UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (38)/CRP1
Issue date: 16 June 2016

THIRTY-EIGHTH MEETING

Date: 28 - 30 June 2016

Venue: Executive Board Room, WHO, Geneva

Agenda item 8

Thematic segment: The role of communities in ending AIDS by 2030

Country submissions

Disclaimer: This compilation of submissions is for information only. With the exception of minor corrections to grammar and spelling, the submissions within this document are presented as they were submitted, and do not, implied or otherwise, express or suggest endorsement, a relationship with or support by UNAIDS and its mandate and/or any of its Cosponsors, Member States and civil society. The content of submissions has not been independently verified. UNAIDS makes no claims, promises or guarantees about the completeness and accuracy of the contents of this document, and expressly disclaims any liability for errors and omissions in the content. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Nor does the content of the submissions necessarily represent the views of Member States, civil society, the UNAIDS Secretariat or the UNAIDS Cosponsors. The published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. UNAIDS assumes no responsibility or liability for any consequence resulting directly or indirectly from any action or inaction you take based on or made in reliance on the information and material contained in this document nor shall UNAIDS be liable for damages arising from its use. While every reasonable effort has been made to use appropriate language in this compilation, UNAIDS expressly disclaims any responsibility for inadvertent offensive or insensitive, perceived or actual, language or pictures.

CONTENTS

INTRODUCTION
AFRICA
1. Botswana : Communities Acting Together to Control HIV (CATCH)
2. Burkina Faso: Amélioration de l'accès à la prévention et aux traitements du VIH/sida et des hépatites au Burkina-Faso, à travers la défense des droits humains des groupes les plus vulnérables
3. Burkina Faso : Promotion des valeurs morales et éducatives dans le contexte de la lutte contre le VIH, le SIDA et les IST
4. Burundi: The role of communities in ending AIDS by 2030
5. Burundi: Improving access to prevention and treatment of HIV / AIDS and hepatitis in Africa and the Caribbean by defending the human rights of the most vulnerable populations (MSM, IDU, SW, transgender people)
6. Burundi: The role of communities in ending AIDS by 2030 (2)
7. Burundi: Application de la science pour le renforcement et l'amelioration des systemes
8. Burundi: Prévention par le dépistage en stratégie avancée
9. Burundi: Protecting sex workers from HIV
10. Burundi : Generation Sans VIH
11. Cameroon: Le Life Center, mon espace communautaire à moi !
12. Cameroon : Continuum of prevention, care and treatment of HIV Aids with most at risk population (CHAMP)
13. Democratic Republic of the Congo: HIV/AIDS prevention amongst Gay men, Men who have sex with men, Transgender (GMT) and Sex workers through voluntary counseling and testing services: field experiences of HIV Community-based Testing Center of NGO"AHUSADEC" in Bukavu, South-Kivu Province, East of DRCongo.
14. Ethiopia: Radio Program to reach out to sex workers and communities
15. Gabon: Le Wé là chez les jeunes
16. Ghana: Stigma and discrimination reduction among plhiv and key population
17. Ghana: "Reinforcing the scaling up of HIV services: Strengthening Community-Based HIV prevention and effective targeting".
18. Kenya, The Omari Project at Malindi GK Prison
19. Malawi : Joint Community-Facility Review of PMTCT Dashboards in Malawi
20. Malawi: Sexual Reproductive Health (including HIV) Prevention with Youth and Addressing Adolescents' Sexual Health and Rights needs and challenges
21. Malawi : Religious Leaders and PLHIV (MANET)
22. Malawi: Community ART Groups (CAGs)
23. Malawi: Mother2Mother (M2M)
24. Morocco: Support for the implementation of the mobile strategy for reducing the risk of AIDS and hepatitis among drug users in the region of Tangiers
25. Morocco: Conseil et dépistage du VIH par des agents communautaires à destination des populations clés au Maroc. Projet pilote de l'ALCS
26. Namibia : From Victims to Victors: Empowering people living with HIV using the Inside-Out Approach

27. Namibia: Joint CSO advocacy for a comprehensive national combination HIV prevention framework
28. Namibia: Encouragement and support for ALHIV through Teen Clubs
29. Nigeria: The Integrated MARPs HIV Intervention Prevention Program (IMHIPP)
30. Sierra Leone: Making Patients Happy And Healthy: Caring For People Living With HIV During The Ebola Outbreak In Sierra Leone
31. Swaziland: Maximising ART for Better Health and Zero New HIV Infections (MaxART)
32. Swaziland: Assistance to Orphaned and Vulnerable Children (OVC) at neighbourhood care points (NCP) and Schools
33. South Sudan: Addressing the issues of child marriages, SGDV and ST's/HIV & AIDS
34. Uganda: A Study on Drug Use Related Vulnerability to HIV/AIDS Infection among Most-At-Risk Populations in Uganda
35. Uganda: Link Up: A voucher for health - Enabling young people in Uganda to access quality sexual and reproductive health services
36. Uganda: Link Up
37. Uganda: HIV and Harm Reduction program supported by Global Fund to Fight AIDS, Tuberculosis and Malaria
38. Zimbabwe: Working with traditional leaders as agent of change in mobilising communities on maternal reproductive and neonatal health.
39. Zimbabwe: Community Impact of Elimination of Mother to Child Transmission (eMTCT)
40. Zimbabwe: Community Monitoring of OI/ART Services By People Living with HIV in Zimbabwe

ASIAN STATES

41. China: China AIDS Fund For Non-governmental Organizations (CAFNGO)
42. India: Pehchan, a community systems strengthening programme for men who have sex with men (MSM), transgender and hijra (collectively MTH) communities to increase reach, scope and quality of HIV prevention and other services responsive to their needs.
43. Iran: National AIDS Control Programme (community-based components)
44. Kyrgyzstan: Participatory community-based research of HIV prevention programmes efficiency was conducted within the overall framework of the program “HIV prevention with sex workers”.
45. Myanmar: PMTCT in Myanmar
46. Myanmar: Increasing access to HIV treatment through a community-supported public private partnership in Myanmar
47. Nepal: Nepal HIVision 2020
48. Thailand: Comprehensive Prevention and Treatment Service Model Led by MSM and TG Communities in Thailand
49. Thailand: The Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated Outreach and Networking (CHAMPION) IDU (2009-2014)
50. Vietnam: Asia Action: community advocacy for harm reduction in Viet Nam

EASTERN EUROPEAN STATES

51. Armenia: Provision of complex medical services as effective model for HIV prevention and expansion of HIV testing among labour migrants.

52. Estonia: Community Based Rapid HIV testing and linkage to HIV Care and Support services
53. Georgia: Harm Reduction program in Georgia – Provision of HIV prevention services to people who injects drugs (PWIDs)
54. Moldova: Community based HIV prevention services in prisons
55. Russian Federation: Street Lawyers Project
56. Ukraine: “Advocacy for access to medical and social services for representatives of vulnerable groups, including people using drugs (PUD), methadone treatment patients (MTP), sex workers (SWs), and former prisoners in five regions of Ukraine”. (“Social mobilization, strengthening of relations, cooperation and coordination”.)
57. Ukraine: Women-led and community based research: Sexual and reproductive health, gender equality and human rights, gender-based violence, economic and political opportunities of women living with HIV in Ukraine
58. Ukraine: All-Ukrainian League Legalife (for sex workers)

LATIN AMERICA AND CARIBBEAN STATES

59. Argentina: Key Population Friendly Health Services (FHS)
60. Argentina: LGBT Citizenship Plan: From legal equality to real equality
61. Bolivia: Peer Educator Promoter strategy in Men Who Have Sex with Men, Gay and Bisexual (MSM GB)
62. Bolivia: Peer Educator Promoters (PEP) Strategy for trans populations
63. Bolivia: Political incidence plan for the allocation of resources for the hiv/aids response in Bolivia
64. Bolivia: Body mapping gender based violence and hiv among women with hiv, transgender women and sex workers in 3 cities in Bolivia
65. Bolivia: 1st Report of Human Rights of People Living with HIV in Bolivia
66. Bolivia: Peer promotor Educator (PPE) strategy for STDs-HIV/AIDS prevention in key populations, antiretroviral compliance along with the peer promotor educators, Mutual Help Groups (MHG) with people living with HIV in the Andean región of Bolivia.
67. Brazil: Viva Melhor Sabendo (Live Better Knowing)
68. Brazil: Educational Leadership in the Youth Movements - Activism and Social Mobilization to HIV/AIDS Response
69. Ecuador: "The 4 M for empowerment" in the context of sexual and reproductive rights and prevention of HIV-AIDS within sex workers in Ecuador - Colombia border.
70. Ecuador: Analysis of social behavior, sexual practices and HIV prevalence on Voluntary Counselling and Testing Service (VCT) of the Fundación Ecuatoriana Equidad Community Centre, at Quito, Ecuador.
71. Ecuador: Mapping of meeting places (locations) of most affected populations (MAPLE – MARP’s)
72. Guatemala: Combined intervention to improve HIV and other sexually transmitted infections prevention for gay, bisexual and other men who have sex with men in Guatemala City.
73. Paraguay: Kuimba’e Clinic. Men’s Wellness Center in Paraguay
74. Peru: Impulse Group for the Surveillance of the Supply of Antiretroviral Medicines: (Peruvian aids network, PROSA, Aid for Aids, Cepesju, Sí, da Vida, Impact, Justice in Health,

Land of Free Boys and Girls, Via Libre, Positive Peruvians, ICW Peru and Movement of People living with HIV).

75. Peru: Community approach by women with HIV to promote the exercise of their sexual and reproductive rights and contribute to reducing maternal and child transmission of HIV in Perú

WESTERN EUROPEAN AND OTHER STATES

76. Canada: Canadian Positive People Network (CPPN)
77. Monaco: Test in the City
78. Portugal: Portuguese Community Based Screening Network
79. Portugal: Checkpoint LX.

MULTIPLE COUNTRIES

80. Asia Pacific Regional: Ending Discrimination against people living with HIV and key populations in healthcare settings in Cambodia, China, Myanmar and Viet Nam
81. Eastern Europe Regional: Regional program, entitled “Harm Reduction Works – Fund it!” is a three –year initiative (from April 2014 to March 2017)
82. Regional ESA (Uganda, Kenya, Tanzania and Zimbabwe): Men’s sexual health and rights initiative in Africa (SHARP)
83. Regional LAC: Advocacy to challenge impunity and violence against transgender people
84. Regional LAC: Advocacy in the defence and promotion of the human rights of female sex workers
85. Global (Athena): ATHENA Network Young Women’s Leadership Initiative
86. Global (Athena): From Talk to Action: Putting Women, Girls and Gender Equality at the Heart of the HIV Response
87. Global (Robert Carr Network): The Robert Carr civil society Networks Fund (RCNF)
88. Global (World Bank): Evaluation of the Community Response to HIV-AIDS

INTRODUCTION

The PCB Thematic Segment of 30 June 2016 will focus on the instrumental role of communities in the history of the AIDS response and their vital importance in ending HIV/AIDS by 2030. In order for the session to be as up to date and evidence-based as possible, PCB Members, countries, partner organizations and colleagues were invited to submit case studies that illustrate key aspects of successful community interventions.

A total of 88 submissions were received: 40 from Africa, 10 from Asia and the Pacific, 8 from Eastern Europe, 17 from Latin America and the Caribbean, and 4 from Western Europe and Other States. In addition, 10 submissions received cover multiple countries.

The submissions reflect the work of communities as well as collaborative efforts with governments to offer innovative approaches to HIV programming. These community actions prove adept and resilient in developing solutions that reach those most affected to promote change, preparedness, response and recovery. Together, they provide compelling evidence of the need to include civil society in all HIV programmes, but especially in relation to four key areas: advocacy, campaigning and participation in accountability; direct participation in service delivery, including mobilizing demand; participatory, community-based research; and community financing.

I. African States

1. Botswana

Title of the Program: Communities Acting Together to Control HIV (CATCH)

CONTACT
Name : Grace Muzila
Title : National Coordinator
Organisation : National AIDS Coordinating Agency (NACA)
Address : Private Bag 00463, Gaborone, Botswana
Tel : 00267 3933057, 00267 3654817
Email : gmuzila@gov.bw, gmuzilareb@gmail.com

Programme is being implemented since: June 2015
Implemented by: Government, Civil Society
Scope of Submissions: Advocacy, campaigning and participation in Accountability and Community-based service in relation to the community as a whole, including PLHIV, women, youth, and others

Has the programme been evaluated / assesed? Yes
Is the program part of the implementation of the National AIDS Strategy? Yes, it is implied in the National Strategic Framework II
Is the program part of the National Plan Broader than the National AIDS Strategy: Yes, as in the National Development Plan 10

Backgroud:

In 2012, the National AIDS Coordinating Agency (NACA) organised a National HIV Prevention Summit attended by various stakeholders. The Summit engaged community representatives in order to discuss progress in regards to HIV and AIDS issues and ideas on how to improve HIV prevention. Based on the recommendation from the Summit a community-approach strategy was formulated, called CATCH. CATCH is a bottom-up community-driven approach led by the traditional leadership of the community (DiKgosi/Chiefs). The approach aims at facilitating a process of deeper and long-lasting change to happen over generations.

Botswana has made impressive gains in the fight against HIV. However HIV prevalence is still high, estimated at 18.5%. While the intention of freely available Anti-Retroviral Therapy (ART) was commendable, complacency towards getting infected with HIV seems to influence negatively the beliefs and safe sex practices especially among youth. Besides, having been provided with a huge range of services since the first case of HIV, communities appear passive recipients, rather than taking an active role in their own health.

In his State of the Nation Address, His Excellency the President Lieutenant General Dr. Seretse Khama Ian Khama recognized the key of HIV prevention and CATCH to be an approach that galvanizes community support in reaching the goal of “zero new infection”.This support at community-level is highly valuable, due to the existing community-system through the leadership

of the traditional chiefs/DiKgosi.

Description :

CATCH's main objective is to build the competence of selected communities in developing behavioural, structural and biomedical interventions that will help reduce new HIV infections to zero. The approach allows community systems to facilitate community-driven activities using a methodology that includes these basic steps:

1. Meaningful consultations through household visits looking at the inherent strengths and knowledge of the community members,
2. building a common vision of where the community wants to be heading together,
3. jointly assessing their current situation, and finally,
4. planning for joint solutions, and
5. implementing and measuring those solutions/actions.

Coordinated by NACA through the assistance of UNAIDS, the pilot phase of CATCH is implemented by a CSO called Humana People to People who supports the traditional leaders, community facilitators and community support groups on a daily basis. At national level a National Facilitation Team comprising of representatives of NACA, Ministry of Health, Ministry of Local Government, UNAIDS, the implementing CSO and community representatives advises and guides the implementation on a regular basis.

As a pilot approach, CATCH has been implemented since June 2015 in the South East District of the country, covering 5 major villages. NACA is planning to roll-out the approach to 3 more districts and improve the national support structures in the process.

Results of the programme :

Since 2015 in the pilot phase of CATCH, over 11 000 individuals have been reached through house to house visits and 51 traditional leaders as well as various key health and community stakeholders have been involved in deeper discussions around HIV, looking at their own strengths as a community. A varied group of 10 community members were trained on appreciative methodology and are facilitating the processes in their communities with strong collaboration of the existing community leaders such as the traditional chiefs but also the Village Development Committee, the District Health Management Team, the District AIDS Coordinator.

Impact of the programme :

Planned as an approach that can improve the HIV response, we see that actions go far beyond HIV and the process stimulates discussions on crucial topics that may or may not be related to HIV but rather look at a healthy lifestyle and a functioning family in general. Specific community-initiated HIV responses include community testing campaigns (158 members tested), community-led condom distribution at underserved/strategic points (3 600 condoms), awareness raising sessions for schools led by community-groups on drug, alcohol abuse and teenage pregnancies (761 youth reached), and resource mobilization at community level for the construction of a water tank to address water-shortage in their village. The aim of CATCH is for communities to measure the impact of their actions themselves. At the moment, communities are setting-up and refining information sharing tools that inform about and track their actions in various community-conform ways.

With the commitments towards Test & Treat and the 90-90-90 targets, CATCH is particularly valid in terms of valuing the community as active part in the HIV response. Health systems will need the strong support of communities to implement scaled up testing, treatment, care and prevention activities such as IEC campaigns to reach far off areas, testing-services such as home-based testing, tracking/referrals to treatment and care, as well as community support mechanisms towards adherence, retention an life-long treatment.

Financing and management:

The main custodian of CATCH is NACA, who has planned to sustain and expand the approach to initially 3 additional districts. The pilot phase is supported by UNAIDS and has received additional financial assistance by FHI360 in terms of the consultancies for setting up and reviewing the process.

Lessons learned and recommendations:

Lessons learned and recommendations: Supporting factors that helped CATCH were

1. the representation of the community leaders and members from the very beginning,
2. the political commitment and institutional flexibility to adapt to community-led activities, and finally but very importantly,
3. the multisectoral coordination and management structure involving various ministries, international and national partners.

Aiming at community-agency and community-owned activities, this approach had, at times, challenges to ensure communities are supported and facilitated, rather than seen as recipients of service, which in turn worked against a sense of community-ownership.

2. Burkina Faso

Titre du programme : Amélioration de l'accès à la prévention et aux traitements du VIH/sida et deshépatites au Burkina-Faso, à travers la défense des droits humains des groupes les plus vulnérables

CONTACT PERSON
Nom: SOME T. Charles
Titre: Chargé de Mission Plaidoyer Droits Humains des populations clés
Organisation: ONG/REVS+
Adresse: 01 BP 382 Bobo-Dioulasso
Tél: +226 70 03 44 32/78 57 38 84
Courriel: somtcharles@yahoo.fr

Le programme est en place depuis: Fevrier 2015
Mis en place par: Société civile
Sujet de la soumission: Plaidoyer, campagnes et participation à la reddition des comptes, Hommes ayant des rapports sexuels avec des hommes, Personnes qui s'injectent des drogues, et Professionnelles du sexe
Le programme a-t-il éte évalué/apprecié? Non
Le programme fait-il partie de la mise en œuvre de la stratégie nationale de lutte contre le sida? Oui

Le programme fait-il partie d'un plan national plus large que la stratégie nationale de lutte contre le sida ? Oui

Géneralités:

Au Burkina Faso, les populations clés face au VIH/Sida présentent des taux de prévalence du VIH des dizaines de fois supérieurs à ceux de la population en général. Ils constituent, de plus en plus, les principaux foyers de transmission, et il devient impossible d'enrayer définitivement l'épidémie sans les intégrer complètement dans les politiques et les dispositifs de lutte contre le sida.Mais leur accès à la prévention et au traitement du VIH/sida est la plupart du temps entravé par la stigmatisation et la discrimination dont ils sont victimes mais aussi par le fait que la société les ostracise. Face à ces constats, le projet se propose de renforcer les capacités d'associations de lutte contre le sida pour défendre les droits humains des populations les plus vulnérables face au VIH/sida, dénoncer les violations de leurs droits, sensibiliser les acteurs clés de la société pour un changement de représentations et d'attitudes à l'égard de ces groupes, renforcer leur plaidoyer auprès des pouvoirs publics pour une amélioration des législations et des politiques publiques.

Description:

Objectif Global: Le renforcement des capacités de plaidoyer des associations partenaires du projet permet d'améliorer le respect des droits humains des groupes les plus vulnérables vis-à-vis du VIH/sida et les hépatites ainsi que les interventions appropriées.

Objectifs spécifiques: L'information / sensibilisation d'acteurs intermédiaires clés, permet de renforcer le respect des droits des groupes vulnérables cibles et d'assurer leur non discrimination dans la lutte contre le VIH/sida. **OS 2**: Les associations partenaires du projet renforcent leurs capacités de défense des droits des groupes vulnérables cibles. **OS 3**: Le renforcement des activités de plaidoyer au niveau national et dans les instances internationales accentue la pression sur le pays pour un meilleur respect des droits des groupes vulnérables cibles.

Résultats du programme:

1. Les acteurs intermédiaires ciblés (médias, forces de police, acteurs des systèmes judiciaires et des parcours de soins, politiques) ont, chacun dans leur champ d'action professionnelle, un positionnement neutre et non discriminant à l'égard des groupes les plus vulnérables face au VIH/sida.
2. Les groupes particulièrement vulnérables à l'épidémie de VIH/sida sont mieux informés et conseillés sur leurs droits et les appuis qu'ils peuvent solliciter pour les faire respecter.
3. Les violations des droits humains des personnes les plus vulnérables face au VIH/sida et les discriminations dont elles sont victimes dans l'accès à la prévention et au traitement sont répertoriées et dénoncées au niveau national

Impact du programme :

- 10 sessions d'informations et de sensibilisations sur les Droits Humains sont réalisées en 2015 au profit de 150 populations clés.
- 22 populations clés victimes d'abus, de violences, d'agression dont le suivi des dossiers est en cours ont bénéficiées d'une assistance juridique.
- 128 acteurs formés sur le respect des droits humains des populations clés dont : 32 policiers, gendarmes et garde de sécurité pénitentiaire, 32 acteurs de santé, 32 acteurs de média, 32 acteurs du système judiciaire, de la société civile, de l'enseignement et de l'action sociale.
- 01 émission radiophonique sur la campagne du 26 juin a été réalisée.
- 01 interview sur la télévision BF1 a été réalisée pour interpellé le gouvernement à revoir les textes de loi au niveau national qui criminalise les utilisateurs de drogue.
- 02 spots devant la maison d'arrêt et la gare ferroviaire ont été réalisés en vue d'interpeller l'opinion nationale à une approche plus équilibrée de l'usage de la drogue.
- 01 conférence de presse contre le processus non transpirant et inclusif du recrutement des organisations à base communautaires pour la mise en œuvre des subventions du Fonds Mondial.
- 04 cadres de concertations ont eu lieu afin de mener un plaidoyer collectif pour désamorcer le mouvement homophobe.
- 03 actions de plaidoyer ont été menées auprès des leaders religieux.
- Du 06 au 13 février participation à la consultation de la société civile organisée par les Nations Unies dans le cadre de la préparation de l'UNGASS drogues d'Avril 2016.
- Du 13 au 19 mars 2016, Participation à la 59ème session de la commission on Noarcotic Drugs-CND Vienne

Financement et gestion:

Le financement du projet est assuré par l'Agence Française au Développement via l'association AIDES en France dont la mise en œuvre est assuré au Burkina-Faso par l'ONG/REVS+. Ainsi, un chargé de Mission Plaidoyer Droits Humains assure la mise en œuvre des activités entrant dans le cadre du projet sur tout le territoire national.

Enseignements tirés et recommandations :

- L'information/sensibilisation des responsables des services de médias, de police, justice, santé etc… a facilité notre intervention pour le respect des droits des populations clés auprès des agents de chaque corps de métiers.
- L'engagement des autorités politiques et l'accompagnement des institutions des Nations Unies au Burkina nous a permis de contribuer à un environnement favorable et qui respect les droits humains.
- Les sessions de formations et les actions de plaidoyer ont permis de réduire la stigmatisation et la discrimination à l'endroit des populations clés.

3. Burkina Faso

Titre du programme: Promotion des valeurs morales et éducatives dans le contexte de la lutte contre le VIH, le SIDA et les IST

Nom: Dr KIENTEGA Youssouphe
Titre: Coordonnateur National
Organisation: URCB/SD
Adresse: 06 BP 10365 Ouagadougou 06
Tél: 00226 25 36 14 15 et 00226 70 24 97 63
Courriel: urcb_bcn@yahoo.fr / youssouphek@yahoo.fr

Le programme est en place depuis: 2012 à 2015
Mis en place par: Sociéte civile
Sujet de la soumission: **Le programme a-t-il éte évalué/estimé?** Ripostes communautaires dans le contexte humanitaire et fidèles des églises évangéliques, catholique, mosquées et des cours royales, milieu estudiantin.

Le programme a-t-il éte évalué/apprecié? Non
Le programme fait-il partie du plan national de lutte contre le SIDA? Oui
Le programme fait-il partie d'un plan national plus large que la stratégie nationale de lutte contre le sida? Non

Généralités :

L'Union des Religieux et Coutumiers du Burkina pour la promotion de la santé et le développement (URCB/SD) est une organisation interconfessionnelle qui a pour but est de créer une synergie d'actions entre les communautés religieuses et coutumières dans les interventions en matière de santé et de développement. Le Burkina Faso est placé parmi les pays à épidémie généralisée. La prévalence du VIH est passée de 7% dans les années 1986 à 0,82% en 2015 grâce un effort concerté des organisations gouvernementales et de la société civile. L'URCB/SD a défendu et obtenu l'inscription d'un domaine d'action prioritaire dans le cadre stratégique national 2011-2015 en rapport avec la promotion des valeurs morales et éducative comme moyen de prévention efficace contre le VIH et les IST.

Description

L'URCB/SD a défendu et obtenu l'inscription d'un domaine d'action prioritaire dans le cadre stratégique national 2011-2015 en rapport avec la promotion des valeurs morales et éducative comme moyen de prévention efficace contre le VIH et les IST.

Cette proposition a été saluée par les plus hautes autorités de notre pays à l'époque et qui traduit l'engagement des communautés religieuses et coutumières dans la prévention de la pandémie. Les valeurs promues sont l'abstinence et la chasteté chez les jeunes avant le mariage et la fidélité au sein des couples mariés.

Les activités ont été menées dans les 13 régions que compte le pays à travers nos bureaux de coordination régionale ; ce sont :

- L'élaboration d'un document référentiel sur la promotion des valeurs morales et éducatives ;
- la réalisation des séances de sensibilisation dans les églises, temples, mosquées et cours royales des 13 régions du pays
- l'introduction des modules dans les leçons des écoles de dimanche
- la sensibilisation des conseillers conjugaux afin qu'ils tiennent compte de la thématique lors

de la préparation des mariages dans les églises, temples et mosquées
- le plaidoyer auprès des élus locaux (commune et conseils régionaux) pour la prise en compte de la thématique dans les plans d'actions locaux.
- La sensibilisation des étudiants à travers les organisations de jeunesses de nos structures de base (Association des élèves et étudiants musulmans du Burkina (AEMB), Jeunesse estudiantine catholique (JEC), les Groupes bibliques du Burkina (GB))

Résultats du programme :

Le nombre des personnes atteintes et la couverture géographique.

Nombre de sensibilisations réalisées : 1 014
Nombre de plaidoyers réalisés : 24
Nombre de personnes touchées par les sensibilisations : **T** : 876 335 dont **H** : 398 907 et **F** : 477 428
Nombre de personnes touchées par les enseignements sur les valeurs morales et éducatives : 12 237 dont 2 132 Filles, 548 garçons, 2 889 Femmes et 6 668 hommes.
Toutes ces sensibilisations ont concernées l'ensemble des 13 régions et les universités du pays.

Impact du programme:

Ce projet a eu un impact certain car il a permis aux membres et fidèles des églises, temples, mosquées et cours royales de s'impliquer dans la prévention avec des valeurs qu'ils défendaient à travers les saintes écritures et la sagesse africaine.

Le rapportage des activités se fait de façon trimestrielle et transmis au secrétariat permanent de lutte contre le VIH, le SIDA et les IST.

Certes une évaluation normative n'a pas encore été réalisée mais les échos et les appréciations des partenaires sont assez encourageants.

Financement et gestion :

Le financement est assuré en majorité par le budget de l'Etat et des partenaires à travers le Secrétariat permanent de lutte contre le VIH, le SIDA et les IST. La contribution de l'URCB/SD est surtout la mise à disposition des ressources humaines.

Enseignements tirés et recommandations :

- La promotion des valeurs morales et éducatives est la méthode de prévention qui convient au mieux dans les milieux religieux et coutumier et qui est en phase avec leur conviction religieuse
- La promotion des valeurs morales et éducatives est le moyen le plus sûr pour éviter les rebonds de la pandémie du VIH
- La promotion des valeurs morales et éducatives est la méthode qui modifie profondément les comportements en milieu jeune afin d'éviter toute dérive.

4. Burundi

Title of the programme: The role of communities in ending AIDS by 2030

CONTACT PERSON
Name: Ndayimirije Ficard
Title: Legal Representative
Organisation: Burundi Alliance for the Fight Against Tuberculosis and Leprosy "Abtl"
Address: 3, Rohero2, avenue Bututsi
Tel: +25779910045
Email: ndayimfic@yahoo.fr/c.ongabtl@yahoo.fr

Implemented by: Civil Society
Scope of submission: Advocacy, campaigns and participation in accountability; Community-based service delivery (i.e., screening, prevention, care and support, treatment, legal, delegation of tasks, training of health care workers, etc.); Participatory community based research; and Community funding and Community responses in the humanitarian context related to populations of people living with HIV, men who have sex with men, people who inject drugs, sex workers, women and other.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

The Burundian Alliance for the fight against Tuberculosis and Leprosy "ABTL" is composed of member organisations from different organisations including PLHIV, Tuberculosis, drug users, and diabetics. Being a new organisation founded only 6 years ago, it is struggling with key questions relating to the proper functioning of the ABTL and the issue of tuberculosis co-infection was not quickly resolved, except that it is anticipated in the new funding model of the Global Fund, since the concept note was submitted on 30 January 2015 and was accepted by the Global Fund. Note that the ABTL is a community-based organisation and it operates at the community level, claiming to be the sub-recipient of the concept note TB / HIV.

Description:

Community Health facilitators of the ABTL intervene in making communities aware of voluntary screening and behaviour change with regard to the scourge of TB / HIV co-infection. The supervised key populations receive care and there is regular monitoring if they are affected by HIV; additionally, affected police officers are relocated to areas where their daily work is made easier and they receive financial support such as nutritional support which is taken from the fund.

Results of the programme:

There are now 6,669 people affected by TB of whom 42% have AIDS and are followed up by the CDT. They come from different communities and the ABTL had organised the strengthening of the community systems on the gender and human rights component in cases of TB / HIV. During this consultation, recommendations were made, see the report in appendix

Impact of the programme:

This programme, once implemented, could facilitate the affected key populations not to be stigmatized, and could also help the Burundian community

Financing and management:

Our activities are funded by the World Health Organization, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the National Programme in the fight against Tuberculosis, CNLS, STOP TB Partnership, Initiative 5% AIDS, TB and Malaria in monitoring and evaluation. France Expertise (report attached) provides expertise. In certain actions aiming for prevention and permanent staff, we have no partner for the support of permanent staff and the means to travel for monitoring the activities as shown in the appendix report produced by France expertise in April 2015, but we do not have permanent partners for the time being and we continue to advocate and lobby.

Lessons learned and recommendations:

The Burundian Alliance for the Fight against Tuberculosis and Leprosy " ABTL " has implemented one of the committees of Community health facilitators headed by a Focal Point and members, supervisors and others including community supervisors, peer educators and the Burundian Alliance for the fight against Tuberculosis and Leprosy "ABTL" as recommendations. We are appealing urgently to any partner wanting to support this programme within the Burundian Alliance for the fight against Tuberculosis and Leprosy "ABTL" to provide considerable support.

5. **Burundi**

Title of the programme: Improving access to prevention and treatment of HIV / AIDS and hepatitis in Africa and the Caribbean by defending the human rights of the most vulnerable populations (MSM, IDU, SW, transgender people)

CONTACT PERSON
Name: Léonard Nkeshimana
Title: Mission Advocacy Officer for Human Rights
Organisation: ANSS Burundi (www.anssburundi.bi)
Address: Kigobe district south, avenue des USA, No77
Tel: (257) 22 2392 32/79 578 143
Email: leonkeshimana@yahoo.com

Programme is being implemented since: 1 october 2014
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc.) related to populations of men who have sex with men, people who inject drugs, sex workers, and transgender people.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Sub-Saharan Africa and the Caribbean are the regions most affected by the HIV / AIDS epidemic. They account for over 70% of HIV-positive people worldwide[1], with groups extremely vulnerable to HIV / AIDS having prevalence rates dozens of times higher than the general population. Moreover, these groups are the main points of transmission, and it will become impossible to definitively stop the epidemic without integrating them fully in the policies and measures in the fight against AIDS. The increased vulnerability of these groups with regard to HIV / AIDS is primarily due to stigma and discrimination as well as laws that criminalise their practices. Policies and discriminatory practices force MSM, SW, IDU and transgender people underground and confine them in marginal environments where the risk of HIV infection is very high and prevents them from effectively accessing high quality preventive information, good health services, condoms and lubricants, as well as STI management and risk reduction services.

Description:

The project aims to contribute to capacity building of different actors to address the exclusion of vulnerable groups from prevention programmes and treatment of HIV / AIDS, which is a major cause of the spread of the epidemic throughout the world. Indeed, human rights violations and discrimination against those groups most vulnerable with regard to HIV / AIDS occur in all strata of society. Therefore, in parallel to the work on improving access to prevention and treatment for the groups most vulnerable to HIV / AIDS, it is essential to develop a greater awareness and to educate people in terms of changing perceptions and attitudes towards them. Civil society organisations also need to strengthen their advocacy to stop repressive and discriminatory policies and the development of approaches based on rights and scientific data to build policies of protection and access to health for all. This advocacy must be underpinned by the regional and international bodies fighting HIV / AIDS, but also by defending human rights. Finally, the direct targets of the project are the vulnerable groups while advocacy is aimed at the key intermediary actors (care actors, course of justice actors, political, religious leaders, the media, civil society etc.) in order to adopt healthy, neutral behaviour in their actions in favour of these groups.

Results of the programme:

Since the beginning of the project, 75 SW, 35 MSM and transgender people, 50 care actors, 33 course of justice actors, 20 civil society actors and 23 drug users have been informed and made aware of the links between the human rights of vulnerable groups and the fight against HIV / AIDS. In addition, several stakeholders (governmental and non-governmental) involved in the fight against HIV / AIDS and human rights protection have been approached to become our allies in advocacy. The project is conducted throughout the entire territory of the country but so far the activities have been conducted in Bujumbura and in the 3 provinces where the ANSS has its branches (Makamba, Gitega and Kirundo).

Impact of the programme:

The impact of the project is that it has addressed a taboo subject by making the various stakeholders aware, to bring about a change in attitudes and perceptions of these vulnerable

[1] [1] [20.9 million - 24.2 million] Status Report 2011: the global response to HIV / AIDS. WHO, UNAIDS, UNICEF.

groups. Indeed, at the end of the project, we hope to have achieved the following results:

1. The rights of vulnerable groups are respected allowing them easy access to care and quality information, thereby reducing the spread of HIV and their vulnerability with regard to HIV,
2. Violations of the human rights of those most vulnerable with regard to HIV / AIDS and cases of discrimination against them in terms of access to prevention and treatment are documented and condemned nationally and internationally,
3. Violations of the human rights of those most vulnerable with regard to HIV / AIDS and cases of discrimination against them in terms of access to prevention and treatment are condemned by the main international commissions for human rights.
4. The advocacy with different international organisations (WHO, UNAIDS, etc.), for defending the human rights of those most vulnerable with regard to HIV / AIDS and their non-discrimination in terms of prevention and treatment are strengthened.
5. Partner associations involve organisations defending the rights of other specific population groups (children, women, disabled people, etc.) in the defence of the rights of those most vulnerable with regard to HIV / AIDS, including the right of access to prevention and treatment.

Financing and management:

In each country covered by the project, there is a Mission Advocacy Officer for human rights who handles all project activities and who depends on the structure that hosts the project. At the top of the project, there is a coordinator of international advocacy, an Africa advocacy coordinator and a management controller. All the activities in each country are coordinated by the coordination of the association hosting the project and the project funds are managed by the finance department of the associations leading the project. The main project partners are AFD and AIDES.

Lessons learned and recommendations:

People's conventional attitudes based on the customs and beliefs of ancient cultures are the main barriers to the success of the project. In addition, people do not want to change their habits so quickly. Finally, the existence of systems repressing the practices of these groups reinforce discrimination and stigma against them and push them underground, away from care and prevention services, to places where there is higher risk, which increases their vulnerability.
The new guidelines of the Global Fund, UNAIDS, and the WHO in the financing and implementation of activities in the fight against AIDS are useful propositions for our advocacy. The fundamental problem is that governments do not want to follow international guidelines in the fight against AIDS to abolish discriminatory laws and repressive systems that constitute real obstacles to these groups to accessing care and information.

6. **Burundi**

Title of the programme: The role of communities in ending AIDS by 2030 (2)

CONTACT PERSON
Name: Jean Claude Nihorimbere
Title: Officer IEC / CC VCT Iwacu and Member of USLS Security
Organisation: Ministry of Public Safety
Address: Avenue d'UVIRA No. 5

Tel: +25779480631
Email: horimbere2015@gmail.com

Implemented by: Government
Scope of submission: Community-based service delivery (i.e., screening, prevention, care and support, treatment, legal, delegation of tasks, training of health care workers, etc.); Participatory community based research; Community funding; and Community responses in the humanitarian context in relation to people living with HIV, men who have sex with men, and women.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

The Burundian National Police was trained by several members from different bodies, and being young, quickly confined itself to issues of the efficient administration of GDP and the issue of HIV / AIDS was not quickly resolved except for the establishment of a voluntary framework to support people affected by HIV. Given the working conditions of police officers, in other words as an official body but still close to the population, this body is a group most targeted by HIV / AIDS. To deal with the situation, a sector unit has been set up, peer educators have been trained and made aware, and afterwards a VCT / PMTCT was set up with many deficiencies.

Description:

Peer educators in the police have been trained and intervene by making police officers aware of voluntary screening and behaviour change with regard to the scourge of AIDS. Police officers and members of their family or the local population come to our centre and receive care and regular follow-up if they are affected by HIV, additionally, affected police officers are relocated to areas where their daily work is made easier and they receive financial support such as nutritional support which is taken from the fund set aside for this purpose.

Results of the programme:

We currently have 78 people that are followed up by the Centre and who receive healthcare. They come from 18 police stations and have been made aware by peer educators, 45 per station.

Impact of the programme:

This programme, once highlighted, can facilitate affected police officers not to be stigmatized but also can allow the Burundian Police force to have men living and working without HIV / AIDS. And this can be measured from the results obtained in the organised voluntary screening campaigns, given that most police officers are blood donors.

Financing and management:

Our activities are funded by the CEP / CNLS in monitoring and evaluation and for certain actions for prevention but we do not have permanent partners for the time being and we

continue to advocate.

Lessons learned and recommendations:

The Ministry of Public Security has set up a sectoral unit headed by a Focal Point and members, the Ministry of Public Health and the Fight against AIDS certified the VCT / PMTCT within the Burundian Police force, but additionally, the Centre was opened by the first Lady of the country and as recommendations, we are appealing to any partner wishing to support this programme within the Burundian police force to come and the doors are open.

7. Burundi

Titre du programme: Application de la science pour le renforcement et l'amelioration des systemes

CONTACT
Nom : Dr Nkunzimana Alphonse
Fonction : Directeur
Organisation: Programme National de lutte contre le sida et les infections Sexuellement Transmissibles
Addresse : Bujumbura, Avenue des états unis no 1
Tél : + 25722224422
Courriel: nialphonse@gmail.com

Le programme est en place depuis: 2012
Mis en place par: Gouvernement, Nations Unies ou autre organisation non gouvernementale
Sujet de la soumission: Prestation de services à assise communautaire (soit dépistage, prévention, soins et appui, traitement, services juridiques, délégation des tâches, formation d'agents de soins de santé, etc.) avec femmes enceintes ainsi que leurs partenaires et leurs enfants.

Le programme a-t-il été évalué/estimé? Oui
Le programme fait-il partie du plan national de lutte contre le SIDA? Oui
Le programme fait-il partie d'un plan national d'action d'urgence? Oui

Contexte:

Selon l'enquête démographique et de santé réalisée en 2010 , il ressort qu'au Burundi l' épidémie du VIH est de type généralisée à faible prévalence estimée à 1,4% dans la population générale âgée de 15 à 49 ans avec un ratio femme/homme de 1,7 et une prévalence du VIH 4 fois plus élevée en milieux urbains (4,0%) qu' en milieu rural (1,0%). Parlant de la riposte, le Burundi faisant parti des 22 pays prioritaires pour l'élimination de la transmission du VIH de la mère à l' enfant est en train de mettre en œuvre le Plan National éTME avec l' appui des partenaires qui apportent leurs contributions sous diverses formes dans la lutte contre cette pandémie. C'est dans cette optique que le Projet d' Application de la science pour Renforcer et améliorer les systèmes de santé sous financement USAID-PEPFAR collabore avec le Ministère de la Santé Publique et de la Lutte contre le SIDA du Burundi via le PNLS/IST pour améliorer la qualité des services PTME. Avant le début de l'intervention du Projet, une évaluation de base a permis de dégager des gaps en matière de la documentation, du dépistage du VIH et la rétention des soins du couple mère - enfant.

Description:

Les objectifs du Projet sont :

i. améliorer l'utilisation des services PTME,
ii. améliorer la qualité des services PTME,
iii. améliorer la rétention des mères et des nouveaux nés le long du continuum des soins,
iv. renforcer le système de santé communautaire.

Pour atteindre ces objectifs, le Projet appuie le Ministère pour mettre en place un processus d' amélioration de la qualité s' appuyant sur une approche collaborative mettant plusieurs formations sanitaires en réseaux afin de capitaliser les énergies vers l'atteinte rapide des résultats et l' extension des meilleurs pratiques vers de nouvelles structures sanitaires du pays. La première phase du programme a concerné soixante-dix (70) formations sanitaires comprenant les CDS et les Hôpitaux réparties dans quatre Provinces du pays à savoir les provinces de Kirundo, Muyinga, Karusi et Kayanza. Ces structures ayant chacune mise en place une EAQ, travaillent pour analyser le processus PTME et testent les idées de changement en rapport avec les gaps de qualité. Les travaux effectués par les EAQ sont ensuite partages et discutées périodiquement lors des sessions d'apprentissage qui regroupent des représentants de chaque équipe ainsi que l' équipe des coachs provenant des BDS ,BPS, PNLS/IST et le Staff du Projet .

Parallèlement à cela ,un Programme de Renforcement du Système de Santé communautaire a été initié sur 24 sous collines du BDS Giteranyi (Province Muyinga) pour améliorer la performance de l' Agent de Santé Communautaire et ainsi lui permettre d' offrir les services PTME de qualité avec une implication effective du niveau communautaire .

Impact de l'intervention:

- Amélioration de la couverture des services PTME qui a abouti à une diminution de la transmission du VIH de la mère à l'enfant.
- Augmentation du nombre de femmes accompagnées par leurs maris au service de CPN
- Renforcement du lien /collaboration entre le niveau formation sanitaire et le niveau communautaire
- Valorisation de la contribution de la communauté dans la promotion de sa propre santé
- Appropriation/ institutionnalisation de l'approche par les responsables des différents niveau du système de santé

Enseignements tirés et recommandations :

- L'implication totale des responsables sanitaires à tous les niveaux renforce la collaboration et facilite la mise en œuvre du programme ;
- L'implication effective des membres de la communauté, des leaders administratifs et des prestataires facilite l'atteinte rapide des résultats.

8. Burundi

Title of the programme : Prevention par le dépistage en stratégie avancée

CONTACT
Name: Ndayiziga Gisele
Title: Coordinatoor
Organisation: Resaux Solidarité pour le Droit des travailleuses du Sexe

Address : Bujumbura, Commune Gihosha, Zone Kamenge, quartier Taba
Tel: +25775817033
Email: reseausolidalite@gmail.com

Programme is being implemented since: 2014-2017
Implemented by**:** Société civile
Scope of Submissions: Advocacy, campaining and participation in accountability, with popultion of Sex Workers and Women.

Has the programme been evalauted/Assessed: No
Is the programme part of the implementation of the National AIDS Straegy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? No

Background :

Sexual health check-ups and HIV testing. It is important to have regular sexual health check ups even if you never have unprotected sex. Some STIs can be passed on even if you use a condom. Having an STI makes you more vulnerable to HIV infection. Know your HIV status to protect your own health and that of others.

Description:

- Les objectifs : atteindre le plus de personnes possible, les sensibiliser à la prévention et dépister les volontaires.
- Qui le met en œuvre : une équipe multidisciplinaire de conseillers et de laborantins
- Comment il fonctionne : Organisation d'une ou deux campagnes de sensibilisation et dépistage en stratégie avancée, c'est-à-dire que l'équipe va vers la population. Cette dernière se fait dépister en masse lors de ces campagnes.
- Portée programmatique : Le programme ne fait pas beaucoup de résultats faute de moyens financiers (réactifs, frais de collation, frais de communication, carburant, etc).
- Portée géographique : le programme est mis en œuvre dans 4 provinces du Burundi où l'ANSS a des antennes.
- Principal objectif du programme « Motiver la population à se faire dépister pour une meilleure prévention»

Results of the programme:

Protecting sex workers from HIV
- Use condoms consistently and correctly. Use a female condom if the client refuses to use a male condom.
- If the client refuses to use a condom, offer non-penetrative activities such as masturbation, external ejaculation or using clean sex toys.
- Use lubricant to reduce friction and prevent the condom breaking, especially for anal sex.
- Access emergency contraception and emergency HIV treatment (PEP) if the condom breaks.

The program work in 6 provinces per 18.The provinces are Rumonge, Bujumbura, BUBANZA, cibitoke, Ngozi and Kayanza

Sex workers know their rights
They have the right to:

- refuse a client for any reason
- insist on using a condom
- be free from forced sex work, either by an employer, a manager or a client
- be aware of the law on sex work in your country.

Impact of the programme :

With heightened risks of HIV and other sexually transmitted infections, sex workers face substantial barriers in accessing prevention, treatment, and care services, largely because of stigma, discrimination, and criminalisation in the societies in which they live. These social, legal, and economic injustices contribute to their high risk of acquiring HIV. Often driven underground by fear, sex workers encounter or face the direct risk of violence and abuse daily. Sex workers remain underserved by the global HIV response. This Series of seven papers aims to nvestigate the complex issues faced by sex workers worldwide, and calls for the decriminalisation of sex work, in the global effort to tackle the HIV/AIDS epidemic. Sex workers know their rights

Financing the management :

Major partener is ASWAA and ANSS for technic assistance

Lessons learned and recommendations:

- Refuse a client for any reason
- Insist on using a condom
- Be free from forced sex work, either by an employer, a manager or a client
- Be aware of the law on sex work in your country.

9. Burundi

Title of the programme : Protecting sex workers from HIV

CONTACT

Name: Ndayiziga Gisele
Title: Coordinatoor
Organisation: Resaux Solidarité pour le Droit des travailleuses du Sexe
Address : Bujumbura, Commune Gihosha, Zone Kamenge, quartier Taba
Tel : +25775817033
Emal : reseausolidalite@gmail.com

Programme is being implemented since: 2014-2017
Implemented by:Société civile
Scope of Submissions: Advocacy, campaining and participation in accountability in relation to sex workers and women.

Has the programme been evalauted/Assessed: No
Is the programme part of the implementation of the National AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? No

Background :

Sex workers are often stigmatized, marginalized and criminalized by the societies in which they live, and in various ways, these factors that contribute to their vulnerability to HIV. For example, a sex worker who is raped will generally have little hope of bringing charges against their attacker. This lack of protection leaves sex workers open to abuse, violence and rape, creating an environment which can facilitate HIV transmission. In some countries, police use the possession of condoms as evidence of sex work, further impeding sex workers' efforts to protect themselves.

Description:

- Use condoms consistently and correctly. Use a female condom if the client refuses to use a male condom.
- If the client refuses to use a condom, offer non-penetrative activities such as masturbation, external ejaculation or using clean sex toys.
- Use lubricant to reduce friction and prevent the condom breaking, especially for anal sex.
- Access emergency contraception and emergency HIV treatment (PEP) if the condom breaks.

The program work in 6 provinces per 18.The provinces are Rumonge, Bujumbura, BUBANZA, cibitoke, Ngozi and Kayanza

Reach and impact of Programme:

Even though sex work is at least partially legal in some countries, the law rarely protects sex workers. Around the world, there is a severe lack of legislation and policies protecting sex workers who may be at risk of violence from both state and non-state actors such as law enforcement, partners, family members and their clients. With heightened risks of HIV and other sexually transmitted infections, sex workers face substantial barriers in accessing prevention, treatment, and care services, largely because of stigma, discrimination, and criminalisation in the societies in which they live. These social, legal, and economic injustices contribute to their high risk of acquiring HIV. Often driven underground by fear, sex workers encounter or face the direct risk of violence and abuse daily. Sex workers remain underserved by the global HIV response. This Series of seven papers aims to investigate the complex issues faced by sex workers worldwide, and calls for the decriminalization of sex work, in the global effort to tackle the HIV/AIDS epidemic. Sex workers know their rights

Financing and management:

The major partener is ASWAA and ANSS for technic assistance

Lessons learned and recommendations:

- Refuse a client for any reason
- Insist on using a condom
- Be free from forced sex work, either by an employer, a manager or a client
- Be aware of the law on sex work in your country.

10. Burundi

Titre du programme: Generations Sans VIH

Nom : Dr Nkunzimana Alphonse
Fonction : Directeur
Organisation: Programme National de lutte contre le sida et les infections Sexuellement Transmissibles
Addresse : Bujumbura, Avenue des états unis no 1
Tél : + 25722224422
Courriel: nialphonse@gmail.com

Le programme est en place depuis: 2012
Mis en place par: Gouvernement, Nations Unies ou autre organisation non gouvernementale
Sujet de la soumission: Prestation de services à assise communautaire (soit dépistage, prévention, soins et appui, traitement, services juridiques, délégation des tâches, formation d'agents de soins de santé, etc.) avec femmes enceintes ainsi que leurs partenaires et leurs enfants.

Le programme a-t-il été évalué/estimé? Oui
Le programme fait-il partie du plan national de lutte contre le SIDA? Oui
Le programme fait-il partie d'un plan national d'action d'urgence? Oui

Généralites :

Selon EDS 2010, le taux de séroprévalence au Burundi est estimé à 1.4%avec une vulnérabilité accentuée des femmes (1% des hommes contre 1.8% des femmes). C'est dans ce contexte que la PTME avait été, non seulement prise comme une priorité par le PSN 2007-2011, mais aussi par d'autres documents de politique en matière de la lutte contre le VIH/Sida comme la politique nationale de PTME et le Plan é-TME. Pour faire face aux différents goulots de la PTME, le Ministère de la Santé Publique et de la Lutte contre Sida à travers son Programme PNLS /IST en collaboration avec le consortium Food for the Hungry et RBP+ ont initié un projet « GENERATION SANS VIH » qui avait pour objectif global de réduire la transmission du VIH de mère enfant à travers l'approche « community-facility-community » et par un diagnostic précoce des enfants nés des mères séropositives. En effet selon le rapport du SEP/CNLS 2011 le taux résiduel de TME était élevé (33.9% en 2010). A cette époque, le pays avait très peu de prestataires formés en PTME et le taux de dépistage précoce des femmes enceintes était aussi très bas (moins de 37%). Aussi, comme le Burundi enregistrait un taux de mal nutrition classé parmi les plus élevés au monde (60%) et que cette insécurité alimentaire récurrente augmente la vulnérabilité des personnes infectées et/ou affectées par le VIH/SIDA, surtout les femmes enceintes, le programme est venu promouvoir une autosuffisance alimentaire des populations à travers la création des groupements d'épargne et crédit et des chaines de solidarité.

Description:

Le projet « Génération sans VIH » s'articule sur les objectifs spécifiques suivants (i)Réduire la transmission du VIH aux nourrissons nés de 400 mères séropositives grâce à la fourniture de services de gestion de cas pour les couples séropositifs ; (ii)Adoption de comportements positifs en matière de santé sexuelle et reproductive qui empêchent la transmission du VIH; (iii)

Les leaders communautaires et d'opinion prennent des mesures pour améliorer la sensibilisation et l'accès à la PTME et les services de SSR.

Pour atteindre ces objectifs, la première étape a été de circonscrire la zone d'intervention qui était de 43 collines de la commune Gisuru, Province Ruyigi. Ensuite comme RBP+ et FH exerçaient déjà ses programmes dans la localité, ils se sont servis de leur expérience pour la mise en œuvre du programme. Le PNLS/IST quant à lui, assurait la supervision et la coordination des acteurs y compris les FOSA. En effet, ce programme est conçu principalement sur 5 axes (i) Le model de "Community-Facility- Community" ; (ii) Le suivi des femmes enceintes, allaitantes infectées (iii) ; Production des modules de formation ; (iv) Accroitre de la demande des services PTME, (v) Finance.

Cette approche consistait à promouvoir un changement de comportement lié au VIH/SIDA en générale et à la PTME en particulier en fournissant une éducation aux groupes de 25 femmes en âge de procréer chacun suivi par 1 animateur (case manager) dans 3 cohortes et aux groupes d'hommes en âge de procréer de 12 individus chacun suivi par un animateurs (males facilitator) dans 3 cohortes. Aussi, l'approche a facilité la paire éducation dans les groupes cascades et dans les clubs scolaires stop sida.

Rèsults du programme :

1. Grace au projet 202 femmes séropositives ont été accompagnées. Parmi elles, 98 ont été admises sous PTME. 82 enfants, dont 43 ont été testés et connaissent leur état sérologiques. un seul enfant a testé VIH+.
2. 6400 femmes et filles en âge de procréer ont reçues des messages d'IEC/CCC sur l'importance des consultations prénatales précoces, les consultations postnatales, le dépistage volontaire du VIH, la SSR, la PTME, la lutte contre la stigmatisation et le planning familial. Ces messages ont été dupliqués dans la communauté de proximité.
3. 432 hommes en âge de procréer ont été formes sur des messages de changement de comportement sur l'importance des consultations prénatales précoces, les consultations postnatales, le dépistage volontaire du VIH, la SSR, la PTME, la lutte contre la stigmatisation et le PF. A leur tour, ils ont partagé les leçons acquises avec plus de 5184 hommes.
4. 540 leaders communautaires ont été formés sur le CDV, la PTME, la SSR, PF et la lutte contre la stigmatisation. Ils ont été aussi encouragés à partager les connaissances acquises avecla population de leurs villages respectifs.
5. 5440 élèves ont été formées par les encadreurs des clubs scolaires stop sida. A leurs tours, ces élèves ont organisés 23 campagnes de sensibilisation auprès des autres élèves de leurs établissements.
6. 15 campagnes de sensibilisation organisées par 540 leaders communautaires et d'opinion atteignant autour de 12000 personnes.

Impact du programme :

L'impact du programme est mesuré en comparant la situation de base et les données finales atteintes (voir annexes). Des progrès remarquables ont été observés : (i) Amélioration des connaissances sur la santé en général et sur le VIH/sida en particulier pour les bénéficiaires directes et indirects du projet. Au total 17 996 personnes ont été formées, (ii) Adhésion et renforcement de l'observance au traitement du VIH/Sida grâce au suivi régulier du personnel de terrain, (iii) Augmentation de la demande de services dans les structures de soins, suite au suivi et sensibilisation de masse à travers les campagnes,(iv) Une grande implication des hommes

pour l'adhésion au service de prise en charge (accompagnement des femmes aux services de soins ; (v)Implication des bénéficiaires du projet à travers la sensibilisation de proximité au niveau communautaire ; (vi)Développement d'une solidarité communautaire entre les membres d'un même groupement pendant l'apprentissage des leçons et continuité à travers les groupes d'épargne et crédit ; (vii) Réduction des cas de discrimination et stigmatisation liés au VIH/sida grâce à la formation des groupes mixtes de chaine de solidarité.

Financement et gesion :

Le programme a été financé par PACF ViiV HEALTH care par le biais de FH qui assurait le transfert des fonds. Le programme était exécuté en consortium par FH, RBP+ dans l'implémentation et le Ministère de la sante Publique et de la Lutte contre le Sida qui en assurait le suivi à travers son programme PNLS/IST. Au niveau de la mise en œuvre, le SEP/CNLS a été un partenaire indispensable. Concernant la continuité des activités initiées par le Programme, les structures décentralisées mises en place s'en chargeront avec l'appui du PNLS.

Enseignements tirés et recommandations :

Facteurs ayant contribues au succès :
i. La création des groupements d'épargne mixtes et de crédit,
ii. Le développement d'une solidarité communautaire,
iii. La paire éducation,
iv. L'implication des leaders communautaires,
v. L'appropriation du projet par les bénéficiaires et par les FOSA ;
vi. La simplicité de l'approche ;
vii. Le travail synergique des gestionnaires du projet ;
viii. La bonne collaboration entre tous les intervenants,
ix. La provision d'une assistance aux femmes enceintes
x. Les formations de proximité.

Recommandations :
i. Mobilisation des ressources pour dupliquer les acquis du projet « Génération sans VIH »dans les zones non couvertes ;
ii. Accompagner la décentralisation de la prise en charge par le renforcement des prestataires de terrain ;
iii. Promouvoir le dépistage par les actions de sensibilisation communautaire,

Defis:
i. Appareils de suivi biologique souvent en panne,
ii. Un seul appareil PCR au niveau national, Des transferts fréquents des personnels de santé au niveau des structures de soins qui occasionne le départ des personnes formés par le projet dans le prise en charge des personnes vivants avec le VIH/SIDA ;
iii. Manque de fonds pour dupliquer l'approche dans d'autres provinces ;
iv. Rupture de stock de réactifs constitue un obstacle dans la mobilisation des communautés pour le dépistage volontaire.

11. Cameroon

Titre du programme: Le Life Center, mon espace communautaire à moi !

Nom : Denise Ngatchou
Fonction : Présidente de cette structure
Organisation: Horizons Femmes
Addresse : B.P: 8480 Yaoundé - Cameroun
Tél : 237 2 22 31 43 02
Courriel : horizons_femmes@yahoo.fr

Mis en place par: Société civile
Sujet de la soumission: Prestation de services à assise communautaire (soit dépistage, prévention, soins et appui, traitement, services juridiques, délégation des tâches, formation d'agents de soins de santé, etc.) avec Professionnel(le)s du sex et Femmes.

Le programme a-t-il été évalué/estimé? Oui
Le programme fait-il partie du plan national de lutte contre le SIDA? Oui
Le programme fait-il partie d'un plan national d'action d'urgence? Oui

Généralites :

Le Cameroun fait face à une épidémie généralisée, qui se caractérise par une prévalence moyenne du VIH de 4,3% dans la population générale (15-49 ans). L'épidémie s'est féminisée atteignant une prévalence de 5,6% chez les femmes contre 2,9% chez les hommes. Une étude réalisée auprès des Travailleuses de Sexe (TS) en 2009, estime à 36 % la prévalence du VIH dans cette population. Selon l'étude sur les modes de transmission du VIH (2013), la répartition des cas selon les groupes à risque montre que 45,3 % des nouvelles infections sont enregistrées dans les couples hétérosexuels stables ; ensuite viennent les clients des professionnelles de sexe (35,9 %). La prévalence moyenne du VIH chez les TS était de 36%, avec des fortes disparités régionales de 23,9% au Sud à 49,5% dans l'Adamaoua; de 4% au Sud-ouest à 32,2% à l'Ouest.

C'est dans ce contexte que l'ONG Horizons Femmes a créé un centre de santé sexuelle pour les travailleuses du sexe à Yaoundé, Douala et Bamenda afin de promouvoir le Droit à la santé pour tous et spécialement assurer l'accompagnement des travailleuses du sexe à la prévention du VIH et à l'accès aux soins et surtout briser la chaîne de stigmatisation et de discrimination envers les travailleuses du sexe, en leur offrant le tout premier espace dédié à leurs besoins spécifiques au Cameroun.

Description :

« Life Center » est un lieu d'accueil, d'écoute et d'accompagnement pour toute personne se questionnant sur le VIH/sida et en particulier pour les personnes vulnérables. C'est un espace convivial de concentration d'un ensemble de prestations constituées d'un paquet minimum de soins dont la conjugaison participe à la santé et au bien-être pour tous.

Les services disponibles:

- Accueil;
- Services de prévention, soins et traitement des ISTs;
- Le conseil et la PEC psychosociale;
- Appui des experts volontaires;
- Assistance sociale;
- Références vers les Formations sanitaires.

Rèsults du programme :

- Près de 15 000 visites, réparties entre les travailleuses du sexe (TS) en grande majorité, et d'autres personnes vulnérables ;
- Plus de 350 000 préservatifs masculins et féminins, près de 100 000 dosettes de gel lubrifiant et pas moins de 16 000 supports d'information sur les IST et le VIH/sida ont été distribués ;
- 3 455 travailleuses du sexe, 4 048 clients et 68 MSM ont été sensibilisés par les paires-éducatrices et pairs-éducateurs d'Horizons Femmes ;
- 1447 travailleuses du sexe (TS) dépistés dans les « Life Center » de Douala et de Yaoundé ;
- 3125 TS, 39 MSM et 1250 autres populations vulnérables bénéficient de la prise en charge psychosociale parmi lesquels 606 PVVIH

Impact du programme :

- Taux de prévalence parmi les travailleuses du sexe dépistées par Horizons Femmes (10,43 %), ce qui est largement supérieur à celui des autres populations vulnérables dépistées par l'association (3,6 %). Néanmoins, ce taux reste très en-dessous de la prévalence estimée au niveau national parmi les travailleuses du sexe, qui était de 36,8 % en 2014.
- Le changement de comportement et l'adoption des comportements à moindre risque tel l'usage régulier du préservatif et le dépistage volontaire ont été observés parmi les travailleuses du sexe ayant bénéficié des informations adéquates sur leur lieu de travail et/ou ayant pris part aux activités de sensibilisation organisées au Life Center.
- L'élimination de la stigmatisation et de la discrimination envers les travailleuses du sexe au niveau des communautés est un résultat important.

Financement et gesion :

D'une manière générale, le projet d'Horizons Femmes est géré par un groupe de staff qualifié qui comprend : la Directrice exécutive, le Chargé des Programmes ainsi qu'une équipe pluridisciplinaire (mobilisation communautaire, assistante sociale, conseillères psychosociales, pairs-éducateurs et des bénévoles) dédiée au service d'accompagnement. L'association bénéfice également d'un soutien technique d'un pool d'experts (médecin, nutritionniste, juriste). Les principaux partenaires sont :

- CARE Cameroun à travers le Programme HAPP 3 et le Programme CHAMP, financés par le PEPFAR/USAID. Ces partenaires apportent un appui financier ainsi que l'approvisionnement en matériel de prévention, équipement divers, des compétences, appui au suivi-évaluation.
- La Fondation de France dans le cadre de l'appel à projet « Sida, santé et développement : Genre et VIH »
- Le Mouvement Français pour le Planning Familial, à travers son programme « Santé, sexualité, droits et genre : programme de promotion des droits et de la santé en matière de sexualité et d'égalité des sexes
- Le Comité National de Lutte contre le Sida (CNLS)
- L'ONUSIDA qui fournit l'assistance technique

Enseignements tirés et recommandations :

- L'importance primordiale d'avoir établi un lien de confiance avant-même la création du Life Center, à la fois avec les travailleuses du sexe, les communautés, les partenaires et les autres acteurs associatifs locaux ;

- L'importance de la proximité géographique du Life Center avec le public-cible ;
- L'attention qu'il faut porter à la qualité de l'accueil et à la mise à disposition d'un lieu convivial avec plusieurs pièces dédiées aux différents services ;
- La nécessité de mettre des kits de prévention à la disposition permanente du public-cible, de manière à mobiliser et fidéliser les usagères du centre.

Ainsi,

- L'ouverture d'un centre de santé sexuelle génère des effets positifs directs sur la santé des travailleuses du sexe et sur leurs comportements face aux risques d'infection par le VIH ;
- L'ouverture d'un centre de santé sexuelle génère également des effets positifs indirects sur le self estimes des travailleuses du sexe,
- L'amélioration importante des conditions de vie et de travail, et de l'environnement immédiat.

Horizons Femmes souligne que:

- L'animation d'un centre de santé sexuelle répond de manière pertinente et adaptée à des besoins réels et importants des travailleuses du sexe ;
- Le modèle développé par Horizons Femmes est réplicable en tant qu'outil et stratégie de lutte contre le sida en direction des populations clés ;
- L'expertise acquise par Horizons Femmes à travers cette expérience peut être mise à disposition d'autres acteurs de la lutte contre le sida au Cameroun et dans d'autres pays.

12. Cameroon

Title of the programme: Continuum of prevention, care and treatment of HIV Aids with most at risk population (CHAMP)

CONTACT PERSON
Name:Eloundou Atamba Jules Charles
Title: Executive Director
Organisation:Humanity First Cameroon
Address: Essomba Titi Garage
Tel:+237 699497124
Email:eloundou_jules@yahoo.fr

Programme is being implemented since: 2014
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability; Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) and Participatory community-based research in relation to men who have sex with men.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Le cameroun connait actuellement une épidémie généralisée, c'est le deuxième pays en Afrique Centrale et Occidentale après le Nigéria avec un fort poids de l'infection.la prévalence nationale pour les jeunes de 15-49 ans est de 4,3%. Les populations clés comme partout ailleurs ont un taux largement au dessus de la population générale. L'étude IBBS de 2011 a par exemple montré que nous avons un taux de 44,3% seulement à Yaoundé pour les HSH et et 24,3% à Douala. Ce programme a donc pour but de venir réduire le taux d'incidence en s'assurant que conformément aux objectifs 90-90-90 de l'ONUSIDA, les personnes dépistées positives sont mises sous traitement et que tout est fait pour qu'elles aient une charge virale indétectable. Mais cette mission n'est pas facile dans un pays qui condamne l'homosexualité à travers l'article 347 Bis du code pénal

Description:

Le programme CHAMP de USAID est implémenté au Cameroun par l'ONG international care Cameroon.Elle dispose des partenaires de mise en œuvre u niveau communautaire. C'est à cet effet que Humanity First Cameroon mène des action sen direction des hommes ayant des rapports sexuels avec d'autres hommes de la ville de Yaoundé. Nous avons en effet des indicateurs qui nous sommes assignés chaque qu'année, et au niveau communautaire nous mettons en place des activités nous permettant d'atteindre nos indicateurs.

Results of the programme:

En termes de résultats obtenus depuis la seconde année de mise en œuvre du projet allant d'Octobre 2015 à Septembre 2016, nous avons pu dépister **244 HSH** parmi lesquels **146 positifs**. Nous avons mis Jusqu'ici **86** sous traitement qui on tune charge virale indétectatble.

Financing and management:

Le programme est financé par USAID etmanagé par Care Cameroon, nous nous retrouvons au cours des MARPs forums avec toutes les organisations impliquées dans la mise en œuvre de ce projet afin de parler des difficultés que nous rencontrons, c'est également un lieu de partage d'expérience. Nous avons entamé un plaidoyer avec le gouvernement camerounais pour la pérennisation de nos actions. Mais nous sommes conscients qu'il est plus que jamais que nous mettons en place de mesure de pérennisation.

Lessons learned and recommendations:

L'engagement communautaire nous a été d'un grand support. Nous avons une équipe dynamique qui croit en la cause qu'elle défend. Nous pouvons féliciter le partenariat que nous avons noué avec l'hôpital militaire où nous referons nos bénéficiaires pour la prise en charge médicale du VIH.le défis majeur au cours de cet projet étant d'avoir réussir à mettre en œuvre des activités envers les HSH dans un contexte répressif envers l'homosexualité. Mais tout ceci est le résultat d'une coordination entre les instances nationales et internationales pour que seule l'humanité première soit pris en compte et que les personnes retrouvent leur santé et puissent vaquer à leurs occupations.

13. Democratic Republic of the Congo

Title of the programme: HIV/AIDS prevention amongst Gay men, Men who have sex with men, Transgender (GMT) and Sex workers through voluntary counseling and testing services: field experiences of HIV Community-based Testing Center of NGO"AHUSADEC" in Bukavu, South-Kivu Province, East of DRCongo.

CONTACT

Name: Raphael NGELEZA
Title: National Coordinator
Organisation: Humanitarian Action for Health and Development Community (AHUSADEC).
Address : 042, avenue Kibombo, C/Ibanda, Bukavu-South Kivu province, East of DRC
Tel : +243997739056/+243853153050
Emal : rngeleza.ahusadecongo@gmail.com

Implemented by : Civil Society
Scope of Submissions : Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV, men who have sex with men, sex workers, transgender, women, young people and others

Has the programme been evalauted/Assessed: Yes
Is the programme part of the implementation of the National AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

The Democratic Republic of Congo has lived more than two decades in wars and armed conflicts. The East of the Republic is at the center of this leading to the rise in poverty and a high rate of HIV / AIDS.

Gays, Men who have Sex with men, Transgender and Sex workers groups are also affected by this situation and unfortunately have no prevention program for HIV / AIDS, and yet are very vulnerable and exposed to HIV when it is a significant social category the fight against HIV / AIDS. The marginalized status of Gays, Men who have Sex with Men (MSM), transgender and sex workers in the DRC maintains a position of vulnerability because of the prevalence of discrimination based on sexual orientation and gender identity although they are responding to the national struggle against the HIV / AIDS.

The majority of new infections in the DRC concern key populations, so they are a determining factor for the future development of the HIV / AIDS. They are exposed to HIV infection in high percentages. The stigma of sex work and homosexuality, combined with a strong rejection of intolerance made against the sexual minorities, remain powerful barriers to access to services and information about HIV / AIDS.

Description:

Goal:
This project contributes to reducing the spread of HIV / AIDS among vulnerable groups. To achieve this, the project seeks to provide access to 1000 GMT sex workers to HIV voluntary testing so that they can prevent against HIV and facilitate referrals to treatment, care and support for PLWHA in Bukavu town, South-Kivu Province, East of DRCongo.

Specific objectives:

- Improve access to HIV testing / STIs among 1000 GMT sex workers in Bukavu town and its peripheries, South-Kivu Province, East of DRCongo.
- Improve GMT HIV positive reference system to support services for opportunistic infections and ARV treatment in Bukavu town, South-Kivu Province, East of DRCongo.
- Provide support for STI GMT attending HIV/AIDS Testing Center.

AHUSADEC provides HIV testing, counselling, and outreach services to gay men, other men who have sex with men and transgender (GMT) individuals and to female and GMT sex workers. It is the only group in this part of the country targeting GMT individuals with HIV services. These services include the prevention of HIV transmission, improving access to HIV services including voluntary testing for HIV / AIDS. AHUSADEC is also working to combat the stigma, discrimination, and violence GMT individuals encounter, both in healthcare settings and in society in general.

Our HIV / AIDS testing center is open to the rest of the members of the community for reducing stigma and discrimination against GMT. To date, the center is considered as belonging to a whole community, not separatist, not reserved exclusively to GMT. That is how 8 352 members of the community have been touched by our awareness actions coupled to test for HIV / AIDS among which 1,674 have access to HIV testing and 23 were referred to treatment, care and support for PLWHA. Our HIV testing center provided statistical information on HIV / AIDS at the local, provincial and national level regarding the rate of HIV prevalence in the general community and especially for GMT and sex workers.

Our HIV AIDS testing center reached 1 674 people in general public and 908 GMT sex workers who have completed HIV testing, of which 19 have been declared HIV positive.

Results of the programme:

We have successfully tested 908 GMT sex workers in Bukavu town and its peripheries, South-Kivu Province, East of DRCongo. The age of most GMT varies between 18 and 35 years. As well, 8,352 people in the community have been sensitized on the need to know their HIV serostatus. We have successfully tested 1,674 people in general public.

- 19 GMT sex workers (tested HIV positive) have been referred to support services for opportunistic infections and ARV treatment;
- 23 people (tested HIV positive) in the community in general have been referred to support services for opportunistic infections and ARV treatment;
- 121 GMT sex workers have been treated for STIs.

Impact of the programme:

Besides counting the number of beneficiaries of the services we offer, the impact of our work can be measured by checking changes in behaviours observed in the daily life of beneficiaries (acceptability and accessibility of voluntary testing HIV / AIDS among the beneficiaries, acceptability of referral to opportunistic infection treatment services and access to ARVs, acceptability of STI treatment, accessibility and acceptability of using condoms and lubricants).

Ultimately, the services we offer can help in the short and long term to reduce the rate of spread of HIV / AIDS and STIs among the GMT in particular and people in general.

Compared to our target:
The project allowed 1 000 GMT sex workers to know their HIV status. Our HIV/AIDS testing center has treated 121 GMT suffering of STIs and finally, it facilitated the reference of 19 GMT HIV positive to service of care for opportunistic infections and treatment with Anti Retroviral. About our referral system: we have changed and improved our reference system compared to the old system: our current reference system is guided (assisted). Indeed, compared to the old system which delivered only reference card to customers (beneficiaries) to go to the specialized services of psychosocial care and support opportunistic infections and ARV treatment, currently our HIV Testing Center Nurse accompanies them directly to support services. This strategy allows us to reassure a good care of customers.

In addition, our two nurse counsellors under the supervision of the Responsible Nurse organize home visits to reassure the effectiveness of ARV treatment and mental health in general. Now we are codifying records referred HIV-positive clients to ensure confidentiality.

Data provided by our HIV Testing Center is documented and / or capitalized by National Programme fighting against AIDS in its database.

This project has contributed to the efforts of our country to reduce the spread of HIV / AIDS among key populations (GMT) through their involvement both as a key actors as beneficiaries.

Through this project, our organization has developed alliances and / or partnerships with other NGOs and government agencies involved in the fight against HIV / AIDS for effective action against this pandemic in the following areas: prevention, referral and management of opportunistic infections and ARV treatment.

Although our testing center for HIV / AIDS is specific to GMT, it also receives the community members who wish to know their HIV status. The strategy is to minimize the risk that our center is regarded in the community as a center specifically reserved to GMT. That's why we've been able to testing 1 674 people in the community. Additionally 8 352 people in the community have been sensitized on the need to know their HIV status.

We also organize awareness sessions coupled to testing HIV / AIDS in bars, nightclubs, public restaurants. This strategy has allowed us to achieve many of the GMT sex workers and community members who have difficulty to arrive to our center.

Financing and management:

Our organization plays an important role in promoting human rights and health protection for sex workers and Lesbian, gay, bisexual and/or transgender group.

Our organization works with and for LGBTI people. The characteristic of our organization is that the composition of mixed persons, both LGBTI individuals and not. LGBTI individuals are involved in decision-making through their representatives participating in the Senior Management Team.

Details of our Board and Senior Management Team:
- Decisions are taken in a concerted manner at meetings which include the Chief Executive Manager, members of staff and two representatives of the beneficiaries.

- The Senior Management Team is composed of ten members, including two representatives of the beneficiaries: Chief Executive Manager, Program Officer, Logistic & Administrative Officer, Financial Officer, Account Officer (He is a MSM), Women Program Officer (she is a Lesbian sex worker) and HIV Testing Center Nurse- Manager (He is a MSM) and HIV/AIDS & sexual and reproductive health Educator.
- Two representatives of the beneficiaries are involved in the design, implementation, monitoring and evaluation of all our projects.
- The General Assembly elects the members of the Board of Directors for a period of 2 years. The Board of Directors is composed of 7 people, including the President, the Vice President, the Treasurer, the recording secretary and 2 advisors.
- There are MSM & Lesbian sex worker in leadership positions within our organization: the HIV Testing Center Nurse-Manager, the accountant and the Women Program Officer.

Resources and capacity.
Currently our executive team is composed of 10 people, including 8 who work and are paid full-time and two who work and are paid part-time.

Our organization in the past has developed two projects to promote human rights and health protection of key populations including sex workers and lesbians, gay, bisexual and / or transgender through advocacy, communication for behavior change, promotion of voluntary HIV / AIDS, the correct and consistent use of condoms, the management of STIs, the reference to the support services for opportunistic infections and ARV treatment for HIV-positive clients reported and monitoring home.

We currently do not have external donors but our Organization has received funding from the following international organizations:
- [The Netherlands Organization "MAMA CASH" through the "Red Umbrella Fund" in 2012] and
- [amfAR, The Foundation for AIDS Research through GMT Community Initiative in 2013-2014].

With the financial support of our partner amfAR, we have established a HIV / AIDS Center specifically for LGBTI, MSM and sex workers.

These projects are a response to the multiple exclusions of LGBTI sex workers prevention and testing structures of HIV / AIDS.

The two projects developed by our Organization with the financial support of our partners listed below:
- Promoting human rights for 478 sex workers and health protection in Bukavu/South Kivu Province in Democratic Republic of Congo. For a total budget of 25,000 USD, the project targeted 478 sex workers in the city of Bukavu, South Kivu province, East of the DRCongo. This Project Was Funded by the Netherlands Organization "MAMA CASH" through the "Red Umbrella Fund" in 2012. This project was to conduct advocacy for the protection and defence of sexual and human rights of sex workers, in strengthening organizational capacity and facilitating their access to HIV prevention and testing services for HIV / AIDS.
- Improving Social and Health conditions for 908 LGBTI-sex workers in Bukavu/South Kivu Province in Democratic Republic of Congo. This project has the merit of facilitating access of 908 LGBTI-sex workers to HIV voluntary testing so they can protect against

HIV and facilitate their referral to treatment, care and PLVHIV service. This project also led community actions to reduce stigma, discrimination and rejection against LGBTI- sex workers in Bukavu in Eastern of DR Congo. This project was financially supported by the American Foundation amfAR (The Foundation for AIDS Research) through the Community Initiative for Gays, Men having Sex with Men (MSM) and Transgender individuals an overall budget of 47,984 USD, implemented for two years (May 2013-April 2015).

Capacity to manage projects:

- Our organization has at its center a multidisciplinary team including health professionals specialized in the fight against HIV / AIDS, violence based on gender and sexual reproductive health can well lead the activities proposed in this project;
- The two above mentioned projects we have managed with the financial support of amfAR and MAMA CASH through " Red Umbrella Fund " (funds exclusively for sex workers) and Community Initiative Award (funds exclusively for Gays, Men Having Sex with Men (MSM) and Transgender Individuals) are two major accomplishments and great assets that demonstrate our ability to manage the projects. Our organization therefore has a good grasp and understanding of rules and requirements; principles and funding procedures of international donors.
- Our Organization manages a Community HIV / AIDS Testing Center specifically for key populations including sex workers and lesbians, gay, bisexual and / or transgender.

