



Appendix 1.

Peer support models examples and case studies across the cascade

This appendix provides a summary of a number of different examples of peer support models in different contexts and settings, and across different stages of the HIV treatment cascade. This includes information on the purpose of each model, how it works and challenges and lessons learnt from those involved. This may assist in giving you some ideas for how you would like your peer support programme to look, or whether you wish to adopt one of these models. As you consider programme planning in Module 4, you may wish to come back to this information.

1. Health Connectors

2. Link Up

3. Mildmay

4. Sunburst

5. Operation Triple Zero

6. Ariel Adherence Clubs

7. Re-engage adolescents and children with HIV (REACH)

8. BIPAI Teen Club Programme

9. Youth Care Clubs

10. READY

11. Zvandiri - CATS

Examples of peer support models for adolescents and young people

A key component of an effective strategy for addressing the adolescent HIV epidemic in Africa, peer support programmes have been found to enhance care at all points along the HIV cascade including linking, adherence, viral suppression, retention and addressing psychosocial wellbeing. Numerous peer support programmes have been developed and implemented, covering various steps or combination of steps in the cascade, but common to all of them is the provision of psychosocial support and HIV information. At the heart of peer support for adolescents and young people, is the value another young person with a similar experience can provide to an AYPLHIV as they navigate the treatment cascade. Of critical importance, is that this occurs within the context of an adolescent and youth-friendly environment.

This section outlines some of the best practice health facilities-based peer support programmes for AYPLHIV identified in Africa, with the table below summarising the steps in the HIV cascade addressed by each model. From this table, it is apparent that peer support groups cluster around optimising adherence to treatment, retention in care, psychosocial wellbeing and the provision of SRH services.

Table 1: Summary of AYPLHIV peer support programmes and the stages they cover across the HIV cascade

Programme	Pre-vention	Finding	Testing and linking	Psycho-social care and HIV knowl-edge	Ac-cessing SRH servic-es/sec-ondary preven-tion	Adher-ence	Reten-tion	Finding LTFU	Transi-tion to adult care
HC									
Link Up									
Mildmay									
Sunburst									
OTZ									
AAC									
REACH									
BIPAI									
YCC									
READY									
Zvandiri									

Name of programme: Health Connectors (HC)

Country/ies where implemented: South Africa

Developed and implemented by: WITS Reproductive Health and HIV Institute (RHI)

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Background and introduction: Since 2017, Health Connectors (HC) have been embedded in primary health care quality improvement teams in two health sub-districts: Sub-District F, in the City of Johannesburg and Matlosana sub-district, in North West Province, recruiting patients from local clinics.

WHAT:	Purpose: Assist adolescents and young people to access, link to, return to, navigate and remain engaged in services by offering referrals, information and psychosocial support until stable on treatment.		
	Discharge once the client has initiated ART and is attending clinic regularly/ has accessed service needed, preferably once patient has linked to Youth Care Club; or If patient indicates they no longer wish to be part of HC programme (give opportunity to make contact again).		
	HIV-positive and negative clients	HIV-positive clients	HIV-negative clients
	Health promoting behaviours; Risk behaviours/ risk reduction; Social context, schooling, relationships and mental health; Sexual health including family planning and STI screening and treatment.	Link to ART initiation, I-ACT group or Youth Care Club (if available). Psychosocial support including acceptance of HIV status, disclosure, treatment adherence; tracing defaulters and those lost to follow up.	HIV prevention and repeat HIV testing; Encourage patient to bring partner/s on youth-friendly days.
WHO (participants):	<ul style="list-style-type: none"> Adolescents and young people who are HIV-positive or negative, aged 12 to 24 years. HIV positive adolescents until stable on treatment. 		
WHO (facilitators):	Led by peer navigators (Health Connectors) trained in health promotion and basic counselling skills for sexual health, psychosocial health and HIV/ ART-related information.		
WHERE:	Primary health facility-based model with additional remote support via telephone and WhatsApp/ SMS.		
WHEN:	Weekly and on-demand (when young person initiates communication).		
HOW (model):	<ul style="list-style-type: none"> Identify adolescents and young people aged 12 - 24 years attending clinic for the first time. Guide the client to reception desk for new file to be opened. Establish reason for visit and provide relevant information, care and support. Assist in fast-tracking visits, when applicable. Inform and offer confidential Health Connectors (HC) programme, establish preferred means of communication and obtain contact details. Ensure at least one face to face meeting with regular telecommunication. Use handbook and/or www.bwisehealth.com to provide information and answer questions. 		

HOW (peers):	<ul style="list-style-type: none"> • Peers recruited through job adverts: need to be young, energetic. Not all were HIV-positive. Received a salary for their role. • Peers underwent two-week training based on HC training manual. Key areas covered included: • Health system: need to understand the flow of the clinic and referral system etc. <ul style="list-style-type: none"> o Psychosocial support: need to be able to manage client's emotions and recognise when to refer on o HIV treatment cascade: need to understand this in order to determine when VL is needed, etc. • Peers were well integrated into WITS RHI teams and attended some meetings. They were seen as support partners and service providers, but not clinic staff members.
EVALUATION:	During 18 months of implementation, 1,155 young people 12-24 years took part in the HC in two health sub-Districts. Patient spent an average of 5 weeks in regular contact with a Health Connector. The majority were females (82%) and HIV-positive (91%). Commonly discussed topics between health providers and patients were: adhering to treatments, support from friends and family, treatment side effects, clinic navigation, and mental health.
CHALLENGES/ LESSONS LEARNT:	<ul style="list-style-type: none"> • Challenge is to ensure sustainability of the programme now that funding for Adolescent Innovation Project has ended. Looking at ways to adapt model to ensure sustainability: <ul style="list-style-type: none"> o Train and make use of counsellors and community support workers to fulfil HC role. o Get one HC to service a number of clinics in a sub-district. o Create part-time HC positions. o Cut down on length of training programme. • Important that HC's are well supervised, eg. Check phones and scroll through WhatsApp messages to ensure messaging is appropriate. • Important to ensure clinic staff understand the role of the HC and how they can add value, in order that relationships between staff and HC work well. This worked better in some clinics than others. • Making use of youth peers is a very promising approach and with a relatively small investment, a lot can be achieved.
PUBLICATIONS AND RESOURCES:	<p>http://aviwe.wrhi.ac.za/health-connector-programme-2/</p> <p>http://www.wrhi.ac.za/uploads/files/Health_Connectors-_Personalised_health_system_navigation_for_young_people_in_South_Africa_%28INTEREST_2018_-_23_May_2018%29.pdf</p>

Name of programme: Link Up

Country/ies where implemented: Uganda, Burundi, Ethiopia, Bangladesh, Myanmar. This summary will focus on implementation in Uganda.

Developed and implemented by: Frontline AIDS

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Background and introduction: Link Up (2013-2016) was a global consortium led by Frontline AIDS and implemented in 11 districts in Uganda by a consortium of partners, funded by the Government of the Netherlands Ministry of Foreign Affairs. It sought to improve SRHR of over 800,000 adolescents by strengthening the integration of SRHR interventions into existing community and facility-based HIV programmes, and vice versa. Key focus areas of the model included strengthening health facilities' capacity to respond to young people's needs; increasing youth participation and advocacy capacity, including using peers as a key component of the programme, acknowledging that they are best placed to reach young people; and community mobilisation. While the Link Up programme has now ended, the community-based organisations are now funded by other organisations, including FHI360. A significant number of Link Up peer educators transitioned onto other programmes.

WHAT:	Programme that creates linkages between community and facilities-based HIV and SRH services. In addition, provides health education, counselling and peer support to educate and empower adolescents to be aware of their rights, and confident in accessing health services. Aim: to reduce unintended pregnancies, HIV transmission and HIV-related maternal mortality amongst young people most affected by HIV, with a specific focus on vulnerable and marginalised populations.
WHERE:	Combination of health facilities and community-based activities. Peer support groups take place in communities and facilitate referral to health facilities.
WHO (participants):	YPLHIV aged 10-24 years; young people who engage in sex work, young MSM, the fishing community, and young truck and motorbike taxi drivers.
WHO (facilitators):	Peer educators/supporters for the 15- to 24-year olds; community-based organisation (CBO) staff for the 10- to 14-year-olds.
WHEN:	Support groups meet once or twice a month.
HOW (model):	Peer educators were trained to connect with networks of new and existing YPLHIV peer support groups in order to: <ul style="list-style-type: none"> • provide health education • provide counselling (on topics of relevance to adolescents including relationships, fertility awareness, safe conception, preventing HIV and STI transmission, HIV-related stigma, and the rights of YPLHIV to obtain comprehensive SRHR and HIV services) • lead 'youth corners' or where more space was available at facilities, manage the room allocated to youth • lead income-generating activities • conduct home-based visits • lead youth advocacy • They created demand for integrated HIV and SRHR services and distributed vouchers to adolescents to facilitate referrals to youth-oriented public and private facilities for access to ART and SRH services and accompanied youth to these facilities. • Interventions at clinics included: <ul style="list-style-type: none"> • Health provider sensitisation training • Making health facilities youth friendly • Providing quality integrated HIV-SRHR services

<p>HOW (peers):</p>	<p>Recruitment: Peer educators were aged 16-24 years. They were recruited by community-based organisations (CBO's) according to particular criteria. Essentially, they were young people perceived by their peers and the CBO's to be good role models in their communities. Other criteria for selection included being able to commit to the time; interest in supporting their peers; good listening and communication skills; non-judgemental attitude; energetic and reliable; and ability to maintain confidentiality.</p> <p>Training: Peer educators were trained on Frontline AIDS' 'lifeskills and sexuality' tool, as well as using existing Ministry of Health material related to SRHR. The training was not HIV-specific, it covered SRHR more broadly.</p> <p>Support and linkage: Peer educators were provided with support by the CBOs funded under Link Up. They were connected with public and private (Marie Stopes) health facilities that were supported by Link Up.</p>
<p>EVALUATION:</p>	<p>Conducted by Population Council and Makerere University's Child Health and Development Centre in Uganda. 437 support group members (YPLHIV), aged 15-24 years were recruited at baseline and 350 were followed up after a 9-month intervention period. Significant increases were found in self-efficacy, comprehensive HIV knowledge, HIV disclosure, condom use at last sex, STI services uptake, ART uptake, ART adherence, CD4 testing and current use of a modern contraceptive method.</p> <p>Link Up Uganda reached 296,047 community members and 98,099 young people at health facilities with integrated HIV-SRHR services. The project also mentored and supported 548 service providers and involved 3,060 young people in providing integrated and appropriate services for young people.</p> <p>An evaluation was conducted between January 2014 and September 2015 which demonstrated that Link Up interventions increased self-efficacy, knowledge of HIV, condom use, HIV disclosure, uptake of ART, ART adherence, CD4 testing and STI service uptake among young people living with HIV.</p>

