

MeSH Consortium

Measurement & Surveillance
of HIV Epidemics

Developing, testing & implementing innovative & efficient methods for routine HIV measurement & surveillance

Scientific Symposium Report

Using Routine Data to Address Inequalities that Drive the HIV Epidemic

Victoria Falls, Zimbabwe - March 2023

www.mesh-consortium.org.uk



Statement of purpose

To accelerate progress towards sustainable HIV epidemic control our prevention and treatment programme activities need to be data driven. We need to maximise the potential of data collected through surveillance and service delivery platforms, with an intensified focus on subnational levels and key populations, and through more equitable (rights-based / person-centred), sustainable and epidemiologically robust frameworks and measurement approaches, including community-led monitoring. Through strong attention to data quality and use, and careful analysis and investigation of potential biases, we need to facilitate a shift from using routine data purely for descriptive purposes towards directly informing and improving programme performance.

On 8th and 9th March 2023, an expert group of public health practitioners and community representatives gathered in Victoria Falls, Zimbabwe to identify and discuss innovative and efficient methods for the collection and use of routine data that meet the strategic needs of different countries and communities, and closes the gaps leading to inequalities in our HIV response. The two-day symposium was hosted by the MeSH Consortium.

Through a series of presentations and discussions the expert group considered the following topics:

- Collecting and using data that are inclusive of marginalised/affected communities, whilst addressing the concerns of clients and civil society
- Embedding monitoring, evaluation and research within programme cycles and promoting an approach where programmes drive our research agenda
- Operationalising the prevention and care cascades, together with case surveillance, as epidemiologically robust frameworks that can support a differentiated and prioritised response
- Strategically deploying programme-driven surveys to complement our understanding of prevention, testing, and treatment needs

As identified by the group of experts, in this report we present recommendations for collecting and using routine data to reduce inequalities in our HIV response.

Contents

| | |
|--|----|
| Statement of purpose | 2 |
| Contents | 3 |
| Executive summary..... | 4 |
| Data for communities | 5 |
| Accessibility, sustainability, accuracy & data ownership | 7 |
| Gaps in routine care and data systems..... | 9 |
| A inclusive pathway to strengthening routine HIV data systems..... | 11 |
| Appendix 1: Agenda..... | 14 |
| Appendix 2: Delegate biographies..... | 16 |

Suggested citation: Bourdin S, Hartney T, Jones H, Hargreaves J and Rice BD. Using Routine Data to Address Inequalities that Drive the HIV Epidemic. August 2023. MeSH Consortium, London.

Dr Brian Rice (Director of MeSH Consortium) and Professor James Hargreaves wish to thank Kathie Granger, for organising the Victoria Falls Symposium with support from Rebecca Nyman and Fortunate Machingura, and Sarah Bourdin, Thomas Hartney, Harriet Jones and Tsitsi Ndabambi for acting as rapporteurs.

Executive summary

If we are to achieve sustainable epidemic control in sub-Saharan Africa it is essential we develop, deploy and disseminate innovative and efficient methods to attain equitable, person-centred, epidemiologically robust HIV data and data-frameworks that meet the needs of different countries and communities, and help us track and accelerate HIV incidence declines. During the two-day symposium, the challenges and potential solutions for achieving this were considered and discussed in relation to the four topics presented in our statement of purpose. From these discussions, the Victoria Falls participants identified priorities for action.

Over the course of two days of discussions and presentations, community-led monitoring was a main thread. Community representatives shared how to address community concerns and develop a balanced and inclusive approach to data collection, use and ownership. Examples were given from different countries and projects on developing non-stigmatising and confidential service delivery and data collection. Additionally, it was agreed that understanding each individual's experience of HIV-related service use, and how this may affect retention in care, is crucial.

It was agreed that international and national groups, researchers, and community representatives need to work together in strengthening the use of routine data. There were discussions around what routine data does well (collected over long periods of time, timely, cost-efficient and can provide granular data) and some major challenges (duplication of records, missing data, unknown biases, and challenges with linkage), and how to measure these and strengthen routine data. There was an expressed need for improved longitudinal data and the application of consistent and robust methods and definitions to be able to link and compare data over time and space. There were also strong calls for improved and standardised methods to improve system efficiencies and data accuracy and quality.

Sustainability of data was also a major point, with suggestions of attaining this through localised collection, ownership, creation, and collaboration. Part of sustainability is accessibility of data and research to the community, involving them and prioritising the benefits to them. As data accessibility exists at different levels (local, regional, national, and international), it was agreed that it is important to keep in mind where the data ends up and who has access to it.

Data for communities

The symposium provided a space for community representatives to voice their concerns and be actively involved in strengthening routine data systems and their use. Concerns relating to data driven stigma, discrimination, and too much information being collected on focused groups, were raised.

Speakers discussed how **community-led monitoring can act as an accountability mechanism and be used to close data gaps that can exacerbate bias in monitoring and decision-making**. Involving the community as change agents means shifting who sets priorities and decides what is worthy of research and funding. The focus should be on **collecting data for local change and collective action planning**, where healthcare providers and communities own the data and are invited into research.

