Summit Report

Get READY for #PeerPower

PATA 2018 Youth Summit in Partnership with Y+

26 - 28 November 2018
Dar es Salaam, Tanzania
Acknowledgements:
The Power of Partnership

PATA extends special thanks to all contributors to the PATA 2018 Youth Summit in partnership with Y+.

Summit and programme coordination:
Paediatric-Adolescent Treatment Africa (PATA); Global Network of Young People Living with HIV (Y+);

Summit Working Action Group:
PATA; Y+; African Young Positives (AY+); Frontline AIDS; Regional Psychosocial Support Institute (REPSSI); Africaid; PATA Youth Advisory Panel (YAP); Aidsfonds; Adolescent Treatment Coalition (ATC)

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Summit organisation and logistics:
PATA; READY+ consortium partners

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International HIV/AIDS Alliance changed it name to Frontline AIDS in 2019.
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Acronyms

AFHS  Adolescent-friendly health services
ART  Antiretroviral treatment
ATC  Adolescent Treatment Coalition
AY+  African Young Positives
AYPLHIV  Adolescents and Young People Living with HIV
DSD  Differentiated Service Delivery
HYLF  HIV Young Leaders Fund
IAS  International AIDS Society
IPPF  International Planned Parenthood Federation
LGBTQI  Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex
PATA  Paediatric-Adolescent Treatment Africa
P2Z  Peers2Zero
PEERU  Peer to Peer Uganda
READY+  Resilient & Empowered Adolescents & Young People
REPSSI  Regional Psychosocial Support Initiative
SRHR  Sexual and Reproductive Health and Rights
SWAG  Summit Working Action Group
TAP  Technical Advisory Panel
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNICEF  United Nations International Children’s Emergency Fund
UNYPA  Uganda Network of Young People Living with HIV and AIDS
WHO  World Health Organization
WRHI  Wits Reproductive Health Institute
Y+  Global Network of Young People Living with HIV
YAP  Youth Advisory Panel
YCC  Youth Care Clubs
YPLHIV  Young People Living with HIV
ZY+  Zimbabwe Young Positives
Executive Summary

#PeerPower was the focus of the PATA 2018 Youth Summit in partnership with Y+. The summit was held from 26 to 28 November 2018 in Dar es Salaam, Tanzania, and hosted 221 participants. This included 115 peer supporters, youth network representatives and leaders from 11 sub-Saharan African countries, who were joined by 106 health providers, programme implementers and policymakers, to link and learn across programmes and geography.

The summit set out to drive action, advocacy and greater accountability in safeguarding the rights of adolescents and young people living with HIV (AYPHIV) to access quality adolescent-friendly health services (AFHS) that are responsive to their sexual and reproductive health and rights (SRHR) and well-being.

The three-day meeting used plenary sessions, workshops, intergenerational dialogues and skills-building sessions to provide technical assistance and skills-building, highlight best practices, and discuss programmatic barriers and solutions.

PATA Youth Summits seek to create a dedicated safe space and opportunity for young peer supporters living with HIV, who are at the forefront of driving peer-led services across the region, to meet, share experiences, and engage with each other and health providers, youth networks, programme implementers, donors and policymakers to build and strengthen positive health partnerships, drive collective commitment to action and improve services for adolescents and young people.

Youth attending the summit joined their voices in developing Youth Summit Commitments to Action (page 57). The commitments recognise the importance of working collectively, across national and generational boundaries, and in partnership with health providers, governments, donors, policymakers and civil society to achieve the global Fast-Track Targets.
The Youth Summit, entitled Get READY for #PeerPower, was a collaborative meeting, co-hosted, planned and delivered by PATA and Y+. The summit was held from 26 to 28 November 2018 in Dar es Salaam, Tanzania. The summit set out to drive action, advocacy and greater accountability in safeguarding the rights of AYPLHIV to access quality AFHS that are responsive to their SRHR needs and well-being.

Summit objectives

- Provide a linking and learning platform for collective action, advocacy and accountability
- Strengthen capacity to deliver services that are youth-centred, HIV/SRHR integrated and stigma-free
- Build connection and coordination between networks of young people living with HIV and their memberships
- Facilitate intergenerational dialogue between diverse stakeholders to build greater understanding and partnership
- Provide guidance and tools to accelerate meaningful participation of adolescents and young people living with HIV
- Amplify the voice of young people through the development of Youth Summit Commitments to Action

The Youth Summit provided a dynamic and productive linking, learning and networking platform built upon PATA summit methodology. Throughout the summit, young people participated and led the development and delivery of several sessions. The summit used a youth-friendly workshop structure to maximise contribution of all participating young people. Across three days, the programme facilitated dialogue and consensus-building to prioritise AFHS delivery, with a focus on peer support and HIV/SRHR service integration. The summit prioritised youth leadership and facilitated stakeholder groups to share their similar and differing perspectives, experiences, insights, challenges and ideas with one another. This facilitated intergenerational and sectoral dialogue, building bridges of understanding, while strengthening teamwork and effective health partnerships.

The Youth Summit leveraged participation and contribution as well as shared lessons across several PATA programmes, namely READY+, REACH, P2Z, C3 Leading Louder, ARCO, and DSD4A. The Youth Summit was a key deliverable for READY+ and P2Z, and was therefore co-hosted, planned and delivered with Y+, a key consortium partner under the READY+ programme. All summit participants came together under the growing READY movement in its commitment to ensuring that young people are resilient, empowered and knowledgeable and have the freedom to make healthier choices and access services and commodities related to their SRHR.

The Youth Summit relied on the Power of Partnership to work together in developing the concept and programme as well as jointly delivering skills-building sessions and facilitating dialogues throughout. Please see summit programme here.

A collaboration of key messages

The following hashtags were used as trending themes throughout the PATA 2018 Youth Summit:

#PATA2018YouthSummit #PeerPower #WeAreREADY #READYtolead #NothingForUsWithoutUs #FreshVoicesMakingChoices #WhatWorksForUs

Summit participants

The summit hosted 221 participants, including young people, health providers, network members, programme partners and policy-makers from 24 countries. Forty-five health facilities from 11 countries in sub-Saharan Africa were represented. Together, these facilities care for 22,000 adolescents on antiretroviral treatment (ART).

Almost two-thirds (115) of the participant group were youth. Eighty-two of these young people are engaged as peer supporters at health facilities represented at the summit. Each health facility was represented by a pair of peer supporters and one health provider. In addition, 33 were youth representatives, focal persons and youth leaders from networks and partners organisations. With the support of the ATC, the Summit also enjoyed global representation from regional networks outside Africa. Unfortunately, the events in Tanzania preceding the summit heightened safety and security considerations for many of our international attendees, and impacted attendance and participation of Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI) participants. Despite this, and in solidarity with our local Tanzanian partners, regional programme partners and peer supporters operating in similar environments, it was important to proceed. Amidst these constraints, we were still able to facilitate an engaged and robust dialogue that called for increased access to non-discriminatory services for young key populations in a legal and policy environment that recognises their right to live free from violence and criminalisation.

#Cameron, DRC, eSwatini, Ethiopia, Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe
PATA hosts local forums and regional and continental summits, with the methodology having been refined through 12 years of experience. Forums and summits bring stakeholders together to build regional action around paediatric and adolescent HIV treatment, care and support, serving as platforms for multiple cadres of health providers to convene to share promising practices and plan for service delivery improvements. This ‘link and learn’ approach is central to PATA’s work.

Key to the methodology is facilitating opportunity for those on the frontline of service delivery to share experiences with peers; access global guidance and technical input; and discuss operational barriers and solutions with young people themselves, programme implementers, policy-makers and other stakeholders. Often, those on the frontline are absent or not well represented at international conferences or high-level regional and national meetings. PATA Summits and forums fill this gap and offer a valuable platform linking local practice to global policy.

