Best Practices for Adolescent- and Youth-Friendly HIV Services

A Compendium of Selected Projects in PEPFAR-Supported Countries

March 2017

TR-16-134

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation

Best Practices for Adolescent- and Youth-Friendly HIV Services

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-16-134

ISBN: 978-1-9433-6439-8

USAID FROM THE AMERICAN PEOPLE PEPFAR MEASURE Evaluation

ACKNOWLEDGMENTS

We thank all those who submitted proposals or helped to finalize the entries that MEASURE Evaluation compiled. We are grateful to the USAID technical advisors Annaliese Limb and Kristen Wares for their contributions to and participation in the Best Practices Proposal Review Group.

Cover photo: A young boy celebrates his graduation from an HIV awareness class at the Mekelle Youth Center, in northern Ethiopia. The Mekelle Youth Center serves the local community through teaching HIV awareness, English, and computer skills, as well as offering a Girls Club and a sports program.

CONTENTS

ABBREVIATIONS

ALHIV	adolescents living with HIV
AYLHIV	adolescents and youth living with HIV
AMPATH	Academic Model Providing Access to Healthcare
AMREF	African Medical and Research Foundation
ART	antiretroviral therapy
AYLWH	adolescents and youth living with HIV
BCC	behavior change communication
BOCAIP	Botswana Christian AIDS Intervention Program
CAPRISA	Centre for the AIDS Program of Research in South Africa
CATS	community adolescent treatment supporters
CBOV	community-based outreach volunteer
CBVCT	community-based VCT
CeSSHAR	Centre for Sexual Health and HIV AIDS Research
CI	confidence interval
CIPRA	Comprehensive International Program of Research on AIDS
CCC	comprehensive care clinic
CDC	Centers for Disease Control and Prevention
CYPLHIV	children and young people living with HIV
DRC	Democratic Republic of Congo
DREAM	Drug Resource Enhancement against AIDS and Malnutrition
EDARP	Eastern Deanery Aids Relief Program
FACES	Family AIDS Care and Educational Services
FGD	focus group discussion
GBV	gender-based violence
HCP	healthcare provider
HTC	HIV testing and counseling
HIV	human immunodeficiency virus
JSI	John Snow, Incorporated
LVCT	Liverpool VCT, Care, and Treatment
M&E	monitoring and evaluation
MCDMCH	Ministry of Community Development Mother and Child Health
MOH	Ministry of Health
MoHCC	Ministry of Health and Child Care
MoPSLSW	Ministry of Public Services Labour and Social Services
MSM	men who have sex with men
MTRH	Moi Teaching and Referral Hospital
MVCT	mobile voluntary counseling and testing
NIMR	National Institute for Medical Research
NGO	nongovernmental organization
NORAD	North American Aerospace Defense Command
OI	opportunistic infection
OIDP	One2One Digital Platform
OR	odds ratio
OVC	orphans and vulnerable children
PAHO	Pan American Health Organization
PCT	posttest clubs
PEGE	Portal for Gender Equality in Schools (*Portal Equidade de Gênero nas Escolas*)
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	provider-initiated counseling and testing

PLWH	people living with HIV
PMTCT	prevention of mother-to-child transmission
PPPY	per patient per year
PS Kenya	Population Services Kenya
PSC	patient support center
PSI	Population Services International
PSS	psychosocial support
PTSS	posttest support services
RCTP	Research Care and Training Program
RH	reproductive health
SOP	standard operating procedure
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
SSA	sub-Saharan Africa
STI	sexually transmitted infection
SVCT	standard clinic-based VCT
SYMPA	Supporting Youth and Motivating Positive Action
TB	tuberculosis
UCSF	University of California San Francisco
UMATI	Chama Cha Uzazi na Malezi Bora –Tanzania
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
VIP	very important person
VMMC	voluntary male medical circumcision
VSL	village savings and loans
WHO	World Health Organization
YLWH	youth living with HIV
ZDHS	Zambia Demographic and Health Survey
ZIMSTAT	Zimbabwe National Statistics Agency

EXECUTIVE SUMMARY

Adolescents (ages 10-19) and youth (ages 15-24) bear a disproportionate share of the HIV burden, especially in sub-Saharan Africa. However, little is known about what projects are doing to make their interventions adolescent- and youth-friendly and which interventions are effective for changing HIV-related outcomes in this age group. Program managers and policymakers have little evidence derived from rigorous studies on how best to invest resources to achieve 90-90-90 targets among adolescents/young people. In recognition of this evidence, gap, MEASURE Evaluation reviewed the evidence on adolescent- and youth-friendly HIV services as a contribution toward the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) goal of creating an AIDS-free generation. This review had three objectives: (1) document knowledge of what is working and what is not working in terms of delivering adolescent- and youth-friendly HIV services, and why strategies and program activities work or do not work; (2) identify useful lessons learned about key elements of successful adolescent- and youth-friendly HIV services; and (3) promote the use and adaptation of best practices for adolescent- and youth-friendly HIV services in order to improve the quality of HIV services delivered to young people.

Based on a call for proposals regarding best practices and a review of peer-reviewed/grey literature in 22 PEPFAR-supported countries, 13 projects are presented for which permission to publish summaries in the compendium was received. Projects were graded by a review group using well-established criteria. These criteria were adolescent and youth involvement, relevance, effectiveness/impact, reach, feasibility, sustainability, replicability or transferability, ethical soundness, and efficiency. Seven best practices, four promising practices, and two emerging practices were identified, of which five provided strong evidence needed to recommend priorities for action. Projects with best practices included: (1) Adolescent-Friendly Voluntary Medical Male Circumcision Project in South Africa; (2) Fútbol para la Vida (FPV) (Deportes para la Vida) in Dominican Republic; (3) Mema kwa Vijana in United Republic of Tanzania, (4) One2One Integrated Digital Platform in Kenya; (5) Supporting Youth and Motivating Positive Action (SYMPA) in Democratic Republic of Congo; (6) Program H in Ethiopia and Namibia; and (7) Zvandiri Project in Zimbabwe. Projects with promising practices included (1) Integrated Project against HIV/AIDS in Chibombo District, Zambia; (2) Project Accept in South Africa, United Republic of Tanzania, and Zimbabwe; (3) Sunbursts Project in Kenya; and (4) Toolkit and Training Manual for Transition of Care and Other Services for Adolescents with HIV (Kenya). Projects with emerging practices included: (1) Feel the Future, Malawi; and (2) Youth Voluntary Counseling and Testing, Botswana. The interventions these projects provided were classified into four groups based on common characteristics and choices program managers and policymakers might have to make when deciding what to do:

- Clinic-based interventions with or without a community component
- Clinic-based and school-based interventions with or without a community component
- Community-based interventions
- Mobile and web-based interventions

Making Projects Adolescent and Youth Friendly

At the program design and implementation levels, projects took several initiatives to make their interventions adolescent/youth friendly.

- Meaningful engagement of adolescents and youth in program design and implementation

- Increasing accessibility to services by extending services to after-school hours, establishing adolescent centers run trained by adolescents and youth within health facilities, and providing mobile HIV testing services in venues easily accessible to youth
- Affordable fees or free services (e.g., free HIV testing, free condoms, and free medical care for adolescents and youth living with HIV)
- Linkages between schools, youth clubs, youth corners, and other youth-friendly institutions
- Providing alternative ways of accessing information, counseling, or services (e.g., use of digital technologies through mobile or web-based platforms and cartoon videos)
- Training staff on provision of adolescent- and youth-friendly services
- Maintaining privacy and confidentiality (e.g., conducting mock circumcision for male adolescents and youth who test positive to maintain confidentiality and reduce stigma)
- Peer counseling on risk reduction, safer sex, voluntary counseling and testing for HIV, and adherence to antiretroviral drugs

Project Impact on Adolescent and Youth HIV-Related Outcomes

Five projects were categorized as having rigorous evaluation designs (experimental studies with random assignment to an intervention or control condition or quasi-experimental designs involving comparison groups without random assignment): Fútbol para la Vida, Mema kwa Vijana, Program H, Zvandiri project, and Project Accept. Based on the results of the impact evaluation, projects were categorized into five non-mutually exclusive groups:

- Effective for HIV-related and attitudinal outcomes (e.g., Mema kwa Vijana, Program H)
- Effective for HIV-related behavioral outcomes
    - Sexual behavior (MEMA kwa Vijana)
    - Condom use (MEMA kwa Vijana)
    - Intimate partner violence (Program H)
    - HIV testing (Project Accept)
    - Disclosure and ART adherence (Zvandiri project)
- Not effective for HIV-related behavioral outcomes
    - Sexual behavior (Project Accept)
- Effective for HIV-related biological outcomes
    - Clinical STI symptoms and signs (MEMA kwa Vijana)
- Not effective for HIV-related biological outcomes
    - HIV incidence and herpes simplex virus [HSV]-2 prevalence (MEMA kwa Vijana)

Eight projects used using nonrigorous or qualitative evaluation designs. In some cases, these projects found positive effects on HIV-related knowledge, attitudes, and behavioral outcomes. Non-rigorous designs are often cost-effective for establishing the need for and reach of an intervention and building the existing evidence base. However, progress in identifying effective strategies for meeting the HIV-related

needs of adolescents and youth is dependent on the use of more rigorous methods for determining what works, how long, and for whom.

Lessons Learned by Projects

- Clinic-based interventions with or without a community component:
    - When implementing curricula among HIV-positive youth, it is to be noted that the educational level of participants can be variable. Outside of school-based settings, specific activities requiring written responses would need to be adapted for adolescents and youth who are unable to write (SYMPA project).
    - To manage the unique needs of adolescents and youth who are living with HIV, individualized transition-to-adult care programs must be built (Toolkit and Training Manual).
    - In a context where few health facilities offer HIV services that are tailored to adolescents and youth, counselors are able to reach more adolescents and youth during mobile testing as opposed to fixed-site service delivery (Project Accept and Youth VCT [Voluntary Counseling and Testing] Project).

- Clinic-based and school-based interventions with or without a community component:
    - Community involvement and consultations are critical for creating an enabling environment for recruitment of in-school adolescents for VMMC services (Adolescent-friendly VMMC project).
    - A single training during scale-up of a school-based curriculum appears to be insufficient to impart skills required for teaching the psychosocial aspects of the curriculum. Systematic pre-service training of teachers would be more cost-efficient (MEMA kwa Vijana).

- Community-based interventions:
    - Involvement of local people and community-based governmental and nongovernmental organizations is critical to success in improving HIV-related knowledge and attitudes among adolescents and youth (Fútbol para la Vida/Deportes para la Vida).
    - If HIV testing services are provided in convenient and accessible locations such as markets, churches, community and shopping centers, and transportation hubs, adolescents and youth will make use of the services and new populations not serviced by facility-based services can be reached (Project Accept).
    - There is no magic bullet for community mobilization. Strategies used in varying combinations included stakeholder buy-in, community coalition building, direct community engagement, community participation in project-related activities, raising community awareness, involving community leaders, and creating partnerships with local organizations (Project Accept).

- Mobile and web-based interventions:
    - Mobile platforms are a crucial delivery point for adolescents and youth because these age groups favor them and because they are anonymous. Anonymity makes it easier for

adolescents and youth to ask questions and seek advice about health issues (One2One Digital Platform [OIDP]).

Additional Considerations

- Programs should document their activities in detail to clarify what is being done and the expected outcomes.
- Most programs need high-quality monitoring and impact evaluation of interventions among adolescents and youth. Where possible, future evaluations should use randomized or quasi-experimental designs to strengthen the level of evidence.
- More research is needed on the best practices are for engaging adolescents and youth in planning, implementing, and evaluating HIV-prevention, care, treatment, and retention services.
- Studies are needed to identify features or characteristics that increase the effectiveness of adolescent- and youth-friendly HIV programs.
- Programs need to make substantial investment in providing estimates of program efficiency and estimates of cost-effectiveness. These data were lacking (or not in the public domain) for most projects included in this compendium.
- During scale-up of adolescent- and youth-friendly interventions that have been proven to be effective, attention must be paid to maintaining intervention quality (e.g., providing a supportive implementation infrastructure, ongoing capacity strengthening activities for program implementers, and increased attention to supportive supervision and monitoring).
- Assessment of the long-term impact of programs is needed. MEMA kwa Vijana, one of the most rigorously evaluated and document programs, had only a limited effect on reported sexual behaviors and no effect on HIV and HSV-2 prevalence at the nine-year follow-up.
- Adequate funding must be allocated for rigorous impact evaluation, for assessments of program efficiency, and for strengthening the methodological expertise of implementing partners and research staff in PEPFAR-supported countries.

INTRODUCTION

Globally, an estimated 35 million people were living with HIV at the end of 2013 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014). Although new HIV infections continue to decline globally, in 2013, young people (15–24 years old) accounted for a substantial share of people estimated to be newly infected with HIV globally. At the end of 2013, more than 15 percent of women living with HIV ages 15 years and older were young women 15 to 24 years old, of whom 80 percent lived in sub-Saharan Africa (UNAIDS, 2014). Substantial differences in the prevalence of HIV are seen between young men and young women. In sub-Saharan Africa, for example, women ages 15 to 24 years acquire HIV infection at least 5 to 7 years earlier than their male counterparts and are twice as likely as to be living with HIV (UNAIDS, 2014). In many countries supported by the PEPFAR, large numbers of young people are already living with HIV. Owing to the availability of antiretroviral drugs, HIV-positive infants are surviving into adolescence. Even as the number of new infections among young people has declined worldwide since 2001, the proportion of young people who have received an HIV test and learned the result has increased worldwide since 2000, HIV testing rates in sub-Saharan Africa have remained low, with only 15 percent of adolescent girls and young women ages 15 to 24 being aware of their HIV status (UNAIDS, 2014).

One of the action steps in PEPFAR's goal for an AIDS-free generation is to "encourage implementing partners providing pediatric and adult treatment and care, as well as PMTCT [prevention of mother-to-child transmission], to adopt evidence-based best practices in youth-friendly healthcare and services" (U.S. Agency for International Development [USAID], 2012a, p.35). To achieve this objective, it is important to identify and document best practices for adolescent- and youth-friendly HIV services. Without an understanding of best practices for adolescent- and youth-friendly HIV services, and of barriers to and facilitators of the use of HIV services by adolescents and youth, especially adolescent girls, it would be challenging for countries to maximize the impact of core HIV prevention, treatment, and care interventions that have been scaled up. It would also be difficult to achieve the UNAIDS 90-90-90 targets among adolescents and youth. These 90-90-90 targets are that by 2020, 90 percent of all people living with HIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART), and 90 percent of all people receiving ART will have viral suppression (UNAIDS, 2014).

The goal of this compendium is to answer critical questions that move forward USAID's mission of supporting (a) the adoption of evidence-based practices in adolescent- and youth-friendly HIV care and services to help at-risk adolescents (ages 10–19 years) and youth (ages 15–24 years) stay HIV-free, and (b) the provision of comprehensive packages of HIV prevention, care, treatment, and retention services to adolescents and youth living with HIV in order to promote their successful transition to adulthood. The objectives were:

- To document knowledge of what is and is not working in terms of delivering adolescent- and youth-friendly HIV services, and why strategies and program activities work or do not work
- To identify useful lessons learned about key elements of successful adolescent- and youth-friendly HIV services
- To promote the use and adaptation of best practices for adolescent- and youth-friendly HIV services in order to improve the quality of HIV services delivered to young people

It is hoped that other organizations may be able to learn from the programs and strategies described in this compendium to inform the development and implementation of similar approaches to adolescent- and youth-friendly service provision.

METHODS

MEASURE Evaluation issued a call for best practices for adolescent- and youth-friendly HIV services in May 2015. This environmental scan focused on persons ages 10 to 24 years in 22 PEPFAR-supported countries: Botswana, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Haiti, Jamaica, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. The call was disseminated through the following listservs: AF-AIDS, AfrEA, Afro-Nets, AIDSFree, Ethiopia HIV and AIDS Resource Center, Nigeria-AIDS, SAfAIDS, KCA AIDS, Sexual and Reproductive Health e-Group, HIF-NET, Interagency Gender Working Group (IGWG), CLICK4HP, Global HIV M&E Information, ProNut-HIV, SEA-AIDS, Monitoring and Evaluation, Young People's Sexual and Reproductive Health, CHILD2015, CS Community, Interagency Youth Working Group, ProCAARE, The Communication Initiative Network, and M2Front. The call was also disseminated to the Office of HIV/AIDS, USAID Missions, and the USAID/Washington Youth listservs (youthcorps and youthmissionmaillist). In addition, the call was translated into French and issued to organizations in Francophone Africa upon request. The best practices proposal submission form is included in the Appendix.

Due to the relatively low response received, MEASURE Evaluation conducted literature searches in PUBMED and OVID between September and December 2015. Searches were limited to the 22 PEPFAR-supported countries listed above, with key word search teams focusing on four variables: (1) *adolescent*: adolescent*, teen*, youth*; (2) health services: health service*, healthcare, medical care, male circumcision; (3) *HIV and AIDS*; (4) *existing adolescent programming*: social marketing, intervention*, best practice*, program*, health promotion, health education, HIV infection/prevention/control, prevention. (The asterisk denotes that any variation of the word was included in the search.) Adolescence was defined as 10 to 19 years, and youth as ages 15 to 24 years, in accordance with World Health Organization (WHO) guidelines (WHO, 2008). Articles were excluded if the projects were ended more than 15 years ago and/or if they did not include an intervention or were purely descriptive. Articles that focused solely on family planning were excluded. Through this process, MEASURE Evaluation was able to identify five potential "best practices" from the published literature. Authors of journal articles/unpublished manuscripts of identified potential "best practices" were contacted for additional information to supplement the best practice proposals compiled by MEASURE Evaluation from the peer-reviewed and gray literature.

A four-person review group was established to review submitted and compiled best practice proposals and determine where each practice fell along the continuum of levels of effectiveness and evidence of public health impact, from "emerging" to "promising" and "best" practices based on the following criteria: adolescent/youth involvement, relevance, effectiveness/impact, reach, feasibility, sustainability, replicability/transferability, ethical soundness, and efficiency. These criteria were modified from the WHO guidelines for documenting and sharing best practices (WHO, 2008). During the review process, the group met regularly to discuss each proposal and practice and compare notes on each of the criteria. Group members were not required to reach consensus or change their ratings based on comments from other members.

The rating criteria and cut-off points for emerging, promising, and best practices are presented in Table 1. Final ratings for each practice were based on the average ratings of individual review group members. MEASURE Evaluation notified authors of identified/submitted practices of the results of the

review/evaluation of the practice and provided suggestions as to how their proposal could be strengthened if they were to participate in a future call for best practices proposals. MEASURE Evaluation also requested updated contact information, content, and references for each submitted/identified best practice proposal and sought permission from authors to publish information about their projects in the compendium. Permission was obtained from all but one submitted/identified best practice proposal.

Table 1. Criteria score cut-off guidance

Criteria	Emerging	Promising	Best
Youth involvement	1	2	3-4
Relevance	1	2	3-4
Effectiveness/impact	1	2	3-4
Reach	1	2	2-4
Feasibility	1	2	3-4
Sustainability	1	2	2-4
Replicability	1	2	2-4
Ethical soundness	1	2	3-4
Efficiency	1	2	3-4
Total	9-17	18-23	24-36

The projects described in this compendium are organized according to whether they were categorized as best practices, promising practices, or emerging practices based on the available information. We have provided complete contact information for each practice where possible so that end users can get additional information on practices that are of interest. Also where possible, each practice contains a section on references/related documentation in which end users can find bibliographic references for obtaining more information. When adapting ideas from best practices, it is recommended that end users consider the criteria presented in Table 1, as well as other factors such available resources, feasibility, collaboration/integration, and the social, cultural, physical, and political environment which may influence the acceptability/adaptability of a practice in a given setting.

RESULTS

Overall, the review revealed a lack of recent, rigorously evaluated projects focusing on delivery of HIV prevention, care, and treatment services to adolescents and youth in PEPFAR-supported countries. The topics most commonly addressed by the thirteen programs included in this compendium were sexual/HIV education (9), peer education (9), and prevention, safe sex, and risk-reduction counseling (9). The topics least commonly addressed were voluntary medical male circumcision (VMMC) (1), and antenatal/postnatal/delivery care and prevention of mother-to-child transmission (PMTCT) of HIV (1). HIV treatment with antiretroviral drugs and HIV-related opportunistic infection prophylaxis and treatment were each addressed by two programs. Most programs addressed adolescents and youth in the general population (12) and those who were in school (12). No programs served incarcerated or transgender adolescents and youth. Two programs served female sex workers and an equivalent number served refugee and displaced adolescents and youth.

Project Approaches

Descriptions of projects included in this compendium are presented in Table 2. The projects fall into four groups:

- **Clinic-based projects with or without a community component:** These projects included the Supporting Youth and Motivating Positive Action (SYMPA) positive prevention project in the Democratic Republic of Congo (DRC), the Zvandiri project in Zimbabwe, the Toolkit for Transition of Care and Other Services for Adolescents Living with HIV (ALHIV) and Training Manual for Health and Community Care Providers (hereafter referred to as Toolkit and Training Manual) in Kenya, and the Youth Voluntary Counseling and Testing (VCT) project in Botswana. In general, these projects sought to increase access to and use of VCT and ART services among adolescents and youth, contribute to the decline of HIV infections, and improve the quality of life of HIV-affected youth. In addition, the SYMPA project sought to address youth's developmental needs and help them cope with HIV in the context of their emerging independence and sexuality. While most projects tended to focus on health outcomes among adolescents and youth, the target audience for Toolkit and Training Manual was not only adolescents and youth living with HIV but also health and community care providers, families, and caregivers. The objectives of this project were to provide a framework to track and measure an adolescent's/youth's transition to self-care and adult-focused services, as well as tailor a package of holistic care, support, and treatment services for ALHIV.
- **Clinic- and school-based projects:** These projects included the Adolescent-friendly VMMC project in South Africa, Feel the Future in Malawi, and MEMA kwa Vijana in Tanzania, with the latter two projects also including a community-based component. These projects sought to prevent sexually transmitted infections (STIs)/HIV among adolescents and youth and increase their uptake of health services (STI and family planning services in the case of MEMA kwa Vijana, and free medical care and treatment for ALHIV in the case of Feel the Future). The Adolescent-friendly VMMC project assessed the feasibility, accessibility, and uptake of VMMC services when combined with novel demand-creation strategies among high school students. The objectives of MEMA kwa Vijana were to delay sexual debut among youth, reduce the number of sexual partners among those who were sexually active, promote the correct and consistent use of condoms among those who are sexually active, and increase the uptake of STI and family planning services. Feel the Future sought to combat, among other things, stigma and discrimination by creating an inclusive network around and promoting a welcoming approach towards adolescents and youth living with HIV (AYLHIV). Each clinic and school-based project included a training component for adolescents and youth, facility- and community-based health workers, and teachers.

Table 2. Description of interventions included in the compendium

Study Location and Program	Type	Target Population	Description
BEST PRACTICES			
South Africa: Adolescent-Friendly Voluntary Medical Male Circumcision (VMMC)	Clinic- and school-based	In-school male adolescents ages 16–20 years in rural areas	• Community consultation and engagement • In-school VMMC awareness sessions and service access facilitation • Health facility-based HCT and VMMC service access • Peer recruitment
Dominican Republic: Fútbol para la Vida (FPV) (Deportes para la Vida)	Community-based	Mobile and migrant, street, in-school, and out-of-school adolescents and youth; orphans and vulnerable children in rural and urban areas	• Bilingual Spanish/Haitian Kreyol soccer camps and courses • Training-of-trainer workshops for community-based peer educators (local *batey* soccer players), local nongovernmental organization (NGO) staff, public schools, and health programs • Support for youth camps, soccer tournaments, and other outreach opportunities
United Republic of Tanzania: MEMA kwa Vijana	Clinic-, school-, and community-based	Adolescents ages 12–19 years in rural areas	• Teacher-led, peer-assisted sexual health education curriculum in schools • Youth-friendly health services • Community-based condom promotion and distribution by youth • Community activities (e.g., youth health weeks)
Kenya One2One Integrated Digital Platform (OIDP)	Mobile and web-based	Adolescents and youth ages 10–24 years in six HIV high-burden counties	• Mobile-based sexual and reproductive health (SRH)/HIV/gender-based violence (GBV) services • Provision of health information and counseling through web-based platforms • Engagement of AYLHIV and key populations in message development • Toll-free hotline
Democratic Republic of Congo: Supporting Youth and Motivating Positive Action (SYMPA)	Clinic-based	Youth living with HIV (YLWH) ages 15–24 years seeking care at a clinic in Kinshasa	• Positive prevention curriculum development and implementation • Monthly peer education sessions • Peer support groups
Ethiopia and Namibia: Program H	Community-based	Young men ages 15–24 years	• Validated curriculum and educational video for promoting attitude and behavior change among men

			• Lifestyle social marketing campaign for promoting changes in community or social norms related to what it means to be a man • Group discussions to promote critical dialogue and reflection about gender norms for young men
Zimbabwe: Zvandiri Project	Clinic- and community-based	Adolescents and youth 15–24 years	• Monthly community-based support groups run by trained facilitators (including AYLHIV) • Community outreach conducted by a multidisciplinary team (an HIV clinician, nurse, counselors, a social worker, a psychologist, and a network of community adolescent treatment supporters [CATS]) • Peer counseling by trained ALHIV ages 17–23 years in clinics and through home visits. • Establishment of clinic-based adolescent/youth Zvandiri Centres run by CATS • Community-based HIV testing and counseling (HTC) for children and young people • Caregiver training by CATS to improve their understanding of the needs and experiences of the adolescents in their care • Multimedia advocacy campaigns and participation in policy and guidelines development by Zvandiri adolescents and youth • Provision by Zvandiri Youth of training and mentorship for health workers, social workers, and community organizations to strengthen the integration of psychosocial support and clinical care
PROMISING PRACTICES			
Zambia: Integrated Program Against HIV/AIDS in Chibombo District	Community-based	Adolescents and youth ages 15–24 years in six rural communities	• Peer educator training in life skills education, behavior change communication, and psychosocial support for OVC • Peer-led social mobilization and awareness raising on HIV/AIDS/STI prevention, and gender issues related to child abuse, rape, and early marriage • Income-generating activities for caregivers
Zimbabwe, Tanzania, and South Africa: Project Accept	Community-based	Ages 16–32 years in urban and rural areas	• Community mobilization (volunteer recruitment, integration of HIV-infected and uninfected people around educational, social, and political goals, community events) • Community-based VCT (free HIV testing, post-test counseling, free male and female condoms to those who tested)

			• Community-based post-test support services (information-sharing group sessions; psychosocial support groups; crisis counseling; coping effectiveness training; and stigma-reduction workshops)
Kenya: Sunbursts Project	Community-based	Children ages 6–9 years and adolescents ages 10–14 and 15–19 years in urban areas	• Peer-led community support group program (open discussion, educational lessons, artistic and therapeutic activities, games and role-playing) • Family social events • Community outreach for stigma reduction • Summer camp program for children living with life threatening illnesses
Kenya: Toolkit and Training Manual for Transition of Care and Other Services for Adolescents Living with HIV	Clinic-based	Healthcare providers and AYLHIV	• Development of toolkit and training manual • Pilot of toolkit • Comprehensive training conducted for healthcare and community care providers in four sites • Monthly supportive supervision visits • Adaptation of toolkit to local contexts
EMERGING PRACTICES			
Malawi: Feel the Future: A Strategy to Fight the Stigma and Discrimination Related to the HIV/AIDS Epidemic among Adolescents: Experience from the DREAM Program Community of Sant'Egidio	Community-based	AYLHIV	• Direct counseling of AYLHIV • Dedication of physical space at DREAM (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) health centers for AYLHIV • Creation of age-based support groups for AYLHIV (ages 11–16, 17–20, and 20–24 years) • Community-based activities to combat stigma and discriminations
Botswana: Youth Voluntary Counseling and Testing	Clinic-based	Adolescents and youth in the general population	• HIV testing and counseling • Support for ongoing counseling and social support • Referrals for family planning or CD4+ testing • Continuous education, behavior change communication campaign to increase awareness • Post Test Clubs for youth and promotion of positive living

- **Community-based projects:** These projects worked predominantly at the community level and consisted of Fútbol para la Vida (FPV) (now referred to as Deportes para la Vida) in the Dominican Republic; Program H in Ethiopia and Namibia; Integrated Program against HIV/AIDS in Chibombo District, Zambia; Project Accept in Zimbabwe, Tanzania, and South Africa; and Sunbursts Project in Kenya. They generally sought to create a supportive environment around adolescents and youth and foster attitudinal and behavioral change at the community level. Fútbol para la Vida aimed to improve knowledge about HIV/AIDS among adolescents and youth and create an enabling and friendly environment in which they felt comfortable discussing sexual and reproductive health (SRH) issues among peers and with community role models. Program H focused on creating a safe space to allow young men to question traditional views about manhood and critically reflect on gender, gender injustices, gender rigidities, and how these are linked to other social injustices. Integrated Project Against HIV/AIDS aimed at contributing to the decline of HIV infections and improvement in the quality of life of HIV-affected people, with a community component that included savings and loan schemes, peer education, and creation of referral mechanisms. Project Accept focused on destigmatizing and normalizing HIV counseling and testing, inculcating a sense of collective commitment to addressing the HIV epidemic, raising awareness about HIV, and modeling positive acceptance of those infected and affected by HIV/AIDS. The primary goal of the Sunbursts Project was to address the social psychological needs of children/teens living with HIV/AIDS by providing a safe, welcoming, and nurturing environment for them to build positive relationships, increase their self-esteem, and reinforce positive health behaviors that ensure a healthy transition into adulthood.
- **Mobile and web-based projects:** One2One Digital Platform (OIDP) in Kenya is an innovative project that seeks to achieve and maintain improved health, knowledge, and access to comprehensive SRH, gender-based violence (GBV), and HIV prevention and treatment services among adolescents and youth in Kenya. This project uses a complementary mix of multimedia approaches that include digital platforms, direct health, and HIV information delivery including linkages to appropriate services, capacity development, and policy advocacy for and with adolescents and youth.

Theoretical Foundations of Practices

One of the characteristics of effective interventions is that they are theory driven (Nation, et al., 2003; Small, Cooney, & O'Connor, 2009). The best practices proposal submission form included, therefore, a question on the theoretical foundation of the practice. Some of the practices reviewed did not present evidence to indicate that their designs were informed by established social, psychological, and behavioral change theories or perspectives. Other practices described their individual project theory of change. Although we did not systematically examine the theories underpinning the design of practices described in this compendium, below we summarize information gleaned from the best practices proposal or published/gray literature about established theories that guided the design of the specific practice or its theory of change.

- **Social Cognitive/Social Learning Theory:** The design of the Adolescent-friendly VMMC project in South Africa (George, at al., 2014) was guided by social cognitive theory (Bandura, 1977a, 1978, 1989) and that of MEMA kwa Vijana (Hayes et al., 2005; Doyle et al., 2011) by social learning theory (Bandura, 1997b). These theories argue that human behavior is determined by the interactions between behavior, personal factors, and environmental influences. Behaviors

are learned through watching the actions and outcomes of others' behaviors (observation) and imitating the actions of others (modeling), but behaviors are also influenced, according to these theories, by motivation (that is, by being rewarded or punished for those actions). Learning is strengthened if an individual models a behavior he or she has seen rewarded, which motivates the person to model the behavior in order to get a similar reward (positive reinforcement). According to these theories, self-efficacy (a person's capability and confidence to perform a particular behavior) is one of the most important prerequisites for behavior change.

- **Transtheoretical (Stages of Change) Model:** This model underpinned Program H and its theory of change (http://www.nsmcentre.org.uk/resources/showcase/program-h?view=all). The transtheoretical model states that for most persons, a change in behavior occurs gradually, with individuals moving through stages. The model proposes five distinct stages of behavior change: (1) pre-contemplation (being unaware that the behavior is problematic, being uninterested, or being unwilling to make a change in the foreseeable future); (2) contemplation (beginning to consider the pros and cons of changing one's behavior); (3) preparation (intending to take action to change one's behaviors in the immediate future and starting to experiment with small changes); (4) action (having taken definitive actions to change one's behavior); and (5) maintenance (having sustained behavior change for at least six months and working to prevent relapse) (Prochaska, et al., 1982, 1992).

- **Ecological Model:** Program H also drew on the ecological model and the importance it gives to understanding and addressing barriers and constraints to behavior change at multiple levels. Hence Program H interventions included the promotion of individual reflection, peer and interpersonal group education, and a broader community-based component. As conceptualized by Bronfenbrenner (1979), the ecological model has five levels: (1) the individual level, which comprises the characteristics of an individual that influence behavior change; (2) the immediate social environment in which the person interacts, such as family, friends, peer, co-workers, religious networks, school, and the neighborhood; (3) the social environment that exerts an influence on the individual but without the individual's direct interaction (e.g., local government, village associations, businesses, transportation); and (4) the broader social, policy, and enabling environment (e.g., local, state, national, and global laws; economic and social policies; social and cultural norms, etc.).

- **Unified Theory of Behavior:** The design of the Zvandiri Project was driven by the unified theory of behavior (Mavhu et al., 2013). According to the unified theory of behavior (Jaccard, et al., 1999, 2002; Olin, et al., 2010), a person's behavior is influenced by two groups of factors: (1) immediate determinants (consisting of five factors—knowledge and skills for performing the behavior, environmental constraints or facilitators, salience of or priority attached to the behavior, habit and automatic processes, and intention or decision to perform the behavior); and (2) the individual's willingness, intention, or decision to perform the behavior (consisting of six factors—attitude toward the behavior, beliefs and expectancies, social norms, self-concept, affects and emotions, and self-efficacy). The theory argues that to effect behavior change, strategies that address both the determinants of behavioral intentions as well as actual behaviors may be necessary.

- **Diffusion of Innovations Theory:** This theory guided the community mobilization component of Project Accept (Khumalo-Sakutukwa, 2008). Diffusion of innovations theory describes the process through which new ideas or innovations spread and become adopted by the wider society (Roger, 2003). Rogers stated that there are four main elements of the diffusion process: the innovation, the communication channels through which the innovation is diffused, time, and

the social system. Adopters fall into four categories based on their rates of adoption of the innovation: innovators, early adopters, early majority, late majority, and laggards. Potential adopters go through an individual-level decision-making process that consists of five stages: (1) knowledge about the innovation; (2) persuasion or forming a favorable or unfavorable attitude toward the innovation; (3) decision or taking steps that lead to adopting or rejecting the innovation; (4) implementation; and (5) confirmation, which may also involve integrating the innovation into lifestyle (or discontinuation). The social context influences a potential adopter's decision and potential adopters are more likely to adopt an innovation when the change agent is perceived to be similar as compared to different from them (Rogers, 2003).

- **Tipping Point Theory:** The community-based VCT (CBVCT) component of the Project Accept intervention was based on the theory that a "tipping point" occurs when there is a critical mass of adopters in a social network (Khumalo-Sakutukwa, 2008). Three factors are held to determine whether the tipping point occurs: (1) the "law of the few," which refers to the idea that there are a handful of exceptional individuals (e.g., sociable, energetic, knowledgeable, influential) who are capable of generating social change by influencing the masses; (2) the "stickiness factor," which is the quality that compels people to pay close, sustained attention to an idea, product, message, or behavior; and (3) the power of context, which acknowledges that human behavior is sensitive to and strongly influenced by its environment (Gladwell, 2002).
- **Social Action Theory:** This theory guided the development of the post-test support services component of Project Accept (Khumalo-Sakutukwa, 2008). Social action theory views health-protective behaviors as a function of the interaction between (1) the self-regulatory capabilities of the individual, (2) the environmental context, and (3) responses to internal affective states (Ewart, 2009). The theory focuses on how the physical and social environment shapes a person's goals, social interactions, problem-solving, self-efficacy, and projected outcomes, which can enhance or hinder behavioral change (Ewart, 2009; Reynolds, et al., 2010).

Making Services Adolescent and Youth Friendly

It is increasingly realized that programs need to be adolescent and youth friendly to make it easier for young people to obtain the health services they need. Initiatives undertaken in this regard by the projects included in this compendium fall into two groups: (1) programming characteristics and (2) provider characteristics.

Adolescent- and Youth-Friendly Programming Characteristics

- **Meaningful involvement of adolescent/youth in program design and implementation:** The Zvandiri project provided an illustrative example of this characteristic. The community adolescent treatment supporters (CATS) program model was *developed in partnership with ALHIV* and in response to their request for a safe place where they could come together to learn about and share their experiences in order to better cope with their health condition and its impact on their lives. Trained HIV-positive adolescents and youth ages 17–23 years were mentored by peer counselors, who provided adherence literacy, home-based counseling and monitoring, and psychosocial support. CATS played a vital role in the case management of young people with HIV. In addition, Zvandiri adolescents and youth organized innovative multimedia advocacy campaigns on their own, participated in policy and guidelines development, and provided training and mentorship for health workers, social workers, and community organizations to strengthen the integration of psychosocial support and clinical care. Program H provided another example of adolescent/youth involvement in

program design and implementation as illustrated by its community strategy, in which youth activism and *youth-designed campaigns* were carried out in nearly all sites where group education was conducted.

