Guidelines on Best Practices for Adolescent- and Youth-Friendly HIV Services

An Examination of 13 Projects in PEPFAR-Supported Countries

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An Examination of 13 Projects in PEPFAR-Supported Countries

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Cover photo: A group of young women at SUPPORT Girls Center, in Mumbai, India. SUPPORT provides vocational training and educates street children on STDs, AIDS, and sexual abuse.

ABBREVIATIONS

AYLHIV	adolescents and youth living with HIV
CATS	community adolescent treatment supporters
HSV2	herpes simplex virus 2
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SYMPA	Supporting Youth and Motivating Positive Action
USAID	U.S. Agency for International Development
VMMC	voluntary medical male circumcision

INTRODUCTION

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 what interventions are effective for changing HIV-related outcomes for these age groups. Program managers and policymakers have little rigorous evidence on how best to invest resources to achieve 90-90-90 targets among adolescents and young people. Recognizing this evidence gap, MEASURE Evaluation—funded by the U.S. Agency for International Development (USAID)—reviewed the evidence on adolescent- and youth-friendly HIV services as a contribution to the goal of an AIDS-free generation that the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is pursuing. 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 and to attract adolescents and youth to retain them in those services.

"Best Practices for Adolescent- and Youth-Friendly HIV Services: A Compendium of Selected Projects in PEPFAR-Supported Countries" reflects the results of a call for best-practices proposals and an examination of peer-reviewed and gray literature in 22 PEPFAR-supported countries. These guidelines are a companion to that document.

The 13 projects covered in the compendium are those we received permission to summarize. A review group graded the projects 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. Best practices are (1) Adolescent-friendly Voluntary Medical Male Circumcision Project, in South Africa; (2) Futbol para la Vida (Deportes para la Vida), in Dominican Republic; (3) Mema kwa Vijana, in the United Republic of Tanzania, (4) One2one Integrated Digital Platform, in Kenya; (5) Supporting Youth and Motivating Positive Action (SYMPA), in the Democratic Republic of the Congo; (6) Program H, in Ethiopia and Namibia; and (7) Zvandiri Project, in Zimbabwe. Promising practices are (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. Emerging practices are (1) Feel the Future, in Malawi; and (2) Youth Voluntary Counseling and Testing, in Botswana. (For details on all of these, see Table 1).

The interventions these projects provided were classified into four groups according to common characteristics and choices that 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- and 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 by trained adolescents and youth within health facilities, and providing mobile HIV testing services in venues easily accessible by youth
- Affordable fees or free services (e.g., free HIV testing, free condoms, and free medical care for adolescents and youth living with HIV [AYLHIV])
- Linkages between schools, youth clubs, youth corners, and other youth-friendly institutions
- Providing alternative ways to access information, counseling, or services (e.g., use of digital technologies through mobile- or web-based platforms and cartoon videos)
- Training staff to provide adolescent- and youth-friendly services
- Maintaining privacy and confidentiality (e.g., conducting mock circumcision for male adolescents and youth who test positive for HIV, to maintain confidentiality and reduce stigma)
- Peer counseling on risk reduction, safer sex, voluntary counseling and testing for HIV, and adherence to antiretroviral drugs

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): Futbol para la Vida, Mema kwa Vijana, Program H, Zvandiri project, and Project Accept. Based on the results of the impact evaluations, projects were categorized in five nonmutually exclusive groups:

- Effective for HIV-related and attitudinal outcomes (e.g., Mema kwa Vijana and 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 adherence to antiretroviral therapy (Zvandiri project)
- Not effective for HIV-related behavioral outcomes
    - Sexual behavior (Project Accept)
- Effective for HIV-related biological outcomes
    - Clinical symptoms and signs of sexually transmitted infection (STI) (MEMA kwa Vijana)
- Not effective for HIV-related biological outcomes
    - HIV incidence and HSV2 prevalence (MEMA kwa Vijana)

Eight projects used nonrigorous or qualitative evaluation designs. In some cases, these projects found positive effects on HIV-related knowledge, attitudes, and behavioral outcomes. Nonrigorous designs are often cost-effective for establishing the need for and reach of an intervention and for building the evidence base. However, progress in identifying effective strategies to meet the HIV-related needs of adolescents and youth depends on the use of more rigorous methods for determining what works, for how long, and for whom.

LESSONS LEARNED FROM THESE 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 vary. 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 to teach the psychosocial aspects of the curriculum. Systematic preservice 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 (Futbol 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 are 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 also because they are anonymous. Anonymity makes it easier for adolescents and youth to ask questions and seek advice about health issues (One2One Integrated Digital Platform [OIDP]).

POTENTIAL FOR SUSTAINABILITY

Sustainability was interpreted in terms of sustaining project activities, transferring best practices to other programs and settings, identifying new funding streams, and maintaining improved health outcomes for adolescents and youth over time. Projects identified several factors that contribute to the sustainability of their adolescent- and youth-friendly practices:

- Integration of project activities in existing health systems and government and community structures
- Community buy-in and advocacy for the project
- Collaborative relationships and partnerships
- Coordinating funding from multiple sources to sustain the project
- Evaluation results demonstrating that the project is making a difference

However, 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 and other support, even programs that rigorous evaluations have shown to work may not continue beyond the life of the initial intervention.

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 evidence.
- More research is needed on the practices that are best 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 these guidelines.
- During scale-up of adolescent- and youth-friendly interventions that have been proven to be effective, attention must be paid to maintaining an intervention's 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.
- Adequate funding must be allocated for rigorous impact evaluation, for assessments of program efficiency, and to strengthen the methodological expertise of implementing partners and research staff in PEPFAR-supported countries.

Table 1. 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 voluntary medical male circumcision (VMMC) awareness sessions and service-access facilitation • Health facility-based HIV counseling and testing and VMMC service access • Peer recruitment
Dominican Republic: Futbol para la Vida (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-trainers workshops for community-based peer educators (local *batey* soccer players), local nongovernmental organization 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 counties with a high burden of HIV	• Mobile-based services for sexual and reproductive health, HIV, and gender-based violence • Provision of health information and counseling through web-based platforms • Engagement of AYLHIV and key populations in message development • Toll-free hotline
The Democratic Republic of the 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	• Development and implementation of a curriculum on positive prevention • Monthly peer education sessions • Peer support groups

Ethiopia and Namibia: Program H	Community-based	Yong men, ages 15–24 years	• Validated curriculum and educational video to promote attitude and behavior change among men • Lifestyle social marketing campaign to promote 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 among young men
Zimbabwe: Zvandiri Project	Clinic- and community-based	Adolescents and youth, ages 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 counseling and testing 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 development of policy and guidelines 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 orphans and vulnerable children • Peer-led social mobilization and awareness raising on preventing HIV and other sexually transmitted infections, 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 of HIV-positive and -negative people and integration of them around educational, social, and political goals in community events) • Community-based voluntary counseling and testing (free HIV testing, post-test counseling, free male and female condoms to those who test)

			• Community-based posttest 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 & 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
Toolkit and Training Manual for Transition of Care and Other Services for Adolescents Living with HIV	Clinic-based	Healthcare providers and AYLHIV	• Development of a toolkit and training manual • Pilot of the 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	Community-based	AYLHIV	• Direct counseling of AYLHIV • Dedication of physical space at DREAM 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 discrimination
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 and behavior-change communication campaign to increase awareness • Post Test Clubs for youth and promotion of positive living

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