Note:
We work also worked with the National Programme fighting against AIDS (PNMLS) which is a public state institution responsible for coordinating the fight against AIDS in DRC. Its role is to coordinate, harmonize and monitoring and evaluation of interventions of all stakeholders in the fight against HIV and AIDS in the respect of the principle: a single frame of action against HIV / AIDS, only one instance of coordination at the national level, one monitoring and evaluation framework responding to global policy to fight against AIDS.

Lessons learned and recommendations:

- The Sex workers, transgender and MSM are actively involved in the fight against HIV / AIDS through the "Champion Community" approach that ensures leadership in the fight against HIV / AIDS;
- The program includes the prevention of HIV transmission, improving access to HIV testing services, treatment of sexually transmitted infections, the establishment of a reference system to support treatment opportunistic infections and ARV treatment;
- Awareness sessions coupled with testing of HIV / AIDS in bars, nightclubs, public restaurants. This strategy has allowed us to achieve many of the GMT sex workers and community members who have difficulty to arrive to our center; - The HIV/AIDS prevention needs and access to treatment of opportunistic infections and ARV services are great but resources are limited.

Major challenges:

- Most MSM and sex workers showing signs of sexually transmitted infections (STIs) is 90%, but unfortunately we do not cure completely;
- The rupture of stock testing kits for HIV / AIDS because of the high customers demand for testing;
- The need to strengthen the referral system for HIV clients by close monitoring and / or

home monitoring;
- The stigma of sex work and homosexuality, combined with a sharp rejection of intolerance levelled against these sexual minorities remain powerful barriers to access to services and lifesaving information on HIV / AIDS.

Recommendation:
- Establish a clinical holistic management of STIs for Key populations.

14. Ethiopia

Title of the programme: Radio Program to reach out to sex workers and communities

CONTACT PERSON
Name: Hanna Hagos
Organisation: Nikat Charitable Association
Address: Bole Sub-City, Woreda 4, House no. 956
Tel: +251-912608431, +251-911444138
Email: nikatcharitableassociation@gmail.com

Programme is being implemented since: 2014
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to sex workers

Is the programme part of a national plan broader than the National AIDS Strategy? No

Background:

Very religious community who discriminates and criticizes sex workers. Always think that sex workers are the one that have HIV and transmit HIV as well. Low income country where many are forced to enter into sex work due to economical problems.

Description:

The Association transmitted a once weekly radio program that advocates for the prevention of trafficking, discussion about HIV/AIDS, radio diary of a sex worker life since the beginning, peer education, discussion of sex workers about their health and life and a follow up program with stakeholders related to sex workers. Also to advocate for prevention of trafficking/exploitation of young people/minors to the sex industry, SRHR rights and the law on minors.

Results of the programme:

The program has reached more than 2,000,000 audiences in Addis Ababa and its surroundings.

Impact of the programme:

Respecting the rights of sex workers by the community, raising awareness level of SRH and HIV through Participatory approach of the program for audience. Increase the support of the

community for sex workers.

Financing and management:

Through donation from Aids Fonds, International HIV/AIDS Alliance, Canada Embassy in Ethiopia.

Lessons learned and recommendations:

It was a new experience to have a sex worker talk about her life on public media.
The community is accepting that the problem also rises from them. It's not only the sex workers who are transmitting the disease of HIV but the community as well.

15. Gabon

Titre du programme: Le Wé là chez les jeunes

Nom : Alain Guy OBIANG MBELLA
Fonction : Directeur
Organisation: Fondateur en charge des stratégies et politiques
Addresse : 1105 s/c Allogo Mezui Rolland Hervé Libreville
Tél : +241 04 35 57 04
Courriel: alain.amsplus@gmail.com

Le programme est en place depuis: 2016
Mis en place par: Gouvernement, Société civile, Secteur privé Nations Unies ou autre organisation non gouvernementale

Sujet de la soumission: Prestation de services à assise communautaire (soit dépistage, prévention, soins et appui, traitement, services juridiques, délégation des tâches, formation d'agents de soins de santé, etc.) avec femmes enceintes ainsi que leurs partenaires et leurs enfants. Recherche participative à assise communautaire, Financement communautaire, Ripostes communautaires dans le contexte humanitaire

Le programme a-t-il été évalué/estimé? Non
Le programme fait-il partie du plan national de lutte contre le SIDA? Oui
Le programme fait-il partie d'un plan national d'action d'urgence? Oui

Généralités :

Depuis la déclaration de 1e cas de sida au Gabon en 1985, le pays s'est engagé à faire de la lutte contre le sida une des priorités de son action Gouvernementale. Dans la riposte contre ce fléau, l'engagement politique se situe au plus haut niveau de l'Etat. En effet, le pays s'est engagé en souscrivant à toutes les Déclarations adoptées par la communauté internationale et au niveau national par la mise en place des stratégies efficaces pour répondre au problème VIH/sida.

La couverture du financement est à 92% par l'Etat (nette écart entre 2013,soit 5 636 268 324 milliard et 2014, soit 2 926 694 672 milliard) ce qui favorisé la création d'un fond de solidarité thérapeutique pour permettre aux personnes conditionnées par le VIH de bénéficier d'un

traitement Anti Rétro Viral gratuit.

Il est fort du constat, que les mesures importantes prises par le Président de la République en 2011 ne sont pas effectives, il en va pour :

- Les examens biologiques et traitement des maladies connexes qui reste un problème
- La gratuité de l'accouchement pour les femmes conditionnées par le VIH
- La décentralisation de la prise en charge des personnes conditionnées par le VIH
- La création des comités ministériels de lutte contre le sida, ainsi que l'allocation budgétaire desdits comités ministériels ; L'intégration des curricula sur le VIH/sida dans les programmes scolaire à tous les niveaux d'enseignement.

Des plans stratégiques nationaux quinquennaux de riposte contre le VIH/sida sont élaborés et mis en œuvre depuis 2001. Actuellement, les programmes de riposte au sida sont élaborés et mis en œuvre conformément aux stratégies et résultats visés par le Plan Stratégique National (PSN) 2013-2017 dans les domaines de la prévention, de la prise en charge, de la transmission mère-enfant, des droits humains, du genre et de la gouvernance.

Description du Programme:

Contexte VIH/sida Gabon :
En 2014, aucune enquête ou étude spécifique au VIH n'a été menée. De manière rétrospective, l'épidémie à VIH au Gabon a connu une évolution ascendante de prévalence entre 1986 (1,8%) et 2003 (8,1%), puis elle se stabilise entre 2007 (5,9%) et 2009 (5,2). En 2012, l'enquête EDSGII estime cette prévalence dans la population générale à 4,1%.

Cette prévalence présentant de grandes disparités selon les provinces, l'âge et le sexe. Sur les 9 provinces en effet, 5 affichent une séroprévalence supérieure à la moyenne nationale. Il s'agit du Woleu-Ntem (7,2%), du Moyen-Ogooué (5,8%), de la Ngounié (4,9%), du Haut-Ogooué (4,2%) et la Nyanga (4,2%). Il faut signaler que sur les 1,8 millions d'habitant la province de l'Estuaire à elle seule abrite plus 70% de population avec ces 3,9% qui semble insignifiant.

Les écarts hommes-femmes toujours aussi visible. Chez les femmes de 15-49 ans, la prévalence est de 5,8% et est de trois fois moins chez les hommes. Cette réalité témoigne de la forte vulnérabilité des femmes face à la pandémie au Gabon.
Entre 15-19 ans 1,5% sont séropositives et ce taux augmente très rapidement et atteint un max de 9,1% à 35-39 ans ; il baisse ensuite à 7% à 45-49 ans. Chez les hommes par contre la prévalence est beaucoup plus faible de 0,4% entre 15-19 ans et augmente plus lentement et atteint 3,8% entre 35-39 ans, 5% entre 45-49 ans et 7,2 % entre 50-59 ans.
Les nouvelles infections on diminuées entre 2013, soit 1 700 et 2014, soit 1 536 (-9,64%) dans la population générale. Les nouvelles infections chez les jeunes de 15-24 ans sont estimées alors entre 580 en 2013, 426 en 2014, soit 322 pour les filles et 104 pour les garçons.
Les cas de décès sont quant à eux entre 2 100 pour 2013 et 1 456 en 2014.
21 759 PVVIH sont sous TAR.

La transmission mère-enfant note une légere de 12,1% en 2013 pour 11,79% en 2014, du à la couverture du fait de la decentralisation de la dispensation des ARV dans les SMI (62% en 2013 pour 68,8% en 2014)

Pour les populations clefs, aucune donnée n'éxiste faute d'enquête. La dernière enquête sur les PS était en 2009 et laprévalence était de 23%. La connaissance liée àl'environnment VIH/sida

et les pratiques des jeunes méritent une attention particulière.
L'EDSGII revéle en effet que 30% des femmes entre 15-24 ans on tune connaissance exacte des moyens de prevention sur le risqué de transmission sexuel et rejettent les idées fausses, contre 36% d'hommes de la même tranche d'âge. De même, que le marketing social du préservatif reste assez faible. Chez les 15-19 ans, 63,9% des femmes contre 78% d'hommes déclarent avoir utilise un préservatif au cours de l'année.

2 cibles : 15-24 ans et 25-35 ans
Zone : Estuaire ; Haut Ogooué ; Ogooué Maritime ; Woleu Ntem

Durée du programme : 2016-2018

Objectif généraux :

Objectifs spécifiques :

1. Promotion du dépistage et connaissance du statut sérologique VIH chez les jeunes (prévention),
2. Accompagner, soutenir et éduquer les nouveaux cas dans le circuit de prise en charge (traitement),
3. Favoriser la charge virale supprimée chez les jeunes conditionnés d'ici 2018 (accompagnement et appui psychosocial et thérapeutique).

Mise en œuvre : Medzoe Santé Plus (AMS+) et Partenaires Techniques et Financiers

Fonctionnement:

Présentation de l'organisation : Medzoe Sante Plus (AMS+) crée, le 15 Juin 2013, contribue positivement dans la vie des jeunes/adolescents vivants et affectés par le VIH/sida, conformément aux dispositions de la loi 35/62 du 10 décembre 1962 relative aux associations République Gabonaise, reconnu sous le n° 017/MISPID/SG/ZER domicilié à FINAM, agence de Nzeng-Ayong sous le n° A10005249, compte EMF-FINAM SA. BICIG CENTRALE n° 40001 09070 00424400049 pour les paiements en chèque ou virement bancaire au nom de Medzoe Santé PlusFondée par Alain Guy Obiang Mbella « Medzoe » signifiant histoires en langue vernaculaire Fang à une époque où les problèmes de société se réglaient dans un corps de garde.

À propos d'AMS+
Afin de faire avancer l'agenda concernant la prévention, le traitement et les soins pour les jeunes, AMS+ contribue également aux consultations dans le cadre du pacte social, et a participé à l'initiative du CrowdoutAIDS UNAIDS et les ACT 2015 des Nations-Unies. En tant que premier réseau de jeunes vivant avec le VIH/ affecté par le VIH, des formations des pairs et une formation des formateurs ont été organisé avec l'appui de l'ONUSIDA. Des outils de soutien ont été élaborés et des activités de counseling-écoute et appui aux pairs ont commencé dans les C.T.A' s et en dehors des C.T.A' s. Le dynamisme du jeune réseau a fait de Medzoe Santé Plus un partenaire incontournable, non seulement dans la riposte au sida mais aussi sur les questions de santé, droits et justice sociale.

Jusqu'à maintenant, des appuis techniques ponctuels et ad hoc, surtout de l'Onusida ont encouragé les jeunes volontaires à s'investir et à développer leurs capacités. Cependant, un appui plus systématique permettra de consolider les acquis, d'aller d'avantage vers les lieux et les populations clés ou il y les besoins et d'évoluer en tant qu'acteur dans les programmes de mise en œuvre pour l'atteintes des objectifs du millénaire pour la sante, VIH-sida et les IST, afin

de renforcer et innover la prévention du VIH et d'intensifier la prise en charge des adolescents infectés et entant que facilitateur naturel auprès des pairs.

Résultats du programme :

Soit pour tout le programme :
Les 4 zones les plus touchées par le VIH et le sida qui sont Estuaire, Haut-Ogooué, Ogooué-Maritime et le Woleu - Ntem ont accès aux informations et services adéquat via les agents communautaires 6 pairs sont formés et peuvent informer et donner le bon message à travers différents canaux de communication adéquat aux jeunes et disponible ; 15 agents formés, disponibles, appuyent et accompagnent les personnes conditionnées par le VIH pour les 2 premières années dans l'Estuaire; 10 000 jeunes ont la bonne information ; près de 7 000 jeunes sont testés au VIH, 6 500 jeunes sont sous ARV et ont une charge virale supprimée.

Impact du programme :

Flyers, Booklet et spots pour la prévention et l'orientation des jeunes sur les droits humains et accompagnement communautaire ; La mise en place d'un pool d'agent communautaire pour l'appui psychosocial et thérapeutique.

Premier déploiement d'agent communautaire locaux et les expériences régionales prouvent l'efficacité et le rôle important de ces agents comme relais essentiel aux professionnels de santé, d'où l'utilité de sa mise en œuvre au Gabon appuyé par l'hotel de ville de Libreville dans le cadre de l'initiative des villes, dont la Gabon est signataire et la Mairesse de Libreville occupe la vice-présidence Afrique.

Financement et gestion :

Structure du programme :
En collaboration avec les pouvoirs publics, les Agences du Système des Nations-Unies au Gabon, le projet sera géré par AMS+. Un comité de pilotage composé du secrétaire-Exécutif d'AMS+ et des "co-parrainants" de l'ONUSIDA et de la DGPS sera mis en place et se réunira une fois par semestre.

La gestion financière du projet sera assurée par l'ONUSIDA. Les décaissements seront effectués dans le respect des procédures de gestion financières du S.N.U et selon les plans de travail annuels par semestre retenus et validés par le Comité de pilotage. Le Comité de pilotage sera assuré par AMS+ et les "co-parrainants" de la DGPS et de l'ONUSIDA.

Tous les fonds mobilisés seront versés dans le compte d'AMS+, placés sous sa gestion et selon ses procédures. L'Agence d'exécution fera régulièrement le point de la gestion des fonds à AMS+ et aux autres partenaires dans le cadre des réunions programmées du comité de pilotage du projet.

Les activités du plan d'action d'AMS+ font parties des objectifs conjoints « zéro discrimination, zéro nouvelles infection et zéro décès liés au VIH/sida et des trois 90 ». Ces activités seront intégrées dans le programme conjoint sur le sida et le cadre d'évaluation national, et feront donc partie du cadre d'évaluation du programme conjoint sur le sida.

Coordination du programme :
AMS+; OPALS; CNJG; PNUD;ONUSIDA; DGPS; PLIST

Partenaires Techniques et Financiers :
Secteur public, secteur privé, système des Nations-Unies et Organismes Bilatéraux

Cycle annuel du programme :
Sur une base semestrielle, une réunion de suivi de qualité permettra d'enregistrer les progrès réalisés dans l'accomplissement des résultats clés du projet selon des critères et des méthodes bien définies. Un rapport annuel des progrès accomplis devra être soumis par le responsable du projet.

Le responsable du projet suivra et informera sur d'éventuels problèmes ou changement qui surviendront, ou qui qui sont survenus au cours du trimestre. En fonction de l'analyse initiale des risques, le responsable du projet devra régulièrement actualiser les risques en revoyant le contexte environnemental qui peut affecter la mise en œuvre du projet. Le rapport annuel sera préparé par le responsable du projet et partagé avec le comité de pilotage du projet.

Audit :
Les comptes du projet suivront les procédures d'audit des agences du Système des Nations-Unies. Tous les fonds transférés à Medzoe Santé Plus pour assurer la mise en œuvre des activités feront aussi l'objet d'audit en suivant également les procédures du S.N.U. Selon le cycle du rapport annuel

Financement :

Part annuel : 68 000 0000 FCFA
Total programme : 205 000 000 FCFA sur 3 ans

Enseignements tirés et recommandations :

Le programme a été soumis à l'ONUSIDA Gabon, qui a décrit le programme comme ambitieux. D'où la mise en place d'un mécanisme de coordination multipartite, au vu de la faible expérience de l'organisation

Reste que AMS+ est encore la seule organisation spécifique des jeunes conditionnés et affectés par le VIH au Gabon et fournit la quasi-totalité des données Gabon avec l'appui de l'ONUSIDA et autres partenaires tel que l'OPALS qui bénéficie de ses expertises.

Il est aussi à mettre en évidence que l'organisation paie le tribut de la gestion faite par les prédécesseurs, ce qui a favorisé le retrait du Fonds mondial au Gabon. Il a subi des averses dues au contexte politique et économique délicat, et tente de démarrer dans les délais raisonnables. Mais sa pertinence n'est plus à prouver.

L'appui de l'ONUSIDA et l'OPALS dans la réalisation de ce programme démontre l'intérêt à s'activer dans cet environnement vierge.

1. Outiller, former et appuyer les OSC au Gabon dans la gestion des programmes ;
2. Favoriser à la création des OSC à base communautaire ;
3. Intégrer au niveau régional et international d'élaboration et mise en œuvre des politiques et programmes les OSC du Gabon

16. Ghana

Title of the programme: Stigma and Discrimination Reduction among PLHIV and Key Population

CONTACT PERSON
Name: Efua Mansa Ewur
Title: Legal Officer
Organisation: Commission on Human Rights and Administrative Justice
Address: P. O BOX AC 489, ARTS CENTRE, OLD PARLIAMENT HOUSE, ACCRA
Tel: 233-26-9822076/ 233-203154861
Email: efuaewur@gmail.com

Implemented by: Government
Scope of submission: Advocacy, campaigning and participation in accountability
Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV, men who have sex with men, sex workers, and transgender people

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy?Yes

Background:

In Ghana though the HIV prevalence rate stands at 1.5% , the infection rate among the Men who have sex with Men (MSM)and female sex workers (FSW)stands at 17.5 and 11% respectively. Both groups unfortunately suffers disproportionate stigma, discrimination, and poor access to health and human rights violations, and this has contributed to the high rate of HIV infection among them. The stigma and discrimination faced could be physical, verbal , institutional or a combination of both Though there are institutions and structures for every person in Ghana to access justice, the PLHIVs and KPs most often are unable to access justice because of the high level of stigma and discrimination they face on daily basis. To address this issue and to further reduce the HIV infection among them, the Commission on Human Rights and Administrative Justice (CHRAJ in Collaboration with the Ghana AIDS Commission (GAC) launched a Discrimination Reporting System (DRS)on the World AIDS Day in December, 2013.

Description:

The Discrimination Reporting System implemented by the CHRAJ uses both online Web based and SMS reporting modules. The system is designed to facilitate the reporting and tracking of cases online and also send text message via the phone to CHRAJ whilst reducing human contact.

To ensure effective implementation of the DRS, the CHRAJ set up a specialised desk known as the Health Rights Desk to handle complaint received from the PLHIV and the KPs. The desk is manned by the National Health Rights desk Task Team. The CHRAJ also trained National Facilitators to carry out further trainings to the staff of the CHRAJ.

Concerns arisen at the inception of the programme by the PLHIVs and the KPs were around issues of Privacy and confidentiality. To address this concern, the CHRAJ developed and Privacy and Confidentiality Policy in December, 2014 to address issues around disclosure, trust

and secrecy. The Policy aims to protect the identities of the people using the system and most importantly protect the information that comes within the domain of CHRAJ and sanctions any staffs that breaches the confidentiality. The policy is the first of its kind at the CHRAJ since its establishment about 23 years ago.

Results of the programme:

- As part of the programme, the CHRAJ embarked on institutional capacity development programme. Between 2013 and 2015, the CHRAJ trained about 200 staff including frontline staff on stigma and non discriminatory practices. Trainings have been conducted in 7 Regions of Ghana namely; Ashanti, Eastern, Western, Central, Brong Ahafo and Volta. These regions are identified as the hot spot of high HIV prevalence rate.
- A year after the implementation of the programme, the CHRAJ observed that cases trickled in slowly and only 22 cases had been reported. The CHRAJ identified it as a knowledge gap on stigma, discrimination and human rights issues. The CHRAJ quickly worked with Civil Society Organisation (CSOs) to bridge the gap and generate demand for case. The CHRAJ as part of its demand generation trained about 464 PLHIVs, KPs and Service Providers between May 2015 - September 2015 in 6 regions of Ghana namely; Greater Accra, Eastern, Western Central, Ashanti and Volta Region.
- Other activities conducted to generate demand for cases include;
- Developed social marketing materials including brochures, cards and fliers
- Distributed over 1000 brochures and cards nationwide
- Developed and distributing anti-stigma and discrimination posters over 200 sites nationwide
- Developed target radio advert aimed at PLHIV and aired over a period of 2 weeks.

Impact of the programme:

The implementation of the programme has made justice more accessible for the PLHIV and the KPs by strengthening legal support services for redress. It has also empowered the PLHIV and the KPs to fight against social injustices, right to privacy and non disclosure and all socio-cultural consequences which impede the right to health. The DRS provides the sources for data on discrimination for advocates and policy makers in Ghana.

Financing and management:

The Programme was first implemented with the technical support from the USAID/HPP. The UNAIDS and the UNDP supported the CHRAJ after the USAID existed in July,2015. The CHRAJ exercised Institutional oversight and redirection

Lessons learned and recommendations:

The factors that helped the programme were:

- The Technical Support from the USAID/HPP and the UNDP after the USAID existed in July, 2015.
- The setting up of the Health Rights Desk to quickly and effectively work on the cases.
- Institutional Support/Political Will and commitment from the Commissioners/ Management.
- Institutional capacity building of the CHRAJ staff
- Effective collaboration with Key Partners such as the Ghana AIDS Commission, the

UNAIDS, the UNDP, Family Health International (FHI360) and other CSOs to market the System. Organisations like the FHI360, West African Aids Foundation (WAAF) , CEPHERG gave CHRAJ the Platform to market the system. FHI 360 assisted in the dissemination of the information of the system though SMS messaging to the PLHIV.
- Funding is one of the major challenges that the CHRAJ faces as the CHRAJ does not generate funds and has to rely on Government of Ghana funds to implements its activities.
- Another challenge is the issue of socio-cultural/Religious Practices.
- Learn from the best practices from the implementation of the discrimination reporting system.
- Make human Rights an integral part of HIV manual.
- Make the Discrimination Reporting system an integral part of CRIS.
- Need to integrate Human Rights education into schools curriculum

17. Ghana

Title of the programme: “Reinforcing the scaling up of HIV services: Strengthening Community-Based HIV prevention and effective targeting”

CONTACT PERSON
Name: Gabriel Gbiel Benarkuu
Title: Chief Executive Officer
Organisation: Mihoso International Foundation
Address: BOX 1694, Sunyani, Brong Ahafo
Tel: 0233-20-8500875
Email: hopeforsociety@yahoo.com

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) and participatory community-based research in relation to people living with HIV, sex workers, transgender people and young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? No

Background:

Ghana is experiencing a mixed HIV epidemic comprised of a low-level, generalized epidemic among the general population, coupled with a high prevalence epidemic among key populations. In 2013, the HIV prevalence among the general population was estimated at 1.30%. However, HIV prevalence among FSW and MSM is more than ten times that of the general population. In 2011, the HIV prevalence rates among the FSW and MSM were 11% and 17.5% respectively. In addition to their increased risk for acquiring and transmitting HIV infection, MSM and FSW face formidable legal, social and institutionalized barriers that limit their access to health and social protective services.

To address the situation in Ghana, the Global Fund (GF) has designed a partnership New Funding Model (NFM), made up of governments, civil society, the private sector and people

concern in fighting HIV, TB and malaria, and to constantly evolve to meet connected challenges in global health.

ADRA Ghana Partnered MIHOSO INTERNATIONAL FOUNDATION as a Sub-Recipient (SR) to implement part of the NFM interventions in the Ashanti Region.

Description:

MIHOSO as a Sub-Recipient (SR) is implementing the Global Fund (GF) New Funding Model (NFM) interventions in the Ashanti Region with 5 participating communities/districts. Thus 3 Municipals and two (2) Districts Assemblies (MDAs) in the Ashanti Region, namely Asokore Mampong Municipal, Ejisu Juabeng Municipal, Bekwai Municipal, Kwabre and Adansi North District Assemblies.

The primary focus of the programme is on; ***community-based advocacy, Demand for HIV/TB service delivery (HIV prevention, treatment, care and support, Human Rights sensitisation etc), evidence based-research, and livelihood empowerment of key population.***

The project goal is to reduce new HIV infection and death among Key Population in the next 3 years (2014-2016).

The specific objectives of the project are:

I. To promote the adoption of Safer sexual practices among the Key Population.
II. To promote health and the adoption of safer sexual practices among the Key Populations.
III. To strengthen the institutional capacity and community systems for scaling-up HIV and AIDS,STI and TB prevention services.

Community-based Activities

The program activities that were carried out during the past one and half years are as follows:

a) Conduct one-on-one/small group HIV prevention education with FSWs
b) Conduct Peer-led community engagement
c) Conduct Love and Trust Outreach activity
d) Conduct monthly review meetings for Peer Educators (PEs)
e) Conduct mobile HIV Testing and Counseling (HTC) sessions among key population.
f) Conduct Community Conversation Enhancement (CCE Methodology) sessions on Stigma and Discrimination Reduction
g) Provide drop-in-centres for STI/HIV Testing and Counseling (HTC) services
h) Supervision and Evidence-based Monitoring of project activities
i) Conduct monthly review meetings for CCE facilitators
j) Conduct condom activation sessions
k) Conduct meetings for hot spot owners and managers

Results of the programme:

Achievements made in 5 communities:

1. 1,001 new FSWs have been reached by our trained Peer Educators through their daily outreach HIV prevention massages.
2. 121 health workers reached with HIV/TB stigma reduction massages using CCE

methodology.
3. 237 FSWs have been reached with CCE stigma reduction messages.
4. A total of 615 FSWs received STIs /HTC services and 28 beneficiaries put on drugs.
5. A total of 968 738 male condoms have been distributed among key population communities during outreaches and one-on-one /small group engagements by peer educator's as part of their dairy activities.

62 Hot Spot Owners/Managers and care takers participated in the one day orientation meeting and they declared their support for the project.

Impact of the programme:

A total of 615 FSWs received STIs /HTC services and 28 beneficiaries put on drugs, Two Self Help Groups (SHG) of FSWs have been formed in Bekwai and Asokore Mampong, Two Drop in centres (DIC) were established in Asokore Mampong and Bekwai communities and are in active operation, providing access to HIV/TB and STI services and finally The project used community capacity enhancement (CCE) methodology and reached 615 FSWs with HIV stigma reduction messages.

Financing and management:

The project is being managed and coordinated by ADRA and financed by Global Fund.
The various stakeholders of the project, capacities are being built to ensure sustainability issues are address; Peer Educators, Ghana Health service, Self Help Groups, Drop-in-Centres, Private health facilities, community groups, key populations and the media.

Lessons learned and recommendations:
Best practices identified in the project implementation included; The feedback and debriefing sessions by project teams improved service delivery in the 5 communities, frequent monitoring by program M&E team, coaching, use of social media; WhatsApp platform created, refresher training and regular monthly review meetings, guidance received from ADRA Team and technical support from MIHOSO management Team.

18. Kenya

Title of the programme: The Omari Project at Malindi GK Prison

CONTACT PERSON
Name: Dilmua Mohammed
Organisation: The Omari Project
Tel: 0728896797
Email: theomariproject@gmail.com

Programme is being implemented since: 1995
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) and Community-responses in the human context in relation to people living with HIV, people who inject drugs, women, and prisoners.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

The Malindi G.K prison has a capacity of about 800 inmates in the male wing and 50 in female wing. It was realized that 50% of clients have drug related problems and so there was a need to offer services to the inmates with drug problems at the prison.

Description:

The Omari Project was founded with the objective of preventing drug addiction and its related problems. It provides counselling, education and prevention activities — especially targeting young people. The policy of the NGO is to promote healthy lifestyles by offering rehabilitation and minimizing harm.

We visit the prison twice a week – on Wednesdays, we visit the male wing and on Fridays, we visit the female wing.

We provide:
- HTC for the inmates (at least 300 received the service)
- Group counselling (25 to 40 clients per session)
- One on one addiction counselling sessions
- Human rights lessons
- We act as link between the inmate and the family - particularly when we are preparing for the release of the client.
- We assist in ensuring inmates get ID cards in collaboration with prison welfare officers and the registration office.
- We offer TB, STI and HEP B screening in collaboration with Malindi Sub county hospital.

Results of the programme:

- Strong partnership between NGO and prisons services
- Presented as best practice at national meeting.
- Effective mainstreaming of our services with the prison day to day activities.
- Over than 300 inmates per year are reached Harm reduction information and services.

Financing and management:

Yes the been evaluated by various donors including.UNODC.Aphia plus.Kenya Red cross.Mainline.KANCO

19. Malawi

Title of the programme: Joint Community-Facility Review of PMTCT Dashboards in Malawi

CONTACT PERSON
Name: Braeden Rogers

Title: HIV/AIDS Specialist
Organisation: UNICEF
Address: 3 UN Plaza New York NY 10017 USA
Tel: + 1 212 326 7202
Email: brogers@unicef.org

Implemented by: Government, Civil society, and UN
Scope of submission: Advocacy, campaigning and participation in accountability
Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV and women

Has the programme been evaluated /assessed? Yes, this case study was a product of a broader evaluation and the case was developed through external review of the programme
Is the programme part of the Implementation of the national AIDS Strategy?
Yes, this work is in line with the national eMTCT strategy
Is the programme part of a national plan broader than the National AIDS Strategy?
No

Background:

Malawi has made good progress towards the goal of eliminating mother-to-child transmission of HIV. In just four years, the country has halved the number of new infections among children—from 21,000 in 2010 to 10,000 in 2014. However, getting to zero still remains a challenge. Because treatment interruptions during pregnancy or breastfeeding increase the risk of passing the virus to the infant, preventing these gaps is a key concern of PMTCT programmes.

Given the high rates of loss-to-follow up in Malawi and in many other high-burden countries, there is a strong push to identify how best to support women enrolled in PMTCT programmes so that they do not drop out of care. A recent review commissioned by UNICEF and supported by the Governments of Sweden and Norway concluded that better *community-facility linkages* can significantly improve PMTCT outcomes. The review identifies eleven promising practices in community-facility linkages that are associated with increased service uptake, adherence to drug regimens and retention in PMTCT, antiretroviral treatment (ART) or maternal, newborn and child health (MNCH) care,[8] including engaging community leaders. The review found that "purposeful community leader engagement is associated with increased service uptake, male partner involvement and positive shifts in community attitudes."

Description:

In order to address loss-to-follow up in facilities in three districts (Mzimba North, Mzimba South and Dedza), the Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women Initiative (OHTA) convened community leaders and facility staff to strengthen linkages between the facilities and communities they serve.

The aim was to formalize these linkages and jointly identify where gaps and challenges are occurring so that pregnant and breastfeeding women would be better supported by both the facility and their communities to stay in care. The process included four phases:

1. Identifying existing Health Advisory Committees (HACs) and revitalizing those which were not active

2. Conducting training sessions with HAC members
3. Convening joint review sessions with HAC representatives, other community representatives, and health facility staff to review quarterly health facility data
4. Follow up and support

Phase I: Identification of Health Advisory Committees

HACs are a formal structure in Malawi to support linkages between health facilities and communities. Established by the Ministry of Health in 1997 with the Malawi Decentralization Act,[9] HACs are intended to be a standard part of all health facilities in Malawi. Composed of 10 community members selected by communities themselves, HACs promote accountability and aim to improve the quality of facility health services. By using HACs, the OHTA Initiative built upon and enhanced support to existing structures that were already known and understood. In areas where HACs were dormant, the programme worked to re-establish or revitalize the groups.

Phase 2: HAC Training

Under the OHTA initiative, training programmes were held for 85 HACs in the three districts. The topics covered during the three-day trainings included reviewing the role of the HAC, conflict resolution, leadership concepts, community mobilisation, HIV/AIDS literacy and the importance of PMTCT. A key emphasis of the training was community participation in quarterly facility data review meetings so that the community understands the major challenges facing their facility in service delivery and so that the community can discuss obstacles to access and continuity of care from its perspective.

Phase 3: Joint Data Review Meetings

Facilitated by a member of the district task team, the joint data review meetings take place at the local clinic and involve district health office representatives, facility-based health workers, HAC members, and other community representatives including traditional leaders, faith leaders and community based educators.

At the meeting, participants review simple dashboards which illustrate quarterly performance for a number of indicators through colour-coded graphs (see Annex 1). The dashboard includes thirteen key indicators, including antenatal care (ANC) attendance during the first trimester, male participation in ANC, delivery in health facilities, and retention in HIV care of women and children. Participants then discuss reasons why indicators are coloured red (poor performance), yellow (making some progress), or green (achieving targets). The use of red, yellow and green to evaluate performance is easily understood by participants and helps to prioritize areas for action.

Tracking progress visually helps provides concrete justification for community actors to encourage community members to adjust behaviour or practices related to indicators showing poor progress. It also helps visualize improvements over time.

Phase 4: Follow up and support:

At the end of each data review meeting, priority actions were recorded and OHTA district task teams provide ongoing support to community representatives and facility staff, to ensure agreed-upon actions were implemented. Support tools included registers for recording action plans, and teaching and learning materials sourced from the Health Education Unit (HEU) of the Ministry of Health. These materials included leaflets that were shared with men and posters for display in homes or public places with HIV prevention, care and treatment messages. The district task teams also conducted meetings with village chiefs to ensure the accuracy and

appropriateness of messages on various topics, such as the importance of partners attending ANC together and importance of facility based deliveries.

Results of the programme:

Since the quarterly facility-community review meetings were established, participating facilities in the three districts have seen a number of improvements in indicators related to male involvement, ANC attendance, skilled delivery, and early infant diagnosis of HIV. For example:

- Couples testing rates rose from 31 per cent in January 2015 to 34 per cent in June 2015, with Dedza district reaching a project high of 44 per cent
- Uptake of HIV exposed infant HIV testing at 12 months at Jenda heath centre increased from 13 per cent in May 2015 to 100 per cent in July 2015
- Uptake of HIV-exposed infant testing within two months of delivery increased from 0 per cent in March 2015 to 100 per cent in April - August 2015 at Katete Community Hospital
- Attendance at 4 ANC visits, 12-month retention of pregnant women on ART and 2 month infant HIV testing uptake increased in two districts (Mzimba and Dedza)

Impact of the programme:

The impact of these reviews has not yet been measured aside from results noted above.

Financing and management:

This work is financed from contributions from the government (district coordinator and health worker staff time), communities (time), and UNICEF funding for an NGO partner coordination and technical support (EGPAF). Sustainability is being built by creating a culture of data review and utilization, as well as citizen accountability.

Lessons learned and recommendations:

Lessons learned:

- Joint community-facility reviews can result in better prioritisation of health activities/interventions to improve the impact of PMTCT programmes.
- Involving communities to identify areas to be strengthened can provide a better conduit to community-level adjustments of behaviour and practices.
- When involving communities in data review, it is critical to present the data in a simple manner that encourages joint problem solving and action.

Conclusion:
While national-level data is important to monitor overall country progress, it can obscure specific issues facing individual health facilities and communities. By using facility-level data to diagnosis problem areas, health workers and community members are able to engage more meaningfully in conversation about how to improve health outcomes in their own communities.

20. Malawi

Title of the programme: Sexual Reproductive Health (including HIV) Prevention with Youth and Addressing Adolescents' Sexual Health and Rights needs and challenges

CONTACT PERSON

Name: Phillip Nyoni
Title: Executive Director
Organisation: Centre for Youth Development and transformation - CYDT
Address: P. O. Box 33, Luchenza,
Tel: +265 1 476 487
Email: cydtorg@yahoo.com / phillipnyoni@yahoo.com

Programme is being implemented since: April 2013 – March 2017
Implemented by: Civil society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc.) in relation to people living with HIV, sex workers and young people.

Has the programme been evaluated /assessed? No
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

The project supported the need for empowerment strategies targeting individual risk factors and broader SRH issues including;

1. harmful community norms that promote early sexual debut, early marriage, and gender based violence
2. access to and uptake of youth friendly health services including condoms and family planning for sexually active youth

Adolescents aged between 10 and 19 years are often overlooked by health interventions, unless they fall seriously ill or become pregnant. The period between 10 to 14 years is a relatively healthy stage of life, however, these adolescents may be at risk of neglect and mistreatment, and may have lingering health problems that are undiagnosed. The older adolescents 15-19 may be especially hard to attract to health services because of their semi-independence, reliance on their peers for knowledge and advice on such matters as sexual health, or as young mothers and/or wives with little education and limited power in their own sexual and reproductive choices. Adolescents who are not living in a stable home, whose caregiver may be one parent, a grandparent or a guardian, are especially vulnerable, not only in terms of health care but also other social protection. Some girls are forced into early marriage and child-bearing without having had sufficient access to education and childhood play that would support their psychological, emotional and mental development, thereby undermining their capacity to make informed and healthy choices as mothers and adults and sustaining the cycle of poverty (NSP 2015-2020; SRHR Strategic Plan 2011-2016, Youth Friendly Health Services strategy 2015-2020).

Description:

The goal of the project is to demonstrate an integrated HIV mainstreaming and continuum of care cascade model in increasing adolescents' access to sexual health, HIV and unintended pregnancy prevention, and rights support services

Centre for Youth Development and Transformation CYDT, with support from Southern Africa AIDS Trust and GIZ, is implementing these has rea projects and has proven a success as it

has already facilitated the establishment of teen clubs in health centers, youth clubs in the targeted communities, increased time for HIV Testing and Counselling from 6 hours a week to 6 days with extended time to 5 o'clock so that in school youth have access to the services after knocking off from school, increased utilization of contraceptives, most especially condoms by the youths and SRHR talks in schools that has significantly decreased dropout rate of female learners in school at E.G Mendulo Community Day Secondary School from 15 last school session of 2014 to 3 in 2015.

The primary focuses of the program are youth aged 10-24 both in and out of school, married or working class. Realising that the majority of the youths are those in schools, school structures such as Parent Teacher Associations are essential. School Management Committee and Mother Groups are also equipped knowledge and skills so that they also contribute positively to the reduction of the youth SRHR issues. As such, there is a linkage between Government Health Facility Officials and Schools and this is increasing community empowerment in making sure that cases of SRHR both in schools and communities are jointly addressed by both schools and health officials. Support HAS to reach out to youths/ adolescents with HRSR services in communities where they are serving, a tactic which is proven to be vital as many youths who are far from government health facilities can access some of the these products and services through HSAs.

The program success is also derived from the realisation that no new structures are established but only rests on using government recognised ones and linking them to health. The success comes in because all these are accepted voluntary structures which the community members nominates and are always ready being engaged whether at school, health facility or any other group. Community Based Organisations (CBOs) embraces many community structures in other sectors such as construction. Plantation and sanitation. Working with these also has increased youth access to health services and help in advocating for community by laws aiming at child protection or bringing community concerns to authorities

Results of the programme:

Has reached 3,000 adolescents, including 162 living with HIV, in Thyolo and Mulanje districts have access to targeted SRH and HIV prevention and treatment youth friendly health services. 15 community structures (including religious communities, CBOs, local governance structures) in the 2 targeted districts have developed capacity to deliver relevant SRH and HIV prevention information, risk reduction education and demand creation for utilization of services.

Impact of the programme:

The program has achieved an increasing number of teen club memberships at Chonde and Mangunda Government Health Facilities. Chonde has 69 members and Mangunda has just started in 2015 with 25 teen club members. It has empowered female learners by providing them with sanitary pads and undergarments that help to prevent them from continuously missing school due to monthly periods. 250 adolescents were provided with sanitary pads and undergarments so that they no longer needed to engage in sexual intercourse for money in order to have appropriate sanitary wear, soap, and cosmestics, which often led to sexual abuse, rape, harassment, STI/HIV infections or impregnation.

The program has also helped with outreach of SRHR information to 80 sex workers and established a group so that they are easily reached with information and other services. They are also provided with Human Rights information that has led to them being prevented from

unlawful detention by police officers, which had in the past led to cases of rape, but has now indefinitely stopped.

Financing and management:

The program is financed by Southern Africa AIDS Trust SAT and GIZ but implemented by various SAT partners in the north, central and southern Malawi. SAT also provides capacity building to all its partners such as financial management, issue mapping, gender transformative HIV programming, budgeting and Results Based Commitment Establishment.

Lessons learned and recommendations:

CYDT has, over the past four years, leant that community members, when meaningfully involved, let it play its role, engage with it through community leadership and institutional authorities and brings a successful program results. CYDT has built sound relations with health and educational organizations, local institutions and community structures. This has made the program a success. The popularisation of SRHR policy, Youth Friendly Health Service Strategy and the 90: 90: 90 Strategy has, among others, provided a conducive environment for the implementation of the program.

The biggest challenge is the issue to increase resources in order to expand the project coverage so that it benefit more youths. In addition, CYDT is still working on dominant cultural religious practices and beliefs that promote inequality amongst men and women, exposing women to Gender Based Violence that mostly leads to being infected with HIV or other devaluing factors.

21. Malawi

Title of the programme: Religious Leaders and PLHIV

CONTACT PERSON
Name: Safari Mbewe
Title: Executive Director
Organisation: Malawi Network of People living with HIV (MANET+)
Address: Area 14, Plot 14/40, Private Bag B377, Lilongwe 3, Malawi
Tel: +265888899282
Email: safarimbewe2008@rocketmail.com

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability,in relation to people living with HIV.

Background:

The HIV epidemic in Malawi has evolved since the first case was diagnosed three decades ago (in 1985) to become one of the major causes of mortality in the country and has placed tremendous demands on the health system and the economy. The epidemic has affected all sections of society – children, youths, adults, women and men. The country's response to this epidemic has also evolved over the years from a health sector led response to a multi-sectoral one coordinated by one national authority, one strategic framework and one monitoring and

evaluation framework. And response to the epidemic has been improving in tandem with the increase in availability of reliable and comprehensive data, enabling the country to sharpen its focus on the key HIV transmission areas and populations to reduce new infections.

While this has been the case, religious leaders have not been proactive in the national HIV and AIDS response, with some being perpetrators of stigma and discrimination towards PLHIV, promoting faith healing and praying for PLHIV on HIV Treatment, and advising PLHIV to stop taking treatment.

Description:

Over 90% of Malawians are believers and, therefore, working with religious leaders will ensure that we reach more people. Religious leaders have a lot of influence on the government as well as the community at large. Religious institutions have established structures throughout the country from national to grassroots levels

The Framework for Dialogue between Religious Leaders and PLHIV is an advocacy initiative. It brings together religious leaders and PLHIV to have a face to face dialogue in order to strengthen the response of religious leaders and the faith community in meeting the needs of PLHIV and identify priority areas of collaboration.

Results of the programme:

The initiative has reached over 100 religious leaders both Christians and Muslims across Malawi, and it has created a formal linkage between RLs and PLHIV that had not previously existed in the country. There has been a platform initiated where PLHIV call for meetings with RLs and there has been a change in the language among RLs towards PLHIV. Some religious institutions have taken on HIV interventions in their institutions and some have started establishing support groups of PLHIV within their churches and mosques. The project has initiated debate on sensitive issues such as issues affecting key populations (Men who have sex with men, sex workers) and condom use amongst religious leaders which had not previously existed. Through the project, some key religious leaders have been identified to act as role models on fighting homophobia against MSM. The initiative has managed to create obligations on the religious leaders to start handling issues affecting PLHIV in their respective institutions, be it churches or mosques

Impact of the programme:

Religious leaders are now keen and ready to tackle issues affecting PLHIV in the various churches and mosques. Stigma and discrimination towards PLHIV has drastically reduced in churches and mosques, and judgmental preaching targeting PLHIV has reduced.

Financing and management:

The major challenges were very limited resources to complete each of the activities and that there were delays in fund disbursements which negatively affected the implementation of the activities.

Collaboration of various stakeholders helped to solve some of the challenges and made the initiative to be a success

22. Malawi

Title of the programme: Community ART Groups (CAG's)

CONTACT PERSON
Name: Nicollette Jackson
Title: Implementing Community ART Groups in Malawi
Organisation: Medecins Sans Frontieres
Address: 78 rue de Lausanne, Case Postale 116, 1211 Geneva 21, Switzerland
Tel: +265 (0) 1772910
Email: msfocb-lilongwe-deputyhom@brussels.msf.org

Programme is being implemented since:): Since 2012 as a pilot in Thyolo District in Southern Malawi
Implemented by: UN or other inter-governmental organization and the Government
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? No
Is the programme part of a national plan broader than the National AIDS Strategy? No

Background:

Malawi remains one the least developed countries in the world, ranking 174 of the 187 countries on the United Nations Development Programmes 2013 Human Development Index. HIV prevalence stands at 10.6% among adults 15 – 49 years old. There are geographical heterogeneities in HIV prevalence with the Southern region HIV prevalence at 14.5 % being twice as high as that of the Northern and Central regions. Thyolo and Nsanje districts, both in the Southern region and where the programme described herein is implemented, have estimated HIV prevalence of 21.6% and 15.5%, respectively.

Although Malawi has made significant progress in its HIV and AIDS response, the country is still experiencing structural constraints, especially in the health sector. Human resources for Health are limited and unable to maintain good levels of care to a growing number of clients. Additionally in the rural areas, access to HIV-related services might be jeopardized by the distance to the facilities and the frequent number of visits to collect a life-long treatment. Moreover, the move to test and treat will entail a growing number of PLHIV starting ART when they feel healthy rendering treatment adherence and retention in care important considerations for the national HIV and AIDS response. The Community ART Groups (CAGs) actively engages community of PLHIV to surmount some of the health system challenges cited hitherto.

Description:

The Community ART Groups (CAGs) are self- forming groups constituting 4- 8 HIV- positive persons who are on ARVs, are stable, and living in the same community. The primary objectives of the CAG model are: to reduce congestion and waiting time in ART clinics thereby reducing workload of health workers; promote adherence through peer support; and minimise

geographical barriers to accessing ART.

Implementation dynamics for CAGs entail various activities enhancing care and support. CAG members take turns to pick up ARVs (for the whole group) at the health facility and distribute them among the other group members in the community on the same day of refill. Each member visits the facility once a year for clinical consultation and Viral Load testing (if due that year), effectively reducing opportunity cost of multiple clinic visits for respective members. CAG members also meet in the community to discuss and provide support to each other pertaining to their care, including: adherence to treatment, psychosocial support. Precisely, the CAG model affords PLHIV opportunity to manage their own health and share experiences about living positively with HIV.

CAGs are currently implemented by District Health Offices in two districts of Thyolo and Nsanje (both in the Southern Region). In Thyolo, implementation of the CAGS was in collaboration with MSF up until the end of 2015, now the District is implementing the CAGs directly, while in Nsanje MSF is providing some technical assistance to the district.

Results of the programme:

By mid 2015, slightly more than 10% (4933 / 41,494) of the ART cohort in Thyolo District were in CAGs. In Nsanje, CAGs are being implemented in catchment areas for all 14 of the health facilities under Nsanje District Health Office. To date 1,764 people living with HIV on ART have joined CAGs in Nsanje since the model was introduced in January 2015.

Impact of the programme:

A study to measure the impact of CAGs indicated the following key findings:

- Retention in care rates for stable patients (two years after the introduction of CAGs) was 96.3% for CAG members as compared to 94% for non-CAG patients.
- Reduction in number of ART refill visits by 59.3% per person per year, affording opportunity to undertake other economically productive activities

A qualitative component of the study revealed acceptability of the CAG model by PLHIV, health workers and district managers. Other benefits cited include:

- Improving HIV treatment literacy through information sharing within the group
- Promoting adherence to treatment and retention in care
- Bringing community ownership to the ART program and hence fostering autonomy of PLHIV in their care
- Supporting the diffusion of information from the health facility back to the community

Financing and management:

At community level, CAGs elect a leader who coordinates the group and is supported by Health Surveillance Assistant who provides supportive supervision. At district level, the ART coordinator oversees implementation of CAGs and liaises with the District Health Management Team on management support that is required.

In both Thyolo and Nsanje, MSF provided financial support for the start up of the programme and subsequently engaging CAG supervisors to support implementation. At present, MSF is only supporting Nsanje with some technical assistance where CAGs have recently been

initiated. In Thyolo, management aspects have been taken up by the District Health Office, effectively ensuring implementation sustainability of the CAG.

Lessons learned and recommendations:

Implementation of CAGs requires paying attention to various critical enablers, including the following:

- Active involvement of networks of people living with HIV during set up and implementation as they are critical in: linking CAG members to other initiatives e.g income generating activities; strengthen voice of PLHIV in communities and national response.
- Reliable procurement, pharmacy and supply-chain management that ensures consistent availability of HIV commodities and the duration of drug supply that is adapted to the PLHIVs' needs
- Clear stipulation and assigning of responsibility to specific groups and cadres.
- Mechanisms to identify problems with other CAG members should be clearly put in place and additionally PLHIV need to be educated on common Opportunistic Infections (OI), to monitor weight loss and to be alert for specific ART related toxicities, any of which would require them to present back to the health services. This helps members to be committed and sustain membership as benefits transcend collecting drug supplies for each other.
- Systematic supervision of the implementation and outcomes of the model which provide lessons and opportunity to implement remedial action
- What were the biggest challenges?
- Addressing the fear from Ministry of Health (in the face of national challenges around drug misappropriation) that the approach of empowering CAG members to hand out ARVs to their fellow group members risks drugs being sold/lost. This long standing fear of lost of control of tracking HIV drugs is impeding the adoption of the model at a national level. No cases of CAG members stealing drugs has ever been documented, either in Malawi or in the other countries where CAGs are in operation, in fact pill count amongst PLHIV improves significantly when patients are in CAGs because it is documented and reported collectivley – nevertheless this perception is proving very challenging to shift.

23. Malawi

Title of the programme: Mothers2Mother (M2M)

CONTACT PERSON
Name: VEENA SAMPATHKUMAR
Title: Country Director
Organisation: mothers2mothers
Address: no 4 ARWA HOUSE LILONGWE MALAWI
Tel: +265 1 774124
Email: veena.sampathkumar@m2m.org

Implemented by: UN or other inter-governmental organisation
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV and Women.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes

Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

Current estimates indicate that 1.1 million Malawians are living with HIV in 2014, with over half a million (585,660) alive on ART.

In 2011, Malawi pioneered Option B+, a PMTCT-focused “test-and-treat” strategy that makes treatment initiation easier and more available, and addresses the needs of HIV-positive women throughout their reproductive years. While the policy was developed in response to resource constraints (i.e., limited infrastructure), it has become a global success and solution for most countries.

Option B+ has registered astounding levels of women initiating on treatment. The Ministry of Health (MOH) Malawi reports that the average number of pregnant women registered for ART each quarter increased almost 6 fold from 1,221 in the 12 month period before introduction of Option B+ to an average 6,500 since Quarter 4 2011. However, up to 20% of women testing HIV-positive in antenatal or postpartum clinics dropped out before initiating ART[2]. In larger sites, Option B+ patients who started ART during pregnancy were five times more likely to fail to return to the clinics after the initial visit than patients who started ART for their own health. A study found that women 27 years and older and on ART for at least 3 months had decreased likelihoods of optimal adherence and that 77% of lost to follow up clients interviewed had stopped taking ART[3].

Learnings from m2m’s work suggests that failure to take-up ART after the first dispensing visit is a particular concern in the context of Option B+, and that treatment acceptability may be a key issue. The very simplicity of Option B+ may be at the root of the problem. Same-day ART initiation, the implication of the test-and-treat strategy, means that virtually no effort goes into ensuring that PMTCT clients are prepared and ready for taking up lifelong treatment. The fact that many newly diagnosed women may be asymptomatic complicates the uptake of lifelong treatment, adherence, and retention-in-care.

Despite the concerted efforts to scale up the PMTCT program, every year there are an estimated 58,000 HIV-exposed infants born, with 7,400 new pediatric HIV infections[4] still occurring. ART coverage for eligible HIV-positive children in Malawi is only 37%, compared to 76% for HIV positive adults[5]. Unfortunately, pediatric HIV care and treatment programming (i.e. identification of HIV-positive children, linkages to, initiation and retention in care) has not progressed in parallel with improvements in PMTCT programming. Children’s vulnerability stems from programmatic gaps across the pediatric care and treatment continuum and the number of children requiring HIV treatment remains substantial.

---

[2] Tenthani L., et al. (2014). Retention in care under universal antiretroviral therapy for HIV-infected pregnant and breastfeeding women (‘Option B+’) in Malawi. *AIDS.* doi: 10.1097/QAD.0000000000000143

[3] Tweya, supra note 4.

[4] UNAIDS HIV Estimates, May 2014

Malawi intends to be one of the first countries to embrace and roll out universal treatment and aggressively work towards the 90-90-90 treatment targets. The plan for rapid gains in achieving 90-90-90 in Malawi must include: catalysing rapid identification, enrolling and retaining at-risk and high-need clients, and simultaneously closing the gap on new infections among at-risk populations. Currently the Malawian national health system has no specialized facility-based cadre of health workers responsible for HIV Testing and Counselling (HTC) or ongoing adherence to care and treatment support and counselling. In addition, the health surveillance assistants (HSA) who are tasked with community support and follow up care are overburdened and increasingly facility-based. With competing time demands and a high volume of clients, clinical staff is unable to dedicate adequate time to support clients individually and address their specific needs.

With implementing partners' support, the Malawi MOH will utilize HIV Diagnostic Assistants (HDA) to support provider-initiated HIV testing and counseling (PITC) in high yield points across the high volume facilities. While the HDAs will be instrumental in identifying HIV-positive individuals, the demand for patient support services to improve uptake of PITC, support to initiation in care, ongoing adherence support and ensure retention in care remains an unmet need.

Description:

m2m is a leader in delivering non-clinical complementary care and support services through its Mentor Mother Model, a widely supported, evidence-based peer intervention that ensures mother-baby pairs access the full cascade of reproductive, maternal, newborn, and child health (RMNCH) and PMTCT services.

m2m's flagship prevention of mother-to-child transmission of HIV (PMTCT) program— training, employing, and empowering HIV-positive women who have been through PMTCT to work as peer Mentor Mothers in health centers and communities— has set a strong foundation of a highly scalable, replicable peer-based model of client support services for HIV care.

Mentor Mother services include: group pre-test education; health education talks; individual peer education and support; adherence monitoring and support; retention services including mother-baby pair follow-up; family support groups; and improved linkages and referrals between the facility and community, as well as integrated service uptake within the health facility.

Results of the programme:

Since 2008, m2m has been implementing the Mentor Mother Model in 14 districts in Malawi. m2m currently employs 305 Mentor Mothers and 115 Community Mentor Mothers in 94 high volume and hard to reach facilities and 25 traditional authority areas. In 2015, m2m enrolled 23,943 new clients in m2m services. 146,486 women received group pre-HIV test education in 2015. 328,388 one-on-one interactions with clients in antenatal and postnatal clinics in 2015

Impact of the programme:

Annually, m2m conducts an internal program evaluation. The m2m 2014 evaluation looked at clients who initiated care in 2012 and completed their eMTCT cascade in 2014. The results showed that in Malawi 89% of antenatal m2m clients were initiated on Option B+, 89% of clients had disclosed their status, 96% delivered in a health facility, and 81% of infants were tested for

HIV at least once, with 91% of those tested receiving results. Of the infants who tested positive, 96% were initiated on ART for life. Inferential analysis conducted as part of the 2014 annual evaluation shows that m2m clients with two or more m2m visits were statistically significantly more likely than clients with only one visit to disclose their HIV status, use modern family planning, practice exclusive breastfeeding for the first 6 months after birth, and be retained in care along the PMTCT cascade.

A transmission rate of less than 5% is the standard by which the UN determines elimination of pediatric AIDS. 3.73% of babies of m2m clients across all m2m countries, on average, tested positive for HIV after 18 months. In Malawi, m2m clients had a 4.56% transmission rate compared to 12.7% nationally.

In 2014, an independent evaluation found that Mentor Mother Model, as implemented under the USAID-funded STAR-EC Program in Uganda, has a significantly positive impact on maternal and infant PMTCT outcomes, compared to outcomes at health facilities with no m2m presence, including improved retention-in-care of HIV-positive women 12 months after being initiated on triple antiretroviral drugs (90.9% vs. 63.6%) and uptake of early infant diagnosis test for HIV 6-8 weeks after birth (71.5% vs. 45.8%). The study also demonstrated that the m2m Mentor Mother Model has a high return on investment when comparing the significant benefits of the program to the costs required for its implementation. For every U.S. dollar spent ($1) on the Mentor Mother program in Uganda, there is $11.40 in cost savings associated with averted HIV treatment and diagnostic costs

Financing and management:

m2m services are supported through project grant funding. Our key donor partners for 2016-17 are UNICEF, EGPAF, Partners in Hope and Johnson and Johnson Foundation. Since 2001, m2m has grown from a single support group in South Africa to an organisation operating in nearly 600 health facilities and employing 1,500 HIV-positive women in Malawi, Kenya, Lesotho, South Africa, Swaziland and Uganda.

As an African-based organization, m2m has the experience, capacity and qualifications to manage this project. m2m has developed strong working relationships with the MOH in all its program countries. In its headquarters and country offices, m2m is staffed with skilled leaders with significant experience in the design and implementation of the Mentor Mother model as well as direct HIV/PMTCT and clinical experience. m2m's M&E system comprises a dynamic integration of inter-related tools and processes embedded in a comprehensive system that is responsive to, and further drives, program innovation along the ambitious programmatic platform described above.

The Govt of Malawi is donor reliant (40% of the Govt budget). Within the MOH, there is no community health strategy or community HRH system to support the current needs and disease burden in the country. The ultimate aim of m2m is to work with the MOH to include a lay health community cadre that will address eMTCT on an RMNCH platform using the peer based model. The advocacy and integration can only be feasible when the MOH has a clear community health strategy and community health cadres. The integration and absorption of mentor mothers by the MOH is actively pursued as the long term objective by m2m in Malawi. In the interim, we see our role as catalytic within the various health initiatives currently being pursued by MOH in Malawi. Some of these initiatives are the first of their kind globally - Option B plus is now replicated across the world, making Malawi the first country to offer Universal HIV treatment by the end of 2016.

Two of m2m's country offices (South Africa and Kenya) provide capacity building support for their respective governments to institutionalize and scale up peer education and psychosocial support services for PMTCT/RMNCH towards improved child and maternal health outcomes, so we are well positioned and experienced in supporting this kind of systemic change.

Lessons learned and recommendations:

Support and guidance from the Ministry was key to support operational start up and integration in the clinics.

24. Morocco

Title of the programme: Support for the implementation of the mobile strategy for reducing the risk of AIDS and hepatitis among drug users in the region of Tangiers

CONTACT PERSON
Name: Monssef Bendriss
Title: Directeur
Organisation: Association Hasnouna de Soutien aux Usagers de Drogues.
Address: 18, Rue Moulay Driss, Hasnouna, Tanger.
Tel: 0672171530
Email: monssefbendriss@gmail.com

Programme is being implemented since:
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e., screening, prevention, care and support, treatment, legal, delegation of tasks, training of health care workers, etc.), and community funding in relation to people who inject drugs.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background :

Drug users are particularly vulnerable to contamination by HIV and HCV and other social-health risks due to several risk behaviours associated with drug use. The social and stereotypical perception of a drug addict results in the fact that drug users no longer believe in themselves, or in other people. They are given few rights, or none at all, to speak out. People believe in some cases that they are victims, but more often that they are culprits who deserve their fate.

This is a population excluded and rejected by their very close circle and by society in general, bearing in mind that Moroccan society still considers a drug user as a criminal who is dangerous, an outlaw, and not someone who is sick. These negative social representations maintain the stigmatisation and exclusion of drug users, which forces them underground in groups, in isolated and extremely unsanitary places (Squats and Kharabats). In every case, they become a population which is difficult to reach, closed, and with multiple risk practices.

This secrecy also imposes a type of human relations dominated by mutual distrust and, often, a

lack of solidarity. Users typically spend most of their resources and income to purchase the products they need for their daily consumption. They spend their day looking for the necessary money and then the product, which takes up a lot of energy, both moral and physical. Concerns related to health are often disregarded in favour of concerns about obtaining and / or using drugs.

The health and social risks remain high and there are insufficient and inadequate care facilities specialising in the management of drug addiction (lack of a support centre for addiction throughout the entire northern region). It is therefore impossible for drug users to get by alone. An intervention in favour of this group as well as a preventive approach is therefore priority and needs to improve the living conditions of this population.

Description:

The project is based on a risk reduction philosophy while taking account of all its dimensions and highlighting its social dimension, which largely complements the health component. The project therefore consists of a series of participatory awareness activities and activities to prevent contamination of HIV, HCV, tuberculosis and other health risks associated with drug use, as well as complementary activities aimed among others to improve the living conditions of users, i.e. daily management as well as psychological and legal support and finally participatory advocacy. All these activities aim to change negative social representations often associated with drug users.

The project is part of the National Strategic Plan for the Fight against AIDS, as well as the action plan to implement risk reduction measures in the northern region of Morocco. It is therefore an innovative project in Morocco that is trying to provide, as much as possible, an answer to the problem of addiction strongly present in the city of Tangiers.

Results of the programme:

Since 2007, the project has targeted more than 2,000 drug users (injectors and smokers), in the city of Tangiers, Asilah, the city of Larache and Ksar El Kebir.

Impact of the programme:

According to the latest RDS study of May 2015, the rate of HIV among drug users in the city of Tangiers is 0% due to the risk reduction efforts undertaken since 2007. 700 drug users have received methadone since 2010.

Extension of the risk reduction intervention throughout the kingdom and also in the MENA region and Francophone Africa through the Resource and Training Centre.

Financing and management:

The project is managed by the Hasnouna Association for the Support of Drug Users, funded and coordinated by the Ministry of Health and the Global Fund to Fight AIDS, Tuberculosis and Malaria and the technical support of UNAIDS.

Lessons learned and recommendations:

High-level political commitment;

Innovative approach;
Strong involvement of all activists in the field of risk reduction in the city of Tangiers.

25. Morocco

Title of the programme: Conseil et dépistage du VIH par des agents communautaires à destination des populations clés au Maroc. Projet pilote de l'ALCS

CONTACT PERSON
Name: Pr Hakima Himmich
Title: Présidente
Organisation: Association de Lutte Contre le Sida (ALCS)
Address: Rue Salim Cherkaoui, quartier des hopitaux, Casablanca
Tel: 05 22 22 31 13
Email: h.himmich@gmail.com

Programme is being implemented since: 2015
Implemented by: Civil Society
Scope of submission: Prestation de services à assise communautaire, pour la population des Hommes ayant des rapports sexuels avec des hommes, Professionnel (le)s du sexe et autres.

Has the programme been evaluated /assessed? Oui
Is the programme part of the national AIDS plan? Oui
Is the programme part of a national emergency response plan? Non

Background:

Malgré la mobilisation du ministère de la Santé et de la société civile pour étendre l'accès au dépistage du VIH, 65% des personnes vivant avec le VIH au Maroc ignorent leur infection. Et parmi les populations clés, seulement 31% des hommes ayant des rapports sexuels avec des hommes (HSH), 25% des professionnelles du sexe (PS) et 28% des migrants sub-sahariens (MS) ont fait le test les 12 derniers mois et connaissent leur statut.

Jusqu'en 2014, le dépistage a été exclusivement médicalisé ce qui limitait l'accès de certains groupes de populations prioritaires. Compte-tenu de la disponibilité insuffisante des médecins et du besoin de lever les freins au dépistage, l'ALCS a expérimenté, avec l'accord du ministère de la Santé, un projet pilote de dépistage communautaire démédicalisé du VIH dans quatre villes ; Agadir, Casablanca, Marrakech et Rabat, dédié aux populations clés non ou peu desservies par le dépistage classique, plus proche géographiquement, à horaires flexibles et qui lutte contre la stigmatisation et la discrimination.

Description:

L'objectif du projet pilote était d'évaluer la faisabilité d'une offre de dépistage du VIH pratiqué par des intervenants terrain, non médecins, proches des communautés cibles, formés à cet effet et utilisant des tests rapides «DETERMINE» dans le cadre des programmes de prévention combinée auprès des hommes ayant des rapports sexuels avec d'autres hommes, des

professionnelles du sexe et des migrants subsahariens en utilisant les stratégies de dépistage fixe et mobile (véhicules mobiles et mallettes). Les personnes dépistées positives étaient référées vers les centres hospitaliers pour confirmation par le Western Blot (WB) et, le cas échéant, prise en charge globale de l'infection à VIH.

L'expérience a été conduite entre mars et octobre 2015. Les conseillers communautaires ont été sélectionnés selon des critères tels que l'acceptation par la communauté cible, le respect de la confidentialité, la capacité d'écoute et la motivation pour la pratique de cette activité. Ils ont ensuite reçu une formation théorique sur le conseil et dépistage volontaire du VIH, suivie d'un stage de qualification. L'accompagnement des conseillers communautaires s'est maintenu tout le long de l'expérience à travers des supervisions formatives. Une enquête a été menée auprès des usagers de la nouvelle offre en utilisant un questionnaire pré-test pour recueillir des données sur leurs attitudes vis-à-vis du dépistage et un questionnaire post-test de satisfaction.

Results of the programme:

Un total de 8392 tests VIH ont été réalisés dont 43% chez les PS, 41% chez les HSH et 16% chez les MS. Parmi les personnes testées, 126 (1,5%) étaient séroréactives sur test rapide. La plupart des usagers (68%) n'avaient jamais fait le test VIH auparavant et affirment être stressés à l'idée de se faire dépister par un professionnel de santé dans 21% des cas. La majorité des bénéficiaires (95%) sont satisfaits de cette offre.

Impact of the programme:

Parmi les personnes ayant confirmé le test rapide positif par WB, 94% sont inscrites à la prise en charge. Les focus groupes avec les usagers révèlent que ce nouveau dispositif répond mieux à leurs attentes, qu'ils sont confiants pour faire le test VIH pratiqué par leurs pairs et qu'ils sont disposés à accepter le résultat du test qu'il soit positif ou négatif.

Financing and management:

Le projet a été coordonné par un comité de pilotage présidé par le programme national de lutte contre le sida. Tout le projet pilote a été financé par le Fonds Mondial avec engagement du ministère de la Santé de généraliser le dépistage communautaire non médicalisé si l'expérience venait à être concluante. L'ONUSIDA a financé l'évaluation du projet par un consultant externe.

Lessons learned and recommendations:

Le dépistage communautaire a été capable d'atteindre des populations plus exposées au risque n'ayant pas recours au service médicalisé et les agents communautaires ont montré leur capacité à réaliser le dépistage du VIH dans une démarche de prévention combinée auprès des populations clés. La nouvelle offre a été bien intégrée au service classique permettant une bonne synergie en matière d'utilisation des ressources. Au regard des résultats très probants de cette expérience pilote, le comité de pilotage a décidé d'intégrer cette approche dans la stratégie nationale du dépistage VIH et de définir les modalités de sa mise à l'échelle, ce qui est en cours.

26. Namibia

Title of the programme: From Victims to Victors: Empowering people living with HIV using the Inside-Out Approach

CONTACT PERSON
Name: Casper W Erichsen
Title: Director
Organisation: Positive Vibes Trust
Address: 49 Pasteur Street, Windhoek, Namibia
Tel: *264 61 245 556
Email: casper@positivevibes.org

Programme is being implemented since: 2002
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV and young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy?Yes
Is the programme part of a national plan broader than the National AIDS Strategy? No

Background:

Namibia is one of the countries most affected by HIV/AIDS. Today, about 260,000 Namibians over 15 years old are living with HIV. The country has responded with the rollout of a highly successful ARV treatment (ART) programme that now reaches more than 120,000 people through the public health sector. Namibia has embraced the ambitious triple 90 targets and seeks to further increase access to ART, including for key populations.

In Namibia, people living with HIV (PLHIV) initially experienced high levels of stigma and have, at best, been considered as victims with little power over their situation. As a result, early support projects often viewed PLHIV with empathy but with little potential for agency. Over the past 10-15 years, Namibia has become one of the societies most tolerant of PLHIV in Africa (Dulani et al. 2016). Yet, effects of stigma and self-stigma continue to affect ART uptake and adherence in general and among key populations in particular. Also, PLHIV often continue to be seen as passive “beneficiaries” rather than as a key to achieve ambitious treatment and prevention goals with a limited amount of human and financial resources.

Description:

As early as 2002, Positive Vibes (PV) recognised the urgent need to work *with* and not just f*or* PLHIV in addressing issues of (self-) stigma and facilitate meaningful participation in HIV programmes. PV set out to develop an approach that would strengthen the individual and collective capacity of PLHIV to take on active roles in protecting their health, realise rights, improving quality of life and addressing HIV in their communities.

Drawing inspiration from late South African AIDS activist Peter Busse and the thought of Brazilian educator Paolo Freire and through continuous interaction with Namibians that were living with HIV, the Inside-Out Approach evolved:

- Its basis is **Personalisation.** Participants gain an actual understanding of what

HIV/AIDS is and what it means to live with HIV. Through discussion and reflection, participants internalise knowledge and break through states of denial, guilt and depression and move towards acceptance. Acceptance of the situation sets the foundation for further growth.

- In subsequent steps, **active dialogue** with others facilitates mutual support and allows for exploration of coping strategies. It creates hope and builds a sense of self-efficacy.
- Greater self-efficacy allows participants to make their **voices** heard and to take **action**. PLHIV now can address crucial issues in their own lives and contexts. For some, this can extend to reaching out to others, whether in their immediate social circle or the wider community. Personal **transformation** becomes a catalyst for **social change** and gradually breaks down external stigma.

Central to the approach is the facilitation of the process by people living with HIV. All facilitators first experience the Inside-Out methods as participants and have moved towards action. Activities include intensive workshops over several days, which create safe spaces for participants rarely found elsewhere. Sessions are participant-centred and seek to create positive group interactions through participatory methods. A typical activity cycle consists of a foundation workshop, focusing on understanding and personalisation, intensive sessions exploring issues creatively (e.g. through art therapy, peer counselling methods), and action-oriented sessions on self-help and skills such as positive speaking or use of media. Activities can be adjusted to the specific needs of different projects, audiences and locales.

Results of the programme:

Over the past decade, the Inside-Out approach has been widely applied in Namibia, e.g.
With PLHIV self-help groups. More than 10,000 support group members have participated in Inside-Out sessions since 2002. Many participants have become facilitators themselves. Also, this work has produced many people who have become active in the Namibian HIV response as positive speakers, advocates or project implementers.

Positive Health, Dignity and Prevention. Core ideas of the Inside-Out process were integrated into community-based PHDP sessions that have become part of the national HIV response and reached more than 30,000 Namibians with HIV since 2011.

Young Voices/Moving On, Moving up. PV adopted the Inside-Out process for work with children and adolescents infected and affected by HIV as early as 2005. Today, the Namibian Ministry of Health has established Teen Clubs in health facilities across the country.
PV supported 18 of these with Inside-Out activities, reaching more than 1500 adolescents.
Voice. We estimate that more than 20% of Namibians have been reached by community advocacy and outreach activities led by PLHIV graduating from Inside-Out projects.

Looking in – Looking out (LILO). The inside-out concept has been adapted to the specific needs of LGBT and been used to train activists across the entire Southern African region.

Impact of the programme:

Impacts of the Inside-Out approach have been documented by various studies and project evaluations:

Improved self-esteem, reduced risk. Support group members that experienced Inside-Out

approaches were more likely to disclose their HIV status to partners and displayed higher levels of confidence and self-esteem. Among PLHIH, increased self-esteem has been linked to higher levels of condom use and lower risks from multiple partnerships (Van Zyl, 2009).

Addressing stigma. HIV-positive individuals and groups of PLHIV "push back" stigma and discrimination in their communities. Non-confrontational, low-level advocacy opens new channels for communication with families, communities but also with local government, particularly around service delivery. Some self-help groups adapted the Inside-Out Approach to mobilise PLHIV in neighbouring communities (Boyd, 2009, Mouton and Auala, 2009).

Increased uptake of support services. Participants on ART taking part in abridged PHDP sessions are more likely to understand the value and voice interest in participating in support groups and accessing counselling services (Tjituka et al. 2015).

Financing and management:

Delivery of a full cycle of Inside-Out sessions requires engagement over expanded periods of time and matching investment. Positive Vibes has benefited from donor relationships that allowed the approach to evolve and be made available to large numbers of groups and people. Key activities such as the foundational HIV & Me training or PHDP sessions have been condensed to make sessions available at lower cost within PEPFAR and GFATM funded projects. This allowed decision-makers in the health sector as well as within the donor community to become familiar with PLHIV led and empowerment focused interventions. Today, such activities are part of national strategies and plans. For instance, Teen Clubs are now articulated as part of the Ministry's National Guidelines on Adolescents Living with HIV (2012). PHDP sessions continue to be implemented at scale through a PEPFAR funded programme to strengthen ART Adherence and Retention. Importantly, the Inside-Out projects have resulted in substantial numbers of empowered PLHIV and PLHIV community groups that continue to contribute to combating HIV and AIDS in Namibia at community and organisational levels.

Lessons learned and recommendations:

Stable relationships with donors that were interested in developing alternative and people-centred approaches to strengthen community-based and PLHIV led responses were crucial in the early stages of the project. This made it possible to build trust relationships with PLHIV and develop approaches over time, make and learn from mistakes and ensure a prominent role of affected community members. PV realised that there would be a need to compromise on some elements of the approach to reach larger numbers of people. While this has created greater exposure and helped inclusion of the approach into national strategies, increasing medical focus and rigid top-down management of some projects diminished the potential of the approach. For PV, this has led to a renewed focus on more constructive donor relationships and increased advocacy with health sector to find an appropriate balance between scale, cost and quality to tap the potential and ensure participation of PLHIV in the current ART scale up.

27. Namibia

Title of the programme: Joint CSO advocacy for a comprehensive national combination HIV prevention framework

CONTACT PERSON

Name: Casper W Erichsen
Title: Director
Organisation: Positive Vibes Trust
Address: 49 Pasteur Street, Windhoek, Namibia
Tel: *264 61 245 556
Email: casper@positivevibes.org

Programme is being implemented since: 2002
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Namibia is one of the countries most affected by HIV/AIDS with an estimated adult prevalence rate of 14% (MoHSS & ICF 2014). The country is well known for its successful ARV treatment programmes. But Namibia has also achieved positive change in other domains: Stigma against PLHIV has greatly reduced, making Namibia one of the most tolerant countries in Africa (Dulani et al. 2016). Condom use and HIV-testing rates are among the highest on the continent. And sexual risk behaviours such as multiple partnerships also have declined. The combined effects of successful treatment and prevention programmes is thought to be responsible for a reduction in HIV incidence of close to 45% between 2002/3 and 2012/13 (MoHSS 2009, Spectrum data). However, against a backdrop of a slow but steady scale-down of donor resources and a transition to greater domestic funding, incidence rates have now stabilised at a lower level. While local Government funding has offset reductions in external funding in clinical programmes, withdrawal of donor funds greatly affected the delivery of HIV programmes by civil society organisations (CSO). In Namibia, CSO have driven the majority of media and community-based HIV programmes in the past, including sexual risk reduction programmes, efforts to address harmful norms, demand creation for services, programmes for key populations and non-medical support to PLHIV. In 2013, it became increasingly clear that the funding transition and shift towards clinical programmes was not only eroding key community capacities. There also was a risk of a prevention gap – caused by a rapid decline of "conventional", community-based prevention programming well before clinical programmes had reached sufficient coverage to compensate for this decrease.

Description:

By 2012, major Namibian CSO active in HIV realised that they had to move from being mostly implementers of external donor agendas to a more active role in the national discourse about the future of HIV programming. Facilitated by Positive Vibes (PV), a group of 6 organisations formed a loose alliance called the Mutual Action for Development (MAD) to:

- Create greater dialogue among CSO about common concerns and issues facing the sector and the HIV/AIDS work they were involved in,
- Gain greater understanding of emerging global and local policy and funding trends and

their implications for the national response and the communities CSO were serving,
- Facilitate dialogue with Government and key development partners, both through direct engagement and active and informed participation in public consultations,
- Create greater awareness about the value of community-based and CSO driven HIV work and the need to sustain key capacities housed in CSO.

The group intended to complement the national HIV network organisation, whose capacity for coordination and advocacy was largely taken up by the management of GFATM grants.

Results of the programme:

For a first time, the programme moved major Namibian NGO's involved HIV to engage in coordinated policy analysis and independent advocacy work. MAD partners succeeded in:
- Formulating a joint position on the future of HIV programming, pointing to the need to safeguard CSO competencies and define the future roles of CSO and communities in an increasingly medicalised and domestically funded HIV response (MAD 2015).
- Raising awareness about the underfunding of comprehensive, community-based HIV-prevention programming, which remained at the core of national strategies.
- Supporting the formulation of a costed Combination Prevention Strategy (RoN 2014) to provide a national framework for coordinated prevention programming.
- Providing consolidated and critical input to national coordinating bodies such as the National AIDS Executive Committee, during the review of the National Strategic Framework and during PEPFAR´s consultation on its country strategy

Delivering independent local research, e.g. on entry points in the national funding cycle or a rapid assessment of the state and outlook of HIV/AIDS programming by CSO.

Impact of the programme:

Despite its brief duration, the project managed to achieve some important successes. Most notably, advocacy of MAD partners:
- Ensured a continued commitment of the Namibian Government to Social and Behaviour Change programming in its national strategic framework
- Led to the formulation of a national Combination Prevention strategy that re-validated the importance of a broader prevention portfolio (including structural interventions) alongside national efforts to increase coverage of biomedical services.
- Successfully advocated for the inclusion of budget positions for CSO and community-based activities that will guide resource mobilisation and allocation of funds.

The programme also had many "soft" impacts that represent important shifts within CSO and with regard to the relationship of CSO with the Namibian Government. The project aligned, formulated and communicated joint CSO positions on issues affecting the HIV response. This independent and often critical engagement created a more positive perception of CSO among local Government officials who had often perceived CSO as conduits of external donor agendas. Government officials repeatedly came out in support of MAD positions and started to actively engage with MAD partners. Through its association with the International HIV/AIDS Alliance (IHAA), the support of UNAIDS and its own efforts, the project also managed to carry key messages into regional and global forums. How far these efforts supported and increased advocacy for prevention and greater acknowledgment of the role of community-based programmes is difficult to say. However, it definitely added a rare country-level voice to this

process.

