HPAG Project

IMPACT & INNOVATION HANDBOOK

"HIV Prevention for Adolescent Girls and Young Women Innovations Project in Uganda"

Wakiso District | April 2024–March 2026

Implemented by

AIDS INFORMATION CENTRE-UGANDA

With Funding from

ViiV Healthcare POSITIVE ACTION

PUBLICATION INFORMATION

About this handbook

This handbook documents the design, delivery, achievements, promising practices and human stories of the HIV Prevention for Adolescent Girls and Young Women Innovations Project in Uganda (HPAG). It is designed for implementers, government partners, funders, health workers, youth leaders and communities seeking practical, adaptable approaches to combination HIV prevention.

EVIDENCE NOTE Results are drawn from the HPAG project close-out presentation and validated project records supplied to AIC. Interview quotations are retained from the consultant's field documentation and lightly edited for clarity. They should not be interpreted as population-level causal evidence.

Project owner: AIDS Information Centre-Uganda (AIC)

Funding partner: ViiV Healthcare Positive Action

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Geographic focus: Wakiso District, Uganda

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Safeguarding: Some stories concern adolescents and vulnerable populations. Identifying details have been minimized; photographs and quotations should be used only within the scope of documented consent.

OPENING

Acknowledgements

AIC gratefully acknowledges the adolescent girls and young women, adolescent boys and young men, peer educators, parents, community leaders and health workers who shaped, delivered and documented this work. Their knowledge and leadership made the project relevant to everyday realities in Wakiso District, including island communities where access barriers are especially acute.

We recognize the Wakiso District Local Government, District Health Team, Community Development Department, Bussi Sub-county leadership, supported public and private-not-for-profit health facilities, youth groups and savings groups. Their stewardship connected project innovations to existing systems and created pathways for continuity after close-out.

AIC extends sincere appreciation to ViiV Healthcare Positive Action for investing in community-owned HIV prevention innovation and learning. We also acknowledge the HPAG project team, AIC leadership and documentation contributors for translating implementation experience into a resource for learning, adaptation and scale.

Project and community stakeholders at the handover of the 3D Boat Initiative in Bussi.

FOREWORD

A message from AIC leadership

"The HPAG Project demonstrated that innovative, community-led approaches can overcome barriers to HIV prevention in underserved settings."

Implemented with support from ViiV Healthcare Positive Action, HPAG brought HIV prevention closer to adolescent girls and young women through peers, responsive health facilities, digital communication, integrated outreach and a locally managed boat linking health, education and livelihoods. The project linked 23,281 people to HIV prevention services and tested 19,121 clients for HIV, while investing in structures that communities can continue to use.

The most important lesson is not a single number. It is that young people are not merely beneficiaries: they are designers, messengers, navigators and stewards of solutions. The practices in this handbook invite adaptation—grounded in local evidence, safeguarding, government leadership and meaningful participation.

Dr Linus Karl Amandu
Executive Director, AIDS Information Centre-Uganda

LEADERSHIP REFLECTION

From service delivery to sustainable agency

HPAG combined biomedical prevention with the social conditions that influence whether a young person can seek, start and remain on prevention. Health workers and peers strengthened referral pathways; radio and mobile platforms widened access to information; education support helped learners with disabilities remain connected to school; and savings and livelihood support increased collective agency.

The project also generated practical lessons. Commodity continuity matters. Mobile populations require flexible follow-up. Digital platforms work best when linked to trusted people and services. Community ownership must be planned from the beginning, with clear roles, operating arrangements and local oversight.

OUR COMMITMENT AIC will continue to embed youth leadership, integrated services, digital linkage and community ownership in HIV prevention programming, while strengthening measurement of retention, quality, equity and sustainability.

Ms Medius Teriyeitu
Director, Program Management and Capacity Development

NAVIGATION

Contents

How to use this handbook

- Start with pages 7–11 for the project logic and delivery footprint.
- Use pages 12–23 to understand each promising practice and its implementation mechanism.
- Use pages 24–28 for verified output and outcome data.
- Use pages 40–44 as adaptable checklists and planning tools.

