Male Case-Finding Assessment in Namibia

Final Report

September 2019

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation

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September 2019

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-19-384

ISBN: 978-1-64232-203-3

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ACKNOWLEDGMENTS

The authors—all of the United States Agency for International Development (USAID)- and the United States President's Emergency Plan for AIDS Relief (PEPFAR)-funded MEASURE Evaluation project—thank USAID and PEPFAR for their support of this work.

We thank the Namibia Ministry of Health and Social Services, USAID/Namibia, the United States Centers for Disease Control and Prevention, Development Aid from People to People, IntraHealth, the International Training and Education Center for Health, Project HOPE (Health Opportunities for People Everywhere), the Society for Family Health, and Walvis Bay Corridor Group. Without the input of these stakeholders, this study would not have been possible.

We especially thank the 122 men and transgender women who gave us their time and invaluable perspective to improve HIV services. We are indebted to you.

Cover:

Tulonga Nampala (facilitator) leading a focus group discussion with men in Tsumeb, Namibia. Photo: Stephanie Watson-Grant, MEASURE Evaluation

Suggested citation:

Mswia, R., Reynolds, Z., & Watson-Grant, S. (2019). Male Case-Finding Assessment in Namibia: Final Report. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina.

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ABBREVIATIONS

ART	antiretroviral therapy
FGD	focus group discussion
MOHSS	Ministry of Health and Social Services
MSM	men who have sex with men
NAMPHIA	Namibia Population-Based HIV Impact Assessment
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
TGW	transgender women
USAID	United States Agency for International Development
VMMC	voluntary male medical circumcision

EXECUTIVE SUMMARY

Introduction

The 2017 Namibia Population-Based HIV Impact Assessment (NAMPHIA) report and other country reports have indicated that men 20 to 39 years of age have the lowest coverage of antiretroviral therapy in the country. The objective of this study, conducted by MEASURE Evaluation—a project funded by the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR)—was to explore the factors affecting barriers to and facilitators of HIV testing and prevention services among young men in Namibia. In keeping with the USAID and PEPFAR goals of controlling the epidemic, the study aimed to determine the right places, the right times, and the right ways to engage young men in these services, and to make recommendations on improving this engagement based on the primary data collected.

Methods

We conducted a landscape analysis and determined six topic areas for the study: (1) barriers to testing, (2) facilitators of testing, (3) where to get tested, (4) index and self-testing, (5) community leaders, and (6) prevention. Focus group discussions (FGDs) were conducted in 13 locations across Namibia. Stratified purposive sampling was used to recruit participants from different population subgroups in different geographic areas. A short demographic survey was used to collect selected data to track responses of the different participants. Digital recordings from each FGD were transcribed, cleaned, and uploaded to Nvivo, and deductive thematic analysis was conducted.

Results

One hundred twenty-two people—119 men and three transgender women (TGW)—participated in the 13 FGDs. Most men and two of the three TGW were unemployed (n=97), most had received an HIV test in the past 12 months (n=97), most completed either grade 10 or 12 (n=86) and most were in a relationship (n=82). Therefore, there was little difference in the participants by employment, HIV testing status, and educational attainment and relationship status. Fear, absence of information or education, and a perceived lack of confidentiality were the primary barriers to HIV testing. Increasing education, providing incentives, and involving more male health workers were mentioned as possible facilitators. Home, mobile sites, and facilities with extended open hours were the preferred types of testing sites. Participants were divided on the merits of self-testing and index testing but were enthusiastic about voluntary male medical circumcision. Community leaders were not involved in HIV prevention but could provide HIV leadership in the community. Condom use was mostly influenced by relationships and family planning.

Recommendations

We recommend (1) crowdsourcing a positive HIV message and promoting it countrywide; (2) expanding home testing, having "VIP" clinic services, and targeting outreach testing for men; (3) promoting self-testing and developing a protocol for counseling and linkage with treatment; (4) continuing the implementation of index testing; and (5) promoting and distributing condoms and offering pre-exposure prophylaxis and post-exposure prophylaxis for men.

INTRODUCTION

The 2017 Namibia Population-Based HIV Impact Assessment (NAMPHIA)[1] and other country reports have indicated that men 20 to 39 years of age have the lowest antiretroviral therapy (ART) coverage in the country. This is a critical area of underperformance related to adult male case finding and linkage to ART.

USAID/Namibia asked MEASURE Evaluation to conduct a study to help identify innovative approaches to deliver appropriate and effective HIV/AIDS services for young men, increasing their rapid uptake of HIV testing, linkage to HIV treatment, and achievement of viral suppression. The study was meant to provide clear recommendations to improve case finding for men 20 to 39 years of age, particularly high-yield testing interventions for men in this age group. The mission desired to engage high-risk men in testing and care, as men in this age group are the least likely to be tested, to know their status, and to be on treatment.

Specifically, USAID/Namibia was interested in generating knowledge that could contribute to increases in:

- HIV case finding for young men ages 20 to 39, with a yield greater than 10 percent
- The number of young men enrolled in HIV treatment and care

This study and related activities focused on gathering qualitative information from diverse groups of young men to help improve the implementation of HIV prevention programs.

Objectives

The main objective of the study was to better understand the factors that young men between 20 and 39 years of age in Namibia consider to be the barriers to and facilitators of HIV prevention—from HIV testing, to seeking medical care and treatment. Specifically, the study aimed to:

1. Determine the right place, the right time, and the right way to engage men (particularly those ages 20 to 39) in HIV prevention and testing.
2. Make recommendations on improving the engagement of young men at risk of HIV transmission in HIV prevention and testing based on primary data collection.

[1] PHIA Project. (2018). *NAMPHIA 2017. Summary sheet: preliminary findings.* Retrieved from https://phia.icap.columbia.edu/countries/namibia/.

METHODS

Initial Landscape Analysis and Data Gathering

Following the protocol development and approval by the Ministry of Health and Social Services (MOHSS) in Namibia, MEASURE Evaluation and USAID/Namibia conducted a landscape analysis. The purpose of the analysis was to understand modalities of HIV services being offered in the country and to identify challenges for engaging men in HIV testing, determine what interventions that had already been attempted, and explore interventions that were ongoing to improve HIV case finding.

Stakeholders involved in the landscape analysis included the MOHSS, USAID/Namibia, the United States Centers for Disease Control and Prevention, Development Aid from People to People, IntraHealth, the International Training and Education Center for Health, Project HOPE (Health Opportunities for People Everywhere), the Society for Family Health, and Walvis Bay Corridor Group. The stakeholders provided information previously mentioned but also suggested activities that could be performed if additional resources were available, geographic areas for conducting the study, and recruitment ideas for target groups. This information was used to determine six topic areas for the study (Table 1).

Selected Qualitative Method

The primary data collection method was focus group discussions (FGDs). This method was chosen because it can allow participants to feel comfortable, respected, and free to give their opinions without being judged. It is an effective method for determining the perceptions, feelings, and thoughts of consumers about issues, products, services, or opportunities.[2] Additionally, MEASURE Evaluation conducted a similar study with FGDs in eSwatini. We therefore adapted the FGD guide used in eSwatini, organized it into the six topic areas, and shared it with the MOHSS, USAID, and implementing partners for their review and feedback.

Table 1. Study topic areas

1. Barriers to testing
2. Facilitators of testing
3. Where to get tested
4. Index and self-testing
5. Community leaders
6. Prevention

Sampling

Stratified purposive sampling was used to recruit participants. The intention was to recruit men in different subgroups in different geographic areas. Stakeholders assisted with identifying the geographic areas and the subgroups. These subgroups were the general population, men who have sex with men (MSM) representing key populations, and miners and farmers representing at-risk populations. Thirteen FGD locations and subgroups were identified (Table 2). Participants were identified and recruited through regional and district implementing partners from the selected geographic areas. Each FGD had between eight and 12 participants, except for an FGD with MSM in Oshakati, which had more than 12.

[2] Kruger, R. (2009). *Focus groups: A practical guide for applied research*. 4th Ed. Thousand Oaks, CA, USA: Sage Publications.

Table 2. Focus group discussion locations and population subgroups

FGD location	Subgroup
Windhoek	General population
Windhoek	MSM
Swakopmund	MSM
Walvis Bay	General population
Tsumeb	Farmers
Tsumeb	Miners
Keetsmanshoop	General population
Katima	General population
Nyangana	General population
Oshakati	General population
Oshakati	MSM
Eenhana	General population
Engela	General population

Focus Group Discussions

Table 3 provides a summary of the FGD process. FGDs were led by MEASURE Evaluation researchers, with assistance from local research assistants who led the discussions at the sites where either Afrikaans or Oshiwambo was the main language. The research team was divided into two teams, with each team composed of one researcher from MEASURE Evaluation and one research assistant, plus a driver.

Table 3. Focus group discussion process

1. Convened meeting in a predetermined venue
2. Sought verbal consent from participants
3. Asked each participant to complete a demographic profile and assigned each a number
4. Attributed each response during discussion to an assigned number
5. Recorded and transcribed FGDs
6. Completed deductive thematic analysis

One team conducted FGDs in the selected areas in the Central, Southern, and Coastal regions, and the other team covered areas in the Northern region. In the districts where FGDs were conducted with MSM, an additional research assistant who coordinates MSM support groups joined the research teams to assist with recruitment and facilitation of the discussions.

Each focus group began with the facilitator acknowledging the purpose and structure of the focus group (see Appendix 1 in the study protocol [Appendix A of this report]). The facilitator followed the protocol and discussion guide to establish the ground rules for the group and help put participants at ease with sharing their opinions and concerns. Afterward, each member of the group was asked to give informed verbal consent to participate in the FGDs and to complete a 12-question demographic survey to collect selected data to target

responses of the participants in different groups (see Appendix 2 in the study protocol). Each survey included a participant ID number.