<p>CHALLENGES/ LESSONS LEARNT:</p>	<p>Lessons learnt: General</p> <ul style="list-style-type: none"> • Preventing commodity shortages, reducing wait times, and modifying hours of operation to accommodate YPLHIV's school and work schedules can make services more accessible to them. • Facilities should ensure waiting rooms are clean, well lit, and not too crowded. • HIV-related stigma continues to affect YPLHIV's self-efficacy and healthcare access. • Confidentiality is critical: YPLHIV fear rumours spreading about their HIV status, which reinforces hesitancy to disclose their status and increases a desire to seek care at a time or place where YPLHIV are less likely to be recognised. Training should be provided to health providers serving YPLHIV to enable them to deliver comprehensive SRHR and HIV services in a sensitive and respectful manner. <p>Working with peers:</p> <ul style="list-style-type: none"> • Agree to roles, responsibilities, and expectations together. • Support young people's leadership by giving them decision-making roles in all stages of the project. • Check with them how meaningful participation can be improved. • Identify opportunities and support young people to advocate for their issues. • Build skills and knowledge of young people so they can take part in implementation. • Use language that is understandable, respectful, and accessible to everyone. • Give young people enough support and resources (financial and other) in a timely manner; do not expect them to volunteer their time. • Value and respect their views and perspectives. • Support consultation and feedback between young people and the communities they represent. • Trust young people to take responsibility and be accountable for program delivery (Stackpool-Moore et al; 2017).
<p>PUBLICATIONS AND RESOURCES:</p>	<p>https://www.popcouncil.org/research/link-up</p> <p>http://teampata.org/wp-content/uploads/2017/12/pp2.pdf</p> <p>Ross, D. A., & Santelli, J. (2017). Sexual and reproductive health and rights and HIV programming among young people most affected by HIV: lessons from the link up project in five countries. <i>Journal of Adolescent Health, 60</i>(2), S1-S2.</p> <p>Stackpool-Moore, L., Bajpai, D., Caswell, G., Crone, T., Dewar, F., Gray, G., ... & Orza, L. (2017). Linking sexual and reproductive health and rights and HIV services for young people: The Link Up Project. <i>Journal of Adolescent Health, 60</i>(2), S3-S6.</p> <p>Vu, L., Burnett-Zieman, B., Banura, C., Okal, J., Elang, M., Ampwera, R., ... & Yam, E. (2017). Increasing uptake of HIV, sexually transmitted infection, and family planning services, and reducing HIV-related risk behaviours among youth living with HIV in Uganda. <i>Journal of Adolescent Health, 60</i>(2), S22-S28.</p>



Name of programme: Mildmay Uganda Experience (Mug)

Country/ies where implemented: Uganda

Developed and implemented by: Mildmay Uganda

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Background and introduction: Since 2007 several structures have been implemented to support SRH of young people (10-24 years) at MUG. These include Our Generation Mildmay Adolescent Club (OGMAC), Safe youth Club (SYC) for 15-24-year olds, Positive Speakers Club (PSC), Noah's Ark Choir, Unique Stars (talent support group), Kisaakye Youth Centre (KYC) and Young Parents Club. In 2009, MUG established a programme to focus on adolescent reproductive health (ASRH), using a peer-led approach to empower YPLHIV to live positively and increase awareness of their rights.

WHAT:	Peer-led approach aimed at increasing SRHR and positive living in adolescents.
WHERE:	Health-facilities based
WHO (participants):	ALHIV aged 10-24 years
WHO (facilitators):	Peer counsellors
WHEN:	As needed
HOW (model):	Peer counsellors' roles include: Identifying HIV+ve adolescents needing support from communities. Providing support to adolescents in terms of the following: <ul style="list-style-type: none"> • SRH information • Adherence to medication • Positive living • Psychosocial support Referring adolescents for further SRH support or other services (STI treatment, PMTCT, family planning, cervical cancer screening) where applicable. Holding monthly meetings and documenting all ASRH implemented activities, including challenges faced during implementation. The project also issued an annual magazine with HIV testimonies. Other services include life skills training, recreational activities, career guidance, computer training.
HOW (peers):	Ten health workers were trained on delivery of adolescent services, who then trained 100 peer adolescent counsellors, who subsequently trained 63 adolescent peer educators across two age groups (10-14 and 15-24 years). Peer counsellors undergo one week of training and quarterly workshops Currently 30 peer counsellors
EVALUATION:	Between 2007 and 2012, the number of adolescents in care increased from 1,356 to 2,117 (56% increase). Disclosure to sexual partners increased from 40% to 84% and adolescents accessing family, planning, cervical screening and PMTCT increased steadily (with 87% of adolescents reporting a pregnancy accessing PMTCT in 2012).

CHALLENGES/ LESSONS LEARNT:	<p>Challenges:</p> <ul style="list-style-type: none"> • Stigma: makes disclosure and exploring sexuality a real challenge for this age group. • In some cases, caretaker / guardian advice and support may differ from that of health providers. • Interruption in services: School terms may interrupt peer-to-peer follow up, especially for those ALHIV who have to spend time away at boarding school and do not have access to communication technology. • Scaling up: Most facilities do not have sufficient staff capacity to provide comprehensive ASRH. <p>Factors that have contributed to success:</p> <ul style="list-style-type: none"> • Integration of adolescent-friendly SRHS into routine HIV care. • Strong programme focus on individual responsibility, disclosure and building self-esteem. • Training of health providers in ASRH improved communication between adolescents and health providers. • A peer-led approach has increased referral and uptake of services. • Linkages established with other ASRH service providers enabled wider choice of service providers for adolescents, increasing uptake of services beyond MUG. • Differentiation of support groups by age, gender, sexual activity status and socio-economic status, eg. a peer support group was established to support young people from more socio-economically advantaged families (called the Safe Club), as this population has access to internet and has different needs. • Education and counselling of caretakers of ALHIV. • Continuous needs assessment enabled the programme to adapt to meet the changing needs of the target population.
PUBLICATIONS AND RESOURCES:	UNICEF (2013). Field Lessons. Strengthening Health Services and Outcomes for Adolescents Living with HIV



Name of programme: Sunburst Projects

Country/ies where implemented: Kenya

Developed and implemented by: Sunburst Projects, University of California San Francisco, Research, care and Training Program/FACES

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Background and introduction: Sunburst Projects aims to bring psychosocial support to children and their families living with HIV/AIDS. In 2010, Sunburst Projects partnered with the University of California San Francisco (UCSF) and Research Care and Training Program (RCTP)/FACES in Kenya to further develop models of best practice. Sunburst Projects-Kenya has partnered with over 20 Kenyan organisations, services, and programmes for ALHIV and employed peer leaders to provide support to children and adolescents enrolled in care at three FACES health facilities. The project has also been conducting community outreach targeting schools, churches, and the general population within the Kisumu municipality. Key psychosocial services and programmes are run by young peer leaders and include peer-run support groups, youth camps and clubs. The programme has employed 18 peer leaders and recruited 100 volunteer youth counsellors for annual camps. It has served over 2,000 ALHIV enrolled within the FACES programme and around 3,000 youth in the community.

WHAT:	Sunburst Projects aims to address the psychosocial needs of children and ALHIV in Kenya. By providing a safe, welcoming, and nurturing environment it aims to increase self-esteem, and reinforce positive health behaviours that ensure healthy transition into adulthood. The project also aims to improve ART adherence and linkage to and retention in care; increase employability, decrease stigma, reduce HIV risk and improve HIV knowledge.
WHERE:	Health facilities and community-based
WHO (participants):	Children 6-9 years, and adolescents, 10-14 years & 15-19 years, in urban areas
WHO (facilitators):	Unemployed high school graduates 18-24 years living with HIV who have undergone training
WHEN:	Support groups weekly for 3 months; family social events every 3 months; community outreach monthly; camps annually
HOW (model):	<p>The project uses 5 main strategies:</p> <ol style="list-style-type: none"> 1. Recruit young peer leaders to run project activities: 2 peer leaders per facility. 2. Provide peer leaders with a two-week induction training. 3. Implement a peer leadership programme (described below). 4. Continuously evaluate the programme. 5. Offer capacity-building and prioritise programme development. <p>The programme consists of a number of approaches/activities:</p> <ul style="list-style-type: none"> • Peer-led community-support group programme (up to 40 participants), requiring a weekly commitment of 3 months by participants (open discussion, educational lessons, artistic and therapeutic activities, games, and role-playing). • Family social events, open to children and adolescents' families, held every 3 months and include sports, games, art therapy, songs, dance and drama. Parents can discuss disclosure and other challenges with counsellors • Community outreach for stigma reduction and HIV awareness in schools and communities, conducted monthly. • 5-day Summer camp programme for children living with life-threatening illnesses to address unmet social, psychological and emotional needs and acquiring life skills.