PATA Summits occur annually with Youth Summits taking place biennially. This was PATA’s second Youth Summit, the first taking place in 2016 in partnership with AY+. PATA Youth Summits seek to create a dedicated safe space and opportunity for young peer supporters at the forefront of driving peer-led services across the region, to meet, share experiences and learn from one another.

Each day ended with different stakeholder groups coming together to engage in intergenerational and intersectoral dialogues. These discussions culminated in the development of a Youth Summit Commitments to Action, where participants across generational and geographical boundaries were able to voice their choices and prioritise collective advocacy for action.

Summit methodology

Communities of Practice: “Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.” - Wenger, et al, 2001

The summit was interactive and highly engaging, employing a variety of different session formats that each built upon and related to the day’s theme. Presentations and world café workshop sessions provided updates, and highlighted service delivery models, sharing key lessons and implementation guidance. Eleven skills-building sessions provided capacity-building opportunities targeting the two major stakeholder groups attending the summit: peer supporters and health providers. Peer supporter and health provider skills-building sessions were run in parallel, ensuring that the days theme was carried throughout while being responsive to each of the groups, their roles, needs and contexts. All skills-building sessions drew on the knowledge and experience of young people as leads or co-facilitators.

Skills-building workshop sessions were developed by the Summit Working Action Group. Each session lead was responsible for planning and shaping the session’s content, methodology, resource requirements and facilitation.

Each day started with scene setting and presentations linked to the day’s theme. Presentations and world café workshop sessions provided updates, and highlighted service delivery models, sharing key lessons and implementation guidance. Eleven skills-building sessions provided capacity-building opportunities targeting the two major stakeholder groups attending the summit: peer supporters and health providers.

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A big thank you to all the wonderful summit facilitators who supported the Youth Summit!

Nevala Kyando  David Gwaisa  Leon Essink  Consolata Opilo
Marissa Vicari  Annah Sango  Fileuka Ngakwonga  Grace Ngulube  Hayley Gleson
Lynn Phillips  Agnes Ronan  Julian Kerbohghyan  Hellen Soeters
Mercy Ngulube  Linda Ndlovu  Prosper Ndlovu  Gillian Makota
Virgilio Suande  Cedric Njinahazwe  Mo Barry  Denis Dube  Felicitus Ngubo
Alexandra Stanciu  Nadege Munyarabunga  Blessings Banda  Rumbidzai Chidora
Amy Whiting  Violet Nguga  Moses Bwire  Nienke Westerhof  Moses Rutatina
Karesma Mushiri  Nicholas Nkwagaba  Mandlenkoszi Mazibuko  Refilwe Mafawane
Kelvin Makura  Tammy Burdock  Clever Ndanga  Elona Toska  Camille Wittaseale
Chengeta Dziva  Chikondi Kateta  Tinashe Rufurwadzo  Jaqueline Mushiri

Several opportunities throughout the summit were created to showcase adolescent-friendly service through poster exhibitions and a daily market place where clinic teams could share materials and income-generating items. Fun activities and team-building took place each evening with beach volleyball and soccer as well as a farewell dinner and awards celebration.
Setting the Scene

Each day opened with global and regional updates, providing an overview of each day’s theme. Dr Anath Rwebembera from the Tanzanian National AIDS Control Program (NACP) warmly welcomed participants and officially opened the summit on the first day. She highlighted the importance of regional collaboration and thanked PATA and partners for the opportunity created for young people, especially as 4.7% of adolescents (aged 10 to 19) are living with HIV in Tanzania.

Mercy Ngulube (IAS) provided a global overview highlighting where we are falling behind on targets. She reminded us that if we are to improve the human condition, our priority must be to create opportunities in Africa’s fastest-growing countries. And this means investing in young people!

“Jet us hope that at the summit, all young people will share their lessons and best practices so that we can get much better in reaching young people, ensuring that they are tested and linked to care with the necessary support to ensure they remain adherent and virally suppressed.” – Dr Anath Rwebembera, Tanzania MoH

Global Adolescent HIV

- 2016 – 2.1 million adolescents (15-24) living with HIV (including 610,000 incident infections)
- The number of adolescents living with HIV has increased by 30% between 2005 and 2016.
- Adolescents are the only population group for whom HIV-related mortality continues to increase

“Young people have enormous potential to drive growth. They are the activists, the innovators, leaders and workers of the future.” – Mercy Ngulube, IAS
Ulrike Gilbert-Nandra (UNICEF Tanzania) provided a regional update on new HIV infections and prevalence, drawing attention to country differences and gender disparities in East and Southern Africa.

HIV in 2017 for children and adolescents in East and Southern Africa

<table>
<thead>
<tr>
<th>2017</th>
<th>Children 0-9 years</th>
<th>Adolescents 10-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with HIV</td>
<td>760,000</td>
<td>1,090,000</td>
</tr>
<tr>
<td>On Treatment</td>
<td>53% (0-14 years)</td>
<td>-</td>
</tr>
<tr>
<td>AIDS-related deaths</td>
<td>43,000</td>
<td>22,000</td>
</tr>
</tbody>
</table>


Within-region distribution of adolescents aged 10-19 living with HIV by country, 2017 (Source UNAIDS HIV Estimates, July 2018)

Ulrike Gilbert, UNICEF Tanzania

- “You need to know your status, but you also need to know your viral load.”
- “Stigma and legal barriers continue to be a bottleneck.”
- “We have learned that support clubs improved retention and viral load suppression among AYPLHIV. But we need data. Not many projects collect outcome data; we need more of this to advocate for new programmes.”
- “The SDGs are important reference points; this is where countries are being held accountable.”

AT A GLANCE

In sub-Saharan Africa, three in five new HIV infections among 15-19 year-olds are among girls.

- 52% of all women aged 15–19 who were married before the age of 18 were married before the age of 15.
- 40% of all women aged 15–19 who were married before the age of 18 were married before the age of 15.
- 47% of all women aged 15–19 who were married before the age of 18 were married before the age of 15.

7 out of 10 women in conflict settings and in refugee populations are exposed to gender-based and sexual violence.

Women who have experienced violence are 50% more likely to be living with HIV.

Women who have been physically or sexually abused by their partners report higher rates of mental health issues, including depression and anxiety, higher use of alcohol and less control over sexual decision-making.

In rural areas, more than 50% of women aged 15–24 had a pregnancy before the age of 18.

Each year, 12 million girls are married before the age of 18—married too soon, endangering their personal development and well-being.

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Each year, 12 million girls are married before the age of 18—married too soon, endangering their personal development and well-being.
Julian Kerboghossian (Y+) emphasised the need for young people to receive technical support and guidance, and not simply money. He called for the agenda of young people to move beyond youth engagement and participation to real and tangible youth partnership and leadership.

New developments and drug optimisation for AYPLHIV was presented by Dr Patrick Oyaro (PATA and FACES) on the final day of the summit, drawing attention to advancements in HIV treatment: reducing toxicity, increasing resistant barriers, reducing drug interactions, safer use across different age groups and populations, and reducing cost. Current available treatment options for AYPLHIV under the age of 14 in the region are ABC, 3TC and EFV, while those 15 years of age and older can be put on an adult regimen of TDF/3TC/EFV or TDF/3TC/DTG-FDC. Exciting insights were shared on new treatment developments on the horizon, including a once-a-month injection with much discussion and clarification provided on the use of dolutegravir following safety concerns for women of reproductive age.

