



PROMISING PRACTICES

As young people, we need HIV and SRH services that are comprehensive and integrated. A comprehensive package should include private and confidential HIV prevention, treatment and monitoring; supportive psychosocial and mental health services; and sex-positive messaging and counselling. We demand options for unwanted pregnancy and access to a range of family planning methods, including regular cervical screening

- Call to Action -
Peers to Zero Dar es Salaam
Peer Supporter Declaration

Promising practices in integrating HIV and SRH services for adolescents and young people living with HIV

“Every adolescent clinic day I feel very excited to look out for young people to refer to the SRH unit”

BACKGROUND

Significant progress has been made in HIV treatment and prevention, with various global targets speaking to the end of AIDS. Evidence however suggests that such optimistic targets remain far from reach for adolescents and young people¹. While annual AIDS-related deaths decreased by 35% from 2005 to 2013, deaths among adolescents living with HIV (ALHIV) increased by 50% in the same time period^{1,2}. In the age of antiretroviral therapy (ART), AIDS-related illness is the leading cause of death among adolescents in sub-Saharan Africa². Compared to children (0-14 years), new infections amongst adolescents (15-19 years) and young people (20-24 years) have not decreased to the same degree; since 2009, new infections have decreased in children by 60%, while in the same period, new infections in adolescents have only decreased by 8%³. The evidence

is strong that much still needs to be done for adolescents and young people in HIV prevention and treatment.

Adolescence is a period of physical and emotional change, which places adolescents and young people at increased risk⁴ of poor sexual and reproductive health (SRH) and HIV-related health outcomes. Adolescents are discovering their sexuality, and changes in their brains and bodies influence their decisions and choices. Peer pressure, alcohol and drug use, early sexual debut, multiple partners, unsafe sexual practices, stigma and limited access to information and relevant services render this group more vulnerable to HIV and SRH issues⁴⁻⁸. Living with a highly stigmatized, life-long sexually transmittable infection makes an already difficult stage of life more complex⁹. As a result, adolescents and young people living with HIV (AYPLHIV), face additional challenges^{8,10} as they navigate relationships and explore their sexual identity. Disclosing their HIV status¹¹, adhering to treatment, navigating safe sex and safer conceptions^{12,13}, and

the risk of mother-to-child-transmission (MTCT) are additional issues that AYPLHIV face, and if not addressed, may act as further drivers of the epidemic¹⁴. Risk factors for non-adherence to ART and sexual risk-taking amongst adolescents are similar¹¹, making it important to integrate efforts to improve adherence and SRH¹⁵. Risk factors include socio-economic drivers, disrupted family structures, non-disclosure of HIV status by an appropriate age, exposure to violence and conflict, mental health issues and stigma.

As they reach sexual debut¹⁶, regardless of HIV status, adolescents and young people should have access to comprehensive SRH information and services. Although evidence shows that this leads to improved health outcomes¹⁷⁻¹⁹, existing SRH services generally are not comprehensive and do not meet the unique needs of adolescents and young people²⁰. Unfriendly service environments, marked by inconvenient operating hours, insufficient privacy, and SRH services being provided for adolescents and young people alongside adults, reduce

Adolescents age 10-14 years attending a health talk, Link Up Uganda



the uptake of services^{21,22}. Judgmental health providers, stigma and discrimination from families and communities, and gender inequalities⁶ further discourage adolescents and young people from seeking services^{11,23-29}. Age of consent restrictions limit young people's independent access to HIV testing and other healthcare services, and laws that criminalise same sex relationships, drug use, the selling of sex and HIV transmission promulgate discrimination and prevent access to and retention in critical services^{8,30,31}, undermining AYPLHIV rights to SRH. If we are to reach the global targets of 90-90-90, adolescents and young people, including young key populations, must be afforded equitable access to life-saving treatment and prevention services, including appropriate and comprehensive SRH services.

The aforementioned-evidence makes a clear case for the importance of comprehensive SRH services offered alongside HIV services. Integrating HIV and SRH services, when done well, has the potential to increase access to and uptake of services for improved SRH and HIV knowledge and

holistic health management. However, operationalization at facility and policy-level remains difficult, as there are few promising models of practice upon which to design such services. While there may be basic understanding and will to offer responsive SRH services that move beyond condom distribution, what these can and should feasibly include, and how they should be integrated with HIV services to meet the needs of adolescents and young people remains unclear. This promising practice brief highlights successful facility-level models that respond to the unique SRH service needs of AYPLHIV. While novel operational approaches do exist, they often go unreported, limiting their impact to isolated facilities. This document draws on data from six surveys submitted from PATA network members and partners through a call for promising models of practice in comprehensive HIV and SRH services.

