

THEMATIC SEGMENT

HIV PREVENTION 2020: A GLOBAL PARTNERSHIP FOR DELIVERY

COUNTRY SUBMISSIONS

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INTRODUCTION

The PCB Thematic Segment, which will be held on 29 June 2017, will focus on “HIV Prevention 2020: a global partnership for delivery”. The Thematic Segment focuses on revitalising and scaling-up of primary HIV prevention programmes at national and sub-national levels.

To ensure that the session is informed as much as possible by the reality at the country level, PCB Members, countries, partner organizations and colleagues were invited to submit cases that reflect HIV prevention results and achievements in line with the 2016 Political Declaration Commitments and Targets and/or challenges and barriers regarding prevention programme scale-up.

A total of 65 submissions were received: 23 cases from African States, 6 from Asian States, 4 from Eastern European States, 8 from Latin American and Caribbean States, 12 from Western European and Other States, and 12 cases which cover multiple countries or regions.

The submissions reflect the work of governments, civil society, United Nations and international organizations, as well as collaborative efforts. The case studies highlight different aspects of HIV prevention and scale-up of prevention programmes while covering a broad range of topics. Some submissions for example illustrate how to put the requirements for scale-up into practice, exemplify scale-up services for key populations and indigenous populations, or display interventions to address harmful gender norms and empower young women and girls. Other cases emphasise voluntary male medical circumcision (VMMC), pre-exposure prophylaxis (PrEP) scale-up, or anti-retroviral therapy (ART), and exhibit that it is possible to overcome challenges in linking people to care and treatment adherence.

I. AFRICAN STATES

1. ALGERIA

TITRE DU PROGRAMME:

Approche multipartite pour une prévention de proximité combinée du VIH auprès des populations exposées au risque

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Le programme est en place depuis: 2016

Partie/parties responsable(s): Gouvernement / Société civile / ONU / Autres

Groupe(s) de populations bénéficiaires: Hommes ayant des rapports sexuels avec des hommes / Personnes qui s'injectent des drogues / Travailleurs/euses du sexe

Est-ce que le programme a été évalué /analysé? Non

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

Est-ce que le programme fait partie d'un plan national autre que la stratégie nationale sur le sida? Non

CONTEXTE

L'Algérie s'est engagée depuis 30 ans dans la riposte au VIH/sida, malgré une épidémie peu active, grâce à un engagement politique, maintes fois affiché. La riposte au VIH/sida s'est, aussi,

parallèlement inscrite dans le cadre des engagements internationaux ratifiés par l'Algérie notamment la vision d'ONUSIDA 90-90-90 et la Déclaration d'Alger sur l'accélération du dépistage du VIH au Moyen-Orient et en Afrique du Nord qui visent, à terme, l'élimination de l'épidémie de sida d'ici 2030.

Depuis la notification obligatoire en 1990 par le Laboratoire National de Référence (LNR) des cas de sida et de séropositivité VIH, le profil épidémiologique du VIH a toujours été celui d'une épidémie de type peu active, avec une prévalence inférieure à 0.1% dans la population générale mais concentrée dans certains groupes de population les plus exposés au risque : les professionnelles du sexe (PS 5.5%), les hommes ayant des relations sexuelles avec d'autres hommes (HSH 4.4 %) et les consommateurs de drogues injectables (CDI 4.5 %).²

En matière de prévention, les actions pour la promotion des comportements sexuels à moindre risque, l'utilisation des préservatifs et le dépistage du VIH inscrites dans les précédents PNS n'ont pas cessé avec une participation active de la société civile, des secteurs institutionnels et des médias, ces actions ont permis de sensibiliser la population générale et les jeunes en particulier à travers de différentes campagnes au niveau des structures et dans les espaces publics.

Au regard du profil épidémiologique, de la faiblesse des données sur les populations exposées au risque VIH (PS, HSH et CDI) et compte tenu des domaines financés par le gouvernement algérien (prévention, dépistage et prise en charge globale), il a été retenu la nécessité de centrer la riposte nationale au sida sur la prévention de proximité combinée auprès et avec les populations les plus exposées au risque VIH procéder à une mobilisation de ressources catalytiques auprès du Fonds Mondial.

La soumission d'une note conceptuelle approuvée en octobre 2016 par le Fonds Mondial, est le résultat d'un processus national de concertation entre toutes les parties prenantes de la riposte en Algérie, qui sous l'égide du CCM Algérie ont analysé les gaps programmatiques et financiers du PNS 2016-2020, pour lesquels les priorités ont été retenues pour renforcer l'accès aux services de prévention des populations exposées au risque VIH, (HSH, PS et CDI), les interventions retenues seront mise en œuvre principalement par les organisations de la société civile avec une collaboration étroite des services de santé (centres de dépistage et de prise en charge des PVIH) et l'appui technique de ONUSIDA.

RESULTATS ET IMPACT

La démarche de mise en œuvre du programme de prévention au titre de la subvention du Fonds Mondial consistera d'approfondir les connaissances épidémiologiques et comportementales, d'estimer la taille des populations les plus exposées au risque VIH (PS, HSH, CDI) et de mettre en œuvre des actions de prévention combinée par des pairs éducateurs à travers l'intervention des organisations de la société civile. Ces activités de prévention seront associées à des

² Rapport de la riposte Algérie-2016

interventions de lutte contre la stigmatisation et la discrimination tant au niveau des structures de soins qu'au niveau de la population.

Les personnes dépistées séropositives pour le VIH au niveau des centres de dépistage (CD) du Ministère de la Santé seront orientées et accompagnées par les éducateurs pairs vers les centres de traitement (CDR) pour une prise en charge médicale et psychosociale entièrement financée par le budget du gouvernement algérien. Cette approche globale permet d'établir des liens entre les associations et les structures de santé (CD et CDR) dans une démarche complémentaire.

Le programme permettra d'offrir un paquet de services à 9800 PS, 7700 HSH et 1500 CDI sur une période de 3 ans et vise à contribuer aux résultats d'impact définis dans le PNS 2016-2020 qui sont: D'ici fin 2020, le nombre de nouvelles infections à VIH sera réduit à moins de 500 par an.

FINANCEMENT

Le budget global du PNS 2016-2020 est estimé à 157 millions \$. Comme par le passé, l'Etat algérien continuera à assurer la presque totalité de ce budget (95%). La subvention du Fonds Mondial couvrira 4% de ce budget (6.5 millions \$). Le budget dédié au programme de prévention combiné représente 42% du montant total de cette subvention.

Il est prévu de procéder sur la base des résultats de ce programme à l'élaboration d'un programme de transition pour assurer sa pérennisation dans le cadre de l'action de l'état de la généralisation de l'accès universel à tous sans laisser personne de côté.

GOUVERNANCE

Le Décret exécutif N° 12-116 du 18 Rabie Ethani 1433 du 11 mars 2012³ a mis en place le Comité National de Prévention et de Lutte contre les IST/VIH/SIDA(CNPLS). Le CNPLS, présidé par le Ministre de la santé, « est un organe permanent de consultation, de concertation, de coordination et de suivi et évaluation de l'ensemble des activités de prévention et de lutte contre les IST et le sida » impliquant les secteurs gouvernementaux, les OSC et les secteurs académique et privé, les partenaires multilatéraux sont membres du CCM. Sur la base des accords avec le FM, le CNPLS a mis en place un CCM. La gestion du programme est assurée par le Ministère de la Santé comme PR en collaboration avec les SPR de la société civile et le CCM avec une approche multisectorielle et décentralisée.

³ Décret exécutif N° 12-116

ENSEIGNEMENTS TIRES ET RECOMMANDATIONS

Le présent programme est centré sur les interventions auprès des populations les plus exposées au risque VIH, il permettra la réduction de la transmission sexuelle du VIH auprès ces populations avec l'amélioration des indicateurs de couverture pour atteindre les cibles du PNS et des 90-90-90, il se traduira par des interventions à travers un circuit d'accompagnement visant à promouvoir :

- la prévention combinée auprès des (PS, HSH et CDI) à travers notamment des actions de proximité (CCC, Préservatifs, Lubrifiant, Seringues, Aiguilles, conseil au Dépistage),
- l'accès universel au dépistage intégré du VIH, HBV, HCV et Syphilis,
- Prise en charge médicale (Traitement ARV, IO, HBV, HCV et IST) et psychosocial.

2. CAMEROON

TITRE DU PROGRAMME:

Partenariat du gouvernement et de la société civile pour améliorer le lien et la rétention au traitement ARV afin prévenir la transmission du VIH au Cameroun

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Le programme est en place depuis: 2016

Partie/parties responsable(s): Gouvernement / Société civile / ONU ou autre organisation inter-gouvernementale

Groupe(s) de populations bénéficiaires: Personnes vivant avec le VIH / Autres : Population générale

Est-ce que le programme a été évalué /analysé? Oui

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

Est-ce que le programme fait partie d'un plan national autre que la stratégie nationale sur le sida? Oui. Plan de rattrapage pour accélérer la réponse nationale au VIH: SIDA au Cameroun (2016-2018)

CONTEXTE

Au 31 décembre 2016, seules 205 359 PVVIH étaient sous traitement antirétroviral soit 32% de la cible 90. Cette couverture chez les femmes enceintes est évaluée à 67,6% (24 080 femmes enceintes) et seulement 8 486 enfants sont sous traitement ARV. Etant donné que le traitement est une stratégie pour la prévention de la transmission du VIH, vue la faible couverture en ARV, le gouvernement Camerounais avec ses partenaires techniques et financiers ont élaboré un plan de rattrapage ambitieux afin de combler les lacunes. C'est dans ce contexte que le Ministre de la Santé Publique, Président du Conseil National de Lutte contre le Sida a pris un certain nombre de décisions et instruit par lettres circulaires les services compétents pour l'adoption de la stratégie « Test and Treat » et la désignation des organisations à base communautaire (OBC) pour la dispensation communautaire des ARV.

De novembre 2016 à mars 2017, la première phase de la dispensation des ARV par les organisations à base communautaires a été mise en œuvre dans 4 régions du Cameroun (Centre, Littoral, Nord-Ouest et Ouest) impliquant 14 associations et 14 formations sanitaires. Tous les centres et les unités de prise en charge impliqués dans la mise en œuvre de la dispensation communautaire devraient au terme du second semestre 2017, avoir orienté 10% de leur file active vers OBC de rattachement. Pour ce faire, l'adhésion et un partenariat fort entre le ministère de la santé et la société civile était nécessaire.

RESULTATS ET IMPACT

- L'évaluation de cette première phase montre que 913 patients sur les 205 359 sous ARV ont été orientés vers les OBC, soit 4.55% de la file active. L'implication des organisations à base communautaire a été bénéfique pour les patients car cela leur a permis d'avoir accès à un service convivial, ainsi qu'un appui personnalisé à l'observance et à la prévention du VIH dans la communauté.
- On a également observé une meilleure compréhension et appropriation du rôle des organisations à base communautaire dans le modèle de soin à base communautaire au niveau des régions concernées et en liaison avec les responsables des centres de santé.
- Cependant plusieurs goulots d'étranglement ont été identifiés entre autre la faible communication et sensibilisation des patients et des formations sanitaires, la faible capacité des OBC et la supervision insuffisante sur le terrain.

FINANCEMENT

Le financement a été assuré essentiellement par le Fonds Mondial et le gouvernement camerounais.

GOVERNANCE

La mise en œuvre de cette activité est sous la supervision du Ministère de la santé sous la coordination du Secrétariat permanent du comité national de lutte contre le sida.

ENSEIGNEMENTS TIRES ET RECOMMANDATIONS

- Il est primordial de renforcer les capacités des membres des organisations à base communautaire pour accélérer l'accès et le maintien sous traitement ARV pour tous les PVVIH afin de prévenir la transmission du VIH et garder les personnes en vie.
- Un environnement favorable et une collaboration entre le Ministère de la santé et la société civile est indispensable pour renforcer la prévention et la prise en charge médicale

- L'élaboration des Plans de suivi de la mise en œuvre des activités communautaires est recommandée avec un accent particulier sur la prévention.

3. CÔTE D'IVOIRE

3.1. TITRE DU PROGRAMME:

Renforcement de la réponse nationale au VIH pour le passage à l'échelle de la prévention et de la prise en charge globale prenant en compte le genre et les populations clé à haut risque d'infection à VIH

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Est-ce que le programme à été évalué /analysé? Une évaluation à mi-parcours à été faite en Avril 2016. Une analyse de la cascade des soins est réalisée annuellement.

CONTEXTE

La Côte d'Ivoire est l'un des pays les plus touchés par le VIH de la région l'Afrique de l'Ouest et du Centre (AOC), après le Nigeria, le Cameroun et la République Démocratique du Congo (RDC). Un nombre élevé de Personnes Vivant avec le VIH (PVVIH) estimé à 460 000 (Estimations ONUSIDA 2015)⁴. La prévalence du VIH dans la population générale est de 3,7 % (EDS-MICS, 2011-2012)⁴. L'épidémie de VIH en Côte d'Ivoire est de type généralisé dans la population générale avec des prévalences élevées au sein des populations clés, ((PS: 11.4% (Abidjan), HSH: 11.5% (Abidjan: 29.3%). Le pays bénéficie d'un financement du Fonds Mondial de lutte contre le sida, la tuberculose et le paludisme (FM) pour la thématique VIH/SIDA dans le cadre de la phase du Round 9 qui a fait l'objet d'une extension.

Alliance Côte d'Ivoire a pour mission de soutenir l'action des communautés et des organisations de la société civile pour réduire l'expansion et l'impact du VIH/sida. Elle à été retenue comme Récipiendaire Principal du Fonds Mondial de lutte contre le Sida, la tuberculose et le Paludisme pour la gestion du volet communautaire. La subvention VIH qui a démarré le 01 Octobre 2013 et prendra fin le 31 décembre 2017. Le programme communautaire couvre 44 districts sanitaires dont

⁴ Enquête démographique et de santé à Indicateurs multiples, 2011-2012, MSLS juin 2013

16 pour les populations clés. Il mobilise 312 Conseillers communautaires (CC) dont 32 pour les populations clés et 628 pairs éducateurs dont 140 pour les populations clés. La contribution des acteurs communautaires devraient permettre l'identification et la mise sous traitement des TS et HSH VIH+, la prise en charge des cas IST diagnostiqués. Concernant les populations clés, Alliance Côte d'Ivoire a initié un programme de prévention et de prise en charge des HSH et TS dans 16 Districts sanitaires en Côte d'Ivoire en lien avec les structures de santé publiques et les financements Fonds Mondial. Les stratégies développées se sont basées sur:

- (i) Renforcement des capacités du personnel soignant et des acteurs communautaires;
- (ii) Séances d'IEC/CCC couplées au dépistage du VIH;
- (iii) Cliniques de nuit sur les sites prostitutionnels avec offre de services gratuits de prévention et prise en charge du VIH et des IST;
- (iv) Distribution de moyens de réduction de risque (préservatifs et gels lubrifiants);
- (v) Lutte contre la stigmatisation et la discrimination.

RÉSULTATS ET IMPACT

Au niveau du premier et deuxième 90

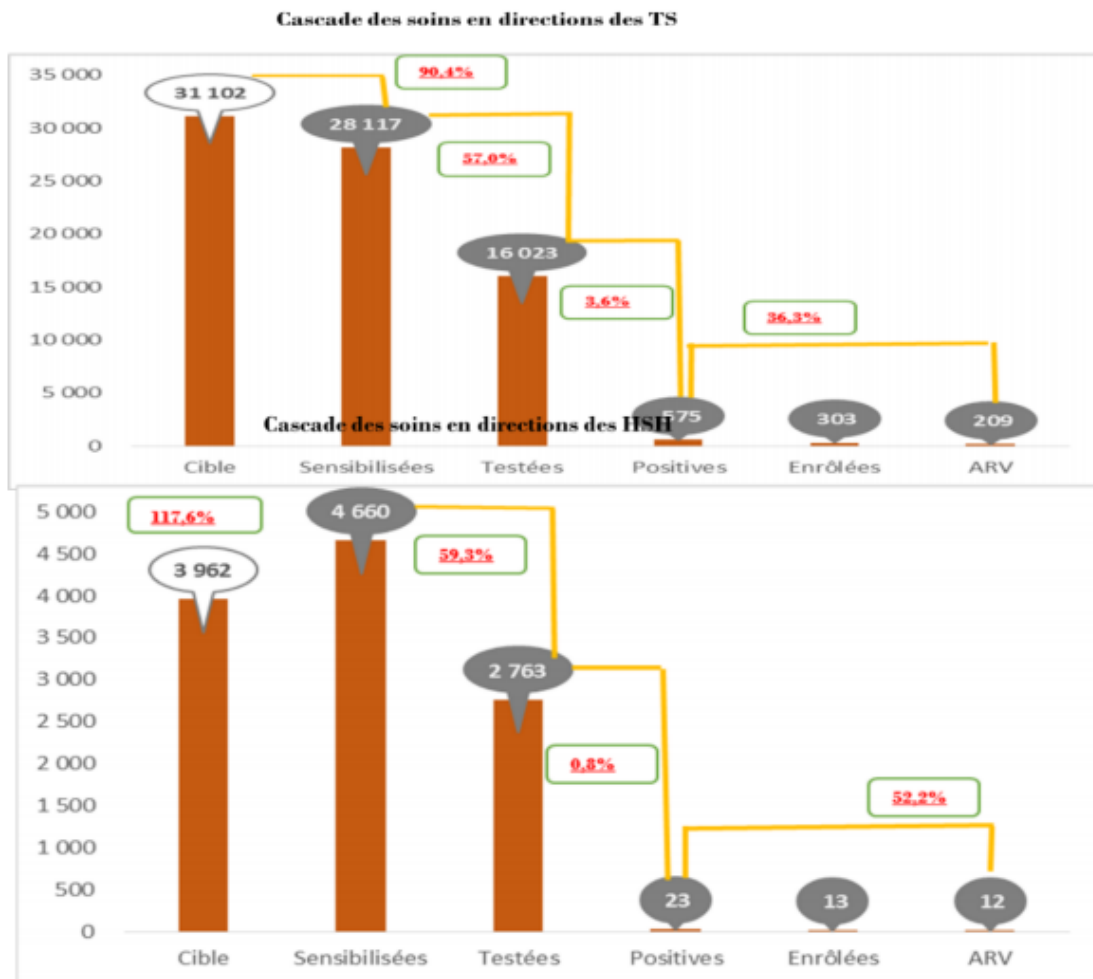
- ✓ 598 TS et HSH VIH dépistés connaissent leur statut sérologique soit 575 pour les TS et 23 HSH
- ✓ 316 TS et HSH VIH enrôlés dans les soins dont 303 pour les TS et 13 HSH
- ✓ 221 TS et HSH VIH mis sous traitement ARV dont 209 TS et 12 HSH

Au niveau du Troisième 90

- ✓ 161 TS et HSH sont en suppression virale dont 152 TS et 9 HSH

Prévention

- ✓ 28 117 TS ont bénéficié de programme de prévention par les pairs.
- ✓ 4 660 HSH ont bénéficié de programme de prévention par les pairs
- ✓ 890 711 préservatifs distribués gratuitement



FINANCEMENT

Fonds Mondial de lutte contre le Sida, le Paludisme et la Tuberculose d'un montant de 441 377 euros soit 289 524 333 FCFA

GOUVERNANCE

La mise en œuvre du programme communautaire a nécessité une coordination permanente entre le récipiendaire gouvernemental et communautaire. Le programme a mis l'accent sur la coordination au niveau central et districts pour la gestion et l'utilisation optimale des données pour la prise de décision. Cette coordination comprend le suivi des services/interventions, le lien entre intervenants communautaires et sanitaires et la supervision des prestataires et des acteurs communautaires.

ENSEIGNEMENTS TIRÉS ET RECOMMANDATIONS

1. Les interventions auprès des TS et HSH nécessitent une approche combinant la lutte contre les IST/VIH/Sida, la stigmatisation et la discrimination en milieu de soins et dans la communauté et la santé de la reproduction
2. La forte mobilité des TS implique des stratégies d'intervention innovantes telles que les Cliniques de nuit qui renforcent la confiance entre médecins prescripteurs et populations clés
3. L'offre gratuite de kits IST, préservatifs et gels lubrifiants constitue un élément de motivation pour l'utilisation des services

ANNEXES

Poster de la stratégie, Rapport évaluation

3.2. TITRE DU PROGRAMME:

Lutte contre les IST, le VIH, le sida et les grossesses précoces en milieu scolaire

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Le programme est en place depuis: 2014

Partie/parties responsable(s): Gouvernement

Groupe(s) de populations bénéficiaires: Jeunes gens

Est-ce que le programme a été évalué /analysé? Non

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

Est-ce que le programme fait partie d'un plan national autre que la stratégie nationale sur le sida? Oui. Plan Accelere de Reduction de Grossesses Precoces à l'école

CONTEXTE

Avec un taux de prévalence de 3.7% (ONUSIDA 2012), La Côte d'Ivoire demeure le pays le plus touché par l'épidémie du VIH en Afrique de l'Ouest. Le Ministère de l'Education Nationale (MEN) de Côte d'Ivoire compte à ce jour 5 400 789 élèves, dont 46% sont des filles et 18 755 salles de classe réparties sur l'ensemble du territoire national. Le milieu scolaire n'est épargné ni par l'épidémie du VIH et ni par le phénomène des grossesses précoces. Au cours de l'année scolaire 2012-2013, 97 nouveaux cas de VIH positifs ont été enregistrés chez des élèves dont 65% chez les filles. Ce constat montre la persistance des comportements à risque (rapport sexuels non protégés, multi partenariat sexuel...) chez les adolescents et jeunes scolarisés. Face à cette situation le MEN a mis en place un programme de lutte contre le VIH/sida et axé sur la prévention (abstinence, fidélité et utilisation de préservatifs, le renforcement des capacités et l'éducation par les pairs). Les grossesses précoces à l'école ont connu un pic à 5 076 cas au cours de l'année scolaire 2012-2013. Pour juguler cette situation, le Gouvernement ivoirien à travers le MEN a lancé en février 2014 à Bondoukou la campagne « Zéro grossesse à l'école » en vue de donner à tous les enfants, en particulier les jeunes filles une chance de terminer leur cursus scolaire.

Stratégies

Le programme de lutte contre le sida et les grossesses précoces a été bâti autour de sept (07) axes stratégiques qui se résument en:

- (i) Implication des leaders (responsables politiques, administratifs, coutumiers, religieux, parents d'élèves, élèves, syndicats...) pour créer un environnement favorable pour la campagne « zéro grossesse à l'école »;
- (ii) Information, Education et Communication sur la Santé Sexuelle et Reproductive (SSR) pour un changement de comportement;
- (iii) Création de centres d'écoute conviviaux animés par des travailleurs sociaux dans plusieurs établissements secondaires;
- (iv) Renforcement de l'offre des Services de SR en milieu scolaire et promotion de l'accès des méthodes contraceptives auprès des jeunes filles vulnérables (sensibilisation sur l'utilisation des préservatifs, de la pilule du lendemain et le dépistage du VIH en milieu scolaire en vue de l'atteinte de trois 90 avec l'accord des parents pour les élèves âgés de moins de 16 ans;
- (v) Utilisation des arts, de la culture, des sports, des Technologies de l'Information et la Communication dans la promotion de l'offre des services en santé sexuelle et Reproductive chez les jeunes à l'école ;
- (vi) Coordination, suivi-évaluation de la campagne « zéro grossesse à l'école »;
- (vii) Ouverture du call center avec la ligne gratuite (verte) 107.

RÉSULTATS ET IMPACT

1. **Engagement et Leadership du Gouvernement** avec une Communication en Conseil des Ministres suivi d'actions concrètes sous le leadership du MEN:
 - (i) Comité de coordination et de suivi mis en place,
 - (ii) Lancement officiel de la campagne suivi de la déclaration du Gouvernement relative aux grossesses précoces en milieu scolaire, Rencontre et Plaidoyer auprès des leaders religieux et communautaires pour leur adhésion à la campagne.

2. **Réduction de 25% du nombre de grossesses précoces à l'école sur les 3 années d'activités (2012 à 2015)** : Évolution des cas de grossesse au cours des trois (3) dernières années scolaires (voir figure en annexe).

Approche de diffusion de leçon de vie en SSR ayant touché 61,6% (2 771 927) soit un peu plus de la moitié des élèves du primaire (CE2-CM2), du secondaire et des CAFOP, 49% soit 7 637 écoles avec 43 732 enseignants impliqués.

Intégration des modules sur la SSR dans les manuels scolaires et dispensation des différents cycles scolaires.

Renforcement des capacités: implication des familles et de la communauté: 388 Encadreurs (Enseignants, Éducateurs...) et 2 239 Leaders de Clubs scolaires formés qui ont animé en direction de leurs pairs les causeries de groupe sur les inconvénients des grossesses précoces.

Elaboration d'un recueil de textes juridiques nationaux, régionaux et internationaux qui adressent les questions de la sexualité des adolescents pour la protection des filles contre les agressions et harcèlements sexuels.

Festival National des Arts et Culture en Milieu Scolaire organisé chaque année a eu pour thème sur les 3 dernières années « zéro grossesse à l'école »: plus de 3 000 élèves provenant de 400 clubs et troupes scolaires impliqués (théâtre, poésie, contes, etc.) ont été sensibilisés.

Campagne multimédia: 8000 Affiches, 500 dépliants, 30 kakemonos, Le contenu du message est : « Ma priorité ce sont mes études. Je préfère m'abstenir de rapports sexuels afin d'éviter le VIH ou une grossesse »

LIGNE VERTE, numéro d'appel d'urgence (**N°107**): 8 977 visiteurs, 1841 référencements. L'objectif est d'informer, éduquer, conseiller et orienter les élèves et aussi tout autre usagers et sur

les IST/VIH/sida, VBG, Harcèlement sexuel, grossesses précoces : environ 140 appels par jour

Offre de services intégrés SR/PF/VIH intensive et de qualité au niveau des services de santé scolaires et universitaire (SSSU) sur les 3 années: information, préservatifs masculins et féminins, la pilule du lendemain, services conviviaux. 135 000 jeunes filles scolarisées touchées. Plus de 80 000 jeunes filles utilisatrices de méthodes contraceptives modernes protégées.

FINANCEMENT

SNU (UNICEF; UNFPA) & Gouvernement de Côte d'Ivoire: MEN /DMOSS, Ministère Santé/Fonds National de Lutte contre le Sida (FNLS). Coût global: 153 000 000 F CFA soit 25 500 USD hors contribution UNFPA.

GOUVERNANCE

Assurée par le MEN à travers la DMOSS, Direction de la Pédagogie et de la formation continue (DPFC) et les chefs d'établissement scolaire.

ENSEIGNEMENTS TIRÉS ET RECOMMANDATIONS

- Prise de conscience des élèves des risques liés au VIH et aux grossesses précoces;
- Maintien des filles à l'école ;
- Réinsertion des filles mères dans le cursus scolaire après accouchement ;
- Réduction des comportements à risque chez les élèves, en particulier les filles.
- Étendre les activités du programme à tous les établissements scolaires du pays ;
- Renforcer les capacités des filles éducatrices de pairs ;
- Renforcer les capacités techniques des structures de mise en œuvre: DMOSS, Clubs santé, Comité école santé.

ANNEXES

Voir documents joints.

3.3. TITRE DU PROGRAMME:

“ICAP Community health worker approach” ou projet icap d’expérimentation de différents types d’agents de santé communautaires en côte d’ivoire (ICHAP)

PERSONNE CONTACT

Name: Samba Mamadou

Title: Directeur

Organisation: Direction de la Santé Communautaire

Tel: 20 32 39 83 / 07 07 41 14

Email: mamadou.samba@gmail.com

Le programme est en place depuis: 2014

Partie/parties responsable(s): Gouvernement / Société civile / Institution académique

Groupe(s) de populations bénéficiaires: Personnes vivant avec le VIH / Femmes / Filles / Jeunes gens / Autres: Population générale

Est-ce que le programme à été évalué /analysé? Oui

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

Est-ce que le programme fait partie d’un plan national autre que la stratégie nationale sur le sida? Oui. Plan Stratégique Nationale de la Santé Communautaire

CONTEXTE

- À la fin de l'année 2012, faible rétention (< 80%) des personnes vivant avec le VIH/Sida sous TARV au sein des établissements de santé soutenus par ICAP en Côte d'Ivoire.
- Analyse situationnelle a montré l'efficacité des Agents de Santé Communautaires (ASC) dans la promotion de l'accès aux services de santé.
- Existence de plusieurs modèles d'agents de santé communautaires en Côte d'Ivoire: l'agent de santé communautaire (ASC) et le conseiller communautaire (CC). Les ASC travaillent de façon périodique afin de soutenir des campagnes et des efforts de promotion de la santé et les CC se concentrent, quant à eux, sur des activités en lien avec le VIH et sont recrutés par des ONG.
- Nécessité de choix d’un type d’ASC efficace dans le contexte ivoirien utilisable par tous.

RESULTATS ET IMPACT

Détermination de la faisabilité de l'intégration des activités de promotion de santé mère-enfant et de réduction du VIH/Sida

- Préférence de l'intégration des activités ASC à celles spécialisées.
- Charge de travail supportable pour les ASC (plus de 6 000 visites à domicile effectuées et plus de 100 000 personnes touchées par les causeries de groupes sur les PFE)
- Les ASC, tous modèles confondus, ont contribué à l'achèvement des CPN et à l'amélioration d'autres indicateurs de soins primaires comparativement aux périodes avant la mise en œuvre du projet.
- Mais, les ASC avaient des difficultés pour continuer les travaux, du fait des besoins non satisfait en matière de revenu. Il faut donc résoudre la question de leur « motivation. » qui est largement pris en compte dans l'élaboration des documents normatifs (cadre National de mise en œuvre des interventions à base communautaire, Plan stratégique National de la Santé Communautaire, Statut, motivation, etc.) de l'utilisation des ASC

Comparaison des différences relatives de prestation des services entre les trois modèles d'agents de santé communautaire

- L'évaluation du projet a montré que les modèles "ASC-Coach" et "ASC-PE" ont de meilleurs résultats que l'ASC-Base. Le Coach aidait les ASC à améliorer leurs interactions avec les individus et les communautés et en même temps, il facilitait un monitoring plus complet.
- Les réunions hebdomadaires entre ASC ont créé un esprit de corps qui constituait également une source de motivation pour les ASC.
- Les informations collectées auprès des ASC et des infirmiers font ressortir un consensus pour un modèle mixte comprenant un ASC-Coach avec 5 à 6 ASC de base et 1 à 2 ASC-PE dans lequel l'ASC-PE peut prendre en charge les familles avec PVVIH et donner un soutien aux autres personnes dans le domaine du VIH.

Evaluation des variations de résultats liés au VIH à court terme

- Le projet a montré un consensus pour l'intégration des messages sur le VIH avec les messages pour la Santé de la Mère et de l'Enfant (SME).
- Avec le temps, les PVVIH ont accepté de discuter de leur séropositivité avec leur ASC.
- L'augmentation des CPN et des accouchements Assistés du fait des actions du corps a contribué à l'augmentation des femmes pour le dépistage du VIH et par ricochet la mise en route de la PTME
- Les taux de rétention montrent une augmentation mineures, mais la période pilote était trop courte pour évaluer un impact majeur sur la rétention à 12 mois.
- Les soutiens du projet aux services VIH/Sida ont contribué à l'amélioration des indicateurs de soins VIH à travers tous les sites pilotes où le nombre de personnes dépistées au VIH (y compris

les enfants), participant à la PMTE étaient plus élevées chez.

FINANCEMENT ET GESTION

HRSA (Health Resources and Services Administration)/CDC/PEPFAR

GOUVERNANCE

Assurer par le MSHP à travers la DSC et l'ONG ICAP-CI

ENSEIGNEMENTS TIRÉS ET RECOMMANDATIONS

Ce projet pilote a permis à la Côte d'Ivoire de choisir l'intégration de plusieurs activités dans le paquet minimum des ASC. Ainsi, la nouvelle stratégie pour la santé communautaire retient le concept d'intégration et préconise la mise en place d'une équipe ASC-Coach qui inclue 1 à 2 membres "ASC-PE". L'ASC-PE peut répondre directement aux clients qui s'expriment comme séropositive. Il peut servir comme personne de référence pour les autres ASC sur les difficultés de rétention dans le traitement. Il peut aussi travailler comme personne ressource pour l'infirmier qui éprouve des difficultés à suggérer ses services aux clients séropositifs.

ANNEXES

Le rapport du projet ICHAP en accompagnement de la soumission.

3.4. TITRE DU PROGRAMME:

Projet d'amélioration de l'accès des populations clés au service de prévention et de prise en charge des IST et du VIH /SIDA

PERSONNE CONTACT

Name: Anoma Camille

Title: Directeur Exécutif

Organisation: ONG ESPACE CONFIANCE

Address: 05 BP 1456 ABIDJAN 05 (CI)

Tel: 07692548/21254123

Email: espaceconfiance@yahoo.fr

Le programme est en place depuis: 2004

Partie/parties responsable(s): Société civile

Groupe(s) de populations bénéficiaires: Personnes vivant avec le VIH / Hommes ayant des rapports sexuels avec des hommes / Personnes qui s'injectent des drogues / Travailleurs/euses du sexe / Transgenres

Est-ce que le programme à été évalué /analysé? Oui

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

Est-ce que le programme fait partie d'un plan national autre que la stratégie nationale sur le sida? Non

CONTEXT

Dans le cadre de l'atteinte des objectifs de l'élimination de l'épidémie du sida d'ici 2030, et de la réalisation des objectifs 90-90-90 l'une des priorités du programme de prise en charge des patients VIH positifs est de les garder sous traitement ARV le plus longtemps possible. La rétention des patients sous traitement ARV est un important indicateur de qualité du programme. Les performances recommandées au plan national sont fixées à 80% à M6 (6 mois) et à M12 (12 mois). Espace confiance joue un rôle majeur dans la prise en charge des populations clés et a mis en place des stratégies permettant d'améliorer le taux de rétention.

RESULTATS ET IMPACT

1- Résultats: plusieurs stratégies ont été mises en œuvre pour l'atteinte de ces résultats:

- Envoi de messages écrits codés et consensuels à partir d'un logiciel mis en place par une maison de téléphonie mobile;
- Relance téléphonique pour les patients non vus à J15;
- Visite à domicile aux patients non vus dans les soins;
- Insertion dans un groupe de soutien pour les patients qui posent un problème d'observance aux traitements avec prime de transport à l'appui;
- Renforcement des relations prestataires /patients par une participation active dans leur quotidien (baptême, mariage, funérailles et autres activités récréatives);
- Intervention d'un psychologue pour les nouveaux cas, les patients dans le déni et le refus de traitement, et pour les non observants.

2- Impact: ces différentes stratégies ont permis:

- D'améliorer notre taux de rétention de 40% à 86% puis stabiliser à 100% (voir tableau ci-dessous)
- De mettre en confiance le client et favoriser l'estime de soi chez ce dernier, avec une meilleure implication de celui-ci dans sa prise en charge
- Des relations de convivialité entre les clients/clients; prestataires/clients.

Tableau de l'évolution de la rétention

Mois	Taux de rétention à M12
Août 2016	40%
Septembre 2016	86%
Octobre 2016	100%
Novembre 2016	100%
Décembre 2016	100%
Janvier 2017	100%

FINANCEMENT

SIDACTION, AFD/AIDS/ANSS, HEARTLAND ALLIANCE INTERNATIONAL, FONDS MONDIAL/HACI, FONDATION ARIEL GLASER, MÉDECINS DU MONDE, ANRS, FEI 5%, ETAT DE CÔTE D'IVOIRE

GOVERNANCE

- Assemblée générale
- Conseil d'administration
- Direction exécutive
- Responsable Financier
- Responsable Ressources Humaines
- Chefs de service

ENSEIGNEMENTS TIRÉS ET RECOMMANDATIONS

- Enseignements tirés :

- ❖ Implication des acteurs de santé dans le quotidien des patients pour une meilleure observance aux traitements
- ❖ Meilleure acceptation du statut sérologique
- ❖ Bonne collaboration Prestataires/ Patients

- Recommandations :

- ❖ Rendre disponibles les ARV pour une dotation de 03 mois
- ❖ Plaidoyer multisectoriel pour le respect des droits humains
- ❖ Renforcer le système de référence et contre références entre les services de prise en charge.
- ❖ Renforcer le système national de traçabilité des PVVIH.

4. EGYPT

TITLE OF THE PROGRAMME:

FHI

CONTACT PERSON

Name: Makar Naeem Daowd

Title: MR

Organisation: FHI

Address: Assiut Egypt

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Email: makar.naeem2016@yahoo.com

Programme is being implemented since: 2014

Implemented by: Civil society

Population group(s) being reached: People living with HIV / Sex workers / Women

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? Yes

5. GHANA

TITLE OF THE PROGRAMME:

HIV / STI Intervention for key population – FSW and MSM

CONTACT PERSON

Name: Comfort Asamoah-Adu (mrs.)

Title: Executive Director

Organization: WAPCAS

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Tel: +233 501 301 013

Email: comfort.asamoa@gmail.com

Reviewed and submitted by: Dr. Stephen Ayisi Addo, Programme Manager – National AIDS/STI control programme, Ghana Health Service.

Programme is being implemented since: 1996

Implemented by: Civil society

Scope of Submissions: Men who have sex with men / Sex workers

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? Yes

Is the program part of the National Plan Broader than the National AIDS Strategy? Yes.
National MARP Strategy

CONTEXT

Ghana provides Key populations (FSW, MSM, PWID) HIV interventions for about a decade now despite laws that criminalize sex work and injection drug use. Interventions for PWID have not been implemented yet though there is evidence of pockets of this community in the country. Interventions for FSW and MSM have been possible because of the evidence-based and rights-based approach used as a justification at the national level.

Ghana –West Africa Programme to Combat AIDS and STI (WAPCAS) as an entity started implementing a full scale programme for FSW in Ghana as part of a sub-regional project in 9 West African countries with funding from the Canadian International Development Association (CIDA) from 1996 to 2006. This followed a brief pilot of intervention for FSW by Family Health International in the late 1980s. WAPCAS became a locally registered national Non-Governmental Organization

(NGO) in Ghana in 2006. Within the context of the last National HIV Strategic Plan 2011-2015, WAPCAS was a sub-recipient of Global resources under the Ghana AIDS Commission.

Initial agreement with the Ministry of Health (MOH) saw WAPCAS use a “low-key” approach to its programme activities because FSW activities were not socially accepted. After the first year of project implementation with home based sex workers in Accra, the capital of Ghana, the project was expanded to Kumasi, the second busiest city in the country. By the end of the CIDA project in 2006, WAPCAS was implementing a combination of preventive and curative HIV and STI intervention for FSW, mainly in seater communities in 8 out of the 10 regions of Ghana. Currently WAPCAS is implementing a combine preventive HIV programme for FSW and MSM nationwide.

The approach is a combination of prevention and curative HIV prevention through outreach education led by community health nurses and linkages with project established STI clinics within the Ghana Health facilities even before the introduction of ART in the country. Twenty one (21) STI clinics have been established within government health facilities to ensure continuity and sustainability of service to the FSW and other key population. These STI clinics were opened to the general population and were not labeled for purposes of reducing stigmatization against key population. There is also a strong collaboration with the Ghana Police Service to sensitize the police force on the rights of FSW. These are complemented with operational studies which create the platform for discussion on key population to informed future programming for key populations especially FSW and MSM. Notable among these studies were HIV prevalence studies among FSW in Accra and Kumasi in 1997 and 1998, also an exploratory study on MSM activities in Accra 2003.

The approach to key population programming and the package of services have evolved over time. Currently, peer education is the approach to the national key population programming and the package of services is a full range of combination prevention activities; evidence-based, rights based, community owned with a mix of biomedical, structural and behavioural interventions targeted at reaping the greatest results within priority populations.

The pioneering work of WAPCAS has been recognized by the national HIV coordinating body, the Ghana AIDS Commission (GAC), having thrown light on the role key populations in fueling the epidemic largely informing both the 2011-2015 and the 2016-2020 national HIV strategic plans. The project contributed to donor agencies like USAID, DANIDA, GIZ and the Global Fund investing in key population activities as part of the national strategy to reduce new HIV infection. Key Population implementation programming funded by the Global Fund and USAID is undertaken within the current strategic plan for HIV 2016-2020.

RESULTS AND IMPACT

WAPCAS currently is working directly with over 60% of the total estimated FSW community in Ghana (IBBSS, 2011).

A critical impact of WAPCAS’ programme for FSW is that it opened up the gates for a national HIV response for key population programming. Both the 2011-2015 and 2016-2020 actually made

mention of key population as a priority population for the national response. This previously was not the case. The initial project with CIDA funding could be said to be the project that paved the way to mainstream KP programming in the national HIV & AIDS Response.

According to the modes of transmission study in 2009 and 2014, the contribution of key population (FSW, MSM, PWID) to new HIV infections decreased from 43% to 27.5% respectively. It can be said that WAPCAS contributed immensely towards this achievement through the delivery of comprehensive prevention package including an annual delivery of 9 million condoms to KPs in the major cities and commercial towns across the country.

HIV prevalence among FSWs continue to decline according to studies conducted, though the prevalence still is way above the national prevalence. In an Integrated bio behavioural surveillance survey (IBBSS) commissioned by AED-SHARP project in 2006, FSW prevalence was 34% and 25.1% in 2009, 11.1% in 2011 and less than 7% in 2015. Both 2011 and 2015 IBBSS among FSW was commissioned by GAC and it was done on a national basis. Comprehensive combination prevention programming for key population over the years can be said to contribute to this trend, among other factors.

FINANCING

The initial 10 years of activities was funded by CIDA. Since then, funding has been by USAID, DANIDA, GIZ, AJWS and the Global Fund. Currently implementation is with funding support from the Global Fund and USAID.

GOVERNANCE

WAPCAS is a locally registered NGO with the Registrar General's Department and the Social Welfare Department. It has a 6 member Advisory Board which has representation from academia, technocrats and a co-opted member from the key population. The Executive Director of WAPCAS is a member of the Advisory Board. The Advisory Board provides guidance and expert advice to the Management of WAPCAS who are responsible for the day to day running of the organization. WAPCAS has its head office in Accra with 27 other satellite offices across the country. WAPCAS currently has a staff strength of 47 and over 400 volunteers supporting the implementation of activities for key populations. It is currently a sub-recipient of GF funding under the Ghana AIDS Commission.

LESSONS AND RECOMMENDATIONS

A comprehensive HIV programming for key populations (FSW, MSM, PWID) is possible even in a socially non-accommodating and legally unfriendly society. One will have to do a social situation analysis and structure programs to suit local context.

