THEMATIC SEGMENT CASE STUDIES

HIV and men, in all their diversity, how can we get our responses back on track?

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Introduction

The Thematic Segment of the 51st UNAIDS Programme Coordinating Board (PCB) meeting will be held on 16 December 2022 and will focus on "***HIV and men, in all their diversity, how can we get our responses back on track?***".

In preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of best practices and country case studies. The case studies inform the development of the background note to the thematic segment as well as the discussions during the day.

A total of 39 case submissions were received. The submissions reflect the work of governments, civil society and other stakeholders, as well as collaborative efforts. The case studies highlight how to reach men, in all their diversity with HIV services in different parts of the world taking into considerations the differences in social, cultural and economic contexts.

AFRICA

Democratic Republic of the Congo: case study

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- **Timeline of the case study**: September 2020 through January 2021

- **Case study submitted by**: International non-profit organization

- **Title of approach or best practice or initiative**: Using multi-disease health screening campaigns to increase uptake of HIV testing and other health services and engage men in the health care system in the Democratic Republic of the Congo.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV testing; linkage to HIV treatment services; co-infection/co-morbidity detection (sexually transmitted infections [STIs]; non-communicable diseases [NCDs])

- **In which geographic area is the approach being carried out?** Sakania, Kenya, and Ruashi health zones (HZs) in Haut-Katanga province in the Democratic Republic of the Congo (DRC).

- **What problem was being addressed and how was it identified?**

The HIV epidemic in the DRC is a generalized epidemic with a prevalence of 1.2% percent among the general population (2013-2014 Demographic Health Survey). While progress has been made over the past two years to increase case-finding and antiretroviral therapy (ART) coverage among males, with 183,340 males enrolled on ART out of an estimated 209,190 males aged 15 and older (87.6% ART coverage), coverage remains below global HIV epidemic control targets, especially among younger males (Spectrum 2022 Version 6.16 estimates). Programmatic quantitative and qualitative data from the DRC indicate that men are not regularly accessing health services, instead only seeking facility-based health services when they become very ill or at an older age. This trend can be observed in implementation data collected by PATH in Haut-Katanga province, where males accounted for only 28–30% of people receiving facility-based HIV testing services (HTS) from January through September 2020. Additional granular analysis of HTS data from all projects funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in the DRC show that most males are reached through inpatient and tuberculosis modalities. This leads to a situation where men aged 25-45 years of age unaware of their HIV status are being missed by current HTS activities or are only being identified when they are at later stages of HIV infection (World Health Organization stage 3 or 4). Thus, new HTS

strategies that proactively reach and identify HIV positive men at a younger age and/or earlier stages of HIV infection are critical, both for ensuring better treatment outcomes for HIV positive males as well as preventing onward transmission.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Our intervention was offered to people in the general population aged 15 years and older, with a particular focus on males, especially younger males in the 20-39 age range.

- **What type of approach is it?**

Our approach comprised using a multi-disease screening campaign, offering HIV testing services (HTS) in combination with screening and testing for diseases, to increase uptake of HTS and accelerate HIV case-finding, while also facilitating earlier identification and treatment for other infectious and NCDs. This screening campaign was delivered using a hybrid community/facility approach, with extended, community outreach led by community health workers (relais communautaire; ReCo) within communities surrounding eight health facilities in Haut-Katanga province—four in Kenya HZ; three in Ruashi HZ; and one in Sakania HZ. ReCos were linked to these eight health facilities and provided referrals for appointments at the linked health facility to clients who expressed interest in multi-disease screening. Male-friendly services were also incorporated as part of our multi-disease screening approach, with clients provided with the option to schedule screening appointments outside of typical working hours or on weekends, based on their schedule and availability.

- **What was the logic and rationale behind choosing this approach or practice?**

Use of multi-disease screenings as a strategy for enhancing engagement in HIV services has been documented within the published and grey literature. For example, the Sustainable East Africa Reach on Community Health study in Kenya and Uganda, which tested whether offering HTS within larger community screening programs for NCDs and malaria with a streamlined linkage to care model would increase testing demand and linkage to care, achieved 86% testing coverage among men, including a high percentage of first-time testers. As part of their “Finding Younger Men” initiative, PEPFAR/DRC encouraged projects in the DRC to introduce new strategies that would: 1) meet men where they are based on their needs; 2) offer more flexible service hours or extended clinic hours; and 3) promote targeted testing in NCD clinics (PEPFAR DRC Country Operational Plan 2021). Our multi-disease screening approach incorporated elements from these three recommendations by incorporating a community outreach element through ReCos to meet men where they are; offering facility appointments during weekends or non-working hours; and combining HTS with screening for NCDs. Informal, qualitative data collected at our project-supported facilities also indicated that males were less likely to come to facilities for services due to the long wait times to receive one health service or due to services only being offered during business hours. Therefore, offering males the opportunity to access and receive multiple health services at one touch point and outside of typical business hours would be seen more favorably and better align with work schedules, thus increasing male willingness to come to health facilities for services.

- **Full description of the approach or best practice:**

Under this model, ReCos conducted sensitization campaigns in the areas surrounding the eight health facilities, disseminating tailored messaging based on contextual factors to raise awareness of free multi-disease screenings being offered at these facilities. Individuals interested in multi-disease screenings were given an appointment slip by ReCos to return to the health facility for a free consultation and screening services during non-working hours, either in the evenings or on weekends. Facility-based providers offered free screenings for hypertension, hyperglycemia, STIs using the syndromic approach, pneumonia, and dermatitis, based on client eligibility and preference. Following screening for these diseases, the client's HIV risk was assessed using the national HIV risk assessment tool, and the client was offered HTS if they screened positive. Clients who screened or were confirmed positive for any disease were linked to follow-on care and treatment services at the facility, including same-day ART initiation for those confirmed HIV-positive.

- **Who were the key implementers, collaborators, and partners in this approach?**

This approach was offered under the Integrated HIV/AIDS Project in Haut-Katanga (2017-2023), with funding from PEPFAR through the United States Agency for International Development. It was developed and implemented in partnership with the provincial Programme National de Lutte contre le Sida; Kenya, Sakania, and Ruashi HZ management teams; and administrators, facility-based providers, and ReCos affiliated with or linked to the following health facilities: Kasumbalesa Douane Referral Center; Ujana Health Center; Wantanshi Health Center; Mama na Watoto Health Center; Le Rocher Health Center; Atlas Health Center; Sangaji Health Center; Mamba 1 Health Center.

- **How was the community involved/engaged?**

As ReCos were the frontline faces of this multi-disease screening campaign, working within communities to increase awareness of the campaign; offer screening services; counsel individuals on the importance of being screened for NCDs, STIs, and HIV; and schedule appointments for screening at linked facilities, they played a critical role in the uptake of multi-disease screening services and engagement of males.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

2,860 individuals participated in the multi-disease screening campaign, among whom 57% (1,629) were male. 1,822 (64%) screened eligible for HTS, of whom 96% (1,746) accepted. 210 were confirmed HIV positive (12% testing positivity), and 192 (91%) were enrolled on ART. Among the other diseases areas, most clients opted for hypertension screening (94%), followed by pneumonia (61%), STIs (60%), hyperglycemia (53%), and dermatitis (47%).

Among males specifically, 95% of the 1,055 eligible for HTS accepted, with 117 diagnosed with HIV (12% testing positivity) and 104 (89%) enrolled on ART. A greater percentage of

males than females accepted screening for STIs (69% versus 49%), pneumonia (65% versus 55%), hyperglycemia (59% versus 45%), and dermatitis (51% versus 41%), while more females accepted hypertension screening than males (96% versus 92%).

While prevalence rates were generally higher among females during this campaign, more males accepted and received screening services across all disease areas, indicating the campaign's success in engaging and screening males for HIV and other co-infections/co-morbidities. The campaign also had a higher testing positivity rate than the project's overall HTS rate in these HZs during the same period (12% versus 6.4%), highlighting the campaign's success in reaching people more likely to have HIV.

- **What worked well and contributed to success, and why?**

The above results highlight the promise of using multi-disease screening campaigns to increase male engagement in health services and accelerate HIV case-identification among people living with HIV who are unaware of their HIV status.

Key differentiators of the multi-disease screening approach that contributed to its success was: 1) bundling an integrated package of screening services for HIV, NCDs, and STIs, thereby increasing the cost-benefit of going to and waiting at a health facility for service; 2) scheduling appointments on days or at times that were more accessible to males (such as weekend of evening hours); and 3) offering fully-subsidized screening services for non-HIV testing services, which incentivized people to take the opportunity to be screened now.

The content and quality of messaging delivered by ReCos as part of awareness-raising and demand generation was also critically important in ensuring the uptake of screening services and targeting outreach to those most likely to be HIV-positive. This impact can be seen clearly when looking atHZ-disaggregated campaign data, where the testing yield varied greatly, with Sakania HZ at 14% testing positivity compared to Kenya HZ at 9%. This difference can be attributed to the tailored messaging and outreach being done by ReCos, with those in Ruashi and Sakania HZs focusing outreach on individuals who seemed to be showing symptoms of STIs.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

N/A

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Human resources costs implicated in the multi-disease screening campaign included stipends for ReCos to conduct community-level awareness raising and counseling in health areas surrounding each health facility (two ReCos in each health area) and stipends for two providers from each health facility to be available after 3 PM and during the weekends. The project also directly paid for any consumables required to screen individuals, such as strips for glucose screening tests, to remove any user fees charged

by the facility. HIV test kits were supplied directly to facilities through the DRC government supply chain system with support from PEPFAR.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

While this method proved effective at reaching males in Haut-Katanga, the associated costs of funding a multi-disease screening campaign (namely subsidizing screening costs for non-HIV services) hampers the easy replicability and expansion of this intervention across DRC or other similar contexts. We would recommend implementation of this approach if donor or funding is available to conduct these multi-disease campaigns periodically, particularly in areas of higher HIV prevalence but low facility attendance. This approach did highlight a high HIV/STI coinfection rate (14%), indicating the critical importance of offering combined HIV and STI screening services as an easy and more cost-efficient mechanism for reaching people living with HIV who remain unaware of their and linking them to ART or pre-exposure prophylaxis services.

- **Annexes:** Oral presentation during the “Building bigger and better together: Lessons in service delivery integration” at the 2021 International AIDS Conference. Session recording and presentation materials can be accessed here: https://theprogramme.ias2021.org/Programme/Session/16

Kenya: case study 1

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- **Timeline of the case study**: 2012 - ongoing

- **Case Study submitted by:** Nongovernmental organisation

- **Title of approach or best practice or initiative**: Community-led clinic for male sex workers and other men who have sex with men

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Multiple components: prevention, testing, treatment and care

- **In which geographic area is the approach being carried out?:** Started in Nairobi and later on expended to Nyeri, Kajiado, Tharakanithi, Kirinyaga and Meru counties in Kenya.

- **What problem was being addressed and how was it identified?:** HOYMAS with support from Aidsfonds conducted an extensive study on HIV transmission and the SRHR needs of sex workers in Kenya. This study showed high HIV prevalence among male sex workers, low access to essential HIV services, high levels of stigma and discrimination in available services.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** male sex workers and other men who have sex with men.

- **What type of approach is it?** Male-friendly service, outreach, peers.

- **What was the logic and rationale behind choosing this approach or practice?** There are many barriers to accessing HIV prevention, treatment and care services for sex workers, and very limited prevention, treatment, care and support strategies are in place. Educational materials about SRHR were not adapted to the needs of sex workers and sex workers are not meaningfully involved in the national response to HIV/AIDS. Research showed that sex workers generally lacked sufficient knowledge of their sexual and reproductive health and rights (SRHR) and were reluctant to seek health care due to stigmatisation and discrimination by healthcare providers. Over 80% of male sex workers and over 70% of female sex workers in Kenya, avoided or delayed needed health services, because they feared being ridiculed, harassed or denied care.

- **Full description of the approach or best practice:**

HOYMAS is a male sex worker led community-based organisation that implements a comprehensive package of community led activities and services for male sex workers and men who have sex with other men (MSM). HOYMAS has a community led clinic where sex workers and MSM access HIV and STI prevention, treatment and care services.

Aidsfonds, HOYMAS, KESWA and North Star Alliance conducted an extensive study on HIV transmission and the SRHR needs of sex workers in Kenya during Bridging the Gaps phase 1 (2011-2015) and concluded that sex workers were in need of accessible, affordable and friendly services. Evidence shows that effective HIV prevention packages for sex workers should include combinations of tailored biomedical, behavioural, and structural interventions, and be led and implemented by sex worker communities. To bring together those communities, HOYMAS and the national sex work movement – the Kenya Sex Workers Alliance (KESWA) – began a successful partnership, which first focused on bringing together all 74 individual sex worker led organisations in Kenya. The partnership between HOYMAS and KESWA grew to include other key stakeholders such as the Gay and Lesbian Coalition of Kenya (GALCK) and the Kenya Network of People Using Drugs (KENPUD). This cooperation across communities was a strong basis to collectively and constructively engage the government during the process of opening the first ever community led clinic in Kenya.

The clinic opened in 2015, and sex workers lead the design, implementation and evaluation of the services provided and, through a peer-education and outreach programme, sex workers can refer peers to the clinic. Since 2015, the reach of HOYMAS has increased significantly due to collaboration with the government, which has led to the government not only recognizing key populations but also involving them in decision making and policy formulation. HOYMAS and KESWA brought together sex workers, sex work organizations, supportive policy makers, law enforcement officers, representatives of the judicial system and healthcare workers to jointly frame the agenda for advocacy. This joint advocacy led to the government's development of a national guideline for HIV and STI programming with key populations, including sex workers. This guideline uses a combined public health and human rights framework of HIV programming for sex workers, men who have sex with men and injecting drug users.

The effect of the community-led approach taken by HOYMAS is clear. The total number of sex workers testing HIV positive at the clinic dropped from 7% when the clinic first opened its doors in 2015, to 2.7% in 2018. At the same time, HOYMAS has expanded its work from one area to 17 sub-counties to reach more underserved sex workers.

HOYMAS is currently receiving a grant under the Love Alliance programme, funded by the Dutch Ministry of Foreign Affairs, to continue to serve male sex workers and other men who have sex with men with HIV prevention, testing, treatment and care services. They currently have a membership of over 10,500 members from the different counties. Over the last two years, HOYMAS has adapted digital innovations to increase demand and service uptake of Sexual Reproductive Health Services e.g. telehealth, social media platform.

- **Who were the key implementers, collaborators, and partners in this approach?** HOYMAS (community-led clinic), national sex worker movement (KESWA), funding and support (Aidsfonds and UHAI EAHSRI) and stakeholders including the Ministry of Health.

- **How was the community involved/engaged?** The community is not involved, they are in the lead. The clinic is led by the community.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The intervention was focused on improving SRHR and preventing new HIV infections AND fostering stronger partnerships between civil society and governments result in more services that adhere to normative guidance.

HOYMAS has been part of independent evaluations as part of the Bridging the Gaps programme (2012-2020). The change process has been documented in a track record case (available upon request). Its success has been proven in the independent end evaluation of Bridging the Gaps, conducted by INTRAC Consultancy, it concluded:

"A community-led approach is fundamental to Bridging the Gaps' interventions in Kenya. A significant example is the case of HOYMAS (Health Options for Young Men on HIV/AIDS/STI)32. In 2015 HOYMAS became the first community-led clinic to provide HIV Prevention, treatment and care to male sex workers and men who have sex with men in Nairobi County. With support from Aidsfonds and KESWA (Kenya Sex Workers' Association), the umbrella organisation of Kenyan sex worker-led groups based in Nairobi. HOYMAS currently meets the HIV and other health service needs of over 6,000 people from key population communities, including all sex workers (female and male). The HOYMAS clinic in Nairobi has become an important training and learning centre for government health service providers, as well as for other key population led organisations involved in HIV-related service provision. HOYMAS has also been instrumental in leading dialogue between community-led organisations and government, resulting in government endorsement for establishment of community-led clinics - a major milestone in bridging gaps in service provision for key populations. A testament to its success has been that teams from the United States, Tanzania, South Africa and Botswana have visited the clinic training centre to learn from this experience."

- **What worked well and contributed to success, and why?**

1. Sex worker movement building and organising has ensured that sex workers speak with one voice and undertake advocacy work as a collective, working on the same agenda. The strong partnership with KESWA has led to improved outcomes and community led programming that enables sex workers to take the lead. This has been coupled with strengthening of leadership through mentoring and training to ensure that sex work advocates have the right competence to engage with advocacy targets.

2. Strong partnerships, collaborative advocacy and constructive engagement with government has ensured that sex workers are now accessing quality HIV and STI prevention, treatment, and care services from the community led clinic. Engaging in crosscommunity movement building and joint advocacy can be a key way of collectively engaging national governments and increasingly the likelihood of success.

3. HOYMAS's clinic has become a learning site and a model for community led organisations providing community led services and clinic services. Having been recognised for its uniqueness in HIV and human rights programming, HOYMAS has opened its doors to other groups and delegations that want to learn from its best practices. They have also prepared IEC materials, which capture these best practices, to share with other organizations and individual sex workers.

4. HOYMAS has integrated digital innovations in enhacing the reach and uptake of SRHR among key populations in Kenya.

- **What tools and toolkits worked effectively in the approach to engage men and boys?** HOYMAS uses the SWIT tool to develop its services. They conduct research on the SRHR and HIV needs among male sex workers and men who have sex with men.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?** HOYMAS clinic has been piloted with Aidsfonds funding and later on scaled with funding from Global Fund, PEPFAR and national budget of HIV/AIDS.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?** HOYMAS has become a learning centre and their approach has been replicated in multiple other countries. In addition, they scaled their approach to multiple sub-counties over the years.

- **Annexes:** available upon request.

Kenya : case study 2

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- **Timeline of the case study**: July 2017 to March 2018

- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: Accelerating achievements of Fast Track Targets in High Burden Counties in Kenya through Male engagement in Homabay and Siaya Counties

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Gender Norms, Male Friendly HTS services and Community Outreach through religious and traditional leaders.

- **In which geographic area is the approach being carried out?** South Kasipul Ward, Rachuonyo Sub County, Homabay County and West Yimbo Ward , Bondo Subcounty, Siaya County

- **What problem was being addressed and how was it identified?**

Poor uptake of HIV testing services by men in Homabay and Siaya County, two HIV high-burden counties with the most significant gaps in HIV identification and treatment. It was identified through data at national and county level.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

General men population above 18 years.

- **What type of approach is it?**

Gender Norms, Male Friendly HTS services through training of health service providers and Community Outreach through religious and traditional leaders that were engaged as male champions.

- **What was the logic and rationale behind choosing this approach or practice?**

The successful 2012 Luo Nyanza traditional leaders voluntary medical male circumcision (VMMC) experience, as well as the increased uptake of VMMC through education of religious leaders in Tanzania are promising experiences. In addition, literature points to the finding that HIV testing methods outside of the health facilities, including mobile testing, home based testing and HIV self-testing, are more acceptable among men. HIV self-testing, specifically, forms a new opportunity for reaching testing targets in Kenya

after its national launch in May 2017. Hence the intervention to mobilize men to utilise HIV services, leveraging on the social capital of religious and cultural leaders.

- **Full description of the approach or best practice:**

This approach sought to harness the clout of Religious and Traditional leaders to increase uptake to HIV services by men through a joint HIV mobilization campaign that was undertaken to sensitize and mobilize a critical mass of men in Homabay and Siaya Counties. The undertaking was designed to contribute towards the achievement of the Fast Track targets to end AIDS in Kenya, as reflected in the Kenya AIDS Strategic Framework of 2017/2018. HIV testing served as an entry-point to increase uptake of prevention and treatment services among men, with particular focus on linkage, adherence and retention. In addition community events were used to share information on HIV, with dedicated messages on stigma and discrimination and other structural drivers.

Specifically, the strategies uitilised were dialogues ,KIIs and FGDs to determine the main structural and gender equality-related issues at community-level affecting uptake of, and access to HIV services, particularly testing services, by men through pre-intervention research , used the findings to develop targeted messages together with religious and cultural leaders that they would use to mobilize men to know their HIV status and access HIV prevention and treatment services ,MENKEN developed a training tool, built the capacity of community-identified champions from among religious and cultural leaders who then spearheaded the mobilization campaign in the two counties to influence health-seeking behavior of men, with a specific focus on HIV and undertook HTC outreaches utilizing both in-reaches (facility based) and outreaches in the community and congregations.. This was complimented by the training of service providers from select health facilities to provide male-friendly SRHR services.

- **Who were the key implementers, collaborators, and partners in this approach?**

Kenya Network of Religious Leaders Living with AIDS (KENERELA+ and Men Engage Kenya (MENKEN) funded by UNAIDS Kenya.

- **How was the community involved/engaged?**

The community was involved in the identification of main structural and gender equality-related issues at community-level through FGDs and KIIs; recruitment of male champions from religious and cultural leaders and in the development of targeted behavior change communication messages.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

- Increased demand creation for HIV services by men.
- Increased uptake of HIV testing services by men.
- Improved knowledge on HIV and structural barriers to health seeking behavior among men.

Homabay County: Total reach 7,010 men, Total referred for testing 4,495, 3,140 men tested and 55 HIV positive men and linked to ART
Siaya County: Total reach 4,904 men. Total referred for testing 4,679, 3,078 men tested and 14 HIV positive men and linked to ART

- **What worked well and contributed to success, and why?**

1. Engaging the community in the recruitment of male champions (religious and cultural leaders) because of ownership
2. The training of service providers which equipped them with knowledge and skills that helped them to address the structural barriers to uptake of HIV services in their health facilities hence making them male-friendly
3. Use of referral coupons that provided linkage between the male champions and service providers and allowed for data tracking for results in addition to facilitating access to services by the men reached by the intervention.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

1. Engaging Men to Improve the Uptake of HIV Services
2. Service Providers training Tool on male friendly service provision

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

48 male champions to carry out community outreach, 2 team leaders ,stipend for the champions to cover transport and meals (Ksh. 1,700,000), HTS Counsellor fees (Ksh. 400,000), Project staff (Ksh.1,800,000). We worked with the county government to house the project within their county male engagement strategies for further scale-up and the male champions remained in the community to continue the advocacy within their spheres of influence.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, when given an opportunity and support in more counties with a larger number of champions and service providers. The USAID-funded program on Faith and Community Initiative in Kenya was informed by the lessons from this project which is being implemented in many counties in Kenya.

- **Annexes:** www.menken.or.ke

Kenya : case study 3

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- **Timeline of the case study**: Oct 2021- Sept 2022

- **Case study submitted by**: NGO

- **Title of approach or best practice or initiative**: Best Practices in Engaging, Enrolling and Retaining MSM-TGs in PHDA-SWOP Program

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Prevention, care and treatment.

- **In which geographic area is the approach being carried out?** Nairobi, Kenya

- **What problem was being addressed and how was it identified?** Access to HIV Prevention services by MSM and Transgender persons.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** MSM and Transgender who are over 18 years.

- **What type of approach is it?**

Peer led model, micro planning, outreach, in-reach, snowballing, social network strategy (SNS), safe clinic network app, and collaboration with other partners.

- **What was the logic and rationale behind choosing this approach or practice?**

Buy in and support by the community, sustainability, cost effectiveness, and yields results.

- **Full description of the approach or best practice:**

Partners for Health and Development in Africa (PHDA) is a local Non-Governmental Organization (NGO) that manages the Sex Workers Outreach Program (SWOP), a leading Key Population (KP) Program in Nairobi, Kenya. SWOP program provides HIV/STI prevention, care and treatment services to men who have sex with men (MSM), Female Sex Workers (FSWs) and transgender persons (TGs) in Nairobi. Since 2008 SWOP has been providing key population (KP) friendly services utilizing ten accessible, friendly, and standalone facilities located in low socio-economic areas in different Nairobi sub-counties.

SWOP program implements a peer-led model to identify, mobilize, refer and link MSMs and TGs for services. Through micro-planning, the peer educators (PE) continuously keep track of the hotspots that are closing or opening including their peak operating time. The PEs are responsible for a contact listing of the MSM and TGs in these mapped hotspots. This helps in planning for commodities (condoms and lubes) distribution and outreach program interventions as well as documenting incidences of violence. The SWOP program works with well-trained, friendly and experienced prevention and clinical teams, who provide the health services on offer. PEs also receive a monthly stipend in accordance to the NASCOP guidelines as a token of appreciation for their community work. This community-led approach encourages the MSM and TGs to be more involved and in control of their service provision enhancing ownership and sustainability.

PHDA-SWOP has also ventured into hard-to-reach spaces such as virtual spaces where MSMs and TGs solicit clients and interact with peers. This peer-led hot spots-based model has been adopted by NASCOP and cascaded to other sites. It is also in the ministry of health guidelines that advise KP service provision. Services are provided in the clinical facilities and/or in the mobile/community/hotspots. PHDA has also invested in a robust technology that supports outreach, in-reach, and clinical data collection and analysis to enable the SWOP program to make informed decisions in consultations with the community members. These consultations help select the best strategies to implement, the type of services needed, and where and how to offer them.

During COVID-19 pandemic to ensure minimum service interruption, telemedicine and tele-counselling were also offered and continue to be employed. PHDA-SWOP uses a biometric system to ensure the unique identification of MSMs and TGs, in order to facilitate access to services across all the clinic sites including the hotspots. This also curbs double registration and reduces the burden of carrying clinic cards or remembering their clinic numbers.

To further support access to services, SWOP established a mobile application Safe Clinic Network App where MSMs and TGs access information on planned clinical activities such as outreaches, routine clinical/community updates, report violence, and personal inquiries. The novelty of the application, its flexibility, and its user-friendly nature has made it widely acceptable by the community. These strategies as well as phone call reminders and physical tracing via peer educators have facilitated the retention of those accessing services in SWOP clinics. MSMs and TGs face a lot of stigma, discrimination, and violence that impacts negatively on their mental well-being. Compromised mental health affects access and uptake of services such as care and treatment, and ARV adherence. To ensure comprehensive services are availed to the growing numbers of MSM-TG keen on health care services in Nairobi County, SWOP has a well-trained and experienced clinical team that provides psychosocial, clinical, therapeutic support, and referrals for mental ailments.

- **Who were the key implementers, collaborators, and partners in this approach?**

Over the last decade, PHDA/SWOP has received funding from USAID, PEPFAR-CDC, Bill and Melinda Gates Foundation, European Union, among others, making it possible to continue providing services to the KP community.

- **How was the community involved/engaged?**

Community engagement is a core value of the program too. The Community Advisory Group (CAG) provides guidance and solutions on services delivery, study implementation, and research ethics. SWOP has participated in several studies and clinical trials that target MSMs and TGs contributing to the growing knowledge body of HIV prevention among this unique population.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The SWOP program has so far reached 17,332 MSMs and 1,465 TGs with a comprehensive package of HIV prevention care and treatment services. PHDA through the SWOP program has empowered MSMs and TGs groups to form Community Based Organizations (CBOs), Civil Society Organizations (CSOs), and NGOs. PHDA through its partnership with the refugee community CSO has been able to conduct consultative meetings and also provide clinical services to the refugees who are from the MSMs-TGs community promoting a dynamic response to an increasingly complex and evolving humanitarian environment. Through this, approximately 150 refugee TGs have accessed services.

- **What worked well and contributed to success, and why?**

Peer-led model- has led to buy-in and support by the community, sustainability, cost-effectiveness, and yields results.
Micro-planning - has helped in data collection and planning and accounting for commodities.
Outreach, in-reach, and snowballing has helped us reach new people, retention of the existing ones, and trace lost to follow-up clients
Social network strategy (SNS) - Improved HIV testing uptake and linkage to care among social groups.
Safe clinic network app - This as well as phone call reminders and physical tracing via peer educators have facilitated the retention of those accessing services in SWOP clinics. It has also helped clients to plan and manage how and where they access services.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Microplanning tools - Peer calendars, Contact listing, Outreach summary, condom and lube requisition.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Peer educators, outreach workers, Prevention officers, data officers, Receptionists, Nurses, Counsellors, Clinician, Pharmacist, Drivers.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, using the same strategies since most of them have been adopted by the government and cascaded to other counties.

- **Annexes:**

https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205056
https://pubmed.ncbi.nlm.nih.gov/31295225/
https://www.icop.or.ke/wp-content/uploads/2016/10/KP-National-Guidelines-2014-NASCOP.pdf
https://www.health.go.ke/wp-content/uploads/2020/05/KENYAN-GUIDANCE-ON-CONTINUITY-OF-ESSENTIAL-HEALTH-SERVICES-DURING-THE-COVID-OUTBREAK-20MAY-2020-complete.docx.pdf
http://www.phdaf.org

Kenya: case study 4

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- **Timeline of the case study**: 2021-2023

- **Case study submitted by**: UN or other international organisation and Government

- **Title of approach or best practice or initiative**: Implementation of the Local Innovation Scaled Through Enterprise Network Model; Lessons Learned from Male Champions as a Community of Practice, Kiambu, Kenya.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Single component: HIV prevention and testing services.

- **In which geographic area is the approach being carried out?**

Kenya-Kiambu County Government.

- **What problem was being addressed and how was it identified?**

From documented programme and evaluation reports, men generally have been known to have a poor health seeking behaviour and this has led to low uptake of services among men. Through the use of the Human Centered Approach under the Local Innovations Scaled Through Enterprise Networks (LISTEN) process, the team analysed the data and engaged the men to identify both health and non-health priorities which was documented on a Male Champions Charter for implementation.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The approach targeted general population that includes Adolescents and Young People as well as older men of Kiambu County.

- **What type of approach is it?**

The male champions as a community of practice utilizes digital (WhatsApp forum), peer to peer engagements where they visit male at their touch points, community social networks and outreaches. They also engage other sectors of the county government through the county innovation Community of Practice that is made up of county leadership.

- **What was the logic and rationale behind choosing this approach or practice?**

The primary assumption of LISTEN, validated by studies across a range of disciplines, is that the most effective and innovative problem-solving occurs at the local level. While many local communities develop solutions intuitively, there is no systematic process to

link these communities and facilitate the sharing of best practices to drive greater impact. The purpose of LISTEN is therefore to catalyze and capture innovation at every level of the health delivery system, from urban and rural communities to county and national leadership to increase demand for, and maximize impact with, currently available tools and to accelerate the uptake of health services and new technologies. Communities are a resource and having them at the center of co-designing and implementation of evidence based solutions makes them resilient and provides an opportunity for owning the solutions for sustainability.

- **Full description of the approach or best practice:**

From documented programme and evaluation reports, men generally have been known to have a poor health seeking behaviour and this has led to low uptake of services among men. Through the use of the Human Centered Approach under the Local Innovations Scaled Through Enterprise Networks (LISTEN) process, the team analysed the data and engaged the men to identify both health and non-health priorities which was documented on a Male Champions Charter for implementation.

