, but by 2013, the country had succeeded to stem the tides by mobilizing 90% domestic funding for HIV control programs.

During discussions, some concerns were express as to the ongoing mapping in Cameroon. It was observed that this mapping targets more of hotspots than key populations, thus reducing the chances to better identify this target group which is particularly mobile. As for the choice of sites, a documented selection was done with countries and this helped identify priority sites.

Furthermore, we learned from this presentation that the Global Fund is not part of the USAID, World Bank and UNAIDS partnership; meanwhile, the Global Fund identified 20 countries in which it will like to invest, among which 11 are situated in this region. Every year, the Global Fund invests and loses about 30% of resources due to the absence of themes such as those

presented by the World Bank, UNAIDS and USAID partnership. In an effort to maximize the rational use of the funds it invests, the Global Fund made the proposal to join the World Bank, USAID, and UNAIDS partnership.

"The World Bank, USAID, UNAIDS entered into a partnership to support targeted Sex Workers (SW) programs. The purpose of this partnership is to provide technical support to improve the scale-up, efficiency, roll-out, targeting, coverage, quality and measurement of the impact of HIV services for SWs."

Learning and sharing experience platform (JAIDS, South to South exchange) by Laurent Kapesa


Dr. Laurent Kapesa explaining a point during his presentation

This presentation eased the understanding of the concept of sharing knowledge and benefits of this practice. It is based on the USAID vision which is a center for learning and mobilization of partners to improve the health status of vulnerable populations in West Africa through sustainable and evidence-based solutions. Knowledge sharing it was said is two-dimensional and helps to: (1) identify transferable changes and results, (2) deeply understand challenges and experiences shared, (3) improve cooperation in order to influence policies and direct relations between stakeholders, projects, organizations, countries, and regions. With regards to attaining the 90-90-90 objective, a special journal on HIV in West and Central Africa (JAIDS) was published, study trips to SHARE project India organized, and a forum on best practices in West Africa organized.

The first edition of JAIDS hit the stands in March 2015 under the theme "*HIV Risks and Vulnerabilities among Key Populations in West and Central Africa*: *Evidence to Inform HIV Prevention, Treatment, and Care."* This edition has 23 articles written by more than 100 persons. It received contributions from 11 countries in West and Central Africa. Regarding key populations, the journal treats issues with the following degree of focus: 57% on sex workers, 09% on MSM, 04% on PWID, and 30% on other issues. JAIDS is available for free online: http://journals.lww.com/jaids/toc/2015/03011.

We also learned about South-South experience-sharing from the SHARE project through the trip to India. The goal of this trip was to share the two-way experience on major HIV control impact policies, practices and innovations in programs between India and Africa so as to improve health results. This experience was in three stages namely: implementation, technical support and global information sharing. Several approaches were combined to attain the objective of South-South information sharing among which was the Africa-India meetings, on-line storage of HIV resources, guided exhibition tours, short courses, in-country technical cooperation,

"The first issue of JAIDS released in March 2015, under the theme "HIV Risks and Vulnerabilities among Key Populations in West and Central Africa: Evidence to Inform HIV Prevention, Treatment, and Care."

and remote virtual technical assistance. Between 2014 and 2015, 19 participants visited India under a program dubbed S2S-PC. Participants came from Benin, Cameroon, Togo, Burkina Faso and the West and Central Africa Region in general. Lessons learnt during this trip to India incited important recommendations to beneficiary countries among which:

Togo:

- Set up paralegal clinics, develop an HIV program for prisons, monitoring and referral through collaboration between communities and care and treatment structures, request the technical assistance of SHARE project in the area of paralegal clinics, and share access links to documentation and resources.

Cameroon:

- Design a macro map and estimate the number of KPs in hotspots, advocacy of involvement of journalists, monitoring and referral by formalizing collaboration between WCA and treatment centers, request technical assistance from SHARE project in the area of advocacy with journalists and share access links to documentation and resources.

Burkina Faso :

- Design a targeted strategy, design a map of PWID, determine the minimum package of activities, organize a parliamentary forum on HIV, set up paralegal clinics for HIV-infected and affected persons, present the Indian trip nationwide, request technical assistance, replicate the center of excellence for KPs and share access links to documentation and resources.

Regarding knowledge sharing, it is imperative to ask fundamental questions before getting involved such as: are there strong evidence to justify the choice of program strategies and practices? Are these practices transferable to meet similar needs in other countries or regions? Can we resort to large-scale cooperation? How should it be done? What resources are available? What are the next steps?

Lessons learnt reveal that experience-sharing provides the ability to:

- Replicate and scale-up best practices that have been successful elsewhere;
- Avoid errors by drawing lessons from failed approaches;
- Avoid the same errors by requesting information from partners on ideas that did not work.

SESSION 3: APPROACHES TO MEETING THE 90-90-90 GOALS FOR KP IN WCA

Understanding the 90-90-90 UNAIDS goals and Minimum package to achieving this goal by Hugues Lago

This presentation eased the understanding of UNAIDS's ambitious objective that targets 90% new infected cases in order to eradicate the HIV epidemic by 2030. This vision holds that if we are able to screen 90% of all HIV infected persons, treat 90% of persons tested positive with anti-retroviral drugs, reduce the viral load of PLHIV by 90%, then we would eradicate the epidemic by 2030. This vision can be achieved if there is a constant coverage in prevention and treatment services which will then lead to a constant reduction in new infections and deaths. To achieve this, it would be necessary to implement continuum of care so that persons tested positive can be placed on care and ART till their viral load reduces. Current results from the sub-region are still far below the mark as far as the 90-90-90 objective is concerned. Efforts must be doubled in three key areas if this 90-90-90 objective must be attained (HIV testing, treatment, viral load suppression). It is in this light that UNAIDS issued several directives and guidelines to help


A cross section of participants

countries work toward attaining this objective. However this 90-90-90 objective faces several obstacles that hamper the efforts of the countries. The obstacles are mainly social and include: cost variations in health units, gaps in the treatment cascade, inconsistent funding, and HIV control among adolescents and children. One of the major recommendations for the attainment of this objective is to develop partnerships with several sectors (political, technical / normative, financial, associations) in order to build an efficient national response. Also, it is necessary to envisage measuring progress through studies that will enable a better understanding of the epidemic, the effects and results of our actions and an assessment of the impact of our efforts on the disease.

As a lesson learnt, to implement The "Fast-Track" Strategy simply means: remain focus, innovative, go faster, track down, and find pockets of infected persons and place them on rapid treatment, ensure that each person on ART gets their viral load reduced to zero.

> "UNAIDS is therefore recommending the "Fast-Track" approach which consists of: 1) having the political courage to dealt with the HIV issue among KPs; 2) focusing on the objectives, having in-depth knowledge of the target groups and the services provided; 3) changing the strategies that did not work with new approaches which are working well and ensure good results; 4) accelerate the scale-up of the coverage of services in the next five years; 5) provide services in a consistent and sustainable way; 6) promote human rights in the fight against HIV among KPs."

Understanding PEPFAR 3.0 priorities by Gaston Djomand

This presentation revealed PEPFAR's vision which is to build an AIDS-free generation through science. PEPFAR has thus been funding several programs for the fight against the epidemic throughout the world since 2003. It has saved millions of lives as it enabled 7.7 million PLHIV worldwide to be placed on ART. PEPFAR has also helped bring 1 million HIV-free babies into the world, reached out to 21 million persons through prevention campaigns, etc. All of this was achieved thanks to the American Government which, since 2003, has provided more than $60 million through PEPFAR for the fight against this epidemic. Thus between 1990 and 2013, the epidemic witnessed a spectacular reduction in PEPFAR intervention areas (Caribbean, Asia-Pacific, Eastern Europe, Central Asia, Latin America, North Africa, and sub-Saharan Africa).

Meanwhile, the burden of the disease is still very much felt in sub-Saharan Africa although PEPFAR has taken the commitment to eradicate the epidemic with currently available resources. PEPFAR targets mainly children, young girls, and adolescents.

The speaker summarized the vision of PEPFAR in the fight against HIV by recommending that the right things must be done in the right places at the right now in partnership with UNAIDS, WHO, GF and host country for an AIDS-free generation.

PEPFAR's work must continue; otherwise, more than 2,880 children and 20,000 adults will die of AIDS throughout the world. These figures clearly show how much work needs to be done to eradicate the epidemic. PEPFAR's work is therefore, not finished yet.

However, one of the recommendations ensuing from this presentation is the need to face the fact that PEPFAR and the Global Fund are gradually withdrawing. Therefore, there is the need to set up an advocacy system to take over. It is, therefore, in this light of that a meeting has been scheduled in Dakar, to discuss the role of the civil society. It is equally imperative to develop local funding; more so because, in most of the countries of the sub-region, there is a huge movement of illicit funds or misappropriation of huge sums of money due to deep-rooted corruption.

MSMIT – Key program management guide by Cameron Wolf

Dr. Cameron Wolf taking participants through the MSMIT

This presentation targeted the practical support guide for the design of quality HIV control programs among MSM through MSMIT tools. This tool hinges on the 2011 directives on MSM and transgenders. Themes treated under these directives include amongst others, human rights and non-discrimination in health care settings, prevention of HIV transmission, HIV testing and counseling, interventions targeting behavioral change, information, education, communication, Substance use and prevention of blood-borne infections, HIV care and treatment, Prevention and care of other sexually transmitted infections.

The MSMIT is equally based on the WHO 2014 consolidated guidelines for key populations. The areas covered are: HIV prevention, harm reduction for people who use drugs, HIV testing and counseling, HIV treatment and care, prevention and management of co-infection and co-morbidity and sexual and reproductive health.

These themes are based on four levers namely: review of laws, policies and practices; laws that favor protection and non-discrimination; health services offered, accessible and acceptable; the strengthening of means of action.

MSMIT, therefore, allows for reliance on WHO 2011 recommendations and 2014 consolidated guidelines. It serves a guide for the implementation of interventions for MSM. This tool is intended for public-health officials, managers of HIV and STI programs, NGOs, community and civil-society organizations, health workers. MSMIT provides a global view of lessons drawn from successful intervention approaches among MSM. The tool was developed following a broad based process by a group of experts including those from communities in October 2014 in Bangkok in partnership with The Global Forum on MSM & HIV and led by UNFPA to help implement HIV-related services for the MSM community.

The tool is structured around the following thematic areas: (1) Community empowerment; (2) addressing violence; (3) Condom and lubricant programming; (4) Health-care service delivery; (5) Using information and communication technology; (6) Program management. MSMIT integrates egalitarian human rights, non-discriminatory laws, zero tolerance for violence, community engagement and mobilization.

