THE COACH MPILO PLAYBOOK

A Practical Guide for Implementers

BACKGROUND

In 2017, the Bill & Melinda Gates Foundation provided a grant to PSI, in consortium with Ipsos Healthcare and Matchboxology, to support stakeholders in South Africa in engaging and retaining men with HIV testing and treatment.

One product of that investment is the Coach Mpilo model, which employs a peer-support approach for men's linkage and early retention, employing men who are living well with HIV as coaches and mentors to men who are newly initiated or experiencing a treatment interruption.

The aim of this guide is to orient interested stakeholders on the insights that informed the design of the model, the fundamentals of the model, how to plan and prepare for implementation of the model, and potential adaptations of the model.

WHY FOCUS ON MEN?

Men in South Africa are less likely than women to know their HIV status, more likely to delay starting treatment, less likely to stay on treatment, and more likely to die of HIV-related causes.

Linkage and retention have been a particular challenge: as of March 2023, an estimated 92% of men in South Africa knew their HIV status, but only 70% of those were on treatment.

Many men disengage within the first six months after initiation, often struggling to understand the need for and benefits of treatment, build motivation for daily adherence, navigate disclosure to family and friends, and cope with internalized and external stigma.

High rates of disengagement among men are a cause for concern first and foremost because they bode poorly for men's own health and wellbeing. They are also a concern from a broader perspective of achieving and sustaining epidemic control.

As of March 2023, an estimated 92% of men in South Africa knew their HIV status, **but only 70% of those were on treatment.**

WHAT ARE MEN'S BARRIERS?

How did we find out?

By talking to a lot of men! **Over 2000 in total.**

We started by **shadowing 18 men for a full day**, with the aim of understanding the broad context of their lives, beyond just health and HIV. Our researchers let each man decide where to go, who to see, and what to talk about. We learned a lot about their relationships, friendships, priorities, pleasures, hopes, dreams, fears, anxieties, pressures, expectations...the whole spectrum.

From there, we conducted **in-depth interviews with a further 58 men**, where we began to explore attitudes and behaviours specific to health and HIV. Men shared their thoughts and feelings around sex, relationships, healthcare, gender norms, risk perception, testing, prevention, treatment, stigma, disclosure, etc.

Our research phase concluded with **a quantitative survey of 2019 men**, focused on bringing greater precision to the range of issues and barriers that men consider when contemplating HIV testing, prevention and treatment. The quantitative data also allowed us to identify five segments or archetypes of men, distinguished by their attitudes and behaviours around HIV.

Note: Our research took place in KwaZulu-Natal and Mpumalanga Provinces of South Africa, with men **20 to 34 years old**, which may affect generalizability of findings and insights. However, we have since heard from various stakeholders working in other geographies and/or with other demographics that the core insights appear to hold.

WHAT ARE MEN'S BARRIERS?

What did we learn?

We learned that the way that we see things as public health professionals is often very different from the way that the average man sees things.

We are often operating from assumptions and stereotypes that may not be true, contributing to the disconnect between men and the health system.

It all starts with fear

We might think men don't care about HIV because they've learned to put on a tough face and pretend that it doesn't bother them.

But we know from talking to men that HIV leaves many of them feeling anxious and afraid. They often feel like life is over. They're not stubborn, they're scared.

The bottom line: Men don't need high-pressure approaches to testing and treatment. **They need reassurance that everything will be ok.**

WHAT DO MEN FEAR?

In a word: **LOSS**

- Loss of **health and strength**
- Loss of **sexual intimacy and pleasure**
- Loss of **friends and family**
- Loss of **status and respect in the community**
- Loss of **lifestyle and enjoyment**
- Loss of **control over their own lives**
- Loss of **time and money**

WHAT DO MEN FEAR?

LOSS OF...

Health and strength

It may seem unbelievable to people working in the public health sector, but for many men, testing positive can trigger fear ofan early death.

While most men do know about treatment, many think that treatment will only help them for so long, and that HIV will eventually leave them weak, sick and dying.

We need to help men understand that HIV treatment can keep them perfectly healthy and allow them to live just as long as someone without HIV.

Sexual intimacy and pleasure

Testing positive can also trigger fear of sexual death, which many men dread even more than physical death.

We found fear of disclosure to their partner to be most men's #1 fear.

Many expect that their partner will leave them, and that no other person will ever want to be with them. leaving them without any hope of intimacy or sexual pleasure.

We need to support men in sharing their HIV status with their partner. We also need to help them understand that most relationships survive an HIV diagnosis and in fact many come out stronger and more supportive.

Friends and family

Many men also fear that disclosure to friends, family and community will result in isolation and social death.

While we should not ignore the reality of stigma and discrimination, carrying a secret can be heavy and most men feel better after telling someone. Most also find that their friends and family accept and support them.

We need to help men understand the benefits of disclosure, and support and even accompany them in telling their friends and family.

WHAT DO MEN FEAR?

LOSS OF...

Status and respect

Men in our society are expected to be physically and mentally strong, naturally healthy, self-sufficient, and able to 'power through' any health issues on their own.

Many men fear that needing or accepting support will be viewed as a sign of weakness and result in a loss of status and respect.

We need to help men understand that it's ok to get support, and we need to give them sources of support that feel safe and relatable.

Lifestyle and enjoyment

Some healthcare providers give men the message that they must give up or cut back on many of the things they enjoy – sex, drinking, junk food, etc.

While the intention may be good, the result of forcing men to choose can be that they choose the things they enjoy rather than choosing treatment.

We need to avoid rigid and restrictive guidance and focus first on helping men get stable on treatment. Other health messages can come later.

Control

We may think we're being helpful by being proactive with testing and treatment, through provider-initiated testing, index testing, tracking and tracing, etc.

But many men feel hunted and ambushed. They feel that we are treating them like 'naughty children' and fear losing control over their own lives and decisions.

While it's good to be proactive, we need to help men feel that they are still in control of their own decisions and help them understand the benefits of testing and treatment so they can build their own motivation.