- **Who were the key implementers, collaborators, and partners in this approach?**

National Syndemic Diseases Control Council formerly National AIDS Control Council, Kiambu County Government department of health, Center for Global Health Practice and Impact of Georgetown University, Bill and Melinda Gates Foundation, Global Fund.

- **How was the community involved/engaged?**

Through the use of the Community of Practice mapping tool, the county innovation Community of Practice (CP) -that has representatives from county departments, implementing partners and the community - and the community were engaged and identified the male champions who formed a Community of Practice. Thirty-six Male Champions, spread across the 12 sub counties of Kiambu, were then trained through HCD approach to target men in non-health settings to respond to their health needs and address barriers for health outcomes. They use community advocacy forums and peer engagements to reach out to men and provide information to address male gender health disengagement; vulnerabilities; societal perception of masculinity and promote sexual and reproductive rights. The male champions take leadership in the implementation and are linked to other sectors through the innovation CP.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The implementation is for three years, and midterm evaluation is planned end of this year December 2022. However, we have been able to document the 2021 data as indicated below.

  - Number reached with HIV Information- 221,545
  - Number reached with information on male engagement and uptake of Health services- 169,691
  - Number sensitized on correct condom use - 160,051

- No. of people counselled and tested - 21,013
- No. of condoms distributed - 536,500
- Number reached with wellness services - 181,073
- No. of Information Education Materials (IEC) materials distributed - 21,335
- No. of focus group discussions conducted - 1,400

- **What worked well and contributed to success, and why?**

1. Male Engagement has a potential to steer HIV response through advocacy, creation of awareness and neutralizing stigma.
2. Man to man talk enhances positive health seeking behaviors among the male gender.
3. HIV prevention tools like condoms are readily accepted by men when introduced to them by their peers.
4. Men generally have a poor health seeking behaviour and the use of the Male Champions as advocates reverses negative masculinity perception.
5. Through HCD approach, men open to their fellow men and come up with implementable health solutions.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

There are a number of tools that were developed to support the process and include Community of Practice mapping and segmentation tool, CP Charters and HCD tools and training materials- see annexes.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The initial financial resources were provided by Gates Foundation through the Center for Global Health Practice and Impact and leveraged on Global Fund support. The model utilises the existing structures and human resources at both county and national levels for sustainability. Linkage to other sectors enhances integration for sustainability. The costing is being planned to determine the cost of implementation.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Currently we have established more than 4 communities of practice in Kiambu and 4 in Homa Bay county. The LISTEN process is now being scaled to additional 11 counties after the training of key implementers across the 47 counties through the HCD. We have also adapted training materials for the targeted audience across the counties. An e-learning platform for the HCD training also being developed with a robust pathway for mentorship. The LISTEN Process can be applied both in health and non-health sectors.

- **Annexes:**

https://drive.google.com/drive/folders/12Jn-6vOgGnKS9xYgyycKPVNKFNVG5mE?usp=share_link

Kenya: case study 5

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- **Timeline of the case study**: 2014 – 2022

- **Case study submitted by**: Government; Other: Technical Support Unit to NASCOP Department of Ministry of Health, Kenya Government.

- **Title of approach or best practice or initiative**: "Medically Assisted Therapy (MAT) Program in Kenya".

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**

Multiple components: Needle and syringe programmes and opioid substitution therapy for preventing HIV and HCV transmission among people who inject drugs.

- **In which geographic area is the approach being carried out?:**

Currently there are 14 counties where PWID are reached by NSPs and 7 counties where PWID have access to OST/ MAT.

- **What problem was being addressed and how was it identified?:**

The MAT program started on 8th December 2014. To date there are 11 MAT sites across 7 counties offering methadone. The goal of the MAT program is to assist the People who Use Drugs to reduce or stop injecting or using opioid in order to eliminate HIV and harms associated with drug use practices.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Current criteria include all drug users. Decentralization of MAT dispensing has taken place with initiation of MAT site in prisons and through mobile vans as the first best practices to improve MAT among men with the target age group being 15 years and above. Outside of Prisons, the program also targets the Key Population members of both Men and Women from communities with injecting drug users. The program has succeeded in reaching more men that women and is considered a best practice for reaching men.

- **What type of approach is it?**

The implementation method adopted combination four-pronged approach that include developing national policies, strategies and guidelines; building county capacity; improving service delivery and improving monitoring and evaluation.

- **What was the logic and rationale behind choosing this approach or practice?**

To ensure we can document successes, monitor progress and build long lasting capacity.

- **Full description of the approach or best practice:**

The implementation method adopted four-pronged approach:

Strategy I: Adopting policies, strategies and guidelines to increase PWID access to evidence-based services and interventions.

- Sustained engagement of government and non-government partners through regular technical working groups meetings.

- Review and drafting of policies, guidelines and operational plans;

- Study tours to benchmark and learn from best practice MAT sites;

Strategy II: Increasing access to comprehensive PWID package of HIV Prevention, care and support;

- Structured assessments of MAT clinics established at selected public health facilities;

- Implementing partners supported operationalization of new MAT clinics while national and county governments provided health commodities and human resources;

- CSOs awarded grants to conduct community outreach to mobilize, refer and follow up enrolled MAT clients;

- Mentorship support for newly recruited MAT clinic staff by twinning with experienced service providers from existing clinics and CSOs;

- Eligible opioid dependent persons accessed methadone under direct observation treatment and other related services; including psychosocial counseling; treatment for co-morbidities and other co-morbidities;

- CSO Drop-in Centers enabled client recovery from drug use and regaining of dignity through basic social support.

- Counties MAT forums that meet on a quarterly to review service data, progress and challenges.

- The introduction of Buddy System that enables those on MAT to bring and have their peers inducted into the MAT program.

- Introduction of buprenorphine as an alternative to methadone for the clients on MAT

- Decentralization of the MAT services in prisons and through mobile vans

Strategy III: Strengthening policymakers and community support for PWID HIV prevention interventions.

- Conducted advocacy and sensitization meetings with national, county and community stakeholders (policy makers, judiciary law enforcement, media, cleric, opinion leaders, affected family members and the general community); TV and radio broadcast of documentaries on PWUD; awareness campaigns on World AIDS Day and International Day Against Trafficking and Illicit Drugs;

- Vocational training and entrepreneurship skill building offered by CSO partners for MAT clients with funding from OSIEA, EU, county governments, foundations etc.

Strategy IV: Improving capacity to monitor and evaluate PWUD programs

- MOH defined a core set of core indicators for MAT M&E system;

- Periodic supportive supervision and data quality checks;

- Development of Real Time i-Health Portal to track program implementation.

- The country migrated its KP data to the Kenya Health Information System (KHIS) to enable all MAT sites report on one platform.

- Introduction of the EMR system for the MAT sites

- **Who were the key implementers, collaborators, and partners in this approach?**

Collaboration of National Government, County Government, Donors (PEPFAR, Global Fund, UN and Private foundations); community-based organizations, Peer systems of service recipients.

- **How was the community involved/engaged?**

Peer and Buddy system working in close coordination with CSOs and Health care workers to recruit and provide ongoing support.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The country has been able to initiate/enrol a total of 6268 males and 1761 females onto MAT.
MOH defined a core set of core indicators for MAT M&E system.
- Periodic supportive supervision and data quality checks;

- Development of Real Time i-Health Portal to track program implementation;
- The country migrated its KP data to the Kenya Health Information System (KHIS) to enable all MAT sites report on one platform.
- Introduction of the EMR system for the MAT sites

- **What worked well and contributed to success, and why?**

MAT clinics are primarily funded and run by MOH through the various County Governments with support from NASCOP and Pharmacy and Poisons Board however, the MAT HRH is partly supported by implementing partners

- CSOs play a pivotal role in MAT program through:

- Preparation of clients for MAT induction and referring the clients to the MAT clinic this contributing to the number of clients reached with MAT

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Follow up of Clients initiated on MAT to ensure retention in MAT through the phased of induction, stabilization and weaning off.
- Provided feedback to the MAT team on those relapsing for additional support
- Support demand creation for MAT services through Peer Education to PWID clients, engaging stakeholders including religious leaders among others.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Annual commodity cost is USD 867,869 for methadone and USD106,084 for Methadone dispensing cups. Human resource for a static high threshold MAT clinic: 2 Medical Officers, 3 clinical Officers, 2 Pharmacists, 2 pharmaceutical technologists for dispensing, 5 nurses, 3 addiction counsellors, 2 social workers, 2 data officers, 4 Security personnel. Human resource for Mobile MAT Van: 2 drivers,2 Clinicians/Nurses, 2 Security officers, 2 outreach workers, 2 Pharmaceutical Technologists/ Pharmacist, 2 peer educators and 1 Mobile van dispensing coordinator.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, continuous engagement with partners to support infrastructure set up, county governments to support staffing and national government to support supplies and commodities. We currently have 11 MAT clinics and plans are underway to expand.

- **Annexes:** KHIS - https://hiskenya.org/

Standard Operating procedures for the Implementation of Mobile MAT services for Persons Who Inject Drugs in Kenya.

NATIONAL IMPLEMENTATION GUIDELINES FOR MEDICALLY ASSISTED THERAPY For People With Opioid Use Disorders.

Kenya : case study 6

CONTACT PERSON

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- **Timeline of the case study**: June 2020 to November 2021

- **Case study submitted by**: UN or other international organization, Civil society and Trade Union
- **Title of approach or best practice or initiative**: Reaching long distance truck drivers and sex workers in Kenya with HIV self-testing

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Prevention, Testing and Linkage to treatment

- **In which geographic area is the approach being carried out?** Machakos and Kilifi Counties in Kenya

- **What problem was being addressed and how was it identified?** Men lagging behind in accessing HIV services. Identified through county specific data on testing and treatment services.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** Long distance truck drivers and their assistants - male dominated sector

- **What type of approach is it?** Male friendly services and outreach services along the transport corridors and weigh bridges offered in collaboration with the Kenya Long Distance Truck Drivers Union leadership and management of transporting companies

- **What was the logic and rationale behind choosing this approach or practice?**

In 2020 the COVID-19 pandemic posed a challenge, with restrictions leading to a slowdown of HIV interventions. In response to this an integrated programme was designed to enhance COVID-19 prevention and provide HIV Self-Testing (HIVST) for truckers and sex workers. The programme was initiated because truck drivers were facing discrimination and long waiting time for COVID-19 testing and clearance processes at the border. The truckers spent long periods of time on the road with long traffic jams spanning over 40km of stand-still trucks. This provided an opportunity for engaging with the drivers on COVID-19 mitigation measures and also on HIV prevention and HIVST.

- **Full description of the approach or best practice:**

Recognizing that men are being left behind in HIV testing and treatment access, the ILO, under the UN Joint Team on HIV, has been focusing on male-dominated sectors to enhance the uptake of HIV services. Since 2015 the ILO has partnered with the Federation of Kenya Employers, the Central Organization of Trade Unions, the National AIDS Control Council, the National AIDS & STI Control Programme and the Swedish Workplace HIV/AIDS Programme, supporting the Kenya Long Distance Truck Drivers Union and its health arm, Highway Community Health Resource Centre, to establish HIV workplace policy and programmes in 30 transport companies.

The programme provides truckers and sex workers at HIV hotspots along the northern transport corridor with HIV prevention and testing services and linkage to treatment. Advocacy with the management of participating workplaces, conducted by the Federation of Kenyan Employers and the ILO, resulted in the establishment of workplace HIV committees and/or integration of HIV services into existing occupational safety and health programmes. Campaigns to raise awareness of HIV testing and its benefits for workers, for their families and for enterprises were undertaken. Information on social protection entitlements and support for registration to the National Hospital Insurance Fund were also provided. In 2020, the COVID-19 pandemic posed a challenge, with restrictions leading to a slowdown of HIV interventions. In response to this, the partners designed an integrated programme on COVID-19 prevention and HIVST addressing truckers and sex workers (see photo). The programme was initiated because truck drivers who had tested positive for COVID-19 reported facing discrimination and long waiting time in COVID-19 testing and clearance processes. This provided an opportunity for engaging with the drivers on COVID-19 mitigation measures and also on HIV prevention and HIVST. Those who took HIVST kits were offered post-test counselling by telephone. Between June 2020 and November 2021, a total of 6015 HIVST kits , over 217 688 condoms, 12000 masks and over 8625 packs of hand sanitizers were distributed to truckers and sex workers.

· **Who were the key implementers, collaborators, and partners in this approach?** International Labour Organization, Central Organization of Trade Unions in Kenya, Kenya Long Distance Truck Drivers Union, Highway Community Health Resource Centre, Kenya Pipeline Company, Directorate of Occupational Safety and Health Services

· **How was the community involved/engaged?** Outreach HIV services were provided to surrounding communities and sex workers

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.** Between June 2020 and November 2021, a total of 6015 HIVST kits, over 217 688 condoms, 12000 masks and over 8625 packs hand sanitizers were distributed to truckers and sex workers.

- **What worked well and contributed to success, and why?** Engagement with transport sector trade unions has been key in facilitating ease of follow-up, structured approaches for expansion of reach and increased access to HIV for the truck drivers and their assistants.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**
  https://www.ilo.org/global/topics/hiv-aids/WCMS_215899/lang--en/index.htm

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?** The programme is integrated into the Kenya Long Distance Truck Drivers Union which set up a health arm, Highway Community Health Resource Centre to respond to HIV among truckers and their assistants. The union has counselors stationed at the resource centre to provide HIV services to the truckers, their assistants with outreach services to sex workers along the northern transport corridors. The union/health arm has continued to sustain the services in partnership with the government

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?** Yes. The approach can be scaled up at multiple sites along the transport corridors, weigh bridges and sex workers hotspots in other counties. Transporting companies would also be engaged o enhance management commitment and support to the programmes and to enhance sustainability through integration into employee health and wellness and occupational safety and health programmes

- **Annexes:**
  http://highwaycommunity.org/index.php?option=com_content&view=article&id=48&Itemid=30

Lesotho : case study

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- **Timeline of the case study**: Started in August and its continuing

- **Case study submitted by**: UN or other international organisation

- **Title of approach or best practice or initiative**: IMPROVING ACCESS AND UPTAKE OF HIV SERVICES FOR MEN AND BOYS IN THEIR DIVERSITY: THE CASE OF LESOTHO

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV testing, VMMC as an HIV prevention strategy, linkage to care and treatment of those testing positive for HIV.

- **In which geographic area is the approach being carried out?** Certain districts in Lesotho.

- **What problem was being addressed and how was it identified?**

Unmet needs of HIV services among men and boys.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

From the ages of 15-29 years.

- **What type of approach is it?**

Engaging traditional leaders and initiation schools in the provision of Medical Male Circumcision.

- **What was the logic and rationale behind choosing this approach or practice?**

The progress towards achieving 80-90% VMMC coverage is slow as most men and boys prefer traditional initiation (MMC as 31.5% and traditionally circumcised men as 31.9 (LePHIA, 2020) indicating that the coverage remains under the levels needed to achieve saturation.

- **Full description of the approach or best practice:**

The Lesotho Défense Force clinicians who have gone through the traditional circumcision work with the traditional leaders and initiators in taking care of men and boys in the initiation schools. The military health personnel possess a level of authority among this population which was leveraged by the Ministry of Health.

- **Who were the key implementers, collaborators, and partners in this approach?**

Lesotho Ministry of Health, Lesotho Defense Force and Jhpiego as an implementing partner.

- **How was the community involved/engaged?**

Through meetings with initiation school committees.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The total number of clients served through this initiate is 114 in the period of three months since the collaboration. Age cohort 15-19 dominates in terms of the proportion of the clients served as it contributed 65% of the initiates; followed by age cohort 20-24 which contributed 32% of the total initiates who received VMMC services. The initiates went through testing and counselling as a package of VMMC service delivery, of the 114 clients served; 113 tested negative and there was only 1 client who tested positive for HIV. 100% of the initiates were followed up in the first 48hours as the team stays in the initiation schools until the first follow ups are conducted. The collaboration presents a potential strategy for providing comprehensive health services to the male population in hard-to-reach areas.

- **What worked well and contributed to success, and why?**

The military health personnel possess a level of authority among this population, the support with logistics that were provided by Jhpiego and the involvement of the ministry of health.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

VMMC manual https://apps.who.int/iris/bitstream/handle/10665/272387/9789241513593-eng.pdf

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Human resources were provided with refresher training, they were provided with transportation, accommodation and meals to carry out the activity, there are plans for sustainability and the Ministry of health is leading the initiative, the cost for the three months is approximately 4,774.03USD.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

The approach is continuing in the different imitation schools in the country.

- **Annexes:**

https://phia.icap.columbia.edu/lesotho-final-report-2020/

Malawi: case study

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- **Timeline of the case study**: The program started in 2021 and will run for four years until September 2025

- **Case study submitted by**: Academic institution and Civil society

- **Title of approach or best practice or initiative**: Decentralised ART provision through the private clinics - a game changer for improving ART adherence for men

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV testing and Treatment including care.

- **In which geographic area is the approach being carried out?** Six districts in Malawi (Kasungu, Lilongwe, Mangochi, Machinga, Blantyre and Mulanje)

- **What problem was being addressed and how was it identified?**

The case study, as presented, emerged from HEARD's 2022 regional assessment on adolescent boys and young men's (ABYM) sexual and reproductive health and rights. The assessment, commissioned by UNFPA ESARO, included a policy analysis and mixed methods study in 5 countries including Malawi. A systematic analysis of the Malawian policy landscape showed ample attention to the particular needs of men as clients of SRH services, and their support role in SRH services. In HIV policies and strategies, the complexities of retaining men in care were seen to be addressed through various mobilisation strategies for this group, however, no separate budgetlines could be identified in support of these strategies (while strategies for adolescent girls and young women, and for key populations do have separate budgetlines). Family Health Services (FHS) participated in the mixed methods study and presented a novel strategy to mobilising HIV-positive men to enter and stay in care. Data from the Department of HIV/AIDS Management information System (DHAMIS) and Family Health Services' own monitoring and evaluation systems data show that treatment adherence is a particularly large problem in the 15 – 35-year-old group of male clients, who are asymptomatic, on treatment and not virally suppressed. Limited treatment adherence for male clients living with HIV is partly influenced by distance to points of care and less than conducive environments at public facilities. Due to time demands (waiting times and travel distance to ART provision sites), the opportunity costs for accessing services in the public sector facilities remains a

substantial barrier for men to adhere to their treatment, and through the FHS' intervention male clients are provided with an option to access their HIV care from a nearby private health facility.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** General population, and the age group 15–35-year-olds, with men as a special category.
- **What type of approach is it?** Family Health Services (FHS - formerly PSI/Malawi), in collaboration with FHI360 and Ministry of Health rolled out the Decentralized ART Drug distribution in the private sector using private clinics. Through this model, private clinics help decongest public facilities. Private facilities are mapped against public facilities in a hub and spoke model. This allows PLHIVs from hub facilities to transfer clients to the private clinics for ART refills, viral load testing, PreP and overall care. The private clinics are often closer to where large numbers of PLHIV live and work, with operating hours that are more convenient to working people and offer a level of privacy currently unavailable in the public health facilities. PLHIVs pay an administration fee $2.70 to get drugs refill. This appears to be less costly, when compared to costs they have to incur on transportation, waiting time and food when accessing public facilities.

- **What was the logic and rationale behind choosing this approach or practice?**

The theory of change for the decentralized ART through private clinics is that adherence outcomes for clients, especially among men aged 15-35 years will improve when services are closer to them and offered in convenient spaces. Key expected outcomes include:

- Increased adherence to ART treatment
- Increased uptake of HTS
- Improved efficiency of HIV/AIDS services due to reduced societal costs incurred by the clients due to time and transportation costs The Decentralised ART Drug Distribution model through private sector clinics help to decongest the public facilities and offer the much needed privacy and convenience for stable ART clients. These are factors that will help retain clients on ART treatment and help PLHIVs achieve viral load suppression. Of late, the project has seen significant increase in males who access ART refills at the Decentralised Drug Distribution clinics. The model is self-sustaining, with all private clinics included in the model accredited by MoH as ART distribution points. Key assumption include continued demand and ability of clients to pay the administration fee. Further, it is assumed that the Government's capacity to provide commodities and quality assurance services can be sustained.

- **Full description of the approach or best practice:**

The project aims at increased ART adherence and improved service uptake by the population where distance and limited convenience are barriers to access. It draws from the experience of Malawi's rapid and successful ART scale-up within a context of limited resources. Public facilities have high numbers of clients on ART with low human resources for health, resulting in congestion, delays, overworked staff, suboptimal client-provider interaction time, poor client satisfaction and retention on treatment. Hence, the opportunity costs of accessing services in the public sector remain a substantial barrier to adherence. PLHIVs can opt, against a drug refill fee, to transfer their care to a private clinic, which is

closer to their home and offers privacy and convenient opening hours. At this clinic, clients can obtain ART refills, viral load testing, PreP and overall care.

- **Who were the key implementers, collaborators, and partners in this approach?**

The project is implemented in 6 districts through private clinics. The Family Health Services partners with FHI360, Malawi Business Coalition Against AIDS, Malawi Ministry of Health to implement the project. The Ministry of Health supports the supply chain logistics for both ARVs and PrEP. It further helps with quality accreditation and quality assessments of the private clinics participating in the project. The public facility ART personnel support the private clinics with the tracking of clients that are transferred to the private clinics.

- **How was the community involved/engaged?**

The community is well informed about the model through intensified demand creation activities by FHS. In addition, the community actively participates through the ART Expert Clients who also undertake promotional activities related to the project. The need to actively engage other community level structures such as HIV/AIDS Support Groups, community-based organizations and Village Health Committees is being actively pursued for greater community engagement and participation.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The intervention has assisted with the decongestion of public facilities that provide ART, improved client satisfaction and adherence to drug pickups, more especially for men. Currently, there are 11 private clinics that have been fully rolled out serving 1500 clients, 40 % of whom are men. The initiative will see an expansion to more private clinics (potentially 56) as implementation progresses. The private clinics report financial and professional gains, and the public hospital staff confirmed a reduced workload resulting in greater effectiveness. The project provides a platform for continuous quality improvement practice through the quality assurance and accreditation processes by MoH. A mid-term evaluation is planned for later in 2023, although anecdotal evidence from FHS M&E system suggests efficiency improvements through reduced societal costs. The need for an effectiveness and cost and technical efficiency assessment for the intervention have also been recognized.

- **What worked well and contributed to success, and why?**

The model has been recognised by stakeholders as a sustainable, decentralised ART distribution model. A number of lessons have been learned during the design and implementation of the decentralized ART project which includes the following:

- The need for an adequate understanding of the challenges faced by men and young people on their journey to access ART. The FHS undertook a thorough needs

assessment to that end. This helped to better design an intervention that addressed their immediate challenges to ART adherence.

- Retention of a multi-stakeholder collaboration framework is key to the successful implementation of a decentralized ART programme.

- A quality assurance framework is required to maintain ART and service provision standards

- A functioning M&E framework is key to the documentation of lessons and learning.

- Better commodity supply chain management by MoH is key to the effectiveness of the decentralized drug delivery

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

N/A

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

It costs about $500 to set up a Decentralised Drug Distribution (DDD) ART clinic and this includes the provider training and the accreditation processes by the Ministry of Health.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

The model is highly replicable and sustainable with the private clinics accredited as ART distribution sites by Ministry of Health. The model has already been acknowledged for scale up by the Ministry of Health to contribute to the resolution of both equity and adherence issues in ART and HTS.

- **Annexes:** More information can be found on https://www.fhs.org.mw

Mozambique: case study

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- **Timeline of the case study**: The case study is of 2020 to 2022

- **Case study submitted by**: Private sector

- **Title of approach or best practice or initiative**: Workplace adopts new approach to provide HIV services

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV prevention through promotion of condoms and HIV testing.

- **In which geographic area is the approach being carried out?**

The intervention has taken place in Maputo province (Matola city), in Maputo city, Nampula province (Nacala), Tete province (Tete city) and Sofala province (Dondo district).

- **What problem was being addressed and how was it identified?**

The Business Coalition on AIDS with support of the ILO, PSI and MoH launched the HIV self-Testing campaign aiming to increase the HIV test uptake and guarantee confidentiality and reducing stigma and discrimination in the Health unities.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The intervention is reaching out general men population, through male engagement, and target young men (18 to 25) and adults up to 35 years old.

- **What type of approach is it?**

The approach that has been engaged is outreach and community by peer-to-peer communication at enterprise and workplace surrounding communities.

- **What was the logic and rationale behind choosing this approach or practice?**

It has been demonstrated that the workplace is an important entry point to tackle HIV and AIDS.

- **Full description of the approach or best practice:**

Workplace adopts new approach to provide HIV services in Mozambique.

- **Who were the key implementers, collaborators, and partners in this approach?**

Mozambique Business Coalition (ECOSIDA), workers organization (OTM-CS), MoH, ILO, WHO, UNAIDS (CE).

- **How was the community involved/engaged?**

The social mobilization campaign has engaged the workplace surrounding communities. When a given session takes in the SME the following part is to provide HIV services to the communities nearby these SME.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

A total of 42,065 HIV self-test kits were distributed, 60% to workers and 28% to their partners and 12% to workplace surrounding communities.
Men were mostly reached, with 85% of those taking on an HIV self-test being male, with a peak in young men between 20 and 35 years of age. 58% of the male workers who took an HIV self-test had not tested for more than 12 months and 15% were first-time testers. Among young men between 18 and 29 years of age, 20% were first-time testers.

- **What worked well and contributed to success, and why?**

The HIV self-testing approach stimulate people to take the test because it ensure confidentiality to the takers.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The social mobilization communication strategy.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

ECOSIDA has trained 68 counselors and peer educators on HIV self-testing. Due to the outcomes, ECOSIDA has been selected to run the phase 3 with support from Global Fund under FDC recipient.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes. Using the established working group (ILO, MoH, PSI, UNAIDS, WHO) and the capacity at ground level composed by counselors, peer educators and partnership with service providers and local authorities.

- **Annexes:** N/A

Namibia: case study

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- **Timeline of the case study**: July-September 2022

- **Case study submitted by**: International NGO

- **Title of approach or best practice or initiative**: Transforming gender norms and improving HIV focused health-seeking behavior: Our Approach to Male Involvement

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Structural interventions Harmful gender norms, HIV prevention, GBV/ SRH, Linking men and boys for Biomedical interventions, Linking men and Boys for Psycho-social support, and Community engagement.

- **In which geographic area is the approach being carried out?** Kavango East and Oshana Regions, Namibia

- **What problem was being addressed and how was it identified?**

Various gender inequalities remain an impediment to the attainment of equitable HIV prevention and treatment outcomes. Differences exist in HIV prevalence and health-seeking behaviors between men and women. Harmful gender norms and negative masculinity limits the participation of men in HIV and Reproductive health services and contributes to the ill-health outcomes of women and children. Globally, the uptake of HIV services-testing, treatment and care is comparatively lower for males in their diversity as compared to their female counterparts. Namibia has a generalized HIV epidemic, with 8.2% of the general population living with HIV. The Namibia Population-Based HIV Impact Assessment (NAMPHIA) conducted in 2017 showed that the annual incidence was higher among women aged 15-24 years (0.99%), 33 times higher than among men of the same group (0.03%). According to COP 2021 PEPFAR guidance, Namibia is estimated to be at 95-95-91 in the HIV cascade, with predominant testing and treatment gaps among children <9 years, and males aged 20-34 years. Health-seeking behaviors of men and boys are impacted upon by existing norms that inhibit health-seeking behaviors and also contribute to their HIV risk and that of their female partners. Women are more disproportionately affected with those aged >25 years accounting for 38.8% of new infections, in comparison to men (23.1%), followed by young women and girls (15-24 years) who account for 23.6% of new infections (2021 Spectrum Model). The HIV treatment gap is also highest among young men 15-24 and older men 25+ years. Data shows that the average age of sexual debut in Namibia is between 13-14 years old. Additionally, among adolescent girls, intergenerational relationships continue to keep the

HIV incidence among this age group high. Programmatic data demonstrates the higher HIV infection rates and unintended pregnancies among AGYW could be as a result of the sexual relationships (consensual/coerced) with older men (25-34) who have high HIV transmit rates to AGYW. Hence our project focuses on reaching Adolescent Girls and Young Women (AGYW) through Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) interventions, by also engaging men and boys who are either change agents in the community, or partners to these girls, and also users of HIV/SRH services. Addressing the uptake of HIV services among adult men is believed to improve men's health and men's health but can also improve HIV testing, treatment, and adherence outcomes among women and girls.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Our primary target was adult men in the general population reached through the project structural interventions. The specific focus was on those aged 25 – 34 years, who through project activities were found to constitute typical sexual partners and support networks of Adolescents Girls and Young Women (AGYW) reached through the ACHIEVE program. However other age groups were not excluded from the interventions.

- **What type of approach is it?**

We apply a community-level, peer- to peer and social networks approach to male engagement. Entry points for male engagement include community settings, schools, workplaces, and Health facilities. Male facilitators are trained, and they further recruit other male champions within their networks of influence or community settings.

- **What was the logic and rationale behind choosing this approach or practice?**

The Adolescents and Children, HIV Incidence Reduction, Empowerment, and Virus Elimination (ACHIEVE) project is a five-year, USAID-funded global project to reach and sustain HIV epidemic control among pregnant and breastfeeding women, adolescents, infants, and children. In Namibia, the goal of ACHIEVE is to avert new HIV infections among adolescent girls and young women (AGYW) in four districts. Through the risk mapping that was undertaken at the onset of the project, and resulting community consultative forums, we established the role of men in shaping norms and behaviors in the families, social networks, and wider community. The need to use a peer-to-peer approach and facilitation of dialogues with men and boys in community safe spaces to explore gender norms and sexual reproductive health including HIV was preferred by community leaders, men, and other opinion leaders in the community. Our focus on men and boys was also informed by their influence (positive and/or negative) on the AGYW HIV-related risks and on their HIV testing, treatment, and care outcomes. As a result, our intervention was centered around identifying and empowering champions to act as role models in linking men to HIV-related services and facilitate educational dialogue sessions with strong links to HIV services, such as HTS,PrEP, distribution of condoms, STI screening, and treatment, VMMC and ART.

- **Full description of the approach or best practice:**
  Our approach to male engagement entailed:

  (i) Design of a male champion selection criteria: champions were recruited through the standard organizational recruitment process. The minimum requirements for recruitment for champions include - males aged 18 and above, residents of the communities where they will be assigned, and willing to commit time to facilitate sessions with fellow men.

  (ii) Training of the male champions: The champions underwent a 3-day training using the Ministry of Health's National Training Manual and Training plan for Men and Boys on GBV, SRH, and HIV /AIDS. The training package comprises seven educational sessions on different topics - understanding gender, HIV risks and prevention, gender and power relations, gender-based violence, sexual and reproductive health, gender norms, and violence. The training also involved value clarification exercises and facilitation skills. The trainees were required to accrue 10 hours in the training to be considered as having meaningfully engaged and graduated as champions. A total of six male champion facilitators were recruited, trained, and deployed in the four districts of Oshakati, Rundu, Andara, and Nyangana. After training, they were provided with the training, referral booklets and registers for them to be able to execute their work as expected.

