UNAIDS
EVALUATION REPORT

RAPID REVIEW TO TAKE STOCK OF THE JOINT UNAIDS-IAPAC FAST-TRACK CITIES PROJECT

December 2020 | UNAIDS Evaluation Office

Disclaimer

This report has been authored by Lisa M. Butler, Lauren Chender, Agnès Papone, and Greg Szekeres. The views expressed in this report are those of the evaluators. They do not represent those of UNAIDS Secretariat, IAPAC or of any of the individuals and organisations referred to in the report.

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The Joint UNAIDS-IAPAC Fast-Track Cities Project, launched in 2018, is a collaboration between UNAIDS and the International Association of Providers of HIV Care (IAPAC), which is supported by USAID. It aims to provide essential technical support to 15 priority high-burden cities to accelerate their HIV responses towards achieving key Fast-Track targets and delivering on the commitments of the *Paris Declaration on Fast-Track Cities Ending the AIDS Epidemic*.

The UNAIDS Evaluation Office, in collaboration with the UNAIDS Fast-Track Department and IAPAC, commissioned a rapid review of the project. The rapid review took stock of progress over the first phase of the programme (2018-2020) in all the 15 high-burden cities.

We are grateful to the evaluation team, composed of Lisa M. Butler, Lauren Chender, Agnès Papone and Greg Szekeres. We also wish to acknowledge Roshaneh Jaffer and Timothy Lane for their contributions to the planning of the evaluation, and to Leonie Marinovich and Nathalie Gouiran for design and layout of the report. We sincerely thank all who gave freely of their time and shared their knowledge, experience, ideas, and suggestions as part of the review. These included staff of UNAIDS and IAPAC, as well as representatives of municipalities, implementing partners, civil society organisations, and the Global Fund. We particularly acknowledge UNAIDS and IAPAC staff based in the countries covered by the review. Special thanks are owed to the members of the reference group which provided guidance on the scope and content of the review as well as quality assurance throughout the process.

The review provides constructive feedback to UNAIDS, IAPAC and municipalities for improving collaboration and achievement of results, informing the next planning phase, and enabling continued progress through 2022. We are confident that the review will also contribute to understanding the impact of COVID-19 on the HIV response, addressing gaps, and identifying key areas for collaborative efforts to contain and mitigate the COVID-19 and HIV pandemics.

UNAIDS Evaluation Office

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Abbreviations and Acronyms

BMGF	Bill & Melinda Gates Foundation
ART	Antiretroviral therapy
ARV	Antiretroviral
COVID-19	Coronavirus disease 2019
CPO	IAPAC Consultant Program Officer
FTCP	Joint UNAIDS-IAPAC Fast-Track Cities Project
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
IAPAC	International Association of Providers of AIDS Care
IRB	Institutional review board
KI	Key informant
KP	Key population
LGBT	Lesbian, gay, bisexual, and transgender
M&E	Monitoring and evaluation
MoH	Ministry of Health
MSM	Men who have sex with men
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	Person/people living with HIV
QoC	Quality of Care
PWUD/PWID	Person or people who use(s) drugs / person or people who inject(s) drugs
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN-Habitat	United Nations Human Settlements Programme
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Introduction

Purpose

This mid-term review was commissioned by the UNAIDS Evaluation Office and conducted by an external evaluation team. The review was designed to take stock of progress overall and by project objective over the first phase of the programme (2018 to 2020) in the participating 15 priority high-burden Fast-Track cities in sub-Saharan Africa, Eastern Europe, Asia, and the Caribbean; to provide constructive feedback to UNAIDS, IAPAC, and municipalities on overcoming challenges and barriers that will enable continued progress through 2022; and to understand the impact of COVID-19 on the HIV response and project activities, address programmatic gaps, and identify key areas for collaborative efforts to contain and mitigate both pandemics.

Evaluation questions were guided by the Fast-Track Cities project (FTCP) Theory of Change *(See Annex 1)*, which indicates how project activities are expected to work independently and synergistically to lead to higher-level project outcomes.

Timeline

The evaluation was conducted between September – December 2020, including preparation of the inception report (September), data collection (October – November), and analysis, report writing, and presentation preparation (November – December).

Methods

A mixed-methods approach to data collection was used and included consultation with UNAIDS and IAPAC leadership, review of over 300 documents *(See Annex 4)*, and contact with 71 key informants, including 67 interviews by teleconference and four written submissions from key informants who were unable to talk by teleconference due to schedule conflicts *(See Annex 6 for information on key informants)*.

Findings

New and strengthened partnerships. Overall, the FTCP has led to new and strengthened partnerships in all 15 cities, including with local and national governments, civil society organisations, PLHIV networks, the private sector, academia, health care providers, and other stakeholders and partners. In all cities, high-level political support has been secured and civil society actively engaged in the HIV response. Respondents in all cities reported improvements in the coordination of the HIV response as a result of political leadership and commitment, new and strengthened partnerships, and the establishment of coordination structures such as steering committees and technical working groups that guide and track the response. Considerations for the future include increased engagement with civil society, as well as the need for continued work to align FTCP activities and approaches with city priorities.

Strengthened strategic information management and monitoring and evaluation activities. All 15 cities have engaged in activities related to the strategic collection, analysis, use, and reporting of key data on the HIV epidemic and response. At headquarters level, activities have begun in order to develop standardized epidemic profiles for each of the 15 cities together with a city database that can be used by relevant partners and stakeholders. The importance of data for advocacy and programming was recognized by all respondents. However, noted challenges include problems (in some cities) to access current data, particularly where governments are unwilling to share data that reveal service gaps, as well as in cities where data are collected by various implementers but not freely shared. Migration in and out of cities presents unique challenges for data capture and consolidation. Also noted was the need for focused capacity building for municipal monitoring and evaluation staff, particularly having greater capacity for analysing data at regular and frequent intervals to assess progress and make decisions towards 'moving the needle' on 90–90–90 targets.

City-specific dashboards featuring HIV coverage data and cascade estimates are available for all cities. In general, key stakeholders across sectors have found the dashboards to be useful as a source of city-level data on key HIV indicators as well as HIV services. The dashboards have improved accessibility of city-level HIV data and are seen by city leadership and other stakeholders as valuable. While some city dashboards are quite comprehensive with plans for further expansion, a few of the city dashboards are outdated (reflecting problems of data access, noted above), or are missing basic information (such as location and hours of operation for clinics). There is a need to amplify the availability of the dashboards, improve the user experience with the dashboards, and increase dashboard utilization.

Trainings for clinicians have been successfully implemented in all cities. In-person group, online self-directed, and webinar-based capacity-building trainings are ongoing and have continued (with some modifications) due to COVID-19. Trainings are perceived to be relevant, of high quality, and highly valued.

The breadth of content was also appreciated; in particular, informants cited the modules on adolescents and young people, LGBT, HIV, and aging, and noncommunicable diseases as being particularly valuable. Informants emphasized the value of partnering with local government, clinician professional groups, and other bodies to maximize the reach and value of trainings.

Trainings for HIV service providers to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities have been successfully implemented in all cities. A comprehensive, peer-reviewed, multi-language training curriculum focused on eliminating stigma and discrimination in health care settings has been delivered online, via tablet, and through in-person groups. While impact data are not yet available, respondents expressed a general sense that there is starting to be better comprehension of stigma and discrimination in health care facilities. Respondents stressed the importance of country/city-specific adaptations to the stigma mitigation trainings, even more so than for the clinical trainings. They noted the variability of localized contexts of stigma and discrimination, and warned against using a one-size-fits-all approach. Informants also advocated for more robust involvement of clients, PLHIV, key populations, and civil society.

Implementation of the Quality of Care Survey is underway in most cities and completed in one city. While analysis of the survey has begun in one city (Kigali), other cities are either preparing for or currently implementing the survey. Informants identified delays in the Quality of Care (QoC) survey process due to COVID-19. One site reported delays in recruitment as PLHIV receiving multi-month dispensing of ART due to COVID-19 no longer had a reason to go to their health care facility (where the survey was being administered). Other cities noted delays in the protocol approval process.

In addition to conducting the surveys, a total of 40 interventions, policies, and practices from nine cities were identified for inclusion in the Best Practices Repository, the goal of which is to identify, document, validate, and disseminate existing interventions, policies, and strategies that have been undertaken in Fast-Track Cities to increase the demand for and sustained use of HIV services in the context of urban HIV responses. The repository can act as a resource for city programme managers, health departments, implementers, advocates, civil society, and donors to better determine how to scale up programmes effectively and gain maximum benefit from resource investments.

Overall, UNAIDS and IAPAC activities were reported to be well coordinated and reported to have improved over time. These improvements were attributed to equity, mutual understanding, and communication between UNAIDS and IAPAC representatives. Although recognized broadly across informants that the UNAIDS − IAPAC partnership is continually strengthening at both headquarters and city levels, there remain differing ideas about the degree to which the project is perhaps too bifurcated between these two agencies. The need was identified to better ensure sharing of plans to increase harmonization of efforts and minimize duplication, and that increased focus and attention on these issues at the headquarters level could help to find ways for city-level partnerships to be maximally robust.

The COVID-19 pandemic has caused significant disruption in all 15 cities, including disruptions to HIV services, due to restrictions on movement, the shift in priorities for health care workers toward COVID-19, and the fact that health care workers themselves are at high risk for COVID-19. Despite such disruption, all cities have developed contingency plans that have allowed for the continuation of FTCP activities, with adaptations that are often quite innovative. Notably, FTCP also supported and contributed to larger contingency and recovery plans for the cities to mitigate the impact of COVID-19 and to ensure the continuation of HIV services.

Recommendations

1. Work to align FTCP activities and approaches with city priorities so as to foster buy-in from city stakeholders. For example, leverage relationships with other UN agencies and NGOs and fostering connections and communications that can be mutually beneficial in reaching shared goals.
2. Find value-added activities to foster collaboration with civil society, including PLHIV and key populations. For example, create fora to discuss issues affecting communities; invite community representatives and civil society organisations more consistently to meetings and conferences.
3. Develop briefing kits that explain the goals, objectives, and operations of FTCP to reduce lost time when there is turnover at government agencies and other stakeholder organisations. These could include written or multimedia material.
4. Identify a dedicated FTCP focal point at the city-level with responsibility for data.
5. Expand data collection at the municipal level to include other vulnerable populations (e.g., migrants, homeless persons, refugees, prisoners), or identify opportunities for data sharing if these data are available elsewhere. Explore harmonization of FTCP data with existing data on other relevant indicators

(e.g., maternal-child health, family planning, non-communicable diseases), in line with the spirit of UN multisectoral approaches.

6. Encourage increased data sharing amongst stakeholders across sectors (e.g., municipal, civil society, academic, international agencies such as PEPFAR and the Global Fund).
7. Consider whether and/or how to integrate city data from other available city- and national-level dashboards and online platforms, where available, in order to strengthen policy and decision-making, enhance political leadership and advocacy, and facilitate intra-city communications and collaborations.
8. Develop strategies for wider dissemination of and increased use of the city dashboards among all stakeholders. These can include working with key stakeholders to ensure they understand how to access and use the dashboards; taking search engine optimization (SEO) steps to maximize ease of finding dashboards in search engine results; and designing alternate ways to make dashboards more accessible, particularly for those who may not have access to electronic media (such as having “dashboard” kiosks or ways to provide written information in key locations throughout the city where people could access health information).
9. Develop non-financial ways to encourage participation in the capacity-building trainings, particularly in settings where training is readily available. For example, consider whether to have training certification count toward continuing education requirements.
10. Continually engage providers to poll them on important topics of interest for future training modules.
11. Engage PLHIV and members of key populations into some portion of the capacity-building trainings, where safe to do so, to facilitate bidirectional communication and promote mutual understanding. Also, incorporate a greater focus on the needs of children, adolescents, and young people with HIV into the capacity-building trainings, including issues of medication adherence.
12. Ensure there is the opportunity for thorough country/city-specific adaptations to the stigma elimination trainings to ensure they are locally relevant and impactful; involve clients, PLHIV, key populations, and civil society in such local adaptations.
13. Assess whether integration of Quality of Care survey efforts and findings may be advantageous in countries where existing stigma surveys are being conducted.
14. Focus more intensively at UNAIDS and IAPAC headquarters on greater harmonization of broad goals and objectives. Ensure that there is a true depth of shared mutual understanding of each other’s goals and objectives. Find mechanisms to enhance regular communication and cooperation at both global and city levels to operationalize the shared vision.
15. Create mechanisms that foster communication amongst FTCP partners across cities to share strategies and learn from one another. For example, set an expectation for formal and informal communications between and amongst city-level staff to engage and learn from one another (e.g., virtual meetings, phone calls, in-person meetings when possible).
16. Identify opportunities to work more closely with other agencies and sectors such as UN Women, UN-Habitat, and the International Labour Organization to improve gender equality and improve the health and wellbeing of both women and men; and with higher education institutions to address sexual and gender-based violence, sex work, and safe campus environments and to reach young men.
17. Determine how best to incorporate adaptations to FTCP activities developed in response to COVID-19 for the remainder of the project and to share useful adaptations with other FTCP cities.
18. Leverage FTCP expertise to help cities develop robust strategies for readiness for COVID-19, future pandemics, and other emergencies.
19. Document, monitor, and address capacity needs regarding data use, analysis, utilization, and training to ensure sustainability of core FTCP activities.
20. Collect lessons learned from FTCP to create a platform of best practices, and strategies to implement them that could be used by cities and municipalities around the world to adapt to their own HIV epidemics.

Background to the Fast-Track Cities Project

The Joint UNAIDS-IAPAC Fast-Track Cities Project (FTCP), launched in 2018, is a collaboration between UNAIDS and the International Association of Providers of HIV Care (IAPAC), supported by USAID, that aims to provide essential technical support to 15 priority high-burden cities to accelerate their HIV responses towards achieving key Fast-Track targets and delivering on the commitments of the *Paris Declaration on Fast-Track Cities Ending the AIDS Epidemic*.[1] The goal is to ensure that city stakeholders are enabled and capacitated to accelerate the HIV response, and that communities in cities, including people living with HIV (PLHIV), have access to an efficient, effective, people-centred, well-resourced, and locally appropriate HIV response, free from stigma and discrimination.

The 15 cities supported through the project include Blantyre, eThekwini (Durban), Jakarta, Johannesburg, Kampala, Kigali, Kingston, Kinshasa, Kyiv, Lagos, Lusaka, Maputo, Nairobi, Yaoundé, and Windhoek. Together these cities account for nearly three million PLHIV.

Strategic areas of work that are supported through this project include:

1. Supporting the coordination, development/revision, and operationalisation of city HIV strategic plans and processes;
2. Creating and strengthening an enabling environment for implementation;
3. Strengthening the availability, analysis, reporting, and use of strategic information on the HIV epidemic and response;
4. Building the capacity of care providers, communities, and other stakeholders to facilitate an effective and locally appropriate HIV response that is free of stigma and discrimination.

The six project objectives that underlie the above strategic areas of work are:

Objective 1: Optimizing HIV service delivery through promoting leadership, accountability, and impact in the HIV response, by strengthening critical partnerships, creating an enabling environment, and supporting the development and/or implementation of robust city HIV strategic plans. Also supporting innovative or catalytic interventions that may be scaled up and fully funded from domestic or donor resources.

Objective 2: Supporting cities to collect, analyse, and report strategic information and data on the HIV epidemic and response, and to use the information to track progress and to guide the response.

Objective 3: Developing city-specific dashboards featuring HIV service coverage data, progress towards optimizing treatment and prevention continua, and data on HIV-related comorbidities.

Objective 4: Strengthening the capacity of clinicians and PLHIV in the respective cities to achieve and maintain optimal HIV prevention and care continua, leading to attaining the 90–90–90 targets.

Objective 5: Strengthening the capacity of HIV service providers in the respective cities to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities.

Objective 6: Assessing quality of care (QoC) perceptions among PLHIV in Fast-Track cities and facilitating the sharing of best practices.

The FTCP developed from a larger Fast-Track Cities Initiative (FTCI), launched in 2014 in collaboration with four core global partners—UNAIDS, IAPAC, the City of Paris, and the United Nations Human Settlements Programme (UN-Habitat). The larger initiative recognizes the critical role that cities play in fast-tracking the HIV response and achieving the United Nations Political Declaration goal of ending AIDS by 2030.

Political mobilization, together with strong leadership and commitment, has resulted in more than 300 cities and municipalities around the world having signed the *Paris Declaration on Fast-Track Cities Ending the AIDS Epidemic*,[1] and pledged their commitment to:

- Ending the AIDS Epidemic by 2030;
- Putting people at the centre of the AIDS response;
- Addressing the causes of risk, vulnerability, and HIV transmission;
- Using the AIDS response for positive social transformation;
- Building and accelerating an appropriate response to local needs;
- Mobilizing resources for integrated public health and development;
- Unite as leaders, working inclusively and reporting annually on progress;

as well as pledging their commitment to achieving the 90–90–90 targets – that by 2020:

- 90% of all people living with HIV will know their HIV status;
- 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART);
- 90% of all people receiving ART will have viral suppression.

The 15-city FTCP is being implemented in the context of larger and more comprehensive city initiatives, and in close collaboration with relevant local and national stakeholders and partners. Work plans and activities included under the project are aligned to existing national, district, and/or municipal HIV-related plans, and consider programmes supported by PEPFAR, the Global Fund, and other partners and stakeholders.

UNAIDS is responsible for the overall management and reporting on the joint project, however, both UNAIDS and IAPAC monitor the activities linked to their respective objectives. Consolidated programmatic and financial reports on the implementation and progress of the project are sent to USAID semi-annually and activity updates are submitted to USAID monthly. UNAIDS-led activities at city level are coordinated by UNAIDS Country Offices. IAPAC-led activities at city level are coordinated by IAPAC city programme officers (CPOs) in each of the 15 cities.

Approach

Purpose of Review

This FTCP review is intended as a mid-term exercise that takes stock of progress overall and by project objective in the participating 15 high-priority cities around the world, representing high-HIV burden areas in sub-Saharan Africa, Eastern Europe, Asia, and the Caribbean. It seeks to understand the perspectives of a diverse group of global and local stakeholders involved in the HIV response in each municipality; highlight positive developments and best practices from the first three years of the Project (2018-2020); and provide constructive feedback to UNAIDS, IAPAC, and municipalities on overcoming challenges and barriers that will enable continued progress through 2022. It also seeks to understand the impact of COVID-19 on the HIV response and project activities, address programmatic gaps, and identify key areas for collaborative efforts to contain and mitigate both pandemics.

Methods

The evaluation team (*See Annex 7* for bios) used a mixed-methods approach to data collection so as to triangulate sources to inform the review of the FTCP with respect to its strengths, challenges, and innovations. Data sources were:

Document review. A comprehensive review of over 300 documents was completed, including city-level project plans, budgets, and reports; HIV data, Fast-Track cities progress reports, and other relevant documents that provided structural context for the project objectives, goals, and implementation. Global- and city-level documents were made available by UNAIDS and IAPAC and were supplemented with other publicly available materials. *Annex 4* provides a full list of the documents reviewed.

