Scaling up an evidence-based model of health, happiness and hope for children and adolescents living with HIV across the Africa region
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- Project Hope
- READY+ Consortium
- Regional Psychosocial Support Initiative (REPSSI)
- Rippleworks
- Rwanda Biomedical Centre (RBC)
- The ELMA Foundation
- UNICEF
- United States Agency for International Development (USAID)
- Global Network of Young People Living with HIV (Y+ Global)
- WHO
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AYALHIV</td>
<td>adolescents and young adults living with HIV</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>CANGO</td>
<td>Coordinating Assembly of Non-Governmental Organizations</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CAYALHIV</td>
<td>children, adolescents and young adults living with HIV</td>
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<tr>
<td>CATS</td>
<td>Community Adolescent Treatment Supporters</td>
</tr>
<tr>
<td>CHAG</td>
<td>Christian Health Association of Ghana</td>
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<tr>
<td>COP</td>
<td>country operational plan</td>
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<tr>
<td>DATS</td>
<td>Determined Adolescent Treatment Supporters</td>
</tr>
<tr>
<td>DSD</td>
<td>differentiated service delivery</td>
</tr>
<tr>
<td>EMTCT</td>
<td>elimination of mother-to-child transmission</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
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<tr>
<td>IP</td>
<td>Implementing Partner</td>
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<tr>
<td>LGBTQIA+</td>
<td>lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, plus</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<tr>
<td>MHPSS</td>
<td>mental health and psychosocial support</td>
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<tr>
<td>MHSS</td>
<td>Ministry of Health and Social Services</td>
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<tr>
<td>MoHCC</td>
<td>Ministry of Health and Child Care</td>
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<tr>
<td>MoU</td>
<td>memorandum of understanding</td>
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<tr>
<td>MoH</td>
<td>ministry of health</td>
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<tr>
<td>MTCT</td>
<td>mother-to-child transmission</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council</td>
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<tr>
<td>NACP</td>
<td>National AIDS/STI Control Programme</td>
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<tr>
<td>NATS</td>
<td>Namibian Adolescent Treatment Supporter</td>
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<tr>
<td>NGO</td>
<td>non-governmental organisation</td>
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<td>NSP</td>
<td>national strategic plan</td>
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<td>PEPFAR</td>
<td>The United States President’s Plan for Emergency AIDS Relief</td>
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<tr>
<td>RBC</td>
<td>Rwanda Biomedical Centre</td>
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<tr>
<td>READY</td>
<td>Resilient and Empowered Adolescents and Young People</td>
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<tr>
<td>REPSSI</td>
<td>Regional Psychosocial Support Initiative</td>
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<tr>
<td>SADC</td>
<td>South African Development Community</td>
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<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
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<tr>
<td>SRHR</td>
<td>sexual and reproductive health and rights</td>
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<tr>
<td>ToT</td>
<td>training of trainers</td>
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<tr>
<td>TSU</td>
<td>Technical Support Unit</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Childrens' Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YAPS</td>
<td>Young People and Adolescent Peer Supporters</td>
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<tr>
<td>YMD</td>
<td>Young Mentor Dads</td>
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<tr>
<td>YMM</td>
<td>Young Mentor Mothers</td>
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<tr>
<td>ZM</td>
<td>Zvandiri Mentor</td>
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Executive Summary

Zvandiri, ‘As I am’, assures health, happiness and hope for young people living with HIV. We support governments to deliver services to young people living with HIV at scale through trained and mentored peers who connect with them and support them to survive and thrive. Programme and research data confirm Zvandiri improves uptake of HIV testing services, adherence, retention in care, viral suppression and mental health — all outcomes that link with improved survival, health and well-being for children, adolescents and young adults living with HIV (CAYALHIV) in Zimbabwe.

This case study documents the scale-up of the Zvandiri Model from Zimbabwe to nine additional countries in the region. It provides a brief summary of the global and regional context for CAYALHIV. We describe the Zvandiri Model and how it offers a comprehensive and evidence-based package of interventions tailored to the holistic needs and challenges of CAYALHIV. We explain the rationale, standard technical assistance package and process for Zvandiri regional scale-up since 2016. The findings section presents qualitative programmatic and evaluation data compiled from programmatic reports and key informant interviews with government representatives and other implementing partners, together with results from a survey with Zvandiri’s Technical Support Unit staff.

The findings demonstrate Zvandiri’s substantial contribution to the lives of CAYALHIV across the region. Following the inception of the Regional Programme in 2016, nine countries outside Zimbabwe are now successfully implementing the Model with 1,564 CATS* — Community Adolescent Treatment Supporters — who have been trained and mentored and are collaborating with health care workers in 610 health facilities, supporting 37,231 CAYALHIV. All nine countries describe significant progress towards WHO’s Quality Standards for Adolescent Service Delivery, including improved health care worker capacity, integration of trained, mentored peer counsellors within service delivery, and increased engagement, viral suppression and well-being among adolescents living with HIV. Viral suppression among CATS ranges from 94 per cent to 100 per cent. The success of the Regional Programme has extended Zvandiri’s reach to 96,000 CAYALHIV supported by 3,000 CATS across Zimbabwe and the nine regional countries.

Our experience of South-to-South collaboration provides further evidence that the Zvandiri Model not only works, but is transferrable. Our partner countries have successfully established systems for the delivery of quality, integrated peer-led HIV and mental health services for CAYALHIV, supporting governments to deliver on national HIV strategies and national strategic plans, and ‘unlocking’ other funds. Factors for success include government multisectoral leadership, mutual, respectful and supportive partnerships; dedicated implementing partners; prioritisation of CATS within both facility- and community-level responses for CAYALHIV; an expert technical team; and a standardised technical assistance package.

This report provides a firm foundation from which Zvandiri will further expand towards our vision for longer term, sustainable impact for CAYALHIV across the region, thus supporting and playing a key role in the goals of the Global Alliance to end AIDS in Children by 2030.

*NATS — Namibian Adolescent Treatment Supporters (Namibia); YAPS — Young People and Adolescent Peer Supporters (Uganda); DATS — Determined Adolescent Treatment Supporters (Nigeria)
1. Introduction

This case study documents the scale-up of the Zvandiri Model from Zimbabwe to nine additional countries in the region. It provides a brief summary of the global context for children, adolescents and young adults living with HIV (CAYALHIV), and the current situation in Zimbabwe. We describe the Zvandiri Model and how it offers a comprehensive and evidence-based package of interventions tailored to the prevailing needs and challenges of CAYALHIV. We explain the rationale, standard technical assistance package and process for Zvandiri regional scale-up since 2016 — its successes, challenges and lessons-learned. Finally, the recommendations section will inform further scale-up to realise our vision of expanding Zvandiri to 20 countries by 2030 to deliver health, happiness and hope to one million young people living with HIV.

The information in this case study is compiled from programmatic reports, key informant interviews with government representatives and other implementing partners (IPs), and the results of a survey with the Zvandiri Technical Support Unit Staff (TSU) involved in regional scale-up, from initial scoping meetings and providing ongoing technical assistance, to training and mentorship with our partner countries.

Background

As a global community, we have come a long way on our journey to improve health outcomes for CAYALHIV. More than ever before, we listen to and work with adolescents to understand their development, the impact of behaviours, and their lived needs and experiences. Adolescents are now key priorities in global health and HIV plans. At a national level, we are seeing strong political commitment and leadership — dedicated adolescent HIV staff, inclusion of adolescents in national policies, and the roll-out of adolescent-specific national trainings and implementation tools. There are regional initiatives and catalytic funds focused on adolescents, for example, the Global Fund, PEPFAR and 2gether4SRHR through SIDA — the Swedish International Development Cooperation Agency. We have seen efforts to improve data, which are being used to inform targeted programming, and have an increased understanding of which interventions work, along with strong, youth-led advocacy.

Despite this progress at global, regional and national levels, our work is far from over. In 2020, 2.78 million children and adolescents were living with HIV globally, nearly 88 per cent of them in sub-Saharan Africa; 300,000 children were newly infected with HIV — or one child every two minutes — and 120,000 children and adolescents died from AIDS-related causes — or one child every five minutes. In 2021, only 52 per cent of infected children (0–14 years) were on HIV treatment compared to 81 per cent of pregnant women living with HIV and 76 per cent of adults overall; among 21 sub-Saharan African countries reporting in 2021, only 55 per cent of adolescents were on treatment. Every day, 1100 young people (15–24 years) became newly infected with HIV.\(^1\)
Between 2010 and 2020, there was a 34 per cent decline in new HIV infections among adolescents aged 10–19 — however, this is a far cry from the target of a 75 per cent reduction for this period and is insufficient to meet global targets. In 2020, approximately 1.75 million adolescents 10–19 years were living with HIV worldwide. Projections show that at the current rate of new infections, without acceleration of efforts and investment, a total of two million adolescents could become newly infected between 2018 and 2030.3

In short, none of the global targets for HIV treatment and prevention agreed by the General Assembly in the 2016 Political Declaration on Ending AIDS have been reached, especially those for children and adolescents4 who continue to bear the burden of new infections, morbidity and mortality. This gap not only creates a roadblock to achieving global HIV epidemic control, but, importantly, affects young people’s ability to survive, thrive and reach their full potential.

Zimbabwe remains at the epicentre of the HIV epidemic in East and Southern Africa. In 2020, an estimated 2,700 adolescent girls were newly infected with HIV compared to 400 boys in the same age group. Of the 81,000 adolescents living with HIV, 20 per cent are not on life-saving antiretroviral therapy (ART) and an estimated 1,600 adolescents (10–19 years) died in 2020 from AIDS-related causes.5 The rate of viral load suppression among adolescents and young people (15–24 years) falls far below the national target of 95 per cent;6 only 66.2 per cent of young women and 49.2 per cent of young men are virally suppressed.7

While Zimbabwe has seen significant success towards the elimination of mother-to-child transmission (EMTCT) — with 87 per cent of pregnant women living with HIV receiving lifelong ART — in 2020, 1 in 10 HIV-exposed infants was HIV positive. Zimbabwe also has a high rate of early childbearing — in 2019, 24 per cent of women aged 20–24 years gave birth before the age of 18.8 Sexual violence against girls remains unacceptably high; 9 per cent of girls 18–24 years have experienced sexual violence before the age of 18. For 17 per cent of girls who have had sexual intercourse, their first experience was physically forced or coerced.9
At Zvandiri, we look beyond the data. Listening to young people, they tell us that they remain underserved by HIV services, and young mothers face challenges in accessing EMTCT services. Children, adolescents and young adults encounter a myriad of obstacles that are unlike those faced by adults, including orphanhood, difficulties attending school, late disclosure, stigma and discrimination from their peers and family, self-stigma, barriers to sexual and reproductive health and rights (SRHR) services, and misinformation. This cascade of struggles, lack of support, and the many barriers to services mean young people have significantly worse access to HIV testing and treatment. Added to this, Zvandiri has led the way in identifying high rates of common mental health conditions among adolescents and young adults living with HIV (AYALHIV), which correlate with poor adherence and virological failure. Young people are at high risk of loss-to-follow up, and they still are confronted with stigma and negative attitudes from health care providers.