Time and money

For many men, a clinic visit means the loss of a day's income. Even men who are not employed may be missing the chance to pick up a day job. The cost of transport to and from the clinic can be a further barrier.

THE FEAR STARTS EVEN BEFORE TESTING

Even before men test for HIV, they're imagining what will happen to them if the result is positive, and they often imagine the worst.

This is why many men avoid testing. The anticipated loss is so great that they would rather not know.

That means we can't wait until men test to help them understand that they can live a happy, healthy life with HIV. We need them to know even before testing that they're going to be ok, whatever the outcome.

GENDER STEREOTYPES AND MISCONCEPTIONS MAKE THE SITUATION WORSE

We identified various perceptions about men among healthcare providers that do not align with reality, which aggravate the disconnect and make it even harder to engage with men effectively.

Perception	Reality	Implication
Men are stubborn and apathetic about HIV. They don't listen and they don't care.	While men may wear a mask of indifference, HIV leaves many of them feeling anxious and afraid.	We need to give men encouragement and reassurance, not scolding and pressure.
Men are mainly just workers who only need practical solutions like extended hours and quick service.	Men are complex human beings who face social and emotional barriers as well as practical ones.	We need solutions that address both practical and psychosocial barriers.
Men are being overly dramatic. Everyone knows that HIV is no longer a death sentence. They should just get on with it.	Too many men are unaware of the benefits of treatment. They do not believe it is possible to live a long, healthy, happy, 'normal' life with HIV. Many anticipate physical, social and sexual death.	We need to tell the 'new HIV story'—one pill a day and you're back to normal. We also need to eliminate stigma among non-PLHIV, particularly men's partners.

GENDER STEREOTYPES AND MISCONCEPTIONS MAKE THE SITUATION WORSE

Perception	Reality	Implication
Treatment is life-saving and easy to take, so men should embrace it. It's not that hard.	For many men, treatment can be a reminder of failure and a marker of disease, exposing them to stigma.	We need to help men see treatment as part of the solution rather than part of the problem.
Sources of support are available; men just fail to access them. They don't really want support.	Many men are hungry for support in coping with HIV but see no sources that feel safe or relatable.	We need to give men the right sources of support for HIV testing, prevention and treatment.
Even when healthcare providers are caring and compassionate, men simply are not open.	Many men find healthcare providers intimidating and close themselves off as a defence.	Providers need more strategies and support for understanding and connecting with men.
Counselling is provided, but men simply do not listen or comply.	Many men find counselling to be scripted, one-directional, overly technical, and often judgmental.	We need to drop our scripts and learn how to have empathetic, personal conversations.

GENDER STEREOTYPES AND MISCONCEPTIONS MAKE THE SITUATION WORSE

Perception	Reality	Implication
Healthcare providers are being helpful by being proactive with testing and treatment.	Men often feel hunted and ambushed. They fear loss of control over their own lives and decisions.	We need to help men develop their own internal motivation to test and stay on treatment.
Treatment is life-saving and easy to take, so men should embrace it. It's not that hard.	Too many men are unaware of the life-saving benefits of treatment.	We need to help men understand 'the new HIV story'—that with treatment they can live a long, healthy, happy, normal life.
Men are behaving irrationally by avoiding HIV testing and treatment.	When men weigh the costs and benefits, putting off testing and treatment seems quite rational.	We need to reduce the costs and communicate the benefits, so that the cost-benefit analysis is favourable.

DIFFERENT MEN, DIFFERENT FEARS

It's important to remember that **not all men are the same**. Not every man will be experiencing all of the fears we've talked about. That means we can't just give the same messages and support to every man we meet.

Here are a few different types of men in relation to their attitudes about HIV.

MR TEAL

The Good Guy

Mr Teal is the guy who is always friendly and willing to lend a hand. Everyone calls him when they need help. He feels pretty good about life. He might not have much, but he has his friends, and he feels connected to his community. His self-image and reputation are important to him. He cares a lot about being known as a good person.

His main fear about HIV is that it would turn him from 'the good guy' into 'the bad guy'. If people know he has HIV, they might think of him as risky, irresponsible, etc. He is very sensitive to feeling judged and may need reassurance that having HIV does not change who he is or make him a bad person. He might also respond to the messagethat being on treatment is the responsible thing to do.

DIFFERENT MEN, DIFFERENT FEARS

MR ROSE

The Fun Guy

Mr Rose is ‘living his best life’. He’s all about fun and good vibes. Like Mr Teal, he feels pretty good about life and where he’s headed. He’s quite social, likes to go out with friends. He may also have one or two casual partners in addition to his main one.

His main fear about HIV is that it’s ‘the end of the party’. It will mean giving up all the things he enjoys in life—stop having sex, stop drinking, stop eating junk food, etc. He doesn’t care about a ‘long and healthy life’ so much as a happy, enjoyable life. He needs counseling that focuses on being able to live the life he wants, rather than what he must give up.

He is also sensitive to feeling judged about his lifestyle, so when we talk to him, we need to be sure that we are coming from a place of empathy and support, rather than trying to change him.

MR GREEN

The Hard Luck Guy

Mr Green’s luck in life has not been good. Life is hard, and he doesn’t really expect it to get easier. He might show signs of anger, anxiety or depression, as well as excessive drinking. He might not have anyone he can talk to, and he probably does not feel safe talking to a healthcare provider.

His main fear about HIV is that it will be one more failure in life, one more thing that drags him down. He would rather just not think about it or deal with it until he has to. What he needs most is a friend, someone who can give him a safe space to talk through his problems and help him build the confidence that being on treatment is something he can manage and even feel successful in doing. He may be particularly receptive to peer-to-peer and support group approaches.

DIFFERENT MEN, DIFFERENT FEARS

MR BLUE

The Going Nowhere Guy

Mr Blue might look like he's doing ok — maybe he even finished matric and got a decent job. He might have a wife and kids. But while his life might be stable, he feels like his best days are in the past and he doesn't have much to look forward to. He doesn't have many sources of motivation in his life and may not have any close connections to family and friends.

