ADVOCACY IN ACTION

A GOOD PRACTICE GUIDE

FOR PARTICIPANTS

2022

PAEDIATRIC-ADOLESCENT TREATMENT AFRICA

Contents

List of Annexures

SECTION 1

COURSE INTRODUCTION

Background

Welcome to PATA's Advocacy in Action Training! This training has been developed for frontline health providers working with adolescents and young people (AYP) in all their diversity, specifically in providing sexual reproductive health (SRH) and HIV services.

Frontline health providers play a crucial role in facilitating adolescent and youth-friendly health services (AYFHS) and are key to open, trusting, and confidential relationships with AYP. By respecting their rights and offering services that are people-centred and free from stigma, health providers can promote the development of AYP whilst supporting their autonomy.

Purpose

The purpose of this training is to enable health providers to advocate for AYFHS, especially in the area of integrated HIV and SRHR services for AYP. The training also aims to help health providers identify opportunities to provide an integrated package of services to address some of the adolescent health needs and problems.

The objectives of the training are:

- To sensitise health providers to the role of advocacy in AYFHS and integrated SRHR/HIV for AYP
- To enable health providers to be strong health advocates by applying relevant advocacy tools and techniques to develop and deliver advocacy campaigns
- To identify opportunities for promoting and delivering integrated SRHR/HIV services to AYP and those living with HIV.

Target audience

Frontline health providers working with AYP.

Training methodology

This Good Practice Guide (GPG) is one of several resources which PATA has developed to strengthen the capacity of health providers to deliver integrated AYFHS. It is complementary to the:

- Online (self-study) training curriculum
- Face-to-face (in person) training

This guide relies predominantly on self-study and self-assessment activities. We encourage you to attempt all activities as it will promote effective learning and retention of information. The model answers are available as an annexure for review and correction.

There are 5 modules in this course. Section 2 provides the course content, with each module detailing the **learning objective(s), key definitions, theory, strategies and tools, key messages, and exercises** to complete.

Below is a list of icons and a description of their use in this manual.

Icon	Description
	Pre- and Post-Training Test
	Self-Assessment Activity
	Case Study

SECTION 2

COURSE MODULES

MODULE 1 Health providers and advocacy

Learning objectives:

- ✓ Understand the concept of advocacy, its related activities, and main goals.
- ✓ Identify key stakeholders in advocacy and develop a power analysis.
- ✓ Apply a human rights-based approach to advocacy.
- ✓ Understand the role of a health provider advocate.

Introduction and background

This module introduces the concept of advocacy and the role that health providers play in delivering and advocating for AYFHS, including integrated SRHR/HIV services for AYPLHIV. The key skills, tools and techniques are provided for stakeholder mapping and power analysis as well as tips on how health provider advocacy can strengthen health systems through engagement with peers, the community, decision-makers, and other stakeholders.

1.1 Advocacy

ADVOCACY means working for change and involves speaking up, drawing community attention to important issues, and influencing change in policies, behaviours, practices, and public perceptions. There are different types of advocacy activities:

AWARENESS RAISING	Provide persuasive and evidence-based messages on the issue, e.g. the need for comprehensive family planning services for AYP
LOBBYING AND NEGOTIATING	Have one-on-one discussions with decision-makers to influence policy change, practice or behaviour related to delivering AYFHS.
CAMPAIGNING	Create, mobilise, and change the perceptions of health providers towards the need for AYFHS and build support to influence decision-makers and key stakeholders.
RESEARCH, PUBLICATIONS	Illustrate the underlying causes and possible solutions to the shortcomings of the issue (e.g. family planning services for AYP in a particular community) and present recommendations for decision-makers and key stakeholders to address.
CONFERENCES, EVENTS, MEETINGS	Bring together a variety of stakeholders and decision-makers to highlight the causes and identify the solutions to the shortcomings in AYFHS for AYPLHIV, with concrete, follow-up, and immediate actions.

1.2 Stakeholders and powerholders

Important Terminology	Definition
1. Stakeholders	All the actors (individuals, organisations, institutions, and groups) that have a role in a particular advocacy goal/effort, in that they can either gain or lose. There are four types of key stakeholders: opponents, beneficiaries, allies, and decision-makers
2. Stakeholder mapping	A tool to map all the actors involved in a particular advocacy issue.
3. Power mapping grid	A tool to map the key actors that you need to target to achieve the changes desired for your advocacy objectives and those who can influence your key actors.

IDENTIFY THE KEY TARGETS:

WHO are the decision-makers

WHERE are decisions made

WHAT is the decision-making process

WHICH of the decision-makers have the final say (decisive influencer) and who are their consultants (secondary targets)

WHO are supportive of, and opposed to, the desired change

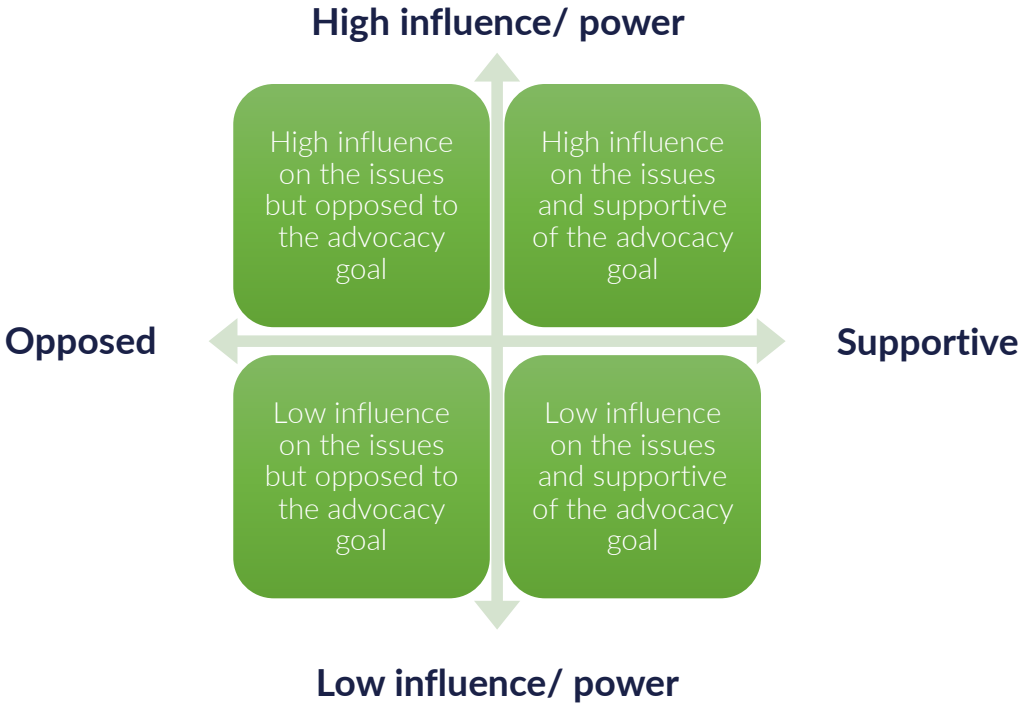
Case Study Scenario – 'Ensuring that pregnant young girls and women living with HIV in your community have access to affordable treatment, care, and support to ensure prevention of mother-to-child transmission (PMTCT)'.

Stakeholder mapping can help to understand who you need to work with and who are the decision-makers involved in the advocacy issue. The stakeholder mapping grid can be used when developing advocacy initiatives, to identify the relevant role players. Think about who will support your initiative to help bring about the desired change. Use the grid below to identify the decision-makers, allies, opponents, and beneficiaries in this scenario, and write them in the appropriate block.

(See Annexure 1 for answers)

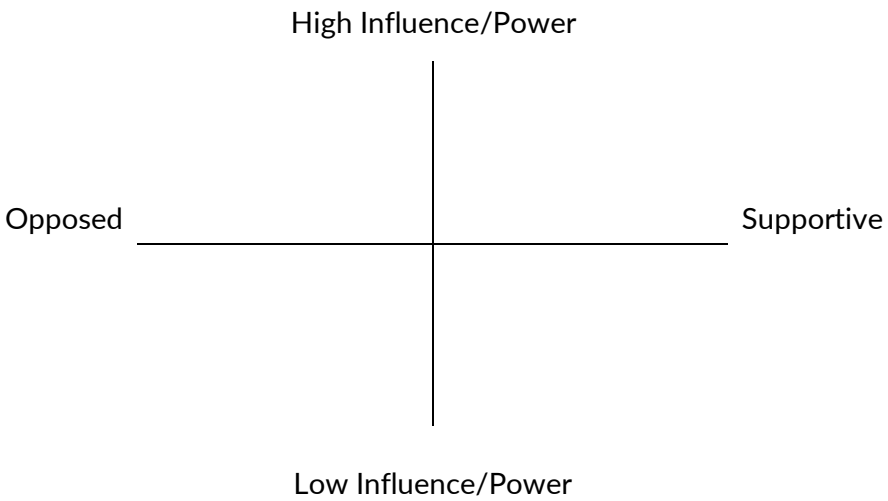
Decision-makers	*Allies*
Opponents	*Beneficiaries*

The power mapping grid helps to identify the advocacy targets and their influencers, understand their power and whether they support or oppose the advocacy objective.



Case Study Scenario – 'To have an adolescent day and teen club on Saturdays where HIV treatment (ART), care and support is provided together with family planning and SRHR services. SRHR/HIV services are integrated, and AYPLHIV only need to visit the facility as scheduled for their teen club'.

