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Delivering sexual and reproductive health and HIV services beyond health facilities to reach young people in East and Southern Africa

Implementation Brief

2gether 4SRHR

SYP Safeguard Young People PROGRAMME

Acknowledgements:

This publication was developed with technical and financial support from 2gether 4 SRHR, a joint United Nations Regional Programme, in partnership with Sweden, which brings together the combined efforts of UNAIDS, UNFPA, UNICEF and WHO to improve the sexual and reproductive health and rights (SRHR) of all people in Eastern and Southern Africa. We also acknowledge the financial and technical support of the Safeguard Young People (SYP) Programme, a regional youth programme supported by the Swiss Agency for Development and Cooperation (SDC) and the Embassy of the Kingdom of the Netherlands.

This brief covers one of five themes examining sexual and reproductive health (SRH) and HIV programme evidence and implementation experiences for adolescents and youth in East and Southern Africa (ESA). This series serves as a resource for programmers aiming to implement strategies and understand potential barriers to scaling-up effective programmes for adolescents and youth.

For citation of this publication, please use: United Nations Population Fund and United Nations Children's Fund, 2026. Delivering sexual and reproductive health and HIV services beyond health facilities to reach young people in East and Southern Africa: Implementation Brief. Johannesburg: United Nations Population Fund.

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Acronyms

AGYW	Adolescent girls and young women
ART	Antiretroviral therapy
CSE	Comprehensive sexuality education
ESA	East and Southern Africa
HIV	Human immunodeficiency virus
ITH	In Their Hands
PrEP	Pre-exposure prophylaxis
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STIs	Sexually transmitted infections
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VMMC	Voluntary medical male circumcision
YKP	Young key populations

Background

HIV and sexual and reproductive health among adolescents and young people in East and Southern Africa

The youth population (aged 15 to 24 years) in sub-Saharan Africa is rapidly growing and expected to increase from 225 to 350 million between 2021 and 2040 (Box 1) [1]. Currently, over 170 million young people aged 10 to 24 years live in ESA – accounting for almost 10 per cent of the world's population of youth [2]. Young people in ESA experience a substantial burden of SRH challenges, including high rates of unintended pregnancy, HIV and sexually transmitted infections (STIs), as well as unmet need [1] for family planning [3]. ESA has one of the world's highest incidences of HIV among young people, with an estimated 160,000 new infections in 2023 [4]. Addressing the SRH needs of adolescents and youth is essential to achieving multiple global development objectives, including the International Conference on Population and Development Programme of Action [5] and the Sustainable Development Goals [6].[2]

Box 1: Adolescents and youth

Young people represent a diverse population with unique health needs. In ESA, young people experience complex individual, sociocultural, health system and legal barriers to accessing quality, comprehensive and integrated HIV and SRH services. Definitions of adolescent, youth and young people vary by country and region. In this brief, unless otherwise stated, adolescents are defined as individuals aged 10 to 19 years, youth as those 15 to 24 years and young people as individuals 10 to 24 years [7].

1 Unmet need for family planning is the disconnect between fertility preferences and contraceptive use. It is defined by the World Health Organization as individuals "who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child" [91].

2 Improvements in SRH among young people relate to multiple Sustainable Development Goals, including reducing maternal mortality (target 3.1), ending the AIDS epidemic (target 3.3), ensuring universal access to SRH services (target 3.7), and ending gender-based violence (targets 5.2 and 5.3) [6].

Populations of focus: Young people and adolescent girls and young women

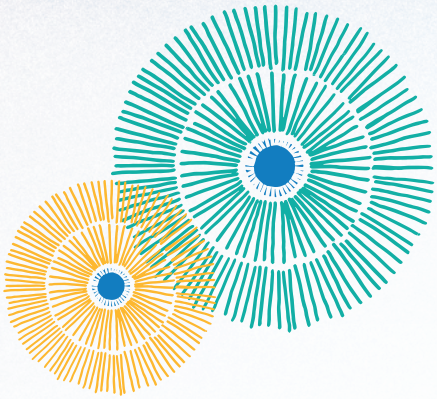
Adolescence represents an important period of development, transition and substantial biological, social and psychological changes [7,8]. Young people's sexual and reproductive health and rights (SRHR) is shaped by their social, cultural, religious, legal, political and economic contexts [7]. Multiple intersecting factors, such as age, gender, sociodemographic characteristics (e.g. education, employment, income), marital status and geographic location, influence young people's autonomy and power to make decisions about their health and SRHR [3,8]. Despite recent improvements in SRHR among young people globally, inequities both between and within countries persist [3,8].

Among young people, young key populations[3] (YKP) bear a disproportionate burden of HIV [9–11], and experience increased risk of violence, social exclusion and systemic discrimination due to laws that criminalize same-sex relationships, drug use and sex work, and health systems that inadequately address their needs [12]. Adolescents who are married, out-of-school, living in rural areas, have parents with low levels of education, and those who have limited communication with their parents on SRH issues are at increased risk for poor SRHR outcomes, including early and unintended pregnancy [13]. To ensure that all young people receive appropriate, high-quality care, a range of implementation strategies may be required. Approaches that identify and reach the most vulnerable segments of the adolescent and youth population (including YKP) and respond to their intersecting social identities and diverse SRH needs are critical to ensure that no young people are left behind.

Adolescent girls and young women (AGYW) in ESA are at increased risk of experiencing poor STI/HIV and SRH outcomes due to a complex interaction of individual (e.g. age, sex, gender, substance use, educational status, low self-esteem and sexual orientation), sociocultural and environmental (e.g. peer influence, unequal gender power relations, community and social norms, lack of comprehensive sexuality education, gender-based violence, intergenerational relationships and early sexual initiation) and structural factors (e.g. income and gender inequality, and a lack of economic and educational opportunities) [9,11,14,15].

3 YKP include young men who have sex with men, young people who use or inject drugs, young women who sell sex, young transgender people, and adolescent girls and young women.

HIV and sexual and reproductive health services



Health services that address SRHR among adolescents and youth include the provision of comprehensive sexuality education, access to contraceptives, youth-friendly antenatal, obstetric and postnatal care, safe abortion services and treatment of complications of unsafe abortion, as well as counselling, testing, prevention (e.g. pre-exposure prophylaxis (PrEP)[4] and voluntary medical male circumcision (VMMC)) and treatment of HIV and other STIs [16]. In addition, menstrual health management, referrals for individuals experiencing sexual and gender-based violence, the prevention, detection and management of reproductive cancers, and information/counselling on subfertility/infertility and sexual health, are all important components of care for adolescents and youth [17].