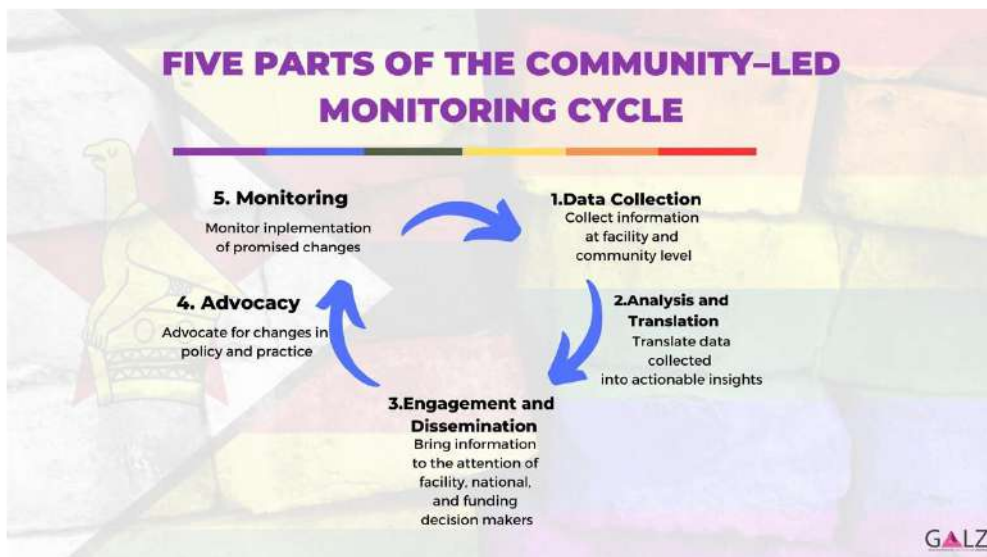
Throughout the symposium discussions focused on mechanisms for working toward community leadership in data collection, analysis and use. At the clinic level, many individuals may feel more comfortable working with those who understand their experiences, and who they can consult without fear of being judged or shamed. This is especially true for populations who regularly face stigma and discrimination, such as members of the LGBTQ+ community and sex workers.

Fears and mistrust around the data being collected were aired, including concerns pertaining to information often being utilised without the community seeing the benefits, and the potential for intimate information being leaked or becoming public. Unique identifiers were raised as an issue, as individuals may not feel safe providing identifiable information resulting in false information being provided, which it turn can lead to challenges in data linkage and false conclusions relating to continuity of service engagement. Some community representatives reported individuals feeling coerced to give information – this highlights the need to build and maintain trust and establish confidential safe spaces.

Suggestions to address such issues included working with community leaders, using confidential social media platforms, building educational awareness and community capacity, and training community members to collect data (for example, such as in microplanning). We need to consider why we are collecting data, who has access to it, how it is stored and who benefits from it. Beyond

data collection, the community should be involved in analysing and translating data into actionable responses at the local and national level, including advocacy for changes in policy and practice and monitoring. A couple of models for promoting community-led monitoring were shared (see figure 1)

Figure 1: Community-led monitoring models presented by Samuel Matsikure (GALZ) and Solange Baptiste (ITPC).



ITPC's Community-led Monitoring Model



Accessibility, sustainability, accuracy & data ownership

Improving data collection and accessibility requires involving localised creation, collection, and ownership of data as well as governance of health systems. Where data exists locally, and/or is being collected by national governments, it may not be accessible to the community. Where there is a collective desire to share data more widely, the resources for data management and curation may be lacking. Awareness of the existence of data and its potential to inform change is often sub-optimal, meaning that similar information may be repeatedly collected rather than utilising already existing data or sources.

In promoting data sustainability, we need data that are comparable through consistent definitions, populations and methods. Barriers to achieving this include funding constraints, data collection methods that are not context specific, local or national government regulations. There is a paucity of data on certain populations, especially prison populations in sub-Saharan Africa and a lack of accurate population size estimates (PSEs) for stigmatised and criminalised groups to inform local programme planning. The UNAIDS country-led HIV estimates process among the general population has a strong country data collaboration and ownership, and they are looking to replicate this with KP estimates.

Governments, community and international groups need to work together to improve data systems. In Mozambique, the government has been working with community groups to plan, implement, analyse and disseminate bio-behavioural surveys. The data generated by this partnership, and the co-ownership of the data, has led to additional key population-led studies being conducted and improved community involvement and engagement, particularly in relation to advocacy. It has highlighted the need to diversify funding sources to address high-dependence on international donor organisations.

Figure 2: Recommendations for strengthening HIV surveillance among key and priority populations using collaborative approaches. Presentations by Makini Boothe (UNAIDS Mozambique) and Jeff Eaton (Imperial College London).

Recommendations

1. **Overlapping vulnerabilities** of key populations must be further explored to effectively design targeted prevention and treatment services, free from stigma and discrimination.
2. **Improved service delivery and programming** adapted to the realities of key populations.
3. Behavioral and structural interventions are needed that encourage **participatory engagement** in the design, implementation and monitoring of prevention and treatment services.



**LEAVE
NO ONE
BEHIND**



1

Imperial College
London

Country-led HIV estimates process



Gaps in routine care and data systems

Discussions covered experiences in finding and describing data gaps and applying novel approaches, including programme-driven surveys, case surveillance and modelling, to understand data needs.

Routine data have been used to inform estimates of HIV incidence and prevalence. Developing a minimum dataset structure can be used to strengthen case surveillance, longitudinal monitoring and integrated disease surveillance. As no single data source captures all information of interest and/or all people of interest (for example, individuals not regularly attending healthcare services), triangulation with other data sources, including programme-driven surveys and model outputs, can lead to improved patient management, service delivery and programme performance.

Bio-behavioural surveys and venue-based data collection can strengthen HIV surveillance, particularly among key populations and other groups missed by clinical-based data collections. Members of key populations can play a key role in this, as both peer educators and co-investigators. These can illustrate inequalities and intersecting vulnerabilities, that can perpetuate both HIV risk and other negative outcomes – considering these in the causal pathway can help to identify prevention gaps and inform locally-driven decisions.

Other potential opportunities for data collection improvement include incorporating data from an increasing diversity of settings, including pharmacies and workplaces. Community workers can leverage digital technology and independent systems to track events like treatment stock-outs, but this will involve thinking about how to capture heterogeneous data via dedicated software or structured forms, while maintaining transparency and anonymity.

