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Peer Provider Programming

for Adolescent and Youth Health and Wellbeing in Eastern and Southern Africa

Implementation Considerations for an Emerging Youth Health Workforce

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Foreword

Being a peer provider is far more than a job; it is a calling rooted in the power of shared experience and the ability to say, "I have walked this journey, too". Across communities, health facilities, and organizations, we serve as a bridge between health systems and the young people they are meant to serve.

For many of us, the path began in the face of harsh realities, growing up in environments marked by socioeconomic marginalization, early pregnancy, and a glaring lack of sexual and reproductive health knowledge. We remember the exhaustion of navigating clinic corridors where long lines, unfriendly staff, and lack of privacy led to accidental disclosures of HIV status and deep-seated stigma. Without a peer provider, many young people feel there is no space to express fear or confusion and often abandon care entirely.

As peer providers, we stepped into these gaps to ensure no young person walks alone. However, our work is highly demanding. We routinely hold space for others' trauma while managing our own realities, such as living with HIV, navigating disabilities, facing the same pressures as those we support. For too long, our roles have been misconceived as merely informal support. This resource marks a turning point by recognizing peer provision as structured, skilled work that requires intentional training, institutional recognition, and professional supervision.

When we are genuinely involved in design and delivery, health initiatives become more trusted and effective. We are not just beneficiaries; we are agents of change. To decision-makers and donors, we emphasize that meaningful engagement requires sustained investment and clear career pathways. Peer providers must be equipped not only to deliver services but to shape policy and drive innovation.

Our approach is grounded in listening to adolescents and young people, working collaboratively, and taking practical action to strengthen the systems that support them. By centring lived experience and working together, we can build a future where every young person is supported, empowered, and able to thrive.

Paul Ndhlovu, Communications Associate, former peer provider, Zvandiri and **Bongile Kanganga**, Peer Provider

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Executive Summary

The Urgency and the Opportunity

Eastern and Southern Africa is home to one of the fastest-growing adolescent and youth populations in the world, with the total population projected to reach nearly 1 billion people by 2050. At the same time, the region continues to face high burdens of HIV, early and unintended pregnancy, gender-based violence, and mental health challenges, all compounded by structural poverty including high youth unemployment and strained public services. Critical shortages of trained health workers and rising demand for integrated, youth-responsive services require deliberate investment in the systems and structures that enable peer providers to be integrated, supported, and sustained at scale.

Peer providers are already an integral part of adolescent and youth health and wellbeing programming. Young people are trained and supported to deliver health information, psychosocial support, service navigation, and referrals to services for their adolescent and young peers — extending services into communities and settings where formal health workers have limited reach. Their impact is evident. Realising their full potential now requires moving from project-based approaches to structured, system-integrated models that are safe, well-supported, and sustained over time. This resource addresses that transition, focusing on the systems, workforce conditions, and programmatic structures required for peer provider models to operate with quality, accountability and sustainability within national health systems.

Peer providers are transforming adolescent and youth service delivery.

What the Evidence Shows

This resource synthesizes research from 40 studies, operational experience across 10 countries, and the direct narratives of peer providers. Across these sources, a consistent finding emerges: peer provider models are most impactful when embedded within broader service delivery systems and supported by structured training, supervision, meaningful participation, and clear institutional arrangements, including remuneration. These lessons build on what is already working across the region rather than introducing parallel models. Grounded in experience from Eastern and Southern Africa, these lessons are relevant across diverse settings facing similar health system and workforce pressures.

A Critical Turning Point

Peer service provision has evolved from primarily volunteer-based roles into a structured service delivery model that requires defined roles, competencies, supervision, and accountability. Peer providers now deliver psychosocial support, facilitate access to services, manage referrals across sectors, and contribute to routine programme monitoring and reporting.

From project-based models to system-integrated approaches.

Across the region, however, peer provider models remain uneven in scope, quality, and degree of integration with national systems. Many continue to operate through short-term or parallel arrangements, with limited clarity on standards, career pathways, or long-term financing. Addressing these gaps is the central implementation challenge.

The timing is also critical. Community health workforces across Eastern and Southern Africa are expanding, and countries are investing in primary health care and community-based services. Peer providers represent a growing pool of trained young people with lived experience, community trust, and practical service delivery skills. When deliberately supported, peer providers offer both an adolescent and youth-responsive service delivery solution and a pathway into a sustainable, skilled and localised youth workforce. This shift positions peer providers not only as programme actors, but as part of an emerging workforce within community and primary health care systems.

Strengthening systems that support peer provider programming is therefore both a service delivery and workforce issue, requiring coordinated action across health, education, protection, and youth sectors.

What Requires Deliberate Attention for Quality and Sustainability

Experience from programmes across the region highlights a consistent set of operational conditions that determine whether peer provider models function safely and effectively at scale. These conditions require sustained attention and resourcing, including:

- Clearly defined roles and scopes of practice
- Structured training, supportive supervision, and safeguarding arrangements
- Effective referral pathways and coordination across sectors
- Integration into routine monitoring and reporting systems
- Workforce planning, including fair remuneration, and career pathways aligned with community and primary health workforce policies, cadres, and systems

These elements are foundational to programme quality, safety, continuity, and sustainability.

Quality depends on the systems that support peer providers.

Six Programme Priorities

Synthesising evidence, programme insights, and implementation experience, this resource presents six Programme Priorities that support government efforts to strengthen community and primary health care systems. These priorities need to be intentionally designed, managed and protected as peer provider models are scaled and integrated within national systems. These are not unrealistic ideals — they are operational foundations.

1 Build a skilled, supported, and resilient peer provider workforce

Peer providers are increasingly part of a paid youth health workforce, that contributes to the sustainability and expansion of community health and community health worker systems. Training, supervision, mentorship, and occupational care are core workforce components — supporting quality, sustainability, and progression into future employment and leadership pathways.

2 Design peer-led programmes grounded in theory and global standards

Programmes must be guided by a clear theory of change and aligned with recognised global standards for adolescent-responsive services and meaningful participation. This supports consistency, ethical delivery, accountability, effectiveness, and credible evidence generation as programmes evolve and are delivered at scale.

3 Integrate peer providers within community-based primary health care systems, with fair remuneration and career pathways

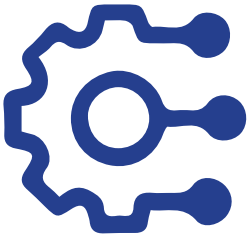
Peer providers are most effective when embedded within government-led PHC systems rather than parallel project structures. Integration strengthens service continuity, clarifies roles and accountability, and supports alignment with national workforce structures. Fair remuneration and visible career pathways within these systems are essential — not optional.

4 Embed meaningful participation of peer providers, adolescents and young people across the programme lifecycle

Peer providers shape programmes most effectively when involved in design, implementation, monitoring, and adaptation — not only delivery. Authentic participation, appropriately resourced and safeguarded, improves programme legitimacy, responsiveness, and sustainability.

5 Deliver multi-sectoral, person-centred support through coordinated referral and case management

Adolescent and youth needs are interconnected across health, nutrition, protection, education, social services and employment. Peer providers must be positioned as navigators within wider service ecosystems — supported by clear referral pathways, case management systems, and active follow-up to reduce fragmentation and loss to care.



6 Leverage digital tools, routine data, and learning to adapt and scale up

Peer provider programmes are more responsive and sustainable when routine data, embedded learning processes, and digital tools inform decision-making. Monitoring should capture the outcomes of peer provider models — including health and well-being outcomes for adolescents and youth, career development for peer providers, system reach, and community-level change.

Moving Forward

Peer providers now play a critical part of service delivery for adolescents and young people across Eastern and Southern Africa. Their impact is established, and their role within community and primary health care systems is expanding. Sustaining and scaling up that impact requires deliberate choices — in policy, financing, and programme design, aligned with government efforts to strengthen community and primary health care systems. Peer provider models must move from ad hoc delivery arrangements towards durable system-embedded services that are safe, accountable, and sustainable.

Investing in peer providers strengthens health systems and young people alike.

Investing in peer providers is both a youth development strategy and a practical, systems-level pathway to expand effective adolescent and youth-responsive services today while building the health workforce of tomorrow. When peer providers are recognised, supported, and embedded within national systems, they strengthen continuity of care, extend the reach of services, and contribute to more responsive and resilient health and social systems.

Table of Contents

Note: Annexes are provided in a separate companion document and include the detailed methodology, outcomes examined in the scoping review and programme data, peer provider programme example overviews, and multi-component programming strategies.

About this Resource

This resource provides practical direction on the design, implementation, integration, and sustainability of peer provider models to improve adolescent and youth health and wellbeing in Eastern and Southern Africa (ESA). It supports the integration of peer providers as an emerging youth health workforce across SRHR, HIV prevention and care, and mental health, while strengthening integrated primary health care (PHC) services at community and facility levels[1–7].

The resource is designed primarily for:

- Government actors responsible for policy development, workforce planning, and service delivery across health, education, youth, and social sectors
- Programme managers and implementers responsible for designing, integrating, and scaling peer provider models within community and PHC systems
- Stakeholders addressing community health workforce gaps, including those working on community health worker (CHW) programmes and workforce development

The resource may also be useful for:

- Donors and development partners seeking to invest in integrated, system-aligned peer provider and community-based service delivery models
- Researchers and evaluators interested in implementation, measurement, and scale
- Youth advocates, peer providers, and youth-led organisations involved in service delivery, programme governance, or workforce development

It brings together evidence from published and programmatic literature, programme experience across ESA, and peer provider perspectives. It focuses on how peer provider models can be designed, integrated within community and primary health care systems, and sustained through effective supervision, financing, monitoring, and career progression.

This document operationalises and complements existing global and regional frameworks, including WHO and UNICEF guidance on adolescent health, PHC, CHW, and adolescent participation[2,4,5,7,8]. It is intended to inform programme design, adaptation, scale-up, and investment decisions, not as a prescriptive model.

Why focus on Eastern and Southern Africa?

ESA has seen sustained investment in HIV, community health, and adolescent programmes, enabling countries to test and scale peer provider models within real service delivery systems. While examples reflect regional experience, the operational principles outlined here are applicable across diverse settings facing similar health systems and workforce pressures.

How to use this resource

This resource supports different entry points depending on your role:

- Policymakers and senior decision-makers: See the Executive Summary, Key Insights, and Programme Priorities to inform policy direction, integration within PHC systems, and investment decisions
- Programme managers and implementers: See the Key Implementation Considerations for practical guidance on designing and strengthening peer provider programmes
- Partners supporting scale and systems integration: Review the Emerging Pathways for Sustainability and Innovations section alongside Programme Priorities to identify opportunities for alignment with national systems and financing mechanisms
- Youth advocates, peer providers, and youth-led organisations: Refer to the Key Implementation Considerations and Meaningful Engagement sections to understand roles, responsibilities, and opportunities for leadership, participation, and career development

Key Concepts and Terminology

- **Adolescents, youth and young people:** – 10-24 year-old people, recognising the developmental importance of adolescence (10-19 years) and youth (15-24 years)[4,5].
- **Adolescent-responsive services:** Rights-based, non-judgmental, and timely interventions tailored to adolescents' autonomy and evolving capacities, particularly within marginalized settings[9].
- **Psychosocial support (PSS):** Interventions addressing interconnected psychological (mental/emotional) and social needs to foster resilience, well-being, and recovery[10–12].
- **Community health worker (CHW):** Local providers with abbreviated healthcare training, who deliver culturally appropriate health services to improve community-level access and equity[13–15].
- **Service delivery:** Organized provision of services through systems (e.g., health systems) by combining inputs (e.g., workforce, training, infrastructure, financing) to make services accessible to people16.
- **Primary healthcare (PHC):** A society-wide approach prioritising integrated primary care and public health, and coordinated multi-sectoral action to improve health and well-being[13,17].
- **Health systems:** Organizations, people, resources, and institutions that work to improve, maintain, and restore health. Effective health systems deliver quality services, establish financing and governance mechanisms, and address social determinants of health[17].
- **Social services:** Services provided by government to improve the social welfare of communities who need them[13].
- **Systems integration:** The strategic coordination of service components to provide a cohesive continuum of services, eliminating fragmented, isolated care or support[18].
- **Meaningful participation & engagement:** Rights-based inclusion where adolescents and stakeholders hold genuine roles in planning, decision-making, and evaluating programs that affect them[13,19].
- **Skills and competencies:** Competencies refer to the combination of knowledge, skills, and attitudes required to perform a role effectively, while skills refer to the abilities an individual can effectively apply in practice20. Both terms are often used interchangeably in programme and curriculum contexts and can include transferrable skills (cognitive and social abilities e.g., empathy, problem-solving) that enable adaptation across life and work contexts and technical skills (job-specific vocational abilities required for defined roles within the workforce)[20].
- **Multi-sectoral programming:** Coordinated action across health, education, social services, and finance to address complex issues that single sectors cannot solve alone[13,21].
- **WHO adolescent well-being framework** consists of five domains, which include[1,21]:
  - Agency: Capacity to make meaningful choices and control one's future.
  - Connectedness: Positive relationships with family, peers, and community.
  - Health: Complete physical, mental, and social well-being.
  - Learning/Skills: Motivation and development of competencies for economic and social engagement.
  - Safety: Protection from physical, emotional, and social harm or violence.