REFERENCE

Acronyms and key terms

Term	Meaning
AGYW	Adolescent girls and young women
ABYM	Adolescent boys and young men
AIC	AIDS Information Centre-Uganda
ART	Antiretroviral therapy
DSD	Differentiated service delivery
GBV	Gender-based violence
HC III	Health Centre III
HIVST	HIV self-testing
MEL	Monitoring, evaluation and learning
PBFW	Pregnant and breastfeeding women
PrEP	Pre-exposure prophylaxis
SILC	Savings and Internal Lending Community
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
VMMC	Voluntary medical male circumcision

PROJECT AT A GLANCE

A two-year innovation platform

24 months	9	18
April 2024–March 2026	supported health facilities	trained peer educators

Goal

To contribute to a reduction in new HIV infections among adolescent girls and young women in their diversity through innovative, evidence-based combination prevention approaches.

Primary populations

- 3,000 AGYW aged 15–24, including AGYW with disabilities and young sex workers.
- Teenage mothers, pregnant and breastfeeding women.
- Young men and adolescent boys in fishing communities and sexual partners of AGYW.

Geography

Wakiso District, including hard-to-reach island communities served through Bussi HC III, Zinga HC III and Rapha HC III.

Island access conditions shaped the project's integrated transport and service-delivery response.

PROJECT AT A GLANCE

Why an integrated response was needed

AGYW face overlapping risks: limited access to confidential services, low risk perception, stigma, gender-based violence, poverty, mobility, judgemental provider attitudes, myths about PrEP, limited partner support and the practical cost of reaching services. These barriers are amplified in fishing and island communities where transport is expensive and weather-dependent.

DESIGN IMPLICATION A prevention programme focused only on commodities would leave major barriers untouched. HPAG therefore combined biomedical services with peer trust, gender-transformative dialogue, digital access, education support and economic strengthening.

Barrier	HPAG response
Distance and transport cost	Integrated outreach and 3D Boat Initiative
Mistrust or stigma	Peer-led navigation and youth-friendly providers
Information gaps	WhatsApp, radio and Sauti 116 promotion
Economic vulnerability	SILC groups, start-up kits and livelihood support
Fragmented services	Integrated HIV, SRHR, STI and GBV pathways

PROJECT AT A GLANCE

Three objectives, one prevention journey

01	Create informed demand Use community-based advocacy and education to raise awareness of HIV prevention technologies.
02	Bring services closer Scale HIV testing and prevention through community-based innovations.
03	Sustain linkage and retention Develop community models that support AGYW throughout the prevention journey.

The objectives form a connected pathway: credible information builds demand; accessible services convert demand into uptake; and trusted follow-up supports continued prevention use.

PROJECT AT A GLANCE

The delivery ecosystem

Actor	Core contribution
AGYW and ABYM peers	Mobilisation, education, referral, follow-up and feedback
Health workers and focal persons	Clinical services, counselling, data, quality and commodity coordination
District and sub-county leaders	Stewardship, joint planning, oversight and sustainability
Community and group leaders	Safe spaces, dialogue, safeguarding and local ownership
AIC project team	Technical assistance, coordination, supplies, performance review and learning
ViiV Positive Action	Financing and learning partnership

Peer educators and health workers linked community demand with facility-based services.

INNOVATION PORTFOLIO

Six practices working as one system

Practice	Distinct contribution
1. Peer-led prevention	Trust, proximity and continuous navigation
2. Digital linkage	Fast, discreet communication and referral
3. Integrated service delivery	Multiple needs addressed through one contact
4. 3D Boat Initiative	Health, education and livelihoods connected through transport
5. Gender and leadership dialogue	Social norms and local accountability addressed
6. Education and economic support	Structural vulnerability reduced and agency strengthened

HIGH-IMPACT LOGIC The innovations reinforced one another. Peers generated demand; digital tools maintained contact; facilities delivered services; dialogue strengthened acceptance; and structural supports helped young people remain connected.

INNOVATION 1

Peer-led prevention and navigation

A trained peer educator reflects the project's youth-led approach.

Eighteen AGYW/ABYM peer educators were trained and linked to nine supported health facilities. They translated technical information into accessible language, mobilised their networks, distributed prevention commodities, referred clients, followed up appointments and surfaced barriers to the project team.

18	9	1:1
peer educators	facility linkages	trusted peer contact

WHY IT MATTERS Shared age, context or lived experience can reduce social distance. The peer becomes a bridge—not a substitute for clinical care—between the young person, community and facility.