Consistency in programming for key population is what is needed to achieve results. WAPCAS and for that matter Ghana has over the past 21 years steadily increased coverage for key populations.

This consistency and scale-up of activities is beginning to show some remarkable results.

It is possible to sell commodities such as condoms and lubricating gel to key population in programming. This must however be considered within a country's own commodities policy.

It is also possible to work with the police and other human rights institutions even in countries where activities of key populations are illegal using the evidence-based and rights-based approaches.

6. KENYA

6.1. TITLE OF THE PROGRAMME:

Stepping Up, Stepping Out (SUSO) – Economic empowerment for sex workers

CONTACT PERSON

Name: Sally Hendriks

Title: Sex Work Programme Manager

Organisation: Aidsfonds

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Email: Shendriks@aidsfonds.nl

Programme is being implemented since: 2012

Implemented by: Civil Society / Academic Institution

Scope of Submissions: People living with HIV / Men who have sex with men / Sex workers / Transgender

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? No

Is the program part of the National Plan Broader than the National AIDS Strategy? No

CONTEXT

In Kenya, as in many other countries across the globe, more than a hundred thousand men and women earn money through sex work (UNAIDS Aidsinfo website). Regardless of the circumstances that led them into the trade, sex workers face heavy stigma and discrimination. They face violence from unscrupulous managers, police officers and clients and doctors frequently refuse to treat them medically. They are often rejected by their own families and excluded from their communities. Even though sex work is not officially criminalized in Kenya, it is not legal either, leaving sex workers vulnerable to exploitation and arbitrary arrests and often not legally protected in cases of violence or exclusion. All these factors contribute to the fact that sex workers are much more vulnerable to HIV than the general population. In Kenya the HIV prevalence is 6%, however, among female sex workers it is 29% and for male sex workers rates up to 40% are found (UNAIDS 2014 and 2012).

Through the *Stepping Up, Stepping Out* (SUSO) programme, Aidsfonds⁵ supported Health Options for Young Men on HIV, AIDS and STIs (HOYMAS), a community-based organisation in Kenya founded in 2009 by male sex workers and men who have sex with men living with HIV/AIDS. Together they aimed to increase sex workers' economic empowerment to ultimately improve their health, safety and well-being.

Economic empowerment refers to the amount of control people have to determine their own economic destiny. Economically empowered sex workers are better able to take rest in times of illness or low season. Furthermore, when a sex worker is not fully dependent on sex work for survival, he or she has more leverage to say "No" in dangerous situations, such as to violent clients or clients that demand unprotected sex. As such, economic empowerment is an important factor in improving sex workers' access to health care, psycho-social support and protection from violence.

RESULTS AND IMPACT OF THE PROGRAMME

Results

Due to the stigma and discrimination sex workers face it is often difficult for them to access financial systems, such as bank accounts. Even in more informal community systems such as saving groups it is not easy to enter as a sex worker. HOYMAS addressed this by setting up savings and credit systems for sex workers specifically. They trained male sex workers in financial skills and set up a Savings and Credit Cooperation (SACCO). In 2014, HOYMAS partnered with the Small Micro and Enterprise Programme (SMEP) for follow-up trainings focusing on financial management, business development skills, and savings and loans acquisition processes. In total, 310 sex workers participated in trainings for economic empowerment, 123 sex workers participated in saving systems and 50 sex workers received micro financing or loans for new businesses.

Impact

An assessment of the training showed positive changes in habitual behaviour: more male sex workers started saving in bank accounts, rented houses rather than staying in hotels, and minimised expenses on alcohol and clothes. HOYMAS also realized that at impact level it was more important to develop the habit to save, rather than the actual amount that was saved. This was illustrated by the fact that local savings groups amongst sex workers, so-called *chama's*, usually fell apart after some time. However, the *chama's* set up with SUSO support sustained their existence beyond the programme. The trainings that were provided to sex workers, proved to be an important factor in this regard.

Independent researchers from the Dutch Centre for International Development Issues Nijmegen (CIDIN) carried out an extensive mid-term and end-term evaluation of the SUSO programme. In this evaluation, sex workers reported improvement in their economic situation, their social acceptance, their health condition, their sense of safety and their control over life. Conclusion of the researchers

⁵ Aidsfonds is a Dutch NGO that supports everyone living with HIV/AIDS, both in The Netherlands and abroad

of CIDIN is that the programme has a positive impact on sex workers' lives.

FINANCEMENT

The SUSO programme was funded by the Netherlands Ministry of Foreign Affairs and ran from 2012 to 2016. The main recipient of the funds was Aidsfonds. In cooperation with ICCO, another Dutch NGO, Aidsfonds coordinated the programme by supporting 15 implementing partners. ICCO worked with its five partners in Latin-America and Aidsfonds supported nine sex worker-led organisations in Africa and Asia. In addition, Aidsfonds supported the Global Network of Sex Work Projects (NSWP), which has membership organizations in 72 countries worldwide and which advocates for sex workers' rights and builds leadership among sex workers and their networks nationally, regionally and globally.

The SUSO grant for HOYMAS was € 180.534. This was used for economic empowerment activities as well as activities that improved sex worker's access to health services and activities to reduce stigma and discrimination, such as police sensitization, peer outreach and the HOYMAS drop-in center.

LESSONS LEARNED AND RECOMMANDATIONS

The main economic empowerment strategies for sex workers are to diversify their income and to ensure their inclusion in existing social and financial systems, such as banking, loans, pensions and insurances. It is important to note that economic empowerment is not necessarily a way out of sex work. For some sex workers it may mean learning to speak English and acquiring negotiation skills to help attract better paying clients and work in less dangerous locations. For others, economic empowerment means that they can supplement their income from sex work by learning a new skill through vocational training or accessing loans or saving groups to start a small business.

An interesting finding from the evaluation was that from the five dimensions on which impact of the programme was measured (economic situation, social acceptance, health, sense of safety, and control over life) the impact was least on the economic situation of sex workers. While there was an improvement, it was to a lesser extent compared to the other dimensions. This can be explained because sex workers who choose to exit the business tend to report a substantial decline in their income. This may have a negative impact on the economic dimension, but is likely to show more positively on other dimensions of their wellbeing and safety and even benefits their economic security in the longer term. However, it underlines that it is very difficult to substitute income from sex work with other income sources and that retreating from sex work is a gradual, long-term process. Therefore, the aforementioned strategies to include sex workers in social and financial systems are equally important when implementing economic empowerment programmes.

Another important lesson was that basic financial skills are a precondition for the success of other economic empowerment activities. Sex workers are great in finding ways to make money. However, they often do not keep track of how much they earn and they often spend money on an ad hoc

basis, making it hard to save up. Social and cultural habits played an important role in this regard too. Among the sex workers in Kenya there was a habit of *dirtying the table*, which means that if a sex worker had made a lot of money in a day, they would share it with colleagues and friends by treating them on drinks and food. However, this means that in the end the profit they made is gone. By learning how to budget and to save, sex workers can plan for the future and gain financial security. They also become more aware of how their financial priorities and decisions may impact their health and safety.

Support systems proved important as well. Follow-up with 80 of the men that were trained in microfinance and business skills in Kenya showed that mentorship and motivation are crucial elements in supporting individual entrepreneurs.

Finally, changing the economic situation of sex workers generally takes a substantial period to materialize, and adding an economic programme to the existing regular activities of HOYMAS required time for adoption and capacity building. Therefore it is recommended that programmes that include economic empowerment activities for sex workers are implemented throughout a longer period of time. Aidsfonds ensured the sustainability of HOYMAS' economic empowerment activities by continuing to support them beyond SUSO through other sex work programmes, such as Bridging the Gaps, to foster longer term impacts.

ANNEXES

- SUSO overall report achievements
- SUSO Best practice report

Both reports are available at:

<https://aidsfonds.org/about-us/suso-empowering-sex-workers-around-the-world>

6.2. TITLE OF THE PROGRAMME:

Capacity Building on HIV Human Rights and the Law for Sex Workers in Kisumu County

CONTACT PERSON

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Programme is being implemented since: 2014

Implemented by: Civil society

Scope of Submissions: People living with HIV / Female Sex workers / Sex workers

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? Yes

Is the program part of the National Plan Broader than the National AIDS Strategy? Yes.

Kenya Correctional Services (Law Enforcement) programming to work with Key populations.

CONTEXT

Sex workers in Kisumu County, Kenya—as is the case in many places regionally and globally—experience prevalent sexual and other abuse, harassment and discrimination with impunity, exclusion from formal employment and education, and lack of bargaining power in condom use which leads to high rates of HIV infection, economic and social marginalisation and poor health outcomes due to stigma and discrimination in health facilities. While stakeholders have increasingly recognised the need for programmes targeting sex workers, the work of CSOs on sex worker issues is a prerequisite to meaningful access to health services and the realisation of human rights for this population. As illustrated by the work of ARASA partners, without community-based organisations that are composed of and whom work closely with sex workers, it will not be possible to reach this marginalised and vulnerable population. ARASA has supported several national projects of this nature.

For example, in 2014, the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) with the support of ARASA, undertook a project entitled *Capacity Building on HIV Human Rights and the*

Law for Sex Workers in Kisumu County with the overall objective of enhancing protection of the rights of sex workers in the area. Through the project, KELIN trained 25 representatives of sex workers on HIV, human rights and the law; created a database of sex workers trained on HIV, human rights and the law; utilised various platforms to raise awareness on sex worker issues and generate discussion on HIV and human rights issues facing sex workers and generated evidence on the human rights and practical challenges of sex workers in Kisumu County.

The sex workers' forum was essential to provide an opportunity for sex workers to voice their concerns, learn about their rights and report cases. Due to self-stigma and stigma from the community, many sex workers previously were afraid to report cases of violence and abuse or did not know their rights. For example, some sex workers thought that violence committed against them was an occupational hazard, rather than wrongful and illegal. Further, sex workers were able to utilise the information they learned to sensitise the community, which has further empowered them and the community to take steps to protect the human rights of sex workers and other vulnerable groups.

Sex workers face double stigma and discrimination because most of them are living with HIV. It becomes difficult [for them] to protect themselves and their clients.

-Ted Wandera, KELIN

The sex workers were also able to form the Kisumu Sex Worker's Association which has been successful in working with local administration and even partnering with police. The Kisumu Sex Worker's Association is extremely diligent. Even when there are no funds available for advocacy, the Association utilises innovative and inexpensive means to conduct community outreach such as soccer and volleyball games which create a safe space in which sex workers can discuss issues with community members. The Association has also been able to air grievances to local government administration. While not all government officials accept sex workers in Kisumu, the ability to speak freely about sex worker issues is a significant achievement as compared to other places in Kenya.

RESULTS AND IMPACT OF THE PROGRAMME

As a result of the positive community changes resulting from this project and other related advocacy work, sex workers in Kisumu now feel that it is safe to report cases to the police. KELIN and the Alliance have formulated clear reporting structures whereby sex workers report cases to the Sex Workers Alliance, who then send all the cases to KELIN who maintains a central database of cases. Since the Sex Workers Alliance has been trained to document and handle such cases, this ensures that essential information is collected and helps facilitate needed support for victims. Once the cases come to KELIN, the cases can then either be handled at a local level or KELIN attorneys can handle appropriate cases. While most cases are handled locally by the Alliance and allies, KELIN has been successful in intervening in criminal cases when police failed in their due diligence. For example, in one case the police failed to take action in a case in which a sex worker was stabbed. After KELIN intervened, the perpetrator was arrested and prosecuted. The case is

ongoing.

LESSONS LEARNED AND RECOMMANDATIONS

A number of lessons were learned through the project including: sensitisation on HIV, human right and the law for commercial sex workers is a crucial step to reduce transmission of HIV in sex workers, their clients and partners in Kisumu County; a multi-stakeholder's approach is the most effective way to enhance the realisation of human rights for sex workers in Kisumu County as opposed to just targeting the commercial workers in isolation; changing public perception and attitudes is a key step towards struggle to decriminalise sex work, securing the realisation of human rights for commercial workers in Kisumu County; advocacy is a powerful strategy for tackling intolerance, ostracisation, and stigmatisation of commercial sex workers in Kisumu for enhanced realization of rights of sex workers in Kisumu County; and targeting a larger population of MARPs would be more efficient since they would be able to cascade information.

The project gave sex workers a voice so they could air grievances and violations. Before they kept quiet. The project also let them know about their voice. People don't demand rights if they are ignorant. This is a good starting point to end violations.

-Ted Wandera, KELIN

Personal Story: The Impact of Human Rights Trainings

Ingrid, a Sex Worker in Kisumu County:

"Sometime in October 2014 I got a client who was a police officer. We negotiated, agreed and went to his house. After I provided him with the services he declined to pay me. When I demanded for my payment he urinated into a container and forced me to drink his urine. I did not want to but he assaulted me and I had to drink his urine. He then chased me away. After about two weeks I met Salima who was one of the beneficiaries of the ARASA project. She informed me of my rights and encouraged me to report the incident to the police. The officer was from Nyamasaria Police station. I was afraid to report at the station so I called the Chief Inspector who is a champion for the rights of sex workers and informed him of my predicament. Chief Inspector reported my case to the regional commander. I have since been informed that the police officer was sacked."

Recommendations: Kenya and other countries in the region and programmatic interventions should prioritise the following to safeguard the rights of sex workers and effectively prevent and address HIV: (i) provision of targeted information and programming on HIV and human rights for sex workers; and (ii) strengthening access to justice for sex workers through provision of information to law enforcement and ensuring adequate mechanisms are in place for sex workers to report human rights violations.

7. MALAWI

TITLE OF THE PROGRAMME:

Enhancing CCM engagement and Global Fund funding for MSM in Malawi

CONTACT PERSON

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Implemented by: Civil society

Scope of Submissions: Men who have sex with men / Sex workers

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? No

Is the program part of the National Plan Broader than the National AIDS Strategy? Yes. The National AIDS Programme, through the CCM and Global Fund.

DESCRIPTION

ARASA has engaged in advocacy to ensure that there is meaningful key population representation and funding allocated to key population organisations in Southern and East Africa. In 2015 there was a call for proposals under the Global Fund grant in Malawi. ARASA partner Centre for the Development of People (CEDEP) applied for funding to the Action AID, which was the principal recipient, as a sub recipient for the MSM module specifically; in this they showcased their longstanding expertise working with the MSM community, and representing MSM on various national and regional platforms. CEDEP was rejected, however, and was not provided reasons for this. Two organisations were selected that had no expertise concerning MSM programming in Malawi. They were international organisations. Furthermore, in January 2016 Action AID had engaged with CEDEP to draw from their expertise on how to implement activities within the MSM community, thus acknowledging that they did not have expertise on MSM programming and CEDEP did. CEDEP assumed that their application would be reviewed again and that they possibly would receive the funds to implement the MSM module. However, this did not happen.

During the Regional Activist workshop in May 2016, hosted by ARASA and ITPC as part of this project, a discussion emerged concerning ongoing issues regarding Global Fund structures and the

lack of engagement or funding for key population organisations. Thereafter a joint letter outlining these issues was drafted and sent to key persons at the Global Fund secretariat as well as to the CCMs.

During the 2016 International AIDS Conference in Durban in July, a meeting was held with the Global Fund as a follow up to the advocacy letter that had been sent. At this meeting representatives from the Global Fund CRG were present as well as representatives from the civil society delegations to the board of the Global Fund. All in-country partners who took part in writing the advocacy letters were present as well, and the meeting was hosted and facilitated by ARASA and ITPC. After this meeting Action AID, the Principal Recipient (PR) in Malawi, asked to meet with CEDEP, and started a short period of engagement surrounding the issues concerning the MSM module that continued into August 2016.

In November, after a meeting of civil society organisations, an additional letter was forwarded to the CCM by the in-country partners in Malawi concerning the MSM module when CSO members were being selected to the CCM. This issue was then further raised at the CCM meetings by the Key Population representative. Questions were raised during the CCM meeting by civil society, specifically concerning where the allocation for KPs in the grant will go, and who will be the Sub-Recipient (SR) for this particular module. The technical writing group in Malawi also engaged the CCM on this issue. The PR stated that this was given to other organisations, as the key population organisations were considered to not have the capacity to properly implement this work. However, the two organisations that were initially selected as SRs to implement the module later refused to do so, explaining that their boards had rejected the implementation of the MSM module. During the engagement with the CCM and the PR, the in-country partners advocated that key population organisations and experts should be involved in the selection of an SR for the MSM module, as they understand best what this module required. This was accepted eventually by the PR.

As a result of the strong advocacy by CEDEP and its partners about the ability of key population organisations to implement activities to meet the needs of their communities, which was directly supported with a grant from ARASA / ITPC, CEDEP and the Southern Africa AIDS Trust (SAT) Malawi have been awarded US\$ 1,2 million of the country Global Fund grant for key populations interventions.

As a result of this advocacy, CEDEP, the organisation in the best position in Malawi to represent KPs and to effectively implement MSM programming, received needed funds. CEDEP has also secured funding of about 200 000 USD from PEPFAR for MSM programming in 2015 for the first time – this funding was continued in 2016. Other results included the formation of the first ever Female Sex Workers Alliance, which is also presented on the CCM. Additionally, advocacy by the national coalition in Malawi ensured that the TORs of the CCM stipulate that there are 2 positions for key population representatives (one representative and one alternate).

Further, through this project ARASA and partner organisations gained experience navigating Global Fund processes and successfully advocated for funding being appropriately allocated to those in

the best position to implement evidence-informed programming that addresses the needs of key populations.

8. MOROCCO

8.1. TITRE DU PROGRAMME:

"Dar El Borj": un centre de santé sexuelle et reproductive pour les Hommes ayant des rapports sexuels avec des hommes (HSH) de l'Association de Lutte Contre le Sida (ALCS) à Marrakech, Maroc

PERSONNE CONTACT

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Fonction: Directrice Générale

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Partie/parties responsable(s): Société civile

Groupe(s) de populations bénéficiaires: Hommes ayant des rapports sexuels avec des hommes

Est-ce que le programme a été évalué /analysé? Oui

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

CONTEXTE

Au Maroc, la prévalence du VIH est faible en population générale mais concentrée parmi les groupes les plus exposés aux risques d'infection par le VIH notamment les HSH. Selon une étude bio comportementale menée, selon la méthode RDS, par le programme national de lutte contre le sida (PNLS), en 2014 auprès des HSH au Maroc, la prévalence VIH a été estimée à 5,3% à Marrakech, 4,4% à Casablanca, 3,2 à Tanger et 3,7% à Agadir.

L'ALCS, association leader dans le domaine de la lutte contre le sida au Maroc, créée en 1988, a mis en place, dès le début des années 90, un programme de prévention de proximité destiné aux HSH. Son objectif principal est de réduire le risque d'infection par les IST/VIH en mettant en place une série d'interventions à l'échelle communautaire portées par des membres de la communauté. Il vise également l'amélioration de l'accès des HSH aux services de prévention des IST/sida, de prise en charge de l'infection à VIH et le travail sur l'estime de soi pour les HSH, qui sont souvent marginalisés dans un environnement d'intervention peu favorable où l'homosexualité est socialement et culturellement réprimée et punie par la loi 489 du code pénal marocain par 6 mois à 3 ans d'emprisonnement et 120 à 1.200 MAD d'amende.

Mais le paquet de services prévus initialement dans le cadre du programme HSH ne suffisait plus

en regard des besoins exprimés par la communauté ; c'est pour cela que l'ALCS a mis en place d'un centre avec des services et outils plus spécifiques aux HSH. Ainsi l'ALCS, section – Marrakech, a ouvert, en octobre 2010, "Dar El Borj", le premier centre pour la santé sexuelle et reproductive (CSSR). Il s'agit d'un projet pilote au Maroc, soutenu et financé par l'American Foundation for AIDS Research (AmFAR), puis par la Mairie de Paris et SIS Réseau.

Ce centre offre aux HSH un espace pour parler de leur sexualité, de leur santé et obtenir un suivi médical, et ce de façon anonyme et confidentielle. Ils peuvent ainsi se faire dépister pour le VIH et les autres IST, mais aussi parler de leurs difficultés psycho-sociales. Dans le contexte marocain où l'homosexualité est un délit, le CSSR est un lieu rare où l'homosexualité masculine n'est pas taboue. La prise en charge des traitements du VIH et des autres IST y est également assurée, et en cas de besoin, une orientation externe se fait systématiquement vers des services gay-friendly.

RESULTAT ET IMPACT

Plus de 665 HSH suivis depuis l'ouverture (21 Octobre 2010 à 30 Mars 2017). Le centre de santé sexuelle Dar El Borj a ouvert ses portes le 21 octobre 2010. Dès la première année, 59 personnes ont demandé la création d'un dossier de suivi. En moyenne, une soixantaine de dossiers sont ouverts chaque année, à l'exception de 2013 comptabilisant 110 nouveaux bénéficiaires. Plusieurs éléments expliquent cette affluence exceptionnelle :

- des actions d'aide sociale ont été développées pour limiter l'impact de l'isolement et de la stigmatisation (distribution de paniers alimentaires, aides financières pour le loyer, etc.) ;
- les consultations psychologiques ont été modifiées avec l'arrivée d'un médecin arabophone.

Ainsi, à fin mars 2017 la file active du CSSR atteint 665 bénéficiaires ayant ouvert un dossier de suivi.

Bilan sur 6 ans de fonctionnement

- L'âge moyen est de 25 ans
- 74% réclament le dépistage VIH au moment de l'ouverture des dossiers
- 12%, la consultation IST et soutien psychologique 11% et le soutien social 7%.
- 1102 tests de dépistage du VIH, dont 2,80 % sont revenus positifs.
- 627 tests syphilis dont 3.78 % de positifs.
- 1321 consultations effectués depuis 2010, une sur cinq portes sur un diagnostic d'IST (suite à l'observation de symptôme tel que l'écoulement...)
- 1114 rencontres de soutien psycho-social
- 133 aides sociales notamment 61 paniers alimentaires et 68 aides financières pour des soins médicaux.

- 193 consultations assurées par le psychologue du centre

FINANCEMENT

Le projet continu à s'appuyer sur les activités subventionné par la Mairie de Paris ce qui permet de contribuer aux salaires du personnel acteur dans le centre de santé (conseillers, médecin, psychologue) et permet également la pérennisation des services fournis (dépistage syphilis, caisse de solidarité pour la prise en charge médical des usagers, actions d'aide social)

Le budget alloué pour le centre de santé de Marrakech est de 265 200 MAD / année (le détail du budget est en annexe)

GOVERNANCE

Le centre opérationnel offre ses services aux HSH deux jours par semaine.

- o Equipe du centre : 1 coordinateur, 1 conseiller, 1 médecin, 1 psychologue, 1 médiateur thérapeutique.
- o Le coordinateur gère les différents services du centre en faisant le lien entre les différents acteurs qui y interviennent
- o Les HSH sont accueillis par le conseiller qui procède à l'ouverture des dossiers pour les HSH consentants tout en respectant l'anonymat. Il procède à un interrogatoire pour évaluer les connaissances de la personne sur les IST/VIH/sida, les prises de risques, les addictions... Si besoin, la personne est orientée vers les autres services (dépistage VIH, dépistage syphilis, PEC des IST, appui psychologique, appui social...)
- o Enfin, un plan de prise en charge et d'accompagnement individualisé est établi avec la personne.

ENSEIGNEMENTS TIRES ET RECOMMANDATIONS

- Le suivi individualisé permet de mieux comprendre les besoins et les problématiques, et ainsi mieux y réponde par une stratégie d'accompagnement personnalisée et adaptée.
- L'offre de soin continue et étalée dans le temps permet la fidélisation des HSH dans le circuit d'accompagnement pour que les personnes séronégatives reste séronégatives
- Le centre capte les HSH les plus vulnérables vis-à-vis de l'infection à VIH.
- La santé mentale constitue un axe à ne pas dissocier du travail de prévention (pratiques à risque plus élevées).

En six ans de fonctionnement, plus de 665 personnes ont ouvert un dossier au CSSR pour un suivi perçu comme essentiel en matière de prévention des IST/VIH/sida. Les bénéficiaires consultés par focus groups expriment une grande satisfaction vis-à-vis des prestations du centre. Ils arrivent au

CSSR parce qu'ils se sentent stigmatisés et discriminés en tant que HSH dans les centres de santé classiques. Ils y restent parce qu'ils se sentent respectés et y trouvent une offre de qualité adaptée à leurs besoins.

ANNEXES:

Annexe 1: Présentation du centre de santé Al Borj

Annexe 2 : Étude d'effet / Centre de Santé Sexuelle et Reproductive Al-Borj

Annexe 3 : Rapport Statistiques et évaluations

Annexe 4 : Budget type du centre de santé sexuelle

8.2. TITRE DU PROGRAMME:

Prévention des IST/sida auprès des hommes ayant des rapports sexuels avec d'autres hommes (HSH) par les nouvelles techniques de communication. Programme de l'Association de Lutte Contre le Sida (ALCS), Maroc

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Partie/parties responsable(s): Société civile

Groupe(s) de populations bénéficiaires: Hommes ayant des rapports sexuels avec des hommes

Est-ce que le programme a été évalué /analysé? Oui

Est-ce que le programme fait partie de la stratégie nationale sur le sida? Oui

CONTEXTE

La prévention par internet a été initiée par l'ALCS en 2006, elle s'appuie sur l'usage des

applications et sites de dialogue et de rencontre fréquentés par des hommes ayant des rapports sexuels avec d'autres hommes (HSH) pour diffuser l'information sur le VIH/sida et informer sur les services de prévention et prise en charge de l'infection à VIH de l'ALCS.

L'objectif de la prévention par les nouvelles techniques de communication (NTIC) est de sensibiliser et informer sur les IST/SIDA une sous-catégorie de HSH qui ne fréquentent pas les sites de rencontres physiques classiques (parcs, bars ...) par crainte de s'afficher dans des milieux de rencontre connotés gay, pour éviter d'être stigmatisés ou d'être sujets à des représailles, voire des poursuites judiciaires, l'homosexualité étant illégale au Maroc.

Une étude bio-comportementale réalisée fin 2010 selon la méthode RDS auprès des HSH a démontré que 19,5% à Agadir et 22% à Marrakech nouent des relations via internet. La réalité des sites de rencontre classiques (physiques) caractérisée par la fréquence des agressions verbales et corporelles, l'homophobie, l'insécurité et les rafles policières, fait que certains HSH préfèrent l'usage d'internet pour se rencontrer et dialoguer.

L'apparition d'applications sur smartphones permettant aux HSH de se connaître, de développer leurs réseaux sociaux et créer des groupes d'échanges a permis de rendre cette approche encore plus profitable en matière de prévention de l'infection à VIH ; ceci par la diffusion de messages sur la prévention, sur le dépistage VIH, par l'annonce des itinéraires de passage de la clinique mobile de dépistage VIH et la prise en charge des IST et la promotion des services que l'ALCS offre aux HSH en matière de santé sexuelle et de prise en charge de l'infection à VIH.

Ainsi, en complément de la prévention via les sites de rencontres, l'ALCS a mis en place une plateforme SMS (appelée "bil7araje", un jeu de mots mélangeant arabe et français et signifiant "sans tabou") qui permet la diffusion de « textos » et de créer des groupes d'échange par SMS ("WhatsApp").

Cette approche permet également la mise en place de questionnaires en ligne pour des études ou pour consulter l'avis de la communauté sur les services de l'ALCS. C'est un des moyens que l'ALCS compte utiliser de façon très active pour la promotion du dépistage communautaire et l'annonce de l'expérience pilote de la prophylaxie pré exposition (PrEP).

RESULTAT ET IMPACT

Cette approche de prévention du VIH/sida par internet est basée sur des permanences réalisées par un conseiller communautaire qui se connecte sur les sites de rencontres gays au rythme de trois permanences par semaine, lors des horaires de forte affluence sur ces sites. Un message type, rédigé en français et en arabe, est envoyé aux personnes connectées pour les inviter à échanger sur le VIH, les IST et la santé sexuelle. L'historique des discussions est enregistré de façon anonyme, ce qui permet d'analyser les caractéristiques sociodémographiques des participants (âge, ville, profession, travail du sexe...). Après les discussions, et une fois les besoins identifiés, les participants sont orientés vers les services de l'ALCS ou vers une association partenaire.

En 2016, 111 permanences ont été réalisées avec une prise de contact avec 1 111 personnes.

Parmi ces derniers, 682 sont de nouveaux contacts et 429 des anciens. Le nombre de refus reste faible ; 74 personnes n'ont pas souhaité poursuivre la discussion sur le VIH et les IST soit près de 7%.

Les deux thématiques les plus abordées avec les internautes sont la prévention du VIH/sida et la promotion du dépistage et services de l'ALCS. Les discussions sur les IST, les pratiques à risques et le port du préservatif viennent en seconde position. Souvent à la fin des discussions, les personnes sont orientées vers les services de l'ALCS (482 usagers). Les personnes ayant confirmé s'être rendues aux locaux de l'association sont au nombre de 34 mais cette information n'est souvent pas disponible et reste dépendante du feedback volontaire de la personne.

Tout récemment l'ALCS a développé un partenariat avec l'application "Grindr" qui est le réseau social par excellence, accessible depuis une application sur smartphone et cible les hommes gays et bisexuels. Cette application permet d'entrer en contact avec d'autres utilisateurs se trouvant à proximité grâce à un système de géolocalisation. Elle a été développée en 2009 et fonctionne depuis sur tous les smartphones quel que soit le système d'exploitation utilisé (Android ou IOS). Cette application permet la diffusion des messages de prévention de l'infection à VIH, ce qui est le cas de l'ALCS qui a communiqué sur son réseau de centres de dépistage du VIH.

FINANCEMENT

L'action de prévention par internet et la plateforme SMS sont financées par le Fonds mondial de lutte contre le sida la tuberculose et le paludisme qui permet de contribuer aux indemnités de deux intervenants à Marrakech, le coordinateur de la plateforme SMS ainsi que les frais de fonctionnement de ce dispositif.

GOVERNANCE

L'activité est coordonnée par un référent qui supervise les intervenants qui réalise 3 permanence par semaine, a des tranches horaires où le taux de fréquentation des sites internet est élevé.

ENSEIGNEMENTS TIRES ET RECOMMANDATIONS

La permanence numérique est une approche originale, qui a permis non seulement de toucher une catégorie spéciale et inaccessible des HSH au Maroc, mais qui s'est avérée aussi un moyen facile et pratique pour diffuser les messages de prévention auprès de cette communauté et donc compléter les programmes de proximité de l'ALCS.

Cette nouvelle stratégie de prévention a démontré sa faisabilité vue l'acceptation de l'intervention de la part des internautes. Son expansion par la création d'une plateforme intégrée « Internet et SMS » qui s'appuie sur les nouvelles technologies de communication favorisera la transmission des messages de prévention et donnera aux acteurs de prévention la possibilité de suivre les groupes cibles en fonction des modes de rencontre les plus adaptés.

9. NIGERIA

9.1. TITLE OF THE PROGRAMME:

Pre-exposure prophylaxis as a tool to fast track zero new HIV infections among men who have sex with men and female sex workers in Nigeria

CONTACT PERSON

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INTRODUCTION

Concerted actions are required by all stakeholders to end the HIV epidemic by 2030 in Nigeria. These actions include expedited use of effective existing tools to increase and enhance treatment access for people living with HIV, and access to a combination of effective HIV prevention tools by those most vulnerable to HIV infection.

Should the HIV prevention package include pre-exposure prophylaxis (PrEP)? To answer to this question, Heartland Alliance and UNAIDS organized a national stakeholder meeting on the 12th and 13th of July, 2016 at Dennis Hotel, Abuja to (i) to provide update to key stakeholders on the status of PrEP research and PrEP use around the world; (ii) to discuss perspectives on PrEP access and uptake by Key Populations in Nigeria; and (iii) to build consensus on how to create an enabling environment for PrEP roll-out in Nigeria for key populations and use of strong recommendations to advocate for a national policy and strategy on PrEP based on evidence.

METHODOLOGY

Leading up to the meeting, a rapid online survey, taken by 519 respondents, was conducted nationwide to determine how much and how well members of the community of MSM and FSW understood PrEP. Also, 22 Focus group discussions consisting of 10 persons each were conducted with MSM and FSW with the objectives of exploring their perspectives about appropriate target populations for PrEP, logistical barriers to access to PrEP, possible facilitators of access to PrEP and requisites for using PrEP. The findings from the online survey and the focus group discussion were presented at the two days consultative meeting held with 65 key stakeholders. The objectives of the consultative meeting were to identify barriers, challenges, and facilitators to implementing PrEP for MSM and FSW, develop strategies to address each barrier and challenge, identify roll-out strategies for implementing PrEP for MSM and FSW in Nigeria including ways to create demand for PrEP, and the cost and funding implications for PrEP roll-out for MSM and FSW. At the end of the meeting, the immediate next steps were also defined.

ADDRESSING POTENTIAL BARRIERS TO PREP UPTAKE FOR MSM AND FSW

Barriers and concerns about PrEP and PrEP access include poor understanding of PrEP by the general population including MSM and FSW which increases the prospect for stigmatizing the use of the product and the people who use the product; possibility of condom migration which increases the risk for STI and pregnancy for FSW; challenges with adherence to hospital visits especially if services are provided by public health care services not friendly to key populations and if there is a cost associated with PrEP access. Efforts need to be made to improve community awareness about PrEP through integration of information into a revised peer education training manual and re-training of peer educators to provide information about PrEP, and PrEP should be provided free as a national policy in Nigeria. The current unsupportive legal environment makes it challenging for MSM and FSW to access current HIV prevention tools. Addressing the unfavourable legal environment and those barriers will yield a significant increase in uptake of PrEP by MSM and FSW.

PLANNING FOR PREP ROLL-OUT FOR MSM AND FSW

PrEP should be included in all National and State policies and HIV guidance documents as a recognized HIV prevention tool. It should be included in the minimum HIV prevention package intervention for all populations at substantial risk for HIV infection. A national policy on PrEP access is required and so is a plan for PrEP supply logistics. Health systems also need to be strengthened for PrEP roll out. This would require that the capacity of health care workers be built about PrEP provision. PrEP access by MSM and FSW can also be facilitated through the use of drop-in-centres and one-stop-shops. As outcome of this policy dialogue meeting which brought together all the key stakeholders, all the recommendations were included in the Nigerian National Strategic Framework 2017-2021 with a clear target stating that 90% of Key Populations will be using PrEP by 2021 .

9.2. TITLE OF THE PROGRAMME:

Adolescent Reproductive Health Peer Education Training and HIV/AIDS awareness campaign for prevention and management

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Title: Director of Programs

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Programme is being implemented since: 2007

Responsible party/parties: Civil society / UN or other inter-governmental organization

Populations group(s) reached: Men who have sex with men / Sex workers / Girls / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

DESCRIPTION

NYSC in partnership with UNICEF trained youths corper peer educators, where I was privileged to partake in 2007, wherein I and my PET partners carried out peer education training among secondary school students in Osun state and community awareness campaign on HIV/AIDS on the need to shun discrimination of people living with the virus as well as impact mitigation of the disease on those living with the virus as well as those affected by the disease, in 2011 we visited the Benin Prisons where raw information regarding welfare condition as well as the causes of homosexual behavior of the inmates was obtained, and recently 2015, we also had interaction with young female sex workers in a brothel in Benin City with the aim of proffering alternative means for self sustenance.

CONTEXT

Lack of or inadequate information, poverty and unemployment is one of the major reasons adduced to increasing HIV/AIDS infection rate, hence this area should be given a priority attention.

RESULTS AND IMPACT

200 peer educator trainers were trained with adequate knowledge of HIV/AIDS prevention, followed by community awareness campaign at the central market with a talk show wherein participants became endowed with adequate information, the visitation to prisons and brothel gave us the opportunity to speak and listen to some inmate and sex workers with the satisfaction of self worth and sense of belonging

FINANCING

Self-financed (except the prison visitation where we partnered with church and HEPA)

GOVERNANCE

Mr Edwin Asibor(Director of programmes), Mr Philip Imumoren(Planning/ implementation) Mr

Charles Osazuwa(Finance/ logistics), Miss Blessing ose(Secretary), Com Iziegbe Ibizugbe (Reserch /development), Com Osasu Usenbor(communication/fund raising)

LESSONS LEARNED AND RECOMMENDATIONS

- Most ladies especially young girls engaging in commercial sex venture have no alternative means of livelihood due to extreme poverty and unemployment which is in concomitance to the increasing HIV infection rate.
- Most new inmates became induced into homosexuality by their older colleague thereby increasing their vulnerability due to lack of or inadequate awareness campaign by NGOs and FBOs to the prisons.

Recommendations

- Nigeria government should create jobs and massively employ her teeming youths into every available institutions, ministries and establishments to reduce poverty and consequently risky behavior among vulnerable groups
- Nigeria social welfare institution should be strengthened with budgetary allocation to cater for vulnerable groups especially girls and women with skill building and take off grants for entrepreneurship to discourage them from going into prostitution as well a job creation.
- Young and passionate NGO like ours should be encouraged, trained and given grants to carry out awareness campaign and entrepreneurship program for Nigeria prisons to stem the increasing rate of homosexuality among inmates which is one of the reason behind the increasing infection rate.
- Nigeria Government should be compelled to enhance the welfare condition of the prison inmates, erect more building with modern facilities with a call doctor on standby, and the speedy dispensation of justice for those in awaiting trial to decongest the prison.

10. SOUTH AFRICA

TITLE OF THE PROGRAMME:

Supporting scale-up towards prevention targets in South Africa

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Programme is being implemented since: 2015

Responsible party/parties: Government / Civil society / UN or other inter-governmental organization / Academic institution

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers / Transgender / Women / Girls / Young people

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. District Implementation Plan (DIP) for programme scale-up from FY2016/17

DESCRIPTION

The South African Government has committed to the globally promoted 90-90-90 scale-up targets and shares the vision of Ending AIDS by 2030 (Sustainable Development Goal time horizon, 95-95-95 targets). In 2016, the Universal Test and Treat policy came into effect, with early antiretroviral treatment (ART) considered a key intervention to preventing HIV transmission and AIDS in South Africa.

The World Bank has been supporting the South African Government with a program designed to inform the scale up of prevention services, both at country and health district/city level. This program was initiated with a descriptive allocative efficiency study at the national level, followed by 2 additional targeted assessments of interventions in 2016: an analysis of the status and scale up towards prevention targets in the city of Johannesburg, and the optimization of resources across service delivery modalities to improve the continuum of HIV care in the country. The current

submission will focus on the results and lessons learnt from the Johannesburg study, which was carried out in the context of this broader package of support.

CONTEXT

WHY WAS THIS ANALYSIS DONE?

In 2012, it was estimated that in South Africa, two-thirds of new HIV infections occur in urban areas (over 300,000), and that the incidence rate in informal urban settlements was at 2.5% compared to 1.1% nationally. The Gauteng cities of Johannesburg, Ekurhuleni and Tshwane, and the KwaZulu-Natal metro of eThekweni, are the health districts (metros) driving the national HIV statistics. The Johannesburg Health District alone is thought to have 22% of all people living with HIV (PLHIV) in any of the eight metros. Johannesburg District has a population of approximately 4.8 million and annual population growth of about 3%. Cities and metropolitan areas offer both scope and opportunities to take the country closer to the 90-90-90 targets due to the concentration of population and HIV burden. South Africa's eight metros only cover 2% of the national territory but account for 39% of the country's population. They are responsible for 70% of the Gross Domestic Product, and contain half of all unemployed South Africans. The metros are vital areas for HIV and health interventions to succeed due to their economic importance for national prosperity.

WHY IS ALLOCATIVE EFFICIENCY IMPORTANT?

Given the size of the South African HIV epidemic and the associated health care costs, allocating HIV resources optimally at local level remains a national priority. The health district is the unit for HIV planning and resource allocation and all 52 districts have a District Implementation Plan (DIP) for programme scale-up from FY2016/17. The South African DIP process in 2015 showed that relatively little analytical/modelling evidence is available to support target-setting and district-level decision-making on resource allocation. While there is effective ART available, there are other proven interventions such as medical male circumcision, condoms, and pre-exposure prophylaxis (PrEP) for sex workers, which showed up as key response elements in the National HIV Investment Case. There are also novel service combinations such as the DREAMS package for young women and adolescent girls. With these various interventions available, the country intends to reach the internationally promoted 90 targets. The necessary scale-up of HIV services needs to take into account the epidemic and demographic dynamics of the city, and allocate HIV resources in an optimal way for impact.

FINANCING AND GOVERNANCE

The analysis was led and financed by the World Bank, conducted in partnership with the South African government, an academic institution (Burnet Institute) and other local stakeholders including NGOs working with key populations. *Optima HIV* was used for allocative efficiency analysis across

HIV responses and across the HIV care cascade. This software provides epidemic modelling, resource projections for reaching specific targets, and impact/cost-effectiveness analysis. The analysis built on South Africa's 2015 HIV investment case and linked to the DIP targets. It took into account the general population based and sex work-based transmission networks. Data on the HIV epidemic and response, HIV expenditure, population size estimations, among others, were captured in *Optima HIV*, the available DREAMS plans for Johannesburg Health District were reviewed, and cost functions established. The epidemic model was calibrated using data from 2000–15 on 26 population groups to ensure best fit. Stakeholder discussions were held in a data workshop and the Durban fast-track meeting in March 2016, where preliminary findings were presented.

RESULTS AND IMPACT

1. Johannesburg has rapidly expanded HIV diagnosis and treatment between 2010 and 2015, reaching 267,236 PLHIV with the ART programme in 2015
2. The projected health impact of successfully scaling-up HIV testing (HCT), treatment and ART adherence to the 2020 and 2030 SDG target levels is very large in Johannesburg
3. The dynamic Optima HIV model provides target numbers for planning and factors in the prevention effect of ART on the future PLHIV numbers
4. A realistic scale-up of other proven HIV interventions would yield a 5–10% reduction in total treatment costs whilst still achieving the three 90s:

Treatment needs (and costs) are reduced if the HCT/ART scale-up is combined with medical male circumcision, an expanded condom programme, and comprehensive service packages for FSWs and young females (DREAMS package). With this combination approach, an additional ~13 thousand infections would be averted 2016–30. 2030 targets would be reached with ~526 thousand people on ART, compared to ~553 thousand if the prevention packages were not scaled-up. The cumulative difference in the annual treatment need to 2030 would be ~285 thousand PLHIV (or approximately R 1.1 billion saved at current prices).