His main fear about HIV is that it will be another burden to carry in a life that already has a lot of burdens. He needs to know that living with HIV is now easy: one pill a day and he's sorted.

He also needs an easy way to collect his meds—the promise of being able to switch to decentralised meds collection once he's stable on treatment is likely to be meaningful.

MR GREY

The Traditional Guy

Mr Grey embraces traditional values and respects the traditional ways. He might be living in a rural area, or perhaps he grew up in a rural area but has come to the city for work. He enjoys the status that comes from being a traditional man—head of his family, respected by other men in his community. He may also embrace traditional gender norms of men being self-sufficient and able to handle things without help from others.

His main fear about HIV is that it would cause him to lose status and respect within his family and community. He may need support in sharing his HIV status with his family and community, particularly peer-to-peer support from another man. He may also be inclined to listen to authority figures in his community.

WHAT DO MEN NEED?

How did we find out?

Once we had explored men's problems in relation to HIV, **our next task was to design and test potential solutions.**

To ensure that the solutions were relevant and appealing, we put men at the centre of the design process. We engaged a total of 82 men across a series of three multi-day design workshops in brainstorming and refining dozens of ideas and concepts on making it easier for men to deal with HIV.

What did we learn?

Solutions converged around **four broad themes:**

1. Change the HIV story
2. Give men the right source of support
3. Improve the healthcare experience

WHAT DO MEN NEED?

1

CHANGE THE HIV STORY

ART often triggers a negative emotional response. We need to flip that script so that men can feel good about being on treatment.

From a daily reminder that...	To a daily reminder that...
I've failed →	I'm **winning**
I'm weak →	I'm **powerful**
I'm sick →	I'm **healthy**
I've lost control →	I'm **in control**
I'm damaged goods →	I'm back to **normal** - the same person I always was
I'm a danger to my partner →	I'm the **safest** partner someone could have
I'm a problem →	I'm part of the **solution**
I'm ashamed →	I'm **proud**

WHAT DO MEN NEED?

2

GIVE MEN THE RIGHT SOURCE OF SUPPORT

Treatment leaves many men feeling alone, afraid and ashamed. Many men feel there can be no good life after an HIV diagnosis. Men often feel they have no one they can trust or talk to. Many anticipate that living with HIV will mean social death.

But men also have the capacity to acknowledge and work through their fears when a safe space was available to them. They appear to be particularly open to the idea of advice and support from a man who is living with HIV and doing well. Someone who has walked the same journey.

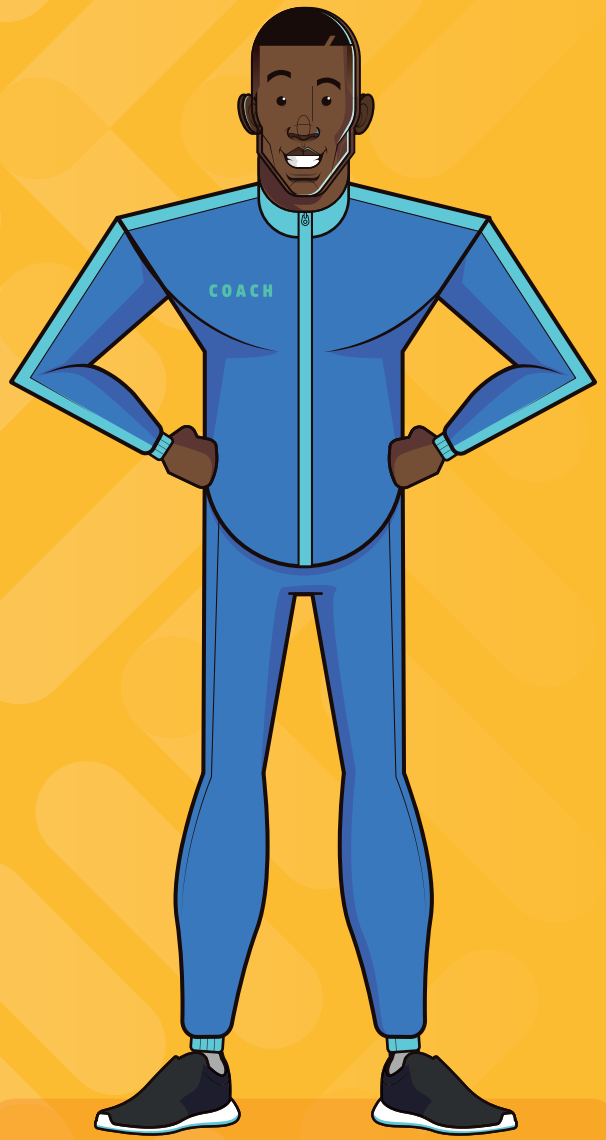
3

IMPROVE THE HEALTHCARE EXPERIENCE

Many men either anticipate or have had a negative experience of the clinic. The clinic can be an unfamiliar space that men feel incompetent to navigate. Privacy and confidentiality are often not assured. Some clinic staff think of men as 'a problem', which then reflects in their interactions.

Getting more men into treatment will mean making the healthcare experience more pleasant and convenient. For some, this means making the clinic a more welcoming and familiar space. For others, it may mean taking services out of the clinic and into community spaces that are more familiar and appealing.

WHAT IS COACH MPILO?



What is the essence of the model?

Coach Mpilo is a reimagined peer support and case management model that employs men living well with HIV as coaches of newly diagnosed men and men who have disengaged from treatment, helping them to navigate the early part of the HIV journey, including issues of adherence and disclosure, up to the point of viral suppression.

How does it address men's needs?

Coach Mpilo speaks directly to several major barriers that men identified in the research and design phases:

1. **HIV leaves many men feeling anxious and afraid. They need comfort and reassurance.** Beyond just transferring clinical and practical knowledge, coaches focus on meeting men's emotional needs, leading with their own story of coping with an HIV diagnosis, navigating the treatment journey, disclosing to loved ones, overcoming external and internalized stigma, etc. Coaches break through the isolation and paralysis that many men feel and give them the reassurance that everything is going to be ok.