Key informant interviews. A total of 71 key informant (KI) interviews with stakeholders were conducted at the global and city level, including at least three interviews in each city including representatives from UNAIDS, IAPAC and representatives from the municipal government and/or civil society organisations and/or the Global Fund. Interviews were conducted using interview guides (See *Annex 3*) based on FTCP's Theory of Change *(See Annex 1*) and an Evaluation Matrix *(See Annex 2)* and reviewed amongst consultants daily to incorporate additional insights or areas of further inquiry that emerged over the course of fieldwork. Interviews were audio-recorded, with participant's permission, transcribed, translated to English (where necessary), analysed using an iterative rapid assessment framework.[2] A tally and breakdown of the key informant interviews is provided in *Annex 6*.

Key Informant Contact (Email). Consultants initiated contact with a slate of suggested KIs provided by UNAIDS and IAPAC by email. The email included an introduction to the consultants, the scope of the review project, a statement regarding confidentiality, and a letter of introduction from UNAIDS.

Key Informant Interviews (Virtual). The consultants conducted semi-structured, in-depth interviews with a purposively selected sample of UNAIDS- and IAPAC-identified stakeholders at the global level (UNAIDS and IAPAC), and with three to seven individuals in each of the 15 cities with: UNAIDS Country Directors and Advisers working on FTCP, IAPAC Consultant Program Officers (CPOs), Global Fund Portfolio Managers, and other key stakeholders including national health authorities (e.g., from MoH or national-level HIV/AIDS coordination), city authorities in charge of HIV/health programmes, and civil society/community representatives inclusive of key populations and PLHIV.

Two interview guides outlining the domains of inquiry were developed for this review— one for city-level KIs and one for global-level KIs (*see Annex 3*).

KIs were interviewed via teleconference using Zoom, Microsoft Teams, or telephone, by one to two consultants. Interviews lasted approximately one hour each. At the beginning of each interview, KIs were provided with a brief overview of the purpose of the interview and assured that anything discussed in the interviews would be anonymised and not be attributable to a specific individual. It may be possible to attribute comments to specific constituencies in an aggregate form. In four instances, KIs were unable to speak via teleconference and provided written responses to interview questions by email; email correspondence to KIs included the information on confidentiality. Interviews were audio recorded with permission of the KI; KIs were informed of their right to opt out of audio recording.

Field notes, combined with transcripts, served as the primary data for the review.

Audio recording files were destroyed following completion of the edited field notes and corresponding analysis.

Anonymised field notes were stored as documents in a secure project database and indexed for thematic analysis. Analytic themes were based on the FTCP Theory of Change, Evaluation Matrix, and Interview Questions (*See Annexes 1, 2, and 3, respectively*).

Limitations

The following limitations to this review are highlighted:

Reliance on web-based or telephonic interviews. All interviews were conducted via web-based video conference or telephone. Overall, this approach was sound; interviews were scheduled at times convenient for participants while also feasible for the evaluation team members (based in the United States, Canada and France). Due to COVID-19-related constraints that have affected populations worldwide, most KIs participated from their homes by necessity. In some cases, network connectivity was difficult, requiring repeated re-connections and general communication strain, or poor audio quality due to poor connection or environmental noise. Ideally, the evaluation would have included on-site visits that would better enable a full assessment. However, this evaluation was initiated during worldwide restrictions due to COVID-19.

Participant selection and response. The list of potential respondents was provided by FTCP partners. As such, there was the potential for bias in the sampling approach. However, the lists provided included a broad representation of stakeholders including those who were directly and indirectly involved in the FTCP. Further, there is the potential for bias in the content of responses due to an inherent conflict of interest, especially for those who are most directly involved in the FTCP. We sought to minimize those potential biases by ensuring anonymity; within this report we do not attribute quotes to specific individuals, organisations or cities. We invited 125 individuals to participate in the review, 71 responded (57% response rate). We had a particularly difficult time getting responses from government officials. It should be acknowledged that many government officials were very busy with their city's COVID-19 response. It is possible that those who did not respond hold views that are divergent from those who were included.

Timeline for the evaluation. The time required for data collection, analysis, and reporting was very limited. Scheduling and coordinating with respondent's busy schedules, especially given that many were also involved in the COVID-19 response, was challenging. We sought to minimize this challenge by scheduling interviews with great flexibility. This was also made possible by our team with a broad range of scheduling options.

Lack of denominators for number of providers trained. While data were available and are reported here on the number of providers trained in clinical capacity building (Objective 4) and stigma elimination (Objective 5), the denominators (total number of clinicians and other providers in the communities) were not readily available.

Despite these limitations, the review has generated a robust set of findings, a set of clear conclusions, and has presented targeted recommendations for the FTCP senior management team and representatives at country and city levels to consider.

Findings

A total of 125 individuals were invited by email to participate in the review. A total of 71 accepted the invitation, 67 of whom were interviewed by teleconference and four of whom responded by email. A detailed tally and breakdown of the key informant interviews is provided in *Annex 6.*

Objective 1

Optimizing HIV service delivery through promoting leadership, accountability, and impact in the HIV response, by strengthening critical partnerships, creating an enabling environment, and supporting the development and/or implementation of robust city HIV strategic plans. Also supporting innovative or catalytic interventions that may be scaled up and fully funded from domestic or donor resources.

Findings

"If I were to judge this initiative on one factor alone, the catalytic effect is tremendous".

High-level political support has been secured and sustained for the FTCP work, despite changes in leadership in several cities, and projects have been implemented under the leadership of local and/or national authorities. City leadership has played a particularly important role during the COVID-19 outbreak to ensure the continuation of HIV services at local and national levels. For example, the mayor of **eThekwini (Durban)** has appointed an AIDS Coordinator to coordinate the multi-sectoral response in the city. Political leaders in **Lusaka** have started to allocate additional resources to the HIV response. The mayor of **Windhoek** has recommitted his support for FTCP and is encouraging other cities in Namibia to also accelerate their responses.

In response to a question *"What accomplishment to date are you most proud of?"* one respondent stated:

"Oh, the big one is to have the mayor of Maputo City signing the Maputo City declaration with the UNAIDS Executive Director, with the Minister of Health of Mozambique, with the Governor of Maputo City, they signed the Maputo city declaration. They owned that declaration, and it was based on that declaration that Mozambique formalized the 90–90–90… Maputo City said, we can do it, as a city. And based on that the Minister of Health just took it from there. For me this is really an example of how a city can influence bigger decisions."

The FTCP has led to new and strengthened partnerships in all 15 cities, including with local and national governments, civil society organisations, PLHIV networks, the private sector, academia, health care providers, and other stakeholders and partners. In **Windhoek**, the partnership between city authorities and civil society organizations has led to the implementation of joint activities and improved support for key population interventions.

"We work as a family, as a unit, to achieve the objectives."

Civil society has been actively engaged in the HIV response in all 15 cities. In **Johannesburg**, for example, the civil society organization Men Sector has supported two campaigns: A "Welcome Back" campaign to encourage men to test for HIV, and enroll and stay on treatment; and a campaign against gender-based violence. In several cities, partnerships have also been strengthened with faith-based leaders (**Lagos**), and academia (**Blantyre, Kinshasa**). Civil society has been critically important in all cities in ensuring the maintenance of the HIV response during the COVID-19 pandemic.

"We really appreciate how the network of people living with HIV are involved in the project… we appreciate very much the collaboration and coordination of the units as at any level, any circumstances, we are called to give our perspective, we are called to give our point of view so that we improve this programme."

Private sector engagement has occurred in several cities, including **Jakarta, Lagos**, and **Yaoundé**. In **Jakarta**, a situational analysis on the impact of HIV, a business case for HIV programmes in the workplace, and a private sector engagement strategy were developed to be used as advocacy materials to enhance HIV policy in the workplace. In **Lagos**, the private sector was actively engaged to support people living with HIV during the COVID-19 pandemic. In **Yaoundé**, a private sector task force has been put in place to work closely with the International Labour Organization (ILO).

In general, partnerships with USAID/PEPFAR were reported to work quite well at local levels. Regular coordination with USAID Country Missions appears to ensure alignment of PEPFAR work plan priorities and that strategic value is added. It was reported that some city authorities now have seats on PEPFAR committees.

Coordination of the HIV response has improved in all cities. Respondents in all cities reported improvements in the coordination of the HIV response as a result of political leadership and commitment, new and strengthened partnerships, and the establishment of coordination structures such as steering committees and technical working groups that guide and track the response. In several cities, city representatives are now also engaged in national-level activities such as the development of national HIV strategic plans and participation in national structures overseeing the HIV response. Informants spoke about the importance of the process of coordination and the relationships involved.

> *"I feel very strongly about this - the process, it's as important and critical as the result itself. Once you have a good and right process that leads you there it's very important because you can get the result. It's in the process where we get the commitment and the ownership."*

City strategic plans have been developed and are in place guiding the HIV response in 12 cities; five of these cities (**eThekwini (Durban), Johannesburg, Kampala, Lagos,** and **Nairobi**), are in the process of updating/revising their strategic plans. Strategic plans in three cities (**Blantyre, Kingston, and Maputo**) are in development.

Advocacy and community outreach activities, including to key populations, innovative interventions, and capacity building activities in several cities including **Jakarta, Johannesburg, Kigali, Kinshasa, and Nairobi**, have reached large numbers of key populations and other vulnerable populations and have resulted in improved uptake of services. For example, an HIV chatbot platform developed in **Jakarta** has reached over 6,300 young people (mostly MSM) and HIV testing efforts in four sub-counties in **Nairobi** increased the number of key populations newly tested from 307 in 2018 to over 20,000 by June 2020.

Activities and lessons learned in several cities have been used to inform national processes. For example, in **Lusaka**, representatives from the city are now engaged in the development of the National Strategic Plan. Lessons learnt and best practices in **Nairobi** have been rolled out to four additional cities in Kenya. In **Yaoundé**, the results and lessons learned from the FTCP have been incorporated into the next Global Fund proposal and the update of the National Strategic Plan for HIV/AIDS (2020 - 2023).

Innovative approaches to increase the uptake of services amongst key populations and other vulnerable populations have been developed in several cities. A few selected examples are provided below.

In **Jakarta**, *Tanya Marlo* ("Ask Marlo") is an artificial intelligence (AI)-driven chatbot developed to reach key populations, particularly young MSM. Created in partnership with Nimbly Technologies using the existing LINE messaging app, *Tanya Marlo* provides simulated conversations about HIV advice, connections to online (human) counsellors, and referrals to HIV testing, treatment, and care services. The platform provides options for young people to get information and support in ways that work best for them and is being updated to include information on COVID-19. Through September 2020, it had reached more than 6,300 young people. The platform has been transitioned to a local civil society organization to ensure its sustainability. It will be useful to assess what will be required to reach scale with this innovation.

In **Kinshasa**, the *Landela* platform was developed to improve paediatric HIV services. The platform uses a unique identifier with fingerprint and QR code to reduce double counting and improve patient follow-up. It continues to be expanded throughout Kinshasa and has also been implemented in four other large cities in the Democratic Republic of the Congo (DRC).

In **Nairobi**, strategic capacity building activities with key populations and young people in informal settlements led to a significant increase in service uptake. Between 2018 and June 2020, HIV testing uptake amongst young people increased from 6,631 to 11,697; family planning uptake amongst new clients aged 10-19 years increased from 1,507 to 22,412; and the number of health facilities offering integrated services to key populations and young people increased from zero to five. The number of key populations newly tested also increased from 307 in 2018 to 20,661 by June 2020 in the four targeted sub-counties.

Turnover of personnel at all levels of stakeholder agencies and local government is a continual challenge. Although progress has been made toward FTCP objectives in all cities despite this phenomenon, time is lost because of needing to "start over" with agencies when this occurs. The issue was raised as to whether there could be ways to develop "briefing kits" (written, online, video, via media partnerships) that could be shared with incoming government and other stakeholder personnel to reduce the time it takes to re-engage them.

"And one of the key results of that would be to have this multisectoral plan, which we still have not finalized. We had a couple of changes at the municipality which sometimes also delays. Because you have to start over with new people, you have to start new negotiation. So that's one of the challenges that we have - the turnover of people."

To achieve 90–90–90, it is imperative to invest in and support the capacity of **key populations and communities**.

"...there are some very important communities, let's say the transgender community and some women living with HIV. They don't have the capacity to voice their needs and to participate in all these important processes. And also, to reach their own communities, like for transgender people, the only way we can really have access to these communities is through transgender people themselves. But we, as a response, up to this point we ... use them … to do HIV testing and expand testing. ... but that's not the right approach, unless we build their own capacity and then empower them to get to their communities. But just using them to get them tested, for whatever our goals are, it doesn't work. We need to support them to build their own way of reaching their peers. And that cannot be just without investing into these communities. I hope that we'll be doing this through the Global Fund in the coming round, but if not, I think that's also one thing that probably FTCP can support because nobody is supporting this community. I mean, no one, like PEPFAR, is not investing. They're investing in the treatment sites and Return to Care Campaign … but not in the communities. But without the communities we can't really reach the people we want to reach. And nobody wants to spend on working and building the capacity of communities because it's a long and tedious process."

Civil society respondents consistently expressed the **value of the FTCP and their connection to it, but also the need for greater engagement**.

"And we really appreciate that they understand us like the Coordinating Board of people living with HIV, and also the respect the instruction towards elimination or linking decrease of stigma and discrimination and the community. And also, we appreciate the value that the programme itself gives to beneficiaries."

Several respondents felt that PLHIV are too often left out of conferences, meetings, and other fora, and emphasized the value of their consistent inclusion.

"…we really need to have capacity building on what organizations should know about FTCP objectives… so that we can implement knowing that we are also monitoring the programme cycle."

Challenges arise when there are divergent or competing priorities between municipalities and FTCP priorities. It was apparent in conversations with informants that municipal buy-in to FTCP priorities across cities is variable. For some mayors there is limited interest in projects that do not address pressing structural issues such as unemployment, malnutrition, housing, or crime.

Concern for sustainability. The issue of how to plan for and ensure the sustainability of FTCP activities and the endeavour as a whole was brought up extremely frequently across cities, types of respondents, and objectives.

"In its current state, FTCP is a beautiful initiative that seriously risks ending definitively at the project's term. What we really want is to make it sustainable and to remain in perpetuity."

"Of course, in terms of sustainability, we always try with the government to make sure that despite the global solidarity, we make sure that the government is putting more resources for the sustainability. So, this is where we have a lot of challenges, because of competitive agendas of the government. Now, with the COVID, we see that tomorrow, resources of health are allocated to COVID. And we are trying now… to advise the government together with the U.S. government, particularly USAID and PEPFAR...we are part of the countries, we reached 90–90–90. Now the question is how we sustain it, how we can help [municipalities] to develop a sustainability framework."

Objective 1 - City Status Table	
City	**Status of Objective 1 Activities**
Blantyre	The city strategic plan and implementation plan are currently under development, and commitment for the project has been secured from Blantyre City Council, the main implementing partner. Collaboration between the District Health Office and City Council have improved significantly. A mapping exercise of HIV service providers has been completed and will inform the development of the strategic plan.
eThekwini (Durban)	The coordination of the HIV response in the city has been improved through a newly appointed AIDS Council Secretariat in the Mayor's Office. The District AIDS Council Functionality Assessment and gap analysis and update have been completed and have revealed important gaps in the response and focal areas for impact. Relevant stakeholders have been brought together through FTCP activities and are functioning in a more coordinated and collaborative way around a set of common goals. UNAIDS and IAPAC have also been able to use FTCP as a platform to engage city leaders in the HIV response.
Jakarta	The innovative online *Tanya Marlo* ("Ask Marlo") chatbot, which provides comprehensive information about HIV to young people, has reached over 6,300 young people. Management of this initiative was transferred to a civil society organization to help ensure its sustainability. Private sector engagement efforts are ongoing and a situational analysis on the business case for HIV programmes in the workplace and private sector engagement strategy have been developed. The development of the acceleration plan, with targets, is underway and implementation will be initiated by the Ministry of Health with support from development partners.
Johannesburg	Continued leadership has been secured for the FTCP work despite the recent change in local leadership. The new Mayor of Johannesburg was introduced to the FTCP, resulting in continued engagement of the city health authorities. An annual multi-sectoral implementation plan has been developed, and a new one that will cover 2020-2030 is under development by a consultant. The FTCP work plan will be aligned to this. Active engagement of civil society through the men's sector.
Kampala	The participation of city political leaders in the supervision and monitoring of HIV/AIDS and TB services in Kampala has improved significantly through leader's accountability forums and supportive supervision visits. Compliance of implementing partners to account for their support towards HIV/AIDS and TB services has also been strengthened. A rapid assessment of the Kampala Capital City Authority HIV and AIDS Strategic Plan has been conducted and a draft report is available. This assessment will guide the development/review of the new plan for 2021-2025, in line with the National Strategic Plan.
Kigali	The city of Kigali developed a 5-year Strategic Plan in 2018 that is guiding the city HIV response. Stakeholder annual review meetings have been held in three districts to improve accountability and the integration of HIV activities into the annual planning report for the City of Kigali. A legal aid support desk and toll-free line have been established to facilitate access to legal aid for key populations who are victims of violence. A social behavior change campaign was launched with a focus on prevention of HIV infection, eliminating stigma and discrimination, and strengthening strategic partnerships, especially as it relates to key populations.
Kingston	The development of the city implementation plan is underway; however, it has been delayed due to competing priorities of health managers, at both the national and local levels, and an increase in workload associated with the COVID-19 pandemic. Technical support has been provided to the Ministry of Local Government and Rural Development for the review of shelter policies and standard operating procedures to improve the management of HIV and other health-related issues among the homeless. Final drafts of the situational analysis on the HIV epidemic and the directory of HIV services in the city have been submitted to the Steering Committee.
Kinshasa	Pediatric treatment has improved in the city of Kinshasa with the involvement of the local NGO "La Main sur le Cœur" and the rollout of the *Landela* platform in hospitals, including maternity hospitals. Technical and financial assistance has been provided to the Union Congolaise des Organisations des Personnes vivant avec le VIH (UCOP+) for the development of an advocacy plan for civil society on

	access to HIV and TB services in the context of health crises. A report on barriers to accessing HIV services has also been completed and validated.
Kyiv	Kyiv has received strong political leadership, commitment, and support, in particular from the mayor of Kyiv, to advance the HIV response, and has advocated for other cities in Ukraine and Eastern Europe to join the Fast-Track Cities Initiative. UNAIDS and the Kyiv City Public Health Center signed a Memorandum of Mutual Understanding and Cooperation in September 2020 in order to join efforts for the implementation of the FTCP activities.
Lagos	The coordination of HIV service delivery programmes has significantly improved in the city, together with information sharing among partners. Services provided by partners have also become better aligned; there has been less duplication of services, and resources have been used to address gaps. The high visibility of HIV programmes encouraged the city government to release funds to the Lagos State AIDS Control Agency and Lagos State Ministry of Health. The COVID-19 pandemic resulted in the development of an HIV/COVID-19 contingency plan to address HIV related issues, strengthening of private sector engagement, and a collaborative synergistic approach to retaining clients in care.
Lusaka	The city developed an FTCP action plan to guide its response and facilitate coordination among the various HIV implementing partners operating in the city. There has been improved coordination and collaboration among the various implementing partners due to the multi-sectoral convening arrangements established through the FTCP Steering and Technical Committees. Political leadership and management of Lusaka City have understood and appreciated their unique coordination role in the city's HIV response and have consistently been allocating part of their own limited resources to the HIV response in their past two annual budgets. Lusaka city now has representation in several national structures.
Maputo	The terms of reference for a consultant to help develop Maputo's FTCP multi-sectoral plan has been developed. Capacity building activities for civil society organisations strengthened their ability to meaningfully engage in the development of various mechanisms (e.g., National HIV/AIDS Strategic Plan, Global Fund proposal, Country Operational Plan 2020). The platform for the PLHIV constituency has also been reactivated, resulting in improved coordination and a stronger voice for this population. Traditionally, city leadership has not had a clear role in the HIV response, with all responsibility being assumed by the Provincial AIDS Council. However, during the COVID-19 pandemic, the city has taken on a larger role and engaged in activities to specifically support PLHIV.
Nairobi	The number of adolescent and young person-friendly health sites and sites offering integrated adolescent and young people and key population services in informal settlements has increased, and has led to an increase in service uptake, as a result of the project. Coordination of the project continues to be improved and monitored through joint review meetings and Nairobi City Council supervisory/monitoring activities.
Windhoek	Strong political commitment and support has been obtained from the city leadership, who has also encouraged other cities to accelerate their HIV responses. Establishment of a functional FTCP steering committee composed of diverse stakeholders has strengthened the coordination of the HIV response. Improved partnerships between HIV implementing entities, line ministries, civil society, and other local authorities has also had a positive impact. A midterm review of the city strategic plan had commenced to assess implementation progress.
Yaoundé	Political commitment and leadership from all seven municipalities have been mobilized and active coordination mechanisms have been established between the municipalities. Lessons learned from the FTCP response have been incorporated into the updated National Strategic Plan and the Global Fund concept note and have guided the response to COVID-19. Collaboration between the municipalities and civil society organisations has been significantly strengthened.