The facilitator used the interview guide to guide the discussion. He or she also added prompts and probing questions to solicit additional information and delve deeper into participants' comments. The participants were asked to identify themselves before speaking, using the participant ID number from the demographic survey. This identification would allow each participant's response to be linked to the corresponding demographic profile while maintaining anonymity during the FGDs. For three questions, participants were asked to rank their responses in order of preference. For questions related to testing barriers and testing strategies, either participants individually wrote their responses on notepaper or the facilitators wrote the responses on notepaper as they were shared by the group, before the responses were ranked. For the question related to preferred type of testing site, seven types were predetermined and given to the participants to rank.

Each session was digitally recorded. Transcripts were developed from the recordings by a team of seven transcribers.

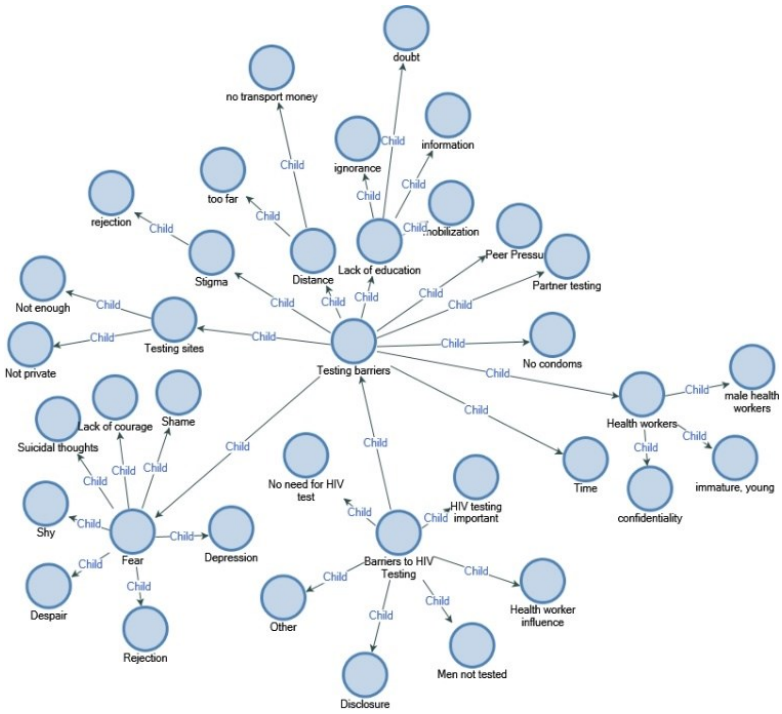
Data Analysis

Digital recordings from each FGD were transcribed, cleaned, and uploaded to Nvivo—a qualitative data analysis computer software package. A codebook developed by the researchers contained two main types of codes. The first type, descriptive codes, summarized the main topic of the selected section of the transcript. We generated these codes using the six FGD topics included in the interview guide. (Figure 1 shows a code map for the topic area of barriers to testing.) Second, demographic codes were generated from the 12-question survey that participants completed before the start of the FGDs.

Eight main codes (parent codes) and 103 subcodes (child codes) were created in Nvivo for descriptive coding, and 24 codes were created for demographic coding. See Figure 1 for an example of a code map for barriers to testing and Appendix 3 in the study protocol for code maps for the other focus areas.

In the 13 transcripts, participants' responses were coded with both selected descriptive codes and demographic codes to link each response to the profile of a participant. Facilitator statements were also coded when they summarized participants' responses or when the ranking of testing barriers, testing strategies, or preferred testing sites were being discussed by the group. Descriptive codes were created when a new topic not previously included in the codebook was identified in the data. When coding was completed, descriptive and demographic codes were cross tabulated to identify patterns in the data and relationships between different demographic and descriptive codes.

Figure 1. Code map for barriers to testing



RESULTS

Participants' Profile

One hundred twenty-two people (112 men and three transgender women [TGW]) participated in the 13 FGDs. Most of the participants were in the age cohorts 20–24 and 25–30 years. Even though the study addressed men between 20 and 39 years of age, the FGDs also included seven men younger than 20 years and five men older than 40 years (Table 4).

Table 4. Participant age ranges

Age (years)	Number of participants	%
<20	7	6
20–24	40	33
25–30	33	28
31–34	19	16
35–39	14	13
40+	5	5

Most of the men and TGW had completed grade 10, 11, or 12. Fewer had completed less than grade 10 or held national certificates (e.g., boilermaker, information and communication technology, electrical engineering) or university degrees. Only two participants had never attended school (Table 5).

Table 5. Educational attainment

Education level	Number of participants	%
Never attended school	2	2
<Grade 10	17	14
Grade 10–12	86	70
National certificate or degree	17	14

Most men and two of the three TGW were unemployed (n=97), most had received an HIV test in the past 12 months (n=97), and most were in a relationship (n=82). Therefore, there was little difference in the participants by educational attainment, employment, HIV testing status, and relationship status.

Key Findings

Barriers to Testing

Most participants expressed **fear** as the primary barrier to HIV testing. There were no notable differences by age, educational attainment, employment, HIV testing status, relationship status, or location. The participants expressed fear mostly as despair and rejection. They perceived an HIV-positive result as the end of their lives, and they expressed the belief that they would be rejected by family, friends, communities, and workplaces if they disclosed their status. Some participants expressed **stigma** as the reason for fear. They mentioned the belief that HIV was a "disease of shame" unlike other illnesses that could lead to death. They mentioned how the community treats other illnesses and health conditions with sympathy, but those infected with HIV are "different." None of the participants talked about fear of managing medication regimes and care, but they expressed not believing that they could handle the diagnosis. Suicidal thoughts or committing suicide if diagnosed with HIV was mentioned in six FGDs and referenced more than 30 times during these conversations.

> *The perception most Namibians got at the inception was, when you got exposed to what HIV is, it is the scariest thing. I believe most of them believed that [it's] the end of the line. It's the end of the world.*
>
> —32-year-old, Oshakati, general population

The participants talked about the **absence of HIV education and information**. They expressed being given information in school but that the messages were about sickness and death. They mentioned not knowing what the testing process was like, and they didn't know what treatment regimens would entail.

> *I know from the root, where we have grown up, we have been hear*[ing] *HIV is* [a] *killer disease. That mentality is still in our mind even though there are medicines. But from the root, we have not been given enough information about HIV.*

The participants also mentioned the influence of **health workers** on their decisions to test. They talked about their concern that health care workers would share their HIV status with others. This **lack of confidentiality** was perceived as both passive and active. This was mentioned in six FGDs (Keetsmanshoop, Nyangana, Tsumeb farmers and miners and Windhoek MSM) and referenced sixteen times by men. Men and TGW talked about health care workers actively sharing their HIV test results by word of mouth and on social media platforms such as WhatsApp. Participants in rural locations talked about female health workers passively sharing their status with other women in the community by discouraging them from having relationships with men who test positive for HIV. Participants also expressed lack of confidentiality at stand-alone testing sites where others can easily identify who has had an HIV test or picked up antiretroviral drugs.

For instance, I am dating a girl but now the girl's mother is a nurse. So, I go to the hospital, the mother tests me while the mother knows that I am dating her daughter. From there the mother comes back from work, she will tell the daughters, stay away from that boy.

—24-year-old man, Nyangana, general population

Most participants believed that men do not **test with their partners**. They thought that they will test with their partners if they test themselves first and have a negative HIV result or if they are in a stable long-term relationship, such as marriage. Multiple partners and fear of a relationship ending were the main factors that influenced men to test by themselves.

Some participants expressed **no need to test**. Their partners' status was theirs by default. They believed that if they didn't feel sick, they didn't need to get tested. In Oshakati, Keetsmanshoop, Nyangana, and Tsumeb, the participants believed that testing is for women and associated testing with pregnancy. One participant in Nyangana said, "Boys can't get pregnant, so they don't need to go for testing."

Facilitators of Testing

Participants noted that **men get tested** when they start a new relationship; they want to have unprotected sex; they want to start a family; the testing is job-related; they donate blood; they, a friend, or a relative gets sick; or a condom breaks.

Education or raising awareness through outreach efforts was the main facilitator of testing. This education and awareness could be through celebrities talking about HIV and making HIV testing look "cool."

Teach us the right way, not just sick pictures, showing more people like Magic Johnson that you can live with it comfortably.

—28-year-old man, Tsumeb, miner

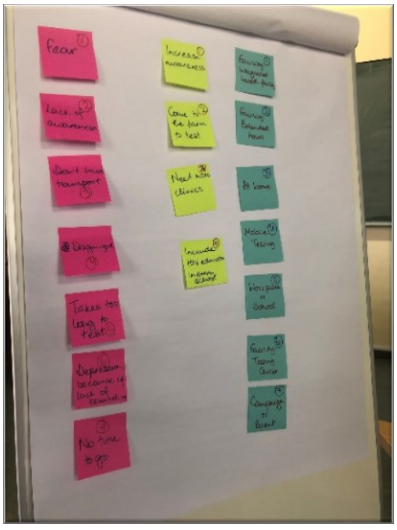
Participants in Windhoek, Tsumeb (miners), and Keetsmanshoop talked about convening men's groups to "talk and test." While participants suggested outreach as a testing strategy, they were divided about whether people should come directly to their homes. Participants in Windhoek (general population) and Walvis Bay wanted outreach workers to go to homes, but participants in Keetsmanshoop did not want outreach workers going to homes. This could suggest that men in smaller towns or rural areas do not prefer home testing, while men in urban centers prefer home testing. Farmers thought more outreach testing should be offered to them, because they tended to be in remote settings.