2. **Many men do not believe that it is possible to live a long, healthy, happy, 'normal' life with HIV.** By their very appearance and demeanor, coaches quickly dispel the notion that a good life with HIV is not possible. Coaches are men who are thriving with HIV—not just clinically stable but socially connected and emotionally well-adjusted. They provide living proof that it's possible.

3. **Most men are hungry for support in coping with HIV but see no sources that feel safe and relatable.** When we asked men about the ideal source of support, they told us it would be another man who has been in the same situation and knows what it's like. As men living with HIV themselves, coaches have an immediate advantage in building trust and rapport and encouraging openness. Men know immediately that they are not going to be judged or misunderstood.

4. **Many men find counselling to be scripted, one-directional, and overly technical.** Coaches engage with men first and foremost as people, leading with their own lived experience, tailoring their support to each man's needs and circumstances, and engaging in conversation rather than monologue. Because they are not trained health professionals, they find it easier to avoid clinical jargon in favour of plain language.

Why call them coaches?

The framing may seem stereotypical or superficial at first. (Men and sports, ugh.) But we learned in the design workshops that words matter, and the wrong name can be a barrier to men engaging.

Men disliked the term counsellor, which can imply that there's something wrong with them that needs fixing. They disliked the term case manager, which can leave them feeling like they're simply another case to be managed. They disliked linkage officer, which felt cold and formal.

But they loved the term 'coach'. Not only because of the sports allusion, but because 'coach' carries various positive emotional connotations. A coach wants to help you reach your potential and do your best. He pays attention to what you're struggling with and gives you individual guidance and support. He helps you win. And if you have a coach, it also means you're not alone; you're part of a team.

How is Coach Mpilo different from other peer approaches?

The Coach model is of course not entirely new—we have been using peer-based approaches within the sector for many years, including expert clients and peer navigators. There are some important differences, however.

Expert clients and peer navigators may or may not be men living with HIV. They are often associated with and based in the clinic, rather than the community. Their focus is often imparting clinical knowledge and building familiarity with clinical terminology, rather than providing psychosocial support using everyday language. And they often have a narrow behavioural focus rather than dealing with the whole person.

While Coach Mpilo is not radically different from some previous peer-based approaches, we believe the use of a participatory design approach has led to a model that is more human-centred. Coaches are always men living with HIV, who have walked the same journey and know what it's like. They speak from lived experience rather than a set of clinical talking points. And they support men not just in navigating the clinic but in navigating life with HIV, including social and emotional dynamics.

What results has the Coach Mpilo model produced?

We piloted the Coach Mpilo model with two implementing partners in South Africa over a period of seven months in 2020, with **63 coaches** supporting **70 clinics** and enrolling a total of **3848 men**.

- **3811 of those men (99%) were linked or returned to care.**
- **At the end of the pilot, 3653 men (96%) were retained.**

The model has since been integrated into the large-scale treatment programs of several PEPFAR partners in South Africa, **with a total of 347 coaches supporting 300 clinics as of August 2023**. While not all partners are collecting and reporting granular M&E data, those that are have **enrolled 28,388 men, with 26,591 of those men (94%) linked or returned to care and 25,261 men (95%) retained during the period of April 2021 to August 2023**.

> **In South Africa, as of July 2023, about 70 percent of men** who knew they had HIV were on treatment, meaning that men with a coach have been doing significantly better than average.

How do coaches feel about being coaches?

Although some coaches are initially a bit anxious about the role, they generally report finding it to be **highly empowering and fulfilling.**

Being a coach can help men with HIV reframe their identity and reclaim their social status. They express pride, self-confidence and sense of purpose. Most coaches talk about their work as a mission or calling, not just a job. Many have developed close bonds of friendship with other coaches and with the men they support.

Here are just a few quotes from coaches on how they feel about their work:

> “When they see me now they are so happy. They call out to me on the street. I feel like I have done something really important.”

> “I feel powerful, and I am ready to bring change to my community. I am glad that this program has turned my bad story into a great story that will help other men out there.”

> “Yesterday I was a hero and that is because I managed to find a young man who was lost... I counselled him, and all went well.”

> “Finding out I was to be a coach gave me so much courage. I’ve learned to love my work and I know there is so much light after the diagnosis. I hope to share this light with others in the future.”

HOW DOES THE COACH MPILO MODEL WORK?

Who can be a coach?

The primary and essential requirement for being a coach is to be a **man living with HIV.**

Beyond that, while coaches may have experienced their own challenges and even treatment interruptions in the past, they should be currently stable on treatment and open about their HIV status.

To be able to manage record-keeping and data collection requirements, coaches should also have basic literacy and numeracy, although no particular level of formal education is needed.

Coaches also need not have any previous experience working in the health sector; in fact, it may be better if they do not, since that may mean fewer bad habits to unlearn!

Why can't a man without HIV be a coach?

The simple answer is that he has not walked the HIV journey, so he doesn't know what it's like. He has no personal HIV story to tell. He has no lived experience on which to draw in advising and supporting men with HIV. He doesn't provide living proof that a good life with HIV is possible.

'Men's champions' and other male-specific cadres that do not specify HIV status as an eligibility criterion may have value in the context of other programs and approaches. The Coach Mpilo model is distinct, in that it relies fundamentally on tapping into each coach's own HIV journey.

To be clear: There is no circumstance in which a man without HIV should be employed as a coach. That would make it a completely different model.

IS IT LEGAL TO PRIORITISE RECRUITMENT OF MEN LIVING WITH HIV?

Under South African labour law, it is entirely legal to give preference to someone living with HIV within the context of the requirements of the job.

Chapter 2, Section 6 of the Employment Equity Act, which reads as follows:

1. No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex. pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.
2. It is not unfair discrimination to-
   a. take affirmative action measures consistent with the purpose of this Act; or
   b. distinguish, exclude or prefer any person on the basis of an inherent requirement of a job.

South Africa's Commission for Conciliation, Mediation and Arbitration (CCMA) has provided similar guidance:

The law sets out four grounds on which discrimination is generally allowed—

- Discrimination based on affirmative action;
- Discrimination based on inherent requirements of a particular job;
- Compulsory discrimination by law; and
- Discrimination based on productivity.

