



Regional Update on Adolescent HIV: Progress and Priority Actions

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Outline



Super Fast Track Targets



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

BY 2020!!



Outline



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

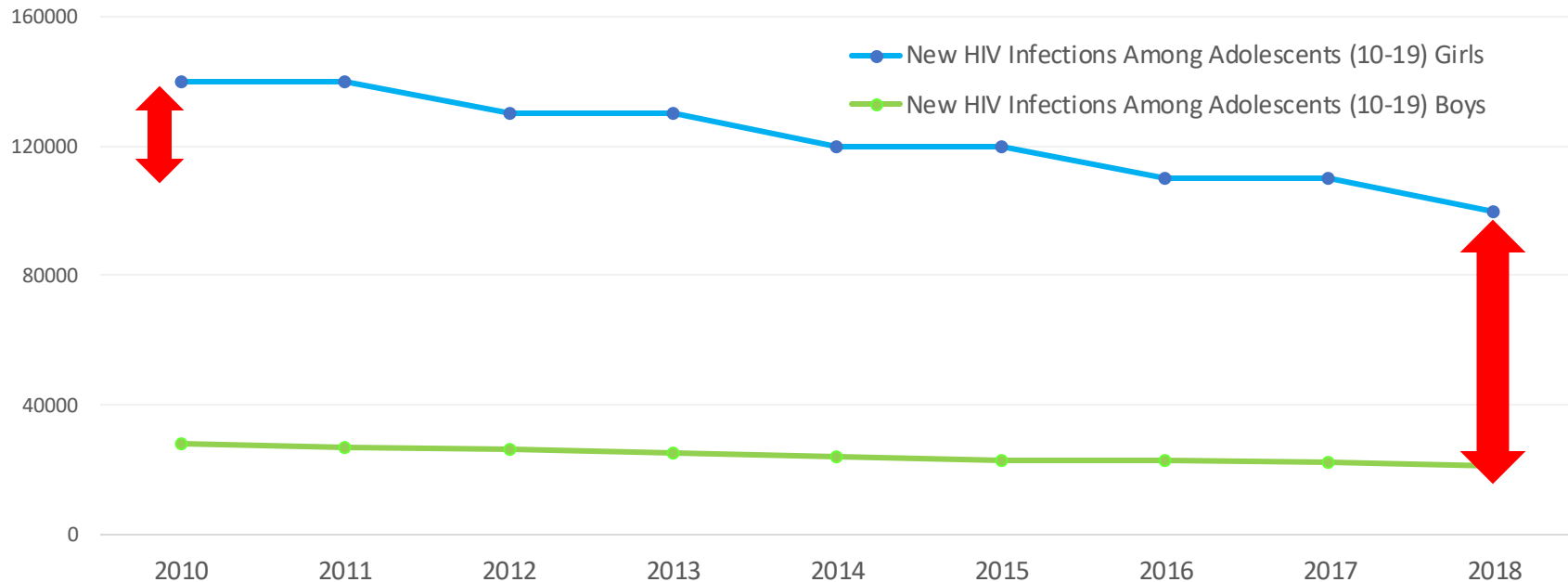


GLOBAL NETWORK OF
YOUNG PEOPLE
LIVING WITH HIV

New Infections



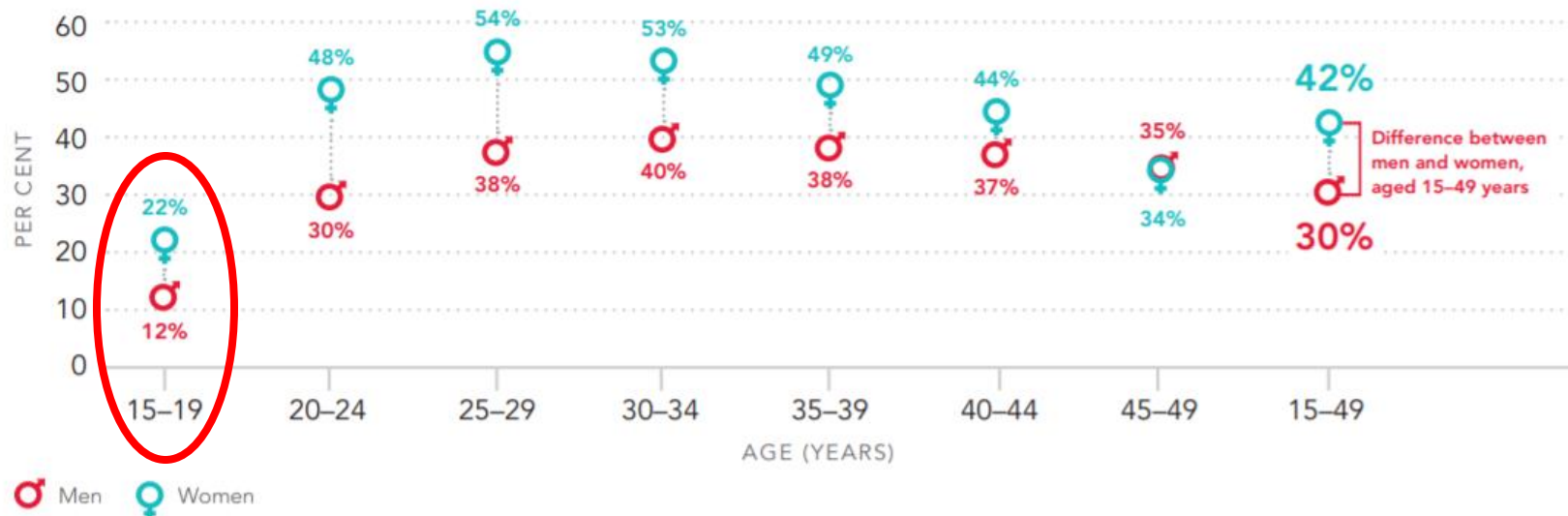
New HIV Infections amongst Adolescent Boys and Girls (10-19 years old): 2010-2018, ESA



HIV Testing Gap



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



Source: Population-based surveys, 2011–2016.