Financing and management:

The project greatly benefited from funding and technical support by the IHAA and its network of linking organisations. Through PV, MAD became a partner in a four-country project to strengthen CSO advocacy for the sustainability of comprehensive HIV/AIDS programmes. Efforts to win over MAD partner organisation to contribute further financial, human or in-kind resources to joint advocacy work were hampered by the low levels of untied funds organisations had command over as well as diminishing human resources that stretched organisational capacities to the limit.

Lessons learned and recommendations:

Many CSOs active in HIV/AIDS have focussed mostly on delivering on the requirements of large grants from key donors such as PEPFAR or the GFATM. In Namibia, this has undermined the capacity of both network and individual organisations to engage in independent advocacy work related to the broader national response. Also, focus on donor priorities has led to fragmentation in CSO work and substantial organisational dependency. As the responsibility for HIV programming increasingly transitions to country levels, donor agencies need to take such possible detrimental effects on participation into account when funding CSO. This can be addressed by creating greater access to untied resources that allow organisations to more independently engage in advocacy, contribute to programmatic innovation and engage in productive dialogue with other country stakeholders. CSO, however, also need to look to access funding in ways that allow for greater organisational independence. Developing a culture of coordinated collective action can allow organisations to achieve impact with limited resources.

28. Namibia:

Title of the programme: Encouragement and support for ALHIV through Teen Clubs

CONTACT PERSON
Name: Tapuwa Mutseyekwa
Title: C4D Specialist
Organisation: UNICEF
Address: UNICEF CO Namibia
Email: tmutseyekwa@unicef.org

Implemented by: Civil society, Government and UN.
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV and young people.

Background:

HIV infections among adolescents in Namibia are not declining as quickly as among other age groups. Of the estimated 8,136 new infections in 2011–2012, an estimated 43 per cent of them occurred among the age group 15–24 years, with females accounting for more than two thirds of those new infections. Comprehensive knowledge about HIV and AIDS is also still very low among adolescents in Namibia.

Description:

Established in 2010, the teen club at Katutura Hospital in Namibia's capital city, Windhoek, is one of 15 teen clubs which UNICEF supports. The clubs are positioned to provide integrated youth-friendly health and psycho-social services for adolescents living with HIV. This is done through addressing the specific needs of young people, including counselling, peer support and knowledge on how to face the stigma and discrimination associated with people living with HIV.

Young people lead the club sessions on their own.

Apart from playing games and socialising, the monthly meetings at the Teen Club are important for the introduction of discussion topics which relate to the issues faced by adolescents living with HIV in the outside world. These include how to make friends, how to handle disclosure, the importance of treatment adherence and how to handle their sexuality. Larry adds that as a group, they have since taken advantage of emerging technology and activated a mobile phone based chat group for the members.

This has been an important space for daily interaction and peer support, such as sending out reminders for everyone to take their medications.

Results of the programme:

More than 35 young people are actively engaged with the Teen Club at Katutura Hospital, one of 15 Teen Clubs supported by UNICEF.

Impact of the programme:

Success story from an adolescent living with HIV:

Besides explaining to Larry, an adolescent living with HIV, that he had to take his medicine daily so that his chances of survival are increased, the doctor introduced him to the hospital-based Teen Club at the Katutura Hospital in Namibia's capital city, Windhoek. At first Larry regarded the Teen Club as a transit centre, where he would go as he waited for the doctor to attend to him during his monthly visits. Six years down the line, Larry regards the Teen Club as a safe haven for him to live better and positively with HIV.

"Since 2010 when I joined the Teen Club, I have made great friends with people who are going through what I am going through and also have the same fears that I have," says Larry, his beaming smile speaking a lot for the sense of belonging that he has achieved from being in the Teen Club.

For young people like Larry, the Teen Club has nurtured strong leadership skills and a fired up ambition to achieve the best in life. "I now have big dreams, dreams which I never thought were possible. I now know that it is very possible for me to live a long and healthy life if I continue to take my medication, and so I have set my mind on pursuing a dream of becoming a lawyer or a journalist".

Financing and management:

UNICEF supports the programs, with hospital staff providing administrative assistance. All Teen Club meetings are run by the youth, for the youth.

29. Nigeria

Title of the programme: The Integrated MARPs HIV Intervention Prevention Program (IMHIPP)

CONTACT PERSON
Name: Michael Akanji
Title: Director of Programmes
Organisation: The Initiative for Equal Rights (TIERs)
Address: 9B, Nob-Oluwa Street, Ogba Eatate Scheme II, Ogba, Lagos
Tel: +234 8082873254
Email: makanji@initiative4equality.org

Programme is being implemented since: 2009
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to men who have sex with men

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

Men who have sex with Men (MSM) linger on as one of the most vulnerable population to HIV/AIDS infection in Nigeria. With total national infection rate of 17.2% and a prevalence of 15.8% in Lagos State according to the IBBSS 2010 report.

Discriminatory laws, policies and societal prejudice have further driven the MSM community underground. This has led to limited access in the MSM community accessing HIV prevention and care services for fear of been identified as an MSM.

The program provide HIV/AIDS intervention programme through community led approach in the provision of services at the community level through the use of community based peer educators that are providing HIV/AIDS education, safer sex commodities, HIV testing and counselling services and referral services to their sexual and social peers at the community level.

Description:

The Integrated MARPs HIV Prevention Program (IMHIPP) is a USAID funded project through Heartland Alliance International-Nigeria and implemented by The Initiative for Equal Rights (TIERs). The project, which started in 2009, is aimed at reducing the HIV/STI prevalence and the impact of AIDS on MSM and their sexual partners in Lagos state through a coordinated and systematic approach. The project objectives are as follows:

- Provide MSM and their sexual partners with high quality HIV prevention and referral
- Improve partnership with LACA, SACA and other key stakeholders to ensure access to health care and enabling policy environment for MSM
- Increase access to condoms and condom compatible lubricants for MSM in Lagos state
- Increase access to health care services and income generating activities for MSM in Lagos

The project focuses on Comprehensive HIV prevention service, Advocacy, referrals and capacity strengthening. This project is implemented by The Initiative for Equal Rights (TIERs) through a network of trained Outreach coordinators who supervise the peer educators to reach their peers with high quality HIV prevention messages.

Results of the programme:

- Over 10,000 MSM in Lagos State reached with HIV prevention messages since inception of the project
- Over 3,000 MSMLWHA, their female sex partners and their dependents in Lagos State reached with PHDP services
- Establishment of an MSM specific support group for MSMLWHA

Impact of the programme:

- The project has created more awareness on HIV/AIDS and other sexually transmitted infections.
- It has also made accessibility to safer sex commodities easier through the pick up centre.
- It has taken HCT services to the MSM community through provision of testing services during peer sessions and outreaches specific to MSM.
- Through advocacy to healthcare facilities, MSM can now access services at the facilities free from stigma and discrimination.

The impact was measured through mid term assessments carried out with focus on the service delivery and Knowledge of the subject by the beneficiaries

Financing and management:

Major Partners: Heartland Alliance Nigeria

How the programme is managed, coordinated and Financed: Monthly disbursement of Project activity funds in line with approved budget and also monthly financial reports.

How is financial sustainability of the project addressed: The project design addresses the need for a community led intervention and this encourages community ownership of the project. The design is based on the provision of HIV intervention through community based peer education to their sexual and social peers.

This approach helps with the sustainability of the project as the project beneficiaries continues to assess intervention through their peers within the community and the continues referral services to MSM friendly clinic that are trained for the provision of non-discriminatory services

Lessons learned and recommendations:

The factors that helped the success of the project are:
- The implementing organization is community led
- The relationship with the State AIDS Control agency (SACA) and Local AIDS control Agencies (LACAs)
- The linkages with the health facilities
- Community involvement in the development of IEC materials
- Establishment of hotlines alongside a Toll-free line for enquiry, counselling and report of violation cases based on the client's sexual orientation.
- The relationship between the gate keepers, members of the community and the organization

The biggest challenges are:
- Difficulty in tracking referred clients due to poor documentation at the health facilities
- Retaining clients in care and support services
- The same sex marriage Act which has further driven the community into hiding

30. Sierra Leone

Title of the programme: Making Patients Happy And Healthy: Caring For People Living With HIV During The Ebola Outbreak In Sierra Leone

CONTACT PERSON
Name: Edmund Makiu
Title: HIV/AIDS Specialist
Organisation: UNICEF Sierra Leone
Address: Central Medical Stores Compound, Jomo Kenyatta Road, Freetown, Sierra Leone
Tel: +232 76 428 640
Email: emakiu@unicef.org

Implemented by: Government, Civil Society and UN or other intergovernmental organisation.
Scope of submission: Community-responses in the humanitarian context, in relation to people living with HIV, women and young people.

Has the programme been evaluated /assessed? No
Is the programme part of the Implementation of the national AIDS Strategy? No
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

The outbreak of Ebola Virus Disease (EVD) that hit Sierra Leone in May 2014 ravaged communities, severely disrupting general health services and reducing access to those services. The epidemic rapidly spread to all districts in the country, with varying levels of intensity. In Sierra Leone, as of December 2015, there were 8,704 confirmed cases of EVD, with an additional 5,418 probable and suspected cases. There were 3,589 confirmed deaths due to Ebola, and an additional 400 probable and suspected deaths. A rapid assessment of health facilities conducted by the Ministry of Health and Sanitation with support from UNICEF

found a significant decline in the uptake of maternal and child health services in October 2014. The results showed there was a 23% decline in the number of PMTCT visits, a 50% decline in HIV testing and a 21% increase in patients lost to follow-up most likely as a consequence of the Ebola outbreak.

Description:

HAPPY (HIV/AIDS Prevention Project for Youth) is a national non-governmental organization supported by UNICEF. It aims to mitigate the impact of HIV/AIDS on the lives of children and adolescents infected and affected by HIV/AIDS through ensuring access to quality care, treatment and support. While primarily focused on providing services to children and adolescents living with HIV, the project also builds the capacity of caretakers, and informs and sensitizes the general population on HIV/AIDS.

During the EVD outbreak HAPPY recognized the need to proactively reach out to people living with HIV who were not able to access health services and had thus defaulted from their life-saving treatment.

HAPPY created a program to trace people living with HIV who had not returned for their treatment on time with the aim of returning the 1,444 pregnant and lactating women and 541 HIV-exposed and-infected children in the districts where HAPPY operated, including districts that were most affected by Ebola at the start of the outbreak, to life-saving treatment in non-medical facilities. While loss to follow-up had previously been a concern for the national HIV programme, this strategy was specifically designed in the context of the EVD outbreak due to the higher rate of people not returning for their treatment due to fears about contracting Ebola at health facilities. This activity was later incorporated into the national HIV response.

Results of the programme:

As part of the response, HAPPY launched the Patient Tracing Project to ensure ongoing treatment and support for people living with HIV during the Ebola outbreak, reduce the number of patients missing appointments and prevent loss to follow-up. The project facilitated continued access to treatment and care for people living with HIV by tracing patients, supplying ARVs, and providing HIV services at HAPPY centres when health facilities were closed.

As a result, both healthcare staff and HIV-positive patients felt more comfortable going to HAPPY facilities to pick up their ARVs, receive adherence counselling and seek other health care services, despite the fear around Ebola. HAPPY social workers and counsellors provided individual counselling to older children and counselling for the parents/caregivers of younger children. Nurse counsellors from the health facilities conducted outreach visits to the HAPPY centres at agreed times to dispense ARVs and other medications and supplies. This was important for clients who did not wish to go to health facilities but still needed access to ARVs. Patients who needed additional testing or presented with complications were referred to a fully equipped health facility.

The HAPPY teams were also trained to distribute ARVs and provide adherence counselling to clients who refused to go to the health facility and/or HAPPY centres to pick up their medication,

either due to long distances or if clients were quarantined in their homes or communities. In these cases, the teams brought the medication to their homes and provided them with counselling sessions and information. Clients who were unable to leave their homes were given multi-month supplies of ARVs and caretakers were provided with ARVs for their children. Tracer teams worked together to ensure that HIV-positive and-exposed children, adolescents and women adhered to treatment during the Ebola outbreak.

Impact of the programme:

The project facilitated continued access to treatment and care for people living with HIV by tracing patients, supplying ARVs, and providing HIV services at HAPPY centres when health facilities were closed. When the programme was launched in August 2014, 30% of the 686 children in 12 health facilities had defaulted on their HIV treatment. By the end of the project, 60% of children and 84% of pregnant women who were lost to follow-up were re-initiated on treatment. Improvements in access and retention were achieved by triangulating the existing facility data with the information obtained from outreach to patients lost to follow-up. As a result of this experience, the national programme has increased its focus on retention monitoring. As part of the HIV mitigation strategy in the EVD outbreak, the National AIDS Secretariat (NAS) engaged the Network of People Living with HIV (NETHIP) in Sierra Leone to conduct large scale tracing of patients lost to follow-up.

Financing and management:

Major partners included HAPPY, the National AIDS Secretariat (NAS), the Network of People Living with HIV (NETHIP) in Sierra Leone, Voice of Women (VOW), the Ministry of Health and Sanitation (MOHS), SOLTHIS and UNICEF with support from the Swedish National Committee for UNICEF.

Lessons learned and recommendations:

In Sierra Leone, the Ebola outbreak demanded that community-based structures and organizations such as the HAPPY centre played a central role in educating communities and delivering basic health services. Peer outreach and proactive follow-up were adopted by the National AIDS Control Programme to address persistent challenges retaining people living with HIV in care. Likewise, building on existing mechanisms such as support groups and a trained pool of counsellors accelerated the pace of implementation. As part of the recovery, this model was replicated and adapted in the five districts with the highest HIV burden under the leadership of NAS, with support from UNICEF, UNFPA, UNAIDS and the World Food Programme (WFP). The national EVD recovery plan also featured tracing and follow-up of patients who missed appointments or stopped treatment as a result of the success of the approach implemented by the HAPPY teams.

31. Swaziland

Title of the programme: Maximising ART for Better Health and Zero New HIV Infections (MaxART)

CONTACT PERSON
Name: Françoise Jenniskens

Title: Acting programme manager MaxART
Organisation: STOP AIDS NOW!
Email: FJenniskens@stopaidsnow.nl

Programme is being implemented since: 2011
Implemented by: Government and Civil Society

Scope of submission: Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) and Participatory community-based research, in relation to population group of people living with HIV, women, young people and other (men and general population)

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? No

Background:

The Kingdom of Swaziland has a population of 1.1 million people. SHIMS showed 31% HIV prevalence among adults (18-49). Young women (18-19) had a 14 times higher HIV prevalence than young men. HIV and AIDS had a devastating effect with life expectancy dropping and increased mortality leading to poverty, more OVCs and the breakdown of family support systems. A study in 2013 showed that 65% of adult PLHIV were not virally suppressed. Of those on ART, 85% were virally suppressed. 50% of all HIV positive men were not aware of their HIV+ status in 2011 (SHIMS) and in 2010 only 40% of people aged 15-49 had tested for HIV in 12 months preceding the survey. These figures prompted a stakeholder consultation initiated by STOP AIDS NOW! with the Ministry of Health (MoH), CHAI and community partners. Gaps in the national response and reflection on possible solutions culminated in formulating the dream of eliminating HIV through treatment as prevention in the MaxART proposal.

Description:

MaxART aims to reach all people in Swaziland in need of treatment in preparing the country for the possibility of ending the HIV epidemic. Goals:

1. Achieving universal access to testing and treatment;
2. Assessing the impact of treatment on prevention;
3. Demonstrating treatment as an effective form of prevention in a high prevalence setting.

MaxART is implemented under the leadership of the MoH by a consortium of partners[6] from national and international NGOs and academic institutions. The focus is on *service delivery, implementation research and advocacy* with men and youth as hard to reach target groups. One of issues raised during the gap analysis was the undervaluing role of the community and planning done top-down in the national response. From the inception of MaxART, the voices of the community and the role of the community in relation to HIV services was guiding the design

[6] STOP AIDS NOW! , Clinton Health Access Initiative (CHAI), Southern Africa HIV and AIDS Information and Dissemination Service (SAfAIDS), University of Amsterdam (UvA), SWANNEPHA, Global Network of People living with HIV (GNP+), Southern African Centre for Epidemiological Modeling and Analyses (SACEMA)

and implementation of interventions and informed by social science research. **Phase 1[7] (2011 - 2014)** focused on countrywide scale up and implementation of innovative, comprehensive, evidence-informed, inclusive and rights-based interventions along the continuum of care, aligned with national HIV treatment guideline[8]. MaxART focussed on demand and supply side[9] and re-enforcing each other. Community interventions were aimed at awareness raising, treatment literacy and mobilisation for HIV testing and linkage to care as well as enhancing support structures. The network of PLHIV operationalised human rights based responses starting with a PHDP[10] study and GIPA. Social science research and human rights monitoring generated evidence on barriers and opportunities for scaling up. **In phase 2 (2014-2017)** the consortium implements an effectiveness trial testing the feasibility, acceptability, clinical outcomes, affordability, and scalability of offering ART to all in a government-managed health system.

Results of the programme:

The community partners trained 103 traditional leaders, held 270 demand creating community dialogues (40% coverage), organised fast track HIV testing in 35 out of 55 constituencies, and community volunteers made over 650,000 door-to-door visits. HTC services were provided on site and about 50% of people attending community events were tested for HIV. Many more people attended clinics[11], who initially had challenges to cope with the increasing demand[12]. Yet all targets were (over) achieved as measured by the MoH national statistics. By June 2015: annually 284,680 people were tested for HIV trough HCT, HBHCT, PIHTC as well community based testing; 134,083 people were on ART and LTFU was 10% in the 2013 cohort. This case is part of the “Communities Deliver” report and was presented in Washington DC (2016). His Majesty the King in his speech at opening of Parliament reiterated the importance of all communities to address HIV and raised the budget for the HIV programme.

Impact of the programme:

- Many more people know their HIV status and access treatment; stronger engagement of traditional leaders in the HIV response; Anecdotal evidence[13] of less fear of HIV, more disclosure of HIV status and PLHIV networks report less stigma.
- National Policies are addressing human rights issues and GIPA[14]. Advocacy resulted i.e in reducing the age of consent for testing to 12 years in Child Protection and Welfare Act.
- Now broad recognition amongst government and partners of the importance of the role of communities in scaling up access and care. Communities express need for more ownership
- The full impact of Early Access to Treatment for All trial results will be available as of

[7] **Phase 1 targets** for end 2014 included: 1) Increase the number of people tested each year from 137,406 (2009) to 250,000; 2) Increase % of people on treatment to 90% of those in need from 46,883 (March, 2010) to 101,734;3) Reduce loss-to-follow-up rates at 12 month of those on ART from 22% to 10%.
[8] At that time, individuals were eligible for treatment with a CD4 count below 350 cells/mm^3
[9] The HSS component had national coverage and 1,034 different level health workers were trained in Provider Initiated Testing and Counselling, 501 nurses were trained in Nurse led ART Initiation (NARTIS) resulting in 87% of initiations done by nurses in 2013. Further support was given to laboratory systems, commodity and consumable planning and transport for lab samples
[10] Positive Health and Dignity and Prevention study was done in 2011 informing the interventions from the start
[11] The exact % of effective referrals could only be measured towards the end of phase 1.
[12] Introduction of the national referral sheets in 2014, but not yet analysed at national level.
[13] Focus group discussions with three communities with men, youth, health workers in 2014 – see CSS case study report
[14] SWANNEPHA contributed to the development of: National Stigma and discrimination reduction Action plan; Client friendly patients charter’ advocacy tool “What are your rights”; review of all training curricula and SOPs from human rights perspective.

2017.

Financing and management:

For partners see footnote 5. STOP AIDS NOW! is initiator and responsible for overall management and reporting. CHAI houses two MaxART staff for coordinating activities of the different partners in country. The PI for the effectiveness trial is the MoH and the MoH guides research and implementation. MaxART is funded by the Dutch Postcode Lottery Fund. The Royal Netherlands Embassy regional HIV programme also contributes to phase 2. Successful interventions from phase 1 were incorporated in national strategies, training curricula and guidelines (some still under development, especially for community component). The trial is implemented under government conditions working within available resources for health care. The community and human rights component is financed by MaxART. MaxART works with the MoH towards the development of a roadmap for community health systems strengthening in which sustainability will be a key element.

Lessons learned and recommendations:

- The thoughtful, problem oriented and inclusive[15] design process resulted in a programme addressing key and real barriers to access HIV testing, treatment and care felt by young people, men, communities and PLHIVs. The social science research informed these too.
- Working from a multidisciplinary perspective led by a strong and committed MoH resulted in a consortium that is well positioned to address both community and health systems perspectives needed for a successful treatment for all study.
- National Community structures are underfunded, civil society and NGOs are donor dependent and there are no paid health workers at the community level in Swaziland. There is need to further strengthen community health systems and linkages between community and health services to further enhance sustainability and reach 90-90-90 targets. Structural funding for community systems is essential for a sustainable HIV response at community level.

A big challenge is that some health facilities have difficulties in dealing with the increased demand for services i.e in terms of human resources, adequate physical space in the facilities, challenges with transport of laboratory specimen etc.

32. Swaziland

Title of the programme: Assistance to Orphaned and Vulnerable Children (OVC) at neighbourhood care points (NCP) and Schools (Project Number 200422)

CONTACT PERSON
Name: Cassandra Chiang
Title: Nutrition & HIV Consultant
Organisation: WFP
Address: 733 73rd Avenue, 23rd Floor, New York
Tel: +1-646-556-6918
Email: Cassandra.Chiang@wfp.org

[15] Of PLHIV networks, communities, civil society and other stakeholders

Programme is being implemented since: 01 January 2013
Implemented by: UN
Scope of submission: Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to women and young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes

Background:

The Kingdom of Swaziland has a population of 1.1 million and ranks 150 out of 188 in the 2015 HDI. Swaziland faces significant development challenges including high income inequality, high unemployment and the impact of HIV and AIDS.

Swaziland has a very high HIV prevalence: 26% of the population between the ages of 15-49 and 41% of pregnant women receiving antenatal care live with HIV. 45% of children are orphaned or vulnerable. The 2012 review of social safety nets in Swaziland by the World Bank identified orphans and vulnerable children (OVC) as one of the most vulnerable groups affected by poverty and food insecurity in Swaziland.

Chronic malnutrition is a concern in Swaziland: Stunting affected 25.5% of children under 5 years in 2014. The south-eastern part of the country is particularly vulnerable to drought and El Niño conditions have led to extensive crop losses and cattle deaths. An estimated 23.5% of Swazis are moderately to severely food insecure as of early lean season in 2015.

Constrained economic growth is expected to hinder implementation of social policies benefiting vulnerable Swazis in years of increased need.

Description:

WFP assistance aims to improve food and nutrition security and the livelihoods of the most vulnerable households impacted by poverty and HIV/AIDS. This programme recognizes that one of the most visible effects of HIV and AIDS in Swaziland is the growing number of OVC – many who cannot yet access other social safety nets. WFP provides food assistance by leveraging the knowledge, skills and scale of community-driven child care centres called neighbourhood care points (NCP).

NCPs are the traditional centres of support for OVC. At NCPs, community volunteers prepare two meals a day, a breakfast of Supercereal porridge and a midday meal of maize meal and beans cooked with fortified vegetable oil. Meals are part of a package of services provided by these volunteer caregivers, defined by the national NCP Strategy that also include early education, recreational activities, psychosocial support and links to basic health care.

The programme contributes to government priorities outlined in the National Strategic Framework for HIV and AIDS (eNSF) for 2014-2018, and aligns with priorities of the National Development Strategy, and the Government of Swaziland's National Plan of Action for Children (2011-2015). It also aligns with the Swaziland Joint United Nations Programme of Support for

HIV and AIDS (JUNPS).

Results of the programme:

The programme targets OVC aged 2-8 years who are attending one of 1,594 NCPs across all four regions of Swaziland. Through the programme WFP was able to distribute 50% of the planned food reaching 50,845 children, or 98% of the planned totals in 2015, despite severe funding constraints.

Impact of the programme:

The programme has resulted in higher school enrolment, better access to food, higher certainty about the next meal and better access to health care amongst children in communities with a functioning NCP as compared to their counterparts in communities without NCPs.[16] NCPs play such a significant role because many OVC are not covered under national social safety nets and can only access services such as food assistance, early education, and links to health care through NCPs. An external evaluation of the OVC food support programme implemented by WFP from December 2012 to February 2014 showed that the provision of food to OVCs resulted in a perceived health benefit by their caretakers, confirmed by field assessments: children had no visible signs of malnutrition; and they did well in monthly growth monitoring assessments.

While these community-run centres fill the gaps in the health and social protection systems, their effectiveness would drop without adequate food assistance. A nationally representative baseline of NCPs showed that when food is not present in NCPs, 64% of all NCPs closed.[17] Thus, food assistance remains a critical success factor for NCPs.

Overall, this programme increases food security and promotes gender equality. Through these community-run centres, OVC have access to two meals every weekday. The ratio of girls to boys enrolled in NCPs is 1.05 and on-site meals mean that girls are more likely to receive a full serving (take-home rations could be split unequally between boys and girls in their households).With greater food security, the promotion of gender equality and greater access to education and health services, the vulnerability of OVC and their likelihood of engaging in negative coping behaviors that could lead to new HIV/AIDS infections is reduced.

Financing and management:

The main factor posing a risk to WFP's ability to ensure consistent assistance to young OVC is funding constraints. The approved budget for the project as of December 2015 was USD 14.9 million. Confirmed contributions, however, only reached USD 7.2 million. These limited resources forced WFP to reduce or stop food assistance in certain months.

The program is intended to be handed over to the national government. The preparations for the handover coincided with El Niño, the worst drought Swaziland has experience in recent history, so the program was extended until December 2016. WFP continues to support a transition to full national ownership.

---

[16] UNICEF 2006.
[17] WFP 2012.

To ensure program sustainability, WFP built capacity of caregivers at NCPs. WFP also maintains key partnerships that include the Ministry of Tinkhundla Administration and Development (MTAD), the Office of the Deputy Prime Minister (DPMO), as well as the National Emergency Response Council on HIV and AIDS (NERCHA).

Lessons learned and recommendations:

Resource constraints were identified as the top risk to WFP's ability to fully implement assistance to OVC at NCPs. The government's capacity and financial resources available to absorb the program were identified as the second greatest risk to WFP's support to young OVC.

WFP learned the best path forward is to work in closer partnership with the communities, government, UN agencies and other development partners on capacity development to enhance national social protection systems. Entry points relating to WFP strengths include technical assistance in nutrition and HIV, supply chain management, and monitoring, evaluation and quality assurance.

WFP is already shifting to more sustainable assistance with its engagement with national social protection working groups. WFP advocated for nutrition- and HIV-sensitivity of safety nets through the 2015 National Social Protection dialogue. This dialogue reaffirmed government commitment to developing a comprehensive national social protection strategy and laid out key steps to enhancing the social protection system. WFP will continue to support this dialogue in 2016 and promote the inclusion of community-engagement and responses in national plans.

33. South Sudan

Title of the programme: Addressing the issues of child marriages,SGDV and STIs/HIV & AIDS among young people in South Sudan

CONTACT PERSON
Name: Joseph Kenyi Samuel
Title: (Mr) President
Organisation: UNA-South Sudan
Address: Civic Engagement Center,Juba,South Sudan
Tel: +211954354936
Email: unass.juba@gmail.com

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

Despite recent progress, including the development of the 2008 Child Act in South Sudan, the country still needs to effectively implement protection and health programs for children and the

youth generally, and particularly for adolescent girls. This results in the observed vulnerability of these girls. Adolescent girls have particular protection needs and are vulnerable to sexual and gender-based violence (SGBV) and early marriages. The increased risk of rape for adolescent girls particularly in armed conflict situations comes with many unwanted pregnancies and other negative reproductive health effects. Sexual exploitation of girls puts them at risk for STIs/HIV & AIDS.

Description:

The project is needed in order to address the issues of child marriages, GBVs, and HIV that exist amongst the youthful population of South Sudan.

Adolescents make up 60% of the population in South Sudan and they are prone to diseases, child marriages, GBVs and other risks.

The expected contribution of the organization to address the problem at stake is by production of free monthly magazines that are distributed to schools in which the pupils' views and opinions are shared amongst themselves.

The organization is involved in such an issue because the developmental transitional phase of adolescents and young adults are particularly sensitive to influences from family, peer groups, school and films. These can support young people's health and wellbeing.

The objectives of the project are;

- To foster a healthy, prosperous and peaceful society of adolescents and young adults.
- To reduce high school dropouts amongst adolescents and encourage them to know their rights.
- To reduce unplanned teenage pregnancies, child marriage, STIs and HIV/AIDs.
- To combat adolescents' excessive abuse of alcohol and substance use.
- Advocate for investment in young people's education, health and livelihood along with protection of their human rights; increased financial and human resources to improve access of young people to comprehensive reproductive health services; and information and education to therefore increase retention in school and eventually improve their economic livelihood in South Sudan

Results of the programme:

Over the last six months (October2015-April 2016), the program has reached 8,000 pupils in Juba, South Sudan. We need to reach to other places in South Sudan when we secure some funding from any benevolent sources.

Impact of the programme:

So far, as a result of the program, three primary schools in Juba have established the HIV/AIDS Clubs to address the issues related to the disease with other pupils and the communities around the schools.

Financing and management:

The program is coordinated and managed by the Youth Sector of the United Nations

Association of South Sudan (UNA-South Sudan). The program is solely run on a voluntary basis, though the Universal Printers Co.Ltd in Juba, South Sudan, is able to freely produce the publications for the outreach activities.

Lessons learned and recommendations:

The key finding by the UNASS-Youth on the project implementation was that sexuality education is still lacking in schools and most adolescents and youth shy away from discussing on issues of sex and sexuality. Sexuality education is not included in primary and secondary school syllabuses, which would have helped in preventing teenagers' pregnancy, HIV/AIDS and other STIs among young people in the country. Knowledge and skill gap in reproductive health and HIV/AIDS among the youth is very minimal, which explains why education and skills development were noted as the most affordable and scalable preventive options to solve health and HIV/AIDS related problems among young people in South Sudan.

Despite recent progress, including the enactment of the Child Act 2008 in South Sudan, state capacity to effectively implement policies and systems for protection of adolescent girls in particular is inadequate. This results in the reported and observed vulnerability of female children and youth. Particularly in the current situation of armed conflicts, there is increased vulnerability of female youth to sexual and gender-based violence (SGBV) and child marriage. The increased risks of rape for adolescent girls in armed conflict situations comes with unwanted pregnancies and other negative reproductive health effects.Additionally, sexual exploitation of girls puts them at the risk for contracting STIs /HIV infections.

34. Uganda

Title of the programme: A Study on Drug Use Related Vulnerability to HIV/AIDS Infection among Most-At-Risk Populations in Uganda

CONTACT PERSON
Name: Wamala Twaibu
Title: Executive Director
Organisation: Uganda Harm Reduction Network
Address: P.O Box 31762 Kampala, Uganda
Tel: (256) 414 664 730, Mob. (256) 702 980 968
Email: uhrnetwork@gmail.com/admin@ugandaharmreduction.org

Programme is being implemented since:
Implemented by: Civil society
Scope of submission: Advocacy, campaigning and participation in accountability, Participatory community-based research, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people who inject drugs.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

There is growing evidence that drug users have high HIV prevalence, though there has not been a comprehensive study to this effect at the national level. Available national information through a combination of UNAIDS and UNODC data provide estimates that HIV prevalence rate of PWID in Uganda is 11.7%. Additionally, a small-scale study of 67 sex workers who use drugs found a HIV prevalence rate of 34 per cent (IDPC Briefing Paper, HIV prevention among people who use drugs in East Africa; September 2013). Another study conducted in Kampala by (Most At Risk Population (MARPS) Network in 2012-2013) highlighted HIV prevalence at 17% among injecting drug users. They may have a major contribution to the 7.3% (Uganda AIDS Indicator Survey 2011) prevalence of the total population of Uganda; however, little attention is being given to them.

While alcohol and drug use was highlighted as one of the risk factors driving the HIV epidemic in Uganda's HIV Modes of Transmission and Prevention Response Analysis (Synthesis Report 2014, Draft), there has not been detailed social studies in Uganda to explore this relationship to inform national programming. Evidence is scanty on the effects of specific types of drug use, levels of addiction and other predisposing factors. The available study on alcohol use among the two fishing communities on Lake Victoria indicates a likelihood of low use of condoms when under influence of alcohol (Tumwesigye et al. 2012) but not much data is available on the use of other drugs and its influence on the users to HIV/AIDS acquisition.

Description:

This study targeted drug users (both injecting and non-injecting), networks and organisations in Kampala district and Eastern Uganda districts of Busia, Tororo and Mbale to explore the perceived relationship between drug use and vulnerability to HIV/AIDS as well as their direct and indirect bearing on HIV/AIDS programming. The exploratory study was informed by extensive document review and in-depth interviews with drug users, organisations and networks targeting drug users, government line officials (Mulago and Butabika health officials), UNODC officials, and police departments among others. The study was implemented by MARPs Network Secretariat and Uganda Harm Reduction Network with support from the Global Fund Country Programme (2015) who committed to conduct an exploratory study to establish the possible relationship between drug and substance use to acquisition of HIV/AIDS.

Results of the programme:

A total number of 415 respondents were interviewed in the selected districts of Busia, Kampala, Tororo/Malaba and Mbale. Twelve percent (n=51) were Injecting Drug Users (IDUs); 50% (n=214) used other types of drugs (none injecting), 11% (n=48) were Hot Spot Operators, 3% (n=15) Civil Society Organizations staff, 4% (n=16) Health service providers, 5% (n=22) Community leaders, 2% (n=9) Security and police officials, 5% (n=22) Peer leaders and 4% (n=19) national key informants including MoH staff, Butabika, Police, Mulago and prisons.

Impact of the programme:

The study findings indicated a growing number and network of injecting Drug users (n=51) including some young adolescents as well as a big population of drug users (n=135) though none injecting. There was a good number of females Injecting Drugs (n=15) as well as men (n=36) in the targeted areas but the research findings pointed out that they could double if further network members would be brought on board. Majority of injecting drug users (both male and female) had a strong tie of family member use with few depending on friends to inject them and some with rich affluence. Non–injecting drug users (n=213) included a wide range of users

including sex workers; truck drivers, bar attendants, hawkers, bodaboda riders, youth at washing bays and streets and seemingly the entire slum dwellers in the hot spots of the target districts.

Overall, there was a strong adhesive social network of drug users in the study areas and indeed drug use is on the increase in Uganda. Injecting drug use specifically is a growing hidden network yet has a positive relationship with acquisition and transmission of HIV and AIDS. For non-injecting drug users, the use of drugs is normative behaviour for everybody in communities irrespective of age, sex, levels education and social status. However, not much attention has been given in terms of policy and programmes on the likely influences of drug use and acquisition of HIV and AIDS in Uganda. This information will be useful for all national key stakeholders (such as the Ministry of Health, Uganda AIDS Commission and implementing partners) in implementing needed national interventions based on known facts about these groups.

Financing and management:

MARPs Network Secretariat and Uganda Harm Reduction Network (UHRN) jointly managed and coordinated an exploratory study to establish the possible relationship between drug and substance use to acquisition of HIV/AIDS with support from the Global Fund Country Programme (2015). Specifically, the study tried to explore the profiles of drug users, types of drugs used, the perceived risky behaviors associated with drug use and how they predispose them to Acquisition of HIV/AIDs. Such information will be useful for all national key stakeholders (such as the Ministry of Health, Uganda AIDS Commission and implementing partners) in implementing needed national interventions based on known facts about these groups.

MARPs Network Secretariat and Uganda Harm Reduction Network (UHRN) remain committed to providing national technical guidance to support MARPs targeted HIV responses by enhancing awareness, knowledge and understanding about the drug/substance-HIV links (i.e. associated major predisposing risk and protective factors).

Lessons learned and recommendations:

Lessons learned:
Overall, there is a strong adhesive social network of drug users in the study areas and indeed drug use is increasing in Uganda. Injecting drug use specifically is a growing hidden network with a relationship with acquisition and transmission of HIV and AIDS. For non-injecting drug users, the use of drugs is normative behaviour for everybody in communities irrespective of age, sex, levels education and social status. However, not much attention has been given in terms of policy and programmes on the likely influences of drug use and acquisition of HIV and AIDS in Uganda.

Recommendations:
A combination of accessible HIV prevention approaches are needed to reduce HIV transmission among people who inject drugs. Some of these strategies need to take account the risk and vulnerable factors to drug use as well as creating health policy environment that allows these groups to seek healthcare services including harm reduction measures.

a. **Design programmes to address risk factors that make drug users vulnerable** including peer related influence, relieving stress and boredom, covering painful memories in their past, helping them fit in society and amongst peers, and family history.
b. **Implement harm r*eduction strategies:*** Harm reduction interventions including:

community-based outreach, risk reduction counseling and behavior change interventions, HIV testing and counseling, HIV care and treatment, condom distribution and promotion, access to and safe disposal of injection equipment (needle and syringe exchange programmes), and treatment for drug use and dependence (opioid substitution therapy) should be piloted in Uganda.

c. **Create a health policy environment that allows drug users to seek healthcare** services based on a good practice from Tanzanian government that has rolled out needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST).
d. Develop and adopt evidence-based guidelines in the government for prescribing opioids in emergency departments, including restrictions on the use of long-acting or extended-release opioids for acute pain.
e. **Ensure drug users access health friendly services through their networks:** Access to mental health services, sexual health check-ups and condoms are necessary. Pre-exposure prophylaxis (PrEP) could be given to high risk groups especially sex workers that use drugs**.**
f. **Target programs for prisons settings**: Incarcerated persons who are drug users in a prisons setting need to be supported with needle and syringe exchange programmes (NSPs) to reduce sharing of syringes.
g. **Address youth related issues:** There is need for comprehensive and regular programmes targeting the youth in and out of schools to reduce harm associated with drug use.
h. **Partnership with NGOs and drug use organisations:** There is need for partnership between government and Uganda Harm Reduction Network to sensitise the community and provide friendly services.
i. **Strengthen epidemiological and social data on PWUDs in Uganda:** There is need for a national wide situation analysis to establish the HIV prevalence among people who use drugs including; Injecting drug users in Uganda.

35. Uganda

Title of the programme: Link Up: A voucher for health - Enabling young people in Uganda to access quality sexual and reproductive health services

CONTACT PERSON
Name: Bharam Namanya
Title: Executive director
Organisation: Community Health Alliance Uganda
Address: Plot 19, Kawalya Kaggwa close, Kololo, Kampala, Uganda
Tel: +256 414 533 487
Email: bnamanya@chau.co.ug

Programme is being implemented since: 2013
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV, sex workers, women and young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes

Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

Young people in Uganda have significant unmet sexual and reproductive health (SRH) needs. This is particularly the case for young people from key populations. The prevalence of HIV among sex workers of all ages is between 35% and 37%, five times higher than the general population. Sex workers also face other serious sexual and reproductive health and rights (SRHR) issues, including high rates of unintended pregnancies and sexually transmitted infections (STIs). The situation for young lesbian, gay, bisexual, transgender and intersex people is also difficult. They face serious challenges in accessing SRHR services at a time in their lives when accessing these services is critical. The Uganda AIDS Indicator Survey (2011) and other studies show these groups to be at high risk of HIV. The 2009 Uganda HIV Prevention Response and Modes of Transmission Analysis estimates 0.61% HIV prevalence among men who have sex with men (MSM), while the Crane survey of 300 MSM in Kampala suggests an HIV prevalence of 13.7% (although this was 3.9% for MSM aged 18-24 years). In this context, offering both a choice of providers through partnerships with private health providers and offering high quality services that are sensitive to young people's needs are key to widening access to age-appropriate and comprehensive SRHR and HIV services.

Description:

Link Up is an ambitious project (2013-2016) that has improved the sexual and reproductive health and rights of almost 800,000 young people most affected by HIV, aged 10-24, in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda.

In Uganda, the Link Up project focuses on young people living with HIV and those considered most at risk of HIV. This includes young people who engage in sex work, men who have sex with men, the fishing community, and young truck and boda-boda (motorbike taxis) drivers who are usually young men.

Since 2013, Marie Stopes International Uganda and Community Health Alliance Uganda have been working together through the Link Up programme on exactly this issue. Link Up built on Marie Stopes International's wide experience of voucher schemes which they have used mainly to utilise the large but unregulated private sector by incentivising providers to deliver key health services at greatly improved standards, and to make them affordable.

The Link Up youth voucher scheme was launched in March 2014. The aim was to both offer a choice of providers through partnerships with private health providers, but also high quality services which were sensitive to young people's needs – particularly those from key populations.

- Vouchers allowed each young person two visits for HIV testing, three visits for family planning and three visits for STI management; all services were free.
- The vouchers were attractively designed – and included messages targeting young people and tested prior to production.
- Vouchers were disseminated by 70 young people aged 17-26 who were trained as community-based distributors (CBDs), who also offered health education and accompanied young people to the clinics if they wished.
- CBDs were paid by the facilities for every voucher redeemed – with quarterly 'mystery shopper' or client verification exercises being conducted to ensure the authenticity of

services claimed.
- 80 clinical officers and nurses from 40 health facilities and clinics were trained to work with young people who sell sex and young MSM, including the use of appropriate language, their specific vulnerabilities, and how to refer them (e.g. for HIV treatment, gender-based violence support and the prevention of mother to child transmission).

Additionally, 44 young people from specific key population groups were trained, and then stationed at each health facility to welcome and assist young people during their visits.

Results of the programme:

Between March 2014 and March 2015, the Link Up voucher scheme in Uganda extended sexual and reproductive health and HIV services to over 30,000 young people.

Impact of the programme:

The greatest uptake of services was for HIV counselling and testing (92%), STI management (75%) and family planning (37%).
- There was a noticeable shift in family planning uptake – 51% receiving long-term family planning services and 49% receiving short-term family planning services.
- The scheme was successful in reaching young people who sell sex (1,438), slum dwellers (4,188) and young people living with HIV (225). The presence of young people from key populations as both CBDs and as facility based volunteers was key.
- However, young men who have sex with men were harder to reach. Marie Stopes International Uganda are trying to address this by improving their working relationships with Uganda's MSM organisations, and further addressing the values transformation required among its staff.

In relation to reaching the most vulnerable young people with HIV and SRHR services, 1,438 sex workers, 4,188 slum dwellers, 225 young people living with HIV, 3 young transgender people, 537 fisher folk, 19,073 vulnerable youth, and 2,217 truck and boda-boda drivers have accessed services.

Financing and management:

The Link Up project was funded by the Ministry of Foreign Affairs of the government of the Netherlands. The project was implemented by the global consortium of Athena Network, Marie Stopes International, Global Youth Coalition on HIV/AIDS, Population Council and STOP AIDS NOW!, led by the International HIV/AIDS Alliance. In Uganda, the country consortium was made up of Community Health Alliance Uganda (CHAU), Marie Stopes Uganda (MSU), Uganda Youth Coalition on Adolescent Sexual Reproductive Health and HIV/AIDS (CYSRA), International Community of Women Living with HIV Eastern Africa (ICWEA), Ugandan Network of Young People Living with HIV (UNYPA), and the Population Council.

The project facilitated sustainability by ensuring community and youth ownership; strengthening partnerships between civil society organisations and public health facilities; and strengthening youth leadership. In Uganda, funding has been secured by MSU and CHAU to continue elements of the project, including continuing relationships with the youth-led organisations.

Lessons learned and recommendations:

Some of the challenges that have been identified:

- Data shows success in reaching vulnerable young women, young people in slums and sex workers. However, the number of young people living with HIV and MSM reached is low.
- Demand for additional services not covered under the Link Up voucher scheme (ie cervical cancer screening, safe abortion). Young women from key populations seeking these services were referred to other MSIU programmes and government or public health facilities as appropriate and where services were available.
- It is important to consider the future of the programme and manage the expectations of Link Up clients in the event that the vouchers cease to be available. MSIU is keen to integrate the aspects of its work with Link Up into other service delivery programmes in order to use funds from other donors.

Link Up's experience in Uganda demonstrates the success empowered young people living with and affected by HIV can have in achieving greater access to SRHR and HIV services for their peers. Future programming should continue to invest in interventions led by young people living with HIV and extend this type of programming to other districts in Uganda.

It is important to promote strategies that engage young people living with HIV in all their diversity – including young people living with HIV who sell sex, young people who identify as lesbian, gay, bisexual, transgender or intersex and sell sex or use drugs – as they may be the best placed to reach others living similar lives with the tailored information and services they need to access their sexual and reproductive health rights.

36. Uganda

Title of the programme: Young people aged 15-24 account for 40% of new HIV infections globally.

CONTACT PERSON
Name: Bharam Namanya
Title: Executive director
Organisation: Community Health Alliance Uganda
Address: Plot 19, Kawalya Kaggwa close, Kololo, Kampala, Uganda
Tel: +256 414 533 487
Email: bnamanya@chau.co.ug

Programme is being implemented since: 2013
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV, sex workers and young people.

Background:

Young people aged 15-24 account for 40% of new HIV infections globally. However, often young people most affected by HIV are unable to access sexual and reproductive health (SRH) services including family planning, sexually transmitted infection (STI) screening and treatment. Young women living with HIV, young people who sell sex, young men who have sex with men,

young transgender people, and young people who use drugs face stigma and discrimination based on age, gender, HIV status, and sexual orientation when accessing services.
Uganda has the world's youngest population; over 78 percent of Ugandans are below the age of 30 (UDHS, 2011). Just under half (47%) of the 1.8 million people living with HIV are young people (Uganda National Youth Policy, 2011). Overall, young people account for 37.4% of the population. Uganda faces significant challenges in meeting its young people's needs today and their challenges tomorrow, as its population continues to grow at a rate of 3.2 percent annually.

Description:

Link Up is an ambitious project (2013-2016) that has improved the sexual and reproductive health and rights of almost 800,000 young people most affected by HIV, aged 10-24, in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. The project is:

- *Linking up* SRHR and HIV information, education and communications materials and trainings for peer educators and service providers
- *Linking up* services within health facilities and between health facilities
- *Linking up* services between community-based organisations (CBOs) and clinical health facilities
- *Linking up* policy and decision-makers working on SRHR and HIV.

In Uganda, the Link Up project focuses on young people living with HIV and those considered most at risk of HIV. This includes young people who engage in sex work, men who have sex with men, the fishing community, and young truck and boda-boda (motorbike taxis) drivers who are usually young men.

At the heart of Link Up's interventions are peer educators: young people living with HIV who have been trained on a range of SRHR and HIV issues. Peer educators play an important role in reaching out to other young people with information, counselling and commodities (e.g. male and female condoms, information materials), referring peers for services, and conducting follow-up visits. Through Link Up, a 'snowball method' has been used in order to mobilise young people to access services. This means working with a group of young people who then mobilise other young people, who in turn mobilise their peers.

Peer educators deployed three main strategies to encourage the young people they met in the community to visit a health facility:

- Referral slips - When a young person visits a health facility using a slip, it ensures they are given the time and services suitable to their needs.
- Vouchers - Peer educators also refer young people to private BlueStar health facilities (Marie Stopes International – Uganda social franchise clinics based in communities). Under Link Up, peer educators provide young people with a voucher that enables them to access HIV, STI and family planning services for free from these clinics. BlueStar service providers are trained to provide tailored, appropriate and friendly services to young people referred through the project.
- Accompaniment - As some young people are afraid of going to health facilities, peer educators accompany them. This coupled with follow-up home visits for those who access services, is important for enabling SRH in the longer term.

In order to reach young people who do not want to go to health facilities, implementing partners take SRHR and HIV services to places where young people living with HIV already meet. When

conducting clinical outreach for young people living with HIV, collaboration with local organisations of people living with HIV is key. These organisations are able to identify young people who may want services and promote those services so that, when the clinical outreach team comes, young people are already aware of the services offered. It also helps young people living with HIV understand that those offering the services have been trained on important issues such as confidentiality and informed consent.

Results of the programme:

In Uganda, the project has reached over 344,000 young people most affected by and living with HIV in 11 districts (Kampala, Wakiso, Luwero, Nakasongola, Mukono, Kayunga, Mayuge, Iganga, Kamuli, Bugiri and Namutumba) with community- and facility-based HIV and SRHR services.

A snapshot of who was reached:
10,360 young people living with HIV; 39,806 young people who sell sex; 2,093 young men who have sex with men; 51 young transgender persons; 70,199 track/boda drivers; 47,631 fisher folk; 52,634 slum/pavement dwellers; 3,215 young people who inject drugs; and 16,2270 other vulnerable youth.

292,289 young people accessed VCT, of the young people who accessed VCT, 60% received post-test counselling. Over 2,315 young people accessed ART through the project.

Impact of the programme:

Through Link Up Uganda, young people most affected by and living with HIV were able to access integrated HIV and SRHR services in 190 service delivery points. These included public health facilities, private service providers and clinics. Young people living with HIV, selling sex, truckers and fisher folk among others received youth friendly integrated HIV/SRHR services including HIV counselling and testing, STI screening and treatment; and contraception and family planning information, commodities and traditional services.

Overall, the most accessed services were safer sex counselling for HIV and STIs; voluntary counselling and testing (VCT); and family planning. Safer sex counselling for HIV and STIs and family planning and VCT and family planning were the two most popular integrated services accessed by young people in the project.

Financing and management:

The Link Up project was funded by the Ministry of Foreign Affairs of the government of the Netherlands. The project was implemented by the global consortium of Athena Network, Marie Stopes International, Global Youth Coalition on HIV/AIDS, Population Council and STOP AIDS NOW!, led by the International HIV/AIDS Alliance.

In Uganda, the country consortium was made up of Community Health Alliance Uganda (CHAU), Marie Stopes Uganda (MSU), Uganda Youth Coalition on Adolescent Sexual Reproductive Health and HIV/AIDS (CYSRA), International Community of Women Living with HIV Eastern Africa (ICWEA), Ugandan Network of Young People Living with HIV (UNYPA) and the Population Council.

The project facilitated sustainability by ensuring community and youth ownership; strengthening

partnerships between civil society organisations and public health facilities; and strengthening youth leadership. In Uganda, funding has been secured by MSU and CHAU to continue elements of the project, including relationships with the youth-led organisations.

Lessons learned and recommendations:

Link Up's experience in Uganda demonstrates the success empowered young people living with HIV can have in achieving greater access to SRHR and HIV services for their peers.

Future programming should continue to invest in interventions led by young people living with HIV and extend this type of programming to other districts in Uganda.

It is important to promote strategies that engage young people living with HIV in all their diversity – including young people living with HIV who sell sex and young people who identify as lesbian, gay, bisexual, transgender or intersex and sell sex or use drugs – as they may be the best placed to reach others living similar lives with the tailored information and services they need to access their sexual and reproductive health rights.

37. Uganda

Title of the programme: HIV and Harm Reduction program supported by *Global Fund to Fight AIDS, Tuberculosis and Malaria*

CONTACT PERSON
Name: Kyomya Macklean
Title: Executive Director
Organisation: Alliance of Women to Advocate for Change (AWAC)
Address: Katwe Off Entebbe Road
Tel: +256 774 603 754
Email:info@awacuganda.org/awacuganda@gmail.com

Implemented by: Civil Society
Scope of submission: Participatory community-based research in relation to people who inject drugs.

Has the programme been evaluated /assessed? No
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

Uganda does not included PWUDs in the national HIV Strategic Planning, making it hard for service providers to provide services to target or include PWUDs due to limited data, criminalization and marginalization of this community. Fear of being reported to the police and other authorities by health workers hinders access to medical and drug treatment. Criminal laws, disproportionate penalties, and punitive law enforcement practices exacerbate stigma and result in human rights abuses, including police mistreatment, arbitrary detention, and denial of essential medicines and health services. Legal prohibitions on the provision of sterile needles and OST directly impede HIV prevention efforts. Testimonies confirm that police raids and arrests of centres and outreach workers impede service delivery and keep PWUD away from

services, resulting in an increase of risky behaviour.

We don't "see" PWUDs in most discussions about prevention, access to care & treatment, funding for support services and research from the mainstream society. And yet people who use drugs already make up a hidden population due to criminalization and stigma. HIV prevalence is 28 times higher among people who inject drugs and most injecting drug users have regular contact with the general population. HIV prevalence amongst people who use drugs is unknown, although a small-scale study of 67 sex workers who use drugs found a HIV prevalence rate of 34 per cent (IDPC Briefing Paper, **HIV prevention among people who use drugs in East Africa;** September 2013) Another study conducted in Kampala (Most At Risk Population (MARPS) Network in 2012-2013) highlighted HIV prevalence at 17% among injecting drug users; A rapid assessment was undertaken in Central division and four divisions of Kampala city with drug using sex workers (SWs)to investigate practices putting them at risk for contracting HIV, among the SWs who agreed to test for HIV34% tested positive. Interviews revealed inconsistent condom use with other risky sexual practices and needle sharing. (19th International AIDS Conference: Abstract no. PUB052). Alcohol and drug use was highlighted as one of the risk factors driving the HIV epidemic in Uganda's HIV Modes of Transmission and Prevention Response Analysis (UNAIDS Report March 2009). However little attention is being given to them and yet they may have a major contribution to the 7.3% (Uganda AIDS Indicator Survey 2011) prevalence of the total population of Uganda.

Effective interventions to prevent HIV among people who use drugs (such as NSPs and OST) do not currently exist in the country, although a national drug policy has been in development since 2005. The National HIV Prevention Strategy 2011-2015 does not include the provision of harm reduction services for people who use drugs – rather it merely states: 'It is globally acknowledged that IDUs and MSM play a major role in HIV transmission. Nevertheless, the Strategy does commit to 'ongoing surveillance of risk behaviors among IDUs'. The lack of harm reduction services in Uganda reflects a lack of political will to even acknowledge the existence of injecting drug use. If people who use drugs are not recognized as a population in need of services, they will not be mentioned in the key policy documents. This can be a major barrier to implementation.

Equity is a core pillar of the 90-90-90 target. All populations affected by the epidemic must obtain meaningful, timely access to life-saving testing and treatment services in order to make 90-90-90 a reality, and treatment services must be founded on a human rights approach. Given the substantial and growing HIV burden among key populations including PWUDs, it will be impossible to reach the 90-90-90 target without dramatically expanding access to evidence- and rights-based HIV testing and treatment for these groups. Reaching the 90-90-90 target for PWUDs will not only demand service innovations and enhanced political commitment, but also establishment of an enabling environment and implementation of critical enablers to extend the reach, acceptability and impact of services

Description:

Background

- East African regional HIV and harm reduction grant by Global fund in 8 countries (Uganda, Kenya, Tanzania, Ethiopia, Seychelles, Zanzibar, Mauritius and Burundi), 3 years
- Over 1 Million PWIDs in Sub Saharan Africa with 5-10% PLHIV

- Little info on epidemiological profile of KPs in East Africa – can't measure extent of HIV transmission among PWIDs
- Insufficient knowledge about risk practices & HIV needs of PWIDs
- Illegal nature of IDU, stigma and poor policy on illicit drug use negates PWIDs participation in national HIV research responses
- No available strategic data linking PWIDs with HIV in Uganda

Goal: Increased access to essential HIV and harm reduction services for people who inject drugs in Uganda

Objectives:

- Creating an enabling environment to conduct harm reduction activities in Uganda
- Strengthening of community systems for a sustained HIV response among people who inject drugs in Uganda
- Generating and utilizing strategic information on drug use related interventions in Uganda

Beneficiaries:

- PWIUDs
- Central, eastern and northern region (Kampala, Mbale and Gulu) Yr 1
- Western region (Mbarara) year 2

Core intervention models:

- Removing legal barriers to access
- Community Systems Strengthening
- HSS-Health Information Systems and M&E
-

Minimum Service package:

- HCT
- Hep C testing and treatment
- Needles and syringes exchange
- Opiate replacement therapy
- ART enrolment
- TB screening and treatment
- Condom distribution

Results of the programme:

1. Number of documented commitments of national decision-making bodies supporting roll-out/scale up of harm reduction program
2. Regional HIV and injecting drug use research agenda
3. Regional policy report

Impact of the programme:

- National drug policy assessment (analysis of legislation and enforcement practices) and dialogue
- Regional dialogue on drug policy, including EAC
- Research on drug use, size estimation, mapping, HIV prevalence in Uganda
- Initiation support for needle exchange pilot

- Support to CCM to increase harm reduction capacity
- Support to establishment of a local network of people who use drugs
- National involvement of PWIDs in research and policy work
- Participation in East African Harm Reduction Network.
- Drugs users and sex workers secured an office to transact their activities as a network of support

Financing and management:

Implementing partners:
- KANCO – Supervision/coordination and Implementation
- MoH – Facilitates and regulates demonstration projects and Research ethical approval
- CHAU – Country level policy & dialogue, delivery of demonstration projects and capacity building of HR Networks and strategic partnerships (UNAIDS, CCM)
- Uganda Harm Reduction Network Uganda (UHRN) – demand creation, referrals and linkages
- Demonstration project – Service delivery

Lessons learned and recommendations:

What factors helped success of the programme
- Project implemented by PWUDs
- The drug user network secured a big and enough office to transact its activities
- The beneficiaries were massively involved right at the beginning e.g consultative meeting, organised the in country consultative dialogues, presented the regional concept to the Uganda CCM
- 80% of the funds were directly channelled to drug user network, a direct implementer
- UHRN is the first ever key population organisation that has received the biggest percentage of funding to execute its activities in Uganda without being influenced by the donor, PR and SSR.

What were the biggest challenges?
- Stigma and discrimination
- Police harassment
- Criminalising laws
- Exclusion of PWUDs from the National strategic plan
- Small office space

38. Zimbabwe

Title of the programme: Working with traditional leaders as agents of change in mobilising communities on maternal reproductive and neonatal health

CONTACT PERSON
Name: Edinah D. Masiyiwa
Title: Executive Director
Organisation: Women's Action Group
Address: 11 Lincoln Road, Avondale
Tel: +2634308738
Email:edinah@wag.org.zw / wag@wag.org.zw

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability, in relation to people living with HIV, women and young people.

Background:

In Zimbabwe, the mortality rate of 614 deaths per 100 000 lives births was reported in 2014 (WHO). In response to this challenge, WAG Implemented the H4+ programme in 2014- 2015 with support from UNAIDS. The programme is implemented in 3 hard to reach districts of Zimbabwe. WAG worked closely with traditional and religious leaders at community level as they are quite influential in their communities. During the implementation period, the political climate was relevantly calm in the four districts allowing for un-interrupted programming. The period of programming was also characterised by increased campaigns against child marriages. Meanwhile the socio economic trends in Zimbabwe was characterised with two consecutive seasons of failed rains which has resulted in disastrous consequences for harvests and family food reserves. The districts where the programme was being implemented (Chipinge, Gokwe North, Mbire and Hurungwe) were the worst affected. Chipinge lost a lot of cattle and other livestock due to starvation and this has increased the poverty levels at community level. In Mbire, they have retained their livestock and the situation has slightly improved due to the late rainfall. Crops in the four districts have been destroyed by the heat. The effects of the drought have made it difficult for families to access food. A bucket of maize in some areas is costing $10.00, an amount which most Zimbabweans cannot afford. In view of the challenging socio economic situation, the President has declared a state of national disaster. There are fears of malnutrition affecting women, children under five and people living with AIDS because of the food shortage. This situation has increased the vulnerability of women and girls to HIV infection that comes about through early marriages and gender based violence.

Description:

WAG has implemented the H4+ programme with support from UNAIDS. The programme seeks to accelerate progress towards the MDGs 4 and 5, ensuring that women and girls access quality Reproductive Maternal Neonatal and Child Health (RMNCH) and Gender Based Violence (GBV) services, improved integrated management of Maternal, New-born and Child Health, Sexual and Reproductive health, Nutrition and comprehensive PMTCT package of services. The objectives of the programme are to strengthen community processes to demand health services, to increase service utilization, to create awareness on RMNCH and to enable communities to demand health care provision as a human right and influence positive health seeking behaviours. WAG implemented the programme in the 4 hard to reach districts namely Chipinge, Hurungwe, Gokwe North and Mbire. The primary focus of the programme was advocacy. WAG advocated for quality Maternal, Sexual Reproductive health, Newborn and Child Health and comprehensive PMTCT services. WAG also mobilised communities to demand and utilise these services at community level. Community mobilisation was done through traditional and religious leaders as they are role models and their words are listened to by their followers. Traditional and religious leaders were useful in addressing some of the harmful religious and cultural practices that hinders women and girls from accessing RMNCH and GBV services such as early marriages and home deliveries. The programme also sought to decrease incidence of HIV transmission through dialogues on factors that pre dispose people to HIV, most of them are closely linked to cultural and traditional practices. Traditional and religious leaders were engaged through dialogues. Participatory methods such as role plays,

drama and case studies were used during the dialogues to bring out the challenges faced by communities to access health services and the strategies that could be employed to overcome those challenges. To enhance the capacity of the leaders, a toolkit to guide the leaders on dialogues was developed. The leaders were trained on how to use the toolkit. This was quite crucial as the Traditional and religious leaders were to cascade and share the information with their communities. Towards the end of the project, there was a health day that was held in the community. This was aimed at promoting health seeking behaviours among members of the community. Women had an opportunity to have cervical cancer screening and family planning services. The leaders led their communities for HIV tests.

Results of the programme:

A total number of 1 309 people were reached by the programme in the four districts. The people were reached through community dialogues, trainings and community health day. A total of 168 people were reached in Chipinge, 285 in Hurungwe, 490 in Mbire and 366 in Gokwe North districts. These people included the traditional and religious leaders, health and GBV service providers and the community

Impact of the programme:

Positive changes were noted from the programme. Traditional leaders are now speaking out on harmful cultural practices such as girl pledging and forced wife inheritance which contributed to HIV infections. In addition, some traditional leaders banned home deliveries in their villages for example in Mbire, traditional leaders under chief Chitsungo made commitments that those who deliver at home will make a pay a fine in the form of 2 goats to the village head and the chief. This has helped in reducing home deliveries in the districts and given women the opportunity to book early access antenatal care and PMTCT services at the clinics, thus reducing maternal related deaths and HIV infections. A slight increase in the number of deliveries at health centres was noted at Chibuwe and Rimbi clinic in Chipinge. The numbers of deliveries from October to December 2015 were 149 and 153 from January to March 2016. Though there is a slight change, the numbers of people utilising heath services for deliveries has been maintained.

A case study of Chirunya clinic in Mbire demonstrated results: The clinic in 2015 has projected population of 6 909 people and 1 520 women of child bearing age. Before the project, the clinic attended on average 0 to 3 deliveries a month which during project implementation improved within a short time to on average 7 to 8 deliveries a month. “Figures would have been higher had there been a waiting home for pregnant women”. The nurse in charge of Chirunya clinic reiterated. The truth of the statement is corroborated by the fact that from January to June 2015, the clinic booked 84 clients and attended 54 deliveries in the same period. In the absence of a waiting mother’s home high risk pregnancies and those living far from the clinic have to be transferred to the nearest Chitsungo hospital facility with a waiting home. Home deliveries decreased. From January to June 2015 the clinic recorded 3 home deliveries compared to 16 in similar months of 2014.

Furthermore, the programme has also contributed to health seeking behaviours. It has been noted that male involvement has improved as they are now utilising the HIV/AIDS Testing and Counselling (HTC) services. Evidence from Chibuwe and Rimbi clinics in Chipinge district showed an increase in couple testing by almost 50% from 39 in October 2015 to 69 by March 2016.Traditional leaders also influenced male involvement in Maternal Health related issues as men are now supporting their wives financially and accompanying them to the clinics for antenatal care. With the knowledge they acquired through community dialogues and trainings,

traditional and religious leaders in Gokwe North are now conducting community dialogues with their community members on their own, discussing RMNCH and GBV issues. This reflects the sustainability of the programme as traditional and religious leaders are now conducting these meetings at their own initiative after the programme ended.

Financing and management:

The programme is supported by UNAIDS. The WAG director has full responsibility on this programme. WAG has signed memorandum of understanding with the local councils in the districts where the programme is being implemented. The traditional leaders fall under the Ministry of Local Government. There is also a memorandum of understanding with the Ministry of Health and Child Care. The ministry is also part of the H4+ programme implementation and their focus is on ensuring that the health services meet the demand from communities. This has helped in terms of sustainability as both ministries are also involved in programme implementation.

A programme officer from WAG is responsible for implementing the activities under this programme.

Lessons learned and recommendations:

- Working with traditional leaders has increased our reach because of the multiplier effect where one village head is responsible for more than eighty households
- The development of IEC materials on RMNCH, HIV and GBV assist in disseminating information and community leaders used the materials for reference purposes when encountered with questions by the community.
- Bringing services to the people promotes health seeking behaviours. This was evidenced by the large number who accessed HTC, VIAC and Family planning services on the Community Health Day
- Continued dialogue between service providers and communities helps to address issues of health worker attitudes. This in turn brings confidence to communities to utilise the health services.

39. Zimbabwe

Title of the programme: Community Impact of Elimination of Mother to Child Transmission (eMTCT)

CONTACT PERSON
Name: Martha Tholanah
Title: Coordinator
Organisation: International Community of Women Living with HIV in Zimbabwe (ICW-Zimbabwe)
Address: 8 Alice Lane, Avondale West Harare
Tel: +263772347276
Email: martha.tholanah@gmail.com

Implemented by: Civil Society
Scope of submission: Participatory community-based research, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc), Advocacy, campaigning and participation in accountability

in relation to women and young women.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

ICW-Zimbabwe, in partnership with UNAIDS, embarked on the project that sought to assess community awareness, community experiences of Option B+, and advocate for community engagement and coordination to support women's access and utilisation of eMTCT services which ensure retention of mother-baby pairs, and children living with HIV in the continuum of the care model through facility-based care approaches that promote uptake and follow-up services. The project links with our advocacy for holistic care of women's health management and the right to have healthy and HIV-free babies even when parents are HIV-positive. There is also a critical need to address and ensure access to services and continued support for those women who may choose not to take up Option B+; those who may have taken up Option B+, but for some personal reasons may find they need to opt out after some time.

Description:

The overall objective in carrying out the project was to learn from the community their experiences of the programme since the national rollout of the "Elimination of New HIV Infections in Infants and Lifelong Treatment for HIV-positive Pregnant and Lactating Mothers", also commonly known as Option B+.

ICW-Zimbabwe made a deliberate choice of selecting a location in one district each in eight provinces. The selection of the area in each province was made in close collaboration with the ICW-Zimbabwe provincial focal women and girls. This was done in an effort to ensure that we reached places where other NGOs and CSOs would not usually reach out to with their activities and programmes. The areas selected were therefore a mix of rural, farming, mining and peri-urban areas.

Role Play:
The young women led the dialogue, which started by dividing the participants into two groups for role-playing. One group was asked to develop a role-play of what happens (at home, amongst the community members and at the health care facility) when a woman who is HIV-positive falls pregnant. The other group was asked to develop a role-play where a couple who were HIV-positive wanted to have a baby and the process they would go through. The role plays and the discussions, besides looking at basic HIV treatment and care issues, brought out themes around adherence, spousal and extended family support, prevention of new infections and re-infections, importance of supervised ante-natal, pre-natal and postnatal care, gender-based violence and stigma and discrimination. The role plays also provided an indication of the level of awareness of up-to-date information in terms of services that are provided as the government updates policies on the minimum package of care, particularly the roll-out of Option B+. It was evident that health care worker attitudes and service provision were varied depending on the area, as in some areas there was a highly positive portrayal of the health care workers and the service they provided, while others portrayed the health care workers as uncaring and sloppy.

Results of the programme:

The programme reached at least 160 people collectively in eight districts in eight provinces.

1. Option B+ was well known in some areas, while others were not so aware. There were those who indicated that all they knew about elimination of mother to child transmission, which they still call PMTCT was the Option A and Option B.
2. Discomforts were expressed with the way the communities experienced Option B+. It was indicated that once a pregnant woman went to the health care facility to register for pregnancy monitoring and facility-based delivery, they would be tested for HIV without being prepared (pre-test counselling), and they had no choice over that. They expressed that it was a big emotional struggle to deal with the pregnancy, HIV testing and positive diagnosis, immediate commencement on anti-retroviral medicines, and the burden of whether to disclose and who to disclose to even before they come to terms with the condition.

Stigma and discrimination were indicated to be problematic in all the areas visited. People living with HIV faced stigma and discrimination in their communities from other community members who knew of, or suspected, their HIV status. This resulted in PLHIV being the subjects of malicious gossip, and being deliberately not informed left out of community activities.

Impact of the programme:

The programme raised awareness of the advancements in the eMTCT programme. ICW-Zimbabwe learned of challenges that include gender based violence that came about through finding HIV results during ANC visit. ICW-Zimbabwe also learned that solutions would come through facilitated discussions in the community, and that there is need for sustaineded interventions that address stigma and discrimination, gender based violence and empowering women to stand up for their rights, use of the female condom and also economic projects that will assist them to address the issue of depending on their partners for income or engaging in harmful practices in order to fend for their families. It is also important to include all community structures in the quest for solutions.

Financing and management:

The programme was run under the financial support of UNAIDS Zimbabwe. ICW-Zimbabwe's young women ran the programme, UNAIDS disbursed fund into the account which was then budgeted for and used by the young women themselves. The grant for this project was consumed, hence ICW-Zimbabwe is in the process of looking for more funds to address and assist with the emerging outcomes that arose during the implementation of this project. UNAIDS is the sole partner.

Lessons learned and recommendations:

Option B+ programme is now a Zimbabwean government policy that has been rolled out in all the clinics of Zimbabwe in order to test and treat.

Treatment literacy, information dissemination and awareness needs to be done intensified in these areas and many other areas. Stigma is still high, and due to the patriarchal society we still live in, women still have no voice and say little to nothing when it comes to the family structure. Treatment and health literacy needs to be strengthened. The lack of basic needs for survival needs to be addressed so that communities, particularly women, are able to take in the issues

and take charge of the health needs, particularly prevention, of their own lives and their families. Most women have no control over their bodies and sexual and reproductive issues, hence family planning and spacing is decided upon by the man even if it has negative implications on the woman's health. We suggest that more engagements addressing SRH, GBV and awareness need to be done to ensure that we have a healthy community. Most communities we visited spoke of strengthening their support groups, having money saving clubs and skills sharing projects that would help the family to gain income; and also male involvement in order for the men to support their partners as well as inform their friends

40. Zimbabwe

Title of the programme: Community Monitoring of OI/ART Services By People Living with HIV in Zimbabwe

CONTACT PERSON
Name: Freeman Dube
Title: Research and Documentation Coordinator
Organisation: National AIDS Council
Address: 100 Central Avenue, Harare
Tel: 00263 4 790575
Email: fdube@nac.org.zw

Implemented by: Civil Society
Scope of submission: Advocacy , campaigning and participation in accountability
Participatory community-based research related to people living with HIV.

Has the programme been evaluated /assessed? No
Is the programme part of the Implementation of the national AIDS Strategy? Yes

Background:

There were reports of challenges with supply of and access to antiretroviral therapy services by people living with HIV in Zimbabwe. This included reports of unavailability of ARV medicines and regular stockouts, malfunction of diagnostic equipment, and unaffordable user fees among others. In their totality, the challenges amounted to a disruption of services leading to drug resistance and death of people living with HIV across the country.

This gave rise to consultation across the divide of the national response but inherently involving people living with HIV. As a result, an agreement was reached to establish a community monitoring programme led by a multi-sectoral team of people whose responsibilities would among others include:

- To assess the availability of ARVs in the OI clinics
- To discuss best practices and challenges of the ART Programme.
- To discuss with OI clients the quality of services they get from OI clinics and challenges they face.
- To assess the state of diagnostic equipment for OI/ART services

Description:

The programme combines a mix of approaches and is multi-sectoral. Representatives are

drawn from organisations representing people living with HIV, the national AIDS coordinating authority, the Ministry of Health and Child Care, community members, community based organisations and representatives of non-governmental organisations. In implementing the programme, the uses the following strategies:

- Visits to health institutions for interviews
- Observations
- Reports
- Stakeholders meetings to share reports and discuss solutions
- Follow up on implementation of recommendations

Results of the programme:

The programme is national in its reach and periodically, the team visits a specific province wherein a number of districts are visited. The team also responds to emergencies that are raised through the membership of people living with HIV and the media. To date all the country's ten provinces have been visited with over fifty districts having also been specifically visited.

Although the programme is largely in the domain of HIV treatment and therefore targets people living with HIV primarily, it also includes prevention and economic as well as social empowerment of people living with HIV and their dependants.

Treatment has become a major strategy of HIV prevention as its success limits the amount of viral load in HIV positive people. As such, people living with HIV through their support groups, as a result of the community monitoring programme, have become strong advocates of ART adherence for prevention. Through this programme, support groups have been empowered to provide both treatment and prevention literacy to both HIV positive and negative people in various communities.

Impact of the programme:

Through the community monitoring programme, there have been a number of positive outcomes that have been registered. Various provinces and districts have already scrapped user fees which were inhibiting access to treatment by people living with HIV. Although some resistance exists, there is a strong lobby currently with policy makers across the country to have user fees scrapped as a national policy position.

Through efforts of the programme, after noting gaps during field visits, treatment literacy was included in the successful proposal application to the Global Fund under the new funding model.

Specifically, there have not been reports of medicines stock-outs in the press or at meetings as the case was, following the work done under the programme.

Support groups have also become very active across the country as they provide the forums where people living with HIV meet and discuss their challenges, which are then communicated to the programme. In addition, the programme has been able to address cases of stigma, especially self stigma as issues of access to treatment are getting quick and adequate attention.

The programme has also created unity in people living with HIV, who in majority now speak with one voice in such issues and as a result are being taken serious by policy makers.

Financing and management:

The National AIDS Council provides secretariat services to the programme, which is funded also from NAC and other stakeholders. The committee that runs the programme established its own structure, which reports to the National Partnership Forum and also gives feedback to organisations representing people living with HIV.

The major partners are:
- People living with HIV representative organisations (Zimbabwe National Network of People with HIV (ZNNP+)
- NAC
- Ministry of health and Child care
- CBOs
- And partners in the National Partnership forum

Lessons learned and recommendations:

The biggest lesson from this programme is that people living with HIV have capacity to meaningfully participate and contribute to the national response.

It has been learnt that proper institutional arrangements are key to facilitating work by people living with HIV. The arrangements in place in Zimbabwe have cleared hurdles such as financing and coordination for the implementation of this project.

A major recommendation is for the programme to have a secretariat supported by partners, and that it be expanded to cover other emergencies such as TB and Cancer, which have now been included in the response to HIV.

II. Asian States

41. China

Title of the programme: China AIDS Fund For Non-governmental Organizations (CAFNGO)

CONTACT PERSON
Name: Yang Weizhong
Title: Director
Organisation: Fund Management Committee Office
Address: 418 Hua Thai Hotel, East End of Jinsong, Chao Yang Distract, Beijing 100021 China
Tel:+86-10-84039875
Email: ywz126@vip.sina.com

Programme is being implemented since: 2015
Implemented by: Government, Civil society, Private sector and UN or other inter-governmental organisation
Scope of submission: Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to populations of people living with HIV men who have sex with men, people who inject drugs and sex workers.

Has the programme been evaluated /assessed? No
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

- Sexual transmission has become the main HIV transmission route, the transmission pattern is relatively more hidden.
- NGOs have advantages in connecting special social groups, working in flexible ways and high efficiency.
- Under the support of governments and international cooperation projects, the number of NGOs participating in AIDS prevention and treatment was significantly increased; NGOs have played an important role in AIDS prevention and control.
- With the end of the Global Fund and other international cooperation projects, China's NGOs are facing the shortage of funding in their participation in AIDS prevention.

The establishment of China AIDS Fund For Non-governmental organizations is an important step in transformation of government functions, purchasing social services and constructing the service-oriented government.

Description:

CAFNGO was established jointly by the National Health and Family Planning Commission, the Ministry of Finance and the Ministry of Civil Affairs as a national public welfare special fund in June 2015.

CAFNGO aims to support NGOs to undertake education and communication activities, prevention interventions, testing and counselling among high risk groups, as well as care and support for people living with HIV/AIDS (PLWHA), in accordance with national and local HIV/AIDS response plans and policies.

NGOs registered in civil affairs departments and NGO incubation units assigned by civil affairs departments or health and family planning departments are eligible for application of CAFNGO projects. NGOs who have not registered can also apply for projects via NGO incubation units and under their management.

The Fund Management Committee Office (hereinafter referred to as the "Office") organizes preliminary screening of projects applications. If projects applications met the application eligibility criteria, the Office shall accept the application and make public the names of the applicant organizations and their directors and the project titles. If project applications were deemed ineligible, the applicant organizations shall be notified according with the project application guidelines by the Office. Then the Office shall arrange expert evaluation to review the accepted project proposals. Experts shall review and make comments in full consideration of HIV/AIDS prevention demand, the characteristics of the NGOs, the project feasibility, project outcomes, and the annual funding plan. The Office shall make public the expert evaluations, including the nominated project titles, applicant organizations and the expected amount of funding, etc. Based on the expert evaluations and the feedbacks from the publicity, the office will determine which projects to fund and announce the funded project titles, NGOs and amount

of funding. The Office will sign agreements with the applicant NGO incubation units or NGOs, and disburse project funding in accordance with agreements.

Results of the programme:

754 projects elected from 467 NGOs which covered 30 provinces in China were funded by the CAFNGO in the year of 2015. Total amount of funding was 45.21 million RMB. Projects were about undertaking education and communication activities, prevention interventions, testing and counselling among high risk groups, care and support for people living with HIV/AIDS. Nearly 385,000 target people expected to be covered by the projects.