INTRODUCTION

Adolescent and youth health needs in a changing system context

Young people aged 10–24 years represent the fastest growing population group in Eastern and Southern Africa (ESA), with projections suggesting this region will have one of the largest youth populations globally in the coming decades[22,23]. This demographic shift, often described as a youth bulge, is increasing demand for services responsive to young people's evolving health, psychosocial, and social needs[24–27].

ESA continues to experience a high and interconnected burden of HIV, early and unintended pregnancy, gender-based violence, and mental health challenges among adolescents and youth[25, 26, 29]. These are driven by structural inequalities, harmful gender norms, poverty, high youth uemployment and limited access to adolescent-friendly services, further compounded by humanitarian crises and economic constraints[26,28,29].

Health, education, and social systems are operating under growing pressure to deliver integrated, people-centred care with limited and ageing workforces, against a projected shortfall of approximately 6.1 million health workers in the African Region by 2030[26,30]. Within this context, peer provider programmes have emerged as an increasingly important component of adolescent- and youth-responsive service delivery[31–34].

Peer providers within an emerging youth health workforce

Without new delivery models, existing systems are unlikely to keep pace with the scale and complexity of young people's health needs[26,30]. Peer providers are young people trained and supported to deliver health, psychosocial, and navigation services to their peers, contributing to improved outcomes across HIV, sexual and reproductive health (SRH), mental health, and related areas[31–33,37]. Working alongside health and social service professionals, they support demand generation, linkage to care, adherence counselling, psychosocial support, community-based monitoring, and cross-sector referral [38–40].

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***Peer providers** are young people trained and supported to deliver health, psychosocial, and navigation services to their peers*

Peer provider models align with broader workforce and employment priorities across the region. By offering structured roles that build practical skills, work experience, and professional networks, these programmes support learning-to-earning pathways and long-term livelihoods across community health, social services, education, and related sectors [34,41,42].

Why peer-led approaches strengthen adolescent-responsive service delivery

Adolescence is a period of rapid biological, cognitive, and social development during which peer relationships strongly influence behaviours and decision-making[43–47]. Evidence from developmental, behavioural, and public health research indicates that adolescents are more likely to engage with information and support delivered by peers who share similar lived experiences and social contexts[43,46–48]. This trust and credibility, often difficult for formal health workers to replicate, make peer providers effective in addressing sensitive issues in non-judgmental, accessible ways.

From innovation to system-aligned peer provider models

Peer provider models in ESA have evolved over the past two decades, from peer education to multifaceted, integrated roles within health systems, including facilitating referrals and linkages across multi-sectoral support services. This evolution reflects the growing recognition of their value and the increasing demand for adolescent-centred models at scale[38,39,49–59]. Governments and partners now support diverse peer provider models—such as Community Adolescent Treatment Supporters, Young Mentor Mothers, peer navigators, and digitally enabled peer support—adapted to national priorities and service delivery contexts[38,60–62].

Expansion has been uneven, with models varying in scope, quality, supervision, compensation, and degree of integration within national systems[63,64]. In many settings, peer providers still operate through project-based arrangements, with limited clarity on standards, career pathways, or long-term financing[65,66]. Addressing these gaps requires stronger alignment with community health systems already institutionalised within national frameworks and budgets[65,66].

These considerations draw on evidence, programme experience across ESA, and peer providers' perspectives to outline key implementation considerations for strengthening the quality and impact of peer provision. It also supports integration of peer providers within community and primary health systems, while contributing to the development of a younger, more responsive health workforce.[1,2,5,40].

APPROACH

This resource was developed using a practical, evidence-informed, multi-method approach, integrates research evidence, programme experience, and the perspectives of peer providers, recognising that effective implementation depends on all three.

Three complementary sources of evidence informed this resource:

1. Comprehensive scoping review of recent scientific literature on peer provider models, reported outcomes, and implementation features associated with effectiveness;[67]

2. Insights from active peer-led programmes across ESA on how models are designed and delivered in real-world settings, including training, supervision, and referral systems; and

3. Narratives from young peer providers, documenting perceived impact on their own development and on the adolescents and youth they support.

The methodology applied the WHO adolescent well-being conceptual framework, recognising the diversity and multidimensional nature of young people's lives[6,68,25]. The evidence base includes 40 peer-reviewed studies and programme data from 10 countries in ESA, alongside qualitative inputs from programmers and peer providers. Figure 1 summarises the approach and sampling across all three sources.

This work was co-led by the University of Cape Town research team and UNICEF with oversight from a multidisciplinary steering group of 15 members including technical representatives from country and regional levels, peer providers, and early-career researchers. Consultations were conducted between April 2024 and September 2025. The steering group contributed to the conceptual framework, search terms, data extraction tools, and reviews of this document.

Further details regarding the study design and search strategy are provided in companion annex document, Annex 1.

Three methods to gather scientific, programmatic evidence and lived experiences:

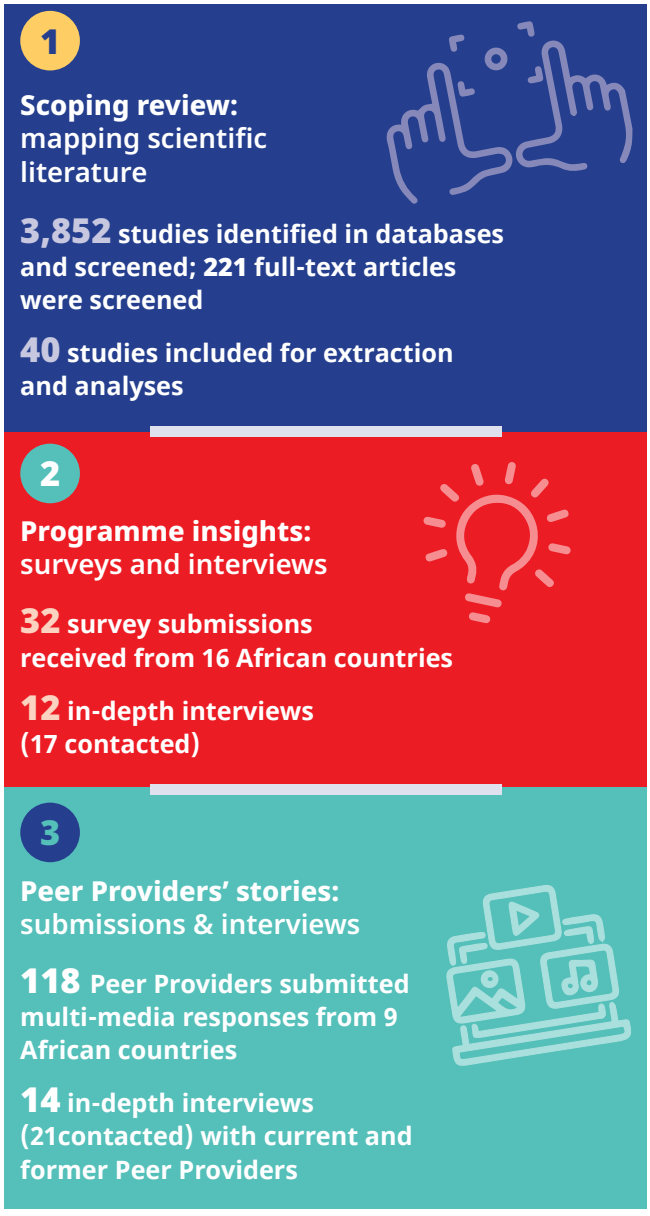

FIGURE 1.
Approach and sampling for the multi-method study

EVIDENCE-INFORMED INSIGHTS ON PEER PROVIDER PROGRAMMING

This section synthesises findings from the scoping review, programme data, and peer provider interviews to describe the current landscape of peer provider models for adolescent and youth health and well-being in ESA. It focuses on who peer providers are, what they do, and the conditions under which these models function effectively in real service delivery systems.

Peer providers for adolescent and youth health and well-being: who they are and what they do

Peer providers are typically community members aged 18-35 with local cultural and language fluency and education ranging from secondary school to vocational training. Their roles transcend information sharing to include psychosocial support, service navigation, data monitoring, and social role modelling. They act as agents of change and mentors, and leverage their lived experience, such as their health and parenthood status, to establish unique credibility and trust with peers in similar circumstances.

Peer providers are well positioned to address sensitive issues such as HIV, sexual and reproductive health, mental health, and gender-based violence in ways that are perceived as credible, relevant, and non-judgmental[31–37]. Across diverse programme settings in ESA, peer provider-led approaches have been associated with improved service uptake, retention in care, adherence to treatment, and psychosocial outcomes, particularly when embedded within broader systems of referral, supervision, and professional support[38,39,49–55].

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Who peer providers are and what they do

- Young people from the communities they serve, with relevant education and language skills
- Provide psychosocial support, health information, service navigation, referrals, and basic monitoring
- Draw on lived experience to build trust and sustained engagement
- Act as intermediaries between adolescents and formal health and social services
- Contribute to outcomes in HIV, SRHR, and mental health through relational support and strengthened decision-making
- Most effective when embedded within broader health and community systems.

The review of 40 peer provider models shows multi-domain impact across the WHO adolescent well-being framework, with most programmes designed to address more than one outcome. The most common combination targeted were good health, safety and supportive environment, and agency and resilience. The strongest evidence exists for HIV, family planning, and mental health, with improvements in SRH-related self-efficacy. Interventions that combine demand generation, referrals, and mentorship build agency and resilience. Crucially, findings indicate that peer providers are most effective when integrated into broader service delivery ecosystems and aligned with WHO quality standards, rather than acting as standalone interventions. Further detail on the outcomes reviewed is provided in Annex 2 of the companion annex document.

Outcome evidence summary

- **Strongest evidence - HIV outcomes, SRH, adherence, service uptake**
- **Promising evidence - mental health, self-efficacy, norms change**
- **Emerging evidence- connectedness, agency, long-term economic outcomes**

Contextual and programmatic enablers of peer provider programmes

All three data sources identified key contextual and programmatic enablers that support the effective functioning of peer provider models: conditions that shape how peer providers are positioned, supported, and able to operate in practice.

1) **Systems integration: Embedding peer providers to maximise reach and quality of services.** Peer provider models function most effectively when they are embedded in existing community and facility health services. Often, peer providers were recruited by and working alongside trained professionals such as healthcare workers, social workers, educators, counsellors, and midwives. These relationships range from formal, integrated systems to informal or unacknowledged linkages, shaping how much peer providers can influence service quality and continuity. Where integration is intentional, peer providers' support service delivery across HIV, mental health, and SRH, - acts as a bridge between adolescents and formal services. Programmes that explicitly mapped, managed, and maintained referral pathways, demonstrate stronger adolescent-responsiveness by reducing fragmentation and support continuity of care.

2) **Adolescent-responsive services: Peer providers facilitating age and developmentally tailored services.** Programmes consistently demonstrated a commitment to person-centred adolescent-responsive approaches that reflect adolescents' developmental stages, lived realities, and social contexts. Recruiting peer providers from intervention communities is needed to ground interventions content and approaches within cultural relevance and to make contextual adaptations. Peer providers' roles frequently extended beyond information provision to address mental health needs, build life skills, and facilitate access to education, protection and economic strengthening through coordinated referrals. These approaches recognise that multi-dimensional adolescents' health outcomes are shaped by broader social and structural factors.