Power analysis classifies the stakeholders according to how much influence they have on achieving the desired changes for the advocacy objectives. It is helpful to know who to target (primary targets) and who can influence them (secondary targets). Use the power mapping grid below to identify where each of the following stakeholders are located: Schools, AYPLHIV, health facility managers, traditional leaders, caregivers. *(See Annexure 1 for answers)*



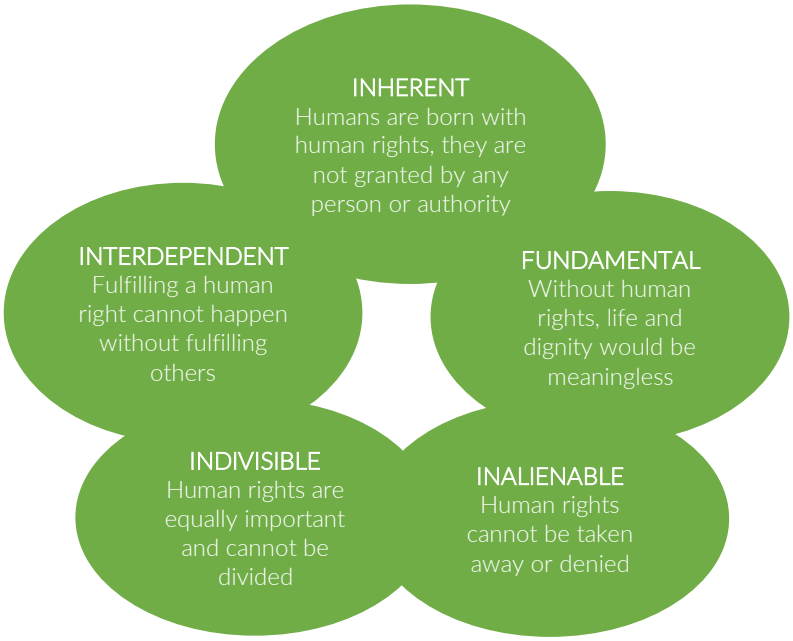
1.3 Human rights

Important Terminology	Definition
1. Human rights	Values and principles that are universal (apply equally and to everyone) and are essential to human dignity.
2. Right to health	A state of complete physical, mental, and social wellbeing, consisting of four core components: availability, accessibility, acceptability, and quality.
3. Human Rights Based Approach (HRBA)	The rights that people have, the shortfalls in their enjoyment of these rights and the ways in which decision-makers and powerholders influence and determine the shortfalls.

HUMAN RIGHTS are

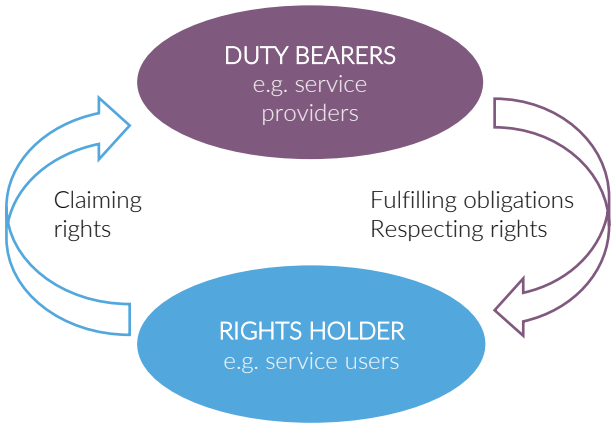
BASIC rights and freedoms
THAT all people are entitled to
REGARDLESS of:

- nationality,
- sex,
- age,
- national or ethnic origin,
- race,
- language, or
- other status.



Key characteristics of human rights

DUTY BEARERS AND RIGHTS HOLDERS



- In health, **duty bearers** are the **health providers** and **rights holders** are the **service users.**
- Service users can claim their rights and health providers have the obligation to fulfil and respect these rights
- Duty bearers have the obligation to respect, protect and fulfil human rights

The **RIGHT** to **HEALTH** includes 4 core components:	
Availability	Ensuring enough health facilities, health commodities, services and programmes are available for all.
Accessibility	Ensuring that health facilities, goods, services, and programmes are accessible to everyone.
	This means they are: - Non-discriminatory - Physically accessible (reachable) - Economically accessible (affordable) - Information is accessible (understandable in language and style)
Acceptability	Ensuring that all health facilities, goods, services, and programmes are respectful to medical ethics, are culturally appropriate, gender-sensitive and acceptable to all.
Quality	Ensuring all health facilities, goods, services, and programmes are medically and scientifically approved.
	Quality health services are: - Safe - Effective - People-centred - Timely - Equitable - Integrated - Efficient

☑ Quick Quiz – select the best answer by circling your response

In each of the following examples, the right to health is unfulfilled. Please indicate in which of the four core components the shortfall in the realisation of the right to health lies.

1. Bahati is not able to make an informed decision about what form of contraceptive she wants to use to prevent pregnancy because she does not really understand the information the health provider gives to her.
   a. Availability
   b. Accessibility
   c. Acceptability
   d. Quality

2. Silvano has a sore throat and has been coughing for the last two days. He went to see the health provider, but due to the long waiting times he is advised to go home and come back in two days. In the meantime, Silvano's situation worsened. Two days later the health provider diagnoses a severe respiratory infection and Silvano needs to be hospitalised because of his extreme difficulties with breathing.
   a. Availability
   b. Accessibility
   c. Acceptability
   d. Quality

1.4 Health provider advocacy

Health providers are well placed to have an impact on advocacy issues because they have **credibility** (they are trusted and believed in) and **legitimacy** (perceived to be objective and reasonable). The five areas of health provider advocacy and activities are:	
Advocacy engagement	Practice- or system-level activities aimed to create lasting change for a community or population of clients.
	E.g. Applying skills of persuasion, communication, and collaboration to achieve desired change when engaging with stakeholders (e.g. local governments, peer health providers, schools, parents, women's groups, religious leaders).
Knowledge dissemination	Activities aimed at disseminating knowledge to the community and decision-makers.
	E.g. Using media outlets (including press, radio, and internet) to spread information and create awareness of a relevant issue. Clients and communities, in turn, show evidence of improved knowledge, attitudes and self-efficacy.
Community outreach	Building relationships to empower communities or populations.
	E.g. Engaging beyond the level of the individual client and addressing social determinants of health and health disparities. Organising community dialogues with community leaders about importance of SRHR/ HIV integration. Community members, in turn, perceive a positive interaction, improved knowledge and a client-health provider relationship is established.
Advocacy teaching and mentoring	Activities using everyday data and evidence to motivate for change.
	E.g. Collecting and using information and evidence on an issue to inform and influence decision-makers. Health providers train on advocacy skills and devise an advocacy project targeting AYPLHIV.
Advocacy leadership and administration	Leadership positions that positively affect population health outcomes or advance the field of advocacy.
	E.g. Taking a leadership position that will lead to policy or systemic change and, in turn, improved outcomes for populations of clients.

SUMMARY:

- Advocacy can highlight issues and build awareness of disadvantaged or vulnerable populations to bring them to the agenda of decision-makers and powerholders.
- Advocacy activities aim to bring about change benefiting the target population.
- Advocacy activities include awareness raising, lobbying, negotiating, campaigning, and undertaking research or evidence gathering.
- Human rights are values and principles that are essential to human dignity. They are universal, meaning that they apply equally and to everyone.
- The right to health consists of availability, accessibility, acceptability, and quality.
- HRBA reflects on human rights values to achieve the desired change. The starting point is to identify the shortfalls in the realisation of the rights of rights holders/beneficiaries. Next is to identify the duty bearers/decision-makers and powerholders who contribute to such shortfalls.
- Health providers are well-placed to have an impact through advocacy activities as they have societal power that can be leveraged to achieve a desired change.

Useful links

- ARASA (2015). Sexual orientation, gender identity, HIV and human rights: An advocacy toolkit. The AIDS and Rights Alliance for Southern Africa (ARASA).
- Athena Network (2016). Step up, link up, speak up: A tool to support mentoring for youth advocacy.
- Carroll, A., & Fernandez, B. (2010). Make It Work: Six steps to effective LGBT human rights advocacy. ILGA.
- International Planned Parenthood Federation (2010) Handbook for Advocacy Planning. IPPF.
- ITPC (2014). ACT Toolkit, Advocacy for Community Treatment: Strengthening Community Responses to HIV Treatment and Prevention. International Treatment Preparedness Coalition.
- UNICEF (2010). Advocacy toolkit: A guide to influencing decisions that improve children's lives. United Nations Children's Fund (UNICEF), New York, 2010.
- WHO (2018). Advocating for change for adolescents! A Practical Toolkit for Young People to Advocate for Improved Adolescent Health and Wellbeing. Geneva: World Health Organization; 2017.

MODULE 2 Communication and facilitation skills

Learning objectives:

- ✓ Know what effective communication is and how to express yourself in a clear and open way.
- ✓ Understand the important qualities of professional relationships and the establishment of a strong partnership between the health provider and client.
- ✓ Develop basic facilitation skills to support discussions with AYP.
- ✓ Have the necessary skills to undertake a community dialogue.

Introduction and background

This module highlights the value of good communication in advocating for and delivering health services. An equal health partnership between provider and client is important. When services are provided in a respectful, friendly manner, AYP are more receptive to the health information received, enabling them to make well-informed decisions. Essential skills, tools, and techniques show the health provider how to start conversations about sensitive topics with AYP and facilitate sessions with open and clear communication.

2.1 Communication skills for advocacy

COMMUNICATION is the transmission of information, thoughts, and feelings so that they are satisfactorily received or understood.	
Verbal communication	Communication you can hear, such as volume of speech, speed of talking, tone of voice and the words you choose.
Non-verbal communication	Behaviour that you can see, such as eye contact, facial expressions, how near somebody is to you and body gestures.

Key communication techniques to help health providers communicate effectively with AYP:

- Provide limited and essential information at any one time. Resist telling the AYP too much information in one conversation or period of time.
- Avoid using words or critical or judgmental statements that show your personal emotions.
- Remember to use simple words and terms that the AYP may understand without difficulty.
- Ask open-ended questions that promote interaction; avoid closed questions where the adolescent can only answer “yes” or “no”.
- Paraphrase or summarise what they have said to ensure that you have understood.

WHY is good listening important for good communication?	
Good listening skills	Elicit more information and check that is it more accurate
	You can quickly avoid and solve problems
	You can reduce errors
Poor listening skills	Creates misunderstandings
	Wastes time
	Increases the risks of making mistakes

Qualities of health provider-client relationships:

- Confidentiality
- Consent
- Empathy
- Respect
- Responsibility

Show AYP that you respect them by incorporating the following elements in your communication with them:

- Speaking with a **clear and calm voice**
- Showing **empathy**
- Recognition of the AYP's **individuality**, **dignity**
- Attention to their **needs**

☑ Quick Quiz: Tick the box to show which of the following examples of communication are verbal and which are non-verbal.

Statements	Verbal	Non-verbal
1. Body language that supports your verbal message	ϒ	ϒ
2. Asking follow-up questions	ϒ	ϒ
3. Rephrasing key point(s)	ϒ	ϒ
4. Posture	ϒ	ϒ
5. Making eye contact	ϒ	ϒ
6. Using open-ended questions	ϒ	ϒ
7. Storytelling	ϒ	ϒ
8. Moving around the audience	ϒ	ϒ
9. Changing the tone and volume of your voice	ϒ	ϒ
10. Facial expressions that support your verbal message	ϒ	ϒ

(See Annexure 1 for answers)

2.2 Facilitation skills

A **FACILITATOR** is a person who leads a group discussion, introducing the purpose and encouraging participation in the discussion.