LESSONS LEARNED AND RECOMMENDATIONS

- a) A very large effort is needed: Analysis shows that the HCT/ART scale-up was rapid in the last 5 years, but that a doubling of scale-up is needed to reach the 2020 targets
- b) Strategic investments in proven interventions such as medical male circumcision, an expanded condom programme, and comprehensive packages for FSWs and young females will help “get” Johannesburg the 90 targets (and with these, the 95 targets too)
- c) Evidence-informed programmes for young women and adolescent girls (like DREAMS) are likely to make a significant contribution to incidence reduction in these age groups, if implemented at scale

- d) An innovative mix of HIV testing approaches is needed to reach more PLHIV not sufficiently covered with current services (an additional 100–160 thousand diagnoses needed by 2020, and finding new HIV cases is becoming harder to achieve)
- e) Rapid scale-up of funds is needed to achieve aspirational targets, especially in the context of rising prices. Stagnant HIV budgets likely lead to increases in infections and deaths and undermine the scale-up momentum the City of Johannesburg has gained
- f) Analytical approaches supported by modelling can be useful to help set targets, monitor progress and project the health and financial impacts
- g) Johannesburg with its strong economic position and elevated human development offers large opportunities for successful scale-up and as a city benefits from the proximity of population to services, good communication networks, and a mix of providers.

11. TANZANIA

11.1. TITLE OF THE PROGRAMME:

Promoting visibility and representation of Key Population on the CCM in Tanzania

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Programme is being implemented since: 2015 – 2017

Responsible party/parties: Civil society

Populations group(s) reached: People who inject drugs / Sex workers / Transgender

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? Yes. The National AIDS Programme, through the CCM and Global Fund

DESCRIPTION

ARASA has engaged in advocacy efforts to ensure that there is meaningful key population representation and funding allocated to key population organisations in Southern and East Africa.

Since the CCM in Tanzania was established in 2004, there had not been key population representation on this platform. Key populations were not considered as part and parcel of CCM decision-making structure.

CONTEXT

ARASA has engaged in advocacy efforts to ensure that there is meaningful key population representation and funding allocated to key population organisations in Southern and East Africa.

Since the CCM in Tanzania was established in 2004, there had not been key population representation on this platform. Key populations were not considered as part and parcel of CCM decision-making structure. The national coalition of ARASA in-country partners in Tanzania

identified that the gap was in the governance manual of the CCM where there was no clear and separate inclusion of key populations as a constituency, which allowed CCM members to marginalise key populations. However, the 3rd National Multi-Sectoral Strategic framework (NMSF III) stipulated the need for engagement with KPs in terms of the response to the HIV epidemic in Tanzania. Moreover, the Global Fund New Funding Module (NFM) clearly stated the importance of greater and meaningful participation and engagement of KPs.

After identifying the gap in the CCM governance manual that led to the exclusion of KP representation on the CCM, the in-country partners requested that they would be allowed to attend the Non State Actor's (NSA) platform meeting before the CCM meeting, and did so in May 2015. The chair of the NSA gave an opportunity for the in-country partners to make their case, and provided a space for engagement on the issue of key population exclusion. The engagement led to three members the NSA seconding a proposal to table this particular issue at the next CCM meeting. After the meeting the ARASA in-country partners requested observer status for the national coalition from the chair of the CCM, which was granted in May 2015. In-country partners continued engagement with CCM members, mostly on one-on-one bases, to state their case regarding the importance of key population representation at the CCM. Furthermore, they also engaged various development partners for support.

The CCM meeting was held at the Prime Minister's office in May 2015, and the issue of key population inclusion and representation was tabled. Due to the engagement preceding the meeting, a majority of CCM members supported the idea of amending the governance manual to provide for direct key population representation at the CCM, citing the NMSF II and the Global Fund NFM guidelines.

In October 2015, following the successful amendment of the CCM governance manual, elections were held for key population representatives. A representative from CHESA was elected as full member, and a representative from TANPUD was elected as an alternate. Furthermore, currently the key population full member is part of the oversight committee and was further elected to chair the NSA in 2016.

Since key population representation was achieved at the CCM, in-country partners have been involved in the national concept note writing, and have actively been engaging at the CCM to ensure key population allocations in the budget. Notably, for the first time there is inclusion of transgender people, with a size estimation study to be done during the grant-making.

As a result of this advocacy and engagement, there is direct KP representation on the CCM which has already been shown to have positive impact. In Tanzania key achievements included the following: Governance manual of the CCM mandated to have a full member and alternate member to directly represent key populations; direct representation of key populations on the CCM for the first time; 800 000 USD allocation to key population programming under the Global Fund grant.

In addition to confirming the importance of meaningful KP representation on the CCM, inclusion on the CCM has further increased the technical expertise of CHESA, allowing them to more effectively represent and advocate for KPs.

11.2. TITLE OF THE PROGRAMME:

Strengthening Girls' Networks and Clubs in Response to Female Genital Mutilation (FGM), Child Marriage and HIV Prevention Strategies in Mara Region

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Programme is being implemented since: 2013

Responsible party/parties: Civil society

Populations group(s) reached: Girls / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

ARASA and the Children's Dignity Forum (CDF) have prioritised addressing child marriage, FGM, and other forms of gender discrimination that impede the realisation of girls' rights to sexual and reproductive health, non-discrimination, and education and cripple the fight against HIV. Despite regional and international treaty commitments, child marriage and FGM are pervasive in some regions of Tanzania. In some regions of the country, FGM prevalence rates are higher than 39% amongst 15-49 year olds.⁶ Child and early marriage disempowers girls and leads to poor health outcomes by exposing them to HIV and resulting in adolescent pregnancy which has a high risk of complications that can be detrimental to the health, education, well-being and the lives of adolescent girls. Adolescent girls run a disproportionate risk of dying during or after childbirth⁷ and are more vulnerable to pregnancy-related complications.⁸

After completing the 2012 ARASA HIV, TB and Human Rights Training of Trainers (TOT) course,

⁶ National Bureau of Statistics (NBS) [Tanzania] and ICF Macro (2011). Tanzania Demographic and Health Survey 2010.

⁷ WHO & UNFPA, Pregnant Adolescents: Delivering on Global Promises of Hope 5, 10 (2006), available at http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.

⁸ *Id.*, at 13-15.

Children's Dignity Forum (CDF) received a small grant from ARASA, to cascade lessons learned. With the aim of strengthening the capacity of young girls around their human rights and sensitising communities about the violations that were being experienced, in 2013, CDF with the support of ARASA implemented this project during which these partners trained sixty girls on girls' rights and sexual and reproductive health and rights. The trained participants conducted five community-based health education sessions on child marriage and FGM where 761 people received training. CDF also produced and distributed IEC materials and facilitated sensitisation workshops for teachers and parents on children's rights. The project has had significant impact on the community through the provision of accurate information and has empowered girls who have formed clubs and networks which provide a forum for discussion and also allow for referrals to the district hospital. The project has also led to a number of changes in the community including empowering and improving the confidence and self-esteem of girls which in turn, allows them to discuss sexual rights and health and report violations. For example, CDF has found that as a result of the trainings and access to information, girls who had been victims of rape are empowered to stand up and discuss issues around sexuality.

Further, the sensitisation and outreach initiatives provided forums to address misperceptions, stigma and related HIV issues and ensure that community members were accurately informed about HIV prevention, transmission and human rights concerns. Access to accurate information empowered individuals to protect themselves from HIV exposure and de-stigmatised HIV in the communities, particularly once it was understood that HIV cannot be spread through casual contact. For example, some outreach participants believed that HIV infection could be transmitted through sharing eating utensils.

One participant explained: *"I am living with my sister in law who is HIV infected and has all the signs and symptoms, due to fearing of us being infected by her, we have separated her food utensils (spoon, cup and plate) so they are not used by others to avoid HIV infection from her."*

Participants had an opportunity to ask questions and in some cases highlighted community misperceptions on HIV transmission and prevention. For example, individuals asked the following:

Is it true that if unprotected sex is done during menstrual period, there is no chance of being infected because there is blood shedding during that period?

Can HIV transmission occur if a man didn't reach ejaculation?

After CDF answered questions and provided accurate information concerning HIV transmission and prevention, participants were able to disseminate the information to their families and communities, including that sharing food utensils and casual contact does not spread HIV and that menstruation does not prevent HIV transmission. Similarly, while FGM remains a significant issue in the region, CDF found that providing girls with accurate information on the human rights and health implications of FGM had a cascading effect, effectively empowering girls within clubs and networks as well as those who are not part of such networks and may otherwise be without such information. CDF has worked on a number of related projects and initiatives including a three-year project *Mobilising Action to Safeguard Rights of Girls in Tanzania*. The success of the project has also resulted in additional funds from UNFPA and Forward UK to continue work on these issues.

Personal Story: Lina from Nyamwaga

“I was born in Nyamwaga and all my mates were mutilated so they started laughing at me while others said that, I should be mutilated so that I can get some gifts and get married. Due to those praises I decided to undergo mutilation. I was eight years when I tell my parents that I want to be mutilated and my father was very happy and promised to buy “Kitenge” i.e. a piece of cloth for me. During the cutting season all arrangement was made and I was among the young girls who undergone mutilation that time. It was very painful and I regret it because, they hurt me very bad, they remove both the clitoris, labia majora and labia minora then they wash my wound with a cob the thing which increased the pain. It took me almost two months to heal. The bad thing is that they never sent me to hospital although my wound was very bad. I also like to thank CDF and this project for helping me to open up because before I was not able to speak in front of people especially about the cutting. From my own experience, I don’t want my own child or any other child out there to be mutilated because what I have experience is enough. I will continue the fight by raising awareness on FGM, HIV and its effect as well as other issues relating to violation of girls’ rights to other girls who are members of Umoja network and other girls who are not in the clubs so that they can educate others.”

RECOMMENDATIONS

Tanzania and other countries in the region and programmatic interventions should prioritise the following to safeguard the rights of girls and effectively prevent and address HIV: (i) provision of age appropriate information and programming on HIV, gender equality, child marriage, SRHR, FGM and human rights for girls and adolescents; and (ii) addressing FGM, child marriage and HIV through community sensitisation, outreach, empowerment and where appropriate, investigation and prosecution of such crimes.

12. UGANDA

12.1. TITLE OF THE PROGRAMME:

Unjust and Unhealthy and Addressing Human Rights, HIV and TB Issues of Prisoners in Uganda

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Programme is being implemented since: 2014

Responsible party/parties: Civil society

Populations group(s) reached: People living with HIV, women, other

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? Yes

DESCRIPTION

In Southern and East Africa, severe financial and human resource limitations and broken continuity of care when prisoners enter and leave prison systems are major barriers to effective prevention, treatment and care. Weak health and criminal justice systems, high rates of pre-trial detention and severe overcrowding in the region contribute to poor health and human rights outcomes.

Overcrowding in prisons exacerbates the spread of opportunistic infections and stress and malnutrition weaken the immune system, increasing the risk of illness amongst people living with HIV. Due to *inter alia* high prevalence of sexual assault and unsafe sexual practices, unsafe drug injection practices, and lack of access to protective barriers and harm reduction, prisoners are at high risk of HIV and TB infection and too often lack access to effective HIV testing, treatment and support. To address these major challenges, ARASA has undertaken a regional campaign entitled *Unjust and Unhealthy* which aims to: promote better understanding of prisoner's rights and health issues amongst policy and decision-makers; encourage review and amendment of policies that impede prisoners' rights and access to health services; increase funding to ensure that prisoners have access to a minimum service package and; to create public awareness of prisoner's rights to

human dignity and challenges prisoners face realising the right to health. In prisons, access to information on HIV, TB and human rights empowers prisoners, prison staff and health providers, allowing them to improve the realisation of human rights in custodial settings in terms of health delivery, HIV prevention, testing and treatment.

In 2010, as part of the *Unjust and Unhealthy* campaign, ARASA, Human Rights Watch and Prisons Care and Counselling Association published a report documenting the human rights and public health implications of the poor health system in Zambian prisons. In part to respond to issues identified in the report and related advocacy work, the President's Emergency Plain for AIDS Relief funded the establishment of a clinic in Chipata, Zambia which will improve access to health services for prisoners at Namuseche Correctional Centre and people in nearby communities.

Simultaneously, at a local and national level, ARASA's small grants have provided funding for ambitious projects aimed at addressing prison-related gaps and challenges in the context of HIV and human rights. These projects have shown the impact of community-focused and driven projects on the realisation of human rights in prisons and the potential to alter the course of the HIV epidemic within custodial settings. One country project was implemented in 2014 by the Uganda Network on Law, Ethics and HIV/AIDS (UGANET) with the support of ARASA. UGANET carried out a multi-faceted project in Kampala Extra region to address gaps in HIV and TB prevention and access to services for prisoners and strengthening access to justice for prisoners. UGANET first conducted a needs assessment for prisoners held in the Kampala Extra region prison stations and using their findings, developed and distributed an issues paper. In addition to identifying and prioritising identified human rights and related challenges for prisoners, UGANET engaged with policy-makers; increased access to legal aid services and awareness for prisoners living with HIV and TB; and strengthened service systems to facilitate an enabling legal environment and an improved HIV and human rights response.

Recognising that prison staff and prisoners were in the best position to ensure a human rights-based approach to HIV and TB in the prison, UGANET trained key prison staff on issues identified in the issues paper and trained prisoners on HIV and human rights. Prisoners were trained to work as paralegals and to provide support in prisons, including how to make referrals for those with TB symptoms. Through these trainings, UGANET was able to establish a network of women who meet weekly to address the challenges of new prisoners living with HIV and TB and access to justice in health care. Male prisoners also provide a monthly report which is submitted to UGANET. One lesson learnt, is that the provision of information and empowering prisoners and prison staff should be a priority. For example, UGANET trainings have empowered prisoners, many of whom for the first time feel comfortable asking questions to a magistrate or judge about their case, which has a positive effect on meaningful access to justice. Further, trainings and working with prison officers has helped facilitate UGANET access to prisons and they now have quarterly meetings with junior and senior officers where all parties can share challenges and strategise on how to address them. While budget limitations and insufficient procurement of ARVs remain major challenges in the country in general and in prisons in particular, the creation of this forum was an essential step towards overcoming them. Through the project, UGANET lawyers have also been able to provide direct legal support to some prisoners whose notices of appeal were never filed.

ARASA and UGANET prison advocacy has confirmed the importance of strong, effective partnerships and networks to meaningfully prevent and address HIV and TB in prisons. In addition to establishing networks within the prison, UGANET has partnered with several other NGOs including the National Forum for People Living with HIV, the Uganda Palliative Care Association and the Network of Public Interest Lawyers. Through their work with the National Forum, a prison network has been established which provides social support, counselling, and links PLHIV and TB to treatment and services, appropriate nutrition and medical care. Through their work with the Network of Public Interest Lawyers, there has been some success in addressing the issue of 20-year delays in decisions on ministerial orders which must be issued by the Minister of Justice instead of a doctor. While one judge has ruled in their favour that it should be a doctor to make medically-related ministerial orders, UGANET and partners are currently working to facilitate systemic challenges to reduce extensive wait times on ministerial order decisions by working directly with the Ministry of Justice.

This project also allowed UGANET to obtain additional funding from the Open Society Initiative of East Africa to address access to justice for prisoners, including through direct representation and working with the prison service and the judiciary to address a number of practical and legal challenges that impede access to justice including: missing case files, a high number of cases where individuals are on remand without their cases being heard; improper and non-filing of notices of appeal. UGANET has been successful in having several cases dismissed where case files were lost and in improving systems to ensure cases proceed efficiently. For example, since the prison does not have transport to take the notices of appeal to the courts, UGANET has been able to help facilitate transportation and ensure that these case files are not lost.

“People should know that the small grant made [prison workers] respond differently and look at human rights and access to justice in a different angle. Also, before we [UGANET] were only focusing on people outside the prison. Now we look at prisons and PLHIV as a priority. There is still a big need and we need to continue working together to address issues.”

-Immaculate Owomugisha, UGANET

RECOMMENDATIONS

Uganda and other countries in the region and programmatic interventions should prioritise the following to safeguard human rights and effectively prevent and address HIV and TB in prisons: (i) improving access to information on HIV, TB and human rights for prisoners and prison staff through sensitisation and training; (ii) addressing overcrowding and poor prison conditions by adequately funding prisons and criminal justice systems; and (iii) strengthening access to justice and provision of legal aid for inmates.

12.2. TITLE OF THE PROGRAMME:

A Model for Scaling up ART among Key and Priority Populations in Uganda

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Programme is being implemented since: 2012

Responsible party/parties: Government

Populations group(s) reached: Men who have sex with men / People who inject drugs / Sex workers / Other

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? N/A

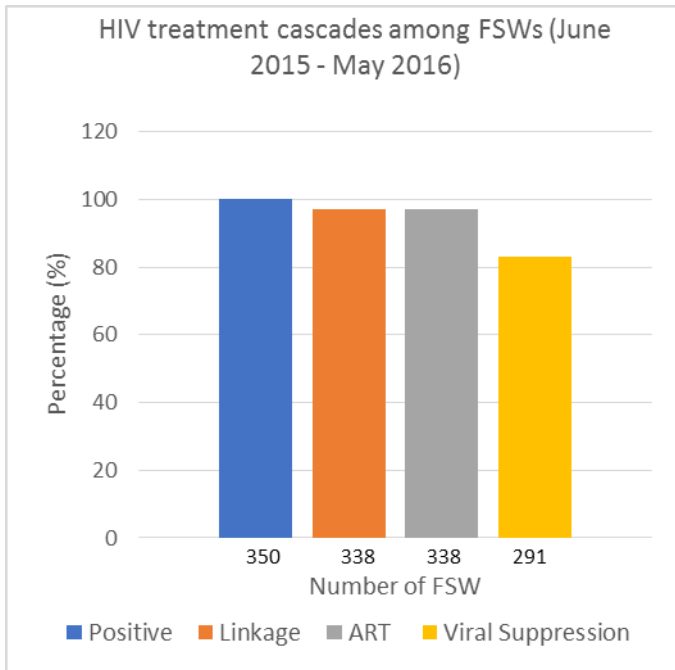
Is the programme part of a national plan other than the national aids strategy? N/A

DESCRIPTION

Reach Out Mbuya (ROM) has provided services for female sex workers (FSW), fisher folk (FF), uniformed men, truckers (TR), people who inject drugs (PWID), and men who have sex with men (MSM) since 2012. These populations are reached through static and outreach clinics and offered HIV testing and are fast tracked for ART. Between 2012 and 2015, the number of PLHIV in care increased from 60 to 751, representing a 12 fold increase.

From June 2015 to May 2016, 5670 individuals belonging to different key and priority population groups were tested and a total of 525 HIV positives were identified. Figure 26, below, shows the HIV treatment cascade. The program has high linkage and ART initiation rates for FSW, FF and TR but ongoing challenges with MSM and PWID. Among those on ART, adherence is reported to be at 88% and retention at 90.6%. This model has successfully used peers to mobilize KP for testing, psycho-social counselling, same day CD4 testing, and use of different ART delivery models that included a roving clinician for timely ART initiation, peer ART drug pick-ups, adherence clubs, and individualized appointments.

Figure 26



13. ZAMBIA

13.1 TITLE OF THE PROGRAMME:

Zambia Prisons Health Systems Strengthening

CONTACT PERSON

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Programme is being implemented since: 2013

Responsible party/parties: Government / Civil society / UN or other inter-governmental organisation

Populations group(s) reached: Prisoners

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

The Zambia Correctional Services (ZCS) manages an average of 17,038 inmates a year. While prevalence of HIV in Zambia is reported as 11.9%(PEPFAR,2016) and prevalence 0.7% in the population aged 15-49 years, the Zambia National AIDS Strategic Framework 2014 – 2016 acknowledges that access to treatment and care remains particularly poor in prison inmates. Prison inmates are classified as key populations, and it is estimated that in some Zambian correctional facilities (CF) prevalence rates are as high as 27.4% (Zambia Daily nation, 2016). Despite this, country wide only 17 of the 87 Correctional facilities in Zambia offer internally-accessible basic health care services.

In 2013, the Centre for Infectious Disease Research in Zambia partnered with the ZCS to increase inmates' access to health care in CF through a European Union funded action entitled, "Building capacity for sustained oversight and coordination of prison services in Zambia". The program sought to strengthen high-level and mid-level governance in support of innovative solutions to improve access to, and quality of health care; the centre piece of this innovation was the formation of Prison Healthcare Committee (PrHCs), which, unusually in the African setting comprised both

officer and inmate members, working jointly with remit for health education, health promotion and facility-level monitoring. The project targeted 11 of Zambia's largest facilities.

RESULTS AND IMPACT

Committees were successfully constituted, trained and mobilized in all 11 facilities and at 12-18 months' follow-up remained active. Twelve month evaluation data demonstrated a series of positive material, and knowledge-based outcomes. Positive material impacts included PrHC collaboration with (external and internal) primary healthcare clinics providing services to inmates, as well as NGO partners, to facilitate routine and one-off HIV and TB-testing activities; in several sites PrHCs took responsibility for developing their own follow-up systems to improve access to services and medication adherence for chronic patients. While not wholly attributable to this project, PrHCs played an important role facilitating inmate access to and utilisation of health services: including some 6324 inmates screened for TB and 4666 inmates screened for HIV in 2015/16.

PrHC members and non-members, confirmed by officers-in-charges, reported improved environmental health in at least six sites, via strengthened PrHC-led monitoring and promotion of basic hygiene practices (hand washing, regular bathing), removal of environmental health hazards (routine garbage collection), renovation of unhygienic or unsafe structures (re-routing of water drainage systems to reduce prevalence of mosquitoes and improve bathing stalls), and in one site the reintroduction of gardens for therapeutic nutrition. Participants including members and non-members of PrHCs consistently described PrHCs as having a positive impact on PrHC members' confidence, knowledge, awareness and skills in relation to basic health and disease prevention as well as their capacity to impart this knowledge and strengthen awareness among other inmates; several case-studies have focused on strengthened access to ART arising from PrHC interventions. PrHC and non-PrHC members in most sites also commented that the committees had improved standing relations between officers and inmates by providing a sanctioned forum for exchange, sharing of concerns and brokering of solutions.

GOVERNANCE

The formation and training of PrHCs in CF has been approved by the ZCS Commissioner General. PrHCs are governed on a day-to-day basis by CF Officers in Charge, with guidance from a terms of reference published in the *Zambian Prisons Health Systems Strengthening Framework (2013)*; this document was an early output of the same project, and the result of extended multi-sectoral discussion and debate including stakeholders from ZCS, Ministry of Health, and Ministry Community Development.

FINANCING

Training of the initial PrHC members was financed as part of the project, but incorporated a training-of-trainers approach. New committees, refresher trainings, and training of new (e.g.

replacement members) for existing committees are overseen by existing PrHC members with guidance from the ZCS Health Directorate.

LESSONS LEARNED AND RECOMMENDATIONS

Further work is needed to capacitate the ZCS Health Directorate to continue training PrHC members in remaining facilities. Project evaluation also highlighted the central role played by individual Officers in Charge, who are responsible for enabling PrHC activities; where that support were lacking PrHCs would likely be ineffective. High rates of inmate turnover within CFs also negatively impacts the efficacy and momentum of some PrHCs as members leave prison or are transferred to other facilities.

Notwithstanding these challenges, PrHCs are a low-cost intervention that leverage and empower a previously untapped resource in cash-strapped CFs – inmates themselves. Formation of these groups has demonstrated the critical importance of having a legitimate forum in which inmates and officers can communicate and jointly problem-solve. In a highly resource constrained setting, this forum has empowered both inmates and offices, enabling low-cost solutions to chronic (albeit often basic) problems relating to environmental health, health information and critically, health service access. PHCs could be an important mechanism to ensure that national HIV policy and guidelines reach correctional facilities and can be used by detainees to hold government institutions and other stakeholders accountable for providing high-quality services along the entire continuum of HIV prevention, treatment and care. Scale-up of this simple and low-cost intervention should continue to all static facilities, starting with sensitization of all CF Officers in Charge of the potential benefits that can arise from their support for such a scheme.

ANNEXES

1. Results Oriented Monitoring Report by EU External Consultant
2. Project Evaluation Report

13.2 TITLE OF THE PROGRAMME:

Comprehensive HIV Prevention Roadmap (Indicators and Targets-2020) 2017-2021, Zambia
Target setting on HIV prevention program and funding. The indicators and targets are set against the 10 HLM commitment areas.

CONTACT PERSON

Name: Ellen Mwila C Mubanga

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Organisation: National AIDS Council (NAC)

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Tel: +260 211 255044 | 0973 480499 | 260 977823900

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Programme is being implemented since: 2016

Responsible party/parties: Government, Civil society, UN or other inter-governmental organization, Academic institution

Scope of Submissions: People living with HIV, Men who have sex with men, People who inject drugs, Sex workers, Transgender, Women, Girls, Young people, People with disability, Faith based Organizations

Is the program part of the implementation of the National AIDS Strategy? Yes

Is the program part of the National Plan Broader than the National AIDS Strategy? Yes.
National HIV prevention Program

DESCRIPTION

A description of how national programmatic prevention targets were set and what the targets that were set entail. These should be related to the 5 pillars in the UNAIDS Prevention Gap report :

The Government of the Republic of Zambia has taken accelerated actions in adopting fast track approach and revising national strategies so as to set targets that will ensure that the fast track targets by 2020 are met. In this regard, HIV prevention being a critical component in preventing new infections, an urgent need of setting clear targets at national and sub national levels among the major population groups has emerged. Such targets are an important basis for the partners to plan their programme activities, resource allocation as well as for monitoring and reporting the progress.

FOLLOWING ARE THE SPECIFIC DESCRIPTION AGAINST EACH PILLAR

- Combination prevention, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners in high-prevalence locations: The target setting in this Pillar included specific indicators informed by the Global AIDS Reporting indicators 2017. In each indicator 90%V of target is set for 2020 from the baseline coverage in 2016. In the indicators, data is not available; advocacy will continue to strengthen the monitoring and reporting system including national program reporting. Young women, adolescent girls and boys were involved in setting targets and identifying strategies to achieve the HLM target in this pillar. The HLM target number 3, 4, 5 and 6 have been covered within this Pillar.
- Evidence-informed and human rights-based prevention programmes for key populations, including dedicated services and community mobilization and empowerment: For the first time in Zambia, the global definition of key population (MSM/TG, SWs and PWID) have been adopted as they are and included them in the national AIDS strategic framework (NASF). The HIV prevention targets on key populations have been set for each key population with combination prevention program. The targets are consistent with the fast track targets. Service delivery as well as community mobilization related targets are set considering the HLM target-30% of all service delivery is community led. The indicators on preventing stigma and promoting social protection have been also set. Key populations were consulted as key informants for gathering the suggested strategies endorsed in the document.
- Strengthened national condom programmes, including procurement, distribution, social marketing, private-sector sales and demand creation: This pillar has received a key priority for the prevention program contributing to prevent both HIV/STI transmission and unintended pregnancy. Teenage pregnancy being one of the major gender issues in Zambia, the target has been set using condom as combination prevention. Innovative strategies to make condoms accessible to adolescents following the comprehensive sexuality education both in and out of school have been proposed.
- Voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men: Zambia has already achieved 54% of VMMC coverage and it has set clear target at 90% by 2020. A detailed operational Plan on VMMC has been developed with national and subnational targets and indicators. (VMMC Plan Attached). Adolescent boys were part of the operational plan development. The Zambia was awarded by PEPFAR as one of the successful VMMC program in East and Southern Africa region. National VMMC technical Working Group was intensely involved in developing this plan and setting the targets.
- Pre-exposure prophylaxis for population groups at higher risk of HIV infection: The Roadmap clearly: The target includes both PrEP and PEP as prevention services and has set targets at least to reach with 90% coverage to the population in need.

The document, as a part of National AIDS Strategic Framework-NASF, provides indicators, targets and key strategies in the entire comprehensive prevention program at national level that are consistent with the HLM commitment and targets. The documents itself will serve as a national guidance document on HIV prevention strategic plans and reporting. Intensive advocacy on no one is left behind has resulted in inclusion of key populations (SWs, MSM and PWID) in the new NASF hence in the roadmap in setting targets. The set targets are consistent with the UNAIDS Global AIDS reporting Indicators 2017. GFATM new application has stronger component on prevention with more targeted prevention programs to specific population and considerable budget allocation.

PROCESS

The consultant had desk reviewed all the relevant documents and reports. The findings informed the outline of the status and gaps in each prevention area. A first draft framework of indicators was developed based on the national monitoring system and the global reporting indicators. Key informants from the Government Ministries, CSOs and donors were consulted on the draft framework. The framework was then taken to the Extended HIV Prevention Advisory Group for their inputs and endorsement. Once refined incorporating the group's comments, the framework was taken to the wider group of stakeholders for their inputs on the target as well as for suggested strategies to address each target. An extensive consultation with various stakeholders including national technical working groups, members of PLHIV, key populations, Adolescents and women, and the targeted consultation with National HIV prevention Theme Group have resulted in agreed set of indicators, targets and suggested strategies to achieve the targets, which are owned by the Government of Zambia. The document makes an integral part of the NASF on HIV Prevention.

RESULTS AND IMPACT

Following the development of the roadmap, implementing partners have begun to develop respective action plan using the indicators and targets. The Quarter for Prevention advocacy has resulted in increased resource allocation to prevention program and linkage to other services for enabling to prevent new HIV infections. The new GFATM Application, 29% of the total budget has been allocated to HIV prevention Program. Out of the total amount, 7 Million USD goes for cervical cancer screening and treatment and social cash transfer and direct payment of school fee to Adolescents Girls and vulnerable Children beside the other traditional HIV prevention programs. The NASF, more specifically the HIV Prevention Roadmap informed the new Adolescents Health Strategy for its targets and strategies to reach the Adolescents with various SRHR and HIV prevention and treatment services. As a result of advocating on the importance of a scaled program, the DREAMS program has now expanded to additional 5 districts in COP 17. This roadmap also builds on the roll out of the National guidelines on integrating HIV, SRHR and GBV. It has been already observed that GBV issues are accepted by the partners in programming more with commitment than before

FINANCING

UNAIDS provided technical and financial support to the National AIDS Council (NAC) to conduct the exercise. A qualified national consultant was employed to support the working group. The VMMC operational plan was developed with technical assistance from PEPFAR and MOH.

GOVERNANCE

Government has Governed the entire national plans on HIV/AIDS and Adolescents Health. A working group led by the NAC was established to supervise the target setting work. Government line ministries (MOH, MO Gender, MO Higher Education, MO Community development and Social Welfare), City Council, CSOs, Bilateral and multilateral partners engaged in the working group that provided oversight to the entire process.

LESSONS LEARNED AND RECOMMENDATIONS

The document is produced with full participation of the stakeholders. The timeframe was very short due to funding agency requirement. It would have been able to make the process more intensive by engaging stakeholders from the province and district levels that may have provided more illustration to the provincial and district target setting. It is also recommended that the reporting indicators 2017 are not changing frequently but are consistent until 2020 reporting.

ANNEXES

1. PDF version of the Roadmap 2017-2021.
2. National Operational Plan on VMMC (2016-2020)

Please find the dropbox link to the three documents as mentioned above:

<https://www.dropbox.com/s/5revajw0x5ii35h/HIV%20Prevention%20Roadmap%20final%20PRT.pdf?dl=0>

https://www.dropbox.com/s/wfl3f4s6i3c33h2/Zambia%20VMMC%20Operational%20plan%202016%20-%202020_Final%20print%20%20version.pdf?dl=0

14. ZIMBABWE

TITLE OF THE PROGRAMME:

VMMC Demand Creation through Grassroots Soccer Program in Zimbabwe

CONTACT PERSON

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Title: Director of HIV Prevention

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Programme is being implemented since: 2014

Responsible party/parties: Government

Scope of Submissions: Young people

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? N/A

Is the program part of the National Plan Broader than the National AIDS Strategy? N/A

DESCRIPTION

A recently published study has reported on the success of creating demand for VMMC in secondary school males age 14-20 years through a Grassroots Soccer-based program known as Make-The-Cut-Plus (MTC+). In the school program, a trained, recently circumcised young male 'coach' led a one hour soccer-themed session in school. For participants with interest in VMMC, transport to a VMMC clinic was then arranged with the 'coach' sometimes accompanying the young male. Twenty-six schools in Bulawayo, Zimbabwe, were randomized to either receive MTC+ at the start or end of a 4-month period in 2014. The MTC+ intervention increased the odds of VMMC uptake by approximately 2.5 fold. Restricting to participants who did not report being already circumcised at baseline, MTC+ increased VMMC uptake by 7.6%. The number of participants who would need to be exposed to the demand creation intervention to yield one additional VMMC client was 22.7 (or 13.2 reporting not already being circumcised). This translated to approximately \$49 per additional VMMC client yielded.

This follows an earlier trial of the program in adult men in which the proportion accepting VMMC was 4.8% compared with 0.5% in the control arm. Following the Zimbabwe studies in adult and adolescent males, Grassroots soccer has started working with partners outside of Zimbabwe

including the Uganda Virus Research Institute and London School of Hygiene and Tropical Medicine, CHAPS Swaziland other partners in South Africa, Zambia, Kenya, and Botswana.

<http://journals.lww.com/jaids/toc/2016/10012>

II. ASIAN STATES

15. INDIA

15.1. TITLE OF THE PROGRAMME:

Samarth Community Clinics: Health and HIV Testing for MSM, Transgenders and Hijras in India

CONTACT PERSON

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Title: Senior Programme Officer

Organization: India HIV/AIDS Alliance

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Programme is being implemented since: June 2016

Responsible party/parties: Civil society

Populations group(s) reached: Men who have sex with men, transgender and young people

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

HIV prevalence among MSM and TG population in India remains alarming high at 4.3% and 8.82% respectively (NACO Annual Report, 2014-15). Despite increased coverage, HIV testing among MSM and TG populations is low i.e. 60% (NACO, 2014). Studies have shown that community based HIV testing and counselling had achieved higher rates of services uptake, reached people with higher CD4 count and linked people to care (Suthar AB et al PLOS Medicine 2013, Issue 8, e1001496). While India has about 16,283 government facilities for HIV testing, various barriers discourage MSM and TG from accessing these services, such as social stigma, discrimination, punitive laws, lack of sensitized workers, and unresponsive service hours and locations (IBBS report 2016). Knowing ones status is now considered a strong prevention approach whereby it forms the critical link to the continuum of care from prevention to treatment. Knowing ones HIV status complimented by counselling and posttest services including prevention and linking to treatment cascade where required ensures prevention of further transmission of the virus

irrespective of the screening result.

RESULTS AND IMPACT

“Samarth” programme implemented in six sites in India, has successfully conducted 3,631 HIV screening test with 2871 MSM and 760 TG people by March 2017, that is less than 7 month of starting its first HIV screening test service in September 2016. Out of these 3631 clients, 2752 (75.72%) have reported to have first ever undergone HIV screening test in their life. The programme has identified 49 HIV positive clients and have been successful in linking them with treatment services. One key approach to promoting HIV screening especially among MSM and TG communities has been event based mobilization such as health camps, festivals and parties. This has led to at risk individuals who are not in the gambit of focused HIV prevention programs also be reached with HIV messaging and services.

FINANCING

This programme is funded by Elton John AIDS Foundation (EJAF) - Governance Samarth programme is managed by India HIV/AIDS Alliance at national level, with experienced CBOs namely Lakshya Trust, Udaan Trust, Amitie Trust and Shaan Foundation as clinic implementing partners at field level. At both the levels a dedicated team strategies, monitor, implement and evaluate the activities. It is to be noted that the programme lead at national level and 80% of the field level staffs are MSM and TG community members.

LESSONS LEARNED AND RECOMMENDATIONS

Samarth programme has proved that community acceptance is higher in receiving services from community run testing centers as opposed to public health facilities or private laboratories. Secondly, India is initiating its own process for scale up of Community Based Testing under its prevention programme. The Samarth project provides invaluable lessons to this roll out. Thirdly, the prevention programme has limited reach among the community groups, particularly to those visible at cruising points or hotspots, however the event based approach has been successful in teasing out hard to reach key populations.

ANNEXES

Samarth quantitative progress

15.2. TITLE OF THE PROGRAMME:

Wajood: Empowering Transgender and Hijras to Access Sexual Health (SH) and Human Rights in India

CONTACT PERSON

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Programme is being implemented since: November 2015

Responsible party/parties: Government / civil society

Populations group(s) reached: Transgender

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. Human Rights

CONTEXT

In India, transgender/hijra (TGH) people are ossified due to their alternative gender identities and typical heteronormative norms of the society. Though after April 15, 2014 they are part of 'third gender' category' as decided by Supreme Court of India, still nothing much has been done towards keeping their overall wellbeing in mind. India HIV/AIDS Alliance has started implementing a unique project, named 'Wajood' (In Hindi means Identity and Pride) which focuses on Sexual health, crisis mitigation and social welfare and entitlement. Funded by Amplify Change under Strengthening Grant, Wajood is working in five states of India reaching out to 6,000 transgender/hijra people in two years (November 2015 to October 2017). Gender based violence and challenging stigma, discrimination, attitude and laws are the two main thematic areas of Wajood with three main objectives - strengthen community systems for TGH through capacity development & expanded access to quality sexual health services responsive to their needs, to increase awareness and reporting of gender based and sexual violence among TGH and action for mitigation and

prevention and to support community-led efforts for policy change for TGH to contribute to their overall health and wellbeing protecting their rights.

RESULTS AND IMPACT

India has seen a success in decline of new HIV infections among Trans gender Population (NACO 2015- 15) IBBS have stated HIV prevalence among transwomen in India were 8.82% however (NACO 2016 annual report) mentions the Sero prevalence among trans women is 7.5%. In the early stage of the project by July - September 2016 conducted baseline study and followings were the findings;

- Facing wide range of violence (physical, emotional, sexual and financial) from family members, community, goons and service providers of both government and non-government.
- Difficult to avail the sexual health service In Govt health care settings
- Lack of knowledge about feminization
- Difficult to get access to social welfare and social entitlements (election cards, general identity cards, passport etc).

By considering all these findings we implemented the project over a year and impact of the project shows

- Increased uptake of sexual health services to 3346 clients out of 3805 registration.
 - 2445 out of 3346 tested for HIV and 1716 clients referred for STI examination.
 - 2.08% new sero positive found while availing SRH service
- Increased uptake of Social welfare scheme by 12.05%
- An over of 300 cases been documented on violence and provided support within 48hrs though crisis response team (CRT).
- As per the Analysis through Martus application (documenting and generating evidence based advocacy approach application) violence is more within the age group of 18-29 however these violence's have a huge contribution from family members and local goons. Among the same age group 18.43% were forcible sex and 7.1% cases were forcible sex between the age group of 30-39.

FINANCING

This Innovative approach of community ownership program is Funded by The Amplify Change

under Strengthening Grant (2015- 2017).

LESSONS LEARNED AND RECOMMENDATIONS

Capacity building of Tran's genders and the services provided to these populations have proved successful through Wajood in a relatively short period of time. Community system strengthening of Trans CBO's has created an enabling environment and encouraged healthy sexual behaviours amongst Transgenders, but further progress can still be made with more time. Wajood has created an 'innovative intervention model' to supplement the national HIV/AIDS programme and improve national HIV service uptake towards the missed transgender identities such as jogappa, mangalmukhi, shivashakti and dera based Hijras Therefore it is important that these interventions continue to be provided to these communities, and that TGH continually access the services that the Trans led CBOs offer, as they directly address the needs of the Trans communities.

ANNEXES

NACO annual report 2016, www.martus.org (screen shoot attached), Wajood assessment study, etc.

16. ISLAMIC REPUBLIC OF IRAN

TITLE OF THE PROGRAMME:

Integrated HIV/SRH/PMTCT programme in Primary Health Care system

CONTACT PERSON

Name: Mohammad Mehdi Gooya

Title: Director General Center for Communication Diseases Control

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Programme is being implemented since: 2013

Responsible party/parties (tick all that apply): Government / UN or other inter-governmental organisation

Populations group(s) reached: Women / Girls

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. National Safe Motherhood Program

CONTEXT

In line with Sustainable Development Goals, related HIV Political Declarations and the National HIV Programme's bold targets of 90-90-90; establishing universal access to reproductive health and HIV prevention, care, support and treatment services has become a priority in the national response.

Focusing on girls and women as one of the main targets of HIV comprehensive combination prevention programme and also provision of integrated SRH/HIV to at risk population are among the highlights of I.R. Iran 4th National Strategic Plan.

Linking sexual and reproductive health services to HIV/AIDS services could potentially have a significant effect in controlling the epidemic. Connection between HIV/AIDS and sexual and reproductive health on the other is becoming more prominent as the number of women affected by the disease is increasing and mode of transmission is changing from unsafe injection of drugs to sexual routes. In addition, world experience shows that over 75% of the all cases of HIV infection worldwide stem from sexual contact, pregnancy, childbirth or breastfeeding. STIs tend to increase

the risk of HIV infection. In addition to this direct effect, there are also a host of other common issues that affect these matters both. These include: poverty, social stigma, urban marginalization, most-at-risk populations etc.

The national AIDS response in Islamic Republic of Iran is one of the most noteworthy in the Middle East, with Harm Reduction central to prevention efforts. Sexual transmission is playing a growing role in the propagation of HIV. Women's share of the total number of registered cases has doubled over the past five years. In response to this, the National AIDS Programme has reviewed its priorities and incorporated the 90-90-90 goals and Fast-Track approach into its national strategy.

As of September 2016, the National HIV Case Registry has recorded 34 846 people living with HIV/AIDS. Men account for 84 per cent of registered PLHIV. According to official statistics, around 68 per cent of cases so far registered have been due to injecting drug use and another 18.5 per cent to sexual transmission. However, in 2016, women accounted for 30% of identified cases. Sexual transmission constituted 40% of modes of transmission while injecting drug use stood for 38% of cases.

Reproductive health programs were among the earliest services delivered by the Iranian PHC network. Strengthening the links between these two programmes with greater coordination and cooperation among them aimed to add to the strength of HIV response and accelerate progress toward achieving the committed goals over the next five years.

The term 'linkages' is intended to imply two-way coordination in policies, programs, services and support mechanisms related to HIV and sexual and reproductive health (SRH). Some of the advantages of such linkages included:

- Elimination of mother to child transmission
- Increased access and utilization of key HIV and RH services,
- Greater access of PLWH to sexual and reproductive health services that are suitable to their needs,
- Reduction of the burden of HIV stigmatization and discrimination,
- Increased program efficacy and impact.

Linking RH and HIV control programs aiming to eliminate MTCT was planned along the following three implementation phases:

- Phase 1- Pilot phase in 170 PHC centers and 40 hospitals in 14 provinces across the country
- Phase 2- expansion of PMTCT programme to sub-urban areas of all cities aiming integration of PMTCT in PHC system
- Phase 3- Nation-wide integrated HIV/SRH/PMTCT programme

Given the rise in sexual transmission of HIV together with the rise in HIV cases in women, attention to PMTCT-as a key strategy of the 4th National strategic Plan endorsed by the Cabinet and supported by the President of the state- drew more attention among policy makers.