Key barriers to accessing HIV and sexual and reproductive health services

Young people experience significant individual, sociocultural and structural barriers to accessing HIV and SRH services both within health facilities and beyond (i.e. in schools and communities) [3]. Individual level barriers include a lack of comprehensive knowledge related to HIV and SRH, limited self-efficacy and agency, feelings of fear and shame, stigma and discrimination [12,18]. Limited transportation, health facility hours/locations/wait times, availability of commodities, inadequate training and/or negative attitudes of health-care providers and educators, as well as a lack of private, confidential and quality youth-friendly care may also prevent adolescents and youth from seeking HIV and SRH services [3,19,20]. Inequitable social and gender norms and socioeconomic factors

4 PrEP is the daily use of an antiretroviral drug to block acquisition of HIV infection by uninfected individuals [92]. PrEP is an effective measure to protect health and limit HIV transmission, particularly among high-risk key populations [93].

(e.g. education levels and socioeconomic status) also limit young people's decision-making power and their ability to access SRH care [18]. In addition, restrictive age of consent laws and policies undermine young people's ability to obtain SRH and HIV services without parental consent [1,21].

Public health emergencies and natural disasters can significantly exacerbate these barriers (see Box 3). Key facilitators supporting uptake of SRH services include community outreach, school health education and policies that enable high-quality youth-friendly services [18].

Box 3: Lessons learned from COVID-19 for future shocks and pandemics

The COVID-19 pandemic disrupted youth-friendly HIV and SRH services across many African countries, exposing system vulnerabilities. HIV testing declined by 40 per cent among children (1 to 14 years) and 28 per cent among older adolescents (15 to 19 years) across 14 countries between April and June 2020 [24]. In South Africa, youth cited mobility restrictions, long wait times and fear of infection as key barriers [25]. Public health measures, such as school closures and resource reallocations, further strained services, increasing early marriage, violence and unintended pregnancies in some ESA countries [26–29].

The World Health Organization emphasized maintaining essential SRH and HIV services during the pandemic, recommending measures, such as alternative information delivery, waiving restrictive access policies, telehealth counselling and leveraging community networks [74]. Lessons from the early HIV response and past health crises informed strategies, including decentralized service delivery, telehealth, and youth peer networks to sustain services during COVID-19. These key strategies included:

- Collecting and sharing real-time, disaggregated data to support programming and continuity of services.
- Coordinating with government leadership and rapidly adapting national guidance.
- Strengthening health systems and HIV service delivery via provision of personal protective equipment, health provider training, robust communications campaigns and pivoting to virtual service provision.
- Strengthening and promoting community-based delivery of health services.

- Ensuring adequate supplies and quality lab systems.
- Ensuring services and support were people-centred.
- Engaging young people in both SRHR and COVID-19 response.
- Collaborating across sectors to address the intersection of multiple vulnerabilities among young people [75,76].

Increased mental health challenges and demand for psychosocial support during the COVID-19 pandemic exposed significant health system gaps and catalysed a shift towards digital health interventions and use of telemedicine to deliver mental health services [77,78]. Many SRH programmes also pivoted to using virtual platforms to ensure continued service delivery during lockdowns. For example:

- In Botswana, the United Nations Children's Fund (UNICEF) and the MTV Staying Alive Foundation adapted HIV and SRH peer education modules into audiovisual materials and shared them via social media (e.g. WhatsApp and Facebook) to guide virtual discussion groups [75].
- In Zambia, implementation of Yathu Yathu, a community-based programme involving peer-led SRH services for young people, provided comprehensive sexuality education via Facebook and WhatsApp during hub closures, and emphasized the importance of handwashing and use of personal protective equipment [59].

Innovative approaches to reach young people beyond health facilities[5]

Access to quality HIV and SRH information, commodities and services is vital to improve SRH among young people. However, many adolescents and youth – particularly those at greatest risk for experiencing poor HIV and SRH outcomes – are unlikely to utilize traditional facility-based services [30,31]. More consciously considering where, when, who and what

5 A summary of approaches of reaching young people beyond health facilities was developed based on a critical review of peer reviewed and grey literature from 2012-2022.

health services are provided is recognized as essential to reach adolescents and youth with HIV and SRH care [32].

Differentiated[6] models of HIV and SRH service delivery adapt interventions by population, location or provider cadre [33] to strengthen the accessibility, appropriateness and acceptability of SRH services for young people [34,35]. In addition, the use of assessment tools to further segment adolescent and youth populations (e.g. AGYW) for screening, targeting and tailoring interventions based on behavioural, biological and structural vulnerability or HIV risk factors is increasingly recognized[7] [36]. Implementing differentiated, youth-centred approaches is critical to acknowledge the heterogeneity of young people in ESA, and adapt services to address their diverse needs. Importantly, different service delivery strategies may be required to reach young people in various social circumstances (those experiencing gender-based violence, child marriage and YKP, for example). Providing adolescents and youth (particularly AGYW) with tailored, alternative sources of information and services is critical to realizing their SRHR [37].

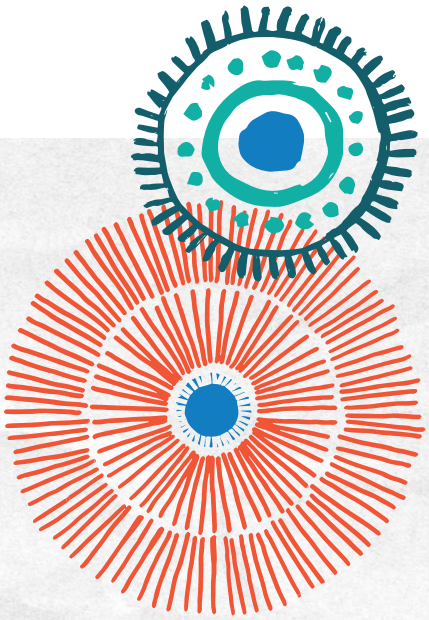


Figure 1 illustrates various evidence-based HIV and SRH delivery approaches beyond health facilities include:

a. peer-to-peer mentorship and lay provider models;
b. outreach and community-based strategies (e.g. door-to-door, community distribution points, mobile clinics and pharmacies);
c. school-based delivery;
d. youth centres/youth hubs;
e. social protection programmes; and
f. technology and digital health platforms [30,31,38–40].