3) **Addressing stigma and social norms: Peer providers as advocates for positive norms change.** Peer providers are often positioned as credible agents of norms change within their communities. Programmes documented their engagement with community members, leaders, and caregivers to build community support and acceptability, and to address stigma related to HIV, SRH, mental health, and adolescent pregnancy. Through these efforts, peer providers challenge harmful social norms and create more enabling environments for adolescents and young people to seek care and support.

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Common elements of successful peer provider programmes

These elements[1] describe the actions peer providers undertake and the mechanisms through which programmes seek to influence adolescent health and well-being. Unlike enablers, these elements reflect mechanisms through which change is generated in practice.

1. **Adolescent and youth participation in programme design, implementation, and measurement enhances programme relevance and effectiveness.** Many studies documenting positive effects described the involvement of adolescents and young people in programme design, implementation, and measurement. While the degree of meaningful participation varied and could not be assessed, these processes were associated with improved relevance and acceptability of interventions.

2. **Participatory delivery of health education and psychosocial support using structured guidance creates productive group and individual dynamics.** In several studies, peer providers were trained to deliver participatory psychosocial support using manuals and curricula. Participatory approaches—such as facilitated discussions, role-play, and guided reflection assisted young people in overcoming stigma and isolation, strengthen problem-solving skills around relationships and reinforce positive health behaviours across group-based and individual engagement.

3. **Peer provider-led referrals and linkages connect adolescent and youth to health professionals and social services.** A central function across many models was the facilitation of referrals and linkages to health and social services. Peer providers facilitated connections to HIV testing, voluntary male medical circumcision, family planning, STI testing, adolescent-friendly clinics, and youth centres. These linkages helped overcome barriers to access and facilitated more positive interactions with healthcare workers, while also supporting service tailoring. While referral systems to mental health services were common, programmes faced challenges related to service availability and quality, cost and stigma, highlighting ongoing system capacity gaps beyond the control of peer providers.

4. **Multi-component programming combining behavioural, biomedical, structural, and systems-strengthening strategies addresses multiple dimensions of adolescent and youth health and wellbeing**. Programmes commonly integrated peer provider activities across multiple domains. Behavioural interventions included structured participatory curricula, sometimes

complemented with sports based, embodiment activities or digital engagement. Biomedical services were facilitated through demand generation and service navigation Structurally, peer providers worked to reduce HIV-related and intersectional stigma, and some promoted economic strengthening and social inclusion interventions. Peer providers trained in mental health could administer screening tools and undertake group therapy interventions or refer to mental health professionals. Through these activities, peer providers contributed to community health systems strengthening through documentation, monitoring, reporting, and bridging clinical and community-based services. Further detail on multi-component programming strategies is provided in Annex 3 of the companion annex document.

5. **On-the-job skill development, supervision, and recognition builds peer provider capacity, career pathways and programme quality.** Peer providers demonstrated significant growth in skills, including communication, psycho-social counselling, and advocacy supported by on-the-job professional development and supervision approaches, i.e. shadowing and co-facilitation with experienced professionals. These arrangements enhanced programme quality while supporting career pathways for the peer providers. However, persistent gap in the formal recognition and remuneration remains a key barrier to legitimising their roles and ensuring the sustainability of their participation and impact.

What defines effective peer provider models

- **Peer providers function as system navigators and connectors, not just educators.**
- **Impact depends less on peer age and more on integration, training, supervision, and referral practices.**
- **Programmes succeed when they address multiple domains of adolescent well-being simultaneously.**
- **Peer providers are most effective when positioned as credible actors within community and facility systems, not volunteers working in parallel to healthcare providers.**
- **The sustainability of peer models hinges on recognition, compensation, supervision, and transition pathways.**

The twelve programmes in Figure 2 are drawn from the scoping review and programme insights. Reflecting the diversity of peer provider models across ESA, varying by target population, delivery platform, peer provider profile, and degree of system integration, they are referenced as illustrative examples throughout this guide rather than an exhaustive list. Fuller profiles including system integration, outcomes, and evidence base are in Annex 4 of the companion document.

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FIGURE 2. **Programme example gallery**

Zvandiri
15 countries across ESA

Peer provider: Young people living with HIV trained as Community Adolescent Treatment Supporters (18–24 yrs)

Peer providers are embedded within national HIV plans, supervised by government health workers, and financed through government systems — a model of full system integration supporting adherence, retention, and differentiated care at scale.

Sauti ya Vijana
Tanzania

Peer provider: Peer group leaders living with HIV, recommended by clinic (23–29 yrs)

Structured two-week training, weekly supervised practice, and youth advisory boards give peer providers a defined role in both service delivery and programme direction, with a clear transition pathway on graduation.

IMPAACT
Botswana, South Africa, Zimbabwe, Malawi

Peer provider: Youth peer mentors living with HIV (23–29 yrs).

Adolescents and young people are involved in programme design from the outset and contribute to ongoing direction through periodic check-ins — embedding meaningful participation as a core feature of the model.

Tiko
Burkina Faso, Nigeria, Ethiopia, Kenya, Uganda, South Africa

Peer provider: Young peer mobilisers and connectors (18–26 yrs)

End-to-end tracking via the Tiko app, performance-based incentives, and co-financing partnerships with Ministries of Health combine to create a girl-centred SRHR ecosystem that is digitally enabled and embedded in government systems.

Jik'izinto
South Africa

Peer provider: Out-of-school and tertiary adolescent girls using tech and media as peer engagement tools (18–24 yrs)

Chatbots and TV drama reach young women outside formal health settings — a digitally native model that builds SRHR knowledge, addresses misinformation, and supports mental health coping without requiring physical service access.

MTV Shuga
South Africa, Nigeria, Kenya

Peer provider: Young facilitators linked to media content (18–30 yrs)

Relatable storytelling through the MTV Shuga series creates an entry point for peer-facilitated dialogue — positioning young facilitators as community change-makers who translate media content into conversation and referral.

Grassroot Soccer
Sub-Saharan Africa (global)

Peer provider: Young coaches delivering sport-based health and life skills (18–35 yrs)

The 3Cs model — Curriculum, Community-based Coaches, and positive youth Culture — links sport-based SKILLZ sessions to youth-friendly services, with coaches accredited as Community-based Distributors through government partnerships.

Waves for Change
South Africa

Peer provider: Young coaches delivering surf-based wellbeing support (18–24 yrs)

A structured 10-month surf therapy programme with aftercare, operating from beach hubs close to under-served communities — using sport as a sustained therapeutic relationship rather than a single-session engagement.

Tackle Africa
Zambia, Burkina Faso, Côte d'Ivoire, Benin, Senegal, Kenya, Uganda

Peer provider: Football coaches trained as peer providers (18–22 yrs)

A standardised 5-step football methodology delivers SRHR and gender content across highly varied country contexts — geographic flexibility built around a common participant group and consistent approach to at-risk focus.

loveLife
South Africa

Peer provider: Young community-based peer motivators and groundbreakers (18–30 yrs)

A one-clinic one-school strategy links groundbreakers recruited from within clinical catchments to a wide stakeholder network — driving demand for SRHR and clinical services while screening for SGBV, mental health, TB, and STIs within the same touchpoint.

DECIDE
Uganda

Peer provider: Peer providers trained in inclusive facilitation and sign language

Trusted peers from the same communities are embedded in formal district systems — combining inclusive outreach across youth, disability, and male engagement with accountability roles in technical working groups and community-led monitoring.

Help Lesotho
Lesotho

Peer provider: Young Mother Mentors elected from young mother groups (15–24 yrs).

Groups self-elect their own leaders and self-facilitate sessions around self-identified priorities — extending across health, education, parenting, food security, and livelihoods, integrated with nutrition clubs and village health workers.

Platform: Community · Facility · School · Digital · Mobile · Social enterprise · Sport · Media

KEY IMPLEMENTATION CONSIDERATIONS

This section outlines core implementation considerations for designing, integrating, and sustaining peer provider models within health service systems. These considerations provide practical guidance on recruiting, supporting, and embedding peer providers to strengthen service quality, youth engagement, and system performance.

1. Recruitment and Compensation

Key Messages

- **Recruit peer providers based on age proximity, community trust, and lived experience**
- **Transparent and inclusive criteria strengthen equity and relevance**
- **Fair, predictable compensation sustains motivation and continuity**
- **Recruitment can serve as an entry point into future employment and career pathways in the health system and beyond**

Recruitment and compensation strategies shape the credibility, continuity, and sustainability of peer-led services. Intentionally selecting young people with relevant lived experience from their communities builds trust and meaningful engagement. Fair, predictable compensation affirms the legitimacy of peer provider roles, supports retention, and creates entry points into the broader health workforce.

Approaches

Effective recruitment relies on standardized, transparent, context-appropriate criteria that support credibility with young people, service providers, and community stakeholders. Prioritising lived experience, communication skills, motivation, and familiarity with local service environments strengthens relevance and trust.

Programme managers often work with local stakeholders, such as schools, health facilities, youth organisations, and community leaders, to identify trusted candidates and strengthen community trust. Recruitment approaches that intentionally seek diversity backgrounds enhance equity and relevance. Planning for turnover, age transitions, and time-bound roles is strengthened when programmes maintain a pipeline of trained peer providers. At a systems level, recruitment approaches are more sustainable when aligned with national community health strategies and reflected in policy frameworks. This includes expanding age eligibility and establishing clear entry pathways for younger community health workers, to strengthen integration within the broader health workforce.

Compensation structures play a central role in motivation, retention, and programme sustainability. Remuneration that is fair, predictable, and align with time commitments, transport costs, and emotional labour helps maintain continuity, particularly when these costs are built into programme budgets rather than managed informally.

In Practice – Strengthen Recruitment and Compensation

Programmes typically strengthen recruitment and compensation when they:

- Use transparent selection criteria developed with community input
- Plan recruitment cycles that anticipate age transitions and turnover and support integration with the younger community health workforce
- Budget for stipends, transport, and communication costs from programme inception
- Communicate clearly what compensation covers and does not cover

Peer Providers' narratives: South Africa

> *Peer providers need to be paid. It's ethical and meaningful to compensate them for the hard work they do. You can't expect someone to walk miles in the sun to bring a young person back to treatment and not pay them. Would you want your child to do that without support? Passion is great, but it doesn't put food on the table.*

(Female, former peer provider)

Programme examples – Recruitment and training grounded in lived experience and inclusion

Across contexts, programmes highlight the importance of recruitment and training approaches that recognise lived experience, diversity, and inclusion, shaping relevance, safety, and ethical practice.

- Help Lesotho works with community leadership, government, and civil society to support young mothers' groups, which elect their own peer leaders (Young Mother Mentors). This community-anchored approach strengthens legitimacy, trust, and ownership from the outset.
- DECIDE applies an inclusive training approach that equips peer providers with communication skills, including sign language, alongside financial literacy, entrepreneurship, and problem-solving. Multimodal tools such as video and digital storytelling support engagement across literacy levels and languages.
- MTV Shuga implements trauma-informed, experiential training approaches that enable peer providers to engage with sensitive content as participants, supported by structured reflection and safeguarding.

Peer Provider Profile

George Mfanando | 28
Tanzania | Former Peer Provider

George, who lives openly with HIV, became a peer provider after witnessing his peers struggle with mental health challenges, stigma, and limited access to SRH information. He now facilitates sessions for adolescents living with HIV, provides counselling and life skills guidance, and co-leads a peer mental health initiative offering young people a safe, nonjudgmental space.

> *"Nothing for us without us — young people must shape the services meant for them."*

Read George's full story here.

2. Training

Key Messages

- **Training is competency-based, practice-oriented, and continuous**
- **Standardised curricula and certification strengthen quality and scale**
- **System-facing skills (referrals, safeguarding, data) and competencies supports integrated, multisectoral service systems**
- **Well-trained peer providers are more trusted, confident, and effective**

Competency-based training equips peer providers to deliver services safely, ethically, and effectively within defined scopes of practice. It combines technical knowledge relevant to programme roles with transferable skills such as communication, problem-solving, and basic digital and referral competencies that support service delivery and system integration. Standardised curricula and certification strengthen quality assurance and sustainability, helping peer providers function as confident and credible members of primary health and community service systems. Training functions as a continuous process that evolves alongside peer providers' roles and is reinforced through supervision and mentorship (See section 3. & 6.).

