

THEMATIC SEGMENT: REDUCING THE IMPACT OF AIDS ON CHILDREN AND YOUTH

Country Submissions

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TABLE OF CONTENTS

INTRODUCTION	5
I. AFRICAN STATES	6
1. Botswana: MTV-Shuga "Ma2000bw"	7
2. Cameroon: Project DELTA: GBV and HIV Integration in Cameroon	10
3. Central African Republic: Family HIV testing (index testing)	13
4. Côte d'Ivoire: Study on active research of HIV infected children 0-14 years old from index subject.....	17
5. Eswatini: Neighborhood Care Points Programme	20
6. Ghana: Family HIV Testing in Ghana	23
7. Kenya: Eastern Deanery AIDS Relief Program	27
8. Kenya: #WhatGirlsWant: Mentoring Girl Leaders	31
9. Kenya: MARA Reloaded - Leaving No Adolescent Behind!	36
10. Kenya: Improving the life chances and quality of life of vulnerable Adolescents through HIV Sensitive Social Protection in Kisumu County, Kenya.....	39
11. Kenya: Innovations in pediatric case finding in Kenya	43
12. Lesotho: ADORE.....	45
13. Lesotho: Adolescent Health Corners in Lesotho	49
14. Lesotho: Let Youth Lead: Adolescent Participating Through Social Accountability to Improve The Quality of Adolescent Friendly Health Services.....	52
15. Lesotho: Improving SRHR/HIV outcomes for Young Mothers in Rural Lesotho through peer mentorship and support	55
16. Malawi: Enhancing Capacity of Adolescents Living with HIV/AIDS to Demand for Care, Support and Treatment	58
17. Malawi: Make Art/Stop AIDS (MASA) Youth: Participatory, arts-based, near-peer SRH Education in South East Zone	62
18. Mauritius: Scaling up and expanding access to timely diagnosis and treatment for children living with HIV	66
19. Mozambique: The integration of gender-based violence prevention and care into HIV programs in Mozambique.....	69
20. Namibia: Support access to teen clubs and psycho- social services for Adolescents Living with HIV in Namibia	72
21. Sierra Leone: Family centered approach to HIV care and support for children and adolescents	76
22. South Africa: Reaching adolescent and young mothers through peer mentors	79
23. Tanzania: Ariel Adherence Clubs	84
24. Uganda: Scaling up a national package for management of advanced HIV disease among people living with HIV towards epidemic control: Uganda experience	87
25. Uganda: Scaling up the advanced HIV disease management package for people living with HIV in Uganda	91
26. Uganda: Pediatric anti-retroviral optimization for children < 15 years living with HIV in Uganda.....	96
27. Uganda: Sparked Women	100
28. Zimbabwe: Zvandiri.....	103
29. Zimbabwe: U-report Zimbabwe: Engaging Adolescents and Young People through a Mobile Platform to Increase their Access to HIV and Sexual Reproductive Health Prevention and Treatment Services	107
II. ASIAN STATES	109
30. China: Improving uptake and retention in services through comprehensive innovative measures in college and university settings	110
31. China: Improve Adherence to Antiviral Treatment to Ensure Children Living with HIV to grow healthy-Practice in Yunnan, China.....	114
32. China: National Health Commission-UNICEF Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B Project	117
33. Indonesia: Module for PMTCT	121
34. Indonesia: LOLIPOP (Linkage of Quality Care for Young Key Populations)	123

35. Mongolia: Hidden Love: A short documentary on young LGBT community in Mongolia	126
36. Thailand: THE TIME IS NOW: Guidance and inspiration for a new era of SRHR and HIV programming for young key populations in Asia-Pacific	128
III. EASTERN EUROPE AND CENTRAL ASIAN STATES	131
37. Kazakhstan: Densaulyk	132
IV. LATIN AMERICAN AND CARRIBEAN STATES.....	134
38. Antigua and Barbuda: Prevention of Mother-to-child Transmission Programme	135
39. Colombia: Programa de VIH	137
40. Venezuela: Plan de Reduccìon del Embarazo a Temprana edad y en la Adolescencia. PRETA	140
IV. WESTERN EUROPEAN AND OTHER STATES	142
41. The Netherlands: Multidisciplinary transition clinic for perinatally hiv infected adolescents in the Amsterdam UMC	143
42. Puerto Rico (United States): Peer support.....	146
43. United States: E-VOLUTION	149
44. United States: Atlanta Family Circle HIV/AIDS Network for Women, Infants, Children and Youth (Ryan White Part D)	154
45. United States: Comprehensive Family AIDS Program	157
V. MULTIPLE COUNTRIES	160
46. Angola, Madagascar, Mozambique, Zambia, Zimbabwe: Linking Policy to Programming Strengthening Legal and Policy Environments for Reducing HIV Risk and Improving Sexual and Reproductive Health for Young Key Populations in Southern Africa .	161
47. Botswana, Cote d'Ivoire, Haiti, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zambia, Zimbabwe: DREAM Partnership: Combination HIV prevention for adolescent girls and young women	165
48. Côte d'Ivoire, Eswatini, Lesotho, Mozambique and Zimbabwe: Securing Pediatric ARV Access Now (SPAAN)	168
49. Mozambique, Eswatini, Tanzania and Zimbabwe: READY+.....	170

INTRODUCTION

The Thematic Segment of the 45th UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 12th of December 2019 and will focus on “*Reducing the impact of AIDS on children and youth*”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of effective and innovative practices integrating HIV with UHC. A total of 49 good practice submissions were received, showcasing the wide range of efforts of prevention, treatment and care for children and youth living with HIV/AIDS from African States, Asian States, Latin American and Caribbean States, Western European and Other States.

The submissions reflect the work of governments and civil society, as well as collaborative efforts. The case studies highlight different approaches in HIV prevention, treatment and care and protecting HIV-related human rights for children and youth.

I. AFRICAN STATES

1. Botswana

TITLE OF THE PROGRAMME: MTV-Shuga "Ma2000bw"

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- **Programme is being implemented since:** 2018 – **End:** 2021
- **Responsible Parties:** Government, Civil society, Academic institution
- **Population Group(s) reached:** Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed?** Yes
- **Is the programme part of the national AIDS strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND INFORMATION

There is generally a decline in HIV prevalence in Botswana, however this is not the case for Adolescents and Young People (AYP), their prevalence and incidence rates have an upward move and gets worse for young adults (20-24).

Issues attributed to this are mostly age of sex debut, inconsistent condom use, transactional sex and not knowing one's HIV status. AYPs have high factual knowledge but it is not comprehensively understood and personalized hence behaviour is contradictory to the knowledge levels. 90% of adolescents know where to get tested but only 10% of AYPs know their HIV status. 80% of young people know that you can't tell if someone is HIV positive by looking them but 39% of them do not use condom consistently. 95% know that ARVs cut chances of transmission but only 50% of HIV positive AYPs are on treatment. Therefore, this suggests knowledge is not transforming into action and the key is to enable adolescents and young people to have the agency to transform their knowledge into positive sexual behaviour.

DESCRIPTION

MTV Shuga is an initiative developed by MTV Stay Alive Foundation that combines entertainment media, social media, print media, mobile (SMS and interactive voice response [IVR]), and live performance, bringing to the attention of young people the social complexities of negotiating safer sexual and lifestyle decisions. The aim is to improve the quality of life and health of people in African countries with an HIV-burdened population by

empowering individuals with the agency to protect themselves and others from sexually transmitted infections (STIs), particularly HIV/AIDS, such as by getting tested for HIV. UNICEF Botswana in collaboration with National AIDS and Health Promotion Agency (NAHPA) adopted the MTV Shuga and produced a drama series that focused on intergenerational relationships, transactional sex, HIV testing, condom use and pressure to have sex. The concept of the radio show was to use mass media through a mix of serial drama and live discussion as a pivot to empower adolescents and young people (AYPs) to make necessary changes in their sexual and love lives. Other linkages such as social media, interpersonal communications and interactive voice response (IVR) were created to advance the message reach within platforms natural to young people.

The radio was national and reached both urban and rural audience, the first airing was done on an urban centric youth radio station, Yarona FM, and later re-aired on a more inclusive radio station, RB2 FM, that has wider geographical coverage nationally. The radio show was a 15-minute drama series followed by in studio discussions with young people for 15 minutes, making it a 30-minute show. The peer education component was limited to 2 target districts, Boteti and Selebi Phikwe, which have high HIV prevalence among AYPs, and this was done through an implementing partner, Makgabaneng. The IVR was introduced to allow young people who don't necessarily have radios or can't listen to the show at a particular time to be able to listen through at their own time, and could be accessed by anyone using the Orange network at any time, free of charge. All of the channels of communications had a monitoring and evaluation component to gauge its effectiveness.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Three major channels were utilized in reaching the target audience – male and female 10-19 years: Interpersonal Communication (IPC), Interactive Voice Response (IVR) platform, and Mass media (radio show).

- IPC – 244 out of school youth through listenership groups and 6,000 students through school rallies were reached.
- IVR, 12,838 Adolescents and Young People (AYP) were reached where 68% were female and 22% were male. Finally.
- Radio shows, the programme was able to reach 100,000 AYP.

Pre and post assessment showed that IPC and Radio Show contributed a 20% and a 16% positive impact, respectively, on the attitude towards intergenerational sex, while there was a 9% negative impact through IVR. On the intention towards HIV testing, there was a 12% and a 9% positive impact through IPC and radio show respectively, while there was no impact through IVR. Additionally, IPC contributed a 3% positive impact, IVR contributed a 5% positive impact, and an 8% positive impact on the attitude towards transactional sex. The impact of the programme on condom use recorded a 14% positive impact through In-school IPC, a 5% positive impact through IVR, and a 12% through the radio shows. Finally, on the self-efficacy of resisting the pressure to have sex/unsafe sex, the programme recorded a 35% positive impact through In-school IPC, and a 6% positive impact each through IVR and the radio show.

In summary, the programme had an impact of 16.8% through IPC, 1.4% through IVR, and 12.2% through the radio show.

LESSONS LEARNED AND RECOMMENDATIONS

After completion of season 1 UNICEF and NAHPA hosted a feedback session with all major stakeholders to learn about successes, challenges and lessons learned for future programming. And the list below is what came out of the meeting.

- Local radio and TV stations do not have a mechanism that tracks listenership rates, unless it is outsourced at a very high cost. This makes it hard to quantify actual value of using mass media.

- Scale up plan need to be agreed with Government from the beginning.
- For surveys done using technology based systems, there should be incentives to encourage participation and keep the survey as short as possible to avoid non completion by respondents.
- For baseline and endline survey. Only one channel of communication was used, WhatsApp, while the intervention used different channels of communication (radio, Facebook, interpersonal communication) and this was a limitation for those who can be reached through other channels to respond to the survey as it did not reach them. Recommendation is to use all intervention channels for baseline and endline survey.
- Pre and post assessment for platform 124 produced significant positive shift, however for one thematic area (intergenerational relationships) there was a negative shift where target audience increasingly indicated that intergenerational relationships are okay. This might have been caused by the age difference of the characters which was mostly below 5 years, and in the context of Botswana these may not be viewed as intergenerational or risky. Therefore, next production should take into account context and potential interpretation to align properly for message to be clear.
- Duration of the show on Yarona FM (15minutes) was too short to have meaningful in studio discussions and have time for SMSs and call ins. Some messages and call usually came in minutes after the show and they couldn't be aired at that time. Such a show should ideally be 30 minutes.
- For interviewees who will be sharing their individual experiences it is important for the presenter to have a chance to talk to the interviewee before going live on air, just to have a sense of what they are comfortable with sharing and what they may not be.
- Training for all player on the programme and basic programmatic issues should be organized to get everyone well vested with the issues and what to expect.
- If next production and show continue with in-studio discussions, it will be more impactful if they were all live instead of pre-recorded, as this gives room for direct engagement with actively participating audience.
- Recordings of in-studio discussions should be shared on Social media and also on the '124' platform to buttress and provide clarity on any misinterpretation. This can also include linkage to services where audience can be informed of where to access certain services.
- There should be incentives such as winning a t-shirt or something to encourage more active participation by audience during the show.
- For in-school interventions, it is recommended that school management, regional education management and guidance and counselling teachers be taken through a programme sensitization workshop before intervention are taken to the schools for them to appreciate the programme and its intended results as well as what is expected from them.
- It is very helpful to include HIV testing services during publicity events such as road shows, however this needs to be planned well to ensure that quality of service is not compromised while trying to garner more numbers.

ANNEXES: N/A

2. Cameroon

TITLE OF THE PROGRAMME: Project DELTA: GBV and HIV Integration in Cameroon

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- **Programme is being implemented since:** 2018 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Adolescent girls and young women
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy:** No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Some reports indicate that close to 50% of women in Cameroon experience some form of sexual and gender-based violence (SGBV) in their lifetime. Survivors of violence suffer a number of psychological and health consequences, including higher risks of HIV at time of violence and in future relationships. HIV prevalence rates for adolescent girls and young women in Cameroon are disproportionately high, with females up to six times as likely to be HIV-infected compared to males. SGBV and HIV are interrelated risks making one more vulnerable to contracting the other. Yet, no reporting, demand creation, national systems, or up-to-date training around SGBV of health providers existed in the country.

DESCRIPTION

To address SGBV and mitigate the life-altering effects survivors face, the Elizabeth Glaser Pediatric AIDS Foundation in Cameroon (EGPAF-Cameroon) worked with partners and the Ministry of Health (MOH) to create a robust technical assistance plan facilitated through its United States Centers for Disease Control and Prevention (CDC)-funded DELTA Project. This plan included policy landscape and site assessments to inform changes, capacity building at all levels of the health system, and community awareness and engagement to link survivors to GBV services at nearby health facilities.

Site and policy landscape assessments were first performed to better comprehend SGBV-

specific resources and needs at national and community levels. This review, conducted in 2018, confirmed that no recent national guidelines were in place to prevent or treat SGBV in the context of HIV in Cameroon. No resources nor tools existed to help health workers identify and treat survivors of SGBV.

EGPAF developed a minimum SGBV care package and piloted its use in 6 pilot sites in Yaoundé and Douala clusters. A training curriculum was developed by EGPAF alongside the MOH. This training was provided in 2018 to MOH staff at national and site levels, as well as staff at partner organizations, to better help health workers identify victims of SGBV, linking victims to specialized post-violence care (including post-exposure HIV prophylaxis [PEP]). Tools and resources were developed and disseminated to sites, with health workers and program implementers trained on their use. Tools and resources included a SGBV screening tools, job aids, standard operating procedures [SOPs] on SGBV, and monitoring forms.

EGPAF also built a referral system to link communities and SGBV services, and improved data collection and reporting to track progress. Key players in linking communities to these health services included a variety of community service organizations (CSOs). CSOs, particularly those working with high risk groups such as orphans and vulnerable children and adolescent girls and young women, were instrumental in linking these key populations to needed SGBV services.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

The Ministry of Health now has tools, a set of skilled trainers, and evidence that investing in SGBV care in the context of HIV is both a public health need and a required service to be made available. Over a 9-month period, 304 survivors received services at the six pilot sites. In total, 374 health care workers received GBV training.

With the use of tools developed to build capacity and provide quality and holistic care, and the knowledge from the trainings, targets for identifying SGBV victims were surpassed across the six facilities. Thanks to revised reporting forms, the MOH can now assess outcomes of these initiatives in public settings.

Additionally, this project focused on improving turnaround time for case reporting and the provision of PEP. Of the 144 sexual violence cases, 56.9% (82/144) were reported within 72 hours of the incident, and 67.1% (55/82) of those who reported within 72 hours of the incident received PEP.

LESSONS LEARNED AND RECOMMENDATIONS

The community and local stakeholders played an instrumental role in project planning, implementation, and monitoring. To identify stakeholders prior to planning, a community mapping of CBOs that are involved in SGBV and OVC programs in the six health districts was done. During the project start-up phase, the team had working sessions with OVC partners to find common ground for collaboration concerning improving the bi-directional referral system, training CSOs, and providing referral registers.

Thereafter, training on SGBV and the OVC population was provided to CSOs and key community, opinion, and religious leaders who were identified. Training focused on SGBV case finding and referrals focusing on children and adolescents.

Community SGBV PSS groups were formed in areas where they did not exist and strengthened in areas where they were already established. SGBV survivors were referred to these community groups to receive peer PSS. With health care workers trained on PSS and the availability of community-based PSS groups, the capacity to provide support for the

recovery and social reintegration for OVC who survivors of SGBV were possible.

At the broader health systems level, monitoring and management systems were set up to ensure coordination across stakeholders and the collection of data across the intervention. Staff were trained on the monitoring and evaluation requirement to report on the SGBV interventions. SGBV data were collected and analysed monthly by trained staff. These data were later shared with the MOH and the Regional Delegations of Public Health.

One challenge with data management was the absence of GBV indicators in DHIS2 – the national reporting system. Advocacy is ongoing with the Health Information Unit of the MOH (Cellule des Informations Sanitaires) for the introduction of these indicators into DHIS2 so that GBV data will be reported monthly at the national level.

ANNEXES: N/A

3. Central African Republic

TITLE OF THE PROGRAMME:

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- **Programme is being implemented since:** February 2017 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Families of PLWHIV, Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy:** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes

BACKGROUND

Since 2012, the Central African Republic has been facing unprecedented recurrent military and political crises that have destroyed state institutions. Socio-economic conflicts have led to the destruction of basic social services, massive displacement of people fleeing conflict, looting, destruction of social health infrastructure and numerous cases of gender-based violence. The health sector has been one of the most affected, with a breakdown of all the pillars of the health system. A WHO survey conducted in April 2014 indicated that only 52% of health facilities were functional in the country. To date, the country is divided into 03 security zones: secure, medium secure and unsecured with $\frac{3}{4}$ of the country under rebel control.

HIV/AIDS remains a public health priority in Sub-Saharan Africa due to its magnitude and devastating consequences on the general population. Indeed, it is still one of the most important causes of morbidity and mortality in this part of the world with about 30 million people worldwide, two-thirds of whom live in sub-Saharan Africa (UNAIDS 2018).

Like the most affected countries, the Central African Republic has been facing a generalized HIV/AIDS epidemic for several decades with an estimated prevalence of 4% in the 15-49 age group according to UNAIDS estimates in 2018. In 2018, the number of people living with HIV is 110,000, including 8,900 children aged 0-14 years (EPP Spectrum projections). This situation constitutes a real public health and human development problem for which

CAR, with the support of its partners, has been implementing the national ARV access programme since 2004.

Although CAR is among the countries that have reduced new HIV infections worldwide by more than 25% (UNAIDS 2018), many challenges remain:

- Low coverage of ARV treatment: 37% in adults and 30% in 0-14 year olds
- Screening limited to pregnant women and tuberculosis patients, with only 42% of pregnant women and 12% of children born to seropositive mothers having access to screening.
- Lack of access to HIV testing for PLHIV family members
- Difficulty in providing screening kits for the 13 functional VCTs out of 21 in CAR

DESCRIPTION

The objectives of the HIV family testing (index testing) is to accelerate the active identification of HIV+ infected children and adolescents and their linkage to ARV treatment and care. The implementing partners were the Ministry of Public Health (MoH) through the HIV/AIDS programme in partnership with the National Aids Commission (NAC). Réseau Enfant VIH Afrique (EVA), People living with HIV associations. The coordination was led by the MoH and NAC.

The programme was implemented since January 2017 and covered 16 districts in CAR (3 districts of Bangui and 13 provincial districts) from January 2017 to march 2019.

The actions undertaken were:

In 2017

- Coaching for the decentralization of paediatric HIV in adult ARV care units (2017-2018) under the Ministry's lead
- A family HIV testing pilot campaign was conducted in 3 districts of Health Region 2 in the first semester of 2017. It targeted the family of PLHIV in Adult ARV sites, PMTCT services in collaboration with the districts management team, under the leadership of the Ministry of Health
- In the second semester of 2017 a Family HIV testing campaign in Bangui was conducted under the leadership of NAC targeting the family members (children and partners) of adults in ART sites including PMTCT clients.
- Community mobilization at the national and decentralized level was conducted
- Orientation and awareness meetings for health facility teams under the leadership of NAC and MoH were conducted.

In 2018:

- Launch of the national family HIV testing campaign by the First Lady of CAR in line with the free to shine campaign.
- Family HIV testing campaign was conducted in 13 districts across the country at health facilities and community level
- Identification and training of PLHIV to provide HIV testing at community level through task shifting
- Patient mobilization and awareness were conducted at facility level and data on under 20 years old data was collected using the tool " Index case screening matrix" which identified children with unknown HIV status
- For the community testing, CHWs provided the first screening with determine. The positive cases to determine were referred to the health facilities for confirmation with UNIGOL.
- Families were provided with transport fees and positive cases were referred for ART at the same facility level. - Sample collection for viral load was provided in some districts in collaboration with the national laboratory.

Results, outcomes and impact of the programme

16485 PLHIV families were targeted in the 16 districts (Bangui-11346 and 5139 in the region) out of which 12254 families were reached (74,3%) (Bangui 8281-73% and region :

3973-77%).

In total 17333 children (11033-Bangui, 6300-region) with unknown HIV status were identified out of which 12975 (74%) were tested for HIV.

The HIV prevalence in children was 1,6% (219 positive cases out of 12975 tested) among which 87% were put on ART.

The positive cases aged above 10 years were 110 (60%). All went through a disclosure process, attended a 2 days training on HIV/AIDS and were referred to the adolescent HIV club for peer counselling activities.

The HIV prevalence among partners of positive pregnant women (in PMTCT services) tested was 15.7% (29 out of 195 tested). They all have been linked to Care and treatment services.

LESSONS LEARNT AND RECOMMENDATIONS

Success factors

- Ownership by MoH and NAC
- Political support" First Lady and the Minister of Health,
- Involvement of the beneficiaries (PLHIV) in all phases of development and implementation
- Advanced strategy for access to viral load has been a motivating factor for families in the provinces
- Immediate care for children who tested positive strengthened family trust
- Involvement of the adolescents living with HIV club in capacity building and peer counselling activities
- Capacity building of health personnel through coaching has enabled the decentralization of paediatric care and the increase in the service accessibility
- Close monitoring and coaching of service providers

Challenges

- High stigmatization by health care workers and at community level
- Shortage or inadequacy supply of screening tests
- Diversion of HIV testing supplies
- Shortage of paediatric ARV
- Long distance from household to the health facilities

Lessons learned

- High level political commitment has removed bottlenecks in health structures
- The provision of transport fees for families removed the financial barrier
- The coaching of service providers is paramount for the success of task shifting
- Access to partner's screening and the availability of care in health facilities has increased family confidence
- Capacity building of actors on the HIV disclosure process has reduced the stigmatization of health workers
- Psychological support by peer adolescents has led to better adherence to adolescent treatment
- The provision of HIV testing at the community level has reduced the cost of transport and increased access to adolescent
- The outcome of this project have led to the adoption of family testing in routine at the national level

Recommendations

- Increase funding for HIV commodities through other stakeholders / donors including domestic funding
- Increase MoH ownership through regular monitoring and review of the implementation of the program

- Increase family education on HIV/AIDS, human right, discrimination/ stigmatisation
- Develop a sound social protection system (cash transfer...)