- **Increased accessibility of adolescents and youth to services:** In the adolescent-friendly VMMC project, HTC services were undertaken in public sector clinics closest to schools where there was a demand for VMMC, with post-surgical assessments being undertaken in school the following week. To make services more convenient for adolescents, the project, which offered HTC services on weekdays during school hours, extended services to after-school hours to avoid having students miss class to undertake the procedure. Some other projects included adolescent/youth centers. For example, Zvandiri adolescent centers were constructed within health facilities as an entry point for young people, HIV positive or negative, to access information, peer counseling, skills development, and referral to services for HCT, opportunistic infections, ART, tuberculosis (TB), sexual and reproductive health, PMTCT, and child protection. Adolescent centers were run by trained and mentored CATS, supervised by clinic staff. The centers also referred young people to other services, including HTC, family planning, diagnosis and treatment of STIs, PMTCT, and mental health and social services.
- **Affordable fees:** In 2006, Liverpool VCT, Care and Treatment (LVCT Health), which hosts OIDP, started a toll-free hotline at its premises in Nairobi. LVCT Health was originally set up to serve men who have sex with men (MSM) in response to their identification of a lack of HIV-appropriate information, especially for those who did not go to the VCT, and a lack of posttest-counseling information for those who did. This mobile-based platform was extended to include Bulk SMS and was hosted by Safaricom, and hence free to its subscribers. The costs for handling the OIDP platforms were absorbed by the donors, thereby enabling adolescents and youth to access free health information and services though the platforms. Another example was Project Accept's community-based VCT services, which provided free *HIV testing* in easily accessed venues to enhance the convenience and visibility of the services and to encourage young people to use VCT services. In addition, free male and female condoms were offered to all clients at the time of HIV testing. Similarly, Feel the Future ensured free medical care for HIV-positive adolescents and youth.
- **Linkages with schools, youth clubs, and other youth-friendly institutions:** Under the MEMA kwa Vijana project, health workers visited local primary schools to introduce services available. Periodic visits were also arranged from the schools to the clinics to familiarize students with the facilities.
- **Alternative ways to access information, counseling and services are provided:** Two projects stood out in this regard: OIDP and Program H. OIDP has harnessed the growing use of digital technologies by Kenyan adolescents and youth to provide HIV, SRH, and GBV services. Currently the hotline operates daily from 7:40 a.m. to 8:00 p.m., with counselors working a morning shift from 7:40 a.m. to 2:00 p.m. and an afternoon shift from 2:00 p.m. to 8:00 p.m. This peer-led innovative and evidence-based program offers comprehensive quality services and literacy to over one million adolescents and youth (ages 15–24 years) in Kenya annually. OIDP is comprised of a mobile and web-based platform. The mobile platforms include the hotline and Bulk SMS hosted by Safaricom. The web-based platforms include Facebook (One2One KE), Twitter, YouTube, and Instagram (@one2oneKE), blog (www.one2oneyouthkenya.wordpress.com), email (one2one@lvcthealth.org), and WhatsApp (0700121121), all of which are anchored to the project website (one2onekenya.com). All of these channels provide opportunities through which youth can engage with a professional adolescent/youth-friendly counselor at any time on issues pertaining to HIV/SRH/GBV information and services.

Program H's activities include a wordless cartoon video, called "Once Upon a Boy," which presents the story of a young man from early childhood through adolescence to early adulthood. Scenes include the young man witnessing violence in his home, interacting with his male peer group, experiencing social pressure to behave in certain ways to be seen as a "real man," having his first unprotected sexual experience, having an STI, and facing an unplanned pregnancy. The cartoon video is used to quickly engage young men across cultures and get them to create dialogue and project their personal stories into the video. In addition to the Program H curriculum, Promundo and partners have worked with men themselves to identify their preferred sources of information and cultural outlets in the community, and to craft messages—in the form of radio spots, billboards, posters, postcards, and dances—to make it "cool and hip" to be a more gender-equitable man.

Adolescent- and Youth-Friendly Provider Characteristics

- **Staff is trained on provision of adolescent- and youth-friendly services:** This approach was commonly used by the practices examined. Under the MEMA kwa Vijana project, for example, health workers were trained for one week in the provision of youth-friendly health services and were supervised quarterly, with the main emphasis being on adopting a welcoming and nonjudgmental attitude toward young people.
- **Privacy and confidentiality are maintained:** Privacy and confidentiality were emphasized in service delivery and informed by professional guidelines. In the Adolescent-friendly VMMC project, this entailed conducting a mock circumcision for male adolescents and youth who tested HIV positive to maintain confidentiality and reduce stigma and discrimination. The Toolkit and Training Manual reinforced the importance of health and community care providers maintaining the confidentiality of adolescent/youth services.
- **Peer counselors are available:** Most of the projects included in this compendium had a peer education component. Under the Zvandiri CATS initiative, AYLHIV aged17-23 years who were coping well with their health were trained and supported to become counselors for their peers and provide clinic-based services and make home visits. Their personal experiences with anxiety, guilt, fear, shame, rejection, depression, and feelings of hopelessness made them credible to adolescents and youth who were struggling with a new HIV diagnosis or with treatment, and gave them a unique value as normative role models. The Sunbursts project in Kenya employed HIV-positive young adults to provide support to children and adolescents enrolled in care at three Family AIDS Care and Education Services (FACES) clinics. The peer-led training curriculum that was used with these AYLHIV had three main sections: becoming an HIV/AIDS expert, facilitating social psychological care and support for vulnerable children and adolescents, and social entrepreneurship and community development.

Quantitative Impact on HIV-Related Outcomes

The projects examined set out to achieve a wide variety of outcomes (Table 3). To synthesize the evidence of what works to improve adolescent/youth health outcomes, projects included in this compendium were classified as having either a rigorous or non-rigorous evaluation design. Rigorous evaluation designs included experimental studies with random assignment to an intervention or control condition (e.g., randomized controlled trial) or quasi experimental designs involving comparison groups without random assignment. Pre–post designs were classified as non-rigorous evaluation designs.

Table 3. Summary of intervention outcomes

Intervention Site	Outcomes
Clinic/health facility	Number of male circumcisions performed (output), HIV incidence, STI incidence, retention in care, self-reported adherence to ART, and psychological well-being
School	Knowledge of HIV acquisition, knowledge of STI acquisition, attitudes toward sex, sexual initiation, number of partners, condom use
Community	HIV-related knowledge, attitudes and communication, use of health facility for recent STI symptoms, attitude toward GBV (Gender-equitable Attitudes in Men [GEM] scale), GBV perpetration, HIV testing, disclosure of HIV status
Mobile and web-based	Knowledge of HIV, knowledge of GBV

Five projects had rigorous evaluation designs: (1) Fútbol para la Vida, (2) MEMA kwa Vijana, (3) Program H, (4) Zvandiri, and (5) Project Accept. Some of these projects, like MEMA kwa Vijana, evaluated comprehensive interventions that combined education or skills-building curricula with community-based and/or health facility-based interventions, but these evaluations were the exception. Fútbol para la Vida was a grassroots soccer project in which local *batey* soccer players—role models in their communities—were trained to deliver interventions in community centers and in Fútbol para la Vida camps. The Fútbol para la Vida curriculum consisted of 10 hours of instruction and was typically administered over the course of five days. MEMA kwa Vijana had four main components: (a) sexual health education through an in-school teacher-led and peer assisted curriculum; (b) youth-friendly government health services; (3) community-based condom promotion and distribution by youth; and (4) other community activities. Program H consisted of four components: (1) a validated curriculum that included a manual series and an educational video for promoting attitudinal and behavior change among men; (2) a lifestyle social marketing campaign for promoting changes in community or social norms related to what it means to be a man and questioning men's use of violence against women; (3) a research-action methodology for reducing barriers to young men's use of clinic services; and (4) a culturally relevant validated evaluation model (the GEM Scale) for measuring changes in attitudes and social norms around masculinity). The Zvandiri project consisted of a peer-led intervention involving weekly home visits by trained, mentored CATS and monthly support groups. The Project Accept intervention included: (1) community mobilization activities, (2) community-based VCT, and (3) community-based post-test support services.

Fútbol para la Vida was evaluated using a quasi-experimental design in six migrant settlements in the Puerto Plata Province of the Dominican Republic. The impact of MEMA kwa Vijana was evaluated through a community-randomized trial, in which 20 communities were randomized to intervention or control arms, and a cohort of adolescents was recruited at study schools in both arms and followed up for three years to record outcomes of interest. Baseline and follow-up surveys were carried out within the study schools. In the Zvandiri project, 50 10- to 15-year-olds on ART who received a 12-month peer-led intervention involving weekly home visits by a trained, mentored CATS and monthly support group were compared with 50 10- to 15-year-olds receiving standard of care at the clinic. Qualitative and quantitative data were collected monthly and every six months in both arms to measure retention in care, self-reported adherence, and psychosocial well-being. Project Accept was a randomized control trial of 10

communities in Tanzania (Kisarawe District), 8 communities in Zimbabwe (Mutoko District), and 16 communities across two sites in South Africa (8 in Kwazulu-Natal and 8 in Soweto).

Projects with rigorous evaluation designs were categorized into five nonmutually-exclusive groups based on whether they were effective or ineffective for HIV-related knowledge, and attitudinal, behavioral, and biological outcomes:

(1) Effective for HIV-related knowledge and attitudinal outcomes

Adjusting for baseline differences as well as age, sex, community, and descent, the results of logistic regression analysis revealed that the Fútbol para la Vida intervention was associated with a significant increase in HIV-related knowledge (adjusted odds ratio [OR]=13.02, 95% confidence interval [CI]=8.26, 20.52), reported attitudes (adjusted OR=12.01, 95% CI=7.61, 18.94), and reported communication (adjusted OR=3.13, 95% CI=1.91, 5.12) (Kaufman, et al., 2012). These effects remained significant at four-month follow-up, but declines in post-intervention knowledge were observed in the intervention group while gains in knowledge and reported attitudes were observed in the control group. Similarly, the impact evaluation of MEMA ka Vijana showed that at the final survey, there were substantial and statistically significant differences in the proportions of both male and female participants who answered all three questions "correctly" for each of the three knowledge outcomes, and for the reported attitudinal outcome. The adjusted relative risks [RR] for these four outcomes ranged from 1.28 to 1.77 for male participants and from 1.41 to 1.58 in female participants. In general, intervention/comparison differences in reported attitudes were greater among participants with more years of potential exposure to the in-school intervention, especially in young men (Ross, et al., 2007).

Program H has undergone nine impact evaluations, most of which have used quasi-experimental designs, although a few have had random assignment of control and intervention schools or communities. Six out of nine evaluations found that participants in the programs demonstrated significantly less support, on average, for gender-inequitable attitudes after taking part in the activities based on Program H. These changes have been observed through quantitative and qualitative data and have been consistent across settings.

(2) Effective for HIV-related behavioral outcomes

Sexual behaviors:

The impact evaluation of MEMA kwa Vijana showed that the proportion of young men reporting sexual debut during follow-up was 60 percent in the intervention and 72 percent in the comparison communities (adjusted RR=0.84, CI=0.71, 1.01). There was little difference among young women (adjusted RR 1.03, CI 0.91, 1.16). Similarly, the proportion of male subjects who reported more than one sexual partner in the past year was significantly lower in the intervention (19%) than in the comparison communities (28%; adjusted RR=0.69, CI=0.49, 0.95), but no significant difference was seen in female participants (adjusted RR=1.04, CI=0.58, 1.89) (Ross, et al., 2007).

Condom use:

The proportions of adolescents and youth who reported initiating condom use during follow-up were substantially and significantly higher in MEMA kwa Vijana intervention communities among both male and female participants. The proportions reporting condom use at last sex were higher in intervention than control communities in both sexes but this was only significant in young men. Absolute levels of condom use at last sex remained relatively low (less than 30%) (Ross, et al., 2007).

Intimate partner violence:
In Ethiopia, Program H found that the proportion of young men who reported using physical violence against a female partner dropped significantly, from 36 percent to 16 percent, after taking part in an intervention that included elements from the Men as Partners manual as well as activities from Program H, while no such change occurred among the group of nonparticipants.

HIV testing:
The evaluation of Project Accept revealed that the proportion of clients ages 16 to 32 years receiving their first HIV test during the study was higher in CBVCT communities than in standard clinic-based VCT (SVCT) communities in Tanzania (37% versus 9%) and Zimbabwe (51% versus 5%) (Sweat, et al., 2011). SVCT consisted of services at existing district hospitals or local healthcare facilities, which were also available in communities with the community-based intervention. A larger percentage of HIV testers were 16 to 17 years of age in intervention communities (CBVCT) than in control communities (SVCT) (Sweat, et al., 2011).

Disclosure and ART adherence:
At the time of data collection, the Zvandiri project was half way through a 12-month study evaluating the effectiveness of the CATS intervention in improving retention, adherence, and psychosocial well-being among adolescents with HIV in a rural setting of Zimbabwe. The preliminary data from this study suggested that this adolescent-led intervention was effective in improving self-reported adherence and psychosocial well-being six months after the intervention. Participants report improved adherence (60% of those in the intervention group never missed taking medicines compared to 0% in the control group) and psychosocial well-being following engagement with a CATS (97.3% in intervention group versus 59.7% in the control group). Retention in support groups was 90 percent and healthcare workers reported improved clinic attendance of support group members compared with standard of care. Disclosure of HIV status by participants to caregivers improved (100% of participants who were unaware of their status at the start of the study had disclosed their HIV status to caregivers compared to 0% in the control group).

(3) Not effective for HIV-related behavioral outcomes

No overall effect of Project Accept on sexual risk behavior (measured by the number of unprotected sexual acts) was detected. However, in individuals with HIV, a significant reduction in high-risk sexual behavior was noted in the intervention group. The number of sexual partners of HIV-positive men ages 18 to 32 years was reduced by 18 percent (95% CI 8-46, P=0.034) but, unfortunately, these results were not presented separately for young people and older people (Coates, et al., 2014).

(4) Effective for HIV-related biological outcomes

Clinical STI symptoms and signs:
At the final survey, the proportion of participants reporting genital pus or abnormal genital discharge during the past year was substantially lower in MEMA kwa Vijana intervention communities than in the control communities, both among male participants (adjusted RR = 0.58, CI = 0.41, 0.83) and female participants (adjusted RR = 0.59, CI = 0.43, 0.80). Among those reporting STI symptoms, however, there was no significant difference in the proportion who reported having sought care at a local health facility for their most recent STI episode during the past year, in either sex (Ross, et al., 2007).

(5) Not effective for HIV-related biological outcomes

HIV and sexually transmitted infections:
The two primary outcomes of the MEMA kwa Vijana project, HIV incidence and HSV-2 prevalence, were based on biological tests. Only 45 participants (5 boys and 40 girls) seroconverted to HIV during 23,730 person-years of follow-up. After adjustment, HIV incidence in females was 25 percent lower in the intervention than in control communities, but this difference was not statistically significant (adjusted RR=0.75, CI=0.34, 1.66). Overall, 12 percent of male and 21 percent of female participants were HSV-2 seropositive at the final survey, but there was no difference by trial arm for either male participants (adjusted RR=0.92, CI=0.69, 1.22) or female participants (adjusted RR=1.05, CI=0.83, 1.32) (Ross, et al., 2007). Another follow-up study conducted an average of 8.9 years after the start of the intervention found no significant long-term impact of MEMA kwa Vijana on biological outcomes (Doyle, et al., 2010). The Project Accept interventions also did not decrease HIV incidence in young people ages 18 to 24 years, regardless of gender (Coates, et al., 2014).

Some projects reported the results of single-group cross-sectional surveys, external assessments, and pretest-posttest designs. In some cases, positive effects on HIV-related knowledge, attitudes and behavioral outcomes were identified by projects using non-rigorous evaluation designs. While non-rigorous designs are often cost-effective for establishing the need for and reach of an intervention, and for building the evidence base, progress in identifying effective strategies for meeting the HIV-related needs of adolescents and youth is dependent on the use of more rigorous methods for determining what works, how long, and for whom.

Qualitative Evaluation Results

While some projects implemented mixed evaluation methodologies, the SYMPA project undertook a purely qualitative evaluation of its HIV curriculum's (1) acceptability, (2) implementation, (3) adaptation, and (4) limited efficacy. The outcomes associated with each of the four components of the evaluation are described below:

- **Acceptability:** satisfaction, perceived appropriateness, intent to continue use
- **Implementation:** degree of execution, amount, implementation ease, efficiency, and quality
- **Adaptation:** factors specific to intervention modification
- **Limited efficacy:** knowledge of sexual prevention topics, condom use skills, ability to deal with triggers for unsafe sex, autonomy in decision making, ability to negotiate safer sex, openness to discussing sexual behavior with caregivers, and ability to develop positive goals in the future.

The evaluation found that adolescents and youth reported improving their problem-solving skills, increasing their knowledge of sexual prevention topics, improving their condom use skills, improving their ability to deal with triggers for unsafe sex, and their capacity to assess the level of risk of different behaviors. AYLHIV also reported increasing their autonomy in decision making and openness to discussing sexual behavior with their caregivers, and improving their ability to develop positive goals for their future. Youth reported that they felt better prepared to deal with potential future problems (Parker, et al., 2013).

Potential for Sustainability

Sustainability was interpreted in terms of sustaining project activities, transferring best practices to other programs/settings, identifying new funding streams, and maintaining improved adolescent/youth health outcomes over time. Several factors were identified by projects as contributing to the sustainability of their adolescent- and youth-friendly practices:

- **Integration of project activities into existing health systems and government/community structures:** Two illustrative examples were provided by the VMMC and Zvandiri projects. The VMMC demand-creation strategies in schools fit well into the existing health system, making it more likely to be sustained by the South Africa Ministry of Health. Also, since VMMC is a one-off surgical procedure, service provision could be easily integrated into regular school visits to maintain high coverage rates, and into comprehensive school-based sexual reproductive health services. The Zvandiri project was also designed to be integrated into facility-based care and has been integrated into government systems for more than 10 years. A toolkit of Zvandiri materials, resources and tools has been created for use by service providers, CATs and communities well beyond the life of the project. Likewise, the village savings and loans schemes of the Integrated Project against HIV/AIDS in Chibombo District, Zambia, though not targeted specifically to adolescents and youth, have been linked to the Ministry of Agriculture and Livestock from which support is received for farming inputs, capacity, and mentorship.
- **Community buy-in and advocacy for the project:** In the Integrated Project against HIV/AIDS peer groups were formed by the communities themselves, making it likely for youth to continue implementing activities beyond the life of the project. The youth-friendly corners will also most likely continue being used by adolescents and youth. As these project components are in tandem with government policy of preventing HIV transmission among youth, in some communities, these components have been absorbed by the Ministry of Community Development, Mother and Child Health (MCDMCH). Similarly, Fútbol para la Vida programs has been successfully implemented and replicated in other communities across the Dominican Republic and its expansion into areas where health and life decision-making education is much needed by adolescents and youth is supported by a nationwide network of facilitators (Kaufman, et al., 2011).
- **Collaborative relationships and partnerships:** These are key factors in the sustainability of the Sunbursts project. The Project has formed strong partnerships with the Kenyan Ministry of Health and various organizations to support the implementation of peer-led support groups, family social events, community outreach, and camp programs for AYLHIV. The project has liaised with faith-based organizations and schools for the offer of venues and accommodations free-of-charge or at an affordable costs, and has assembled a team of volunteers to help sustain project activities. Numerous local private and public partners also offer Sunbursts a wide range of support, from medical expertise to program development.
- **Coordinating funding from multiple sources to sustain the project:** In many projects, financial sustainability has been ensured by continued grant writing and networking with other organizations. In the case of the Sunbursts project, donations have also been procured from private entities and individuals through online systems.
- **Evaluation results demonstrate the project is making a difference:** A case in point is Program H, which has demonstrated its ability to make an impact on gender norms and sexual

violence perpetration by men in a cost-effective way. The program has been maintained, replicated, and scaled up in a large variety of settings. The Program H approach is being institutionalized through the development of an online teacher-training portal that aims to promote gender equality among both teachers and students in Brazil's public school system.

It is to be noted, however, that unless partnerships are built with communities, governments, and local organizations right at the program design stage, and unless communities are taught how to secure continued funding/support, even programs shown by rigorous evaluations to work may not continue beyond the life of the initial intervention(s).

Lessons Learned by Projects

- **Clinic-based projects with or without a community component:**
    - An important lesson learned by the SYMPA project, which implemented a curriculum among AYLHIV, was that **the education level of participants was variable and specific activities requiring written responses needed to be adapted for those who were unable to write** (Parker, et al., 2013)**.**
    - The implementation of the Toolkit and Training Manual revealed that the unique needs of adolescents and youth should be taken into account when implementing HIV care, support, and treatment services. I**ndividualized transition-to-adult care programs must be built** to strengthen the ability of young women and men to manage their own care.
    - The Youth VCT project in Botswana revealed that **counselors were able to reach more adolescents and youth during mobile testing as opposed to fixed-site service delivery** in settings where facilities offering adolescent- and youth-friendly HIV were lacking.

- **Clinic- and school-based projects:**
    - **Community involvement and consultations were critical for creating an enabling environment for the recruitment of in-school adolescents for VMMC services.** This was a major contributor to the acceptability and success of the Adolescent-friendly VMMC project.
    - While the detailed nature of the MEMA kwa Vijana curriculum and the intensive in-service teacher training appeared to facilitate teacher motivation and the implementation of the practice, the low level of supervision in schools after scale-up likely had a negative effect on the quality and sustainability of the intervention. Furthermore, **a single training during scale-up appeared to be insufficient to impart skills required for teaching the psychosocial aspects of the curriculum**. Systematic pre-service training of teachers would be more cost-efficient and likely to influence acceptance and uptake of the practice (Renju, et al., 2011).

- **Community-based projects:**
    - **Community involvement (of local people, their respected models, and local and governmental organizations in the community)** was a key factor contributing to the success of the sports-based HIV prevention project Fútbol para la Vida in improving HIV-related knowledge and attitudes (Kaufman, et al., 2011).
    - **The skill of the educator or facilitator was the most important factor for promoting** reflection and changing gender-related attitudes among young men participating in Program H.
    - Based on the experience of Program H and the Zvandiri project, **sustainability is enhanced when adolescents and youth are involved in activities that enhance**

their competence, capacity, and civic engagement. Supporting adolescents and youth to carry out their own campaigns and activism empowers them to become agents of change and influence public policies.

- **Providing mobile VCT is a feasible way to increase adolescents and youth uptake of HIV counseling and testing**. If HIV testing services are provided in convenient and accessible community locations such as markets, churches, community centers and shopping centers, social events, and transportation hubs close to where adolescents and youth live, work, and gather, they will make use of the services, and new populations not serviced by facility-based services will be reached (van Rooyen, et al., 2012).
- **There is no single strategy for community mobilization**. In Project Accept, seven major community mobilization strategies were used in combination: (a) stakeholder buy-in, (b) forming community coalitions, (c) direct community engagement, (d) community participation in project-related activities, (e) raising community awareness, (f) involvement of community leaders, and (g) creating partnerships with organizations (Tedrow, et al., 2012).
- **Multidisciplinary and multifaceted approaches play an integral role in ensuring optimal viral suppression among adolescents**. The Sunbursts Project showed that peer leadership psychosocial programs can augment medical services and be part of a lifelong continuum of care for youth living with HIV/AIDS. This approach helped streamline youth from pediatric medical care, to adolescent care, and then into adult treatment and care services.

- **Mobile and web-based projects:**
  - **Digital platforms are a crucial delivery point of information and services for adolescents and youth**. Mobile technology, in particular, is an effective way of reaching young people with SRH information, as it is the "in thing." Making services anonymous for young people facilitates their asking questions about health issues.

DISCUSSION

This report summarizes what we know about best practices for adolescent- and youth-friendly HIV services in PEPFAR priority countries based on submissions received in response to a call for best practices proposals and the existing literature. The call for best practice proposals was guided by the following research questions: (1) What are the most practical and innovative approaches to providing adolescent- and youth-friendly HIV prevention, care, treatment, and retention services and supports? (2) What creative, promising, and proven strategies and approaches can we rely on to ensure that services and supports are clinically effective, culturally appropriate, and achieve desired outcomes among adolescents and youth? (3) What are the best practices for engaging adolescents and youth in planning, implementing, and evaluating HIV prevention, care, treatment, and retention services? (4) What practical strategies can be utilized to support and sustain adolescent/youth-led organizations to ensure authentic adolescent/youth voices in HIV prevention, care, treatment, and retention services?

The results showed that strategies for providing adolescent- and youth-friendly HIV prevention, care, treatment, and retention services and supports varied from multisite to single-site interventions and ranged from clinic-based approaches with or without community components to clinic-based projects with school-based components, community-based projects, and mobile/web-based projects. As a group, the projects in this compendium touch on the four elements of USAID's Youth in Development Policy (USAID, 2012b) to varying degrees: (1) support (meeting basic youth developmental needs and valuing their contributions); (2) protect (preventing and responding to violence, exploitation, abuse, and neglect, and ensuring young people are safe and receive care); (3) prepare (building youth competencies and skills to become informed, healthy, and productive citizens); and (4) engage (creating channels for dialogue and participation that enable youth to contribute to their own and their communities' development). Few projects addressed social norm change. It would be difficult for adolescents and youth to have long-term behavior change in social, cultural, and political environments that restrict their access to information and services related to sexual health and HIV.

While it was difficult to determine which of the strategies presented were the most practical and innovative, OIDP's digital and web-based platform stood out as an information provision strategy that would appeal to most adolescents and youth due to the opportunities provided for them to engage anonymously with a professional adolescent- and youth-friendly counselor at any time to obtain SRH and HIV information and service, using a platform that they consider to be an "in thing." Practical approaches for reaching adolescents and youth with HIV and AIDS services were exemplified by demand creation for VMMC in schools in South Africa, the sports-based HIV prevention intervention offered by Fútbol para la Vida, the CATS component of the Zvandiri project, the Program H processes of engaging young men in changing inequitable and violent norms related to masculinity, and the Project Accept approach of providing mobile VCT in convenient locations in the community—outside schools and at local social events—where young people were likely to be.

Various initiatives were undertaken by the projects examined to increase the adolescent/youth friendliness of the services provided. At the program design and implementation levels, these initiatives included engaging adolescents and youth in program design and implementation in meaningful ways, increasing accessibility to services, providing free services or instituting affordable fees, establishing linkages with schools, youth clubs and other youth-friendly institutions, and providing alternative ways for youth to access HIV-related information, counseling, and other services. At the health facility level,

initiatives consisted of training staff on provision of adolescent- and youth-friendly services, maintaining privacy and confidentiality, and ensuring that peer counselors were available.

The submissions received underscored the lack of integrated monitoring and evaluation (M&E) systems. The Zvandiri project, for example, stated that in retrospect, it would have been much easier to demonstrate the impact of the community-based intervention in improving ART retention and adherence and adolescent/youth psychosocial well-being if there had been a stronger shared M&E system with health facilities. The lack of community-facility integrated health information systems made it difficult to analyze the impact of the project on biological outcomes such as CD4 count and viral load and behavioral outcomes such as clinic attendance. Feel the Future also pointed to the lack of M&E systems to track outcomes of interest among the beneficiary population.

The lack of rigorous evaluations of projects serving adolescents and youth was an issue of concern and well noted by a number of projects. The Adolescent-friendly VMMC project noted, for example, that having control schools/communities in different settings and with different components of the strategy could have helped to assess the impact of the project. For multifaceted projects, it was also observed that the effect of each individual component on desired adolescent/youth health outcomes could not be quantified, which suggested a need for multicomponent evaluation designs. Similarly, it was noted that to ensure the contextual and cultural appropriateness of the Toolkit and Training Manual, it would have been necessary to pilot the manual in a variety of settings in sub-Saharan African countries over a longer period of time, and conduct a rigorous evaluation to examine the health impact of the toolkit on adolescents living with HIV. These factors constrained our ability to determine the best practices for achieving desired health outcomes among adolescents and youth.

The limited information provided by the five projects with rigorous evaluation designs revealed that they had a clear and beneficial impact on HIV-related knowledge and attitudes, sexual behaviors especially among men, HIV testing, and disclosure. The only project that included a long-term impact assessment impact, about nine years after the initial intervention, was MEMA kwa Vijana. The long-term follow-up evaluation study found that SRH knowledge improved and that this knowledge was retained for many years. However, MEMA kwa Vijana had only a limited effect on reported sexual behaviors and no effect on HIV and HSV-2 prevalence at the nine-year follow-up. Although the findings could not be generalized to other adolescents and youth, it was suggested that youth HIV prevention programs be integrated with risk-reduction programs that tackle social norms, as that might be a more successful approach (Doyle, et al., 2010).

This review has several limitations. There was also a general lack of interest in responding to the call for best practice proposals. We believe that this highlights a persistent problem in the field in that the majority of programs are not well documented and never make it to publication in the grey or peer-reviewed literature. It was difficult to find sufficient detail of the interventions and outcomes even from references provided by a given project or to identify relevant documents in the grey literature. In addition, our synthesis did not entail a systematic and comprehensive assessment of the extent to which the projects reviewed were adolescent and youth friendly. Few projects provided costing data, an important omission for end users who may want to consider the evidence when choosing interventions.

A number of other factors need to be considered when interpreting the findings. Although issues of replicability, sustainability, and retrospect are addressed in the best practice proposals, it is difficult to determine whether intervention quality would be ensured when a practice is scaled up and whether a pilot

project would work in a real-world setting where the social, religious, and political context is likely to exert a nontrivial influence on program success. Most projects included in this compendium were not rigorously evaluated and assessment of their long-term impact was even more limited. Although it cannot be assumed that a practice that has not been evaluated is ineffective, progress towards identifying best practices for adolescent- and youth-friendly HIV services is contingent on the allocation of adequate funding for rigorous impact evaluations, for assessments of program efficiency, and for strengthening of the methodological expertise of implementing partners and research staff in PEPFAR-supported countries.

ADDITIONAL CONSIDERATIONS

- Programs should document their activities and outcomes in detail to clarify what is being done and the expected outcomes.
- Most programs need high quality monitoring and impact evaluation of interventions targeted at adolescents and youth. Where possible, future evaluations should use randomized or quasi-experimental designs to strengthen the evidence.
- More research is needed on the best practices for engaging adolescents and youth in planning, implementing and evaluating HIV-prevention, care, treatment, and retention services.
- Studies are needed to identify conditions of effectiveness of programs targeting adolescents and youth and establish for which groups (e.g., males versus females) or geographical areas (e.g., rural areas versus urban areas) a given program works.
- Programs need to make substantial investment in providing estimates of program efficiency and estimates of cost-effectiveness. These data were lacking (or not in the public domain) for most projects included in the compendium.
- During scale-up of adolescent- and youth-friendly interventions that have been proven to work, attention must be paid to maintaining intervention quality.
- Assessment of the long-term impact of programs is needed.
- Adequate funding must be allocated for rigorous impact evaluation, for assessments of program efficiency, and for strengthening of the methodological expertise of implementing partners and research staff in PEPFAR-supported countries.

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APPENDIX 1. CALL FOR BEST PRACTICES FOR ADOLESCENT- AND YOUTH-FRIENDLY HIV SERVICES

MEASURE Evaluation welcomes proposals for inclusion in a Compendium of Best Practices for Adolescent- and Youth-Friendly HIV Services. The goal of this activity is to answer critical questions that move forward USAID's mission of supporting (a) the adoption of evidence-based practices in adolescent- and youth-friendly HIV care and services to help at-risk adolescents (ages 10–19 years) and youth (ages 15–24 years) stay HIV-free, and (b) the provision of comprehensive packages of HIV prevention, care, treatment, and retention services to adolescents and youth living with HIV in order to promote their successful transition to adulthood. Add your voice, knowledge, and expertise in answering these questions:

- What are the most practical and innovative approaches to providing adolescent- and youth-friendly HIV prevention, care, treatment, and retention services and supports?
- What creative, promising, and proven strategies and approaches can we rely on to ensure that services and supports are clinically effective, culturally appropriate, and achieve desired outcomes among adolescents and youth?
- What are the best practices for engaging adolescents and youth in planning, implementing, and evaluating HIV-prevention, care, treatment, and retention services?
- What practical strategies can be utilized to support and sustain adolescent/youth-led organizations to ensure authentic adolescent/youth voices in HIV prevention, care, treatment, and retention services?

This environmental scan of adolescent- and youth-friendly HIV services focuses on persons ages 10–24 years in 22 countries receiving support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). These countries include Botswana, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ethiopia, Haiti, Jamaica, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

Why submit? This is an excellent opportunity for you or your organization to showcase your programs and share your expertise with colleagues. Sharing your program's successes, challenges, and lessons learned with colleagues, public health specialists, program managers, and policy makers provides an opportunity to enhance the field of HIV prevention, care, treatment, and retention. Furthermore, submitting your best practices for adolescent- and youth-friendly HIV services could enable you to provide peer-to-peer support for program and policy replication.

Please send the completed form directly to Anastasia Gage of MEASURE Evaluation/Tulane University at agage@tulane.edu, with a copy to mdo@tulane.edu. The form should be sent as a Microsoft Word attachment. If you do not receive an e-mail reply within three business days, please contact Anastasia Gage at 504-988-3647 or agage@tulane.edu. All Best Practices submissions must be received by **June 30, 2015**.

How are best practices selected? A Best Practices Review Group composed of USAID, implementing partners, and other experts in the HIV/AIDS field will review submissions and determine if a practice meets the designated criteria for a best practice or whether it should be classified as a promising practice. Submitters will be **notified about the status of their proposal via email on October 1, 2015.**

To submit your proposal, please fill out the form below – one form for each submission. If you have any questions or should encounter difficulty in filling out this form, please contact agage@tulane.edu.

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☐ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☐ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☐ Peer education	☐ Mental health services for adolescents and youth living with HIV
☐ Prevention, safer sex, and risk-reduction counseling	☐ Other (specify)
☐ Other (specify)	☐ Other (specify)
☐ Other (specify)	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☐ 10–14 years old
☐ 15–19 years old
☐ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☐ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☐ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☐ Health facility
☐ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Please complete all fields.