6 Differentiated service delivery models adopt a person-centred approach that simplifies and adapts services to better meet individuals' needs and optimize health system resources [94].

7 HIV risk screening tools and targeting young people are examined in greater depth in the HIV self-testing implementation brief.

Figure 1:

Available out-of-facility HIV/SRH service delivery platforms (adapted based on [30,31,38,39])

Many programmes integrate education for youth and/or parents, skill-building (e.g. decision-making around sexual health and condom use) and youth-friendly health services; psychosocial elements often include training on assertiveness, communication and problem-solving [41]. Effective interventions have catalysed improvements in SRH knowledge and education, HIV and STI prevention and education as well as contraceptive uptake and effective condom use, sexual self-efficacy, gender-based violence education and gender equity [41]. Some evidence suggests that social protection programmes and livelihood training may improve socioeconomic and HIV and SRH outcomes [42].

A recent systematic review of SRH-focused interventions among adolescents and youth in low- and middle-income countries found that education on adolescent SRHR delivered via school- and community-based interventions, sports-based interventions, cognitive/ behavioural therapy, communication

campaigns and multicomponent strategies led to improvements in SRH knowledge, attitudes and practices. In addition, educational interventions, integration of financial incentives and comprehensive post-abortion family planning services were particularly effective at increasing SRH knowledge, use of health services and contraception and preventing unintended pregnancies [39].

Delivery of HIV and SRH services outside of health facilities is most effective when integrated within existing health systems and implemented in close coordination with local health-care providers and facilities [3]. For example, community distribution points or mobile health clinics providing antiretroviral therapy (ART) or HIV testing services where youth live or gather leverage existing health system resources, commodities and providers.

Similarly, providers may lead peer support groups, which involve counselling, psychosocial support and distribution of medications to increase ART adherence [33,34]. Other community-based models provide HIV testing and mental health/ psychosocial support for young people living with HIV or connect youth peer counsellors with facility-based providers to ensure adequate training, sustained mentorship and supportive supervision [43,44]. Implementing out-of-facility HIV and SRH services may help to minimize the need for repeated clinic visits by young people and alleviate health system burden by extending care-seeking opportunities into local communities [3,30].

A synthesis of service delivery strategies, methods, outcome evidence and implementation considerations is presented in Table 1.

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Table 1:

Synthesis of HIV and sexual and reproductive health delivery strategies beyond health facilities: methods, outcomes and implementation considerations to reach young people (adapted based on [30,31,39,41,45,46])

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
Peer-to-peer mentorship and lay provider models	Interventions that train and engage young people to provide HIV and SRH counselling, services and support to peers or the community.	• Peer-to-peer models: Increased HIV and SRH knowledge [47], age of sexual debut [34] and condom use [47]. High uptake of HIV testing, yield and linkage to care [48], decreased rates of early marriage and school drop outs [49]. • Youth support groups/clubs: Increased HIV and SRH knowledge and attitudes, self-efficacy for condom use and safer sex; decreased HIV incidence and other sexual risk factors [39]. Improved attitudes towards contraceptive use and desire to delay pregnancy [41].	• Integrating peer and lay providers in existing health systems is essential to ensure training, mentorship and supportive supervision for quality of HIV and SRH services for young people [43]. • Many effective SRH interventions incorporate psychosocial components into programmes [41].
Outreach and community-based strategies	Strategies or interventions that provide HIV or SRH services within communities, including door-to-door, campaigns, mobile health clinics, pharmacies, community drug distribution points or support groups [30,31,45,46].	• Door-to-door community-based strategies[8]: High uptake of HIV testing and average yield[9] [45]; door-to-door life skills training improved SRHR behaviours, including delayed sexual initiation and fewer sexual partners, increased condom use, and communication between youth and parents [39]. • Home-based strategies[10]: High uptake of HIV testing and low yield [46]. Family-focused interventions delayed sexual debut, increased condom use [39] and improved SRH knowledge [38]. • Mobile health clinics: High uptake of HIV testing and average yield [46]; youth perceived mobile clinics as more acceptable than conventional clinic settings [50].	• Community-based differentiated service delivery models improve accessibility of HIV and SRH services for youth by overcoming facility-related barriers (e.g. distance, transportation, hours and wait times). Some evidence suggests community-led approaches, such as community distribution points, may support treatment retention and ART adherence among youth [52] and should be evaluated further. • Alternative community-based approaches, including pharmacies, may be acceptable and feasible options for HIV testing among young people [45]. However, further evidence on both linkages to care of alternative models and the effectiveness of delivering other SRH services via community-based pharmacies is needed.

8 Door-to-door community-based strategies may involve visits and training conducted by lay providers or health educators [39].

9 Yield refers to the proportion of people with HIV who are newly diagnosed [9].

10 Home-based testing includes self-testing using rapid or oral HIV testing conducted in home environments [45].

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
		• Community pharmacies: Low uptake of HIV testing and average yield [45]. • Community distribution points and targeted campaigns: Average HIV testing uptake and low yield among central distribution options [46], versus high uptake and yield achieved via targeted outreach campaigns [45,46]. • Sports-based activities: Increased HIV and SHR knowledge, attitudes and communication [39]. • Community dialogue and mobilization: Increased condom use, HIV testing and fewer concurrent sexual partners among men, limited data on outcomes among young people [51].	• Some evidence from low- and middle-income countries suggests that pharmacies are a key source of contraceptives within the private sector [53]. Similarly, a systematic review of high- and middle-income countries found that over-the-counter emergency contraceptive is feasible, acceptable and offers timely access, yet further research in ESA is needed.
 **School-based delivery strategies**	Provision of HIV or SRH information, education, services or support in school-based settings (e.g. clinics or nurses in schools, school-linked service referral) [31].	• Comprehensive sexuality education (CSE): Improved SRHR knowledge, attitudes and behaviours, communication on sexual health issues and contraceptive and condom use. Education interventions reduced the prevalence of STIs and HIV among young people, delayed sexual debut [39] and reduced early and unintended pregnancies among in-school girls [54]. CSE also increases the likelihood of HIV testing among youth; however, data on uptake, yield and linkage to care is limited [55]. • Support groups in schools: Increased knowledge of STIs and pregnancy prevention, improved condom use self-efficacy and resilience [41].	• Many effective SRH interventions, particularly in humanitarian or low-resource settings are delivered in school settings or multiple settings (e.g. combined school and community-based approaches) [41]. Recent evidence suggests that linking CSE to local health services reduces early and unintended pregnancies among AGYW [54].