The people driving around telling us to go for testing, we never listen to them… It's just like a normal day, people walking around and saying things…it's just a local thing, because everybody does it, there is a church coming, as people voting for something; same thing.

—19-year-old man, Swakopmund, MSM

Time to testing site and **open hours of testing site** could also facilitate testing. Participants mentioned times ranging from early weekday mornings to after lunch, weekday evenings, and weekends. The common thread was times when the facilities were not busy and the participants would not be seen taking an HIV test. Participants mentioned various **travel times to get an HIV test,** ranging from two minutes to three hours. The TGW expressed wanting to travel shorter distances to test. Men expressed both not wanting enough travel time that they could change their minds on the way to clinic and wanting to travel long distances to ensure the confidentiality of their HIV test results.

> *Saturday, because…everybody is out on their things, so you don't have to worry about who to go meet at the hospital because you know they aren't at the hospital…people are busy at home.*
>
> —19-year-old man, Swakopmund, MSM



Six FGDs discussed **incentives** as a facilitator of testing. Some men stated that the government should pay men to get tested, that there should be incentives such as the promise of "cool drinks" or cash, or that offering transportation money would persuade more men to get tested. Other ideas included peer-to-peer promotion of testing and offers of free general checkups that included HIV testing.

> *The government can give each a 50 dollar for taxi if they go for tests, if they just give something small in this Namibia everyone will be tested, even just to buy cooldrink when they come from testing.*
>
> —38-year-old, Walvis Bay, general population

HIV promotions were not seen as persuasive. Participants recalled HIV promotions such as advertisements on television related to condoms, a televised UNICEF program, t-shirts with the slogan "Stop spreading HIV," and World AIDS Day promotions. The participants, however, did not think that these promotions persuaded them to get an HIV test.

Seven FGD uncovered a preference for **male health workers**. The participants felt that they would be more comfortable and relate better to men. The Tsumeb miners specified that a male health worker should be "someone who just recently went through what you're going through." The TGW and men in Walvis Bay mentioned a preference for older, rather than younger, health workers because they felt they were more trustworthy. TGW noted that they wanted the person testing them to be registered (which would be obvious by the uniform lapel).

Participants in all FGDs except those among MSM in Windhoek and the general population in Windhoek, Keetsmanshoop, and Eenhana mentioned having **community meetings**. The participants further stated that the meetings were not being useful to men, men did not attend them, or HIV wasn't discussed at the meetings.

Participants had various **sources of health information**, including friends and family, private doctors, health facilities, the Internet, and social media platforms such as WhatsApp. There were no notable differences by age, educational attainment, employment, HIV testing status, relationship status, or location.

Where to Get Tested

Participants discussed privacy or not wanting to be seen by anyone they know, as well as the time it takes to test in a public facility, as the main reasons for **testing outside of health facilities**. All seven testing site types were included in the top three by participants for each FGD (see table 6 for ranked listing of preferred testing sites).

Table 6. Testing sites ranked

1. Home
2. Mobile testing
2. Facility with extended hours
3. Integrated facility
4. Stand-alone testing center
5. Workplace or school
6. Campaign or event

Home was the testing site participants most preferred. They expressed home testing to be convenient and private. Conversely, some participants said home testing was "chaotic" when men lived with their partners.

Mobile testing and **facilities with extended hours** were tied for the next most popular site among all focus groups. Participants mentioned anonymity and not having to wait as reasons for ranking these sites highly.

Integrated facilities also provide some anonymity, as participants mentioned people not knowing why you are at the facilities as the reason for the high ranking.

Stand-alone testing centers were ranked next, because of the perceived ease of receiving HIV testing there. Workplaces, schools, and campaigns were the least popular overall. Workplace testing and school testing were discussed as convenient, and campaigns were seen as conducted "by people that just come here and go." Other places participants suggested for HIV testing included churches, brothels, bars, and prisons. There were no notable differences by age, educational attainment, employment, HIV testing status, relationship status, or location.

Index and Self-Testing

Most participants were aware of the finger prick self-test, but not many were aware of the oral self-test. The participants identified privacy as the main benefit of a **self-test**. Self-testing is done when a participant is ready; he or she doesn't have to travel anywhere to get the test, and the results remain private. The two disadvantages mentioned were the absence of counseling services and the possibility of not getting correct results, because the test was not done as instructed. Participants expressed being suspicious of their partners bringing them a self-test kit. "Why would somebody out of the blue give me a test?" They mentioned that their choice to use the self-test kits depended on their relationships and if they already knew their HIV status.

> *I say it's safer to do the self-testing because you don't panic immediately and you also don't get a fright immediately and it is more comfortable for yourself.*
>
> —25-year-old TGW, Keetsmanshoop, general population

Participants stated that they would prefer to hear their partner's HIV test results directly from their partner. Other participants also wanted to be **notified by a health provider** (doctor, nurse, social worker, or counselor) if their partner tested positive. Their reaction to the news of being invited for HIV testing included shock, numbness, depression, anger, and violence. Most FGD participants said they would not go to the facility to test if called by a health worker. There were no notable differences by age, educational attainment, employment, HIV testing status, relationship status, or location.

> *It's difficult to accept, it is very difficult to be called and told my partner is there and is found positive. Firstly, it is shock and I might even ignore going to the hospital and wait for her, the first thing that will have to happen be an argument. I will ask who gave her permission to give my contact number and all, you just brought me problems and I say I will go the following day but I never go.*
>
> —32-year-old man, Engela, general population

Community Leaders

Participants did not recall **community leaders** talking about HIV activities, but they did recall them talking about hepatitis, hygiene, and the environment. Participants thought that some community leaders understand HIV and some don't. Participants thought that community leaders could organize outreach activities to raise HIV awareness, advocate for more condoms, publicly encourage people to get tested (and if positive, to take their medication), organize mobile testing, and provide food for those on medication. There were no notable differences by age, educational attainment, employment, HIV testing status, relationship status, or location.

Prevention

Participants generally had a positive perception of voluntary male medical circumcision (VMMC). The main benefits of **VMMC** mentioned were protection against HIV, better hygiene, and increased sexual pleasure. When discussing the barriers to VMMC, participants spoke of pain, fear of injections, loss of sensitivity in the penis, reduction in penis size, and cultural and religious barriers. Partner preference for circumcision was noted by participants, as both male and female partners preferred circumcised penises; in many cases this preference motivated men to get circumcised. Participants had no negative feedback on VMMC services except for one participant who expressed a preference for women performing the procedure.

> *I have two reasons: (1) It's very safe because there is 60 percent safe of getting HIV and AIDS;(2) It's very sweet when you are circumcised it smack when you are chopping.*
>
> —24-year-old man, Nyangana, general population

Participants noted that **condom use** is influenced by a desire to stay healthy, doubt when relationships are new or during "one-night stands," the need to prevent unwanted pregnancies, and the ease of anal penetration. They also noted that condoms are not usually used in long-term relationships, when women use a long-acting reversible contraceptive method such as injectables, when men know they are HIV-negative, and when men want to start a family. Participants easily named places where they could get condoms, including gas stations, health facilities, pharmacies, counselors' offices, shebeens (unlicensed bars), and bars. They quickly noted the names of condoms such as Smile, Dr. Lee, Dr. Long, Cool Rider, National Defense Force, G-Spot, Rocky, Sense, and Durex. They also noted a preference for flavored, scented, dotted, thin, and smooth condoms. There were no notable differences by age, educational attainment, employment, HIV testing status, relationship status, or location.

> *In this generation of ours you keep condoms at home like you keep an extra bar of soap or deodorant or an extra toothpaste.*
>
> —28-year-old man, Tsumeb, miner

Finally, participants noted that pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) were not included in the discussion. They asked for more information and better promotion of these HIV prevention options.

DISCUSSION

The FGDs obtained men's perspectives on barriers to and facilitators of the HIV prevention and testing services offered in Namibia and sought their opinions and ideas on innovative approaches for encouraging young men to be tested for HIV to increase the uptake of services. Because the study was limited to men between the ages of 20 and 39 and those from the communities in which the focus groups were conducted, the results are not representative of all men. However, the sampling was designed to achieve a wide representation across Namibia with 10 of the 34 health districts (29%) in eight of the 14 regions (57%) of the country. The participants recruited had many demographic characteristics in common (e.g., HIV testing status). This limited variability in data analysis and may have contributed to saturation (i.e., no new themes, findings, or concepts emerging from the data). It is difficult to determine when saturation was attained, because the FGDs were conducted concurrently. FGD digital recordings were assigned to different transcribers based on language capability and coding was done as transcripts were completed.

Among the young men in the study, the major concerns or barriers to seeking HIV services were stigma and fear of rejection, lack of positive campaign messages on living with HIV, and lack of preferred testing and treatment services.

To address fear of stigma and discrimination, there is a need to provide more education in the community about HIV, the diagnosis, and living positively with the virus. More psychosocial support through peers and counselors is needed for young men who have not yet been tested or those who have been tested and found to be positive for HIV. Additionally, increasing the anonymity of testing and the counseling rooms in health facilities would be well-received by men. Young men are less likely to go to health facilities where HIV clinic rooms are labeled, because of fear of being seen by people they know or other community members who are at the clinic for other reasons.