**How do we move forward?**

With less than a decade left to reach the global goal of ending AIDS by 2030, support and services for CAYALHIV still have glaring gaps and urgently need to be intensified. A new Global Alliance to end AIDS in children, led by the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and United Nations Children’s Fund (UNICEF), brings together a strong, strategic and action-oriented alliance of multisectoral stakeholders at national, regional and global levels to work with women, children and adolescents living with HIV, national governments and partners to mobilise leadership, funding and action to end AIDS in children by 2030.¹⁰

According to WHO, we need ‘to scale up peer-driven adolescent HIV models that have already shown results or significant promise, through South-to-South learning to extend the benefits of successful interventions to other countries and regions. With a substantial range of effective and appropriate interventions that can be delivered at scale, progress can be accelerated to meet international targets and to improve adolescent HIV services and ultimately the health and well-being of adolescents living with HIV.’ ¹¹

It is against this backdrop that we established the **Zvandi Regional Programme.**
2. Overview — the Zvandiri Model

Zvandiri, ‘As I am’, is transforming young lives through peer connections to assure health, happiness and hope for young people living with HIV. We support the whole person, throughout childhood and adolescence into adulthood. At Zvandiri, young people are not just a statistic — they are human beings whose health and well-being are determined by a wide range of evolving, often complex clinical and psychosocial factors. Our work is driven by gaining a deep understanding, commitment and connection to the lived experiences of young people to foster love and self-acceptance. We work with governments to deliver services to young people living with HIV at scale through trained and mentored peers who connect with them and support them to survive and thrive. Our evidence-based model provides a holistic approach that is innovative and ensures sustainable impact.

Established in Harare, Zimbabwe, in 2004, Zvandiri began with six young people living with HIV who wanted more than just medicines and clinic visits. They started a support group that has evolved into the Zvandiri Model of community, clinic and digital health services. The Ministry of Health and Child Care (MoHCC) and National AIDS Council (NAC) in Zimbabwe adopted Zvandiri, cascading it through national plans and embedding it into the national HIV programme and other health and protection services. Zvandiri not only contributes to the national HIV response, but supports national adolescent health more broadly, for example, it is a key component of the Department of Social Welfare’s national case management system and contributes to Adolescent Sexual and Reproductive Health Strategy targets. The MoHCC has now scaled the Model to 51 of 63 districts, transforming the lives of 67,790 CAYALHIV across the country. In this way, Zvandiri has evolved from an NGO-led Model with strong community-clinic linkages, into a government-led, decentralised and sustainable approach, with Zvandiri continuing to provide technical and implementation support.

Young adults know what their peers need, and CAYALHIV are at the heart of Zvandiri, taking the lead in developing, planning, delivering and monitoring interventions. We are committed to helping CAYALHIV to develop the knowledge, skills and confidence to cope with their HIV status and to live happy, healthy, safe, fulfilled lives. This relies not only on access to HIV medicines, but also on evidence-based interventions that view young adults holistically as individuals, addressing their physical, social and psychological needs, both within and beyond the health facility.

Through the Zvandiri Regional Programme, the Zvandiri Model has been adopted and scaled from Zimbabwe to nine additional countries in the Africa region.
Zvandiri — The 7 pillars

Centre
Our goal is health, happiness and hope for all children, adolescents and young people living with HIV.

Inner circle
We achieve this by influencing multiple dimensions of their health and well-being.

Outer circle
This is delivered through 7 complementary pillars, with young people living with HIV at the forefront of each.
Service delivery

Zvandiri connects young people with trained, mentored peers — young adults living with HIV (aged 18–24) we call ‘CATS’ — Community Adolescent Treatment Supporters, Young Mentor Mothers (YMMs) and Young Mentor Dads (YMDs) who are integrated within paediatric and adolescent HIV treatment and care. As part of the health facility team, they provide information, counselling and support to their clients in clinics, communities and homes through support groups, home visits and mobile health. They address, not only HIV-related issues, but broader health, mental health, sexual and reproductive health (SRH) and protection. CATS identify and link CAYALHIV to HIV testing, supporting those who test HIV positive to access services along the HIV care cascade — from ART and disclosure to viral suppression. Those testing HIV negative are connected to prevention services.

Between clinic visits, CATS and YMMs follow up with their clients for counselling, psychosocial support, adherence monitoring, and to screen for and identify ‘red flags’ that require further investigation or support from clinic, social welfare or mental health services. Working with the facility and community teams, CATS refer and link to services that they cannot provide themselves. The level of support clients receive (standard or enhanced) is determined by the clinical and psychosocial circumstances of each individual young person. CATS co-facilitate support groups for young adults, which are integrated within facility-based ART refill groups and adolescent days, combining mental health and psychosocial support (MHPSS), ART refill and viral load monitoring. They also work with caregivers through home visits, clinics and caregiver groups and workshops. Zvandiri Mentors (ZMs) provide training and capacity building for CATS, YMMs and YMDs, as well as for health care workers and other community cadres, to strengthen child and adolescent service delivery.

Young people are not a homogenous group — with an age range spanning 0–24, their needs change as they move through childhood and adolescence to become young adults. Zvandiri responds to this and is a theoretically grounded, multicomponent differentiated service delivery (DSD) model — arguably the largest national DSD model for CAYALHIV in sub-Saharan Africa. It is more than the ‘where’ and when’ of ART — it simplifies and adapts HIV services across the cascade, linking with broader health and protection services, to better identify and respond to individual needs and reduce unnecessary burdens on the health system.

As well as responding to age-related differences, the Zvandiri DSD Model is further adapted to sub-populations of young people. We have designed specific packages for young people in all their diversity, including training curricula, screening tools, information, education and communication (IEC) materials and training for lay supporters (Box 1).
Zvandiri differentiated service delivery tailored to specific needs and sub-populations

• **Mental health:** CATS are trained and mentored peer counsellors, drawing on cognitive behavioural therapy, positive psychology and narrative therapy. They promote mental health literacy and mental well-being, conduct mental health screening, identify red flags, make referrals, and support the management of those with common mental health conditions. Randomised control trials show a reduction in common mental disorders from 68 per cent to 2 per cent among CAYALHIV receiving enhanced counselling from a trained CATS.

• **Disability:** Zvandiri has invested in inclusivity and understanding of the needs of young people with disabilities. Specific CATS training focuses on disability and direct work with MoHCC is improving accessibility in clinics.

• **Social Protection:** We work directly with the Ministry of Social Welfare in Zimbabwe to ensure collaboration and seamless care. Social protection is at the core of CATS’ training and mentorship, enabling them to identify, refer and link CAYALHIV who may be at risk of abuse or neglect, are in child-headed households, facing challenges with schooling or food, or are otherwise in need of extra support.

• **Young mothers:** Young Mentor Mothers are specifically trained to support peers who are young mothers: 98 per cent of mothers in Zvandiri are virally suppressed with less than 2 per cent mother-to-child transmission (MTCT) compared to the national average of 6 per cent.

• **Young dads:** Trained Young Mentor Dads provide information, counselling, support and linkages to services for adolescent boys and young men who are fathers. This intervention seeks to improve the physical, mental and social health and well-being of young dads as well as their spouses and children.

• **Young key populations:** Those selling sex, members of the lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, plus (LGBTQIA+) community, and young people who use drugs are taking up the CATS roles. This is ensuring highly vulnerable adolescents and young adults receive services delivered by peers who understand their specific needs and can help them navigate the multiple layers of stigma and discrimination and the many challenges they often experience accessing services.

Importantly, for Zvandiri, care does not stop at the clinic — health services are linked with community outreach, MHPSS, protection services and advocacy initiatives. This means CAYALHIV are supported holistically through a continuum of care between the health facility, their caregivers and the community, improving their health, safety and psychosocial outcomes as they grow up into adulthood.

**Strengthening the evidence**

The Zvandiri model is rooted in proven methods for what works best for the unique needs of young people living with HIV. Programme and research data confirm improved outcomes across the HIV cascade among young people receiving Zvandiri services in Zimbabwe, with 42 per cent of young people more likely to have a suppressed viral load, and a reduction in poor mental health from 68 per cent to 2 per cent. Data also confirm that Zvandiri leads to significant
improvements in the capacity of health facilities and caregivers to respond to the clinical and psychosocial needs of AYALHIV. This evidence informed WHO’s review of its service delivery guidelines for AYALHIV and the decision to recommend that all countries adopt MHPSS within their national guidelines for AYALHIV.16

Advocacy
Zvandiri trains and mentors young adults to advocate for HIV policies, services and community systems that are responsive to their specific needs at all levels, from community to district level, and from national to global fora. Young adults from Zvandiri are now internationally recognised for their role in championing the needs of their young peers living with HIV, and in 2015 and 2020 they contributed to the WHO adolescent-specific guidelines for HIV treatment, care and support.17,18

Guidelines and tools
Zvandiri has a long history of developing paediatric and adolescent HIV guidance, training curricula and tools to inform and support service delivery. Working together with the Government of Zimbabwe and adolescents living with HIV, we have produced a wide range of creative materials that are age- and developmentally-appropriate to support children, adolescents and those that care for them.19

Strengthening the workforce
Through virtual and on-site training, mentorship and supervision, scheduled case management support and quality improvement initiatives, we orientate and build the capacity of health care workers, social workers, implementing partners and lay cadres, such as CATS, YMMs and YMDs, community health workers and case care workers, to provide quality holistic services in line with WHO policies, guidelines and standards. These services are integrated within the clinical care provided by government, as well as protection and education services.

The Zvandiri-ECHO Hub for Paediatric and Adolescent HIV is a virtual platform that has enabled us to build capacity to scale the Zvandiri Model, delivering blended training, technical assistance and ongoing e-mentorship across Zimbabwe and to our nine partner countries. In 2021, we launched The Zvandiri Paediatric and Adolescent HIV Service Delivery Programme — a virtual, modular training and mentorship programme to strengthen knowledge, skills and confidence in supporting the comprehensive needs of CAYALHIV. The programme is unique in that it combines the voices of young people and carers with evidence-based technical sessions in line with WHO Global Standards.

Families and communities
Zvandiri works with caregivers, schools, faith and religious leaders and community members to create supportive environments that promote young people’s health and well-being. We provide information, counselling and support for the caregivers and families of CAYALHIV. In addition, we focus on tuberculosis (TB) prevention, mental health support and links to education, social welfare services, disability services and economic strengthening. The Zvandiri package of care enables families and communities to take a leading role in the care and support of their children and adolescents living with HIV.
Partnerships

At Zvandiri we believe that it is essential to develop strong partnerships. Importantly, we collaborate with governments and ministries of health (MoH), social protection, youth and education to support national plans and to fully embed the Model in the national response. Evidence of the success of this can be seen in Zvandiri’s strong partnership and close collaboration with the MoHCC in Zimbabwe. In all regional partner countries, Zvandiri has encouraged full engagement with and support from governments. In Eswatini, Mozambique and Tanzania, this has been through the READY+ Consortium. Where possible, a memorandum of understanding (MoU) is signed with the government or MoH, creating a strong foundation for ownership and sustainability.

Our partners also include a range of funders who are supporting or have supported Zvandiri throughout the journey to scale, including PEPFAR, United Nations (UN), governments, foundations, trusts and other implementing organisations. As our clients live within a network of families, schools, churches and communities, it has been important to establish other relevant partnerships, for example, with youth organisations, non-governmental organisations (NGOs), churches and community leaders, to ensure holistic care of the client.
3. The Zvandiri Regional Programme — scaling up the Model

Rationale

The Zvandiri Regional Programme was born out of recognition in Zimbabwe and further afield of the efficacy, relevance, innovation and sustainability of the Zvandiri Model. Programme and research data confirm our approach improves uptake of HIV testing and mental health services, adherence, retention in care and viral suppression — all outcomes that link with improved survival, health and well-being for CAYALHIV in Zimbabwe. Key players, such as WHO, PEPFAR Solutions, the Bill & Melinda Gates Foundation, UNICEF, UNAIDS and the Southern African Development Community (SADC) widely recognised and documented the Model, recommending it for scale-up, and in 2016, regional governments, potential implementing partners and donors started to turn to Zvandiri for technical expertise.

WHO initiated a partnership with us to scope potential expansion to the 21 AIDS Free Priority Countries and, since 2016, the Zvandiri TSU has been providing technical assistance to regional governments and other IPs, sharing expertise, best practice, resources, training and mentorship. The Zvandiri Model has now successfully been adopted in Eswatini, Ghana, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda and Zambia. In 2022, work will start in Angola in collaboration with Frontline AIDS and the READY+ Consortium. Other countries are approaching us for support and we hope to continue towards our vision of expanding to 20 countries by 2030 to deliver health, happiness and hope to one million young people living with HIV.