ANNEXES

Family HIV testing campaign testing, CAR experience report (NAC report)- 2017

4. Côte d'Ivoire

TITLE OF THE PROGRAMME: Study on active research of HIV infected children 0-14 years old from index subject

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- **Programme is being implemented since:** October 2018 - **End** (if applicable): April 2019
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Children living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy:** No
- **Is the programme part of a national plan other than the national aids strategy?**
Yes

BACKGROUND

Côte d'Ivoire remains the country most affected by the HIV epidemic in West Africa

Despite the decline in HIV prevalence among the population from 4.7% in 2005 to 3.7% in 2012 and 2.5% in 2018 (3.6% for women and 1.4% for men), Côte d'Ivoire still has significant gaps in terms of testing and treatment for HIV-positive people. The number of people living with HIV is estimated at 495,143 (UNAIDS, 2018), including 38,172 children and 30,000 new infections each year. New infections in children have increased from 6800 in 2011 to 3800 and 2017 (AIDS Info).

The UNICEF UNAIDS report "Accelerating the pace..." launched in December 2017 in Abidjan at the ICASA conference comes at a crucial time in the global response to the HIV/AIDS epidemic. In our region, significant progress has been made in preventing vertical transmission of HIV. This progress must be maintained and amplified. Nevertheless, the report notes significant gaps in access to treatment for children and adolescents living with HIV; as well as insufficient progress in HIV prevention among adolescents.

Every day in West and Central Africa, about 165 children aged 0-14 years and nearly 170 adolescents aged 15-19 years are infected with HIV. Of an estimated 540,000 children aged

0-14 living with HIV, 420,000 or 8 out of 10 do not have access to HIV testing services. We are in the region where the ARV treatment coverage rate is the lowest in the world for children with only 21% of HIV-positive children on treatment.

In Côte d'Ivoire, while enormous progress has been made in reducing mother-to-child transmission and thus reducing the number of newly infected children each year, more work remains to be done. In 2018, new infections among children aged 0-14 years were estimated at 3832.

38,172 children aged 0-14 years are living with HIV in Côte d'Ivoire, in 2018, 10,354 are currently under treatment, representing less than 27% of children living with HIV. On average, the increase in the active file of children undergoing treatment is increasing by 13% per year, at this rate it will take more than 10 years to reach the country's target of 95% of children undergoing treatment.

DESCRIPTION

The objective of the project is to increase the provision of pediatric HIV testing and treatment services in the community for people living with HIV, with the following specific objectives :

- Establish a computerized list of people living with HIV and their biological children aged 0-14
- Ensure the screening of children aged 0-14 years born to HIV-positive mothers of unknown status and
- Put HIV-positive children on treatment as early as possible
- Ensure the retention of these children in the health care system.
- Ensure the screening of mothers of unknown status whose children are HIV-positive according to the family approach guide
- Identify spouses/partners (male, female) whose status is not known
- Inform - educate - follow people living with HIV.

The project is implemented through the network of people living with HIV (RIP+) in 2 districts (Duekoue and San Pedro), based on the gap in the identification of children living with HIV. This project is being conducted over a six (06) month period from October 2018 to April 2019.

RESULTS, OUTCOMES AND IMPACT OF PROGRAMME

The implementation of the project identified 1,544 children born to HIV positive mothers, of whom 1,441 (92.7%) were tested, 5.6% of whom tested positive for HIV. 72.7% of HIV-positive children are on antiretroviral treatment. 48.2% of the children tested are girls and they represent 40.9% of HIV-positive children.

2,904 partners of HIV positive person were also identified, 2,100 tested, of whom 42 found to be positives and put on treatment (2%).

The project also contributed to raise awareness among medical personnel on the importance of family testing and follow up for routine implementation.

LESSONS LEARNED AND RECOMMENDATIONS

Increased communication and proximity to populations reduces misconceptions about HIV and promotes adherence to awareness messages and acceptance of voluntary HIV testing. A good explanation of the disease done by people living with HIV themselves promotes acceptance of HIV testing.

The close collaboration between provider and community health worker or counsellor in the provision of care promotes familiarity between these actors and the people tested and

contributes to the patient's inclination to be tested and to enrol in care, including their commitment to testing their children.

Index testing managed by the network of people living with HIV is a relevant and effective strategy to identify children living with HIV. It also gives confidence and opportunities to people living with HIV to share their experience. It strengthens their competences.

5. Eswatini

TITLE OF THE PROGRAMME: Neighborhood Care Points Programme

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- **Programme is being implemented since:** November 2012 - **End** (if applicable): present
- **Responsible party/parties:** Government, UN or other inter-governmental organisation
- **Population group(s) reached:**
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy:** No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

The Kingdom of Eswatini is a landlocked lower middle-income country with a population of 1.1 million. The country ranks 144 out of 189 countries on the Human Development Index. With a gender inequality index of 0.569 (ranking 141 out of 160 countries), Eswatini has the highest HIV prevalence in the world, at 27 percent of the adult population. Women are disproportionately affected by HIV with 35.1 percent of all women living with HIV compared to 19.3 percent of men. However, the country has made significant achievements in HIV treatment with ART coverage of 82% and a reduction of the mother to child transmission from 2.69 in 2017 to 1.8 in 2019. Eswatini is also amongst the countries that have also achieved the 90-90-90 targets by 2019.

The impact of HIV and AIDS in Eswatini has led to the disruption and destabilization of families and communal support systems and seen a dramatic increase in the number of vulnerable children, child and elderly headed households. A staggering 71 percent of Emaswati children are orphans and vulnerable children (OVC), largely due to the impact of HIV and AIDS. These OVC constitute the most vulnerable section of the population, with one in four children having lost one or both parents. An estimated 38 percent of rural households care for at least one orphan. Lack of proper care for orphans is exacerbated by the fact that many of the adults in the extended family who care for orphans are also HIV-positive or

living with AIDS.

National estimates indicate that there are presently about 355,349 OVC between 0-17 years with an estimated 90,127 OVC under the age of 5. OVC's are either infected or affected by HIV, whereby their caretaker's ill-health and economic challenges, results in reliance on elderly family members, the community or Government to provide necessary support and protection. The number of orphans is projected to decline following the impact of treatment coverage leading to reduced AIDS mortality. Traditional gender roles for women and girls mean that they shoulder the burden of caring for sick family members and maintaining agricultural productivity, often at the expense of their education.

DESCRIPTION

In partnership with the Government of Eswatini's Ministry of Tinkhundla & Administration (MTAD), WFP supports the Neighborhood Care Points (NCP) programme, a safety net for orphans and vulnerable children (OVCs). OVCs who are either infected or affected by HIV, with their caretakers' ill-health and economic challenge resulting in reliance on elderly family members, the community or Government to provide necessary support and protection. WFP provides social safety nets for 55,000 OVCs of pre-primary school age (3 to 6 years) across Eswatini through access to food and basic social services via the NCPs.

The aim of the project is to provide nutritious meals to orphans and vulnerable children (OVC) in pre-school age attending community-led day care centres called neighborhood care points (NCPs), across the country. The project aims to increase OVC access to nutritious food and basic social services, such as early childhood education, psychosocial support and basic health services provided at the NCPs. It also aims to strengthen the capacity of the Government to provide assistance to OVC with the prospect of eventually handing over the project.

Neighbourhood Care Points (NCPs) provide a safe place for boys and girls, many of whom live with relatives or in child-headed households, to equally access early education and basic care services. These children are too young to attend primary school, and caregivers cannot afford to send them to private pre-schools or day-care centres. Volunteer caregivers who manage the NCPs provide services such as early childhood education and links to basic health care, as many of the children cannot yet access other social safety nets, such as school meals or education grants.

Vulnerability of children increases long before the death of a parent or guardian, they often face loss of family and identity, increased malnutrition and reduced opportunity for education. Without adequate care and support, many are exposed to exploitative child labour and abuse, and face increased vulnerability to HIV infection. HIV-affected children experience lower school attendance and performance, linked to food insecurity and inadequate nutrition, as well as social challenges.

OVC are particularly exposed to malnutrition and food insecurity during Eswatini's recurrent droughts, therefore making safety nets even more crucial in supporting these children to grow up and lead healthy and productive lives.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

In 2018, WFP provided safety nets for 55,000 OVC of pre-primary school age across Eswatini through the provision of food assistance at neighborhood care points (NCPs). 1700 of these day care centres run by community volunteers were reached throughout the country with almost 2,000 mt of food composed of cereals, pulses and fortified vegetable oil. The

provision of food at NCPs is an on-site meals programme that supports access to early childhood education, health and other services equally for both boys and girls. Due to increasing food insecurity and poverty nationwide, beneficiary numbers gradually increased throughout the year at the respective NCPs and new NCPs opened. An evaluation of the programme conducted in 2014 found that WFP should strengthen its advocacy for continued provision of social safety nets targeting OVC and a multi-sectoral approach to social protection which is the positioning of the programme in 2019.

LESSONS LEARNED AND RECOMMENDATIONS

For the implementation of this programme, WFP partnered with the Office of the Deputy Prime Minister (DPMO) and the Ministry of Tinkhundla Administration and Development (MTAD). Under the national strategy for neighborhood care points (NCP), MTAD is the government ministry responsible for coordinating NCP services at all levels. WFP's partnership with MTAD enabled improved access to communities and strengthened the support to NCPs.

While there are sufficient policies and frameworks in place in Eswatini to face food and nutrition challenges, implementation and coordination of these policies remain a challenge. WFP aims to assist the Government in creating well-targeted, evidence-based, nutrition-sensitive and expandable safety nets that equitably benefit women, men, girls and boys, according to their needs and priorities.

ANNEXES

WFP Factsheet: Eswatini Neighbourhood Care Points Programme & Evaluation of the Swaziland - Development Programme 200422: Support to Children and Students Affected by HIV and AIDS - 2013- 2014

6. Ghana

TITLE OF THE PROGRAMME: Family HIV Testing in Ghana

CONTACT PERSON

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- **Programme is being implemented since:** 2016 - **End** (if applicable): Continuing
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organisation
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy:** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** The program is captured in Ghana National Pediatric HIV Acceleration Plan. It's also captured in the workplan for UNICEF country office and the national Pediatric HIV task team under the National HIV Control Program

BACKGROUND

The population of Ghana is estimated at 27 million people (2015) with a general population HIV prevalence of 1.6%, which amounts to approximately 270,000 people living with HIV (PLHIV). About 60% of PLHIV are women with a prevalence of 1.8% among pregnant women attending ante-natal care (ANC). Approximately 18,577 (7%) of people living with HIV are children.

The country's HIV prevalence reflects a generalized epidemic with the highest prevalence of 3.2% in the Greater Accra Region. In 2015, of the estimated 12,803 people newly infected with HIV, 2,197 (17%) were children, with an estimated annual AIDS-related death of 12,646, of which 1,423 (11%) were children.

Ghana is currently among nine countries in West and Central Africa contributing to 90% of new paediatric HIV infections in the West and Central Africa sub-region and has low paediatric anti-retroviral treatment (ART) coverage. Despite high immunization coverage of 95% and high ANC attendance, overall HIV testing provided within ANC settings is less than 80%; the number of pregnant women given ARVs is less than 70%; and coverage of EID services is barely less than 20%. Thus, there are missed opportunities in testing, low of service integration and linkages in health delivery in Ghana.

Ghana faces the double burden of diseases where morbidities and mortalities from communicable diseases are still high while those of non-communicable diseases are also increasing, and HIV and TB are among the communicable diseases of high morbidity and mortality. However, the number of trained doctors and other professionals are inadequate to ensure the expected coverage and practice has shown that nurses, midwives and other mid-level health professionals can safely perform some of the tasks originally performed by these cadres.

As task sharing has shown potential for increasing coverage, it has thus become a viable approach for scaling up the strategic interventions being undertaken in the treatment of HIV/TB and other co-morbidities in Ghana. Thus, at national level, the NACP and Ghana Health Service developed an Operational Policy and Guidelines for Task Sharing to address identified service delivery gaps.

The national acceleration plan for Pediatric and adolescent's HIV services (2016-2020) has the aim of putting 90% of estimated number of children and adolescents (0-19) living with HIV in Ghana on treatment by 2020, to drastically reduce HIV/AIDS related morbidity and mortality.

To address the paediatric HIV gap, the National Acceleration Plan for Pediatric HIV Services (2016 – 2020) identified Family HIV Testing as a game changer that can deliver quick gains for the paediatric HIV response in Ghana. Family Testing promotes access to HIV interventions for children who are often missed as they access routine primary health care services.

DESCRIPTION

Since 2016, with the support of UNICEF, the National AIDS/STI Control Programme (NACP) has been implementing index testing of partners and children of a known HIV positive client in areas of high HIV prevalence. Five high burden regions with the highest HIV prevalence were chosen for the pilot implementation of Family Testing: Ashanti, Brong Ahafo, Central, Greater Accra and the Western Regions. The initiative was launched in one health facility in Eastern Region and in 2018 was scaled to 41 high burden facilities in the other five burden regions in Ghana. A series of steps were followed to roll-out Family HIV Testing including: 1) the development of an Operational Policy on Task Sharing; 2) the selection of regions(5) with the highest HIV prevalence for the pilot implementation of Family Testing; 3) a one-day orientation on family HIV testing, conducted by the Regional Health Management Team for participants from 41 facilities; 4) the development of action plans to implement the procedure; 5) a constant support from the Regional Health Management Team to facilities during the implementations.

In addition, the National AIDS/STI Control Programme (NACP) adopted the new World Health Organization (WHO) recommendations to treat all people living with HIV with ART, regardless of immune status or clinical stage. The adoption of this recommendation sits alongside the ambitious 90-90-90 targets by 2020.

Overall, a total number of 41 health facilities were chosen and a total of 240 professionals were selected to take part in the initiative. There were 48 participants from each of the five regions, from the following professional categories: prescribers, HIV counsellors, biomedical scientists, pharmacists and pharmacy staff, midwives and members of the community-based organization Models of Hope.

All the participants went through a one-day orientation on family HIV testing, conducted by the Regional Health Management Team, with support from the NACP and GHS. They received information on: the situation of People living with HIV in Ghana and the epidemiology of pediatric HIV; the provision of differentiated HIV Testing and the procedure of Family HIV testing. A great focus was put on disclosure of results, counselling and linkage to treatment.

They were also provided with a set of forms, such as the Family HIV testing matrix and each facility benefited of a facilitated discussion to guide the development of action plans to implement the procedure.

The participants from the 41 facilities received constant support from the Regional Health Management Teams, who developed monitoring checklists for each health facility for routine data collection and who visited all sites to assess the level of implementation and to verify and collect the data captured. During the intervention, more monitoring tools were added, such as a monthly summary sheet for all performed tests.

In April 2019, the National AIDS Control Program in Ghana and UNICEF (Country Office, Regional Office and UNICEF NYHQ) conducted a joint study visit in Sekondi-Takoradi, Western Region, at the Daboase Ahmadiyya Hospital, Kwesimintim Hospital and Effia Nkwanta Hospital and in Cape Coast, Central Region, at the Twifo Praso Hospital. The team had meetings and interviews with the main stakeholders at central, regional and local level (hospital administration, health care providers, social workers, community leaders), with community-based organizations (Models of Hope) as well as with families who underwent the procedure of family HIV testing. Additional information was obtained during a National consultative meeting with the family testing Task Team in Accra.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Results show that in the 41 facilities (selected in the Five high burden regions) there were 1553 children listed by index clients. Of these, 621 were successfully contacted and 519 tested. 76 were identified as HIV positive with 71 linked to treatment and for the remaining five the procedure of linkage to treatment was ongoing during the period of case study documentation.

Overall, the results of the three-month implementation of Family testing indicate an acceptance rate by index clients of 77% (1295/1676), a yield of 15% (76 identified positive of 519 tested) among children and 40% (114 identified positive of 284 tested) among partners, and treatment linkage of 93% (71/76) for children and 95% (108/114) for partners.

LESSONS LEARNED AND RECOMMENDATIONS

Interviews with the Regional Health Management Teams of Central and Western Regions, with health facility managers and health workers show that the main enablers for the results of Family Testing piloting were:

- The quick cascading of training beginning with few staff trained in December 2018 who trained the rest of respective facility staff to begin implementation of Family Testing
- The commitment of staff, who innovate in data collection, client flow and referrals to improve services
- The multi entry point service delivery with testing and treatment initiation at all points in differentiated service delivery (DSD) sites
- The robust community health system termed Community-based Health Planning and Services (CHPS) comprised of Community Health Zones (known as CHPS zone) serving a population of 3000, with a Community Health Compound (infrastructure) that is staffed at minimum by a community health nurse (CHN) and in some cases a midwife as well. The CHN has a target of 120 household visits in a month. They have integrated HIV counseling, testing and referral into the package of services they provide and are key for the scale up of Family Testing and the linkage, treatment and retention continuum.
- The involvement of Models of Hope, a peer support community-based organization that supports tracking, referrals and psychosocial support for people and families living with HIV are also key for the scale up of Family Testing and the linkage, treatment and retention continuum
- The Use of the Regional Operational Guidance for the Implementation of Family testing to undertake rapid assessment and identification of 54 districts prioritized for scale up.

The main challenges during implementation were:

- Disclosure to partner, especially in cohabitating /not married couples – may lead to

violence, separation;

- The issue of space and time for counselling (especially in small health facilities) – there is need for a friendly, dedicated space for counselling, and for more time allocated to counselling. In small facilities, if people come for counselling, they are immediately identified by other facility clients as being HIV positive;
- Missed opportunity with school-going children (80% of junior- and senior-secondary school going children are in boarding schools) – need to create special testing opportunities during school vacations/role for collaboration with the education sector
- Stigma and discrimination resulting in non-disclosure and Family Testing declines – need to broaden scope of current training curriculum to include skills strengthening for disclosure and psychosocial support

This result achieved within three months of implementation demonstrate that Family Testing can be implemented successfully in the context of Ghana despite the challenges. The program can achieve higher success if the above challenges are addressed.

To further improve the programme or similar interventions in other settings we recommend:

- That Service providers find other means to reach more school-going children and adolescents and test them through the Family testing approach (campaigns and outreaches may be considered) .

Secure enough supplies to test as many children as possible

- Increase the capacity of Mothers of Hope NGO to cover more clients and to increase their network by attracting more mothers into the organizations (rationale: although they did not disclose their status outside the family for fear of stigma, interviewed mothers declared they would recommend family testing to a close friend, if they had been approached);
- Conduct refreshers and updated trainings on family testing for community nurses;
- Develop and make available support materials for promotion of family testing, pre-testing and post-testing counselling and disclosure of outcome.

ANNEXES

1. Family HIV Screening Matrix 2. Results graph

7. Kenya

TITLE OF THE PROGRAMME: Eastern Deanery AIDS Relief Program

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- **Programme is being implemented since:** 1993 - **End** (if applicable): Continuing
- **Responsible party/parties:** Faith Based Organization, Private sector
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations, Adolescent boys and young men in general population, Migrants, refugees or internally displaced children and young people
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy:** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

The Eastern Deanery AIDS Relief Program (EDARP) was founded in 1993 by Fr. Edward Philips, MM (a Maryknoll priest working in Nairobi) and Mrs. Alice Njoroge (a Kenyan Nurse) within the eastern slums of Nairobi. They were soon joined by Maryknoll Brother John Mullen together trained and supported local volunteers from nearby Catholic parishes as community health workers. All were welcome to receive care and support. During these early years there was minimal funding and very little medicine for treating pain and opportunistic infections. The focus was on care, compassion and meeting the spiritual and pastoral needs of patients as they prepared for inevitable death.

As the HIV epidemic continued to expand in Nairobi, additional staff members were added to manage and train the outpouring of generous local individuals willing to be trained as EDARP Community Health Workers and provide support, care and accompaniment for their neighbours living with HIV and AIDS. The focus of the work continued to be a compassionate outreach for those nearing the end of life. In 2002, the first electronic (computer) record keeping was initiated to meet the reporting requirements of this rapidly expanding program. Data on physical, emotional, social and spiritual information was documented. However, the emphasis on spiritual care was focused more on the growing numbers of staff and community health workers who often experienced the same stigma and discrimination of the patients they served and became known as "angels of death."

In 2004, EDARP was one of the early recipients of PEPFAR (the President's Emergency Plan for AIDS Relief) under the CDC (the US based Centres for Disease Control). This brought to the Nairobi slums, the advent of HAART, highly active antiretroviral therapy for patients living with HIV and AIDS. While spiritual care and support for staff and volunteers continued, the emphasis for patients focused on their physical health to remain adherent to the new life-saving medications.

This new funding from the US government (PEPFAR) enabled EDARP to continue an incredible expansion of clinical services to the eastern slums of Nairobi. By 2016, advanced medications, point-of-care diagnostics for monitoring patients, integration of HIV and TB clinical care, resulted in a rapidly declining mortality. The focus gradually became focused on the patient's physical well-being, increasing CD4 counts and decreasing HIV viral loads. Adherence to medication and clinic visits are paramount. By 2016, 23,000 patients, including 900 children were receiving care, treatment and support through 14 EDARP.

At the beginning of 2016, despite quality clinical service provision, viral load suppression among children (birth to 9 years) was only at 67% and for adolescents at 66%. The management, clinical staff and community health workers believed we had to change the work of EDARP to meet the ambitious United Nation's targets of "90-90-90." We strongly believed that to meet these UN goals and to bring about HIV epidemic control, the response must be a comprehensive public health intervention that includes assessment and treatment for each individual person's physical, emotional, social, and spiritual well-being and health. Like all health interventions, for quality patient care these interventions (in all domains) must be documented and shared with the interdisciplinary team.

It was clear that to reach the 95-95-95 targets, more than bio-medical interventions were required.

DESCRIPTION

EDARP is a local Catholic FBO providing HIV/TB prevention, care and treatment. EDARP now has 26 years of continuous provision of high quality, compassionate services in the eastern part of Nairobi. The target area has 95 slums with an estimated population of 2,157,960 and is served by one sub-county hospital. Nairobi county has the highest HIV burden with 182,856 people estimated to be living with HIV—a prevalence of 6.1%, led in the number of new infections contributing 7,159 and the highest number of new infections among young people between 15 and 24 years at 2,587. Nationally, over 300,000 youth are HIV positive with 184,719 aged between 10 to 24 yrs. (Kenya HIV estimates report, Oct, 2018). There is now increased emphasis on programs to focus on prevention, care and treatment for youth and young adults, with those aged 15-29 years accounting for 38.6% of Nairobi's total population.

Currently EDARP provides comprehensive care and treatment services for 1,600 HIV positive children and adolescents under the age of 18 years.