Any discrimination based on the inherent requirement of the particular job does not constitute unfair discrimination. An inherent requirement of a job depends on the nature of the job and required qualifications. If such requirements can be shown, discrimination will be fair, for example a person with extremely poor eyesight cannot be employed as an airline pilot.

In brief, the law prohibits discrimination against people living with HIV but 1) supports the principle of acting affirmatively in prioritising the recruitment of PLHIV within HIV programs and 2) allows for the fact that in positions like Coach, one's experience of living with HIV can legitimately form part of the inherent requirements of the job.

IS IT ETHICAL TO REQUIRE COACHES TO BE LIVING OPENLY WITH HIV?

Some stakeholders have also expressed concern that it may be unethical to require coach candidates to disclose their HIV status, as it could expose them to stigma and discrimination.

While no one should ever feel pressured to disclose involuntarily, we have found almost universally that coaches find it empowering to reject the guilt and shame often associated with HIV, living openly and confidently and leveraging their own experience to help other men and even bring about change at the level of their community.

While some coaches are initially unsure of what level of openness and visibility they will be comfortable with, most ultimately come to desire maximum visibility in their communities precisely because their focus on helping other men makes that valuable.

As far as we are aware, there has not been any instance of a coach being subjected to stigma or disclosure that he did not feel capable of handling.

Here are just a few quotes that we've collected from coaches on their experience of being a coach:

"I feel powerful, and I am ready to bring change to my community. I am glad that this program has turned my bad story into a great story that will help other men out there."

"Finding out I was to be a coach gave me so much courage. I've learned to love my work and I know there is so much light after the diagnosis. I hope to share this light with others in the future."

"Yesterday I was a hero and that is because I managed to find a young man who was lost...I counselled him, and all went well."
– Coach in Gert Sibande

"When [my players] see me now they are so happy. They call out to me on the street. I feel like I have done something really important."

HOW DOES THE COACH MPILO MODEL WORK?

How are coaches recruited?

While a standard newspaper or website advert is fine, most implementers find that these are insufficient for identifying a strong pool of coach candidates. Men are underrepresented in the health sector, and many do not automatically think of themselves in the context of 'caring' professions, so may not be looking in the places where such opportunities are posted.

Implementers often find it more productive to disseminate the coach job posting via PLHIV networks (formal or informal), adherence clubs, NGOs, community groups, civil society structures, clinics, etc. Nurses in particular are often aware of men in their care who are doing well on treatment, are well respected in the community, and have the right personality to succeed as a coach.

Once the program is operational in a particular geographic area, existing coaches often become an additional source of referrals for new coaches.

Sample advert

Sample job description

How are coaches selected?

We have found that there are certain personal characteristics that make for a good coach:

- A man who is open and confident about his HIV status, rejecting any shame or stigma
- A "people person" who enjoys helping people and feels connected to his community
- A good communicator who is comfortable talking to a diverse range of people about personal topics
- A good listener who can tailor his advice and support to a man's particular barriers and needs
- A problem solver who can work collaboratively to generate practical and creative solutions

We have developed a personality assessment tool to assist with identifying candidates with the right personality for the role. The tool covers 15 relevant personality traits and can be used to identify candidates with the highest likelihood of being effective:

Personality assessment tool

How are coaches trained?

A key advantage of the Coach Mpilo model is that minimal training is needed, since each coach understands intuitively, from lived experience, the emotions that a man experiences upon diagnosis and the psychological, social, and practical barriers that he faces.

Each coach's personal experience of overcoming his own barriers and living well with HIV is the foundation on which the Coach Mpilo training is built. The four-day training then aims to equip the coach with additional knowledge and skills that will help him to be effective in his role.

Coaches are trained on a customised curriculum that draws on SETA-accredited HIV counselling and testing content, the BEST relationships model, and the GROW problem-solving model. The curriculum focuses on interpersonal communication, mentorship, establishing and maintaining trust, building coping skills, and supporting problem-solving.

Coaches are usually trained in groups of no more than 15, given the personal/intimate nature of some of the discussions, which include issues of self-esteem, disclosure, trauma, etc.

We have found that it is helpful for coaches to have a day of 'refresher' training after they have been in the field for a couple of months, to bridge theory with practice and address any challenges or concerns that may not have come up in the initial training.

- Coach training deck
- Post-training questionnaire
- Sample training certificate

Who can train coaches?

Although a training deck is available as a reference, we strongly advise against anyone attempting to conduct a coach training without having gone through a process of apprenticeship, even if they happen to be an experienced and capable trainer.

For someone to become a Coach Mpilo trainer,
the ideal process is to

1. observe a training,
2. co-facilitate a training alongside an established trainer, and
3. lead a training with an established trainer observing and providing feedback.

This is because it is not a standard classroom training focused primarily on imparting skills and information, but rather one that focuses heavily on personal vulnerability and transformation. The best way to understand this is first to witness it.

How are coaches supervised?

Each implementer will have their own staffing and supervisory structures. However, it is important that coaches have access to supportive supervision from someone with adequate bandwidth to give them time and attention.

In the pilot, we conceptualised this position as a 'squad manager', and we found that one squad manager can generally support a team of ±20 coaches, depending on the size and nature of the geographic coverage area. (Squad managers with coaches spread across a large or remote geography may not be able to effectively supervise as many coaches.)

- Sample job description
- Sample advert

How are coaches supported?

While most coaches find the job intrinsically motivating and fulfilling, many of them also carry a heavy load that could lead to eventual burnout if the appropriate support is not provided.

Although coaches focus primarily on barriers to HIV testing and treatment, they are inevitably exposed to a range of other challenges that their players are facing, many of which are beyond their scope and ability to address. Some coaches must also process the feelings of grief and failure that come with being unable to help men who refuse help. While these are few in number, losing even one player can be highly traumatic.