How did we scale-up?

Technical expertise

With support from The ELMA Foundation and Maruva Trust, Zvandiri established TSU — a dedicated unit to lead on regional expansion. Beginning with READY+, our team learned how to collaborate and engage with partners in other countries. As we worked with the consortium and contributed to the READY+ programme, we learned so much and integrated that learning into our TSU. Our multidisciplinary TSU comprises experienced technical specialists and trainers, including young adults who have grown with Zvandiri. From a variety of backgrounds, including those who have been CATS, these young adults are now Technical Advisors and Trainers, Youth Advocates, Zvandiri Associates and Zvandiri Mentors. They are the ones with first-hand experience, they have learned the lessons, developed best practices and implemented the Model in Zimbabwe.
Replicating an evidence-based model in different country contexts requires a technical team that understands the key enablers for successful scale-up (Box 2). The majority of these have been at the core of Zvandiri programming in Zimbabwe over the past 18 years and are therefore already embedded in everything we do — from government partnership and our DSD approach, to standardised training curricula, forging strong community links and youth engagement. For example, our young people ensure all our tools, resources and activities are created, shared and implemented with a quality, youth-friendly focus. TSU’s strategy, operational guidelines and approach are grounded in global best practice for service delivery for CAYALHIV, including WHO policies, guidelines and Global Standards. We combine technical expertise and experience in Zimbabwe with the latest global research and monitoring and evaluation data and are constantly learning and updating our technical approach as lessons are learned from new partner countries and their youth.

Fidelity to the Model has always been paramount and specialist skills and experience are essential to ensure the core building blocks — the components that make Zvandiri work — are established and stay faithful to the Model. For example, our method for building health care worker capacity and strengthening health facility systems for quality DSD for all young people using standardised curricula based on WHO Global Standards; how we engage and support CATS using Zvandiri selection criteria, operational procedures for CATS Care, and our CATS training; our special brand of tools and ongoing mentorship, as well as the critical bi-directional links we create with caregivers and the wider community. At the same time, the technical specialists in TSU are mindful that what works in one country or district may need to be adjusted slightly in another. TSU members visited each of the countries, analysed data and worked very closely with in-country partners and youth to support, adapt and ensure that the interventions were appropriate, while staying faithful to the Zvandiri Model.

In interviews with partner countries, 100 per cent of respondents told us that it was TSU’s expertise, best practice and experience they most valued, and the way that this was ‘on tap’, ongoing and regularly shared with them — from training, mentorship and materials adaptation to troubleshooting, support with M&E and data collection. They also appreciated the strong partnerships that TSU took time to build with them and the feeling of being in a team with Zvandiri, jointly problem solving.
Key enablers for effective scale-up of peer-based, adolescent-friendly models

- **Overarching and strong partnerships** with national governments for government ownership, leadership and coordination and to embed the response firmly in national strategies, policies, plans and resource allocation for HIV and mental health.

- **Quality HIV and mental health service delivery** through:
  - A differentiated service delivery model that recognises that CAYALHIV require services that are not only age- and developmentally-appropriate and tailored to diverse, evolving physical, mental and social needs, but that can address the challenges faced by specific sub-populations (Box 1).
  - Quality assessment processes using the WHO Global Standards.
  - **Strengthened workforce and health systems** through:
    - Training, mentoring and supporting clinical service providers, sensitising them to the specific needs of CAYALHIV in their diversity and building capacity to provide DSD services that meet WHO standards and guidelines, as well as in working with and supporting CATS.
    - Training, mentoring and supporting dedicated peer counsellors (CATS, YMMs, YMDs) that are embedded in health facility teams and connect to the community through outreach.

- **Triangulation between health facilities, communities, families** and homes to extend beyond traditional clinic-based interventions:
  - Peers who are supporting young people in their communities and through digital health at all stages of the HIV treatment cascade — from early diagnosis and ART initiation to adherence. By increasing confidence, self-esteem, mental health and well-being, peers improve treatment adherence and viral suppression, resulting in better general health and SRH outcomes.
  - Support to families and caregivers to improve the environments in which young people live, in turn promoting uptake of HIV testing, adherence support, HIV-status disclosure, and reducing household stigma, resulting in improved viral suppression, mental health and well-being.

- **Ongoing mentorship and support** to implementing partners, health service providers and peer counsellors to:
  - adapt the Model to their country context while maintaining fidelity to the evidence based Zvandiri Model.
  - monitor ongoing quality.
  - adopt M&E frameworks with age-disaggregated indicators that are integrated within national tools.

- **Young people's agency in evidence-generation** and its use in advocacy, influencing policies and guidelines, resource allocation and service provision.

- **Advocacy** for HIV policies, services and community systems that are responsive to the diverse and specific needs of CAYALHIV at all levels, from community to district level, and from national to global fora.

- **Multisectoral partnerships** to achieve the comprehensive and holistic response CAYALHIV need to survive, thrive and realise their full potential.

- **Sustaining CAYALHIV at the centre — not only listening to them**, but fully engaging, capacitating and continuing to mentor and support them to lead in programme design, delivery, and M&E, and to develop youth-led **guidelines, tools** and training materials.
Partnership with WHO

In 2018, Zvandiri collaborated with WHO to focus on quality adolescent-friendly health services, SRHR integration and establishing peer-driven models in the 21 AIDS Free Priority Countries. This led to paediatric and adolescent technical working groups in 10 of the countries where, with support from The ELMA Foundation and UNICEF, WHO and respective ministries of health, we shared lessons and evidence from Zvandiri in Zimbabwe. Multisector stakeholders from each country took part, including ministries of health, IPs, donors and young adults. Meetings were specific to each country’s epidemic, existing services, successes and challenges.

Young people from Zvandiri and host countries came together, enabling peer-to-peer learning and sharing as well as stakeholder understanding of young people’s capacities. For participants, it became clearer that the issues adolescents face are similar, regardless of language, culture or country, making the Zvandiri Model potentially transferrable. MoHCC Zimbabwe engaged with host ministries, promoting understanding of government leadership and offering opportunities for ministry-to-ministry conversations and planning. The result — we were able to share the Model with potential partners across the region and offer technical assistance. During the workshops, we worked with countries to develop national plans for implementation and scale-up of services for CAYALHIV.

In interviews, several countries said that it was these technical working groups and endorsement from WHO and other ministries of health in the region that gave them confidence that the Model would meet their needs and contribute to the goals of their national strategic plans (NSPs) for HIV.

Zvandiri standard technical assistance package

Building on WHO’s key considerations for adapting and scaling up peer-based, adolescent-friendly models for service providers and implementing partners, TSU developed and delivered a standard package of technical assistance, mentorship and support that follows phased steps and spans two years from signing an MoU to accreditation (Box 3).
Kicking off with learning visits to Zimbabwe, government representatives, funding partners, implementing partners and young adults living with HIV from potential partner countries experienced the Zvandiri programme in action. Convinced by what they saw on these visits, governments and other IPs signed MoUs to guide programme partnership and implementation, formally establishing Zvandiri as a technical assistance partner.

TSU conducted baseline assessments utilising an adapted version of the *WHO Global Standards for Quality Health Care Services for Adolescents*, which focuses specifically on HIV, to measure existing provision of child and adolescent HIV service delivery and to inform capacity development plans and programme implementation. Our TSU worked closely with IPs to layer and integrate Zvandiri processes and tools within existing structures and programmes and to adapt individual programme plans and approaches where necessary.
In Nigeria, most school-age children attend boarding schools, therefore we adjusted client-contact methods and times to ensure young people were being cared for but not missing school nor inadvertently disclosing their status to others.

We supported countries to adapt implementation tools for local contexts, such as translating IEC materials, creating local videos and M&E tools.

Working with ministries of health and other IPs, we jointly selected CATS according to Zvandiri criteria and delivered health care worker and IP orientation, CATS training and support group leader training in partnership with respective ministries of health and local IPs. From the outset, dedicated members of TSU and CATS from Zimbabwe provided constant and ongoing support and mentorship to host country ministries of health and IPs. Zvandiri M&E specialists also capacitated countries to jointly monitor, evaluate, track data and analyse trends to inform ongoing programme quality and scale-up.

4. Key findings

Following the regional expansion of Zvandiri from 2016 to date, nine countries are now successfully implementing the Model (in addition to Zimbabwe); 1,564 CATS have been trained and are collaborating with health care workers in 610 health facilities, supporting 37,231 CAYALHIV; and 97 per cent of CATS and 68 per cent of clients are virally suppressed across the nine countries. While this figure shows a critical gap in viral suppression, it needs to be read in the context of limited viral load data. Despite this, countries report a significant improvement in viral suppression among those receiving support from CATS since implementing the Zvandiri Model.
Country interviews

We conducted in-depth key informant interviews with regional partners in Eswatini (CANGO and our Zvandiri Technical Assistant based in Eswatini); Ghana (NACP and CHAG); Namibia (MHSS, a Paediatric HIV Senior Medical Officer and a Senior NATS); Nigeria (IHVN); Rwanda (Dream Village); Uganda (MoH); Zambia (Project Hope). Representatives from REPSSI in Mozambique and Tanzania completed online questionnaires.

Why Zvandiri?

Box 4

What attracted countries to the Zvandiri Model?

- It relies on government ownership and leadership
- It aligns with and promises to deliver on NSPs, goals and targets for CAYALHIV
- It’s a client-centred, evidence-based DSD model that caters to the diverse needs of young people
- It comes highly recommended by WHO, national technical working groups, trusted donors and NGOs, and is respected by government ministries
- It is a multisectoral approach that not only strengthens the health system, but engages with community at multiple levels
- Partners had first-hand experience of the efficacy of Zvandiri
- It’s an inclusive model that offers the most effective holistic outcomes for CAYALHIV
- The aspiration is that all young people have an equal right to health
- CATS are embedded in the health system, are in facilities all the time, and provide vital links to the community
- It puts young people at the centre, is peer-led and young people are involved at all stages
- It truly responds to ‘nothing about us without us’ for young people
- Youth-led resources can be adapted to country contexts
- Excellent tools, resources and IEC that young people can take home
- Components can be added to respond to country-specific needs e.g., economic empowerment.

Box 5

Zvandiri technical assistance — the highlights

- Zvandiri’s long-standing experience and respected expertise
- Quality of Zvandiri mentorship and training
- Training and mentorship are continuous and regular
- Learning and sharing visits to Zimbabwe
- Bidirectional learning between Zvandiri and country partners
- Strong collaborative and supportive partnership between countries and Zvandiri TSU.
Alongside global recognition that a ‘one size fits all’ approach to HIV service delivery is inadequate, there are many reasons countries looked to the Zvandiri Model (Boxes 4 and 5). For Zambia, the Project Hope Regional Director had witnessed first-hand the value Zvandiri brought to the DSD model and HIV interventions in Namibia. Seeing how CATS were changing the lives of their peers, disclosing, sharing experiences and counselling others, he recommended Zvandiri to the MoH in Zambia, who believed the Model would be effective in supporting government efforts to address adolescent HIV. The MHSS in Namibia was also convinced Zvandiri could address the specific challenges young people in Namibia faced with viral suppression. The NACP in Ghana saw the Model as the answer to many of the gaps it was facing in the paediatric and adolescent HIV cascade, and Dream Village in Rwanda told us, “It talks to the Rwandan MoH Strategic Plan in terms of holistic support for AYLHIV, with support groups, home-based care, enhanced and standard care.”