Challenges and priorities highlighted during Setting the Scene sessions:
- Inequitable progress by region and population
- Persistent structural barriers, including stigma, discrimination, legal restrictions - age of consent and access to sexual and reproductive health and rights
- High percentages of treatment failure related to suboptimal adherence amongst adolescents in some programmes
- Need of disaggregated data (10-14) and (15-19) and implementation science that can identify effective models that are scalable and cost effective
- Need for drug optimisation and differentiated service and ARV delivery models
- Need for greater investment and commitment to youth leadership and genuine partnership
It’s tough taking ARVs every day!

Throughout the summit, young people and health providers highlighted everyday challenges in adherence, and why it’s tough taking ARVs every day. How can we prioritise our programmes to better speak and respond directly to these barriers?

“There is a big challenge to take medication because of peer influence and fear of discrimination.” – Health Provider, Ethiopia

“They said the tablets are very big and difficult to swallow.” – Health Provider, Zambia

What makes it most difficult for AYPLHIV clients to take their ARVs every day:

<table>
<thead>
<tr>
<th>Health Provider perspectives (n=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of support</td>
</tr>
<tr>
<td>Pills are too big</td>
</tr>
<tr>
<td>Pill side effects</td>
</tr>
<tr>
<td>Non-acceptance of HIV status</td>
</tr>
<tr>
<td>Lack of knowledge</td>
</tr>
<tr>
<td>Poverty/lack of access to food/poor nutrition</td>
</tr>
<tr>
<td>Inconvenient with times &amp; schedules/too busy &amp; forget to</td>
</tr>
<tr>
<td>Peer pressure/influence</td>
</tr>
<tr>
<td>Pill burden/fatigue</td>
</tr>
<tr>
<td>Non-disclosure</td>
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<tr>
<td>Stigma &amp; discrimination</td>
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</tbody>
</table>

What makes it most difficult for AYPLHIV clients to take their ARVs every day:

<table>
<thead>
<tr>
<th>Peer Supporters perspectives (n=46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of money to reach hospital</td>
</tr>
<tr>
<td>Pill side effects</td>
</tr>
<tr>
<td>Lack of knowledge</td>
</tr>
<tr>
<td>Pills are too big</td>
</tr>
<tr>
<td>Witchcraft/religious or cultural practices</td>
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<tr>
<td>Peer pressure/influence</td>
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<tr>
<td>Poverty/lack of access to food/poor nutrition</td>
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</tr>
</tbody>
</table>

““They haven’t fully accepted that they are HIV positive and young people haven’t disclosed their status to partners so this makes them not to take [their medication].” – Peer Supporter, eSwatini

““There is a big challenge to take medication because of peer influence and fear of discrimination.” – Health Provider, Ethiopia

“They said the tablets are very big and difficult to swallow.” – Health Provider, Zambia
The Power of Partnerships

The summit explored the value of a multi-stakeholder approach with meaningful and effective partnerships in the HIV response. There is increased chance of success with far greater impact when strong alliances are established, working together at all levels, pooling the experiences, resources and skills of peer supporters, health providers, youth networks, programme implementers, policy-makers and communities. Each stakeholder’s unique role and responsibilities were unpacked, exploring why and how stakeholders fit together, and identifying the factors and strategies that can strengthen partnerships so that they become more effective and impactful.

Luann Hatane (PATA) provided an ecological model to demonstrate the multiple pathways of partnership and the many intersections across a set of dynamic and ever shifting relationships. Laws, policies, culture, gender and other factors add additional layers of complexity in how we navigate relationships and often create service level barriers. Central to our partnerships is working together to overcome service-level barriers and close the widening gaps between practice and policy.

Meaningful youth participation means that young people participate on equal terms with adults, or work independently, at all stages of programming and policy design, implementation, monitoring and evaluation.

“I think that the solution is in partnerships across generations. Young people have new ideas and enthusiasm. Older people have experience and wisdom. But how do we establish partnerships? That is the critical question.” – Jeroen Verheul, Dutch Ambassador to Tanzania, Madagascar, Mauritius, & the Comoros

“I am a person who is much more than my HIV.” – Kelvin Makura, ZY+

Agnes Ronan (PATA) presented the ‘three lens approach’, a framework that engages young people first as patients, then as providers (through the peer support role), and, finally, as advocates for adolescent health services.
Key questions and challenges put toward health providers and youth-serving implementing partners highlighted the overuse of terms such as “meaningful youth participation” with little consideration on how this is put into action and applied with genuine and consistent commitment.

- “How well do we meaningfully engage young people as equals?”
- “What mechanisms have we put in place to hold ourselves actively accountable or listen to their needs and take their feedback into account?”
- “Do young people have the power to influence our decisions as partners in the HIV response?”

Ultimately, the fundamental right for young people to participate in decision-making processes that affect their lives and well-being goes beyond forum participation. How can we do better?

Julian Kerboghossian (Y+) outlined a number of ways in which young people are being insufficiently acknowledged and compensated within the HIV response despite their significant contributions. He called attention to the high expectations placed on peer supporters to deliver services but explained how these expectations are not reinforced by favourable working conditions, fair compensation and technical support. His message to the young people in the room was “Be proud. Take great care of yourselves. And demand your space in the HIV response.”

The need to provide practical tools to facilitate constructive and responsive feedback around service delivery was highlighted throughout the three days. These tools should not only allow for feedback but should also lead to and harness improvements in service delivery.

Cedric Nininahazwe (Y+) presented the READY+ scorecard, a unique client satisfaction tool developed by young people to help facilities to routinely and meaningfully assess how well they are supporting their young clients. The 15-item scorecard is a pragmatic mechanism to facilitate communication between health providers and their young clients and is available here.

“Ensure a youth-centred, participatory approach throughout all aspects of programme design, delivery, and evaluation.” – Dennis Dube, Grassroot Soccer
Health providers: Key partners in the HIV youth response

Frontline health providers are the backbone of an effective HIV response. Providers have the ultimate power to shape the service experience of a young person, because at the heart of HIV management and patient-centred care, is a partnership between a provider and a young person.

Health partnerships can have significant impacts on health outcomes when it becomes a mutually agreed upon and equal “contract” between the health provider and the client. Dr Patrick Oyaro (PATA) showed how a commitment to “triple zero” (zero missed appointments, zero missed drugs and zero viral load) yielded an 80% viral suppression rate from a baseline of 68% in a 2017 study.

“Service users and service providers share equal responsibility to drive treatment adherence and achieve viral suppression.” - Luann Hatane, PATA

“Providers should establish and maintain a therapeutic alliance and positive health partnership with their young clients.” - David Gwasira, REPSSI

OPERATION TRIPLE ZERO ‘OTZ’ Overview

To harness the power of health providers, they need training, tools and guidance so that they are equipped and empowered to deliver sensitive, client-centred and responsive services.

Voicing our Choices: In surveys completed at the summit, young people were provided with a series of choices between hypothetical clinics within which the following five attributes were varied: wait time (no wait, or a one-, three-, or five-hour wait time); distance from home (1km, 10km or 20km); visit frequency (one-, three- or six-monthly); clinic hours (weekdays until 16h00, or weekdays until 18h00 plus weekends); and health provider attitudes (“friendly and kind” or “rude and unfriendly”). For each hypothetical choice, young people exhibited a strong preference for the clinic with “friendly and kind” providers, regardless of wait time, distance from home, visit frequency or operating hours. Young people were willing to accept a longer wait time (five hours as opposed to no wait), greater distance from home (20km as opposed to 1km), more frequent visits (monthly as opposed to six-monthly), and shorter operating hours (weekdays until 16h00 as opposed to weekdays until 18h00) in order to access “friendly and kind” providers.

These findings suggest that for young people, positive health provider attitudes matter and are the most desired feature of care. Moreover, young people are willing to relinquish convenience to be able to access client-centred friendly providers. To satisfy young people’s preferences and enhance the quality of the client experience, programmes must invest in health provider training and sensitisation, with ongoing support and monitoring of friendly and positive service quality.