A topic that emerged from discussions was the need for a whole-person centred data environment (see Figure 3 below), not just focused on HIV and HIV-related outcomes but also building monitoring systems for chronic comorbidities, co-infections and well-being. This requires stronger person-centred, longitudinal monitoring to retain and re-engage people and to link people to TB, sexually transmitted infections, viral hepatitis and other health services. It also requires thought as to how such a broadened data environment can be compatible with the need for more nuanced HIV-focused strategic information.

There should be an emphasis on the importance of developing and strengthening programmatic data collection systems, to ensure useful information is being collected in a sensitive and safe way. Also on the importance of investing in these systems to make sure they are easy to implement, and reliable and robust and, critically, that they are developed in partnership with communities.

Community organisations and programs that provide services should be supported to develop these systems and ensure that data from these programs are considered credible/valid and are incorporated into other data systems and statistics. The development of digital data systems represents a great opportunity to understand key populations and to enhance services - but also comes with risks. These systems need to be developed sensitively and in partnership with community and for community, and individuals, to have ownership of their own data.

Monitoring retention in care can incorporate client satisfaction with health service provision – interpersonal interactions are important, and patients are often willing to travel to see healthcare professionals who they trust. Human-centred design approaches can inform approaches that address negative patient experiences, through training and coaching, gathering data on patient experiences and providing facility-level incentives.

Figure 3: Person-centred guidelines for moving towards plugging gaps in HIV routine data. Presentation by Shona Dalal & Bradley Mathers (WHO).

New HIV strategic information guidelines to respond to current & future data needs

As countries work to reach the 95–95–95 HIV targets 3 strategic information priorities will be essential:

1. **A greater focus on impact**, with more individual, granular data to fill gaps with a stronger results chain linking services to reduced incidence and mortality.
2. **Building HIV monitoring systems for chronic health care** as people remain on treatment for life. This requires stronger person-centred, longitudinal monitoring to retain and re-engage people and to link people to TB STIs, viral hepatitis and other health services.
3. **Digitization of health data** makes the interconnection of different data sources possible for improved patient management, service delivery and programme performance.



A inclusive pathway to strengthening routine HIV data systems

A topic of discussion that was raised on a number of occasions was how to balance the desire for more linked, granular and individual-level data with the concerns and interests of communities. Researchers and policy makers must consider how to balance the different levels of data needed for routine surveillance and prevention/treatment purposes (e.g. for recording risk category based on route of transmission or dynamically). Routine data may need to be validated with biomarkers from bio-behavioural surveys. Populating cyclical HIV prevention and treatment cascades can help to understand patterns of retention and follow up, and identify trends in these over time which suggest potential actions to be taken.

The digitisation of health data and increasing use of data repositories makes the interconnection of different data sources possible for improved patient management, service delivery and programme performance. Interoperability and comparability are key in data sharing. Having a common and agreed upon smaller set of core indicators for programme management & monitoring in specific regions or globally is a step in the right direction. Care must be taken to integrate both donor indicators and relevant community-defined indicators in data collection.

Moving away from reliance on external funding and towards sustainable local and regional funding is another step, however this is not always feasible. Diversifying funding sources will begin to address the high-dependence on international donor organisations. Collaborating locally with the population and government, and between groups allows data to be collected and used in a way that is efficient and purposeful. When priorities are determined with end-users as active participants in the process, the concerns of the communities can be mitigated while maintaining trust and putting in place targeted actions for real change. Relationships built over time bring sustainable change when data is transformed into action.

Figure 4: Challenges that remain in integrating community-led monitoring into data collection, ownership and use. Presentation by Solange Baptiste (ITPC).

Challenges and Questions

- Varying nature of what is being scaled in CLM:
 - Conflate other critical community -led initiatives with CLM
 - Need for tighter national and global CLM coordination and harmonization
 - Aspects of CLM not resolved (data ownership, ethics considerations etc.)
- The need to accommodate donor indicators while maintaining relevant community defined ones when the don't overlap
- Sustainability concerns:
 - Heavy reliance on external funding; Not yet refined value proposition for governments to take up paying for CLM; Weaker (or no real) community ownership where governments are more authoritarian.
- Low levels of investment and a thin research agenda on aspects of CLM required to make it a core discipline:
 - How much monitoring is enough?
 - What does effective monitoring cost?
 - Who is best placed to implement and/or host CLM?
 - To what extent is the monitoring the intervention for CLM?
 - Should CLM be embedded routinely in national M&E data? What would the challenges be?
 - What set of indicators would be useful to have routine community data on?



Improved but still sceptical view of community role beyond advocacy and demand creation leading to undervaluing of community data and by extension CLM

**Thank you to all who contributed to the
Victoria Falls symposium!**



Appendix 1: Agenda

Day 1 – Wednesday 8th March 2023

- 8:30am Registration & coffee
- 9:00am **Aims of the meeting & introductions – Brian Rice**
- 9:30am **Welcome / Mauya / Siyalemukela – Getrude Ncube, Zimbabwe MoHCC**
- 9:45am **Keynote presentation: Addressing inequalities through routine community data: a look into community-led monitoring – Solange Baptiste**
- 10:15am Coffee break
- 10:30am **Session 1: Building confidence in data through community-led monitoring**
Chairs: Fortunate Machingura & George Rutherford
- Community & client perspectives on how data inclusive of marginalised/affected communities should be collected & used, and the mechanisms for community-led data activities - Martha Antonio, Tsitsi Ndabambi, Samuel Matsikure (60 mins)
 - Questions & discussion - lead discussant George Rutherford (30 mins)
- 12:00pm Lunch
- 1:00pm **Session 2: Incorporating key population data in programme improvement**
Chairs: Frances Cowan & Tungamirirai Simbini
- Advancing person-centred program data to identify service gaps and guide programming - Shona Dalal & Bradley Mathers (25 mins)
 - Incorporating disaggregation in our modelling activities to identify and address characteristics that lead to inequalities - Leigh Johnson & Jeff Eaton (25 mins)
 - Identifying and responding to new infections among female sex workers accessing the Sisters programme in Zimbabwe: Challenges and Opportunities - Fortunate Machingura, Galven Maringwa & Harriet Jones (30 mins)
 - Questions & discussion (15 mins)
- 2:35pm Coffee break
- 2:45pm **Session 3: Birds of a feather – topic specific table discussions on how data can address inequalities (50 mins) & feedback (25 mins)**
- Recommendations, & identify topics for day two open-mic session
- 4.00pm **Wrap up/learnings from the day – lead rapporteur Sarah Bourdin (10 mins)**
- 4.15pm *Sunset cruise before dinner (to be ready at shuttle 4.20pm)*