Implementers are advised to pay close attention to each coach's mental and emotional well-being, including self-esteem, optimism, purpose, feelings of competence, sense of connectedness, and ability to cope with adversity. This means building in mechanisms for management staff to regularly connect with each coach, particularly given that their geographic dispersion can lead to them being 'out of sight and out of mind'.

The initial Coach training aims to lay the foundation for good mental health and wellbeing, including sessions on trauma, boundary setting, management of expectations, and referral of players to additional sources of support as appropriate. Throughout the training there are also exercises that help coaches to embrace a spirit of openness and become comfortable with personal vulnerability, rather than remaining stoic and guarded.

In addition to the initial training and the supportive supervision of the squad manager, we have found that coaches' most preferred source of support is each other. Fellow coaches understand the highs and lows of the job better than anyone else, and are often able to offer advice and encouragement to a coach who is feeling down or facing a challenge. During and after the initial training, many form strong feelings of brotherhood that allow them to lean on and be there for each other.

Implementers can help by putting mechanisms in place that make it easier for coaches within a team to stay connected. This may include periodic in-person gatherings where coaches are able to connect face to face, given that they are generally spread out across their communities. It may also include the formation of a coach WhatsApp group—ideally with minimal to no management presence to allow for candid conversation.

How are coaches supported?

Implementers can also play a role in helping each coach to form a positive and supportive working relationship with the clinic team in his community, initially by ensuring that he is properly introduced and his role is properly explained, and subsequently by helping to resolve any tensions or frustrations that may arise within the coach/clinic team relationship.

Various implementers have also made other sources of support available to their coaches, including:

- Periodic refresher trainings, which also serve as an opportunity for connecting and sharing
- Site visits to observe directly how each coach is doing within his context
- Access to a staff psychologist or social worker
- Access to an employee wellness program
- Formal psychotherapeutic debriefing sessions, either one-on-one or in a group
- Informal debriefing sessions, either one-on-one or in a group
- Self-reflection exercises
- Teambuilding activities
- Calls and WhatsApp chats focused on providing encouragement and support
- Other ‘caring for the carer’ activities and resources

Strengthening referral pathways can also help coaches to maintain good mental and emotional health by ensuring that they do not try to take on more than they are able. Implementers are advised to help coaches identify all potential referral resources within their catchment area and establish relationships with other types of service providers and sources of support.

Lastly, implementers can work to create a culture where coaches (and other staff) feel safe and welcome to share their problems and challenges and to ask for help.

How does a coach work with the clinic team?

It is essential for any clinic that will be assigned a coach to be well oriented on the Coach Mpilo model and particularly how the coach is intended to function within the context of the clinic team and environment.

Even before a coach is hired in a particular community, it is advisable for the implementer to meet with the clinic team (or, at a minimum, the facility manager) to explain the position and address any questions or concerns. Once the coach has been hired, an initial meeting to introduce the coach to the clinic team and outline the role he will be playing, is also advisable.

The squad manager or equivalent should also check in periodically with both the coach and the facility manager to identify and address any issues or challenges.

There are a few risks that a coach faces when integrating with the clinic:

- **The clinic team expects him to be clinic-based**, or at least to check in at the clinic frequently. Generally, this happens because the clinic team appreciates the coach and wants to keep him close. However, it's a problem because it can hinder the coach from being out in the community and connecting with the men who need his support. A coach may often accompany men to the clinic, deliver periodic health talks in the waiting area, and coordinate care with clinic staff as needed, and should be present often enough to build and sustain strong working relationships. However, the coach is not meant to be clinic-based.

- **The clinic team expects him to be available for other tasks.** Particularly when a coach is too closely tied to the clinic, it can be tempting for the clinic team to pull him into other tasks—meetings, admin, etc. Every hour that is taken on these types of tasks is an hour lost to working directly with men.

How do coaches work within the community?

Each implementer shapes the coaches' scope of work in the way that best meets their priorities and objectives.

Some implementers have focused their coaches primarily on supporting newly diagnosed men and returning men to care following a treatment interruption—i.e., engaging with men already known to the clinic. In those instances, engagement with the community may be less of a priority, since coaches are able to connect with men via the contact information provided by the clinic.

Other implementers have tasked their coaches with promoting HIV testing and linking men to care who may never have engaged with the clinic previously. For coaches with that mandate, engaging with the community is likely essential. Coaches need to be vocal and visible for men to know that their support is available and for community stakeholders to be able to refer men to a coach.

Coaches are advised to introduce themselves and their service to community influencers who can refer men to them and/or give them a platform for speaking to men directly. These may include traditional healers, traditional leaders, pastors, teachers, social workers, employers, ward councillors, sporting event organisers, community radio hosts, etc. Early introductory meetings with these stakeholders are essential, to explain what a coach does and to enlist support.

The community mapping tool helps coaches identify different pathways for connecting with men.

Community mapping tool

What resources do coaches require?

THE COACH MPILO 'KIT'

It is important for each coach to be provided with a branded Coach Mpilo kit, which consists of 2 shirts, 1 cap, 1 jacket, and 1 name badge. (These will need to be replaced periodically due to wear and tear.)

The kit is important because it conveys credibility not only with their players but also with other stakeholders in the clinic and the community. Unlike the uniforms donned by other cadres, the Coach kit also avoids the HIV-related logos and symbols that can be off-putting to men who are struggling with HIV stigma.

It is further recommended that the kit should be procured from one of the high-quality, top-tier athletics brands (Adidas, Nike, etc.), which provides further visual reinforcement of the coach's status and credibility. A high-quality brand also helps to ensure that the kit remains professional in appearance over a longer period of time. Since Coach Mpilo is about trust and discretion, words (HIV, PEPFAR, etc.) and images (red ribbon, organisational logos, etc.) associated with HIV should not be added anywhere on the kit.

Kit specifications

SMARTPHONE AND DATA/AIRTIME

A smartphone is a coach's primary means of communication and therefore an essential tool. Coaches also need a data/airtime stipend or contract that is adequate for the amount of interaction that they have with their players. Each coach puts his number on his marketing materials and uses WhatsApp chats and voice calls to stay in touch with his players, his squad manager, clinic staff, and other stakeholders.

