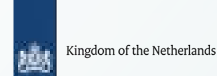

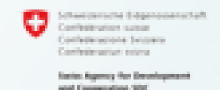

Mental health and psychosocial support for young people living with HIV in East and Southern Africa

Implementation Brief

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 and human immunodeficiency virus (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. Mental health and psychosocial support for young people living with HIV 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
AYM	Adolescent and young mothers
CATS	Community Adolescent Treatment Supporters
CAYPLHIV	Children, adolescents and young people living with HIV
ESA	East and Southern Africa
HIV	Human immunodeficiency virus
MHPSS	Mental health and psychosocial support
PrEP	Pre-exposure prophylaxis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YPLHIV	Young people living with HIV

Background

Mental health among young people in East and Southern Africa

Mental health is an integral component of health and well-being that enables young people (Box 1) to cope with the stressors of life, realize their abilities, learn and work well, and contribute to their communities [1]. Mental health represents a continuum ranging from episodes of acute mental health disorders to experiences of positive coping, resilience and to overall well-being [2]. It is estimated that approximately 10 to 20 per cent of children and adolescents worldwide experience mental health conditions[1] [3]. In 2019, nearly 37 million adolescents were living with a mental disorder in Africa, and anxiety and depression accounted for almost half of the conditions experienced [4]. The most common mental health challenges among young people living in sub-Saharan Africa include depression (27 per cent), anxiety disorders (30 per cent), emotional and behavioural problems (41 per cent), post-traumatic stress disorder (22 per cent) and suicidal ideation (21 per cent). Anxiety and depression represent more than 60 per cent of mental disorders experienced by adolescent girls in ESA [4]. These conditions are often exacerbated by experiences of orphanhood, conflict and violence [5]. Recent evidence suggests that mental health challenges have increased globally among adolescents and young people, especially those living with HIV and young key populations, with further exacerbation during the COVID-19 pandemic [6], highlighting the urgency of scaling up effective mental health and psychosocial support (MHPSS) interventions in ESA.

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1 Internalizing and externalizing disorders, mood disorders, emotional distress, cognitive disability and substance misuse [3].

Box 1: Adolescents and youth

Young people represent a diverse population with unique health needs, who experience complex challenges in accessing quality, comprehensive and integrated HIV and sexual and reproductive health and rights information and services. Definitions of adolescent, youth and young people vary by country and region. In this brief, adolescents are defined as individuals aged 10 to 19 years, youth as those aged 15 to 24 years and young people as individuals aged 10 to 24 years [7].

Populations of focus: young people living with HIV and young mothers living with HIV

In 2023, an estimated **1 million adolescents (aged 10 to 19 years)** and **1.7 million young people (aged 15 to 24 years)** were living with HIV in the ESA region, with approximately **74,000 new HIV infections in 2023 occurring among adolescents aged 10 to 19 years out of the total new infections of 160,000 in the region**. [8]. Young people living with HIV (YPLHIV) experience poorer HIV-related health outcomes than any other age group, including higher mortality rates, lower retention in HIV care, poor adherence to treatment, inadequate linkage to services, and limited HIV knowledge and engagement in care [9]. Adolescence represents a critical period of development, transition, risk-taking and independence. YPLHIV must also navigate challenges related to their physical and emotional health, including stigma, isolation and fear of rejection [9].

A bidirectional relationship exists between HIV and mental health, as HIV intensifies existing mental health problems [10]. Mental health disorders are associated with increased substance use and risky sexual behaviours, poor adherence to treatment, poorer health outcomes and increased risk of HIV transmission [2,11]. A recent systematic review of mental health among YPLHIV in sub-Saharan Africa found that nearly 25 per cent experienced psychiatric disorders and 30 to 50 per cent reported emotional or behavioural difficulties and psychological distress [9]. Key risk factors for experiencing mental health problems include older age (15 to 19 years), being out of school, as well as experiencing poverty, bullying and HIV-related stigma [12]. Cumulative adverse childhood experiences and environments (e.g. orphanhood due to acquired immunodeficiency syndrome, violence, discrimination, family substance use or mental illness, poverty and food insecurity) further increase the risk of behavioural and psychiatric conditions among YPLHIV [13,14]. Social support (including peer support) and positive

parenting practices represent protective influences for mental health and well-being among YPLHIV [12].

Approximately 300,000 adolescent girls and young women (AGYW) living with HIV became pregnant in 2020 in sub-Saharan Africa, and 42 per cent of pregnant and breastfeeding women who acquired HIV were aged 15 to 24 years. Living with HIV and adolescent pregnancy are both associated with mental health challenges among young people, and this burden is much greater when experienced together [15,16]. Adolescent and young mothers (AYM) living with HIV must manage HIV alongside multiple other challenges, including navigating adolescent development, pregnancy, childbirth and parenting, adherence to lifelong antiretroviral therapy (ART), concerns around preventing HIV transmission to infants, the possibility of caring for a child with HIV, as well as mental health concerns related to the stigma and discrimination associated with their HIV status [17].