Day 2 – Thursday 9th March 2023

9:15am Recap of Day 1 & Introduction to Day 2 – James Hargreaves

9:35am **Opening day address by Mary Mahy**

9:50am **Session 4: Building blocks of a person-centred & equitable data environment**

Chairs: Stanley Luchters & Nisha Jacob

- Consistency of definitions, study design and analyses among key populations – Lucy Platt, Thomas Hartney & Oliver Stevens (30 mins)
- Learnings from routinely collected data in Zambia - Kombatende Sikombe (20 mins)
- Strengthening HIV surveillance among key and priority populations in Mozambique – Mikini Boothe (20 mins)

11:00am *Coffee break*

11:20am **Session 4 cont.**

- An iterative approach to service delivery driven by local leaders: the Blantyre Prevention Strategy – Stanley Kalyati & Dylan Green (30 mins)
- What can community cohort studies tell us about strengthening routine data? – Emma Slaymaker (20 mins)
- Exploring the socio-behavioural factors that drive the spatial heterogeneity of HIV in SSA – Olivia Keiser (20 mins)
- Questions & discussion (30 mins)

1:00pm *Lunch*

2:00pm **Session 5: Understanding and addressing gaps and biases in our data response**

Chairs: Stone Mbiriyawanda & Raymond Yekeye

- Capturing non-linear care pathways in the Western Cape - Vanessa Timmerman & Andrew Boule (30 mins)
- Results from an enhanced venue-based testing protocol in Blantyre, Malawi - Emmanuel Singogo & Sharon Weir (30 mins)
- Questions & discussion (20 mins)

3:20pm *Coffee break*

3:40pm **Open mic session (3x15 mins slide free) & consensus statement (Michelle Morrison)**

4:45pm **Wrap up & thank-you – Brian Rice**

Appendix 2: Delegate biographies



Andrew Boule (He/Him)

andrew.boule@uct.ac.za

Professor Andrew Boule is a public health physician with the health department in the Western Cape Province of South Africa, and the University of Cape Town School of Public Health. His work focuses on HIV cohorts, routine health information systems, and more recently on the use of routine person-level health data for patient care, service improvement and addressing epidemiological and health service questions.



Audrey Mushonga (She/Her)

audreymushonga@gmail.com

Audrey Mushonga is holder of a BA Honours degree in History and Development Studies trying to further her studies. She has a keen interest in studying public health, GBV issues and children issues as this will go a long way in helping the sex worker community. She is a member of the AMETHIST Community Advisory Board and joined CeSHHAR Zimbabwe in 2017 as a volunteer microplanner working as a bridge between the clinic and her peers. She is currently working with the sex worker community, making sure that they have access to HIV prevention packages.



Bradley Mathers (He/Him)

mathersb@who.int

Dr Bradley Mathers is a consultant to the WHO, focusing on strategic information among key populations. He has recently been involved in the development of simplified bio-behavioural surveillance methodologies for key populations, and development of guidance on the collection and use of individual-level program data on HIV prevention interventions.



Brian Rice (He/Him)

brian.rice@lshtm.ac.uk

Dr Brian Rice is an Epidemiologist with over 20 years of experience in developing methods that strengthen the infrastructure of public health HIV surveillance platforms and improve the collection of high-quality data. Brian is currently PI/co-PI on two data-focused consortia at LSHTM (MeSH & SDG-HaW), sits on UNAIDS and WHO advisory groups, and is the co-director of the LSHTM Centre for Evaluation.



Chris Seebregts (He/Him)

chris@jembi.org

Dr Chris Seebregts is a digital health and informatics professional with a background in biomedical research, computer science and information systems and over twenty years of experience in developing digital health solutions. He is the founder, CEO and Executive Director of Jembi Health Systems NPC, a South African non-profit company, and an accomplished track record in developing and implementing innovative health information systems in low-resource settings in Africa. He has established health informatics academic and training programmes and initiated several international open-source digital health and informatics communities.



Dylan Green (He/Him)

dylan@coopersmith.org

Dylan Green's recent portfolio of work has focused on the use of both novel and routine HIV data for epidemiological inferences in Zambia and Malawi. He has also researched the impact and cost-effectiveness of HIV prevention interventions among key populations in Thailand and Viet Nam. He supports the development of an HIV data pipeline and dashboard in Blantyre, Malawi. Finally, he has participated in a technical working group charged with the development of guidelines for the ethical use of machine learning and big data for HIV in Africa.



Edwin Sibanda (He/Him)

edmzingwane@gmail.com

Dr Edwin Sibanda has been employed as director city health City of Bulawayo since 2017. He is responsible for overall management of health issues in the city including environmental health issues as well as disease outbreak prevention, detection and control. On TH/HIV responsible for a cohort on ART numbering close to 70000, with at least 2000 on second line. TB notification rate of 1500 annually. He sits in two university councils.