Community-based peer educators at work, Link Up Uganda



Spotlight

Link Up for Uganda



Programme location: Uganda

Programme implementers:

Global level:	National level	Community level
International HIV/AIDS Alliance	Community Health Alliance Uganda and Marie Stopes International Uganda	Mildmay Uganda
Population Council	Uganda Network of Young People Living with HIV (UNYPA), Coalition on Adolescent Sexual Reproductive Health and HIV/AIDS (CYSRA) and International Community of Women Living with HIV – Eastern Africa (ICW-EA)	Naguru Teenage and Information Health Centre (NTHIC)
Marie Stopes International ATHENA Network	Child Health and Development Centre Ministry of Health, Uganda	Most at Risk Population Initiative (MARPI) Integrated Community-Based Initiatives (ICOBI)
Global Youth Coalition on HIV/AIDS (GYCA) STOP AIDS NOW!	Ministry of Gender, Labour and Social Development, Uganda UN agencies: UNFPA, UNAIDS, WHO	Family Life and Education Centre (FLEP) Uganda Youth Development Link (UYDEL)

CONTEXT:

There are 1.5 million people living with HIV in Uganda, of whom only 10% receive necessary treatment. Young people are an especially vulnerable group, with as many as 3% living with the virus³², and 65% not knowing how to prevent transmission³³. Poor adherence and retention in care are particular challenges in the adolescent population in Uganda, with an assessment of 1,021 facilities showing that only 29% of eligible ALHIV were receiving ART, and only 17% retained in care³². An aggravating factor has been the passing of the Uganda Anti-Homosexuality Act of 2014, which may create environments hostile towards the lesbian, gay, bisexual and transgender (LGBT) community, and make access to necessary health information and services for several young key populations difficult and even dangerous³³.

Link Up was a three-year project implemented from 2013 to 2016 in 11 districts across Uganda.

The project focused on young people (10 to 24 years) most affected by HIV, with a specific emphasis on young people living with HIV, young people who engage in sex work, young men who have sex with men, the fishing community, and young truck and motorbike taxi drivers. To better meet the diverse needs of young people most affected by HIV, the project focused on integrating HIV and sexual and reproductive health and rights (SRHR) services³⁴.

AIM:

The overall aim of the project was to reduce unintended pregnancies, HIV transmission and HIV-related maternal mortality amongst young people (10-24 years) most affected by HIV, with a specific focus in Uganda on vulnerable and marginalized populations.



APPROACH:

Key strategic focus areas included:

- Strengthening health facilities' capacity to respond to young people's needs, through:
 - » Health provider sensitization training
 - » Making health facilities welcoming spaces for adolescents and young people
 - » Providing quality integrated HIV-SRHR services
- Increasing youth participation and advocacy capacity through:
 - » Youth-led initiatives
 - » Peer-to-peer education, including training of young leaders and champions on HIV and SRHR service provision
 - » Home-based visits by peers
 - » Youth-led policy and advocacy
- Community mobilization through:
 - » Community dialogue meetings with gate keepers, religious leaders and parents
 - » Taking services to young people in the community

The project made use of HIV-SRH integration models at community and health facility level that were based on the various contexts in which the project was implemented, whilst actively creating linkages between the community and its health facilities.

Community-based interventions:

Community-based interventions included peer-led outreach, active referrals and follow-up. The overall goal of outreach and referral interventions was to increase access to SRHR and HIV information and services for young people who are outside of the ambit of healthcare and/or had been lost-to-follow-up, so that they began to access high-quality, integrated and non-judgmental services. For young women selling sex, an HIV-SRHR basic package of services was provided at specific drop-in centres, with referrals of specialized cases.

Health facility interventions:

Interventions at the health facility level included provider initiated service provision, where health providers offer clients services in addition to the service for which they have originally come to the clinic, and training service providers in improved attitudes towards young people. The aim of these interventions was to improve integrated HIV and SRHR service provision, either in a one-stop-shop model or through referrals for specialized services to other participating service providers.

At a minimum, the most basic package of care offered to all young people included **HTC, family planning and contraception counselling and services, and STI services.**

Examples of HIV services provided within the project included:

- » HIV testing and counselling (HTC)
- » ART
- » Opportunistic infection treatment
- » Psychosocial and positive living support counselling
- » Adherence support
- » Palliative care
- » Livelihood support

Examples of SRHR services provided within the project included:

- » Family planning and contraception counselling and services
- » Condoms, lubricants and information, education and communication (IEC) materials
- » Sexually transmitted infection (STI) diagnosis and syndromic management
- » Post-abortion care and services

“It had always been either you have a niche in HIV, or it is SRH, but not both. If you tell people about HIV issues, then what? What about their reproductive health? What about their advocacy?”