Approaches

Effective training is evidence-informed, trauma-aware, and adapted to local context, supported by standardised curricula, manuals, and job aids that promote consistency. Practice-based learning approaches—such as role-plays, simulations, teach-backs, and observed assessments—help ensure readiness for real-world interactions. Competency-based training typically includes clear standards, observed assessments, and certification thresholds to support quality assurance and scalability[38–40].

Ongoing assessment throughout training helps identify skill gaps, monitor knowledge retention, and inform continuous improvement within defined scopes of practice[38–40]. These approaches also prepare peer providers to contribute to broader community health activities and align with evolving community health worker roles and integrated service delivery models.

To support integration within health systems, training includes system-facing competencies such as referral and service navigation, communication across cadres, recognising cases requiring escalation, safeguarding, ethical data handling, and use of digital tools. Strong facilitation and public communication skills further strengthens engagement with individuals, groups, and communities. Training is most effective under ongoing supervision and mentorship to sustain quality and responsiveness to evolving roles and system needs (See section 3. & 6.).

Peer Providers' narratives: South Africa

I have gained a lot of skills in the journey of peer mentorship. I have gained skills in capacity building, advocacy, interpersonal skills, leadership skills, empathy and compassion, problem solving skills, and critical thinking.

(Female, 22 yrs, current peer provider)

Peer Provider Profile

Bongile Kanganga, 22
Zambia | Current Peer Provider

Bongile describes himself as a "sparkplug" and "catalyst for change" who uses advanced communication skills and deep self-awareness to deliver health services and guide adolescents through life's challenges. He believes peer providing is a "gift and a calling" that allows him to help young people recognise their own strengths.

I'm a sparkplug, igniting minds—a catalyst for change, one conversation at a time.

In Practice - Strengthen Training

Programmes typically strengthen training when they:

- Develop or adapt standardised curricula aligned with defined competencies and scopes of practice
- Combine classroom learning with structured role-plays, simulations, and observed practice before independent service delivery
- Conduct pre- and post-training assessments to identify skill gaps and guide refresher sessions
- Provide job aids and quick-reference tools to reinforce learning in service settings
- Schedule periodic refresher training linked to supervision findings and evolving programme needs
- Include modules on safeguarding, referral navigation, ethical data handling, and escalation of complex cases
- Provide certificates or documentation that recognise skills gained through training and support progression toward national accreditation pathways

3. Supervision

Key Messages

- Supervision strengthens quality, safeguarding, and peer provider well-being
- Supportive, coaching-based supervision reinforces learning and professional accountability
- Structured supervision helps reduce burnout and sustain engagement
- Tiered supervision models support leadership development and long-term sustainability

Supervision is a structured, ongoing process that supports peer providers to deliver safe, effective, and accountable services within community and PHC systems. It combines coaching, mentoring, reflective practice, and performance support to reinforce quality and professional accountability. Effective supervision strengthens competencies, builds professional confidence, and helps peer providers navigate complex psychosocial issues. It also plays a critical duty-of-care and safeguarding role by creating structured space to reflect on emotional burden, identify distress early, and guide appropriate escalation. When integrated within routine PHC and community health team structures, supervision strengthens coordination, service continuity, and reinforces supervision as a core system function.

Approaches

Supervision combines regular, non-judgmental feedback with clearly defined supervisory roles, reinforcing competency-based practice and consistent guidance. Supportive supervision approaches emphasise coaching, reflective learning, and problem-solving to help identify skill gaps and guide ongoing development.

Supervision models that incorporate structured reflection and debriefing support well-being and help reduce emotional fatigue and burnout. These may include peer support groups, facilitated reflection sessions, or access to mental health support, particularly for peer providers working with complex or traumatic cases. Tiered supervision structures can further strengthen sustainability and leadership development by enabling experienced peer providers to take on mentoring or coordination roles.

Positioning peer providers within existing PHC and community health team structures aligns supervision with routine workflows and referral pathways. This integration strengthens coordination between facility- and community-based services and reinforces supervision as a core system function.

In Practice - Strengthen Supervision

Programmes typically strengthen supervision when they:

- **Define clear supervisory roles, responsibilities, and reporting lines from the outset**
- **Schedule regular structured supervision sessions (e.g., monthly) that combine case review, coaching, and well-being check-ins**
- **Integrate structured reflection or debriefing spaces, particularly for peer providers working with sensitive or traumatic cases**
- **Train supervisors in coaching and supportive feedback approaches rather than inspection-based monitoring**
- **Establish safeguarding and escalation pathways and ensure peer providers know when and how to seek supervisory support**
- **Link supervision findings to refresher training and programme adaptation**
- **Embed supervision within existing PHC or community health structures to prevent parallel systems**

Peer providers' narratives: South Africa

> *Supervisors should check in monthly to ensure peer providers are supported. Rejection from participants can be tough, and we need guidance to navigate these challenges.*

(Female, 24 yrs old, current peer provider)

Programme examples - Supervision, safeguarding, and quality assurance in peer-led models

Several programmes demonstrate how structured supervision and safeguarding systems support quality, trust, and sustained peer provider engagement:

- Sauti ya Vijana transitioned from externally supported supervision to locally led supervision conducted in Swahili, strengthening cultural relevance, trust, and sustainability while maintaining quality and safeguarding.
- Waves for Change peer providers are supported through monthly clinical case reviews, weekly skills practice ("teach-backs"), and live feedback from supervisors. Strong safeguarding policies underpin this supervision model.
- Zvandiri peer providers use simple digital platforms to support supervision, reminders, and routine communication with clinic staff, complementing in-person engagement.

Peer Provider Profile

Joseph Moyo, 29
Zimbabwe | Former Peer Provider; now a Programme Associate

Joseph began as a support group member before becoming a Community Adolescent Treatment Supporter, driven by witnessing a close friend face HIV stigma, and built his skills through home visits, counselling, and clinic support. With mentorship and fair remuneration, he completed his tertiary studies, transitioned into a Programme Associate role, and now supervises peer providers to strengthen community-based HIV services.

> *I gained information that I am proud to share with other young people so that they can survive and thrive.*

Read Joseph's full story here.

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4. Multi-Sectoral Programme Strategies

Key Messages

- Adolescent needs are multi-dimensional and require coordinated, person-centred responses across sectors
- Peer providers function as navigators who connect young people to services across systems
- Active referral and follow-up strengthen continuity of care and reduce fragmentation
- Strengthening social networks and supportive norms reinforces sustained behaviour change

Multi-sectoral strategies position peer providers as system navigators who identify needs, facilitate referrals, and link adolescents to coordinated services across sectors such as health, mental health, education, and social protection. Rather than delivering isolated interventions, these models strengthen integrated primary health care responses that address interconnected drivers of adolescent health and well-being.

Adolescent needs are often shaped by social, economic, and protection-related factors that cannot be addressed through single interventions alone. Through structured referral, follow-up, and linkage, peer providers help young people overcome barriers such as stigma, limited information, and complex service pathways, strengthening service utilisation and continuity of care across systems.

Approaches

Effective multi-sectoral strategies position peer providers as system navigators across health and non-health services. Their roles include identifying needs beyond immediate concerns, mapping appropriate services, facilitating referrals, and following up to support continuity of care.

These approaches rely on clearly defined referral pathways, shared accountability, and feedback mechanisms between sectors that reduce loss to follow-up. Active referral practices such as accompaniment, coordination with service providers, and follow-up—help address barriers related to system complexity, stigma, and fear of discrimination. Supporting peer providers to recognise safeguarding and protection "red flags" and guide appropriate escalation further strengthens safety and coordination across services.

Multi-sectoral impact is reinforced through engagement with caregivers, communities, and service providers across sectors. By facilitating dialogue, supporting community awareness activities, and working with local leaders to address harmful social norms, peer providers help create enabling environments for sustained behaviour change. Positioning peer providers within broader service networks strengthens continuity and coordination across systems.

Peer providers' narratives: Zimbabwe

> *I can be a voice to the voiceless, I got to strengthen my own voice...adolescents can be able to be given their differentiated care services. As adolescent we are not a homogenous group, we have different needs...*

(Female, former peer provider)

In Practice - Strengthen Multi-sectoral Strategies

Programmes typically strengthen multi-sectoral strategies when they:

- **Map available health, protection, education, and social services before rollout and update referral directories**
- **Establish clear referral pathways with named focal points and defined escalation processes**
- **Formalise feedback loops so peer providers are informed when referrals are completed or require follow-up**
- **Track referral completion and follow-up rates to identify bottlenecks or service gaps**
- **Clarify peer provider scope to focus on navigation, accompaniment, and follow-up**
- **Engage caregivers, community leaders, and service providers to reinforce supportive norms and reduce stigma.**

5. Meaningful Engagement

Key Messages

- Adolescents and young people have a right to participate in decisions affecting their health and well-being
- Meaningful engagement goes beyond consultation to shared decision-making, influence, and accountability
- Embedding peer providers in governance and learning structures strengthens ownership and responsiveness
- Authentic engagement supports sustainability by ensuring services reflect young peoples lived realities

Meaningful engagement refers to the intentional inclusion of adolescents and youth as active participants in decisions that affect their health and well-being. In peer provider models, this goes beyond consultation to shared decision-making across

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programme design, implementation, monitoring, and learning. This approach upholds the right to participation while enabling genuine influence and accountability in decision-making.

Meaningful engagement strengthens programme ownership, responsiveness, and sustainability by ensuring services reflect young people's lived realities rather than adult assumptions. When participation is appropriately resourced and recognised, it supports sustained engagement and equips peer providers with advocacy skills that enable meaningful participation in community and national decision-making processes.

Approaches

Meaningful engagement is strengthened when peer provider models are designed around partnerships between adults and adolescents, with clear roles, shared accountability, and appropriate safeguarding. Creating structured and supportive spaces enables young people—including those from marginalised groups—to participate meaningfully in programme decision-making and learning processes. Clear feedback loops and safeguarding mechanisms help ensure participation is safe, ethical, and influential [38–40,70].

Effective approaches embed adolescents and young people within governance and learning structures, including participation in programme planning, adaptation, monitoring and evaluation, and learning activities, as well as engagement in policy dialogue where appropriate. Sustained involvement—rather than one-off consultation—builds continuity, trust, and programme responsiveness.

Meaningful engagement is further reinforced when programmes invest in ongoing mentorship and leadership development and support adult stakeholders to shift from gatekeeping roles toward facilitation. Ensuring diverse representation across gender, age, disability, geography, and other vulnerability dimensions strengthens equity, confidence, and responsible participation.

Peer providers' narratives: Zimbabwe

> *"Through advocacy I got to be interested more in data management, like how many adolescents out there are receiving treatment, how many adolescents out there are having a full package of the services they want and analyze all these perspectives..."*

(Female, former peer provider)

In Practice - Strengthen Meaningful Engagement

Programmes typically strengthen meaningful engagement when they:

- **Define clear decision-making roles for adolescents and peer providers within governance structures, ensuring diverse representation**
- **Establish regular feedback forums where young people's inputs are documented and acted upon**
- **Allocate resources (time, compensation, transport, mentorship) to support safe and sustained participation**
- **Provide leadership and facilitation training to peer providers engaged in governance roles**
- **Orient adult stakeholders to facilitative, non-gatekeeping approaches**
- **Integrate safeguarding and accountability mechanisms to ensure participation is ethical and meaningful**

Peer Provider Profile

Milicent, 33
South Africa | Former Peer Provider; now Executive Director

Milicent began as a peer provider supporting young people living with HIV through community engagement, advocacy, and linkage to care, where programme training and mentorship shaped her leadership skills. She now serves as an Executive Director, continuing to advocate for the health and rights of young people.