- A health advocate needs to be able to work with different groups of people and facilitate discussions on potentially sensitive topics where opinions may differ.
- Different activities or methods should be used to allow all participants a chance to engage, e.g. brainstorming, role play, throw the ball, agree-disagree, group Q&A, and dialogues.
- A safe environment respects peoples' opinions and confidentiality, provides knowledge and information, and encourages meaningful discussions by removing barriers, e.g. stigma, shame, and embarrassment.

QUALITIES of a **good facilitator**:
• **Sees the participants as experts** with experiences, information, and skills to share, rather than seeing her/himself as the expert in the room.
• **Thinks of themselves as guiding** the process rather than thinking of the participants as empty bowls to be filled with knowledge from the facilitator.
• **Believes people learn by doing**, experiencing, practicing, and feeling, rather than thinking that people learn by memorising, repeating, and recording information.
• **Sees many possible answers** to a situation or question rather than only one right answer.
• **Thinks it is important** for all to participate and be involved in the process, rather than thinking that controlling the complete learning process is better.

Create a safe space by **setting ground rules**:

- Use correct, non-offensive terms as much as possible.
- Respect each other and listen to others when they are talking.
- Respect personal boundaries. No one is obliged to answer a question or share something or do something they do not want to do/share.
- Discussions are confidential: whatever happens in this session, stays in this session.
- Speak for yourself and not others. Not everything experienced or felt is applicable to the others in the group.

FACILITATION METHODS	
Brainstorming	• Everyone is invited to spontaneously share ideas about the topic, without judgement. • Collect the ideas on a flipchart, chalkboard, post-it notes or online. • Can be used to open a topic for further discussion, collect ideas and pre-existing knowledge and enhance knowledge or correct misinformation, myths, and misconceptions about the topic.
Role-play	• Participants experience and explore realistic situations in interactions with others and experiment with new behaviours by imagining themselves in a specific situation and playing a certain role. • Can be used to gain experience for future situations or an alternative perspective to their own point of view. • Effective for practicing and modelling new skills in a safe, supportive environment.
Throw the ball	• Standing in a circle, group members throw a ball to each other, asking questions related to the topic, providing an answer, and formulating a new question for the next participant to answer. • Used to explore pre-existing knowledge or summarise knowledge gained after a session.
Agree-disagree	• Two signs (agree and disagree) are placed on opposite sides of the room with the facilitator presenting a statement about a topic (related to opinions and feelings rather than facts) and asking participants to move to the side of the room corresponding with their viewpoint. • Participants are invited to share their opinions to stimulate a discussion and establish what influences the viewpoints, showing that people think differently about certain things and there are no right or wrong answers.
Group Q&A	• Facilitator poses a question to a small group, or several groups, and allows time for discussion before the groups are invited to present their answers. • Stimulates group interaction and discussions and reveals existing levels of knowledge in the group while participants learn from each other. • Feedback to the broader group provides opportunity for learning new information or correcting myths and misconceptions about the topic.
Quiz	• Individuals or teams compete for the most correct answers to a set of questions aimed to assess existing knowledge or test the uptake of new knowledge.
Dialogue	• Interactive discussions between different groups of people (e.g. within a community or between different generations) to share knowledge and experiences with a problem and the root causes, increasing understanding of viewpoints and together identifying potential solutions. • Useful to bring about attitudinal change, break down stigma and popularise different health services • Build bridges of understanding between different groups, ages, cultures, religions, and genders in the community

SUMMARY:

- It is important to always establish an open, safe, and friendly environment when talking with AYP.
- Important qualities of a health provider–client relationship are confidentiality, consent, empathy, respect, and responsibility.
- Effective communication skills can influence personal health choices and are important to achieve healthy behaviour and relationships.
- A good facilitator increases the likelihood of meaningful discussions by removing barriers such as stigma, shame, and embarrassment, to create conditions and a safe environment that stimulate the group to share their experiences.
- Facilitation methods are different activities that can be used to elicit discussions and engagement with a group of people.

MODULE 3 Reaching out to and engaging with adolescents

Learning objectives:

- ✓ Learn how to apply case management theories (person-centred management) when working with AYP.
- ✓ Define the various characteristics of AYFHS and how to provide these services.
- ✓ Improve health provider interactions with AYP on SRHR topics.
- ✓ Understand the concept of health partnership and how to meaningfully involve young people in the services or projects that affect them.
- ✓ Understand the concept of clinic-community collaboration, and the steps required to initiate such a collaboration.

Introduction and background

An important topic in this training is working with AYP and AYFHS. Knowing how to reach out to AYP and build trusting relationships is critical to providing integrated SRHR/HIV services. Different entry points in the health system provide opportunities for meaningful participation, e.g. consultation, case management, group work and peer-led service delivery. Engaging with AYP in a respectful, friendly manner ensures that they are treated as equal partners in their healthcare journey and empowers them to adopt positive health behaviours such as adhering to treatment and remaining in care.

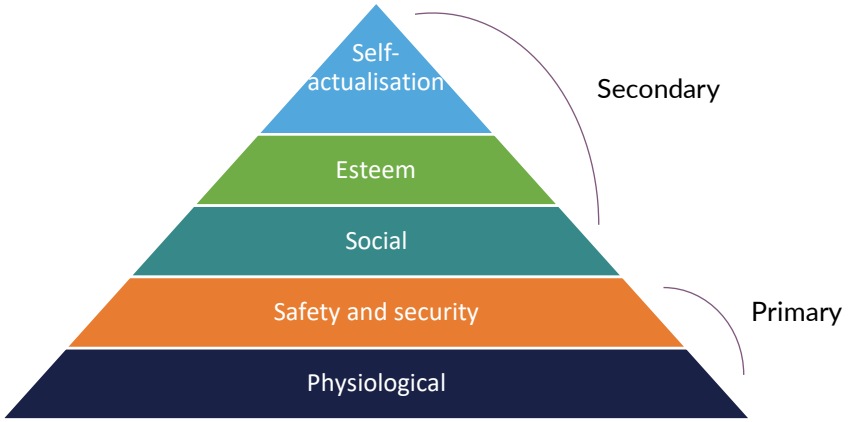
3.1 Understanding adolescence

ADOLESCENCE is a stage of development, for individuals between the ages 10 to 19 years, during which physical, cognitive, emotional, social, and sexual changes occur at different times depending on individual factors and whether they are girls or boys.

It is a period of opportunity as well as a time of vulnerability during which experimentation is common, as they find their own identity and autonomy, and they may be vulnerable to health risks and negative health outcomes.

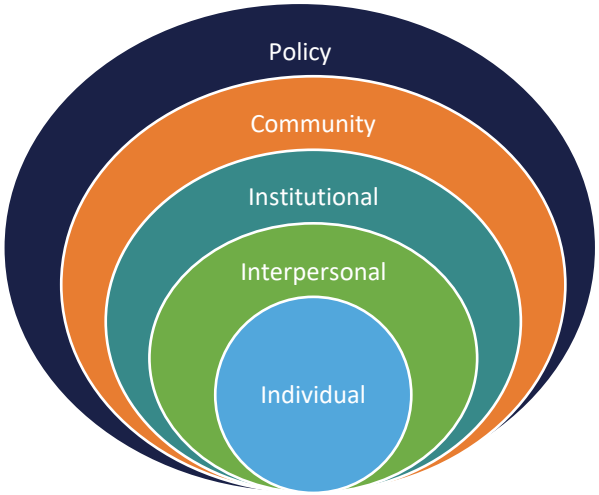
Understanding the needs of AYP

1. **Maslow's hierarchy of needs** illustrates human needs starting at the base of the pyramid and moving up the subsequent layers as needs are fulfilled.



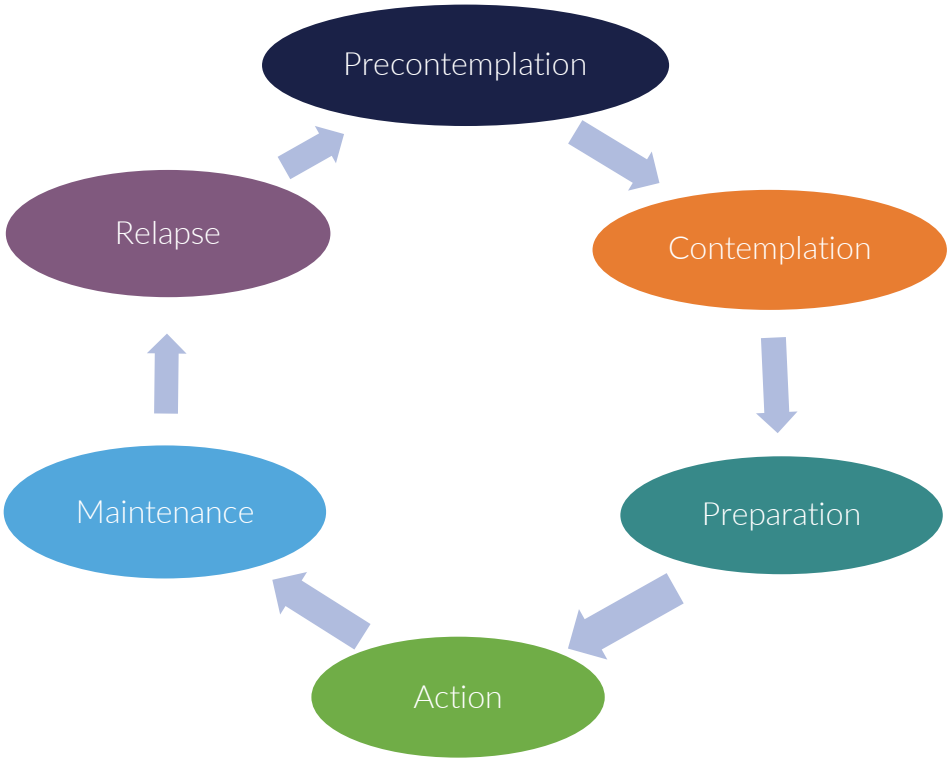
Self-actualisation needs: self-expression, development of talents and abilities
Esteem needs: self-esteem, reputation
Social needs: love and belonging, family, friends
Safety and security needs: stability, order
Physiological needs: food, water, sleep, physical health, etc.