- Link Up Uganda programme implementer

- » Self-examination for breast cancer
- » Cervical cancer screening
- » Violence prevention and post-violence counselling and management
- » Gender and sexuality support and counselling

AYPLHIV participation:

From the onset, young people were involved in project design, implementation and evaluation to ensure that the project met their specific and diverse needs. Young people were involved in **project design** through:

- Youth dialogues to share their experiences, priorities and visions for their lives
- Consultative meetings to identify which life skills they wanted to improve
- Development of the Link Up Uganda communication strategy

In terms of **project implementation**, young people:

- Participated as peer educators conducting a number of tasks, including:
 - » Managing youth-friendly corners
 - » Conducting community mobilisation and sensitisation via flash mobs, drama and music
 - » Providing health education at health facilities
 - » Escorting peers to health facilities and follow-up visits
 - » Conducting home visits
- Planned and participated at district and national events, including World AIDS Day and World Contraception Day
- Worked as data collectors and data enterers
- Documented human rights violations using a specific tool

Young people were involved in **project evaluation** through:

- Participating in quality improvement exercises as mystery clients

- Acting as co-consultants in the project's mid-term evaluation
- Participating alongside the Population Council in research to evaluate activities that use peer-to-peer strategies

KEY RESULTS:

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.

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.

“Truth is, I took [the news of a positive HIV test result] badly and I was shocked as well but they later comforted and told me that not everyone who is HIV positive dies. Then I asked them whether I could give birth to my unborn child HIV negative. I became strong and started living day by day. And I had my child HIV-negative”

- Link Up Uganda participant

For more information:

<http://www.aidsalliance.org/our-impact/link-up>

Spotlight

Improving uptake of SRH services among adolescents

Programme implementer: Baylor College of Medicine Children's Foundation - Uganda

Programme location: Baylor Uganda Centre of Excellence (COE) Clinic at Mulago Hospital



CONTEXT:

Baylor Uganda's Centre of Excellence (COE) Clinic was experiencing low uptake of SRH services among adolescents (10 – 19 years) despite offering a unique SRH unit operated by two youth-friendly and highly experienced midwives, health providers trained in the Home, Education/employment, peer group Activities, Drugs, Sexuality and Suicide/ depression (HEADSS) approach, and services provided according to Positive Health, Dignity and Prevention (PHPD) operational guidelines. Between January and June 2016, only 35 of the COE's 438 adolescent patients (8%) accessed SRH services. Through a consultative process with peer supporters, the COE began implementing a project to improve SRH access and services.

AIM:

The project aimed to increase the uptake of SRH services among adolescents from 8% to 50% between July and December 2016. SRH services included health education, family planning and contraception, and STI treatment. Priority was given to those who were sexually active, teen mothers, post-abortion clients and those with genital discharge or ulcers.

APPROACH:

To increase access amongst adolescents, health providers approached peer supporters to help them to understand the barriers to uptake. Through a workshop process, peer supporters came together with health providers and identified some of the causes for the low uptake of services. Young people explained that there was limited awareness of the availability of SRH services, as well as misconceptions as to what services were provided and whom they were intended for. Young people also raised concerns around judgmental attitudes on the part of some health providers. Based on the identified issues, activities were designed to improve uptake, remove barriers, and make SRH services more adolescent-friendly. The activities focused either directly on adolescents and peer supporters, or on health providers and facility processes and systems.

- Activities targeted towards adolescents and peer leaders included:
 - » Training peer supporters on SRHR
 - » Creating awareness of SRH services through peer-led discussions, general health talks and one-on-one consultations
 - » Promoting SRH services through the dissemination of IEC materials

“I had no idea what used to go on in the reproductive health unit. I now realise there are many services offered for young people in a pleasant way”

- Baylor College of Medicine Children's Foundation participant

- Activities focused on health providers and facilities included:
 - » Continuing medical education (CME) for health providers on adolescent-friendly services and using the HEADSS approach with adolescents
 - » Developing referral criteria to guide and prioritise adolescents in most need of SRH services
 - » Health providers accompanying adolescents to the SRH unit
 - » Setting up documentation and registration of adolescents referred to the SRH unit and which services were taken up
 - » Holding regular review meetings to assess progress of the project and involving peer supporters in these meetings

Peer leaders and young people were involved at all levels of the project design, implementation and evaluation, which was crucial to its success.

“Many young people are opening up and talking about SRH. Every adolescent clinic day I feel very excited to look out for young people to refer to the SRH unit”

- Baylor College of Medicine
Children’s Foundation peer leader

“Adolescents are shy about SRH issues but when you make them feel relaxed, they open up and share a lot about their sexual issues.”

- Baylor College of Medicine
Children’s Foundation implementer

KEY RESULTS:

The project increased SRH service uptake from 8% to 46% between July and September 2016. Seventy-five percent of those accessing SRH services were older adolescents age 15-19 years, with the remaining 25% age 10-14 years. Contraception was the most taken up service, at 75% of those accessing SRH services (most frequently contraceptive injections for women), followed by cervical cancer screening at 15% and STI treatment at 10%.

Overall, the project has increased awareness among adolescents of the availability and importance of SRH services at the clinic, and the clinic environment and health providers have become more adolescent-friendly.