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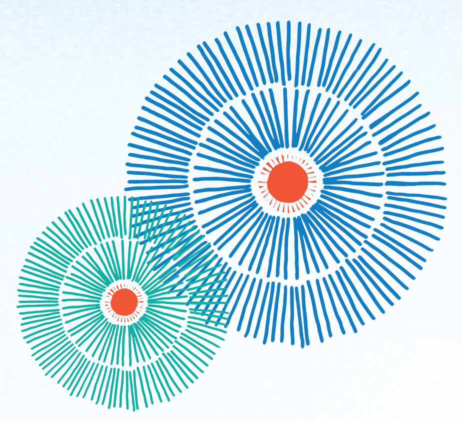
Mental health and psychosocial support services



MHPSS encompasses psychological, social and behavioural approaches designed to improve health and related outcomes [9]. Implementation of MHPSS interventions for YPLHIV is associated with moderate improvements in ART adherence and viral suppression [9]. Global consultations with YPLHIV emphasized that MHPSS is essential to improving their well-being, mental health and social connectedness, which directly impacts their engagement in HIV-related health services and treatment success [18,19]. As a result, the World Health Organization (WHO) has recommended psychosocial interventions for all YPLHIV, including peer support, counselling and support groups, to improve young people's engagement in HIV care, adherence to ART and health outcomes, particularly viral suppression [20].

Barriers to accessing mental health and psychosocial support services

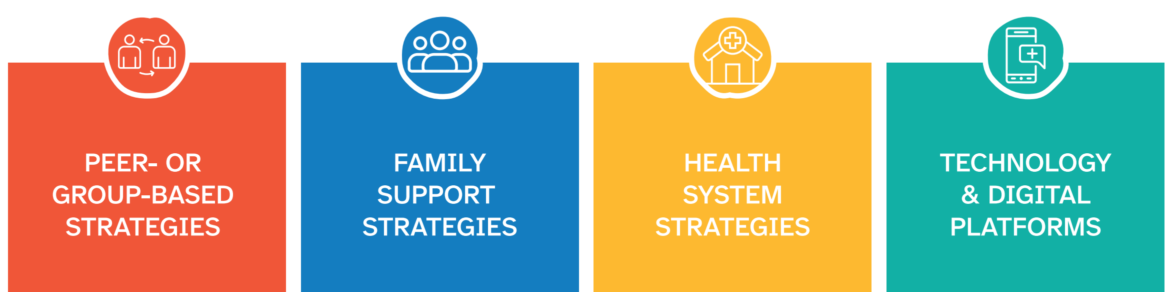
Despite the prevalence of mental health conditions among YPLHIV in ESA, the limited availability and accessibility of MHPSS remains a critical challenge. Lack of mental health knowledge and awareness at individual, family and community levels contribute to stigma and discrimination that compromise care-seeking and overall quality of life for youth [21,22]. The provision of MHPSS is further constrained by severe shortages of specialized health-care providers, inadequate infrastructure and referral pathways, and limited integration of MHPSS into primary health-care services [2,21,23]. Lack of adolescent-specific mental health policies at national level, piecemeal and/or limited policy implementation and inadequate financial resources are further obstacles to mental health support for YPLHIV [21]. Adult-oriented policies (including restrictive age of consent laws), and fragmented health systems also undermine equitable access to sexual and reproductive health and HIV services among YPLHIV [9,24].

Mental health and psychosocial support service strategies for young people living with HIV[2]

Evidence-based MHPSS approaches for young people living with or affected by HIV in ESA, include peer or group-based strategies, family-support strategies for adolescents and caregivers (including economic strengthening initiatives) and health system strategies [11]. Technological and digital platforms are promising MHPSS initiatives targeting YPLHIV in low-resource settings [2,14] (Figure 1).

Figure 1:

Available approaches for delivery of MHPSS among YPLHIV



Many MHPSS interventions are delivered in home-, school-, community- or health facility-based settings [11], by facilitators ranging from specialized therapists to trained lay health workers or adolescent peer support counsellors [14]. Problem-solving, mindfulness, cognitive behavioural therapy approaches and family support are key strategies employed in many evidence-based interventions for YPLHIV [2] (Table 1). Adaptive integration of mental health assessment, prevention and treatment into HIV care across multiple levels (family, community, facility and health system) is recommended to support the clinical management of HIV among YPLHIV and to improve their psychosocial and mental health (Box 2) [14,27].

2 A summary of MHPSS strategies was developed based on critical review of peer reviewed and grey literature from 2012-2022.

