#READYTogether

Integrating HIV & SRHR through Clinic-Community Collaboration

PATA 2019 SUMMIT

16-18 October 2019
Johannesburg, South Africa
Thanks and acknowledgements

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Acronyms

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<th>Description</th>
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<tbody>
<tr>
<td>ABCD</td>
<td>Ask, Boost, Connect, Discuss</td>
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<tr>
<td>AFHS</td>
<td>Adolescent-friendly health services</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>AVAC</td>
<td>AIDS Vaccine Advocacy Coalition</td>
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<td>AYP</td>
<td>Adolescents and young people</td>
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<td>AYPLHIV</td>
<td>Adolescents and young people living with HIV</td>
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<tr>
<td>C^2</td>
<td>Clinic-Community Collaboration</td>
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<tr>
<td>CANGO</td>
<td>Coordinating Assembly of NGOs</td>
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<td>CATS</td>
<td>Community Adolescent Treatment Supporters</td>
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<td>CBO</td>
<td>Community-based organisation</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CTO</td>
<td>Community Treatment Observatory</td>
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<td>DTG</td>
<td>Dolutegravir</td>
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<tr>
<td>DTHF</td>
<td>Desmond Tutu HIV Foundation</td>
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<td>EGPAAF</td>
<td>Elizabeth Glaser Pediatric AIDS Foundation</td>
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<tr>
<td>eMTCT</td>
<td>Elimination of mother-to-child transmission</td>
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<tr>
<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<tr>
<td>FACES</td>
<td>Family AIDS Care and Education Services</td>
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<tr>
<td>FTT</td>
<td>Find, Test and Treat</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GNP+</td>
<td>Global Network of People Living with HIV</td>
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<td>IAS</td>
<td>International AIDS Society</td>
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<tr>
<td>ICAP</td>
<td>International Center for AIDS Care and Treatment Programs</td>
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<tr>
<td>ITPC</td>
<td>International Treatment Preparedness Coalition</td>
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<tr>
<td>LGBTQI</td>
<td>Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex</td>
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<td>LILO</td>
<td>Looking In Looking Out</td>
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<td>LL</td>
<td>Leading Louder</td>
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<td>LTFU</td>
<td>Lost-to-follow-up</td>
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<tr>
<td>MOE</td>
<td>Ministry of Education</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>PACF</td>
<td>Positive Action for Children Fund</td>
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<td>PATA</td>
<td>Paediatric-Adolescent Treatment Africa</td>
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<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
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<td>REACH</td>
<td>Re-Engaging Adolescents and Children with HIV</td>
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<td>READY+</td>
<td>Resilient Empowered Adolescents and Young People</td>
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<td>REPSSI</td>
<td>Regional Psychosocial Support Initiative</td>
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<td>SAfAIDS</td>
<td>Southern Africa HIV and AIDS Information Dissemination Services</td>
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<td>SANAC</td>
<td>South African National AIDS Council</td>
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<td>SAT</td>
<td>SRHR Africa Trust</td>
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<td>SRHR</td>
<td>Sexual Reproductive Health Rights</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>TAP</td>
<td>Technical Advisory Panel</td>
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<td>UBII</td>
<td>Unfinished Business</td>
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<tr>
<td>UTT</td>
<td>Universal Test and Treat</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>Y+</td>
<td>Global Network of Young People Living with HIV</td>
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<td>YPLHIV</td>
<td>Young People Living with HIV</td>
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Executive Summary

The PATA 2019 Summit titled READY together! Integrating HIV and SRHR through Clinic Community Collaboration brought together over 200 participants from the 16-18 October 2019 in Johannesburg South Africa. The summit focused on three themes – #READY to Integrate HIV and SRHR Services, #READY to Reach and Serve All and #READY for Clinic-Community Collaboration.

The summit provided an overview on progress and shortfalls against the HIV prevention, treatment and care targets for adolescents and young people. The #READY to Integrate HIV and SRHR Services on day one focussed on showcasing comprehensive, person-centred service delivery models that integrate clinical and psychosocial care and support. The power of partnership and the role of community-based support and meaningful involvement of young people was highlighted as a central- and cross-cutting theme. Emphasis was placed on adolescent and youth-friendly service delivery – hearing young people’s voice and offering choice.

Central to HIV and SRHR integration is ensuring that we leave nobody behind. The #READY to Reach and Serve All theme of day two addressed the challenges faced by young people who are most marginalised in accessing treatment and care. Attention was drawn to experiences of young key populations and young mothers living with HIV together with the need to reach young men and boys in the HIV response and SRHR programming. Policy and legal barriers that impede access and HIV and SRHR service delivery were highlighted together with strategies to challenge or mitigate. Models presented addressed mental health support to young mothers, adolescent friendly differentiated services with a strong reminder on the importance of prevention and expanding access to pre-exposure prophylaxis (PrEP). Schools and community-based programmes were shown to be effective entry points to reach young people, particularly those marginalised in traditional health settings. Day two confronted stigma as a persistent barrier to service delivery and emphasized the urgent need for health providers to be supported and held accountable in offering non-judgemental and youth-friendly services, and making safe spaces available in both clinic and community settings.

Integrated HIV and SRHR services will only be possible through partnership. The #READY for Clinic-Community Collaboration theme discussed integration across the prevention and treatment cascade with clinics and community-based organisations working together in a coordinated and effective manner. The role and leadership of young people on the frontline was recognised together with the importance of self-management of care. Models presented included community involvement and shared accountability mechanisms to share and analyse data as part of an ongoing service delivery quality improvement cycle. Models and case studies demonstrated joint planning, implementation, coordination and evaluative processes between the clinic and community-based implementing partners. Day three identified the key elements for building positive and effective clinic and community partnerships.

The summit provided a dynamic and productive linking, learning and networking platform to examine progress and feature service delivery models that are effectively crossing divides, building bridges and breaking barriers in HIV and SRHR service delivery, linkage and community engagement.
The PATA 2019 Summit was co-hosted by PATA, Frontline AIDS and the Resilient Empowered Adolescents and Young People (READY+) programme. It was coordinated through a Summit Working Action Group (SWAG).

Paediatric-Adolescent Treatment Africa (PATA) is an action network of multidisciplinary teams of frontline health providers caring for children and adolescents living with HIV. PATA’s mission is to mobilise, strengthen and build resilience in a network of health providers, facilities and communities on the frontline of paediatric and adolescent HIV service delivery in sub-Saharan Africa. PATA’s vision is that all children and adolescents living with HIV in sub-Saharan Africa receive optimal treatment, people-centred care and support and live long, healthy lives.

READY+ seeks to ensure that adolescents and young people living with HIV are resilient, empowered and knowledgeable and have the freedom to make healthier choices and access services and commodities related to their sexual and reproductive health and rights. READY+ aims to advance sexual and reproductive health rights (SRHR), psychological wellbeing, care and treatment with, by and for 30,000 adolescents and young people living with HIV (AYPLHIV) in Mozambique, Eswatini, Tanzania and Zimbabwe. READY+ is a consortium led by Frontline AIDS and includes PATA, REPSSI, M&C Saatchi World Services (Saatchi), Y+, CANGO and Africaid Zvandiri.

The summit offered a powerful linking and learning platform for the growing READY movement. The summit facilitated regional collaboration, skills building, and peer-to-peer exchange – closing gaps and building bridges. #READYTogether!
The PATA 2019 Summit

The PATA 2019 Summit entitled READY Together! Integrating HIV and SRHR through Clinic-Community collaboration was held from 16-18 October 2019 in Johannesburg, South Africa.

The PATA 2019 Summit reached 214 frontline providers across 17 countries, with 59 health facilities and 49 implementing community-based partners. Ministry of Health representatives, policy-makers, partners and donors from Cameroon, Democratic Republic of Congo (DRC), Eswatini, Kenya, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

The PATA summit methodology leveraged participation and contribution from several PATA programmes namely: Resilient Empowered Adolescents and Young People (READY+), Re-Engaging Adolescents and Children with HIV (REACH), Clinic-Community Collaboration (C³), Leading Louder (LL), Ask, Boost, Connect, Discuss (ABCD) and Unfinished Business (UBII).

“Collectively across the READY, REACH, C³, and UB II programmes more than 290 000 children and adolescents are accessing antiretroviral therapy (ART). This is remarkable and constitutes nearly one third of all children and adolescents on treatment. This is however a sobering reminder and call to action that still, out there, today only half the children and adolescent requiring ART in the world are able to access this life-saving treatment.” – Luann Hatane, PATA

PATA 2019 Summit in numbers

#READYTogether

# of Children and Adolescents on ART at health facilities attending the PATA 2019 Summit:
295,564

# of countries represented:
17

# of health facilities represented:
59

# of participants:
214

# Partnering Organisations attending/participating:
49
The PATA 2019 Summit READY to:

- review progress and share lessons, skills and models in HIV-SRHR service integration
- prioritise service delivery and be accountable
- reach, engage and deliver stigma-free services to all
- cross divides and build bridges
- prioritise self-care and reflective practice
- amplify voices and offer choices

PATA summit methodology

The summit methodology has been refined over 14 years of bringing stakeholders together in summits and forums to build regional action around paediatric and adolescent HIV treatment, care and support. PATA’s tried and tested ‘link and learn’ approach is well recognised and valued in the sector. The PATA methodology provides a platform and springboard to those on the frontline of service delivery to network, share promising practices, develop service delivery improvements, build capacity, access guidance and technical input whilst offering a safe space for inter-generational and inter-sectoral dialogue that links local practice to policy making.

