Regional Update on Adolescent HIV: Progress and Priority Actions

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Super Fast Track Targets

➢ Reduce new infection among AGYW by 95%
➢ Ensure 95% of all adolescent living with HIV are on ART

BY 2020!!
Progress!

- Understanding of Adolescence
- Global Health and HIV plans
- Country-level Political Commitment and Leaders
- Regional Initiatives and Catalytic Funding
- Improved Data and Use
- More evidence of what works!
- Strong Youth-led Advocacy
New Infections

New HIV Infections amongst Adolescent Boys and Girls (10-19 years old): 2010-2018, ESA

Data Source: UNAIDS Estimates, July 2019
HIV Testing Gap

Percentage of men and women who ever tested for HIV and received results by age: 2011 - 2016, SSA

HIV/SRH Knowledge

Young people (15 - 24 years) still have **low or incorrect knowledge** about HIV prevention.

Only in **3 ESA countries** do 50% of young people have adequate HIV prevention knowledge.

In Kenya, fewer than **1 in 4** samples students (15-17 years) had learnt about contraception.

Only **15%** knew **where to get access** to contraception.

Data Source: UNAIDS Estimates, July 2019
APHRC & Guttmacher Institute, 2017
Linkage to Health Services

**Limited understanding** linkage for adolescents including HIV Self Testing

**Higher rates of loss to follow up** for 15-19 and 20-24 year old’s

**Complex barriers** to accessing services
Estimated number of Adolescents living with HIV

Data Source: UNAIDS Estimates, July 2019
AIDS–related Deaths

Number of AIDS-related Deaths among 0-24 years in Five-Year Age Bands:
ESA (2010 – 2018)

Data Source: UNAIDS Estimates, July 2019
Adolescents Initiated on ART

10 - 14 year olds
64% initiated ART

15 - 19 year olds
44% initiated ART

Maskew et al. Lancet 2019 Oct 1
Virologically Suppressed

Eswatini PHIA – 2016-2017

Uganda PHIA – 2016-2017

Tanzania PHIA – 2016-2017

Malawi PHIA – 2015-2016

PHIA Survey, ICAP https://phia.icap.columbia.edu/
Mental Health Of ALHIV

- Clinic study in Nairobi
  - 50% had depressive symptoms
  - Complex associations – clinical, environmental, social

- Clinic study in Johannesburg
  - ~30% had 1 or more symptoms of depression, anxiety, PTSD or suicidality

- Contributes to negative outcomes at each stage across the HIV cascade

Parcesepe et al, 2018; Gaitho et al, 2018; Wollet et al, 2017; Remien et al, 2019
**SRHR of ALHIV**

**Sexual Debut**  
Nearly ½ adolescents had had sex  
Between 1/2 and 2/3 reported older sexual partner during first sex

**High risk sexual practices**  
1/3 – ½ of participants reported unprotected sex at last sex  
1 in 5 reported engaging in transactional sex or having sex for money or goods

**Contraception use**  
1/3 are on a form of contraception  
Only 5% on combined contraception – (1 study in Uganda)

**Sexually Transmitted Infections**  
HSV-2 was found in 50% of ALHIV and HPV at 88%

Toska et al. PloS One 2017 Jun 5
Pregnant and breast feeding ALHIV

Over **130 births for every 1,000 adolescent girls** in 5 ESA countries

**Lower PMTCT** service uptake

**Higher rates** of mother-to-child HIV transmission

Callahan, Tet al. JIAS 2017 Aug 4; 20 (1):21858
WHO global data observatory accessed 29/09/2019
Cross-cutting issues: COORDINATION AMONG PARTNERS, STIGMA REDUCTION, ADDRESSING STRUCTURAL ISSUES [e.g. mobility], IMPROVING DATA QUALITY AND AGE DISAGGREGATION, BUILDING CAPACITY, OFFERING SUPPORTIVE SUPERVISION TO ALL STAFF
Scaling Up Services

Strengthen use of data to inform programmes
- Age, sex and sub-national disaggregated data!
- Ensure interventions scaled, work
- Expand understanding of key clinical AND psychosocial outcomes
- Use the data advocacy and resource mobilisation

Galvanise the role of national programmes
- Facilitate coordination and partnership mechanisms i.e. TWG’s also at district level
- Ensure interventions for ALHIV are incorporated in national HIV plans and policies with implementation plans
- Harness the expertise of NGO’s to support national programme scale up of ALHIV interventions
Reaching ALL Adolescents

Build the capacity of implementers
• Standardise national packages including operational tools and training curriculum
• Clearly define peer provider roles and responsibilities, with accountability and compensation.
• Implement supervision, mentorship and support mechanisms

Prioritise sustainability
• Champion the broader adolescent health agenda
• Advocate for inclusion of scale up funding within broader funding mechanisms
• Understand cost considerations, prioritizing the elements of greatest impact

Explore new interventions and approaches!
• New interventions that take into consideration the diversity of ALHIV including understanding the role of digital technology
Takeaways!