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

Linkage to Health Services

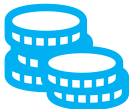


Limited understanding linkage for adolescents including HIV Self Testing



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

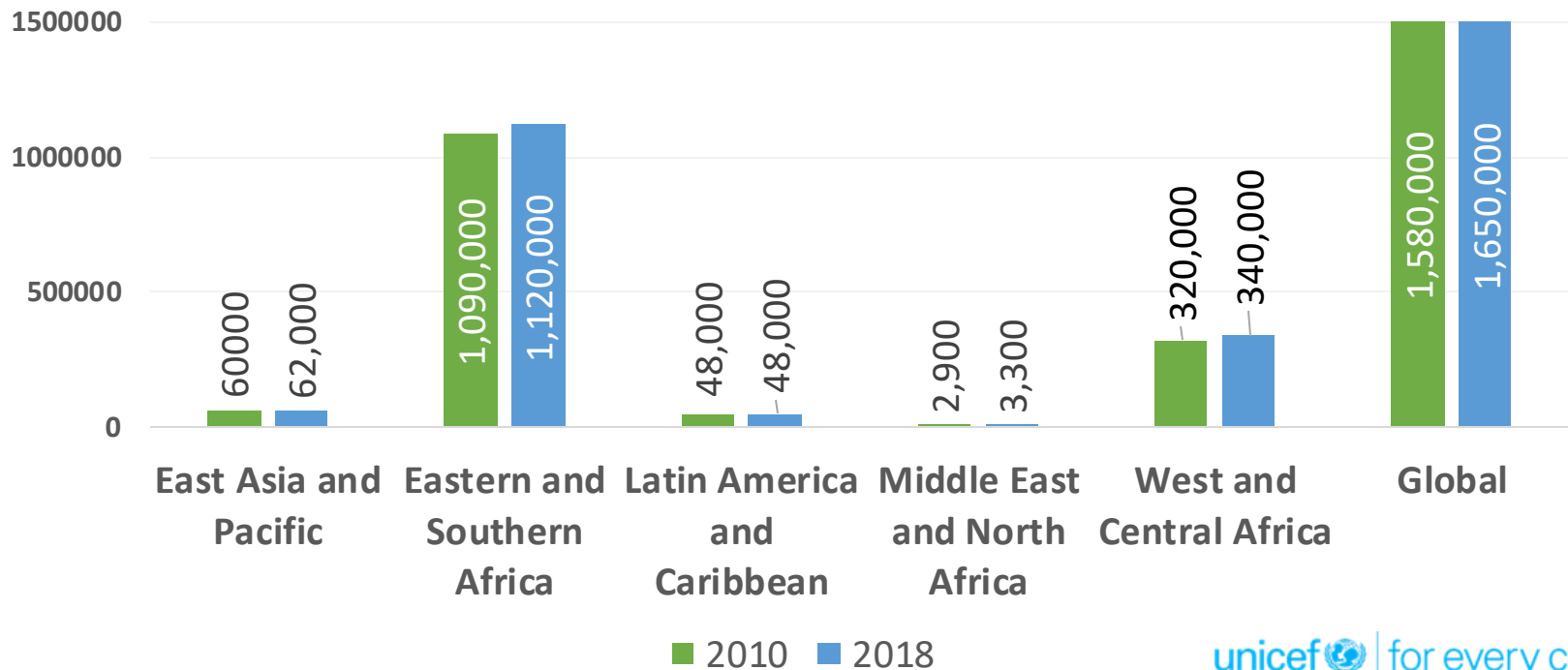