Objective 2

Supporting cities to collect, analyse, and report strategic information and data on the HIV epidemic and response, and to use the information to track progress and to guide the response.

Findings

All 15 cities have engaged in activities related to the strategic collection, analysis, use, and reporting of key data on the HIV epidemic and response, with corresponding strengthening of strategic information management and M&E in all cities. In **eThekwini (Durban)**, M&E activities at the facility level have started, following the training of M&E staff from 30 facilities in District Health Information System (DHIS) data validation and the use of analytical tools. In **Jakarta**, the government is beginning to use data generated by FTCP in presentations. In **Kyiv**, a data collection and reporting mechanism for HIV has been developed, in the absence of a national mechanism, to help strengthen data collection and reporting in the city. In **Lusaka**, the newly established M&E unit—the first of its kind in the city—has been capacitated and is fully functional, making programming more targeted and potentially effective. In **Maputo**, data are used to better understand the **specifics** and the treatment cascade in different districts, thereby increasing efficiency of service delivery. In **Nairobi**, granular data and qualitative assessment exercises have been utilized to plan and prioritise programmes.

Other selected noteworthy accomplishments have included calculating key population size estimates in **Jakarta**; updating the district profile in **Johannesburg**; finalizing data maps and a situational analysis on the HIV epidemic and response in **Kingston**; validating HIV programme data for local government areas in **Lagos**; and analysis of "Know Your Epidemic and Response" in **Maputo**. Additionally, in **Lagos**, medical doctors at health facilities have been trained on the importance of data management and use. Also, in **Lagos**, FTCP partners are working with traditional birth attendants and private facilities to ensure that pregnant women get tested and counted.

Activities have begun in order to develop standardized epidemic profiles for each of the 15 cities together with a city database that can be used by relevant partners and stakeholders. In **Blantyre, eThekwini (Durban), Jakarta, Johannesburg,** and **Kampala**, HIV epidemic modelling (using Spectrum, Thembisa, and the Asian Epidemic Model) has been finalized and estimates produced. **Lusaka, Maputo**, and **Nairobi** had also completed modelling exercises in 2019. Estimates and projections will be used to inform programme planning and to guide decision-making.

FTCP partners recognize the importance of data for advocacy and programming.

> *"We are hoping that when we will have the data we can make a case saying that 'look at the trend of the epidemic in a community because we are not giving them the services'."*

Some governments are unwilling to share data when these show gaps. FTCP representatives frequently noted that is it often difficult to get agreements from the government to share data, in part due to concerns about revealing programme gaps or challenges to the public. This makes it difficult to extract sub-national level data from the system, which then hampers the development of city dashboards.

> *"When we started the Situation Room data visualization [i.e., a national software platform designed to support decision-making on countries' health responses], some of the government did not want to have the data going on air, they wanted to have some restrictions on access. I realized they don't want to make it quite public, they wanted to limit it to certain partners, except analysed data like UNAIDS publishes in the global report, because in the electronic era, when everybody's working together, they are more willing to share the information where they are making good impact. And that's what our advocacy entry point is also, to convince them to do better, because then you will have better data, showing more impact of your intervention means you will be happy to share with others, but while there are critical gaps, and then certainly they want to hide it."*

Data often sit in different places, making access difficult. Data are often collected by various implementers but not always shared freely. In **Johannesburg** there is considerable effort through the project to compile and consolidate data, including key population data, that are being collected by the various implementers and to make those data available to municipal authorities to help guide planning and programming.

Municipal boundaries can present challenges for measurement. For example, in Maputo, peri-urban areas (such as Matola) are not officially part of the city, but people move back and forth and get services in both**. This** has implications for HIV transmission and service provision, but also data capture and consolidation**.**

"We capture the data from the health facilities, but if we look at where people live, many might be having treatment in Maputo city, but they live in Matola. Because they're working in the city … it's easy for them then go back in and go to work. It looks like the city with a high number of people and treatment compared to Matola. But it's just because people from Matola are also getting treatment in Maputo city."

There is a need for more capacity building for municipal staff (e.g., monitoring and evaluation staff) so they can effectively analyse data, especially at regular, frequent intervals to assess progress and make decisions to 'move the needle' on goals. Having these skills will also help to ensure continuation of activities beyond the end of the project period.

"We should invest in capacity building and particularly on data. But also, when we invest in capacity building, we have to always link to the data back where the data are stored at the national level. Because in HIV, whether we like or not, the entire data is managed and is stored by Ministry of Health. They are the custodians and without having them engaged or convincing them that they have to work with the local authorities on data, it's difficult. So, we have to invest in both areas. Having said that, for me if the local authorities are fully on board in collecting, generating as well as utilizing the data, then the system itself will link them with the Ministry of Health or the DHS system. Through the [National] Situation Room platforms they [municipalities] can see their data and they can use it for their programming as well as for advocacy. And we need to really support them with the electronic data system."

There is a need to promote stronger "ownership" of city-level data within municipalities, in terms of both data quality and utilization, independently from the level at which data are analyzed/produced.

"I think what we have to improve is that this data—although produced at central level—are also owned by the city, so that the city can also move with data that is related to the city."

Data collection, analysis, and use at city level could expand to include other populations and indicators. Examples suggested by informants included data on migrants, homeless persons, refugees, and prisoners; metrics focused on HIV care/ART follow-up, primary care, family planning, maternal and child health; and tracking of civil society involvement, which was seen as a way to bring greater precision to the HIV response. In some cases, data may already exist (such as for migrants and on primary care metrics), and there can be a focus on more strategic sharing and use of existing data.

"Our bucket is leaking with respect to loss to follow-up of people on treatment for very vulnerable populations, highly mobile groups—e.g., migrants, refugees—data on these groups are very challenging to collect."

"For the key populations, to understand their behaviour, to understand the prevalence and to understand incidence, it has been a very, very difficult conversation."

"We assume what the [HIV-related] *problems are in communities, but greater analysis and measurement could help to inform programmes."*

Identifying additional outside funds could provide value-added benefits. Respondents identified several ways that additional resources could be directed to accelerate progress on FTCP goals and objectives. These included systems to make data sets available, to encourage data analysis by stakeholders (e.g., academic researchers), supporting electronic medical record systems in facilities (instead of the paper-based systems or patient-held medical record cards that many facilities currently rely on), increasing the number and capacity of data entry clerks at health facilities, and improving the capacity of municipalities to do more frequent data monitoring.

Some cities face challenges due to the **lack of essential IT equipment, poor telecommunications infrastructure**, and/or expensive costs for data/bandwidth that can make communications and participation in virtual trainings difficult.

"Cities [all levels] need the computer equipment and network connections to perform basic data collection tasks, they are currently under equipped. At the level of the cities the resources are really non-existent."

Issues of Sustainability. Respondents consistently raised the need to focus on planning for transition to a sustainable model, and some of the challenges in doing so (e.g., political will, ongoing communication, and coordination to ensure continued momentum, resources for staff and activities required for a sustained response).

"But what our time is now mostly mobilizing communities for the data management, data gathering, as they will actualize analysing and advocacy for them. So, we are also part of the community led response, we have also started now, including the statistic information and evidence from the communities, mobilizing communities. So that will complement certainly and that will also help the local government realize how important to have the data analysed by themselves. So, we are making the politicians more accountable to the people by sorting through the evidence in the [National Health] Situation Room, we have supported those cities' leadership with the equipment, the computers, and the Situation Room platform training, and all the support from our side for them to be equipped on utilizing some of the data, but actual generation and really managing the entire data by themselves is underway. So, yeah, it is in a more sustainable way, but it is not moving as fast as we wanted to see."

Objective 2 – City Status Table	
City	**Status of Objective 2 Activities**
Blantyre	Though HIV data collection has been challenging for Blantyre City, epidemic modelling has been conducted and the results will be used to inform the city's HIV response.
eThekwini (Durban)	The capacity of eThekwini District Health's HIV/AIDS, STIs, and TB M&E system has been strengthened through capacity assessment, staff training, and the development of draft epidemic estimates. A 'nerve center' has also been created to enable better tracking of treatment adherence, loss to follow up, and other factors affecting the 90–90–90 cascade.
Jakarta	Strategic information on the HIV epidemic and response has improved. The development of sub-national-level data on key population size estimates has contributed to strengthened targeted HIV programming. The development of strategic information tools will help to guide and inform target setting and national- and city-level HIV responses.
Johannesburg	City HIV/AIDS profiles, maps, epidemic modelling, and a key population database have been developed. This information has assisted in the identification of gaps and improved targeting of city resources, which has contributed to substantial increases in the number of people being tested and on ART. A 'nerve center' has also been created to enable better tracking of treatment adherence, loss to follow up, and other factors affecting the 90–90–90 cascade.
Kampala	District-level epidemic estimates have been created and will inform the programme development and implementation. A monitoring and evaluation plan that addresses improvements in project implementation, data management, and dissemination is in development.
Kigali	Data collection and analysis efforts have been undertaken to improve the HIV response. A report on HIV and aging found that the HIV burden in Kigali is shifting to older age groups. A baseline study was also conducted on the association between substance abuse practices and HIV infection among PWUD/PWID to improve the response for this population.
Kingston	Strategic information products have been developed, including a city health profile, HIV service directory, health data maps, and a situational analysis on the HIV epidemic and response.
Kinshasa	The availability of strategic information on the HIV epidemic and response has been improved and will help guide the city's HIV response. Key outputs include the

	availability of disaggregated data by health zone, the development of epidemiological profiles, and a study on barriers to accessing services.
Kyiv	Kyiv Public Health Center's M&E capacity has been strengthened through the support of the project's technical assistance and advice, and the city HIV programme includes an M&E framework with key strategic information indicators. The city's HIV data flow is now regulated by an appropriate algorithm, which can improve HIV data collection and reporting in the absence of a national mechanism. Data was also collected on stigma and discrimination and patterns of local drug use to strengthen programming and services.
Lagos	A mapping exercise of health facilities that provide HIV services was conducted and provided insight into referral services system improvements and service underreporting. The city also conducted an HIV programme data validation exercise in all 20 local government areas.
Lusaka	An M&E unit has been established in the planning department to coordinate data processes and oversee progress in the implementation of the HIV strategic plan. This is a first for any city in Zambia. The availability of strategic information has been strengthened through the collection of targeted age and gender disaggregated data and the development of an epidemic profile, a situational analysis, and epidemic modelling.
Maputo	Strategic information on the epidemic has been strengthened through epidemic modelling, development of "know your epidemic/know your response" profiles, prevention score cards, and prevention maps.
Nairobi	Priority setting and decision making has been significantly strengthened through the production of granular level data, service delivery assessments, and epidemiological profiles.
Windhoek	An M&E framework has been developed to monitor implementation of the strategic plan. The City is working closely with the MoH M&E department and UNAIDS to share and use data for policy and programme planning.
Yaoundé	Data collection has been expanded and improved. HIV estimates, epidemiological profiles for each of the seven municipalities, and a mapping of key populations and "hot spots" are now available and reported on the city's dashboard.

Objective 3

Developing city-specific dashboards featuring HIV service coverage data, progress towards optimizing treatment and prevention continua, and data on HIV related comorbidities.

First launched at the 21st International AIDS Conference (AIDS 2016) in **eThekwini (Durban)**, a web portal has been developed with 'dashboards' presenting 90–90–90 targets and relevant progress for HIV care for Fast-Track Cities (https://www.fast-trackcities.org/dashboards). The dashboards have been designed to serve clinicians, the public health community, affected communities, and the general public by presenting any or all of the following 10 domains:

- Visualisation of key data on the HIV epidemic and response, including trend data;
- Progress against 90–90–90 targets;
- Location of HIV services;
- Highlighting community advocacy through key leadership messages;
- Fundraising efforts;
- Resources and/or trainings;
- Best practices.

The expectation is that the dashboard will be used to:

- Facilitate inter-city communications and collaborations;
- Strengthen policy and decision making;
- Enhance political leadership and advocacy.

Dashboard data for the 15 FTCP cities is provided in *Annex 5*.

Findings

Dashboards have been made publicly available for all 15 cities. Updated data and other content, developed in consultation with city stakeholders, have been added to dashboards in eight cities between April to September 2020 (**Blantyre, eThekwini (Durban), Kingston, Kinshasa, Kyiv, Lagos, Maputo, and Yaoundé**). Dashboards are currently managed by IAPAC headquarters in Washington, DC.

In general, key stakeholders across sectors have found the dashboards to be useful as a source of city-level data on key HIV indicators as well as HIV services. Where available, they are being used to track progress on 90–90–90 goals and contribute to improved care by providing maps to places for HIV testing and other services. In some cities, respondents indicated that the availability of a dashboard has had a catalytic effect, creating interest for having dashboards in other parts of the country. Cities where data goals under Objective 2 are robust provide a stronger foundation from which to build effective dashboards.

The dashboards have improved accessibility of city-level HIV data.

"Before this project, it was quite difficult to get specific information of HIV in one central place for Kigali. It doesn't mean the information was not available, but it was not centralised. The focus was not on the city. The focus was national level."

The availability of city-level data is valuable to municipal leadership.

> *"We can see that many people are using it to get information, not only the public, but also I have seen that many of the people in our leadership, they consult that website often when they are going to take some decisions, or you want to get some information."*

The availability of city-level data has facilitated the work of partners. For example, disaggregated key population data in cities can be used by civil society partners for more targeted and effective advocacy.

> *"If there is a partner who wants to work with [the municipality] on HIV related, then they don't have to come to the Ministry of Health asking for information because they have almost all the information related to HIV in (the city) in one place. So, it has actually facilitated their work."*

By making data available, data gaps are more apparent – and can lead to action.

> *"…the information on the dashboard needed to be updated on a regular basis because things change locally, persons move from positions, organisations are formed or are providing new*

services, etc. And when we initially looked at the dashboard, it wasn't an exhaustive list of service providers that we had, a lot were missing. So, what we did was to go back and to do an assessment and do a mapping of the services. In the city, especially, there are the sites that are providing services, whether it's anything related to HIV, related to human rights, anything related to providing services for the LGBT community, etc. So, we did a mapping. And what was good for us in Kingston as well was that UNAIDS also needed this information in terms of organisations providing services. So, we work together on this".

Some cities are actively working to expand the information available on their city's dashboard (e.g., more detailed information about health services including location and opening hours; COVID-19 infection rates and locations for testing; information about co-morbidities such as TB). Discussions have been initiated with city stakeholders in three cities— **eThekwini (Durban), Jakarta, and Lagos**—to secure HIV epidemic control indicators for development of Dashboards 3.0. A series of data-sharing exploratory calls has taken place with stakeholders in four cities (**Blantyre, Kampala, Lusaka, and Nairobi**) with the aim to embed selected indicators from the National Health Situation Rooms into their dashboards.

FTCP engagement with the Stop TB Partnership is underway to secure TB 90–90–90 data for three cities (**Lagos, Jakarta,** and **Johannesburg**). TB-HIV coinfection data are now being reported on the **Maputo** dashboard.

The dashboard utilization survey is used to catalogue what types of data each city's dashboard is tracking as well as how the dashboard is being used by FTCP partners and stakeholders. **The survey has been completed in 13 cities** (**Blantyre, eThekwini (Durban), Jakarta, Johannesburg, Kampala, Kigali, Kingston, Kinshasa, Kyiv, Lagos, Lusaka, Maputo,** and **Windhoek**) with multiple stakeholder groups including health departments, communities, and clinicians. In addition, representatives from a total of 12 cities (**Blantyre, eThekwini (Durban), Jakarta, Johannesburg, Kampala, Kigali, Kingston, Kyiv, Lagos, Lusaka, Maputo,** and **Windhoek**) reported that their dashboards have been effectively leveraged by the municipality, i.e., utilizing the dashboard in a minimum of five ways across 10 domains.

The FTCP dashboard is less accepted in cities where it is felt to be duplicative of other dashboards.

"… there's already a lot of information available through other partner dashboards. That came prior to the FTCP dashboard. So, for example, the city uses DHIS too for their data visualization. And that's where they upload all their data. The national programme also has a dashboard that they use to look at City indicators as well as national indicators. So, when the FTC dashboard was launched, which was before I joined, I found it up already, there was an effort to move it to a more detailed dashboard 3.0 that has a lot more detailed information around TB, and other indicators other than just HIV. However, USAID has been uncomfortable with the FTC dashboard, because they felt that it was a duplication of all the other dashboards that are available in the city. And the city also felt that it was just another dashboard for them to have to plug in information to. So, in terms of its use for the city, I would unfortunately have to say it has not been useful. So, my recommendations have always been, at the very least, we need to pull the data from other dashboards and not request the city to plug in data into it, because it's not going to happen."

The dashboard has limited usefulness in cities with weak telecommunications infrastructure. This concern was raised in particular by respondents in **Kinshasa, Windhoek,** and **Yaoundé**.

"They are asking what the data and photos are used for and we send them dashboard links by WhatsApp groups whereas they don't have Internet access. We really need to offer the cities a way of using the dashboards."

There are opportunities to increase the utilization and amplify the availability of the dashboards. Several informants indicated that more frequent and strategic communications with stakeholders could help them to understand the advantages of the dashboards, including knowledge about resources, promoting linkages, fostering synergies, and other value-added benefits. **Several implementing partners and community representatives reported being unaware of the dashboards or not knowing where to find them.** One respondent suggested that there might be opportunities to partner with private sector allies in these efforts, as they often are used to and understand the value of working with dashboards. Another proposed involving the IT departments at the municipal level so they know how to support staff to pull up the dashboards and use them more. Such efforts could also facilitate a move toward sustainability.