Begin with the end in mind!

Think about scale

Love you data!

Use it, learn from it
Thank you!

Acknowledgements
Laurie Gulaid
Alice Armstrong
ASRHR: The Mildmay Uganda one stop shop experience
Background

- 1998, Mildmay opened to strengthen paediatric HIV and AIDS service delivery in Uganda

- Followed by adult care, adolescents were left out

- Young children growing into adolescence and later adulthood

- Before 2007, had abstinence gospel but adolescents were getting pregnant

- Many are sexually active without protection against STIs and pregnancy, fear disclosure of status, sexual activity and pregnancy
• In 2009, the peer-led approach to empower young PLHIV for SRHR

- Health workers trained on delivery of adolescent services: clinicians
- Adolescent counsellors
- Adolescent peer educators: YPLHIV
Services offered

- 10-14 - hygiene, academics, making choices, acceptable behavior in society, expected changes in adolescence etc. (Tuesdays)

- 15-19 - managing adolescence, career guidance, life skills, Relationships, family planning and abortion, entrepreneurship (Thursdays)

- 20-24 - entrepreneurship, career guidance, relationships, transition and SGBV among others (Fridays)

- Other services include peer counseling by the peer educators and the adolescents are involved in multiple age appropriate peer support groups
• Multidisciplinary team approach
The Adolescent clinic block

**Peer/ Counsellor/ clinician**
Health education on general and specific topics, as the clinic goes on... peer to peer talk/ one on one, adolescents needs picked up, Peer attachments, sharing contacts for on going

**Clinician**
Clinical and other needs assessment, uses the RH tool which identifies specific needs through probing.

**ADOLESCENT**

**Social worker**
Empowerment, social/ economic/ education which may be formal or apprenticeship

**Reproductive health staff**
Registration, specific RH counselling, service provision, brochures given, condom dispenser refills
• Sample clinician’s tool

<table>
<thead>
<tr>
<th>DATE</th>
<th>SEX</th>
<th>ON ART</th>
<th>ON APPOINTMENT</th>
<th>SEXUALLY ACTIVE</th>
<th>PARTNER DISCLOSURE</th>
<th>CONDOM USE</th>
<th>OTHER FAMILY PLANNING</th>
<th>BABY &lt;2 YEARS</th>
<th>STATUS OF BABY</th>
<th>CAX SCREENING IN THE LAST 1 YEAR</th>
<th>ON/EVER RECEIVED IPT</th>
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<tr>
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SRH services offered

• counselling and support on HIV prevention and SRH
• call-in centre for adolescents to talk to someone about health concerns
• basic health screening and management of STIs
• family planning services
• cervical cancer screening, breast examination
• eMTCT
• adherence and positive prevention counselling services
• consultations with various technical staff at MUg including counsellors, doctors, nurses, social workers, among others.
Result ranges on selected parameters through quarters

- Total number .......... 1400 to 1550 adolescents
- Viral suppression ........ 90% to 94%
- Retention in care ......... 98%
- Sexual activity ........ 9% to 12%
- Partner disclosure ......... 65% to 80%
- Condom use ............... 62% to 78%
- Cervical cancer screening .... 2% to 4%
Challenges

- **Stigma:** Balancing positive living and exploring sexuality is a real challenge for this age group.

- **Conflicting desires and expectations:** Some caretakers may persuade pregnant ALHIV to have an abortion, sometimes choosing unsafe environments.

- **Interruption in services:** School terms may interrupt peer-to-peer follow up, especially for those ALHIV who have to spend time away at boarding school.
Factors for success

- Integration of adolescent-friendly sexual and reproductive health services into routine HIV care

- Strong programme focus on individual responsibility, disclosure and building self-esteem.

- Training of health workers in ASRH opened communication between adolescents and health workers.

- A peer-led approach led to increased referral and uptake of services
Factors for success

- A one stop shop for all ASRH services resulting in satisfied customers

- Segmentation of groups by age, gender, sexual activity status, etc

- Education and counselling caretakers of ALHIV

- Continuous needs assessment allows the programme to adapt to meet the changing needs of the target population.
Community Youth Clubs

A differentiated model of care for HIV positive youth integrating SRHR services
Background

- South Africa's population is largely made up of young people (66% below the age of 35 years)\(^1\) with a high HIV prevalence and incidence\(^2\).