Impact of the programme:

- The CAFNGO has played a positive role in promoting NGOs' participation on AIDS prevention and control work.
- The CAFNGO has promoted the growth and development of NGOs and improved the ability of social governance in China.
- The CAFNGO has improved the policy implementation of purchasing social services.

The CAFNGO has promoted multi-cooperation, especially cooperation among NGOs, hospitals and CDCs.

Financing and management:

The CAFNGO implements project management and determines which projects to support by releasing project proposal guidelines, accepting proposals, reviewing the proposals and evaluating.

China government provided 50 million RMB for initial funding in 2015.The National Health and Family Planning Commission, the Ministry of Finance and the Ministry of Civil Affairs jointly issued the 《Circular of management regulations of China AIDS Fund For Non-governmental Organizations》.The National Health and Family Planning Commission, the Ministry of Finance and the Ministry of Civil Affairs jointly established the Fund Management Committee, committee members were from the three ministries/commission and representatives from major donors. The Fund Management Committee assigned China Preventive Medicine Association as the Fund management agency and setd the Fund Management Committee Office.

Lessons learned and recommendations:

The following are the main aspects that the fund is running smoothly:
- The national government attaches great importance to the CAFNGO.
- The Global Fund and other international cooperation projects offered commendable reference experience.
- Conduction in strict accordance with the measures of the management regulations.

The following are the challenges:
- Management mechanism was not adequately perfected.
- Funding cannot fully meet the demands of NGOs.

NGOs' capabilities to participate in AIDS prevention and control were not enough and needed to be further improved.

42. India

Title of the programme: Pehchan, a community systems strengthening programme for men who have sex with men (MSM), transgender and hijra (collectively MTH) communities to increase reach, scope and quality of HIV prevention and other services responsive to their needs.

CONTACT PERSON
Name: Sonal Mehta
Title: Director: Policy & Programmes
Organisation: India HIV/AIDS Alliance
Address: 6 Community Centre, Zamrudpur, Kailash Colony Extension, New Delhi 110048 INDIA
Tel: +91-11-4536-7700
Email: smehta@allianceindia.org

Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc.) in relation to men who have sex with men and transgender people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the Implementation of the national AIDS Strategy? Yes
Is the programme part of a national plan broader than the National AIDS Strategy? Yes

Background:

Like many Asian countries, India has a concentrated epidemic where the infection is highest among key populations, including MTH. Social taboo and punitive laws such as the repressive Section 377 which criminalizes homosexuality further made it difficult for members of the MTH community to avail services and increase vulnerability and exploitation from threats, extortion and violence.

Description:

Pehchan (named for the Hindi word meaning 'identity', 'recognition' or 'acknowledgement'), strengthened and built the capacity of 201 community-based organisations (CBOs) to provide effective, inclusive and sustainable HIV prevention programming to clients in MTH populations in 18 states in India.

Results of the programme:

Pehchan registered and served more than 435 000 clients from MTH communities, providing nearly 340 000 of them to HIV prevention services for the first time. Fourteen exclusive

transgender and hijra CBOs were established and strengthened. A total of 169 MTH community members and leaders were trained as master trainers, of whom 80 were transgender women or hijras. More than 228 000 MTH were tested for HIV with nearly 2% positivity and over 95% of them were linked to care and treatment services.

Impact of the programme:

As a result of Pehchan, clients accessed previously difficult-to-access services beyond basic condoms for prevention, including STI treatment, community-friendly HIV counselling and linkages to testing, as well as counselling on partner violence, family support, disclosure, sex reassignment, pyscho-social support, legal aid, and general health concerns. Pehchan raised the issue of gender violence as a barrier to accessing services, and data reflected increased reporting of violence and a decrease in these incidents against MTH. States such as Kerala, Punjab, Chattisgarh and Jharkhand had programme interventions for MTH for the first time, and more than fifteen states started regular Pride walks including in smaller cities, such as Lucknow, Bhuvaneshwar, Pajim, Ranchi, and Imphal. A number of states adopted more progressive policies; for example, Kerala state was earlier hostile to the needs of transgenders and has now adopted policies supportive of them.

Pehchan worked with the National AIDS Control Organisation (NACO) to map transgender people in all 18 programme states. Pehchan also supported, in consultations, advocating against Section 377, India's regressive anti-homosexuality law, and for protecting the rights of the Third Gender. MTH community organisations proved to be the best vehicles not only for advocacy but also for service provision to their communities. Importantly, Pehchan served 2,497 female partners of MTH providing counselling and linkages to sexual and reproductive services in a non-threatening environment.

Financing and management:

The overall cost of Pehchan for five years (October 2010 – March 2016) was approximately US$23 million. Within the above-mentioned budget, the programme gave an average of 22 months of support to clients. The per capita crude cost of Pehchan was INR 1,496 (US$23) against the INR 2,500 (US$39) of National AIDS Control Plan MTH prevention intervention.

Lessons learned and recommendations:

It is crucial to create platforms where different stakeholders such as the government, MTH community, state actors, service providers and other civil society members can come together to build trust and support quality interventions. State Oversight Committees were formed in every state of Pehchan as part of this platform. In quarterly meetings, State AIDS Control Societies and MTH communities developed working relationships that supported both the programme and longer term agendas. It takes time to mobilise communities and convince policy makers to support marginalised communities like MTH. Five years was too short a period for such an important ambition; seven to ten years would be necessary to ensure long-term impact. Pehchan's success was largely based on the community involvement and MTH leadership at all levels of implementation, including in national and state-level programme leadership and management.

43. Iran

Title of the programme: National AIDS Control Programme (community-based components)

CONTACT PERSON
Name: Dr Mohammad Mehdi Gouya
Title: Director-General, Centre for Communicable Diseases Control
Organisation: Ministry of Health and Medical Education
Address:
Tel: 0098 (21)
Email: mgouya57@gmail.com

Programme is being implemented since: 2003
Implemented by: Government, Civil Society and UN or other intergovernmental organisation.
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to populations of people living with HIV, people who inject drugs and women.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

Iran is a country that has undergone rapid demographic and epidemiologic transition over the past generation. This has proven to be both an opportunity and a challenge. Although the Islamic Republic of Iran's HIV epidemic remains primarily concentrated among male injecting drug users, there is now clear evidence of an important sexual component to the epidemic. Recognising that an effective national response hinges on the capacity to reach the people most vulnerable to and affected by HIV, the National AIDS Control Programme has for many years adopted the approach of delegating community-level service delivery and outreach to community-based, non-governmental organisations, which function as an integral part of the national response whilst enriching it with their contextualised knowledge and experience.

According to data from the national HIV case registry, more than 30 thousand people have so far been diagnosed with HIV in Iran, of whom 85 per cent have been men. More than 40 per cent of these cases were between 26 and 35 years of age at the time of infection, whilst injecting drug use has been the probable route of transmission in two-thirds of instances. However, the number of registered cases is only a fraction of the estimated HIV population and the challenge, as in many other countries, is to identify people living with HIV and link them to effective treatment, care and support services, and to help ensure a full and productive life. Hence the national programme needs more than ever to reach deep into the communities most vulnerable to and affected by HIV in order to achieve its overarching goal of ending the HIV epidemic by 2030.

Description:

The National AIDS Control Programme is a nationwide, multi-sectoral and multi-stakeholder programme. Its fourth iteration was endorsed by the Council of Ministers in March 2015. The 4th NSP is structured around 11 strategies, which include HIV testing and counselling; harm reduction and HIV prevention among people who inject drugs; prevention of sexual transmission, condom promotion and the management of sexually transmitted infections; and

treatment, care and support for people living with HIV. The programme is formulated with inputs from all the major stakeholders, including non-governmental and community-based organisations, based on the best evidence available in-country. The programme also sets out strategies to promote greater synergy between programme pillars; these include, wherever possible, integration of HIV-related services within the existing healthcare system and outsourcing of service delivery to community-based organisations. We cite three examples of how a CBO or NGO can effectively integrate its work within the framework of the national response:

The AIDS Bus:
Launched in November 2015, this innovative mobile VCT campaign began as a joint initiative between the Ministry of Health, the Municipality of Tehran and a community-based organisation, but has now been extended to 7 other towns and cities in Iran. The AIDS Bus aims to provide a convenient alternative to facility-based VCT for people who would not otherwise seek these services. The AIDS Bus team of counsellors provide IEC for all clients and, if indicated, voluntary counselling and rapid HIV tests. The AIDS Bus typically visits densely populated locations (e.g. entrance of tube stations during peak commuting hours, or outside shopping arcades and also high risk areas) to maximise access.

Positive Clubs:
Positive Clubs were first set up in 2006 to provide psychosocial support for people living with HIV and promote the Positive Health, Dignity and Prevention approach, as well as cooperate with VCT facilities in providing health services to patients. Positive clubs work with their local Universities of Medical Science and or Welfare Organization in order to close the prevention gap and improve access to services. The majority of Positive Club activities focus on education and training on a wide range of HIV-related topics; linkage to VCT and ART services; linkage to other medical, welfare and social services, including medical insurance; vocational, occupational and entrepreneurship training; and advocacy activities focused around the World AIDS Campaign. Positive Clubs have direct input into the policies and programmes that affect their performance, through their Annual General Meeting with the management of the National AIDS Control Programme.

Results of the programme:

AIDS Bus:
More than 3 300 people have so far undergone counselling and testing in 8 towns and cities (multiple locations) in Iran. The majority of clients/visitors so far have been men. Where data is available, it appears to indicate that the client base for mobile VCT services is distinct from that captured by facility-based VCT services and that this approach has great potential for capturing people who would otherwise not seek counselling and thus miss the opportunity to become aware of their HIV status. Mobile VCT services such as the AIDS Bus can therefore significantly contribute to achieve the first 90 of 90-90-90 initiative.

Positive Clubs:
Approximately 7 000 people living with and affected by HIV have enrolled in 25 Positive Clubs across the country. Around two-thirds of these are women. In 2014, Positive Clubs organised more than 460 education events for their members on various HIV-related topics, conducted some 850 group and individual counselling sessions, organised specialist referrals for around 1000 members, arranged health insurance for more than 1 300 members and followed up reimbursements, and enrolled more than 400 PLHIV in various vocational training courses. Positive clubs are a crucial link in 90s initiative especially by ensuring adherence to treatment to

make the third 90 to happen.

Vulnerable Women's Centres:
33 VWCs are currently active across the country. Between April and September 2015, they provided a combination of facility-based and outreach services, distributing more than 110 000 syringes and 510 000 condoms, screening nearly 12 000 clients for STIs, and conducting individual and group HIV counselling for 16 000 clients (as well as 2700 tests). VWCs play an important role in providing access to services by women and ensuring 90-90-90 among this group.

Impact of the programme:

These programmes have set important precedents, and have helped reach and serve population groups that would otherwise have been denied these services in most cases, or else would have sought them from the private sector outside the normative reach of the National AIDS Control Programme. As such, they have clearly had social, cultural and political impact.

However, it is not easy to ascribe impact to these various programme components individually because they are pieces of a much larger jigsaw. However, given that the national response has well-documented HIV testing and ART coverage gaps, we may conclude that these community-based services need to be scaled up significantly if these gaps are to be bridged effectively so as to enable the country to achieve its goal of ending the AIDS epidemic by 2030.

Financing and management:

The day-to-day administration of the facilities linked to these programme components are delegated to local community-based organisations, which function under the supervisory guidance of the local university of medical sciences, which in addition to its academic role oversees all aspects of public health and clinical services within its jurisdiction. Overall supervision and normative guidance is provided by the Secretariat of the National AIDS Control Programme, in the Ministry of Health & Medical Education.

Programme components are largely funded from national resources, although international assistance (Global Fund, UN agencies) plays an important role, especially in terms of knowledge transfer, capacity development, and the procurement of strategic commodities such as rapid diagnostic kits and second-line antiretroviral medication.

Lessons learned and recommendations:

These three components all benefit from strong, sustained political support and are integrated into the national strategy. They are funded largely from the national budget or, in the case of the Positive Clubs, will soon be. The CBO partners are selected carefully and have proven to be effective partners in the national response. All these interventions are to be scaled up further and given sustained financial and technical support so they can have an even bigger impact on the epidemic in future.

44. Kyrgystan:

Title of the programme: Participatory community-based research of HIV prevention programmes efficiency was conducted within the overall framework of the program "HIV

prevention with sex workers".

CONTACT PERSON
Name: Shahnaz Islamova
Title: Director
Organisation: Tais Plus
Address: Panfilova st, 36 a, Bishkek, Kyrgyzstan
Tel: +996 312 54 46 13, +996 555 88 93 07
Email: taisplus@gmail.com , shislamova@gmail.com

Programme is being implemented since: 2000
Implemented by: Civil Society
Scope of submission: Participatory community-based research in relation to sex workers.

Has the programme been evaluated /assessed? Yes, There was an overall evaluation of the program "HIV prevention with sex workers". In 2003 the program was described as best practice and included into the UNAIDS publication. In 2013, Tais Plus's work was listed among examples of best practice by the NSWP.
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

Individual sex work by consenting adults was decriminalized in 1998. However, we are still witnessing illegal actions by police, such as systematic unlawful raids, detentions and extortions. The government and the Parliament made three attempts to re-criminalize sex work – in 2005, 2012 and 2015 respectively. We have successfully resisted all three of them with the support of partner organizations.

The first state program on HIV prevention was introduced in 1997. The state has continuously demonstrated political commitment to fight HIV and thus is currently implementing the 4th such program.

Kyrgyzstan used to be considered a low-income country; however, in 2014, it was moved to the "lower-middle income countries" category. The collapse of the Soviet Union and the resulting (and lasting) economic crisis prompted internal and international labour migration where people moved from rural areas to Bishkek and further abroad in search of income. 70% of Bishkek sex workers are women from provincial towns and remote settlements. 70-80% of sex workers have either underage or pension age dependants.

Stigma and discrimination of sex workers have traditionally been very high, but recently the situation has worsened drastically due to the emergence of movements for "traditional values".

The main goal of our program is to empower the sex worker community to attain higher standards of life. Health issues are not a priority for sex workers, which is why we, as a community organization, are planning our prevention programs based on community needs and opportunities. Regular research and evaluation help us understand how well we are able to achieve our principal goal.

Description:

Tais Plus has started conducting regular evaluations of HIV prevention programs in 2000; the research is conducted bi-annually. We have been using adapted FHI questionnaire since 2004, and, since 2008, we have been conducting national level research. Our last research was conducted in 2014.

The goal of the research is to evaluate HIV programs' efficiency which includes evaluation of knowledge on safer sexual behavior and uptake of STIs screening and treatment as well as uptake of HIV testing.

The research design, sampling, data analysis and interpretation are made by the organization. The interviews are conducted by trained outreach workers. The questionnaire is similar to that used in the sentinel surveys. Data analysis is, however, different, since we take context and sex workers' voices into account. For example, one can frequently come across a conclusion whereby it is stated that sex worker awareness of the ways HIV is transmitted, is low, and this in turn leads to low levels of condom use. At the same time our research has demonstrated that even though awareness changes, condom use for the past ten years has been at a permanently high level of 90%.

Results of the programme:

Our HIV program evaluation covers almost all the provinces – the capital and six regions. We do not conduct research in only one region where the programs have just rolled out. The most recent 2014 research sample is about 512 persons; overall there were 5 733 sex workers participating in the HIV prevention program (GFTAM-supported program data).

Impact of the programme:

We are using research results to insist that sex worker voices should be taken into account in the course of program planning. We can also see that the data gathered in other research on sex workers differs from ours. We advocate for not compiling official national program data based exclusively on AIDS-center conducted sentinel surveillance results. We have to compare results and build consensus both with respect to numerical data and with respect of its interpretation.

Financing and management:

Starting from 2000, our research was financed by a number of donors, including UNDP, GFTAM, and UNFPA. In 2016, we are going to be engaged in sentinel surveillance on all stages, starting from design and to interpretation. This is not something we have done before, which is why the interpretation of the sentinel surveillance results has been somewhat biased, as our priorities were downgraded compared to the public health objectives.

Lessons learned and recommendations:

All research that impacts sex workers should be designed together with sex workers.

- Data of the researches on sex workers that were conducted in the same period of time should be aligned, so that we will be able to get a general picture of the efficiency of the programs to adjust further programming
- AIDS-service and state medical care do not see sex workers as partners; they speak of

them as clients, who should receive condoms and be made aware of the ways HIV is transmitted
- Legal barriers to access are still being overlooked by the state health care system; namely the practices of law enforcement that are preventing access to services are not being sufficiently addressed.

45. Myanmar

Title of the programme: PMTCT in Myanmar

CONTACT PERSON
Name: Su Myat Lwin / Penelope Campbell
Title: HIV/AIDS Specialist / Chief of Health and Nutrition
Organisation: UNICEF
Address: UNICEF Myanmar Country Office
Email: smlwin@unicef.org / pcampbell@unicef.org

Implemented by: Government, Civil Society and UN.
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people living with HIV, women and others.

Background:

Since 2001, prevention of mother-to-child transmission of HIV (PMTCT) program has progressively scaled-up. As of early 2016, 301 out of the 330 townships in Myanmar are included in the PMTCT program. HIV testing of pregnant women is integrated as a component of antenatal care in hospitals and rural health centres.

Until 2013, HIV testing of pregnant women at the community level was done by collecting blood samples on a particular day of the month. Samples were transported to the township lab, where they were processed with rapid test kits. The test results were communicated to the health staff at a later date, who would then counsel the pregnant women on their HIV status.

Description:

In 2013, a program performance review and a rapid feasibility assessment deemed that it was feasible to start using point-of-care (POC) HIV testing using whole blood for screening pregnant women. POC testing was implemented after training of staff, and included: management of supplies, and periodic review and monitoring. All of these aspects were integrated with existing platforms in the maternal health and HIV programs. This was progressively scaled-up to all existing and new PMTCT townships.

Results of the programme:

The introduction of point-of-care HIV testing has resulted in:

- Increasing the number of pregnant women who are tested for HIV from 321000 in 2012 to 746000 in 2015; and

- Increasing the proportion of pregnant women receiving antenatal care that have tested and received results for HIV from 50% in 2012 to 80% in 2015.

Impact of the programme:

This simplified testing strategy has enabled the program to reach conflict-affected areas that have a higher prevalence of HIV and were previously inaccessible. Community volunteers screen pregnant women, resulting in equitable access for all.

Since the intervention was integrated with existing maternal health and HIV programs, the cost of the scale-up was close to only that of additional test kits, making it cost-effective.

Based on the initial expenditure analysis for PMTCT (final figures are expected to be available in April) the cost for:

- HIV testing and providing the result per pregnant women is less than $2 USD;
- Identifying one HIV positive pregnant women and providing a three drug regimen is $600 USD; and
- Every new HIV infection averted among infants is $1,230 USD.

The PMTCT program in Myanmar has been cost-effective compared to other countries, and has significantly contributed to the pool of HIV-infections identified every year in the country. Across Myanmar, almost 40% of new infections annually are estimated to be among low risk women, further illustrating the benefits of this approach.

Financing and management:

The key partners involved in the PMTCT program are: the Ministry of Health, UNICEF, WHO, Clinton Health Access Initiative, the network of people living with HIV, and multiple Non-Government Organizations.

Lessons learned and recommendations:

Based on assessments and programmatic observations, there is still a need to improve quality assurance mechanisms for point-of-care HIV testing. Additionally, the group is looking at introducing dual HIV-syphilis tests. Both of these items will remain a priority for the coming years.

46. Myanmar

Title of the programme: Increasing access to HIV treatment through a community-supported public private partnership in Myanmar

CONTACT PERSON
Name: Soe Naing
Title: Executive Director
Organisation: International HIV AIDS Alliance – Alliance Myanmar
Address: 24, 2nd Street. Hlaing Township, Yangon, Myanmar
Tel: +95 1 500619, +95 1 525715
Email: cd.alliancemm@gmail.com

Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) and Participatory community-based research in relation to populations of people living with HIV.

Background:

There has been a rapid increase in the number of people living with HIV in Myanmar over the last decade, the majority of who are eligible for treatment. Alongside this increase has been an effort by the ministry of health to rapidly scale up provision of treatment in order to reduce HIV-related illnesses and deaths. By the end of 2013, a total of 147 sites were providing ART across almost all of the states and regions of the country, compared to 57 sites in 2008. Early results are promising: in 2013 alone, a total of 13 834 people were initiated on ART, bringing the total number of adults and children receiving ART to 67 643 at the end of that year. Myanmar has an ambitious national strategic goal of providing ART to 106 058 people by the end of 2016. The health system in Myanmar is already stretched, and to achieve this goal, innovation in ART delivery will be required in-order to ensure that ART is provided close to communities, without compromising quality.

Moreover, the rapid scale up of ART provision has not always been matched with a similarly rapid increase in trained healthcare providers. This has led to overloaded clinicians who have to provide clinical care to a large number of people living with HIV, which ultimately reduces quality of care. This situation is frequently compounded by the long distance that patients have to travel to obtain ART in some areas, which further impacts on adherence and retention in care, and ultimately, leads to sub-optimal viral suppression and mortality outcomes.

Description:

To address this situation, and in an effort to decentralise ART delivery, since the 2009 Alliance, Myanmar has been operating a partnership with private sector general practitioners. Under this partnership the Alliance developed terms of reference and contracted GPs to provide HIV testing, assessment and WHO staging, diagnosis and treatment of opportunistic infections and other aspects of clinical management of sexually transmitted infections and tuberculosis. The general practitioners then prescribe and initiate antiretroviral therapy (ART) according to the national guidelines and monitor patients immunologically, via CD4 count as well as clinically. When patients are not progressing well, or showing signs of failing treatment, the general practitioners discuss the case with Alliance staff and request a viral load (HIV-RNA) test from private laboratories. Based on results, they switch patients from first to second line drugs. When patients develop OIs requiring inpatient care, general practitioners refer them to public government facilities. The Alliance supports the general practitioners by providing them with commission based funding, technical assistance and quality assurance; and by collecting, monitoring and reporting data related to patient outcomes.

In addition, the Alliance supports treatment literacy, adherence support, support with disclosure, homebased care, and tracing of lost-to-follow-up patients through community based activities. These activities are implemented through outreach workers who are deployed from a network of community-based organisations (CBOs) and key population (KP) networks in Yangon. Provision of these community-based follow up services strengthens the continuum of care - from testing to long-term retention on ART – for people living with HIV. At the same time, CBOs are able to link those that test negative to an on-going package of HIV prevention. Engagement with CBOs complements clinical care that is provided by private sector general practitioners.

Results of the programme:

Increased access to ARV therapy: between March 2009 and April 2015, a total of 2 119 patients have been provided with ART. This has meant that Alliance Myanmar is the third largest provider of ART in Myanmar, contributing significantly to the national response in terms of ART provision.

Impact of the programme:

The most important outcomes of the programme are related to the improvement in the CD4 count during treatment and the retention in care and ART.

Between 2009 and 2015, the programme experienced very good outcomes related to cd4 count recovery. The general health of people living with HIV enrolled in the programme improved, their CD4 count increased and they all became less likely to fall ill of common opportunistic infections. Patients CD4 counts progressively increased over the period of follow up and retention in the programme from a baseline of 177 cells/mm3 to 482 at 60 months. For what concerns the retention in care, the treatment retention rate at the end of the first year was over 97% and at 96% at the end of the second year. By the end of the programme out of 2 119 PLHIV in ART, only 70 (3.3%) became lost to follow up and 90 (4.2%) transferred to other health facilities. High retention rates of over 96% were maintained up to the 6th year on treatment.

Financing and management:

The programme was financed by the Global Fund and managed by Alliance Myanmar. Major partners in programme implementation included the network of community based organisations and key populations in Yangon, the private sector general practitioners and private laboratories.

Lessons learned and recommendations:

The public private partnership model has shown good outcomes in terms of immunological (CD4 cell count) recovery and retention on ART. The essential lesson here is that well managed partnerships with general practitioners can achieve good outcomes. Peer-driven services from CBOs also play a critical role in helping patients achieve optimal adherence to ART and good retention in care.

Other key learnings include: (1) quality improvement is essential in maintaining good outcomes from a public private partnership. Given that HIV training is not intense during medical training in Myanmar, regular training on HIV clinical management forms a core part of ensuring that the quality of HIV services provided by the general practitioners continuously meets national guidelines. In this partnership, general practitioners were trained on: eligibility assessment, initiation, management of failure, switching to second line (among others), (2) provision of ART through private general practitioners can support decentralisation of ART, relieve over-burdened government health systems, and provide additional options for people living with HIV in terms of where they can access care. In this model, people living with HIV were allowed to choose their preferred general practitioner, and were able to build a long-lasting relationship with a consistent provider. In practice, clients chose private providers that practise closest to their homes, showing how important distances to health providers are to people living with HIV on ART, (3) existing community and private sector health system infrastructure and resources can be

harnessed to increase coverage of ART without investing in new facilities. This model leveraged existing community groups and community based organisations that were already providing peer-based community outreach testing, enabling them to work across the continuum of care by making referrals and providing essential adherence support. It also leveraged existing private sector general practitioners who were already providing a wide range of primary health care services in their communities, and supported them to also provide ART. This ensured that the model built on and strengthened existing health and community systems rather than establishing entirely new structures and clinics.

47. Nepal

Title of the programme: “Nepal HIVision 2020:” Task-Sharing in a prevention-treatment continuum, towards ending the AIDS epidemic in Nepal, by 2030

CONTACT PERSON
Name: Ruben F del Prado
Title: Country Director to Nepal and Bhutan
Organisation: UNAIDS
Address: UN House, Pulchwok, Lalitpur, Nepal
Tel: +977 980 1000 889
Email: delprador@unaids.org

Submitted on behalf of the 7 National Community Networks of Key Populations in Nepal and the National Centre for AIDS and STD Control, NCASC.

Programme is being implemented since: 2016
Implemented by: Government, civil society, private sector and UN or other intergovernmental organisation.
Scope of submission:
Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc), Participatory community-based research, Community financing and Community-responses in the humanitarian context, in relation to people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender people, women, oun people and male labour migrants and their spouses.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

The HIV response in Nepal depends largely on foreign aid; for instance, by as much as 80 percent in 2015. External funding is rapidly declining, and it is more-than-ever imperative that actions and strategic allocation of resources for reducing the country’s HIV burden are prioritized though wise, evidence-informed investment choices. Most prominent investments in “Nepal HIVision 2020,” the country’s 2016 to 2021 National HIV Strategic Plan (NHSP), are mutually beneficial public-private partnerships between government and non-government, to drastically improve the scope, scale, intensity, quality, speed and innovation of Nepal’s HIV response.

Description:

The development of Nepal's NHSP 2016-2021, was initiated in 2015 through consultations led by the Ministry of Health's National Centre for AIDS and STD Control, which led to the establishment of governing and coordination structures for the strategic plan development.

- A High Level multi-sector **Steering Committee (SC)** to guide the development of the NHSP, chaired by the Secretary of Health, with membership of other sector Ministries' high-level officials; Civil Society; the UN, and other key partners
- A multi-stakeholder, technical **Strategic Plan Development Team (SPDT), comprising six (6) thematic groups**, assisted by the Joint UN HIV Team, other partners, and four national and international consultants:
    - **Key populations**: Priority sub-populations; prevention-treatment services modalities; community 'in-reach;'
    - **Systems for health**: Integration; harmonisation; access to services; workforce competencies; quality; prevention-treatment continuum; 'case finding' and 'case management'; public-private partnerships, and task-sharing;
    - **Evidence and Strategic Information**: collection, generation, analysis, 'translation' and use of strategic information; monitoring; special studies; research; programme and project evaluations
    - **Governance**: Leadership, partnerships, investments, accountability;
    - **Human rights**: Gender justice; zero tolerance for discrimination; social protection;
    - **Emerging issues, Innovation**: new technologies; social media; emergency preparedness.

Not only did the national networks of key populations stand central during the NHSP development - as the conveners of these six thematic areas - the roles and responsibilities of civil society, as accountable actors in Nepal's response towards ending its AIDS epidemic by 2030, are now specifically articulated in formalised divisions of labour, through public-private partnerships.

Results of the programme:

The Nepal NHSP covering the period 2016 to 2021 drives an increased demand for services, by identifying and reaching key populations towards preventing HIV; by recommending HIV screening and testing for 'case finding,' and through 'case management' by providing ARV and retaining people on ART. Collaboration between the government and private sector health facilities, NGOs, and community service providers will be formalised through task sharing to address crucial HIV programme failures, notably: the lack of reaching and testing key populations; entering only a minor portion of HIV positive persons on ART, failing to ensure a continuum of care and retaining those in treatment to achieve an undetectable viral load.

Impact of the programme:

Someone living with HIV, once 'reached', needs access to a continuum of services: HIV testing and diagnosis, linkages to appropriate treatment and other health services, support while in care, access to antiretroviral treatment and support while on treatment, and retention on treatment. The barriers to getting tested, staying in care, and starting and adhering to antiretroviral treatment include: a) fragmentation of services; b) prejudice and discrimination; c) poverty, food insecurity and homelessness, and; d) drug dependence issues; e)unmanaged co-

infections and mental health issues.

The spirit through which Nepal's NHSP was developed and will be implemented; the smart strategic priorities chosen for investment, and its building on the Fast-Track principles, with communities of key populations at its centre, are the critical enablers of this National HIV Strategic Plan of Nepal, for drastically improved efficiencies and effectiveness.

Financing and management:

An AIDS Epidemic Modelling (AEM) exercise that was conducted in Nepal, from December 2014 to July 2015, generated a number of scenarios, based on projected numbers of new infections; previous spending patterns, and future investment potential, recommended three (3) scenarios for Nepal to optimize the county's return on HIV-related investments. Of these, the 'Optimized Scenario' would have the highest cost effectiveness. Taking into consideration that increased health financing from domestic sources is a key recommendation in Nepal's Health Sector Strategy 2015-2020, it is expected that this would translate into more domestic funding available for the HIV response.

Civil society organisations and networks of key populations are supported by international NGOs; mainly as sub-recipients and implementing partners, through Global Fund mechanisms. These are, without a doubt, the cornerstone of Nepal's HIV response towards HIV prevention. It is good to note here that Nepal has way exceeded UNAIDS' proposed "Quarter for Prevention" target, as in 2015, activities to prevent HIV constituted 46% of the total HIV expenditure. The NHSP 2016-2021 maintains investments to prevent HIV at least at this level.

Lessons learned and recommendations:

Extensive national and sub-national consultations were conducted during the NHSP planning process, applying the good practices in the implementation of the previous AIDS Strategy, by government and non-government, including civil society. The overarching recommendations from these consultative meetings were: 1. Focusing on priorities; 2. Achieving cost savings by rationalising and integrating services; 3. Formalising public-private partnerships, and 4. Improving programme management and coordination.

With 100 percent community engagement and leadership in its formulation and communities' commitments to equally participate in its implementation, Nepal's NHSP emphasises: the integration of government and community level services; community-based actions to prevent HIV; 'case finding' and 'case management'; a prevention-treatment continuum; the introduction of innovative approaches to task-sharing and community testing, supported by both public, private and community health facilities.

It is not only possible, but essential that communities, especially of key populations and people living with HIV play a prominent role in leading and conducting extensive consultations and country dialogue, to ensure prompt development of relevant and realistic operational plans and their implementation.

Not only on paper – especially in practice!

48. Thailand

Title of the programme: Comprehensive Prevention and Treatment Service Model Led by MSM and TG Communities in Thailand

CONTACT PERSON
Name: Dr. Nittaya Phanuphak
Title: Chief, HIV Prevention Department
Organisation: Thai Red Cross AIDS Research Centre
Address: 104 Rajdamri Road, Lumpini, Pathumwan, Bangkok, 10330 Thailand
Tel: +66-81-825 3544
Email: nittaya.p@trcarc.org

Programme is being implemented since: 2015
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) and participatory community-based research, in relation to men who have sex with men, sex workers and transgender people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

HIV epidemic in Thailand is concentrated largely in the populations of gay men and other men who have sex with men (MSM); sex workers (SW); and transgender persons (TG). These populations contribute, respectively, 38% (MSM), 8% (MSW) and 3% (TG) of annual new infections and bear 9% (MSM), 1.2% (TG) and 0.5% (TG) of the national burden of the disease. The people from these population groups, especially those exposed to the highest risk of infection, often remain out of reach of the health systems, even as robust and well decentralized as they are in Thailand. Community-based, community-led services tailored to the needs of these populations are an effective, cost-efficient solution to reaching the hardest to reach.

Description:

A comprehensive community-led service model has been developed, ready to go to scale in Thailand. The model has integrated HIV and other health services for men who have sex with men and transgender persons. The range of services includes: HIV/STI testing; point-of-care CD4 measurement; ART maintenance; tuberculosis screening/prophylaxis; pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); and retention support to clients. Recently, the list of services for transgender people was expanded to include hormone therapy and other specific health services of importance for transgender persons.

The model is implemented, as part of an implementation research, through a partnership of community-based organizations (CBOs) and public health professionals from the Thai Red Cross AIDS Research Centre and local public health facilities. The public health professionals provide training, coaching, supportive supervision and ongoing quality assurance/quality improvement. The services are managed by CBOs and delivered by the community members themselves. CBO staff have been meaningfully engaged through the whole implementation research cycle from the design and implementation to result dissemination.

To date, four CBOs are implementing the comprehensive community-led HIV service model for MSM and TG. SWING works with male sex workers in Bangkok and Pattaya; Rainbow Sky Association of Thailand works with MSM/ TG in Bangkok/ Hat Yai; Sisters works with TG/TG sex workers in Pattaya; and Caremat works with MSM/TG in Chiang Mai. The Thai Red Cross AIDS Research Centre and the networks of health professionals in each city provide local oversight and support case referral when needed.

Results of the programme:

From May 2015-January 2016, the engaged CBOs provided HIV testing to 1569 clients, diagnosed 269 HIV-positive individuals, and 83% successfully initiated ART within a median time of 15 days. From October 2015, CBO staff already started PrEP on 130 HIV-negative individuals. CBO staff are now leading the charge not only in reaching and engaging MSM and TG but also in providing HIV testing, PrEP/PEP, and antiretroviral treatment support to these populations in four hotspot cities in Thailand.

Impact of the programme:

Thus far, about 17 percent of all participants have been diagnosed with HIV, confirming that community services attract and serve individuals facing disproportionately high risk of HIV.

Community-based service centres do not duplicate but complement most effectively the effort of the public health system in reaching the most at risk populations with quality combination prevention and treatment. The MSM and TG accessing the community service are different from those using the services of public health facilities. The clients of community-based service centres generally have a lower level of education and lower levels of income while facing a higher risk of infection.

Financing and management:

The implementation costs of this initiative has been supported mainly through the LINKAGES programme financed by USAID/PEPFAR. PrEP medication is supported through the Thai Red Cross Princess Soamsawali Prevention Fund. Generic FTC/TDF drug used for PrEP was provided to the program from the Thai Government Pharmaceutical Organization at a lower than market price. Antiretroviral treatment and HIV laboratory monitoring for MSM and TG diagnosed with HIV are available through the National Health Security Office Program.

Thai Red Cross AIDS Research Centre, together with LINKAGES, have provided clinical and management technical supports directly to the CBOs. Local public health facilities, which include the Provincial Health Office, the Office of Disease Prevention and Control, and key public hospitals, also have their capacity strengthened to take on the local technical support and ongoing quality assurance and quality improvement roles.

A systematic effort is underway to ensure sustained diversified domestic financing of CSO/ CBO engagement in disease responses and wider health.

Lessons learned and recommendations:

The comprehensive community-led service model is in line with the national Ending AIDS Strategy and Operational Plan.

The model has been shared to obtain national support for endorsing, sustaining and expanding these community-led HIV services. Advocacy is ongoing, concerted efforts will be needed to inform and reform policy and regulatory frameworks to i) permit CBO staff to perform health-related tasks, ii) formalize their status and professionalization to enable the funding and training required, and iii) overcome resistance of other health professionals and institutions.

49. Thailand

Title of the programme: The Comprehensive HIV Prevention Among Most-At- Risk Populations by Promoting Integrated Outreach and Networking (CHAMPION) IDU (2009-2014)

CONTACT PERSON
Name: Pascal Tanguay
Title: Executive Board Member
Organisation: Ozone Foundation
Address: Bangkok
Tel: +66 869144117
Email: pascalembours@gmail.com

Programme is being implemented since: 2009 - 2014
Implemented by: Government and Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to people who inject drugs.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

Thailand has long been considered a leader in the response to HIV for its successful interventions to reduce HIV transmission among sex workers in the early 1990s and for the provision of generic antiretroviral treatment (ART) to over 80% of people who need it. However, for more than two decades, HIV prevalence among people who inject drugs (PWID) has remained alarmingly high – between 25% and 50% since 1989.[18] Recent studies indicate that as many as 90% of PWID are living with hepatitis C virus (HCV).[19]

The focus on law enforcement and public security in addressing drug-related issues in Thailand has led to:

[18] Canadian HIV/AIDS Legal Network. 2009. Drug use and HIV/AIDS in Thailand.
[19] Hayashi, K. 2011. “Low Uptake of Hepatitis C Testing and High Prevalence of Risk Behavior Among HIV Positive Injection Drug Users in Bangkok, Thailand” in J Acquir Immune Defic Syndr, 56:5.

- **Mass incarcerations**: with over 60% of the prison population being incarcerated for drug-related crimes,[20] Thailand's prisons are overcrowded – operating at double the maximum capacity[21] – and offer little in the way of health services to address HIV and drug dependence besides ARV.[22]
- **Forced detention**: hundreds of thousands of individuals are detained in the name of drug treatment. For example, between 1 October 2011 and 30 September 2012, the Thai government recorded over 500,000 people entering so-called drug treatment centers,[23] more than three times the number sent to such centers during the 2003-2004 war on drugs.[24] Across Thailand, the government records over 1,200 such centers[25] with the vast majority being operated by military personnel who have little or no medical training or certification.[26] People sent to drug treatment centers do not have access to due process, legal support or an appeal system.[27]
- **Human rights violations:** physical, sexual and psychological abuse has been documented at the hands of law enforcement, in community[28] and closed[29] settings. Far too common to be ignored, the testimonies of people who use drugs indicate that routine bribery, drug planting, and exchange of sexual favors with law enforcement with comparably few opportunities to hold law enforcement accountable.
- **Public health barriers:** law enforcement focused approaches are now widely acknowledged to drive people who use drugs underground, further away from essential health services, while fuelling stigma and discrimination as well as the transmission of HIV and other blood-borne infections like hepatitis C. Clients of the CHAMPION-IDU have been recorded saying that "I would prefer to get HIV than be (re) arrested", testifying to the significant amount of violence from law enforcement against PWUD.

The passing of the National Harm Reduction Policy in February 2014 was an encouraging step towards government buy-in and support for interventions to improve the health and well-being of PWUD in Thailand. However, despite efforts to foster an enabling environment for harm reduction service delivery, elements within the Thai government and society at large remain sceptical, even opposed, to harm reduction. In particular, the harmonization and synchronization of public health imperatives with law enforcement practices continues to pose important challenges to effective roll out of HIV prevention services for PWUD as well as other populations. Indeed, the self-elected National Committee on Peace and Order has just re-launched yet a new wave of war on drugs in September 2014.[30] The National Harm Reduction

[20] UNODC. 2006. *HIV/AIDS and Custodial Settings in South East Asia: An Exploratory Review into the Issue of HIV/AIDS and Custodial Settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam*.
[21] International Center for Prison Studies: www.prisonstudies.org/info/worldbrief/wpb_country.php?country=114
[22] Kaplan, K. 2011. "HIV and Prison in Thailand", in HIV Australia, 8:4.
[23] Office of the Narcotics Control Board. 12 September 2012. Press Release.
[24] Kaplan, K. and Tanguay, P. 2013. "One Step Forward, Two Steps Back: Consequences of Thailand's Failure to Adopt Evidence-based Drug Policy" in "Drug Law Reform in East and Southeast Asia. (In print).
[25] 17 August 2012. "Govt war on drugs hailed a success" in Bangkok Post.
[26] Canadian HIV/AIDS Legal Network. 2009. Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002).
[27] Ibid
[28] Thai AIDS Treatment Action Group. 2012. Reducing Drug-Related Harm in Thailand: Evidence and Recommendations from the Mitsampan Community Research Project.
[29] Open Society Institute. 2010. Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand.
[30] Tibke, P. 15 September 2014. "Thailand steps up its dubious war on drugs" in Asian Correspondent.

Policy expired in October 2015 and the Minister of Justice recently said in a STAR Project meeting that he did not agree with harm reduction and that he would block efforts to pass this policy again.

See additional information in the IDPC Drug policy brief on Thailand and CHAMPION-IDU narrative PUDR reports.

Description:

CHAMPION-IDU was designed as a peer-based HIV prevention project and operated between 2009 and the end of 2014 to improve the quality of life of PWID. CHAMPION-IDU is a community-based, peer-led project almost exclusively implemented by civil society. This strategy has been very successful in recruiting PWID and facilitating access to health services because of the innate trust that exists between peers – government drug treatment centers have seen up to a fourfold increase in in- and out-patient admissions since the initiation of the CHAMPION-IDU project. In fact, approximately 80% of the 350 CHAMPION-IDU workers hired have been active and/or recovering from drug use, giving a real employment opportunity to PWID and building their capacity to become productive members of society. Peers operate drop-in center based and outreach-based activities, including behavior change communication to reduce risks, education, sterile injecting equipment, condoms, overdose prevention with naloxone, and referrals to HTC, MMT, ART and STI.

Unfortunately, because of the hostile operating environment, retention of peers and staff has been a crippling challenge to the project; CHAMPION-IDU workers and staff are routinely arrested, detained, abused and stigmatized by law enforcement and health service providers across Thailand (Over the project life-cycle, an average of 2-3 workers were arrested every month, with a maximum of 12 in one given month). Despite CHAMPION-IDU being integrated in the national response, the government (and the CCM) never issued ID cards to protect workers despite promises to do so. In turn, such arrests impact on capacity and willingness of workers to stay on – outreach workers can't distribute condoms or sterile injecting equipment when they are in prison. To address the high turnover of workers, PSI Thailand deployed a range of measures detailed in the attached programmatic narrative report.

To increase demand for HIV services, PSI initiated additional service components to complement the CHAMPION-IDU package supported by GFATM and combat significant HIV-messaging fatigue among Thai PWID. In January 2013, an overdose prevention and management project – called SCOOP – was initiated and generated massive success (see attached SCOOP report). In addition, CHAMPION-IDU partners, particularly PSI and Thai Red Cross, worked in Thai prisons to provide education, training and behaviour change support to thousands of inmates over the program term as well as sensitization of hundreds of prison guards – the prison component was so successful that PSI was invited by the Department of Corrections to formally include the CHAMPION-IDU training curriculum on life skills, drugs, HIV and sexual health in the regular yearly prison program. In addition, expanded support was negotiated with the Thai CCM and GFATM to use the CHAMPION-IDU infrastructure to reach out to vulnerable PWID and provide them with HCV testing and access to treatment, with support from the private sector. Unfortunately, the NFM envelope to Thailand was significantly reduced and the funding for PWID reduced dramatically, and agreements to expand service delivery to include HCV were regretfully cancelled.

Additional synergies have been established despite the lack of support from the Thai

government, in particular with national agencies responsible for provision of methadone in Thailand – the Bangkok Metropolitan Administration (BMA) and the Princess Mother Institute for Treatment of Drug Abuse (formerly known as the Thanyarak Institute). Here, synergies were generated between national opioid substitution systems, CHAMPION-IDU and SCOOP projects where naloxone is now in the official national guidelines on methadone and is kept at all methadone access points. In addition, all trainings on opioid substitution are now conducted in partnership between the Princess Mother Institute, BMA and PSI. Note that prior to CHAMPION-IDU, all methadone related trainings were delivered by the Princess Mother Institute with extremely poor results (see World Bank, 2011, *Harm reduction policies and interventions for injection drug users in Thailand*).

To address law enforcement barriers, PSI hired a senior Thai police officer to act as an advisor to CHAMPION-IDU with the mandate to establish effective working relationships with local law enforcement agencies and bodies at all CHAMPION-IDU sites; build capacity of CHAMPION-IDU program and field teams in terms of interacting with law enforcement agencies, officials and officers; identify strategic opportunities to raise the profile of harm reduction at policy level with law enforcement agencies, officials and officers; and facilitate access to the Royal Thai Police Academy to sensitize and train Thai law enforcement.

At the end of the CHAMPION-IDU project, PSI Thailand was not re-selected by the CCM as Principal Recipient and efforts were made internally to localize the network of drop-in centers operated by PSI; in December 2014, the Ozone Foundation was formally registered as a local Thai NGO (with no ties to PSI whatsoever) and in January 2015, Ozone became a sub-recipient under the STAR Project operated by Raks Thai Foundation. The Ozone Foundation currently delivers approximately 70% of the total volume of harm reduction services in Thailand (PSI Thailand used to deliver 70% of the volume of harm reduction services). Ozone receives 100% of its funding from the Global Fund.

Under the NFM, PWID is just one component of the STAR project which targets all key populations in Thailand.

Results of the programme:

Over the project life cycle (2009-2014), over 13 000 of the estimated 40 300 PWID were reached by CHAMPION-IDU project services across 19 of the Kingdom's 76 provinces. The CHAMPION-IDU project was the ONLY national scope intervention to prevent HIV and improve the quality of life of PWID. The STAR Project's reduced scope remains the only vehicle for PWID to access stigma-free health and social care services in Thailand. CHAMPION-IDU recruited more than 20 private sector pharmacists who support the provision of health services, including distribution of health commodities, and referrals to additional services. No other civil society or government agency has ever reached as many PWID as CHAMPION-IDU. See CHAMPION-IDU narrative PUDR reports for additional information.

Impact of the programme:

The CHAMPION-IDU project was rated B2 by the GFATM performance measurement framework. Unfortunately, target setting was based on outdated data and evidence that drove targets beyond realistic expectations (see Global State of Harm Reduction 2012 section 3.5).

The CHAMPION-IDU project provided skills, salaries and support to over 350 PWID over 5 years. PWUD in Thailand, after a first arrest, are prevented from working in many sectors,

including government and most privates sector businesses. As a result of regular work and social support, many of the CHAMPION-IDU workers have reduced their drug use.

Ozone became independent and fully localized. The transition, required by the CCM as a condition for continued funding, was initiated in June 2014 and completed by 1 January 2015. Though this was part of the PSI Thailand plan – to localize Ozone – the timelines forced unto PSI have been unreasonable and against best practice, while such decisions have pushed the majority of risks related to operating 70% the national response to HIV among PWID onto a nascent NGO. Despite requests for technical support, none has been mobilized given the hurdles imposed by the CCM which does not want to 'lose face'. That said, Ozone remains the largest provider of health services to PWID at national scale.

In the context of the Support Don't Punish campaign, CHAMPION-IDU partners lobbied the Office of the Narcotics Control Board in June 2013 to ensure deployment of a national harm reduction policy which had been pending for years. Less than 12 months later, the Deputy Prime Minister of Thailand signed the official policy. Unfortunately, the concentration of funding ofr advocacy under the STAR project in the Principal Recipient's and one Sub-Recipient's hands has left Ozone without funds to carry on drug policy advocacy work. As noted above already, the expiration of the national harm reduction policy is not surprising given that since the transition towards the NFM was initiated in mid-2014, very few activities have been implemented targeting drug control authorities to maintain political pressure to sustain the government's commitment to harm reduction. (See additional details in PUDR narrative reports)

Financing and management:

GFATM provided PR-PSI with $16.6 million under Round 8 to implement CHAMPION-IDU; additional funding for overdose prevention was provided by OSF. Major partners included Raks Thai Foundation, Thai Drug Users' Network, Thai Red Cross, Foundation for AIDS Rights and 12D.

In Thailand, external donors, including the Global Fund, have provided the bulk of funding for HIV prevention targeting vulnerable populations. The government has provided extremely limited financial support for harm reduction services and the Global Fund has funded virtually 100% of the HIV prevention services targeting PWID since 2002. Out of the total amount granted to Thailand for HIV by the Global Fund since 2002, funding for harm reduction represents only 6% (less than $20 million).

As noted above, the sustainability of GFATM's investment is under significant threat since Thailand moved into the NFM. Localization of Ozone, changes in PR and management systems, suspension of harm reduction services in at least 7 of 19 provinces (with no transition plan), increase in programmatic targets by 300% with concomitant 50% reduction in budgets has already caused significant harm to service delivery and PWID's access to those services (for example, needles and syringes have been stocked out since Q2 2015 and procurement has just been completed in March 2016, a blatant failure of both GF and implementing partners in Thailand) while the previous investments to prevent HIV transmission among PWID in Thailand are still under threat (elimination of advocacy and technical assistance which are essential for safety and effectiveness of outreach teams; significant reduction in scope and quality of data collection, critical to monitoring and evaluation). It seems that GFATM itself is neglecting to ensure the sustainability of its own investment among the group most vulnerable and affected by HIV in Thailand.

Poor planning and oversight in the so-called transition has left PWID extremely vulnerable to HIV as well as human rights abuses once again. There is currently no overall transition plan in place and funding from the Global Fund officially ends on 31 December 2016. Yet, prior to the NFM, financial sustainability plans involving partnership with private sector actors had been developed and negotiated in collaboration with GF and PSI to sustain harm reduction service delivery. Unfortunately, negotiations were abruptly discontinued from GF's side in October 2013 without discussion or dialogue with PR-PSI, leading to a collapse of the agreement. In addition, where CHAMPION-IDU partners had negotiated tentative agreements with three different government agencies for funding significant components of the national harm reduction response, the transition to the NFM has eroded those commitments and compromised opportunities to access national funds due to reduced scope, resources and opportunities for sustainability. Since initiation of the NFM, financial support for HIV prevention among PWID was reduced by ~50%, from ~$3m per year to less than $1.5M per year and no national funding has been made available to fill those gaps. The government of Thailand has invested a minuscule amount of funds to support harm reduction service delivery to date. Meanwhile, international donors have de-prioritized funding for Thailand given the 'success' reported by the Global Fund. Though discussions are underway to develop a post-NFM funding plan, that plan is far from finalized (after 15 months of working on the plan since the NFM actually started) and Ozone has had extremely limited opportunities to contribute to the planning process. To Ozone's knowledge, not a single baht has been earmarked for HIV prevention activities starting on 1 January 2017. In that context, the risks related to financial continuity are very high due to high likelihood of occurrence and the significant severity of such risks - if materialized, this would mean complete cessation of harm reduction activities as of 2017. (See additional details about financial management in PUDR narrative reports – there is a deep financial analysis in there.)

Lessons learned and recommendations:

CHAMPION-IDU received extremely limited support from Thai national government agencies. On the contrary, many Thai government agencies, particularly law enforcement, have diametrically opposed objectives to those assigned to CHAMPION-IDU by the CCM. In addition, the rapid rotation of key supporting individuals – UNAIDS UCC, CCM members, GFATM country team – massively undermined the continuity and sustainability of the project given that no handovers were done relating to PWID/CHAMPION-IDU and inbound representatives had completely different ideas about the future and understanding of what happened in the past. Essentially, in 2013, CHAMPION-IDU lost all support from UNAIDS, GFATM CT and CCM.

The IPSR evaluation noted that significant barriers to scaling up CHAMPION-IDU had to do with total lack of coordination with Thai government agencies – from Ministries of Health and Justice, including ONCB, BMA, PR-DDC, Thanyarak, police. However, local collaboration has been very successful, especially in the deep south of Thailand where religious leaders were leveraged to mobilize high level government support, resulting the official endorsement of needle and syringe distribution by the National Islamic Committee. Despite local successes, there is zero high level support for harm reduction still in Thailand, even though an official policy endorses the services and strategies that are currently in place.

At the end of the CHAMPION-IDU project, a number of reports were published to highlight lessons learned, best practices, and innovations in service delivery. The reports are available online at:

- CHAMPION-IDU: Innovations, Best Practices and Lessons Learned: http://www.psi.org/publication/champion-idu-innovations-best-practices-and-lessons-

learned/

- Servicing communities with opioid overdose prevention: https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf
- Community-based Methadone Maintenance Therapy: https://www.psi.org/wp-content/uploads/2015/07/Small-Santikhiri-Community-Methadone-Best-Practice-Report.pdf

Significant positive achievements made on the CHAMPION-IDU project involved many government and non-government partners, as well as PWID who both implemented and benefited from the project services. Despite enormous challenges, the project achieved results across a wide range of areas, including successes in service delivery, behavior change, policy development as well as establishing good practices and important lessons learned for harm reduction in Thailand. Despite these documented, decisions regarding the NFM and other aspects of the response to HIV among PWID in Thailand have been made with limited attention to these components generated under this national harm reduction project.

Under the NFM, CHAMPION-IDU partners have retained important roles: RTF will play a key leadership role as the new HIV-TB CSO PR,[31] while FAR, Ozone, and TDN are set to continue roll out of activities targeting PWID as SRs. Meanwhile, the overall funding allocation for PWID has decreased from an average of USD 3.1 million per year under the CHAMPION-IDU, to USD 1.6 million per year to prevent HIV among PWID under the NFM.

Despite the appearance of programmatic continuity, the drastic and sudden reductions in financial contributions to key areas of the HIV response in Thailand have already had a visible impact on the scope, scale and quality of services targeting PWID. Already in the last quarter of 2014, a total of seven CHAMPION-IDU project sites have suspended activities with no readily available opportunities to continue provision of health and social care services to clients in those provinces. Many workers were laid off or sought employment elsewhere.

Since initiation of the NFM, the impact on the 13 key innovations documented in a recently published report has been significant. The Table below summarizes the state of those components under the NFM as of 1 June 2015 (the components are extracted from the "CHAMPION-IDU: Innovations, Best Practices and Lessons Learned" report).

Status of CHAMPION-IDU innovations, best practices and lessons learned under the NFM

Intervention	Status under the NFM
Client needs at the center of program design and implementation	Ozone will maintain a client-centered approach under the NFM and this is reflected in the organizational strategic plan
Data production, management and dissemination	Production, management and dissemination of data under the NFM's PWID component is significantly weaker than under the CHAMPION-IDU project; similarly Ozone M&E systems have been weakened though workers will continue to collect the same amount of data about clients as under the CHAMPION-IDU project

[31] In the past, RTF has been PR for four GLOBAL FUND grants, including: THA-H-RTF; THA-202-G03-H-00; THA-304-G06-H; and THA-809-G12-H.

Successful deployment of the national harm reduction policy	The NFM includes support for policy advocacy under SR-FAR which will lead on developing an enabling environment for all MARPs across HIV and TB; however, the significant reduction in funding has compromised interest from many national and local government agencies while political instability limits how much this issue can be prioritized; Ozone will continue to work with local and national government partners to support deployment and monitoring of the policy though the organization has no specific dedicated funds to do so
Partnerships with law enforcement	Though the Law Enforcement Advisor is no longer officially supported under the NFM, UNODC has provided some limited support to maintain some of the Advisors' roles and responsibilities towards Ozone under the NFM; however, under the NFM, there are currently no funds earmarked to address law enforcement issues related specifically to drugs and harm reduction
Hiring and working with active and recovering PWID	Virtually all the supportive systems and policies designed to reduce risk, support workers, motivate peers and improve project performance have not been carried forward under the NFM
Education and health services for prisoners	Though the NFM does include a very small provision for operations in prisons, the funds are earmarked for TB interventions; no funds have been earmarked to carry the work undertaken by CHAMPION-IDU partners, including Ozone, in the NFM
Peer-led methadone in a rural community	Funding for operations at Ozone Chiang Rai and Tak is included in the NFM, covering the community-based methadone models developed under the CHAMPION-IDU project for two years
Resource mobilization to stimulate demand for health services	No funding has been earmarked under the NFM to address HCV or overdoses; however, Ozone has already mobilized support to maintain SCOOP through 2015 and is currently exploring opportunities to work with partners on a research-based HCV project among PWID in Thailand
Pharmacy-based voucher scheme	The CHAMPION-IDU public-private partnership with local pharmacies has not been carried forward under the NFM
Working with religious leaders	Though the Ozone team members will continue to use the tools and strategies developed under the CHAMPION-IDU project, no additional funding has been earmarked under the NFM to facilitate collaboration with religious leaders in the South
Safety and security	Though the Ozone team members will continue to use the tools and strategies developed under the CHAMPION-IDU project, no additional funding has been earmarked under the NFM to address safety and security risks among project workforce, especially in the troubled South

Transition from PR-PSI to local ownership	Though Ozone has successfully transitioned to local ownership and now plays a formal role in the NFM roll out, significant risks remain that will undermine performance as well as sustainability of the entire response to HIV among PWID in Thailand

Fewer support systems and policies are now in place to support and motivate the workforce. Meanwhile, expectations in performance have risen dramatically: where CHAMPION-IDU partners reached over 5,000 individual clients in the final year, implementing agencies targeting PWID under the NFM are expected to reach more than three times the numbers with reduced budgets and fewer supportive mechanisms. For example, the peer-to-client ratio has increased thereby inflating the workload of individual workers.

The fact that fewer, smaller, and more vulnerable CSO are now involved in harm reduction service delivery in the NFM compared to under CHAMPION-IDU and that those CSO have access to fewer resources to meet higher targets while individual workers' workload is increased, implies serious risks for the continuity of harm reduction in Thailand under and beyond the NFM. In parallel, with two thirds of the infrastructure and services under a newly established (though technically strong) local NGO, the risks that affect Ozone by default impinge on the national response to HIV and other drug-related harms among PWID.

It is unreasonable to expect that performance can increase to meet higher targets under the NFM unless key implementation barriers are effectively, systematically and sustainably addressed. As noted earlier, the NFM allocations are significantly insufficient to support the majority of best practice components which were designed to address those very implementation barriers. It is therefore difficult to foresee a scenario under which more can be done with less without addressing the barriers that have systematically impeded performance for several years already.

PR-PSI and Ozone have worked to mobilize additional support to maintain and continue SCOOP activities, while the community-based methadone delivery will continue under the NFM. Unfortunately, virtually all other components, including the protections and support systems developed by PR-PSI under CHAMPION-IDU, have not been carried forward into the NFM. This implies that the transition from CHAMPION-IDU to NFM has been extremely costly, with Thai PWID and project workers being the most affected. Though Thailand may indeed achieve national independence from external support and can demonstrate rapid and effective localization towards continuity of service delivery, such successes should not be pursued at the expense of sustainability, at the expense of the health and well being of clients, or at the expense of hard-won gains in policy and implementation.

Where the CHAMPION-IDU project was poised and strategically positioned to expand in scope and scale, based on plans developed between 2013-2014 in collaboration with the Global Fund Country Team, those plans were discarded in light of the financial constraints created by the NFM allocation. Planned expansion components that could have generated significant value for the HIV response – like drug and HIV prevention in schools, piloting community-based drug dependence treatment including for ATS users as well as many research and policy-level activities – have not been pursued given the significant funding gaps.

Meanwhile, the reduction in financial support for HIV prevention among PWID is not only generating a significant impact on CSO implementing agencies but also on government agencies. CHAMPION-IDU partners mobilized significant endorsements from multiple

government agencies to support harm reduction in Thailand, with some among them even showing interest in funding part of the response in the future. However, the reduction in NFM funding and the important gaps in the response to HIV among PWID left at program and policy levels as well as in other HIV and TB components across the Kingdom previously covered by the Global Fund has tempered interest from most government agencies. With a larger proportion of the cost expected be borne locally and with much shorter timelines than any agency expected, potential investors have deprioritized harm reduction.

In this regard, a CHAMPION-IDU project progress report submitted to the CCM, the LFA and the Global Fund Country Team on 15 May 2014 notes:

> *With these commitments in the pipeline but many yet formalized, it is critical that appropriate financial and technical support and guidance be provided to Thai government and civil society agencies until national arrangements are settled [under the NFM]. In that respect, the potential close-out of the CHAMPION-IDU project […] represents a major unaddressed risk to the sustainability of the investments made by the Global Fund, PSI, MOPH and other key agencies and individuals over the past five years and more importantly, to the potential for national investments to take over financing of a large proportion of the national response to HIV among PWID in Thailand. PSI is especially concerned about the lack of opportunities to handover, expand and perhaps even continue to operate service delivery for PWID at a time where government agencies are finally ready to contribute to the national response.*

While the plans for the NFM were only finalized in June 2015, there are still no formal plans in place that will ensure continuity and sustainability beyond 2016. As noted in a recent essay titled *Civil Society and Harm Reduction in Thailand – Lessons Not Learned*,[32] the implications of Thailand's transition are serious and should be considered carefully and integrated in planning processes, especially in countries where CSO are Global Fund-recipients. Indeed, serious and difficult questions about the sustainability of the HIV response among PWID in Thailand must be raised and discussed to ensure that steps are taken to protect and safeguard the gains that have been generated with external funds up until 31 December 2014.

The serious risks that could significantly compromise the fragile harm reduction response in Thailand have not been raised, discussed or acknowledged by any high-level officials though many key leaders in the HIV sector have praised and applauded the Thai government while encouraging the world to take example on its leadership and initiative. [33]Yet alternative funding streams, as well as a comprehensive risk mitigation strategy have not been put in place *before* initiating the transition, as recommended by best practices in management. Such endorsements could easily be misinterpreted to imply that sacrificing the health and well-being of certain population groups is acceptable as long as the majority of those who benefited from the national HIV response continue to do so in the future. The dramatic reduction in funding and the overall deprioritization of harm reduction has already undermined the sustainability of the Global Fund's $20 million investment in Thailand over the past decade as well as the overall response to HIV among PWID in the Kingdom.

---

[32] Tanguay, P. 2015. Civil Society and Harm Reduction in Thailand – Lessons Not Learned, www.mei.edu/content/map/civil-society-and-harm-reduction-thailand-–-lessons-not-learned.

[33] See Sidibé, M. 27 October 2014. “Thailand Leads Way to Ending Aids” in Bangkok Post (http://www.bangkokpost.com/opinion/opinion/439819/thailand-leads-way-to-ending-aids) and The Global Fund to Fight AIDS, Tuberculosis and Malaria. 28 November 2014. “Transitioning in Thailand” in Global Fund News Flash (http://www.theglobalfund.org/en/blog/2014-11-28_Global_Fund_News_Flash).

The impact of Global Fund's reduced support for harm reduction globally is mirrored in Thailand, where potential government investors have desisted themselves from taking the responsibility for financing harm reduction interventions. Instead of stimulating ownership and encouraging national financing, the immediate impact of the NFM has scared away investors and compromised plans elaborated in consultation with government, CSO and Global Fund representatives since 2013.

Despite the challenges in the NFM and beyond, the results and successes of the CHAMPION-IDU project, especially in terms of generating lessons learned, best practices and innovations, have contributed to strengthening the overall response to HIV among PWID in Thailand and will hopefully continue to do so in the future. Most notably, the CHAMPION-IDU project has been the most important mechanism to improve the health and quality of life of PWID in Thailand between 2009 and 2014. In parallel, CHAMPION-IDU contributed to the professional development of the workforce, attracting and strengthening the knowledge, skills and capacity of people who use drugs.

The support from the Global Fund for the CHAMPION-IDU project has been greatly appreciated, particularly among PWID and their civil society representatives.[34] The Global Fund has been the leading source of funding to support harm reduction programming globally.[35] However, the implications of the NFM in Thailand represent a radical deviation, at least in the short-term, from previous levels of support as well as from the Global Fund's own objectives to foster a sustainable response. In that respect, it will be critical for the local and international community to closely monitor and observe the roll out of activities in Thailand under the NFM, particularly in the context of HIV prevention among PWID.

50. Vietnam

Title of the programme: Asia Action: community advocacy for harm reduction in Viet Nam

CONTACT PERSON
Name: Oanh T H Khuat
Title: Executive Director
Organisation: Center for Supporting Community Development Initiatives
Address: 240 Mai Anh Tuan Street, Thanh Cong, Ba Dinh District, Hanoi
Tel: +84 4 35720689
Email: oanhkhuat@scdi.org.vn

Programme is being implemented since: 2013
Implemented by: Government and Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to people who inject drugs.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No

---

[34] Parry, J. 1 July 2013. "Addressing HIV prevalence among gay men and drug users in Thailand" in The Guardian.
[35] Bridge, J. et al. 2012. "Global Fund investments in harm reduction from 2002 to 2009" in International Journal of Drug Policy, 23(4).

Is the programme part of a national emergency response plan? No

Background:

There are an estimated 256,000 people living with HIV (PLHIV) in Viet Nam. In 2013 the greatest number of new infections occurred among men who share needles while injecting drugs; 45%.

Prior to 2013, Drug Control Law in Viet Nam stipulated that people who use drugs who failed to quit could be sent to compulsory rehabilitation in a closed setting for up to four years. This policy was ineffective in helping people who use drugs deal with their addiction; it drove them away from harm reduction programs, and became the subject of international concern. In 2013, Viet Nam had 123 compulsory rehabilitation centres each with the capacity to accommodate hundreds or thousands of people who use drugs. Drug use was considered as a “social evil” and people who used drugs were severely discriminated against.

In response, the government of Viet Nam released the Renovation Plan for Addiction Treatment which set out to scale down compulsory rehabilitation – from 63% in 2013 to 6% in 2020 - and scale up voluntary services so that 90% of drug users would get treatment by 2020.

However, the lack of in-country experience and competency in evidence-based addiction treatment threatened the survival of the Plan, and with it the opportunity to transform drug treatment policy.

Description:

The aim was:

- To contribute to improving the policy environment around drug use and HIV in Viet Nam.
- To achieve an increased commitment by the government of Viet Nam to evidence based and rights based policy on drug use and HIV.

What happened:

- From 2013-2015, the Centre for Supporting Community Development Initiatives (SCDI) – a local NGO whose mission is to improve the lives of marginalised populations - worked alongside government departments and the drug user community to realise the Renovation Plan.
- Bac Giang province which had a committed local government structure was selected to pilot the development of a voluntary drug treatment system - consisting of a facility with residential capacity and several community sites - to provide a wide range of services from methadone maintenance and detoxification, to psychosocial therapies and supports.

Results of the programme:

- In May 2015, the first community-based voluntary treatment site for people with drug addiction in Viet Nam opened at the health center of Cao Thuong commune, Tan Yen district, Bac Giang province. This marks a new era for drug addiction treatment in Viet Nam when voluntary, evidence-based, community-based treatment is growing, pushing compulsory institutionalised rehabilitation to close.
- On 13 April 2015, the Department of Social Vice Prevention and Control, the Ministry of

Labor, Invalids and Social Affairs asked SCDI to disseminate their experiences of the pilot, and develop the government's guidelines for community-based addiction treatment.
- From 1 Jan 2014 to the present, no individual drug users have been sent to a compulsory centre in Bac Giang. The compulsory centre itself is being redeveloped to provide methadone maintenance and voluntary services.

Impact of the programme:

The new government guidelines developed by SCDI for voluntary treatment centres and satellite facilities released in 2016 (after the programme ended) will contribute to supporting the commitment by the government of Viet Nam to scale up voluntary services so that 90% of drug users are getting treatment by 2020.

Financing and management:

The project was funded by the European Union from 2013-2015. It was led by the International HIV/AIDS Alliance together with national NGO partners in Asia (AIDS Care China, Alliance India, Malaysia AIDS Council, Rumah Cemara (Indonesia), KHANA (Cambodia) and SCDI (Viet Nam).

In Viet Nam, the work continues beyond the life of the project. SCDI has since been requested to support four more provinces. They will do this with the support of the International HIV/AIDS Alliance, along with the French Embassy in Viet Nam, Open Society Foundation, the US's SAMHSA and many international experts. Voluntary addiction treatment is slowly becoming a reality in Viet Nam.

Lessons learned and recommendations:

- Advocacy 'asks' (e.g. specific advocacy outcomes), and advocacy logs (e.g. advocates' diaries about key changes in the political context, results and blockages) have been useful planning, monitoring and evaluation tools. They help to focus activities on achieving significant change and to evaluate individual and organisational contributions to bigger policy changes.
- Three approaches to advocacy have been particularly instrumental. Firstly, advocacy focussed on addressing the most urgent needs of people who use drugs living in a specific geographic location. The experience gained in this pilot area is then used as the 'practical evidence' for advocacy in other locations. Secondly, advocacy delivered in a strategic partnership works best, for example with UNODC. Last but not least, advocacy positioned as finding solutions for the government works. Particularly in areas where progressive policies have been developed but practical models for policy implementation do not exist.
- The forms and mechanics of community advocacy are culturally specific and vary from developing improved service delivery models to lobbying. It is important to give space to local community advocates to allow them to develop the approach which best suits their context.

III. Eastern European States

51. Armenia

Title of the programme: Provision of complex medical services as effective model for HIV prevention and expansion of HIV testing among labour migrants

CONTACT PERSON
Name: Samvel Grigoryan
Title: Director
Organisation: National AIDS Center
Address: 2 Acharyan St., 0040 Yerevan, Republic of Armenia
Tel: (+37410) 61-07-30
Email: armaids@armaids.am

Programme is being implemented since: 2013
Implemented by: Government
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) in relation to labour migrants and their family members.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

In the past few years, the HIV epidemic in Armenia has acquired some specific features. More than half of all registered HIV and AIDS cases have been diagnosed within the last 5 years (56.8% of all the registered cases), and 75% of them were infected through heterosexual practices. 57% were infected outside the country, also predominantly through heterosexual practices (75%). Given the fact that 13% of the HIV cases registered within the last 5 years were migrants' partners, 70% of all the registered cases are associated with migration. Proportion of "classical risk populations" (PWID, MSM and SWs) among registered HIV cases made up less than 20%. The scale of labour migration is significant and it has an essential impact on the HIV epidemic in Armenia.

Description:

Based on various studies, conducted among migrants, the most effective model of provision prevention services for migrants and their partners was developed, aimed at increasing access to HIV testing and counseling, early HIV diagnosis with timely provision of treatment and care. The specificity of the model is provision of HIV testing in the package of other related medical services, which is the most relevant and acceptable for labour migrants.

Starting in 2013, the model of services provision for migrants and their partners was introduced into 60 communities of Armenia within the framework of the Russian Government-supported Programme assisted by UNAIDS and AIDS Infoshare Fund. Starting in 2014, with the GFATM support, this model provision covered additional 40 communities. Therefore, the project was implemented in 100 communities in Armenia.

In these communities, the preliminary trained employees, recruited from the communities' representatives, performed outreach work and provided peer education among local population. Through the mobile medical teams, at rural outpatient clinics, and at multi-functional mobile

clinic, donated under the programme, migrants and their partners were provided (free of charge, based on the principle of confidentiality) with medical services package including counselling and testing for HIV, hepatitis B and C, STIs and doctor's advice.

Also, ultrasound scan, gynecological examination and consultation were provided at mobile clinic.

Results of the programme:

The preventive activities covered 53 367 labour migrants and their partners, as well as community representatives. 25 072 persons underwent testing for HIV, hepatitis B and C. Thirty seven of those surveyed were diagnosed with HIV and they were followed up with consequent provision of treatment, care and support. Also, 274 positive results were obtained from the testing for hepatitis C, and 92 - from the testing for hepatitis B. These programme beneficiaries were provided with relevant counseling and referral to the appropriate specialist.

Impact of the programme:

56.3% of HIV cases revealed under the programme complied with the early diagnosis criteria (CD4 counts above 350 cells/mL) whereas the average level within the same period of time was 43.2% from total number of registered cases. All HIV cases diagnosed under the programme were linked to care services.

Before the project started, less than 100 labour migrants were tested annually. Starting in 2014, the programme of HIV testing among migrants has gradually been playing a more significant role in revealing HIV cases, having exceeded, for two years of implementation, the contribution in HIV diagnostic and linkage to care of all outreach projects conducted for 4 years among key populations taken together.

Financing and management:

The programme on HIV prevention and testing among migrants was managed and coordinated by the National AIDS Center. The programme partners at the community level were primary health care workers and rural administrations.

In 60 communities of Armenia, the programme was implemented with the financial support of UNAIDS and AIDS Infoshare Fund, in 40 communities - with the GFATM financial support.
An agreement was reached to continue the activities in 2016-2018 within the framework of the Russian Government-supported programme and GF NFM.

Provision of services by mobile medical teams after the donor financing is over will be financed from the State Budget allocations.

Lessons learned and recommendations:

The project implementation demonstrates that this model of services provision, when HIV testing is offered by mobile medical teams in a package with other medical services in rural communities, ensuring full anonymity and confidentiality of the results (which could not be achieved locally with the existing system of primary health care) is the most appropriate for labour migrants, especially for those living in rural areas, and effective for increasing the access of labour migrants and their families to HIV testing and counseling services, followed by

provision of treatment and care, if HIV infection is detected.

52. Estonia

Title of the programme: Community Based Rapid HIV testing and linkage to HIV Care and Support services

CONTACT PERSON
Name: Latsin Alijev
Title: Director
Organisation: NGO Estonian Network of People living with HIV
Address: Õismäe tee 36-8, 13511, Tallinn
Tel: +372 56506376
Email: latsin.alijev@ehpv.ee

Background:

The first HIV case was diagnosed in 1988. Since then a total of 9 159 HIV- positive cases had been reported (updated 4 Aug, 2015). The rate of newly diagnosed cases of HIV has decreased over the last decade (from 62 cases in 2003 to 25 per 100 000 in 2013). However, the percentage of infected people to the size of the population still makes Estonia's HIV rate one of the highest in Europe.

New HIV infections are primarily found in three locations. Tallinn had 138 new cases in 2014, while the city of Narva had 59 and Ida-Virumaa county (not including Narva) had 62 newcases respectively. That means that Tallinn, with a population of roughly 434 000, had HIV rate of 32 people per 100,000, while Narva, with a population of roughly 59,000 has a rate approaching 101 people per 100,000.

The HIV epidemic in Estonia is mainly concentrated among specific most-at-risk subpopulations, mainly people who inject drugs (PWIDs), sexual partners of PWIDs, commercial sex workers and men who have sex with men.

According to these numbers, HIV positive advocates and their supporters created the Estonian Network of people living with HIV (EHPV) in 2005 to ensure involvement of PLWH in policymaking process and active participation in service provision. Our mission is to provide quality and streamlined services and advocacy for PLWH in Estonia. To this end, we use innovative approaches and programs to address the needs of people affected by HIV and AIDS and stop HIV as a crucial target.

The following 4 strategic directions that drive actions and interventions of the Network:

- Advocacy for people infected with and affected by HIV and AIDS
- Improving access to quality health care and non-medical service for PLHIV
- Increasing community of PLHIV capacity
- Normalization of HIV and reduction of stigma and discrimination towards PLWH

Goals:

Goals are to provide psychosocial counselling and conduct group work for people living with HIV and their families, with the aim of improving the quality of life, the return people in society and improve their social status.

Achievements:

- Implementation of innovative services based on community needs.
- Good level of communication with government and its institutions.
- Successful involvement of PLWH in policymaking process: Ministry of Social Affairs committee on planning and procurement of ARVs, governmental committee on HIV and AIDS, Ministry of Justice independent ministerial commission on prisons affairs.
- EHPV initiatives like RT and peer to peer counselling services were accepted by public health institutions and integrated into the national HIV programs.
- The recommendations of EHPV concerning counselling and rapid HIV testing were adopted in national guidance and protocols concerning HIV testing and referral pathways.
- Creation of a community based and client-centred clinic in Narva. Linda Clinic provides access to testing, treatment and referral to other healthcare services for stigmatized and hard-to-reach populations. It`s the first HIV clinic operated by HIV-positive people in Europe.
- Peer counselling was recognized as a standard of psychosocial support services for PLWH.

Population served:

- PWID (People Who Inject Drugs or take drugs by other ways. Special attention should be paid to PWIDs who take stimulants and “new” drugs as is it often associated with risky sexual behaviour)
- Sexual partners of PWIDs
- General population and migrants in the most vulnerable regions (Tallinn, Narva, cities in the Northeast Estonia)
- MSM (special attention should be paid to the “hidden” MSM groups that do not visit gay bars and nightclubs and use web space instead. This approach should be based on a specialised centre for MSM)
- Families of people living with HIV

Description:

The program aims at decreasing HIV prevalence, improving access to HIV treatment and care services in relation to the most vulnerable populations by increasing the availability of HIV testing and ensuring effective communication programs with HIV positive people for the care and treatment of HIV. The program is targeted at those hard to reach, the most vulnerable populations, not accessible for health care institutions, offering traditional HIV testing services. The program is being implemented in the cooperation with the National Institute for Health Development and with the financial support from international non-governmental organizations.

Firstly, an innovative approach of HIV testing is not organized in the hospitals, but in the places

traditional for the target group. Secondly, the whole process of testing organization from the beginning to the end takes place with direct participation of affected communities (PLHIV, MSM, PWID). This process involves planning dates, events and places for testing along with the involvement of the public service responsible for testing at the national level, the direct participation of trained professionals from the community in the course of testing during pre- and post-test counseling, as well as offering support with the services, linking to programs for HIV care and treatment for newly diagnosed HIV-positive.

Population served and non-medical setting venues/places were used for rapid HIV testing:

Target groups	**venues/places for rapid HIV testing**
MSM	Gey Sauna, night clubs, LGBT centers, community based organisations
“hidden” MSM groups that do not visit gay bars and nightclubs and use web space instead.	Specialised centre for MSM cruising place, invitations to HIV-tests through social networks
PWID (People Who Inject Drugs or take drugs by other ways. Special attention to PWIDs who take stimulants and “new” drugs as is it often associated with risky sexual behaviour)	Needle exchange sites, social houses, the market in the living suburbs and the Russian-speaking regions, night shelters, drug addicts at rehabilitation centers, rehabilitation centers and villages.
Sexual partners of PWIDs	Night clubs, youth cabinets, outreach testings, home testings
General population in the most affected by HIV regions (Tallinn, Narva, cities of the Northeast Estonia)	Shopping malls, street testings, testings at railways, markets, sity fairs
Families of people living with HIV	Night clubs, youth cabinets, outreach testings, home testings
Sex workers	Places, where sex workers gather, support centers for sex workers
Women	Social houses for women, social help centers
Young people	Youth cabinets, Schools, Universitys
Migrants (Tallinn, Narva, cities of the Northeast Estonia)	Centers for migrants, Universities, Factorys

Another unique feature of the program is its identification of HIV positive people who already know their status, but who for various reasons have dropped out of the care and treatment programs and are unable to start or continue with ARV therapy. In general, it is vulnerable populations and people who use drugs who belong to this group. In order to attract those populations, reward system is being used (inexpensive souvenirs or food packages). Then, during the process of motivation and social support, the clients are being linked to the program for HIV treatment and care.