The tool describes the implementation of each essential component of the MSMIT by giving details of the actions to be undertaken and the efficient implementation approaches for MSM programs.

How to reach the most-at-risk and hidden KPs: ICT (social networks, social media and mobile phone) – by Nana Fosua Clement & Harvey de Hardt-Kaffils

This presentation was done in two phases. The first presentation done by Nana Fosua Clement highlighted the advantages of recruiting MSM for HIV testing through social media in Ghana. Through this strategy, about 200 MSM were reached, 101 of whom tested positive and were placed on treatment. This strategy may very well enable a huge number of MSM to be reached, but it is very slow compared to other recruitment strategies. It can thus not be used alone but along with others in the approach dealing with various communication strategies.

The second presentation, done by Harvey de Hardt-Kaffils, informed participants on the innovative approaches through which KPs are reached. These include mHeath4KPs approach which consists in using SMS as an alert system to ensure behavioral change and strengthen adherence to ART. This approach had as objective to remind PLHIV that they have to take their ARVs according to the doctor's prescription, and systematically use the condom during sexual intercourse. Through this approach, KPs were encouraged to go for HIV testing and early STI treatment. They were also reminded to confirm their serological status every 3 months. Another innovative approach consisted in recruiting hard to reach key populations by using social media such as Facebook, Gay Romeo, Drague.net, Whatsapp, Badoo, etc. This approach also contributed to the attainment of objectives.

"The use of the social media must be considered in the variety of communication strategies approach, for more effectiveness."

The messages that were delivered using these two approaches were approved by the countries before they were disseminated through SMS and on social media. As such, from November 2014 to September 2015, 279,785 messages were sent in Togo, and reached 1,041 PLHIV, 287 MSM, and 360 FSW. Meanwhile in Burkina Faso, 12,341 messages were sent during the period of February to September 2015 and reached 181 FSW, 10 MSM, and 15 PLHIV.

Nevertheless, this strategy still faces a number of challenges notably: the difficulty to obtain KP telephone numbers; lack of confidentiality despite precautionary measures taken to move the platform to another country in order to guarantee confidentiality; illiteracy and technological ignorance.

Due to these weaknesses, it was recommended to reinforce the confidence level of KPs with regards to the confidentiality of their phone numbers; to develop voice messages for illiterate people; to recruit and train MSM PE in the mastery of technology; to provide them with internet data bundles as well as mentoring and support of community outreach workers.

Although this approach was effective, it was observed that the documentation about the referral of KPs to service providers still constitute a challenge and that it is necessary to carry out periodic studies in order to improve the results of these approaches.

"It was recommended to reinforce the confidence level of KPs with regards to the confidentiality of their phone numbers; to develop voice messages for illiterate people; to recruit and train MSM PE in the mastery technology; to provide them with internet data bundles as well as mentoring and support of community outreach workers."

New testing approaches: Self-testing by Stefan Baral

This presentation was based on the first 90-90-90 objective which is to diagnose 90% of persons living with HIV. As of this day, in the light of this objective, 49% of the target has not yet been tested for HIV. This highlights the urgent need to develop strategies that can hasten the attainment of this objective by 2020. It is in this light that the self-testing was designed to complement the approaches which will contribute in screening 90% of PLHIV. The self-testing was inspired by the pregnancy test model where an individual gets his/her blood sample, tests it and interprets the result. The self-testing can also be done using urine, but it has not yet been approved by WHO. It is a sensitivity test that must be confirmed in a health center. This practice is highly accepted among adolescent who do not wish to visit a health center. Its distribution is official in some African countries such as Kenya and South Africa, but unofficial in countries like Nigeria and Tanzania. It can equally be bought online. However, in Botswana and Germany, the HIV self-testing is illegal.

"The uptake of HIV self-testing is very high among adolescent who do not wish to visit a health center."

Nonetheless, this test is limited in that, in the absence of a psychosocial counselor, the risk of suicide and self-inflicted violence is not controlled in individuals who opt for this type of test. There are almost no directives to normalize the implementation of this strategy and it is difficult to monitor and report the data of the HIV self-testing in the national system.

Conclusively, the self-testing must not be considered as a substitute to the usual HIV testing mode in healthcare units; rather as a complementary strategy used to quickly meet up with the objective to test 90% of PLHIV. The WHO directives on the implementation of this strategy are being developed and will have to be taken into consideration in the recruitment of target groups to be tested.

One lesson learnt from this presentation is that to make up for the absence of a counselor during the self-testing, there is pre and post-test information adapted to the youths, who are the main users. It is available online on YouTube. This information provides advice on what should be

done at each stage. From all evidence, this approach cannot replace healthcare services because it only contributes to scaling up the number of persons to be reached.
PrEP by Gaston Djomand

This presentation highlighted the PrEP method also referred to as Pre-exposure HIV Prophylaxis. It is an HIV prevention method targeting persons not infected by HIV but who run a substantial risk of being infected. The method consists in taking a tablet of Truvada each day. The daily intake of Truvada by a person exposed to HIV prevents the virus from developing. This method is recommended for the following persons at risk: drug users, heterosexuals who have sex with same sex partners, and discordant couples. At the moment, its efficiency has been 86% proven among those who respect Truvada as prescribed, although there is very little data on prevention by Truvada among the youths and adolescents. In general, this prophylaxis prevents HIV transmission but one must have access to it.


At the right hand side, Dr Ettiegne-Traore of PACTE-VIH, and at the left hand side, Dr Bakouan of SP/CNLS of Burkina Faso with participants in the background

In the African context, PrEP has the potential to significantly reduce the incidence of HIV among KPs. But there is the need to define norms and strategies to control its use.

The success of this method depends on the good information given to users about the effectiveness of PrEP; education on adherence support and cognitive taking of Truvada; counseling on perceived risks and on the benefits of this method.

Obviously, PrEP is highly recommended for KPs due to its advantages because this population is more motivated to use PrEP and diligently take Truvada. However, in the African context, it is necessary to determine whether or not PrEP is a good method of prevention. But we must think especially how to maintain adherence and even assess the optimum level of adherence; it is also necessary to clarify how many times the test should be repeated.

EARLY LINKAGE AND RETENTION IN CARE

What interventions do we need to increase early linkage and retention?

Approaches and Practical ways of reaching Women in Transactional Sex and/or Non-Brothel Based Female Sex workers - by Ahmed Issa Bello

This presentation provided a means to assess the experience of the implementation of the SHiPS for MARPs Project in Nigeria, which aims to strengthen care services for KPs and specifically for FSW. This project targets several categories of FSW and has implemented various strategies to provide care services to them. The approaches used include recruitment of target groups through contacts, the approach to recruitment through key informants including students (male and female), hotel owners and staff, street FSW, nightclub managers, and community facilitators. One of the major activities was to engage peer educators in the cohort while community facilitators were trained to manage cohorts. These facilitators also form the basis of the project in that they are responsible for maintaining the cohorts throughout the

duration of the project. Community interventions have been developed to identify the needs of individuals and/or community groups after registration. Community facilitators are therefore considered as mentors the FSW can trust and who can easily help them to access care. In this context, the national peer educator model was adopted to promote and support sustainable behavioral change and combined prevention.

Several innovative activities were developed under this project including the commitment of street FSW to act as peer educators, community facilitators and HIV counselors; the recruitment of new FSW by the "guardian angels" who act as mentors within the community; intensification of the use of social media and messages about condom use; the forum of "boyfriends" to address low condom use with regular or "non-paying" partners.

"The community facilitators are considered as mentors the FSW can trust and who can easily help them to access care."

However, this approach is handicapped by the frequent mobility of FSW, the difficulty in identifying the target, a strong involvement of the general population, the holding of discussion sessions with PE are not defined, hence the prospect of conducting a study to document evidence that will identify programs that address the needs of target populations.

The use of case managers by Sodji Dometo

This presentation highlighted the use of mediators and strengthened education to prevent HIV among FSW and keep the FSW PLHIV in the continuum of care. The case manager has the essential role to quickly align to the care system and maintain PLHIV in the care system. The case manager must therefore be a member of the community or close to the KP; they must be someone the community can trust; they must be trained to monitor the PLHIV and be "KP-Friendly".

His/her role is to refer and monitor HIV positive FSW by fixing appointments, searching for lost cases following an alert, and ensuring that HIV+ FSW are received at health centers. The case manager's role is also to dispel the anxiety related to first visits to a health center, reassure the beneficiary on the availability of care and propose care service offers to the FSW by presenting the advantages she stands to gain from being monitored as a member of the KP. This approach helps reduce dropouts after enrollment.

The second aspect of the role of the case manager is to reduce the rate of lost-to-follow-ups by building a close relationship with care providers, guiding patients in the care circuit (entry and exit), holding group discussion, identifying "non-observant" HIV+ FSW in collaboration with the medical management team to help them find solutions to their problems, seeking lost-to-follow-ups, and conducting home-based visits (VAD) and facility-based visits (VAH).

"The involvement of the case managers from the HIV testing to follow up of HIV+ FSW reduced attrition while the "test and treat" approach has reduced inequality in access to care."

However, these approaches have witnessed some difficulties namely: distrust of beneficiaries for enrollment, HIV+ FSW who can no longer work, the mobility of HIV+ FSW, knowledge of HIV status by community members is a factor of competition in the sex trade. In response, several possible solutions were proposed, namely: encourage the expression of emotions by HIV+ FSW, promote teamwork through weekly meetings, mediation and community conflict management.

Finally, it became clear from this presentation that the recruitment and retention of KP in the continuum of care requires consideration of psychosocial determinants of health including life events, social networks, capital and social stress, autonomy and self-esteem. The involvement of the case managers from the HIV testing to follow up of HIV+ FSW reduced attrition while the "test and treat" approach has reduced inequality in access to care. Moreover, as the centerpiece, the case manager becomes more effective as s/he is in continuous training which is necessary for his/her understanding and ownership of this mission.

How to remove barriers that inhibit access to treatment:

Gender-based violence - by Thiam Niangoin Marguerite

Dr. Thiam Niangoin Marguerite making her presentation

This presentation focused on gender-based violence in the context of KP. It sets out by defining the concept of gender-based violence as violence directed against a person on the basis of biological sex, gender identity, and compliance/non-compliance with gender-related norms defined by the society. In this sense, there are several forms of gender-based violence namely, physical, sexual, emotional, threats, intimidation or arbitrary deprivation of freedom; economic deprivation included.

Unfortunately gender-based violence abounds in a difficult environment. Thus, in Burkina Faso, touching testimonies from young MSM – drawn from the QAYN 2015 report - who were physically assaulted and abused, were presented. The intensity of the phenomenon is confirmed in Togo, where a 2014 report (R2P) reported physical harassment rate among SW of 37.9% in Lome and 27.6% in Kara. In fact, data on gender-based violence in Burkina Faso are alarming: 52% FSW claim to have suffered some form an abuse ranging from verbal harassment (38.66%), to sexual violence (6%), through police raids (18%) and physical abuse (15%).