Participants indicated that they were given little or outdated information on HIV prevention and other health issues. Most HIV-related information was related to what not to do, such as not engaging in sex to avoid being infected with HIV. However, messages that inform men what to do if they suspect they may have contracted HIV or have already tested positive for HIV is often missing. More innovative health promotion strategies are needed to improve access to HIV testing for young men.

Collective recommendations from FGD participants included making HIV education, testing, and treatment more relevant for young men so that they can use the information when making decisions about seeking health services in general, and HIV services in particular.

RECOMMENDATIONS

Based on the findings from FGDs, there is indeed a need to consider and provide a "VIP" package of HIV services for young men in Namibia. These services should not be implemented as single interventions but as combination interventions addressing psychosocial issues and access to testing and prevention services. It is important to note that while TGW participated in the FGDs, our recommendations are intended to reach men. Therefore, we recommend to:

Table 7. Key recommendations

- Crowdsource a positive HIV message and promote it countrywide
- Expand home testing, have special "VIP" clinic services, and target outreach for men
- Promote self-testing and develop a protocol for counseling and linkage to care
- Continue to implement index testing
- Promote and distribute condoms, PrEP, and PEP

1. Crowdsource a positive HIV message and promote it countrywide.

From the conversations with the participants, they have a negative, fatalistic perception of HIV. If positive messages of HIV testing and living positively had been shared with men, they were not effective. We recommend including men in developing an HIV testing message. If the message is short, specific, and targeted like that for VMMC, then men's perception of HIV may change. A crowdsourcing competition could be staged with an associated prize. An integral part of the competition would be to organize meetings with men to share the findings from this study. The winning slogan could be selected by a panel of national figures, community leaders, and celebrities who are also aware of NAMPHIA and this study's results.

2. Expand home testing, have special "VIP" clinic services, and target outreach testing for men.

Men mentioned privacy as one of the main reasons for not having an HIV test. This is partly because of the shame surrounding HIV and partly because of the multipartner culture. Until stigma surrounding HIV is lessened for men, home testing with a provider should be promoted and expanded as a testing option. In clinics that operate only during regular clinic hours, we recommend reducing clinic wait times by providing "fast-track" services for young men and introducing more male-friendly services for greater discretion. That is, the HIV clinics should offer not only HIV services but also comprehensive health services for men, such as routine medical checkups (e.g., testing for blood pressure and blood sugar), reproductive health services, tuberculosis screening, and screening for non-communicable diseases. We also recommend increasing the number of male clinic staff to attend to the health care needs of young men. This will encourage men to be tested and disclose HIV issues more freely to staff. This may require promotion of these services at shebeens, bars, and other places where men gather. In areas such as farms and rural areas, we recommend periodic outreach testing, distribution of self-test kits and extended clinic working hours.

3. Promote self-testing and develop a protocol for counseling and linkage to care.

Men expressed an interest in using self-test kits. In many parts of the country, the kits are not available and men do not know how the self-tests are linked to pre- and post-test counseling and treatment. We recommend making self-test kits more broadly available in Namibia, perhaps even distributing them through peer networks. These test kits should include information on whom to contact for counseling and referral services, or on or a hotline service (e.g., LifeLine ChildLine). A campaign or other information-sharing effort should be developed to promote the use of the kits through social and other media. Additionally, pharmacists and others who sell the kits should be trained to counsel men, and the men who buy the kits should be encouraged to share their contact information for follow-up and linkage to care.

4. Continue to implement index testing.

Program data suggest that 57 percent of people tested through index testing are male, although men in the FGDs expressed displeasure about being notified about their partner's HIV status. Most participants actually wanted to be notified about a partner's HIV-positive test, but they were more concerned about how they were notified. The index testing protocol[3] outlines one on one counseling of and offer of HIV testing to identified sexual partners after the index case test case tests positive. We recommend this modality continue but include index testing in awareness efforts to demystify the practice. As more positive HIV messages are shared with men, this testing modality will be reinforced.

5. Promote and distribute condoms, PrEP, and PEP.

The HIV prevention stakeholders in Namibia did well promoting and implementing VMMC. Lessons learned from implementing this prevention strategy can be applied to PrEP and PEP. Men wanted more information about these pills and wanted access to them. Men see condoms as part of their sexual experience; therefore, we recommend more emphasis on ensuring a steady and sufficient supply of condoms, especially in the regions of the north.

[3] AIDSFree. Partner and Family-Based Index Case Testing: A Standard Operating Procedure. Retrieved from https://aidsfree.usaid.gov/sites/default/files/pn_sop_slides.pdf.

APPENDIX 1. STUDY PROTOCOL

HIV Male Case Finding Qualitative Assessment in Namibia

Project Personnel:
MEASURE Evaluation Principal Investigator: Zahra Reynolds

MEASURE Evaluation Co-Investigator: Dr. Robert Mswia

MOHSS Contact: Dr. Edington Dzinotyiweyi

Date: 6/17/2019

Version 2

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Brief summary

Purpose: To determine the right place, the right time, and the right way to engage men (particularly those aged 20-39) in HIV prevention and testing; To make recommendations on improving engaging young men at risk of HIV transmission in HIV prevention and testing based on primary data collection.

Participants: Target populations for the assessment are men ages 20 to 39. Specifically, the focus group discussions will recruit men in that age group in specific geographic areas. Separately, a crowdsourcing contest will be open to the general population, but we will seek out entries from men in the target age group.

Procedures: Data collection will include focus group discussions with men ages 20 to 39 to better understand barriers and facilitators to HIV prevention followed by a crowdsourcing content to identify innovative approaches to male testing.

Specific aims:

The study aims to generate knowledge that will improve HIV case finding among young men in Namibia.

Specifically, the study will

- Determine the right place, the right time, and the right way to engage men (particularly those aged 20-39) in HIV prevention and testing;
- Make recommendations on improving engaging young men at risk of HIV transmission in HIV prevention and testing based on primary data collection.

Statement of the Problem

The 2017 Namibia Population-Based HIV Impact Assessment (NAMPHIA) and other Annual Progress Report on the number active on ART, indicated that men 20 to 34 years of age have the lowest ART coverage in the country. This is a critical area of underperformance related to adult male case finding and linkage to ART.

USAID/Namibia has requested MEASURE Evaluation to conduct a study that will help identify innovative approaches to deliver appropriate and effective HIV/AIDS services for young men, increasing their rapid uptake of HIV testing, linkage to HIV treatment, and achievement of viral suppression. The study should provide clear recommendations to improve case finding for men 20- 39 years of age, particularly high yield male testing interventions for men in this age group. The mission desires to engage high risk men in testing and care, as men in this age group are the least likely to be tested, to know their status, and to be on treatment.

Specifically, USAID/Namibia is interested in generating knowledge that could contribute to an increase in:

- Case findings of young men ages 20-39 with a yield greater than 10 percent
- Young men enrolled in care

Limitations

The results of the study will be limited to the study population for the focus groups, namely men between the ages of 20 and 40. The results will not be representative of all men. They also will be limited to representing the communities in which the focus groups take place. That being said, the sampling was designed to achieve a wide representation across Namibia.

Delimitations

Geographic area

The focus group portion of the activity will take place in:

- Katima Mulilo in Zambezi
- Nyangana in Kavango East
- Eenhana in Ohangwena
- Engela West
- Oshakati in Oshana
- Windhoek in Khomas
- Swakopmund/Walvis Bay in Erongo
- Tsumeb in Oshikoto
- And Keetmanshoop in Karas

Eligibility criteria

- Requirements for participation in the focus groups is:
- Gender: male
- Age: 20-40
- Residence: In the community or neighboring communities of the focus group location

Definitions of terminology

- Crowdsourcing: A method for gathering input from a large group of individuals
- Focus groups: A qualitative research method utilizing semi-structured interviews in a group setting
- HIV: Human immunodeficiency virus
- MEASURE Evaluation: The implementer of the study, a project of USAID
- MOHSS: The Ministry of Health and Social Services of Namibia
- PrEP: Pre-exposure prophylaxis
- UNC: The University of North Carolina, the home organization of MEASURE Evaluation
- USAID: The U.S. Agency for International Development

Literature Review

During the landscape analysis phase, a literature review was conducted to identify resources related to HIV engagement of men in HIV testing, initiation, and treatment. The review included both peer-reviewed and gray literature. Search terms included HIV, men, male engagement, Africa, testing, and initiation. The identified resources are listed below:

Resource Title	Link	Publisher	Methods	Country/ Region
Systematic review of strategies to increase men's HIV-testing in sub-Saharan Africa	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4819892/	AIDS	Systematic review	Sub-Saharan Africa
A qualitative explanation of social network influence on men's HIV testing behavior in Dar Es Salaam, Tanzania: implications for increasing HIV testing and promoting HIV self- testing among men	http://hivst.org/evidence/a-qualitative-explanation-of-social-network-influence-on-mens-hiv-testing-behavior-in-dar-es-salaam-tanzania-implications-for-increasing-hiv-testing-and-promoting-hiv-self-testing-among-men	International Conference on AIDS and STIs in Africa	Qualitative data collection	Tanzania refugee camp
HIV Testing Programs	https://www.avert.org/professionals/hiv-programming/testing	AVERT	Guidance	Global
Consolidated Guidelines on HIV Testing Services	https://apps.who.int/iris/bitstream/handle/10665/179870/9789241508926_eng.pdf;jsessionid=D635A6DAD340A40561E098A30D3E518B?sequence=1	WHO	Guidance	Global
Knowledge is Power: Know your status, know your viral load	http://www.unaids.org/sites/default/files/media_asset/jc2940_knowledge-is-power-report_en.pdf	Joint United Nations Programme on HIV/AIDS (UNAIDS)	Guidance	South Africa results of MenStar Coalition Study
				Malawi
				Sub-Saharan Africa
Blind Spot: Reaching out to men and boys	http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf	UNAIDS	Guidance	Global