  (iii) Community engagement efforts: Trained male champions were required to mobilize and facilitate community dialogue sessions with men, and recruit men from the four districts where other DREAMS intervention is being implemented. Male Champions were tasked to link men for biomedical service such as HTS, PrEP, VMMC, STI screening and treatment other SRH services. They also distributed condoms were in the community. Community engagement efforts are geared towards fostering behaviors that will result in increased and improved sexual and reproductive health outcomes for men and women.

  (iv) Community level supervision: The male champions are supported by the project team (Team lead, MEL, Gender officer and Gender Advisor) during facilitation of the male dialogue sessions. This is done to ensure they are well supported to effectively they are given a holistic support to make sure that they are able to execute their work. The team provides Administrative and technical support.

- **Who were the key implementers, collaborators, and partners in this approach?**

ACHIEVE is a USAID-funded project implemented through a consortium of partners-PACT(Lead), Jhpiego, and two local organizations – Catholic AIDS Action and Star for Life. The male engagement approach is implemented through Catholic AIDS Action. ACHIEVE works within the government frameworks by collaborating with the Ministry of Gender Equality poverty eradication and social welfare, the Ministry of Education, art and culture, the Ministry of Safety and Security (GBV Unit), the Ministry of Sport, Youth and

National Services, and Ministry of Information, Communication and technology. At the community level ACHIEVE works with the community leaders who have power if influence in the community.

- **How was the community involved/engaged?**

A consultative meeting was held with the gatekeepers (governor, councilors, church leaders, and traditional leaders) to introduce and sensitize them about the program. Their input was incorporated into the implementation approach. The local organization in this Consortium (Catholic AIDS Action) identified male champions based on the discussions with the gatekeepers. The Male Champions who were drawn from the target communities conducted sensitization meetings within the community settings. The program continues to engage with community leaders by providing updates, obtaining feedback, and co-creating solutions to challenges identified during the dialogue sessions.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

During the period July- September 2022, six male champions were identified and trained to facilitate Gender norms sessions. These facilitators have since recruited an additional 687 men into the male engagement program. So far, 238 (34%) men have completed the sessions while others were still going through the sessions, 83 men were linked for HTS, 75% of whom have completed the referral, and; 7 men were initiated on PrEP. A total of 2035 male condoms have since been distributed in the community. These male dialogue sessions provide men with safe spaces to discuss issues, such as male experiences with GBV. A component of psychosocial support has been added to this intervention as a result of the 4 men who have disclose of abuse inflicted by their female partners upon disclosure of their HIV status. As a result of the learnings drawn from this approach, the Ministry of Health is set to roll out a program called ‘Men Star’ which aims at improving initiation and retention of men on ART.

- **What worked well and contributed to success, and why?**

The engagement of a trained HTS provides as a male champion: This made it easy for him to conduct a rapid test a male client who requested for this service without having to refer the client.

Trust building between the champions and the men: The fear of getting an HIV test was dissipated, as a result of the relationship the men attending targeted, and peer led dialogue sessions. This made it easy for some of the men to request for HIV testing services during their second session. We link this success to the modules that was covered in session 1 on ‘understanding gender’ and session 2, on ‘HIV risks and misconception’ which served to clarify myths and misconception around HTS.

Ease of access to condoms: Availing condoms in male-safe spaces worked to increase their uptake of condoms.

Small group sessions contributed to interactive dialogues among men: Engaging men to facilitate small group sessions with their fellow men made it possible to them to openly

discuss otherwise sensitive topics – HIV, sexuality, partner violence, etc. These groups also provide an opportunity to engage boys in their formative years to address the harmful gender and cultural norms, and male parents of AGYW.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

• National Training Manual and Training Plan for Men and Boys On GBV, SRH and HIV /AIDS: https://jhpiego.sharepoint.com/sites/ACHIEVENamibia/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FACHIEVENamibia%2FShared%20Documents%2FGeneral%2FNATIONAL%20TRAINING%20MANUAL%20AND%20TRAINING%20PLAN%20FOR%20MEN%20AND%20BOYS%20ON%20GBV%20SRH%20AND%20HIV%20OR%20AIDS%2Epdf&parent=%2Fsites%2FACHIEVENamibia%2FShared%20Documents%2FGeneral)

• PEPFAR 'S Monitoring Evaluation and Reporting indicator reference guide: (https://jhpiego.sharepoint.com/sites/ACHIEVENamibia/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FACHIEVENamibia%2FShared%20Documents%2FGeneral%2FPEPFAR%20MER%20Indicator%20Reference%20Guide%20%28Version%202%2E4%20FY20%29%2Epdf&parent=%2Fsites%2FACHIEVENamibia%2FShared%20Documents%2FGeneralf)

• DREAMS informational booklet:(https://jhpiego.sharepoint.com/sites/ACHIEVENamibia/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FACHIEVENamibia%2FShared%20Documents%2FGeneral%2FDREAMS%20Information%20Booklet%5FV08%2E12%2E2020%2Epdf&parent=%2Fsites%2FACHIEVENamibia%2FShared%20Documents%2FGeneral)

• Male engagement register:(https://jhpiego.sharepoint.com/:x:/r/sites/ACHIEVENamibia/_layouts/15/Doc.aspx?sourcedoc=%7B0E7A06AC-A108-436E-A03E-35D5DBE1C8CB%7D&file=Male%20Engagement%20Register.xlsx&action=default&mobileredirect=true

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

1. Personnel (Purpose: Trained facilitators to train male champions and trained male champions to facilitate community dialogue sessions) (Cost element: Staff time, refreshments during training), 2. Training materials and job aids (Purpose: To aid facilitate sessions (classroom and community)) (Cost Element: Training materials and Job aids (Audio-visual and print)), 3. Community own resource persons (Purpose: To participate in the male engagement program, Provide venue to hold the session, and Influence community members to be part of the program) (Cost element: Time and Refreshments), and 4. Transport (Purpose: To transport Male champion to the sessions) (Cost elements: Vehicles and staff time).

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, our learning from this approach showcases how the engagement of men who have been empowered on gender equitable norms and health-seeking behaviors is a critical component to both structural and biomedical HIV interventions. Men and boys' impact on HIV/SRH outcomes, bodily autonomy, and decision-making by women and girls, hence why we would consider replicating this approach to reach men and boys in their diversities. These initiatives geared towards giving men and boys the opportunity to unpack and challenge gender norms are an absolute necessity and promise to yield very good results in the quest for HIV risk reduction, HIV infection alleviation and reduction of harmful gender practices among their partners. In our approach to scale, we would consider strategies that allow for us to engage men/boys in their adolescence and young adulthood to explore and help shift harmful gender norms and positions of power that exacerbate inequitable outcomes between men/boys and women/girls.

- **Annexes:**

IGWG Male Engagement Resource page (https://www.igwg.org/priority-areas/male-engagement)
Namibia Country Operational Plan (COP) 2021 Strategic Direction Summary (https://www.state.gov/wp-content/uploads/2021/09/Namibia_SDS_Final-Public_Aug-13-2021.pdf

Nigeria: case study

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- **Timeline of the case study**: October 2021- March 2022

- **Case study submitted by**: NGO

- **Title of approach or best practice or initiative**: Community-based organization (CBO) led distribution of HIV self-test kits to increase access to HIV testing services among general population men and male members of key populations in Nigeria.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Prevention, Self-Testing, Linkage to confirmatory HIV Testing Services (HTS) and antiretroviral therapy (ART).

- **In which geographic area is the approach being carried out?** Sub Saharan Africa-Nigeria (Lagos, Rivers and Akwa Ibom states).

- **What problem was being addressed and how was it identified?**

The intervention addressed barriers of limited access and coverage of HTS among younger and working-class men as well as male KP in Nigeria. Men and adolescents have been known to have poorer access to HIV testing, and are tested, diagnosed, and started on ART later than other populations, creating a huge gender gap in access to HIV prevention, treatment and care.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The community-based distribution of HIVST kits through CBOs, focused on both general men population and key population- men who have sex with men (MSM) and male persons who inject drugs (PWID) across these age groups:

  - Adolescent boys aged 10-19 years,
  - younger men, 20-29 years and
  - Older men 30 years and above

- **What type of approach is it?**

Community Approach.

- **What was the logic and rationale behind choosing this approach or practice?**

Given the body of evidence that men do not readily access health facilities in Nigeria for HIV prevention, testing, treatment and care, hence the need to expand access to HTS for men through this out-of-facility HIVST distribution by involving community-based organizations embedded in local communities. By engaging men-focused and adolescent-led CBOs in community distribution of HIVST kits, younger men, working class men and KP men (men who have sex with men and male PWID) could access this life saving service that is more convenient, private, confidential and self-administered. The approach would leverage on the existing community structures and benefits of HIV self-testing in reaching men.

- **Full description of the approach or best practice:**

The initial review of the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) of 2018 revealed heterogeneity in population drivers of HIV epidemic in Nigeria with high new infections among adolescent and young people in urban Lagos and key population as key epidemic drivers in Akwa-Ibom and Rivers state. There was also an initial assessment and mapping of various community-based organizations, intervention focus and focus LGAs (the administrative unit below the state) across the selected states of Akwa-Ibom, Rivers and Lagos.

- The initiative subsequently engaged 3 CBOs for community distribution of HIVST with focus on Men and KP (MSM, PWID) in Rivers and Akwa-Ibom states and Adolescent and Young People (AYP) in Lagos state. These CBOs were selected based on their experience in implementing community projects targeting specific populations (such as men) and proven capacity to leverage existing structures such as referral and linkage networks within the communities.
- In Rivers and Akwa-Ibom states where CBOs focused on Men and KP, they deployed various distribution modalities targeting the priority population. These modalities targeted men at their social and leisure spots, workplaces, and KP-specific social networking venues (e.g., MSM pride parties, PWID camps etc.) for the distribution of HIVST kits. Male- dominated community hotspots were also mapped to achieve targeted distribution. HIV self-testing was also integrated into community health promotion initiatives/intervention. In Lagos with focus on AYPs, adolescent-led CBO mapped locations like schools, venues for football novel matches, betting centers, football viewing centers etc., where AYPs often patronize. These were combined with AYP-focused demand creation activities such as youth contest, Instagram video challenge, novelty matches, radio call-in to drive community demand for HIVST among young people.
- Community volunteers with good knowledge of the communities were engaged for distribution and provision of post-test follow-up support for beneficiaries. These volunteers also facilitated referral and linkage to other required services such as pre-exposure prophylaxis, confirmatory HIV testing and linkage to ART.
- Collaboration with existing community-embedded structures such as community pharmacies and patent proprietary medicine vendors, KP-focused CBOs, faith-based communities (churches, mosques etc), chairmen of transit points, community gate keepers played critical role in building sustainability to this implementation approach. The approach facilitated seamless community entry and access. Also, the collaboration with U.S. President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners was instrumental in facilitating linkage to confirmatory HIV testing services, initiation of ART

and other prevention services such as preexposure prophylaxis (PrEP), condom and lubricants.

- The community approach was holistic and brought together different compendium of services and stakeholders' engagement.

- **Who were the key implementers, collaborators, and partners in this approach?**

Funded by Unitaid through the Population Services International (PSI) with technical oversight from the World Health Organization (WHO), the program was implemented in collaboration with the National AIDS/STI Control Program in Nigeria, National Agency for the Control of AIDS (NACA), State Ministries of Health (SMOH), Local Government Areas (LGAs), PEPFAR implementing partners, Non-Governmental Organizations (NGOs), local partners/CBOs, health facilities/ART centers, community leaders, faith-based communities, Men groups and associations, youth-friendly centers, community pharmacies (CPs) and patent proprietary medicine vendors (PPMVs).

- **How was the community involved/engaged?**

The communities were initially engaged through advocacy visits to get buy-in from the relevant community stakeholders/leaders. Subsequently, the introductory meeting was held with relevant community stakeholders and the Ministries of Health across the states. Several periodic consultative meetings were also held with community leaders after the initial community mobilization/ entry efforts to ensure that the community was carried along at every stage of the implementation. The approach engaged gate keepers/leaders in targeted LGAs for support in the promotion of targeted distribution of HIVST kits to men. Sensitization and awareness creation activities targeting men and young male adolescents were implemented within the communities in collaboration with other community structures, including informal providers. Community stakeholders who were familiar with community terrain were actively involved in the initial community mapping and movement planning for targeted community HIVST distribution until saturation was achieved. The involvement and participation of community stakeholders in planning and review meetings has fostered ownership and acceptance of this intervention.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

- The approach employed targeted distribution to reach men of different population and age groups. In total, 30,942 men were reached with HIV self-testing through different distribution modalities, of which 29% were male KPs. Community distribution reached 45.1% of older men (30 and older), 41.9% of men aged 20-29 and 12.9% of adolescent boys.

- Through the approach, a total of 300 men reported reactive HIVST results and were linked to confirmatory testing, of which 255 (85%) were confirmed to be HIV positive following a confirmatory HTS. 97.6% linkage to ART was achieved.

- Specifically, a total of 204 older men (30 years and older) reported reactive HIVST results, of which 94.6% (193) were confirmed HIV positive and 98% linked to ART.

Adolescent boys who reported HIVST reactive result contributed 6% (19) to the total number reporting reactive results, and 100% of adolescent boys who confirmed HIV positive were subsequently linked to ART.

- 808 eligible men were placed on PrEP and 13,717 men were offered other prevention services such as HIV counselling and condoms.

- **What worked well and contributed to success, and why?**
- The engagement of CBOs with vast experience in implementing population specific interventions facilitated easy access to target population, stakeholder/community engagement.
- The initial mapping of community resources and CBOs as well as collaboration and partnership with other existing community structures was quite invaluable for efficient allocation of resources, leveraging opportunities and streamlining implementation efforts without duplication or parallel systems.
- Assisted linkage to health facilities and community-based differentiated service delivery models was crucial for timely linkage of men to confirmatory testing and subsequent initiation on ART or PrEP. This prevented delays so that men do not become disinterested.
- Distribution at male dominated spaces and use of existing social network encouraged targeted distribution.
- Integrating with community health promotion activities made HIVST attractive as men could access other health interventions at a spot.
- Social contract between community volunteers and male beneficiaries on preferred follow-up method and timeline, facilitated post-test support including referral and linkage to care based on their choices.

- **What tools and toolkits worked effectively in the approach to engage men and boys?** N/A

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The program established a sustainable mechanism of total market approach, through the local pharmacy distribution Networks of informal patent medicine vendors and community pharmacist that continue to work with these community-embedded organizations to identify and refer men and other vulnerable groups, thereby improving access to HIVST commodity at a subsidized and affordable price. These sustained partnerships between community-based/embedded organizations and the Local distribution Network of Pharmacies and the longer-term price reduction contract sealed with HIVST manufacturers in this initiative, continue to facilitate access of eligible men and other vulnerable groups to HIV self-testing, prevention, care and treatment services in the absence of donor funding. These community-led organizations have also received adequate resources, tools and capacities from this initiative, which they are currently deploying to implement similar interventions through seed fund from other donors like UNICEF as well as Government of Nigeria through NACA.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes. Community based model of HIVST distribution has been scaled up through other bigger donors like UNICEF, PEPFAR and Global Fund in Nigeria. The initiative is also being scaled from 3 initial pilot states (Lagos, Rivers and Akwa-Ibom) to 17 additional states in Nigeria through market-based intervention (demand side financing) that would make HIVST available in community pharmacies and PPMVs at affordable prices. In achieving scale through market-based interventions, CPs and PPMVs will continue to rely on the experience and capacity of these CBOs to identify and refer men and other vulnerable groups to access HIVST and related services in their premises.

- **Annexes:** N/A

Rwanda : case study

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- **Timeline of the case study**: June 2019-March 2020

- **Case study submitted by**: UN or other international organisation

- **Title of approach or best practice or initiative**: "HIV couples testing: An opportunity to reshape gender norms on HIV and sexual and reproductive health in Rwanda"

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Multiple components: HIV testing services and linkage to treatment; prevention of vertical transmission of HIV; and gender norms.

- **In which geographic area is the approach being carried out?:** Rwanda

- **What problem was being addressed and how was it identified?:**

Limited testing uptake by men and lack of male partner engagement in programmes to prevent vertical transmission. The issue was identified through monitoring the PMTCT programme and national estimates.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Men in partnerships with pregnant women.

- **What type of approach is it?**

Innovative HIV self-testing that is facility-based with male-friendly services and community outreach; home-based.

- **What was the logic and rationale behind choosing this approach or practice?**

Men living with HIV in Rwanda and many countries throughout ESA region are less likely than women to know their HIV status, adhere to treatment and be virally suppressed. Many do not engage with their partner's antenatal and postnatal care. Conducting outreach to men through antenatal care with male-friendly services and at-home HIV self-testing is potentially an easy, affordable and acceptable way to reach men who may otherwise not attend HIV testing services and may also improve engagement with their partner's antenatal care, childbirth and postnatal follow up.

- **Full description of the approach or best practice:**

In 2019-2020, UNICEF and the Rwanda Biomedical Center piloted an innovative project designed to increase HIV testing among hard-to-reach male partners of pregnant women attending ANC clinics at six health facilities. Health workers received training, supervision and mentorship to provide enhanced counselling and HIV testing for couples as a routine part of ANC and to support at-home HIV self-testing. Health workers issued invitations to men to accompany their partners to ANC where they were offered HIV testing and counselling. If the man had still not joined his partner after two ANC visits, the pregnant woman was provided with an HIV self-test kit for the man to use at home. At the end of the project, focus group discussions were held with pregnant women, male partners and health workers to better understand the motivators and barriers to male partner HIV testing.

- **Who were the key implementers, collaborators, and partners in this approach?**

UNICEF, Ministry of Health, Rwanda Biomedical Center.

- **How was the community involved/engaged?**

The project engaged District Health Officers, facility-based health workers, and community health workers in creating an enabling environment for pregnant women and their male partners to attend ANC together for HIV testing services, and for men to use self-test kits.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

During the project period, average partner testing in the six sites increased from 69 per cent to 85.5 per cent. Partner testing was 69 per cent (N=4776) on the first ANC visit, and 12.5 per cent (N=860) on the second ANC visit, while 4 per cent (N=274) used HIV self-testing. Sharing of test results between couples was nearly 100 per cent, with no reported or observed negative impact. Although domestic violence was low, it was not zero. Women whose partners did not attend ANC and who expressed fear of conflict were not provided with HIV self-test kits to avoid unintended, harmful consequences. Male attendance at ANC or use of HIV self-test kits was least likely when the pregnancy was unintended, the pregnancy occurred while the woman was a minor, women were not in a permanent relationship, or the male partner was ill or living elsewhere (e.g., for work or in prison.) Partners who tested HIV positive were subsequently initiated on treatment. Participants cited cost, distance and time as some of the barriers addressed by HIV self-testing. Indirect benefits included improved communication and trust between partners, particularly on sexual and reproductive health issues, and greater engagement by men in maternal health.

- **What worked well and contributed to success, and why?**

Men valued accessible, confidential, high-quality SRH/HIV information and services. Formal communication from the health facilities influenced men's decision to accompany

their partners to ANC. Men appreciated that the invitations underscored the importance of knowing one's own HIV status as a way to contribute to their child's health. Whether receiving HIV testing during ANC visits or using self-test kits, men and women noted that couples testing could lead to changes in sexual behavior and better communication. However, men also acknowledged that sexual behaviors may be slow to change. Both men and women voiced concern that disclosure of results be mediated carefully, as a positive or discordant test result might trigger marital discord, rejection, or violence. While there are numerous HIV testing options available to men, men appreciated the ease of receiving services through the ANC platform. Men also valued the privacy, convenience and control that HIV self-testing afforded, confirming the importance of client-centered services. Health workers noted that men's visits at ANC were an opportunity to provide a range of SRH information. Health workers also indicated that men expressed a willingness to take greater responsibility for their health and that of their families. Overall, the project demonstrated that tailoring information and services to men can catalyze changes in social and gender norms as men became more active users of SRH/HIV services and stronger advocates for both their own and women's health and the health of their children.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Health workers were provided with numerous tools: HIVST register, HIVST algorithm, monthly reporting forms for indicators, monthly reporting forms for HIVST kits use, invitations for ANC service. In addition, a supervision schedule, supervision checklist, and reporting format for supervisors were developed and used.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Health workers received training, supervision and mentorship to provide enhanced counselling and HIV testing for couples as a routine part of ANC and to support at-home HIV self-testing. Moving forward, HIV self-test kits are now part of Global Fund and PEPFAR budgets, and ANC nurses will incorporate invitation to men and self-testing as part of routine service delivery.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes. The approach is replicable at scale as minimal additional resources are required. ANC nurses are already trained in HIV testing and counselling. HIV self-test kits were procured through existing supply chain management systems. Future programming will also consider outreach to male partners during postnatal care and the breastfeeding period. The indirect benefits on male engagement and couples' interaction are of value for multiple HIV and related health outcomes.

- **Annexes:** The summary report can be found here: https://www.childrenandaids.org/node/1507

South Africa: case study 1

CONTACT PERSON

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- **Timeline of the case study**: April 2021 onwards

- **Case study submitted by**: Government

- **Title of approach or best practice or initiative**: Rolling out PrEP among High-Risk Men in Correctional Centers

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Pre-Exposure Prophylaxis, Linkage to Health Services upon release

- **In which geographic area is the approach being carried out?** South Africa

- **What problem was being addressed and how was it identified?** High HIV infection rates among men in prison.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** Men aged 18 and older in correctional centers.

- **What type of approach is it?** Peer education and support of correctional services officials.

- **What was the logic and rationale behind choosing this approach or practice?** Peer communication (face to face, and in groups) in prisons is an effective channel of communication as inmates do not have access to cell phones, social or other media. Sensitizing prison officials as role models was important to ensure de-stigmatization.

- **Full description of the approach or best practice:**

Although the South African Department of Correctional Services allows the provision of condoms and lubricants in correctional centers, HIV infection is high, at 12%. We also recognized that the risk of HIV infection (and onward transmission) was highest on release/parole from prisons; this risk is exacerbated by low rates of linkage to public health facilities. We proposed rolling out daily oral PrEP among men in prisons. Continuity on PrEP would be assured through the use of an electronic pharmacy (e-pharmacy) that was

developed for men who have sex with men). The inmate's details would be provided (with consent) to the e-pharmacy upon release. The e-pharmacy would then maintain contact with the released inmate, provide PrEP refills (and self-testing kits) through courier services, and arrange for tests/prescription renewal as necessary. This was met with some resistance from the Department of Correctional Services initially, but a strategic meeting with the Deputy Minister for Correctional Services and Inspecting Judge Edwin Cameron led to the roll out in April 2021. PrEP uptake has increased from 118 initiations in FY21Q2 to triple that amount in the last Quarter. In FY22, we had initiated a total of 2,225 inmates on PrEP

- **Who were the key implementers, collaborators, and partners in this approach?**

TB HIV Care, South Africa Partners, CDC South Africa, South African Department of Correctional Services

- **How was the community involved/engaged?**

The peers within prisons work to promote awareness of and uptake of PrEP within prisons. Linkage officers and community corrections support linkage to the epharmacy that ensures continuity on prEP during the high-risk post-release period.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

PrEP uptake has increased from 118 initiations in April 2021 to triple that amount in the last Quarter. In FY22, we had initiated a total of 2,225 inmates on PrEP. We continue to create demand through peers and continue to monitor PrEP uptake.

- **What worked well and contributed to success, and why?**

Peers motivation and demand creation was critical to de-stigmatizing PrEP. It was important to emphasize that the high-risk period would be upon release.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

TB HIV Care created a board game, similar to hop-scotch that inmates used to promote messaging

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

No additional costs beyond the development of effective messaging, and training clinicians within correctional services

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

This is being implemented in all large correctional centers in South Africa. After nearly two years of implementation, the Department of Correctional Services plans to make PrEP provision a standard part of the package of services.

- **Annexes:** N/A

South Africa: case study 2

CONTACT PERSON
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- **Timeline of the case study**: January 2020 to November 2022 (ongoing)

- **Case study submitted by**: NGO

- **Title of approach or best practice or initiative**: Coach Mpilo: A peer support approach for reaching and retaining men with HIV services

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, testing, linkage, adherence, viral suppression

- **In which geographic area is the approach being carried out?** Implemented in 8 of 9 South African provinces, total of 17 districts with a further 20 districts launching by year end.

- **What problem was being addressed and how was it identified?**

The model addresses many men's lack of safe, relatable sources of support, which we found to be a significant barrier to engagement with HIV testing and treatment. Men in South Africa are less likely than women to test for HIV and to start and stay on treatment. Linkage to and retention on treatment are a particular challenge: 92% of men know their HIV status, but only 70% of those are on treatment. Many men are lost within the first six months after initiation, as they struggle to understand the need for and benefits of treatment, build motivation for daily adherence, navigate disclosure to family and friends, and cope with internalized and external stigma. In formative research with more than 2000 men, we found inadequate support to be a significant barrier to HIV treatment among men. Contrary to conventional wisdom, men are eager to connect with sources of support; however, they rarely find sources that feel safe and relatable. Men report feeling intimidated by nurses and alienated by counseling that is often scripted, one-directional, and overly technical. We took those insights into a series of workshops with 82 men, aiming to design 'the right source of support'. Their challenge: If you want us to believe it is possible to live a normal life with HIV, show us a man who is doing it. The result was Coach Mpilo.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Coach Mpilo targets men who are newly diagnosed, experiencing an interruption in treatment, or otherwise in need of support in coping with an HIV diagnosis and becoming

stable on treatment. The model was designed for men 20-35 years of age, but in implementation we have found it to be effective in supporting men of all ages. The model has also been adapted to the unique needs of MSM with regard to sensitivity and discretion.

- **What type of approach is it?**

Coach Mpilo is fundamentally a peer support model but also draws on engagement of clinic teams, community mapping and outreach, transformation of gender norms, and a mix of digital and in-person support.

- **What was the logic and rationale behind choosing this approach or practice?**

This model emerged from a rigorous participatory design process with men, based on findings from formative research with men. The core insights were that men experience fear and anxiety in relation to HIV, desire support from a safe and relatable source, and need living proof that a happy, healthy, 'normal' life with HIV is possible.

- **Full description of the approach or best practice:**

Coach Mpilo employs men living well with HIV, both clinically and psychosocially, as life coaches to men who are struggling with barriers to testing, linkage, retention, and viral suppression. Having walked the HIV journey themselves, coaches draw on personal experience to provide empathetic support. They reframe the HIV story, dispelling feelings of failure, weakness, shame, secrecy, and isolation, and replacing them with feelings of triumph, strength, confidence, openness, and acceptance.
Coaches complete a one-week training and are then linked to a clinic though based in the community. They identify clients via clinic referrals as well as community outreach, and then provide six months of one-on-one mentoring, tailored to each client's needs. The aim is for each client to become stable on treament and virally suppressed by the six-month mark, at which point the coach supports transition to a decentralized ARV collection option.

- **Who were the key implementers, collaborators, and partners in this approach?**

PSI, Ipsos Healthcare, Matchboxology, South African Department of Health, Gates Foundation, USAID, CDC, Anglo American, Anova, Aurum, BroadReach, Community Media Trust, Health Systems Trust, MatCH, Right to Care, TB HIV Care, Wits Reproductive Health Institute.

- **How was the community involved/engaged?**

Coaches are recruited from their communities and based in their communities, and conduct extensive community mapping and engagement to ensure that all relevant stakeholders are leveraged in identifying and referring men for support.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

In the pilot evaluation, the Coach Mpilo model showed high acceptability, feasibility, and effectiveness. 3848 men were enrolled in the seven-month pilot. 3696 men (96%) were

linked or returned to ART during the pilot period. Of those, 3511 (95%) were retained in care at pilot endline. 618 (16%) experienced at least one treatment interruption, of which 464 (82%) returned to treatment during the pilot period. Comparable numbers have been reported by PEPFAR partners implementing the model in South Africa.

- **What worked well and contributed to success, and why?**

Support from a true peer--not just another man but another man who has walked the HIV journey and is doing well not just clinically but socially and emotionally. This kind of support achieves several things:
1. It immediately breaks through the isolation and paralysis that many men report feeling upon diagnosis. Coaches have experienced the same feelings and know how to connect by drawing on their own story.
2. It provides a safe and relatable source of support. Clients know from the outset that a coach is not going to judge them or misunderstand them, having already walked in their shoes.
3. It provides living proof that a good life with HIV is possible. Even the visual image of a coach who is physically strong and healthy, and open and confident about his HIV status, can assuage a client's fears.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Various tools and resources are available at www.coachmpilo.co.za.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Coaches are the primary HR cost, and are paid at the same level as community health workers--approximately $300/month in the South African context, plus a modest stipend (~$100) to cover transport and data expenses so that they can stay in contact with their clients. Training is an initial once-off cost, with a duration of one week, preferably off-site.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

The Coach Mpilo model has been introduced to government, funders and implementers in other East and Southern African countries, and the response has been positive in terms of relevance and replicability.

- **Annexes:** www.coachmpilo.co.za

South Africa: case study 3

CONTACT PERSON
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- **Timeline of the case study**: November 2020 to September 2022

- **Case study submitted by**: Private sector

- **Title of approach or best practice or initiative**: MINA. For Men. For Health: The impact of consumer-driven marketing design in enhancing uptake of HIV Testing and Treatment in South Africa among men.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV Testing, ART initiation, ART adherence, viral load literacy.

- **In which geographic area is the approach being carried out?** 8 Provinces, 24 districts across South Africa

- **What problem was being addressed and how was it identified?**

Uptake of HIV testing and subsequent uptake of ART was sub-optimal among men. The incidence of HIV among men has been reported as highest among men aged 25-34 years of age. Based on national and provincial data, HTS and ART uptake was highest among women across all age categorizations, with men trailing behind by up to 15% in some provinces.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The target of the campaign intervention comprised general population men, aged 25-39 years of age.

- **What type of approach is it?**

The campaign is 360-degree approach focusing on men, leveraging in-facility collateral, digital media and social media. The campaign is implemented across the country within public health settings, supported by community outreach staff, whilst digital and social media is implemented by Project Last Mile, through media agencies targeting Websites, Facebook, Radio, TV, Youtube.

- **What was the logic and rationale behind choosing this approach or practice?**

PLM's expertise draws from private sector marketing approaches and best practices from The Coca-Cola Company, and applies consumer-driven approaches to the development

of public health campaigns. To address the substantial disparity in men accessing HTS and uptake of ART, PLM designed the MINA. For Men. For Health. campaign targeted at men to address this gap.