Name	*Name of project, policy, law, or strategy*
Country	*Country where the practice is or was carried out*
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)*
Year	*When did the practice start? When did it finish? When is it expected to finish?*
Contact Person	*Name* *Title*
Contact information	*Mailing address* *Phone* *Fax* *E-mail* *Website, etc.*
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information.* *If it was a partnership, who were the partners?* *Were adolescents and youth involved in the implementation of the practice? How were they involved?* *Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?*

Funding	*Who provided the funding and other resources?*
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?*
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?*
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?*
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.*
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.*
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3.* *Was the practice implemented in urban or rural areas or both?*
Outcomes/results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.*
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.*

Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?*
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.*
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).*
Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.*
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they – or could they be – overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?*
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?*
Retrospect	*Discuss anything that might have been done differently if applicable.*

Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.*
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?*
References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.*

When submitting your application, please remember to:

- Answer all questions as completely as possible
- Clearly explain what you did, why you did it, what population you targeted, how you measured success, and what the results of your activities were
- Please clearly define all acronyms the first time they were used
- Check spelling
- Attach extra pages if you wish to give more information

APPENDIX 2. BEST PRACTICES

Adolescent-Friendly Voluntary Male Medical Circumcision (VMMC) Project, South Africa

Carl Montague

Best Practices Submission Form – Part 1

E. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☑ Access to HIV services (location, hours, facility environment)	☑ Counseling and testing for HIV
☐ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☑ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☑ Diagnosis and treatment of sexually transmitted infections
☑ Social mobilization	☑ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☐ Mental health services for adolescents and youth living with HIV
☐ Prevention, safer sex, and risk-reduction counseling	☐ Other (specify)

F. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

G. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☐ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth
☑ Male adolescents and youth	☐ Transgender adolescents and youth

☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

H. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☑ School
☐ Worship place
☐ Work place
☑ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Adolescent-Friendly Voluntary Medical Male Circumcision (VMMC)
Country	*Country where the practice is or was carried out* South Africa
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* 1. Access to HIV services (location, hours, facility environment) 2. Peer education 3. Counseling and testing for HIV 4. Medical male circumcision
Year	*When did the practice start? When did it finish? When is it expected to finish?* June 2010 with community consultations, and continued until February 2013
Contact Person	Carl Montague Chief Operating Officer
Contact information	Dr. Carl Montague, PHD, MBA Chief Operations Officer: CAPRISA Manager: DST-NRF Centre of Excellence in HIV Prevention Doris Duke Medical Research Institute (2nd Floor) University of KwaZulu-Natal, 719 Umbilo Road Durban, South Africa Tel: +27 (0)31 260 4564 Fax: +27 (0)31 260 4549 C: +27 (0)71 678 4604 Carl.montague@caprisa.org Professor Quarraisha Abdool Karim CAPRISA Doris Duke Medical Research Institute (2nd Floor), University of KwaZulu-Natal 719 Umbilo Road Durban, South Africa Tel: +27 -31 – 2604550 Quarraisha.abdoolkarim@caprisa.org
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information. If it was a partnership, who were the partners? Were adolescents and youth involved in the implementation of the practice? How were they involved? Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?*

	The Centre for the AIDS Program of Research in South Africa (CAPRISA) implemented this practice in partnership with a local NGO, ZimnadiZonke. CAPRISA was created in 2001 and formally established in 2002 under the NIH-funded Comprehensive International Program of Research on AIDS (CIPRA) by five partner institutions: University of KwaZulu-Natal, University of Cape Town, University of Western Cape, National Institute for Communicable Diseases, and Columbia University in New York. CAPRISA is a designated UNAIDS Collaborating Centre for HIV Prevention Research. The main goal of CAPRISA is to undertake globally relevant and locally responsive research that contributes to understanding HIV pathogenesis, prevention, and epidemiology, as well as the links between tuberculosis and AIDS care. Adolescents and youth were involved in the implementation of the practice and some served as peer educators and recruiters.
Funding	*Who provided the funding and other resources?* PEPFAR, through the U.S. Centers for Disease Control and Prevention (CDC) under the terms of 5U2GPS001350.
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* The main objective of this practice was to assess the feasibility, acceptability, and uptake of VMMC services when combined with novel demand-creation strategies in high school students in the Umgungundlovu district.
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* KwaZulu-Natal in South Africa is at the epicenter of the global HIV epidemic with an estimated prevalence of 24.7% of the general population in 2011. The rural Umgungundlovu district in KwaZulu-Natal is one of the three highest HIV disease burden districts in South Africa and is a priority district for HIV prevention intervention efforts. Surveillance data in this district have demonstrated that the risk of HIV infection among males increases dramatically after adolescence, with prevalence of 2-3% and 11-12% among males of age 15-19 years and 23-24 years respectively. Voluntary medical male circumcision (VMMC) has been demonstrated to reduce risk of HIV acquisition through heterosexual vaginal sex in males by 50–73%. Therefore, targeting VMMC at young males as part of such a combination prevention program in schools before entry into the high-risk period could represent a directed and cost-effective means of altering current HIV epidemic trend.
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement*

	required or solicited during the planning stage. What was the theoretical foundation of the practice? After appropriate scientific ethical approval, community leaders and key stakeholders were also engaged to help them to understand the details and importance of the practice and get their support and acceptance of the intended practice. This was followed by engaging all 42 high schools in Vulindlela (a rural sub-district of Umgungundlovu). These high schools were all mixed-sex day schools and the number of males per school ranged from 91 to 892 with an average per school of 317. Only male students were recruited for the VMMC procedure and a total male population of 11,088 was recruited between March 2011 and February 2013. The target age group was 16 to 20 years, but services were also available to younger volunteers ages 12 to 15 years who had parental consent and to out of school volunteers over 20 years old. VMMC information and awareness-raising sessions, centralized HIV counseling and testing (HCT) service access and VMMC service access facilitation, and peer recruitment and decentralized HCT service access were all done in the schools. In each of the 42 high schools, the principal identified a teacher to serve as the liaison with the VMMC recruiters. The role of this teacher was to provide oversight of the VMMC program in the school and to alert CAPRISA should there be any problems. The teachers were not actively involved in the recruitment of students for VMMC.
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* The practice was implemented in three phases: **Phase I:** This involved a seven-month (starting in June 2010) community consultation and engagement with traditional, school, and community opinion leaders to assess the support and acceptance of the practice by the community. After these consultations, consent and collaboration were attained with the community and a local NGO in other to initiate the dissemination of information explaining the evidence that VMMC prevents HIV acquisition and the VMMC procedure. These outreach activities were done in churches, primary healthcare clinics, and other small informal community groups. **Phase II:** This involved in-school VMMC awareness sessions, centralized HCT service access, and VMMC service access facilitation starting from May 2011. Four VMMC coordinators were appointed to disseminate information on the HIV risk and the preventative benefits of VMMC and local VMMC service points during school assemblies. VMMC information was also incorporated into sexual and reproductive health classes for students.

	The local NGO counselors provided HCT services to students in schools and also arranged referrals to the clinic for the surgical procedure, with transport to and from the school provided. In the school, information and HCT services took place on Monday through Thursday and surgical procedures were performed on Friday afternoons and Saturdays. Nurses did postsurgical assessments in schools in other to minimize disruption of schooling. **Phase III:** This involved peer recruitment and decentralization of HCT service access starting March 2012. Students who successfully underwent the VMMC procedure were recruited to serve as peer recruiters. Their role was to inform their colleagues about the VMMC surgical procedure and its benefits. They were also tasked with scheduling and properly coordinating transport to the CAPRISA VMMC clinic. They were well trained and also received incentives within ethical limits. Also in this phase, HCT was undertaken at the CAPRISA clinic, as well as in other public sector clinics closest to the schools where there was demand. Postsurgical assessments were undertaken in schools the following week. In other to make the practice much more adolescent friendly: • The CAPRISA VMMC clinic, which offered HCT services on weekdays during school hours, extended its services to after-school hours to avoid having students miss classes. • At the CAPRISA clinic, HCT services were offered to all male volunteers, including those who tested HIV negative and positive. Circumcision was not done for those who tested positive. They were rather referred to CAPRISA's AIDS treatment program. However, a mock circumcision process was performed for those testing positive to maintain confidentiality and reduce stigma and discrimination. • Also, volunteers were screened for other STIs and if necessary treated appropriately according to a standard protocol. VMMC was rescheduled for those males who successfully completed STI treatment. • Trained and qualified clinicians performed the circumcision procedure followed by appropriate postsurgical management.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* 1. Male adolescents and youth 2. In-school adolescents and youth 3. Out-of-school adolescents and youth

Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3.* 1. Health facility 2. School *Was the practice implemented in urban or rural areas or both?* It was implemented in rural areas.
Outcomes/results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* There was high acceptability of the VMMC program in rural Umgungundlovu. Although no baseline data were available for adolescent uptake of VMMC services in this setting prior to this pilot, a 5.4-fold increase in VMMC uptake was observed following the demand-creation strategies—from an average of 58 procedures/month among instant and early adopters, to a peak of 308 procedures/month on initiation of phase three of the demand-creation strategy in March 2012.
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* VMMC is part of routine service provision in South Africa, and implementation is in accordance with WHO guidelines. Ethical review was sought by the project and granted by the Biomedical Research Ethics Committee of the University of KwaZulu-Natal for chart review of clients using the VMMC services. The implementers did not just impose this practice on the community but rather consulted and engaged them to obtain their consent, support, and collaboration. These consultations were critical for creating an effective enabling environment for the recruitment of adolescents for VMMC services. The mock circumcision process for the HIV-positive males was considered ethically necessary to prevent social harm to males through unintentional disclosure of their HIV status on the day of the VMMC clinic visit.
Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* Although no baseline data were available for adolescent uptake of VMMC services in this setting prior to the pilot, an impressive 5.4-fold increase in VMMC uptake was observed following demand-creation strategies, from an average of 58 procedures/month among instant and early adopters, to a peak of 308 procedures/month on initiation of phase three of the demand-creation strategy. This means that this practice was widely acceptable in the community and will therefore have the public health benefit of reducing the

	risk of HIV acquisition through heterosexual vaginal sex in males in the community. Also, because this program involved some level of screening before the circumcision, it meant that adolescents who were HIV- and or STI-positive and in the asymptomatic phase were identified early enough to initiate treatment to reduce the risk of further spread of the disease.
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.* Calculating the coverage of this program proved challenging. From the number of male students and the VMMC participants from each school, an estimated 47 percent coverage was the highest level attained. High schools in low male circumcision, high HIV-risk settings provide a convenient venue for reaching large numbers of young males who would benefit most from VMMC services, which over time could become normative. Since recruitment was done from all 42 high schools in the community, school-going adolescents in the community were well represented in the sample of participants. However, further work will be required to reach more vulnerable adolescent populations who have dropped out of schools.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* Working closely with community members who understand the benefits of the program enabled the project to negotiate and collaborate with existing local NGOs, community health centers, and targeted high schools with ease without the need of reinventing the wheel. This enabled the project to use resources already available in the community to achieve program goals. Also, incorporating information on VMMC into the school life skills curriculum served as a resource-efficient approach that is cost effective and more likely to be successful and sustainable in the community. Reaching young males with VMMC as part of a combination prevention program in schools before entry into the high-risk period could represent a direct and cost-effective means of altering current HIV epidemic trends.
Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* Findings of an increase in VMMC rates among adolescent males in a low-VMMC region following community awareness, sensitization, and involvement have also been demonstrated by the Department of Health

	survey in Tanzania. There were no control areas in the evaluation of this practice.
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they – or could they be – overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* The scheduling of clinic operations that took into account school timetables was mainly responsible for the program's success. However, there were marked reductions in VMMC demand during examination periods and school holidays, which therefore posed some challenges with respect to optimization of service provision, predominantly in terms of clinic staffing. The marked VMMC coverage variation observed between schools needs further evaluation to understand the causes of such variation, as well as to determine maximal VMMC coverage levels. These steps will be important in determining the feasibility of wide-scale implementation of a school-based VMMC program. More work will also be required to improve linkages to care, and to reach more vulnerable adolescent populations who cannot be reached through the educational settings.
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* Community involvement and consultations are critical in creating an effective enabling environment for the recruitment of adolescents for VMMC services. This is a major contributor to the acceptability and success of the practice. Monitoring, review, and adaption also led to the success of the VMMC demand-creation strategies in schools, with the launch of both the short in-school awareness sessions and the peer recruitment system dramatically increasing service uptake.
Retrospect	*Discuss anything that might have been done differently if applicable.* Since the various components of the demand-creation strategy were designed to be complementary, it is not possible to quantify the effect of each individual component on VMMC uptake. External factors that are not part of this program may have influenced the uptake of this practice. Therefore, having control schools in different settings and with the different components of the strategy will help to evaluate/assess the impact of the different component and other possible influential factors.
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.*

	This practice has mainly been implemented in high schools in particular communities with low circumcision rates and high risk of acquiring HIV. Therefore, more work will be required to improve linkage to care and reach more vulnerable adolescent populations who have dropped out of school. Community involvement and participation are essential components that should be maintained.
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* VMMC is already part of the routine health service in South Africa and its implementation is in accordance with World Health Organization guidelines. The VMMC demand-creation strategies in schools fit well in the existing health system, which makes it more likely to be sustained by the country's Ministry of Health. Also, since VMMC is a one-off surgical procedure, service provision could be easily integrated into regular school visits to maintain high coverage rates and VMMC information integrated into comprehensive school-based sexual reproductive health services. Increased coverage in VMMC would in the future reduce HIV acquisition for adolescents through heterosexual vaginal intercourse.
References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.* George, G. I., Strauss, M., Chirawu, P., Rhodes, B., Frohlich, J., Montague, C., & Govender, K. (2014). Barriers and facilitators to the uptake of voluntary medical male circumcision (VMMC) among adolescent boys in KwaZulu-Natal, South Africa. *African Journal of AIDS Research*, 13, 179–87. Montague, C., Ngcobo, N., Mahlase, G., Frohlich, J., Pillay, C., Yende-Zuma, N.,…Karim, Q. A. (2014). Implementation of adolescent-friendly voluntary medical male circumcision using a school based recruitment program in rural KwaZulu-Natal, South Africa. *PLoS ONE*, *9*, e96468.

Fútbol para la Vida (Deportes para la Vida), Dominican Republic

Jon Erickson

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☑ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☐ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☐ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk- reduction counseling	☑ Other (specify)
☐ Other (specify)	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☐ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☑ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☑ Other (Orphans and vulnerable children)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☐ Health facility
☑ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☑ Other (Fútbol Para la Vida camps)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Fútbol Para la Vida (Deportes para la Vida) Program
Country	*Country where the practice is or was carried out* Dominican Republic (DR)
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* 1. Sex/HIV education 2. Peer education 3. Prevention, safer sex, and risk-reduction counseling 4. Communication on HIV/AIDS
Year	*When did the practice start? When did it finish? When is it expected to finish?* 2002
Contact Person	*Name:* Z.A. Kaufman
Contact information	Yanlico Munesi Dusdal Dream Project – Deportes para la Vida Plaza Novus Mare, Local 11 Segundo Piso, Carretera Cabarete Entrada de La Callejon de la Loma Cabarete, Puerto Plata República Dominicana yanlico21@gmail.com Dr. Jon Erickson George D. Aiken Center University of Vermont Burlington, VT 05405 jon.erickson@uvm.edu The Dream Project: Dominican Address: Plaza Novus Mare, Local 11 Segundo Piso, Carretera Cabarete Entrada de La Callejon de la Loma Cabarete, Puerto Plata

	República Dominicana Tel: +1 (809) 571-0497 info@dominicandream.org The Dream Project: U.S. Address 916 Williams Rd, Unit 2 Colchester, VT 05446 Tel: +1 (607) 216-4697 Fax: +1 (815) 550-1727
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information.* *If it was a partnership, who were the partners?* *Were adolescents and youth involved in the implementation of the practice? How were they involved?* *Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* Fútbol para la Vida (FPV) is now referred to as Deportes para la Vida (DPV) (Sports for Life), and is a core part of the youth leadership program of the Drug Resource Enhancement against AIDS and Malnutrition (DREAM) Project based in Cabarete, Dominican Republic. It originally started at Batey Libertad as a partnership with the University of Vermont and Grassroot Soccer. Over the years, DPV has grown into a nationwide program. DPV is an HIV/AIDS prevention education and youth leadership program in the Dominican Republic that uses sports, game-based activities, and peer mentoring to engage youth in the creation and practice of healthy life choices through bilingual Spanish/Haitian Kreyol camps and courses. Adolescents and youth were involved in the implementation of the practice by using soccer players as the role models in their communities to deliver the FPV interventions. FPV targeted at-risk youth populations in Haitian migrant communities, where a lack of investment in healthcare and education has contributed to some of the highest rates of HIV infection in the Caribbean and Latin America. DPV partners are mainly local communities, Dominican NGOs, international NGOs, and universities. DPV is a member of the international Grassroot Soccer network and provides bilingual Spanish/Haitian Kreyol camps and courses; training-of-trainers workshops for community-based peer educators, local NGO staff, and public school and health programs; and support for youth camps, soccer tournaments, and other outreach opportunities.

Funding	*Who provided the funding and other resources?* Kaminsky Family Fund through Dartmouth College's Dean of Faculty as well as the John Sloan Dickey Center for International Understanding. It was also supported by the Fundación de Libertad, the Lintilhac Foundation, and the William Jewett Tucker Foundation. DPV, which has grown into a nationwide program, has support from Peace Corps and funding from PEPFAR.
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* The program aims to improve youth's knowledge about HIV/AIDS, in order for them to believe and realize that they can protect themselves from contracting HIV, and to create an enabling and friendly environment in which they feel comfortable discussing sexual and reproductive health issues among peers and with community role models. The study therefore evaluated the short-term outcomes of FPV interventions to determine whether they significantly influenced what adolescent/youth knew, thought, and communicated about HIV and whether any observed effects were sustained over several months of follow-up.
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* The significantly higher HIV prevalence among Haitian migrants in deprived communities that lack investment in healthcare and education in the DR compared to the national average (3.2% in *bateyes*, four times the national average of 0.8%, and roughly 1.5 times the Haitian national average of 2.2% [CESDEM, 2007a; UNAIDS, 2008) with the difference more pronounced (5.2% vs. 2.3%) among mothers ages 21–25 years (Roman-Poueriet, et al., 2009). Also, the low HIV-related knowledge and attitudes, and common stigma and beliefs in myths among the Haitian migrant population in the DR suggest that HIV-prevention knowledge is low (Lopez Severino & De Moya, 2007; Martinez, 2005). Risky behavior is also of concern in these communities. While this underscores the need to reach adolescents in these communities with effective prevention programs, there were no published studies at the time to assess the outcomes of HIV-prevention interventions serving this population.
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?*

	Participants were invited to participate in a five-day FPV camp. Ninety-nine chose to participate (the intervention group), 41 chose not to participate (the control group), and 24 were lost to follow-up. DPV is a member of the international Grassroot Soccer network and provides bilingual Spanish/Haitian Kreyol camps and courses; training-of-trainers workshops for community-based peer educators, local NGO staff, and public school and health programs; and support for youth camps, soccer tournaments, and other outreach opportunities. DPV partners were mainly local communities, Dominican NGOs, and international NGOs and universities.
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* The partners trained local *batey* soccer players—role models in their communities—to deliver FPV interventions in community centers and in FPV camps. FPV interventions consisted of 10 hours of instruction, typically administered over the course of five days. Each activity had an interactive component and a discussion component.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* 1. Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth 2. In- and out-of-school adolescents and youth 3. Orphans and vulnerable children
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3.* 1. Community 2. FPV camps *Was the practice implemented in urban or rural areas or both?* The practice was implemented in both urban and rural areas.
Outcomes/ results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* The outcomes were HIV-related knowledge, attitudes, and communication among the targeted adolescent/youth. The program sought to determine whether FPV interventions significantly influenced what young people knew, thought, and

	communicated about HIV and whether any observed effects were sustained over several months.
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* The practice was implemented according to the values of the DREAM project, which include acting and treating all participants with respect, responsibility, honesty, and authenticity (integrity) and equity.
Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment, and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* The results of this practice suggested that this sports-based intervention could play a valuable role in HIV-prevention efforts in the Caribbean, particularly those targeting early adolescents. At post-intervention, significant differences were observed between groups in HIV-related knowledge, reported attitudes, and reported communication. These differences remained significant at four-month follow-up.
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.* There was significantly greater increase in knowledge of the sexual transmission of AIDS, knowledge of condoms as a prevention method, communication, and self-efficacy to avoid AIDS in the intervention than in the control group post intervention and at four-month follow-up, after adjusting for age, sex, community, descent, and baseline responses. The small sample size, high loss to follow up, and short-term scope had a major effect on the generalizability of this practice.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* This practice is thought to be resourceful as the development and application of the practice involves using soccer as a platform to develop youth leaders, mobilizing community assets, and training community/local role models as FPV peer educators.

Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* A quasi-experimental study was done in which structured face-to-face interviews were conducted at baseline with 164 adolescents ages 10–20 years in four *bateyes* and two Haitian barrios in the north coast province of Puerto Plata. Interviews were conducted prior to, immediately following, and four months after the intervention program. While the evaluation included an intervention group and a control group, the study did not include measures of reported sexual risk behavior or biological endpoints. The instrument used was calibrated through pilot testing with 45 youth (non-study participants) in two of the communities. This practice has also been supported by similar studies with peer review in sub-Saharan Africa with significant effects on HIV-related knowledge.
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they—or could they be—overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* The main problems encountered in implementing this practice were limited funds and loss to follow-up. Further evaluation of sports-based interventions should include indicators assessing behavioral and biological outcomes, longer-term follow-up, a larger sample, randomization of study participants, and strenuous efforts to minimize loss to follow-up. All of these will require adequate funding.
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* The most important lesson learned is that the potential success of sports-based HIV prevention in improving knowledge and attitudes is mainly due to the involvement of the local people, their respected models, and local and governmental organizations in the community rather than bringing in foreign-based policies or activities.
Retrospect	*Discuss anything that might have been done differently if applicable.* Since the evaluation of the intervention revealed that participants did not retain knowledge of partner reduction/faithfulness as a prevention method as compared to knowledge of condoms, improvements are needed in FPV. FPV activities in the curriculum should be modified or supplemented to increase emphasis on partner reduction/faithfulness as a prevention method without detracting from education about abstinence and condoms.
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be*

	included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain. This practice has been replicated across similar settings (resource-limited settings in sub-Saharan Africa, e.g., Kenya, Tanzania, and Zimbabwe) with similar results. Activities in the FPV curriculum should be modified or supplemented to increase emphasis on partner reduction/faithfulness as a prevention method. Also, elements/indicators assessing behavioral (sexual risk behaviors) and biological outcomes are needed to be included in this practice as measures of the effectiveness/impact of this practice.
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of effects over time—even without ongoing funding/support?* In terms of sustainability, this practice has developed programs that can be successfully implemented and replicated in other communities across the country, leaving behind the necessary tools for future generations to continue their development. DPV currently hosts two facilitator trainings and one National Conference each year for youth leaders and Peace Corps volunteers from across the Dominican Republic. This has created over 200 facilitators who have been trained since 2010, and over 1,400 students who have received the curriculum each year. This nationwide network of facilitators enables the program to grow into many areas, where health and life decision-making education is much needed. This has made DPV grow into a nationwide program with support from Peace Corps and funding from PEPFAR.
References/ related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.* CESDEM (2007a). Prevalencia de VIH en la República Dominicana, ENDESA 2007.Santo Domingo, Dominican Republic: CESDEM. Retrieved from http://www.cesdem.com/html/prevalencia_de_vih_en_la_republica_dominicana_endesa_2007.pdf Fundación de Libertad. Retrieved from: https://bateylibertad.wordpress.com/. Kaufman, Z. A., Welsch, R. L., Erickson, J. D., Craig, S., Adams, L. V., & Ross, D. A. (2012). Effectiveness of a sports-based HIV prevention intervention in the Dominican Republic: A quasi-experimental study. *AIDS Care*, 24, 377-85.

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Mema kwa Vijana, United Republic of Tanzania

David Ross

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☑ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☑ Condom provision	☐ Care and support for adolescents and youth living with HIV
☑ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☐ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☐ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☑ Other (Training and supervision of health workers to provide "youth-friendly" sexual health services)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10-14 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☐ Pregnant adolescents and youth

☐ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health Facility
☑ Community
☑ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*MEMA kwa Vijana* ("Good things for young people")
Country	Tanzania, Mwanza Region
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* Sex/HIV education Condom provision Peer education Other (Training and supervision of health workers to provide "youth-friendly" sexual health services)
Year	*When did the practice start? When did it finish? When is it expected to finish?* 1999 to 2002
Contact Person	David A. Ross, Angela I. N. Obasi, Jenny Renju, Aoife Doyle, and Richard Hayes, Fern Terris-Presholt
Contact information	David Ross World Health Organization Department of Maternal, Newborn, Child and Adolescent Health Avenue Appia 20 1211 Geneva 27 Switzerland dross.rbridge@googlemail.com Angela Obasi angela.obasi@lstmed.ac.uk Dr. Rita Noronha Acting Country Representative AMREF/Tanzania 1019 Ali Hassan Mwinyi Road P.O. Box 2773 Upanga Dar es Salaam Tanzania Tel: +255 22 211 6610 Fax: +255 22 211 5823 Dr. Serafina Mkuwa Program Manager for Health Research AMREF/Tanzania 1019 Ali Hassan Mwinyi Road P.O. Box 2773 Upanga Dar es Salaam Tanzania Tel: +255 22 211 6610 Fax: +255 22 211 5823

	Dr. Jenny Renju (PhD) Department of Epidemiology and Biostatistics Kilimanjaro Christian Medical University College (KCMCUCo) Moshi Tanzania Tel: +255789734603 Email: jenny_komrower@yahoo.co.uk Skype: jenny.renju
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information.* *If it was a partnership, who were the partners?* *Were adolescents and youth involved in the implementation of the practice? How were they involved?* *Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* The practice was implemented by African Medical and Research Foundation (AMREF) in Mwanza, Tanzania, in collaboration with the Tanzanian National Institute for Medical Research (NIMR), the Ministries of Education and Culture and of Health of the Government of Tanzania, and the London School of Hygiene and Tropical Medicine. AMREF Health Africa was officially founded in 1957 to deliver mobile health services and to provide mission hospitals with surgical support. A medical radio network was developed to coordinate the service and provide communication. AMREF Health Africa's current strategy (2007–2017) focuses on finding ways to link health services to the people that need them by focusing more on people and less on diseases—tailoring responses to specific community needs. Adolescents were involved in the implementation of the sexual health education component of the practice through a teacher-led, peer-assisted program of lessons on sexual health delivered in the last three years of primary school (standards 5–7).
Funding	*Who provided the funding and other resources?* The practice was supported by grants from the European Commission, the UK Department for International Development, and Irish Aid, with additional funding support from the Medical Research Council of Great Britain and UNAIDS.
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* The objectives of MEMA kwa Vijana were to: a. Delay sexual debut among youth b. Reduce the number of sexual partners among those who were sexually active c. Promote the correct and consistent use of condoms among those who are sexually active d. Increase the uptake of STI and family planning services

Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* Sub-Saharan Africa has the highest HIV prevalence in the world, with an estimated 27 million people living with HIV/AIDS in 2003. Around half of new infections in 2003 were among young people ages 15–24 years. Although HIV prevalence among 10–14-year-olds tends to be low even in countries with hyperendemic scenarios, as adolescents become sexually active, especially girls, they are at high risk of acquiring HIV and other STIs. HIV prevalence among young girls/young women rises to 20 percent or more by age 20 in some settings. If HIV reduction targets are to be achieved, effective interventions will need to be implemented on a wide scale in countries where young people are at risk. There is clearly a need for specially designed interventions to improve the sexual health of adolescents, and to help them establish behavioral patterns that will reduce their risk of STIs, HIV, and unwanted pregnancies. Unfortunately, little is known about what interventions are effective, and policymakers have little rigorous evidence of how best to invest the available resources for AIDS control. The MEMA kwa Vijana project was carried out in rural Tanzania to meet this information need. The aim was to develop an innovative adolescent sexual health intervention and to evaluate its impact and cost-effectiveness through a community randomized trial. The practice was carried out in rural areas of Mwanza Region for several reasons. First, there was a wealth of background information on the epidemiology and control of HIV and other STIs in this region. Second, the community-randomized design was easier to implement in a large rural area, in which distinct, well-separated communities could be selected and randomized. Third, out-migration and consequent loss to follow-up were expected to be less of a problem in rural than urban areas. Finally, apart from a pilot project in the district capitals and a small-scale church project, there were no other initiatives specifically targeting adolescent sexual health in districts in the region. The full effect of the intervention could therefore be assessed (Hayes, et al., 2004).
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?* The intervention was based on social learning theory. The design and development of the intervention was coordinated by a small team working within AMREF, in collaboration with officials from the Ministry of Education and Culture, the Ministry of Health (MoH), and the London School of Hygiene and Tropical Medicine. The intervention was developed in four phases:

	Phase 1: From 1996 to 1998, a framework for the intervention was developed using best practice reviews and recommendations and data from epidemiological and intervention studies in Mwanza Region and other parts of Africa. Phase 2: From March to December 1997, as part of a WHO-funded situation analysis, interviews were conducted with senior officials from all the relevant government ministries; with the program directors of the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Chama Cha Uzazi na Malezi Bora – Tanzania (UMATI) (the leading family planning organization), and Population Services International (PSI) (the lead condom social marketing organization in Tanzania); and with senior social scientists at the Muhimbili University Centre for Health Sciences. Teams also visited six schools in Mwanza town and at least two rural schools and two health units in each of the four trial districts, and interviewed head teachers, curriculum development teachers, teacher guardians, pupils, lead health workers, and staff in charge of family planning services. The interviews aimed to ascertain existing levels of, national and local priorities for, and obstacles to the provision of health and education services for youth. They were also intended to ensure the appropriateness of the intervention with respect to existing needs, capacity, and policy. Phase 3: A school curriculum was developed incorporating modified exercises from various programs, including the WHO/United Nations Educational, Scientific and Cultural Organization (UNESCO) guides (WHO & UNESCO, 1994a; WHO & UNESCO, 1994b; WHO & UNESCO, 1994c), the UK SHARE program (Wight & Abraham, 2000), and experience from visits to other programs in East and Southern Africa (Obasi, 1996; Kinsman, et al., 1999; Shuey, et al., 1999). Youth-friendly services and condom promotion interventions were developed in partnership with PSI. Pilot testing of different components of the intervention took place from 1998/1999 (Chima, et al., 1999; Cleophas-Frisch, et al., 2000a; Obasi, 2001). Phase 4: The intervention was further modified over the subsequent three-year impact evaluation period based on continued process evaluation of the implementation of the intervention conducted by intervention staff, the MEMA kwa Vijana qualitative research program (HALIRA), and external evaluators, (e.g., Guyon, et al., 2000; Obasi, et al., 2000; Lugoe, 2001; Cleophas-Frisch, et al., 2002).
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* The program had four main components: - Sexual health education - Youth-friendly health services - Community-based condom promotion and distribution by youth - Community activities

	Sexual Health Education This component was a participatory, teacher-led, peer-assisted, in-school program, comprising an average of 12 40-minute sessions per year, held in normal school hours in years 5 to 7 of primary school. The program built on the experience of adolescent reproductive health projects in Tanzania aimed to include all 10 characteristics previously identified as associated with effective programs. Youth-Friendly Health Services In all 20 trial communities (both intervention and comparison), staff of all health units were trained in syndromic management of STIs, and the project ensured a regular supply of STI drugs and other supplies. In addition, in the 10 intervention communities only, health workers were trained for one week on the provision of youth-friendly sexual and reproductive health services, and they were supervised quarterly. The main emphasis was on adopting a welcoming and nonjudgmental attitude toward young people, and ensuring privacy and confidentiality. Health workers visited the local primary schools to introduce the services available and periodic visits were arranged from the schools to the clinics to familiarize students with the facilities. Condom Promotion and Distribution Young men and women, elected by youth in each community, were trained to promote and supply condoms to adolescents and young people at an affordable price (US$0.08 for a packet of 3 condoms) using a social marketing approach. Community Activities An advisory committee was established in each community, and meetings were held with parents, religious leaders, local government authorities, and women's groups to inform them about the program. Youth health weeks were held annually, during which there were special activities linked to sexual health. Health units held special open days for youth, which included condom demonstrations (Obasi, et al., 2006; Hayes, et al., 2005).
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* Adolescents and youth in the general population In-school adolescents and youth
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3. Was the practice implemented in urban or rural areas or both?* • Community • School • Health facilities The practice was implemented in rural areas of Mwanza region. The practice involved 62 primary schools in 10 intervention communities, 18 health units, 189 teachers, 62 head teachers, 2248 class peer educators, 228 condom promoters/distributors, and 54 health staff trained in the provision of youth-friendly services (Obasi, et al., 2006; Hayes, et al., 2005).

Outcomes/results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.*
	
	The outcomes that were measured were:
	- Knowledge of HIV acquisition
	- Knowledge of STI acquisition
	- Knowledge of pregnancy prevention
	- Attitudes to sex
	- Sexual initiation
	- Number of partners
	- Condom use
	- Contraceptive use
	- Use of health facility for recent STI symptoms
	- Biological outcomes
	  o HIV
	  o Herpes simplex virus (HSV-2)
	  o Syphilis
	  o Chlamydia trachomatis
	  o Gonorrhea
	  o Pregnancy
	  o Genital discharge
	  o Genital ulcer

Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* The trial protocol received ethical clearance from the Tanzanian Medical Research Coordinating Committee and the Ethics Committee of the London School of Hygiene & Tropical Medicine. Signed informed consent was obtained from each participant on the day of the survey. Additional signed consent was obtained from parents of participants under the age of 18 years.
Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment, and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* <u>Knowledge and reported attitudes</u>: At the final survey, there were substantial and statistically significant differences in the proportions of both male and female participants who answered all three questions correctly for each of the three knowledge outcomes, and for the reported attitude outcome. The adjusted RR for these four outcomes ranged from 1.28 to 1.77 for male and from 1.41 to 1.58 in female participants. These results were independently confirmed by the results of a school examination administered to year seven students in July 2002.

	Sexual behaviors: The proportion of young men reporting sexual debut during follow-up was 60 percent in the intervention and 72 percent in the comparison communities (adjusted RR 0.84, CI 0.71, 1.01). There was little difference among young women (adjusted RR 1.03, CI 0.91, 1.16). Similarly, the proportion of male subjects who reported more than one sexual partner in the past year was significantly lower in the intervention (19%) than in the comparison communities (28%; adjusted RR 0.69, CI 0.49, 0.95), but no significant difference was seen in female participants (adjusted RR 1.04, CI 0.58, 1.89). Condom use: The proportions who reported initiating condom use during follow-up were substantially and significantly higher in intervention communities among both male and female participants. The proportions reporting condom use at last sex were higher in intervention communities in both sexes, but this was only significant in young men, and absolute levels of condom use at last sex remained relatively low (<30%). Clinical STI symptoms and signs: At the final survey, the proportion of participants reporting genital pus or abnormal genital discharge during the past year was substantially lower in intervention communities, both among male (adjusted RR 0.58, CI 0.41, 0.83) and female (adjusted RR 0.59, CI 0.43, 0.80) participants. Among those reporting STI symptoms, however, there was no significant difference in the proportion who reported having sought care at a local health facility for their most recent STI episode during the past year, in either sex. HIV and sexually transmitted infections: The two primary outcomes of the trial, HIV incidence and HSV-2 prevalence, were based on biological tests. Only 45 participants (five boys and 40 girls) seroconverted to HIV during 23,730 person-years of follow-up. After adjustment, HIV incidence in female subjects was 25 percent lower in the intervention communities, but this difference was not statistically significant (adjusted RR 0.75, CI 0.34, 1.66). Overall, 12 percent of male and 21 percent of female participants were HSV-2 seropositive at the final survey, but there was no difference by trial arm for either male (adjusted RR 0.92, CI 0.69, 1.22) or female (adjusted RR 1.05, CI 0.83, 1.32) participants. In general, intervention/comparison differences in knowledge, reported attitudes, and reported risk behaviors were greater among participants with more years of potential exposure to the in-school intervention, especially in young men (Ross, et al., 2007).
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.*

	The practice was designed as a community randomized trial. This meant that mass media and other national or regional approaches could not be included. The cohort studied also excluded in-migrants and 27 percent of the initial cohort were lost to follow-up despite considerable efforts to trace members who were absent during the follow-up rounds. An analysis of socioeconomic differentials in the impact of the intervention revealed some evidence of a greater impact on STI knowledge among never-married women (P=0.07). The effect on HIV incidence was substantially greater in never married women (adjusted RR 0.40, CI 0.10–1.59) than ever-married women (adjusted RR 0.98, CI 0.47–2.03), although this was not statistically significant. There was no consistent difference by marital status for any of the behavioral or other biological outcomes.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* This trial demonstrated the feasibility of large-scale implementation of an adolescent sexual health intervention using existing government staff and structures in sub-Saharan Africa. The average annual cost of the intervention was almost US$30,000 per trial community (approximately equivalent to an administrative ward, mean total population approximately 15,000) during the trial phase, including all start-up and capital costs, approximately equivalent to US$10 per adolescent per year within the primary target age range (12–19 years). Within a districtwide program, first-year costs are projected to be US$22,000 per ward (US$7.30 per 12–19-year-old), decreasing to US$3,600 per ward (US$1.20 per 12–19-year-old) in subsequent years (Ross, et al., 2007).
Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* The impact of the intervention was evaluated through a community-randomized trial, in which 20 communities were randomized to intervention or control arms, and a cohort of adolescents was recruited at study schools in both arms and followed up for three years to record the outcomes of interest. Baseline and follow-up surveys were carried out within the study schools. At final follow-up, all communities were visited twice to maximize follow-up. Up to three visits were made to the homes of cohort members to trace those not presenting to the survey team. An attempt was made to trace cohort members reported to have moved within the same ward, or within a 30-minute drive of the ward boundary. During April 2002, a survey team visited major migration points in Mwanza Region and neighboring regions in an attempt to locate cohort members who had migrated from their original communities. In 2007, a cross-sectional survey was conducted in the 20 trial communities among 13,814 young people (ages 15–30 years) who had attended intervention or comparison schools between 1999 and 2002 to assess the long-term impact of the practice.

Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they—or could they be—overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* Regarding problems or obstacles with the implementation of the practice, there was greater coverage of biological sessions (e.g., puberty, HIV/AIDS, STIs) than life skills-based session when the practice was scaled up (Renju, et al., 2011).
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* The detailed nature of the curriculum and the intensive in-service teacher training appeared to facilitate teacher motivation and implementation of the practice. The low level of supervision in schools after scale-up likely had a negative effect on the quality and sustainability of the intervention. Furthermore, a single training during scale-up appeared to be insufficient to impart skills required for teaching the psychosocial aspects of the curriculum. Systematic pre-service training of teachers would be more cost-efficient and likely to influence acceptance and uptake of the practice.
Retrospect	*Discuss anything that might have been done differently if applicable.* Interventions that were tested in the trial were all directly targeted at adolescents themselves. In retrospect, community-wide interventions aimed at changing societal norms that compromise the ability of adolescents to change their sexual behavior should have been implemented.
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.* A tenfold scale-up of the practice started in 2004 to include all schools and health units. The scale-up (hereafter referred to as MkV2) adopted a training cascade mechanism from the region through the district, to the ward and school level, and culminating in the selection and training of three science teachers per school. Teachers, assisted by selected students known as classroom peer assistants, were expected to teach 10 adolescent sexual and reproductive health sessions per year to students in each of the final three years of primary school (years 5–7). The class peer assistants were expected to perform role plays as discussion starters, as specified in the teachers' guides. The following modifications were made to the intervention to make it feasible on a larger scale: • The role of the NGO that implemented the trial phase changed from direct responsibility for conducting the teacher training and

	school-level supervision to merely facilitating the local government employees in these roles. • There was a reduction of training for teachers from once per year to once overall. • There was a change in training class peer assistants from annual NGO-supervised training to ad hoc training by teachers. • There was a decreased level of supervision from once per quarter by an NGO-led team to inclusion as part of routine district observations. • The annual youth health week was replaced by one-day events (e.g., Day of the African Child and World AIDS Day). The low level of supervision in schools after scale-up likely had a negative effect on the quality and sustainability of the intervention. Furthermore, a single training during scale-up appeared to be insufficient to impart skills required for teaching the psychosocial aspects of the curriculum (Renjuet, al., 2011).
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* An assessment of the long-term impact of MEMA kwa Vijana in 2007 revealed that the impact on pregnancy prevention knowledge and reported attitudes to sex increased with years of exposure to the practice. It has been recommended that implementers take steps to ensure that intervention quality is maintained through supervision and retraining of teachers, especially if new teachers are recruited as others are transferred out.