2. **Ecological model** describes the different environments in which AYP live which may impact their growth, development, emotional state, and decision making (individual- and population- level determinants of health and interventions)



Policy: Local, state, and federal policies and laws that impact health and behaviour (e.g. consent regulations for HIV testing for children, infrastructure, political priorities).
Community: Availability and location of resources that promote behaviour, social networks, and social norms (e.g. transportation, healthcare services, social/cultural norms).
Institutional: Rules and regulations of organisations and institutions that impact behaviour (e.g. privacy rules, incentive policies)
Interpersonal: Relationships with others and effects on one's social identity (e.g. peer influence, family, social networks).
Individual: The individual characteristics that influence behaviour (e.g. skills, knowledge, motivation, gender identity, attitudes)

STAGES OF BEHAVIOURAL CHANGE:



The stages of behaviour change by Prochaska and Di Clemente

PRECONTEMPLATION: The individual has not considered a change in behaviour. They may lack the correct information to make a change in their behaviour, which can possibly contribute to active unwillingness.

CONTEMPLATION: The individual begins to consider a change in behaviour. They may doubt their capacity to change, and rather seeks support from other people. Ultimately, in this stage, the individual begins to understand why it is important to make a change.

PREPARATION: The individual recognises a change in behaviour is needed. They accessed information to support a change in their behaviour. During this stage, the individual decides whether they will change their behaviour and how this will be done.

ACTION: The individual changes their behaviour. The decision is set in action and implemented. Individuals feel confident at this stage, because they believe in the possibility of changing and in seeing their decision through.

MAINTENANCE: The individual is trying to strengthen achieved results. The most important thing is to practice new behaviour and keep meaningful people and resources around.

RELAPSE: Sees return to prior behaviour, and the return from action or maintenance to an earlier stage. Individuals often recycle numerous times before behaviour is changed, as sustainable behaviour change relies on practice. The model can be cyclic if an individual returns to an earlier stage and starts the process again.

An individual may leave at any stage when the behaviour is truly changed.

3.2 Key principles in working with adolescents to establish a trusting relationship

	KEY PRINCIPLES to be applied when engaging with AYP
Confidentiality	• Protects individuals from disclosure of their personal and confidential information to others except to such person authorised to receive and evaluate such information.
Informed decision-making	• AYP can make their own decisions (informed decision making) and take responsibility for their actions. • Health providers offer information, provide guidance, and discuss advantages and disadvantages of different options. • AYP has final decision to accept service and/or change behaviour.
Client-centred approach	• Based on the individual. • Health providers see client as an equal partner and prioritises their needs and respects their choices. • Health providers work with AYP at their level and at a suitable speed.
Voluntariness	• The AYP has the right to choose and refuse services. • The health provider carefully and neutrally explains any potential impacts of the AYP's decision.
No judgement	• Accepting and respecting the norms and values of AYP which may differ from one's own. • Personal opinions must be set aside, focussing on the service needed or requested, which is delivered without judgement or stigma.

Case Study Scenario – read the following story. Think about the characters in the story. Who do you like or not like? Rank them in order of who you liked the most and who you liked the least.

Mary is a 19-year-old single mother of two living with HIV, who has come to the facility to ask about what contraceptives she can use. She has multiple partners but doesn't want to get pregnant again because the father of her two kids is not supportive and she is exploring going back to school as she didn't finish her secondary school.

Questions

i. How would you react to this client?
ii. What would you tell her and how would you guide and support her?
iii. What services do you offer her?

3.3 Adolescent-friendly health services

AYFHS:	The services are delivered:
• Attract AYP • Meet their needs with sensitivity and comfort • Retain them in care	• At the right place • At the right price (ideally free) • In the right manner that is acceptable to AYP

The Five Characteristics of AYFHS	
Accessible	AYP are able to obtain the health services they need
Acceptable	AYP are willing to obtain the health services provided
Equitable	All AYP can benefit from the services provided and not just selected groups
Appropriate	Services provided are appropriate to the needs of AYP
Effective	The right health services are provided in the right way

AYFHS FACILITY CHECKLIST	Yes	No
Staff preparedness		
• Are health providers trained and sensitised to work with AYP?		
• Do health providers show respect and a non-judgemental attitude to AYP clients?		
• Are staff respectful of confidentiality and privacy?		
• Are staff comfortable and able to support and provide stigma-free services to AYP from key populations?		
Efficiency and effectiveness of service delivery		
• Is there enough time allowed for provider-AYP interaction?		
• Are there job aids available to assist health providers working with AYP?		
• Are AYP involved in decision-making about how programmes and services are delivered?		
• Are services friendly to both male and female AYP as well as their partners?		
• Are appointment systems and tracking systems in place for AYP who miss appointment?		
Access to services		
• Does the facility provide services at times that are convenient to AYP, e.g. after school?		
• Does the facility have a separate space and separate hours for AYP?		
• Is there a sign that gives information on services and facility hours?		
• Are services safe and affordable or no fees for services?		
Facility Environment		
• Is there adequate space and privacy?		
• Are the surroundings comfortable and not overcrowded?		
• Is the waiting time short?		
• Is there a safe space for AYP?		
Choice of Services		
• Are youth support groups available in the facility?		
• Are peer supporters available to assist in the facility?		
• Are youth-friendly educational materials available?		
• Do AYP have information that will allow them to access information off-site, e.g. telephone hotlines?		
• Are AYP provided with referrals to other services/organisations if there are services the facility is not able to provide, e.g. specific support for substance abuse?		
• Are mechanisms in place for AYP to give feedback on the services they receive?		

BARRIERS TO SRHR SERVICES UTILISATION: Many factors affect the use of SRH services by AYP, these can be individual/ personal factors, cultural/ social factors, and institutional factors. Health providers have a vital role in addressing barriers to ensure services attract and meet the needs of AYP, and hence retain them in care.

Case Study Scenario

Thandi is a 16-year-old young woman who is sexually active but wants to delay pregnancy until she reaches 20-years-old and finishes school. She knows the health facility in her vicinity provides SRH services including contraceptives, but it is 30 minutes' walk from her home, and she doesn't want to visit the health facility when most adults will be there for services.

One day after school she went to the health facility only to find it was closed. She tried on another day but this time the guard at the gate shouted at her, saying the services were not for schoolgirls of her age. As she was in desperate need of contraceptives, she tried once more to visit the facility but this time along with adult clients. She waited a long time until all the adults had received services and their expressions were discouraging. Eventually she got into the consultation room and told the health provider that she needed contraceptives. Without taking Thandi's full history, the health provider said she was already exhausted and had to close the facility. In addition, she said contraceptives were not for girls of her age and asked her why she was sexually active at this age. The health provider has not been trained in AYFHS provision and had no interest in exploring Thandi's history or needs.

Questions:

i. Do you think the health facility is providing AYFHS? If yes, explain why. If not, explain why not. Think in terms of the key characteristics you can check to make sure that AYP are getting quality health services.

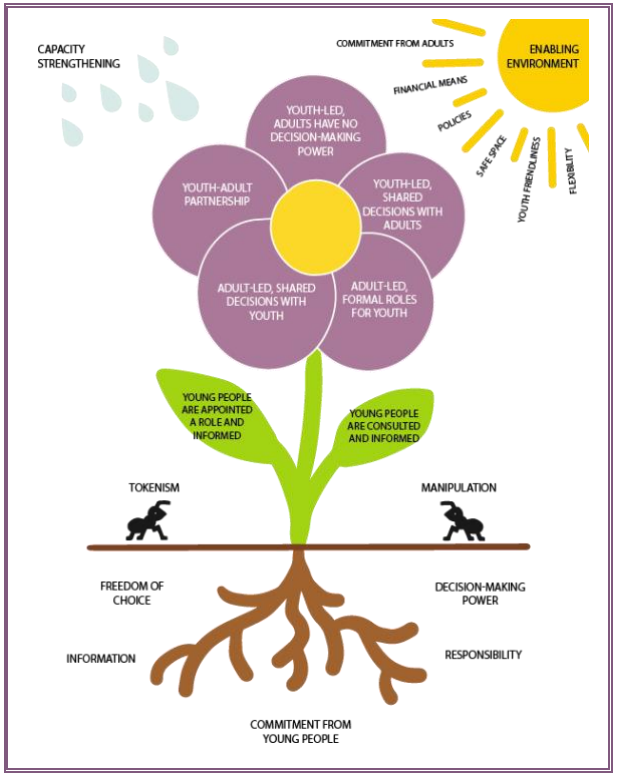
ii. What are the barriers to Thandi's utilisation of SRH services? Categorise them under individual, cultural/ social, and institutional factors.

3.4 Applying adolescent-friendly health services

MEANINGFUL YOUTH PARTICIPATION is an inclusive, intentional, mutually respectful partnership between adolescents, youth, and adults whereby power is shared.

- It is a range of processes that empower young people to take an active role in decision-making and involves working together with AYP and not merely for them.
- Youth participation is viewed as youth–adult partnership and includes peer support, governance, advocacy, and monitoring and evaluation.
- Partnerships with youth arise from the premise that AYP have a right to participate in developing the programmes that serve them, and to have input in developing the policies that will affect them.
- Youth participation can enhance programme outcomes.

FLOWER OF PARTICIPATION



The **Flower of Participation** aims to give an increased understanding of youth participation. The flower consists of multiple levels but of importance here is: 1) the insects 2) the leaves, and 3) the petals.

1. **INSECTS** The insects are not considered as meaningful youth participation, as none of these forms of participation involves responsibility. Ultimately, the insects eat the plants and the flowers and hence destroy meaningful participation. They separate the leaves and petals (meaningful youth participation) from the roots which cause the plant to die.
   Manipulation: This takes place when AYP do not have any understanding of the issues and don't understand their actions. An example is when a fourteen-year-old orphan living with HIV shakes the hand of the President of the United States to make them invest more in orphans.
   Tokenism: AYP are given a voice but have little say on the subject and are given little or no opportunity to formulate their own opinions. This can happen when AYP are given seats on conference panels or when they are included in a delegation but are not allowed to say anything.
2. **LEAVES** The leaves represent forms of participation with low or limited responsibility falling on AYP.
   AYP are appointed a role and informed (low responsibility): AYP understand the aim of the project, they know who made the decisions concerning their involvement and why, and they have a meaningful role. They volunteered for this project after the project was explained to them. However, they do not hold any decision-making power, with limited responsibility and voice.
   AYP are consulted and informed (limited responsibility): The project is designed and run by adults, but AYP understand the process, are consulted, and their opinions are treated seriously. Their suggestions are considered however they do not make the final decision as to whether their input is incorporated or not.
3. **PETALS** All the forms of participation that the flower petals represent are based on equality. Each form of participation works differently and leads to different results. It is important that the form of participation fits the project, its objectives and, most importantly, the needs of the involved AYP.