Strategy	Description	Delivery methods and impact on key outcomes	Implementation considerations
 **Youth-centred spaces**	Provision of comprehensive HIV and SRH information or services in youth-friendly centres or spaces[11], often provided alongside other services/ support [56].	• Youth centres: Limited impact demonstrated on SRH outcomes [57,58]. • Community-based youth hubs[12]: Increased knowledge of HIV status [59].	• Integrating SRH services at youth centres may not represent a cost-effective approach due to substantial operating costs to deliver non-health related services (e.g. vocational support, life skills and recreational activities), as well as low service uptake and limited young people reached [31,58]. • Community-based SRH "youth hubs" are promising alternatives to provide a range of SRH services and increase uptake of HIV testing. Service delivery may also be complemented by incentives (e.g. points to be exchanged for rewards – soap, toothbrush and toothpaste) for young people [59].
 **Social protection programmes**	Cash or cash plus social protection schemes offer cash transfers plus complementary adolescents and youth-focused services [60].	• Government social support, combined with mentorship and vocational training, health facility strengthening and grants to support education/business goals: Increased knowledge of contraception and HIV prevention, increased HIV testing. Limited data on uptake, yield or linkage [61].	• Strong government ownership and integration in existing social protection frameworks are essential to sustainability. • Investments in both demand generation and supply-side factors (e.g. training providers in youth-friendliness) supports accessibility of HIV testing services [61].
 **Technology and digital health platforms**	Technology or digital interventions that employ social media, internet or mobile phones to provide HIV and SRH information and education and promote utilization of services.	• Digital or mobile health interventions: Increased SRH knowledge, behaviour and service uptake, particularly contraceptive counselling and uptake [40]. • Entertainment education and social media campaigns: Increased safer sexual behaviours and practices among young people, increased testing and management for STIs [62].	• mHealth App initiatives with two-way, interactive functions that incorporate behaviour change techniques had a greater impact on the uptake of SRH services among young people [40]. • Digital approaches may help overcome gaps in availability of in-person services, yet the "digital divide" and gender disparities in access to technology remain important implementation considerations (Box 2).

11 Youth centres are typically mixed-use facilities that emphasize youth development or SRH, offering a "one-stop-shop" for training in vocational and life skills, recreation, and health information/services [58].

12 Youth hubs are community-based groups that deliver SRH services (including HIV testing, CSE and contraceptives) by peer support workers, a nurse and a supervisor [59].

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Many of these strategies and adaptations may help young people to overcome key individual, family/community, health system and policy environment barriers to accessing HIV or SRH services (Figure 2).

Figure 2:

Key barriers to HIV/SRH services and promising implementation approaches

Box 3: Leveraging digital platforms to reach young people with SRH

Digital platforms, including mobile phone applications, social media and Internet-based services, are promising strategies to improve access to HIV and SRH services among young people [40]. Digital health interventions can be used to deliver convenient, accurate and non-judgmental SRH information and services to young people at low cost [40]. They may also overcome issues related to distance, transportation and human resource shortages, and support continuity of services during periods of disruption (e.g. public health or natural emergencies) [63,64].

Although digital health interventions are useful to overcome in-person service delivery gaps, they are not a panacea and may exacerbate the "digital divide" [65]. While access to mobile phones and Internet-based services has increased among adults globally [66], only 29 per cent of male and 18 per cent of female youth use the Internet in ESA [67]. Other barriers include low digital literacy, limited mobile network coverage, and the high cost of devices/airtime [68]. As such, maintaining offline strategies to connect young people to health-care providers and services is critical. This is especially true for AGYW in ESA, many of whom do not have access to mobile devices or the Internet and limited digital/technological skills [67].

Emerging evidence: Self-care interventions for sexual and reproductive health among young people

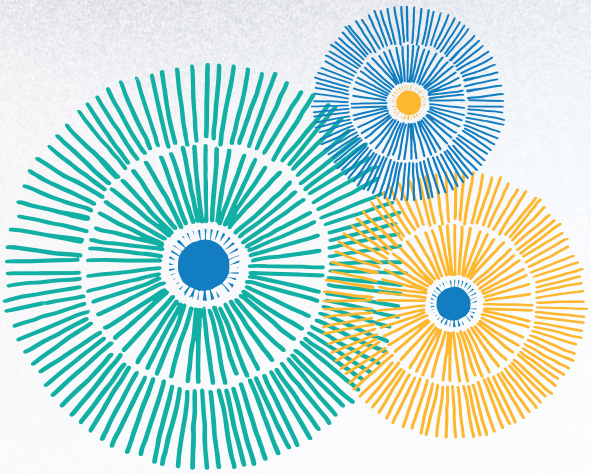
Self-care[13] interventions are relatively new approaches to address young people's SRH, health and well-being [69,70]. These approaches focus on empowering and supporting young people with the necessary knowledge, skills and resources to make informed, autonomous decisions about their own SRH [71]. Self-care interventions may include self-management (e.g. medication, treatment,

13 Self-care is defined by the World Health Organization as the "ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider." [69]

examination, injection, administration or use), self-testing (e.g. sampling, screening, diagnosis, collection and monitoring) or self-awareness for health promotion (e.g. education, regulation, efficacy and self-determination) [72]. For SRH, this includes the self-management of contraception or self-diagnosis of STIs, for example, through HIV self-testing or self-collection sample kits for human papillomavirus. Self-care strategies aim to increase young people's engagement and autonomy over their SRH, improve equity and efficiency of health systems, and overcome sociocultural, gender and geographical barriers to care [71].

