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Analysis of Community Competences on HIV and AIDS in SDC Priority Countries:

Mozambique, Tanzania and Zimbabwe

Dr Kate Molesworth

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SDC Contact

Viviane Hasselmann, SDC – Swiss Agency for Development and Cooperation

SDC - Head office, Freiburgstrasse 130, 3003 Berne

e-mail: viviane.hasselmann@eda.admin.ch, www.deza.admin.ch

Author

Kate Molesworth,

Health and Social Development Advisor

Swiss Centre for International Health

Swiss Tropical and Public Health Institute

Socinstrasse 57, 4002 Basel, Switzerland

Tel +41 61 284 8179

Fax +41 61 284 8103

Internet: kate.molesworth swisstph.ch, www.scih.ch / www.swisstph.ch

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1 Introduction

The Swiss TPH has been mandated to conduct an analysis of community competencies in HIV and AIDS, as well as competencies surrounding the inclusion of men, in SDC priority countries of Mozambique, Tanzania and Zimbabwe. The purpose is to provide a snapshot to the themes of community HIV competence and male inclusion and to assess the extent to which the focal persons are equipped to strengthen these approaches to the HIV response and what is needed to enhance their capacities.

As well as informing SDC on its internal knowledge and competence, this analysis will also inform the development of a subsequent facilitator guide to support focal persons in strengthening community HIV and AIDS competencies.

1.1 What is "community HIV competence"?

The community competence approach is built on the rationale that while effective individual responses to AIDS is the end goal, it cannot achieve desired results without competent communities that can reinforce, adapt, and share successful responses and approaches. It incorporates communities' needs and knowledge, and recognizes the value of community ownership in developing effective programme planning and performance through collaboration.

AIDS-competent communities are defined as:

- Communities that "can facilitate sexual behaviour change, reduce HIV/AIDS–related stigma, support people living with HIV/AIDS, and cooperate in HIV–related prevention practices."[1] (Reed et al 2014)
- "… a social setting in which people are most likely to work collaboratively to optimize HIV/AIDS prevention, care and treatment"[2] (Campbell et al 2012)
- "… the ability of people to maintain and improve the quality of their lives by facing up to HIV and AIDS. They determine and manage their own responses to the HIV/AIDS epidemic in their own community by assessing accurately the factors that make them vulnerable to, or put them at risk of infection with, HIV. They act so as to reduce their vulnerability and those risks, and they mobilise adequate holistic care and support when infected with, or affected by HIV/AIDS". Lamboray et al 2001, quoting UNAIDS 2000[3])

1.2 How do we define the term "community"?

According to the TOR of this mandate: "Community is to be understood as any group of people having social ties (could be workers at an embassy, SDC employees, workers in a project, beneficiaries of a SDC project, etc)." Within the context of this analysis of community competences on HIV and AIDS in

[1] Reed SJ, Miller RL, Adolescent Medicine Trials Network for HIV/AIDS Interventions. Connect to protect and the creation of AIDS-competent communities. *AIDS Educ Prev*. 2013;25(3):255-67.
[2] Campbell C., Skovdal M., Mupambireyi Z., Madanhire C., Nyamukapa C., Gregson S. Building adherence-competent communities: Factors promoting children's adherence to anti-retroviral HIV/AIDS treatment in rural Zimbabwe. Health Place. 2012;18:123–131. doi: 10.1016/j.healthplace.2011.07.008.
[3] UNAIDS Department of Policy, Strategy and Research. 2000. Keynote, Local Responses to HIV/AIDS.UNAIDS Update 5.

SDC priority countries, the term "community" refers to "the community of people working at embassy" and the "community of partner organizations receiving SDC grants".

1.3 Value and evidence base for community competency approaches to HIV and AIDS

The importance of community competence in tackling the HIV epidemic and responding to AIDS has been acknowledged for almost two decades. During this time there have been a few research and descriptive publications describing AIDS competence as used in the UNAIDS agenda[4] and proposing of a framework to guide practitioners and interventions in strengthening community awareness and responsiveness to perceived risk.

To provide chronic disease care within the realities of struggling health systems and human resource shortages, as well as physical and economic access, there is a need to draw on the prevention and potential of communities to build health-enabling environments and societies that can support the wider national and global HIV response as well as fostering broader health and well-being in a sustainable manner. It is argued that to do this interventions are need to strengthen HIV and AIDS knowledge, reduce stigma, encourage HIV testing, improve health care seeking behaviour, and support behaviour change towards safer sexual practices - in other words community AIDS competence.[5]

Approaches supporting community HIV competence have been shown to achieve a substantial impact on knowledge and preventive behaviour. In a study in rural Uganda in 1995, during the first five months of an information campaign delivered by community facilitators to improve community prevention of HIV, knowledge about condoms was shown to have increased from 26% to 63% in women and 57% to 91% in men. Additionally, condom use during casual sex increased from 6% to 33% in women and 27% to 48% in men.[6] Similarly the UNAIDS/UNITAR AIDS Competence Programme reported significant changes in knowledge, attitudes and action among communities in North-eastern Thailand over a two-year period. This is shown in table 1 below:

OUTCOME	BASELINE (2003) *	CURRENT (2005) *
Knowledge and acknowledgement of HIV and AIDS	46%	77%
Positive Attitudes Towards People Living with HIV	51%	80%
Women Participation and Support in AIDS Work	45%	80%
Resource Mobilization	42%	71%
Identification and addressing of Risks and Vulnerabilities	49%	86%
Treatment Availability for People Living with HIV	37%	71%

Table 1 Changes in knowledge, attitudes and action among communities in North-eastern Thailand[7]

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[4] UNAIDS / UNITAR. 2005. Evaluation of the UNAIDS/UNITAR AIDS Competence Programme. http://data.unaids.org/publications/irc-pub06/jc1144-acp.evaluation_en.pdf

[5] Masquillier, C., Wouters, E., Mortelmans, D., & van Wyk, B. (2015). On the road to HIV/AIDS competence in the household: building a health-enabling environment for people living with HIV/AIDS. *International journal of environmental research and public health*, *12*(3), 3264-92. doi:10.3390/ijerph120303264

[6] Schopper, D., Doussantousse, S., Ayiga, N., Ezatirale, G., Idro, W.J., and Homsy, J. Village-Based AIDS Prevention in a Rural District in Uganda. Health Policy and Planning (2): 171-180, 1995

[7] UNAIDS / UNITAR. 2005. Evaluation of the UNAIDS/UNITAR AIDS Competence Programme. http://data.unaids.org/publications/irc-pub06/jc1144-acp.evaluation_en.pdf

While developing community AIDS competence has the potential to create a health-enabling environment,[8] research shows that it is also subject to a number of HIV-specific barriers such as stigma, discrimination and local HIV-related myths[9] [10] [11] in addition to broader challenges such as existing community tensions[12] and a lack of resources and skills.[13]

1.4 Why is SDC interested in male stigma and HIV and AIDS competence?

Although very few of the documents on community HIV and AIDS competence in the literature present any targeted efforts to reduce male stigma or to better include men and boys in community competence-building, gender inequalities and damaging gender norms related to sexual behaviour and negotiation, as well as care seeking, are recognised to be important drivers of the HIV epidemic. Singly and in concert, these present substantial obstacles that hamper effective HIV responses at the grass-roots, national and global levels. For the majority of the AIDS response, gendered approaches have tended to focus on women and girls as a consequence of their heightened biological, social and economic risks determined by their lack of autonomy and empowerment. While access issues to HIV services for women and girls persist, however, UNAIDS and other organisations have come to acknowledge the growing evidence showing that by neglecting and effectively excluding men and adolescent boys within HIV gender programming, interventions have not yielded the most effective or efficient results.

