

Clinic-Community Collaboration Adolescent Toolkit:


HOW CLINICS AND COMMUNITIES CAN WORK
TOGETHER TO IMPROVE HIV SERVICE DELIVERY
FOR ADOLESCENTS AND YOUNG PEOPLE



ACKNOWLEDGEMENTS

Since its publication, nearly 2500 copies of the initial toolkit have been disseminated, while the online learning programme has been accessed by more than 350 individuals in 27 countries.



Paediatric-Adolescent  Treatment Africa (PATA) and ViiV Healthcare's Positive Action express our sincere appreciation to the organisations and individuals who contributed to the development of this toolkit and whose data, lessons and stories are included herein.

In 2017, we published the initial Clinic-Community Collaboration (C³) toolkit with a focus on prevention of mother-to-child transmission (PMTCT) and paediatric HIV treatment, care and support. We were strongly supported in the compilation of this toolkit by technical partners Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and the Project ACCLAIM programme, and by Aidsfonds and the Towards an AIDS Free Generation in Uganda (TAFU) programme and EngenderHealth.

This C³ toolkit on PMTCT and paediatric HIV treatment, care and support can be accessed through the [Clinic-Community Collaboration Toolkit](#) and the [Be Connected online learning programme](#).

PATA and ViiV Healthcare's Positive Action acknowledge with deep gratitude the 36 health service providers and community-based organisations across Cameroon, Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Nigeria, Uganda, Zambia and Zimbabwe who took part in the C³ programme on which the C³ toolkit on PMTCT and paediatric HIV treatment, care and support was based, contributing their substantial learnings over a three-year period.

This C³ adolescent toolkit is a follow-on from the earlier toolkit, based on the experiences and expertise of 19 partners in Kenya and Zambia who have continued to use the C³ learnings in their work with adolescents and young people. This toolkit is a testament to their dedication and fortitude in taking the C³ programme beyond its initial audience, applying the principles of collaboration to their important work. We want to particularly thank our Clinic-CBO and institutional partners for contributing content for the case studies: George Odhiambo (Peer Support Project), Elijah Ogasa (Nyandiwa Hospital), Stella Njue (Moving the Goalposts), Martin Mwalimu (Ganze Health Centre), Bernard Sichinga (Chilanga Youth Awake), Namamuna Mulele (Kazimva Clinic), Shenaaz Pahad (WITS RHI), Maserame Mojapele (WITS RHI), Vusile Butler (WITS RHI), April Ricotta (Zvandiri), Nicola Willis (Zvandiri), and Rogers Simiyu (EGPAF).

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More information about the C³ programme can be found in [Appendix I](#) of this document.

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CONTENTS

PART I: ABOUT THE TOOLKIT	5
PART II: COLLABORATION IN ACTION	17
Cross-cutting principles	20
Adolescent and youth-friendly	21
Data-driven	23
Peer-led	25
Differentiated	29
Cascade: step-specific considerations	30
Prevent	32
Locate	39
Link	46
Treat & Retain	53
PART III: HOW TO COLLABORATE	61
Assessing & identifying	63
Initiating & formalising	66
Planning & resourcing	70
Implementing & building relationships together	76
Documenting, reviewing & monitoring	80
Messaging for a broader impact	84
APPENDICES	89
Appendix 1: The C ³ Programme	90
Appendix 2: Glossary of key definitions	92
Appendix 3: List of acronyms	94
Appendix 4: Tools & templates	95
Appendix 5: List of clinic-community collaborations	114
Appendix 6: References	115

FOREWORD

We need to invest and strengthen the capacity of communities to become an integral part of the health service through developing and promoting innovative, high quality, user-responsive models of care that effectively link and support facility and community organisations in a continuum of excellence.

Adolescents and young people account for an estimated 45% of all new HIV infections, of which 70% live in sub-Saharan Africa. Within this age group, young women and key populations are disproportionately affected. Despite having the necessary tools, diagnostics and treatment, only half the number of adolescents who require antiretroviral therapy are accessing this life-saving treatment. Adolescents and young people continue to be underserved and left behind, and as a result are experiencing higher rates of new HIV infections, poor virologic suppression and AIDS-related deaths. As we fail to reach the 2020 super-fast-track targets by a substantial margin, intensified focus on linking adolescents and young people to services is urgently needed.

Amplifying best practices and evidence-driven solutions in finding, treating and retaining adolescents and young people will require service delivery mechanisms that can move beyond a siloed biomedical response to ones that address the underlying psychosocial barriers and intersecting forms of discrimination, stigma and structural inequality affecting their lives. A holistic, integrated approach is needed, one that listens, understands, and responds to their needs, whilst putting young people and their communities at the centre of that response.

We need to invest and strengthen the capacity of communities to become an integral part of the health service through developing and promoting innovative, high quality, user-responsive models of care that effectively link and support facility and community organisations in a continuum of excellence. This toolkit provides much-needed support to that linkage, offering several strategies and case examples across the treatment cascade on how clinics and local organisations are working together, whilst outlining a clear plan for collaboration that may be taken up across the region.

The development of these toolkits is based on a partnership between ViiV Healthcare's Positive Action and PATA, that was initiated in 2016. The partnership focused on clinic-community collaboration, working across nine countries, whilst supporting and drawing lessons from 36 of such clinic-community collaborative partnerships. This led to the development of the first edition of the Clinic-Community Collaboration (C³) Toolkit 'Working together to improve PMTCT and paediatric HIV treatment, care and support' and the 'Be-Connected Course' in 2017. This second edition of the C³ Toolkit once again offers a practical "how to" application of the methodology that is centred on cooperation, joint planning and structured partnership, with the focus now on how clinics and communities can work together to improve service delivery for adolescents and young people. This edition of the tool has been informed through drawing lessons from 20 clinic-community collaborations across Zambia and Kenya. We are honoured to continue the scale up of clinic-community initiatives, while furthering the evidence on their value, with such evidence used to advocate for investment, resource allocation and capacity building. Today more than ever, clinic-community collaboration is needed to ensure that HIV service delivery remains a priority, human rights are respected, protected and fulfilled, and policymakers and implementers are held accountable to working collaboratively at all levels.



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PART I: ABOUT THE TOOLKIT

SETTING THE SCENE

Responsive HIV service delivery for adolescents and young people



Adolescents in sub-Saharan Africa are key in determining the course of the HIV epidemic, yet adolescents continue to be underserved by current HIV programming.”

- International HIV/AIDS Alliance,
Adolescent HIV programming: READY—Here we come!, 2017¹

In recent years, it has become widely recognised that the needs of adolescents and young people (aged 10-24 years) should be given greater prominence in the global HIV response.

While global efforts have had a tremendous impact on the HIV epidemic resulting in less than 800,000 people dying in 2018 from AIDS-related illnesses and 23.3 million on treatment, adolescents (10-19 years) and young people (15-24 years) are being left behind.² With HIV as the primary cause of death for adolescents in Africa,³ and second worldwide,⁴ it is clear that too many adolescents and young people living with HIV are not getting the treatment and care that can save their lives.

An estimated 3.9 million [2.1-5.7 million] adolescents and young people are currently living with HIV globally.⁵ Many of these adolescents acquired HIV at birth and with treatment gains in the past several years, more children living with HIV are ageing into adolescence and young adulthood. At the same time, 36% of new infections worldwide are among youth aged 15-24.⁶

Studies from South Africa and other countries indicate that adolescents and young people are less likely than other age groups to access antiretroviral therapy (ART).^{7, 8, 9} Adolescent girls and young women and young key populations are particularly vulnerable to HIV, yet they find it difficult to access health services that cater to their unique needs.¹⁰



At the same time, adolescent and young people of reproductive age often have an urgent unmet need for SRHR services. Each year, approximately 16 million young adolescent women aged 15-19 years give birth in developing countries.¹¹ An additional 2.5 million girls under the age of 16 give birth in these same regions.¹² A significant portion of these births are unplanned; yet contraceptive use remains low.^{13, 14} In Africa nearly two-thirds (62%) of sexually active adolescents wanting to avoid pregnancy experience unmet need.¹⁵ For adolescents and young people, particularly young women, to gain the benefits of longer schooling, work experience and parenting readiness, they require access to comprehensive SRHR education, services and tools.¹⁶



Effective HIV service delivery and access to comprehensive sexual and reproductive health and rights (SRHR) services are key to making gains in health for adolescents and young people.



DEFINITIONS

> Young Key Populations

Often defined as four target groups:

- young men who have sex with men
- young transgender people
- young people who sell sex
- young people who inject drugs

This definition can also be expanded to include other marginalised populations, such as young girls and young pregnant women. **Young key populations** have unique needs that need to be addressed in order to ensure effective access to services and care.

> Comprehensive sexual and reproductive health services

Comprehensive SRHR services are services that allow all people, regardless of their nationality, age, sex, gender, sexual orientation, health or HIV status, to make informed and free choices regarding their own sexuality and reproductive well-being. In the toolkit, we often link SRHR services to HIV services since there is overlap between the two service types.

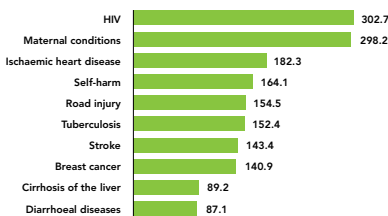
AT A GLANCE



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

Source: UNAIDS 2019 estimates.

AIDS-related illnesses are the leading cause of death among 15–49-year-old females globally (hundred thousands)



Source: Global health estimates 2016: deaths by cause, age, sex, by country and by region, 2000–2016. Geneva, World Health Organization; 2018.

21X

HIV INCIDENCE IS 21 TIMES HIGHER AMONG FEMALE SEX WORKERS THAN AMONG THE GENERAL POPULATION

Source: UNAIDS, 2019.

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

Source: www.unwomen.org/en/what-we-do/humanitarian-action/facts-and-figures.

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

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

Source: Jewkes, R. et al (2010). Intimate partner violence, relationship power inequality, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet 376(9734):41-48.



16% of rural currently married adolescent girls and young women who live in sub-Saharan Africa report using a modern contraceptive.



23% of urban currently married adolescent girls and young women who live in sub-Saharan Africa report using a modern contraceptive.



Of every five new HIV infections among young people (15–24 years), three are among young women.

Source: UNAIDS 2019 estimates.

52%

of adolescent girls and young women in rural areas are unable to make decisions about their own health, compared with

47%

in urban areas.

Source: Population-based surveys, 2011–2016. The statistics are based on available data from 28 countries in which 83% of all women aged 15–24 years in sub-Saharan Africa live.

IN SUB-SAHARAN AFRICA, 42% OF WOMEN LIVING IN URBAN AREAS AGED 15–24 HAD A PREGNANCY BEFORE THE AGE OF 18.

IN RURAL AREAS, MORE THAN 50% OF WOMEN AGED 15–24 HAD A PREGNANCY BEFORE THE AGE OF 18.

Source: Population-based surveys, 2011–2016. The statistics are based on available data from 27 countries in which 80% of all women aged 15–24 years in sub-Saharan Africa live.

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

Source: United Nations Children's Fund 2018 estimates.

AROUND

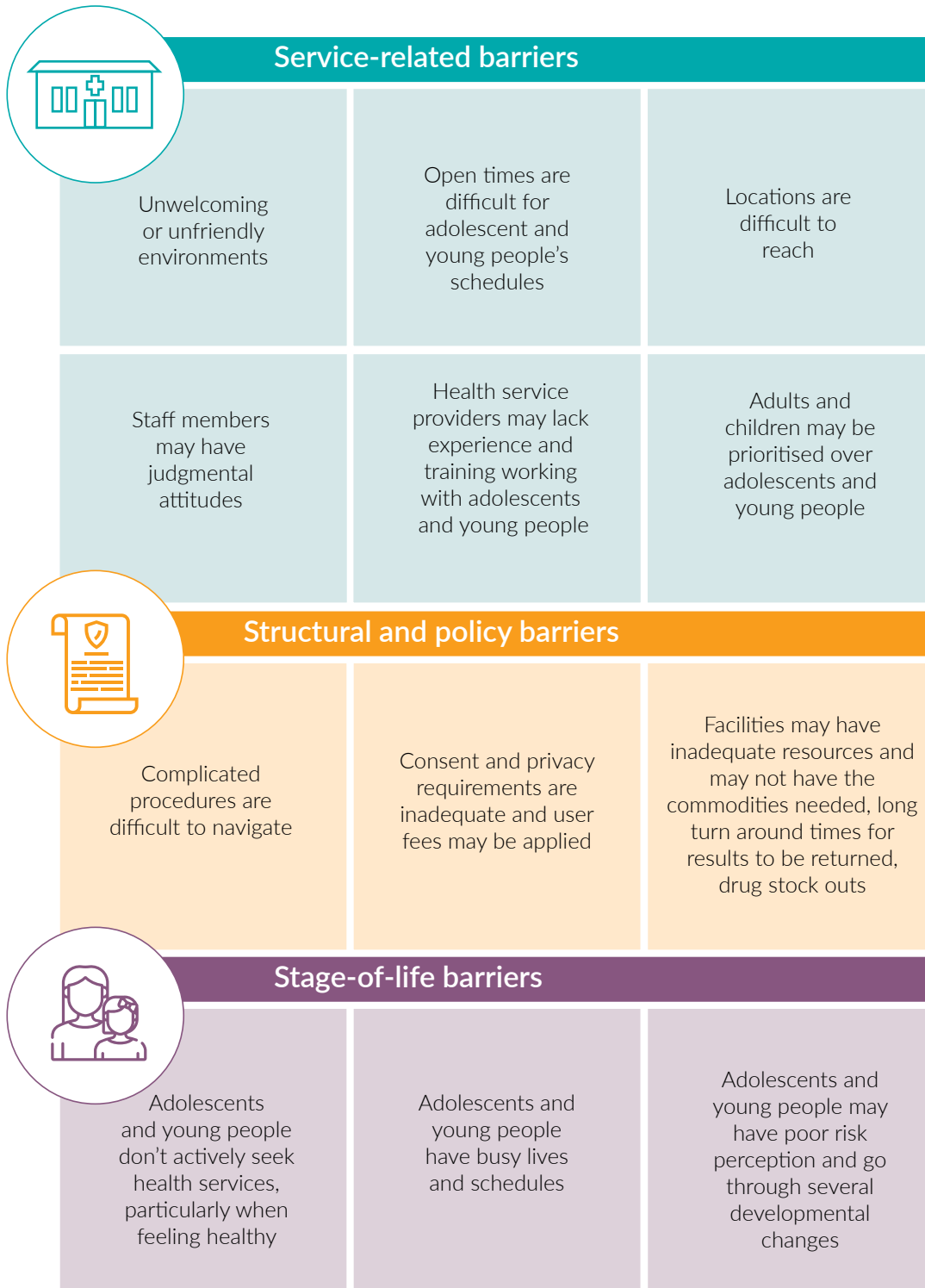
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adolescent girls (10–19 years) died of AIDS-related illnesses every day in 2018.

Source: UNAIDS 2019 estimates.



BARRIERS TO ADOLESCENTS ACCESSING HEALTH SERVICES



Why clinic and community collaboration is important for service delivery for adolescents and young people.



Adolescents and young people are capable of managing and advocating for their own health and well-being, when strongly supported by clinics and communities. Clinics are any facility or service providing healthcare, and communities are groups of people living in a shared geographical area. Yet, adolescents and young people access health services differently than adults and children. These differences need to be taken into account for health systems and programmes to be fully responsive to the needs of adolescents and young people.


Reaching people with the greatest need for HIV services—including adolescents and young people—requires a community-centred approach.¹⁸ While health service facilities have a critical role to play, the social and structural barriers to accessing HIV prevention, treatment and care require the sustained and meaningful engagement of communities.

The experience of C³ has demonstrated that clinic-community collaboration leads to increased service uptake, improved retention in care and increased trust between health service providers working in clinics and members of communities.¹⁹ The data set is small and the findings are not generalisable for all contexts and settings. However, we believe these indicators are suggestive of improved health outcomes.



However, too often, clinics, community-based organisations (CBOs)—a group of people who work together at a local level, and not for profit, to improve life for all or some of a community’s residents—and other community groups operate independently, relying on informal arrangements that do not lead to sustainable and meaningful outcomes. To date, there has been little practical guidance available on **how** communities and clinics can be engaged as effective partners.

This C³ adolescent toolkit brings together real-life examples of clinic-community collaboration focused on HIV service delivery for adolescents and young people while also providing guidance for how formal collaborative partnerships can be initiated and maintained, based on the experience of the C³ programme.

 “A holistic approach is needed to reach young people with the information and services they need to protect themselves from HIV and to enable them to exercise their sexual and reproductive health rights. Health facilities, schools and community-led organizations all have important roles to play and services to provide, coordinated and supported by the local HIV authority.”

–UNAIDS, Communities at the Centre, 2019¹⁷

PURPOSE AND AUDIENCE OF THE TOOLKIT

This C³ adolescent toolkit supports clinics and communities to partner with each other to improve HIV service delivery for adolescents and young people.

Importantly, it complements existing national and international guidelines, such as those issued by the World Health Organization (WHO),^{20, 21} with a special focus on collaboration between healthcare facilities, CBOs and other community groups. In particular, this toolkit supports collaboration and partnership with organisations that value and facilitate meaningful engagement and participation of adolescents and young people.

The toolkit is designed to:

- Highlight **cross-cutting principles** that are critical for HIV service delivery for adolescents and young people
- Showcase **opportunities across the HIV service delivery cascade**—including gaps, approaches and case studies—to inspire clinics and communities to work together to improve outcomes for adolescents and young people. In this toolkit, we refer to the cascade as the sequential programmatic that HIV programming should follow in order to improve health outcomes
- Share a **systematic methodology** for clinics and communities to partner together through shared service delivery focused on adolescents and young people



Who is the toolkit for?

This C³ adolescent toolkit is developed primarily for **those working to deliver services to adolescents and young people**, including clinics, CBOs and health-focused community groups. This includes those at various levels, such as clinic managers, health service providers, clinic officers, CBO managers, programme coordinators, community health workers—and peers engaged in all aspects of service delivery.



DEFINITION

MEANINGFUL ENGAGEMENT

Meaningful engagement exists when adolescents and young people are fully engaged in all stages of service delivery, including decision-making. Importantly, they should be able to engage on equal terms with adults at all levels and participate independently and make decisions on important aspects of service delivery.



HEALTH SERVICE PRACTITIONER DEFINITIONS

In this toolkit, we refer to the following health service practitioners using the following terms:

> **Health service provider:** Someone from any number of cadres working as a practitioner within the health system to provide HIV, SRHR and broader health services.

> **Community health workers:** Members of the community who provides or facilitates access to basic health services for their fellow community members.

> **Peer roles, including mobiliser, navigator and supporter/mentor:** Generally speaking, **peer mobilisers** work to increase demand for services, **peer navigators** assist clients in accessing care, and **supporters/mentors** provide information, education, treatment adherence and psycho-social support often through individual and group sessions.

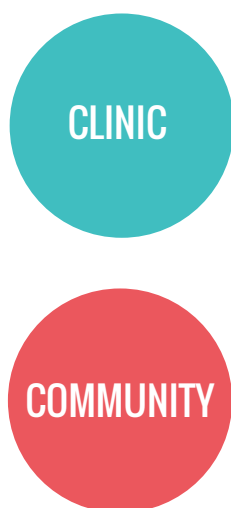
In addition, this toolkit supports **community groups working outside of health** such as schools, faith-based organisations and youth-centred organisations—essentially any group of people who are invested in the well-being of adolescents and young people in their communities.

Finally, the toolkit should be of interest to **policy-makers and programme managers with a focus on service delivery for adolescents and young people**, including district health management, national ministries of health, national and international NGOs and donors, as well as United Nations (UN) agencies wanting to support collaboration between health systems and communities. This is because the toolkit's principles are cross-cutting and, while they apply predominantly to local-level activities, can be encouraged and supported by district, regional, national and global efforts.

We focus on **low-resource settings** and assume that clinic-community collaborations will operate in the absence of supplementary resources, although dedicated funds will accelerate progress.

How collaboration happens

C³ for adolescents and young people is not a one-size-fits-all methodology, due to differences between adolescent populations, countries and settings. However, the C³ programme generally follows a pattern, first evident in the paediatric HIV care programme, and now represented in the early stages of the adolescent and young people collaborations:²²



Prior to collaboration, **clinics and communities often have their own perspectives** and do not necessarily recognise the value that collaboration could bring. Collaboration, if any, is informal, inconsistent and driven by individuals, and there may be a lack of trust and transparency, while roles may be poorly defined. In this circumstance, adolescents and young people often have difficulty navigating the clinic-community divide to access the services they need.



Clinics and communities often **start by working together on an initial aspect of service delivery**, collaboratively determined and focused on their most important shared priority for children, adolescents and young people. These areas of collaboration include aspects such as providing adolescent-responsive care, increasing linkages between adolescent HIV and SRHR services and/or improving adolescent adherence. During the process of undertaking an initial aspect, the two groups of people (one based at a clinic, the other in a community) learn how to work with one another.



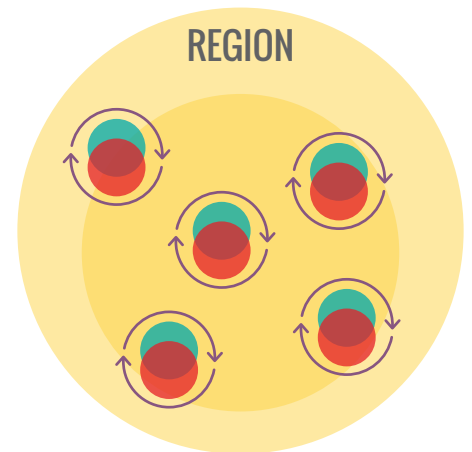
During these initial engagements, **a relationship between the clinic and community is often formalised**, either through an MOU or other documentation. Clear terms of reference and roles are defined and joint commitment to and ownership of services is established. Services—such as HIV and SRHR—are increasingly integrated under the same roof, with stronger referrals and linkages. Peers may also become an increasing part of clinic-community efforts.



Clinic-community partners begin to build trust in one another and **increasingly collaborate on ongoing activities**. Over time, cooperation becomes engrained in each of their ways of working. This was evidenced in that partners in the C³ programme for PMTCT and paediatric HIV treatment, care and support rated each other significantly higher in value-add to HIV services²⁰ and continued cooperation beyond the programme duration. Joint leadership may be realised, with shared goals and ongoing collaborative routines and procedures. Importantly, adolescents and young people are meaningfully engaged and a formal part of the clinic-community team.



As a collaboration demonstrates success through more trusting relationships and improved outcomes for adolescents and young people, the collaboration often grows to multiple aspects of service delivery. As this materialises, **clinic-community collaboration becomes integral to the district-level response**, and is integrated into planning, monitoring and evaluation frameworks. These partnerships may be replicated across the local health system.



The ultimate goal is for clinic-community collaboration to become **a sustainable way of working** for clinics and communities across a district or region.



WHAT WE HOPE THE TOOLKIT WILL ACHIEVE

This toolkit has been developed with you (those working in clinics, CBOs and community groups) in mind. It is hoped that contents of these pages (tools, templates, case studies and models) will enable you to:

- ✓ **Start small and build.** Even small examples of collaboration can be inspirational to clinics and communities who are interested in working together. The toolkit includes both simple and elaborate examples in this toolkit to show that collaboration can start at any point and be set up in diverse ways
- ✓ **Inspire others:** When you are successful, share your experience—it will likely inspire others to get started too! When you encounter a challenge, don't be afraid to share that too—frustration is part and parcel of success
- ✓ **Work with what you have.** Many of us work in low or middle-income contexts, with limited human and financial resources. Leverage that which is available to you, and build collaborative partnerships that are not necessarily dependent on additional funds
- ✓ **Tailor strategies to your unique context.** There is no standardised approach to service delivery—no 'silver bullet.' Each community is different in terms of its available resources, infrastructure, leadership and socio-economic, political and cultural landscape. Your effectiveness will depend on your ability to leverage the strengths of your situation
- ✓ **Lead the change.** Whatever your role, you can influence what is around you and inspire others to do the same
- ✓ **Do what you can.** While the toolkit outlines a 'gold standard' process for collaboration, you may not be able to complete all steps or all aspects of a step. There is still value to be had in doing as much as you can
- ✓ **Collaborate.** Working with others in your community is fundamental to accomplishing your goals, especially when information and resources can be shared
- ✓ **Participate.** Collaboration requires partners to contribute to and invest in the relationship and service
- ✓ **Innovate.** Be creative. Think up 'game changers' for your context, and don't wait for resources before you shift your practices

HOW THE TOOLKIT IS ORGANISED

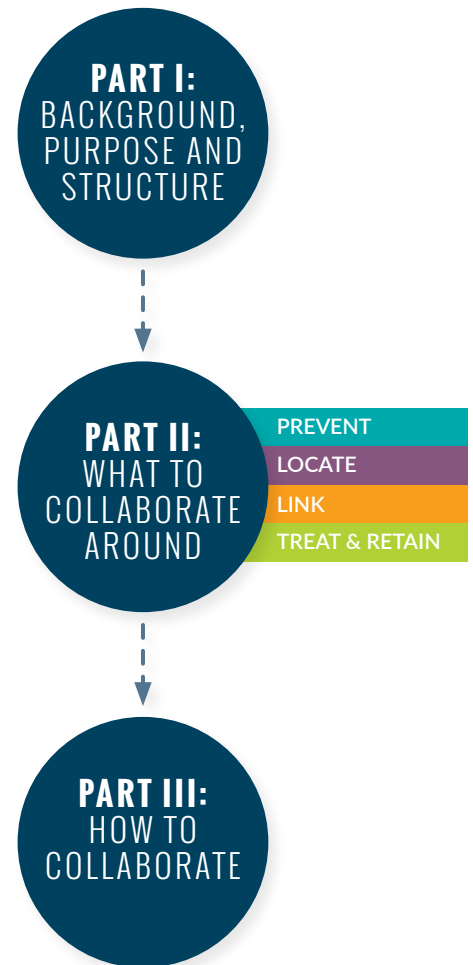
This toolkit is organised into three sections:

- **Part I** explains the background, purpose and structure of the toolkit
- **Part II** focuses on *what* to collaborate around, along the HIV service delivery cascade, using real-world examples of collaboration along the way
- **Part III** examines *how* to collaborate using C³'s pragmatic 6-step methodology

Together, Parts II and III describe the major lessons we and our frontline partners have learned about clinic-community collaboration for adolescents and young people.

Throughout the toolkit and in the [Appendices](#), we share tools, templates, case studies and models we have learnt from C³ and other programmes. However, while the toolkit is rich with examples across countries and programmes, we strongly encourage you to think about what will work best within your local setting while adapting and innovating for the best results specific to your unique context.

A description of the [C³ programme](#), a [list of acronyms](#) and a [glossary of key definitions](#) is included in the Appendix for referencing.



ICONS

You will find the following **icons** in the toolkit:



DEFINITION: A key word is defined the first time it appears in the toolkit



TOOL: A practical instrument you can use as you perform a given activity or step



KEY MESSAGE: A critical piece of information or guidance



QUOTE: Words from a C³ programme participant



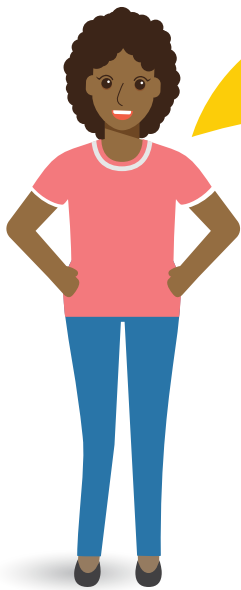
LESSON FROM C³: A learning directly from the C³ programme experience



MEANINGFUL ENGAGEMENT: A tip to ensure that adolescents and young people are meaningfully engaged and participate fully in your collaboration

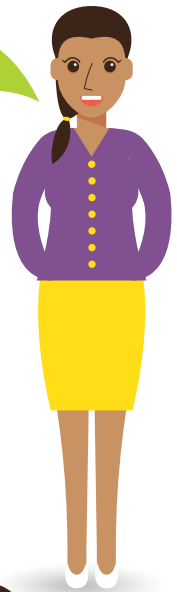
CHARACTERS

You will meet the following **characters** in the toolkit. These are not *actual* people, but characters inspired by individuals we have met through the C³ programme:



Molo! I'm **Bulelwa**, a 20-year-old South African. I recently joined the clinic in my neighbourhood of Khayelitsha as a peer supporter. I was diagnosed with HIV as a child and my grandmother disclosed my status to me as a young teen. I went through a stage of heartbreak and denial when I didn't want to take my medication. Now I'm living proof that these stages can be overcome! I enjoy working with adolescents and young people who are newly diagnosed, helping them to make the linkage to treatment and care more smoothly than my own experience.