The presence of an enabling environment deeply impacts individuals' access to and use of health services, including the availability of a trained health workforce, regulated and quality products/interventions, commodity security, health financing, access to justice, economic empowerment, education, information, protection from violence/coercion/stigma/discrimination, psychosocial support, supportive laws and policies, and health literacy [69]. While self-care interventions may be useful for some young people, they are not a replacement for adequate health-care services and systems. Treating self-care as a set of complementary strategies, firmly integrated within existing health systems, is important to ensure timely linkages, referrals and access to support and skilled health providers to support young people's SRHR [71,73].

Programme case studies



Evidence on programme experiences, impact and contributors to success is critical to better understand how various HIV and SRH delivery platforms can effectively reach adolescents and youth in ESA beyond conventional clinic settings. Programme case studies[14] were purposively selected based on expert consultation to examine strategies employed to reach young people across diverse geographic locations.

Case study 1
The Sista2Sista Programme: peer group intervention for adolescent girls and young women in Zimbabwe

Programme description:

The Sista2Sista Programme provides safe spaces to support and mentor vulnerable AGYW aged 10 to 24 years. Clubs of 25 girls are organized according to age categories (10 to 14 years, 15 to 19 years and 20 to 24 years), led by female peer mentors ("behaviour change facilitators") and meet weekly for one year, guided by a 40-exercise curriculum and mentorship manual. Behaviour change facilitators use group storytelling, debates, songs, visual representation and other methodologies to examine key SRH topics including interpersonal communication, gender and power, family planning, STIs, HIV, menstrual health, gender-based and sexual violence, traditional and cultural practices and financial literacy. AGYW with increased vulnerabilities are identified by peer mentors using community-based outreach and a risk assessment tool to assess individuals' self-awareness, education levels, social relationships (e.g. living circumstances, marital status and number of children), sexual knowledge and financial awareness [49].

14 Best practices were identified by UNICEF/UNFPA country offices in ESA and purposely sampled by technical experts to reflect diversity of HIV and SRH delivery approaches. Case studies were produced using a descriptive qualitative approach to data generation and analysis [95]. Multiple research methods were employed, including document analysis of peer reviewed and grey literature, and key informant interviews with programme implementers.

Timeline:

The Zimbabwe Ministry of Health and Child Care, the United Nations Population Fund (UNFPA), and partners developed the Sista2Sista Programme in response to key health challenges facing AGYW. It was implemented from inception with support from UNFPA, through various community-based organizations and the Health Development Fund. Initially implemented in six districts in 2013, since 2016 the Sista2Sista Programme has been scaled up to 26 districts. After programme support ended in 2020, districts supported by UNFPA were taken up by the National AIDS Council. As of 2023, the programme has been scaled up to 38 districts, with 18 districts supported by the Global Fund and 20 districts by the National AIDS Council; UNFPA has maintained its role as a technical partner. In 2022–2023, the Sista2Sista approach was adapted for humanitarian settings and implemented by UNFPA with the United States Agency for International Development (USAID) funding in six drought-affected areas in Zimbabwe.

Programme impact:

From 2013 to 2019, 91,612 AGYW aged 10 to 24 years were enrolled in Sista2Sista peer groups led by 130 behaviour change facilitators. Approximately 64 per cent of enrolled AGYW completed 30 out of 40 group exercises and graduated from the programme. Graduates were three times as likely to seek HIV testing, and less likely to get married or drop out of school compared to non-graduates [49]. Monitoring and evaluation data indicates that 44,180 AGYW were enrolled in the Sista2Sista Programme from 2020 to 2022. Other key programme outcomes were as follows:

- AGYW who completed all 40 programme exercises were more likely to return to school, use contraception, report experiences of sexual violence and less likely to become pregnant.
- Completing all Sista2Sista exercises was associated with an increase of 38 per cent in contraceptive use among AGYW [49].
- Participants who completed at least 30 out of 40 exercises were more likely to know their HIV status, and less likely to get married or drop out of school [49].

Contributors to success:

The Sista2Sista peer groups created a safe space for AGYW to meet, form social connections and relationships, and receive evidence-based information on HIV and SRH topics. The clubs also provided menstrual products in response to AGYW needs and promoted HIV testing and linkages to vocational and economic empowerment initiatives.

"The real benefit was the group setting where the girls also support each other… in our communities it's not easy for the 'girl child', they live in very strong patriarchal societies and most adolescent girls and young women, they

just stay at home and they really don't have platforms where they meet [and] discuss, especially issues that concern their sexual and reproductive health. So [the Sista2Sista] intervention really provided a safe space where young girls at a similar age could meet and form relationships." (Representative of Sista2Sista)

- Administering risk assessment tools via door-to-door visits identified vulnerable or at-risk AGYW in the Sista2Sista clubs and allowed tailoring of programme curriculum to meet the needs of local young people.
- Engaging community stakeholders and leaders to identify peer mentors increased awareness, understanding and support of the programme.
- Training, sustained mentorship and linkage between adolescent peer mentors, community-based organizations and health facilities formed a critical support structure, contributing to increased access to SRH services, including HIV testing.

Case study 2
In Their Hands – a mobile and incentive initiative for young people in East Africa

Programme description:

In Their Hands (ITH) is a digital health intervention that aims to improve knowledge and uptake of quality SRH services among AGYW aged 15 to 19 years living in urban and peri-urban areas in Kenya. Using a mobile-based membership platform called Tiko, ITH increases the availability of subsidised youth-friendly health services to eligible youth [79]. By creating local ecosystems of health-care providers and retailers, the ITH intervention generates demand and links AGYW with quality SRH services. Ecosystem components include: a) trained community-based mobilizers to enrol new members and communicate with young people on SRH and behaviour change; b) community-based organizations to provide mentorship and support for local mobilizers; c) youth-friendly SRH service providers, primarily social franchise networks or private clinics (e.g. Marie Stopes Kenya, Population Services Kenya, the Tunza network, etc.); d) pharmacies to facilitate access to HIV self-testing, emergency contraception and oral contraception; e) recent expansion into the public sector health clinics; and f) a retail shop for Tiko members and mobilizers to redeem the rewards they earn for rating services and referring peers to the platform.

Community-based activations, social media and other channels are employed to share SRH information and promote the free services available through Tiko. AGYW are enrolled onto the platform through community mobilizers, self-enrolment or peer-to-peer referrals and register to the programme using WhatsApp, SMS or a membership card with a QR code (scanned by the community mobilizer). Users can search for, and choose local health providers to, access free SRH services. These services include contraception; HIV testing (and self-testing); PrEP and ART and more recently, mental health and psychosocial support for individuals and groups. In addition, skill development services have also been recently incorporated in specific geographies.