In all regions of the world HIV prevalence is consistently higher among men within key populations - comprising sex workers and men who inject drugs. In many countries adolescent boys and young men who belong to key populations face heightened risks of HIV infection, yet they also have poor knowledge regarding transmission risk and prevention and have low uptake of HIV services. Key populations are often deterred from accessing services by punitive laws and policies, police harassment as well as stigma, rejection and discrimination within health settings.

Looking at table 2, showing new infections in the United Stated of America, disaggregation by sex, ethnicity and sexuality, it can be clearly seen that men and boys with same-sex contact have the highest number of diagnosed cases. The significant difference in the number of cases between men with same-sex contact disaggregated by ethnicity is an indicator of the importance of the different constructs of masculinity that impact on the ability to have reduced-risk sexual contact – by carrying appropriate condoms and lubricants, for example.

[8] Campbell C., Skovdal M., Mupambireyi Z., Madanhire C., Nyamukapa C., Gregson S. Building adherence-competent communities: Factors promoting children's adherence to anti-retroviral HIV/AIDS treatment in rural Zimbabwe.
[9] Gardner E.M., Young B. The HIV care cascade through time. Lancet Infect. Dis. 2014;14 doi: 10.1016/S1473-3099(13)70272-X.
[10] Kilmarx P.H., Mutasa-Apollo T. Patching a leaky pipe: The cascade of HIV care. Curr. Opin. HIV AIDS. 2013;8:59–64
[11] Nhamo M., Campbell C., Gregson S. Obstacles to local-level AIDS competence in rural Zimbabwe: Putting HIV prevention in context. Aids Care. 2010;22:1662–1669. doi: 10.1080/09540121.2010.521544.
[12] Gruber J., Caffrey M. HIV/AIDS and community conflict in Nigeria: Implications and challenges. Soc. Sci. Med. 2005;60:1209–1218. doi: 10.1016/j.socscimed.2004.06.053
[13] Russel M., Schneider H. A Rapid Appraisal of Community-Based HIV/AIDS Care and Support Programs in South Africa. Centre for Health Policy. University of Witwatersrand; Witwatersrand, South Africa: 2000

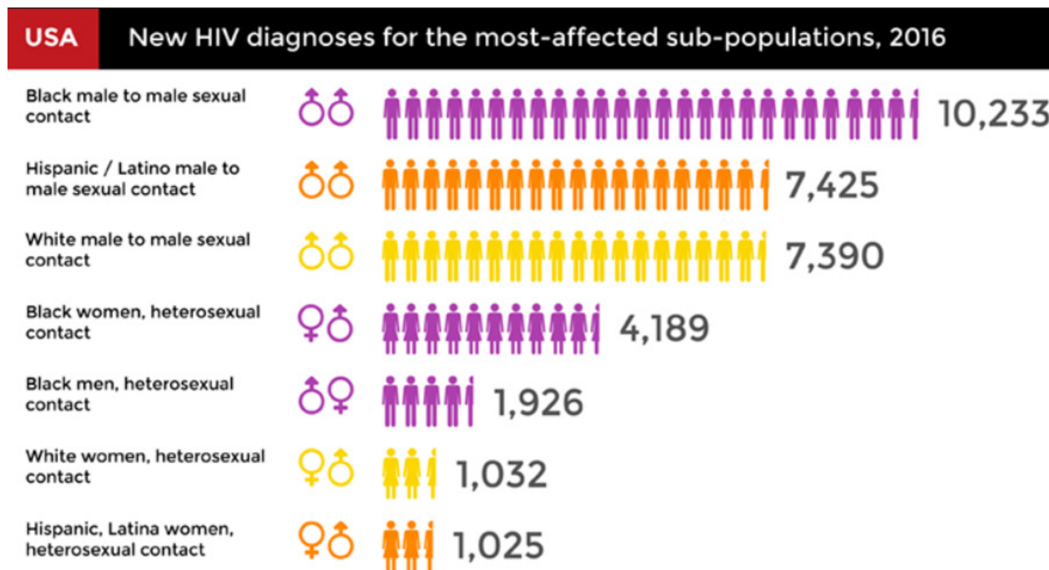

Table 2: HIV risk differences by sex, ethnicity and sexual orientation in the USA. 14

Given the lack of programming to address male vulnerability and risk, adolescent males in particular, seek diagnosis and treatment much later than their female counterparts, who have more better-tailored services. Young males are further hampered from accessing preventive information and consumables (condoms and lubricants) as well as test, treatment and care, by stigma related to cultural concepts of masculinities. International organisations are beginning to respond to this aspect of neglected gender bias and in the last two years the 2018 report "The health and well-being of men in the WHO European Region: better health through a gender approach"[15] and the 2017 UNAIDS report on addressing the unmet HIV and AIDS needs of males entitled "Blind Spot. UNAIDS: Reaching out to men and boys"[16] are supporting a more gender-equitable and effective programming.

The SDC Gender and Health Thematic Guidance Sheet, due for distribution in the coming months, elaborates neglected gender-related vulnerabilities of males, as well as females, and presents some of the recent programming and results on targeted programing for male engagement in HIV and AIDS responses, for example, male failure to comply with medical appointments and treatment linked with disbelief in the diagnosis, fear of losing paid employment and perceived effects of medication combined with alcohol use.

Service coverage gaps among males are evident across a range of geographic and epidemic settings, from North American cities to rural areas in southern Africa, threatening progress towards the 90–90–90 treatment targets (shown in figure 1). Across sub-Saharan Africa, men and boys living with HIV are 20% less likely than women and girls living with HIV to know their status and 27% less likely to access treatment. In Kazakhstan and Niger, knowledge of HIV status among men living with HIV is a third

[14] Centers for Disease Control, 2017. HIV Surveillance Report
[15] http://www.euro.who.int/en/publications/abstracts/the-health-and-well-being-of-men-in-the-who-european-region-better-health-through-a-gender-approach-2018
[16] http://www.unaids.org/en/resources/campaigns/blind_spot

lower than among their female counterparts, and viral suppression among men is half that of women. Gender gaps are also evident in treatment: In 2016 antiretroviral therapy coverage among men aged 15 years and older was 47% globally, compared with 60% among women. This disparity was greatest in western and central Africa, where 25% of men living with HIV and 44% of their female counterparts were accessing antiretroviral therapy and a similar trend was evident in eastern and southern Africa. Consequently men are more likely than women to die of AIDS-related causes than women and in 2016 males accounted for 58% of the estimated 1.0 million AIDS-related deaths world-wide.