Box 2: Opportunities for multisectoral collaboration for mental health and psychosocial support service interventions

Recent evidence promotes the "layering" of MHPSS interventions for YPLHIV, particularly community-based interventions, family support and social protection programmes [2]. For example, research on "development accelerators" highlights the potential synergistic impact of multiple interventions (e.g. parenting support and safe schools) on key Sustainable Development Goal targets, including good mental health among adolescents living with HIV [28]. Multisectoral collaboration and co-financing of multiple evidence-based interventions to enhance the mental health of YPLHIV alongside other health and social development outcomes is recommended [28].

A synthesis of strategies, delivery methods, outcome evidence and implementation considerations are presented in Table 1 to guide the design and implementation of MHPSS interventions.

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Table 1:

Synthesis of promising mental health and psychosocial support services delivery approaches

Strategy	Description	Delivery methods and impact on outcomes	Implementation considerations
Peer or group-based strategies	Mental health and psychosocial support, information and connection provided by peers or in group settings (e.g. peer supporters, educators or counsellors or young mentor mothers, support groups) [2,14].	• Peer-based strategies: positive impact on psychological well-being (self-confidence, self-esteem and self-worth), lower perceived stigma and improved adherence to ART, linkage to care and quality of life among YPLHIV [29–33]. • Peer support and training in schools: increased HIV knowledge, decreased reported stigma, increased disclosure of HIV status and increased linkage to care [34,35]. • Group-based intervention: increased ART adherence and improved virologic outcomes [36].	• Peer counsellors may act as a “bridge” to connect YPLHIV to MHPSS in facilities. • Training, mentorship and sustained supportive supervision of peer counsellors is essential. • Peer- and group-based interventions offer MHPSS for YPLHIV in homes, schools, communities, health facilities and/or via social media.
Family support strategies	Interventions promoting family support, skill-building, communication and child-caregiver relationships (e.g. family or group education on HIV and mental health). This includes family-level economic support programmes [14].	• Family-based strategies: improved connection and communication about sexuality, improved social support, mental health and decreased symptoms of depression among YPLHIV (or young people affected by HIV); improved HIV knowledge and ART adherence [37]. • Family-level economic strengthening: improved self-awareness [38] and reduced hopelessness and depression [39].	• Family-based approaches are feasible and acceptable to deliver MHPSS, particularly in settings with few specialized health providers. • Connecting YPLHIV and caregivers with other affected families in home- or community-based settings offers opportunities to examine issues of family loss, stigma, relationships, identity and family functioning [37].
Health system strategies	Interventions offered in health-care settings, such as clinics or hospitals (e.g. training providers on MHPSS and adolescent-friendly health services) [14].	• Health provider training: may support increased linkage to and retention in care [40], adherence to treatment [41] and improved viral load suppression [42].	• Value clarification and attitude transformation training for health-care providers to provide adolescent-friendly health services helps to ensure quality of care and increases engagement of YPLHIV [40].
Technology and digital platforms	Digital or technology-based interventions using social media, text-based or internet platforms [14].	• Digital/mHealth mobile platforms: emerging evidence that digital MHPSS strategies may: a) reach many YPLHIV with information, support, connection, counselling from peers; and b) support and/or complement clinical care [43].	• Digital platforms for MHPSS can be used to overcome accessibility and availability issues, such as distance, transportation and human resource shortages. • Support continuity of services during periods of disruption (e.g. public health or natural emergencies) [2,14].

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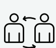
Implementing a combination of these strategies may help young people overcome individual, family/community, health system and policy environment barriers to accessing MHPSS as illustrated in Figure 2.

Figure 2:

Key barriers to MHPSS and promising implementation strategies (adapted based on [21])

	INDIVIDUAL	FAMILY/ COMMUNITY	HEALTH PROVIDER & FACILITY	POLICY & LEGAL
KEY BARRIERS	Limited knowledge or awareness of mental health and MHPSS among adolescents and young people and risk factors (e.g. HIV/AIDS, orphanhood, poverty or trauma)	Lack of knowledge or awareness, and stigma, violence and discrimination	Shortage of specialized health-care providers; lack of knowledge and skills among health-care providers; inadequate integration in primary and HIV care	Lack of adolescent mental health policy, poor policy implementation, and inadequate financial resources
APPROACHES	 Peer- or group-based counselling Education and awareness	Family-focused counselling and interventions Digital health and mass media outreach	Train health providers on MHPSS Youth-friendly health services Integrate MHPSS in HIV care	Youth mental health policy Train & retain health providers Invest in MHPSS for AYPLHIV