There are many **enabling factors** needed to grow youth participation in a nurturing environment.

Adult-led, shared decisions with youth (medium responsibility): These projects are initiated by adults and the adults are primarily in charge of the programme. However, decision-making is shared with AYP who have a voice in the design, implementation, monitoring and evaluation. AYP enjoy certain (but not all) decision-making power and responsibility.

Youth-led, shared decisions with adults (high responsibility): These projects are initiated by AYP, who ask adults to join in their activity. The AYP oversee the programme and ask adults to participate for learning purposes and to enhance the quality of the programme, activity, or organisation.

Youth-led and directed (high responsibility): Young people work together cooperatively in large groups, and design and run their own projects with some adult support as needed. Adults can be consulted and invited for capacity strengthening but hold no decision-making power. AYP are completely autonomous.

Health providers can interact with AYP in a way that supports the transition from an unequal, authoritarian relationship to a trusting, positive and equal health partnership.

Services can be made more adolescent- and youth-friendly by engaging with AYP during:

1. Consultation and case management
2. As peer supporters for peer-led service delivery
3. Clinic-community collaboration
4. Community service provision and community monitoring

CONSULTATION AND CASE MANAGEMENT:

- AYP typically present a health matter they would like to discuss or a concern they are seeking support around.
- AYP may have other health problems and concerns but may not say anything about these unless directly asked, which is why it is important to go beyond the health matter and ask them if they have any other concerns.
- The HEADSS framework can help health providers understand and assess risk-taking behaviours and provide appropriate interventions. It is designed to progress from important but less threatening questions like age, sex, and education level to those considered highly personal e.g., sexual behaviours, drug use and HIV status.

The HEADSS Assessment	
Socio-demographic characteristic	Age, sex, education level, relation to the caregiver.
Home environment	Relationships with other household members, changing homes in the last 1-year, missing meals, and physical violence.
Education	School performance, bullying, repeating classes, inability to pay school fees, change of schools in the last two years, and reasons for missing school.
Activity and routine	Involvement in extracurricular activities and religious activities.
Drugs	Use of drugs and substances of abuse.
Sex	Involvement in sexual activity, practice of safe sex, dual protection, and worry about pregnancy/STIs. Questions on sexual activity in different settings are restricted by age, aged 12 years and above is the norm in most places.
Suicide and depression	Any AYP with a score of 1 or more on Patient Health Questionnaire-9 is considered to have a depressive symptom.
Adherence to ARV medication (if applicable)	Missing medication and determine why e.g. not taking medication in front of others, having trouble in taking medication daily or on time, characteristics of the medication (size, taste, colour etc), other more complex reasons.
Full disclosure of HIV status (if applicable)	Full disclosure occurs if the AYP voluntarily listed HIV as part of the reason for visiting the clinic and know why they are taking medication.

PEER SUPPORT AND PEER-LED SERVICE DELIVERY:

- Peer support is practical, social, and emotional support between people in a community of common interest.
- It offers the kind of support and practical help from those who share similar experiences, with the aim to provide empathetic support and share positive coping strategies between peers.
- It enables health providers, programmes, and services to be more responsive, acceptable, and relevant for AYP, and is therefore an important treatment strategy in improving treatment outcomes and adherence among AYPLHIV.
- Examples include treatment buddy programmes, support groups and one-on-one peer-to-peer counselling.

BENEFITS OF PEER SUPPORT FOR CLIENTS AND COMMUNITIES:
Improves early diagnosis, timely treatment, and treatment adherence through individual follow up and counselling.
Peer supporters are a valuable tool in following up on patients who default from care and providing support to remain in care.
Peer supporters are visible members of their communities and can act as role models to other people living with HIV (PLHIV).
Research shows that peer support can improve adherence, viral suppression, retention, and psychosocial well-being of AYPLHIV.
BENEFITS OF PEER SUPPORT FOR HEALTH PROVIDERS:
Complements and supports the work of health providers.
Lessens the burden by task-shifting to allow more time to focus on quality of care.
Reduces facility waiting times.
Strengthens age-appropriate service delivery for AYP and key populations.
Makes a difference where there are staff shortages.
Gives health providers feedback on service provision allowing them to make improvements.
Enables health providers to improve relationships and understanding of adolescent issues.
Provides an effective platform to engage with AYP.
Offers a cost-effective way of providing support where funding is limited.
Opens a line of communication with, and insight into, the local community, and enables the sharing of information about services within communities.
Provides an effective strategy to reach AYP of similar ages who may not feel confident in the health system or may feel uncomfortable talking about SRH and HIV with a health provider or elder.
BENEFITS OF PEER SUPPORT FOR PEER SUPPORTERS
Peer support programmes increase opportunities for meaningful youth participation.
Peer supporters learn new skills and earn a modest source of income.
The work experience can lead to new opportunities to move from peer support to other forms of meaningful participation, including leadership development, capacity building and youth-led advocacy.
Boosts self-esteem, resilience, and self-confidence.
Increases knowledge and creates awareness of the benefits of a healthy lifestyle and can improve uptake of healthier behaviour through setting an example for others.
Increases skills, competencies and experience and provides access to training.

CLINIC-COMMUNITY COLLABORATION (C3) is the joint efforts of clinics and community-based organisations (CBOs).

Through **shared projects** C3 aims to
- **expand access** to prevention, treatment and care for pregnant women, children, and AYP in the community by
- creating **linkage pathways** between the clinic and the community.

- Health providers play an important role in building collaborative partnerships.
- See PATA's Clinic-Community Collaboration Adolescent Toolkit for more information about how clinics and communities can work together to improve HIV service delivery for AYP.

COMMUNITY SERVICE PROVISION AND COMMUNITY MONITORING:

- Many health services can be offered in the community, increasing accessibility for AYP(LHIV).
- Differentiated Service Delivery (DSD) is a patient-centred approach to ART delivery which tailors service provision to the patient's needs and other factors, hence offering opportunities for decentralising services to the community. Factors may include age, distance from health facility, whether they are pregnant and their stability on treatment.
- Community monitoring provides a feedback loop to assess the level of satisfaction with services, improving services based on feedback and ensuring the needs of the community are met.
- The READY to care scorecard can be used to anonymously assess the quality of services provided to AYPLHIV.

READY to Care Client Satisfaction 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 do not have to provide your name. This is your opportunity to share your experiences.

Name of health facility visited			
Age			
Gender	☐ He/Him	☐ She/Her	☐ Them/They
I agree to complete this client satisfaction scorecard	☐ Yes	☐ No	
Which of the following key populations do you identify yourself with (please tick all that apply)	☐ Men who have sex with men (MSM) ☐ Women who have sex with women (WSW) ☐ Young people who sell sex ☐ Young people with disabilities ☐ Transgender and gender diverse (TGD) ☐ People who use drugs ☐ Young people with disabilities ☐ Prefer not to say ☐ None of the above		

For each of the statements below please indicate "Always," "Mostly," "Sometimes," or "Never."

		Always	Mostly	Sometimes	Never
1	Health providers greet me with a SMILE.				
2	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.				
3	Health providers listen to my questions without judgement.				
4	Health providers provide me with answers that are positive and give me hope.				
5	Even when health providers are busy, they give me time to talk.				
6	Health providers explain things clearly and make sure I understand everything and can make my own choices.				
7	Health providers treat me with respect and don't talk about me with others.				
8	Health providers respect my privacy. They speak to me in a confidential space and no-one else can see me during my consultation as the door and/or curtains cover me from the view of others.				
9	Appointments with health providers are quick and smooth, so I am not waiting around. The appointment procedures and waiting times are kept at a minimum.				
10	Health providers are fair to me and do not allow older clients to jump the queue ahead of me unnecessarily.				

READY to Care Client Satisfaction Scorecard continued					
		Always	Mostly	Sometimes	Never
11	The facility provides me with all services I need. They make sure that the services are provided on the same day or visit so that I don't have to schedule for another visit.				
12	Health providers behave appropriately, they are friendly and professional when providing me with services and do not burden me with any stress they may be feeling.				
13	Health providers make sure that the medication or other self-care products they give me are correct and are not expired, they explain to me when I must take it and what I need to know to be able to take it or use it correctly.				
14	Health providers care about me and make me feel cared for, understood, and protected.				
15	Sometimes I do not get the services I want because of a lack of medicines, lack of other self-care commodities (e.g., condoms, contraceptives), lack of equipment, or because the equipment was not functioning or other reasons.				
16	The health providers are knowledgeable, and their behaviour makes me feel confident that they know what they are doing.				
17	The facility structures and flow of services are friendly for receiving SRHR and or HIV care (family planning products, termination of pregnancy for pregnant women etc), without provoking stigma/ discrimination.				
18	The facility has designated youth-friendly spaces where young people can receive services, access adolescent specific tools and information or meet for support groups, peer-to-peer appointments etc.				
19	The facility has designated spaces where young key populations can receive services.				
20	The health providers do not show unfriendly and stigmatising behaviour towards young key populations.				
21	Young key populations feel comfortable to go and receive services from the facility.				
ONLY young mothers or those currently pregnant, should complete these questions					
22	The facility provides me with all services I need. They make sure that the services are provided on the same day or visit as my baby's so that I don't have to schedule for another visit for the baby.				
23	Health providers care for me and my baby without any judgement.				
24	I feel comfortable to go to the facility with my baby as the environment is so friendly.				