PATA hosted health sensitization training focusing on SRH services, where health providers engaged with young people



For more information:

<http://www.baylor-uganda.org>

KEY IMPLEMENTATION STRATEGIES

Several cross-cutting strategies emerged across the surveys received around how best to provide comprehensive SRH services.

- **Peer support:** AYPLHIV trained as peer supporters are able to support the health, wellbeing and uptake of services by their peers by providing highly relevant and responsive services. At the same time, engaging peer supporters provides additional human resource capacity to over-stretched health facilities and reduces staff workload. Peer supporters also act as links between facility and community, and can support AYPLHIV around treatment literacy, disclosure and treatment adherence through home visits. Peer supporters can facilitate support groups and offer one-on-one counselling to improve psychosocial, ART and health outcomes, as well as provide the space to discuss sexuality and relationships and equip young people with the understanding they need to make healthy choices around their sexual health. Adolescents and young people are most likely to feel comfortable confiding in peers about their SRH challenges and needs and can therefore drive service uptake through supporting AYPLHIV to navigate the services available to them. For more information on PATAs peer support promising practice, see PATAs website (www.teampata.org).
- **AYPLHIV involvement in designing, implementing, monitoring and evaluating services:** AYPLHIV themselves are best placed to understand and appreciate their peers' SRH and HIV interests and concerns, and should be engaged at all stages of service planning, execution and assessment, as well as driving youth-led advocacy and policy work at community and national levels. AYPLHIV should be recognised as leaders in their own health response, helping to provide a holistic approach that places the patient at the centre and protects his or her human rights.
- **Safe spaces:** Supporting AYPLHIV in care includes ensuring that the health facility itself feels safe and secure for young people. AYPLHIV require a space where they can meet up with peers, feel comfortable, relaxed and welcome, and ultimately develop positive associations with healthcare. The health facility should be a space where young people can engage without fear of judgement, and openly discuss sexuality. AYPLHIV are entitled to privacy, confidentiality and the provision of correct and accessible information. Clinic operating hours must also be convenient for AYPLHIV.
- **Health provider competencies:** Health providers must be adequately trained and capacitated in order to respond holistically to the unique needs of AYPLHIV, and support improved retention in care, psychosocial wellbeing and health outcomes. In addition to clinical management, health providers and support staff should know how best to respect, protect and fulfil AYPLHIV rights to information, privacy, confidentiality and non-discrimination. The role of those at the frontline is vital in contributing to a stigma- and discrimination-free environment, where every person is treated with dignity and respect, and quality services are provided for all AYPLHIV irrespective of age, gender, education and sexual orientation.

“We learnt a lot about our rights in the outreach and from health workers. I have right to take my ARVs, a right to information, a right to education. I have a right to confidentiality. A health worker should not shout at me in public instructing me to go for counseling”

- Link Up Uganda participant

- **Community mobilization, sensitization and linkages:** Traditional models of healthcare delivery – with the clinic at the centre and peripheral, if any, community engagement – are increasingly unfeasible and ineffective in today’s high prevalence settings. For the benefits of widespread ART to be realized, community-based and community-focused HIV care are the way forward, particularly in adolescent populations – where peer influence and social support are key. Communities must play a critical role as we advance adolescent HIV and SRH services. Communities should be enabled to support the adolescent-focused response, including increasing demand, supporting retention in care, monitoring quality, combatting stigma and discrimination and advancing human rights. Communities have a critical role to play around service provision and clinic- community linkages are essential to leveraging community activities that may drive people into and reinforce care.
- **Information, education and communication:** Materials around HIV and

SRHR form a key part of adolescent programmes and ensure that AYPLHIV have access to information that can improve their health. These materials should be accurate and up-to-date, as well as support a rights-based perspective. Materials should also provide the information needed for young people to know where and how to access services, as well as sensitize the community to ensure that they too are well informed. Sharing IEC materials with parents, caregivers and guardians, will advise them around the support that AYPLHIV require around their SRHR, and facilitate improved dialogue and communication with AYPLHIV.

CHALLENGES

- **Poor health provider attitudes and capacity:** There is increasing acknowledgement of stigma within healthcare settings, and the impact this may have on patient satisfaction and retention. Providing HIV and SRH services for adolescents and young people requires specific skills, both clinically and in terms

Condom demonstration with young women age 15-24 years, Link Up Uganda



of the ways in which clinical and other services are provided. Due to social norms and religious influences, some health providers may struggle with negative attitudes towards young people, sex, sexuality and substance use, and find it difficult to separate personal norms and values from professional obligations. Health providers who condemn or criticize young people discourage them from accessing the services they need. Further, the severe shortage of health providers and imbalanced skills mix in low resource contexts is a crisis which jeopardizes the quality of healthcare in the region.