The PATA 2019 Summit employed a similar methodology to previous summits building upon the theme of integrating HIV and SRHR through clinic-community collaboration. Cross-cutting themes across the summit emphasised adolescent-friendly health services ‘AFHS’, ‘stigma free services’, ‘peer power’, ‘safe spaces’ and resilience and wellbeing. The summit was designed over three days under the theme of #READY Together! Day one was titled #READY to Integrate HIV and SRHR Services, day two #READY to reach and serve all, and day three, #READY for Clinic-Community Collaboration.
PATA 2019 Summit

**DAY 1**
#GetREADY4Integration

- SCENE SETTING
- TEA
- AFRICA CAFE
- SKILLS BUILDING
- LUNCH
- SKILLS BUILDING
- TEA
- MARKET PLACE & NETWORKING

**DAY 2**
#READY2StandUp2Stigma

- SCENE SETTING
- TEA
- AFRICA CAFE
- LUNCH
- SKILLS BUILDING
- TEA
- LEKGOTLA
- MARKET PLACE & NETWORKING

**DAY 3**
#ClinicCommunity Collaboration

- SCENE SETTING
- TEA
- AFRICA CAFE
- LUNCH
- SKILLS BUILDING
- TEA
- LEKGOTLA
- CLOSURE
- DINNER & AWARDS
#READY to Integrate HIV and SRHR Services

Setting the scene

Adolescents and young people (AYP) account for an estimated 45% of new HIV infections worldwide, with young women disproportionately affected. Sub-Saharan Africa is home to 70% of all new HIV infections among adolescents and young people. Approximately 1.2 million of the 1.6 million (75%) adolescents living with HIV in the sub-Saharan region are living in Eastern and Southern Africa. At a time when HIV-related deaths are decreasing in all other age groups, HIV remains the leading cause of death among adolescents aged 10-19 years in Africa yet only half of the adolescents who require ART, access this life-saving treatment and those who have access face many barriers to long-term retention in care.

Restrictive laws and policies, together with persistent poverty, inequality, patriarchy, limited access to health facilities, lack of political will, and cultural, religious and institutional discrimination remain major barriers to realising rights and ensuring choice for AYP. While HIV and poor sexual and reproductive health share common root causes, the respective service delivery and implementation of policy for each remain poorly aligned, insufficiently coordinated and under-resourced, especially for AYP.

3 Jessica Rodrigues. Let’s Not Forget Prevention in Clinic and Community Collaboration PowerPoint presentation AVAC.
START FREE STAY FREE AIDS FREE

“The failure to reach the 2018 targets to reduce new HIV infections among children and adolescents and to widen access to life-saving treatment is both disappointing and frustrating … We need to act quickly to turn this situation around and honour the commitment to end the AIDS epidemic for the next generation.” – Gunilla Carlsson, UNAIDS Executive Director

Missing the targets:

The Start Free Stay Free AIDS Free framework challenges countries to implement high priority interrelated evidence-informed actions to reach ambitious targets for 2018 and 2020. The 2018 global data show that progress is occurring — but far too slowly.


<table>
<thead>
<tr>
<th><strong>Target 2020</strong></th>
<th><strong>Progress 2018</strong></th>
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<tbody>
<tr>
<td>Reduce the annual number of children newly infected with HIV to fewer than 40 000 (and to fewer than 20 000 by 2020)</td>
<td>160 000 [110 000-260 000] 5</td>
</tr>
<tr>
<td>Reduce the annual number of adolescent girls and young women aged 10-24 years acquiring HIV to fewer than 100 000</td>
<td>310 000 [190 000-460 000] – this is 6000 per week, down from 8000 per week in 2010 and 7000 per week in 2015 5</td>
</tr>
<tr>
<td>Provide 1.6 million (approximately 95%) children aged 0-14 years living with HIV with antiretroviral therapy</td>
<td>937 000 [824 000-974 000] [54% [37–73%]) children aged 0-14 years were receiving antiretroviral therapy – this represents over half of all children living with HIV in 2018 compared to 20% in 2010</td>
</tr>
<tr>
<td>1.2 million adolescents aged 15-19 years living with HIV with antiretroviral therapy</td>
<td>Global estimates of ART coverage among adolescents aged 15-19 years living with HIV were not available for 2018. Many countries are not reporting the number of adolescents aged 15-19 years receiving antiretroviral therapy. In 2018 only 55 countries reported these data through the Global AIDS Monitoring tool 5</td>
</tr>
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4 Schermbrucker, K and Brune, A. Treating HIV-positive children with speed and skill. 2019. UNAIDS.
Welcome

The first day of the summit addressed the integration of HIV and SRHR services. Luanne Hatane from PATA and Tinashe Rufurwadzo from Y+ provided an overview and welcomed participants. Mapaseka Steve Letsike from the South African National AIDS Council (SANAC) and Access Chapter 2 provided the official welcoming and opened the 2019 PATA Summit.

“It is these spaces that give birth to new ideas and service delivery improvements that we can take home to implement, monitor and document.”
- Luann Hatane, PATA

“Efforts around prevention, treatment and access to services rely on integration of HIV and SRHR through clinic and community-based approaches so the theme of the summit is both relevant and timely.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2

Regional Update on adolescent HIV: Progress and priority actions

Dr Mariame Sylla, UNICEF

The regional update recognised that progress has been made in prioritising AYPLHIV. AYPLHIV have been integrated into global and national budgets and plans, more data has been generated, and there have been notable increased levels of youth-led advocacy and participation. Despite this progress, commitments and targets have however not been met.

“There is a need to put AIDS back on the agenda along with financial investments that reach communities in order to achieve the 2030 goals that have been set.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2

“Waiting for results.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2

“Prevent, care, treat, support, advocate.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2

“Having a stronger community allows us to reach the last one.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2

“End Aids and Sickle Cell together.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2

“Let’s prioritise AYPLHIV.”
- Mapaseka Steve Letsike, SANAC/Access Chapter 2
Fast facts:

- Adolescent girls continue to be more affected than boys
- Testing gaps among boys remain, with only 12% of boys testing and 22% of girls testing
- Around half of adolescents are sexually active, but young people continue to have low levels of knowledge of HIV prevention and contraception
- Adolescents are more likely to have unprotected sex and one in five young people reported engaging in transactional sex
- Adolescents have the highest lost-to-follow-up (LTFU) rates and do not know where or how to access services
- 15-19-year-olds have the lowest rates of viral suppression
- Many girls and young women are having children. Younger mothers have lower rates of prevention of mother-to-child-transmission (PMTCT) uptake and higher rates of mother-to-child transmission
- Studies have shown high rates of depression among AYPLHIV which contributes to negative outcomes at each stage across the HIV cascade
- Studies have found that sub-Saharan Africa accounts for 9 in 10 of adolescent AIDS-related deaths

New infections among adolescent boys and girls (10-19 years old): 2010-2018 Eastern and Southern Africa (ESA)

New HIV Infections amongst Adolescent Boys and Girls (10-19 years old): 2010-2018, ESA

Data Source: UNAIDS Estimates, July 2019

Dr Mariame Sylla, Regional Update on adolescent HIV: Progress and priority actions’ PowerPoint presentation, UNICEF
HIV and SRHR integration for adolescents and young people: Are we delivering?

Georgina Caswell, GNP+

AYP need to be provided with choice, quality, affordability and ease of use when integrating HIV and SRHR services. Services need to be responsive to the individual needs and circumstances of the young person. Offering multiple services in one place has the benefit of saving time and money as young people don’t have to travel to multiple destinations. In addition, one-stop services simplify the health system, can reduce stigma and discrimination, and be a better use of scarce human resources. The integration of HIV and SRHR at facility level supports adolescent-friendly service delivery in that it streamlines services for adolescents and young people.

“We want adolescents to get all the services they need in one place, ideally in one visit, or through linkages and facilitated referrals.”
– Georgina Caswell, GNP+

“Sex is often fun, and a young person wants to have sex for pleasure and fun. We need to listen to adolescents and young people from that perspective and support them to make it safer.”
– Georgina Caswell, GNP+
What does an integrated package of care look like?

1. **SRHR and HIV prevention**
   - HIV testing and counselling
   - Condoms and negotiation skills
   - Contraception
   - STI screening and treatment
   - Harm reduction services
   - Antenatal care, safe delivery and postnatal care
   - Cervical and breast cancer screening
   - Post-violence care, including post-exposure prophylaxis
   - Safe abortion and post-abortion care
   - PrEP

2. **HIV and other treatment**
   - ART
   - Viral load and CD4 monitoring
   - Adherence support
   - Managing side effects
   - Prevention of vertical transmission services
   - Ol screening and treatment
   - Hep B screening and vaccination
   - Hep C screening and treatment

3. **Care and support**
   - Psychosocial support
   - Mental health screening and management
   - Disclosure support
   - Support groups and networks of adolescents living with HIV
   - Shelter and nutritional support
   - Lifeskills development, vocational training and education
   - Legal information and services
   - Violence prevention and support
   - Support for caregivers

To support integration, a number of resources were shared including the SRHR and HIV Linkages Toolkit (toolkit.srhhivlinkages.org) which looks at HIV and SRHR bi-directional linkages at the policy, systems, and service-delivery levels and identifies current critical gaps in policies and programmes.

**Priorities highlighted in the regional update:**

- There is a need to scale up services and programmes that are informed by data
- National programmes need to be galvanised to ensure that there is effective implementation
- NGOs have experience that can support national programmes – communities make a difference!
- Service provider and implementer capacity needs to be built to reach all adolescents
- Improved coordination responses between relevant ministries charged with care of adolescents and young people living with HIV is needed
- Policies and operational tools that promote integration need to be implemented
- Build leadership of young people living with and most affected by HIV – it is important to partner with young people, youth networks and youth organisations
- Establish clear mechanisms and pathways of linkages and referrals
- Ensure that the needs of the most marginalised are being met

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7 Georgina Caswell, HIV-SRHR integration for adolescents and young people: Are we Delivering?, PowerPoint presentation, CNP+.
Delivering integrated HIV and SRHR services through partnerships: models that are promising and scalable

PATA summits have continuously promoted meaningful and effective partnerships. There is an increased chance of success with a greater impact when partnerships are formed that pool and share resources, experience, skills and information. Partnerships in integrating HIV and SRHR services will contribute to overcoming service-level barriers.