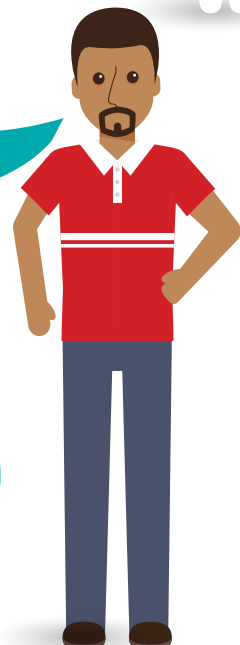
Moni! I'm **Patience**, a 30-year-old programme manager working for a non-governmental organisation in Kitwe, Zambia. We support peer mobilisers and navigators, as well as provide training and capacity building to clinic staff across the city. My passion is collaboration, ensuring that we work closely with clinics and give them the support that we need. I have also been inspired by young people who are advocating for their own health needs, given the right support and opportunities.



Jambo! I'm **Sister Zawadi**, the sister-in-charge at a clinic in Eldoret, Kenya. We have recently developed an adolescent and youth corner in our facility and we have launched a youth club for adolescents and young people living with HIV. They are growing steadily and we are seeking more partnerships with community-based organisations to improve our services, since we know we can't do everything by ourselves. I am looking forward to strengthening these collaborations and bringing in more young people as team members who can relate to our young clients.



Oli Otya, I'm **Akiki**. I'm 17 years old and I work as a peer mobiliser/navigator for a community-based organisation in Lira, Uganda as a peer mobiliser. I have always enjoyed bringing together my fellow schoolmates and now I get to do this as a full-time job! I work in schools, providing education and referrals to clinic services. I often find that young people just need an invitation to take more control of their health—I can provide that encouragement, particularly when I have a good relationship with the clinic that they will be visiting.



PART II:
COLLABORATION
IN ACTION

INTRODUCTION

Adolescents and young people access health services in different ways than adults and young children

Adolescence and young adulthood are periods of immense physical, cognitive and emotional development. During these phases of life, young women and men exhibit new attitudes and behaviours toward decision-making and risk-taking.²³ If the adolescent and young person's environment responds appropriately to this developmental phase, a healthy transition from childhood to adulthood ensues.

Ensuring adolescent and young peoples' access to affordable, high-quality HIV and SRHR services and supplies greatly enhances their health and well-being, while also engages their own agency for future opportunities and realising their right to choose.

However, adolescent attitudes and behaviours, as well as environmental and structural constraints, also present unique challenges for health service providers and the systems in which they work. Adolescents and young people do not seek health services in the same ways that adults or caregivers of young children do. To reach adolescents and young people effectively, health services should be "**safe, equitable, acceptable, accessible, effective and appropriate**"²⁴ to meet the unique needs of those in this stage of life.



Adolescent and young people characteristics/behaviour ^{25, 26}	Appropriate health system responses
Frequently seek health support outside of health facilities.	Share messages and identify entry points within the broader community where adolescents and young people make everyday health decisions.
Have different needs from children and adults, particularly regarding privacy and confidentiality—the act of maintaining privacy for adolescents and young people while ensuring that young clients are aware of any needs to inform others about their care.	Be present in places that are not traditionally associated with health service provision while training health service providers in the specific needs of adolescents and young people.
Engaged in school (and home/work) activities that often make it difficult to attend normal clinic hours.	Be flexible to the schedules that adolescents and young people necessarily prioritise in their decision-making.
Influenced more by peers than professionals and may be reluctant to see support from a health provider.	Incorporate trained and supported peers as integral members of clinic and community teams.
Experience developmental milestones that change the way they make choices.	Ensure multiple ways of intervening and influencing that are consistent and mutually reinforcing.
May belong to key populations that further affect access to health services.	Extend services and outreach beyond clinic doors to places where marginalised or excluded adolescents and young people might feel more comfortable.
May feel excluded from decisions that affect them and powerless to change the health service experience.	Include accountability mechanisms that promote engagement with young people on the service experience and how it can be improved.

Collaboration is key for adolescents and young people to access HIV services

Collaboration between clinics and communities is critical to ensuring that adolescents and young people can access health services and make healthy decisions.

For effective service provision for adolescents and young people, services must extend beyond the clinic itself, to partnerships with community groups where adolescents and young people are present, including schools, faith-based institutions and youth centres.

To reach adolescents and young people who are marginalised—particularly those who are criminalised, abused or living in extreme poverty—collaborations should happen with these groups themselves.

This section outlines two critical opportunities for clinic-community collaboration for adolescents and young people and showcases real-world stories as examples.

In Part II, we highlight:

1. **Cross-cutting principles:** ‘Ways of working’ that increase the effectiveness of clinic-community collaborations at any step in the HIV cascade
2. **Cascade step-specific recommendations for collaboration:** Specific gaps, opportunities, approaches, tools and case studies that illustrate what collaboration can look like at each step of the cascade. We also include detailed checklists to illustrate how the cross-cutting principles apply to each step

CROSS-CUTTING PRINCIPLES



In this toolkit, we promote four principles—‘ways of working’—that increase the effectiveness of clinic-community collaborations for improved services for adolescents and young people across the HIV service delivery cascade.



KEY MESSAGE

These cross-cutting principles are ‘mutually reinforcing’, meaning that the more principles you apply, the more effective your collaboration will be.

In the following pages, we will describe each principle. Then, in the remainder of Part II, we will explain ways in which these principles can be applied to opportunities at each step of the HIV service delivery cascade for adolescents and young people.



ADOLESCENT AND YOUTH-FRIENDLY

What do we mean?

Adolescent and youth-friendly refers to health services that are designed by and for adolescents and young people. They recognise adolescents and young people as key stakeholders and partners in the development and delivery of health services. Adolescent and youth-friendly services are **safe, equitable, acceptable, accessible, effective and appropriate**²⁷ with the ultimate aim of increasing uptake and use of HIV and SRHR services by adolescents and young people for improved health outcomes.

Why is it important?

Adolescents and young people are in a distinct period of life with its own challenges and opportunities.

According to the World Health Organization (WHO), “Adolescents often find mainstream primary care services unacceptable because of perceived lack of respect, privacy and confidentiality, fear of stigma and discrimination and imposition of the moral values of health-care providers.”²⁸

General health services are usually geared toward adults and/or young children, while services for adolescents and young people are often “highly fragmented, poorly coordinated and uneven in quality.”²⁹

Evidence is emerging that adolescents and young people who are served by adolescent and youth-friendly health services compared to standard care exhibit small but significant improvements in health outcomes.³⁰

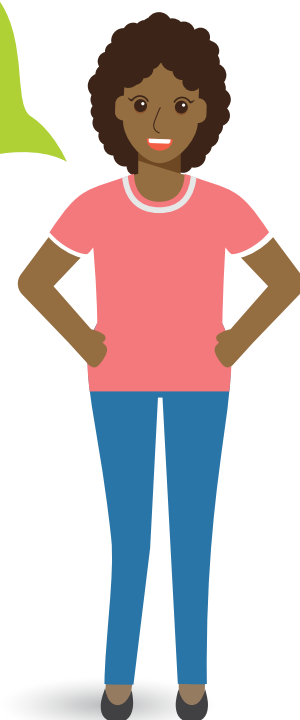
“My schedule is filled with commitments that are different from adults. I have school and extracurriculars, plus a part-time job, chores at home and friends. I need services that fit into my schedule.”

– Bulelwa, Peer Supporter



KEY MESSAGE

Services are most effective when tailored to specific needs and rights of adolescents and young people.



What does it look like for clinic-community collaboration?

When clinics and communities collaborate in adolescent and youth-friendly ways, they:

- Deliver **comprehensive and integrated** health services for adolescents and young people
- Ensure **clear and consistent linkages** between community groups and facilities
- Accommodate **schedules and competing priorities** of adolescents and young people (such as school conflicts, transport challenges and job schedules)
- Acknowledge the **emotional, psycho-social and privacy needs** of adolescents and young people
- Acknowledge **the importance of sexual health** that is pleasurable, fulfilling and free from coercion, discrimination and violence, through respect and protection of human rights
- Consider **safety, inclusivity, age-appropriateness and enjoyment/fun** when designing and delivering services
- Recognise the **rights and diversity** of adolescents and young people

GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS

Adolescents' health literacy	Standard 1. The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	Standard 2. The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services	Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach. ¹
Providers' competencies	Standard 4. Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Facility characteristics	Standard 5. The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity and non-discrimination	Standard 6. The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Data and quality improvement	Standard 7. The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	Standard 8. Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

¹ Service provision in the facility should be linked, as relevant, with service provision in referral level health facilities, schools and other community settings.



DATA-DRIVEN

What do we mean?



Data-driven refers to health services that **use data in all aspects of design, delivery, monitoring and evaluation**. Data should inform how services are conceptualised, the way in which adolescents and young people receive services, when and where services are provided, and continual service improvement efforts.

Why is it important?

Data is often considered a 'final output' and used to report on activities at the end of a reporting cycle to government ministries and/or funders. Yet, data is an essential tool to use at each point in delivering health services.

Data can be used as a starting point to determine what services should look like, who needs them, who is not being reached, and where and when they should be delivered.

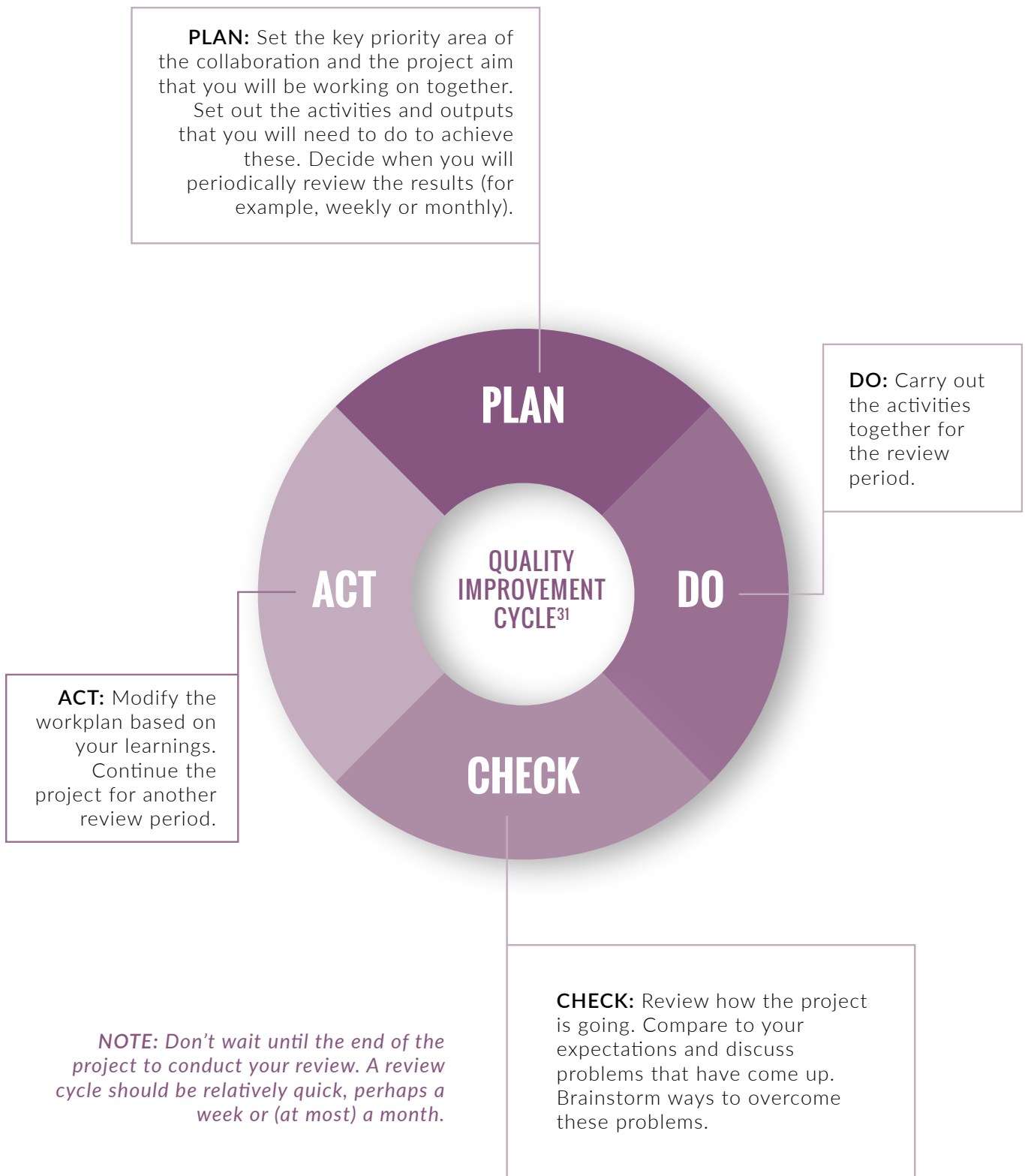
Data can then be utilised throughout service delivery to prioritise activities and ensure that resources are used effectively, particularly in resource-limited settings.

Data can also be used by clinics and communities to measure progress and keep teams motivated while identifying and responding to challenges and opportunities as they arise. Importantly, data can also tell us how services are being experienced by those who utilise the service.

What does it look like for clinic-community collaboration?

When clinics and communities collaborate in data-driven ways, they:

- Work together to **identify appropriate indicators of success**
- **Share the burden of collecting data**, according to their key strengths
- **Involve adolescents and young people** at each stage of the process
- Ensure that **data is 'disaggregated'** (measures specific groups of people) in order to identify trends in age, sex, gender identification and key population groups
- Spend time together **analysing data** and understanding what it means for their partnership
- **Set targets** and compare to data collected at the beginning of a project (baseline)
- **Continuously use the data**, at regular intervals, to find out what is working well and to improve those activities or services that are not working well





PEER-LED

What do we mean?

Peer-led refers to health services that engage adolescents and young people as leaders in all aspects of service provision, including design, delivery, monitoring and evaluation of programmes. Peers are those who share one or more characteristics with clients— adolescents and young people seeking and requiring health services— such as age, stage-of-life, HIV status, gender, sexual orientation and/or key population status.



In collaborations that use peer-led strategies, adolescents and young people are supported to engage meaningfully in each of these aspects of service provisions, serving as integral members of clinic and community teams and acting as a primary point of contact for adolescents and young people seeking health services.

Why is it important?

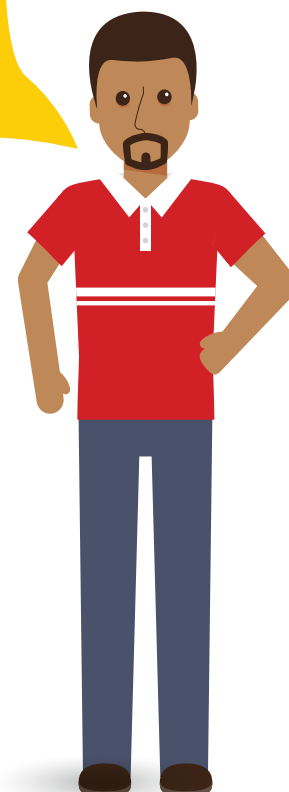
Adolescents and young people are often more strongly influenced by peers than professionals.

Peer-led strategies are based on “the assumption that, especially among adolescents, peers learn from each other, are important influences on each other, and that norms and behaviours are most likely to change when liked and trusted group members take the lead in change.”³²

Peer-led strategies have been shown to contribute to better knowledge of HIV and SRHR, delay of sexual debut and overall uptake of healthy behaviours.³³ Peer-led interventions have also been linked to improved linkages to services, retention in care, adherence and psycho-social well-being.³⁴

“I am motivated by this work, particularly when I have a chance to be part of designing programmes and learning from the results. I am particularly interested to see if our work has impact—and discovering the data that proves it.”

– Akiki, Peer mobiliser/navigator



What does it look like for clinic-community collaboration?

When clinics and communities collaborate in peer-led ways, they:

- Engage peers formally as **team members** in both clinics and communities
- Provide **adequate training on HIV services and psycho-social support** with capacity-building for peers
- Continuously **supervise and support** peers in their work
- Involve peers in **decision-making**, particularly regarding client needs and how services can be improved
- Provide peers with **access to data** to make informed decisions concerning their clients
- Empower peers with **knowledge about HIV treatment and care** so that they feel capable of assisting clients within well-defined boundaries
- Create mechanisms for adolescents and young people to evaluate the services they receive and link this to ongoing quality improvements in the clinic

The READY to care scorecard is a tool for your health facility, giving young people a chance to give feedback on your services, let you know how you are doing and measure your progress

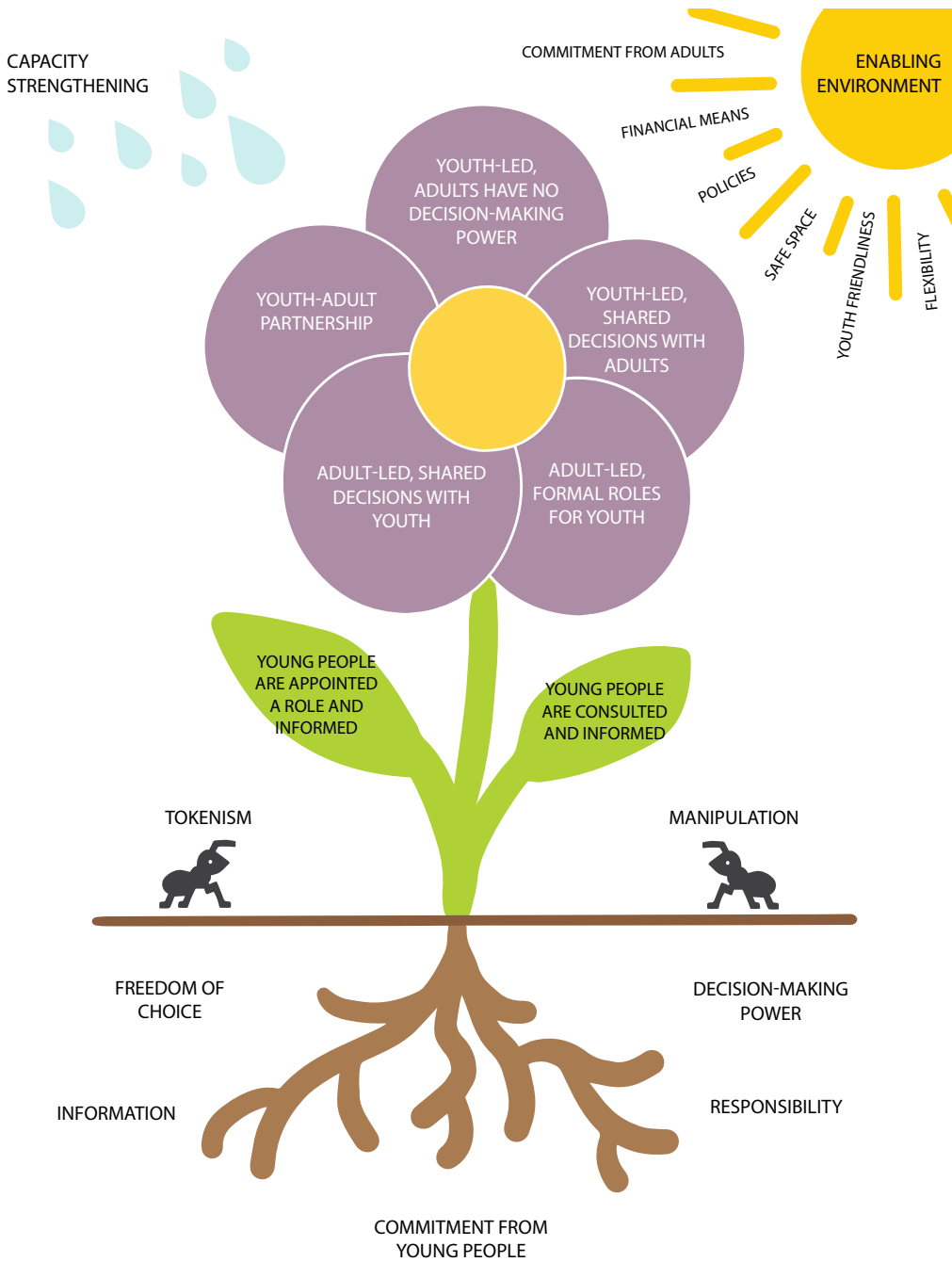
Resource can be found at <http://teampata.org/portfolio/service-providers-guidance-for-working-with-young-people-living-with-hiv/>



Scorecard

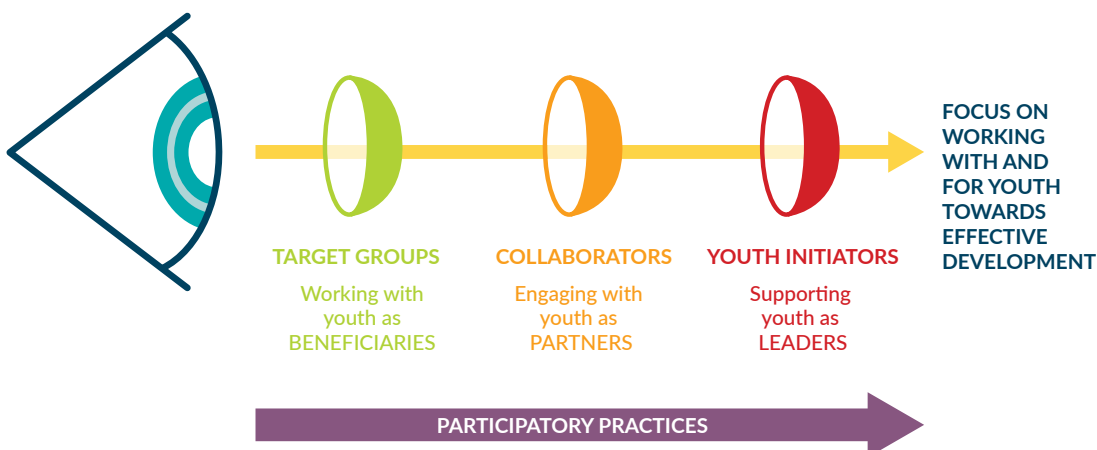
We have committed to providing adolescent and youth-friendly health services at this health facility. If you are between the ages of 10-24 years, please complete this survey. Your responses will help us to improve our services. This survey is anonymous – you don't have to write your name. This is your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

		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 and will speak to me in a confidential space.				
9	Health providers make appointments quick and smooth so I am not waiting around.				
10	Health providers are fair to me and do not allow older clients to jump the queue ahead of me unnecessarily.				
11	Health providers find ways to make sure that I do not have to visit the clinic too often and that I get the range of services I need.				
12	Health providers do not behave inappropriately – they don't flirt with me, gossip about me or insult me.				
13	Health providers make sure that the medication they give me is correct, not expired and they explain to me what I need to know to be able to take it.				
14	Health providers do not burden me with any stress they may be feeling.				
15	Health providers care about me and make me feel cared for, understood and protected.				



The many enabling factors needed to grow youth participation in a nurturing environment.

Sourced from <https://www.youthdoit.org/assets/Uploads/Flower-of-Participation.png>



The three-lens approach is a tool for engaging youth as beneficiaries, partners and leaders, adapted to the HIV response.

Sourced from Youth participation in development: a guide for development agencies and policy makers. London (UK): Department for International Development – CSO Youth Working Group; 2010. www.unaids.org/sites/default/files/media_asset/youth-and-hiv_en.pdf

Key principles of peer interventions

- Provide appropriate training, mentorship and supervision:**
 - Build on previous knowledge and skills through regular training.
 - Match peer workers with an older, more experienced peer worker.
 - Offer weekly debrief sessions with supervisors.
 - Facilitate opportunities for further education and qualifications.

- Provide appropriate resources for peers to carry out their responsibilities:**
 - Ensure adequate supplies of IEC materials, job aids and referral forms.
 - Cover associated costs, including transportation and mobile phone use.
 - Pay acceptable remuneration.

- Ensure the protection and safety of all peer workers:**
 - Require pair or group work.
 - Ensure peers know how and who to ask for help and provide access to phones for emergencies.
 - Ensure peers have a mechanism to ensure protection of children and that complaints are dealt with appropriately.

- Establish clear mechanisms of referral and support:**
 - Provide protocols and policies that outline when and how to refer, including contact details for immediate support.

- Recognise that adolescents are diverse and need different types of support:**
 - Not all will want to participate in peer activities.

- Ensure that peers are as diverse as the group of adolescents they are supporting or serving:**
 - Consider age, sex, sexual orientation and other differentiating characteristics, is key to establishing trust and a sense of safety.

- Ensure peer-based interventions do not replace the roles and responsibilities** of service providers, parents, caregivers or other community members.

- Foster collaboration between health facilities and youth organisations** to facilitate regular ongoing feedback and opportunities for shared creative activities.

- Reward and acknowledge young people for their contribution.**



DIFFERENTIATED

What do we mean?

Differentiated health services “take a client-centred approach, simplifying and adapting services to better meet the needs of people living with HIV and reducing unnecessary burdens on the health system.”³⁵ For adolescents and young people living with HIV, differentiated services ensure that treatment and care are adapted to the particular needs of adolescents and young people whilst recognising diverse sub-groups and key populations.

Why is it important?

A one-size-fits-all approach to HIV service delivery is often challenging for adolescents and young people, who comprise multiple age bands, socio-economic backgrounds, gender identifications and sexual orientations, amongst other differentiators.

Adolescents and young people living with HIV face a lifetime of treatment and care, and their circumstances will change dramatically over the 10-24-year age period. It is important that services evolve over time to respond to life changes. It is also important that the transition from adolescent to adult care is managed effectively.

Differentiated treatment and care can improve the quality of life for adolescents and young people living with HIV as well as increase the efficiency and outcomes of health systems.³⁶

What does it look like for clinic-community collaboration?

When clinics and communities collaborate in differentiated ways, they:

- Work together **to identify population and client-specific needs** using data to inform decision-making
- **Separate ‘refill’ visits from ‘clinical’ visits**, particularly for adolescents and young people who are stable and thriving
- Identify **community-based ART distribution points** (group and individual) to make collection convenient for adolescents and young people
- Ensure that services are **tailored to marginalised and vulnerable populations**, including tracking and following up on those who are lost to care
- **Combine family visits** to meet the scheduling needs of families and new mothers
- Design services to take into consideration **specific needs and preferences of adolescents and young people**, including pregnant adolescents, young mothers, adolescents with mental health and psycho-social issues, and those living with HIV who are transitioning to adult care



KEY MESSAGE

Adolescent girls and boys have different experiences that require differentiation in care. Girls often reach developmental milestones sooner than boys. Societal expectations of boys and girls are also different, particularly in relation to cultural and sexual norms. Boys and girls receive different social messaging about sexuality and sexual debut. Significant attention needs to be given to both physiological and social-cultural differences associated with sex and gender when developing health services for adolescents.