- **Full description of the approach or best practice:**

MINA is a through-the line communications campaign designed to motivate men living with HIV to start and stay on life-saving treatment. MINA was developed using a consumer-driven marketing approach, using co-creation with the target audience, namely men, MLHIV, and healthcare workers. The campaign development commenced in late 2020, and completed 4 rounds of consumer testing in 2 provinces. The messaging, tagline, visual identity and digital assets were derived using an iterative process, with consistent input from the target market. The campaign launched in FY2021, with a phased clinic roll-out supported by a national media campaign targeting TV (Men's Real Stories campaign), digital (Facebook and WhatsApp – through MenConnect: https://menconnect.org/), and national radio. At present, MINA is active in ~531 facilities across 24 PEPFAR districts and the national media campaign is ongoing and has reached over 4 million men aged 25-39Y across South Africa across various mass media channels.

- **Who were the key implementers, collaborators, and partners in this approach?**

The key implementer was Project Last Mile, funded by USAID, with collaborators comprising the National Department of Health, PEPFAR, local implementing partners, local Departments of Health (provincial and district), local community members and healthcare workers.

- **How was the community involved/engaged?**

Across 2 provinces, men, MLHIV and HCWs supported the development and consumer-testing of the campaign materials, messaging platforms, messages and visual design of the campaign. Our consumer-testing approach was exclusively focused on men living within the local communities in these two provinces, who facilitated the iterative process of campaign design.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Evaluation includes media reach and pre-/post-campaign analysis of HTS and ART uptake among men within MINA-active facilities. The MINA campaign is active across 531 facilities in 24 districts in SA.

Across mass media, MINA reached 21 million South Africans between October 2021 and September 2022 (1 year). Digital media revealed 36,3 million and 2,3 million impressions on Facebook and Youtube respectively, with a further 10,7 million impressions through programmatic display. HTS among men increased by 22% across MINA active facilities since campaign launch in 2021, with 2 million men testing for HIV in MINA facilities, of which 112K tested positive. There was a 3% increase in ART initiation (244K) nationally, with 116K men initiating ART within MINA active facilities. Furthermore, an increase in ART retention of 109K men were reported nationally, with an estimated increase of 50K

men in MINA facilities. Data revealed that 416K men returned to ART nationally, of which 183K were in MINA active facilities.

- **What worked well and contributed to success, and why?**

The consumer-driven model was the foundation of the success of the campaign, as it is designed by men, for men, within the target population. The campaign remains dynamic as feedback from the communities and stakeholders is continuously used to tweak and improve the messaging. Furthermore, Men telling real stories of their experiences in diagnosis, and their journey with HIV and ART, brings life and identity to the campaign, with relatable content, relevant to the local context.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The campaign materials are designed by the target population, enabling client experiences to drive campaign messaging and delivery of on-point and contextually relevant touch-points with men. As a 360 campaign, messaging is within-facility, out-of-facility, digital; out-of-home and mass media (TV and Radio). With this increased reach across multi-modal channels, and content co-developed and delivered via “real stories” by the target audience, men were effectively engaged with context specific materials in local languages.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Strategic marketing expertise and a thorough understanding of the South African cultural and health landscape was essential in the design, alignment with target audience and operationalization of the campaign. Additional resources include purchasing of Mass Media slots (TV and radio), digital media space across social media, and out-of-home media purchases such as billboards and wall murals. The campaign is housed within the National Department of Health, and implemented across various PEPFAR supported partners. The campaign will expand to all districts within SA under the banner of the NDoH.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, we are currently exploring adaptation of the MINA campaign for the Namibian context. The MINA campaign is highly adaptable, and requires smaller-scale consumer-testing for new target markets to ensure resonance and alignment with target audiences. Within SA, we are exploring the expansion of the campaign to include TB, mental health and other public health priorities.

- **Annexes:**

https://www.facebook.com/MINAForMenForHealth
https://www.minaformenforhealth.co.za

Uganda: case study

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- **Timeline of the case study**: 2017- 2022

- **Case study submitted by**: Cultural institution

- **Title of approach or best practice or initiative**:

Men are Stars- “Abaami Munyenye” Harnessing traditional leadership to increase uptake of HIV services by men and boys in Uganda.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**

Male engagement for HIV prevention, testing, treatment and care cascade.

- **In which geographic area is the approach being carried out?**

Eastern and Southern Africa- Uganda targeting the central region of Uganda (28 districts).

- **What problem was being addressed and how was it identified?**

HIV prevalence is highest in the Central region (10.4%)- of Uganda and lowest in Karamoja region (0.2%) . A comparison of risk across population groups expressing incidence as the risk of infection per 100,000 persons shows that women contribute about 21000 new HIV infections for every 100,000. Central 1 and 2 are catchments of Buganda region which is the largest region in Uganda with a total population of approximately 12 million people. In 2022, Central 1 and 2 (Buganda region) registered over 30,000 new infections out of the countries annual estimate of 54,000. The region trends indicate an increase of 5% in the number of adolescents and young people infected with HIV. It’s significance in incidents and ART enrolment makes it the most affected region calling for immediate attention.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Men - 15- 49 years of age(adolescent and young men, general population of men including the key populations).

- **What type of approach is it?**

Radio attracting approximately 2 million listeners, Television with over 50,000 reach, social media platform, Kabaka Birthday Run marathon attracting 50 000 to 60 000 participants (85% of whom are male), and the Masaza Football Cup attracting 20 000 to 30 000 fans, Campfires targeting 10,000 adolescent and young men.

- **What was the logic and rationale behind choosing this approach or practice?**

Using the Uganda AIDS Indicator Survey regional demarcations 2020, HIV prevalence is highest in the Central region (10.4%)- of Uganda and lowest in Karamoja region (0.2%) . A comparison of risk across population groups expressing incidence as the risk of infection per 100,000 persons shows that women contribute about 21000 new HIV infections for every 100,000. Central 1 and 2 are catchments of Buganda region which is the largest region in Uganda with a total population of approximately 12 million people. In 2022, Central 1 and 2 (Buganda region) registered over 30,000 new infections out of the countries annual estimate of 54,000. The region trends indicate an increase of 5% in the number of adolescents and young people infected with HIV. It's significance in incidents and ART enrolment makes it the most affected region calling for immediate attention. Studies show us that the King of this region has the power to transform his people and he is a key pillar to transformation of cultural norms, beliefs and customs that impact on the communities in Central 1 and 2 region of Uganda which also hosts the capital city of Uganda.In Uganda, cultural institutions and leaders play an important role in influencing behavior and way of life of people in communities. They are constitutionally recognized and widely respected in many parts of the country. Buganda is led by the King (also known as Kabaka) of Buganda, His Majesty Mutebi II, has, over the course of his reign, used his considerable influence to champion health and wellbeing for his subjects – spearheading health related campaigns amongst others to promote polio immunisation, blood donation, maternal healthcare, child nutrition, physical exercise, as well as the prevention of malaria, hepatitis, HIV, sickle cell. Anaemia, Fistula and other diseases. An example of the King's influence was the boost of child immunisation. An immunisation coverage rate of only 20% in 2003 with the involvement of the King, the immunisation rates in the region rose to 73% in 2005 and 95% in 2009 which is above the national average of 89%. As an influential figure, the King has been able to attract financial support from private sector partners such as Airtel Uganda, DFCU Bank, Nile Breweries to contribute to health promotion campaigns. It was therefore an obvious choice to engage the Kabaka in mobilising men to improve their HIV-related behaviour. From 2017- 2022, the Kabaka engaged on campaign on Good Health for Men and Ending AIDs by 2030, statistics show a 52% decline in HIV infections in Central 1 and 2, Increased HIV testing knowledge from 89% in 2016 to 94% in 2020, increase enrolment on treatment from 64% in 2016 to92% in 2020.

- **Full description of the approach or best practice:**

The King uses his power to save the lives of his people: Harnessing traditional leadership to increase uptake of HIV services by men and boys in Uganda

A project run by the Kingdom of Buganda, under the leadership of His Majesty Ronald Edward Frederick Kimera Muwenda Mutebi II is the 36th Kabaka (King) of Buganda. as UNAIDS Goodwill Ambassador for ending AIDS among men in Eastern and South African.

Introduction

Throughout East and Southern Africa, men and boys are less likely to test for HIV, to initiate antiretroviral therapy and to remain engaged in care and are therefore dying of AIDS-related illnesses and many other diseases at disproportionately higher rates than their female counterparts. Uganda is no different, and, in 2016, the country decided to

harness the influence of traditional leadership to encourage men and boys to come forward to test for HIV, and for those who tested positive to start and stay on treatment.

Buganda is the traditional kingdom of the Baganda people within present-day Uganda. The King (also known as Kabaka) of Buganda, His Majesty Mutebi II, has, over the course of his reign, used his considerable influence to champion health and wellbeing for his subjects - spearheading campaigns to, amongst others, promote polio immunization, blood donation, maternal healthcare, child nutrition, physical exercise, as well as the prevention of malaria, hepatitis B, HIV, sickle cell. Anaemia, Fistula and other diseases. An example of the King's influence is the boost he gave to child immunization. As recently as 2003, the counties which overlap with the Buganda Kingdom had an immunization rate of only 20%; with the involvement of the King and Queen, in rates in these counties rose to 73% in 2005 and 95% in 2009. As an influential figure, the King was able to attract financial support from private sector partners such as Airtel Uganda, DFCU Bank, Nile Breweries to contribute to health promotion campaigns.

It was therefore an obvious choice to engage the Kabaka in mobilizing men to improve their HIV-related behavior. Thus, in March 2017, UNAIDS appointed the King of Buganda as a UNAIDS Goodwill Ambassador on Ending AIDS among men in East and Southern Africa so that he could use his influence on norms, beliefs and customs to impact on men's access to HIV services.

The intervention

As part of his ambassadorial role, the Kabaka launched an HIV advocacy campaign called "Men are Stars - Abaami Munyenye". The aim of the campaign was to sensitize and mobilize a critical mass of men and boys in Uganda and throughout East and Southern Africa to access HIV services. The campaign targeted men and boys between the ages of 15 and 49 years within 25 high HIV burden districts. One of the main ways which the Men are Star's campaign reached men was through popular sporting events. These included the Kabaka Birthday Run marathon attracting 50 000 to 60 000 participants (85% of whom are male), and the Masaza Football Cup attracting 20 000 to 30 000 fans. Other initiatives included use of the Kingdom's radio station and television station to communicate advocacy messages for the campaign, as well as organizing traditional campfire events for adolescent boys and young men.

In total, the project aimed to directly reach over 7 million Ugandans (and via a multiplier effect, more than double that number), through the combined platforms of sports, radio and television stations, community dialogues, edutainment at schools, churches, and mosques, as well as via social media and the Abaami Munyenye Twitter account. The content of the messages focused on mobilizing adolescent boys to prevent HIV through voluntary male circumcision, and mobilizing men and boys to test for HIV, to adhere to treatment in order to reduce viral load. The campaign also stimulated discussion on social and structural drivers of HIV such as harmful gender norms, gender-based violence, stigma and discrimination.

- **Who were the key implementers, collaborators, and partners in this approach?**

Buganda Kingdom and it's implementing institutions together with Private Sector companies like Airtel Uganda, DFCU and centenary bank.

- **How was the community involved/engaged?**

Through Kabaka's voice, radio enragements, television, social media platform, Kabaka birthday run marathon, campfires, Masaza Football Cup and Campfires.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The campaign contributed to significantly improved HIV-related outcomes in the Buganda region between 2017 and 2020 including:

- Increased knowledge of HIV status from 89% to 94%
- Increased HIV treatment coverage from 64% to 92%
- A 52% decrease in new HIV infections.

A closer look at the HIV treatment cascade data in 2020 showed a great improvement amongst men and boys. As the Men are Stars campaign is the only one in the Buganda region which has focused on improving mens' HIV- and health-related behaviour, it certainly seems as if the campaign has made a contribution towards these improved outcomes. In addition, the campaign has made a contribution to Uganda's commendable achievement of the 2020, 90-90-90 targets - one of only eight countries globally that managed to do so.

- **What worked well and contributed to success, and why?**

Use of the King (Kabaka) as a UNAIDS Good Will Ambassador.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

familyincluded.com/male-engagement-community-women-champions-uganda

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The overall amount of the proposed was 3,900,840,000/= (Three billion and nine hundred millions) equivalent to US$, 10,571,382. The biggest amount of this money will be covered by the Private sector companies (Airtel Uganda, DFCU, Central Broad Casting services, Buganda Broadcasting television, New vision, Century bottling company and others). UNAIDS facilitated with 100,000 USD for three years equivalent to 33,000 USD per year branding of the football jerseys for masaza cup with HIV messages, stickers, football pitches for selected fields, branded route marks procurement and branding of masks, wrist bands, umbrellas, Executive T shirts, enhanced social media campaign.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Practice at scale to facilitate the attainment of the 2030 targets. UNAIDS. UNAIDS has again engaged the King of Buganda (Kabaka) as a UNAIDS Good Will Ambassador for Africa that will lead to the attainment of success of global 2030 targets in the region. Building on the previous campaign, Buganda Kingdom would like to hold a similar HIV advocacy campaign through Kabaka run, Masaza cup and Royal regatta dubbed as Men are Stars- "Abaami Munyenye" that will aim at sensitizing and mobilizing a critical mass of men and boys in the region and Uganda at large to access of HIV and other health services for themselves and also fight stigma and discrimination. The campaign will target men and boys between the age of 15 years – 49 years with interim focus on central 1 and 2 and other parts of the Country but with more concentration on Islands and cities that contribute greatly to the new HIV infections in the region. The King being a UNAIDS Good Will Ambassador for Africa, He will also hold regional meeting with other Kings and also participate in South-to-South visits plus regional and Global engagements held for cultural/traditional and religious leaders.

- **Annexes:**

UNAIDS_MALE ENGAGEMENT FINAL.mp4
Thousands take part in the Kabaka Birthday Run to support the HIV response in Buganda | UNAIDS.
https://www.newvision.co.ug/category/news/kabakas
https://www.monitor.co.ug/uganda/news/national

Zambia : case study 1

CONTACT PERSON
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- **Timeline of the case study**: 15th to 26th August 2022

- **Case study submitted by**: Non-Government Organization

- **Title of approach or best practice or initiative**: Community TB Active Case Finding

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Single component

- **In which geographic area is the approach being carried out?** Kitwe and Ndola Districts, Copperbelt Province, Zambia

- **What problem was being addressed and how was it identified?**

The problem was low TB case finding identified through four facilities under Defense Forces of Zambia. The quarterly target for the four facilities was 64 TB patients. In quarters 1 and 2 FY22, the facilities reported 23 (36%) of the quarterly target out of which were 14 (61%) males and 32(50%) of the quarterly target out of which 27 (84%) were male respectively.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

General Male Population.

- **What type of approach is it?**

The diagnostic truck was used in Community Outreach health services and it was mounted near the football grounds, markets, bars and restaurants and schools where men are found.

- **What was the logic and rationale behind choosing this approach or practice?**

Males are usually reluctant to attend health facilities due to their busy schedules. Hence, taking the services to where they are found in order to increase TB screening uptake and TB treatment initiation.

- **Full description of the approach or best practice:**

Outreach activities were conducted in communities surrounding Defense Force Health facilities using a mobile truck that has digital diagnostic tools (gene Xpert and digital X-

ray). Community lay workers and demand creation officers went into the communities to create awareness and invite the community for TB screening and HIV testing services using a PA system. All presumptive TB cases were subjected to sputum examination, digital chest X-ray, and HIV testing. All clients that were found with TB were initiated on TB treatment and those that had a positive HIV test were initiated on ART according to the national guidelines.

- **Who were the key implementers, collaborators, and partners in this approach?**

Jhpiego, DFZ Staff were the main implementers with the collaboration of MOH. These includes: clinicians, lab-technicians, demand creation officers and community lay workers.

- **How was the community involved/engaged?**

The communities were engaged through the gatekeepers: Zonal facility leaders, Market chairmen, village headmen and school headmasters/ mistresses. The facility community lay workers conducted door to door campaigns and awareness.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

136 males out of 739 attendants were screened for TB, representing 18%. In quarter Q3, the facilities conducted community outreach and reported 56 (88%) of the quarterly target out of which 48 were male. The outreach activity contributed a Total of 32 clients diagnosed with TB out of which 26 (81%) were men. 18 were clinically diagnosed while 8 were diagnosed through laboratory screening. Meanwhile, 6 men were newly diagnosed with HIV of which 4 started ART and 2 were initiated on TB treatment.

- **What worked well and contributed to success, and why?**

The services were brought into the community, and diagnostic services offered at point of contact including initiation to treatment.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The men and boys were attracted to the track which had pictures of a boy kicking a ball, this resonated with their daily social entertainment activity. Following men in the market place and restaurants, school football grounds proved to be accessible for men.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Clinicians, lab-technicians, demand creation officers and community lay workers. The cost was minimal as it included fuel and lunch allowances for the MOH staff.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

This approach can be implemented at a larger scale and also for a longer period of time to reach out to more men.

- **Annexes:** N/A

Zambia : case study 2

CONTACT PERSON
Name: Dr. Carolien Aantjes, research fellow, and Professor Kay Govender, research director
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- **Timeline of the case study**: January 2018 – On going

- **Case study submitted by**: Academic institution and Civil society

- **Title of approach or best practice or initiative**: Reaching youth with sports; SRHR/HIV skills building and transformation for boys and young men.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** The best practice concentrates on prevention and testing. In collaboration with clinical partners, HIV positive youth are referred to treatment services, the target group to services.

- **In which geographic area is the approach being carried out?** Southern Zambia, Livingstone District

- **What problem was being addressed and how was it identified?**

The case study, as presented, emerged from HEARD's 2022 regional assessment on men and boys' sexual and reproductive health and rights. The assessment, commissioned by UNFPA ESARO, included a policy analysis and mixed method study in 5 countries including Zambia. A systematic analysis of the Zambian policy landscape showed very limited attention to men and boys' health and wellbeing and poor linkages between health sector policy, such as the adolescent health standards, and the educational policies on SRHR, which inform the curriculum of comprehensive sex education for boys and young men in the school setting. Moreover, the country's CSE curriculum was observed to primarily focus on information dissemination, lacking a skills building and gender transformative approach. Play it Forward participated with their youth and staff in the mixed methods study, and highlighted the importance of using football as the hook for boys and young men to learn about their own health, gender roles and where to access health services, if needed. The football model was developed from a vision that people's love for football can be used to build opportunities, especially in the remote areas of Zambia, where access to public services and meeting one's basic needs are a challenge. Play it Forward effectively deploys the attractiveness of the sport to bring in boys and

young men and offer them the opportunity to, for example, know their HIV status, where static clinics have difficulty in getting this target group to come forward. The organisation also offers critical skills building for boys and young men in a context where religious and traditional beliefs continue to strongly shape gender roles and have a negative effect on SRHR outcomes. The breadth of the organisation's work extends to the development of rural and disadvantaged youth and includes also the much needed economic skills set (e.g. digital skills training) to offer boys and young men perspective.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** Play it Forward works with the age band 10-24 years old and with both adolescent boys and young men and adolescent girls and young women from disadvantaged communities in Livingstone.

- **What type of approach is it?**

Play it Forward provides orphans and vulnerable children and young people with evidenced-based, age-appropriate, HIV prevention support and services through football drills conducted by peer coaches with support from project coordinators and project officers. The primary objective of the HIV prevention interventions for the project focuses on education and reducing the rate of infections among adolescents who are the most vulnerable to HIV infections.

- **What was the logic and rationale behind choosing this approach or practice?**

Football is a widely accepted sport in Zambia and many young people even in hard to reach rural communities use football for recreational purposes. Play it Forward harnesses the power and popularity of football to empower young people with SRHR knowledge and other life skills.

- **Full description of the approach or best practice:**

Play it Forward provides adolescent boys and young men with age-appropriate HIV prevention support as they enter into adulthood. Our bespoke and specially designed curriculum includes topics including, but not limited to, voluntary medical male circumcision (VMMC), HIV education, gender equality and safeguarding. SRHR education is essential in giving young people the skills and knowledge to protect themselves, their family, and their friends, and engage in healthy relationships.

Peer coaches are trained from various clubs in Livingstone District and empowered with the knowledge and skills to become change agents in their communities. Coach training is conducted for 5 days and includes SRHR & HIV education as well as elements of character development (confidence, resilience, leadership, communication, etc). The coaches then deliver weekly football sessions for 10 weeks at a time and thereafter, community football tournaments are held 3 x per year after each block of 10 weeks. At the community tournaments, pitch-side HIV counselling and testing and free condoms are available in medical tents set up by our clinical partners. This allows the young people and the community to access services and testing away from traditional clinics which often have long waiting times and where there may not be youth-friendly services. Peers coaches also link and refer beneficiaries to partners such as Planned Parenthood

Association Zambia (PPAZ) and GBV one-stop centres to access services such as HIV & STI testing and further treatment.

- **Who were the key implementers, collaborators, and partners in this approach?**

Play it Forward uses a peer-to-peer model by engaging peer coaches to deliver weekly HIV & life skills sessions with support from project coordinators. Play if Forward has created sustainable partnerships with organisations providing HIV prevention support to maximise the delivery of services to our beneficiaries. We currently work with partners such as TackleAfrica, Planned Parenthood Association of Zambia, Chreso Ministries and the GBV one stop centre, to deliver SRHR services in Livingstone. Community representatives, parents & other local stakeholders play a key role in the success of our projects.

- **How was the community involved/engaged?**

Play it Forward harnesses a community led approach by engaging the community at every stage of project implementation from a selection of the beneficiaries and quarterly parent and stakeholder meetings which allow the organisation to inform and tailor programs to the specific communities' needs. We enjoy a healthy relationship with communities in Livingstone and this helps us to overcome resistance by parents or elders in the community against discussing sex and sexuality and gender issues with young people in the community.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

In a joint study with TackleAfrica in 2020 before the COVID- 19 pandemic, we conducted a survey among 522 programme beneficiaries at baseline and 390 at endline. The objective of the survey was to ascertain levels of knowledge and attitudes toward SRHR and HIV/AIDS. There was a positive increase in knowledge across most questions from baseline, the largest increase in participant knowledge was observed in response to the questions on STIs and contraception. Correct responses to “girls who carry condoms are easy’” had doubled after the second block of training, which showed a change in attitudes towards women. Refusal of unwanted sex and negotiation of condom use also showed an increase. Ability to access HIV testing and services showed a steady increase over all three blocks, rising from 72% at baseline to 86% at endline. Comprehensive knowledge of HIV followed a similar trend to the rest of the questions in the survey, rising significantly from 36% at baseline to 69% at endline. The high player reach demonstrates the popularity of football and how this can be harnessed to deliver vital SRHR messages to young people.

- **What worked well and contributed to success, and why?**

We can identify four major lessons, notably:

1. In the context of multiple barriers in male health-seeking behavior (i.e. scant availability of health facilities, lack of youth-friendly services, shyness/fear to visit a health facility), our programme environment provides boys and young men with

a safe place to discuss sensitive issues and receive tailored information and support from a trusted source.

2. Leveraging our football for development model has been a huge factor in successfully attracting boys and young men as there are few organisations implementing such programs in Livingstone, and linking them to care.

3. Working with various partners such as TackleAfrica, PPAZ and other organisations to complement efforts and bridge gaps in terms of SRH service provision and information dissemination in the rural areas of our country.

4. Our community led approach allows the community to take ownership of the project, and create a greater understanding and support base for SRHR communication to youth in the community.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Play it Forward developed its own curricula to engage boys and young men. These documents can be obtained from the organization via the contact provided.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Play it Forward uses a resource efficient training of trainer model to ensure that the project can create impact both in the short and long term. This project seeks to strengthen the capacity of coaches by providing them with the knowledge, confidence and skills to become highly skilled HIV/SRHR educators. This 'training of the trainer' model ensures that once the project is complete, the skills remain with little to no cost to continue the delivery once the project has completed. We'll also ensure sustainability in the following ways: 1. Human resource capabilities - Play it Forward has 15 competent employees as well as 28 volunteers that contribute to the successful management of the projects. Our Senior Management team includes the Programmes Manager and Accountant who oversee the management, administration, and reporting of projects. Together they create the annual budgets, fundraising strategy and develop partnerships. The project trains voluntary community health coaches every year who are equipped with the knowledge, skills and confidence to be ambassadors of positive health behaviours in the communities they live in beyond the end of the project delivery cycle. 2. Future financing of the project - Play it Forward is always working on income generating activities that enable us to keep running our programmes. Fundraising from Play it Forward UK contributes to our annual core/administration costs giving us future stability to pursue more projects. We are applying for future funding through trusts and foundations so we can continue delivering this project. Other revenue generating activities include the hiring of the bus by local schools and businesses, and other fundraising events in Livingstone. The project relies on volunteer peer education that is both highly effective and low cost.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Play it Forward has a partnership with School Club Zambia on a large-scale 3-year project called Own Your Destiny in Sinazongwe District that is funded by Comic Relief & The Scottish Government. In this project we have replicated the same football for development

model. So far 20 peer coaches have been trained to empower 750 young women who have dropped out of school with SRHR knowledge and life skills to build their confidence to re-enter the education system. As the momentum for boys and men's health is rising in the region, we hope to also expand our programme for adolescent boys and young men and replicate the practice in other rural areas of the country.

- **Annexes:** https://play-itforward.org/ On the website, there is a 5 - minute video which showcases the programme. The curricula are not available online but can be sourced directly from Ms Natasha Chirambo, as well as the 2020 survey report.

Zimbabwe: case study 1

CONTACT PERSON

Name: Peggy Kuchocha

- **Timeline of the case study**: November 2021-September 2022
- **Case study submitted by**: Private sector

- **Title of approach or best practice or initiative**: Strengthening the engagement of adolescent boys and young men in HIV prevention, testing, treatment and care through peer-led interventions in Zimbabwe

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, It addresses HIV prevention, PMTCT, HIV testing, linkage to PrEP and Antiretroviral treatment, and mental health

- **In which geographic area is the approach being carried out?** Zimbabwe-Harare

- **What problem was being addressed and how was it identified?** The goal of the program was twofold: 1) To strengthen the engagement of male partners of young mothers living with HIV, to promote maternal viral suppression and SRH, PMTCT of HIV and syphilis, GBV prevention 2) To strengthen the engagement of young fathers living with HIV to support healthy families through building the skills of young men to care for themselves, their partners, and babies

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention**: Adolescent boys and young men living with HIV, 15-24 years old • including young dads

- **What type of approach is it?** Peer-led information, counselling, monitoring, support and linkages to services are delivered by Young Mentor Mothers (YMMs) and Young Mentor Dads (YMDs) in health facilities, home visits, support groups and through mobile health

- **What was the logic and rationale behind choosing this approach or practice?** Zvandiri is grounded in the power of peers to design, deliver, monitor and evaluate their own solutions to HIV. It's Community Adolescent Treatment Supporter (CATS) model has been proven to be feasible, scalable, effective and sustainable and results in improved uptake of HIV testing, retention, viral suppression and mental health among ALHIV supported by CATS. With support from UNICEF, the CATS model was evolved into the Young Mentor Mother (YMM) intervention for pregnant and breastfeeding adolescent girls

and young women. We found similar benefits - high rates of viral suppression (98-100%) and 2% MTCT. But formative research funded by UNICEF – The Third Generation Study – confirmed high rates of poor maternal mental health correlating with GBV, stigma, and lack of support from male partners. Having learned lessons from the YMM intervention, including the successes of male engagement, we have extended the YMM intervention into a pilot of the YMD intervention.

- **Full description of the approach or best practice:**

1) To strengthen the engagement of male partners of young mothers living with HIV, to promote maternal viral suppression and SRH, PMTCT of HIV and syphilis, GBV prevention

The Young Mentor Mother intervention is led by trained, mentored young mothers living with HIV, 18-24 years old, who are attached to health facilities and supervised by MoHCC health care workers. They case manage a caseload of pregnant and breastfeeding AGYW, (up to 24 yrs old), ensuring they have the information, counselling and support they need to make safe, informed decisions about their own health and their infant's, and are linked and engaged in the services they need. The goal is improved maternal and child health (including SRH and mental health) and PMTCT. Beyond the successes in improved viral suppression and PMTCT, we also found that the YMMs are highly effective at engaging male partners: supporting young mums to make informed, safe decisions about disclosure to their partners, linking male partners to HIV testing, and ensuring they are linked to PrEP and ART as needed.

We also learned that young dad living with HIV are eager to do more for other young mums and dads, resulting in the evolution of the YMD pilot intervention, as below.

2) To strengthen the engagement of young fathers living with HIV to support healthy families through building the skills of young men to care for themselves, their partners, and babies.

The YMD intervention was launched in Zimbabwe as a pilot in November 2021 and informed by the expressed needs of young dads who wanted to more for their male peers. They saw the work being done for young mothers and wanted to amplify these efforts by engaging with other ABYM . A total of 7 Young Mentor Dads, who were already trained, experienced CATS, were trained to support their male peers with information, counselling and support specifically tailored to their needs. The goal is to support the development of healthy families and children who are physically and mentally healthy. The training capacitated the young dads on reproductive health services, counselling, HIV self-testing, EMTCT and addressed unique pressures of young dads and adolescent boys. The YMDs also participated in a mental health workshop to explore their own mental health needs and experiences, which generated vast learning about the service delivery gaps and mental health needs of ABYM. We are now expanding this for more ABYM.

- **Who were the key implementers, collaborators, and partners in this approach?**

Ministry of Health and Child Care, Zvandiri , UNICEF, ZimTTECH, Maruva Trust, CeSHHAR, Young Mums and Dads

- **How was the community involved/engaged?**

The YMM and YMD interventions have been planned and integrated within national EMTCT plans. This facilitated engagement at provincial and district level for effective planning and implementation. Training and mentorship is facilitated by MoHCC and Zvandiri using standardized curriculum and service delivery tools. Through district-based Zvandiri Mentors, we engaged facility-based health workers and community health workers in creating an enabling environment for data collection, including electronic mother-baby pair registers, and subsequent engagement of the target population at facility level and in the community. Home visits and follow-up of clients was done in the community.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Results from the YMM intervention: As above, the YMM intervention was informed by formative research supported by UNICEF. A formal evaluation is currently being planned. Program data confirms the intervention is effective at engaging male partners. Key results are as follows:

-65% of YMs reported a partner
-92% of male partners tested for HIV (the first time for most)
-66% partners identified with previously undiagnosed HIV
-99% partners who tested HIV-positive were initiated on ART
-98% who tested HIV-negative subsequently linked to PrEP
-Improved disclosure by YMs to their partners

Results from the YMD intervention: There was no pre-planned, formal evaluation. The pilot is still underway. To date, 91 young dads, adolescent boys and young men have been registered in the program. Viral load coverage is 78% (71/91); viral suppression is 67% (61/91). All the registered adolescent boys reported using condoms though only 32% reported consistent condom use which was an increase of 17% from before the program implementation period. There was a marked decrease in defaulters as young mentor dads offered support to their peers. Support group meetings also provided a platform for discussions related to the GBV and this is reported to have had an impact on GBV reduction. Young Dads report this to be highly acceptable and value the focus on their specific needs, with opportunity to engage with their male peers who understand and validate their experiences. As above, the findings from the mental health workshop with YMDs indicate alarming gaps in attention to the mental health needs of ABYM and we intend to expand this further in response. A full evaluation of the YMD intervention is being planned before scaling further.