The fact that the Zvandiri Model is respected and endorsed by WHO, trusted donors and ministries was an incentive for several countries. The MoH in Uganda and NACP Ghana trusted WHO’s endorsement, and the MoH and Global Fund in Eswatini had witnessed its success first hand through data from the READY+ Programme, leading to a Global Fund grant for scale-up to 21 health facilities. The Zvandiri Model was recommended to Dream Village in Rwanda by their donor — the Leonard Bachman Foundation.

Most countries were attracted by the fact that Zvandiri truly places young people at the centre of programming. “This was so influential — the CATS programme is all for young people — they are at the centre of providing services. We really believe young people can provide focused care, and from experience we know this will influence others living with the same situation. CATS are based at the facility so they can meet all young people when they visit, and they also go out into the community for home visits. So they are everywhere — in and out of the facility” (Namibia).

Ministry officials, young people and donors from Eswatini, Ghana, Namibia, Rwanda, Uganda and Zambia thought the learning exchange visits to Zimbabwe provided an important opportunity to experience the Model. Many of them were impressed by how Zvandiri has strengthened the national infrastructure and systematic response to child and adolescent HIV in the country. Ghana noted how ministers knew the Model so well and valued the strong collaboration between Zvandiri and MoHCC. Representatives from Namibia were also “amazed by the work Zvandiri was doing with the MoHCC” and were particularly struck with how much young people were truly at the centre, which responds to current demands for a ‘nothing about us without us’ approach.

Following their exchange visit to Zvandiri, Dream Village and the Rwandan MoH were “convinced this was the model for us because it offered the best holistic outcomes. It aimed to address our challenges and we liked that the CATS are always in the health centre.” Many respondents were inspired by meeting CATS and YMMS, seeing them in action and talking to them and their young clients. Following exchange visits, Ghana, Namibia, Nigeria, Rwanda, and Zambia signed MoUs with Zvandiri. In Eswatini, Tanzania and Mozambique, the IPs are implementing the Model as part of the READY + consortium; in all three countries, the MoH is fully invested in the Model.
All country partners expressed how much they appreciate, value and benefit from Zvandiri’s extensive experience and lessons learnt in Zimbabwe. “Every engagement with the Zvandiri team was a learning moment” (Ghana). Eswatini, Ghana, Mozambique, Namibia, Rwanda, Tanzania and Zambia said that continuous training and regular mentorship from TSU were highly valued core elements of technical assistance. Countries appreciated frank, open and ongoing discussions about how they could troubleshoot issues, maintain quality and improve. “E-mentorship is really, really helpful. Every time we meet there is something new to be learnt and learning is not just uni-directional — there are opportunities for dialogue” (Ghana). The Namibian MHSS found mentorship empowering, saying that it built skills in many areas they had struggled with. Common topics included how to maintain quality of services, effective data collection and tools adaptation.

Namibia and Zambia reported that the training of trainers was incredibly useful and empowered them to train others, which was particularly helpful for Namibia as they expanded to new regions and felt capacitated to conduct their own training. Eswatini said that our virtual training really helped during COVID-19, and Tanzania appreciated our blended approach to technical assistance.

Countries were unanimous about the value of Zvandiri’s adolescent-friendly documents, tools and resources and TSU’s support to adapt these to their country contexts. This was particularly true of M&E and baseline tools, which have improved reporting in Ghana and Namibia.
Successes and observed changes

Significant contribution to the HIV response at a national level

Eswatini, Ghana, Mozambique, Namibia, Rwanda and Zambia report early evidence that the Zvandiri Model is contributing to the goals and targets of NSPs and their HIV response at a national level. For Rwanda, Zvandiri is responding to government priorities by providing holistic support for young people through support groups and home-based care. Dream Village, Rwanda, and the Rwandan MoH agree that the Zvandiri Model is proving to be the most appropriate to holistically address milestones in the NSP. It is supporting the social and economic lives of young people and was included in the 2019–2020 Annual HIV/AIDS Report. To feed into national planning processes, health centres have selected CATS representatives who present their challenges and needs to a national committee. For NACP Ghana, “The fact that that the CATS Programme is embedded in the MoH is part of its success” and “the CATS Programme helped us improve treatment coverage for children because we improved linkages as well as retention in care...CATS improved 6-month retention, which increased from 84 per cent to 96
per cent. When it comes to achieving epidemic control through the NSP targets, the Zvandiri Programme has helped us and improved the paediatric contribution towards epidemic control in Ghana.” Zvandiri addresses key pillars in Ghana’s NSP 2025 in terms of greater involvement of CAYLHIV, ensuring they are reaching out to their peers, as well as decentralisation of services.

The MHSS in Namibia told us “The NATS programme is well placed to address adolescent health and issues connected to adolescents living with HIV and young people and SRH, which are priority areas in the NSP. I really feel the NATS programme is well placed to fulfil the goals of the NSP and the MHSS.”

For Project Hope in Zambia, “Every intervention around the CATS is squarely aligned with the 95-95-95 goals. It has already been picked by the MoH that we are contributing to the NSP through the CATS interventions.”

In Eswatini, priorities in the NSP include community and health facility support. CATS and YMMs are addressing gaps in these areas and the Model is contributing significantly to the NSP indicators “We are the first country among SADC to reach 95-95-95...Our indicators for children and adolescents used to be really low. That’s when CATS were introduced. Since then, they have played such a key role in improving our indicators. Zvandiri ensures that each and every child is cared for. It is not just about the pill count. This is changing lives. Zvandiri monitors each child at an individual level. If there is one investment our country can make, this is the one.” The MoH in Eswatini has demonstrated commitment to the Model by providing the IP with a dedicated space — the Adolescent Sexual and Reproductive Health Unit. The implementation of the Zvandiri Model in Mozambique is delivering on the two main NSP objectives: reduction in the number of HIV infections among adolescents and young people, and reduction of the number of HIV and AIDS-related deaths.

In Rwanda, Eswatini and Mozambique, advocacy at national level has meant young people’s voices are increasingly heard at national meetings. On World AIDS Day 2021, in Rwanda, CATS were the ones giving testimonies about fellow young people across the country. Dream Village proudly told us “Out of more than 13,000 in the country, one of our young people stood on a platform in front of over 5,000 invitees. Before he became a CATS he wouldn’t have done that. The mentorship you have given us has extended to the CATS and has supported him to be free to stand up and tell people about his life and the challenges young people face and to give words of encouragement to others.”
Improved quality of adolescent-friendly services

To strengthen quality of adolescent service delivery across the eight WHO Global Standards, 1,564 CATS and 35 YMMs have now undergone Zvandiri training across the nine countries (in addition to Zimbabwe). 1,347 CATS are active in 610 health facilities and are receiving ongoing mentorship. They are working with Zvandiri-trained and supported health care workers in every facility to provide services and support to peers; facilitating support groups and providing outreach to over 37,231 clients. Health care providers are working with CATS, are trained in DSD, leading support groups and providing health education, counselling and referrals.

### Table 1

<table>
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<tr>
<th>Country</th>
<th>Trained CATS</th>
<th>Active CATS</th>
<th>YMM</th>
<th>Health Facilities</th>
<th>Clients</th>
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<td>10</td>
<td>48</td>
<td>1887</td>
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<td>1011</td>
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<td>388</td>
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<td>119</td>
<td>108</td>
<td>37</td>
<td>1872</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,564</strong></td>
<td><strong>1347</strong></td>
<td><strong>35</strong></td>
<td><strong>610</strong></td>
<td><strong>37,231</strong></td>
</tr>
</tbody>
</table>

**STANDARD 1**

Adolescents’ health literacy

The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.

Because CATS are part of the health facility team and are in facilities from Monday to Friday, Project Hope Zambia has observed increased knowledge among CATS, who are cascading this to their clients and improving linkages to services. Dream Village also reported an increase in young people’s knowledge, especially through targeted support groups, for example, groups for specific ages. Young mothers’ groups have provided them with information on how to support their children, how to link to care and treatment, nutrition, income-generation groups and access to health insurance for treatment. Dream Village also has support groups for young people with high viral load, which are helping them to understand what is impacting on their viral load, for example, economic and emotional factors, domestic violence and stigma. Outreach, home visits and CATS-led WhatsApp groups are enabling young people to share their challenges and receive information and support around the clock on, for example, SRHR, family planning, challenges with taking drugs etc.
In Namibia, teen club numbers are growing and “staff at NATS implementing facilities report that children and adolescents are more open to discussing personal information with NATS. Their knowledge around HIV has increased and they are getting more support with their different challenges.”

Eswatini, Rwanda, Namibia and Mozambique have increased availability of IEC materials. In Rwanda, these have been translated into many different languages; Ghana has developed IEC to simplify quality paediatric care for clinicians; and in Namibia IEC materials include videos.

Through CATS outreach activities in Ghana, adolescents have become more aware of the health services available to them, such as index testing, which is linking young people to HIV testing, prevention and care services. NACP Ghana said “After going to Zimbabwe, we realised index testing with children was really important. In 2020 we had about a 40 per cent increase in the number of children enrolled into care. About 80 per cent of them came from index testing, which we learnt about through the Zvandiri Programme.” Eswatini CATS are now seen as the “foot soldiers on the ground — disseminating information and creating demand for various health and social protection services.”

Since CATS have been in the facilities helping health care workers in Eswatini, attendance has increased, and Mozambique has seen an upturn in peer-to-peer information and support that is reaching CAYALHIV. According to feedback from young people in Uganda, since the programme started, the YAPSii have been providing essential information and linking to other services.

**What CATS say**

“I am more confident than ever before. I have become more knowledgeable; I have learnt different skills and I am now able to talk in public! It’s really been a great journey.”

CATS Zambia

**What our partners say**

Many young people have become resilient and have more information now through the programme; they are able to make decisions, for example, about accessing commodities... The overarching effect we are seeing with the programme is the empowerment of young people, who gain skills besides helping beneficiaries — especially at facility level.”

REPSSI Tanzania

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ii Young People and Adolescent Peer Supporters (YAPS)
The health facility implements systems to ensure that parents, guardians and other community members and community organisations recognise the value of providing health services to adolescents and support such provision and the utilisation of services by adolescents.

Working with families and communities is one of Zvandiri’s 7 Pillars. Caregivers are engaged in all our partner countries and the majority are operating caregiver support groups.

Caregivers are now fully involved at health facilities in Namibia and NATS\textsuperscript{iii} work and conduct home visits with a cadre of community health workers. NATS are making referrals to social services and other community-based services, for example, local counsellors who also provide food.

Dream Village, Rwanda, told us “We carry out rigorous home-based care. We ask questions such as ‘do relatives and friends understand young people’s challenges? Can we support the families?’ Sometimes they don’t have food. We ask how we can work with them, for example, with small business support.”

Dream Village is operating caregiver support groups, which are responding to challenges with viral suppression and addressing stigma for children below 14 years. “Nothing will change unless an adult steps in, so we created caregivers support groups, which are also killing stigma and the idea that these children are not of value to families.” For example, bringing a variety of parents into the groups is helping to prove to those who do not have high hopes for their children that it is possible for young people living with HIV to go to university and get jobs. Dream Village also works in partnership with the network of people living with HIV (PLHIV) in Rwanda, which has peer educators based in health centres across the country, including those specifically for young people. Seeing the potential for synergy and mutual support, Dream Village has linked CATS with existing peer educators so that they conduct home visits and support groups and identify red flags together.

Recognising that young people in schools in Ghana need support, NACP is working with the national network of PLHIV — some members are teachers living with HIV and are helping CATS to reach young people in school. REPSSI Mozambique is promoting and conducting community dialogues with stakeholders to build support networks for CAYALHIV.

\textsuperscript{iii} Namibian Adolescent Treatment Supporters [NATS]
STANDARD 3  Appropriate package of services

The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.