HOW (peers):	<p>Recruitment of peer leaders:</p> <ul style="list-style-type: none"> • Two peer leaders per site (ideally one male and one female) recruited from health facilities through a competitive interview process. • Unemployed HIV-positive high school graduates 18-24 years. • Given detailed job descriptions and dedicated supervision. <p>Training of peer leaders:</p> <ul style="list-style-type: none"> • 2-week induction training to build capacity to provide psychosocial support; training in support group facilitation; communication; public speaking and computer skills; HIV and SRH counselling; risk reduction, ART adherence, positive living. <p>Peer integration:</p> <ul style="list-style-type: none"> • Integrated into all department activities including staff meetings. • Receive mentorship from peer leader mentors. • Receive psychosocial support from supervisors and on-site counsellors. • Enrolled in scholarship programme for courses they wish to take. • Wages are provided for peer leader mentors and programmes co-ordinators. • Transport provided for peers conducting home visits.
EVALUATION:	<p>A mixed-methods approach is used to evaluate and assess the programme continuously. Both qualitative and quantitative methods of data collection are used to determine pre and post intervention outcomes/impact. Three primary indicators are used: (1) improved health and drug adherence, (2) improved psychological well-being, and (3) increased knowledge about HIV.</p> <p>Caregiver surveys are conducted to determine child's attitude toward taking their medication and attending clinic visits as well as school performance. Peer leaders administer pre and post-test measures to assess changes in HIV/AIDS knowledge. Evaluations are also conducted during community outreach to evaluate community knowledge, perceptions, and attitudes about stigma and discrimination.</p> <p>Outcomes indicate:</p> <ul style="list-style-type: none"> • Increased comfort in disclosure of HIV status both for parents disclosing to their children and young people disclosing to others. • Improved attitudes towards clinic and school attendance and adherence to medication. • Stigma reduction in schools and reduced guilt and secrecy. • Improved communication with health providers and participants gave positive feedback on the value of age-appropriate peer support. <p>Research to evaluate the overall impact of the intervention is currently underway. The project has not yet been piloted in other settings/sites. A goal is to scale up the programme and evaluate the treatment outcomes of the peer-led interventions.</p>
CHALLENGES/ LESSONS LEARNT:	<ul style="list-style-type: none"> • Inadequate funding to scale up the model to other counties and FACES sites. • Peer support programmes can strengthen and complement medical services and be part of a lifelong continuum of care for YPLHIV. • Peer support programmes assist in streamlining transition from paediatric medical care, to adolescent care, and then into adult treatment and care services. • Early disclosure is key in realising better adherence outcomes. • Multidisciplinary and multifaceted approaches play an integral role in ensuring optimal viral suppression among adolescents.
PUBLICATIONS AND RESOURCES:	<p>http://teampata.org/portfolio/peer-led-services-promising-practices/?portfolioCats=175%2C413%2C398%2C172%2C19%2C171%2C17</p> <p>Best Practices for Adolescent- and Youth-Friendly HIV Services March 2017 TR-16-134</p> <p>A Compendium of Selected Projects in PEPFAR-Supported Countries https://www.measureevaluation.org/resources/publications/tr-16-134</p>

Name of programmes: Operation Triple Zero (OTZ)

Country/ies where implemented: Kenya

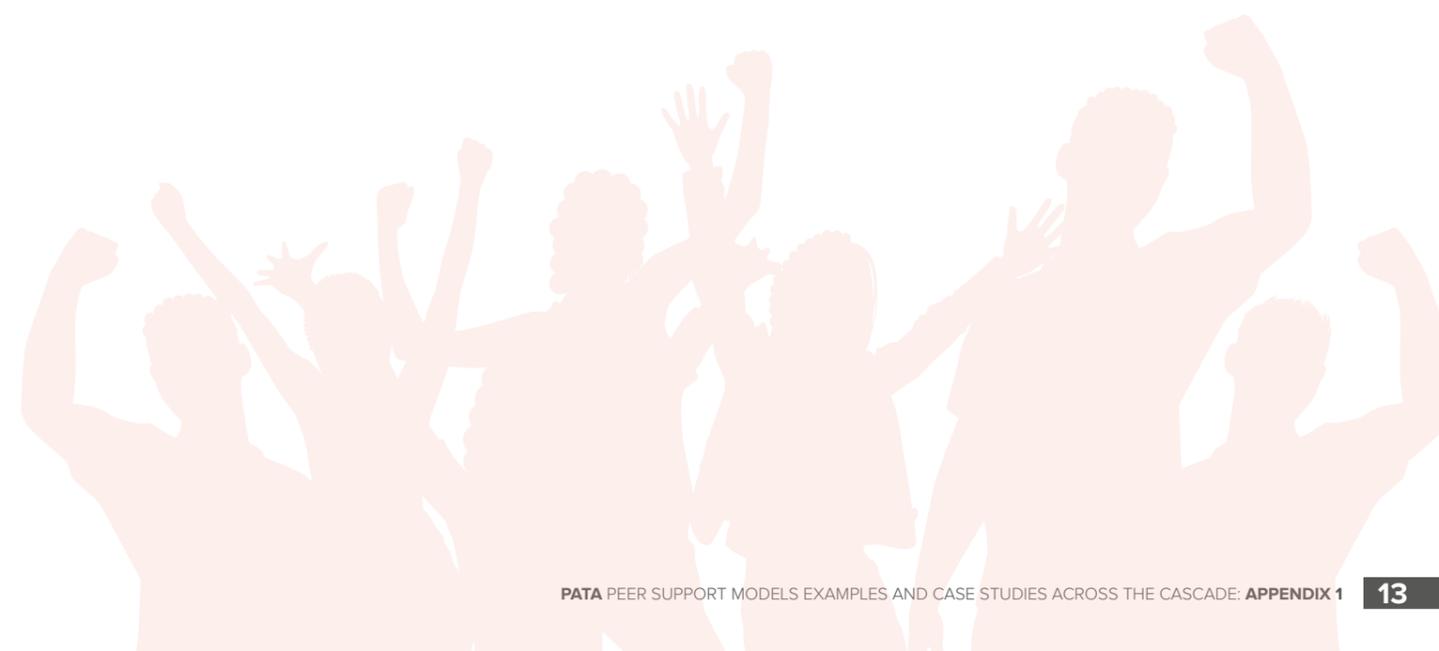
Developed and implemented by: PEPFAR

Contact person:

Background and introduction: The Operation Triple Zero (OTZ) initiative is an asset-based programme that aims to nurture the potential within AYPLHIV to be part of the solution regarding their own health and uses positive peer interactions to foster change. Asset-based programmes focus on identifying strengths; seeing adolescents as co-producers and the answer to a problem; and developing their potential. This is in contrast to a deficit-based approach which responds to a problem that needs to be fixed; sees adolescents as passive recipients; and implementing a programme as an answer. OTZ aims for three zeroes (zero missed clinical appointments, zero missed drugs, zero viral load) and identifies those who achieve it as heroes. The motto of the programme is "Heroes for Zeroes and Zeroes for Heroes, It takes a Hero to be a Zero and a Zero to be a Hero" Heroes encourage other OTZ members to become heroes too. This model has been scaled up in Kenya, where AYPLHIV of different ages, cultures, and education levels have adopted and owned the initiative, spreading it across peers. From 2016 to March 2018, the initiative expanded nationally, reaching 27 high HIV burden counties and over 11,000 AYPLHIV.

WHAT:	<p>The primary aim of OTZ is to increase adherence, retention in care and viral suppression. It is geared towards motivating adolescents and young people to take responsibility for their health and commit to achieving the three zeroes – Zero missed clinical appointments, Zero missed drugs and Zero viral load. The programme also promotes other “zeroes”, including zero stigma, zero deaths, zero sex for those abstaining, zero unprotected sex for the sexually active, and zero mother-to-child HIV transmission for pregnant and breastfeeding AYPLHIV.</p> <p>Through a comprehensive HIV treatment literacy package and support from peers and health providers, participants are empowered to take charge of their health and their decisions.</p>
WHERE:	Facilities-based.
WHO (participants):	AYPLHIV aged 10-24 years old.
WHO (facilitators):	OTZ graduates or ‘champions’ recruited from the programme for 10- to 19-year-olds.
WHEN:	

HOW (model):	<p>AYPLHIV receiving HIV treatment at clinics are encouraged to voluntarily join an OTZ club, irrespective of viral load levels. Health providers or adolescent peers who enrol AYPLHIV support them to develop an individual treatment plan aimed at achieving triple zeroes.</p> <p>The OTZ package contains three modules: 1) health provider, 2) caregiver, and 3) adolescent.</p> <ul style="list-style-type: none"> • Health provider: Trains health providers to provide asset-based programming through motivational interviewing • Caregivers: Provides caregiver treatment literacy training and enhances their capacity to empower AYPLHIV to be self-health managers. • Adolescents: In addition to adolescent support groups, OTZ members are trained on self-health management, effective participation, positive thinking about the future, and the transition into adult care. Members connect with one another through meetings and social media groups that facilitate motivational messaging to uplift and sustain the goals of OTZ. During meetings, OTZ members highlight their talents, and share motivational messages through song, dance, poetry and plays. Clubs recognize and celebrate OTZ members who achieve viral suppression, in order to encourage maintained suppression and support transition to reduced clinic appointments. <p>The intervention is tailored to nurture intrinsic and extrinsic developmental assets in order to promote positive health behaviours. Intrinsic assets are strengthened for adolescents through providing comprehensive treatment literacy and goal setting, promoting resilience, and enabling positive peer interactions, independence and connectedness. Extrinsic assets are cultivated by providing knowledge and skills to health providers and caregivers to support AYPLHIV. The combination of both intrinsic and extrinsic assets results in empowered, confident AYPLHIV who are manage their own health.</p> <p>The role of peers (OTZ graduates) in the programme is to enrol new members, provide psychosocial support to newly diagnosed HIV-positive adolescents and young people, provide support to AYPLHIV with high viral loads, co-ordinate OTZ clubs, and oversee various OTZ activities, including social media.</p>
HOW (peers):	Peer leads, or “champions”, are recruited from graduates of the OTZ program for 10- to 19-year-olds. Champions are sensitised during a half day OTZ training on how to provide support and guidance to AYPLHIV.