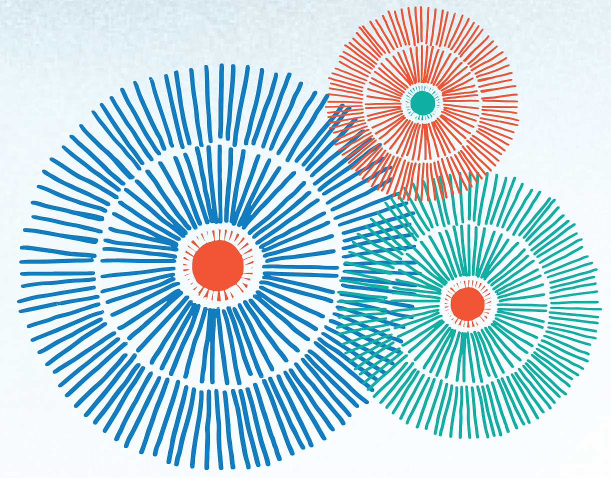
Box 3: Lessons from COVID-19 for future shocks and pandemics

The COVID-19 pandemic significantly worsened mental health challenges among YPLHIV. Interrupted access to essential health services, including ART, alongside disruptions to education, travel restrictions and increased exposure to poverty and violence, created compounded vulnerabilities. These socioenvironmental and political shifts heightened levels of distress, anxiety and uncertainty among young people in ESA [25]. School closures and limited opportunities for peer interaction or engagement with support groups further contributed to feelings of loneliness, isolation and depression among young people. These challenges underscored critical gaps in MHPSS systems. The pandemic revealed the fragility of existing interventions and the pressing need to invest in sustainable, integrated and youth-centred MHPSS strategies [26].

Some of the lessons include:

- **Innovative adaptations in service delivery:** Public health restrictions during the COVID-19 pandemic spurred several innovative adaptations to ensure the continuity of HIV services and MHPSS for YPLHIV. These included differentiated service delivery models and novel strategies to bring care closer to where young people live, ensuring accessibility despite the challenges [44].
- **Digital programme adaptations:** The pandemic demonstrated the potential of digital platforms (e.g. mobile devices and social media) to create new opportunities for YPLHIV to seek information, social connection and support [26]. For example:
    - In **Lesotho**, remote mental health consultations were provided to pregnant and breastfeeding AGYW via WhatsApp/telephone and U-Report, an online social messaging tool and data collection system. Additionally, engagement surveys helped identify and address obstacles to health service delivery.
    - In **Zimbabwe**, Zvandiri's peer-delivered MHPSS transitioned to virtual counselling, monitoring and support for pregnant and breastfeeding AYM. Notably, 96 per cent of supported AYM achieved viral load suppression despite pandemic-imposed challenges [44].
- **Responsive and flexible implementation:** Overall, the responsive and flexible implementation of MHPSS interventions was critical to meeting the evolving mental health needs of YPLHIV during the pandemic. These adaptations ensured continuity and impact, even under the constraints imposed by a public health emergency [44].

Programme case studies



Evidence on programme implementation experiences, impact and contributors to success is critical to understand how various MHPSS strategies can effectively reach YPLHIV in ESA. Programme case studies[3] were purposively selected based on expert consultation to examine strategies employed to reach YPLHIV across diverse geographic locations.

Case study 1
Zvandiri, *"As I am"*: a community-based peer-led model for MHPSS for YPLHIV in Zimbabwe

Programme description:

The Zvandiri *"As I am"* model uses a differentiated[4] community- and peer-based model to provide information, counselling and support services to improve the physical, social and mental well-being of children, adolescents and young people living with HIV (CAYPLHIV) (aged 0 to 24 years) [45]. Central to the Zvandiri approach is the recruitment and training of YPLHIV (aged 18 to 24 years) as Community Adolescent Treatment Supporters (CATS) or Young Mentor Mothers (young mothers living with HIV) to provide MHPSS. Peer mentors identify, refer and support CAYPLHIV or young mothers and their babies through home visits, support groups, facility visits and mobile health communication across the HIV care continuum [46]. They are integrated into local health facilities, supervised by local clinicians and supported by local Zvandiri mentors [45].

CATS also promote mental health literacy and well-being, perform mental health screenings, refer individuals at risk of

3 Best practices were identified by UNICEF/UNFPA country offices in ESA and purposely sampled by technical experts to reflect a diversity of approaches. Case studies were produced using a descriptive qualitative approach to data generation and analysis [60]. Multiple research methods were employed, including document analysis of peer reviewed and grey literature, and key informant interviews with programme implementers.

4 Differentiated service delivery is a person-centred approach that simplifies and adapts HIV services across the care continuum to better meet the needs of people living with or vulnerable to HIV, and to optimize available health system resources [20].

mental health conditions to health facilities, provide counselling for CAYPLHIV related to adherence, provide monitoring and support for ART or psychiatric medications, support case management, and lead individual/ group therapy and support groups. Peer mentors are also engaged to implement the *"Friendship Bench"*, a community-based mental health counselling intervention delivered by lay providers to support CAYPLHIV through problem solving therapy [32]. Zvandiri's holistic approach has improved the uptake of HIV testing services, ART initiation and adherence, viral suppression, mental health and linkage to other social and health services among YPLHIV [45].