MODEL FOR DIFFERENTIATED CARE FOR ADOLESCENTS AND YOUNG PEOPLE

WHAT: HIV Care Components for Adolescent and Young People



- ART initiation and refills
- Adherence support
- Psychosocial support
- Laboratory tests
- Opportunistic infection management
- Mental health services
- SRHR services
- Case management
- Outreach and re-engagement
- Education and career services

WHEN: Service Frequency & Intensity



- Appointment frequency and timing
- Ease of scheduling and flexibility
- Duration and intensity of appointments

WHO: The HIV Care Team



- Health care providers
- Social service providers
- Peers
- Family and caregivers
- Community health workers

WHERE: Location of Service Delivery



- HIV clinic or hospital
- Primary care clinic
- School-based clinic
- Pharmacy
- Community organisation
- Home
- Mobile technology

CASCADE: STEP-SPECIFIC CONSIDERATIONS

In this toolkit, we divide the HIV cascade into four steps:

PREVENT: Clinics and communities working together to prevent new HIV infections

LOCATE: Clinics and communities working together to test and find adolescents and young people living with HIV

LINK: Clinics and communities working together to connect and initiate adolescents and young people living with HIV to treatment and care

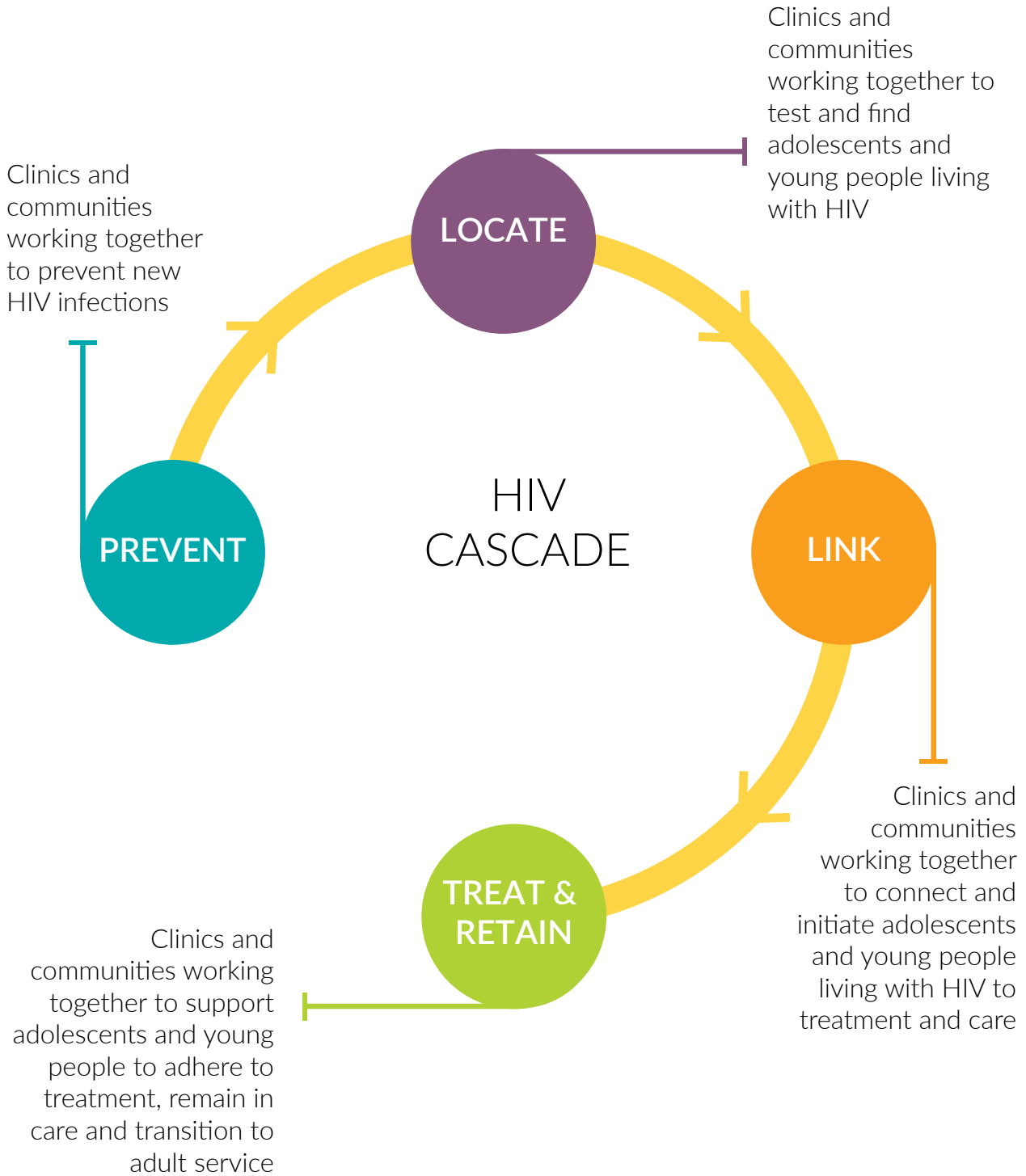
TREAT & RETAIN: Clinics and communities working together to support adolescents and young people to adhere to treatment, remain in care and transition to adult service

In the pages that follow, we will dive more deeply into clinic-community collaborations at each step of the HIV cascade.

While some of the principles, approaches and case studies showcased at specific steps within the HIV cascade can be applied across *multiple* steps or even the *entire* cascade, we have chosen to situate each at their most applicable step.

For each of the cascade steps, we will look at:

- **Gaps:** What issues and barriers can clinics and communities work together to address?
- **Opportunities:** What opportunities exist for clinics and communities to work together to improve service delivery?
- **Approaches:** What types of approaches can clinics and communities work on together?
- **Principles:** How can clinics and communities apply the cross-cutting principles?
- **Tools:** What forms, checklists and/or activity descriptions or standard operating procedures can help clinics and communities to support their efforts?
- **Case studies:** What are some examples of clinics and communities successfully working together?



What does effective collaboration for HIV prevention for adolescents and young people look like?

Adolescents and young people seek and can access comprehensive HIV prevention and SRHR services both in communities and facilities, gaining the tools, information and services they need to make informed decisions. Adolescents and young people in vulnerable situations can talk to trusted peers, supported by adults, who connect them with the services they need.

GAPS IN HIV PREVENTION

Issues which hinder adolescents and young people from accessing prevention services include:

- **HIV services not integrated with SRHR services:** HIV and SRHR services are often not integrated, and may be unavailable, unacceptable and/or unfriendly to adolescents and young people, frequently due to cultural norms and values which do not acknowledge adolescents and young people as potentially sexually active
- **Restricted access to prevention and SRHR commodities and tools:** Clinics, communities and adolescents and young people may have restricted access to commodities such as HIV self-tests, contraception and information pamphlets. Access to prevention strategies such as VMMC, PEP or PrEP are not always offered
- **Insufficient knowledge and awareness:** Adolescents and young people may lack knowledge and awareness of HIV prevention and SRHR services, sometimes due to stigma associated with HIV or being sexually active
- **Contextual factors that increase vulnerability to HIV:** Adolescents and young people are vulnerable to early school leaving, unintended pregnancy, gender-based violence and intergenerational and transactional sex, all of which increase vulnerability to HIV
- **Legal gaps:** Adolescents and young people may find it difficult to confidentially access HIV prevention and SRHR services due to a high legal age of consent. In some instances, comprehensive services (including access to various contraception methods and access to abortion) may not be available

PREVENT: COLLABORATION OPPORTUNITIES & STRATEGIES

Collaborations between clinics and communities focused on *HIV prevention* for adolescents and young people seek to:

OPPORTUNITY	STRATEGIES
Provide HIV prevention services with comprehensive SRHR services.	Make comprehensive HIV prevention and SRHR services more broadly available and accessible —in communities as well as clinics, through mobile clinics, community services and school-based services. Advocate for and ensure information on where to access to prevention services such as PEP, PrEP and VMMC.
Ensure availability of prevention commodities and tools.	Make sure that commodities and tools, such condoms, HIV tests and contraception, are available in places that are accessible to adolescents and young people —such as schools, youth centres, faith-based institutions, youth centres and areas where key populations gather.
Improve HIV and SRHR information and knowledge. Create increased demand for services.	Bring HIV prevention and SRHR knowledge and information to everyday situations —such as schools—where adolescents and young people can ask questions and make healthy choices, while reducing stigma. Provide information on where services can be accessed.
Mitigate contextual factors that increase vulnerability to HIV.	Provide safe community spaces in schools, faith-based institutions and youth centres for discussion of unhealthy and risky behaviours while promoting alternatives through peer modelling. Secure linkage to socio-economic strengthening programmes, social protection, mental health and psycho-social support services. Join efforts to combat all forms of gender-based violence and discrimination against marginalised populations.
Advocate for adolescent- and young people-friendly policies.	Join with adolescents and young people to advocate for policies that provide access to comprehensive services and lowered age of consent that match developmental stage and protect confidentiality through attending public fora, writing briefings, addressing public figures and participating in social media campaigns.

“Some of my staff are uncomfortable talking about sex with teenagers; it’s just not the way it’s usually done. I find that if we face these discomforts and talk about them, adopting a sex-positive approach, we can serve our young clients in a better way.”

– Sister Zawadi, Sister-In-Charge



PREVENT: APPROACHES

Approaches for clinic and community collaborations that promote *HIV prevention* for adolescents and young people include:

Comprehensive HIV prevention and SRHR services:

Partnering to deliver HIV prevention and SRHR services into broader community health and education initiatives by disseminating knowledge, creating demand and linking adolescents and young people to health services

Partnerships with schools, faith-based organisations and youth centres:

Working together to deliver life-skills programmes, peer education programmes and health education initiatives in non-traditional locations

Dedicated spaces for services for adolescents and young people:

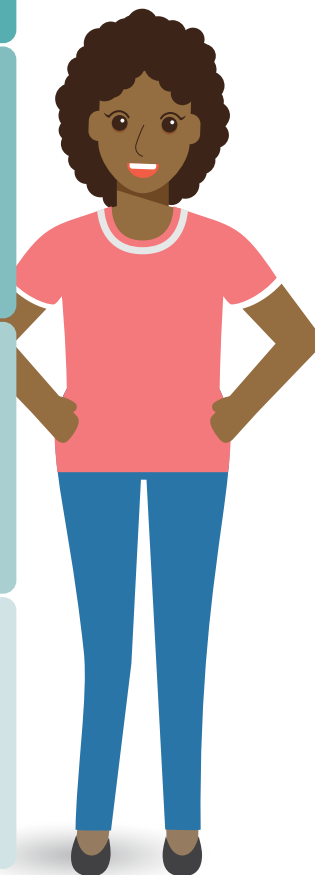
Collaborating to increase the availability of HIV prevention and SRHR services within the community, through youth clinics, adolescent days at clinics and mobile health services

After-school or after-work safe spaces: Co-delivering programmes for HIV and SRHR education and stigma reduction, including youth clubs, camps, 'sports' events, music and dance events and drama, art and film productions

Sensitisation and demand creation: Co-creating opportunities to drive demand for services, including communication campaigns that reach community leaders and key institutions



Prevention programmes which simultaneously seek to address complementary approaches— including biomedical, behavioural and structural—offer the most effective way to deliver prevention services.³⁶



PREVENT: APPLYING THE PRINCIPLES

Clinics and communities should apply the cross-cutting principles to ensure that collaborations are most effective for *HIV prevention* for adolescents and young people:

ADOLESCENT AND YOUTH-FRIENDLY	DATA-DRIVEN	PEER-LED	DIFFERENTIATED
<ul style="list-style-type: none"> <input type="checkbox"/> Do we understand which SRHR services adolescents and young people need and want to access, integrated with HIV prevention and located in the same place at the same time? <input type="checkbox"/> Can adolescents and young people access prevention services and commodities easily, without stigma and judgement? <input type="checkbox"/> Are we creating spaces that ensure engagement and physical/emotional safety for adolescents and young people while exploring their sexuality and learning how to stay healthy? 	<ul style="list-style-type: none"> <input type="checkbox"/> What are the key indicators for HIV prevention and SRHR services in our local area? At a minimum, do we know the number of adolescents and young people receiving HIV prevention and SRHR services? <input type="checkbox"/> What changes do we hope to see in these metrics based on our intervention? <input type="checkbox"/> How will we know that our prevention programme is working? <input type="checkbox"/> How will we share information with each other? <input type="checkbox"/> Do we know where comprehensive SRHR services and HIV prevention services such as VMMC, PrEP and PEP are available? 	<ul style="list-style-type: none"> <input type="checkbox"/> Are we engaging adolescents and young people meaningfully in the provision of prevention and SRHR services—including design, delivery, monitoring & evaluation? <input type="checkbox"/> Have we included peers on our team? Are they included in decision-making? <input type="checkbox"/> How are we supporting and building the capacity of peers on our team? <input type="checkbox"/> Do we have mechanisms to check in with adolescents and young people on how they experience the service and how they think it could be improved? 	<ul style="list-style-type: none"> <input type="checkbox"/> Do we understand the diversity and varied life circumstances of the adolescents and young people we serve? <input type="checkbox"/> Have we created service lines that cater to these diverse needs? <input type="checkbox"/> Do we accommodate transitions between age categories and into adulthood? <input type="checkbox"/> Are we ensuring that young key populations and those most marginalised can easily access our SRHR and HIV prevention services?



TOOLS & LINKS

[TOOL 1: MAPPING SRHR AND HIV PREVENTION SERVICES](#)

[TOOL 2: MAPPING POTENTIAL PARTNERS FOR PREVENTION PROGRAMMES](#)

WHO. Advocating for change for adolescents: a practical toolkit for young people to advocate for improved adolescent health and wellbeing, 2018. <http://teampata.org/portfolio/advocating-for-change-for-adolescents-a-practical-toolkit-for-young-people-to-advocate-for-improved-adolescent-health-and-well-being/>

Linkages. Health4All: Training health workers for the provision of quality, stigma-free HIV services for key populations, 2018. <http://teampata.org/portfolio/health4all-training-health-workers-for-the-provision-of-quality-stigma-free-hiv-services-for-key-populations/>

PREVENT CASE STUDY 1:

READY (Resilient and Empowered Adolescents and Young People)

LOCATION(S): Zimbabwe, Eswatini, Tanzania, Mozambique, Burundi, Ethiopia, Uganda, Cote d'Ivoire, Namibia and India

ORGANISATIONS: The Global Network of Young People Living with HIV (network partner); Frontline AIDS (NGO partner); PATA (communications partner); Regional Psychosocial Support Initiative (NGO partner); M&C Saatchi World Services (media partner); Government of the Netherlands (funding partner); and additional technical resource partners and in-country implementing partners.

CONTEXT: An estimated 430,000 adolescents and young people in eastern and southern Africa acquire HIV each year, often due to poor access to relevant and responsive health services. Negative cultural attitudes to young people's sexuality, gender norms and practices, violence, poverty, as well as the lack of participation of young people in decisions that affect their lives, all contribute to this lack of access.

STATISTICS: READY is a movement comprising a portfolio of programmes, including READY+, READY to Lead, the READY Fellowship, and READY Teens. In 2016, READY helped connect more than 775,000 young people to HIV prevention services and more than 193,000 young people living with HIV to comprehensive HIV services.

COLLABORATION: READY works through interlinked partners in each country. Partners include peer networks who deliver services to adolescents and young people and implementing partners who coordinate the work and facilitate the activities of the peer networks.

**OBJECTIVES:**

- Ensure that adolescents and young people are ready to make informed decisions about their health and wellbeing
- Assist parents, caregivers and communities to support young people while promoting their rights, health and wellbeing
- Ensure that service providers are ready to deliver youth-friendly services, including HIV and SRHR services, psychosocial support and information
- Advocate for decision-makers to champion the SRHR of adolescents and young people living with and affected by HIV

ACTIVITIES:

- Peers provide information through sports and edutainment to encourage young people to access HIV testing
- HIV testing is provided in both clinical and non-clinical settings
- NGO partners provide training to service providers on youth friendly SRHR service provision and psychosocial support
- CBOs provide mentoring and coaching support to peers
- Peers run support groups and assist adolescents and young people to navigate the health system
- Peers provide one-on-one support in homes to engage on health issues, including HIV treatment and care

IMPACT:

A mid-term review showed that the model has been well accepted in Tanzania, Eswatini, Mozambique and Zimbabwe where it is focusing on HIV positive adolescents and young people.

**LINKS AND SOURCES:**

<http://teampata.org/ready/>

<https://frontlineaids.org/were-on-the-frontline-of-supporting-young-people/>

<http://teampata.org/portfolio/ready-mid-term-review-key-findings-and-learning/>

PREVENT CASE STUDY 2:

Integrating PrEP into Comprehensive Services for Adolescent Girls and Young Women

LOCATION(S): Priority areas of South Africa: OR Tambo (Eastern Cape), Nelson Mandela District (Eastern Cape), Tshwane (Gauteng), eThekweni (KwaZulu-Natal)

ORGANISATION(S): University of the Witwatersrand Reproductive Health and HIV Institute (WITS RHI, academic partner), National Departments of Health, (government partner), Unitaid (funding partner)

CONTEXT: Adolescent girls and young women in South Africa have the highest incidence of HIV in the country. PrEP is a once-a-day pill HIV prevention method that can reduce the risk of HIV infection from sex by more than 90%.

STATISTICS: The project aims to reach 6,640 adolescent girls and young women aged 15-24.

COLLABORATION: WITS RHI is working in eight clinics and their respective communities across South Africa to engage learners, schools, communities, and parents while collecting data about PrEP initiation and continuation for adolescent girls and young women. Working jointly with the National Department of Health, Wits RHI aims to initiate 6,640 adolescent girls and young women on PrEP by December 2020.

OBJECTIVES:

- Reduce new infections among adolescent girls and young women
- Test strategies to reach those at most risk of contracting HIV
- Create demand, improve linkage to services and retain young women in treatment and care

ACTIVITIES:

- **Capacity building:** The National Department of Health provides clinical management of oral PrEP, demand creation and M&E training to PrEP implementing partners including WITS RHI. Thereafter, WITS RHI replicates and re-enforces the National Department of Health training with professional nurses, lay counsellors, and other staff at clinic level. This additional training also includes SRHR services, adolescent and youth friendly services, HIV testing services and research elements. WITS RHI also provides intensive ongoing mentoring sessions for all staff trained in each National Department of Health clinic. Mentoring sessions include supportive supervision, one-on-one and group coaching.
- **Demand creation and community mobilisation:** To facilitate large scale access of PrEP by adolescent girls and young women, a range of demand creation campaigns and messaging for different target audiences (adolescent girls and young women in schools, in tertiary education, in employment and the unemployed) were designed and are currently being implemented and monitored. The project has worked hard to create demand for PrEP amongst adolescent girls and young women across many social media platforms such as Facebook, twitter and on the 'www.myprep.co.za' website. Targeted activities are undertaken on an ongoing basis at a local level, the broader community and within the clinic space and IEC materials such as PrEP posters, the PrEP pocketbook are used in these engagements. Further, the WITS RHI demand creation team train CBOs to conduct community mobilisation activities like stakeholder and youth engagements and traditional, religious and community leaders' dialogues. CBO's receive orientation on oral PrEP to effectively sensitise and mobilize young people for comprehensive SRHR including PrEP.
- **PrEP provision:** With regular visits to identified hotspots in the surrounding community, the WITS RHI mobile clinic teams and the DoH clinic staff provide comprehensive SRHR services including PrEP, to young women aged 15-24 years.
- **Ongoing Routine M&E data collection and research:** Routine M&E activities are undertaken on a regular basis to monitor and report on programmatic progress. As part of the study, WITS RHI fieldworkers are trained to collect data – quantitative surveys and targeted qualitative data collection among service users and health care providers and community service providers.

IMPACT:

At scale, the project will initiate 6,640 AGYW on PrEP, however it is important to note that following the first 10 months of implementation, a growing demand for PrEP outside of AGYW is being seen. Out of a total of 5 406 initiations at the end of October 2019, 54.5% of those are AGYW (2 949) and 45.5% (3 691) are other clients (including AGYW male partners). The project therefore has the potential to, at community level, demonstrate achievement of epidemic control.



Session providing SRHR information and education on PrEP



LINKS AND SOURCES:

<http://www.wrhi.ac.za/expertise/detail/unitaid-prep-project>

<https://unitaid.org/news-blog/south-africa-launch-hiv-prevention-project/#en>

PREVENT CASE STUDY 3:

Communities in support of HIV/AIDS negative adolescent girls and young women

LOCATION(S): Homa Bay County, Suba South Sub-County (Kenya)

ORGANISATIONS: Peer Support Project (CBO partner); Nyandiwa Level 4 Hospital (government clinic partner)

CONTEXT: Homa Bay County is an area of Kenya with higher-than-average rates of early marriage and teenage pregnancy. Peer Support Project (PSP) is a CBO in Nyandiwa Fishing Beach that has developed an intervention that uses a combination HIV prevention approach to mobilize adolescent girls and young women and the fishing community to address social norms that contribute to new HIV infections. The key determinants addressed include low economic status, inadequate negotiation skills and limited access to HIV prevention services.

STATISTICS: The collaboration has mapped and enrolled 329 adolescent girls and young women aged 15-24 into the programme. Together, they have also strengthened the capacity of 20 peer educators and engaged four HIV testing services counsellors and one nurse to offer community-based HIV prevention and SRHR services.

COLLABORATION: PSP, a local CBO, is working together with Nyandiwa Level 4 Hospital to engage adolescents and young women in an HIV prevention education programme that includes health education sessions conducted by PSP and HIV testing, treatment and SRHR services conducted by clinic staff.

OBJECTIVES:

- To generate demand for HIV prevention services among adolescent girls and young women of ages 15 to 24 (and their male partners) through life skills and sexual reproductive health interventions
- Increase access to prevention, care and treatment services through strengthened referrals and linkages and follow up of adolescent girls, young women and their prospective partners
- Reduce vulnerability to HIV infections in fisher folk young women through effective socio-economic interventions

ACTIVITIES:

- PSP maps adolescents and young women in the catchment area and enrolls as participants in the programme
- PSP conducts health education sessions with participants using a curriculum focused on 'safe choices'
- PSP refers and links programme participants to the clinic for HIV testing and broader SRHR services
- Clinic staff deliver services in the community outreach spaces

IMPACT: The project aims to reduce new HIV infections among 800 adolescent girls and 400 young women between the ages of 15-24 by 50% in 11 beaches in Suba South Sub-County. The project has improved referral systems that link the various beaches, health facilities and service provision points leading to 100% completion of all referrals.



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PEER SUPPORT PROJECT
Media Peace Games



LINKS AND SOURCES:

<http://peersupportproject.yolasite.com/>

https://www.afidep.org/download/Afidep_ASRH-Homabay-County-Final.pdf

What does effective collaboration for locating adolescents and young people living with HIV look like?

Adolescents and young people seek and can access HIV testing services in both clinics and communities. Adolescents and young people consider testing and repeat testing as a normal part of a healthy lifestyle, and do so without facing stigma from health providers, family and peers.

GAPS IN LOCATING ADOLESCENTS AND YOUNG PEOPLE LIVING WITH HIV

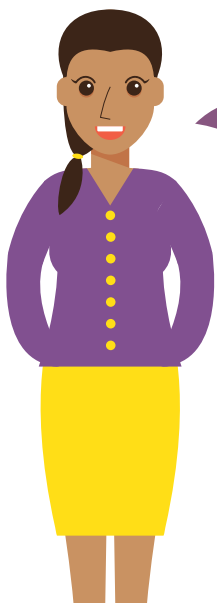
Issues which hinder adolescents and young people from accessing HIV testing services include:

- **Structural barriers to testing:** Adolescents and young people may struggle to get tested at facilities, due to lack of transport, fees, schedule conflicts and wait times. Health service providers may also exhibit judgemental or discriminatory attitudes that prevent adolescents and young people from accessing testing
- **Restricted access to testing:** Adolescents and young people may have restricted access to facility testing, due to lower prioritisation or lower perception of need. HIV testing may not be routinely offered as part of SRHR services. At the same time, access to community- and self-testing is still limited
- **Stigma associated with getting tested, knowing one's status and managing disclosure:** Adolescents and young people may not want others to know that they are getting tested for HIV, or they may be fearful of knowing or eventually needing to disclose their status. For those infected perinatally, there may be issues with non or partial disclosure
- **Stage-of-life factors that inhibit testing:** Adolescents and young people may experience denial, invincibility, lack of awareness or a heightened susceptibility to how they are perceived by others that can hinder testing uptake
- **Legal and cultural gaps:** Adolescents and young people may find it difficult to confidentially access testing services due to high legal age of consent. Low HIV and sexual health knowledge is a key barrier to accessing HIV testing and prevention services. Furthermore, unaccommodating attitudes towards sex outside of marriage and the restricted social autonomy of women and young girls can reduce their ability to access sexual health and HIV services

LOCATE: COLLABORATION OPPORTUNITIES & STRATEGIES

Collaborations between clinics and communities focused on *locating* adolescents and young people living with HIV seek to:

OPPORTUNITY	STRATEGIES
Make facilities more adolescent-friendly for those seeking testing services.	Partner together to add features that matter to adolescents and young people , including days and hours of service, fees, no fee options, health providers who are sensitised and comfortable to talk about sexuality and integrate HIV testing as routine practice into various services, dedicated rooms and fast-track services for adolescents and young people.
Improve access to testing for adolescents and young people.	Task-shift testing to community organisations , including locations such as schools, faith-based institutions and areas where young key populations gather. Introduce self-testing, if available, with follow-up and support. Work together to integrate provider initiated testing and counselling (PITC) for adolescents presenting with opportunistic infections (in and out patient). Integrate HIV testing in SRHR services with the option of voluntary couple testing and voluntary assisted partner notification.
Influence positive staff attitudes and behaviour toward testing adolescents and young people.	Integrate peers into clinic and community healthcare teams as voices for the needs of adolescents and young people to increase uptake of testing and other services.
Address stage-of-life factors that inhibit testing uptake.	Integrate HIV education by trained peers into everyday activities, such as school, so that initial testing, routine testing and treatment become routine, non-stigmatised activities.
Advocate for policies that allow adolescents and young people to take charge of their own health through routine testing.	Promote and support adolescents and young people in advocacy groups, networks and coalitions so that they have a voice in their own health provision.



“We were surprised to see that the clinic was trying to run an HIV education programme that overlapped with so many of our own messages.

It just made sense for us to start working together. The clinic sister was keen to offer education talks at our school and even suggested offering health screening and HIV testing services.”

– Patience, CBO Programme Manager

LOCATE: APPROACHES

Approaches for clinic and community collaborations that promote *locating* adolescents and young people living with HIV include:

Adolescent-friendly facilities that encourage testing:

Partnering to increase the accessibility and friendliness of facility-based testing services

Community-based testing services to increase accessibility and friendliness: Working together to perform testing and referrals in conjunction with community services, including schools, faith-based institutions, mobile clinics and areas where key populations gather

Self-testing: Developing ways together to overcome social, structural and health system barriers through investing in adolescent and young peoples' preferences for self-testing

Peer mobilisers as team members: Co-training and co-facilitating peer mobilisers and community health workers for testing and referrals

Innovative tools to encourage testing: Working together to use innovative ways to bring adolescents and young people to testing, particularly those populations who are more difficult to reach. These innovative ways may include vouchers and e-vouchers with incentives and unique identifiers to increase and track uptake of services

Creative methods to de-stigmatise testing: Co-creating programmes that use sports, drama and music, as well as social media and peer influencers, to encourage testing and de-stigmatise HIV, creating demand

LOCATE: APPLYING THE PRINCIPLES

Clinics and communities should apply the cross-cutting principles to ensure that collaborations are most effective for *locating* adolescents and young people living with HIV:

ADOLESCENT AND YOUTH-FRIENDLY	DATA-DRIVEN	PEER-LED	DIFFERENTIATED
<ul style="list-style-type: none"> <input type="checkbox"/> Have we explored integrating testing services with other SRHR services, as well as bringing them out of the clinic and into the community? <input type="checkbox"/> Are these services clearly linked between clinic and community? <input type="checkbox"/> Is the referral process clear and are adolescents and young people fully aware of the HIV testing protocol? <input type="checkbox"/> Are our services and programmes clear and engaging, using language and messaging that speaks to adolescents and young people? 	<ul style="list-style-type: none"> <input type="checkbox"/> What are the key metrics for HIV testing uptake and referrals in our local area? At a minimum, do we know the number of adolescents and young people and those most marginalised testing for HIV and their test results? <input type="checkbox"/> What testing uptake targets do we anticipate based on our intervention? <input type="checkbox"/> For mass campaigns, how will we know that testing uptake is attributed to our services/programmes? <input type="checkbox"/> How will we share information with each other? <input type="checkbox"/> Where should we target our testing for higher yields in case finding? 	<ul style="list-style-type: none"> <input type="checkbox"/> Do we have peer mobilisers on our team? Are they included in decision-making? <input type="checkbox"/> Are peer mobilisers fully trained and supported, confident in their ability to answer questions and engage with adolescents and young people about testing and referrals? <input type="checkbox"/> Are we engaging adolescents and young people meaningfully in the education and testing process—including design, delivery, monitoring and evaluation? 	<ul style="list-style-type: none"> <input type="checkbox"/> Are we ensuring that key populations of adolescents and young people can access our testing services? <input type="checkbox"/> Have we considered community-based testing points, such as schools, nightclubs and youth centres? <input type="checkbox"/> Are we supporting self-testing through our programmes? What might be the opportunities and/or barriers? <input type="checkbox"/> Are we partnering with organisations that have experience working with adolescents and young people, and young key populations?