Zvandiri’s approach to case management through standard or enhanced care packages is impacting on adherence and viral suppression. Interventions have had a positive impact on viral suppression for CATS and beneficiaries across the countries. Whereas low viral load coverage is a challenge for the majority of countries supported, there has been an increase from an average of 77 per cent viral suppression to 88 per cent among those able to report this data.

NACP Ghana “… noticed significant impact on viral suppression in facilities with CATS compared to facilities that don’t have CATS” and CATS in Ghana are using tablets to report on data. REPSSI Mozambique responded to a specific need for MHPSS, and CATS interventions in Mozambique show that the peer-to-peer model is supporting adherence and retention on treatment and the programme is contributing to mental and psychosocial well-being.
In Namibia, NATS beneficiaries recorded an increase in viral load suppression rates from 68 per cent at baseline to 94 per cent at endline assessment — conducted 2 years after implementation began. The NATS viral load suppression improved from 89 per cent at baseline to 98 per cent at endline. The CATS rates for all countries have been maintained above 95 per cent with the extra care and support services provided through CATS Care.

In all countries, CATS are working with health care workers to identify red flags and are making referrals to services outside the facility. CATS follow up on referrals, for example, in Namibia NATS chaperone clients during referrals and linkages to social workers. In Ghana, CATS use a Vulnerability Assessment Matrix to identify those who need support and link to community organisations that can provide it.

**What CATS say**

“I am now able to identify adolescents that are defaulting from medication and give them the help they need.”

CATS Zambia

**What our partners say**

“Certainly, I would recommend it [Zvandiri]! I have seen how it has really contributed. Using volunteers — quite a lot of clients were lost, but with the CATS, most of the ones they lost are coming back. I wish you could hear these words from the community care workers themselves of how they appreciate what the CATS are doing to supplement their work when it comes to, for example, defaulter tracing, engaging adolescents that could have defaulted at any point. Zvandiri contributes to retention in treatment and viral suppression for all CAYALHIV.”

Project Hope, Zambia
STANDARD 4  Providers’ competencies

Health care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfil adolescents’ rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.

Zvandiri trained and mentored CATS and health care providers are now in 100 per cent of partner countries (Box 6). In some countries, through implementation of the Zvandiri Model, the actual number of health facilities providing paediatric and adolescent HIV services has increased. Several countries told us that including health care workers in CATS’ training enabled them to really understand the Model and how to work with CATS to get the best outcomes for CAYALHIV.

In Zambia, the Zvandiri training was the first-time health care workers had been introduced to WHO Global Standards, now Project Hope reports that most health staff are trained in quality standards and know how they can provide quality services to adolescents.

For NACP Ghana, the introduction of the DSD Model and associated training was a turning point that transformed services.
The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

The majority of countries — Eswatini, Ghana, Mozambique, Namibia, Rwanda, Tanzania and Zambia — reported improvements in terms of adolescent-friendly spaces.

Dream Village told us “When you go to health centres where Dream Village is, you can see a difference. If you compare where we are now, you can see changes that have happened over the past 2–3 years.” Dream Village now has adolescent-friendly spaces in all health facilities for support groups and for CATS to see clients, as well as adolescent-only days. Ghana has adolescent corners, and in Namibia most facilities now have spaces for NATS to provide services confidentially. Eswatini has dedicated areas, and now that facilities outside the programme have seen this, they are pushing for spaces in their facilities and want to adopt the Model.

Following Zvandiri training, facilities have adjusted working hours to suit CAYALHIV. For example, one facility in Ghana set up an adolescent day starting at 4am so that young people can attend before school and so their education is not affected. They can also pick up drugs during holidays and after school. NACP Ghana has further plans to make sure HIV and access to treatment don’t limit children’s education.
The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.

Zvandiri CATS and health care worker training focuses on addressing stigma and discrimination and breaking down related barriers to health services.

Ghana reported that Zvandiri is helping to address many stigma-related challenges for young people. Previously, this young population felt they could not open up to older people and health care workers, but now they share freely with the CATS. “CATS have helped us to understand young people’s issues at home, for example, with caregivers, and CATS have enabled health care workers to engage caregivers and social workers to improve care.” In Namibia, NATS are capacitating their peers to challenge stigma and discrimination through teen clubs and one-on-one counselling. CANGO in Eswatini told us that because the Model is peer-led and youth-friendly and CATS are working side by side with the health care workers, young people are more comfortable and access to services has increased.

In Mozambique, within the Frontline AIDS-supported READY 4 an AIDS Free Future programme, young people from key populations, specifically men having sex with men and young people selling sex, are selected, trained and mentored as CATS and are supporting other young people in particularly vulnerable situations. CATS from Mozambique have documented their journeys since the onset of training and are contributing to an incredibly valuable learning process for all of us.

CATS from key populations in Mozambique told us “I had never met anyone like me before. The experience of being with other young people living with HIV was very important for me because it was my first time to have a chance to talk about myself, say everything about me, without fear of discrimination, stigma or any kind of abuse.”

“What surprised me the most about being a CATS is that there is value in my experiences and I can be myself. I do not have to pretend to be someone I am not for me to help my peers.”
STANDARD 7 Data and quality improvement

The health facility collects, analyses and uses data on service utilisation and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff are supported to participate in continuous quality improvement.

Monitoring and evaluation is a key component of Zvandiri training for IPs, health care workers and CATS. Our M&E team received particular appreciation from interviewees who told us the constant mentorship around M&E, especially tools adaptation, has improved their data collection and reporting.

In addition, all countries received baseline, midline and endline assessments based on WHO Global Standards. These assessments are part of the Zvandiri standard technical support package and are enabling constant monitoring, alerting TSU to areas that require technical assistance and mentoring.

REPSSI in Eswatini told us “They always say 'you learn from the best' and from the beginning we used the data collection tools from Zvandiri, which made our work easier.” They made some minor adjustments for their country context and looked at the indicators that were of interest to the Ministry. “The Ministry can see the indicators we are responding to and these are aligned with national indicators. We are now looking into how we can link our system with the HMIS — health management information system.”

CATS in Ghana have been issued with tablets which are facilitating timely data collection and monitoring.

In Rwanda, our M&E team worked with Dream Village to develop an online Google reporting tool. The Dream Village team valued this collaboration and mentorship as reporting of the work in the health facilities is now streamlined, more effective and much simpler.
Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

1,347 CATS are fully embedded in health teams at 610 health facilities across all nine countries. All nine countries mentioned this as a factor contributing to the success of the Model. As an example, MHSS Namibia and Project Hope Zambia told us how NATS and CATS are fully involved in planning, monitoring, providing feedback to health care teams and advising on how to improve client services.

Change at an individual level

As well as having a positive impact on national level goals and targets, and improving quality of services in health facilities, importantly, countries are reporting changes to young peoples’ lives at an individual level.

**Zambia**

“Being a CATS has really helped me a lot whereby I have accepted who I am today. I have come to terms with things that used to bother me. At first, I was bothered by my HIV status, I felt it was a burden. Ever since I became a CATS, everything is fine.”

CATS

“Me being a CATS encourages me to take my medication exclusively. It’s an amazing thing for me in the sense that I have gained skills on how to support adolescents living with HIV.”

CATS

**Zambia**

“I am able to help those that are having difficulties in accepting their status.”

CATS

**Zambia**

“I have become proud of myself by sharing my story to help an adolescent adhere to ART and become virally suppressed.”

CATS

**Tanzania**

“My proudest time is when I see CAYALHIV are happy and they are socialising with other children. For CATS, most of them are now doing small scale business and some have been employed because of being CATS ... most of them are looking healthy and of course they are getting married.”

REPSISI
Scaling up an evidence-based model of health, happiness and hope for children and adolescents living with HIV across the Africa region

A case study of South-to-South learning

**Mozambique**
My name is Margarida. I am 18 years old and I am a CATS for the READY+2 Project. I felt nervous and scared because I did not know what the training would be like. When I got there, I found many boys and girls of my age, which made me more relaxed. During the training, I realised that everything was just a negative thought in my mind. I learned a lot of things, such as the rights of adolescents and young people living with HIV and the forms of prevention and care that we should take. I feel very proud and very excited to be able to support other girls and boys in my community. Today I am a different girl, the training made me realise that we are all equal and have the same rights.”

CATS

**Eswatini**
Many young people become have resilient and have more information. They are able to make decisions, for example, about accessing commodities. The overarching effect we are seeing with the Model is the empowerment of young people.”

CANGO

**Nigeria**
“My life was meaningless and HIV made my life lifeless, hopeless, no one really cared about what happened to me. Becoming a peer educator gives me new meaning and a whole lot of friends.”

DATS

**Namibia**
“Having been part of the NATS programme from the start I have witnessed young people get a voice, a space in the health care system. Many have made new friends and through that many questions have been brought to light.”

Health care worker

**Nigeria**
“I am proud of myself today because you did an amazing job to change my mindset, I love the person I am today because of all the support.”

DATS

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iv Determined Adolescent Treatment Supporter (DATS)
Additional components and linkages

Beginning with the READY+ Consortium, Zvandiri worked with Frontline AIDS and the other consortium members (Y+ Global, CANGO, PATA, MC Saatchi, and REPSSI) to create a larger, comprehensive package that includes CATS. In addition to the standard Zvandiri Model, Rwanda and Ghana have added complementary components. Through the CATS programme, Rwanda provides start-up support for young people who want to set up a new business. Young people running a catering business are now preparing food for support groups and others are learning design and crafts.

Similarly, in Ghana, NACP provides resources to start-up businesses and links with the National Vocational Training Institute for certified apprenticeships. Also, through the CATS, NACP recognised that many social issues affect adherence to treatment for young people out of school — some have little access to funds, for example, for transport to collect medication. CATS are identifying those most vulnerable and referring for soft skills training for economic empowerment. CATS have been trained to work specifically in school boarding houses, resulting in a reduction in health-related missed classes and improved adherence. Uganda has also
Further scale-up

There is clear evidence for success of the Model in the fact that Namibia and Ghana have already scaled up from the initial number of pilot districts and regions, even before they have been accredited. Eswatini, Mozambique, Rwanda, Tanzania, Uganda and Zambia are either looking for

**Eswatini 2022**
Eswatini MoH has shown great interest in seeing the model further cascaded down based on what it has learnt from READY+ and initial results from the Global Fund project. The MoH is keen to explore opportunities to convince the Global Fund to further expand.

**Ghana 2022**
Ghana has already piloted and scaled up from 2 to 11 regions. From the results of the pilot, the Global Fund agreed this intervention works and committed to scale up and increase funding. CHAG was engaged at the beginning of 2022 to lead scale-up.

**Mozambique 2022**
Mozambique would like to scale up to provinces with high HIV seroprevalence.

**Namibia 2022**
MHSS Namibia started with two pilot regions, quickly expanding to five, and now plans to scale up to two more regions for COP 22.

**Rwanda 2022**
Dream Village will carry out an evaluation with MoH and RBC in 2023 to make a comparison between Dream Village and non-Dream Village sites as a basis for scaling up. The aim is to expand to 40 health centres in Kigali and potentially later across the country.

**Tanzania 2022**
The Tanzanian Government and other stakeholders are asking why the Model is not in other districts.

**Uganda 2022**
MoH Uganda is planning to scale to all districts in the country.

**Zambia 2022**
Project Hope is committed to looking for funding to scale up and train more CATS in 2023.
Challenges

CATS graduation

Preparing CATS for graduation out of the programme is an area that the majority of countries felt they would like to improve. However, Rwanda reported success in this area, providing a ‘graduation package’ of vocational skills and an informal savings scheme for small business start-up. Dream Village has a robust system of working with health care centres, counsellors and psychologists to prepare young people to live independently. Ghana is currently developing a transition plan for launch in 2022. The MHSS in Namibia is planning to include activities to transition NATS in the COP 22. In Eswatini, there is some skills building through the READY+ programme and CANGO is currently exploring an internal savings and lending schemes programme. Zambia is only in Year 1, but will focus on linking adolescents to private sector or advocacy organisations. Tanzania is encouraging its young people to make savings for when they leave the programme. This is an area that clearly needs focus in future scale-up and Zvandiri has developed a standard operating package for graduation and will be sharing this with partners in 2022/2023.