Key elements of the current package of interventions:

Monthly support group meetings—appropriate disclosure part of each session
Extended activities during school holiday periods
All support focusing on OTZ—0 missed appts, 0 missed doses, 0 viral load
Peer-support pairing individual peers with "high VL" and "low VL" for mutual support
Peer-to-peer support via closed WhatsApp groups
Selecting expert peer mentors, those with viral load suppression for more than 6 months to support others

EMR and POC laboratory so that clinicians have the immediate data
Weekly multi-disciplinary team meetings to discuss clients with high VL. Clients invited to this meeting for transparent discussion
Home visits with CHW and Case Manager
Parent/Guardian support and assessment
Each child/adolescent paired with a Community Health Worker, trained in paediatric/adolescent care and support
CHWs provide data to the clinic through a mobile platform
CHWs work with parent/guardian and child on appropriate disclosure
Site Team Leaders (Management) identify staff with the gifts, abilities and inclination to work with children and adolescents.
Child/Adolescent sees the SAME clinician during each visit.(Relationship is KEY to understanding a child's challenges with adherence)
Increase training for Social Work staff and CHWs for routine psychosocial screening for abuse and neglect, behavioural problems, school problems, depression, anxiety and substance use and abuse.
Routine spiritual assessment for every client to understand how spiritual beliefs and practices may impact treatment adherence
Increased inter-collaboration support and education between EDARP and boarding schools where EDARP clients are enrolled as learners
Increased EID and PCR capabilities to avoid delays with national reference laboratory

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Viral Load Suppression:

<3 years: 72%
3-9 years: 87%
10-14 years: 86%

Viral Load Suppression for Adolescents and young adults enrolled in Operation Triple Zero (OTZ) intervention:

Baseline: 65%
6 months: 72%
12 months: 79%
18 months: 82%
24 months: 84%

100% of all children and adolescents are screened for TB infection. 100% of children and adolescent either on treatment for TB or IPT.

LESSONS LEARNED AND RECOMMENDATIONS

All clinic staff, both clinical and administrative must be trained in child/adolescent friendly services.

Those clinicians with a special affinity toward pediatric services become regular providers of care and support.

Community Health Workers with special affinity for children and adolescents receive additional training and support for this population.

Bio-medical interventions, alone, are not sufficient to reach 90-90-90. A comprehensive bio-psycho-social-spiritual model is required.

Program support and interventions must be constantly adaptable to meet a child/adolescent rapidly changing developmental realities.

Community Health Workers provided the critical connection between community and clinic.

Clinicians must have real-time data to make the most effective and efficient clinical

decisions.

Both adult and peer support are critical to achieve viral load suppression.

ANNEXES: N/A

8. Kenya

TITLE OF THE PROGRAMME: #WhatGirlsWant: Mentoring Girl Leaders

CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End** (if applicable): 2019
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

HIV disproportionately affects adolescent girls and young women and many factors including unequal access to information and education; limited agency and gender inequality contribute to this reality and have limited the success of HIV prevention for and with adolescent girls and young women to date. While there is increasing prioritization and focus in the global HIV response, especially in Eastern and Southern Africa, adolescent girls and young women are most often framed as targets and beneficiaries, with few platforms available to articulate their priorities or actively shape the programs and policies affecting their lives, health and livelihood. Effective HIV prevention programmes for adolescent girls and young women critically depend on developing and expanding the leadership, platforming the voices, realizing the knowledge and implementing based on the solutions of adolescent girls themselves.

Mentoring has increasingly become recognized as a means to support the growth, development and leadership of adolescent girls and young women. However, access and availability to participate in mentorship programs can be unequal. There are unique barriers that limit the participation of adolescent girls below the age of 18. Too often, programs designed to illuminate and address their particular needs, and expand their participation, are sorely lacking. Girl Leaders are indispensable role models who can powerfully communicate and inspire within their own communities. Adolescent girls living with or affected by HIV who are able to confidently, meaningfully and on their own terms discuss HIV and how it affects them, are best placed to support other girls to ask questions about sex and reproduction,

access HIV testing, to learn about and access available prevention methods, to link to care and/or treatment, and, critically, stay in care and treatment programmes once initiated.

We brought this principle of meaningful engagement, leadership and mentorship to this #WhatGirlsWant project, which has helped to ensure that the social, economic, educational daily realities of adolescent girls, in all their diversity, shape the programs and policies designed to reduce the HIV burden in this population.

#WhatGirlsWant has linked experienced young women leaders, who have been trained and cultivated mentorship experience through the ATHENA LEARN – DREAM Innovation Challenge Project. The dynamic young women leaders are designated as #WhatGirlsWant Champions. The Champions serve as mentors to adolescent girls; providing training and mentorship to support their growth and to propel them into their own taking on leadership and advocacy roles. #WhatGirlsWant has been anchored on youth-led, youth-developed and youth-tested tools to provide training and ongoing support to bring adolescent girls living with and affected by HIV into advocacy and decision-making spaces to speak up for #WhatGirlsWant, and work with other adolescent girls in their communities to develop advocacy agendas that represent #WhatGirlsWant; act as role models and peer supporters, on HIV prevention, testing, treatment and care; disclose their HIV status in an empowering, personal and informed way, when and if they choose to; and develop the capacity and skills of adolescent community leaders. #WhatGirlsWant has promoted adolescent girls' leadership and capacity to function as powerful change agents – with the support and guidance of young women aged 20-24 as their mentors and champions.

1. http://www.athenanetwork.org/assets/files/WhatWomenWant/ATHENA_WhatWomenWant_AGYW_powering_HIV_prevention_2017.pdf

DESCRIPTION

The ATHENA-led #WhatWomenWant platform has been expanded to include #WhatGirlsWant. This added dimension offers tools and a community for younger women and girls to discover and share their needs and priorities. It creates a broader and more diverse group of girls and women engaged in advocating for their own agendas and holding institutions to greater account. #WhatGirlsWant promotes adolescent girls' leadership and capacity to function as powerful change agents, with the support and guidance of young women mentors and champions. This offers a different model of working with adolescent girls in the context of HIV, SRHR, health and advocacy. It places meaningful engagement at the center to create a distinctive opportunity for adolescent girls to gain leadership skills, receive ongoing support, build their mentorship and develop advocacy capacity. #WhatGirlsWant uses tools developed, tested and led by young people to provide training and ongoing support.

Objective: The overall objective of our project was to ensure that the daily realities and experiences of adolescent girls, in all their diversity, shapes the programs and policies designed to reduce the HIV burden within this population.

#WhatGirlsWant was conducted in 2018 and 2019 in Nairobi and Homa Bay County, Kenya, the project linked young women leaders – with mentorship experience gained from the ATHENA-led LEARN project (DREAMS Innovation Challenge) – to younger adolescent girls. These dynamic young leaders were designated as #WhatGirlsWant champions with the skills to mentor other adolescent girls to take on leadership and advocacy roles of their own.

#WhatGirlsWant champions were selected based on their interest, knowledge, expertise in mentorship, advocacy experience and commitment to partnering with other young women. The peer mentors were nominated by community partners, who were invited to identify

young women that were actively involved in leadership programs with adolescent girls in their communities. Four #WhatGirlsWant champions were each paired with three peer mentors. A WhatsApp group kept everyone in touch and fostered team-building.

The project supported #WhatGirlsWant champions and peer mentors to work together to:

- ≥ Know and articulate their needs and concerns, within an age-appropriate human rights empowerment framework
- ≥ Develop #WhatGirlsWant advocacy agendas around comprehensive sexuality education, menstrual health, gender equality and other topics central to the health, rights and wellness of adolescent girls and young women
- ≥ Enable peers and other community members (families, teachers, faith-based leaders, etc.) to appreciate, support and advocate for the rights of adolescent girls
- ≥ Mobilize greater awareness of, and advocacy around, adolescent girls' rights
- ≥ Serve as effective advocates for a girl-centered agenda in relevant fora at community, national and global levels
- ≥ Serve as role models and peer mentors on HIV prevention, testing, treatment and care for adolescent girls in their communities.
- ≥ Build empowerment around HIV disclosure with a focus on choice, empowerment and leadership.
- ≥ Develop the capacity and skills of adolescent community leaders in health and rights.

The #WhatGirlsWant team in Kenya operated with Nairobi and Homa Bay County and the main sponsors were Positive Action for Adolescents (PAA), a project by ViiV Healthcare, ATHENA Network, Teenseed Africa, Positive Women Voices and Government line ministries including Ministry of Health, National AIDS Council and Members states to the county. #WhatGirlsWant has proven to be a sustainable model of young female leadership and the opportunity to connect with other activists for inter-generational learning and mentorship. The project is able to bring young women into spaces where they can have opportunities to advocate for their issues be it on a local, national, regional and global landscape.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

#WHATGIRLSWANT COMMUNITY OUTREACH

Monthly safe space meetings and community dialogues were held in local settings, , both in Nairobi and Homa Bay, easily accessible and familiar to adolescent girls. In each area, the same place was used throughout the project, creating continuity and increasing participation. Peer mentors invited 16 or more adolescent girls to attend and talk about the challenges they face, ask questions and learn about their bodies and their rights in a nonjudgmental space whilst also having fun together. The champions mentored the peer mentors by offering logistical support, documentation, guidance and shared facilitation. The meetings created an important and unique space for adolescent girls to get correct information about SRHR and HIV prevention and treatment. In these safe spaces, the adolescent girls could share their HIV status, receive treatment adherence counselling and get advice on other issues. The meetings provided a face-to-face opportunity for mentorship and leadership-building.

Our quantitative output measures include:

8 advocacy engagements with stakeholder and decision-makers, measured by advocacy logs.

462 adolescent girls engaged in community dialogues, measured by participant registration

12 adolescent girls participating in local, national, and global SRH/HIV advocacy activities

12 adolescent girls newly applying leadership skills through advocacy, mentoring or peer education/mobilization

296 AGYW mentored by new young women / girl leaders, or reached with community education and mobilization activities every month for tenure of the project

296 of AGYW reporting improved knowledge, skills and confidence in SRHR, HIV, leadership and other focus areas, measured by pre and post questionnaires

IMPACT

From community outreach and dialogues to media advocacy, #WhatGirlsWant champions and peer mentors were supported to know and articulate their needs, mobilize greater awareness of adolescent girls' rights and to advocate for a girl-centered agenda. The work aimed to be impactful at many different levels, including:

≥ Participating in a radio program: #WhatGirlsWant champions and the project lead went live on air to talk about SRHR and HIV prevention on a radio program with national reach.

≥ Supporting women human rights defenders: When Caroline Mwatha, Nairobi-based human rights defender was discovered dead, #WhatGirlsWant adolescent girl leaders helped organise a vigil and took part in a demonstration demanding Kenyan officials investigate her death.

≥ Representing young women at a UN knowledge seminar: #WhatGirlsWant peer mentors represented young women at a seminar organized by the UN Women Eastern and Southern Africa Regional office to launch the report Ending female genital mutilation and other harmful practices in Nairobi. Two peer mentors shared their story as survivors of teenage pregnancies and early marriage and spoke powerfully on what girls want.

≥ Participating in an advocacy meeting on LGBTQI rights with religious leaders in Kenya: A #WhatGirlsWant peer mentor and Winny Obure, project leader, participated in an advocacy meeting at the Amnesty International office in Nairobi on human rights (including abolishing Sections 162 and 165 of the Kenyan Penal Code).

≥ Using social media: Facebook and Twitter was used to increase the reach of messages from community dialogues and meetings. Follow the #WhatGirlsWant hashtag to track where the champions have been, their impact, and where they are setting a new and different agenda.

≥ Engaging on platforms: Greater numbers of adolescent girls took up positions and opportunities for leadership, including on conference panels, steering committees, community advisory boards, guidelines-setting committees at all levels.

Evaluation

The project was measured and evaluated using qualitative data collection, for example pre- and post-questionnaire, WhatsApp consultations, journals, monthly reports, and interviews to explore views.

LESSONS LEARNED AND RECOMMENDATIONS

Learning

The model of meaningful involvement of young women is powerful but not without challenges. Having young women lead other young women created tensions around power dynamics and who is in charge. As the project progressed, it was noticeable that champions and peer mentors coming from a grassroots activist space to a professional and formal project environment, would benefit from professional development. Learning from the project included:

- ≥ Allow time to build confidence, skills and professional development, for example: in using email, internet and WhatsApp; attending meetings and representing peers; planning, budgeting, and reporting; leading outreach, mobilizing, and facilitating.
- ≥ Take into account practical considerations when working in the community, for example, access to a smartphone, good Wi-Fi connection, mobile data costs, transportation costs, and money for refreshments.
- ≥ Have an accountable and easy to access system for reimbursement, for example, champions and peer mentors need to quickly access funds for transport and meals.
- ≥ Embrace an iterative process of working with adolescent girls and young women at the local community level.
- ≥ Have nimble systems as community work and mobilization are fast paced and dynamic
- ≥ Open doors and facilitate engagement with key decision-makers in HIV, SRHR, and gender equality, at local, national and global levels, including with donors and United Nation (UN) family.

Recommendations

- ≥ Extend the coverage of this mentoring model to other geographical areas where adolescent girls and young women are experiencing similar challenges. Increase the 'dosage' of the mentoring project. Feedback indicated that it was too short. Mentorship is a process that cannot be done in a day, especially given that the level of understanding differs from person to person, and mentees can benefit from follow-up contact. The impact will only begin to be properly felt over longer periods of time.
- ≥ Widen the reach and ensure that mentoring and support is accessible for ALL adolescent girls and young women, for example girls from childheaded households or under the care of grandmothers. Support should include help with school fees, uniforms and sanitary pads as some girls cannot afford to cover even their basic needs.
- ≥ Include a focus on related sexual and reproductive health issues, such as preventing and reducing cervical cancer among adolescent girls and young women.
- ≥ Continue to support the mobilisation and education of adolescent girls and young women so that they are more informed, confident, aware of their rights, able to live an impactful life in society and be a role model to the upcoming generation. "When one girl is empowered, the whole society gains wisdom."

9. Kenya

TITLE OF THE PROGRAMME: MARA Reloaded - Leaving No Adolescent Behind!

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- **Programme is being implemented since:** October 2018 - **End** (if applicable): December 2019
- **Responsible party/parties:** Government; Civil society; UN or other inter-governmental organization
- **Population group(s) reached:** Adolescents and young people living with HIV; Adolescent girls and young women; Adolescents and young people among key populations; Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

Background

AIDS is the leading cause of death among adolescents in Africa (UNAIDS 2014) with 11% of all AIDS related deaths in Kenya being among adolescent and youth aged 15-24 years (Kenya HIV Estimates; 2015). The same report estimated that 51% of all new HIV infections in Kenya were among adolescents and youth (15-24 years). KAIS 2014 indicated low levels of comprehensive HIV knowledge (17.4% for adolescents 10-14yrs), condom use (11% among female and 43% among males 15 – 24yrs) and low ART coverage (42% of eligible adolescents were not on ART).

There is a poor rate of retention, adherence and viral suppression among adolescents in care nationally. LVCT Health 2016 data showed viral suppression among adolescent 15-19 years at 51% while the adults are at 90%. Parents that have not disclosed to their children have indicated that they find it difficult to disclose and this has emerged as one of the issues that affected the adolescents' adherence. There have been reports of schools that expelled children due to their HIV positive status. Adolescents have complained of stigma in schools caused by fellow students, teachers, matrons and nurses that affect adherence.

The key population (KP) programs in Kenya does not program for adolescents KPs. A situational analysis conducted by LVCT Health, NASCOP and UNICEF in 2016 found that there are a significant number of adolescents 10-19 years among key populations (sex

workers, MSM and injecting drug users) in Kenya. The adolescents expressed challenges in accessing HIV and health services and some expressed the desire to come out of the behaviour that places them at risk. In 2016, over half of all new HIV infections (51%) were among young people aged 15-24 years with adolescent girls and young women contributing over a third of those infections (33%).

LVCT Health facilitated improved quality and access to services for HIV negative adolescents in the general population, adolescents living with HIV and Most at Risk Adolescents in a fifteen months project dubbed MARA plus with key focus in catalytic activities to optimize HIV prevention and treatment outcomes among adolescents and young people in seven counties.

Description

The program will achieve the following within the period of implementation:

1. 72,310 adolescent boys and girls 10-19 years (40% girls;60% boys) with increased access to HIV, GBV and SRH information through the one2one web and mobile based platforms and other information sharing platforms by December 2019
2. Improved identification, linkages, adherence and viral suppression amongst adolescents (boys and girls) in 5 target counties (Nairobi, Mombasa, Kisumu, Migori and Homa Bay) by December 2019
3. Enhanced capacities of government, implementing partners and young people on programming and policy advocacy for adolescents including those reporting same sex, sex work and drug use strengthened by December 2019
4. Improved knowledge management for best practices, lessons learnt and recommendations to inform MARA and ALHIV programming at national and county level by December 2019

Results, outcomes and impact of the programme

Capacity building of AYP

1. Training and facilitating AYP as youth advocates for policy change
 - a. Establishment of Youth advisory councils for health (YACH) – eight counties have taken up this approach with 10 YACH members per county (Nairobi, Mombasa, Kilifi, Kisumu, Homabay, and, Migori)
 - b. Training of YACH members on advocacy
 - c. Participation in technical working groups at national and county level
 - d. Training and engagement of AYP as peers for delivery of services – 120 peers have been trained
2. Building capacity of AYP organizations to receive grants and manage programs – LVCT utilizes an organizational systems' strengthening approach to build capacity of YP organizations to receive and manage grants. We have applied this model to 5 youth organizations to deliver services in their communities

Policy support for AYP programming

1. We have provided technical support to 5 counties to develop multi-sectoral AYP strategies and supported their dissemination and implementation. We provide technical support for adolescent technical working groups in 8 (eight) counties

Lessons learned and recommendations

Scalability and sustainability of ODP through a stepped care model of health

1. Content development (thematic based) for ODP

2. Technical support in evaluation of the digital solutions
3. Research (implementation science to develop evidence across digital solutions)
4. Personnel support to deliver on quality health services at hotline
5. Scaling up of stepped care model (Mhealth solutions) among adolescent and young people

Integration of services;

1. Integration of young key population services in public health facilities
2. Capacity building of health care providers to provide adolescent and young persons' responsive services.
3. Provide technical support to supported counties in strengthening systems for data collection, reporting and utilization to inform programming for adolescents and young persons.

Meaningful engagement of Adolescent and Young People;

1. Mentorship to adolescents and young persons through youth networks and groups to engage in meaningful policy advocacy.
2. Capacity building for young people to undertake evidence generation and documentation for advocacy.
3. To establish/ strengthen a functional youth advisory council (YAC) in supported counties.

Multi-sectoral coordination;

1. Facilitate supported counties to convene stakeholder forums on adolescent and young people to monitor progress based on existing county AYP strategy frameworks.
2. Provide technical support to supported counties to convene quarterly adolescent and young people technical working group (TWG) to address AYP HIV and SRHR issues to inform programming and policy.
3. Facilitate dissemination of relevant adolescent and young people HIV/ SRHR policies and guidelines.
4. Facilitate cross learning across counties.

10. Kenya

TITLE OF THE PROGRAMME: Improving the life chances and quality of life of vulnerable Adolescents through HIV Sensitive Social Protection in Kisumu County, Kenya

CONTACT PERSON

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- **Programme is being implemented since:** 2017 - **End** (if applicable): 2018
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Adolescent boys and girls aged 10-19 years, Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Despite overall progress in reducing new HIV infections and AIDS related deaths, progress for adolescents (10-19 years) has been uneven in Kenya. The national HIV prevalence is at 6%, with adolescents and youth (10-24 years) contributing to 46% of all the new HIV infections and 14% of all the AIDS-related deaths in the year 2015.

Kisumu is one of the counties that carry the greatest burden of HIV/AIDS with an HIV prevalence of 19.9% (which is estimated to be higher in the informal settlements of Nyalenda, Obunga and Manyatta), falling third nationally after Homabay and Siaya. With an estimated population of 268,568 adolescents (10-19 years), the county has approximately 13,988 adolescents living with HIV (ALHIV), 2,688 new annual HIV infections and 217 annual AIDS-related deaths.

The informal settlements are characterized by temporary housing structures, overcrowding, poor sanitation and insecurity. Poverty, compounded by this upsurge of HIV/AIDS and the weakening community structures has exposed children into vulnerability that is manifested in food shortage and other forms of insecurity, lack of shelter, lack of medical care, high school drop-out, malnutrition, high mortality rate, and peer pressures to conform to particular cultural and gender norms; and this has worsened the living conditions of this segment of the society with the result being exposure of young people to risky sexual behaviors including early sexual debut, low contraceptive use, transactional sex, sexual coercion/abuse, high

burden of unintended pregnancies, and drug and alcohol abuse in the slums. The rural Seme and Nyakach sub-counties as well have the lowest share of residents with secondary level of education in the county, and this has an effect on economic and health outcomes among the residents; with the adolescent OVC in the areas facing a lot of challenges such as: child labour (fishing, brick, sand harvesting and ballast making), school dropouts, sexual abuse and poor access to essential services. Additionally, casual workers at the brick and ballast industry and businessmen lure girls into sex and child marriage.

It is estimated that in Kenya there are ten million orphans, with 2.6 million being orphaned and vulnerable children (OVC) and a segment of this group are in need of special care and protection. The same adolescents face multiple deprivations, with one out of 5 children under 18yrs having lost one or both parents. According to Lee et.al. (2014) OVC support services were low for medical (3.7%), psychological (4.1%), social (1.3%), and material support (6.2%); educational support was slightly more common (11.5%).

In response to the challenges above, the Government of Kenya with support from the Development Partners launched a Cash Transfer for Orphans and Vulnerable Children (CT-OVC) Programme in 2004 with the aim of supporting households living with and taking care of orphans and vulnerable children and since then the programme has expanded to support approximately 480,000 children, out of which only 14,770 OVC (approximately 10,000 households) currently benefit in Kisumu County. In the 4 targeted sub-counties, the CT-OVC beneficiaries are as follows: 1,216 in Kisumu Central, 2,255 in Kisumu East, 2,106 in Nyakach and 2,417 in Seme.

The CT-OVC programme has not reached all the deserving OVC at the national, county and sub-county level and for those it has reached, it only supports children up to 18 years. Those who attain 19 years are likely to be exposed to lesser access to services, hence increased vulnerability. Weak systems and capacities of community-based care and social welfare services which address a range of vulnerabilities that drive the HIV epidemic is evident in the four sub-counties. Another challenge is the inadequate capacity at the county level of both county and national government departments to plan, implement and monitor joint social protection and HIV programmes.

DESCRIPTION

The programme endeavours to engage and support OVC adolescents (10-14 years and 15-19 years) and their caregivers in the CT-OVC households for enhanced parenting and care through the provision of cash top up of KSh. 500, plus care interventions. The proposed interventions will focus on the human capital side, and will include a combinations of cash with the following package: integrating behaviour change communication; access to HIV and health care (HIV prevention, Care and treatment) through enrolment in national health insurance scheme (HISP); Access to education; layered targeted interventions, services and information at the point of cash delivery such as skilful parenting, financial literacy and mentorship. Skilful parenting, social enterprise and financial literacy education will address poverty as a driver for HIV infection. The program seeks to shift several HIV prevention paradigms to expand and accelerate impact for adolescents through service provision and linkages to care and treatment. Finally, the programme will capacitate and incentivize County and National government departments to plan, coordinate budget for and monitor (through strong systems), initiatives to protect the most vulnerable children.

Outcome Result: By June 2018, 8,110 more vulnerable adolescent girls and boys aged 10-19 years in CT-OVC- households' access affordable and quality HIV-sensitive social protection services underscored by functional government systems in selected sub-counties of Kisumu, Kenya.