Department of Family Health and Center for Communicable Disease Control in collaboration with UN jointly developed PMTCT protocol and training modules in 2013. During the pilot phase (2014-2016), 80 focal points of HIV and family health of medical universities and PHC were trained. In addition, in order to have support of care givers in the private sector, midwives and OB/GYN specialists were sensitized and trained in national seminars.

In 2016, phase 2 started up by capacity building of 300 focal points and development and/or expansion of the required infrastructure. By now, focal points of all medical universities (58) of the country were trained to implement the programme.

RESULTS AND IMPACT

Before start-up of PMTCT and integration of HIV in PHC and SRH, only high risk women who came to HIV centers were tested. In 2012, 3,116 high risk pregnant women were tested which resulted in identification of 74 positive cases. Now, PMTCT is implemented in ANC clinics and more people are benefiting from testing and counselling services.

By the end of 2016; 205,406 mothers got tested out of which 68 were positive. All mothers however received ARV treatment as the country had embraced Option B+. All mothers who were identified in their 1st trimester (51) and received prophylaxis gave birth to healthy infants.

Since 2012, number of tested pregnant women has seen an increase of approximately 900%. Number of infants born free of HIV has increased of 42 infant in 2012 to 63 in 2016.

FINANCING

98% of the programme budget is from domestic resources; UN and GF financially support some elements such as procurement of HIV kits, knowledge transfer and organizing training seminars and workshops.

GOVERNANCE

Center for Communicable Disease Control, Family Health Department and Health Network Expansion Department (PHC) Department of the Ministry of Health work together with medical universities to implement the programme.

LESSONS LEARNED AND RECOMMENDATIONS

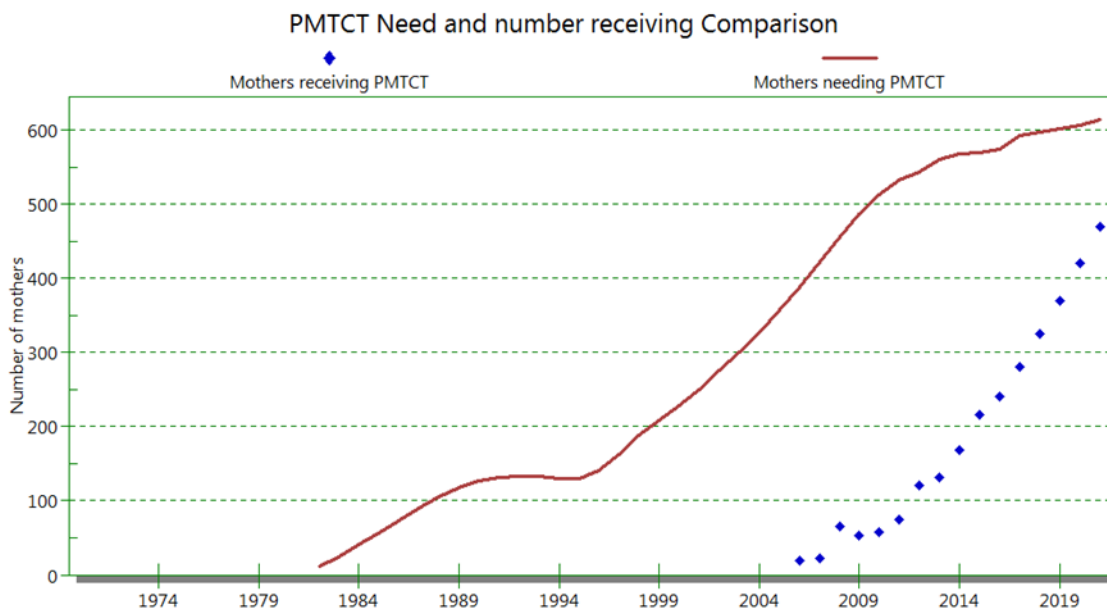
- Piloting in 160 centers was a very useful approach. Piloting such a big programme helped both policy makers and implementers to have a clear picture about potential challenges and various requirements for smooth expansion of the programme.
- Despite some concerns on Opt Out approach before implementation of the programme, Opt out strategy turn out to be very feasible and responsive to the need to people.

- Inter and intra sectoral collaboration between Health Network Expansion Dept & Family Health & CDC turned to be essential for success of the programme. (important)
- Sensitization and advocacy w private sector actors namely midwives and OB/GYN specialist is necessary for increasing testing uptake, effective prophylaxis and reducing loss to follow up.
- Integration of PMTCT in PHC system facilitated all logistics and programme implementation requirements by more effective use of existing resources.

FUTURE PLAN

Based on the concept of Location/Population and in order to increase testing uptake, the programme is being expanded to marginalized sub urban area in 2017. The next step –by March 2018- is full coverage of the entire country by attending the remaining areas.

ANNEXES



17. NEPAL

TITLE OF THE PROGRAMME:

“Nepal HIVision 2020” – “Identify, Reach, Recommend, Test, Treat and Retain” Case finding’ and case management, through task-sharing and ‘in-reach’ across the HIV prevention/treatment continuum.

CONTACT PERSON

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Programme is being implemented since: 2016

Responsible party/parties: Government / Civil society / Private sector / UN or other inter-governmental organisations / Academic institutions

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers / Transgender people / Women / Girls / Young people / Male labour migrants and their spouses / Prisoners

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. Nepal HIV Investment Plan 2014 to 2016

DESCRIPTION

Putting in practice that “Prevention is an Outcome,” Nepal’s HIV response has resulted in a steady decline of new infections over the past decade. In 2016, there were an estimated 900 new HIV infections - down 83% from 2001. There were approximately 100 new HIV infections among children in 2016, a decline of 82% since 2001. How did Nepal manage to do this? These declines are a result of national solidarity and mutual accountability to address HIV in Nepal. In the last few years this was done within a framework of strategies and activities guided by the ‘Nepal HIV Investment Plan (NHIP) 2014-2016, in which prioritised investments were agreed upon, of a scope, scale, intensity, quality, speed and innovation to save the maximum number of lives, to keep

people healthy, and to avert as many HIV infections as possible. The NHIP laid the foundation for 'Nepal HIVision 2020,' the country's new 5-year National HIV Strategic Plan (NHSP) for the period 2016 to 2021. This NHSP, with its Investment Plans positions and drives Nepal on its Fast-Track trajectory, towards ending the AIDS epidemic, by 2030.

See 'Nepal HIVision 2020' at: <https://tinyurl.com/koqy2h5>

Inspired by "A Quarter for Prevention," stated in the Political Declaration, and following the UNAIDS Executive Director's November 2015 "Directive on Prevention," the UNAIDS Country Office in Kathmandu steadfastly advocated for, led, convened and participated in consultations and discussions to set ambitious HIV prevention targets, and to calculate the investments that would be necessary to achieve these goals.⁹ **In Nepal, no less than 65 percent of HIV investments are a combination of strategies¹⁰ and innovative actions through, both government and non-government task-sharing, to prevent HIV.¹¹**

Establishing functional public-private partnerships to bridge the prevention-treatment continuum through task-sharing is one of the most important strategies to overcome fragmentation, and for our several partners to stay 'on track.' An additional 8 to 10 percent investment of the HIV budget will go towards critical social and programme enablers, such as cash incentives for pregnant women with HIV, encouraging institutional delivery and early infant diagnosis; zero tolerance for prejudice in the health care settings – and all workplaces; testing for Hepatitis B and C of people who inject drugs; decentralisation of testing and treatment sites; increase, by USD 5 million, of domestic funding for the fiscal year 2017/2018, by the Government of Nepal, including for the procurement of first-line anti-retroviral drugs. All this, in the case finding-case management continuum that is Nepal's formal HIV response architecture.¹²

Innovations towards prevention in Nepal include 'in-reach,' whereby communities of key populations play their crucial part in the country's HIV response, by **Identifying, Reaching and Recommending** members of their own communities for HIV **Testing**, and actually lead and conduct such rapid HIV screening themselves – through the mechanism of test-for triage.¹³ Those who screen negative will, with trained members of their own communities remain re-engaged for regular HIV testing, and receive a combination of services to prevent HIV, including access to condoms, needles/syringes and pre-exposure prophylaxis. Persons who screen HIV positive are

⁹ See letter of appreciation from the Director of the National Centre for AIDS and STD Control to the UNAIDS Executive Director – ANNEX I

¹⁰ See the NHSP, page 17: "Strategies" (3.1.2) – ANNEX II

¹¹ See the 2018/2019, 2019/2020 and 2020/2021 investment distribution graphs in the NHSP Investment Plan – ANNEX III

¹² See the NHSP, page 20: Prevention-Treatment Continuum (Fig. 7a) - ANNEX IV

¹³ See the NHSP, page 25: Community Led HIV Testing – ANNEX V

supported and accompanied for HIV confirmation testing at a National Public Health Laboratory accredited facility. Those with confirmed HIV positive test results will immediately be offered **Treatment** and are encouraged and supported - by a combination of health professionals and trained lay persons from the communities themselves - to **Remain** on treatment towards life-saving viral load suppression. **With this, 'Identify, Reach, Recommend, Test, Treat and Retain (IRRTTR)' are at the heart of Nepal's HIV response.**¹⁴

In partnership with the communities of key populations, implementing- and technical partners, Nepal is developing innovative tools for communities of key populations to 'reach in.' The "Nepal National HIV Testing and Treatment Guidelines 2017," were completed in April 2017. There is an upswing in HIV testing, while additional districts offer services towards the elimination of vertical HIV transmission, and keeping mothers well and alive (eVT). Modern viral load equipment is on order, and a patient tracking systems is being developed.

Implementation of "IRRTTR" was discussed by key government and non-government partners, from all regions of Nepal, in the first week of April 2017. Their knowledge and competencies about this prevention-treatment/case-finding case- management continuum were assessed through a process of self-assessment. It was agreed, from this, that the two key competencies that drive ending the AIDS epidemic in Nepal will be 'task sharing' and 'in-reach.' Similar discussions took place in the 5 development regions of Nepal, throughout the months of April and May. It is noteworthy that these workshops have provided platforms as 'country dialogue' for the submission of Nepal's HIV funding request to the GF, in August 2017.

Nepal, a small land-locked country in the Himalayas, proofs that we have recaptured imagination. Our innovative approaches to prevent HIV, as an outcome of smart and strategic investments, are herewith being shared with the world, as a contribution to our global commitment to deliver results, with people at the center, for a world of sustained wellness and well-being.

Because we can, and we do. --- Namaste.

¹⁴ See the NHSP, page 20: 'IRRTTR:' Identify, Reach, Recommend, Test, Treat and Retain (fig. 7b)- The core of Nepal's HIV Response – ANNEX VI

18. PHILIPPINES

TITLE OF THE PROGRAMME:

Community Based HIV Screening (CBS)

CONTACT PERSON

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Programme is being implemented since: Piloted in June 2016 by HASH. Full implementation in 2017 onwards

Responsible party/parties: Government / Civil society / Private sector / UN or other intergovernmental organisation

Populations group(s) reached: Men who have sex with men / People who inject drugs / Sex workers / Transgender / Women / Young people

Has the programme been evaluated /assessed? Yes. The CBS pilot project's process evaluation is on-going and expected to be completed by end of June 2017. However, mid-pilot evaluation showed very encouraging results.

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. National Intervention Plan for MSM and TGW

CONTEXT

The Philippines is one of the countries where HIV infection is on the up-trend particularly among males having sex with males, transgender women, people who inject drugs, and among young key populations. Program coverage remains low because these clients do not access traditional testing in laboratories and the government testing outreach. To raise testing uptake and to link reactive clients to testing and treatment, Community-based screening or CBS was implemented. CBS is : a) a rapid HIV screening done in a non-laboratory setting by a trained CBS Motivator who is a part of the community, b) a testing option that is envisioned to help increase testing uptake, as well as to link reactive clients to the continuum of care by maximizing the engagement of community-based organizations (CBOs), c) meant to be a one-on-one approach, d) not meant to replace diagnostic

testing options currently available in the country. Rather, it complements the range of screening and testing options available to clients. It is community-led.

RESULTS AND IMPACT

The reactivity rate in CBS is the same or even higher than in the mobile VCT conducted by the program. • CBS helps in destigmatizing HIV testing. There is pronounced increase in MSM clients seeking screening. • CBS promotes human rights and gender equality. • CBS highlights the limitation of HIV prevention services • CBS provides further evidence for the need to enable minors to access HIV screening and testing.

FINANCING

The development of formative documents such as CBS policy, training manual, CBS messages, CBO protocols and procedures, and M&E Plan, was supported by UNAIDS. The pilot was supported by the Global Fund NFM country project. Roll out in 2017 is also through the Global Fund financing.

GOVERNANCE

There are established committees to oversee CBS implementation namely: CBS Technical Working Group under the national HIV-TWG; City CBS committees whose membership are community-based organisations and the local city health offices where CBS is being implemented. These committees meet regularly to monitor CBS progress, and resolve issues and challenges. The CBS motivators regularly conduct learning group sessions to share experiences and strategies to reach more clients.

LESSONS LEARNED AND RECOMMENDATIONS

- The government's support through the issuance of a CBS policy promoted the acceptance of CBS by the local health offices;
- Engagement of the Philippines Association of Medical Technologists (PAMET) which was initially opposed to CBS, (citing the Medical Technology Law that prohibits testing to be done by lay people) to become CBS partners in various ways proved beneficial to the CBS program;
- CBS engendered a renewed recognition of CBOs as critical partners in the country's HIV response;
- Motivators find CBS empowering because of the added skills, knowledge, and the immediate results that they get
- Innovative use of social media platforms and applications for specific CBS purposes (e.g., to create a virtual community of CBS motivators through which requests for testing are shared,

motivators are mobilized, accomplishments are monitored, reported and celebrated; reach and recruit clients, follow up clients) was significantly useful. (e.g., CBS motivators are now not limited to a specific geographic area (ex, motivators from Metro Manila can be mobilized to go to Antipolo, Bulacan, etc. with proper logistics support).

- M & E is an essential part of CBS protocol;
- CBS should be implemented across the country. However, proper SOPs and quality assurance standards should be in put in place.

ANNEXES

1. PowerPoint presentation during the Meeting on Progress of CBS Demonstration Project, 15 November 2016 at Crimson Hotel, Muntinlupa City, Philippines
2. Community - Based HIV Screening Demonstration Project Phase 2- End of CBS Phase 2 Report
3. CBS Job Aid

19. THAILAND

TITLE OF THE PROGRAMME:

PrEP Demonstration Programs in Thailand

CONTACT PERSON

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Programme is being implemented since: 2014

Responsible party/parties: Government / Civil society / Private sector / UN or other inter-governmental organization / Academic institution

Populations group(s) reached: Men who have sex with men / Sex workers / Transgender / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? Yes. Thailand National Guidelines on HIV/AIDS Treatment and Prevention

DESCRIPTION

Thailand has made great strides in combating the growth of the HIV/AIDS epidemic. Whilst the number of new HIV infections has been reduced sharply, prevalence remains relatively high among Transgender Women (TG) and Men who Have Sex with Men (MSM) (11.8% and 9.2%, respectively, in 2014), who now account for more than half of all new HIV infections annually. Though a number of HIV interventions have taken place, the HIV incidence among these groups are still as high as 7.6 per 100 person-year in 2014, putting MSM and TG as prime candidates for Pre-Exposure Prophylaxis (PrEP) according to the WHO Guidelines. With this very high incidence data, Thailand immediately included PrEP as part of the combination HIV prevention packages recommended in its 2014 National Guidelines on HIV Treatment and Prevention, although it is not covered by the National Health Care schemes. To urgently boost the momentum of integrating PrEP into the National AIDS Strategy, several PrEP demonstration projects have been executed by multiple institutions to determine the demand and the feasibility of PrEP in Thai setting. The following paragraphs will describe the progress made regarding the expansion of PrEP services to the key populations.

Strong collaborative partnerships have made significant progress in PrEP movement

Despite some barriers, including the low perception of risks to HIV infection among these populations, the lack of clear understanding of PrEP use/application among the broader NGOs and health advocates, progress has been made possible through multiple stakeholders, including civil society, community-based organizations (CBOs), and international funders. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has been providing funding through the U.S. Agency for International Development (USAID) and the Thai MoPH-U.S. Centers for Disease Control and Prevention Collaboration (TUC) to assist Thailand in assessing and implementing PrEP demonstration projects. TUC has been working with the Bureau of AIDS, Tuberculosis and Sexually Transmitted Infections (BATS), focusing their works on PrEP service delivery in facility-based settings. On the other hand, USAID, through FHI 360 LINKAGES, has been collaborating with the Thai Red Cross AIDS Research Center (TRCARC) in PrEP projects conducted in community-based settings. These partnerships have allowed Thailand to make progress in: 1) showing the feasibility of PrEP provision in both facility and community settings; 2) demonstrating PrEP's effectiveness in preventing new HIV infections and increased use of condoms at no additional cost to the health facilities; 3) identifying future direction and necessary steps in Thailand for a PrEP scale-up model.

Community-Led Health Service model established to delivery PrEP to key populations

Soon after PrEP was recommended in the National, TRCARC through its Anonymous Clinic started to offer the first fee-based "PrEP-30" service to its clients. This program was established to create awareness in the communities of accessible service, as the PrEP offered was the generic TDF/FTC PrEP (Teno-Em), which costs 630 Baht (US\$18) per 30 tablets. Subsequently, TRCARC integrated PrEP into the USAID-funded community-based Test & Treat implementation research called "Community-based PrEP Substudy" to offer free PrEP to MSM, MSW and TG receiving services at the CBOs in Bangkok and Pattaya under the Community-Led Health Service (CLHS) model. This CLHS model contributed 42% to the national HIV testing among MSM, MSW and TG, accounts for 24% of total HIV diagnosed among these populations (Routine Integrated HIV Information System, 2016). The CLHS PrEP model was further expanded in 2016 to provide free PrEP service under the "Princess PrEP" program to more than 700 MSM, MSW and TG through 7 CBOs in Bangkok, Chiang Mai, Chonburi and Songkhla, with the support of the royal patronage and public donation money. This program will expand to other key populations in 2017.

Government-led PrEP programs for scale up at national level

One of the most notable PrEP programs that has been initiated is the "PrEP2START" – the first PrEP program that is led by the government, with technical and funding support from PEPFAR through TUC. The program was developed based on lessons learnt from the "Facility-based PrEP Substudy", conducted by BATS and TUC, to study the integration of PrEP into the facility-based Test & Treat implementation research. Recently launched in January 2017, the PrEP2START program aims to strengthen public health system and to enhance capacity of healthcare professionals in increasing access to PrEP among MSM, MSW and TG, seronegative partners in serodiscordant relationship and clients of the sexually transmitted infection clinics. And, more

importantly, some of the objectives for PrEP2START are to determine and develop the most suitable PrEP service models for scale up at national level.

Evidence-informed large-scale implementation

In October 2015, PEPFAR conducted a study on the feasibility and acceptability of PrEP provision to MSM and TG at 2 government health facilities and four community sites in Bangkok and Chonburi. Participants were recruited from the overall Test and Treat study mentioned above. It was found that 40-45 percent of HIV-negative high risk MSM and TG accept PrEP. The rate of PrEP acceptability is higher in the sites in Bangkok than the sites in suburban cities. HIV risk perception plays an important role in PrEP acceptance. The adherence rate among PrEP users was as high as 84-95 percent. Condom use among the PrEP clients has increased over time due to intensive counseling received over the course. Implementing PrEP in Thailand will involve targeting MSM, MSW and TG who perceive themselves to have moderate/high risk of acquiring HIV, while also promoting condom use and addressing stigma around PrEP use in the community. It is also critical to include both an assessment of a client's perceived risk, and education about HIV risk factors that will improve the accuracy of a client's perceived HIV risk.

Small steps to big changes

In addition to the programs described above, other programs have been instigated to increase access to PrEP service in provinces with high prevalence of MSM and TG. PrEP@Piman, led by Research Institute for Health Sciences (RIHES), focuses on MSM and TG in Chiang Mai. PrEP at Silom Community Clinic (SCC) @TropMed is another fee-based PrEP service catering to MSM and TG populations. Though some of these projects are still in their infancy, the current data illustrates the importance and demand of PrEP among key populations in Thailand. The number of PrEP users in Thailand has dramatically increased from less than 10 people in 2014 to 300 in 2015 and 2000 in 2016.

The data further suggested that we would get at least 30% and up to 90% of clients with high-risk behaviors to start PrEP when providers have positive PrEP mindset. This means that the uptake of PrEP in Thailand among key populations has a potential to grow significantly if there is a stable system in place to support PrEP providers and equip care providers with the correct knowledge and positive attitude towards PrEP. Furthermore, preliminary estimated cost of PrEP service in facility settings does not show a significant increase in service costs, except for the cost of drug.

To combat the epidemic, access to more prevention options will be critical to safeguard a larger proportion of the populations most at-risk of becoming infected. Strong advocacy framing PrEP-and-condoms, rather than PrEP-or-condoms, and valid scientific-based evidence must be used to inform all relevant bodies and pave the path for the inclusion of PrEP into Thailand's national health care schemes.

III. EASTERN EUROPEAN STATES

20. GEORGIA

TITLE OF THE PROGRAMME:

Needle and Syringe program in Georgia – Provision of HIV prevention services to people who injects drugs (PWIDs) and their sexual partners

CONTACT PERSON

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Programme is being implemented since: 2006

Responsible party/parties: Civil society

Populations group(s) reached: People who inject drugs / women / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. National HepC Elimination program

DESCRIPTION

Georgia is among low HIV prevalence (0.07%) countries being at high risk for an expanding epidemic due to widespread injecting drug use and the population movement between Georgia and neighboring high HIV prevalence countries such as Ukraine and Russia.

In the early years of the HIV epidemic in Georgia, as in most Eastern European countries, injecting drug use was the major transmission mode. Since 2010, transmission has shifted toward the heterosexual mode, among all registered cases 44.1% comes to PWIDs, and 43% to heterosexual transmission way http://aidscenter.ge/epidsituation_eng.html. Number of new HIV cases is increasing year by year; the reason of this fact has not been studied so far, although it is considered that might be linked to increased volume of HIV screening (case detection).

The number of PWIDs is estimated to be 50,000. <http://curatiofoundation.org/population-size-estimation-of-people-who-inject-drugs-in-georgia-2015/>. Prevalence of risk behavior is high among PWIDs, with only 74% of PWID reporting use of sterile injecting equipment; 8% of PWIDs report sharing injecting equipment during last injection (BSS study, 2016, Georgia).

By support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and OSF (at initial stage) Needle and syringe program (NSP) and OST programs had started in the country for more than 12 years (first NSP site was opened in 2001), but coverage remained significantly low (12% of PWIDs were covered by NSPs, less than 6% were covered by OST program in 2012). The governmental entity - National Center for Disease control and prevention (NCDC) – reveals the principal recipient of GF grant in the country.

The main problem that 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 Law 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 is an outreach work here. Effective implementation of the program is often hampered by the police. Outreach workers have to work under very strict environment, under the routine and everyday threat of police arrest. During many years lots of outreach workers were arrested and moved to mandatory Urine Drug Testing.

RESULTS AND IMPACT

Provision of HIV prevention services to people who injects drugs (PWIDs) and their sexual partners in Georgia

The program has been initiated from 2006, but with low coverage rate. From 2013 the number of NSP sites has increased and today Georgian Harm Reduction Network (GHRN www.hrn.ge) is being implementing the program in 14 NSP drop-in centers in 11 major cities. Harm reduction centers provide a basic package of services to PWID, including distribution of sterile injection equipment; voluntary counseling and testing (VCT) for HIV, HCV, HBV, and syphilis; distribution of safe sex information and prophylactics; 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 overdose prevention (i.e., distribution of naloxone). Services are provided within the drop-in centers as well as through outreach services.

It should be emphasized, that these entire comprehensive package is being performed under the strict drug law environment and under high stigma and discrimination condition.

Within the GFATM project, 6 mobile laboratories were procured to expand the geographic coverage of VCT services. Currently, the outreach program covers 65 cities in 10 regions of the country; According to NSP program data, HIV testing rates have dramatically increased during the last few years (NCDC, unpublished data, 2016) (Figure 1) likely as a result of such efforts. According to program data 34% of HIV testing was carried out by mobile ambulances.

From 2014 GHRN had defined its main strategy of work by including community based organizations to provide low threshold HIV services to PWIDs. The main personnel at NSP program (69%) now are people who has/had drug related problem. They are more trusted and respected in PWID community, besides they are equipped with needed networking skills to find and attract new PWIDs in NSP program, who stayed hard to reach during many years by other HIV programs.

The enrolment of community in service delivery from 2014 had played a crucial role in scale-up of program coverage (increase 4 times, Figure 2), 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. Number of delivered sterile syringes and needles had increased 4 times within the program (Figure 4).

According to BSS studies that have been conducted in country in every 2 years, the program performance indicators had increased in 2015. According to study results <http://curatiofoundation.org/bbs-7cities-2015/>, Knowledge of HIV/AIDS among PWID remains relatively good. The majority is aware of primary transmission risks associated with injection and sexual behavior. Besides, There is significant increase in proportion of PWID who were tested during last 12 months and know their status. Increase is observed across all cities. In general one in four injecting drug user has been recently tested on HIV. BSS studies shows that the HIV prevalence among PWIDs has decreased in 2015, that we can consider that the increased scale up harm reduction program from 2013 has played meaningful role for hampering HIV epidemic among PWIDs (Figure 24).

According to the last BSS study more drug injectors have safe sexual contacts with occasional partners than in previous years in some study locations, although protective behavior remains at alarmingly low levels and needs special attention <http://curatiofoundation.org/bbs-7cities-2015/>. Just to address these risky factors there existed a need to develop targeted interventions. From 2016 there was developed special strategy to work with sexual partners of PWIDs within the program framework. At harm reduction sites sexual partners of PWIDs are being offered voluntary counseling and testing (VCT) for HIV, HCV, HBV, and syphilis; distribution of safe sex information and prophylactics, consultations of medical personnel and psychologist. Total number of reached sexual partners of PWIDs is 2,393 in 7 month period. This intervention is planned to be continued during next 3 years.

In order to increase the reach to hidden population (young PWIDs, female PWIDs) Peer Driven Intervention (PDI) methodology was introduced since 2010 (Figure 3). PDI was complemented by community-based outreach services. This unic methodology gives the program possibility to work in different direction simultaneously. Based on specially elaborated design and monetary incentives PDI support NSP program:

1. To attract new PWIDs, that were never covered by any HIV prevention services before;
2. To educate new PWIDs with targeted harm reduction educational module;
3. To use the attracted PWIDs to recruit other PWIDs (chain referral sampling model);
4. To include new PWIDs in NSP program, provide free HIV testing and other needed services.

Besides the service delivery, NSP program has Advocacy component as well. 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 GHRN had initiated to create 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 by the community itself: Solidarity and protest actions for people vulnerable with HIV.

FINANCING

The main supporter of NSP program in Georgia, like in most EECA countries remains the Global Fund. According to country HIV profile and HIV National Strategy the coverage of PWIDs has increased dramatically, accordingly the financing increased several times in comparison to previous year (Figure 5). Just for the imagination the NSP program financing had been increased 119% in comparison with 2013 year.

As the Global Fund will soon leave EECA region and among them Georgia, transitional plan had been prepared to ensure sustainable financing for harm reduction program in Georgia. Government took its responsibility to fully finance OST program from 1 July, 2017, but in regard to NSP program there is planned to increase state financing from 2019. Civil society, the mentioned program personnel and GeNPUD activists are included in transition plan elaboration and monitoring process.

GOVERNANCE

The program is being financed by the Global Fund since 2006 in the country. From 2014 the principal recipient of Global Fund money is government (National center for disease control and prevention). GHRN is sub-recipient of GF program. Together with governmental bodies the program is being effectively implemented and coordinated not only in regard of HIV, but for HCV as well.

From 2015 Georgia with support of CDC Atlanta and Gilead Pharma had initiated National HCV Elimination program, according to signed agreement Gilead provides the country free DAAs and government pays additional costs for diagnostic and treatment monitoring. By our side civil society and GHRN is highly included in HCV elimination program, as elimination cannot be done without harm reduction. Accordingly the NSP program had increased its scope of work by integrating HCV diagnostic, linkage to care and treatment components within its HIV prevention purposes. As in Georgia there is a high HCV prevalence among general population (7.7%) and especially among PWIDs (more than 66%), PWIDs come to NSP centers mostly to test on HCV and tandem testing on HIV is provided to them as well. So the combination of HIV and HCV services became more fruitful after initiation of elimination program.

LESSONS LEARNED AND RECOMMENDATIONS

Inclusion of key population in NSP service delivery services from 2013 gave possibility the program to increase its coverage 4 times, besides the HIV testing had increased 4 fold.

Community members are more included in program redesign process as well. They are useful resources to be used by mobile ambulatories for mobilization PWIDs as well. They have excellent network capacities, can deliver harm reduction messages in simple and proper manner to their peers, and they can better attract and recruit their peers to NSP program.

Besides, the fact that the NSP program envisages advocacy component in its framework, gives us possibility to use their meaningful resource for drug policy change advocacy process, community mobilization and empowerment for better access to vitally important HIV prevention, treatment accessibility, Evidence-informed and human rights-based prevention programs.

As a conclusion to all above mentioned the program “Provision of HIV prevention services to people who injects drugs (PWIDs) and their sexual partners in Georgia” plays a crucial role an effective implementation the both HIV and HCV national programs.

ANNEXES

Figure 1

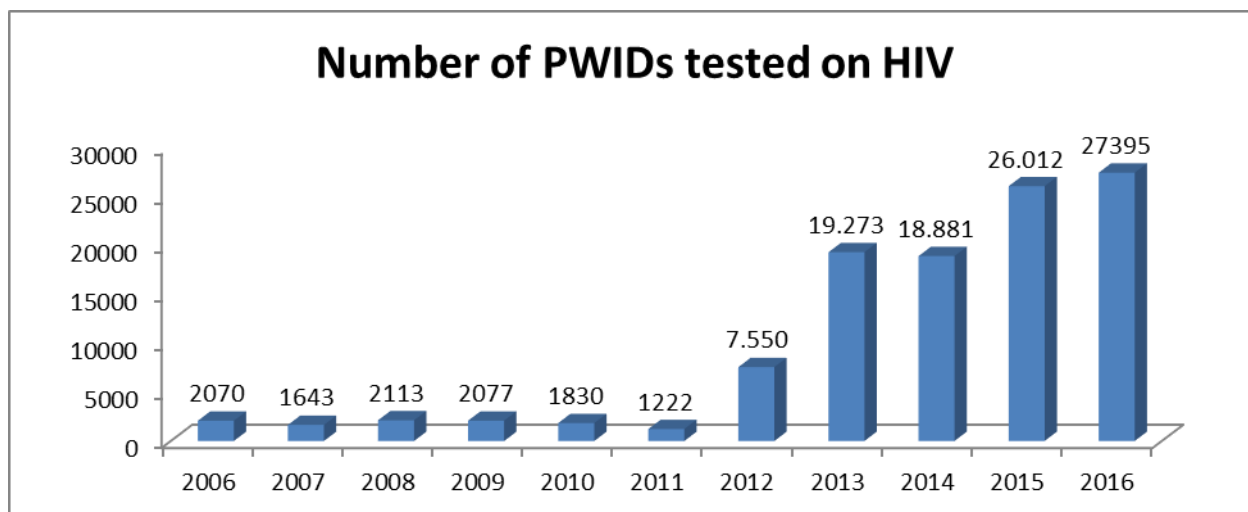


Figure 2

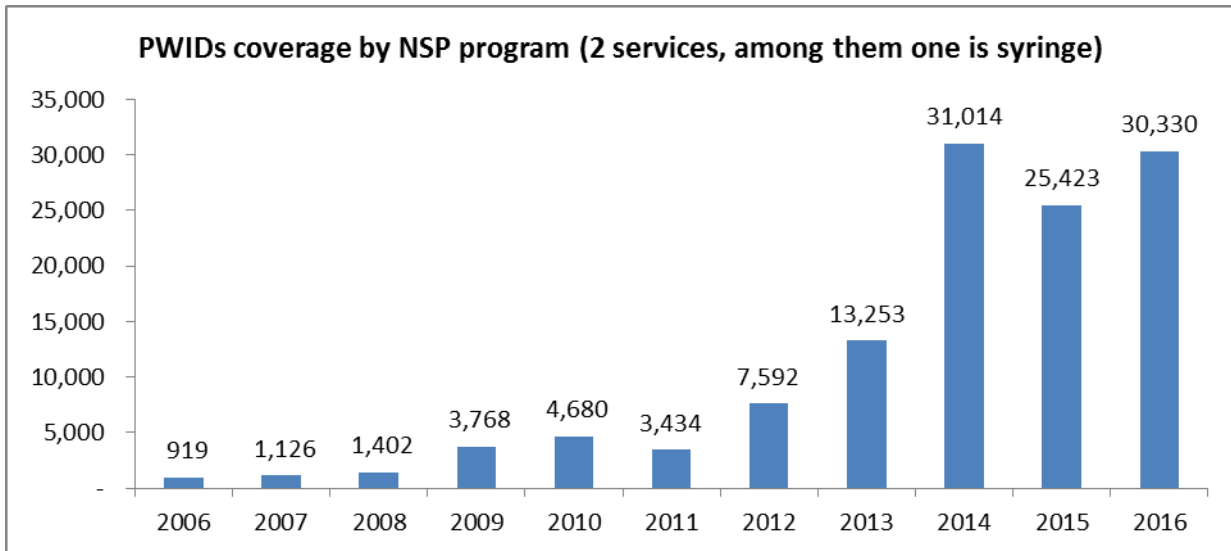


Figure 3

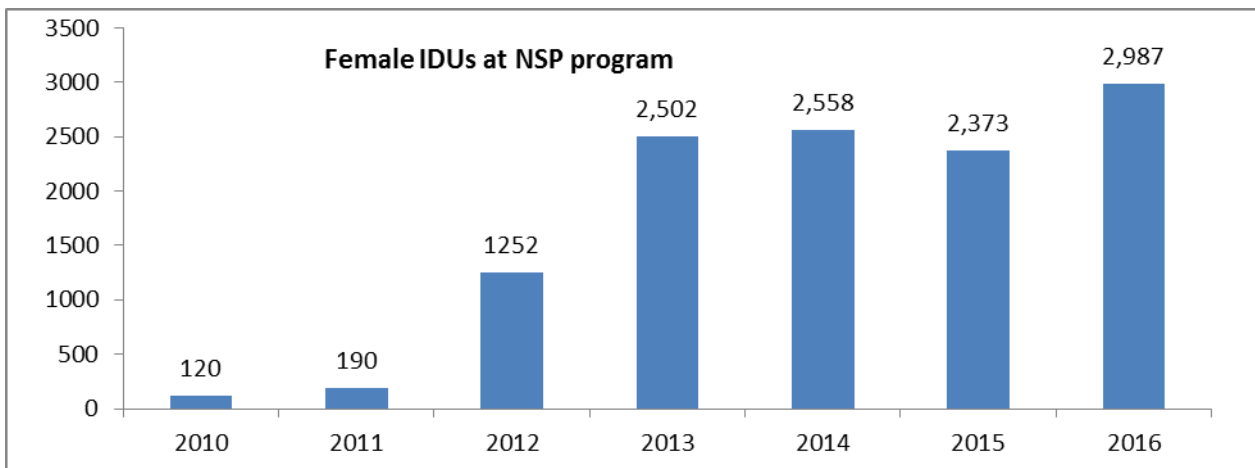


Figure 4

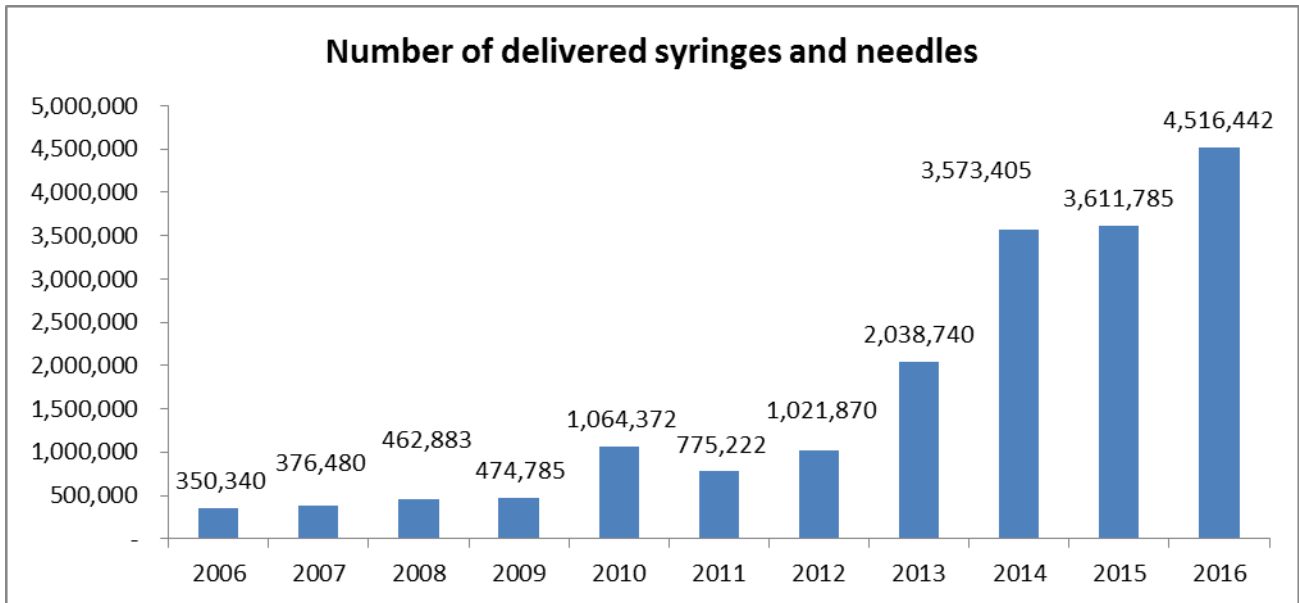
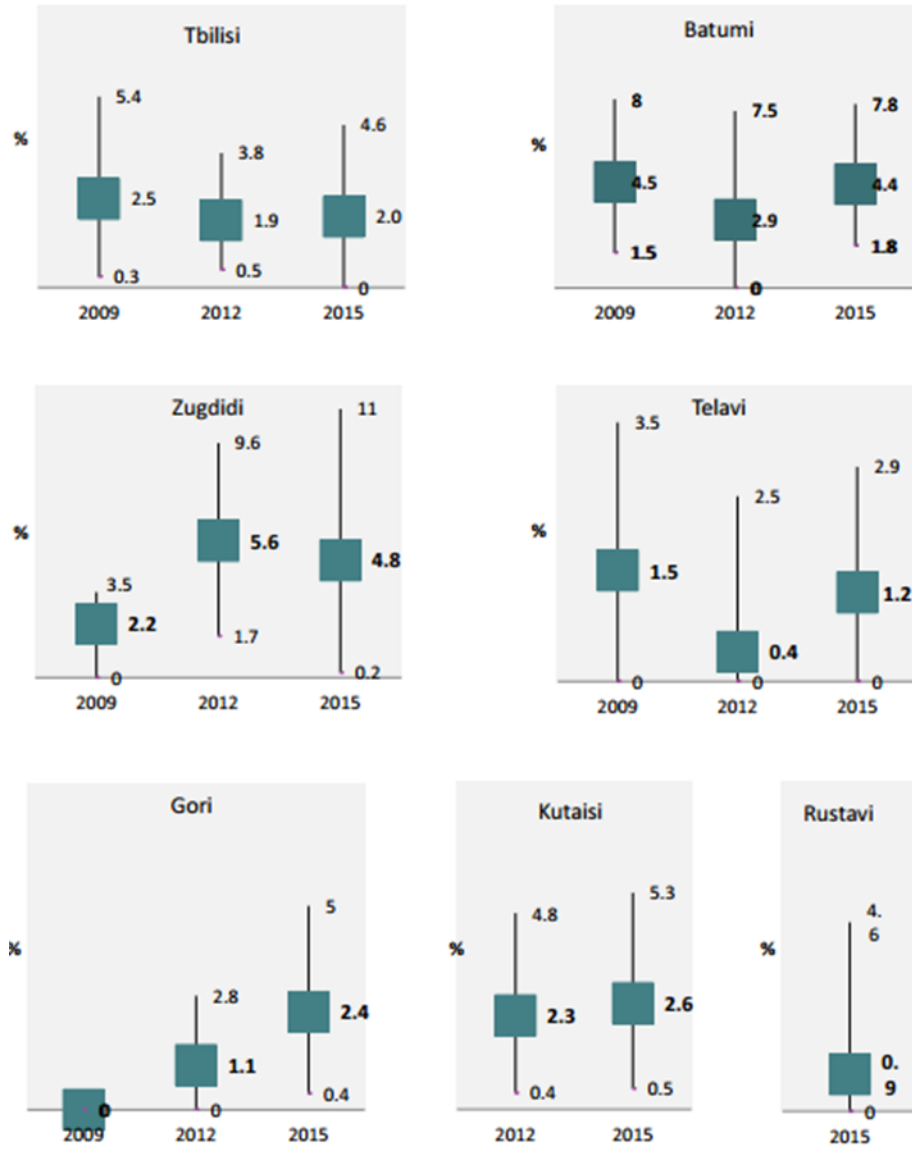


Figure 5

Year	Amount of money (GEL)
2011	700,398
2012	1,149,790
2013	1,539,336
2014	2,605,342
2015	2,824,212
2016	2,761,568
2017	3,368,256

Figure 24: Prevalence of HIV by cities, 2009-2015²³



21. UKRAINE

21.1. TITLE OF THE PROGRAMME:

City leadership as a key to fast-track: experience of Kyiv, Ukraine

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Responsible party/parties: Government / Civil society / UN or other inter-governmental organization

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

With general population prevalence at 0.9%, HIV epidemic in Ukraine is concentrated among key populations – people who inject drugs, sex workers, men having sex with men. The most affected regions are South and East of Ukraine and the city of Kyiv.

Cities bear significant burden of national HIV cases. Kyiv is home to some estimated 23 100 PLHA (or 11 454 registered with health facilities) which is approximately one tenth share of the overall PLHA number in Ukraine. Current reach of prevention programs in Kyiv by NGOs through Alliance for Public Health and its partner NGOs under the Global Fund program makes 42 278 key populations groups, or 55% of estimate. Yet, HIV care cascade is at the level of 50%-29%-25% of the city PLHA estimate and further steps are needed to consolidate response at the city level.