INNOVATION 1

How the peer pathway worked

Step	Action	Output
1	Map peers, hotspots and service points	Defined catchments and referral options
2	Share accurate prevention information	Informed demand and myth correction
3	Offer or arrange community contact	HIVST, condoms, outreach or appointment
4	Refer and accompany when needed	Completed linkage to clinical or GBV services
5	Follow up through phone or in person	Appointment reminders, refill and retention support
6	Document and escalate barriers	Programme learning and corrective action

Quality safeguards

- Defined scope of practice and referral boundaries.
- Routine supervision by facility focal persons and AIC staff.
- Confidentiality, consent and safe data handling.
- Updated job aids and clear escalation for clinical or safeguarding concerns.

INNOVATION 1

From participant to role model

“Before the HPAG project trained me, I was not informed about HIV prevention. Now I reach young people and want to see more empowered young people—especially girls—who can plan for their future.”

— Peer educator, Bussi Island

Peer educators described personal change as part of their credibility. One explained that becoming a visible role model changed how peers responded to prevention messages. Others mapped bars, lodges and informal settlements so that condom dispensers could be replenished and referrals could reach people at times and places that matched their lives.

Small-group engagement created space for questions, referral and collective problem-solving.

INNOVATION 2

Digital communication linked to human support

18	18	Sauti 116
smartphones provided	peers connected	national referral line

Smartphones, airtime and data bundles enabled peer educators to maintain WhatsApp groups, respond to questions, support appointments and connect young people to integrated HIV and GBV services. Radio talk shows widened community reach, while promotion of the government Sauti 116 line gave adolescents an established channel for reporting abuse.

Channel	Best use
WhatsApp groups	Peer education, myth correction, reminders and referral
Direct calls/messages	Confidential follow-up and navigation
Radio talk shows	Broad awareness, dialogue and demand creation
Sauti 116	Child protection and GBV reporting

DESIGN PRINCIPLE Technology amplified trusted relationships. It did not replace peers, counsellors, health workers or safeguarding systems.

INNOVATION 2

Digital reach with accountable referral

2,385	640	251
abuse reports	adolescents counselled	HIV prevention inquiries

These Sauti 116 figures were reported during project period. They demonstrate use of the promoted channel, but they should not be interpreted as cases caused or resolved by HPAG without case-level attribution data.

A practical digital session

- Begin with one clear, verified topic.
- Invite anonymous or private questions where appropriate.
- Correct misinformation without shaming the participant.
- Provide the exact next step: facility, outreach date, peer contact or hotline.
- Record only minimum necessary data and protect devices.
- Escalate clinical emergencies and safeguarding concerns immediately.

Youth-friendly group engagement complemented phone-based communication.

INNOVATION 3

Integrated, differentiated service delivery

HPAG linked HIV testing, PrEP screening and initiation, condoms, HIV self-testing, STI/SRHR information, GBV screening and referral, and prevention counselling. Services were delivered through facilities, community outreach, peer referral, hotspot distribution and maternal-health touchpoints.

Contact point	Integrated opportunity
Community outreach	HIV testing, STI screening, condoms education & distribution, HIVST, risk assessment and referral
Facility youth-friendly point	Clinical assessment, PrEP, care linkage and follow-up
ANC/PNC/EPI platform	PrEP screening for pregnant AGYW and prevention counselling
Peer contact	Demand creation, commodity access, referral and retention support
Hotspot dispenser	Discreet and regular condom access

Community mobilisation brought integrated prevention services closer to intended populations.

INNOVATION 3

Facility readiness and quality

28	10	9
health workers trained	KP/PP focal persons	supported facilities

Training covered HIV prevention, testing, care and treatment, data collection and reporting, community mobilisation, and GBV prevention, referral and linkage. Facility focal persons provided an operational anchor for peers and community referrals.

Readiness domain	Minimum practice
People	Trained provider and focal person with youth-friendly attitudes
Place	Confidential, accessible and non-judgemental contact point
Products	Forecast, monitor and redistribute commodities where possible
Pathway	Clear referral, feedback and emergency escalation
Performance	Review disaggregated uptake, linkage, refill and client experience

Health workers were central to safe, technically sound and respectful service delivery.

INNOVATION 4

The 3D Boat Initiative

The community-managed boat addressed water-transport barriers in Bussi Island communities.

HEALTH	EDUCATION	LIVELIHOODS
workers, supplies and outreach	school and examination access	income and group savings

The 3D model treated transport as a cross-sector constraint. A boat managed through a youth savings structure supported movement of health workers and supplies, free or supported transport for school-going children and teachers, and subsidised passenger services that generated income for operations and the youth group.