Concerns for Sustainability. Informants consistently voiced their concern as to how dashboards for their cities would be maintained once the formal project period ends. They are seen as incredibly valuable resources, and it was not clear how the dashboard websites and the data that feed them would be

maintained. It was noted that this might be of particular concern in cities that have relatively less agency (i.e., where health policies are set primarily at the national level).

Objective 3 – City Status Table	
City	**Status of Objective 3 Activities**
Blantyre	Blantyre's city dashboard was made publicly available in April 2020 and data were updated in May 2020. The Dashboard Utilization Survey suggested that city stakeholders are using the dashboard across seven key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; accessing resources and/or trainings; facilitating inter-city communications and collaborations; enhancing political leadership and advocacy; and informing programmatic planning.
eThekwini (Durban)	The Dashboard Utilization Survey was fielded in eThekwini and the city reported effectively leveraging the dashboard across 10 key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; highlighting community advocacy through key leadership messages; supporting fundraising efforts; accessing resources and/or trainings; showcasing best practices; facilitating inter-city communications and collaborations; strengthening political leadership and advocacy; and enhancing political leadership and advocacy. Work is underway to obtain TB data and epidemic control indicators for the development of Dashboard 3.0.
Jakarta	The Dashboard Utilization Survey was fielded in Jakarta and the city reported effectively leveraging the dashboard across seven key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; accessing resources and/or trainings; showcasing best practices; facilitating inter-city communications and collaborations; and enhancing political leadership and advocacy. TB data have been collected and approvals are in progress for publication on Jakarta's Dashboard 3.0.
Johannesburg	An updated Dashboard Utilization Checklist is being fielded across multiple stakeholder groups. Collaborative work is being undertaken to obtain TB data for development of Dashboard 3.0.
Kampala	The Dashboard Utilization Survey was fielded in Kampala and the city reported effectively leveraging the dashboard across six key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; accessing resources and/or trainings; enhancing political leadership and advocacy; and informing programmatic planning. An updated Dashboard Utilization Checklist is being fielded across multiple stakeholder groups.
Kigali	Kigali has reported effectively leveraging the dashboard across 11 key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; highlighting community advocacy through key leadership messages; supporting fundraising efforts; accessing resources and/or trainings; showcasing best practices; facilitating inter-city communications and collaborations; strengthening policy and decision making; enhancing political leadership and advocacy; and informing programmatic planning.
Kingston	Kingston has reported effectively leveraging the dashboard across six key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; accessing resources and/or trainings; facilitating inter-city communications and collaborations; and strengthening policy and decision making. The HIV service mapping section on the dashboard has also been updated in consultation with city stakeholders.
Kinshasa	Kinshasa has reported leveraging the dashboard across four key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; and highlighting community advocacy through key leadership messages. The Dashboard has been used to inform organisations' planning activities in Kinshasa.
Kyiv	The Dashboard Utilization Survey was fielded in Kyiv and the city reported effectively leveraging the dashboard across 11 key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; highlighting community advocacy through key leadership messages; supporting fundraising efforts; accessing resources and/or trainings; showcasing best practices; facilitating

	inter-city communications and collaborations; strengthening policy & decision making; enhancing political leadership and advocacy; and informing programmatic planning. HIV services have been updated on the city Dashboard and discussions around data for the Dashboard 3.0 have been initiated.
Lagos	The Dashboard Utilization Survey was fielded in Lagos and the city reported effectively leveraging the dashboard across six key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; accessing resources and/or trainings; strengthening policy and decision making; and informing programmatic planning. Data visualizations, counters, HIV services, and information for the new Commissioner of Health were updated. Collaborative work is being undertaken to obtain TB data for development of Dashboard 3.0.
Lusaka	The Dashboard Utilization Survey was fielded in Lusaka and the city reported effectively leveraging the dashboard across eight key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; highlighting community advocacy through key leadership messages; accessing resources and/or trainings; showcasing best practices; facilitating inter-city communications and collaborations; and strengthening policy and decision making.
Maputo	The Dashboard Utilization Survey was fielded in Maputo and the city reported effectively leveraging their dashboard across six key areas: tracking progress against 90–90–90 targets; mapping HIV services; accessing resources and/or trainings; showcasing best practices; enhancing political leadership and advocacy; and informing programmatic planning. TB/HIV co-infection data are being reported and will be routinely updated on the Dashboard.
Nairobi	The Dashboard Utilization Checklist is being fielded across multiple stakeholder groups, including health departments, communities, and clinicians.
Windhoek	The Dashboard Utilization Survey was fielded in Windhoek and the city reported effectively leveraging their dashboard across 11 key areas: visualizing key data; tracking progress against 90–90–90 targets; mapping HIV services; highlighting community advocacy through key leadership messages; supporting fundraising efforts; accessing resources and/or trainings; showcasing best practices; facilitating inter-city communications and collaborations; strengthening policy and decision making; enhancing political leadership and advocacy; and informing programmatic planning.
Yaoundé	An updated Dashboard Utilization Checklist is being fielded across multiple stakeholder groups, including health departments, communities, and clinicians. City stakeholders have appreciated the development of the Dashboard 2.0 and its ability to help them track the 90–90–90 targets. City mayors have been engaged with the development of leadership and advocacy messages for the dashboard.

Objective 4

Strengthening the capacity of clinicians and people living with HIV (PLHIV) in the respective cities to achieve and maintain optimal HIV prevention and care continua, leading to attaining the 90–90–90 targets.

Four core, self-directed, narrated training modules were developed covering testing/linkage to care, ART initiation, adherence and retention in care, pre-exposure (PreP) and post-exposure prophylaxis (PEP) and improving outcomes for key populations. In addition, there are four optional modules covering paediatric care, adolescent care, HIV and aging, and the integrated management of HIV and non-communicable diseases. Training curricula have been internally and externally peer reviewed and designed to be easily updated (including incorporation of evolving WHO guidelines), interactive, and flexible (adaptable by each city). Thus, there is some variation in the trainings among cities for using a horizontal, collaborative approach to the trainings that includes country-led input and local presenters. Trainings are then translated into local languages where needed (i.e., Bahasa Indonesian, French, Portuguese, and Ukrainian).

Findings

Capacity-building training has been provided to a total of 6,919 clinicians and other health care providers across 621 facilities in 14 cities—Blantyre, eThekwini (Durban), Johannesburg, Kampala, Kigali, Kingston, Kinshasa, Kyiv, Lagos, Lusaka, Maputo, Nairobi, Windhoek, Yaoundé—through varied approaches including group sessions and via online self-directed and webinar platforms.

> *"We had four training workshops that clinicians were facilitating—they came out so beautifully, the participants were very happy. We used all eight modules and were also able to slot in slides with Namibian examples, statistics, data."*

Trainings have been completed in Nairobi with 347 health care providers across 140 facilities in the 10 sub-counties; this exceeded the initial goal of reaching 186 health care providers across 100 facilities. Evaluation of the trainings in Nairobi is ongoing.

In-person group, online self-directed, and webinar-based capacity-building trainings are ongoing (as of October 2020) in 13 cities, including Blantyre, eThekwini (Durban), Johannesburg, Kampala, Kigali, Kingston, Kinshasa, Kyiv, Lagos, Lusaka, Maputo, Windhoek, and Yaoundé.

Trainings have continued despite disruptions due to COVID-19. One strategy reported has been to have more frequent but smaller in-person groups, where allowed, using social distancing in larger spaces and provision of protective gear (some respondents noted having FTCP-branded "comfort kits" with masks, hand sanitizer, and gloves). Another approach has been pivoting to online self-administered trainings or live webinars. In some cities, it was possible to provide data bundles so that participants could access web-based trainings without using their own data time, which can be prohibitively expensive. Most cities used some combination of these adaptations.

For the most part, informants have reported that the virtual trainings have worked well, but there have been exceptions. In **Windhoek**, for example, discussions with the Directorate of Special Programs within MoH responsible for mentoring health care workers, as well as with the Namibian HIV Clinicians Society, revealed that online trainings in Namibia often do not work well due to unreliable broadband and a general lack of familiarity with this approach.

Informants emphasized the value of partnering with local government, clinician professional groups, and other bodies to maximize the reach and value of trainings.

> *"The Namibian HIV Clinicians Society was able to help get materials through the health professions council, which allowed for accreditation for continuing education points. That's the beauty of collaboration and partnering, because if I had attempted this on my own, it would have been a process and a half [i.e., a long and complex process]."*

Trainees received certification upon completion of the training, and in some cities, certificates confer points toward continuing education credit; this was reported to be highly valued by clinicians. There was inquiry from some respondents as to whether city-level IAPAC CPOs can be given at least partial access to the pre-/post-test results database, as it was reported that the platform that manages pre-/post-test results and certificates is managed by IAPAC in Washington, DC, and cannot be accessed directly.

Some informants noted that initially there were concerns at the city level, both about the idea that an "outside" training curriculum might be imposed, as well about possible duplication of existing efforts. Many

noted these perceptions have improved with the on-the-ground presence of the IAPAC CPOs. Most respondents also expressed coming "on board" due to the perceived quality and value of the overall approach and the trainings themselves. The breadth of content was also appreciated; in particular, informants cited the modules on adolescents and young people, LGBT, HIV and aging, and noncommunicable diseases as being particularly valuable.

One respondent noted a way to improve the adolescent and young person module, namely that, in many sub-Saharan African countries, adolescents (often infected as children) are those most likely to be on 2nd- or 3rd-line ART due to resistance caused by challenges with adherence, and that trainings could focus on ways health care workers can do a better job of educating, preparing, and supporting the adolescent and young people for these challenges.

Other informants expressed challenges addressing issues of key populations **in the trainings**. While it was said that health care workers and other staff at facilities are often comfortable talking openly with and about key populations and their issues, it was also recognized that authorities further up the chain of command (at government levels, etc.) may object to this, and that this has at times been a difficult balance to maintain. One respondent suggested the value of doing some portion of the trainings in joint sessions with health care workers and PLHIV, including key populations where safe to do so, as this could promote greater mutual communication and understanding.

Despite overall recognition that the trainings are of high quality, some informants emphasised the **need to incentivize health care workers**, such as providing continuing education credits or data bundles.

> *"We recognize that there must be an incentive for persons to want to participate. Training modules, capacity building, are a dime-a-dozen, especially for us in developing countries that have public health issues such as HIV. So, providing CME hours or credit for health care workers, providing data and phone cards for persons to go online and do these sessions is stuff we have considered and put in place to attract persons to it."*

Others suggested that trainings could be held closer to health care facilities to reduce travel time and transport logistics; this was done successfully in Johannesburg.

IAPAC has partnered with the International Treatment Preparedness Coalition (ITPC) on **community peer educator trainings** to strengthen the capacity of PLHIV communities to promote high-quality HIV prevention, care, treatment, and support services in Fast-Track Cities. These have been scheduled and logistics are in place for 11 cities (**Blantyre, eThekwini (Durban), Johannesburg, Kampala, Kigali, Kingston, Kinshasa, Lagos, Lusaka, Maputo,** and **Windhoek**).

Objective 4 – City Status Table	
City	**Status of Objective 4 Activities**
Blantyre	Clinicians (n = 249) have accessed capacity-building modules across 12 health facilities since the start of the project. In-person group capacity-building trainings took place with 149 clinicians across 11 health facilities. An IAPAC COVID-19 and HIV training took place with 90 participants across 11 health facilities.
eThekwini (Durban)	Clinicians (n = 569) have accessed capacity-building modules across 30 health facilities since the start of the project. Individual tablet-enabled capacity-building trainings took place with 34 clinicians across two health facilities.
Jakarta	Training in Jakarta has been challenging because modules require approval by the MoH. The MoH is currently conducting a series of online trainings for health care providers. Consultation is currently underway to integrate IAPAC training modules into existing MoH materials. Clinicians (n = 101) have accessed capacity-building modules since the start of the project. An IAPAC sponsored COVID-19 and HIV webinar took place with 150 participants.
Johannesburg	Clinicians (n = 837) have accessed capacity-building modules across 32 health facilities since the start of the project. In-person group capacity building trainings took place with 273 clinicians across 24 health facilities and 56 clinicians accessed individual tablet-enabled capacity-building trainings in one health facility.
Kampala	Clinicians (n = 1,632) have accessed capacity-building modules across 106 health facilities since the start of the project. In-person group capacity building trainings

	took place with 193 clinicians across six health facilities and 32 clinicians accessed individual tablet-enabled capacity-building trainings in one health facility.
Kigali	Clinicians (n = 807) have accessed capacity-building modules across 99 health facilities since the start of the project. In-person group capacity building trainings took place with 110 clinicians across eight health facilities and 23 clinicians accessed individual tablet-enabled capacity-building trainings in one health facility. IAPAC COVID-19 and HIV trainings took place with 65 participants total across 45 health facilities. Trainings have been acknowledged and reported in the Rwanda HIV annual report signed by Minister of Health and the modules are being adopted into the e-learning system.
Kingston	Clinicians (n = 221) have accessed online capacity-building modules across 14 health facilities since the start of the project. Two IAPAC COVID-19 and HIV webinars took place with 54 participants. The International Training and Education Center for Health (I-TECH) at University of Washington agreed to support the delivery of training modules via Zoom and the existing ECHO distance learning platform to extend the reach of the trainings across the island. The Ministry of Health and Wellness has approved the FTCP training modules and will administer training and accreditation for all ART providers across Jamaica.
Kinshasa	Clinicians (n = 204) have accessed online capacity-building modules across 14 health facilities since the start of the project.
Kyiv	Clinicians (n = 116) have accessed the online capacity-building modules across six health facilities since the start of the project. The capacity building modules are being delivered under the official certification of the National Academy of Medical Science and the Kyiv City Centre for Public Health and are attributing credits to MDs for the renewal of their medical licenses. Two COVID-19 and HIV webinars took place, with six participants total. Three in-person COVID-19 and HIV trainings took place with 63 participants in total.
Lagos	Clinicians (n = 626) have accessed the online capacity-building modules across 63 health facilities since the start of the project. This initiative has improved employee morale and technical expertise through targeted relevant professional development opportunities. In coordination with the State Ministry of Health, State AIDS Programme, and Lagos AIDS Control Agency, IAPAC hosted a COVID-19 and HIV training with 180 trainees across 104 facilities.
Lusaka	Clinicians (n = 821) have accessed online capacity-building modules across 28 health facilities since the start of the project. In-person group capacity-building trainings took place with 196 clinicians across 19 health facilities. An IAPAC COVID-19 and HIV training took place with 32 trainees across four health facilities.
Maputo	Clinicians (n = 109) have accessed online capacity-building modules across 20 health facilities since the start of the project. An IAPAC COVID-19 and HIV training took place with 111 trainees across eight health facilities.
Nairobi	Capacity-building trainings have been completed and targets have been exceeded. A total of 347 clinicians (target 186) in 140 facilities (target 100) across 10 sub-counties were trained using both in-person and online training. The project expanded the reach of these trainings. Health care workers were empowered to better manage adolescent and paediatric HIV clients whose HIV outcomes lag behind those of adults. An IAPAC COVID-19 and HIV training was conducted with 208 trainees across 140 health facilities.
Windhoek	Clinicians (n = 189) accessed the online capacity-building modules since the start of the project. In-person group capacity-building trainings took place with 75 clinicians across 10 health facilities. An IAPAC COVID-19 and HIV training took place with 75 trainees across 10 health facilities.
Yaoundé	Clinicians (n = 192) accessed the online capacity-building modules across 47 health facilities since the start of the project.

Objective 5

Strengthening the capacity of HIV service providers in the respective cities to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities.

Three standardized, self-directed training modules were developed with the objective of eliminating stigma and discrimination in health care settings that deliver HIV services. As with the clinician capacity building modules, the stigma modules are translated into local languages as needed and available through virtual and tablet-based trainings. A standardized facility-level stigma assessment tool consisting of a self-assessment checklist and a stigma elimination action plan template are implemented, and workshops conducted for health facility administrators with direct technical support for developing facility-level stigma elimination action plans. Finally, a peer education programme is implemented in health care facilities that focuses on addressing self-stigma, the importance of achieving/maintaining viral suppression, and "U=U" (*undetectable* = *untransmittable*).

Findings

A comprehensive, peer-reviewed, multi-language training curriculum focused on eliminating stigma and discrimination in health care settings has been delivered online, via tablet, and through in-person groups. A total of 3,686 trainees have participated, 72% of whom scored 70% or higher on post-stigma training knowledge assessments. In **Johannesburg** and **Yaoundé** there was an improvement in knowledge assessment from 37% and 62% (pre-training) to 50% and 71% (post-training), respectively.

Stigma trainings have been completed in Nairobi, reaching a total of 313 health care providers in 140 facilities across the 10 sub-counties; this exceeded the original goal of reaching 186 health care providers in 100 facilities.

Stigma training is ongoing in 13 cities—Blantyre, **eThekwini (Durban), Johannesburg, Kampala, Kigali, Kingston, Kinshasa, Kyiv, Lagos, Lusaka, Maputo, Windhoek,** and **Yaoundé.**

Sense of progress. Several informants, while acknowledging that data are not always available, expressed a general sense that there is starting to be better comprehension of stigma and discrimination in health care facilities.

> *"Now, when you go to the health facilities, where a number of people took the courses, and the places where they did not take courses, you can see the differences on their biases."*

Respondents stressed the importance of country/city-specific adaptations to the stigma mitigation trainings, even more so than for the clinical trainings. They noted the variability of localized contexts of stigma and discrimination, and warned against using a one-size-fits-all approach.

Informants also advocated for more robust involvement of clients, PLHIV, key populations, and civil society, both in local adaptation of the stigma trainings, but also in everyday activities in facilities, such as involving civil society representation when going through an agency's "complaint box" and thinking together about how to best make necessary adjustments.

> *"Better feedback loops from clients and civil society can drive innovative approaches."*

Health care workers and related COVID-19 stigma. Several key informants observed that, as health care workers in their cities are at high-risk of COVID-19 due to their occupation, many of these health professionals were experiencing stigma in this regard. For some, this served as a moment of enlightenment in their own experiences of stigma which gave them better insight into the stigma and discrimination their patients and clients face due to their HIV status and/or being members of key populations.