Joint effort of UNAIDS in Ukraine, civil society organizations and national and local government, as well as international donors have led to unprecedented HIV leadership demonstration by the capital of Ukraine. On April 6, 2016, Mayor of Kyiv Vitaliy Klitchko signed Paris declaration of ending AIDS, becoming the first Eastern European city to do so.

After Kyiv joined FTCl on April 6, 2016 substantial developments in city AIDS response occurred:

- Kyiv city HIV/TB program was developed and approved for 2017-2021 in December 2016 and is based on 90-90-90 targets;
- In order to reach 90-90-90 targets, the city of Kyiv has planned expansion of ART from 6693 (January 2017) to 21804 (2021);
- The program budgeted 1.46 Billion UAH (54 Million USD), with 19% sourced from national budget, 16% from Kyiv budget, rest – other including international. For the first time Kyiv budget is planned to source 150-400 opioid substitution therapy patients (out of 1550-1800 total);
- Private funding was attracted to support 1700 ART patients;
- Expansion of opioid substitution therapy is planned from current 990 patients to new 500 patients in 2017 with PEPFAR support;
- PrEP pilot for 100 MSM with CDC support has been planned for 2017. This will be one of the first PrEP initiatives in Eastern Europe and Central Asia region.

Most importantly, ART coverage has significantly increase in Kyiv with 33% growth in 2016 compared to 2015.

Taking example of Kyiv and as part of The Global Fund Eastern Europe and Central Asia regional project, Odesa joined fast-track cities initiative on February 28, 2017, and is now in the phase of situation assessment to design its HIV/TB fast-track city program. It is expected that joint effort, political support and increased allocations from city budget for key populations programs will form the basis of sustainable and effective city-based HIV response leading to 90-90-90 targets achievement in Ukraine.

21.2. TITLE OF THE PROGRAMME:

Pharmacy based services and mobile clinics as means to scale up established harm reduction intervention: experience of Ukraine

CONTACT PERSON

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Responsible party/parties: Civil society

Populations group(s) reached: People who inject drugs

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

With general population prevalence at 0.9%, HIV epidemic in Ukraine is concentrated among key populations – people who inject drugs (PWID), sex workers, men having sex with men. The most affected regions are South and East of Ukraine.

Response programs among key populations in Ukraine are implemented by civil society organizations starting late 1990s, based on needle syringe programs, information materials distribution, outreach, rapid HIV testing. Within the current program Alliance for Public Health and its partner NGOs across Ukraine are reaching annually to 224 872 (64,8% of national estimate) persons injecting drugs. The intervention distributes 25M syringes, 13M condoms, performs 230 000 rapid HIV tests per year, constituting the main entry to HIV treatment programs. These interventions led to the decline in new HIV infections in Ukraine: among drug users - starting 2008 and general population - starting 2012. Ukraine program is considered a model for the region and is internationally acknowledged to be among best response practices in concentrated HIV epidemics.

Analysis of 15 years of program implementation points out to interventions contributing to the most substantial increase in service coverage after initial service reach saturation. Between 2008 and 2009 the most significant programmatic growth occurred with 50% increase in annual service coverage: from 102 562 PWID in 2008 to 150 815 in 2009. The factors contributing to this growth are the two interventions introduced in 2009 – pharmacy based harm reduction and mobile clinics based programs, covering respectively 15 529 PWID and 29 947 visits to clinics contributing to 80% of the 2009 coverage increase.

Since then Ukraine program continues to support these interventions which are forming significant share of its programmatic reach today. In particular, in 2016, 105 pharmacies have reached some 19 922 PWID (8,9% of the annual reach) with prevention service package of syringe, consultation and referral. Similarly, 29 mobile clinics that operate in 21 out of 27 regions of Ukraine have reached over 25 000 PWID, out of them 7.5 thousand PWID who have never been reached by prevention programs before (this is 14.2% of all the newly reached PWID in 2016); almost 40 000 HIV tests have been conducted in mobile clinics for PWID in 2016.

Annual cost of all PWID interventions to source the reach of over 220 thousand PWID (including mobile clinics and pharmacy based interventions) within the Global Fund program make up 7M USD.

After almost 10 years of NGO-led outreach and community center programs, new developments were needed in reach modalities and new interventions have contributed to making critical reach expansion. Pharmacy based interventions and mobile clinics have significantly broadened the reach of PWID thanks to geographic expansion and reach to the clients that did not attend harm reduction services as part of previously existing approaches. Experience of Ukraine shows that these two interventions serve as a practical tool of how to bring harm reduction services to scale.

21.3. TITLE OF THE PROGRAMME:

Ensuring 100% public financing of OST with future expansion of the number of patients

CONTACT PERSON

Name: Iaroslav Zelinskyi

Title: Head of advocacy team

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Programme is being implemented since: 2016

Responsible party/parties: Government / Civil society

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers / Other

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. The strategy of ensuring sustainable response on HIV and TB epidemic till 2020; Regional social programs on HIV/AIDS prevention in 24 regions of Ukraine.

CONTEXT

From 2004 till 2016 all funding for OST programs in Ukraine for over 8 500 drug users was provided by the Global Fund to Fight AIDS, TB and malaria. According to the Agreement between the GF and the government of Ukraine financing of OST programs had to be done from state funding from 2016. Despite this funding of medicines for OST program wasn't included in the National program for the procurement of medicines for 2016. At the same time, lots of complaints have been received from OST patients from different regions regarding preparation to transition to a paid model of the program from 2017 at drugs delivery sites.

The 12-year OST program in Ukraine not only did not become sustainable, but was on the verge of collapse. In 2016, due to nonfulfillment of obligations by the Ukrainian government, the risk of losing \$27 million of financial assistance appeared (15% of the total amount of the GF grant).

RESULTS AND IMPACT

To ensure state funding for the OST program the Network conducted following activities:

- Participated in the formation of the state priorities through participation in the Ministry of Health work groups that form the list of procurement medicine, work groups forming the Terms of Reference for the purchase of drugs in the frames of the National program. Since August 2016 representatives of the Network have joined the National Council on HIV. As result of joint advocacy activities with the Public Health Centre, the National Council on HIV was headed by the Vice Prime Minister of Ukraine. The issue on the OST program funding has been escalated to a higher level.
- Participation in the Ministry of Health planning. Consideration of effective scenarios of the advocacy campaigns – allocation of additional funds by the government, redistribution of the Ministry budget, redistribution of funds within AIDS program. Formation of a united position on the program funding.
- Monitoring the expenses of the Ministry of Health. Search for savings in running programs. Search for opportunities to optimize funds. Communication with the Ministry of Finance on changing the program budget.
- Wide information campaign. All verbal agreements with the government were covered in media. All results of any meeting with certain achievements or facts of interference of advocacy goals had been delivered to partners and key beneficiaries. Involvement of partners and international organizations in the process of advocacy activities.

FINANCING

For the first time in 12 years of OST treatment in Ukraine budget of the Ministry of Health of Ukraine includes medicines for OST. 13 million UAH in 2016 and 17 million UAH in 2017 were allocated for OST medicines in frames of state program. 8 500 patients in 2016 and 11 000 patients in 2017 are covered by medicines by state funding. All GF projects funded patients will start receiving medicines funded by state budget from the second quarter of 2017. The purchase order from the Ministry of Health had been placed to international purchasing agency Crown Agents.

GOVERNANCE

For the first time in the history of Ukraine, the government started to purchase methadone and buprenorphine for the OST program. Such investments from the government should become a turning point in the transition from donor funding to state funding.

State funding covered additional 20% of patients and program funding increased by 23%.

LESSONS LEARNED AND RECOMMENDATIONS

1. Pro-active position of civil society helps to achieve the sustainability of programs
2. Advocacy activities should be fully technically assisted till the finish of campaign
3. Advocacy strategy should include complete solution for the government.

ANNEXES

1. Budget of the Ministry of Health of Ukraine (2016)
<https://drive.google.com/drive/u/1/folders/0B3CpEorAYnGGVGk5Vm9RQURaTkU>
Budget includes medicines for OST (page 4, line 10, budget line 4.2)
2. Budget of the Ministry of Health of Ukraine (2017)
<https://drive.google.com/file/d/0B3CpEorAYnGGemNwOUI4ZEswcGc/view?usp=sharing>
Budget includes medicines for OST (budget line 4.2)

IV. LATIN AMERICAN AND CARIBBEAN STATES

22. BRAZIL

22.1. TITLE OF THE PROGRAMME:

Public Consultation on PrEP: implementing PrEP as a public policy with civil society and academic participations.

CONTACT PERSON

Name: Adele Benzaken

Title: Director of STIs, HIV/AIDS and Viral Hepatitis Department

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Programme is being implemented since: 2017

Responsible party/parties: Government / Civil society / Academic institution

Populations group(s) reached: Men who have sex with men / Sex workers / Transgender / Other: Serodiscordant couples

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

As part of the inclusion of Pre-Exposure Prophylaxis (PrEP) as a public policy in Brazil, the National Commission for Technology Incorporation (CONITEC) recommended PrEP to public consultation during a 20 days period.

CONITEC has the mandate to analyze and evaluate the inclusion of all new technologies to the National Public System, taking into account aspects such as effectiveness and safety, as well as cost-benefit and cost-effectiveness.

During 20 days of open web-based public consultation, between the 23rd February and the 14th March 2017, more than 3,500 people had contributed to the Brazilian PrEP guideline and implementation plan, giving suggestions and supporting the policy.

The incorporation of PrEP in Brazil, as an alternative method of Combination Prevention to key populations, is also being designed and put in place through ongoing demonstration projects, which will inform national policy roll out during the second-half of 2017.

RESULTS AND IMPACT

PrEP web-based Public Consultation had more than 3,500 people contributing to the policy implementation plan and guideline. Majority of respondents were white (66%), male (92%) and young adults (25-39y/o; 56%). Main source of information about the public consultation was through social media (80%) and majority of respondents agreed with the policy proposal.

More frequent suggestions were related to: inclusion of new priority population groups for PrEP (target groups); frequency of routine tests for other STI and Hepatitis; and emphasis on the importance of communicating combination prevention with PrEP offer.

The results will be presented to CONITEC in early May, 2017, and the STI, HIV/AIDS and Hepatitis Department is willing to include suggestions from the public consultation. After that, Brazilian government will have 180 days to offer PrEP in specific public services in the country.

FINANCING

Unit price considered: US \$ 276.00 / prophylaxis / year, as proposed by Gilead, on January 2017.

Three pharmaceutical companies (Gilead, Blanver and Mylan) had submitted the inclusion of TDF-FTC as prevention (Truvada® and under generic label) to the Brazilian National Regulatory Health Surveillance Agency (ANVISA).

Gilead patent has been refused at the Brazilian National Institute of Intellectual Property (INPI) and is under administrative appeal.

PrEP has proven to be cost-effective in Brazil for key population (P.M. Luz, B. Osher, B. Grinsztejn, et al. The cost-effectiveness of HIV preexposure prophylaxis (PrEP) in high-risk men who have sex with men (MSM) and transgender women (TGW) in Brazil. Oral presentation. 21st International AIDS Conference Reference No: A792030007622.).

GOVERNANCE

Since 2013, the Minister of Health of Brazil (MoH) has co-financed five PrEP demonstration projects, with Brazilian academic institutions, as a way to provide the Brazilian upcoming National PrEP policy with consistent scientific evidence. In addition to these five projects, we are now supporting two new initiatives in partnership with UNITAID: Demonstration Project to HIV Prevention in Sexually Active Older Adolescents (aged 15 – 19) at substantial risk of HIV acquisition; and, PrEP demonstration project in adult MSM population and Trans people.

Besides working with academic institutions to implement PrEP, the MoH is also actively including other civil society organizations and key population representatives into PrEP implementation process in Brazil. Last April 13th, face-to-face meeting with 30 participants was held, aiming to present the web based public consultation results and discuss further collaboration for PrEP national implementation.

LESSONS LEARNED AND RECOMMENDATIONS

Scientists, sponsors of PrEP trials and other stakeholders have contributed with substantial resources to provide us the evidence of PrEP efficacy. Now there is a crucial path in turning evidence into policies, and then policies into services.

As in any HIV prevention implementation process, PrEP planning and rollout must involve its beneficiaries in the decision-making process. This can be done by civil society working closely with national and local policy makers to map the landscape and PrEP agenda together. It is key to ensure that communities are provided with adequate and accurate information about PrEP, so they can support policy proposal, contribute to guidelines and create demand for PrEP.

Their participation can be expressed in different forums such as community meetings, informal dialogues, web-based consultations and in conferences, to name a few. Alongside civil society participation, it is also crucial to have health care workers onboard.

22.2. TITLE OF THE PROGRAMME:

“Live Better Knowing” (Viva Melhor Sabendo)

CONTACT PERSON

Name: Adele Benzaken

Title: Director of STIs, HIV/AIDS and Viral Hepatitis Department

Organisation: Ministry of Health of Brazil

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Programme is being implemented since: 2013

Responsible party/parties: Government / Civil society / UN or other inter-governmental organization

Populations group(s) reached: Men who have sex with men / People who inject drugs / Sex workers / Transgender / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

It is estimated that there are some 827,000 people living with HIV/AIDS in Brazil, corresponding to

a national prevalence rate of 0.4% in the general population. Nevertheless, the epidemic is largely concentrated in key populations, with studies showing HIV prevalence rates of 5.9% among people who use drugs (PUD), 10.5% among men who have sex with men (MSM) and 4.9% among female commercial sex workers (FCSW). Besides the higher risk of infection, the Brazilian key populations – men who have sex with men, transgender people, sex workers and people who use drugs – are also affected by legal and social barriers in accessing health services.

To address the many determinants of HIV epidemic, a multisectoral response is required, operating in individual, social and programmatic levels. Founded in the combination prevention standards, the Department of STI, AIDS and Viral Hepatitis (DIAHV) of the Ministry of Health of Brazil launched in 2013 an intervention called “Viva Melhor Sabendo” (Live Better Knowing). This intervention, carried out in partnership with non governmental organizations (NGOs), involves a combination of HIV prevention strategies targeted at the most-at-risk groups, delivered by peers at the community level. The intervention offers rapid oral fluid HIV testing (DPP HIV-1/2 Bio-Manguinhos/Fiocruz), counseling, prevention education, supplies distribution, referral to PEP and monitored linkage to health services for treatment and care. Testing is free and held in social venues where key populations meet.

The DIAHV team developed a special monitoring and evaluation plan using field log, monthly activity worksheets and technical reports with data collected during testing. These information and also data collected from people who wanted to join the strategy was inserted in SIMAV-pro - an online monitoring system developed for this strategy. The targeted population reached by the initiative was invited to answer a structured questionnaire containing sociodemographic data and information about their risk and prevention behaviors. Prior to testing, they were informed about HIV VCT activities and signed a consent form.

So far, 160 projects have been funded and the investment made is around \$ 3.000.000 (three million dollars). By January 2017, almost 90 thousands tests were performed - of those, almost 60 thousands were performed between June 2015 and January 2017, during the implementation of 4th phase. Among those 67% were nonwhite and 64% aged 19 to 39 yo. 62% reported drug use and 17% drug use and commercial sex combined. 52% reported condom use at last sexual intercourse and 9% reported STI symptoms in the last 12 months. Overall test performed during the 4th phase, 46% had been tested for HIV at least once before the strategy. The general proportion of HIV positive test found in the 4th phase was 1.6%. Among young people aged 15 to 24yo, ciswomen, transvestites, transsexual women, transsexual men, MSM and heterosexual men it was 1.2%, 0.9%, 6.6%, 5.5%, 1.4%, 3.4%, and 0.9% respectively.

Transvestites and transsexual women constitute a high-risk population for HIV in urgent need of responses able to tackle the vulnerabilities related to the HIV acquisition in these groups. The participation of the key populations, composing the NGOs teams, in the execution of the strategy was crucial to impact structural variables in addition to improve the uptake of prevention technologies through biomedical and behavioral interventions.

23. DOMINICAN REPUBLIC

TITLE OF THE PROGRAMME:

Reducir nuevas infecciones y aumentar las expectativas de vida en personas que viven con el VIH-SIDA en la República Dominicana, de manera sostenible mediante el fortalecimiento de la Respuesta Nacional basados en una coordinación multisectorial y efectiva.

Objetivo Estratégico: Desarrollar programas y campañas de promoción y prevención dirigidas a población general y a los grupos más vulnerables.

Programa Nacional para la Reducción de la Transmisión Materno Infantil del VIH-Sifilis.

CONTACT PERSON

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Programme is being implemented since: Plan Estratégico Nacional (2015-2018)

Responsible party/parties: Government / Civil society / UN or other inter-governmental organisation / Academic institution

Populations group(s) reached: People living with HIV / Men who have sex with men / Sex workers / Transgender / Women / Girls / Young people / Other (migrantes)

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes.
Estrategia Nacional de De Desarrollo 2030. Plan Plurianual del Sector Publico 2015-2018.

CONTEXT

La Respuesta Nacional al VIH y al Sida de la República Dominicana ha evidenciado notables avances con el transcurrir de los años y su compromiso con el impulso de acciones y con la adopción de medidas adecuadas para el logro de las metas asumidas, tanto en el plano local como en el plano internacional.

RESULTS AND IMPACT

La Respuesta Nacional al VIH a trabajó arduamente con el propósito de alcanzar las poblaciones clave (trabajadoras sexuales, hombres que tienen sexo con hombres, TRANS, mujeres en situación de vulnerabilidad, y migrantes) con medidas de prevención combinadas. Entregando paquetes de prevención que incluye lo siguiente: Entrega de condones, lubricantes, Orientaciones a través de charlas informativas y referimiento a realizarse la prueba. Durante el año 2016 se alcanzaron 58,493 trabajadoras sexuales, 62,701 hombres que tienen sexo con hombres, 2,488 TRANS y 42,898 migrantes.

Los avances en la mejora del acceso a los servicios de salud a los jóvenes son los siguientes: Se promovieron acciones de prevención combinadas, se realizó una amplia campaña dirigida al público en general. Los servicios de SSR y VIH se fortalecieron con el apoyo de diferentes agencias: ahora se dispone de un documento sobre la Política Nacional de Salud Sexual y Reproductiva, una estrategia para promover los anticonceptivos; Un Plan Estratégico de la Comisión para la Disponibilidad y Seguridad de los Anticonceptivos y una guía sobre la violencia obstétrica. Se instalaron dispensadores de preservativos y se capacitó a los recursos humanos de salud en el cuidado de la obstetricia respetuosa. Se está implementando una campaña nacional de prevención del embarazo en adolescentes, "Tu No Ta Pa' Eso" que asegure la inclusión del VIH

En cuanto al Programa Nacional de la Transmisión Vertical. Los resultados principales de la evaluación intermedia de la evaluación del Plan Estratégico para la Eliminación de la Transmisión Materno-Infantil (ETMI) señalaron la necesidad de ampliar la prueba del VIH a todos los centros de salud, incluidas las unidades de atención primaria, y de implementar todos los servicios las intervenciones previstas por el PNTMI. Existe el compromiso de fortalecer el enfoque de derechos humanos entre el personal de salud con el fin de evitar el estigma y la discriminación contra las personas afectadas por el VIH y mantener la confidencialidad. La necesidad de introducir un sistema de control de calidad en los laboratorios, así como la necesidad de vincular los sistemas de información del recién nacido y la madre, se consideraron prioritarias para los próximos años. Debido a los resultados explicados anteriormente, el UNICEF y la OPS apoyan a los Servicios Nacionales de Salud fortaleciendo la capacidad de los médicos en la Asesoría, la prueba del VIH y la derivación de las mujeres embarazadas VIH positivas en el Centro de Salud. Es necesario proseguir el duro trabajo sobre la PTMI a fin de reducir la transmisión de madre a hijo, que es del 4,4%.

FINANCING

Los recursos locales para la adquisición de ARV y suministros en 2017 se incrementaron en un 54,45% (en comparación con 2015 y 2016). Un caso de inversión está disponible y permite a las autoridades locales elegir el mejor escenario financiero para la respuesta al VIH. Con el apoyo técnico de diferentes agencias el país ha llevado a cabo Estudios y se han fortalecido los sistemas de información y se dispone de nuevas tecnologías para el acceso a información de calidad sobre

los temas de educación sexual en las escuelas.

En cuanto a los paquetes de prevención, este esfuerzo se realiza con apoyo de los recibidos por el país de parte de Fondo Mundial. Así como las pruebas que se realizan a las embarazadas se compran con el apoyo de estos fondos. Mientras que los fondos para los ARV a las embarazadas se compran con fondos del estado Dominicano.

GOVERNANCE

La Respuesta Nacional a las ITS-VIH/SIDA, en la República Dominicana está trabajando de manera coordinada con las instancias para el fortalecimiento institucional, la eficacia y los mecanismos transparentes tal como lo plantea el PEN 2015-2018.

LESSONS LEARNED AND RECOMMENDATIONS

La estrategia combinada de prevención (entrega del paquete mínimos de prevención, el referimiento a la realización de la prueba de VIH para el conocimiento de su status serológico y los positivos insertos en los servicios de atención integral al VIH), ha sido de las buenas practicas que el país ha implementado, así también el Gobierno Dominicano ha asumido en los últimos años el financiamiento de los medicamentos antirretrovirales (ARV), asegurando sostenibilidad.

La integración a los planes nacionales, de los compromisos internacionales que constituyen un marco de acción favorable para la respuesta al VIH en el país. A partir de estos compromisos se han creado estructuras intersectoriales para dar respuestas a los requerimientos acordados. Además, se han entregado en los plazos establecidos los informes correspondientes a los compromisos contraídos y se han adoptado buena parte de las recomendaciones emanadas de las revisiones.

La visualización de las intervenciones para reducir el estigma y la discriminación mediante un objetivo estratégico en el Plan Nacional Estratégico (PEN 2015-2018), que permite reducir la brecha sobre la desigual de la epidemia en los distintos géneros, el avance en los procesos que definen la diversidad y el surgimiento de evidencias que sostienen la efectividad de un abordaje del vínculo género y VIH imponen la necesidad de impulsar acciones enmarcadas en un enfoque de derechos, basado en algunos casos en la revisión de marcos legales y normativos, el fomento a la participación y el abordaje estratégico de la violencia.

ANNEXES

Componente: VIH	Total	M	F	Año	Fuente
Incidencia (Adultos, 15-49, estimación)	0.03			2015	Estimaciones Nacionales
Prevalencia (Adultos, 15-49, estimación)	0.8	0.9	0.7	2013	ENDESA
Nuevas infecciones diagnosticadas	2,040	1,260	780	2015	Estimaciones Nacionales
Número estimado de personas que viven con VIH (PVVIH).	68,882	35,518	33,364	2015	Estimaciones Nacionales
Número de personas que viven con el VIH (PVVIH) que están en los Servicios de Atención Integral	46,208	21,324	24,884	2016	Sistema Único de registro de los Servicios de Atención Integral (SURSAI)
Número de muertes relacionadas con el SIDA	1,289	714	575	2015	Registro Nacional de Defunciones

24. ECUADOR

TITLE OF THE PROGRAMME:

Servicios de Base Comunitaria para la ampliación de la cobertura y acceso a pruebas de VIH y vinculación efectiva a los servicios de prevención y atención del VIH de las PEMAR

CONTACT PERSON

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Title: Coordinador Comunitario

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Responsible party/parties: Civil society

Populations group(s) reached: Men who have sex with men / Sex workers / Transgender

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

CONTEXT

La epidemia en el Ecuador está concentrada en dos grupos poblacionales: Hombres que tienen sexo con otros hombres (HSH) y Trans femeninas (TF), entre quienes la prevalencia de VIH supera el 5% (11% y 32% respectivamente) (ENS-MSP, 2012), información obtenida a través de estudios transversales de vigilancia realizados hace 5 -6 años: en HSH en Quito (2010 - 2011) y Guayaquil (2011-2012) y en TF de Quito (2012). Si bien estas dos poblaciones son consideradas como prioritarias para la respuesta frente al VIH, la principal política aplicada de prevención y atención del VIH se centran en la prevención de la transmisión vertical (PTMI) a través de la cual se ofrece la prueba de VIH a madres gestantes y sus parejas, y en la atención y tratamiento del VIH por la Red Pública Integral de Salud. Si bien es cierto el acceso a los servicios de salud es para todos los ecuatorianos y se encuentran descentralizados con un enfoque de la atención universal de cualquier condición de la salud, desmontándose las unidades de atención específicas como de las ITS o para las poblaciones como las trabajadoras sexuales, prevalece el enfoque de la atención materno-infantil, lo que ahonda la brecha y extiende los límites del acceso a la atención tanto a los HSH como a las MTF, en particular en su demanda tanto de atención de las ITS como del acceso a las pruebas de VIH y por ende el ingreso oportuno a los servicios de atención y tratamiento del VIH, pudiendo solamente acceder a ellos tardíamente así como su detección tardía de VIH.

La Corporación Kimirina con participación de las comunidades diseñó el Programa de

Servicios de Base Comunitaria de Pruebas de VIH para través de la coordinación con la Estrategia Nacional de VIH y las Estrategias a nivel sub nacional fortalecer la sinergia colaborativa entre gobierno y sociedad civil.

La prestación de los servicios del programa utilizó la metodología de pares a través de los cuales se formaron promotores y brigadistas que trabajaron en los lugares considerados como prioritarios e identificados a través del Mapeo para la Programación, focalizado en los lugares de encuentro de nuevas parejas sexuales y apoyado por Centros Comunitarios y unidades de atención de referencias del MSP realizando actividades de promoción y prevención del VIH así como la realización comunitaria de pruebas de VIH, en cumplimiento de los siguientes objetivos:

- Incrementar la cobertura diagnóstico temprano de VIH, mediante la estrategia de "Prueba de Base Comunitaria dirigida a Población Clave"
- Aumentar el acceso oportuno a los servicios de atención y tratamiento del VIH en el Sistema

En el año 2015, se realizó un piloto del programa para evaluar tanto la factibilidad y aceptabilidad del mismo por la poblaciones clave, así como para evaluar los mecanismos de coordinación con los diversos niveles de la Estrategia Nacional y Zonal del VIH del MSP, piloto que dio como resultado la consolidación del programa para el año 2016 y la fijación de las metas a alcanzar sobre la oferta de las pruebas de VIH tanto para HSH como TF y las actividades de promoción y prevención del VIH.

RESULTS AND IMPACT

- Estrategias Zonales de VIH vinculadas en el monitoreo, seguimiento y evaluación del programa así como en la gestión de la calidad basada en la asistencia técnica y habilitación de los equipos comunitarios.
- Convenios de cooperación con las Estrategias Zonales de VIH para el aseguramiento de la sostenibilidad del programa con la provisión de los insumos de prevención y pruebas de VIH destinados específicamente para las poblaciones HSH y TF y coordinación de servicios.
- Alcance de 11,118 HSH y 2339 TF en actividades de promoción y oferta de pruebas de pruebas de VIH en lugares de encuentro y búsqueda de parejas sexuales, previamente mapeados y que fueron visitados por brigadistas comunitarios.
- 4,521 de HSH y 439 TF solicitaron y se realizaron la prueba rápida de VIH con los brigadistas comunitarios y recibieron orientación sobre servicios de referencia, atención y tratamiento de VIH.
- Centros comunitarios de Asesoría para pruebas voluntarias de VIH, unidades móviles y brigadistas, facilitaron la recurrencia de las poblaciones clave a las pruebas rápidas de VIH de acuerdo a su propia valoración de riesgo y el diagnóstico oportuno al momento de la seroconversión.
- Mayor eficiencia en la vinculación de la población con resultados reactivos al VIH a los servicios de referencia para confirmación, atención y tratamiento.

- La oferta de la prueba fuera del ámbito de los servicios de salud es más eficiente ya que supera los tiempos de espera y horarios de atención.
- Se comprobó el concepto de oportunidad ya que al estar la prueba a disposición en los lugares fuera de los servicios de salud las poblaciones aprovechan el momento y motivación para realizarse la prueba de VIH

FINANCING

El programa fue financiado por: MSM Global Forum (Piloto); Fondo Mundial, Estrategias Zonales del VIH-MSP

GOVERNANCE

La Corporación Kimirina como organismo no gubernamental combina sus esfuerzos a través de la respuesta Nacional del VIH/Sida, coordinando con las diferentes instancias comprometidas en la respuesta tanto a nivel institucional, privado, organizaciones de la sociedad civil y con otros socios como los donantes internacionales como Fondo Mundial, las agencias de cooperación como ONUSIDA, OPS/OMS, otros socios como la Coalición Internacional Sida Plus y la Alianza Internacional contra el VIH/SIDA. El programa se implementa bajo la coordinación del Ministerio de Salud Pública y sus unidades concebido como una extensión de sus actividades extramurales y con la visión del acercamiento de los servicios a las poblaciones clave, contribuyendo substancialmente con recursos no financieros como son los insumos de prevención y habilitando al personal comunitario para el ejercicio coordinado de las acciones.

LESSONS LEARNED AND RECOMMENDATIONS

- El acercamiento de los servicios de prevención y prueba tanto a los HSH como a las TF por parte de brigadistas comunitarios pares en los lugares, aumenta la confianza de estos usuarios ante el testeo frecuente y desmitifica temas relacionados como el estigma y discriminación frente a la prueba de VIH para lo cual es necesario que dichos servicios se constituyan como centros de formación para otros servicios y asegurar de esta manera la cobertura, el mejoramiento de la atención y la satisfacción de dicha demanda.
- El reconocimiento mutuo entre prestadores de servicios de salud tanto a nivel de servicio como administrativo y el personal comunitario permite el establecimiento de alianzas que contribuyen a sortear limitaciones tales como las probabilidades de desabastecimiento de los insumos, las barreras que los mismos servicios presentan a este tipo de usuarios y capitalizan los conocimientos para futuras transferencia de conocimiento en el mismo nivel de los prestadores de los servicios de salud y el desarrollo de acciones conjuntas.
- Las intervenciones basadas en el Mapeo Programático permite la vinculación sistemática de los lugares de encuentro al programa y se constituyen como fuentes de información para las comunidades que asisten a dichos lugares, así como del aumento de la confianza de la población clave frente a los servicios de prevención.

- Aumento en las poblaciones clave del reconocimiento de sus factores de riesgo frente al VIH potenciando la demanda recurrente de las pruebas de VIH evidenciándose en la posterior demanda de recurrencia de los mismos, tanto en los servicios de salud como en los centros comunitarios y con esto la notificación y registro oportuno en el sistema de información.
- HSH y TF vinculan a sus redes personales al programa aumentando la confianza de los mismos en los servicios tanto de los servicios de salud como la aceptación de los Centros Comunitarios como herramientas de apoyo subsecuente para lo cual es clave mantener a los equipos comunitarios actualizados y habilitados para satisfacer dicha demanda, así como asegurar otros recursos como la prestación de servicios de atención de las ITS y otros servicios de laboratorio.

25. GUATEMALA

TITLE OF THE PROGRAMME:

Young indigenous Mayans' leadership program to prevent and reduce the gaps in universal access to information and answers related to HIV and AIDS in Guatemala: Guatemalan Parliament of Children and Adolescents.

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Responsible party/parties: Civil society

Populations group(s) reached: People living with HIV / Men who have sex with men / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes

CONTEXT OF THE NATION

According to the National Institute of Statistics 2012, Guatemala is a multicultural, multiethnic and multilingual country, with a population of approximately 15,073,375 individuals, of which 69% are under 30 years old; 4,152,411 people are between 15 and 29 years old. 5,999,203 (39.8%) inhabitants in Guatemala are indigenous Mayans, and 51% of the population lives in rural areas of the country. According to the Public Health and Social Assistance Ministry's National Epidemiology Center, there is a record of 35,660 HIV cases in the 1984-2016 period, of which 95% is related to sexual transmission, 13,701 are female cases and 21,566 are male cases, in the main five Guatemalan Departments with indigenous population. HIV and AIDS prevalence is found in all groups of age, with the highest number of cases being between 20 and 39 years old (74.5%). (Note: Departments in Guatemala are equivalent to States or Provinces).

The training and HIV - AIDS prevention process within indigenous communities is holistic, just as the planting of corn: the seed is selected, nurtured, fed and harvested. This same process is

done for HIV and AIDS prevention. People with HIV are accompanied, a profile of each one of them is created on a virtual platform (using the four colors of Mayan culture) and the progress of HIV prevention and its response is evaluated in Comprehensive Care Units from the Public Health Ministry. In this way, monitoring of prevention and treatment is strengthened with Mayan ceremonies: some energy is established for each person, according to the Four Chargers, and it is done taking into account the characteristics of knowledge and sexual behavior, and the nature of the job done by the organizations they represent. They are also defined by a color, according to their sexual behavior and knowledge about sexual and reproductive rights. The following table shows the colors and their characteristics:

RESULTS AND IMPACT

480 indigenous adolescents and young people (65% women and 35% men, from Mam, K'iche', Aguakateco and Ixil cultures) are capable of carrying out citizen monitoring through the ICT's.

There is a virtual platform, software and installed applications that can respond to the demand of adolescents concerning their sexual and reproductive rights and improve the effectiveness of information in real time.

Through the exercise of civil responsibility from adolescents and young people, the provision of relevant quality sexual education, family planning methods, emergency kit, HIV testing and easy access to antiretroviral treatments, the demand has been successfully achieved.

It has been possible to monitor health services according to the sexual and reproductive rights indicators recognized by the Guatemalan Government; UNGASS, BEGING 20 and ODM.

Relevant data on sexual and reproductive rights has been published and spread from a youth's rights view, so that it can involve authorities in the analysis of demand and supply, and then look for effective strategies to improve access to information.

19 community radio broadcasters transmit information about the sexual and reproductive rights of adolescents and young people and promote a virtual monitoring platform in local languages with an audience of 15,000 families.

Adolescent men and women produced a communication campaign to eliminate stigma and discrimination towards people with HIV in the community environment in mostly indigenous communities. The campaign was held through social networks, community radio broadcasters and local cables, during a period of 6 months with the participation of seven Departments of the country.

The leaders who form the Guatemalan Parliament of Children and Adolescents have been able to develop pairs of adolescent to adolescent through the methodology of the planting of corn.

Adolescents and young people have HIV test days in each of the municipalities, speaking local languages to guarantee high reliability.

FINANCING

HIVOS International and UNICEF

GOVERNANCE

The intervention methodology consisted of organizing groups of adolescent and young indigenous Mayans in three departments of the West: Quetzaltenango, San Marcos and Sololá de Guatemala, selected by indigenous authorities such as midwives, spiritual leaders and committees under the Mayan worldview who promote HIV and AIDS prevention using their indigenous language and information community media. The process started with monitoring health services in Indigenous communities, with the intention of later being able to demand changes to violations of Indigenous peoples rights, according to ILO Convention 169 and the United Nations' Declaration on the Rights of Indigenous Peoples, to have information services and access to HIV tests and medicines understood and accepted in Indigenous communities of Mayan people in Guatemala.

Leadership was formed using the corn process as a methodology (corn in the Mayan world is spiritual and sacred), Mayan colors (red, black, yellow and white), the Four Chargers that support time and the Universe (the Sun, the Moon, Venus and the Earth) and 4 leaders in the communities, selected in each municipality to integrate 60 participants (men and women). In addition, leaders have an influence on decision-makers within municipalities, and they are recognized by organizations such as the Observatory on Sexual and Reproductive Health (OSAR, Spanish initials), the Multisectoral Departmental Network on HIV and AIDS, Naleb Indigenous Agency, Friendly Spaces (which belong to health centers from the Health Ministry) and the base group of the Guatemalan Parliament of Children and Adolescents.

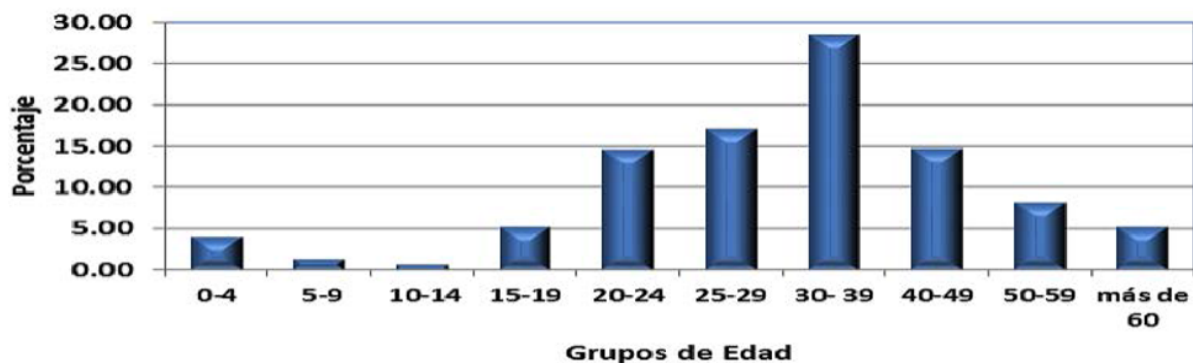
LESSONS LEARNED AND RECOMMENDATIONS

Indigenous HIV prevention activities must fit into the cultural framework in order to be successful. Mainstream interventions do not work in Indigenous communities. When working with Indigenous Peoples and communities there is a duty to consult BEFORE developing methodologies and implementation strategies as enshrined in the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). Free, prior and informed consent is essential. Indigenous Peoples have collective rights as well as individual human rights meaning that the recognized Indigenous authorities must be engaged and their consent received before approaching individual community members, who also have the right to say yes or no in regards to participation in any intervention.

ANNEXES

Division according to color and characteristics			
Charger		Characteristics	Characteristics description
	Kej	Sexually active	Adolescents and young people with HIV, pregnant adolescents, men and women living together or married
	Noj	Conservatives	Adolescents who participate in young religious groups – JACRO, EVANGELICAL ALLIANCES, YOUNG ADVENTIST CORES
	Iq`	Those who speak freely about sexuality	Adolescents who participate in youth networks with training processes in integral sexual education
	E`	Those with no sexual education	Adolescents from educational centers and adolescents with no educational background

VIH Porcentaje de Casos por Edad, Guatemala 2014



26. HONDURAS

TITLE OF THE PROGRAMME:

U.S. Government/PEPFAR Key Populations Work in the Garifuna Indigenous Population in Central American Regional Program

CONTACT PERSON

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Programme is being implemented since: 2012

Responsible party/parties: Government

Populations group(s) reached: Indigenous People

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? N/A

Is the programme part of a national plan other than the national aids strategy? N/A

DESCRIPTION

The U.S. government has partnered with the Honduran Ministry of Health to provide HIV services to the ethnic minority Garifuna community since 2001. Integrated bio-behavioral surveillance surveys conducted with technical assistance from PEPFAR in 2006 and 2012 demonstrated high HIV prevalence rates among the Garifuna, standing at over 4% in both surveys- tenfold higher than the national prevalence estimate. HIV services are provided at Ministry of Health clinics and community outreach services are provided by local Garifuna civil society organizations. A wide range of services has been provided: prevention services, HIV counseling and testing, and linkages to care and treatment. As an effect of these comprehensive HIV preventive interventions, condom use with an occasional partner rose from 32 percent in 2004 to 98 percent in 2009 within the adult population. Another example of this approach was the diffusion of a educational radio drama series geared toward 38 Garifuna communities along the north coast of Honduras, reaching 47,133 beneficiaries (19,596 males; 27,537 females). A rapid survey conducted shortly after the broadcast began showed 82.6

percent of the target audience reported accurate recall of the HIV prevention messages within the radio drama, demonstrating both its reach and clarity of message, and an increase in HIV self-efficacy and condom use among regular listeners. Due to effective promotion of VCT services and scale-up of mobile units, HIV testing among the Garifuna has significantly increased, reducing the proportion of positives found. During July-December 2016, 1154 people were tested through PEPFAR support, with a 1.2% yield. In 2017, seroprevalence, behavior survey and clinical cascade studies are being implemented in eight Garifuna communities, in order to provide updated information on the HIV situation among this ethnic group.

42. MEXICO

TITLE OF THE PROGRAMME:

National HIV prevention strategy

CONTACT PERSON

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Programme is being implemented since: 2013

Responsible party/parties: Government / Civil society / Academic institution

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers / Transgenders / Women / Girls / Young people / People in detention

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes.
Health sectoral programme.

DESCRIPTION

Since 2013, the national HIV and STD program in Mexico has developed an integrated strategy to prevent HIV and other sexually transmitted infections among key populations, in strong collaboration with NGO's in order to maintain the HIV National Response at the end of grant funds by Global Fund.

One of the main components of the strategy is a community-based approach focused to the populations in greater risk and vulnerability reached through peers. More than 24 million US dollars of public funds have been invested in the last five years for the implementation of community projects based on scientific evidence, human rights and gender perspective, focused to strength HIV and STD detection, health promotion and HIV prevention.

All the projects were linked with public health services, HIV detection and preventive supplies (rapid tests, condoms, lubricants and syringes) and with active participation of each population, in order to reach the fast-track targets 90-90-90, to reduce the number of unprotected sex practices and increase the social marketing of preventive supplies. The HIV and STD National Program invested in additional 29 million US dollars for HIV and syphilis supplies. At the same time, academic institutions developed strategic projects to evaluate and improve the HIV community strategy and HIV policies.

Based on our experience, it is necessary to distribute reliable information, free of stigma and discrimination that promotes respect for the rights of all people; therefore, we designed a strategy to promote information through the hotline Telsida and our powerful and influential social networks in the region.

Innovative strategies as PrEP are already in a pilot project in Mexico, supported by UNITAID and in coordination with Brazil and Peru.

ANNEXES

www.gob.mx/censida

www.telsida.org

www.smap.censida.net

27. PARAGUAY

TITLE OF THE PROGRAMME:

Men's Wellness Center "Kuimba'e"

These findings were extracted from the case study "Innovative Community-Based Responses to HIV: Good Policy & Practices of SOMOSGAY in the National AIDS Response in Paraguay - Milestones and Lessons Learned with the Kuimba'e Clinic" developed in October 2016.

CONTACT PERSON

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Programme is being implemented since: SOMOSGAY started its activities in 2009 and the Kuimba'e Clinic in 2013.

Responsible party/parties: Government / Civil society

Populations group(s) reached: People living with HIV / Men who have sex with men / Transgender / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

Gay men and other men who have sex with men (MSM) account for almost one in two HIV diagnoses among men in Paraguay, yet policies and programs to prevent HIV transmission among gay men are not fully developed. SOMOSGAY is the leading LGBT organization in Paraguay and one of the most relevant groups working on HIV policy-making and advocacy in Latin America, and has put in place its own programme to address this situation.