Timelines:

Zvandiri was implemented in Zimbabwe from 2004 to 2021, in collaboration with the Ministry of Health and Child Care (MoHCC) and multiple partners. Since 2016, it has been scaled up regionally through government and international partnerships in other countries, including: Angola, Eswatini, Ghana, Mozambique, Namibia, Nigeria, Rwanda, the United Republic of Tanzania and Uganda [47].

Programme impact:

As of 2021, the Zvandiri mental health model reached 67,790 CAYPLHIV via health facilities, home visits, support groups and digital delivery methods; 95 per cent of YPLHIV reached were screened for mental health conditions and 16 per cent were referred for further assessment or care [48]. Common mental disorders decreased drastically from a baseline of 70.3 per cent to 2.4 per cent among YPLHIV receiving enhanced adherence counselling using problem solving therapy by CATS over 12 months; individuals receiving standard counselling also achieved reductions in common mental disorders to 10.3 per cent [32]. YPLHIV engaged in Zvandiri interventions were 42 per cent more likely to be virologically suppressed relative to those receiving standard HIV care [33]. Other key outcomes include:

- From 2019 to 2021, 786 young mothers living with HIV received MHPSS. In 2021, 93 per cent of young mothers achieved viral suppression and 61 per cent were screened and referred for mental health conditions. Most sexual partners were encouraged to learn their HIV status and 84 per cent of male partners that tested negative for HIV initiated pre-exposure prophylaxis (PrEP)[5] [46].
- Zvandiri's peer-led and focused approach to MHPSS informed the development of multiple international guidelines, tools and curricula to support service delivery for YPLHIV [45,48].

5 Pre-exposure prophylaxis (PrEP) is the daily use of an antiretroviral drug to block acquisition of HIV infection by uninfected individuals [61]. PrEP is an effective measure to protect health and limit HIV transmission, particularly among high-risk key populations [62].

Contributors to success:

- Differentiated service delivery models are essential to reaching YPLHIV with MHPSS provided by peer counsellors in a combined community- and facility-based approach.

- Zvandiri's peer-based approach to MHPSS enables YPLHIV to share mental health challenges openly with peers of similar age who have shared lived experience with HIV. Peer mentors understand the challenges facing YPLHIV (e.g. adherence, stigma, discrimination and desire to hide their HIV status), offer a safe space for social support and act as role models for living with and managing HIV [49]. Involvement in the Zvandiri programme also supported CATS' own adherence behaviour and improved skills and self-worth [31].

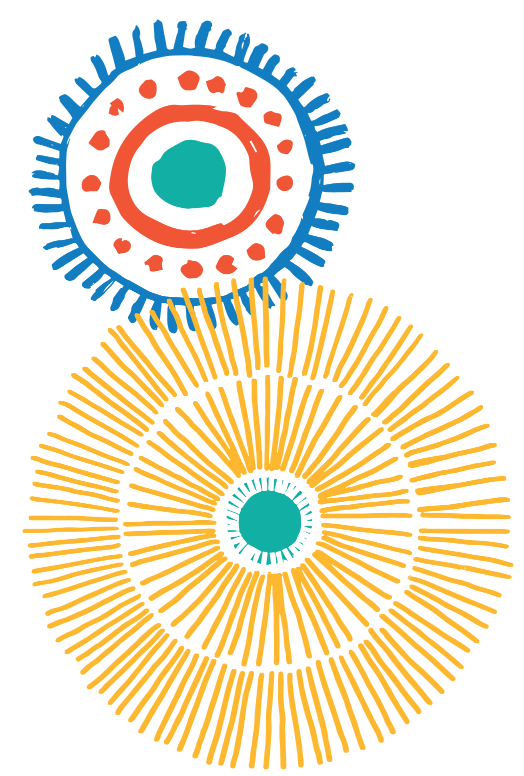
- Establishing partnerships with the Government and integrating Zvandiri into existing health system structures facilitated its scale-up and sustainability [45].

- Engaging YPLHIV throughout the intervention design, implementation and monitoring and evaluation shaped Zvandiri's approach to better serve young people with MHPSS.

- Ongoing training, supervision and mentorship for CATS is vital to support peer counsellors to provide MHPSS for YPLHIV [49].

"Trainings and support are not one off…particularly when you're working with adolescents and young adults, you have to do the trainings, but you have to follow through with ongoing support, continued skill development, capacity-building… to the peer counsellors. We need to be providing for them, what we want them to be providing for their peers."
[Zvandiri Representative, Zimbabwe]

- Virtual mental health training and e-mentorship helped strengthen the capacity of health-care workers, Zvandiri mentors and CATS to provide mental health services and psychosocial support [48].