Output 1: By June 2018, 8,110 HIV-affected Orphaned and vulnerable adolescent boys and girls in OVC-CT households are reached with financial protection through cash and social transfers.

Output 2: By June 2018, Coordination, planning and accountability systems at national, County and selected sub- county levels strengthened to provide and scale up initiatives to protect the most vulnerable adolescent girls and boys affected by HIV.

Output 3: By June 2018, 8,110 (1,160 boys and 6,950 girls) orphaned and vulnerable adolescents 10-19 years access comprehensive, affordable and quality services, including education, HIV and health care, health insurance and birth registration.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Project outcomes

- 3,053 (1,593 males and 1,460 females) adolescents received HTS services; 52 (1.6%) tested positive for HIV and all linked to care.
 - Birth registration increased from 82% at baseline to 95% at endline.
 - 69% of 8527 adolescents reached with HIV prevention, care and treatment services.
 - 2,323 caregivers of 5,191 (2,119 boys and 3, 072 girls) adolescents registered with NHIF.
 - 71% of adolescents linked to mentors.
- Seme Sub County was identified to be one of the most affected areas in GBV and on 1st March 2018 International Women's Day gave an opportunity to share information on GBV.
- ICS supported Technical Working Groups and are currently functional. As a result, beneficiaries have made use of funds received in form of cash transfers for OVCs through case plans and goal setting methodologies per each of eligible households.
- Community systems strengthening was effective in increasing knowledge and awareness thus adoption of positive practices. Strengthened partnership and coordination of adolescents by supporting the policy document development. Capacity building through mentorship of officers at community and facility levels has improved service delivery related to children services.
- Ascertained from the project's end line evaluation was that, through an integrated approach, access to government services would be effective and efficient as a sensitization undertaken during the project encouraged majority of the households to register for NHIF cards and select preferred hospitals.
- A sub county children's officer in Seme reported "despite the fact that civil registration is a government directive: ICS facilitated and built capacity of communities to understand importance of civil registration, including NHIF. In addition, ICS partnered well to promote these services, which are initiatives of the government.

Lessons learnt and project outcomes

- Project design: designed through a consultative process that was informed by a thorough analysis of operating context and priority needs.
- Capacity building: Training of children officers on soft skills resulted in tremendous improvement in utilization of services and client satisfaction.
- Community Systems Strengthening (CSS; technical and organizational capacity of grassroots CSOs and BWCs were built to support them to take lead in community mobilization, awareness creation and addressing structural barriers.
- Multi-sectoral approach and coordination by the DCS; involved other sectors such as education, health led to improved access to quality adolescent services.
- Parenting education skilful parenting training encouraged open communication of sexuality issues with adolescents reducing HIV incidences by an equal measure of the reduction in HIV risk factors.
- Evidence-based advocacy: Collaborative project implementation based on open dialogue

and mutual accountability for results, including incorporating government counterparts as members of a project implementation team, was noted as a best practice that offers valuable opportunities to influence policy and practice.

- Use of outreaches; integrated outreaches enabled project to improve coverage by reaching complex population with several different services at the same time.
- Provision of scholastic material; in consultation with the DCS, ICS procured scholastic materials such as solar lamps, dignity packs and uniforms.
- Learning Exchange visit: a learning visit for pupils in the ICS health clubs and as a result, pupils were motivated and felt as part of the project.

Project outcomes by June 2018;

- Outcome 1: 8,110 HIV-affected adolescent girls and boys in OVCT-CT households in Nyakach, Seme, Kisumu Central and East sub-counties were reached with financial protection through social transfers.
- Outcome 2: coordination, planning and accountability systems at Social Protection Assistance Unit (SAU), Kisumu County and 4 selected sub-counties were strengthened to provide and sc.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learnt

The following promoting factors should be considered:

- Enhance Outreach services: The outreach activities enhanced coverage and accessibility of health care services especially in the hard to reach areas.
- Strengthen Community Systems: Building the capacity of grassroots CSOs and Beneficiary Welfare Committees, supporting them to take lead in community mobilization, awareness creation and addressing structural barriers to adolescents' accessing health and social services.
- Employ Multi-sectoral approach and coordination by lead government agency: (Adolescent TWG) Involving other sectors such; education, health; and supporting AACs at locational, sub county and county levels.
- Contextualize Parenting training: Parenting education tailored to specific needs of caregivers of adolescents to help them address parenting challenges.
- Promote Adolescent Advocacy: Adolescents to be in the leadership position to champion their agenda.

Innovative ways of engaging adolescents

Some of the innovative ways by which we engaged adolescents included:

- Creating Adolescent Safe Space in and out of schools: A good platform for adolescents to share challenges and experiences on subject areas like HIV risk factors, relationships, career and talent.
- Assigning adolescent mentors: These mentors engage with adolescents in structured sessions including life skills and HIV&AIDS education.
- Engaging adolescents in advocacy platforms: Voices of adolescents picked from the adolescent symposia activities were used to beef up Kisumu County Adolescents and young person's Health policy.
- Parenting training for caregivers/parents of adolescents: Provided appropriate skills and tool for parents of adolescents to support them in their caregiving role and promote responsive caregiving and positive parenting.

11. Kenya

TITLE OF THE PROGRAMME: Innovations in pediatric case finding in Kenya

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- **Programme is being implemented since:** October 2016 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

In Kenya, nearly 30,000 children living with HIV are not yet diagnosed, despite the wide scale up of pediatric case finding strategies. Index case contact testing is an effective strategy for identifying HIV-positive children and adolescents missed by PMTCT and early child health services. HIV-diagnosed adults have traditionally been index clients. However, millions of HIV-positive adults have died, potentially without disclosing their HIV status to family members or having their children tested. Also, many adolescents independently present for HIV testing and initiate ART at a facility other than where their parents receive ART.

DESCRIPTION

Working in tandem with county health officials at the facility and community levels and with funding from PEPFAR, EGPAF adapted index testing approaches to use deceased individuals with known or suspected HIV infection as index clients at 22 sites, and adolescents as index clients at 14 sites in Kenya. Records of deceased index clients were reviewed to determine the eligibility of their children for HIV testing. Ministry of Health patient cards were used to obtain family contact information, and providers contacted them with the discrete offer of HIV home-based testing, without disclosing the HIV status of the deceased family member. Providers were trained to collect information on adolescents' siblings, document eligibility for HIV testing, and contact caregivers for consent for siblings below 15

years of age. Known HIV-positive adolescents and their siblings were encouraged to attend clinic days for health talks and HIV testing or provided with testing at home.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Using deceased individuals as the index client among 1,021 tested resulted in positivity of 3.2% (4 positive) among children aged 18 months-4 years, 3.7% (9 positive) among children 5-9 years, and 4.1% (11 positive) among adolescents 10-14 years. Among 1,390 children tested using adolescents as index clients, positivity was 0% among those aged 18 months-4 years, 3.4% (16 positive) among 5-9 year olds, and 3.7% (16 positive) among 10-14 year olds. Comparatively, index case contact testing using a living, HIV-positive adult resulted in a positivity of 1.4% among 27,732 children tested aged 0-14 years.

LESSONS LEARNED AND RECOMMENDATIONS

As the number of undiagnosed HIV infected children and adolescents continues to decrease, more innovative strategies are required to reach those children and adolescents remaining. These pilot approaches were particularly effective at diagnosing children aged 5-14 years, the group often missed once they age out of facility based PMTCT and early childhood health services. Expanding the use of deceased individuals and adolescents as index clients should be considered for scale, alongside the continued expansion of traditional index testing approaches.

12. Lesotho

TITLE OF THE PROGRAMME: ADORE

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- **Programme is being implemented since:** October 2018 - **End** (if applicable): 2019
- **Responsible party/parties:** Government, UN or other inter-governmental organization, Academic institution
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Lesotho, a small land-locked country surrounded by South Africa, has the second-highest adult HIV prevalence in the world with 25.6%. Compared to the other Southern African countries, Lesotho as well presents one of the highest HIV-incidence among adolescent girls and young women. Reaching the first UNAIDS target is still suboptimal als due to the geographic characteristics of Lesotho. About 70% of Lesotho's population lives in rural mountainous areas (>1500m) characterized by widespread poverty, poor transport infrastructure and hard-to-reach villages. Thus, access to the health care facilities remains a major barrier for testing and further engagement in care. Furthermore, men, young people and key populations are disproportionally underdiagnosed by current testing strategies (UNAIDS 2019). Offering HIV testing and counseling at people's home is highly acceptable in Southern Africa and has the potential to reach more first-time testers. Home-based testing is therefore a key strategy endorsed by the World Health Organization (WHO). Home-based testing data from Lesotho have demonstrated testing uptake of over 90% (Labhardt ND et al. PLOS Medicine 2014), similarly high rates between men and women, young and old and a substantial number of first-time testers (Labhardt ND et al. BMC Pub Health, 2019). When discussing the first UNAIDS 90 target, though, it is critical to distinguish between testing uptake (proportion of population reached for testing that accepted it) and testing coverage (proportion of population eligible for testing that received it). Only if we can reach full testing coverage, a sustained impact along the HIV care cascade can be achieved. While uptake is

high during home-based testing, the coverage often remains below 90% due to the household members who are absent at the time of the campaign.

In Lesotho, testing catch-up visits during weekends have shown to increase coverage, however, remains a costly strategy especially in a rural setting. As progress in Southern Africa has resulted in lower test positivity rates, leading to increased testing cost per HIV-positive person identified, and at the same time donor investment stagnated, innovative and more cost-effective home-based testing strategies are needed (UNAIDS 2019).

Oral-fluid rapid HIV self-testing (HIVST), e.g. OraQuick®, can increase uptake in facility- and home-based testing models, particularly among men and young people (Johnson CC et al. JIAS 2017 & Hatzold K et al. JIAS 2019).

ADORE (ADolescent ORal tEsting) was an implementation programme, that measured the effectiveness and acceptability of secondary distributed oral HIV self-tests (HIVST) among adolescents and young adults (AYA) in Lesotho.

DESCRIPTION

Two specifically trained teams, each consisting of 6-10 lay-counsellors, one campaign organizer and one supervising nurse (Community ART Nurse) conducted home-based testing campaign in two districts (Butha-Buthe and Mokhotlong). First, the team obtained written consent from the household head (or representative aged 18 years or older) to enter and enumerate all household members living in the household. Second, the teams proposed HIV testing and counselling as well as additional multi-disease screening and prevention services to all present household members. For consenting household members, point-of-care blood-based HIV testing followed the national testing algorithm. Additionally, the teams asked for consent to leave an oral HIV self-test (HIVST) for every AYA 12 years or older who was absent or declined HIV testing on the day of the testing campaign. The oral HIVST was OraQuick® ADVANCE HIV I/II. The team prepacked the kit, included a written and pictorial instruction for use in the local language (Sesotho), and added a written request to consult the village health worker (VHW) within 2 weeks after use of the test – irrespective of the result. In cases where more than one trained VHW served the village, the household chose the preferred VHW. The team labeled the kit with the name of the absent AYA before dispensation. One present household member was tested and trained using the oral HIVST. The VHWs received a list of all AYA for whom an oral HIVST was dispensed. The VHW visited all households 2-4 weeks after the campaign to collect the oral HIVST in case it was not returned to him/her. In the case of a reactive oral HIVST, the VHW provided further blood-based testing or organized referral to the health facility of the catchment area for confirmatory testing. All VHWs received a specific training about blood-based and oral HIVST, handling disclosure and stigma, and data entry in the patient's health booklet.

This program was implemented by a Consortium involving different partners:

- Ministry of Health Lesotho and the two involved District Health Management Teams (DHMTs).
- An NGO/NPO called SolidarMed, who is an official clinical implementation partner of the Ministry of Health for the two districts (Butha-Buthe and Mokhotlong).
- Swiss Tropical and Public Health Institute as the technical partner for the evaluation

The testing campaign which included more than just HIV testing and counseling was conducted under their lead of the DHMTs as they anyway perform regular similar home-based testing campaigns. During the project costs were mitigated between the partners (DHMT provided all the material, SolidarMed helped with staff costs and transport costs). The Oral HIVST (OraQuick) is currently in the roll-out phase in the country.

The project made use of the VHWs, a long-standing and trusted lay health cadre, funded

through Ministry of Health. Small training costs occurred, otherwise, during the implementation, no additional costs occurred.

This program can easily be taken up by any partner who is doing home-based HIV testing campaigns, be it the District Health Management Team or NGOs. The successful results (see below) were already presented to DHMTs and they are discussing the bigger implementation of this approach now.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

This programme was evaluated in a nested mixed-method study of a bigger cluster-randomized trial.

Methods

In intervention clusters (i.e. villages), the above described approach was used. The quantitative outcome was testing coverage among adolescents and young adults (AYA, age 12-24) within 120 days after home-based testing, defined as a confirmed HIV test result, known HIV+, or recent HIV- result, analyzed with adjusted random effects logistic regression models. The qualitative method entailed a case-control approach using in-depth interviews about the perception of the intervention among AYA who used the HIVST (control) and among those who did not use it (case), following the concept of saturation, coded and analyzed according to the Framework Method. Trial registration: NCT03598686.

Results

1065 consenting households with 2685 AYA were enrolled (intervention arm: 56 clusters, 572 households, 1447 AYA; control arm: 47, 538, 1236). In intervention arm, 937 AYA were absent or declined testing. An HIVST was left for 790, and 487 (62%) were returned. In control arm, 860 HM were absent or declined testing; 7 (1%) went to the facility for testing. 120 days after the home-visit, coverage was 1083/1447 (75%) in intervention versus 469/1236 (38%) in control (odds ratio 5.21 [95% confidence interval 3.83-7.09]; $p < 0.001$). The intervention effect was greater in male (70% vs 24%; 7.94 [5.55-11.37]) than female (79% vs 50%; 3.96 [2.81-5.59], p -interaction < 0.001). 11 case-interviews and 10 control-interviews were performed. In-person assistance during and after usage of the HIVST as well as convenience of testing emerged as key qualitative themes.

LESSONS LEARNED AND RECOMMENDATIONS

Home-based HIV-testing campaigns have been shown to be very effective in achieving high testing uptake, especially in resource-limited countries, also among young people especially in rural areas. However, one major question is still unanswered: How to reach the absent people during these campaigns in a cost-effective way? Especially as these absent people are overproportionally young people, an important group to reach.

This project demonstrated that secondary distribution of oral HIVST among AYA achieved an increased HIV testing coverage of $>35\%$. The intervention was particularly successful among males. The training of the present household member and the involved VHW about the HIVST usage is key.

Linkage to further testing and care after usage of oral HIVST was provided by the VHWs, a trusted and longstanding public-sector cadre. VHW programs exist in all countries of Southern Africa and are being expanded. If cost-effective, the HOSENG approach could easily be scaled up in the region, as the provision of oral self-test kits, followed up by VHWs, requires little additional human resources, finances, and logistics.

ANNEXES

See page 15 for the abstract of this project: https://www.virology-education.com/wp-content/uploads/2019/09/Programbook_3ADOL_program1.pdf

13. Lesotho

TITLE OF THE PROGRAMME: Adolescent Health Corners in Lesotho

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- **Programme is being implemented since:** 2016 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society;
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Within Global Fund programming

BACKGROUND

Lesotho has the second highest HIV prevalence in the world (UNAIDS). Yet, in 2015, the country had limited differentiated adolescent and young people's (AYP) HIV services. Furthermore, the services that were available were often outside the public health sector. The prioritization of epidemic control left no room for doubt that there were more young clients in need of comprehensive services than ever before, in addition to other significant factors impacting the wellbeing of this population (I.e. an aging paediatric HIV cohort and a surge of adolescent girls and young women newly identified as HIV positive). AYP living with HIV also faced challenges with emotional and social support, adherence and retention to treatment, access to viral load testing, and availability of convenient, centralized sexual health services.

DESCRIPTION

Beginning in January 2017, EGPAF – with funding from the President's Emergency Plan for AIDS Relief (PEPFAR), and in collaboration with Lesotho's Ministry of Health (MoH)– established adolescent corners at eight health facilities. These spaces are known as corners, because they are provided in areas secluded from adults receiving services. Multidisciplinary teams include a mix of service providers such as paediatricians, nurses,

social workers, psychologists, counsellors, pharmacists, and youth ambassadors to provide comprehensive and integrated services. These centres offer: HIV and STI risk-reduction counselling, HIV testing, care, and treatment, disclosure and adherence support, TB screening and treatment, peer-led psychosocial support, and social services to enable transition to adult care, among others (e.g., antenatal care for pregnant teenagers; sexual and reproductive health services, including STI screening and treatment; family planning; post-exposure prophylaxis [PEP]; post-rape care and counselling; and, as of October 2017, PrEP). Notably, these services are offered all week, including weekends: specifically, in the mornings and after school – for increased accessibility.

Beyond this, EGPAF hired youth ambassadors, who were attached to the aforementioned facilities. These youths provide HIV testing services, mobilize their peers to engage in health services, link clients in need of specialized care back to the MDT, and establish and facilitate peer support groups. EGPAF also developed a Peer Support Group guide for leaders to develop groups and to ensure standardization of support group activities that can evolve in chronic care. Groups address age and gender-specific needs; there are separate groups for key populations and young mothers. Support group members are encouraged to share their experiences and support one another in disclosure and treatment management. Members discuss resistance to discrimination, AIDS-free living and sexual health.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

At the national level, capacity for adolescent and youth-friendly HIV services has increased exponentially. Previously, only a few providers would attend specialized trainings from these eight sites. Using a modular approach for training, which was provided at facility-level EGPAF supported the Ministry of Health to build the capacity of 562 lay staff (counsellors and youth ambassadors) and 870 clinical staff (consisting of nurses, counsellors, psychologists, social worker and pharmacists).

The adolescent corners provide HIV services to 20% of the AYP population on ART in five districts (3,561/17,483). Between October 2017- September 2018, the eight adolescent centres accounted for about 25% of HIV testing and yield outcomes. Furthermore, over 32,000 AYP were tested for HIV. Of those tested, 1,027 were HIV-positive and 1,240 were initiated on ART during this same period. This is a reflection of the demand for friendly services and common transfer-ins, especially for 15-19 year olds, who choose to initiate ART at adolescent corners. With high volume care, peer support groups are vibrant on weekends. Youth-friendly ante- and postnatal care is available along with prevention of mother-to-child transmission (PMTCT) services are available. About 1 in 5 pregnant adolescents and young women are HIV positive, which includes young women who knew their HIV status prior to pregnancy.

The adolescent corners also serve HIV-negative AYP, using peer mobilization and testing as entry points to sexual risk awareness and risk reduction counselling and services. These spaces also serve to address the complete SRH needs of pregnant and sexually active youth. Of all AYP accessed through all eight centres, 6.8% were treated for STIs. Each year, over 1,000 adolescent girls and young women access long and short-acting contraceptives at corners, with injectable ones being the most popular. Moreover, a high number of confirmed TB cases are treated each month, totalling 300 cases each year, on average.

LESSONS LEARNED AND RECOMMENDATIONS

Key lessons through the process:

- Having a strong partnership with the Ministry of Health and keeping them involved throughout
- Involving young people in design, implementation and monitoring. Youth Ambassadors are employed staff who run many activities and have made a big difference in the care package.
- Adolescents and young people in urban settings/at high volume facilities need integrated

and comprehensive services. When built with a team of capable staff, clients will use these services and HIV care and treatment outcomes improve.

- When projects are hiring new youth-friendly staff, plan for staff sharing in other places in the hospital and encourage non-project staff exchanges. This is how HIV specific funding can leverage other connected needs more directly, while building staff capabilities to handle HIV and any other health need in high prevalence settings

14. Lesotho

TITLE OF THE PROGRAMME: Let Youth Lead: Adolescent Participating Through Social Accountability to Improve the Quality of Adolescent Friendly Health Services

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- **Programme is being implemented since:** 2018 - **End** (if applicable): N/A
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Reproductive, Maternal, Neonatal, Child, Adolescent Health & Nutrition Strategic Plan 2017/208/-2021/2022

BACKGROUND

Adolescents make up 18% of Lesotho's population (2016, Lesotho Bureau of Statistics). Like young people elsewhere, they face complex and changing environments during a period of great opportunity. However, in Lesotho, many of their challenges are particularly acute and concerning, given a context of widespread poverty in which 67.3 per cent of 13–17-year-olds are deprived in multiple dimensions of well-being, such as healthcare, nutrition, education, safe water, housing and information (2018, UNICEF). While HIV-related outcomes have improved for other age groups, this is not the case for adolescents. Young women aged 15–24 years are an immediate concern in Lesotho due to high levels of new HIV infections with 1.49% incidence—10 times higher than among young boys 15–24 (2017, LePHIA). Overlapping risk factors such as high teenage pregnancies (1 in 5), low condom use (1 in 4), low comprehensive knowledge of HIV (1 in 3) and low awareness on HIV status (1 in 3) place adolescent girls and young women in high risk of HIV (2014, LDHS; 2017 LePHIA). Sexual and reproductive health (SRH) services for adolescents and young people (AYP) are not readily available, and only a third of health facilities comply with existing guidelines on adolescent-friendly health services (AFHS) (2017, UNFPA). Against this background, Let Youth Lead, was initiated to improve the quality of AFHS and access to SRH services for AYP through social accountability.

DESCRIPTION

UNICEF Lesotho recognises the urgency of providing quality and friendly services for adolescents and young people that meet their needs to improve health and HIV outcomes—in alignment with the National HIV & AIDS Strategic Plan 2018/2019-2022/23.

Sentebale, Skillshare, and UNICEF support the Ministry of Health, through the Joint UN 2gether4SRHR programme, to increase youth participation in the monitoring of adolescent-friendly health services (AFHS) through social accountability. Specifically, the intervention builds the capacity of 185 adolescents/youth (15-24) and 95 health workers in 7 districts (Berea, Leribe, Botha Bothe, Mokhotlong, Berea, Mafeteng, Thaba Tseka) to monitor the delivery of adolescent-friendly health services. The intervention has a two-prong approach: the first involves training and mentoring young people to consult with their peers, service providers, and other stakeholders at community level on improving adolescent service delivery, and the second approach will be to improve the capacity of service providers to respond to these adolescent health challenges at the health centre level, and their ability to advocate for changes at district and national levels. The implementation ensures that a feedback loop among adolescents, service providers and communities is inbuilt to ensure sustainability.

The interventions complement Sentebale's and Skillshare's work with the Global Fund in the five districts, which include increasing adolescents' demand for health services and building capacity of service providers to deliver adolescent-friendly services. The youth advocates are currently working with Sentebale and Skillshare—creating demand for combination prevention HIV and sexual reproductive health services at the community level.

The Ministry of Health leads the programme with financial support from UNICEF and the Swedish International Development Cooperation Agency. The main implementing partners, Sentebale and Skillshare, work in partnership with community councils, local leadership (chiefs and councillors), Ministry of Health (health centres, village health workers), and Civil Society Organizations with projects in the same areas to ensure sustainability. The programme also forges strong partnerships with the Ministry of Education, through schools, to allow increased access to adolescents and young people.

The programme aligns within the Government of Lesotho's priorities in implementing the National HIV & AIDS Strategic Plan 2018/2019-2022/23 and the Reproductive, Maternal, Neonatal, Child, Adolescent Health & Nutrition Strategic Plan 2017/208/-2021/2022.