- We are struggling in reaching the 90-90-90 for youth with only 40% of HIV positive youth (15-24) on ART

- Facility youth clubs have shown good retention in care

- Community models of care:
  - decongest facilities
  - appealing option to youth (meeting outside facilities that are not always youth friendly)
  - Convenient and quick

1. UNFPA http://southafrica.unfpa.org/en/topics/young-people-1
Background: SRHR context

- In context of high rate of unplanned pregnancies and high rate of gender based violence, provision of SRHR services to youth is key

- Integrated sexual and reproductive health with HIV services is recognized as key by policy makers internationally (WHO guidance on youth-friendly services) and nationally (SA National Adolescent & Youth Health Policy 2017)

- Community youth clubs is a model of care that offers integrated SRHR and HIV services
Local context

- Khayelitsha: Peri-urban township of ~500,000 people outside Cape Town

- MSF supporting City of Cape Town in Youth clinics (age 12-25) since 2009:
  - Termination of pregnancy since 2009
  - Youth clubs since 2012
  - Youth community clubs since 2017
  - PrEP provision since 2017 (study)
The Building Blocks of Community Youth Clubs

**WHAT**
- Group of 15-20
- Age 20-25 in clubs for >2 yrs
- ART refill
- Adherence support
- Psychosocial care

**WHERE**
- Community hall

**WHO**
- Nimart nurse
  (clinical management including pap smear, family planning)
- Counselor / Facilitator
  (club preparation, symptom check, facilitate sessions)

**WHEN**
- 2 monthly
## Services provided to youth club members

<table>
<thead>
<tr>
<th>WHEN</th>
<th>STABLE ART</th>
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<tbody>
<tr>
<td>DURING CLUB</td>
<td>Weight</td>
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<tr>
<td>Lay counsellor</td>
<td>Symptom check, Phone number check, Pre-packed ART refill</td>
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<tr>
<td>AFTER CLUB</td>
<td>Annual VL + annual clinical review, Family planning</td>
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<td>Club allocated nurse</td>
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Running CYC sessions

**Phase 1**
- Weight & symptom check
- Phone number confirmation
- Register completion
- Group files, next YC date written on card

**Phase 2**
- Quick ice breaker,
- Introduce topic (including SRHR topics)
- Encourage youth to participate in discussion

**Phase 3**
- Distribute pre-packs to youth
- Take rest of pre-packs to nurse
- Condoms and lubricants distributed
- Send youth who need to see nurse for family planning
- Annual HIV clinical check up done by nurse, including pap smear (done at the facility) and provision of family planning
Topics covered on the YCC session guide

Session 1: Welcome to your Youth Club
Session 2: Disclosure and relationships: do I, don’t I?
Session 3: Adherence and social life: tips and experiences
Session 4: Stigma and discrimination: sexual orientation and HIV
Session 5: Sex and relationships
Session 6: Stress and coping skills (includes colour images for printing)
Session 7: Who am I?
Session 8: My future (includes colour images for printing)
Session 9: Gender roles and expectations
Session 10: Violence within relationships
Session 11: Communication within relationships
Session 12: Being a young parent (includes colour images for printing)
Session example

• Violence within relationship

Divide the club into small groups of two or three and provide them with scenarios and questions to discuss.

• Now think about who has the power in those different relationships and why. Encourage discussion, e.g. boyfriend has power over girlfriend because he is stronger, teacher over pupil because he is older, husband over wife because he has the money etc.

• When there is a strong power imbalance in relationships the ‘stronger’ person may take advantage of the other. This may happen in the form of verbal, physical, sexual or economic abuse. It is not healthy and you should seek support.
Outcomes

*Out of 79 club members, 3 transferred out and of the remaining 76, 65 (86%) completed a VL at 18 months. Out of 65, 64 (98%) had a suppressed VL.*
Lessons learned

• Community youth clubs can provide integrated HIV care and SRHR services to youth (family planning, pap smear, education)

• Psychosocial support is a vital component of SRHR services and some of it can be provided via youth club models

• Community youth clubs show non inferior results to youth facility clubs

• Challenges in running community youth clubs include availability of transport, need for dedicated nurse at each visit as well as good planning of the services.
THANK YOU 😊
Acknowledgements

• City of Cape Town
• The youth
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• TAC (Treatment Action Campaign)
• Provincial Department of Health
Thank you for joining a webinar hosted by the Children and AIDS Community of Practice.

*The Children and AIDS Community of Practice connects professionals around the world on HIV and AIDS topics on children, adolescents and women. Led by UNICEF, the Community has over 4000 members.*

*To learn about upcoming webinars, events and learning activities as well as stay up to date on research and publications on these topics, join the Community: [www.knowledge-gateway.org/childrenandaids/join](http://www.knowledge-gateway.org/childrenandaids/join)*

The webinar presentations and recording will soon be available on [www.childrenandaids.org/webinar](http://www.childrenandaids.org/webinar)

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