EVALUATION:	<p>Preliminary data from the OTZ Initiative show that the majority of AYPLHIV who participate in OTZ attend their scheduled clinic appointments. Stable OTZ members receive multi-month prescriptions and do not attend clinics monthly.</p> <p>Self-reported adherence has improved significantly across programs increasing from 88% in October 2017 to 96% in February 2018.</p> <p>Overall viral suppression also showed improvements over time. In Siaya County, 86% of adolescents (aged 10-19) who were currently on ART had enrolled in OTZ by June 2018. From July 2017 to June 2018, viral suppression increased from 65% to 80% among 10- to 14-year-olds and from 66% to 84% among 15- to 19-year-olds.</p> <p>Preliminary data for clients aged 10-24 years from six PEPFAR/CDC supported implementing partners show a substantial improvement in viral suppression. Of 2,742 AYPLHIV, viral suppression increased from 71% to 82% after 6 months of enrolment into OTZ.</p> <p>The program also plans a future evaluation to determine the impact of OTZ on the social and mental wellbeing of AYPLHIV in OTZ.</p> <p>The OTZ initiative was rapidly scaled up from one site in 2016 (with 70 members) to 400 PEPFAR/CDC supported sites (with over 40,000 members) by March 2018 after results showed increased viral suppression rates for sites that were implementing OTZ. The main supporters of OTZ have been PEPFAR, civil society and the Kenyan government.</p>
CHALLENGES/ LESSONS LEARNT:	<ul style="list-style-type: none"> • AYPLHIV of different ages, cultures, and education level quickly adopted and owned the initiative, spreading it rapidly across peers. • Ownership of the OTZ initiative by adolescents and young people saves time and resources that would otherwise be used for counselling, making it easier and more cost-effective to scale up.
PUBLICATIONS AND RESOURCES:	<p>https://www.pepfarsolutions.org/solutions/2018/10/30/operation-triple-zero-empowering-adolescents-and-young-people-living-with-hiv-to-take-control-of-their-own-health</p> <p>https://www.iasociety.org/Web/WebContent/File/15_James_Wagude_Retention_in_ART_Kenya_Experience.pdf</p> <p>https://www.pepfar.gov/documents/organization/285543.pdf</p>

Name of programmes: Ariel Adherence Clubs (AAC)

Country/ies where implemented: Uganda, Kenya, Tanzania, Malawi, Mozambique, Swaziland, Lesotho, Ivory Coast, and Democratic Republic of Congo (this summary focuses on Tanzania)

Developed and implemented by: Elizabeth Glaser Pediatric AIDS Foundation

Contact person:

Background and introduction: AACs are psychosocial support groups for CALHIV 5-19 years and have been implemented since 2007. They are based on the premise that CALHIV will optimise health outcomes if clinical services are complemented with excellent social support and age-appropriate information about HIV infection, treatment, adherence, HIV status disclosure, positive living, and life skills needed for growing into healthy, HIV-positive adults. AACs are currently being implemented by EGPAF in nine countries. Clubs are contextualised in each country to ensure they address local and context-specific challenges for the children and adolescents accessing care. EGPAF supports AACs at 105 facilities across six regions in Tanzania.

WHAT:	<p>The aim of AACs is to improve ART adherence, clinic retention and viral suppression, and to provide psychosocial support to ensure adjustment to living with HIV and transitioning to adulthood and adult HIV care.</p> <p>The model offers a package of psychosocial activities including individualized counselling sessions by trained service providers, dedicated and age-appropriate facility spaces, and monthly support group meetings to address issues related to drug adherence, the experiences of children and adolescents living with HIV, and self-stigma reduction.</p> <p>Providers also work with caregivers to facilitate disclosure of HIV status to children and adolescents as this is a requirement of programme participation.</p>
WHERE:	Facilities-based.
WHO (participants):	HIV-positive CALHIV 5-19 years. Must be aware of their HIV status.
WHO (facilitators):	Health providers involved in adherence counselling and clinical management of children/ adolescents facilitate AACs (after training in psychosocial support). In addition, ALHIV (peer educators) also assist in facilitating AACs and integrating peer education.
WHEN:	Support groups are monthly.
HOW (model):	<p>Sites chosen to start AACs are higher volume sites, where the number of children/adolescents in care is sufficient to justify the club meeting service model.</p> <p>Key elements of AACs include:</p> <ul style="list-style-type: none"> • integrated clinical service delivery (ART refill, labs, clinical care) on same day as monthly support group meeting; also assists in addressing bottle necks and overcrowding at facilities and streamlining care • psychosocial support and group/peer health education in safe spaces to enable participants to engage with other children and adolescents living with HIV to discuss everyday matters (not always about HIV), have fun, play, and normalize their experience of living with HIV • caregiver counselling (to assist in improving adherence) through health education and individual counselling sessions
HOW (peers):	ALHIV have been recruited by AACs to be trained as facilitators during club meetings and integrate peer education. Peer educators accompanied by health care workers also provide outreach health education to schools and sometimes help to track adolescents who miss appointments in the community

<p>EVALUATION:</p>	<p>Viral load suppression:</p> <p>Data show increased HIV viral suppression among patients 5-19 years attending sites with AACs (60%) compared to those attending sites with no AACs (49%), although this difference did not reach significance. However, there is a significant difference when comparing patients 5-19 years attending health centres with AACs (60%) compared to health centres without AACs (35%). However, viral suppression rates remain lower than expected overall. This may be as a result of clinicians focusing on those with more advanced disease progression for viral load testing.</p> <p>Visit attendance (proxy for ART adherence):</p> <p>An evaluation of patients at selected AAC sites showed that monthly visit attendance was significantly higher for those who attended AACs (91%) compared to those who did not attend AACs (82%).</p> <p>However, participation rates are low overall, with less than half of adolescents 10-19 years attending AAC meetings. In addition, AAC attendance is associated with being enrolled at a younger age. Participation is significantly higher among those who enrolled under the age of 15 years (37%), compared to those enrolled at 15-19 years (12%). This suggests that adolescents over 15 years who are diagnosed and linked to care (likely horizontally infected) have particular psychosocial needs which require more differentiated care in order to better meet these needs. Data indicates that this group requires more active follow up, counselling, and HIV treatment education. Therefore, where AACs are supporting adolescents aged 15- 19 years, clients may benefit from being paired with an experienced treatment buddy or adolescent peer educator to support their treatment outside of the clinic and club.</p> <p>Efforts have been made to increase the proportion of older adolescents in care through addition of a peer facilitation component to the AACs. In addition, groups have been separated by age to better accommodate the needs of older adolescents.</p>
<p>CHALLENGES/ LESSONS LEARNT:</p>	<p>Key issues to ensure success:</p> <ul style="list-style-type: none"> • It is important to work in collaboration with government to ensure alignment with national HIV guidelines in the development of training materials for service providers, as well as to build sustainability by ensuring AACs are included in annual budgets and plans. • Identify health facilities that are most suitable to implement the AAC model, eg. those with a high volume of HIV patients aged 5-19 years so that groups are large enough to justify the amount of staff and other resources required. However, groups should be capped at around 25 participants to avoid long waits. • Ensure that health providers supporting AAC activities are appropriately trained and sensitised to work with CALHIV, and receive appropriate oversight and supervision. • Recognise the value of engaging peers who are good role models (stable on treatment) to conduct support group discussions and share their own experiences growing up with HIV in the local environment. • Facilitate linkages from AACs to other social protection and community development opportunities, eg. education and nutrition support, spiritual guidance, and income generation assistance. <p>Lessons learnt:</p> <ul style="list-style-type: none"> • Adolescents over 15 years who are diagnosed and linked to care have particular psychosocial needs which require more differentiated care to better support these needs. This group requires more active follow-up, counselling, and HIV treatment education and may benefit from being paired with an experienced treatment buddy or adolescent peer educator to support their treatment outside of the clinic and club.
<p>PUBLICATIONS AND RESOURCES:</p>	<p>https://www.pepfarsolutions.org/solutions/2018/1/13/ariel-adherence-clubs-increase-retention-and-adherence-among-children-and-adolescents-living-with-hiv-in-tanzania-fzwj</p> <p>Evidence from Ariel Adherence Clubs in Tanzania. Gretchen Antelman. Elizabeth Glaser Pediatric AIDS Foundation, Tanzania. AIDS conference 2018</p>

Name of programme: REACH (Re-Engage Adolescents and Children with HIV)

Country/ies where implemented: Ethiopia, Uganda, Malawi, Cameroon, Kenya and Zambia

Developed and implemented by: PATA, with Positive Action Adolescent Fund and previously, One to One Children's Fund

Contact person: Luann Hatane luann@teampata.org

Background and introduction: REACH was launched in 2015 with One to One Children's Fund and completed a successful 22-month pilot with the integration of 59 YPLHIV peer supporters across 20 facilities in Ethiopia, Uganda, Malawi, DRC and Cameroon. Key findings from the pilot phase showed promising evidence that the integration of peer supporters into health facilities can contribute toward improved health services for AYPLHIV that are more adolescent-friendly. In 2017, PATA then partnered with the Positive Action for Adolescents Fund (PAAF) to develop REACH beyond its pilot phase into an implementation model with embedded regional learning across six sub-Saharan African countries. REACH was implemented in 20 health facilities (12 existing facilities and 8 new facilities) across Cameroon, Ethiopia, Kenya, Malawi, Uganda and Zambia. PAAF supported the implementation of REACH in 15 of these facilities, while the M.A.C AIDS Fund supported five facilities.

<p>WHAT:</p>	<p>Peer support model which integrates YPLHIV as peer supporters into health facilities in order to improve HIV treatment and care services and treatment outcomes in adolescents. The model also enables skills development and training opportunities for career development for peer supporters.</p> <p>The programme focuses on three objectives:</p> <ol style="list-style-type: none"> 1. Improve adolescent-friendly health services (AFHS) and adolescent orientation. 2. Build peer supporter capacity, agency and resilience. 3. Build and share evidence for a facility-based peer support model.
<p>WHERE:</p>	<p>Health facilities.</p>
<p>WHO (participants):</p>	<p>AYPLHIV, 10-19 years.</p>
<p>WHO (facilitators):</p>	<p>YPLHIV, 18-24 years. Two peer supporters recruited per facility Living openly with HIV, adhering successfully to treatment and actively involved at facilities as volunteers.</p>
<p>WHEN:</p>	<p>On duty daily, no more than 4 hours per day</p>
<p>HOW (model):</p>	<p>Peer supporters receive supervision, relevant training and a practical toolkit to help them:</p> <ul style="list-style-type: none"> • Develop and deliver peer-to-peer services. • Provide operational support in resource-limited health facilities. <p>Tasks can include:</p> <ul style="list-style-type: none"> • Psychosocial tasks: Peer support groups. • Counselling tasks. • Educational tasks: HIV and HIV management. • Outreach/community work: visit client's homes, trace those LTFU. • In-clinic tasks: administrative and operational tasks.