Resource Title	Link	Publisher	Methods	Country/ Region
Risk perception and the influence on uptake and use of biomedical prevention interventions for HIV in sub-Saharan Africa: A systematic literature review	https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0198680&type=printable	PLOS One	Systematic review	Sub-Saharan Africa
Technical Approaches for Engaging and Retaining Men	file:///C:/Users/User/Downloads/Engaging%20and%20Retaining%20Men%20-%20Technical%20%20Approaches%20Slidedeck_2019_1_24.pdf	Office of HIV/AIDS, USAID	COP Guidance	All
Addressing the Blind Spot in Achieving Epidemic Control in Malawi: Implementing "male- friendly" HIV services to increase access and uptake	https://www.pepfarsolutions.org/solutions/2018/12/19/addressing-the-blind-spot-in-achieving-epidemic-control-in-malawi-implementing-male-friendly-hiv-services-to-increase-access-and-uptake	PEPFAR Solutions	Case Study	Malawi
Male-Friendly Clinics in Lesotho: Demand Creation Targeting HIV-Infected Men to Access Comprehensive Health Services	https://www.pepfarsolutions.org/solutions/2018/11/6/male-friendly-clinics-demand-creation-targeting-hiv-infected-men-to-access-comprehensive-health-services	PEPFAR Solutions	Case Study	Lesotho
Men “missing” from population-based HIV testing: insights from qualitative research	https://www.tandfonline.com/doi/full/10.1080/09540121.2016.1164806	AIDS Care	Qualitative Research	Eastern Africa
Perceptions of Men With Regard To Human Immunodeficiency Virus (HIV) Voluntary Counselling and Testing, Windhoek	http://www.iosrjournals.org/iosr-jnhs/papers/vol7-issue3/Version-3/G0703035459.pdf	Journal of Nursing and Health Science	Qualitative methods	Windhoek, Namibia
HIV Quality Improvement Conference	https://www.dropbox.com/sh/5x8j22oxk44xlbu/AAA6wGp_USW5XFGnfsG25w1Va?dl=0		Presentations on site- level research	Namibia

Research Methodology

This will be a qualitative research design utilizing focus groups. Focus groups collect data through semi-structured group interviews led by a moderator. The moderator will employ a standardized set of questions that will allow for discussion to emerge organically. The size of focus groups will utilize best practice standards to ensure participation and quality conversation.

Research Population

Total number of subjects: 96

MEASURE Evaluation is planning on conducting 12 focus group discussions throughout Namibia. Each focus group discussion will involve approximately 8 participants. Focus group participants will be men between the ages of 20 and 40.

It is anticipated that subjects will speak different languages depending on the region in which the focus group is taking place. The preferred language for the focus groups will be English, but study staff will speak a variety of languages to ensure that questions can be translated appropriately for the audience. Study personnel will confirm with potential participants of their preferred language.

The crowdsourcing contest will be advertised nationally and will be open to anyone who would like to enter. We cannot anticipate the number of entries we will receive and the number of participants in the contest.

The contest will be advertised in English, but entries will be accepted in all languages.

No special protections are required for non-English speaking subjects, as this is an expected characteristic given the study setting in Namibia. All study materials will be in English.

Research Design and Approach

This activity will focus on qualitative information gathering with diverse groups of young men that directly improves program implementation. The activity will take on three phases: 1) landscape analysis/formative research to identify what is currently being done and gaps in knowledge; 2) qualitative data collection with young men; and 3) a crowdsourcing activity to identify innovative approaches.

<u>Phase 1: Landscape analysis and formative research</u>

This phase will focus on ensuring we are asking the right questions in the right way to ensure that quality information is gathered that can have a practical application to HIV prevention and treatment programs. This will involve speaking with USAID implementing partners and other HIV stakeholders (such as the MOHSS) involved in programming for young men to 1) know what HIV testing programs and interventions are being offered to young men currently; and 2) what programs have been successful and which have not been in increasing male testing and yield of HIV positive men. Some of these may be small scale interventions that have the potential to be scaled up.

MEASURE Evaluation will also review existing documentation and literature surrounding best practices in engaging men in HIV prevention and treatment that could be applied in Namibia. A key resource document will be the PEPFAR MenStar Coalition Policy. Both the desk review and the formative research will inform the next phase of data collection.

Phase 2: Qualitative data collection

The primary qualitative data collection method will be focus groups. MEASURE Evaluation will work closely with IPs to identify young men to participate in focus group discussions. These men will be representative of the target population (ages 20-39) and represent different pre-identified male "profiles" that will be determined in phase 1. These could be urban office workers, older farm workers, HIV+ and HIV-, etc. These would be men from USAID priority districts. The content of the focus groups would be on how they would like to be engaged in HIV testing, preferences for receiving prevention services, preferences for types of support for linking to treatment, what are the key influencers for testing and VMMC, etc. The final content of the focus group guides will be determined based on Phase 1 data. MEASURE Evaluation anticipates conducting 6 focus groups in 3 different districts.

Phase 3: Crowdsourcing contest

This phase revolves around the implementation of a contest that uses crowdsourcing techniques to illicit novel ideas for HIV testing programming for young men. The contest would be applied in USAID priority areas. The exact content of the contest will be determined based on findings from phase 1 and 2.

Examples of potential contest questions include:

- Broad:
  - What are ways to get young men engaged in HIV services?
  - What are places or times where men could be better engaged?
- Specific:
  - How did you overcome a barrier to testing? Submit a photo with a caption, a skit, or story of how you overcame a barrier.
  - Fill in the blank: I was reluctant to 1) get tested for HIV or 2) get circumcised or 3) get ART because _____ but I did it anyway because_____.
  - Design an advertisement for VMMC for young men that includes graphics and messaging.
  - How do we get men tested? How do we get men on PrEP?

Local community stakeholders in those districts would be asked to participate in advertising and judging the contest. A system of submission of entries will be developed that would be appropriate for the areas in which it is applied (a website, phone number, static collection point, etc.). A reward or prize will be provided for winning entries. Participation awards may also be given in addition to the larger prize for winning entries.

The useful entries will also be compiled for sharing with USAID and IPs as ideas with potential for implementation success in Namibia. They will feed into recommendations that MEASURE Evaluation will provide based on all 3 phases of data collection.

Sampling Methods

The study follows a 2-stage sampling technique. The first stage is identifying the communities in which the focus groups will take place. This was done purposively to target communities where the US Government technical assistance is implemented as well as to reach both urban, peri-urban, and rural communities. The communities for inclusion were identified in a collaborative effort during the landscape analysis process. Implementing partners and government stakeholders were asked which communities they would like to know more about. Sites where the most stakeholders agreed needed more data were selected as well as those communities that would provide breadth of information.

The second stage of sampling is to select participants for the focus group discussions. Focus group participants will be recruited in person. MEASURE Evaluation will work with local implementing partners working in the communities selected for focus group discussions to help identify people who could be recruited. A standard recruitment script will be provided to implementing partners to assist in the recruitment. Participants will be asked to provide a number (that will not be stored with the study materials), so their participation can be confirmed by the study staff prior to the focus group date.

Crowdsourcing contest entrants will self-select based on advertisement of the contest. Advertisement for the crowdsourcing contest will be through multiple channels. It will be advertised online through Facebook and a website, through social media such as WhatsApp and Twitter, through traditional media such as newspapers and radio. In rural areas, we may also utilize community meetings and traditional channels of communication. The rules of entry will be spelled out in the call for entries. Participation will be voluntary.

Sample Size

The number of focus group discussions planned was determined based on the geographic scope of USAID interests as well as areas where greater information is needed. Because we are only interested in one group (namely men ages 20-39), only one focus group is planned in each area for most areas. In areas with a more established, open MSM community, an additional focus group discussion will be held with MSM in that age group.

The number of participants in the crowdsourcing contest cannot be completely anticipated, because it is through self-selection. It is anticipated that there will be at least 50 participants.

Data Collection

Start and end dates

Focus group data collection will begin after approval by all relevant IRBs. This includes UNC (which has provided a waiver) as well as Namibia's in-country IRB. Focus group data collection will last approximately 2 weeks. Data analysis will conclude 2 months after the completion of data collection.

The crowdsourcing contest will begin once focus group data has been analyzed. The call for entries will be advertised and a four-week period for entries will begin. The contest will conclude after that point, and entries will be reviewed by the steering committee to identify winning entries.

Subject Contact, Duration and Privacy

Focus group discussions will be no longer than 2 hours. Participation time will be communicated to focus group members during the consent process. Their contact will involve participating in the discussion, but they are not required to answer any question that they do not want to. They are not required to participate in any particular way, but will be encouraged to share their experience and thoughts on the topics of the focus group. The questions do not require participants to share their personal experience; rather, they focus on community values, ideas, and perceptions over their individual experience. We therefore believe there is minimal risk to the participants necessitating particular privacy measures.

Description of Consent Process

Focus group discussion respondents will be consented when they arrive for the focus group discussion. They will be asked to give verbal consent, because signing a consent form would be the only document in which their name would be collected. The consent process will include a description of the study, benefits and risks of participation, what is required for participation, the voluntary nature of participation, confidentiality of responses, incentives, what will be done with the data, and an opportunity to ask questions.

Inclusion and exclusion from consent

Decisionally-impaired respondents will not be included in the study.