With a strong community-based component, the health area of SOMOSGAY started in 2010 as a community testing and counseling center for rapid HIV testing for gay and bisexual men and other MSM. This model of testing center evolved later on, in 2013, to the Kuimba'e Clinic, becoming the first men's wellness center focused on HIV and STI diagnosis for gay men in Latin America. "Kuimba'e" means "Men" in Paraguay's indigenous and native language, Guaraní, and

this clinic has now expanded programs on linkage to care, peer-to-peer counseling as well as other services that are free of charge for users, with referral, support and constant follow-up in collaboration with the Ministry of Public Health in Paraguay.

RESULTS AND IMPACT

In 2013, SOMOSGAY set up the first men's wellness center in Latin America for and by gay men and other MSM. Among other services, it provides a package of essential HIV combination prevention services to one of the key populations most affected by HIV in Paraguay. Over five years of operations with the Kuimba'e Clinic, SOMOSGAY has provided high-quality data and an extensive collection of best practices that have enriched local processes through the National Forums on Epidemiology, as well as in other areas of discussion and decision-making on budget, strategic planning, monitoring and evaluation of actions on HIV/AIDS.

In adapting the first model of testing center, which started as a basic site for early HIV and STI diagnosis for gay men, the Kuimba'e Clinic adopted three major modalities of combination HIV prevention to its work, including (see annex image in page 3 for more detailed information):

- Biomedical interventions that use medical and clinical methods (provision of condoms, water-based lubricants, antiretroviral treatment for those living with HIV), as well as other treatment as prevention modalities, including PrEP;
- Structural interventions that include the promotion of safe and enabling environments for LGBT people as well as interventions aimed at reducing stigma and discrimination based on sexual orientation, gender identity and expression and HIV status, among other, and also
- Behavioral interventions that encourage safer behaviors (risk-reduction counseling, peer-to-peer education programs, social marketing campaigns), etc.

The Kuimba'e Clinic offers primary clinical care, rapid HIV testing, peer counseling, psychological support, legal counseling and linkage to care for more than 1,080 people living with HIV, with constant monitoring of the National AIDS Program and the Ministry of Health, working to meet the 90-90-90 goals as recommended by UNAIDS. 98% of these people receive treatment through the Kuimba'e Clinic and, since opening in 2013; the center has provided comprehensive prevention packages to more than 8,326 users and has implemented several educational campaigns combined with outreach services.

In 2017, this model of community clinic is looking to scale up services in order to sustain actions for innovative health and wellbeing strategies, including a strong component on available new prevention technologies such as pre-exposure prophylaxis (PrEP) along with other actions currently recommended by UNAIDS to achieve the 90-90-90 targets as well as by WHO in the new consolidated treatment guidelines.

FINANCING

SOMOSGAY has identified the lack of funding opportunities for community groups as a constant challenge to develop advocacy plans and other service delivery actions. We believe funding needs and must be assessed at local and national levels, and data suggests that HIV/AIDS budgets must be based on realistic costing of prevention services. We also believe that advocacy may be needed to ensure that governments invest in their / our own HIV response, where necessary national budgetary allocations to health may need to be increased.

A quick estimation of costs related to our clinic activities showed that the average amount spent (invested) in each user did not exceed USD 29.14 per capita in 2015, and as other analyzes done in the past showed (USD 52.25 per capita in 2013 and USD 49.99 per capita in 2014), these findings prove our model to be highly efficient, replicable and cost-effective.

GOVERNANCE

SOMOSGAY has a Board of Directors responsible and elected under the current statutes of the association, with a formal description of the roles and functions each Board member should develop. The organization keeps a record of proceedings, meeting notes and agendas, attendees and decisions made, and Board members participate in the process of developing the strategic objectives and policies of the institution. The organization has a strategic plan focused on sustainability and this is outlined in the mission and vision of the organization.

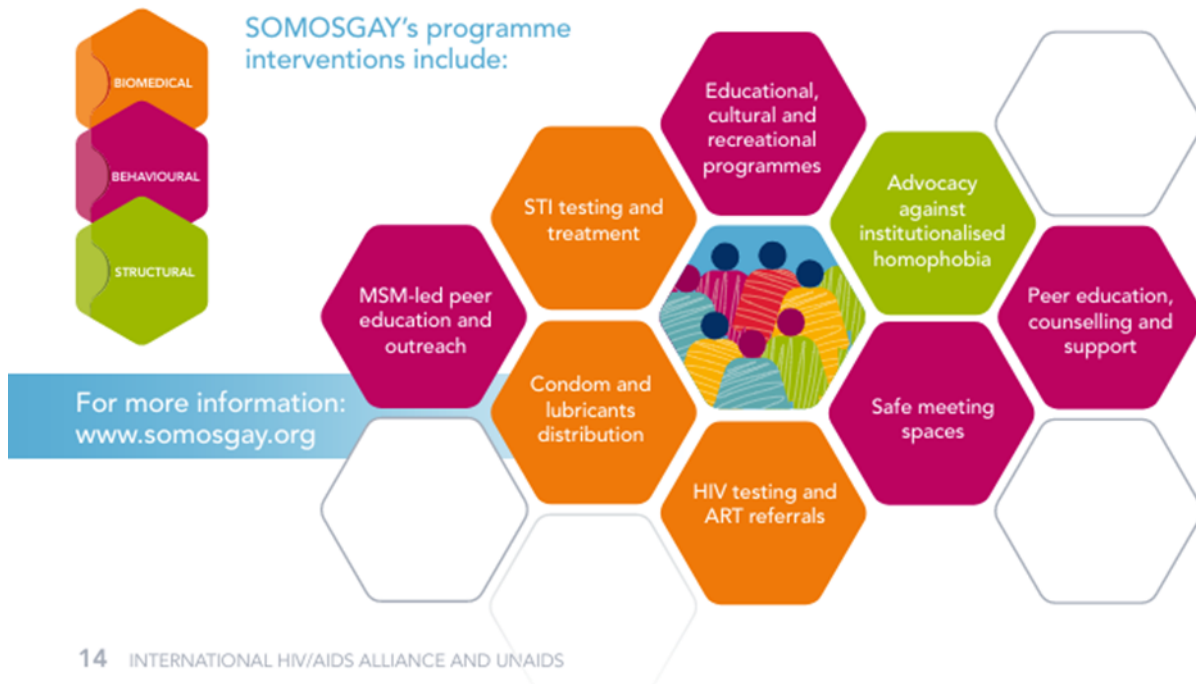
LESSONS LEARNED AND RECOMMENDATIONS

SOMOSGAY aims to present and utilize the accumulated evidence of eight years as a tool for advancing advocacy actions and community service delivery at the local and regional levels. Our organization has learned so much and since become one of the few community-based groups in Latin America that promotes holistic health services for gay men and other MSM. Our recommendation is for similar services to be open to all citizens, it is expected that such safe environments encourages consultations with younger gay and bisexual men, as well with heterosexual men and those engaged in sex work, since these also suffer significant barriers in access to health services in general.

The biggest challenge has been, and still is, to keep working and strengthening the territorial work that also has to do with the more bureaucratic and formal aspects of the work. Working in a community-based organization is a permanent advocacy with people, politicians, social leaders, the media, other organizations and social movements.

ANNEXES

See image showcasing the levels of interventions made by SOMOSGAY (developed by The International HIV/AIDS Alliance and UNAIDS in 2016):



V. WESTERN EUROPEAN AND OTHER STATES

28. CANADA

28.1. TITLE OF THE PROGRAMME:

Women's Leadership and PAW Den Paw-licy Statement

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Programme is being implemented since: 2007

Responsible party/parties: Civil society

Populations group(s) reached: People living with HIV / Sex workers / Women

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? Yes.
Aboriginal Strategy on HIV and AIDS in Canada and Environments of Nurturing Safety

CONTEXT

Research and programming to support Indigenous women living with HIV has been rooted in responding to issues of vulnerability, abuse and ill health. Prevention has been oriented towards reducing risk of exposure to HIV by addressing violence and highlighting the sacred role of women in Indigenous culture. The 2010 research report "*Our Search for Safe Places: A Qualitative Study of the Role of Sexual Violence in the Lives of Aboriginal Women Living with HIV/AIDS*" described how sexual violence negatively influences Aboriginal women's ability to negotiate health management, to protect themselves from exposure to HIV, and in the case of Aboriginal women living with HIV/AIDS (AWHAs), to effectively manage their HIV.

While this was timely and powerful research, the resulting story did not meet the prevention needs of Indigenous women in Canada. Women were searching for 'safe spaces' which mobilized a strengths-based response to women's leadership. Acting on the research, a new project developed the Positive Aboriginal Women's (PAW*) Den Paw-licy (policy). The PAW-

licy statement is endorsed by the Canadian Aboriginal AIDS Network Board of Directors and designed to highlight the sacred role of women, the needs of women and families AND suggest how to operationalize a supportive response. Scale up and endorsement is reinforced through dissemination and the ongoing actions of the Canadian Aboriginal AIDS Network to re-orient programming and research to a strengths-based approach

FINANCING

The original research and follow-up project were funded at CAD \$350,000. Scale up is very low-cost requiring adoption of the PAW-licy, intentional re-orientation within an organization towards strengths-based research and program design and implementation as feasible of PAW-licy recommendations. Implementation might range from a small budget for snacks to office renovation to make new spaces available.

GOVERNANCE

All activities related to this initiative are governed by the Canadian Aboriginal AIDS Network Board of Directors. Project specific leadership is supported by the Voices of Women (VoW) Committee in and implemented by the Research and Policy Unit in research design.

LESSONS LEARNED AND RECOMMENDATIONS

Approaching Prevention from the context of honouring the sacred role of women in Indigenous culture, identifying strengths and facilitators of good health and well-being, safety and family need has a profound impact for Indigenous women 'at risk' and living with HIV. This approach also inspires staff and researchers to design prevention interventions that reinforce positive approaches rather than fight to change negative realities. This is not a naïve rejection of the challenges that women must overcome and/or experience regularly but a mindful effort to create safe, respectful and secure alternative solutions to putting a 'Band Aid' on a barrier.

*the term PAW was first proposed by Kecia Larkin

ANNEXES

PAW Den PAW-licy

Aboriginal people across Canada are working to address the impacts of HIV and AIDS in the lives of Aboriginal women. The Canadian Aboriginal AIDS Network (CAAN) completed the research project *Our Search for Safe Spaces: A Qualitative Study of the Role of Sexual Violence in the Lives of Aboriginal Women Living with HIV/AIDS* in 2009. This research maps connections between gender, culture, HIV, sexual violence and impacts on health management. The report clearly provides evidence regarding the gendered issues of colonization, poverty and sexual violence. These issues continue to disrupt the collective wellbeing of Aboriginal communities, establishing harmful beliefs and practices that put

Aboriginal women and girls at high risk for violence, HIV and AIDS. In response to this context, HIV Positive Aboriginal Women (PAW) along with representatives of CAAN member organizations have organized nationally as the standing committee CAAN Voices of Women (VOW).

Environments of Nurturing Safety (EONS): Aboriginal Women in Canada, Five Year Strategy on HIV and AIDS, 2010 - 2015 (CAAN, 2010), details a coordinated effort among existing organizations and strategies to make desirable outcomes for 2015 achievable. Central to this effort is the creation of safe spaces and networks which support Aboriginal girls and women to learn, heal and contribute to the strategy. These “PAW Dens” are havens for women, whose healing and experience will provide guidance, wisdom and support for all other branches of the strategy.

There is an immediate need to improve the circumstances of PAW, by alleviating poverty and improving access to services which help PAW to manage their health and to sustain their families and communities. The continuum of sexual violence present in the lives of many PAW makes it difficult to manage chronic illness. Gender-based violence occurs in public and private domains and includes any act that is likely to or does result in harm or suffering of a girl or woman, including threats of violence, coercion or arbitrary deprivation of liberty (WHO 2009:1). To respond to this, CAAN recommends the creation of environments where PAW can thrive; nurturing spaces to address the impact of trauma and violence. Together, men, women, children, and Elders can all support PAW and their children in every region of Turtle Island. We invite all CAAN member agencies and organizations which provide services to PAW to join us in this work by adopting and implementing the policy statement below;

Policy Statement

The {insert organization name} is committed to “stand up and speak up” to stop gender-based violence and its role in the spread of HIV and AIDS among Aboriginal women and girls. Specifically, establishing safe spaces that support PAW wellbeing in the context of HIV and AIDS is a priority. These safe spaces, “PAW Dens” are part of rebuilding the sacred circle within Aboriginal communities. As an organization, {insert org acronym or name} is committed to:

- 1. Strengthen the networks and supports for PAW, their children and their partners (whether male or female).*
- 2. Collaborate in the improvement of the availability and accessibility of culturally appropriate care, treatment and support services for PAW.*
- 3. Contribute to policy shifts to remove and /or alleviate existing barriers to services and safety for PAW and their children.*
- 4. Increase prevention, education and awareness of HIV and AIDS for ‘at risk’ populations of Aboriginal women and girls.*
- 5. Continue to undertake community based research specific to Aboriginal women and girls.*

Policy is most effective when it is directed to a specific audience. The following recommendations are suggestions to meet the unique needs of PAW in various settings and/or systems:

Recommendations for Aboriginal Organizations:

- Allocate space, money, and/or time for Positive Aboriginal Women (PAW) to meet, share and support each other.

- Creatively and directly respond to child care, transportation, scheduling and accessibility needs.
- Use technology and travel to connect PAW who are isolated.
- Consult with PAW about ways to involve men and boys in this initiative.
- Consult with PAW about ways to involve their life partners in this initiative.

Recommendations for HIV and STI clinics:

- Learn about the role/impact of violence in Aboriginal Women's lives.
- Link services with trauma counselling that is culturally safe and gender specific.
- Account for the context of trauma in all service delivery: sexual, emotional, and discriminatory violence are all traumatizing; services must not re-traumatize.
- Eliminate gender based barriers to accessing HIV and AIDS service provision such as:
 - o accommodating children and/or childcare needs,
 - o building awareness and sensitivity to trauma-based anxiety surrounding medical examinations (particularly related to women's health).
- Provide anonymous testing in discrete settings for women at risk for violence with increased awareness that the risk of violence may be from intimate partners.

Recommendations for communities and governments:

- Pursue policy, programs and infrastructure to support secure housing, income, food and clothing for PAWs and their families.
- Provide domestic services for PAW in response to episodic needs which will contribute to supporting families remaining together.
- Educate Positive Aboriginal Women: trauma and illness interrupt learning.
- Implement Harm reduction strategies that reduce HIV and AIDS infection rates.
- Encourage, promote and increase early identification and treatment of HIV to reduce AIDS.
- Fund and promote education by and for Aboriginal people and communities about HIV and AIDS.

Recommendations related to Justice Systems:

- House Trans-gendered PAW safely and respectfully when they are in jails or prisons.
- Deliver continuous care and nutritional supplements to PAW inmates.
- Provide opportunities for PAW inmates that include counselling, traditional and cultural healing methods such as access to an Elder, smudge and prayer.
- Create awareness that supports PAW who have partners in institutions and are striving to care for them while also maintaining their own health and possibly caring for a family
- Develop resources that help people newly released from jail or prison and their partners to reduce risk of harm while transitioning to a return to community life.

An implementation Guide has also been developed.

28.2. TITLE OF THE PROGRAMME:

The Sex You Want- an Ontario response to gay and bisexual men's health

CONTACT PERSON

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Programme is being implemented since: The Sex You Want launched on January 23 2017

Responsible party/parties: Civil society: The campaign was funded by the Ministry of Health and Long Term Care (Ontario)

Populations group(s) reached: People living with HIV / Men who have sex with men

Has the programme been evaluated /assessed? Yes: ongoing comprehensive evaluation plan. We do have preliminary data to share.

Is the programme part of the national aids strategy? No, it is part of a provincial HIV strategy in Ontario, Canada.

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

In the Canadian province of Ontario, gay, bisexual and other men who have sex with men remain disproportionately impacted by a sustained high rate of HIV incidence. This is similar to other high income settings and increasingly, low and middle income regions.

In January 2017 the Gay Men's Sexual Health Alliance launched a comprehensive online sexual health promotion campaign for cisgender and transgender gay, bisexual and other men who have sex with men. The Sex You Want (www.theseyouwant.ca) was developed in response to the increasing relevance of new HIV prevention technologies like PrEP and 'treatment as prevention' in the lives of men who have sex with men and to support a provincial network of AIDS service organizations in communicating complex biomedical information.

Feedback on the campaign has been universally positive with many appreciating the sex positive tone, inclusive language and creative direction. The Global Forum on MSM and HIV (MSMGF) referenced The Sex You Want in its endorsement of "Undetectable = Untransmittable"- <http://msmgf.org/msmgf-endorses-consensus-statement-sexual-risk-hiv-undetectable-viral-load/>. The campaign content spans many topics including primary sexual

health strategies (condoms, nPeP, PrEP, UNDL) for HIV prevention but also the importance of regular testing, accessing HIV treatment and addressing syndemic health impacts. Together in both English and French it comprises 120 pages of content including: animated videos, comics, info-graphics and web copy.

The Sex You Want was funded by the Ministry of Health and Long Term Care, AIDS Bureau. The attached campaign toolkit includes more contextual information about this tailored health promotion initiative. Lessons learned from the development, implementation and evaluation of The Sex You Want will inform other priority population health campaigns in Ontario and has broad applicability to others working in the HIV response.

The campaign has reached its audience of gay and bisexual men across the province. Requests have been received from organizations in Canada and in the United States to use it in their work providing education and outreach to affected communities. There is potential for scale up of the campaign across many settings and for organizations who include sexual health education in their mandates.

For more information on the GMSH please visit www.gmshe.ca

See our campaign at: www.thesexyouwant.ca

ANNEXES

- campaign analytics report for the time period January 23-March 20th 2017
- campaign toolkit

29. FRANCE

TITLE OF THE PROGRAMME:

FAQ AIDES' role in community mobilisation, research, advocacy administrative process and expert recommendations in getting PrEP authorized in France

CONTACT PERSON

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Programme is being implemented since: 2016 for the FAQ, but involvement on PrEP goes back at least to 2011

Responsible party/parties: Civil society

Populations group(s) reached: Men who have sex with men / People who inject drugs / Sex workers / Transgender / Women

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

Pre-exposure prophylaxis (PrEP) has been available in France since January 2016. Civil society and in particular, AIDES played a central role in obtaining this additional arm to fight HIV in France.

AIDES is a French, community led and based NGO with over 800 volunteers and 450 salaried staff. Its aim is to mobilize and empower individuals and communities to transform society to fight HIV infection and viral hepatitis. Whilst remaining resolutely political since its creation in 1984, AIDES response to the epidemic changes as the epidemic and its effects evolve. Over the years, these changes have meant the contents of words like support, harm reduction and prevention have shifted from what they originally encompassed. For AIDES, they have changed primarily because the meanings for our communities have changed. Prevention, once based on condom and clean needles promotion, now has a range of physical and medical tools available to minimize the risk of passing on or becoming infected with HIV. What has not changed,

however, is that generalized access to these prevention tools has to be argued and fought for and then defended.

For AIDES it has always been important to make sure claims and demands for change are grounded in evidence. Based on the wish to respond to expressed needs aggregated from our field workers and identified by analysis and collection of our statistics, the research department has undertaken numerous community-based projects to enrich and create new knowledge. Several of these have been specifically on PrEP.

- IPERGAY, 2012-2016, was a study looking at the efficacy of an intermittent dosage regime of PrEP (Truvada) coupled with community peer support. It was carried out in conjunction with ANRS. 400 participants
- Flash PrEP France, 2014, was carried out to investigate interest and possible barriers for PrEP amongst HIV-negative people attending AIDES rapid testing facilities. 3000 respondents (self-funded)
- Flash Prep Europe, 2016, looked at harmonizing data on knowledge, interest in using and actual use of PrEP across 12 European Union countries. 15800 respondents. (self-funded)

As the results of the first two studies became available, both the research and the advocacy teams started to use them to build up social demand in the communities and to communicate publicly on the needs and results at conferences and via media. We used them to influence clinicians and experts when working on French recommendations for HIV (Rapport Morlat) and to lobby the Health ministry both publicly and privately to create the right framework for PrEP delivery and for it to be made available using a temporary authorization.

The announcement in November 2015 that PrEP was to be made available in France, fully reimbursed by the health system, and caused great interest amongst both European civil society colleagues and beyond. AIDES was inundated with requests to explain and share 'how we did it'.

We started to compile the questions being asked and decided to bring them together in a FAQ.

RESULTS AND IMPACT

The FAQ covered the following questions: (the complete version with our answers is provided in annex)

- How did PrEP get started in France?
- What is the current legal framework for PrEP access?
- How was the RTU (temporary authorization) obtained?
- What are the expert recommendations for implementing PrEP in France?
- Exactly which populations are concerned?
- How many people are likely to receive PrEP?

- Who can prescribe PrEP within the legal framework?
- What does community peer support consist of? What does the training involve, and who provides it?
- Is the hospital network going to be able to meet the demand? Does it have sufficient resources for this?
- What coverage (reimbursement) is provided for the medications?
- What coverage (reimbursement) is provided for the medical visits and laboratory tests?
- What is the cost of PrEP to the public health insurance program?
- What about physicians who aren't "for" PrEP? Can they choose not to prescribe it?
- Is PrEP also used informally?
- Is there a black market for PrEP?
- Has there been any protest against the government's decision?
- How do you mobilize the community?
- How do you talk about PrEP to communities?
- Are the mobilized communities only MSM, or have you also worked with DU, trans, SW, migrant or other organizations?
- Are all the populations exposed to HIV being informed about PrEP? Is there a good level of coverage?

The FAQ was sent to all the NGO on the EU's Civil Society Forum list. It was then transferred to discussion groups within member's organizations such as European AIDS Treatment Group, AIDS Action Europe, and International HIV Partnerships.

Not only was feedback generally positive, it created further specific questions which we answered directly.

It contributed to keeping AIDES centre stage on questions of PrEP. We were asked to give feedback at the Civil Society Forum meeting on the roll out of PrEP. Requests for speakers at national conferences in Germany, the UK and Finland to talk specifically about how to advocate for PrEP in addition to sharing experiences about the format of delivery and the barriers people still meet in accessing PrEP in France.

FINANCING

In 2015, AIDES had a budget of 42.9€ million of which 18.8€ million came from private sources.

GOVERNANCE

AIDES is governed by an administrators board of volunteers, renewed every two years by the 800 volunteers. The administrators elect the president.

LESSONS LEARNED AND RECOMMENDATIONS

- This was perhaps dependent on the national context on France, however it illustrates a magic formula, a mobilized community taking full and integral part in scientific research, adding to a knowledge base which it then used in lobbying and advocacy at a national and then international levels
- Imagine from the start that you will want to share the experience at one point, so keep a tab on everything you do that contributes to achieving your goal. It makes modelling your response easier when you come to share experiences and if you're from a non-English speaking country seriously consider a translation budget.
- Remember that civil society needs to know what is being done every
- Think about methods and channels of internal communication. Particularly true in bigger organizations. This was a prime example of the left hand needing to know what the right hand was doing so as to coordinate efforts and create virtuous circles (eg. Between the researchers and those advocates working with the ministries on the new health act, and with those working on the expert recommendations for HIV)

We started thinking about and working on our advocacy plan whilst still at the beginning stages of Ipergay research. It is an important link so as to hit the ground running when the results start coming in.

30. PORTUGAL

30.1. TITLE OF THE PROGRAMME:

ICAT – Intervenção Comunitária para a Adesão à Terapêutica (Community Intervention for Adherence to Therapeutics)

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Responsible party/parties: Civil society

Populations group(s) reached: People living with HIV

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

Amadora and Sintra are two regions of Lisbon district, with significant population groups with high health illiteracy and poverty. A large number of African immigrants living here and in addition to the above characteristics, they also have difficulties with Portuguese language, the illegal situation in the country, living in slums and/or housing overcrowding.

With around 700,000 inhabitants, these two cities have maintained a high incidence rate for HIV: Amadora with 35.6/100,000 inhabitants and Sintra with 22.1 (2015 data).

A single hospital serves these two cities and the work of AJPAS with people living with HIV has been developed in partnership with the hospital infectious disease service. Due to the high number of people who don't comply with the treatment, reported by hospital, since 2010 we have developed a health education and treatment project, with the aim of promoting adherence and retention in treatment, trying to make disappear the causes of non-adherence and/or withdrawal of treatment. People are referred to us by hospital infectious disease service, with which we are in permanent contact, giving the feedback of the patient evolution.

In this project, we adapt the support to the needs and characteristics of patients. We work mainly with immigrants living in social exclusion situation, with difficulties in the Portuguese

language and health illiteracy. Their poverty condition also puts them at a disadvantage in accessing health services and others. Beyond these factors, cultural and religious issues are, in many cases, obstacles to understanding the disease and to good treatment adherence.

After identifying the difficulties of each person, an intervention plan is defined, to try to give them skills for a good management of their illness. This intervention may include: health education, psychological support, social support, collection of antiretroviral medication at the hospital pharmacy, organization of medication and delivery in their homes. Social support includes legalization, job search, support for trips to medical appointments and exams, food support, etc. We also have African workers who go with patients to the medical appointments serving as translators.

The work is carried out, mainly in the context in which patients and their families live.

After 18 months it is intended that the patient has reached autonomy for the management of the disease and will be discharged from the project. In the following 2 years, a follow-up is made, with semiannual contacts to verify that adherence is maintained.

- Every year we get very close results. In 2016, 103 people were integrated in this project, of which 82% reached and kept undetectable viral load. Of the 15% who did not reach, 40% had a viral load of <200 copies. 3% didn't have analytical results because they have integrated the project in the last 3 months of 2016.

In addition to the positive impact on the general health of these people, this intervention promotes an increase in health literacy, particularly in relation to HIV infection, and greatly contributes to adherence to treatment and retention in health services. Consequently, it has a strong impact on improving the quality of life of these people and their families.

- From 2010 to 2013 this project was funded by the national AIDS program and since 2014 by the pharmaceutical industry.

- This project has 1 project manager and one multidisciplinary team composed of 1 psychologist, 1 nurse, 1 social worker and 2 mediators (pairs).

LESSONS LEARNED AND RECOMMENDATIONS

Health is not a priority in very socio-economic disadvantaged contexts.

- Cultural and religious issues can be major obstacles to treatment adherence and retention in health services, and peer intervention is therefore indispensable.

- People with multi diseases, people with psychiatric and/or neurological disorders, very old people, they can't achieve autonomy for the management of their health, so their adherence and retention in treatment will always require extra-hospital support.

30.2. TITLE OF THE PROGRAMME:

RESEARCH AND PRACTICE: A Community Driven Screening Network

CONTACT PERSON

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Programme is being implemented since: 2015

Responsible party/parties: Civil society / Academic institution

Populations group(s) reached: Men who have sex with men / People who inject drugs / Sex workers / Transgender / Other: Migrants

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

At the time of the ambitious 90–90–90 HIV targets, and in general to cope with the SDGs, new strategies are needed for what the UNAIDS scientific and technical advisory committee called a HIV testing revolution. HIV testing is the gateway for care, still being the late HIV diagnosis identified as the single greatest barrier to increase rates of viral suppression globally. To achieve the desired 90% of people living with HIV knowing their HIV status by 2020, countries need to reach those less aware but who need to be tested. Knowing and eliminating barriers to HIV test and moving testing services to the communities require combined efforts from concerned communities, public health practitioners and scientists.

In Portugal, in 2015, some 50% of the 990 HIV diagnosis notified were considered late diagnosis and Portugal presented one of the highest AIDS diagnosis rates among EU/EEA countries (2.3 vs 0.8 per 100 000 population). Sex between men, which is the main transmission mode in the other EU/EEA countries, is reported in 39.2% of new infections in Portugal and, for the first time since 1984, represented over 50% of all new HIV male cases, reflecting a consistent time increase, both in absolute numbers and relative contribution. Nowadays, it is also estimated that sharing of injection material — typically relevant for concentrated epidemics — is responsible for less than 5% of the new cases in Portugal. A quarter of new HIV diagnoses

occurred in people born outside Portugal, three quarters in sub-Saharan African countries. It is estimated that over 80% of the newly diagnosed individuals in 2015 lived mainly in the larger urban areas. Broadly speaking, this portrait of the Portuguese epidemic points to relevant asymmetries shaping the risk profile, but also access to screening tests, further reinforcing the importance of a strategy designed towards the most affected populations — such as men who have sex with men (MSM), sex workers (SW), migrants and injecting drugs users (IDU) — for whom prevalence estimates reach 10% (except regarding migrants).

As it is now recognized and recommended, HIV testing can be an opportunity to screen for other communicable diseases (such as viral hepatitis and syphilis) which frequently coexist with HIV due to shared transmission routes and for which much less is known about the frequency and time trends.

Lack of high quality data and scientific networks connecting research, practice and community leadership, prompted academic and community leaders to call for a national and community driven response to increase HIV, viral hepatitis and STI testing and linkage to care among key populations, developing new strategies and in-depth continued cooperation. A Community Screening Network was established involving community structures, an academic partner and a tertiary hospital. It aimed at implementing an additional and decentralized access to HIV, hepatitis B and C and syphilis testing, ensuring effective support and monitoring along the process of linkage to the Portuguese National Health Service (SNS) structures. These networks was designed also as a research infrastructure, providing adequate conditions to cross-sectional evaluations, and prospectively study the incidence of these infections, their predictors and test possible interventions.

RESULTS AND IMPACT

The community screening network was able, so far, to involve 28 community-based structures from 18 organizations to whom training and testing kits were offered, as well as, centralized laboratorial supervision, in-loco quality assessment visits and monthly reports of their activity indicators. Over 80 persons, at least two representative of each organization, received training to provide testing and counselling and to collect data, and support to establish referral protocols and regulatory processes. These 28 structures cover the all country. Two are specifically dedicated to MSM, three are specifically dedicated to migrants, four to sex workers and six to PWUDs the remaining target more than one of the key populations. None of the organizations excludes anyone from testing or pose any barrier to testing.

A standardized data collection was developed based on a European tool, developed by COBATEST project, used by community-based HIV screening services and aiming to gather data on socio-behavioural indicators, as recommended by the WHO and ECDC. A final version became available in January 2016 after a pilot involving all partners. The questionnaire is available online through a URL only accessible to partner organizations. Users that perform at least one rapid screening test — HIV, HCV, HBV or syphilis — and are 18 or more years old, are invited to give additional information to generate a code, that allows the linkage of different

records of the same individual, namely follow up visits, with guaranteed anonymity. Only when reactive cases are detected is anonymity broken for SNS or another previously agreed referral. Nominal data are never linked to screening data. This allows for the prospective follow up of people who test at these structures.

In 2016, 11,502 users were reached by the community screening network and 7209 (62.7%) belong to key groups, showing effective outreaching. A total of 35,494 tests were performed – 12,261 HIV tests to 11,247 users, 7450 HCV tests to 7025 users, 5765 HBV tests to 5610 users, and 10,018 syphilis tests to 9206 users. Reactive results were 188 (1.7%) for HIV, 207 (2.9%) for HCV, 134 (2.4%) for HBV and 298 (3.2%) for syphilis; 56 (7.2%) persons had a reactive result for more than one infection, highlighting the added value of a combined testing offer. Successful referral to HIV care was over 75%. The proportion of first testers was high, especially for viral hepatitis and syphilis. For HIV 48.7% had a previous test, while for hepatitis C this proportion was 22.2%, for hepatitis B 20.6% and for syphilis 15.3%. These data was used to feed the national and international routine monitoring, overcoming the absence of a national agency. These large new results follow those generated by the first community-based voluntary HIV testing and counseling structure in Portugal – CheckpointLX (member of the network) directed to and led by MSM, and a frame sampling for the Lisbon Cohort of MSM recruitment. We built on top of that experience and source of knowledge about primary and secondary prevention uptake that made possible the first Portuguese estimate of HIV incidence and its predictors among MSM in Portugal.

The close cooperation between community and academia bringing together action and research with action feeding research questions and research questions providing clues to adapt action.

FINANCING

The Community Screening benefited from 278,000€ grant from Iceland, Liechtenstein and Norway through the EEA Grants, Iniciativas em Saúde Pública (“Public Health Initiatives”) Program, operated by the Central Administration of the Health System from March 2015 to April 2016. Since April 2016, a partnership between GAT and AIDS Healthcare Foundation ensured GAT’s access to screening tests, which were distributed to all the organizations involved in the project. The sustainability of this project is currently a challenge, given non regular funding calls aiming this type of projects or the absence of programmatic funding. Applications for international funds were submitted and results are expected soon. The importance given to this example of work makes it central in our internal investment decisions.

GOVERNANCE

The Institute of Public Health of the University of Porto has longstanding partnerships with GAT – a NGO that promoted the partnership with other NGOs and leads the community screening network, and with the tertiary hospital (São João). A board of members meet regularly, define strategies and designed a contingency plan.

LESSONS LEARNED AND RECOMMENDATIONS

- The community involvement from inception is crucial: to design research that respect human rights and mobilize the concerned populations making action - to bring testing services closer to key populations – and knowledge more rewarding
- The results showed the benefits of offering combined testing – the great majority of viral hepatitis and syphilis infections identified would remain unidentified if only HIV testing was offered
- Research outputs must be drawn from and to action

Ways to get feedback from the National Health System structures regarding referred participants after a reactive test need complex negotiations, involving the service providers, data protection and record linkage solutions but are essential to monitor the impact of the community screening network.

31. SWEDEN

It is an honour for us to have the opportunity to present the Swedish achievements in relation to HIV prevention. Sweden, has reached the 90-90-90 target, by estimated 90 percent of people living with HIV know their status, 95 percent of those diagnosed receive antiretroviral therapy and 95 percent of those on therapy have durable viral suppression. The Swedish HIV epidemic remains low and stable, mainly prevalent among men who have sex with men (MSM) and among migrants arriving to Sweden from countries with a high prevalence of HIV.

In Sweden, there has been a political consensus and a strong leadership commitment to HIV prevention, including annual Government funding, since the beginning of the HIV epidemic in the 1980th. This has made possible a comprehensive long term prevention initiative at both national and regional levels. Based on the 2001 Declaration of Commitment on HIV/AIDS and the declaration approved at the ministerial meeting in Dublin in 2004, Sweden adopted A National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases in 2005. In the Swedish strategy, quality development has been prioritized, in three target areas: national coordination, monitoring & evaluation and knowledge development.

The implementation of the national strategy, including the national coordination of the HIV prevention is directed by the Public Health Agency of Sweden. The Government funding has contributed to coordination and support to the county councils, being the body responsible for healthcare in Sweden, and the civil society organizations at regional level, and is carried out in close collaboration and dialogue. Meetings between the Public Health Agency of Sweden and the county councils are held on a regular basis. Over the years, all county councils and civil society organizations receiving governmental funding for HIV prevention have established a result-based management and advanced their skills in HIV prevention project management. The cooperation between smaller counties as well as with and between civil society organizations, has increased continuously. This development has strengthened the overall prevention work and increased both quality and efficacy.

In accordance with the statements in the UN Declaration of Commitment on HIV/AIDS, Sweden has implemented monitoring and evaluation of plans and goals. The epidemiological monitoring system as well as the monitoring of treatment efficacy have been complemented by research on knowledge, attitudes and behavior (KAB) in the general population and in the specific key populations identified in the national strategy. For example, results from studies in Sweden show that people living with HIV rate their quality of life fairly well, though stigma and discrimination remain. Altogether, results from research guide the planning and development of the HIV preventive work in Sweden. Initiatives have focused on both broad interventions, raising awareness among the general public, and on targeted need-based interventions of key populations, as well as involving key populations in design and implementation.

The Swedish healthcare system offers HIV-prevention by providing confidential, pre-test information, post-test referrals and follow-up, in order to facilitate a linkages to care, support, treatment and regular viral load monitoring. All testing and treatment are free of charge. Moreover, all over the country, young people have access to specific youth friendly health

services. Sweden also has a long tradition of comprehensive sexuality education and school programmes that provide knowledge and skills, to ensure young people's sexual health, protecting themselves from HIV, other sexually transmitted infections (STI) and unwanted pregnancies.

For many years, a great deal of the Swedish prevention funding has been allocated to spreading updated knowledge and methods among healthcare professionals, counsellors, teachers and other staff meeting young women and men and key populations at risk for HIV and STIs. This is an ongoing work that has to continue in order to secure all people's right to correct and adequate information and thus decreasing health inequalities.

In order to end AIDS and preventing HIV the key populations most at risk must be reached.

Therefore, the public sector has in close cooperation with community based organisations, implemented targeted prevention interventions and specific healthcare facilities to meet the needs experienced by key populations such as migrants and MSM. LGBTQ-organisations, organisations representing people living with HIV, and a general strong civil society have played an important role and have shown to be the key in the HIV prevention, making Sweden reach the 90-90-90 goals.

The Swedish health promotion and HIV prevention emphasis on:

- maintained focus on key populations at high risk of HIV infection
- increased awareness of and access to HIV testing, in order to achieve early detection
- elimination of stigma and discrimination of people living with HIV
- increased gender equality and health equity in sexual and reproductive health and rights

32. SWITZERLAND

TITLE OF THE PROGRAMME:

Comprehensive Swiss drug policy

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Responsible party/parties: Government

Populations group(s) reached: People who inject drugs

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes

BACKGROUND

According to UNAIDS Global Report on the Aids epidemic 2013, coverage of HIV prevention services for people who inject drugs has improved but remains low in many countries. Also, according to the contribution of the Executive Director of the United Nations Office on Drugs and Crime to the high-level review in the implementation of the Political Declaration and Plan of Action on International Cooperation toward an Integrated and Balanced Strategy to Counter the World Drug Problem, conducted by the Commission on Narcotic Drugs in March 2014, several countries that have implemented evidence-based programmes to reduce the adverse consequences of illicit drug use among people who inject drugs appear to have reduced the number of HIV infections among such people. This seems to have been the case, for example, in many countries in Western Europe and Oceania, where needle and syringe programmes and opioid substitution therapy, combined with a range of other health and social services, appear to have resulted in a decline in unsafe injection drug use, which is related to the spread of HIV. Despite the encouraging progress observed in such countries, the global HIV epidemic among people who inject drugs is far from being resolved.

So the question of interest is how did Switzerland, that in 1986 officially reported the highest rate of HIV cases in Western Europe, manage to turn the tide?

APPROACH

The Swiss drug policy

End of the 1980s the public pressure on the political sphere increased mainly because of the open drug scenes and the high HIV/AIDS prevalence among drug users. After consulting with the cantons and people working in the field, the Federal Council decided that a shift from maintaining public order to ensuring public health as the main goal of the Swiss drug policy was necessary. The new national drug policy was based on four pillars - prevention, treatment, harm reduction as well as law enforcement and control. The policy's aim is to direct actions in the four pillars in a way that they become mutually reinforcing. Thanks to this approach, focused on pragmatism, effectiveness and efficiency, Switzerland achieved positive results, like the reduction of drug related deaths and the improvement of addicts' health. Its aims are

- Reduction of illicit drug abuse,
- Reduction of negative effects of illicit drug consumption and
- Reduction of the negative effects on the health of the addicts.

It is this four-pillar policy that has led to a decrease in HIV infection prevalence. But it is essential that it was not one measure but the overall balanced and multidisciplinary approach that lead to the reduction and stabilization at a low rate. It is therefore essential to understand what the measures of each pillar are.

1) Prevention:

This pillar intends to prevent the start of drug use and therefore the development of an addiction. The health of the person is put at the center of reflections which, in a broader sense, contributes to the overall quality of the person's life. Thus, prevention doesn't aim primarily at preventing a first consumption of drugs but is aimed at preventing the negative health outcomes in a more general way. Consequently, prevention is increasingly transformed into health promotion and influences the respective target groups (children, youth) indirectly through structural changes.

2) Treatment

Therapeutic integration of affected persons, improvement of their physical and mental health, social and socio-professional reintegration as well as the creation of conditions which allow a life free of addiction on a permanent basis are general goals of therapies for persons with addictive behavior. The objectives of a therapy are adapted to the individual's needs and possibilities.

The most important services in addiction treatment are ambulatory and residential psycho-social counselling and therapies, psychiatric therapies, substitution assisted treatment (ambulatory or residential), detoxification units or clinics, abstinence-based residential treatment, follow up care and assisted accommodation. The provision of services lies within the competencies of the Cantons.

Substitution assisted treatment is a medically supervised therapy whereby an illegally consumed opioid (usually heroin) is replaced by a legal medicament and accompanied by additional therapeutic measures. Substitution assisted treatment is nowadays one of the standard therapies in case of opiate addiction in Switzerland.

3) Harm Reduction

Harm reduction intends to ensure that people who at some point in their life use drugs can overcome this phase with the smallest possible physical, mental or social harm. Specific objectives are lowering risks of infectious diseases, stabilization and improvement of the health conditions of drug users, and improvement of their social reintegration. Further, harm reduction measures aim at leading drug users towards therapeutic services. For society, harm reduction measures intend to reduce social costs of drug addiction and ensure public safety. For instance, measures can include the exchange of syringes (so they are not discarded in public), provision of sterile injection equipment (in order to stem the transmission of infections) but also offering contact centers or injection rooms (in order to get into contact with the addicts in the first place).

4) Law enforcement and control

Law enforcement is responsible for reducing the supply to illicit drug markets, especially, but not limited to, large scale supply. According to Swiss Narcotics Law, supply reduction measures should be carried out by cantonal police forces. The Federal Office of Police and the Federal Criminal Police assist cantonal police forces in carrying out such operations upon request and if appropriate. Operationally, a complex set of laws and regulations not necessarily in accordance with national drug policies in all instances governs cantonal police actions on drug matters. This creates the risk that the law enforcement and control pillar is perceived as being separate from the other pillars, acting sometimes in contradiction to the efforts of those pillars concerned with public health issues.

In order to mitigate this risk and reduce contradictory outcomes of law enforcement actions on public health efforts, the Federal Office of Police regularly consults with representatives of all other pillars and at all relevant levels of governance. These consultations aim at better understanding how police action interacts with other – e.g. health-based – interventions into drug markets, identifying shared interests among pillars and creating synergies by acting in together with other actors in the drug field. Furthermore, the Federal Office of Police, together with the Federal Office of Public Health is co-chairing a national working group on the cooperation on police and public health. The working group organizes among others conferences and seminars in which best practices in the cooperation between police and public health professionals are developed, documented and shared as well as training opportunities for police and public health identified.

REACH OF THE INTERVENTION

Drug policy with national coverage. Comprehensive approach covering 4 areas: prevention, treatment, harm reduction, law enforcement and control (more details, see above).

Impact of the intervention: What did the intervention achieve in terms of HIV outcomes in prevention, treatment, care and support? How was this impact measured?