<p>HOW (peers):</p>	<p>During the first five months of REACH implementation, peer supporters were recruited, completed their orientation training, received job descriptions and signed a Memorandum of Understanding (MOU). Each peer supporter was assigned to a peer supporter supervisor who was a health provider at their designated facility who provided them with ongoing supervision and support.</p> <p>Training of peer supporters has been facilitated by a PATA toolkit, supervision and support by peer supporter supervisors and linkage to national networks of YPLHIV and advocacy activities. WhatsApp groups have enabled a platform for dialogue, advice-sharing and information gathering.</p> <p>In addition, peer supporter supervisors, supported by small grants from the REACH programme, were tasked with identifying and sourcing local trainings for peer supporter (on disclosure, adherence, SRHR, general HIV education and HIV treatment) – designed to meet training needs and maintain low-cost, sustainable approach.</p> <p>Peer supporters and peer supporter supervisor receive support from PATA through:</p> <ul style="list-style-type: none"> • A multi-country WhatsApp Community of Practice. • Monthly telephonic check-ins. • Occasional site visits. • Access to additional tools and guidance at PATA's Resource Hub.
<p>EVALUATION:</p>	<p>Feb to Oct 2017: (1 year of follow up, after pilot phase completed) At REACH facilities:</p> <ul style="list-style-type: none"> • Improvements in provision of adolescent-friendly spaces and services. • Increased number of differentiated support groups. • Increased number of creative methodologies for AYPLHIV per facility. • Increased involvement of peer supporters in psychosocial support services. • Majority of facilities offered at least one local training to further capacitate peer supporters. • Peer supporter supervisors reported offering 16 hours pm supervision per peer supporter including on work performance and debriefing. • Some involvement of peer supporters in facility team meetings - requires greater attention. • Most facilities reported that peer supporters were involved in advocacy activities. • Evidence shared through PATA Continental Summit 2017; journal publication; poster presentation; PATA promising practices publications; meetings; workshops; social media. <p>April 2018 to March 2019:</p> <p>To build the capacity, agency and resilience of 32 HIV-positive adolescent peer supporters in 16 sub-Saharan African health facilities through training, mentorship, peer-peer engagement and livelihood strengthening.</p> <ul style="list-style-type: none"> • 3mths into the programme, 90% of peer supporters had an individualised development plan. • 100% of peer supporters report having received monthly mentorship sessions from their in-country PATA Technical Advisor or peer supporter supervisors over the past year. • 94% of peer supporters attended the PATA 2018 Youth Summit. • 87% of peer supporters attended two local technical trainings, internally or externally facilitated. • 3 peer supporters were elected onto PATA's Youth Advisory Panel (YAP) for 2019 – 2021. <p>To evaluate a simple, low-cost health facility-based adolescent peer support model on both peer supporter and client outcomes</p> <ul style="list-style-type: none"> • Increase of 54% in number of AYPLHIV tested for HIV. • Of those testing positive, 99% were initiated on ART. Baseline ART initiation was 90%. • LTFU and not VS rates decreased from 9% and 8% respectively, to 5% each in 23,450 AYPLHIV on ART. • 280 (39%) of LTFU returned to care by 12 months after REACH began. • 44% of those not VS prior to REACH, were suppressed by 12 months. • Qualitative surveys provided further support of these results and included reports of reduced waiting times, health provider workloads and reduction in missed visits and LTFU.

<p>CHALLENGES/ LESSONS LEARNT:</p>	<p>Model implementation challenges:</p> <ul style="list-style-type: none"> • Model must be time and cost effective to ensure its sustainability beyond REACH programme. • To this end, additional resources should be allocated to the design and delivery of the initial set up training. • While utilising local trainers ensured contextual relevance, it can compromise the integrity and fidelity of the model. • Developing a suite of training toolkits, guides and job aids to complement face-to face training provided locally, could address this. • Collecting aggregate-level patient outcome data remains challenging, and verification of the reliability and validity of this data is problematic due to PATA's remote location. • A need for simple, standardised, user-friendly data collection tools and continued M&E capacity building, to support health providers to benefit from these tools. <p>Peer supporter challenges:</p> <ul style="list-style-type: none"> • Required to perform tasks that are beyond the peer supporters' role and their capabilities. • Relied upon as volunteers or poorly compensated. • Temporary role, which must be transitioned out of. • Hierarchical health team structure, with peer supporters not always sufficiently recognised, respected or meaningfully engaged by health providers. • High responsibility with limited training and support. • Long hours, high patient burden, emotional exhaustion, depersonalisation and burnout. • Limited resources and space to implement peer supporter activities and ensure privacy and confidentiality. • Long distances between health facilities and client homes which presents a challenge for client tracing and home visits. <p>To address these challenges, peer supporter programmes require:</p> <ul style="list-style-type: none"> • Good planning and sufficient investment. • Standardised guidelines, a job description and a defined scope of work. • Fair remuneration, or at least a stipend to support travel and basic needs. • Pre-service training and ongoing in-service support through mentorships, regular supervision and performance reviews. • Access to job aids, supportive materials and regular feedback from health providers and clients. • Integration into the health team and appropriate meetings. • Training to maintain boundaries with clients and colleagues, and to prioritize self-care. • Debriefing and psychosocial support. • A conducive clinic environment, including sensitised health providers.
<p>PUBLICATIONS AND RESOURCES:</p>	<p>http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf</p> <p>http://teampata.org/wp-content/uploads/2017/06/REACH_WEB.pdf</p> <p>https://www.iasociety.org/Web/WebContent/File/meeting_report_clinical_models_care_adolescent_2016.pdf</p>

Name of programme: BIPAI Teen Club programme

Country/ies where implemented: Uganda, Malawi, Tanzania, Botswana, Eswatini, Lesotho

Developed and implemented by: Baylor International Pediatric AIDS Initiative (BIPAI).

Contact person: Teresa Steffy tfstefy@bcm.edu (Lesotho Teen Club)

Background and introduction: In August 2003, the first BIPAI-sponsored Teen Club for HIV-positive adolescents began in Uganda in partnership with Mulago Hospital. Since then, Teen Club has expanded to many other country locations and has been used as a globally recognized intervention model that through the provision of peer support empowers HIV-infected adolescents to build positive relationships, improve self-esteem, and ultimately improve clinical and mental health outcomes. Expansion of satellite Teen Clubs to various outreach sites has allowed adolescents who are not enrolled in a primary Centre of Excellence (COE) in a particular country to benefit from the Teen Club model. For some countries, these satellite Teen Clubs operate at satellite COEs. In other circumstances, COEs partner with NGOs and ARV hospitals in towns and villages to implement satellite Teen Clubs, enabling decentralisation of psychosocial care and support interventions for adolescents – particularly Teen Club. Details below may vary somewhat for different Teen Clubs, depending on location, size, resources, etc.

WHAT:	Teen Club aims to empower HIV-positive adolescents to build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, adult role-modelling and structured activities, ultimately leading to improved clinical and mental health outcomes as well as a healthy transition into adulthood.
WHERE:	Health facilities-based
WHO (participants):	Fully disclosed ALHIV, 10-19 years (Lesotho supports ALHIV 11-25 years). Should be on ART, not married or pregnant, need caregiver consent. Must agree to confidentiality - disclosing status of a peer results in immediate dismissal from Teen Club (for staff or clients).
WHO (facilitators):	Peer educators who are ALHIV
WHEN:	Teen Talk is weekly; Teen Club is monthly (usually on Saturdays); one to one peer counselling as needed.

HOW (model):

The model is based on peer educators providing various education and support services, the extent to which will vary at different sites/centres, including:

- Peer counselling sessions at clinic facilities. Sessions are one-on-one, and frequently focus on ART adherence, clinic attendance and disclosure. A drop-in service is also available so that young people can receive psychosocial services without an appointment.
- Teen Talk: The clinic has a designated weekly adolescent-focused day, where peer educators conduct Teen Talk, a group counselling session focused on topics such as peer pressure, nutrition, stigma and discrimination.
- Pre-Teen Club: Peer educators assist with coordination and preparation of monthly Pre-Teen Club meetings and help to brainstorm themes, icebreakers, lecture topics and strategies to engage participants.
- Teen Club: Peer educators assist in the implementation of Teen Club, a monthly psychosocial support group. They coordinate the introduction of club events, perform educational skits, lead icebreakers and discussions and encourage active participation. Teen Club events usually include large group games, drama/theatre activities, pool parties, safaris, sports and art sessions. Educational components covering HIV education, disclosure, adherence, life skills, college preparation, personal finance management and goal-setting are also included. The club is facilitated by a club mentor/s (trained and mentored in the Baylor Teen Club curriculum). During the club activities, a nurse sees each adolescent individually for their ART refill (including a pill count) and clinical review. Attending adolescents receive transport reimbursement and a snack.
- Home visits: Peer educators conduct home visits to patients identified as requiring additional support and follow-up.
- SRH Counselling: Peer educators provide education around adolescent SRH for peers at the clinic. Female peer educators also provide counselling about hygiene and pregnancy for adolescent girls.
- Camps: provide new opportunities for friendships to form among the patients. In many cases teen leaders from Teen Club are included as counsellors and members of the leadership committee. They serve as role models (for adherence) and mentors to whom the campers can relate.
- Transition Training (T2) Programme: developed to assist with transition to adult care. The programme creates a safe space for young adults to learn how to balance career advancement while addressing concerns around stigma, discrimination and disclosure.

Baylor also provides technical support to other implementing partners to establish, run and manage teen clubs and teen camps, and train teen leaders to assist in the facilitation of teen club meetings. They also assist in setting up a standard curriculum to facilitate replication of the model, to ensure a standardised and sustainable strategy for care of ALHIV.