Objective 5 – City Status Table	
City	**Status of Objective 5 Activities**
Blantyre	Participants (n = 153) have accessed stigma modules across 12 health facilities since the start of the project. In-person group stigma trainings took place with 133 participants across 11 health facilities. The modules and trainings have helped to change service providers' attitudes towards patients and there is a noticeable effect on team efforts to reduce stigma at facility levels.
eThekwini (Durban)	Participants (n = 447) have accessed capacity-building modules across 30 health facilities since the start of the project. In-person group stigma trainings took place with 337 participants across 30 health facilities and 26 clinicians accessed

	individual tablet-enabled stigma trainings in one health facility. Trainings have been well received and have increased awareness amongst health care workers of HIV-related stigma.
Jakarta	Training in Jakarta has been slower because modules require approval by the MoH. The MoH is currently conducting a series of online trainings for health care providers. Consultation is currently underway to integrate FTCP training modules into existing MoH materials.
Johannesburg	Participants (n = 665) have accessed stigma modules across 32 health facilities since the start of the project. Webinar-based stigma trainings took place across 11 health facilities with 13 trainees, in-person group stigma trainings took place with 312 participants across 27 health facilities and 71 clinicians accessed individual tablet-enabled stigma trainings across two health facilities. Increased demand for stigma trainings has resulted in city plans to extend access to other sectors (e.g., community groups, PLHIV, faith-based organisations, and trade unions).
Kampala	Participants (n = 867) have accessed stigma modules across 42 health facilities since the start of the project. In-person group stigma trainings took place with 229 participants across seven health facilities and 63 clinicians accessed individual tablet-enabled stigma trainings across two health facilities.
Kigali	Participants (n = 690) have accessed stigma modules across 87 health facilities since the start of the project. Individual tablet-enabled stigma trainings took place with 22 clinicians in one health facility. These trainings have been acknowledged and reported in the Rwanda HIV annual report signed by Minister of Health and the modules are being adopted into the e-learning system.
Kingston	Participants (n = 141) have accessed online stigma modules across 14 health facilities. The Ministry of Health and Wellness has approved IAPAC training modules and will administer training and accreditation for all ART providers across Jamaica.
Kinshasa	Participants (n = 101) have accessed online stigma modules across 14 health facilities since the start of the project. The stigma modules have been used by health care providers and civil society activists to strengthen stigma elimination efforts in health care facilities.
Kyiv	Participants (n= 13) have accessed online stigma modules across 2 health facilities since the start of the project.
Lagos	Participants (n= 670) have accessed online stigma modules across 63 health facilities since the start of the project.
Lusaka	Participants (n= 489) have accessed online stigma modules across 21 health facilities since the start of the project.
Maputo	Participants (n = 164) have accessed online stigma modules across 20 health facilities since the start of the project. Webinar-based stigma trainings took place with 40 participants across 20 health facilities. In-person group stigma trainings took place with 120 trainees across 12 health facilities. Health care worker awareness of stigma related to HIV in health facilities and its impact on engagement and retention of PLHIV on ART has significantly increased.
Nairobi	Stigma trainings have been completed and targets have been exceeded. A total of 313 Participants (target 186) in 140 facilities (target 100) across 10 sub-counties were trained using both in-person and online training. These trainings have helped the facility staff create better, targeted strategies and develop impactful activities to effect rapid change in terms of stigma reduction for PLHIV.
Windhoek	Participants (n = 9) have accessed online stigma modules across 5 health facilities since the start of the project.
Yaoundé	Participants (n = 922) have accessed online stigma modules across 63 health facilities since the start of the project. In-person group stigma trainings took place with 275 participants across 63 health facilities

Objective 6

Assessing quality of care (QoC) concerns among PLHIV in Fast-Track Cities and facilitating the sharing of best practices.

The QoC survey was designed to identify care quality successes and challenges faced by PLHIV by measuring perspectives on key indicators across the continuum of care, in addition to non-health related determinants such as economic accessibility. The survey has an observational, cross-sectional study design using tablet enabled or paper-based questionnaires to administer an anonymised survey to eligible PLHIV who consent to participate. Gaining insight into the perspectives on the quality of care of PLHIV can help guide strategies to improve their engagement and retention in care and attain the 90–90–90 goals.

In order to conduct the QoC surveys with PLHIV, FTCP partners in each city must identify a principal investigator, obtain approval from the relevant institutional review board (IRB), collect the data (often in partnership with one or more local civil society groups), analyse the data, and report their findings.

Findings

A total of 1,142 people living with HIV were surveyed for the QoC survey, including from key populations, in 4 cities—Kigali (416 respondents), **Kinshasa** (360 respondents), **Lusaka** (26 respondents), and **Yaoundé** (340 respondents).

Institutional Review Board (IRB) approval has been obtained to begin the survey in five additional cities—eThekwini (Durban), Johannesburg, Lagos, Lusaka, and Yaoundé,

Analysis of the QoC survey data has begun in Kigali.

> *"That aspect of how the beneficiaries are accessing services, what is their perception of the service that they are being offered, it matters a lot on improving the service. And so, I could see when people were being interviewed, they were very excited to express themselves—what they think and what they want to be improved. So, I assume that the results will be very informative to the government of Rwanda in terms of improving HIV services. We're keen to see the results."*

Impact of COVID-19. Informants identified delays in the QoC survey process due to COVID-19. One site reported delays in recruitment; because PLHIV were receiving multi-month dispensing of ART due to COVID-19, they no longer had a reason to go to their health care facility (where the survey was being administered). Other cities noted delays in the protocol approval process.

> *"At the same time, I know for sure the Quality of Care survey is something that COVID has impacted because even the submission of the protocol to the IRB— because of COVID was not meeting. One of the things you were told is that the majority of the participants on the IRB are persons who were over the age of 65. And so, the IRB did not meet for a while."*

In addition to conducting the surveys, a total of 40 interventions, policies, and practices from nine cities were identified for inclusion in the Best Practices Repository, the goal of which is to identify, document, validate, and disseminate existing interventions, policies, and strategies that have been undertaken in Fast-Track Cities to increase the demand for and sustained use of HIV services in the context of urban HIV responses. The repository can act as a resource for city programme managers, health departments, implementers, advocates, civil society, and donors to better determine how to scale up programmes effectively and gain maximum benefit from resource investments. The cities include **eThekwini (Durban), Jakarta, Kingston, Kinshasa, Kyiv, Lagos, Lusaka, Maputo,** and **Nairobi**. The Best Practices repository has been designed and is currently being piloted by 5 IAPAC city consultant program officers. The launch of the webpage, which will be housed on the Fast-Track Cities Global Webportal, is planned for the end of January

Objective 6 – City Status Table	
City	**Status of Objective 6 Activities**
Blantyre	The Principal Investigator for the QoC survey has been identified and the protocol is ready to be submitted for IRB approval.
eThekwini (Durban)	IRB approval has been secured for the QoC survey. Eight Best Practices have been identified for publication in the online Best Practices Repository.
Jakarta	QoC survey IRB application has been completed and is awaiting submission. Five Best Practices have been identified for publication in the online Best Practices Repository.
Johannesburg	IRB approval for the QoC survey was secured.
Kampala	IRB approval was granted for the QoC survey to be conducted in Kampala, and the facilitators have been identified and trained. Four Best Practices have been identified for publication in the online Best Practices Repository.
Kigali	Implementation of the QoC survey is complete. PLHIV (n = 416) have been surveyed, including individuals from key populations. Analysis of the survey data has begun.
Kingston	QoC survey IRB application is currently under review. Two Best Practices have been identified for publication on the online Best Practices Repository.
Kinshasa	PLHIV (n = 360) have completed the QoC survey, including individuals from key populations. Three Best Practices have been identified for publication on the online Best Practices Repository.
Kyiv	IRB approval for the QoC survey has been secured and four interviewers have been recruited to collect the survey data. Five Best Practices have been identified for publication on the online Best Practices Repository.
Lagos	IRB approval for the QoC survey was secured and facilitators trained. Four Best Practices were identified for publication on the online Best Practices Repository.
Lusaka	IRB approval for the QoC survey was secured, and the facilitator trainings completed. PLHIV (n = 26) have been surveyed to date for the QoC survey, though recruitment of key populations (e.g., MSM) has been challenging. Five Best Practices have been identified for publication on the online Best Practices Repository.
Maputo	The protocol for the QoC survey has been submitted for IRB approval. Seven Best Practices have been identified for publication on the online Best Practices Repository.
Nairobi	IRB approval for the QoC survey is pending. Nine Best Practices have been identified for publication on the online Best Practices Repository.
Windhoek	The protocol for the QoC survey has been submitted for IRB approval. Three Best Practices have been identified for publication on the online Best Practices Repository.
Yaoundé	PLHIV (n = 340) have completed the QoC survey, including individuals from key populations. The survey has helped PLHIV to identify knowledge gaps in some areas of care. City stakeholders have expressed that they will use the results to guide quality of care improvements in the city. Two Best Practices have been identified for publication on the online Best Practices Repository.

Project-Wide Issues

Informants across cities and roles and at global-, regional- and city-levels shared their insights into project-wide partnership, coordination, communication, and administrative issues, as well as with regard to interactions with the Global Fund.

Findings

There are adequate structures to support communication between UNAIDS and IAPAC headquarters globally and at city level. Overall, city IAPAC and UNAIDS respondents reported there to be adequate opportunity to speak with programme leadership. While many respondents noted that they meet with leadership frequently on an as-needed basis, there are scheduled monthly to quarterly meetings with the UNAIDS and IAPAC teams from global and city levels, for all 15 cities, for the purpose of updating one another on progress and to discuss and resolve issues. The headquarters teams meet virtually on a biweekly basis.

> *"I think in terms of what has helped us succeed…. I think the check-in calls are useful. And I guess the relationship that I have with my counterpart has also helped just sort of keep things moving forward, and sort of checking in on each other. So, I think it really boils down to our individual desire to see the project succeed and making sure that those channels of communication are open."*

In general, city IAPAC and UNAIDS activities are well coordinated, and are reported to have improved over time, due to:

- **Equity:** being treated as equal partners in this endeavour,
- **Mutual Understanding:** amongst UNAIDS and IAPAC representatives that each other's objectives mattered and are shared objectives, and
- **Communication:** the ability for IAPAC and UNAIDS representatives to have ready communication with each other.

Although recognized broadly across informants that the UNAIDS - IAPAC partnership is continually strengthening at both headquarters and city levels, there remain differing ideas about the degree to which the project is perhaps too bifurcated between these two agencies. Discussions with informants at global and city levels suggested that each agency is not always as clear as it could be on what the other is doing and how it relates to their own objectives and mandate. The need was identified to better ensure sharing of plans to increase harmonization of efforts and minimize duplication, and that increased focus and attention on these issues at the headquarters level could help to find ways for city-level partnerships to be maximally robust.

Integration of roles is a strength. In most cities, IAPAC CPOs are working closely with UNAIDS and other partners in the implementation of project activities and participate in FTCP stakeholder meetings. One respondent noted that the objectives are interlinked and not easily separated on the ground, and that how this is thought about affects the partnerships (who does what) and the granularity of the work. They felt the objectives could be considered separately for reporting purposes, but regarding the work a more holistic approach may be more effective.

Another informant shared that there is teamwork and coordination to go to conferences and meetings, but less coordination with reporting, as this is done separately to IAPAC and UNAIDS.

> *"I think one of the things that we did that I haven't heard other cities doing is that the focal person on the city side is actually the same for UNAIDS and IAPAC. So, the city then is able to get a 360 view of the activities that are happening. So, they know what came up on the UNAIDS side, as I'll call it, and what we're doing on the IAPAC side, so that once and for me, the focus is definitely once the project is over, then the city has a full understanding of what has been done and what they need to continue."*

> *"And despite we all have different activities under the different objectives, we also ensure that as the direct implementing agencies for the FTC programme, that we're all on the same page, and we're also supporting each other in terms of the different activities."*

Progress towards achieving FTCP goals could be accelerated by increasing human bandwidth. UNAIDS and IAPAC are not always full-time on FTCP and/or have responsibilities other than FTCP (in some cases this was identified as somewhat of a strength, in that access to other agencies and programmes is facilitated).

"If we had more dedicated time, we could help city to build this capacity more."

"Kinshasa is like a country, its population is 12 million. Big field, not enough plowmen! IAPAC needs more capacity. The responsibility is too heavy for one single person."

"IAPAC has a dedicated person to do the Fast-Track Cities Project. [At UNAIDS], I'm doing on top of so many other things - right? I'm a focal point, right, but I'm not a dedicated person just for FTC. How do we ensure that we have even partial capacity to dedicate our time to the FTC, because what I think is, even this data that is produced, if we had a more dedicated time, we could have helped the city to build this capacity to use the data that is produced because we could also link the city with the data that is generated at the central level. But as it is, it's not being easy because we can't be with them on a day-to-day. I wish that I had more time to dedicate because I really like the approach. I like the project and it gives us a very, very unique opportunity to make change at city level."

Desire to connect more with counterparts in other cities. Several informants voiced the need to have opportunities and platforms for greater interactions with other cities belonging to FTCP. Others wanted to find ways to leverage FTCP to increase mechanisms for "South-to-South" learning in general.

"Certainly, when we go into the next year is to have touch points between other cities, especially other cities that are at the same stage of us. You know, I think that that would certainly be helpful. And hasn't really been that strong. And I think anybody who's wanted to contact somebody has just done it of their own volition rather than something being orchestrated. But it is something that I know, a couple of other CPOs have suggested, can we have maybe three or four cities at the same stage to talk and sort of help? And, you know, sort out bottlenecks with implementation and that sort of thing?"

Reporting requirements. Several respondents, primarily at UNAIDS country and city levels, discussed the frequency and detail of reporting requirements, and were emphatic that the time required for reporting was onerous and felt like somewhat of a distraction from focusing on the actual work. There was also questioning as to whether the reporting could be less metric-driven and instead incorporate more focus on reflection and thinking strategically.

"I just feel that there is too much emphasis on reporting. Like too many reports, too many updates. I don't think that it's giving us enough time to think strategically - what are the things that we wanted really to highlight? And maybe the report format could also maybe, maybe, push us to reflect on how we are reporting. For me, reporting should really be to monitor the progress. But monthly? I think it's not helping because we're just reporting because we have to report, not reflecting on what we are reporting. I think the reporting could be more strategic."

Impact of COVID-19 and Responses

The COVID-19 pandemic has caused significant disruption in all 15 cities, including disruptions to HIV services, due to restrictions on movement, the shift in priorities for health care workers toward COVID-19, and the fact that health care workers themselves are at high risk for COVID-19. Despite such disruption, all cities have developed contingency plans that have allowed for the continuation of FTCP activities with adaptations, often quite innovative. Notably, FTCP also supported and contributed to larger contingency and recovery plans for the cities to mitigate the impact of COVID-19 and to ensure the continuation of HIV services.

Contingency plans were developed at city and global levels to ensure that FTCP activities can continue throughout the duration of the COVID-19 pandemic.

A COVID-19 webinar was held by UNAIDS in July 2020 with representatives (UNAIDS, IAPAC, and city stakeholders) from all 15 cities to discuss the impact of COVID-19 and to share experiences and lessons learned in relation to the continuation of activities during COVID-19.

The Virtual Fast Track Cities 2020 conference, held 9-10 September 2020, featured a pre-conference on 8 September 2020 devoted to the impact of COVID-19 on FTCP activities, and included sessions focused on clinical research on and management of COVID-19, key populations, stigma mitigation, service delivery, and issues related to the interactions of COVID-19, HIV, and hepatitis C activities.

Impact of COVID-19 on Objectives 1-2

While there was initial disruption to many of the meetings and other in-person interactions that characterized the activities related to optimizing HIV service delivery and strategic data, adaptations to these mechanisms were rapidly put in place to ensure the continuity of the momentum built thus far. Meeting have often been held virtually rather than in person, and innovative strategies were developed to ensure continuity of HIV services and engage communities, including home delivery of medications and services, multi-month dispensing of ART and other medicines, self-screening, online hotlines, and WhatsApp groups.

For example, in Nairobi, project beneficiaries, including trained youth champions and community health workers, have helped to ensure the continuation of HIV services among communities in informal settlements. In Yaoundé, the lessons that have been learned through FTCP were used to engage mayors and city authorities and to guide the COVID-19 response.

Impact of COVID-19 on Objectives 3-6

The impact of COVID-19 on the momentum of Objectives 3-6 was less disruptive than initially anticipated, as these activities were able to be quickly adapted to virtual/online methods. Objective 3 was largely unaffected, as stakeholders could respond to data queries.

The capacity building and stigma-reduction trainings for health care workers under Objectives 4-5 were able to continue to be delivered through a combination of self-directed online modules, live webinars, and small group gatherings following COVID-19 safety protocols, where permitted. Significant numbers of health care workers have been successfully trained through these approaches.

For the QoC survey under Objective 6, smaller numbers of PLHIV have been able to complete the survey using a combination of online surveys and socially distanced in-person surveys, where possible.

Other Impacts and Adaptations

Across objectives, COVID-19 disrupted physical meetings and groups. While in many cases there was a successful transition to virtual interactions, this was not universal. Informants pointed out that working and training remotely can be very challenging in settings with poor network infrastructure and/or high cost of Internet connectivity. It was also noted that not everyone can afford a smartphone to participate in WhatsApp groups, and that people with lower literacy levels can experience challenges accessing online meetings and groups.

Informants relayed information about infringements of human rights as part of the COVID-19 response. LGBT drop-in centres were raided in some cities, and sex workers were frequently unable to travel back to their home countries due to travel restrictions, and so were stranded, unable to work. In some instances, UNAIDS was able to help monitor human rights vis-à-vis COVID-19 in key populations. In **Jakarta**, there has been the ability to assist transgender women with support for food and other basic needs.

Respondents in many cities shared creative and quite effective adaptations to ensure continuity of activities and services despite COVID-19-related disruptions.

In **Johannesburg**, data staff that would typically be packed together in small IT offices with little ventilation are now using mobile IT vans with fewer staff that can visit facilities to collect data.

In **Kinshasa**, facilities offering multi-month dispensing of ART due to COVID-19 are finding that most patients took their drugs correctly. And many facilities want to retain multi-month dispensing for stable patients to reduce burden on facilities and patients.

In **Kyiv**, medications for HIV pre-exposure prophylaxis (PrEP) are being delivered using taxis, and opioid users are being given 5-10 days' supply of methadone.

In Lusaka, some facilities have designated one person to pick up medications for 15 people, who can then come one at a time to get their medications.

Health Care Worker-Related COVID-19 stigma

Several key informants observed that, as health care workers in their cities are at high-risk of COVID-19 due to their occupation, many of these health professionals were experiencing stigma in this regard. For some, this served as an enlightenment moment in which their own experiences of stigma gave them better insight into the stigma and discrimination their patients and clients face due to their HIV status and/or being members of key populations.

Gender Equality

Respondents noted both the compelling need to **better engage men in all aspects of HIV service delivery**, as well the necessity to **address sexual and gender-based violence and the needs of female sex workers**.

Challenges with reaching men. Informants across almost all cities consistently identified the need to significantly improve the engagement of men, who are lagging behind in HIV testing, treatment, and prevention services.

> *"We understand that we need to reach men in some different ways. Some of the partners in the national response expressed that probably this way of reaching men better with services and services that are appealing to them, providing them in the way that they feel safe, and we'll utilize them will allow us to reach also, let's say, vulnerable communities like men who have sex with men [MSM], gay, and other non-binary, with services when they don't self-identify as such, because they will more generally, they will go to the men-friendly clinics, let's say but not to an MSM clinic. So yes, that discussion is there but I don't think we really have started to implement models for reaching men. And, to assess them to see how and what best will work in Jamaica. So definitely, this is the thinking and it's something to be done."*

Some cities have developed strategies to increase men's engagement. In **Johannesburg**, civil society partners have been enlisted in campaigns for men to be tested and retained in care, and to address gender-based violence. In **Maputo**, there is a national-level men's engagement strategy**, and PEPFAR** has worked with the MenStar initiative to reach men in workplaces**. In Windhoek, male engagement workshops have been conducted, and it was reported that they are close to their 95-95-95 targets with regard to gender equity. The clinical metrics for men were said to be quite good, with non-clinical metrics being more challenging.**

Informants recognize the imperative to address sexual and gender-based violence and the needs of female sex workers.