> *"Peer provider programmes can create leadership pathways when training, mentorship, and opportunities for engagement are sustained."*

6. Mentorship

Key Messages

- Mentorship focuses on growth, transition, and future pathways
- Distinct from supervision, it supports reflection and goal setting
- Cohort and individual mentorship approaches are complementary
- Mentorship benefits both peer providers and programme sustainability

Mentorship refers to structured guidance that focuses on the personal and professional growth of peer providers over time. Distinct from supervision, which focuses on performance and quality assurance,

mentorship supports reflection, goal setting, and preparation for future roles beyond the peer provider position Where programmes offer defined career pathways, such as progression into supervisory, coordination, or advisory roles, mentorship can actively support navigation of those trajectories. It recognises peer providers as young people in a formative life stage, balancing service delivery responsibilities with their own development and transition needs.

Well-designed mentorship enables peer provider roles to function as developmental opportunities that build skills, confidence, and readiness for readiness for defined career pathways within and beyond the programme. By supporting structured reflection and transition planning, mentorship helps translate peer provider experience into transferable skills and contributes to workforce development while strengthening programme quality and sustainability.

Approaches

Mentorship is strengthened when programmes combine cohort-based and individualised support. Cohort-based mentorship creates shared spaces for reflection, peer learning, and mutual support, while individual mentorship provides tailored guidance aligned to each peer provider's goals and development needs. These approaches support both collective learning and personalised transition planning.

Mentorship is further strengthened when it includes structured reflection and deliberate support for career exploration and transition, helping peer providers prepare for progression into education, employment, or leadership roles, such as leadership development, interview preparation, CV-building, and financial literacy. Linking mentorship to regular check-ins, goal reviews, or documented learning helps consolidate skills, support decision-making, and sustain programme learning across cohorts.

Clear mentor roles and appropriate support arrangements are also important for effective mentorship. When mentors are clearly identified, trained, and supported—with defined expectations, safeguarding considerations, and referral options, emotional support needs can be recognised and addressed appropriately.

In Practice - Strengthen Mentorship

Programmes typically strengthen mentorship when they:

- **Clearly distinguish mentorship from supervision in role descriptions and scheduling**
- **Assign named mentors with defined expectations and time allocations**
- **Combine cohort-based peer reflection spaces with individual goal-setting sessions**
- **Integrate career exploration, CV-building, and transition planning into mentorship**
- **Provide mentors with training in facilitation, safeguarding, and boundary-setting**
- **Document mentorship goals and learning to inform programme improvement and workforce transition planning**

In practice – Career pathways

Programmes typically strengthen career pathways for peer providers when they:

- **Provide recognised certification or documentation so skills gained through peer provider roles are formally recognised[71]**
- **Create progression opportunities such as senior peer provider, mentor, or supervisor roles within programmes[71]**
- **Recognise peer provider experience as relevant work experience within health and community systems[71]**
- **Link peer providers to further education, internships, or employment opportunities, including within the health workforce and other relevant sectors[20]**
- **Include 21st-century skills development such as communication, leadership, digital literacy, financial literacy and entrepreneurship[20]**
- **Partner with government, training institutions, private sector or civil society organisations to support transitions into employment[20,71].**

Peer providers' narratives: Zimbabwe

> *Beginning my journey as a peer provider I was someone who was eager to support other peers...I became more of someone who is a researcher. I enrolled for a degree.*

(Male, Current peer provider)

Programme examples - Workforce development, transitions, and livelihood pathways

Peer provider programmes increasingly illustrate how their roles can function as time-bound entry points into broader workforce and livelihood trajectories.

- Sauti ya Vijana peer providers receive individualised mentorship focused on career planning, financial literacy, and future pathways, supported by additional funding for education and skills development.
- Grassroot Soccer, Waves for Change, and Tackle Africa all integrate accredited coaching training and embodiment-based activities, with several programmes tracking transitions into education, employment, or supervisory roles after peer providers age out. Zvandiri peer providers are enrolled in a national diploma programme, ensuring accredited qualifications, professionalisation and career pathways within the national health system.
- Tiko embeds micro-entrepreneurial elements into peer-led adolescent SRH delivery, linking service provision with exposure to income-generating pathways.

Peer Provider Profile

Kundai Manyika, 31
Zimbabwe |
Former Community-Based Peer Provider; now National SRHR Advisor

Kundai began as a peer provider delivering HIV prevention and SRH outreach in marginalised communities, where training and mentorship built the skills and confidence that launched her career. She now works in a national advisory role with civil society organisations to strengthen SRH, mental health, and psychosocial support programmes for young people.

> *Peer provider programmes can create pathways from community outreach to policy engagement when training, mentorship, and system support are in place.*

Read Kundai's full story here.

7. Systems Integration

Key Messages

- Integration embeds peer providers within routine government service delivery systems
- Clear roles, supervision, and accountability prevent parallel structures
- Alignment with policy, financing, and data systems enables scale
- Peer providers contribute to routine data systems, ensuring their role and impact are visible within national reporting
- Integrated models strengthen youth responsiveness and system resilience

Systems integration ensures peer provider roles are embedded within existing government-led and community PHC systems rather than functioning as parallel, time-limited projects. By aligning roles, supervision, and data flows with existing service structures, peer providers operate as a distinct but complementary cadre alongside CHWs. This integration fosters government ownership and sustainability beyond individual funding cycles. When peer providers are part of routine, multidisciplinary teams, they enhance the reach and responsiveness of PHC, driving consistent, youth-responsive services at scale. Ultimately, this model reinforces existing systems while building an emerging youth health workforce equipped to address the holistic needs of adolescents.

Approaches

Effective systems integration requires clear role definition, supervision, and accountability. Peer provider roles operate most effectively when their scope of practice is explicitly defined, including responsibilities for connecting adolescents to multi-sectoral services and clear boundaries for referral to trained professionals.

Integration operates through alignment with existing government structures. Pairing peer providers with CHWs or facility-based staff and supervising them through established public-sector systems strengthens coherence, legitimacy, and continuity, while reducing reliance on parallel NGO management arrangements.

Carefully mapped and actively managed referral pathways link peer providers to existing accountability mechanisms and service networks, improving collaboration, risk management, and service quality.

In Practice - Strengthening Systems

Programmes typically strengthen systems integration when they:

- **Define peer provider scopes of practice in alignment with national CHW or PHC strategies**
- **Formalise supervisory reporting lines within existing government structures**
- **Ensure peer provider activities are captured within routine reporting systems, using existing indicators where possible.**
- **Cost peer provider roles within programme and government budgets rather than relying on short-term stipends**
- **Establish clear referral and accountability mechanisms linking peer providers to facility- and community-based teams**
- **Engage ministries and sub-national actors early to support progressive institutionalisation**

Systems integration is shaped by enabling policy, financing, and data environments. Formal recognition of peer provider roles within national or sub-national strategies and service delivery frameworks supports scale and consistency. Financing approaches that move beyond ad hoc stipends toward predictable remuneration–reflected in costed programme plans–strengthen motivation and continuity. Ensuring peer providers contribute to routine national information systems improves visibility of their contributions and reduces duplication. In many settings, parallel reporting processes obscure the role peer providers play in influencing service uptake and outcomes.

Programme examples - Embedding peer providers within systems and service pathways

Several programmes illustrate how peer provider models are embedded within existing health, social service, and governance systems, strengthening continuity, accountability, and sustainability.

- **Zvandiri recruits Community Adolescent Treatment Supporters (CATS) in partnership with health facility staff, ensuring peer providers are trusted, clinically aligned, and integrated into service delivery teams. Peer providers are supervised by primary healthcare workers, ensuring quality case management including screening, follow-up, referrals, and continuity of care in clinics, community and digital platforms.**
- **Waves for Change operates a bi-directional referral system linking peer providers with departments of health and social development, schools, and specialised mental health services. Peer providers are embedded within clinically led supervision and case management structures, reinforcing safeguarding and quality.**
- **DECIDE peer providers participate alongside programme staff in government Technical Working Groups, contributing to costed implementation plans and strengthening accountability through participatory monitoring and youth engagement.**

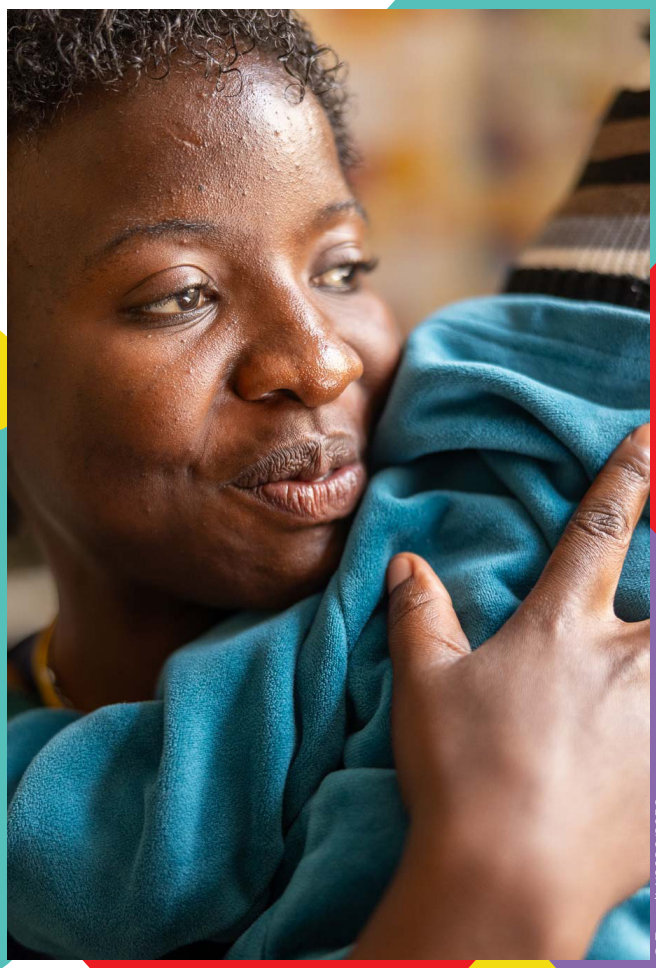
Peer Provider Profile

Karabo Mogoba, 24
South Africa | Clinic-based Mentor Mother

Karabo became a peer provider as a young mother lacking confidence and had limited knowledge of antenatal care, and has since grown into a supervisory role supporting other peer providers in the clinic. She now helps adolescents and young mothers living with HIV navigate care, maintain treatment adherence, and stay engaged in services.

> *"I learned how to monitor viral loads, the stages of pregnancy, and PCR testing."*

Read Karabo's full story here.



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PROGRAMME PRIORITIES

The Programme Priorities synthesise evidence and implementation experience to support decision-making in contexts of limited resources and evolving constraints. While the Implementation Considerations provide practical guidance on how to design and deliver peer provider programmes, the Programme Priorities identify the conditions that require deliberate protection and investment to sustain quality, equity, and long-term effectiveness.

Recognising that implementation is phased and context-specific, these six priorities highlight the areas that country teams and partners should safeguard when designing, adapting, or scaling peer provider programmes. They signal what must remain consistently resourced and maintained if peer provider models are to remain credible, safe, and sustainable over time.

Programme Priority 1

Build a skilled, supported, and resilient peer provider workforce

What capabilities and support are required for peer providers to deliver services safely, effectively, and sustainably over time?

Peer providers are increasingly positioned as an emerging paid youth workforce rather than volunteers. This section focuses on the capabilities, support, and well-being measures required for safe and effective service delivery. Training, supervision, mentorship, and occupational care function as core workforce components. When in place, these core components support programme quality and sustainability, and youth workforce progression into future education, employment, entrepreneurship, or leadership.

What implementing this priority requires

- Competency frameworks that encompass technical and life skills, psychosocial competencies, and professional or work-readiness capabilities
- Regular supervision that prioritises learning, service quality, safeguarding, and ethical practice
- Access to mentorship and developmental support, including structured linkages with experienced CHW or other professionals
- Training and supervision approaches that are gender-transformative, age-sensitive, and trauma-informed
- Mechanisms to support peer provider well-being, including psychosocial support, debriefing, and access to safe spaces or care
- Opportunities for formal recognition and progression into education, employment, entrepreneurship, or leadership pathways
- Appropriate use of digital tools to strengthen training, supervision, communication, and peer learning

Minimum implementation of this priority

In constrained resource settings, programmes ensure that peer providers have clearly defined capabilities, access to regular supervision, and basic psychosocial support, recognising these as foundational to safety, quality, and sustainability.