Gender-based violence naturally has an impact on HIV and health; among the most outstanding include decrease in the quality of care because of the difficulty in disclosing HIV status, propagation of risky behavior, less frequent HIV testing, etc.

However, there are three key components to help prevent gender-based violence, namely: (1) prevention of primary or recurrent acts of GBV by working with NGOs, civil society organizations, key community stakeholders including men and boys; (2) the management of GBV by identifying and facilitating access to services for survivors in cases of violence; (3) responsibility to ensure that perpetrators are punished and to end impunity by strengthening the legal and judicial systems.

"Watchdog committees should be set up at community level that will collect complaints and accompany victims when they are abused."

Therefore, to prevent violence, it was recommended that safety in particular should be promoted by listing and publishing images of violent customers and police

"Gender-based violence naturally has an impact on HIV and health."

officers, collecting local data on violence and mapping risky areas. It is also important to raise awareness among the police to make them allies and not violent actors; by involving bar and brothel owners, pimps and community centers; mobilizing and sensitizing communities on GBV; including KP and religious leaders. Meanwhile, it is also necessary to advocate for political and legal reforms.

We can also learn from the responses of other countries with regards to GBV, which include:

- Setting up informal foster homes where the survivors are welcomed;
- Information sharing on the rights of KP;
- Training in Stigma & Discrimination for health personnel, law enforcement officers, stakeholders in the justice system;
- The development of a list of workers in the health and justice sectors and the development of referral and counter referral systems;
- The creation of multi-sectoral networks or networks of allies;
- Collaboration with civil society organizations and health facilities;

Moreover, it could be understood from ensuing discussions that watchdog committees should be set up at community level that will collect complaints and accompany victims when they are abused, although prevention will reduce violence upstream.

Safety and security by Robert Amoako

This presentation served as an extension of the solutions to the fight against violence. The speaker focused on the safety of people who work with MSM, who can also be victims of violence. The objective of this presentation was to draw attention to prevention strategies that can ensure safety in the workplace. The presentation thus brought out the near-lack of programs that focus on safety in the workplace for an organization of MSM.

However, to deal with it, it is necessary to define one's ability and strength in security matters and learn about the rules of Kung Fu and Judo for self-defense if attacked. Peer educators are obviously the targets for violence. It is in this regard that the following were strongly recommended:

- Conduct training in security matters;
- Establish a security budget;
- Map out hotspots and no-go areas;
- Have a home security staff for those working with MSM.

Staff Trained in SW/MSM Sensitivity by Dr Hortense Me-Tahi

This presentation was geared toward informing staff on "KP-Friendly" training techniques. In a context marked by the stigma and discrimination of KP, which impact negatively on visits to health services, it becomes important to develop the concept of "KP-Friendly" to improve the environment in which prevention and care of the KP must be established.

This concept consists in improving the environment through the training of health providers to provide services to KPs in a supportive and friendly environment. The trainers consist of KPs trained in leadership and offering services to KPs; health workers and other KP stakeholders. It is a short term training which lasts two days for health personnel and one day for administrative staff and support staff. The developed modules for this training include: the epidemiological situation, perceptions and representations on sexual orientation, stigma and discrimination of KPs, and role plays. The main purpose of this training is to improve the doctor-patient

relationship; and build confidence of KPs. These lessons are enhanced by testimonies from KPs on their daily lives and by role plays in order to better convey the message of the concept of "KP-Friendly". The training provides the ultimate characteristics of a "friendly" health service. It must be welcoming and non-stigmatizing, with a patient circuit that respects the human dimension. The attitude of the care staff should be one that avoids negative looks, gestures or words and judgment towards KPs; s/he administers treatments tailored to meet the needs of the target.

"KPs must be involved in the behavior change process."

"KP involvement in the creation of 'KP-Friendly' services also contributes in reducing prejudices vis-à-vis the KP and strengthens collaboration between KP and caregivers

The key lessons learned from this presentation include the following:

- Increase "friendly" health centers by training healthcare providers in this concept;
- Involve KPs in the process of behavior change as trainers;
- Involve KPs in the creation of "KP-Friendly" services. This also contributes to the reduction of prejudices vis-à-vis the KP and strengthens collaboration between KPs and caregivers.

FSW engagement in Togo by Mensah Télè

Ms Mensah Tele explaining the engagement of FSW in Togo

This presentation was made by a leader of an FSW association based in Togo. This leader presented her association called Association of Amazon Women (AFAZ). Founded in 2013, this FSW identity association consists of 15 SW leaders. This group has set up five self-support groups in Kpalime, Lome, Kara, Dapaong and Cinkasse. The group's activities are conducted in a participatory manner with the FSW showing involvement and ownership at all levels of the process. This group receives support and guidance from the NACP, NAC, FAMME, FHI 360/PACTE-VIH.

AFAZ objectives are to educate FSW on HIV prevention in sex work environment; distribute condoms and lubricants in sex work settings; improve the practice of HIV/AIDS prevention among women in a position to receive FSW; and ensure the psychosocial care of HIV+ FSW for better quality of life.

Dr Leopold Zekeng of UNAIDS RST WCA and Dr Hortence Me-Tahi, Coordinator of PACTE-VIH ing Togo giving a standing ovation to the FSW representative after her presentation

The work of the AFAZ association has already produced some remarkable results including the involvement of the association in the activities of the Country Coordinating Mechanism (CCM) which now have a KP representative with the AFAZ leader as a substitute; AFAZ participation in the country dialogue for the development of the proposal to the Global Fund for the Fight against AIDS, malaria and tuberculosis; participation

in the development of the National HIV/AIDS Strategic Plan, etc.

To forge ahead, however, AFAZ must face the challenges of maintaining the hopes of FSW expressed during their General Assembly; mobilize all FSW in Togo; mobilize financial resources to run the association; to enable all FSW take ownership of the association.

The following are strong recommendations to further this cause:

- Strengthen the capacity of FSW in human rights, leadership, petty trades, literacy and financial management;
- Make them less vulnerable to violent "boyfriends" and customers by developing income-generating activities.

DAY 1 KEY RECOMMENDATIONS

Recommendations were made following Day 1 deliberations. Generally, there is the need to:

1. Build on practices that have worked elsewhere by avoiding past mistakes;
2. Update data on key populations for 2005 data is still in use. It is, therefore, necessary to stop for a moment to think, pool information and determine the source from which data can be documented. Data on KP is usually patchy and therefore cannot be disaggregated based on sexual orientation;
3. Set up a working group with a program manager, scientists and technical partners especially in Central Africa because WAHO is not enough;
4. Develop partnerships with different sectors (political, technical/normative, financial and with associations) to build an effective national response. Measure progress through studies that provide better knowledge on the epidemic, know the effects and results of our actions and assess the impact of our efforts on the disease;
5. Reinforce the confidence level of KPs with regards to the confidentiality of their phone numbers; to develop voice messages for illiterate people; to recruit and train MSM PE in the mastery technology; to provide them with internet data bundles as well as mentoring and support of community outreach workers;
6. Promote their safety notably by listing and publishing images of violent customers and police; by collecting local data on acts of violence and mapping out risky areas.

DAY 2:

Roll-out of viral load testing

The first presentation was given by Dr. Abdoulaye Wade of Senegal and focused on ***KP treatment scale-up (test and treat)***

The main recommendations of this introductive presentation are that:

Prof Coumba Toure Kane making her presentation

- HIV programs for key populations need to be comprehensive in nature addressing multiple barriers and facilitators to HIV prevention and treatment for key populations
- It is important to understand the environment that you are in and develop programs accordingly that are effective and evidence-driven
- What if all donors stopped funding HIV programming tomorrow? Does the country have a plan in place for this and if not, it should. Senegal has taken steps to gradually take over funding from external donors, towards sustainability.

A series of 3 presentations on Roll-out of viral load testing was given:

Roll-out of viral load testing by Prof Coumba Toure Kane

This presentation highlighted the need for a situational analysis in order to identify implementation gaps, identify challenges ranging from political to limited human resources through the problems of stock outs, equipment maintenance, and sample transportation difficulties. It also focused on the opportunities available at country level to facilitate scaling up.

This presentation derives from the premise that at least less than 10% of PLHIV have access to this important tool in our area. One of the reasons stems from the fact that WHO introduced the viral load only in 2013 whereas countries were already on ARVs ten years before.

However, the introduction of viral load (VL) in a country requires prior detailed analysis of the situation to determine gaps related to the functionality of the VL. Secondly, countries must develop a powerful biology for the diagnosis.

Viral load will help annihilate HIV. But this requires a strong political will that will allows for VL to feature in national policies; there is the need for referrals and alternative techniques and machines; proper maintenance of machinery; there is need to develop innovative systems for the transport of reagents; there is need for

"There is the need for strong political will that will allows for VL to feature in national policies."

trained human resources. In short, there is need to mobilize financing; forge strong partnerships with clinicians, laboratory experts, the community, the civil society, etc.

It was also learned from this presentation that it is also possible to develop innovative ideas to deal with difficulties related to the transport of reagents. The use of the drone in Senegal to transport reagents is a great example of innovation, which is efficient and cheaper.

The main recommendations at the end of this presentation and discussions that followed include:

- Every country has at least a single viral load machine but situational analyses are needed to inform the breakdown in regular viral load monitoring observed in many settings
- Characterizing the appropriate methods for viral load monitoring in each setting is going to be important to help inform monitoring scale up given the increasing importance of viral loads as compared to CD4 in the era of test and treat.

The Community Based ART Clinics for KPs (One-Stop-Shop to achieve the 90/90/90): Lessons learnt from Nigeria, by Godwin Emmanuel.

"The "one-stop shops" are located throughout the territory due to huge presence of KPs in a site. They can be both "homogeneous"; and "heterogeneous"

This presentation was an opportunity for the speaker to talk about the experience of the drop-in center (DIC) where ART is integrated into other services such as comprehensive HIV prevention, psychosocial counselling, life skills building, paralegal trainings and other forms of community empowering interventions in a supportive and non-discriminatory manner. He also highlighted the experience of Community-Based ART Clinics (CBACs) where KP individuals have the opportunity to learn to live in the community and to take control of their lives, a place that offers a safe, supportive environment within the community for KP individuals to access comprehensive HIV/AIDS prevention, treatment and care services in a non-discriminatory and friendly environment. The main lesson of this presentation is that one stop shops integrated within broader health facilities can serve as effective models of linkage and retention in ART programs.