The Africa Café presentations highlighted that linking HIV and SRHR is important to make services accessible, friendly, responsive and comprehensive for young people. Linking HIV and SRHR services leads to better HIV testing outcomes; improves quality of care; enables better use of scarce human resources for health; has the potential to reduce HIV-related stigma and discrimination; and improves coverage, access to, and uptake of both SRHR and HIV services for at risk and vulnerable populations.
<table>
<thead>
<tr>
<th>Organisation/Partnership</th>
<th>Model</th>
<th>Programme</th>
<th>Results</th>
<th>Key lessons</th>
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<tbody>
<tr>
<td>READY+</td>
<td>Delivering integrated HIV-SRHR services through partnerships</td>
<td>- Trained AYPLHIV as peer supporters, known as Community Adolescent Treatment Supporters (CATS) Trained caregivers and health providers on SRHR  - Contributed to quality improvement at facility level  - Addressed stigma at community and facility level  - Held decision-makers accountable</td>
<td>- 353 CATS trained  - 18,431 AYLHIV accessed one to one peer support  - 76% of CATS reported feeling supported by implementing partners and health providers  - 207 health providers trained</td>
<td>- Training YPLHIV builds leadership and advocacy skills  - Integrated and coordinated youth friendly services in the clinic and community encourage improved uptake and utilisation of services by AYPLHIV</td>
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<td>Mildmay Uganda</td>
<td>Providing adolescent SRHR services as a one-stop-shop</td>
<td>- Developed age appropriate information sessions and formed support groups to address changing SRHR needs  - Set up a call centre  - Offered comprehensive package of services  - Trained LGBTQI focal persons</td>
<td>- 98% retention in care  - 90-94% viral load suppression</td>
<td>- A one-stop shop service meets the needs of AYPLHIV  - Differentiate services by age  - Educate and counsel caregivers  - Young people need a self-selected support person to disclose to  - Building trust with young people improves uptake of services</td>
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<tr>
<td>MSF South Africa</td>
<td>Integrating clinical and psychosocial care using Youth Care Clubs</td>
<td>Formed community-based youth care clubs where YPLHIV access ART information and support</td>
<td>- Of 86% of members who had a viral load test, 98% were virally suppressed  - Decongested health facilities  - Built clinic community collaboration</td>
<td>- Retention in care is enhanced with a buddy system and WhatsApp group  - Clubs outside of health facilities appeal to young people  - Retention is enhanced when the topics addressed are relevant and relatable to young people  - Sustainable as done in partnership with the Department of Health</td>
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**Key resource:**

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8 Felisitas Ngubo. READY+ model: Delivering integrated HIV-SRHR services through partnerships. PowerPoint presentation. (AfriCaid Zvandiri)
"Psychosocial support is a vital component of SRHR services and some of it can be provided via youth club models. Young people want to be listened to and support is needed."

– Pumeza Runeyi, MSF
Delivering integrated HIV and SRHR services through partnerships: skills building

Delivering counselling and consultation for choice: optimising contact time with AYPLHIV

Working with AYP on HIV and SRHR integration can be complex as it can be influenced by service providers culture, religion, personality, history, value system and other factors. These can lead to services that are influenced by service providers personal judgements of behaviour that they deem acceptable or appropriate. The approach of the service provider can make a young person feel stigmatised, which inhibits openness and access to services. Service providers are not always trained and supported to address difficult issues related to gender, sexuality and rights or taught how to offer services that are confidential and non-judgemental. Both the client and service provider can experience discomfort, embarrassment and difficulties trying to talk about sexual health and sensitive topics. These complexities can be amplified by consultations that are rushed and lack privacy.

The skills building sessions addressed how to optimise consultations to ensure that young people can make informed decisions.

“Health providers are key in shaping the service experience for adolescents and young people and have a huge influence on whether AYP return for services and stay in care.”
- Luann Hatane, PATA

“Health workers must not give the ‘mother look’ when helping young people. Sometimes you have to suppress your own feelings and judgements. You need to make the patient feel heard and acknowledged and then give the best available options.”
- Dr Mo Archary, King Edward 111/UKZN

Key messages: counselling and consultations for choice
- Acknowledges AYPLHIV as individuals first and foremost and NOT a one-size-fits-all approach
- Recognises the autonomy of the AYPLHIV
- Builds trust and respects self-determination and self-management
- Recognises AYPHIV abilities and strengths
- Reframes conversation so that AYP are made to feel they have choices
- Supports and facilitates AYPLHIV to make informed decisions
- Harnesses the power of dreaming and hope

Participants were introduced an adapted HEADSS+ framework (http://teampata.org/wp-content/uploads/2018/03/CHWToolkit_2017update_WEB.pdf).
Establishing and maintaining safe spaces

Adolescent-friendly, person-centred health services are the cornerstone of HIV and SRHR integration, together with the provision of holistic care and linkages to support services including psychosocial support and community-based safe spaces.

AYPLHIV often feel stigma, discrimination and social isolation. Linkage to safe spaces is an important element within a comprehensive package of care. Adolescents and young people need safe spaces to come together, hang out, and participate in decision making processes as well as freely express themselves. Safe space environments include healthcare and community settings which offer places of safety and refuge, free from stigma, maltreatment and violence. Interventions need to be responsive to the unique needs of AYHPLHIV and must be informed and led by AYP. Safe spaces need to include young people who are least likely to access services.

A safe space is...
A place, environment or space in which a person (or group) of people i.e. AYP can feel confident and safe that they will not be exposed to discrimination, criticism, harassment, or any other emotional or physical harm.
A place that has been created for individuals who feel marginalized to come together to communicate or find support regarding their shared circumstances and/or experiences. This could be particularly important and useful for topics related to HIV and SRHR.
Examples of safe spaces: youth-friendly spaces, virtual spaces, youth clubs, etc.

A support group is...
- A group of individuals with similar issues, common needs, experiences and/or circumstances who meet up to provide support to each other
- Often has a group facilitator
- Usually goal-orientated and time-bound

Meaningful involvement of AYPLHIV

The only way to truly end the HIV epidemic among young people is by putting young people at the forefront of the HIV response. Young peoples’ involvement in decision making processes, in the planning, delivery and evaluation of services must be nurtured and resourced.

Meaningful youth involvement means that young people participate on equal terms with adults at all stages of programming and policy design. Young people can advocate for their own issues and play an integral role in supporting other young people. The skills building session looked at involving young people in organisational programming, at health providers involving young people in clinical and community settings; and the involvement of young people in research, monitoring and evaluation.

“Engaging with young people is not just about inviting young people to meetings. It is also about supporting them to participate and contribute meaningfully. There are high levels of expectation and this can become exploitative when not supported correctly.”
- Cedric Nininahazwe, Y+

“Young people can play a leadership role in clinic settings and in this context, they can also progress to become health providers. Young people are essential partners in developing and monitoring quality improvement plans at health facilities. Young people can be involved in training health providers to equip them to better serve the needs of young people.”
- Summit participant
Youth Summit Report 2019

“Young people’s unique talents and potential needs to be nurtured. Mentorship can include job shadowing and pairing a young person with a more senior staff member.”
– Summit participant

“At the heart of why we are here is about how to secure good services for adolescents.”
– Georgina Caswell, CNP+

A number of examples were shared where young people were involved in service delivery, research and monitoring and evaluation. A READY+ app that is used to track adherence is done in the form of a game and the READY scorecard evaluates service level experiences.

On research, there is a need for young people to author or co-author research papers. Young people who participate in research projects need to be more effectively involved and supported, and where young people provide input, they must also be afforded feedback and be acknowledged in research findings. Data can also be collected and shared in ways that are appealing to young people such as through audio-visual means including documentaries, visual diaries, YouTube and through social media channels.

Aiming high: 10 strategies for meaningful youth engagement

1. Agree together to roles, responsibilities and expectations among youth and other partners/stakeholders
2. Support young people’s leadership by giving them decision-making roles in all stages of the project
3. Regularly ask young people whether their views and ideas are being heard, and how meaningful participation of young people can be improved
4. Identify opportunities and support young people to advocate for their issues, and to safely share their experience and knowledge as experts
5. Build skills and knowledge of young people – including through mentorship – so they can confidently and effectively take part in both decision-making and implementation
6. Use language that is understandable, respectful, and accessible to everyone (this includes providing translation support)
7. Give young people enough support and resources (financial and other) in a timely manner; do not expect them to volunteer their time
8. Value and respect the perspectives and views of young people
9. Support consultation and feedback between young people and the communities they represent
10. Trust young people to take responsibility and be accountable for programme delivery

Key resources:

Case-based learning: listening to their voice and delivering choice

Case-based learning sessions highlighted the complexities of individual cases, which beyond biomedical HIV care, are impacted by: poverty, migration, difficult family situations, substance abuse, ART side-effects, the medication that the young person is taking and their reaction to it, disclosure, challenges in managing viral loads among children, facility-level stigma, sexuality, age of consent, gender-based violence (GBV) and other factors.