CATS selection and retention

Most countries reported challenges with CATS recruitment and retention. Some were related to health facilities not fully understanding the role of the CATS and therefore not selecting the right young people. In some cases, health care workers selected a relative. In Namibia there have been challenges because NATS have exited the programme due to pregnancy or unsuppressed viral load, and others were already nearly 24 when they were trained so had to leave shortly afterwards. Some NATS have struggled with disclosing to beneficiaries, which, although not an absolute requirement, limits their ability to share lived experiences and coping strategies. Patient load has also been an issue as initially the client numbers were high. Zambia experienced a high rate of CATS drop-out, and although much of this is due to college or other jobs, Project Hope feels they were not carefully selected and the health facilities did not really understand what it means to be a CATS. Eswatini suffered CATS attrition as CATS thought they received too little compared to the PEPFAR Expert Clients Programme. Mozambique also reported CATS attrition to similar programmes with a higher stipend.

Health facility buy-in and health care worker workload

Some facilities needed a lot of lobbying to adapt to adolescent-specific days. Others have found that working with the Model and the CATS takes up more time because supporting young people holistically means health care workers are required go deeper into young people’s lives. In Ghana, some facilities expected money for working with the CATS and when this was not forthcoming they pulled the spaces that had been allocated — giving them to another project that came with remuneration. Health facilities in Mozambique experienced a lack of specific health providers to respond to the programme and some facilities lacked dedicated spaces. In Namibia, after three years, they still struggle to secure space for NATS at facilities.
Finances

In Ghana and Zambia, clients expected refreshments in support groups, but this had not been budgeted for. For Namibia, a complex system for paying NATS' allowances delayed payment and NATS also felt the amounts were inadequate as they often use them as a source of income to take care of finances at home. NATS often don’t have enough airtime to remind clients to come for follow-up, and CATS in Zambia found that transport refunds were not sufficient. In Eswatini, CATS reported stipends were not enough to cover travel to rural communities and health care workers expected to get allowances in Tanzania. Some facilities in Ghana agreed to implement the Model, but when it was clear there was no monetary benefit, one facility pushed the CATS out because another project was paying to refurbish the space the CATS were using.

Viral load testing

Several countries reported issues with broken viral load testing equipment, prolonged turnaround time and delayed results, leading to challenges in viral load data. The Zvandiri team will carry out a root cause country context analysis to establish the challenges and provide support. During this time, Zvandiri will continue to provide mentorship, support and training to country teams to enable sustainable data collection methods. With improved data collection, the measurement of viral loads as a key indicator for programme impact will improve, enabling Zvandiri and the country ministries to truly appreciate the impact of peer support.

Technical assistance

E-mentorship was not always constant for Programme Officers or NATS in Namibia. Eswatini, Mozambique, Namibia and Zambia reported lack of adequate IEC at the beginning of the programme and before trainings.
Quotes from Zvandiri partners

During key informant interviews, we asked our country partners if they would recommend the Zvandiri Model to other countries.

“I would 100 per cent recommend the CATS Model to any country that wants to see outcome-based solutions for young people living with HIV. It is one of the few models that works closely with the health system — it is not in isolation. The health centre becomes a basis for interventions and also solutions. At the same time, the community is involved in what is happening at the health centre. For any country that wants to really adapt to support young people — I would recommend.”

Dream Village, Rwanda

“Surely, I would recommend the Model — it has proved to be effective among adolescents, especially in ensuring enrolment and adherence to treatment.”

REPSSI, Mozambique

“Definitely I would recommend it to other countries as it is helpful to the age group, as long as they are willing to commit to it.”

Dr Frans, Namibia

“Thumbs up!”

Lazarus, Senior NATS, Namibia

“I believe the NATS programme can be a great model. It can be a challenge also. It depends on who you are dealing with. Most young people are so passionate about what they are doing in the regions, but there are those who are so laid back and you wonder if they are really keen to support others. I would say the ones who do their job properly really impact on young people during one-to-one and teen clubs. I can definitely recommend it for another country.”

MHSS, Namibia

“In terms of recommending Zvandiri to other countries and partners — it’s a big yes! We are seeing a lot of partners in-country who are really interested in the programme. I would recommend the Model because we are the lead now in Eswatini — we have the expertise. This has led to expansion through the Global Fund.”

CANGO, Eswatini

“Oh I surely will recommend it... It is very good, apart from just improving numbers in the country. For the young ones, it’s not just HIV, this model supports them comprehensively and provides the complete care that they need. I would recommend it to any country any day.”

NACP, Ghana

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CANGO, Eswatini

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Lazarus, Senior NATS, Namibia
Hopes for the future

- All countries expressed a desire to scale up to additional districts and or regions
- Several want to gather evidence for future funding for scale-up
- Some intend to add in other components, such as Young Mentor Mothers and Young Mentor Dads
- Most partners are very keen to continue to work with Zvandiri to ensure ongoing learning, quality and fidelity
- Some countries would specifically like to expand their work around MHPSS and economic strengthening.

Technical Support Unit survey results

Successes

Overall, technical staff involved in the regional programme reported significant increases in MoH participation, national ownership and leadership for peer-led clinic and community interventions, showing promise in terms of potential sustainability. Many staff thought the fact that several countries have already scaled up before they have been accredited demonstrates the acceptability and success of the Model.

TSU staff reported an increase in young people’s capacity to provide services to their peers in all the supported countries and CATS have developed other skills, such as data entry. IPs are showing commitment to the Model and demonstrating good CATS Care. There is evidence of positive living and improved quality of life among CAYALHIV, as well as reduced stigma. CATS tools have been adapted to individual country contexts and are readily available.

Some of the proudest moments for those who have been involved include leading Zvandiri’s first-ever in-country technical assistance for regional countries and breaking barriers in terms of MoH participation in the Model. Other examples include being involved in developing guidelines for adolescents living with HIV. One member of TSU said she was really proud of “being able to shine and share Zvandiri.” Other team members loved witnessing the Model’s impact on the lives of young people regardless of geography; seeing CATS from Zimbabwe mentoring CATS in other countries; watching young people in new countries learn, grow, take pride in their work and benefit at a personal level; hearing feedback from the CATS, health care workers and IPs on how the Model has impacted on the lives of young people. The team were also proud of their ability to quickly adapt to virtual platforms (the Zvandiri-ECHO Hub) and continuously support young people when COVID-19 threatened to impede the roll-out.

Challenges

Some respondents encountered language barriers when training and mentoring. COVID-19 obviously impacted on travel and TSU’s ability to conduct face-to-face assessments, training and mentorship, but this was addressed by the establishment of the Zvandiri-ECHO Hub, which delivered these activities virtually. Funding issues led to one country dropping from the programme. By far the biggest concern was maintaining fidelity to the Model, and the danger of ‘diluting’ the programme through replication and through training others to conduct training
that was usually delivered by Zvandiri staff trainers. Some countries were looking for more of an adaptation than Zvandiri felt comfortable with, as we know our Model works and we have the evidence behind it. Situations such as these can be challenging, but we continue to support, learn and document with all our partners to maintain quality services to all CAYALHIV around the continent.

Overwhelmingly, the team was impressed by the level of buy-in and ownership from ministries of health; the way that countries adapted and implemented the Model, and how much a single adolescent programme could change how services are provided in another country. One respondent said “I was surprised by the amount of knowledge we possess as Zvandiri and the power of peer support.”

**Lessons-learnt**

There were some things team members would do differently or they thought could be improved. Recommendations included integrating components of the Model into national guidelines, templates and tools; signing MoUs with ministries for the duration and working directly with them in all countries; providing in-country technical assistance in the first six months (a reference to the inability to travel during COVID); balancing on-site and virtual CATS mentorship; adjusting the upper age of CATS to 26; ensuring CATS are prioritised and improving IP support to them, including MHPSS and continuing professional development; increase youth engagement in programme design and ongoing adaptation. One respondent suggested the phased timeline be extended from 2–4 years to monitor quality after the intense technical assistance phase and when the partner is working more autonomously.
Recommendations for future scale-up

Zvandiri has now been adopted and scaled in 10 countries (including Zimbabwe) with 3,000 trained CATS and YMMs currently supporting 96,000 young people in 1,133 health facilities across the region. We have a bold vision to expand Zvandiri to 20 countries by 2030 to deliver health, happiness and hope to one million young people living with HIV. We believe this review provides strong evidence that this is realistic.

The following recommendations will help us to improve the process as we move forward towards our vision. They incorporate feedback from our partner countries and the Zvandiri TSU. Some of them confirm elements and approaches inherent in the Zvandiri Model that we already knew worked, but that have been further confirmed by this review, illustrating their efficacy regardless of geography. We therefore recommend that these remain as key components going forward and that additional suggestions for improvement are adopted that reflect learning from this review and the first six years of the Zvandiri Regional Programme.
The Model

- **Start with a robust, evidence-based DSD model** based on best practice and global standards and guidelines, tailored and nuanced, not only to age and developmental stages and those who need standard or enhanced care, but also to sub-groups, for example, those in need of MHPSS, those with disabilities, young people who need extra social protection, young parents, and young key populations (See Box 1). All training, tools and IEC should reflect these nuances to meet the needs of all young people.

- Strengthen and **scale up MHPSS** within the Model at various levels of intervention.

- Consider **community HIV testing** via mobile units for the regional countries (already operational in Zimbabwe).

- Continue to **develop processes to ensure checks and balances are in place to sustain fidelity to the Model** and programme quality.

Partnerships

- **Ensure signed MoUs** between Zvandiri, regional governments and IPs.

- **Ensure government engagement, leadership and coordination** to embed Zvandiri systems and processes in national plans, services, guidelines and tools, training, supervision and mentorship of national, regional and local service providers within national systems.

- **Promote active MoHCC Zimbabwe involvement** in bilateral engagements at ministry level.

- **Increase engagement and partnership with WHO**.

- **Increase partnerships with other bodies** such as PATA, REPSSI, Baylor, UNICEF, Y+ Global and the Elizabeth Glaser Pediatric AIDS Foundation.

Methodology

- **Employ an evidence-based standard technical assistance package**, including standardised tools and training to ensure fidelity to the Model, which is delivered by a **trained and experienced technical support/training team**. At the same time, be mindful of country contexts and work with partners to adapt while remaining faithful to the Model.

Facility buy-in

- **Invest more time in health care workers** so that they fully understand the Model and the time involved in delving deeper into young people’s lives; are clear about remuneration; realise the importance of dedicated spaces, adolescent days and appropriate filing systems.

- **Be clear about what is involved in working with CATS**.

- **Include health care workers in CATS training** so they know the roles and responsibilities of CATS and to enable them to fully support them.

CATS selection and retention

- **Invest time in selecting CATS** according to strict criteria, ensuring that health care workers fully understand their role and how they will work together. Support CATS to make informed decisions about disclosure to others.

- **CATS Care** make sure systems are in place to enable CATS to deliver and have impact, recognising our moral obligation to support their own health and well-being. This includes providing mental health support and continuing professional development.

- **Adequately provide for CATS and allocate resources** to ensure stipends are sufficient and that there is a prompt and robust system for dispensing them.

- **Develop a pathway for graduation** including preparing young people when they first join the programme, starting savings groups, providing vocational training and partnering with the private sector.
Training, capacity-building and mentorship for health care workers, IPs and CATS

- **Ensure training, capacity-building and mentorship** are continuous to allow for staff turnover and updates in technical information. For example, mental health, social protection, YMMs, M&E
- **Consider language barriers** when training.