Non-English-speaking participants will be included in the study. It is expected that most participants in Namibia will speak either English or the local language. Informed consent will be obtained in a language the participant feels comfortable speaking. All study personnel obtaining consent will be fluent in the local language.

Who is obtaining consent?

Local study staff in Namibia will be obtaining consent.

Selection and training of data collectors

Focus group discussions will be led by MEASURE Evaluation staff with support from local consultants with prior experience in qualitative research.

The crowdsourcing contest, while not traditional research, will engage a local consultant hired through a competitive process to assist with logistics and implementation. Entries will be judged by a panel of experts selected by MEASURE Evaluation with input from local stakeholders.

Request for wavier of written documentation of informed consent

Because the consent form would be the only document linking participants to the research, the study will only be collecting verbal consent for focus group discussions. This is appropriate, because the study does not ask about specific individual behaviors.

Instruments

See attachments.

Measures of Validity and Trustworthiness

Focus group discussion data will be analyzed using thematic analysis. Because the number of focus groups is not too large, we anticipate doing analysis manually rather than using a software. Results will be reported in a narrative report as well as a slide deck. Analysis will highlight the emerging themes from the conversation as they relate to barriers and facilitators to HIV testing, treatment and prevention. Analysis will be completed by two researchers to ensure the thematic analysis has internal validity.

Crowdsourcing entries will be reviewed by the study team. The study team will eliminate entries that do not meet the criteria for inclusion as set prior to advertising the study. Those entries that remain will be reviewed by the steering committee and judged with a grading rubric. The judging will be "blind" in that reviewers will not be given names and contact information of entrants. This data will be stored separately in a database. Winning entries will be notified, and the winning entries shared with stakeholders as well as the general public.

Ethical Principles

The study leads will be CITI certified for the ethical conduct of research with human subjects. The study team will ensure that the principles of respect for persons, beneficence, and justice are adhered to.

Benefits to subjects and/or society

The results of this study will provide information that is potentially useful for HIV prevention everywhere, and more specifically in Namibia. Furthermore, results will be provided to stakeholders involved in healthcare delivery and HIV prevention working with the target populations.

Individuals participating in the focus group discussions may benefit from local HIV prevention programs if they are still in the area when any new action plans based on the assessment results are implemented. This assessment provides specific data that can be used for getting AIDS prevention messages and services to men in the priority area.

Risks and measures to minimize risks

Embarrassment may occur infrequently among focus group participants, which includes inquiries into the HIV testing knowledge, attitudes and behavior in their community. Focus group moderators will be trained to be sensitive to these reactions and collect responses in a neutral manner.

Participants will be reminded during the interview process that they are at liberty to refuse to respond to any question and that answers will remain confidential. Participants will be asked not to use names when speaking in focus group discussions, so that names will never be associated with responses. It is possible that participants may know each other in the focus groups, so we will reiterate that information shared in the discussion should remain confidential. Focus group discussions will be conducted in a private setting where responses will remain confidential.

While there will be no formal data safety and monitoring board or committee, the principal investigators and the study team will conduct ongoing review of study processes throughout the data collection period. Regular phone calls between the data collection team and the PI
will occur throughout the data collection period. The initial training of the field teams will identify potential situations or types of situations that would require immediate notification by phone to PI, such as a breach of confidentiality or extreme emotional distress of a subject.

Focus group discussions will be recorded using digital voice recorders. Audio files will be saved on password-protected, encrypted computers. Voice recordings will be reviewed to ensure that protocols were adhered to. However, the procedures involved in this study, with the exception of a gross breach of confidentiality, do not pose more than minimal risk to participants' safety.

As the study is cross-sectional and requires only a brief one-time interaction with each subject in which no intervention is delivered, subjects will not require withdrawal from the study. Subjects will be informed that they have the right to withdraw themselves and cease all involvement in study procedures at any point during their participation.

For the crowdsourcing contest, we do not anticipate any possible harm to the people who choose to submit entries. They do not have to have their name associated with their entries, should the chose to. Entries will be judged by a panel of judges who will agree to confidentiality of names and entries until winners are selected. At that point, winners will be contacted in order to get their permission to publish their name with their winning entry.

Adverse Event Reporting

Should moderators be notified of human rights abuses or adverse events that require psychosocial support, the individual will be linked to services according to MOHSS. Any human rights abuses will be reported to Out-Reach Namibia to filter into their human rights documentation system, REACT. The PIs and the Research & Ethics Committee will be notified of all unintended breaches of confidentiality and data loss within 72 hours of the occurrence.

Identifiers

For the focus group discussion, no personal identifiers will be collected. While basic demographic information such as age, marital status, education level, etc. will be collected, these do not qualify as personal identifiers.

For the crowdsourcing contest, persons entering the contest will be required to provide their name, age, and a contact number.

Confidentiality of data

Anonymous data collection strategies are put in place to maintain a high level of confidentiality in the focus group discussions. No study materials will contain names or other explicit identifiers aside from the area of data collection. Names will not be associated with responses in any way.

All data will be password protected and accessed only by authorized members of the research team. Digital data such as audio files will be stored in a password protected computer. Once audio files are uploaded, they will be removed from the digital voice recorders. Similarly, entries to the crowdsourcing contest will be stored on encrypted, password-protected computers. A database of contacts for entry staff will be also be stored on a password-protected computer and will only be accessible to study staff.

Deductive disclosure

Although the study team is taking steps to ensure anonymity of study participants, it is still possible that a participant could be identified through deductive disclosure based on focus group discussion comments. The study team will ensure that any comment be excluded from direct quotation that could lead to deductive disclosure.

Activity Timeline

Benchmarks and Tasks	Responsible Party	2019								Deliverables
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Benchmark 1: Landscape analysis completed										
1.1 Review existing data and literature	Z. Reynolds	X								• Landscape analysis
1.2 Meet with stakeholders in country	Z. Reynolds		X							
Benchmark 2: Qualitative data collection completed										
2.1 Design focus group guides	R. Mswia Z. Reynolds					X	X			• Focus group guides • Focus groups
2.2 Conduct focus groups	R. Mswia Z. Reynolds						X			
2.3 Analyze focus group transcripts	R. Mswia Z. Reynolds							X		
Benchmark 3: Crowdsourcing contest completed										
3.1 Design contest and methods	Z. Reynolds R. Mswia						X			• Contest design documents • Recommendation report
3.2 Advertise contest	Z. Reynolds							X		
3.3 Judge contest entries and select winner	Z. Reynolds R. Mswia								X	
3.4 Report recommendations on interventions	Z. Reynolds R. Mswia								X	

Finance and Resource Use

Funding for the study comes from PEPFAR, an entity of the US Government.

APPENDIX 2. FOCUS GROUP DISCUSSION GUIDE

Male HIV Case Finding in Namibia

Young men ages 20-39

INTRODUCTION TO FOCUS GROUP PARTICIPANTS

Introductions

Welcome. Thank you for being here. My name is _____ and I work with _____. As we explained during the informed consent process, we are trying to understand attitudes, perceptions, and experiences when your community interacts with HIV prevention services. We are especially interested in how men like you would like to be reached with HIV testing. The information you provide will be used to eventually improve HIV programs for men like you. We will not use your names or otherwise identify you personally in the analysis and reporting of the results of our discussion today.

Ground Rules

We encourage everyone to participate, knowing there are no right or wrong answers. Speak up if you agree or disagree with someone, as we want to understand everyone's experiences and opinions. We will record this discussion to help us capture everything we need for the analysis and summary, but we will not identify you personally, we will use the numbers you were assigned at registration. Does everyone agree to record this discussion? This discussion will probably take about 2 to 3 hours. Do you have any questions before we get started?

Icebreaker if necessary

If you could visit any place in Namibia, or in the world, where would you go and why?

FOCUS GROUP QUESTIONS

INTRO

We want to ask about men in your community more broadly.

1. What do men in this community value most in their life? What makes a man successful here? Try to think of the 3-5 most important things.

2. What challenges do men here face?

BARRIERS TO HIV TESTING

Specifically, in our discussion today, I'd like you to think about men ages 20 to 39 in your community as they interact with HIV outreach services. The first topic that we would like to explore with you is testing for HIV.

3. Do men think testing for HIV is important? Why?

4. What do you think are the main reasons men age 20-39 do **not** get tested? Why do you think men usually avoid testing for HIV?

5. We will hand out some pieces of paper. Please write what you think are the barriers to testing. Write as many as you wish. Then place them on the wall.

Facilitator: When the writing and posting is finished, read each post, put duplicates together and then ask the men to vote on the top 3-5 barriers and put them in order highest to lowest. Take a picture!

6. **Going with a partner.** Do men generally get tested for HIV with their partner or by themselves?
7. For men who test with their partner, why do you think they do that? What would be hard about getting tested with their partners?

8. **Time**. Sometimes counseling, testing, and post-test counseling can take up some time at the facility. With this in mind, when is an ideal time for men to be tested?
    - Probe: On a weekday during the day? On a weekday during the evening? The weekend?

9. **Travel time.** What do you think is the maximum length of time men would travel to be tested?

10. **Disclosure.** Do you think fears of telling others is a barrier to getting tested for HIV?

11. **Service providers.** Does the thought of interacting with health worker influence your decision to be tested? Why?

FACILITATORS OF HIV TESTING

12. What are some of the reasons men **do** get tested?
    - Probe: If you have been tested, what prompted you to get tested?

13. What strategies could be used to motivate men to get tested? Please write what you think are the strategies for getting men to test. Write as many as you wish. Then place them on the wall.

Facilitator: When the writing and posting is finished, read each post, put duplicates together and then ask the men to vote on the top 3-5 strategies and put them in order highest to lowest. Take a picture!