Additionally, the programme is a key activity in the signed compact between the Ministry of Health and UN agencies under the Joint UN Programme for SRH/HIV integration (2Gether4SRHR). The cost of the intervention during the first year was USD 4 per young people reached (3,284). The programme will include an evaluation to document results against the Theory of Change, and for advocacy for government scale-up.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The programme is implemented in seven out of ten districts of Lesotho and is generating evidence on health centre compliance against the Adolescent Friendly Health Services Standards. During the first year of implementation (21 June 2018 to 20 August 2019) the programme realized promising achievements including the strengthening community-facility linkages, the institutionalization of AYP participation in HCCs (100%), changes in facility opening hours to accommodate AYP, or the introduction of specialized days for adolescent services where time adjustment was not possible. Other achievements include:

- 3,284 AYP mobilised through the implementation of the score-card
- 42% improvement in youth advocate knowledge of SRHR (from 30% to 72%)
- 40% improvement in health worker knowledge of AFHS (30% to 70%)
- 100% of health centres have adolescents participating in health centre committees

LESSONS LEARNED AND RECOMMENDATIONS

The main success factor for the programme was that adolescents and young people are part of the development and the monitoring of the intervention. Let Youth Lead generated understanding of AYP experiences and needs, placing them at the forefront of the action. It strengthened community-facility linkages, improved AYP knowledge on SRHR and improved quality of AFHS. Most importantly Let Youth Lead created awareness among AYP of their rights. Next steps in the implementation of Let Youth Lead includes monitoring of community scorecard action plans, interface meetings at district and national level, and scale up to an additional two districts.

ANNEXES

Brief: Let Youth Lead

15. Lesotho

TITLE OF THE PROGRAMME: Improving SRHR/HIV outcomes for Young Mothers in Rural Lesotho through peer mentorship and support

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- **Programme is being implemented since:** 2018 - **End** (if applicable): N/A
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Reproductive, Maternal, Neonatal, Child, Adolescent Health & Nutrition Strategic Plan 2017/208/-2021/2022

BACKGROUND

Adolescent girls and young women (AGYW) make up ten per cent of Lesotho's population (2016, Lesotho Bureau of Statistics). Like young people elsewhere, they face complex and changing environments during a period of great opportunity. However, in Lesotho, many of their challenges are particularly acute and concerning, given a context of widespread poverty in which 67.3 per cent of 13–17-year-olds are deprived in multiple dimensions of well-being, such as healthcare, nutrition, education, safe water, housing and information (2018, UNICEF).

The National teenage childbearing rates are 19% and 55% of all pregnancies in Lesotho are among adolescent girls and young women (2014 LDHS). A whopping 92% of girls who experienced early pregnancy are multidimensionally poor (2018, UNICEF). The HIV prevalence in Lesotho for adolescents 15-19-year old is 5.7 % and 16.7% among 20-24-year-olds (2017 LePHIA). Young women aged 15-24 years are an immediate concern in Lesotho due to high levels of new HIV infections with 1.49% incidence—10 times higher than among young boys 15-24 (2017, LePHIA). Overlapping risk factors such as high teenage pregnancies (1 in 5), low condom use (1 in 4), low comprehensive knowledge of HIV (1 in 3) and low awareness on HIV status (1 in 3) place adolescent girls and young women in high risk of HIV (2014, LDHS; 2017 LePHIA).

DESCRIPTION

UNICEF Lesotho recognises the urgency of providing tailored services for AGYW that meet their needs to improve health and HIV outcomes for AGYW—in alignment to the National HIV&AIDS Strategic Plan 2018/2019-2022/23. As such, UNICEF and Help Lesotho are supporting the Ministry of Health, through support of the joint UN 2gether4SRHR programme, to implement a peer-led intervention to increase knowledge and improve health outcomes for pregnant and breastfeeding AGYW. The intervention contributes to generate demand for SRH/HIV services and increase access to health and social services for 300 pregnant and breastfeeding AGYW in two districts. The programme is complemented by interventions which will ensure an adequate supply and capacity of health workers to provide quality adolescent-friendly health and social services.

The programme uses community mobilisation, adolescent participation, community outreach, and peer-support as the main strategies to increase the knowledge of pregnant adolescents and young mothers 10-24 and facilitate their link to existing social services. The pregnant AGYW are provided with a layer of interventions, including training using tested curriculums, psychosocial support, and outreach services and followed-up in cohorts for two years. The interventions work synergistically to offer a comprehensive package of services that optimise their health and resilience. At the end of their participation, 300 pregnant adolescent girls and young mothers (10-19) in Butha Buthe and Thaba Tseka will have increased knowledge of the availability and use of health and social services.

The Ministry of Health leads the programme and the Swedish International Development Cooperation Agency, and Unified Budget, Results and Accountability Framework (UBRAF) Country Envelope and UNICEF financially support. The main implementing partner, Help Lesotho, works in partnership with community councils, local leadership (chiefs and councillors), Ministry of Health (health centres) and the district line ministries such as the Ministry of Education and Training, Ministry of Home Affairs and the Ministry of Agriculture and Food Security, Child and Gender Protection Units, as well as Civil Society Organizations with projects in the same areas. The programme also forges strong partnerships with the partners of the youth girls and their families to strengthen the intervention's acceptance at the household and community level.

Establishing village support networks and income-generating activities provides young mothers with long-term support in their communities and instil a sense of belonging. The programme relies on partnerships with health centres, village chiefs, the education sector, and village health workers to support the sustainability of the programme.

The programme aligns within the Government of Lesotho's priorities in implementing the National HIV&AIDS Strategic Plan 2018/2019-2022/23. Additionally, the programme is a key activity in the signed compact between the Ministry of Health and UN agencies under the Joint UN Programme for SRH/HIV integration (2Gether4SRHR). The cost of the intervention during the first year was USD 49 per mother-baby pair per month. The programme will include a mid-term and end-term assessment, including economic cost-effectiveness analysis, to inform government scale up.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The programme is implemented in two out of ten districts of Lesotho and is generating evidence on which layered interventions have the best outcomes for pregnant and breastfeeding AGYW. During the first year of implementation (21 June 2018 to 20 August 2019) the programme realised promising achievements, which include:

- 2200 condoms distributed
- 100% of young mothers know their HIV status
- Self-reported comprehensive knowledge of SRHR/HIV increased by 36% (36% vs 72%).
- Increase of 55% of AGYW using a modern method of contraceptive (an increase from 34% baseline);

- Increase in 49% of AGYW reported attendance to ANC services within the last 30 days (an increase from 30%).
- Increase of 25% increase from baseline (62% to 87%) of young mothers who play and stimulate their children;
- Through the development of 15 village support groups, an additional 335 pregnant and breastfeeding adolescents were reached at the community level.

LESSONS LEARNED AND RECOMMENDATIONS

The main success factor for the programme was the focus on providing multisectoral approaches and interventions to the AGYW—addressing their needs holistically. The programme worked across sectors to ensure comprehensive, holistic, and layered support for AGYW, including education, protection, social protection, and interpersonal communication. Additionally, the programme included partner and mother-in-law engagement to address social dynamics within communities and households that act as barriers for AGYW to access SRHR/HIV and SGBV services.

Despite the achievements in year one, structural factors (poverty, gender and economic inequality) and household/community beliefs (gender beliefs, myths, power dynamics) influence the young mother's access to SRHR/HIV services. While the programme successfully addressed demand determinants among the beneficiaries (knowledge, service utilisation, individual cultural practices), social norms remain an issue. To mitigate this, year two of the programme includes community dialogues with male partners, mothers in-laws, and key community influencers to address structural factors and social norms.

ANNEXES

Improving SRHR/HIV outcomes for Young Mothers in Rural Lesotho through peer mentorship and support Brief

16. Malawi

TITLE OF THE PROGRAMME: Enhancing Capacity of Adolescents Living with HIV/AIDS to Demand for Care, Support and Treatment

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- **Programme is being implemented since:** 2016 - **End** (if applicable): 2019
- **Responsible party/parties:** Government, Civil society, Private sector
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Adolescents are affected by the epidemic by contracting the disease from their mothers and/or by losing one or both parents to the disease. In 2009, an estimated 120,000 children in Malawi were living with HIV, and 650,000 had been orphaned by AIDS. The traditional extended family and other support systems are overwhelmed by the situation, as the majority of children affected by HIV and AIDS have no extended family networks on which to rely following the death of their parents.

Societal attitudes toward PLWHA let alone Adolescents living with HIV/AIDS affect people's willingness to be tested for HIV and their initiation on and adherence to ART. HIV/AIDS is still stigmatized in Malawi, but the situation is improving. 80 – 98% of women and men 15 to 49 years old now think a teacher with HIV should be allowed to continue teaching; they are also willing to care for a family member who has HIV and buy fresh vegetables from a shopkeeper with HIV. However, there is still reluctance to reveal a family member's infection with HIV let alone when one is a minor like the Project's targeted beneficiaries. Women are much more likely than men to want to keep secret a family member's infection with HIV (71% versus 58%). While there is consistent awareness of HIV's existence throughout the population and knowledge of HIV prevention is increasing, there is still a need for significant improvements in behaviors to reduce stigma and Discrimination and create a better

environment for Adolescents living with HIV to enjoy their right to childhood.

Other barriers to prevention, treatment, care, and support for Adolescents living with HIV include the limited coverage of behavioral change communications, inadequate empowerment of Adolescents living with HIV, limited access to services, insufficient focus on pediatric cases, inadequate laboratory services, lack of trained staff, and limited capacity for home-based care.

Malawi has had impressive success in rapidly scaling up ART. 49- 57% of people in need of treatment were receiving ART at the end of 2010. ART has been provided free of charge in the public sector since 2004. Despite the impressive scale up of the ART program, Malawi struggles with limited capacity in the health sector, which creates constraints in delivering needed testing, care, and treatment services to all citizens. There are continued government efforts to expand the basic package of health services provided at no cost to all citizens, increase the number of facilities offering services, and decentralize the health system to care for those in rural communities. Health services that previously were only provided for free at government-run clinics are now available at many Christian Health Association of Malawi clinics, while many other non-profit organizations provide counselling and testing at stand-alone and mobile facilities. Improving the quality of community-based care and its linkage to facility-based services to improve patient outcomes is also an important priority.

Background of the Target Areas (Mzimba and Mzuzu)

Northern Region districts including Mzimba and Mzuzu have almost similar prevalence rates according to the records at Mzimba District Hospital which stand at 12%. Records also show that there has been a rise in HIV/AIDS incidences due to the following major contributing factors.

Inadequate information on HIV/AIDS and SRH: Awareness and general knowledge has reached the community but there is little and limited discussions of HIV/AIDS issues in families between parents and children. Faith based institutions; there is disparity in the knowledge base between women and men. Men know more than women. The youth get information through fragmented sources that inadequate and reliable i.e. from peers, newspapers, school, and radios. Cultural values play a big role to the effect that the elders are not supposed to speak about sex freely with the youth.

DESCRIPTION

The project aims to address issues that Adolescents living with HIV/AIDS face in their day to day lives. The project would like to address the HIV and AIDS related stigma and discrimination against the Adolescents living with HIV/AIDS in Mzimba and Mzuzu face to improve their quality of life and lead the life as that of a normal child and have full access to their basic rights (i.e. education, proper healthcare services and not to be discriminated, etc)

Consultations with children, guardians, community members and stakeholders (both and Government and Civil Society in the targeted districts have revealed that adolescents living with HIV and AIDS in the district encounter a number of problems including; lack or no access to treatment, HIV/AIDS related stigma and discrimination, lack of awareness, and lack of forum for Adolescents living with HIV and AIDS to share ideas on how living positively. Availability of support groups have really helped People living with HIV to meet and share ideas unfortunately these are friendly for adolescents hence the need to create adolescent friendly forums.

These inadequacies have resulted into HIV/AIDS related stigma and discrimination against adolescents living with HIV/AIDS or their parents/guardians (for dependent children) are

reluctant to be tested, to disclose HIV status or to take antiretroviral drugs and reduce their chance of survival further. Adolescents living with HIV/AIDS have encountered hostility from their extended families and community, or have been rejected, denied access to schooling and health care, and left to fend for themselves. These have undermined efforts in as far as the fight against HIV and AIDS are concerned.

PROJECT DESIGN (Project Objectives, Targets and Components)

Overall Objective and Purpose

The overall objective of the project is to improve the quality of life of Adolescents living with HIV/AIDS in Mzimba and Mzuzu.

The purpose of the project is to help Adolescents living with HIV/AIDS in Mzimba and Mzuzu to live a normal childhood by lifting the stigma of the disease amongst their family, friends and the community and increasing access to Treatment, care and Psychosocial Support Care.

Specific Objectives

- To strengthen the capacity of adolescent living with HIV/AIDS in Mzimba and Mzuzu to demand access to support, care and Treatment by June 2019;
- To increase awareness of target groups (family, peers and community) about the rights of Adolescents living with HIV/AIDS;
- To enhance the role of Adolescents living with HIV/AIDS's in the community and their involvement in HIV/AIDS prevention
- To facilitate the identification of adolescent living with HIV/AIDS needs in relation to self-development and health well-being and engage duty bearers and advocate for the provision of relevant health services by June 2019.

Project Targets

The major stakeholders of the project are Adolescents living with HIV, their families, peers, and the general population of target districts. The project also aims to empower them so they can take the lead in communicating about the disease and propose interventions that can lessen the stigma against them.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The project reach out to 11,300 through strengthen the capacity of adolescent youths living with HIV to demand access to support, care and Treatment; "Adolescents living with HIV are empowered and are able to demand access to support, care and Treatment"

To increase awareness of target groups (family, peers and community) about the rights of Adolescents living with HIV/AIDS; "Community members, families and peers are aware of the rights of Adolescents living with HIV"

To enhance the role of Community Members and health workers to support Adolescents living with HIV/AIDS's. "Community members, health workers take active roles in supporting adolescents living with HIV"

LESSONS LEARNED AND RECOMMENDATIONS

There is a still need for continued funding of more advocacy efforts to strengthen adolescent capacity to be able to influence policies that affect them and create an enabling environment for services. There is a need to seek for more partners and financial support and sustain the hotlines for HIV/AIDS linkage.

Call by CBOs and NGOs to have their capacity strengthened so that they are able to continue sensitization on ending stigma and discrimination. More sensitization of the public on the existing situation in Malawi and about rights is needed to reduce stigma and

sensitivity for people living with HIV/AIDS.

There is also a need to discuss how to strengthen the provision of information to adolescents based on their needs with community-based organization and youth groups. Ongoing training and capacity building for hotline volunteers is needed.

What is important is to reach out to as many adolescents as possible so that when communities should have had adequate information that would enable them to make informed choices. Funds permitting, it would worthwhile reaching out to other district on raising awareness for Prep and pep

17. Malawi

TITLE OF THE PROGRAMME: Make Art/Stop AIDS (MASA) Youth: Participatory, arts-based, near-peer SRH Education in South East Zone

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- **Programme is being implemented since:** 1 July 2017 - **End** (if applicable): 30 June 2018
- **Responsible party/parties:** Government, Civil society, Academic institution
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Youth under 25 form two-thirds of Malawi's population and many are sexually active. Young men are twice as likely to have had sex before age 15 (26% young men: 12% of young women). For young women, early marriage and early pregnancy are major factors influencing sexual and reproductive health and wellbeing. Young women aged 15-19 are 10 times more likely to be married than their male counterparts (20% young women: 2% young men). More than 1 in 5 young women have begun child bearing by age 17, which not only increases health risks for mother and child, but often leads them to leave school prematurely (Malawi DHS, 2010)

In Malawi, 3.6% of young women and 2.5% of young men (aged 15-24) are living with HIV; young people account for 50% of new HIV infections, with HIV prevalence higher among certain subgroups, including 15-17 year olds (AVERT, <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/malawi>). Young women are especially vulnerable. "The pervasive social, legal and economic disadvantages faced by girls and women" according to The National HIV and AIDS Strategic Plan: 2015-2020, "reduce their ability to protect themselves from HIV infection." In fact, more than three times as many females than males ages 15-19 and more than two times as many females

than males ages 20-24 are HIV positive (A Vision for the Health and Well-Being of Malawi's Young People, 2014).

Data for urban areas in Southern Malawi point to a strong need for SRH and HIV specific SBCC interventions. More young women are married before age 18 in the Southern region (55%) than in the Northern (50%) or Central region (43%). More young women give birth before age 18 in the Southern region (42%) than in the Northern or Central regions (29%). In the Southern region, the overall HIV prevalence rate is 14.5%, twice as high as the prevalence rate in the Northern or Central regions. The HIV prevalence rate is almost twice as high in urban (17.4%) as in rural areas (9%) (The National HIV and AIDS Strategic Plan: 2015-2020). For young women ages 15-24, the highest HIV prevalence rate is in urban areas (11%) and in the Southern region (8%) (Malawi Youth Data Sheet, Population Reference Bureau, 2014).

While critical Life Skills (LS) and Comprehensive Sexuality Education (CSE) classes are now part of secondary school education across Malawi, less than one-third of youth report knowledge of YFHS and only 13% report having accessed them. Comprehensive knowledge of HIV among youth (ages 15-24) stands at 55% for boys and 44% for girls, well below the 75% Universal Access targets. Condom use is low among sexually active 15-to-19-year-olds, with 40% of sexually active males, 30% of sexually active unmarried females.

Barriers to safe sexual practices include gender inequality, multiple and concurrent sexual partnerships, low and inconsistent condom use, suboptimal implementation of HTC, late initiation of HIV treatment, harmful cultural practices; and stigma and discrimination. This calls for a need for prevention programs that are community based and create an open forum for discussion of sensitive socio-cultural issues. Improving access to and quality of prevention, testing, treatment and care for youth will only be effective if contextual and societal attitudes are addressed. Information needs to be delivered in contextually appropriate and engaging ways. Because of the pervasive disparity in power balance between genders when negotiating sexual activity, SRH education initiatives and HIV prevention programmes must target both young women and young men.

The target audiences of this project closely align with the priorities of the National HIV and AIDS Strategic Plan 2015-2020. The Plan identified male and female adolescents and youth as vulnerable populations in particular need of SRH education, HIV/AIDS prevention programs, as well as HIV testing, treatment and care services.

DESCRIPTION

Art and Global Health Center Africa (ArtGlo) and Dignitas International (DI) received funding from Malawi's National AIDS Commission (NAC) to implement a project called Make Art Stop AIDS (MASA) Youth- a participatory, arts-based, near-peer SRH education project in South East Zone of Malawi. MASA Youth ran for 12 months in three districts (Zomba, Phalombe and Machinga) commencing in July 2017. The primary target populations were secondary school and university students. ArtGlo and DI worked closely with other stakeholders such as District Education Managers (DEMs), District Health Officers (DHOs), local youth friendly health services (YFHS), DI Teen Clubs and other local support groups, college administration, secondary school teachers, school administration, and PLHIV. The project was aimed at empowering Malawian youth to take control of their sexual and reproductive health rights, contributing to reduced HIV incidence and higher quality of life. Specifically, the project aimed to:

1. Create a peer support network and a safe, positive environment for secondary and tertiary education students to openly discuss SRH issues and improve SRH knowledge, attitudes and practices.

2. Facilitate knowledge of and access to HTS and YFHS services, among secondary and tertiary education students and members of the wider community.

3. Equip secondary school teachers with the knowledge and skills needed to use participatory arts-based approaches to educate students on SRH and provide support to students living with HIV.

During the first phase of the project, MASA Squads (4 squads of 10 students each- 5 boys and 5 girls) were recruited at Chancellor College and Domasi College of Education. College students participating in squads were trained to use participatory, arts-based approaches to SRH education. Each Squad created a performance dealing with SRH issues, including preventing and living with HIV. With an emphasis on peer education, MASA Squads performed on their respective college campuses, complemented by facilitated discussions and HTS.

In the second phase of the project, at eight secondary schools in Zomba, Phalombe, and Machinga, MASA Squads ran a series of SRH workshops using the participatory, arts-based approaches they learned. Each series constituted intensive workshops that encouraged secondary school students (30 students per workshop: 15 boys and 15 girls) to engage critically with issues of sexual reproductive health, share personal stories, and express themselves through the arts. Workshops culminated into MASA Festivals, in which secondary school students performed along with the MASA Squads and displayed their work to spark an open dialogue on SRH in their schools and communities. Workshops were complemented by facilitated discussions, HTS, and the development of School Action Plans (SAPs) in which secondary school students collaborated with teachers, staff and community members to address issues raised during the discussions. Activities within the SAPs continue to be implemented by the schools using their own locally available resources. Nearly eighty secondary school teachers from participating schools were trained in using participatory, arts-based approaches to SRH education, so that they can bolster the work of MASA Squads and provide support to youth living with HIV (YLHIVs) in their schools.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

- 40 tertiary school students were trained in participatory, arts-based approaches and comprehensive SRH
- 234 secondary school students were trained in participatory, arts-based approaches and comprehensive SRH
- 3400 students were reached during Secondary school festivals and tertiary school performances
- 445 of people reached through the tertiary school performances and festivals received HTS during the events
- 60 secondary school teachers trained in SRH and participatory methods
- 75.2% of students in secondary and tertiary institutions reported an increase in knowledge and awareness of key sexual and reproductive health issues, with an emphasis on HIV.
- 39% of trained students in secondary and tertiary institutions reported improved attitudes towards PLHIV.
- 40% of trained students in secondary and tertiary education institutions reported having increased knowledge and awareness of youth friendly health services, including HIV-specific services.
- 100% of trained teachers reported learning new participatory methods of providing SRH education and support

Reference: MASA Youth Evaluation Report 2018- <https://www.artgloafrica.org/s/MASA-Youth-Evaluation-2018.pdf>

LESSONS LEARNED AND RECOMMENDATIONS

The MASA project included participatory arts training for student participants and teachers of sexual and reproductive health courses. In the future, the project would benefit from including parents in trainings, activities, and focus groups.

An exciting and unexpected outcome of the project was that students were not only educating their near-peers on the topics they had learned, but students also stated in focus groups that they were able to educate their parents on sexual and reproductive health information. Some students referenced their parents not being formally educated and therefore they learned valuable insights from the MASA youth project from their children. Some participants also mentioned minor disagreements with their parents due to differences in SRH information they were taught in the project, and information they had learned from their parents. Including parents in the project will involve a new and essential audience as well as foster parental support and understanding of the project's activities, content, and goals.

In the MASA-Youth project, clinical/technical staff from DI would educate tertiary students on SRH and these students would go on to work with secondary students who then went on to educate their peers. In this model, the clinical staff were only able to control the quality of information that went to the tertiary students. However, there was need for oversight at all levels of information flow to ensure better quality of information was passed on at all levels. It is therefore, recommended that in the next iterations of this project clinical/technical staff oversight should be provided at all levels.

The project has resulted in improved knowledge, attitude and practices of the students. Expansion of the project to additional districts is recommended for future iterations. Efforts should be made to randomize project participants during replication. It is also recommended that the future project iterations should place emphasis on the areas that the students expressed interest to learn more about, and topics where there was less change seen in the KAP surveys through this project.