Complex barriers to accessing services



Adolescent Living with HIV



Estimated number of Adolescents living with HIV

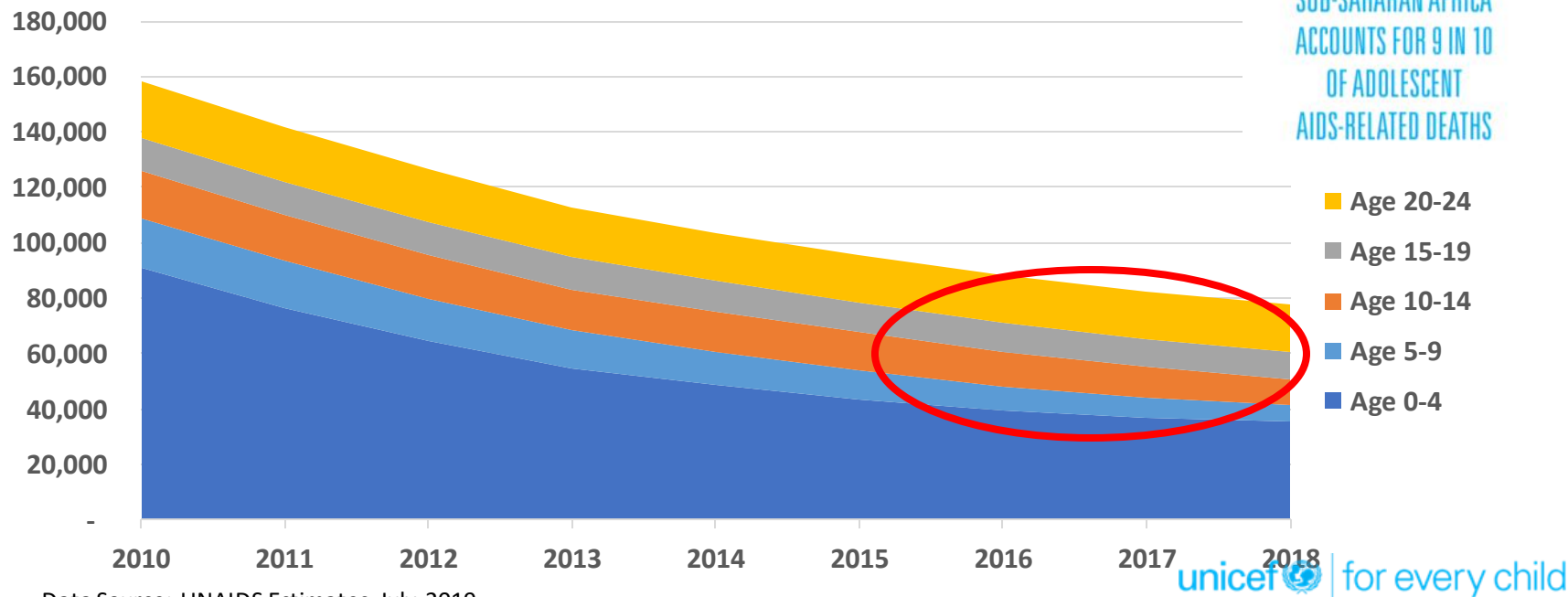


Data Source: UNAIDS Estimates, July 2019

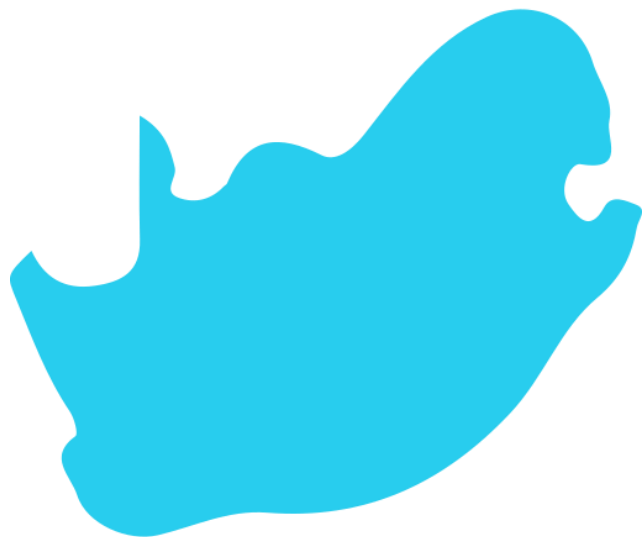
AIDS-related Deaths