INNOVATION 4

3-D BOAT INITIATIVE

Dimension 1: health access for underserved

For island communities, availability at a mainland or distant facility does not equal access. The boat helped move health workers, medicines and other supplies and supported outreach across landing sites. Prevention messages could also be shared during journeys, turning travel time into a community education opportunity.

REPLICATION CONDITION Before using a transport asset for health delivery, define safety procedures, authorised routes, passenger limits, weather decisions, fuel controls, maintenance, safeguarding and referral responsibilities.

- Link trips to an agreed outreach and supply schedule.
- Maintain passenger and trip records without recording sensitive health details.
- Budget for maintenance, safety equipment, licences and insurance where applicable.
- Ensure health commodities remain secure and within required storage conditions.

INNOVATION 4

Dimension 2: education continuity for school going adolescents

Learners and families described transport costs as a cause of irregular attendance and dropouts. The boat provided free transport for school-going children and teachers and supported the movement of examinations. Interview accounts indicate improved regularity and reduced pressure on household transport spending.

> *"In a week I could go twice or once because of lack of transport money. With the free boat transport, I now go to school daily."*
>
> *— Adolescent learner, Bussi Island*

The boat created a shared access platform for health, education and community mobility.

Evidence caution: The handbook reports participant experience. Routine attendance or dropout data would be needed to quantify educational impact.

INNOVATION 4

Dimension 3: livelihoods support to reduce vulnerability, enhance local ownership & sustainability

Group records supported transparent management and accountability.

The boat created a sustainable source of income for the **Ganyana Youth Group**, a locally registered youth-led organization, while strengthening members' economic resilience and reducing their vulnerability to risky behaviours. Through subsidized passenger transport services, the group established a reliable revenue stream that supports both members' livelihoods and the boat's routine operation and maintenance. AIC further strengthened the group's capacity in financial management, business operations, savings, and internal lending. This enabled members to access affordable loans for individual and collective livelihood activities. The initiative has expanded the group's revenue base, improved its financial stability, and positioned it for growth. The group is now in the process of procuring an additional boat to expand its transport services. Its strengthened governance, savings culture, and demonstrated income-generating capacity have also increased its eligibility to access government livelihood programmes, grants, and affordable financing opportunities.

Operating principle	Application
Community ownership	Defined group mandate and leadership
Transparent finance	Trip, revenue, expense and savings records
Social purpose	Protected health and education commitments

Cost recovery	Affordable passenger income supports recurrent costs
Public oversight	Sub-county supervision and agreed accountability

WHAT MAKES IT INNOVATIVE A single community asset was designed to produce health, education and economic value rather than operating as a stand-alone medical transport intervention.

RESULTS AND REACH

What the project achieved

23,281	19,121	4,209,142
linked to HIV prevention	tested for HIV	condoms distributed
2,150	**2,169**	**215**
initiated on PrEP	PrEP refills recorded	HIV-positive clients linked

Headline results show very strong reach in prevention linkage and testing, with 96% (215 of 224) of clients testing HIV-positive linked to care. PrEP initiation reached 93% of the project target (2,150 of 2,322).

READING THE DATA Counts describe service contacts or outputs as reported at close-out. They should not automatically be added together to estimate unique people, and refill counts do not necessarily represent unique clients.

RESULTS AND REACH

Performance against selected targets

Indicator	Target	Achieved	Performance
People linked to prevention	3,564	23,281	653%
Clients tested for HIV	3,564	19,121	536%
Condoms distributed	3,000,000	4,209,142	140%
Clients initiated on PrEP	2,322	2,150	93%
PrEP refills recorded	2,322	2,169	93%
HIV-positive clients linked	95%	215/224	96%

The exceptional reach in linkage and testing reflects the project's multi-channel delivery model: radio and community mobilisation, peer networks, integrated outreaches, facility services and hotspot distribution. Performance should be interpreted alongside data-quality and denominator definitions.

RESULTS AND REACH

PrEP integration for pregnant AGYW

8,929	3,439	720
screened for eligibility	found eligible	initiated on PrEP

Integrating PrEP screening into maternal and community service platforms created additional entry points for pregnant AGYW. Of those found eligible, 720 were reported initiated. The result signals meaningful uptake while also showing a gap between eligibility and initiation that future programmes should investigate.