- **Environments that are not enabling:** It is critical to establish environments that facilitate implementation and integration of HIV and SRH services. There are many barriers to adolescents receiving the care to which they have a right. Policy and legislative barriers include age of consent restrictions and criminalization of same-sex relationships. Program-level bottlenecks may include insufficient infrastructure, operational

barriers such as long turnaround time between tests and results, late initiation, loss to follow-up and poor availability of paediatric formulations. Without an enabling environment, adolescents and young people will remain out of reach.

- **Insufficient service delivery protocols:** At a procedural level, there is a lack of standard operating procedures, training manuals, guidelines and tools for providing adolescent- and youth-friendly HIV and SRH services. Protocols ensure that services are offered at a locally agreed standard to which providers are accountable. Regularly updated protocols are required for health providers to offer standardized, high quality and responsive services.
- **Stock-outs:** As a result of various logistical and legislative challenges, many programs fail to offer consistent and timely supplies to their patients. Frequent stock-outs of drugs and other commodities affect service provision, constrain patients' ability to access treatment and undermine retention in care.

Training session on adolescent- and youth-friendly health facilities, Link Up Uganda



SUCCESSSES AND LESSONS LEARNT

- **Adolescents and young people should be placed at the centre of the integrated HIV-SRH response**, and equipped with the knowledge, skills, tools and confidence to care for themselves and support one another. Enabled adolescents and young people may play highly effective roles for instance around self-regulation and peer motivation, decreasing risk and improving health-seeking behaviours. Young people's circle of care – including parents or guardians, teachers and peers – as well as circle of influence – local role models and leaders – should also be engaged and provided sufficient attention.
- **Young people should be engaged in all aspects of youth-focused service and programming.** Involving young people themselves in identifying their own needs and challenges, and how these affect how they receive a service (if at all), provides a significant opportunity and potential for building youth leadership and improving relevance, legitimacy and treatment outcomes.
- **Community education and sensitization** around services and their availability is vital to ensuring that services reach those who need them, including those young people who may be marginalized or socially excluded. Community mobilization should include building treatment literacy and awareness and may include orientation meetings with community leaders and community resource groups, community dialogues and door-to-door visits.
- The role of health providers is vital to providing HIV and SRHR support for adolescents and young people as they gain independence and seek and maintain healthcare with increasing autonomy. In order to be able to provide this support, care, information and advice, **it is important that health providers receive the training they need as well as continuing education and support.** Equally important is that they build their capacity around working with adolescents and young people in a friendly, welcoming and non-judgmental manner that is respectful of adolescents as individuals, their gender, sexuality and life decisions.
- HIV and SRH responses have mutually beneficial impacts, and their responses are interlinked (see Figure 1). **Integration refers to how different kinds of HIV and SRH services or programs can be joined together to maximize collective improved outcomes.** However, integration may be defined and/or interpreted differently in different contexts, with various models and approaches having been described (see text box), and no single approach being suitable to all settings.

MODELS OF INTEGRATION:

- HIV and SRH services are offered at the **same facility and location within the facility, but at different times.** For example, separate HIV clinic times or days and SRH clinic times or days
- HIV and SRH services are offered at the **same facility and location, at the same time.** For example, one appointment where HIV and SRH services are provided
- HIV and SRH services are offered at the **same facility, but at different locations within the facility.** For example, internal referrals between where HIV services are provided and where SRH services are provided
- HIV and SRH services are offered at the **different facilities.** For example, receiving HIV and SRH services at different facilities, with an effective referral system between them, where adolescents are tracked and traced in order to ensure they are receiving all necessary services