Services are provided by pre-qualified, youth-friendly health services within the ecosystem [80]. AGYW can also opt for delivery of select products to their homes or a preferred location. Girls are motivated to access SRH services through reminders, follow-ups, subsidies and rewards, known as "Tiko Miles" [81]. AGYWs provide feedback and rate services to increase quality of care and provider accountability and earn miles. After rating the services received, AGYW earn Tiko Miles which can be used in local shops to purchase items, such as sanitary pads, notepads and pens or household goods [81,82]. AGYW also provide feedback and rate services to increase quality and accountability and earn points. Facilities are incentivized to improve the quality of care, as higher ratings contribute to facility improvements and provider incentives, and the reimbursement of services also encourages private health providers [80].

Timeline and programme sites:

ITH was initially funded by the Children Investment Fund Foundation and implemented by Well Told Story (now Shujaaz Inc.), Marie Stopes Kenya and Triggerise across 18 counties in Kenya from 2018 to 2020 [79]. Since then, the ITH model has been scaled up, both within Kenya [80], and across other countries in sub-Saharan Africa, including Burkina Faso, Ethiopia, South Africa and Uganda [83].

Programme impact:

By 2020, ITH had reached over 350,000 young people in Kenya, leading to improved contraceptive method mix [15], increased access to a diverse range of SRH service providers (e.g. public, private, non-governmental organizations and pharmacies), and improved measures of informed contraceptive choice, quality of care and service satisfaction among AGYW [79]. Between January 2021 and July 2023, approximately 488,969 AGYW (15 to 19 years) were enrolled onto the Tiko platform; from this total, 405,247 AGYW

15 Contraceptive method mix is the distribution of modern contraceptive users by the method used and underscores that providing diverse options of contraceptive is essential to ensure quality care and realizing individuals SRH and rights [93].

successfully accessed SRH services resulting in a conversion rate of 83 per cent. This is the percentage of young people who access a service out of the total enrolled [84]. Other notable outcomes included:

- AGYW receiving information related to SRH services increased by 28.1 per cent between baseline/endline evaluations, use of modern contraceptives to prevent pregnancy increased by 31.1 per cent and information related to HIV prevention increased by 19.6 per cent [79].

Contributors to success:

- Establishing a local ecosystem that simultaneously addresses demand- and supply-side barriers helps to address barriers related to SRH and HIV knowledge, accessibility and quality of care for young people.
- The novel use of technology and mobile application allows for real-time data generation and analysis, which guides implementation, quality assurance and accountability of service delivery. Monitoring key quality assurance metrics (e.g. ratings, method mix, time for service provision, age of girls reached, etc.) informs rapid adaptations and improvements to service delivery (e.g. skewed results of contraceptive method mix or negative ratings from AGYW prompt quality assurance supervisory visits to health facilities, capacity-building of health providers, ongoing monitoring and potentially a performance improvement plan).
- Providing low-technology pathways increases accessibility for many AGYW. Most AGYW accessed Tiko using membership cards and QR codes, rather than higher-technology (e.g. WhatsApp) options to earn miles.
- Obtaining public sector buy-in through stakeholder engagement at the county level prior to implementation was also recognized by implementers as an important facilitator.
- Training health-care providers to deliver youth-friendly health services helped to address bias, social stigma, judgment and negative attitudes towards young people seeking SRH and HIV services.
- Offering multiple strategies to reach AGYW (e.g. choice of provider/location or even delivering products directly to AGYW) empowered girls and young women to make decisions and overcome accessibility barriers.

"[AGYW] can have the [SRH] product delivered directly to their homes or wherever they choose…the community centre, their friend's house…So it's really about bringing the services closer to the girls for those that really don't want to go to a physical facility."
(ITH Representative)

- Engaging diverse partners (e.g. strong network of private providers, pharmacies and community-based organizations) represents a significant strength of the ITH initiative and creates ample options for young people and quality of SRH service provision to safeguard AGYW.

"That diversity of service delivery for the girls is really important because they get [a] choice in where to go and it's not us telling them."
(ITH Representative)

Case study 3
TuneMe – digital platform for improving sexual and reproductive health knowledge among young people in East and Southern Africa

Programme description:

TuneMe was originally designed as a web-based platform for mobile phone devices (also called a mobi website) by UNFPA and the Praekelt Foundation. TuneMe aims to improve SRHR among young people by providing accurate, evidence-based SRHR information and connecting young people to local youth-friendly health services [85]. This information focuses primarily on SRHR, such as STIs and HIV, family planning and pregnancy, contraception, gender-based violence, harmful cultural practices (e.g. child marriage), as well as psychosocial and relational topics (e.g. coping strategies, planning for the future, friendship and relationships).

Timeline and programme sites:

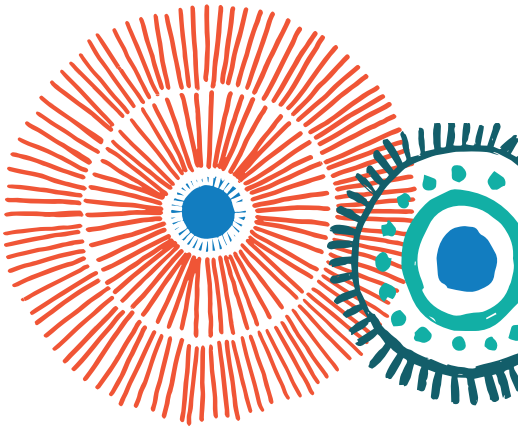
The TuneMe digital platform has been implemented from 2015 to present in seven countries (Botswana, Eswatini, Lesotho, Malawi, Namibia, Zambia and Zimbabwe). In 2021, a TuneMe app was developed to complement the mobi site and reach more adolescents and youth with smartphones with SRH information (e.g. HIV, SRH, puberty, menstruation and gender-based violence) [86]. The app enables young people to access the same content as on the mobi site offline after an initial download. Additionally, the app includes new features, such as a period tracker and options to schedule reminders for medications and appointments.