TOOLS & LINKS

[TOOL 3: PEER MOBILISER JOB DESCRIPTION & RECRUITMENT](#)

[TOOL 4: VOUCHERS & E-VOUCHERS](#)

CDC and USAID. Strategies for identifying and linking HIV-infected infants, children and adolescents to HIV care and treatment, 2018. <http://teampata.org/portfolio/strategies-for-identifying-and-linking-hiv-infected-infants-children-and-adolescents-to-hiv-care-and-treatment/>

EGPAF. Using differentiated service delivery models to scale up testing and case identification among children and adolescents, 2017. <http://teampata.org/portfolio/2912/>

LOCATE CASE STUDY 1:

ZVANDIRI

LOCATION(S): Throughout Zimbabwe; expanded to Mozambique, Tanzania and Swaziland in 2017; adapted in Uganda and adopted in Rwanda in 2019

ORGANISATION(S): Africaid (NGO partner); Zimbabwe Ministry of Health and Child Care, Ministry of Public Service, Labour and Social Welfare, the Ministry of Primary and Secondary Education and the National AIDS Council of Zimbabwe (government partners); Funding partners include UNICEF, USAID PEPFAR, Frontline AIDS and ViiV Healthcare's Positive Action



CONTEXT: Zimbabwe has a high HIV prevalence (12.7%) with 1.3 million people living with HIV.³⁷ HIV prevalence is 6.7% among young women and 2.9% among young men age 15-24.³⁸ The Zvandiri model was initiated in 2004 when a group of adolescents living with HIV in Harare requested help to establish a support group where they could share experiences and develop skills for growing up with HIV.

STATISTICS: In Zimbabwe, Zvandiri has scaled nationally and is now in 51 of 63 districts. Since 2004, the programme has expanded from a single support group to a comprehensive model of clinic and community based differentiated services for over 40,213 children, adolescents and young people living with HIV.

COLLABORATION: Africaid and district health facilities collaboratively recruit Community Adolescent Treatment Supporters ('CATS'), young people living with HIV aged 18-24 years. 1100 CATS are trained and mentored and embedded within health facilities and supervised by Zimbabwe Ministry of Health and Child Care staff with technical support from Africaid-employed, district-based Zvandiri Mentors.

OBJECTIVES:

- To link children, adolescents and young people to prevention services
- To locate children, adolescents and young people living with HIV and link to treatment and care
- To improve young people's experience across HIV diagnosis, disclosure, linkage, adherence, retention and viral suppression and to provide on-going support for their mental health, social protection and sexual and reproductive health
- To equip children, adolescents and young people living with HIV with the knowledge, skills and confidence to cope with their HIV status and to live happy, healthy, safe, fulfilled lives

ACTIVITIES:

- The national Zimbabwe Ministry of Health and Child Care conducts the planning and implementation of Zvandiri services with provincial and district cadres coordinating services through their respective clinics
- Clinics provide support and supervision to CATS, who identify and refer undiagnosed children, adolescents, and young people; support pre- and post-test HIV counselling and disclosure; support the linkage of HIV-negative clients to HIV prevention services; and enrol those testing HIV-positive in Zvandiri
- CATS manage a caseload of up to 60 children, adolescents and young people whom they support through home visits, support groups, clinic visits, and mobile health communication
- Africaid employs Zvandiri district-based mentors who provide technical support and training to facility staff

IMPACT: A randomised control trial study in a rural district of Zimbabwe showed improved self-reported adherence (44.2% to 71.8%) after 12 months enrolment in the Zvandiri programme.³⁹ Numerous other studies have exhibited improved case finding, improved linkages to care and increased adherence to treatment.⁴⁰ The Zvandiri Trial, a cluster randomised trial found that the Zvandiri programme resulted in 42% lower prevalence of virological failure or death at 96 weeks among participants compared to those only receiving Zimbabwe Ministry of Health and Child Care standard of HIV care at rural clinics.⁴¹

**LINKS AND SOURCES:**

<https://www.africaid-zvandiri.org/resources>

<https://www.pepfarsolutions.org/adolescents/>

<http://www.differentiatedservicedelivery.org/Resources/Resource-Library/Zvandiri-Cluster-Randomized-Control-Trial-Policy-Brief>

LOCATE CASE STUDY 2:

SELF-TESTING AFRICA (STAR)

LOCATION(S): Malawi, Zambia, Zimbabwe, South Africa, Lesotho and Swaziland

ORGANISATIONS: London School of Hygiene & Tropical Medicine (academic partner); WITS RHI (academic partner), Population Services International (PSI, NGO partner); Society for Family Health (NGO partner); Unitaid (funding partner); numerous other NGO and CBO partners (for a full list, visit <http://hivstar.lshtm.ac.uk/>)

CONTEXT: Globally, an estimated 79% of all people living with HIV know their status. This is significantly lower than the 2020 goal of 90% set by the global community. This gap is particularly evident among men, young people and vulnerable populations. While HIV self-testing is still uncommon in Africa, it has the potential to increase uptake of HIV testing among those who are reluctant to access testing through facilities.

STATISTICS: STAR is a 5-year project to increase the uptake of HIV self-testing. By November 2018, STAR distributed 2.3 million HIV self-test kits in Eswatini, Lesotho, Malawi, South Africa, Zambia and Zimbabwe.

COLLABORATION: STAR is the largest evaluation of HIV self-testing in Africa to date. The project brings together a coalition of research institutions, NGOs, CBOs and health systems to roll out self-testing kits in the target countries, with a particular emphasis on men and young people.⁴³

OBJECTIVES:

- Understand the market for HIV self-testing in southern Africa
- Determine strategies and cost-effectiveness of HIV self-testing across six southern African countries
- Generate research that will inform WHO guidelines about distribution and uptake of HIV self-testing

ACTIVITIES:

- NGO partners provide self-testing kits and training to facility staff and community-based volunteers who are residents of the communities in which distribution takes place
- Volunteers distribute self-testing kits through door-to-door household visits and provide information and/or referral cards for confirmatory testing at private or public clinics or other HIV testing sites
- In facility-based models, facility staff distribute HIV self-testing kits either directly or to volunteers
- NGO partners conduct outreach visits to volunteers at one- and three-weeks post-provision of self-testing kits

IMPACT: STAR will distribute 5 million self-test kits by mid-2020. Evidence generated by the initiative has shown that self-testing is a sustainable, effective and cost-effective approach to increasing HIV testing uptake.⁴⁴ Other studies have shown that self-testing is highly accepted by young people.⁴⁵ As of 2018, 59 countries have policies that promote self-testing and 28 countries are actively pursuing such strategies.



Self-testing in action



**HIV SELF-TESTING
AFRICA
INITIATIVE**

Preliminary results from STAR indicate that self-tests are helping to close knowledge-of-status gaps for groups that have traditionally been hard to reach with other HIV testing services, particularly young people and men,

-STAR Initiative Director,
Karin Hatzold⁴²

**LINKS AND SOURCES:**

<https://unitaid.org/assets/STAR-Initiative-Report-Knowing-your-status%E2%80%93then-and-now.pdf>

<http://hivstar.lshtm.ac.uk/>

LOCATE CASE STUDY 3:

HIV & SRHR EDUCATION FOR GIRLS THROUGH FOOTBALL IN KILIFI

LOCATION(S): Kilifi District (Kenya)

ORGANISATION(S): Moving the Goalposts (MTG, CBO partner); Ganze Health Centre (government clinic partner)

CONTEXT: Although HIV prevalence in Kilifi County (4.4%) is slightly lower than the national average (5.6%), women and young people are disproportionately affected. In 2014, it was estimated that 70% of the population did not know their HIV status.

STATISTICS: MTG is a sport for development organisation that works with over 9000 girls and young women between the ages of 9-25 in coastal Kenya. In 2019, they joined together with Ganze Health Centre to join C³ and develop a collaborative project to increase testing and referrals in Kilifi County.

COLLABORATION: MTG and Ganze Health Centre are working collaboratively to increase testing through facility-based testing and self-testing. Their partnership aims to increase the numbers of adolescents and young people visiting the health clinic for testing and SRHR services.

OBJECTIVES:

- Increase uptake of facility-based testing and self-testing
- Increase knowledge and awareness of HIV and SRHR services
- Increase enrolment of adolescents and young people living with HIV in youth adherence clubs

ACTIVITIES:

- MTG identifies and refers adolescents and young people to the clinic for clinic-based HIV testing
- Ganze Health Centre clinical health officer and HIV Testing Services (HTS) counsellor conduct focus group discussions on self-testing, PEP and PrEP
- Ganze Health Centre staff issue self-testing kits and other HIV and SRHR services to adolescents and young people
- MTG and Ganze Health Centre hold bi-monthly meetings to trace and re-engage adolescents and young people living with HIV who have been lost to follow-up
- Sub-county STIs and HIV coordinator and Ganze Health Centre HTS counsellor sensitise facility staff on youth adherence clubs
- Together, meetings have been held with sub-county officials to develop a new case referral tool for adolescents and young people

IMPACT:

As of August 2019, the collaboration has reached nearly 700 adolescents and young people with focus groups, facility-based testing and self-testing kits. Ten health service providers have been introduced and sensitised on the Operation Triple Zero (OTZ) youth adherence clubs (see case study in the Treat & Retain section).



Sensitisation session for young mothers at health facility



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**LINKS AND SOURCES:**

<https://mtgk.org/about-us>.

<https://nacc.or.ke/mdocs-posts/kilifi-county-hiv-aids-strategic-plan/>

What does effective collaboration for linking adolescents and young people to treatment and care look like?

Adolescents and young people living with HIV can quickly initiate treatment and care after learning their status, while feeling confident to navigate the health system which comprises services within both the clinic and community. Whilst initiating treatment, adolescents and young people receive age-appropriate psycho-social support, in places that are safe, convenient and comfortable, to assist with the difficult steps of disclosure and adherence.

GAPS IN LINKING

Issues which hinder adolescents and young people from being linked to treatment and care services include:

- **Process barriers to linking to treatment:** Adolescents and young people may experience long wait times for confirmation, mandated peripheral tests and other steps in the treatment process
- **Poor linkages between clinics and communities:** The process of initiating treatment and care can be particularly cumbersome for adolescents and young people who may experience difficulty navigating a system that is poorly linked between clinic- and community-based services
- **Staff capacity and confidence:** Clinic staff may lack the knowledge and confidence to initiate same-day treatment. Staff may lack awareness of how to interact and support adolescents and young people following a HIV-positive result. Staff may have limited skills or experience in imparting treatment literacy information that can facilitate treatment initiation
- **Social and cultural issues:** Adolescents and young people who test positive can face fear and denial, with complex disclosure issues that make treatment initiation difficult
- **Adult-focused materials and language:** Materials focused on treatment and care are often written for adults and do not speak to the specific issues and concerns that adolescents and young people face

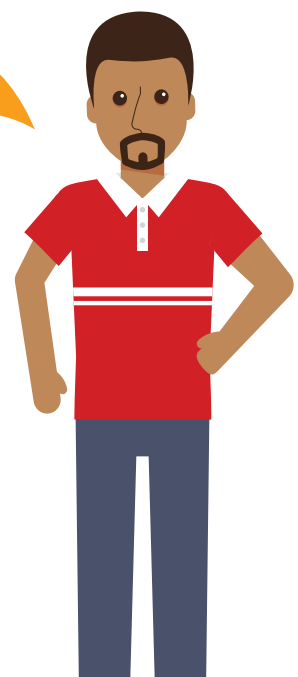
LINK: COLLABORATION OPPORTUNITIES & STRATEGIES

Collaborations between clinics and communities focused on *linking* adolescents and young people seek to:

OPPORTUNITY	STRATEGIES
Create a seamless transition from testing to treatment.	Create strong referral pathways between clinics and communities, ensuring two-way communication and follow-up. Facilitate same-day ART initiation for improved linkage to care.
Ensure that adolescents and young people understand the path from testing to treatment.	Integrate peers into clinic and community healthcare teams, who support adolescents and young people to navigate services between clinic and community and or within the clinic. Peers can also be positive role models by sharing their own experiences, including the benefits of initiating treatment.
Increase the capacity and confidence of facility staff to motivate clients on the benefits of ART initiation and to provide the necessary information and treatment literacy as required.	Educate and support all staff, including peer navigators and educators, particularly those who move between community and clinic. Training and empowerment of healthcare workers in best practices for patient follow-up including better recordkeeping processes, phone calls and home visits.
Address the special life-stage needs of adolescents and young people in treatment initiation.	Provide adolescents and young people-focused treatment literacy to support initiation and provide psycho-social support and care in clinic and community while ensuring two-way linkage remains consistent and supportive.
Ensure that adolescents and young people can understand and engage with informational materials.	Collaborate on materials development and staff training with community organisations and institutions that have experience with developing factual messaging for adolescents and young people audiences.

“In the past, I was worried that clients I sent to the clinic would not be received well. I know what this is like: to feel like you don’t belong there, or that everyone is looking at you. Now, with the partnership with the clinic I am happy to refer our clients. I know they will be treated well and will be supported by peers to join a youth club that is geared for recently diagnosed young people who have been initiated on ART.”

– Akiki, Peer mobiliser/navigator



LINK: APPROACHES

Approaches for clinic and community collaborations that promote *linking* adolescents and young people include:

Dedicated health spaces: Working together to create dedicated spaces where services are provided to adolescents and young people and integrated with other health services

Effective case management shared by clinics and communities: Co-developing systems that track adolescents and young people who have tested positive and are referred for treatment and care. These systems may include referral forms, health passports and universal ID numbers, but should be designed to accommodate confidentiality and privacy concerns. Better record-keeping processes, phone calls and home visits can ensure services are effectively coordinated and followed up on

Peer navigators as team members: Working together to engage and support adolescents and young people as recognised healthcare team members in both clinics and communities to assist new clients

Support groups for newly-diagnosed and newly-initiated adolescents and young people living with HIV: Co-facilitating support groups in communities and/or clinics to assist newly-initiated adolescents and young people. Disclosure paves the way to developing a network of support. Linking recently diagnosed clients with treatment literacy support, adherence counselling or other peers can provide access to additional psycho-social support, information and provide a sense of belonging

Training and materials designed for adolescents and young people: Co-developing age-appropriate training and materials for adolescents and young people. Informing adolescents and young people clearly about their HIV-positive status can contribute to understanding the importance of taking medication regularly and encourage increased responsibility in taking medication without supervision



LINK: APPLYING THE PRINCIPLES

Clinics and communities should utilise cross-cutting principles to ensure that collaborations are most effective for *linking* adolescents and young people:

ADOLESCENT AND YOUTH-FRIENDLY	DATA-DRIVEN	PEER-LED	DIFFERENTIATED
<ul style="list-style-type: none"> <input type="checkbox"/> Are service times appropriate for adolescents and young people schedules? <input type="checkbox"/> Can adolescents and young people easily and confidentially access our services? <input type="checkbox"/> Is there quick turnaround time for tests and clear communication about the process? <input type="checkbox"/> Is same-day ART initiation available? <input type="checkbox"/> Are signage and materials clear and engaging, using language that speaks to adolescents and young people? 	<ul style="list-style-type: none"> <input type="checkbox"/> What are the key metrics for linkage to care and early adherence for adolescents and young people in our local area? At a minimum, do we know the number of adolescents and young people initiated on treatment and whether they are in care and adherent? <input type="checkbox"/> Is this data disaggregated by age, gender and other factors that are important to our service? <input type="checkbox"/> What treatment initiation targets do we anticipate based on our intervention? <input type="checkbox"/> How will we know that referrals are working and that we are not losing clients? <input type="checkbox"/> How will we share information with each other? 	<ul style="list-style-type: none"> <input type="checkbox"/> Do we have peer navigators on our healthcare team? Are they included in decision-making? <input type="checkbox"/> Are peer navigators fully trained and supported, confident in their ability to answer questions and engage with adolescents and young people about treatment initiation? <input type="checkbox"/> Does our service or programme link peers to new initiates, either in-person or through mobile communication? <input type="checkbox"/> Are we engaging adolescents and young people meaningfully in the treatment process—including design, delivery, monitoring & evaluation? 	<ul style="list-style-type: none"> <input type="checkbox"/> Is our treatment initiation process differentiated for age group, stage-of-life, and other factors, such as pregnancy? <input type="checkbox"/> Does our disclosure and treatment initiation support offer different approaches for adolescents vertically and horizontally infected? <input type="checkbox"/> Are we ensuring that young key populations and marginalised groups are supported to initiate treatment and addresses any barriers they may face? <input type="checkbox"/> Do staff and peers approach all adolescents and young people in a non-judgemental and stigma-free manner?



TOOLS & LINKS

[TOOL 5: PEER NAVIGATOR LINKAGE REFERRAL PAMPHLET](#)

[TOOL 6: TIPS FOR COMMUNICATING WITH ADOLESCENTS AND YOUNG PEOPLE](#)

UNAIDS, Young people's participation in community-based responses to HIV, 2019.
<http://teampata.org/portfolio/young-peoples-participation-in-community-based-responses-to-hiv/>

LINK CASE STUDY 1:

HEALTH CONNECTORS

LOCATION(S): City of Johannesburg Metropolitan Municipality & Dr. Kenneth Kaunda District Municipality (South Africa)

ORGANISATIONS: University of the Witwatersrand Reproductive Health and HIV Institute (WITS RHI, academic implementing partner); Gauteng Department of Health, North West Province Department of Health (government partners); USAID PEPFAR (funding partner)

CONTEXT: In South Africa, adolescents and young people are frequently lost to care between HIV diagnosis and treatment initiation. Contact with peer navigators has been found to reduce barriers for people to link and be retained in care.⁴⁶ As a result, peer navigators (renamed Health Connectors) who help guide adolescent and youth patients through the health care system in a youth-friendly manner, while positively influencing their treatment initiation and retention, as well as HIV prevention practices have been embedded into the public health care system.

STATISTICS: Piloted in March 2017. Over an 18-month period, Health Connectors (HCs) connected with 1155 adolescents and young people in two South African health sub-districts.

COLLABORATION: WITS RHI implementing partners work together with clinics to embed HCs in public healthcare services. HCs are young people, often graduates of the loveLife [GroundBreaker programme](#) recruited from the community and paid a salary. They receive training on health promotion of chronic diseases and counselling skills to navigate adolescents and young people attending clinics in the public health system. HCs work across a few clinics, supported and supervised by clinic-based health service providers.



Health Connectors

**OBJECTIVES:**

- Increased uptake of SRHR services and HIV testing and repeat testing
- Enhanced knowledge of HIV status and linkage to appropriate services
- Improved initiation on ART treatment for adolescents and young people living with HIV
- Increased psychosocial wellbeing, disclosure and adherence to treatment
- Provide increased support to vulnerable adolescents and youth in an adolescent friendly manner

ACTIVITIES:

- Skilled clinical and psychosocial health care providers conduct a two-day health promotion on chronic diseases and counselling skills training programme for HCs
- Health clinic staff provide support and supervision for HCs
- WITS RHI and implementing partners provide mentorship to HCs and ongoing capacity support to clinics
- HCs assist adolescents and young people by offering referrals, information and psycho-social support until clients are initiated and stabilised on ART treatment
- HCs remain in contact with adolescents and youth via phone text message or in-person meetings; dependent on the patient's preference of communication style.

IMPACT:

Over an 18-month period, data show that 73% of enrolled clients initiate treatment and remain in the HC programme for 5 weeks on average. Adhering to treatment, treatment side effects and support from family and friends are the most common topic of discussion between HCs and clients.

**LINKS AND SOURCES:**

<http://aviwe.wrhi.ac.za/health-connector-programme-2/>.

http://www.wrhi.ac.za/uploads/files/Health_Connectors_-_Personalised_health_system_navigation_for_young_people_in_South_Africa_%28INTEREST_2018_-_23_May_2018%29.pdf

LINK CASE STUDY 2:

LINK UP

LOCATION(S): Throughout Uganda (also implemented in Burundi, Ethiopia, Bangladesh, & Myanmar)

ORGANISATIONS: International HIV/AIDS Alliance (consortium leader), Population Council (NGO partner), Marie Stopes International Uganda (NGO partner), Uganda Ministry of Health (government partner), Government of the Netherlands (funding partner)

CONTEXT: Accessing and adhering to lifelong treatment presents specific challenges for adolescents and young people, including persistent usage of services, disclosure and support for mental health and well-being. Uganda has a particularly high HIV prevalence and a difficult cultural and legal environment for adolescents and young people and vulnerable populations.

STATISTICS: From its inception in 2013 to 2016, Link Up Uganda reached over 300,000 young people with integrated SRHR and HIV services. The project mentored and supported 548 service providers and involved 3060 young people in providing integrated and appropriate services for young people.⁴⁷

COLLABORATION: Link Up facilitated the delivery of an expanded package of HIV and SRHR services for adolescents and young people by linking communities and facilities through training, capacity-building and advocacy to peers, health service providers and community decision-makers. Peer educators were trained to provide health education, counselling, support groups, income-generating activities, home-based visits and advocacy. They also created demand for integrated HIV and SRHR services through a youth-oriented voucher programme.

OBJECTIVES:

- Reduce unintended pregnancies, HIV transmission and HIV-related maternal mortality amongst young people most affected by HIV
- Link young people to facility HIV and SRHR services
- Provide a specific focus on vulnerable and marginalised populations

ACTIVITIES:

- LinkUp implementing partners trained peer educators to connect with new and existing peer support groups for young people living with HIV
- Peer educators provided health education, counselling and linkages through referral vouchers to facility-based HIV and SRHR services
- Twelve health facilities, operated by Marie Stopes International Uganda and the Uganda Ministry of Health, received referral vouchers and delivered HIV and SRHR services
- Health facilities and LinkUp partners developed youth-friendly corners in all facilities, where young clients could collect educational material and meet with peer educators

IMPACT: An evaluation of the Uganda programme found that the intervention model “appears to have been effective in improving knowledge and self-efficacy for healthy living, increasing condom use, and increasing the utilisation of SRHR and HIV services among young people living with HIV.”^{48,49} Support groups led by peers were found to be safe and supportive environments and peer educators were successful in linking adolescents and young people to youth-friendly services.



Engaging youth mothers in integrated health services.

Photo credit: International HIV/AIDS Alliance

**LINKS AND SOURCES:**

<https://www.popcouncil.org/research/link-up>

<http://www.aidsalliance.org/our-priorities/current-projects/28>

LINK CASE STUDY 3:

RED CARPET PROGRAM

LOCATION(S): Homa Bay and Turkana Counties (Kenya)

ORGANISATIONS: Elizabeth Glaser Pediatric AIDS Foundation (EGPAF, NGO partner); Kenya Ministry of Health (government partner); Positive Action (funding partner)

CONTEXT: In Kenya, 33% of new HIV infections occur among adolescents and young people. Poor linkage and retention to treatment and care have resulted in HIV being the leading cause of death among adolescents and young people. The Kenyan Ministry of Health has launched a National Adolescent Package of Care to strengthen adolescent-friendly care across the entire health system.

COLLABORATION: The programme brings together youth-friendly healthcare providers at 'Red Carpet Facilities,' health facilities with VIP Express Services, trained school staff and adolescent and youth peer advisory groups to provide adolescent-friendly HIV services.

STATISTICS: The programme was launched in 2016 and initially targeted 50 facilities and 25 boarding schools in Homa Bay County and expanded to 66 health facilities and 87 schools in 2018.⁵⁰

OBJECTIVES:

- Increase the number of adolescents and young people linked to care
- Increase the proportion of adolescents and young people living with HIV who attend their first, second and third HIV care and treatment appointments
- Increase the number of adolescents and young people living with HIV who are retained in treatment and virally suppressed
- Strengthen adolescents and young people's meaningful involvement in their own prevention, treatment and care routines

ACTIVITIES:

- Kenya Ministry of Health and EGPAF sensitise clinics and schools, and identify and train adolescent and young people advisory group leaders and school-based advocates
- Advisory group members design VIP services, including the VIP express card, while nominating champions to participate in an Adolescent Technical Working Group
- Project staff identify and train school-based advocates and peer educators to support adolescents and young people living with HIV
- Facilities develop fast-track services and integrate adolescent and youth-friendly components
- Facilities host peer counselling and psycho-social support services

IMPACT:

Project evaluation has shown that implementation of the Red Carpet Program was associated with significant improvement in linkage to and early retention in care among Adolescents and young people. The proportion of adolescent and youth clients who were linked to care increased from 56.5 to 97.3% from July to December 2016. By December 2018, The RCP has consistently shown steady retention of 81%, 78% and 81% at 6, 12 and 18 months for the newly identified adolescents and young people enrolled since the project inception after expansion to additional sites in Kenya.⁵¹



Peers working together.
Photo credit: EGPAF



**Elizabeth Glaser
Pediatric AIDS
Foundation**



MINISTRY OF HEALTH

**LINKS AND SOURCES:**

<https://www.pedaids.org/resource/the-red-carpet-program-improving-linkage-to-care-and-optimizing-early-retention-of-adolescents-with-newly-identified-hiv-infection-in-homa-bay-county-kenya/>

What does effective collaboration for treatment and retention for adolescents and young people look like?

Adolescents and young people adhere to treatment and achieve viral suppression and transition smoothly into adult care. Adolescents and young people access support from trusted peers and professionals—in clinics and communities—to make informed decisions about health-seeking behaviour, sexual activity, relationships and parenthood.

GAPS IN TREATMENT & RETENTION

Issues which hinder adolescents and young people from adhering to treatment and remaining in care:

- **Structural barriers to retention in care:** Adolescents and young people may struggle to maintain long-term retention in care due to ‘unfriendly’ facility practices, including requirements for frequent clinic visits, long wait times and hours which conflict with school or work schedules
- **Limited access to commodities and tools:** Clinics, communities and adolescents and young people may struggle to access ART, viral load testing and other equipment and supplies necessary for long-term treatment
- **Complexity of medication adherence:** Adolescents and young people—particularly those who have been on treatment since early childhood—may struggle with issues such as chronicity of medication, long-term side effects and more complicated regimens. Adolescents and young people may also experience treatment fatigue
- **Psycho-social and mental health and well-being:** Adolescents and young people may experience mental health issues, substance abuse, poverty and food insecurity, violence or safety concerns, disinterested caregivers or unstable home life, stigma from the community, family and adolescents and young people themselves—all of which have been shown to negatively impact adherence and retention. These barriers are especially compounded for young key populations
- **Stage-of-life and developmental issues:** Adolescents and young people may go through periods that make adherence difficult, such as a desire to fit in with peers, increased risk-taking, sexual experimentation, heightened anger or frustration, treatment fatigue and competing priorities such as education and employment. Young people transitioning to adult care may also experience adherence challenges

TREAT AND RETAIN: COLLABORATION OPPORTUNITIES & STRATEGIES

Collaborations between clinics and communities focused on *treating and retaining* adolescents and young people seek to:

OPPORTUNITY	STRATEGIES
Ensure that facilities are warm and welcoming to adolescents and young people living with HIV.	Create safe spaces, such as adolescent and youth rooms/corners staffed by peers, that receive clients in a friendly, non-judgemental and stigma-free environment.
Change the frequency, location and/or duration of visits depending on adherence levels and viral suppression.	Develop differentiated service delivery elements, including prescription length, fast track collection, streamlined clinic visits, and community-based treatment and care services.
Prescribe treatment that suits the lifestyle needs of adolescents and young people.	Ensure availability of medication, while coordinating between clinic and community about availability of medication.
Educate adolescents and young people about long-term treatment and anticipated milestones.	Create times and places for conversations, including youth clubs, treatment literacy and check-ins about adherence, side effects, treatment resistance and overall concerns.
Support adolescents and young people beyond clinic visits, at the times and in the places where help and support are required between visits.	Ensure support from peer educators and mentors, both in and outside the clinic, who can respond to adolescents and young people in their everyday needs, including mental health support, nutrition advice, SRHR, navigating relationships, sex and sexuality, substance use, livelihood skills and reaching life goals.
Promote human rights and gender equality for adolescents, including challenging harmful social norms that act as barriers to individual agency, decision-making and well-being.	Together, ensure that adolescents and young people are meaningfully engaged and actively involved in planning, delivering and monitoring the services they receive and have the power to influence service delivery in the clinic and community.
Advocate for differentiated care that responds to the diversity of adolescents and young people.	Acknowledge the agency and autonomy of adolescents and young people, including those from young key populations, to become advocates for their own unique and differentiated needs, promoting their own growth and self-care.
Integrate a package of services to be delivered at the same time, at the same place.	As much as possible, provide an integrated and comprehensive package of services where HIV treatment, SRHR, mental health and psycho-social support can be accessed together, in the same place, and at the same time. Ensure there is effective linkage between services when they are delivered in different spaces or at different times.