Case study 2

One2one peer-based digital health intervention for young people in Kenya

Programme description:

The one2one intervention employs a peer- and digital-based health model to provide online and in-person counselling services, referrals and linkage to care for young people (aged 10 to 24 years) on issues of sexual and reproductive health, sexuality, HIV and relationships, gender-based violence and mental health [50]. Young people are engaged using a stepped care model[6] that coordinates online and offline services to support their mental health needs. Services provided include: a) general information via the one2one youth website or mobile application; b) personalized information through chatbots; c) virtual and in-person peer educators or support groups; d) youth-friendly health services and psychotherapy by trained health-care providers online and through a telephone-based call centre; and e) in-person consultations with trained health-care providers [51].

The one2one initiative targets young people, particularly YPLHIV and young key populations (e.g. sexual minorities, youth identifying as LGBTQI and adolescent girls and young women), youth identifying as lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender and sexual identities to provide credible, non-judgmental, anonymous and confidential counselling and linkage to services. One2oneLVCT Health also provides training and supportive supervision of youth counsellors and sensitization of health-care providers on MHPSS. The one2one platform is a popular and accessible source of information, counselling and referral to available local services to support mental health and well-being among young people in Kenya [52].

Timeline:

The one2one platform was introduced in Kenya in 2006 by LVCT Health, a local non-governmental organization, and initially offered information, counselling and service linkage through a telephone hotline and SMS [52]. LVCT Health also provides training and supportive supervision of youth counsellors and sensitization of health-care providers on MHPSS. Since 2019, the platform has expanded to include social media platforms (e.g. Facebook and Instagram), WhatsApp, a dedicated website, interactive voice response, an AI

6 The stepped care model is an "evidence-based, staged system comprising a hierarchy of interventions from the least to most intensive, matched to the individual's needs [51]."

chatbot, as well as mobile-based mental health and period tracker applications. YouTube, Spotify and podcasts are additional platforms employed by one2one to reach young people.

Programme impact:

Among YPLHIV participating in the one2one intervention (including a five-day peer counsellor training session, training for caregivers and weekly support groups) 60 per cent of adolescents (aged 10 to 14 years) and 64.3 per cent of young people (aged 15 to 19 years) had achieved viral suppression [53]. Other key outcomes include:

- Between July and November 2020, over 3 million individuals were reached through one2one using social media (56.3 per cent aged 13 to 24 years; 34.2 per cent aged 25 to 34 years) and 64 per cent of those reached were male [54].
- Between October 2019 and September 2021, 1,197 calls related to mental health were received through the one2one hotline; the most frequently discussed issues were stress (44 per cent), depression (18 per cent) and substance use (14 per cent) [51].
- Data collected during phone calls (e.g. age, education level, marital status and issue of concern) informed dialogue and advocacy by LVCT Health and the development of targeted information, education and communications materials [52].
- LVCT Health has supported the development of national HIV guidelines and frameworks, as well as county-level strategies focused on young people.

Contributors to success:

- Establishing a public–private partnership with the telecommunications company, Safaricom, helped to secure financing and improved the accessibility and reach of one2one and MHPSS for young people.
- Adoption of a peer-led approach and training and support of Youth Advisory Champions for Health led to meaningful engagement of youth in the design and implementation of interventions and youth-led advocacy to meet the needs of young people [55]. In addition, LVCT Health supported a qualitative study on mental health among young people in Kenya, which identified key challenges, including legislative (e.g. limited prioritization, implementation or financing of mental health policies), health system and service provider (e.g. lack of adolescent-friendly spaces, inadequate screening tools, health provider attitudes and limited mental health promotion) and adolescent or individual (e.g. inadequate parent support, substance use and low mental health literacy), and offered recommendations [56].
- Delivery of MHPSS via multiple online and offline platforms and use of appropriate and targeted language has helped to reach more young people and young key populations.

“Providing different interventions across a spectrum…you’re a young person…and you want to access the service, either you have a feature phone, a smart phone or you are near a facility, so you have an opportunity to select and pick what is most likely available to you and you’ll be able to get the support.”
[Representative, LVCT Health]

“The language that we use, the tone that we use and the response that we have given to them – be it in the chatbot or the counsellors - they are culturally-sensitive, and they are trained… not to be biased… we also do quality checks with feedback from th[e] different [priority] subpopulations.”
[Representative, LVCT Health]

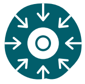
Case study 3
Pregnant AGYW Peer Mentor Programme in South Africa

Programme description:

Implemented by UNICEF and mothers2mothers, in partnership with the South African Department of Health, the pregnant AGYW peer mentor programme provides health education and psychosocial support services to AGYW (aged 15 to 24 years) who are young mothers. Young peer mentors (mothers aged 15 to 24 years living with HIV) deliver comprehensive sexual and reproductive health information, youth-friendly health services, mental health and psychosocial support, ART counselling and adherence support, information on PrEP, education on parenting and childcare skills and socioeconomic support. They also identify AGYW experiencing gender-based violence and provide referrals and follow-up [57]. Peer mentor mothers deliver services to individuals and support groups and facilitate access to facility-based care [57].