Learning question	What to examine
Choice and readiness	Client preference, risk perception and timing
Clinical pathway	Waiting time, provider availability and contraindications
Commodity continuity	Stock status and refill reliability
Partner and family context	Support, disclosure concerns and safety
Follow-up	Early contact after initiation and differentiated refill options

RESULTS AND REACH

Demand creation and structural support

38	**760**	**16**
community dialogues	dialogue participants	radio talk shows
83,073	**50**	**20**
radio mobilisation reach	learners with disabilities supported	start-up/seed-grant recipients

Community dialogues addressed HIV prevention, PrEP, condoms, VMMC, GBV, SRHR and gender norms. Education enablers included scholastic materials and hygiene packs. Start-up kits and seed grants to saving groups complemented savings-group approaches.

HIGH-IMPACT FEATURE Demand creation was linked to real service and referral options. Structural support was targeted to barriers—school participation, income and transport—that influence health vulnerability.

RESULTS AND REACH

A balanced dashboard for future scale

Dimension	Example measure
Reach	Unique AGYW reached, disaggregated by age, location and vulnerability
Uptake	Testing, PrEP initiation, condoms and HIVST
Continuity	PrEP continuation, refill timeliness and completed referrals
Quality	Confidentiality, respectful care, waiting time and client feedback
Equity	Coverage of islands, disability inclusion and underserved groups
Systems	Commodity availability, trained providers and functional referral loops
Sustainability	Peer integration, local financing and asset performance

Future scale should preserve the project's strong output monitoring while deepening measurement of unique reach, continuation, client experience, cost, equity and contribution to behavioural or health outcomes.

HUMAN-CENTRED STORIES

A learner's route back to regular school

THE BARRIER

A young learner living on Bussi Island described missing school because her family could not consistently meet daily transport costs. This puts her at several risks including school dropout, early pregnancy and HIV infection.

THE CHANGE

Free school transport through the 3D Boat Initiative made daily attendance more feasible and reduced pressure on household spending for scholastic materials.

HER VOICE

"It was very expensive for my mother and I would miss school when she failed to raise the money. I am happy for the free transport."

The 3D Boat Initiative was rooted in the practical geography of island life.

Identity has been withheld to protect the young participant.

HUMAN-CENTRED STORIES

A peer becomes a prevention leader

Peer educators used lived experience, local networks and structured referral to reach other young people.

A peer educator described moving from limited knowledge and risky behaviour to a visible community role. Training provided prevention knowledge; supervision and facility linkage provided a pathway for action; and the youth group created a collective platform beyond the project.

"For one to help others, one should be a role model. Personally, I have changed…my peers see me as a changed person."

PRACTICE INSIGHT Peer programmes create value at two levels: they extend services to networks that programmes may struggle to reach, and they can strengthen the agency and leadership of the peer educators themselves.

HUMAN-CENTRED STORIES

Making prevention available where it is needed

Peer-led hotspot follow-up supported discreet and regular access to prevention commodities.

A peer educator mapped busy bars and lodges in informal settlements and built working relationships with managers. This enabled routine checks of condom dispensers and timely replenishment. The practice converted a broad distribution target into a simple local supply chain with a named person, defined points and feedback.

Micro-practice	Why it worked
Map priority outlets	Focused effort on places with demand
Agree a focal person	Created local responsibility
Check stock routinely	Reduced empty-dispenser time
Replenish and document	Connected consumption to supply planning
Pair with information	Supported correct, voluntary use

HUMAN-CENTRED STORIES

A health worker's role in the trust chain

Facility focal persons connected technical quality, referral and peer support.

Peer mobilisation creates an expectation: that the referred young person will receive respectful, confidential and technically sound care. Health workers therefore carried both a clinical and relational responsibility. Their readiness determined whether community trust translated into uptake and continuation.

- Welcome young clients without judgement.
- Explain options, benefits, side effects and choice clearly.
- Protect privacy and informed consent.
- Provide an actionable plan when a commodity is unavailable.
- Close the referral loop with the peer without disclosing unnecessary clinical information.

HUMAN-CENTRED STORIES

“We are stronger together”

Community-based engagement connected households, peers and local structures.

Youth group members described routine meetings, shared plans and stronger mutual support. Registration of the group and its savings mechanism increased visibility to local government and created a pathway to future opportunities. Community ownership was therefore both social—shared identity and mutual accountability—and institutional—recognised structures, records and oversight.