Feedback from focus groups participants revealed sexual and reproductive health topics the students wished to learn more about such as; menstrual health, female condom usage and demonstration, gender-based violence.

Students also felt the project would be essential for people in rural areas with less access to formal education, they wanted the project in more schools, for longer periods of time, and in more regions! Students also recommended greater inclusion for participants with disabilities, hearing, and visual impairment, to ensure everyone could learn and understand these essential subjects.

18. Mauritius

TITLE OF THE PROGRAMME: Scaling up and expanding access to timely diagnosis and treatment for children living with HIV

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- **Programme is being implemented since:** 2016 - **End** (if applicable): ongoing
- **Responsible party/parties:** N/A
- **Population group(s) reached:** Children living with HIV
- **Has the programme been evaluated/assessed:** N/A
- **Is the programme part of the national aids strategy** N/A
- **Is the programme part of a national plan other than the national aids strategy?**
N/A

BACKGROUND

With the first HIV positive case detected in 1987, Mauritius has a low HIV prevalence at 1 %. The HIV epidemic, however, is concentrated (>5%) among the Key Populations which consist of the People Who Inject Drugs, Men who have Sex with Men, Female Sex Workers, Transgender and the Prison Inmates. As at end June 2019, a total of 7,617 (M-5,615, F-2,002) individuals have been diagnosed with HIV. Injecting Drug Use is the main driver of the epidemic in the country while there have been 86 children who have been HIV infected through vertical transmission. There are 1,541 AIDS-related deaths registered at the AIDS Unit including 10 children.

Mauritius is a welfare state. All health and support services including those for the People Living with HIV (PLHIV) are free of user-cost at the state-owned health care levels. Antiretroviral drugs are not accessible in the private health institutions.

In Mauritius, more than 95% of all deliveries occurs in the public hospitals where all Pregnant Women (PW) are screened for HIV and Sexually Transmissible Infections. The PW who are found to be HIV infected are referred to the AIDS Unit for treatment, care and support.

The Prevention of Mother-To-Child-Transmission (PMTCT) program coverage is high at > 95% for the past three years. However, each year there are about 1-2 infants born with HIV through vertical transmission.

The number of PLHIV ever registered at the 8 HIV health care points and the prisons' settings across the island is 6,098 and 3,881 have been initiated on antiretroviral treatment (ART). 74% of the PLHIV are adherent to their treatment. Out of the 45 children under 15 years of age, there are 38 children who are compliant to their treatment.

There is an updated PMTCT protocol (2018) being implemented to improve adherence rate among the HIV infected pregnant women. The new protocol includes better tolerated with less side-effects antiretroviral drugs which will result in better pregnancy outcomes for the infants born to HIV positive mother.

Mauritius had adopted the B+ options for the PMTCT program since 2010 and with the Test and Treat Strategy being rolled out as from August 2017, most of the HIV infected pregnant women are initiated earlier on ART. ART is deferred only upon request and these relate mostly to the PW with addiction issues, in the denial state or with acute depression. A multidisciplinary team of Health Care Professionals is at the disposal of the PW. It includes the services of dedicated staff of the AIDS Unit, Harm Reduction Unit, HIV doctors, Gynaecologists, Paediatricians, Nurses and Midwives trained in HIV Counselling and Testing, Social Workers, Peer Educators from NGOs, Psychiatrists and Psychologist.

To further reduce MTCT, the PW with HIV infected partners are closely followed with access to all facilities till they are confirmed as being HIV negative. Whenever, at the time of delivery if there are no HIV test results recorded in the PW case-notes or for those who have not had any Ante Natal Care, HIV Rapid Diagnostic Tests (ROT) are performed and the PMTCT protocol is followed accordingly.

Infants born to HIV positive mothers are not breastfed and formula milk for the babies is provided free of user-cost. The HIV exposed infant is initiated on HIV prophylactic treatment for 28 days and followed till 2 years of age. The first Polymerase Chain Reaction (PCR) is performed at 3 months of age except for infants born to pregnant mothers with late HIV diagnosis. Babies born to mothers with late HIV diagnosis have PCR performed at birth prior to initiation of prophylactic HIV treatment.

All infants with positive viral load are treated immediately as from date of the first result. A second specimen for viral load is sent to the laboratory for confirmation before lifelong ART initiation. Earlier ART initiation greatly reduces infant mortality rate and enhances quality of life of the children.

For those children with a negative PCR at 3 months, a second PCR is performed when they are 6 months of age. The HIV antibody test (ELISA) is done after the HIV exposed babies reach 18-20 months of age. Thus, the babies born to HIV positive mothers have their HIV status confirmed after 18-20 months of age. The HIV infected child is then followed by the HIV doctor life-long at the AIDS Unit and by the paediatricians whenever required.

DESCRIPTION

Index testing: HIV positive women are counselled to have their children tested to know their status. The pregnant women who have been newly diagnosed with HIV is encouraged to undergo HIV Counselling and Testing (HCT) as well as her partner and children from previous pregnancies.

Point of care testing is carried out in the shelters where children with vulnerable background are found. These children are accompanied and followed by the social workers.

Capacity-building of the paediatricians in the follow-up of children living with HIV and the HIV treatment protocol has led to early infant diagnosis of children from vulnerable or neglected

backgrounds. Conventional HIV testing are conducted at entry points such as paediatric wards, paediatric outpatient department. Children with history of abuse are also tested for HIV.

To optimise HIV case finding among children, the Health Care Providers have been empowered on the HIV diagnostics, protocol and national targets to end AIDS by 2030. Increased knowledge on HIV, the benefits of Early Infant Diagnosis followed by treatment has definitely increased HIV case findings among children in the past two years. In 2017 and 2018, 3 and 9 HIV positive children were newly detected through intensive case-findings.

The provision of a patient-centred and age-appropriate disclosure counselling among the Mauritian children living with HIV. Counselling support is available throughout the disclosure process. There is a strong collaborative working relationship with the NGOs providing psychosocial support to the children living with HIV. There are 1-2 adolescents who are lost to follow up or are non-adherent to the ART. With a strong networking and community involvement, the AIDS Unit dedicated team is actively engaged in contact tracing and linking these adolescents to care. Direct Observed Therapy is applied with the collaboration of social workers from the community organisations.

19. Mozambique

TITLE OF THE PROGRAMME: The integration of gender-based violence prevention and care into HIV programs in Mozambique

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- **Programme is being implemented since:** 2016 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Adolescent girls and young women
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Responding to gender-based violence (GBV) is a critical component of comprehensive HIV prevention and treatment programs. In Mozambique, where the HIV prevalence is 11.5%, one in three women (ages 15 to 49) report having experienced GBV in their lives (emotional, physical, or sexual violence) and 12% report having been sexually coerced. Thirty-five percent of women in Gaza Province have experienced GBV, which is the second-highest percentage among all provinces in the country. The intersection of GBV and HIV epidemics highlights the need for integrated, coordinated efforts.

DESCRIPTION

The program implemented tactical, multifaceted GBV programming at the clinical and community level, to both increase demand and supply for these services in Mozambique. The strategy for such a pervasive issue requires capacity to raise awareness of GBV and service delivery among communities and health settings. To facilitate successful integration of services, EGPAF-Mozambique established one-stop-centre models at referral health facilities that provide comprehensive care in one secure location. This allows health professionals to address survivors' various physical, mental, emotional, and social needs without a change in location.

Collaboration between Mozambique's Ministry of Health and DREAMS/PEPFAR investments facilitated nationwide training, using a developed national curriculum and comprehensive GBV package, of a diverse set of stakeholders. This training cascaded into both community and clinical interventions in select districts, such as Gaza. As a clinical

partner, EGPAF's work focused on supporting health facilities as they identify, register, and provide appropriate services for survivors of violence. Health facility staff were trained to support survivors of violence based on a comprehensive curriculum on post violence care (PVC). PVC offers opportunities for care and treatment for survivors. Facilities can attend to physical injuries, treat STIs, and, if within 72 hours, provide PEP for HIV and emergency contraception to prevent unwanted pregnancy. A paediatric PVC model was also provided, addressing parent/guardian consent and adolescent assent, along with treatment dosing for a child, including PEP.

At the community level, targeted outreach among leaders aimed to build community awareness on gender equity, rights, and access to PVC in clinics. GBV screening and education were also employed during home visits with project field officers following up on index case patients and their families. Program activities worked with diverse stakeholders, including to sensitize police to the physical and emotional needs of survivors and created linkages at facilities across Gaza Province to support survivors in exercising their legal rights after experiencing violence.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

This tactical programming resulted in a significant increase in GBV cases reported and receiving services at facilities from 94 in 2012 to 7,867 in 2018. By prioritizing children, adolescents, and adult clients' access to comprehensive services at the facility, PVC services were accessible in 90 high-volume sites in Gaza.

Since 2013, technical staff have trained 2,354 health care workers in 109 facilities on providing a comprehensive package using the national curriculum. A diverse group of professionals received the training, including lay counsellors, health providers, mentor mothers, police agents, community leaders, teachers, and peer educators. Training sensitized participants to GBV and types of GBV, the role of the health sector in responding to GBV, integrated care for survivors of violence, principles and components of PVC, documentation, and ensuring provision of appropriate referrals.

Before the project conducted the training sessions, many providers believed that PEP was intended solely for occupational exposure. Peripheral health facilities did not have access to PEP and would refer patients to other facilities, further delaying the effective timing of the treatment prior to the training. Expanding access to and capacity for the provision of PVC ensured quality care for survivors seeking care. For example, following training, access to and uptake of PEP rose significantly: 1,225 survivors were initiated on PEP from 2013 to 2018.

LESSONS LEARNED AND RECOMMENDATIONS

One-stop shops provide all necessary services in one dedicated space (that is, integrated services). Such facilities allow for post disclosure activities, private interview and examination space, and the provision of complete PVC, counselling, and referrals to other health, social, and legal services. Possible services provided, based on need, include clinical care, prophylaxis including PEP for HIV and treatment for other STIs, and emergency contraception, among others. Guidance concerning the provision of certain services is in accordance with national standards.

Recognizing that survivors of violence have needs that go beyond the clinical, the project prioritized the creation of linkages between facilities and other social services and the police. For example, a dedicated police officer is available for when cases of violence present themselves at the facility. Therefore, with consent of the survivor, legal processes can be initiated without delay.

Stakeholders from the local environment especially around facilities—including teachers, lay workers such as mentor mothers and peer educators, and community leaders—were involved in training sessions to ensure participation from the local environment and build

knowledge around GBV and promote referrals to facilities with services available. The introduction of a register at health facilities allowed for the continuous tracking and monitoring of delivery of services. Training on the use of the register was important in ensuring correct usage and routine recording of data. The registers collected information concerning screening, identification of survivors of violence, and delivery of certain services including emergency contraceptives, STI treatment, HIV testing, and provision of PEP. Regular collection of such data allows for the routine monitoring of trends and early identification of possible issues and facilitates timely response.

20. Namibia

TITLE OF THE PROGRAMME: Support access to teen clubs and psycho- social services for Adolescents Living with HIV in Namibia

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- **Programme is being implemented since:** N/A - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify here:** Adolescents Living with HIV Programme

BACKGROUND

Namibia has one of the world's highest HIV prevalence rates, with an estimated 12.6 % of adults 15-64 living with HIV (NAMPHIA, 2017). To date, great progress has been made and Namibia is on track to reaching the UNAIDS global 90-90-90 targets set for 2020 - with 86% of all people living with HIV diagnosed, 96% of all people diagnosed with HIV have access to antiretroviral therapy (ART) and 77% of all people receiving antiretroviral therapy are virologically suppressed¹. However, Namibia's adolescents living with HIV (ALHIV), have not experienced the same level of positive health outcomes. Compared to any other age group, adolescents have the lowest rates of virological suppression (68%) . HIV testing among 15-19-year olds is low with only 28.5% of females and 13.9% of males in Namibia tested and given their results in the past 12 months ART coverage for ALHIV is worse than the adult population at 74% for females and 86% for males. This is concerning for the future health and well-being of ALHIV and those at risk of HIV in Namibia – a country with a growing adolescent population.

References:

1MoHSS and ICAP. Summary Sheet: Preliminary findings. Namibia Population-based HIV

Impact Assessment NamPHIA 2017

2. UNAIDS. Global HIV estimates 2018. <http://aidsinfo.unaids.org>

3. Agolory S, de Klerk M, Baughman AL, Sawadogo S. et al. Low case finding among men and poor viral load suppression among adolescents are impeding Namibia's ability to achieve UNAIDS 90-90-90 targets. Open Forum Infect Dis. 2018 Aug 11;5(9):eCollection 2018 Sep

Agolory S, de Klerk M, Baughman AL, Sawadogo S. et al. Low case finding among men and poor viral load suppression among adolescents are impeding Namibia's ability to achieve UNAIDS 90-90-90 targets. Open Forum Infect Dis. 2018 Aug 11;5(9):eCollection 2018 Sep

DESCRIPTION

Adolescents in Namibia, just like in most of the countries in sub-Saharan Africa, are key in determining the course of the HIV epidemic, yet adolescents continue to be underserved by current HIV programming. Reversing this trend requires an intensified focus on adolescents and young women.

The purpose of the Adolescent Living with HIV (ALHIV) programme is to increase access to comprehensive services for HIV prevention for ALHIV in the targeted five regions of Oshana, Ohangwena, Karas, Kunene and Kunene in Namibia

The programme aims to improve linkage to care and treatment for ALHIV and other relevant social services. The above is achieved through provision of psychosocial support, coordination and convening of Teen Club meetings at ART clinics and/or in communities; leadership training, supporting adherence, Viral load monitoring, and continuous capacity building of the health worker and Adolescents Living with HIV and caregivers on emerging issues and guidelines on ALHIV through supporting monthly Teen Club meetings and activities to discuss best practices and/or conduct training for Teen Club facilitators.

Nationally, the programme is coordinated by the MOHSS National Paediatric ART Care Coordinator, and the Chief of Health Programme coordinates the programme at regional level and the District Health Officer at District level.

To date, the programme is funded by UNICEF with support from CDC/PEPFAR in the regions of Oshana and Ohangwena and UNICEF funds directly the other regions of Kunene, Karas and Kunene respectively. The Ministry of Health and Social Services funds other development partners funds the rest of the remaining regions.

In October 2019, as part of the sustainability plan, UNICEF started to transition the teen clubs in Oshana region to the Ministry of Health and Social Services. Subsequently, UNICEF will handover, Ohangwena region to the ministry of health and Social Services by September 2020.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Nationally there are 98 Teen Clubs with 3291 members. Teen Clubs currently operate in 12 of the 14 regions of Namibia, with national coverage of Teen Clubs at approximately 30% of health facilities. Regional coverage however varies. In Kunene and Kunene only 7% of facilities offer Teen Clubs, whereas in Ohangwena, the region with the second highest HIV prevalence at 17.9%, 32 Teen Clubs are in operation - covering 94% of facilities within the region.

Approximately 30% of adolescent living with HIV in Namibia regularly attend Teen Club. Regional uptake of Teen Club among ALHIV ranges from 8% in Otjozondjupa to 53% in Ohangwena, with regions more recently establishing Teen Clubs having lower uptake by

adolescents.

Snapshot of OShana Region:

In Oshana region, 73% of Teen Club members had undetectable viral loads (<20 copies/ml), 16% were virologically suppressed (<1000copies/ml) and 20% showed virological improvement.

84% of Oshana Teen club members had good clinic attendance, with higher rates seen among females (64%) and those 15-19 years (63%).

The adolescents attending Teen Club reported significant additional benefits of being a member including: a sense of belonging, gaining knowledge, building resilience, feeling empowered, developing leadership skills, and feeling healthy and strong.

LESSONES LEARNED AND RECOMMENDATIONS

Key Enablers to Establishing Teen Clubs

- Advocacy meetings and steering committee
- Assessment of the ALHIV services
- Capacity building of management, staff and partners/NGO working with PLHIV
- Ownership by the hospital management and ART clinic
- Partnership and coordination

Key Enablers to Establishing Teen Clubs

- Normative Guidance and National ALHIV Guidelines
- Disaggregated data and programming assessments
- National Ministry leadership
- Supportive resources i.e. starter pack
- Partnership and coordination
- Inclusion in regional workshops and budgets.

Key Lessons Learned:

Operational

- Teen Club has been successfully scaled up to 30% of facilities nationally however further efforts are required to increase the uptake and coverage of Teen Club for ALHIV
- Scheduling clinic appointments on the same day as Teen Clubs and holding Teen Clubs during out of school hours reduces attendance barriers
- Group or individual sessions with caregivers facilitate disclosure and help caregivers understand the benefits of Teen Club
- Providing transport costs and refreshments supports ongoing engagement of ALHIV

Capacity

- Selecting health providers who are intrinsically motivated and enjoy working with adolescents as Teen Club focal points facilitates the effective set-up of Teen Clubs
- Training builds knowledge, skills, confidence and expertise of service providers and peer leaders
- Technical resources and tools (i.e. the starter pack, registers and paediatric disclosure booklet) are essential to support newly establish Teen Clubs and to ensure standardisation of the model during scale up
- Peer leaders are central to creating a welcoming and friendly environment where adolescents feel free to engage.

Programmatic.

- Political will and leadership by MoHSS is critical in facilitating the scale-up of Teen clubs
- Effective collaboration between a range of partners – donors, technical and implementing partners, NGOs and youth-lead organisations – encourages collective ownership and commitment with each partner contributing towards a common goal, ultimately enhancing impact.
- Including Teen clubs in National normative guidance allows for more standardised programming and ensures implementation throughout the country
- Demonstrating the impact of Teen Clubs through data and by sharing experiences of adolescent members is a powerful advocacy tool.

Recommendations

Evidence base and demonstration of impact

- Conduct clinical level data analysis or evaluation on the impact of Teen club (i.e. clinical attendance and viral load) in other regions to further demonstrate impact and support reflective programming.
- Establish and strengthen caregivers clubs to facilitate disclosure and support understanding of the importance of psychosocial support.
- Actively recruit all ALHIV attending facilities, with the support of peer leaders – consider open days, introduction sessions, information leaflet or showing the new Teen Club video during clinic

Content and quality of Teen Clubs

- Expand and improve the information provided on Sexual Reproductive Health including aspects that are specific to being HIV positive i.e. how to disclose to partners, rights and responsibilities, risk mitigation etc.
- Strengthen the Mental Health component of Teen Club through referrals to other multidisciplinary providers and targeted Teen Club sessions
- Conclusion:

Teen club is an effective service delivery model that encourages clinical attendance , and likely to contributes to adolescents viral load suppression, clinical attendance and provides key psychosocial support. Teen Club has been successfully scaled up to 30% of facilities nationally, however further efforts are required to reach ALHIV in Namibia

ANNEXES

Teen Cub documentation report that informed this case study

21. Sierra Leone

TITLE OF THE PROGRAMME: Family centred approach to HIV care and support for children and adolescents

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- **Programme is being implemented since:** 2018 - **End** (if applicable): N/A
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify here:** The National Acceleration Plan for HIV (Global Fund)

BACKGROUND

Sierra Leone has the lowest life expectancy (at birth); the fourth highest child mortality rate and the highest maternal mortality rate in the world (UNDP Human Development Report, 2018). Whilst important disparities persist, over the last ten years there has been progress in the coverage of reproductive, maternal, neonatal, child and adolescent health services, which has led to greater use of antenatal care, a higher rate of delivery in institutions, more systematic immunization of children and care-seeking for infectious diseases, as well as a greater use of family planning. However, the vulnerability of the health system was exposed when Sierra Leone was hit by the outbreak of the Ebola Virus Disease in 2014. The poor early recognition of the virus, accompanied by the inadequate infection prevention and control (IPC) standards, led to the transmission of the virus in health facilities, which significantly deteriorated the community confidence in health services. The epidemic also put considerable pressure on the health system, in particular the workforce. Since the end of the outbreak, health management information system (HMIS) data suggests a reversal of negative trends in health service coverage indicators observed during the outbreak. However, poverty and the affordability of care remain major barriers to health for the entire

spectrum of mother and childcare.

HIV prevalence is estimated to be 1.5% (UNAIDS Spectrum, 2017). In 2017, 62% of women who received ANC from a health professional for their last pregnancy were tested for HIV compared with 22% in 2010; and 49% received the test results compared with 12% in 2010 (NACP, 2017). Only 12% of HIV-exposed infants received timely HIV testing (early infant diagnosis (EID)), of which 17% were HIV positive (NACP, 2017).

As of December 2016, only 18% of children aged 0-14 living with HIV (785 out of 4,400) were enrolled on antiretroviral (ARV) treatment (NACP, 2016). Case detection for HIV for children and adolescents and subsequent provision of life saving treatment and care are key gaps in the HIV response in the country. Almost all the HIV testing is done in health care settings. This strategy limits the opportunities to identify children and adolescents living with HIV outside of clinical settings. Even those that are captured within the health facilities often present when they are symptomatic; at which point the antiretroviral therapy (ART) is less effective.

DESCRIPTION

Almost all HIV testing in Sierra Leone is based in a health facility. With high HIV-related stigma and discrimination, people do not actively seek HIV testing services, especially for children and adolescents. In an effort to improve access to HIV testing and treatment interventions for children and adolescents, the UN Joint Team on AIDS (UNJT) developed a pilot project for community-based HIV testing services using a family HIV testing strategy to promote increased access to HIV testing services especially for children and adolescents that may have been missed out of facility-based testing.

Family HIV testing in the community is complementary to the facility-based HIV testing services and is a means of expanding and providing targeted HIV testing for adults, adolescents and children to capture those in the asymptomatic stage so they can be enrolled for early care and support. The aim of this project was to test 30,000 children for HIV in 2018, and if HIV-positive, link to appropriate treatment, care and support services.

The project included the following activities to meet the project objectives:

- Training and provision of support to community workers to conduct community/family-based counselling and testing
- Community demand creation through radio, engagement with religious leaders, theatre etc
- Family outreach sessions
- Data collection and documentation

This project was implemented by the UNJT under the management of UNICEF, in partnership with the national authorities (National AIDS Secretariat and the National AIDS Control Programme) and HAPPY Kids and Adolescents. The UNJT provided oversight and technical guidance, UNICEF implemented and managed the project, the National AIDS Secretariat provided coordination, and the National AIDS Control Programme provided facility-based HIV testing and treatment services. HAPPY Kids and Adolescents, a non-governmental organization established in 2006, was selected to implement the project in the community given their trusted relationship in the communities to improving the lives of vulnerable children and adolescents especially those affected by HIV and AIDS.

The pilot project was implemented in six districts (Kenema, Bo, Bombali, Pujehun, Western Area Urban and Rural).

Financing for the project was through the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF). The results from the project are being used to advocate for inclusion of targeted community-based testing services as part of the national response.

Once the national response is detailed in the National HIV/AIDS Strategic Plan in 2019, advocacy will focus on bringing this project to scale using funds in the Global Fund 2020-2022 grant cycle.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Across six districts (Kenema, Bo, Bombali, Pujehun, Western Area Urban and Rural), HAPPY Kids and Adolescents trained 60 HIV/TB community health workers in the provision of HIV testing services. The community health workers reached 20,413 family members of which 18,881 (92.5%) were below 19 years of age. More females (59%) were tested than males (41%).