Emma Slaymaker (She/Her)

emma.slaymaker@lshtm.ac.uk




Dr Emma Slaymaker is an epidemiologist but has worked for so long with demographers that the disciplinary boundaries are rather blurred. She works on HIV and sexual behaviour, mainly in African populations, using survey and demographic surveillance data. A major part of her work is with the ALPHA Network, which brings together the sub-Saharan African longitudinal population-based studies with data on HIV. She has recently been looking at trends in incidence and risk factors for new infections in these studies and has a longstanding interest in methods to improve data management and sharing.



Emmanuel Singogo (He/Him)

esingogo@unclilongwe.org

Dr Emmanuel Singogo is a Medical Statistician with more than 10 years of experience managing large research portfolio at national-level and multidisciplinary research teams in Malawi. He has worked in programs, clinical trials, epidemiological and implementation science studies for different diseases including HIV, TB, maternal, child & adolescent health, cervical cancer, non-communicable diseases (hypertension and diabetes), and laboratory diagnostics. He has research interests in spatial epidemiology and disease mapping for HIV/AIDS, MNCH, transfusion medicine and NCDs.

| | |
|---|---|
|  | <p><u>Fortunate Machingura (She/Her)</u></p> <p>fmachingura@ceshhar.co.zw</p> <p>Dr Fortunate Machingura is a development anthropologist of Southern Africa with over 17 years' experience undertaking research, evaluation, and programming to increase coverage and uptake of health services. Dr Machingura joined CeSHHAR in 2020, bringing a wealth of experience working with communities, key populations, donors, governments, universities, and NGOs in Africa. She leads a Southern Africa Key Populations research agenda in direct collaborations with the University of Oxford, LSHTM and LSTM.</p> |
|  | <p><u>Frances Cowan (She/Her)</u></p> <p>frances.cowan@lstmed.ac.uk</p> <p>Professor Frances Cowan is a clinical epidemiologist and Professor of Global Health at LSTM. Since 1999 she has lived and worked full time in Zimbabwe where she established a broad portfolio of HIV and sexual and reproductive health implementation research focusing on marginalized and vulnerable populations including sex workers in their diversity, adolescents and high-risk men. She is PI of the Wellcome Trust funded AMETHIST Consortium and of the MeSH Consortium in Zimbabwe.</p> |
|  | <p><u>Galven Maringwa (He/Him)</u></p> <p>galven@ceshhar.co.zw</p> <p>Galven Maringwa is a Research Statistician at CeSHHAR under the MeSH Consortium. He is currently analysing the Longitudinal Coital diary data and Recent Infection Testing Algorithm (RITA) data to understand the HIV epidemic and impact of prevention & treatment interventions. He is also analysing PLACE survey data to understand the drivers of local HIV epidemics, identify gaps in services, and provide evidence to support tailored interventions. He is currently pursuing his PhD in Global Health with Liverpool School of Tropical Medicine (LSTM) characterizing male sexual partners and partnerships among female sex workers (FSW) in Zimbabwe.</p> |



Gary Murphy (He/Him)

garymurphy200@gmail.com

Dr Gary Murphy's PhD was the first to describe the confounding factors and improved estimation of HIV incidence in target populations through the use of serological assays. He has over 30 years of laboratory experience and has had an interest in laboratory methods for determining recent infections for 25 of them. He was the principal investigator of the 1st Consortium for the Performance and Evaluation of HIV Incidence Assays (CEPHIA) grant, which performed the first independent evaluation of candidate HIV incidence assays and developed the methodology for the evaluation of future assays. Gary has worked closely with WHO and other groups to further the application and implementation of HIV recency assays.



George Rutherford (He/Him)

george.rutherford@ucsf.edu

Prof George Rutherford, M.D., is Professor of Epidemiology, Preventive Medicine, Pediatrics and History at University of California San Francisco. His work focuses on the epidemiology and control of communicable disease and his current academic interest is HIV and other epidemic-prone diseases in low- and middle-income countries. He has held positions in public health agencies and is an advisor to the World Health Organization. He is currently an Honorary Professor in the Department of Public Health, Environments and Society at the London School of Hygiene and Tropical Medicine for the 2022-23 academic year.



Gertrude Ncube (She/Her)

getrudencube@yahoo.co.uk

Gertrude Ncube is the National HIV Prevention Coordinator at the Ministry of Health and Child Care Zimbabwe. She coordinates and provides leadership, guidance, and technical support for Zimbabwe's full range of comprehensive HIV prevention strategies.



Harriet Jones (She/Her)

harriet.jones@lshtm.ac.uk

Harriet Jones is a PhD student at LSHTM and Research Fellow for the MeSH Consortium. For her PhD, Harriet works with the Centre for Sexual Health and HIV/AIDS Research (CeSHHAR) in Zimbabwe, analysing data from the Sisters programme to understand trends over time in HIV testing and seroconversion. She supports the work of the MeSH consortium in Malawi and Zimbabwe. Harriet has degrees in public health and epidemiology and over 10 years' experience working in the international development sector, primarily focusing on the monitoring, evaluation and development of HIV programmes.



James Hargreaves (He/Him)

james.hargreaves@lshtm.ac.uk

Professor James Hargreaves is a Professor of Epidemiology and Evaluation at LSHTM. He is interested in HIV epidemiology, health inequalities, programme evaluation.



Jasper Maguma (He/Him)

jasper.maguma@ceshhar.co.zw

Jasper Maguma is a Biostatistician with strong analytical skills which have been strengthened by his experience in data management of various projects. He has experience collecting and analysing both quantitative and qualitative data using various data collection tools. Besides his technical skills he also has excellent leadership and management skills. In his role with CeSHHAR he has taken on a number of project coordination roles. Most recently he coordinated the PLACE (Priorities for Local AIDS Control Efforts) Zimbabwe surveys to understand risk at venues and led 34 teams in 4 provinces of Zimbabwe, supporting the PI with extensive stakeholder engagement. In 2021, for the AMETHIST trial he assisted in the design of a discreet choice experiment, piloting of a questionnaire, management of samples and coordination of survey teams implementing the endline survey using respondent driven sampling.