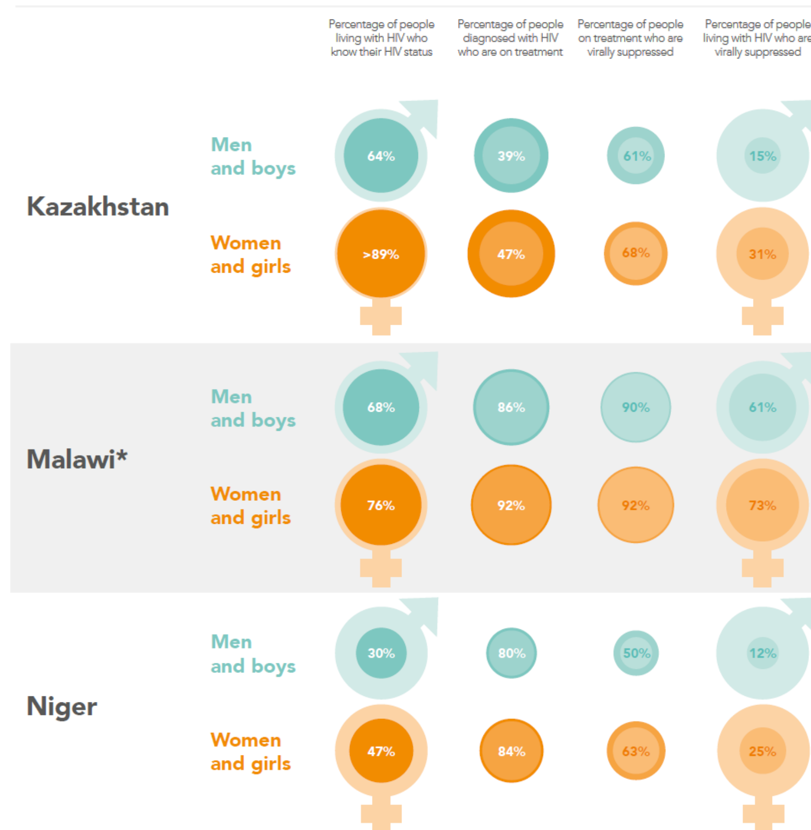

Figure 1: Gender gaps in progress towards the 90-90-90 targets in selected countries[17]

Decision-making and behaviours of men and boys are influenced by multiple and interacting gender norms that heighten male HIV risks and at the same time discourage them from accessing health services. In many cultures concepts of masculinity and stereotypes associated with it create conditions that do not support safer sex, sexual negotiation, HIV testing, access and adherence to treatment. In cultures where masculinity is associated with dominance over women, having multiple sex partners, alcohol and substance use, refusal to use condoms or take medication regularly, males and their partners are at heightened risk of HIV infection.

Figure 2: Bottles of ARVs discarded by male patients in a septic tank at St Francis Hospital Ifakara, Tanzania

[17] UNAIDS (2017). Blind Spot. Reaching out to men and boys.

Men are also more reluctant than women to seek professional medical assistance or to fully disclose symptoms when they do seek assistance. Male use of health services is hampered by stigma, concerns over time-off from paid work needed for travelling to and waiting at health facilities, and the attitudes of staff in service outlets that are largely oriented towards female clients.

Changing detrimental gender norms has the potential to improve sexual discussion and negotiation, to reduce sexual violence and to support protective sexual behaviours that in turn, act to prevent the transmission of HIV and other sexually transmitted infections. Investing in male HIV competence and stigma reduction has a potential triple dividend for public health and household economies: When men access HIV prevention and adhere to treatment, they protect themselves, their sexual partners and their families, as an HIV-negative or virally suppressed man is less likely to transmit the virus to sexual partners. Consequently fewer women become infected, which also lowers the risk of vertical transmission to children during pregnancy.

2 Methods

2.1 Secondary analysis – review of internal documentation from the COOFs

SDC provided a library of 13 internal documents that included two general documents – the SDC HIV Mainstreaming Toolkit and the 2018 "Know Your Status": World AIDS Day 2018 Communication Support Package for COOFs.

Eleven documents were provided by the three country offices of Mozambique, Tanzania and Zimbabwe shown in table 3 below.

General SDC 2018 "Know Your Status": World AIDS Day 2018 Communication Support Package for COOFs SDC HIV Mainstreaming Toolkit
SDC Mozambique 1. HIV and General Wellbeing Action Plan 2018 – 2020 2. 2015 HIV and Health Promotion Workplace Policy 3. 2015 Report on current situation of health, wellbeing and HIV and AIDS with recommendations for a workplace programme on Health Promotion, HIV and AIDS and wellbeing for staff
SDC Tanzania 4. 2017-2018 HIV Mainstreaming Work Plan 5. 2016 Report on the F2F Health in Dar-es-Salaam, Day N°4 10th to 13th of May, 2016 6. Undated. HIV/AIDS Workplace Policy for Embassy of Switzerland and its Cooperation Office, Dar es Salaam. 7. Undated. Terms of References Consultant: HIV-Mainstreaming Backstopper 8. Undated. Workplace Health Promotion Plan. 9. Undated. Mainstreaming in key PCM milestones. 10. 2014 SDC. Do no harm: An assessment tool for HIV and AIDS mainstreaming for SDC and implementing Partners
SDC Zimbabwe 1. 2017 Annual Mainstreaming report

Table 3: List of documents provided by SDC for the analysis.

2.2 Broader literature on community competence and male engagement

A broader review was also conducted on the literature relating to community competency in HIV and AIDS, notably inclusion of males, particularly on researched approaches and results achieved, as well as frameworks, policy and programming. Information collated in this way has been integrated into this report to provide a broader global context to this analysis.

2.3 Primary data: semi-structured interviews

After reviewing the SDC documents and wider literature, a semi-structured interview (SSI) guide was developed and shared with SDC and used to structure discussions with the three focal persons in a way that left room for the interviewees to express opinions and relate experience in a relatively free manner, while keeping the primary data gathering aligned to the objectives of the analysis. The SSI guide is included an annex 2.

3 Findings

3.1 HIV and AIDS activities in the three COOFs

From the documentation submitted for this analysis (set out in Table 3 above), it can be seen that there was great variation in the number and scope of documents produced by each CO. A review of the documentation indicated that HIV and AIDS activities within the three country offices were on-going and guided by an explicit work place policy. Table 4 illustrates variation in documented activities and work plans. One CO produced a two-yearly mainstreaming plan and another annual plan. A work plan for the Zimbabwe CO was not produced for review, although in interview with the focal person the information was provided that a work plan for HIV and AIDS mainstreaming existed.

Table 4 illustrates that different themes were addressed by the three COs ranging from HIV awareness, sexuality, comprehensive sexuality education, to nutrition and first aid related to HIV infection. None of the COs had addressed **male engagement** in competencies in HIV and AIDS, although the Mozambique CO had worked on some gender issues with an emphasis on male perspectives, together the CO gender focal person. Table 4 illustrates that from the documentation presentations made to staff and their families varied between the three COs.

All focal persons followed basic workplace competence by ensuring that **condoms** were available in all washrooms. Links with **specialist support service and supervision** were very mixed ranging from an in-house expert, to linkages with a local clinic that gave presentations. However, only two of the three COOFs **posted information on local support groups, counselling, testing and treatment services**, although all three offices reported regular presentations from experts and service providers to which all **staff and household members** are invited to participate. The Tanzania office had within its work plan for 2017-18 the intention to develop a **minimum package of HIV and AIDS information** and to disseminate it.

COOF	WP policy	HIV Workplan	Support mechanism	Committee/ working group	Condoms	Presentations	Male focus?
Zimbabwe[18]	2016	Not provided	2016 with local clinic	👍	👍	HIV awareness Sexuality and CSE	None specified
Tanzania[19]	undated	2017-18	Senior in-house specialist	👍	👍	Staff testing Nutrition & HIV First aid & HIV	None specified – only specific female & child foci.
Mozambique[20]	2015	2018-2020		👍	👍	WAD 2018 staff testing and support Expert presentations Health fairs	Not for HIV specifically. “Men in the kitchen” activity with the gender focal person. Exploring stereotypes

Table 4: Key elements of the CO literature review

3.2 Current AIDS competence in the three COOFs

Responsibility for mainstreaming HIV and AIDS is a part of broader job descriptions of the focal persons and as a consequence, previous experience and expertise in HIV is variable between duty-bearers. In addition to this is the variation in the periods of time in post – this ranged between one month and a few years.