Of all the children and adolescents tested 276 (1.4%) were positive and all were referred to treatment, care and support services. As of June 2019, 1,000 (children (<15) are on ART and 29,296 (15+), an increase from 785 children (<15) and 17,058 (15+) on treatment as of December 2016 (NACP).

Of the adults tested (1,532), 80% were either sex partners of the index case or the father to a child index case). There were 84 (5.5%) adults that were identified as HIV positive.

Family testing for HIV increased case detection, improved on disclosure, care, support and adherence to treatment. The results of this pilot were shared amongst stakeholders. As the country is preparing to develop a new National Strategic Plan, advocacy is underway to encourage inclusion of community-based family testing in the Plan.

LESSONS LEARNED AND RECOMMENDATIONS

A large part of this success was related to the implementing partner, HAPPY Kids and Adolescents, as they are trusted in the communities. This partner is known for their dedication to improving the lives of vulnerable children and adolescents especially those affected by HIV and AIDS, and for their ability to handle confidential information with discretion. This enabled HAPPY to reach out to the index case and encourage family testing for HIV.

This project was challenged by delayed funding to the implementing partners and delayed procurement due to discussions around the implementation arrangements. The delayed procurement did result in a shortage of test kits which impeded achievement of results.

Supportive disclosure of HIV status within the family is still challenging due to the high rate of HIV related stigma which makes it difficult for some to accept family testing services. Combining the family HIV testing services with other health services like blood pressure checks, child under 5 check-ups etc. may help to increase access and reduce stigma within households and communities. It would also be useful to PLHIV support groups to enhance their knowledge about the family testing to increase access to index cases.

It would also be good to provide support for active follow up of those referred to services to enhance initiation and adherence to treatment.

22. South Africa

TITLE OF THE PROGRAMME: Reaching adolescent and young mothers through peer mentors

CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End** (if applicable): 2020
- **Responsible party/parties:** mothers2mothers, Government, UN or other inter-governmental organization
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

The impressive global effort to reduce mother-to-child transmission (MTCT) of HIV is one of the signature health and development successes of recent years. The roll-out and prioritization of prevention of mother-to-child transmission (PMTCT) in HIV services have been largely responsible for averting an estimated 2 million new infections in children since 2000 – 1.6 million of them since 2010.

Globally, of the estimated 1.4 million pregnant women living with HIV in 2016, about 1.1 million had access to effective antiretroviral drugs (ARVs) for PMTCT. Yet progress across the world has been uneven and expanding PMTCT services remains a challenge in some countries and regions. Moreover, far too often infants exposed to HIV who test negative at initial screening are acquiring HIV during the breastfeeding period. This typically occurs when lactating women with HIV do not adhere to their ARVs or drop out of care. Much more difficult to track and respond to are women who have been newly infected during the breastfeeding period and remain unaware of their HIV status and thus are not on treatment. In such cases, follow-up testing for these women and their infants after birth often does not take place.

A major challenge on the path to controlling the global HIV epidemic is the persistently high vulnerability of adolescents – in particular adolescent girls and young women. Between 2010 and 2016, the rate of new HIV infections among adolescents aged 15–19 years declined by only 14 per cent, in sharp contrast to the rate of new infections in children aged 0–14 years, which decreased by 47 per cent over the same period. In addition, AIDS-related deaths among adolescents have increased over the past decade while decreasing among all other age groups. However, as treatment access improves for young children living with HIV, they are living longer and surviving into adolescence. As a result, in 2016 an estimated 2.1 million adolescents aged 10–19 years were living with HIV worldwide – 30 per cent more than in 2005 and 15 per cent more than in 2010. Only 36 per cent of these adolescents accessed treatment in 2016.

South Africa is home to the largest global HIV epidemic, with approximately 7 million people living with HIV, including nearly one-third of pregnant women. There were approximately 12,000 new infections among children under two years in 2016 and only 55 per cent of children living with HIV were on treatment. Despite significant efforts to turn around the HIV epidemic in South Africa, rates remain unacceptably high particularly amongst adolescent girls and young women. Up to 2,000 adolescent girls and young women are infected weekly. The estimated HIV prevalence among females is eight times that of their male counterparts, suggesting that females aged 15 to 19 years are more likely than their male counterparts to have sex, not with their peers, but with older partners, often forced or for financial reasons. Sexual risk behaviour remains unacceptably high amongst young people. This is exacerbated by their persistent lack of access to information and prevention services at school and in clinics; and as a consequence, low levels of testing and poor access to treatment, leading to disproportionately high levels of AIDS-related deaths in this age group. At the same time, although fertility rates have been declining steadily over the last thirty years, the pregnancy rate for adolescents in South Africa still remains high with around 16 per cent of 15-19-year-old women reporting ever having been pregnant.

References:

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https://www.unicef.org/publicpartnerships/files/Annual_Results_Report_2017_HIV_And_AIDS.pdf>
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HIV and STI NSP, 2017

DESCRIPTION

UNICEF is proposing a novel integrated innovation approach that focuses on providing peer-based facility and household linked psychosocial and health education support to adolescent girls and young mothers to access PMTCT, Maternal Newborn Child and Women's Health (MNCWH), Sexual Reproductive Health and Rights (SRHR) and nutrition services. The social innovation is that this will be provided for adolescent girls, by adolescent girls. The project will target pregnant adolescent girls and young mothers, in pregnancy and postnatal period, aged 15 to 24 years and their children up to two years of age. The innovation involves deploying 150 Young Peer Mentors across 75 facilities to provide key non-clinical complementary PMTCT and MNCH services along the antenatal care (ANC) and postnatal (PNC) continuum of care. The Young Peer Mentors will be recruited from the community, will be aged between 18-25 years, and will themselves be young mothers who had previously accessed PMTCT and MNCH services. Some of the Young Peer Mentors will be young women living with HIV who have freely disclosed their HIV status. The mentor group will undergo a competency-based two weeks training, complemented by routine on-site

mentoring by supervision staff. The Young Peer Mentor mothers will be paired and work closely with clinic nurses and existing community health care workers.

Furthermore, this innovative approach will integrate a package of services and tools that will be developed for use by the Young Peer Mentors to support pregnant and breastfeeding adolescent girls and young women visiting the clinics or identified within the surrounding communities. The package of services will include the following interventions:

- One-to-one education and psychosocial support on contraceptive use in postnatal period;
- Promoting HIV testing among pregnant and postnatal young mothers, including TB pre-screening;
- Skills to support adolescent girls and young women who tested HIV negative to remain negative;
- Support for HIV treatment initiation, adherence education and follow-up to improve retention in care;
- Nutritional assessment, counselling and support;
- Education on and promotion of breastfeeding, including safe infant and young child feeding (IYCF) practices, especially among young mothers living with HIV to prevent MTCT; and,
- Referrals and linkages to clinical and non-clinical services including supporting girls to return to school and registration in the national mom-connect program for easy follow up.

Once trained and deployed, Young Peer Mentors will be required to identify mothers either from the clinic antenatal care programme / Labour and Delivery Wards at hospitals and MOUs (maternity obstetric units) or from the ward based outreach teams (WBOTs); once an adolescent mother has been identified, the peer mentor will follow up with her at home and or at clinic visits depending on the client.

Currently the project is rolled out in 17 facilities in Tshwane and is being scaled up in Johannesburg and KwaZulu Natal. The implementing partner is mothers2mothers in association with District Department of Health and District PEPFAR partners.

This project aims to meet the following deliverables:

- 40 Peer Mentors are recruited, trained and deployed in 20 facilities in 2 districts in KZN;
- 35 facilities are supported Mentors in 2 districts in Gauteng;
- 11050 AGYW and their babies receive services from Mentors until December 2020.

The project outcomes

- 9,945 adolescent girls and young women (AGYW) aged 15-24 enrolled and retained in postnatal care 24 months post-delivery
- 8,951 AGYW aged 15-24 enrolled and tested for HIV
- 2,788 AGYW aged 15-24 living with HIV enrolled and initiated on ART
- 2,509 HIV-positive AGYW virally suppressed as a result of the Young Peer Mentors support program

The project is donor funded however Gauteng peer mentors are paid by the department of health.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Over a 21-month period, the project enrolled a total of 883 AGYWs, with 385 (44%) enrolled at Dark City clinic and 498 (56%) enrolled at Soshanguve CHC. Of the enrolled AGYWs, 339 (38%) were pregnant and 544 (62%) were breastfeeding. Participants were followed for at least 24 months post-delivery. Some of the results include the following:

Findings included:

- Improved retention in care. At least 93% remained in care at the end of the 24 months

follow-up period after delivery, compared to national retention rates of less than 50%.

- Improved early ANC HIV testing. Through the support of the Young Peer Mentors, 141 out of 160 pregnant AGYW (88%) at Dark City clinic and 126 out of 179 pregnant AGYW (70%) at Soshanguve CHC accessed ANC services before 20 weeks gestation. This represents an average of 79% of first antenatal visits before 20 weeks, which was above the district performance of 59.9% and national performance of 66% during the same period.
- Improved HIV re-testing rates. The HIV retest rate among AGYW enrolled in the project was 98%, more than the national and Gauteng provincial average coverage rate of around 67%.
- Improved ART initiation rates. According to the South African Antiretroviral (ART) guidelines, all HIV-positive pregnant women should receive ART with appropriate counselling from their first ANC visit regardless of gestational age, CD4 count and/or WHO staging. In the two facilities, the ART initiation rate among AGYW enrolled in the project averaged 98%, with 100% at Dark City and 97% at Soshanguve, above the district and national rates of 96% and 95% respectively.
- Improved infant HIV testing rates at birth: At Dark City clinic, all enrolled HIV-exposed babies had the HIV PCR test at birth, while at Soshanguve Clinic, 76% of the HIV-exposed babies had the test. This represents an infant birth HIV PCR test rate of 86%, which is above the district rate of 59.8% and national rate of 68.9%.
- Improved exclusive breastfeeding rates: The project prioritized support for exclusive breastfeeding among the enrolled AGYW. Due to their young age, most AGYWs are hesitant to breastfeed their babies due to fears of gorging of breasts, relatively easy access to formula milk, work and school commitments. During health education sessions, the peer mentor mothers explained the benefits of exclusive breastfeeding for at least six months. At Dark City clinic 68% of infants under-six months were exclusively breastfed, and 39% at Soshanguve, resulting in a project average of 54% versus an average coverage of 46.9% in Gauteng Province.
- Improved immunisation coverages. The Expanded Programme on Immunization (EPI) is one of the most successful and cost-effective public health initiatives to reduce infant morbidity and mortality from vaccine-preventable diseases. At Dark City, 92% of the children under one year were immunized and 91% at Soshanguve CHC were also immunized, representing 92% of children under one were fully immunized within the project cohort, compared to national average of around 60% for under one immunisation coverage. This success can be attributed to a high level of engagement between Young Peer Mentors and their clients, reviewing the Road to Health Booklets (personalised booklets with mother and baby health information) and reminding mothers in a timely manner to take their children to immunization appointments.
- Improved uptake of contraception services. National uptake averaged 69%, compared to 75% at Dark City and 63% at Soshanguve Clinic. Key issues addressed during health education sessions focused on prevention of both HIV and pregnancy (dual protection), prevention of high-risk sexual behaviour (transactional sex and multiple concurrent partners) as well as avoiding substance abuse.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learnt from the pilot phase included the following, all of which will be focused on during the transition-to-scale phase:

- Effective bi-directional facility-to-community linkage systems lead to high uptake and utilization of services, and retention in care.
- Targeted case finding and instituting a minimum standard for routine household visits (active follow-up) is key to ensure that clients are provided with relevant support and are retained in care.
- Peer-to-peer mentorship enhances high uptake of services through sharing of experiences and advice, thereby positioning Young Peer Mentors as a key resource to address the needs

of pregnant and breastfeeding AGYW.

- Integration of PMTCT outcomes (HIV testing, initiation, viral load suppression) with MNCWH&N outcomes (breastfeeding, family planning, child nutrition, etc.) is key to reducing infant and under-five mortality rates.
- Effective referral and linkage systems to non-clinical services is key to addressing other needs of girls and young women. Most girls expressed a desire to return to school to fulfil their professional and academic dreams. The National Integrated School Health (ISHP) programme would be a key platform to assist girls to achieve better health as well as school outcomes.
- Community mobilizations interventions create expectations on the services to be rendered at the facility, and therefore facility staff must be supported to meet the increased demand for services.

23. Tanzania

TITLE OF THE PROGRAMME: Ariel Adherence Clubs

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- **Programme is being implemented since:** 2007 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Ariel Adherence Clubs are psychosocial support groups for CALHIV 5–19 years and have been implemented since 2007. They are based on the premise that CALHIV will optimise health outcomes if clinical services are complemented with excellent social support and age-appropriate information about HIV infection, treatment, adherence, HIV status disclosure, positive living, and life skills needed for growing into healthy, HIV-positive adults. Ariel Adherence Clubs are currently being implemented by EGPAF in seven countries. Clubs are contextualized in each country to ensure they address local and context-specific challenges for the children and adolescents accessing care, amidst changing treatment packages and technology. From 2017-2019, EGPAF supported Ariel Adherence Clubs at 105 facilities across six regions in Tanzania within the USAID/Afya Boresha Northern Zone Project.

DESCRIPTION

Ariel Adherence Clubs are psychosocial support groups for children and adolescents living with HIV, aged 5-19, and have been implemented by the Elizabeth Glaser Pediatric AIDS Foundation since 2007.

The aim of Ariel Adherence Clubs is to improve ART adherence, clinic retention and viral suppression, and to provide psychosocial support to ensure adjustment to C/ALHIV prior to transitioning to adulthood and adult HIV care. The model offers a package of psychosocial activities provided by peers and health care providers including individualized counselling

sessions by trained service providers, dedicated and age-appropriate facility spaces, and monthly club meetings to address issues related to drug adherence, the experiences of children and adolescents living with HIV, and self-stigma reduction. Providers also work with caregivers to facilitate disclosure of HIV status to children and adolescents as this is a requirement of programme participation. Caregivers are invited to the facility on a regular basis to support ALHIV as they learn to navigate adherence for themselves. Ariel Adherence Clubs are facilitated by health care providers trained in psychosocial support. In addition, peer educators (adolescents living with HIV) also assist in facilitating the Ariel Adherence Clubs and integrating peer education.

Key elements of AACs include:

- integrated clinical service delivery (ART refill, labs, clinical care) on same day as monthly support group meeting – also assists in addressing bottle necks and overcrowding at facilities and streamlining care.
- psychosocial support and group/peer health education in safe spaces to enable participants to engage with other children and adolescents living with HIV to discuss everyday matters (not always about HIV), have fun, play, and normalize their experience of living with HIV.
- caregiver counselling (to assist in improving adherence) through health education and individual counselling sessions.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

From 2017-2019, the Elizabeth Glaser Pediatric AIDS Foundation supported Ariel Adherence Clubs at 105 facilities across six regions in Tanzania, with support from the USAID/Boresha Afya Northern Zone Project.

Ariel Adherence clubs facilitated by an adolescent youth peer educator saw increases in the number of attendees and the frequency in which adolescents attended the clubs. More than half (53%) of all adolescents attending adolescent youth-facilitated sites attended at least one Ariel Adherence Club, compared to only 37% of adolescents at non-adolescent youth facilitated sites. Further, the distribution of number of groups attended was significantly different between adolescent youth facilitated sites and non-adolescent youth facilitated sites, with adolescents at adolescent youth facilitated sites being much more likely to attend groups more frequently.

Adolescents at adolescent youth facilitated sites who were eligible for HIV viral load (HVL) testing were significantly more likely to have HVL taken (72%). While adolescents at adolescent youth facilitated sites who were eligible for HVL were significantly more likely to have HVL taken, there was no difference between viral suppression rates at adolescent youth facilitated sites (67%) compared to non-adolescent youth facilitated sites 66%; (p=.582).

In an analysis of only the 20 adolescent youth facilitated sites, 78% of HVL-eligible adolescents who attended Ariel Adherence Clubs had a viral load compared to 29% among those not attending. Almost 92% of those attending Ariel Adherence Clubs in their first 6 months on ART were retained at 6 months, compared to 79% among those not attending. A cost analysis showed that Ariel Adherence Clubs can be implemented at an annual cost of \$117 per adolescent client supported, or \$340 per month, per facility (assuming about 35 ALHIV attend). These costs reflect the initial start-up program year, including training costs, but not salaries of existing Ministry staff. In subsequent program years, costs would decrease with the removal of national training, and 5-day peer training. Subsequent years would retain annual meeting costs and the equivalent of about a 2-day training as a refresher for selected providers and/or peers.

LESSONS LEARNED AND RECOMMENDATIONS

A number of key issues have been identified to ensure the success of Ariel Adherence Clubs. These include:

- working in collaboration with government to ensure alignment with national HIV guidelines in the development of training materials for service providers, as well as to build sustainability by ensuring Ariel Adherence Clubs are included in annual budgets and plans,
- Identifying health facilities that are most suitable to implement the Ariel Adherence Clubs model e.g. those with a high volume of HIV patients aged 5–19 years so that groups are large enough to justify the amount of staff and other resources required,
- Ensuring that health care providers supporting Ariel Adherence Club activities are appropriately trained and sensitized to work with C/ALHIV and receive appropriate oversight and supervision,
- Evolving club approaches to address client needs,
- Recognizing the value of engaging peers who are good role models (stable on treatment) to conduct support group discussions and share their own experiences growing up with HIV in the local environment,
- Facilitating linkages from Ariel Adherence Clubs to other social protection and community development opportunities e.g. education and nutrition support, spiritual guidance, and income generation assistance.

A key lesson learned was that adolescents over 15 years who are diagnosed and linked to care have particular psychosocial needs, which require more differentiated care to better support these needs. This group requires more active follow up, counselling, and HIV treatment education and may benefit from being paired with an experienced treatment buddy or adolescent peer educator to support their treatment outside of the clinic and club.

24. Uganda

TITLE OF THE PROGRAMME: Scaling up a national package for management of advanced HIV disease among people living with HIV towards epidemic control: Uganda experience

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- **Programme is being implemented since:** October 2018 - **End** (if applicable): N/A
- **Responsible party/parties:** Government
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Through implementation of the Test and Treat policy, substantial progress has been made in availing antiretroviral therapy to people living with HIV (PLHIV). Despite this, the progress on early HIV diagnosis and early treatment is still sub optimal. As a result, about 1 in 3 PLHIV present to care with Advanced HIV disease (AHD) and a growing number of PLHIV are returning to care with advanced disease following a period of treatment interruption. People with advanced HIV disease are particularly at high risk of death, even after initiating ART, with this risk increasing with decreasing CD4 cell count. The most common causes of death are tuberculosis (TB), severe bacterial infections, and cryptococcal meningitis (CCM). Diagnosis of these individuals is hindered because many patients are asymptomatic, despite being severely immunosuppressed and there is limited access to diagnostic tools, treatment, and preventative services for AHD in most low- and middle-income countries (LMICs), leading to high mortality rates. The World Health Organization (WHO) guidance emphasises the need to focus on management of HIV advanced disease in addressing HIV related morbidity and mortality.

In Uganda, approximately 32,800 PLHIVs (20%) of newly identified PLHIV present to care with CD4 less than 200cells/mm³ and about 10% die within the first three months of enrolment. Furthermore, 11% of PLHIV in care experience treatment failure to ART regimens and given the suboptimal retention in care (12 months retention is estimated at about 61%), a growing number of PLHIV are returning to care with AHD after treatment

interruption. By October 2018, the country status on Advanced HIV disease implementation revealed weakness in indicator performance as follows; Baseline CD4 testing for new clients was 60% among adults and 40% among children, TB Lam testing 25%, Cryptococcal Antigen testing was at, Isoniazid Preventive Therapy access was 25%. In addition, the country faced challenges of limited diagnostic tools, inadequate forecasting and use of available commodities, as well as inadequate commodities to support scale up

In line with the World Health Organization (WHO) guidance, Uganda revised and developed the revised 2018 consolidated guidelines for HIV prevention, care and treatment with a focus on addressing Advanced HIV disease as part of its strategy towards achieving epidemic control. The country guidelines recommended management of Advanced HIV disease for people with a CD4 below 200, all children below five years of age and those with stage 3 or 4 conditions. The guidelines recommend it as a package of interventions addressing early diagnosis, prophylaxis, pre-emptive therapy, rapid ART initiation and adherence support for Tuberculosis, Cryptococcal meningitis, severe bacterial infections in that population. In addition, to further strengthen the scale up process and improve performance of the key indicators, the country has developed an implementation plan, highlighting key strategies to support this process. The strategies will focus on improving efficiencies through redesigning key processes and systems for scale up. This paper will describe the key steps the country has taken, interim results to demonstrate process and also highlight key lessons learnt that can be adopted by other countries.

DESCRIPTION

Program : Implementation of the Advanced HIV disease care package through supporting key stakeholders and service providers at all levels to plan and implement the multi-layered proposed interventions with the aim of reducing HIV related morbidity and mortality in Uganda as a result of Advanced HIV Disease as per set National consolidated HIV guidelines. This highlights key programmatic steps taken

Objectives

1. To support identification & timely management of PLHIV with Advanced HIV Disease
2. To support rapid ART initiation among PLHIV with AHD
3. To describe a standardized package and pathways that will support timely decision making for management of AHD

Programmatic and Geographical reach:

A National program anticipated to reach all newly identified PLHIV that attend 1,800 ART sites in Uganda as well as all clients returning to care after loss. The program will reach all ART sites supported to screen, identify, manage or refer all cases of Advanced HIV disease. This will include children below 5 years of age and all clients being identified at the clinics with a CD4 less than 200 cells

The program will be implemented within the general HIV programming for the country through the AIDS Control program; This will include leadership and coordination, guideline development, Human resource support, infrastructure, commodities and implementation by districts at the sub National level.

The key partners include Government, CHAI and PEPFAR that supports financially and technical assistance through implementing partners at the subnational level to implement with the districts and civil society to support uptake of services. In addition, the Government has received catalytic funds through UNIT AID grant to support receipt of optimal products in country as well as support implementation through building capacity of health providers. These approaches will ensure financial sustainability of the program

Preparatory phase;

A number of activities were done during this phase and spanned a period between October 2018 and May 2019. The following are the processes that contributed to this phase; Adopted AHD in the HIV consolidated guidelines; upon release of the guidelines on

management of AHD by WHO, Uganda revised its national policy guidelines on HIV and included a section on advanced HIV disease so as to align with WHO guidance. Formation of the Advanced HIV Disease Technical Working Group (AHD TWG); To guide implementation of the AHD program area. The working group convenes on a monthly basis and brings together expertise of members with different backgrounds that are galvanized to move the advanced HIV disease agenda forward. This supports the development of tools, guidelines and oversees implementation.