Jeffrey Eaton (He/Him)

jeffrey.eaton@imperial.ac.uk

Dr Jeffrey Eaton is a Reader in Epidemiology, Demography, and Applied Statistics at Imperial College London. He co-chairs the UNAIDS Reference Group on Estimates, Modelling and Projections. His research involves developing new mathematical models, statistical methods and surveillance tools to characterize HIV epidemic trends, transmission dynamics and the demographic impacts of HIV in sub-Saharan Africa. His team within the MRC Centre for Global Infectious Disease Analysis at Imperial College London develops software tools used by national HIV programmes to produce national and subnational epidemiologic estimates to guide their response to national HIV epidemics.



Kathie Granger (She/Her)

kathie.granger@lshtm.ac.uk

Kat Granger is the Project Manager for the MeSH Consortium. She maintains responsibility for the overall strategic management and financial control of all budgets and administration for the project. Playing a key role within the MeSH Secretariat ensuring the consortium functions as a cohesive unit she provides information and direction of the consortium to help achieve the overall goal of the project.



Kombatende Sikombe (He/Him)

kombatende.sikombe@lshtm.ac.uk

Kombatende Sikombe conducts research in Implementation Science of HIV public health programs at the Center for Infectious Disease Research in Zambia (CIDRZ). Komba previously led the "Better Information for Health in Zambia," project in 32 facilities across 4 provinces in Zambia and the Person Centered Care study in Zambia that trained providers to be more person centered using while using client experience data to drive quality improvement decisions with the ultimate goal of improving retention in care. He is currently pursuing a PhD with the London School of Hygiene and Tropical Medicine with a focus on quality of HIV services.



Leigh Johnson (He/Him)

leigh.johnson@uct.ac.za

Dr Leigh Johnson is an epidemiologist and modeller at the University of Cape Town. His particular interests are in HIV, tuberculosis and STIs, and more recently he has led work on the intersection between these infectious diseases and non-communicable diseases. His recent work focuses on the social determinants of HIV and other diseases, and quantifying the impact of structural interventions. He leads the development of the Thembisa model, an integrated HIV, TB and demographic model that is used to inform health policy in South Africa.



Leslie Nyoni (He/Him)

leslie.nyoni@ceshhar.co.zw

Leslie Nyoni is a research assistant at the Centre for Sexual Health HIV and AIDs Research (CeSHHAR) Zimbabwe since 2022. He is responsible for organising a national stakeholder feedback forum, coordinating field teams, training team members, organising the technical working group discussions for the PLACE study in Harare and analysing, interpreting and presenting data from PLACE Study.



Lucy Platt (She/Her)

lucy.platt@lshtm.ac.uk

Professor Lucy Platt started her career developing approaches to monitor HIV among people who inject drugs and sell sex. Now, her research has extended to include a broad definition of health including sexual and mental health, violence, access to services alongside HIV and to evaluate how social and health policies and interventions affect these health conditions among vulnerable populations. She is an epidemiologist, applying different quantitative techniques to estimate population sizes to measure the health status of these populations and evaluate social policies and complex interventions. She works closely with sociologists applying qualitative methods alongside quantitative approaches to understand the pathways through which these effects are realised.



Maganizo Chagomerana (He/Him)

mchagomerana@unclilongwe.org

Dr Maganizo Chagomerana is an Assistant Professor in the Department of Medicine at University of North Carolina (UNC) at Chapel Hill and the Director of the Analysis and Manuscript unit at University of North Carolina Project–Malawi. He obtained his MSc in Biostatistics from Harvard T.H. Chan School of Public Health and PhD in Epidemiology from UNC at Chapel Hill. Dr. Chagomerana was the HPTN International Scholar for 2018–2019 and a fellow at ACTG Statistical and Data Analysis Center, Harvard TH Chan School of Public Health in 2019–2020. Dr. Chagomerana served as a Data Core Leader and Biostatistician at Kamuzu University of Health Sciences. Dr. Chagomerana’s research interests include epidemiologic methods, HIV prevention, and epidemiology of HIV-related malignancies.



Makini Boothe (She/Her)

boothem@unaids.org

Dr Makini Boothe, PhD MPH is the Strategic Information Advisor at UNAIDS in Mozambique. She is an Epidemiologist with over 10 years’ experience in program management, data analysis and HIV strategic information. She has technical expertise in HIV/AIDS, TB, women’s, adolescent and key populations health, community mobilization, social network analysis, disease modelling, data triangulation, financial sustainability analysis, and training/capacity-building.



Martha Nalitye Antonio (She/Her)

nalitye1994@gmail.com

Martha N. Antonio is a 29 year old young women from Namibia born and living with HIV. Martha is currently a volunteer at Young Women Empowerment Network (YWEN), which aims at improving the living conditions of young women living with HIV, by claiming their sexual and reproductive health and rights. Through YWEN she works with adolescents girls on an initiative of sanitary pads which aim to keep a girl child in school. Martha is currently a nurse graduate.



Mary Mahy (She/Her)

mahym@unaids.org

Dr Mary Mahy has over 22 years of experience using data to transform the HIV response and is the current UNAIDS Director for the Data for Impact Practice. Through the DFI Practice, she promotes the goal of ensuring that countries use data to improve their HIV response and ultimately end AIDS as a public health by 2030. Mary has played a pivotal role in ensuring programme managers, leaders, and donors have information about how the HIV epidemic affects our world. She is also passionate about unpacking the impact of HIV on children and has contributed to the understanding of causes of vertical transmission and the worsening inequality gap in HIV treatment coverage for children.