HOW (peers):

EVALUATION:	<p>An evaluation study conducted by Baylor at Zomba Central Hospital in Malawi showed that teen club members were three times more likely to stay on ART compared to non-members.(Agarwal et al; 2013)</p> <p>Malawi: Mackenzie et al (2017) conducted a nested case-control study using programmatic data from 2004 to 2015. Patient records were reviewed retrospectively and participants were followed starting in March 2010, the month in which Teen Club was opened. Follow-up ended at the time patients were no longer considered retained in care or at end of 2015. ALHIV with no Teen Club exposure were less likely to be retained than those with Teen Club exposure when adjusted for sex, ART initiation age, current age, reason for ART initiation and year of ART initiation. Exposure to the Teen Club package is associated with 3.7-times lower odds of attrition than not being exposed to Teen Club. ALHIV 15 to 19 years were more likely to have attrition from care than ALHIV 10 to 14 years.</p> <p>Lesotho: Engelbrok et al (2017) assessed pre and post Teen Club knowledge of HIV. In 2015 the HIV Knowledge Test was administered to Teen Club participants and then between December 2016 and February 2017, 720 Teen Club members and 54 new enrollees completed the tool in various locations in Lesotho. The average score for current Teen Club members was 55% correct. The average score for new enrollees was 42%. Scores increased as age increased, from 37% correct among 10-year-olds, to 57% among 15-year-olds, to 65% among 20-year-olds. Compared to initial administration in 2015, the average score among Teen Club members 14-18 years of age in Maseru decreased from 63% to 61%, while the average score for Teen Club members 11-14 years of age in Maseru increased from 42% to 52%.</p>
CHALLENGES/ LESSONS LEARNT	<p>Key factors that have contributed to the success of this project:</p> <ul style="list-style-type: none"> Working in partnership with government, and with local community service organisations and ART clinics Innovative and responsive staff
PUBLICATIONS AND RESOURCES:	<p>MacKenzie, R. K., van Lettow, M., Gondwe, C., Nyirongo, J., Singano, V., Banda, V., ... & Hrapcak, S. (2017). Greater retention in care among adolescents on antiretroviral treatment accessing "Teen Club" an adolescent-centred differentiated care model compared with standard of care: a nested case-control study at a tertiary referral hospital in Malawi. <i>Journal of the International AIDS Society</i>, 20(3), e25028.</p> <p>http://www.differentiatedcare.org/Portals/0/adam/Content/C_b8Pha-6kyxt5iZ-bWmSQ/File/Agarwal%202013_Dignitas%20Teen%20Club%20outcomes%20IAS%202013.pdf</p> <p>http://www.differentiatedcare.org/Portals/0/adam/Content/6fT3wVA2XkC69AeuuaCOaA/File/Ngoma_Country_presentation_Malawi.pdf</p> <p>https://www.msh.org/resources/teen-clubs-help-retain-adolescents-in-hiv-care-and-treatment</p> <p>Best Practices for Adolescent- and Youth-Friendly HIV Services March 2017 TR-16-134 A Compendium of Selected Projects in PEPFAR-Supported Countries https://www.measureevaluation.org/resources/publications/tr-16-134</p> <p>http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf</p> <p>Sharer, Melissa, and Andrew Fullem. 2012. Transitioning of Care and Other Services for Adolescents Living with HIV in SubSaharan Africa. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.</p> <p>https://www.who.int/hiv/pub/guidelines/adolescents/en/</p>

Name of programme: Youth Care Clubs (YCC)

Country/ies where implemented: South Africa

Developed and implemented by: Médecines Sans Frontières initially, now Keth'Impilo. Soon to be handed over to ANOVA

Contact person: Pumeza Runeyi MSFOCB-Khayelitsha-Youth@brussels.msf.org

Background and introduction: Since 2012, MSF has worked with City of Cape Town Health to pilot the YCC model in Site C Youth clinic, a City of Cape Town youth friendly clinic in Khayelitsha. The model has thus far been scaled up to a total of 5 facilities in Khayelitsha and was also adopted in the 2015 Western Cape ART adherence club guidelines. The aim is to offer services in one space and at one time through a peer support format targeted at adherence and retention while reducing work load on clinical services. In 2018, the clubs began transitioning to NGOs including Keth' Impilo and were held in community spaces rather than at health facilities. Scale-up at other facilities in Khayelitsha continues. The evidence of the effectiveness of the community-based clubs are not yet published, although a report is imminent.

WHAT:	<p>Group-based HIV management approach integrating psychosocial and clinical care to improve adherence and retention in care.</p> <p>Each session includes 3 stages (each 1-2 hours):</p> <ul style="list-style-type: none"> Screening (TB, sexual health including STIs and FP, nutrition, mental health). Interactive discussion/ structured peer support group (I-ACT for adolescents curriculum). Prepacked ART refill or fast-track nurse visit when indicated. Peer support groups cover various topics including adherence, disclosure, stress and coping skills, identity, sexuality and gender, relationships, effective communication, risk behaviours, pregnancy and FP.
WHERE:	Facility-based (clinic)
WHO (participants):	<p>Closed groups of 15-20 (minimum 10, maximum 20) AYPLHIV with age groups 12-15, 16-19, and 20-24 years.</p> <p>There is further grouping by mode of transmission (perinatal and horizontal) and sometimes by whether or not clients are in school.</p> <p>To facilitate peer learning each group will mix clients newly initiated on ART (NI), clients on ART with suppressed VL (VS) and those not suppressed on ART (NVS). Groups are also mixed in terms of those who are good adherers, confident, active and motivating with those who are still coming to terms with their status and disclosure.</p> <p>Inclusion criteria:</p> <ul style="list-style-type: none"> Full disclosure/ ability to comprehend HIV status. Able to take responsibility for own treatment. No known cognitive disabilities or other chronic co-morbidities.
WHO (facilitators):	Led by trained lay provider (YCC facilitator) and supported by health provider (e.g. NIMART-trained nurse or doctor responsible for clinical management). The YCC facilitator could be a peer educator or a lay counsellor from the facility who is usually young and not necessarily HIV-positive
WHEN:	Initially monthly sessions (to encourage social cohesion and ensure clinical management). Then reduce to bimonthly sessions – outside of school hours (after minimum 10 months).

HOW (model):	<ul style="list-style-type: none"> • All new and existing HIV positive patients are informed about clubs and invited to join if eligible. • They will be allocated to a category (newly initiated or stable on treatment) • At the start of a YCC, clinical data is captured, and it is determined whether clients need to see the nurse for bloods, FP or clinical visit. • Peer supporters conduct interactive discussion/ structured peer support group. • All stable patients can collect pre-packaged ART refills (from YCC facilitator) and will have: <ul style="list-style-type: none"> o Bloods taken at month 6 and every 12 months thereafter. o Nurse visit the month after the bloods were taken. • Where VL is unsuppressed client receives monthly nurse visits, adherence support, and repeat VL after 3 months. Once the VL is suppressed the client is transferred back to the stable group. • If the client fails to suppress their VL after 3 months, referral to a doctor is needed. • When club members do not attend they are traced and followed up as soon as possible. • For a first missed visit: pre-packed ART can be collected within 5 days directly from club nurse • For a second consecutive late or missed visit: client is referred to club nurse for full clinical visit and normal ART script. Client then forfeits privilege of pre-packed ART and returns to clinic care. • When patients reach 25 years they can transfer to adult care if well. Participants age together and can naturally transition to an adult adherence club, offering some continuity of care.
HOW (peers):	<p>YCC facilitators (peer educators or lay trained counsellors) were trained by MSF to conduct group psychosocial support adapted to youth, as well as how to run groups. Nurses were also trained to provide YFS and to integrate FP with HIV clinical management. All clinic staff are trained to recruit clients to YCC.</p>
EVALUATION:	<p>An outcomes analysis of 337 youth enrolled from March 2012 to May 2015, found overall retention at 12-months was 81.7% and varied significantly by enrolment category with high retention amongst those youth that enrolled into youth clubs on ART and low retention of ART ineligible youth (prior to test and treat policy in South Africa).</p> <ul style="list-style-type: none"> • ART ineligible: 52.9% retention • Newly ART initiated youth: 86.4% retention • Stable on ART: 94.3% retention <p>During this period 18 youth became eligible for ART and initiated and 84 newly initiated youth became stable on ART. 60 youth turned 26 years old and graduated from the youth clinic to adult services.</p> <p>Data show 75% viral suppression and 81-86% retention at 12 months.</p>

CHALLENGES/ LESSONS LEARNT:	<ul style="list-style-type: none"> • Inconsistent recruitment by nurses. Motivating nursing staff to consistently invite youth on ART to join YCC was challenging and improved after targets were set and monitored by City Health. Pro-active recruitment of youth by all staff at the clinic is essential to ensure effective utilization of this model. Pamphlets advertising clubs and additional information offered during waiting room talks can further support recruitment efforts. • Reluctance by nurses to provide clinical oversight of youth club register and monitoring of schedule for CD4 counts and FP with attempts to shift this responsibility to YCC facilitators. • Intermittent club attendance by some who only attended every second club session, highlighting the importance of carefully balancing the value of establishing group cohesion with clinic visit frequency based on youth inputs. • Poor retention of ART ineligible youth. Attendance 'rules' for ART ineligible youth club members were more relaxed, allowing them to miss up to three consecutive club sessions before being asked to exit the club and return to routine clinic care. This may have impacted group cohesion (no longer relevant with advent of test and treat policy in South Africa). • It is feasible to integrate FP into simplified group ART delivery models, reducing risk of missed FP appointments. • In a setting with both perinatally and horizontally infected youth, it is recommended that separate YCC be formed for each group so that discussion and interaction can be tailored to needs. • YCC have gone beyond establishing peer networks of support to members, empowering youth to disclose their status publicly and talk about being young and HIV positive in South Africa.
PUBLICATIONS:	<p>http://www.differentiatedcare.org/Portals/0/adam/Content/sflyjK7W3E6yrfB_wB4jtw/File/11.%20Wilkinson%20Poster%20Youth%20clubs%20(AIDS%202016)-1-2.pdf</p> <p>https://samumfsf.org/sites/default/files/2017-07/10_Youth%20Report_Khayelitsha_2016.PDF</p> <p>http://www.differentiatedcare.org/Models/YouthClubs</p>



Name of model: **READY (Resilient and Empowered Adolescents and Young People)**

Country/ies where implemented: Zimbabwe, eSwatini, Tanzania, Mozambique, Burundi, Ethiopia, Uganda, Cote d'Ivoire, Namibia and India

Developed and implemented by: Frontline AIDS

Contact person: Cecilia Kihara ckihara@frontlineaids.org

Background and introduction to model: READY is a youth-led movement, working with and for adolescents and young people aged 10-24 years living with and affected by HIV in East, Central and Southern Africa, with a growing presence in West Africa and Asia. We work with and for adolescents and young people in their diversity – regardless of their sexual orientation, gender identity or expression – to understand their SRHR and make healthier choices. READY emerged from the Link Up programme on SRHR/HIV integration that reached almost 1,000,000 adolescents and young people in their diversity with SRHR/HIV information and services.

The model places adolescents and young people at the centre and aims to increase their HIV/SRHR knowledge, participation and advocacy capacity, which includes peer support as the core component of all its interventions. The READY model engages with the entire system in which the young person grows and provides comprehensive response to meet their needs. Incorporated in the model are three critical principles: strengthening health facilities' capacity to address the needs of diverse adolescents and young people; using the family-based approach that integrates parents or caregivers in the care of young people; and integration of psychosocial support and sexual and reproductive health services.