This experience from Nigeria proposes the "one-stop shop" concept in which KPs constitute the driving force in the treatment and care process. The intervention focuses on the work of KPs, particularly through the introduction of ART in friendly centers (Drop-In Center). This concept builds confidence among KP while eliminating stigma and discrimination. The "one-stop shops" are located throughout the territory due to huge presence of KPs in a site. They can be both "homogeneous"; that is to say they provide services only to KPs and "heterogeneous"; that is to say they are open to everyone but with divisions for KPs.

Ghana's Viral Load Testing by Dr. Stephen Ayisi Addo.

This presentation indicated that nine functional viral load equipment are available in Ghana with plan for 1 more to make up 10. Au Ghana actuellement, toute personne qui vit avec le VIH doit être testée sur la machine virale tous les 6 mois.

This was possible thanks to the Ghanaian **"SCIENCE"** component, divided as follows:

1) **S**cience: it is the basis of all actions through education, proper mapping of stakeholders, etc.

2) **C**onstruct a consensus with all stakeholders involved in services for KP in order to have a unified response with 15 local NGOs;
3) **I**mplementation: document key lessons and innovations;
4) **E**xpand access;
5) **N**o discrimination and stigma, despite the fact that the law criminalizes the act;
6) **C**onsolidate data, capacities, evaluate cohorts of people who come for treatment;
7) **E**valuation: measure progress.

According to the experience of Ghana, the three 90s can be achieved provided key commodities are available through financing, a strong health care system, community initiatives and evidence-based implementation.

"Construct a consensus with the community, the government and the academia represents an important approach to develop sustainable HIV prevention and care and support."

The main recommendations identified from this presentation and the question and answer session that followed include:

- Building consensus across community, government, and academia represents an important approach to develop the most sustainable HIV prevention and treatment care programs
- Documentation of implementation with effective measures of impact and cost-effectiveness is crucial

How to ensure the sustainability of viral load testing by Dr Wade Abdoulaye

This presentation addressed the issue of sustainable programs for the fight against AIDS that go beyond external financing. The reflection derives from the observation that AIDS remains a concern in our countries that have made a commitment to scale-up and respect the three 90s. Meanwhile, the fight against AIDS gets only weak contributions from States and so depends largely on external funding.

This presentation focuses attention on the possibility of the withdrawal of donor funds by 2017 and calls on countries to anticipate possible solutions. So, faced with the question as to what is going to happen in our countries if donors decide not to fund the fight against AIDS as from 2017, the author proposes the following solutions: (1) commitment and country ownership; (2) involvement of all stakeholders; (3) innovative and domestic funding; (4) public-private partnership that places particular emphasis on the acquisition of machines, troubleshooting, and maintenance of machines; the viral load must also be included in the training curricula.

Senegal's experience is eloquent in the sense that this country has experienced a gradual increase in the local budget for the fight against AIDS; the country has built an early response to the disease through viral load; there is strong leadership with the private sector, which has allowed the country to acquire 10 viral load machines at no cost. Thus, these machines have been sent into the regions based on the prevalence.

Senegal also has a reference laboratory for the evaluation of tests, quality control and training. There is, therefore, an urgent need to act by mobilizing domestic funding and investing in high-impact strategies.

The discussions that followed the presentation highlighted the fact that although the issue of stigma was very little developed the programs, particularly in Senegal, one of the strong

principles of the fight against AIDS among KP is that there is need for a favorable environment to implement the programs. However, the environment must be peaceful, without upsetting habits and so it must be done taking into account the context of each country.

It is also necessary to face the fact that homophobia is not exclusive to Africa but it also exists in Europe. In this regard, progress is indeed slow but things are moving. The right to health is more accepted and easily tolerated than the right to prostitution or homosexuality. But the reason we are here is health for all.

Drawing on the experience of Senegal, he identified the following possible key solution:

- Country commitment and ownership
- Innovative and domestic financing
- Public-private partnership (to acquire machines, ensure repairs and maintenance)
- Include Viral load testing and use of VL in training curricula

The session on HIV-related co-morbidity was an opportunity for two speakers to present the following:

Hepatitis C by Dr. Mampedi Bogoshi

This presentation showed that, unlike HIV, where there is a downward trend in infection rates, hepatitis is quite on the rise. Hepatitis transmission factors include, use of injectable drugs, blood transfusion and organ transplant, HIV patients, multiple partners, etc.

The life cycle of the virus is the same as that of HIV. But unlike HIV, hepatitis can be treated. The maximum treatment duration is 24 weeks. In addition, considerable progress has been made in the treatment regimen. Thus, from 2013 to 2015, the treatment regimen moved from multi-drug treatment regimen to a single tablet treatment regimen. Up to 90% of patients can be treated and there are approved drugs that have few side effects.

“The majority of people who are infected with hepatitis and HIV die of hepatitis and not HIV.”

In cases of co-infected patients, HIV must be treated first, then hepatitis but everything depends on the patient and each patient should be treated case by case. Hepatitis is curable and policies must go hand in hand with the treatment of AIDS, hence this strong advocacy to donors because they must also think of designing hepatitis control programs in the countries.

In the concluding part of this presentation, it was also learnt that the majority of people who are infected with hepatitis and HIV die of hepatitis and not HIV; whereas, hepatitis can be cured as opposed to AIDS. HIV treatment is a lifelong therapy while hepatitis can be treated between 8-24 weeks. Hepatitis B is more infectious than hepatitis C which is more infectious than HIV/AIDS. Hence, it is imperative to act on the fight against hepatitis.

The main recommendations of this presentation include:

- There is a need to determine what the size of the problem is and to characterize the specific risk factors for Hepatitis C Virus (HCV) across Sub-Saharan Africa including household determinants, socio-cultural determinants like tattooing, sexual transmission primarily via anal intercourse, and also shared injecting equipment in hospital settings or with illicit drugs
- The new treatments for HCV can cure Hepatitis C Virus in as little as 8-12 weeks
- The first step in advancing HCV treatment programs is developing national treatment guidelines and this process is already underway in several countries in the region

Other sexually transmitted infections (herpes, syphilis, gonorrhea, mycoplasma genitalium) by Dr Camille Anoma

This presentation brings to the spotlight the need to implement systematic diagnosis and treatment of STIs among KPs, according to WHO recommendations. The diagnosis of STIs should extend to screening for cervical cancer among sex workers. However, in most countries, care for STI is neglected by programs.

The major recommendations made after this presentation highlighted the following:

- There is a disconnection between current nearly exclusive reliance on syndromic surveillance for multiple sexually transmitted infections and the reality that most sexually transmitted infections are asymptomatic.
- There is a need to have national discussions about newer models of STI diagnosis and including potentially presumptive testing for oral, anal, and peri-genital STIs and even presumptive treatment for very high risk populations
- There is a need for physicians, nurses and other health providers to be aware of and trained in the presentation of STIs in KP. For instance, anal or oral presentations of STIs in MSM
- Given the shared risk factors between human papilloma virus (HPV) and HIV and the increased likelihood of progression to cervical or rectal cancers among those living with HIV, targeted screening with pap smears and anoscopy and the consideration of HPV vaccinations programs are important.

"The diagnosis of STIs should extend to screening for cervical cancer among sex workers."

A panel discussion was organized on country experiences and challenges to the achievement of objective 90-90-90. This discussion allowed panelists to respectively present the City strategy approach (Fast Track approach), the experience of the operationalization of Continuum of prevention, care, and treatment in Cameroon on the one hand and in Togo on the other.

The first panelist (Dr. Leo Zekeng) presented: Fast-track cities: Ending the AIDS epidemic by 2030. This is a strategy that targets 15 African countries, which alone account for the vast majority of PLHIV on the African continent. This is a new approach based on location and populations that aims to making HIV services available in places where the density of people living with HIV and the populations at higher risk is substantial. This presentation shows that if properly implemented, the fast-track approach will avert 28 million new HIV infections and 21 million deaths by 2030.

The panelists are from L to R: Dr Leopold Zekeng of UNAIDS RST WCA, Prof Ehui of Côte d'Ivoire, Dr. Denis J. Hynes, COP CHAMP, Dr Assetina Singo-Tokofai of PNLS Togo

This approach consists in targeting cities where HIV prevalence is high. It is based on the principle that by 2060, 65% of people will live in urban areas. We must therefore focus on cities following the "Fast-Track" logic. Cities are, therefore, good entry points to end the epidemic. If the HIV problem is solved in these cities, there would be at least a 50% reduction of HIV infection.

It is with this understanding that advocacy is ongoing to ensure that cities benefit from the Global Fund financing. The targeted cities are Douala, Yaounde, Lome, Abidjan, Libreville, Dakar, Brazzaville, Kinshasa, Bamako, Cotonou, Lubumbashi, Ouagadougou, Lagos, and Abuja. Thus, UNAIDS encourages the development of action plans to fight against HIV in cities. Once again, one of the funding options is public-private partnership.

However, country dependence on external financing is a challenge that must absolutely be overcome. To do this, countries must be politically committed. But now, government's commitment is poor although they can do better. Countries with limited income must make tradeoffs in allocating funding priorities. In this context, the civil society, the media, and parliamentarians must also ask governments to render accounts of their commitments. We must resolve to boldly work towards making our response sustainable by getting rid of dependence on external financing.

The next panelist (Dr. Assétina Singo-Tokofai) examined the Experiences and Challenges in attaining the 90-90-90 Targets: Case of Togo. Her presentation highlighted the encouraging results obtained with a reduction of 62 percent of new HIV infections between 2010 and 2014, a decrease of 24 percent in mortality between 2010 and 2014 and a one point drop from 2000-2014. Experience of good public-private partnership practices was identified. It consisted of a partnership with the post office to transport the DBS and then bring back results to reduce waiting time.

The experience of Togo is a striking example of transporting reagents through the post office. This experience increased PMTCT sites because the post office has a wide coverage. However, where the post office service cannot reach, nurses carry reagents to the laboratories.

The panelists from L to R: Dr Jean-Thomas Nouboussi & Hyeyoung Lim from the Global Fund, Dr Didier Bakouan, SP/CNLS Burkina Faso, Dr Youssouf Sawadogo & Dr Sylvain Parent, Global Fund

A session was devoted to Global Fund presentations. During this session, two presentations were made including one on Working with the GFATM on the grant implementation by Sylvain Parent and the second entitled Global Fund and Human Rights by Hyeyoung Lim.

Worthy of note from this presentation is the New Financing Model of the Global Fund which starts with the development of the National Strategic Plan in which the KPs must be involved. The participation of all stakeholders, including key populations is an important criterion in the development of the concept note. Thus, several grants worth for $1.6 billion were signed for the fight against HIV in the region. But there is still the issue of low capacity to utilize resources in many countries. One reason is the fear of rating which has led to underestimation of objectives in the countries.