The Swiss National Programme on HIV and other STI (NPHS) 2011–2017 groups HIV and STI interventions and measures into three axes. The definition of the three axes of intervention is based on considerations of prevalence and vulnerability. Axis 2 is about individuals who engage in risky behavior or are vulnerable in an environment with an increased prevalence. Axis 2 identifies several groups, one of which is the IDU, besides MSM, Sex Workers, migrants from high prevalence countries and people in prisons. They require additional, specific measures, since they have a greater risk of infection, such as

- The harm reduction measures are basically maintained, and adapted to their needs,
- Centers for IDU also encourage prevention of HIV and other STI,
- Preventative measures, specific information for IDU working as sex workers and
- Raising awareness about the risk and high prevalence of hepatitis C.

As for the situation in Switzerland today, the general epidemiological situation regarding HIV diagnoses among injection drug users (IDU) can be summarized as follows: At the beginning of the HIV epidemic, in Switzerland, needle exchange between injection drug users was the most common way of infection. By the late 1980s, the proportion of transmission within IDUs reached 50% of the new diagnoses, but then it fell rapidly to less than 15% by the late 1990s. Over the last 5 years, this proportion has remained at less than 5%. In 2013, it even fell to less than 3%, with a total of 15 diagnoses (absolute numbers): 12 men and 3 women. Given the small figures, it is difficult to interpret the changes occurring from one year to another and generate any tendency whatsoever. Among IDUs diagnosed in 2013, 80% were Swiss nationals and three quarters men, which corresponds to roughly to the proportion of men among all IDU.

FINANCING AND MANAGEMENT

How is the intervention managed, coordinated and financed? How is financial sustainability of the project addressed? Who are the major partners?

The four pillars of the Swiss policy is anchored in the Federal Law on Narcotic Drugs which ensures the implementation of said pillars and their respective interventions, guaranteeing a certain sustainability. The interventions are managed and coordinated by the cities and the cantons, with a coordination bodies ensuring regular exchange. It is the cities, the cantons and the federal government that share the finances according to the respective competences.

The total costs of illicit drug consumption are difficult to measure as they imply social and human costs as well and can only be measured with various indices, therefore being merely

estimates. With regards to the 4 pillars, the costs can be divided into 60% repression and control, 20% treatment, 10% prevention and 10% harm reduction.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy? What were the challenges?

HIV was only one of the driving forces that lead to a fundamental rethinking of the Swiss drug policy, resulting in expansion of evidence-based services. Therefore, Switzerland encourages deliberations on approaches that could be more efficient and effective than drug policies focused on enforcement of measures strictly aiming at abstinence and without offering alternatives in therapy or measures to reduce the harm caused by the adverse consequences of drug abuse.

A health-centered approach to addressing illicit drug use and drug dependence is still not sufficiently implemented in all countries, even though significant progress in this direction has been made in several parts of the world over the last few decades.

Similarly, people who illicitly use drugs and people who are dependent on drugs and living with HIV/Aids often experience stigma, discrimination and human rights violations, discouraging them from seeking the health and social services they need even if such offers exist. Though the coverage of services based on scientific evidence has increased in some countries, it is still inadequate in most countries.

Cooperation between the different players such as health and social workers and police are essential in order to understand each other's aims and to support their goals.

The reduction of HIV-incidences does not allow for inactivity, but raises the challenge to keep the incidence at such a low rate.

ANNEXES

- Open source book "From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland", October 2012
<http://www.opensocietyfoundations.org/reports/mountaintops>
- Switzerland's National Drug Policy (2006-2011) that was extended to the year 2016.
<http://www.bag.admin.ch/shop/00035/00204/index.html?lang=en>
- The Swiss National Programme on HIV and other STI (NPHS) 2011–2017
(http://www.bag.admin.ch/hiv_aids/05464/05465/12491/index.html?lang=en)

33. TURKEY

TITLE OF THE PROGRAMME:

HIV/AIDS national program

CONTACT PERSON

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Programme is being implemented since: The fight against HIV / AIDS in our country has been carried out politically with the leadership of our Ministry since 1985 when the first case was reported. The National AIDS Commission (UAK) was established in 1996 to provide coordination between the sectors and the purpose of providing control of HIV / AIDS infection and supports the coordination of national level activities on the basis of National Objectives and Strategies.

Studies on the preparation of 2017-2021 National Strategic Plan for HIV / AIDS.

Responsible party/parties: Government / Civil society / Private sector / UN or other inter-governmental organization / Academic institution

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers / Transgender / Women / Girls / Young people / Other: Refugees

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes. Good practices dissemination program which is the part of the HIV/AIDS stratejic plan

CONTEXT

Studies on the preparation of 2017-2021 National program for HIV / AIDS; Academicians, non-governmental organizations, and a wide working group formed by the participation of staff working in the central and provincial organizations of our Agency

RESULTS AND IMPACT

- It is necessary to closely monitor international developments in diagnostic and treatment standards and to ensure that national standards are rapidly updated and nationally applied in the light of these developments. The "HIV / AIDS Diagnosis Treatment Guide" published in 2013 is the first and the only guide in our country and updating studies as "HIV / AIDS Guideline" are continuing.
- Efforts are continuing to increase the capacity of service provision in terms of diagnosis of existing patients, treatment access of the diagnosed patients and continuity of treatment. Antiretroviral drugs since 2015 in order to reduce the transition from mother to baby; It is provided by our Institution for "emergency use" for protection against HIV positive mothers and infants during and after childbirth.
- In order to determine the presence of HIV infection in our country, any person who has a risky behavior and / or complaints is tested in case of applying to the desired health institution and if the test result is positive, the patient is followed up and taken care of. The General Health Insurance Practice, which allows all patients diagnosed and reported to have access to treatment and care services, is an example that can set an example for many countries.
- Electronic HIV / AIDS, which keeps patient privacy at the highest level for the purpose of collecting collected data in a way that prevents faster, reliable and duplicate registrations and shortening the verification period and intervening in case of time, regular follow-up and treatment of HIV positive persons and ensuring the continuity of treatment and monitoring HIV positive pregnancies Information System was established.
- Establishment of centers that provide anonymous consultancy and testing services throughout the country, starting from the big illnesses, focusing on the tourism sector, going abroad and having high migration and population mobility, so that healthy communities can access to quality and preventive health services and access to preventive health services by HIV / AIDS risk groups Studies are among our basic strategies.
- In these centers, HIV / AIDS sensitive and important groups; Information about HIV / AIDS protection and transmission routes are provided, free and confidential HIV testing service is provided, counseling service is provided before and after the test, and the correct center for treatment is provided according to the result of the test. Within this scope, studies are being carried out to increase accessibility of existing centers and to establish new centers.

FINANCING

State budget

GOVERNANCE

Ministry of Health

LESSONS LEARNED AND RECOMMENDATIONS

Multi Sectoral approach and work with whole stakeholder is necessary for the national program development and sustainability.

34. UNITED KINGDOM

34.1. TITLE OF THE PROGRAMME:

Harm reduction in prisons

CONTACT PERSON

Organization: Harm Reduction International

CONTEXT

Prevalence of HIV is consistently and substantially higher among prisoners than the broader population, and high levels of injecting drug use are documented in prisons in every region of the world.¹⁵ Today, well over 10 million people worldwide are incarcerated at any given time, at least 1 in every 5 of which are being held for drug-related offences. Indeed, people who use drugs make up about one third to one half of the world's prison population,¹⁶ and UNAIDS has estimated that up to 90% of people who inject drugs will be incarcerated at some point in their life.¹⁷

A large body of evidence demonstrates that harm reduction services - including needle and syringe programmes (NSPs) and opioid substitution therapy (OST) - are the most effective way to reduce HIV transmission among people who inject drugs. Early implementers of NSPs and OST such as Switzerland, the UK and Australia, for example, lowered new HIV infections among people who inject drugs to practically zero.¹⁸ Harm reduction is also very cost-effective. A study from Australia, for example, estimated that every dollar invested in NSPs returned four dollars in health care savings.¹⁹

HARM REDUCTION IN PRISONS: RESULTS AND IMPACT

Numerous studies have found that harm reduction can be safely and effectively implemented in prisons with evidence of reduced HIV transmission, among other positive outcomes.²⁰ One study conducted over ten years and published in 2012 assessed the effectiveness of a prison-based NSP in Spain in reducing both the sharing of injecting equipment and the prevalence of infections associated with injecting. It found that over ten years, 15,962 syringes were supplied

¹⁵ Dolan, K., Moazen, B., Noori, A., Rahimzadeh, S., *et al.* (2015) People who inject drugs in prison: HIV prevalence, transmission and prevention. *International Journal of Drug Policy*, 26(1), pp. S12-S15.

¹⁶ See footnote 1

¹⁷ UNAIDS (2014) *The GAP report*.

¹⁸ Cook, C., Bridge, J., Stimson, G. (2010). *The diffusion of harm reduction in Europe and beyond*. Lisbon: EMCDDA.

¹⁹ Australian Government Department of Health and Ageing. (2009) *Return on investment 2: Evaluating the cost effectiveness of needle and syringe programmes in Australia*. Canberra: Department of Health and Ageing.

²⁰ Kamarulzaman, A., Reid, S.E., Schwitters, A., *et al.* (2016) Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners. *The Lancet Series: HIV and related infections in prisoners*.

to 429 people who inject drugs, 70% of which were returned; the prevalence of HIV and HCV decreased from 21% to 8.5% and from 40% to 26.1% respectively; and most prisoners and prison staff believed that the NSP enhanced the hygienic living conditions in the prison without increasing injecting drug use.²¹ In Moldova, where prison-based harm reduction services, including NSPs and OST, have been provided since 1999, a reduction in HIV and HCV incidence has been documented without an increase in drug use. Additionally, the training that accompanies service delivery has resulted in widespread awareness about HIV, HCV and risk behaviours among prisoners and prison staff in the country, contributing to a reduction in stigma and discrimination.²² Importantly, in all the NSPs implemented or piloted in prisons to date, not one instance of syringe-related violence has been reported.²³

The implementation of harm reduction in prisons has been recommended by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and UNAIDS, among many others. It is also widely recognised as a legally binding human rights obligation.²⁴

HARM REDUCTION IN PRISONS: GAPS AND BARRIERS

Despite the fact that harm reduction saves lives, reduces HIV transmission, protects human rights and saves money, harm reduction services remain extremely limited in prisons. Currently, 90 countries implement NSPs outside of prison settings, while only eight provide the service in at least one prison. Similarly, whereas 80 countries make OST available to the non-prison population, only 52 implement the service in at least one prison.²⁵ The major barriers to harm reduction provision in these settings is the lack of political support (or outright political opposition), and closely related to this, a major shortage of funding.

LESSONS LEARNED

Despite the unequivocal evidence that harm reduction works, and the clear need for these services in prison settings, the provision of key harm reduction services in prisons remains extremely limited, with potentially serious public health and human rights implications.

²¹ Ferrer-Castro, V., Crespo-Leiro, MR., García-Marcos LS et al. (2012). Evaluation of a Needle Exchange Program at Pereiro de Aguiar prison (Ourense, Spain): A ten year experience. *Revista Española de Sanidad Penitenciaria: RESP*; 14(1): 3-11.

²² Hoover, J. Jürgens, R. (2009). *Harm Reduction in Prison: The Moldova Model*. Open Society Institute, Public Health Program.

²³ See footnote 6.

²⁴ See, for example, Puras, D (2015) Open Letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Puras, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNAGASS) which will take place in New York in April 2016.

²⁵ Stone, K (2016). *The Global State of Harm Reduction*. London: Harm Reduction International

RECOMMENDATIONS

- In order to scale up harm reduction services, including in prisons, governments need to invest the necessary financial resources. The funding crisis facing harm reduction is not one of resource shortage, as vast sums are spent incarcerating people who use drugs. Governments can address this by rebalancing funding from punitive approaches to harm reduction and providing alternatives to prison for people who use drugs.
- Alongside this, governments and policy makers must also take steps to address stigma around drug use and communicate the benefits of harm reduction, particularly in terms of health outcomes, social impacts and cost benefits, in order to increase its political acceptability.
- In some contexts, governments will need to remove legal and operational barriers to the availability and accessibility of harm reduction services in prisons. They should also enhance cooperation and coordination between the criminal justice, prison and public health systems, vest jurisdiction for prison health in the Ministry of Health and ensure that existing national disease and harm reduction programs are fully integrated into the prison health system.
- Finally, national authorities should monitor and report on HIV, HCV and harm reduction in prisons and all data collected should be publicly available. Independent monitoring mechanisms should also be established to hold state bodies accountable for meeting obligations relating to prisoners' health and human rights under domestic and international law.

34.2. TITLE OF THE PROGRAMME:

Terrence Higgins Trust's national self-testing service to decrease undiagnosed HIV infection

CONTACT PERSON

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Responsible party/parties: Civil society

Populations group(s) reached: Men who have sex with men

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? Yes. It is part of Terrence Higgin Trust's national strategy

CONTEXT

To benefit from combination HIV prevention efforts, the UK needs a dramatic increase in targeted HIV testing in order to reduce the numbers of people living with undiagnosed HIV who are not on treatment, and are transmitting the virus on to others. UNAIDS has set the global 90:90:90 target which aims to ensure 90% of people with diagnosed HIV, 90% on treatment and 90% with an undetectable viral load. In the UK we have already achieved the second two 90% targets – but still have unacceptably high rates of undiagnosed infection (13% overall – but higher in heterosexual and black African groups). In order to address this we need a dramatic increase in the number of HIV tests undertaken each year in those groups most at risk and more regular testing in those at on-going risk of acquiring HIV (especially men who have sex with men).

Mathematical modelling data has demonstrated that increasing HIV testing alone could significantly reduce HIV transmissions in MSM with an even greater impact when testing is used in combination with PrEP and treatment as prevention (TasP).

With Sexual Health services already at capacity and facing year on year budget cuts from their local authority commissioners there remain huge practical and financial barriers to achieving the testing rates required to make an impact on the HIV epidemic in this country. Home testing or self-testing offers the potential to significantly increase the number of tests undertaken and may offer a more acceptable solution for regular testing for some people. Self testing also offers the cheapest cost-per-test of current HIV testing technologies and is therefore likely to be cost effective, especially when done at scale.

Self testing for HIV offers immediate results with a greater degree of control over how and when they are received by the service user. The unique benefits of this technology could lower some of the barriers which prevent people from testing.

Terrence Higgins Trust (THT) has significant experience in piloting new testing technology and has considerable experience of reaching at risk communities and using social media to both disseminate health improvement messaging around HIV as well as promoting on-line testing services.

THT designed and delivered a pilot of national HIV Home Testing which ran from June – August 2016. The service was available for those who identified as MSM. The service was promoted through adverts on Grindr and Scruff, via Twitter, on THT's website and through targeted Facebook adverts.

People were asked for a mobile number and an e-mail address to confirm their details and which were used to registering their result, deliver a post-test survey and to make the fundraising ask. Prior to being able to order a test kit people were asked to answer 6 risk assessment questions.

Users were later asked to log into a secure page on the website to inform us of their result. Anyone with a reactive result was called by THT's Medical Director to offer any support and advice and to ensure access to care for confirmatory testing.

RESULTS AND IMPACT

The pilot ran from 24th June 2016 until 5th August 2016. A total of 4,879 were fulfilled. 3,021 people (62%) informed us of their result. 4,865 (97.8%) orders were from men and 4,820/4,865 (99%) identified as MSM. Overall the mean age was 31.

28/3,021 (0.92%) people reported a reactive result. 3 (10.7%) people already knew they were HIV positive and one result was confirmed as a false positive. Of the remaining 24 all were men who have sex with men (MSM) and their mean age was 34.3. 50% of those reporting a positive result came to the service via promotion on a smartphone dating application. 15/24 (62.5%) identified as white British. Contact was made with 22 (92%) all of whom had accessed or were going to access sexual health services for confirmatory testing.

Overall 19% had never had an HIV test and a further 37% had last tested over a year ago. 81% reported 2 or more partners in the last year with 21% reporting between 6 and 12 partners and 14% reporting 13 or more. The majority (68%) reported condomless anal sex in the previous 3 months with 28% reporting this with 2 or more partners. 47% reported "sometimes" having sex under the influence of drink or drugs and 14% reported this occurred "most of the time" or "always".

The main reason people gave for using the service was wanting an immediate result (64%). Having confidence in THT as an HIV test provider was next (45%) and then inconvenient clinic opening times (37%) and not wanting to attend an STI testing site in person (35%).

91% of respondents either agreed or strongly agreed that "self testing encouraged me to do the test" and 91% agreed or strongly agreed that they were happy with the support they received after their result

97.3% of respondents would recommend the service to a friend they expected to test negative and 73% would recommend it to a friend they expected to test positive.

FINANCING

This pilot was funded through THT's own funds. Planning is now underway to fund an ongoing service providing 100,000 tests per year through a combination of grants, fundraising and commercial partnerships.

GOVERNANCE

Clinical governance and pathways into care were provided by THT clinical team. Information was provided according to the Information Standard accreditation process. Data governance was provided by THT.

LESSONS LEARNED AND RECOMMENDATIONS

The HIV self test pilot clearly demonstrates the acceptability and feasibility of an HIV self testing service, particularly when targeted at MSM. Social media (in particular Facebook and 'dating apps' such as Grindr can be highly effective at reaching at risk MSM.

It also demonstrated that more than half testers would notify THT of their results. Of the 25 who reported a new positive result we were able confirm access to care for confirmatory testing in 23 (92%) and the feedback from those who were spoken to over the phone was universally positive.

35. UNITED STATES OF AMERICA

35.1. TITLE OF THE PROGRAMME:

Get Tested Coachella Valley

CONTACT PERSON

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Title: Executive Director

Organisation: Desert AIDS Project

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Responsible party/parties: Civil society / Private sector

Populations group(s) reached: People living with HIV / Men who have sex with men / Transgender / Women / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? Yes

Is the programme part of a national plan other than the national aids strategy? Yes

CONTEXT

Get Tested Coachella Valley is a public health initiative designed to dramatically reduce the spread of HIV by:

Making voluntary HIV testing standard and routine medical practice;

Making HIV testing and HIV care available to everyone, including those who don't see healthcare providers on a regular basis;

Educating the community on how to protect their health and prevent infection.

Over half of Coachella Valley residents have never been tested for HIV and the HIV/AIDS prevalence rate in the Coachella Valley is over two times higher than the national rate—putting everyone at greater risk.

RESULTS AND IMPACT

2014/2015- 52,000 HIV tests conducted; 250 tested HIV positive, 90% linked to HIV healthcare services.

FINANCING

\$5 million for the initiative

GOVERNANCE

More than 95 organizations participate in the CSO driven initiative

LESSONS LEARNED AND RECOMMENDATIONS

A CBO can manage and coordinate a large scale HIV testing program.

Raising funds for HIV can be very challenging at times.

ANNEXES

<https://gettestedcoachellavalley.org/wp-content/uploads/2016/06/Get-Tested-2015-Annual-Reportcompressed.pdf>

www.gettestedcoachellavalley.org

www.haztelapruebavalledecoachella.org

35.2. TITLE OF THE PROGRAMME:

The Undetectables: Scaling Up Viral Suppression Support for Vulnerable Populations

CONTACT PERSON

Name: Charles King

Title: President and CEO

Organisation: Housing Works

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Programme is being implemented since: 2014

Implemented by: Government / Civil society / Academic institution / Private sector

Scope of Submissions: People living with HIV / Young people / Men who have sex with men / People who inject drugs / Sex workers / Transgender / Women

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? No

Is the program part of the National Plan Broader than the National AIDS Strategy: Yes.
The program is part of the State plan for Ending the AIDS Epidemic in New York City and State by the year 2020.

CONTEXT

The Undetectables is an antiretroviral therapy (ART) support model combining a superhero-themed social marketing campaign with a “tool-kit” of evidence-based adherence supports, including financial incentives, to enhance care for persons with HIV (PWH) who face barriers to medication adherence. The intervention was pioneered by New York City (NYC) community-based service provider Housing Works and has been scaled up by the NYC Department of Health and Mental Hygiene (DOHMH), which has contracted with seven agencies to implement the Undetectables program citywide to serve 1,500 PWH in the coming year.

The scientific evidence is now conclusive that persons with HIV (PWH) who are on antiretroviral treatment (ART) that consistently suppresses the virus to an “undetectable” level (used here synonymously with the term “virally suppressed,” meaning a viral load of 200 copies/ml or less) not only successfully protect their own health but cannot transmit HIV to sexual partners. This fact underscores the importance of programming and messaging to support Treatment as Prevention (TasP), and has the potential to reduce the self- and societal stigma that negatively affect HIV testing, treatment uptake and health outcomes globally.

The incontrovertible evidence that HIV cannot be sexually transmitted if one is durably virally suppressed is also something that we all celebrate as a key milestone in ending AIDS as an epidemic. DOHMH and Housing Works were among the first of the many experts and community members that have now endorsed the “Undetectable Equals Untransmittable” (“U=U”) Consensus Statement issued by the Prevention Access Campaign. (See <https://www.preventionaccess.org/consensus>). Housing Works, DOHMH and the New York State (NYS) Department of Health AIDS Institute held an April 2017 outdoor rally and dance party at the AIDS Memorial in NYC to celebrate U=U and to launch a public campaign to share the message that U=U provides even more reason for every person to know his or her HIV status, and for every person with HIV to start and maintain treatment without delay—to protect their own health and the health of their community. However, far too many PWH face demonstrated barriers to sustained viral suppression, including housing and food insecurity, lack of transportation, behavioral health issues, stigma, discrimination and criminalization. Innovative interventions are needed to address the social and structural barriers to ART adherence that continue to drive HIV health inequities. A core component of the NYS Blueprint for Ending the

AIDS Epidemic (ETE) by 2020 are recommendations for increasing the number and percentage of New Yorkers able to achieve and sustain viral suppression—by ensuring universal access to HIV care, supporting retention in care and ART adherence, and providing the support services necessary for all people with HIV to benefit from treatment.

RESULTS AND IMPACT

Housing Works launched the Undetectables program in March 2014 as a core component of its ETE commitment. The program added a quarterly \$100 gift card incentive to existing agency services that include primary care, psychosocial services, and case management, to test whether financial incentives, when added to integrated care, can improve durable viral load suppression for marginalized people who face multiple barriers to medication adherence. The related social marketing campaign affirms the message that people with HIV on ART that maintain viral load suppression are “superheroes” who protect their own health and prevent transmission to end AIDS as an epidemic. (See www.liveundetectable.org).

A rigorous evaluation by the University of Pennsylvania of Housing Works’ two-year Undetectables demonstration showed significantly increased rates of viral suppression despite high rates of mental illness (52%), illicit drug use (63%) and literal homelessness (66%). Among 502 study participants, 85% were virally suppressed at 24 months, compared to 66% at enrollment ($p < .0001$). As of March 2017, 90% of 596 current Housing Works program participants were virally suppressed, with a 93% suppression rate among those enrolled for three months or more. More importantly, rates of durable viral suppression increased significantly post-enrollment, demonstrating that financial incentives added to existing integrated services significantly improved ARV adherence and time spent virally suppressed in a population of socially vulnerable people with HIV who face demonstrated barriers to medication adherence. Regression analyses showed that significant disparities in viral load suppression rates at baseline associated with markers of social vulnerability disappeared post-enrollment, indicating that marginalized clients benefitted equally or even more from the intervention than their counterparts. Based on initial Housing Works results, DOHMH and Housing Works formed a consortium of stakeholders in mid-2015 to develop a scalable model of the intervention. The group worked collectively to explore the model, identify essential elements and develop programmatic criteria for successful scale-up in NYC and beyond. We developed a plan for the provision of training and technical assistance on site-specific implementation, best-practice case management for viral suppression, quality improvement-focused management, social media marketing and the program’s fiscal sustainability, and began outreach to health planners, providers and payers working on HIV-related projects.

FINANCING

Private foundation funding supported the two-year Housing Works demonstration project, beginning in 2014, as well as Housing Works' collaboration with DOHMH and other partners to develop the scalable intervention. In July 2015 DOHMH awarded over \$1.5 million in contracts to seven agencies to implement the intervention citywide. Housing Works was also awarded a contract to serve as technical assistance provider to the other agencies; in this role, Housing Works provided training to prepare each agency for implementation and continues to provide support and program monitoring to help agencies ensure smooth operations and effective participant health outcomes. Over the next three years, DOHMH and Housing Works will work in collaboration with the agencies funded to implement the Undetectables to create systems necessary to meet and exceed service targets, as well as reach new clients who can benefit from ART adherence supports. The intervention model and materials can also support a greater number of health care agencies, hospital systems and community-based organizations to provide this model of innovative care to those people with HIV who need support most. Financial incentives are currently funded through the DOHMH contracts and other health care innovation strategies, but work is underway to secure a sustainable source of funding through the public Medicaid program.

GOVERNANCE

As noted, efforts to support viral load suppression are a core component of the New York City and State initiatives to End the AIDS Epidemic by 2020. The Undetectables intervention was launched with private funding from the NY based Robin Hood Foundation, and has now been adopted by the NYC DOHMH, which has funded and will manage and evaluate three-year contracts to bring the intervention to scale to serve marginalized PWH.

LESSONS LEARNED AND RECOMMENDATIONS

The development and scale-up of the Undetectables intervention provides a valuable example of how public and nonprofit partnerships can respond quickly to a public health goal and leverage a range of resources toward that goal. DOHMH and Housing Works were among the first voices to publicly affirm the scientific evidence that people with HIV on ART that suppresses the virus to an undetectable level not only successfully protect their own health but also cannot transmit HIV to others. Innovative strategies are urgently needed to support vulnerable people with HIV to achieve and sustain viral suppression—to protect their health and to end AIDS.

VI. MULTIPLE COUNTRIES

36. Multiple African Countries

36.1. TITLE OF THE PROGRAM:

A Quarter for Prevention? Global Fund Investments in HIV Prevention Interventions in Generalized African Epidemics

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Programme is being implemented since: 2014-2016 Global Fund funding cycle; 2015-2017 implementation period

Implemented by: Government / Civil society / UN or other intergovernmental organisation

Scope of Submissions: People living with HIV / Men who have sex with men / People who inject drugs / Sex workers / Transgender / Women / Girls / Young people / Other

Has the programme been evaluated / assessed? Yes

Is the program part of the implementation of the National AIDS Strategy? Yes

Is the program part of the National Plan Broader than the National AIDS Strategy: No

CONTEXT

In July 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) announced that global efforts to reach fewer than 500,000 new HIV infections by 2020 are off track. Indeed, since 2010, the number of new adult HIV infections has remained unchanged, with an estimated 1.9 million occurring globally each year. The freeze on prevention progress is occurring at the same time as the world is preparing to achieve ambitious global targets to dramatically reduce new infections and end the epidemic as a public health threat by 2030. In November 2014, UNAIDS set the global Fast-Track targets to accelerate progress against ending AIDS, including goals to reach fewer than 500,000 new adult infections by 2020 and fewer than 200,000 new adult infections by 2030.

Based on UNAIDS modeling, ending AIDS will cost an estimated \$25 billion each year until 2030. Slightly more than a quarter of this amount (26%) represents resources required for prevention. The Global Fund to Fight AIDS, Tuberculosis and Malaria is a major financier of

African HIV responses and a vital source of prevention investments. By 2015, the Global Fund supported 3.6 million HIV-positive pregnant women to receive ARV prophylaxis in order to prevent transmission to their unborn children and distributed 5.3 billion condoms. The Global Fund's new strategy (2017- 2022) is aligned to global targets, including the Fast-Track.

Is the Global Fund investing “a quarter for prevention” in Africa?

To answer this question, a search was performed for Global Fund funding requests and signed grant agreements from a sample of 25 African countries over the 2014-2016 funding cycle. Funding requests were accessed for 23 countries and signed grant agreements were accessed for 15 countries. Some documents were not publicly available.

Of the 23 funding requests examined, 11 countries requested at least “a quarter for prevention”, dedicating 26% or more of their total funding requests to HIV prevention interventions (Figure 1). The remaining 12 had prevention requests below 26%. Mauritius' request for prevention was the largest (proportionally), at 67%, and Mozambique's prevention request was the smallest, at 3%.

Overall, an average of 19% of the total funding requested was dedicated to HIV prevention. Of the 15 signed grant agreements examined, just three countries – Botswana, Ghana and Liberia – had at least 26% of the budget dedicated to HIV prevention (Figure 2).

Across the 15 countries, 69% of the prevention funding that was requested got included in signed grants. As a proportion of the total invested, the amount the Global Fund invests in prevention is 20%, slightly higher than the 19% that countries requested.

Among the sample, 70% of HIV prevention funding is implemented by a government principal recipient (PR), 25% by a civil society PR, and 5% by UN agencies. There is a significant correlation between the annual number of new HIV infections in a country and the amount of prevention funding requested from the Global Fund ($r=.747^{**}$, $p<.01$). This suggests that funding requests are largely in line with country context. There is also a significant correlation between the wealth of a country, expressed as GDP per capita, and the proportion of funding requested for prevention ($r=.676^{**}$, $p<.01$).

This is likely because wealthier countries are able to cover treatment costs with domestic funding, freeing up more of their Global Fund allocation for prevention activities.

There is a need to increase Global Fund investments in HIV prevention in Africa from current levels (20%) towards the recommended 26%. Historically, the Fund has invested much more in HIV prevention, with 30% of the Global Fund's cumulative HIV expenditure from 2002-2011 going to prevention. Part of the solution must be to stimulate greater HIV prevention requests from countries. Advocacy from civil society and communities is absolutely vital, particularly on urging countries to request greater HIV prevention funding for key and vulnerable populations.

ANNEXES

Figure 1: Proportion of 2014-2016 HIV and TB/HIV Global Fund Funding Requests Dedicated to HIV Prevention Interventions

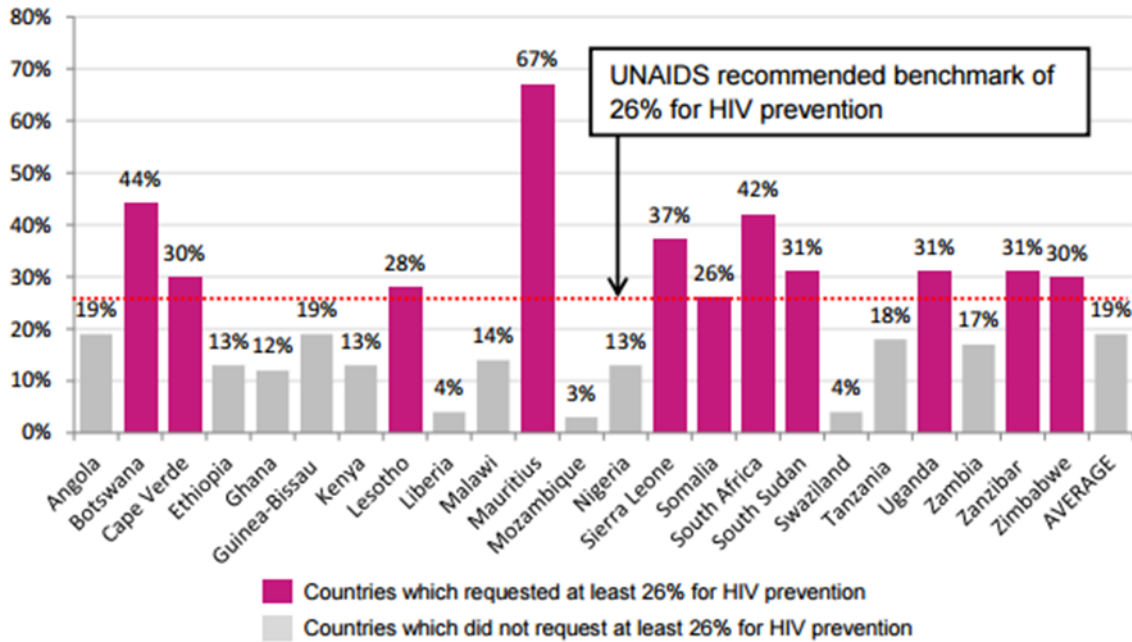
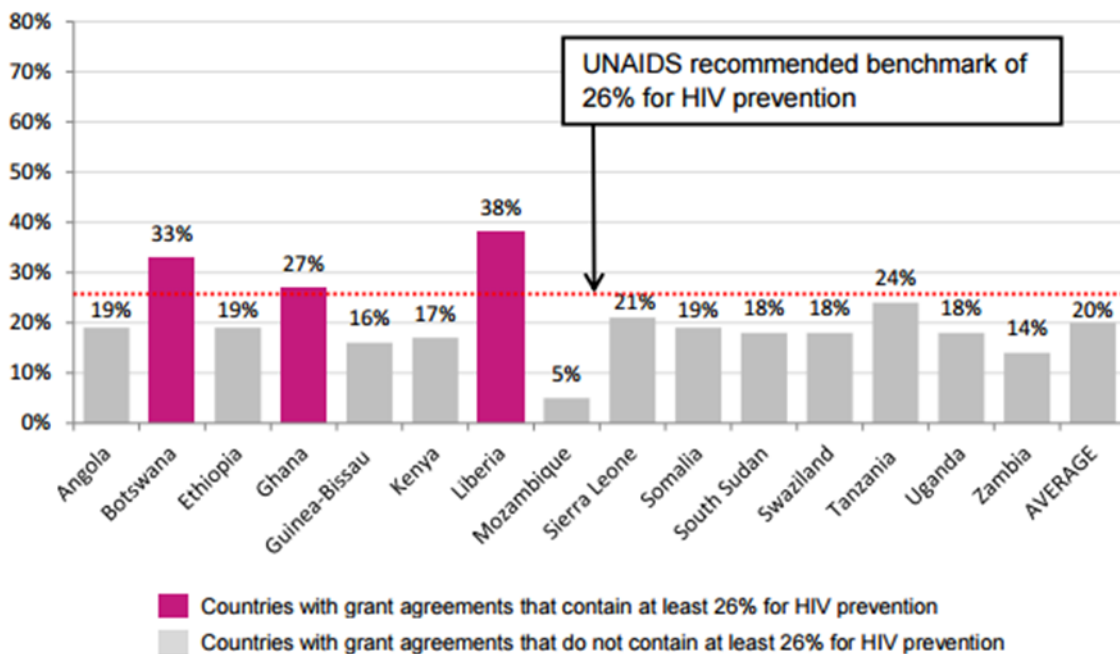


Figure 2: Proportion of 2014-2016 HIV and TB/HIV Global Fund Signed Grant Agreements Dedicated to HIV Prevention Interventions



36.2. TITLE OF THE PROGRAMME:

Central funding for procurement and distribution of condoms for PEPFAR programs

CONTACT PERSON

Name: Heather Watts

Title: Director of HIV Prevention

Organisation: Office of the Global AIDS Coordinator

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Email: wattsdh@state.gov

Programme is being implemented since: Central procurement of condoms by PEPFAR has occurred for many years, but in 2017, all PEPFAR countries became eligible for central procurement.

Responsible party/parties: Government

Populations group(s) reached: People living with HIV / Men who have sex with men / People who inject drugs / Young people / Sex workers / Transgender / Women

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? N/A

DESCRIPTION

Condoms are a key component of HIV prevention. PEPFAR procures nearly 1 billion condoms/year. Formerly, budgeting for condoms and lubricants was included in country operational plans, which had a fixed budget level. Beginning in COP17 (fiscal year 2018 programming) condoms and lubricants are procured and distributed with central funding, while condom distribution and demand creation are funded in the COP. A gap analysis of needed commodities and funding for distribution and demand creation was completed for the seven highest need countries, and funding levels were recommended. COP's are being submitted currently, and the increase in condom procurement and distribution with the new policy will be tracked in upcoming months. Results should be available in late May, 2017.

36.3. TITLE OF THE PROGRAMME:

Community mobilization and norms change to reduce gender based violence, school drop out in girls, and early marriage

CONTACT PERSON

Name: Heather Watts

Title: Director of HIV Prevention

Organisation: Office of the Global AIDS Coordinator

Address: Washington DC

Tel: +1-202-663-2547

Email: wattsdh@state.gov

Programme is being implemented since: 2016

Responsible party/parties: Government

Populations group(s) reached: Girls / Young people / Other

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? N/A

Is the programme part of a national plan other than the national aids strategy? N/A

DESCRIPTION

Lesotho: PSI has reached over 5,000 men with a 10-hour curriculum to change gender norms. They target men between the ages of 20 and 49 for gender and social norms change and link them to HIV testing at the end of their week-long training. Trainings have proven to be very popular among men and no problems reported with retaining men in the program. They are recruited through soccer clubs, local chiefs, at construction sites, taxi ranks, or other workplaces. When asked what they value about the sessions, they said they especially enjoy learning about ways to control anger and protect partners without resorting to violence. PSI reports that men are asking for the program to include their partners so as to better re-inforce their new learnings.

Malawi: At Mtubwi Primary School in Machinga, mother's groups and the female Group Village Headman (GVH- chief), Malindima, have taken steps to ensure every girl in the surrounding area have access to schooling and education. Together, they have come up with bi-laws for the community stating that all children must go to school including girls. Those who break the bi-laws are subject to pay a fine. The bi-laws have been distributed to other local chiefs, the District Commissioner and the police. As well, girls have been encouraged to not marry below

25 years old. So far, the GVH has annulled 7 marriages of young girls. As well, members of the mother's groups are now actively monitoring initiation ceremonies in the villages to ensure no harmful practices are forced upon any girl child. Over the past year, 12 girls were brought back to Mtubwi Primary School after they had dropped out and 9 to secondary school.

Swaziland: HC3 is working with 5,000 community leaders and other key gatekeepers across all 19 DREAMS Tinkhundla, in order to support DREAMS by changing social norms, creating safer environments for AGYW and mobilizing HIV service uptake by men. Activities include training of traditional chiefs, their wives and inner council members, pastors and other local-level leaders to deepen their understanding of the HIV epidemic and appropriate community responses. As part of the training process, training participants jointly develop community action plans to address the epidemic. Tools have also been developed to ensure standardization and quality assurance in the work with community leaders. HC3 interventions for community leaders have been well received by traditional leaders and the Ministry of Tinkhundla. Traditional leaders have been especially appreciative of careful attention to appropriate protocols for community entry and the opportunity to deepen their understanding of the situation in their communities.

ANNEXES:

Swaziland

Strengthening community leadership and male involvement in the local HIV response to increase the uptake of HIV services, reduce vulnerabilities, and protect AGYW.

BACKGROUND/CONTEXT

Swaziland is a small country of 1.1 million people with an extremely high burden of HIV (31% HIV prevalence among adults²⁶), as well as high rates of sexual and gender-based violence (8 in 10 women report having experienced violence in their life). Swaziland is divided into four administrative regions: Hhohho, Lubombo, Manzini, and Shiselweni that are led by a Regional Administrators²⁷. The Regional Administrator (RA) is responsible for governance, administration, and the coordination of the various sector activities. All ministries except for foreign affairs are represented in each region. These regions are subdivided into 55 Tinkhundla (districts) and 385 Chiefdoms (communities). The Chiefdom is the lowest governmental administrative unit of the Ministry of Tinkhundla Development and Administration (MTAD²⁸), led by the Chief with the

²⁶ SHIMS 2011

²⁷ Regional Administrators (RA) are similar to a Governor

²⁸ MTAD is responsible for rural development and government administration – similar to Department of Interior or Home Affairs. Urban administration falls under the Ministry of Housing and Urban Development

assistance of an elected administrator (Buchopo), inner council members, and Community Development and other committees. The Chieftdom is responsible for the coordination and oversight of all development programs in the community and for the health and well being of its population. In addition, to administrative and governmental responsibilities, the Chieftdoms have a solid well-structured formal traditional hierarchy that consists of Chiefs, Headmen, and Inner Council, who regularly advise the Chief. Through the traditional structure the Chiefs report directly to the Monarchy.

The Expanded National Strategic Framework for AIDS (eNSF) 2014-2018 recognizes the critical importance of community engagement and community leadership in the HIV response. Attaining and maintaining 90-90-90 and preventing new infections to reach His Majesties vision of an AIDS free generation by 2022 could only become a reality with the ongoing active engagement and leadership at the Chieftdom level.

In 2014, PEPFAR/Swaziland, through the Health Communication Capacity Collaborative (HC3) began efforts to strengthen the local governmental and traditional leadership structures at the Chieftdom level in response to the eNSF under the leadership of the National Emergency Response Commission for HIV/AIDS (NERCHA). To support a more coordinated and locally led HIV response, HC3 with the Ministry of Health (MOH) and MTAD²⁹, under the leadership of NERCHA, drafted community engagement guidelines which call for, “a systematic approach to catalyzing a sustained community-led and community owned HIV response.” However, to build robust community ownership of the local HIV response, Chiefs, their inner councils and key community gatekeepers needed to have a good understanding of HIV in Swaziland; the biologic, behavioral, and structural determinants, the drivers of the epidemic; and the barriers to HIV prevention, treatment and care. They needed current data and information, and the tools and skills to become active leaders to turn the tide of the epidemic. The HC3 program was designed to provide these critical tools and skills and capacitate the local governmental and traditional structures to support and coordinate the continuum of the HIV response in their communities.

PROJECT OVERVIEW

HC3 is a 4-year project ending September 2017. With PEPFAR support, working through and with existing structures, HC3 strengthens community capacity to lead an effective HIV response including addressing the socio-cultural and gender norms that create barriers to service uptake and increase vulnerability. HC3 began their work in the chieftdoms of three Tinkhundla in Manzini Region. With the addition of DREAMS support in FY2016, PEPFAR/S was able to expand the HC3 model to the chieftdoms within the 19 DREAMS focus Tinkhundla. Subsequently in FY 16 PEPFAR introduced a pilot (“game-changer”) performance-based support for select chieftdoms to

²⁹ November 2014 National Guidelines for Community Engagement: A Step-by-Step Guide for Community Engagement towards Elimination of New HIV Infections and Mitigation of its Effects on Individuals, Families and Communities. P. 2 and 4.

streamline the development of outcome-based HIV plans to support the achievement of 90-90-90 and prevent new HIV infections in their communities with a focus on engaging men. Leadership training and program monitoring for Chiefs and their inner council members will be an important component of this pilot. In addition the pilot will actively engage men in assuring their own health and taking an active role in the health and well being of their families and communities.

The overall purpose of the HC3 project is:

To strengthen the capacity of community leaders and systems to address the HIV/TB epidemic and guide an effective and sustainable response

The objectives of the HC3 project are:

1. To strengthen the capacity of community leaders to address the socio-cultural and gender norms that increase risk of HIV acquisition and transmission, and create a safe, protective environment for AGYW
2. To strengthen Chieftdom structures to plan, coordinate and monitor a comprehensive local HIV program
3. To improve access to and increase up-take of high impact HIV/TB services and support adherence to HIV prevention and treatment.