The session demonstrated the benefits of working in multi-disciplinary teams within health facilities and the need for comprehensive referral pathways and partnerships to ensure that social, psychological or economic issues affecting treatment and adherence can be effectively addressed. It highlighted the importance of establishing a strong partnership between the health provider and the client, one that is mutually reinforcing and beneficial. It is important for young people access correct and up-to-date treatment literacy and information. An overview of available treatment options should be made available, clearly explaining the pros and cons of each treatment options. This assists young people in being engaged and motivated to set and meet goals in their health plan in ways that provide them a voice and choice. This approach acknowledges the young person as being the central force in their health care management, and promotes longer-term adherence and chronic care through developing an effective partnership that is based on trust and open communication versus compliance and scaremongering.

Adolescent-friendly integrated services on display

Health facility teams, with peer supporters, created posters that reflected how their facility provided one of the following services:

- Providing friendly, comprehensive and integrated HIV and SRHR services
- Delivering adolescent and youth-friendly, stigma-free services
- Working in partnership and making a difference together with your community

The posters highlighted the range of integrated services provided and the pathways to access the services. The posters and pictures created a powerful demonstration of the multiple youth friendly services offered to young people and highlighted the value of HIV and SRHR integration and partnerships at clinic and community level.

Congratulations to all health facility teams, including health providers and young people, who put in the time and effort developing and sharing their posters.

“Clinicians must assist adolescents and young people to see a bigger picture and vision of their future. They must encourage young people to have goals for their lives and work towards achieving them.”

– Dr Mo Archary, King Edward 111/UKZN

The issue of how to communicate Undetectable = Untransmittable (U=U) was raised. U=U is a positive development in that it can address internal and external stigma, as well as contributing to HIV prevention. It is however important to educate AYPLHIV as the U=U data was generated with people in stable relationships who have access to regular viral load testing. U=U is reliable only when people are adhering well and when viral loads are known. U=U does not protect young people from unwanted pregnancies or other sexually transmitted infections (STIs). Messaging on U=U needs to take these factors into account to ensure that young people can make informed decisions.
PATA 2019 summit health facility poster submissions
The second day of the summit began with a regional overview of the policies, guidelines and legal considerations that impact, accelerate or hinder HIV and SRHR treatment access for diverse groups of AYP. The focus of much HIV and SRHR programming is on biomedical responses, sometimes at the expense of addressing behavioural and structural aspects that limit or deny access to appropriate, comprehensive HIV and SRHR services in safe and protected environments. Programming needs to uncover blind spots to reach the most marginalised. This requires a prioritisation on the R in SRHR – Rights! Comprehensive and resilient health systems require integrated service delivery to be ‘normalised’ rather than an ‘optional extra.’ For public health approaches to work, human rights must be placed at the centre.

Restrictive laws and policies, together with persistent poverty, inequality, patriarchy, lack of political will and cultural, religious and institutional discrimination remain major barriers to realising rights and ensuring access to comprehensive and stigma-free services. Young people continue to be affected by high rates of HIV infection, child marriage, intergenerational sex, unintended sex and unintended pregnancies in sub-Saharan Africa.

The links between GBV and HIV are bidirectional with GBV being both a cause and a consequence of HIV. Girls and women exposed to violence are more vulnerable to contracting HIV and are more vulnerable to experience violence because of an HIV status. Intimate partner violence is an obstacle to women seeking and remaining on treatment. GBV screening and support services for survivors needs to be integrated into HIV and SRHR interventions including post-rape care.

SRHR strategies are often silent on the broader SRHR needs of people living with HIV. Renewed effort is needed to advocate for stigma-free, rights-based SRHR services for PLHIV including: pre-conception; infertility; contraception (non-coercive and full range); cervical, breast and other related cancer screening and management; prevention and treatment of STIs; counselling and support for a satisfying sex life; access to appropriate, and safe and non-coercive termination services (where legal) and post-abortion care.

The most marginalised and inadequately served adolescents and young people include Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI) adolescents and young people, adolescents and young people who sell sex, adolescents and young people who use drugs, young mothers, young people in conflict zones and young people with disabilities. Other adolescents who are vulnerable to HIV include those who are sexually abused and/or exploited and those in prisons and other closed settings.

Key message:

Better laws, policies and programmes are needed to improve young people’s access to youth-friendly, affordable and confidential SRHR and HIV services. More focus is needed on up-skilling health providers and building their resilience to respond effectively as they facilitate and shape the service delivery experience.

– Luisa Orza, Frontline AIDS
Policing bodies: Policy and legal barriers to delivering SRHR for adolescents
Felicita Hikuam, ARASA

Laws and policies can be protective and facilitative or can further entrench barriers. The upsides of the law include setting obligations and duties for service providers and shaping standards. Positive enforcement of legal protections can support key populations and ensure access to justice. Downsides of the law are that law can perpetuate inequalities and restrict access to service, particularly for key populations. Punitive laws can create a climate of impunity and fuel violence and harassment. Laws and policies that discriminate and entrench stigma make it harder for particularly key populations most vulnerable to HIV, to access comprehensive HIV and other services.

Legal and policy barriers can lead to stigmatisation of adolescent sexuality. Laws can define the age of consent which has implications for access to SRHR information, services and medical procedures. Laws and cultural practices impact on marriage and can support harmful cultural practices including female genital mutilation. Some countries have laws that criminalise HIV transmission; discriminate on property and inheritance; set limitations to the provision of comprehensive sexuality education; criminalise key populations; criminalise abortion; and affect pregnant learner school retention and re-entry.

Recommendations:

- Invest in human rights programmes as recommended by UNAIDS
- Repeal and replace laws that create barriers to accessing the full range of HIV and SRHR services for adolescents
- Enact and enforce laws ensuring the right to comprehensive sexual health education
- Limit the use of “conscientious objection” in healthcare where the health and lives of others are or may be at risk as a consequence
- Outlaw child marriage, promote gender equality and women’s autonomy, liberalise abortion laws, and prohibit discrimination against people with diverse sexual orientations and gender identities and expression
- Enforce civil laws – customary laws and practices might continue to perpetuate violations of individual rights even when the legal system supports SRHR
- Provide access to SRHR information and services to adolescents regardless of their age or marital status
- Promote health provider sensitisation with the necessary training and support to ensure the provision of comprehensive and stigma-free SRHR services

“The law often seems abstract and distant, and it can be hard to comprehend. But for people living with HIV, for their families and communities, for key populations and those vulnerable to HIV, the law is neither abstract nor distant. It is police harassment or clean needles, prison cells or self-help groups – the law is the torturer’s fist or the healer’s hand.” – HIV and the Law Commission, 2012

Felicita Hikuam, ‘Policing Bodies. Policy and Legal Barriers to delivering SRHR for Adolescents’ PowerPoint Presentation, ARASA
A key theme of the summit was around offering young people choices and assisting them to make informed decisions around the choices available.

### Choice in today’s era of treatment optimisation: Leaving nobody behind

**Dr Nandita Sugandhi, ICAP**

“Supporting choice for young people requires understanding how young people make decisions.” – Dr Nandita Sugandhi, ICAP

### Table: Optimal ARVs for Adolescents and Young People

<table>
<thead>
<tr>
<th><strong>Optimal ARVs</strong></th>
<th><strong>Decision Making in Young People</strong></th>
<th><strong>What do AGYW need to support choice of ARV treatment options?</strong></th>
<th><strong>A few additional thoughts about supporting AGYW choices about sexual reproductive health</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacious</td>
<td>Favour their own experiences and anecdotal evidence over information about statistics</td>
<td>Adolescent-friendly health care workers!</td>
<td>Adolescent girls are eligible for all methods of contraception</td>
</tr>
<tr>
<td>Low toxicity</td>
<td></td>
<td>Information in language that is understandable, honest answers to questions, info that is positive &amp; not scare mongering</td>
<td>Long acting reversible contraception may be preferable for adherence reasons</td>
</tr>
<tr>
<td>Well tolerated and easy to take</td>
<td>Influenced by peers and social media</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable/High genetic barrier to resistance</td>
<td>View occasional health threatening acts as less risky</td>
<td>Corrected misperceptions they may have heard and explanation as to why guidance has changed</td>
<td>Adolescents are less tolerant of side effects. May need additional support to choose or switch forms of contraception</td>
</tr>
<tr>
<td>Better sequencing/ Switching</td>
<td>May misperceive independent risks as cumulative (i.e. I won’t fall pregnant if I only have sex occasionally)</td>
<td>Continued discussions over time, ongoing questions answered factually, require understanding and need to be respected when choose to make a different choice</td>
<td>Rates of STIs are disproportionately high. U=U is a message that has spread but emphasize that dual protection (i.e. condoms) protect their health</td>
</tr>
<tr>
<td>Harmonized across populations (Preg, TB, Peds)</td>
<td>Accept information from people they trust</td>
<td></td>
<td>Fertility intentions and choice to use contraception may change over time and must be supported</td>
</tr>
<tr>
<td>Reduces cost</td>
<td></td>
<td></td>
<td>Guidance and programmatic approaches to introduction of DTG-based regimes</td>
</tr>
</tbody>
</table>

A central choice for adolescents and young people living with HIV to make is around antiretroviral (ARV) treatment options. For many years, there have been ongoing efforts to develop better ARVs. In 2016 the World Health Organisation (WHO) guidelines included Dolutegravir (DTG) as a recommended ARV.

In July 2019 the WHO updated its guidelines and made DTG a preferred drug for children, adolescents and adults without the requirement that women be on contraception. This has improved choices for adolescents and young women.

In 2018, a study in Botswana found cases of neural tube defects among babies of women who were taking DTG. DTG was then only recommended for women who were on contraception which limited access for some women. Ongoing research led to a review of this recommendation as the potential for neural defects were found to be low in further studies. Young participants at the summit raised concern over some side effects experienced with DTG including weight gain, headaches and high blood pressure. This highlighted the importance of providing effective treatment literacy and the need for greater attention to be given to nutrition and lifestyle counselling aspects of care. There is a need for health providers to document and report side effects that are emerging.
Reaching the most left behind: Where are the young mothers in the HIV response?