References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.* Changalucha, J., Weiss, H. A., Hayes, R. J., & Ross, D. A. (2010). Impact of the MEMA kwa Vijana adolescent sexual and reproductive health interventions on use of health services by young people in rural Mwanza, Tanzania: Results of a cluster randomised trial. *Journal of Adolescent Health,* 47, 512–522. Chima, K., Obasi, A.I., Cleophas-Frish, B., Ross, D.A.B.M., & Balira, R. (1999). Impact of a teacher led reproductive health intervention on pupil knowledge in primary schools in Mwanza, Tanzania. 13th meeting of the International Society for Sexually Transmitted Diseases Research, Denver. Cleophas-Frisch, B., Obasi, A., Manchester, T., Rwakatare, M., Magadula, A., Charles, J., et al. (2000a). Pilot Study of a Village-based Condom Social Marketing Initiative in Rural Mwanza, Tanzania. XIII International AIDS Conference, Durban. [Abstract:ThPe5356] Cleophas-Frisch, B., Obasi, A., Mshana, G., Wayomi, J., Plummer, M., Rwakatare, M., et al. (2002). Evaluation of the youth-friendliness of reproductive health services in rural Tanzania using simulated patients. XIV International AIDS Conference, Barcelona. [Abstract:WeOrD1277]Doyle, A. M., Weiss, H. A., Maganja, K., Kapiga, S., McCormack, S., Watson-Jones, D., ... Ross, D.A. (2011). The long-term impact of the MEMA kwa Vijana adolescent sexual and reproductive health intervention: Effect of dose and time since intervention exposure. *PLoS ONE,* 6 (9), e24866. Doyle, A. M., Ross, D. A., Maganja, K., Baisley, K., Masesa, C., Andreasen, A., … Hayes, R. J., for the MEMA kwa Vijana Trial Study Group. (2010). Long-term biological and behavioural impact of an adolescent sexual health intervention in Tanzania: Follow-up survey of the community-based MEMA kwa Vijana Trial. *PLOS Medicine*, 7, e1000287. Doyle, A. M., Weiss, H. A., Maganja, K., Kapiga, S., McCormack, S., Watson-Jones, D., … Ross, D. A. (2011). The long-term impact of the MEMA kwa Vijana adolescent sexual and reproductive health intervention: Effect of dose and time since intervention exposure. *PLOS ONE,* 6, e24866.

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One2One Integrated Digital Platform (OIDP), Kenya

Chelimo Keter

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☑ Counseling and testing for HIV
☑ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☑ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☑ Care and support for adolescents and youth living with HIV
☑ Family planning services	☑ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☑ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☑ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☑ Other (sexual and reproductive health)
☐ Other (specify)	☐ Other (specify)
☐ Other (specify)	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☑ Pregnant adolescents and youth
☑ Female sex workers	☐ Incarcerated adolescents and youth
☑ Male adolescents and youth	☐ Transgender adolescents and youth
☑ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☑ Married adolescent girls
☑ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☐ Health facility
☐ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☑ Other (Integral Digital Platform)

Best Practices Submission Form – Part 2

Name	One2One Integrated Digital Platform (OIDP)
Country	Kenya
Topic area	Counseling and testing for HIV Sex/HIV education Staff preparedness to serve adolescents and youth Care and support for adolescents and youth living with HIV Family planning services Sexual abuse/violence prevention and treatment Social mobilization Substance use (including alcohol) Referrals and linkages to services Peer education Mental health services for adolescents and youth living with HIV Prevention, safer sex, and risk-reduction counseling Sexual and reproductive health messages
Year	Started in 2006 The end date not determined, as we continue to ensure the sustainability of the intervention.
Contact Person	Chelimo Keter Adolescents and Youth Programs Coordinator
Contact information	P.O. Box 19835 – 00202 Nairobi Kenya cketer@lvcthealth.org one2one@lvcthealth.org www.one2onekenya.org Tel: +254723612705

Implementers	OIDP is a peer-led practice implemented by LVCT Health in partnership with a cellular service provider (Safaricom) for technological support, with financial support from Hivos, Population Services (PS) Kenya, and UNICEF. Adolescents and youth including those living with HIV and key populations were involved in the design of OIDP and are currently involved in the implementation, including in the development of simple messages that resonate with them. They have also been involved in the development of the OIDP information, education, and communication materials used today.
Funding	HIVOS PS Kenya UNICEF
Goals/objectives	Our goal is to achieve and maintain improved health, knowledge of and access to comprehensive SRH, GBV, and HIV prevention and treatment services among adolescents and youth in Kenya.
Background	The low HIV, SRH and GBV knowledge levels, linkage and service uptake among adolescents and youth vis-a-vis the high mobile telephony and internet penetration in at 80%, in urban, peri-urban and rural settings led to this program. In context, the comprehensive HIV knowledge among 10–14 years is only at 17.4 percent (Kenya AIDS Indicator Survey, 2012) and among youth 15–25 years is at 64 percent for boys and 54 percent for girls (Kenya Demographic and Health Survey, 2014). This shows that there is a gap in information and services provision. The practice was implemented to create a forum for open discussion, sharing and counselling for young people to explore HIV and AIDS, sex, sexuality, and SRH issues and make informed decisions.
Design	In 2006, LVCT started a toll-free hotline at its premises in Hurlingham, Nairobi. The hotline was originally set up to serve men who have sex with men, in response to their identification of lack of HIV appropriate information, especially for those who did not go to VCT, and post-counseling information for those who did. Until 2011, the One2One hotline operated with two work stations, having five trained counselors from 20 to 30 years of age who were working in shifts to keep the lines open between 8:00 a.m. and 8:00 p.m. on weekdays and 10:00 a.m. to 4:00 p.m. on weekends. More than 32,000 calls were answered at the hotline from 2006 to April 2011, representing about 50 percent of calls received. Recognizing opportunities to harness the fast-growing mobile telephone use in Kenya and better infrastructure, in April 2011, the hotline began operations at the Safaricom Jambo Call Centre in

	a public private partnership in which Safaricom waives 30 percent direct operational costs, among other benefits to the hotline with LVCT funding the rest from donor funds. The number of counselors was increased to seven, with six work stations. In the first quarter (April and July 2011) of the move to Safaricom, a total of 37,958 calls were received. At that time, the other digital platforms were also introduced. An assessment of the OIDP utilization in 2013 indicated that it largely served 15–24-year-old youth from the general population. The LVCT Health's innovative OIDP has hence harnessed the growing use of digital technologies by the Kenyan adolescent and youth populations to provide SRH/ HIV/GBV services. Currently the hotline operates daily from 7:40 a.m.–8:00 p.m. with counselors working a morning shift from 7:40 a.m. to 2:00 p.m. and an afternoon shift from 2:00 p.m. to 8:00 p.m. This peer-led innovative and evidence-based program offers comprehensive quality direct services and health literacy to over one million adolescents (10–19 years) and youth (15–24 years) in Kenya annually.
Main activities	One2One uses a complimentary mix of multimedia approaches that includes digital platforms, direct health, and HIV information delivery, including linkage to appropriate services, capacity development, and related policy advocacy for and with adolescents and youth. OIDP comprises mobile and web-based platforms. The mobile-based platforms include the hotline and Bulk SMS hosted by Safaricom and hence free from their numbers. The web-based platforms include Facebook (One2One KE), Twitter, YouTube and Instagram (@one2oneKE), Blog (www.one2oneyouthkenya.wordpress.com), email (one2one@lvcthealth.org), and WhatsApp (0700121121), all anchored to our website (one2onekenya.com). All these channels provide opportunities through which youth can engage with a professional adolescent and youth friendly counselor at any time on issues related to SRH information and services. These activities are complemented by mainstream media (radio, TV, teen magazines) and below-the-line adolescent/youth activations.
Beneficiaries	Age 10–14 Age 15–19 Age 20–24
Implementation sites	OIDP is implemented nationally with a focus on the six HIV high-burden counties (Nairobi, Kisumu, Homabay, Siaya, Mombasa, and Turkana). In this regard, the practice is implemented in urban, peri-urban, and rural settings.

Outcomes/results	In 2013–2014, over 2.8 million adolescents and youth were reached with information on HIV, SRH, and GBV through the integrated digital platform. The bulk SMS tool has improved HIV literacy, and linkage to and uptake of HIV services. Reminders sent to HIV-positive clients have increased the keeping of medical appointments from 72 percent to 83 percent. We have seen increased SRH, HIV, and GBV knowledge among young people by creating a forum for open discussion, sharing, and counseling for young people to make informed decisions. We have linked adolescents and youth with targeted and appropriate services. The OIDP has mobilized teens and young people for peer-to-peer education and advocacy.
Ethical soundness	The professional counsellors who implement the OIDP follow ethical principles of counseling, including confidentiality and being nonjudgmental.
Relevance	OIDP uses the one thing adolescents and youth highly depend on to share the information they highly lack. This practice has been shown to reach a large number of adolescents and youth in different parts of the country with information and services for HIV and GBV prevention.
Reach	OIDP has the capacity to reach over 20 million adolescents and youth countywide with information on HIV, SRH, and GBV among other health, adolescent/youth-related issues. Currently, only 10 percent of this population is being reached, which includes those using drugs, those most at risk, those HIV positive, and so on. The first step is always to gather the demographics of the clients who contact us; hence, we can disaggregate the data to highlight the region they are from, their age, their HIV status, their disability status, their level of education, and the issue they are concerned about without any discrimination. The mobile-based platforms of the OIDP can be accessed by any simple phone and hence can help us achieve health equity.
Efficiency	OIDP has proven to be very effective with only 10 counselors serving over 2.8 adolescent and youth clients annually. The cost for handling the OIDP platforms are absorbed by the donors and hence free to the clients, which meets their expectation because these adolescents and youth cannot yet absorb the costs. The fact that they can access the platforms in the comfort of their homes also demonstrates that it is also efficient for the clients.
Effectiveness/impact	Between July and September 2014, an external assessment supported by UNICEF and HIVOS was conducted to analyze the level of access, service utilization, characteristics of adolescent and youth clients, service methods, issues addressed, and potential for scalability. The literature review, focus group discussions (FGDs), and key informant interviews showed that the populations reached by the OIDP services were

	predominantly boys and young men ages 10–24 mainly from urban areas. The primary service of all the digital platforms was interactive forums and a safe and enabling space for young people while offering free SRH information and services though the OIDP platforms. The ages of clients varied by type of service. Youth 20–24 years and adolescents 15–19 years of age accounted for the majority of respondents, while fewer than 4 percent were below 14 years of age. At the hotline, the leading three topics pertained to interpersonal relationships; pregnancy and sexual health and HIV. Topics covered on the website, blog, Facebook, and Twitter were more varied. Results from the FGDs highlighted that most adolescents had more concerns about psychosocial issues than the physical aspects. It recommended that the relevant government body provide leadership in setting policies for designing adolescent- and youth-friendly services, taking into account digital platforms as service delivery points; that a legal and regulatory framework be put in place to guide operations of health hotlines in Kenya; that a national coordination body be formed to bring together all the service providers in this space to share experiences and enrich practices; and that data from the service are utilized as instant evidence for advocacy to policymakers.
Feasibility	Guidelines and standards for operating a health helpline in Kenya was a big gap as the program was being implemented, and LVCT Health had to define its path as the practice unfolded, adapting to needs as they emerged. With the learnings obtained, the organization worked together with the Ministry of Health (MOH) to put together guidelines for other emerging helplines.
Lessons learned	Some of the key lessons learnt with the OIDP are: - Digital platforms are a crucial delivery point for information and services for adolescents and youth. - Mobile technology is an effective way of reaching young people with SRH information as it is the "in thing." - Peer-led programs work well as they relate with issues the target audience is going through, thus providing maximum support. - A service that has anonymity makes it is easy for adolescents and youth to ask any question. - This is a successful public-private partnership for health improvement.

Retrospect	The 1190 toll free number is currently only open to Safaricom subscribers, and it would have been great if it was available on more than one mobile network.
Replicability	The practice has been implemented in urban, peri-urban, and rural areas and hence continuously adapted to fit the context. The main change we have had to consider is training the counselors to respond to the varied needs of this population.
Sustainability	With the experience in implementing different components of the OIDP and the high impact and results demonstrated, the next step is to bring the government on board for the MOH to adopt the call center to ensure adolescents and young people get accurate, correct, and age-appropriate information and services.
References/related documentation	Memiah, D., Mahasi, G., Ikua, W., Kemboi, S., & Oyugi, G. (2014). The digital platform: Assessment of adolescents' and youth HIV/SRH programming through digital technology, service provision and policy advocacy. Nairobi, Kenya: LVCT Health.

Supporting Youth and Motivating Positive Action (SYMPA), Democratic Republic of Congo

Lisa Parker

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☐ Sex/HIV education	☑ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☐ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☐ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☐ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☐ Adolescents and youth in the general population	☐ Pregnant adolescents and youth

☐ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☐ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☑ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☐ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	Supporting Youth and Motivating Positive Action (SYMPA)
Country	*Country where the practice is or was carried out* Democratic Republic of Congo (Kinshasa)
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* Prevention, safer sex, and risk-reduction counseling
Year	*When did the practice start? When did it finish? When is it expected to finish?* The practice started in April 2012 and ended in May 2012.
Contact information	Lisa Parker Monitoring and evaluation technical advisor 308 West Rosemary Street, Suite 203A Chapel Hill, NC 27516 Tel: +1 919 240 4403 lparker@futuresgroup.com Dr. Jean Lambert Chalachala Local study coordinator chalasjl@yahoo.fr Dr. Faustin Kitetele Healthcare provider kitetele@hotmail.com Dr. Catherine Akele Director Kalembe Lembe Pediatric Hospital Kinshasa The Democratic Republic of Congo. akelekat@yahoo.fr
Implementers	The program was implemented by the Futures Group Chapel Hill, North Carolina, in collaboration with the Department of Medicine and the Gillings School of Global Public Health at The University of North Carolina at Chapel Hill, the Kinshasa School of Public Health, and Kalembe Lembe Pediatric Hospital, Kinshasa, Democratic Republic of the Congo.Adolescents and youth living with HIV (AYLWH) were involved in implementation through monthly peer educational sessions and peer support groups through which medical doctors, counselors, and people living with HIV (PLWH) volunteers delivered basic positive prevention messages.

Funding	The HIV care and treatment program in Kinshasa received funding or support from multiple donors including the CDC Global AIDS Program originally as part of the University Technical Assistance Program; Providing AIDS Care and Treatment in the DRC under the President's Emergency Plan for AIDS Relief; the William J. Clinton Foundation; the Elizabeth Glaser Pediatric AIDS Foundation; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the United Nations Children's Fund; and the Belgian Cooperation. Funding for the implementation of the SYMPA was received from the Ruth L. Kirschstein National Research Service Institutional STD/HIV Pre-Doctoral Training Award (National Institutes of Health) through the University of North Carolina at Chapel Hill Institute for Global Health and Infectious Diseases.
Goals/objectives	The goal of the project was to develop a positive prevention program that addressed youths' developmental needs and helped them cope with HIV in the context of their emerging independence and sexuality. The central purpose of the program was to (1) ensure AYLWH did not transmit the virus to others; (2) ensure AYLWH remained physically healthy; (3) ensure AYLWH remained on treatment; and (4) ensure the involvement of PLWH in prevention activities.
Background	Over 60 percent of the population in DRC is under the age of 20 years. The prevalence of HIV among youth ages 15–24 is 0.8 percent nationwide and 1.4 percent in Kinshasa, the capital (Ministry of Planning Democratic Republic of the Congo, 2007). A study conducted in Kinshasa found that over half of young women and a quarter of the young men had already had sexual intercourse. Only 53 percent of sexually-initiated young women and 67 percent of their male counterparts reported using a condom at their most recent sexual encounter (Behets & Pettifor, 2008). Therefore, this population was at risk of transmitting the virus to their partners through unprotected sex.
Design	The SYMPA intervention was adapted from the Healthy Living Project and guided by social action theory. The adaptation process followed the four steps of the CDC ADAPT framework (assess, select, prepare, and pilot), which is based on Rogers' diffusion of innovations theory and includes principles of community health education, social work, participatory research, and community empowerment. The process included: • Conducting an in-depth literature review of the literature to determine risk behaviors and their determinants in the target population • Reviewing relevant theories based on their relevance and changeability using intervention mapping as a guide

	• Assessing empirical data from previous research with AYLWH in both the United States and sub-Saharan Africa • Adapting and adding components to the intervention. The intervention added a very important person (VIP) component. The VIP was an individual the AYLWH identified as a trusted person to whom he/she would be willing to or had already disclosed his/her HIV status and to whom the AYLWH would go for support. Two additional adaptations were made: (1) reducing the number of sessions from 15 to six through combining sessions and eliminating content not directly relevant for the target population; and (2) change from an individual adult format to a single-sex youth group format. • An analysis of the capacity of the clinic to implement the pilot intervention (program staff supplies, space, funding for participant incentives, access to the targeted population of AYLWH, and intervention's fit with the clinic's mission) • Identifying existing and potential stakeholders and areas of capacity building and increasing staff capacity • Pretesting the intervention materials • Implementing a two-day training of the SYMPA intervention with the Kinshasa-based program coordinator and four facilitators to increase staff capacity for effective implementation of the intervention • Piloting the SYMPA intervention
Main activities	The intervention was implemented with two single-sex groups with between five and 10 participants each. Each session was planned to last approximately 90 minutes with the six sessions spread over six weeks. Sessions were as follows: Session 1: Living with HIV Session 2: Coping and problem solving Session 3: Safer sex I Session 4: Safer sex II Session 5: Social support and disclosure Session 6: Well-being and health maintenance Sessions were taught by one male and three female facilitators. Three were psychosocial counselors and one was a nurse with training in family planning. One male and one female facilitated the young men's group, while two females facilitated the young women's group. A Congolese medical doctor served as the Kinshasa-based program coordinator. The roles and responsibilities for each member of the study team were laid out in eight standard operating procedure documents.

Beneficiaries	Beneficiaries were AYLWH ages 15–24 years of age seeking care at the clinic in Kinshasa, DRC.
Implementation sites	The intervention was implemented in one hospital in Kinshasa, the capital city of DRC.
Outcomes/results	A qualitative feasibility analysis was conducted on four areas: (1) acceptability, (2) implementation, (3) adaptation, and (4) limited efficacy. The outcomes of interest were as follows: *Acceptability:* satisfaction, perceived appropriateness, intent to continue use *Implementation:* degree of execution, amount, implementation ease, efficiency, and quality *Adaptation:* factors specific to intervention modification *Limited efficacy:* knowledge of sexual prevention topics, condom use skills, ability to deal with triggers for unsafe sex, autonomy in decision making, ability to negotiate safer sex, openness to discussing sexual behavior with caregivers, and ability to develop positive goals in the future Youth reported improving their problem-solving skills, increasing their knowledge of sexual prevention topics, improving their condom use skills, improving their ability to deal with triggers for unsafe sex, and their capacity to assess the level of risk of different behaviors. AYWLH also reported increasing their autonomy in decision making, openness to discuss sexual behavior with their caregivers, and improving their ability to develop positive goals for their future. Youth reported that they felt better prepared to deal with potential future problems.
Ethical soundness	Written informed consent was obtained from youth living with HIV (YLWH) ages 18–24. All study procedures were approved by the UNC Institutional Review Board and by the Kinshasa, DRC School of Public Health Ethics Committee.
Relevance	The practice achieved the desired results. The adapted intervention was acceptable, satisfying, and attractive to both program facilitators and participants; able to be implemented effectively; and showed promise of success with the target population. As the feasibility analysis was qualitative, statistical significance of the findings could not be determined.

	All outcomes were relevant to HIV/AIDS care and treatment. The benefits of the intervention outweighed the risks/potential for harm.
Reach	As of April 2012, the family-centered HIV care and treatment program at the pediatric hospital in Kinshasa had served more than 191 AYLWH ages 15–24 years. The intervention was tested with six males and seven females. It was difficult to determine whether youth reached by the intervention were representative of AYLWH in Kinshasa. Therefore, findings were not generalizable.
Efficiency	No information was provided to determine whether the intervention cost and resource efficiency (i.e., expenses such as time, staffing, and materials were appropriate in relation to the benefits).
Effectiveness/impact	The evaluation was largely qualitative and guided by the Bowen Feasibility Framework. Data were collected from (1) demographic questionnaires with AYLWH participants, (2) in-depth interviews with facilitators, (3) evaluation reports completed by the facilitators after each session, (4) FGDs with facilitators, (5) single-sex FGDs with AYLWH participants conducted after each session, and (6) activity sheets completed by AYLWH participants. All in-depth interviews (IDIs) and FGDs were audio recorded and translated into French. The IDIs and FGDs collected information about the acceptability, implementation, adaptation, and limited efficacy of the intervention. There was no third-party verification of the results. The feasibility analysis results have been published as peer-reviewed journal articles. The analysis showed that the intervention was suitable, satisfying, and attractive to program facilitators and participants and able to be implemented effectively.
Feasibility	Implementation challenges pertained to (1) conflict with youth's schooling, which could be addressed by implementing the intervention during the school summer vacation; (2) long hours of implementation, which could be address by reducing the length of each session, spreading the content over a greater number of sessions, cutting content from activities that AYWLH and facilitators did not find helpful; and (3) low educational level of AYWLH participants, which could be addressed by further simplifying the curriculum.
Lessons learned	The curriculum should be simplified to reflect the educational level of participants and specific activities requiring written responses should be adapted for youth who are unable to write. Having VIPs participate in more than one session would strengthen the intervention.
Retrospect	Prior to wider implementation, the intervention should have (1) included more content on navigating marriage while living with HIV and disclosure, and (2) adjusted intervention timing and session length. Although sessions were intended to be 90 minutes, the average length was

	approximately 3.5 hours, with additional time spent in the FGDs after each session. The program was implemented over six successive Saturday afternoons to avoid interfering with schooling. However, many youth participants found it difficult to attend sessions on time because they were required to attend school on Saturday morning. It was felt that Saturday afternoons were not ideal to hold the intervention because youth were distracted.
Replicability	The intervention has not been replicated across similar contexts or applied in different contexts. Future applications of the intervention should consider modifying the sessions on disclosure to include the differences between disclosing to friends and family members versus sexual partners and be explicit about not pushing youth to disclose. To address conflict with youth schooling, the intervention should be implemented over the school summer vacation. For future implementation, the length of each session should be reduced to a maximum of 90 minutes, with up to 10 total sessions.
Sustainability	The practice has not been maintained over time.
References/related documentation	Behets, F., & Pettifor, A. (2008). Preventing HIV transmission and promoting psychosocial wellbeing among HIV+ youth: R01 grant application submitted to the NIH. Kinshasa, Democratic Republic of the Congo: The University of North Carolina Chapel Hill. Ministry of Planning Democratic Republic of the Congo. (2007). HIV prevalence: Results from the Democratic Republic of the Congo 2007 Demographic and Health Survey. Parker, L., Maman, S., Pettifor, A., Chalachala, J. L., Edmonds, A., Golin, C. E., . . . Behets, F. (2013). Adaptation of a U.S. evidence-based positive prevention intervention for youth living with HIV/AIDS in Kinshasa, Democratic Republic of the Congo. *Evaluation and Program Planning*, 36, 124–35. Parker, L., Maman, S., Pettifor, A., Chalachala, J. L., Edmonds, A., Golin, C. E., . . . Behets, F. (2013). Barriers to provider-delivered sexual behavior counseling for youth living with HIV/AIDS in the Democratic Republic of the Congo. *Journal of HIV/AIDS & Social Service*s, 12. Parker, L., Maman, S., Pettifor, A., Chalachala, J. L., Edmonds, A., Golin, C. E., . . . SYMPA Study Team. (2013). Feasibility analysis of an evidence-based positive prevention intervention for youth living with HIV/AIDS in Kinshasa, Democratic Republic of the Congo. *AIDS Education and Prevention*, 25, 135–50.

Program H—Working with Young Men, Ethiopia and Namibia

Alexa Hassink

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☑ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☑ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☐ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☑ Other (specify) Violence prevention
☐ Other (specify)	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☐ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth

☑ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☑ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Program H: Working with Young Men
Country	*Country where the practice is or was carried out* Promundo and partners have adapted Program H for implementation in more than 20 countries worldwide in partnership with local civil society organizations and United Nations agencies, including in the Balkans, Ethiopia, India, Tanzania, Vietnam, Chile, USA, and Canada. Program H has been subject to rigorous impact evaluations in Brazil, India, the Balkans, Ethiopia, and Namibia.
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* Sex/HIV education Social mobilization Peer education Prevention, safer sex, and risk-reduction counseling
Year	*When did the practice start? When did it finish? When is it expected to finish?* 2002 - present
Contact Person	Alexa Hassink Communications Officer
Contact information	Promundo-US 1367 Connecticut Avenue NW Washington, DC 20036 USA Tel: + 1 202 588 0061 and 588 0060 Fax: + 1 202 588 0063 a.hassink@promundoglobal.org Skype: alexahassink www.promundoglobal.org
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information.* *If it was a partnership, who were the partners?*

	Were adolescents and youth involved in the implementation of the practice? How were they involved? *Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* In 2002, four Latin American NGO partners launched a comprehensive process to engage young men in changing inequitable and violent norms related to masculinity called Program H—"H" for *homem* or man in Portuguese and *hombre* in Spanish. Since then, the partners—Promundo, ECOS, and Instituto PAPAI in Brazil, and Salud y Género in Mexico—and new organizations—including local civil society organizations and UN agencies, have continued adapting, implementing and evaluating Program H in diverse settings internationally. In each implementation site, campaigns, which are combined with group education, are informed and led by youth program participants.
Funding	*Who provided the funding and other resources?* Funding for Program H implementation and adaptations has been provided by multiple sources, including: USAID (India), MacArthur Foundation (Brazil, Mexico), UN Trust Fund to End Violence Against Women and Girls (Brazil, Chile), North American Aerospace Defense Command (various sites in the Balkans), Dutch Ministry of International Cooperation (Rwanda and other sites).
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* Program H is named after *homens* and *hombres*, the words for men in Portuguese and Spanish. Launched in 2002 by Promundo and partners and now used in more than 22 countries, it primarily targets men, ages 15– 24, to encourage critical reflection about rigid norms related to manhood. Ultimately, this process contributes to achieving two sets of objectives: 1) Gender equity, by which we mean fairness and justice in the distribution of opportunities, responsibilities, and benefits available to men and women, and the strategies and processes used to achieve gender equality. 2) Attitude and behavior changes at the individual and community level that lead toward transformed gender norms within specific objectives (for example, increased condom use, lower rate of self-reported intimate partner violence, lower self-reported rates of STI symptoms, and greater likelihood to contribute to household chores).
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?*

	When Program H was being developed, within the fields of sexual and reproductive health, HIV/AIDS prevention, and gender equity, there had begun a growing consensus of the need to engage young men. Many of the major UN agencies working in health, gender, and HIV/AIDS—including UNFPA, WHO, Pan American Health Organization (PAHO), the World Bank, and UNAIDS—had confirmed the importance of engaging boys and young men in the promotion of health and gender equity. And, a growing body of research on young men (15–24) affirmed numerous reasons for focusing attention on their socialization. Worldwide, an estimated 25 percent of new cases of HIV/AIDS were among young men under the age of 25. In most societies, adult and young men had and have more power in intimate and sexual relationships and generally decide when and how sexual activity takes place. In addition, young men who have sex with other men are generally stigmatized in much of the world and have unmet health needs. Awareness about HIV/AIDS and access to and use of condoms had all increased in most parts of the world. Nonetheless, the percentage of young men who used condoms consistently was still less than desired—and lower than their reported knowledge about condoms and HIV/AIDS. This gap between knowledge and behavior suggests a continuing resistance to condom use that can be explained, in part, by how young men view gender roles and sexual activity. In some settings, for example, young men may perceive that risky or unprotected sex is the only sex "that counts," or that reproductive and sexual issues, including condom use, are women's responsibilities. Other aspects of young men's behavior put them and their partners at risk. We know from international data that in many parts of the world young men generally have sex earlier and with more partners before forming a stable union than do young women. In some settings, young men have their first sexual experiences with sex workers, potentially creating lifelong patterns of viewing women as sexually subservient. Young men are also more likely than young women to have occasional sexual partners outside of a stable relationship. Some young men are abusive or violent toward their intimate partners. In survey research Promundo and partners carried out with 750 men in low income areas in Rio de Janeiro, Brazil, up to two-thirds of young men believed that violence was acceptable against women when a woman is unfaithful, and a quarter of all men ages 15–65 had used physical violence at least once against an intimate female partner. Young men ages 20–24 had the highest rates of self-reported physical violence against women (in their current or most recent intimate relationship) than any other age range. To develop the Program H curriculum and approach, Promundo also carried out household surveys and qualitative research with young men

	showing more gender-equitable attitudes and determined critical factors in helping boys and young men adopt similar attitudes and behaviors. These life histories that we carried out with young men in a low-income setting in Brazil found similar factors associated with more young men having more gender-equitable attitudes: (1) being part of an alternative male peer group that supported more gender-equitable attitudes; (2) having personally reflected or experienced pain or negative consequences as a result of traditional aspects of manhood (for example, a father who used violence against the mother, or a father who abandoned the family); and (3) having a family member or meaningful male role models (or female role models) who showed alternative gender roles. Partners around the world have since adapted these activities based on local research findings.
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?* Program H ("H" for *homem*, or man in Portuguese, and *hombre* in Spanish), through group education and community activism, seeks to engage young men in reflection on rigid gender norms related to manhood and to promote respectful and non-violent behavior and to encourage them to take responsibility for caring for their children and being equitable partners. First and foremost, the activities focus on creating a safe space to allow young men to question traditional views about manhood and to critically reflect on gender, gender injustices, gender rigidities, and how these link to other social injustices. These activities are informed by a belief that young men are not empty vessels for the passive reception of gender or other social norms; rather, they have the capacity to develop their own gender consciousness, or critical attitudes about gender norms. Program H also includes a community strategy based on youth activism and youth-designed campaigns, which have been carried out in nearly all the sites where the group education has been conducted. Program H's "theory of change" is for participants to: 1) learn through questioning and critical reflection about gender norms, (2) rehearse equitable and non-violent attitudes and behaviors in a comfortable space, and (3) internalize these new gender attitudes and norms, applying them in their own relationships and lives. Supporting institutions and structures, when accompanying this integral group education process, encourage young individuals and organizations to develop and use the tools to become agents of change for gender justice and social justice.

	Four main concepts are fundamental to understanding Program H: (1) gender consciousness; (2) gender as relational; (3) diversity as a cross-cutting theme, inseparable from gender; and (4) gender-synchronized approaches. 1. "Gender consciousness" was derived from a notion developed by Paulo Freire (1970) called "conscientization" (and also in feminist literature). The "conscientization process," according to Freire, refers to individuals' capacity to reflect on the world and choose a particular course of action informed and empowered by that critical reflection. This process of critically reflecting on the history of the cultural conditions and class structures that support and frame experiences of gender inequality (and other forms of inequality) can promote personal growth, political and social awareness, and activism. In turn, engaging in activism and living in more egalitarian ways can create the conditions for achieving greater gender justice and social justice. 2. By "gender is relational," we mean that gender is not isolated or finite; rather, it is expressed and produced through constant negotiations and interaction. Program H constitutes a set of tools for incorporating a relational notion of gender into youth programming. Gendered social norms affect both men and women, offering benefits and costs in areas such as health, security, or violence, and with implications for diverse types of relationships. Through the activities, youth consider the "costs" of rigid gender norms, and benefits that come with more gender-equitable ways of being a man or woman and interacting in the context of intimate and family relationships. 3. Diversity refers to differences in terms of sexual orientation, race, ethnicity, age, socioeconomic status, marital status, maternal or paternal status, disability or health status, and culture. Inequalities due to these characteristics are closely tied to inequalities related to gender, and should be understood in order to promote inclusion and positive relations. Program H includes specific activities that promote respect for sexual diversity and tolerance. 4. Program H represents part of a "gender synchronized" approach, in that it "actively strives to examine, question, and change rigid gender norms and imbalance of power as a means of reaching gender equity objectives." Depending on context, Programs H and M (a companion program designed for young women) can be implemented with single-sex groups at times and with young women and men together (mixed groups) at other times. Practitioners can make this decision in consultation with youth themselves and considering the context. Our intention is to engage young women and men in confronting and changing gender inequalities in ways that are safe, meaningful, and effective.

Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* Program H focuses on helping young men question traditional norms related to manhood. It consists of four components: (1) a validated curriculum that includes a manual series and an educational video for promoting attitude and behavior change among men; (2) a lifestyle social marketing campaign for promoting changes in community or social norms related to what it means to be a man that are combined to promote a critical dialogue and reflection about gender norms for young men, including questioning men's use of violence against women; 3) a research action methodology for reducing barriers to young men's use of clinic services; and (4) a culturally relevant validated evaluation model (the GEM Scale - Gender Equitable Attitudes in Men Scale) for measuring changes in attitudes and social norms around manhood has been developed to measure outcomes of the initiative. These components were developed based on Promundo and partners' baseline research, previously mentioned, which identified important programmatic implications: 1) the need to offer young men opportunities to interact with gender-equitable role models in their own community setting; and 2) the need to promote more gender-equitable attitudes in small group settings and in the greater community. Promundo and partners' research also confirmed the need to intervene: 1) at the level of individual attitude and behavior change; and 2) at the level of social or community norms, including among parents, service providers, and others, that influence these individual attitudes and behaviors. The centerpiece of the Program H approach is group discussions carried out generally with male facilitators who serve as gender-equitable role models. The program includes 70 activities, available for download, to be carried out with young men (ages 15–24) on gender, sexuality, reproductive health, fatherhood and caregiving, violence prevention, drug use, and preventing and living with HIV/AIDS. Each module includes a series of activities lasting between 45 minutes and two hours. It is recommended for partners to implement 10 to 16 activities, once a week, over a period of several months, in conjunction with community awareness campaigns created by youth themselves. The activities in the manual series are designed to be carried out in a same-sex group setting, and generally with men as facilitators who also serve as more gender-equitable role models for the young men. Activities include role-plays, brainstorming exercises, discussion sessions, and individual reflections about how boys and men are socialized, the positive and negative

	aspects of this socialization, and the benefits of change. The process also seeks to encourage boys to question gender stereotypes, behaviors, and attitudes and to engage those who already act as "voices of resistance" to rigid gender norms. The manuals are accompanied by a no-words cartoon video, called "Once Upon a Boy," which presents the story of a young man from early childhood through adolescence to early adulthood. Scenes include the young man witnessing violence in his home, interactions with his male peer group, social pressures to behave in certain ways so as to be seen as a "real man," his first unprotected sexual experience, having an STI, and facing an unplanned pregnancy. The video was developed in workshop processes with young men in diverse settings in Latin America and the Caribbean. By being a cartoon video, it quickly engages young men and transfers easily across cultures. And by having no words, facilitators work with young men to create dialogue and to project their personal stories into the video. In addition to the Program H curriculum, Promundo and partners also developed a "lifestyle social marketing" process for promoting a more gender-equitable lifestyle among men in a given cultural setting. This involves working with men themselves to identify their preferred sources of information, identify young men's cultural outlets in the community, and craft messages—in the form of radio spots, billboards, posters, postcards, and dances—to make it "cool and hip" to be a more gender-equitable man.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* Young men ages 15–24, including: • Adolescents and youth in the general population • Male adolescents and youth • In-school adolescents and youth • Out-of-school adolescents and youth
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3. Was the practice implemented in urban or rural areas or both?* Program H has been implemented in both rural and urban settings. **School-based**: In these sites, educational workshops, social marketing campaigns, and individual outreach were incorporated in various settings. **Community-based**: In these sites, group education sessions, community campaigns, lifestyle social marketing campaigns, and sports tournaments were incorporated in various settings.