“My favourite days are Youth Club days at the clinic. Each month, we have three different clubs based on age and adherence levels for adolescents and young people living with HIV. I work with the clinic staff to prepare a short exercise in advance, plus we leave a lot of time to answer questions and just be with each other. Sometimes issues come up that are difficult and scary; in these moments, I know I can rely on my clinic colleagues to help with answers and support.”

– Bulelwa, Peer Supporter

TREAT AND RETAIN: APPROACHES

Approaches for clinic and community collaborations that promote *treating and retaining* adolescents and young people include:

Youth adherence clubs: Co-promoting youth clubs that create cohorts of adolescents and young people with similar profiles (based on age bands, adherence levels and/or parenting profiles) to encourage adherence and retention in care. Adherence clubs allow clinics and communities to utilise positive peer modelling and higher service levels to encourage adherence and retention

'Skip the queue' or reduced-services visits: Co-developing services for those who are virally suppressed and adherent including 'skip the queue' and 'script renewal-only' services, as well as longer prescriptions and community-based treatment and care

One-stop shop: Co-designing integrated services where HIV treatment and SRHR information and or services can be accessed together in one appointment and location. Incorporating bi-directional referrals and pathways between the clinic and community provide more secure mental health and social protection services, as well as access to specialist services where required

Tracking and tracing: Working together to identify and follow up on missed appointments through active tracking and tracing can assist in tracking adolescents and young people who have not been retained in care

Peer supporters/mentors as team members: Working together to engage and support peer mentors as 'buddies' to provide adherence counselling. Peer supporter/mentors provide much-needed contact and psycho-social support between clinic visits and assist in facilitating support groups and adolescent friendly corners

Safe spaces: Working together to establish, strengthen or support existing safe spaces where adolescents can engage, discuss issues related to treatment literacy and adherence as well as learn about sexuality, HIV and SRHR without fear or judgement. Safe spaces must be interactive and can also be fun and creative. They are also particularly important for young people who are marginalised

Mobile follow-up and reminders: Co-developing mobile apps that 'push' reminders and treatment information to adolescents and young people, and 'pull' information, such as questions and adherence data, to clinics and communities

School models: Co-creating models for in-school treatment, holiday care and camps. Treatment and care models can also be developed for adolescents and young people in boarding schools

"At first, the other nurses were really worried that the youth club would take up a lot of time and energy. Everyone is already so busy and work can be stressful as it is. However, the youth club has actually helped us in so many ways. We can integrate much of our work with adolescents and young people into a few days each month, with better service delivery for our clients. It's been a really positive addition to our clinic."

– Sister Zawadi, Sister-In-Charge



TREAT AND RETAIN: APPLYING THE PRINCIPLES

Clinics and communities should utilise cross-cutting principles to ensure that collaborations are most effective for *treating and retaining* adolescents and young people:

Adolescent and youth-friendly	Data-driven	Peer-led	Differentiated
<ul style="list-style-type: none"> <input type="checkbox"/> Are HIV services integrated with other clinical services, to minimise time in facilities? <input type="checkbox"/> Are adolescents and young people able to 'skip the queue' and/or access dedicated services in a special location or through distinct staff members? <input type="checkbox"/> Is there a club for adolescents and young people to encourage adherence? Are services designed to encourage attendance and adherence? <input type="checkbox"/> Are adolescents and young people who are lost to care tracked, traced and encouraged to return to care? <input type="checkbox"/> Are health providers well trained, confident and supported to provide information that is correct and service that is friendly and stigma-free? 	<ul style="list-style-type: none"> <input type="checkbox"/> What are the key metrics for adherence and retention for adolescents and young people in our local area? At a minimum, do we know the number of adolescents and young people on treatment, and their adherence and viral suppression status? <input type="checkbox"/> Is this data disaggregated by age, gender and other factors that are important to our service? <input type="checkbox"/> What treatment adherence or viral suppression targets do we anticipate based on our intervention? <input type="checkbox"/> Can we use this data to continuously improve our service or programme? <input type="checkbox"/> Is data shared between the clinic and community, and is it discussed together for joint service delivery monitoring and quality improvement? 	<ul style="list-style-type: none"> <input type="checkbox"/> Do we have peer mentors or educators on our team? Are they included in decision-making? <input type="checkbox"/> Are peers fully trained and supported, confident in their ability to promote and answer questions related to treatment and adherence? <input type="checkbox"/> Do peers know how to identify and refer adolescents and young people who are experiencing adherence challenges? <input type="checkbox"/> Are we engaging adolescents and young people meaningfully in the adherence process—including design, delivery, monitoring & evaluation? <input type="checkbox"/> Are we engaging adolescents and young people as equal partners with autonomy and agency in their treatment and care? 	<ul style="list-style-type: none"> <input type="checkbox"/> Is our treatment and care differentiated for those who are adherent and/or virally suppressed as well as for those who are not? <input type="checkbox"/> May adherent clients attend clinic less frequently and/or receive longer prescriptions than clients who are struggling with adherence? <input type="checkbox"/> Are we ensuring that key populations and marginalised groups are supported in ways that meet their unique needs? <input type="checkbox"/> Are there safe spaces and groups, differentiated by age, gender, stage of disclosure and interest area?



TOOLS & LINKS

[TOOL 7: ADOLESCENT SUPPORT GROUP FACILITATOR'S GUIDE](#)

[TOOL 8: YOUTH CLUB/SUPPORT GROUP POSTER & CALENDAR CARDS](#)

WITS RHI. Working with adolescents living with HIV: a toolkit for healthcare providers, 2015. <http://teampata.org/portfolio/working-with-adolescents-living-with-hiv-a-toolkit-for-healthcare-providers/>

READY+. Ready to care: improving health services for young people living with HIV, 2018. <http://teampata.org/portfolio/service-providers-GUIDANCE-FOR-WORKING-WITH-YOUNG-PEOPLE-LIVING-WITH-HIV/>

TREAT & RETAIN CASE STUDY 1:

YOUTH CARE CLUBS

LOCATION(S): The model was piloted across facilities in two health sub-districts: sub-District F of the City of Johannesburg Health District and the Matlosana sub-District of Dr Kenneth Kaunda District, North West Province (South Africa). It is currently being rolled out across South Africa in USAID-supported districts.

ORGANISATION(S): WITS RHI (academic pilot implementing partner); Gauteng Province Department of Health and North West Province Department of Health (government partners); USAID PEPFAR (funding partner) and the National Department of Health

CONTEXT: South Africa has the largest HIV prevalence globally, with nearly 8 million people living with HIV.⁵² Adolescents and youth people living with HIV have diverse profiles and require differentiated services to cater to age bands, initiation stage, adherence levels and viral suppression attainment and lifestyle needs. It has been shown that peer support amongst adolescents living with HIV can have a positive effect on emotional well-being and treatment adherence.^{53,54}

STATISTICS: The model was piloted between September 2016 and December 2018 and has served 795 adolescents and young people in two sub-Districts of South Africa.

COLLABORATION: WITS RHI, provincial departments of health and the National Department of Health are partnering together to roll-out Youth Care Clubs (YCCs) across the country. YCCs are closed groups of 15-20 adolescents living with HIV (including newly initiated patients, those with viral load suppressed and with viral load not suppressed) who meet monthly and receive integrated psycho-social (PSS) and clinical care from clinicians and lay counsellors.



Youth Care Clubs Appointment Cards

**OBJECTIVES:**

- To provide adolescents living with HIV with an adolescent youth friendly service that improves their adherence and retention in care while receiving peer learning and support
- To provide integrated clinical and psychosocial care for adolescents living with HIV that is efficient, comprehensive and convenient
- To optimise clinic time for adolescents living with HIV and health care providers
- To foster supportive relationships and lessen isolation among adolescents living with HIV

IMPACT:

An analysis of 795 adolescents living with HIV, 67% female and 33% male, with a median age of 18 years old, had 86% viral load suppression at 12 months. 77% of adolescents living with HIV were retained in the clubs over the pilot period.

ACTIVITIES:

- Facility staff receive YCC training from WITS RHI or download training videos from: <http://www.aipbestpractices.com>
- WITS RHI provides mentoring support and supervision on how to implement YCCs in facilities
- Facilities conduct the AYFS File Audit to understand the adolescents living with HIV population in the facility, recruitment of eligible adolescents living with HIV into age appropriate groups, preparing for all types of YCC visits, setting-up the YCC group
- YCCs are closed groups of 15-20 adolescents separated by age, mode of transmission and school attendance. They are mixed adherence, including newly initiated, virally suppressed and non-virally suppressed
- YCCs are co-led by lay counsellors. During group sessions, participants receive screening (for HIV symptoms, TB, STIs, contraception, nutrition and psychosocial well-being), participate in group discussion and adolescents living with HIV with suppressed viral loads receive pre-packed prescription refills while others visit the nurse
- YCCs meet on a monthly and bi-monthly basis, and can have annual outings

**LINKS AND SOURCES:**

<http://aviwe.wrhi.ac.za/category/clearinghouse/adolescent-innovations-project/adolescent-innovation-project-resources/>
https://samumsf.org/sites/default/files/2017-07/10_Youth%20Report_Khayelitsha_2016.PDF

TREAT & RETAIN CASE STUDY 2:

OPERATION TRIPLE ZERO (OTZ)

LOCATION(S): Kenya

ORGANISATION(S): Kenya National AIDS and STIs Control Programme (government partner)

CONTEXT: In Kenya, adolescents and young people account for approximately 20% of all people living with HIV.⁵⁵ Like many other countries, there are significant challenges related to treatment outcomes, including a high loss-to-follow up, low adherence to treatment and low rates of viral suppression.

STATISTICS: Operation Triple Zero (OTZ) started in 2016 with 70 members and has grown to over 400 facilities with over 40,000 members as of March 2018.⁵⁶

COLLABORATION: OTZ clubs are facility-based, facilitated jointly between implementing partners and clinic staff. County governments and civil society partners provide training. OTZ employs an asset-based programming approach that engages adolescent and young people as integral agents in the management of their own health. OTZ members are encouraged to achieve the three zeroes: zero missed appointments, zero missed treatment days and zero viral load. OTZ package consists of HCW, caregiver and adolescent components.

**OBJECTIVES:**

- To improve treatment outcomes among adolescents and young 10-24 years people living with HIV
- To compare viral suppression rates among adolescents and young people living with HIV enrolled in the asset based OTZ programme
- To Improve self-reported adherence among adolescents and young people living with HIV enrolled in OTZ
- To improve appointment keeping among adolescents and young people living with HIV enrolled in OTZ

ACTIVITIES:

- Implementing partners provide training to health service providers on the adolescent package of care, who then facilitate training of adolescents, young people and caregivers on OTZ
- Implementing partners provide support for skills-building, and comprehensive treatment literacy training for caregivers
- Adolescents and young people voluntarily join OTZ clubs where they receive a comprehensive HIV treatment literacy package and are encouraged to become 'self-health managers'
- OTZ adolescent and young people "champions" participate in enrolment new members, psychosocial support to newly diagnosed adolescents and young people, provide support to club members with high viral loads, co-ordinate OTZ clubs, and oversee various OTZ activities, including social media

IMPACT: Self-reported adherence has increased from 88% in October 2017 to 96% in February 2018. Preliminary data shows a significant increase in viral suppression, from 71% to 82% after 6 months of OTZ participation.⁵⁷

**LINKS AND SOURCES:**

<https://www.pepfarsolutions.org/solutions/2018/10/30/operation-triple-zero-empowering-adolescents-and-young-people-living-with-hiv-to-take-control-of-their-own-health>

https://path.azureedge.net/media/documents/Improving_Treatment_Outcomes_For_Young_Kenyans_Living_With_HIV.pdf

TREAT & RETAIN CASE STUDY 3:

C³ ADOLESCENT HIV RESPONSE PROJECT

LOCATION(S): Chilanga District (Zambia)

ORGANISATION(S): Chilanga Youth Awake (CYA, CBO partner) and Kazimva Clinic (government health clinic partner)

CONTEXT: HIV/AIDS is the top health threat in Zambia and is the leading cause of morbidity and mortality among adults.⁵⁸ HIV prevalence among 20- to 24-year-olds is four times higher among females (8.3%) than among males (2%). Viral suppression rates are much lower for adolescents and young people.

STATISTICS: Since the start of the project in October 2018, the collaboration has trained 15 peer educators and reached more than 100 adolescents and youth through their monthly adherence meetings.

COLLABORATION: CYA is a youth focused NGO/CBO working with young people to realise a healthy nation by engaging them in community life with access to the resources needed to develop their potential. CYA and Kazimva Clinic are collaborating to increase treatment adherence and retention in care for adolescents and youth living with HIV in Chilanga District, Zambia.



Kazimva Youth Supporters

OBJECTIVES:

- Improve the adolescent and youth-friendliness of the clinic facility
- Increase treatment adherence and retention for adolescents and youth living with HIV
- Share knowledge and improve the capacity of staff to meet national guidelines for HIV service delivery

ACTIVITIES:

- Kazimva Clinic dedicates space for adolescent and youth adherence meetings
- Kazimva Clinic provides training, advice or technical input to CYA staff
- CYA provides adolescent and youth-friendly services at the facility
- CYA and Kazimva Clinic together train peer educators on HIV and SRHR services
- Peer educators, supported by CYA and with oversight from clinic staff, host clinic-based adolescent- and youth-targeted meetings monthly to disseminate SRHR messages on adherence and positive living

IMPACT:

Successive facility and district quarterly reports show a significant improvement in ART retention and viral load suppression among the general population and adolescents and young people. There is reduced stigma among adolescents and young people that access ART from the clinic. The partnership has also provided a platform for strengthened collaboration and networking between CYA, Kazimva Clinic and policy-makers, leading to integration of the activities as a component in the National Adolescent Health Strategy Operational Plan.

**LINKS AND SOURCES:**

<https://www.facebook.com/chilanga.youth.awake/>

PART III: HOW TO COLLABORATE

INTRODUCTION

Part III is focused on the **how** of collaboration: *how* to get started, *how* to keep going and *how* to grow a partnership to be successful.

In the pages that follow, we will introduce six steps of collaboration. While not all partnerships follow each of these steps exactly, our experience through the C³ programme has shown that these steps are each useful in building successful collaborations and effective partnerships.

Each step has a set of activities associated with it. These activities are outlined briefly in this toolkit. For more detailed descriptions, diagrams and tools, you may visit our previous [toolkit](#) online. You may also want to sign up for our online e-learning course, [Be Connected](#), which covers these topics and more.



THE STEPS

STEP 1

ASSESSING & IDENTIFYING

The first step of collaboration is to **assess your context** and **identify a partner (or partners)** to take your project forward.

The objective of this step is to better understand what approaches, strategies and actions will allow you to achieve your goals.

It will also help you determine what types of partners might be useful for the project.

WHY?

By assessing and understanding your unique community context, you will be in a good position to identify a potential partner.

The process of assessment requires you to dive deeply into your context and ask important questions. Your answers to these kinds of questions will determine where existing services and community resources for adolescents and young people are falling short, and must be enhanced and strengthened.

Once you have a greater understanding of the issues and gaps, you will be better placed to assess what partnerships can be leveraged to successfully address them.



KEY MESSAGE

Before you begin the process of collaborating to solve a problem, you need a clear understanding of the problem itself.

SUMMARY OF ACTIVITIES

This step includes **five activities**:

1 Appoint a key driver

Key question: Who will be the primary point person of our partnership?

The first activity is to identify and nominate a 'key driver', the person who will act as the initiator of the partnership process, providing direction and ensuring that the project moves forward.

This person serves formally or informally as the project leader, acting as a central point for all activities and communications. This person is also responsible for the team who is working on the project, ensuring that they have the motivation, skills and capacity to perform their roles.

2 Gather relevant information

Key question: Where and how can I get the information I need to find out more about the context?

The next activity is to gather information to help you identify your future partner. It is helpful to identify the local policies, laws, services and stakeholders that are currently in place in your community.

By gathering these sources of information, you can begin to piece together the 'big picture' of how treatment and care for adolescents and young people is being accessed and used in your community. This information will help you better identify key gaps.

3 Analyse the stakeholders in your community

Key questions: Who are the key stakeholders in my community? What are their interests? Who holds what power in terms of resources and decision-making?

Once you have gathered the relevant information, you are now ready to analyse the stakeholders and service providers who are operating in your community. Stakeholders are individuals and organisations that will be impacted by your work. The purpose of a stakeholder analysis is to understand the relationships between different stakeholders and service providers that currently exist.

Gather a group together—including adolescents and young people (including networks of young people living with HIV) who are already in your clinic or community—to brainstorm and list the service providers who are already working in your community. Make a list of the stakeholders, including their contact details, services and any notes about how and with whom they work. (You can use [Tool 1](#) in the appendix). Your aim is to identify who is working together, add after first comma, what services they provide, how they are working together, and where there are gaps and opportunities.



MEANINGFUL ENGAGEMENT

Adolescents and young people, particularly those who show leadership and influence among their peers, should be recruited and included to help gather information and assist with the analysis at this stage. They will likely have access to information that adults will find difficult to gather.



LESSON FROM C³

Identify a **single** key driver for the project. This helps ensure that there is a single person who is accountable for the project's progress and momentum.



LESSON FROM C³

After you have gathered and analysed the relevant information, it is a good idea to produce a presentation or report that you can later share with your partner and community.



4

Make sense of the information

Key questions: What does the information I have gathered tell me about the situation? What are the key problems your community is facing?

Once you have gathered information and analysed the stakeholders in your community, it is time to assess the context with this information. Through this process, you are trying to fully understand the problems that are facing your community. These are the problems that you will hope to improve with your collaboration.

A problem tree analysis ([Tool 9](#)) will help you to identify the underlying or root causes of your problem and identify data you need to better understand this problem. This will then help you to prioritise which aspect/s of prevention, treatment and care for adolescents and young people on which to focus your project and partnership.

5

Identify the best possible clinic-community collaborative partner

Key question: Who will we work with towards a shared goal?

After completing your information gathering and analysis, you are now in a good position to identify the most appropriate partnership to help you to address the underlying root causes you have identified. You may want to identify a single potential partner or several potential partners.

Review the stakeholder analysis from the activity above. You will want to select a partner or group of partners that:

- Shares your problem in some way
- Is already active in providing services or undertaking activities relevant to the problem
- Has complementary strengths and weaknesses



MEANINGFUL ENGAGEMENT

Include adolescents and young people in this exercise – they will have relevant and useful information, and will be able to give their own experiences with these stakeholders.



TOOL

A problem tree analysis supports us to move beyond the symptoms of a problem to a deeper understanding of the underlying issues on which to focus our actions.



KEY MESSAGE

Your prospective partner should have similar interests to your own organisation. They should also provide complementary services and activities that would be useful to the patients and clients that you serve, or hope to serve.

STEP 2

INITIATING & FORMALISING

The second step of collaboration is to **initiate and formalise your partnership**, which will give you a solid foundation on which to build future projects and ongoing collaboration.



The objective of this step is to lead a **Partnership Initiation Workshop**—a workshop which includes identifying shared objectives, agreeing on a key priority area, establishing the type of partnership, and developing relationships, roles and responsibilities.

After defining the partnership, you will want to formalise the collaboration with a written agreement.

WHY?



A partnership is generally understood to be two or more organisations working collaboratively together to achieve shared aims.

Partnerships are 'greater than the sum of their parts', meaning that you can do more together than you would be able to achieve alone.

However, partnerships need definition, formalisation and mechanisms to support collaboration in order to work effectively.

Launching your collaboration with a Partnership Initiation Workshop and formalising your collaboration with a written document will provide a good framework for your initiative, ensuring that all partners are clear in their roles and activities moving forward. A formalised agreement is important for your collaboration to be recognised and supported by the Ministry of Health or local authority.

MEANINGFUL
ENGAGEMENT

Include adolescents and young people—such as current or potential peer mobilisers, navigators, mentors, supporters and networks of young people living with HIV—in the process of initiating and formalising. By including adolescents and young people at the beginning of the partnership, you will signal the importance of their voice and participation in the entire process.

SUMMARY OF ACTIVITIES

This step includes **six activities** designed to answer the questions below:

1 Conduct a Partnership Initiation Workshop

A good way to begin your partnership is with a Partnership Initiation Workshop, a 1-2-day working session where all of the key partner members come together to discuss and agree on various aspects of the partnership. The Partnership Initiation Workshop can incorporate all of the activities in this step.

 The initial [Partnership Initiation Workshop] was very helpful in defining our different but complementary roles. And at the start of the project, we also had a joint meeting for our staff and volunteers. This also helped to match our expectations. It is something we recommend for other partnerships.”

- Karambi Health Centre II & Youth Empowering Initiative Partnership, Uganda (C³)

2 Establish shared interests and expectations

Key questions: What are the interests and expectations that I share with my future partner? How will we work together to achieve these shared interests?

When forging a partnership with a key stakeholder, you will want to consider their point of view. Once you understand your future partner's point of view, you can develop a vision of what you can achieve together.

Spend some time in the Partner Initiation Workshop discussing your short-term objectives and long-term expectations. Highlight which areas are similar and which are different. Going forward, you can ensure that you build the project around these **shared** objectives and expectations.

TOOL

Use the sample agenda in the Appendix to develop your meeting agenda.

KEY MESSAGE

Clinics and community organisations often have motivations that are distinct from one another. This can sometimes result in different objectives. That can be surprising, since both organisations are working to improve the health of adolescents and young people. However, these differing driving forces highlight why partnership is so important: both the clinic and the CBO bring different strengths and priorities to the relationship.

3 Identify your first key priority area

Key question: What will be the first challenge that we will work on together with our partner?



Next, you can identify the first key priority area that your partnership will work on together. The key priority area is the most pressing challenge that you and your partner share that is both urgent and addressable.

One way to identify a key priority area is to brainstorm a list of challenges that you could potentially work on together. Then, spend some time prioritising the list by categorising it into four areas: (1) Important but not urgent; (2) Important but not urgent; (3) Not important but urgent; (4) Not important and not urgent.

The 'priority' is the challenge that is in the #1 area: a challenge that is urgent and important.

4 Agree on the type of partnership

Key questions: What type of a partnership should we create? How will this evolve over time?

Based on the shared interests and key priority area that you have identified, you can now consider the type of partnership that you wish to establish.

There are many types of partnerships that you may want to explore with your partner. This chart provides examples of different types of partnerships that emerged from the C³ programme. They range from very simple partnerships to more complex relationships.

	Type of Partnership	Possible activities
Simple	Information exchange	<ul style="list-style-type: none"> • Clinic and CBO share information with one another • Strengthened referrals and referral monitoring between clinic and CBO
	Resource sharing	<ul style="list-style-type: none"> • Clinic and CBO share physical resources, including space • Clinic and CBO share human resources
	Training & capacity-building	<ul style="list-style-type: none"> • Clinic provides training, advice or technical input to CBO • CBO provides training, advice or technical input to clinic
	Joint activities partner	<ul style="list-style-type: none"> • Clinic and CBO undertake joint activities such as case finding, HIV testing, defaulter tracking, psycho-social support, follow-up, joint awareness raising
Complex	Joint accountability on quality improvement	<ul style="list-style-type: none"> • Develop a quality improvement plan attached to your collaboration and have clinic-community based monitoring systems or scorecards that can regularly feedback into your quality improvement process

C³ LESSON FROM C³

A word of caution: often, it is very difficult to identify just ONE key priority area to address with your partner. However, we strongly advise that you focus your project on just one key priority area. We have found through C³ that projects are far more successful if one challenge is focused on at a time.

KEY MESSAGE


Collaboration and partnership is like any other skill—it takes practice. It is always easier to start with a simple partnership first, and then move on to more complex partnerships when you have achieved success.

5 Define shared purpose, relationships, roles and responsibilities

Key questions: What will our relationship look like? What should be my role in the partnership? What should be my partner's role? What will our responsibilities be?

The key to the success of your partnership is ensuring that the people who are involved in the partnership are able to work together as effectively as possible. For people to work well together, there are generally four things to consider: shared purpose, relationships, roles and responsibilities.

- **Shared Purpose:** The foundation of partnership rests on sharing a complementary vision and having similar values. Partnerships need to be purposeful to remain effective, motivated and relevant.
- **Relationships:** An effective relationship starts with understanding; you must fully understand how the people in your partner organisation work so that you can collaborate effectively. Relationships in a partnership respect the autonomy and independence of each partner whilst offering transparency and mutual accountability within the partnership.
- **Roles:** A role is the function that each person plays in the partnership. The people who will be involved in the partnership need to be aware of their roles so that they can be prepared and ready to work together for the benefit of the partnership.
- **Responsibilities:** Responsibilities are different from roles; they are the specific tasks that each of the people in the partnership will perform to make the partnership work.

 Wherever we have warm, trusting and open relationships, all kinds of surprising possibilities begin to open up to us, enabling and unlocking many positive things in ourselves and in others. We find that we can speak more honestly and freely, we can be more of ourselves, more creative, more productive, even more generous. We are less afraid of making mistakes and more able to collectively learn from them.”

- <https://issuu.com/dougreeler/docs/barefootguide1/56>

6 Develop and sign a written agreement

Key questions: What are the key terms that we should include in our Memorandum of Understanding (MOU), that will form the basis for our partnership?

An **MOU** is a non-binding agreement between two or more parties, signed to show a mutual agreement to work together. The MOU does not have to be a long or complicated document; the most important thing is that intentions are set out clearly, with defined timeframes and responsibilities.

It is important to formalise your partnership with an agreement such as an MOU. Formalisation provides a structural arrangement and sets out mechanisms that will support the partnership. Agreements are put in writing, so that all partners are clear on the terms of reference, including timelines, responsibilities and lines of accountability. An agreement may be needed for your collaboration or joint activity to be recognised and supported by the Ministry of Health or local authority.



Use the sample MOU in the Appendix ([Tool 10](#)) to develop your written agreement.

STEP 3

PLANNING & RESOURCING

The third step of collaboration is to **plan and resource** your first project together, giving you a solid foundation on which to build your future projects.

The objective of this step is to plan your first joint project and identify resources to sustain the project.

Through this process, you will identify the aim for this project, define what success looks like for the project, and articulate the activities and deliverables to make the aim a reality.

You will also develop a workplan and budget to secure the resources that you will need to get your project off the ground.

WHY?

Planning can be a very satisfying process. With your partner, you will start to see your shared objectives take shape into a set of actionable activities that you will be able to work on together.



An important distinction to make at the outset is the difference between a **partnership** and a **project**. As we discussed in Step 2, a partnership is two or more organisations working together to achieve shared objectives. Projects, on the other hand, are a time-bound set of activities that help to achieve these objectives. Importantly, projects have a start and a finish.

It is through projects that you will begin to see the value of your partnership. Throughout Step 3, we will be referring to projects: specifically the first project that you will be working on through your partnership. We hope that this first project will be the first of many that you will embark on together.