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



Adolescents Initiated on ART



10 -14 year olds

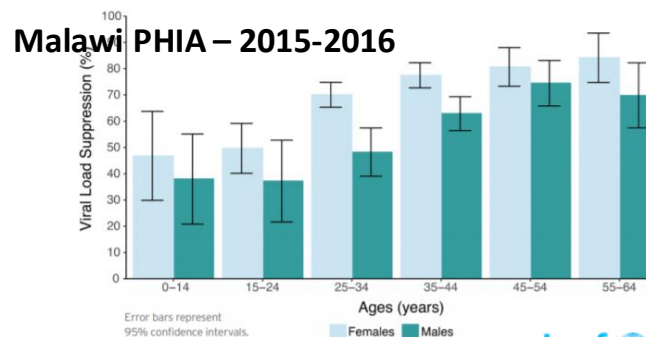
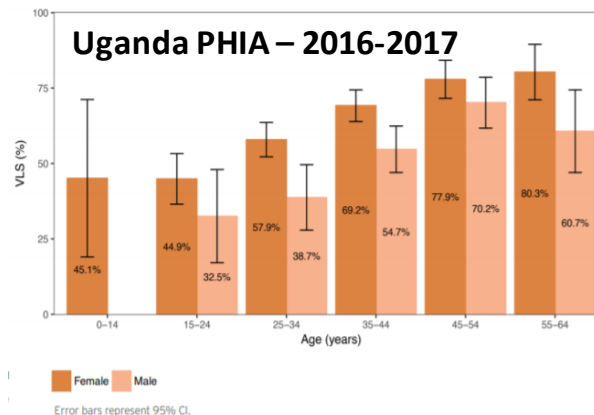
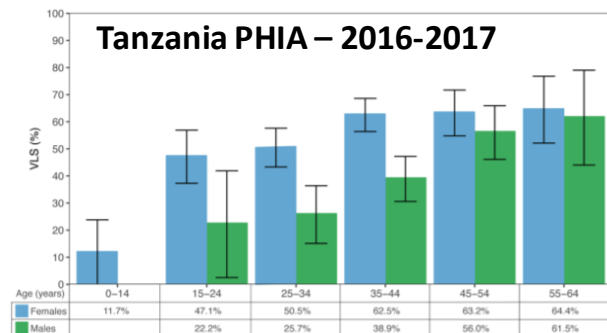
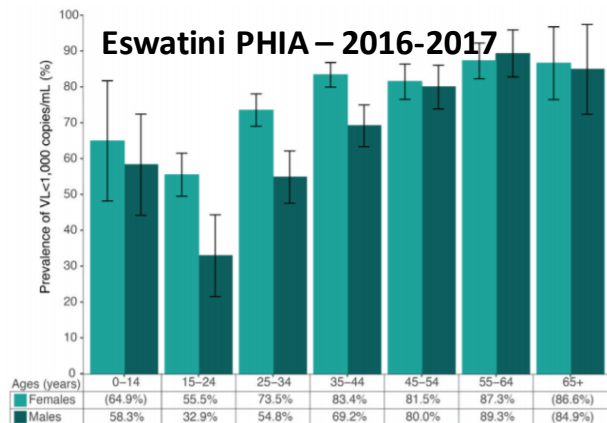
64% initiated ART