Timeline and programme sites:

The programme was initially piloted from April 2016 to December 2017 and then initiated and integrated within the Department of Health in Tshwane in October 2018, and sites in KwaZulu-Natal in March 2020 [57].



Programme impact:

The pregnant AGYW peer mentor The pregnant AGYW peer mentor programme increased access to quality youth-friendly health services (including MHPSS) for 33,956 adolescent girls and young mothers

between October 2019 and December 2021. Universal uptake of HIV testing (100 per cent among eligible individuals) has contributed to high initiation of ART and adherence among HIV-positive AGYW (98 per cent in eThekwini, 94 per cent in Tshwane and 98 per cent in uMgungundlovu), and 81 per cent of AGYW achieved viral suppression which is above the national rate. Infants experienced high rates of early diagnosis and low HIV positivity rates (2 per cent) [57]. Other key outcomes include:

- Bidirectional facility–community linkages contributed to high uptake and service utilization and retention in care [58].
- Integration of peer mentor mothers in facilities helped reduce staff workload and improve quality and efficiency of services for adolescent girls and young mothers [57].

Contributors to success:

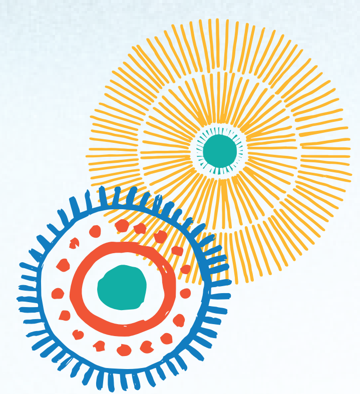
- The peer-to-peer model helped increase uptake of services and retention in care through shared lived experiences, education and support [58], and enhanced communication between young mothers and peer mentors. Integrating youth as lay providers helped offset busy health facilities, relieve burden on health-care providers and reduce waiting times [59].
- Ownership and buy-in from the Government of South Africa helped facilitate implementation, as the programme was closely aligned with government policy priorities to support pregnant young mothers, and to reduce pregnancy and HIV infection. This ensured continued engagement of national, provincial and district level Department of Health staff [57].
- Establishing robust data monitoring and reporting systems facilitated quality assurance and ensured implementation milestones were met.

" Sharing the successes and the data that [demonstrate] results -- I think that is the main [implementation] facilitator… and also, having national level meetings where we convene all the provinces to share their successes and challenges, but also to get input from them on how to review and revise components of the programme."

[Representative, AGYW Peer Mentorship Programme]

- Peer mentors received capacity strengthening and technical and advocacy support at facility, district and provincial levels, which supported implementation, sustainability and scale-up.
- Ongoing mentorship and supportive supervision of peer mentor mothers were critical.
- Pivoting to WhatsApp and online platforms during the COVID-19 pandemic ensured that counselling and support groups continued while public health restrictions were in place [59].

Overall summary of lessons learned



Taking stock of lessons reported in the literature and by case study programme experiences, several key takeaways may inform the development and implementation of future MHPSS programmes for young people in ESA:

- **Differentiated service delivery** of MHPSS interventions centres for YPLHIV and their needs, including the needs of youth identifying as lesbian, gay, bisexual, transgender, queer, intersex, asexual and other gender and sexual identities, to provide appropriate, age-responsive care. Adapting psychosocial interventions, strategies and tools to reflect local contexts and young people's intersecting biological, psychological and social needs is critical to ensure that MHPSS approaches are accepted by YPLHIV. Using multiple platforms or delivery models to reach young people with services "where they are" is paramount.
- **Peer-delivered approaches** represent promising alternatives to reach YPLHIV with MHPSS, including AYM. Successful programmes underscore the importance of institutionalizing lay peer cadres to provide MHPSS and to strengthen the connections between individuals, communities and health facilities. Trained peer counsellors are trusted sources of information, counselling and support; they are role models for youth, families and communities for living and managing HIV. Training, supportive supervision and mentorship for peer counsellors is essential to the successful implementation and sustainability of peer-based MHPSS approaches.
- **Meaningful engagement of youth** to inform all stages of MHPSS intervention design, implementation and evaluation ensures that programmes reflect their needs and preferences.
- **Technology and digital MHPSS interventions** have the potential to reach many YPLHIV with information and education to tackle issues of systemic HIV- and mental health-related stigma and discrimination. Innovative technologies (e.g. AI-powered chatbots) offer new ways to share targeted MHPSS information with YPLHIV. While promising, these tools require further evaluation to understand pathways to impact.
- **Strengthening health system linkages and referral pathways** is crucial to ensure that demand generation strategies are balanced with quality provision of MHPSS for YPLHIV. Training

health-care providers on mental health and adolescent-friendly health services helps to improve adherence to ART and youth engagement in HIV care, which is linked to positive mental health outcomes. Combining these strategies would improve the availability, accessibility, affordability and quality of MHPSS for YPLHIV.