- **What worked well and contributed to success, and why?**

Young dads and adolescent boys value youth-led, confidential and high-quality services. Health care providers refer ABYM struggling with adherence issues or having challenges

with acceptance and disclosure to the young mentor dads with interesting results. Health care workers report significant improvements in adherence and viral suppression among ABYM previously considered to be 'complex cases'. The YMDs provide first line support to their male peers when they arrive at heath care facilities which has helped them to navigate the system more easily and with confidence. This has also made it quicker for the ABYM to get the services they need, something they report as being a huge positive as they do not want to spend long in the clinic. HIVST training also assisted YMDs in offering testing services to partners in their home environment, improving access to HTS in safe, private spaces. Inclusion of gender, communication and conflict resolution skills development has been requested by ABYM within the programme

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Standardised tools include caseload planners, the national Early infant diagnosis algorithm, HIVST screening tools, TB screening tools and STI screening tools.

Young dads were provided with mobile phones for data capturing. The data was captured into the Zvandiri data base for data consolidating.

We have a training curriculum for ABYM living with HIV which we are still piloting but is proving successful.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?** YMM / YMD package of support: Monthly Stipend, Bike, Phone, Data/ Airtime, T-shirts • Training, supervision and mentorship: Zvandiri Mentor, Zvandiri Coordinator/Trainer • Training Workshops for YMM and YMD • Sustained, on site mentorship and supervision: travel costs for site visits • SIE: database maintenance and support, monitoring systems; printing of tools • HIV self test kits, availed by MoHCC

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes. The YMM intervention is being scaled in Zimbabwe and replicated in the region (Tanzania, Eswatini). The YMD has not been funded so we are mobilizing resources for that so that we can scale it up, layering within Zvandiri's existing CATS and YMM programmes with MoHCC and National AIDS Council.

- **Annexes:** N/A

Zimbabwe : case study 2

CONTACT PERSON
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- **Timeline of the case study**: 2015-2022 (ongoing)

- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: N/A

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Multiple components: HIV testing, treatment, prevention and care and mental health.

- **In which geographic area is the approach being carried out?:** Started in Harare and later on scaled to 5 major cities.

- **What problem was being addressed and how was it identified?:**

In 2015, GALZ conducted a context analysis, in which several factors that may result in delay or failure to seek healthcare were identified. These included:

- The government had no official HIV prevalence rate or size estimate data published. This meant it could not ear-mark any resources for the delivery of sensitive and competent sexual health services to men who have sex with men (MSM) in Zimbabwe.
- Low health-seeking behaviours amongst MSM;
- Low access and quality of health-service provision for MSM, even more so for young MSM (below 24 years old);
- Discrimination by service providers towards MSM presenting a major barrier to accessing health services.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** Gay and bisexual men.

- **What type of approach is it?** Male-friendly services (drop-in-centres), training of healthcare workers.

- **What was the logic and rationale behind choosing this approach or practice?** Lack of friendly services. Little access to international funding.

- **Full description of the approach or best practice:**

After intense lobby by Aidsfonds and global networks, Global Fund specifically started to ear-marked funding for key populations in 201. This development was used by GALZ to

become part of Global Fund CCM and resulted in the Zimbabwean government scaling-up delivery of HIV-related services for gay and bisexual men. It approved the training of healthcare professionals to deliver those services sensitively and competently across 45 sites in five cities identified by the community. This included doubling of targets and commensurate increases in funding support to reach more MSM from 2016-2018 as well as ear-marked investments for the training of healthcare providers in 2018. In addition, the Zimbabwean MOHCC, the CCM and the National Aids Council allocated $2 million for programs and services for MSM in 2017. The resources were earmarked to increase uptake in HIV services through establishment of drop in centres and linkage to services within new centres and public health facilities viewed as friendly by MSM and other key populations. GALZ and UNFPA with other key populations went into partnership to implement programmes in five cities around Zimbabwe under the grant. In 2017, GALZ signed its ever first GF funding contract to develop three Drop In Centres (DICs) for community mobilisation and empowerment, access to health services and psychosocial support. Up until this latest grant, no funds had been allocated directly for MSM programming, despite this being a global priority for the GF. For GALZ, the DIC model was a critical opportunity to extend access to health and rights for (young) LGBTI in the country through the provision of safe spaces and other resources for community mobilisation and individual empowerment in combination with improving access to HIV and sexual health interventions offered through partners such as Population Services International (PSI). The DICs have been recognized as a best practice by UNAIDS in its 2019 report . In 2018, 7,000 MSM were targeted under the GF grant with increases expected each year till 2020. In 2018, GALZ conducted a client satisfaction survey among 78 people and found that over 80 per cent of service users is (very) satisfied. In 2021, the government of Zimbabwe showed interest to scale the DICs to nation level, building on the service model of GALZ.

- **Who were the key implementers, collaborators, and partners in this approach?** GALZ (LGBTQI+ network Zimbabwe), Ministry of Health, other key population organisations, M-PACT, COC and Aidsfonds. Dutch government has funded the developing, testing and scaling model.

- **How was the community involved/engaged?** The full intervention has been led by the community.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Other results include:

- GALZ was able to directly access resources from PSI to mobilise MSM and transgender people linking then to HIV testing, STI screening, Pre-Exposure Prophylaxis (PrEP) and information regarding sexual health and rights.

- Since the training of parliamentarians, GALZ-led engagement saw an improved respect for the rights of LGBTI persons from political key players. And through collaboration with the Handsoff programme (see case study x), relationships with police

officers have been built. This resulted in GALZ staff experiencing less police violence and there have been no office raids anymore. However, violations (including assault, rape and threats) against LGBTI people are still high and remain vastly reported. In the upcoming years, GALZ will need to accelerate its work on violence.

- In 2017, a key populations position was created within the MoHCC to oversee programs for key populations in Zimbabwe. As a result of advocacy efforts, in 2018, the Zimbabwean MOHCC in close partnership with GALZ developed and piloted its first-ever 'Key Populations Manual for Healthcare Providers' and launched a 'Minimum Service Package for Key Populations.' The training curriculum of MPACT, John Hopkins University and GALS has been used as basis for this package.

The results of the Service model of GALZ has been documented in independent studies, including a study conducted by HEARD (2018) Case Study of GALZ, available upon request and recognized in the 2019 UNAIDS report (https://www.unaids.org/en/20191226_WAD2019_report_power_people) and outcomes are captured by the M&E framework of GALZ, including Referral Service Satisfaction Surveys

- **What worked well and contributed to success, and why?**

Best practices and lessons learnt of GALZ successes were documented by multiple studies, shared through learning events in Bridging the Gaps and regional and global conferences and acknowledged in the UNAIDS report 2019. It took years for GALZ and other key population organisations to access GF and PEPFAR funding. GALZ has shown resilience in a harmful and conservative context that resulted in a shrinking space for civil society.

GALZ changed its way of operating multiple times to mitigate risks and make use of strategic opportunities. For example, GALZ made use of the opening up the CCM to key populations in Zimbabwe to influence GF strategy. In addition, GALZ needed to postpone its ambition to work on young people since this would have hampered its advocacy attempts with MoHCC and therefore decided to slowly integrate it into its core work.

In addition, GALZ sometimes chose to go with silent diplomacy tactics to prevent public backlash or provide access to young MSM (16 – 24 years old) underground to safeguard the work, staff and community members. With Dutch funding and support, partner organisations are showing resilience and are able to continue at least parts of their work to ensure that gains made in the past are not lost.

During their strategic planning GALZ requested feedback from MOHCC and this was very helpful in rethinking their strategy as, from the perspective of the MOHCC, without structural change, efforts to address the health and rights of LGBTI could not advance. When GALZ and MOHCC jointly started looking at issues around HIV it became an opportunity for engagement to try and leverage opportunities.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The MSMIT

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

GALZ has received long-term funding through various Aidsfonds projects. To ensure a lasting impact GALZ works on a number of sustainability strategies:

- GALZ improved its cooperation with the government and has now a good relationship with Ministry of Health. GALZ's efforts are now embedded in Zimbabwe's National AIDS Strategy and in the new ZNASP. This plan uses a public health and human rights framework for key populations. In 2019, 70 Members of Parliament from the HIV/AIDS, Justice, Gender and Community Development committees and several support staff, visited the drop-in-center in Mutare. This visit was a joint effort with strategic partners UNAIDS, UNFPA and NAC. In addition, MSM also have been included in the national PReP strategy.
- By training and raising awareness among healthcare workers, there is now a more positive attitude towards MSM embedded within these services.
- GALZ has partnered with women, feministic, key population and human rights organisations to join forces in advocacy campaigns. In addition, in the religious sector the World Council of Churches (WCC) has been an ally in open dialogue with religious leaders on sexual orientation and gender identity.
- Build capacity to strengthen civil society and ensure local ownership. For example an external evaluation showed that GALZ through Bridging the Gaps (2011 – 2020) has grown into a mature and stable organisation within the Zimbabwean landscape for LGBTI issues (see infographic 4). GALZ acquired considerable ability and agency to bring about change, particular at the present time when important shifts in the operating environment are occurring. GALZ has adopted a new role in supporting the movement for the country, particularly through sharing its considerable capacity with newer entities as well as to use its credibility and legitimacy to convene allies and stakeholders and to initiate new mechanisms for collaboration and solidarity.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

The service model of GALZ has been scaled to 5 major cities and the government has committed itself in 2021 to scale to nationwide level.

- **Annexes:** Available upon request

Zimbabwe : case study 3

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- **Timeline of the case study**: 2019 to present

- **Case study submitted by**: Government and Civil society

- **Title of approach or best practice or initiative**: Demand generation through the Brotha2brotha program

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, the focus of the programme was on HIV prevention, ASRH and life skills training for young vulnerable young men. The young men were taught on HIV prevention and motivated to take up prevention services like HTS, VMMC and condom services among others. Soccer was used as edutainment to recruit youths into the clubs and generate demand for service uptake.

- **In which geographic area is the approach being carried out?** The program is currently being implemented in Uzumba- Maramba- Pfungwe, Marondera Districts and Harare Metropolitan Province (5 National AIDS Council Districts).

- **What problem was being addressed and how was it identified?**

In 2016, around 610 000 new HIV infections were recorded among youths (15 – 24 years) and 41% of these were young men. In Zimbabwe, only 36% of young men have basic knowledge on how to protect themselves from HIV, half of the young men in Zimbabwe do not know their status and are less likely to start HIV treatment than women (DHS, 2016). An estimated 60% of youths in Zimbabwe use illicit drugs, with 66% of them being male users yet these young men and boys are usually marginalized from health and development focused programs that mainly target women and girls. More so, some of these boys are faced with the same vulnerabilities as the girls like orphaned, drop out of school, live in poverty and become heads of households at very young ages yet no programs have sought to target such boys and young men. The ZIMPHIA results show that HIV infection among young women predominantly come from young men, as opposed to trends from previous years where young women would mostly get infected by adult men. (sugar daddies). PEPFAR health cascades have shown that boys and men are not accessing services as would be expected. When men can access HIV prevention and treatment services, there is a triple dividend—they protect themselves, they protect their sexual partners, and they protect their families. When a man is HIV-negative or virally

suppressed he is unlikely to transmit HIV to his sexual partner. When fewer women are infected by men, fewer children are at risk of acquiring HIV. Hence the National AIDS Council (NAC) through implementing partner (ZICHIRE) initiated a programme targeting adolescent boys and young men (AGYW) coined Brother2 Brother to run alongside the Sista 2 Sista for adolescent girls and young women (AGYW).

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Adolescent boys and Young men (ABYM)aged 15-24 years

- **What type of approach is it?** Community based intervention

- **What was the logic and rationale behind choosing this approach or practice?**

Community action translates into results. It can achieve improved health outcomes, mobilize demand for services, support health systems strengthening, mobilize political leadership, change social attitudes and norms, and create an enabling environment that promotes equal access.

- **Full description of the approach or best practice:**

Brotha2brotha clubs are mentorship groups for vulnerable adolescent boys and young men aged 10-24. These clubs offer safe, youth friendly and comprehensive SRH information. Sport-centered intervention and Community based approach, (avoids institutions). The clubs serve as information centres for vulnerable young men and offer referral pathways for Health (ASRH, STI, HIV and AIDS) and GBV services. Young men are recruited through sport, home visits, referrals (clinics, victim friendly unit, social welfare, schools). Each mentor leads two groups of 25 boys in each group. 24 sessions are done over a 12-month period (Manual available) and Sessions are conducted in community halls, soccer clubs/grounds.

- **Who were the key implementers, collaborators, and partners in this approach?**

ZICHIRE, Ministry of Health and Child Care, National AIDS Council, Community health workers, Victim Friendly Unit, Ministry of Small to Enterprise Development and Ministry of Education and Ministry of Youth.

- **How was the community involved/engaged?**

Community volunteers are trained as Behaviour Change Facilitators (BCFs) and Mentors to implement the program on the ground and will remain in their respective communities. To a large extent, the community owns the program, they organise their own community graduations, they also see the volunteers and identify with them as they label them “their own “and at the community usually mobilises ABYM that are recruited into the Brotha2Brotha program. The community cadres are equipped with necessary material such as manuals and program facilitation aids, that become theirs and do not need to be returned after the program is completed. The cadres are also linked to other community stakeholders and when a program is completed it is handed over to relevant community stakeholders.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Access to services such as HIV testing (62% of participants were tested on joining club entry and 12% got tested at the end of the programme), STI, HIV, VMMC and services. Club members are continually reminded of the benefits of such services and encouraged to access them based on their individual needs. 48% of reported alcohol users also reported that they had stopped drinking.

Provision of safe spaces, the B2B club is a safe space for ABYM. Evidence from programming suggests boys enjoy the clubs as its their opportunity to forget stresses of everyday life and take a breather. The clubs offer positive psycho social support.

Provision of accurate knowledge, 96% participant showed knowledge of at least one SRHR topic, with 86% reporting they learnt something new.

Talent identification, at least 8 of B2B clubs members are now playing soccer at Zimbabwean premier league level. With a notable graduate now plying his trade in Belgium.

Producing responsible young men who shun GBV and stand against it. Most of the graduates indicate that the B2B clubs taught them to respect women and girl.

- **What worked well and contributed to success, and why?**

ZiCHIRe has worked with MoHCC, as most clients are referred to MoHCC facilities. Our good working relationship with MoHCC ensure that our referees get to the respective clinics and in some cases receive priority services (those with referral slips are served first.) The linkages of the programme contributed to the efficiency of programme implementation and management, for example National AIDS Council is now funding the Brotha2brotha program that ZiCHIRe champions, reports can be collected using partners or community leaders, partners using one vehicle for field visits to save on fuel and time, transporting deliveries for the clinics.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**
    - Brotha2brotha Manual,
    - Risk Assessment tool
    - Risk Assessment Score Sheet
    - Risk Assessment Cards
    - Club members registration form,
    - monthly reporting form,
    - monthly planning form,
    - HTS and VMMC Verification form
    - Database
    - Field Visit Checklist
    - Quarterly Report
    - Annual Report

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The benefits of the program will be maintained because the BCFs and Mentors implementing the program on the ground will remain in their respective communities and they were already volunteers before they were recruited hence will continue.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

These programmes are supported by NAC, MoHCC, Ministry of youth among others. These institutions do express ownership of the program and implement national programs.

- **Annexes:**

https://unaids.sharepoint.com/sites/FSESA/UCOZWE/Forms/AllItems.aspx?id=%2Fsites%2FFSESA%2FUCOZWE%2FBROTHA2BROTHA%20PROGRAM%2FBROTHA2BROTHA&viewid=07337a87%2Da6a9%2D4c36%2Db6d2%2D1c8eaaedc6bf

ASIA PACIFIC

India: case study 1

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- **Timeline of the case study**: January 2022–present

- **Case study submitted by**: Global Nonprofit Organization

- **Title of approach or best practice or initiative**: Adolescent and Youth-Friendly Facility for Young People Who Inject Drugs

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV outreach and screening; HIV testing (mobile; index); HIV care and co-infection management (hepatitis screening; overdose management; counselling; family-based therapy; harm reduction (referrals and support groups for opioid substitution therapy).

- **In which geographic area is the approach being carried out?**
Churachandpur district of Manipur state, India.

- **What problem was being addressed and how was it identified?**
Churachandpur, a district in Manipur state in northeast India, has a high incidence of injecting drug use among its younger adolescent population especially boys, facilitated by easy access to low-priced narcotics and psychotropic drugs and tendency for experimentation with drug use. Community consultations with young people who inject drugs revealed that younger populations were unwilling to access HIV testing, HIV treatment and harm reduction services from the traditional facility-based service providers like Targeted Interventions (TIs) and ICTCs, due to lack of knowledge about HIV care and OST services and increasingly due to privacy concerns. They experienced discomfort in visiting facilities frequented by adults and feared being seen by family, friends or relatives at an HIV care centre, and were even at risk of expulsion from school. Additionally, this population being underage needed to get consent of parents before accessing government healthcare services. Since government-funded drop-in centers cater mainly to older people who inject drugs, ensuring youth could access HIV and harm reduction services remained a challenge.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** The initiative targeted young, male people who inject drugs below 24 years of age.

- **What type of approach is it?** A multi-layered approach was taken, comprising youth-friendly service provision at both the facility and community-levels, peer and social network outreach, and individual and group-based counseling with family members of the adolescent boys and group counselling.

- **What was the logic and rationale behind choosing this approach or practice?** As adolescents who inject drugs in Churachandpur were not keen on accessing opioid substitution therapy (OST), harm reduction, and treatment services from traditional service providers at drop-in centers, there was a need for a youth-focused HIV care facility where staff provided services in a sensitive, non-judgmental, and respectful manner that catered to the needs of younger people who inject drugs. This led to the establishment of the Adolescent- and Youth-friendly Centre for Young People who inject drugs ("Youth Centre") in January 2022. The Youth Centre provides a safe and friendly space for younger people who inject drugs to access HIV and other care services. To ensure that the Youth Centre provides services aligned with preferences and needs of youth and adolescents, clients of the Youth Centre are actively engaged in brainstorming ideas on Centre activities and participate in decision-making processes as well.

- **Full description of the approach or best practice:**

Background:

A key approach of the Government of India's efforts to achieve 95-95-95 HIV epidemic control targets by 2030 includes saturating primary prevention interventions to reduce new HIV infections. PATH India with support from CDC under PEPFAR and in coordination with ITECH India, implemented Project Sunshine in the three North-East states of Mizoram, Manipur and Nagaland and in the district of Mumbai in Maharashtra since October 2021, supporting national HIV program in achieving the 95-95-95 targets by 2030, including saturating primary prevention to reduce new infections to achieve HIV epidemic control.

Intervention:

The initiative exclusively targeted young, male people who inject drugs below 24 years of age. Following the establishment of Youth Centre in Churachandpur, one Outreach Worker (ORW) and five Peer Volunteers (PVs) were recruited, each from different communities (tribal/non-tribal; hilly/plain areas) to ensure equitable coverage among young people who inject drugs across the district. ORW and PVs are selected from people who inject drugs and are trained to promote harm reduction practices among young adults and adolescents who inject drugs. ORW guided the PVs and accompanied them on field visits. PVs used various interactive outreach strategies, ranging from one-on-one interactions to small group presentations, role-play events, or games. In addition, the Youth Centre trains Youth Counsellors, also part of the staff at the Youth Centre. They provide counseling on OST and give referrals to the Centre for those interested in OST.

The Youth Centre provides special service packages, such as OST, needle and syringe exchange programs, HIV testing services, and linkage to antiretroviral therapy (ART) for those who do not meet the age requirement for coverage through the National AIDS Control Program.

While Centre membership was limited at first (among 8 boys registered at the Youth Centre initially, 5 were school-going people who inject drugs) they expanded community mobilization activities to encourage enrollment, including events such as a monthly "bring your buddy day," where Centre clients were encouraged to bring their friends and non-registered clients. These events were also used as forums to inform attendees about upcoming events, which that a spill-over effect that engaged additional clients. Currently, 96% of total registered are adult males.

Other activities held at the Youth Centre include arts and sports competitions, family engagement meetings for young people who inject drugs, and knowledge-building workshops for adolescents and parents on topics like HIV care and OST services.

Furthermore, the Youth Centre works with OST Role Models. They are some of the OST adherent clients identified by the OST centre, who are recommend to the Youth Centre upon their consent. Society for HIV/AIDS and Lifeline Operation in Manipur (SHALOM), a civil society working in te North-East region of India, trains the OST Role Models on topics like HIV and benefits of OST. They serve as shining examples to those men and boys who inject drugs who are unable to adhere to OST at the Youth Centre. The role models share with them details about HIV care and encourage them to further refer their friends to OST. The Centre also enhances the capacity of OST Role Models to provide overdose management and organize OST Support Group meetings; there are two such support groups- one for young male who inject drugs held at the Youth Centre and the other for older male OST clients, held at the OST Centre.

Healthcare services offered to Centre clients include testing for HIV, hepatitis B, and hepatitis C (HCV); index testing; and referrals for HIV and viral hepatitis treatment and adherence monitoring in coordination with the YRG Care-funded Stop-C project, implemented by SHALOM.

- **Who were the key implementers, collaborators, and partners in this approach?**

This approach was implemented by PATH and I-TECH India under Project Sunshine, funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Centers for Disease Control and Prevention. The approach was implemented with the Manipur State AIDS Control Society and SHALOM (Society for HIV/AIDS and Lifeline Operation in Manipur), a civil society partner under Project Sunshine.

- **How was the community involved/engaged?**

The Youth Centre is primarily community-driven, with PVs hailing from communities across Churachandpur district driving community mobilization efforts, and Centre clients

heavily involved in decision-making, program planning, and activity organization through regular consultations.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Within nine months, from January through September 2022, the Centre has achieved the following, please note all clients were either adult, young or children who inject drugs:

a. Clients registered: 195
b. No. of adult males registered: 187 (96% of total registered)
c. No. of male children below 19 years of age: 8 (4% of total registered)
d. Clients provided HIV testing: 118
e. Clients diagnosed HIV positive: 3 (3% positivity)
f. Clients linked and successfully initiated on ART: 3 (100% linkage to ART)
g. Clients screened for HCV: 86
h. Clients screened reactive for HCV: 62 (73% reactive case)
i. Clients linked to HCV treatment: 46 (67% linkage)
j. Clients successfully referred for OST: 26 (13% of total registered)

- **What worked well and contributed to success, and why?**

Engagement of SHALOM as a civil society partner was critical for creating a seamless mechanism for linking the Youth Centre's clients to different health programs supported by SHALOM, such as the HCV program (Stop-C Program under YRG Care), for treatment initiation and linkage to OST services. SHALOM staff also accompanies the clients to OST Centres. An enabling environment and safe space are created for the boys and men by training the staffs of in HIV response, organizing recreational activities, making it easier for SHALOM to refer them to appropriate service providers.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The following activities were effective in mobilizing the male who inject drugs:

a. Art therapy
b. Music therapy
c. Media campaigns. For e.g.Street play centered around the theme of drug use, harm reduction and included sharing of recovery stories by former drug users
d. Sports events such as football, volleyball
e. Knowledge-building sessions with families - Aimed as a first step in reaching out to parents, family engagement meetings are typically held after these sessions. Inviting parents on a general knowledge building session on drug use and harm reduction is much easier than immediately talking to them about the drug use of their children which makes many families uncomfortable and unresponsive.
f. Family engagement meetings - Mainly intended to help family members facilitate the access of their children to HIV services and provide a supportive environment for service access. Patterned on OST where it has been observed that adherence to OST is much higher among clients whose parents/guardians/spouses are involved in the treatment and are supportive.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

HUMAN RESOURCES a. Youth counselors: 2 b. Nurses: 1 c. Peer Volunteers: 5 d. Outreach workers: 1 e. Program Coordinator: 1 (SHALOM employee) f. Accountant: 1 (SHALOM employee) FACILITIES a. Room for the drop-in center COMMODITIES AND SUPPLIES a. Carrom board b. Chess sets c. HIV test kits: supplied by the Manipur State AIDS Control Society's Targeted Intervention program. d. HCV screening kits: Supplied by SHALOM's Stop-C project. SUSTAINABILITY - To ensure the sustainability of the Youth Centre, PATH and I-TECH India work closely with the SACS and District Health Officer to include this model in the Adolescent Reproductive and Sexual Health Clinic implemented by District Health Department. The Youth Centre will continue running as a unit of SACS providing comprehensive package to people who inject drugs. PATH and I-TECH India are also engaging with other faith-based organizations and youth associations to further expand this model for out-of-school youth as well as with District Education Officers for in-school youth.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

There is an increasing need to address the specific preferences of young people who inject drugs in order to ensure that they are able to access high-quality health care services. Two additional Youth Centres are also planned to be established in Nagaland and Manipur states in northeast India, in conjunction with the District Health Department's Adolescent Reproductive and Sexual Health Clinics. I-TECH India and PATH are also engaging with other faith-based organizations and youth associations to further expand this model for out-of-school youth as well as with District Education Officers for in-school youth.

- **Annexes :** https://path.box.com/s/nslyozmxfnkv4o4gpsouvn8y5xbz06bc

India : case study 2

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- **Timeline of the case study**: August 2021–present

- **Case study submitted by**: Global Non-profit Organization

- **Title of approach or best practice or initiative**: Health-on-Bike Initiative

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV outreach and prevention (counseling; condom distribution); HIV testing (including index testing); HIV treatment and monitoring (at-home antiretroviral therapy [ART] distribution, viral load sample collection); Co-infection management and care (tuberculosis [TB] and syphilis screening and treatment/linkage to treatment, opioid substitution therapy [OST]).

- **In which geographic area is the approach being carried out?** Noklak district of Manipur state in north-eastern India

- **What problem was being addressed and how was it identified?**

Noklak is a hilly district in remote Nagaland state with 38 hard-to-reach villages that as of September 2022, are home to 634 people who inject drugs and 630 people living with HIV. It is important to note that all 634 people who inject drugs are men. Except for HIV confirmation test, which is also done only at two sub-district level, all the HIV care services are located at district level. Over the years, data from the ART Centres indicated that this region had very high HIV positivity, low treatment adherence and high lost to follow up amongst community. This was due to the hilly terrain and remote location of villages which made HIV and other healthcare services harder to access. Multi-stakeholder consultations with Churches, Civil Society, Student Body, Mother's Association, administration and law enforcement agencies revealed that service providers were not able to travel to interior villages due to poor road conditions and lack of public transport, preventing them from providing services for harm reduction, HIV, sexually transmitted infections (STI), and tuberculosis. The Health-on-Bike initiative was designed to enable access to high-quality healthcare services for people living in these remote and inaccessible villages.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The model targeted adult males (18 years and older) in the general population and among people who inject drugs as well as male children between 2 and 18 years of age.

- **What type of approach is it?**

The approach comprises male-friendly service delivery and outreach within communities and through social networks.

- **What was the logic and rationale behind choosing this approach or practice?**

While the terrain and roads in Noklak district were impassable using larger motor vehicles (such as cars or other public transportation vehicles), motorbikes are able to easily traverse this inaccessible terrain, leading to the development of a mobile healthcare delivery approach (Health-on-Bike), with providers using motorbikes to deliver essential HIV and other healthcare services.

- **Full description of the approach or best practice:**

BACKGROUND:

PATH India with support from CDC under PEPFAR and in coordination with ITECH India, implemented Project Sunshine in the three North-East states of Mizoram, Manipur and Nagaland and in the district of Mumbai in Maharashtra since October 2021, supporting national HIV program in achieving the 95-95-95 targets by 2030, including saturating primary prevention to reduce new infections to achieve HIV epidemic control. The Health-on-Bike initiative was part of this project.

INTERVENTION:

Noklak district in Nagaland consists of 38 villages and these were divided into five clusters, each with on Service Delivery Points (SDPs), for the purpose of Health-on-Bike initiative. The Health-on-Bike team comprises two bike outreach coordinators (BOCs) who operate one motorbike to visit the five SDPs. The Health-on-Bike team provides screening for HIV, STI, and TB, harm reduction services, ART delivery, and viral load sample collection to people residing in these 38 villages. Index testing is also conducted under this approach, which cover the children of PLHIV. As people who inject drugs are exclusively men, OST is exclusively provided for men. Except for HIV confirmation test (which is located in two SDPs) all the services are located at district level. The BOCs ensure that access to services are done through accompanied referrals.

The BOCs visit at least one SDP each week. The SDP is selected during a weekly planning meeting where BOCs, a field mentor (they are technical staff who provide onsite support to TI NGO and are supported through Project Sunshine), the Noklak District Hospital's senior medical officer (SMO), and Nagaland Targeted Intervention (TI) staff decide which of the five SDPs the BOCs should visit that week. The BOCs work out of the TI office and the weekly planning meetings are also held there. During these meetings, the list of services to be provided to the community are shared and the items that the BOCs would need during the visit are provided to them.

Upon reaching the SDP, BOCs connect with health facility staff (at either Primary Health Centre, Sub-Centre or TI) and affiliated peer educators, who provide them with information and further logistical support for beneficiaries requiring services that week. At times BOCs

are unable to travel back to their base location due to unfavorable weather or poor road conditions, they remain in the village overnight with support from the local church. The BOCs on a monthly bases report all the activities of the initiative and share with relevant stakeholders.

- **Who were the key implementers, collaborators, and partners in this approach?**

Health-on-Bike was implemented by PATH and I-TECH India under Project Sunshine, funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Centers for Disease Control and Prevention, and with logistical and technical support from the Nagaland State AIDS Control Society.