Alexandra Stanciu (Frontline AIDS) led a skills-building session titled “Time to talk: providing stigma-free services” for health providers focused on sensitisation and values clarification for stigma-free HIV/SRHR services. This session demonstrated the importance of openness towards young people’s sex and sexuality, as well as gender-sensitivity with attention given to the specific needs of those who are hyper-vulnerable (young mothers, young people exposed to violence and those who identify as LGBTQI). Health providers reflected upon how stigma and discrimination towards young people (and specific groups of young people) can play out in service delivery, in both direct and indirect ways. The group considered and reflected upon their own stigma and potential behaviours that may be experienced as discriminatory when providing services for young people.

• What stigma do we hold that we may not even be aware of?
• What is underpinning our stigma?
• How do we balance our own religious, cultural, and social beliefs with our professional requirement to provide stigma-free HIV services?
• What dilemmas does this place on us, and how does this play out in our engagement with young people?
• How can we identify and manage our blind spots better?
Agnes Ronan (PATA) presented on what health providers can do differently and better.

**WHAT CAN HPs DO DIFFERENTLY AND BETTER? KEY POINTS**

1. Value clarification
2. Treat with respect and without judgment or stigma
3. Invest in interpersonal relationships with young clients
4. Take time to understand young people and engage as equal partners
5. Meaningfully engage AYPLHIV in service delivery
6. Health providers to rethink the way they speak to young people about sex and sexuality
7. Young people should not be treated as a homogenous group
8. Lastly, health providers must exercise self-care for their own resilience

“We acknowledge that Africa is diverse with many different cultures and value systems. Even when we have the same culture, we all have our own values and beliefs. When working with adolescents and youth, it is important to be aware that their values and beliefs might differ from our own as healthcare providers and this is okay.” – Refilwe Mafojane, Wits RHI

The summit focused on adolescent-friendly and youth-centred, non-discriminatory, stigma-free, integrated HIV and SRHR services that are free and available to all young people in all their diversity.

Annah Sango (ZY+) helped participants to explore the intersections between HIV and SRHR services, in terms of target populations, characteristics and desired outcomes, in order to understand the rationale for linkage between these services.

Because of the synergies between HIV and SRHR services, when well-linked, these services can be complementary and mutually reinforcing, collectively ensuring a continuum of care. Where not integrated within the same facility, linkages and referrals between HIV and SRHR should be bidirectional and may be approached in different ways, but each approach requires effective partnership pathways between different departments within health facilities, and between service providers and the communities they serve.

To successfully implement these service partnerships, participants discussed helpful mechanisms and tools including referral directories, referral forms and client referral registers. Another useful strategy is for a health provider or a peer supporter to accompany a client to the referral endpoint.

During the meeting, young people also raised concerns around HIV-specific services, explaining that when clinic operations and infrastructure provide separate services and spaces for people living with HIV, this can lead to involuntary disclosure which is a deterrent for young people. Examples provided include specific rooms or spaces that are labelled, as well as queues, and service times that provide HIV services only. In addition, concerns were raised with the inconvenience of time and cost in having to attend multiple service points in any one day or having to attend on a different day to receive HIV or SRHR services separately.

Service partnerships: HIV and SRHR integration and referrals

Why Integration?

- Reproductive Health and HIV have similar characteristics, target populations and desired outcomes:
  - Both mainly serve reproductive age populations
  - Majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding
  - Risk of HIV transmission and acquisition can be further increased by the presence of certain STIs
  - Sexual and reproductive health and HIV share root causes eg poverty, gender norms & inequality, cultural norms etc

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#PeerPower

Let’s get READY

26-28 Nov
Dar es Salaam
A skills-building workshop led by Annah Sango (ZY+), Agnes Ronan and Dr Filueka Ngakongwa (PATA) on the what and how of HIV/SRHR integration discussed various steps and highlighted integration markers that can be found here.

Please see the Frontline AIDS’s Adolescent HIV Programming as a Good Practice Guide.

The summit prioritised clinic-community partnership models that provided effective linkage and referral pathways between health facilities and community structures for testing, linkage, and quality treatment and care. Such models link young people to psychosocial support and social protection as is aligned to the Sustainable Development Goals and the promotion of Universal Health Coverage.

Edwick Mapalala, REPSSI, outlined the social ecology model of adolescence which – aside from the clinic – includes the relationship to the family, school, other health services, the community and wider society. An adolescent or young person is only at the clinic one day per month at most; spending the rest of the time with their family, at school and in the community. These spaces have significant influence in a young person’s life and are thus often better placed to provide psychosocial support. This requires partnership and collaboration between the clinic, family and community. Programmes should identify existing capacities and resources in the family and community and link with these. Providers should work with caregivers to ensure a continuum of care, offering services such as family counselling and parenting skills workshops.

Wellness is not just about health services, but about every facet of the social ecology model.

REPSSI utilises the Tree of Life to assist in describing the needs of an adolescent, a tool that is widely used in humanitarian contexts across the world. The tool uses different parts of a tree as metaphors to represent the different aspects of our lives.

Community partnerships: Providing psychosocial support

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REPSSI utilises the Tree of Life to assist in describing the needs of an adolescent, a tool that is widely used in humanitarian contexts across the world. The tool uses different parts of a tree as metaphors to represent the different aspects of our lives.
During skills-building sessions, REPSSI highlighted the 5Cs of adherence counselling: constructed connected, cooperative, caring and client-centred. Within this framework, Karesma Mushu (REPSSI), Jaqueline Mushu and Nobelrich Makere (TACOSODE) guided health providers on practical pointers, for example how to plan a conversation with adolescents and young people. The need to build a relationship based on trust and positive health partnership was emphasised.

Health facility teams brought hand-made posters to display at the summit to showcase how their health facility is youth-friendly. The posters drew attention to the range of services provided by peer supporters and emphasised the empathic support that young people bring to one another through support groups and the role that they play in linkage, assisting their peers navigate different pathways to access the services they need. The posters and pictures created a powerful demonstration of the multiple roles performed by peer supporters and highlighted the value of peer support in the clinic and the community.

Thank you to the health facility teams, including health providers and young people, who went above and beyond to showcase their important and valuable contributions in delivering services and support on the frontline. Many of the posters brought to the summit were hand drawn and painted and took considerable time and effort to prepare.
The Power of Peers in Service Delivery

One of the most important messages to come out of the summit is that young people should be active and equal partners in their own healthcare, and they should have the right to inform and lead programmes and services that affect them.

The summit emphasised peer support as a vital intervention for adolescents and young people in the HIV response that must be adequately resourced and reported against. Sessions focused on the unique role that peer supporters play in clinics and communities, improving retention, adherence and viral suppression, while increasing levels of disclosure and sensitising health providers. The role also provides opportunity for young peer supporters to learn new skills, attend meetings and trainings, and through developing increased confidence and opportunities for personal growth, decrease their own self-stigma.

“Support clubs with adolescents at health facilities have improved retention and viral load suppression in adolescent girls and boys.” – Ulrike Gilbert-Nandra, UNICEF Tanzania

“We should not underestimate the power of peer education. It is unstoppable if we utilise it in the right way.” – Moses Bwire, PEERU

Young people have so much potential!

- We have energy
- We have ideas
- We have lived experiences
- We want to learn, gain professional experience and develop ourselves

Kelvin Makura (ZY+) promoted peer support as a strategy to leverage the potential of young people and provided an overview of READY+ and P2Z Campaign as successful health partnerships between young people, health facilities and implementing partners. READY+ aims to advance SRHR, psychological well-being, care and treatment with, by and for 30,000 AYPLHIV in Mozambique, Swaziland, Tanzania and Zimbabwe. The programme is currently being implemented by an innovative and multidisciplinary consortium.