Michelle Morrison (She/Her)

michelle.morrison@gatesfoundation.org

Michelle Morrison is a Program Officer, HIV Epidemiology and Surveillance, in the Global Health Program of the Bill & Melinda Gates Foundation. Since she joined the foundation in November 2012, Ms. Morrison has concentrated on strategy development and managed investments focusing on developing tools and methods for understanding HIV incidence, as well as acquisition and transmission risk. In addition, she is interested in understanding what facilitates better use of epidemiological and risk data in policy and program decisions.



Mina Hosseinipour (She/Her)

mina_hosseinipour@med.unc.edu

Dr Mina Hosseinipour is the Scientific Director of UNC Project Malawi and Professor of Medicine at the University of North Carolina at Chapel Hill. She has lived and work in Malawi since 2001 with a broad HIV treatment and prevention research focus. She is the co-chair of the landmark clinical trial that demonstrated superiority of Injectable Cabotegravir every 2 months over daily oral PrEP with TDF/FTC.



Nisha Jacob (She/Her)

nisha.jacob@uct.ac.za

Dr Nisha Jacob is a public health physician and PhD student at the University of Cape Town. She has worked in clinical, managerial and research settings in South Africa. Her work centres around strengthening health surveillance in the Western Cape province using routine data sources, most recently evaluating the feasibility, validity and utility of HIV testing data as key components of HIV case-based surveillance. Her other interests include non-communicable diseases and child health. She is also actively involved in undergraduate and postgraduate public health education.



Oli Stevens (He/Him)

o.stevens@imperial.ac.uk

Oli Stevens' work focuses on the HIV epidemic in Mozambique, and antenatal clinic data and key populations throughout sub-Saharan Africa. He has recently collated data on key population size, HIV prevalence, and ART coverage in SSA from 2010-2022, and produced extrapolated estimates for all countries in the region (Key population size, HIV prevalence, and ART coverage in sub-Saharan Africa: systematic collation and synthesis of survey data).



Olivia Keiser (She/Her)

olivia.keiser@unige.ch

Professor Olivia Keiser is an Assistant Professor of Epidemiology at the University of Geneva and the Director of the GRAPH Network. She is also the Head of the Infectious Diseases and Mathematical Modelling Division where her group takes an interdisciplinary research approach by combining mathematical modelling, analyses of cohort data, data- and text mining, systematic reviews, and qualitative research techniques. Predominant areas of focus include HIV, tuberculosis, and COVID-19. International collaboration are at the center of the group's activities with the overall goal of building capacity in low and middle income countries.



Prosper Chonzi (He/Him)

prochonzi@gmail.com

Dr Prosper Chonzi has been with the city of Harare for 21 years working in the department of health services and took the directorship of the department in 2004. He has tremendously transformed the health service delivery system of the city and has enhanced primary health care. The city has gone through several episodes of diseases outbreaks like cholera and typhoid and always came out victorious. He has also established key population clinics including commercial sex workers clinic in the city. He participated as a national response lead in major outbreaks like Ebola and the recent Covid-19 with success. He also undertook consultancy work for big and international organizations like WHO for various epidemics.



Raymond Yekeye (He/Him)

ryekeye@nac.org.zw

Raymond Yekeye is the Director for Programs with the National AIDS Council of Zimbabwe. He has over 20 years' experience in the HIV and AIDS programming and his expertise includes programme design, implementation, monitoring and evaluation as well as research. Previously he has also served on a number of global and regional platforms and worked in the Ministry of Health at District and Provincial focusing on Health Promotion and Public Health.



Samuel Matsikure (He/Him)

progs@galz.co

Samuel Matsikure is a Human Rights Activist and Programmes Manager at GALZ an LBGTI Association in Zimbabwe. He has vast experience in program management, policy, human rights and sexual and reproductive health. He is also a counsellor with great experience working with individuals, groups, couples and families. He specialises in sex and sexuality, relationships and marital issues.



Sarah Bourdin (She/Her)

sarah.bourdin@lshtm.ac.uk

Sarah Bourdin has a background in sexual and reproductive health and rights in the UK and Southern & West Africa. She joined the MeSH Consortium at LSHTM in 2021, and her current work includes analysing and writing up a qualitative exploration of participants' experience of recency testing with CeSHHAR, collaborating with UNC Project-Malawi on utilising blood donation data for understanding HIV & syphilis epidemiology in Blantyre, piloting the PLACE study in Zimbabwe. She also leads the dissemination and knowledge translation activities of the Consortium.



Sharon Weir (She/Her)

sharon_weir@unc.edu

Dr Sharon Weir is an epidemiologist at the University of North Carolina. She is the UNC Co-PI for the MeSH Consortium and served as a PI in the first MeSH Consortium. Weir focuses on epidemiologic research to identify and characterize local sexual and injecting drug use networks. She aims to improve strategies that lead to effective, ethical, and evidence-based prevention programming. Weir developed and piloted the Priorities for Local AIDS Control Efforts (PLACE) method in South Africa in 1999 to identify where to reach persons most at risk of acquiring and transmitted HIV. Weir has collaborated with UNAIDS and the World Health Organization since 2009.



Shona Dalal (She/Her)

Shona Dalal is an epidemiologist and the Technical Officer for Surveillance at the WHO's Department of Global HIV, Hepatitis and STIs Programmes. She also leads the department's work on HIV and cervical cancer. Shona has developed global guidance on HIV testing and prevention including partner notification and PrEP, on HIV strategic information, and on cervical cancer vaccination, screening and treatment. She coordinates the development of digital HIV tools and SMART Guidelines. Her past work includes conducting population-based surveys and implementation research in a number of countries



Solange Baptiste (She/Her)

sbaptiste@itpcglobal.org

Solange Baptiste is Executive Director of the International Treatment Preparedness Coalition (ITPC). She leads community activists and allies to deliver ITPC's mission to enable people in need to access optimal and affordable HIV treatment through health education, demand creation, community-led monitoring and interventions to make medicines more affordable. Solange has over 17 years of global program management and advocacy experience and specializes in monitoring and evaluation. Solange is member of various technical working and advisory groups.