SUMMARY:

- It is important for health providers to be aware of assumptions and recognise that AYP are not a homogenous group.
- The stages of behaviour change describe five phases: pre-contemplation, contemplation, preparation, action, maintenance.
- To change behaviour, four conditions need to be in place: information, training, resources, and recognition.
- A client-centred approach is based on the individual, with a health provider prioritising the needs of the AYP and respecting their choices.
- AYFHS are services that are delivered in the right place, at the right price (ideally free), and in a manner that is acceptable to AYP.
- Five key characteristics of AYFHS are: accessible, acceptable, equitable, appropriate, and effective.
- Individual/personal factors, social/cultural factors and institutional factors affect the utilisation of available SRHS by AYP.
- Health providers have an important role in ensuring that services meet their needs and attract AYP, and hence retain them in care.
- AYP participate in a meaningful way when they are actively informed and voluntarily involved in decision-making processes.
- The HEADSS framework is a useful tool to address the initial problem the AYP presents with and then go beyond this problem to discuss (potential) additional health problems.
- Peer-led service delivery (peer support) is an important strategy in improving treatment outcomes and adherence among adolescents and young people living with HIV (AYPLHIV), and also increases opportunities for meaningful youth participation.
- Clinic-community collaboration leads to increased service uptake and improved retention in care as it helps link services and ensures we engage and reach AYP inside and outside of the clinic.
- Community monitoring is important to understand the level of satisfaction of community members, including AYPLHIV, in the quality of services provided.

Useful links

- International HIV/AIDS Alliance (2015). Sexual and reproductive health and rights, and HIV 101 workshop guide: A guide to facilitating a workshop on linking up HIV and sexual and reproductive health and rights with young key populations.
- Mark, D., Lovich, R., Walker, D., Burdock, T., Ronan, A., Ameyan, W., Hatane, L. (2019). Providing peer support for adolescents and young people living with HIV. World Health Organization.
- PATA & PACF (2017). Clinic-Community Collaboration Toolkit: Working together to improve PMTCT and paediatric HIV treatment, care, and support.
- UNAIDS (2018). Youth and HIV: Mainstreaming a three-lens approach to youth participation.

MODULE 4 Sexual and reproductive health and HIV integration

Learning objectives:

- ✓ Understand what gender beliefs, roles and norms are, and how they affect the way you treat other people.
- ✓ Communicate with AYP and others about gender and sexual orientation.
- ✓ Understand what gender-based violence (GBV) is, recognise factors that cause GBV, and the consequences of GBV.
- ✓ Discuss steps in family planning with AYPLHIV and facilitate family planning counselling with these clients.
- ✓ Understand risky behaviours during adolescence, their consequences, and the role service providers play in addressing such behaviours among AYP.
- ✓ Understand the difference between integration of and linkage between services, what approaches exist to integrate services, and how to successfully integrate SRHR and HIV services.
- ✓ Understand what stigma and discrimination are, what negative outcomes they have, and how to address them.

Introduction and background

This module explores sexuality, the continuums of sexual orientation and gender identities, and enhances the understanding around the social construction of gender. An introduction to the impact of gender and social norms on sexual and health seeking behaviours is provided, including the steps in family planning counselling for AYP. Lastly, the module examines the integration of SRHR and HIV services and how these can be incorporated into service delivery.

4.1 Gender and Sexuality

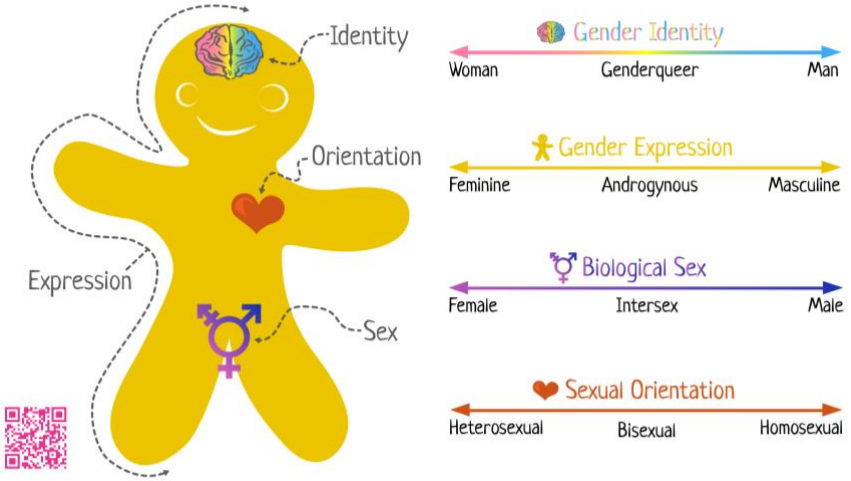
During puberty, AYP start asking themselves questions about their identity:

> *Who am I? Who do I want to be?*
>
> *How do I express myself*
>
> *Who do I feel attracted to?*

THE GENDERBREAD PERSON (Sam Killermann):

Can be used to explain the concepts of sexuality in a way that you can also explain it to the AYP you work with.

Sexuality	Sexuality encompasses all concepts outlined below: biological sex, gender identities, gender expressions, sexual orientation and more. Sexuality therefore comprises more than acts of sex. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, physical appearance, emotions, and personality. Sexuality can be fluid and change over time. Sexuality can be viewed on a continuum from 100% heterosexual through to 100% homosexual, with everyone fitting somewhere within that continuum. Sexuality is experienced and expressed differently for different individuals. Being aware of these differences helps cater to individual needs and provide effective services to adolescents and young people living with HIV.



Gender identity	Gender identity is how you think about yourself (male, female, transgender, gender neutral, non-binary, and all, none, or a combination of these). It is partially defined by our hormones (biological) and partially by our environment (social and cultural).
	Transgender and transexual: A person who identifies as **transgender** is someone who feels that their gender identity does not correspond to the one, they were given at birth.
Gender expression	Gender expression is how you demonstrate your gender through the ways you act, dress, behave, and interact. It is the external manifestation of a person's gender identity, which may or may not conform to the socially defined behaviours and external characteristics. These behaviours and characteristics are expressed through movement, dress, grooming, hairstyles, jewellery, mannerisms, physical characteristics, social interactions, and speech patterns (voice). Gender expression is commonly referred to as either masculine or feminine. Non-confirming gender expression is when a person's gender expression is (1) neither masculine nor feminine, or (2) different from traditional or stereotypic expectations of how a man or woman "should" appear or behave.

Biological Sex	Biological sex refers to the objectively measurable organs, hormones, and chromosomes.		
	Female (vagina, ovaries, XX chromosomes)	Male (penis, testes, XY chromosomes)	Intersex (a combination of the two)
Sexual orientation	Sexual orientation relates to who you feel physically or emotionally attracted to. Attraction includes romantic, physical, psychological, emotional, intellectual and/or sexual connection to someone. A person's gender identity does not predetermine their sexual orientation.		

Heterosexual (straight): A person who is attracted to the opposite sex; a man attracted to women, or a woman attracted to men, on all levels of attraction.
Homosexual: A person who is attracted to the same sex; a man attracted to men and a woman attracted to women, on all levels of attraction.
Bisexual: A person who is attracted to people of both sexes ('bi' meaning two), on all the levels of attraction.

GENDER ROLES AND NORMS

Gender roles	A societal position with a list of prescribed behaviours and responsibilities.
Gender norms	Informal rules about how someone belonging to a certain gender is expected to behave and/or which characteristics they should possess.

Gender roles and norms are:

- **Relational**, i.e., they exist in the relationships between men and women and how these relationships are socially constructed.
- **Hierarchical**, i.e., they are linked to established differences between women and men and tend to attribute greater importance and value to the characteristics and activities that are associated with being masculine, and result in unequal power relationships.
- **Change over time**, in that roles and relations associated with gender change over time and therefore, have potential for modification through development.
- **Context specific**, i.e., variations in gender roles and gender relations depend on the context: such as ethnic group, socio-economic group, and culture for example.
- **Institutional**, i.e., the relations between women and men exist at the personal and private level, and the social system that is supported by values, legislation, and religion.

GENDER INEQUALITIES

- Gender inequalities are social structures and constructs that increase or decrease an individual's control (power) over their life and health and do not depend solely on individual behavioural or physical characteristics.
- Fixed gender roles can and have led to various inequalities between men and women.

GENDER-BASED VIOLENCE (GBV) is a violation of human rights and can be directed to any gender, however, it disproportionately effects women and girls.

CONSEQUENCES OF GBV
1. **Physical** consequences of GBV • Injuries • Unintended pregnancies • (Unsafe) abortions • Sexually transmitted infections (STIs) • HIV • Gynaecological problems • For pregnant women who suffered IPV: miscarriages, stillbirth, preterm delivery.
2. **Psychological** consequences of GBV • Depression • Post-traumatic stress disorders • Anxiety disorders • Sleeping or eating problems • Substance misuse or abuse • Suicide or suicide attempts • Risky behaviours (heavy drinking and smoking, unprotected sex)
3. **Socioeconomic** consequences of GBV • Isolation • Retreat from regular activities that keep them connected to the community or society • Sometimes unable to work and provide for their families

THE ROLE OF THE HEALTH PROVIDER in GBV is to provide care and support services to AYP who are experiencing violence.

- It is important to ask direct questions and provide first line support to any AYP you suspect may be at risk of, or experiencing, any form of GBV, providing practical care and responding to the victim's emotional, physical, safety, and support needs, without intruding on their privacy.
- The LIVES approach (**Listen, Inquire, Validate, Enhance safety and Support**) can be used to ensure that psychological first aid is provided to help people who have been through upsetting or stressful events, including being subjected to violence.

4.2 Family planning:

- Means preventing unwanted pregnancies by safe methods of prevention
- Allows individuals and couples to anticipate and attain their desired number of children and determine the spacing and timing of pregnancies
- Achieved using contraceptives
- Services should offer a wide range of contraceptives and counselling services
- Should be integrated with prevention and treatment of STIs and PMTCT

HEALTH PROVIDERS have a **duty** to AYP to discuss family planning and contraceptive methods, regardless of whether the AYP are currently sexually active or not.

FAMILY PLANNING AND HIV
Dual protection means preventing unintended pregnancies and STIs (including HIV) • Primary prevention of HIV among women of reproductive age. • Prevention of unintended pregnancies among women and girls living with HIV. • Consistent use of condoms. • Use of condoms plus another family planning method. • Delay sexual debut and avoid all penetrative sex. • AYPLHIV in serodiscordant relationships should encourage their partners to take pre-exposure prophylaxis (PrEP) to prevent HIV infection.
FAMILY PLANNING FOR AYP
• Services must be adolescent-friendly, respectful, and non-judgemental no matter their age, provided in a private, confidential space. • AYP are eligible to use any contraceptive method and efforts should be made to provide reproductive health services in youth centres.

4.3 HIV and STI prevention and management

Risky Behaviour	Risky behaviour is the behaviour which exposes one to potential negative outcomes or harm.
Vulnerability	Vulnerability is the range of factors that reduce a person's ability to avoid risk.