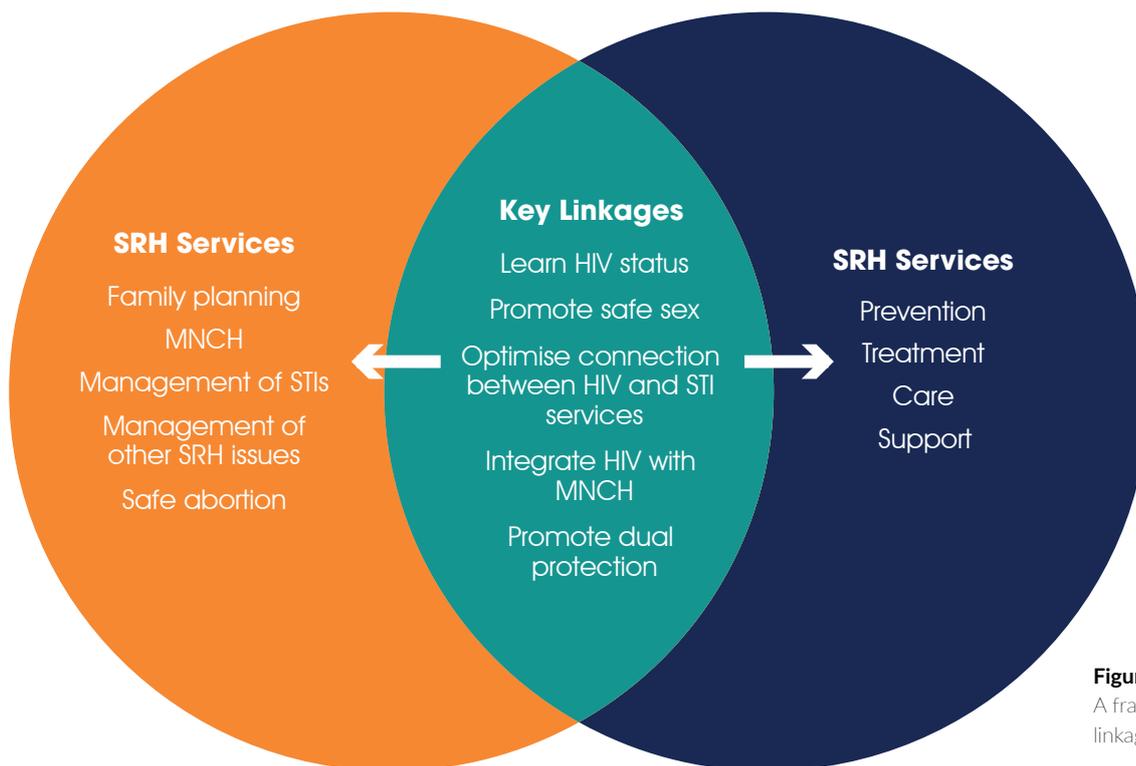


Figure 1:
A framework for priority linkages

Source: Adapted from WHO (2005), Sexual and reproductive health and HIV/AIDS: a framework for priority linkage

CONCLUSION

Integrating HIV and SRH services is a critical part of providing adolescent-friendly health services and reaching global HIV prevention and treatment targets for adolescents and young people. Adolescents and young people, regardless of HIV status, have the right to accurate information that is in line with their needs as well as full access to uninterrupted, comprehensive SRH services and commodities. However, for this to happen several barriers to an enabling health service and socio-political environment must be removed. Existing SRH services generally are not comprehensive and do not meet the unique needs of adolescents and young people. Challenges to HIV and SRH integration include policies that are not enabling, poor health provider attitudes and insufficient capacity, inadequate service delivery protocols, and stock-outs.

However, providing comprehensive HIV and SRH services will ensure that young people have improved health outcomes and greater freedom of choice. The spotlights contained in this document highlight potential approaches for integrating HIV and SRH services in different contexts. Although there are differences between the models presented, the important and cross-cutting elements of providing HIV and SRH services for adolescents include peer support, AYPLHIV involvement, safe spaces, health provider competencies, community mobilisation and IEC. Spotlights also reflect the importance of placing adolescents and young people at the centre of the integrated HIV-SRH response. It is however important to equip young people with the knowledge, skills, tools and confidence to fulfil this role.

Resources & Links

- Increasing uptake of HIV, Sexually Transmitted Infection, and Family Planning Services, and Reducing HIV- Related Risk Behaviours Among Youth Living with HIV in Uganda [http://www.jahonline.org/article/S1054-139X\(16\)30351-2/abstract](http://www.jahonline.org/article/S1054-139X(16)30351-2/abstract)
- All In #EndAdolescentAIDS http://www.unaids.org/sites/default/files/media_asset/20150217_ALL_IN_brochure.pdf
- Children, Adolescents and HIV: A simple toolkit for community health workers and peer supporters http://www.teampata.org/uploads/CHWTToolkit_web.pdf
- Addressing the Needs of Young People Living with HIV: A Guide for Professionals http://www.stopaidsnow.org/sites/stopaidsnow.org/files/PY_Adressing%20the%20needs%20of%20young%20people%20living%20with%20HIV.pdf
- Encouraging the community to reach 90-90-90: a review of evidence and implementation strategies in Malawi <http://samumsf.org/documents/2015/10/engaging-the-community-to-reach-90-90-90-in-malawi.pdf>
- Searching for the Second R in Sexual and Reproductive Health and... Rights [http://www.jahonline.org/article/S1054-139X\(16\)30859-X/abstract?cc=y%3D](http://www.jahonline.org/article/S1054-139X(16)30859-X/abstract?cc=y%3D)
- 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 [http://www.jahonline.org/article/S1054-139X\(16\)30860-6/abstract](http://www.jahonline.org/article/S1054-139X(16)30860-6/abstract)
- The Use of Narrative for Behavior Change in Adolescent and Youth Sexual and Reproductive Health <http://www.e2aproject.org/publications-tools/pdfs/the-use-of-narrative-behavior-change-aysrh.pdf>
- Uganda: Working with young adolescents (10-14 years old) on sexual and reproductive health and rights and HIV <http://www.aidsalliance.org/news/740-uganda-working-with-young-adolescents-on-srhr-and-hiv>
- Global standards for quality health-care services for adolescents http://apps.who.int/iris/bitstream/10665/183935/1/9789241549332_vol1_eng.pdf