Nyasha Sithole, ATHENA Network

Most teen pregnancies are unplanned and young mothers suddenly find themselves torn between being adults and young people. They are faced with uncertainty around antenatal and postnatal care, fears around childbirth and concerns around mother-to-child transmission. They can be confronted with disclosure, experience issues with their partner and face socio-economic challenges. Many young mothers do not have strong support systems which can lead to depression. Retention on ART for pregnant and breastfeeding women is low, with 20% of women in sub-Saharan Africa who start ART dropping out of care before delivering their babies. There are different experiences for girls and young mothers who learn their HIV status through pregnancy and those who knew that they were HIV positive before getting pregnant.

The attitudes of health providers can unlock access to services or create a barrier. Girls and young women may be reluctant to access contraceptive services or ask for condoms for fear of disapproval or scolding from health staff for being sexually active at a young age. In turn they are at greater risk of unintended pregnancy, HIV and other STIs. Unintended pregnancy may be the result of GBV and/or may significantly reduce a young woman’s life choices, especially if access to safe, legal abortion is not available. The chances of further pregnancies and/or violence, and other SRHR challenges, including heightened risk of HIV acquisition may follow.

Many young mothers are denied re-entry into school. Some policies force young mothers to drop out and others leave as a result of stigma and social isolation. Once a young woman has a baby, she is often isolated from her peers, may be stigmatised (by peers, family members and community members including teachers) and may lack the confidence, resources and support to return to full time education. With the responsibility of caring for a child, young mothers are often excluded spaces and forums to support young people.

Resources from the Coalition for Children Affected by AIDS:

- Video on young mothers and their experiences: https://childrenandhiv.org/blog/listen-young-mothers-children-affected-hiv/?fbclid=IwAR0c6TFsqtT6t9M-MVWaqcVihardtX9fXyruwCS_Eq--6-sZu0mODxic79I

“Stigma faces young mothers in the health care system. The first question is ‘why are you pregnant when you are living with HIV?’ or ‘why are you having sex when you are so young or living with HIV?’” – Nyasha Sithole, ATHENA Network

“Young mothers can find themselves feeling like social misfits and can lose attachment to their peers.” – Nyasha Sithole, ATHENA Network

How can we support young mothers?

- Include childcare in budgets for youth/young mother support activities so that they are not excluded
- Address barriers to school re-entry
- Provide comprehensive sexuality education for out-of-school young mothers
- Improve access to opportunities (economic and educational) for young mothers
- Address psychosocial and mental health support needs of young mothers
- Improve maternal health care for young mothers, including cervical cancer screening and treatment
- Provide parenting skills and support in early bonding and childhood development
- Address stigma and discrimination against young mothers in health care facilities and the community
- Ensure young mothers are retained in care and are supported in the EID, regular HIV testing and ART initiation of their young infants if required

“We need to see youth friendly health services, not youth friendly corners, right from the security guard at the entrance who should not be looking young women up and down.”

– Nyasha Sithole

ATHENA Network

Blind spots: Missing the mark

Angelica Pino (Sonke Gender Justice)

“It takes two to tango: Where are the boys in the SRHR space?” – Angelica Pino

“AIDS-related deaths among young people declined from 2010 to 2017 among adolescent girls and young women (15-24 years) while they increased among adolescent boys and young men.” – Angelica Pino, Sonke Gender Justice

- More men than women are dying of HIV
- Men are less likely to test
- Men are more likely to spread HIV to their partners
- Men start ARVs late; are more likely to be lost to follow up and have lower viral load suppression
- Younger men have low levels of knowledge on HIV
"The white elephant in the room is men. Macho, mobile men with money who do not go to health facilities." – Mapaseka Steve Letsike, SANAC/Access Chapter 2

Angelica Pino, ‘Blind Spots: Missing the Mark’ PowerPoint Presentation, Sonke Gender Justice

13
# Africa Café sessions: Putting the R back into SRHR-models that are promising and scalable

## Key messages:

SRHR access plays a vital role in the lives of AYP, enabling them to decide freely and responsibly on all aspects of their sexual life and sexual health. Health providers facilitate and shape their experience in accessing information and guidance to make responsible sexual decisions, and provide tools, commodities and treatment to protect their health, as well as that of their partners and future children.

## Organisation/Partnership | Model | Programme | Results | Key lessons
--- | --- | --- | --- | ---
ABCD Malawi | Peer-led mental health support groups for young mothers | Pilot smartphone app to provide psychosocial and mental health support to young pregnant women and young mothers ages 18-24 | Improved mental health and health seeking behaviour among participants. A total of 81 sessions were held by 20 peer supporters with 147 young moms engaged. 83% of engaged young moms attended two-thirds of sessions offered. | • ABCD can be integrated into an existing programme • ABCD is participatory and was co-developed with young mothers • ABCD offers confidential support to young mothers • ABCD is evolving. It needs to include GBV

DTHF South Africa | Differentiated service model delivering adolescent friendly services and PrEP | Pilot project that offered PrEP to sexually active HIV negative females ages 15-24 in six AFHS | Retention was low as young people do not like taking pills and the medication is associated with HIV | • Peer navigators helped to identify participants • The process to access PrEP needs to be simple with short waiting times • All health providers need to be included in offering PrEP • Health providers need training and support • PrEP can be a valuable tool and one of the prevention choices available to young people

DTHF South Africa Kheth’Impilo South Africa | School-based model delivering integrated SRHR services for marginalised youth | A schools-based SRHR model that sought to ensure that South Africa’s Integrated School Health Policy was implemented | More AYP accessing services Decline in pregnancy rate Pregnant girls assisted to return to school after delivery | • School are useful entry points in hard to reach areas • A key requirement for youth to access services is whether they are youth-friendly • Working with school governing bodies and other stakeholders can turn gatekeepers into partners

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**UNAIDS. In sub-Saharan Africa, three in four new HIV infections among 10 – 19-year-olds are among girls.** 2019
Program Components

- Structured SRHR
- School-Based SRHR Prevention Services
- Youth-friendly Health Services
- Referral pathways for Health & Social Protection
- Holiday Programs, ART Adherence club
- Community outreach and social mobilization

“Adults were tiptoeing around difficult issues but young people want to talk about issues, they want to know about issues.”

– Dr Najma Shaikh, Kheth’Impilo

15 Blessing Banda (We Care) and Grace Ngulube (Zalewa Clinic), ABCD model: peer-led mental health support groups for young mothers, PowerPoint presentation, We Care and Zalewa Clinic.

16 Dr Najma Shaikh, ‘School-based model: delivering integrated SRHR services for marginalised youth’, PowerPoint presentation, Kheth’Impilo, South Africa.
Addressing barriers to achieving inclusive access to integrated HIV and SRHR services: Getting to the heart of stigma

STANDING UP TO STIGMA AND VIOLENCE!

“When a young person arrives here, they have so many questions... They have a lot of prejudices about contraception, so we talk it through and explain all the different methods.”
- Selenge, a nurse in Cameroon

“Discrimination is a direct action that results from stigma.”

“‘But to combat the social phenomenon of stigma, we need a strategy that is fundamentally both social and personal in nature.”

“The persistence of stigma in the context of HIV also causes immense human hardship and diminishes us as a global community.”

“I keep fighting because my mother taught me to be whoever I want regardless of background or culture.”
- Susan Shembe, Jackie and human rights activist, South Africa

“Stigma, stigma and stigma. We know that this has been the problem at the very core of this epidemic since 1981... We know that if we can deal with stigma, we will have travelled very far in dealing with this epidemic.”
- The Honorable Mmamorae, Justice of the Constitutional Court of South Africa, AIDS 2019

“Our task is to listen, hear her needs and support her. It is not about judgements, shying away or giving up… if our personal belief systems affect the way that we support adolescents and young people, then we need to address this.” – Summit participant

“Change starts with us. It requires a different attitude and perspective. It requires opening your heart. How would you like to be spoken to if you were in the same position?” – Dr Shaffiq Essajee, UNICEF

Stigma remains a significant obstacle to accessing integrated HIV and SRHR services. The WHO estimates that the high rates of infection among young people is, in part, due to stigma. Stigma affects the engagement of individuals in healthcare settings, motivation for seeking services, and overall quality of life, including mental health as it can be isolating. There is growing global attention and commitment to addressing HIV-related stigma.

What is stigma?

Stigma is an expression of a negative value. It impacts on access to services as young people who anticipate that they will be judged or stigmatised because of their HIV status, gender, sexual orientation, drug use, selling sex, disability, age, religion, poverty, sexual activity or other reason, often do not seek out services. Stigma can be subtle and a subjective experience. It is perceived by the young person. Stigma often leads to discrimination, which is an action that can be witnessed or observed. Laws and policies can contribute to stigma and discrimination or play a powerful role in combatting stigma. Policies such as those guiding youth friendly services can make young people feel welcome and encourage health seeking behaviour. Stigma is informed by our attitudes, values and morals which are shaped by cultural and social norms. These can change over time and are influenced by family background, religion, leaders, peers, the media and the law.

Addressing barriers to achieving inclusive access to SRHR: LILO

The skills building sessions helped participant to explore their own value systems to assess if their attitudes and practices were facilitating youth friendly services or getting in the way of service provision. The Looking In, Looking Out (LILO) methodology developed by Positive Vibes allowed summit participants to explore and share their own experiences around their first SRHR messages and the values that underpin their opinions about sex and sexuality. Participants reflected varied experiences that were influenced by culture, gender, religion and other factors. Many participants spoke of their first messaging around SRHR as being threatening or being told about sexuality in a negative way.