Facilitator: Depending on what the men write you can probe for

Increase preferred type of counselor or tester. We mentioned that HIV testing involves pre- and post-test counseling to help people understand the test, risk factors, how to prevent HIV, and what the results mean. The counselor often does the HIV test as well. Do you think men have preferences about the type of counselors or tester they would see? What makes that person preferred? Gender? Prior relationship? Particular type of training the person received?

14. Have you seen any kind of promotion about HIV testing that was particularly persuasive? What was it? Why was it persuasive?
15. What, if any role, would a (female) partner play on a man's decision to be tested?
16. **Reduce ignorance. Improve education.** If someone has a question or concern about his own health, where does he go to get information?
17. In general, how do men in this community like to receive information about their health?
    - Probe for media, community leaders, digital/social media like WhatsApp groups, health providers, etc.)
    - Why is [each source] trusted by men here?

18. **Set up information sessions.** Sometimes there might be a community health activity, like an information session or discussion where men get together and talk and learn about their health. Is that something men do around here? Why/why not?

WHERE TO GET TESTED

19. Can you tell me a specific name of place where men in this community like to be tested and why?
20. Different places were named. Is the location where you get a test important? Why might men prefer to get tested somewhere besides a health facility?

READ: Here are cards representing different types of HIV testing options. Rank them in order of your preferences. Also, feel free to fill in a blank card if you think of another option.

[Cards will say:

Facility-based testing, a standalone testing center

Facility-based testing, an integrated health facility

Facility-based testing, but extended hours

Mobile testing that moves to different places either in a van or a tent

Workplace or school place testing

At home

Campaigns or events]

21. Where do you think it would be good to offer testing that currently does not offer testing if we want to encourage men who are not being tested and may be at risk to test for HIV?

INDEX AND SELF-TESTING

22. There are HIV test kits that you can do yourself by swabbing the inside of your cheek. You can find out the results by yourself and then go to a health facility if it suggests you are HIV-positive. They are called HIV self-testing kits.
    - Do men in your community know about this?
    - How do you think they would feel about doing self-testing?
    - What do they say about it?
    - What are some of the benefits of a person being able to give himself an HIV test?
    -
    - What might some of the drawbacks be? If a health provider or a community health worker gave someone an HIV self-test kit, do you think he would use it? Why/why not?
    - What about if a man's partner (wife, etc.) gave him an HIV self-test kit? How do you think he would feel? Do you think he would use it? Why/why not?

23. If a man or woman is found to be HIV positive, their counselor will often ask them about their recent sexual partners, because those people could also be positive. If you had a partner that found out that he or she was positive, how would you like to be notified?
    - Probe: by partner? by health staff? other?

24. If health staff from a health facility were to call you and say that you had a sexual partner who was found to be positive and they would like you to come for an HIV test, how would you react? Would you go for a test? Why or why not? What do you think other men in your community would do?

COMMUNITY LEADERS

READ: We would like to ask you a few questions about leaders in your community whether they are religious, civic, or other.

25. Do community leaders here do activities to promote health? Are the activities useful? Why/why not?

26. Have you heard local leaders in this community talking about HIV? Do you think they are concerned about HIV? Why/why not?

27. What else could leaders do to help prevent HIV infections and support people living with HIV?

    - Probe: to start treatment? to stay on treatment? to be accepted in the community?

28. Do you think leaders understand the HIV epidemic in the community? How can they keep themselves updated on the HIV response here?

PREVENTION

READ: Now we want to talk about some methods of HIV prevention with you. The first thing we want to discuss is voluntary male medical circumcision or VMMC.

29. Have people in this community heard of VMMC? What do they say about it?
    - Probe: positive, negative perceptions

30. People who get circumcised, what motivates or convinces them to do it?
    - Probe: A message on personal hygiene? A message on preventing HIV. Information from community mobilizers or peer educators? Opinion of a female partner? Message from community leader?

31. What might stop a man from getting circumcised?
    - Probe for fears, financial barriers, cultural barriers

32. If someone was not convinced about the benefits of VMMC, what would you tell them if they ask you about VMMC?

33. Do you think women (and partners) around here support circumcision? Why/why not?

34. What do people say about circumcision services? (probe for likes, dislikes) Have you heard of men who had negative experiences with circumcision? Why do you think that happened? What about positive experiences?

35. Where do people around here get condoms? What are the preferred types or brands of condoms?

36. What influences people to use condoms or not? Do you think women/partners prefer that men use condoms? Why/why not?

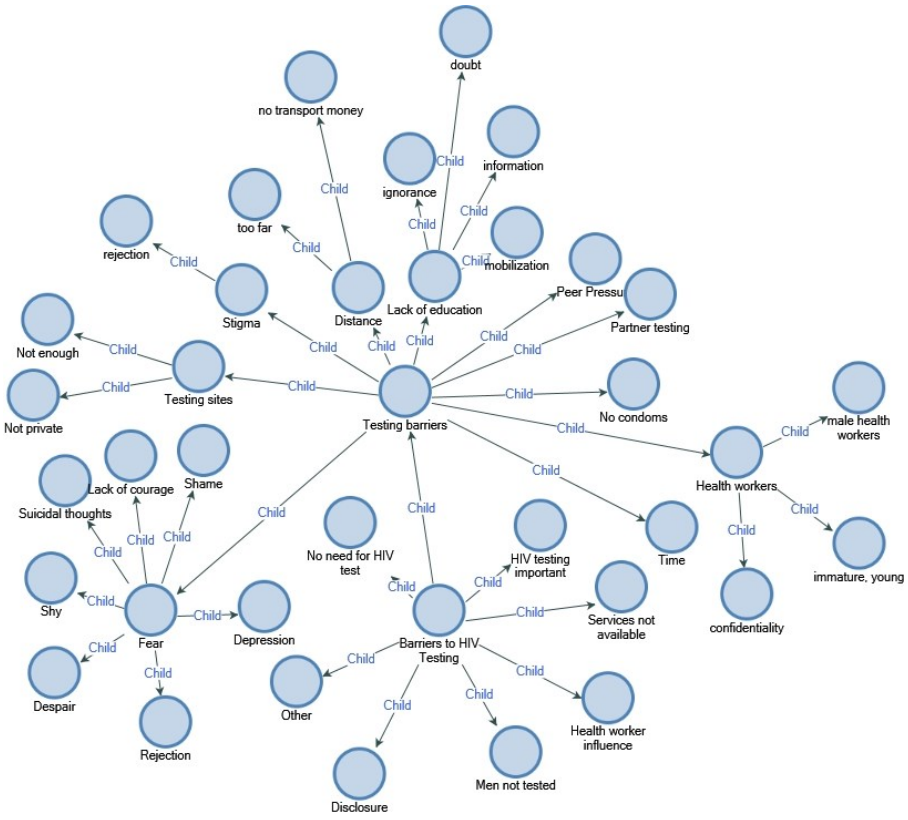
Closing

Thank you very much for your time and sharing your knowledge and opinions. The information you have provided will help people throughout Namibia and other countries to improve HIV services. As a reminder, we will not share the discussion recordings with anyone outside the study team and you will not be identified in any results we share with others. We appreciate your participating in the discussion today.

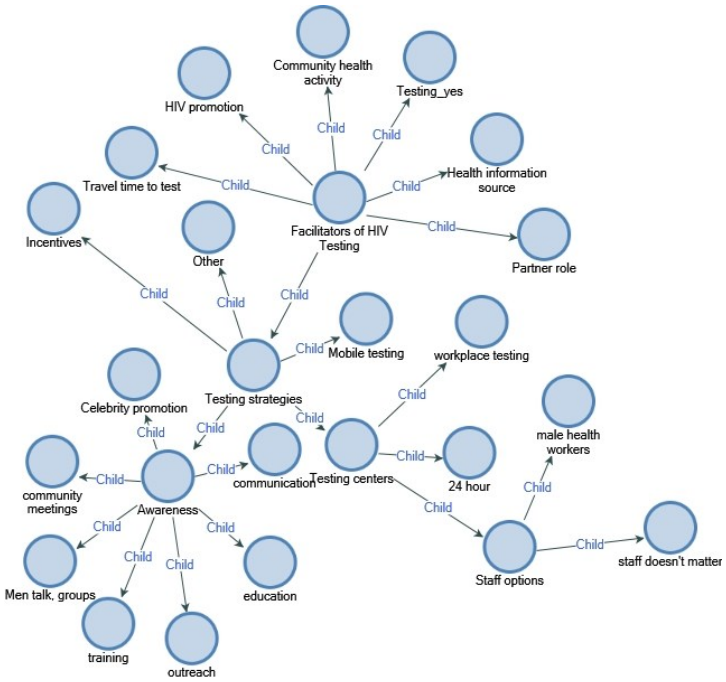
APPENDIX 3. DEMOGRAPHIC SURVEY

Focus Group Demographics			
Please complete the following questions for yourself			
Region		District	
Participant ID number		Gender	
How old were you on your last birthday?		Have you been tested for HIV in the past 12 months?	
Are you currently in school?		Are you employed?	
What is your highest level of education?		If employed, what is your occupation?	
Currently, are you married, or do you have a girlfriend / boyfriend / partner?		In which community are you currently living?	