References

1. UNAIDS. 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Geneva: UNAIDS. 2014. http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf
2. WHO, Health for the world's adolescents, 2014. <http://apps.who.int/adolescent/second-decade/>.
3. <https://data.unicef.org/topic/hivaids/adolescents-young-people/>
4. Mark D, Armstrong A, Andrade C, et al. HIV treatment and care services for adolescents: A situational analysis of 218 facilities in 23 sub-Saharan African countries. *Under Rev.* 2017
5. Cortez R, Quinlan-Davidson M, Saadaat S. Knowledge brief: challenges for adolescent's sexual and reproductive health within the context of universal health coverage. *World Bank Group*: Washington, DC.
6. Stockl H, March LM, Pallitto C, Garcia-Moreno C. WHO Multi-country Study Team. Intimate partner violence among adolescents and young women: prevalence and associated factors in nine countries: a cross sectional study. *BMC Public Health* 2014; 14: 751.
7. Gibbs A, Willan S, Misselhorn A, Mangoma J. Combined structural interventions for gender equality and livelihood security: a critical review of the evidence from southern and eastern Africa and the implications for young people. *J Int AIDS Soc.* 2012; 15(Suppl 1): 17362.
8. Pretorius L, Gibbs A, Crankshaw T, Willan S. Interventions targeting sexual and reproductive health and rights outcomes of young people living with HIV: a comprehensive review of current interventions from sub-Saharan Africa. *Global Health Action.* 2015;8:10.3402/gha.v8.28454.
9. Sohn AH, Hazra R. The changing epidemiology of the global paediatric HIV epidemic: keeping track of perinatally HIV-infected adolescents. *J Int AIDS Soc.* 2013;16(18555):1-8.
10. Bernays S, Jarrett P, Kranzer K, Ferrand RA. Children growing up with HIV infection: the responsibility of success. *Lancet* 2014; 383: 1355_7.
11. Toska, E., Cluver, L. D., Hodes, R., & Kidia, K. K. (2015). Sex and secrecy: How HIV-status disclosure affects safe sex among HIV-positive adolescents. *AIDS Care*, 27 (Suppl 1): 47–58.
12. Zamudio-Haas S, Mudekunya-Mahaka I, Lambdin BH, Dunbar MS. If, when and how to tell: a qualitative study of HIV disclosure among young women in Zimbabwe. *Reprod Health Matters* 2012; 20: 18_26.
13. Matthews LT, Crankshaw T, Giddy J, Kaida A, Smit JA, Ware NC, et al. Reproductive decision-making and periconception practices among HIV-positive men and women attending HIV services in Durban, South Africa. *AIDS Behav* 2013; 17: 46170. 1
14. Hudelson C, Cluver L. Factors associated with adherence to antiretroviral therapy among adolescents living with HIV/AIDS in low-and middle-income countries: A systematic review. *AIDS Care* 2015;27(7):805-816.
15. Gittings L, Toska C, Hodes R, Cluver L, Zungu N, Govender K, Chademana KE, Gutiérrez VE. Resourcing resilience: the case for social protection for HIV-positive children on antiretroviral treatment in Eastern and Southern Africa. *RIATT-ESA Report*, June 2016.
16. UNFPA. Youth participation and leadership. 2015. Available at: <http://www.unfpa.org/youth-participation-leadership#sthash.ken5LDSb.dpuf>. Accessed December 13, 2016.
17. MacPherson, P., Munthali, C., Ferguson, J., Armstrong, A., Kranzer, K., Ferrand, R. A., & Ross, D. A. Service delivery interventions to improve adolescents' linkage, retention and adherence to antiretroviral therapy and HIV care. *Tropical Medicine & International Health*, 2015; 20(8): 1015-1032.
18. Dick B, Ferguson J, Chandra-Mouli V, Brabin L, Chatterjee S, Ross DA. Review of the evidence for interventions to increase young people's use of health services in developing countries. *World Heal Organ - Tech Rep Ser.* 2006;(938):151-204.
19. Paediatric AIDS Treatment for Africa. *One-Stop Adolescent Shop - Delivering Adolescent-Friendly Sexual and Reproductive Health, HIV and TB Services in Kafue, Zambia.* Paediatric AIDS Treatment for Africa (PATA); 2015.
20. <http://www.aidsalliance.org/our-impact/link-up/research-and-evidence>
21. Fick C, Fairlie L, Moultrie H, et al. *Working with Adolescents Living with HIV: A Handbook for Healthcare Providers.* Johannesburg; 2015.