Programme impact:

In the first four years of implementation, the TuneMe mobile site reached over 3 million young people. As of December 2022, over 8 million unique users had accessed TuneMe resources [87]. Significant increases were observed in participants' perceived SRH knowledge and frequency or depth of SRH discussions with peers/ friends, parents, teachers and partners. A programme evaluation reported a 30 per cent increase in the use of SRH services among app users [85].

Contributors to success:

- The platform was created using a youth-centred approach whereby young people led the design process (including look and feel, name and content) and were engaged throughout implementation, monitoring and evaluation.
- TuneMe is a trusted resource offering young people accurate and age-appropriate SRHR information on over 200 topics to help promote SRH and support informed decision-making and improve sexual health behaviours [85,88,89]. Youth can access SRH information independently and privately.
- In Zambia (and other countries), sustainability plans to institutionalize TuneMe into national government systems were part of the initial programme development process and in 2018 ownership of the initiative was transferred to the Ministry of Youth, Sport and Child Development, the Ministry of Health and the Ministry of Information and Broadcasting Services. Together these ministries support programme marketing efforts and generate and review content to ensure that SRH information aligns with current national guidelines.
- During the pandemic, information and resources related to COVID-19 prevention were integrated into programme materials. Information on menstrual health, gender-based violence and access to SRH services during the pandemic were also published.
- Regional solutions and SRH content were adapted to provide country-specific information and services, such as the inclusion of a menstrual period tracker and SRH service finder.



Case study 4
Mobile delivery of integrated HIV and sexual and reproductive health services for young people in Zambia

Programme description:

Mobile delivery of integrated HIV and SRH services in select districts of Zambia, via the project Access to HIV Testing Services for Adolescents, aimed to: i) improve comprehensive knowledge of HIV prevention among young people; ii) increase uptake of HIV testing services among young people; iii) improve the responsiveness of integrated SRH and HIV services to address the needs of young people; and iv) promote linkage to HIV prevention, care, treatment and support services for young people [90]. Static community-based sites (e.g. booths) and mobile outreach caravans were used to deliver an integrated/holistic package of HIV and SRH services (e.g. information, HIV testing, contraceptive counselling and access to condoms, STI screening/treatment, referrals to HIV treatment, care and support services, referral for ART, PrEP, post-exposure prophylaxis and VMMC, as well as sexual and gender-based violence services). Youth peer educators (trained by the Ministry of Health and connected with local health facilities) worked to increase awareness and mobilize young people to attend outreach activities. Lay counsellors were trained to provide HIV self-testing kits, referral to health facilities and follow-up to support treatment adherence. The initiative also expanded to train health-care providers in delivering disability-friendly HIV and SRH services for young people [90].

Timeline and programme sites:

The initiative was implemented by MSI Zambia, in partnership with UNICEF, from February 2020 to March 2022 in eight peri-urban areas of the Lusaka and Ndola districts of Zambia [90].

Programme impact:

The programme reached approximately 1,157,130 adolescents and young people across the eight programme sites. A qualitative analysis also found that young people considered the mobile HIV and SRH services to be acceptable, available and of good quality. They also reported reduced distances to seek HIV and SRH services and waiting times as a result of mobile service provision [90]. Other outcomes included:

- 40 peer educators were recruited, trained and deployed to support implementation in communities. Peer educators were trained on mobilizing

young people to seek HIV testing services, communications and to reach youth with disabilities.

- The programme reached 31,742 young people with information on contraceptives via brochures, discussions with peer educators and lay counsellors.
- The integration of optional escorted referrals to health facilities by lay counsellors improved follow-up rates to nearly 100 per cent.
- Almost all adolescents and young people in need were successfully referred for VMMC, ART, PrEP and post-exposure prophylaxis.

Contributors to success:

- Collaborating with the Government of Zambia and adopting a public sector strengthening model helped to ensure stakeholder engagement in programme design and implementation.
- Leveraging existing facility and district government structures (e.g. peer educators, lay counsellors and health providers) was a key contributor to successful implementation, by offering opportunities for collaboration, capacity-building, knowledge exchange and generated local awareness and trust.

"The use of existing structures, not reinventing the wheel, the use of peer educators who are already recognized and mandated by the Ministry of Health to do the work that they are doing, and also these peer educators who are recognized and respected in their communities as bearers of information for the Ministry of Health, did help. 90 per cent of our clients that came to the caravan came because a peer educator mentioned it to them… a majority of them came because someone who is trusted with information in their communities spoke to them about it."
(MSI Zambia Representative)

- Employing a human-centred design approach ensured that youth were engaged in intervention development, and that interventions addressed relevant obstacles to care among young people (e.g. confidentiality and privacy).
- Delivering SRH and HIV services in convenient locations for young people (e.g. markets, shops, bars and schools) or areas considered hot spots is critical to reaching young people, including those at greater risk.
- Linkages between mobile outreach caravans and health systems facilitated training, and integration of monitoring and evaluation with local health management information systems.
- Community sensitization activities led by peer educators in advance of the mobile caravan visits helped to increase awareness of HIV and SRH issues and increase community acceptance.

- Training health providers and adapting services to provide both youth- and disability-friendly HIV and SRH services (e.g. Braille health materials, interpreters, etc.) helped to increase accessibility of services and dismantle stigma and discrimination among health-care providers.
- Despite public health restrictions during the COVID-19 pandemic, the mobile outreach caravans enabled continuity of care by delivering SRH services to young people closer to home.

Case study 5
Bi-directional linkage of comprehensive sexuality education to sexual and reproductive health services in Zambia

Programme description:

The linkage of CSE to local SRH services was evaluated in a three-arm randomized control study in Zambia. The provision of CSE was provided in all three arms, with variations of in- and out-of-school integration and linkage to SRH services evaluated. Arm 1 of the study involved only the provision of in-school routine CSE and availability of SRH services in local facilities (as per current Government standards), but no additional interventions. In arm 2, in addition to CSE, health providers delivered HIV counselling and testing, pregnancy testing, contraceptive counselling, HIV education and counselling around menstrual health, hypertension and obesity during monthly health fairs and outreach on school premises. Other services (e.g. HIV and STI treatment) were available via an anonymous referral slip system to ensure linkage to health facilities. Lastly, arm 3 included CSE and connected schools with local health facilities, trained health providers to deliver youth-friendly health services and trained teachers on available SRH services to facilitate linkages and destigmatize SRH services [54]. Facility-based peer educators trained by the Ministry of Health helped to increase awareness, support peer-to-peer counselling and service delivery and facilitate local CSE clubs in-schools. CSE clubs offered additional opportunities to improve SRH education and awareness through drama, poetry, music and other activities.