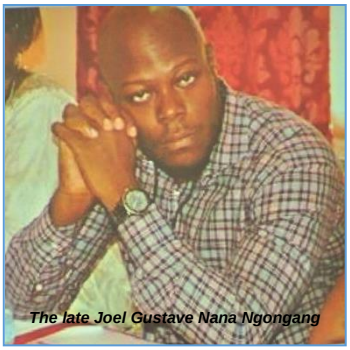
The second presentation of the Global Fund dwelt on the issue of human rights, a concept dear to the Global Fund. It is in this light that the Global Fund has made commitments to protect human rights.

These commitments are reflected in the following requirements:

- Integration of human rights conventions in the development of concept note drafting process;
- Increased investment to address human rights issues;
- Existence of 05 human rights standards in agreements with beneficiary countries.

Consequently, the Global Fund does not fund programs that violate human rights; on the contrary, it encourages programs to react to political violence against KPs.

Panel discussion on Human Rights and KP perspectives



The late Joel Gustave Nana Ngongang

Before the start of the panel discussion on human rights, tribute was paid to Mr. Joel Gustave Nana Ngongang, who passed away on October 15, 2015, at the age of 33 years in Cameroon, after a brief illness. This tribute revealed that Joel was a staunch human rights defender. As a young student, he began working with AGALES, a small human rights association. He created the African LGBTI Advocacy website, worked with Behind The Mask, the International Gay & Lesbian Human Right Commission and at 27, he founded the AMSHER network (African Men for Sexual Health and Rights) that brings together the most active and best organizations of key populations in Africa, and to create synergies and partnerships that have made AMSHER a strong and indispensable partner in the regional struggle for human rights and access to healthcare for LGBTI in Francophone and Anglophone Africa. After his departure from AMSHER in 2013, Joel founded the PARIDEV consultancy and began an international expert career.

Panelists from L to R: Yves Kugbe from Togo, Jean-Paul Enama Ossamba from Cameroon, Djiby Sow from Senegal (moderator), Badoube Sydonie from Cameroon and Tety Josiane from Côte d'Ivoire

The panelists from this session included Yves Kugbe, Badoube Sydonie, Tety Josiane and Jean Paul Enama Ossomba.

It is clear from this exchange on human rights that the legal environment is unfavorable in several countries. In Cameroon, for example, Article 347 criminalizes prostitution and sex between people of the same sex.

The existence of this law favors the manifestation of verbal, physical and social abuses towards KPs. In Cote d'Ivoire, there are legal gaps that produce the same negative effects: rape, raids, arrests and of all sorts of abuses by security forces.

While much has been done in the field of health, much remains to be done regarding human rights. For this it is necessary to include parliamentarians in advocacy approaches; ministries of health and justice should work together; involve the population concerned although the KPs themselves must learn to defend their situation; there is the need to clear the legal void, because laws must go in the direction of a peaceful environment so health can also be improved.

The day ended with a field visit to the Drop-In Center (DIC) and later in the night by nocturnal activities on FSW itineraries.

The main recommendations from this panel discussion include:

1. Strengthen the training of MSM and FSW in human rights, in advocacy and in leadership
2. Intensify advocacy actions by KP targeted at the Police, the media, the religious leaders, families, the ministry of justice and health providers
3. Encourage the progressive setting up of a collaborative working mechanism between the security personnel and the KP including their training in human rights
4. Create synergy between the key populations, the ministry of health, the ministry of justice and the ministry of interior in each of the countries in West and Central Africa so as to allow the real implementation of the 2015 Dakar declaration, initiated by WAHO
5. Remove the legal barriers to the universal access of key populations to prevention and full care and support services
6. Countries should respect the commitments they make at international level.

Creating an enabling environment for KPs interventions through focused advocacy and community engagement to i) **address barriers** (social, cultural, religious, political, and legal) to effective interventions and ii) **reduce vulnerability, stigma and discrimination** among KPs.

Field visits:

Some of the participants who took part in that visit also shared their experiences and lessons learnt. This is what some participants who participated in the field visits had to say:

- ***Participant 1*** visited MSM DIC: "Congratulations to the organizers and the managers of the MSM DIC. The flow is patient is very good and the services provided and good but there is the need to think about the sustainability".
- ***Participant 2*** visited the FSW DIC: "We are impressed by the income generating activities put in place at the DIC to empower the FSW. But we should think of how to sustain this good initiative".
- ***Participant 3*** visited the mobile unit during the night visit: "The use of the mobile unit is very interesting. This is very appropriate for hotspot and the FSW due to their mobile nature and countries might want to consider it."
  "The mobile unit is well built, well put together and HIV services including Family planning are provided".
- ***Participant 4*** visited the mobile unit during the night visit: "I noticed that FSW leaders were around to mobilize people including FSW and even a police officer for HTC. I also noticed that condoms were put to sale at the site. I liked it".

Field visit

KEY RECOMMENDATIONS OF DAY 2

1. Viral Load testing is an increasingly important aspect of the management of people on ART. Innovative approaches to public-private partnerships, as well as government commitment to take over funding are required for sustainable access to VL testing.
2. Care and treatment services need to be client-friendly, and free from discrimination.
3. One stop shops and other integrated service delivery models are to be explored as approaches to reaching and enrolling, and retaining on treatment member of key populations who may be reluctant to make use of 'general population' services.
4. An enabling and conducive environment is essential if key populations are to have access to and make use of prevention, care and treatment services, and if 90-90-90 targets are to be achieved. This will require respect for the rights of all humans, including key populations, addressing legislative and policy barriers, and overcoming social and cultural barriers.

DAY 3:

SESSION 4: MEASURE OUR INTERVENTION AMONG KP

The use of the Unique Identifier Code to document the unduplicated number of KP reached: Does it work? By Marian Honu and Zakaria Zoungrana

This presentation described the Unique Identifier Code used by PACTE-VIH, how the code is generated. The presentation also highlighted on some achievements and some key challenges when resolved, will help the project report accurately on indicators, tally de-duplicated persons reached without compromising confidentiality, and track beneficiaries while maintaining individual anonymity.

The main recommendations at the end of this presentation and discussions that followed include:

- To ensure sustainability, merge the UIC with the national database

Stepped-Wedge design by Dr Gina Etheredge

"The stepped-wedge design is best used at the community level and must be used to measure the effect of the intervention on the target population in a real situation."

The presentation provided insight to participants on what Stepped-Wedge design was all about, when it can be implemented. It is a clustered randomized sequential extraction. The clusters are not randomized for the benefit or not from the intervention, contrary to a randomized controlled trial. Initially, none of the clusters benefits from the intervention. Then it is serially implemented (stepped) for each cluster in a random and predetermined manner. Visually, the planning of this method looks like two triangles (wedge). This method enables to distinguish between the intervention effect and the time effect.

The presentation also highlighted the advantages and challenges of this design compared to others.
Some of the advantages of this design include:

- The method allows measuring what happens in the target population without the intervention: during analysis you are able to separate the effect of the intervention from the effect of time
- The stepped-wedge design provides more statistical power to detect the effects of the intervention compared to classical parallel design studies
- Easier logistical and financial management.

However, it came out clear that this method is a very complex one which requires more time to complete.

One key recommendation is for Programs themselves to be designed to accommodate the stepped-wedge method.

The last presentation under this session 4 was from Evidence for Development, titled: ***Research and Evaluation for promoting targeted and effective health policies and programs*** by Dr Jacques Emina

This presentation afforded participation the opportunity to know more about the E4D program, what they do across the region and the evaluation they conducted for PACTE-VIH on behalf of USAID.

This ended the round of presentations in this session and this paved the way for a panel discussion. The objective of this panel was to discuss the importance of new evidence for KP program planning, including the operationalization of some approaches such as the use of the unique identification code (UIC) at all stages of the continuum of prevention, care, and treatment. It will also discuss how to determine the coverage of interventions for KP and other methodologies to fill in information gaps on KP communities.

The panelists from L to R: Zakaria Zoungrana of PACTE-VIH, Jacques Emina of E4D, Sheila Mensah of USAID/WA and Gina Etheredge of FHI 360

Panelists tried to answer the following questions:

- How to measure actual coverage of programs: (a) what are appropriate methods of assessing denominators through size estimations? And (b) how can mapping data be used use to inform differential coverage across different sites, cities, regions?
- How to assess treatment outcomes among key populations: (a) how should UIC be linked to national treatment programs? And (b) How can it be done while protecting the confidentiality of program participants?
- As the stepped-wedge design involves sequential roll-out of an intervention, what factors should come into consideration when deciding which groups/ sites have to wait until step 2 or later? Who should be involved in the decision? And how would the process be operationalized?

At the end of the panel discussion on measuring our interventions among KPs, the following recommendations have been made:

- Take advantage of open data sources that are available in processing data
- For the UIC to be useful, it should be linked with the national system. There is the need to be a linkage between the different types of codes that are being used (between the government system to track patients on treatment and the outreach programs that are donor-funded) but it is very complex.
- The stepped-wedge design is better used at the community level and is to be used to measure the effect of the intervention at the target population level in a real-world setting.

SESSION 5: REPLICATION AND SCALE-UP

This session was sub-divided into two; the first sub-session dealt with the general concept of replication and scale-up and the second showcased some country experiences in the region.

The first presentation under this session was by Sheila Mensah of USAID/West Africa. Her presentation was aimed at setting the stage for discussion on replication and scale-up. The presentation tried to explain scale-up on one hand and replication on the other and their importance.

According to USAID, scale-up in the intervention context is: "Expanding a model, practice or policy to more facilities within a geographic area or to reach more of a targeted population". Replication on the other hand is: "A model, practice or policy is fully implemented by another organization/ national government, with reasonable fidelity to the original practice or model".

The presentation also highlighted the opportunities for regional scale-up and the existing potential platforms which include the ECOWAS Good Practices Forum in Health, regional workshops and other south-south exchanges in the region.

This presentation therefore set the stage for discussion and at the end of discussion, the following key recommendations were made:

- Need to build human resource base to ensure scale-up
- Need to conduct SWOT analysis
- Need to build coalition with the government to have their support
- Need to document the interventions implemented
- Need to have a good mapping of target groups

To succeed interventions targeting KPs, there is the need to:

1) Involve KP association in the design, implementation and evaluation of interventions;
2) Work in synergy with all key stakeholders in order to take advantage of good practices;
3) Create an enabling environment.

Country experiences in replication and scale-up followed up immediately and the opportunity was given to the Abidjan-Lagos Corridor Organization (ALCO) and Nigeria to share their experiences.