Engagement of Focal Persons

All the focal persons were found to be highly engaged and conversant with issues relating to HIV and AIDS within their countries of work. Although their thematic support mechanisms varied widely from having an HIV and AIDS specialist as a supervisor to no specialist supervision, all were grounded in offices that had a clear a workplace policy and as guided by this, all maintained condom supplies in washrooms for staff and visitors, and all had both male and female designated personnel to support staff issues arising. Additional HIV and AIDS expertise were differently organised within the three

[18] Zimbabwe. Document presented for review:
COOF 2017 HIV Mainstreaming report. PowerPoint Presentation. 10 October 2017

[19] Tanzania. Documents presented for review:
Report on the F2F Health in Dar-es-Salaam, Day N°4 10th to 13th of May, 2016 Jean François Golay
2017-2018 HIV Mainstreaming Work Plan
2016 Report on the F2F Health in Dar-es-Salaam, Day N°4 10th to 13th of May, 2016
Undated. HIV/AIDS Workplace Policy for Embassy of Switzerland and its Cooperation Office, Dar es Salaam.
Undated. Terms of References Consultant: HIV-Mainstreaming Backstopper
Undated. Workplace Health Promotion Plan.
Undated. Mainstreaming in key PCM milestones.
2014 SDC. Do no harm: An assessment tool for HIV and AIDS mainstreaming for SDC and implementing Partners

[20] Mozambique documents presented for review:
HIV and General Wellbeing Action Plan 2018 – 2020.
2015 HIV and Health Promotion Workplace Policy.
2015 Report on current situation of health, wellbeing and HIV and AIDS with recommendations for a workplace programme on Health Promotion, HIV and AIDS and wellbeing for staff

COOFs; one was a supervisor of the focal point and the other COOF took a team approach and had four designated male and female support staff.

Mainstreaming work plans and activities

Two of the three COOFs had annual HIV and AIDS mainstreaming work plans that were available to this review. To inform its mainstreaming approach, the Mozambique COOF in 2015 conducted an **in-house HIV and AIDS Knowledge, Attitudes and Practice (KAP) baseline study** with participation of 83% of all staff. The study outcome indicated that a considerable vulnerability among staff members, with almost 30% reporting concurrent sexual partnerships, 50% of which did not involve consistently using condoms to protect against sexually transmitted disease. Furthermore, stigma surrounding infection was found to be substantial, with approximately a third of participants stating that they did not want to work with HIV positive colleagues, indicating a high-level of shame and a lack of understanding risk and transmission modes overall. As a result of the study and the information it yielded, the COOF changed its mainstreaming approach to a two year plan with greater emphasis on behaviour change, to include broader risk reduction related to NCDs.

> **Informed response:**
>
> The Mozambique KAP study informed on the low-uptake of generic, unbranded condoms available free in SDC washrooms. After switching to known brands, uptake was improved as users had greater trust in the products, which they also considered to be more attractive.

Male engagement

Only one of the COOFs had planned and executed any activities to specifically address male engagement and gender issues. The Mozambique CO reported planning and conducting HIV and AIDS activities together with the gender focal person and together they have presented a role play activity called “Men in the kitchen.” All of the focal persons during the interviews for this review responded that they had no training or guidance on male inclusion and HIV competency. All stated that they would need additional capacity-building and guidance to address these issues.

World AIDS Day (WAD)

SDC headquarters provided a guidance and support package: “Know your Status: World AIDS Day 2018” to the focal persons to assist the COOFs in preparing and executing plans for WAD. All three COOFs held events for WAD on December 1st for staff and their household members offering in-house information and presentations by local health workers who also offered counselling and testing. Staff that tested positively were supported in their entry to treatment and care. Of note, in the Tanzania office, Hepatitis B infection was the most common positive blood test result, requiring additional counselling and treatment referral.

Promising practice:

The Mozambique COOF provided regular information materials on HIV and NCDs, developed by an internal communications task force. To motivate staff learning, a quiz was held on each topic and prizes such as a month's gym membership awarded to the best male and best female quiz entries.

Peer exchange

All focal points expressed the opinion that there are not adequate fora for exchange and support with peers in other countries. Some expressed that they found the Shareweb site to be too general and that focal persons would benefit from regular updates, topical discussion and experience sharing.

3.3 Barriers to the HIV and AIDS competence of young men in SDC communities in the 3 countries

Reflecting the findings of the literature review, all focal persons expressed the opinion that **males in their country of work had to contend with unaddressed vulnerabilities** and **inequalities with regard to accessing information, diagnosis and care** in relation to HIV and AIDS. All focal persons considered that this was in part due to the focus of government, bilateral and NGO programming towards women and girls, as well as concepts of masculinities hampering male approaches to testing and treatment. Women generally have more opportunities to be diagnosed than men as they access HIV testing through maternal services, among others. In Tanzania, for example, men only test if their wives are tested positive in the course of maternity services and assume that if their wives test negative, they are too.

One focal person highlighted the contextual issue that although HIV and AIDS are included in modern school curricula in many countries in the region, **many adults have missed out on key factual information** related to the epidemic. Apart from the nature of infection, importance of safer sexual practices, particularly in concurrent relationships, many in the SDC staff community lack the basic knowledge prerequisites to protect their own health and that of their families. In the interviews conducted for this review, focal persons expressed concern that there is high **loss to follow-up, particularly among males testing positive** due to distance to facilities and work responsibilities, coupled with **resistance to approaching health facilities and fear of stigma**. Additionally there is a tendency for males, rather than females to **resist anti-retroviral (ARV) adherence and discard medicines – indicating that there are many issues that need targeted approaches to better address unmet male needs**.

None of the focal persons had received any **capacity-building on guidance documentation on better inclusion of males** in HIV and AIDS services and approaches and felt they would benefit from strengthening their knowledge and skills in order to develop targeted approaches to serve the needs of their colleagues and partners.

3.4 General barriers to community HIV and AIDS competences

Apart from the identified need for specific capacity-building and guidance on approaches to improve male competence, the main barriers to focal persons improving the HIV and AIDS competence of their colleagues and partners was:

- **Their own knowledge gaps**: There seems to be too little organisation-wide aligned thematic or approach training for focal persons.
- **Inadequate guidance**: All focal persons were of the opinion that the SDC HIV and AIDs Toolkit is out of date and is very unwieldy. It does not enable easy access of focussed reference or guidance.
- **Lack of updated information**: focal persons reported that they would benefit from the stimulation of simple research updates a few times each year and structured discussions for facilitate exchange.
- **Lack of peer exchange**: All the focal persons reported very little peer exchange with other colleagues. None reported using **the SDC CUG** for this purpose. This seemed to be because they felt that the Health Network was too broad for specific HIV and AIDS mainstreaming discussions and there was a lack of familiarity with the Community of Practice. From the overall review, it was apparent both from the internal literature provided by the COOFs as well as the semi-structured interviews, that even within the region, there is little evidence of capitalising on each other's approaches and experience. This is apparent in the different content of Workplace HIV and AIDS policy, guidance documentation and the fact that only one of the three COs had conducted a KAP study to inform its approaches and measure change in HIV competence.

3.5 Review of Community HIV and AIDS Competence Frameworks

Since the 1980s competency frameworks have been used to define the necessary attributes and ways of working to enhance organisational effectiveness and changes in the nature of work. This method has been adapted for use in community HIV and AIDS competence and in this section a review is presented with a view to informing an SDC community HIV and AIDS competence framework.

The UNAIDS Secretariat competency framework shown below includes core organisational values related to the HIV response, together with crucial competences from the organisation and management. While a framework adapted from this model might serve in guiding SDC's vision of community competency in HIV and AIDS, it does not provide a structure for assessing the knowledge within the organisation or planning action to address gaps and new thematic responses.

Figure 2: UNAIDS Secretariat competency framework[21]

Masquillier et al (2015) [22] proposed the framework of community HIV and AIDS competence that is focussed at the household level. While this illustrates interdependent cycles, its complexity and household focus do not offer a direct framework for use by SDC's COOFs.