- **How was the community involved/engaged?**

The following community entities are engaged through the Health-on-Bike initiative: 1.Church: Village churches provide logistical support to BOCs, such as meeting halls or guest houses for overnight stays. Churches also generate awareness of services provided through the Health-on-Bike initiative and upcoming visits. 2.Peer networks: Peer networks and peer educators are critical to the success of this initiative. They identify beneficiaries within villages who need Health-on-Bike services and share this information with BOCs during their weekly visits. 3.TI: Staff from two community-driven TI programs (affiliated with the National AIDS Control Organization) operating in Noklak are actively involved in planning BOCs travel and SDP visits. The following tools facilitated greater engagement of men and boys within the Health-on-Bike initiative. While these were used to create awareness and demand for HIV care services amongst community, they were also used to share information on Health-on-Bike. • One-on-One meetings between the Project Sunshine team and key populations. • Focus group discussions each with key populations and women. It is also important to note that by involving the women in the initiative, it helps the BOCs to reach the boys and men in a coordinated manner, who might have been otherwise missed. • Church-led awareness campaigns to increase awareness of the importance of HIV testing, treatment, and adherence.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

a) No. of individuals covered by HIV testing services: 344 (198 male adults and 146 male children below 19 years of age)
b) No. of individuals detected HIV positive: 15 (4%)
c) No. of individual linked and initiated ART: 15 (100% of all positive)
d) Of the total 344 tested, no. of individuals tested through Index Testing Services: 216
e) No. of individuals detected positives through Index Testing Services: 15 (7%)
f) No. of Index Testing positives linked and initiated ART: 15 (100% of all positive)
g) Of the total 344 tested, no. of individuals tested through Community Based Screening: 128 (No positive cases detected)
h) No. of PWID linked with OST: 204
i) No. of PWID reached through Needle Syringe Exchange program: 128
j) No. of PWID linked with Targeted Intervention: 7

- **What worked well and contributed to success, and why?**

The active involvement of Church greatly contributed to the success of the Health on Bike initiative. With 98% population of Nagaland following Christianity, the Churches played an important role in mobilizing and creating an enabling environment for the communities to come forward and access the services.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

N/A

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Equipment and supplies a.One motorbike b.Fuel c.Harm Reduction commodities such as Needles and Syringes, Condoms and Syphilis screening kits provided by the TI NGO supported by NACO through NSACS. d.OST medicines provided by the OST Centre. e.Sputum collection bottles, ART medicine, CBS kits and Vails for collection of sample for viral load testing provided by the District Hospital; Human resources: Two BOCs

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Based on the successful rollout of the Health-on-Bike initiative in Noklak district, which showed the feasibility and acceptability of this approach in reaching men and boys who inject drugs or are living with HIV in 38 remote villages, the Nagaland State AIDS Control Society has agreed to scale up this initiative in another district. The next phase will be at Kiphire which will be reflected in the Annual Action Plan of NSACS for the financial year of 2023 - 2024.

- **Annexes:** https://path.box.com/s/tk5vqeog3r5hi9zg7nzq6fsnxjyp17p0.

India: case study 3

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- **Timeline of the case study**: April 2021- present

- **Case study submitted by**: International Non-profit Organization

- **Title of approach or best practice or initiative**: Case Detection Units in Mizoram State

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV testing (confirmatory testing; index testing); HIV treatment (linkage to antiretroviral [ART]); HIV care and monitoring (collection of blood sample for baseline investigation to initiate ART for confirmed positive cases).

- **In which geographic area is the approach being carried out?** Five districts (Aizawl, Lunglei, Champhai, Kolasib, and Mamit) in Mizoram state in north-eastern India.

- **What problem was being addressed and how was it identified?**

Mizoram state is a relatively remote area of northeastern India, with certain areas of the state being difficult to traverse and located further away from larger villages and towns. Individuals living in Mizoram faced challenges traveling to health centers for needed HIV and other health services, which created difficulties reaching individuals with confirmatory HIV testing results and referrals for ART initiation. The greater distances between peripheral facilities and facilities with equipment required to produce baseline analyses for ART initiation resulted in long turnaround times, sometimes as long as three days, leading to challenges with follow-up for ART initiation, especially among more mobile population groups. There was also very low coverage in closed settings, such as prisons. ART initiation is a challenge as the prisoners cannot come to the ART center for initiation.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The model targeted adolescent and adult males (aged 15–50 years of age) among the general male population as well as key and priority populations of people who inject drugs, men who have sex with men, migrants, truck drivers and prison inmates. The prison inmates have maximum number of vulnerable men and adolescent young men. Total no. of individual reached/tested during FY22: 7058

- Below 19 (Boys): 235
- Above 19 (Men): 5188

- **What type of approach is it?**

The approach comprises male-friendly service delivery, facility-based services, and outreach through community engagement and utilization of peer and social network facility.

- **What was the logic and rationale behind choosing this approach or practice?**

As described above, the geographic terrain in Mizoram hampers the provision of HIV services to ensure people are aware of their HIV status and able to access needed services. The concept of bringing services closer to the people they are meant to serve rather than bringing people to the services was the foundational principle behind the Case Detection Unit (CDU) model, with the CDU serving as an decentralized mobile arm of a stand-alone HIV Integrated Counseling and Testing Centre (ICTC).

- **Full description of the approach or best practice:**

Vulnerable Men and boys are key priorities of the CDU. Six CDUs have been established across five districts of Mizoram state. Each CDU has a three-person team consisting of a counselor, a laboratory technician, and navigator who conduct HIV confirmatory testing for people screening positive for HIV who live in hard-to-reach villages of Mizoram or receive services at private hospitals.

PATH and I-TECH India, through Project Sunshine, coordinate with the Mizoram State AIDS Control Society (MSACS) to identify remote areas that also have high HIV prevalence or large presence of people from key or priority populations (including prisons or drug rehabilitation centers located in these remote areas). Once identified, Project Sunshine and MSACS develop a travel route for the CDU team to visit prioritized remote areas/villages and provide HIV confirmatory testing and linkage to ART services. The six CDUs also coordinate with their respective District AIDS Prevention and Control Units and Targeted Interventions sites to identifying priority villages for service delivery. Each CDU is directly linked to an existing ICTC where CDU data is reported into the national HIV reporting system. The sexual and injecting partners of the new positive cases are covered for index testing

Each CDU was also equipped with a mobile phones, with contact numbers shared on social media so that residents in these districts could call the CDUs directly to request HIV testing services at a location of the client's choice. Additional demand generation activities include the "Know your Status" campaign and other youth engagement events like futsal competitions, where local celebrities are invited to generate awareness of HIV testing and treatment services.

- **Who were the key implementers, collaborators, and partners in this approach?**

The CDU was implemented by PATH and I-TECH India under Project Sunshine, funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Centers for Disease Control and Prevention. Key collaborators include SHALOM; MSACs and the five

District AIDS Prevention and Control Units; and ICTCs operating in the intervention districts.

- **How was the community involved/engaged?**

Community supports the CDU and Project Sunshine The PLHIV community informs the Field Team when they want their spouse, partners and children to be tested. They help in arrangement like fixing the time and place, for testing.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Since inception 7,363 individuals were tested for HIV and detected 335 positives at the case detection rate of 5%. Of the total tested, 7,046 (96%) were adult males and 317 (4%) were male children below age group of 19 years, respectively. Of the total positive 335, 323 (96%) were adult males and 12 (4%) were male children, respectively. 255 (76%) of positive have been linked and initiated ARTC. The turnaround time between initial HIV screening and confirmation of diagnosis/linkage to ART was reduced, from 5 days to 2 days. The turnaround time between initial HIV screening and confirmation of diagnosis/linkage to ART was reduced, from 3 days to same day initiation.
The CDU team was also able to assist in Index Testing for the 167 confirmed cases during the period and 5 of them are found to be positive.

- **What worked well and contributed to success, and why?**

A mobile CDU that brought HIV testing services directly to the communities and provided the option for individuals to contact the CDU directly via telephone to arrange for requested services were both critical to the success of this model. The rapid linkage to ART approach also worked really well under CDUs. Rapid linkage to ART refers to same day initiation of ART by having the baseline investigation report before meeting the ART doctor. Linking each CDU to an existing ICTC was important to ensuring that CDUs were well-supplied, and that CDU data was incorporated into national service delivery and commodity management information systems. Finally, as CDUs were initiated and run by MSACS, this ensures the longer-term sustainable of these units through to built-in ownership of the CDUs by MSACS.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The following tools were particularly useful in mobilizing men and boys:
a. Use of social media platforms to promote the CDU services.
https://www.instagram.com/shalomforyouth_/ (1545 Followers)
https://www.instagram.com/hmingteachhangte_/ (54.7K Followers)
b. Collaboration with the Client Navigation team. There are two Key Population Navigators placed with the CSO.
c. Peer referral mechanism for young key populations to improve referrals. 8 IDU adolescent boys are identified as Peer Volunteers. They refer their peers for HIV services.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

HUMAN RESOURCES CDU staff comprised: - One Counselor - One Lab Technician - One community Navigator COMMODITIES, SUPPLIES, AND OTHER OPERATING COSTS - Travel support - Mobile phones, the phone credits are covered by CSO partner SHALOM. - Commodities (such as test kits) and all consumables (disposable syringes, gloves, etc.) were furnished by the linked ICTC.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, the CDU model will be scaled up to other districts in Mizoram state that have existing mobile or fixed ICTCs.

- **Annexes:** https://path.box.com/s/yr52usxigekxno3i9y0o2pxkpw0yxube

Indonesia: case study

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- **Timeline of the case study**: September - November 2021

- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: Survey of quality and policy of HIV service providers during the covid 19 pandemic

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Single component

- **In which geographic area is the approach being carried out?** Bekasi, Banjar and Cirebon-West Java Province, Kendari - Southeast Sulawesi province, Bandar Lampung - Lampung Province. Indonesia

- **What problem was being addressed and how was it identified?** The problems addressed were the obstacles faced by the Gay, transgender and MSM communities in 5 areas while accessing HIV services during the COVID-19 pandemic, the method used was through a survey process.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**
General MSM population between 18 - 50 years old.

- **What type of approach is it?**
The approach is carried out by utilizing the social network and peer to peer communication.
- **What was the logic and rationale behind choosing this approach or practice?**
The main target of this survey is the MMS community that has access to VCT services so that the peer to peer approach and social networking are the most applicable approaches.

- **Full description of the approach or best practice:**
The focal points in 5 regions have been equipped with survey tools to explore the problems faced by communities in each region in accessing HIV services during the 19th period. The focal points, which are outreach officers, will directly select beneficiary representatives to obtain data from the survey.

- **Who were the key implementers, collaborators, and partners in this approach?**
The key implementers of this survey are focal point of GMT community in 5 selected area.

- **How was the community involved/engaged?**

The community fully involved during the concept process, implementation and evaluation process.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The outcome of this approach is that there is data from the MMS community who accessed VCT services during the COVID-19 pandemic, this data is evidence for us to advocate for health service providers for quality improvement and policies that favor the community.

- **What worked well and contributed to success, and why?**

Overall, all processes went well and could contribute to the sustainability of the data collection, but it should be realized that not all MSM communities are open to others, so sometimes the current approach is not fully successful.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The tools that we used is a survey tools that developed by the community vocal point assisted by consultant.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The resource needed in this approach is a communication strategy to approach the MSM community that is the target or beneficiary of the program.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

We will re-implement this process with a different site, and we are currently conducting a follow-up survey with the same site.

- **Annexes:**

https://docs.google.com/document/d/1RmJPD3Evxg0VNZVacQTZ89oNuB95kQUP/edit?usp=share_link&ouid=104060575243027399602&rtpof=true&sd=true

Malaysia: case study

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- **Timeline of the case study**: April 2020 to October 2022

- **Case study submitted by**: Other: Peer support, grassroots organisation

- **Title of approach or best practice or initiative**: "BEYOND 66 – A Hybrid Chemsex Addiction Recovery Program"

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**:
Multiple components: Chemsex addiction recovery, awareness campaigns, peer support, HIV awareness and community-based testing.

- **In which geographic area is the approach being carried out?:**
Central region, Malaysia (Selangor and Kuala Lumpur); Northern region, Malaysia (Penang).

- **What problem was being addressed and how was it identified?:**
Along with the surge in chemsex activities over recent 5 years, it is observed (on a ground level) that chemsex has direct attributes to the HIV prevalence in Malaysia amongst the MSM community; The Covid-19 pandemic and numerous lock downs have gravely changed the course of chemsex in Malaysia towards being an epidemic in the MSM community; Malaysia reported an increase in HIV infections with more than 90% are MSM via sexual transmissions; There remains a barrier of trust between chemsex users and the Malaysian public health care providers, and the latter is often not their first point of contact for help; There is a severe lacking of safe spaces in Malaysia for affordable consultation, effective support and treatment of chemsex addiction.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**
The friends in recovery (aka clients) supported by LEV8 are: Predominantly MSM (and 2 heterosexual males); in urban setting of major cities in West Malaysia; adult male age 26 – 50.

- **What type of approach is it?** Peer counsellors; Community safe spaces.

- **What was the logic and rationale behind choosing this approach or practice?**

Training and empowering peer counsellors to conduct peer-to-peer support on chemsex addiction recovery will greatly benefit the community at large, bridge the gap and lessen the time for access to help, and lighten the load on public healthcare providers.

- **Full description of the approach or best practice:**

LEV8 adopts a dark marketing approach in our communications to reach and engage the target audience while being tactical in trust-building and to avoid raising the attention of law enforcing authorities (police, religious bodies, etc).

LEV8 runs the Beyond 66 Program to help friends in recovery to confront and free themselves from their addiction to chemsex and/or meth. It also engages mind and habit forming as an intervention to correct past habits in 66 days or more.

Beyond 66 is an abstinence-based hybrid chemsex addiction recovery program designed by Benjamin Thain (LEV8 founder) that adopts practices from CBT (Cognitive Behavioural Therapy), The Twelve Steps, and peer support.

LEV8 also conducts counselling for the client's support system (family members, partner, friends) to help them better understand addiction, their pivotal role in the client's recovery, and help guide them on ways to being a stronger support system.

- **Who were the key implementers, collaborators, and partners in this approach?**

Program lead, community influencers, digital content producers.

- **How was the community involved/engaged?**

The drug using community lacks trust and is selective in people whom they trust. Hence this trust in seen to be earned through regular communication and follow-up (both friend in recovery and the support system), and non-judgemental safe spaces that maintains strict confidentiality.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

To date, LEV8 and the Beyond 66 program has helped 28 friends in recovery (clients) and thus far 80% of them have recovered and fully abstained from meth and/or poly-drug use. The Beyond 66 (pilot program) started in Q2/2020, and the first client remains free from chemsex and meth addiction (30 months to date).

- **What worked well and contributed to success, and why?**

LEV8 runs the Beyond 66 Program to help friends in recovery to confront and free themselves from their addiction to chemsex and/or meth. It also engages mind and habit forming as an intervention to correct past habits in 66 days or more.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Benjamin has also developed the Beyond 66 visualisation infographic (likened to being a chemsex addiction litmus test) that maps out the addiction journey, and the mental health condition and behavioural changes of a chemsex addict. This infographic helps addicts better see where they are in their path of chemsex addiction and where they could end up, and it also serves as a good wake-up call with conditions that an addict can relate to.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

LEV8 Recovery Center will run on a social enterprise model and practice whereby all services are chargeable (at a subsidized and substantially lower than market rate). This is to further enforce the project to be more self-sustainable moving forward. LEV8 programs focus on hiring competent manpower, providing jobs for manginalised communities, and building staff capacity to continue program activities. This ensures staff have the knowledge and skill sets necessary to carry the projects with efficiency. LEV8 will empower peer counsellors, develop training or curriculums (such as train-the-trainer, training peer counsellor models, etc). LEV8 programs often emphasize the importance of working with partner organizations to plan for sustainability. In some cases, partners may take on responsibility for continuing certain program components, such as program activities, services, staff training, or other implementation activities with other clinics in Selangor region.

For example:

- Engage with Hospitals, such as PPUM and Hospital Klang (psychiatric unit) to make training on substance use disorder a requirement for staff development.
- Collaborate with community-based organizations to integrate educational efforts and training of community health workers on existing harm reduction methods for drug addiction intervention.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, The Beyond 66 Chemsex Addiction Recovery Program is scalable and and executed in LEV8 Recovery Centers in major cities nationwide (dependent on funding). The program could also be replicated and adopted by existing rehabilitation centres, community healthcare providers, and/or shelter homes dedicated to the MSM community.

- **Annexes:**

https://drive.google.com/file/d/1B1IT7Z4jWOXstitAC-YkR6HFvZub7KKE/view?usp=sharing

Mongolia : case study

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- **Timeline of the case study**: 14.AUG.2020-31.June.2022

- **Case study submitted by**: Government; Civil society; Private sector; Academic institution; Other: communities (Gay and bisexual men, transgender women)

- **Title of approach or best practice or initiative**: “test4UB”

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Multiple components: HIV prevention, testing, treatment, HIV related stigma, discrimination.

- **In which geographic area is the approach being carried out?:** Ulaanbaatar city, Mongolia

- **What problem was being addressed and how was it identified?:**
Increased coverage of HIV testing among gay and bisexual men and trans women and increase the range go activities. HIV prevention package and opportunities and testing approach has been created.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**
Gay and bisexual men, transgender women 15-45 aged more unreached target population.

- **What type of approach is it?**
Based on digital system. created web site and provide information through the videos, posters, pictures, online training etc. also, we used Instagram, apps and podcasts, mangos.

- **What was the logic and rationale behind choosing this approach or practice?**
The reason for this was that the people of target group were hidden and difficult to reach and deliver HIV information. Due to Mongolian society has a lot of negative attitude and discrimination related SOGIESC.

- **Full description of the approach or best practice:**
The demand generation campaign in Mongolia is implemented by YFH NGO with the technical assistance of APCOM. The campaign, titled as test4UB, is modelled after

APCOM's flagship campaign testXXX and was launched in August 2020 in Mongolia's capital Ulaanbaatar city among MSM as the sole campaign target audience.

The test4UB campaign started with a series of focus group discussions (FGDs) with MSM to assess community perspectives on key visuals, communication channels and messages to promote HIV-related services among MSM.

Community views have been reflected in the development of the campaign concept. Embarking with the "TEST. PrEP. SEX. REPEAT." slogan, test4UB campaign primary intends to promote PrEP as an innovative intervention, and increase the uptake of HIV testing among the MSM community in Ulaanbaatar city. In order to achieve it's goal, the campaign aims to reach a wider MSM audience with outreach and information regarding general HIV awareness, testing and treatment (including stigma & discrimination), and generating and maintaining their interest in the use of PrEP, HIV testing and other HIV-related services.

Specific objectives include:

- To develop an innovative HIV awareness campaign tailored to MSM needs;

- To implement demonstration projects to make CBT, HIVST and PrEP available to MSM in the capital Ulaanbaatar;

- To engage MSM community in developing and sustaining test4UB digital outreach campaign.

The campaign activities were significantly impacted and postponed due to a series of COVID-19 related quarantine measures in Mongolia. As a result, the campaign was officially launched in August 2020 and the following major activities have been implemented in 2020-2022:

• Demand generation digital campaign activities:

- Developing and maintaining www.test4ub.org campaign website in line with the APCOM's flagship testXXX campaign branding guidelines in order to provide clear information and contact details to access HIV testing and other related services;

- Establishing strong online presence using popular social media platforms such as YouTube, Facebook and Instagram;

- Using online dating applications (Grindr) to scale-up digital outreach.

• Offline campaign activities:

- Producing series of creative videos, animations and podcasts to promote the benefits of HIVST, CBT, PrEP and other HIV-related services;

- Printing educational manga comics and other targeted printed materials for promoting differentiated intake and benefits of PrEP, HIVST and CBT;

- Offering confidential community-based HIV testing and counselling services;

- Offline events to enhance target population knowledge about HIV and test4UB campaign, to distribute campaign materials and to offer free HIV test services.

• Stakeholder mobilization and policy dialogue:

- National consultation on integration of the community-based HIV service guidelines into national HIV guidelines;

- Dissemination of campaign and demonstration project reports to stakeholders.

The campaign is expected to provide 2,500 MSM with CBT, and to enroll 1,500 MSM in HIVST demonstration project and 200 MSM in PrEP demonstration project over the course of 12 months.

A year into the campaign implementation, YFH in close coordination with APCOM, has conducted a mid-term evaluation in 2021 to assess the continued penetration of test4UB campaign into target audience, and the progress made towards achieving its planned objectives. Findings of the mid-term assessment provided a baseline data to be compared with the results of current final evaluation.

- **Who were the key implementers, collaborators, and partners in this approach?**

Youth for health centre NGO and SKPA project was key implementer and APCOM and AFAO were collaborators and partners.

- **How was the community involved/engaged?**

The assessment findings indicate that the exposure of MSM to the test4UB DG digital campaign activities seemed to be high. The overwhelming majority (95%) of 308 MSM, who participated in the study, had heard of the test4UB campaign or came across the campaign materials regardless their age and HIV status. They mostly accessed for information about the campaign via Facebook (70%). The test4UB website (62%), Instagram (42%), YouTube (33%) and Chat/Messaging Apps (26%) were identified as other online platforms, in which MSM were accessed for information about the campaign. The majority of the respondents were remembering about the components and activities of the campaign. Among those, the campaign community activities (46%) and promotional items (45%) were mentioned by highest number of the respondents. In general, MSM had a favorable attitude and very positive feedback toward the campaign content and images and the relevance and importance of information and messages received from the campaign. The respondents reported that campaign photo model (61%), product/service

details (38%) and slogan (32%) were caught their attention more. Nearly half (49%) of the respondents viewed the campaign messages and information as being informative, and one-third (41%) found demonstrative. The information about PrEP (51%), HIV self-testing (43%), where to get HIV testing (43%) and community-based screening (43%) were rated by the respondents as particularly important information from the test4UB campaign.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

These findings indicate that the test4UB campaign successfully penetrated into the MSM community in Ulaanbaatar. MSM found the campaign useful for them and acknowledged the importance of the campaign.

Finally, the assessment identified perceived need of MSM in learning more about HIV and sexual health issues, and their most preferred information sources, and the campaign components and strategies. The issues, such as STI management (37%), HIVST (34%, n=106), HIV basics (33%, n=103), PrEP (30%, n=91) were identified by the respondents as most interested information to learn more in the future.
Facebook (49%), dating apps (34%), website (32%) and Instagram (29%) were identified as most preferred sources to get information on HIV and other sexual health issues. The physical events (56%), short video formats (33%) and online challenges (17%) were indicated by the respondents as most interested campaign formats/strategies to be engaged. It is hoped that these perceived need of MSM will be helpful in implementing stronger and more sustainable campaigns among them in the future.
Achievements of the campaign and factors contributed
According to the SKPA program implementation team at YFH, number of MSM, who involved in CBT at YFH, has increased by more than one-third from 2,195 in 2019 to 2,986 in 2021. By May 2022, 1505 MSM received HIVST at community-based center of YFH which is expected to achieve the initial target to reach 2,500 MSM with more than 100%. Furthermore, a total of 192 MSM enrolled in PrEP and 1,439 MSM – in HIVST so far which accounted 96.0 percent of both initial targets. These major facts indicate that the test4UB campaign has succeeded in motivating MSM to access to HIV-related services.

- **What worked well and contributed to success, and why?**

The assessment results clearly demonstrate the specific features of the test4UB demand generation campaign, such as innovative design; use of digital technology and multiple online venues and branding, regularly updated content and formats. These advantages made the campaign informative, attractive, most importantly, useful for MSM community. Almost all MSM (95%), who participated in the study, had heard or came across the campaign. Over 70 percent of the participants was accessed the campaign Facebook and other online platforms and received and used the information about HIV and services. By June 2022, a total 239,328 users were visited www.test4ub website and 29,607 users were used it regularly. These evidences show wider reach and successful penetration of the test4UB campaign into the MSM community. So, the first conclusion is: it has worked well! The campaign has being accessible and relevant to MSM needs, and the community accepted it well.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The study participants were asked to rate online platforms with regards to overall appearance, variety of content, ease of access, and frequency of updating of the test4UB campaign information, about ninety percent (89-93%, n=299) of MSM rated the campaign Facebook page as highly adequate (mean rating 4.3 - 4.4) across all above characteristics of the online platforms. Other online platforms, such as test4UB website Instagram, YouTube and Chat/messenger applications, were also rated by MSM largely adequate/highly satisfactory (mean rating of 3.9 – 4.3). There were no significant differences in mean ratings of online platforms by age and HIV status.

Table 9. Mean rating of the campaign online platforms (1-5)

	Overall appearance	Variety of content	Ease of access	Frequency of updating
Facebook	4.4	4.3	4.4	4.3
Website	4.3	4.3	4.3	4.2
Instagram	4.0	4.1	4.1	4.0
YouTube	4.0	4.0	4.1	4.0
Chat/Mes Apps	3.9	3.9	3.9	3.9

Actions did upon seeing the campaign: It is very important to note that the surveyed MSM were motivated to do something useful for them or others upon seeing the campaign materials and activities. Percentage of the respondents, who were motivated to visit HIV related facility for testing (90%, n=268), participate in HIVST pilot study (55%, n=164); share information with friends (51%, n=153), promote campaign through social network (51%, n=151), to some extent had increased, compared to the mid-term assessment results.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The test4ub approach has been included in the budget of the national project and it has been ensured that it can be carried out continuously.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?** Youth for health centre, we are working to scaling up this approach and practice at the national level especially in the rural areas.

- **Annexes:** www.test4ub.org

Pakistan : case study

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- **Timeline of the case study**: Aug to Sep 2021

- **Case study submitted by**: UNDP Pakistan

- **Title of approach or best practice or initiative**: situation analysis of substance use & misuse (Chemsex) among key msm & transgender communities in Pakistan

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, HIV prevention, including PrEP, HIV Information, testing, treatment, viral load suppression transmission and usage of drugs within the community and ways of the use of drugs.

- **In which geographic area is the approach being carried out?**

In this study, we have covered all provinces of the county of Pakistan.

- **What problem was being addressed and how was it identified?**

This study investigates the relationship between substance use, chemsex, and healthcare access within Pakistan's gbMSM community. Because of a lack of investigation into this phenomenon and the community, this report seeks to act as an assessment of the needs of this community and a look into what factors are at play when considering the relationship between vulnerable populations and the use of substances. We have included the name of the Transgender community as a cover to reduce the enormous risks in Pakistan.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

After the survey, there were a total of 319 respondents for this research study: the online survey was circulated to 689 community members and responses were received from 256(172 in English and 84 in Urdu), and 63 were filled in the field due to illiteracy of the community with the help of CBOs and Peers, out of total population 254 (80%) of the respondents identified themselves gay men and other men who have sex with men, Aside from this, 19% of respondents identified as transgender women or Khawaja sira, and another 1% of respondents identified themselves as transgender men. Out of the total gbMSM of 254, adolescent boys 15 – 19 participants were 64 (25.19%) and young men 20 – 29 participants were 173 (68.11%), and there were more 29 years to 50 years old.

- **What type of approach is it?**

The type of approaches was very innovative; we used a digital online survey to know community friends through WhatsApp and also reach out to the gbMSM communities through dating apps, private close groups, and online sessions on different types of social networks, and national peer support work with the support groups and networking and also with the inclusion of the national activists of SOGISC Communities.

- **What was the logic and rationale behind choosing this approach or practice?**

It was not an easy task to collect the data through the usage of digital platforms and from all over Pakistan so, so due to security issues, we had to share the survey in close groups and known communities who already linked through peers or directly through several works on the chemsex issues in Pakistan. The reminder again and again to communities to fill out the survey and the logic behind approaching the Community of MSM, to document the evidence-based data of the chemsex issues and solutions that were looking for.

- **Full description of the approach or best practice:**

A questionnaire (Annex I) was prepared after in-depth research, including a review of over 114 studies related to HIV Prevention, PrEP, knowledge of the status of HIV, chemsex, substance use, and the law in Pakistan and across the world. The survey, aimed at collecting quantitative data, was shared with members of the MSM and transgender community in Pakistan through a trusted team of community mobilisers, friends, and people engaged in MSM and transgender community-based organisations.

An online survey was used for several reasons. It would expand the reach to smaller groups of men who have sex with men and transgender persons. Using an online survey also allows for increased protection of the responses and mitigates risks of data leaks or threats to participants. Additionally, due to restrictions because of the COVID-19 pandemic, conducting interviews in person would be difficult, tedious, and have to be done over time. Therefore, the survey was only shared in trusted groups where the participants' sexual orientation and gender identity were known. Initially, the survey was only shared with small groups due to privacy and security issues in the first week of September 2021. Still, to improve the number of responses, reminders were sent out through messages and emails to encourage people to participate and fill out the questionnaire.

The survey development was a collaborative process that consistently incorporated feedback from the technical team associated with this report. The survey has also been shared with the UNDP technical support team for input and support. An informed consent form was also attached to the study, and a subscription was purchased from the website freeonlinesurveys.com. This helped make the survey far more secure and avoided data leaks.

The survey also included colloquial terms associated with chemsex and substance use to make it accessible and easier to understand. As well as being shared in English, the survey was also shared with participants in Urdu. This helped to extend the study's reach beyond the groups of participants that could speak and understand English.

Furthermore, desk reviews were conducted with participants who could not read in either English or Urdu to improve overall accessibility.

- **Who were the key implementers, collaborators, and partners in this approach?**

UNDP and UNAINDS were the technical teams to review the initial work and supported the review of all the reports. In addition to data collection, CBOs with relevant focus areas, particularly those working with the MSM and transgender community, was invited to a focus-group discussion to discuss the impact of the use of substances and growing rates of chemsex engagement within their target populations. The focus group discussion aimed to provide relevant context to the issues of substance use in Pakistan, particularly within these vulnerable groups. A meeting was also undertaken with the team from Nai Zindagi, a Pakistan-based organisation offering harm reduction services to those impacted by substance use and dependence. Another conference was organised with Dr Ayesha Isani Majeed, the National Program Manager for the NACP, the National AIDS Control Program.

- **How was the community involved/engaged?**

was a community-based work, and we approached all community-based organisations working for MSM and TG communities in Pakistan; we also engaged the community activists, leaders, workers and Peer workers of Pakistan; the community was involved in it directly with good relationships and trusted long work relationships.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Regarding substance use, 76% of respondents stated they had tried using substances.

- **What worked well and contributed to success, and why?**

Community-based organisations did not have any work on the mental health of the men or any on the chemsex issues. Hence, the inclusion of the national community base organisation worked to support reach the community and engage the peers and activists. In contrast, community bases organisations did not exist, so the hiring of community leaders, peers, and activists.

CBOs and the UN technical team with National Aids Control Progoms contribution made it successful and found out the issues of the chemsex in Pakistan primarily focused on the youth.

The online survey helps us to collect data from all over the provinces of Pakistan.

Every Organisation and network well-known the epidemic of HIV is increasing in the MSM community of Pakistan, and all were worried this was the main reason to make it successful to know the reality of the issues.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Outreach to the Men and Boys through dating apps closed groups, and personal links through Peers, and CBOs, with proper knowledge and Rights bases, approaches with the mitigation of the plans.

Create support groups and friendly spaces for people who use substances in Pakistan, specifically for the gbMSM community.