KEY MESSAGE

Planning and resourcing is the process of creating a 'road map' for your project. Through the planning and resourcing process, you are working together to visualise how the project will progress from start to finish.

**MEANINGFUL ENGAGEMENT**

Include adolescents and young people in each of the planning meetings that you have with your partner. This will keep the project focused on the most important issue of all: ensuring that adolescents and young people are involved and empowered through the services that you create together.

SUMMARY OF ACTIVITIES

This step includes **five activities** designed to answer the questions below:

1

Determine the project aim

Key question: What will be the aim of the first project that you will work on together as a partnership?

Based on the key priority area of your partnership and the problem you wish to address together, you can now set the **project aim**. The project aim is the expected long-term impact of a project on your key priority area. By setting your project aim, you are defining what your project will set out to achieve.

How do you select an aim that is achievable for your project? One of the ways to ensure that your aim is achievable is to make sure that it is SMART. SMART stands for:

- **Specific:** Be very specific about what you want to achieve with your project
- **Measurable:** Make sure that you can measure the progress of your project
- **Attainable:** Ensure that the aim is achievable
- **Relevant:** Consider whether your project aim is relevant to adolescents and young people
- **Time-bound:** Finally, make sure that your aim has a start and an end point

C³

LESSON
FROM C³

Similar to the key priority area, we strongly suggest that your project set just **ONE** aim for the project. By selecting a single aim, you will have a strong focus, and avoid being pulled in multiple directions.

Using data to identify key priority areas

Reviewing data along the HIV cascade

Unique identifier codes enable service providers to:

- understand the client pathway reached with a service as well as the services each individual is receiving
- ascertain the number of people lost to care in between stages and find out reasons why
- avoid double counting of clients who are attending several services to access comprehensive care

Assessing key areas for improvement

- coverage of services and interventions
- choice of services
- adolescent's understanding of health and access to information
- community support for delivery of services to adolescents
- delivery of appropriate package of services through integration and linkages
- accessibility of services, including distance and location of facilities, opening and waiting times
- acceptability of services and interventions
- affordability of services for adolescents
- barriers for adolescents
- gender norms, roles and responsibilities, and how these act as barriers or enablers for access to information and services
- provider attitudes and skills
- health facility characteristics
- equity and non-discrimination of services
- data collection and systems
- participation of adolescents at all levels of programming



2 Define activities and outputs

Key question: What will be the key activities and outputs that we will work on together in this project?

To define the activities for your project, it is easiest to work backward from your project aim, and think about the key **milestones**—measurable and observable progress markers—that you will need to reach in order to achieve that aim. Remember that you should be reasonably sure that the activities you are going to undertake will lead to the desired aim.

After you define the activities, you can then define the outputs for your project activities. An **output** is any tangible thing that is delivered as a result of the activities in a project. Outputs are the concrete results of the project, and are one of the most important elements to understanding if your project is on track.

Working collaboratively, each of the partners' activities should be mutually reinforcing. In other words, while different partners may be responsible for different activities, these activities are inter-linked so that they collectively reach and serve more adolescents and young people, resulting in good treatment outcomes, empowerment and well-being.

3 Identify what success looks like

Key question: How will we know if our project is successful? How will we measure the success of our work together?

An important part of planning is deciding what success looks like for your project. First you need to develop your baseline, the metric which shows the current situation. Then, you'll need to develop your **success indicators**, the metrics that will show your progress.

Finding your baseline

In order to know what is changing, you first need to know the way things are right now. This requires that you collect some data prior to your project's start, so that you know the baseline information to make your comparison.

For example, let's say that you are interested in measuring the percentage increase in retention for adolescents and young people who have initiated treatment. To determine your baseline, you will need to identify:

- **Timeframe:** What timeframe are you going to use to start your baseline? This may be a week, a month or multiple months, depending on your community situation
- **Adolescents and young people initiated:** How many adolescents and young people initiated treatment during your timeframe?
- **Adolescents and young people retained:** How many adolescents and young people who were initiated on ART have kept all their clinic appointments during your timeframe?

$$\frac{\text{\# AYP Retained (during timeframe)}}{\text{\# AYP Initiated (during timeframe)}} \times 100 = \text{\% AYP Retained}$$

Once your project has determined the baseline, consider what will be different for your patients and community once your project is running successfully.

Success indicators are things to keep track of in order to know if your project is achieving its aim. You can choose from the following types of success indicators:

- **Input indicators:** things that are put into a project, such as money or people's time
- **Activity indicators:** activities that are happening as part of a project, such as training, coordination or awareness-raising through events
- **Output indicators:** the results of project activities, such as the number of health service providers successfully trained
- **Outcome indicators:** changes resulting from the project such as an increase in adolescents and young people testing or an increase in adolescents and young people retained in care
- Within established timeframes, as per your country guidelines, these are the key metrics that you may want to understand:
 - » Number of adolescents tested for HIV
 - » Number of adolescents testing HIV-positive
 - » Number of adolescents initiated on ART
 - » Number of adolescents receiving ART
 - » Number of adolescents LTFU
 - » Number of adolescents LTFU returned to care
 - » Number of adolescents virally suppressed

4

Develop a workplan

Key questions: What will the milestones and timeline for the project be? Who from each organisation will be responsible for these activities?

Once you have defined the activities and deliverables for your project, you will be able to create a detailed workplan. This workplan will become a key planning document for implementing your project.

A workplan is a detailed schedule of events for your project. It breaks down the activities that you developed in the previous section into concrete actions that will occur at each stage of the project.

C³ LESSON FROM C³

You should only choose a limited number of indicators for your project. It is helpful to limit the things that you will measure so that you can focus your efforts in a few areas only. You should choose indicators that are meaningful to your project, and that you are practically able to measure. We have made suggestions of a few important indicators that should be monitored across the HIV cascade.

KEY MESSAGE

Creating a workplan can be quite detailed, so you may want to assign the task to one or two people to create a draft prior to a meeting within the larger group. Once you have a draft, you can meet to review the workplan together. In effective partnerships there are several mutually reinforcing activities that are undertaken by different partners in support of one workplan.

TOOL

Use the budget template in the Appendix ([Tool 11](#)) to develop your budget.

5

Leverage resources

Key questions: How will we leverage the resources that already exist in our partnership and community? Do we need to secure outside resources that we need to launch and sustain our project?

As you are creating your workplan, you will likely begin to have a good idea of what resources you will require to accomplish the activities and tasks. In many cases, you will be able to identify resources and services that already exist within your clinic and community.

In the case that you need outside resources, you can develop a budget using the tool below to identify alternative sources of funding and assistance.



Use the budget template in the Appendix ([Tool 12](#)) to develop your budget.

“ We have identified some smart ways of funding our activities. We extended our collaboration to secondary and tertiary health facilities and that has resulted in some key services for our clients at no cost to us. We have also identified a related programme area of the CBO and have used this programme to serve children and adolescents accessing services from the clinic. By extending our collaboration to other clinics, we have been able to merge the resources available. Finally, we are engaging philanthropists in the community and they are taking care of some components of our activities cost.”

– Lovet Onyendilefu, Referral PHC Ozubulu & Victorian Clarion Foundation, Nigeria

Securing outside funding

If your partnership has been operating well and you are considering outside sources of funding, you may want to prepare yourself to secure grant funding.

GRANT FUNDING

The most traditional way to raise funding for your partnership is to identify foundations, government agencies or businesses who provide grants and funding for the type of work that you are doing. Some tips include:

- **Start with your local structures:** Work in partnership with district or local coordinating structures. This can secure buy-in and recommendation from local authorities for your plan and request and can provide avenues into securing local government funding and or integration into district health and development planning
- **Networking:** While many grants involve an official 'call for proposals', it is usually difficult to know about these in advance. Take the time to establish close working relationships with associations, agencies and governmental and non-governmental institutions in your local area
- **Be ready!** Grant proposals will require detailed information about your organisation, the partnership, and your project workplan and budget. Make sure that all of this information is up-to-date and ready to be included in a grant proposal, or to send to a donor upon request
- **Map the donor landscape:** Spend time with your partner making a list of the potential donors for your project. Consider the following types of potential donors: businesses, local offices for international NGOs, communities of faith (churches, mosques), embassies or consulates and local or regional government
- **Do your homework:** Research these potential donors and identify those who provide funding for the type of work that your project is doing. Make sure that you understand the grant making guidelines, timelines and requirements prior to making a request
- **Reach out:** Once you have a list of potential donors and understand their grant making guidelines, make contact with the prospective donors and learn about specific call for proposals and grant timelines
- **Keep trying:** Fundraising is a learning process. Often, you will need to make several attempts before finding the right donor fit for your proposal. If a request is unsuccessful, ask for feedback on what could be improved for your next proposal. Remember that a 'no' is an opportunity to learn for the next proposal or donor request

INDIVIDUAL DONATIONS

Another source of funding could come from individuals in your community, country or even globally who are passionate about the work that you are doing in your project. Some tips include:

- **Create a brochure or annual report:** Creating a simple brochure or annual report will allow you to communicate with potential donors by showing what your project is doing, and including ways to donate
- **Social media:** By setting up a Facebook page, Twitter account or WhatsApp group for your project, you can stay in touch with individuals who may be interested in following and donating to your project
- **Events:** Reach out to local vendors for sponsorship for events and meetings. This can be through donating food, space, entertainment and volunteer support
- **Online giving sites:** Online giving platforms, such as Global Giving (www.globalgiving.org) and Just Give (www.justgive.org) allow you to create a profile of your project and access funding from people around the world

STEP 4

IMPLEMENTING & BUILDING
RELATIONSHIPS TOGETHER

The fourth step of collaboration is to **collaborate and implement** your first project together, carrying out the activities that you identified in your workplan, and to build your relationship.

This first project sets the tone for the working relationship with your partner. By focusing on the relationship with your partner while you are implementing your first project, you will develop a sustainable way of working together for future collaborative projects.

WHY?

Implementation and relationship building are primarily about managing and motivating your team. A large part of 'getting things done' is ensuring that everyone on the team is motivated and in sync with the work of each other.

In a nutshell, implementation is making sure that people do the right thing with the right resources at the right time.

However, ensuring that your team is on track is not just about making sure that people are in the right place and hoping that they complete their activities on time. Implementation and partnership-building are also about ensuring that your team has the right skills and capacity to perform their work effectively, and keeping them motivated and inspired to do their work in the best way possible.

 KEY MESSAGE

Implementation and relationship-building are about people. As you move through this Step, consider the different talents, skills and needs of your team. The primary role of your key driver at this point is ensuring that the team is motivated and in possession of the skills and resources that they need to do their jobs and undertake their assigned role in the partnership effectively.

MEANINGFUL
ENGAGEMENT

With formal roles on your project, adolescents and young people—including local networks of young people living with HIV—should be included in all of your project meetings as a central partner so that they can be as effective as possible in the work that they are doing.

SUMMARY OF ACTIVITIES

This step includes **five activities** designed to answer the questions below:

1 Conduct a project kick-off meeting

Key question: How will we get the project off to a good start?

Implementation often starts with a 'project kick-off meeting', a term borrowed from the sports field, where a team begins the game by getting the ball moving.

The project kick-off meeting is a chance to get everyone who will be involved in the project together to ensure that the entire team is familiar with the workplan, timelines and roles that they will play.

Collaboration thrives on structure and routine. To be effective, ensure that in your project kick-off meeting you discuss the mechanisms for hosting regular meetings, sharing information, recording information, sharing data and reporting.

2 Motivate and retain team members

Key question: What will we do to motivate and retain team members for our project?

Your team members are the most valuable resource for conducting your project. As you work together as a team, you will also be setting the tone for the partnership going forward. Ultimately, it is the decisions and actions that they take on a daily basis which will determine the success of your project and partnership.

Communication is critical to keeping the team on track and committed to project activities. When team members are in communication about their accomplishments and challenges, a project is able to move along smoothly and efficiently.

KEY MESSAGE

Preparation must be undertaken in order to ensure that the kick-off meeting marks the start of the project. All project planning should take place prior to the project kick-off meeting.

TOOL

Use the sample 'kick-off meeting' agenda in the Appendix ([Tool 13](#)) to develop your workplan.

LESSON FROM C³

Clinics and CBOs often have unique challenges that make communication especially difficult. To the extent possible, clinic and CBO partnerships should aim to use information technology (IT) resources to maintain strong communication links during the project. Time and energy should be invested at the outset of the project to try to secure IT skills and capacity.

3 Build skills and capacity

Key question: What kind of skills and capacity will our team members need to be successful in their roles?

It is very likely that members of the team will need new skills and capabilities in order to carry out their project roles. It is important to acknowledge that building the skills and capacity of your team is not a departure from the work of your project—rather, these activities are integral to the project itself.

Partnership and relationship-building is a skill—it is highly advisable that investments and time are put to relationship-building and partnership strengthening throughout (see activity 5 for more detail).

Training refers to activities intended to build specific skills that team members need to be able to do their jobs. By contrast, capacity-building is the overall support that is given to team members and even organisations generally so that they can grow in their positions, develop their careers and take on more advanced roles and functions in the future.

4 Learn from your mistakes

Key question: How will we build a 'culture of learning', where we learn from our mistakes and use them to improve the project?

Every plan will encounter difficulties along the way. One of the most important aspects of keeping a project moving forward is identifying how your team and partnership will respond to these uncertainties. Specifically, how will you respond to mistakes and failures so that you learn from them, rather than repeat them?

To create a 'culture of learning', project drivers must work to destigmatise failure—this means that team members must believe that mistakes will not lead to blame and loss. Rather, mistakes and failure should be an opportunity for learning and improvement.

KEY MESSAGE

Team members are often committed to a project with the anticipation that they will learn new skills and advance their careers. By building the skills and capacity of your project team, you will also contribute to their motivation to do their work effectively, increasing you and your partner's organisational capabilities beyond the project itself.

LESSON FROM C³

In C³, we call our mistakes 'famous failures!' We decided early on that we needed to celebrate failure—since, very often, failure is what is needed in order to ultimately succeed.



5

Maintain the relationship with your partner

Key question: How will we build and maintain a good relationship with our partner?

One of the important elements of delivering on your project is ensuring that your partnership itself is also growing and improving over time. In order to develop your partnership, it is useful to evaluate how your partnership is progressing on a regular basis.

The 6 R's⁵⁹

As you look for ways to improve your relationship with your partner, consider the six Rs.

- **Recognition.** Partners want to be recognised for their leadership and activities
- **Respect.** Everyone wants respect. By joining in community activities, we seek the respect of our peers
- **Role.** We all like to feel needed. We want to belong to a group in which our unique contribution is appreciated
- **Relationship.** Organisations are networks of relationships. Organisations draw us into a wider context of community relationships that encourage accountability, mutual support and responsibility
- **Reward.** To sustain each partner's role in your project, try to identify their interests and find out what rewards appeal to them
- **Results.** Nothing works like results! If your partnership is formed in response to community needs, results will be welcomed and enhance your partnership's credibility. Build in visible, short-term successes for your work



MEANINGFUL ENGAGEMENT

The 6 R's are particularly important for adolescents and young people who are part of your team—show them the list and ask for their opinions about how to improve the relationship with the team.

STEP 5**DOCUMENTING, REVIEWING
& MONITORING**

The fifth step of collaboration is to **document, review and monitor** the work that you are doing together,

In this step, you will identify the data that you will need to gather in order to measure the progress of your project.

You will also be able to put a monitoring plan in place for your project, and use the information that you collect to help your project team to communicate effectively with stakeholders, while learning and growing from the project as it moves forward.

WHY?

While you are implementing and maintaining your partnership and your project, it is important that you document your work, review your successes and challenges, and assess how your project is progressing.

These activities are often referred to as 'MEL', which refers to 'monitoring, evaluation and learning'.

While this might sound very technical, the purpose is actually simple. Ultimately, you want to use information from your project to work out if you are making a positive difference for adolescents and young people in your community, and if there are changes or improvements that you can make so that your work is even more effective.

 **KEY MESSAGE**

Information is a powerful tool for your project and partnership. Without a sound plan to collect and use data, it is difficult to know if your project is working successfully.

**MEANINGFUL
ENGAGEMENT**

Adolescents and young people should be integrally involved in the monitoring, evaluation and learning process. They can often be the most important gateway to understanding the way the work is unfolding in your project and have first-hand knowledge in the service delivery experience.

SUMMARY OF ACTIVITIES

This step includes **five activities** designed to answer the questions below:

1 Develop an MEL plan

Key question: How will we collect and check the information that is being measured by our project?

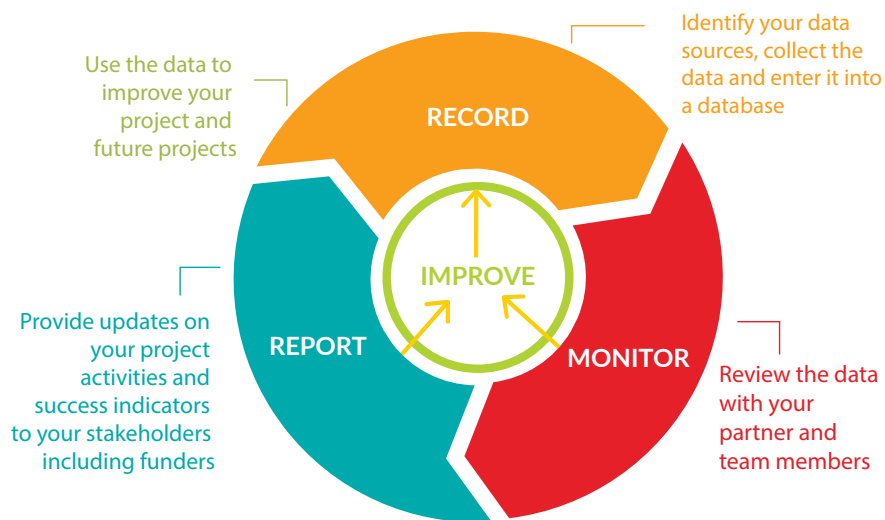
In order to know if your project is on track, you can use the MEL cycle help you create a plan for keeping track of your project. This plan does not have to be complicated— in fact, the easier it is to develop, the more likely you will be to use it!

Your plan will be a cycle consisting of four key activities. We will review each of these activities in the sections that follow:

- **Record:** Identify your data sources, collect the data and enter it into a database
- **Monitor:** Review the data with your partner and team members
- **Report:** Provide updates on your project activities and success indicators to your stakeholders, including funders
- **Improve:** Use the data to improve your project and future

C³ LESSON FROM C³

Often, this step can be made more difficult than it needs to be. You are looking to create a plan to collect information that will help you to determine whether your project is on track or not. The easier you can make this process, the more likely that it will be implemented.



2**Record: Identify and use your data sources**

Key question: What data will we collect and use for our project?

In Step 3, you defined your success indicators. In this activity, you will need to determine what data you will use to verify that these success indicators are heading in the right direction.

First, consider what sources of data are easily available to you or your partner. It is always easier to work with data that is already being routinely collected than to create a new process.

Consider these sources of data:

- Attendance registers
- National or regional health information systems
- Clinic databases
- Patient registers
- Surveys
- Focus groups
- Participant interviews

If you are not yet collecting the data that you need to verify your success indicator, brainstorm ways that you can collect this data with your partner. You may need to create a tool to collect it, such as a:

- Checklist
- Form
- Survey
- Questionnaire

Once you have developed your collection tools, you should consider the database where you keep the data that you collect. If there are existing health databases in your health district or community, this is the ideal place to keep the information. However, the type of database that you choose to use is entirely based on what will be most useful to you and your team. Your database can be a:

- Notebook
- Printed logbook
- Computer spreadsheet
- Cloud-based spreadsheet (i.e. Google Sheets)


KEY MESSAGE

Data can improve service delivery. It is of critical importance that clinic and community partners, together with adolescents and young people, look at the data together, talk about what it means and discuss the progress and challenges of collaboration. Don't be afraid to record negative data. Together, this data can help partners to develop plans to accelerate areas where there is slow progress. to their motivation to do their work effectively, increasing you and your partner's organisational capabilities beyond the project itself.

3**Monitor: Get your team involved**

Key question: How will our team members, including adolescents and young people, be involved in recording and monitoring process?

Monitoring your success indicators simply means reviewing them on a regular basis. It helps to include monitoring alongside other activities you are doing for your project. For example, if you have a monthly or bi-monthly meeting with your partner to discuss your project, incorporate monitoring into the meeting agenda.

4

Report: Communicate your progress to stakeholders

Key question: How will we report on the project to our stakeholders, including funders?

Data is an important way to communicate with your stakeholders. Data also helps your team members to do their jobs better and learn and grow within the partnership. When you and your partner are secure that your project is progressing, it will give you a strong sense of confidence to continue your work.

Once you have a monitoring system in place, you can now create reports that can be used both internally and externally. It is important to create reports regularly—not just when funders request them!—so that you can continuously see how your project is performing.

5

Improve: Learn from the process

Key question: How will we ensure that we continue to learn from our project?

While recording and monitoring are most often associated with reporting to stakeholders and funders, it is just as important that the information is used for your team to learn and improve the work you are doing with patients and communities. This is also a good opportunity to give feedback to the community on how the project is progressing.


KEY MESSAGE

In order to ensure that the reporting template is completed on a regular basis, make sure that the task is assigned to someone and that there is a regular due date for its completion.

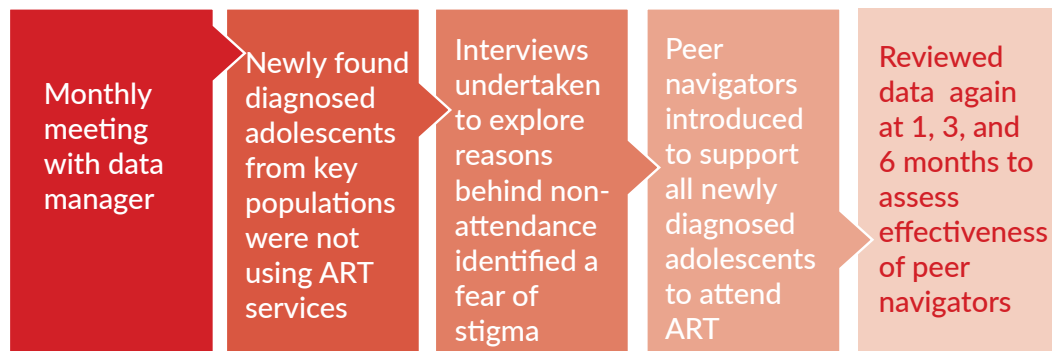

TOOL

Use the progress report template in the Appendix ([Tool 14](#)) to develop your report.


KEY MESSAGE

The information you are gathering is one of the most important assets of your project. Not only is the information valuable to promote the work of your project, it is also an essential learning tool for your team.

Example of how data can be used to improve service delivery:



STEP 6

MESSAGING FOR A
BROADER IMPACT

The sixth and final step of collaboration is **messaging**—communicating the broader impact of the work that you are doing together,

Through this step, you will be able to view the impact of your partnership and project through a broader lens, enabling you to see your collaboration in the context of the local health response.

Drawing on these lessons, you can deepen your collaboration, undertake new projects together and expand this methodology into your community. This has the potential to offer a more collaborative approach to community or district planning overall, which will ultimately sustain the work that you are doing with your partner.

We will also discuss how to advocate for the policies and resources to increase collaboration in your local health system, identify champions in your community and communicate the value of clinic-community collaboration as a central methodology to various community decision-makers, including stakeholders and funders.

WHY?

At this point, you have reached an important juncture in your collaborative work. You have now identified your partner, formalised and initiated your partnership, planned and resourced your first project, launched the implementation of your project and begun the process of documenting, reviewing and monitoring your project.

Throughout this process, your partnership and capacity for collaboration has grown and evolved. While it is crucially important that you continue to successfully implement your project, the ability to see the bigger picture of your work will ultimately allow you to identify ways to sustain the activities of your project for the long-term and ensure that you can embark on new projects into the future.

KEY
MESSAGE

Clinic and community partnerships have an important impact on local public health systems and communities. The work that you are doing with your partner is part of a bigger picture that is changing how health services are provided to members of your community. Demonstrating effective health partnerships and how the collective impact of clinics and communities collaborating is very powerful.

MEANINGFUL
ENGAGEMENT

Adolescents and young people—including networks of young people living with HIV—should be empowered to lead these activities, as they will be the most effective spokespersons for the work of your project and your collaboration.

SUMMARY OF ACTIVITIES

This step includes **five activities** designed to answer the questions below:

1 Identify the broader impact of your partnership

Key question: What is the impact that our work is having and what value does it provide our community beyond undertaking one joint project?

When you are busy implementing a project, it is easy to become very focused on the project aim and activities that you are implementing. However, your partnership is operating in a local public health system and community environment that has many moving parts.

To identify the broader impact of your partnership, consider the following possibilities:

- What **other stakeholders** might contribute to our partnership? What are their goals, strengths and weaknesses?
- What **guidelines, policies and laws** might we seek to change to support the work that we are doing together?
- What **local (district), national and global groups** can we join or create to scale up the work that we are doing together?

2 Explore the integration and sustainability of your partnership

Key question: How does integration and sustainability of collaborative work strengthen the local response?

Once you have begun to understand the broader impacts that your partnership is having on the local public health system and community, it is time to consider how your collaboration can become part of the larger health response.

Integration and sustainability are important for two reasons: (1) by sharing resources across multiple projects, you can become more effective and efficient; and (2) there is a greater chance that the activities of your partnership will be sustained far into the future.

Examples of what integration could look like for your partnership and other clinic-CBO partnerships in your local area:

- Community health workers and peers currently employed by CBOs are fully integrated into clinic operations
- Community health workers and peers are absorbed into and employed by the health system, providing a career path with salaries and benefits
- Data collected by your partnership is integrated into the health information and data collection system
- Service delivery and quality improvement planning, monitoring and review for adolescents and young people engages clinic and community partners

G³ LESSON FROM C³

As the implementation of your project begins to reach a steady state—approximately 6-12 months into your partnership—it is a good idea to add an agenda item to your regular meetings to discuss the broader impact and messaging of your project.

3

Advocate for policies and resources

Key question: How can our partnership advocate for the policies and resources that support and ensure long-term sustainability for collaborative partnerships, including our own?

Advocacy is any activity that ensures that all voices—**including** adolescents and young people—are heard when decisions are being made about policies and resources. Advocacy may seem complex, so it helps to consider the various activities that make up advocacy work. In fact, it is very likely that you or your partner are already engaging in some forms of advocacy.

Advocacy activities can include:

- Analysing legislation, policies and existing guidelines
- Writing position papers, briefing notes and fact sheets to influence decision-makers
- Face-to-face meetings with key decision-makers
- Presentations and appearances at public forums to make the case for policy and budget decisions
- Drama or storytelling which influences public opinion
- Media exposure, such as press releases and radio interviews, which influence public opinion
- Working from the inside, such as having a team member seconded to government who can provide technical assistance for policy development

4

Recruit community champions

Key question: How will we identify the champions who will support our partnership?

Another way to influence the way decisions are made is to recruit champions who will support the work that you are doing at the local level. A community champion is someone who will assist your partnership in taking your project and future work to the next level, helping you to reach the broader vision that you have developed.

These people may include:

- Community leaders and elders
- Public officials with a concern for public and community health
- Business leaders with an interest in community development
- Religious or education leaders with influence in the community
- Local celebrities and personalities
- Young social media influencers

Adolescents and young people are important and influential champions. Liaising with networks of young people living with HIV in the community can help identify youth leaders who can support the partnership and amplify its impact.

5 Communicate the broader vision

Key question: How will we communicate this broader vision and methodology of clinic-community collaboration to key decision-makers, including stakeholders and funders?

A good starting point to developing a communication plan is to identify your communication objectives. Your communication objectives lay the foundation for your communication plan. They are what you want to happen based on your broader vision.

Objectives may include:

- Public awareness of project objectives and vision
- Policies that support your project and partnership
- Budget line items reserved for project sustainability
- Donor funding for your project

After you identify your objectives, it is time to determine your **target audiences** and your key messages. It is important to do some research to understand who will be receptive to your message and to identify the key messages that will resonate with these audiences.