Outcomes/results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* Program H ("H" for *homem*, or man in Portuguese, and *hombre* in Spanish) was developed and validated in Latin America and the Caribbean and has since been tested, implemented, and adapted to local cultures by project partners in South and Southeast Asia, the Balkans, other parts of Latin America and the Caribbean, the US, and several settings in sub-Saharan Africa. Program H has undergone nine impact evaluations and has shown consistently to lead to changes in GBV-supported attitudes and in some settings to lead to reductions in young and adult men's reported rates of use of GBV. Interventions are evaluated using a culturally relevant, validated evaluation model (the GEM Scale—Gender-Equitable Men Scale) that seeks to measure the degree to which young men and women change their attitudes as a result of the interventions. Most of the evaluations of Program H so far have used quasi-experimental designs; a few have had random assignment of control and intervention schools or communities. Six out of nine evaluations found that participants in the programs demonstrated significantly less support, on average, for gender-inequitable attitudes after taking part in the activities based on Program H. The consistent changes observed through quantitative and qualitative findings across settings affirms that Program H has shown itself to be adaptable and apt for scaling up as a promising and successful approach to achieving changes in gender norms and practices among young and adult men, with important implications for women and girls. Program H has been named a best practice in promoting gender equality by UNICEF, the World Bank, UNFPA, United Nations Development Programme (UNDP), the Inter-American Development Bank and WHO/PAHO.
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* Promundo follows all standard ethical procedures for research with children, including parental consent procedures. Additionally, if anyone in the group shows a need for special attention due to an act of violence they have suffered, the facilitator should consider referring the young man to appropriate services and discuss the issue with other senior staff at your organizations.
Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care,*

	treatment, and retention, and if so, to what extent? What were the benefits versus risks/potential for harm? Program H has shown to have self-reported decreases in STI systems in addition to increases in condom usage, both directly related to HIV and AIDs prevention. Additionally, Program H seeks to address the norms that perpetuate risky sexual practices—including addressing and challenging gendered power dynamics and rigid gender norms. The following are some of the key results of these evaluation studies: • The impact evaluation of the application of Program H in the favelas of Rio de Janeiro, **Brazil,** found that young men participants had fewer self-reported symptoms of STIs compared to similar youth who had not participated. In one of the groups which received both group education sessions and a community campaign, the percentage of young men with STI symptoms decreased by almost one-third, from 23 percent to 14 percent, over the course of the program. • In **India**, young men who participated in the Yaari Dosti program were almost 2 to 3 times more likely to use a condom during sex after completing the program than young men in a control group. • In **Ethiopia**, the proportion of young men who reported using physical violence against a female partner dropped significantly, from 36 percent to 16 percent, after taking part in an intervention that included elements from the Men as Partners manual as well as activities from Program H, while no such change occurred among the group of non-participants. • In **Bosnia and Herzegovina** and **Croatia,** students who attended classroom sessions combined with residential educational retreats were significantly more likely to have increased their support for gender-equitable norms—including a rejection of homophobia—when compared to their peers who did not participate as intensively.
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.* Since its inception, Promundo and partners have reached more than 250,000 young men and women in over 20 countries with actions to prevent gender-based violence, including the Program H toolkit, which combines group education with youth-led activism to achieve equality and reduce violence. Public school systems in Brazil, India, Croatia, Chile, Nicaragua,

	and elsewhere have officially adopted the approach as a part of their school curriculum.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* When programming is being implemented and facilitated directly by trained staff, the intervention costs approximately US$25–75 per individual. When facilitators are trained via an online teacher training portal, the cost is approximately US$5 per individual group participant.
Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* Major international organizations are recognizing Program H as a best practice in promoting gender equality. In 2007, Program H was cited in UNDP's report "50 Jeitos Brasileiros de Mudar o Mundo" (translation: "50 Brazilian Ways to Change the World") and in UNICEF's report on the State of the World's Children. In 2008, UNFPA recognized Program H as an effective strategy for engaging young men in the promotion of sexual and reproductive health in its State of World Population report. In 2010, PAHO and the WHO named Program H as a best practice in integrating a gender perspective in health. In 2011, former UN Women Executive Director Michelle Bachelet named Program H a good practice in the prevention of violence against women, and the World Bank has listed Program H as a best practice in programs integrating gender and HIV/AIDS prevention. See references below for relevant published literature.
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they—or could they be—overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* Overall, Program H is a cost-effective, accessible initiative that with institutional buy-in can be implemented successfully across a variety of settings and contexts. Given the short timeline of many interventions with young men, it is often unrealistic to expect behavior change and difficult to measure such change. The GEM Scale—an attitude scale used to assess the degree to which men believe in a more rigid or more equitable view of manhood (which is highly associated with men's self-reported behaviors in terms of GBV, condom use, and sexual behavior), and has since been used in more than 20

	countries as an evaluation and baseline tool, including in studies supported by USAID, PEPFAR, and the World Bank—thus provides a potentially more sensitive evaluation instrument for measuring attitude changes that suggest a movement or change in the direction of gender equity on the part of young men. Promundo and partners' work would suggest that attitude and behavior change are possible to achieve, but more research would be necessary—and ongoing interventions and policy-level discussions—to confirm and sustain long-term gender equity.
Lessons learned *What are the most important lessons that a reader should take from this practice? What are the keys to its success?*	A key factor in Program H implementation is the educator or facilitator. It is up to him/her to know whether the young men feel comfortable with these themes and to administer the activities in such a way that honest reflection is promoted, but without becoming a group therapy session. The facilitator must also be aware when specific participants may need individual attention, and in some exceptional cases, even referrals to counseling. The purpose behind this type of group intervention is to go beyond mere provision of information, to a stage of prompting reflections and changes in attitudes. Also, Promundo recommends supporting youth to carry out their own campaigns and activism as a way to promote the core themes and to engage youth directly at the school or community levels. Campaigns and other community actions empower youth and organizations to become agents of change and influence public policies essential for achieving gender and social justice.
Retrospect *Discuss anything that might have been done differently if applicable.*	With regard to evaluations conducted of Program H, including various quasi-experimental studies, the impact of group education has been captured more comprehensively to date. In the future, further efforts should be made to capture the successes and impact of the community campaigns and the combined, added valued of implementing these campaigns alongside group education. Furthermore, efforts to incorporate elements of diversity into the curriculum have been made through Program D, however, in the future these activities should be even more deliberately integrated into Program H's core curriculum, to ensure that participants acknowledge and embrace diversity of gender identities, sexuality, race, etc.
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.* Promundo has adapted Program H for implementation in more than 20 countries worldwide in partnership with local civil society organizations and United Nations agencies, including in the Balkans, Ethiopia, India,

	Tanzania, Vietnam, Chile, United States, and Canada. Program H has been subject to rigorous impact evaluations in Brazil, India, the Balkans, Ethiopia, and Namibia. In each context, partners select and implement 10 to 16 activities, tailored to the theme and audience they seek to address. Experience in using these materials has shown that it is preferable to use the activities as a complete set (or selecting groups of activities from the different sections) rather than using just one or two activities. Many of the activities complement each other and when used together contribute to richer experience than using just one activity. Carrying out a carefully selected combination of activities is recommended over holding scattered or isolated group educational activities. In any implementation of Program H, a facilitator and other program staff member should go through a thoughtful process to design the program and select the activities best suited to bring about the desired changes in attitudes and behaviors and that best work for the particular group of participants.
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* The practice has already been replicated, maintained, and scaled up in a large variety of settings. To avoid having an isolated impact, and to maximize sustainability, it is necessary to institutionalize this approach. An example of this is illustrated here, through the Portal for Gender Equality in Schools, or PEGE ("*Portal Equidade de Gênero nas Escolas*" in Portuguese), which is an online teacher-training portal that aims to promote gender equality among both teachers and students in Brazil's public school system. After years of programming and evaluation experiences in schools, Promundo aimed to scale up its flagship initiatives, Programs H and M. PEGE was launched in 2011 to fulfill a demand for a tool designed for educators that could be used to spread the methodology behind Programs H and M to a larger audience. It has since become the centerpiece of Promundo's work in the education sector in Brazil and is now being adapted for use with teachers in Croatia.
References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.*

	Barker, G., Nascimento, M., Segundo, M., & Pulerwitz, J. (2004). How do we know if men have changed? Promoting and measuring attitude change with young men: Lessons from Program H in Latin America." In *Gender Equality and Men: Learning from Practice*, edited by S. Ruxton, 147–161. Oxford: Oxfam GB. Guedes, A. (2004). Addressing gender-based violence from the reproductive health/HIV sector: A literature review and analysis. Washington, DC: USAID, Bureau for Global Health. Pulerwitz, J., Barker, G., Segundo, M., & Nascimento, M. (2006). Promoting more gender-equitable norms and behaviors among young men as an HIV/AIDS prevention strategy. Horizons Final Report. Washington, DC: Population Council. UNDP (2007) Jeitos Brasileiros de mudar o mondo. Retrieved from: http://www.oei.es/oeivirt/50jeitos.pdf. UNICEF (2006). The state of the world's children 2007: Women and children, the double dividend of gender equality. Retrieved from: http://www.unicef.org/sowc07/docs/sowc07.pdf. World Health Organization. (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from program interventions. Geneva. Retrieved from: http://www.who.int/gender/documents/Engaging_men_boys.pdf.

Zvandiri Project, Zimbabwe

Nicola Willis

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☑ Access to HIV services (location, hours, facility environment)	☑ Counseling and testing for HIV
☑ Sex/HIV education	☑ HIV treatment with antiretroviral drugs
☑ Staff preparedness to serve adolescents and youth	☑ HIV-related opportunistic infection prophylaxis and treatment
☑ Condom provision	☑ Care and support for adolescents and youth living with HIV
☑ Family planning services	☑ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☑ Diagnosis and treatment of sexually transmitted infections
☑ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☑ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☑ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☑ Other (Vocational Skills Training)
☐ Other (specify)	☑ Other (Integration of adolescents with HIV and disability and those living on the street)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☑ Pregnant adolescents and youth
☑ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth

☐ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (Adolescents with disabilities)

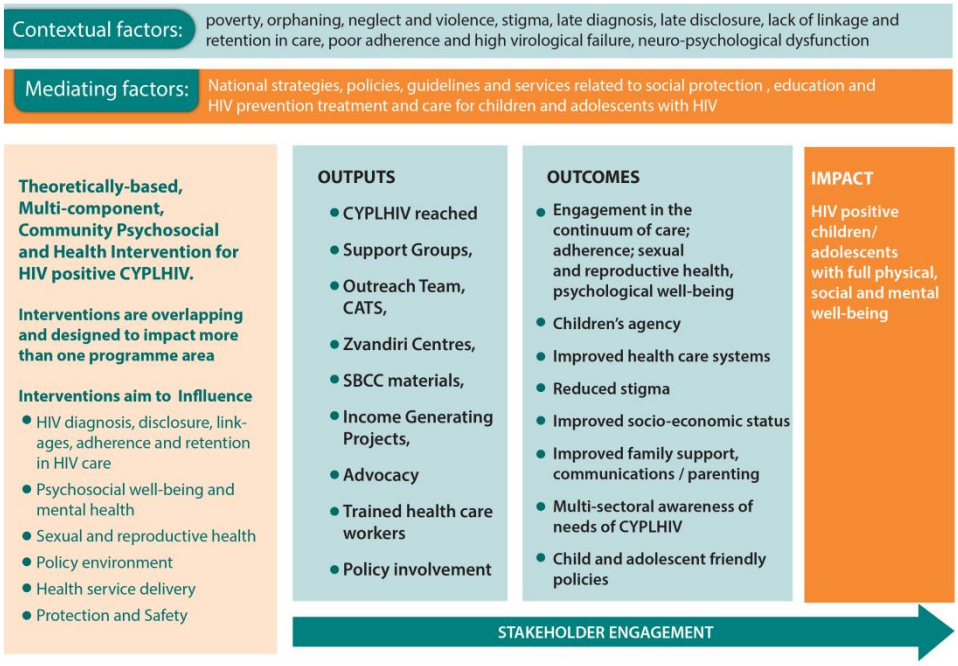
D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☑ School
☐ Worship place
☐ Work place
☐ Outreach
☑ Other – churches

Best Practices Submission Form – Part 2

Name	Zvandiri
Country	Zimbabwe
Topic area	1. Counseling and testing for HIV 2. Care and support for adolescents with HIV 3. HIV treatment and antiretroviral drugs 4. Staff preparedness to serve adolescents/youth
Year	Zvandiri started in November 2004. It continues to be scaled up nationally
Contact Person	Name: Nicola Willis Title: Director
Contact information	Zvandiri House 12 Stone Ridge Way Avondale, Harare Zimbabwe Tel: +263 731 253205 Nicola@zvandiri.org www.africaid-zvandiri.org
Implementers	The Zvandiri model was developed and implemented by Africaid, a local private voluntary organization in Harare, Zimbabwe. Africaid was established in Zimbabwe in 2004 by a group of volunteers who were working in pediatric HIV facilities at a time when ART was just beginning to be rolled out for children and adolescents. Yet there was very little, if any, opportunity for young people with HIV to access posttest support in the community. There was a critical need for psychosocial support services that recognized AYLHIV's broader psychological, social, and developmental needs, in addition to clinical care. When a group of six adolescents asked Africaid for assistance in establishing a support group for children and adolescents growing up with HIV, the first Zvandiri support group was established—named, created, and planned by adolescents with HIV themselves, with support from Africaid's group of volunteers. Over the years, Africaid has evolved from a voluntary-based, community organization in Harare to a national, multi-donor funded organization supporting the steady growth of adolescent-friendly HIV services through the Zvandiri model. It has been adopted by the Ministry of Health and Child Care

	(MoHCC) and the Ministry of Public Services Labour and Social Services (MoPSLSW) as a key model in the treatment cascade for adolescents with HIV and case management of vulnerable children and adolescents. This growth has been a partnership with AYLHIV and their families, the MoHCC, the MoPSLSW, the National AIDS Council, Harare City Health Department, and multiple funding partners, as described below. In the same way that young people were at the focus of designing and planning the first support group, they have remained at the heart of the Zvandiri model, setting the standard for meaningful participation of adolescents with HIV in planning, implementing, monitoring, and evaluating their programs, in addition to implementing their own research.
Funding	Africaid was initially funded by donations from individuals and small grants. However, over the years, its funding based has increased to large, multi-donor grants. Financial and/or technical support for Zvandiri has come from the government of Zimbabwe, multi- and bilaterals (especially UNICEF, USAID through World Education Inc., PEPFAR through the US Public Affairs Section, the Child Protection Fund [including the European Union, Department for International Development, Royal Netherlands Embassy], Sida, UNAIDS, and UNFPA), and from foundations and similar sources (ELMA, Elton John AIDS Foundation, Bristol Myers Squibb Foundation), as well as from civil society organizations working in partnership—such as Southern Africa AIDS Trust (SAT), Gesellschaft fur Internationale Zusammenarbeit (GIZ), Swiss AIDS Care International (SACI), and the Centre for Sexual Health and HIV and AIDS Research (CeSHHAR). Africaid's operating budget for 2015 is $1,200,000.

Goals/objectives	Zvandiri is a theoretically-based, multicomponent, community psychosocial and health intervention for HIV-positive children and young people living with HIV (CYPLHIV). The goal is for CYPLHIV to have physical, social, and mental well-being. In 2014, Africaid worked with young people living with HIV, program staff, and stakeholders to develop the Zvandiri theory of change, as below: 
Background	While Zimbabwe has reported a decline in HIV prevalence, it remains one of the countries most affected by HIV in the world, with 15 percent of adults ages 15–49 years living with HIV (Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2012)). Zimbabwe has a generalized, mainly heterosexually-driven HIV epidemic in which HIV transmission to children mainly occurs vertically, but also through unprotected sex in cases of sexual abuse and as children mature and become sexually active. This is having a devastating impact on the nation's children and adolescents. Of the 1.3 million people living with HIV, approximately 11 percent (148,089) are children and adolescents (MOHCC, 2014). Antiretroviral treatment (ART) has substantially increased in Zimbabwe in recent years, but many factors impede early diagnosis and successful treatment for adolescents. District health information system data for 2014 showed that the antiretroviral therapy (ART) coverage for adolescents living with HIV is 48 percent for the 10–14 age group, 51 percent among those ages 10–19, and 54 percent for adolescents ages 15–19. Approximately half of adolescents living with HIV in need of ART are not on treatment; and those not on antiretroviral treatment and care have a high likelihood of dying prematurely. This situation urgently needs to improve. Although the recent ALL IN! country assessment pointed to the gradual decline in new HIV infections and AIDS-related deaths among adolescents in Zimbabwe, the report highlighted that intensive, accelerated efforts are required

	within the national HIV program response on adolescents, if Zimbabwe is to reach its targets of 75 percent reduction in HIV new infections and 65 percent reduction in AIDS-related deaths in this age group (UNICEF, 2015). In everyone's lives, adolescence is a period of substantial physical, emotional, and social change, the transition from childhood immaturity and dependence to adulthood roles, relationships, and responsibilities. Adolescents with poor immunity because of HIV face huge additional challenges, from repeated bouts of ill health, stunting, and delayed growth and development, to multiple psychosocial stressors. These arise directly from their physical ailments and from fear, stigma and discrimination, low self-esteem, and all too often, orphanhood and insecurity at home. Adherence is known to be challenging in this age group and two clinics in Harare have reported virologic failure rates of 40 percent in their adolescent cohorts. As increasing numbers of children born with HIV survive into adolescence and adulthood, mainly through improved treatment access, there is ever-increasing need to provide for them a comprehensive continuum of care. It is clear that support for psychosocial needs and mental health, supportive and well-informed caregivers, reduced stigma and discrimination, and youth-friendly health provider attitudes and facilities are essential, in addition to the availability of prophylaxis and treatment for opportunistic infections, antiretroviral medication and adherence support, and sexual and reproductive healthcare. These are the challenges that the Zimbabwean civil society organization Africaid set out to address in its Zvandiri program.
Design	The Zvandiri model has been developed in partnership with ALHIV, with the different components of the model being piloted then scaled up progressively over the years in response to the emerging, evolving needs of HIV-positive adolescents growing up in Zimbabwe. The Zvandiri community support groups were the first step, developed in response to young people themselves asking for a safe place where they could come together to learn about and share their experiences so that they may be able to cope with their condition and its implications in their lives. Once the groups were running, decentralized in the community, and found to be therapeutic and supportive, the support group members, their families, and health service providers expressed the need for additional follow up support at home for those with counseling needs or adherence difficulties that needed support beyond the clinic. The multidisciplinary outreach team was, therefore, formed and has been working in close partnership with clinics and health service providers for the past decade in Harare, strengthening bidirectional referral and follow-up of adolescents throughout the treatment cascade. In 2009, the community adolescent treatment supporters (CATS) intervention was then piloted in response to the need for innovative, adolescent-friendly, sustainable adherence interventions. HIV-positive adolescents, 17–23 years old, are trained,

mentored peer counselors who provide adherence literacy, counseling, and monitoring in the home, together with counseling for their broader psychosocial support needs. As the CATS initiative was found to be effective and accepted by families and health service providers, it was then scaled up across Harare, led by the CATS themselves, who are widely accepted by service providers, families, and young people themselves as playing a critical role in the case management of young people with HIV, through case finding (e.g., for HTC, opportunistic infections OI, ART, investigations for treatment failure, child protection cases) followed by enhanced support in the home and community for adherence, mental health disorders, SRH, PMTCT, and child protection. In addition to the CATS, Zvandiri Centres were constructed within four health facilities as adolescent centers, led by CATS themselves. These centers are an entry point for young people, HIV positive or negative, for information, peer counselling, skills development, and referral to other services (e.g., HTC, OI/ART, TB, SRH, PMTCT, child protection).

Each component has been planned, developed and implemented with or by young people with HIV, with strong liaison and collaboration with health facilities, families, the Department of Social Services, and National AIDS Council. Without these partnerships, the model would not have been possible. Africaid now provides technical assistance to MoHCC and MoPSLSW through training healthcare providers, social welfare officers, and community-based organizations how to integrate the Zvandiri within their programs, and this has been documented in the Zvandiri Toolkit. The Toolkit contains a variety of tools designed to support implementers in establishing the Zvandiri model or integrating it within their existing programs, with sustained mentorship support from Zvandiri Provincial Officers.

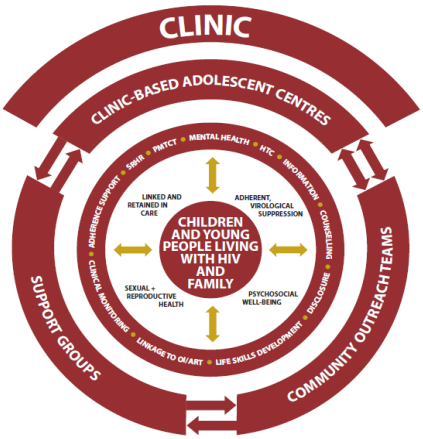
Although the Zvandiri model in its entirety has not yet been costed, the CATS intervention has recently been costed by the Clinton Health Access Initiative, as follows, with costs being calculated per patient per year (PPPY):

CATS program costs (PPPY)	Personnel	Equipment	Buildings	ORC	Trainings	Total
Harare (Zvandiri-led)	$36.13	$2.93	$2.23	$9.42	$1.68	$52.39
Provinces (MOHCC-led with Zvandiri support)	$49.44	$4.49	$2.30	$10.48	$1.48	$68.18
Provinces (MOHCC-led with Zvandiri support at scale-up)	$14.83	$0.84	$0.77	$4.23	$1.86	$22.53

ORC Operating and running costs

Source: Pangaea and Clinton Health Access Initiative (2015

Main activities	As described above, Zvandiri has evolved over time and combines community-based psychosocial support, health services, training, and advocacy for children and young people living with HIV through a network of community support groups, outreach teams, community adolescent treatment supporters (CATS), and adolescent-focused "Zvandiri Centres." These are integrated within clinical care in government and private sector clinics.



There is bidirectional referral between clinics and community. Zvandiri aims to directly influence young people's experience of HIV diagnosis, disclosure, linkages, adherence, and retention in HIV care. As well as the direct focus on treatment, it involves ongoing support for their psychosocial well-being and mental health, protection, and sexual and reproductive health throughout the HIV care cascade.

In addition to direct implementation of the model in Harare, Africaid provides training and mentorship for health services and CBOs wishing to integrate Zvandiri within their programs. Working with partners, a baseline capacity assessment is conducted, followed by a program of training and mentorship. Over the past three years, the majority of training and mentorship has been conducted through the MoHCC, beginning with training of facility-level nurses and counselors, together with the provincial and district nursing officers. Training focuses on the specific treatment, care, and support needs of adolescents with HIV, followed by an introduction to the role of Zvandiri in strengthening the HIV care cascade for this group. Clinics have then gone on to request further support in establishing community support groups, CATS services, and linkages between the community and clinic. CATS are engaged as training facilitators in all training and mentorship.

Zvandiri combines the interventions described below:

1. Monthly community-based support groups run by trained facilitators (including YPLHIV) providing structured activities to build resilience, confidence, and self-esteem, to develop knowledge and skills related to HIV, to promote adherence, and improve sexual and reproductive health more generally. These support groups provide opportunities for sharing experiences and developing friendships and support networks, and an opportunity for informal review of beneficiaries' well-being. Youth groups and young parents' groups are also run to respond to the evolving needs of this group of young people with HIV.

2. Community outreach conducted by a multidisciplinary team, which includes an HIV clinician, nurse, counselors, a social worker, a psychologist, and a network of CATS, provides home-based clinical monitoring, counseling, and adherence

	support, and ensures linkage to and retention in care. The team identifies and refers back to the clinic children requiring ART, laboratory investigations, management of opportunistic infections (OIs), possible ARV-related toxicities and treatment failure. **3. The CATS initiative** was established in 2009. Young people living with HIV between 17 and 23 years old who are coping well with their own HIV have been trained and supported to become counselors for their peers, working in clinics and through home visits. CATS have experienced and therefore understand many of the issues around ill-health, anxiety, guilt, fear, shame, rejection, depression, and hopelessness. They have also benefited in terms of personal growth and transformation from Zvandiri, and this enables them to support others effectively. Their lived experience makes them particularly credible to others struggling with a new HIV diagnosis or with treatment, and they have a unique value as normative role models. Remuneration of US$100/per month has enabled individual CATS to further their education and support themselves and family members and has contributed towards 100 percent retention of CATS in the program. **4. Clinic-based Zvandiri Centres** were established in 2013 in four clinics in Harare. These centers provide an adolescent-focused environment for young people to access HIV and SRH related information, counseling, peer support, life skills training, and recreational activities. Trained and mentored CATS from Zvandiri run the centers, supervised by clinic staff. The centers also refer young people to other services including for HTC, family planning, treatment for STIs, PMTCT, and mental health and social services, e.g., for school fees. **5. Community-based HTC** for children and young people began in 2012 to improve the uptake of HTC services for this age group. CATS conduct information sharing sessions with community groups and schools, advocating for early testing and treatment for children. The community outreach team then provides counseling and referral to the local clinic for children and families seeking HTC. Children testing HIV positive are then referred back to Zvandiri by the clinic for posttest support. CATS also identify siblings who have not yet been tested and they refer those for HTC. Africaid is the lead technical partner to the MoHCC in the training of healthcare workers in the provision of adolescent-friendly HTC services and actively supports the national HTC campaigns, ensuring that adolescents are reached and referred by CATS for posttest support. **5.** Zvandiri links with one of the main referral centers in Harare, Newlands Clinic, to support young people in establishing a range of **income-generating projects**, (e.g., hairdressing, graphic design, painting, dressmaking). This is only implemented in Harare. **6.** Programs for **parents and caregivers** of CYPLHIV began in 2010 after research suggested they felt ill-equipped to support the children in their care. Caregivers are trained by CATS and Zvandiri trainers with the aim of improving their understanding of the needs and experiences of the adolescents in their care.

	7. Zvandiri adolescents have strengthened services and support for CYPLHIV through their own innovative, multimedia **advocacy** campaigns and **participation in policy and guidelines development.** **8.** Zvandiri youth provide **training and mentorship** for health workers, social workers, and community organizations to strengthen the integration of psychosocial support and clinical care.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* **Adolescents with HIV:** The primary beneficiaries of Zvandiri are children and young people living with HIV, 6–24 years old. Beneficiaries have driven program development through their insights into the specific needs and gaps they see in existing service provision and support, barriers in their home, school and social environments to coping with their HIV status and related concerns; and how they think these can best be addressed. In addition to being the recipient of services, they also take the lead in the delivery of services as counselors in their own communities, national trainers, and advocates at the community, national, and international levels. As part of this focus on adolescents with HIV, attention is included to awareness raising and strengthening of service provision for HIV- positive adolescents from vulnerable populations including those with disabilities, those with mental illness, young sex workers, MSM, young offenders, and those living on the streets. Examples include: • CATS are providing enhanced ART support and counseling for adolescents on ART with depression through daily home visits and liaison with the HIV clinic and psychiatry service. • Young people with HIV and hearing impairment were identified through partners, counseled, and integrated within the community support groups. CATS were trained in sign language and the adolescent's caregivers were trained and counseled. • Africaid is also in the process of strengthening partnerships with organizations working with LGBTI to improve access to services for this population of adolescents. • We have also assisted The Centre for Sexual Health and HIV AIDS Research CeSHHAR in the training of sex workers to provide adherence support for their peers, drawing on the same methodologies we use in Africaid. We have also begun enrolling young sex workers within our vocational skills training program, following referral by partners and government. • Adolescents with a diagnosis of HIV who are in conflict with the law are referred to Africaid by the national case management system. Africaid then provides counseling, treatment support services, support in court proceedings, and linkage to other services as required.

	In-school adolescents—Through a partnership with the National AIDS Council and the Ministry of Primary and Secondary Education, CATS have been conducting information sharing sessions and advocacy campaigns in schools, advocating for supportive, stigma-free environments in school, a greater awareness and understanding of what it means to growing up with HIV, and the importance of HIV testing and counseling and ART. This has been extremely effective in mobilizing young people who have then gone on to access HTC services at their local clinic and also made contact with Zvandiri for counseling and referral to the Zvandiri support groups. Africaid was also invited by the National AIDS Council to train teachers and guidance counselors in adolescent HIV. This has been extremely well received and is now continuing in other provinces.
Implementation sites	1. Community: Most Zvandiri services are implemented in the community, as described above, with robust bidirectional referral pathways between the community and clinic. For example, the support groups and CATS are implemented in the community, but adolescents are referred to them by the clinics, as part of their treatment, care, and support. CATS who identify adolescents who are at risk in some way (e.g., pre-ART yet eligible, unwell, non-adherence, possible treatment failure, child protection issues) will then refer them back to the clinic. The clinic will also refer adolescents who are lost to follow-up to the CATS who then trace them and refer back to the clinic. 2. Clinics: CATS also work within the clinic, assisting the counselors and nurses with counseling, disclosure support, adherence, and broader psychosocial issues for adolescents. Zvandiri Centres are only in four clinics in Harare but other clinics have established adolescent corners drawing on the same principles. Africaid's training and mentorship program is also targeted at health facilities and strengthening the knowledge, skills, and attitudes of service providers in order to improve access for adolescents to adolescent friendly prevention, treatment, care and support services. Zvandiri has been successfully rolled out in both urban and rural settings, working with local stakeholders including young people themselves.

Outcomes/results	Zvandiri secures multiple benefits for its young beneficiaries, their caregivers, and overstretched health professionals, with potentially much wider benefits for managing the HIV and AIDS epidemic as a whole. The program helps make health services more efficient and effective by taking extensive responsibility for linkage to care, loss to follow up, and adherence monitoring, as well as changing health provider attitudes and building their skills to provide strong youth-friendly services. By strengthening disclosure, treatment access, adherence, and retention in care, Zvandiri contributes substantially to HIV-positive health, dignity, and prevention as part of wider SRH benefits and improved mental health. In turn, these can generate substantial cost benefits and cost savings over time through fewer new infections, earlier access to testing and treatment, and reduced occurrence of drug resistance and subsequent treatment failure. More broadly, Zvandiri also contributes to advocacy, raising awareness, and challenging stigma and discrimination in schools, churches, and the community at large. Finally, Zvandiri contributes to policy and guideline development and training. In 2014, an independent consultant documented the impact of the Zvandiri model and reported the following: ***Overarching benefits*** • Effective bi-directional links between community and clinic to strengthen the HIV care cascade including uptake of HTC, linkage and retention in care, and adherence • Psychosocial well-being, including improved resilience and confidence, improved mental health, earlier and supported disclosure, better adherence, and better health outcomes for HIV positive children, adolescents, and young people • Improved linkage to child protection services that prevent and respond to neglect, violence, stigma, and discrimination • Support for HIV prevention, including for the next generation and for wider sexual and reproductive health (positive health, dignity, and prevention) • Reduced incidence of drug resistance, treatment failure, and transmission of resistant virus • Long-term cost benefits through contribution to HIV prevention and improved sustainability of treatment and care with reduced opportunistic infections and need for second- or third-line ARV regimens • Strengthened child- and youth-friendly health service provision • Improved capacity of families and communities to support children and young people with HIV

	• Youth empowerment as future adults, workers, and parents that benefits themselves and their communities • Expansion of the documented experience of effective approaches for children and young people with HIV • Model for active participation with potential for sustainability and scale-up that can be used by different organizations with other vulnerable children and young people. ***Benefits for children and young people living with HIV*** *Psychosocial and mental health benefits:* • Reduced isolation, improved psychosocial well-being and mental health, including alleviation of fear, depression, and anxiety • Increased self-esteem, confidence, motivation, and capacity • Increased HIV-related knowledge, understanding, and life skills • Greater capacity to handle stigma and discrimination • Improved family communications and parenting, happier home life • Opportunities for regular involvement in activities and group events—fun, uplifting, involving, inspiring, developing skills and information, and making friends *Direct health benefits:* • Earlier diagnosis, supported disclosure, adherence, and retention in care, leading to lower rates of treatment failure and better overall health outcomes • Better sexual and reproductive health, including treatment for sexually transmitted infections, reduction in unintended pregnancy, improved access to PMTCT services *Indirect and long-term benefits:* • Improved education: less time lost due to illness, reduced stigma and discrimination; more acceptance and understanding by peers and teachers • Vocational training and potential for improved socioeconomic status • Direct support and social welfare referral to meet some material needs • Improved, more youth-friendly healthcare systems • Reduction in HIV transmission and new infections in sexual partners • Improved access to PMTCT, reduced infant infections and mortality, supported parenthood • As CATS, learning valuable skills, personal empowerment, opportunities to give back, and generate some income

	Benefits for caregivers • Improved knowledge and understanding about HIV • Reduced fears of infection • Healthier children and adolescents—fewer needs, illness, and costs • More support from HIV-positive child/adolescent in the home and for the future • Improved capacity to cope appropriately • Less isolation and stigma ***Benefits for clinic staff and health services*** • Strengthened community–clinic linkages for a greatly improved holistic and comprehensive continuum of psychosocial well-being and healthcare • Training opportunities for healthcare providers at different levels, increased understanding of adolescent needs, and skills development • Time saving, suggestions for more efficient practice, reduced stress • Fewer repeat visits by children, adolescents, and young people for ill-health, increased counselor involvement, suggestions for more efficient operating patterns • Improved linkage between health and child protection services • Support to develop youth- and gender-friendly health services • Support for defaulter tracing, reducing loss to follow-up • Improved track records for successful disclosure, treatment access, and adherence and retention in care • More job satisfaction through greater engagement and better results
Ethical soundness	Zvandiri is rooted in the principle of child rights and seeks to uphold: • The **rights of adolescents to knowledge** about their own health in ways they can understand and cope with through supporting families and health service providers with disclosure and ensuring policies and guidelines are in place to support disclosure; to ensure that adolescent-focused information and health and treatment literacy is available for them • **Their right to health**, through early access to adolescent-sensitive HIV testing and counselling, treatment and care services; sustained, effective adherence support, and early detection of nonadherence and potential treatment failure, opportunistic infections, and treatment toxicities, followed by effective referral and follow-up; engagement in evidence-based activities and services that promote optimal sexual and reproductive health and mental health • The **right to supportive and stigma-free** environments in the home, community, schools, churches, and their daily lives

	• The right to be **actively engaged** in issues affecting them. Zvandiri is built upon the meaningful engagement of young people at local, national, and international levels, whether providing adherence counseling in adolescents' homes or advocating for optimal treatment, effective monitoring, and adolescent-focused service delivery in the WHO guidelines development group Africaid is registered with the MoPSLSW under the Private Voluntary Organization Act. All staff are registered with the relevant professional licensing body (e.g., nursing, social work). Africaid has a strict code of conduct, policies, and guidelines within which it operates to ensure that program beneficiaries are kept safe from harm. Of particular importance are the measures that Africaid puts in place to safeguard young people's rights and to prevent involuntary disclosure when engaged in their service delivery, training, or advocacy roles. Africaid has a Peer Advisory Board comprising young Zvandiri representatives from across the country who represent their peers in the districts and report to the Board of Trustees on issues affecting them. All potential research is considered by the Zvandiri Research Committee, which reviews each protocol. This committee comprises young people with HIV, staff, and board members.
Relevance	The Zvandiri model has proved to be highly relevant to the need for adolescent-friendly services, through recognizing and responding to the needs of HIV-positive adolescents for earlier access to HTC and for disclosure, linkage to ART, support for retention in care, adherence, mental health, and sexual and reproductive health, in addition to support with the transition to adulthood. This model has been evolving over the past 11 years, yet the need for adolescents to have access to services which effectively respond to their needs are only just being recognized nationally and internationally. This established model is now recognized to be highly relevant and has therefore been included in the national accelerated treatment plan for adolescents and the All In! plans, and has also been documented in the WHO's guidelines on Adolescent HIV in 2013. Furthermore, the director was selected to join the WHO's Guidelines Development Group for the 2015 guidelines, ensuring adolescent needs were represented.
Reach	The Zvandiri program has continued to increase its reach each year since the inception of the program in 2004, initially in Harare then in Bulawayo, Manicaland, and Bulawayo. As described above in the Zvandiri theory of change, Zvandiri seeks to improve: • Engagement in the continuum of care, sexual and reproductive health, and psychological well-being • Children's agency • Improved healthcare systems • Reduced stigma • Improved socioeconomic status • Improved family support, communications/parenting

- Multisectoral awareness of needs of CYPLHIV
- Child and adolescent friendly policies

In 2014, an independent consultant conducted a review of the Zvandiri program against these outcomes, using the theory of change as an evaluation framework. This approach was adopted to provide evidence of the reach and outcomes of the Zvandiri program and to inform future programming. Both this document and an academic paper that has been submitted for publication document the way Africaid has been successful in meeting these expected outcomes for adolescents with HIV, their families, service providers, policymakers, and communities.

The total number of beneficiaries reached in 2014 was 5,009, representing nine percent of the number of adolescents on ART at the end of 2014. Although this is a relatively low percentage of the total number of adolescents in need of treatment support, this was achieved in 18 districts alone. Africaid now aims to achieve health equity for adolescents in different districts through continued scale-up, a process that is achievable as Zvandiri is an integral component of national plans and initiatives, including (1) the national accelerated treatment plan for infants, children, and adolescents, (2) ALL IN! and (3) The new Global Fund incentive funding. Africaid has also applied with two separate consortiums for (a) DREAMS and (b) the Zimbabwe HIV Treatment and Care Mechanism.