Stanley Kalyati (He/Him)

skalyati@pakachere.org

Stanley Kalyati is the Monitoring & Evaluation Director at Pakachere Institute for Health and Development with over 10 years of experience in the field. He provides strategic direction in monitoring and evaluation and leading the development and implementation of the program's MEL framework and plan. He has also led technical design and development of data collection, analysis, and visualization systems for local partners and has strengthened partners' capacity to analyze and use data for decision-making, conducting training on data collection, and monitoring interventions.



Stanley Luchters (He/Him)

stanley.luchters@ceshhar.co.zw

Professor Stanley Luchters is a Professor in Population Health and Environment at LSTM, and the Executive Director at CeSHHAR Zimbabwe. With over 20 years working in medical and population health research, as well as program implementation in various low- and middle-income countries. He has particular expertise in the design, conduct, management and analysis of clinical, behavioural, and health systems interventions that have a population health impact. Since 2019, he has made the work around the impacts of climate change on health a priority topic.



Stone Mbiriyawanda (He/Him)

smbiriyawanda@hivmw.org

Stone Mbiriyawanda is a statistician at the Department of HIV and AIDS at the Ministry of Health Malawi since 2014. He has been working with the Ministry of Health and National Statistical Office Malawi for about 20 years.



Sungai Chabata (He/Him)

sungai@ceshhar.co.zw

Sungai Chabata is a statistician at CeSHHAR Zimbabwe, and is currently finalising his PhD with Erasmus Medical Center where he is characterising HIV risk and exploring strategies for HIV control among young women who sell sex in Zimbabwe. His interests are HIV prevention and care among vulnerable populations, and using behavioural sciences to improve HIV programmes and health services. At CeSHHAR, he is involved in conducting evaluations which support and strengthen the evidence for HIV prevention and care programmes. He is part of the AMETHIST consortium which seeks to assess the impact of a differentiated prevention and care model to reduce the risk of HIV acquisition and transmission among female sex workers in Zimbabwe.



Thomas Hartney (He/Him)

thomas.hartney@lshtm.ac.uk

Tom Hartney has been working in the fields of HIV surveillance and sexual health promotion for over 15 years, with a particular interest in routinely collected data, behaviour change and HIV testing. He joined the MeSH Consortium at LSHTM in 2020, and his current work includes contributing to analyses of engagement and tracing outcomes in Sisters programme data, carrying out a literature review of key population definitions and collaborating on a comparison of HIV screening strategies using CLOVE study data. He has a background as a data analyst and sexual health promotion scientist at Public Health England, and is in the process of writing up his PhD thesis on HIV testing in UK general practice.



Tsitsi Ndabambi (She/Her)

tsitsindabambi@gmail.com

Tsitsi Ndabambi is a multi-award winning photojournalist, independent photographer, film maker, human rights activist and philanthropist. She is an empowerment worker at CeSHHAR Zimbabwe working with the transgender, male and female sex workers. She is the founder of Intersex Community Trust Zimbabwe and a member of the Africa Intersex Movement steering committee and board of Transmart Trust Zimbabwe. Tsitsi filmed and produced her first ever documentary titled “Dire Straits of Zimbabwean Male Sex Workers” which touches on the lifestyle and challenges faced by gay men and transgender sex workers in Zimbabwe.



Tungamirai Simbini (He/Him)

simbinit@gmail.com

Dr Tungamirai Simbini, has 18 years’ experience in building health informatics systems in Zimbabwe and SADC Region. He is currently supporting the formulation of the Community Health Management Information Systems in Zimbabwe which looks at collecting health performance data, and tracking patients at community level. He has introduced Undergraduate and Post graduate degree programmes in Medical Informatics and Analytics at the University of Zimbabwe. He is the Director of the Health Informatics Training and Research Advancement Center, at the University of Zimbabwe.



Vanessa Mudaly (She/Her)

vanessa.mudaly@westerncape.gov.za

Dr Vanessa Mudaly is a medical doctor with an interest in Public Health. She has worked at the Department of Health in the Western Cape since 2015 in Health Programmes, focusing on HIV & TB policy and guidelines development, translation and implementation. She was also closely involved in the provincial COVID-19 outbreak response activities and a member of the provincial Project Office for implementation of COVID vaccines.



Venessa Timmerman (She/Her)

venessa.timmerman@westerncape.gov.za

Dr. Venessa Timmerman is a data scientist at the Provincial Health Data Centre, Western Cape Provincial Department of Health. She has a background in biology, epidemiology and computer science and has worked in the health informatics and health system strengthening field since 2003. Her expertise is in data management and visualisation and worked extensively as a database manager for clinical trials. Her current focus areas at the PHDCs are to support data integration and developing reporting tools for public health sector recipients in the Western Cape.



Vivian Chitiyo (She/Her)

vivian@zvandiri.org

Vivian Chitiyo is a Technical Advisor of Zvandiri. She is a public health professional with more than 10 years' experience in the design, implementation and dissemination of operational and implementation science research, strategic information, and evaluation for HIV and associated health conditions. Vivian is responsible for providing Zvandiri with technical leadership to enhance program performance and demonstrate the impact of the Zvandiri model. She is also tasked with effective generation, packaging and dissemination of program knowledge and technical evidence for learning and information, decision making and policy improvement/adaptation.



Wezzie Lora (She/Her)

wezzie.lora@lstmed.ac.uk / wloram@mlw.mw

Dr Wezzie Lora is a Medical Anthropologist with over 10 years' experience in multi-sited and multi-disciplinary research. Much of her work has been on understanding the relationship between individuals and biomedical technologies and the implementation of emerging therapeutic, pharmaceuticals, and vaccines employing various research designs like participatory and mixed research methods. Wezzie is leading the research activities of the AMETHIST study in Malawi.