☑ Identify the risky sexual practices by ticking the box where the statement belongs.

	Risky sexual practice	Non-risky sexual practice
1. Changing sexual partners frequently	ϒ	ϒ
2. Having multiple sexual partners	ϒ	ϒ
3. Using birth control	ϒ	ϒ
4. Having sex without a condom	ϒ	ϒ
5. Young people (20-24 years) having sex	ϒ	ϒ
6. AYPLHIV having sex when they are virally suppressed	ϒ	ϒ

(See Annexure 1 for answers)

FACTORS INFLUENCING RISKY BEHAVIOURS IN AYP:	
Individual	Age, sex (girls are more vulnerable), physical development, knowledge, attitude and perception about risks, influence of alcohol or drugs.
Relationships	Parent-child relationships, peer relationships.
Community	Schools, neighbourhood, culture and traditions, gender norms, religion, poverty.

FIVE A's of addressing risky behaviours with AYP: **The role of the health provider in dealing with risky behaviour among AYP**	
ASSESS VULNERABILITY	Identify features which make the AYP vulnerable.
ADVISE	Guide the AYP to identify their vulnerabilities and avoid risky behaviour, to get involved in risk reduction strategies and activities which avert them from engaging in risky behaviour.
AGREE	Conduct open dialogues with the AYP and encourage sharing of experiences to devise a behaviour change plan to reduce risk taking.
ASSIST	Equip the AYP to evaluate risks, anticipate the consequences of their choices, and develop strategies for diverting their energy into healthier activities.
ARRANGE	Support and guide the AYP to seek help if they notice they are getting involved in risky behaviour.

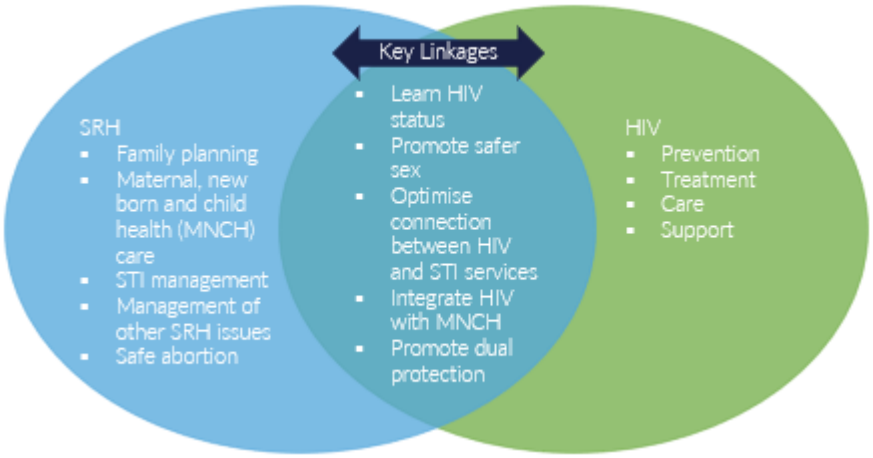
4.4 SRHR and HIV integration

Linkage	The connection between services that use different methods and/or approaches, but when linked together, are complementary and generate synergy.
Integration	Clearly defined, joint implementation processes in different services that converge at different levels acting to enhance outcomes.

Integration and **linking** of SRHR and HIV in policies, programmes and services can improve health outcomes for AYP, as:

- SRHR and HIV are strongly interrelated
- Most HIV infections are sexually transmitted or transmitted through pregnancy, childbirth, or breastfeeding
- The risk of HIV transmission and acquisition can be further increased by the presence of certain STIs
- SRHR and HIV interventions are both focussed on behavioural change and addressing high-risk behaviour and vulnerability

A framework for priority linkages



Source: adapted from WHO (2005), 'Sexual and reproductive health and HIV/AIDS: a framework for priority linkages'.

APPROACHES TO SERVICE INTEGRATION	
One-stop shop	Provision of comprehensive and integrated services, such as drop-in centres or clinics that offer HIV services (HCT, prevention, care, and treatment) with SRH services (FP, STI, EMTCT), maternal neonatal child health (MNCH), safe abortion.
Outreaches and referrals	An HIV service provides information and referrals for SRH services and similarly an SRH outreach provides HIV services.
Physical and functional integration	Physical and functional integration of services, including: • Different SRHR and HIV services provided in the same room • Same health provider providing both SRHR and HIV services • Same health facility providing both SRHR and HIV services but in different rooms • Same health provider providing both SRHR and HIV services but in different rooms or at different times • A combination of both SRHR and HIV services received in one visit

Guidance for establishing a successful referral or linkage system for AYP(LHIV)

AYP peer supporters	Select and train AYP peer supporters for the facility to help navigate services (the number is dependent on patient load).
Referral list	Create a list or referral directory of SRH and HIV care and support services and pin up at relevant service points in your facility, including the waiting areas.
Client flow	Ensure a clear client flow to reduce waiting times.
Follow-up	Follow-up with clients who have been referred to you and/or you have referred to other health facilities to establish and ensure successful linkage.
Linking and integrating	Try to strengthen linkages with referrals to services outside your health facility and strengthen integration by offering additional services within your health facility.
Community-based services	Strengthen linkages with community-based services. including home-based care and psychological support groups.
Tools	Introduce mechanisms and tools for effective referrals e.g. referral letter templates capturing key information, contact details, referral register.
Psychosocial interventions	Refer for other social support as needed.
OVC	Develop concrete linkages with orphans and vulnerable children (OVC) programmes.

4.5 Stigma and discrimination

Stigma	Is the process of reducing the value of a person and can be attached to many aspects of a person's identity.
	Can influence how, if, and when someone will access healthcare.
Discrimination	Is the unfair and unjust treatment of an individual.
	Is an action, also known as enacted stigma, whereby people can treat others unfairly based on stigma.
Stigma reflects an attitude and discrimination is an act or behaviour	

AYPLHIV might experience stigma in the following ways:

- Stigma due to a medical diagnosis, including HIV. For example, when someone (a health provider or family member) views a person who is living with HIV in a negative way or holds unfair beliefs about this person based on their HIV status. This could discourage the AYP from accessing key SRHR/HIV services and affect other aspects of their lives, such as when they travel, use health facilities, or seek employment.
- Multiple layers of stigma (intersectional discrimination). For example, AYPLHIV frequently experience stigma and discrimination because of their HIV status, and also because of the groups they belong to, the ways they self-identify and the things they do.
- Multiple intersecting layers of stigma. For example, AYP who self-identify and/or belong to a certain group, such as sex workers, lesbian, bisexual, gay, transgender, and intersex (LGBTI) people and people who use drugs.
- Stigma related to gender expression and sexual orientation. This can lead to discrimination and fear of not being accepted in the community, and/or by family, friends, colleagues, or service providers, which can have an adverse effect on the person's health, e.g. higher risk of mental health disorders and self-harm behaviour.

Tips to Decrease Stigma and Discrimination in your own practices, and those of your peers and colleagues:	
REFLECT:	Reflect on your own preconceptions and prejudices which might impact on your provision of quality and AYFHS for AYP(LHIV), and key populations. • What are some common assumptions or beliefs you may have about AYP or key populations accessing services? • How might these assumptions or beliefs impact your engagement with them? • What is the impact of these beliefs on service delivery?
EMPATHIZE:	It is important to empathize with your clients – put yourself in their shoes, understand their world, feel what it is like to be in their world, even for a moment. This helps to create and maintain an inclusive and affirming space.
REACH OUT:	Proactively reach out to AYP on their broad health and social needs.
RESPECT:	Treat all people with complete respect. Treat others as you would like to be treated. Respect your clients right to privacy and confidentiality. Remind yourself of your professional obligations
PREPARE:	Prepare for and practice answering tough questions.
LANGUAGE:	Avoid using language that is stigmatising towards certain groups, both in their presence and with other community members. Avoid using ambiguous terms when speaking with AYPs. Use inclusive language and correct terminology. Be aware of your body language.
CHALLENGE:	Challenge other counsellors or health providers who show stigmatising attitudes to AYP(LHIV) and key populations by providing correct information.
COGNISANCE:	Be cognisant of the many layers of stigma and the various ways in which a stigmatised AYP may present.

Preferred language when talking about HIV (Adapted from CDC's Guide to Talking about HIV)		
Problematic language	**Preferred language**	**Explanation**
AIDS	HIV or HIV and AIDS	AIDS in itself is not a condition; it is a syndrome that occurs when a person's immune system is weakened by HIV infection.
To catch/pass on HIV	To be diagnosed with/acquire/ transmit HIV	HIV can be transmitted, but it is not hereditary.
Body fluids	Blood, amniotic fluid, semen, pre-ejaculate, vaginal fluids, rectal fluids, breast milk	Body fluids covers all fluids coming from the body and not just those involved in the transmission of HIV, be specific.
Victims/ sufferers/ contaminated/ sick/ patients	People living with HIV	Words like victims imply that PLHIV are powerless, with having no control over their lives. The word "patient" implies a (constant) state of illness that can be misleading or demoralising.
Death sentence/fatal condition/life-threatening condition	Chronic and manageable health condition	HIV is a chronic and manageable health condition as long as people are in care and treatment
To die of AIDS	To die of AIDS-related illness or AIDS-related complications or end-stage HIV	People do not die of AIDS; they die because of AIDS-related illness or complications.

SUMMARY:

- The beliefs that we hold about gender, gender norms and roles, affects the way we treat other people.
- GBV is a violation of human rights. It is one of the major public health issues when it comes to gender and can have immense physical, sexual, psychological, and socio-economic consequences.
- Family planning is a form of dual protection, preventing both unintended pregnancy and STIs (including HIV). It allows people to anticipate and attain their desired number of children and determine the spacing and timing of pregnancies.
- Health providers play an important role in communicating with AYP about the outcomes of risky sexual behaviour.
- Preventing risky sexual behaviours and managing health-related problems, can help AYP to adapt attitudes and behaviours that support their health and well-being and reduce the risk for HIV/AIDS, other STIs and unwanted pregnancies.
- Integrating SRHR and HIV services increases the efficiency of services and improves the quality of care and the access to and uptake of services.
- Three approaches to integrate services include: 1) one-stop shop, 2) outreach & referrals and 3) physical and functional integration.
- All people have the right to be free from discrimination. Stigma and discrimination are often linked to violations of these rights. AYPLHIV frequently experience multiple layers of stigma, and this is called intersectional discrimination.