The model of a quick testing program consists of seven following parts. It was developed by the AHF foundation and is based on WHO recommendations; these are not detailed instructions, but a common framework that an organization carrying out quick testing activities should follow.

The model has the following concept:

- Creative approach in marketing and targeting client groups

- Service free and available for all the clients
- Quick group or individual pre-test advising with all the clients who want to do the test is mandatory
- Testing that should be carried out using quick tests, not venous blood sampling
- Results of testing should be released at the same day that testing was taken
- Each client should have a free access and ability to get free preservatives
- Clients who are suspected of HIV infection should be connected with treatment

Results of the programme:

The program mostly covers North-Eastern Estonia and capital city Tallinn, where rates of HIV are the highest. During the summer youth festivals, and in the case of special events, where the participation of target groups is expected, street testing will be carried out in other cities. For example, several times a year testing is conducted at private MSM parties in Tartu. Testing in the field, trips to hardly accessible areas, testing at industry sites in North-Eastern Estonia also make a part of the activities.

Totally during 2015 year:
- were tested – 12 143
- newly diagnosed among 12 143 – 46
- secondary diagnosed among 12 143 – 204
- linked with care among 12 143 – 93

As a sample:

The results of the work with the rehabilitation centres during six months in 2016:
- Tested - 235
- Primary tests taken - 14
- Primary HIV-positive detected – 2
- Positivity rate – 0,85%
- Linked with care – 14

The outcomes of the work with the rehabilitation centres during six months in 2016 in the rehabilitation centres:
- Tested - 500
- Primary tests taken - 30
- Primary HIV-positive detected - 10
- Linked with care – 40

Impact of the programme:

Achievements:
- Innovative approach based on community needs has been implemented;
- Community based and a client-centred service provides access to testing, treatment and referral to other healthcare services for stigmatized and hard-to-reach populations.
- Good level of communication with Government and its institutions has been reached;
- Successful involvement of affected communities including PLWH in programme making process;
- Community initiatives like community based rapid HIV testing and peer to peer

counselling services were accepted by public health institutions and some of the elements were integrated into the national HIV programs;
- The community recommendations on counselling and use of rapid HIV testing were adopted in national protocol on HIV testing and referral pathway;
- Peer counselling was recognized as an integral part of psychosocial support services for PLWH.

Financing and management:

We conduct activities with partners from the public side- Institute of Public Health, with the NGO communitys, NGOs, AIDS service organisations, international foundations who support the testing events and tests, and medical centers with medical licenses.

Lessons learned and recommendations:

The process of testing, linkage and retention in treatment for the key vulnerable populations including PWIDs and MSMs should be done using the social support method and based on principles of an integrated approach to the health of PWIDs, MSMs and other key vulnerable groups and in the interests of public health.

The motivation system should be implemented and based on identification of the requirements/needs for saving health of the PWIDs, MSMs and other target groups of testing (e.g. incentives, food packages).

In countries where legally, non-medical personnel are not allowed to perform HIV testing, regulatory and legislative barriers to this approach could be overcome by flexible attitudes from government side, showing political will and creativity.

53. Georgia

Title of the programme: Harm Reduction program in Georgia – Provision of HIV prevention services to people who injects drugs (PWIDs)

CONTACT PERSON
Name: Maka Gogia
Title: HIV Program Director
Organisation: Georgian Harm Reduction Network
Address: Shartava 24, apt 6, Tbilisi, Georgia
Tel: +995 599 218123
Email: marine_gogia@yahoo.com; mgogia@hrn.ge

Programme is being implemented since:
Implemented by: Civil Society
Scope of submission: Advocacy campaigning and participation in accountability, community-based service eliver (i.e. testing, prevention, care and support, treatment, legal services, task shifting, traingin of health care workers, etc, community-responses in the humanitarian context in relation to people who inject drugs.

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

The main route of HIV transmission was hardly associated to injecting drug use from the very beginning of HIV epidemic in Georgia. The rate of HIV transmission through injecting drug use has declined in the last 5 years and but it remains dominant at 46% (43% heterosexual contact; 8% homosexual contact) http://aidscenter.ge/epidsituation_geo.html. We have a steady growth trend of newly detected HIV cases year by year.

Number of PWIDs is estimated as 50 000. In comparison to recent years, number of PWIDs is increasing year by year. According to expert opinions, this fact is strongly related to strict drug law environment, lack of needed treatment programs, law coverage of OST programs, and absence of rehabilitation and re-socialization programs and so on.

Harm reduction programs (OST and Needle and Syringe programs (NSP)) were adopted for adequate and timely response to HIV epidemic among PWIDs in the country since 2001. Since 2013, the number of NSP sites has increased and, during the selection process, priority was given to newly created community based organizations.

Harm Reduction program in Georgia is being implemented by Georgian Harm Reduction Network (GRHN) within The Global Fund (TGF) grant since 2006. TGF is the only funder and supporter of NSP program in Georgia during the recent decade. The governmental entity - National Center for Disease control and prevention (NCDC) – reveals it as the principal recipient of GF grant in the country.

Mainly community based organizations are providing law threshold HIV services to PWIDs. The main personnel at NSP program are people who have/had drug related problems; accordingly, these VCT consultants and outreach workers are well trusted and reliable persons for PWID, who remained hard to reach during many, many years by other HIV programs.

The enrollment of community service delivery has played a crucial role in the scale-up of program coverage, community mobilization and increased access to vitally important social and health services, self-stigma reduction, case management and other. Female outreach workers were involved to increase coverage and retention of female PWIDs in NSP program.

The main problem that the NSP program is facing in the country is drug policy. Drug consumption and possession of drug (lowest amount for personal use) is subject to significant money penalty or imprisonment. Due to strict drug laws, Georgia is the only country in the world where needle exchange can't be done; only distribution of sterile equipment is available.

The only way to deliver HIV services here is through outreach work. Effective implementation of the program is often hampered by the police. Outreach workers have to work under a very strict environment, under the routine and everyday threat of police arrest. For many years, many outreach workers have been arrested and moved to mandatory Urine Drug Testing.

In order to increase NSP program geographical coverage and HIV and HCV case detection, the NSP program adopted a new working strategy with Mobile Ambulances several months ago. Before the initiation of this work, GRHN together with NCDC had negotiated with the ministry of Internal affairs to achieve more balanced and collaborative relations in order to avoid program

failure. The draft of Memorandum of Understanding between different stakeholders (Ministry of Internal affairs, NCDC and GHRN) was created and sent to the Ministry of Internal affairs. Unfortunately, the memorandum was not approved officially, but we had another high level meeting with deputy ministries of Internal Affairs and we received a verbal promise from them, according to which Police will not interrupt daily work of NSP program. But this was only a promise and reality is quite severe so far.

What situation regarding effective HIV response do we have now in Georgia? The government has double face in reality: on one hand, it approves National HIV and HCV strategy, prioritizes the importance of harm reduction programs in different papers and at international meetings (for example at UNGASS recently), receives money from TGF and delivers to different NGOs to better address the HIV epidemic in the country. However, on the other hand, the government has no political will to change strict drug policy and to review and revise drug laws. Accordingly, PWIDs who receives HIV services are under threat of arrest and of great money penalties, which results in worse social and health outcomes of PWIDs and society in common.

Description:

Primary focus of the programme – advocacy, service delivery (HIV prevention, treatment, care and support, legal etc), research, and financing.

The NSP program is being implemented by GHRN in 11 cities and 14 harm reduction sites (one of which is located in conflict region of Abkhazia). Different NGOs and community led organizations are involved in service delivery for PWIDs.

The program has two main directions: HIV service provision and Advocacy component.
Service delivery includes in its scope: HIV prevention, HIV counselling, testing and linkage to care and support, demand creation and service update, medical, social and legal care, case management, Peer Driven Intervention, education on harm reduction issues, overdose prevention and other interventions. It should be emphasized that all these comprehensive packages are being performed under this strict drug law environment and under high stigma and discrimination condition.

Advocacy component includes community mobilization for drug policy change and better accessibility and continuity of needed healthcare, social and harm reduction services. For this purpose, we created Georgian Network of People who Injects Drugs (GeNPUD) in 2013. Technical support and trainings are being provided to network members; several important advocacy campaigns were conducted and more is planned to be accomplished in nearest future.

Results of the programme:

NSP program coverage with the minimal HIV package had increased 4 times in comparison to 2012 due to emphasizing the community role in HIV service delivery. The number of female IDUs has increased 10 times by providing female specific services and by involving female outreach workers broadly among outreach work staff. More than 31 000 PWIDs are reached and provided with needed HIV services in 2015; More than 22 000 people were tested for HIV, as well on HCV, HBV and Syphilis, ten times more than in 2012. Outreach work done by community members has highly supported us in TB screening and referral as well. Till the end of 2016, the geographic coverage will be increased significantly due to innovation work by mobile ambulances.

Impact of the programme:

Harm reduction programs had the following impact: HIV epidemic among PWIDs is stabilized according to last BSS studies: HIV prevalence is not increasing (but decreasing) among PWID; Sharing of injecting equipment is less; knowledge about HIV is better. More information can be found in the BSS report. http://curatiofoundation.org/wp-content/uploads/2016/03/PWID-BBS-Report-2015-ENG.pdf

Financing and management:

The NSP program is managed by GHRN which is the Sub-recipient of The Global Fund Grant. The Principal Recipient of the Grant is NCDC.

Financial sustainability is ensured just for the next 3 years, before the Global Fund leaves the country. After TGF, GHRN and other experiences NGOs are under threat of financial stability. The main question that is routinely raised is:

- Will government prioritize HIV prevention?
- Will it finance HIV services in a volume as has been done by TGF?
- Will it use the resources of community or will it be integrated in other primary health care settings?

Lessons learned and recommendations:

The main factor that helped the success of the program was community involvement in HIV service delivery – they played a crucial role to increase coverage, identifying ways to reach hidden populations, among them sub-populations: young injectors and female injectors. Peer based support was the basic for delivering life-saving services at outreach base.

Other achieved success relates to community mobilization to defend their right and achieve better access to health and social services. PWIDs started to openly discuss their problems and needs in media, TV and radio talk shows, participate in street protest or solidarity actions, demand free HCV treatment, create and sign petitions, collect signatures to initiate drug law change process and so on.

54. Russian Federation

Title of the programme: Street Lawyers Project

CONTACT PERSON
Name: Anya Sarang
Title: President
Organisation: Andrey Rylkov Foundation for Health and Social Justice
Address: Biruzova 17-82, Moscow, 123060, Russia
Tel: +7 926 155 87 99
Email: rylkov.foundation@gmail.com

Programme is being implemented since: 2013
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and

support, treatment, legal services, task shifting, training of health care workers etc) in relation to population of people who inject drugs.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Russian drug policy is known as one of the most conservative and repressive among those around the world. It declares a zero tolerance towards drug use, inflaming the stigma and discrimination towards people who use drugs because of their drug dependence. They are primarily considered not as patients who need proper treatment and support but as criminals. This restricts the access of people who inject drugs to vitally important information on health issues and the health services needed such as opioid substitution treatment (OST), which is widely recognized as an effective and evidence based treatment of drug addiction and measure of HIV prevention, as well as to other harm reduction services.

The basic rights of drug users in Russia including the right to health are constantly cruelly violated and the Russian government provides zero support for secondary HIV prevention and psycho-social work with this key HIV-affected population. As a result of such drug policies, Russia has one of the fastest growing HIV epidemics in the world with over 830 000 officially registered HIV cases. About 70% of all HIV cases in Russia are associated with the use of injecting drugs and the main way of HIV transmission is parenteral. On average, 37.2% of the injecting drug users live with HIV and in some cities, up to 90% of people who use injecting drugs are infected with hepatitis C. There are more then 150 000 imprisoned people in Russia sentenced for drug related crimes – mostly for the possession of certain amount of illegal substances for personal use. According to the estimates, nearly 5 million people use illegal drugs in Russia, 1.7 million of who are opiate users.

Description:

Our Street Lawyers Project is a part of the Harm Reduction Program we implement in Moscow. Since 2013, we have provided legal assistance to our project participants within the Street Lawyers project. Its main concept is to teach legal defence skills to people who have no formal legal education – to social workers and representatives of key populations affected by HIV in Moscow. Today our outreach workers are well-trained and have sufficient legal skills to be able to provide to drug users brief and timely consultations addressing basic legal issues.

The core stages of the street lawyers work are as follows:
- Informing: about the project, about rights through workshops (this stage addresses about 40% of all cases);
- Mediation: in most cases, dealing with problems solves them, and social workers can solve the problems at this stage. During mediation, outreach workers themselves become lawyers (this stage addresses about 30% of all cases);
- Official requests: addressing the source of the problem. There is a wide range of people that have formal or de facto authority, and the list of such people is unlimited (doctors, investigators, passport issuing office clerks, etc.) (this stage addresses about 15% of all cases);
- Formal complaints to the authorities: officials, police, custodial services, custody

agencies, the Federal Penitentiary Service and the Federal Migration Service (this stage addresses about 10% of all cases);
- Judicial protection: the goal of this project is to solve the problem at the information and mediation stages. We believe that judicial tools should be used only as a last resort, when all preceding mechanisms have been exhausted (this stage addresses about 5% of all cases).
- Street lawyers aim to give the project participants that require legal assistance both moral and legal support and, most importantly, confidence in their own abilities.

Results of the programme:

Our social workers and participants of the harm reduction program have obtained skills in preparing legal documents (complaints, statements, letters of attorney and solicitations) using the experience they have accumulated while implementing this project. Our work with drug users has become more efficient, and our legal services are even more accessible now. During this past year, we prepared 167 legal documents (including appeals within the court trials in criminal and civil cases, requests to the public authorities, statements of claim and statements challenging the actions of public authorities), as well as about 20 court appeals. Our social workers took part in about 20 court hearings. The key topics for our legal work in 2014-15 were: protection in drug-related criminal cases, protection of the right to health (access to ARV), protection from discrimination of people who use drugs and live with HIV and hepatitis C.

One example of this ARF work related to a drug-using woman living with HIV who was refused dental treatment at a government-funded clinic. Marina had to visit a doctor to get a surgical dental treatment. For that reason she went to the governmental dental clinic. But when Marina informed the dentist that she was HIV positive, he refused to provide her medical help. Marina went to another dentist at the same clinic who told her she would provide her with medical assistance but only after all the other patients. In Marina's opinion, such an attitude of dentists was discriminating and illegal, which is why she approached ARF and asked us to help her to protect her rights. Social workers helped her to prepare and submit the compliance to the head of this clinic. The compliance included a description of the situation and a request to take relevant measures to educate the staff personal on HIV/AIDS issues and also to prevent further discrimination of people living with HIV in this governmental health care facility. As a result, the head of the clinic responded to Marina, apologized to her and informed that he will not allow discrimination of people living with HIV in his clinic anymore. Marina received required medical assistance and cured her teeth.

Impact of the programme:

One of the key achievements of the project is the improvement of access for the people who use drugs - participants of our harm reduction program reach necessary medical services, both those provided within governmental health system and those provided by our organization. Also street lawyer cases allow the use of human rights laws to fight Russia's authorities. We track cases where rights of people who use drugs have been violated, do strategic litigation, and take bold campaigns to the public. Such cases almost always fail in the Russian courts so we take them further. We have taken more than a dozen cases to national and international courts. One of these is Irina Teplinskaya, a drug user who filed a complaint to the UN Special Rapporteur on her right to health in 2011, and, in 2012, filed a case in the Russian courts on her inability to access OST. Her case, together with two similar cases, is now under review with the European Court of Human Rights.

Financing and management:

The program is funded by Levi Strauss Foundation. We don't receive any support from the government for these or any other of our activities. Taking into account the difficult political situation in Russia and constant pressure experiencing by those NGOs receiving foreign funding the financial sustainability of the project is unclear. Our main partner for this project is Canadian HIV/AIDS Legal Network which always supports us in our drug-policy related advocacy and strategic litigation work.

Lessons learned and recommendations:

Street lawyer's component became an important part of our Harm Reduction program. When we started this activity, almost no one could believe that an ordinary Russian drug user could change things and oppose the soulless and oppressive justice machine without VIP lawyers and using only available resources, with support from social workers and a legal consultant. But only a year has passed and we have already accumulated a lot of examples proving that the street lawyers program works. Now we have about 20 legal cases, four fine young lawyers and a stock of successful cases. Two years ago, there were hardly any drug users ready to try and defend their civil rights with our support. Today people approach us on the street, call the hotline, write and ask through friends.

55. Moldova

Title of the programme: Community based HIV prevention services in prisons

CONTACT PERSON
Name: Ruslan Poverga
Title: Chair of the CBO
Organisation: CBO "New Life" in Moldova
Address: Community Centre New Life, Independentei 6/2 str., Chisinau 2043, Republic of Moldova Moldova
Tel: +373 022664586, +373 69115457
Email: newlifemoldova@yahoo.com

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability; Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.); and community financing in relation to people living with HIV, people who inject drugs, women, young people, and people in prisons

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

The volatile HIV epidemic in Moldova, fuelled primarily by people who inject drugs (PWIDs), is concentrated in prisons. Starting with 2000, CBOs and NGOs had a lead position in developing policies and services to prevent HIV and TB in prisons. Currently, the 12 out of 15 interventions recommended within the UNODC/ILO/UNDP/WHO/UNAIDS comprehensive package of HIV

services for prisons are implemented in Moldova. 16 years later, the role of CBOs and NGOs are essential in ensuring prevention, treatment care and support to HIV services and co-infections in prisons. CBO “New Life” is a key population led organisation, consisting of people who inject drugs and former inmates providing support to PLHIV and PWIDs in prisons. All in all a team of 25 peer to peer consultants, social workers, psychologists and coordinators are working in 17 prisons in Moldova, covering a population of nearly 8000 inmates, both women and men.

ADVOCACY, CAMPAIGNING AND PARTICIPATION IN ACCOUNTABILITY

1. Advocacy and raising awareness campaigns organized on the occasions of Candlelight Memorial Day, Word Drug day and World AIDS Day. The uniqueness of advocacy and raising awareness campaigns is defined by the direct participation and involvement of inmates. Moreover, with the scope of minimizing stigma and discrimination, public personalities are usually involved in the campaigns. All campaigns organized by the CBO have national coverage. One of the examples is the Intellectual Contest for inmates “Brain Ring”. Very unusually, for the first time, inmates who won the contest at the prison and regional levels were brought to a public space accompanied by public well-known personalities and inmates’ relatives. For more information:

http://positivepeople.md/en/reportaj-s-finala-brain-ringa/
http://positivepeople.md/en/fleshmob-v-dpu/

2. “New Life” plays an active role in the participatory process of policy and strategies development at the level of prison administration, health authorities and Ministry of Justice. New Life represents key population at the level of CCM HIV/AIDS, Technical Working Groups at the level of CCM, TWG at the level of prison administration and as a member of multidisciplinary team working in prisons. They actively contribute to the development and successful implementation of the National HIV/AIDS program (including prisons component), Prisons Development Strategy 2016-2020, Clinical Treatment Protocols on HIV, OST, Hepatitis and National Drug Strategy 2012-2018.

3. CBO “New Life” timely draws the attention of the prisons and health authorities with regards to access to testing, treatment, support and care to HIV. CBO is raising the awareness at the level of relevant stakeholders and authorities to ensure availability of screening and ARV for patients in time. The latest example, with regards to timely access to testing and diagnostics to HIV/AIDS for inmates, was raised at the level of Prime Ministers’ cabinet.

COMMUNITY-BASED SERVICE DELIVERY IN PRISONS (I.E. TESTING, PREVENTION, CARE AND SUPPORT, TREATMENT, LEGAL SERVICES , TRAINING OF HEALTH CARE WORKERS ETC)

TESTING:

1. HIV testing in prisons. Since 2013, CBOs and NGOs provide VTC to HIV on saliva for inmates. The new practice has increased the number of inmates and PWIDs in prisons accessing the testing service. Advocacy and informative session and individual counselling are conducted on a regular basis in all prisons by CBOs and NGOs to motivate inmates for early detection of HIV and testing.

PREVENTION:

2. IEC - Information, education and communication in prisons is provided mainly by the CBOs and NGOs. “New Life” organizes group informative sessions on the occasion of

Candlelight Memorial Day and WDA in all 17 prisons. Individual or smaller groups' sessions are organized in target groups several times a year. IEC materials about HIV and means of transmission are developed and disseminated in all prisons.

3. Since 1999, NSEP (Needle Syringe and Exchange Program) in prisons was implemented by the NGOs based on peer to peer principle; later in 2014, the administration of the program was passed over to the prison administration. Peer to peer workers from NSEP sites also participate in the distribution of the IEC materials on HIV and are also trained to provide first aid to inmates who may suffer from an overdose in prisons, including Nalaxone.

TREATMENT, CARE AND SUPPORT:

4. Since 2004, prisons are implementing antiretroviral therapy. CBO is providing psycho-social support and referral of patients from the moment of HIV status confirmation throughout the entire treatment with the scope to ensure adherence to treatment.
5. Since 2005 pharmacotherapy with methadone (OST) is implemented in prisons. Currently, OST is available in 13 prisons out of 17, including a female prison.

Within the ARV and OST several individual and group services are provided:

(a) Individual, case management approach to each HIV patient is provided by peer to peer, social workers and psychologists.

(b) Group work (support groups for patients in prisons, info-sessions for patients in prisons, trainings, vocational non-formal trainings for patients, support groups for family members) are provided.

(c) CBO is offering IEC and support to PWIDs, both men and women, in prisons in order to increase motivation to initiate OST in prisons. For OST patients, based on the case management approach, CBOs are providing individual psycho-social support for patients in OST, including initiation of treatment, maintenance in treatment to prevent drop-out, assistance of poly-drug users, and management of OST withdrawal.

(d) Referral to medical, social assistance and other services for patients after their release. Educational work with patients to be released in to order to ensure continuity of treatment outside of prison and social integration of patients into the communities.

(e) CBO is closely monitoring the necessity to ensure timely diagnostic, including regular testing on CD4 and WB. "New Life" is raising the awareness at the level of relevant stakeholders and authorities to ensure availability of screening and ARV for patients in time.

(f) CBO is providing legal support services to inmates as part of the individual counselling, referral in the process of trial, also as part of the group informative sessions with regards to patients' right and access to health.

TRAINING OF HEALTH CARE WORKERS

Since 2014 a multidisciplinary approach to PWIDs and PLHIV is being implemented in each prison. The team consists of prison medical personnel and psychologist, CBO peer to peer, social assistant and psychologist and a sentenced volunteer inmate. Following the principle of multidisciplinary, besides the possibility of evaluating each individual case, organizational issues related to the quality and access to services are commonly solved by prison administration and CBO. Within the collaborative environment, the barrier between CBO and prison authorities is overcome following the principle of collegiality.

With the scope of protecting prison staff from occupational hazards and HIV prevention, this also increases the level of awareness and knowledge amongst prison personnel. Furthermore, CBO is developing and disseminating thematic IEC materials. Seminars amongst staff and

specialized trainings are on a regular basis for medical unit, educational unit, security and operational unit.

COMMUNITY FINANCING

Mostly psycho-social support is prisons provided by the CBO "New Life are supported by the GF, however resource mobilisation is being undertaken. On the local level CBO is conducting resource mobilization within the national campaign "The bright colour of good cause"
http://positivepeople.md/en/category/campaigns/faptele-bune-au-culoare/
http://positivepeople.md/wp-content/uploads/2016/03/Booklet_ru.pdf

As of now 16 local business companies are part of the campaign. Each partner is contributing financial resources in the campaign's fund. Also, this business partners are active in promoting stigma and discrimination against PLWHIV, PWUDs and inmates. For more information:
http://positivepeople.md/en/pokolenie-bez-spida/

Description:

The objective of the program with national coverage implemented by CBO "New Life" in prisons is to reduce HIV related burden amongst inmates. Within the overall objective, several goals were set including: increase access to screening and testing to HIV, universal access to treatment, care and support and decreasing the level of stigma and discrimination against PLWHIV, PWUDs and inmates. All program related goals and objective are reached due to the cascade related services based the complex, participatory and multidisciplinary approach. The specific and effectiveness of the program is achieved due to involvement of the key affected population in the process of planning, development, implementation and evaluation of the program.

Results of the programme:

The program has national coverage as it is implemented in all 17 prisons covering a population of nearly 8000 inmates, both women and men. Five mobile teams undertake regular visit to prisons, therefore ensuring weekly consultancy and coverage of each and every beneficiary. As a result of joint interventions implemented by prisons and health authorities, UN agencies and non-governmental including CBO organizations, in terms of statistics, the number of annual new cases of HIV infection detected amongst inmates decreased from 32 cases (2003) to 21 cases (2013). The proportion of people living with HIV (PLHIV) under ART share of people in ART increased from 2% (2005) to 62% (2013). Deaths amongst PLHIV in prisons has dropped three times from 23% (2007) to 8.6% in (2013). These successes are the result of the consolidated efforts between community based organizations, NGOs, prison and health authorities, UN agencies and other partners.

Impact of the programme:

Direct impact is illustrated by the IBSS results amongst inmates (2007, 2010 2012) which show a decrease in blood-borne diseases such as HIV and viral Hepatitis. HIV prevalence among inmates declined from 4.2% (2007) to be 1.9% (2012). Prevalence of HCV decreased from 21% (2007) to - 8.6% (2012). Integrated HIV knowledge indicator has increased from 30.8% (2007) to 42.2% (2012).

Indirect impact by COB work in prisons in terms of HIV is translated into the openness of the

prisons authorities towards collaboration and implementation of the innovatory and evidence-based approaches. The collaboration between COB and prison administration also leads to the increasing level of tolerance towards inmates and vulnerable groups by prison personnel.

Financing and management:

Currently, psycho-social programs in prisons are financed mostly by the GFATM. In 2014, the DPI took over the management over the needle exchange program while ensuring the maintenance of the two programs in case of no external financial support. The major partners are: NP (MoH), Narcology/Addiction Treatment Service, Soros Foundation-Moldova, CSOs: New Life and “AFI”, also UNODC, UNAIDS, LEAHN.

Lessons learned and recommendations:

Success:

- ✓ In 2015, on the 37th session of PCB, Moldova was presented as one of the best practice on Harm Reduction in prisons, http://www.unaids.org/sites/default/files/media_asset/20151012_UNAIDS_PCB37_15-21_EN.pdf
- ✓ Openness of the prison authorities in implementing prevention, treatment and care programs to HIV in prisons
- ✓ Increasing level of tolerance towards inmates and vulnerable groups by prison personnel
- ✓ Scale up of OST, NSEP, ARV and other essential services in prisons
- ✓ The partnership with the community medical service and CSOs has a positive impact over the HIV/AIDS epidemic and HR programs in prisons
- ✓ Multidisciplinary approach increased the effectiveness and quality of service provision
- ✓ Due to national advocacy campaign, the prejudices and public opinion are changing towards positive attitude and tolerance
- ✓ The level of literacy in terms of HIV, drug consumption, TB, Viral hepatitis has increased amongst inmates and prison personnel

Challenges:

- ✓ Hostile attitude portrait by the criminal subculture
- ✓ Due to the fervent change in prison personnel and administration, there is a need to ensure continuous education and information with regards to the importance of the services that are being implemented
- ✓ One of the main risks is the financial sustainability of services, including CBO psycho-social support since most of the financial support is provided by the GFATM.

56. Ukraine

Title of the programme: “Advocacy for access to medical and social services for representatives of vulnerable groups, including people using drugs (PUD), methadone treatment patients (MTP), sex workers (SWs), and former prisoners in five regions of Ukraine”. (“Social mobilization, strengthening of relations, cooperation and coordination”.)

CONTACT PERSON
Name: Marcus Oda
Title: Program & Advocacy Officer
Organisation: Eurasian Coalition on Male Health

Address: Vaike-Ameerika 8, Tallinn Estonia
Tel: +372.5608.2060
Email: marcus@ecom.ngo

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability, in relation to populations of men who have sex with men, people who inject drugs, and sex workers.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

At present, almost all programs aimed at the provision of harm reduction services, HIV/AIDS prevention, care and support for populations most vulnerable to HIV/AIDS in Ukraine are implemented using funds from international donors, primarily the Global Fund. Given that the Global Fund is planning to transfer the responsibility of funding all HIV/AIDS programs to the government by 2017, it is of particular important to ensure the sustainability of these services in order to prevent new outbreaks of HIV/AIDS and TB. However, a number of factors currently prevent the preservation of ham reduction, care, and support programs, including: a lack of developed financial mechanisms for financing HIV prevention, care and support programs for vulnerable groups from local budgets; the lack of interests of government officials, the frequent changes in local governments, and high levels of corruption; and the poor economic situation in the country, as well as the military conflict with Russia.

Description:

The primary goal of the program is to ensure the sustainability of medical and social services for representatives of groups vulnerable to HIV by transitioning from donor funding to funding from local budgets; and, following the transition, to strengthen community leadership capacity in five regions of Ukraine to enhance their influence on decision makers. We are currently working in the regions of Odessa, Kherson (from the beginning of 2016), Kirovograd, Cherkasy and Vinnitsa, and, until the end of 2015, were working in the regions of Sumy and Lviv as well.

In order to accomplish our goals in all areas of the project implementation, Regional Community Councils (RCC) were created as consultative and advisory bodies, comprising leaders and activists from populations most vulnerable to HIV, which are designed to significantly enhance the mobilization capacity of communities through joint advocacy actions, including increasing access of representatives of vulnerable communities in the region to medical and social services. Increasing the influence of communities is achieved by: joining and participating in the work of various coordinating mechanisms and experts groups on the development of different policies, through monitoring the practical implementation of programs and policies; cooperating with various structures (for example, working with local government centers providing free legal assistance in order to protect the rights of representatives of vulnerable populations) and by representing the interests of the RCC and various events.

Aside from the RCC meetings, we have also used round tables with civil society and government representatives, individual negotiations with government officials, drafting official letters to government officials, signing memoranda of cooperation, and other advocacy activities

as means of fulfilling the goals of the program. An important objective of the program is conducting informational and educational trainings for leaders and activists from vulnerable groups to increase the level of knowledge in the field of advocacy and to improve the organizational capacity of communities; as well as providing technical assistance to the regional coordinators of the of “Gay-Alliance” and community leaders.

Results of the programme:

The following main results were achieved in the five regions, thanks to the project implementation in 2015:

1. Four regional programs on HIV/AIDS and one regional program to combat drug addiction were adopted for a period ending at the end of 2018. Funding for MTP programs, HIV/AIDS prevention programs for PUD, MSM, and SWs come from the local budget. The rehabilitation program “Step into a new life”, beginning in 2017, which prepares convicts from groups vulnerable to HIV for release, was supported by the State Penitentiary Service Department in the Cherkassy Region.
2. Funding for opioid substitution therapy (buprenorphine) was allocated from local budgets in Kirovograd, and in the Vinnitsa region, a program began aimed at providing opioid substitution therapy through primary healthcare providers.
3. The issue of access to ARV-treatment for HIV-positive detainees from groups most vulnerable to HIV in detention centers were resolved (Kirovograd).
4. The number of representatives from vulnerable groups, involved in the development of programs and policies was 61.
5. 21 meetings of Regional Coordinating Councils were held. In just the second half of 2015 alone, 22 new representatives of PUD/MTP, 8 MSM representatives, 10 SW representatives, and 4 former convicts were involved in the work of the RCCs.
6. Over the course of the year, 25 community activists took part in meetings of local Coordinating Councils on TB and HIV/AIDS. Over the course of 2015, several new activists (MSM and former convicts) became members of these local coordinating mechanisms.
7. 19 round tables with representatives of civil society and the government were organized by regions in order to increase the access of community representatives to services. In total, 250 people participated in these events.
8. Experts from “Gay-Alliance” conducted 13 technical assistance visits in the regions, with over 56 people covered by the visits (regional coordinators and community activists).
9. Educational trainings on advocacy and working with government officials were held for PUD, MTP, MSM, SW, and former convicts.
10. A Memorandum of Cooperation was signed establishing a system to forward clients to local government centers providing free legal assistance in cases where their rights have been infringed upon. This service was introduced in existing harm reduction programs for groups vulnerable to HIV.

Financing and management:

The Program is financed by the Global Fund, with support from the organization “All-Ukrainian Network of People Living with HIV” and the “Alliance for Public Health” for the period from January 2015 to June 2017. Work in the five regions is implemented through regional coordinators and partner non-profit organizations, as well as through assistance from the Regional Community Councils, specialized medical institutions (AIDS centers, drug treatment clinics, TB clinics), public health departments of local government administrations, and other governmental agencies of local government, public, and patient organizations.

Lessons learned and recommendations:

In the first year of implementation, the Program already has a network of partner organizations, which, in most cases, successfully assist us with influencing decision-makers at the local level, under the current conditions of a gradual decentralization of power and reform of the healthcare system. However, despite the gradual decrease in funding of Global Fund programs and other medical and social programs for vulnerable communities financed by external donors, the government has demonstrated its indifference and is in no hurry to finance medical, social, or prevention programs related to HIV/AIDS, thereby placing the stability of current programs and projects under threat following the exit of the Global Fund in 2017.

Consequently, we would like to highlight the main problematic moments in the program implementation:

1. The reluctance and indifference of many key decision-makers to the problems and needs of the community groups most vulnerable to HIV, and, sometimes, their overt xenophobia and homophobia. The same applies to the medical staff of many medical institutions, especially in small towns.
2. Clear social standards for working with representatives of the groups most vulnerable to HIV were not developed or adopted at the national level, nor was a standard package of services, which should be presented on a per-client cost basis, defined; thus, it is now unclear how to develop a mechanism for providing services to vulnerable groups from funds from local budgets (including the introduction of social contracting).
3. The reservedness and the inaccessibility of these vulnerable groups in medium-sized and small cities, especially MSM and SWs, and the lack of motivation of representatives of the groups to participate in advocacy processes caused by economic and social factors.

57. Ukraine

Title of the programme: Women-led and community based research: Sexual and reproductive health, gender equality and human rights, gender-based violence, economic and political opportunities of women living with HIV in Ukraine.

CONTACT PERSON
Name: Svitlana Moroz
Title: Project's Manager
Organisation: ACO "Positive Women"
Address: Mezhygirska Str., 87B, Kyiv, 04080, Ukraine
Tel: +38 067 625 35 58
Email: svetamorozgen@gmail.com

Implemented by: Civil Society
Scope of submission: Participatory community-based research, in relation to people living with HIV and women.

Background:

Ukraine has one of the highest prevalence rates of HIV in Europe and Central Asia, with HIV prevalence in the age group of 15-49 years making up 0,62%. There is growing registration of

HIV cases of women compared to men: at early stages of intervention 80% of men using drug injections were diagnosed and gradually the number of HIV-infected men and women equalized. A presumption is not supportive to the efficiency of HIV-epidemic strategy: the lack of proper gender consideration in the HIV interventions is visible. The current state of HIV and AIDS within the country is worsening with the increased need for informed and targeted interventions. Moreover, the gender-dimensions of HIV and AIDS are generally overlooked, putting women and girls at higher risk.

Description:

Programme focuses at advocacy by providing research-based evidence for developing gender Based approaches to address HIV epidemic in Ukraine. The main objectives include:

1. collection and analysis of challenges and needs of women living with HIV in Ukraine on sexual and reproductive health, gender equality and human rights, gender-based violence, economic and political opportunities;
2. identifying priorities for the national agenda; creation of the platform to maximally engage women to discussion and addressing of the identified gaps;
3. setting the foundation for advocacy activities at the national and regional levels.

Work performed by the NGO:

- Research on HIV and AIDS trends, issues, opportunities, and challenges and its impact on women and girls in Ukraine, based on the methodology of the recent global survey among women living with HIV "Global values and preferences survey regarding the sexual and reproductive health and human rights of women living with HIV".
- National consultation with the Stakeholders on validation of the gap analysis and mapping of key stakeholders in the HIV and AIDS response - in close collaboration and consultation with the UN Women Programme Office in Ukraine, ECA RO and HQ, and based on the findings of the research and in line with UNAIDS UBRAF, the development of a full project proposal or concrete set of recommendations to engender existing UN interventions on HIV and AIDS in the country or address existing gaps.
- Participation of women living with HIV in strategic regional or sub-regional initiatives.
- Research consisted of a survey of 1 000 women living with HIV in all regions of Ukraine, four community consultations in the form of focus groups discussions and expert review of the HIV and AIDS policies and programs.
- The research is unique as, for the first time in Ukraine, it was organized and conducted by the women living with or affected by HIV.

Results of the programme:

Preliminary Research findings (to be completed by the end of May 2016): Only 3% of the focus group participants believe that the state is fulfilling its duties towards people living with HIV. 37% focus group participants are not aware and have not heard about the National TB and HIV/AIDS Council. While women constitute 40% of the total number of the regional councils' members, only 7% of the leadership teams are women. Necessity to address the issues of gender-based violence (98.3%) and violations of women's rights (98.2%) is an almost one-hundred percent priority for both women-activists The survey participants expressed the highest degree of disagreement with the statements: "I can receive free and high-quality treatment, information, services on sexual and reproductive health, when I need them" and "I believe that health care workers are well." 35% of respondents have experienced violence from a sexual partner or spouse, 28% have experienced violence from a member of family/ neighbours, 40% have

experienced violence in the community, 57% have experienced violence in health settings, 17% have experienced violence from the police/military/prison or detention services, 58 have experienced fear of violence.

Impact of the programme:

The current program was designed, led and conducted by women living with HIV. 1 000 women from all Ukraine's regions (including warzone aria), completed the survey's questionnaires, which was conducted in 2 languages. The survey was supported by National Reference Group of women living with HIV with diverse expertise and backgrounds and are leading national activists. This is the largest survey of women living with HIV in Ukraine (including 57 women-activists and services providers in 4 focus groups). Respondents came from a diverse range of backgrounds and experiences, including women who: are heterosexual, use drugs, do sex work, are single, in stable relationships, have tuberculosis (TB)/malaria/hepatitis C/other co-morbidities, have been incarcerated, are internally displaced, have other disabilities, have been detained, incarcerated or who have been homeless. This research is comprehensive: it helps to identify the challenges on reproductive health and to determine the scope of human rights violations and incidences of discrimination and stigma. The very fact that it is the women themselves that supervise, coordinate, and directly collect the initial data greatly increases the probability of reliability of the collected information, frankness in the responses, and reduces avoiding answering the touchy questions, which often happens in surveys.

This programme has responded to general concern and helped to overcome knowledge gaps considering the trends in the expansion of the epidemic and its gender profile. Besides, the programme discovered significant setback in female participation in the decision-making and consultative bodies on HIV/AIDS at regional (oblast) and national levels. Program contributes in empowerment of women living with HIV. This survey is their ownership and instrument to strategize advocacy actions.

Financing and management:

The programme was managed and coordinated by the Positive Women NGO (Ukraine), in collaboration with women's rights advocates, activists, regional affiliates of All-Ukrainian network of PLHIV. The project proposal is directly linked with the implementation of the Outcome and outputs 2.1 of the UN Women ECA Regional Office's Project 00095737 on "HIV and AIDS Strategy implementation". Total budget: $59,000

Lessons learned and recommendations:

The research used an appreciative enquiry, life course approach, grounded in human rights. It aimed first and foremost to identify what is already working for Ukrainian women living with HIV, in the context of the realities of their lives, and to build on these achievements to strengthen the HIV response in relation to the human rights of women living with HIV. To this end, the implementers intended to reflect on all stages of women's life, from conception to grave, and to give voice to women to tell their stories through the platform of the survey. A secondary intention was to support women's advocacy at local, regional and national levels to make significant contribution to HIV pandemic response. We managed key challenges, which accordingly stimulated programme success:

- Ethics Approvals: Dependent on the methodology proposed and agreed upon for the country-level study, ethical approval was obtained prior to initiation of data collection with appropriate national and international bodies.

- Participatory approach: careful and thoughtful involvement of women living with HIV as implementers, consultants and respondents stimulated their awareness and helped to alleviate their rigidity for participation and inclusion. The survey and focus group discussions were supported by the National Reference Group of women living with HIV who are leading Ukrranian activists.
- Local partnerships: The inclusion of local partners for implementation of country-level study was a priority throughout the full cycle of the studies. Local partners represented HIV-service NGOs, government agencies and sociological companies.
- Partnerships with gender human rights NGOs helped to widen the focus to key issues of Human rights and general social and cultural context for people living with HIV.

58. Ukraine

Title of the programme: All-Ukrainian “Legalife-Ukraine” (for sex workers)

CONTACT PERSON
Name: Natalia Isaeva
Title: Director
Organisation: All-Ukrainian Charity Organization “Legalife-Ukraine”
Address: Ukraine, Kirovograd, Marko Volochka st. 18
Tel: +380979790474
Email:nataisaeva.isaeva@gmail.com

Implemented by: Civil Society
Scope of submission:
Community-responses in the humanitarian, Advocacy, campaigning and participation in accountability, Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers etc) and Participatory community-based research in relation to sex workers

Background:

The sex worker community started its activities in Ukraine in 2009 with the aim of community strengthening, community mobilization and empowerment, as well as for the purpose of advocacy, awareness-raising and improvement of the quality of services provided both by state bodies and NGOs. The sex worker community is marginalized and constantly discriminated against everywhere in Ukraine. Sex worker’s human rights are being violated by police and medical staff because of the widespread belief that sex workers can afford to pay for the otherwise free services. It is believed that all sex workers are HIV-positive substance abusers who are also a factor of infection. Sex wok in Ukraine is penalized. Many sex workers are avoiding conflicts with police and continue to pay corrupt policemen for the so-called permission to work. Police continues using physical and psychological violence and extorting bribes. Even when a sex worker is paying, the detention protocol for the administrative offence of prostitution may be drawn. Sex workers are forced to provide sexual services for free (in the framework of the so-called «subbotniks”). Both police and medical workers disclose confidential data about sex workers health, namely their HIV status and dependence on drugs to clients and family members, and this leads to the escalation of violence. Sex workers thus become psychologically and materially dependent on police and medical workers. Sex workers’ access to justice is limited, they do not have a possibility to complain about human rights violations and power abuses by police and medical workers. Sex workers, who decide to complain, will be

harassed and targeted for physical and psychological violence not only directly by perpetrators themselves but also through other sex workers. Sex workers become more vulnerable to violence and are frequently depressed. Frequently, we also come across cases when a sex worker will have drugs or arms planted on her while she is in detention. They will often be charged with pimping, which is a criminal offence. This situation breeds violence and promotes extortions of bribes. As a result, sex workers are afraid to go to police when their constitutional rights, their human rights, are being violated. Due to stigma and discrimination, sex workers also lack motivation to turn for health services.

Description:

The goals of the program were to improve sex workers' access to justice, to reduce violence and human rights violations and further hold perpetrators accountable; to improve access to medical and social services as well as egagement with authorities. We were also striving to strengthen sex workers' community and our own feeling of self-worth and self-esteem and to improve our literacy. We have initiated change of legislation around sex work in Ukraine and worked towards the impovement of the general situation around the epidemics with the help of the data on human rights violations by police we have collected. We also submitted reports to various human rights bodies that had influence over sex workers' situation in Ukraine.

Financing and management:

The sex worker community at its inception was supported by the International Charity Foundation "HIV/AIDS Alliance in Ukraine (currently "Public Health Alliance) and funded from the GFTAM's funds. This support was both for various trainings and sex worker mobilization. As a result, the first sex worker organization in Ukraine, the All-Ukrainian League Legalife was registered; it had both sex workers and outreach workers from the service providing organizations among its members. The All-Ukrainian League Legalife was engaged in community mobilization.

The support came to an end in 2013, and the Alliance started to focus more on supporting PUD/substitution therapy clients' community, leaving sex workers confused and lacking financial stability.

As a result of the capacity building, the second organization, All-Ukrainian Charity Organization "Legalife Ukraine," was registered in 2012. The organization conducts active advocacy and awareness-raising, as well as provides community based services. The members of this organization are meaningfully engaged in the work of various working groups and councils that monitor and evaluate services. Legalife Ukraine's key priorities include advocacy, monitoring availability and quality of services (not only for sex workers, but also for PUD, MSM/LGBT, prison inmates, children and young people as well as their communities). We shape the demand, lobby sex worker community interests, provide consultations to community itself as well as to service-providers. We conduct various community-based researches as well as serve as external experts in other's research. Since the funding is scarce and the working hours are limited, the main focus of Legalife-Ukraine's activities is advocacy and provision of various services, including legal services.

Open Society Institute is our main donor; some of our activities have also been supported by the Red Umbrella Fund and some other international donors. The latter, however, were short-term and project-based; we could not substantially impact the situation and were not able to attract additional funds.

Lessons learned and recommendations:

Community engagement in prevention and treatment programs is lacking. Sex worker led organizations have never implemented GFTAM and other major donor funded programs aimed at service provision (HIV-prevention, treatment, care and support; legal services, etc.), and have never received relevant funding. Currently GFTAM primary recipients and sub-recipients are unwilling to disburse funds to sex workers themselves. There are services provided to sex workers without sex worker engagement. Even when sex workers are employed by the services providers as outreach workers, they have no due influence over the quality of services for sex workers. NGOs and other stakeholders believe that they know better what sex workers need. These NGOs currently pose as sex worker community partners, but if the community will insist on taking programs over, they will become enemies. In order to stop the HIV epidemics in Ukraine, communities should implement programs and provide services itself. This will be the most powerful response to the epidemics.

Sex worker community and sex worker led organizations are mobilizing their own resources and are trying to fundraise for further community mobilization and capacity building, but these efforts are not enough!

Sex workers are trying to strengthen their voice and influence decision-makers by nominating themselves into various bodies!

IV. Latin American and Carribean States

57. Argentina

Title of the programme: Key Population Friendly Health Services (FHS)

CONTACT PERSON
Name: Carlos Falistocco
Title: Director of AIDS and ITS of the Health Ministry of Argentina
Organisation: Direction of AIDS and ITS of the Health Ministry of Argentina
Address: 1925 9 de Julio Avenue Buenos Aires City
Tel: +54-11-4379-9000 Int. 4056 or 4017
Email: cfalistocco@msal.gov.ar

Programme is being implemented since: 2010
Implemented by: Government, Civil Society and UN or other intergovernmental organisation
Scope of submission: Community-based service delivery (i.e. testing, prevention, care, and support, treatment, legal services, task shifting, training of health care workers, etc.) and Community financing in relation to people living with HIV, men who have sex with men, sex workers, and transgender people

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

The HIV epidemic in Argentina, as in the rest of Latin America, is concentrated and disproportionately affects gay and other men who have sex with men (12-15%), transgender women (34%) and female sex workers (2-5%).

This epidemiological reality makes it important to design policies and practices in such way that the barriers these populations experience in accessing services will be reduced. It is not enough to have public health services available but they also need to be accessible and acceptable to the key populations most affected by HIV. This can only be achieved by the involvement of these populations in the design and implementation of the services. The FHS project was initiated in order to respond to this challenge.

Consequently, a Friendly Health Services Program was designed and implemented by the AIDS and STI Directorate of the Ministry of Health of Argentina, in collaboration with the United Nations Development Program (UNDP), the United Nations Program on HIV and Aids (UNAIDS), United Nations Population Fund (UNFPA) and the Pan-American Health Organization - World Health Organization (PAHO-WHO) and with participation of civil society organizations, aimed to guarantee access to stigma and discrimination free health facilities and to implement programs to address specific determinants of vulnerability of LGTBI and of sex workers. The initiative started in 2009 with a study implemented in 14 geographical areas to better understand the social and cultural aspects of sexual diversity in different regions of the country and to identify barriers in accessing public health facilities. The affected communities were actively involved in the design and implementation of this study.

Three factors were identified as main obstacles for LGTBI population and sex workers to access to health services:

- Concern about disclosing their sexual orientation and sexual practices because of the possible negative impact on the relationship with health care providers
- Fear of the transgender individuals of being discriminated against and mistreated by health care providers
- Lack of capacity and sensitivity of health care providers to address LGTBI health needs

These findings and the epidemiological evidence that HIV epidemic is concentrated in these population groups justified the design of a strategy aimed to guarantee access to comprehensive health services for LGTBI as well as for sex workers as part of the national policy on universal access to prevention, treatment, care and support, and taking advantage of the legal framework which supports the human rights of LGBTI populations.

Description:

With the objective of increasing access to HIV prevention, diagnostic and care services for LGTBI as well as for sex workers, the “Friendly Health Services (FHS)” project was implemented in 2010. In line with international guidelines and recommendations, and to guarantee sustainability, the program builds on existing health resources, involves LGTBI groups and is implemented by health care providers in collaboration with NGOs who have work experience in HIV/AIDS and sexual rights. NGOs are responsible for reaching out to the target population in the community, promoting access to services and providing support to patients.

Health providers in public services have been trained, amongst other topics, on sexual diversity and human rights, structure and operation of friendly health services, hormone therapy, anal health, and diagnosis of HIV and other STIs; as well as legal aspects of HIV and human rights.

Health facilities that participate in the program work with flexible schedules, especially during the evenings and, on demand, provide a number of services such as clinical care, counseling, HIV and other STI diagnosis, psychosocial support and hormone treatment for trans people.

The National AIDS and STI Directorate of the Ministry of Health is responsible for the coordination of the project through a steering committee that ensures:

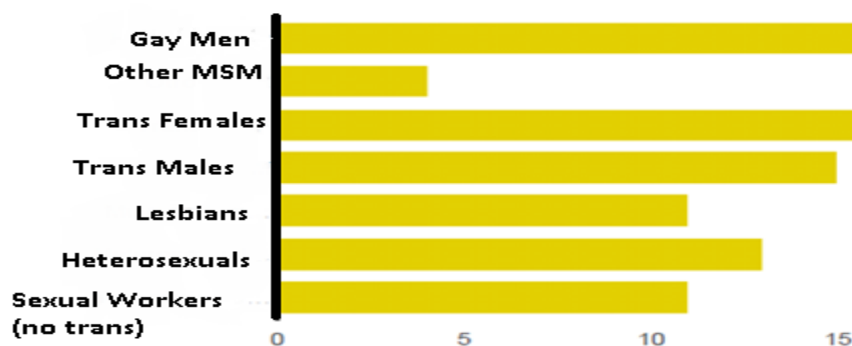
- Training of health care providers on LGBT health
- Financing of NGO projects directed to prevention and health promotion for LGBTI
- Provision of supplies needed for project implementation (education materials, condoms, lubricants)
- Monitoring and Evaluation of the program

Results of the programme:
The following table shows the 21 C.A's geographical location and year of creation.

Province	Location	Health Care Center Name	Year of creation
Buenos Aires Province	Mar del Plata	Centro de Salud 1	2010
	San Martin	Hospital Local Alexander Fleming	2012
	Lanús	Hospital Evita	2012
	José C. Paz	Centro de Salud "Las Heras"	2013
	Tigre	Programa municipal. Varios centros de salud.	2013
	Ezeiza	SPF CPF 1	2013
	Chivilcoy	CIC	2014
	Morón	Hospital Municipal Lavignole Consultorios Externos	2014
Buenos Aires city		NEXO	1992
		Hospital Ramos Mejía	2006
		Centro de Salud y Acción Comunitaria 11	2009
		Centro de Salud y Acción Comunitaria 25	2013
		Hospital Fernández	2013
		Hospital de Clínicas	Sin fecha
Santa Fé	Rosario	Centro de Salud Martin	2006
	Rosario	Hospital Centenario	2012
San Juan	San Juan	Hospital Dr. Guillermo Rawson	2010
	Departamento Rawson	Centro de Adiestramiento René Favaloro	2010
	Pocitos	Hospital Dr. Federico Cantoni	2014
	Chima	Centro de Salud Baez Laspiur	2014
San Luis	Villa Mercedes	Policlínico Regional Juan Domingo Perón	2013

FHS visited by each group

For example: of the total of 21 FHS, 18 were visited by gay men.



Gay men	18	85.7%
Other MSM	4	19%
Trans Females	20	95.2%
Trans Males	15	71.4%
Lesbians	11	52.4%
Heterosexuals	13	61.9%
Sexual workers (no trans)	11	52.4%

References:

- Gay men: men who perceive themselves as gay
- Other men who have sex with men: men who have sex with men but do not necessarily perceive themselves as homosexual.
- Females Transgender: people born with male genitalia that identifies themselves as women
- Males Trans: people born with female genitalia that identifies themselves as men
- Lesbian: women whose sexual orientation is homosexual and identified themselves as lesbian
- Heterosexuals: men and women with heterosexual orientation or self-perceived in a sexual diversity category but opt to no disclose their orientation or preferences. In many cases it is people of heterosexual orientation that take advantage of the friendly schedules of the services (afternoon, evening)

The population that mostly uses the friendly services of the program is transgender people, mainly transgender women, followed by gay men. This could be due to the fact that this has been the most discriminated population in health services and because they have very specific health needs (hormone therapy, implants, surgery).

Total number of people who accessed to the 21 FHS (2010-2015)

Population group	Number of people accessing the services
Gay men	2353
Men who have sex with men	3

Trans Female	900
Trans Masculine	119
Lesbian women	467
Heterosexual men and women	1465
Sex workers (not including transgender)	202
Total	5509

While the number of consultations of the gay population in this table is higher than the number of consultations by the trans population, it is important to note that trans females accessed the services in 20 of the 21 FHS locations in the different parts of the country (i.e. only one of the centers did not have consultations by transgender population).

Impact of the programme:

- The program has been sustainable over six years of implementation and is part of a public policy that guarantees access to health care to the LGTBI population as well as sex workers, with a human rights perspective.
- The program has helped reduce stigma and discrimination towards the target populations and has increased their uptake of services.
- The program provides training for health services personnel and includes the production of educational material for health services, LGBTI people and the general population.
- The program set up a network of 21 friendly health services along the country that operate in accordance with the policies of the National Aids and STI Directorate.
- The program, aimed to address the specific health needs of the target population, is built on existing services and resources, which ensures sustainability.
- The program fully involves civil society organizations and key population groups, particularly transgender women, enabling partnerships between the public sector and civil society.

Financing and management:

In the initial phase of the program, some of the FHS received seed funding from UNAIDS and UNDP while others have received a subsidy from the National HIV-AIDS Directorate of the Ministry of Health to support the work of the non-governmental organizations (NGO). Professionals and civil society promoters are financed by provincial and municipal health systems. In the case of the province of San Juan, trans promoters are financed by the local Ministry of Labor. GECAL program (Managements employment in job training).

Lessons learned and recommendations:

- The role of community promoters is essential to promote the demand for the health services. Promoters should represent the different groups of sexual diversity, mainly people who identify themselves as gay or transgender. Lesbians and sex workers should also be included as appropriate for each location and context.
- It is necessary for the promoters to be individuals who openly self-identify themselves as gay, transgender, lesbian, sex worker, etc. However, it is also important for the person to have or to acquire peer work experience so that they can build bonds of trust with the target population
- It is important to know community settings to promote services, particularly in “red zones” or sex work circuits where dangerous situations can be generated if unaware of

the context.
- The distribution of free condoms and gels is an indispensable resource for promoters' work.
- The offer of hormone therapy with the support from the health team has been one of the most valued aspects of the program by the transgender population.

In relation to FHS location and schedule, the following lessons learned can be highlighted:
- For the target population, the evening is the best moment of the day to access services, which needs a special service schedule.
- It is advisable for services to start by opening four hours once or twice a week. Since these working schedules require a greater effort, it is not advisable to extend for longer unless the service counts with different health teams to cover attention. It should be noted that demand of services from target population increase over time as trust in services is built.
- In most localities it was observed that FHS was the entry point to the health system for the target population who is traditionally excluded from the health system. The FHS also allowed these populations to access the other health services provided within the same facilities.
- It is recommended FHS be located in easily accessible locations, close to the entrance of the hospital.
- It is extremely important to identify the FHS when it is located within the hospital. Distribution of brochures with clear indications of the location has demonstrated to be a good practice.
- The teamwork must anticipate how to handle those aspects that are usually resolved during the day (i.e. during usual hospital opening hours), such as medical records, referring system, storage and processing of blood samples, provision of basic medication, cleaning services, etc.
- Although this program is related to HIV AIDS care, the experience shows that FHS should be located within the general health facilities of the hospital, and served by general practitioners and gynecologists, leaving the infectious disease specialist for referrals when needed. Opening FHS within infectious disease or HIV specialized services reinforces the false and stigmatizing relationship between AIDS and LGTBI population, which discourages demand of services by the target population.
- The FHS can successfully operate both in a public hospital as well as in health facilities of the first level of attention. While the hospital may offer the possibility of multi specialist medical assistance, primary health care facilities are friendlier community-based and can offer interdisciplinary attention.

58. Argentina

Title of the programme: LGBT Citizenship Plan: From legal equality to real equality

Implemented by: Government and Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc) in relation to people living with HIV, men who have sex with men, sex workers, transgender people, women, and young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes

Is the programme part of a national emergency response plan? Yes

Background:

The HIV prevalence in the general population of Argentina is estimated at 0.4%. However, it is worrying that there is a high HIV prevalence among gay men, especially among those between the ages of 18 and 25 (estimated at 12-15% by the National AIDS Programme) and among transgender women (estimated at 34%).

Despite the fact that Argentina has laws that advance equality for the LGBT populations (such as the Equal Marriage Law of 2010 and the Gender Identity Law of 2012), in practice discrimination on the basis of sexual orientation or gender identity persist all over the country, especially in places where the different forms of violence and discrimination have traditionally been invisible and/or naturalised in some ways.

It is also worth noting that despite the recently adopted protective laws, the current legal framework does not explicitly protect LGBTI against discrimination or recognise the rights of these populations to the equality of opportunities and to equal treatment in all settings. Many provinces and municipalities have by-laws that effectively criminalise homosexuality or transgender individuals and transvestites. Many of these by-laws allow the police to penalise certain behaviours without judicial intervention, and they often lead to institutional violence by the police against LGBTI and have a negative impact especially on the ability of transvestites, transsexuals and intersex, and to a lesser degree lesbians, gays and bisexuals to fully exercise their rights as equal citizens.

Civil society organisations that work with and for the rights of the LGBTI populations receive increasing numbers of complaints and queries related to discrimination as well as to social issues, such as integration of LGBTI in the context of the family, school and the workplace. A specific response is needed to address these situations and to provide guidance and accompaniment to the individuals involved.

The "*Project for the provision of integrated care for gay men and other men who have sex with men in Latin America and the Caribbean*", developed by an expert group convened by the Pan American Health Organization (PAHO) established that "… the health problems among men who have sex with men have profound impact on the health and wellbeing of men who have sex with men in Latin America and the Caribbean." The HIV epidemic, for example, demonstrates this clearly. In the region, men who have sex with men have 33% higher possibility of being infected by HIV than the general population.

In relation to the policies to address this reality, the same PAHO report adds that "despite of the evidence that HIV epidemic is increasing among men who have sex with men, only a few countries in the LAC region have taken proactive measures to address this crisis, or to establish adequate health services for the vulnerable or at-risk groups. Programmes targeted to men who have sex with men account for only 1% of the total HIV expenditures in the LAC region, despite the fact that a quarter of the people diagnosed with HIV are men who have sex with men. This reflects a general tendency since few resources in the region in general are dedicated to supporting the MSM communities." The experts add that "the key to understanding this omission and the barriers that men who have sex with men face in access to services is the context of social exclusion and marginalisation experienced by these communities. HIV and other health problems are a reflection of that marginalisation and exclusion. Despite three decades of

advocacy by the gay communities around the world for the recognition of their human rights and for an equal access to health services, men who have sex continue to encounter obstacles in their access to HIV and other health services (including general health services, drug addiction services, mental health services).

The programme ***LGBT Citizenship Plan: From legal equality to real equality*** aims to address these underlying social determinants of the vulnerability of gay men, other men who have sex with men and transgender women to HIV, to create a supporting legal and policy and framework for the HIV response, and to advance the equality, social inclusion and human rights of the LGBTI communities as a whole. In fact, the overall objective of the programme is the advancement of the human rights of the LGBTI. However, HIV prevention and access to HIV and other health services are among the main objectives within the programme. The programme is an important platform for the HIV response among the LGBTI communities in Argentina and contributes positively to several health and social indicators among these populations.

Description:

The programme "*LGBT Citizenship Plan: from legal equality to real equality*" is an effort to realise the rights of the LGBTI communities in all spheres of life and sectors of government though practical measures that promote equality and social inclusion.

The first action of the programme was the development and publication of the first version of the "Citizenship Plan for LGBT" in 2011 (http://www.falgbt.org/ciudadania-2/plan-for-lgbt-citizens-2012/), produced with the support of UNAIDS and UNDP. The Plan is a compendium of different laws, policies and other measures which are necessary in order to achieve equality for the LGBT populations in all spheres of life. It serves as an advocacy tool, has given a momentum to the establishment of policies and practices for the LGBT social inclusion and has strengthened the collaboration between the State, civil society and international organizations. The plan was reedited in 2013 to reflect the legal and policy reforms achieved as well as the lessons learnt in the implementation of the plan (http://www.falgbt.org/ciudadania-2/plan-de-ciudadania-lgbt-segunda-edicion/).

Implementers:
The programme was designed by the Argentine Federation of Lesbians, Gays, Bisexuals and Trans (FALGBT), a civil society coalition which works to promote social inclusion and equality for gays, lesbians, gays, bisexuals, transgender and intersex people nation-wide, and is involved in the HIV prevention among these populations and in the improvement of the quality of life of people living with HIV. The Federation is composed of 70 member organizations and has presence in all the 24 Provinces of the country.

The FALGBT advocates for the implementation of the programme all over the country. However, the actual actions included in the Plan are implemented jointly by local governments (see below) and the FALGBT.

The FALGBT had a fundamental role in the advocacy for the Equal Marriage Law of 2010 (from the presentation of the original law proposal to the Congress, the lobbying for the multiparty consensus, and the initiation of legal cases across provinces to ensure the recognition of equal marriage through the court system). The FALGBT was also the motor behind the Gender Identity Law which was approved by a large majority of the Argentine Parliament in 2012 and which has had a significant positive impact on the quality of life of trans individuals.

The Federation also successfully advocated for the inclusion of the sexual orientation and/or gender identity as an aggravating factor in the crime of femidice of the penal code, and for the inclusion of same sex couples and single women within the coverage of the law on assisted human reproduction of 2013. More recently, in 2015, the FALGBT successfully campaigned for the approval of an anti-discrimination law in the city of Buenos Aires – a law which is considered one of the most advanced laws on the prevention and penalization of discrimination.

The actions included in the “Citizenship Plan for LGBT” are implemented jointly by the FALGBT and different areas of local governments through collaboration agreements signed between the FALGBT and the governmental bodies. Currently, the Plan is being implemented by the following local government institutions:

- Sub-secretary of the Sexual Diversity Policies of the Province of Santa Fe
- Provincial Directorate of Sexual Diversity Policies, Province of Neuquén
- LGBT Ombudsman, City of Buenos Aires
- Directorate for Sexual Diversity and Sexual Minorities, Province of San Luis
- Sexual Diversity and Citizenship Programme, Province of Santiago del Estero
- Sexual Diversity Programme, Province of Mendoza
- Sexual Diversity Programme, Province of Salta
- Sexual Diversity Offices of the municipalities of Rosario, Neuquén, Salta, Caleta Olivia, Puerto Madryn, Mendoza capital, Las Heras, Godoy Cruz, Maipú, Guaymallén, Moreno and Santa Fe

The objectives of the Citizenship Plan are:

- To contribute to the construction of a full citizenship for lesbians, gays, bisexuals, and trans in the whole country
- To propose a comprehensive set of policies that promote the rights of LGBT and increase social inclusion at national, provincial and municipal levels and in all the sectors of government
- To advocate for a national anti-discrimination law
- To advocate for legislation which explicitly protects rights and prohibits discrimination in the most important cities of the country
- To promote the establishment of spaces of dialogue between LGBT organisations and local, provincial and national governments
- To plan and implement activities to prevent the transmission of HIV in the LGBT populations
- To coordinate the activities of the LGBT organisations in the country with the National AIDS Directorate of the Ministry of Health, with UNAIDS, UNDP and other relevant actors
- To create linkages and advocate with local and Provincial governments, municipal councils, and Provincial parliaments with the objective to increase the access of LGBT to human rights
- To promote the establishment of a “friendly” services which are accessible and acceptable to the sexual diversity, especially in the area of HIV prevention and health in general

The primary focus of the Plan is advocating for affirmative action in the executive, legislative and judicial branches of the government. This includes law reform (e.g. the Equal Marriage law, Gender Identity law, laws and by-laws against discrimination), the implementation of friendly health services (e.g. the comprehensive and integrated health services for trans populations in

Rosario and Santa Fé), the availability of legal services specializing in LGBT issues (e.g. Ombudsman in the city of Buenos Aires) and other actions and campaigns that promote the full enjoyment of human rights by the LGBT populations.

The implementation of the activities included in the Citizenship Plan is financed by the budgets of the Provincial and local governments. These are agreed upon in the collaboration agreements signed with the FALGBT.

Results of the programme:

The Plan is currently being implemented in the City of Buenos Aires and in the Santa Fe, Neuquén, San Luis, Mendoza, Santiago del Estero, and Salta Provinces through different sub-secretaries, directorates, programmes and areas established through collaboration agreements between the different State institutions and the FALGBT. The Plan is also being implemented in the cities of Rosario, Neuquén, Salta, Caleta Olivia, Puerto Madryn, Mendoza, Las Heras, Godoy Cruz, Maipú, Guaymallén, Moreno and Santa Fe.

This geographic distribution means that over 10 million people across the country benefit from the programmes and activities being implemented.

Impact of the programme:

The programme "*LGBT Citizenship Plan: From legal equality to real equality"* has had an extremely positive impact. The impact can be measured in the quantity of services established, laws that have been approved, number of people who have accessed the HIV prevention, testing and care services, the number of services established in the context of the implementation of the Gender Identity Law and the Medically Assisted Reproduction Law, among others.

Some of the most important results include the following:

- Enactment of the Gender Identity Law and the Access to Integrated Health care for transgender people (Proposals A and B in the 2011 version of the Citizenship Plan)
- Derogation of the prohibition to donate blood by the trans and by gay men (proposal LN2 of the 2013 version of the Plan)
- Establishment of the Programme on the Integrated Health Care for trans population (proposal LN11 of the 2013 version)
- Enactment of the new Adoption Law (proposal LN7 of the 2013 version)
- Establishment of the LGBT Ombudsman Programme within the National Ombudsman's office (proposal LN11 of the 2013 version)
- Enactment of the Law on the Medically Assisted Reproduction which includes LGBT couples (proposal LN16 of the 2013 version)
- Enactment of the Anti-Discrimination Law which explicitly prohibits discrimination on the basis of sexual orientation or gender identity, among other grounds, in the City of Buenos Aires (proposal LP of the 2013 version)
- Establishment of the National Sexual Diversity Programme (proposal PE1 of the 2013 version)
- Establishment of the Sub-Secretary of Sexual Diversity Policies in the Province of Santa Fe (proposal PE2 of the 2013 version)
- Establishment of Sexual Diversity Areas, Directorates and Programmes in various Provinces and municipalities (proposal PE2 of the 2013 version)

- Implementation of the Integrated Health programme for trans people in the Province of Santa Fe (proposal S1 of the 2013 version)
- Establishment of the LGBT Ombudsman's office in the city of Buenos Aires (proposal LN11 of the 2013 version)
- New parental leave system which takes into consideration same sex couples in Tierra del Fuego (proposal LN9 of the 2013 version)

Financing and management:

The programme is funded from the budgets of the national, provincial and local State institutions. This helps guarantee the sustainability of the programme. The State actors manage the funds. However, the civil society organisations monitor their use and participate in the definition of the activities to be implemented and the direction of the programmes to achieve the proposed objectives.

Lessons learned and recommendations:

The success of this programme is based on the capacity of the Argentinean LGBT rights movement to mobilise itself throughout the country, thanks mainly to the FALGBT which brings together 70 local LGBT organizations. It is has been crucial for the movement to be able to leave aside the differences between the different organisations and to focus on the common objectives. It is important to note that the FALGBT has a pluralist structure which ensures the representation of all the political perspectives of the different political parties of Argentina within the Federation.

Because of this, the campaigns implemented by the FALGBT have ensured that the LGBT rights issues have been put high on the agenda of the different political parties, and have led to the adoption of various programmes and measures to increase social inclusion and the protection of human rights of the LGBT population.

Another important factor of success has been the increasingly inclusive social climate of the country, achieved partly through the adoption of the laws that promote equality and social inclusion. These laws have also helped empower the LGBT communities in the country. The capacity of the civil society to mobilise itself as well as the support of the different social sectors and of UNAIDS and UNDP, have also contributed to the success.

The main challenges have been the strong resistance of the Catholic Church to the sexual and reproductive health issues. In some Provinces, religious leaders have a close relationship with the decision-makers. However, the increasing visibility of the LGBT communities in the different parts of the country has given a human face to the issues and has allowed the organisations involved to overcome many of these challenges. This can be seen clearly for example in the Mendoza Province which is considered to be one of the most conservative ones in the country but which has adopted the Citizenship Plan and committed to implementing the activities included in it.

59. Bolivia

Title of the programme: Peer Educator Promoter Strategy in Men Who Have Sex with Men, Gay, and Bisexual (MSM GB)

CONTACT PERSON
Name: Amanda Tellería - Claudia Cardozo
Organisation: Hivos Principal Receptor
Address: Calacoto 25th Street, Corner by Fuerza Naval and Tomasa Murillo Avenues
Tel: +591-2-2118219
Email: atelleria@vih.org.bo ; ccardozo@vih.org.bo

Programme is being implemented since: 2013
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to men who have sex with men

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

To reduce the occurrence of new cases of HIV in the MSM GB population in our country, we have implemented activities through organizations called Sub receivers.

A 2010 study on Male Sexuality and HIV in Bolivia (SEMBVO) reported information the following HIV prevalence rates: 15% in Santa Cruz, 10.2% in Cochabamba and 9.6% in La Paz/El Alto. The Syphilis prevalence was determined by 10.2% in Santa Cruz, 5.7% in Cochabamba and 3.5% in La Paz/El Alto.

This study showed that MSM GB population was the most vulnerable and the most affected by the epidemic and it was therefore vital to encourage the development of strategies and actions that were reflected in the proposal of the ninth round by Bolivia to the Global Fund in the component HIV.

It was also the space to demonstrate the importance of having more appropriate and timely strategies, considering developing specific actions to improve understanding of the dynamics of the epidemic in this population group, and the interpretation and identification of various behaviors and attitudes towards STI and HIV that would help raise and improve the country's response to the epidemic. Likewise, the promotion and dissemination of strategies related to the correct and consistent use of condoms as a preventive practice of STIs and HIV was considered.

For this reason, one of the strategies proposed to enhance the promotion of community services for HIV prevention was the PEP strategy for HSH GB, which grouped the population of men who have sex with men, gays, bisexuals and transgender population into a single strategy effort during 2011 and 2012. But as a result of providing a specific and adequate attention to each population since 2013, this strategy was differentiated specifically for MSM-GB population.

Regarding the estimation population for this group, according to the UNAIDS estimation, the MSM GB population in our country reached 60,000 people.

The 2014 EPT study (study of prevalence and population sizes) showed that MSM GB population reached up to 34,416 persons throughout Bolivia, of which 24,406 correspond to

MSM in the greatest burden of disease population identified (Santa Cruz, Cochabamba and La Paz). The EPT study provided information on the knowledge of MSM GB population on HIV, showing that 67% of MSM GB had correct knowledge on the subject.

With this background and the need for activities involving the community HSH GB in preventive and promotional activities of health care in the field, and in order to show the results of the PEP MSM GB strategy, an evaluation in 2015 thereof was made to continue with its implementation and improve or redesign activities for future proposals for the new concept note for 2016-2018 management.

Description:

Geographical Coverage: National level in the 9 departments.

Executing Institution: The activity was implemented by three organizations Sub receivers:
- Asuncami, in the cities of La Paz/El Alto, Oruro and Potosí.
- Vivo Positivo, in the cities of Cochabamba, Sucre and Tarija.
- Fundacion Igualdad, in the cities of Santa Cruz, Beni and Pando.

Duration of intervention: 2013, 2014, 2015 managements.

The evaluation of the strategy was made in the country's principal axis during 2015 management.

Objective: To promote a change of behavior through prevention of STDs and HIV, promoting healthy behavior and correct and consistent condom use in MSM GB population nationwide.

Description: Strategy activity implementations were done through formal and informal activities. Formal activities were aimed at STIs, HIV and correct and consistent condom use. Empowerment activities were oriented on issues of interest of the population, such as self-esteem, stigma and discrimination, self-care, relationships and sexual diversities.

Within informal activities consisted of events that could be conducted interpersonally or be performed as a group such as the exhibition of films or specific activities of the population such as the Condom night in alternative spaces, the program takes advantage of situations and opportunities where key messages in a timely manner were held to enhance knowledge and self-care of the population.

Clearly we should also mention that these activities were developed by teams of PEP that, apart from being highly trained, had a high commitment and solidarity, even beyond their responsibility and character of volunteers. They had knowledge of the way in which the community is moving and, being mostly young people, they were aware of all the technological advances in communication and social networks that were used to reach the population.

In all the activities implemented, condoms as a prevention tool were provided.

Results of the programme:

- With the implementation of the strategy the following results were achieved:

Description	2013	2014	2015	Total

Number of trained PEP	47	48	34	79
Number of reached MSM GB through PEP strategy	2.840	4.581	5.401	9.039
Number of distributed condoms with PEP strategy	354.358	509.624	538.604	1.402.586

Impact of the programme:

- With the PEP MSM GB strategy focusing on the target population using activities seeking to encourage the process of behavioral change (STI prevention, HIV and correct use of condoms) and encourage access to health services, the organization has achieved an involved, attractive, innovative, flexible and appropriate context for each site activity.
- The evaluation of the PEP MSM GB strategy showed the potential of it to strengthen HIV intervention strategies in Bolivia and become an opportunity to work among the community, merging the National Program and the social context.

Financing and management:

Management and Coordination: The organization coordinates activities with the target population, with other sub receiver organizations, and, at times, with departmental programs.
Financing: The activities were financed by the Global Fund, through Fundacion Hivos
Activity budget:

Activity	2013	2014	2015
HSH GB	188,081.97	210,711.96	142,893.96

Sustainability: The continuity of the PEP MSM GB strategy and its activities with this population is of high interest and has raised the same within the new concept note proposed by the country for the 2016-2018 management.

Lessons learned and recommendations:

Learned lessons:
- Having trained PEP MSM GB nationwide (STIs, HIV correct condom use) has facilitated the implementation of the project.
- Regular monitoring of the activities of PEP through a standardized Monitoring & Evaluation system for coverage and scope of goals.
- The proximity of the Sub receivers and PEP MSM GB to vulnerable populations, as well as knowledge of the meeting places, and using creative strategies for finding MSM GB has facilitated the implementation of the activity.
- High commitments, solidarity, and a great sense of volunteerism have been indispensable for the implementation of this activity.
- The strategy PEP MSM GB has meant a series of efforts, achievements and lessons learned in the development of activities, illustrating aspects to be improved or reoriented to better implementation in the future.
- Increased coordination with other organizations of civil society (sub receivers, groups,

families) more closely and regularly has allowed us to reach many more MSM GB with informative and preventive activities.

- The specific approach of this population according to their needs and interests with the implementation of this strategy has provied to be a potential tool for the response to HIV.
- The provision of free condoms has motivated participation in the various activities of this population, and indirectly, has increased the possibilities of using this prevention tool.
- Continuous processes of formation of MSM GB PEPs have exposed spaces for personal fulfillment, strengthening their self-esteem, and showing them that they are able to achieve results and open doors to new opportunities for personal growth.

Challenges:

- Linking the PEP MSM GB to the public health system, seeking the sustainability of this strategy, and understanding the symbiosis between the public health system and the community.
- Achieving the PEP strategy as it extends to MSM GB that are not identified as such, which are considered adolescent population group, and those who could not come to activities because they are in rural areas.
- Achieve certification strengthening and competency profile of PEP MSM GB in coordination with the National Programme.
- Achieving greater leadership of the institutions of civil society and empowerment of beneficiaries.

60. Bolivia

Title of the programme: Peer Educator Promoters (PEP) Strategy for trans populations

CONTACT PERSON

Name: Amanda Tellería - Claudia Cardozo
Organisation: Hivos Principal Receptor
Address: Calacoto 25th Street, Corner by Fuerza Naval and Tomasa Murillo Avenues
Tel: +591-2-2118219
Email: atelleria@vih.org.bo ; ccardozo@vih.org.bo

Programme is being implemented since: 2013
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to transgender women

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

The second generation epidemiological surveillance study among trans women was done in 2012 and reported a prevalence of HIV of 19.7%, of 21.3% for syphilils, and of 1% for hepatitis B. These prevalences support the fact that the backbone of the country (the axis formed by La Paz / El Alto, Cochabamba and Santa Cruz de la Sierra) has the highest disease load, with prevalences in Santa Cruz of 29.3% for HIV, 25.9% for syphilis, 1.3% for hepatitis B; Cochabamba 27.6% for HIV, 32.8% for syphilis, and 3.4% for hepatitis B; and for El Alto/La Paz

6.4% for HIV, 12.9% for syphilis and 0% for hepatitis. Regarding knowledge about HIV, 29% of trans women who participated in the study had correct knowledge about this disease.

Due to the HIV and STI prevalence found in this population, upon their request and to better understand their behavior in order to strengthen and promote specific prevention strategies and activities, it was decided in 2013 to develop a strategy for peer educator promoters (PEP) for trans women. As such, this strategy was developed apart from a similar one for gay, bisexual and other men who have sex with men (PEP HSH GB).