Programme Priority 2

Design peer-led programmes grounded in theory and global standards

What defines quality, accountability, and learning across diverse peer provider programmes?

Peer provider programmes are strengthened when guided by a clear theory of change and informed by recognised global standards for adolescent-responsive systems and meaningful participation. Grounding programmes in theory and standards supports consistency, ethical delivery, and accountability while enabling learning, adaptation, and credible evidence generation as programmes evolve or scale.

What implementing this priority requires

- A clearly articulated theory of change that explains how peer provider activities are expected to contribute to individual, service, and system-level outcomes
- Alignment of programme design and delivery with recognised global standards for adolescent-responsive services, participation, and safeguarding
- Mechanisms to support contextual adaptation of programme design while maintaining alignment with core principles and standards
- Alignment between the theory of change, logic models, supervision priorities and monitoring frameworks
- Use of routine data and learning processes to test assumptions, refine delivery, and strengthen quality and accountability

Minimum implementation of this priority

Across all contexts, programmes clearly explain how and why peer provider activities are expected to lead to outcomes, and use this logic to guide supervision, adaptation, and learning.

Programme Priority 3

Integrate peer providers within community-based primary health care systems, with fair remuneration and career pathways

Where do peer providers sit within the health system, and how are their roles institutionally anchored over time?

Peer providers are most sustainable and effective when integrated within existing community and PHC systems rather than operating in parallel structures. Integration clarifies roles, builds accountability, strengthens referral systems, and supports service continuity. Fair and transparent remuneration, alongside visible career and transition pathways, reinforces peer provider roles as a legitimate entry point into the youth health workforce and contributes to longer-term system sustainability.

What implementing this priority requires

- Government-led alignment of peer provider roles with national CHW strategies, PHC priorities, and adolescent-responsive service frameworks including eligibility criteria that enable inclusion of younger community health workers
- Clearly defined and differentiated scopes of work and referral relationships between peer providers, CHW, and facility-based teams, and alignment with evolving community health workforce structures
- Early and ongoing engagement with ministries and sub-national actors to support progressive institutionalisation government ownership, and reduced reliance on parallel delivery models.
- Institutional mechanisms for recruitment, onboarding, supervision, and accountability that are consistent with broader health system practices
- Fair, transparent, and predictable remuneration arrangements that reflect workload, responsibilities, and work-related costs
- Visible career and transition pathways, including progression into paid roles, education, internships, or leadership
- Strategic partnerships, including with private sector actors and social enterprises, to support sustainable financing and workforce transition pathways

Minimum implementation of this priority

Across contexts, peer provider roles are aligned with existing PHC workforce structures and referral systems, even where formal policy integration or workforce absorption is still evolving.

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Programme Priority 4

Embed meaningful participation of peer providers and adolescents across the programme lifecycle

Who holds power, voice, and decision-making authority within peer provider programmes?

Peer providers are most effective when they meaningfully shape programmes rather than only delivering or engaging with services within them. Embedding participation across design, implementation, monitoring, and adaptation strengthens programme legitimacy, responsiveness, and accountability. When participation is intentional, equitable, and resourced, it reinforces adolescent rights and ensures programmes remain grounded in lived realities.

What implementing this priority requires

- Clear and transparent mechanisms for peer provider and adolescent participation in governance, advisory, and decision-making processes
- Attention to power-sharing, including how adolescent and peer inputs influence programme priorities, design choices, and adaptations
- Regular and structured feedback loops from adolescents that inform programme adaptation and learning
- Participatory monitoring, evaluation, and learning approaches that centre adolescent perspectives and experiences
- Deliberate strategies to include adolescents who are often marginalised or excluded, including by age, gender, disability, geography, or social status
- Adequate resourcing for participation, recognising the time, skills, and care required for meaningful engagement

Minimum implementation of this priority

Across contexts, peer providers and adolescents have structured opportunities to provide feedback and input that influence programme decisions and adaptations.

Programme Priority 5

Deliver multi-sectoral, person-centred support through coordinated referral and case management

How are complex and intersecting adolescent needs addressed end-to-end across sectors?

Peer provider models function effectively within a wider ecosystem spanning health, education, nutrition, protection, and social services. Coordinated referral and case management enable adolescents with complex needs to access person-centred support across sectors.

Clear role definition and strong coordination allow peer providers to support continuity of care without overextending their responsibilities.

What implementing this priority requires

- Clear and functional referral pathways linking health, education, protection, and social services
- Defined case management or coordination mechanisms for adolescents with complex needs
- Explicit role clarity for peer providers, including escalation pathways and referral responsibilities
- Systems to support referral follow-up and continuity of care, including when services are delivered by external actors
- Flexible delivery platforms that facilitate access and continuity across facility-based, community-based, and digital services
- Attention to the full range of adolescent needs, including psychosocial well-being, protection, and social support, through coordinated multi-sectoral responses
- Support, including psychosocial services, for peer providers to ensure that complex cases are manageable and vicarious trauma is addressed

Minimum implementation of this priority

Across contexts, programmes enable peer providers to navigate, initiate, and follow up referrals so that adolescents with complex needs can access coordinated support across services.

Programme Priority 6

Leverage digital tools, routine data, and learning to adapt and scale

How do peer provider programmes learn, adapt, and demonstrate value over time?

Peer provider programmes are more responsive, scalable, and sustainable when routine data, digital tools, and embedded learning processes inform decision-making. Using data and digital platforms as practical enablers supports quality improvement, adaptation, and alignment with national systems. Engagement with digital and analytical tools both requires and strengthens transferable competencies, including basic digital literacy relevant to wider youth health workforce pathways. Routine monitoring should capture broadly —across adolescents, peer providers, health systems, and communities—to strengthen learning, advocacy, and financing.

What implementing this priority requires

- Simple routine data systems that prioritise learning and decision-making over reporting burden, and capture outcomes for adolescents reached, peer provider development, and service reach
- Monitoring and learning tools that are co-designed with peer providers to ensure usability and relevance
- Regular feedback loops that enable data to inform programme adaptation, supervision, and quality improvement
- Embedded implementation learning processes during pilot phases, expansion, and scale-up
- Progressive alignment of monitoring and information systems with national health platforms where feasible
- Appropriate use of digital tools to support service delivery, follow-up, supervision, reporting, and peer learning
- Exploration of partnerships and financing approaches, including with social enterprises to support digital innovation, sustainability, and youth workforce pathways

Minimum implementation of this priority

Across contexts, data generated through peer provider programmes are routinely reviewed and used to inform programme decisions and adaptations, not only to meet reporting requirements.

EMERGING PATHWAYS FOR SUSTAINABILITY AND INNOVATIONS

As peer provider models mature and integrate into national health systems, attention is shifting to how they can be sustained and scaled within constrained financing environments. Long-term impact depends not only on implementation quality, but on hoe peer provider roles align with workforce capacity, learning systems, and financing realities. The section highlights emerging practice shaping how peer provider models adapt and remain viable as implementation experience continue to evolve.

Institutional anchoring and system fit

Peer provider models are increasingly positioned within wider PHC, community health, and youth workforce agendas as countries expand and renew community health workforces. Sustainability depends on how these roles align with institutional arrangements, including policy frameworks, supervision structures, financing mechanisms, and information systems.

Where peer provider models remain project-based, continuity and ownership are often fragile. By contrast, alignment with service delivery, accountability, and reporting frameworks strengthens visibility, legitimacy, and integration. System fit depends less on formal absorption and more on incremental alignment with how systems function in practice. For example, when peer providers are recognised within facility workflows, included in supervision and reporting processes, and linked to existing referral and accountability mechanisms, system integration can progress even where employment or financing arrangements remain transitional.

In practice - Aligning peer providers within community health systems

Several system entry points can support alignment of peer provider roles with community health workforce development:

- **Embed peer provider roles in national community health strategies, particularly during strategy development, review, and evaluation processes**
- **Integrate youth participation and peer provider representation within community health governance structures, such as health centre or community health committees and their terms of reference**
- **Include youth peer cadres in community health worker mapping and registry systems to strengthen visibility, coordination, and workforce planning**
- **Recognise peer provider experience within community health workforce career pathways, supporting progression and workforce development**
- **Position peer provider roles within health system planning and financing processes, including national budget planning, workforce investment strategies, and mechanisms such as the Global Fund**

Workforce continuity and system capacity

Peer provider roles are widely understood as time-bound and shaped by young people's life stage. As programmes mature and cohorts turn over, sustainability depends on what capacity remains within systems once peer providers exit their roles. Workforce continuity depends not only on recruitment and training, but on whether investments translate into retained skills, institutional memory, and strengthened service delivery.

In contexts with ageing community health workforces and limited employment opportunities for young people, peer provider models are increasingly viewed as structured entry points into broader community and PHC workforce pipelines rather than short-term jobs. How transitions are managed affects motivation, continuity, and the long-term value of peer-based approaches for both systems and young people

Entrepreneurship and livelihood-linked pathways

Some programmes are exploring entrepreneurship and livelihood-linked approaches as part of peer provider models. Emerging models focus on transferable skills such as communication, digital engagement, community mobilisation, and financial literacy, while linking peer providers to livelihood opportunities beyond the health system through mentorship and developmental support. These may include employment opportunities within community health services, youth employment initiatives, social enterprise programmes, or other community-based work.

Career guidance and mentorship remain central to these pathways, helping peer providers translate their experience into longer-term employment or education opportunities. These approaches are not a substitute fair remuneration but to support transition, skill portability, and economic resilience. Early experience suggests potential benefits for motivation and transition, while continued learning is needed to understand when and how these models strengthen sustainability.

Programme examples - Entrepreneurship and livelihood-linked peer models

Across the region, programmes are integrating entrepreneurship and livelihood approaches into peer provider models to support workforce transitions.

- **Entrepreneurship-linked peer delivery pilots in Kenya have linked peer delivery for substance use and SRH interventions with entrepreneurship skill development, enabling peer providers to build competencies in organisation, communication, and community outreach alongside service delivery.**
- **Tiko's peer provider models incorporate micro-entrepreneurial elements, embedding income-generating pathways into programme design while maintaining a focus on adolescent SRH service delivery.**
- **Zvandiri's peer providers are connected with vocational skills training, micro-finance and economic strengthening opportunities, supporting both immediate and longer-term income-generating pathways.**

These examples illustrate social enterprise-linked approaches connecting peer provider roles to income-generating pathways alongside service delivery.

From service delivery to monitoring, adaptation and learning systems

Routine monitoring, digital tools, and implementation learning are increasingly recognised as central to programme adaptation and resilience. Peer provider models generate multiple impacts that should be reflected in how programmes measure and use data, including outcomes for adolescents, workforce development, service reach, and community engagement.

Capturing this range of impact strengthens learning, policy dialogue, and decisions about scale. Programmes are exploring pragmatic ways to generate timely, disaggregated insights while keeping data systems proportionate and feasible. Digital platforms are being used to support outreach, supervision, peer support, and feedback loops with adolescents, while complementing in-person engagement. At the same time, digital access, data protection, and safeguarding considerations continue to shape how learning systems are implemented equitably.

Programme examples - Digital approaches supporting service delivery and supervision

Digital tools are increasingly used to complement — not replace — in-person peer provider engagement, helping programmes extend reach, strengthen supervision, and maintain continuity of support, particularly where infrastructure is limited or disruptions affect service delivery.

Several programmes demonstrate how digital approaches are being integrated into routine service delivery and supervision.

- **ELIMIKA uses a web-based platform that enables peer providers to engage young people through live chats, moderated forums, and digital learning tools. This flexible outreach model generates real-time data to inform programme improvement and reach young people who may not access services in person.**
- **Insaka's peer mentors use mobile group chats to facilitate peer support groups and receive ongoing guidance from supervisors, strengthening supervision and continuity of support in settings with limited formal infrastructure.**
- **Zvandiri's peer providers use an integrated package of digital tools for case management, service and referral tracking, supervision, and AI-supported coaching to strengthen counselling competencies and quality of care.**

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Digital approaches can expand access, but equity and safety considerations remain central. Connectivity gaps, digital literacy, and privacy and safeguarding risks require strong human oversight and ethical design.