Finally, you can choose the **specific channels** that you will use to deliver those messages to your audiences. Specific channels can include:

- Printed materials, such as fact sheets, brochures and reports
- Letters, emails and phone calls to influential decision-makers
- Website or blog posts to which you can direct your audiences
- Print media, such as national and community newspapers
- Social media, such as Facebook, Twitter and Instagram
- Radio and television interviews

**TOOL**

Use the communications plan template in the Appendix ([Tool 15](#)) to develop your plan.

CONCLUSION

Being responsive to the needs of adolescents and young people requires a collaborative approach to HIV service delivery. Clinics and communities **working together** have critical roles to play, ensuring that the barriers for adolescents and young people to access HIV prevention, treatment and care are meaningfully overcome.

Our C³ experience has allowed us to see that clinic-community collaboration can tackle persistent gaps in service provision, leading to increased service uptake, improved retention in care and increased trust and perceptions of value between members of clinics and communities.⁶⁰

Through this toolkit, we have provided practical guidance on how communities and clinics can be engaged as effective partners, based on lessons from the C³ partnerships. We have also included real-life stories of clinics and communities who are making strides toward more collaborative ways of working.

Collaboration often begins with just a single key priority, borne out of shared objectives and a desire to see improved health services for adolescents and young people. Even simple collaborations can lead to increased engagement by adolescents and young people themselves, taking charge of their own health and well-being and that of their peers.

We hope that the stories and lessons contained in this toolkit will inspire you to reach out and get started—even small steps taken together will create the momentum we need toward increased collaboration, ultimately leading to healthier and more empowered adolescents and young people.

APPENDICES

APPENDIX 1

THE CLINIC-COMMUNITY COLLABORATION (C³) PROGRAMME

Since 2014, Paediatric Adolescent -Treatment Africa (PATA) and ViiV Healthcare's Positive Action have supported the **Clinic-Community Collaboration (C³) programme**, a methodology which improves HIV treatment and care through collaborative clinic-community interventions across sub-Saharan Africa.

- **PATA** was founded in 2005 and aims to mobilise, strengthen and build resilience in a network of frontline health service providers, facilities and communities on the frontline of paediatric and adolescent HIV service delivery in sub-Saharan Africa
- **Positive Action** was created by ViiV Healthcare in 1992 as the first pharmaceutical company programme to support communities affected by HIV and AIDS. The programme works with those communities most vulnerable to HIV, including youth, girls and women, sex workers, men who have sex with men (MSM), transgender people, injecting drug users (IDU), the homeless and prisoners and other incarcerated people

Together, PATA and ViiV Healthcare's Positive Action conceptualised the C³ programme, to link the PATA clinic network and the Positive Action CBO network in clinic-community collaborative engagements for improved HIV outcomes in vulnerable communities and sub-populations.

C³'s objectives are to:

1. **Improve** HIV service delivery;
2. **Engage** communities in HIV service delivery and link clinical services and communities in health collaborations;
3. **Identify and disseminate** challenges, lessons learned and best practices for clinic-community collaboration.

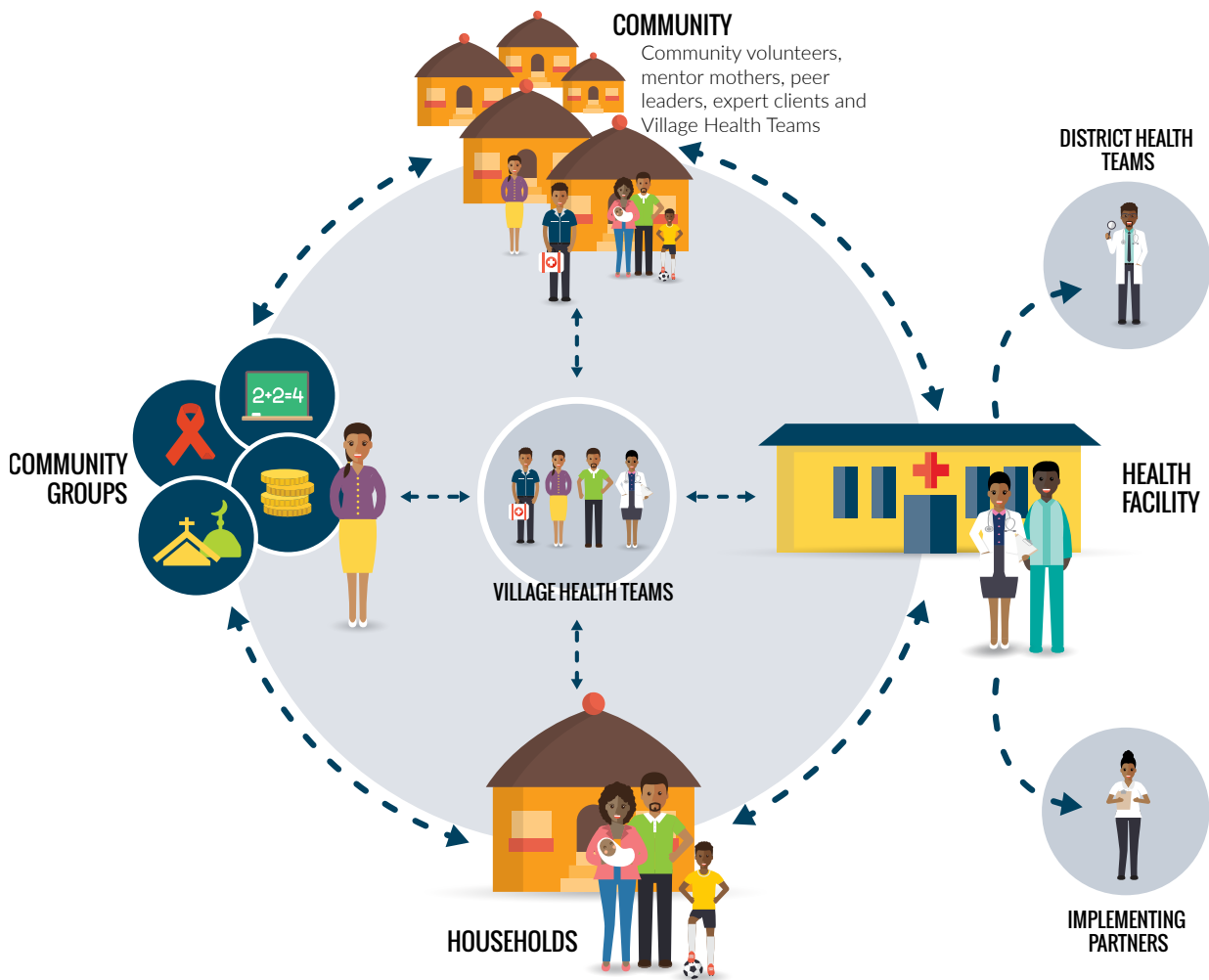
From 2014 to 2016, C³ initiated and supported **36 clinic-community collaborations** across nine focus countries: Cameroon, Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Nigeria, Uganda, Zambia and Zimbabwe. These partnerships centred around prevention of mother-to-child transmission (PMTCT) and paediatric HIV service delivery, within the five major domains of (1) community sensitisation; (2) demand mobilisation; (3) patient outreach; (4) care and support; and (5) enabling environments.

Data from the programme showed improved relationships between clinic and community partners, as well as improved health outcomes, including reduced loss to follow-up (LTFU) (38% decrease) and increased tracing and re-engagement of clients (9% increase).^{61,62} Further results and lessons learned can be found on the PATA website [[here](#) and [here](#)].

The programme culminated in the PATA-ViiV Healthcare's Positive Action 2016 Continental Summit, held in Entebbe, Uganda, where key lessons on the role of clinics and communities in PMTCT and paediatric HIV service delivery were shared.

Following the success of the C³ methodology in increasing uptake of services and improving retention in care, PATA and ViV Healthcare’s Positive Action recognised the potential for C³ to address some of the similar persistent issues in adolescent HIV service delivery. To this end, from 2018-2019, C³ initiated **19 adolescent-focused clinic-community collaborations** across two focus countries: Kenya and Zambia. These collaborations are currently in process and are focused on the areas of (1) linkage and referral; (2) case finding; (3) retention and adherence; and (4) stigma and community awareness.

These collaborations have taught us much about how clinics and communities can work together to improve service delivery for adolescents and young people, inspiring us to develop this new iteration of the C³ toolkit to share these learnings more broadly.



Building clinic-community engagement, adapted from graphic by [Aidsfonds/Towards an AIDS Free Generation in Uganda \(TAFU\) programme](#)

APPENDIX 2

GLOSSARY OF KEY DEFINITIONS

Throughout the toolkit, we refer to certain concepts by specific names. To help you to understand what we mean, below are some key definitions:

Adolescents and young people: This toolkit adopts the term *adolescents and young people* to encompass all young people aged 10-24 years.

Cascade: The sequential programmatic steps (Prevent, Locate, Link, Treat and Retain) that HIV programming for adolescents and young people should follow in order to improve health outcomes. The *cascade* includes various steps and helps in analysing health system performance and bottlenecks.

Case studies: Stories of programmes at the local, national or regional level that show examples of collaboration between clinics and communities.

Client: We use the term *client* rather than the word *patient* to refer to adolescents and young people seeking and requiring health services.

Clinic: Any facility or service that provides healthcare. This may range from a large district hospital to a small local clinic, inpatient to outpatient service or public to private setting. The clinic may provide specialised HIV care only or offer a routine health service that includes HIV care.

Community: People in a shared geographical area (eg. village or neighbourhood).

Community-based organisation (CBO): A group of people who work together at a local level, and not for profit, to improve life for all or some of a community's residents. A CBO may be registered or not, and work within health, education or food security for example (or across several of these areas). CBOs in this toolkit can also refer to faith-based organisations with similar interests. In relation to the toolkit's focus on the HIV cascade, CBOs of particular interest are those that aim to improve HIV prevention and treatment access for adolescents and young people.

Community health worker: Member of the community who provides or facilitates access to basic health services for their fellow community members. This includes, for example, village health workers, health promoters, health aides, and health advisors.

Comprehensive SRHR services: These are services that allow all people, regardless of their nationality, age, sex, gender, sexual orientation, health or HIV status, to make informed and free choices regarding their own sexuality and reproductive well-being. In the toolkit, we often link SRHR services to HIV services since there is overlap between the two service types.

Confidentiality: The act of maintaining privacy for adolescents and young people while ensuring that young clients are aware of any needs to inform others about their care.

Gaps: Issues that create barriers to adolescents and young people accessing or receiving treatment and care.

Health service provider: Someone from any number of cadres working as a practitioner within the health system to provide HIV, SRHR and broader health services. This could be, for example, a doctor, nurse, pharmacist or psychologist.

Success indicator: A metric or data point that shows progress.

Key driver: An individual who is responsible for ensuring that all aspects of the partnership are moving forward. This person can be a staff member of a clinic or CBO, or a member of the community. We have found that partnerships are usually more successful if there is an individual who is tasked with keeping the partnership on track.

Key priority area: The challenge that the partnership is working together to solve. This challenge should be a critical problem that the partners decide upon together. It can change over time as the partnership and context evolves.

Meaningful engagement: Adolescents and young people are fully engaged in all stages of service delivery, including decision-making. Importantly, they should be able to engage on equal terms with adults at all levels and participate independently and make decisions on important aspects of service delivery.

Milestone: A scheduled event that indicates the completion of a major deliverable of a project. Milestones are measurable and observable and serve as progress markers.

Opportunities: Circumstances in clinics and communities that make it possible to collaborate to improve the quality of HIV service delivery for adolescents and young people.

Organisation: Clinics, CBOs and community institutions are referred to interchangeably as *organisations*.

Output: Something that the collaboration produces, such as a training, workshop or joint activities.

Partnership: Two or more organisations working together to achieve shared aims.

Peer roles, including mobiliser, navigator and supporter/mentor: Peers can be engaged at multiple steps along the cascade. Generally speaking, *peer mobilisers* work to increase demand for services, *peer navigators* assist clients in accessing care, and *supporters/mentors* provide information, education, treatment adherence and psycho-social support often through individual and group sessions.

Principles: 'Ways of working' that increase the effectiveness of clinic-community collaborations for improved services for adolescents and young people across the HIV service delivery cascade.

Project: A time-bound set of activities that are undertaken to achieve specific aims. Within C³, clinic-community partnerships undertake one or more projects with mutually reinforcing activities in order to address their *key priority area*.

Project aim: The expected long-term impact of a project on a *key priority area*.

Service: Any treatment, care or support that is provided for adolescents and young people in the clinic or community.

Stakeholder: Individual or organisation that will be impacted by or who could influence a project or service.

Strategies: Actions that can be taken in response to an opportunity to increase the effectiveness of services for adolescents and young people across the HIV service delivery cascade.

Tools: Examples of checklists, exercises, job descriptions, agendas or other useful items that can be used when carrying out the strategies and approaches described in the toolkit.

Training and capacity-building: We use *training* to refer to activities intended to build specific skills people need to do their work, and *capacity-building* as broad support given to people so that they can grow in their positions, develop their careers and take on more advanced roles and functions in the future.

Young key populations: Often defined as four target groups: young men who have sex with men; young people who sell sex; young transgender people; and young people who inject drugs. This definition can also be expanded to include other marginalised populations, such as young girls and young pregnant women. *Young key populations* have unique needs that need to be addressed in order to ensure effective access to services and care.

APPENDIX 3

LIST OF ACRONYMS

ART	Antiretroviral therapy
C³	Clinic-CBO Collaboration
CATS	Community Adolescent Treatment Supporters
CBO	Community-based organisation
CHW	Community health worker
CYA	Chilanga Youth Awake
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBO	Faith-based organisation
HC	Health Connectors
HCW	Health Care Worker
HIV	Human immunodeficiency virus
HTS	HIV testing services
NGO	International non-governmental organisation
LTFU	Loss to follow-up
MEL	Monitoring, evaluation and learning
M&E	Monitoring and evaluation
MOU	Memorandum of Understanding
MTCT	Mother-to-child transmission
MTG	Moving the Goalposts
NGO	Non-governmental organisation
IT	Information Technology
OTZ	Operation Triple Zero
PACF	Positive Action for Children Fund
PATA	Paediatric-Adolescent Treatment Africa
PSP	Peer Support Project
PEP	Post-exposure prophylaxis
PIF/ PIW	Partnership Initiation Forum/ Partnership Initiation Workshop
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PrEP	Pre-exposure prophylaxis
READY+	Resilient & Empowered Adolescents & Young People
SMART	Specific, measurable, achievable, reasonable and timebound
SRHR	Sexual and reproductive health and rights
STAR	Self-testing Africa
STI	Sexually transmitted infection
TAFU	Towards an AIDS Free Generation in Uganda
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
USAID PEPFAR	United States Agency for International Development President's Plan for AIDS Relief
VMMV	Voluntary medical male circumcision
WHO	World Health Organization
WITS RHI	University of Witwatersrand Reproductive Health and HIV Institute
YCC	Youth Care Club

APPENDIX 4

TOOLS & TEMPLATES



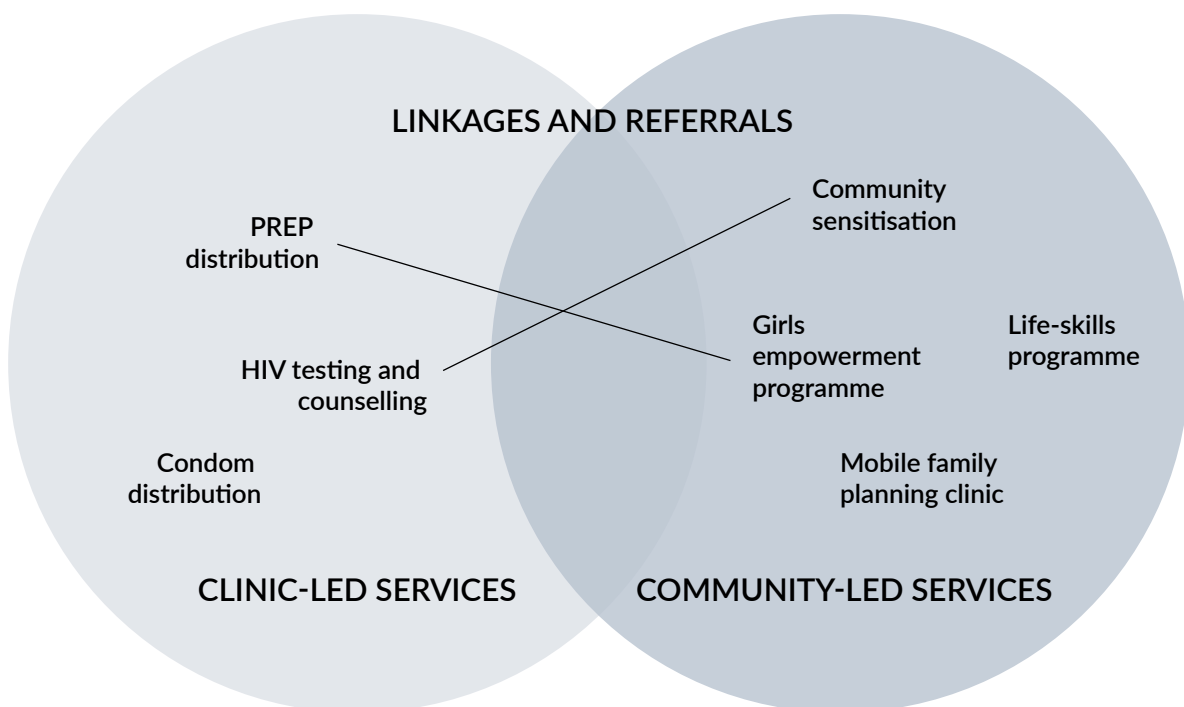
MAPPING SRHR AND HIV PREVENTION SERVICES

The following diagram can be used by your clinic-community partnership to map *what and where* SRHR and HIV prevention services are being provided across your clinic and community. The example demonstrates how you may identify specific relationships between clinic-led services and community-led services.

This tool and exercise provides the chance to see opportunities to *close gaps* as well as *improve linkages and referrals* between services in order to better serve adolescents and young people for their comprehensive SRHR and HIV prevention needs.

WAY TO USE THE TOOL:

- Brainstorm services:** In a partnership meeting, use sticky notes to write down the SRHR and HIV prevention services that are provided in your clinic and across your community. These can be services that your organisation or other organisations provide. Use one sticky note per service. You can also use different coloured stickies for different organisations.
- Plot services:** On a whiteboard or a large piece of paper, draw a diagram like the one below. Together, plot the sticky notes on the diagram, indicating where the services are provided. In the space between the two circles, draw lines to note where linkages and referrals already exist.
- Discuss together:** What services are missing? What services have been requested by adolescents and young people, but not available? Which services are not linked? Where are referrals broken? Should some services be moved or replicated in either the clinic or community space?



Adapted from International HIV/AIDS Alliance, Integration of HIV and sexual and reproductive health and rights. https://frontlineaids.org/wp-content/uploads/old_site/507-Good-Practice-Guide-Integration-of-HIV-and-Sexual-and-Reproductive-Health-and-Rights_original.pdf?1405586821



MAPPING POTENTIAL PARTNERS FOR PREVENTION PROGRAMMES

The following worksheet can be used by clinics and communities seeking collaborators for HIV prevention programmes focused on adolescents and young people OR for clinic-community partners who are seeking additional collaborators.

HOW TO USE THE TOOL:

- **Brainstorm potential partners:** First, list each of the potential partners. Expand your potential pool of partners beyond the 'usual suspects' to include places where adolescents and young people gather and spend their time. These might include schools, training and employment agencies, faith-based organisations and organisations providing services for young key populations.
- **Partner analysis:** Next, use the four questions below to consider each of the partners and determine who might have interest and ability to jointly provide services for adolescents and young people with you.

Potential Partner Name	Contact Details	What do you think their interest level may be?	Would they be supportive?	What would they require?	How should we connect with them?	Services provided
HARAMBEE HOSPITAL	THANDI MASITO 073 504 6723 MZAMOT@HARAMBEEHEALTH.ORG	HIGH	YES	ASSISTANCE WITH DEMAND CREATION AND TESTING REFERRALS	(ALL TO SET UP MEETING)	HIV TESTING PREP SRHR
[Organisation 2]						



MEANINGFUL ENGAGEMENT

It is important to involve adolescents and young people in completing the worksheet to get a full picture of what might be available in your community.



PEER MOBILISER JOB DESCRIPTION & RECRUITMENT

This job description can be modified for other peer roles, including peer navigators and supporter/mentors.

Peer mobilisers generate demand by sharing information, creating interest and normalising uptake in the community for HIV and SRHR health services. Peer mobilisers may be the first point of contact for adolescents and young people who are considering their health needs, and their ability to provide information, answer sensitive questions and exhibit a non-judgemental tone is extremely important for locating adolescents and young people living with HIV.

HOW TO USE THE TOOL:

- (1) **Explore key considerations of hiring a peer mobiliser:** Identify the role of a peer mobiliser in your programme and collaboration needs. Consider the reasonable level of support you can provide, while also managing the ethical concerns of hiring or engaging peer staff and maintaining a structure of support and empowerment
- (2) **Modify the job description:** Use the template as a guide for developing a peer mobiliser role for your clinic-community collaboration. In modifying the job description, consider both your collaboration needs and the support you have capacity to provide. Job descriptions will give prospective peers a clear idea of what the role entails as well as direction when the role is assumed
- (3) **Distribute the job description:** Use the channels available to you to spread the word about the peer mobiliser position. You can use direct posting, such as community notice boards, school notice boards and mobile communication. You can also ask for referrals from trusted community members, such as teachers, faith leaders and traditional leaders
- (4) **Interview and select:** It is important to have a conversation with prospective peer mobilisers to learn about their motivations and telling them more about the role and responsibilities. You may want to set up a committee to undertake the selection process so that the process is objective and fair
- (5) **Train and support:** Peer mobilisers need training and ongoing support to be effective, particularly through emotionally demanding tasks. Consider with your team who will provide the ongoing training, supervision and support for these key members of your team

PEER MOBILISER JOB DESCRIPTION

[Organisation Name]

[Project Name]

Job Title: Peer Mobiliser

Stipend: [Include stipend here]

Days and times: [Include days and times here]

Location: [Include clinic and address here]

Reporting to: [Insert name here]

Job purpose/summary: The peer mobiliser will work with the clinic and community teams to increase awareness and knowledge in [local community] about HIV testing and treatment.

Qualifications:

[Minimum education requirements]

[Language requirements]

Desire to engage people and make a difference in the lives of others;

Ability to prioritise confidentiality and needs of clients;

Prompt and professional behaviour for all activities.

Duties and responsibilities:

Attend mobiliser training to learn HIV basics and peer mobilisation skills;

Assist with the planning of community campaigns and events;

Attend community campaigns and events to meet prospective clients;

Provide information on the benefits of HIV testing;

Develop referrals for clients seeking health referrals;

Follow up with referrals and ensure that clients access appropriate health and HIV services;

Participate in planning and continuous improvement meetings with clinic and community staff.



VOUCHERS & E-VOUCHERS

Vouchers and e-vouchers (mobile phone or digital codes distributed via text message or WhatsApp) have been proven to facilitate referrals and to recruit clients with higher risk profiles for testing and treatment.⁶³ While incentive schemes can increase the cost of service provision, and may require additional public or private funding, this may be offset by overall cost-effectiveness of a programme.

HOW TO USE THE TOOL:

1. **Determine which services will be covered by vouchers.** These could include: SRHR services, testing, counselling and/or follow-up for positive tests to determine treatment
2. **Consider a reward or reimbursement for each redeemed voucher,** such as transport costs or airtime
3. **Determine distribution points,** such as testing sites, schools, faith-based institutions, youth centres and other venues where young key populations are present
4. **Decide on policies,** such as how many vouchers each client will receive and whether they will be encouraged to pass along extra vouchers to friends and family
5. **Develop a referencing system** that assigns a unique code for each voucher. Ensure that staff are able to capture the code when the voucher is redeemed
6. **Design and produce visually attractive vouchers** that are easy to reproduce and distribute (see the examples below)
7. **Continuously monitor** use of the voucher and authenticity



Red Carpet Voucher,⁶⁴
Elizabeth Glaser Pediatric
AIDS Foundation



Adolescent and Youth
Vouchers,⁶⁵ Marie Stopes
International



PEER NAVIGATOR LINKAGE REFERRAL PAMPHLET

A pamphlet can be used by facility staff to connect Peer Navigators to clients when navigators are not immediately available. The pamphlet explains how the navigator can answer questions and help them access services at the clinic.

WAY TO USE THE TOOL:

1. **Design a pamphlet for your collaboration:** Use the sample pamphlet below to design a custom pamphlet for your collaboration. Include information about your peer navigation programme and provide areas where health service providers can write in the necessary information for clients to connect with peer navigators
2. **Develop a protocol for delivering pamphlet referrals to peer navigators:** Ensure that peer navigators receive the referral form portion of the pamphlet within 24 hours of receipt by the client. Develop a protocol for how and within what timeframe peer navigators should contact their new clients. Ensure that peer navigators are supported in the referral process
3. **Introduce the pamphlet to health service providers:** Conduct a sensitisation meeting with facility staff to introduce the pamphlet and how it will be used to connect peer navigators with young clients. Explain that the pamphlet should be given to clients with the referral form removed to be given to peer navigators
4. **Print and make available in the health facility:** Ensure that copies are available in the facility and prominently displayed in areas where young clients will be served

What is a Health Connector?
A Health Connector is someone who works with the clinic to help you get the care and support services you need.

What can a Health Connector do for you?
A Health Connector can answer your questions, let you know where to go and what appointments you might need now or later. They can also share health information and be there to listen when you need.

How would I connect with a Health Connector?
Tell the Health Connector how you would like to communicate - it could be in person meetings, SMS, WhatsApp, or phone calls. You can talk to the health connector as much or as little as you need to.

How much does it cost?
It is free to you - you might just have to pay for the phone calls or SMSes that you make.

I'm interested, how do I get in touch with a Health Connector?
Send me a "Plz Call Me", SMS or WhatsApp message and a Health Connector will get back to you within 48 hours OR visit the clinic.

Remember, talking to the Health Connector is your choice so you can stop any time you like.

Hi, I'm _____ [name] and I am the Health Connector that supports your clinic. I am _____ [age] years old and I live in _____ [place].

I know that sometimes it can be hard to know where to go and what to do next to get the care and support you need, but I am here to help.

If you have questions about your care and support services at your clinic, I am available at _____ day/s at _____ [time].

Or you can send me a "Plz Call Me", SMS or WhatsApp message on _____ [cell number] and I will get back to you within 48 hours.

Fill out contact form at on the next page and the health connector will contact you.

Remember, talking to the Health Connector is your choice so you can stop any time you like.

Health Connector referral form

Name & Surname:				
Age:				
Date of birth:				
Clinic attending: (if applicable)				
How would you like to communicate?	phone	SMS	WhatsApp	Visit
Phone number				
Do you share the phone?	Yes	No		
What is the best time to contact you?				
By signing this form, I give a Health connector permission to contact me and document my information....				
Your Signature:				



TIPS FOR COMMUNICATING WITH ADOLESCENTS AND YOUNG PEOPLE

Good communication is key to working with and alongside adolescents and young people. A diagram like the one below can help to remind health service providers, community staff and peers what works and what doesn't to communicate more effectively with their young clients.

HOW TO USE THE TOOL:

1. **Include this diagram in training materials:** Use the sample diagram (or a modified version) in training materials designed for health service providers, community staff and/or peers who will be working with adolescents and young people
2. **Post this diagram in staff and meeting rooms:** Print and display the diagram in prominent places in health facilities, community offices and meeting rooms



From Aviwe Technical Assistance for HIV Programming Clearinghouse-A project by WITS RHI, YCC training slide. (<http://aviwe.wrhi.ac.za/health-connector-programme-2/>)



ADOLESCENT SUPPORT GROUP FACILITATOR'S GUIDE

Health service providers and peers should be fully trained before leading support groups and conducting psycho-social support sessions. Below is one example of how a support group can be run by a health service provider or a peer mentor/supporter.