This differentiated approach would provide better inputs for the development of STI and HIV prevention strategies more adequate for this population. Promotion of intensified community-based services with focalized and specialized interventions was also sought. Promotion and diffusion of strategies related to the correct and systematic use of condoms as tools for HIV and STI prevention were considered.

In 2015, in order to evaluate the reach of the implementation of the PEP strategy among trans populations, this strategy was studied in order to demonstrate its achievements, improvements and to redesign necessary elements for the future, and in order to write the concept note for 2016-2018.

Description:

Geographic location: La Paz / El Alto, Cochabamba and Santa Cruz de la Sierra

The evaluation of the strategy was done during 2015.

Implementing entity: Asuncami

Objective: Promote behavior change through STI and HIV prevention, promotion of healthy behaviours and correct and systematic use of condoms among trans Women in the Bolivian backbone.

The implementation of the strategy was done through formal and informal activities. Formal trainings included activities named replications and empowerment. Replication aimed at training on three subjects: STI, HIV, correct and systematic use of condoms. Empowerment activities were aimed at issues of interest of the population that would complement the strengthening of messages distributed in replications. Among those issues were the use of silicone, hormone substitution therapy, self-esteem, negotiation of condom use, stigma and discrimination.

Among the informal activities, events were done between persons, between the peer [trans] educator and the trans woman, or through work with groups, in such activities as elections of Miss Trans. These were thus done in alternative spaces and taking into consideration situations and opportunities where key messages were distributed, to reinforce the knowledge and self-care of this population.

For the development of these activities, trained peer educator promotors were present and, in all activities, condoms as prevention tools were distributed.

Results of the programme:

Description	2013	2014	2015	General Total
Trained trans PEP	8	8	7	23
No of trans reached	232	388	473	608
No. of condoms distributed at PEP trans activities	89.422	152.928	140.544	382.894

Impact of the programme:

- Information for prevention in self-care and improved knowledge on STI, HIV and AIDS.
- The PEP trans strategy was shown to be a potential complement to the response to the need to strengthen prevention strategies in the country, working closely with trans populations.
- This strategy has met the goals and targets proposed for the implementation of this Project.

Financing and management:

The activity was implemented by the sub recipient Asuncami, which coordinates actions with the beneficiaries and other sub receptors.

All activities here detailed were financed by the Global Fund, through HIVOS, the Principal Recipient.

Budget of Activities:

Activities	2013	2014	2015
TRANS	38,471.01	38,471.00	27,421.00

The continuity for the PEP trans strategy and activities with this population is of high interest.

Lessons learned and recommendations:

- PEP trans must be trained on HIV, STI, and correct use of condoms, which facilitates project implementation
- Trans women reached with information on HIV, STI prevention and correct use of condoms in Bolivia’s backbone have improved their knowledge regarding self-care measures that must be followed to ensure well-being
- Regular follow-up of PEP activities through an m&e system has provided inputs to improve activity implementation.
- Specific approaches of this population, in agreement with their needs and interests, with the implementation of this strategy, have been a positive way of potentially responding to HIV.
- Provision of condoms, free of charge, has promoted participation in several activities with this population and, indirectly, has increased possibilities of using this prevention

tool
- Continuous training of trans PEP has proven to increase self-esteem, showing them their capacity to achieve results and to open new avenues for personal growth.

Challenges:
- Linking trans PEP to the public health system, looking for sustainability of the strategy and of the activities as well as synergies between the public health system and community.
- Reaching a higher number of trans women that up to now have not been identified
- Achieve the strengthening and certification of trans PEP competency profiles in coordination with the National AIDS Programme.
- More regional leadership of trans populations, as well as empowerment of beneficiaries.

61. Bolivia

Title of the programme: Political Incidence Plan for the Allocation of Resources for the HIV/AIDS Response in Bolivia

CONTACT PERSON
Name: Gracia Violeta Ross Quiroga
Title: President
Organisation: National Network of People Living with HIV/AIDS (REDBOL)
Address: Calle Guerrileros Lanza 1563, 4TO Piso, Miraflores La Paz-Bolivia
Tel: 591-70678041
Email: graciavioleta@gmail.com

Programme is being implemented since: 2012
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to people living with HIV

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? Yes

Background:

Bolivia has 10 million habitants and an HIV/AIDS epidemic with a prevalence of HIV in 0, 05% of 14,312 cases (1984-June 2015). In 2010, Bolivia was declared a Middle Income Country; as a direct consequence, the international cooperation reduced drastically. Currently, 70% of all HIV care and prevention services are paid by The Global Fund. With the goal of achieving the sustainability of the AIDS response, the Bolivian Network of People Living with HIV/AIDS developed a *Political incidence plan for the allocation of resources for the HIV/AIDS response in Bolivia* independent of the international cooperation.

Description:

Objectives: To insert budget lines for HIV in 5 municipalities, departments or in the national government, independent of the international cooperation.

Actors: This program was implemented by people living with HIV and targeted the national, departmental and municipal governments.

Programmatic and geographic reach: This project was implemented in 9 departments of Bolivia and the cities of El Alto and Llallagua. It included advocacy for resources oriented for HIV care and prevention.

Primary focus: The main focus of this project was advocacy for budget allocation at country level. The strategy included the revision of local laws (HIV, autonomies and the Constitution) which guarantee the right to health. This project included a social mobilization with mass media.

Results of the programme:

The project benefited 10.000 people living with HIV that are known to be alive and LGBT communities that benefited from allocation of resources targeted for HIV prevention.

Impact of the programme:

The programme achieved: *Clear information on the budget sources destined for HIV, which started at the amount of 1 million Bs. (Bolivianos, local currency) in 2012 and ended with 8 million Bs. in 2015 (end of programme). *Information on budget available for HIV both from national sources and international aid. *Budget allocation for HIV in the municipalities of El Alto, Cochabamba, Santa Cruz, Sucre, Tarija and local laws for HIV in Pando, La Paz and project laws in Cochabamba and Santa Cruz. *Community mobilization among people living with HIV and LGBT communities with the aim of sustainability. *Visibility of people living with HIV as actors in political incidence.

Financing and management:

Management and Coordination: The programme was managed by people living with HIV members of the Bolivian Network of People Living with HIV/AIDS (REDBOL) with the administrative support of Association Un Nuevo Camino (ASUNCAMI) and Association Vivo en Positivo. Financing: The programme had financial support from HIVOS and the Global Fund. Partners: This project was implemented with support of ASUNCAMI, Vivo en Positivo.

Lessons learned and recommendations:

Institutional set up: This programme was implemented with the support of local organizations of people living with HIV such as ASUNCAMI and Vivo en Positivo, for the administrative role while

REDBOL focused on the political incidence and mobilisation. Legislative and policy environment: The programme allowed an in-depth revision of laws that guarantee HIV services (HIV law, Autonomies law and the Constitution). This project allowed the generation of local HIV laws in cities like Pando, Cochabamba, Santa Cruz, La Paz and El Alto. Coordination, Political, mobilisation and support: This programme allowed a better organization of communities living with HIV, a sharper strategy for advocacy and a uniformed discourse and demand. Advocacy: People living with HIV have a clear plan with a demand for resources for the sustainability of HIV care and prevention services. Challenges: The incidence with local authorities takes a lot of time. An overall evaluation of people living with HIV shows the project was successful in 40%; however any gains in 2012-2014 need a follow up. Constant change of local authorities was and continues to be a main challenge, new authorities don´t have information on the HIV epidemic and have no knowledge on how to plan and implement HIV projects locally.

62. Bolivia

Title of the programme: Body mapping gender based violence and HIV among women with HIV, transgender women and sex workers in 3 cities in Bolivia

CONTACT PERSON
Name: Gracia Violeta Ross Quiroga
Title: President
Organisation: National Network of People living with HIV/AIDS (REDBOL)
Address: Calle Guerrileros Lanza 1543, 4TO Piso, Miraflores LA Paz-Bolivia
Tel: 591-70678041
Email: graciavioleta@gmail.com

Programme is being implemented since: 2012
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Participatory community-based research in relation to sex workers, transgender people, and women

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Women living with HIV, transgender women and sex workers in Bolivia consistently report multiple forms of gender based violence; however these experiences were not captured in any report. The Bolivian Network of People Living with HIV with technical support of Cayetano Heredia University and the financial support of UNAIDS implemented a qualitative and quantitative study of HIV and gender based violence in 3 cities with the highest HIV prevalence in Bolivia. The project included an advocacy strategy targeted for local authorities.

Description:

Objectives: To explore the linkages between HIV and gender based violence among women living with HIV, transgender women and sex workers in La Paz, Cochabamba and Santa Cruz.

Actors: Women living with HIV, transgender women and sex workers. Programmatic and geographic reach: This project was implemented in La Paz, Cochabamba and Santa Cruz. The project only focused on self-reported experiences of gender based violence in the period of the study.

Primary focus: Community based participatory research, advocacy and empowerment.

Results of the programme:

The study explored the experiences of HIV and gender based violence in 340 women (survey) and 100 women (focus group and individual interviews) who were able to speak up about their gender based violence experiences, in most cases, for the first time. These women were able to meet with local authorities and speak up about their life experiences of HIV and gender based violence. The gathering of different groups of women allowed empowerment regardless of their specific identities or vulnerabilities.

Impact of the programme:

The programme achieved:
Data including graphics (body maps) of the linkages of HIV and gender based violence in the 3 populations of women.
Psychological support for women who had never spoken about violence.
Community empowerment and alliances between different groups of women.
Mobilisation of support from local authorities and sectors that typically don´t engage on HIV (churches, women and youth associations, etc.)

Financing and management:

Management and Coordination: This project was implemented by women living with HIV, transgender women and sex workers.
Financing: This project had financial support from UNAIDS.
Partners: This project had administrative support from Association Un Nuevo Camino (ASUNCAMI).

Lessons learned and recommendations:

Institutional set up: This project allowed strategic alliances between different groups of women who already face stigma and discrimination.
Legislative and policy environment: The project allowed awareness of laws that are supposed to be protecting women´s rights, access to justice and protect against the impact of the “macho” culture in Bolivia.
Coordination, Political, mobilisation and support: The project allowed the alliances with other partners that are not traditionally supporting these groups, such as the catholic church, feminist and women´s organizations.
Advocacy: The project allowed the discussion of alliances that start with the reality of gender based violence (not HIV).

Challenges: The level of gender based violence is huge in Bolivia and there is need to implement a follow up project oriented to on-going psychological support.

63. Bolivia

Title of the programme: 1st Report of Human Rights of People Living with HIV in Bolivia

CONTACT PERSON
Name: Gracia Violeta Ross Quiroga
Title: President
Organisation: National Network of People living with HIV/AIDS (REDBOL)
Address: Calle Guerrileros Lanza 1543, 4TO Piso, Miraflores LA Paz-Bolivia
Tel: 591-70678041
Email: graciavioleta@gmail.com

Programme is being implemented since: 2012
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Participatory community-based research in relation to men who have sex with men, sex workers, transgender people, women, young people, and indigenous people

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

People living with HIV consistently report multiple violations to human rights perpetrated by families, partners, health workers, employers and even public authorities. At the end of 2014, a local authority divulged the HIV status of another public authority in public television, thus violating the right to confidentiality. The Bolivian Network of People Living with HIV (REDBOL) organized a Rapid Qualitative Research of human rights with the participation of leaders/representatives from all cities in Bolivia. Subsequently, REDBOL organized 3 Local Dialogues on Human Rights and HIV.

Description:

Objectives: To conduct a Rapid Qualitative Research led by people living with HIV about the situation of Human Rights of people living with HIV and to conduct 3 Local Dialogues targeting local authorities and partners.

Actors: 35 leaders living with HIV from the 9 departments of Bolivia.

Primary focus: Rapid Qualitative Research led by community followed by an advocacy and empowerment strategy.

Results of the programme:

The Rapid Qualitative Research explored the situation of human rights among people living with HIV. The study concluded there are several violations to human rights of people living with HIV, specifically the sub populations (transgender, youth, children, indigenous, women, gay men, sex workers and incarcerated people living with HIV). The outcome of the rapid study was used to organize 3 Local Dialogues (La Paz, Cochabamba and Santa Cruz) on the situation of human rights of people living with HIV; these Dialogues targeted local authorities and partners from the wider civil society movement. People living with HIV and partners concluded the need to update this report regularly.

Impact of the programme:

The programme achieved:
Data including graphics (situational maps) of the situation of human rights of people living with HIV, organized in the 1st Report of the Situation of Human Rights of People Living with HIV in Bolivia.

Community empowerment and alliances between people living with HIV from different sub-populations working together with the issue of human rights as the centre of the advocacy strategy.

Mobilisation of support from local authorities and from civil society from the human rights movement.

Community mobilization using mass media creating awareness of the multiple violations of human rights in the context of HIV.

Financing and management:

Management and Coordination: This project was implemented by people living with HIV.

Financing: This project had financial support from HIVOS and UNAIDS.

Partners: This project had administrative support from Association Un Nuevo Camino (ASUNCAMI) and Association Vivo en Positivo.

Lessons learned and recommendations:

Institutional set up: Although the issue of human rights was central in REDBOL´s strategy since its inception, this project allowed the recapitulation of the centrality of human rights for the AIDS response.

Legislative and policy environment: The 1st Report of the Human Rights of people living with HIV in Bolivia includes a brief revision of the legal background that protects human rights of people living with HIV; plus a qualitative analysis of the gaps between what the law states and the daily lives of people living with HIV.

Coordination, Political, mobilisation and support: This project allowed the mobilisation of support from the Human Rights movement and some local authorities.

Advocacy: The project allowed the reaffirmation of the centrality of human rights for the AIDS response.

Challenges: Unfortunately, human rights of people living with HIV continue to be violated.

64. Bolivia

Title of the programme: Peer promotor Educator (PPE) strategy for STDs-HIV/AIDS prevention in key populations, antiretroviral compliance along with the peer promotor educators, Mutual Help Groups (MHG) with people living with HIV in the andean región of Bolivia.

CONTACT PERSON
Name: Javier Palacios
Title: Director
Organisation: Asociacion Un Nuevo Camino
Address: Guerrilleros Lanza Nº 1536
Tel: +591 (2) 2220484
Email: asuncami@asuncami.org

Programme is being implemented since: 2009
Implemented by: UN or other intergovernmental organisation
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to people living with HIV, men who have sex with men, and transgender people

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

Bolivia is a free, independent, sovereign, democratic, intercultural, decentralized Unitarian Social State of Plurinational Community Law with self-governing that founds itself in plurality, and political, economic, legal, cultural, linguistic pluralism. According to Health Ministry approximations through the Spectrum model in 2014, Bolivia had a total of 18,000 people living with HIV, with a national prevalence of 0.16%, a prevalence of 0.30% [0.2%-0.5%] in adults from 15 to 49 years, 1,300 new infections estimated until 2014 and an incidence of 0.10 per thousand people. Bolivia presents a gathered epidemic with a prevalence that tops 5% inside the gay, bisexual, men that have sex with other men (MSM) and trans populations. The first case identified in the country goes back to 1984. Since then, until December of 2014, 13,180 cases have been notified. Cases identified between 2009 and 2014 represent 71% of the records compiled since 1984. Starting in 2009, an annual average of 1,553 cases has been

notified, with 2,087 cases reported in 2014 alone. In 2014, 383 of the cases are in AIDS stage and 1,704 in HIV, recording an increase of 15% in the total of the cases reported of HIV and AIDS in comparison to 2013. The accumulated growth shows an exponential tendency that reflects in the apparition of new cases, mainly in the younger populations.

Description:

Educate and Prepare Peer promotor Educators that live with HIV work to find an appropriate approach to the rest of the poz population in order to achieve antiretroviral compliance, training about opportunistic infections, and constant clinical tracking and their pertinent health care centers. Certify effectiveness and tracking of the activities related to people living with HIV with antiretroviral treatment, to achieve an appropriate awareness with antiretroviral compliance. Elaborate a strengthen plan of self-supporting groups nationwide that includes a training methodology of people living with HIV at an urban and rural range. Use of innovative strategies that crucially contribute to increase the antiretroviral compliance in people that live with HIV. Make strategic alliances with other organizations that work with HIV. Create educational material that supports awareness and that teaches about the antiretroviral treatment, promote activism applying rights and obligations in different themes as antiretroviral compliance, stigma diminution, discrimination to people that live with HIV. Guarantee activities that strengthen the antiretroviral compliance, as a backup of methodological processes of awareness and appropriate record in the instruments of tracking and evaluation. Ease the access to condoms, promote the health care, testing and clinical tracking along with the state programs, health care centers for integral attention to people that live with HIV:

1. Strengthen the Peer Promotor Educator to expand the coverage of HIV prevention between MSM, gay and bisexual men. (Andean Region)
2. Boost the Peer Promotor Educator strategy to expand the coverage of HIV prevention between trans women in the main axis of the country.
3. Strengthen the mutual help groups and proactive accompaniment with peers that also live with HIV to achieve antiretroviral compliance, training about opportunistic infections and availability of monitoring tests to poz people.

Results of the programme:

	2008	2009	2010	2011	2012	2013	2014	2015
ACTIVIDADES REALIZADAS								
PROMOTORES EDUCADORES PARES CAPACITADOS		29	19	24	28	30	31	9
PARTICIPANTES EN TALLERES DE INFORMACION Y SENSIBILIZACION A HSH-GB	483	326	78	410	908	1014	1480	3416
TALLERES DE INFORMACION Y SENSIBILIZACION A HSH-GB		21	32	27	13	10	185	216
PARTICIPANTES EN TALLERES DE INFORMACION Y SENSIBILIZACION A MUJERES TRANS						251	202	887
TALLERES DE INFORMACION Y SENSIBILIZACION A MUJERES TRANS						25	50	55
GRUPOS DE AYUDA MUTUA CON PVV		5	13	36	85	134	141	136
PARTICIPANTES EN GRUPOS DE AYUDA MUTUA		381	60	200	90	814	1172	1018
SEGUIMIENTO A PVVS PARA LA ADHERENCIA AL TRATAMIENTO		1	45	154	151	80	179	140
DISTRIBUCION DE CONDONDES A HSH-GB		50250	6570	70501	138966	147098	243876	191784
DISTRIBUCION DE CONDONES A MUJERES TRANS						89200	137845	111648
DISTRIBUCION DE CONDONES A PVV		4569	2910	28784	31017	48390	61590	76662

Impact of the programme:

The impact of our program can’t be measured at this level, as ASUNCAMI we make operatives activities. The impact measure is concentrated in the Health Ministry.

Financing and management:

ASUNCAMI acts as a sub receptor of funds and activities from the main receptor HIVOS, to achieve an implementation of the Global Fund for HIV/AIDS, tuberculosis and malaria.

Lessons learned and recommendations:

As ASUNCAMI we consider the following factors as the keys of success.

- To get people involved with key populations with antiretroviral compliance
- Always consider necessities of the population that lived with HIV and their demands.
- Look for strategic alliances with health workers
- Be an institution affiliated to REDBOL, a national network that supports our work

65. Brazil

Title of the programme: Viva Melhor Sabendo (Live Better Knowing)

CONTACT PERSON
Name: Fábio Mesquita /
Tainah Lobo
Title: Community-based testing for key populations in Brazil: an experience by the Brazilian Ministry of Health in partnership with NGOs.
Organisation: Department of STI, Aids and Viral Hepatitis – Ministry of Health of Brazil
Address: SAF Sul Trecho 02, Bloco F, Torre 1, Edifício Premium, Auditório – CEP 70070-600 - Brasília/DF – Brasil
Tel: 556133157726
Email: fabio.mesquita@aids.gov.br /
tainah.lobo@aids.gov.br

Programme is being implemented since: 2013
Implemented by: Government and Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to men who have sex with men, people who use drugs, sex workers, transgender people, and young people

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Brazil's HIV epidemic is largely concentrated among key populations who are affected by intense discrimination and limited access to health facilities, increasing their risks to HIV infection - which can be up to 20 times higher than those observed in the general population. The many factors that affect the HIV epidemic require health policies to go well beyond biomedical responses, and look at key populations' behaviour patterns and at legal issues that have an influence on their vulnerabilities. In this regard, the 'Live Better Knowing' (Viva Melhor Sabendo – VMS) project, characterized by testing for key populations (female and male sex workers, people who use drugs, transgender people, gay and other men who have sex with men) in partnership with NGOs, proved to be a correct community-based testing strategy in tackling the epidemic in Brazil.

Description:

The VMS project is a nationwide initiative launched by the Department of STI, AIDS and Viral Hepatitis (Ministry of Health of Brazil - BMoH) in 2013 and, so far, a total 109 projects have been funded. Within the project, NGOs offered HIV testing, prevention education, counselling, prevention supply distribution, patients' referral to PEP and monitoring of their linkage to health services – from diagnosis to treatment. Testing is free and is carried out confidentially, in places where key populations usually meet, based on peer-to-peer methodology.
The test is offered in a timely, voluntary, and confidential way with the use of the rapid oral fluid HIV assay (DPP HIV-1/2 Bio-Manguinhos/Fiocruz) for screening and, if the result is positive, people are referred to a health service to complete the diagnosis and to be linkage to care. Participants are interviewed by means of a brief questionnaire containing sociodemographic data and high-risk behavior for HIV.

Results of the programme:

Between January 2014 and April 2015, a total 29,723 tests were administrated; among them, 791 (2.7%) presented a reactive result (Table 1). The greatest proportions of reactive results were found among transvestites (12.6%), transsexual people (6.2%) and MSM (4.8%). People who declared having had at least one STI in the 12 months immediately before the test presented 7.2% reactive results. Furthermore, among men who declared themselves commercial sex workers, the proportion of reactive test results was 8.7%.
Another important finding is that the proportion of reactive tests among people who had never before been tested for HIV was twice the proportion observed among those who had already been tested at some time (3.4% and 1.7%, respectively).

Impact of the programme:

The strategy has brought important outcomes: empowerment of NGOs –which, for the first time in Brazil, were able to carry out HIV rapid testing, a relevant structural intervention in the field of HIV prevention; key populations were reached by peers in their usual settings and routines – resulting in the acceptance of the strategy and its success; patients' access to health services and consequent linkage was eased by NGO teams. Thus, normative changes concerning the diagnosis of HIV in the country had to be made, so that lay providers (previously trained by the BMoH) could carry out testing.

Financing and management:

NGOs receive financial support through public notices, with free competition, published by the BMoH channels on the internet, based on suitability criteria for partnership with the public administration. For the Public Notice of conducting oral fluid HIV testing in key populations, NGOs need proven experience of at least three years in prevention approach to HIV/AIDS and/or community intervention for key populations. The selection notices for financing activities of NGOs are governed by the legislation and other related standards on the same matter
When it comes to management, mapping of testing sites and coordination with local health management and referral services are carried out. The beginning of field work is monitored through the technical supervision of the Department of STI, AIDS and Viral Hepatitis' team. Detailed information is provided in an institutional booklet. Frequent visits are made by the team to supervise field work and ensure its quality. For sustainability, we recommend that this strategy should be integrated into the routine of health services.

Lessons learned and recommendations:

VMS has eased the access of key populations to HIV testing and counseling, through peer point-of-care oral fluid HIV testing. Furthermore, the fact that the strategy is carried out by peers, in places of their special social interest and at alternative times of the day, has increased test acceptance by key populations.
One very important aspect in the implementation of the VMS was the intense contact it promoted between the Brazilian Federal Government and state and municipal STIs and HIV/aids managements. This kind of connection plays an important role within the operation of the Brazilian Unified Health System (SUS), since Brazil's three Government spheres – the Union, states and municipalities – are mutually independent, and their autonomy is ensured by the Brazilian Federal Constitution.
The large number of reactive tests found during the project – five times higher than in the general population – and the proportion of people who were never been tested for HIV before this project, reinforces the need for initiatives focused on the key populations that concentrate the highest HIV burdens. Therefore, one of the main challenges we observed is the need to expand strategies such as the VMS – thus achieving the capillarity necessary to a significant impact on the HIV/aids epidemic in a country with the continental dimensions of Brazil.

66. Brazil

Title of the programme: Educational Leadership in the Youth Movements - Activism and Social Mobilization to HIV/AIDS Response

CONTACT PERSON
Name: Fábio Mesquita /
Vitor Araújo
Title: Educational Leadership in the Youth Movements - Activism and Social Mobilization to HIV/AIDS Response
Organisation: Department of STI, Aids and Viral Hepatitis – Ministry of Health of Brazil
Address: SAF Sul Trecho 02, Bloco F, Torre 1, Edifício Premium, Auditório – CEP 70070-600 - Brasília/DF – Brasil
Tel: 556133157726
Email: fabio.mesquita@aids.gov.br /
vitor.araujo@aids.gov.br

Programme is being implemented since:
Implemented by: Government and UN or other international government organisation
Scope of submission: Advocacy, campaigning, and participation in accountability in relation to young people

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

HIV/AIDS epidemic in Brazil is concentrated in key populations (gay men and other men who have sex with men, transgender people, female sex workers, people who use drugs) and has

been increasing among the youth. Data shows that while in general population, AIDS detection rate has been decreasing, among people aged 15 to 24 years old, detection rate has been getting higher (Figure 1). Considering this epidemiological scenario and considering that:

1. In many public spaces, debates and policies the youth is underrepresented;
2. In many cases, young people struggle to have their voices heard in social movements and civil society organizations;
3. Young people need to deal with specific problems and have a specific agenda when it comes to rights, roles and responsibilities;
4. Young people have particularities regarding HIV/AIDS prevention, diagnosis, treatment and adherence to medication;

It was developed a strategy for young leaders' education to monitor and debate public policies of the Brazilian Unified Health System (SUS) and, also to share the knowledge for prevention, diagnosis and improvement of the quality of life of young people living with HIV/AIDS, from the perspective of peer-to-peer methodology.

Description:

In order to address the abovementioned issues and to encourage the youth to monitor and debate public policies of the Brazilian Unified Health System (SUS), three presential editions of the course "Educational Leadership in the Youth Movements" were held in Brasília. Young people of key populations who showed leadership were chosen, among them people living with HIV/AIDS, prioritising more vulnerable regions and populations. The five-day courses were held in 2015 with the themes: HIV/AIDS, SUS, human rights and key populations, leadership, activism, communication. In those five days, participants were encouraged to talk about specificities regarding their sexual and reproductive health, to discuss the current challenges of public policies within SUS and to find possible solutions to respond to the epidemic in their territories and with their peers. Peer education and youth empowerment are the main pillars of the project.

Results of the programme:

The three editions together counted 150 participants out of 1,019 applicants. With the exception of two states out of 27, there were representatives of all Brazilian states and all the key populations – an overcome challenge, considering the proportions of the Brazilian territory.
The participants agreed to report on the activities pursued in their communities for a period of one year and it was designed a network including all participants of all editions, so they can all be in touch, share examples of good practices within their territories and discuss the problems they still face in their communities.

Impact of the programme:

As the reports from the participants are being received over this year, the impact evaluation is a long term process. From the first round of reports that participants sent, it was already notable the change in the participants' knowledge on HIV/AIDS and what they were able to do in terms of advocacy and campaigning in their communities. Most of the youngsters visited HIV/AIDS related services in their territories; met the coordinators of the state and municipalities AIDS programs in order to evaluate and improve the focus on adolescent friendly services; engaged in civil society organizations that work with any of the key populations and their rights; and, engaged in online activism in social media and with their peers in the communities. Based on those feedbacks, one of the major results of the initiative was the profound change in the

youngsters' lives and in their role within the community.

Financing and management:

The courses were financed by the Department of STI, Aids and Viral Hepatitis of the Ministry of Health of Brazil and were developed in partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS-Brazil), the United Nations Educational, Scientific and Cultural Organization (UNESCO-Brazil), the United Nations Children's Fund (UNICEF-Brazil) and the United Nations Fund for Population Activities (UNFPA-Brazil).

Lessons learned and recommendations:

The constant search for a dynamic and participative methodology, and content based on the three axes of combination prevention (biomedical, behavioural and structural) has proved essential; the diversity of the participants showed that the search for representativeness within the selection process was successful, considering the size of the country and its social and cultural diversity. Another relevant aspect was the dialogue among people of different realities, strengthening the discussion of public policies (in order to build up a more comprehensive health care for the youth); and creating opportunities for young protagonists to change the HIV response in the near future.

67. Ecuador

Title of the programme: Methodology "The 4 M for empowerment" in the context of sexual and reproductive rights and prevention of HIV-AIDS within sex workers in Ecuador - Colombia border

CONTACT PERSON
Name: Pilar Pallares
Title: Coordinadora
Organisation: Asociación de Trabajadaoras Sexuales "21 de Septiembre"
Address: Esmeraldas-Ecuador
Tel: 593-986665429
Email: asotrasex21@yahoo.com

Programme is being implemented since: 2015
Implemented by: Civil Society and UN or other inter-governmental organisation
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to sex workers.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

On the border between Ecuador and Colombia, the dynamics of sex work are complex; the violence generated by present conflicts is affecting the overall health of female sex workers (FSW) which is increasingly vulnerable. We highlight some situations:

- The presence of "captive" men groups such as military, police, oil workers, armed groups (Colombia), drug trafficking and criminal networks trafficking for labor and sexual exploitation.
- The Imaginary of FSW that in this area "exists a lot of money" makes this activity profitable.
- A high-mobility or rotation of the FSW, who remain between 30-45 days in the same place and then move to another place. According to the rules of MOH, people must use the services within a limited geographical scope to home.
- Freedom of association limited by the owners of sex work establishments shows the articulation of these local networks to organized crime. Fearing legal and social reprisals, many FSW do not use the services or attend punctually for specific controls.
- Gender-based violence suffered by FSW and the entry into sex work is seen as normal, often due to the economic necessity that their families face and to increase their income. In the case of Colombian women, their vulnerability is greater, mainly because the lack of documentation and their mobility, which exacerbates the risk of falling into exploitation and danger.
- The status of migrant FSW from Colombia is the reason for its most vulnerable condition, to which stereotypes about Colombian women are added. They are categorized as exotic objects of pleasure, which allows the increase of the profits of the premises' owners; and in a strange country, far from their families and their support networks, they live in a circle of greater violence than the Ecuadorean SW, who perform their work in known spaces and without the stress of not having identity papers which enables them to exercise their rights. Arbitrary arrests are a form of structural violence and extortion is an intrinsic part of these practices, 32.3 % reported having delivered an average of $ 227 to be released. Sexual favors are another common form of extortion.
- The FSW know that they are vulnerable to sexually transmitted infections, so much so that 99% of respondents, along the four provinces that form the border with Colombia, use condoms with their clients. This high level of awareness responds to the training they have received from the organizations of sex workers, to the information received by the premises' owners, discussions and exchange of experiences among colleagues and also the service delivered by health professionals Comprehensive Sexual health Services, SAISS. However, we should mention that only 35% use condoms with their regular partners.
- If we compare this data with the fact that 70 % of the FSW mentioned that they end their workday intoxicated, the fact that 99% of them using condoms with their clients could be much lower.
- The care given to sex workers in specialized health centers of the Ministry of Public Health continues to focus on the care of their genitals with an epidemiological approach, neglecting the care of their overall health. 94% of respondents said that their health checks are performed frequently; however, this contradicts the fact that in the last year, 35% of women do not have the cytology test performed. The current Comprehensive Health Card is a conquest achieved by organized sex workers.

Description:

These considerations and the need to break-down the concept of " sexual = HIV and AIDS workers", raised the proposal "The 4 M's to empowerment "to be implemented within health services through borrowers, as well to the sex workers to reach their pairs.

Contents:

Following the contents of the methodology, considering important to have this report in detail due to the generation of important information for the workshops development:

The proposal has 4 axes:

1. I PROTECT MYSELF: SAFE SEX, For each sex a condom. protected sex
2. I TAKE CARE OF MYSELF: I go to the comprehensive health services, regulation 4911, comprehensive care guide for sex workers
3. I RESPECT MYSELF, I have rights
4. I LOVE MYSELF- I live free of violence. sexual violence, sexual exploitation, trafficking

Each proposal works from a case and / or from a specific information about the situation of sex workers. Information and questions that enable dialogue is presented.

After a participatory workshop with organizations of sex workers in Esmeraldas (in Sucumbios, it has not been possible to sustain an organizational process due to its highly dangerous), UNFPA and the Ministry of Health defined the methodology and a traveler case with cosmetics was built containing key ideas to strengthen the training topics. A methodological approach was developed so the workshop would last no more than three hours, due to the high mobility of women and the little time available for training.

The key idea contains a phrase that motivates and proactively remembers key messages of the training; this technique responds to the FSW a widely felt need and mentally integrates a reminder of each of the 4M messages.
Description of the Travelers Case:
A functional case with a notebook with information of the institutions where the violation of rights can be reported, a magnet with the same information, a male and female condom.

4 (four) Cosmetics.

- 1 LIPSTICK: I LOVE MYSELF-FREE FROM VIOLENCE
- 1 FACE POWDER CASE: FOR EACH SEX A CONDOM
- 1 EYE SHADOW: I GO THE COMPREHENSIVE HEALTH SERVICES
- 1 MASCARA: I RESPECT MYSELF-I HAVE RIGHTS

Results of the programme:

1. Defined and implemented the methodological proposal made with the participation of female sex workers.
2. 500 female sex workers know their rights route enforceability, and especially the right to a quality service.
3. 80 health professionals trained from selected areas. Implemented the methodology in the health service.

Impact of the programme:

- Local and national sex workers organizations, established with the MOH, advocacy and evaluation spaces to ensure the implementation of the established norm for FWS attention.
- Significant barriers that violate the human rights of the FSW are detected. The barriers are institutional, personal and social.

- The FSW require mechanisms to enable their empowerment, as the first element to exercise their rights. One of these mechanisms was the definition of a methodology to decrease the working time, be informed and know complaint mechanisms when right are violated.
- The implementation of the proposal has enabled allegations of personal cases and nationwide coordinated action of FSW organizations.

Financing and management:

- The United Nations Population Fund, UNFPA provided technical and financial resources for the structuring of the methodology
- The Association of Sex Workers "September 21" leads the training of FSW with the methodology peer.
- Trained health professionals at the Health Districts, realize training workshops at the health office in coordination with existing FWS organizations and / or directly with sex workers who are not organized. This is an important element of sustainability that will enable a continuous application of the methodology.
- The methodological support given by the travel case contents represents an innovative approach with prevention and protection messages related to the sexual and reproductive health care with rights approach, and a more comprehensive approach to prevention of HIV and AIDS STI.

Lessons learned and recommendations:

- It is essential to have the direct participation of female sex workers (FSW) in defining the agenda and work strategies. The MOH has considered the participation of nationwide sex workers organizations for the development of new legislation for comprehensive care of people who perform sex work.
- The high mobility of the FSW (average 40 days, remain in a fixed place), hinders a sustained training processes.
- Changes in the health care legislation, little known by the MOH, hinder access to the FSW health services.
- The decisions of local authorities to enforce regulations where local work is performed.

68. Ecuador

Title of the programme: Analysis of social behavior, sexual practices and HIV prevalence on Voluntary Counselling and Testing Service (VCT) of the Fundación Ecuatoriana Equidad Community Centre, at Quito, Ecuador.

CONTACT PERSON
Name: Efrain Soria Alba
Title: Coordinador General
Organisation: Fundación Ecuatoriana Equidad
Address: Av. Seis de Diciembre N24-253 y Lizardo García
Tel: (+593) 9 9252 9887
Email: efra88@hotmail.com / esoria@equidadecuador.org

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and

Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to people living with HIV, men who have sex with other men, sex workers, and transgender people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Ecuador presents a concentrated epidemic in men who have sex with men (MSM), with a prevalence between 11% and 19%, and in transgender and transsexual people (34%) in contrast with the general population (less than 2%). According to the Ministry of Public Health, it has an accumulated total of 41,375 people diagnosed with HIV by 2014, but only 13,300 people were undergoing treatment due to a variety of reasons. The public policy on health care has implemented a lot of improvements which must find a way to be sustainable. In contrast, there is the "Plan Familia", a National Strategy which directly depends on the Central Government, which focuses on prevention of teenage pregnancies, promoting the abstinence and traditional family values as a method of prevention.

Description:

The objectives of the VCT Service analysis are to establish the epidemiological profile of service users. It will delve into the most relevant aspects related to sexual behaviors, discrimination, and knowledge about HIV / AIDS inside the most affected populations (HSH and trans), in order to compare the national prevalence of MSM with the prevalence of MSM diagnosed by the Foundation. It will serve to improve the goals reached until now by the national response on HIV. In addition, the data generated by this analysis, will be extremely useful to create better communication strategies, not only for the campaigns which are created by the organization, but for the national efforts on communication.

Results of the programme:

During 2015, the VCT Service attended 987 HIV tests, 728 of which were MSM people. They requested the service from January to December 2015 in the Fundación Ecuatoriana Equidad Community Centre, at Quito, Ecuador.

Impact of the programme:

The Foundation complements the VCT service with a wide range of health services at affordable prices for the key populations. These services include: Medical Service, Psychological Service and Legal Service (this completely free). This whole package of services generate confidence among the population, because they feel they are accompanied by a team of professionals which works to reach better life conditions for LGBTI people and for those most affected by the HIV, including the couple and family.

Financing and management:

At the start of service in 2000 (the Foundation since its inception has always offered this service as a fundamental part of their community action), this organization received funding from

international organizations. Few years ago, this development assistance has been declining because Ecuador has been listed as a country of medium-high incomes. This is a challenge to make, not only the VCT Service but also the whole package of health services, sustainable. With this certainty, the Foundation is now looking for new strategies to generate our own resources. For example, paid consultants for private enterprises who need to, according to the law, create their internal policy of prevention of HIV.

Lessons learned and recommendations:

It is important for the work of the Foundation to have mechanisms of cooperation and coordination (institutional, beyond officials) with instances of health with both the national government as well as the sectional governments of cities, specifically Quito and Guayaquil. The whole experience of the Foundation could be used even better to enable research on the populations most affected by HIV. Universities with the EEF and who maintain cooperative relations could be allies in an initiative of this nature.

69. Ecuador

Title of the programme: Mapping of the encounter places of the most exposed populations (MAPLE – PEMAR)

CONTACT PERSON
Name: Amira Herdoiza
Title: Executive Director
Organisation: Corporación Kimirina
Address: Bosmediano E14-38 y Gonzáles Suárez, Conjunto Rodríguez
Tel: 2449585
Email: aherdoiza@kimirina.org

Programme is being implemented since: September 2014
Implemented by: Civil Society
Scope of submission: Participatory research based in the community in relation to men having sex with men and transgender people.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

In Ecuador, the available data of the HIV epidemic situation is limited and is insufficient to measure the relative importance in the design of interventions for the monitoring of key populations such as: Men who have sex with men (MSM), transgender women (TW), and female sex workers (SW). Moreover, the research has been developed from the health public sector, from civil society organizations or universities, and it has not always counted on the active participation of the communities, which will help identify some variables that characterized these communities and their relation to HIV.

Description:

The main objective of MAPLE - PEMAR, is to provide strategic information that supports the design and improvement of focalized prevention programs. The MAPLE - PEMAR study was designed in reference to the methodology of the Programmatic Mapping that combines the elements of the PLACE method, and the epidemiologic evaluation method. It was developed in 11 cities. Since the beginning, a technical committee (scientific and community-based) was formed, which had the participation of representatives of the three communities (MSM, Female sex workers and transgender women). The committee revised and approved the protocol and the instruments of data collection; there upon, it reviewed and discussed the results. Members of the communities participated in focal groups of the survey preparation and field mapping.

Results of the programme:

They obtained maps with 924 places located in 11 cities. The maps that were generated included (through symbolism), characteristics related with: type of group from the most exposed populations that visit them, sexual practices in the region, availability of condoms and the predisposition to carry out prevention programs. It also identified the characteristics of these places related to: schedule, days of more attendance and client mobility, average of consumption, services that are being offered, among others. Through individual surveys, it was possible to characterize the users of the encounter places, identify risky practices, as well as the access to prevention services of HIV.

Impact of the programme:

The results of the study MAPLE are being used for the planning of activities of the extension of the HIV Project supported by round 9 of the Global Fund, as well as the educational activities among pairs like those of the program of the community-based test “Say Yes, Test you”. The population sizes are being used for the calculation of the goals in intervention programs, such as the conceptual note of the Global Fund for Ecuador.

Financing and management:

The design and implementation of MAPLE, was in the charge of Corporación Kimirina, that worked with technical and community teams (MSM, transgender women and women sex workers) through its area of research in coordination with the National Strategic of HIV/AIDS-STIs of the Ministry of Public Health and the technical assistance of Coalition Plus and UNAIDS; the sponsor of the study was the Global Fund. In front of the utility of the programmatic mapping, there is a demand for the transferring of the methodology used in the MAPLE study for governmental and non-governmental institutions. Nowadays, the methodology is being used to maintain updated mapping and enlarge it to other cities.

Lessons learned and recommendations:

The programmatic mapping is a utility tool for the design of interventions that respond to the necessities of the most at risk populations. The methodology of the research and the implementation of programs have shown that the direct participation of key communities at all levels and with decision capacity is fundamental. Moreover, besides the knowledge and evidence that was generated, it has managed to empower community experts. To improve its utility, it is necessary to establish mechanisms of constant updating, supported by periodical publications and diffusion. This process should be institutionalized with the participation of civil society organizations where key populations contribute actively in synergy with the public health sector. At this time, it should be financed by the state and managed through public-private mechanisms, or with another organization like UNAIDS that monitors the HIV epidemic at a

national, regional and global level.

70. Guatemala

Title of the programme: Combined intervention to improve HIV and other sexually transmitted infections prevention for gay, bisexual and other men who have sex with men in Guatemala city

CONTACT PERSON
Name: Cesar Galindo-Arandi
Title: Secretario Junta Directiva
Organisation: Colectivo Amigos Contra el Sida –CAS
Address: 7 calle 3-42 zona 1. Ciudad de Guatemala. Guatemala. C.P.01006
Tel: +502 30097759
Email: cesar@galindoarandi.org

Programme is being implemented since: 2014
Implemented by: Government, Civil Society and UN or other inter-governmental organization
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to men who have sex with men.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

In Guatemala there are no friendly services for HIV diagnosis and treatment of sexually transmitted infections. The Guatemala Government, together with the Centers for Disease Control (USA) have tried to implement STI surveillance clinics (VICITS); however, few men who have sex with men (MSM) are attending them, due to stigma in these services, inappropriate opening hours for MSM, lack of counselling based on infection probability among gay men and lack of interest in recruitment efforts to increase access.

Description:

With the technical and financial support of the Guatemalan Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Centers for Disease Control and Prevention (CDC, USA), Del Valle University of Guatemala and the United Nation's Population Fund (UNFPA), Colectivo Amigo contra el Sida (CAS) implemented a combination intervention, with the objective of increasing access and coverage of HIV and STI diagnostic, treatment and care services for MSM. Four basic strategies were implemented.

a) Development of a behavioral prevention and community development model based on evidence (Mpowerment).
b) Implementation of an HIV and STI diagnosis service in a community center, near gathering spaces for gay, bisexual and other men who have sex with men in downtown Guatemala City.
c) Implementation of home and community-based testing.
d) Development of a recruitment model for MSM in order to increase access to testing and

prevention services through social media and the internet.

Results of the programme:

Mpowerment activities are implemented during the week; the community clinic has functioned for 15 months, on Saturdays, from 14:00 to 21:00. This schedule was extended in January 2016 from Monday to Friday from 16:00 to 20:00. Community based testing is done every day except for Sundays in places that are agreed between clients and health promoters. All the beneficiary population is recruited in Guatemala City and neighboring counties. To date, more than two thousand men have received services.

Impact of the programme:

The program has been very well received among MSM in Guatemala City and participation has been very good.

Financing and management:

The main financing source for this prevention program is the Guatemalan Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. There has been additional funding from UNFPA and the CDC (Atlanta, USA) through Universidad del Valle de Guatemala. Additionally, we have counted on the participation of 30 volunteers from CAS that have dedicated time and resources for the implementation of the program.

Lessons learned and recommendations:

a) Implementation of combination prevention activities to increase recruitment of people, offering diverse services, including social activities, education on HIV prevention, counselling and HIV testing in a community based clinic and home-based, diagnosis and treatment of STIs, mental health program, among others.
b) The location of this service in the country’s most important gathering zone for MSM, the historic center of Guatemala City, facilitates access to this population.
c) Services are available at schedules that are accessible for MSM. Activities are implemented at the end of the afternoon and early evening and weekends, facilitating increased coverage.
d) The addition of institutional efforts to ensure an intervention with multiple components facilitates access to prevention programs.

71. Paraguay

Title of the programme: Kuimba’e Clinic. Men’s Wellness Center in Paraguay.

CONTACT PERSON

Name: Simon Cazal
Title: Executive Director
Organisation: SOMOSGAY
Address: Independencia Nacional 1032 casi Manduvirá
Tel: 59521 495802

Email: simon@somosgay.org

Programme is being implemented since: 2009 and 2013
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.)

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

According the recent World Bank book published in 2015 ‘‘Shared Prosperity and Poverty Eradication in Latin America and the Caribbean’’, Paraguay has a volatile economy and one of the highest poor rates in the region which affects both the rural and urban populations, causing lack of opportunity amongst poor people. In addition, the fiscal system is not effective (http://bit.ly/1Qcez9Y). Paraguay is also characterized for its social and political context (and structure) of cultural misogyny and homophobia, and the lack of laws to protect LGBTI people which was made more evident with the recent advance of a neoliberal government led by the conservative and hegemonic party, which recently hit harder the advances in human rights and social development (http://nyti.ms/1Yuow9O, http://bit.ly/1Sks5eZ, http://bit.ly/1OgGEAY, http://bit.ly/1HnbYNj)) after a short period of transition of a progressivist coalition of parties and social movements. That process of transition was interrupted by a parliamentary coup, also led by the same party who again assumed the government in 2013 after 61 previous consecutive years of their governance. This general context in terms of public health, HIV, human and LGBT rights, disproportionately affects the key population and particularly to gay men, including all men, and other men who have sex with men.

The prevalence of HIV in Paraquay is 0.4%, with a total of 17,000 people living with HIV1. Studies indicate that up to 13% of men who have sex with men and 2.8% of female sex workers are living with HIV2. Homophobia including widespread stigma and discrimination in the health care system meant that there was no safe space for men who have sex with men to go for sexual health. In 2009, the Community Centre first opened and particularly welcomed MSM along with others to access HIV and syphilis testing and peer counselling. In 2013, the Kuimba’e Clinic was established specifically for men’s health and additionally for trans and female sex workers.

Sources:
1: http://www.ncbi.nlm.nih.gov/pubmed/18719799
2: http://www.unaids.org/en/regionscountries/countries/paraguay

Description:

Kuimba'e Clinic is situated in the SOMOSGAY Community Centre and is part of a wider programme to support men who have sex with men and people living with HIV. The programme was conceptualised and is implemented by members of the MSM and people living with HIV community. SOMOSGAY provides a range of social and health services, and advocates for public health, education and other public policies. It also provides an incubator for grassroots groups to meet and two such networks have already emerged – LEVOS a group of lesbian women and DIVERSA a national youth advocacy network of those living with and affected by HIV.

Kuimba'e Clinic is a wellness centre, offering free clinical care, testing, treatment vaccines and referrals, with particular emphasis on HIV and STI prevention. The clinic opens Monday through Saturday and operates a schedule that is not covered by the public health system. Peer counselling is offered for HIV along with condoms and water-based lubricants. Another closely linked programme 'Community Agents of Human Rights and Health' runs a cycle of workshops focused on training and empowerment of young LGBT providing basic information, prevention packages, counselling, leadership and networking training. Currently there are more than 200 Community Agents across the country who work with Kuimba'e on different activities, in particular providing information, prevention packages and referrals to the Kuimba'e Clinic and other public health services.

The clinic also runs massive HIV testing programmes and campaigns in public places – hospitals, squares, schools and colleges. Through this approach, it reaches large numbers of people with information, prevention supplies, testing, counselling and onward referrals and linkage to care. It supports clients on their journey and helps them with linkage to care, treatment and ongoing monitoring. When a client is tested HIV positive at the clinic, he or she is referred and accompanied to PRONASIDA (The National Program for AIDS and STIs Control) where ARVs are prescribed. Kuimba'e works closely with PRONASIDA and the Ministry of Public Health.

Results of the programme:

The amount of people reached by the Centre and the overall programme has grown cumulatively over time. The number has grown from 1,915 persons in 2009 who visited the centre in its first year, to 4,020 people in 2015. In 2015, 8,326 clients visited the Kuimba'e clinic. 227 HIV cases were detected, 668 cases of syphilis and 183 people on ARV therapy and 32 were on pre-ARV therapy. Also, since 2013, 12 people diagnosed with HIV have not followed-up the steps to linkage to care for personal reasons. The National Campaign of HIV Test, started last year and lead by SOMOSGAY and the Ministry of Public Health seeks to destigmatize the HIV test and the fact of living with HIV among the general population, focused on key populations and specifically on the gay community. In 2015, 1,030,560 people were reached via Facebook. Since May 2013, 13,666 HIV tests had been provided and in 2015, 2,681 HIV tests were provided. Most people reached by the services of SOMOSGAY, are from Asunción and the Central Department (Departamento Central).

Impact of the programme:

SOMOSGAY is a community-based organization and part of a social movement that understands that research, advocacy and communication via social media and media are key elements of all programme activities. That's why the Kuimba' e Clinic is crucial, not just in terms

of providing services, but also a generator of scientific evidence for the national HIV response. SOMOSGAY worked closely with PRONASIDA and the Ministry of Public Health to revise the new national treatment guide for people living with HIV and it finally is coherent with the global standards.

From March 2016, SOMOSGAY gradually replicates its health model in a number of regions around the country with the support of the Ministry of Public Health and the AIDS Healthcare Foundation.

Regardless the homophobic context of the current government, the political relationship between SOMOSGAY and the Ministry of Public Health is productive. SOMOSGAY, through its Advocacy Unit established a strong political and technical relationship with the Ministry of Public Health and PRONASIDA. We all know working with the communities is the only way to end AIDS by 2030.

Financing and management:

This programme has been supported by the AIDS Healthcare Foundation (AHF) since its inception in 2013, the previous support of amFAR and the Global Fund (The GF is also currently supporting community interventions) also contributed to the development of a strong, effective and sustainable programme initiated as a center of free, voluntary and confidential HIV and Syphilis testing. With the interinstitutional work between SOMOSGAY, the Ministry of Public Health and AHF, the program projection is that it can be funded by the government, with its inclusion in the national budget of public health.

Lessons learned and recommendations:

- It is important to always generate and work with scientific evidence.
- Let’s not try to reinvent the wheel: there are a lot of ideas and models that can be perfectly replicated (adapted) to other contexts
- Staying connected to the global networks and scenarios helps a lot with the advocacy, service provision, research and funding
- The communication process is a fundamental element to build the proposals and actions. Always stay connected to the community.
- People involved in the program should be, ideally or preferably, an activist
- The program must be connected to all activities of the organization; one program must not be seen as an isolated action. It must have a clear projection and sustainability. Volunteering and community funding is a way to achieve sustainability
- A Knowledge Management Area is an excellent way to generate, manage and democratize the information.
- Technology and social media must be permanent and transversal allies in every process and activity.
- Having the support of media, journalists and other hegemonic institutions can be very helpful.

The biggest challenges are to respond to our community as a first step for the HIV response (human rights and services), to generate an environment of cooperation with the government, and to secure the future of the future of the HIV response and human and LGBT rights as well.

72. Peru

Title of the programme: Impulse Group for the Surveillance of the Supply of Antiretroviral Medicines: (Peruvian aids network, PROSA, Aid for Aids, Cepesju, Sí, da Vida, Impact, Justice in Health, Land of Free Boys and Girls, Via Libre, Positive Peruvians, ICW Peru and Movement of People living with HIV).

CONTACT PERSON
Name: Marlon Castillo Castro
Title: Coordinator
Organisation: GIVAR
Address: Calle Henry Arredondo 201 – Lima 31
Tel: (01) 4810392 – (01) 942118412

Programme is being implemented since: 2010
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to people living with HIV

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

In 2004 Peru initiated HAART (Highly Active Antiretroviral Therapy) by the Law 28243, after a constant struggle for access to medicine, in which many people died in the hope of obtaining medication.

But six years later (2010), various organizations found that episodes of shortages of drugs were still a serious, but invisible problem on all levels. The long struggle for access to medicine seemed to have succumbed to bureaucratic situations in the state apparatus. So we formed GIVAR.

Description:

GIVAR aims to monitor the supply of medicines for HIV.

The heart is our portal “Complaints GIVAR” (www.givarperu.org), where citizens of any region of Peru report the situation of the drug supply, anonymous or in an identifiable manner. The coordinating team is responsible for verifying and comparing information and coordinating with the authorities to solve the problem in the shortest possible time.

GIVAR maintains direct dialogue with health authorities and carries out social mobilization. It also urges legal action in cases of shortages. It presents annual reports to the authorities on the results of citizen oversight.

Results of the programme:

From October 2010 to March 2016, 568 complaints were made of shortages nationwide, helping to improve the supply of medicines to some 22 thousand people (adults and children) who are in

medical treatment nationwide. 16 complaints were made with the Public Ministry of Peru.

Impact of the programme:

GIVAR thus promotes good medicine adhesion and prevents new infections or future deaths. It also improves the supply system of Antiretroviral Medicines in public bodies, with tangible examples like: The Ministry of Health established a system of transparency in drug stocks. Social security adopted policy measures that improve their purchase of medicines and the Ministry of Health with Civil Society implemented a similar model to GIVAR to monitor medicines for Cancer and Maternal Health, given the success of our portal surveillance system, which also allows better monitoring management of medicines.

Financing and management:

GIVAR member organizations, contribute in different ways to the financial management of the group, including a surveillance component in the budget of each institution. However at present, it lacks funding for training new leaders.

Lessons learned and recommendations:

Breaking barriers. I think this is crucial for success. The first issue is to contribute to the education of people to defend their rights and lose their fear of registering a complaint. The organization. Develop and promote a monitoring system using Technologies of Information and Communication (ICT). Social mobilization and media visibility. Prosecution of cases before various instances (criminally - crime prevention – Susalud, within the Ministry itself) and submission of technical proposals to improve the system of supply of medicines nationally.
Our biggest challenge is to make GIVAR part of the integrated monitoring system of the country.

73. Peru

Title of the programme: Community approach by women with HIV to promote the exercise of their sexual and reproductive rights and contribute to reducing maternal and child transmission of HIV in Perú

CONTACT PERSON
Name: Luz Guiselly Flores Arroyo
Title: Executive Director
Organisation: Peruvian Network of women living with HIV
Address: Pasaje Hernán Velarde N° 41 Lima 1
Tel: +51 968148301
Email: guisellyflores@gmail.com

Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to people living with HIV and women.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes

Background:

The health progress from the perspective of health services has not changed in the last five years. Peru holds 4.1% for 2015, pending closing the gap missing in screening for HIV and syphilis in pregnant women (25% average and more). Lima and Callao, where a third of the Peruvian population lives, account for 72% of reported AIDS cases, and in conjunction with the departments of Loreto, Arequipa, Ica, La Libertad, Piura, Lambayeque, Ancash, Junín and Tumbes, accounted for 95% of all reported AIDS cases from 1983 to 2015, in which 35% of the cases are women.

The exercise of sexual and reproductive rights in general is not completely guaranteed and even more so for women with HIV. Women living with HIV report that, although people have information about HIV transmission, in practice discrimination and exclusion remain. Although we have made efforts to coordinate across sectors with links to the Ministry of Health, the Ministry of Women, and justice, the reality is that HIV policies are designed and implemented without dialogue among different sectors, and participation of women leaders living with HIV. From the state, there have been very few strategies to contribute effectively to ending mother-child transmission and the impact of obstetric violence makes women newly diagnosed with HIV stay away from the health facility.

Peruvian Network of Women Living with HIV was proposed to the Ministry of Health as part of comprehensive care community approach where women with HIV addressed pregnant women with HIV and helped them return to health facilities.

Description:

GOAL: ENJOYMENT OF SEXUAL AND REPRODUCTIVE RIGHTS OF WOMEN WITH HIV AND REDUCTION OF MOTHER CHILD WITH HIV IN PERU

PURPOSE: Community helps to reduce barriers to continuity of care of pregnant women living with HIV and their RN identified in health facilities.

The intervention included the effective participation of Peruvian Network of Women Living with HIV (All HIV) for fieldwork, led by the community coordinator, an instructor and 6 counselors to search and monitor pregnant women with HIV. This peer relationship reinserting discovered a significant percentage of pregnant mothers received their diagnosis away from the health system, primarily for denial of discrimination.

Results of the programme:

This project with a community approach to reduce vertical HIV transmission was able to identify 171 women in six hospitals in Lima and Callao for eight months of intervention.

Impact of the programme:

Some of the results:
This number includes pregnant women, postpartum women and women with children exposed to HIV. Some partial results show that 60% of women have experienced some form of violence, while 54% live in poverty and 46% did not finish school. It also identified that 13.5% of these women were teenagers. Teenage girls are not biologically or psychologically prepared to face motherhood, making it harder to escape poverty. So far the intervention has identified that over

70% of mothers are irregular in their adherence to treatment, which jeopardizes their health and child.

What we can identify:
On the other hand barriers identified at the level of health services include ignorance of the current Technical Standard for Vertical Transmission by staff providing health care for women with HIV and children exposed. In addition, the lack of monitoring of this population and persistent levels of stigma and discrimination together increase the vulnerability of the rights of women and children affected, obstetric violence, and many cases of forced sterilizations among others.

We propose to provide a comprehensive approach to women living with HIV with community support, the monitoring of children exposed to HIV, the implementation of the standard insertion technique and the Comprehensive Health Insurance (SIS), and access to justice.

Financing and management:

The project was an initiative of Peruvian Network of Women Living with HIV, submitted to the Ministry of Health, through the National HIV strategy in a long process. Funding for the Pilot 2015 was achieved through partners in health headquarters Peru. The Ministry of Health made a commitment to sustainability through the national plan of mother-child transmission, projecting in the state budget from the budget result - PPR from 2017.

Lessons learned and recommendations:

The pilot of this intervention, establishments in Lima and Callao, has successfully managed to reinstate pregnant women especially in peripheral areas and extreme poverty to health facilities. From this experience and others, we have identified the following challenges:

1. Strengthen coordination with the responsible PMTCT of service stations to improve the house search of pregnant women.
2. Develop joint strategies with HIV to ensure ESN ES free from stigma and discrimination especially in the context of sexual and reproductive rights of women living with HIV.
3. Provide feedback more regularly CEPS community work with the multidisciplinary health team.
4. Incorporate activities PMTCT awareness campaigns with community participation EBDH with MVS for staff health networks and micro-system networks.
5. Incorporate the community PMTCT approach, as community management rights TvVIH maternal health, to immediate implementation that allows the extension of the approach to other service stations and other regions of the country.
6. Incorporate those responsible for the SIS in joint meetings with the ESN HIV PMTCT feedback.
7. Promote the presentation of the systematization of the experience of this project managements and regional health directorates to incorporate it as a strategy in health policy in their region or locality.
8. Conduct advocacy with MIDIS, MIMP, Ministry of Justice and other state authorities regarding the situation we face in the bond of HIV poverty-violence.

V. Western European and Other States

74. Canada

Title of the programme: Canadian Positive People Network (CPPN)

CONTACT PERSON
Name: Christian Hui
Title: Co-Founder & Community Engagement Officer
Organisation: Canadian Positive People Network (CPPN)/
Réseau canadien des personnes seropositives (RCPS)
Address: c/o Christian Hui
705–321 Sherbourne St., Toronto, ON, Canada M5A 2S4
Tel: +1 647 832 9681
Email: achui108@gmail.com

Programme is being implemented since: June 2015
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to people living with HIV, people living with HIV and HIV co-infections, and young people.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

This case submission on the Canadian Positive People Network (CPPN), a new, independent, national grassroots network for and by people living with HIV (PLHIV) and HIV co-infections in Canada formed in June 2015, highlights the critical role of communities and meaningful engagement of people living with HIV as an essential component in the global efforts to reach the UNAIDS 90-90-90 targets and ending AIDS by 2030.

At the end of 2014, Canada had approximately 71,300 PLHIV (Public Health Agency of Canada, 2014). Despite being a high income country, the current Canadian HIV strategy, the Federal Initiative to Address HIV/AIDS in Canada, dates back to 2004. During close to a decade under the rule of the Conservative Government between 2006 to 2015, evidence-informed strategies to prevent HIV such as harm reduction gave way to ideologies that created more harm than good: In 2012, Refugees living with HIV saw their rights to access adequate healthcare and medication stripped away in the name of cost-saving; In 2015, HIV incidence rates amongst resource-poor Indigenous communities in the province of Saskatchewan were comparable to rates found in sub-Saharan Africa. Clearly, an HIV crisis was taking place in Canada and the needs of the most marginalized were being more than left behind. Until June 2015, more than 30 years since the discovery of HIV, Canada lacked a national PLHIV network like many other countries where the affected communities act as the main drivers of the local HIV response. The formation of CPPN stemmed from the wish of people living with HIV in Canada wishing to advocate for their rightful place to be meaningfully engaged throughout the entire HIV response as stated in the Greater Involvement of People Living with HIV (GIPA) principle; to campaign with the government, the AIDS service sector, and the community for a re-energized PLHIV movement where the people are once again placed at the forefront of the HIV movement; and to demand for accountability from the government and HIV sector that the needs of PLHIV and key affected populations are met so no one is left behind.

Description:

CPPN is an independent network for and by people living with HIV and HIV co-infections in Canada. We exist as a people's network to represent the needs of all persons and communities affected by HIV and HIV co-infections. As a new, unfunded grassroots network, CPPN has received overwhelming support from a number of AIDS service organizations, demonstrating the vital need of the existence of a PLHIV network in Canada and the importance of inter-agency collaboration within an increasingly neo-liberal economic environment. Since the network's inception, CPPN has received financial and in-kind support: for example, CPPN was given the use of a web-based project management platform to connect PLHIV members across the country in community advisory committee and working groups free of charge by a national HIV research collaborative. Other examples include CPPN being approached by existing organizations to partner and co-host events for the PLHIV community without financial commitments, demonstrating the importance of the public, non-profit, and private sectors to proactively create opportunities to engage PLHIV and key affected populations meaningfully engagement in the HIV response.

As a people's network, our mission is to be at the forefront of the HIV response in Canada. Our goal is to help ensure that the movement is coordinated nationally, provincially, regionally, and locally to benefit the affected people and communities, and that we are connected with the global HIV response. Our aim is to work with AIDS service organizations, service providers, partner organizations, policy makers, and funders so that all persons and communities affected by HIV and HIV co-infections are engaged, empowered and have access to holistic supports and improved social determinants of health. A key part of what CPPN does is advocacy on the national and international levels: examples include 1) helping to lead the creation of the Canadian Declaration by PLHIV at the IAS Conference 2015 to support the Vancouver Consensus on expanded testing, treatment and the use of new prevention technologies such as PrEP, yet highlighting the human rights concerns as expressed by an international group of PLHIV delegates on the approach as left out by the consensus statement; and 2) representing the needs of PLHIVs and civil society by making an intervention on GIPA at the UN Civil Society Hearing in April 2016. Other areas of focus include: building strategic alliances with service organizations of national, regional and local reach such as co-hosting the HIV, Aging and Income Security Think Tank with the Canadian Working Group on HIV and Rehabilitation (CWGHR); and filling the gaps of existing programming by working with HIV+ youth and YouthCO to create a Youth HIV Disclosure Project.

Results of the programme:

CPPN has a national reach and currently has over 125 PLHIVs living across Canada since its inception in June 2015, along with organizational and individual supporters.

Impact of the programme:

Since inception, CPPN has achieved the following in advocacy, campaigning and participation in accountability: 1) the creation of an online petition during the federal election in 2015 and a community press conference to ask candidates to commit to placing PLHIV at the forefront of the HIV response; 2) led a group of PLHIV activists at IAS 2015 to craft the Canadian Declaration by Persons living with HIV to highlight the human rights considerations needed in the expanded testing, treatment and use of new prevention technologies approach; 3) Co-hosting an HIV, Aging and Income Security Think Tank with a national partner; 4) Participate in national consultations and working groups including the Canadian Consensus Statement on the

Health and Prevention Benefits of HIV ARVs & HIV testing, the National Coalition Working Group on the development of a new community-driven HIV strategy, and the national CanPrEP working group to provide perspectives of PLHIVs on PrEP to facilitate the listing of PrEP on drug formularies; 6) identification of program gaps and development of programs with partners including the Youth HIV Disclosure Project and to plan for HIV is Not a Crime trainings for PLHIVs in Canada; 7) made an intervention at the UN Civil Society Hearing on GIPA, and participating in consultations on the UNAIDS PCB thematic working groups and Canadian HLM consultations.

Financing and management:

CPPN currently has a working board of PLHIV members, a community advisory committee, and working group committees (by-law creation, communication, community engagement, fundraising and finance, youth). PLHIV join the network as members at no cost, while organizations and non-PLHIV can become supporters and contribute financially or through in-kind support. The major partners of CPPN include: the Interagency Coalition on AIDS and Development (ICAD), of which CPPN has strengthened its strategic partnership and recently applied for federal funding as a sub-grantee; REACH2.0 CIHR Community-based Research Collaborative for the use of their web-based project management platform; the Canadian Working Group on HIV & Rehabilitation (CWGHR) on co-hosting a think tank on aging and income security issues; the Canadian HIV/AIDS Legal Network (CHLN) on collaborating on capacity building trainings for PLHIV advocates around the issue of the criminalization of HIV non-disclosure; YouthCO HIV & Hep C Society on the Youth HIV Disclosure Project; and other partners such as the Canadian Treatment Action Council (CTAC), CATIE, and the Canadian Aboriginal AIDS Network (CAAN) for in-kind support; & other regional organizations.

Lessons learned and recommendations:

Key factors that sustain CPPN/RCPS as a grassroots PLHIV network include: meaningfully engaging PLHIVs in the operations and decision-making process; developing strong community partnerships; engaging stakeholders through online technologies and social media; ability to access key events and policy makers; addressing resource challenges and accessibility concerns of PLHVs. Utilization of a fluid and shared-responsibility approach to operations, and the ability to strategically engage key stakeholders, are critical to new PLHIV networks like CPPN/RCPS. Some of the biggest challenges facing CPPN currently include: financial sustainability a new, grassroots network without core funding; a lack of dedicated human resource staffing and organizational infrastructures to allow the network to engage the types of advocacy and community-mobilization work it strives to achieve on a large scale. While having support (financial and in-kind) from organizations has allowed the network to grow and complete a number of milestones, the new network needs to continue growing and engaging PLHIVs across the nation with limited resources. The provision of support from governments, funders, and private sectors in recognizing the critical roles communities and PLHIV networks like CPPN play in reaching global targets to end the AIDS epidemic is a crucial and essential one. To leave no one behind and to end AIDS mean investing in community-driven programs and PLHIV networks locally, regionally, and globally. Insights from this case study serve to inform possible ways to strengthen PLHIV-driven responses globally.

75. Monaco

Title of the programme: Test in the City

CONTACT PERSON
Name: AESCHBACH Hervé
Title: Coordinateur
Organisation: FIGHT AIDS MONACO
Address: 11 Bd Charles III – 98000 MONACO
Tel: +377 97 70 67 97
Email: herve.aeschbach@fightaidsmonaco.com

Programme is being implemented since: 2012
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to women, young people, and others.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Le dépistage du VIH à Monaco peut se faire en laboratoire privé ou au Centre de Dépistage anonyme et gratuit établi au C.H. Princesse Grace. Le coût dans le privé et le lieu médicalisé accueillant le CDAG, ainsi que l'anonymat réduit par la crainte avérée de croiser une personne de connaissance sont des freins au dépistage. Selon la volonté de S.A.S. la Princesse Stéphanie de « sortir le dépistage du médical » et le rendre accessible facilement, il a été décidé de lancer un TESTING dans la rue.

Description:

Cette action novatrice des tests rapides d'orientation diagnostique de l'infection à VIH 1 et 2, a pour objectifs :

- un accès facilité et renouvelé à la connaissance de son statut sérologique vis-à-vis de l'infection par le VIH ;
- une adaptation des stratégies préventives de chacun en fonction de la connaissance actualisée de son statut sérologique et de celle de ses partenaires ;
- l'entrée et l'accompagnement dans une démarche de soins la plus précoce possible pour les personnes découvrant leur séropositivité au VIH.

La facilité d'utilisation du test rapide d'orientation diagnostique de l'infection à VIH 1 et 2 permet son usage hors les murs et à des horaires diurnes ou nocturnes. FIGHT AIDS MONACO propose un dépistage par test rapide d'orientation diagnostique intégré dans une offre complète de prévention (information, conseils, distribution de documents et matériel de prévention...).

Results of the programme:

7 journées réalisées, 4 autour du 1er décembre et 3 avant l'été. 1 122 tests réalisés dont trois indéterminés. Le nombre par journée allant de 63 à 262 personnes dépistées, le record étant la dernière journée en novembre 2015 avec 5 postes de dépistage et 10 « trodeurs », formés à la technique spécifique des tests INSTI.

Une fiche d'information remplie par les trodeurs pour chaque personne renseigne sur le public reçu.

Impact of the programme:

Un Arrêté Ministériel n° 2012-264 du 27 avril 2012 a été pris après avoir rencontré le Gouvernement Princier puis convaincu l'Ordre des médecins, arrêté fixant les conditions de réalisation des tests par FIGHT AIDS MONACO.

L'implication et la formation à cette nouvelle pratique des permanents et bénévoles de FIGHT AIDS MONACO (8 personnes à ce jour), auxquels se sont joints une infirmière de la Croix-Rouge monégasque et une animatrice du foyer socio-éducatif du Lycée Technique et Hôtelier de Monaco. Des jeunes bénévoles de 17 à 25 ans, venant d'un groupe de prévention « les Anges gardiens » et d'une société privée de communication « Second Sens » se relaient pour rencontrer le public, leur présenter l'action et les inviter à se faire dépister.

Le service des Urgences du C.H. Princesse Grace est associé à cette journée en proposant les mêmes jours les TROD aux patients qu'ils reçoivent et aux autres personnes de l'hôpital.

Financing and management:

L'action est prise en charge par FIGHT AIDS MONACO, autant sur l'organisation que sur le financement (soutien de Carrefour Monaco). Une convention avec la Direction des Actions Sanitaires de Monaco est établie (reconduite le 13 novembre 2015), pour la définition et le contrôle de la procédure.

Lessons learned and recommendations:

La dynamique du départ a été l'annonce de cette journée avec le dépistage de S.A.S. la Princesse Stéphanie et de personnalités monégasques pour inciter au dépistage. Le soutien de la Princesse et sa visite à chaque journée cautionne l'action et mobilise la population monégasque (nationaux, résidents et travailleurs pendulaires).

Il a fallu un véritable plaidoyer pour faire accepter au monde médical le fait que des personnels non soignants puissent surtout réaliser les tests, comme la tenue des entretiens pré et post tests.

La diversification des lieux de dépistage a permis de toucher un public différent, à proximité d'un lycée, ou bien d'une galerie marchande, ou encore d'un quartier de travail…

Un travail de proximité avec les médecins de ville est nécessaire afin de pouvoir orienter auprès d'eux en cas de besoin ; la confirmation d'un test positif se faisant comme la prise en charge médicale par le service référent du CH Princesse Grace.

76. Portugal

Title of the programme: Portuguese Community Based Screening Network

CONTACT PERSON
Name: Daniel Simões and Rosa Freitas

Title: Project Management
Organisation: GAT
Address: Avenida Paris, 4, 1º dto 1000-228 Lisboa, Portugal
Tel: +351 210 967 826
Email: daniel.simoes@gatportugal.org and rosa.freitas@gatportugal.org

Implemented by: Civil Society
Scope of submission: Advocacy, campaigning, and participation in accountability; Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.); and Participatory community-based research in relation to people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender people, and migrants.

Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

The Portuguese HIV epidemic has one of the highest incidences in Western Europe. It is a concentrated epidemic, both geographically and in key groups. Early infection diagnosis and late presentation are still major issues influencing the treatment cascade. According to WHO estimations, around 60-65,000 people live with HIV in Portugal, while only roughly 35,000 are in the National Healthcare Services. Every year approximately around 50% are late presenters.

Surveillance is only made through compulsory medical notification of new cases, and clinical data of patients being followed was only integrated into a national system in 2015 (previously registry was hospital based and very hard to analyse).Despite a progressive scale-up of HIV testing, testing for viral hepatitis and syphilis is very rare in formal settings and with the dynamics of the epidemics being interconnected, most diagnostic opportunities are still missed. In 2009, GAT contested the Decree-Law 145/09 of 17 of June 2009 and through a clarification on its website the Portuguese National Medicine Agency, with the support from the National AIDS Coordination and the Imunohemotherapy Service of São João Hospital, stated that in certain conditions, it was not mandatory that rapid tests be performed by healthcare professionals.

The specifications were very clear: a centre could open if its laboratory supervision/quality control was ensured. It became clear and official to have lay workers performing rapid tests and the first community based testing centre opened in 2011: CheckpointLX, a pilot project from GAT aimed at the MSM population. Since then, the implementation of community testing projects has been slow due several reasons: lack of national guidelines for informal healthcare sites (after 5 years of work), lack of funding (public funding from the Health Directorate to testing centres started in 2013) and lack of capacity building for community level organizations.

Description:

The Portuguese Community Screening Network is a project coordinated by GAT, in partnership with the Institute of Public Health of the University of Porto (data collection and analysis) and the Imunohemoteraphy Service of São João Hospital (quality control and laboratory supervision), that aims to promote early diagnosis of HIV, hepatitis B and C virus, and syphilis through civil society organizations, focusing its work on the groups most affected by these infections: sex

workers, people who use drugs, migrants and men who have sex with men, although all the centres are open to everyone.

The project aims also to collect and report data based on community based organizations, enabling the epidemiological surveillance of the screened infections. The project intends to complement the intervention provided by the formal health system ensuring appropriate linkage to care (people with reactive results are offered escorted referral by a team member to the healthcare system). The project made possible that community based organizations could offer not only HIV tests (as it happened until 2015), but also HCV, HBV and syphilis rapid tests, following certain criteria.

Main activities of the program:

- Up to date basic and advanced training that includes: screening procedures, counseling (including information on the infections, tests, prevention and treatment);
- Supply of test kits and consumables to network members. HIV test supplied by a partnership between GAT and AHF Europe; the remaining ones (HCV, HBV and syphilis) are procured and distributed centrally in order to ensure better prices;
- Laboratorial supervision and quality control, as well as in loco technical audits by the Imunohemotherapy Service of São João Hospital staff;
- Regular monitoring to all members of the network, with the objective of improving local service delivery and develop locally adjusted strategies, with a special investment on recent testing sites;
- A common online questionnaire, with specific questions added by request for each center, managed by the Public Health Institute of Porto. The data feeds into an anonymous prospective cohort, which will progressively allow for seroconversion predictor identification, as well as to obtain robust data on the epidemics at both local and national levels, with an emphasis on key affected groups;
- Centralized production of information materials and dissemination of the network partners (contacts and services provided) at a national and international level;
- Support in legal and regulatory processes, such as accreditation with Regulatory Health Agencies, information on processing of potentially contaminated residues, among others;
- Continuous capacity building on specific subjects, identified by the network members;
- Networking and partnership development between members;
- Standards for referral to care and a framework to register and follow up linkage to care processes.

Results of the programme:

From August 2015 to March 2016, both pilot phase and in the implementation phase, the participating NGOs performed a total of 4984 HIV tests (98 reactive results – 1,96%); 2217 HCV tests (35 reactive results –1,57%); 1585 HBV tests (30 reactive results – 1,89%); 3340 Syphilis tests (135 reactive results – 4,04%).

The linkage to care data collection began in November 2015 and the data presented is from December 2015 to February 2016 (data from March will only be available in May):
HIV - 84,62%; HVC - 88,24%; HBV - 91,67%; Syphilis - 66,6%.

Impact of the programme:

The program has 3 major components that will:

- Promote availability of information and screening of HIV, viral hepatitis and syphilis in Community Based settings in Portugal, with the highest possible standard of quality;
- Generate national data on the screened epidemics that enable the detection of trends and the adjustment of responses to these epidemics, both geographically and by group(s);
- Ensure timely and efficient linkage to healthcare services for diagnosis confirmation and treatment initiation upon a reactive result.

The project aims to contribute to the first two 90-90-90 targets by increasing awareness and promoting access to screening and diagnostics, ensuring effective linkage to the healthcare system, thus promoting access to continuum of care/treatment.

Financing and management:

The project is managed and coordinated by GAT. At this point, the project received 85% funding through the financial mechanism EEA Grants until April 2016 and a small grant from Gilead International. This grant allowed full implementation of the network as well as the scale-up coverage of the program nationally, from north to south (www.redederastreio.pt/organizacoesparticipantes). A future continuation of EEA Grants support is foreseen at medium term, but a delay period with absence of funding will exist and it may endanger the continuity of the project. GAT is working actively to find other sources for financial sustainability.

Lessons learned and recommendations:

GAT is in the process of establishing a partnership with the National AIDS Program (NAP) in order to ensure access to entry level, anonymous data of people referred to care by the network members, in order to analyse CD4 cell count and viral load of referred people, allowing for a better understanding of the contribution of community based structures in the early diagnosis of HIV and, in the future, to attempt a similar protocol for HCV indicators. Collected data may be used as an advocacy tool both to support community based testing in presenting recommendations to the Health Ministry, as well as to improve existing preventive interventions and the quality of service delivery of community based testing centers by presenting a draft for official guidelines. Additionally, linkage to care data will contribute to advocacy efforts to identify constraints and minimize barriers in the linkage and relinkage processes.