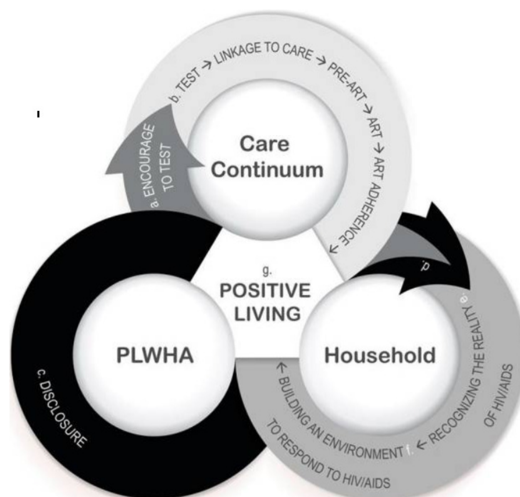

Figure 3. The route to household HIV and AIDS competence proposed by Masquillier et al (2015)

Perhaps the most widely implemented framework of community HIV and AIDS competence is that of Lamboray and the Constellation community development organization[23] through combined approaches: of "SALT: Stimulate, Appreciate, Learn, Transfer", and Community Life Competence Process (CLCP) shown below.

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[21] UNAIDS / UNITAR. 2005. Evaluation of the UNAIDS/UNITAR AIDS Competence Programme. http://data.unaids.org/publications/irc-pub06/jc1144-acp.evaluation_en.pdf

[22] Masquillier, C., Wouters, E., Mortelmans, D., & van Wyk, B. (2015). On the road to HIV/AIDS competence in the household: building a health-enabling environment for people living with HIV/AIDS. *International journal of environmental research and public health*, *12*(3), 3264-92. doi:10.3390/ijerph120303264

[23] www.communitylifecompetence.org

Figure 5 illustrates the role of facilitators and communities in using the SALT approach to understanding the context and existing knowledge within communities of HIV and AIDS as well as developing dynamic processes for action, learning, knowledge management and sharing.

Figure 4: The Constellation approach for AIDS Competence[24]

Figure 6 shows how the Community Life Competence Process (CLCP) is a form of learning cycle where communities take action and learn from experience, which in turn becomes the basis for further rounds of action and learning.

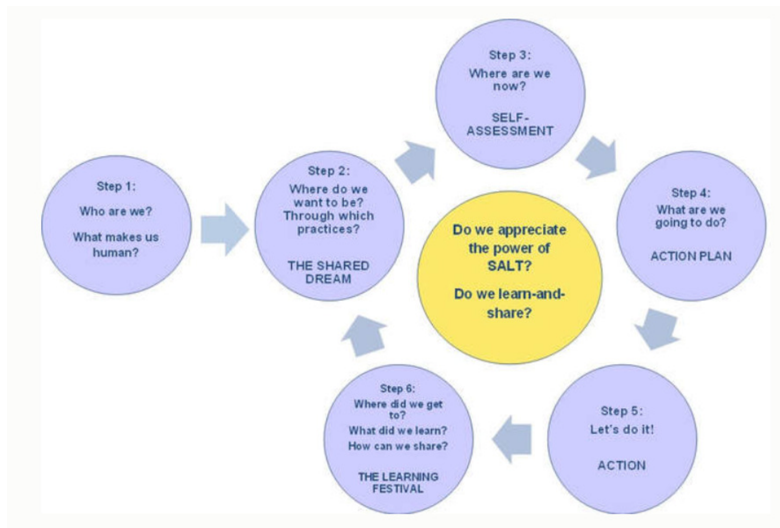


Figure 6: The Community Life Competence Process (CLCP)[25]

Key concepts of concern to the SDC community are elaborated within the frameworks of Lamboray et al i.e. assessing HIV knowledge and determining "what we know "(e.g. HIV status, attitudes and practice surrounds protective and risk behaviours and practices) and how knowledge is stored and shared. The CLCP and Constellation frameworks as they stand are somewhat complex and a more simplified model, aligned to the needs of the COOF and their focal persons is proposed in the following section.

[24] The Constellation 2014. Measuring AIDS Competence Our experiences– 14 Oct 2009 Nairobi 14-10-2009
[25] www.communitylifecompetence.org/our-approach.html

4 Conclusions

The research literature provides evidence that approaches to strengthening community HIV and AIDS competence have positive impacts on knowledge and behaviour linked to reducing risk and enhancing preventive behaviours. Within the SDC community, HIV and AIDS competence seems to be very varied due to the lack of strategic capacity-building of focal persons and gaps in thematic and methodological guidance.

Only two COOFs submitted workplace policies for review, although Zimbabwe reported during interview that it had one. The two that were reviewed appeared to have been written directly by the offices and might have benefitted from a core SDC template, referring to key guidance documents and approaches such as conducting KAP studies to inform approaches and measure results. As a consequence the COOFs had work plans that elaborated different details of engagement.

Similarly, there was great variability in the number and scope of documents provided by the COOFs for review. Assuming that all COOFs cooperated with SDC HQ request for documents for this analysis, there is evidence that some of the COs might need support in order that a basic standard of activities, outputs and reporting can be achieved to mainstream HIV and AIDS. Given the findings of the Mozambique KAP study and the way it shaped the CO response, there is a clear need for improved sharing and alignment of promising approaches that currently seems to be sub-optimal.

None of the COOFs had worked directly on male vulnerabilities and unmet needs regarding HIV and AIDS competencies. Given the acknowledged gap in global responses to the unmet need highlighted recently by UNAIDS, it is timely that SDC plans to address this.

Gendered approaches to development practice and health that were motivated by inequalities in autonomy, power, access to resources and ultimately well-being, morphed very early into focussing almost exclusively on women and girls. While this may have been necessary in the past to address the wide disparities between men and women, boys and girls, the majority of approaches have focussed on females to the exclusion of males and the realities of gender relations and dynamics as they play out in households, families, communities, places of work, politics and governance.

But gender is not just about women and girls, who tend to receive most attention under the banner of gender programming, and there is a need for more holistic approaches that take into account the crucial role of gender *dynamics* that determine health inequalities. Male health issues and constructs of masculinity determined by societies not only impact on women, but also compound health risks and risk taking and inhibit men from timely health seeking. In the next section, recommendations are offered for SDC to consider in its planning to enhance its community HIV and AIDS competence, particularly to better meet the needs of men and boys.

5 Recommendations

Although the analysis of community HIV and AIDS competencies in the three priority countries of Zimbabwe, Mozambique and Tanzania was limited, findings revealed a host of knowledge and approach gaps in mainstreaming, particularly in relation to male engagement and stigma reduction. For this reason, it is not recommended to produce a Facilitator Guide immediately as indicated by the TOR, but to start by determining needs, planning to address these with capacity-building and

information sharing as well as continuous and sustained information sharing and expert support, then adopting a framework of community HIV and AIDS competence. Recommendations to enhance the effectiveness of the COOFs and the HIV and AIDS focal persons in enhancing the AIDS competence of the SDC staff community and their household members and to better respond to the needs of men are made in a step-wise manner to be considered in planning immediate, medium and longer-term competence strengthening.