15 -19 year olds

44% initiated ART

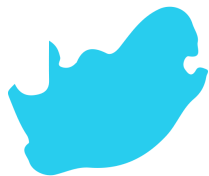
Virologically Suppressed



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**

SRHR of ALHIV



Sexual Debut

Nearly $\frac{1}{2}$ adolescents had had sex

Between $\frac{1}{2}$ and $\frac{2}{3}$ reported older sexual partner during first sex



High risk sexual practices

$\frac{1}{3}$ – $\frac{1}{2}$ 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

$\frac{1}{3}$ 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%

Pregnant and breast feeding ALHIV



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



Lower PMTCT service uptake

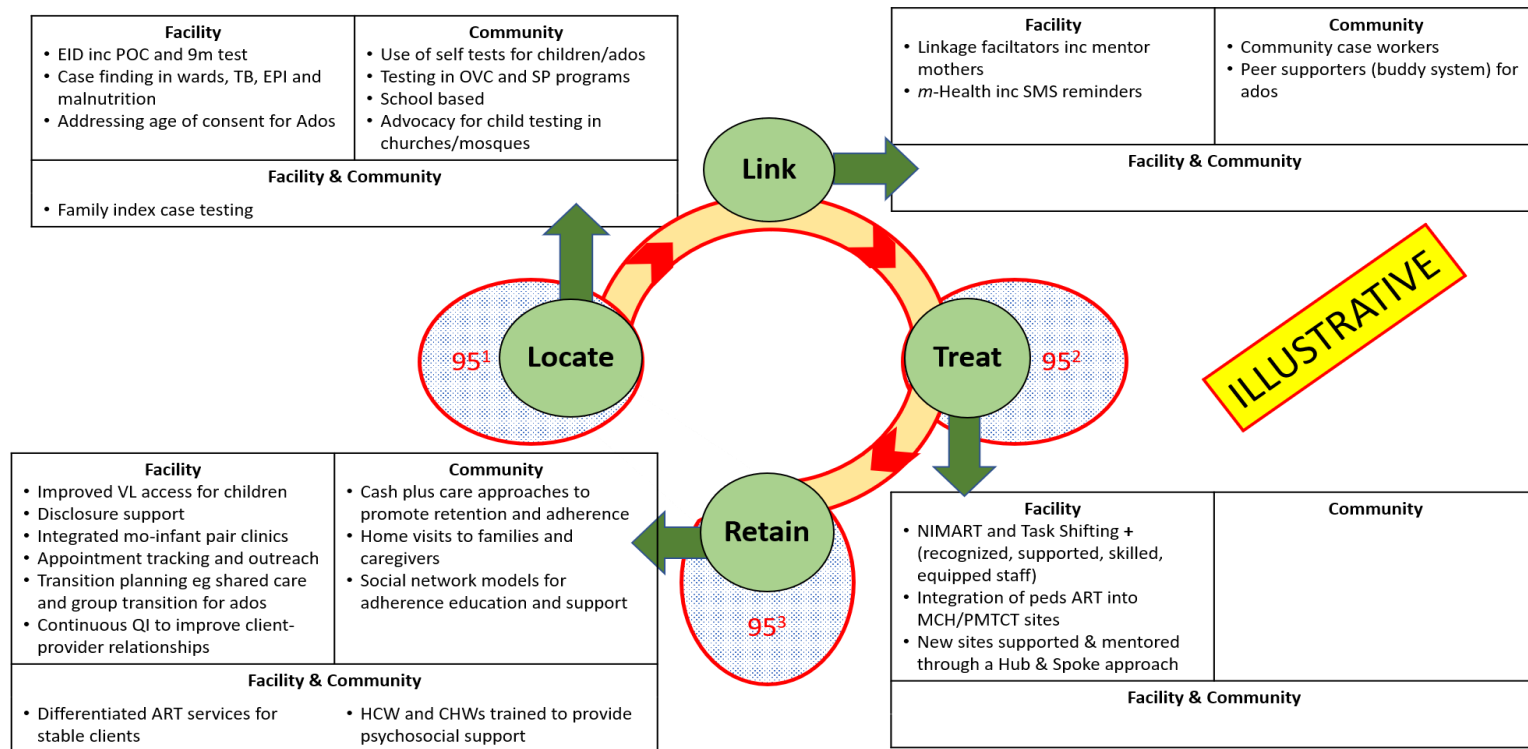


Higher rates of mother-to-child HIV transmission

Outline



Framework



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

Back ground

- 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



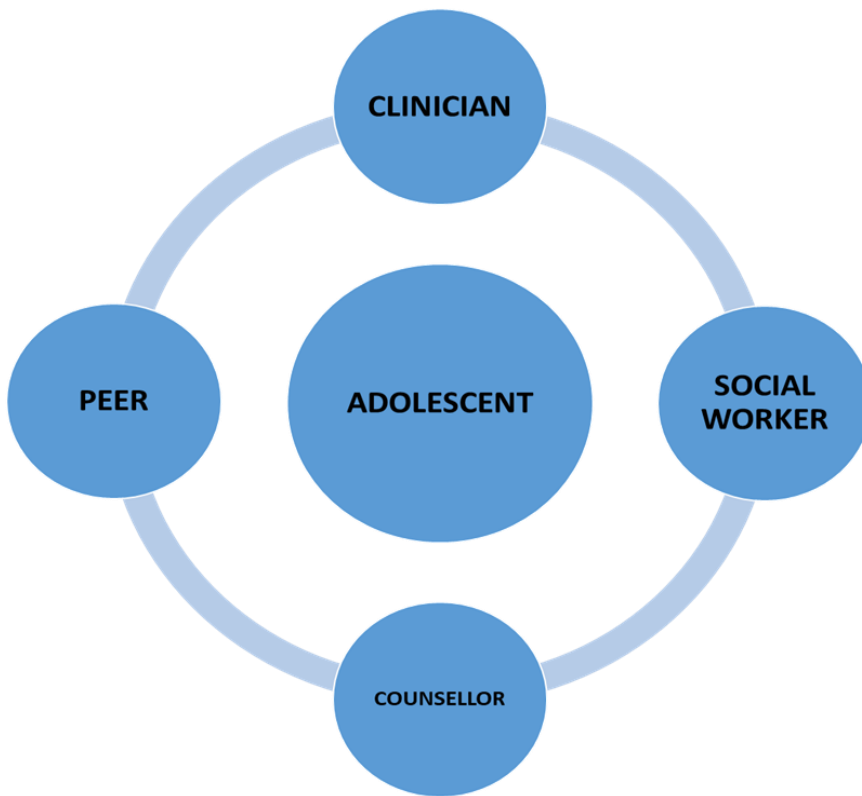
- Adolescent peer educators: YPLHIV

Services offered

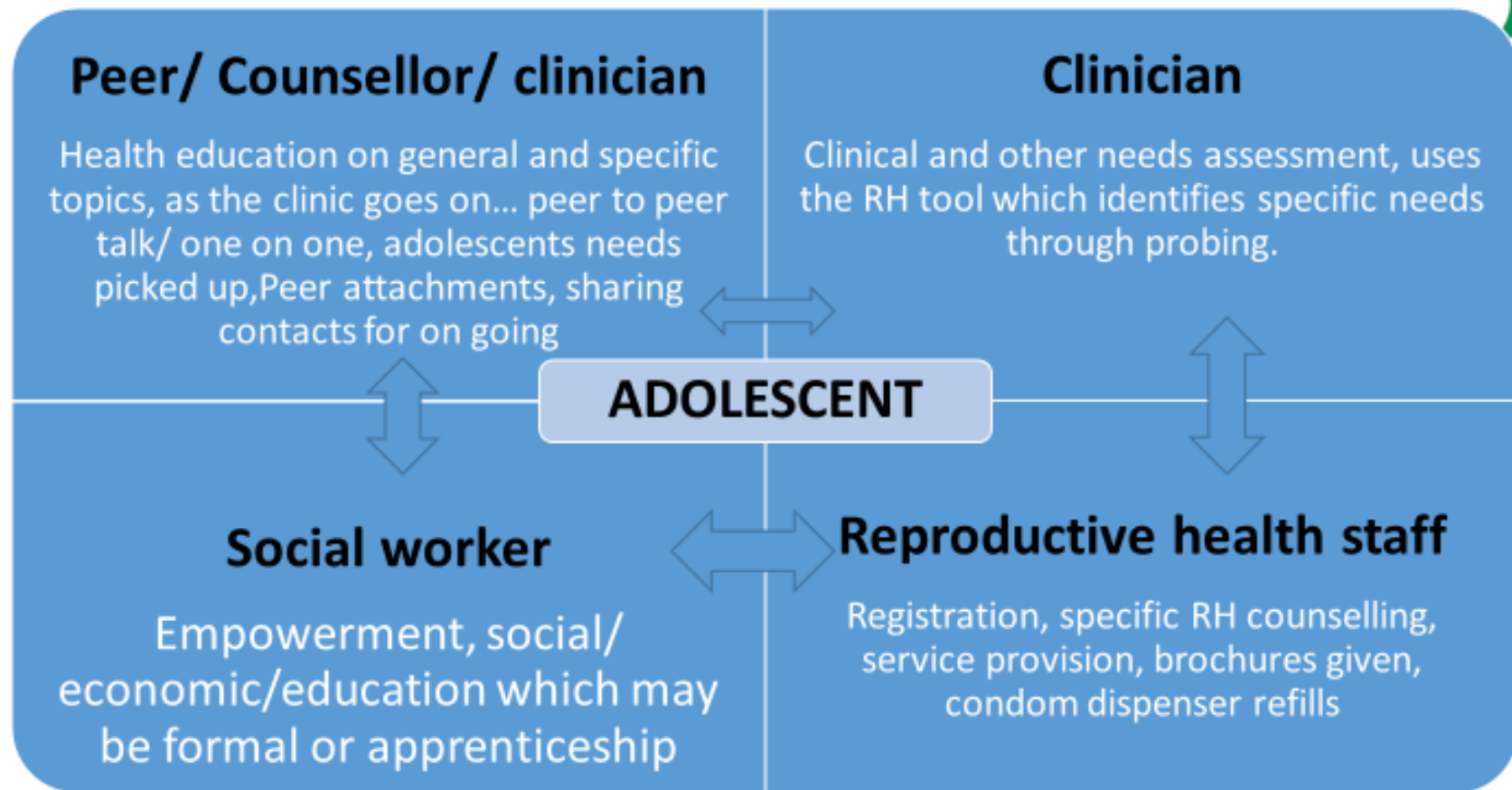


- ❑ 10-14 - hygiene, academics, making choices, acceptable behavior in society, expected changes in adolescence etc. (**Tuesdays**)
- ❑ 15-19 - managing adolescence, career guidance, life skills, Relationships, family planning and abortion, entrepreneurship (**Thursdays**)
- ❑ 20-24- entrepreneurship, 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



- Sample clinician's tool

DATE	SEX		ON ART		ON APPOINTMENT		SEXUALLY ACTIVE		PARTNER DISCLOSURE		CONDOM USE		OTHER FAMILY PLANNING		BABY <2 YEARS		STATUS OF BABY			CACX SCREENING IN THE LAST 1 YEAR		ON/EVER RECEIVED IPT	
	F	M	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	+VE	-VE	UNK	YES	NO	YES	NO

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 use62% 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.