“In our group as youth, we routinely meet and share good plans. We are now stronger together, supporting and guiding each other.”

LEADERSHIP AND LEARNING

Government engagement as an implementation strategy

Level	Engagement
District leadership	Technical oversight, joint planning and performance review
District Health Team	Facility selection, clinical standards, supervision and commodity coordination
Community Development	Group registration, livelihoods and social protection linkages
Sub-county leadership	Local oversight of the boat and youth structures
Community leaders	Mobilisation, dialogue, safeguarding and accountability

Leadership engagement was not a ceremonial add-on. It helped align project activities with government systems, connect innovations to existing structures and define continuity responsibilities before close-out.

Local engagement supported stewardship of island-focused implementation.

LEADERSHIP AND LEARNING

Why these are promising practices

Criterion	Evidence from HPAG
Relevance	Directly addressed trust, distance, information, economic and service barriers
Reach	23,281 linked to prevention and 19,121 tested
Integration	Health, SRHR, GBV, education and livelihoods connected
Ownership	Peers, facilities, groups and local government held defined roles
Adaptability	Practices can be tailored by geography, population and delivery channel
Sustainability potential	Peers embedded, dispensers assigned, digital groups active, boat locally managed

IMPORTANT DISTINCTION "Promising" reflects strong implementation experience and plausible contribution. Replication should include a context assessment and stronger outcome and cost evaluation before labelling a practice proven or cost-effective.

LEADERSHIP AND LEARNING

Six lessons for implementers

1. Design with young people, not only for them.
2. Link every demand channel to a functioning service pathway.
3. Treat access barriers—transport, cost, stigma and time—as programme variables.
4. Integrate digital contact with human safeguarding and clinical support.
5. Build ownership through roles, records, supervision and financing.
6. Measure continuation, experience and equity—not only reach.

LEADERSHIP AND LEARNING

Challenges and adaptive priorities

Challenge documented at close-out	Adaptive priority
Stock-outs of HIV self-test kits, PrEP and condoms	Forecasting, minimum stock alerts, redistribution and client communication
Health workforce shortages	Task sharing within scope, focal persons, appointment planning and integrated outreach
High mobility, especially on islands	Portable records, flexible refill options, phone follow-up and multi-site referral
Weather and transport constraints	Route planning, safety decisions, buffer time and local contingency arrangements
Post-project financing pressure	Cost tracking, local revenue, government integration and diversified partnerships

LEADERSHIP AND LEARNING

The sustainability pathway

Asset or practice	Continuation arrangement
Peer educators	Integrated into routine facility operations and community referral
Condom dispensers	Assigned to facilities, peers and focal persons; AIC buffer support
WhatsApp platforms	Peer-led awareness, referral and follow-up
3D Boat Initiative	SILC ownership with sub-county supervisory role
Technical standards	SOPs, job aids and manuals transferred to implementation teams
Government linkages	District and sub-county stewardship and livelihood referral

SUSTAINABILITY TEST A practice is not sustained because stakeholders value it. It is sustained when there is an accountable owner, recurrent resources, technical capability, demand, monitoring and a mechanism to solve problems.

LEADERSHIP AND LEARNING

Recommendations for scale and investment

- Scale the integrated peer–facility model while maintaining supportive supervision and safeguarding.
- Prioritise island and other underserved geographies using locally appropriate mobility solutions.
- Strengthen PrEP continuation and investigate the gap between eligibility and initiation among pregnant AGYW.
- Maintain digital channels but invest in privacy, moderation, referral completion and device security.
- Institutionalise commodity early-warning, redistribution and client communication protocols.
- Track unit costs and asset operating costs to inform realistic financing.
- Use youth and client feedback as a routine quality indicator.
- Commission a stronger mixed-method evaluation of outcomes, equity, cost and sustainability.

Leadership perspectives are essential for institutionalising and financing effective models.

REPLICATION TOOLKIT

Tool 1: readiness assessment

Question	Yes/No	Action required
Is the target population defined with young people's input?		
Are service and transport barriers mapped?		
Are functional referral services available?		
Are peer roles, supervision and safeguarding clear?		
Are commodities and redistribution mechanisms reliable?		
Are digital privacy and escalation protocols in place?		
Is local government engaged in planning and oversight?		
Are recurrent and start-up costs budgeted?		
Are outcome, equity and quality indicators defined?		
Is there a transition or continuity owner?		