77. Portugal

Title of the programme: CheckpointLX

CONTACT PERSON
Name: Miguel Rocha
Title: Community Public Health Nurse
Organisation: GAT Portugal
Address: Travessa Monte do Carmo, 2, 1200-277 Lisboa
Tel: +351 910 693 158
Email: geral@checkpointlx.com

Programme is being implemented since: 2011

Implemented by: Government and Civil Society
Scope of submission: Advocacy, campaigning, and participation in accountability; Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.); and Participatory community-based research in relation to men who have sex with men.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Three cross-sectional studies targeting men who have sex with men (MSM) living in Portugal collected extensive self-reported information, leading to the first alarming estimates of the point prevalence of human immunodeficiency virus (HIV) infection: 10.9% [EMIS, 2010], 10.3% [PREVIH, 2012] and 17,1% [SIALON II, n.d.]. Portugal estimates that 20 to 25,000 people living with HIV are undiagnosed and in high prevalence settings, such as Lisbon, men stay behind with late or delayed linkage to prevention, care and support. WHO recommended that countries with HIV concentrated epidemics have to prioritize and focus on tailored community-based HIV testing sites (HTS) approaches for those who remain undiagnosed and at greatest ongoing risk for HIV infection. In 2011, Treatment Activist Group (GAT) opened the first community-based HTS in Portugal and tailored to MSM.

Description:

CheckpointLX is a community-based centre for MSM, for anonymous, confidential and free screening of HIV and other sexually transmitted infections (STIs), sexual counselling and referral to health care. The entire team consists of qualified MSM who give support and peer education, allowing easy access to prevention and sexual health more effectively and consistently with MSM reality. Thus, the purpose of this centre is to increase sexual health literacy, early detection of HIV and STI, and quick/timely referrals to the health care. The centre objectives are (1) empowering MSM for preventive risk management of HIV and other STIs transmission, (2) refer MSM with reactive tests at CheckpointLX for confirmatory testing and / or treatment, (3) implement epidemiological and behavioural research related to MSM community and sexual health, (4) disseminate the results of studies and screening programs (carried out in the MSM community) and (5) advocate and collaborate with organizations and community partners for the effective access of MSM to sexual health services and information. This centre provides services: (1) condoms and lube, (2) tailored counselling, (3) HIV, syphilis, HCV, gonorrhoea, chlamydia and HPV screenings programs, (4) escort those with HIV/viral hepatitis reactive test to hospital for care and (5) gives access to web-based anonymous partner notification. This centre generates HIV 2nd generation surveillance data through an open cohort, a joint GAT and ISPUP-EPIUnit collaboration, and is a platform for community-based participatory research. Since 2012, that CheckpointLX team has been advocating for MSM sexual health prevention, specifically for PrEP implementation and anal cancer early detection and HPV vaccination. CheckpointLX opened on April 2011 and is one of GAT screening centres. GAT is a non-governmental organization which mission is to "advocate for legal and policy changes that positively affect the health, rights and quality of life of people living with HIV or at risk of being infected" through "quick access to medical devices and drugs, testing, diagnostics that prevent or treat HIV infection or improve the quality of life of people who live or are especially vulnerable to infection".

Results of the programme:

Between April 2011 and December 2015, 10,002 HIV tests were performed in MSM, 4.1% reactive overall. According to official surveillance data, per civil year, on national level, CheckpointLX found 8.71% (2011), 15.27% (2012), 19.95% (2013) and 26.29% (2014) of MSM new HIV infections. Linkage to care was 79.49% (2011), 73.97% (2012), 78.05% (2013), 83.33% (2014) and 74.78% (2015). Of all referred, 2.3% had confirmed primary HIV infection. In 2014, almost 40% of the MSM new cases were late presenters at national level, whilst our data showed only 15%. Between April 2011 and February 2014, 804 MSM were followed for a total of 893 person-years. The overall seroincidence was 2.80/100 person-years (95%IC: 1.894.14).

Impact of the programme:

CheckpointLX has had an increasing impact on MSM early diagnosis and linkage to care on both local and national levels. The replication of this centre in other Portuguese high prevalence settings is urgent. Due to persistent high incidence estimates, new HIV prevention tools rollout is pressing, namely pre-exposure prophylaxis. This centre has been recognized by ECDC as a new and innovative service developed in Portugal reflecting the Communication's emphasis on key vulnerable populations and selected by WHO as an example of good practice reflecting the new HTS recommendations.

Financing and management:

The team is entirely composed of MSM with scientific medical supervision and peer technical supervision. Exclusively recruited employees by GAT, CheckpointLX volunteers are involved in outreach activities only. The centre manager is a member of GAT board. Funding is granted by General Health Directorate from Portugal Ministry of Health, Lisbon Municipality, AIDS Healthcare Foundation, small grants from pharma industry and private donations from MSM community: public funding 30% and private 70%. Full stakeholders **here.**

Lessons learned and recommendations:

In 2009, GAT/newly formed CheckpointLX team contested the Decree-Law 145/09 of 17 of June 2009 and through a clarification on its website the Portuguese National Medicine Agency, with the support from the National AIDS Coordination and the Imunohemotherapy Service of São João Hospital, stated that in certain conditions, it was not mandatory that rapid tests be performed by healthcare professionals. Since then community-based and peer testing is allowed in Portugal and testing scale-up in key populations feasible. Community-based HTS has shown that they are important to find those living with HIV and linking them to care. Increasing support and funding to community-based HTS to scale up testing, such as those from Portuguese Community Screening Network (which we join in 2015), are mandatory to end AIDS epidemic by 2030 in Portugal!

VI. Multiple Countries

78. Asia Pacific Regional

Title of the programme: Ending Discrimination against people living with HIV and key populations in healthcare settings in Cambodia, China, Myanmar and Viet Nam

CONTACT PERSON
Name: Gareth Durrant
Title: Director of Capacity Building and Community Initiatives (CBCI)
Organisation: Asia Catalyst (AC)
Address: Bangkok, Thailand
Tel: +66 947524019
Email: gdurrant@asiacatalyst.org

Programme is being implemented since: 2014
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Participatory community-based research in relation to people living with all key population groups (people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender people, women, and young people).

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Discrimination in healthcare settings is one of the foremost barriers preventing people living with HIV and key populations from accessing critical health services. Community-led responses are essential to creating a discrimination free society and getting to zero. While Cambodia, China, Myanmar and Vietnam are among the twelve countries accounting for more than 90% of people living with HIV and new HIV infections in Asia, community involvement in HIV policies has been inconsistent. Discrimination against PLHIV remains prevalent. Community leaders living with HIV face an environment of increasing legal restrictions to independent civil society action. However, with the right tools, expertise, and support, these courageous activists can build support networks with national and regional peers and engage a broad spectrum of stakeholders and policy makers to ensure change is lasting, institutionalized, and wide reaching. To do so, people living with HIV must have the access, knowledge and resources to translate what they know into positive reform for all.

Description:

In December 2014, Asia Catalyst (AC) commenced the Regional Rights Training Program to increase the knowledge and skills of community based organizations on the human rights framework, human rights based documentation, and evidence-based advocacy. 8 community-based organizations (CBOs) representing communities of people living with HIV from Cambodia, China, Myanmar and Viet Nam participated in the program. Over the course of 18-months, the program brought together advocates from the 4 countries for an intensive workshop series on international human rights frameworks, documentation and advocacy; participant CBOs identified pressing issues of discrimination faced by their communities that prevented or discouraged them from accessing health services; The documentation topics included discrimination against women living with HIV in accessing sexual and reproductive health services; access to surgery services for gay men, MSM, and transgender persons living with HIV; discriminatory fees charged to people living with HIV and sex workers living with HIV when accessing services. Advocacy implementation is continuing on this project, and forthcoming is a

Best Practices Guide for human rights documentation and a Country Context and Advocacy Tool for each country, to be disseminated in English and the predominant local language for each country.

Results of the programme:

This program increased the capacity of grassroots health rights community based organizations in Cambodia, China, Myanmar and Viet Nam to conduct human rights documentation and advocacy. Furthermore knowledge and content learned through the workshops were transferred to the local level as each CBO conducted additional training sessions reaching 209 CBO staff and volunteers in 4 countries and 11,787 indirect beneficiaries by training members of their boarder networks of people living with HIV, Lesbian, Gay, Bisexual, Transgender (LGBT) communities and men who have sex with men, women, and sex workers based on the material that he or she learned at each of the Asia Catalyst workshops. Once trained, the participants developed rights based documentation tools; carried out 202 interviews in four countries; and developed and implemented advocacy plans to address this discrimination. Documentation findings were synthesized in a report: First, Do No Harm: Discrimination in Health Care Settings against People Living with HIV in Cambodia, China, Myanmar and Viet Nam, which includes recommendations jointly developed by the CBOs. Evidence based advocacy is ongoing, but under this program, four of the eight CBOs formed in-country coalitions and conducted joint activities for the first time. Using the evidence collected, all CBOs established spaces where people living with HIV were able to share their experiences of discrimination first-hand with health care providers and authorities and engage them in meaningful dialogue. In Cambodia specifically this garnered commitments from Commune leaders and police in Battambang and Thbong Khmom Provinces to strengthen access for people living with HIV and key populations to healthcare services and an acknowledgement of lack of knowledge of HIV laws at the local level and lack of awareness of sexual and reproductive health issues of women living with HIV.

Impact of the programme:

Asia Catalyst enhanced human rights documentation and advocacy skills of 16 participants from 8 CBOs representing PLHIV or key affected populations in four countries. The program increased collaboration between PLHIV CBOs, with CBOs in Cambodia and Myanmar working on rights-based documentation and advocacy together for the first time. Through human rights-based based advocacy projects, it has led to increased awareness of the health rights concerns of people living with HIV among health care providers and authorities. In Cambodia, authorities acknowledged the issue of discrimination in healthcare settings and are now discussing concrete steps for solutions with CBOs. In China, a transgender network was formed whose mandate is to advocate for the rights of transgender persons in the region as well as a social media platform for community members to actively participate in discussions, share information and report on discriminatory experiences. In Myanmar, 49 additional community members were trained in human rights advocacy. In Vietnam, 30 women living with HIV and 30 MSM were reached through 1 joint event with UN Women and 5 community consultations. 1 advocacy event targeting health care workers, 1 letter writing campaign, and 2 advocacy brochures were also developed.

Financing and management:

Asia Catalyst coordinated this program from its regional office in Bangkok, bringing together multiple donors to support the capacity building and documentation project. The program gained technical support from regional based agencies, including UNAIDS Regional Office and the

regional networks of PLHIV and key populations such as Human Rights Education Associates and Asia Pacific Council Of AIDS Service Organizations. Asia Catalyst also carried out two monitoring and coaching visits to each country to provide support to the CBOs, as well as bi-monthly calls with each group. While a sub-grant was provided to the CBOs to implement the activities, the program ensured that the planned activities were in sync with the on-going work of the CBOs – hence CBOs will continue the work beyond the scope of this program with Asia Catalyst. Major donors included; Levi Straus Foundation, National Endowment for Democracy, UNAIDS, Elton John AIDS Foundation, ViiV Healthcare, and The Embassy of Switzerland in Bangkok.

Lessons learned and recommendations:

Asia Catalyst's strong integration in global and regional health advocacy spaces meant, together with the CBOs, we were able to successfully consolidate community-led research and effective practices from the project reaching international and regional audiences, and ultimately, court new human rights allies for local CBOs. Participating groups served different key populations, but united around the similar issue of discrimination in healthcare settings, raising the issue in each country and highlighting its pervasiveness. That being said, additional work is needed in each country to build networks amongst extremely marginalized communities within the country so that participants and other CBOs can establish cross-thematic coalitions and peer-to-peer learning for maximum impact. The challenges faced during the eighteen-month implementation of the program, particularly the technological difficulty in long distance engagement with CBOs coupled with the language barriers between the CBOs, made it ineffective to conduct this dialogue through an online medium. This was the main driver for in-country advocacy coaching site visits; however on-going localized support is crucial. AC plans to add a domestic training program for trainers and mentoring component between current and previous partners to ensure coalition work and enhance national movement building.

79. Eastern Europe Regional

Title of the programme: Harm Reducation Works- Fund it!

CONTACT PERSON
Name: Anna Dovbakh
Title: program director of EHRN
Organisation: EHRN
Address: Vilnius, Svigrigailos, 11B
Tel: +37068-777-959
Email: anna@harm-reduction.org

Programme is being implemented since: 2014
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Participatory community-based research in relation to people living with HIV, people who inject drugs, women, and young people

Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

For over a decade, Eastern Europe and Central Asia (EECA) have been home to the world's fastest growing HIV epidemic. With $ 679.5 million designated for HIV and TB EECA programming in 2014-2016, the Global Fund is at the front lines of support for harm reduction in many EECA countries.

But while the Global Fund investments have ensured that needle/syringe program (NSP) and OST have gained a foothold in the region, still less than 15% of harm reduction (HR) funding comes from governments. In financial crisis situations, the governments are looking for approaches on how to optimize resources usage.

For the purposes of the regional advocacy program EHRN developed methodologies to:

- ✓ assess the total costs and unit costs of needle and syringe programs and opioid substitution treatment programs in a country for two financial years;
- ✓ study the opinions of program clients about the accessibility of and demand for services;
- ✓ identify harm reduction funding gaps to develop arguments for advocacy;
- ✓ demonstrate the efficiency of investments in harm reduction.

Description:

The assessment was conducted in six sentinel countries of the Regional Program: Belarus, Georgia, Kazakhstan, Lithuania, Moldova and Tajikistan.

The community-led assessment of service quality and priorities had dual aims of building PWID community capacity and formally documenting service quality issues that require attention through further investment and greater political will. Led by community groups, the two-part assessment included structured discussion and qualitative data collection at PWID community sessions and the administration of questionnaires to assess five elements of quality: accessibility, acceptability, continuity, linkage to other services, and safety.

Monitoring of harm reduction services and investments in harm reduction programs has been conducted within the Regional Program "Harm Reduction Works – Fund It!" being implemented by Eurasian Harm Reduction Network (EHRN) with financial support of the Global Fund to fight AIDS, tuberculosis and malaria.

Results of the programme:

The assessment was conducted by PWID community groups, who were trained by EHRN project staff in use of the assessment instruments. A total of 68 discussion groups were held, 3 Sentinel countries range from high income (Lithuania), upper middle income (Kazakhstan, Belarus), upper-lower middle income (upper – Georgia), lower-lower middle income (lower – Moldova), to low income (Tajikistan).

Regional Report summarized the results of active participation in focus-groups of 612 people who use drugs and of 1,829 questionnaires completed. 1,310 of the questionnaires were completed by NSP clients, while the remaining 519 were completed by OST clients; 77% of questionnaires were completed by male respondents, and 23% of respondents were female.

Impact of the programme:

Community-led assessments identified a variety of gaps in services that should be considered when planning services through a successful transition from the international donor to domestic funding.

Kazakhstan: “This methodology was used to compile the state public health development program for 2016–2020. Based on the needs of people who inject drugs, rapid tests, naloxone, thin insulin needles and larger-volume (10 ml.)”

Belarus: “The tool was used in the planning of government programs for 2016–2018. In such a rapidly changing environment the list of services should be regularly updated. The methodology helped define the budget for services that reflect the real needs of people”.

Moldova: “We used the results of the assessment in the development of the national program. Prior to that the budget was developed only on the basis of the previous year, when no systematic review was in place. Based on the results of the assessment, we proposed new budget calculations or verified that the initially budgeted funds were correct. Now the numbers in the budget for harm reduction programs are actually agreed and justified.”

Financing and management:

The main partners - the financial experts of the State, in which the assessment is conducted and the vulnerable group, who make their part of assessment in the services availability and prioritization.

These methodologies helped:

- policymakers make decisions on funding harm reduction services;
- finance experts develop an appropriate budget;
- clients receive services that improve their health and even save their lives;
- civil society influence the level of funding for harm reduction.

Lessons learned and recommendations:

Assessment conducted by community help community leaders to build their capacity in developing arguments and find supporting facts for effective negotiations with decision makers. Conducting the assessment for each of community group becomes an important factor of self-organization, community mobilization and joint defining of the advocacy goals.

From gained experience it become clear that participatory service assessment need to be conducted simultaneously with financial research done by national funding experts with involvement of community leaders.

The combination of two parts of assessment provides enough arguments for national or local authorities to plan funding of the services.

This convenient method is already used by countries (Moldova, 2015-2016) for the valuation and prioritization of prevention and treatment services for HIV vulnerable populations. The methodology can be adapted on request.

These methodologies provided arguments to develop advocacy plans. The main aim of the

advocacy plans was to influence policy makers and ensure state commitments in budgeting national Harm Reduction programs. To facilitate these tasks EHRN organized a High-level Regional dialogue in Tbilisi in September 2016. Prior to the Dialogue participating governments had to prepare their "country positions" with financial and programmatic commitments in harm reduction.

80. Regional ESA

Title of the programme: Men's sexual health and rights initiative in Africa (SHARP)

CONTACT PERSON
Name: Gavin Reid
Title: Regional Advisor: Men's Sexual Health and Rights
Organisation: International HIV AIDS Alliance
Address: 122 Longmarket street, Unit 1043, 4th floor, Westminster House, Cape Town, 8001, South Africa
Tel: +27 (0)72 994 4188
Email: greid@aidsalliance.org

Programme is being implemented since: 2013-2015 (3 year programme)
Implemented by: Civil Society
Scope of submission: Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to men having sex with men, sex workers, and young people

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

MSM in Africa continue to be at considerably higher risk of HIV than men overall. Modes of transmission analyses, in Kenya, found new HIV infections among MSM to be important components of the national epidemic. Various studies have also shown that HIV prevalence among MSM in capital cities across East Africa is on average 13 times higher than in the country's general population. In 2012, according to national Global AIDS Response Progress Reports, Eastern and Southern Africa reported one of the highest HIV prevalence among MSM with 15% prevalence.

While data on HIV service access of MSM remains limited, the high prevalence indicates that service coverage and quality remains insufficient, though it varies greatly across countries and regions. This situation is exacerbated by limited funding for MSM programming, especially from national governments, and other challenges, including the restraining effects of homophobia - in particular stigma and discrimination - on the ability or willingness of MSM to seek essential HIV services. Punitive laws regarding same-sex sexual relations also create a climate of fear and intolerance that is inconsistent with a rights- and evidence-based HIV response.

Description:

It is against this context that SHARP was developed to specifically target MSM, their intimate

partners and families. The programme aimed to effectively reduce the spread and impact of HIV among MSM in Eastern and Southern Africa and to build healthy MSM communities. In each of the 4 countries (Kenya, Tanzania, Uganda and Zimbabwe), SHARP worked through the International HIV AIDS Alliance affiliated NGOs that provided funding to smaller MSM-led organisations (Implementing Partners) which contributed to common programmatic objectives including:

I. To increase reach of MSM, their sexual partners and family members in the region.
II. To increase access to and uptake of better quality HIV and health programmes and services by MSM in the region.
III. To enhance social, political and structural environments for evidence- and human rights-based public health interventions targeting MSM in the region.
IV. To strengthen MSM community-based organisations and networks in the region and increase capacity of other sectors to better serve the needs of MSM.

Results of the programme:

The SHARP programme considered an MSM 'reached' when accessing two or more elements of a package of core HIV/Sexual Health targeted interventions. The programmatic cumulative reach of the SHARP programme was of 14,900 MSM, which represented a 6-fold increase if compared to the programme baseline of 2,579 MSM. Similarly, the geographic reach of the programme implementing partners grew considerably: in Western Kenya, IP expanded its presence from Kisumu county to 6 adjacent counties. The IP in Eastern Tanzania, increased its reach from two districts to a total of five and the one in Zimbabwe reached a total of 11 districts starting from a baseline of 2. Finally, the implementing partner in Uganda, initially operating only in Kampala, managed to expand its reach to 14 cities and towns spanning all the country's regions.

Impact of the programme:

Although the lack of reliable estimates for the MSM populations in the 4 countries does not allow the presentation of the programme impact in terms of coverage, implementing partners successfully provided HIV prevention, treatment, care and support services to thousands of MSM well beyond the programme initial targets. More in detail, by the end of year 3, SHARP programme had distributed more than 270,000 condoms and 150,000 lube sachets, provided HIV testing to 5,493 MSM and of those who tested positive for HIV 148 MSM were successfully initiated on ART. STI screening services were provided to 3,231 MSM and 2,427 have received treatment for STIs. The programme sensitisation components on MSM needs and rights reached more than 1,031 policy makers, 561 law enforcement agents, 1,206 healthcare providers and 710 religious and community leaders.

Financing and management:

The SHARP programme was financed by the Danish government and managed by the International HIV AIDS Alliance, through a decentralised managerial structure. In each of the 4 SHARP countries IHAA linking organisations (independent national NGOs) contracted MSM-led organisations to be responsible for programme implementation. All implementing partners have been supported through organisational development activities, including strengthening financial management and programming and monitoring and evaluation systems and skills and in profiling the organisations in national, regional and international fora.

Lessons learned and recommendations:

The SHARP model and its' interlinked strategies are the main factors that ensured the success of the programme. Remarkably, the strong partnerships developed between MSM-led CSOs and the more traditional HIV clinical service providers constitute an important step forward in the provision of non-discriminatory quality HIV services to MSM and a critical element of programmatic sustainability. Moreover, knowledge developed and shared through south-to-south technical support platforms enabled SHARP main stakeholders to jointly address common problems, first and foremost, widespread intolerance and hostility towards MSM. To this end a human rights monitoring and response system (REACT – annexed) has been rolled out in two of the four countries. In addition, the political and cultural hostile environments, in which SHARP activities have been implemented, constituted the main challenge, especially the Anti Homosexuality Bill in Uganda which was signed into law (and subsequently repealed) during the programme implementation timeline.

Some of the key learnings of the programme include (1) the importance for MSM HIV programming of attending the broader dimensions of sexual health, satisfaction and pleasure through holistic models of care, (2) the critical role played by peer education in ensuring reach and the synergic and empowering effect that mobile technologies and social media can have within peer education and peer outreach.

81. Regional LAC

Title of the programme: Advocacy to challenge impunity and violence against transgender people

CONTACT PERSON
Name: Marcela Romero
Title: Executive Secretary
Organisation: REDLACTRANS
Address: Callao 339 6° B C1022AAD, Ciudad Autónoma de Buenos Aires, República Argentina
Tel: + 54 11 5032 6335
Email: marcelaromero_40@yahoo.com.ar

Programme is being implemented since:
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.) in relation to transgender people

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Transgender women in Latin America have an average life expectancy of 35 years. The lives of transgender women in Latin America are marked by a dynamic of exclusion that is the consequence of family, social and institutional transphobia. This begins at a young age when they are often rejected by their families, essentially excluded from the educational and health

care systems. This lack of education and access to job opportunities pushes the vast majority of transgender women in the region into sex work. Transgender women experience numerous violations of their human rights including extrajudicial executions, torture, cruel, inhuman and degrading treatment and arbitrary detention. They are the population with the highest prevalence of HIV in Latin America.

Description:

REDLACTRANS works to highlight the vulnerability and inequality of transgender women in Latin America, inciting States to take immediate action to rectify this situation and contribute to creating a political and legal environment that favours the inclusion of transgender women in society. It is focused on advocating for transgender rights, as well as the development of the network and its focal points. Recognition of their gender identity is a first step to making sure that the existence of transgender people is recognised. This is crucial to being able to gather data and evidence of human rights abuses specifically against transgender people. It is also a prerequisite for inclusive HIV and health policies that meet their needs. REDLACTRANS organises regional workshops and meetings about action to take when reporting crimes, such as hate crimes, human rights' violations, institutional violence, and gender based violence as well as carrying out training within the inter-American human rights system. Activists allege that in the majority of cases, the violence and threats come from State actors, the very people charged with the responsibility of protecting human rights and seeking justice, so sensitisation training of judges, secretaries, and the police plays an important role.

Results of the programme:

The Network has focal points in 14 countries in the region (Argentina, Belize, Bolivia, Chile, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, and Uruguay). Through its partnership with the International HIV/AIDS Alliance, the work of REDLACTRANS is shared with Alliance partners, covering 32 countries globally.

Impact of the programme:

The main achievement of the network to date is their instrumental role in the introduction of gender identity laws in Argentina. In the majority of Latin American countries, the gender identity of transgender people is not recognised by law, and so they are condemned to an existence that does not coincide with their gender identity. This law seeks to reduce discrimination based on gender identity by guaranteeing the rights and dignity of transgender people. It includes mechanisms for allowing people to change the gender and name given in their identification documents. In 2012, REDLACTRANS and the International HIV/AIDS Alliance published a report entitled "The Night is Another Country", which, in the absence of qualitative data due to the invisibility of the transgender population, provides powerful testimonies from the community. REDLACTRANS is continuing its advocacy work in order to generate changes in society and culture, battling for social, labour market and educational inclusion of the transgender populations of Latin America and the Caribbean.

Financing and management:

REDLACTRANS is a strategic partner of the International HIV/AIDS Alliance and as such receives a small grant each year to support work on advocacy and communications/research. In 2016, REDLACTRANS is being funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria to start a project on access to justice access to services (health, education) for

transgender people.

Lessons learned and recommendations:

REDLACTRANS feels it is essential that transgender organisations, civil society and the government work together to be able to prevent abuse of authority by the police, and to ensure fair treatment of all people, regardless of their gender identity. Sensitisation training is not an opportunity that is welcomed by the judicial authorities, so the training itself cannot be carried out without strong advocacy for it to take place. REDLACTRANS has learnt about the importance of evidence: where gender diversity does not exist, data is not disaggregated by gender and so gathering reports of human rights violations against Trans people in the region is vital.

82. Regional LAC

Title of the programme: Advocacy in the defence and promotion of the human rights of female sex workers

CONTACT PERSON
Name: Elena Reynaga
Title: Executive Secretary
Organisation: RedTraSex
Address: Avda. Independencia 3550, C1225ABQ -
Ciudad de Buenos Aires, Argentina
Tel: + 54 11 4931 0210
Email: secejecutiva@redtrasex.org

Programme is being implemented since: 2012-2016
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to sex workers

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Female sex workers (FSW) belong to one of the populations most affected by HIV, with a prevalence in Latin America of 2.57%, which is over 6 times greater than the regional prevalence of the general population at 0.4%. At the same time, it is one of the most neglected populations when it comes to public policies on prevention and treatment, due to the stigma and discrimination that arise from the adverse conditions under which sex work must be carried out.

Description:

RedTraSex was established in 1997 with the aim of strengthening the National Organisations of Female Sex Workers in the defense and promotion of human rights. The organisation's missions are the defense, promotion, recognition, and respect of the human rights of female sex workers, in particular, their working rights. Operating under the motto "sex workers are not the

problem but part of the solution" RedTraSex joins the collective effort in the fight against HIV/AIDS with a specific vision: the belief that the best way to stop transmission of the virus is to have an integral health perspective (physical and mental) and to consolidate the empowerment of people extending beyond condom distribution campaigns, recognising that we are all human beings with rights and that we must exercise these rights. To this end, RedTraSex promotes the strengthening and training of national and regional organisations and seeks to make the voice of sex workers heard in decision-making spaces regarding policies that affect them. RedTraSex does not seek to change the nature of sex work but rather the conditions that it is subject to and that put sex workers' rights in jeopardy.

Since 2012 (and until the end of 2016) the RedTraSex network is implementing a regional Global Fund grant aimed at decreasing HIV prevalence among sex workers in Latin America and the Caribbean through the strengthening of sex workers' organisations and an increased participation of sex workers' in the political debate about sex work and the stigma and discrimination that surrounds it. The organization is empowering sex workers so that they understand their rights and can better demand services (including HIV ones) that are often difficult to access.

Results of the programme:

Since the beginning of the programme, RedTraSex has participated actively in the Cairo+20 discussions in the Latin America and Caribbean region. RedTraSex also achieved the following results:

1) Improved participation of Female Sex Workers in national and regional HIV spaces to influence programmes, policies, laws and regulations and their implementation.
2) Carried out organisational capacity building with the national sex worker organisations
3) Improved knowledge about sex work and HIV and stepped up the fight against stigma and discrimination in 15 countries.

Impact of the programme:

The Network has member organisations in 15 countries in Spanish-speaking Latin America and the Caribbean —Argentina, Bolivia, Chile, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, Mexico the Dominican Republic, and Belize. Through its partnership with the International HIV/AIDS Alliance, the work of RedTraSex is shared with Alliance partners, covering 32 countries globally.

In 2013 RedTraSex reached 17,306 FSW for the first time, and over 30,000 taking into account prior contacts. In 2014 13,950 new FSW were reached, bringing the total for that year to 39,850. From November 2013 to January 2014, 7 national workshops on financial and technical capacity building were held, with the participation of 225 women. In 2014, six national workshops were held, bringing together 117 FSW. In addition, RedTraSex runs sex work sensitisation workshops with health and security officials in order to raise awareness and reduce stigma and discrimination. By January 2015, 1,062 people had been reached with these activities, significantly surpassing the original goal of 700. These represent a few areas of their work.

Financing and management:

RedTraSex's main source of funding comes from the Regional Proposal of the Global Fund

which ends at the end of 2016. RedTraSex is a strategic partner of the International HIV/AIDS Alliance and as such receives a small grant each year to support work on advocacy and communications/research/

Lessons learned and recommendations:

The daily life of women, and especially sex workers, is affected by a whole set of prejudices, pre-concepts, stigmas, and above all, inequalities (economic, cultural, and social) – emerged from ideological bases that the patriarchal system has structured. Organised sex workers are defenders of their sexual and reproductive health and human rights. This makes them more visible and often exposed to violence including institutional violence.

Female sex workers are first and foremost women, and want to join forces with other women's movements. It has been proven that the strategy of organising themselves is the most complete way to fight for sex worker rights, and modify state and police structures on behalf of their claims.

83. Global (Athena)

Title of the programme: ATHENA Network Young Women's Leadership Initiative

CONTACT PERSON
Name: Luisa Orza
Title: Programmes Director
Organisation: ATHENA Network
Address: 97a East Street, Bridport, UK, DT6 3LB
Tel: +44 7792 394209
Email: luisa.orza@gmail.com

Programme is being implemented since: 2011
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability in relation to people living with HIV, people who inject drugs, sex workers, transgender people, women and young people.

Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

While it is widely known that young women are disproportionately affected by HIV, their needs have been historically under-recognized and their voices under-represented as research agendas, policies, and programmes are being developed. Recognizing the unique needs and challenges facing young women in all of their diversity, the dearth of avenues open to young women for meaningful participation in the HIV response, and the need for adolescent girls and young women to actively participate and lead in the HIV response, ATHENA has developed an evolving leadership strategy for young women living with HIV and in all of their diversity.

Description:

Launched in partnership with the Global Coalition on Women and AIDS and UNAIDS at the International AIDS Society's 2011 Pathogenesis, Treatment and Prevention Conference, the YWLI is a leadership, advocacy and mentoring programme that aims to:

- increase the visibility of young women living with HIV, supporting them to claim spaces within key policy fora;
- define priority issues affecting young women living with HIV, and also showcase leadership and community-drive solutions; and
- increase their knowledge, skills and advocacy experience, particularly with regard to achieving sexual and reproductive rights in the context of HIV

Results of the programme:

To date approximately 75 young women living with and most affected by HIV are 'graduates' of and peer mentors within ATHENA's YWLI, from all regions of the world.

The programme has developed spaces and strategies to create and support meaningful engagement in the HIV response, through providing to girls and young women:

- Support to engage in national, regional, and international policy fora, and to engage as well as inform entities such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and PEPFAR
- Opportunities as country focal points to shape, inform and implement in-country project work
- Support to conduct and participate in community dialogues, and lead participatory action research
- Opportunities on global reference groups alongside more experienced women living with HIV activists
- Opportunities to meet and be in informal dialogue with key global leaders such as Ambassador Birx and Members of Parliament in the UK
- Advocating for and ensuring support for the mentored participation of young women at the Commission on the Status of Women; the International Conference on Family Planning; the African Sexual Health and Rights Conference; regional and international AIDS Conferences; R4P; and other ATHENA-convened spaces including the Women's Networking Zone.

Impact of the programme:

The ATHENA YWLI has seen participants of the programme develop and emerge as powerful leaders in their own right. One participant of a YWLI at AIDS 2012 went on to speak in a plenary session at AIDS2014 and to address the Human Rights Council. Another previous participant opened this year's plenary session at the Civil Society Hearing to the High Level Meeting on HIV and AIDS in April 2016. Other prior participants are sitting on the Global Fund Country Coordinating Mechanism of their country, engaging in critical dialogues about the roll-out of PEPFAR's DREAMS initiative, sitting on the UNAIDS Dialogue Platform for women living with HIV, and leading participatory research and advocacy in their countries and communities, and mentoring other young women to become spokespersons, advocates and leaders for human rights and gender equality.

Through this expanding cadre of leaders, we have seen direct impact in terms of WHO guideline processes being more reflective of and accountable to young women's realities; a zero draft Political Declaration for the High Level Meeting on AIDS that has substantive attention to young

people; and a robust portfolio of new leadership reigniting the HIV response through movement building, political engagement, and advocacy in the respective communities where our YWL alumnae live.

Financing and management:

ATHENA has resourced this initiative through pooling and leveraging resources (including in-kind support) from numerous partners including UNAIDS, Stop AIDS Now!, AVAC, and The Women and HIV/AIDS Research Initiative. Our most recent work has been funded through the Link Up consortium under BUZA.

Lessons learned and recommendations:

The success, sustained impact, and multiplier effect of the YWLI has been because ATHENA has served as an on-going platform and resource for our young women colleagues to be integrated within a broader community of practice, so that the knowledge sharing, mentorship, and inter-generational exchange is on-going and not limited to one workshop or one political moment.

More, ATHENA has actively sought to continually build new and diverse opportunities for these YWLI 'graduates' to lead in the HIV response, serve as mentor champions, and grow as our collaborators in all levels of our advocacy, research, and movement building.

84. Global (Athena)

Title of the programme: From Talk to Action: Putting Women, Girls and Gender Equality at the Heart of the HIV Response

CONTACT PERSON
Name: Tyler Crone
Title: Founding Director
Organisation: ATHENA Network
Address: 2565 8th Ave, Seattle, WA 98119
Tel: +1(206) 697 4789
Email: tyler.crone@gmail.com

Programme is being implemented since: 2011-2013
Implemented by: Civil Society and UN or other inter-governmental organization
Scope of submission: Advocacy, campaigning and participation in accountability in relation to people living with HIV, women, and young people.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? Yes

Background:

Women and girls are disproportionately affected by HIV in much of the world. This is especially true of the generalised epidemics of southern and eastern Africa, where 60% of people living with HIV are women and girls; women and girls shoulder a disproportionate burden of care

within the context of HIV and AIDS; and gender-based violence is clearly recognised as both a cause and a consequence of HIV transmission. Underlying all of these elements is gender inequality, which heightens the vulnerability of women and girls to HIV as well as fuels and is fueled by the epidemic.

National Strategic Plans have the potential to serve as influential instruments for articulating and supporting a gender responsive agenda for women, girls, and gender equality in the context of HIV, and yet to date this potential has not been fully met. The programme, From Talk to Action: Putting Women, Girls and Gender Equality at the Heart of the HIV Response, was born out of recognition of this potential, and the outstanding gaps and priorities in NSPS, and in line with Pillar 2 of the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV (UNAIDS Agenda), "Translating political commitments into scaled-up action to address the rights and needs of women and girls in the context of HIV."

The Framework for Women, Girls and Gender Equality in National Strategic Plans on HIV and AIDS in Southern and Eastern Africa ("the Framework") was developed by the ATHENA Network and the Gender Equality and HIV Prevention Programme at HEARD in collaboration with 19 organizations and networks working to advance gender equality and women's rights in the context of HIV. A review against the Framework, of over 20 existing NSPs in southern and eastern Africa was undertaken by HEARD and ATHENA. The review, From Talk to Action, provided a 'snapshot' of current strengths, weaknesses, and gaps and included an analysis identifying key priorities and recommendations.

Description:

Building from the process of Framework development and NSP analysis, ATHENA co-convened – in partnership with the UN Interagency Working Group on Women, Girls, Gender Equality and HIV, and the MenEngage Alliance – a series of multi-country and multi-stakeholder consultative workshops and trainings over the period October 2010 to December 2013. The workshops aimed to strengthen understanding around GBV and HIV, and provide delegates with tools and knowledge for strengthening their countries NSPs around these issues with evidence based programming. Delegates spanned representatives of National AIDS Commissions, Ministries of Health, Ministries of Gender and Women Affairs, the UN family, networks of women living with HIV, women's rights organisations, organisations engaging men and boys for gender equality, and entities with expertise in addressing gender-based violence, and with specific emphasis on the meaningful involvement of young women and women living with and affected by HIV.

Results of the programme:

These processes brought together key stakeholders across the HIV response, strengthened the engagement of those most affected by HIV in policy analysis and setting, and generated a broader global audience for the tools and products than that originally conceived. Through the series of 8 multi-country meetings, the programme reached more than 250 governmental, non-governmental, and UN partners have been directly involved in ATHENA initiated and convened efforts to strengthen the HIV policy framework for women, girls, and gender equality across Southern and Eastern Africa, and globally, in 45 countries (see map attached as annex)

Impact of the programme:

In a follow-up impact assessment, and through informal feedback mechanisms, delegates reported some of the results that have been catalysed across participating countries, including:

- Identifying gaps and priorities in national policies plans on HIV and AIDS
- Strengthening language around gender equality and gender-based violence integrated into national policies, including in accountability structures
- Promoting increased engagement and leadership of women living with HIV and other key affected women
- Empowering the grassroots
- Catalysing for the engagement of men and boys as agents to halt gender-based violence and advance gender equality
- Encouraging partnership and cooperation between NAC and civil society

Financing and management:

The Framework development was funded by HEARD at the University of Kwa Zulu Natal through SIDA. The multi-year series of workshops was conducted in partnership with The UN Interagency Working Group on Women, Girls, Gender Equality and HIV, (specifically: UNFPA, UNDP, UNAIDS, UN Women, UNICEF and WHO), and civil society partners including MenEngage, Sonke Gender Justice, HEARD, and Salamander Trust. It was financed by UNDP and UNFPA primarily with financial and in-kind donations from UNAIDS (Secretariat) and regional offices in West and Southern Africa.

Lessons learned and recommendations:

ATHENA's ability to realize change with documented impact was because we were committed to a community driven and led process for women, girls, gender equality, and HIV, and had a baseline of core funding through HEARD to facilitate a multi-country and cross regional core team to lead the work and pro-actively pursue and create key political moments. More, strengthening the capacity of women living with and most affected by HIV as team members and as the leaders to operationalize the Framework at the country level was a cornerstone of this initiative.

It was from this foundation that we were able to scale the work and pursue a multi-country, multi-year process with a particular focus on strengthening attention to gender-based violence in policy frameworks with UN partners.

The experience also highlighted the value and importance of bringing civil society, community partners, UN family, and key government folks together outside of their respective home countries to meet, work together, and share experiences, establishing a peer-led forum for exchange and learning.

We see this groundwork and approach as a key model to inform how to strengthen forthcoming generations of NSPs, build opportunities for community partners and key women leaders to be active partners in leading the HIV response in their countries and regions, and take one step further to link with resource mechanisms such as the Global Fund to Fight AIDS, Tuberculosis, Malaria.

85. Global (Robert Carr Network)

Title of the programme: The Robert Carr civil society Networks Fund (RCNF)

CONTACT PERSON

Name: Irene Keizer
Title: Fund Manager Robert Carr Networks Fund
Organisation: Aids Fonds
Address: Keizersgracht 392, Amsterdam
Tel: +31 – 20 6262669
Email: secretariat@robertcarrfund.org

Programme is being implemented since: 2012
Implemented by: Civil Society
Scope of submission: Advocacy, campaigning and participation in accountability and Community financing in relation to all key populations (people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender, women, and young people).

Has the programme been evaluated /assessed? Yes

Background:

The creation of the Robert Carr civil society Networks Fund was an urgent reaction to specific and threatening trends in the landscape for civil society action on HIV, such as: reduced overall funding for HIV; a shift in donor funding towards the country level; and a push towards greater coordination among civil society players. These trends were occurring against the backdrop of persistent marginalization and human rights abuses against the inadequately served populations (ISPs) known to be central to 'know your epidemic' responses. Yet the bodies recognized as critical coordinators and advocates for such communities – namely global and regional civil society networks, especially those by and for ISPs – were suffering from a severe, and worsening, lack of resources and capacity. Many were 'falling through the cracks' of existing financing mechanisms – facing acute restrictions on their work, even closure.

Description:

The RCNF is a unique cooperation of donors and civil society networks active in the area of HIV. Working towards Ending AIDS in 2030 - the HIV response needs to scale up dramatically in the upcoming five years. Civil society networks that strengthen country level responses will play a critical role in this scale-up. The RCNF enables civil society networks to live up to that role. It is the first international fund that specifically aims to strengthen global and regional networks across the world, providing them with both programmatic and core funding.

RCNFs four objectives/outcome areas are: 1. To improve global and regional network capacity; 2. To enhance HIV response implementation; 3. To support human rights advocacy; and 4. To increase resource accountability for the HIV response.

The programme is implemented by the communities and populations, who shoulder the burden of HIV, yet receive inadequate responses and insufficient resources to meet their needs and to reverse the impact of the epidemic. Inadequately served populations include people living with HIV, gay men and other men who have sex with men, people who use drugs, prisoners, sex workers and transgender people. In a number of localities, women and girls, youth, migrants and people living in rural areas could also be considered ISPs.

ISPs continue to be disproportionately affected by HIV, but they lack access to decision-making. There are a number of existing processes and funding channels to support civil society action at

the country level. Making maximum use of these – and securing the resources, services and political environment that ISPs need - requires the analysis, expertise and action that only regional and global networks can mobilise and provide.

The RCNF operates on a global, national and regional level in Eastern and Southern Africa, Latin America, South-East Asia and Eastern Europe/Central Asia.

The primary focus of the fund is on advocacy and capacity strengthening, to enhance the quality, effectiveness, relevance and equity of AIDS responses reaching inadequately served populations.

Results of the programme:

The RCNF has made significant and impressive progress. With the allocation of 38 grants (worth $ 18,217,092) the fund provided a lifeline to some of the most important global and regional civil society actors in the response to HIV. There are multiple concrete examples of how the Funds resources have strengthened networks' structures, programmes and advocacy – and in turn, boosted their ability to make a difference to inadequately served populations in HIV responses.

Impact of the programme:

The overall conclusions of the Mid-term review, conducted in 2014 (see annex 1), were that the RCNF has identified a unique and strategic niche within the global architecture; developed effective grant-management policies and processes; and established appropriate and highly committed governance bodies. The RCNF's grantees are achieving impressive outputs across the RCNF's four outcomes – with strong indications that, in combination, these are ensuring stronger support to ISPs and more effective responses to HIV at the country, regional and global levels.

Financing and management:

The Robert Carr civil society Networks Fund has three bodies: the International Steering Committee (ISC), the Program Advisory Panel (PAP) and the Fund Management Agency (FMA). All three are linked, but operate separately.

The RCNF is overseen by a governing body, the International Steering Committee (ISC), bringing together the founding donors, Norad, DfID, PEPFAR and the Bill & Melinda Gates Foundation (BMGF), and representatives of civil society networks working on AIDS at global and regional levels. The ISC is responsible for the Fund. They set strategic direction, define funding priorities in a given funding cycle, maintain oversight and approve proposals for funding, based on the advice of the Program Advisory Panel (PAP). The ISC also instructs the Fund Management Agent (FMA), Aids Fonds, whose role it is to operationalize decisions, enter into agreements with grantees and donors, and manage, monitor and report on these agreements. Aids Fonds functions as the RCNF secretariat.

The PAP operates independently from the ISC and with logistic support provided by Aids Fonds (FMA); the panel is peer-led and includes technical experts in areas under consideration for funding. The PAP reviews the proposals submitted for consideration and provide funding advice.

Lessons learned and recommendations:

The Robert Carr Civil Society Networks Fund has been designed as a pooled funding mechanism, to ensure that civil society networks have sufficient and predictable resources to enhance the quality and effectiveness of AIDS responses. The RCNF operates at various levels, which is fundamental to its focus on the support of regional and global networks. It has a Theory of Change (annex 2), enabling the Fund to monitor its overall progress, at the same time allowing regional and global networks to trace their impact to local and national responses. The RCNF case study was included into the "Communities Deliver" publication from UNAIDS and the STOP AIDS Alliance.

86. Global (World Bank)

Title of the programme: Evaluation of the Community Response to HIV-AIDS

CONTACT PERSON
Organisation: The World Bank

Programme is being implemented since: 2009
Implemented by: UN or other inter-governmental organisation
Scope of submission: Advocacy, campaigning and participation in accountability; Community-based service delivery (i.e. testing, prevention, care and support, treatment, legal services, task shifting, training of health care workers, etc.); and Participatory community-based research in relation to all key populations (people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender people, women, and young people) in addition to heterosexual men.

Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes
Is the programme part of a national emergency response plan? No

Background:

In the HIV and AIDS field, community-based organizations (CBOs) have been at the forefront of the global response to the epidemic since it emerged. The first responses to AIDS came, almost universally, from HIV-positive individuals, their families and communities, who organized themselves to care locally for those in need. Now, CBOs working on HIV and AIDS represent a complex, international web of groups working along the entire continuum of prevention, care, treatment and support, and enabling communities to adjust their behaviors in order to halt the epidemic by creating space for social dialogue around HIV and AIDS.

Over the last decade, donors recognized the important role played by CBOs, especially in reaching certain populations and in scaling up successful approaches. Currently, community systems and services remain at the forefront of the HIV and AIDS strategies of critical actors like UNAIDS, PEPFAR and the Global Fund, and national-level programs.

The evaluation explored the link between community response and outcomes.
DFID and the World Bank agreed to collaborate on an evaluation, which was formed around a compelling hypothesis: a strong community response contributes to a stronger national HIV and AIDS response, and hence improves HIV and AIDS-related outcomes. The evaluation asked

several specific questions:

1. Do communities with a strong community response to the HIV and AIDS epidemic show greater access to and utilization of HIV/AIDS services; better knowledge, attitudes, perceptions and behavior with respect to HIV and AIDS; better HIV and AIDS outcomes; and differences in social transformation?
2. How does the allocation of funding by CBOs contribute to the community response?

Description:

Given the multiplicity of community responses, the researchers selected an approach that involved several countries, several methods, and several types of studies. A total of 11 studies were carried out in eight countries (Burkina Faso, India, Kenya, Nigeria, Lesotho, Senegal, South Africa and Zimbabwe), selected for their diversity of epidemic status (generalized vs. concentrated), HIV prevalence (from high to low) and regional location. The methodology varied across countries. Of the 11 studies, three used an experimental design with individual, household or community randomization; five were quasi-experimental using repeated cross-sectional surveys and matching methods to establish comparison groups; and two studies were descriptive analytical studies. The experimental and quasi-experimental studies used robust methods for establishing a counterfactual. Most country studies also collected a range of qualitative data. Desk studies review existing documentation, use new survey data and analytical frameworks to inform and complement country evaluations. To capture the diversity of community responses, the evaluation covered different types of community organizations –from more to less formal.

Results of the programme:

The findings provide strong evidence of community results in the 8 countries covered (Burkina Faso, India, Kenya, Nigeria, Lesotho, Senegal, South Africa and Zimbabwe). The evaluation produced findings for each of the target questions. Unless specific population groups are noted, the findings relate to adult men and women in the general population. A summary of the findings is presented below; more detailed findings are available in the final publication, as well as in several country-specific study briefs.

The financial and human resources of communities, the institutional structure and the activities of the groups generated by communities, the extent to which community members are empowered to take action against the spread of HIV infections as well as the overall policy environment and health infrastructure provided by government and other organizations are some of the key factors that affect the outcomes of the community response to HIV and AIDS.
The evaluation found strong evidence (causal, associative and suggestive) that depending on country contexts and delivery mechanisms of services, the community response can:

1. Help mobilize substantial local resources
    - Volunteers (Kenya, Nigeria, Zimbabwe)
    - Local donations (in kind and financial)
2. Improve knowledge and behaviour in the following areas:
    - HIV knowledge (Kenya; Burkina Faso)
    - Use of condoms (Kenya; India, Zimbabwe)
    - Sexual risk perception(India)
    - HIV testing uptake (Senegal; Zimbabwe)
    - Behaviour of the partners of HIV positive individuals (Senegal; causal evidence)
3. Increase the use of services

- Prevention, treatment, care and support (Nigeria)
- HCT and PMTCT (Zimbabwe)
- ART treatment (timeliness of clinic and hospital visits, South Africa)
- STI (India)

4. Affect social processes outcomes in different ways:
    - There is strong causal evidence that home-based HIV counselling and testing affects community leaders and members beliefs concerning stigma (Kenya)
    - There is mixed evidence on the contribution of CBOs to social transformation related to:
        - Gender norms
        - Domestic violence and abuse
        - Stigma
5. Impact HIV incidence and other health outcomes
    - There is strong evidence that:
        - Being part of a community group can decrease HIV incidence, however, the effects differ by gender, the type of community groups and the stage of the HIV epidemic (Zimbabwe)
        - Community groups generate benefits that extend to the whole community and not just their members (Zimbabwe)
        - The mobilization process of groups at high-risk of infections (FSWs, MSM and transgenders) can lead to reduced STI prevalence (India).

Impact of the programme:

Although there are areas that require further study, the overall evaluation provides robust, relevant and actionable findings that can be utilized by nearly all stakeholders engaged in improving national responses. Taken in isolation, each evaluation provides only partial information on the effects of the community response. Taken together, however, the various studies advance corroborating evidence that helps provide a full picture of the impacts and enablers of community responses.

Financing and management:

This Programme is the result of collaboration between DFID and the World Bank.

Lessons learned and recommendations:

Different aspects of the community response contribute to the success of the national response. The community response helps increase the community's access to and use of government services. It can also modify behaviour and thereby reduce the number of HIV infections. This means that the role of community groups can expand beyond simply providing an enabling environment that stimulates access to services. Resource-poor communities and CBOs may need additional if limited financial resources. CBOs have largely unrecognized assets in the form of volunteers who are already playing a key role in the day to day response to HIV and AIDS. The contributions of this resource could be enhanced. There is a need for a greater formal recognition of the role of volunteers, coupled with increasing their capacity to improve the quality of services. To maximize the effectiveness of the community response, governments, development partners and civil society may wish to consider: (i) improving the focus of CSOs on specific actions, services, populations (priority and at risk), interventions and results; (ii)

improving the consistency between HIV epidemic and CBOs actions and services; (iii) Maximizing effects of community groups on men and women; (iv) making specific the roles of CBOs to complement efforts by other actors (Government, donors, international NGOs); (v) providing CBOs with greater access to better targeted technical assistance; and (vi) exploring different ways to enable CBOs to improve their accounting and show how they provide value.

Overview of Case Studies submitted for the 38th PCB Thematic Segment: Communities Role in Ending AIDS

I. AFRICAN STATES

#	Country	Title of the programme and submitting organisation	Subject of the Case Study	Comments/ links to background note
1.	Botswana	Communities Acting Together to Control HIV (CATCH) By: National AIDS Coordinating Agency (NACA)	CATCH is a bottom-up community-driven approach led by the traditional leadership of the community (DiKgosi/Chiefs). The approach aims at facilitating a process of deeper and long-lasting change to happen over generations. CATCH main objective is to build the competence of selected communities in developing behavioural, structural and biomedical interventions that will help reduce new HIV infections to zero. The approach allows community systems to facilitate community-driven activities using a methodology that includes these basic steps: (1) meaningful consultations through household visits looking at the inherent strengths and knowledge of the community members, (2) building a common vision of where the community wants to be heading together, (3) jointly assessing their current situation, and finally, (4) planning for joint solutions, and (5) implementing and measuring those solutions/actions. Since 2015 in the pilot phase of CATCH, over 11'000 indivPWUDals have been reached through house to house visits and 51 traditional leaders as well as various key health and community stakeholders have been involved in deeper discussions around HIV, looking at their own strengths as a community.	● Advocacy, community-based research ● Community wide ● Traditional leaders ● Civil society & government-led
2.	Burkina Faso	Improving access to prevention and treatment of HIV / AIDS and hepatitis in Burkina Faso by defending the human rights of the most vulnerable populations By: ONG/REVS+	Strengthening the advocacy capabilities of project partner associations will improve the respect of the human rights of the most vulnerable groups vis-à-vis HIV / AIDS and hepatitis, as well as the appropriate interventions. Overall objective: Strengthening the advocacy capabilities of project partner associations will improve the respect of the human rights of the most vulnerable groups vis-à-vis HIV /	● Advocacy ● Civil society-led ● MSM, PWUD, sex workers Hep C & HIV

			AIDS and hepatitis, as well as the appropriate interventions. Specific objectives (SO)1: Information / awareness of key intermediate actors will enable the strengthening of the respect of the rights of target vulnerable groups and ensure their non-discrimination in the fight against HIV / AIDS. SO 2: Project partner associations strengthen their capabilities to defend the rights of vulnerable target groups. SO 3: Strengthening of advocacy at the national level and within international bodies to increase the pressure on the country to better respect the rights of vulnerable target groups.	
3.	Burkina Faso	Promotion des valeurs morales et éducatives dans le contexte de la lutte contre le VIH, le SIDA et les IST By: URCB/SD	L'Union des Religieux et Coutumiers du Burkina pour la promotion de la santé et le développement (URCB/SD) est une organisation interconfessionnelle qui a pour but est de créer une synergie d'actions entre les communautés religieuses et coutumières dans les interventions en matière de santé et de développement. L'URCB/SD a défendu et obtenu l'inscription d'un domaine d'action prioritaire dans le cadre stratégique national 2011-2015 en rapport avec la promotion des valeurs morales et éducative comme moyen de prévention efficace contre le VIH et les IST. Cette proposition a été saluée par les plus hautes autorités de notre pays à l'époque et qui traduit l'engagement des communautés religieuses et coutumières dans la prévention de la pandémie. Les valeurs promues sont l'abstinence et la chasteté chez les jeunes avant le mariage et la fidélité au sein des couples mariés.	• Humanitarian • Faith-based • Civil-society
4.	Burundi	The role of communities in ending AIDS by 2030 By: BURUNDI ALLIANCE FOR THE FIGHT AGAINST TUBERCULOSIS AND LEPROSY "ABTL"	Community Health facilitators of the ABTL intervene in making communities aware of voluntary screening and behaviour change with regard to the scourge of TB / HIV co-infection. The supervised key populations receive care and there is regular monitoring if they are affected by HIV, additionally, affected police officers are relocated to areas where their daily work is made easier and they receive financial support such as	• Advocacy • Service delivery (HIV/TB) • Community-based research

			nutritional support which is taken from the fund. There are now 6,669 people affected by TB of whom 42% have AIDS and are followed up by the CDT, they come from different communities and the ABTL had organised the strengthening of the community systems on the gender and human rights component in cases of TB / HIV. During this consultation, recommendations were made.	● Financing ● Humanitarian ● Civil society ● PLHIV, sex workers, PWUD, MSM,young people
5.	Burundi	Improving access to prevention and treatment of HIV / AIDS and hepatitis in Africa and the Caribbean by defending the human rights of the most vulnerable populations (MSM, IDU, SW, transgender people) By: ANSS Burundi	This project by ANSS Burundi aims to strengthen capacity of various actors to challenge the exclusion of vulnerable groups from programmes for the prevention and treatment of HIV. ANSS Burundi recognized that in parallel to working to improve access to prevention and treatment among those most vulnerable to HIV, it also is critical to sensitize and educate the general population to change their perceptions and attitudes towards vulnerable groups. Since the start of the project, 75 sex workers, 35 men who have sex with men and transgender people, 50 health facilitators, 33 legal workers, 20 civil society actors, and 23 drug users have been reached with information and sensitized regarding the links between the human rights of vulnerable groups and the struggle against HIV. Additionally, many government and non-government actors working in the areas of HIV and protection of human rights have been approached to become involved in advocacy activities. The project is being conducted throughout the territories of the country, but until now the activities have been led from Bujumbura and in 3 provinces where ANSS has branches (Makamba, Gitega and Kirundo). The project's main impact is that it has been able to approach a taboo subject by sensitizing stakeholders to generate a change of attitudes towards vulnerable groups.	● Advocacy – rights-based ● Service delivery ● MSM, PLHIV, TG, Sex workers, PWUD ● Civil society
6.	Burundi	The role of communities in ending AIDS by 2030 By : Ministry of Public Safety	Peer educators in the police have been trained and intervene by making police officers aware of voluntary screening and behaviour change with regard to the scourge of AIDS. Police officers and members of their family or the local	● Service delivery ● Community-based

			population come to our centre and receive care and regular follow-up if they are affected by HIV, additionally, affected police officers are relocated to areas where their daily work is made easier and they receive financial support such as nutritional support which is taken from the fund set aside for this purpose. We currently have 78 people that are followed up by the Centre and who receive healthcare. They come from 18 police stations and have been made aware by peer educators, 45 per station.	research ● Finance ● PLHIV, MSM, women Government
7.	Burundi	Application de la Science pour le Renforcement et l'amelioration des Systemes By: Programme National de Lutte Contre le Sida et les Infections Sexuellement Transmissibles	(i) améliorer l' utilisation des services PTME , (ii) améliorer la qualité des services PTME , (iii) améliorer la rétention des mères et des nouveaux nés le long du continuum des soins, (iv) renforcer le système de santé communautaire . Pour atteindre ces objectifs, le Projet appuie le Ministère pour mettre en place un processus d' amélioration de la qualité s' appuyant sur une approche collaborative mettant plusieurs formations sanitaires en réseaux afin de capitaliser les énergies vers l' atteinte rapide des résultats et l' extension des meilleurs pratiques vers de nouvelles structures sanitaires du pays. La première phase du programme a concerné soixante-dix (70) formations sanitaires comprenant les CDS et les Hôpitaux réparties dans quatre Provinces du pays à savoir les provinces de Kirundo, Muyinga, Karusi et Kayanza. Ces structures ayant chacune mise en place une EAQ, travaillent pour analyser le processus PTME et testent les idées de changement en rapport avec les gaps de qualité. Les travaux effectués par les EAQ sont ensuite partages et discutées périodiquement lors des sessions d'apprentissage qui regroupent des représentants de chaque équipe ainsi que l' équipe des coachs provenant des BDS ,BPS, PNLS/IST et le Staff du Projet . • Amélioration de la couverture des services PTME qui a abouti à une diminution de la transmission du VIH de la mère à l'enfant.	• Service delivery • Pregnant women and their families • Government & UN

			• Augmentation du nombre de femmes accompagnées par leurs maris au service de CPN • Renforcement du lien /collaboration entre le niveau formation sanitaire et le niveau communautaire • Valorisation de la contribution de la communauté dans la promotion de sa propre santé • Appropriation/ institutionnalisation de l'approche par les responsables des différents niveau du système de santé	
8.	Burundi	Prévention par le dépistage en stratégie avancée By: Association Nationale de Soutien aux Séropositifs et malades du sida (ANSS)	• Atteindre le plus de personnes possible, les sensibiliser à la prévention et dépister les volontaires. • Qui le met en œuvre : une équipe multidisciplinaire de conseillers et de laborantins • Comment il fonctionne : Organisation d'une ou deux campagnes de sensibilisation et dépistage en stratégie avancée, c'est-à-dire que l'équipe va vers la population. Cette dernière se fait dépister en masse lors de ces campagnes. • Portée programmatique : Le programme ne fait pas beaucoup de résultats faute de moyens financiers (réactifs, frais de collation, frais de communication, carburant, etc). • Portée géographique : le programme est mis en œuvre dans 4 provinces du Burundi où l'ANSS a des antennes. • Principal objectif du programme « Motiver la population à se faire dépister pour une meilleure prevention • Le nombre des personnes atteintes : dans les 3 dernières années, sur 2931 personnes sensibilisées, 1367 se sont fait dépister ; 35084 condoms et 350 fémidoms ainsi que 2720 pièces de gels lubrifiants ont été distribués	• Service delivery (prevention) • MSM, TG, sex workers, PWUD, women, young people

9.	Burundi	Protecting sex workers from HIV By: Resaux Solidarité pour le Droit des travailleuses du Sexe	Use condoms consistently and correctly. Use a female condom. If the client refuses to use a condom, offer non-penetrative activities such as masturbation, external ejaculation or using clean sex toys. Use lubricant to reduce friction and prevent the condom breaking, especially for anal sex. Access emergency contraception and emergency HIV treatment (PEP) if the condom breaks. The program work in 6 provinces per 18.The provinces are Rumonge, Bujumbura BUBANZA ,Cibitoke ,Ngozi et Kayanza	• Advocacy • Service delivery • Not a complete template
10.	Burundi	Generation Sans VIH BY: Programme Nationale De Lutte Contre Le Sida Et Les Infections Sexuellement Transmissibles (PNLS/IST)	Le projet « Génération sans VIH » s'articule sur les objectifs spécifiques suivants (i)Réduire la transmission du VIH aux nourrissons nés de 400 mères séropositives grâce à la fourniture de services de gestion de cas pour les couples séropositifs ; (ii)Adoption de comportements positifs en matière de santé sexuelle et reproductive qui empêchent la transmission du VIH; (iii) Les leaders communautaires et d'opinion prennent des mesures pour améliorer la sensibilisation et l'accès à la PTME et les services de SSR. Grace au projet 202 femmes séropositives ont été accompagnées. Parmi elles, 98 ont été admises sous PTME. 82 enfants, dont 43 ont été testés et connaissent leur état sérologiques. un seul enfant a testé VIH+. 6400 femmes et filles en âge de procréer ont reçues des messages d'IEC/CCC sur l'importance des consultations prénatales précoces, les consultations postnatales, le dépistage volontaire du VIH, la SSR, la PTME, la lutte contre la stigmatisation et le planning familial.	• Service delivery (pregnant women, SRH) • Civil society
11.	Cameroon	Le Life Center, mon espace communautaire à moi! By: Horizons Femmes	New, independent, national grassroots network for and by people living with HIV (PLHIV) and HIV co-infections in Canada formed in June 2015. CPPN does is advocacy on the national and international levels: examples include 1) helping to lead the creation of the Canadian Declaration by PLHIV at the IAS Conference 2015 to	● Advocacy Young people, people with HIV co-infections,

			support the Vancouver Consensus on expanded testing, treatment and the use of new prevention technologies such as PrEP, yet highlighting the human rights concerns as expressed by an international group of PLHIV delegates on the approach as left out by the consensus statement; and 2) representing the needs of PLHIVs and civil society by making an intervention on GIPA at the UN Civil Society Hearing in April 2016. Other areas of focus include: building strategic alliances with service organizations of national, regional and local reach such as co-hosting the HIV, Aging and Income Security Think Tank with the Canadian Working Group on HIV and Rehabilitation (CWGHR); and filling the gaps of existing programming by working with HIV+ youth and YouthCO to create a Youth HIV Disclosure Project.	PLHIV
12.	China *	China AIDS Fund For Non-governmental Organizations (CAFNGO) By: Fund Management Committee Office	CAFNGO was established jointly by the National Health and Family Planning Commission, the Ministry of Finance and the Ministry of Civil Affairs as a national public welfare special fund in June 2015. CAFNGO aims to support NGOs to undertake education and communication activities, prevention interventions, testing and counselling among high risk groups, as well as care and support for people living with HIV/AIDS (PLWHA), in accordance with national and local HIV/AIDS response plans and policies. 754 projects elected from 467 NGOs which covered 30 provinces in China were funded by the CAFNGO in the year of 2015. Total amount of funding was 45.21 million RMB.	● Financing (national fund to support NGOs) ● Advocacy ● Service delivery ● PLHIV, sex workers, PWUD, MSM ● Civil society, government, private sector, UN-led
13.	Democratic Republic of the Congo	HIV/AIDS prevention amongst Gay men, Men who have sex with men, Transgender (GMT) and Sex workers through voluntary counseling and testing services:	This project contributes to reducing the spread of HIV / AIDS among vulnerable groups. To achieve this, the project seeks to provide access to 1000 GMT sex workers to HIV voluntary testing so that they can prevent against HIV and facilitate referrals to treatment, care and support for PLWHA in Bukavu	● Service delivery – testing, linkage to care

		field experiences of HIV Community-based Testing Center of NGO"AHUSADEC" in Bukavu, South-Kivu Province, East of DRCongo. By: Humanitarian Action for Health and Development Community (AHUSADEC).	town, South-Kivu Province, East of DR Congo. AHUSADEC provides HIV testing, counselling, and outreach services to gay men, other men who have sex with men and transgender (GMT) indivPWUDals and to female and GMT sex workers. It is the only group in this part of the country targeting GMT indivPWUDals with HIV services. These services include the prevention of HIV transmission, improving access to HIV services including Our HIV AIDS testing center reached 1674 people in general public and 908 GMT sex workers who having made the HIV testing of which 19 have been declared HIV positive.	● PLHIV, sex workers, MSM, transgender, women, young people, other ● Civil society ●
		L'émergence du leadership agissant des travailleuses/eurs du sexe et MSM pour la prévention de la transmission sexuelle du VIH/sida: Enjeux pour la protection de la santé publique en RDC, Expérience de l'ONG ALCIS	L'émergence du leadership agissant des travailleuses/eurs du sexe et MSM pour la prévention de la transmission sexuelle du VIH/sida ». Ce programme a été monté dans l'urgence pour répondre à l'urgence nationale pour une nouvelle orientation du cadre d'investissement de riposte nationale contre le VIH/sida. Ce programme vise premièrement à placer les travailleuses/eurs du sexe et les MSM à l'avant-garde de la lutte nationale contre le VIH/sida et amener les populations clés à tracer la voie pour une Génération sans sida en RDC	• Advocacy • Template not completed – concept note/description submitted
14.	Ethiopia	Radio Program to reach out to sex workers and communities By: Nikat Charitable Association	The Association transmitted a once weekly radio program that advocates for the prevention of trafficking, discussion about HIV/AIDS, radio diary of a sex worker life since the beginning, peer education, discussion of sex workers about their health and life and a follow up program with stakeholders related to sex workers. Also to advocate about prevention of trafficking/exploitation of young people/minors to the sex industry, SRHR rights and the law on minors. The program has reached more than 2,000,000 audiences in Addis Ababa and its surroundings. Outcomes - Respecting the rights of sex workers by the community, raising awareness level of SRH and HIV through Participatory approach of the program for audience. Increase	● Advocacy ● Sex workers ● Radio re. rights and health,

			the support of the community for sex workers.	
15.	Gabon	Le Wé là chez les jeunes By: Medzoe Santé Plus	1- Promotion du dépistage et connaissance du statut sérologique VIH chez les jeunes (prévention), 2- Accompagner, soutenir et éduquer les nouveaux cas dans le circuit de prise en charge (traitement), 3- Favoriser la charge virale supprimée chez les jeunes conditionnés d'ici 2018 (accompagnement et appui psychosocial et thérapeutique). Flyers, Booklet et spots pour la prévention et l'orientation des jeunes sur les droits humains et accompagnement communautaire ; La mise en place d'un pool d'agent communautaire pour l'appui psychosocial et thérapeutique. Premier déploiement d'agent communautaire locaux et les expériences régionales prouvent l'efficacité et le rôle important de ces agents comme relais essentiel aux professionnels de santé, d'où l'utilité de sa mise en œuvre au Gabon appuyé par l'hotel de ville de Libreville dans le cadre de l'initiative des villes, dont la Gabon est signataire et la Mairesse de Libreville occupe la vice-présidence Afrique.	● Service delivery (linkage to care, HTC, psychosocial) ● Community-based research ● Financing ● Humanitarian ● PLHIV, sex workers, young people, other ●
16.	Ghana	Stigma and discrimination reduction among PLHIV and key population By: Commission on Human Rights and Administrative Justice	HIV prevalence in the general adult population in Ghana is 1.5%; however, prevalence among men who have sex with men and female sex workers is much higher, at 17.5% and 11%, respectively. This has been driven by stigma, discrimination, poor health services access, and health and human rights violations. Although structures are ostensibly in place to ensure that everyone in Ghana has access to means for justice, the daily stigma and discrimination makes it difficult for people living with HIV and key populations to access these systems in practice. In response, the Commission on Human Rights and Administrative Justice (CHRAJ) created the Discrimination Reporting System (DRS) in 2013. The DRS uses online web-based and SMS reporting modules, to	● Advocacy ● Service Delivery ● Government ● Innovative online

			facilitate the reporting and tracking of cases online and also send text message via the phone to CHRAJ whilst reducing the need for in-person contact. The CHRAJ also trained national facilitators to carry out further trainings for their staff, and the programme operates using a Privacy and Confidentiality Policy developed by the CHRAJ, which is the first of its kind at the CHRAJ since its establishment 23 years ago. The implementation of the programme has made justice more accessible for people living with HIV and key populations by strengthening legal support services for redress. It has also empowered people living with HIV and key populations to fight against social issues that impede the right to health. Between 2013 and 2015, the CHRAJ trained approximately 200 staff on stigma and non-discriminatory practices, across seven regions of Ghana identified as areas of high HIV prevalence. Initially, the CHRAJ noticed that uptake was low, with only 22 cases being reported. Identifying this as due to a knowledge gap on stigma, discrimination and human rights issues, the CHRAJ quickly worked with civil society organizations to bridge the gap and generate demand, to train approximately 464 PLHIVs, members of key populations and service providers during 2015 in six regions of the country, and developing social marketing materials including brochures, cards and fliers. These were distributed nationwide along with anti-stigma and discrimination posters over 200 sites, and a targeted radio advert aimed towards PLHIV was aired over a period of two weeks. The DRS provides data on discrimination for advocates and policy makers in Ghana.	
17.	Ghana *	Reinforcing the scaling up of HIV services: Strengthening Community-Based HIV prevention and effective targeting By: Mihoso International Foundation	The primary focus of the programme is on; community-based advocacy, Demand for HIV/TB service delivery (HIV prevention, treatment, care and support, Human Rights sensitisation etc), evidence based-research, and livelihood empowerment of key population. The project goal is to reduce new HIV infection and death among Key Population in the next 3 years (2014-2016).	● Advocacy ● Service delivery ● Community-based research ● PLHIV, sex

			The specific objectives of the project are: IV. To promote the adoption of Safer sexual practices among the Key Population. V. To promote health and the adoption of safer sexual practices among the Key Populations. VI. To strengthen the institutional capacity and community systems for scaling-up HIV and AIDS,STI and TB prevention services. A total of 615 FSWs received STIs /HTC services and 28 beneficiaries put on drugs, Two Self Help Groups (SHG) of FSWs have been formed in Bekwai and Asokore Mampong, Two Drop in centres (DIC) were established in Asokore Mampong and Bekwai communities and are in active operation, providing access to HIV/TB and STI services and finally The project used community capacity enhancement (CCE) methodology and reached 615 FSWs with HIV stigma reduction messages.	workers, transgender, young people
18.	Kenya	The Omari Project at Malindi GK Prison By : Real Medicine Foundation	Among the 850 inmates at Malindi GK Prison, it emerged that 50% were experiencing drug use problems. In response, the Omari Project was founded, to help prevent drug addiction among inmates, and protect them against related harm, through rehabilitation and harm reduction. The Omari Project conducts two visits to Malindi prison per week, attending the male wing on Wednesdays, and the female wing on Fridays. To date, over 300 inmates have received HIV testing services, and group counselling has been conducted, hosting 25-40 clients per session. The Omari Project's activities have also included one-to-one addiction counselling sessions and human rights education programming, and the project's harm reduction services are accessed by over 300 inmates each year. Furthermore, the Project has also acted as a link between inmates and their families, for example to ease transition upon their release from prison, and it has also collaborated with Malindi Sub-County Hospital to provide TB,	• Community-based research • Service delivery • Women • PLVIH • Prisoners

			STI, and Hepatitis B screening. This strong partnership between an NGO and prison services has been presented nationally as a best practice, and this collaboration has fostered the mainstreaming of the Omari Project's services among day to day prison activities.	
19.	Malawi *	Joint Community-Facility Review of PMTCT Dashboards in Malawi BY: UNICEF	In order to address loss-to-follow up in facilities in three districts (Mzimba North, Mzimba South and Dedza), the Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women Initiative (OHTA) convened community leaders and facility staff to strengthen linkages between the facilities and communities they serve. The aim was to formalize these linkages and jointly identify where gaps and challenges are occurring so that pregnant and breastfeeding women would be better supported by both the facility and their communities to stay in care. The process included four phases: (1) Identifying existing Health Advisory Committees (HACs) and revitalizing those which were not active (2) Conducting training sessions with HAC members (3) Convening joint review sessions with HAC representatives, other community representatives, and health facility staff to review quarterly health facility data (4) Follow up and support Since the quarterly facility-community review meetings were established, participating facilities in the three districts have seen a number of improvements in indicators related to male involvement, ANC attendance, skilled delivery, and early infant diagnosis of HIV.	● Advocacy ● Service delivery (treatment, linkage to care) ● PLHIV, women ● Government, civil society, UN ● Joint planning & review example
20.	Malawi	Sexual Reproductive Health (including HIV) Prevention with Youth and Addressing Adolescents' Sexual Health and Rights needs and challenges	The goal of the project is to demonstrate an integrated HIV mainstreaming and continuum of care cascade model in increasing adolescents' access to sexual health, HIV and unintended pregnancy prevention, and rights support services Centre for Youth Development and Transformation CYDT, with	● Service delivery ● Civil society ● PLHIV, young people, sex

		By: Centre for Youth Development and transformation - CYDT	support from Southern Africa AIDS Trust and GIZ, is implementing these has rea project and has proven a success as it has already facilitated the establishment of teen clubs in health centers, youth clubs in the targeted communities, increased time for HIV Testing and Counselling from 6 hours a week to 6 days with extended time to 5 o'clock so that in school youth have access to the services after knocking off from school, increased utilization of contraceptives, more especially condoms by the youths and SRHR talks in schools that has significantly decreased dropout rate of female learners at in school E.G Mendulo Community Day Secondary School from 15 last school session of 2014 to 3 in 2015.	workers
21.	Malawi	Religious Leaders and PLHIV (MANET) By: Malawi Network of People living with HIV (MANET+)	The Framework for Dialogue between Religious Leaders and PLHIV is an advocacy initiative. It brings together Religious Leaders and PLHIV to have a face to face dialogue in order to strengthen the response of Religious leaders and the Faith community in meeting the needs of PLHIV and identify priority areas of collaboration. The initiative has reached over 100 religious leaders both Christians and Moslems across Malawi and it has created a formal linkage between RLs and PLHIV which had not been there before in the country.	● Advocacy ● PLHIV (network) ● Faith-based
22.	Malawi *	Community ART Groups (CAGs) By: mothers2mothers	In spite of progress in addressing the high prevalence of HIV in Malawi, further gains are impeded by the lack of human resources to provide a high standard of care to PLHIV. Furthermore, in rural areas the distance between communities and facilities in combination with the frequency of visits to collect medication may also hamper adherence both from the patient and provider side. National moves towards increasing testing, and subsequent increases in numbers of individuals starting antiretroviral therapy, underscore the critical importance of adherence and retention in care. These challenges are being addressed by the creation of Community ART Groups to actively recruit communities of PLHIV. These groups are self-forming units of 4-8 PLHIV who are on ARV,	● Service delivery ● Communtiy-led Civil society, government & UN ● PLHIV ● Study shows impact quan & qual

			are stable, and are living in the same communities. Each Community Art Group elects a leader, who receives supportive supervision from a Health Surveillance Assistant. The district ART coordinator oversees implementation of Community Art GroupAGs, and liaises with the District Health Management Team. Community Art Group members take turns to collect antiretroviral medicines for their group from the distribution facility thus reducing the total number of visits, and also disseminate health information among their group, thus reducing burden on formal health system workers. The implementation of Community Art Group led to a 59% decrease in the number of antiretroviral refill visits per person per year, and qualitative research indicated acceptability of the Community Art Group model. Other benefits of the model cited include the improvements in HIV literacy through information sharing within the groups, and promotion of autonomy of PLHIV in their own care. Currently a major challenge to the scale-up of the model is concern at the government level that the approach of empowering Community Art Group members to collect and distribute antiretroviral medicines may lead to theft or loss of the drugs. No such incident has been recorded to date, and the pill count among PLHIV improves significantly when individuals are a part of a Community Art Group due to the collective documentation and reporting of adherence, yet this misconception remains a barrier to the expansion of the model.	
23.	Malawi *	Mother2Mother (M2M) By: mothers2mothers	Estimates indicate that 1.1 million Malawians were living with HIV in 2014, with over half a million (585,660) currently on antiretroviral therapy. In 2011, Malawi pioneered Option B+, a prevention of mother-to-child transmission of HIV (PMTCT)-focused “test-and-treat” strategy that makes treatment initiation easier and more available, and addresses the needs of HIV-positive women throughout their reproductive years. m2m is a programme delivering non-clinical complementary care and support services through its Mentor Mother Model, a widely	● Service delivery (mothers) ● Civil society & government ● Women ● Integrated services

			supported, scalable, evidence-based peer intervention that ensures mother-baby pairs access the full cascade of reproductive, maternal, newborn, and child health (RMNCH) and PMTCT services. The programme trains, employs, and empowers HIV-positive women who have been through PMTCT to work as peer Mentor Mothers in health centers and communities. Mentor Mother services include: group pre-test education; health education talks; individual peer education and support; adherence monitoring and support; retention services including mother-baby pair follow-up; family support groups; and improved linkages and referrals between the facility and community, as well as integrated service uptake within the health facility. m2m operates in 14 districts in Malawi and employs 305 Mentor Mothers and 115 Community Mentor Mothers in 94 high-volume and hard to reach facilities and 25 traditional authority areas. In 2015 23,943 new clients were enrolled in m2m services; 146 486 women received group pre-HIV test education and 328,388 women had one-on-one interactions with m2m in antenatal and postnatal clinics.	(SRH)
24.	Morocco	Support for the implementation of the mobile strategy for reducing the risk of AIDS and hepatitis among drug users in the region of Tangiers By: Association de Lutte Contre le Sida (ALCS)	The project is based on a risk reduction philosophy while taking account of all its dimensions and highlighting its social dimension, which largely complements the health component. The project therefore consists of a series of participatory awareness activities and activities to prevent contamination of HIV, HCV, tuberculosis and other health risks associated with drug use, as well as complementary activities aimed among others to improve the living conditions of users, i.e. daily management as well as psychological and legal support and finally participatory advocacy. All these activities aim to change negative social representations often associated with drug users. Since 2007, the project has targeted more than 2,000 drug users (injectors and smokers), in the city of Tangiers, Asilah, the city of Larache and Ksar El Kebir.	● Service delivery ● Community financing ● Civil society ● PWUD ● HIV & HEP C