- **Documenting and sharing key lessons** learned on how to effectively reach YPLHIV with MHPSS is critical to maximize reach in the region. This can be achieved through robust programme monitoring and evaluation, and opportunities for national/regional knowledge exchange.
- **Multisectoral approaches** are required to address the underlying social and structural determinants of YPLHIV mental health. Interventions that provide multi-level support, such as combined family- and economic-focused support programmes, may simultaneously improve multiple mental, physical and developmental health outcomes for youth.
- **Adaptations to MHPSS during the COVID-19 pandemic** demonstrated innovative, responsive and flexible approaches that helped sustain HIV and MHPSS care for YPLHIV amid unprecedented disruptions to health systems.

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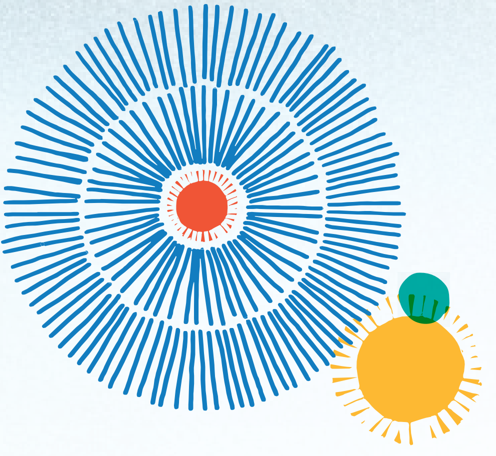
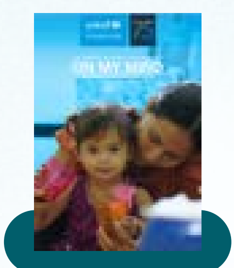
Key resources





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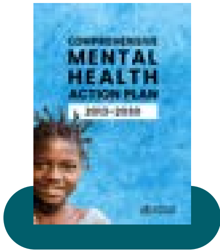

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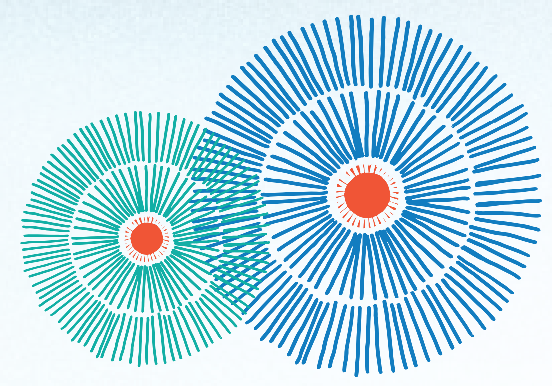

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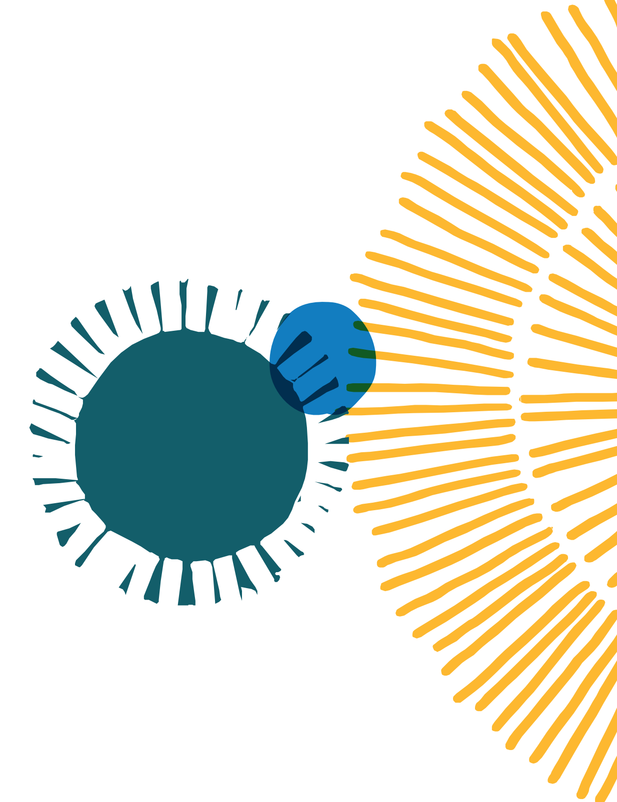

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