An example of work we are doing – READY+

- READY+ = Resilient, Empowered Adolescents and Young People Living with HIV
- Working in 4 countries, including Zimbabwe
- In Zimbabwe, we are part of a collaboration with health facilities to:
  - train and support CATS (to work in health facilities and in communities)
  - to train health providers on adolescent-friendly services, including psychosocial support and SRHR

Another example of work we are doing – P2Z

- P2Z = Peers to Zero Coalition
- Working in East and Southern Africa countries.
- In Zimbabwe, the project also supports health facilities to:
  - improve the quality of adolescent-friendly services provided at the facility.
  - strengthening AYPLHIV engagement in HIV treatment and care

“We should not underestimate the power of peer education. It is unstoppable if we utilise it in the right way.” – Moses Bwire, PEERU

“A problem shared is a problem half solved.” – Kelvin Makura, ZY+

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Models of peer support

The summit showcased best practice case studies and lessons learned from programmes on the frontlines of service delivery.

During the skills-building sessions peer supporters shared practical ideas and strategies for managing cases that require more than they have capacity to provide. These included:
- Having an up-to-date referral directory at hand
- Presenting cases to health providers for advice
- Asking the client which health provider they feel most comfortable with and arrange linkage

What Doesn’t Work

- Entirely taking Peer Supporters and their teams out of some project cycle components e.g. project identification, Planning, M&E, proposal development
- Absence of initial Peer Supporters training
- Unclear definition of their roles in the clinic

Role & Services

- Counseling: One on one or group counseling on adherence, SRH information, and providing support
- Information & education: Sharing health facts, health risks, and information, tool & material distribution
- Clinic services: Management of clinic flow, triage (weight, height, BMS and BP), filing information, assisting transfer to nurse stations, creating safe spaces & adolescent friendly corners
- Psycho-social support: Sharing youth, offering space (PRF), empowering & keeping youth engaged, providing psychological support, help with school & adolescent family issues

Beyond Peer Support

- Expose & sensitize health providers to adolescent concerns, barriers & experiences
- Provide helpful feedback on how service is experienced and how it can be improved
- Link A/YP/LHIV to network structures, youth-led activities & other services in the community

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Blessings Banda (WeCare) and Grace Ngulube (Zalewa Clinic) in Malawi presented on the nuts and bolts of peer support programmes, including programmatic pitfalls. Dennis Dube, Grassroot Soccer, presented on the 3 Cs (Coaches, Curriculum and Culture) highlighting the power of soccer and sport to educate, inspire, and mobilise youth to overcome their greatest health challenges, live healthier, more productive lives, and become agents of change in their communities.

3C Model: Principles

The 3C model combines a sports-based Curriculum, delivered by Coaches trained in youth mentoring, all within a supportive Culture that empowers young people as change makers.

WHY?

- **Curriculum**: SKILLZ curricula uses soccer as a “hook” through sport and play-based learning and discussion in order to engage adolescents and address their unique needs.
- **Coaches**: Young people need someone they can trust to provide critical life skills and SRHR education and build the confidence to access health services.
- **Culture**: Building a trusting and fun-spirited culture empowers young people and keeps them engaged, leading to deeper and more honest levels of discussion to provide crucial support and effectively link them to health and social services.
Differentiated service delivery

Refilwe Mafojane (Wits RHI) shared the Youth Care Club (YCC) model, a real-world example of differentiated service delivery. YCCs are health worker-managed and health facility-based groups for adolescents and young people living with HIV that provide integrated peer support, psychosocial support and clinical care.

3 stages of YCCs

1. Screening
2. Interactive discussion
3. Visit the nurse

YCC visits are made up of three stages:
- Stage 1: The YCC counsellor screens YCC members for tuberculosis, sexually transmitted infections, nutrition, psychosocial well-being and contraception use.
- Stage 2: The YCC counsellor facilitates an interactive, youth-focused discussion.
- Stage 3: The YCC counsellor gives pre-packed medication to all YCC members with a suppressed viral load while all other YCC members visit the YCC clinician for a fast-tracked consultation. Any YCC members who screen positive will also be directed to a counsellor or clinician as needed.

Power of support groups and counselling

Peer supporters attended skills-building sessions on two of their key activities, namely adherence counselling and support groups.

Nicholas Niwagaba (UNYPA) provided peer supporters with practical guidance and capacity-building around managing and facilitating support groups, which included:
- Meaningfully engaging young people throughout
- Having clear goals, norms and agreed values, with a common vision
- Ensuring transparent, fair leadership
- Making membership voluntary
- Sharing responsibility
- Finding an accessible meeting venue
- Emphasising and protecting confidentiality of sensitive issues shared
- Choosing discussion topics that are relevant to the priorities of young people
- Not letting sessions become repetitive, and rather shifting and changing content
- Thinking about who: differentiating support groups according to age, gender or how recently disclosed to, for example
- Ensuring everyone has a chance to talk
- Encouraging outside contact between members

"Share ownership with the group. Share responsibility. Ownership encourages commitment." – Nicholas Niwagaba, UNYPA
Adolescents and young people living with HIV can make a critical contribution as peer supporters.

Peer supporters play a unique role in clinics and communities across sub-Saharan Africa, improving linkage to care, adherence and retention, while increasing levels of disclosure and sensitising health providers. The role also provides opportunity for young peer supporters to learn new skills, attend meetings and trainings, decrease their own self-stigma and build confidence in themselves and the future.

Throughout the various presentations and skills-building sessions, several benefits and barriers to successful peer support were highlighted with recommendations on quality improvement areas made. Here is a summary of these discussions.

### Benefits and Recommendations

**Peer support models can be integrated within and between health facilities and the community.** Well-designed and implemented peer services can improve ART adherence, retention in care, virological suppression and psychosocial well-being. Engaging peers in service delivery through facility-based peer support models can reduce the burden on health workers by creating task-shifting opportunities. Peer supporters can model positive behaviours by demonstrating positive living while still having fun and connecting with peers, which can help to combat the negative effects of self-stigma and peer pressure.

Peer supporters can offer a range of services and activities that may include facilitating support groups, adherence counseling, health education, distributing IEC materials, data entry, home visits, assist with reception, bookings and follow-ups, accompany peers to services, treatment literacy support, pill counting and handling out of pre-packed ARV.

Peer supporters should be recruited from attending and adherent adolescents who are actively involved in support groups and are also:
- of legal working age and not older than 24 years
- virally suppressed
- openly living with HIV

Peer supporters require the following:
- A job description, contract with standardised guidelines and scope of work
- Pre-service and ongoing training, mentorship and skills development
- Ongoing supervision to clarify and coordinate tasks
- Psychosocial support
- Integration within the facility which includes being acknowledged in facility and being invited to staff/case meetings
- Access to IEC materials, necessary job aids and referral forms
- Training and ongoing orientation to protocols
- Fair remuneration and financial in-kind support to support travel and basic needs

Peer support models can be targeted specifically to key populations.

Reasons include restrictive legal and policy environments, stigma, discrimination, lack of awareness and inadequate funding or training. The needs of AYPLHIV are diverse and there is no one-size-fits-all model.

Increased operational research must be undertaken to determine standard operating procedures and guidelines as well as monitor and evaluate the impact of peer support on the overall health and well-being of their peers and on the quality of service delivery.

### Barriers

A significant time investment is required to train, mentor and provide on-the-job and psychosocial support as well as guidance for young peer supporters.