Make PrEP widely available for MSM and TG people in Pakistan and create health promotion initiatives that increase awareness, particularly among those engaging in chemsex.
Ensure all PLHIV have access to treatment and provide pathways that increase adherence
Engage peer support workers to support people who use substances in a one-on-one setting to assist with behaviour, change and rehabilitation services if required.
Improve overall literacy and awareness regarding the impact of using substances, the available resources for support, and the mechanisms through which harm can be reduced and risks can be minimised, particularly in chemsex.
Provide chemsex service packages that community members at large-scale chemsex parties can distribute.

Improve access to more extensive mental health support systems and services catered to people who use substances within the MSM community.
Create safe spaces for substance use treatment and rehabilitation centres introducing harm reduction techniques. This will help create a friendly and supportive environment and raise healthy activities such as vocational training programs. The ultimate goal is to provide the necessary support to recover from dependence and establish a healthy life.
Advocate with more significant stakeholders, such as the Pakistani government working on narcotics-related issues and provincial governments, to create larger opportunities for people who use substances and people living with HIV (PLHIV).
There is an immediate need to focus on developing specialised treatment programs for MSM individuals involved in chemsex. This treatment program must be voluntary and not mandatory.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

For this study, we included ten persons from the community who helped to succeed in the research and for three months, the cost was 6000$. But if we worked on it properly to help the men's health, we need to make a proper sustainable plan for the years and per year minimum of 40,000 $ required to sustain a full-time staff to approach with appropriate full-time human resources.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Yes, we are replicating this practice in the HIV Buddies. Since 2018, we have been raising our voice about the issues of chemsex in Pakistan amongst the gbMSM community; it has been tough to raise our voice when most people don't even know about the word chemsex, and for this purpose, we met with Mat Southwell in Amsterdam. Our work includes one-to-one meetings, online sessions, and sometimes group settings for storytelling. Intervention work provides care and support, helping people move beyond limitations and boundaries, and leads support groups with many KP-PLHIVs and Chemsex practitioners. We are providing one-to-one care, support and counselling for gbMSM and TG communities of mental health services in Pakistan with the help of HOPE: Have Only PositiveExpectations organisation and running a regular monthly support group on different issues of chemsex with our own experiences with and chemsex stories

and with mental health experts. We use a digital approach to reach out to the gbMSM communities through dating apps, private close groups, and online sessions. Since January 2020, we have registered 472 communities using psycho-active drugs and 133 getting mental health services regularly; our main target is to approach youth who suffer badly from mental health issues due to the chemsex. We have done several activities, support group sessions, online sessions, and part of the policy-making chemsex in Pakistan and internationally. HIV Buddies was part of the initiative of a regional forum which is the Asia Chemsex Forum Platform; with the help of individual chemsex experts globally, we are now looking for a donor to establish a secretariat and Executive Board for specific work for Chemsex and the Reshape/IHP chemsex forum platform London is going to start webinars in this month. Even though HIV Buddies have no donor for work with street-based chemsex users, we always try to provide food and syringes and help them maintain hygiene based on harm reduction principles with the help of local arrangements of funds. For middle-class and higher-class communities, we provide mental and health counselling services, sessions to evaluate risks and information about the side effects of Stimulant substance use and the impact of mixing substances. We aim to build the capacity of peer workers to address overdose risks in the closed group parties and chemsex parties. We also counsel on HIV treatment and U=U. Also, our founder has researched substance use and misuse (Chemsex) amongst Key MSM and Transgender Communities in Pakistan for UNDP Pakistan. (Attached in the email) We have developed links among local and national networks, CBOs, and hospitals for sexual health issues, sexually transmitted infections and diseases. I have linked clients to different stakeholders for their well-being and mental health. We have experience in developing low-threshold services to encourage community engagement and ownership.

- **Annexes:**
  - https://www.apcom.org/pakistan-activist-yasir-ali-khan-have-only-positive-expectations-hope
  - https://mpactglobal.org/drug-use-and-sexual-health-in-times-of-covid19
  - www.communityharmreduction.com/chemsexinasia
  - https://www.facebook.com/hivbuddies
  - https://ihp.hiv/asian-peer-support-training-and-exchange-2020-and-2021
  - https://vimeo.com/user/14164183/folder/3265607
  - https://www.apcom.org/chemsex-research-in-pakistan
  - https://www.apcom.org/the-asia-chemsex-platform
  - https://www.facebook.com/HOPECommunitypk/photos/a.117046259774573/559997618812766
  - https://www.facebook.com/HOPECommunitypk/photos/pcb.562004858612042/562004735278721
  - https://www.napud.org/executive-board-members
  - https://filtermag.org/wp-content/uploads/2021/02/Stimulant-Supplemental-Advocacy-Letter-FINAL.pdf
  - https://nawara.org/downloads/2019/report-gf-platform-november-2019-en.pdf
  - https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/19-04568_HIV_Prevention_Guide_ebook.pdf
  - https://ihp.hiv/who-we-are-2

Thailand: case study 1

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- **Timeline of the case study**: Fiscal year 2022 (1 October 2021 - 30 September 2022)
- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: The work of TestBKK on HIVST, Chemsex/harm reduction, U=U

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**:

Multiple components: Reach- (testBKK Online outreach, social media, physical event) Recruit- (testmenow platform) Test-(clinic partners) Treat-(clinic partners), Prevention-(HIV selftest kit, prevention pack) Retain (Clinic partners, Information about U=U and innovative interventions).

- **In which geographic area is the approach being carried out?:** region and country.

- **What problem was being addressed and how was it identified?:**

1. Services for and reaching those that use chemsex is limited – need to do more as these are high risk groups.
2. Needing to invest more in community demand generation for services - for example PrEP for Thailand is not yet at scale Prices for HIV self-testing is still too high.
3. Support to community-based and community-led services to market their services for fee-paying customers.
4. Developing social enterprise that community-based organisations can explore for alternative sources of funding.
5. People are still not coming out to talk about living with HIV. We need to have more PLHIV come out.
6. Requires more young people involvement

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

YMSM, MSM, MSW, TG, TGSW, age of 18-32.

- **What type of approach is it?** Digital, Social network.

- **What was the logic and rationale behind choosing this approach or practice?**

Demand generation strategy specifically tailored regional behavior change campaign for UPs > Mitigate service delivery gaps and barriers > Increase HIV services uptake > Complement existing HIV intervention programme > Boost essential programming elements and innovative interventions.

- **Full description of the approach or best practice:**

testBKK grant remains to implement activities to support the attainment and maintenance of epidemic control among KPs and priority populations (PPs) by delivering HIV prevention, care, and treatment services for these populations and their networks with a focus on MSM, male sex workers (MSW), TGW, and transgender sex workers (TGSW).

Objective: Attain and maintain HIV epidemic control among KPs [MSM, MSW, TGW, and TGSW].

Activity 1: Increase the availability of comprehensive prevention, care, and treatment services including reliable coverage of the continuum of care for MSM;

Activity 1.1 Distribution of Party Pack (condoms and water-based lubricants and HIV prevention information resources catering to high-risk KP)

Activity 2: Increasing the uptake of HIV testing among MSM in Bangkok by increasing the traffic to TESTBKK's website and/or TESTBKK's TestMeNow online booking system

Activity 2.1. Online (Organic) Outreach – Social Media management

Activity 2.2 Online (Non-Organic/Sponsored or Paid Ad) Outreach to increase the uptake of HIV testing among MSM in Bangkok by increasing the traffic to testBKK's website and/or testBKK's TestMeNow online booking system.

- **Who were the key implementers, collaborators, and partners in this approach?**

Donor, clinic partners, private sector.

- **How was the community involved/engaged?**

Very successful each year, the percent of testing uptake is over 1000% in the end of fiscal year 2022.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Each year, testBKK has its indicator which are:
1. the number of Party Pack Bags ordered through testBKK's website and distributed to the people who placed the order

2. the number of on click, reservation for bloodtest, testing uptake both from organic and paid ads.

- **What worked well and contributed to success, and why?**

"Memes" contain bite size information with fun and that made people click the link (TestMeNow, testBKK.org) in each of testBKK post more.

- Videos and short videos remained to be produced for TikTok and Facebook/Instagam Reels. testBKK attempted to adapt the material elements to KOL and discovered that it worked well. Regarding the improvement of the multiple elements of media for articles, images, and videos, testBKK needs further support for the production of media that can attract the audience's attention using KOL and KP-related giveaways.

3. Social media monitoring – During the fourth quarter, testBKK implemented the use of social media management tools to monitor and analyze the follower at the level of daily operation. This will enable testBKK to closely examine each campaign that is launched each day and improve its performance. Facebook, Instagram, and Twitter are the main social media platforms used for this monitoring.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

https://www.facebook.com/testBKK
https://twitter.com/test_BKK
https://www.instagram.com/testbkk
https://www.youtube.com/user/TestBKK
https://www.tiktok.com/@testbkkbyapcom

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Campaigns Officer, Creative Communication and Media Assistant, Finance officer.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

testBKK, Bangkok APCOM, testJKT Jakarta GWL-INA, Indonesia LINKAGES - EpiC FHI360, test4UB Ulaanbaatar Youth for Health, Mongolia The Global Fund AFAO SKPA Project, testVTE Laos CHIAs APCOM AFAO SKPA Project.

- **Annexes:** N/A

Thailand: case study 2

CONTACT PERSON
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- **Timeline of the case study**: 2015 to 2022

- **Case study submitted by**: International nonprofit organization

- **Title of approach or best practice or initiative**: From HIV testing to comprehensive primary health care: Fostering peer-led, community-driven, and integrated care models for men who have sex with men (MSM) in Vietnam

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**
HIV prevention (condoms & lubricants; pre-exposure prophylaxis [PrEP]); testing (HIV lay provider testing, self-testing, and index testing); treatment and care (antiretroviral therapy [ART]; ART adherence counseling).

- **In which geographic area is the approach being carried out?** Ho Chi Minh City (HCMC), Hanoi, and Dong Nai provinces of Vietnam

- **What problem was being addressed and how was it identified?**
Despite a significant decline in newly-reported HIV cases in Vietnam in the early 2010s, localized epidemics were still occurring in underserved areas and among certain population groups. In particular, the HIV burden among young men was on the rise, with the bulk of new HIV infections concentrated among MSM, especially those living in urban areas and in the Mekong River Delta and Southwest Regions. Between 2015 and 2020, there was 8% increase in HIV prevalence among MSM in Vietnam, and in 2021, MSM accounted for approximately 76% of new HIV infections in HCMC and 52% of new infections in Dong Nai, two high-density and high-HIV-burden provinces. In 2014, the MSM community's needs for high-quality, MSM-friendly, and accessible HIV testing and prevention services were not being adequately met. HIV testing services were limited to public facilities and provided by health care workers only. Though a small network of community outreach workers and community-based groups was emerging, these providers were only able to refer clients to public health facilities for HIV testing and prevention services. MSM faced unique and intersecting barriers to accessing basic HIV prevention and testing services, including stigma, discrimination, and social exclusion within their families, communities, and workplaces; lack of knowledge of HIV and self-perception of not being at risk of HIV; lack of convenient HIV testing/prevention service options; and concerns related to confidentiality and privacy in care seeking. Less than one-third of MSM were tested for HIV annually, with reported testing uptake at 30% in

2011, 28% in 2013, and 32% in 2015. A qualitative study with MSM in HCMC described a strong preference for HIV testing services offered in an MSM-friendly environment.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

Our intervention focused on reaching MSM of all ages, with a particular focus on young and middle-aged MSM aged 15-40 years old.

- **What type of approach is it?**

We applied a multi-layered approach to grow the number and types of entry points for MSM to receive HIV prevention and testing services and be linked to follow-up care. This centered around three key strategies: (1) Expanding the role of MSM-led and other key population (KP)-led organizations in delivering HIV-related services through client-centered design; (2) Reforming HIV communications through use of innovative digital tools and unique community engagement; (3) Prototyping and scaling a community-led, integrated care model that holistically responds to the distinct needs and preferences of MSM, including sub-groups such as chemsex users. This work was initiated under the USAID/PATH Healthy Markets (2014-2021) project and continued by USAID/PATH STEPS (2021-2026) funded by the US President's Emergency Plan for AIDS Relief (PEPFAR).

- **What was the logic and rationale behind choosing this approach or practice?**

With a high and increasing HIV burden among MSM, effective strategies were needed to reach this group, increase their trust in and demand for HIV-related services, and link them to friendly services to ensure continuity in care. Experiences from similar country contexts have shown that engaging MSM communities in a range of HIV activities—including demand generation, online outreach, and service delivery—creates a unique opportunity to close the gap between awareness and uptake of HIV testing and other services. In particular, meta-analyses of HIV lay provider and self-testing have found that, when compared to conventional HIV testing, these strategies can significantly increase uptake of HIV testing among new testers, boost frequency of testing, and better reach those that are at risk of HIV.

- **Full description of the approach or best practice:**

The USAID/PATH Healthy Markets project worked closely with KP–led community-based organizations (CBOs) to redefine how communities themselves could contribute to the HIV response. This started with a pilot in 2015 to allow non-health care workers to offer community-based HIV testing for the first time ever in Vietnam. In November 2015, staff from seven MSM-led CBOs in HCMC and five in Hanoi were trained to offer HIV lay provider testing, and began offering services to MSM from December 2015. In May 2016, staff from the same 12 MSM CBOs were then trained to offer HIV self-testing information and support to clients, including what steps to take if the self-test was HIV-reactive.

At the same time, Healthy Markets supported these MSM-led CBOs already engaged in commercial sales, such as condoms and lubricants, to create and submit dossiers for social enterprise registration. Social enterprises were able to expand their business

ventures into medical device and product sales and into non-health areas, enabling them to have greater impact. In 2016, Glink—an MSM-owned and operated CBO turned social enterprise—opened the first-ever KP-led private clinic in Vietnam with support from Healthy Markets. Healthy Markets subsequently supported another 10 MSM-led CBOs to secure social enterprise status and open 16 private clinics.

In March 2017, PrEP services were offered in HCMC as part of the Prepped for PrEP demonstration project initiated by the Vietnam Administration for HIV/AIDS Control (VAAC) and Healthy Markets, enabling same-day enrolment in three MSM-led clinics and four public clinics. Building on this HIV testing and PrEP service platform, Healthy Markets then began to incrementally add on primary health care (PHC) offerings to core HIV services; first by integrating testing for hepatitis C virus and sexually transmitted infections (STI) into the range of HIV services provided at MSM-led clinics, and then through implementing a one-stop shop (OSS) integrative care model at four MSM-led and one MSM-friendly clinic in Hanoi and HCMC. These OSSs offer a range of high-quality health services, including a full spectrum of HIV testing, prevention, and treatment services; STI and viral hepatitis testing and treatment; mental health and drug use counseling; and co-infection/co-morbidity management, including non-communicable diseases, tuberculosis, and opportunistic infections.

Promotional campaigns accompanied these new services, utilizing Facebook, gay dating apps like Blued and Grindr, MTV, and other MSM-preferred platforms to maximize reach among the MSM community. Healthy Markets and MSM influencers established a Facebook page, Rainbow Village, as an open space for MSM to connect and exchange information on HIV, sexuality, and wellbeing. With 320,000 users at its height, the page has been a central platform for posting HIV testing, PrEP, and OSS promotional information; directly connecting MSM with peer counseling; and linking individuals to care. Healthy Markets also engaged MSM influencers and key opinion leaders in co-creating and co-implementing MSM-focused HIV demand creation activities, peer outreach approaches, and campaigns.

In March 2016, eight MSM social network influencers were identified and trained to communicate directly with Rainbow Village followers and provide HIV risk screenings and referrals for HIV lay or self-testing. To further increase ease of HIV testing, a service booking application, iReserve, was launched in February 2017, and was upgraded to an all-in-one platform called Carezone in 2021. Through Carezone, MSM can quickly access trusted information on HIV and sexual health topics; select where and when they want to receive services, including HIV testing, PrEP, ART, and related primary health care services; schedule an appointment with a health provider; and receive virtual counseling and adherence support. In addition, Healthy Markets developed an online risk calculator through which MSM can self-s

- **Who were the key implementers, collaborators, and partners in this approach?**

USAID/PATH Healthy Markets (2014-2021) and USAID/PATH STEPS (2021-2026) funded by PEPFAR; VAAC; Ministry of Health (MOH); MSM-led clinics, social enterprises, and CBOs, including Glink, Galant, My Home, and Alo Care; and private-sector partners.

- **How was the community involved/engaged?**

MSM were engaged in every step of the design, implementation, and scale-up of these interventions. This included partnering with MSM service providers and peer counselors to pilot and scale community-based testing and PrEP models, and working with four MSM-led and one MSM-friendly private clinic to codesign and implement the comprehensive OSS model and differentiated service delivery models such as mobile PrEP service delivery. In addition, the project's partnership with MSM community influencers was essential for developing and implementing effective HIV demand generation activities, including joint behavior change communication campaigns and peer-led offline events.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

MSM-delivered services, promoted through online and face-to-face interactions and offered through a range of differentiated and integrated models, offered important additions to HIV care for MSM in Vietnam. MSM are consistently the primary users of PrEP, HIV testing, and KP-led OSS services in the country. From December 2015—October 2021, 126,066 MSM received lay HIV testing at Healthy Markets-supported sites. 5,673 MSM were diagnosed HIV positive (4.5%), among whom 5,515 (97%) were enrolled in ART. Since 2017, 19,180 MSM have been enrolled on PrEP at Healthy Markets- and STEPS-supported sites, of whom 93% were continuing PrEP after three months (versus average continuation rate of 81% in Vietnam). Nationally, 46,866 MSM have received PrEP services since 2017.

OSS clinics were a key entry point linking HIV testing and PrEP clients to other essential healthcare services. From October 2020—September 2022, more than 17,000 MSM received care at five OSS sites, of whom 7,078 and 6,988 were tested for hepatitis B and C viruses, respectively; 8,006 tested for STIs; and 11,389 received mental health counseling. The OSS approach was an important way to reach new PrEP clients; 19.6% (2,145) of MSM who initially came in for non-PrEP services were linked to PrEP.

- **What worked well and contributed to success, and why?**

MSM-led service delivery models have been a strong entry point into HIV testing, PrEP services, and related HIV care, greatly increasing HIV testing use among harder-to-reach and higher-risk MSM andeffectively linking them to ART or PrEP. As this service model evolved and expanded into integrated PHC delivery over time, is has offered an effective platform for comprehensively meeting the spectrum of MSM health care needs and retaining them in care.

Engaging with and building the capacity of MSM-led CBOs and lay providers to deliver HIV testing and counseling services was a critical first step in growing the community's trust in peer-led and delivered HIV services. Results from this peer-led service delivery were used to inform the first comprehensive national guidelines on HIV prevention, care, and treatment for MSM, released in 2019, which has enabled larger scale up of this approach. Given MSM have range of health care needs that may include, but are not

exclusive to, HIV prevention and treatment, the growth of the OSS clinic model also acted as an important additional entry point into HIV testing, PrEP, and other PHC services.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Healthy Markets introduced several first-ever, cutting-edge tools for attracting clients online and helping them access HIV prevention, testing, and treatment services through automated and nonautomated case management. These include the Rainbow Village Facebook fanpage, Carezone app, online risk calculator, and artificial intelligence chatbot mentioned above, which all contributed to improved HIV prevention, testing, and treatment access and uptake. Healthy Markets also developed a continuous quality improvement toolkit that was used to guide service quality improvement activities at KP-clinics and support better MSM client engagement and retention, and developed SOPs and service delivery tools to support MSM-friendly, high-quality service delivery at both private and public sites.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

PEPFAR, through USAID/PATH Healthy Markets and USAID/PATH STEPS and in partnership with MOH/VAAC, supported the development, piloting, and scale-up of this approach. The approach required a cohort of engaged MSM lay providers and community leaders to initiate MSM-led HIV services and expand them through MSM-clinic, social enterprise, OSS models. VAAC, USAID/PATH STEPS, and other HIV program partners continue to deliver technical assistance, training, and mentoring to support MSM and other KP-organization business development and strengthened sustainability in delivering peer-led health services.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Without MSM-led and acceptable HIV service delivery approaches such as these, it is unlikely that global 95-95-95 targets and HIV epidemic control goals can be met. There is opportunity for this approach to be replicated in similar contexts through strong engagement of and task-shifting to MSM peer providers. These community-delivered approaches should be included in national HIV guidelines and scaled to maximize impact.

- **Annexes:**

1) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055123/;
2) https://pubmed.ncbi.nlm.nih.gov/33653505/;
3) https://programme.aids2018.org/PAGMaterial/eposters/5325.pdf;
4)https://www.differentiatedservicedelivery.org/Portals/0/adam/Content/xJSbv2c4Aka9DfjRMTOEHg/File/bao_vu_slides_vietnam_KP.pdf
5) https://path.box.com/s/qzx6u7g0mkcpj3h9nuumej0s8v2tz12f

EASTERN EUROPE AND CENTRAL ASIA

No submissions were received.

LATIN AMERICA AND THE CARIBBEAN

Guyana: case study

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- **Timeline of the case study**: February 2022-September 2022

- **Case study submitted by**: Government and Civil society

- **Title of approach or best practice or initiative**: Seronegative Support group- For HIV Positive patients (including Men)

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Yes, Counselling, Testing, Prevention as treatment.

- **In which geographic area is the approach being carried out?:** Georgetown, Guyana

- **What problem was being addressed and how was it identified?:** Providing social Support for partners of HIV Positive persons during the Covid 19 pandemic.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** The support group targeted mainly negative persons , a total of 69 men were offered social support services, ages 18-29.

- **What type of approach is it?** Community Service, Social Network, Traditional leaders, Clinicians sharing, Psychology services, role playing.

- **What was the logic and rationale behind choosing this approach or practice?** Trageted session to help with offloading of social issues, health issues and even financial issues faced in the homes and communities.

- **Full description of the approach or best practice:** The Seronegative Group was done with referrals from Sero discordant couples who know each other status. The session focused on key areas of keeping personal health safe and free of HIV while living optimal lives, It involves linking persons to PrEP, Social counseling, supporting HIV

partners with HIV, reducing stigma and discrimination in communities, safe sexual practices, and mental health discussion among other.

- **Who were the key implementers, collaborators, and partners in this approach?** Ministry of health Staff- Social workers, Psychologist, Doctors, case navigators, CDC/PEPFAR.

- **How was the community involved/engaged?** Referrals from CSO and NGOS as well as clinic sites.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.** Increase uptake of PrEP use among Men, more condom Use in men, safer sexual practices, Reduce number of partner sharing. Reduce Drug use. Increase in more frequent testing for HIV and other STI. Less partner conflicts with support towards Adherence and healthy life styles. Reduce GBV.

- **What worked well and contributed to success, and why?** The opportunity to bring men together created an opportunity for - Counseling, education, testing, involvement in treatment options of love ones, community work and even creating ambassadors for communities. A buddy system was developed as well.

- **What tools and toolkits worked effectively in the approach to engage men and boys?** Buddy system, Social Networking, Social media, Use of common role models.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?** Need for available role models- Pastors, Doctors , Psychologists, social workers, Venue and meals. $ 200 US /Session.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?** Yes replication can be done in other districts and region to help the men of those areas.

- **Annexes:** N/A

Uruguay: case study

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- **Timeline of the case study**: July 2021 – July 2022

- **Case study submitted by**: UN or other international organisation

- **Title of approach or best practice or initiative**: Study on sexual and affective practices, sexual health and STI/HIV management among adolescent and young men aged 15-24 years in Montevideo and metropolitan area , through an online methodology based in social networks and apps, as a strategic contribution to the design of public policies based on evidence, particularly in health, education, youth and human rights.

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Prevention: knowledge about both ways of preventing the sexual transmission of HIV and major misconceptions about HIV transmission; use of condom during last intercourse for those men having more than one partner in the last 12 months; use of condom during last intercourse for men having sex only with women; use of condom during last intercourse for men having sex only with men and with men and women; use of condom during last high risk sexual intercourse; experience of physical and/or sexual violence among gay men and other men who have sex with men; experience of stigma and discrimination among gay men and other men who have sex with men; avoidance of health care by gay men and other men who have sex with men because of stigma and discrimination; syphilis prevalence among gay men and other men who have sex with men; people who received pre-exposure prophylaxis (PrEP) at least once during the reporting period. Testing: HIV testing among gay men and other men who have sex with men in the last 12 months; HIV testing among men having sex only with women in the last 12 months; people living with HIV who know their HIV status.

- **In which geographic area is the approach being carried out?** Montevideo and its metropolitan area, Uruguay, Latin America

- **What problem was being addressed and how was it identified?**

Knowing the epidemic as a basic premise for an effective response focused on HIV prevention represents a significant challenge both in the region and in Uruguay. However, since the beginning of the HIV epidemic, the need to generate rigorous and up-to-date information has been hampered by the fact that surveys based on traditional methodologies with representative samples remain complex and costly. Men continue to be over-represented in the epidemiological dynamics of HIV in Latin America and in

Uruguay, so it´s critical to produce new evidence on the current dynamics and configurations of men's sexual and affective practices, beyond sexual and gender self-identities. Two previous studies´ main findings implemented between 2019 and 2021 resulted in the identification of certain particularities of the sexual and affective relational dynamics of adolescent and young men who have relationships with other men, including in their interactions on the online scenario (social networks or apps for intimate relationship purposes) which motivated to deepen in its knowledge. In addition, both studies represented a first experience about the methodological innovation that represents the creative use of social networks and apps based on digital marketing and communication tools to reach the hard-to-reach male population. Therefore, both studies produced significant learning in terms of approach, content and methodological strategy that was fully applied in the design and implementation of this research initiative.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:**

The self-administered online survey distributed through social networks and applications over 80 days resulted in 1,889 responses, which were filtered according to two criteria: age range (15-24 years) and having had sex in the past 12 months. This resulted in a conveniences sample (non-probabilistic sample) of 1,351 men. 68% reported only sex with women in the last 12 months and 32% had sex with men and with both men and women. Mostly men from Montevideo (87%) and the metropolitan region (12%), declared a medium and high educational profile (85% with incomplete and/or complete third level), almost 80% continue studying and 54% state that they also work. There is therefore a bias towards the more educated young population.

- **What type of approach is it?**

The study's methodological strategy is based on a digital approach that aimed to enhance the tools of applied social research with those of digital communication and marketing. To this end, the project created its own graphic identity and a specific institutional account and implemented segmentation actions aimed specifically at the various groups of men who were mapped as targets throughout the process. Almost real-time monitoring of the posting of messages on four networks and apps (Twitter, Instagram, Facebook and Grinder) and their effects in terms of response was carried out in order to review and relaunch the dissemination, supported by regular follow-up meetings with a Technical Committee composed of experts.

- **What was the logic and rationale behind choosing this approach or practice?**

The first dimension of the approach underpinning the study is the “practice does not make identity”, so the starting point is a focus on the concrete affective and sexual practices reported by men, whatever their self-identification. At the same time, it aims to problematize the traditional category of "men who have sex with men", which might no longer be useful for understanding and analyzing men's sexuality. The second dimension of the approach refers to the growing role of social networks and apps as a relevant scenario for the experience and expression of sexuality and the construction of intimate relationships for the 15-24 generation. Therefore, social networks and apps also constitute a cost-effective opportunity to reach a large majority of men. Following the two previous

studies ‘lessons learnt, the methodological strategy for dissemination and recruitment was designed integrating from the beginning the tools of applied social research with digital marketing and communication in order to reach the greatest number and diversity of men in the shortest possible time.

- **Full description of the approach or best practice:**

The survey and the analysis of the data are structured around two intertwined methodological decisions that characterize the approach of this study. According to our approach, “practice does not make identity”, the starting point is the exploration of men's reported affective and sexual practices, beyond their sexual auto identifications, so the study aimed to reach all men between the ages of 15 and 24 (catch all perspective). This methodological decision breaks with the traditional perspective of directing communication only towards men who have sex with men and/or gay men. This study simply called men who had sex, all men, without any categories, identities or labels previously assigned by the researchers. The second methodological decision is according to UNAIDS statement that men with same-sex sexual partners are 28 times more likely to contract HIV than their heterosexual counterparts due to the multiple inequalities, violence and vulnerabilities. So, considering the importance of HIV infection risk management, the survey had a filter question "Have you had sex with another man in the last 12 months?" that allowed for two paths: one for men who had sex only with women and another for men who had sex with men, and also with both men and women. Thus, the respondents are grouped, on the one hand, between men who report only sex with women in the last 12 months and, on the other hand, those who have had sex with men and with both men and women in the last 12 months.

- **Who were the key implementers, collaborators, and partners in this approach?**

This cross-sectional and analytical study was implemented in the second semester of 2021 by the Research Group on Sexualities (GIS) of the Department of Sociology of the Faculty of Social Sciences (FCS) of the University of the Republic (UdelaR), together with the Chair of Infectious Diseases of the Faculty of Medicine (FMED) of the University of the Republic (UdelaR), the United Nations Population Fund (UNFPA Uruguay CO) and UNAIDS Southern Cone and regional, with the support and advice of the Technical Committee composed by national and international experts from academia, public institutions and civil society.

- **How was the community involved/engaged?**

Civil society organizations, particularly those related to the rights of LGBT people, community organizations with work on HIV, feminist groups, youth associations, were strategic partners for the joint work of disseminating the survey through their networks of contacts. Some of them participated in the pre-test phase with comments and suggestions. In addition, the research design was presented to the National AIDS Commission, which brings together public institutions, academia, and civil society, including organizations of people with HIV, and is chaired by the Vice Minister of Health.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Levels of right conceptions about HIV, use of condoms and consultation in sexual and reproductive health services, including knowledge and use of PrEP, are alarmingly low among young men who have sex with men and with men and women surveyed, which is worrying given that this sample corresponds to more educated and socio-economically advantaged men in Uruguay. Combined with the fact that the research also showed that young men reported higher levels of bisexuality and non-monogamy than men who had sex only with women, the picture is worrying as it suggests a risk of concentrated HIV epidemics becoming more generalized.

The data show other main findings in this particular sample of men: critical tensions between practices / identities attractions / orientations that express dynamics of flexibility and change, but also permanencies in men's affective and sexual practices; questioning of the binary and exclusionary perspective of sexuality, including some breakdown movement of traditional masculinity patterns (both hetero and homosexual); 2.5% of men reporting sexual relations with both men/men and women are HIV-positive, almost 12 times higher than the prevalence in men reporting sex only with women in the past 12 months.