Crossing the Divide: Reaching all through integrated HIV and SRHR services

Mental health and wellbeing was a central theme throughout the summit. Lynnette Mudekunye (REPSSI) shared that there is a continuum between mental unwellness and mental wellbeing and that people can live with borderline levels of depression and anxiety. Service providers need to create rapport and build trust with adolescents and young people in order to assess mental health issues and integrate mental health screening into their consultation.

While marginalised groups are integrated into most country strategies and guidelines, there are gaps in implementation. It is important to consider risk and protective factors within families and communities. Reducing levels of family stress promotes wellbeing.

The mental health and wellbeing of caregivers and health staff was emphasised. The summit highlighted the importance of self-care for service providers, including peer mentors, who often become trusted confidants for young people they are serving.

Holding ourselves accountable

Various methods for feedback were shared including data collection, feedback sessions, satisfaction surveys, apps to collect data, scorecards and the generation of accountability reports. The voice of young people was emphasised, “we need young people who can speak up.”
#READY for Clinic-Community Collaboration

Reaching global targets will require a shift away from intensive, individualised care to that of an expanded public health approach which is characterised by decentralisation, simplification, task-shifting and extended community-based service delivery. The biomedical, social and structural barriers to accessing HIV prevention, treatment and care require the sustained and meaningful engagement of both clinics and communities, working together in collaboration. Too often, clinics, community-based organisations (CBOs) and other community groups operate independently and in parallel to one another. Efforts can be duplicated, disjointed and diluted. This undermines opportunities for a collective and coordinated response and weakens sustainable and meaningful health improvements for adolescents and young people.

Effective clinic-community collaboration can lead to an increased service uptake, linkage, improved retention in care and increased trust between clinics and communities.

**Clinic-community collaboration is:**
Health providers and communities working together, listening and learning, jointly planning, implementing and monitoring to provide services that are responsive to the needs and priorities of adolescents and young people.

“It’s all about partnership and no matter where we are, and no matter at what level, in a clinic, in a CBO, or national/global space, if we are going to reach this last mile, we have to be READY to do it together.” – Luann Hatane, PATA

**Key messages:**
Community-driven approaches in collaboration with clinics can heighten the levels of intervention, access, adherence and attendance to follow-ups. Fears of stigma (particularly for key and vulnerable populations), and access to a comprehension of services can be significantly reduced through multi-systemic approaches to HIV-SRHR services.

**Progress made against global and regional commitments to community engagement and partnership**
Presenters updated the summit on progress made against global and regional commitments and investments to community engagements and partnership. Shaun Mellors, ViiV Healthcare’s Positive Action and Grace Ngulube, Zalewa Clinic in Malawi, chaired the session.

“The future of HIV prevention looks bright. We have a responsibility to reignite the prevention agenda and ensure sufficient funding, political commitment and resourced community mobilisation to get prevention back on track.” – Shaun Mellors, ViiV Healthcare’s Positive Action
Let’s not forget prevention in clinic -community collaboration

Jessica Rodrigues, AVAC

While Universal Test and Treat (UTT) has contributed to a reduction in HIV incidence, intensified prevention efforts targeting AYP are needed considering that three-quarters of all new HIV infections are among AYP. The ECHO trial was a multi country random controlled trial that looked at the risk of HIV with one of three effective contraception methods. The study found that women were more likely to protect themselves from pregnancy than from HIV.

Other prevention products in the pipeline include a vaginal ring, long acting ARVs, an HIV antibody and an HIV vaccine. There are considerations for a combined contraceptive and HIV prevention pill. Oral PrEP continues to be piloted in various settings.

Improving Service Delivery: what can health providers do and what do they need?

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many adolescents cite side effects, pill size and need for discretion as barriers to uptake</td>
<td>Proactive management of side effects, counseling with a focus on relationships, more discrete packaging.</td>
</tr>
<tr>
<td>Low PrEP awareness and stigma</td>
<td>Peer navigators and support, youth clubs</td>
</tr>
<tr>
<td>AGYW seeking contraceptives are at high risk of acquiring HIV but services are separate</td>
<td>Community dialogues and sensitization</td>
</tr>
<tr>
<td>Providers not authorized to prescribe PrEP</td>
<td>Effective HIV and SRH integration – all services with the same provider, at the same place at the same time</td>
</tr>
<tr>
<td>Some providers reluctant to prescribe PrEP fearing it will encourage clients to forego condoms, take on more sexual partners, and increase risk of STIs</td>
<td>Community-based provision</td>
</tr>
</tbody>
</table>

While developing a wider range of treatment products could contribute to HIV reduction, the need to address health systems challenges and structural drivers remains.

“Health care workers are frontline advocates too!” – Jessica Rodrigues, AVAC

Jessica Rodrigues, ‘Let’s not forget prevention in clinic-community collaboration’ PowerPoint presentation, AVAC
Models of C³ collaboration between health facilities and communities

Best practice examples, practical mechanisms and tools that build partnership, collaboration and social accountability between health facilities and community organisations, service providers and service users were shared. Find the C³ methodology in the latest Clinic-Community Collaboration Adolescent Toolkit: http://teampata.org/portfolio/clinic-community-collaboration-adolescent-toolkit/

The Operation Triple Zero model aims for zero missed appointments, zero missed drugs and zero viral loads. The model includes the needs of pregnant young girls and women and the needs of young mothers. The project has seen viral load suppression increase from 63% at the baseline study to 86%. The model emphasises the agency and responsibility of young people.

**Self-management and DSD: My treatment, my life, my choice**

Dr Immaculate Mutisya, CDC

“Adolescents are not a problem to be fixed. They are a potential to be nurtured.” – Dr Immaculate Mutisya, CDC

The Operation Triple Zero model aims for zero missed appointments, zero missed drugs and zero viral loads. The model includes the needs of pregnant young girls and women and the needs of young mothers. The project has seen viral load suppression increase from 63% at the baseline study to 86%. The model emphasises the agency and responsibility of young people.

**MOTTO:**
Heroes for zeros and zeros for heroes, it takes a hero to be a zero and a zero to be a hero!

---

Dr Immaculate Mutisya, “Self health management an DSD: My treatment – My life – My choice.” PowerPoint presentation, CDC.
Young people leading the way: Service linkage, delivery and advocacy on the frontline

Cedric Nininahazwe, Y+

The Y+ scorecard improves service provision for young people living with HIV. The scorecard assists the Y+ network to collect evidence that they then use for advocacy. The scorecard has improved services for young people with young people reporting that more service providers are listening to them and offering services with respect and without judgement. You can find the Y+ scorecard here: http://teampata.org/portfolio/service-providers-guidance-for-working-with-young-people-living-with-hiv/

The scorecard

We have committed to providing adolescent and youth-friendly health services at this health facility. If you are between the ages of 10-24 years, please complete this survey. Your responses will help us to improve our services. This survey is anonymous – you don’t have to write your name. This is your opportunity to share your experiences.

Scorecard

To understand the level of satisfaction of YPLHIV in service provision
To support health facilities to provide service that meet YPLHIV needs
To initiate a constant communication between YPLHIV and health providers
To transform the health facilities in best places for YPLHIV

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Mostly</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health providers greet me with a SMILE.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Health providers show me that they believe I can live a full and happy life, have healthy relationships, and have a family of my own.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Health providers listen to my questions without judgement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Health providers provide me with answers that are positive and give me hope.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Even when health providers are busy they give me time to talk.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Health providers explain things clearly and make sure I understand everything and can make my own choices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Health providers treat me with respect and don’t talk about me with others.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Health providers respect my privacy and will speak to me in a confidential space.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Health providers make appointments quick and smooth so I am not waiting around.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Health providers are fair to me and do not allow older clients to jump the queue ahead of me unnecessarily.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Health providers find ways to make sure that I do not have to visit the clinic too often and that I get the range of services I need.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Health providers do not behave inappropriately – they don’t flirt with me, gossip about me or insult me.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Health providers make sure that the medication they give me is correct, not expired and they explain to me what I need to know to be able to take it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Health providers do not burden me with any stress they may be feeling.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Health providers care about me and make me feel cared for, understood and protected.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You can find the Y+ scorecard here: http://teampata.org/portfolio/service-providers-guidance-for-working-with-young-people-living-with-hiv/
Resilient relationships for adolescents and young people living with HIV: What can we do in clinics and communities?

Dr Elona Toska, Mzantsi Wakho

Services supporting adherence and viral load suppression need to adapt to meet the changing needs of young people as they grow up.

<table>
<thead>
<tr>
<th>Age</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>• parental support</td>
</tr>
<tr>
<td></td>
<td>• access to healthy food</td>
</tr>
<tr>
<td></td>
<td>• access to youth friendly health services and peer support</td>
</tr>
<tr>
<td></td>
<td>• support to stay</td>
</tr>
<tr>
<td>15-19</td>
<td>• All of the needs for 10-14, plus</td>
</tr>
<tr>
<td></td>
<td>• SRHR information and referrals before they get pregnant, contract</td>
</tr>
<tr>
<td></td>
<td>• STIs or start having sex</td>
</tr>
<tr>
<td></td>
<td>• Help to manage stress and substance use</td>
</tr>
<tr>
<td>20-24</td>
<td>• All of the needs for 10-19, plus</td>
</tr>
<tr>
<td></td>
<td>• Skills for income generation and employment</td>
</tr>
<tr>
<td></td>
<td>• Access to PMTCT and early childhood development services</td>
</tr>
</tbody>
</table>

“Children do better on treatment when they are in school.” – Dr Elona Toska, Mzantsi Wakho

The UN Development Programme has proposed an approach of development accelerators, provisions that lead to progress across multiple SDGs. Development accelerators include government cash transfers to households, safe schools, free schools, parenting support, free school meals and support groups. A study on Improving lives by accelerating progress towards the UN Sustainable Development Goals for adolescents living with HIV: a prospective cohort study (see resources) suggests that the UN’s accelerator approach for a high-risk adolescent population has policy and potential financing usefulness.