Step 1. Enhancing knowledge sharing and peer support: Proposed topics for discussion at the 2019 regional F2F with HIV focal points

1. **A**n initial **exchange on needs revealed by the analysis regarding male engagement in HIV prevention**, diagnosis, partner notification, treatment adherence and viral management in the different COs and country contexts, could be conducted remotely before the F2F meeting via the planned webinar.
2. Given the reported gaps in information and skills for mainstreaming HIV and AIDS in the context of the COOFs, a **crucial starting point at the F2F would be a mapping of perceived skills and knowledge needed and where those might be obtained from** and in what format (e.g. training or presentation by a supervisor / presentations by peers within the region; a regional specialists or NGO presentation; a webinar with an international specialist; adaptation of tools; development of training packages, etc.).
3. The **three COOFs should consider presenting their approaches to mainstreaming at the next F2F conference**. As well as sharing their tools and approaches, they might discuss and prioritise their needs to strengthen SDC's internal capability in community HIV competence as well as reducing male stigma, strengthening inclusion and optimising the action of men and boys in responding to HIV and AIDS. It is particularly recommended that the **Mozambique team to share their methods, rationale and outcomes**.

The F2F would also provide the opportunity for timely discussion of:

4. The advantages of exchange between the various CO focal persons and peer support that can offer. Discus **how the COP platform on the Shareweb could be better used** for this purpose and other needs arising from the analysis including: training gaps, guidance documentation, skills development including facilitation of community responses; approaches to successful male engagement and stigma reduction.
5. **Is the current SDC HIV and AIDS Tool Kit still relevant to the current nature of the epidemic?** Discussion might include brainstorming what an updated tool kit should look like and what it should inform and enable.
6. How might SDC's approach of strengthening community competence realise its potential to **link existing regional and national HIV groups and societies to create wider knowledge sharing and management** as well as broader change and greater leverage of national and international resources to fund their innovative approaches?

Step 2: Community HIV and AIDS Competence Framework

7. Adopting a simplified **Community HIV and AIDS Competence Framework**, based on those developed by Lamboray et al, is recommended to provide logical, sustained steps to determine the goals for each CO in the planning cycle (annual or bi-annual plans). For example, one goal might be to enhance male engagement, positive behaviour and competence in HIV and AIDS. The simplified model suggested in figure 6 below, sets out the steps of determining "What do we know?" at two levels. First, the capacities and support available to focal persons in the selected themes and identifying gaps in training and guidance documentation - which are addressed in the next step. Second, the capacity-built focal persons then lead an assessment, for example, by developing a KAP study, to determine the community competences and knowledge, thereby revealing the gaps to be addressed and providing contextual detail on how and what in particular might be addressed e.g. emphasising condom use with concurrent partners.
8. Linked to identified goals and planned approaches, SDC might wish to consider **constructing a theory of change to incorporate capacity building competence of its members and partnering organizations, to support AIDS-competent communities**. It might incorporate special themes of interest such as strengthening the inclusion of men and boys to reduce the stigma they face and fully engaging them in community decision-making, planning and action.

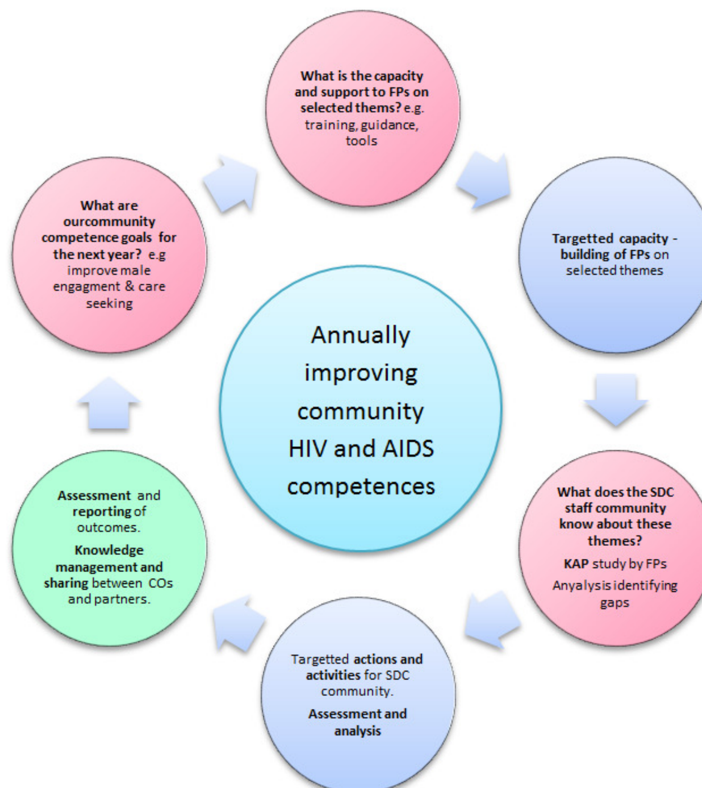


Figure 5: Proposed framework for annual cyclic progression of HIV and AIDS competence assessment, planning, action and knowledge sharing.

Step 3: Enhancing capacities of Focal Persons

9. In order to address gaps in knowledge and know-how surrounding topics of concern such as male inclusion and vulnerabilities, **focal persons should be supported and capacity-built to conduct KAP studies** of community competence within their own COs. These should be conducted and the outcomes of analysis used to inform the internal mainstreaming strategic approach that should be elaborated in **annual work plans, as well as to determine indicators of change**. This might be based on the questions and approaches of the Mozambique COOF.
10. All focal persons should ensure that **information is posted for all staff** to access information on local HIV and AIDS services and support groups. SDC should discuss a minimum information package for all COOFs that should be updated regularly.
11. Focal persons should be enabled to **work together with colleagues in their Human Resources** department to ensure that all new staff are mainstreamed and any issues arising are supported from the HR perspective.
12. It is recommended that SDC determine a **forum for focal persons to discuss and prioritise themes and skills** that they consider to be important to their country contexts and in which they require capacity-building. All focal persons require capacity-building in male engagement, but some have related contextual concerns. For example in Tanzania hepatitis is a concern among the community and yet is poorly addressed nationally. SDC might consider ways in which infectious disease of concern such as hepatitis might be incorporated into on-going HIV and AIDS mainstreaming activities and information broadcasts.
13. As well as developing opportunities for targeted thematic exchange face-to-face, SDC might consider enabling focal persons to make better use of the **Shareweb Community of Practice - HIV Mainstreaming, with a refresher training** and activity, for example this might start with some moderated, focussed discussion, a podcast or brief synopses of research articles, new tools and show-cased CO experience.

Strengthening knowledge to support male competence and stigma reduction

14. To reduce risk and enhance **timely male access to treatment and care**, SDC might consider capacity building its focal persons to develop targeted approaches to encourage males to test and adhere to treatment. One method might be to plan activities to support men in approaching services and discussing their concerns with health workers as well as methods for disclosing positive HIV diagnosis with partners and ensuring their follow-up.
15. To strengthen SDC's mainstreaming approaches to **better respond to male needs and inclusion**, SDC might consider capacity-building focal persons on approaches to better male engagement. To support this, it may wish to **develop guidance documentation outlining best practices for enhancing inclusion of males in the course of HIV and AIDS mainstreaming activities**.
16. Activities on **male engagement and stigma reduction** should be planned together with the SDC gender focal persons and Human Resource specialists within the CO work plan.
17. **Reporting on health in the workplace initiatives and results would benefit from stronger analysis of data by sex**. In this way staff and management will be able to detect more clearly risks and protective factors related to gender. This in turn might support understanding of

gendered issues relating to HIV and AIDS in the workplace and inform approaches to address these.

Tool kit development

18. Depending upon the outcome of the proposed discussion of the 2010 HIV and AIDS Tool Kit, it is recommended that a **more accessible and updated version be developed.**

Annex 1: TOR

BACKSTOPPING MANDATE (BSM)
SDC health network – Swiss TPH

BSM ACTIVITY 3,2: ANALYSIS OF COMMUNITY COMPETENCIES ON HIV and AIDS

TERMS OF REFERENCE (ToRs)

Period: 9.5 days between 01.11.2018. – 30.06.2019.