Timeline and programme sites:

The study was implemented in schools and health facilities in the Solwezi and Mufumbwe districts of the North-Western

Province of Zambia from 2017 to 2020. Districts with high adolescent pregnancy rates were selected as programme sites [54]. This initiative was implemented by the Population Council, Young Women's Christian Association, the Ministry of Health and the Ministry of Education, with funding and support from UNESCO and UNFPA. After 2020, the CSE/SRH bi-directional linkage system was scaled up across UNFPA-supported areas and rolled out nationally by the Government in districts implementing CSE.

Programme impact:

Significant reductions in unintended pregnancy were achieved in both intervention arms 2 and 3 (e.g. CSE and community-based outreach and CSE provision with responsive youth-friendly SRH services). Unintended pregnancies did not significantly decline among AGYW in control arm schools where only CSE was offered. In 2020, the proportion of enrolled schoolgirls who were pregnant in arm 1 was 2.70 per cent, versus significantly lower early and unintended pregnancy in arm 2 (0.74 per cent) and arm 3 (1.34 per cent), respectively [54].

Contributors to success:

- Supporting demand generation by increasing awareness of HIV and SRH issues and services among young people, and improving the availability, appropriateness, accessibility and quality of local youth-friendly SRHR services is a critical contributor to successful implementation.

"Our hypothesis was that if you have demand being generated by CSE and then supply being generated by adolescent health services, then young people are likely to access services…it's a very simplistic tool, but it's very effective because it's supply and demand. It's really a low-hanging fruit, but we have seen the results."

(CSE/SRH Linkage System Representative)

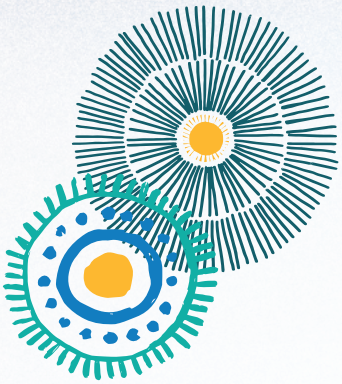
- CSE lessons are reinforced with the establishment of CSE clubs that employ an enter-educate[16] or edutainment strategy. Sessions are guided by the CSE framework for out-of-school young people.
- Linkage and integration of CSE to local HIV and SRH services that are responsive to diverse young people's needs addresses the shortcomings of stand-alone CSE.
- Multisectoral collaboration between education and health stakeholders ensures that quality SRH information is delivered in-schools and helps to maintain bi-directional relationships between schools and health facilities.

16 An enter-educate approach employs "popular entertainment with social messages to change reproductive health behaviour" through songs, soap operas, variety shows and popular entertainment medium [96].

Training school and facility leadership on CSE and health facility linkage fosters a supportive environment for CSE in schools.

- Conducting frequent district-wide training for health providers and teachers helps ensure continuity of knowledge amid human resources shortages and high turnover of school and facility staff.
- Establishing a confidential referral system enables youth to be fast-tracked at health facilities during school hours, overcoming important obstacles to care-seeking (e.g. facility hours, waiting times, stigma from family/communities).

Overall summary of lessons learned



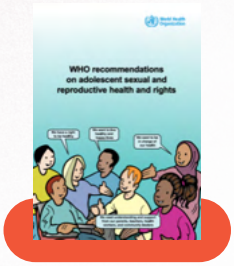
Taking stock of lessons reported in the literature and case study programme experiences, several key takeaways may inform the development and implementation of future SRH initiatives delivered beyond the health facility for young people in ESA:

- Implementation strategies that **identify and reach the most vulnerable segments of the adolescents and youth population, such as AGYW and key populations, including** lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other gender and sexual identities (LGBTQIA+), and **respond to their intersecting social and sexual identities and diverse SRH needs** are critical to ensure that no young people are left behind.
- **Reaching and serving young people with differentiated HIV and SRH services where they live, work, play and learn is essential** to overcoming obstacles that young people have traditionally encountered with facility-based services. Promising community-based HIV and SRH delivery platforms, such as mobile health clinics, community distribution points or local pharmacies, underscores the importance of integration and leveraging existing community and health system structures to bring services closer to young people.
- **Strategies that promote young people's agency and reproductive autonomy and capacity to make decisions related to their health and well-being** – including where, when, how and from whom to seek HIV and SRH services - are essential to realizing SRHR among young people in ESA.
- **Institutionalizing youth as peer counsellors, mentors and lay providers remains a powerful approach** to improve HIV and SRH outcomes among young people. Peer-to-peer service delivery and mentorship models create safe spaces for young people to gain critical SRH knowledge, develop decision-making skills and connect youth to local HIV and SRH services.
- **Innovative approaches to address both demand generation and supply side barriers to care** are critical. For example, pairing community-based mobilization of young people, alongside training of health providers in youth-responsive care provision, subsidized SRH services and increased quality assurance and accountability of SRH services help

to bring high quality, targeted and appropriate care to young people in their communities.

- **Using digital health platforms (e.g. In Their Hands) can empower young people to play an active role in the SRH landscape and hold providers and facilities accountable for delivering quality services.** However, offline connections must be maintained to ensure services continue to reach the most vulnerable young people, including AGYW who may have low digital literacy and/or limited access to devices and mobile services.
- **Improving HIV and SRH knowledge among young people through peer education, comprehensive sexuality education and/or digital platforms** is crucial to overcoming individual-level obstacles to accessing SRH services. However, knowledge alone is insufficient and interventions that connect youth to local health facilities and SRH services are essential to improving health and SRH outcomes.
- **SRH and HIV service delivery for young people must be flexible to efficiently address emerging and critical needs of young people during public health emergencies, including mental health.** Leveraging differentiated service delivery models may help support the health, mental health and well-being of young people in future health emergencies.
- **Integrating self-care SRH interventions in conjunction with existing health services and systems helps to support young people's autonomy and SRH rights.** Supporting and building capacity of young people to engage in self-awareness, self-diagnosis and self-management should be considered complementary to conventional facility-based services moving forward. Future research should assess the individual and combined effects of facility-based and self-care interventions.

Key resources



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