25.	Morocco	Conseil et dépistage du VIH par des agents communautaires à destination des populations clés au Maroc. Projet pilote de l'ALCS By: Association de Lutte Contre le Sida (ALCS)	L'objectif du projet pilote était d'évaluer la faisabilité d'une offre de dépistage du VIH pratiqué par des intervenants terrain, non médecins, proches des communautés cibles, formés à cet effet et utilisant des tests rapides «DETERMINE» dans le cadre des programmes de prévention combinée auprès des hommes ayant des rapports sexuels avec d'autres hommes, des professionnelles du sexe et des migrants subsahariens en utilisant les stratégies de dépistage fixe et mobile (véhicules mobiles et mallettes). Les personnes dépistées positives étaient référées vers les centres hospitaliers pour confirmation par le Western Blot (WB) et, le cas échéant, prise en charge globale de l'infection à VIH. Un total de 8392 tests VIH ont été réalisés dont 43% chez les PS, 41% chez les HSH et 16% chez les MS	● Service delivery ● MSM, sex worker ● Civil society
26.	Namibia	From Victims to Victors: Empowering people living with HIV using the Inside-Out Approach By: Positive Vibes Trust	Positive Vibes (PV) recognised the urgent need to work with and not just for PLHIV in addressing issues of (self-) stigma and facilitate meaningful participation in HIV programmes. PV set out to develop an approach that would strengthen the indivPWUDal and collective capacity of PLHIV to take on active roles in protecting their health, realise rights, improving quality of life and addressing HIV in their communities. More than 10,000 support group members have participated in Inside-Out sessions since 2002.	● Service delivery ● PLHIV, young people ● Civil society
27.	Namibia	Joint CSO advocacy for a comprehensive national combination HIV prevention framework By: Positive Vibes Trust	Facilitated by Positive Vibes (PV), a group of 6 organisations formed a loose alliance called the Mutual Action for Development (MAD) to: • Create greater dialogue among CSO about common concerns and issues facing the sector and the HIV/AIDS work they were involved in, • Gain greater understanding of emerging global and local policy and funding trends and their implications for the national response and the communities CSO were serving, • Facilitate dialogue with Government and key development	● Advocacy (CSO engaging in country dialogue with evidence of change) ● Civil society ● Other

			partners, both through direct engagement and active and informed participation in public consultations, • Create greater awareness about the value of community-based and CSO driven HIV work and the need to sustain key capacities housed in CSO. • Namibian NGO's involved HIV to engage in coordinated policy analysis and independent advocacy work. (number of specific examples listed)	
28.	Namibia	Encouragement and support for ALHIV through Teen Clubs By: UNICEF	Established in 2010, the teen club at Katutura Hospital in Namibia's capital city, Windhoek, is one of 15 teen clubs which UNICEF supports. The clubs are positioned to provide integrated youth-friendly health and psycho-social services for adolescents living with HIV. This is done through addressing the specific needs of young people, including counselling, peer support and knowledge on how to face the stigma and discrimination associated with people living with HIV. More than 35 young people are actively engaged with the Teen Club at Katutura Hospital, one of 15 Teen Clubs supported by UNICEF.	● Service Delivery ● PLHIV, young people ● Civil society, government, UN
29.	Nigeria	The Integrated MARPs HIV Intervention Prevention Program (IMHIPP) By: The Initiative for Equal Rights (TIERs)	The Integrated MARPs HIV Prevention Program (IMHIPP) is a USAID funded project through Heartland Alliance International-Nigeria and implemented by The Initiative for Equal Rights (TIERs). The project, which started in 2009, is aimed at reducing the HIV/STI prevalence and the impact of AIDS on MSM and their sexual partners in Lagos state through a coordinated and systematic approach. • Over 10,000 MSM in Lagos State reached with HIV prevention messages since inception of the project • Over 3000 MSMLWHA, their female sex partners and their dependents in Lagos State reached with PHDP services Establishment of an MSM specific support group for	● Service delivery ● Civil society ● MSM

			MSMLWHA	
30.	Sierra Leone	Making Patients Happy And Healthy: Caring For People Living With HIV During The Ebola Outbreak In Sierra Leone BY: UNICEF Sierra Leone	The outbreak of Ebola virus disease in Sierra Leone in 2014 severely disrupted general health services and reduced access to care. The epidemic rapidly spread to all districts in the country, with varying levels of intensity. A rapid assessment of health facilities conducted by the Ministry of Health and Sanitation with support from UNICEF found a significant decline in the uptake of maternal and child health services in October 2014, with a 23% decline in the number of visits for prevention of mother-to-child HIV transmission, a 50% decline in HIV testing and a 21% increase in patients lost to follow-up most likely as a consequence of the Ebola outbreak. HAPPY (HIV Prevention Project for Youth) is a national non-governmental organization supported by UNICEF, aiming to mitigate the impact of HIV on the lives of children and adolescents infected and affected by HIV through ensuring access to quality care, treatment and support. During the Ebola outbreak HAPPY recognized the need to proactively reach out to people living with HIV who were not able to access health services and had thus defaulted from their treatment. A programme was created to trace people living with HIV, with the aim of re-engaging the 1 444 pregnant and lactating women and 541 HIV-exposed and-infected children in the districts where HAPPY operated, including districts that were most affected by Ebola at the start of the outbreak. By the end of the project, 60% of children and 84% of pregnant women who were lost to follow-up were re-initiated on treatment. Improvements in access and retention were achieved by triangulating the existing facility data with the information obtained from outreach to patients lost to follow-up. As a result of this experience, the national programme increased its focus on retention monitoring. Peer outreach and proactive follow-up were adopted by the National AIDS Control Programme to address persistent challenges retaining people living with HIV	• Humanitarian • PLHIV, women, young people • Civil society, government, UN

			in care. Likewise, building on existing mechanisms such as support groups and a trained pool of counsellors accelerated the pace of implementation. This model was replicated and adapted in the five districts with the highest HIV burden under the leadership of the National AIDS Secretariat, with support from UNICEF, UNFPA, UNAIDS and the World Food Programme.	
31.	Swaziland *	Maximising ART for Better Health and Zero New HIV Infections (MaxART) By: STOP AIDS NOW	With a population of 1.1 million, the Kingdom of Swaziland has a HIV prevalence of 31% among young adults ages 18-49. Prevalence among young women of 18-19 years of age is 14 times higher than that of young men. A stakeholder consultation initiated by STOP AIDS NOW, with Swaziland's Ministry of Health, the Clinton Health Access Initiative (CHAI), and other community partners led to the creation of the MaxART strategy. It is led by the Ministry of Health and implemented by a consortium of partners from national and international NGOs and academic institutions. The focus of MaxART is on service delivery, implementation research and advocacy. Its first phase (between 2011 -2014) focused on countrywide scale up and implementation of innovative, comprehensive, evidence-informed, inclusive and rights-based interventions along the continuum of care, aligned with national HIV treatment guidelines. During the second phase (2014-2017) the consortium is implementing an effectiveness trial testing the feasibility, acceptability, clinical outcomes, affordability, and scalability of offering ART to all in a government-managed health system. The programme has been successful in reaching communities and increasing demand for services. It also fostered stronger engagement among local leaders in the HIV response, and has increased the number of individuals who know their HIV status and access treatment. Current challenges include the lack of paid health workers at community level in Swaziland, and there is need to further strengthen community health systems and linkages between community and health services to further	● Advocacy ● Service delivery ● Community-based research ● PLHIV, men, young people ● Civil society & government

			enhance sustainability. Furthermore, some health facilities face limitations in available human resources, physical space, and logistics. Despite such challenges, Ministry of Health statistics revealed that MaxART's original targets were met and exceeded. By June 2015, annually 284 680 people were tested for HIV, 134 803 were receiving ART, and from patients in 2013 there was a 10% loss to follow-up.	
32.	Swaziland	Assistance to Orphaned and Vulnerable Children (OVC) at neighbourhood care points (NCP) and Schools By: WFP	NCPs are the traditional centres of support for OVC. At NCPs, community volunteers prepare two meals a day, a breakfast of Supercereal porridge and a midday meal of maize meal and beans cooked with fortified vegetable oil. Meals are part of a package of services provided by these volunteer caregivers, defined by the national NCP Strategy that also include early education, recreational activities, psychosocial support and links to basic health care. The programme targets OVC aged 2-8 years who are attending one of 1,594 NCPs across all four regions of Swaziland. Through the programme WFP was able to distribute 50% of the planned food reaching 50,845 children, or 98% of the planned totals in 2015, despite severe funding constraints.	• Advocacy • Service delivery (OVC) • Community-based School feeding programmes • PLHIV • Women • Civil society & UN
33.	South Sudan	Addressing the issues of child marriages,SGDV and STIs/HIV & AIDS among young people in South Sudan By: UNA-South Sudan	The project is needed in order to address the issue of child marriages, GBVs, HIV that exist amongst the youthful population of south Sudan. Adolescents make up 60% of the population in south Sudan and they are prone to diseases, child marriages, GBVs and other risks. The expected contribution of the organization to address the problem at stake is by production of free monthly magazines and distributed to schools in which the pupils' views and opinions are shared amongst themselves. Over the last six months (October2015-April 2016), the	● Advocacy ● Young people ● Civil society

			program has reached 8,000 pupils in Juba, South Sudan. We need to reach to other places in South Sudan when we secure some funding from any benevolent sources.	
34.	Uganda	A Study on Drug Use Related Vulnerability to HIV/AIDS Infection among Most-At-Risk Populations in Uganda By: Uganda Harm Reduction Network	This study targeted Drug users (both Injecting and non-injecting), networks and organisations in Kampala district and Eastern Uganda districts of (Busia, Tororo and Mbale) to explore the perceived relationship between drug use and vulnerability to HIV/AIDS as well as their direct and indirect bearing on HIV/AIDS programming. The exploratory study was informed by extensive document review and in-depth interviews with drug users, organisations and networks targeting drug users, line government line officials (Mulago and Butabika health officials) UNODC officials, police departments among others. The study was implemented by MARPs Network Secretariat and Uganda Harm Reduction Network, with support from the Global Fund Country Programme (2015) who committed to conduct an exploratory study to establish the possible relationship between drug and substance use to acquisition of HIV/AIDS. A total number of 415 respondents were interviewed in the selected districts of Busia, Kampala, Tororo/Malaba and Mbale. Twelve percent (n=51) were Injecting Drug Users (IDUs); 50% (n=214) used other types of drugs (none injecting), 11% (n=48) were Hot Spot Operators, 3% (n=15) Civil Society Organizations staff, 4% (n=16) Health service providers, 5% (n=22) Community leaders, 2% (n=9) Security and police officials, 5% (n=22) Peer leaders and 4% (n=19) national key informants including MoH staff, Butabika, Police, Mulago and prisons.	Community-based research PWUD Civil society

35.	Uganda *	Link Up: A voucher for health - Enabling young people in Uganda to access quality sexual and reproductive health services By: Community Health Alliance Uganda	In Uganda, the Link Up project focuses on young people living with HIV and those considered most at risk of HIV. This includes young people who engage in sex work, men who have sex with men, the fishing community, and young truck and boda-boda (motorbike taxis) drivers who are usually young men. Between March 2014 and March 2015, the Link Up voucher scheme in Uganda extended sexual and reproductive health and HIV services to over 30,000 young people.	● Advocacy ● Community based research ● Service delivery (SRH) ● Civil society ● Innovative ● Financing (voucher)
36.	Uganda	Link up By: Community Health Alliance Uganda	Link Up is an ambitious project (2013-2016) that has improved the sexual and reproductive health and rights of almost 800,000 young people most affected by HIV, aged 10-24, in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. The project is: • Linking up SRHR and HIV information, education and communications materials and trainings for peer educators and service providers • Linking up services within health facilities and between health facilities • Linking up services between community-based organisations (CBOs) and clinical health facilities • Linking up policy and decision-makers working on SRHR and HIV. • In Uganda, the project has reached over 344,000 young people most affected by and living with HIV in 11 districts (Kampala, Wakiso, Luwero, Nakasongola, Mukono, Kayunga, Mayuge, Iganga, Kamuli, Bugiri and Namutumba) with community- and facility-based HIV and SRHR services	● Service delivery ● PLHIV, Sex workers, women, young people
37.	Uganda	HIV and Harm Reduction program supported by Global Fund to Fight AIDS, Tuberculosis and Malaria	Goal: Increased access to essential HIV and harm reduction services for people who inject drugs in Uganda	● Advocacy ● Community-based

		By: Alliance of Women to Advocate for Change (AWAC)	Objectives; ▪ Creating an enabling environment to conduct harm reduction activities in Uganda ▪ Strengthening of community systems for a sustained HIV response among people who inject drugs in Uganda ▪ Generating and utilizing strategic information on drug use related interventions in Uganda 4. Number of documented commitments of national decision-making bodies supporting roll-out/scale up of harm reduction program 5. Regional HIV and injecting drug use research agenda Regional policy report	research ●
38.	Zimbabwe	Working with traditional leaders as agent of change in mobilising communities on maternal reproductive and neonatal health. By: Women's Action Group	WAG has implemented the H4+ programme with support from UNAIDS. The programme seeks to accelerate progress towards the MDGs 4 and 5, ensuring that women and girls access quality Reproductive Maternal Neonatal and Child Health (RMNCH) and Gender Based Violence (GBV) services, improved integrated management of Maternal, New-born and Child Health, Sexual and Reproductive health, Nutrition and comprehensive PMTCT package of services. The objectives of the programme are to strengthen community processes to demand Health services, to increase service utilization, create awareness on RMNCH and to enable communities to demand health care provision as a human right and influence positive health seeking behaviours. A total number of 1 309 people were reached by the programme in the four districts. The people were reached through community dialogues, trainings and community health day.	● Advocacy ● PLHIV, women, young people ● Civil society
39.	Zimbabwe	Community Impact of Elimination of Mother to Child Transmission (eMTCT) By: International Community with	ICW - The role plays and the discussions, besides looking at basic HIV treatment and care issues, brought out themes around adherence, spousal and extended family support, prevention of new infections and re-infections, importance of supervised ante-natal, pre-natal and postnatal care, gender-	● Advocacy ● Service delivery ● Women, young people

		HIV in Zimbabwe (ICW-Zimbabwe)	based violence and stigma and discrimination. The role plays also provided an indication of the level of awareness of up-to-date information in terms of services that are provided as the government updates policies on the minimum package of care, particularly the roll-out of Option B+. It was evident that health care worker attitudes and service provision were varied depending on the area, as in some areas there was a highly positive portrayal of the health care workers and the service they provided, while others portrayed the health care workers as uncaring and sloppy. The programme reached at least 160 people collectively in eight districts in eight provinces. The programme raised awareness of the advancements in the eMTCT programme. ICW-Zimbabwe learned of challenges that include gender based violence that came about through finding HIV results during ANC visit.	● Civil society ● Community-led by women living with HIV
40.	Zimbabwe	Community Monitoring of OI/ART Services By People Living with HIV in Zimbabwe By: Research and Documentation Coordinator Organisation: National AIDS Council	The programme combines a mix of approaches and is multi-sectoral. Representatives are drawn from organisations representing people living with HIV, the national AIDS coordinating authority, the Ministry of Health and Child Care, community members, community based organisations and representatives of non-governmental organisations. In implementing the programme. Through the community monitoring programme, there have been a number of positive outcomes that have been registered. Various provinces and districts have already scrapped user fees which were inhibiting access to treatment by people living with HIV. Although some resistance exists, there is a strong lobby currently with policy makers across the country to have user fees scrapped as a national policy position. Through efforts of the programme, after noting gaps during	● Advocacy (community monitoring of services) ● Community-based research ● Civil society

			field visits, treatment literacy was included in the successful proposal application to the Global Fund under the new funding model. Specifically, there have not been reports of medicines stock-outs in the press or at meetings as the case was, following the work done under the programme.	

II. ASIAN STATES

41.	China *	China AIDS Fund For Non-governmental Organizations (CAFNGO) By: Fund Management Committee Office	In China, NGOs have played an important role in HIV prevention and control. Under the support of governments and international cooperation projects, the number of NGOs participating in HIV prevention and treatment has significantly increased, although NGOs now face a shortage of funding with the end access to assistance from the Global Fund and other international cooperation projects. In response, the China AIDS Fund for NGOs was established jointly by the National Health and Family Planning Commission, the Ministry of Finance and the Ministry of Civil Affairs as a national public welfare special fund in June 2015. CAFNGO aims to support NGOs to undertake education and communication activities, prevention interventions, testing and counselling among high risk groups, as well as care and support for people living with HIV in accordance with national and local HIV response plans and policies. More than 750 projects from 467 NGOs, covering 30 provinces in China, were funded by the CAFNGO during 2015, representing a total amount of funding of 45.21 million CNY (~US$6.92 million). Applications for funding are reviewed by the Fund Management Committee Office and subjected to expert	• Financing (national fund to support NGOs) • Advocacy • Service delivery • PLHIV, sex workers, PWUD, MSM • Civil society, government, private sector, UN-led

			evaluation. The CAFNGO has played a positive role in promoting NGOs' participation on AIDS prevention and control work, as well as aiding their growth and development. CAFNGO has facilitated implementation of government policy of purchasing social services, as well as promoted multi-cooperation, especially among NGOs, hospitals, and centres for disease control. Additionally, CAFNGO's work helped reveal gaps in provision, identifying the need for improvements in NGOs' capacity to participate in HIV prevention and control.	
42.	India	Pehchan, a community systems strengthening programme for men who have sex with men (MSM), transgender and hijra (collectively MTH) communities to increase reach, scope and quality of HIV prevention and other services responsive to their needs. By:India HIV/AIDS Alliance	India has a concentrated epidemic of HIV, where HIV prevalence is highest among key populations, including men who have sex with men, transgender, and Hijra. Social taboo and punitive laws criminalising homosexuality have further made it difficult for members of these communities to access of services, thereby increasing their vulnerability, and their risk of exploitation, threats, extortion and violence. Pehchan was set up to strengthen community systems, in order to match the needs of these marginalised communities. Named after the Hindi word meaning 'identity', 'recognition', or 'acknowledgement', Pehchan has strengthened and built the capacity of 201 CBOs to provide effective, inclusive and sustainable HIV prevention programming to clients within these populations in 18 states across India. To-date, Pehchan has registered and served more than 435 000 clients from the communities of men who have sex with men, providing nearly 340 000 with HIV prevention services for the first time. Fourteen exclusive transgender and hijra CBOs were established and strengthened, and a total of 169 MTH community members and leaders were trained as master trainers, among whom 80 were transgender women or hijras. More than 228 000 of these communities were tested for HIV with nearly 2% testing HIV positivite, and over 95% of these were linked to care and treatment services. As a result of Pehchan, clients were able to avail themselves of previously	• Service delivery • MSM, TG • Civil society • Well proven • Community-led • Capacity building of CS

			difficult-to-access services including STI treatment, community-friendly HIV counselling and linkages to testing, as well as counselling on partner violence, family support, disclosure, sex reassignment, pyscho-social support, legal aid, and general health concerns. Pehchan also raised the issue of gender violence as a barrier to accessing services, and subsequent data reflected increased reporting of violence and a decrease in these incidents against MTH. Pehchan also worked with the National AIDS Control Organisation to map transgender people in all 18 programme states, as well as providing support in consultations to advocate against Section 377, India's anti-homosexuality law, and for protecting the rights of the Third Gender. Throughout this, community organisations proved to be the best vehicles not only for advocacy but also for service provision to their communities, and Pehchan's success was largely based on community involvement and leadership among men who have sex with men, transgender and hijra communities at all levels of implementation, including in national and state-level programme leadership and management.	
43.	Iran	National AIDS Control Programme (community-based components) By: Ministry of Health and Medical Education	In Iran, the number of registered cases of HIV is only a fraction of the country's estimated population of people living with HIV. To achieve the 2030 goal of ending the epidemic, it has been recognized that a deeper community reach is needed. The 4th iteration of Iran's National AIDS Control Programme was endorsed by the country's Council of Ministers in March 2015, and was formulated with input from stakeholders, including NGOs and community-based organisations. It includes strategies to improve synergies between programme pillars, including the integration of HIV-related services within the healthcare system, and the outsourcing of service delivery to CBOs and NGOs. Examples of this model include the "AIDS Bus" – a voluntary counseling and testing (VCT) campaign led by the Ministry of Health, the Municipality of Tehran, and a CBO – which aimed to help reach individuals with VCT who	• Service delivery • Civil society, government and UN

			would not normally attend facility-based services. In 2006, “Positive Clubs” were created, to provide psychosocial support for people living with HIV (PLHIV), and to promote the “Positive Health, Dignity, and Prevention” approach. The Positive Clubs link with local Universities of Medical Science or Welfare Organisations to help close the prevention gap and increase access to services. In addition, the Positive Clubs also provide direct policy input through representation at the Annual General Meeting of the National AIDS Control Programme. Local community-based organizations (CBOs), under supervision of nearby medical universities, also run Vulnerable Women’s Centres. These provide a range of services to aid control of sexual transmission of HIV among women, including prevention, harm reduction, VCT, and specialist care. These services have benefitted from strong, sustained political support, and have largely been funded through the national budget with overseas assistance in areas such as knowledge transfer, capacity development, and procurement of strategic commodities such as rapid diagnostic kits and second-line antiretroviral medicines. Together, these community-based components have helped the National AIDS Control Programme reach and serve groups who previously would have had limited access to care.	
44.	Kyrgyzstan	Participatory community-based research of HIV prevention programmes efficiency was conducted within the overall framework of the program “HIV prevention with sex workers”. By: Tais Plus	Tais Plus has started conducting regular evaluations of HIV prevention programs in 2000; the research is conducted bi-annually. We have been using adapted FHI questionnaire since 2004, and since 2008 we have been conducting national level research. The research design, sampling, data analysis and interpretation are made by the organization. The interviews are conducted by trained outreach workers. The questionnaire is similar to that used in the sentinel surveys, data analysis is however different, since we take context and sex workers’ voices into account. We are using research results to insist that sex worker voices	• Community-based research • Sex workers • Civil society • UNAIDS Case study recognised previously

			should be taken into account in the course of program planning. We can also see that the data gathered in other research on sex workers differs from ours. We advocate for not compiling official national program data based exclusively on AIDS-center conducted sentinel surveillance results	
45.	Myanmar	PMTCT in Myanmar By: UNICEF	In 2013, a program performance review and a rapid feasibility assessment deemed that it was feasible to start using point-of-care (POC) HIV testing using whole blood for screening pregnant women. POC testing was implemented after training of staff, and included: management of supplies, and periodic review and monitoring. All of these aspects were integrated with existing platforms in the maternal health and HIV programs. This was progressively scaled-up to all existing and new PMTCT townships. The introduction of point-of-care HIV testing has resulted in: • increasing the number of pregnant women who are tested for HIV from 321,000 in 2012, to 746,000 in 2015; and • increasing the proportion of pregnant women receiving antenatal care who have tested and received results for HIV from 50% in 2012, to 80% in 2015.	● Service delivery ● Civil society, government and UN ● PLHIV, women, other
46.	Myanmar	Increasing access to HIV treatment through a community-supported public private partnership in Myanmar By: International HIV AIDS Alliance – Alliance Myanmar	Myanmar has experienced an increase in the numbers of people living with HIV, and in response the Ministry of Health has moved to rapidly scale up provision of treatment to help reduce HIV-related illness and deaths. The government aims to provide antiretroviral therapy to 106 058 people by the end of 2016, although to achieve this target the already-stretched health system required innovation to ensure that antiretroviral therapy could be provided close to communities without compromising quality. To assist in the decentralization of antiretroviral therapy delivery, Alliance Myanmar has operated a partnership with private sector general practitioners. Under	● Service delivery ● Community-based research ● PLHIV

			this partnership the Alliance contracted general practitioners to provide services such as HIV testing, assessment and WHO staging, diagnosis and treatment of opportunistic infections and other aspects of clinical management of sexually transmitted infections and tuberculosis. The Alliance also supports treatment literacy, adherence support, support with disclosure, home-based care, and tracing of lost-to-follow-up patients through community based activities. These activities have been implemented through outreach workers deployed from a network of CBOs and key population networks in Yangon. Subsequently, Alliance Myanmar has become the third-largest provider of HIV treatment services, contributing significantly to the national response. Between March 2009 and April 2015, 2119 patients were provided with antiretroviral therapy, and only 3.3% had been lost to follow-up. The partnership helped maintain HIV knowledge and expertise among private general practitioners in line with national guidelines, and also helped decentralize HIV treatment delivery, thereby relieving the already-overburdened health services and demonstrating the effectiveness of using existing community and private sector health infrastructure to increase coverage without the need for creation of new facilities.	
47.	Nepal	Nepal HIVision 2020 By: UNAIDS	The HIV response in Nepal depends largely on foreign assistance (with external donors accounting for as much as 80 percent of national AIDS expenditure in 2015). External funding is declining rapidly, and it is more important than ever that actions and strategic allocation of resources for reducing the country's HIV burden are prioritized though wise, evidence-informed investment choices. In 2015, the development of Nepal's National Health Strategic Plan (NHSP) 2016-2021 was initiated through consultations led by the Ministry of Health's National Centre for AIDS and STD Control. A number of governing and coordination structures were established including a high level steering committee, chaired by the	• Advocacy • Service delivery • Financing • Community-based research • Humanitarian • Government, civil society, private sector, UN • All

			Secretary of Health that included members of other sector Ministries, civil society, UN and other partners. Six thematic groups were created and supported by UNAIDS, focusing respectively on key populations, systems for health, evidence and strategic information, governance, human rights and emerging issues/innovation. As a result of full community engagement and leadership in its formulation, commitment in the implementation of the NHSP from civil society, government and all stakeholders is high. Roles and responsibilities of civil society, as accountable actors in Nepal's response towards ending its AIDS epidemic by 2030, are now specifically articulated in formalized divisions of labour, through public-private partnerships. The plan emphasizes the integration of government and community level services; community-based actions to prevent HIV; 'case finding' and 'case management' a prevention-treatment continuum; the introduction of innovative approaches to task-sharing and community testing, supported by both public, private and community health facilities.	populations covered
48.	Thailand	Comprehensive Prevention and Treatment Service Model Led by MSM and TG Communities in Thailand By: Thai Red Cross AIDS Research Centre	A comprehensive community-led service model has been developed, ready to go to scale in Thailand. The model has integrated HIV and other health services for men who have sex with men and transgender persons. The range of services includes: HIV/STI testing; point-of-care CD4 measurement; ART maintenance; tuberculosis screening/prophylaxis; pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); and retention support to clients. To date, four CBOs implement the comprehensive community-led HIV service model for MSM and TG. SWING works with male sex workers in Bangkok and Pattaya; Rainbow Sky Association of Thailand works with MSM/ TG in Bangkok/ Hat Yai, Sisters works with TG/TG sex workers in Pattaya; and Caremat works with MSM/TG in Chiang Mai. The Thai Red Cross AIDS Research Centre and the networks of health professionals in each city	• Service delivery • Community-based research • PLHIV, TG, Sex workers, PWUD • Civil society

			provide local oversight and support case referral when needed. From May 2015-January 2016, the engaged CBOs provided HIV testing to 1569 clients, diagnosed 269 HIV-positive individuals, and 83% successfully initiated ART within a median time of 15 days.	
49.	Thailand *	The Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated Outreach and Networking (CHAMPION) IDU (2009-2014) By: Ozone Foundation	Although progress has been made in reducing the HIV burden among the general population in Thailand, the estimated HIV prevalence among drug users was 25-50% in 1989-2009. A focus on law enforcement and public security when dealing with drug issues led to mass incarcerations, forced detentions, human rights violations, and public health barriers. To help address service delivery gaps through community empowerment, CHAMPION-IDU was designed as a community-led, peer-based HIV prevention project, almost exclusively implemented by civil society, to improve the lives of people who inject drugs, and operated between 2009 and the end of 2014. In spite of a hostile operating environment and challenges with retention of staff and peer supporters, the strategy was successful in recruiting people who inject drugs and facilitating access to health services because of the innate trust that exists between peers. Government drug treatment centers saw up to a fourfold increase in in- and out-patient admissions since the initiation of the CHAMPION-IDU project. Approximately 80% of the 350 CHAMPION-IDU workers hired were active and/or recovering from drug use and participation was seen as means for PWID to build their capacity to become productive members of society. The project provided skills, salaries, and support to these workers over 5 years, and as a result of regular work and social support, many of the CHAMPION-IDU workers were able to reduce their drug use. Peer workers operated drop-in center based and outreach based activities, including behavior change communication to reduce risks, education, sterile injecting equipment, condoms distribution, overdose prevention with naloxone, and referrals to services. Over the project life cycle (2009-2014), over 13	● Advocacy ● Service delivery ● PWUD ● Civil society & government ● Community-led (PWUD)

			000 of the country's estimated 40 300 people who inject drugs were reached by CHAMPION-IDU project services, across 19 of the Kingdom's 76 provinces. However, the project faced difficulties including lack of political support, skepticism in the harm reduction strategy, and lack of funding support.	
50.	Vietnam *	Asia Action: community advocacy for harm reduction in Viet Nam By: Center for Supporting Community Development Initiatives	There are an estimated 256 000 PLHIV in Viet Nam. In 2013, the greatest proportion of new infections occurred among men who share needles while injecting drugs – 45%. Before 2013, drug control laws in Viet Nam stipulated that people who use drugs who failed to quit could be sent for compulsory rehabilitation in a closed setting for up to four years, but this approach had limited success and encouraged drug users to avoid harm reduction programmes. As a result, the government created the Renovation Plan for Addiction Treatment, which aimed to scale down compulsory rehabilitation from 63% of cases in 2013 to 6% of cases in 2020, along with a concomitant scale-up of voluntary services. From 2013-2015, the Centre for Supporting Community Development Initiatives (SCDI) – a local NGO whose mission is to improve the lives of marginalized populations - worked alongside government departments and the drug user community to realize the Renovation Plan. A major aim was to contribute to improving the policy environment regarding drug use and HIV, and to achieve an increased commitment by the government of Viet Nam to evidence- and rights-based policy on drug use and HIV. Bac Giang province, which had a committed local government structure, was selected to pilot the development of a voluntary drug treatment system - consisting of a facility with residential capacity and several community sites - to provide a wide range of services and supports. SCDI subsequently provided key input to the government to develop guidelines for community-based addiction treatment. From the beginning of 2014 until now, there have been no cases of compulsory rehabilitation in Bac Giang province, and the new government guidelines developed by SCDI for voluntary treatment centres	● Advocacy ● PWUD ● Evidence of translation to change (guidelines adopted)

			and satellite facilities released in 2016 (after the programme ended) will contribute to supporting the commitment by the government to scale up voluntary services so that 90% of drug users are getting treatment by 2020.	

EASTERN EUROPEAN STATES

51.	Armenia	Provision of complex medical services as effective model for HIV prevention and expansion of HIV testing among labour migrants By: National AIDS Center	• Provision of HIV testing in the package of other related medical services, which is the most relevant and acceptable for labour migrants. • Provision for migrants and their partners was introduced into 60 communities of Armenia within the framework of the Russian Government-supported Programme assisted by UNAIDS and AIDS Infoshare Fund. Starting from 2014, with the GFATM support, this model provision covered additional 40 communities. Therefore, the project was implemented in 100 communities in Armenia. • In these communities the preliminary trained employees, recruited from the communities representatives, performed outreach work and provided peer education among local population. Through the mobile medical teams, at rural outpatient clinics, and at multi-functional mobile clinic, donated under the programme, migrants and their partners were provided (free of charge, based on the principle of confidentiality) with medical services package including counselling and testing for HIV, hepatitis B and C, STIs and doctor's advice. • Preventive activities covered 53,367 labour migrants and their partners, as well as community representatives.	• Service Delivery • Migrants • Government-led

52.	Estonia	Community Based Rapid HIV testing and linkage to HIV Care and Support services By: NGO Estonian Network of People living with HIV	The program aims at decreasing HIV prevalence, improving access to HIV treatment and care services in relation to the most vulnerable populations by increasing the availability of HIV testing and ensuring effective communication programs with HIV positive people for the care and treatment of HIV. Firstly, an innovative approach is about HIV testing is not organized in the hospitals, but in the places, traditional for the target group. Secondly, the whole process of testing organization from the beginning to the end takes place with direct participation of affected communities (PLHIV, MSM, PWID). This process involves planning dates, events and places for testing along with the involvement of the public service responsible for testing at the national level, the direct participation of trained professionals from the community in the course of testing during pre- and post-test counseling, as well as offering support with the services, linking to programs for HIV care and treatment for newly diagnosed HIV-positive. Totally during 2015 year: were tested – 12 143	● Community-based service delivery (HTC and linkage to care) ● Civil society ● MSM, PLHIV, Sex workers, drug user, young people, women ● Community-led ● Innovative
53.	Georgia *	Harm Reduction program in Georgia – Provision of HIV prevention services to people who injects drugs (PWIDs) By: Georgian Harm Reduction Network	The number of new cases of HIV in Georgia is growing, and the rate of transmission via injecting drug use, although in decline, remains proportionally high. There are an estimated 50 000 people who inject drugs in Georgia, and this number is also increasing. A number of factors have contributed to this increase, including a strict legal environment regarding drugs, and a lack of treatment, rehabilitation, and resocialization programmes. The Georgian Harm Reduction Network (GHRN) is implementing a needle and syringe programme in 11 cities and 14 harm reduction sites, with service delivery for people who inject drugs, incorporating NGOs and community led organisations. The programme has two main components: HIV Service provision and Advocacy. Through emphasizing the community's role in HIV service delivery, the coverage of the need and syringe programme with a minimal HIV package increased four-fold in comparison to 2012. Community	● Advocacy ● Service delivery ● Humanitarian ● Harm reduction ● Civil society ● Community-led

			involvement also facilitated access to hidden populations, among them sub-populations such as young PWID or female PWID, and in particular peer based support helped deliver life-saving services at outreach locations. Community mobilization to defend rights and demand better access to health and social services was also a success, and PWID became more prominent in discussions of their problems and needs in the general media such as on TV and radio programmes, and participating in street protests and action for solidarity. In 2015, over 31 000 people who inject drugs were reached with HIV services, and over 22 000 were tested for HIV, hepatitis B and syphilis, representing a 10-fold increase over 2012. The provision of female-specific services and greater involvement of female outreach workers also helped in uptake among female people who inject drugs. In 2016, GHRN aims to further expand coverage via adoption of new strategies such as working via mobile ambulances.	
54.	Moldova	Community based HIV prevention services in prisons By : CBO “New Life” in Moldova	The HIV epidemic in Moldova is fuelled primarily by transmission during injecting drug use, and is concentrated in prisons. Commencing in 2000, CBOs and NGOs began leading in the development of policies and services to prevent HIV and TB for the country’s inmates. Currently, 12 out of 15 interventions recommended within the UNODC/ILO/UNDP/WHO/UNAIDS comprehensive package of HIV services for prisons are being implemented in Moldova, and the CBOs and NGOs are essential facilitators of prevention, treatment, care, and support for PLHIV and those with co-infections. These actors include the CBO, “New Life” - a key population led organisation, consisting of people who inject drugs and former inmates providing support to PLHIV and people who inject drugs in prisons. Participation of the key affected population in the process of planning, development, implementation and evaluation has been a major factor in the programme’s specificity and effectiveness. A team of 25 peer-to-peer consultants, social workers, psychologists and	● Advocacy ● Service delivery ● Community-led

			coordinators now work across 17 prisons in Moldova, covering a population of nearly 8000 inmates – both women and men. Activities include advocacy, campaigning and participation in accountability as well as community-based service delivery in prisons, including testing, prevention, treatment, legal services, and training of health workers and community financing. The programme has been critical in the scale-up of opioid substitution therapy, needle syringe programmes, antiretroviral therapy and other essential services in prisons. As a result of interventions by multiple stakeholders including prison and health authorities, CBOs, United Nations agencies, and others, the proportion of inmates living with HIV receiving antiretroviral therapy increased from 2% in 2005 to 62% in 2013, and the programme has also helped reduce the number of deaths due to HIV in prisons from 23% in 2007 to 8.6% in 2013. Rates of blood-borne illnesses in general have also been reduced among the prison population, including Hepatitis C, the prevalence of which has fallen from 21% in 2007 to 8.6% in 2012. The programme was additionally successful in creating a culture of openness among prison authorities towards collaboration and implementation of innovative and evidence-based approaches, and furthermore was instrumental in increasing the level of tolerance towards inmates and vulnerable groups by prison personnel.	
55.	Russian Federation	Street Lawyers Project By: Andrey Rylkov Foundation for Health and Social Justice	Strict anti-drug legislation and lack of official support for HIV prevention and psychosocial support has led to a shortfall in service access by drug users in Russia. There are over 830 000 officially registered cases of HIV in the country, and in approximately 70% of cases, transmission was linked to use of injecting drugs. Among Russia's people who inject drugs, approximately 37.2% are living with HIV, and in some cities, as many as 90% are infected with Hepatitis C. Since 2013, the Andrey Rylkov Foundation for Health and Social Justice (ARF) has implemented its Street Lawyers Project as part of a broader harm reduction strategy in Moscow, with the aim of	● Service delivery ● PWUD Civil society

			teaching legal defence skills to people who have no formal legal education, such as social workers and representatives of key populations affected by HIV. The project's outreach workers help provide people who use drugs with brief and timely consultations addressing basic legal issues. Core activities include: Information and awareness generation; Mediation; Official requests; Formal complaints; and judicial protection. In 2015, the project prepared 167 legal documents (including appeals, requests to public authorities, statements of claim, and statements challenging the actions of public authorities), as well as approximately 20 court appeals. The project's social workers also took part in approximately 20 court hearings. Key topics for the project's legal work in 2014-2015 were protection in drug-related criminal cases, and protection of the right to health, including access to antiretroviral therapy, and protection of people who inject drugs living with HIV and hepatitis C against discrimination. One of the key achievements of the project is the improvement of service access among the people who use drugs, and it has also helped in enforcing human rights laws through taking on cases where the rights of people who inject drugs have been violated, representing their cases in the judicial system, and creating public awareness. In situations where such legal challenges fail, the project brings the cases to national and international courts. Three such cases are currently under review with the European Court of Human Rights.	
56.	Ukraine *	"Advocacy for access to medical and social services for representatives of vulnerable groups, including people using drugs (PUD), methadone treatment patients (MTP), sex workers (SWs), and former prisoners in five regions of Ukraine". ("Social mobilization, strengthening of	is to ensure the sustainability of medical and social services for representatives of groups vulnerable to HIV by transitioning from donor funding to funding from local budgets; and, following the transition, to strengthen community leadership capacity in five regions of Ukraine to enhance their influence on decision makers. We are currently working in the regions of Odessa, Kherson (from the beginning of 2016), Kirovograd, Cherkasy and Vinnitsa, and, until the end of 2015, were working in the regions of Sumy and Lviv as well.	● Advocacy ● MSM, PWD, sex workers ● Civil society ● Social contracting ● Although early and no information

		relations, cooperation and coordination".) By: Eurasian Coalition on Male Health	Regional Community Councils (RCC) were created, as consultative and advisory bodies, comprising leaders and activists from populations most vulnerable to HIV, and which are designed to significantly enhance the mobilization capacity of communities through joint advocacy actions, including for increase the access of representatives of vulnerable communities in the region to medical and social services.	about impact, raising real challenges faced by communities trying to engage government in dialogue around transition etc
57.	Ukraine *	Women-led and community based research: Sexual and reproductive health, gender equality and human rights, gender-based violence, economic and political opportunities of women living with HIV in Ukraine By: ACO "Positive Women"	Ukraine has among the heaviest HIV burden in Europe and Central Asia, with a prevalence of 0.62% in the 15-49 age group. There is also an increase in the registration of female cases compared to male and a lack of gender-sensitive HIV responses in general. Qualitative research was carried out by women living with HIV, to gather evidence in support of the development of gender-based approaches to address HIV in Ukraine. Data was collected on the challenges and needs of women living with HIV in relation to sexual and reproductive health, gender equality, human rights, gender-based violence and economic and political opportunities. The challenges confronted by women living with HIV are exacerbated by the overall worsening of the economic, social and political situation in Ukraine and the deterioration of human rights relating to the ongoing armed conflict and humanitarian crisis. Over 100 women were interviewed through community consultations and focus groups. The results highlighted a number of issues including lack of commitment of the National TB/HIV Council as well as the regional and municipal Councils, small % of women in leadership positions within regional administrations, lack of satisfaction in the state's support of people living with HIV and high levels of gender-based violence and violations of women's rights. The community-led research has led to the creation of a discussion platform for women as well as evidence upon	● Community-based research ● Civil society ● PLHIV, women ● HIV+ women-led research

			which advocacy is now being developed at national and regional levels.	
58.	Ukraine	All-Ukrainian League Legalife (for sex workers) By: ACO “Positive Women”	The goals of the program were to improve sex workers access to justice, to reduce violence and human rights violations and further hold perpetrators accountable; to improve access to medical and social services as well as egagement with authorities. We were also striving to stregthen sex workers community and our own feeling of self-worth and self-esteem and to improve our literacy.	• Advocacy • Service delivery • Community-based research • Humanitarian • Civil society • Sex workers

LATIN AMERICA AND CRIBBEAN STATES

59.	Argentina	Key Population Friendly Health Services (FHS) By: Direction of AIDS and ITS of the Health Ministry of Argentina	Friendly Health Services Program was designed and implemented by the AIDS and STI Directorate of the Ministry of Health of Argentina, in collaboration with UNDP, UNAIDS, UNFPA, UNDP and WHO PAHO with participation of civil society organizations. Health providers in public services have been trained, amongst other topics, on sexual diversity and human rights, structure and operation of a friendly health services, hormone therapy, anal health, diagnosis of HIV and other STIs; as well as legal aspects of HIV and human rights. Health facilities of the program work with flexible schedules, especially during the evenings and, on demand, provide a number of services such as clinical care, counseling, HIV and other STI diagnosis, psychosocial support and hormone treatment for trans people. Accessed 5509 in five years	• Service Delivery • Financing • PLHIV, MSM, Sex workers, transgender • Government-led
60.	Argentina	LGBT Citizenship Plan: From legal equality to real equality By: Argentine Federation of	The programme “LGBT Citizenship Plan: from legal equality to real equality” is an effort to realise the rights of the LGBTI communities in all spheres of life and sectors of government though practical measures that promote	• Advocacy • Service Delivery • PLHIV,

		Lesbians, Gays, Bisexuals and Trans (FALGBT)	equality and social inclusion. The first action of the programme was the development and publication of the first version of the “Citizenship Plan for LGBT” in 2011 (http://www.falgbt.org/ciudadania-2/plan-for-lgbt-citizens-2012/), produced with the support of UNAIDS and UNDP. The Plan is a compendium of different laws, policies and other measures which are necessary in order to achieve equality for the LGBT populations in all spheres of life. It serves as an advocacy tool and has given a momentum to the establishment of policies and practices for the LGBT social inclusion and has strengthened the collaboration between the State, civil society and international organizations. The plan was reedited in 2013 to reflect the legal and policy reforms achieved as well as the lessons learnt in the implementation of the plan (http://www.falgbt.org/ciudadania-2/plan-de-ciudadania-lgbt-segunda-edicion/). This geographic distribution means that over 10 million people across the country benefit from the programmes and activities being implemented.	MSM, TG, sex workers, PWUD, young people, other ● Civil society & government
61.	Bolivia	Peer Educators Promoters strategy in Men Who Have Sex with Men, Gay and Bisexual (MSM GB) By: Hivos Principal Receptor	Promote a change of behavior through prevention of STDs and HIV, promoting healthy behavior and correct and consistent condom use in MSM GB population nationwide. Strategy activities implementations were done through formal and informal activities. STIs, HIV and correct and consistent condom use: within formal activities as activities that were aimed Replicas in 3 themes mentioned. Empowerment activities were oriented on issues of interest of the population, such as self-esteem, stigma and discrimination, self-care, relationships and sexual diversities. Within informal activities mentioned to Events, consisting of activities that could be conducted interpersonally, or it could be performed as a group through the exhibition of films or specific	● Civil society ● MSM Service delivery

			activities of the population such as the Condom night in alternative spaces, taking advantage of situations and opportunities where key messages in a timely manner were held to enhance knowledge and self-care of the population. Number of HSH GB reached by the PEP - 9039 Strategy. Number of condoms distributed by the strategy PEP - 1.402.586	
62.	Bolivia	Peer Educator Promoters (PEP) Strategy for trans populations By : Hivos Principal Receptor	Promote behavior change through STI and HIV prevention, promoition of healthy behaviours and correct and systematic use of condoms among trans Women in the Bolivian backbone. The implementation of the strategy was done through formal and informal activities. Formal training were activites named replications and empowerment. Replication aimed at training on three subjects: STI, HIV, correct and systematic use of condoms. Empowerment activites were aimed at issues of interest of the population that would complement the strengthening of messages distributed in replications. Among those issues were the use of silicone, hormone substitution therapy, self-esteem, negotiation of condom use, stigma and discrimination. No. Of trans PEP 23 No. Of condoms distributed at PEP trans activities 382.894	
63.	Bolivia	Political incidence plan for the allocation of resources for the HIV/AIDS response in Bolivia By: National Network of people living with HIV/AIDS (REDBOL)	Bolivia has HIV prevalence of 0.05% with 14 312 cases (1984 - June2015). In 2010, Bolivia was declared a middle income country, and as a consequence the level of international assistance fell. Currently, 70% of all HIV care and prevention services in Bolivia are paid by the Global Fund. With the goal of achieving the sustainability of the AIDS response, the Bolivian Network of People Living with HIV/AIDS developed a plan for the allocation of resources for the HIV response in Bolivia, aiming to insert budget lines for HIV in five municipalities, departments or in the national government for HIV, independent of international cooperation. The project was implemented in nine departments of Bolivia and the cities of El	• Advocacy, campaigning and participation in accountability • Civil society • PLHIV, sex workers, transgender, women • Financing • Community-led •

			Alto and Llallagua, and included advocacy for resources oriented for HIV care and prevention. The strategy included the revision of local laws (HIV, autonomies and the Constitution) that guarantee the right to health, and incorporated social mobilization with mass media. Ultimately, the project was instrumental in increasing resources allocated for HIV, which started at the amount of 1 million BOB (~US$146,628) in 2012, rising to 8 million BOB (~US$1,173,020) in 2015 at the end of the programme. Additionally, the project also helped clairify information on budgets available for HIV both from national sources and international aid. It also contributed to budget allocation for HIV in the municipalities of El Alto, Cochabamba, Santa Cruz, Sucre, Tarija, and development of local and project laws. The project was also successful in fostering community mobilization among people living with HIV and lesbian, gay, bisexual and transgender communities with the aim of sustainability, as well as building visibility of people living with HIV as actors in political incidence.	
64.	Bolivia	Boddy Mapping Gender Based Violence And Hiv Among Women With Hiv, Transgender Women And Sex Workers In 3 Cities In Bolivia By: National Network of people living with HIV/AIDS (REDBOL)	Women living with HIV, transgender women, and sex workers in Bolivia consistently report multiple forms of gender-based violence, but to date,r these experiences have not been captured in any official report. The Bolivian Network of People Living with HIV, with technical support of Cayetano Heredia University and the financial support of UNAIDS, implemented a qualitative and quantitative study to explore the linkages between HIV and gender based violence among women living with HIV, transgender women and sex workers in La Paz, Cochabamba and Santa Cruz. The project also included an advocacy strategy targeted towards local authorities. The study accessed 340 women via survey, and 100 women via focus groups and individual interviews, who were able to speak up about their experience of gender-based violence – in most cases, for the first time. These women were able to meet with local authorities and relate their life experiences of HIV and gender based violence, and gathering the different groups of	• Advocacy • Community-based research • Community-led • PLHIV

			women enabled empowerment regardless of their specific gender identities or vulnerabilities. The programme generated data to help build a picture of the linkages between HIV and gender-based violence in the three targeted groups of women, as well as offering psychological support to those who had never spoken about violence before. It also helped mobilize support from local authorities and sectors that had not traditionally engaged with HIV programmes, such as churches and women's and youth associations. The project was successful in facilitating strategic alliances between different groups of women who already face stigma and discrimination, and helped create awareness of laws aimed at protecting women´s rights, access to justice, and protecting against the negative impact of the stereotypically male-oriented culture in Bolivia. High levels of gender-based violence in the country remain a challenge, and next steps include a follow-up project to provide ongoing psychological support.	
65.	Bolivia	1st Report of Human Rights of People Living with HIV in Bolivia By: National Network of people living with HIV/AIDS (REDBOL)	To conduct a Rapid Qualitative Research led by people living with HIV about the situation of Human Rights of people living with HIV and to conduct 3 Local Dialogues targeting local authorities and partners. The programme achieved: Data including graphics (situational maps) of the situation of human rights of people living with HIV, organized in the 1st Report of the Situation of Human Rights of People Living with HIV in Bolivia. Community empowerment and alliances between people living with HIV from different sub-populations working together with the issue of human rights as the centre of the advocacy strategy. Mobilisation of support from local authorities and from civil society from the human rights movement. Community mobilization using mass media creating awareness of the multiple violations of human rights in the context of HIV.	● Advocacy, ● community-based research ● Community & government implemented ● PLHIV, MSM, sex workers, transgender, women, other indigenous

66.	Bolivia	Peer promotor Educator (PPE) strategy for STDs-HIV/AIDS prevention in key populations, antiretroviral compliance along with the peer promotor educators, Mutual Help Groups (MHG) with people living with HIV in the andean región of Bolivia. By: Asociación Un Nuevo Camino	Educate and Prepare Peer promotor Educators that live with HIV to achieve an appropriate approach to the rest of the poz population to achieve antiretroviral compliance, training about opportunistic infections, constant clinical tracking and their pertinent health care centers. Elaborate a strengthen plan of self-supporting groups nationwide that includes a training methodology of people living with HIV at a urban and rural range The impact of our program can't be measured at this level, as ASUNCAMI we make operatives activities. The impact measure is concentrated in the Health Ministry.	● Service delivery ● PLHIV, MSM, TG ● International CS
67.	Brazil	*Viva Melhor Sabendo* (Live Better Knowing) By: Department of STI, Aids and Viral Hepatitis – Ministry of Health of Brazil	The VMS project is a nationwide initiative launched by the Department of STI, AIDS and Viral Hepatitis (Ministry of Health of Brazil - BMoH) in 2013 and, so far, a total 109 projects have been funded. Within the project, NGOs offered HIV testing, prevention education, counselling, prevention supply distribution, patients' referral to PEP and monitoring of their linkage to health services – from diagnosis to treatment. Testing is free and is carried out confidentially, in places where key populations usually meet, based on peer-to-peer methodology. Between January 2014 and April 2015, a total 29,723 tests were administrated; among them, 791 (2.7%) presented a reactive result The strategy has brought important outcomes: empowerment of NGOs –which, for the first time in Brazil, were able to carry out HIV rapid testing, a relevant structural intervention in the field of HIV prevention; key populations were reached by peers in their usual settings and routines NGOs receive financial support through public notices, with free competition, published by the BMoH channels on the internet, based on suitability criteria for partnership with the public administration. For the Public Notice of conducting oral fluid HIV testing in key populations, NGOs need proven experience of at least three years in prevention approach to	● Service delivery ● MSM, PWUD, sex workers, TG, young people ● Civil society & government ● Social contracting example

			HIV/AIDS and/or community intervention for key populations. The selection notices for financing activities of NGOs are governed by the legislation and other related standards on the same matter	
68.	Brazil	**Educational Leadership in the Youth Movements - Activism and Social Mobilization to HIV/AIDS Response** By: Department of STI, Aids and Viral Hepatitis – Ministry of Health of Brazil	the youth to monitor and debate public policies of the Brazilian Unified Health System (SUS), three presential editions of the course "Educational Leadership in the Youth Movements" were held in Brasília. Young people of key populations who showed leadership were chosen, among them people living with HIV/AIDS, prioritising more vulnerable regions and populations. The five-day courses were held in 2015 with the themes: HIV/AIDS, SUS, human rights and key populations, leadership, activism, communication. The three editions together counted with 150 participants out of 1,019 applicants. With the exception of two states out of 27, there were representatives of all Brazilian states and all the key populations – an overcome challenge, considering the proportions of the Brazilian territory.	● Advocacy ● Civil society & government & UN ● Young people
69.	Ecuador	"The 4 M for empowerment" in the context of sexual and reproductive rights and prevention of HIV-AIDS within sex workers in Ecuador - Colombia border By: Asociación de Trabajadaoras Sexuales "21 de Septiembre"	The primary focus of the programme - the promotion, the provision of services (HIV prevention, treatment, care and legal support, etc.), research, funding. These considerations and the need to break-down the concept of " sexual = HIV and AIDS workers", raised the proposal "The 4 M's to empowerment "to be implemented within health services through borrowers, as well to the sex workers to reach their pairs. 500 female sex workers know their rights route enforceability, and especially the right to a quality service. 3. 80 health professionals trained from selected areas. Implemented the methodology in the health service.	● Service delivery ● Sex workers ● Civil society-
70.	Ecuador	Analysis of social behavior, sexual practices and HIV prevalence on	The objectives of the VCT Service analysis is to establish the epidemiological profile of service users. It will delve the most	● Advocacy ● Service

		Voluntary Counselling and Testing Service (VCT) of the Fundación Ecuatoriana Equidad Community Centre, at Quito, Ecuador. By: Fundación Ecuatoriana Equidad	relevant aspects related to sexual behaviors, discrimination, and knowledge about HIV / AIDS inside the most affected populations (HSH and trans), in order to compare the national prevalence of MSM with the prevalence of MSM diagnosed by the Foundation. It will serve to improve the goals reached until now by the national response on HIV. Also, the data generated by this Analysis, will be extremmly usefull to create better communication strategies, not only for the campaigns which are created by the organization, but for the national efforts on communication. The Foundation complements the VCT service with a wide range of health services at affordable prices for the key populations. These services include: Medical Service, Psychological Service and Legal Service (this completely free). During 2015, the VCT Service attends 987 HIV tests. 728 of them are MSM people.	delivery (VCT) ● PLHIV, MSM< sex workers, transgender ● Civil society
71.	Ecuador	Mapping of the encounter places of the most exposed populations (MAPLE – PEMAR) By: Fundación Ecuatoriana Equidad	In Ecuador, the limited scope of data regarding the HIV epidemic has made it difficult to design intervention programmes that target key populations such as men who have sex with men, transgender women and female sex workers. Past research carried out by the public health sector, NGOs, and universities has not generally included community participation, which could otherwise provide useful data regarding the relationship between these key populations and HIV. The main objective of the MAPLE – PEMAR study carried out across 11 cities was to provide strategic information to support the design and improvement of focused prevention programmes. The programme's technical committee included participation of representatives of the three targeted communities, who worked together with the scientific members to approve the protocol and the data collection tools, as well as review and discuss the results. Members of these communities participated in focus groups in order to prepare the questionnaire and map the field study. Subsequently, they created maps with 924 places located in the eleven cities	● Community-based research ● Civil society ● MSM, Transgender

			studied. The maps that were generated included information such as which of the most exposed populations visit which locations, sexual practices in those places, availability of condoms, and the predisposition to carry out prevention programmes. Other characteristics identified related to schedules of attendance, days of more affluence and mobility of clients, average use of services, and services offered. Individual interviews also helped characterize users of these locations and their own access to HIV prevention services. The results were used to plan activities for peer education, and also for community-based testing. Due to the evident utility of programmatic mapping, there is a demand for transfer of the MAPLE methodology, both from governmental as from non-governmental institutions, and it is now being applied to other cities in Ecuador.	
72.	Guatemala	Combined intervention to improve HIV and other sexually transmitted infections prevention for gay, bisexual and other men who have sex with men in Guatemala City. By: Colectivo Amigos Contra el Sida –CAS_	With the technical and financial support of the Guatemalan Project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Centers for Disease Control and Prevention (CDC, USA), Del Valle University of Guatemala and the United Nation’s Population Fund (UNFPA), Colectivo Amigo contra el Sida (CAS) implemented a combination intervention was implemented, with the objective or increasing access and coverage of HIV and STI diagnostic, treatment and care services for MSM. Four basic strategies were implemented.. Mpowerment activities are implemented during the week; the community clinic has functioned for 15 months, on Saturdays, from 14:00 to 21:00. This schedule was extended in January 2016 from Monday to Friday from 16:00 to 20:00. Community based testing is done every day except for Sundays in places that are agreed between clients and health promoters. All the beneficiary population is recruited in Guatemala City and neighboring counties. To date, more than two thousand men have received services.	• Service delivery (VCT)

73.	Paraguay *	Kuimba'e Clinic. Men's Wellness Center in Paraguay. By: SOMOSGAY	HIV prevalence in Paraguay is 0.4%, with 17 000 people living with HIV. Prevalence among men who have sex with men is estimated to be as high as 13%; however, a culture of homophobia and discrimination, even within the health system, historically meant that there was no safe space for men who have sex with men to access sexual health services. In response, SOMOSGAY Community Centre was conceptualized, and implemented by members of the men who have sex with men and PLHIV communities, providing a range of social and health services and advocating for public health, education and other public policies. It also provides an incubator for grassroots groups to meet and two networks have already emerged to help support the lesbian and young people's PLHIV communities. In 2009, SOMOSGAY opened the Kuimba'e clinic, offering free clinical care, testing, treatment vaccines and referrals, with particular emphasis on HIV and STI prevention. In its first year of operations, 1,915 people visited the SOMOSGAY Centre, rising to 4,020 in 2015. That year, 8,326 clients visited the Kuimba'e clinic. Another closely linked programme 'Community Agents of Human Rights and Health' runs a cycle of workshops focused on training and empowerment of young lesbian, gay, bisexual and transgender people, providing basic information, prevention packages, counselling, leadership and networking training. Currently there are more than 200 Community Agents across the country who work with Kuimba'e on different activities, in particular providing information, prevention packages and referrals to the Kuimba'e Clinic and other public health services. The clinic also runs mass HIV testing programmes and campaigns in public places to reach large numbers of people with information, prevention supplies, testing, counselling and onward referrals and linkage to care. Kuimba'e works closely with PRONASIDA (the National Programme for AIDS and STI control) and the Ministry of Public Health to ensure efficient linkage to care. In 2016, SOMOSGAY began to replicate its	● Service delivery ● MSM, men ● Civil society ● Has been included previously as cases study by UNAIDS

			service model in other regions around the country, with support of the Ministry of Public Health and the AIDS Healthcare Foundation. SOMOSGAY maintains a particular emphasis on research, advocacy, and communications as key elements of programme activities.	
74.	Peru	Impulse Group for the Surveillance of the Supply of Antiretroviral Medicines: (Peruvian aids network, PROSA, Aid for Aids, Cepesju, Sí, da Vida, Impact, Justice in Health, Land of Free Boys and Girls, Via Libre, Positive Peruvians, ICW Peru and Movement of People living with HIV). By: GIVAR	GIVAR, aims to monitor the supply of medicines for HIV. The heart is our portal "Complaints GIVAR" (www.givarperu.org), where the citizen of any region of Peru reports the situation of the drug supply, anonymous or in an identifiable manner. From October 2010 to March 2016, 568 complaints were made of shortages nationwide, helping to improve the supply of medicines to some 22 thousand people (adults and children) who are in medical treatment nationwide. 16 complaints with the Public Ministry of Peru.	● Advocacy (and watchdog) on supply of medicines ● PLHIV ● Civil society ● Innovative
75.	Peru	Community approach by women with HIV to promote the exercise of their sexual and reproductive rights and contribute to reducing maternal and child transmission of HIV in Perú By: Peruvian Network of women living with HIV	ENJOYMENT OF SEXUAL AND REPRODUCTIVE RIGHTS OF WOMEN WITH HIV AND REDUCTION OF MOTHER CHILD WITH HIV IN PERU <u>PURPOSE</u> Community help reduce barriers to continuity of care of pregnant women living with HIV and their RN identified in health facilities. The intervention included the effective participation of Peruvian Network of Women Living with HIV (All HIV) for fieldwork, led by the community coordinator, an instructor and 6 counselors field to search and monitoring of pregnant women with HIV, it peer relationship reinserting achieved a significant% of pregnant mothers having received their diagnosis had been away from the health system, primarily for denial of discrimination. The number of people reached and geographic coverage. This project with community approach to reduce vertical HIV transmission was able to identify 171 women in six hospitals in Lima and Callao for eight months of intervention.	● Advocacy ● Service delivery ● Humanitarian ● Civil society ● PLHIV, women

WESTERN EUROPEAN AND OTHER STATES

76.	Canada	Canadian Positive People Network (CPPN) By: Réseau canadien des personnes seropositives (RCPS)	At the end of 2014, there were approximately 71,300 PLHIV in Canada. Among marginalized populations such as resource-poor indigenous communities and refugees, the ability to access healthcare fell between 2006 and 2015, and HIV rates increased. Prior to 2015, Canada lacked a national PLHIV network to represent the needs of individuals and communities living with HIV. To close this gap, CPPN was created as an independent national grassroots network with support of a number of AIDS service organisations. CPPN has a national reach, and has grown to include over 125 members across Canada. A key activity of CPPN is advocacy on national and international levels, and to date it had several achievements in advocacy, campaigning and participation in accountability. These include the creation of an online petition during the federal election in 2015 and a community press conference to ask candidates to commit to placing PLHIV at the forefront of the HIV response. CPPN also led a group of PLHIV activists at 2015 conference of the International AIDS Society to craft the Canadian Declaration by Persons living with HIV to highlight the human rights considerations needed in the expanded testing, treatment and use of new prevention technologies approach. The organization also co-hosts an HIV, Aging and Income Security Think Tank with a national partner, and participates in national consultations and working groups including the Canadian Consensus Statement on the Health and Prevention Benefits of HIV ARVs & HIV testing; the National Coalition Working Group on the development of a new community-driven HIV strategy; and the national CanPrEP working group to provide perspectives of PLHIVs on pre-	• Advocacy • Young people, people with HIV co-infections, PLHIV

			exposure antiretroviral prophylaxis (PrEP) to facilitate the listing of PrEP on drug formularies. Additionally, working with partners including the Youth HIV Disclosure Project, CPPN has worked on programme development, and is involved in planning of “HIV is Not a Crime” trainings for PLHIV in Canada. As part of its activities to better represent the needs of PLHIV and civil society, CPPN made an intervention on GIPA at the UN Civil Society Hearing in April 2016, and also participates in consultations on the UNAIDS Programme Coordinating Board thematic working groups and Canadian consultations for the High Level Meeting on Ending AIDS (HLM).	
77.	Monaco	Test in the city By: FIGHT AIDS MONACO	Cette action novatrice des tests rapides d’orientation diagnostique de l’infection à VIH 1 et 2, a pour objectifs : un accès facilité et renouvelé à la connaissance de son statut sérologique vis-à- vis de l’infection par le VIH; une adaptation des stratégies préventives de chacun en fonction de la connaissance actualisée de son statut sérologique et de celle de ses partenaires ; l’entrée et l’accompagnement dans une démarche de soins la plus précoce posible pour les personnes découvrant leur séropositivité au VIH. La facilité d’utilisation du test rapide d’orientation diagnostique de l’infection à VIH 1 et 2 permet son usage hors les murs et à des horaires diurnes ou nocturnes. FIGHT AIDS MONACO propose un dépistage par test rapide d’orientation diagnostique intégré dans une offre complète de prévention. Le nombre par journée allant de 63 à 262 personnes dépistées.	• Service delivery • PLHIV, for young people, women and others.
78.	Portugal *	Portuguese Community Based Screening Network By: GAT	The Portuguese Community Screening Network is a project coordinated by GAT, in partnership with the Institute of Public Health of the University of Porto (data collection and analysis) and the Imunohemoteraphy Service of São João Hospital (quality control and laboratory supervision), that aims to promote early diagnosis of HIV, hepatitis B and C virus, and syphilis through civil society organizations, focusing its work on the groups most affected by these infections: sex workers,	• Advocacy • Service delivery • PLHIV, MSM, Sex workers, TG, PWUD • Civil society

			people who use drugs, migrants and men who have sex with men, although all the centres are open to everyone. From August 2015 to March 2016, both pilot phase and in the implementation phase, the participating NGOs performed a total of 4984 HIV tests (98 reactive results – 1,96%); 2217 HCV tests (35 reactive results –1,57%); 1585 HBV tests (30 reactive results – 1,89%); 3340 Syphilis tests (135 reactive results – 4,04%).	
79.	Portugal *	Checkpoint LX By: GAT	There are an estimated 20 000-25 000 people living with HIV in Portugal who remain undiagnosed, and there is a concentrated epidemic among men who have sex with men , with cross-sectional studies indicating a prevalence among this population of 10-17%. In high-prevalence settings such as Lisbon, men frequently enter care late or delay linkage to prevention, care and support. WHO has recommended that countries with concentrated HIV epidemics should prioritize and focus on tailored community-based HIV testing approaches for those who remain undiagnosed and are at greatest ongoing risk for HIV infection. In 2011, GAT opened the first community-based HIV testing site in Portugal tailored to men who have sex with men: CheckpointLX. The centre offers anonymous, confidential and free screening of HIV and other STIs), sexual counselling and referral to health care, delivered by a team made up exclusively of men who have sex with men, supported by scientific medical supervision. Between April 2011 and December 2015, 10 002 HIV tests were performed. The centre has had a transformative impact on HIV testing and surveillance nationwide - according to official data, per civil year, on national level, CheckpointLX found 8.71% (2011), 15.27% (2012), 19.95% (2013) and 26.29% (2014) of all new HIV infections among men who have sex with men. Linkage to care was 79.49% (2011), 73.97% (2012), 78.05% (2013), 83.33% (2014) and 74.78% (2015). CheckpointLX has made a significant contribution to early diagnosis and linkage to care	● Advocacy ● Service delivery ● Community-based research ● Government, civil society

			for men who have sex with men at both local and national levels, has been recognized by the European Centre for Disease Prevention and Control as a new and innovative service, and was selected by WHO as an example of good practice reflecting the new HIV testing service recommendations.	

MULTIPLE COUNTRIES

80.	Asia Pacific regional	Ending Discrimination against people living with HIV and key populations in healthcare settings in Cambodia, China, Myanmar and Viet Nam By: Asia Catalyst (AC)	In December 2014, Asia Catalyst (AC) commenced the Regional Rights Training Program to increase the knowledge and skills of community based organizations on the human rights framework, human rights based documentation, and evidence-based advocacy. 8 community-based organizations (CBOs) representing communities of people living with HIV from Cambodia, China, Myanmar and Viet Nam participated in the program. This program increased the capacity of grassroots health rights community based organizations in Cambodia, China, Myanmar and Viet Nam to conduct human rights documentation and advocacy. Furthermore knowledge and content learned through the workshops were transferred to the local level as each CBO conducted additional training sessions reaching 209 CBO staff and volunteers in 4 countries and 11,787 indirect beneficiaries by training members of their boarder networks of people living with HIV, Lesbian, Gay, Bisexual, Transgender (LGBT) communities and men who have sex with men, women, and sex workers based on the material that he or she learned at each of the Asia Catalyst workshops.	• Advocacy • Service delivery • Community-based research • Civil society • PLHIV, MSM, TG, Sex workers, PWUD, young people, women

81.	Eastern Europe Regional	Eastern Europe Regional programme, entitled "Harm Reduction Works – Fund it!" BY: EHRN (Eurasian Harm Reduction Network)	For over a decade, the Eastern Europe and Central Asia region has been home to the world's fastest growing HIV epidemic. With US$679.5 million designated for HIV and TB programming in the region in 2014-2016, the Global Fund is at the front lines of support for harm reduction in many Eastern Europe and Central Asian countries. However, while such investments have ensured that needle/syringe programme and opioid substitution therapy have gained a foothold in the region, national governments in the region supply less than 15% of harm reduction potentially imperilling the long term sustainability or these essential programs. For the purposes of regional advocacy, the Eurasian Harm Reduction Network (EHRN) developed methodologies to: assess the total costs and unit costs of needle and syringe programs and OST programs in a country for two financial years; study the opinions of program clients about accessibility of and demand for services; identify harm reduction funding gaps to develop arguments for advocacy; and demonstrate the efficiency of investments in harm reduction. The assessment was conducted in six sentinel countries of the Regional Program: Belarus, Georgia, Kazakhstan, Lithuania, Moldova and Tajikistan. This community-led assessment of service quality and priorities had dual aims of building the capacity of communities of people who inject drugs, and formally documenting service quality issues that require attention through further investment and greater political will. The assessment generated evidence that could be applied at several levels, for example contributing to the state public health programme for 2016-2020 in Kazakhstan to help cater to the needs of people who use drugs, and helping create an evidence-based budget for harm reduction in Moldova.	● Advocacy ● Community-based research ● PLHIV, young PWUD, MSM, sex worker, women ● Community-led
82.	Regional ESA (Uganda, Kenya, Tanzania and	Men's sexual health and rights initiative in Africa (SHARP) By: International HIV AIDS Alliance	The programme aimed to effectively reduce the spread and impact of HIV among MSM in Eastern and Southern Africa and to build healthy MSM communities. In each of the 4 countries (Kenya, Tanzania, Uganda and Zimbabwe), SHARP worked	● Service delivery ● MSM, young people

	Zimbabwe)		through the International HIV AIDS Alliance affiliated NGOs that provided funding to smaller MSM-led organisations (Implementing Partners) which contributed to common programmatic objectives including: I. To increase reach of MSM, their sexual partners and family members in the region. II. To increase access to and uptake of better quality HIV and health programmes and services by MSM in the region. III. To enhance social, political and structural environments for evidence- and human rights-based public health interventions targeting MSM in the region. IV. To strengthen MSM community-based organisations and networks in the region and increase capacity of other sectors to better serve the needs of MSM The programmatic cumulative reach of the SHARP programme was of 14900 MSM, which represented a 6-fold increase if compared to the programme baseline of 2579 MSM.	● Civil society
83.	Regional LAC	Advocacy to challenge impunity and violence against transgender people By: REDLACTRANS	The average life expectancy of transgender women in Latin America is 35 years. Due to a dynamic of rejection and transphobia, transgender women are often limited in job opportunities, and, as a result, are frequently pushed into sex work. REDLACTRANS works to highlight the vulnerability and inequality of transgender women in Latin America, encouraging countries to take immediate action to rectify this situation, and that they contribute to creating a political and legal environment that favours the inclusion of transgender women in society. The network focuses on advocating for transgender rights, and its activities support development of the network and its focal points. By improving recognition of transgender identity, REDLACTRANS aims to strengthen the gathering of evidence regarding human rights abuses against transgender people, and to drive the formulation of inclusive HIV and health policies that meet their needs. In addition, noting the difficulty in reaching judicial authorities with sensitization training	● Advocacy ● Service delivery ● Civil society ● Transgender ● Community-led KP network ● Advocacy shows change in laws in Argentina

			towards transgender issues, REDLACTRANS has highlighted the need for strong advocacy for such training to take place. Activities include regional workshops and meetings to provide guidance on steps to take when reporting abuses and crimes including gender-based violence, human rights violations, and hate-crimes. REDLACTRANS also carries out training within the Inter-American human rights system. The network has focal points in 15 countries in the Latin American and Caribbean region, and a major achievement to-date is their instrumental role in the introduction of legislation in Argentina, which seeks to reduce discrimination by guaranteeing equal rights and dignity of transgender people. The work of REDLACTRANS is also shared across 32 countries via their partnership with the International HIV/AIDS Alliance.	
84.	Regional (LAC)	Advocacy in the defence and promotion of the human rights of female sex workers By: RedTraSex	Female sex workers are one of the populations most affected by HIV. In Latin America, HIV prevalence among female sex workers is 2.57% - over six times greater than the regional prevalence of the general population at 0.4%. RedTraSex was established in 1997, with the aim of strengthening the National Organisations of female sex workers in the defence and promotion of human rights, operating under the motto “sex workers are not the problem, but part of the solution”. RedTraSex promotes training, and seeks to make the voice of sex workers heard in decision-making spaces regarding policies that affect them. From 2012 until the end of 2016, the RedTraSex network is implementing a regional Global Fund grant aimed at decreasing HIV prevalence among sex workers in Latin America and the Caribbean through the strengthening of sex workers’ organisations and an increased participation of sex workers’ in the political debate about sex work and the stigma and discrimination that surrounds it. The network spans 15 Spanish-speaking countries across Latin America and the Carribbean, and its work is shared across 32 countries in partnership with the International HIV/AIDS Alliance. In 2013, RedTraSex reached over 17 306 FSW for the first time, and 13	● Advocacy (sex worker network engaging in national dialogue/policy) ● Sex workers ● Civil society

			950 for the first time in 2014. From late 2013 to early 2014, RedTraSex held seven national workshops covering financial and technical capacity building among female sex worker organisations, which brought together 225 women, and during 2014, six national workshops were held which reached 117 women. RedTraSex also holds workshops for sensitization for health and security officials, which by January 2015 had reached 1 062 people, surpassing their original target number of 700.	
85.	Global (Athena)	ATHENA Network Young Women's Leadership Initiative By: ATHENA Network	While it is widely known that young women are disproportionately affected by HIV, their needs have been historically under-recognized, and their voices under-represented, as research agendas, policies, and programmes are being developed. In response to this, ATHENA developed an evolving leadership strategy for young women living with HIV in all of their diversity. Launched in partnership with the Global Coalition on Women and AIDS and UNAIDS at the International AIDS Society's 2011 Conference on HIV Pathogenesis, Treatment and Prevention, ATHENA's YWLI is a leadership, advocacy and mentoring programme that aims to: increase the visibility of young women living with HIV, supporting them to claim spaces within key policy fora; define priority issues affecting young women living with HIV, and also showcase leadership and community-driven solutions; and increase their knowledge, skills and advocacy experience, particularly with regard to achieving sexual and reproductive rights in the context of HIV. To-date, 75 young women living with, and most affected by, HIV, from all regions of the world, are 'graduates' of, and peer mentors within ATHENA's YWLI. The programme has developed spaces and strategies facilitating meaningful engagement in the HIV response, by providing girls and young women opportunities and support. Past participants have emerged as powerful leaders in their own right, prominently addressing high-level international meetings, and contributing towards country coordination. They	• Advocacy • PLHIV, PWUD, SW, TG, women, young people • Civil society • Leadership, innovation

			are also engaging in critical international dialogues, as well as leading participatory research and advocacy in their own countries and communities, whilst also mentoring other young women to become spokespersons, advocates and leaders for human rights and gender equality. To help build the success of the programme, ATHENA has served as an on-going platform and resource for young women to be integrated within a broader community of practice, so that the knowledge sharing, mentorship, and inter-generational exchange is ongoing and not limited to one workshop or one political moment.	
86.	Global (Athena)	From Talk to Action: Putting Women, Girls and Gender Equality at the Heart of the HIV Response By: ATHENA Network	a series of multi-country and multi-stakeholder consultative workshops and trainings over the period October 2010 to December 2013. The workshops aimed to strengthen understanding around GBV and HIV, and provide delegates with tools and knowledge for strengthening their countries NSPs around these issues with evidence based programming . Through the series of 8 multi-country meetings, the programme reached more than 250 governmental, non-governmental, and UN partners have been directly involved in ATHENA initiated and convened efforts to strengthen the HIV policy framework for women, girls, and gender equality across Southern and Eastern Africa, and globally, in 45 countries (see map attached as annex)	● Advocacy ● PLHIV, women, young women ● Civil society & UN ● CS Consultation
87.	Global (Robert Carr Network) *	The Robert Carr civil society Networks Fund (RCNF) By: Aids Fonds	The Robert Carr civil society Networks Fund (RCNF) was created to respond to specific trends in the landscape for civil society action on HIV. These included inadequate funding for HIV; a shift in donor funding towards the country level; and a push towards greater coordination among civil society players. These trends occurred against the backdrop of persistent marginalization and human rights abuses against inadequately served populations, known to be central to 'know your epidemic' responses. There exist a number of processes and funding channels to support civil society action at the country level. However, making optimal use of these – and securing	● Advocacy ● Community financing ● Civil society ● Funding modality to support CS

			the resources, services and political environment that ISPs need – requires the expertise and action that only regional and global networks can mobilise and provide. The RCNF is the first international fund that specifically aims to strengthen global and regional networks across the world, providing them with both programmatic and core funding, in line with four major objectives: 1. To improve global and regional network capacity; 2. To enhance HIV response implementation; 3. To support human rights advocacy; and 4. To increase resource accountability for the HIV response. The RCNF has so far allocated of 38 grants worth US$18,217,092 to provide a lifeline to some of the most important global and regional civil society actors in the response to HIV. The overall conclusions of a Mid-term review, conducted in 2014, were that the RCNF has identified a unique and strategic niche within the global architecture; has developed effective grant-management policies and processes; and has established appropriate and highly committed governance bodies. RCNF grantees are achieving impressive outputs across the RCNF's four outcomes – with strong indications that, in combination, they are ensuring stronger support to ISPs and more effective responses to HIV at the country, regional and global levels	
88.	Global (World Bank)	Evaluation of the Community Response to HIV-AIDS By: World Bank	A total of 11 studies were carried out in eight countries (Burkina Faso, India, Kenya, Nigeria, Lesotho, Senegal, South Africa and Zimbabwe), selected for their diversity of epidemic status (generalized vs. concentrated), HIV prevalence (from high to low) and regional location.	• This paper is heavily referenced in the actual BN • Advocacy • Service delivery • Community-based research • PLHIV, sex workers, PWUD,

				MSM, TG, young people, women, other • UN