ALCO's contribution to the provision of key population-friendly services, by Dr Hugues Guidigbi provided participants with information about the organization, why the focus on KP, how they are going about it, some results and the way forward.

According to OCAL, during the implementation of KP activities, three lessons were learned: 1) stigma, discrimination and the punitive laws constitute a major hindrance to KP access to HIV services; 2) the involvement of KP during the design, implementation and evaluation of interventions help reach KPs; and 3) working in synergy with other stakeholders (NAC, NACP, Futures Group, FHI 360, etc.) ensured build on their good practices.

The presentation by Dr. Abiye Kalaiwo of USAID Nigeria, titled: Coordination of Key Population Programs: Lessons from Nigeria, gave account of a Total Coordination Approach used in Nigeria.

The presenter explained that for Nigeria, the total coordination approach is a prerequisite to meeting the stated objective because: “a coordinated response to HIV is a major challenge to today’s policy makers”.

For a smooth implementation of the overall coordination approach it is recommended to:

- Keep eyes on the set objectives;
- Never be afraid to take tough decision;
- Learn to trade and negotiate
- Understanding your currency

“Provide the right information at the right time to the right people at the right place with the right intention for the right purpose.”

SUMMARY OF KEY RECOMMENDATIONS OF THE MEETING

- Involve the authorities in the process of replication and scale-up to ensure success
- Strengthen the capacity building of men who have sex with men (MSM) and female sex workers (FSW) in Human Rights, Advocacy and Leadership
- Give priority to the progressive setting up of a collaboration mechanism between the security personnel and the KPs, including their capacity building in Human Rights
- One-stop-shops and other integrated service delivery models are to be explored as approaches to reaching and enrolling, and retaining on treatment member of key populations who may be reluctant to make use of ‘general population’ services
- Viral Load testing is an increasingly important aspect of the management of people on antiretroviral treatment (ART). Innovative approaches to public-private partnerships, as well as government commitment to take over funding are required for sustainable access to Viral Load testing.

CLOSING CEREMONY

The closing ceremony was chaired by Professor Vincent Pitche, National Coordinator of CNLS-IST and had in attendance, Dr Virginie Ettiegne Traore, Director of PACTE-VIH, Dr Laurent Kapesa, Senior HIV Advisor for USAID/West Africa, Dr Leopold Zekeng, Deputy Regional Director of UNAIDS RST-WCA and Dr Sylvain Parent, SPO West and Central Africa for the Global Fund.

Unanimously, the second KP regional meeting was adjudged a success and this was highlighted in the closing remarks.

Dr Virginie Ettiegne Traore: « …nous avons atteint nos objectifs, et c'est un grand plaisir et un honneur pour l'équipe de PACTE-VIH qui a le mandat et aussi l'objectif de conduire des activités régionales ; ce mandat ensemble, nous sommes en train de le réussir ».

Dr Laurent Kapesa : « …je félicite le leadership national, …pour avoir accepté d'abriter cette réunion. Je voudrais aussi remercier les populations clés car sans elles, nous ne pouvons rien faire ; l'effort que ce groupe a fait au cours des visites de terrain, la patience et les réponses aux questions témoignent de leur désir à pouvoir contribuer sensiblement à la lutte contre le Sida. Je voudrais donc les assurer que ce momentum qu'on vient de créer …va s'accentuer et que leur accès aux services de santé dans la dignité va s'améliorer ».

Dr Léopold Zekeng: "On behalf of UNAIDS, I wish to express my profound gratitude and delight; this has been a very productive and a very useful meeting. For me, it's been very successful; it was worth coming; I learnt a lot and there is a lot we need to be proud of".

Sylvain Parent : « Bravo aux organisateurs; cet atelier est l'un des mieux organisés auxquels j'ai participé dans ma carrière ».

In his closing remarks, Prof Pitche hinted on the next KP regional meeting to be hosted in a country in Central Africa and specifically in Cameroon.

FEEDBACK FROM PARTICIPANTS

Yves Kugbe, KP Program Officer, Afrique Arc-en-Ciel, Togo (MSM-led association): "From Day One, I never ceased to express gratitude to the organizers for the quality and the relevance of the presentations…I am particularly interested in the SNT and self-testing."

OUEDRAOGO Romain, Program Officer for MSM Intervention for Association African Solidarité of Burkina Faso: "…This workshop brought us new knowledge which we will apply to boost our work in meeting the 90-90-90 objectives. I hope such meetings will be organized periodically."

BADOUBE Madeleine Sydonie, FSW, and Peer Educator from Cameroon: "We were happy to have participated in this experience-sharing get-together. We wish to replicate the experience of Togo where there is a center purposely for the care and support of FSW and we would be very grateful for your support in the identification of potential donors who finance these initiatives."

Adja Magatte Mbodj, Executive Director, Alliance Nationale de lutte contre le Sida (ANCS) from Senegal: "I would like to use this opportunity to congratulate the whole FHI360 team, partners and especially the experts who shared their different experiences on interventions for key populations."

Dr. Leopold Zekeng, Deputy Regional Director of UNAIDS RST-WCA: "We wish to thank you for the invitation and commend you for the great leadership and team spirit. Be reassured of our continued commitment and eagerness to help move this important agenda in the region".

Sylvain Parent, SPO FM Team West Africa, The Global Fund: "I was very happy participating in this workshop and to meet interesting people who are motivated by these challenges.
Congratulations to the PACTE-VIH team who did an excellent job in Lome."

YAO Mathurin, HIV Program Director, PSI Côte d'Ivoire: PSI/CI is honored to have participated in this regional meeting on KPs. We are interested in strengthening our activities targeting FSW by 1) developing DIC, 2) using the Social Network Testing to increase HTC among KPs, and 3) use of community case managers for follow-ups and referral of HIV+ cases.

Jean-Baptiste GUIARD-SCHMID, Director, ICI-Santé: "Congratulations on this regional meeting, which was very interesting and useful. We hope that the technical group will be able to deploy its momentum very quickly and I would be happy to contribute. …Congratulations to all your team ... for the excellent organization and perfect conviviality; everything went smoothly."

ANNEX 1:

WORKSHOP AGENDA

Time	Activity	Presenter	Moderator
Day 0 - October 26, 2015			
3 – 7pm	Arrival and Registration of participants		
4.00 – 5.30pm	Organizing team meeting (steering committee & moderators)		
Day 1 – October 27, 2015			
8.00 – 8.30am	Registration of participants (cont'd)		**Virginie Ettiegne Traore**
8.30 – 9.15am	Opening ceremony - Welcome Address, National Coordinator CNLS-IST - Speech by UNAIDS Dep Reg. Director - Speech by Director Epidemic and Disease Control Department, WAHO - Speech by US Embassy DCM - Keynote Address – "**Enhancing KP Interventions: Taking Stock and Moving Forward**"	- Prof. Vincent Pitche - Dr Leopold Zekeng - Dr Carlos Brito - Mrs Dana Banks - Secretary General of MOH, Togo	
9.15 – 9.30	Overview - Workshop objectives and sessions - Logistic information	- Virginie Ettiegne Traore	
9.30 – 9.55am	**Group Photograph and Coffee Break**		
9.55 – 10.50am	**Session 1: Current Situation Key population**		**Prof Pitche**
9.55 – 10.10am	Dynamics of HIV among Key Populations in West and Central Africa - Epidemiology, programs and policy	- Leopold Zekeng	
10.10 - 10.20am	- Togo epidemiology and response to the Epidemic	- Prof Pitche & - Damien Amoussou	
10.20 – 10.50am	- Clarifications		
10.50am – 12pm	**Session 2: Status of recommendations from last meeting**		**Marguerite Thiam & Jean-Baptiste GUIARD-SCHMID**
10.50 – 11.00am	- WAHO engagement: Dakar Declaration and KP regional TWG	- Carlos Brito	
11.00 – 11.10am	- FSW implementation science TA package (Cameroon, Togo, Burkina Faso)	- Elizabeth Mziray	
11.10 – 11.20 am	- Learning and sharing experience platform (JAIDS, South to South exchange)	- Laurent Kapesa	

Time	Activity	Presenter	Moderator
11.20am – 12 pm	- Clarifications		
12.00 – 1.30pm	**Lunch**		
	Session 3: Approaches to meeting the 90-90-90 goals for KP in WCA		**Johannes Van Dam**
1.30 – 1.40pm	- Understanding the 90-90-90 UNAIDS goals and Minimum package to achieving this goal	- Huge Lago	
1.40 – 1.50pm	- Understanding PEPFAR 3.0 priorities	- Gaston Djomand	
1.50 – 2.00pm	- MSMIT – Key program management guide	- Cameron Wolf	
2.10 – 2.20pm	- Clarifications		
2.20 – 3.20pm	**Increase uptake of HTC among KPs**		**Johannes Van Dam**
2.20 – 2.40pm	- How to reach the most-at-risk and hidden KPs o Social Network o Technology (Social Media, Mobile Phone)	- Nana Fosua Clement - Harvey De Hardt-Kaffils	
2.40 – 3.00pm	- New testing approaches: o Self-testing o PrEP	- Stefan Baral - Gaston Djomand	
3.00 – 3.30pm	- Clarifications		
3.30 – 3.40pm	**Coffee break**		
3.40 – 5.00pm	**Early linkage and retention in care**		**Leo Zekeng**
3.40 – 4.00pm	- What interventions do we need to increase early linkage and retention? o Approaches and Practical ways of reaching and engaging Women in Transactional Sex and Non Brothel/Street Based Female Sex workers o The use of case managers	- Ahmed Issa Bello - Sodji Dometo	
4.00 – 4.40pm	- How to remove barriers that inhibit access to treatment, including addressing: o Gender-based violence o Safety and security o Staff Trained in SW/MSM Sensitivity o FSW engagement in Togo	- Marguerite Thiam - Robert Amoafo - Hortense Me-Tahi - Mensah Tele	
4.40 – 5.00pm	- KP treatment scale-up (test and treat)	- Abdoulaye Wade	
4.00 – 5.30pm	- Clarifications		
6.00 – 7.00pm	**Networking cocktail**		
Time	**Activity**	**Presenter**	**Moderator**
Day 2 – October 28, 2015			
8.15 – 8.30am	Recap of Day 1	Rapporteur	**Prof Coumba**