Program Reach for 2014:

Zvandiri Program Details	
Total number of districts reached	17
Total number of provinces	4
Total number of active CATS	100
Zvandiri Program Reach	
Total number of CAYPLHIV[1] reached with direct services	5,009
Total number of deceased children	12
Total number of CATS attached to health facilities	71
Total number of health facilities supported by CATS	22
Total number of children accessing Zvandiri Centres	2,730
Total number of children reached through support groups	971
Total number of children reached with advocacy campaigns	1,117
Total number of children reached with information only	3,578
Total number of referrals to other service providers	626
Total number of young people reached with youth-friendly sexual and reproductive health and rights (SRHR) services (including information)	374

[1] CAYPLHIV stands for children, adolescents, and young people (ages 5 to 24 years) living with HIV.

	Zvandiri Outcomes		
	% of beneficiaries receiving clinical care services according to national standards	100%	
	% of vulnerable children with increased knowledge, skills and confidence to keep safe and confident	79%	
	% beneficiaries reporting improved psychosocial well-being	81%	
	% beneficiaries reporting that Africaid kept its promises[2]	91%	
	Zvandiri Capacity Building		
	Number of new CATS trained	48	
	Total number of health workers trained in HIV prevention, treatment, care, and support for children, adolescents, and young people with HIV	531	
	Total number of health workers trained in advanced HIV management	257	
Efficiency	The Zvandiri model began as a voluntary program, supported through donations from individuals and small grants. Pilot projects were established with this funding, then scaled up once they were demonstrated to be effective. It has been established and run as a low-cost model with the aim of achieving replicability and sustainability, with cost savings from the use of community venues, volunteers, and integrating the model within the government health system and national case management system. Materials developed have then been scaled up for maximum reach. Africaid has a full-time staff of 21, with 8 of these being Zvandiri provincial mentors, responsible for coordinating the roll out of the model in each province to achieve maximum benefit for the lowest cost.		
Effectiveness/ impact	As referred to above, Africaid is currently half way through a twelve-month study evaluating the effectiveness of the CATS intervention in improving retention, adherence, and psychosocial well-being among adolescents with HIV in a rural setting in Zimbabwe. Fifty 10-to-15-year-olds on ART received a 12- month peer-led intervention involving weekly home visits by a trained, mentored CATS and monthly support group, compared with 50 10-to-15-year-olds receiving standard of care at the clinic. Qualitative and quantitative data were collected monthly and every six months in both arms to measure retention in care, self-reported adherence, and psychosocial well-being. **Results at 6 months:** Intervention participants reported improved adherence (60% never missed taking medicines compared to 0% in the control group) and psychosocial well-being following engagement with a CATS (97.3% in intervention and 59.7% in control). Retention in a support group was 90% and healthcare workers report improved attendance at clinic visits compared with standard of care. Disclosure of HIV status to participants by caregivers was improved (100%		

[2] The Promising Quality Framework is a set of standardized measures for monitoring program quality. This was developed through the Child Protection Fund and uses four specific instruments (i.e., Ask the Expert, Most Critical Interventions, Quality Case File Checklist, and Promise Cards), which when combined aim to tell more about the experience of children who come into contact with Africaid services.

	of participants who were unaware of their status at the start of the study were disclosed compared to 0% in the control group). Identification of participants in need of CD4 count, investigations for possible treatment failure, and linkage to protection services was improved. CATS were valued by healthcare workers and caregivers as a critical component of participant's treatment, care, and support. **Conclusions and Recommendations:** The preliminary data from this study suggest that this adolescent-led intervention is effective in improving self-reported adherence, psychosocial well-being, and retention in rural districts of Zimbabwe. However, further research of effectiveness is now required, with objective measures of viral load. A three-year, cluster randomized trial is about to commence in partnership with the MoHCC with outcome measures of virological suppression, psychological distress, retention, and sexual risk taking. As stated above, the theory of change paper describing the outputs and impact of the Zvandiri model to date has been submitted for publication in a peer-reviewed journal and we are awaiting feedback. Additionally, a mixed-methods study was conducted in 2010 among adolescents living with HIV attending the Zvandiri program. This study provided valuable evidence of the psychosocial support needs of young people growing up with HIV and has been used to inform national and international policy and programming for this population of young people. Other completed and current studies have focused on the clinical and social status of 19 perinatally infected young mothers and their infants, the validation of a mental health screening tool for adolescents, the experiences of adolescents with HIV and depression, the development of a peer-led grief intervention for adolescents with HIV, the experiences of adolescents with HIV accessing SRH services.
Feasibility	Although CATS are fully funded (stipends and transport) in Harare through designated funding, there was initially no funding for CATS in the provinces (the MoHCC model). This model has been costed by CHAI as explained above. Although retention of CATS has been good in the provinces despite the lack of remuneration, we believe there is a need to ensure stipends for them in line with other community cadres. We have been successful in obtaining funding for three districts, and other donors have expressed interest in funding their stipends, recognizing the value of supporting adolescents through the HIV care cascade. CATS have also been included in Zimbabwe's incentive funding application to the Global Fund, which was approved. Zvandiri is being taken on by MoHCC and integrated within service delivery, with technical support from Africaid, as in the costing by CHAI. NGO partners are also being trained in the model so that they may also provide support to local health facilities with support groups and CATS services.

Lessons learned	The most important lessons that a reader should take from this practice are: (1) The key role that adolescents and young people with HIV have to play in (a) the delivery of their own effective, sustainable, adolescent-friendly HIV prevention, treatment, care, and support services for their peers; (b) strengthening the capacity of health service providers, families, communities, and protection services to provide adolescent-friendly services and support; (c) advocating for the prevention, treatment, care, and support needs for adolescents with HIV at the community, national, and international levels. (2) The critical importance of community treatment, care, and support programs for adolescents with HIV in strengthening both health and psychosocial outcomes for adolescents with HIV (3) The importance of integrating community interventions within the national HIV prevention, treatment, and care programs, through strong collaborations with government, civil society, and funding partners
Retrospect	In retrospect, it would have been much easier to demonstrate the impact of a community-based intervention in improving retention, adherence, and psychosocial well-being, in addition to SRH and mental health outcomes, if there had been a stronger, shared M&E system established with the clinics or national system. For example, it has been difficult to systematically analyze self-reported adherence data or retention data without also having health facility-level data, such as CD4 count, viral load, and clinic attendance data. We have made significant progress in this now, as the national M&E system now includes age-disaggregated data for 10- to 14- and 15-to 19-year-olds and individual clinics are now sharing adolescent data, so that these can be analyzed together with our community-level data. Moving forward, this is a critical area to build on so that the role of community interventions can be measured.
Replicability	The Zvandiri model has been adopted by the MoHCC as a model of HIV prevention, treatment, care, and support for adolescents living with HIV in Zimbabwe. Over the past four years, Africaid has worked with the MoHCC to scale up Zvandiri through training and mentorship of health service providers to integrate this approach within the standard of care in both urban and rural districts. Owing to this success and increased demand for continued scale-up, Zvandiri has now been included in the National Accelerated Treatment Plan for infants, children, and adolescents and has also been included in the country's incentive funding application to Global Fund. Young people from Zvandiri have been actively involved in the All In! country assessment and are members of the All In Task Force.

	As documented and costed by Pangea and CHAI respectively (see below), Zvandiri has successfully been integrated in different districts, with Africaid playing a technical support role to those implementing in the districts. When replicated, emphasis has been on two key components of the model—community support groups and the CATS intervention. Key components of the success of this replication have been (a) the engagement and role of young people with HIV in training and mentorship for new sites, mobilizing young people and being trained and supported as service providers themselves, and (b) the strong collaboration and support from government across different sectors (particularly health and child protection) and the role of a Zvandiri provincial mentor (ZPM). However, as districts continue to implement Zvandiri, the ZPM has been able to scale down support and mentorship to then focus on new sites. We are currently conducting a research study in Gokwe South district to evaluate the effectiveness of the CATS and support groups in improving adherence, retention, and psychosocial well-being in a rural setting of Zimbabwe. Fifty adolescents with HIV are receiving standard of care from their clinic plus CATS and support groups, compared with 50 adolescents with HIV who continue to receive standard of care from their clinic. The preliminary six-month results confirm that in the intervention arm, adherence, retention, disclosure, and psychosocial well-being is improved compared with the control arm. The full study results will be available in December 2015. We are hopeful that this study will provide a valuable contribution to the evidence base for community, peer-led interventions for adolescents with HIV in the context of a global gap in such evidence. This study also demonstrates the replicability of the model in a rural setting. While the Harare site has a multidisciplinary team including a nurse, social worker, psychologist, and counselors, the provincial sites where Zvandiri has been rolled out do not have these teams. The role is effectively taken on by the healthcare facility and CATS, who conduct the community outreach. This has been described and costed within the Pangea/CHAI case study (below). In rural settings, the CATS are working with Village Health Workers and Community Health nurses who refer adolescents with HIV to the CATS for continued support. Zvandiri has also been integrated within the MoPSLSW's national case management system, whereby the community case care workers will refer vulnerable children to the CATS, who then provide peer-led information, counseling, and referral to services as required, in partnership with the case care workers, as part of their overall case management plan.
Sustainability	The Zvandiri model has been demonstrated to be sustainable through its integration within government systems over the past 11 years. It has been developed from the ground up, with strong partnerships with communities, young people and their families, the National AIDS Council, and government, ensuring a sense of community ownership. Support groups are run in free community venues, led by volunteers. Once nurses and counsellors have been trained in adolescent

	HIV, they have then gone on to establish community support groups in both rural and urban settings. These continue to function in the most remote parts of the country. Innovative methods of providing mentorship for CATS in different parts of the country have been established, including WhatsApp and Skype technology through which CATS provide peer support and mentorship as a cheap, sustainable methodology for reaching multiple CATS. The Zvandiri model has been integrated into the Zvandiri toolkit so that its materials, resources, and tools may be used by service providers, CATS, and communities well beyond the life of the program. Zvandiri was designed to be integrated within facility-based care and has achieved this, being accepted as a national model for continued national scale-up for adolescent-friendly services.
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PROMISING PRACTICES

Integrated Project Against HIV/AIDS

Victor Silumbwe

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☑ Counseling and testing for HIV
☑ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☑ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☑ Condom provision	☐ Care and support for adolescents and youth living with HIV
☑ Family planning services	☑ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☑ Social mobilization	☐ Medical male circumcision
☑ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☐ Peer education	☐ Mental health services for adolescents and youth living with HIV
☐ Prevention, safer sex, and risk-reduction counseling	☑ Other (PMTCT and VMMC information)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☐ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth

☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (Adolescents with disabilities)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other – churches

Best Practices Submission Form – Part 2

Name	Integrated Project against HIV/AIDS in Chibombo District
Country	Zambia
Topic	1. Sex/HIV education 2. Peer education/counselling 3. Care and support for adolescents and youths living with HIV and AIDS 4. Provision of condoms and family planning information—referrals
Year	2011–2014
Contact person	Victor Silumbwe Federation manager
Contact information	Chibombo Child Development Agency P.O. Box 37610 Lusaka, Zambia vsilumbwe@gmail.com Cell: +260 0977339999
Implementers	Chibombo Child Development Agency is a child-centered organization that operates in six communities of Chibombo District, Central Province, Zambia. The organization implements programs and projects that help to mitigate the root causes of child poverty and, as such, its interventions are in the areas of health, education livelihood, and child protection. In implementing its strategy, the organization worked in partnership with the District Health Office, District Education Office, and the District Social Welfare Office to address the needs of adolescents and youth in six communities. Adolescents and youths were involved from the project design stage. Focus group discussions were held with them, which led to the establishment of committees at a health facility and in the community. Adolescents and youth were also involved in implementation of monitoring and evaluation activities.
Funding	ChildFund Deutschland through ChildFund Zambia
Goals/ Objectives	Goal: To contribute to the decline of HIV infections and improve the quality of life of HIV-affected populations in six communities in Chibombo District Objectives: (a) To reduce the prevalence of HIV and AIDS/STIs among 15,000 adolescents and youth by 2014 (b) To increase access/use of counseling, testing, and ART services among 7,000 youth by 2014

	(c) For 8,500 women of reproductive age to know the risk of HIV transmission to newborns, as well as preventive measures to take (d) To improve the livelihood among 180 households with orphans and vulnerable children (OVC) by 2014 (e) The monitoring and evaluation systems in six communities are strengthened and operational by 2014
Background	With substantial populations living in absolute poverty and a literacy rate of 74.8 percent among women and 86.8 percent among men, Zambia is ranked 165 (out of 182 countries) on the 2009 human development index. Fifty-nine percent of the population lives below the poverty line and 37% live in extreme poverty (World Bank, 2010). Zambia is among the highest HIV-affected countries, with an estimated one million HIV infections (980,000) (The World Fact Book). Agriculture is the main source of income. The HIV infection rate is estimated to be 13–20%, according to WHO/UNAIDS (www.who.int/HIV & AIDSHIVCP_ZMB). The HIV pandemic reduces the life expectancy rate by an average of 38 years. A major problem is early sexual activity (12 years) in adolescents which considerably increases the risk of infection. Zambia is oriented with its HIV national program, in global HIV prevention and health goals and MDGs and has established a policy on treatment and testing. Chibombo District is located in Central Province, Zambia and occupies an area of 13.67 thousand km², with a population of 242,420. Demographically, the six rural communities targeted in the district (Kabile, Kalola, Katuba Keembe, Mungule, and Namayani) have 70,000 people, 30 percent of whom are ages 15–24 years. The health services situation is critical in Chibombo, with 1769 patients per hospital bed in the only hospital. Twenty-two health centers serve a population of 242,420. There is a high birth rate, but only 154 trained midwives are available to provide services to pregnant women. The midwife in the village is often the only chance of delivery assistance for the pregnant women. Only 54 midwives are trained in HIV, which is a low and worrisome figure. There are roughly 184 community health workers who provide services to an area of 13.26 thousand km². Only three institutions provide ART. Mobile services are rudimentary. Health workers are not trained in youth-friendly services, resulting in low confidentiality levels and judgmental attitudes, which hinder services utilization by youth in the six targeted communities.
Design	The project was an extension of Phase I of a project that was implemented 2008–2010, the Integrated Project against HIV/AIDS. The lessons learned from Phase I coupled with consultations with the target groups informed the design of the project. Group discussions were held that underscored the need for the project. The design was based on ChildFund's youth theory of change.
Main activities	• Psychosocial support (PSS) training and club management • Training 60 young people in life skills and youth-friendly services • Training for young people in peer education

	• Training 60 young people in behavioral modification • Establish 12 youth-friendly corners • Strengthen anti-AIDS clubs in 20 schools • Training 30 teachers in PSS/guidance for children • Training 60 teachers in reproductive health, leadership/counseling/support • Conducting quizzes and debates in schools • Training 30 laymen in consulting/counseling • Conduct 16 awareness meetings • Income-generating activities for 12 groups • Training 30 midwives in PMTCT • Training 18 employees of health centers in HIV transmission risk from mother to child, PMTCT, and youth-friendly services • Sensitization meetings for father involvement in PMTCT • Two-day training of 30 caregivers in psychosocial counselling/guidance for children • Training 30 staff and volunteers in psychological counseling • Training 30 staff in youth and advocacy work • Training 60 caregivers in marketing, animal health, and horticulture
Beneficiaries	1. Adolescents and youth in the general population 2. In-school adolescent/youth 3. Out-of-school adolescent/youth
Implementation sites	1. Community offices 2. Health posts
Outcome /results	• With the various health talks held across the six communities, it was expected that youths would access various reproductive health (RH) services from the youth-friendly corners and health facilities. In terms of behavior change, 60.7 percent adopted new behavior specifically for avoiding contracting HIV. • Capacity building for peer educators was conducted using a cascade approach after training the master trainers, with support from the HIV and AIDS coordinator. In this approach, peer educators were trained and expected to roll out a similar training to their peers, who were clustered in groups. The peer groups were trained in peer education, life skills education, behavior change communication (BCC), and PSS for

	OVC. The roles of the trained youths in the targeted six communities included, among others, social mobilization; awareness raising on prevention of HIV, AIDS, and STIs; and raising awareness on gender issues in relation to child defilement, rape, and early marriages. • Adolescent sexual activity, within or outside of marriage, can lead to negative reproductive health outcomes. According to Ruland (2003), early sexual debut can place adolescents at increased risk of unintended pregnancy, HIV, and other STIs. Youths who begin sexual activity early, at between 15 and 18 years old, appear more likely to have sex with high-risk partners or multiple partners and are less likely to use condoms (Central Statistics Office [CSO] et al., 2009). Early sex can further have adverse social consequences, as teenage pregnancies are usually associated with higher morbidity and mortality for both the mother and child. According to the 2007 ZDHS, young men in rural areas are more likely to have initiated sex between the age of 15 and 18, though the difference is not as great for young women. The survey data suggests that more than three quarters (79%) had engaged in sex at the age of 16.7 years. The findings in this survey further suggest that the boys were significantly (P=0.000) more likely to have early sex than girls of the same age. Of the respondents interviewed, 64 percent of those with sexual initiation at an early age were boys. The data suggest that boys had an average of 2.5 numbers of sexual partners, while the girls had 1.6 sexual partners at the time of the survey (CSO, et al., 2009). Ruland (2003) further suggests that youths who begin sexual activity early appear more likely to have sex with high-risk partners or multiple partners and are less likely to use condoms. In this survey, the majority of respondents indicated that they had sexual intercourse with their regular girlfriends, though a very small proportion indicated that they had sex with commercial sexual partners. While the data suggest that the majority of people interviewed had initiated sex at an early age, the national picture suggests that there has been a substantial decline in the proportion of young women and young men who have had sex by age 15 and 18.
Ethical soundness	In any research, fulfilling ethical requirements is of critical importance. Among the many ethical requirements, it is important that a researcher does not coerce the research participants in any way to participant in research. To fulfill the ethical requirement, consent was obtained from the participants and a letter of introduction was obtained from ChildFund. The scope and rationale of the study was explained to the participants. At each research site, respondents were assured that all the information they would give would be kept confidential and would only be used for the purposes of the evaluation exercise.
Relevance	The HIV/AIDS II project was in line with what is espoused by the United Nations Millennium Development Goal (MDG) number six, which is aimed at, among other things, reducing the prevalence of HIV/AIDS among youth, promoting condom use, dissemination of knowledge on HIV and AIDS, and supporting vulnerable children affected by HIV and AIDS. The National Health Strategic Plan (2011–2015) and other national plans such as the Sixth National Development Plan and Vision 2030 also place importance on

	programs addressing HIV and AIDS. The National Multi-Sectoral HIV Policy and Strategic Framework places emphasis on community-led HIV prevention strategies to stop and reverse the trend of new HIV infections in Zambia. Prevention of HIV transmission through HIV testing, PMTCT, and condom use is a government priority. The HIVII project therefore was a relevant project, given its community focus in addressing the spread of HIV and its responsiveness to national HIV priorities.
Reach	The project target was 15,000 young people ages 10–24 but the project reached 18,700 young people in all six communities of Chibombo District Zambia where it was implemented
Efficiency	ChildFund Zambia through CCDA has well-established structures in all six targeted communities to ensure that all the planned activities are implemented within the stipulated time frame. The design of the project of having a coordinator at district level and facilitators at community level contributed to the efficient implementation of activities in the communities. For example, the field-based staff were able to mobilize and conduct trainings within the communities and target the right individuals for specific trainings. Appropriate structures such as youth groups and support groups ensured that project activities were implemented at least cost. In addition, the use of existing structures such as traditional birth attendants and safe motherhood action groups meant that the project did not have to establish new and costly structures that would make implementation expensive and less sustainable. The knowledge obtained by peer educators is still being used to mobilize more youth. The health providers who were trained are also using the knowledge they acquire to support people infected or affected by HIV and AIDS. The village savings and loans (VSL) groups and support groups that were formed are also still functioning, providing livelihood support and linkages between the community members and health facilities. This shows that the support provided to these communities has been efficient.
Effectiveness/impact	The project was able to achieve its objectives and responded to the needs of beneficiary communities in Chibombo. Training of peer educators, community outreach in HIV prevention, establishment of youth-friendly corners, establishment of and continued support of VSL and support groups, and creation of referral mechanisms were among the outputs that contributed to the effectiveness of the HIV project. During the implementation period of the project, a total of 12 peer educator groups were formed, representing 100 percent of the target. According to program reports, the use of peer educator groups proved to be the most effective strategy for reaching out and scaling up sensitization of youth on issues pertaining to HIV and AIDS. Through the use of peer educator groups, a positive uptake of condoms and increased HTC among youths in the targeted communities was recorded. Condom distribution was also increased as over 18,923 condoms were distributed in the final year of project implementation. This shows a substantial increase in the number of condoms distributed as a prevention measure for the transmission of HIV. However, consistent condom use remained low, averaging less than 50 percent, as most of the youths could not use condoms every time they had sex. This may be

	attributed to adolescents' perceptions regarding loss of sexual pleasure because of condom use, their perceptions concerning negative reactions from a partner regarding condom use, and their lack of communication with partners. In terms of HIV testing, close to two-thirds (68.3%) of the respondents had ever taken an HIV test, with the majority being males though not significantly different with the females (71% males and 64% females). The average number of times participants had ever tested for HIV was two times. Knowledge of HIV testing among pregnant women was widespread, with 89 percent of the respondents attesting that women are tested for HIV during antenatal clinic visits. Knowledge was higher among females (91.3%) than males (87.6%). People's knowledge of where to test for HIV was almost universal, with 95.5 percent of the respondents saying they knew where they could get an HIV test. This in part suggests that sensitization on HIV testing facilities that exist was effective among the community members. In terms of livelihoods, 19 VSL groups were established and strengthened during the project life against a target of 18. In addition, support groups were also formed that along with VSLs provided support to 180 households with orphans. The support provided to these groups by ChildFund included mentorship sessions, provision of resource materials, and facilitating linkages. Eight herbal medicinal gardens were established and continued to offer relief and supplementary medication options among HIV infected individuals as well as the general population that included malnourished children. The support group members that were trained have continued educating the community members on the importance of medicinal plants, especially among HIV-infected populations and households where children were malnourished. About 189 malnourished children had benefited from sensitizations and more than 2,088 people had directly received herbal plants across the project. Data suggest that the six communities have continued to record a steady decline in the spread of STIs due to an increase in access to quality interventions. The baseline report suggests that 3.8 percent of the interviewed respondents had had an STI at some point of their life. At the endline survey, only 2.5 percent of the interviewed clients reported having had/or experienced an STI at least once during, the past one year. With continuous sensitizations, there were changes in behavior among youth. For example, 60.7 percent adopted new behavior specifically to avoid contracting HIV. By the end of the first quarter of 2014, 753 women were enrolled in the PMTCT program. This was an overachievement of more than 100 percent from the target number of 428 required in phase II to supplement the 300 attained earlier in the HIVI, making it 728 as set out by the project target. Hence, by the first quarter the project had overachieved by 156 percent. The upswing in the proportion of women accessing PMTCT is a clear indication that they are more aware of the availability of services and are taking precautions to ensure that there is no HIV infection at childbirth. It is worth

	mentioning that the building of capacity of community volunteers such as lay counselors, traditional birth attendants, and community leaders helped to enhance male involvement in PMTCT, which led to increased uptake of PMTCT services from 300 in Phase I to 624 in phase II's quarter one. Knowledge levels of risk factors related to mother-to-child transmission was high among respondents. The survey shows that 98 percent of the respondents are aware that giving ARVs to both the child and the mother reduces the risk of transmitting HIV to the baby. About three quarters (73%) also know that for HIV-positive mothers, breastfeeding a baby increases the chances of transmitting the virus to the baby. The livelihood component of the project registered substantial intended and unintended achievements. Among the achievements, VSL group members interviewed said their livelihoods had improved because of their affiliation to the group and that they had benefited from the loans they had received. The members also benefited through diversifying their sources of income as a result of applying what they had learned from entrepreneurship trainings conducted by project staff. Of the respondents interviewed, 90 percent indicated that they had even managed to acquire household valuables through group barter system arrangements and that the home visitation group member monitoring also prompted members to work hard and improve their household assets. Among the items purchased were blankets, beds, television sets, and kitchen utensils such as plates, cups and pots, while others had managed to buy cattle and additional goats to boost their investments. There is increased demand among community members to belong to the VSL groups as a result of project interventions. For instance, the project had targeted establishment of 18 VSLs, but 19 VSL groups were established and strengthened during the project life representing an achievement of 105%. The support provided to these groups by ChildFund included mentorship sessions, provision of resource materials, and facilitating linkages. Among the things appreciated most was that members of these groups had learned to save money, how to run small businesses, and how to take care of OVCs. Participants of VSL groups received training in village banking, entrepreneurship, animal health, and psychosocial support. Members of the groups are involved in activities such as goat keeping, seasonal farming, village banking and provision of loans to members, donating school requisites to OVCs, sensitization on HIV and PMTCT, and educating each other on herbal medicines and how to take care of children. It was deduced that the integrated approach by the project had broadened its reach to beneficiaries to an extent that most aspects were found to be intertwined. VSL members were able to articulate well the concept of the village savings and loan concept and how it is linked to child care and support, how child rights are linked to providing holistic care and support in the form of food, shelter, education support, protecting children from early marriages, and exploitation. Through such a linkage, the beneficiaries showed appreciation of the VSL concept and learned the importance of saving, investment, and business diversification. For instance, all beneficiaries under VSL and support groups indicated that they had more than one source of income in contrast to the time the project

	started. This fact was authenticated by respondents who demonstrated how the Participatory Wellbeing Ranking Self-Assessment and Goal Evaluation tools had helped them to soar to greater heights. A review of the program reports indicated that the groups were not static, as they were always looking for ways to increase their income. These efforts are clearly being experienced by the groups. In one of the groups, it was established that the savings of the groups since the start of the village bank concept had increased almost six times from K9,660 recorded in year one to K59,880 in year two. The herbal medicinal gardens continued to offer relief and supplementary medication options among HIV-infected individuals, as well as the general population that included malnourished children. Eight medicinal gardens were identified and medicinal plants were planted. These plants included Moringa, artemisia, aloe vera, and lemon grass that provide medicinal value especially to HIV-infected people. The support group members that were trained have continued educating the community members on the importance of medicinal plants, especially among HIV-infected populations and households where children were malnourished. It was established that 189 malnourished children had benefited from sensitizations and by being provided with Moringa, aloe vera, groundnuts, and aramanthus plants. Worth noting was that in all six communities, 95 percent of the respondents reported that cookery demonstrations and sensitization on herbal medicines had been conducted in the areas and that people had appreciated the activities and demonstrated change. It was also established that over 2,088 people had directly received herbal plants across the project. This component of the project however faced substantial challenges that affected the growth of the plants. First, the lack of water for the gardens affected the growth of the plants. Second, the gardens were poorly fenced, which resulted in animals encroaching on the herbal gardens.
Feasibility	
Lessons Learned	
Retrospect	
Replicability	
Sustainability	Sustainability of the project was assessed in terms of the likelihood of project activities continuing, absorption of project activities by permanent structures such as government, and other community-level structures beyond the life of the project. The formation of peer groups was done by the communities themselves and the dedication of the youths in these groups is likely to encourage youths to continue with activities beyond the life of the project. The youth-friendly corners will also most likely continue existing and being used by youth. These activities are in tandem with the government policy of preventing HIV transmission among youths and in some communities have already been absorbed by the MCDMCH. The VSL groups have also been recognized and linked to government through the MCDMCH. The groups have been registered with the government and have already started receiving support in various forms. For instance, under the department of community

	development, caregivers in Mungule and Katuba were trained by the Ministry of Agriculture and Livestock in animal health after which they developed proposals that were funded. In addition to MCDMCH, the groups have also been linked to the Ministry of Agriculture and Livestock in order for them to continue receiving support in form of farming inputs, capacity building, and mentorship from government. In Kalola, three VSL groups namely Koyuma, Kalola, and Mululu had their proposals approved by the Community Development department which had adopted the groups as part of hand-over by ChildFund Zambia. Each of the three groups is expected to receive K10,000 from the government's Women Empowerment Fund.
References	Project document, end of project report, and final evaluation report Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. (2009). *Zambia Demographic and Health Survey 2007*. Calverton, Maryland, USA: CSO and Macro International Inc. Kasonka, C. & Kanjipte, W. (2015). *Integrated programme against HIV/AIDS in six communities in Chibombo District, Phase II: End of project evaluation report*. Lusaka, Zambia: ChildFund. Ruland, C. D. (2003). Abstinence and Delayed Sexual Initiation. YouthLens, no. 8. Retrieved from: https://www.iywg.org/sites/iywg/files/yl8e.pdf.

Project Accept, Zimbabwe, Tanzania, and South Africa

Gertrude Khumalo-Sakutukwa

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☑ Access to HIV services (location, hours, facility environment)	☑ Counseling and testing for HIV
☐ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☑ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☐ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☐ Peer education	☐ Mental health services for adolescents and youth living with HIV
☐ Prevention, safer sex, and risk-reduction counseling	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☐ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old
☑ Other (age 25–32 years)

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☐ Pregnant adolescents and youth

☐ Female sex workers	☐ Incarcerated adolescents and youth
☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☐ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☐ Health facility
☑ Community
☐ School
☐ Worship place
☐ Work place
☑ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Project Accept
Country	*Country where the practice is or was carried out* South Africa, Tanzania, and Zimbabwe
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* 1. Access to HIV services 2. Counseling and testing for HIV 3. Social mobilization
Year	*When did the practice start? When did it finish? When is it expected to finish?* The start dates for the practice were as follows (Khumalo-Sakutukwa, 2008): Zimbabwe: January 2006 Tanzania: March 2006 South Africa: May 2006 The practice ended in 2009.
Contact Person	Gertrude Khumalo-Sakutukwa Research Specialist
Contact information	Center for AIDS Prevention Studies University of California San Francisco 50 Beale Street, Suite 1300 San Francisco, CA 94105 Tel: (415) 597-9228 Fax: (415) 597-9202 gertrude.sakutukwa@ucsf.edu
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information.*

	If it was a partnership, who were the partners? *Were adolescents and youth involved in the implementation of the practice? How were they involved?* *Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* Project Accept was implemented and managed by principal investigators and project managers at the study sites, in partnership with community advisory boards and local government departments. A steering committee of 11 members had a conference call every month, and they met in person twice a year to design and approve all study procedures, monitor study progress, and approve all modifications and study publications. At each site, community working groups (CWGs) were formed and comprised local leaders, representatives from community organizations, churches, schools, health clinics, and traditional leaders. CWGs served as a link between communities and program staff who sought their advice and feedback on mobilization activities (Tedrow, et al., 2012). It is not clear whether people living with HIV or AIDS and adolescents and youth were directly involved in the implementation of the project in Tanzania, Zimbabwe, and South Africa. When the practice was replicated in Thailand, membership in CWGs included people living with HIV/AIDS and youth leaders (Kawichai, et al., 2012). In Zimbabwe and South Africa, staff-established partnerships with community organizations to address community-specific needs such as unemployment (addressed by skills building workshops in Soweto) and hunger (addressed distribution of food supplements, workshops on new agricultural techniques, and identification of partners to donate garden supplies and agricultural support to the community in Zimbabwe) were formed. Project teams also partnered with schools to mobilize youth, and with churches and government health clinics during immunization campaigns (Tedrow, et al., 2012).
Funding	*Who provided the funding and other resources?* US National Institute of Mental Health, HIV Prevention Trials Network (via US National Institute of Allergy and Infectious Diseases), and US National Institutes of Health.
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* The objectives of Project Accept were: • To destigmatize and normalize HIV counseling and testing, inculcate a sense of collective commitment to address the HIV epidemic, raise awareness about HIV, and model positive acceptance of those infected and affected by HIV and AIDS

	• To provide free HIV testing in easily available venues • To provide psychosocial support to clients after being tested for HIV, regardless of serostatus
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* Despite efforts to expand HIV testing and increased funding for VCT programs, the proportion of persons aware of their HIV infection has remained well below what is required to have a significant impact on the epidemic in terms of behavioral risk reduction, linkage to care and treatment, community-level awareness of the scope of the epidemic, and reductions in HIV-related stigma and discrimination. The limited number of people aware of their HIV status and thus unable to access treatment compromises the potential impact of ARVs in reducing HIV infectivity. Furthermore, although significantly more young people are infected with HIV, few youth know their HIV status and even fewer are linked to medical care and services (van Rooyen, et al., 2013). The study was designed to examine the comparative benefit of mobile VCT in reaching large proportions of vulnerable populations (Sweat, et al., 2011).
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?* An intervention working group was created to implement the intervention consistent with the overall research protocol that had been submitted. Representatives from each site included site principal investigators, project directors, and project coordinators. This participatory process allowed each site to address site-specific issues and helped the group to reach consensus on common elements to develop standard operating procedures (SOPs). The group worked via conference calls and face-to-face meetings. The primary change that was made in Zimbabwe was the addition of principles for motivational interviewing to the VCT model of counseling. A three-day meeting was held to develop the standard procedures for community mobilization based on principles from diffusion theory and prior prevention intervention trials. In order to develop procedures for posttest support services (PTSS), the group conducted site visits to four existing posttest clubs in Bulawayo and Chitungwiza, Zimbabwe; Nairobi, Kenya; and Kampala, Uganda. The group then developed a set of standard procedures for PTSS in a three-day workshop. Each of the

	SOPs underwent subsequent review at each site (Khumalo-Sakutukwa, 2008). The theoretical foundations of Project Accept (Khumalo-Sakutukwa, 2008) were the following: (1) Diffusion of innovation theory: This theory guided the community mobilization component of the innovation. The theory contends that all communities have a small number of people who are innovators. These innovators influence others in their social network to adopt the innovation. Eventually, at the network level, there will be a threshold of behavioral adoption, and once that threshold is reached, there will be sustained and widespread uptake of the behavior. The theory argues that uptake of the behavior will proceed faster if opinion leaders in the community are encouraged early on to adopt the innovation. (2) Tipping point theory: The community-based VCT component of the intervention was based on the theory that a "tipping point" occurs when a critical mass of adoption occurs in a social network. Three factors determine whether the tipping point occurs: (1) the "law of the few," (2) the "stickiness" of the behavior, and (3) the context of the innovation. (3) Social action theory: This theory guided the development of the posttest support services component of the intervention. The theory views health-protective behaviors as a function of three interactive domains: (1) the self-regulatory capabilities of the individual, (2) the environmental context, and (3) responses to internal affective states.
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* The Project Accept intervention included: (1) community mobilization activities, (2) community-based VCT, and (3) community-based posttest support services (Khumalo-Sakutukwa, 2008). (1) Community mobilization: Project staff convened a series of meetings and consultations with community members to encourage a sense of community ownership of the project. Volunteers recruited from the community were supported as project team members to educate others about the project and to encourage personal participation from their peers and neighbors. Leaders in the community were encouraged to come and be seen receiving HIV counseling and testing and to give testimonials about their experience. This process was ongoing throughout the life of the project. There were activities to integrate HIV-infected and uninfected people around educational, social, and political goals. Community events were also supported by the project, such as sports teams and presentations in schools and at existing community events. In each site a community mobilization coordinator organized and supervised field activities. There were also additional community mobilization outreach workers on staff at the field level—five in Tanzania and two in Zimbabwe. In addition, local

	volunteers were recruited from each community-based VCT (CBVCT) community who assisted in mobilizing community members to utilize the intervention (an average at any one time of approximately 74 in Tanzania and 42 in Zimbabwe). (2) Community-based VCT: Free HIV testing was provided in easily available venues to enhance convenience and the visibility of both the service and of people coming to receive VCT. Uptake of testing and counseling was tracked, and areas and times of day with high utilization were targeted. In all sites, community volunteers were mobilized when visits occurred, and together with staff they canvassed the area to alert people of the opportunity to come to intervention venues, ask questions, and receive VCT. Project staff at each testing venue provided educational sessions on HIV and HIV testing, and encouraged people to receive HIV VCT. Standards for VCT conformed to the US CDC, WHO, and local national guidelines, and included pretest counseling, rapid HIV testing while the client waited, and provision of the test result in the context of posttest counseling addressing personalized risk reduction. Free male and female condoms were offered to all clients at the time of HIV testing. HIV-infected clients were referred to treatment. (3) Posttest support services (PTSS): This component of the intervention offered psychosocial support to improve quality of life for individuals diagnosed with HIV. The objective of this component was to reduce social harm, increase social support through disclosure, reduce stigma, and decrease the risk of further transmission. There were five basic PTSS activities: (a) information-sharing group sessions, (b) psychosocial support groups, (c) crisis counseling, (d) coping effectiveness training, and (e) stigma-reduction workshops. Project counselors also made referrals to non-Project Accept organizations/agencies and community-based health and social service providers so that members could have their practical, special, and immediate needs addressed.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* The beneficiaries of Project Accept were ages 16–32 years and included adolescents ages 15–19 and youth ages 20–24.
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3.* Project Accept was implemented at the community level and through outreach. *Was the practice implemented in urban or rural areas or both?* In South Africa, Project Accept was implemented in both urban (Soweto) and rural (Vulindela) communities. In Tanzania, the project was implemented in both urban and rural communities (10 communities in total) in Kisarawe District. In Zimbabwe, the project involved 8

	communities that consisted of both urban and rural areas in Mutoko District (Sweat, et al., 2011).
Outcomes/results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* The primary outcome of Project Accept was HIV incidence. Secondary outcomes were social and behavioral (Coates, et al., 2014): • Sexual risk behavior • HIV testing rates • Social norms regarding testing • Discussions about HIV • Disclosure of HIV status • Stigma associated with HIV and • HIV-related negative life events Outcome measures included, but were not limited to: • Service utilization rates • Number of HIV Cases detected • Percentage of individuals ages 16–32 years receiving HIV counseling and testing • Percentage of CBVCT residents ages 16–32 years repeating HIV test at Project Accept CBVCT service venues (Sweat, et al., 2011)
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* The study procedures and instruments were approved by the following ethical review committees: the Medical University of South Carolina Institutional Review Board for Human Research (Tanzania), the institutional review board of Muhimbili University of Health and Allied Sciences (Tanzania), the institutional review board of the National Institute of Medical Research (Tanzania), University of California, San Francisco Committee on Human Research (Zimbabwe), and the Medical Research Council of Zimbabwe (Zimbabwe). Project Accept also has an independent data safety and monitoring board which biannually reviews project benchmarks, outcomes, and adverse events. All clients were provided with printed information sheets explaining that services were being provided as part of a research study. Verbal informed consent was obtained from clients before collection of data for service use (Sweat, et al., 2011). All counseling and testing was done anonymously and in private.

Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* HIV testing: The proportion of clients ages 16–32 years receiving their first HIV test during the study was higher in CBVCT communities than in standard clinic-based VCT (SVCT) communities in Tanzania (2341 [37%] of 6250 vs. 579 [9%] of 6733) and Zimbabwe (5437 [51%] of 10 700 vs. 602 [5%] of 12 150) (Sweat, et al., 2011). SVCT consisted of services at existing district hospitals or local healthcare facilities, which were also available in communities with the community-based intervention. A larger percentage of HIV testers were 16–17 years of age in intervention communities (CBVCT) than in control communities (SVCT) (Sweat, et al., 2011): In Zimbabwe, persons testing for HIV from intervention communities versus comparison communities were more likely to be adolescents and to have tested as an individual rather than couple (Sweat, et al., 2011). SVCT venues have been criticized for not being youth-friendly, which might explain the increased proportions of young people attending mobile services. The percentage of HIV testers ages 16–17 was 21.7 percent from intervention communities versus 8.2 percent from control communities ($p < .001$). In Tanzania, 15.8 percent of those testing for HIV from intervention communities were aged 16–17 years as compared to 8.5 percent from control communities ($p < .001$). In South Africa, young testers (<20 years old) were significantly more likely to be testing for the first time compared to older testers ($p=0.01$ in Vulindlela, $p<0.001$ in Soweto) (Van Rooyen, et al., 2014). HIV detection: CBVCT detected four times more HIV cases among clients ages 16–32 years than did SVCT across the study sites, despite higher HIV prevalence among those testing at SVCT sites. These results were not presented separately for young people and older people (Sweat et al., 2011) HIV incidence: The intervention did not decrease HIV incidence in young people ages 18–24 years, regardless of gender, or in older men. The

	intervention produced slight (30%) reductions in HIV incidence, especially in older women ages 25–32 years (Coates, et al., 2014). Sexual risk behavior: No overall effect of the intervention on sexual risk behavior (measured by the number of unprotected sexual acts) was detected. However, in individuals with HIV, a significant reduction of high-risk sexual behavior was noted in the intervention group. The number of sexual partners of HIV-positive men ages 18–32 years was reduced by 18 percent (95% CI 8-46, P=0.034). These results were not presented separately for young people and older people (Coates, et al., 2014). Social norms: The intervention had a significant effect on social norms for HIV testing among both men and women ages 18–32 years. However, the positive change in social norms was greater for men than for women. These results were not presented separately for young people and older people (Coates, et al., 2014). HIV-related stigma: HIV-related stigma was not affected by the intervention. These results were not presented separately for young people and older people (Coates, et al., 2015).
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.* The intervention did not decrease HIV incidence in young men or women ages 18–24 years. The representativeness of adolescents and youth reached was difficult to determine. The ability to achieve health equity was difficult to determine since the published results were not broken down by socioeconomic characteristics.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* No information is available from public sources on cost and resource efficiency.
Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.*

	The practice was supported by rigorous quantitative evaluations, studies with peer review, and publication. The practice also included control areas. Project Accept was a randomized control trial of 10 communities in Tanzania (Kisarawe District), 8 communities in Zimbabwe (Mutoko District), and 16 communities across 2 sites in South Africa (8 in Kwazulu-Natal and 8 in Soweto). Using community mapping results, communities in each site were matched into pairs according to similar sociodemographic, cultural, and infrastructural characteristics. One community from each pair was randomly allocated by computer (in Tanzania) or by lottery in a public venue so that community members could observe (in Zimbabwe) to receive SVCT (control intervention) or CBVCT plus access to SVCT (test intervention). "All people residing in study communities had access to VCT either in fixed-site clinics or mobile services. Furthermore, people residing in communities assigned to receive CBVCT or SVCT could cross community boundaries to access HIV testing at CBVCT or SVCT venues, irrespective of their study group assignment. No individuals were masked to group assignment because the interventions were community based and data for service use were obtained from forms describing the services received" (Sweat, et al., 2011, p.526). However, the laboratory staff that analyzed study samples were unaware of the intervention assignment of individual communities (Coates, et al., 2014). The baseline assessment was done before randomization and did not include HIV testing. The postintervention assessment was independent of the baseline assessment. For both assessments, data were collected in random samples of community residents, irrespective of their participation in intervention activities. A qualitative data assessment was embedded into the evaluation design for Project Accept. Participants in the qualitative assessment were interviewed four times throughout the study period at baseline, 6, 15, and 30 months of intervention. Participants in the qualitative assessment were community members who were recruited from individuals who participated in the baseline behavioral survey conducted for the main trial. The qualitative cohort was stratified according to gender, age (18-24 years and 25-32 years), and partner status (single vs. coupled). The goal of the qualitative research was to compare community-level change over time from the perspective of the participant (Maman, et al., 2014).
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they – or could they be – overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change*

	and if so, in what way? What resources are absolutely necessary for the practice to be used in the field? 1. Four of the five sites (all except Soweto) experienced difficulties with community-based outreach volunteers (CBOVs), including a lack of defined roles and responsibilities for the volunteers. Not all CBOVs could be paid regularly, especially in Tanzania, where budget constraints limited funding for CBOVs and miscommunication occurred regarding how and when CBOVs would be compensated. This confusion regarding compensation and responsibilities potentially reduced the impact of CBOVs who were crucial in disseminating information, spreading ideas within their social networks, and providing feedback on community mobilization strategies. To be maximally effective, future projects must clearly define roles, responsibilities, and compensations for CBOVs and community working groups. Their roles must be made explicit at the outset or be preexisting roles already functioning within the community, such as using community health workers (Tedrow, et al., 2012). 2. Some challenges arose from community leader involvement. Some participants felt that community leaders could be biased and could cover up problems in interventions. To reconcile those disparities, staff said it was imperative to speak with a wide array of community members as well as leaders, in order to obtain an accurate portrayal of the community (Tedrow, et al., 2012). 3. The dose response of mobilization received by the communities could not readily be determined. Project staff could track process outcomes, such as the number of community volunteers present and the number of community meetings held, but they could not measure outcome variables such as the extent to which communities accepted the intervention and the level of diffusion of project ideas. Future projects should consider developing a comprehensive measurement tool for community mobilization that considers discrete process indicators and that captures the complexity of the mobilization process (Tedrow, et al., 2012).
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* 1. Bringing VCT directly to communities and linking VCT with mobilization efforts and support services after HIV testing results in substantially greater uptake of both HIV testing and HIV case detection than does SVCT. 2. Providing mobile VCT is a feasible way to engage youth in HIV counseling and testing. In South Africa, mobile VCT services were provided in convenient locations in the communities, outside schools and at local social events where young people were likely to be. This explained the result that young testers (<20 years) were significantly more likely to be testing for the first time than older testers, especially

	in Vulindlela, where the median age of participants in mobile HIV testing was 22 years (van Rooyen, et al., 2013). 3. If HIV testing services are provided in convenient and accessible community locations such as markets, churches, community and shopping centers, and transportation hubs close to where people live and work, people will make use of the services, and new populations not serviced by facility-based services can be reached (van Rooyen, et al., 2013). 4. Communities can be mobilized to learn their HIV infection status including remote rural communities with little infrastructure across different regions, epidemic settings, and cultures (Sweat, et al., 2011). 5. In a short period, it is possible to mobilize a large proportion of community members to go through the difficult process of learning their HIV infection status, proving that local communities respond to HIV epidemics when comprehensive, user-friendly services are provided. 6. There is no silver bullet/strategy for community mobilization. Seven major community mobilization strategies were used in combination: (a) stakeholder buy-in, (b) forming community coalitions, (c) direct community engagement, (d) community participation in project-related activities, (e) raising community awareness, (f) involvement of community leaders, and (g) creating partnerships with organizations (Tedrow, et al., 2012). Keys to success were the following: • Taking services to the people, which removed some of the barriers and disincentives to HIV testing (van Rooyen, et al., 2013) • The social mobilization component, which stimulated demand for HIV testing (Sweat, et al., 2011) • Recognizing the unique need and wants of each community and incorporating these into the mobilization (Tedrow, et al., 2012). For example, Zimbabwe and Soweto partnered with organizations to address community needs such as hunger and unemployment. • Taking the significant time and effort required to gain acceptance into the communities where Project Accept worked. This helped to establish trust and to build relationships which were crucial for the mobilization's success (Tedrow, et al., 2012). • Creating a tailored, yet flexible mobilization strategy and process for each community (Tedrow, et al., 2012). For example, going to school and arranging sporting activities for young people was a strategy that was commonly used in some communities. In Tanzania community mobilization teams went to water wells to mobilize groups of women who were otherwise difficult to reach.

Retrospect	*Discuss anything that might have been done differently if applicable.* Not applicable.
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.* The practice was also applied in 14 rural communities in Thailand (Chiang Mai Province). In Thailand, VCT uptake increased from 18 to 28 persons/day on average (t test; t= 7.87 P< 0.0001). Providing free mobile volunatary counseling and testing (MVCT) in community settings along with edutainment during evening hours increased VCT uptake and was particularly attractive to younger adults (Kawichai, et al., 2012).
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* In Project Accept, the communities' ability to sustain the project upon completion of the funded study remains unknown (Tedrow, et al., 2012). The project's funding does not allow for long-term study follow-up beyond the scope of the initial intervention. Building partnerships with local organizations and teaching community volunteers how to secure continued support are important considerations for sustainability.
References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.* Coates, T. J., Kulich, M., Celentano, D. D., Zelaya, C. E., Chariyalertsak, S., Chingono, A., . . . NIMH Project Accept (HPTN 043) Study Team. (2014). Effect of community-based voluntary counselling and testing on HIV incidence and social and behavioural outcomes (NIMH Project Accept; HPTN 043): A cluster-randomised trial. *Lancet Global Health*, 2, e267-77. Kawichai, S., Celentano, D., Srithanaviboonchai, K., Wichajarn, M., Pancharoen, K., Chariyalertsak, C., . . . NIMH Project Accept Study Team. (2012). NIMH Project Accept (HPTN 043) HIV/AIDS community mobilization (CM) to promote mobile HIV voluntary

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Sunbursts Project, Kenya

Nancy Yienya

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☑ Sex/HIV education	☑ HIV treatment with antiretroviral drugs
☑ Staff preparedness to serve adolescents and youth	☑ HIV-related opportunistic infection prophylaxis and treatment
☑ Condom provision	☑ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually-transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance use (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☑ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☑ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☐ 20–24 years old
☑ Other (6–9 years)

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☐ Pregnant adolescents and youth

☐ Female sex workers	☐ Incarcerated adolescents and youth
☑ Male adolescents and youth	☐ Transgender adolescents and youth
☑ Men who have sex with men (including male sex workers)	☐ In-school adolescents and youth
☑ Refugee and displaced adolescents and youth	☐ Out-of-school adolescents and youth
☑ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☑ Adolescents and youth who inject drugs	☑ Adolescents and youth living with HIV
☑ Trafficked adolescents and youth	☐ Other (specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☑ School
☐ Worship place
☐ Work place
☑ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Sunbursts Project
Country	*Country where the practice is or was carried out* Kenya
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* Care and support for adolescents and youth living with HIV Peer education Referrals and linkages to services Mental Health Services
Year	*When did the practice start? When did it finish? When is it expected to finish?* August 2011–present
Contact Person	Nancy Yienya Sunburst Coordinator
Contact information	FACES PROGRAM, 614-40100 Tel: 0722 253 162 nyienya@kemri-ucsf.org www.sunburstprojects.org, www.**faces**-kenya.org

Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information. If it was a partnership, who were the partners? Were adolescents and youth involved in the implementation of the practice? How were they involved? Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* <u>Introduction</u> Thirty years ago, Sunburst Projects began to work with the simple desire to bring hope and social-psychological support to children and their families living with HIV/AIDS throughout the United States. In 2010, after almost 3 decades of work in the United States, Sunburst Projects partnered with the University of California San Francisco (UCSF) and Research Care and Training Program (RCTP)/FACES in Kenya to further develop models of best care for more than 14,000 HIV-positive youth receiving HIV/AIDS medical care at RCTP/FACES clinics. The FACES project currently operates in over 152 clinics in Nyanza Province. Since that time, Sunburst Projects has become incorporated as an NGO in Kenya as Sunburst Projects-Kenya. The mission of Sunburst Projects-Kenya is to address the social-psychological needs of children and teens living with HIV in Kenya by building supportive communities free from stigma to ensure youth living with HIV/AIDS reach their highest potential. Today Sunburst Projects-Kenya has partnered with over 20 Kenyan organizations, services, and programs serving youth living with HIV or AIDS. Sunburst Project employed peer leaders (HIV-positive young adults who are motivated to work with other youth as HIV/AIDS experts and have since have been providing support to children and adolescents enrolled in care at three FACES clinics (Kisumu East District Hospital, Lumumba Health Centre, and the clinic in Nairobi). Our key social psychological services and programs are run by young peer leaders and include: peer-run support groups, youth camps and clubs,
Funding	*Who provided the funding and other resources?* Individual donors and through fundraising

Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* Goals - The primary goal of Sunburst Projects-Kenya is to address the social psychological needs of children/teens living with HIV and/or AIDS by providing a safe, welcoming, and nurturing environment for HIV-positive children/teens to build positive relationships, increase their self-esteem, and reinforce positive health behaviors that ensure healthy transition into adulthood. Objectives: 1. Improve youth employability 2. Increase medication adherence among children/teens 3. Decrease risk behaviors and HIV transmission among all children/teens 4. Decrease stigma associated with HIV and AIDS among children/teens, their families, and throughout their communities 5. Increase HIV and AIDS knowledge among children/teens, their families and communities

Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* Background Throughout Africa, HIV and AIDS has become the leading cause of death among adolescents, and Kenya is among the top three countries globally contributing to nearly half of the adolescent population living with HIV and/or AIDS. HIV and AIDS is disproportionately a heavy burden on the world's children and adolescents. Although the annual number of AIDS-related deaths worldwide fell by 35 percent from 2005 to 2013, deaths among adolescents (ages 10–19) living with HIV are the only age groups in which AIDS-related deaths did not decline. In 2013, there were an estimated 250,000 adolescents (ages 15–19) newly infected with HIV, of which 64 percent were girls. At this percent of new HIV infection rates occurring among young people, this means that every 30 seconds another young person becomes HIV positive. In Nyanza Province of Kenya, where Sunburst Projects-Kenya is located, the rate of HIV infection is among the highest in Kenya, accounting for forty percent of all the cases of HIV or AIDS (531,736) in Kenya. Sustainable, scalable, and replicable psychosocial supportive services for HIV/AIDS-impacted youth are urgently needed if we are to achieve an AIDS-free generation. While in Nyanza Province there are medical treatment programs for people living with HIV and/or AIDS, there is a gap in the provision of ongoing, supportive social psychological support services for youth ages 10–24 living with HIV. Adolescents who are newly diagnosed (or who have only recently learned of their status) need accurate information about their diagnosis and care and treatment options. They need information about preventing transmission to others and guidance about adhering to treatment. In addition to this important information, adolescents living with HIV need long-term counseling and support—not only to come to terms with their diagnosis, but also to discuss what it means to live with HIV, if and when to disclose their status to others, and how to envision their future. Additionally, with the success of pediatric ART, many more infants born with HIV (perinatally infected) are growing into adolescents and young adults living with HIV and require a special set of interventions as they become adolescents. Adolescence also being a time when young people begin having sex increases the chances that adolescents living with HIV might pass the infection to partners who are HIV negative. Another concern is that girls living with HIV may become pregnant; if they do not know about or have access to services for preventing mother-to-child transmission, they can pass the infection to their babies. Through Sunburst project –Kenya programs a space for the voices of children and youth living with HIV, their caregivers as well as the experiences of practitioners is created thus allowing the adolescent to reach their highest potential.

Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?* Project Design/Model Evaluations At the end of each social and psychological therapeutic intervention, the impact of the program was evaluated by looking at indicators such as behavior change, school performance, medication adherence, and the ability to overcome challenges such as stigma and discrimination. Sunburst Projects staff, peer leaders, and FACES medical worker staff worked closely together in evaluating the overall program as well as changes in the attitudes, beliefs, and behavior of participants. Three primary indicators were used to measure our success: (1) improved health and drug adherence, (2) improved psychological well-being, and (3) increased knowledge about HIV. Due to the nature of our collaboration, peer leaders have direct contact with medical providers, ensuring availability of accurate information about health outcomes. In addition to the above indicators, caregiver surveys were also conducted to provide information about whether a child's attitude toward taking their medication has improved and whether they are more willing to attend clinic visits after having attended the support groups. Caregiver surveys also provided information about the child's psychological well-being as indicated by improved performance in school as well as noticeable improvements in the child's demeanor. Finally, the peer leaders themselves also administered pretests and posttests to measure increases in the child's knowledge of HIV/AIDS. Evaluations were also conducted during community outreach to evaluate community knowledge, perceptions, and attitudes about stigma and discrimination and about people living with HIV.

Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* To accomplish our objectives, we conduct activities such as: 1. Support group program New adolescent and children's support groups were established at three sites. The support groups required a three-month commitment from participants and consisted of group gatherings (0–40 participants) led by peer leaders who facilitated open discussion, educational lessons, artistic and therapeutic activities, games, and role-playing. At the end of each three-month block, the impact of the program was evaluated by looking at indicators such as behavior change, school performance, medication adherence, and the ability to overcome challenges such as stigma and discrimination. 2. Family social events In addition to the weekly support groups, peer leaders have organized social events open to the children's families. The social event is conducted once in every three months, immediately after the end of each six-month support group cycle. The social event program is to strengthen family bonding and evaluate the impact of the program to its beneficiaries. 3. Community outreach With the goal of ending stigma associated with HIV in their communities, peer leaders conduct monthly school and community outreach to create awareness about HIV to students and teachers to ensure a conducive environment is created to allow adolescents to thrive. 4. Camp program This is a summer camp program for children living with life-threatening illnesses aimed at responding to the unmet social, psychological and emotional needs of the growing number of children infected with HIV. This has served as a national model program and consultant for a number of similar start-up programs throughout the United States.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* - Children 6–9 years and adolescents 10–14 and 15–19 years
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3.* - The project has been running in three Health FACES facilities: patient support center (PSC) in Kisumu East District Hospital, Lumumba Health Centre, and the Nairobi clinic. - We have been conducting also community outreach targeting schools, churches, and the general population within the Kisumu municipality. - The project is being implemented in an urban setting.

Outcomes/results	*What were the practical outcomes, including the measurable results of the Practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* - The model involves the use of standardized questionnaires to evaluate the sessions. <u>Results</u>: - In support groups facilitated by trained peer leaders, ease in disclosure occurs both for parents disclosing to their children and youths disclosing to others. We target a total of 20–30 adolescents in one cycle/quarter and data show that in this session we have achieved at least 91 percent (28/30) change in attitude towards clinic attendance and medication. Fifty-eight percent (20/34) have disclosed their status to new people since attending the camp program, and there is over 70 percent (110/150) stigma reduction in the schools after the community outreach, thus enhancing acceptance and attendance.
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* - While engaging the target individuals, we ensure that the process is informed by professional guidelines. - For support group participants, we first engage the caregivers and seek their consent. The duly signed consent form is well documented and filed. It includes a photo policy clause which explains how and when photos can be taken and used. Those who are not comfortable with their photos being used can still participate in the sessions. - The same applies when recruiting campers. We conduct intensive medical screening to ensure campers' health stability. We also engage the caregivers in an information-giving forum so that they are aware of what goes on at the camp. All these processes are documented.

Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance). Were the outcomes relevant to HIV/AIDS prevention, care, treatment and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* Peer leaders helped break the barriers faced by youth accessing HIV and AIDS treatment and care services. This model/intervention has led to increased communication between adolescents and their providers. In addition, youth feel less isolated knowing that others their age are also going through the same life situations and have support from their peers. This has led to formation of peer-to-peer and staff-to-client bonding, positive relations and interaction. Increased ownership of care and independence has thus promoted adherence and increased awareness and knowledge of HIV. It has also led to formation of a special adolescent clinic that has reduced patients' waiting time and peer-to-peer bonding, resulting in reduced cases of defaulting, missed appointments, classes, and examinations. Adolescent peer-led programs can be part of a lifelong continuum of care that streamlines youth from pediatric, to youth, to adult services. The success of the Peer Leadership Program has led to our Youth Friendly Sunburst Center at Kisumu District Hospital specializing in youth-centered healthcare, psychosocial, and outreach services which has incorporated HIV testing and counseling services. Over the past four years, this project has fostered a cadre of peer youth leaders empowered to promote social justice, transform their communities, and truly develop the principle of reciprocity in individuals for societies' good. In the long term and in the short term, the project has also had socioeconomic benefits. When communities are educated about HIV and AIDS and have help to ease the discrimination associated with an HIV diagnosis, access to medical treatment becomes more probable. Research has shown that when families are on antiviral medications, there is a considerable impact on the reduction in negative socioeconomic factors, families are preserved, labor is sustained, and parents are better able to ensure the education and well-being of future generations. We believe this youth-focused collaborative and interactive initiative will prompt more HIV-infected adolescents to engage in HIV health services and maintain healthy behaviors.

Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.* It is easier to involve in care, serve, and reach as many children and adolescents living with HIV through this model. We have been able to serve and retain at least 90 percent of all children enrolled in care at the specific sites where we work. Due to the nature of our collaboration, peer leaders have direct contact with client and medical providers, thus ensuring adequate support and follow-up of the adolescents enrolled in care. We work closely with the caregivers, community resource persons, teachers, and school population to create and ensure maximum support to all adolescents living with HIV who are in and out of care. We participate in multidisciplinary team meetings to provide guidance and support in address arising issues. We are currently in the process of conducting research to evaluate the overall impact of the intervention.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* Peer-led initiatives are generally cost-effective interventions that use minimal resources to augment the already existing services and support given by healthcare providers. This initiative used the task-shifting approach to service delivery. The peer leaders are volunteers paid a monthly stipend. Other resources are sustainable and based on need, i.e., transport, accommodation, refreshments for support groups, community outreach, and social events. The camp program is usually a five-day overnight event or more depending on resources/money available. Normally, it is a 100-percent funded event. Groups or organizations that are at their inception can use the resources within their reach to start off the program, i.e., forming partnerships with organizations to support the event, liaising with faith-based organizations/schools to offer free venues accommodations or at an affordable cost. The team can search for volunteers passionate about working with adolescents.

Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* A mixed-methods approach was continuously used to evaluate and assess the progress made with the adolescent peer-led interventions. Both qualitative and quantitative methods of data collection were used to determine pre and postintervention outcomes/impact. Using questionnaires, the impact of the program was evaluated by looking at indicators such as behavior change, school performance, medication adherence, and the ability to overcome challenges such as stigma and discrimination. Three primary indicators were used to measure our success: (1) improved health and drug adherence, (2) improved psychological well-being, and (3) increased knowledge about HIV. Caregiver surveys were also conducted to provide information about whether a child's attitude toward taking their medication had improved and whether they were more willing to attend clinic visits after having attended the support groups. The caregiver surveys also provided information about the child's psychological well-being as indicated by improved performance in school as well as noticeable improvements in the child's demeanor. Finally, the peer leaders themselves also administered pretests and posttests to measure increases in the child's knowledge of HIV and AIDS. Evaluations were also conducted during community outreach to evaluate community knowledge, perceptions, and attitudes about stigma and discrimination and about PLWH.

Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they – or could they be – overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* Continuous capacity building and mentorship to the peer leaders and intensive supervisions so as to continue being responsive to the emerging challenges and unique needs of adolescents comes with a cost. Finding partners/donors to support this course has been a great challenge but by gradually building strong partnerships and scaling up the components of existing programs, this challenge can be overcome. The peer-led model involves a multidisciplinary approach that makes every party responsible and hence provides a long-term and sustainable structure and system. The trained peer leaders become the focal persons and points of referral. This creates a sequential clinical process resulting in streamlined adolescent clinical/community care. The model is tailored to be integrated into the existing organizational system and structure hence does not require any organizational change. Any organization scaling up the model has to identify and train peer leaders and build the capacity of existing staff to offer adolescent-friendly services within the recommended packages of care. Inadequate funding to scale up the model to other counties and FACES sites has been a challenge.
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* 1. Peer leadership psychosocial programs can augment medical services and be part of a lifelong continuum of care for youth living with HIV and AIDS. 2. They help streamline youth from pediatric medical care, to adolescent care, and then into adult treatment and care services. 3. Early disclosure is key in realizing better adherence outcomes. 4. Multidisciplinary and multifaceted approaches play an integral role in ensuring optimal viral suppression among the adolescents, thus ensuring success of this model.
Retrospect	*Discuss anything that might have been done differently if applicable.* None

Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.* We are yet to pilot the project in other settings/sites. Our current aims are to scale up the program and evaluate the treatment outcomes of the peer-led interventions. We are, however, supporting and closely working with other staff and helping them implement the project components/elements that suit their sites, e.g., support groups and camps. The core element is peer-based interventions; hence, peer leaders must be the ones providing social and psychological support in this model. Other components can be adapted based on available resources, i.e., camp programs. It can be modified and replicated easily through forming partnerships and using the available existing resources, such as accommodation and volunteers. This type of model has been implemented in other regions of Africa and has been shown to work.

Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* Sustainability of the peer leadership program has been ensured by strong leadership and the ongoing training of youth peer leaders. Furthermore, FACES enjoys a strong relationship with the Kenyan Ministry of Health and numerous local private and public partners that offer a wide range of support, from medical expertise to programmatic development. Financial sustainability has been ensured by continued grant writing, networking with other development agencies, and procuring donations from private entities. Over time, we also intend to provide trainings on adolescent HIV care and support on a consultancy basis as a form of income generation. The collaborative relationship and partnership has been key to our program sustainability. We have already shared by taking on varied aspects of programming and will likely continue to do so as time goes on, as well as scale up and replicate our program at other FACES satellite areas of the country as part of a comprehensive national adolescent care package. In addition to what has been mentioned above, Sunburst Projects-Kenya has a website that can continuously generate income through online donations. These private donations will be used as contingency funding in case there are any gaps between funding sources. Also, as the teen participants become older and "graduate" from teen leadership camp, we hope they will come back as young adult volunteers and train to become peer leaders for younger youth in their communities and perhaps even eventually staff members, thereby contributing to our program's long-term institutional sustainability.
References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.* 1. Prospectus 2. Newspaper clippings

Toolkit and Training Manual for Transition of Care and Other Services for Adolescents Living with HIV

Melissa Sharer

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☑ Sex/HIV education	☑ HIV treatment with antiretroviral drugs
☑ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☑ Condom provision	☑ Care and support for adolescents and youth living with HIV
☑ Family planning services	☑ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☑ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☑ Substance abuse (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☑ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☑ Other (Loss, grief, and bereavement)
☑ Other (Disclosure)	☑ Other (Protection)
☑ Other (Clinical transition of services)	

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old
☐ Other (specify)

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☐ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth
☑ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☑ Married adolescent girls
☐ Adolescents and youth who inject drugs	☑ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☑ Other (Adolescent girls)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	Toolkit and Training Manual for Transition of Care and Other Services for Adolescents Living with HIV (ALHIV)
Country	Target geographic region: sub-Saharan Africa (SSA). Piloted in Kenya
Topic Area	1) Clinical transition of services for adolescents living with HIV 2) Care and support for adolescents and youth living with HIV 3) Staff preparedness to serve adolescents and youth
Year	2012–2014
Contact Person	Malia Duffy: Senior HIV Advisor Melissa Sharer: Project Director
Contact information	John Snow, Inc. (JSI). 1616 North Fort Myer Drive Arlington, VA 22209 Tel: +1 703 528 7474 Fax: +1 703 528 7480 malia_duffy@jsi.com, Melissa_sharer@jsi.com http://www.jsi.com/
Implementers	To respond to the growing numbers of ALHIV in sub-Saharan Africa (SSA), through the AIDSTAR-one project, JSI developed the Toolkit for Transition of Care and Other Services for ALHIV and an accompanying Training Manual for health and community care providers. The Toolkit and Training Manual were piloted by JSI at four sites in Kenya, including Eastern Deanery Aids Relief Program (EDARP), Lea Toto, the comprehensive care clinic at Machakos District Hospital, and Moi Teaching and Reference Hospital-Academic Model Providing Access to Healthcare (MTRH-AMPATH) in Eldoret, Western Kenya.
Funding	Both the Toolkit and accompanying Training Manual were funded under PEPFAR through the Health Division of USAID's Africa Bureau's Office of Sustainable Development under the AIDSTAR-One Project.
Goals/objectives	**Toolkit goal:** To equip health and community care providers, families/caregivers, and ALHIV with tools and information to transition from pediatric to adult-focused care, treatment, and support services **Toolkit objectives:** Through provision of information and tools, the Toolkit:

	1) Provides a framework that tracks and measures an adolescent's progress towards transition to self-care and adult-focused services 2) Provides a framework to tailor a package of holistic care, support, and treatment services for ALHIVs 3) Builds the skills and knowledge of health and community care providers, families/caregivers, and ALHIV to identify and address the critical needs that ALHIV experience to facilitate a smooth transition to self-care
Background	Recent data from SSA, home to 85 percent of the 2.2 million ALHIV (Kasedde, Luo, McClure, & Chandan, 2013), indicate that many children infected perinatally are entering adolescence, with 36 percent having a median survival age of 16, even without access to ART (Ferrand, et al., 2010). This growing population of ALHIV is unplanned for by policymakers and service providers (Ferrand, et al., 2009; Li, et al., 2010; Petersen, et al., 2010; Valenzuela, et al., 2009). Services for ALHIV in SSA remain limited (Ferrand, et al., 2010). However, significant strides have been made to improve access to treatment and allow children to transition through adolescence into adulthood (Earls, et al., 2008; Patel, et al., 2008). Transition is a "multifaceted, active process that attends to the medical, psychosocial, and educational or vocational needs of adolescents as they move from the child-focused to the adult-focused health-care system" (Reiss & Gibson, 2002). Moving through adolescence with a chronic disease requires youth to actively self-manage their diagnosis (Li, et al., 2010). As the number of vertically infected ALHIV continues to grow, there is an increased need to support these individuals as they transition from pediatric care to self-management/adult care. With the limited number of health and community care providers throughout much of SSA, it is likely that many adolescents will not experience a physical transition from one clinic to another; however, all ALHIV undergo a mental transition to adulthood, and during this time self-care and self-management of HIV is critical. To respond to this gap, JSI developed a Toolkit for Transition.
Design	The Toolkit for Transition was created to guide and tailor services from health and community care providers, so they could have the tools and skills needed to tailor a package of services for ALHIV (i.e., psychosocial support; mental health; sexual and reproductive health; protection; alcohol and substance use; beneficial disclosure; loss, grief, and bereavement; positive living; clinical considerations; and linking health facilities and community programs). This equipped these providers with hands-on information and skills required for adolescents to have a smooth transition to self-care. Health and community care providers are the primary users of the Toolkit, and they should use the Toolkit and distribute content/tools as appropriate to the adolescent and family/caregiver. To test the usefulness of this Toolkit and to gather information on how to adapt it to increase its utility, a pilot program was carried out from 2012–2013 at four health facilities—three in or near Nairobi, Kenya, and one in Eldoret, in the western part of the country. The rapid evaluation included the use of a pre/poststructured qualitative questionnaire and a semi-

	structured qualitative questionnaire to 17 providers from four clinics. Final adaptations to the Toolkit and Training manual were informed by the seven-month pilot program at the four sites serving ALHIV in Kenya, with results showing that the toolkit was useful, acceptable, and feasible to use in resource-limited settings in Kenya.
Main activities	The pilot program began with a comprehensive training for 14 healthcare providers (HCPs) and community care providers (CCPs) from four sites. The session comprised a look at the special needs of ALHIV, an overview of the Toolkit, a description of Toolkit use to provide a framework for transition of care and other services, 10 case studies for examples of how to put the Toolkit into action, information on how to adapt the Toolkit contents into varying cultural contexts, and a practice co-facilitation. A training-of-trainers format was used; individuals who attended this training were prepared to become "transition leaders" at their sites and to provide subsequent on-site training and follow-up leadership and guidance for their colleagues throughout the pilot activity. Immediately following the initial training, site visits were made to gather baseline data, introduce the Toolkit pilot to all site staff, assist in planning for site-level trainings, and provide assistance in starting to adapt the Toolkit to local contexts. To continue testing the Toolkit's usefulness and to explore its feasibility in clinics serving ALHIV, AIDSTAR-One then allowed all the trained providers to use the Toolkit and experience its benefits and challenges, with monthly supportive supervision site visits to identify and address logistical and technical challenges. Following the training, each site received a cascade training by the original trainees as well as an introductory supportive supervisory visit and monthly supportive supervisory visits by an AIDSTAR-One consultant. This training was followed in March and April 2013 by a mixed-methods rapid evaluation. This evaluation gathered information on provider satisfaction and Toolkit utility and feasibility.
Beneficiaries	Beneficiaries include HCPs as well as adolescents and youth living with HIV in their catchment area. Specific information and tools are provided for various subgroups to respond to their individual needs. For example, the sexual and reproductive health module provides information and tools for adolescent girls to understand their unique vulnerabilities around adolescent pregnancy and the importance of PMTCT.
Implementation sites	Four health facilities—three in or near Nairobi and one in Eldoret in the western part of the country—piloted the Toolkit and Training Manual. All health facilities provide psychosocial services for ALHIV in urban and semi-urban settings. The combined total of adolescent clients living with HIV was over 500 from all four clinics.
Outcomes/results	Seven months following pilot initiation, an evaluation was carried out that consisted of a convenience sample of 17 health and community care providers at pilot clinic sites. At each clinic, there were between three and six respondent interviews. Questionnaires were administered individually except at the comprehensive care clinic (CCC) in Machakos District Hospital,

	where a single individual interview was held followed by a group interview attended by three respondents. The evaluation revealed that the Toolkit was used mainly in direct provider–client interactions but sometimes, in addition, as a means to provide group education. The three most often used modules were: • Sexual and reproductive health • Clinical considerations • Psychosocial development The three modules most often listed as difficult to use were: • Alcohol and substance use • Loss, grief, and bereavement • Mental health
Ethical soundness	The training and the Toolkit itself reinforced the importance of confidentiality of adolescent services by encouraging high ethical standards practiced during Toolkit implementation. ALHIV may initially be uncomfortable discussing sensitive topics such as sexual and reproductive health, alcohol and substance use, or protection issues with their provider. To mitigate this, direct referrals were provided for any adolescents who disclosed harm.
Relevance	Pilot findings indicated that the Toolkit was feasible and acceptable among providers in Kenya. Specifically, providers reported several perceived changes in care. Providers' ability to work with ALHIV improved, as they now had access to the tools needed to identify and address issues that arise as ALHIV transitioned to self-care. It was also reported that adolescents shared more information as a result of use of the tools, as well as being more able to adhere to antiretroviral treatment, as reported by the providers. Because this was a pilot activity, the magnitude of the effect size cannot yet be determined. However, initial findings indicate that the Toolkit is acceptable and feasible in Kenya, and it may positively impact adherence and retention for ALHIV. Further investigations may also reveal additional psychosocial changes as well as an increase in capacity to self-manage care as ALHIV transition to adult-focused care.
Reach	The Toolkit demonstrated increased levels of communication between providers and adolescents as well as a reported increase in adherence and retention. Due to the short pilot period timeframe, progress towards transition to self-care was not measured and will require further study to determine its effectiveness in this regard. Due to its strong reception, one of the pilot sites, Lea Toto, rolled out the Toolkit to six other sites with the support of Lea Toto's own funding and made the Toolkit part of the organization's annual operational plan.