Background

In the Eastern and Southern Africa Region

Eastern and southern Africa remains the region most affected by the HIV epidemic, accounting for 45% of the world's HIV infections and 53% of people living with HIV globally. Strong shared responsibility between the region's governments, civil society, international donors and the research community is delivering steep declines in HIV infections and AIDS-related mortality. However, huge challenges remain. Gender inequalities and gender-based violence, combined with stigma [26]and physiological factors, place women and girls in eastern and southern Africa at huge risk of HIV infection. In 10 countries in the region, laws and policies that require parental consent to access sexual and reproductive health services discourage adolescent girls from accessing the services they need to stay healthy. Removal of these requirements is needed, as is the rapid scale-up of intensive combination prevention programme packages, including elements that improve school attendance and empower young women to mitigate their own risk.

AT A GLANCE

1. Strong domestic and international investment has stimulated steep declines in HIV infections and deaths from AIDS related illness.
2. Adolescent girls and young women continue to face a disproportionally high risk of HIV infection.
3. Despite a higher HIV burden among women, men account for the majority of deaths from AIDS-related illness
4. Reaching more men with HIV testing and treatment is critical to breaking cycles of HIV transmission and reducing HIV incidence among young women
5. Community-based service delivery is at the cutting edge of HIV service provision in eastern and southern Africa and holds the key to future progress.
6. Punitive laws, police harassment and widespread social stigma and discrimination stand in the way of efforts to address the extremely high incidence of HIV among key populations.

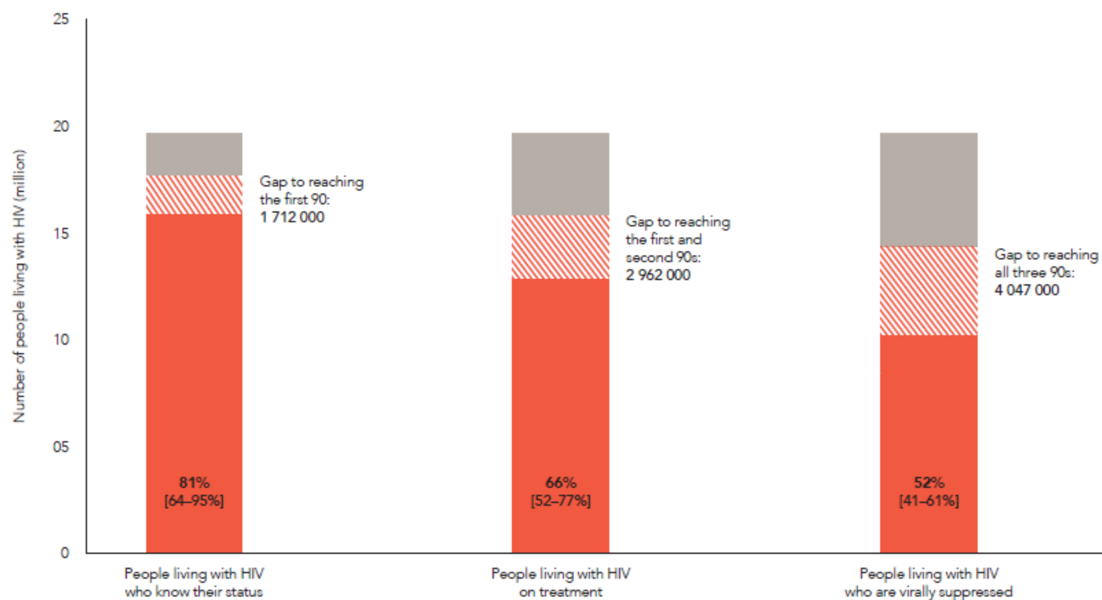
Major progress in averting deaths from AIDS-related illness (there were 42% fewer in 2017 than in 2010) and preventing new HIV infections (30% fewer in 2017 than in 2010) has

[26] in particular stigma in men resulting in negating their status results in young women being at much higher infection risk up to 3 times

brought the incidence/prevalence ratio of eastern and southern Africa to 0.04 [0.03–0.05]. It is steadily moving towards the epidemic transition benchmark of 0.03. The scale of the region's HIV epidemic, however, remains massive. An estimated 800 000 [650 000–1 000 000] people in eastern and southern Africa acquired HIV in 2017, and an estimated 380 000 [300 000–510 000] people died of AIDS-related illness. Mozambique, South Africa and the United Republic of Tanzania accounted for more than half of new HIV infections and deaths from AIDS-related illness in the region in 2017

HIV-related stigma has declined across much of the region since 2000, but it remains high in several countries. More than half of household survey respondents in Comoros and Ethiopia said they would avoid buying vegetables from a vendor living with HIV. This discriminatory attitude was also expressed by 31% of people in Angola, 25% in Uganda, 21% in Mozambique, 18% in Zimbabwe, 15% in Malawi and 13% in Botswana, suggesting that many people still lack basic knowledge about HIV.
Even though the region has been confronting major HIV epidemics for more than three decades, special surveys indicate that discrimination in healthcare settings still occurs, especially towards key populations. About one in three people living with HIV surveyed in Mauritius said they were denied health services because of their HIV status and that their HIV status had been disclosed without consent. In Uganda, almost two thirds (64%) of surveyed people who inject drugs said they avoided healthcare services for fear of discrimination or of being reported to law enforcement authorities.
High levels of intimate partner violence, which has been shown to increase vulnerability to HIV infection, is a major concern. In household surveys conducted in 12 countries between 2013 and 2016, the percentage of adult women who reported that a male partner had physically or sexually assaulted them in the previous 12 months ranged between 16% (Mozambique) and 30% (Uganda).
(Extract of UNAIDS, Data 2018)

Graph 1: HIV testing and treatment cascade in Eastern and Southern Africa, 2017:



Source: UNAIDS special analysis, 2018; see annex on methods for more details.

Botswana and Eswatini have nearly achieved the 90–90–90 testing and treatment targets. Uptake of HIV testing and treatment services in the region continues to be lower among men. Self-testing and assisted partner notification remain important but under-utilized methods to increase HIV diagnoses among men.

At SDC level

Mainstreaming of HIV into international cooperation work remains one of the most important strategies in order to ensure the systematic addressing of HIV and AIDS across sectors. For the Swiss Agency for Development and Cooperation (SDC), contributing to the international AIDS response continues to be a priority and programmatic mainstreaming of HIV should be understood as a shared responsibility by all, or much, of cooperation work.
Mainstreaming of HIV can take place in cooperation activities in various epidemiological contexts with various aid modalities – through bilateral cooperation, humanitarian aid and multilateral aid.
By «mainstreaming», we mean a process that enables development actors to address the causes and effects of HIV in an effective and sustained manner, both through their usual work and within their workplace. It means «wearing AIDS glasses» while working in all sectors and at all levels. All cooperation activities should consider setting up a workplace policy and programme in a participative way, in order to ensure that HIV related needs in the internal sphere of an organisation are being covered. Mainstreaming HIV should happen in the internal sphere (related to the organisation/workplace) and in the external sphere (related to the cooperation work). Three key questions can guide mainstreaming efforts in both spheres:

1. How do HIV and AIDS affect your organisation and your cooperation work?
2. How to do no harm?
3. How can you contribute to the HIV response?

(Extract of SDC Mainstreaming HIV in Practice, 2010)

Scope

In the context of severe human resource shortages in HIV care, task-shifting and especially community-based support are increasingly being cited as potential means of providing durable care to chronic HIV patients. Socio-ecological theory clearly stipulates that–in all social interventions–the interrelatedness and interdependency between individuals and their immediate social contexts should be taken into account. People living with HIV and AIDS seldom live in isolation, yet community-based interventions for supporting chronic HIV patients have largely ignored the social contexts in which they are implemented. Research is thus required to investigate such community-based support within its context.