ACCELERATORS

% IMPROVEMENT ON INCIDENCE RATES OF SDG TARGETS


Dr Elona Toska, *Resilient relationships for adolescents and young people living with HIV: What can we do in clinics and communities?” PowerPoint presentation, Mzantsi Wakho.
Are frontline voices being heard in global decision making: Are we meeting our commitments to community partnership in the HIV response?

Jonathan Gunthorp, SAT

“There’s really no such thing as the ‘voiceless’. There are only the deliberately silenced, or the preferably unheard.” – Arundhati Roy

Top five tips for voices to be heard in global decision making:

- Know your purpose
- Choose the content
- Be authentic
- Know your audience
- Know your channel

Africa café sessions: Clinic-community collaboration in Action
<table>
<thead>
<tr>
<th>Organisation/Partnership</th>
<th>Model</th>
<th>Programme</th>
<th>Results</th>
<th>Key lessons</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITPC <a href="http://itpcglobal.org/wp-content/">http://itpcglobal.org/wp-content/</a></td>
<td>Community Treatment Observatory (CTO)</td>
<td>Community members collect data on HIV prevention, testing, care and treatment services for monitoring and advocacy</td>
<td>The model has assisted to identify gaps and barriers to service delivery</td>
<td>Needs buy-in and collaboration with local and national partners</td>
</tr>
</tbody>
</table>
| SAFAIDS Zimbabwe [http://www.safaids.net/](http://www.safaids.net/) | Find, Test and Treat (FTT), case finding, linkage and referral through clinic-community collaboration | CBOs trained to do home testing Utilised C^3 methodology to set up referral directory and partnership Tests collected data through an app | • Contributed to intergovernmental cooperation  
• Improved relationships between the clinic and the community  
• Combined resourced including models, transport, human and financial resources  
• App assisted to identify hotspots | • Need buy-in from all partners including traditional leaders  
• Budget sufficient time for the inception phase to ensure all on board |
| Clinic-community collaboration Zambia [www.teampata.org/c3/](http://www.teampata.org/c3/) | C^3 model: case finding in Luanshya district through Kawama Clinic and Ndola Nutrition organisation collaboration | Five peer supporters recruited to address barriers facing AYPLHIV to start and remain on treatment | • Built partnerships between MOH, AYPLHIV and community organisations  
• Raised awareness on HIV in the community and schools  
• Improved resource sharing  
• Contributed to reduction in stigma, discrimination and harmful cultural norms | • Joint plan development enhanced transparency and effective project implementation  
• Joint regular meetings helped to address project gaps  
• Peer to peer engagements addressed stigma and discrimination  
• Stakeholder involvement enhanced project implementation |
What is a Community Treatment Observatory?


What is a CTO?

Systematically and routinely collects and analyses qualitative and quantitative data

Uses data for monitoring trends along the HIV care cascade, and to inform targeted action that will improve the quality of HIV services

An organized group of community members collect data on various aspects of HIV prevention, testing, care and treatment services

Can operate at district, provincial, national, regional or global level

Clinic-CBO Collaboration (C3) Assessment Kwekwe: Overall Quality of the relationship

<table>
<thead>
<tr>
<th>Overall Quality of the relationship between the Clinic and the CBO: Clinic Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Assessment</td>
</tr>
<tr>
<td>Very poor</td>
</tr>
<tr>
<td>Poor</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Very Good</td>
</tr>
</tbody>
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</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Very Good</td>
</tr>
</tbody>
</table>

Lessons learned and service delivery priorities

C³ is more than WHAT we do together and is driven by HOW effectively we work together as partners to deliver services for impact.

---

23 Helen Etyaale. *ITPC Community Treatment Observatory (CTO)*. PowerPoint presentation, ITPC

24 Tanyaradzwa Nyakatwa. *FTT Model: Case Finding, linkage and referral through clinic-community collaboration*. PowerPoint presentation, SANAIDS
### Key elements of effective partnership and collaboration:

- Shared vision and purpose
- Incentive- add value- working together helps us do our own work better, faster and improves our chance of success
- Autonomy but interdependent – independent but rely on and need one another
- Mutual accountability- we plan and monitor progress together, succeed and fail together
- Clarity on roles and responsibilities- know what we must each do
- Joint learning- testing, exploring and problem solving together to find solutions
- Structural arrangements- more formal than informal, meetings that are purposeful and directed to quality improvements with joint planning, implementation and monitoring
- Investment- time, energy, patience, relationship-building

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### Clinic-Community Collaboration Toolkit

**Working together to improve PMTCT and paediatric HIV treatment, care and support**

1. **Assess and identify**
   How to assess your context and identify collaborative partners

2. **Initiate and formalise**
   How to initiate the collaboration and formalise the relationship

3. **Plan and resource**
   How to jointly plan and collectively resource the project

4. **Collaborate and implement**
   How to work together and keep relationships progressing

5. **Document, review and monitor**
   How to record and monitor the work you are doing together

6. **Messaging for broader impact**
   How to coordinate and sustain the partnership within a local health response
Central to the PATA 2019 Summit and its C³ approach is recognising health providers as critical partners. UNICEF shared a framework for action to change the pace of paediatric and adolescent HIV testing and treatment through effective and enhanced service delivery. The framework is centrally linked to the C³ methodology to identify the most effective models of clinics and community service delivery so that these can be scaled up.

Effective clinic-community collaboration requires resources. While funds are tight, donors are increasingly recognising the value of community-based interventions and becoming more creative in supporting them. Donors would like to see government allocating resources to community-based organisations which are partnering in supporting paediatric and adolescent HIV interventions.

Key messages:

- Effective clinic-community collaboration leads to increased access, service uptake, improved retention in care and increased trust between clinics and communities
- Effective clinic-community collaboration is an intentional relationship that requires time, effort and commitment
- C³ integration must be normalised as a standard operating practice, not as an occasional optional extra
- Clinic-community collaborations must develop and document more robust evidence to demonstrate positive contributions to health outcomes
Communities make a difference

All over the world, organisations led by people living with or affected by HIV are defending human rights and delivering HIV prevention, treatment, care and support for their peers. Read the UNAIDS World AIDS Day 2019 “Communities make the difference” report: https://www.unaids.org/sites/default/files/media_asset/world-aids-day-2019-communities-make-the-difference_en.pdf

“As donors we have the responsibility to ensure that our funding remains flexible and that we are able to support CBOs.”
- Shaun Mellors, PACF

“Importantly summits are a time to reflect and also celebrate. It is time away from the clinic queues and work deadlines. It’s a time to value self-care and build our own resilience so that we are READY to serve.”
- Luann Hatane, PATA
Conclusion

The PATA 2019 Summit recognised that while progress has been made in HIV treatment, care and support, that gaps remain in the provision of integrated HIV and SRHR interventions focusing on prevention, treatment, care and support services to adolescents and young people, particularly in Sub-Saharan Africa. The most marginalised groups are more affected by HIV-related stigma, discrimination, social isolation, legal and policy barriers and related mental health difficulties. HIV and SRHR services are often silo’ed and highly stigmatised.

<table>
<thead>
<tr>
<th>What is needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#READY to integrate</strong></td>
</tr>
<tr>
<td>• High-quality, welcoming and comprehensive SRHR and HIV services, including creating safe spaces for adolescents and young people</td>
</tr>
<tr>
<td>• One-stop shop – ideally in one visit, or through linkages and facilitated referrals</td>
</tr>
<tr>
<td>• Services must be responsive to the individual needs and circumstances of adolescents and young people</td>
</tr>
<tr>
<td>• Gender is important (harmful gender norms, autonomy, GBV, sexual debut, perceptions and attitudes about sex and pleasure)</td>
</tr>
<tr>
<td>• Mental health is key</td>
</tr>
<tr>
<td>• Most critical is respecting voices and choices of young people</td>
</tr>
<tr>
<td><strong>#READY to reach &amp; serve</strong></td>
</tr>
<tr>
<td>• Put the R back into SRHR and confront marginalisation in service delivery</td>
</tr>
<tr>
<td>• Policy and legal frameworks that promote integrated service delivery and remove barriers to service access</td>
</tr>
<tr>
<td>• Services that work, are accessible, attractive and safe for all – especially for those most marginalised and least likely to access services. E.g. adolescents and young people who are teen mothers, disabled or are selling sex, using drugs, identify as lesbian, gay, bisexual or transgender who may have suffered rejection, violence, mental health difficulties, young men and boys, etc</td>
</tr>
<tr>
<td>• Be aware of our personal belief systems that may get in the way of providing adolescents and young people with the care they need. Provide health services that are free of stigma and personal bias</td>
</tr>
<tr>
<td>• Young clients, peer supporters and health providers must be supported to be literate about rights – so that we can all be assertive and demand high quality services and hold one another accountable</td>
</tr>
<tr>
<td>• Young people must lead, with nothing for us without us</td>
</tr>
<tr>
<td><strong>#READY for Clinic-Community Collaboration</strong></td>
</tr>
<tr>
<td>• A holistic, integrated approach is needed, one that listens, understands, and responds to the needs of adolescents and young people and their communities</td>
</tr>
<tr>
<td>• Invest in and strengthen the capacity of communities to become an integral part of the health service</td>
</tr>
<tr>
<td>• Invest and strengthen the capacity of health providers, and listen to the voices and experiences of frontline service providers</td>
</tr>
<tr>
<td>• Innovative, high quality, user-responsive models of care that effectively link and support facility and community organisations across the treatment cascade</td>
</tr>
<tr>
<td>• Improved coordination, collaboration and partnership – joint planning, data collection and accountability</td>
</tr>
</tbody>
</table>