In surveys completed at the summit, more than a third (35%) of peer supporters reported undertaking tasks not in their job description on a daily basis. They provided examples, such as supporting adult patients and pre-packing medication. Thirty-eight percent reported regularly being required to perform tasks that they do not feel able or equipped to perform. These included recording vital signs such as blood pressure.

Some sentiments raised in the summit suggest that in some instances peer supporters are being taken advantage of, mistrusted and even exploited at some level. Peer supporters spoke about the various disadvantages resulting from not being formally employed, including not having paid leave.

Despite being highly cost-effective, funds for programme activities and financially supporting peer supporters with stipend or salary can be difficult to raise and maintain.

In surveys completed at the summit, more than half (55%) of peer supporters were not satisfied with the monetary stipend they receive. On average, peer supporters reported providing peer support for 58 hours per week (40% more than a standard 40-hour work week) with compensation varying and the average stipend being less than 50 USD per month, and in some instances amounted to less than 1 USD per hour. Almost all (93%) peer supporters said the monetary stipend is their only source of income. Forty percent (40%) of peer supporters reported having to use the stipend itself for conducting home visits.

The above outcomes indicate that peer supporters are burdened with much responsibility, work long hours and are prone to demoralisation, de-personalisation and burnout. Are we providing the necessary support?

The peer support role is transitory in that young people age out of the role and for many young people this is not a career choice.

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Self-care

Being a peer supporter should be rewarding and should lead to skills-building and livelihood strengthening opportunities. Yet fulfilling the role can be physically, emotionally and socially demanding. It is important for peer supporters to look after their own well-being to avoid emotional exhaustion, depersonalisation and burnout. Tinashe Rufuwa and Felicitus Ngubo (Africaid) led peer supporters in a skills-building workshop on self-care. The session focused on maintaining healthy boundaries with both clients and colleagues, and declining responsibilities that are beyond the peer supporter role as forms of self-care. Peer supporters in the session described their challenges, such as the emotional toll of witnessing peers adhering poorly and failing treatment and working very long hours. Some also described receiving inferior personal HIV care when providers began to see them as colleagues who need less care and support.

Tips for staying healthy and happy

- Starting antiretroviral treatment as soon as possible and sustaining it as part of your everyday routine is the best way of ensuring that your immune system stays strong.
- Exercising regularly, eating well, getting enough rest and quality sleep are all vital to maintaining your health.
- Your mental well-being is just as important as your physical health. Talking about your concerns with family, friends or a support group can really help.
- Do not take on what you cannot manage or what is not your responsibility.
- Make sure you take enough time off and time out.
- Reach out to colleagues who are down or are in need of support.
- Make sure you have regular supervision and debriefing.
- Remember that you can only look after others when feeling good and strong yourself.

Find more tips here.

Leaving nobody behind

Peer to Peer Uganda (PEERU) presented on the importance of ‘Leaving No Young Person Behind’, with a mission to implement strategic behaviour change, communication and interventions that address key issues related to SRHR and HIV among young people in Uganda. Moses Bwire (PEERU) described how peer support can reach and assist young people from key populations to access psychosocial support, promote referrals and linkages, sustain support groups within their communities beyond donor funded programmes and continuously advocate for safe spaces for young people.

The role of peer support in reaching YP from key populations

- To support fellow young people access psycho-social support.
- To promote referrals and linkages.
- To sustain support groups within their communities beyond donor funded programs in their communities.
- To continuously advocate for safe spaces for young people.

Moses Bwire, PEERU

- “The role of peer support is to continuously advocate for safe spaces for young people.”
- “We should not underestimate the power of peer education; it is stoppable if we utilise it in the right way.”
- “Key populations are key to both the dynamics of, and the response to, the HIV epidemic.”
The Power of Advocacy

The summit focused on the power of advocacy to drive programme change and policy improvement for youth.

One of the summit’s central messages was that young people must be empowered and equipped with knowledge, confidence and capacity in advocacy. Importantly, making small improvements in daily service delivery through highlighting barriers and offering solutions must not be discounted. It is this frontline advocacy undertaken by peer supporters every day that is shifting and improving the quality of services provided to adolescents and young people.

In surveys completed at the summit, almost all peer supporters (98%) considered themselves advocates. Advocacy activities included community outreach and awareness-raising, adolescent or youth representation on various platforms, and providing peer-to-peer education and support. Most felt they had a major (53%) or fair amount (41%) of influence on improving services. The majority (90%) reported they frequently inform health providers about challenges young people face or make recommendations on AFHS. Most (81%) reported that this led to service improvement. Respondents provided examples of changes resulting from their advocacy, including improvements in existing services and facility procedures, as well as additional services being introduced. One-on-one meetings (62%) were mostly used by peer supporters to raise issues, provide feedback and/or recommendations, followed by staff/case meetings (29%), and suggestion boxes (21%). These findings suggest that peer supporters understand themselves to be agents of change beyond their better-understood role of task-shifting and supporting service delivery. Young peer supporters report being advocates for their peers, who frequently leverage their experience to proactively raise issues, challenge existing practice, provide feedback and make recommendations. Peer supporters are well-placed to mobilise and facilitate community-level advocacy. Advocacy training should be integrated into peer support curricula to build skills and capacity to successfully effect change. Additionally, health facility staff should be orientated toward receiving feedback from peer supporters in a positive light, in a way that can inform and improve services. Finally, facilities should establish mechanisms to facilitate feedback and allow for intergenerational dialogue between peer supporters and health providers to better leverage their advocacy potential.

"Meaningful youth participation is not just about putting young people in leadership positions, but about reaching us to influence change. We need to have the capacity to create change." – Gladwell Muthoni, IAS Youth Champion

Who has the power?
- Who actually has the power to change things?
- Who has influence over them?
- How can we reach them?

Not all power is good power!

THE ACT! 2015 ADVOCACY TOOLKIT
Use this toolkit for your advocacy strategy

8 Steps To Be Taken In An Advocacy Campaign
1. Define the issue or problem you want to change
2. Set your priorities
3. Map your network
4. Pick your targets
5. Make your case and develop your key messages
6. Plan your activities
7. Reflect and review and apply lessons
8. Evaluate and measure your change

"We need to plan for advocacy. We should have advocacy targets.” – Dr Elizabeth Okoth, EGPAF

Mo Barry (HVLF) and Hayley Gleeson (IPPF) led young people in a skills-building workshop around youth leadership, advocacy and activism on the road to 2030. Their central messages included:
1. Advocacy works, saves lives, and changes communities
2. Anyone can be an activist and lead movements for transformational change at every level
3. Young people are the best drivers of change in the youth HIV/AIDS response

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Mercy Ngulube (IAS) drew attention to the structural barriers to an effective adolescent and youth HIV response, highlighting restrictive laws that require parental consent for adolescents to access SRHR, including HIV testing and linkage to treatment and care.

“Stigma and legal barriers continue to be bottlenecks that need advocacy and strategic approaches to solve. Partnerships are vital to ensuring we can bring about sustainable change.” – Ulrike Gilbert-Nandra, UNICEF Tanzania

Moses Bwire (PEERU) highlighted key population groups of young people living with HIV. He described the data limitations in these groups resulting in gaps on where and how best to provide support. This is made more complex amidst heightened stigma and discrimination towards young key populations when accessing SRHR services. Advocacy should focus on eliminating legal restrictions and discriminatory laws which limit service access, harmonising contradictory policies while calling for safer spaces for inadequately served young people, and most importantly, friendlier health services and trained staff who can provide stigma-free services and targeted community outreach.