- **What worked well and contributed to success, and why?**

The study produced significant inputs to explore this sample of 1351 men´s sexuality and affective relational current dynamics (changes, intimate movements and some permanencies), especially including the online dimension of affective and sexual practices and interactions. In particular, knowledge about the affective and sexual practices of men who have sex with men and the range of strategies used to cope with the risk of STIs/HIV has been expanded. Precisely, the innovation of having current data on the forms of affective and sexual relationships of this sample of men made it possible to develop a broad advocacy campaign on the need for public policies to promote sexual health and HIV prevention and sexual education that take into account the diversity of men's practices. In addition, the implementation of this study using a strategy based exclusively on social networks and applications has brought several lessons in terms of social and epidemiological research. First, this modality allowed a significant reach and adherence in terms of responses, in a limited space of time, with reduced costs, compared to what it would be to carry out a survey with other characteristics. Secondly, the time savings made possible by the use of online tools to capture information on various intimate aspects of sexuality, perhaps also because of the eagerness to be able to express oneself on a critical issue for men and to do so under protected conditions of confidentiality and anonymity. Thirdly, the innovation of having designed the integrated research strategy together with the digital communication strategy and not separately as is generally the case in more traditional approaches. Fourth, in order to reach other segments of less educated and lower socio-economic status men, it is necessary to design combined strategies adapted to each project, taking into account the objectives of the research and the limitations it may bring. Mostly urban, educated and socially integrated men were captured, a real bias that leaves a large portion of men in silence. In this case, the effects of COVID-19's restriction on attendance was an obstacle to implementing other complementary actions that would help to reach a more hard-to-reach male audience.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The communication strategy was key to the research strategy, being a cross-cutting component of it. The aim was to strengthen the tools of social research with those of community communication and digital marketing. The dissemination and capture strategy was based on a double approach: a strong focus on survey promotion in social networks complemented by more specialized work in the territory with local organizations. This second component in the territory would make it possible to reach adolescents and young people with a lower socio-economic and educational profile, who were more difficult to reach through social network. However, the methodological strategy ´s second component based on face-to-face communication planned to be developed in youth centers, neighborhood and social organizations, aimed at reaching other men with less education and lower socio-economic status, was severely limited by social distance restrictions due to the COVID-19 pandemic.

The main communication strategy´s success aspect was have been generated its own graphic image associated with the following concepts: fruit, blue, care, pleasure. The aim was to move away from the typical graphic scheme aimed at young people that seeks colorful figures (often infantilized) and based on comics and other repeated graphic resources. The aim was to associate sexual health with pleasure, with fun, to be suggestive with the graphic selection without going beyond limits, but appealing to a clear message aimed at a specific public (all men without beyond any sexual identity). The strategy proved to be cost-effective, achieving 1,889 responses in 80 days online, combining organic and paid messaging. However, we must take into account a key lesson learned: in order to reach other segments of men (in this case men with lower educational and socio-economic levels), it is necessary to design combined strategies adapted to each project, taking into account the objectives of the research and the limitations it may bring.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

The project was developed by a research team made up of 2 sociologists, a specialist in digital communication, a social media community manager and a research assistant. The research team was systematically accompanied and supported by the Technical Committee, whose work was entirely honorary. The committee had the added value of being made up of academics, members of LGBT groups with experience in research, former public officials strongly related to health, human rights and HIV prevention public policies and officials from UNAIDS and UNFPA. The research process was implemented for 10 months and had a joint support of UNFPA and UNAIDS for USD 25,000.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

UNAIDS and UNFPA are currently working together to replicate the study in UNFPA Country Offices interested in having a study on male sexuality and HIV prevention in a cost-effective format.

- **Annexes:**

Advocacy campaign based on study´s results TV CIUDAD: https://www.youtube.com/watch?v=JNFOLkzimpY
CANAL 10 TV: https://www.youtube.com/watch?v=Bw1pKD8Nr_g
LA DIARIA: https://ladiaria.com.uy/salud/articulo/2021/12/varones-que-tienen-sexo-con-varones-tienen-mayor-percepcion-de-riesgo-e-informacion-sobre-transmision-de-vih-que-los-heterosexuales
RADIO SARANDI: https://www.sarandi690.com.uy/2021/12/16/como-viven-la-salud-sexual-los-varones-adolescentes-uruguayos
VTV Cable :

Middle East and North Africa

No submissions received.

Western Europe and Others

Slovenia: case study

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- **Timeline of the case study**: November 2017 - October 2022

- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: "Response to HIV"

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Multiple components: Counselling, testing, support in linkage to care.

- **In which geographic area is the approach being carried out?:** The approach was being carried out nationwide in Slovenia, with community-based testing provided in the capital and 11 other locations throughout the country.

- **What problem was being addressed and how was it identified?:**

The problem addressed by the project was a disproportionately high HIV burden among men who have sex with men (MSM) in Slovenia. According to the criteria of UNAIDS and the World Health Organisation, Slovenia is a low level HIV epidemic country, whereby HIV has not yet significantly spread to any subgroup of the population. Fewer than one person per 1000 inhabitants live with HIV, which is relatively low prevalence compared to other countries in the European Union. However, in the period of the last 10 years (2011-2020), 456 cases of new HIV diagnoses were reported to the National Institute of Public Health, out of which 310 were among men who have sex with men (MSM). The highest number of new diagnoses among MSM was 46 (out of 56) in 2016 and the lowest, 14 (out of 27), in 2020. Therefore, MSM represent the largest segment of new HIV infections in Slovenia.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention**

Population reached by this approach are MSM.

- **What type of approach is it?**

It is a community-based service, organised and implemented by a NGO, community organisation, staffed by peers, in cooperation with a medical institution.

- **What was the logic and rationale behind choosing this approach or practice?**

By choosing a community-based approach, we eliminated the usual barriers that prevent MSM from accessing HIV services like testing in conventional settings (e.g. hospitals). These barriers include stigma, self-stigma, shame, fear from being seen and fear from judgmental or stigmatising attitudes by healthcare workers. Also, our services are provided in (MSM or other) community spaces, bringing the service close to the key population, in non-clinical environment. By enabling clients to get tested and receive counselling and support from peer lay providers in a safe environment, we made sure that the service was acceptable and accessible to the key population.

- **Full description of the approach or best practice:**

Slovenian NGO Legebitra started piloting community testing in 2009 with financial support of Ministry of Health and in co-operation with Institute of Microbiology and Immunology of the Faculty of Medicine of the University of Ljubljana and Department of Infectious Diseases of the University Medical Centre Ljubljana.

Slovenia also participated in the Community-based testing (COBATEST) network and in Euro HIV EDAT Project. The overall purpose of the project Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe (Euro HIV EDAT) was to generate operational knowledge to better understand the role and impact of Community Based Voluntary Counselling and Testing services (CBVCTs) across Europe, as well as to study the use of innovative strategies based on new technologies and social networks, to increase early HIV/STI diagnosis and treatment among the most vulnerable groups.

In 2015 the programme successfully ran for Norwegian grants for the period of 2015-2016. In this period a regular service of anonymous voluntary community-based testing (HIV, hepatitis B and C, gonorrhoea, and syphilis) and counselling was successfully established, in community- and MSM- venues, in the capital and in regional centres. The programme also included counselling and psychosocial support for people living with HIV. From 2017 onwards, the programme is financed by the Ministry of Health of Slovenia as integral part of National Strategy for control and prevention of HIV infection 2017-2025. The programme includes anonymous voluntary community-based testing and counselling for HIV, hepatitis B and C, gonorrhoea and syphilis, in the capital (at the checkpoint and gay sauna) and in 11 regional centres around the country.

Community testing and counselling is a successful supplement to testing in the framework of the health-care system and represents a model of good practice of diagnosing HIV infection among men who have sex with men. For users, it represents a safe environment where they can openly and unreservedly talk about their experiences and sexual practices. Individual counselling is provided before and after testing for persons subject to the greatest risk of HIV infection, whereby they have the possibility to discuss their sex lives with a counsellor and talk about reducing the risks of HIV infection and other sexually transmitted infections. Users with a positive test result, especially for HIV, are provided

support in linkage to care, and any other support (practical or psychosocial) they may require.

Tests used are standard laboratory tests (blood and swabs). They not only provide very reliable and accurate test results, but also official lab results which enable clients to receive immediate treatment at any medical institution that treats those infections. Blood and mucosal samples are taken by a nurse, and are analysed by laboratories of the Institute of Microbiology and Immunology. Everything else - pre- and post-test counselling and the whole running of the service, is performed by trained peer counsellors - lay providers. Expert support to lay providers is provided by the Expert advisory group, made up of 2 infectious diseases doctors, 1 clinical microbiologist and 1 epidemiologist, all professors at the University of Ljubljana Faculty of Medicine.

- **Who were the key implementers, collaborators, and partners in this approach?**

The service itself is implemented in partnership of Legebitra with the Institute of Microbiology and Immunology of the Faculty of Medicine, University of Ljubljana and in cooperation with the Department of Infectious Diseases and Febrile Illnesses of the University Medical Centre Ljubljana. It is financed by the Ministry of Health of Slovenia and the Municipality of Ljubljana.

- **How was the community involved/engaged?**

The community involvement was through Legebitra, which is a community organisation, through the work of Legebitra's employees and volunteers, all coming from the community.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

The outcomes of the intervention are: accessible MSM-friendly testing service in regular operation, changed attittudes of MSM about testing (less stigma atached to testing, more willingness to get tested) and a relatively low numbers of new HIV diagnoses among MSM as a consequence of combined prevention of which this approach is a part.

The service was established in 2009 by providing testing to 50 users, and in 2021 there were 1453 users tested. In 2019, the last pre-covid year, 1430 people (non-uniques) were tested, out of which, 1373 (non-uniques) were tested for HIV and 8 had reactive HIV tests, which were later also tested with confirmation tests and confirmed as HIV positive. That means that in 2019, when 20 MSM were newly diagnosed with HIV on a national level in Slovenia, 40% of them were diagnosed thanks to Legebitra's community-based testing service (source: https://www.nijz.si/sites/www.nijz.si/files/uploaded/hiv_letno_porocilo_2019_-_koncna_verzija.pdf)
Evaluation is done on a permanent basis. We evaluate the satisfaction of our clients after their every visit, with questionnaires. Evaluation analyses show consistent high levels of client satisfaction with the service.

- **What worked well and contributed to success, and why?**

Involvement of lay providers, especially in counselling work, proved to be essential for the success of the initiative. Our clients are much more willing to get tested in a relaxed non-clinical environement by their peers, than in other environments. According to on-going monitoring of client satisfaction, they stated the possibility of performing 'multiple tests in one place', 'confidentiality', 'relaxed atmosphere', 'free of charge service' and a 'possibility to talk with someone who understands' as top five reasons for using the service.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The best tool to engage men were MSM social networking and online dating applications, as it was possible to reach the largest number of MSM through them.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

Resources needed in the financial period November 2019 - October 2022 were € 550000. 14 people worked on the project, including employees, external contractors and volunteers. The National Strategy for control and prevention of HIV infection 2017-2025 envisages continuous funding of the community-based testing for HIV, assuring the sustainability of the approach.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

This service only provides testing for MSM. Other vulnerable groups would also benefit from a community-based, non-clinical approach for HIV testing.

- **Annexes:**

Testing service website: https://kajisces.si

Spain: case study

CONTACT PERSON
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- **Timeline of the case study**: 2016 – present

- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: INDETECTABLES, a HIV fiction series to increase early diagnosis and STI management, and fight against HIV stigma

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, prevention testing, access to treatment and link to care and response to HIV related stigma.

- **In which geographic area is the approach being carried out?** Europe

- **What problem was being addressed and how was it identified?**
Lack of access awareness and prevention campaigns for MSMGB / LGTBIQ community and the big issue with the HIV related stigma that still supposes tha main barrier among MSMGB.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** MSMGB and other LGTBIQ people (specially non binary and trans men), between 18 - +50 y/o.

- **What type of approach is it?** Digital and community service / checkpoint

- **What was the logic and rationale behind choosing this approach or practice?**
The access to sexual health resources and sexuality education is very low in Spain, and other countries around the globe. Our identities and personal development, which is the sexual human approach, are ignored, bullied, stigmatized and implemented in a wrong approach, with strong consequences as LGTBIphobia and / or LGTBI violence, Gender Violence, Bullying, STI and other health outcomes as non-planned birth, etc. There is a huge lack of specialized resources for sexual health, that's why many of the community organizations working on the HIV / aids, or sexual health, response have been assuming this crucial role and we have specialized our staff in those interventions. Beside this problem and experience, there is an extra huge one: the stigma to sexual health also affects the investment and support. What you don't show off, you don't care. In view of this problem of sustainability, we have developed an innovative solution to guarantee the access to sexual health and sexuality education and rights, specially to the most vulnerable people and communities (especially MSMGB, trans women, youth,

migrants,...) and generated this solution beside these communities. Our claims, co-creating from the diversity background are: "Nothing about us without us" and "if you think you are too small to have an impact, try to sleep with a mosquito in your room". We cocreate in Diversity for ending the Stigma.

- **Full description of the approach or best practice:**

AEP is a HUB of community innovation that operates in parallel with the Apoyo Positivo's services and projects, as a community-based NGO since 1993, facilitating diverse entrepreneurship and sustainability for the NGO and free and easy-access sexual and educational services while fighting stigma.

In 2016 we started to design a project with these two goals/problems to solve:

- Easy access to sustainable sexual health and educational / rights services related to Diversity
- Co-create sustainable and innovative solutions for the identified social and community needs that help the future of our organization

From the traditional Apoyo Positivo services, we identify, besides people and communities, their needs and affected rights, and other ones that affect the whole society. This design thinking process, further than our specialized services, is the starting point to create innovative solutions through our diverse HUB. In AEP we create:

- Innovative Testing Point of Care for HIV and other STIs with rapid testing and diagnosis. Fast track of specialized services and link to care with the Public Health System for treatment.
- Social, health, and educational projects based on Diversity as our project for the Chemsex, the problem of sexualized use of drugs, our App for managing sexual health PREPARADXS, and others.
- Audiovisual HUB of diversity, in which we co-create:

A. Campaigns: working with community members/communities and its related creatives, we co-create audiovisual projects, and campaigns, for our organization and other companies, raising funds to maintain the HUB and Sexual Health and Educational Programs.
B. Short films and movies, like DIVERSXS, TRANSVERSALES, ELI, etc.
C. Our series INDETECTABLES about sexual health and diversity: www.indetectables.es known around the globe and with a huge impact in the movie and cultural world.

Apoyo Positivo with AEP has opted to replicate successful models in its work, such as STI checkpoints (as the Strut in San Francisco, the BCN Checkpoint, or 56 Dean Street in London), based on scientific and educational data, accessible to anyone who wants to take active care of their sexual health, and from there, address other aspects of sexual and reproductive rights, as well as the emotional and mental health: our CASA centers.

Our model combines pioneering community Testing, psychosocial care, peer, emotional health, and diversity programs, with a social entrepreneurship model that activates the communities and the sustainability of the entity.

AEP was born in parallel to Apoyo Positivo programs and services, as a model of community entrepreneurship based on diversity, taking as reference models such as Propeller, WeWork or other HUBs of innovation and social entrepreneurship around the world, and creating a community of social innovation, from diversity, that develops solutions to the needs detected together with the labeled communities.

Unlike other community models of sexual health and rights, we are the only community resource in Spain, which has created a diverse HUB, in which developments in Health, Education, and Audiovisual Innovation and Awareness come together that give solutions to the social needs that we respond to in Apoyo Positivo programs and services.

Our vision is to take HIV and diversity experience as something positive, productive, and innovative and not only provide an immediate solution to the problems that its management produces in our society, and in certain communities but also to manage social change through that diversity, its talent and the direct solutions it provides.

- **Who were the key implementers, collaborators, and partners in this approach?**

Together with our professional team, who also belong to the target communities, different members of these communities, especially MSMGB and transgender men, and creatives from these same groups have been the key agents for the development of our AEP HUB as well as key projects such as our fiction series INDETECTABLES. AEP is a project for the community and developed by the community and has been possible thanks to the collaboration of the public administration, initiatives such as UNAIDS Fast Track Cities, the support of the pharmaceutical industry and companies whose social department has common values with those of our NGO Apoyo Positivo. The AEP incubator has the support of entities such as CESIDA or FNETH, community platforms that carry out their campaigns with us or institutions such as the Ministry of Health, which has recognized our work in different spaces and promotes it as good practice, both in the audiovisual and creative entrepreneurship model and in the CASA community centers model of response to sexual health. Our holistic approach includes the whole Health Care System and professionals as part of the attention circuit that we facilitate. We coordinate all our services and link to the specialized care in the public health system, guaranteeing that people has the best attention and zero barriers to health access. But we also train and cocreate new projects with those actors through AEP. Our app PREPARADXS is an example, which was develop in collaboration with the Spanish Society of Hospital Pharmacy to manage sexual health in your mobile device or other projects and campaigns to improve our services and the Health Care system. Our staff are also health professionals, and some of them are also working in the Health Care System which means a straight way to connect both spaces and coordinate them. We also implement specialized services in health care settings as Hospitals (Infection Diseases Departments) and we are part of some Boards of other actors as CESIDA, the HIV / AIDS community platform, scientific societies as SEISIDA or working groups at the Ministry of Health or the Ministry or Equity. We also collaborate with the public administration and run specialized contracts as the one that we have with the Madrid Addictions' Institute to face the chemsex problem, the problematic sexualized use of drugs or our CASA Center in Torremolinos which is part of the Youth City Center.

- **How was the community involved/engaged?**

Our organization belongs to the community. We are PWHIV, LGTBIQ, or belong to more than one of those communities and we have designed this model to engage our community mates on the sexual health care and at the same time to provide a platform for personal and professional growth and development through diversity entrepreneurship.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Right now Apoyo Positivo / AEP has 21 professional staff, from those vulnerables communities (HIV, LGTBI, women, migrants,...) and we have 4 centers, 3 in Madrid (2 CASA Community Centers and 1 CASA Community and Audiovisual Production Center) and 1 in Torremolinos, Málaga, opening a couple more in Orense (Galicia) and Granada along this year.
We test over 4.000 people per year
We educate over 6.000 students per year and over 500 Health Care Professionals
We attend over 1.200 diverse people with social needs per year
We attend over 700 people in psychosocial programs per year
We develop campaigns, movies and our series (www.indetectables.es) that achieve over 2 millions of viewers annually, and are replicating national and internationally
We participate in the most important platforms and working groups of our sector, beside the public administration and Health Care System
Our social networks (@apoyopositivo) have grown to bigger numbers and engaging social media influencers that participate in our activities, and in media, on behalf of the organization. Our online community and it participation is growing faster.

- **What worked well and contributed to success, and why?**

In these years we have managed to consolidate our model and sustainability, being a plausible reality with the forthcoming opening of new centers in Spain. Our productions and innovation already support Apoyo Positivo services, together with public and private grants, making our work more independent, professional, and connected with the communities. And that was the key to success since the beginning.
Our CASA community centers and our HUB AEP based on diversity are two parallel projects made by the community and for the community. They are two solutions that came up working side by side with the community members, professionalizing community members to run Apoyo Positivo as health educators, psychologists, and communication officers, for example... Our team now is an evolution of professionals from, and in straight connection with, the targeted and key communities.

Like the new UNAIDS strategies, through the Seville Declaration, community leadership is key in accelerating HIV responses, especially in communities such as diverse men. The experience, capacity, immediacy and proximity of the community approach make it essential to complement biomedical efforts to control the pandemic and, above all, to manage the sexual and mental health of people whose sexuality has been marked by

patterns of toxic masculinity, by a structure of violence and abuse due to our diverse orientation and identity, and by a complex personal development in adolescence that does not improve in adulthood and becomes even more complicated in old age.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Campaigns connected with trends in social networks.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

We are 21 professionals, specifically 6 people working in the AEP HUB, with communication and audiovisual production profiles. This team is joined by an average of 10 community creatives who develop projects with the entity on a monthly basis. In the specialized services, the profiles range from infectious disease doctors to social workers, psychologists, sexologists, social educators, psychiatrists, etc., and, above all, experts of the target communities, who lead the programs and services with direct community participation. People who gradually join the professional and volunteer team are those who have normally already participated in any level of the NGO, so that structural and professional growth is given together with them and the management of their talent. Our experience, the robustness of a resource with more than 28 years of experience, the network of collaborators and the vision of community social innovation allow us to attract talent that helps to scale our model. Apoyo Positivo already has a strategic and sustainability plan, derived from this experience of more than 28 years, with a network of collaborators and financiers, which allows the development of certain services. AEP arises as a parallel social entrepreneurship to guarantee financial resources when these public and private grants are canceled or there are no funds for the development of specific programs in our areas of health, education and rights. Currently AEP is already sustainable in its structure as well and provides extra funds to finance some programs, but the gap in other public funds makes it necessary to scale the model and obtain even more funds independently to guarantee our services and offer them to more people. To do this, we have first consolidated our model with the combination of the two sources of funding (Apoyo Positivo and AEP) and now we want to increase the workspaces, with a more private collaborative nature, so we have started new collaborations with large companies, larger budgets, which allow us to manage more staff and talent, doing so within an appropriate entrepreneurial structure, that a collaboration with a partner as Ashoka can facilitate us. Our sustainability comes from our own work: the quality of our services and its connection with the key stakeholders and our innovation and creative solutions.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

We are already scaling this model in more Spanish cities, specifically opening two new CASA checkpoints community centers in Ourense, Galicia and Cadiz, Andalusia, which are added to the 4 centers in Madrid and Torremolinos, Malaga, in addition to having opened the online attention in most of our services for the rest of the country, Europe and Latin America especially. In turn, AEP and its projects, such as the INDETECTABLES

series can carry out projects in other places, as well as replicate the model of the series in collaboration with other countries, cities and local entities. In our planning has always been the possibility of making a chapter or season of the series in Latin America or in another European country. We believe that our dual model of sexual health and social and community communication and creative innovation responds to the reality not only of the target communities but also of the new generations and the future of our society and is a model of approaching issues such as education and sexual and reproductive rights close, easy, without barriers, without prejudice and highly professional, from the people who are also part of these communities.

- **Annexes :** www.indetectables.es
https://blogs.20minutos.es/1-de-cada-10/2022/09/08/ya-estas-en-casa-el-checkpoint-de-apoyo-positivo

The Netherlands

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- **Timeline of the case study**: 2015 – present

- **Case study submitted by**: Civil society

- **Title of approach or best practice or initiative**: “Heb ik hiv?”

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?**: Multiple components: testing, treatment.

- **In which geographic area is the approach being carried out?:** Amsterdam area and (later) the whole country

- **What problem was being addressed and how was it identified?:**

Late presenting, this was identified with data from the municipal health service (GGD) and Sichting HIV Monitoring.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** MSM

- **What type of approach is it?** Hebikhiv.nl is a digital approach

- **What was the logic and rationale behind choosing this approach or practice?**
Men are not used to visit a doctor as soon as they feel sick. We are taught to wait it out. But they do tend to Google their symptoms to see what's going on and when they find the right information there that helps them identify their symptoms, they can be convinced to get tested.

- **Full description of the approach or best practice:**
At Hebikhiv.nl, MSM can find information about the early stage of HIV, which usually comes with flu-like symptoms. And they can use the Symptoms Check to see if they should get tested for 'acute HIV'. This test works with an algorithm that is based on the factors that best predict an HIV infection, time between possible infection and symptoms, and symptoms of an early HIV infection. Completing the Symptoms Check leads to an advice to test either straight away, or just test regularly. When MSM get the advice to get

tested as soon as possible, they can make an appointment with the municipal health service at short notice. In Amsterdam it was possible to get tested and treated within 24 hours. In the rest of the country, it is possible in a few days. The idea behind that is that the sooner you get tested, the better for your health.

- **Who were the key implementers, collaborators, and partners in this approach?**

Municipal health centres (GGD Amsterdam, later every GGD in the country).

- **How was the community involved/engaged?**

In a second campaign in 2018, the initial brainstorm was done with creative people from the community. after that, a team of creatives from the MSM community was brought together and a focusgroup of 10 MSM was set up. Members of the focus group shared information about their backgrounds and their feelings and thoughts about HIV and testing. Then a workshop followed where the focus group met the creative team and worked together to see what kind of messages worked and why. Then the creative team worked on 5 proposals. The focus group got to choose their favourite proposal. This proposal was then made into the new campaign.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Outcomes where a high finding percentage among MSM who were given the fast route test. Also, most of them could come into care earlier than usual. From the website data we can conclude that many MSM (and others) where very engaged with the content and have learned about the symptoms that fit an acute hiv infection.

- **What worked well and contributed to success, and why?**

It was the first time we ever focused on the symptoms of hiv. And because of the quick care route, people could take action right away when they were convinced, they might have hiv.

A mayor succes factor was the training employees of the municipal health service (GGD) got. This meant that they were much more alert on symptoms of acute hiv, also when they had a client on the phone, so they could get more people tested in a very early stage.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

The symptoms check at hebikhiv.nl worked very well to engage people with the knowledge about symptoms of early hiv infection. The campaign material was used to reach different groups of MSM. Our 3 leading men where a club kid (https://vimeo.com/372648763), a Dutch Moroccan 30 something at a restaurant with his boyfriend (https://vimeo.com/372648840) and a somewhat older guy in a gay sauna (https://vimeo.com/372648944)

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

0,4 fte communication/project lead and guidance from scientists and team leaders. Everything was based on research already done before this campaign started. Staff of the municipal health services needed to be informed and trained. The project has lasted from 2015 until covid came in, with a new national campaign in 2018 and another boost of it in 2021/2022. The website is still active and in use via our main website mantotman.nl, but there are no further campaigns planned.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

This was already scaled country wide.

Annexes:

www.hebikhiv.nl,
https://vimeo.com/372648763
https://vimeo.com/372648840
https://vimeo.com/372648944

MULTI-COUNTRY

South Africa, Kenya, Mozambique and Indonesia: case study

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- **Timeline of the case study**: Since 2018

- **Case study submitted by**: UN or other international organisation

- **Title of approach or best practice or initiative**: Stepped Care Model approach

- **Is the approach or best practice addressing multiple components of the HIV services prevention testing, treatment, and care cascade?** Yes, Prevention, testing, treatment and care.

- **In which geographic area is the approach being carried out?** At national level in South Africa, Kenya, Mozambique and Indonesia.

- **What problem was being addressed and how was it identified?**

Digital health interventions are often implemented in silos which make it difficult for young people to navigate the services landscape. And due to this quality of services can often also not be assured. Moreover, when interventions are not developed in and embedded in a broader health system they often fail to scale up and are not sustainable when funding stops.

- **Describe the men population(s) reached with the approach and the ages of men and boys that were the target of the approach or intervention:** Adolescent boys 10-19 and young men 20-29.

- **What type of approach is it?** The Stepped Care approach includes digital health interventions such as SCSE websites, decision-making support tools and chatbots with semi- or non-digital interventions such as peer support systems, call centres, health advice and medical services.

- **What was the logic and rationale behind choosing this approach or practice?**

That young people have different kinds of issues and information needs when it comes to sexual and reproductive health. Boys and young men do have their specific needs as well. Some may be helped by reading a self-help online article. Others could benefit from a

phone-call with a peer-support group. Still others may have a physical examination from a licensed doctor. Therefore, different services need to be provided, aligned with the level of complexity and level of self-care possible. The Stepped Care Model approach creates a cohesive SRHR information and services landscape in which diverse young people, including boys and young men, can smoothly navigate to the information of service that meet their need.

- **Full description of the approach or best practice:**

Having the right information and service in the right place, at the right time delivered by the right digital solution or person to meet the specific needs of young people. That is what Stepped Care is about.

The Stepped Care model for sexual and reproductive health is a youth-centered approach that is responsive to the needs of young people, at the lowest possible cost. It is a robust digital health ecosystem facilitating collaboration among stakeholders and organising online and offline SRHR services in a meaningful way for young people. Services that are non-judgmental, age appropriate and sex positive, to help young people navigate and access to the right services and information.

Stepped Care encourages all stakeholders in the field of sexual and reproductive health for young people to coordinate their efforts. A unified branding, messages and links between services guides individuals to a web-based platform that provides quality and engaging comprehensive SRHR information. From this point, digitally-delivered personalized information guides the individual. Self-assessments provide tailored advise and refer to additional online and offline services according to the individual's needs. As moving through a care-seeking journey, the individual is referred to higher steps of the model that incorporate human contact through chat services, hotlines and eventually face-to-face services with healthcare and medical professionals as needed. The lower the step of the model, the higher the reach and self-care, and the lower the cost of services.
All stakeholders working together under the same branding can achieve higher levels of sustainability, increase reach of messages and services, and ultimately lower the burden on the healthcare system.

Health yourneys and interventions that are part of a journey are always co-created with young people incl. young males. In this way we make sure that their needs are taken into account and that interventions speak to them. Boys and young men also inform information and interventions that are specific for them. Think of an article that describes the male body or an explainer on why do men get erections in the morning. Also stories about challenges young men come accros in their lives have been written and published. By engaging boys and young men in story writing their experiences inform other men and boys.

- **Who were the key implementers, collaborators, and partners in this approach?**

The South African National Department of Health, WitsRHI, Love Life, Soul City, CHAI, WHO, UNAIDS, PSI, LVCT Health, PS Kenya, Viamo, Coaliçaõ, Universidade Católica de Moçambique (UCM), Yayasan Kasih Suwitno.

- **How was the community involved/engaged?**

By active participation in workshops, they co-decided on the interventions donors would invest in and in co-creating interventions and various content.

- **What were the outcomes of the approach or intervention? Was there a pre-planned evaluation? Describe the evidence and summarize data if available.**

Digital health coalitions in South Africa and Kenya have been established and work together. Different services have been integrated or jointly developed. E.g., a CSE website that includes a chatbot, an HIV testing tool, contraception tool and an Is PrEP for me tool as well as a toll-free number to call with personal questions and a service finder that helps you find a service nearby. The website has reached almost a million young people that viewed over 6 million pages and the different tools have been used tens of thousands of times. The interventions have all been funded by different stakeholders but are available at the same platform under one brand. This makes it for young people easy to navigate and stakeholders can jointly brand one platform and reach a higher target.

- **What worked well and contributed to success, and why?**

That the Stepped Care Model provides stakeholders with an approach they can use to collaborate and find their unique contribute to a broader (digital) sexual and reproductive health system. Various stakeholders really see the benefit of working together rather than in silos.

- **What tools and toolkits worked effectively in the approach to engage men and boys?**

Co-creation processes through which men and boys meaningfully participated in decision making and intervention development.

- **What were the resources including human resources needed for this approach and are there any plans for sustainability of the approach?**

As the Stepped Care approach builds on what's already there and works towards including new investments into one system rit builds on the resources of a variety of funders. Aidsfonds guides the process which needs 0.5 FTE Stepped Care expert staff per country for about 5 years, a supporting team and resources to organise workshops and to make co-investment. Digital health coalitions are formed and trained on the Stepped Care approach who continue implementation according to the methodology post project.

- **Would you implement this approach or practice at scale or replicate the practice elsewhere? If yes, how?**

Our current ambition is to sustain collaborative implementation of (digital) health according to the Stepped Care approach in the four countries. We are eager to explore partnerships in other countries.

- **Annexes:**

https://aidsfonds.org/stepped-care-model-for-sexual-health
https://aidsfonds.org/resource/stepped-care-model-guidelines-for-implementation