WHAT:	<p>Purpose: and explanation of the model. Where along the Find, Test, Treat and Retain continuum is the model primarily focused – explain.</p> <p>There are five different interventions under READY, all responding to different sub-groups of A & YP, recognising that they are not a homogenous group. The interventions range from supporting those living with HIV, those affected by HIV, specific engagement with adolescent girls and young women, and a specific focus on leadership development. Funded by the Government of the Netherlands Ministry of Foreign Affairs and the Government of Sweden, READY has also been adopted by Global Fund programmes in Cote d'Ivoire, Namibia and India.</p> <p>The main aim of READY is to ensure that adolescents and young people are ready to make informed decisions about their health and wellbeing; that parents, caregivers and communities are ready to support young people and to promote their rights, health and wellbeing; to ensure that service providers are ready to deliver youth-friendly services, including HIV and SRH services, psychosocial support and information; and to ensure that decision makers are ready to champion the SRHR of adolescents and young people living with and affected by HIV.</p> <p>Through outreach, peers provide information through edutainment, including sports to encourage young people to attend HCT which is provided in both clinical and nonclinical settings. For those testing positive, linkages are created to pre-identified facilities where HIV and SRH services tailored for adolescents and young people are provided.</p> <p>Through peer-navigated services, facilities ensure that A & YP receive peer counseling and psychosocial support alongside health services. Also critical is health provider training in adolescent and young people care and peer-led support groups and education programmes delivered through support groups. Health provider training in SRHR and quality improvements made in the integration of HIV-SRHR services creates a more enabling service environment and experience for A & YP.</p> <p>Peers also work in the community to provide the 1:1 support in homes to ensure adequate support to their peers to stay on treatment, and the opportunity for engagement on other issues the young person may be experiencing in relation to their physical and mental health.</p>
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WHO (participants):	A & YPLHIV aged 10-24 years; adolescents and young people affected by HIV; young people engaged in sex work, young MSM, young injecting drug users and adolescent girls and young women
WHO (facilitators):	Peer supporters run support groups once a month; CBOs provide mentoring and coaching support to the peer supporters; partners provide training to service providers on youth friendly service provision and psychosocial support.
WHERE:	Activities take place in both the community and the facility. Community based peer supporters provide information, accompany service providers who provide HCT and they facilitate the referral to health facilities. Peer supporters also work in the community to support their peers to stay on treatment, provide information on SRHR and provide PSS.
WHEN:	Support groups meet once a month but there is ongoing support provided to the peers by implementing partners in country. Outreach activities take place more often.
HOW (model):	<p>The model works through interlinked partners in each country made up of implementing partners who coordinate the work and facilitate the activities of the peer supporters in the community. These activities include:</p> <ul style="list-style-type: none"> • Coordinating safe spaces • Coordinating the training of parents or caregivers • Coordinating the training of health provides • Hosting community dialogues and • Supervisory support to the peers. <p>The peers, aged 17-23 years, have been trained to deliver a set of interventions in the community and within the facilities in close coordination with service providers. Specifically, they:</p> <ul style="list-style-type: none"> • Run the safe spaces which include support group, teen clubs, after school activities) • Man the reception, take bookings and support peers to navigate services within facilities • Provide SRHR and adherence counselling and information on treatment, adherence counselling • Conduct home visits • Distribute commodities • Two-way referral is in place where facility based peers refer to social protection and other services available in the community and to community peers for ongoing support. Community peers refer to facilities for care. • Lead youth advocacy • All peer supporters are trained on data collection and entry.
EVALUATION:	<ul style="list-style-type: none"> • READY+ Midterm Review: A mid-term review showed that the model has been well accepted in Tanzania, eSwatini, Mozambique and Zimbabwe where it is focusing on HIV positive adolescents and young people. The programme design was reported as relevant as it is all encompassing by working with a range of target groups that include service providers, communities and decision makers in order to bring about far-reaching change that transforms the lives of adolescents and young people living with HIV. The review also found out that training and peer support does not only build the capacity, resilience and confidence of young people living with HIV as leaders, advocates, peer supporters and researchers but are also valuable lifelong skills that young people can and will use beyond the programme. • Peer Support: A randomised controlled trial was conducted in rural Zimbabwe to determine the effectiveness of peer supporters on improving linkage to services and retention in care, adherence and psychosocial well-being among adolescents living with HIV.

CHALLENGES/ LESSONS LEARNT:	<p>Challenges:</p> <ul style="list-style-type: none"> • There's need for an even broader focus on issues relevant to adolescents and young people, particularly linking to economic opportunities/vocational skills training and nutritional support • Community engagement and working with parents or caregivers continues to be an area of high priority. While services are provided in the facilities, young people live in the community so awareness and addressing HIV-related stigma and discrimination continues to be important • Investment in service provider capacity development continues to be critical to ensure they have adequate information to provide friendly services to adolescents and young people in their diversity • Confidentiality continues to be of high focus, particularly for adolescents and young people from key populations • Disclosure – how to tell others including parents, teachers or partners their status. • Caring for peer supporters – ensuring adequate mentoring, coaching, supervisory support, compensation for time and work is done to high standard. <p>In working through the peer support model, we have learnt:</p> <ul style="list-style-type: none"> • Understanding of roles and responsibilities is critical, and providing adequate mentoring and accompaniment is key • Meaningful engagement in designing, monitoring and accrediting health services • It's important to investment in youth leadership in advocacy: training, support in developing advocacy asks, accompaniment in influencing spaces, support in development of products with evidence backing up their position, etc.
PUBLICATIONS AND RESOURCES:	<p>M-Health: Under the READY+ programme an adherence application was developed. This application aims to help AYPLHIV to know how well they are doing on treatment and share challenges they may be facing so that the implementing organisations may see how best to support them. This application is being used in Mozambique and eSwatini and will be scaled up to other countries. In order to collect near real time data an application called Wanda that runs on the DHIS2 software is used by all CATS to collect client level data for AYPLHIV. Wanda is also used on the desktop by implementing organisations to collect, analyse and visualise data on the desktop.</p> <p>Other resources developed under the READY portfolio are available in hard copy and online. Many have been translated into French, Swahili and Portuguese.</p> <p>Materials range from informational and educational leaflets aggregated for age and covering different topics such as how to use a condom, talking about STIs, thinking about sex etc. These are tailored to support adolescents and young people who are HIV unaware to get tested and to have safer sex. They are used by peer supporters in support groups as well as by healthcare workers in engaging and educating young people around their own sexual wellbeing and signpost them to further information and support.</p> <p>Additional resources are available that are sex positive, equipping adolescents and young people with the knowledge, positive attitudes and skills to enjoy sexual and reproductive health and well-being. Tools that support peers to stay on treatment, treatment literacy and how to disclose their status to others have also been development for use by peers, health care workers and parents/caregivers.</p>

Name of programme: Zvandiri

Country/ies where implemented: Zimbabwe; currently being used in Zimbabwe, Mozambique, Tanzania and Swaziland.

Developed and implemented by: Africaid

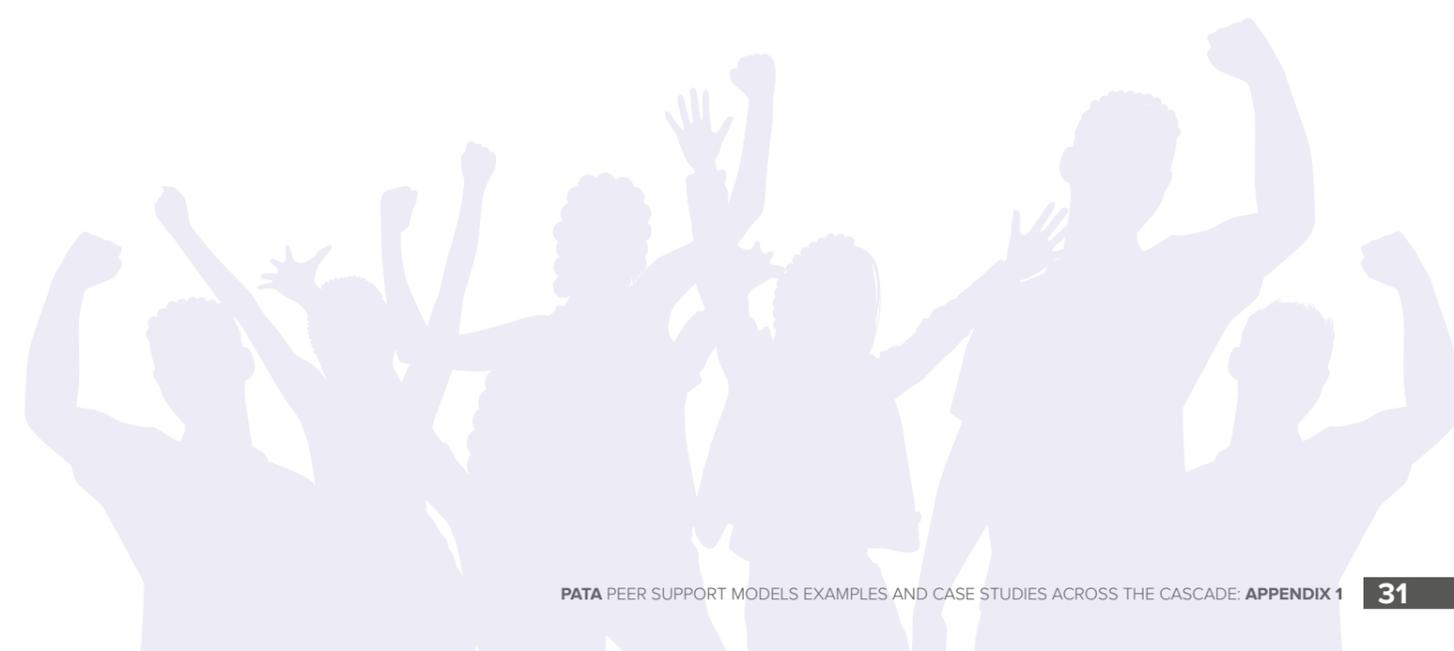
Contact person: Nicola Willis: nicola@maruva.org or info@africaid-zvandiri.org

Background and introduction: The Zvandiri programme was established in Harare in 2004 in response to six adolescents living with HIV who wanted to begin a support group. Zvandiri (meaning 'as I am' in Shona) aims to equip CAYLHIV with the knowledge, skills and confidence to cope with their HIV status and to live healthy, safe, fulfilled lives. Africaid works in partnership with the Zimbabwean Ministry of Health and Child Care (MoHCC), the Ministry of Public Service, Labour and Social Welfare, the Ministry of Primary and Secondary Education and the National AIDS Council of Zimbabwe and since 2009, have been developing a globally recognised, peer-led model for supporting CAYLHIV. This approach centres on Community Adolescent Treatment Supporters (CATS). The model has been developed in partnership with ALHIV, with the different components of the model being piloted then scaled up progressively over the years in response to the evolving needs of HIV-positive adolescents in Zimbabwe. In 2016, the CATS model began being scaled up in Mozambique, Tanzania and Swaziland under the READY+ programme, led by the International HIV/AIDS Alliance. Zvandiri has been adopted by the Government of Zimbabwe and is currently being expanded by the Ministry of Health with PEPFAR support. It is expanding further to include focused support for disabled children and adults living with HIV, young mothers living with HIV, as well as mental health, and SRH services.