FILE FOLDER

Coaches need some form of file folder to organise and store materials and paperwork.

What resources do coaches require?

DEMAND CREATION MATERIALS

Coaches who rely on community outreach (versus clinic referral) to connect with new players will need basic demand creation materials (posters, flyers, business cards, etc.)

Sample demand creation materials

REFERRAL LIST

Although a coach's primary role is to support men in starting and staying on treatment, coaches are naturally exposed to a wide range of needs and challenges faced by their players.

Each coach should therefore be supported in developing a referral list, customised for the services and resources available in his area or virtually.

How do coaches recruit their players?

Coaches may recruit their players in a variety of ways.

Coaches whose focus is primarily to support men newly initiated on treatment and/or returning to care following a treatment interruption will rely primarily on referrals from the clinic. Coaches often work from missed appointment and lost-to-follow-up lists as a starting point.

Coaches with a broader focus on supporting men who may never have engaged with the clinic previously will need creative approaches for engaging with men in the community. (See "How do coaches work within the community?").

The main aim is to ensure that men and their partners know that the coach exists and is available should they wish to engage with him.

What exactly do coaches do day to day?

There is no fixed formula, frequency, or ‘dose’ prescribed under the Coach Mpilo model. Coaches tailor their support to each man’s needs and preferences, with some men needing and wanting frequent in-person interaction and other mean needing and wanting only periodic WhatsApp check-ins.

That said, a man’s first few months of support are generally more intensive. Coaches need to take time to explain the benefits of HIV treatment and how it works in the body, support and potentially accompany a man in disclosing his status to loved ones, possibly accompany him to the clinic for the first few visits, and identify and address any other issues and challenges he may be facing.

Over time, a coach may only need to check in with a man periodically, perhaps shortly before and/or after his scheduled clinic visits, to ensure that he is still on track and determine whether any additional support is required.

Coaches are trained to listen for barriers and motivators that will impact a man’s treatment routine. They become adept at eliminating barriers (and excuses) and identifying reasons that meaningful enough for a man to stay on treatment. Some men develop internal motivation sooner than others. Coach will step away only once he is convinced that a man is capable of standing on his own.

Do coaches have a code of conduct?

Because coaches work largely independently and develop close relationships with their players, coach training puts a heavy emphasis on understanding and practicing appropriate conduct, including setting and maintaining personal and professional boundaries, managing player expectations, respecting privacy and confidentiality, and avoiding potentially compromising situations and conflicts of interest.

The training goes beyond theoretical descriptions of these issues, bringing them to life through role plays of real-life examples that have emerged during the project.

Implementers are encouraged to ensure that coaches understand and are committed to following their particular organisation’s code of conduct as well.

How do coaches ‘graduate’ their players?

Although every implementer decides on their approach, it is recommended that a coach graduate a player after approximately six months of support, assuming the player has received a viral load test, reached viral suppression, and possibly been decanted to an alternative ARV collection point by that time.

In the absence of a graduation strategy, a coach’s caseload will continue to grow over time to a point where it becomes unmanageable. Indefinite support could also inadvertently create an unhelpful dynamic of dependency between the player and the coach.

A coach should frame graduation as a milestone to be celebrated—his player has made it to the point of viral suppression, no longer needs to come to the clinic so often, and has hopefully adjusted socially and psychologically to living with HIV, all of which means the coach is no longer needed. He can stand on his own feet.

At the same time, graduation may also be a moment of anxiety and risk, as it involves a change in routine to something that is currently unfamiliar. The shift from frequent clinic visits to decentralised medication collection may ultimately be more convenient but the transition can be stressful. A coach should ensure that his player is well oriented on the new process, perhaps even accompanying him the first time he collects his meds in a different location.

> Although a man has graduated from the program, the coach may also wish to tell him that he is welcome to get back in contact at any time if he experiences any challenges or has any further questions or concerns. Graduation is not intended to be a ‘hard exit’ in this regard.

What is a coach's average caseload?

A reasonable and realistic caseload for an individual coach depends in large part on his context. A coach in an urban area may be able to visit several men in a single day, whereas a coach in a remote rural area may only be able to visit one.

Coach caseloads may also vary due to the needs of their players. Some men may require more intensive support, particularly at the beginning of the relationship, leaving a coach with less time to reach out to new men.

Implementers are therefore advised to be sensitive to each coach's context and circumstances.

> On average, we would estimate that each coach should be able to connect with and take on **±20 new men per month**

On average, however, we would estimate that each coach should be able to connect with and take on ±20 new men per month, in addition to supporting the men he's recruited previously. If we assume that the average player is supported for a period of six months, that figure would result in a total caseload of ±120 men at any given time and ±240 men per year. While those may seem like large numbers, coaches report that most men overcome their major barriers to adherence within the first 2-3 months and then generally require only light-touch support thereafter.

While caseloads may vary, implementers are strongly advised against turning coaches into 'tracker-tracers' who are given hundreds of men to follow up and have only a few minutes to interact with each man. This runs directly counter to the core of the model, which is that coaches need to be able to establish a meaningful personal connection in order to provide effective support.

Also worth noting is that while coaches may be able to reach fewer men immediately than under other approaches, the model has proven much more effective than average in retaining men over time. It is likely more cost-effective to invest more initially in supporting durable linkage and adherence at the beginning of a man's HIV journey than to invest repeatedly in returning him to care over the course of many years.

How is a coach's performance measured?

A coach's primary goal is to help men start and stay on HIV treatment. His performance can therefore be measured on several levels:

- The number of men he has reached
- The percentage of those men who are on treatment
- The percentage of those men who achieve viral suppression

Coaches and implementers will continually need to calibrate the balance between these variables, so that the number of men reached does not compromise the quality of support provided, resulting in lower linkage, retention and viral suppression.

How does the M&E work?

The Coach Mpilo model was designed to support treatment linkage and early retention, up to the point of viral suppression (i.e., the first six months). Recommended indicators are therefore the number of men accepting the support of a coach, the percentage of men linked to treatment, the percentage of men retained on treatment, and the percentage of men achieving viral suppression at six months.