To build a firm foundation for the project, HC3 conducted transformative sessions on gender and HIV for chiefs and their spouses. The purpose of the trainings was to increase their understanding of GBV and HIV, starting with actual data, followed by information the biologic, behavioral and structural determinants of HIV acquisition and transmission, including the greater risks for adolescent girls; and subsequently an in-depth dialogue regarding Swazi specific gender and socio-cultural norms that are protective and those which are harmful. At the end of the sessions, the Chiefs and their wives sign commitments and create a concrete action plans to reduce S/GBV and to create safe and supportive environments for AGYW in their communities. Chiefs identified specific focus areas including reducing teen pregnancy and keeping girls in school; stopping early marriage, condom promotion and making intergenerational sex taboo. Together, progress is reviewed on a quarterly basis. Inner council members and other key gatekeepers such as traditional healers and pastors also received the HIV and gender training.

HC3 provides assistance to the chiefdoms in implementing comprehensive HIV services and enhancing the uptake of testing and linkage to high impact HIV services for their populations. HC3 supports community engagement committees and through the assistance of trained facilitators, conducted a series of HIV sessions for men, adolescent girls and young women. HC3 coordinated with Testing and linkage partners such as PSI and clinical partners to assure ease of access to testing, early enrollment for HIV positive clients and, for those testing negative, active linkage or referrals to VMMC (for males) and other prevention services. HIV interventions are provided through a variety of channels including small group sessions, door-to-door, the family approach, traditional ceremonies, and community events.

RESULTS

HC3 has provided HIV, gender, program planning and leadership training to:

- Over 121 chiefs and their wives
- 5,700 local government and traditional leaders, including 1177 inner council members

HC3 has reached:

- 32,326 AGYW and men in one half a year from October 2017-March 2018 (80% of their annual target) with a core package of prevention interventions
- Facilitated the testing of 16,052 individuals and assured linkage to appropriate services

36.4. TITLE OF THE PROGRAMME:

Determining HIV Risk for Pre-exposure Prophylaxis (PrEP)

CONTACT PERSON

Name: Heather Watts

Title: Director of HIV Prevention

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Programme is being implemented since: 2016

Responsible party/parties: Government

Populations group(s) reached: Women / Girls

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? N/A

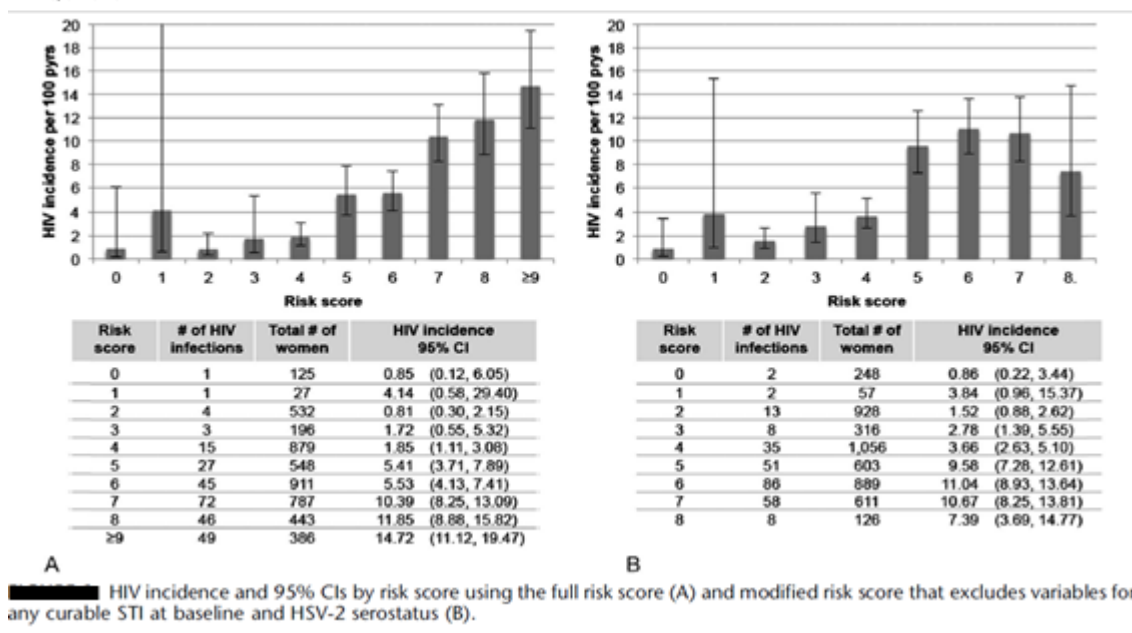
Is the programme part of a national plan other than the national aids strategy? N/A

DESCRIPTION

In many settings, AGYW are at increased risk of HIV acquisition, but determining which AGYW are at significant risk and would benefit from PrEP can be difficult. Investigators combined data

on more than 9,400 women from three prevention studies conducted in Southern and Eastern Africa to identify risk factors for HIV acquisition. The scoring system included categories of risk based on age (<25 versus 25+), marriage/cohabitation, alcohol use, partner providing material support, partner having other known partners, curable STI, and HSV2 seropositive or negative. The risks associated with increasing scores are illustrated in figure 8. A similar risk assessment was performed in a cohort of pregnant women in Kenya and found that unknown partner HIV status, more than one lifetime partner, and having syphilis all conferred increased risk of HIV acquisition during pregnancy.

Figure 8



Balkus JE, et al. An empiric risk scoring tool to predict HIV-1 acquisition in African women. *J Acquir Immun Defic Syndr* 2016;72:333-43

¹ Pintye J, et al. A risk assessment tool for identifying pregnant and postpartum women who may benefit from pre-exposure prophylaxis (PrEP). *Clin Infect Dis* In press

36.5. TITLE OF THE PROGRAMME:

Engagement + Empowerment = Equality!

CONTACT PERSON

Name: Nazneen Damji

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Programme is being implemented since: 2015

Implemented by: Government / Civil society / UN or other inter-governmental organisation

Scope of Submissions: People living with HIV/ Young people / Girls

Has the programme been evaluated / assessed? No

Is the program part of the implementation of the National AIDS Strategy? No

Is the program part of the National Plan Broader than the National AIDS Strategy? No

DESCRIPTION

Gender inequality, violence, lack of information about HIV and discriminatory social norms put young women and adolescent girls at particular risk for HIV infection. 58% of new HIV infections among young people aged 15-24 in 2015 occurred among adolescent girls and young women. The situation is particularly alarming in sub-Saharan Africa, where young women aged 15-24 made up 66% of new infections among young people in 2015. UNAIDS data from seven longitudinal studies across Eastern and Southern Africa show that young women of 15-19 years accounted for three quarters (74%) of new infections in eastern Africa and nearly all of the new infections (91%) in Southern Africa. Evidence demonstrates that older adult men are infecting younger women who lack the power to negotiate safer sex or refuse sex.

To pilot a promising approach to prevent HIV and mitigate its impact among young women and adolescent girls, UN Women designed and funded “Engagement+Empowerment=Equality” effort, which was implemented in Malawi, Kenya and Uganda by the International Planned Parenthood Federation (IPPF) between July 2015 and March 2016. In just 9 months the effort resulted in building leadership capacity of over 1,000 young women and adolescent girls, including 250 living with HIV, in Malawi, Kenya and Uganda. Through the online and face-to-

face mentoring, capacity building, peer support and the use of social media, young champions engaged in the design and validation of the All-In to End Adolescents AIDS country assessments.

The young champions were able to reach thousands of young women through outreach activities and social and print media, by engaging with their peers, sharing information about HIV and the risk factors, mentoring and counselling them. The young champions engaged with parents, teachers, community leaders, religious leaders, government stakeholders to amplify the risk factors that increase the girls' vulnerability to HIV and advocate to address these at community and national level. The young women advocates now feel more confident in raising their priorities with the community leaders and decision-makers.

An enabling environment, with no discriminatory laws and policies; and health systems and workers that respect young women and their access to services and rights to sexual and reproductive health; and communities that lift girls up and support their educational opportunities combined with empowered girls will contribute to ending AIDS. And when empowered girls have the skills to meaningfully engage with decision makers, policy makers, and community stakeholders in an enabling environment, they can be powerful negotiators.

37. INTERNATIONAL

TITLE OF THE PROGRAMME:

Global State of Harm Reduction

CONTACT PERSON

Name: Katie Stone

Title: Research Analyst

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Email: Katie.stone@hri.global

Programme is being implemented since: 2008

Implemented by: Civil society

Scope of Submissions: People who inject drugs

Has the programme been evaluated / assessed? No

Is the program part of the implementation of the National AIDS Strategy? No

Is the program part of the National Plan Broader than the National AIDS Strategy? No

CONTEXT

Harm Reduction International's biennial Global State of Harm Reduction reports track harm reduction worldwide, mapping the response to drug-related HIV, viral hepatitis and tuberculosis. Every two years HRI integrates updated information on harm reduction services into each regional chapter, including on needle and syringe programmes (NSPs) and opioid substitution therapy (OST) provision; harm reduction services in prisons; access to antiretroviral therapy (ART) for people who inject drugs; overdose responses; policy developments; civil society developments; and information relating to funding for harm reduction. With changing patterns in drug use, the 2016 report also reflects the use of, and harm reduction response to, amphetamine type stimulants (ATS). The Global State has become a vital source for researchers and advocates since the first edition in 2008, when it provided the first global snapshot of harm reduction responses.

GLOBAL STATE OF HARM REDUCTION 2016: RESULTS AND IMPACT

Injecting drug use is a global phenomenon, documented in at least 158 of the world's countries and territories.⁽¹⁾ Using primarily government reported data, UN estimates for 2014 found that 11.7 million people injected drugs worldwide, with 14% living with HIV, 52% living with hepatitis C and 9% living with hepatitis B.⁽²⁾ Harm reduction responses, while now in place to some degree in a majority of the world's countries, fall far short of reaching people who inject drugs worldwide. In 2016, 90 countries implemented needle and syringe programmes (NSPs) to some degree and 8 had at least one opioid substitution programme (OST) in place.

The most striking statistic to emerge from the Global State of Harm Reduction 2016 is that since 2014, there has been no increase in the number of countries implementing NSPs – the first time that this has happened since the inception of the report in 2008. Of 158 countries and territories where injecting drug use has been reported, 68 still have no NSP in place, and 78 have no provision of OST.

GAPS AND BARRIERS

Behind these numbers is a gap between new international commitments to end AIDS and scale up harm reduction made over the last two years and the levels of financial and political leadership being shown both by national governments and international agencies. In 2015, as part of the Sustainable Development Goals (SDGs), the UN General Assembly agreed a global target to end AIDS by 2030.⁽³⁾ In 2016, member states at both the UN General Assembly Special Session (UNGASS) on Drugs and the High Level Meeting on HIV and AIDS committed to 'minimising the adverse public health and social consequences of drug abuse', and endorsed harm reduction interventions including 'medication assisted therapy', 'injecting equipment programmes', 'antiretroviral therapy' and 'Naloxone', which can reverse opioid overdose.⁽⁴⁾ Yet as the Global State of Harm Reduction 2016 shows, in many countries coverage of NSP and OST remains substantially below the minimum levels recommended by international guidance and is insufficient to prevent HIV and hepatitis C epidemics among people who inject drugs. There are also an alarming number of countries where coverage of NSP and OST has decreased.

HARM REDUCTION FUNDING CRISIS

Underpinning the data is a deepening funding crisis facing harm reduction. Even in Europe, the region traditionally most supportive of harm reduction, a drop in government funding has resulted in service closures. International donor funding for the HIV response is in decline, and this problem is increasingly pronounced in middle-income countries (MICs) where harm reduction is most needed.⁽⁵⁾ The Global Fund for AIDS, tuberculosis (TB) and Malaria (GFATM) has warned MICs to 'begin or build upon transition preparations during the 2017-2019 period', and has listed 24 countries that will become ineligible for GFATM in the coming years.⁽⁶⁾ With international financing disappearing, harm reduction advocates in MICs are uncertain about

what will replace it. The assumption from international agencies appears to be that national governments will fill this vacuum and invest. In May 2016, UNAIDS released 'global' harm reduction resource needs estimates which did not include high-income countries and assumed that all upper MICs would fund their own responses.⁽⁷⁾ In doing so UNAIDS has left behind some three quarters of people who inject drugs globally^a covering countries such as the US, Russia, Greece, Hungary, Bulgaria, Thailand, China, Mauritius and Belarus, where harm reduction programmes are severely limited even after decades of local advocacy.

LESSONS LEARNED AND RECOMMENDATIONS

Behind the numbers in the Global State of Harm Reduction 2016, remains a landscape of political neglect. In too many contexts, civil society is relied upon to deliver services, gather data, advocate for funding and fight for the rights of people who use drugs. Underfunded and politically ignored, it is no wonder that the harm reduction response is facing stagnation and in some cases regression.

Ahead of the UNGASS on drugs, over a thousand harm reduction and drug policy organisations worldwide signed Harm Reduction International's call for a harm reduction decade, with a new approach to drug use rooted in science, public health, human rights and dignity.

The UNGASS outcome document included the strongest ever language on harm reduction, and UNAIDS and its co-sponsors should now seize the opportunity that this presents, and work closely with governments to scale up the harm reduction interventions that were endorsed by the UNGASS.

In support of this work, UNAIDS should actively promote the recommendation included in its 2015 Do No Harm report, which called for "a rebalancing of investments in drug control to ensure that the resources needed for public health services are fully funded, including harm reduction".

In addition, UN agencies and member states are already embarking on the process to develop the next Political Declaration on Drugs in 2019. If we are truly committed to ending AIDS among people who inject drugs by 2030, this next Declaration will need to be groundbreaking. Harm Reduction International urges UNAIDS and its co-sponsors to lead the way in actively pushing for a rethink of the objectives of global drug policy as well as the indicators by which we measure drug policy success. To better align with the AIDS response, global drug policy indicators will need to encompass coverage of services, reduction of harms, and lives saved, alongside advancements in human rights. If the 2019 process is to be worth even the time already invested, it must secure a new decade of drug policy with harm reduction as a guiding principle.

a – HRI unpublished calculations using national population size estimates from the Global State of Harm Reduction 2014 categorised by country-income status

- (1) Cook C, Kanaef N (2008) *Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics*. Harm Reduction International: London
- (2) UNODC (2016) *World Drug Report*. Vienna
- (3) UN General Assembly (2016) 'On the fast track to ending the AIDS epidemic. Report of the Secretary-General'. Available from:
http://www.unaids.org/sites/default/files/media_asset/20160423_SGreport_HLM_en.pdf.
- (4) UN General Assembly (2016) 'S-30/1. Our joint commitment to effectively addressing and countering the world drug problem. Resolution adopted by the General Assembly, 19 April 2016,' p14, Available from: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N16/110/24/PDF/N1611024.pdf>
- (5) Cook C, Phelan M, Sander G et al. (2016) *The Case for a Harm Reduction Decade: Progress, potential and paradigm shifts*. Harm Reduction International: London
- (6) Global Fund (2016) 'Projected Transitions from Global Fund support by 2025 – projections by component'. Available from
http://www.theglobalfund.org/documents/core/eligibility/Core_ProtectedTransitions2016_List_en/.
- (7) UNAIDS (2016) *Do No Harm: Health, Human Rights and People Who Use Drugs*. Geneva

38. EUROPEAN UNION

TITLE OF THE PROGRAMME:

Harm Reduction Works! Harm Reduction Investment in the European Union

CONTACT PERSON

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Title: Head of Research

Organisation: Harm Reduction International

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Programme is being implemented since: 2015-2017

Responsible party/parties: Civil society

Populations group(s) reached: People who inject drugs

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

Tracking harm Reduction Investment in the European Union - Europe is the birthplace of harm reduction and the region where its successes in averting HIV epidemics among people who inject drugs can be most plainly seen, but even in Europe the provision and coverage of harm reduction services is being hit by a funding crisis fuelled by austerity, the retreat of international donors and low political support for harm reduction.

Harm reduction funding at a glance - As part of the EU funded Harm Reduction Works! Programme, Harm Reduction International has developed a simple set of criteria and working with national harm reduction providers, researchers and advocates, has used these to gain an indication of the health of harm reduction funding in 18 EU countries (as shown in Table 1).

A traffic light system categorises the national situation as poor (red), mediocre (amber) or good (green) on the following criteria: harm reduction coverage, transparency of spending data, government investment in harm reduction and the civil society view on sustainable funding.

Government investment - Since 2008 most governments in Europe have imposed austerity measures which have directly impacted investment in harm reduction. Some states, such as Greece, have dramatically cut funding for harm reduction. Where political will for harm reduction is strong, the impact of austerity on investment in harm reduction has been tempered. But even where domestic funding has remained steady, states such as Portugal have not adjusted investment to reflect the rising cost of living. Where international donor funds have come to an end, a small number of states, in particular Estonia, have increased domestic support for harm reduction, but others, such as Romania, have not, triggering a spike in HIV infections among people who inject drugs. Across the region, investment in ineffective and often repressive drug enforcement measures dramatically outweighs spending on health and harm reduction.

Transparency of spending - With harm reduction often integrated into health systems in European countries, it is extremely challenging to accurately establish what is being spent on harm reduction services. Although some governments carry out dedicated research on this in the context of wider drug policy expenditure, it is not routine and does not drill down to the level of specific interventions. Even in countries that have national mechanisms to track health or drug policy expenditures, harm reduction spending is not isolated. This information is crucial for strategic budget decision-making and to guarantee that dwindling funding is invested where it is most needed and will have the most impact. The current gap in knowledge threatens governments' ability to ensure success.

Sustainability of funding - The future of harm reduction funding in EU member states ranges from fairly certain to extremely insecure. The countries where funding is more certain share common features, including political support for harm reduction, supportive laws and policies and strong and supported civil society. However, even in these countries there remain funding gaps and areas in which the efficiency of government investment could be improved. Where funding is extremely insecure, rapid increases in HIV infection rates among people who inject drugs are feared. At the 2016 UN General Assembly Special Session on Drugs, EU member states committed to reducing the adverse public health and social consequences of drug use, endorsing medically assisted therapy, injecting equipment programmes, antiretroviral therapy and naloxone. The previous year they committed to end AIDS by 2030 under the UN Sustainable Development Goals. Fulfilling these and other international commitments will not be possible without sustainable funding for harm reduction.

RECOMMENDATIONS

National authorities:

- National governments must ensure sustainable funding for harm reduction and must protect harm reduction investments from austerity measures.
- Governments should undertake cost-effectiveness studies into drug policy spending and redirect funds from drug enforcement to harm reduction.

- They should also make harm reduction spending information more transparent and ensure that it is systematically monitored.

European Institutions:

- The European Commission should create a time-bound emergency fund to keep services in operation in countries no longer eligible for Global Fund grants. This fund should be accessible to civil society organisations, avoid cumbersome application processes with very low success rates, and be exempt from the European Union standard co-funding expectations.
- The Commission should also lead the development of a new HIV Strategy and Action Plan with a strong emphasis on ensuring the sustainability of harm reduction services. The next EU Action Plan on Drugs, to cover the period 2017-2020, should support these efforts.
- The EMCDDA and its National Reitox Focal Points should include indicators on harm reduction investment within regular data collection requirements.

The Global Fund to fight AIDS, TB and Malaria:

- The GFATM must do much more to support and encourage governments in EU states where it is withdrawing harm reduction funding to transition to national funding.
- With the 'NGO rule', which provided for directly funding NGOs in some upper-middle income countries, now defunct, the GFATM must ensure that its new emergency fund is an option for countries where government investment in programmes is not forthcoming. Under the NGO rule there was a need to better define what was meant by 'political barriers' and what constitutes proof that these are insurmountable. The emergency fund should respond to these challenges.
- Recognising the value of harm reduction (and law enforcement) resource tracking in holding governments to account, the GFATM and other donors should expand support for resource tracking initiatives and resultant advocacy by civil society organisations.

UN agencies

- Again recognising the value of harm reduction (and law enforcement) resource tracking in holding governments to account, the UNAIDS Secretariat and co-sponsors should actively support civil society organisations to undertake resource tracking and should recognise and publicise the data that these initiatives generate.
- UN agencies must also do much more to support and encourage governments to fund harm reduction.

- In particular, UNAIDS should actively promote the recommendation included in its 2015 Do No Harm report, which called for “a rebalancing of investments in drug control to ensure that the resources needed for public health services are fully funded, including harm reduction”.

ANNEXES

The full report upon which this case study is based can be found at www.hri.global/harmreductionworks along with the research methodology and additional annexes.

Table 1 below provides a snapshot of the state of harm reduction funding with 18 European Union member states.

Country	Harm reduction coverage	Transparency of spending data	Government investment in harm reduction	Civil society view on the sustainability of funding
Bulgaria				
Romania				
Poland				
Hungary				
Greece				
Lithuania				
Italy				
Sweden				
Czech Republic				
Portugal				
Finland				
Estonia				
UK				
Ireland	Not known			
Belgium				
France				
Germany				
The Netherlands				

39. EAST AND SOUTHERN AFRICA (WITH A FOCUS ON KENYA, ZIMBABWE, AND MALAWI)

TITLE OF THE PROGRAMME:

#WhatWomenWant: Adolescent girls and young women put HIV prevention on the Fast-Track through leveraging social media and movements

CONTACT PERSON

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Programme is being implemented since: February – March 2017

Responsible party/parties: Civil society

Populations group(s) reached: People living with HIV / Women / Girls / Young people

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? No

CONTEXT

Our consultation and participatory accountability process, #WhatWomenWant, engaged adolescent girls and young women (AGYW) across East and Southern Africa (with a focus on Kenya, Zimbabwe, and Malawi) to review UNAIDS guidance HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. Through this engagement process we utilised social media to engage AGYW in responding to UNAIDS prevention guidance, reviewing and reacting to the strategies outlined in the guidance, engaging directly with implementers and decision-makers, identifying barriers and challenges, and articulating solutions to these rooted in their lived experience, professional knowledge, and community understanding.

The methodology included an extended focus group discussion conducted using WhatsApp, a working group, informational webinars, bringing policy-makers into direct dialogue with AGYW through social media, and advocacy through Twitter and other social media. 185 young women from more than nine different countries participated in a focus group through WhatsApp,

responding directly to the UNAIDS guidance and providing rich, insightful feedback on what was needed to ensure these strategies were implemented effectively for AGYW.

The approach used for this project operationalized the concept of the first of five prevention pillars in the UNAIDS Prevention Gap report - combination prevention for young women and adolescent girls and their male partners in high-prevalence locations. The #WhatWomenWant focus group were engaged in semi-structured discussions on HIV prevention topics including comprehensive sexuality education, economic empowerment, PrEP, condoms, and youth-friendly sexual and reproductive health services.

RESULTS AND IMPACT

Through leveraging social media and movements, we engaged hundreds of AGYW, across countries and communities, to create a virtual learning platform whereby AGYC identified practical barriers of access, shared social norms around 'appropriate' knowledge and behaviour that prevent them from accessing information or services, described an epidemic of gender-based violence as it impacts their own lives, underscored a lack of knowledge about prevention tools including PrEP, and articulated the failure of negative and risk-based prevention messaging while sharing what works in the contexts of their lives and communities.

KEY RESULTS AND IMPACT INCLUDE THE FOLLOWING:

- ☛ Operationalized key elements of the UNAIDS AGYW HIV prevention guidance namely enhanced leadership, multimedia and new media, and community mobilization.
- ☛ Generating HIV prevention awareness, increasing knowledge and strengthening agency among AGYW (those that we directly reached as well as among their peers and within their networks)
- ☛ Facilitating meaningful engagement of AGYW in HIV prevention policy, advocacy, and research.
- ☛ Mobilizing communities to build power among AGYW, advocate for policy change, and propose solutions to increase access to available services as well as identify what services are needed.
- ☛ Using new social media and digital platforms enabled significant participation, created new pathways for young advocates to participate, provided a platform for AGYW to raise their questions, talk about what matter to them, and present their concerns to decision makers while also presenting their solutions.

FINANCING

This work has built upon the #WhatWomenWant campaign, initiated in 2016, and seed funding was provided by UNAIDS. In addition, the campaign has been resourced by the ATHENA

Initiative, and has been developed to contribute toward the impact and reach of PEPFAR, specifically DREAMS, as well as the AGYW reach of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

GOVERNANCE

The work has been led by a team of young women from the region, and has been supported by a champion mentor, Ebony Johnson of ATHENA.

LESSONS LEARNED AND RECOMMENDATIONS

Through this process, we have demonstrated the potential to engage AGYW in real time, direct accountability processes through using WhatsApp or other tools which are accessible and commonly used. The process would be simple to replicate in other settings, and provides an avenue to reach larger numbers of AGYW including those who face time or access barriers to participating in face-to-face accountability processes. This process must be ongoing, and repeated in each country, region, and community where HIV prevention services, information, and tools for AGYW are yet to achieve their aims.

Of critical importance for the future of the prevention response, including investment in effective HIV prevention, will be developing the leadership, platforming the voices, and realizing the knowledge and solutions of adolescent girls and women themselves. This includes thoughtful consideration and operationalization of the voices, expertise and experience of AGYW for HIV prevention.

ANNEXES

#WhatWomenWant HIV prevention that works for adolescent girls and young women (final version forthcoming)

40. UNITED STATES OF AMERICA AND CANADA

TITLE OF THE PROGRAMME:

Prevention Access Campaign's Undetectable = Untransmittable Campaign (U=U)

CONTACT PERSON

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Programme is being implemented since: 2016- 2018 (Current)

Responsible party/parties: Civil society

Populations group(s) reached: People living with HIV / Other (Public)

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? No. While not supported in a National AIDS Strategy, U=U campaign is endorsed by over 230 organizations from 24 countries including IAS, International Community of Women Living with HIV, MSMGF, ICASO Desmond Tutu HIV Foundation; National AIDS Trust, NAM aidsmap amongst others. In the North American region, U=U is endorsed by Dr. Carl Dieffenbach, Direction of AIDS at the National Institutes of Health in the US amongst others; In Canada, by CATIE, the national knowledge exchange broker, and the Canadian Positive People Network, amongst many others.

CONTEXT

Background: A community of people living with HIV collaborated with the leading researchers on HIV sexual transmission to answer a fundamental question about having an undetectable viral load: Will I pass on HIV to my sexual partner? The science is clear. People living with HIV can

feel confident that if they have an undetectable viral load and take their medications properly, they will not pass on HIV to sexual partners (Undetectable = Untransmittable U=U). For many people living with HIV and their partners, U=U is a message of freedom and hope. It is an unprecedented opportunity to improve lives of people living with HIV, dismantle HIV stigma, and improve treatment uptake and adherence. The health and preventative benefits of U=U underscore the importance of universal access to treatment for all people living with HIV worldwide. However, the majority of millions of people living with HIV do not have access to this information and many do not have access to adequate healthcare and support services. There are still confusing messages, outdated websites, and uninformed policy makers and healthcare workers who are not comfortable sharing this information or don't yet know about it.

NOTE: An undetectable viral load is typically under 40 copies/ml depending on the diagnostic tests. However, studies show a person living with HIV on antiretroviral therapy (ART) with a viral load under 200 copies/ml also cannot sexually transmit HIV. This is called being "virally suppressed."

INFORMATION BARRIERS: For example, in the US, there are many barriers that impede the flow of accurate information about HIV including intersecting stigma and discrimination, racism, patriarchy, inadequate access to healthcare, poverty, cultural and religious bias, gender stereotypes and bias, homophobia, outdated notions of safer sex, low science literacy among healthcare workers, and lack of comprehensive sex education. Young black and Latino men who have sex with men, black heterosexual women, transgender women, sex workers and people in the Deep South are most vulnerable and disproportionately affected by the information gap. As result of these barriers to information, the majority of people living with HIV in the U.S (and around the world) have not been told that with effective treatment they cannot transmit HIV to their sexual partners. The HIV transmission risk is greatly exaggerated which puts people living with HIV at risk of great harm and injustice.

RESULTS AND IMPACT

CONSENSUS STATEMENT: We have issued a Consensus Statement, "Risk Of Sexual Transmission Of HIV From A Person Living With HIV Who Has An Undetectable Viral Load" which is endorsed by leading scientists and over 230 PLHIV groups and organizations serving people living with HIV on the local, national and international scale in 24 countries in various continents and regions around the world (i.e. Asia, Africa, Australia, Europe Middle East, North America). (<https://www.preventionaccess.org/consensus>)

OUR APPROACH

PAC breaks through the politics, stigma and phobias that interfere with the free flow of information so people with and vulnerable to HIV can make informed decisions about their sexual and reproductive health based on science not stigma. PAC works closely with our

Community Partners (<https://www.preventionaccess.org/community>) to change the narrative about people with HIV and HIV prevention through three primary channels:

- **RESEARCH & ADVOCACY:** We develop educational and advocacy tools to encourage influential community, medical and public health leaders and associations to commit to using current, research-based messaging about HIV transmission risk. PAC and over 230 Community Partners from 24 countries have united to ensure the U=U message reaches the people and field it was intended to benefit.

- **COMMUNITY MOBILIZATION:**

- o Our S4 initiative (<https://www.preventionaccess.org/s4>) trains and supports people with HIV and allies to identify, report and resolve issues related to accuracy, bias, and stigma wherever and whenever they find them.

- o Miami pilot program - Our Power of Prevention (PoP) organizers, hired locally, will foster collaboration between existing agencies and community based organizations to improve access to treatment and U=U information, as well as PrEP, and PEP. They will work with community partners to troubleshoot access and improve uptake of prevention strategies by providing co-branded marketing campaigns, events, and structural support.

- **COMMUNICATIONS:**

- o Accuracy Watchdog: In partnership with the Human Rights Campaign and a team of medical advisers, we ensure accurate and responsible reporting about the current realities of HIV prevention and stigma by challenging inconsistencies and biases in digital, social, and print media.

- o Social Marketing Sharing: We facilitate the sharing of social marketing campaigns between Community Partners to alleviate the cost and time associated with the creation of materials.
 - o Media Outreach: We secure coverage for the U=U message in niche and mainstream media.

FINANCING

Thus far, U=U has been almost entirely volunteer-run. Two foundations provided US\$45,000 in seed grants over the past 18 months. U=U has recently made fundraising a priority in order to hire full time staff.

GOVERNANCE

The Prevention Access Campaign (PAC) is a multi-agency health equity initiative to end the dual epidemics of HIV and HIV-related stigma by expanding access to HIV prevention and

empowering people with and vulnerable to HIV with accurate and meaningful information. PAC's Undetectable = Untransmittable (U=U) is a community of HIV advocates, activists, researchers, and Community Partners around the world uniting to clarify and disseminate the groundbreaking but largely unknown fact that people living with HIV on effective treatment cannot transmit HIV. PAC was founded by a Founding Task Force, has a Steering Committee, and now has created a North American Steering Committee and an International Steering Committee.

LESSONS LEARNED AND RECOMMENDATIONS

While the HIV prevention revolution is under way, some of the most important information such as the new information related to undetectability and transmission are not yet reaching the people most affected. For people with HIV: Research confirms that when treatment is effective it will reduce the level of HIV to "undetectable" levels which protects the health of people with HIV and makes them incapable of transmitting HIV to others (Undetectable = Untransmittable- U=U). As a prevention strategy, this is often referred to as Treatment as Prevention. Prevention Access Campaign's U=U movement is a campaign that is centered on the health and well-being of people living with HIV by increasing the health literacy of those infected and affected by HIV and the public---through changing the HIV narrative by uniting with Community Partners around the world to ensure this groundbreaking research reaches the people and the field it was intended to benefit.

To end AIDS by 2030, the global AIDS architecture and response must embrace the new scientific evidence on undetectability and transmission to create a new discourse and reason to re-invest in the HIV response. The health and preventative benefits of U=U underscore the immediate need for universal access to treatment for all PLHIVs around the world who would like to start medication and remain on their regimen without treatment interruption due to drug stock outs, and the importance of having adequate healthcare infrastructures (including availability of diagnostics tools and social determinants of health) to facilitate people in reaching undetectable viral loads worldwide. PAC and our partners recognize that U=U is an unprecedented opportunity to dismantle HIV stigma and empower people living with HIV by freeing them from the fear and stigma associated with transmission. It also transforms the field by improving every stage of the treatment cascade. The more people who are virally suppressed and have access to life-saving treatments, the healthier people with HIV will be and the closer we will come to ending the epidemic. The time is now.

ANNEXES

Example of the S4 Risk Research 1-Page Summary: <http://bit.ly/S4Research>

41. GLOBAL

40.1. TITLE OF THE PROGRAMME:

Global Values and Preferences Survey of sexual and reproductive health and rights of Women living with HIV, to inform WHO's new guideline on this topic

CONTACT PERSON

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Responsible party/parties: Civil society / UN or other inter-governmental organization

Populations group(s) reached: People living with HIV / People who inject drugs / Sex workers / Transgender / Women / Young people

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? We hope it will be

Is the programme part of a national plan other than the national aids strategy? Global WHO Guideline

CONTEXT

The Values and Preferences component of most new WHO guidelines has often been little, late or absent from the process. By contrast, in late 2013, in preparing for a new WHO guideline on the Sexual and Reproductive Health and Rights of Women living with HIV, Dr Manjulaa [Narasimhan](#) of the WHO Dept. of Reproductive Health and Research commissioned a global Values and Preferences Survey on this topic, led by women living with HIV. A core team created a Global Reference Group (GRG) of 14 women living with HIV. Together they developed a global community online survey. The survey contained quantitative and qualitative mandatory and optional questions and was based on a positive, forward-thinking appreciative enquiry approach in which the life-cycle experiences of women living with HIV were

investigated. The same set of questions was also used in focus group discussions led by GRG members.

RESULTS AND IMPACT

The study covered 945 women living with HIV (832 in the survey and 113 in the focus groups) aged 15–72 years in 94 countries. Among the respondents to the optional survey questions, 89.0% (427/480) feared or had experienced gender-based violence, 56.7% (177/312) had had an unplanned pregnancy, 72.3% (227/314) had received advice on safe conception and 58.8% (489/832) had suffered poor mental health after they had discovered their HIV-positive status. The online survey presented the voices of women living with HIV at the start of the development of the new global guideline and the survey findings are presented alongside the peer-review evidence throughout the new Guideline, published in April 2017.

FINANCING

Just under US\$70k was provided by WHO for the survey. In addition, a huge amount of work was conducted on a voluntary basis by the project coordination team, GRG members, translators and all the 945 women who shared their experiences and knowledge.

GOVERNANCE

The survey was shaped by the Global Reference Group of 14 women living with HIV in all their diversities from around the world. It included young women who have grown up with HIV, women who use/have used drugs, women who do/have done sex work, women who identify as lesbian/bisexual, a transgender woman, women who are mothers and women who aren't. Salamander Trust, the coordinating organization, was founded and is led by a woman living with HIV. Collaborators included the ATHENA Network, ICW Global, GNP+, Transgender Law Center, Jòvenes Positiv@s, ICW Asia Pacific and ICW Zimbabwe.

LESSONS LEARNED AND RECOMMENDATIONS

The SRH concerns and rights of women living with HIV are complex and require a stronger response from the health sector. Whilst women living with HIV have been studied in depth, there has been a stark absence of research from the perspective of our own [SRH&R](#). By contrast, this approach offers a strong positive example of a people-centered approach to guideline and policy development which, while promoted in principle by WHO, UNAIDS and others, is all too often lacking in practice. Investment in research led and shaped by those most affected by an issue results in guidelines which are more *relevant* to their lives, more *effective* in creating positive outcomes - for healthcare provider and clients alike - and, critically, more aligned with their *rights*. Incorporation of the priorities of women living with HIV into the new Guideline systematically ensures that we can shape future policy decisions affecting our lives. Implementation science and participatory research are appropriate over-arching approaches to enhance uptake of interventions and to ensure inclusion of women living with HIV, in all our

diversities, globally, at all stages of the new Guideline development process.

ANNEXES

Guideline: New WHO SRH [Guideline](#) April 2017. Survey: Global Values and Preferences [Survey](#).

Findings: JIAS article about [GBV](#). JIAS article about mental [health](#). AIDS2016 poster about [tx](#). AIDSCare article about psychosocial [support](#).

Methodology: WHO [Bulletin](#). JVE [article](#). AIDSCare article about GRADE [process](#).

41.2 TITLE OF THE PROGRAMME:

Essential Services Package for Women and Girls Subject to Violence

CONTACT PERSON

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Programme is being implemented since: 2015-2016

Responsible party/parties: Government / Civil society / UN or other inter-governmental organization

Populations group(s) reached: People living with HIV / Women / Girls / Young people

Has the programme been evaluated /assessed? No

Is the programme part of the national aids strategy? N/A

Is the programme part of a national plan other than the national aids strategy? N/A

DESCRIPTION

Violence against women and girls is widespread, systemic and culturally entrenched. According to a 2013 global review by the World Health Organization (WHO), 35 percent of women worldwide have experienced physical and/or sexual intimate partner violence or non-partner sexual violence.³⁰ More than seven percent of women globally reported ever having experienced non-partner sexual violence.³¹ In some settings women who experience intimate partner violence are 50% more likely to acquire HIV compared to those who do not experience such violence.³²

UN Women, in partnership with ILO, UNDP, UNESCO, UNFPA, OHCHR and WHO developed and launched **A framework to underpin action to prevent violence against women**. The framework contained in this document draws together contemporary knowledge and practice in violence prevention. Its focus is on addressing the root causes as well as risk and protective factors associated with violence against women. It outlines roles that stakeholders working across countries, regions, communities, sectors and disciplines can play in contributing to the eradication of violence against women. It specifically points at the effectiveness of the initiatives that address the issues for which violence serves as a risk factor, including in case of HIV. The framework also acknowledges the need to address violence against women living with HIV.

UN Women, in collaboration with UNFPA, WHO, UNDP and UNODC, also developed **Essential Services Package for Women and Girls Subject to Violence**, which provides service delivery guidelines to ensure the delivery of high-quality services, particularly for low- and middle-income countries, for women and girls experiencing violence, including mitigating risks of acquiring HIV. As part of the response services to the cases of violence, the package also offers services to prevent HIV and link survivors to necessary treatment.

The purpose of the Essential Services Package is to support countries as they work to design, implement and review services for all women and girls who are victims and survivors of violence, in a broad range of settings and situations. The Package is a practical tool for countries setting out a clear roadmap on how to ensure the provision and coordination of quality services of all sectors. It is designed to ensure that the services of all sectors are coordinated and governed to respond in a comprehensive way and are accountable to victims and survivors and to each other. The package has an emphasis on the post rape care, including emergency contraception, safe abortion where such services are permitted by national law, post exposure prophylaxis for HIV infections, and diagnosis and treatment for sexually transmitted infections.

Both strategic documents will be rolled out in 2017 at country level.

³⁰ WHO, 2013. Global and Regional Estimates of Violence against Women, p. 2.
http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

³¹ Ibid, p.18.

³² WHO, 2015. Multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses.

ANNEXES

A framework to underpin action to prevent violence against women:

<http://www.unwomen.org/en/digital-library/publications/2015/11/prevention-framework>

Essential Services Package for Women and Girls Subject to Violence:

<http://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence#view>

41.3 TITLE OF THE PROGRAMME:

Supporting Gender Equality in the Context of HIV and AIDS

CONTACT PERSON

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Programme is being implemented since: 2009

Responsible party/parties: Government / Civil society / UN or other inter-governmental organization

Populations group(s) reached: People living with HIV / Women

Has the programme been evaluated /assessed? Yes

Is the programme part of the national aids strategy? No

Is the programme part of a national plan other than the national aids strategy? No

DESCRIPTION

AIDS is the leading cause of death among women of reproductive age worldwide. In addition to their biological susceptibility, HIV disproportionately affects women and adolescent girls because of their unequal cultural, social and economic status in society. Gender inequality,

gender-based violence, and harmful traditional practices reinforce unequal power dynamics with men and limit women's choices, opportunities and access to information, health and social services, education and employment.

Supporting Gender Equality in the Context of HIV and AIDS, a programme of the European Commission and UN Women, was launched in 2009 with the goal of integrating gender equality and human rights into HIV policies. It was implemented in five countries: Cambodia, Jamaica, Kenya, Papua New Guinea and Rwanda. The results from this programme demonstrated the important progress and changes that can be made to prevent HIV and mitigate its impact, when investments are targeted to implement commitments on gender equality in the HIV response, as well as to empower the leadership and participation of women and girls, especially those living with HIV.

SOME RESULTS OF THE PROGRAMME INCLUDE:

- Political commitment for gender equality in the national HIV response has increased and the national HIV policies became more inclusive of gender equality and human rights.
- The programme has led to an increase in allocation of resources for gender equality priorities in the HIV response. The national AIDS coordinating authorities in Cambodia, Papua New Guinea and Rwanda have set aside funds to support the ongoing training of staff and training of trainers on applying gender analysis to better address the needs of women and girls at national and subnational levels.
- Leadership of women living with HIV has been strengthened to articulate shared priorities and a common agenda, and to call for greater accountability in the HIV response. The programme trained, coached or mentored more than 650 women living with HIV on leadership, gender equality, human rights and advocacy.
- Women living with HIV participated in several national HIV and HIV-related policy making processes. Through their participation in the development and mid-term reviews of national HIV strategic plans, women living with HIV in Cambodia, Jamaica, Kenya, and Rwanda brought critical gender gaps to the attention of policymakers.
- The voices of women living with HIV were amplified in national, regional and international forums. Women were able to voice their concerns, showcase their roles in their communities, and propose solutions for strengthening the gender-responsiveness of HIV policies.
- Greater collaboration of National AIDS Coordinating Authorities and networks of women living with HIV has helped to foster greater support for gender equality and sustainability of efforts.

SOME LESSONS LEARNED:

- Integrating gender equality in national HIV responses is facilitated when there is a respected gender advocate within the organization. Gender mainstreaming is a long-term process that needs to be adequately resourced.
- Transforming the national HIV response so that gender equality dimensions are central requires greater and more sustained investment in political advocacy and technical skills building. Training on gender equality and HIV was a necessary first step, however, was not always sufficient for individuals and organizations to make necessary changes. Thus, the programme often employed
- Additional capacity building strategies, such as coaching, facilitation, and technical advising by gender advisors in the national AIDS council.
- Long-term vision and investment are also essential for promoting the leadership of women living with HIV and building strong networks. Strengthening the leadership capabilities of women living with HIV and their organizations and networks requires long-term commitment and investment.
- Creating institutionalized spaces for ongoing involvement of and dialogue between women living with HIV (rights holders) and duty bearers is as important as changes in HIV strategies and plans.
- An effective HIV response requires multi-stakeholder partnerships and increased coordination among government, gender equality advocates, civil society partners, especially women's organizations, networks of women living with HIV, and the organizations and groups that support them.

ANNEXES

Final Evaluation of the programme:

<http://gate.unwomen.org/Evaluation/Details?evaluationId=4743>