> *"… there is an integrated mechanism to assist the victims of violence, and this mechanism is being supported at central level. But at the city level, how is that also being done? How can we leverage the resources to increase and to reinforce those centres for integrated assistance for violence, to integrate HIV, and to integrate sexual reproductive health-related rights […] because sometimes they [women] get pregnant [in the context of gender-based violence] -- who assists them?"*

Respondents from UNAIDS and IAPAC and city stakeholders suggested exploring available supportive mechanisms and/or collaborating with other agencies to address the multi-faceted issues related to gender, HIV, and sexual and gender-based violence.

> *"While we have this reference group [FTCP] for looking at HIV, how do we link with other groups in the city that also look at critical enablers for HIV? There is a huge niche in the city as well for gender-based violence, and also the link with UN Women. UN Women have this programme or project that they call safe cities with gender-based violence."*

> *"… if we look at the female sex workers… they have double stigma, double vulnerability. They're women, they're positive, they're sex workers. Their situation is very, very bad economically. They're weak. But in the city, we also have phenomena that need to be addressed differently, like higher education students. There's a huge issue of gender dynamics there, not only the sexual violence that might occur on the campus, but also the sex work that sometimes the young girls that are entering into universities or hired at an institution they get into those practice because they need money, they need money to maintain themselves."*

Other issues raised by informants included that issues such as sexual and gender-based violence and sex work may be more pronounced in cities; that not all women have easy access to services—lower-wealth women (as well as men) have increased challenges with access, transportation, and other relevant factors; and that teen pregnancy rates are too high and are also a marker for HIV risk behaviour.

Collaboration with the Global Fund

Communications and meetings have occurred at the global level to update the Global Fund regarding progress on FTCP activities. Two webinars were held in June and July 2020 among Global Fund Portfolio Managers, IAPAC, UNAIDS, and USAID to update the Portfolio Managers on the progress and extension of FTCP. A presentation on FTCP was also made on 18 August 2020 to the Global Fund Situation Room 2020, a platform for partners to discuss HIV-related bottlenecks at country level and plan for joint actions; a meeting is scheduled to present the FTCP activities to the Joint Working Group in November 2020. Monthly updates and progress reports have been shared with Global Fund Portfolio Managers.

At city levels, communication has been maintained with Global Fund principal recipients and implementing partners to provide updates on the FTCP and ensure alignment of city-level activities. There has also been active engagement of city-level representatives, including civil society, in the development of Global Fund concept notes in several cities.

Collaboration with the Global Fund varies by city. Selected examples of city-specific collaborations with the Global Fund include:

Johannesburg has collaborated with the Global Fund principal recipient ANOVA to support the city with data collection and reporting.

In **Kingston**, the Global Fund representative serves on the Country Coordinated Mechanism steering committee, as well as the FTCP steering committee, enabling close communication with both UNAIDS and IAPAC staff.

Kinshasa has benefitted from a large Global Fund grant to ensure the continuation of HIV services during COVID-19. The country has been successful in mobilizing USD 35 million to address the impact of COVID-19 on HIV, TB, and malaria, with Kinshasa being one of the priority areas to receive support.

Nairobi included the participation of 30 adolescents and young people, together with key population leaders, in Global Fund concept note-writing meetings to ensure the integration of the adolescent and young people and key population priorities.

"The beauty about our steering committee [of the FTCP] is that it also includes a representative that sits under Country Coordinated Mechanism which is another steering committee for the Global Fund grant which is implemented in (country)."

"We are always asked to demonstrate how we are partnering with the Global Fund. But with the current areas that the Global Fund is funding in (country), I have to say that we do not really work very closely with the programme management unit of the Global Fund in (country)."

Conclusions

Based on the desk review, key informant interviews, and the resulting findings described throughout this report, several key conclusions have emerged:

- FTCP is led by committed, passionate, and engaged partners at city, regional, and global levels.
- FTCP has accomplished a great deal of very impactful work in diverse, often challenging environments in a relatively short amount of time, with relatively lean human and financial resources, and despite the significant challenges presented by the COVID-19 pandemic.
- FTCP is generally very highly valued by the various stakeholders including municipal, provincial, and national governments; implementing partners; and civil society and community groups.
- FTCP efforts have provided strong “value for money”, and have leveraged many value-added benefits for cities, countries, and stakeholders.
- Overall, FTCP partnerships with stakeholders and engagement with communities and civil society has notably strengthened over the course of the project; that said these connections could be made even stronger, with resulting positive impact on FTCP goals and objectives.
- In particular, FTCP could focus greater attention on highly vulnerable populations including children and adolescents, as well as unhoused, incarcerated, migrant, displaced, and refugee populations.
- The challenges and areas for improvement from key informants noted throughout the report have consistently been from a perspective of maximizing the benefits of the FTCP and not a criticism of the project’s purpose, overall approach, main strategies, or any shortage of accomplishments.
- There is a strong desire to plan pathways to sustainability so that the momentum and activities of the FTCP continue after the end of the formal project period.
- The FTCP could serve as a compelling model for sharing best practices and finding ways to implement these strategies in other cities around the world.

Recommendations

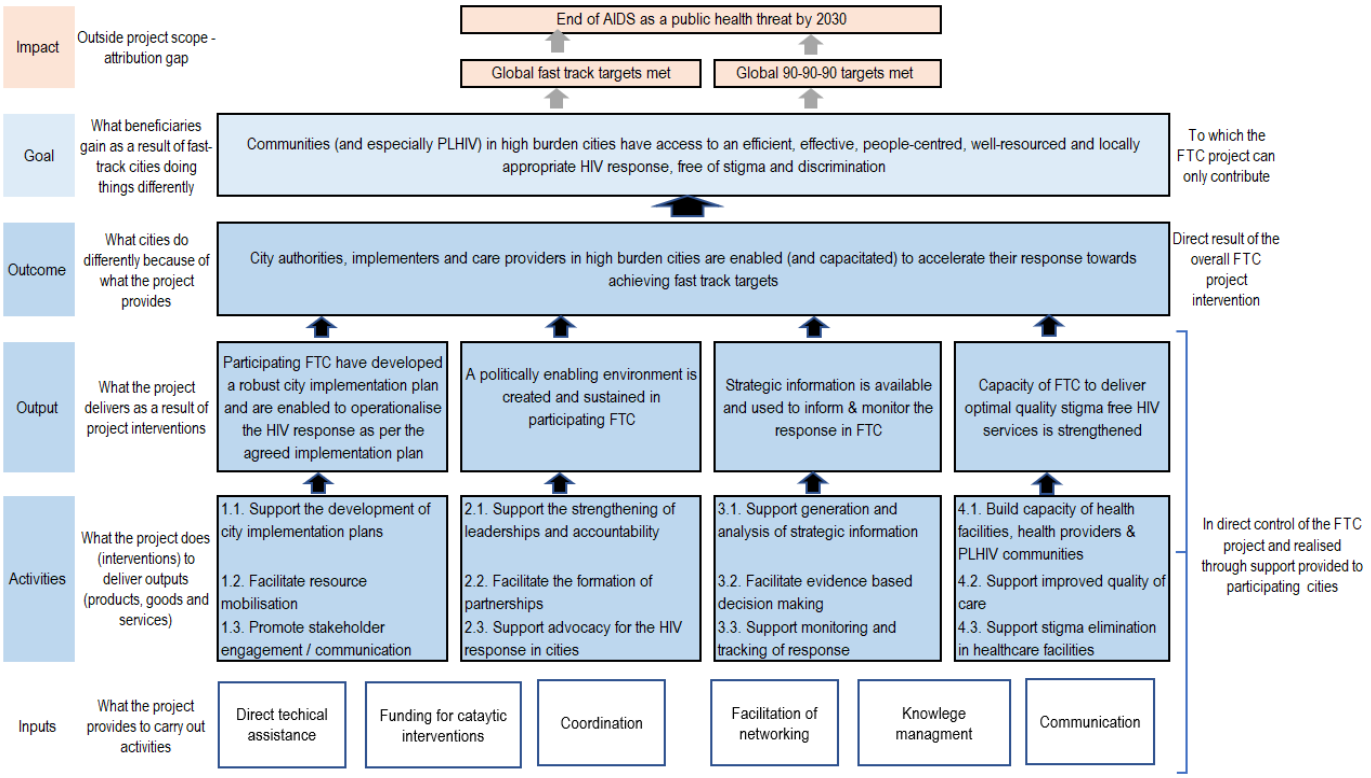
1. Work to align FTCP activities and approaches with city priorities so as to foster buy-in from city stakeholders. For example, leverage relationships with other UN agencies and NGOs and fostering connections and communications that can be mutually beneficial in reaching shared goals (ref. objective 1).
2. Find value-added activities to foster collaboration with civil society, including PLHIV and key populations. For example, create fora to discuss issues affecting communities; invite community representatives and civil society organisations more consistently to meetings and conferences (ref. objective 1).
3. Develop briefing kits that explain the goals, objectives, and operations of FTCP to reduce lost time when there is turnover at government agencies and other stakeholder organisations. These could include written or multimedia materials (ref. objective 1).
4. Identify a dedicated FTCP focal point at the city-level with responsibility for data (ref. objective 2).
5. Expand data collection at the municipal level to include other vulnerable populations (e.g., migrants, homeless persons, refugees, prisoners), or identify opportunities for data sharing if these data are available elsewhere. Explore harmonization of FTCP data with existing data on other relevant indicators (e.g., maternal-child health, family planning, non-communicable diseases), in line with the spirit of UN multisectoral approaches (ref. objective 2).
6. Encourage increased data sharing amongst stakeholders across sectors (e.g., municipal, civil society, academic, international agencies such as PEPFAR and the Global Fund) (ref. objective 2).
7. Consider whether and/or how to integrate city data from other available city- and national-level dashboards and online platforms, where available, in order to strengthen policy and decision-making, enhance political leadership and advocacy, and facilitate intra-city communications and collaborations (ref. objective 3).
8. Develop strategies for wider dissemination of and increased use of the dashboards among all stakeholders. These can include working with key stakeholders to ensure they understand how to access and use the dashboards; taking search engine optimization (SEO) steps to maximize ease of finding dashboards in search engine results; and designing alternate ways to make dashboards more accessible, particularly for those who may not have access to electronic media (such as having “dashboard” kiosks or ways to provide written information in key locations throughout the city where people could access health information (ref. objective 3).
9. Develop non-financial ways to encourage participation in the capacity-building trainings, particularly in settings where training is readily available. For example, consider whether to have training certification count toward continuing education requirements (ref. objective 4).
10. Provide city-level IAPAC CPOs at least partial access to the pre-/post-test results database to ensure greater transparency and ensure participants know which answers they may have answered incorrectly. Also, continually engage providers to poll them on important topics of interest for future training modules (ref. objective 4).
11. Engage PLHIV and members of key populations into some portion of the capacity-building trainings, where safe to do so, to facilitate bidirectional communication and promote mutual understanding. Also, incorporate a greater focus on the needs of children, adolescents, and young people with HIV into the capacity-building trainings, including issues of medication adherence (ref. objective 4).
12. Ensure that there is opportunity for thorough country/city-specific adaptations to the stigma elimination trainings to ensure they are locally relevant and impactful; involve clients, PLHIV, key populations, and civil society in such local adaptations (ref. objective 5).
13. Assess whether integration of QoC survey efforts and findings may be advantageous in countries where existing stigma surveys are being conducted (ref. objective 6).
14. Focus more intensively at UNAIDS and IAPAC headquarters on greater harmonization of broad goals and objectives. Ensure that there is a true depth of shared mutual understanding of each other’s goals and objectives. Find mechanisms to enhance regular communication and cooperation at both global and city levels to operationalize the shared vision (ref. project-wide issues).
15. Create mechanisms that foster communication amongst FTCP partners across cities to share strategies and learn from one another. For example, set an expectation for formal and informal communications between and amongst city-level staff to engage and learn from one another (e.g., virtual meetings, phone calls, in-person meetings when possible) (ref. project-wide issues).

16. Identify opportunities to work more closely with other agencies and sectors such as UN Women, UN-Habitat, and the International Labour Organization to improve gender equality and improve the health and wellbeing of both women and men; and with higher education institutions to address sexual and gender-based violence, sex work, and safe campus environments and to reach young men (ref. gender equality).
17. Determine how best to incorporate adaptations to FTCP activities developed in response to COVID-19 for the remainder of the project and to share useful adaptations with other FTCP cities (ref. impact of COVID-19 and responses).
18. Leverage FTCP expertise to help cities develop robust strategies for readiness for COVID-19, future pandemics, and other emergencies (ref. impact of COVID-19 and responses).
19. Document, monitor, and address capacity needs regarding data use, analysis, utilization, and training to ensure sustainability of core FTCP activities beyond the formal project period (ref. conclusions).
20. Collect lessons learned from FTCP to create a platform of best practices, and strategies to implement them that could be used by cities and municipalities around the world to adapt to their own HIV epidemics (ref. conclusions).

References

1. Paris Declaration. Fast-Track Cities: Ending the AIDS Epidemic – Cities Achieving the 90–90–90 Targets by 2020. City of Paris, UNAIDS, UN-Habitat, IAPAC, 1 December 2014 (amended 24 July 2018). Available at: https://www.unaids.org/en/resources/documents/2014/20141201_Paris_declaration (accessed 8 November 2020).
2. Beebe J. Rapid Assessment Process: An Introduction. AltaMira Press; 2001.

Annex 1: Fast-Track Cities Project: Theory of Change



Annex 2: Evaluation Matrix

Evaluation Name: Rapid Internal Review to Take Stock of the Joint UNAIDS-IAPAC Fast Track Cities Project (FTCP)

Purpose: To take stock of progress through the first few years of implementation in 15 priority cities representing high-HIV burden areas in sub-Saharan Africa, Eastern Europe, Asia, and the Caribbean.

Questions	Information Required and Sources	Scope and Methodology
Objective 1. Optimising HIV service delivery through promoting leadership, accountability, and impact in the HIV response, by strengthening critical partnerships, creating an enabling environment and supporting the development and/or implementation of robust city HIV strategic plans. Also supporting innovative or catalytic interventions that may be scaled up and fully funded from domestic or donor resources.		
How has FTCP provided support to accomplish this objective?	Description of activities designed to promote leadership, accountability, and/or ensure positive impact in the HIV response. Protocols of interventions that have been developed, piloted and/or tested.	Global and city desk review[1] KI interview[2]
How has (city) promoted leadership, accountability, and/or ensured positive impact in the HIV response?		
What critical partnerships has (city) developed and/or strengthened?		
How have these critical partnerships been strengthened?		
How has (city) created an enabling environment, if at all?		
How has the city created an environment that fosters gender equality? If yes, how?		
How has (city) supported the development and/or implementation of robust city HIV strategic plans?		
Describe innovative or catalytic interventions that have the potential to scale up and be funded from domestic or donor resources.		
How have these activities affected HIV service delivery, if at all?		
Objective 2. Supporting cities to collect, analyse and report strategic information and data on the HIV epidemic and response, and to use the information to track progress and to guide the response.		
How has FTCP provided support to accomplish this objective?	Examples of data that have been collected, analyzed and reported on the HIV epidemic and response.	Global and city desk review[1] KI interview[2]
Has the (city) collected data on the HIV epidemic and response (in their catchment)? Examples.		
Has the city collected gender-disaggregated data on the HIV epidemic? If yes, how will this data be integrated to inform the response of the city?		

[1] Sources for desk review include: UNAIDS-provided background documentation for participating cities.
[2] KI participants selected from list provided by UNAIDS.

Has the (city) analysed data on the HIV epidemic and response (in their catchment)? What analytic methods have been used?	Sources: reports, websites	
Has the (city) reported strategic information on the HIV epidemic and response (in their catchment)? How? To whom?		
How has the (city) used the information to track progress and/or to guide the response?		
What is needed, if anything, to improve the (city's) capacity to collect, analyse, and/or report strategic information? Reflect on the gaps and challenges related to data availability.		
Objective 3. Developing city-specific dashboards featuring HIV service coverage data, progress towards optimizing treatment and prevention continua, and data on HIV related comorbidities.		
How has FTCP provided support to accomplish this objective?	URL of the city-specific dashboard Sources: Internet & from KI Specification of specific uses of the dashboard to guide local evaluation and response	Global and city desk review[1] KI interview[2]
Has the (city) developed a city-specific dashboard featuring HIV service coverage data?		
What are the planned activities to strengthen the collection, analysis and report of strategic information?		
How has (city) and other stakeholders used the city-specific dashboard?		
How is the dashboard linked to broader national data (e.g., health situation room or others)		
What challenges, if any, has (city) encountered in the development, maintenance, use, and/or eliciting stakeholder engagement with the dashboard?		
What is needed, if anything, to improve the city-specific dashboard and/or its utilization?		
Objective 4. Strengthening the capacity of clinicians and people living with HIV (PLHIV) in the respective cities, to achieve and maintain optimal HIV prevention and care continua, leading to attaining the 90–90–90 targets.		
How has FTCP provided support to accomplish this objective?	Reports of activities designed to strengthen the capacity and people living with HIV including dates, location, type and number of participants, specific activities. Results of evaluations that may have been implemented (e.g., surveys, pre- post- activity evaluations, etc.)	Global and city desk review[1] KI interview[2]
What activities, if any, has the (city) implemented to strengthen the capacity of clinicians and people living with HIV? (NB: IAPAC is implementing the capacity building component)		
How have activities contributed to attaining the 90–90–90 targets?		
What are the facilitators and/or challenges of implementing capacity strengthening activities?		
Objective 5. Strengthening the capacity of HIV service providers in the respective cities, to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities.		
How has FTCP provided support to accomplish this objective?		

What activities, if any, has the (city) implemented to strengthen the capacity of service providers?	Reports of activities designed to strengthen the capacity of service providers including dates, location, type and number of participants, specific activities. Results of evaluations that may have been implemented (e.g., surveys, pre- post- activity evaluations, etc.)	Global and city desk review[1] KI interview[2]
How have these activities addressed HIV/AIDS-related stigma in health care facilities and/or communities?		
How have these activities eliminated gender discrimination in their response to HIV/AIDS? Has the city taken a gender equality approach or a gender-neutral approach?		
What evidence is available (if any) regarding impact of activities on stigma in health care facilities and/or communities?		
Objective 6. Assessing quality of care (QoC) concerns among PLHIV in Fast-Track Cities and facilitating the sharing of best practices.		
How has FTCP provided support to accomplish this objective?	Reports of activities designed to assess quality of care and sharing of best practices?	Global and city desk review[1] KI interview[2]
How have these activities affected quality of care and/or sharing of best practices?		
What are the facilitators and/or challenges of assessing quality of care and sharing best practices?		
Impact of COVID-19 on programmes How has the COVID-19 pandemic impacted project implementation? What plans have been put in place to mitigate disruption to the project and how are they working? What else could be done to mitigate the impact of the pandemic on the project? What actions have been taken to ensure continuity of HIV services and engagement of communities? What lessons have been learned that can be shared with other cities?		
Potential limitations of the evaluation methodology include: Availability and completeness of documents, availability of key informants, and willingness of key informants to share challenges or perceived shortcomings of their programmatic activities. We do not foresee that these potential limitations will affect the quality of review or its findings. **Global key informants:** Regarding the relevant questions linked to each objective (above), with global key informants we will probe for overall knowledge, views and understandings of progress, achievements, and challenges across cities and stakeholders.		