22. Ngoksin E, Ninahazwe C, Bhila J, Musah L, Beryl CA, Watson K, Armstrong A. "Taking them forever and taking them on time": the treatment and care needs of adolescents living with HIV. 2014. Unpublished.
23. Wood K, Jewkes R. Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reprod Health Matters*. 2006;14(27):109-118.
24. Geary RS, Gomez-Olive FX, Kahn K, Tollman S, Norris SA. Barriers to and facilitators of the provision of a youth-friendly health services programme in rural South Africa. *BMC Health Serv Res*. 2014;14:259.
25. Asia Pacific Network of People Living with HIV/AIDS. *Lost in Transition: Current Issues Faced by Adolescents Living with HIV in Asia Pacific*. Bangkok; 2013. https://www.unicef.org/eapro/Lost_in_Transitions.pdf. (<http://www.popline.org/node/579114>)
26. Chilinda I, Hourahane G, Pindani M, Chitsulo C, Maluwa A. Attitude of Health Care Providers towards Adolescent Sexual and Reproductive Health Services in Developing Countries: A Systematic Review. *Health (Irvine Calif)*. 2014;6(14):1706-1713.
27. Campbell C, Scott K, Madanhire C, Nyamukapa C, Gregson S. Sources of motivation and frustration among healthcare workers administering antiretroviral treatment for HIV in rural Zimbabwe. *AIDS Care*. 2011;23(7):797-802.
28. Campbell C, Scott K, Madanhire C, Nyamukapa C, Gregson S. A "good hospital": Nurse and patient perceptions of good clinical care for HIV-positive people on antiretroviral treatment in rural Zimbabwe-A mixed-methods qualitative study. *Int J Nurs Stud*. 2011;48(2):175-183.
29. Bernays S, Paparini S, Gibb DM, Seeley JA. When information does not suffice: young people living with HIV and communication about ART adherence in the clinic. *Vulnerable Child Youth Stud*. 2016;(February 2016):1-9.
30. Lall P, Lim SH, Khairuddin N, Kamarulzaman A. Review: An urgent need for research on factors impacting adherence to and retention in care among HIV-positive youth and adolescents from key populations. *J Int AIDS Soc*. 2015;18(2):41-53.
31. UNAIDS. Young Key Populations and HIV Technical Briefs.; 2015. <http://www.nswp.org/resource/young-key-populations-and-hiv-technical-briefs>.
32. Uganda AIDS Commission and Ministry of Health. The HIV and AIDS Uganda Country Progress Report.; 2014.
33. <http://www.aidsalliance.org/about/where-we-work/55-community-health-alliance-uganda-chau>
34. <http://www.aidsalliance.org/our-impact/link-up/integrating-HIV-SRHR>

Special thanks to the organisations that shared their peer models and experiences:



BAYLOR COLLEGE OF MEDICINE CHILDREN'S FOUNDATION - UGANDA

Website: <http://www.baylor-uganda.org/>

Email: admin@baylor-uganda.org

LINKUP

LINK UP AND INTERNATIONAL HIV/AIDS ALLIANCE



Website: <http://www.aidsalliance.org/our-impact/link-up>



SOUTHERN AFRICAN AIDS TRUST (SAT)

Website: <http://www.satregional.org/>

Email: info@satregional.org



CHIEDZA COMMUNITY WELFARE TRUST

Email: gmukaratirwa@gmail.com



NETWORK OF ZAMBIAN PEOPLE LIVING WITH HIV AND AIDS

Website: <http://www.nzp.org.zm>

Email: kunyimalbanda@yahoo.com



CHISOMO COMMUNITY PROGRAMME

Getting to know PATA

Our MISSION is to mobilise and strengthen a network of frontline healthcare providers to improve paediatric and adolescent HIV prevention, treatment, care and support in sub-Saharan Africa.

Our VISION is that all children and adolescents living with HIV in sub-Saharan Africa receive optimal treatment, care and support and live long, healthy lives.

PATA's objectives are:

1. To improve the quality of paediatric and adolescent treatment, care and support at health facility level
2. To grow and deepen engagement of the PATA network and increase peer-to-peer exchange between health providers across countries and regions
3. To incubate, document and share promising practices in paediatric and adolescent treatment, care and support in order to effect positive change in policies, programmes and practices at national and global levels

PATA works through four activity streams: PATA Forums, PATA Incubation Projects & Programmes, PATA Practice-Based Evidence & Advocacy and PATA Connect.

© 2017 PATA. All rights reserved.

Writing and editing: Heleen Soeters, Lesley Gittings, Daniella Mark, Luann Hatane, Samantha Malunga, and Agnes Ronan

Publication design: [Jennifer Geib {writing, layout + design}](#)

Published March 2017

PATA Promising Practices

www.teampata.org

For more information:



Paediatric – Adolescent & Treatment Africa
Building 20, Suite 205-5A, Waverley Business Park
Wyecroft Road, Mowbray, Cape Town 7705

Telephone: +27 21 447 9566

Email: info@teampata.org

Website: www.teampata.org

Twitter: [@teampata](https://twitter.com/teampata)

Facebook: [Paediatric – Adolescent Treatment Africa](https://www.facebook.com/Paediatric-Adolescent-Treatment-Africa)

PATA Promising Practices
are kindly supported by
M·A·C AIDS Fund