Implementers are free to adapt their monitoring and evaluation approach to their particular needs.

Some implementers have chosen to conduct very granular M&E, tracking and reporting on the above indicators at client level. Other implementers have taken a big-picture approach, tracking overall trends in men's linkage and retention at facilities supported by a coach.

Implementers conducting granular M&E generally do not rely solely on self-reported data from coaches, but rather conduct regular data quality verification to determine whether the outcomes reported by coaches are in line with clinic records and health management information systems.

Some implementers have also chosen to track and report on client outcomes beyond the six-month point, in order to assess the durability of the intervention over time.

Lastly, some implementers have broadened the coaches' scope to include HIV testing (including facility-based testing, self-testing, and index testing), with key indicators being the number of men tested, the percentage testing positive, and the percentage linked to care.

The Mpilo Project team is available to advise on specific M&E tools and processes as needed.

Can coaches be fully virtual?

Although we designed the original model based on the notion that face-to-face contact would enable the development of trust and rapport, particularly at the beginning of the relationship, we were pleasantly surprised to find that the virtual adaptation was acceptable to clients and effective in supporting linkage and early retention.

Clearly there are certain types of support that can only be provided in person—accompanying a man to the clinic, accompanying him during a disclosure conversation, etc. However, we found that there are still many types of support that can be provided virtually. On balance, an in-person coach may be preferable for most men, but a virtual coach appears to be better than no coach in areas where an in-person coach is not an option.

Coaches who engage with clients in a fully virtual manner do benefit from additional guidance and support on how to develop trust and openness in the absence of face-to-face contact. Additional training for virtual coaches is designed to give them the communication skills to quickly bridge the virtual gap by polishing the first phone interaction to quickly show empathy and build trust, leveraging self-disclosure to grow affinity and connectedness, and establishing boundaries around a virtual coach's availability and the types of support he can provide.

HOW DOES THE COACH MPILO MODEL WORK?

What are the main risks of the model?

✕ TRYING TO TURN MEN WHO DO NOT HAVE HIV INTO COACHES

The essence of the model is that coaches are men living with HIV. Trying to turn men who do not have HIV into coaches negates the core logic of the intervention. While there may be many benefits to engaging more men in the HIV response in other capacities, they should not be employed as coaches unless they have walked the HIV journey themselves.

✕ OVERLOADING COACHES WITH TOO MANY PLAYERS

The Coach Mpilo model is designed to allow coaches to provide personalised support to each of their players. Particularly at the outset, coaches may need to spend the better part of a day with a man helping him identify and work through his barriers, accompanying him to the clinic and/or supporting him in sharing his HIV status with his loved ones.

While a coach's caseload will depend on various factors, implementers are advised to ensure that targets and expectations are aligned with the spirit of the model in allowing coaches to spend adequate time with each of their players.

Coaches who are turned into tracker-tracers, responsible for following up on hundreds of men at a time, will not be able to implement the model with fidelity, which will in turn compromise effectiveness and results.

HOW DOES THE COACH MPILO MODEL WORK?

What are the main risks of the model?

COACHES BEING CONFINED TO THE CLINIC

Some clinic teams will want the coach to be clinic-based or at least to spend a substantial amout of time in the clinic. This is an understandable impulse, but it hinders a coach's effectiveness. While it is important for coaches to have a strong working relationship with the clinic team, implementers should take care to explain that coaches are meant to be based in the community.

There are several problems that arise when coaches are too tethered to the clinic:

1. It prevents the coaches from engaging with and supporting men in the community, which can be particularly important for men who have never come to the clinic or have stopped coming. We must go to them because they will not always come to us.

2. It can create an image of the coach being a representative of the health system, which many men dislike and distrust. The model was designed for men to feel like the coach is their guy, supporting them and advocating for them, not yet another person from the clinic chasing after them.

3. Coaches who are based in the clinic risk being pulled onto unrelated tasks, meetings, visits, etc. This limits their ability to focus on their core task of reaching and supporting men.

CAN I IMPLEMENT THE MODEL FOR POPULATIONS OTHER THAN MEN?

Coach for women

Although the formative insights and design work focused specifically on men's barriers and needs, some implementing partners have opted to adapt the model for women, based on their belief in the applicability of the core insight of the power of someone with HIV leading with their own story from a place of openness and vulnerability.

We are pleased to note that the fundamentals of the model appear to hold across genders. Women coaches have reported a positive experience of the training and a high level of confidence in being able to work effectively as coaches. Partners implementing the model with and for women are reporting linkage and retention numbers comparable to those under the original model.

At the same time, we have observed some important contextual differences in working with women, including a greater sense of shame in having acquired HIV, much greater experience of violence and trauma, including sexual abuse, and a greater desire for regular debriefing.

Coach for adolescent boys amd young boys

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Coach for men who have sex with men (MSM)

Under a parallel project, we conducted an insights and design process with MSM in South Africa that has led to the adaptation of the Coach Mpilo model for this population, with a particular focus on men who are not openly identifying.

While MSM experience many of the same fears as other men in relation to HIV, they carry the additional burden of engaging in sexual activity that is not socially sanctioned in many contexts. The MSM adaptation of the Coach model focuses on the dual stigma of being MSM and living with HIV as well as the social and emotional isolation and trauma experienced by many MSM, the elevated HIV risk associated with receptive anal sex, and the heightened need for sensitivity and discretion in the provision of services and support.

Integration of the MSM adaptation into public health facilities has also required additional thought and effort, to ensure that MSM are referred to clinics where they will be able to access non-judgmental care.

A key lesson from the adaptation process has been that due to their greater needs and barriers, MSM generally require more intensive support over a longer period of time, meaning that coach caseloads and targets must be adjusted downward to be reasonable and realistic.

WHO CAN I TALK TO IF I WANT TO KNOW MORE?

If you have any questions, need more information, or would like to explore implementing the Coach Mpilo model, please do not hesitate to reach out.

We would love to hear from you!

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