Annex 3. FTCP Rapid Internal Review Interview Guides

City-level participants

Introduction & Description

Thank you for taking time to speak with us today. I/we are consultants to UNAIDS, Fast-Track Cities Project. We have been asked to independently evaluate the progress and future plans for the project. This evaluation is for the 15-cities project – not the larger Fast-Track Cities Initiative.

We can begin with introductions. [Introduce self or each evaluation team member]

I /we am/are here to talk to you today about the Fast-Track Cities Project, and specifically progress, challenges and plans to move forward into the second half of the project.

Your name was provided to us by UNAIDS and/or IAPAC given your experience with this project.

We want to emphasise that this is to evaluate the project as a whole; it is not an evaluation of your personal performance or workplace.

Your participation is voluntary, and your responses will be kept confidential and only be used for the purpose of this evaluation. Any information you provide will not be used in reports in a way that can identify you (i.e., your responses will not be attributed to you or your specific position).

This interview/discussion may be recorded to assist us in taking notes, however, the recording will be kept as a secure password-protected electronic file and will be destroyed after notes have been taken. The recording will not be shared with UNAIDS or IAPAC.

If you prefer for our discussion to not be recorded, please let me know and I/we will not make a recording.

Our evaluation team members have signed data confidentiality agreements to protect the confidentiality of data collected for the evaluation.

If any of the questions that we ask feel outside the scope of your work, please just indicate if this is the case.

Our aim is to keep this discussion focused to complete within the hour.

Do you have any questions before we begin?

Are you comfortable with our recording of this discussion?

** YES -- BEGIN RECORDING

Can you please briefly tell me about your organisation and, in particular, its work in [city] under the Fast-Track Cities Project?

Can you describe your role and duties with respect to the implementation of the Fast-Track Cities Project?

- Probe for: Degree of HIV service specialization (i.e., clinical and/or psychosocial support, other health or human development programmatic activity.

What has been the experience of engagement between your organisation and the Global Fund? IAPAC, and UNAIDS?

Do you feel like these partnerships are working? Can you say why? Are there any challenges?

Next I am going to ask about your work with respect to the FTCP objectives. Again, if your organisation's work to date has not addressed a particular objective, just let me know.

Objective 1. Optimising HIV service delivery through promoting leadership, accountability and impact in the HIV response, by strengthening critical partnerships, creating an enabling environment and supporting the development and/or implementation of robust city HIV strategic plans. Also supporting innovative or catalytic interventions that may be scaled up and fully funded from domestic or donor resources.

The first objective of the programme is to optimize HIV service delivery.

- How has FTCP provided support to your organisation to promote leadership, accountability?
- How has FTCP provided support to your organisation to optimise a positive impact in the HIV response?
- What have the successes and challenges been in this regard to date?
- Have there been any innovations in your city in this regard?

- What would your recommendations be moving forward?

Potential probes:

- What critical partnerships has your organisation developed and/or strengthened?
- How have these critical partnerships been strengthened?
- How has your organisation created an enabling environment, if at all?
- How has your organisation supported the development and/or implementation of robust city HIV strategic plans?
- Describe innovative or catalytic interventions that have the potential to scale up and be funded from domestic or donor resources.
- How have these activities affected HIV service delivery, if at all?

Objective 2. Supporting cities to collect, analyse and report strategic information and data on the HIV epidemic and response, and to use the information to track progress and to guide the response.

The second objective is to collect, analyse, report and utilize strategic information and data on the HIV response.

- How has FTCP provided support to your organisation to collect, analyse, and/or report strategic information and data on the HIV epidemic and response?
- What have the successes and challenges been in this regard to date?
- Have there been any innovations in your organisation in this regard?
- Can you please reflect on the gaps and challenges related to data availability?
- What would your recommendations be moving forward?

Potential probes:

- Can you comment on data availability regarding relevant indicators for key populations?
- Has the city collected gender-disaggregated data on the HIV epidemic? If yes, how will these data be integrated to inform the response of the city?
- NB: This may relate mainly to some key indicators (prevalence, PLHIV, KPs, access to services).
- Has your organisation analysed data on the HIV epidemic and response (in their catchment)?
- Has your organisation reported strategic information on the HIV epidemic and response (in their catchment)? How? To whom?
- How has your organisation used the information to track progress and/or to guide the response?
- What is needed, if anything, to improve your organization's capacity to collect, analyse, and/or report strategic information?

Objective 3. Developing city-specific dashboards featuring HIV service coverage data, progress towards optimizing treatment and prevention continua, and data on HIV-related comorbidities.

The third objective is to develop city-specific dashboards.

How has FTCP provided support to your organisation to develop city-specific dashboards featuring HIV service coverage data, progress towards meeting the 90–90–90 goals, and data on HIV-related comorbidities?

- Was your city collecting 90–90–90 data prior to the start of the project?
- If yes, were they publicly reporting these data prior to the project?
- What are the facilitators and/or challenges of developing or maintaining the dashboards?
- Have there been any innovations in your city in this regard?
- What would your recommendations be moving forward?

Potential probes:

- Has your organisation developed a city-specific dashboard featuring HIV service coverage data?
- How has your organisation and other stakeholders used the city-specific dashboard?

- How is the dashboard linked to broader national data (ex. Health situations room or others)
- What challenges, if any, has your organisation encountered in the development, maintenance, use, and/or eliciting stakeholder engagement with the dashboard?
- What is needed, if anything, to improve the city-specific dashboard and/or its utilization?

Objective 4. Strengthening the capacity of clinicians and people living with HIV (PLHIV) in the respective cities, to achieve and maintain optimal HIV prevention and care continua, leading to attaining the 90–90–90 targets.

The fourth objective is to strengthen the capacity of clinicians and people living with HIV (PLHIV).

- How has FTCP provided support to your organisation to strengthen the capacity of clinicians and PLHV to achieve and maintain optimal HIV prevention and care continua, leading to attaining the 90–90–90 targets?
- What are the facilitators and/or challenges of implementing capacity strengthening activities?
- Have there been any innovations in your organisation in this regard?
- What would your recommendations be moving forward?

Potential probes:

- How have activities contributed to attaining the 90–90–90 targets?

Objective 5. Strengthening the capacity of HIV service providers in the respective cities, to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities.

The fifth objective is to strengthen the capacity of HIV service providers + eliminate HIV/AIDS – related stigma in health care facilities and communities.

- How has FTCP provided support to your organisation to strengthen the capacity of HIV service providers in the respective cities, to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities?
- How have these activities addressed HIV/AIDS-related stigma in health care facilities and/or communities?
- What are the facilitators and/or challenges of implementing capacity strengthening activities?
- Have there been any innovations in your city in this regard?
- What would your recommendations be moving forward?

Potential probes:

- How have these activities addressed HIV/AIDS-related stigma in health care facilities and/or communities?
- What evidence is available (if any) regarding impact of activities on stigma in health care facilities and/or communities?

Objective 6. Assessing quality of care (QoC) concerns among PLHIV in Fast-Track Cities and facilitating the sharing of best practices.

The sixth objective is to assess quality of care concerns among PLHIV & sharing of best practices.

- How has FTCP provided support to your organisation assess quality of care concerns among PLHIV?
- How has FTCP provided support to your organisation assess quality of care best practices?
- How have these activities affected quality of care and/or sharing of best practices?
- What are the facilitators and/or challenges of assessing quality of care and sharing best practices?
- Have there been any innovations in your city in this regard?
- What would your recommendations be moving forward?

Potential probes:

- How has (city) assessed the sharing of best practices?

Are there any other successes and/or challenges not already mentioned related to your implementation of the FTCP objectives?

Probe for:

- M&E, funding, procurement, financial reporting?

If not covered previously: **How is your organization addressing/ensuring gender equality in service provision and access?**

NB: Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued, and favoured equally. It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female" – UNEG.

Effects of COVID-19

Finally, I would like to ask about the impact of COVID-19 on your organisation's FTCP-support programmes.

- How has COVID-19 and associated constraints (e.g., lockdowns, travel restrictions, economic disruption) affected (programme)?
- What plans have been put in place to mitigate disruption? How are they working?
- What else could be done to mitigate the impact of the pandemic on the project?
- What actions have been taken to ensure continuity of HIV services and engagement of communities?
- How might we take advantage of this as we plan for the remainder of the project?
- Have there been any unforeseen positive outcomes/changes during this time?
- What problems or interruptions do you foresee?
- What would your recommendations be moving forward?
- Overall, what valuable lessons have been learned that could be shared with other cities?

Are there any questions I have not asked about your organisation that you think provide important context to your experience here?

Are there any other broad reflections regarding successes, challenges, innovations or recommendations that you would like for us to know?

Is there anything else you think would be important for us to understand as we meet other Key Informants in other cities?

Do you have any questions for me?

Please feel free to email me/us if there is anything else you would like to share.

Thank you very much for taking the time to speak with me today.

Global and regional participants

Introduction & Description

Thank you for taking time to speak with us today. I/we are consultants to UNAIDS, Fast-Track Cities Project. We have been asked to independently evaluate the progress and future plans for the project. This evaluation is for the 15-cities project – not the larger Fast-Track Cities Initiative.

We can begin with introductions [introduce self or each evaluation team member].

I /we am/are here to talk to you today about the Fast-Track Cities Project, and specifically progress, challenges and plans to move forward into the second half of the project.

We want to emphasise that this is to evaluate the project as a whole; it is not an evaluation of your personal performance or workplace.

Your participation is voluntary, and your responses will be kept confidential and only be used for the purpose of this evaluation. Any information you provide will not be used in reports in a way that can identify you (i.e., your responses will not be attributed to you or your specific position).

This interview/discussion may be recorded to assist us in taking notes, however, the recording will be kept as a secure password-protected electronic file and will be destroyed after notes have been taken. The recording will not be shared with UNAIDS or IAPAC.

If you prefer for our discussion to not be recorded, please let me know and I/we will not make a recording.

Our evaluation team members have signed data confidentiality agreements to protect the confidentiality of data collected for the evaluation.

If any of the questions that we ask feel outside the scope of your work, please just indicate if this is the case.

Our aim is to keep this discussion focused to complete within the hour.

Do you have any questions before we begin?

Are you comfortable with our recording of this discussion?

** YES -- BEGIN RECORDING

[Regional] Can you describe your role and duties with respect to the Fast-Track Cities Project?

[Regional] Can you describe your involvement with city and global level FTC stakeholders?

[Global] Can you talk to me a bit about your history or role in the Fast-Track Cities Project?

Probe:

- Can you describe your relationship to regional and city level FTCP stakeholders?

What has been the experience of engagement between partners in strategic planning—for example, between you or your organization and the Global Fund? IAPAC? UNAIDS?

Do you feel like these partnerships are working? Can you say why? Are there any challenges?

Overall, what is your opinion on how well the FTCP has accomplished the objective of supporting cities to:

- Optimise HIV service delivery?
- Collect, analyse and report strategic information and data on the HIV epidemic and response?
- Develop city-specific dashboards featuring HIV service coverage data, progress towards optimizing treatment and prevention continua, and data on HIV related comorbidities?
- Strengthen the capacity of clinicians and people living with HIV (PLHIV) in the respective cities, to achieve and maintain optimal HIV prevention and care continua, leading to attaining the 90–90–90 targets?
- Strengthen the capacity of HIV service providers in the respective cities, to eliminate HIV/AIDS-related stigma in health care facilities and mitigate stigma within communities?
- Assess quality of care (QoC) concerns among PLHIV in Fast-Track Cities and facilitating the sharing of best practices?

What aspects do you feel have worked particularly well across cities?

What aspects do you feel need more attention?

To your knowledge, are there any specific innovations that have emerged from the FTCP?

Can you tell me about specific cities where your feel progress has excelled?

Can you tell me about specific cities where progress seems to be lagging or where results have been mixed or suboptimal, for any reason? What have been the challenges to progress? What do you think should/could be done to support these cities?

How might the experience in 'model cities' serve as an example of effective course correction for those that have been lagging?

How has COVID-19 and related constraints affected the FTCP planning, coordination, etc.?

Are there any other broad reflections regarding successes, challenges, innovations, or recommendations that you would like for us to know?

Is there anything else you think would be important for us to understand as we speak with others?

Do you have any questions for me?

Please feel free to email me/us if there is anything else you would like to share.

Thank you very much for taking the time to speak with me today.

Annex 4: Background Documents Used for Desk Review

In addition to the documents and resources enumerated below, over 300 additional background documents at project-wide and city levels made available by UNAIDS and IAPAC were used for the desk review, including but not limited to city strategic plans, city work plans, city COVID-19 mitigation plans, dashboards, FTCP proposals to USAID, implementation manuals, meeting reports, monthly updates, posters from the 2019 London FTC conference, presentation slide decks, semi-annual reports, and training modules and related training documents.

Project-Wide Documents

Accelerating the AIDS Responses in 10 Priority Cities: The Joint UNAIDS-IAPAC Fast-Track Cities Project (Year One Report). UNAIDS, IAPAC, 2019.

Cities Ending the AIDS Epidemic. UNAIDS, 2016. Available at: https://www.unaids.org/en/resources/documents/2015/2015_Fast_Track_Cities_Paris_Outcomes (accessed 8 November 2020).

Cities on the Road to Success: Good Practices in the Fast-Track Cities Initiative to End AIDS. UNAIDS, 2019. Available at: https://www.unaids.org/en/resources/documents/2019/cities-on-the-road-to-success (accessed 8 November 2020).

Cities Unite to Fast-Track to End the AIDS Epidemic. Event Summary: Taking Action World AIDS Day 2014. City of Paris, UNAIDS, UN-Habitat, IAPAC, 2014. Available at: https://www.unaids.org/en/resources/documents/2015/2015_Fast_Track_Cities_Paris_Outcomes (accessed 8 November 2020).

COVID-19 and HIV – 1 Moment 2 Epidemics 3 Opportunities: How to Seize the Moment to Learn, Leverage and Build a New Way Forward for Everyone's Health and Human Rights. UNAIDS, 2020. Available at: https://www.unaids.org/sites/default/files/media_asset/20200909_Lessons-HIV-COVID19.pdf (accessed 8 November 2020).

Ending AIDS: Progress Towards the 90–90–90 Targets (Global AIDS Update). UNAIDS, 2017. Available at: https://www.unaids.org/en/resources/documents/2017/20170720_Global_AIDS_update_2017 (accessed 8 November 2020).

Ending the AIDS Epidemic: The Advantage of Cities. UN-Habitat, 2015. Available at: https://www.unaids.org/en/resources/documents/2015/20150918_Ending_urban_AIDS_epidemic_en (accessed 8 November 2020).

Fast-Track Cities Mid-Year Project Review (slide deck). UNAIDS, IAPAC, 21-22 May 2020.

Integrating Human Rights and Gender Equality in Evaluations. UNEG, August 2014. Available at: http://www.uneval.org/document/detail/1616 (accessed 8 November 2020).

Methodology – Understanding the HIV Estimates in the OUTLOOK: Cities Report. UNAIDS Strategic Information and Monitoring Division, December 2014. Available at: https://www.unaids.org/en/resources/documents/2014/UNAIDS_methodology_cities_report_2014 (accessed 8 November 2020).

On the Fast-Track to End AIDS by 2030: Focus on Location and Population. UNAIDS, 2015. Available at: https://www.unaids.org/en/resources/documents/2015/FocusLocationPopulation (accessed 8 November 2020).

Paris Declaration. Fast-Track Cities: Ending the AIDS Epidemic – Cities Achieving the 90–90–90 Targets by 2020. City of Paris, UNAIDS, UN-Habitat, IAPAC, 1 December 2014 (amended 24 July 2018). Available at: https://www.unaids.org/en/resources/documents/2014/20141201_Paris_declaration (accessed 8 November 2020).

Semi-Annual Progress Report for Directed Activities Under USAID-UNAIDS Grant Agreement April - September 2020: Joint UNAIDS-IAPAC Fast-Track Cities project: Fast-tracking the response to the HIV epidemic in priority cities to attain the 90–90–90 treatment, zero stigma and quality of life targets by 2020. UNAIDS, IAPAC, 2020.

Semi-Annual Progress Report for Directed Activities Under USAID-UNAIDS Grant Agreement October 2019 - March 2020: Joint UNAIDS-IAPAC Fast-Track Cities project: Fast-tracking the response to the HIV epidemic in priority cities to attain the 90–90–90 treatment, zero stigma and quality of life targets by 2020. UNAIDS, IAPAC, 2020.

Semi-Annual Progress Report for Directed Activities Under USAID-UNAIDS Grant Agreement April 2019 - September 2019: Joint UNAIDS-IAPAC Fast-Track Cities project: Fast-tracking the response to the HIV epidemic in priority cities to attain the 90–90–90 treatment, zero stigma and quality of life targets by 2020. UNAIDS, IAPAC, 2019.

Semi-Annual Progress Report for Directed Activities Under USAID-UNAIDS Grant Agreement October 2018 - March 2019: Joint UNAIDS-IAPAC Fast-Track Cities project: Fast-tracking the response to the HIV epidemic in priority cities to attain the 90–90–90 treatment, zero stigma and quality of life targets by 2020. UNAIDS, IAPAC, 2019.

The Cities Report. UNAIDS, 2014. Available at: https://www.unaids.org/en/resources/documents/2014/thecitiesreport (accessed 8 November 2020).

Virtual Fast-Track Cities 2020 (Virtual Conference). IAPAC, UNAIDS, Fast-Track Cities Institute, 8-10 September 2020. Conference videos and documents available at: https://www.iapac.org/conferences/virtual-fast-track-cities-2020/ (accessed 8 November 2020).

City-Specific Documents

Blantyre

Blantyre Dashboard Report January 1, 2020 - September 21, 2020.

Malawi Country Fact Sheet. UNAIDS, 2019

eThekwini (Durban)

District-Level Health Estimates (Dashboard), 2016.

Dr. NI Gxagxisa. eThekwini City Landscape Presentation. IAPAC African Regional Fast-Track Cities Workshop. 7 December 2019.

Draft eThekwini District AIDS Council (DAC) Strengthening Strategy.

eThekwini Dashboard Report January 1, 2018 - September 21, 2020.

eThekwini FTC Conference Poster. 2019.

eThekwini Municipality Health Estimates. 2019.

eThekwini Municipality. Provincial Council on AIDS Meeting, Quarter 2, 2018-19 Presentation. 15 March 2019.

Fast-Track Cities Global Web Portal. eThekwini Data Visualizations.

Joint UNAIDS-IAPAC Fast-Track Cities Project: USAID Monthly Update. UNAIDS, IAPAC, June 2020.

Report on the Status of the eThekwini HAST M&E System Including Interventions and Quality Improvement Recommendations. 19 March 2019.