“We must partner for meaningful youth participation. We are behind on targets and there are persistent challenges. There are structural barriers of stigma, discrimination, consent and access to sexual and reproductive health and rights.” – Mercy Ngulube, IAS

Elona Toska (Mzantsi Wakho) shared recent evidence that can help shape and prioritise our key advocacy messaging, that cumulatively have significant impact on adolescent retention in care. Emerging findings from Mzantsi Wakho and other datasets suggest that we should be advocating for:

- Social protection, such as child-focused grants
- Funds for transportation to the clinic
- Consistent ART supply
- Decentralization to primary care
- Caregiver monitoring and support
- Support groups, peer support and teen clubs
- AFHS and respectful health providers who spend time with clients

Cluver, Pantelic, Toska, Orkin, Casale, Bungane, Sherr (2018) JIAS.
A key theme to emerge throughout the three-day summit was how research and data needs to be utilised in order to shape advocacy work for AYPLHIV, as well as how to use data for better programming and advocacy. Data needs to be relevant, building evidence to advocate for treatment. We must ensure young people are driving the research agenda and are increasingly becoming research leaders.

Skills-building around how to use data for better programming and advocacy took place, with it highlighted that data shows that peer support models work. This data needs to be utilised to integrate peer support models into Ministries of Health district planning.

Community Adolescent Treatment Supporters (CATS) from Africaid Zvandiri also demonstrated how they use the Zvandiri Mobile Database Application to register, monitor and refer AYPLHIV.

Chengetai Dziwa (Frontline AIDS) focused on how to use data for better programming and advocacy, highlighting the central role that peer supporters can play in collecting and using data within their facilities, communities and beyond. During skills-building, peer supporters engaged in a Peer Supporter Café, and focused on questions such as “how can data for referrals, loss to follow-up, viral load and integrated services be used to inform programming and advocacy efforts?”

Viral load data was highlighted as a critical measurement that needs to be tracked regularly. The need for this data resulted in a commitment to action by young people: empowering and equipping ourselves and our peers with knowledge, confidence and capacity to advocate for access to comprehensive and holistic HIV services, including treatment and monitoring with regular viral load testing.

“One of our strongest advocacy points is that we need more and higher quality data; we need to demand better data for decision-making.” – Elona Toska, Mzantsi Wakho

Camille Wittesaele and Elona Toska (Mzantsi Wakho) used skills-building sessions to focus on the tools and skills needed to document the extent of HIV/SRHR service integration at health facilities, while supporting participants to explore ways to measure successes and areas for improvement of integration using data.

“There is need for viral load data to advocate for decision making.” – Elona Toska #PATA2018YouthSummit #READYtoAct #WeAreREADY @teampata @MzantsiWakho

Youth Summit Report 2018
Youth leaders and networks

“We know where the gaps are, and we can speak up and advocate for these, so our health facilities are well-staffed, well-resourced and can serve children, adolescents and young people well.” – Kelvin Makura, Y+.

The HIV youth response must be informed by the voices and choices of young people. For this to happen effectively, young people should be supported to effectively organise, mobilise and structure themselves as networks. Network structures must represent the most important issues of young people, be accountable to their constituents and coordinate well with one another to speak with one voice.

The summit created opportunity for networks of AYPLHIV operating at various levels to reflect on the extent to which they ensure that peer supporters and other local network members participate in their structures and decision-making processes. We workshoped how networks can effectively link to one another, coordinate and undertake collective advocacy better together.

Networks shared challenges in working together and remaining accountable to their memberships. A major focus of the discussions was the breakdown in coordination and effective communication between the global, regional and national networks in Africa. Without these linkages and harmonisation, opportunities for collective advocacy and joint resource mobilisation are being missed, and there is a risk of regional and global networks not effectively representing the voice of their constituents.

The outcome of capacity scans taken at different points of time, designed by PATA, Aidsfonds, Frontline AIDS, Y+ and AY+, and undertaken of several network was presented by Nadege Munyaburanga (AY+). The scans utilised a self-assessment tool to identify capacity strengths and challenges of national networks of AYPLHIV that were discussed during network meetings at the summit.

“Many youth networks are entirely run by volunteers who have no salary but instead receive stipends.” – Nadege Munyaburanga, AY+.

Networks shared the following challenges in trying to secure resources:

- Lack of trust and reluctance of some donors to invest in youth networks due to concerns around the networks’ capacity to manage resources and programmes
- The large number of network structures dilute the potential funding pool
- Insufficient capacity within youth networks to draft funding proposals, manage funds and monitor and evaluate activities
- Lack of transparency and accountability within some networks, making the donor investment higher risk

Opportunities:

- Human resources: provision of TA, in-sourcing human resources with tangible skills and competencies that will support the network to fulfill key functions in the network instead of outsourcing to third parties
- Increased flexibility to understand and develop the set of skills and competencies necessary to run networks
- Incorporating mentorship programs that expand skills and capacities within networks/organizations
- Governance: Capacity development for governance structures within AYPLHIV networks would support YPLHIV understand their roles and responsibilities
- Project and Financial Management: Supports resource mobilisation and eventual transition out of the YPLHIV world
- Increased flexibility to understand and develop the set of skills and competencies necessary to run networks

One of the issues raised was that young people living in smaller cities and rural communities struggle to access youth networks and have their concerns and voice effectively heard and represented. However, a range of opportunities were also unpacked, showing the potential that exists for youth networks.
Health providers as youth advocates

Dr Elizabeth Okoth (EGPAF) described how health providers can very effectively advance the SRHR of adolescents and young people, increase meaningful youth participation and ensure the rights of all clients are upheld. Beyond shaping the experience of services for young people, health providers themselves can and should be stronger and more vocal advocates within the health system, driving change and service improvements for adolescents and young people from within, and always leading by example.

Advocacy: Provider Perspective for HIV services

- Capacity to spend time with clients & available support services
- Sensitivity to the HIV care /SRH needs by age, developmental stage & diversities (integration / specialized / right package / Timing & space)
- Development of trust and long-term relationship with the client & caregiver
- Innovation & Contributing to evidence of what works for AYP
- Empowering AYP / Caregivers
- Advocacy for the client beyond healthcare system
- Inclusive and strategic partnership for effective advocacy

Advocacy in action at the summit

Social media platforms were harnessed throughout the PATA 2018 Youth Summit to drive key advocacy messages and facilitate linking and learning beyond the physical forum to health providers, peer supporters and partners in other countries.

Tinashe Rufurwadzo (Africaid) was key to this momentum, hosting daily Facebook live interviews on PATA’s Facebook page to summarise the day’s key messages and foster knowledge transfer to a wider audience. Tinashe also utilised Twitter and Instagram throughout the three-day summit, boosting PATA’s content and disseminating his own, including on Zvandiri Radio. This created further momentum in the READY Movement, bolstered by Frontline AIDS’s presence and commitment to sharing key advocacy messages and lessons on its own social media platforms.

The IAS Youth Champions, who launched a new youth-led chapter in the Activist Toolkit on Differentiated Service Delivery at the summit, were quick to share advocacy highlights on their social media platforms.

This live digital advocacy action resulted in over 35 accounts tweeting organically about the summit, utilising the relevant hashtags, with an estimated 42,492 accounts reached. Collectively these contributed to the Youth Summit Commitments to Action.

#PATA2018YouthSummit
#PeerPower
#WeAreREADY
#READYtolead
#NothingForUsWithoutUs
#FreshVoicesMakingChoices
#WhatWorksForUs
Intergenerational Dialogues and Concluding Remarks

A success of the PATA 2018 Youth Summit was the intergenerational dialogues. These safe spaces were established daily throughout the summit, and served as an opportunity for knowledge sharing, as well as sharing one another’s perspectives with someone from another participant group, where challenges and key lessons could be discussed in a solutions-seeking way. This dialogue and engagement helped build bridges of understanding between participant groups of peer supporters, health providers, networks of YPLHIV, policy-makers, partner organisations and official ministry representatives throughout the summit. During sessions participants were encouraged to vote on key areas that had emerged which they wanted prioritised. Participants voted on priority areas during the summit, this led to the development of Youth Summit Commitments to Action.