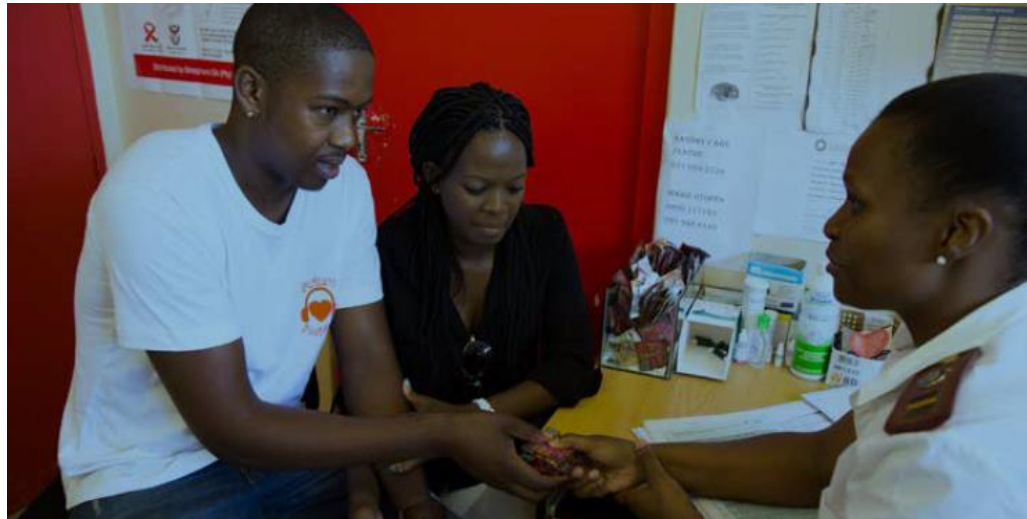


Mildmay Uganda

Communities Transformed for Sustainable Health

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 incidence².
- 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>

2. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012

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

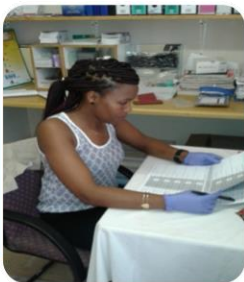
2 monthly



Services provided to youth club members

WHEN By who	STABLE ART
DURING CLUB Lay counsellor	Weight Symptom check Phone number check Pre-packed ART refill
AFTER CLUB Club allocated nurse	Annual VL + annual clinical review Family planning

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)

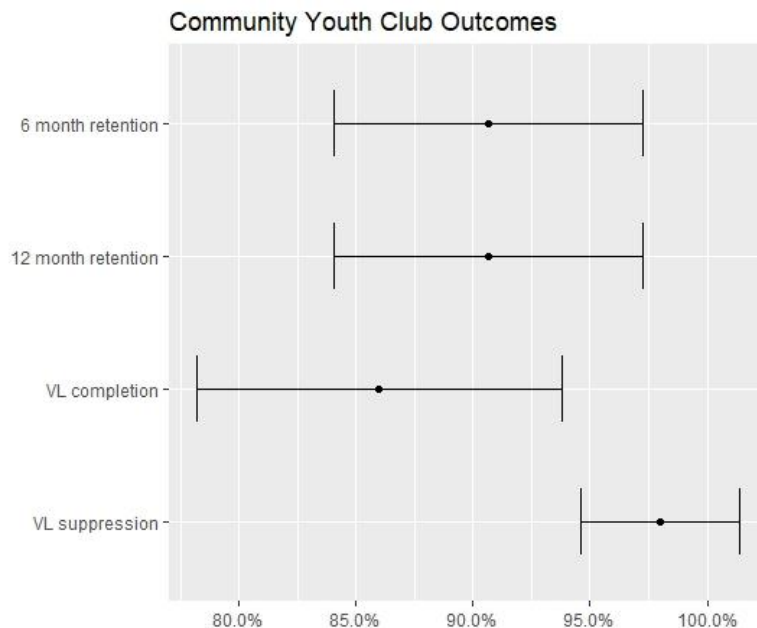
Session example

- 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
- Facility manager at SCY and SCY staff
- TAC (Treatment Action Campaign)
- Provincial Department of Health

THANK YOU



learning collaborative

CHILDREN, HIV AND AIDS

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.

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The webinar presentations and recording will soon be available on www.childrenandaids.org/webinar

Questions or feedback? Contact Rikke Le Kirkegaard (rlkirkegaard@unicef.org)