Time	Activity	Presenter	Moderator
	Roll-out of viral load testing		**Toure Kane**
8.30 – 8.40am	- Challenges and perspectives	- Prof Coumba Toure Kane	
8.40 – 9.00am	**Country experiences** - The Community Based ART Clinics for KPs (One-Stop-Shop to achieve the 90/90/90): Lessons learnt from Nigeria - Ghana experience	- Emmanuel Godwin - Stephen Ayisi-Addo	
9.00 – 9.10am	- How to ensure sustainability	- Wade Abdoulaye	
9.10 – 9.40am	- Clarifications		
9.40 – 9.55am	**Coffee break**		
	Comorbidity in HIV/AIDS		**Stefan Baral**
9.55 – 10.15 am	- Hepatitis C (HCV)	- Mampedi Bogoshi	
10.15 – 10.30am	- Other sexually transmitted infections (herpes, syphilis, gonorrhea, mycoplasma genitalium)	- Camille Anoma	
10:30 – 11.00am	- Clarifications		
11.00am – 12pm	**Panel discussion on country experiences and challenges to meeting the 90-90-90 targets** - Cote d'Ivoire (UNAIDS city approach) - Implementation of the Continuum of Prevention, Care and Treatment in Cameroon - Togo	- Leopold Zekeng - Denis Hynes - Singo Assetina	**Prof Ehui**
12 – 1.00pm	**Lunch**		
1.00 – 1:45 pm	**Working with the Global Fund on the grant implementation**	- Sylvain Parent - Hyeyoung Lim	**Dr Bakouan**
1.45 – 2.45pm	**Panel discussion on Human rights and KP perspective**	- Yves Kugbe, - BADOUBE M. Sydonie, - Tety Josiane	**Djiby Sow**
2.45 – 5.00pm	Field visits	- PACTE-VIH	**Singo Assetina**
9.00 – 11.45pm	Night activities (outreach activity using mobile unit)	- PACTE-VIH	**Hortense Me-Tahi**
Day 3 – October 29, 2015			
8.15 – 9.15am	- Feedback from field visits - Discussion	- Assetina Singo	
9.15 – 10.55am	**Session 4: Measure our Intervention among KP**		
9.15 – 9.25am	- The use of the Unique Identifier Code to document the unduplicated number of KP reached: Does it work?	- Marian Honu - Zakaria Zoungrana	**Sheila Mensah**
9.25 – 9.35am	- Stepped-Wedge design	- Gina Etheredge	
9.35 – 9.45am	- Evidence for Development : Research and Evaluation for	- Jacques Emina	

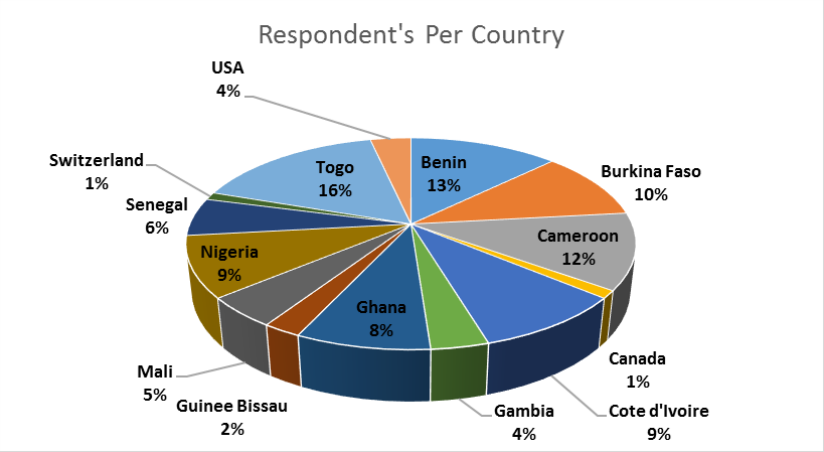
Time	Activity	Presenter	Moderator
	promoting targeted and effective health policies and programs		
9.45 – 10.05am	- Clarification		
10.05 – 10.20am	**Coffee break & Gallery Walk**		**Gina Etheredge**
10.20 – 11.20am	**Panel discussion**	- Sheila Mensah - Stefan Baral - Johannes Van Dam	
11.20 – 12.00pm	**Session 5: Replication and Scale-up**		
11.20 – 12.00pm	- Setting the stage - Clarifications	- Sheila Mensah & Laurent Kapesa	**JP Tchupo**
12.00 – 1.00pm	**Lunch**		
1.00 – 1.40pm	Country experiences in replication and scale-up: - Coordination of Key Population Programs: Lessons from Nigeria - ALCO - Clarifications	- Abiye Kalaiwo - Hugues Guidigbi	**Idrissa Kone**
1.40 – 2.10pm	- Discussions on replication		
2.10 – 2.10pm	- Summary and closing Remarks	USAID & FHI 360	

ANNEX 2:

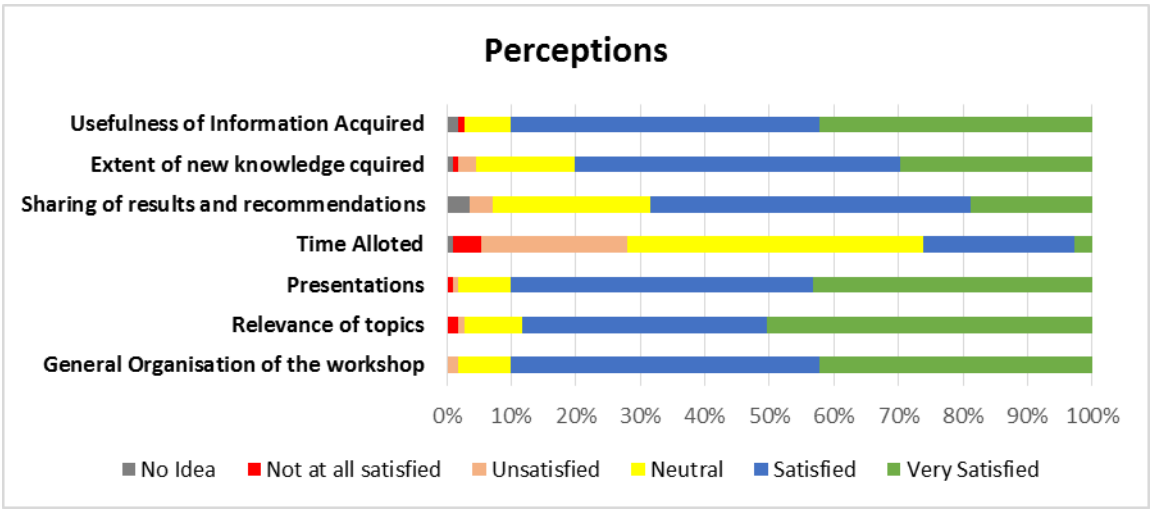
Meeting Evaluation Report

The general organization of the workshop was considered quite successful. 90% of respondents were satisfied with the overall organization of the meeting. 90% expressed satisfaction with the presentation of the topics as well as the usefulness of information acquired at the meeting.

Over 80% acknowledged that the topics discussed at the meeting was relevant to the current trends regarding KP programing and interventions. 80% also expressed satisfaction of having gained new knowledge by attending the meeting. 70% of the respondents were satisfied with the sharing of results and recommendations.



There were mixed responses for the time allocated. Whereas 30% expressed satisfaction of time well allocated, about 40% remained neutral and about 30% more were either not satisfied or had no idea as to time allocation.



ANNEX 3:

List of participants

	Participant	Title	Partner Organization	Country of origin
1	Victoire Sonia FANGNIGBE	Member	BESYP	Benin
2	Michel HOUEGBAN	Peer Educator / PWID	PSI Benin	Benin
3	Justine HOUZANME	CCM Member	ROAFEM/CNCO	Benin
4	Maurice BASSAOU	Communication Officer	SP/CNLS Benin	Benin
5	Dr Ali IMOROU BA CHABI	Coordinator	PNLS Benin	Benin
6	Mabel Agbosu	Présidente	Association Solidarité	Benin
7	Idrissa Kone	Executive Secretary	ALCO	Benin
8	Hugues Serge Guidigbi	Health Specialist	ALCO	Benin
9	Jules Venance Kouassi	Environment Specialist	ALCO	Benin
10	Sylvie Dossou Togbe	Chargée des activités communautaires	PNLS Bénin	Benin
11	Agbodjan Kayissan	Assistant program VIH/SRAJ	UNFPA	Benin
12	Zekeng Patrice	Consultant des Population Clés	Consultant Indépendant	Benin
13	Dr KY André Yolland	Chargé de programme VIH	CNLS-IST, Burkina	Burkina Faso
14	OUEDRAOGO Romain	Chargé de programme HSH	Association African Solidarité	Burkina Faso
15	ZOURE Noël Régis	Chargé de projet FM	IPC/BF	Burkina Faso
16	Dr Carlos Brito	Directeur Dep. Contrôle des Epidemies et des Maladies	WAHO	Burkina Faso
17	Dr Didier Roumuald Bakouan	Permanent Secretary	CNLS-IST, Burkina	Burkina Faso
18	Dr Djénéba Francine KOMPAORE	Head of HIV prevention unit	MOH	Burkina Faso
19	Dr Issouf Konate	Coordinator, Projet Yerelon	Clinique Yerelon	Burkina Faso
20	Pascal Tiendrebeogo	Coordinator	Association African Solidarité	Burkina Faso
21	DINTUI Mariam	FSW	SWAA (AFAFSI)	Burkina Faso
22	Martine SOMDA	Presidente	REVS+	Burkina Faso
23	Jean-Baptiste GUIARD-SCHMID	Director, ICI-Santé	ICI-Santé	Burkina Faso
24	Clotilde Traore	Burkina Coordinator/PACTE-VIH	FHI 360/PACTE-VIH	Burkina Faso
25	Zakaria Zoungrana	Progam Officer/Burkina/PACTE-VIH	FHI 360/PACTE-VIH	Burkina Faso
26	NGOUGO Duplextine Aimé Epse NGUEMNE	M&E	PFM	Cameroon
27	AMBAH Evina Ida Kevin	MSM, CBO Supervisor	Key Population	Cameroon
28	BADOUBE Madeleine Sydonie	FSW, Peer Educator	Key Population	Cameroon
29	Raoul FODJO	CHAMP's Focal Person at the NAC	Ministry of Public Health	Cameroon
30	Jean Paul OSSAMBA ENAMA	Lab technician/psychosocial counsellor	Humanity First Cameroun	Cameroon
31	Carole TOCHE	DIC Manager	Horizons Femmes	Cameroon
32	Denis J. HYNES	Chief of Party	CHAMP/Care Cameroon	Cameroon
33	Halima MOHAMADOU	Regional Coordinator	CHAMP/Care Cameroon	Cameroon
34	Etienne ETOGA	Regional Coordinator	CHAMP/Care Cameroon	Cameroon
35	SALLLA NZIE Annie Michele	Head of HIV unit	PSI Cameroon	Cameroon