To address the shortfalls in treatment and care for adolescents and young people living with and vulnerable to HIV, biomedical responses need to be combined with responses that address social, economic, gender, stigma and other obstacles to accessing services. Health providers cannot do this on their own and thus HIV and SRHR integration will only be possible through partnerships and collaboration that recognise the indispensable roles of health providers, communities and adolescents and young people working and #READYTogether!
Celebrating excellence on the frontline of HIV/SRHR service delivery
Celebrating excellence

Fun/WOW! Awards:
- Fit and Fabulous – for being the first at the gym: Mxolisi Maxwel Simelane
- Summit Fashionista – for dressing to impress: Pamela Jennifer Ngcobo
- Summit Wikipedia – for always having the answers: Dr Patrick Oyaro
- Tech Savvy – for being the social media star of the summit: Caroline Nyandat
- Summit Prankster – for causing the most laughs: Tsini Eddie Mkhatshwa from CANGO
- Mission Impossible – for achieving the impossible: Ariel Ntumba
- Early Bird – for always being on time x 2: Belina Katjangwa and Maria Msuya
- Energizer Bunny – for bringing high energy to every session!: Moses Rutatina
- Young at Heart – for being a number one youth advocate: Siduduzo Manamike
- The Busy Bee – for keeping buzzzzeeee: Tanyaradzwa Nyakatawa

Health Provider Video Submissions Awards
- Electrine Osewe
- Joseph Nyirongo
- Faith Kiruthi

READY scorecard winners
- Temeke Referral Hospital, Tanzania
- Centro de Saúde Munhava, Mozambique

POSTER WINNERS
UNICEF supported PATA throughout the summit by hosting PATA 2019 Summit webinars on each day of the summit, featuring key speakers and presentations within each day’s theme. The first day’s webinar focussed on #READY to Integrate HIV and SRHR Services. In this webinar, Alice Armstrong from UNICEF Regional Office for Eastern and Southern Africa provided an update on the HIV epidemic among adolescents with a focus on the progress made and priority actions in the region. Discussing examples of promising service delivery approaches, Mildmay Uganda’s Violet Nabatte presented a one-stop shop model of providing SRHR services to adolescents. Pumeza Runeyi of MSF discussed the approach and impact of youth care clubs that integrate clinical and psychosocial care for adolescents. The second day focussed on #READY to Reach and Serve All, presenting key takeaways on ensuring the most marginalised groups of adolescents and young people are reached by stigma-free gender-sensitive HIV and SRHR services. Nyasha Sithole of the ATHENA Network highlighted the challenges faced by young mothers living with HIV. Sonke Gender Justice’s Angelica Pino presented evidence on including boys and young men in HIV and SRHR programmes. Najma Shaikh from Kheth’Impilo discussed the results of an innovative school-based model for delivering integrated services. The third webinar focussed on the theme #READY for Clinic-Community Collaboration. Jessica Rodrigues from AVAC discussed the importance of adolescent HIV prevention as a part of HIV and SRHR integration, prevention tools and lessons from oral pre-exposure prophylaxis (PrEP) initiations. Dr Immaculate Mutsiya from the CDC Kenya presented differentiated models of care for adolescents living with HIV, including the impact of self-management. Cedric Nininahazwe of Y+ provided examples of young people working with both clinics and communities and discussed their role as leaders on the frontline.
Health providers, collaborators and supporters also tuned into the summit via the PATA Facebook page, in daily Facebook livestreaming, led by Y+. The facilitated discussions offered daily key-takeways – an innovative way to reach those who were not able to attend the summit in person.


UNICEF’s Rikke Le Kirkegaard supporting PATA with live webinars from the summit.
Feedback on the summit

The summit received positive evaluative feedback and overall, 94% of the delegates were very satisfied with the summit. Most of the participants were very satisfied with the summit content (91%) as well as the speakers and facilitators (74%). Participants also felt comfortable to speak freely and engage in open discussions, and said enough time was spent on workshops and lekgotlas during the summit.

Participants felt the summit promoted skills building and leadership capacity for HIV-SRHR integration improvements, the discussions highlighted key concerns, skills building sessions were informative and practical, and the lekgotlas were interesting and supported relationship building:

- “I have learnt so much, my approach to management will improve.”
  - Health Provider, Zimbabwe.

- “Summit was informative with experiences from different countries being shared.”
  - Health Provider, Eswatini.

- “PATA summit was very good, allowed choice in which skills building to participate in.”
  - Health Provider, Eswatini.

- “Keep up the good work, appreciated the summit, it was like the debriefing time.”
  - Health Provider, South Africa.

![Graph showing feedback results](image-url)
Key resources and links


Avert: Global information and education on HIV and AIDS for professionals. https://www.avert.org/professionals


Frontline AIDS: Uganda: Working with young adolescents (10-14 years old) on sexual and reproductive health and rights and HIV. https://teampata.org/portfolio/uganda_working_with_young_adolescents_10-14_old_on_sexual_and_reproductive_health_and_rights_and_hiv__original/


Interagency Working Group on Sexual and Reproductive Health (SRH) and HIV Linkages (IAWG): SRHIV linkages toolkit. toolkit.srhhivlinkages.org


LINKAGES: Health4All. Training health workers for the provision of quality, stigma-free HIV services for key populations. http://teampata.org/portfolio/health4all-training-health-workers-for-the-provision-of-quality-stigma-free-hiv-services-for-key-populations/

MSF: Health care worker-managed groups Youth clubs. https://www.differentiatedcare.org/Models/YouthClubs

PATA: Clinic-Community Collaboration (C³) toolkits and Be-Connected Course. www.teampata.org/c3


PATA: Resource hub, including all presentation from the summit (which can be found under the ‘PATA presentations’ tab). https://teampata.org/pata-resource-hub/

PATA YouTube Channel: Useful videos, including interviews from the summit. https://www.youtube.com/channel/UCiqaENFNWiqWJxV0XcGt1Pw?view_as=subscriber


READY: IEC Materials (which can be found under the ‘PATA IEC Materials’ tab). https://teampata.org/pata-resources/


<table>
<thead>
<tr>
<th>Country</th>
<th>Participating Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>Chantal Biya Foundation, Nkwen Baptist Health Centre</td>
</tr>
<tr>
<td>DRC</td>
<td>Khalembelombe Clinic</td>
</tr>
<tr>
<td>Eswatini</td>
<td>Bhekinkosi Nazarene Clinic, Bholi Clinic, Emkhuzweni Health Centre, Mbikwakhe Clinic, Pigg's Peak Government Hospital, Siteki Public Health Unit, Nazarene Compassionate Ministries, Super Buddies, Young Heroes, CANGO, SNPY+</td>
</tr>
<tr>
<td>Eswatini</td>
<td>Ambira Sub-county Hospital, Ganze Health Centre, Kenya Legal and Ethical Issues Network on HIV &amp; AIDS, Moi's Bridge Community Welfare Association, Moving The Coalposts, Nyandiwa Subcounty Hospital, Peer Support Project, St Joseph the Worker HC, Sunshine Smiles Clinic, WOFAK</td>
</tr>
<tr>
<td>Kenya</td>
<td>Ambira Sub-county Hospital, Ganze Health Centre, Kenya Legal and Ethical Issues Network on HIV &amp; AIDS, Moi's Bridge Community Welfare Association, Moving The Coalposts, Nyandiwa Subcounty Hospital, Peer Support Project, St Joseph the Worker HC, Sunshine Smiles Clinic, WOFAK</td>
</tr>
<tr>
<td>Malawi</td>
<td>Neno District Hospital, Tsungane Clinic, Zalewa Clinic</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Centro de Saúde Bagamoyo, Centro de Saúde de Boane, Centro de Saúde de Marracuene, Centro de Saúde Munhava, Centro de Saúde Ponta Gea, OASIS, REPSSI Mozambique, Y+ Mozambique</td>
</tr>
<tr>
<td>South Africa</td>
<td>AIDS Foundation of South Africa (AFSA), Amadu Development, ANOVA Health and District Facilities, Health Systems Trust (HST), HIVSA, MATCH, Médecins Sans Frontières (MSF), WITS RHI, Weltevreden Valley Clinic</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Humuliza Organization, Kimara Peer educators &amp; Health Promoters Trust Fund, Kwa Wazee Nshamba, Mwananyamala Hospital CTC, PASADA, PASADA Upendano Hospital, Sinza Hospital, TAYOPA, Temekere Referral Hospital, Vijdweni Health Center, REPSSI Tanzania, NYP+</td>
</tr>
<tr>
<td>Uganda</td>
<td>Baylor Uganda, Joint Clinical Research Council (JCRC), Infectious Diseases Institute Mulago, Lira Infectious Disease Clinic, Mulago COE ISS Clinic, TASO Gulu, Angel Ntege, ICWEA</td>
</tr>
<tr>
<td>Zambia</td>
<td>Chawama Level 1 Hospital, Chazanga Health Centre, Chikupi Rural Health Centre, Chilanga Youth Awake, Kabangwe Creative Initiative Association, Kabwata Clinic, Kazimva Health Centre, Latkins Outreach Program, Mapalo Clinic, Ndola Nutrition Organisation, Shifwankula Health Post, Beata Resort Infectious Diseases Hospital, Chitungwiza Central Hospital, Morgenster Mission Hospital, Mpilo Ol Clinic, MMPZ, United Bulawayo Hospital, REPSSI Zimbabwe, ZYP+</td>
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