WHAT:	Zvandiri is a theoretically grounded, multicomponent, DSD model for CAYPLHIV in Zimbabwe that integrates peer-led, community interventions within government health services. Through the Zvandiri programme, Africaid provides differentiated HIV prevention, treatment, care and support services across the HIV cascade.
WHERE:	Health facilities-based and community-based.
WHO (participants):	6 to 24-year olds
WHO (facilitators):	CATS are YPLHIV, 18-24 years, who work between the health facilities and homes of CAYPLHIV (6-24 years) to improve outcomes across the HIV care cascade.
WHEN:	Monthly community-based support groups; home visits as needed; support at health facilities as needed

<p>HOW (model):</p>	<p>CATS use index case finding and mobilisation activities at high volume events such as music galas, exhibitions and commemorations to encourage HIV testing and to identify and refer adolescents and young people to HIV testing services and support pre and post HIV test counselling. Those who are diagnosed as HIV negative are then linked by CATS to prevention services, while those who are HIV-positive are linked to treatment and care and registered with Zvandiri.</p> <p>CATS then support AYPLHIV to adhere to treatment by providing peer-led, adolescent-focused information, counselling and support, helping them to understand their HIV diagnosis and support treatment adherence, drawing on their own experience This is provided through home visits, group meetings, visits to clinics, and by sending SMS clinic and adherence reminders. Monthly community-based support groups facilitate learning, confidence building, and socialising. Community outreach teams provide more advanced care in the homes of CAYPLHIV. Within health facilities, CATS provide their clients with information and counselling on disclosing their HIV status, ART initiation and adherence. CATS also participate in refill visits and register adolescents and young people for community follow-up at home and in support groups, as well as referring those who need it to services for SRHR, mental health and child protection and educating individuals on SRH and life skills. The programme helps make health services more efficient and effective by taking responsibility for linkage to care, LTFU, and adherence monitoring, as well as changing HCP attitudes and building their skills to provide strong YFS. CATS provide the link between adolescents and health facilities, assisting in ensuring CAYPLHIV are retained within HIV treatment services and play a role in linking adolescents to other SRHR services and support.</p> <p>A young mothers' group has also been established in recognition of the challenges facing young women living with HIV around conception, pregnancy, feeding and parenting. CATS also assist with income-generating projects; programmes for parents and caregivers; and adolescent involvement in advocacy campaigns and policy and guidelines development.</p>
<p>HOW (peers):</p>	<p>Africaid train, mentor and supervise CATS in a supportive rather than directive way. CATS therefore actively participate in all aspects of programme planning, implementation, monitoring and evaluation.</p> <p>The MoHCC and the Zvandiri Mentors are responsible for identifying and selecting new CATS, recruited from Zandiri support groups. New CATS receive two weeks of theoretical and practical training including a vocational skills training programme, and ongoing counselling training, mentoring, support and debriefing while in the role. Once trained, they join staff case management as well as weekly referral meetings. Most CATS fit their work around education or vocational training and are paid a stipend every month and transport reimbursement every week. Individual CATS support a caseload of between 60 and 80 clients from their own or neighbouring communities.</p> <p>CATS are supported through Zvandiri's 'Care for CATS' scheme. This includes clinic-based CATS supervisors providing CATS with on-site mentorship, weekly visits from Zvandiri Mentors and monthly CATS co-ordination meetings. In addition, older CATS support younger CATS and shadow prospective CATS. Some older CATS become provincial mentors in a full-time, paid role that involves supervising larger numbers of CATS over wider geographical areas and liaising with case care workers and multiple service providers.</p> <p>A training-and small-business grants programme was introduced to extend support to the CATS and Zvandiri clients. Partnerships with local colleges and business, who provide training and apprenticeships in subjects such as bakery and mechanics, support older clients and 'graduating' CATS to develop their skills for possible future careers.</p>

<p>EVALUATION:</p>	<p>Zvandiri has been scaled up across Zimbabwe through phased expansion, with replication of the model from Harare in 2004, to 6 districts in 2010, and to 3 provinces in 2011. In 2014, the MoHCC adopted Zvandiri as a key component of its national accelerated action plan for paediatric and adolescent HIV treatment. It has expanded into 51 of 63 districts, reaching 40,213 CAYPLHIV (5312 aged 0-4 years; 5,830 aged 5-9 years; 7976 aged 10-14 years; 11245 aged 15-19 years; and 9850 aged 20-24 years)</p> <p>An RCT was conducted in Gokwe district in 94 adolescents (10-15 years), 47 randomised to standard of care plus CATS services (including weekly home visit) and 47 receiving only standard of care. At 12 month follow-up, with a response rate of 85% (intervention arm) and 60% (control arm), findings indicated that adolescents supported by CATS were 3.9 times more likely to adhere to treatment than the control group. At the start of the programme, adherence was at 44.2%, improving to 71.8%. Linkage to services and retention in care within the intervention group increased compared with a decrease in the control arm. The intervention group reported a statistically significant increase in confidence, self-esteem, self-worth and quality of life compared with a decrease in the control arm. The impact of the intervention was also felt by caregivers. Limitations of the study included small sample size and the use of self-reported adherence (no viral load monitoring) (Willis et al; 2019).</p> <p>Further research is needed to establish the effectiveness of the CATS service on a larger scale and on viral suppression to provide additional evidence.</p> <p>Two RCTs are planned:</p> <ol style="list-style-type: none"> 1. a cluster randomised trial of the multi-component Zvandiri Programme. 2. an RCT of the peer support intervention specifically.
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CHALLENGES/ LESSONS LEARNT:	<p>Partnerships:</p> <ul style="list-style-type: none"> • The importance of integrating community interventions within the national HIV prevention, treatment, and care programmes, through strong collaborations with government, civil society, and funding partners. Government leadership and coordination were critical in driving scale-up of an integrated, sustainable, differentiated service for CAYPLHIV • Integration of training, supervision, and mentorship within national systems from an NGO at national, provincial, and district level has been essential for government ownership and support for CATS. <p>Working with adolescents:</p> <ul style="list-style-type: none"> • Peer-led interventions are extremely effective for adolescents. • Adolescent involvement in all aspects of programme design and delivery, monitoring, evaluation, and research has been critical, acceptable, and sustainable. • The relationship between programme staff and CATS is crucial. • Enabling youth autonomy leads to strong leaders and role models. • Designate a physical space that is welcoming and safe. • Differentiate between ages. • The importance of community treatment, care, and support programmes for CAYPLHIV in strengthening health and psychosocial outcomes. <p>Data and M&E:</p> <ul style="list-style-type: none"> • A shared M&E system established with clinics, or a national system would have helped to demonstrate the impact of a community-based intervention in improving retention, adherence, psychosocial well-being, and SRH and mental health outcomes. • Use of programmatic data, together with partnerships with research institutions, has produced robust evidence for informing policy, service delivery, and scale-up, as well as resource mobilisation. • Strengthened and scaled-up objective markers, including routine VL testing and refined measures of mental health, are needed to demonstrate sustained impact. • Basic cost effectiveness and cost-benefit data can strengthen evidence for good practice and sustainable impact.
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PUBLICATIONS AND RESOURCES:	<p>International HIV/AIDS Alliance (2017). Supporting children, adolescents and young people living with HIV to start and stay on HIV treatment; Africaid Zvandiri</p> <p>Mavhu, W., Berwick, J., Chirawu, P., Makamba, M., Copas, A., Dirawo, J., ... & Mungofa, S. (2013). Enhancing psychosocial support for HIV positive adolescents in Harare, Zimbabwe. <i>PLoS one</i>, 8(7), e70254.</p> <p>Willis, N., Napei, T., Armstrong, A., Jackson, H., Apollo, T., Mushavi, A., ... & Cowan, F. M. (2018). Zvandiri—Bringing a Differentiated Service Delivery Program to Scale for Children, Adolescents, and Young People in Zimbabwe. <i>JAIDS Journal of Acquired Immune Deficiency Syndromes</i>, 78, S115-S123.</p> <p>Willis, N., Frewin, L., Miller, A., Dziwa, C., Mavhu, W., & Cowan, F. (2014). “My story”—HIV positive adolescents tell their story through film. <i>Children and Youth Services Review</i>, 45, 129-136.</p> <p>Willis, N., Milanzi, A., Mawodzeke, M., Dziwa, C., Armstrong, A., Yekeye, I., ... & James, V. (2019). Effectiveness of community adolescent treatment supporters (CATS) interventions in improving linkage and retention in care, adherence to ART and psychosocial well-being: a randomised trial among adolescents living with HIV in rural Zimbabwe. <i>BMC public health</i>, 19(1), 117.</p> <p>Best Practices for Adolescent- and Youth-Friendly HIV Services March 2017 TR-16-134: A Compendium of Selected Projects in PEPFAR-Supported Countries https://www.measureevaluation.org/resources/publications/tr-16-134</p> <p>https://www.pepfarsolutions.org/solutions/2018/1/13/zvandiri-peer-counseling-to-improve-adolescent-hiv-care-and-support-7dfym</p> <p>http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf</p> <p>https://www.iasociety.org/Web/WebContent/File/meeting_report_clinical_models_care_adolescent_2016.pdf</p> <p>https://www.youtube.com/watch?v=zlfCl4_Up2s</p> <p>Sharer, Melissa, and Andrew Fullem. 2012. Transitioning of Care and Other Services for Adolescents Living with HIV in SubSaharan Africa. Arlington, VA: USAID’s AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.</p> <p>https://www.who.int/hiv/pub/guidelines/adolescents/en/</p>
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