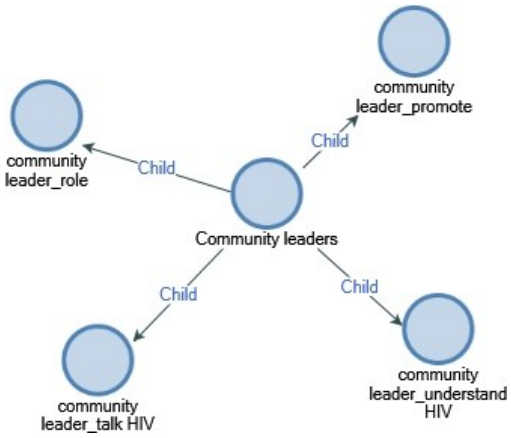
APPENDIX 4. CODE MAPS FOR SIX FOCUS AREAS



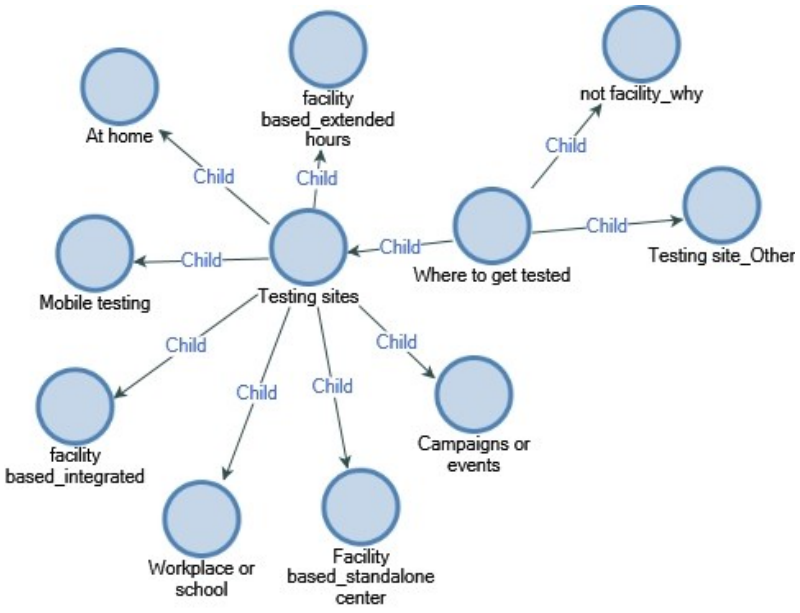
Testing barriers code map



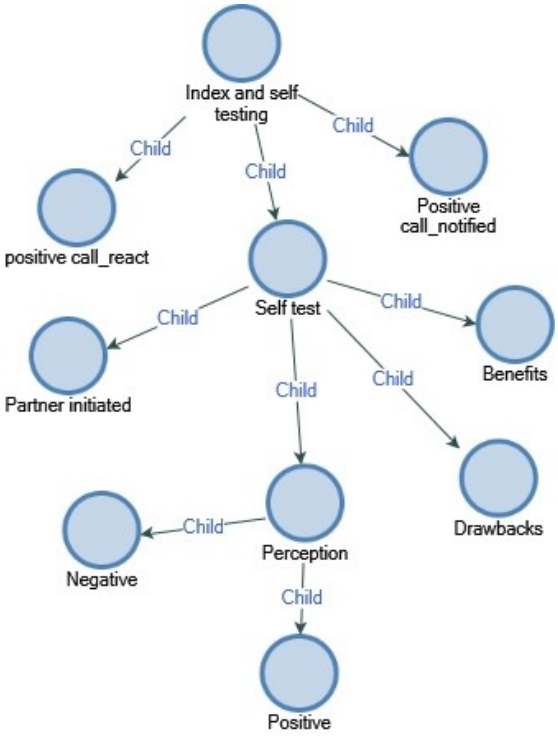
Testing facilitators code map



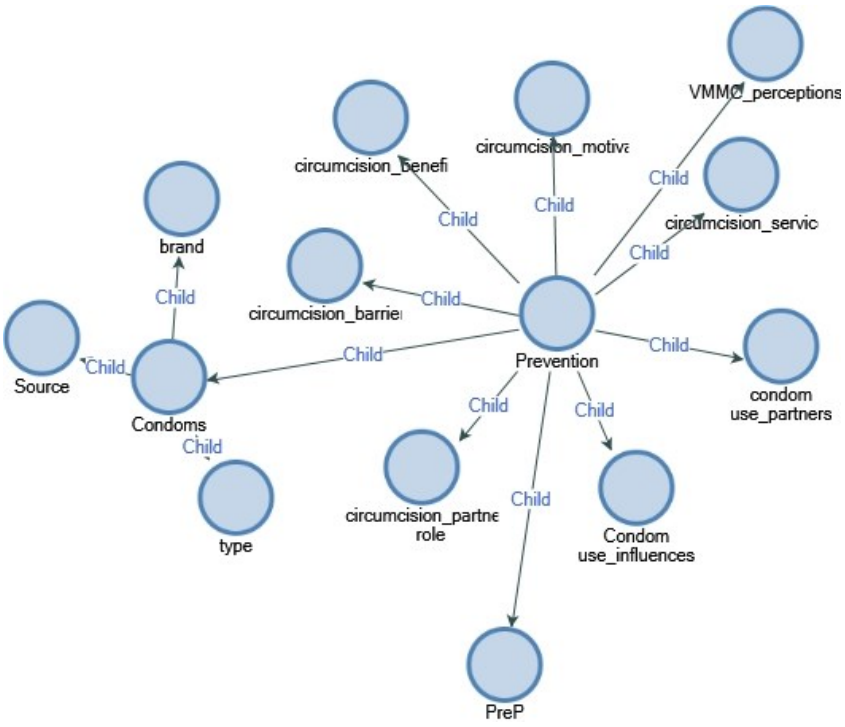
Community leaders code map



Where to get tested code map



Index and self-test code map



Prevention code map

APPENDIX 4. STUDY TEAM BIOS

Robert Mswia, MSc, PhD, is the study lead for the Male Case Finding Study. Dr. Mswia provided overall technical guidance to the study, designing the methods and leading the field work. He is a Senior Technical Advisor, Monitoring, Evaluation and Learning at Palladium Group, working on the MEASURE Evaluation project. He has a PhD (Demography) and an MSc (Demography) from the University of Pennsylvania, USA, and an MSc (Medical Statistics) from the London School of Hygiene & Tropical Medicine, UK. He has a strong background in health systems, vital events, and community-based surveys. His areas of expertise are the implementation of Sample Vital Registration with Verbal Autopsy (SAVVY); measurement of cause-specific mortality indicators; analysis of vital events from civil registration and vital statistics, national census and other population/facility-based data; and M&E of health programs including HIV/AIDS; International Classification of Diseases and related illnesses (ICD-10); and advanced analytical and statistical skills. Dr. Mswia has worked in developing countries including Kenya, Liberia, Malawi, Rwanda, Tanzania, and Zambia, in collaboration with ministries of health, departments of national registration, statistical agencies, and other government and academic institutions in these countries. He has also provided technical assistance to Uganda, Ghana, and Mozambique (where he was involved in the implementation of INCAM-1 in 2007/2008). He has worked for many years in implementing and managing health and demographic surveillance systems (HDSS) in Tanzania and in provision of technical support to HDSS sites in Kenya. Dr. Mswia has extensive experience in conducting capacity building programs through training workshops and individual mentoring; his knowledge of population-based and routine data collection methods, analysis of data from surveys and routine sources, and M&E of health programs is extensive. He has published papers in scientific and academic journals and has analyzed research data and produced country reports for government partners.

Zahra Reynolds, MPH, is a researcher for the Male Case Finding Study. Ms. Reynolds assisted with the study design and was responsible for the landscape analysis; she worked with partners on the logistical arrangements for fieldwork. She has over eight years of experience in the field of international health and development, including specialized training in early childhood nutrition. Ms. Reynolds began her career in the Bureau for Global Health, USAID/Washington, where her work focused on family planning. She has since worked with several USAID-funded projects, the most recent being MEASURE Evaluation. While at MEASURE Evaluation, she has conducted PLACE studies, supervised lot quality assurance sampling outcome monitoring studies, facilitated capacity building workshops on topics such as data analysis and data use, performed data analysis on national survey data related to women's health, and participated in SAVVY activities. Ms. Reynolds has an MPH in Maternal and Child Health from the Gillings School of Global Public Health, University of North Carolina at Chapel Hill.

Stephanie Watson-Grant, DrPH, assisted with the study design, led one of the data collection teams, analyzed the data, and led report writing. Dr. Watson-Grant has 17 years of experience in public health and development, 14 years of which has been working with organizations at the country level. Dr. Watson-Grant held positions in USAID and the Joint United Nations Programme on HIV/AIDS and has extensive experience in a diverse portfolio of work: routine monitoring with mHealth resources, outcome monitoring surveys, outcome evaluations, evaluation capacity building, causal loop mapping to assess risks to task shifting from facilities to communities. Her publications have focused on measurement of country ownership in global health. She is the Director of Field Operations for MEASURE Evaluation, where she leads a team of four country portfolio managers who provide oversight to 36 country operations, implementing activities related to more than eight different earmarks.

APPENDIX 5. EVALUATION COSTS

Items	Assumptions	Amount $USD
Personnel	5 person-months level of effort over 12 months	$117,930
Travel	Travel includes round-trip coach airfare from Chapel Hill, NC to Windhoek, Namibia with visits to other USAID priority districts, ground transportation, lodging, M&IE and miscellaneous expenses. • 1 7-day trips for landscape analysis (traveler: Z Reynolds) • 2 14-day trips for qualitative data collection (travelers: R Mswia and S Watson-Grant)	$44,693
Subcontracts	Local implementation partner	$39,604
Other Direct Costs	None	$0
Total		**$202,227**

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-19-384

ISBN: 978-1-64232-203-3

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