Useful links

- CDC (2020). A guide to talking about HIV.
- GNP+ (2020). Measure it, act on it, do it: Using The PLHIV. Stigma Index to achieve change.
- International HIV/AIDS alliance (2015). Sexual and reproductive health and rights, and HIV 101 workshop guide: A guide to facilitating a workshop on linking up HIV and sexual and reproductive health and rights with young key populations.
- WHO (2021). Factsheet Violence against women.

MODULE 5 Advocacy in action

Learning objectives:

- ✓ Plan advocacy initiatives in six steps by using the advocacy planning checklist and advocacy planning tool.
- ✓ Set SMART advocacy objectives to which your advocacy efforts are aimed.
- ✓ Develop advocacy messages that produce action for different target audiences.

Introduction and background

Advocacy highlights the need for action. It is not just about raising awareness of an issue; but about trying to seek change in the policies, practices, systems, structures, decisions, and attitudes that cause discrimination, exclusion, or injustice. This module provides processes and tools to plan advocacy initiatives, set advocacy objectives and create advocacy messages.

5.1 Six steps to plan advocacy

ADVOCACY means working for change and includes a broad series of activities, such as speaking up, drawing community's attention to important issues, and influencing change in policies, behaviours, practice, and public perceptions.

ADOCACY PLANNING CHECKLIST: SIX STEPS TO PLAN ADVOCACY				
1	Desired **change**	Working with AYP, identify what needs to change.	Identify the problem, explore the causes, examine what needs to change to address the problem.	.AYP PARTICIPATE AT ALL LEVELS
2	Desired **target**	Identify who can make that change happen.	Conduct stakeholder mapping: perform a power analysis to identify key actors (primary targets) and those who can influence them (secondary targets).	
3	Advocacy **approach**	Understand how you can influence the advocacy targets to make the change happen.	Use the Door Test to determine the timing, targets, and strategy for advocacy initiatives.	
4	Identify **allies**	Identify who you can work with.	Consider organisations/ individuals that support your position and can help achieve your advocacy goal.	
5	**Risks** and **mitigations**	Identify obstacles you might face and how can you overcome them.	Identify risks, estimate the chance of them occurring, and mitigate and manage the risks	
6	**Monitoring** and **evaluation**	Monitor and evaluate the advocacy efforts to prove it is working.	Systematic and ongoing monitoring of advocacy activities: assess relevance, efficiency, and effectiveness.	

5.2 Setting advocacy objectives

Goal	A long-term overarching aim of the advocacy effort (vision for change).
Objectives	Specific elements/ actions that are necessary in order to achieve the long-term goal.

SET SMART ADVOCACY OBJECTIVES
Specific: Well-defined, clear, and unambiguous.
Measurable: With specific criteria that measure your progress toward reaching your goal.
Achievable: Attainable and not impossible to achieve given the available resources and time.
Realistic: Within reach, realistic, and relevant to your project/programme.
Timebound: With a clearly defined timeline, including a starting date and a target date.

Who is involved?

What needs to happen?

Is it measurable and timebound?

5.3 Creating advocacy messages

Advocacy messages are short and persuasive statements about the advocacy objectives that aim to initiate a change or action

Each message should answer three questions:

1. What should be done or changed?
2. Why?
3. How?

ADVOCACY MESSAGES should appeal to the **HEAD**, the **HEART**, and the **HANDS**	
HEAD	What do the advocacy targets want to know? • Facts, statistics
HEART	Why should your advocacy targets care? • How do you want your targets to feel about your message? • Appeal to their interests and emotions
HANDS	What do you want your advocacy targets to do? • What is within the power of your targets to do?

SUMMARY:

- Six steps to plan your advocacy are
  1. Desired change: Define what needs to change together with AYP.
  2. Advocacy target: Identify who can make that change happen.
  3. Advocacy approach: Understand how you can influence advocacy targets to make that change.
  4. Allies: Identify who you can work with.
  5. Risks and mitigations: Think of what obstacles or resistance you may face and how to overcome this.
  6. Monitoring and evaluation: Define how you will monitor and evaluate your advocacy efforts to prove that it is working.
- Goals reflect 'the bigger picture' of your project and should be formulated as a broad statement of what you are trying to achieve.
- Objectives are short-term targets that are achievable.
- SMART (specific, measurable, achievable, relevant, and time-bound) objectives will allow you to measure whether your objectives are realised at the end of the advocacy project.
- The purpose of advocacy messages is to initiate change or action and should answer three questions: what should be done/changed, why and how?
- Advocacy messages should appeal to the "head", "heart", and "hands" of the advocacy target.

Useful links

- International Planned Parenthood Federation (2011). Young people as advocates: Your action for change toolkit. IPPF
- UNICEF (2019). Youth Advocacy Toolkit.

REFERENCES

- Alemu, B. (2006). Early marriage in Ethiopia: Causes and health consequences. Exchange Organizational Behaviour Teaching Journal, (July), pp.4–6.
- ARASA (2015). Sexual orientation, gender identity, HIV and human rights: An advocacy toolkit. The AIDS and Rights Alliance for Southern Africa (ARASA).
- Athena Network (2016). Step up, link up, speak up: A tool to support mentoring for youth advocacy.
- Canadian Aids Society, 2012. Women's Biological Susceptibility to HIV, (April, 2012).
- Carroll, A., & Fernandez, B. (2010). Make It Work: Six steps to effective LGBT human rights advocacy. ILGA.
- CDC (2020). A guide to talking about HIV.
- GNP+ (2020). Measure it, act on it, do it: Using The PLHIV. Stigma Index to achieve change.
- Gruen, R. L., Pearson, S. D., & Brennan, T. A. (2004). Physician-citizens—public roles and professional obligations. Jama, 291(1), 94-98.
- International HIV/AIDS Alliance (2015). Sexual and reproductive health and rights, and HIV 101 workshop guide: A guide to facilitating a workshop on linking up HIV and sexual and reproductive health and rights with young key populations.
- International Planned Parenthood Federation (2010). Handbook for Advocacy Planning. IPPF.
- International Planned Parenthood Federation (2011). Young people as advocates: Your action for change toolkit. IPPF.
- ITPC (2014). ACT Toolkit, Advocacy for Community Treatment: Strengthening Community Responses to HIV Treatment and Prevention. International Treatment Preparedness Coalition.
- Killermann, S. (2017). A Guide to Gender. The Social Justice Advocate's Handbook. Austin, Impetus Books.
- Mark, D., Lovich, R., Walker, D., Burdock, T., Ronan, A., Ameyan, W., Hatane, L. (2019). Providing peer support for adolescents and young people living with HIV. World Health Organization.
- Oandasan, I. F. (2005). Health advocacy: Bringing clarity to educators through the voices of physician health advocates. Academic Medicine, 80(10), S38-S41.
- PATA & PACF (2017). Clinic-Community Collaboration Toolkit: Working together to improve PMTCT and paediatric HIV treatment, care, and support.
- Save the Children (2014). Advocacy and Campaigning: 6. Identifying and influencing advocacy targets. The Open University.
- Svanemyr, J., Amin, A., Robles, O.J., Greene, M.E. (2015). Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches. Journal of Adolescent Health, 56(1), pp. S7–S14.
- Tearfund (2015). Advocacy toolkit, second edition.
- UNAIDS (2018). Youth and HIV: Mainstreaming a three-lens approach to youth participation.
- UNFPA (2005). Frequently asked questions about gender equality. Retrieved from: https://www.unfpa.org/resources/frequently-asked-questions-about-gender-equality.
- UNFPA (2007). Make it matter: 10 key advocacy messages to prevent HIV in girls and young women.
- UNICEF (2010). Advocacy toolkit: A guide to influencing decisions that improve children's lives. United Nations Children's Fund (UNICEF), New York, 2010.
- UNICEF (2011). The state of world's children 2022: Adolescence - an age of opportunity.
- UNICEF (2019). Youth Advocacy Toolkit.
- WHO (2003) Information series on school health, Geneva Switzerland, WHO document production service.
- WHO (2006). STOP The Global Epidemic of Chronic Disease: A practical guide to successful advocacy.
- WHO (2021). Violence against women.

- WHO (2018). Advocating for change for adolescents! A Practical Toolkit for Young People to Advocate for Improved Adolescent Health and Wellbeing. Geneva: World Health Organization; 2017.
- WHO (2022). Female genital mutilation.

ANNEXURE 1: MODEL ANSWERS

Section 2: Course Modules

MODULE 1

1.3 Case study 1

Decision-makers: Local government/council
Allies: Women's groups
Opponents: Pharmaceutical corporations
Beneficiaries: Pregnant women living with HIV

1.3 Case study 2

Opposed/High power: Traditional leaders, health facilities
Opposed/Low power: Caregivers
Supportive/High power: Schools
Supportive/Low power: AYPLHIV

1.4 Quiz

1. b) Accessibility
2. d) Quality

MODULE 2

2.3 Quiz

1. Non-verbal
2. Verbal
3. Verbal
4. Non-verbal
5. Non-verbal
6. Verbal
7. Verbal
8. Non-verbal
9. Verbal
10. Non-verbal

MODULE 4

4.3 Tick the column

1. Risky
2. Risky
3. Non-risky
4. Risky
5. Non-risky
6. Non-risky

ANNEXURE 2: ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AYFHS	Adolescent and Youth Friendly Health Services
AYP	Adolescents and Young People
AYPLHIV	Adolescents and Young People Living with HIV
C3	Clinic-Community Collaboration
CBO	Community-Based Organisation
DSD	Differentiated Service Delivery
EMTCT	Elimination of Mother To Child Transmission
FP	Family Planning
GBV	Gender-Based Violence
GPG	Good Practice Guide
HCT	HIV Counselling and Testing
HEADSS	Home environment, Education, Activity and routine, Drugs, Sex, Suicide and depression
HIV	Human Immunodeficiency Virus
HRBA	Human Rights Based Approach
IUCD	Intra Uterine Contraceptive Device
LIVES	Listen, Inquire, Validate, Enhance safety, Support
MNCH	Maternal, Neonatal (New-born) and Child Health
OVC	Orphans and Vulnerable Children
PATA	Paediatric – Adolescent Treatment Africa
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PrEP	Pre-Exposure Prophylaxis
Q&A	Question and Answer
SMART	Specific, Measurable, Achievable, Realistic, Timebound
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
WHO	World Health Organization