36	AHOUAMA ETAMBA VALERIE	BCC Consultant	FHI 360/PACTE-VIH	Cameroon
37	Dr Wognin Kraboué Venance	Head of Department Key Populations	PNLS	Cote d'Ivoire
38	Amani Kouadio Franck Arnaud	MSM Focal point for KP pilot project	Key Population	Cote d'Ivoire
39	N'drin Josiane Anastasie Tety	FSW Focal point for KP pilot project	Key Population	Cote d'Ivoire
40	Dr Camille Anoma	Medical Officer	USAID LINKAGES Project	Cote d'Ivoire
41	Ramata COULIBALY	Strategic Informations Adviser	UNAIDS	Cote d'Ivoire
42	Doumatey Nicole		CDC	Cote d'Ivoire
43	Dr YAO Kouamé Mathurin	Directeur des programmes VIH	PSI Cote d'Ivoire	Cote d'Ivoire
44	Dr Ives Koussan Roland	Coordinateur de programme	Alliance Côte d'Ivoire	Cote d'Ivoire
45	GNAO GBOPO ELVIS JOCELYN	Coordinator	Alliance Côte d'Ivoire	Cote d'Ivoire
46	Dr Esso Yedmel	Strategic Information Officer	Heartland Alliance CI	Cote d'Ivoire
47	Dr Djaki Constant	Clinical Advisor	Heartland Alliance CI	Cote d'Ivoire
48	Dr Thiam-Niangoin Marguerite	HIV regional adviser for West Africa	PALLADIUM	Cote d'Ivoire
49	Prof Eboi Ehui	Medical Officer	FHI 360/PACTE-VIH	Cote d'Ivoire
50	Alpha Khan	Deputy Director	NAS	Gambia
51	Bai Cham	HIV and AIDS Project Manager	AAITG	Gambia
52	Ahmed Jaegan LOUM	Project Coordinator for KPs	World View The Gambia	Gambia
53	Dr Stephen Ayisi-Addo	Ag. Programme Manager	National AIDS Control Program	Ghana
54	Nana Fosua Clement	Project Manager, USAID LINKAGES Ghana	FHI 360	Ghana
55	Robert Amoafo	Technical Advisor/KP Liaison	FHI 360	Ghana
56	Mr Reynolds Afare Asare	Technical Advisor	WAPCAS	Ghana
57	Dr Laurent Kapesa	Senior HIV Advisor/PACTE-VIH AOR	USAID/WA	Ghana
58	Alfred Amoatwo	PACTE-VIH Alternate AOR	USAID/WA	Ghana
59	Sheila Mensah	Senior Communications, M&E Advisor	USAID/WA	Ghana
60	Jacques Emina	M&E	E4D	Ghana
61	Silas Quaye	Strategic Information Advisor	CDC	Ghana
62	Raphael Sackitey	Ag. Projects Manager	Ghana AIDS Commission	Ghana
63	Dr Virginie Ettiegne-Traore	COP/ PACTE-VIH	FHI 360/PACTE-VIH	Ghana
64	Jean-Paul Tchupo	Senior Technical Advisor/DCOP	FHI 360/PACTE-VIH	Ghana
65	Assole Dabire	Associate Director Finance	FHI 360/PACTE-VIH	Ghana
66	Marian Honu	Data Analyst	FHI 360/PACTE-VIH	Ghana
67	Harvey de Hardt-Kaffils	BCC & Advocacy Officer	FHI 360/PACTE-VIH	Ghana
68	Amassi Michelle	Stagiaire	FHI360/ PACTE VIH	Ghana
69	Marie-Gabrielle Onissah	Event Coordinator	FHI 360	Ghana
70	Ndoua Diby Gaston	Freelance Interpreter	Symposia Consult	Ghana
71	Mme TOURE NAGNOUMA	Chef de Département de Communications	CNLS	Guinea
72	Mamadou Gack	Key Population	Association Afrique Arc En Ciel	Guinea
73	Fatoumata Dossou Camara	FSW	Association des Jeunes Filles Dévouées de Taouyah	Guinea
74	Dr Hugues Traoré	Directeur	PSI	Guinea
75	Livramento de Barros	Outreach Director	SNLS	Guinea-Bissau
76	Mme Kátia Ribeiro Barreto	Chargée des Programmes	ENDA Santé	Guinea-Bissau
77	MOUHAMMED DJICÓ OULD AHMED	Executive Secretary	CCM	Guinea-Bissau

78	Souleymane Keita	M&E	SOUTOURA	Mali
79	Mady Gadgigo	Animateur	ARCAD/SIDA-MALI	Mali
80	Dr Bouyagui TRAORE	Director of the HIV/AIDS Unit	MOH	Mali
81	Dr SIDIBE Garangué SOUCKO	Director	SOUTOURA	Mali
82	Madiou Hama Yattara	Health Program Development Specialist	USAID Mali	Mali
83	Mamadou Tieman Doumbia	Director HIV/TB department	PSI Mali	Mali
84	Maiga Rokiatou Diarra	Assistante Responsable Département VIH/TB	PSI Mali	Mali
85	Issa Karimou	KP Representative on CCM	Key Population	Niger
86	Dr Uduak Daniel	Chief Programme Officer, Prev. & SBCC Programme Coordination Department	National Agency for the Control of AIDS (NACA)	Nigeria
87	Abiye Kalaiwo	Program Manager (STP)	USAID Nigeria	Nigeria
88	Isa Iyortim	Manager, KP Project	USAID Nigeria	Nigeria
89	Dr Emmanuel Godwin	Deputy Chief of Party	Heartland Alliance	Nigeria
90	Dr Abang Rogers	Capacity Advisor Heartland Alliance	Heartland Alliance	Nigeria
91	Ms Uduak Nta	SPO	SFH / SHiPS	Nigeria
92	Ahmed Issa Bello	SPO	Society for Family Health	Nigeria
93	Magatte Mbodj	Executive Director	Alliance Nationale de lutte contre le Sida (ANCS)	Senegal
94	Mrs Gabrielle Dieynaba COLL	SE / CNLS	CNLS	Senegal
95	Dr Abdoulaye Sidibé Wade	Medical Officer	DSLI	Senegal
96	Dr Leopold Zekeng	Deputy Director	UNAIDS Regional Support Team for WCA	Senegal
97	Dr Hugues Lago	Senior Advisor Strategic Interventions, KP Treatment & Prevention	UNAIDS Regional Support Team for WCA	Senegal
98	Djiby Sow	Director	ACI	Senegal
99	Pr Coumba TOURE KANE	Département GC&BA-ESP/UCAD	ASLM/Le Dantec Hospital	Senegal
100	Bare Clemence	Adviser	ONUSIDA / DAKAR	Senegal
101	Dr Mampedi Bogoshi	AD. Medical Affairs	GILEAD	South Africa
102	Sylvain Parent	SPO FM Team West Africa	Global Fund	Switzerland
103	Dr. Youssouf Sawadogo	FPM Togo	Global Fund	Switzerland
104	Jean-Thomas Nouboussi	FPM Burkina	Global Fund	Switzerland
105	Hyenyoung Lim	CRG – Human rights team	Global Fund	Switzerland
106	Prof Vincent Pitche	National Coordinator	CNLS-IST, Togo	Togo
107	Damien Kegnide Amoussou	Deputy National Coordinator	CNLS-IST, Togo	Togo
108	Atinedi Gnasse	Communication Officer	CNLS-IST, Togo	Togo
109	Dr SINGO-TOKOFAÏ Assetina	Coordinator	PNLS Togo	Togo
110	Mme Abalo Laure	Responsable de la prise en charge des IST	PNLS Togo	Togo
111	Amedodji Amegnon	Eglise des assemblées de Dieu du Togo	Religious leaders	Togo
112	Dometo Sodji	Director	FAMME	Togo
113	Dr Ephrem Mensah	Director	EVT	Togo
114	Folly Aristide	Chargé de programme PACTE-VIH	EVT	Togo
115	Augustin Dokla	President	RAS+	Togo
116	Télè Mensah	President	Association Femme Amazones (AFAZ)	Togo

117	Wita Akpene	Sex Worker / Secrétaire	Association Femme Amazones (AFAZ)	Togo
118	Yves Kugbe	KP Program Officer	Afrique Arc-en-Ciel	Togo
119	Adadjisso Raymond	MSM Representative at the CCM	MENS	Togo
120	Akou Pignandi	CCM Executive Secretary	CCM	Togo
121	Christophe Sesso Gbeleou	Executive Director	Association Espoir pour Demain	Togo
122	Dr Mouala Christian	Country Director	UNAIDS	Togo
123	Dr Angele Akouavi Maboudou	Strategic Information Advisor	UNAIDS	Togo
124	Dr Jean-François SOME	HIV/AIDS Program Specialist	UNDP	Togo
125	Jeanne Abra Afeli	NPO/HIV/ASRH	UNFPA	Togo
126	Rouguiatou DIALLO	Chief of Party	AgirPF/EngenderHealth	Togo
127	Andre Koalaga	Technical Director	AgirPF/EngenderHealth	Togo
128	Dr Hortense Me-Tahi	Togo Coordinator/PACTE-VIH	FHI 360/PACTE-VIH	Togo
129	Yina Gwatiena	Progam Officer/Togo/PACTE-VIH	FHI 360/PACTE-VIH	Togo
130	Adam Zakillatou	Responsable PEC	PNLS	Togo
131	Aziawo K. Felicien	Conseiller	Men's	Togo
132	Benissan Hugues	President	Club des 7 jours	Togo
133	D'Almeida Stephane	Consultant	PACTE/VIH	Togo
134	Domenya Akofa	Comptable	FAMME	Togo
135	Douamegnon Euloge	Comptable Men's	Men's Togo	Togo
136	Kameti K.M. Habel	Logisticien	EVT	Togo
137	Kelma B. Hidane	Chef d'unité	PNLS- TOGO	Togo
138	Peteyi Eyana	Assistant au suivi strategic	SP/CCM	Togo
139	Salou Mounerou	Pharmacien Biologiste	Biolim CNR VIH/IST	Togo
140	Samarou Izolegnara	Freelance Interpreter	Symposia Consult	Togo
141	Elizabeth Mziray	Operations Officer, Health, Nutrition & Population	World Bank	US
142	Cameron Wolf	Senior HIV/AIDS Advisor for KP	USAID LINKAGES Project	US
143	Dr Djomand Gaston	Medical Officer	CDC Atlanta	US, Atlanta
144	Stefan Baral	Director of Research	JHU	US, Baltimore
145	Johannes Van Dam	Director, Program Sciences	FHI 360/HQ	US, Washington DC
146	Gina Etheredge	Senior Technical Advisor	FHI 360/HQ	US, Washington DC