Engage young people

- **Listen to and ensure young people are engaged** at all stages, from design, planning, training others and implementation to M&E.

Data and M&E

- **Increase provision of dedicated support to countries to strengthen M&E and data collection**, including age-disaggregated indicators; increase young people’s involvement in M&E, for example, select CATS to review data and advise on programmatic improvements.
- **Explore opportunities for youth-led research**
- **Improve tracking of indicators**, especially viral load indicators, and support this endeavour from the onset of the programme
- **Strengthen data collection** to build a body of evidence for **resource mobilisation** for future scale-up, including for ECHO.

Continuing quality assurance

- Several partners are concerned about **maintaining quality** and want to continue to work with Zvandiri to further enhance quality services, including individual quality improvement plans for each facility with concrete action points. One told us “**We want Zvandiri to keep on checking on quality of services.**”

Documentation and communication

- **Document and communicate** the continuing successes and lessons of the Regional Programme, in particular to WHO, potential donors and potential partner countries.
- **Improve visibility of the Regional Programme** on the Zvandiri website and in social media.

Regional learning exchange and symposium

- This process to review our regional scale-up has underlined the wealth of expertise and experience in all 10 countries. Several partners requested opportunities to connect: to bring all CATS, implementing partners and ministry representatives together — a ‘symposium’ to look at what we are all doing — what have we learnt — and how we can support each other with the challenges — how other countries have navigated problems and what others have added to the Model
- **Engage supported countries to champion the Model to other countries.**
Conclusions

We started with an evidence-based Model based on eighteen years’ experience of implementation and expansion across Zimbabwe and grounded in international best practice, global standards and guidelines. We knew it worked — we had the evidence, together with endorsement from WHO, donors and MoHCC Zimbabwe. We built strong regional partnerships and rolled out the Zvandiri Model utilising WHO’s key considerations for adapting and scaling up peer-based, adolescent-friendly models for service providers and implementing partners, the Zvandiri standard technical assistance package and the technical expertise of our TSU. This methodology has led to successful adoption and adaptation in Eswatini, Ghana, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, and Zambia, with work beginning in Angola in 2022, and additional countries showing interest.

The regional scale-up process has provided further evidence that the Model not only works, but is transferrable. Children, adolescents and young adults, regardless of language, culture or geography, thrive on peer-to-peer engagement and access to quality services that are responsive to their individual needs. Zvandiri is enabling these countries to establish systems for the delivery of quality HIV and mental health services for CAYALHIV, and even in the early stages, is supporting governments to deliver on national HIV strategies and NSPs, which is ‘unlocking’ other funds. For example, initial pilots are now being scaled up with funding from Global Fund (Eswatini, Zimbabwe, Ghana) and CDC (Namibia). Seven of the nine countries have already expanded from their pilot districts and regions, are looking for further funding, or have expressed an interest in scaling up the Model within their national context — even before they have reached accreditation.

Importantly, not only are countries seeing the efficacy of the Model, but they also report that the Zvandiri process for scale-up using our standard technical assistance package and the expertise and experience within TSU have been key to success. Throughout the review process, one of the elements that shone through was the mutual, respectful and supportive relationships that have been built between our technical team and in-country partners: government ministries, IPs, CATS and health facilities. There was a general feeling that the Model was not imposed in the different cultural contexts, but that strong partnerships enabled mutual dialogue and a good balance between fidelity and adaptation. There is an expressed desire for these partnerships to continue and for ongoing Zvandiri technical assistance to ensure programmatic quality going forward.

The Zvandiri Regional Programme is demonstrating a unique model of South-to-South collaboration, showing how we can share learning and expertise and scale up while prioritising fidelity, sustainability and collaboration in the countries most affected by HIV.
What will we do going forward?

Zvandiri will take the learning from this review process and recommendations from implementers on the ground. Specifically, we will work on strategies to strengthen health facility buy-in, CATS selection, retention and graduation processes. We will hone data collection tools and processes through adapted tools and continued regional technical assistance, which will help us to build evidence to support further expansion towards our vision of expanding Zvandiri to 20 countries by 2030 to deliver health, happiness and hope to one million young people living with HIV. We will respond to partner requests to explore opportunities to facilitate South-to-South learning so that we capture and share the wealth of experiences and have mechanisms to support each other cross-regionally, including a Zvandiri ‘Learning Exchange Symposium’ and ‘Community of Practice’.

In summary, this report combines qualitative programmatic and evaluation data that show Zvandiri’s substantial contribution to the lives of 96,000 CAYALHIV across the region. The Zvandiri Regional Programme is demonstrating that the Model is transferrable depending on key government support, dedicated implementing partners, an expert technical team, a standardised technical assistance package and approaches that sustain implementation fidelity. The learning and growth that happens over two years of focused collaboration results in accreditation and handover of the package for the partner country to continue to run and support. For impact at scale, focus now needs to be on reaching additional countries, districts and regions while embedding processes that continue to sustain fidelity to the Model and maintain quality as countries work towards and beyond accreditation.

These results provide a firm foundation from which Zvandiri will support and play a key role in the goals of the Global Alliance to end AIDS in Children by 2030 by addressing glaring disparities in the AIDS response and closing gaps in HIV testing, treatment, retention and adherence. The Zvandiri Regional Programme has demonstrated the efficacy and transferability of the Model, and from this we will further expand towards our vision for longer term, sustainable impact for CAYALHIV across the region.

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v Although impact analysis is not yet available, current and future data will contribute to the essential evidence base on strategic approaches that assist CAYALHIV in high HIV prevalence, low resource settings.
Annex: Country Case Studies
The Eswatini Story

The Zvandiri Model has been operational in Eswatini since 2016 under the READY+ Programme. When it came to a Global Fund call for proposals in 2020, the MoH had seen what the Model could do, that it was recommended by WHO, and that this was backed up by the data presented in ministerial meetings. Young people also attended these meetings and testified to the success of the Model for them and their peers. The Global Fund proposal was successful and Zvandiri now provides a dedicated in-country Technical Assistant to support CANGO in implementation.

Implementing Partner:
Coordinating Assembly of Non-Governmental Organizations (CANGO)

Web links:
CANGO: https://cangoeswatini.weebly.com/
READY: https://frontlineaids.org/our-work-includes/ready/

Started implementing Zvandiri:
2016 - READY+ Programme
2021 - Global Fund

No of CAYALHIV living in Eswatini: **16,524**

As of June 2022: 80 trained and mentored CATS are collaborating with health care workers in 48 health facilities to support 1,877 children, adolescents and young adults living with HIV.*

Viral suppression:
96% of CATS are virally suppressed
89% of CAYALHIV are virally suppressed.*

* READY+ and Global Fund figures combined

Key highlights of the Zvandiri technical assistance plan
- CATS training
- Online training and continued mentorship
- Provision of a dedicated Technical Assistant
- “They always say ‘you learn from the best’ and from the beginning we used the Zvandiri data collection tools, which made our work easier.”

Positive change
- “We are contributing a lot in terms of the National Strategic Plan indicators and we are seeing progress with HIV. We are the first country among SADC to reach 95-95-95.”*
- “The CATS Programme is instrumental in bridging the gap between parents, young people and health service providers.”
- “The overarching effect we are seeing with the programme is the empowerment of young people.”

Our proudest moment:
“The CATS are ‘soldiers on the ground’ — they disseminate information for various health and social protection services. They ensure young people know why they are taking ARVs and this creates demand for services. When there are gaps in service delivery, CATS and implementing partners check in regarding issues like gender-based violence etc.”

Factors for success:
- Build and maintain a strong relationship with government ministries
- Align M&E indicators with ministry indicators
- Link the programme with other organisations providing outreach services.

Hopes for the future:
- Expand Young Mentor Mothers programme (included in READY 2)
- Develop a graduation package including skills building and an internal savings and lending scheme.

Would you recommend Zvandiri?
“In terms of recommending the Zvandiri Model to other countries and partners — it’s a big yes!” We are seeing a lot of partners in country who are really interested in the programme. We are saying — as long as they have money, we can provide them with technical assistance. We have seen this with the Global Fund — I would recommend the Model because we are the lead now in Eswatini — we have the expertise. This has led to expansion through the Global Fund.”
The Ghana Story

The Ghana National AIDS/STI Control Programme (NACP) signed an MoU with Zvandiri following a WHO technical working group in Ghana, where the Model was showcased. The NACP could see that Zvandiri spoke to the big gaps it faced in paediatric care. A successful learning visit to Zimbabwe began Ghana’s Zvandiri journey. “We came back and the support didn’t end. The remote support happened on average every two weeks through the pilot phase — every engagement with the Zvandiri team was a learning moment.” In December 2022, the Christian Health Association of GHANA (CHAG) came on board as an implementing partner, scaling up from two to eleven districts. In addition to the standard Zvandiri Model, Ghana is working on economic empowerment, as well in schools with HIV positive teachers who are helping to reach young people.

Implementing Partners:
National AIDS/STI Control Programme (NACP)
Christian Health Association of GHANA (CHAG)

Web link: https://chag.org.gh/

- Started implementing Zvandiri: 2019
- No of CATAL HIV living in Ghana:
  - 26,810 (0–14)
  - 317,410 (15–24)

As of June 2022: 80 trained and mentored CATS are collaborating with health care workers in 46 health facilities to support 1,011 children, adolescents and young adults living with HIV.

Viral suppression
94% of CATS are virally suppressed.

Key highlights of the Zvandiri technical assistance plan
- “The learning visit to Zimbabwe was an eyeopener — we learnt a lot and especially noted the strong collaboration between Zvandiri and the MoHCC.”
- “E-mentorship is really, really helpful. Every time we meet there is something new to be learnt and learning is not just uni-directional — there are opportunities for dialogue.”
- “Tools — we were not just given an M&E tool — Zvandiri worked with us to adapt the tools to suit our country so as not to burden our service providers unduly. Before, we weren’t collecting such data.”
- “The on-site support we received for training CATS. We have learnt a lot and are hoping to replicate this with other cadres, e.g. Mentor Mothers.”

Positive change
- “In 2020 we had about 40% increase in the number of children enrolled into care and about 80% of them came from index testing, which we learnt about through Zvandiri.”
- “This peer support intervention is addressing a lot of stigma-related challenges for younger ones.”
- “The CATS have contributed significantly to improving the treatment cascade for children. Before we started, treatment coverage for children was below 20% (around 2018), but now it’s over 50%.”

- “We noticed significant impact on viral suppression in facilities with CATS compared with facilities that don’t have CATS.”
- “The number of facilities providing paediatric HIV services has increased — we have trained a number of clinicians and developed IEC to support them.”
- “Health facilities now consider appropriate working hours for children so that they don’t miss school.”
- “Success in initial 2 regions (Ashanti and Greater Accra) has already led to expansion to a total of 11 regions.”

Our proudest moment:
- “Zvandiri has helped us achieve epidemic control through the National Strategic Plan targets and improved the paediatric contribution towards epidemic control in Ghana.”

Factors for success:
- Embed the Zvandiri Model in MoH
- Engage with facilities early to recruit the right young people as CATS and work on retention
- Ensure health facility buy-in
- Include health care workers in CATS training so they understand the benefits of the CATS and how to support them
- Fully engage young people in planning, delivery and M&E.

Hopes for the future:
- Scale up to more facilities and regions
- Add Young Mentor Mothers
- Learning exchange between implementing countries in the region and CATS.

Would you recommend Zvandiri?
“Of course I will recommend it. It is very good — apart from just improving numbers in the country, for the young ones—it’s not just HIV—this model supports them comprehensively.”
Dr Raphael Adu-Gyamfi, NACP

“It is a good model that targets the specific needs of young people. I also like the material that you have developed, for example, the Masas’ game.”
Ignatius Terence Ako-Nnubeng, CHAG
The Mozambique Story

The Zvandiri Model has been operational in Mozambique since 2017 under the READY+ Programme. REPSSI Mozambique has a memorandum of understanding with the MoH, which has assigned health facilities for the implementation of the programme.