The BSM activity aims at providing information and guidance to support Swiss cooperation offices in the field to improve the impact their mainstreaming activities and to overcome the above mentioned barriers, with a special focus on male.
To do so, we mandate: **An analysis of community competencies on HIV and AIDS in SDC priority countries (i.e. Mozambique, Tanzania and Zimbabwe)** by using for example the AIDS Competency Framework of Lamboraye et al (UNITAR) regarding (1) “what do I know” about the problem, (2) “what can I do” about the problem myself and (3) “what do I share with others”.
Community is to be understood as any group of people having social ties (could be workers at an embassy, SDC employees, workers in a project, beneficiaries of a SDC project etc.).
The mandate shall encompass following analysis:

- Analyse AIDS competence of local communities, in particular young men in the 3 countries using documents specified by SDC.
- Review of AIDS competence today in the 3 COOFs through interviews with focal persons.
- Identify the main barriers to improved local AIDS competences
- Re commend what SDC can do through mainstreaming activities to overcome these barriers

Specific recommendations to be included:

- Recommend AIDS competency frameworks for use in SDC mainstreaming HIV/AIDS
- Recommend best practices foraddressing male stigma/reluctance
- Identification of practical measures / activities that will enhance the AIDS competence of each of the SDC COOFs
- Propose topics and scenarios that should be discussed at the regional F2F with HIV focal points

Deliverables

1. Review report (max. 10 pages) including desk review and interview findings, analysis and concrete recommendations for COOFs.
2. Follow up facilitator guide (including concrete operational steps by steps actions) intended for COOFs employees, which will help improve "community" competence on male stigma. The guide will be finalized following an iterative and participatory approach with SDC (after a skype call, a webinar and a F2F meeting)

Timeframe

n°	**Activities and Deliverables:**	**Period:**	**n° days*:**
1)	Kick-off briefing per skype with SDC (Thomas Teuscher and Viviane Hasselmann) to discuss detailed approach of the mandate and adapt, if necessary	9th of January	0.25
2)	Development of TOR	-	-
3)	Desk review/analysis, and interview calls with HIV focal points in COOFs Report writing	January-February	4
4)	**Submit review report** to SDC (Thomas Teuscher and Viviane Hasselmann)	22th of February	-
5)	Debriefing skype call with SDC (Thomas Teuscher and Viviane Hasselmann) on review report + discussion on the follow up facilitator guide	4th of March	0.25
6)	Revise study report (if necessary) + **resubmit final version** **Elaborate the first draft of the facilitator guide** according to debriefing call	Beginning of March	2.5
7)	Hold a webinar with SDC colleagues (field and HQ) to present study results and discuss the 1rst draft of the facilitator guide	Mid March (week of 18th?)	0.5
8)	Revise the facilitator guide according to the webinar discussion with NPOs	End of March	1
9)	Present and discuss revised version of the facilitator guide to SDC during the F2F in Nairobi (via skype or live if possible)	11th of April	0.5
10)	Revise and finalize the facilitator guide according to the F2F discussion with NPOs **Submit final version of the guide to SDC**	26th April	0.5

Total 9.5 WD

Annexes

1. Access to the CUG platform "Community of Practice HIV mainstreaming" on the SDC Heatlh Shareweb, with all the available documents related to HIV mainstreaming activities in the 3 COOFs: https://www.shareweb.ch/site/Health/CUG/HIV-Mainstreaming/SitePages/Home.aspx

2. SDC Toolkit on HIV mainstreaming (2010)

Mainstreaming HIV in Practice in EN.pdf

Annex 2: Semi-structured interview guide

The following questions were presented to the three SDC HIV focal persons during interview:

1. **Internal mainstreaming HIV and AIDS as workplace issues – competence within the COOFs**

1.1 Does your COOF have:

a) A specific work plan for HIV (all have policies)?

b) Information posted on local support groups, counselling, testing and treatment services?

c) Condoms available in male and female washrooms?

d) A designated member of staff to support individuals with HIV and AIDS issues? (If not stated in documentation).

If so, what sex are they?

Have they received specific training in this role?

2. **External mainstreaming**

2.1 Have you had any formal opportunities to share with other COOF focal persons on tools and approaches to mainstreaming?

2.2 What HIV and AIDS information do you share with others?

a) Who do you share with? Government and other implementing partners, NGOs, CBOs, communities themselves?

b) In which fora?

c) How frequently?

2.3 Have you done any mainstreaming on inclusion of and stigma reduction among males?

3. **HIV and AIDS competence of local communities**

With regard to local community knowledge and competencies in responding to HIV and AIDS, what can you tell me, in your country of work, about:

3.1 Community knowledge and abilities to respond to HIV and AIDS?

3.2 Any specific examples?

3.3 Are you aware of any projects or initiatives through community awareness-raising on HIV and AIDS using change agents such as NGOs, PLWHIV, and CBOs etc?

3.4 Has this been in terms of behaviour change? Stigma reduction? Inclusion?

3.5 Are you aware of any actions that communities have taken to mitigate the risks, such as identifying and addressing alcohol overuse and addressing it; lighting or repositioning amenities to reduce sexual assaults on girls as they use school toilets; sexual negotiation?

3.6 If so, what techniques and tools have they used: e.g. community conversations, village risk mapping?

3.7 Has any behavioural or other change been monitored by communities?

3.8 Has this been reported (details)

4. Support to focal persons' competencies

4.1 Have you received any training, guidance document or support on better inclusion of males? If so what?

4.2 In your opinion, what do you identify and the main barriers to improving local HIV and AIDS competences in communities, particularly among young men?

4.3 What would be needed to overcome these barriers (by SDC, government, other agencies and institutions?)

4.4 To fulfil your role as HIV and AIDS Focal Person, and specifically in mainstreaming and HIV and AIDS as workplace issues, and in supporting community HIV and AIDS competencies do you feel you have adequate:

a) Training

b) Guidance documentation?

c) Supervision / Support from a specialist?

d) Time?

e) Information and resources?

f) Other?

4.5 What would you need in your role to better support community HIV and AIDS competencies:

a) In your COOF?

b) Among partners, especially those implementing SDC initiatives?

c) Among beneficiaries and their communities?

4.6 Do you feel adequately informed about specific issues and responses to the programming gap surrounding men and boys?

4.7 If not, what would you need to better support this aspect of your knowledge?

Annex 3: References provided by SDC

General

- SDC 2018 "Know Your Status": World AIDS Day 2018 Communication Support Package for COOFs
- SDC HIV Mainstreaming Toolkit

SDC Mozambique

- HIV and General Wellbeing Action Plan 2018 – 2020
- 2015 HIV and Health Promotion Workplace Policy
- 2015 Report on current situation of health, wellbeing and HIV and AIDS with recommendations for a workplace programme on Health Promotion, HIV and AIDS and wellbeing for staff

SDC Tanzania

- 2017-2018 HIV Mainstreaming Work Plan
- 2016 Report on the F2F Health in Dar-es-Salaam, Day N°4 10th to 13th of May, 2016
- Undated. HIV/AIDS Workplace Policy for Embassy of Switzerland and its Cooperation Office, Dar es Salaam.
- Undated. Terms of References Consultant: HIV-Mainstreaming Backstopper
- Undated. Workplace Health Promotion Plan.
- Undated. Mainstreaming in key PCM milestones.
- 2014 SDC. Do no harm: An assessment tool for HIV and AIDS mainstreaming for SDC and implementing Partners

SDC Zimbabwe

- 2017 Annual Mainstreaming report