Financing environments under constraint

Peer provider programmes are operating in constrained funding environments, increasing attention to financing sustainability. Programmes are engaging more deliberately with costing, cost-effectiveness, and alternative financing approaches, including blended and results-linked models. Limited cost visibility can constrain policy dialogue and domestic financing processes, while donor-dependent models remain vulnerable to funding volatility. Although financing innovations remain context-specific, they reflect efforts to diversify financing sources and align peer provider models with broader fiscal realities and youth employment priorities.

Programme examples - Costing, financing, and economic approaches for sustainability

Across the region, programmes are testing a range of financing approaches to support the longer-term sustainability of peer provider models, including results-linked financing, blended financing arrangements, and social enterprise-linked pathways.

- Shamiri, a school-based intervention delivered by trained adolescent and youth providers estimated a total cost of approximately USD 15 per student. Excluding fixed infrastructure costs created a more pragmatic basis for scale-up discussions and supported sustainability planning and policy dialogue.
- Zvandiri's cost-effectiveness analyses of the CATS model have informed national dialogue on the value of peer-led HIV services, alongside domestic resource mobilisation efforts, including tax-linked revenue mechanisms. The model demonstrated how blended financing approaches combining donor and domestic financing can support scale the model within national programmes.
- Tiko's outcomes-linked financing mechanisms, including an Adolescent SRH Development Impact Bond, have been applied to support peer-led adolescent SRH services. In this model, funding is provided upfront and repayment is linked to the achievement of agreed results, helping align financing with performance while strengthening accountability and sustainability.

In practice - Designing sustainability pathways from the start

These emerging workforce and system pathways are already shaping programme design in many settings and have immediate implications for how programmes are planned and resourced today. Programmes are stronger when they:

- Anchor peer providers within systems early, even where formal integration is still evolving
- Plan transitions from the outset, documenting skills and creating progression opportunities before cohorts exit
- Align monitoring and costing with decision-making, so programmes can demonstrate value and sustainability
- Sequence livelihood or entrepreneurship components carefully to support not replace fair remuneration and service delivery

Sustaining peer provider models requires more than funding or scale. It depends on deliberate alignment between institutional arrangements, workforce pathways, learning systems, digital capability, and financing environments. Sustainability will be shaped not by a single solution, but by how intentionally these elements are designed to reinforce one another.

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CONCLUSION

The Eastern and Southern Africa region is entering a decisive period for adolescent and youth health and well-being. Rapid demographic growth, persistent inequities, constrained public financing, and ageing health workforces are placing increasing pressure on systems to adapt. At the same time, peer provider models are already operating at scale, demonstrating their ability to extend reach, build trust, and improve engagement and outcomes for adolescents and young people often underserved by conventional services.

Peer providers are no longer an experimental or auxiliary approach. They represent an established delivery model whose impact will depend on how deliberately they are integrated within government-led PHC and community systems, and how intentionally the needs of a younger workforce are addressed. Integration is most effective when accompanied by investment in training, supervision, duty of care, and clear progression pathways. This resource builds on extensive regional experience and seeks to strengthen what is already working – improving quality, coherence, and system alignment rather than introducing parallel models or starting anew.

The six Programme Priorities in this resource clarify what must be intentionally designed and protected as peer provider programmes scale and interact more closely with public systems. They reinforce that quality, workforce support, and meaningful participation are as critical to sustainability as policy alignment and financing.

The opportunity now is to move from incremental adoption to intentional system design. Investing in peer providers as a system-aligned and developmentally supported workforce offers a practical pathway to expand adolescent-responsive services today, while contributing to workforce renewal and stronger community trust over time. The choices made now — in policy, financing, and programme design — will determine whether peer providers can fulfil their potential as a safe, effective, and sustainable force for adolescent and youth health in the years ahead.

REFERENCES

1. Ross, D. A., Hinton, R., Melles-Brewer, M., Engel, D., Zeck, W., Fagan, L., Herat, J., Phaladi, G., Imbago-Jácome, D., Anyona, P., Sanchez, A., Damji, N., Terki, F., Baltag, V., Patton, G., Silverman, A., Fogstad, H., Banerjee, A., & Mohan, A. (2020). Adolescent Well-Being: A Definition and Conceptual Framework. The Journal of adolescent health: official publication of the Society for Adolescent Medicine, 67(4), 472–476. https://doi.org/10.1016/j.jadohealth.2020.06.042
2. WHO. (2017). Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation.
3. UNICEF. (2020). ENGAGED AND HEARD. Guidelines on Adolescent Participation and Civic Engagement.
4. UNFPA. (2017). Technical Guidance for Prioritizing Adolescent Health. www.everywomaneverychild.org/
5. World Health Organization. (2015). Global Standards for Quality Health-Care Services for adolescents Volume 1: Standards and criteria A guide to implement a standards driven approach to improve the quality of health care services for adolescents.
6. World Health Organization. (2021). HIV Prevention, Testing, Treatment, Service delivery and Monitoring. http://apps.who.int/bookorders.
7. World Health Organization. (2019). Adolescents-friendly health services for adolescents living with HIV: from theory to practice technical brief peer driven adolescent HIV model of care. http://apps.who.int/bookorders.
8. UNICEF. (2021). Scaling up HIV treatment, Care and Support for adolescents living with HIV in Eastern and Southern Africa: Findings and key considerations from a regional review. Retrieved July 15, 2025, from https://www.who.int/news-room/fact-sheets/detail/adolescents-
9. World Health Organization. (2019). Strengthening adolescent-responsive health systems. https://www.who.int/activities/strengthening-adolescent-responsive-health-systems
10. UNICEF. (2019). UNICEF-MH-and-PS-Technical-Note-2019. https://www.unicef.org/media/73726/file/UNICEF-MH-and-PS-Technical-Note-2019.pdf.pdf
11. UNICEF and WHO. 2024. Integration of Mental Health and Psychosocial Support in Primary Health Care. Regional report.
12. Inter-Agency Standing Committee. (2007). Iasc Guidelines on Mental Health and Psychosocial support in Emergency settings. Retrieved March 23, 2026, from https://interagencystandingcommittee.org/sites/default/files/migrated/2014-11/Guidelines%20IASC%20Mental%20Health%20Psychosocial%20%28with%20index%29.pdf
13. World Health Organization. (2020). Operational framework for primary health care Transforming vision into action.
14. Assegaai, T., Schneider, H., & Scott, V. (2021). Developing a district level supportive supervision framework for community health workers through co-production in South Africa. BMC health services research, 21(1), 337. https://doi.org/10.1186/s12913-021-06350-2
15. WHO. (2018). WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes. Geneva: World Health Organization. 4, Objectives and scope of the guideline. Available from: https://www.ncbi.nlm.nih.gov/books/NBK533330/
16. Nolte E, Karanikolos M, Rechel B. Service delivery. In: Papanicolas I, Rajan D, Karanikolos M, et al., editors. Health system performance assessment: A framework for policy analysis [Internet]. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2022. (Health Policy Series, No. 57.) Chapter 7. Available from: https://www.ncbi.nlm.nih.gov/books/NBK590196/
17. World Health Organization. (2019). World Health Organization Health Systems Strengthening.
18. World Health Organization. (2008). INTEGRATED HEALTH SERVICES-WHAT AND WHY? Making health systems work.
19. UNICEF. (2024). Meaningful Youth Engagement in the Multilateral System. https://www.unicef.org/innocenti/media/9701/file/UNICEF-Innocenti-Meaningful-Youth-Engagement-2024.pdf
20. UNICEF. (2019). Global framework on transferable skills. Retrieved March 23, 2026, from https://www.unicef.org/reports/global-framework-transferable-skills
21. UN Major Group for Children and Youth. (2020). Adolescent Well-being Framework: Virtual Youth Consultation Report.
22. UNICEF. (2024). Child population demographics, shifts and trends in Eastern and Southern Africa | UNICEF Eastern and Southern Africa. Retrieved September 28, 2025, from https://www.unicef.org/esa/stories/child-population-demographics-shifts-and-trends-eastern-and-southern-africa

23. Home Page | Data Portal. Retrieved March 4, 2026, from https://population.un.org/dataportal/home?df=0896fbaf-7ee5-4bed-ba8d-f775232d9cda

24. Sheehan, P., Sweeny, K., Rasmussen, B., Wils, A., Friedman, H. S., Mahon, J., Patton, G. C., Sawyer, S. M., Howard, E., Symons, J., Stenberg, K., Chalasani, S., Maharaj, N., Reavley, N., Shi, H., Fridman, M., Welsh, A., Nsofor, E., & Laski, L. (2017). Building the foundations for sustainable development: a case for global investment in the capabilities of adolescents. The Lancet, 390(10104), 1792–1806. https://doi.org/10.1016/S0140-6736(17)30872-3

25. World Health Organization. (2022). PMNCH annual report: strengthening voice and accountability for women's, children's and adolescents' health and well-being. WHO. Retrieved June 18, 2025, from https://iris.who.int/handle/10665/372249

26. Hanefeld, J., Mayhew, S., Legido-Quigley, H., Martineau, F., Karanikolos, M., Blanchet, K., Liverani, M., Yei Mokuwa, E., McKay, G., & Balabanova, D. (2018). Towards an understanding of resilience: responding to health systems shocks. Health policy and planning, 33(3), 355–367. https://doi.org/10.1093/heapol/czx183

27. Baird, S., Choonara, S., Azzopardi, P. S., Banati, P., Bessant, J., Biermann, O., Capon, A., Claeson, M., Collins, P. Y., De Wet-Billings, N., Dogra, S., Dong, Y., Francis, K. L., Gebrekristos, L. T., Groves, A. K., Hay, S. I., Imbago-Jácome, D., Jenkins, A. P., Kabiru, C. W., Kennedy, E. C., Viner, R. M. (2025). A call to action: the second Lancet Commission on adolescent health and wellbeing. Lancet (London, England), 405(10493), 1945–2022. https://doi.org/10.1016/S0140-6736(25)00503-3

28. Cooper, D., De Lannoy, A., & Rule, C. (2015, November). Youth and well-being: why it matters. Children's Institute, University of Cape Town. https://www.academia.edu/18150526/Youth_and_well_being_why_it_matters

29. Ross, D. A., Mshana, G., & Guthold, R. (2021). Adolescent Health Series: The health of adolescents in sub-Saharan Africa: Challenges and opportunities. Tropical medicine & international health: TM & IH, 26(11), 1326–1332. https://doi.org/10.1111/tmi.13655

30. Okoroafor, S. C., & Christmals, C. D. (2023). Task Shifting and Task Sharing Implementation in Africa: A Scoping Review on Rationale and Scope. Healthcare (Basel, Switzerland), 11(8), 1200. https://doi.org/10.3390/healthcare11081200

31. Somefun, O. D., Casale, M., Haupt Ronnie, G., Desmond, C., Cluver, L., & Sherr, L. (2021). Decade of research into the acceptability of interventions aimed at improving adolescent and youth health and social outcomes in Africa: a systematic review and evidence map. BMJ open, 11(12), e055160. https://doi.org/10.1136/bmjopen-2021-055160

32. Bailey, K., Allemang, B., Vandermorris, A., Munce, S., Cleverley, K., Chisholm, C., Cohen, E., Davidson, C., El Galad, A., Leibovich, D., Lowthian, T., Pillainayagam, J., Ramesh, H., Samson, A., Senthilnathan, V., Siska, P., Snider, M., & Toulany, A. (2024). Benefits, barriers and recommendations for youth engagement in health research: combining evidence-based and youth perspectives. Research involvement and engagement, 10(1), 92. https://doi.org/10.1186/s40900-024-00607-w

33. Asuquo, S. E., Tahlil, K. M., Muessig, K. E., Conserve, D. F., Igbokwe, M. A., Chima, K. P., Nwanunu, E. C., Elijah, L. P., Day, S., Rosenberg, N. E., Ong, J. J., Nkengasong, S., Tang, W., Obiezu-Umeh, C., Nwaozuru, U., Merino, Y., Gbaja-Biamila, T., Oladele, D., Iwelunmor, J., Ezechi, O., ... Tucker, J. D. (2021). Youth engagement in HIV prevention intervention research in sub-Saharan Africa: a scoping review. Journal of the International AIDS Society, 24(2), e25666. https://doi.org/10.1002/jia2.25666