Implementing Partner:
Regional Psychosocial Support Initiative (REPSSI), Mozambique

Started implementing Zvandiri: 2017—READY+ Programme

No of CAYALHIV living in Mozambique: 120,000

As of June 2022: 102 trained and mentored CATS are collaborating with health care workers in 25 health facilities to support 6,046 children, adolescents and young adults living with HIV.*

Viral suppression: Data not available

* Combined data from READY + and R4AFF

Key highlights of the Zvandiri technical assistance plan
- CATS training
- E-mentorship with the implementing partners.

Positive change
- “The implementation of the READY programme is supporting the response to the two main objectives of the National Strategic Plan for HIV.” (reduction of the number of HIV infections among adolescents and young people, and reduction of the number of HIV and AIDS-related deaths).
- REPSSI is using its expertise in mental health and psychosocial support to enhance HIV outcomes.
- Adolescents and young people are advocating for their rights on different platforms.
- “The results of the CATS interventions have shown that the peer-to-peer model is supporting young people’s adherence and retention in ART treatment... and the programme is contributing to their psychosocial well-being.”

Our proudest moment:
A positive HIV test left Cristalina very upset — she hadn’t suspected she had HIV and she had a young daughter under four years old. Soon after, Cristalina received counselling and support from a CATS. Initially, she was still not reassured and could not accept her status. The CATS was not put off, visiting her regularly at home, getting to know her and understand her life, and offering regular psychosocial care and support. These regular home visits and phone calls provided Cristalina with the information she needed and supported her to accept her status and begin ART.

One of Cristalina’s biggest fears was disclosing her HIV status to her father as she was afraid of disappointing him. Through continued support from the CATS, she decided that the best thing was to reveal the truth to her father and she opened up and shared her story. Thankfully, he was supportive and she started treatment. Cristalina was very grateful to the CATS and began attending support groups, where she is continuously acquiring more information, enhancing her knowledge of HIV, and she feels really welcomed through the READY+ programme.

Factors for success:
- Collaboration with MoH
- Savings and credit groups for graduating CATS
- Implementation fidelity.

Hopes for the future:
- Scale-up—especially to high prevalence provinces.

Would you recommend Zvandiri?
“Surely, I would recommend the Model—it has proved to be effective among adolescents, especially in ensuring enrolment and adherence to treatment.”
Julio Mutemba, REPSSI Mozambique
The Namibia Story

Following a learning visit to Zvandiri in Zimbabwe, members of the MHSS and a youth advocate “were amazed by the work Zvandiri was doing with the Zimbabwe MoHCC. We visited facilities, met CATS — it was amazing. We came back and started implementation. We developed good relations with the Zvandiri Team who came to Namibia to introduce the programme to others, including health care workers.” The Namibian team was particularly attracted to Zvandiri’s ‘nothing about us without us’ principle that placed young people firmly at the centre of all interventions. The Model was rolled out initially in two regions, rapidly expanding to a further three regions in 2020.

Implementing Partner:
Ministry of Health & Social Services (MHSS)

Started implementing Zvandiri: 2019

No of CAYALHIV living in Namibia: 20,284

As of June 2022: 81 trained and mentored CATS are collaborating with health care workers in 40 health facilities to support 1,910 children, adolescents and young adults living with HIV.

Viral suppression:
- 98% of CATS are virally suppressed.

Key highlights of the Zvandiri technical assistance plan
- “There are just so many! The orientation stands out for me because it gave me a clear picture of how the NATS programme works.”
- “The quality of training, especially training of trainers — now we can cascade the training as we roll out to new regions.”
- “Every contact with Zvandiri is very helpful—even when you couldn’t come—although not face-to-face, we did baseline assessments and you were there to guide us along the way.”
- “Ongoing mentorship empowered me in areas I was struggling with.”

Positive change
- “Teen club enrolment increased and staff at NATS implementing facilities reported that children and adolescents were more open to discussing personal information with NATS. Their knowledge around HIV increased and they got more support. It became clear that the programme is well placed to address adolescent health and issues connected to adolescents living with HIV and their SRH — one of the priority areas in the Namibian National Strategic Framework.”
- “NATS are definitely integrated into the health system and are fully involved in planning and monitoring and patient services.”
- There are adolescent-only days and allocated spaces for support groups and CATS in 10 facilities.
- NATS are helping with stigma and discrimination and conducting home visits together with health care workers.
- The programme is identifying young people with high viral load, communicating with their parents through caregiver groups, and NATS are following up with support and referrals.
- Information, education and communication materials and videos are now geared specifically towards young people.

Our proudest moment:
Tomas came for follow up and his viral load had changed from less than 40 copies per ml to 4,470 copies per ml. The NATS talked to him and he told them he had moved into a hostel and his mother had told him to give his medication to the school matron. His roommates noticed him going to the matron’s office and started bullying him, which made him feel ashamed and he often missed visits to the matron for his medications.

The NATS and her supervisor talked to Tomas about the importance of medication, and the different opportunistic infections he may get if he doesn’t take it properly. They played the Masas’ game with him to explain these issues and together agreed that Tomas would keep the medication with him and take it in privacy. Tomas’ mother was informed and supported the idea. After a few months, his viral load was repeated and was undetectable. He was happy and learnt not to mind what his peers were saying about him.

His mother thanked the NATS for continuous communication with her son, saying it had become much easier to talk to him about issues surrounding HIV and treatment.

Factors for success:
- Take time to select NATS carefully, including ensuring they are comfortable disclosing their HIV status
- Assess and secure spaces in health facilities from the beginning
- Have a robust system to assess and disperse allowances
- Train programme officers together with NATS so they have a good understanding of the work of the NATS
- Ensure the NATS — client ratio is realistic.

Hopes for the future:
- Continue to scale up — already scaled from two pilot regions to an additional three. Now MHSS plans for two more regions for COP 22.

Would you recommend Zvandiri?

“I believe the NATS programme can be a great model... I can definitely recommend it for another country.”

Sylvia Ashikoto, MHSS
The Rwanda Story

The Zvandiri Model was recommended to Dream Village by their donor—the Leonard Bachman Foundation. Following a learning visit to Zvandiri in Zimbabwe, Dream Village and the Rwandan MoH were “convinced this was the model for us because it offered the best holistic outcomes. It aimed to address our challenges and we liked that the CATS are always in the health centre. When you go to Dream Village health centres today, you can see a difference.” As well as implementing the standard Zvandiri Model, Dream Village has added economic empowerment through start-up support for business—for example, young people have started a catering business and are preparing food for support groups.

• “Caregivers support groups are tackling stigma and impacting viral suppression.”
• “Support Groups for young mothers are growing and linking them to care and treatment, nutrition support, income generation and health insurance.”
• “Young people representing Dream Village sit on a quarterly committee, feeding their challenges and needs into national planning processes.”

Our proudest moment:

Jocelyne grew up in a small village about 200km from Kigali. As a child, she was unaware of her HIV status. She was continuously falling ill and finally, at the age of 15, was the only child in her family to test positive for HIV. She had many struggles — self-stigma, stigma from her family and peers, and she didn’t go to school. She felt hopeless and depressed and that she no longer had anything to live for—leading to two suicide attempts aged 20. She survived, but was left blind.

Jocelyne was referred to RBC and Dream Village who connected her to the Blind Association and took her to several other doctors. In March 2020, Jocelyne had an operation and miraculously regained vision in both eyes!

Through Dream Village, Jocelyne was linked with a CATS who listened and provided peer counselling to help her accept her status and to learn to live a healthy, happy and fulfilled life. Her family became more involved and began to support her, accompanying her to clinic visits. She now attends support groups and is sharing her story with her peers. She openly talks about the dangers of stigma and suicide attempts and tells other young people, “When you have a challenge, dying is not the only solution.”

Jocelyne, now 23, has full vision in both eyes, a suppressed viral load, and is filled with hope and a world of new possibilities.

Would you recommend Zvandiri?

“I would 100% recommend the CATS Model to any country that wants to see outcome-based solutions for CAYALHIV. It is one of the few models that works closely with the health system—it is not in isolation. The health centre becomes the basis for interventions and also solutions and the community is involved in what is happening there. For any country that wants to really adapt to support young people—I would recommend.”

Manzi Norman, Director, Dream Village
The Zambia Story

During a visit to Namibia, Project Hope’s Regional Director had seen first-hand the value that Zvandiri was bringing to the DSD model for CAYALHIV. It was evident how CATS in Namibia were changing the lives of their peers, disclosing and sharing experiences. The Zambian team were motivated by the peer-led nature of the Model and how it builds adolescents’ capacity to be part of the solution to challenges faced by their peers. The MoH recognised Zvandiri’s potential to support government efforts to address adolescent HIV in Zambia.

Implementing Partners:
- Project Hope
- Centre for Infectious Disease Research, Zambia (CIDRZ)

Web links:
https://www.projecthope.org/country/zambia/
https://www.cidrz.org

- Started implementing Zvandiri: 2021
- No of CAYALHIV living in Zambia: 65,000
- As of June 2022: 119 trained and mentored CATS are collaborating with health care workers in 37 health facilities to support 2,200 children, adolescents and young adults living with HIV.

Viral suppression
- 98% of CATS are virally suppressed.

Key highlights of the Zvandiri technical assistance plan
- Virtual orientation for health care workers
- Training and ongoing mentorship
- Zvandiri M&E tools and support to adapt them to the Zambian context.

Positive change
- “Every CATS intervention is squarely aligned with the 95-95-95 goals. It has already been picked by the MOH that we are contributing to the national strategic plan through the CATS interventions.”
- “Before the CATS Programme, I am not sure if our health facilities were exposed to the WHO Global Standards. Now most health staff are trained in quality standards and know how they can provide quality services to adolescents.”
- Health staff are now trained as Support Group Leaders and are able to provide quality services and support to CAYALHIV
- CATS are mobilising their peers and providing information sessions around HIV and other issues.
- “The MOH health care workers are very supportive and are driving the programme; they are owning the processes and you can see the cordial relationship between our MOH health care workers, the CATS and other health facility staff members.”

Our proudest moment:
- “Being a CATS has really helped me a lot whereby I have accepted who I am today. I have come to terms with things that used to bother me. At first, I was bothered by my HIV status, I felt it was a burden. Ever since I became a CATS everything is fine.”
- “I am more confident than ever before. I have become more knowledgeable; I have learnt different skills and I am now able to talk in public! It’s really been a great journey.”
- “Me being a CATS encourages me to take my medication. It’s an amazing thing for me in the sense that I have gained skills on how to support adolescents living with HIV.”
- “I am able to help those that are having difficulties in accepting their status.”
- “I have become proud of myself by sharing my story to help adolescents adhere to ART and become virally suppressed.”
- “I am now able to identify adolescents that are defaulting from medication and give them the help they need.”

Factors for success:
- Careful CATS selection and ensuring they understand what it means to be a CATS
- Adequate resources and allowances for CATS
- A path for graduation, e.g. savings groups, private sector job opportunities etc.

Hopes for the future:
- Scale up to more facilities and train more CATS
- Continue to engage with Zvandiri to ensure quality of services in health facilities.

Would you recommend Zvandiri?

“Certainly, I would recommend it! I have seen how it has really contributed. Using volunteers — quite a lot of clients were lost, but with the CATS, most of the ones they lost are coming back. I wish you could hear these words from the health care workers themselves of how they appreciate what the CATS are doing to supplement their work when it comes to, for example, defaulter tracing, engaging adolescents that could have defaulted at any point. Yes, because it contributes to retention in treatment and viral suppression for all CAYALHIV.”

Esther Ngulube-Chileshe, Project Hope
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