Savant, Chalone. eThekwini District AIDS Council (DAC) Functionality Report. UNAIDS.

Savant, Chalone. eThekwini District Multisectoral Implementation Plan Gap Analysis Report. UNAIDS.

South Africa Country Fact Sheet. UNAIDS, 2019.

Stainaz. Final Report: Facility M&E Training and Mentoring in eThekwini District.

Jakarta

2010-2035 Indonesia Population Projection. Indonesia Statistics Office. 2017.

Have any questions about HIV? Just ask Marlo! Presentation. UNAIDS Indonesia.

HIV/AIDS Fact Sheet: Indonesia and Jakarta. UNAIDS, March 2018.

Indonesia Country Overview. UNAIDS, 2018.

Jakarta City FTCP Fact Sheet Spreadsheet. October 2018.

Jakarta Dashboard Report January 1, 2018 - September 21, 2020.

Jakarta FTC Conference Poster. 2019.

National AIDS Programme Data. Ministry of Health Modelling Programme, 2017.

Sudaryo, Mondastri K. Report of the First Agenda: UNAIDS Workshop on Disaggregation Method, AEM modelling of HIV & AIDS, 14 February 2019.

Johannesburg

CIty of Johannesburg: District Profile HIV Epidemic Trends 2017-18. UNAIDS.

Johannesburg Dashboard Report January 1, 2018 - September 21, 2020.

Johannesburg FTC Conference Poster. 2019.

Johannesburg Key Population Database.

WebDHIS. National Department of Health, South Africa, August 2019.

Kampala

DHIS2 (Kampala Fast-Track City Dashboard).

Fast-Track Cities Global Web Portal. Kampala Data Visualizations.

HIV/AIDS Strategic Plan 2015/16 - 2019/2020, Kampala, Uganda. Kampala City Authority.

Kampala Dashboard Report January 1, 2019 - September 21, 2020.

Kampala FTC Conference Poster. 2019.

Uganda Country Fact Sheet. UNAIDS 2019.

UPHIA, 2016 (Kampala Fast-Track City Dashboard).

Kigali

City of Kigali, Rwanda Biomedical Center. City of Kigali Strategic Operational Plan 2018 - 2023 (Dashboard). Fast-Track Cities Global Web Portal. Kigali Data Visualizations.

Fourth Population Housing Census, Rwanda 2012.

Kigali City FTCP Fact Sheet Spreadsheet Version 2.

Kigali Dashboard Report January 1, 2018 - September 21, 2020.

Rwanda NGOs Forum on HIV/AIDS and Health Promotion. Report on Baseline Study to assess the practices of the substance use and its association to HIV infections among

People Who Use or Inject Drugs (PWUD/PWID) in selected hotspots of Districts of the City of Kigali. Kigali, Rwanda, 30 January 2020.

UNAIDS. 2019. Rwanda Country Fact Sheet. 2019.

Kingston

Fast-Track Cities Global Web Portal. Kingston Data Visualizations.

Fast-Track Kingston Launch Report. 25 November 2020.

Jamaica Country Fact Sheet. UNAIDS 2019.

Kingston Dashboard Report, 1 January 2018 – 21 September 2020.

Kingston Fast-Track City Programme Steering Committee Meeting Notes. 19 February 2020.

Kingston FTC Conference Poster. 2019

Ministry of Health and Wellness Treatment Database and Epidemiology Report, 2019 Estimates. (Dashboard)

Kinshasa

Democractic Republic of Congo Country Fact Sheet. UNAIDS, 2019.

Fast-Track Cities Global Web Portal. Kinshasa Data Visualizations.

Kinshasa Dashboard Report 1 August 2018 – 21 September 2020.

Kinshasa Fast-Track City Project Proposal

Kyiv

Fast-Track Cities Global Web Portal. Kyiv Data Visualizations.

Kyiv Dashboard Report 1 January 2017 – 21 September 2020.

Kyiv FTC Conference Poster. 2019.

Kyiv FTCI Report. Ukraine. 2018.

Sustaining Fast-Track Response to HIV During COVID-19. Kyiv, Ukraine, 2020.

Ukraine Country Fact Sheet. UNAIDS 2019.

Ukraine GAM 2019 Report (Dashboard).

Lagos

Fast-Track Cities Global Web Portal. Lagos Data Visualizations.

Lagos Dashboard Report 1 May 2019 – 21 September 2020.

Lagos State AIDS Control Agency. Mid-term Review of the Lagos State HIV/AIDS Strategic Plan 2017-21. Nigeria.

Nigeria Country Fact Sheet. UNAIDS 2019.

Lusaka

City of Lusaka. Lusaka City Fast Track Action Plan 2019-2023.

Fast-Track Cities Global Web Portal. Lusaka Data Visualizations.

Lusaka Dashboard Report 1 November 2019 – 21 September 2020.

Lusaka FTC Conference Poster. 2019.

Zambia Country Fact Sheet. UNAIDS 2019.

Maputo

Fast-Track Cities Global Web Portal. Maputo Data Visualizations.

Maputo Dashboard Report 1 July 2018 – 21 September 2020.

Mozambique Country Fact Sheet. UNAIDS, 2019.

Mozambique Country Overview. UNAIDS, 2018.

Nairobi

Fast-Track Cities Global Web Portal. Nairobi Data Visualizations.

Fast-Track Cities Nairobi 2020 Updates Presentation, 28 July 2020.

Githuku, Jane. A Report on Qualitative Assessment of HIV Service Delivery in Informal Settlements in Four Sub-Counties of Nairobi, 2018.

Kenya Country Fact Sheet. UNAIDS, 2019.

Maputo Dashboard Report 1 July 2018 – 21 September 2020.

Nairobi Dashboard Report 1 January 2017 – 21 September 2020.

Nairobi FTC Conference Poster. 2019.

Windhoek

City of Windhoek HIV/AIDS Strategic Plan 2017 - 2022. City of Windhoek, 24 June 2018.

Fast-Track Cities Global Web Portal. Windhoek Data Visualizations.

Namibia Country Fact Sheet. UNAIDS, 2019.

Windhoek Dashboard Report 1 May 2019 – 21 September 2020.

Windhoek FTC Conference Poster. 2019.

Windhoek HIV/AIDS Data Spreadsheet Version 21.

Yaoundé

Cameroon Population-Based HIV Impact Assessment 2017 (Dashboard).

Fast-Track Cities Global Web Portal. Yaoundé Data Visualizations.

Réduire L'écart À Yaoundé D'ici À 2020 (*Closing the Gap In Yaoundé By 2020*).

UNAIDS GAM 2018 (Dashboard).

UNAIDS. 2019. Cameroon Country Fact Sheet. UNAIDS, 2019.

Yaoundé Dashboard Report 1 June 2019 – 21 September 2020.

Yaoundé FTC Conference Poster. 2019.

Annex 5: Dashboard Data for the 15 FTCP Cities

For an explanation of the difference between the 90–90–90 target data and the HIV care continuum (HIV testing and treatment cascade) data provided in the table, please refer to the graphic, *"What's the Difference? Understanding Measures of Progress Towards 90–90–90"* below.

Up-to-date dashboards can be accessed on the Fast-Track Cities Global Web Portal at: https://www.fast-trackcities.org/dashboards. This includes dashboards for the 15 FTCP cities as well as dashboards for some of the other cities participating in the larger Fast-Track Cities Initiative.

City	Year of Data	90–90–90 Target Data			HIV Care Continuum Data		
		PLHIV Diagnosed	PLHIV on ART	PLHIV Virally Suppressed	PLHIV Diagnosed	PLHIV on ART	PLHIV Virally Suppressed
Blantyre	2019	85%	88%	92%	85%	75%	69%
eThekwini (Durban)	2019	91%	77%	93%	91%	70%	55%
Jakarta	--	N/A	N/A	N/A	N/A	N/A	N/A
Johannesburg	2019	86%	65%	85%	86%	56%	36%
Kampala	2020	57%	72%	95%	57%	57%	54%
Kigali	2018	91%	94%	89%	91%	85%	76%
Kingston	2019	93%	53%	66%	93%	50%	33%
Kinshasa	2018	74%	56%	54%	74%	42%	10%
Kyiv	2019	67%	83%	95%	67%	55%	53%
Lagos	2019	78%	80%	62%	78%	72%	50%
Lusaka	2018	70%	88%	63%	70%	61%	38%
Maputo	2015	N/A	84%	81%	N/A	N/A	48%
Nairobi	2018	79%	99%	92%	79%	79%	72%
Windhoek	2019	85%	89%	73%	85%	76%	55%
Yaoundé	2018	74%	86%	N/A	74%	63%	N/A

WHAT'S THE DIFFERENCE?

UNDERSTANDING MEASURES OF PROGRESS TOWARDS 90-90-90

The 90–90–90 targets and the HIV testing and treatment cascade are two ways of looking at the same data. The targets were instrumental in galvanizing global action for HIV treatment access. Full achievement of 90–90–90 is equal to viral load suppression among 73% of all people living with HIV.

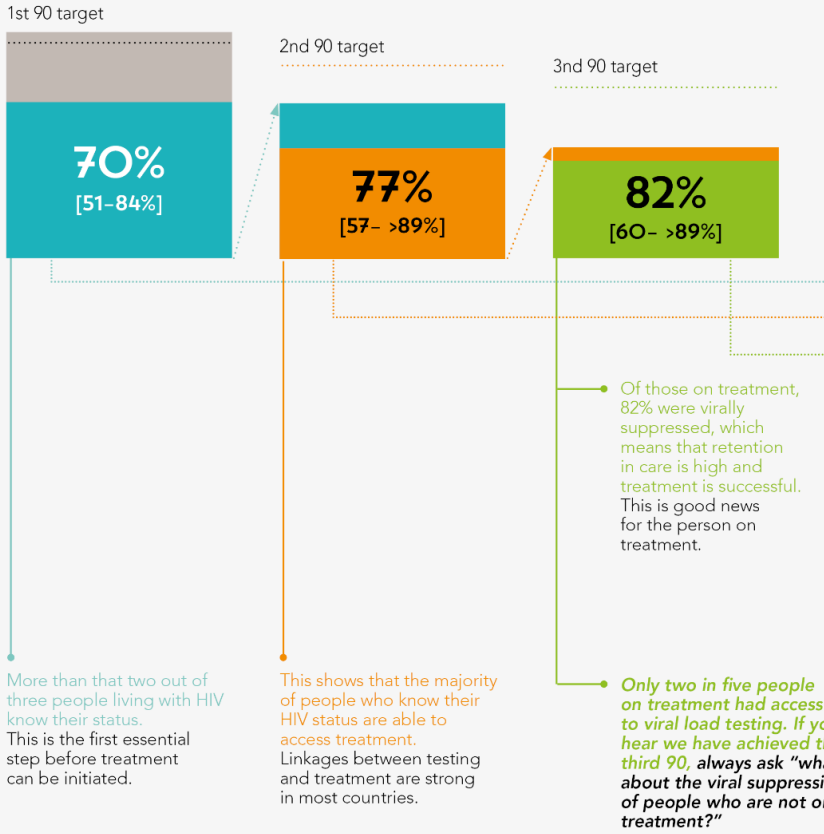
90-90-90 TARGETS

For each of the 90–90–90 targets, the denominator is different. The first 90 value (70%) is the denominator for the second 90, and the second 90 value (77%) is the denominator for the third 90.

People living with HIV who know their status

People living with HIV who know their status and are on HIV treatment

People on HIV treatment who are virally suppressed



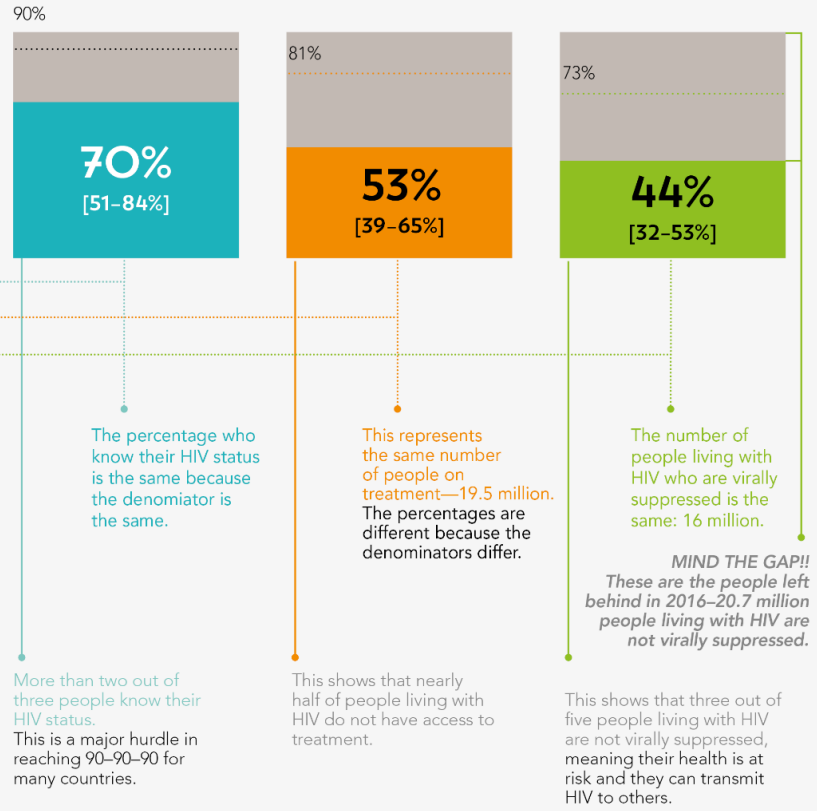
HIV TESTING AND TREATMENT CASCADE

Across the cascade, the denominator for each step remains the same: all people living with HIV.

People living with HIV who know their status

People living with HIV on treatment

People living with HIV who are virally suppressed



Source: UNAIDS 2017. Understanding measures of progress towards 90–90–90 (available at : https://www.unaids.org/en/resources/infographics/measures-progress-909090).

Annex 6: Key Informant Characteristics

The review was conducted between 30 September – 13 November 2020. A total of 125 individuals were invited by email to participate in the review. A total of 71 accepted the invitation, 67 of whom were interviewed by teleconference and four of whom responded by email.

A detailed tally and breakdown of the key informant interviews is below.

Global Level	City/Country Level	
UNAIDS: 3	UNAIDS: 26	Government: 8
IAPAC: 3	IAPAC: 15	Civil Society: 13
		Global Fund: 3

	Number of Key Informants Interviewed				
	UNAIDS	**IAPAC**	**Government**	**Civil Society***	**Global Fund**
Global Level	3	3	--	--	--
Blantyre	2	1	1	--	--
eThekwini (Durban)	--	1	1	--	1
Jakarta	3	1	--	1	--
Johannesburg	1	1	1	2	--
Kampala	1	1	1	--	--
Kigali	1	1	--	1	--
Kingston	2	1**	1	**	--
Kinshasa	1	1	1	2	--
Kyiv	2	1	2	2	--
Lagos	2	1	--	1	--
Lusaka	2	1	--	1	--
Maputo	2	1	--	--	--
Nairobi	2	1	--	1	1
Windhoek	3	1	--	--	--
Yaoundé	2	1	--	2	1
Total	29	18	8	13	3

* Includes community-based organisations (some of which were implementing partners), community representatives, and members of key populations and networks of PLHIV.

** IAPAC respondent is also civil society representative.

Annex 7: Evaluation Team

Lisa M. Butler, PhD, MPH, PhD

Dr. Butler has doctoral training in Educational Psychology *(PhD, UCLA, 2000)* and Epidemiology *(PhD, UC Berkeley, 2009),* and has over 22 years' research and evaluation experience in diverse settings in sub-Saharan Africa and North America. She has methodologic expertise in the design, implementation and analyses of epidemiologic studies and programme evaluation; participatory action research; human centred design methods; visual storytelling methods. Her research and programmatic interests include sexual and reproductive health for adolescents; adolescent friendly health services; HIV prevention and treatment; paediatric HIV disclosure; neonatal, child, and adolescent health and development; maternal-child health; food security and nutrition; mental health; gender-based violence; migrant health; development and evaluation of clinical decision support tools for nurses and community health workers; and vaccine hesitancy. She has experience in the development of training programmes for biomedical health providers, traditional healers and lay health workers, as well as development and evaluation of multi-component interventions targeting low-literacy populations.

Lauren Chender, MPH

Lauren Chender holds a master's in public health from the University of Toronto and a BA in Social Studies of Medicine from McGill University. She has over a decade of experience coordinating and managing global health and youth livelihoods development projects in sub-Saharan Africa and Asia, with expertise in programme reporting and operations. She has worked on HIV prevention, treatment and care programmes with small community-based organizations and large NGOs in South Africa, Ghana, and the United States. From 2010-2012 she served as a Board Director for the Ontario Council for International Cooperation. Currently, she is working on number of research, policy and evaluation projects with the Institute for Work and Health, Youth Challenge International and the Institute for Collaboration on Health, Intervention and Policy at the University of Connecticut.

Agnès Fiamma Papone, MPH

Agnès Fiamma Papone is the former Africa Regional Director of the UCLA Program in Global Health, which was based in Johannesburg, South Africa. She coordinated the HIV prevention research portfolio in Southern Africa for UCLA and UCSF in Malawi, South Africa, Tanzania, and Zimbabwe. Her specific areas for NIMH Project Accept (HPTN 043) were on assays to estimate HIV incidence and accessible, point-of-care laboratory methodologies. She served as an advisor to UCLA Program in Global Health laboratory design and implementation in Lilongwe, Malawi, in collaboration with Partners in Hope. She coordinated an NIMH-funded UCLA collaborative HIV and STI prevention study in Hefei, China on training and capacity building of rural physicians in stigma reduction. She provided technical, training, and scientific support to the operationalisation and implementation of medical male circumcision following the outcomes of the Auvert study in Orange Farm, South Africa. Previously, she oversaw and managed the scale-up and roll-out of PMTCT services in Soweto with the Perinatal HIV Research Unit at Chris Hani Baragwanath Hospital. She received her MPH (international option) from the University of Sydney in 2002. Her research, programme, and policy interests are centred on social norms and behavioural prevention, governance, training, and capacity building in rural and remote settings.

Greg Szekeres

Greg Szekeres has 25+ years' experience creating and managing complex programmes and partnerships within academic and non-profit institutions in the global health space. Mr. Szekeres is the former Deputy Director of the UCLA Center for World Health, which advanced the international and global health mission of the David Geffen School of Medicine at UCLA and UCLA Health. Previously, he served as Multisite Director for HPTN 043, a Phase III randomized controlled trial of a community-based HIV voluntary counselling and testing intervention in 48 communities in South Africa, Tanzania, Thailand, and Zimbabwe. He served as Content and Development Coordinator for the Center for HIV Information at the UCSF School of Medicine, partnering with government agencies, foundations, and international organizations to develop and disseminate clinical, research, and policy information via electronic media. He received his BA in Psychology from UC Berkeley. His research, policy, and programmatic interests include domestic and global health leadership development; HIV; emerging infectious diseases; antimicrobial stewardship; mental health; health information technologies; indigenous peoples; and the intersections of climate change, the environment, and health. He is author on 24 papers published in peer-reviewed scientific and medical journals.

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