34. Obiezu-Umeh, C., Nwaozuru, U., Mason, S., Gbaja-Biamila, T., Oladele, D., Ezechi, O., & Iwelunmor, J. (2021). Implementation Strategies to Enhance Youth-Friendly Sexual and Reproductive Health Services in Sub-Saharan Africa: A Systematic Review. Frontiers in reproductive health, 3, 684081. https://doi.org/10.3389/frph.2021.684081

35. World Health Organization. (2023). Health Workforce statistics database. World Health Organization, Geneva. https://www.who.int/data/gho/data/themes/topics/health-workforce

36. McKinsey. (2024). Sub-Saharan Africa's healthcare worker shortage | Retrieved May 26, 2025, https://www.mckinsey.com/industries/social-sector/our-insights/overcoming-sub-saharan-africas-health-workforce-paradox

37. Mason-Jones, A. J., Freeman, M., Lorenc, T., Rawal, T., Bassi, S., & Arora, M. (2023). Can Peer-based Interventions Improve Adolescent Sexual and Reproductive Health Outcomes? An Overview of Reviews. The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 73(6), 975–982. https://doi.org/10.1016/j.jadohealth.2023.05.035

38. Willis, N., Milanzi, A., Mawodzeke, M., Dziwa, C., Armstrong, A., Yekeye, I., Mtshali, P., & James, V. (2019). Effectiveness of community adolescent treatment supporters (CATS) interventions in improving linkage and retention in care, adherence to ART and psychosocial well-being: a randomised trial among adolescents living with HIV in rural Zimbabwe. BMC public health, 19(1), 117. https://doi.org/10.1186/s12889-019-6447-4

39. Atujuna, M., Simpson, N., Ngobeni, M., Monese, T., Giovenco, D., Pike, C., Figerova, Z., Visser, M., Biriotti, M., Kydd, A., & Bekker, L. G. (2021). Khuluma: Using Participatory, Peer-Led and Digital Methods to Deliver Psychosocial Support to Young People Living With HIV in South Africa. Frontiers in reproductive health, 3, 687677. https://doi.org/10.3389/frph.2021.687677

40. UNICEF Eastern and Southern Africa. (2021). HIV TREATMENT, CARE, AND SUPPORT FOR ADOLESCENTS LIVING WITH HIV IN EASTERN AND SOUTHERN AFRICA A review of interventions for scale.

41. Lee, L., Upadhya, K. K., Matson, P. A., Adger, H., & Trent, M. E. (2016). The status of adolescent medicine: building a global adolescent workforce. International journal of adolescent medicine and health, 28(3), 233–243. https://doi.org/10.1515/ijamh-2016-5003

42. Ssewamala F. M. (2015). Optimizing the 'demographic dividend' in young developing countries: The role of contractual savings and insurance for financing education. International journal of social welfare, 24(3), 248–262. https://doi.org/10.1111/ijsw.12131

43. Blakemore, S. J., & Mills, K. L. (2014). Is adolescence a sensitive period for sociocultural processing? Annual Review of Psychology, 65(Volume 65, 2014), 187–207. https://doi.org/10.1146/annurev-psych-010213-115202

44. Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. The Lancet Child & Adolescent Health, 2(3), 223–228. https://doi.org/10.1016/S2352-4642(18)30022-1

45. Casey, B., Jones, R. M., & Somerville, L. H. (2011). Braking and Accelerating of the Adolescent Brain. Journal of research on adolescence : the official journal of the Society for Research on Adolescence, 21(1), 21–33. https://doi.org/10.1111/j.1532-7795.2010.00712.x

46. Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. Developmental Review, 28(1), 78–106. https://doi.org/10.1016/J.DR.2007.08.002

47. 47. Crone, E. A., & Dahl, R. E. (2012). Understanding adolescence as a period of social-affective engagement and goal flexibility. Nature Reviews Neuroscience, 13(9), 636–650. https://doi.org/10.1038/NRN3313

48. Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afi fi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K., … Ferguson, J. (2016). Our future: a Lancet commission on adolescent health and wellbeing The Lancet Commissions Executive summary. The Lancet, 387, 2423–2478. https://doi.org/10.1016/S0140-6736(16)00579-1

49. Ndhlovu, C. E., Kouamou, V., Dougherty, L., Willis, N., Ojikutu, B. O., & Tariro Makadzange, A. (2021). The transient effect of a peer support intervention to improve adherence among adolescents and young adults failing antiretroviral therapy in Harare, Zimbabwe: a randomized control trial. AIDS Res Ther, 18, 32. https://doi.org/10.1186/s12981-021-00356-w

50. Timol, F., Yacoob Vawda, M., Bhana, A., Moolman, B., Makoae, M., & Swartz, S. (2016). Addressing adolescents' risk and protective factors related to risky behaviours: Findings from a school-based peer-education evaluation in the Western Cape. https://doi.org/10.1080/17290376.2016.1241188

51. Hosaka, K. R. J., Mmbaga, B. T., Gallis, J. A., & Dow, D. E. (2021). Feasibility and acceptability of a peer youth led curriculum to improve HIV knowledge in Northern Tanzania: resilience and intervention experience from the perspective of peer leaders. https://doi.org/10.1186/s12889-021-11876-5

52. Dow, D. E., Mmbaga, B. T., Turner, E. L., Gallis, J. A., Tabb, Z. J., Cunningham, C. K., & O'donnell, K. E. (2019). AIDS Care Psychological and Socio-medical Aspects of AIDS/HIV Building resilience: a mental health intervention for Tanzanian youth living with HIV. https://doi.org/10.1080/09540121.2018.1527008

53. Simms, V., Weiss, H. A., Chinoda, S., Mutsinze, A., Bernays, S., Verhey, R., Wogrin, C., Apollo, T., Mugurungi, O., Sithole, D., Chibanda, D., & Willis, N. (2022). Peer-led counselling with problem discussion therapy for adolescents living with HIV in Zimbabwe: A cluster-randomised trial. PLOS Medicine, 19(1), e1003887. https://doi.org/10.1371/JOURNAL.PMED.1003887

54. Kangwana, B., Mutahi, J., & Kumar, M. (2024). Experiences of integrating a psychological intervention into a youth-led empowerment program targeting out-of-school adolescents, in urban informal settlements in Kenya: A qualitative study. PLOS ONE, 19(4), e0300463. https://doi.org/10.1371/JOURNAL.PONE.0300463

55. Kose, J., Howard, T., Lenz, C., Masaba, R., Akuno, J., Woelk, G., Fraaij, P. L., & Rakhmanina, N. (2024). Experiences of adolescents and youth with HIV testing and linkage to care through the Red Carpet Program (RCP) in Kenya. PLOS ONE, 19(1), e0296786. https://doi.org/10.1371/JOURNAL.PONE.0296786

56. Kågesten, A., Parekh, J., Tunçalp, Ö., Turke, S., & Blum, R. W. (2014). Comprehensive adolescent health programs that include sexual and reproductive health services: A systematic review. American Journal of Public Health, 104(12), e23–e36. https://doi.org/10.2105/AJPH.2014.302246

57. Jaguga, F., Kwobah, E. K., Giusto, A., Apondi, E., Barasa, J., Korir, M., Rono, W., Kosgei, G., Puffer, E., & Ott, M. (2023). Feasibility and acceptability of a peer provider delivered substance use screening and brief intervention program for youth in Kenya. BMC public health, 23(1), 2254. https://doi.org/10.1186/s12889-023-17146-w

58. Zvandiri. (2025). A systems-strengthening: Scaling Zvandiri to support all children, adolescents and young adults living with HIV to survive and thrive framework.

59. Gittings, L., Price, Y., Kelly, J., Kannemeyer, N., Thomas, A., Medley, S., Ralayo, N., Omollo, V., Cluver, L., Logie, C. H., Evalia, H., & Toska, E. (2022). Health and development-related priorities and challenges of adolescents and young people: findings from South Africa and Kenya prior to and during COVID-19 pandemic. Psychology, health & medicine, 27(sup1), 193–218. https://doi.org/10.1080/13548506.2022.2108084

60. Willis, N., Napei, T., Armstrong, A., Jackson, H., Apollo, T., Mushavi, A., Ncube, G., & Cowan, F. M. (2018). Zvandiri—Bringing a Differentiated Service Delivery Program to Scale for Children, Adolescents, and Young People in Zimbabwe. Journal of Acquired Immune Deficiency Syndromes, 78(2), S115–S123. https://doi.org/10.1097/QAI.0000000000001737

61. Tiko. (2025). Tiko – Do more with Tiko. https://tiko.org/

62. Zvandiri. (2025). Survive and Thrive- Zvandiri. https://zvandiri.org/

63. Buthelezi, U. E., van Rensburg, A. J., Moshabela, M., Bucibo, S., Radebe, N., Luvuno, Z., Kathree, T., Bhana, A., & Petersen, I. (2025). A realist perspective on optimizing community health workers' roles and functions to deliver integrated people-centred care. PLOS global public health, 5(9), e0004926. https://doi.org/10.1371/journal.pgph.0004926

64. Mupara, L. M., Mogaka, J. J. O., Brieger, W. R., & Tsoka-Gwegweni, J. M. (2023). Community Health Worker programmes' integration into national health systems: Scoping review. African journal of primary health care & family medicine, 15(1), e1–e16. https://doi.org/10.4102/phcfm.v15i1.3204

65. Jaramillo, J., & Harkness, A. (2023). Supporting the helpers: what do peer deliverers of HIV interventions need to sustain their implementation efforts?. Translational behavioral medicine, 13(11), 826–832. https://doi.org/10.1093/tbm/ibad039

66. Kacmarek, C. N., Johnson, N. E., Osborn, T. L., Wasanga, C., Weisz, J. R., & Yates, B. T. (2023). Costs and cost-effectiveness of Shamiri, a brief, layperson-delivered intervention for Kenyan adolescents: a randomized controlled trial. BMC health services research, 23(1), 827. https://doi.org/10.1186/s12913-023-09856-z

67. Coakley, C., Toska, E., Armstrong, A., Sekgobela, D., & Bekker, L. G. (2026). Peer providers delivering health and wellbeing services for adolescents and youth–a scoping review of implementation experience and impact from Eastern and Southern Africa. AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV. https://doi.org/10.1080/09540121.2025.2611067

68. Ross, D. A., Hinton, R., Melles-Brewer, M., Engel, D., Zeck, W., Fagan, L., Herat, J., Phaladi, G., Imbago-Jácome, D., Anyona, P., Sanchez, A., Damji, N., Terki, F., Baltag, V., Patton, G., Silverman, A., Fogstad, H., Banerjee, A., & Mohan, A. (2020). Adolescent Well-Being: A Definition and Conceptual Framework. Journal of Adolescent Health, 67(4), 472–476. https://doi.org/10.1016/j.jadohealth.2020.06.042

69. Santelli, J. S., Rosen, G., & Ssewamala, F. M. (2022). What can academic researchers contribute to advancing adolescent wellbeing? BMJ, o2543. https://doi.org/10.1136/BMJ.O2543

70. UNICEF Youth-Led Action. (2022). Resources for Meaningful Youth Engagement. Retrieved March 23, 2026, from https://www.unicef.org/youthledaction/resources-meaningful-youth-engagement

71. UNICEF Eastern and Southern Africa. (2024). *The innovation of micro-credentials: Enhancing the recognition of non-formal skills for young people.* Retrieved March 23, 2026, from https://www.unicef.org/esa/reports/innovation-of-micro-credentials

72. Guthold, R., Newby, H., Keogh, S., Afifi, R. A., Austrian, K., Baird, S., Blum, R. W., Bundy, D. A. P., Deardorff, J., Engel, D., Klein, J. D., Kostelecky, S. M., Mackworth-Young, C., Marquez, J., NicGabhainn, S., Requejo, J., Ross, D. A., Saewyc, E., & Mohan, A. (2023). Developing a Global Approach for Measurement of Adolescent Well-Being. The Journal of adolescent health: official publication of the Society for Adolescent Medicine, 73(6), 972–974. https://doi.org/10.1016/j.jadohealth.2023.08.029.

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