Efficiency	There are minimal requirements to implement the Toolkit and the Training Manual. Both materials are available on the AIDSTAR-One (soon to be AIDSFree) website. The Training Manual may be facilitated by a local champion among health and community care providers. The Toolkit can be maintained electronically at a computer at each implementation site, and health and community care providers can print select tools in accordance with the minimum package of services provided to the adolescent to increase resource savings and efficiencies. While exact numbers for ALHIV directly reached by the Toolkit are not available, pilot sites served a total of 533 ALHIV, and a significant proportion were exposed to the Toolkit pilot activity. The adolescents exposed to the pilot activity were a heterogeneous mix of in- and out-of-school youth of varying age ranges residing in urban and semi-urban areas of Central and Western Kenya.
Effectiveness/impact	**Usefulness:** On a scale of 1 to 5, where 5 is the most useful and 1 is least useful, 15 out of 17 respondents rated the Toolkit's overall usefulness as either a 4 or 5, citing the comprehensiveness of its content in addressing all adolescent needs and the relevance of its topics to adolescents. Using the Toolkit helped providers become more organized and systematic in their approach to adolescent clients. Providers reported that their ability to work with ALHIV had improved as a result of using the Toolkit. While their previous work with adolescents had had no logical sequence, they noted that the Toolkit enabled them to more effectively capture and respond to client's problems and issues. All seven providers in one clinic described a more collaborative work style after the training. Additionally, the Toolkit was reported as being helpful as it made ALHIV-related information more readily accessible to staff and provided them additional skills to use in addressing client issues. **Adherence and retention:** Most providers reported an increase in ALHIV adherence to antiretroviral treatment that they attributed to Toolkit implementation. About three-quarters of providers perceived an increase in the number of ALHIV coming to pick up their ART on time. Likewise, about two-thirds of providers believe that since the beginning of the pilot, more adolescents are keeping their scheduled appointments than prior to their training and use of the Toolkit. **Provider-client communication:** Providers reported that using the Toolkit while delivering services to adolescents improved their communication with clients. Several respondents described that when using the tools provided in the Toolkit, their adolescent clients began talking more freely about their problems, the issues they faced, and the reasons behind their occasional nonadherence. **Minimum package of services:** Approximately two-thirds of providers reported an increase in the provision of a minimum package of services for ALHIV due to information and tools

	provided in the Toolkit, resulting in more holistic service provision that attended to individualized adolescent client needs.
Feasibility	Challenges encountered included an implementation learning curve where providers reported that during the first few weeks of implementation, as they were becoming familiar with Toolkit contents, additional time was required to identify the correct tools to use. However, providers who used the Toolkit consistently over the pilot testing period were able to navigate the tools and resources and reported benefits associated with using the Toolkit. Additionally, in busy clinics, some providers reported conflicting priorities due to time pressures. On occasion, there were also difficulties in printing the materials due to lack of access to a functioning copy machine/printer. Implementation of the Toolkit is feasible and acceptable. It does not require organizational changes. Required resources include a computer and printer to download and print the materials.
Lessons learned	Adolescents' unique needs need to be taken into account when implementing HIV care, support, and treatment services. With the right tools and resources in hand, providers are able to provide more holistic and relevant services for ALHIV. The Toolkit fills a critical need that focuses on building an individualized transition program that strengthens the ability of young women and men to manage their own care to better understand the benefits to themselves.
Retrospect	To ensure the contextual and cultural appropriateness of the Toolkit and Training Manual, piloting in a variety of SSA country settings over a longer period of time would have been helpful and would have allowed for a rigorous evaluation that examined the health impact of the Toolkit on ALHIV.
Replicability	Since its publication in January 2014, the materials have been downloaded 195 times from the AIDSTAR-One website from individuals/organizations in 48 countries. In addition, the Toolkit is featured on the following websites: 1) Christian AIDS Bureau of Southern Africa (CABSA) 2) HIV Share Space 3) Interagency Youth Working Group 4) K4Health 5) NCBI.NLM.NIH.GOV as citation in Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations 6) UNESCO HIV and Health Education Clearinghouse 7) University of California, San Francisco: Women, Children, and HIV 8) USAID 9) WHO

Sustainability	The Toolkit materials have been designed for integration to enrich routine care that ALHIV receive. Opportunities for further rollout and expansion of the opportunity are in the process of being identified.
References/related documentation	Earls, F., Raviola, G. J., & Carlson, M. (2008). Promoting child and adolescent mental health in the context of the HIV/AIDS pandemic with a focus on sub-Saharan Africa. *Child Psychology and Psychiatry*, 49, 295-312. Ferrand, R., Munaiwa, L., Matsekete, J., Bandason, T., Nathoo, K., Ndhlovu, C., … Corbet, E. L. (2010). Undiagnosed HIV infection among adolescents seeking primary healthcare in Zimbabwe. *Clinical Infectious Diseases*, 51, 844-51. Kasedde, S., Luo C., McClure C., & Chandan, U. (2013). Reducing HIV and AIDS in adolescents: Opportunities and challenges. *Current HIV/AIDS Reports*, 10, 159-68. Li, R. J., Jaspan, H. B., O'Brien, V., Rabie, H., Cotton, M. F., & Nattrass, N. (2010). Positive futures: A qualitative study on the needs of adolescents on antiretroviral therapy in south Africa. *AIDS Care*, 22, 751-58. Patel, K., Hernán, M., Williams P., Seeger, J., McIntosh, K., Van Dyke, R., Seage, G., & Pediatric AIDS Clinical Trials Group 219/219C Study Team. (2008). Long-term effectiveness of highly active antiretroviral therapy on the survival of children and adolescent with HIV infection: A 10-year follow-up study. *Clinical Infectious Diseases*, 46, 507-15. Petersen, I., Bhana, A., Myeza, N., Alicea, S., John, S., Holst, H., … Mellins, C. (2010). Psychosocial challenges and protective influences for socio-emotional coping of HIV+ adolescents in South Africa: A qualitative investigation. *AIDS Care,* 1, 1-9. Reiss, J., & Gibson, R. (2002). Healthcare transition: Destinations unknown. *Pediatrics*, 110, 1307. Valenzuela, J., Buchanan, C., Radcliffe, J., Ambrose, C., Hawkins, L., & Tanney, M. (2009). Transition to adult services among behaviorally infected adolescents with HIV: A qualitative study. *Journal of Pediatric Psychology*, 1-7.

EMERGING PRACTICES

Feel the Future, Malawi

Giovanni Guidotti

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☐ Counseling and testing for HIV
☑ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☑ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance abuse (including alcohol)	☐ Drug treatment including drug substitution therapy
☑ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☑ Peer education	☐ Mental health services for adolescents and youth living with HIV
☑ Prevention, safer sex, and risk-reduction counseling	☐ Other (Specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☑ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old
☐ Other (specify)

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☑ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth
☑ Male adolescents and youth	☐ Transgender adolescents and youth

☐ Men who have sex with men (including male sex workers)	☑ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☑ Married adolescent girls
☐ Adolescents and youth who inject drugs	☑ Adolescents and youth living with HIV
☑ Trafficked adolescents and youth	☐ Other (Specify)

D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☑ Health facility
☑ Community
☑ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Feel the future. A strategy to fight the stigma and discrimination related to HIV/AIDs epidemics among adolescents.
Country	*Country where the practice is or was carried out* Malawi
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* • Sex/HIV Education • Care and support for adolescents and youth living with HIV • HIV treatment with antiretroviral drugs • Referrals and linkages to services • Peer education • Prevention, safer sex, and risk-reduction counseling
Year	*When did the practice start? When did it finish? When is it expected to finish?* The organization started to implement the strategy in 2008 and it is still working on it.
Contact person	Giovanni Guidotti Project Director
Contact information	Piazza S. Egidio 3A, 00153 Rome, Italy Tel: +39.068992225 Fax: +39.0689922525 dream@santegidio.org www.dreamsantegidio.org
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information. If it was a partnership, who were the partners?* *Were adolescents and youth involved in the implementation of the practice? How were they involved? Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* In 2005, the community of Sant'Egidio started the Drug Resource Enhancement against AIDS and Malnutrition (DREAM) program in Malawi. DREAM is a program with a holistic approach to the prevention, treatment, and care of HIV and AIDS and is present in 10

	African countries. As of July 2015, the DREAM program had 17,000 patients in follow-up in Malawi. The DREAM program provides HIV services (testing and counseling, prevention, treatment, follow-up, laboratory monitoring, peer-to-peer education, social support) and other social and health services needed in the field (education, nutrition, tuberculosis, empowerment of women). The DREAM program has a huge commitment to the social aspects of care and retention in care. The best health program will be ineffective if the patient is not retained in care. From the beginning in every country where DREAM is present, patients have been involved in the program, whether through counseling, as witnesses, and in advocacy, education, retention, and home care. Over the years, many children grew into adolescents and started treatment. The DREAM program addresses problems adolescent patients face in that particular phase of their lives. The DREAM program has much experience in the social aspects of HIV care specifically focusing on HIV-positive adolescents. Adolescents are followed up through both small group meetings and a one-to-one approach. The experiences of the oldest patients (for example, young mothers) or other adolescents are often given as examples of the success of treatment. Another key point of intervention is with parents or adults taking care of the adolescents.
Funding	*Who provided the funding and other resources?* The DREAM program in Malawi is funded by the National AIDS Commission, Clinton Health Access Initiative, Norwegian Church Aid, Leopold Bachmann Foundation, and individual donors.
Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* The main goals of the strategy are: • Ensuring free medical care to HIV-positive adolescents • Facilitating access to treatment for HIV-positive adolescents • Ensuring adherence to therapy of HIV-positive adolescents • Preventing HIV transmission among adolescents • Combating stigma and discrimination The specific objectives are: • Training HIV-positive adolescents in correct information about the virus, its transmission, and the treatment and care of people living with HIV and AIDS. • Training adolescents about the proper use of therapy and on hygiene standards • Dedicating a specific time, resources, and physical space to listening to adolescents at the DREAM health centers in order to reassure them and broaden their perspectives about the future

	• Creating an inclusive network around adolescents • Promoting a welcoming approach towards people living with HIV and AIDS, paying particular attention to adolescents • Awareness raising and sensitization of families and schools
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* Adolescence is often described as a difficult age—the body changes, the ability to communicate increases, and moods are variable. Adolescents search for their own identities, give great importance to friendship, and dream about their future. In Malawi, added to these concerns are the following problems: poverty, few opportunities to attend school, the risk of getting malaria and tuberculosis, being prey to "sugar daddies," becoming pregnant before age 14, being orphans, being alone, and having a life expectancy among the lowest in the world. If a Malawian teenager is also HIV positive, life is even harder! Adolescent patients of the DREAM program show us every day that their lives are difficult, and so all the staff of the program, including health workers, doctors, social workers, and expatriates, fight with them for the right to health and a happy life. Being 10–19 years old and being HIV positive poses important questions: ▪ How do I take the drugs? Who can remind me? ▪ How do I take the drugs while I am at school? And what if I am seen while taking it? ▪ Should I continue to go to school, since the teacher told me that it is useless to study because I could soon die? ▪ The teachers do not engage me anymore because they have discovered that I'm HIV positive. ▪ My classmates avoid me. They are afraid to touch me and they yell at me to stay back. ▪ My friends ask me why I did not grow like them. ▪ I'm not so beautiful, and now I also have this bad herpes. ▪ Best not to be seen around. ▪ I would like to be a lawyer, but who knows if I'll live. I do not think I will become a lawyer. ▪ The prophet told me to not take medication because it is God who heals, so I do not take them anymore. ▪ I want to be a prophet in my future, so I'll be rich and I'll no longer take medication because God speaks to me.

	▪ At school, they say that the medicines make me stupid. ▪ I did not come to the medical check because the neighbors say that my mother is a witch, and she told me that it is better not to leave home, otherwise they will beat us. ▪ Will I be able to marry? And to work? And have a child? ▪ I'm 15 years old and pregnant. The father is 50 years old. He's good. He pays my school fees and he bought me a dress and a pair of shoes. He is HIV positive. I was not positive before but now I am too. Will my son also be positive?" These poignant questions impose a responsibility to respond with a truthful answer that is convincing and concrete. In this way we will try to improve the social and family fabric of this nation of adolescents living with HIV. This is what the project is trying to do.
Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?* Activities with teenagers are part of the broader work of DREAM for the prevention and care of HIV-positive people in Malawi. DREAM is present in Malawi in both rural and urban settings. DREAM has a holistic approach to prevention and care of HIV and AIDS. It is also the backbone of the program with adolescents, one of the most vulnerable segments of the population with regard to nonadherence to treatment and transmission of the virus. The work with adolescents uses two methods: direct counseling and support groups. In parallel, it works with families of adolescents through the group formed by parents and HIV-positive adults. After the first meeting at the clinical center, meetings are held directly in the local communities (rural villages or peri-urban residential areas). In counseling with adolescents, the theoretical reference model is mainly the motivational interview. It is used during the first visit to the clinical center, and when adolescents express the need for counseling or when adherence to treatment is reduced. The adolescent patients of clinical center have formed support groups, divided into three age ranges: 11–16, 17–20, and 20–24. Group meetings are led by a qualified person (usually a trained counselor) supported by

	expert clients of the DREAM program and some teenagers belonging to the 20–24 age group. The support group of adolescents is built in three different phases. First, only adolescents with HIV are included. Second, other adolescents affected by HIV but not HIV positive are also involved in the group. Third, the group is opened to all adolescents of the community. It was designed as an evolving system to encourage development of interpersonal relationships through various stages of adaptation. The group takes on different forms in relation to the various phases: thematic, education, counseling, discussion through support groups and brainstorming, and finally peer teaching. The group leader makes use of various techniques, including games and role-playing.
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* Nine adolescent groups linked to DREAM centers have been established. Each center has activated all three types of groups characterized by age. Each group has an average of 25 teenage participants. Group participants as well as health staff of the centers (medical doctors and nurses) have been trained on the following subjects: • General information on HIV, how to prevent it, how it is transmitted, and how it is treated and • Detailed information on antiretroviral therapy: dosage, how to take it, and why it is important not to interrupt treatment • Why it is important to do the HIV blood test and talk to the doctor regarding results • Basics on nutrition and practical cooking exercise • Notions of personal hygiene, food, and home care with practical exercises • For older adolescents, information about maternity and weaning of children Each clinical center has a counselor who devotes most of his or her time counseling teenagers. Clinical officers and expert clients have sensitized some primary and secondary school students on the transmission and treatment of the virus. We conducted meetings with school teachers and professors whom we met in personal interviews and meetings that included the testimonial of a young 20-year-old who is HIV positive. Part of Malawian society tends to easily stigmatize those who are HIV positive, particularly regarding some religious sects and traditional doctors.

	Speaking to this issue, I DREAM, composed not only of patients of the program but also of other HIV-positive and HIV-negative people, which now includes thousands of expert clients, plays an important role in controlling and fighting stigma in residential areas of cities and in many villages of the central and southern region of the country. Through its history, this group also protects the rights of adolescents by attesting to the ability to live in full social inclusion. Through public meetings and cultural exchanges, the work has opened a dialogue with the various religious denominations in the country to jointly build paths of peace and humanization. It has been very important to address the emergence of sects that preach against taking ART because of the belief that it is God who saves. Unfortunately, such sects are growing in terms of number of adherents and their influence on society.
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* Beneficiaries are from 3 different age groups: - 10–14 years old - 15–19 years old - 20–24 years old They number around 500, representing an increase from the beginning of the project. There is frequent turnover, the need is great, and the problem is widespread.
Implementation sites	*In which sites was the practice implemented? Include up to 2 from the list on page 3.* Both at the facility level (clinical center) and in the communities of the adolescents near the 15 DREAM centers in Malawi *Was the practice implemented in urban or rural areas or both?* Both. Many of the country's DREAM Centers are based near Lilongwe and Blantyre, but there are also several in rural sites. (For map, see: http://dream.santegidio.org/project/malawi/?lang=en.)
Outcomes/results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* Many boys and girls are able to integrate into society and find their identity starting from within. For many, the disease has become strength in their human, spiritual, and social growth. The development of positive personal changes was not measured, but a poignant personal story, described below, expresses results of social, health, and psychological importance. We have known Olivia for 11 years— nice girl from a wealthy family, with a brick house, a car, and parents with good jobs. Like her mother and her father, she is HIV positive. She began getting treatment at our DREAM center. She was very vivacious, expansive, and had a great desire to make

	friends with everyone. She attended school regularly and made good grades. But suddenly her school performance deteriorated. It was not clear why, but Olivia did not want to go to school. She closed herself up in her own world, was isolated, but nonetheless maintained a link with the DREAM center. She participated actively in the adolescent group and was always present. One day she told us that she no longer went to school because her friends had realized that she takes medicine and that she is so sick. Her schoolmates teased and isolated her. Olivia would have loved to go back to school; she missed it and liked to study. After DREAM's intervention with the teachers and her fellow students, Olivia returned to school and earned good grades; her grades were the best in the city (the most populous city in Malawi). It happened, however, that, because her parents lost their jobs, the family found itself in a precarious economic situation. For this reason, and after the death of a neighbor, Olivia's mother was accused of sorcery. She was accused of stealing her neighbor's life, and then became poor. Again Olivia withdrew and she stopped ART. Also, her mother began to attend a religious group whose pastor imposed a medicinal ban for HIV-positive people. Olivia lost hope, wanted to die, and did not want to go to school. Her silence was deafening. She was locked in the house out of fear and had decided to refuse to live. Her weight underwent a sudden drop, and herpes ravaged her face, making it unsightly. She seemed to have fallen into an endless downward spiral—the further down, the sicker she got. We saw her at her home and met and talked with her parents who started attending the I Dream group meetings. Some members of the Group spoke with the neighbors, and others with the pastor of the religious sect. Olivia returned to our center and then began to have a dream: "I want to become a nurse to treat those who are sick like me." This dream expressed aloud left the narrow world behind. We found a school and a supporter to pay for her studies. She began studying to become a nurse. She is really beautiful with her clean white uniform. Today, Olivia is doing her compulsory internship at the city hospital. Her task is to distribute ARV therapy. She does this very well, as she used to receive it with DREAM, talking to people, explaining everything, and recommending that they never interrupt therapy.
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* The principles respected in the activities are: • Centrality of the person in all DREAM activities for teens and patients • Active listening practiced in the individual relationship with the teenager • Respect for every individual, law, justice, and social equity

	• No discrimination according to age, sex, religion, ethnicity, social status, or political ideology • No value judgment expressed about people based on their behavior • Free healthcare and maintenance of confidentiality and privacy in relation to the health of adolescents and their personal, social, economic, and religious situations • Respect for religious diversity • In relations with organizations and associations, provision of information strictly related to the definition of the intervention • Promotion of a culture of solidarity and subsidiarity through the active participation of adolescents and citizenry • Promotion and development of integrated social policies • Attention and research partnerships with institutions working for and with teenagers • Continued provision of training to the operators who work in the DREAM centers to ensure culturally-sensitive, high quality, and evidence-based service provision • Promotion and development of self-determination within each adolescent and fostering a relationship of trust in a constant process of evaluation
Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* The high and positive response of beneficiaries and the turnover over the years have shown that there was need of support for adolescents that was not being provided by public services. The strategy implemented through the DREAM health program has allowed visible results in the long term. First, adolescents attending the groups have been shown to master the main HIV and AIDS tips and can easily serve as educators for their peers and relatives. Furthermore, the main result is definitely the high retention of adolescents living with HIV and AIDS recorded by the health staff, showing that the DREAM program is positively affecting their lives, their future, and the community.
Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to*

	those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain. The need to implement a strategy for the specific need of adolescents was born at the DREAM health centers, where the issue is very popular, because the Malawian population is actually very young. Therefore, it was very easy to find HIV- positive adolescents or HIV-affected adolescents available for support activities. The strength of the strategy is to also involve adolescents not living with HIV and AIDS in order to fight stigma and discrimination. The other groups have been contacted in communities, at local churches, and among the adolescents of the Community of Sant'Egidio that follows the "Youth for Peace" program, which is very popular in the area.
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* Such a strategy relies on the existence of a few assets: the health centers for people living with HIV and the openness of external groups of adolescents involved in structured and welcoming groups such as organizations, schools, and churches. Most of the expenses are related to the human resources needed for the project, including the expert clients or community workers and the health and social professionals involved in their trainings. Then, other health professionals also need to be involved in activities with the adolescents. Since the beginning, the strategy was implemented with modest resources—including volunteer work—but it has led to unexpected and positive results. We estimate that there is an expert client for every 10 adolescents.
Effectiveness/impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* The activities are monitored thanks to the reporting activities of the expert clients involved in the strategy. The results are monitored using patient management software at health centers and the retention rate of the adolescents. This is the main indicator for the success of the strategy, because it is the proof that the adolescent has understood the need to follow the therapeutic path in order to have the possibility of living as bright a future as their peers not living with HIV and AIDS.
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they – or could they be – overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* The biggest obstacle in the implementation of the strategy is the cultural resistance to involving girls in any empowering and inclusive activity. Malawi has one of the highest rates of child marriage in the world, with

	one in two girls married by the age of 18. The expert clients of I DREAM have been trained on the specific issues related to pregnant girls and the prostitution of girls and orphans often due to HIV and AIDS.
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* The key success factor is the proposal of positive models to be followed, such as the statements of young people living with HIV and AIDS that have succeeded in fighting HIV and having a normal life. For adolescents who feel they have no chance of living or having a normal life in the future, this strategy helps them to imagine a future. Furthermore, it is important to help them structure their identity outside of the HIV and AIDS label they wear, and to offer them the possibility to enter welcoming groups of people not living with HIV and AIDS.
Retrospect	*Discuss anything that might have been done differently if applicable.* The organization began the strategy by responding to a critical need and did not build a monitoring and evaluation system at the beginning. It is foreseen to improve the monitoring system to better measure results and improve the strategy.
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.* Expert clients are already common in other countries, and their effectiveness and replicability is evident. Adolescents have very similar problems when affected by HIV and AIDS, especially in facing stigma and discrimination. The model can easily be implemented in other countries if the communities are welcoming.
Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* The service to support adolescents in facing stigma and discrimination is intended to use existing health centers and community meeting places to make possible the encounter between adolescents from different backgrounds (HIV-positive adolescents, HIV-exposed adolescents, and adolescents not exposed to or positive for HIV). Such a strategy has to be implemented in existing networks because this is its strength: making possible the meeting of diverse people in secure environments. The funding requested is related to expert clients and health staff that can include these activities in their regular working life if adequately trained.

	Of course, it is foreseen that public services will take advantage of the successful strategy for adolescents living with HIV and AIDS.
References/related documentation	*Include with your submission any documents that will help us to understand the practice (examples are evaluation reports, project documentation, academic articles, or newspaper clippings). Any documentation of program assessment and external evaluation would be most welcome.*

Youth Voluntary Counseling and Testing Project, Botswana

Irene Kwape

Best Practices Submission Form – Part 1

A. *Please mark the topic areas that the proposed adolescent- and youth-friendly best practice fits into (check all that apply)*:

☐ Access to HIV services (location, hours, facility environment)	☑ Counseling and testing for HIV
☐ Sex/HIV education	☐ HIV treatment with antiretroviral drugs
☐ Staff preparedness to serve adolescents and youth	☐ HIV-related opportunistic infection prophylaxis and treatment
☐ Condom provision	☐ Care and support for adolescents and youth living with HIV
☐ Family planning services	☐ Sexual abuse/violence prevention and treatment
☐ Needle and syringe exchange	☐ Diagnosis and treatment of sexually transmitted infections
☐ Social mobilization	☐ Medical male circumcision
☐ Substance abuse (including alcohol)	☐ Drug treatment including drug substitution therapy
☐ Referrals and linkages to services	☐ Antenatal/postnatal/delivery care/prevention of mother-to-child transmission (PMTCT)
☐ Peer education	☐ Mental health services for adolescents and youth living with HIV
☑ Prevention, safe sex and risk-reduction counseling	☐ Other (specify)

B. *Which age groups of adolescents and youth were beneficiaries of the best practice? (Check all that apply):*

☐ 10–14 years old
☑ 15–19 years old
☑ 20–24 years old
☐ Other (specify)

C. *Which subgroup(s) of adolescents and youth were beneficiaries of the best practice? (Check all that apply)*:

☑ Adolescents and youth in the general population	☐ Pregnant adolescents and youth
☐ Female sex workers	☐ Incarcerated adolescents and youth

☐ Male adolescents and youth	☐ Transgender adolescents and youth
☐ Men who have sex with men (including male sex workers)	☐ In-school adolescents and youth
☐ Refugee and displaced adolescents and youth	☑ Out-of-school adolescents and youth
☐ Non-refugee/non-displaced mobile and migrant adolescents and youth, including street adolescents and youth	☐ Married adolescent girls
☐ Adolescents and youth who inject drugs	☐ Adolescents and youth living with HIV
☐ Trafficked adolescents and youth	☐ Other

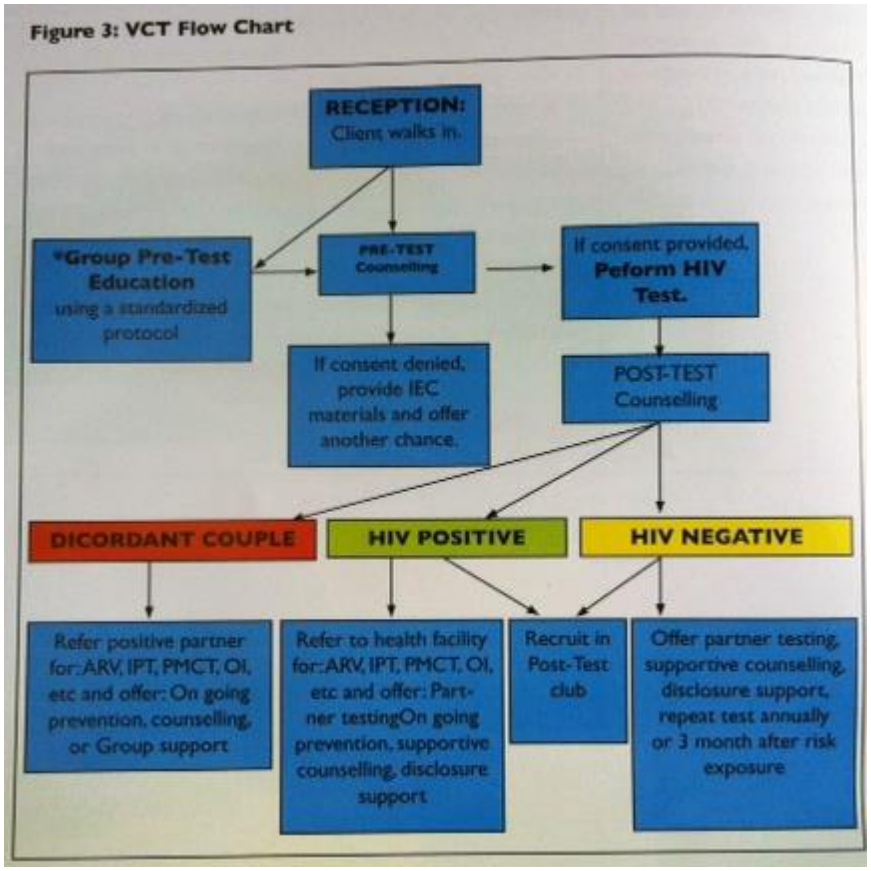
D. *In which site(s) was the best practice for adolescent- and youth-friendly HIV services implemented? (Check all that apply)*:

☐ Health facility
☑ Community
☐ School
☐ Worship place
☐ Work place
☐ Outreach
☐ Other (specify)

Best Practices Submission Form – Part 2

Name	*Name of project, policy, law, or strategy* Youth Voluntary Counselling and Testing project
Country	*Country where the practice is or was carried out* Botswana
Topic area	*Which of the topic areas on page 2 apply to this practice? (Include up to 4.)* Referrals and linkages to services Peer education Counseling and testing for HIV Care and support for adolescents and youth living with HIV
Year	*When did the practice start? When did it finish? When is it expected to finish?* March–September 2012
Contact person	Irene Kwape National Coordinator
Contact information	Botswana Christian AIDS Intervention Programme P.O. Box 601963 Gaborone Botswana Tel: +267 3916454
Implementers	*Who implemented the practice? Please introduce and describe the institution or organization that was responsible for implementing the "best practice." Please do not simply list the information. If it was a partnership, who were the partners? Were adolescents and youth involved in the implementation of the practice? How were they involved? Were adolescents and youth living with HIV/AIDS or their representative groups involved in the implementation of the practice? How were they involved?* Botswana Christian AIDS Intervention Programme (BOCAIP) implemented the project through three of the 11 centers located in different parts of the country
Funding	*Who provided the funding and other resources?* CDC through Tebelopele Voluntary Counseling and Testing Centre as a grantor

Goals/objectives	*What was supposed to change or be accomplished as a result of the practice?* 1. To increase access to both on-site and mobile VCT and provider-initiated counseling and testing (PICT) services to individuals and couples 2. To increase demand of VCT and PICT in three sites:Kanye, Thamaga, and Masunga 3. To reach 50 percent of all clients accessing VCT and PICT services with post services at BOCAIP centers annually 4. To strengthen BOCAIP's institutional capacity to provide VCT and PICT services to reach individuals in three sites
Background	*What historical, medical, social, or other background can help readers understand the need for the practice, or the context in which it was carried out?* BOCAIP started offering HTC services in 2005. Services were offered to the general population, including youth and adolescents. HIV prevalence among youth was high in 2008. As a result, BOCAIP targeted three sites in rural areas to expand and reach out to young people in the community to test for HIV. Some of the factors that hindered youth acceptance of HTC as reported by those who accessed BOCAIP's services was: - Failure to provide age-appropriate services - Services not youth friendly Given the above, through funding from Tebelopele Voluntary Counselling and Testing Centre, BOCAIP expanded HTC services by providing youth-friendly services in some sites. Counselors and peer educators or community mobilisers were recruited to play distinct roles. These were young people not older than 35 years, in accordance with the definition of a young person in the Botswana Youth Policy.

Design	*Describe the methodology used to develop the best practice initiative. There may be any number of tasks that were needed to develop your best practice. This information would be helpful if another organization would wish to pursue the same endeavor. What were the cost and/or budget ramifications? Please include any organizational/institutional involvement required or solicited during the planning stage. What was the theoretical foundation of the practice?* 
Main activities	*Describe the implementation process. What are the main things the practice does to accomplish its objectives? How is the work organized, and who does what? Is there an order in which activities are carried out? Information that concerns the timeline, pitfalls, and issues is helpful to those interested in duplicating your best practice.* HTC, support for ongoing counseling and social support, referrals for family planning or CD4 testing, continuous education, behavior change communication campaign to increase awareness, post-test clubs for youth, and promotion of positive living
Beneficiaries	*Which subgroups of adolescents and youth were beneficiaries of the practice? Include up to 3 from the list on page 3.* Adolescents and youth in the general population Out-of-school adolescents and youth

Implementing sites	*Was the practice implemented in urban or rural areas or both? In which sites was the practice implemented? Include up to 2 from the list on page 3.* Three different sites within Botswana's districts: Thamaga, Masunga, and Kanye
Outcomes or Results	*What were the practical outcomes, including the measurable results of the practice? For example: condom use, HIV testing, abstinence, ART adherence, HIV-related knowledge, personnel performance improvement, client satisfaction, services utilization, HIV/STI disclosure, etc.* These were the results as evidenced by HIV-positive clients: • Linkage to other services for treatment and care • Better management of opportunistic infections and STIs • Ability to make informed decisions out of one-to-one counseling sessions they had with their counselors • Increased adherence to treatment Results for HIV-negative clients were: • Ability to maintain their negative health status due to assistance they got in making their own risk-reduction plans • Encouragement in behavior change and positive living • Making informed decisions, for example, about pregnancy, marriage, and starting a relationship Generally, young people were encouraged to know their HIV status and information was disseminated in order to increase community awareness about HIV and its prevention measures
Ethical soundness	*Please describe how the practice followed standards of social and professional conduct.* BOCAIP uses counselors trained by the National HIV Testing master trainers following the national protocols. During project implementation, the organization follows national guidelines and issues of quality are taken into consideration. The organization has a team of professionals who provide guidance and technical support to the HTC counselors.
Relevance	*To what extent did the practice achieve the desired outcomes? What was the magnitude of the effect size (not just whether it was statistically significant but whether it had public health significance)? Were the outcomes relevant to HIV/AIDS prevention, care, treatment and retention, and if so, to what extent? What were the benefits versus risks/potential for harm?* The beneficiaries were the general population who were tested through mobile and on-site services. The number of young people who tested at the three sites increased as compared to the past years.

Reach	*To what extent did the practice achieve the desired outcomes for the intended population? Who (or what) were the beneficiaries (or processes) that were affected? What proportion of eligible adolescents and youth (or processes) was known to be affected by the practice? (You may calculate a "reach rate" based on available data). How many adolescents and youth (or processes) could ultimately be affected (projected reach)? How representative were the groups of adolescents and youth (or processes) that were reached compared to those ultimately affected by the problem? Is there external validity or generalizability? Is there the ability to achieve health equity? Please explain.* The project managed quite a lot of adolescents, though it was implemented in a short period and was limited to three sites. Of the 1,185 males who were tested, 814 of them were adolescents and youth (386 ages 15–19, 428 ages 20–24). Of the 1,761 females who were tested, 491 of them were youth and adults (104 ages 15–19, 387 ages 20–24).
Efficiency	*Describe how the practice demonstrated cost and resource efficiency (i.e., expenses such as time, staffing, and materials are appropriate in relation to the benefits).* The funds secured were used for staff retention (10 staff members). Overhead costs (utilities, stationery) were paid for, and BOCAIP applied a 10 percent cost-sharing model based on office equipment, buildings, and vehicles.
Effectiveness/Impact	*To what extent has the practice been supported by quantitative evaluations or studies with peer review of practice or publication? Did the practice also have support from qualitative research or use mixed methods? Was there third-party verification of the results? Did the evaluation of the practice include comparison or control areas? Please describe the methodology used for the evaluation and the results.* No evaluation was done due to lack of funding. In addition, the project ran for only a short time, making it impossible to conduct a process evaluation.
Feasibility	*What problems or obstacles were encountered in implementing the practice and how were they – or could they be – overcome? How does the practice streamline or add to existing procedures? Does implementation of the practice require organizational change and if so, in what way? What resources are absolutely necessary for the practice to be used in the field?* Below are some obstacles that were encountered in implementing the practice: • Limited funds to include community mobilisers for demand creation of HTC, especially among young people • Post-test clubs (PTCs) were not sustainable • Resistance by some young people to register in PTCs for fear of stigma and discrimination • Limited competencies in child counseling issues • Ongoing supportive counseling sessions were never complete, as young people were often mobile in search of work and study opportunities

	Resources absolutely necessary for the practice to be used in the field would be finances to allow for recruitment of community mobilisers to create demand for the service.
Lessons learned	*What are the most important lessons that a reader should take from this practice? What are the keys to its success?* • Provider-initiated services are more effective than client-initiated services, as counselors are able to reach more people during mobile testing than during on-site service delivery. • Networking with other service providers plays an important role in avoiding duplication of services that are already provided by other existing service providers. It also enhances working relationships and resource sharing among organizations with similar objectives • HTC services are an entry point to address young people's HIV prevention and care needs. • Young people need care and support services regardless of their HIV status. • HTC can help young people use safer sexual practices and even reduce their rates of STIs. • Giving relevant training to those who are hands-on is very critical. • There is a lack of facilities offering services tailor-made for young people.
Retrospect	*Discuss anything that might have been done differently if applicable.* • Engagement and involvement of adolescents for advocating and creating demand for HTC services among adolescents • Making flexible hours of operation to allow adolescents to access services, since most of them are in school • Engagement and involvement of peer adolescents for mobilization as well as advocacy for the program • Liaise and use existing school clubs for demand creation
Replicability	*To what extent has the practice been replicated across similar contexts and achieved the desired results? When the practice is applied in different contexts, what essential components of the practice must be included without alteration? What elements of the practice can be changed or adapted for different contexts while still achieving the desired results? Have the adaptable elements been changed in different contexts and the practice still shown to be effective? Please explain.* The practice has been replicated to the other eight centers of BOCAIP and produced more results since more people were tested. The practice was modified to include mobile testing, such that the counselors were not confined to one space but could cover a large area. The people who resided outside the towns were reached through mobile testing, which gave an opportunity for hard-to-reach areas to be provided with HTC services.

Sustainability	*To what extent has the practice been maintained? To what extent has the practice achieved desired outcomes over time? To what extent was the practice designed to be integrated into existing programs and/or standard operating practices? To what extent was the practice designed to be incorporated into existing networks and partnerships? To what extent was the practice continued? What were the longer-term effects? What is the practicability of securing ongoing funding/support? Has there been maintenance of/or improvement in effects over time—even without ongoing funding/support?* The practice has been continuing since 2012. In instances where there is no funding, the counselors continue volunteering their services to the organization, since the counselors are the residents of the areas where they are based. In some cases, private companies are charged for services provided.

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-16-134

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