Daily intergenerational and multisectoral dialogues culminated in the final panel discussion of the summit, chaired by Consolata Opio (Y+). The final panel discussion included participant and key stakeholder groups including the Tanzanian Ministry of Health’s Dr Mastidia Rutaihwa – policy-maker; Sister Spiwe Gumbo (United Bulawayo Hospital) – health provider; Gladwell Mwaura (IAS Youth Champion) – a young person; Mo Barry (HYLF) – youth leader and advocate; Dr Patrick Oyaro – health provider; and Nienke Westerhof (Aidsfonds) – donor and partner organisation. Discussion was facilitated around central questions related to themes emerging from the summit.

Key outcomes of the final panel discussion and intergenerational and intersectoral dialogues can be summarised as follows:

- Integrated services are those that are provided in the right place, right time and in the right way and that are convenient and respectful of young people.
- There is an urgent need for primary healthcare systems to be strengthened, especially as we are all tasked to deliver on Universal Health Coverage.
- Legal and service level reforms are needed so that young key populations can access stigma-free service safely.
- Peer support must be recognised as a vital strategy for adolescents and young people in the HIV response, with discussions on the panel questioning the feasibility of this cadre being integrated or fully recognised in the health system without the support of local implementing partners and donors.
- Far greater investments are needed for the capacity-building, mentorship and fair remuneration for youth leaders, youth networks and peer supporters.
- Importantly, implementing partners, donors and policy-makers are to be monitored and held accountable to their commitments on meaningful youth participation. Young leaders must also take greater responsibility in mentoring those that will follow so that we keep growing and developing leaders of tomorrow.
- It was agreed that partners should be working in harmony with one another, rather than competing for scarce resources, with partners cooperating to accelerate the delivery of services and aligning advocacy efforts as we are all involved and working towards achieving the same goal.

Jeroen Verheul, Dutch Ambassador to Tanzania, Madagascar, Mauritius and the Comoros, provided the closing remarks at the summit, thanking PATA and Y+ and acknowledging the READY+ movement. He called attention to the Power of Partnerships, highlighting the value that both young people and older people can bring to an intergenerational space. He challenged participants to leverage the wisdom and experience of older generations and build upon the new ideas and enthusiasm that youth bring in a joint commitment and strong partnership to end AIDS.
Recognised at the summit

While every individual who attended the summit deserves acknowledgement for their commitment to #PeerPower, the following were formally awarded at the meeting:

We thank our previous YAP for their dedication and hard work and look forward to working together with the new representatives.

Health facilities showing a commitment to #PeerPower and the delivery of Adolescent friendly health services

Mulago COE ISS Clinic, Uganda
United Bulawayo Hospital, Zimbabwe

In addition, our WOW Awards were fun and funky tokens of acknowledgement and recognition for the many WOW participants, from those who had the most energy, the movers, the shakers, the early birds, the night owls and the social media gurus! A very big THANK YOU to you all!

Election of new PATA Youth Advisory Panel

The 2019-2021 PATA Youth Advisory Panel (YAP) was elected at the summit. The panel is elected by their peers every two years, with male and female representation from Southern, East and West/Central African regions.

The new YAP consists of the following representatives:

**EAST AFRICA**
Shafah Kyomukama
Edwin Moses Rutatina

**CENTRAL/WEST AFRICA**
Ndiffo Ange Mireille
Ariel Sharon

**SOUTHERN AFRICA**
Grace Ngulube
Phakamani Moyo

We thank our previous YAP for their dedication and hard work and look forward to working together with the new representatives.

Summit Evaluations

The summit received positive evaluative feedback. All participants reported their summit experience to be ‘good’ or ‘excellent’. Ninety-eight percent of participants said attending the summit was ‘worthwhile’, and that they would want to come to a summit again.

Participants felt the summit promoted skills-building and leadership capacity for peer-led AFHS (96%); promoted dialogue between peer supporters, health providers, networks and key partner organisations (90%); and assisted in strengthening linkages between peer supporters, and national, regional and global network structures of young people living with HIV (90%).

Participants also reported that the youth summit was a good platform to learn from each other. And their only regret was that there was not enough time for discussion and Q&A. Skills-building sessions ideally could have been longer and of course, everyone wanted more time to engage with each other and share challenges and success stories.

I was able to learn from and share with peers operating in the same role as myself

I was able to learn from and share with peers from other health facilities

"The summit was empowering and gave me the morale to continue advocating." – Peer supporter, country unknown

"I will improve the way I manage the young people with HIV as I learnt they need love, care, and protection, and they need to be heard." – Health provider, eSwatini

"I will try to be less judgemental to adolescents and inform other colleagues on the importance of providing friendly services to clients to improve the uptake of services and retention into care." – Health provider, Zimbabwe

"We are very grateful to all who joined the summit, especially the many young people who were READY to lead from get-go." – Luann Hatane, PATA
Thank you for celebrating #PeerPower with PATA and Y+

Ultimately, the PATA 2018 Youth Summit was an opportunity to celebrate and have fun together in a linking and learning space. The programme provided for daily soccer and volleyball on the beach, with many participants enjoying the wonders of swimming pool to cool off at the end of the day. The celebratory dinner and WOW Awards acknowledged the incredible effort made by each and every participant, while creating a space for connection and fun after three productive days.

Youth Summit Commitments to Action

We, the young people gathered at the PATA 2018 Youth Summit, join our voices and efforts to uphold a series of commitments to action. We recognise the importance of working collectively, across national and generational boundaries, and in partnership with health providers, governments, donors, policy makers and civil society to achieve the 90-90-90 targets. Together, we have the power and responsibility to participate actively in the change we desire. As young leaders, we amplify our pledge to serve and represent our peers. It is in this unified spirit that we commit to:

1. Supporting adolescent-friendly and youth-centred, non-discriminatory, stigma-free, integrated HIV and sexual reproductive health and rights services that are free and available to all young people in their diversity
2. Empowering and equipping ourselves and our peers with knowledge, confidence and capacity to advocate for access to comprehensive and holistic HIV services, including treatment and monitoring with regular viral load testing
3. Recognising young people as equal and accountable partners in the HIV response, where mechanisms and platforms that enable meaningful youth participation are supported, strengthened and provided at all levels of programming and policy development
4. Being active and equal partners in our own health as well as informing and leading programmes and services that affect us
5. Acknowledging the efforts of frontline health providers and collaborating with them as partners in our health and as central youth advocates
6. Advocating for the provision of training, tools and guidance for frontline health providers so that they may deliver services that are sensitive, client-centred and responsive to the needs of adolescents and young people living with HIV
7. Promoting peer support as a vital intervention for adolescents and young people in the HIV response that must be adequately resourced and reported against
8. Advocating for greater investment in peer supporters’ long-term capacity building, mentorship, career progression and fair remuneration
9. Creating safe spaces for our peers that are context-specific and provide psychosocial support in an environment of trust, privacy, and confidentiality
10. Increasing attention to adolescent mental health with improved screening at health facilities
11. Establishing and investing in clinic-community partnerships for holistic collaboration, comprehensive development and a linking to the broader community where the needs of young people can be situated in the broader context of the SDGs
12. Holding national governments accountable in prioritising services that are targeted for hyper-vulnerable and inadequately served youth and young people from key populations
13. Driving programme and policy decisions that are informed by data that is age- and gender-disaggregated, and is accessible and disseminated to frontline providers to inform daily practice and decisions
14. Investing in the growth and development of youth leadership, while making space for succession and emerging youth leaders
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