Proceed only when critical clinical, safeguarding, commodity and governance gaps have a funded mitigation plan.

REPLICATION TOOLKIT

Tool 2: peer educator supervision checklist

Monthly check	Status / notes
Roster and catchment updated	
Accurate messages and job aids reviewed	
Referrals issued and completed reviewed	
Confidentiality and consent reinforced	
Phone/data and device security checked	
Commodity stocks and distribution records reviewed	
Difficult cases and safeguarding concerns escalated	
Peer wellbeing and workload discussed	
Client feedback and myths documented	
Next month's micro-plan agreed	

REPLICATION TOOLKIT

Tool 3: 3D Boat operating scorecard

Domain	Monthly indicator	Result
Safety	Trips completed without safety incident	
Health	Health-worker/supply trips completed	
Education	Learner/teacher trips delivered as scheduled	
Livelihood	Passenger revenue collected and recorded	
Finance	Fuel, maintenance, savings and balance reconciled	
Equity	Protected free/subsidised commitments honoured	
Asset	Preventive maintenance completed	
Governance	Group and sub-county review held	
Feedback	Complaints and suggestions resolved	

Suggested rule: do not trade off safety or protected social-purpose trips to increase revenue.

REPLICATION TOOLKIT

Tool 4: referral loop

Stage	Minimum data	Responsibility
Need identified	Date, service needed, consent	Peer / provider
Referral made	Destination, appointment or outreach date	Peer
Service contact	Completion status only; protect clinical detail	Receiving provider
Follow-up	Next step, refill or re-referral	Peer / provider
Escalation	Urgency, safeguarding or access barrier	Designated focal person
Closure	Completed, declined, moved or unreachable	Supervisor review

DATA PROTECTION Collect the minimum data needed; separate clinical information from peer tracking; use consent-based contact; secure devices; and define deletion and incident-response procedures.

REPLICATION TOOLKIT

Tool 5: a practical learning agenda

Learning question	Suggested measure
Who is reached—and who is missed?	Unique reach by age, disability, location and population
Does demand become service uptake?	Referral completion and time to service
Do clients continue PrEP?	Continuation at defined intervals and reason for discontinuation
Is care acceptable?	Confidentiality, respect, choice and waiting-time feedback
Does the boat remain viable?	Trips, beneficiaries, revenue, costs, downtime and safety
What does replication cost?	Start-up and recurrent cost per output/outcome
Are structures sustained?	Active peers, groups, meetings, stock points and financing

REFERENCE

Definitions for consistent use

Term	Working definition
Combination prevention	Coordinated biomedical, behavioural and structural HIV prevention tailored to context.
Differentiated service delivery	Client-centred adaptation of where, when, by whom and how services are delivered.
Linkage	Completed connection from identification or referral to the intended service.
Peer educator	A trained young person who provides bounded education, mobilisation, referral and follow-up within a supervised system.
Promising practice	A relevant and feasible approach with encouraging implementation evidence that warrants adaptation and further evaluation.
Safeguarding	Policies and actions that prevent and respond to harm, exploitation, abuse and unsafe disclosure.
Structural intervention	Action addressing social, economic, legal or environmental conditions influencing vulnerability or access.

CLOSING

A final note from the project team lead

As we close the HPAG Project, I am proud of what communities, health workers, peer educators and local leaders achieved together. We demonstrated that HIV prevention becomes more effective when biomedical services are combined with trusted peer support, digital engagement, education and economic opportunity. The 3D Boat Initiative showed how locally led innovation can overcome barriers and strengthen resilience. I sincerely thank ViiV Healthcare Positive Action, AIC leadership, Wakiso District and every participant for building a legacy that will endure.

Nobert Dacan - Project Team Lead

The HPAG Project confirmed that quality data is not simply a reporting requirement; it is the foundation for learning, accountability and better services. Through strengthened HMIS and DHIS2 reporting, routine data-quality assessments, supportive supervision and performance reviews, we helped implementers use evidence to improve reach, linkage and continuity of care. I thank our health workers, peer educators, community leaders, AIC colleagues and ViiV Healthcare Positive Action. The systems and skills established will continue guiding responsive, sustainable national HIV prevention programming.

Brian Musinguzi - Project Mel Manager

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