HOW TO USE THE TOOL:

- (1) **Use in a support session:** The facilitator's guide below can be used in a group support session with adolescents and young people living with HIV. Depending on the length of time, this session can be done in full or over several monthly sessions.
- (2) **Use in a training for peer facilitators:** The facilitator's guide can also be used in a training session for peers who are learning to facilitate support group sessions. The guide can be used as an example of a session and peers may be asked how they would use and/or modify the questions for their audience

Extract on following pages from MSF Paediatric Risk of Treatment Failure, 2018. <https://samumfsf.org/sites/default/files/2018-10/HIV%20Paediatric%20HIV%20Risk%20of%20Treatment%20Failure.pdf>

Appendix 3.1 Adolescent Support Group Session – Facilitator’s Guide

Adolescent Support Group (SG) Session	
Target group	All Adolescent patients (12- 19 years)
Timing	Immediately upon arrival: 12:30pm
Duration	45 min
Mode	Group
Tools	Agree/disagree signs for the wall
<p>Step 1: Introduction:</p> <ul style="list-style-type: none"> • Introduce yourself as the facilitator • Explain to patients why they are in the support group: <i>“All of us here have one thing in common and that is that we all have a high viral load.”</i> • Explain: <i>“As young people, it can feel very difficult to take your ARVs every day for many reasons. We hope that through these group sessions and your individual discussions with your doctor and nurse, we can help to make it a little bit easier.”</i> • <i>“Some of you have been to the support group before and for others this is your first time. At each session, we will discuss general subjects surrounding adherence. However, each time new topics will arise and there will be new things to share.”</i> • Ask the adolescents who have attended previous sessions to help you with the new members – they can help orient the new members and provide support. • Assure the adolescents that they will have their individual clinical consultation with the doctor and nurse after the support group. • Assure confidentiality by yourself, the nurse, the doctor and between patients attending the group. • Support group members should be non-judgmental towards each other. <p>Step 2: Discuss Flexibility in Taking ARVs:</p> <ul style="list-style-type: none"> • <i>“Taking ARVs every day is hard. The good news is that the times during the day when you take your medicine has become more flexible. It is no longer necessary to take your ARVs at the exact same time every day (for example at 7am and 7pm). There can be an hour or two of flexibility.” Also, if you want to change your schedule on the weekends you can do so (for example if you tend to sleep late on weekend days). However, it is still important to take your medicine each day and not to miss doses.</i> <p>Step 3: Discuss Barrier: Mixing Social Life with Taking ARVs:</p> <ul style="list-style-type: none"> • Explain: <i>“We are all young people here, our lives are different from our parents and our older sisters and brothers. Many of us are in school, have many friends, are dating, like going out and socialising”</i> <i>“Our lives are often complicated which can make taking ARVs more difficult.”</i> • Discuss social situations that make it difficult to take their ARVs. <i>“What social situations make it difficult to take your ARVs?”</i> (If no one gives an example, ask about going out with friends and taking ARVs.) • Discuss relationships: <i>“Many of us have boyfriends or girlfriends. We change our partners when we are not happy with our relationship or we meet someone that we like more.”</i> <i>“How could having a boyfriend or girlfriend make it difficult to take your ARVs?”</i> <i>“What plans have you made in the past to help?”</i> <p>Step 4: Discuss Barrier: Stigma and Coping with Stress:</p>	

- Introduce 'agree' or 'disagree' game: We are going to take part in an activity where you let your feet do the talking. You will notice on one side of the room we have a sign saying 'Agree' and on the other side a sign saying 'Disagree'. Let us all come to the middle and when I ask a question, you let your feet answer the question.
 - *Do you feel there is discrimination against young people with HIV?*
 - *Is discrimination based on HIV status fair?*
 - *Have you ever felt discriminated against for any reason?*
 - *Have you stopped a friendship because you thought that the person was discriminating against you?*
- Back in seated group, ask:
 - *"What is stigma?" "What is discrimination?"*
 - *"In what ways is it possible to be discriminated against?"*
 - *"Discuss how it feels to be discriminated against."*
 - *"What can we do to fight against stigma and discrimination due to your HIV status?"*

Step 4: Plan the Way Forward:

- Explain again that after the session all patients will see the doctor and nurse individually in the clinic.
- Explain that they will attend this support group each time they come to the intervention. Each time they come they will first attend the support group and then be seen individually by the doctor and nurse.
- Ask the new patients to stay behind after the group.
- End the session with a positive, reinforcing message.

Guiding Points for Group Facilitation:

- It's important for patients to feel that the session is a learning experience and a time when they can share their feelings and concerns. It is not a time for blaming and finger pointing.
- Try not to put new patients on the spot. Do not ask a new patient "What have you been doing wrong?" It is possible to identify a problem without blame or such a direct question.
- **Let patients do most of the talking.**

Extra Step with New Programme Patients:

- Explain the following:
 - "You are new patients to this clinic. You will be seeing the doctor and nurse after this short session. The team will help you with any difficulties you may be having with taking your treatment and discuss a number of steps that may help you plan for taking your treatment."*
 - "We would like you to prepare a little while you wait."*
 - "We can sometimes struggle with negative thoughts when we are taking treatment every day for a long time. It can help to think of the positive things in your life and your dreams for the future when you take your treatment."*
 - "While you wait, please can you think about:*
 - ***What you would like to do when you are older.***
 - ***What are three things that you want to do in the future?***
- Close with an encouraging message:
 - "This is the beginning of a journey to work together to make taking ARV treatment a little easier, we are here to help and support you as much as you need us."*

Note: The counsellor should not discuss these questions with the patient. These are questions that will be discussed individually with the doctor/nurse.



YOUTH CLUB/SUPPORT GROUP POSTER & CALENDAR CARDS

Attendance at support groups is critical for group formation and adherence support. The tools below can be used in a clinic or community setting to announce support group sessions and to remind adolescents and young people living with HIV of support group dates.

HOW TO USE THE TOOL:

- Print, laminate and reuse posters:** Posters are reusable and should be printed and laminated. Use a whiteboard marker/khoki to indicate the date, time, club name and venue. Post in a place where adolescents and young people will see when they are attending clinic visits or community events.
- Print and distribute calendar cards at adherence club sessions:** Calendar cards can be printed on two sides. Dates should be circled for each monthly support group session. Cards can be printed to be carried in a client’s pocket, wallet or handbag for reference.
- Send out mobile text message or WhatsApp reminders:** In addition to posters and calendar cards, facility staff and/or peers may find it useful to send out mobile reminders to club participants.



Source: Aviwe Technical Assistance for HIV Programming Clearinghouse-A project by WITS RHI <http://aviwe.wrhi.ac.za/category/clearinghouse/adolescent-innovations-project/adolescent-innovation-project-resources/>



PROBLEM TREE ANALYSIS

Time allowed: 3 hours

Participants: Key driver, with help from other team members. You may want to invite members of your client groups and/or members from other stakeholder groups to join you for this exercise.

HOW TO USE THIS TOOL

- 1. Define the problem:** Start with what the information that you have gathered is telling you. Discuss with the group: where are you seeing the gaps along the continuum? Where are your biggest challenges? Find out as much as you can to understand how each of these challenges is a problem, and the extent of the problem. Where for example, along the prevention and treatment continuum, is there the highest fall out and what are the critical entry point into the cascade where you are experiencing problems and barriers?
- 2. Find the root causes of the problem:** Now, draw the trunk of a tree on your flip chart paper and write the problem statement on the trunk. As a group, identify the main causes of the problem. Draw these causes along the large roots of the tree, indicating that they are 'root' problems. Select one of the causes. Ask yourself or others, 'Why do you think this happens?' This question will help you to identify the secondary causes. Write the secondary causes as small roots coming off the larger root of the tree. Repeat the process for each of the main causes.
- 3. Find the main effects of the problem:** Next, begin to identify the main effects of the problem. Write each effect as large branches of the tree. Select one of the main effects. Ask yourself or others, 'Why do you think this happens?' and identify the secondary effects. Write the secondary effects as small branches coming off the larger branch of the tree. Repeat the process for the other main effects.

When completed, consider what the problem tree shows. For example, how do the causes and effects relate to each other?





MOU TEMPLATE

Time estimated: 2 hours

Participants: Key driver, as well as people identified as signatories in Tool 15.

HOW TO USE THIS TOOL

The MOU should be drafted by one of the organisations shortly after the Partnership Initiation Workshop, and then reviewed by the partner organisation. Once both the clinic and CBO are happy with the agreement, two copies of the MOU should be signed by both parties, and a final copy should be given to each organisation.

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) sets forth the terms and understanding between _____ and _____ to collaborate on _____.

Shared interests

Key priority area

Partnership type

Roles and responsibilities

Activity	Partner 1	Partner 2		
Decision-making				
Scheduling meetings				
Day-to-day activities				

Funding

Duration

Contact information and signatures

EXAMPLE



GANTT CHART

Time allowed: 2-3 hours

Participants: Members of the partnership

Materials required: Template Gantt chart copied from the back of this toolkit

HOW TO USE THIS TOOL

One of the tools used by project planners is a Gantt chart. (It is called a Gantt chart because it was designed by an engineer named Henry Gantt in the 1910s.) One of the benefits of a Gantt chart is that you can see how some actions and activities will overlap with others over the course of a project.

You can either assign the Gantt chart to one or two members of your project team and then review the draft chart as a team, or you can fill out the chart together in a joint planning session.

Activity	Actions	Responsible Person	Month 1				Month 2				Month 3			
			1	2	3	4	5	6	7	8	9	10	11	12
Project Management														
PIW														
Select Key Priority Areas														
Activity 1														
Activity 2														
Activity 3														



BUDGET TEMPLATE

Time estimated: 2-3 hours

Participants: “Accountable” members of the partnership team

HOW TO USE THIS TOOL

Work with your partner to brainstorm the categories of resources that you will need for your project. The word cloud is just an illustration – your list will be unique to your project. Once you have completed your brainstorm, you should identify what is or could be available to you.

Activity	Item	Units	Quantity	# of Units	Unit Cost	Total Cost
Activity 1:	STAFF					
	PROGRAMME MANAGER	MONTH	12	1	R20,000	R240,000
	TRAINERS					
	COMMUNITY HEALTH WORKERS					
		SUBTOTAL				
Activity 2:						
		SUBTOTAL				
TOTAL						



KICK-OFF MEETING SAMPLE AGENDA

Time allowed: 2-3 hours

Participants: All current and future staff members who will be involved in the project, as well as key members of the partnership

Materials required: Printouts of the key partnership documents

HOW TO USE THIS TOOL

Work with your partner to develop an agenda for your 'kick-off' meeting. The agenda below is just an example. You can include agenda items that are useful for your project.

AGENDA

Project name: _____

Partners: _____

Meeting date: _____

Meeting time: _____

Meeting location: _____

1. **Introductions:** brief introductions from the participants of the meeting, including their job title and role on the project
2. **Project overview:** a general overview of the project would include:
 - History of the partnership and project: why is this partnership and project needed?
 - Key priority area, what is the problem we want to address together, the project aim and success indicators
 - Supporters and funders of the project
3. **Project timeline:** high-level project plan
 - Activities and outputs
 - Workplan (GANTT chart) and timeline
 - Mechanisms for hosting regular meetings, sharing information, recording information, sharing data and reporting
4. **Project team roles & responsibilities:** distribute and discuss a list of project team members, their contact information, and roles/responsibilities. Don't forget to introduce the project manager if there is one.
5. **Next steps:** specific instruction about what is happening next, including what each person is expected to do
6. **Q&A**
7. **Gratitude:** express thanks for the team members and the roles that they are about to assume.

EXAMPLE



PROGRESS REPORT TEMPLATE

TIME ESTIMATED: 4 hours

PARTICIPANTS: 'Accountable' and 'Responsible' members of the partnership

HOW TO USE THIS TOOL

Complete the table for each project activity. Describe your progress for each activity. Choose a status for each activity (achieved, in progress, or not started).

Activity	
Status	Description/Notes
Progress	
What's working?	

APPENDIX 5

LIST OF CLINIC-COMMUNITY COLLABORATIONS

Country	Partnerships between
Kenya	Kenya Legal and Ethical Issues Network on HIV/AIDS (KELIN) and Kisumu Medical and Education Trust (KMET)
Kenya	OGRA Foundation and Muhoroni County Hospital
Kenya	Peer Support Project and Nyandiwa Sub-County Hospital
Kenya	SOTENI & Ambira sub-county Hospital
Kenya	Moving the Goalposts(MTG) and Ganze Health Centre
Kenya	MOCOWESO and Moi's Bridge Medical Clinic
Kenya	Kisumu Youth Olympic Centre(KYOC) and Migosi sub-county hospital
Kenya	WOFAK and Miniambo Health centre
Kenya	St Joseph Development Programmes and St Joseph Medical Centre
Zambia	Pride Community Health Organisation (PRICHO) and Chanyanya Health Facility
Zambia	Pride Community Health Organisation (PRICHO) and Chikupi rural Health facility
Zambia	Kabangwe Creative Initiative Association (KCIA) and Chazanga Health Centre
Zambia	Kabangwe Creative Initiative Association (KCIA) and Shifwankula Health Post
Zambia	Tiny Tim & Friends CBO AND Tiny Tim and Friends Clinic
Zambia	Tiny Tim & Friends CBO and George Clinic
Zambia	Mapalo Support Group and Chipulusuku Health Centre
Zambia	Chilanga Youth Awake (CYA) and Kazimva Clinic
Zambia	Latkings and Chawama 1st level hospital
Zambia	Ndola Nutrition Organisation (NNO) and Kawama Clinic

APPENDIX 6

REFERENCES

- 1 Armstrong, A., Iorpenda, K., Caswell, G., & Kihara, C. (2017). *Adolescent HIV Programming: READY – Here we come!*. International HIV/AIDS Alliance.
- 2 UNAIDS. *Global HIV & AIDS statistics: Fact Sheet 2019* [3 September 2018]. Available from: <http://www.unaids.org/en/resources/fact-sheet>.
- 3 UNAIDS. (2015). *All In to #EndAdolescentAIDS*. Retrieved from https://www.unaids.org/sites/default/files/media_asset/20150217_ALL_IN_brochure.pdf.
- 4 World Health Organization. (n.d.). *Maternal, newborn, child and adolescent health: adolescent health epidemiology*. Retrieved September 20, 2019 from https://www.who.int/maternal_child_adolescent/epidemiology/adolescence/en/.
- 5 Khalifa, A., Stover, J., Mahy, M., Idele, P., Porth, T., Lwamba, C. (2019). Demographic change and HIV epidemic projections to 2050 for adolescents and young people aged 15-24. *Global Health Action*, 12(1). Retrieved from <https://www.tandfonline.com/doi/full/10.1080/16549716.2019.1662685?scroll=top&needAccess=true>.
- 6 World Health Organization. (n.d.). *Maternal, newborn, child and adolescent health: HIV and youth*. Retrieved from https://www.who.int/maternal_child_adolescent/topics/adolescence/hiv/en/.
- 7 Shisana O et al. (2014). *South African national HIV prevalence, incidence and behaviour survey*. HSRC Press, 2014.
- 8 Bailey, H., Cruz, M., Songtaweasin, W. N., & Puthanakit, T. (2017). Adolescents with HIV and transition to adult care in the Caribbean, Central America and South America, Eastern Europe and Asia and Pacific regions. *Journal of the International AIDS Society*, 20(Suppl 3), 21475. doi:10.7448/IAS.20.4.21475
- 9 Govender, K., Masebo, W., Nyamaruze, P., Cowden, R. G., Schunter, B. T., & Bains, A. (2018). HIV Prevention in Adolescents and Young People in the Eastern and Southern African Region: A Review of Key Challenges Impeding Actions for an Effective Response. *The open AIDS journal*, 12, 53–67. doi:10.2174/1874613601812010053
- 10 Ibid.
- 11 WHO. *Adolescent pregnancy*. (23 February 2019). Retrieved from <https://www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy>
- 12 Ibid.
- 13 Guttmacher Institute and International Planned Parenthood Federation. (2010). *Facts on the sexual and reproductive health of adolescent women in the developing world*. Retrieved from <https://www.guttmacher.org/sites/default/files/pdfs/pubs/FB-Adolescents-SRH.pdf>
- 14 Guttmacher Institute. (2018). *Adding It Up: Costs and benefits of meeting the contraceptive needs of adolescents in developing regions*. Fact Sheet. Retrieved from <https://www.guttmacher.org/fact-sheet/adding-it-meeting-contraceptive-needs-of-adolescents>.
- 15 Maskew, M., Bor, J., Macleod, W., Carmona, S., Sherman, G., & Fox, M. (2019). Adolescent HIV Treatment in South Africa's National HIV Programme: A Retrospective Cohort Study. *The Lancet HIV*, 6(11), e760-e768. doi: 10.1016/S2352-3018(19)30234-6
- 16 Ibid.
- 17 UNAIDS. (2019). *Communities at the centre: defending rights, breaking barriers, reaching people with HIV services*. Retrieved from https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf
- 18 Ibid.
- 19 Mark, D., Chorlton, H., Kemp, D., Ronan, A., Bloch, K., Burdock, T., & Hatane, L. (2018). Clinic-CBO Collaboration (C3) Programme: linking health facilities and communities for improved PMTCT and paediatric HIV outcomes. Retrieved from <http://teampata.org/wp-content/uploads/2018/07/2017-ICASA-poster.pdf>.
- 20 World Health Organization. (2013). *HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV*. Retrieved from <https://www.who.int/hiv/pub/guidelines/adolescents/en/>.
- 21 World Health Organization. (2017). *WHO recommendations on adolescent health*. Retrieved from https://www.who.int/maternal_child_adolescent/documents/adolescent-health-recommendations/en/.
- 22 Chorlton, H., et al. (2019).
- 23 Armstrong, A. et al.
- 24 World Health Organization and UNAIDS. (2015). *Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents*. Volume 1: Standards and criteria. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol1_eng.pdf;jsessionid=DA25ED6B25BD9FE80876D54BA781EB81?sequence=1

- 25 Barker, G. (2007). Adolescents, social support and help-seeking behaviour: an international literature review and programme consultation with recommendations for action. World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/43778/9789241595711_eng.pdf?sequence=1&isAllowed=y.
- 26 Govender et al. (2018)
- 27 WHO and UNAIDS (2015).
- 28 Ibid.
- 29 Ibid.
- 30 WHO. (2016). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*.
- 31 Rakhmanova, N. & Bouchet, B. (2017). *Quality Improvement Handbook: A Guide for Enhancing the Performance of Healthcare Systems*. Durham, NC: FHI 360, 16. Retrieved from <https://www.fhi360.org/sites/default/files/media/documents/resource-quality-improvement-handbook-health-systems.pdf>
- 32 Maticka-Tyndale, E., & Barnett, J. P. (2010). Peer-led interventions to reduce HIV risk of youth: a review. *Evaluation and program planning*, 33(2), 98-112.
- 33 Ibid.
- 34 Willis, N., Milanzi, A., Mawodzeke, M., Dziwa, C., Armstrong, A., Yekeye, I., ... & James, V. (2019). Effectiveness of community adolescent treatment supporters (CATS) interventions in improving linkage and retention in care, adherence to ART and psychosocial well-being: a randomised trial among adolescents living with HIV in rural Zimbabwe. *BMC public health*, 19(1), 117.
- 35 Grimsrud, A., Walker, D., Ameyan, W., & Brusamento, S. (2018). Providing differentiated delivery to children and adolescents. *Approaching 2020: Scaling up key interventions for children and adolescents living with HIV*, 1-4.
- 36 International AIDS Society (2017). *Differentiated care for HIV: A decision framework for differentiated antiretroviral therapy delivery for children, adolescents and pregnant and breastfeeding women*. Retrieved from http://www.differentiatedcare.org/Portals/0/adam/Content/9ErJtsSfUmj_Ska6BoNOQ/File/Decision%20Framework%20for%20children%20adolescents%20and%20pregnant%20and%20breastfeeding%20women.pdf
- 37 UNAIDS. (2018). *Country: Zimbabwe: Overview*. Retrieved from <https://www.unaids.org/en/regionscountries/countries/zimbabwe>
- 38 Government of Zimbabwe. (2015). *Zimbabwe demographic and health survey*. Retrieved from <https://dhsprogram.com/pubs/pdf/FR322/FR322.pdf>.
- 39 Willis N., Dziwa C., Mawodzeke, M., et al. (2015). *An operations research study to measure the effectiveness of the CATS service in Gokwe South District*.
- 40 Willis, N., Napei, T., Armstrong, A., Jackson, H., Apollo, T., Mushavi, A., Ncube, G., & Cowan, F.. (2018). Zvandiri—Bringing a differentiated service delivery program to scale for children, adolescents and young people in Zimbabwe. *J Acquir Immune Defic Syndr* 78(2). Retrieved from https://docs.wixstatic.com/ugd/72d-40f_8fafd9b0e50f4b3199754b8d136c656a.pdf
- 41 DSD policy brief, p. 8 <http://www.differentiatedservicedelivery.org/Portals/0/adam/Content/m2Hhms-MUEEis01eU-igdnA/URL/Zvandiri%20Trial%20Policy%20Brief%207%20August%202019.pdf>
- 42 Unitaid (2017, July 24) World's largest HIV self-testing initiative expands in critical new phase. Retrieved from <https://unitaid.org/news-blog/worlds-largest-hiv-self-testing-initiative-expands-critical-new-phase/#en>
- 43 Wong, V.J., Ford, N., & Agot, K.. (2019). Realizing the potential of HIV self-testing for Africa: lessons learned from the STAR project. *Journal of the International AIDS Society*. 22(1). Retrieved from http://teampata.org/wp-content/uploads/2019/03/JIAS_Vol22-Realizing-the-potential-of-HIV-self-testing-for-Africa.pdf
- 44 Hatzold, K., Corbett, E., Ingold, H., Mwerinde, O., Osigbesan, A., Ross, A.L., Zintzmeyer, S., Baggaley, R., & Johnson, C. (2018). *Knowing your status—then and now: realizing the potential of HIV self-testing*. STAR Initiative, Unitaid and World Health Organization. Retrieved from <https://unitaid.org/assets/STAR-Initiative-Report-Knowing-your-status%E2%80%93then-and-now.pdf>
- 45 Indravudh, P. P., Sibanda, E. L., d'Elbée, M., Kumwenda, M. K., Ringwald, B., Maringwa, G., & Terris-Prestholt, F. (2017). 'I will choose when to test, where I want to test': investigating young people's preferences for HIV self-testing in Malawi and Zimbabwe. *AIDS*, 31(Suppl 3).
- 46 Monroe A, NakigoziG, DdaakiW, BazaaleJM, GrayRH, WawerMJ, et al. Qualitative insights into implementation, processes, and outcomes of a randomized trial on peer support and HIV care engagement in Rakai, Uganda. *BMC Infect Dis*. 2017;17(1):54. Available from: <http://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-016-2156-04>. Bradford, Judith B., Sharon Coleman, and William Cunningham. "HIV System Navigation: an emerging model to improve HIV care access." *AIDS Patient Care STDs* 21.S1 (2007): S-49.
- 47 International HIV/AIDS Alliance. (2016). *Link Up project summary: empowering young people to take control of their sexual and reproductive health and rights*. Retrieved from https://frontlineaids.org/wp-content/uploads/old_site/link_up_newsletter_interactive_final_low-res_original.pdf?1474977190
- 48 Vu, L., Burnett-Zieman, B., Banura, C., Okal, J., Elang, M., Ampwera, R., ... & Yam, E. (2017). Increasing uptake of HIV, sexually transmitted infection, and family planning services, and reducing HIV-related risk behaviors among youth living with HIV in Uganda. *Journal of Adolescent Health*, 60(2), S22-S28.

- 49 Population Council. (2016, May). *Using peers to improve sexual and reproductive health and rights of young people living with HIV in Uganda: findings from a Link Up evaluation*. Retrieved from https://www.popcouncil.org/uploads/pdfs/2016HIV_LinkUp_UgandaEndlineBrief.pdf
- 50 Elizabeth Glaser Pediatric AIDS Foundation. (2016). *The Red Carpet Program: Improving linkage to care and optimizing early retention of adolescents with newly identified HIV infection in Homa Bay County, Kenya*. Retrieved from http://www.pedaids.org/wp-content/uploads/2017/11/ViiV_Red_Carpet_Launch_Brief1.pdf.
- 51 Ruria, E.C., Masaba, R., Kosea, J., Woelk, G., Mwangi, E., Matu, L., Ng'eno, H., Bikeri, B., Rakhmanina, N. (2017). Optimizing linkage to care and initiation and retention on treatment of adolescents with newly diagnosed HIV infection. *AIDS* 2017 (31) Suppl 3, S253-S260. Retrieved from https://www.pedaids.org/wp-content/uploads/2017/12/Optimizing_linkage_to_care_and_initiation_and.8.pdf.
- 52 Stats SA. (2019). Statistical release: mid-year population estimates, 2019. Retrieved from <http://www.statssa.gov.za/publications/P0302/P03022019.pdf>.
- 53 MacKenzie, R.K., van Lettow, M., Gondwe, C., Nyirongo, J., Singano, V., Banda V., et al. Greater retention in care among adolescents on antiretroviral treatment accessing “Teen Club” an adolescent-centred differentiated care model compared with standard of care: a nested case-control study at a tertiary referral hospital in Malawi. *J IntAIDS Soc.* 2017 Nov;20(3):e25028. Available from: <http://doi.wiley.com/10.1002/jia2.25028>
- 54 Oris, L., Seiffge-Krenkel, Moons, P., Goubert, L., Rassart, J., Goossens, E., et al. Parental and peer support in adolescents with a chronic condition: a typological approach and developmental implications. *J BehavMed.* 2016;39(1):107–19.
- 55 PEPFAR. (2018, November 216). *Operation Triple Zero: empowering adolescents and young people living with HIV to take control of their health in Kenya*. Retrieved from <https://www.pepfarsolutions.org/solutions/2018/10/30/operation-triple-zero-empowering-adolescents-and-young-people-living-with-hiv-to-take-control-of-their-own-health>.
- 56 Ibid.
- 57 Ibid.
- 58 Ministry of Health, Zambia. (February 2019). *Zambia Population-based HIV Impact Assessment (ZAMPHIA) 2016: Final Report*. Retrieved from https://phia.icap.columbia.edu/wp-content/uploads/2019/02/ZAMPHIA-Final-Report_2.22.19.pdf.
- 59 Extracted from Keye, G & Resnick, I., *The Six R's of Participation*, New Jersey: Community Development Consultants. http://www.transformcommunities.org/sites/default/files/six_rs_of_participation_0.pdf
- 60 Mark, D. et al (2018). *Clinic-CBO Collaboration (C³) Programme: linking health facilities and communities for improved PMTCT and paediatric HIV outcomes*. Retrieved from <http://teampata.org/wp-content/uploads/2018/07/2017-ICASA-poster.pdf>.
- 61 Mark., D. et al. (2018).
- 62 Chorlton, H., Ndlovu, L., Mark, D., Ronan, A., Hatane, L.. (2019). *From overlooked to recognized: building community partnerships in the era of treat all*. PATA. Retrieved from http://teampata.org/wp-content/uploads/2019/06/InterestPoster_digital.pdf.
- 63 Gorter, A., Omollo, R., Mayanja, L., Omari, A. & Parker, A. (2018). Are vouchers for adolescent sexual and reproductive health services an effective intervention and if so, why? A literature review and assessment of two adolescent voucher programmes. Marie Stopes International. Retrieved from https://www.researchgate.net/publication/329680533_Are_vouchers_for_adolescent_sexual_and_reproductive_health_services_an_effective_intervention_and_if_so_why_A_literature_review_and_assessment_of_two_adolescent_voucher_programmes
- 64 Ombija, M. (n.d.) *Linking Newly Identified Youth to Care*. Elizabeth Glaser Pediatric AIDS Foundation. Retrieved from http://regist2.virology-education.com/presentations/1stHIVAdolescent/13_Ombija.pdf
- 65 Gorder, A. et al 2018.
- 66 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). *Combination HIV prevention: tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections*. Retrieved from https://www.unaids.org/en/resources/documents/2010/20101006_JC2007_Combination_Prevention_paper

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