Conducted a review of existing Program data as at October 2018 to show performance of AHD indicators;

- A recent TB LAM utilization evaluation: showed that uptake of TBLAM at high volume facilities was only 25% and showed that key factors associated were lack of knowledge among health care providers
- Baseline CD4 Testing; A review of program data from recent support supervision across 330 ART sites showed that access to a CD4 test was 60% among adults and 42% among children enrolled into care
- IPT performance: Program data showed that the uptake for IPT among people living with HIV was only 25%
- CRAG uptake among people with CD4 less than 100 cells/mm : Only 22% accessed a serum CRAG
- Those that receive Fluconazole for presumptive treatment: Of those that had a CRAG positive, 65% received fluconazole

Training of Health care providers on the consolidated guidelines: By August 2019, 93% coverage for health facilities trained on advanced disease had been reached and over 18,000 health care providers trained

Developed an AHD implementation plan; To further streamline and strengthen the gains that had been made from implementation of the consolidated guidelines, MoH developed a specific implementation

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Data collected in June 2019 to assess status of AHD implementation after roll out of the consolidated guidelines showed some slight improvements. In addition, a National campaign for increasing uptake of IPT was launched and data was collected post campaign.

- Baseline CD4 Testing; A review of the data showed that 67% of newly identified clients received a CD4 test conducted up from the previous 60%. And of these, 20% had advanced disease
- IPT uptake performance: Program data showed that the uptake for IPT among people living with HIV was now 43.2% from 22% as a result of the campaign that surpassed its target
- CRAG uptake among people with CD4 less than 200 cells/mm: 81% of clients with a CD4 less than 200 cells/mm received serum CRAG testing.
- Uptake for TBLAM for those with CD4 less than 200 cells/mm: 40% received a TBLAM test an improvement from 20%. Of these that received a test, 16% tested positive and only 59% received TB treatment.
- Those that receive Fluconazole for presumptive treatment: Of those that had a CRAG positive, 73% received fluconazole up from previous 63%
- ART initiation for children less than 15 years: Of the 10,212 children newly enrolled in care during 2017-2018, a total of 94.4% were initiated on ART

LESSONS LEARNED AND RECOMMENDATIONS

- The roll out of the consolidated guidelines by the Ministry of Health on advanced disease served as a catalyst to health care providers to start implementation of advanced HIV

disease package, however this did not fully translate into marked improvement in performance of indicators

- Mapping and determining actual country gaps across the country for drug commodities, diagnostics, capacity of providers is critical in supporting the implementation for advanced HIV disease
- The test and treat policy has resulted in early ART initiation among children less than 15 years of age.
- Catalytic funds through donors are helpful in supporting country teams scale up effectively
- Country programs need to develop clear implementation plans and monitor periodically to assess performance for new aspects in programming as guided by WHO.
- With the strengthening of AHD programming at national level and subnational levels by specifying the service package for AHD and building health care capacity on AHD, a number of gains have been realized. The coverage of AHD services has improved tremendously and this in turn has resulted in TBLAM, IPT and CRAG test kits constraints on commodities

ANNEXES

Support supervision report 2017, Report of July 2019 assessments, TB LAM evaluation report,

25. Uganda

TITLE OF THE PROGRAMME: Scaling up the advanced HIV disease management package for people living with HIV in Uganda

CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End** (if applicable): N/A
- **Responsible party/parties:** Government
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Since implementation of the Test and Treat policy for Antiretroviral Therapy (ART) in 2016, substantial progress has been made in availing ART to people living with HIV (PLHIV) in Uganda. Despite this development, the progress on early HIV diagnosis and early treatment remains sub optimal. As a result, about 1 in 3 PLHIV present to care for the first time with Advanced HIV disease (AHD) and a growing number of PLHIV are returning to care with advanced disease following a period of treatment interruption. People with advanced HIV disease are particularly at high risk of death, even after initiating ART, with this risk increasing with decreasing CD4 cell count. The most common causes of death are tuberculosis (TB), severe bacterial infections, and cryptococcal meningitis (CM). The opportunistic infections among these severely immunosuppressed patients present diagnostic challenges because many patients are asymptomatic and there is limited access to diagnostic tools, treatment, and preventative services for AHD in most low- and middle-income countries (LMICs), leading to high mortality rates. The World Health Organization (WHO) guidance 2017 emphasizes the need to focus on management of advanced HIV disease in addressing HIV related morbidity and mortality without delaying ART initiation. In Uganda, approximately 32,800 PLHIVs (20%) of newly identified PLHIV present to care with CD4 less than 200cells/mm³ and about 10% die within the first three months of enrolment. Furthermore, 11% of PLHIV in care experience treatment failure to ART

regimens and given the suboptimal retention in care (12 months retention is estimated at about 79%), a growing number of PLHIV are returning to care with AHD after treatment interruption. By October 2018, Uganda's status on Advanced HIV disease implementation revealed weaknesses in indicator performance as follows; Baseline CD4 testing for new clients was 60% among adults and 40% among children, TB LAM testing was at 25%, Cryptococcal Antigen (CrAg) testing was at 22%, and Isoniazid Preventive Therapy (IPT) access was at 25%. In addition, the country faced challenges of limited diagnostic tools, inadequate forecasting and use of available commodities, as well as inadequate commodities to support scale up.

In line with the WHO guidance, Uganda developed the 2018 consolidated guidelines for HIV prevention, care and treatment that had differentiating care for PLHIV with Advanced HIV disease as one of the central themes. The guidelines recommended a package of interventions addressing early diagnosis, prophylaxis, pre-emptive therapy, rapid ART initiation and adherence support for PLHIV with AHD conditions including Tuberculosis, Cryptococcal meningitis, severe bacterial infections and nutrition assessment and management of severe malnutrition particularly in children. Additionally, to further strengthen the scale up process and improve performance of key indicators, the country has developed an implementation plan, highlighting key strategies to support this process. The strategies focus on improving efficiencies through the redesign of key processes and systems for scale up. This paper describes the key steps the country has taken, interim results to demonstrate process and also highlights key lessons learnt that can be adopted by other countries.

DESCRIPTION

Program: The AHD implementation plan included multi-layered strategies aimed at supporting implementing partners and front-line health workers to deliver the proposed package of interventions with the goal of reducing HIV-related morbidity and mortality in Uganda. The key objectives of Uganda's AHD program include;

1. Support identification & timely management of PLHIV with AHD
2. Support rapid ART initiation among PLHIV with AHD
3. Describe a standardized package and pathways that will support timely decision making for management of AHD

Programmatic and Geographical reach:

The National program was structured to reach all PLHIV with AHD that attend 1,800 ART sites in Uganda—including clients returning to care after loss, children below 5 years of age, as well as all clients identified at the clinics with a CD4 count less than 200 cells or with danger signs and symptoms.

The program is currently implemented within the general HIV programming for the country and steered by the AIDS Control Program (ACP) at the Ministry of Health (MoH). This includes leadership and coordination, guidelines development, human resource support, infrastructure, commodities and implementation by districts at the sub-national level.

Key partners include Government of Uganda, Clinton Health Access Initiative (CHAI), PEPFAR, implementing partners at the sub-national level and civil society. Additionally, the Government has received catalytic funds from Unit aid through CHAI—with an aim to reduce morbidity and mortality by accelerating access to optimal products for the prevention and management of key opportunistic infections, a component of the Unit aid AHD grant is geared towards improving the capacity of selected hospitals to manage Cryptococcal meningitis using optimal commodities procured through the grant.

Preparatory phase

The following processes, conducted between October 2018 and May 2019, contributed to this phase:

1. Adoption of AHD in the HIV consolidated guidelines: Post release of guidelines on management of AHD by WHO 2017, Uganda revised its national policy guidelines on HIV to include a section on advanced HIV disease to align with WHO guidance as described above.
2. Constitution of the Advanced HIV Disease Technical Working Group (AHD TWG): The AHD TWG comprises key stakeholders from MOH, CHAI, PEPFAR, civil society, MSF and is chaired by a representative of academia. Convened monthly, the TWG supports the development of tools, guidelines and guides implementation of the AHD program area.
3. Review of existing program data as at October 2018 to show performance of AHD indicators:
 - TB LAM utilization: An evaluation in October 2018 showed that uptake of TBLAM at high volume facilities was only 25% key factors associated were lack of knowledge among health care providers
 - Baseline CD4 Testing: Review of program data from a support supervision September 2017 across 330 ART sites showed that access to a CD4 test was 60% among adults and 42% among children enrolled into care
 - IPT performance: Program data showed that the uptake for IPT among people living with HIV was only 25%
 - CrAg uptake: Among people with CD4 less than 100 cells/mm³, only 22% accessed a serum CrAg test
 - Fluconazole for presumptive treatment: Of those that had a positive CrAg test, only 65% received fluconazole for pre-emptive treatment
4. Training of health care providers on consolidated HIV guidelines: 93% health facilities, with over 18,000 health care providers, had been trained on the revised guidelines as of Aug 2019
5. Development of an AHD implementation plan: To further streamline and strengthen the gains made from the implementation of the consolidated guidelines, MoH developed an AHD-specific implementation plan to support stakeholders and service providers at all levels. The plan includes key strategies (listed below) and selected indicators that would monitor the AHD implementation. Further, a review of performance indicators was co

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Further, a review of performance indicators was conducted in June 2019 to guide further interventions.

- Develop and support roll out of use AHD management tool kit
- Strengthen commodity security across the cascade
- Strengthen capacity of frontline healthcare workers in the identification, management of AHD and data management processes
- Organize service delivery packages for different levels of health care
- Address key policy shifts related to AHD management
- Conduct program monitoring and support reporting on Advanced HIV Disease

6. Development of training materials (toolkit for AHD): The toolkit contains a symptom screening tool to be used by health workers to identify people with AHD in situations where CD4 tests are not available; Standard Operating Procedures for AHD management at facilities with different levels of capacity; algorithms for screening, diagnosis and management of TB and Cryptococcal disease; treatment protocols for TB, Cryptococcal disease, Pneumocystis Jirovecii pneumonia and other severe bacterial infections and an algorithm for nutrition assessment, classification, and care plan of severe malnutrition.

Implementation Phase

Following the development of the plan, the implementation phase started around May 2019. The key activities that have so far been implemented include:

1. Refresher trainings of health workers on AHD: In order to strengthen provision of AHD services at the facility level, MoH trained a critical mass of health workers as trainers of trainees from all regions of the country, with an intention that these trainees would in-turn translate the AHD knowledge to other health care workers at the facility, resulting in a rapid scale-up of the knowledge base of AHD service provision in the country
2. Assessment on AHD to determine progress, following the roll out of consolidated HIV guidelines: To generate some evidence on the status of AHD in Uganda, the program conducted an assessment, collecting data from January to June 2019 from 604 facilities.
3. Mapping of regions and facilities prioritized for comprehensive AHD service delivery based on availability of commodities: In consideration of the AHD commodities available in country and those in the pipeline, the MoH undertook an exercise to map facilities per region in the country whose capacity would be built to effectively screen and manage PLHIV with advanced disease. This was mapped with available commodities to allow delivery of AHD services as a package.

A total of 913 sites were identified and mapped to diagnostic tests and treatment commodities to enable a comprehensive implementation of the AHD package of care.

In addition, a total of 55 facilities have been selected to comprehensively manage cryptococcal meningitis. These sites have been assessed and will be trained in the management of Cryptococcal meningitis

4. Monitoring and evaluation for AHD: The national HMIS tools have been revised and updated to include data elements on AHD. The updated HMIS tools were rolled out in October 2019 and data on AHD will be reported from facilities to the national level on a quarterly basis. In the interim, before the updated HMIS tools were rolled out, MoH developed a template to enable collection of AHD data elements that were not previously included in the national DHIS2 database. This template was used to collect data on a quarterly basis through data calls.

5. Support supervision on AHD and TPT: Uganda also scaled up enrolment of IPT among PLHIV through “the 100 day IPT scale-up” campaign which aimed at enrolling 300,000 PLHIV on IPT in 100 days. The findings of the support supervision are still being analysed and an evaluation of the IPT scale-up campaign is planned.

Results/Outcomes and Impact

Data collected in June 2019 to assess status of AHD implementation after roll out of the consolidated guidelines showed slight improvements. In addition, a national campaign for increasing uptake of IPT was launched

LESSONS LEARNED AND RECOMMENDATIONS

- Baseline CD4 Testing; A review of the data showed that 67% of newly identified clients received a CD4 test, up from the previous 60%. Of these, 20% had advanced disease (CD4<200 cells/mm³)
- CrAg uptake among people with CD4 less than 200 cells/mm³: 81% of clients with a CD4 less than 200 cells/mm³ received serum CrAg tests. Of those that received a test, 10% tested positive and 73% received fluconazole (up from 63% previously)
- TBLAM uptake among people with CD4 less than 200cells/mm³: 40% received a TB-LAM

test, an improvement from 20%. Of those that received a test, 16% tested positive and 59% received TB treatment.

- IPT uptake performance: Program data showed that the Uptake for IPT among people living with HIV was now 43.2% from 22% as a result of the campaign.
- ART initiation for children less than 15 years: Of the 10,212 children newly enrolled in care during 2017-2018, 94.4% were initiated on ART

Lessons Learnt/Recommendations

- The roll out of the consolidated guidelines by MoH on AHD served as a catalyst to health care providers to start implementation of the advanced HIV disease package, however this did not fully translate into marked improvement of performance indicators
- Mapping and determining actual gaps across the country for drug and other commodities, diagnostics, capacity of providers is critical in supporting AHD implementation
- The test and treat policy has resulted in early ART initiation among children less than 15 years of age.
- Catalytic funds through donors continue to support country teams to scale up effectively
- Country programs need to develop clear implementation plans and monitor indicators periodically to assess performance of new aspects in their guidelines
- With the strengthening of AHD programming at national level and subnational levels by specifying the service package for AHD and building health care capacity on AHD, a number of gains have been realized. The coverage of AHD services has improved tremendously and this in turn has resulted in TB LAM, IPT and CrAg test kit constraints on commodities
- Use of a symptom screening tool has been useful in identifying additional cases that would have been missed for sites that lack of CD4 on site, hence improving immediate ART initiation. (Plan to validate this tool)

26. Uganda

TITLE OF THE PROGRAMME: Paediatric anti-retroviral optimization for children < 15 years living with HIV in Uganda

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- **Programme is being implemented since:** 2014 - **End** (if applicable): ongoing
- **Responsible party/parties:** Networks of adolescents and young people living with HIV, Government, Civil society, Private sector, UN or other inter-governmental organization, Academic institution
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

It is estimated that 102,106 children less than 15 years are living with HIV in Uganda (1). The antiretroviral therapy (ART) coverage for children living with HIV (CLHIV) has improved from 32% (41,520/129,750) in 2013 to 64% (65,359/102,106) by end of June 2019. Majority (88.2%) of CLHIV are receiving first-line ART and by June 2018, 52.2% of CLHIV aged 3-10 years, were receiving Zidovudine/Lamivudine/Nevirapine (AZT/3TC/NVP) as first-line ART (2). The viral load coverage has significantly improved from 34.8% in 2015/16 to 77.9% in 2018/19. The viral load suppression has also increased from 70.9% and 24.6% of children estimated to be living with HIV in 2015/16 to 72.9% and 56.8% respectively in 2018/19. Uganda is one of the high burden countries with HIV pre-treatment drug resistance of 35.7% to non-nucleoside reverse transcriptase inhibitors (NNRTIs) among newly diagnosed infants (3). The World Health Organization (WHO) recommends that countries with pre-treatment HIV drug resistance >10% should use alternative drugs like protease inhibitors (PIs) or dolutegravir (DTG) for first-line ART. WHO also recommends Abacavir/Lamivudine (ABC/3TC) as the preferred NRTI backbone. This preserves the AZT/3TC NRTI backbone for second-line ART. It was therefore important for Uganda to adapt the guidance from WHO.

In Uganda, ART monitoring is done clinically by using the WHO clinical staging and virologically using a viral load test. Strategies to improve viral load coverage from 34.8% in 2015/16 to 77.9% in 2018/2019 were implemented. A CD4 test is only done at baseline or if a patient is non-suppressed, that is, having a viral load test > 1000 copies/ml. For children, a viral load test is done at 6 months after ART initiation, at 12 months after ART initiation and thereafter every six months. Children with a non-suppressed viral load receive three sessions of intensified adherence counselling (IAC) conducted each one month apart of the other and a repeat viral load test a month later. For children failing on second-line ART, a genotype test is performed. Two samples are collected when the repeat viral load test is due. Once the repeat viral test is > 1000 copies/ml, the second sample is sent by CPHL to one of the two HIV drug resistance testing laboratories depending on the type of sample; plasma samples to The Joint Clinical Research Center (JCRC) and both DBS or plasma samples to the Uganda Virus Research Institute (UVRI). The results return to CPHL and are sent to the national third-line ART committee for review.

The ART optimization process in Uganda has happened over a span of 5 years starting in 2014 following the WHO guidance throughout each step below;

Step 1: Transition from AZT/3TC NRTI backbone to ABC/3TC as the preferred NRTI backbone in 2014

Step 2: Transition of NNRTIs (Nevirapine or Efavirenz) to Lopinavir pellets in 2016 and Lopinavir tablets.

According to the national ART guidelines, children aged 3 months to < 3 years old should receive ABC/3TC/Lopinavir-ritonavir pellets as their ART regimen.

Step 3: Introduction of third-line anti-retroviral (ARVs) drugs in the national system (public health facilities) for children who are failing on second-line ART in 2017

Step 4: Transition as well as initiation of newly enrolled children and adolescents who weigh 20Kgs or more to dolutegravir (DTG) in 2018 for first, second and third-line ART.

As mentioned above, as of June 2018, 52.2% of children were still on AZT/3TC/NVP for their first line regimen instead of ABC/3TC/LPV/r or DTG. In June 2018, the ministry of health started planning for the process of optimizing these remaining children. The implementation of those plans is still ongoing. In this paper, we submit the processes we undertook to plan and implement the current paediatric ART optimization strategy for children living with HIV in Uganda.

DESCRIPTION

The ART optimization process was structured through a phased approach involving a preparatory, implementation and monitoring phase.

Preparation Phase: This phase began after the release of the WHO guidelines for 2018.

The WHO guidelines were reviewed in line with the country context to determine considerations for policy changes which are approved by different technical working groups and approved by top management of MOH. Due to the high burden of HIV drug resistance to Nevirapine (NVP) and Efavirenz (EFV) and from program data showing that over 70% of children on these drugs do not re-suppress after IAC, a policy decision was made as follows; all non-suppressed children receiving NVP or EFV for their first-line ART should immediately be switched to second-line ART (LPV/r or DTG containing regimen) after discussing with the caregiver and on-going IAC provided. For suppressed children, the above transitions within their first-line treatment to LPV/r or DTG applied.

Data in the national reporting system (DHIS-2) and the Web-based ART ordering system (WAOS) was reviewed to determine the number of children who needed ART optimization. This information was used for planning, forecasting and procurement of ARVs. Updating of existing materials used for training was done. These include a facilitators and participants manual. National planning meetings were convened on weekly basis by the Ministry of Health (MoH)-AIDS Control Program and the were attended by the Pharmacy and Central public Health Laboratories (CPHL) teams of MoH and AIDS Development partners

(PEPFAR, UNICEF, CHAI) and warehouses for ARVs. A desk job aid, standard operating procedures (SOPs), ART optimization checklist and an action-oriented line listing tool were developed to facilitate learning and implementation at the frontline. The checklist included step-by-step guidance to health care providers to identify eligible CLHIV in need of ART optimization. All eligible CLHIV were then transferred on to the line listing tool to allow, in a central place, for monitoring of actual optimization through routine tracking and follow-up. The line listing tool also allows for identification and follow-up of CLHIV eligible for viral load testing which has not been done as including newly initiated patients, those whose last test is older than 6 months, non-suppressed children who have completed intensified adherence counselling (IAC).

Implementation phase: This phase mainly happened at the sub-national level and followed the endorsement of guidelines and development of the paediatric ART optimization training materials and tools.

Capacity building for health care providers: Health care providers and implementing partners received training in paediatric ART optimization during the sub national roll-out of each round of revised national HIV guidelines. Trainings were conducted through the traditional hierarchical approach; national trainers trained regional trainers who in turn trained district-based teams; the district-based teams, conducted the 3-day non-disruptive facility-based trainings to roll-out the revised guidelines that included paediatric ART optimization.

Supervision of regional, district and facility teams during the roll-out of the guidelines was done for quality assurance. Post-training on-site mentorships were conducted to consolidate learning and to monitor implementation progress.

National Quality Improvement Collaborative: This was implemented to improve viral load suppression, retention, Tuberculosis preventive therapy and psychosocial support. A hierarchical approach as the one mentioned above was used to coach health care providers and to support them start quality improvement projects.

Monitoring Phase: ART optimization indicators were developed and monitored in the surge dashboard. A national third line ART dashboard has also been developed and an online platform for reporting the trainings.

RESULTS, COUTOMES AND IMPACT OF THE PROGRAMME

Step 1-Transition from AZT/3TC to ABC/3TC; The proportions of children on AZT/3TC NRTI backbone as first-line ART has reduced from 76.8% in June 2014 to 48% in June 2019 while that of ABC/3TC NRTI backbone has increased from 21.9% to 46% as per Web-based ARV ordering and reporting system in the same period.

Step 2-Transition from NVP or EFV to LPV/r or DTG; Children aged 3 months to < 3 years old make up 15.8% (8,486/53,744) of children on first-line ART. Majority, 40.7% (21,898/53,744) of children on first-line ART, are aged 3 years to less than 10 years. Of the 8,486 children aged 3 months to <3 years eligible for the pellets, 71.7% (6,085/8, 486) have been initiated on the treatment. Among children aged 3 years to less than 10 years, only 1.14%, (250/21,898) have been able to transition from NVP or EFV containing regimens to more optimal LPV/r. This has mainly been affected by the global shortage of LPV/r tablets. Some of these children have been initiated on DTG as indicated in step 4.

Step 3-Introduction of third-line ART to public health facilities; 0.18% (121/65,359) children have been initiated on third-line ART and 27.2% (33/121) are < 10 years of age.

Step 4-Transition or newly initiated children on DTG; A total of 6,381 children less than 15 years who weigh 20 Kgs or more have been initiated on DTG. Of these, 86% (5,486/6,381) are receiving Tenofovir/Lamivudine/Dolutegravir (TLD); 385 were newly initiated on TLD and 5,101 were transitioned from NVP or EFV. Of the 6,381 children, 14% (895/6,381) are receiving Abacavir/Lamivudine/Dolutegravir (ABC/3TC/DTG); 176 were newly initiated on ABC/3TC/DTG and 719 were transitioned from NVP or EFV. These children were not eligible to receive TLD because even though they can receive DTG, they weigh less than 30 Kgs so are not eligible for Tenofovir.

LESSONS LEARNED AND RECOMMENDATIONS

The need to improve outcomes of children on treatment through ART optimization is influenced by many contextual factors like emerging evidence during the implementation of the guidelines (DTG safety and eligibility criteria according to weight), wastage of ARVs (old regimens) with change in guidelines and transition to recommended preferred ART regimens, global stock out of Lopinavir/ritonavir tablet and long lead times from manufactures for ARVS. At the patient level, changing regimen comes with additional challenges in effectively communicating changes in dosing schedules or administration procedures; particularly for LPV/r pellets and tablets if a child was initially receiving a dispersible formulation.

The lessons learned include;

1. Review of guidelines and training of health workers does not translate into immediate quality of care for CLHIV; Continuous support through mentorship is needed to operationalize changes in guidelines.
2. Caregiver literacy in ART and drug administration of optimal regimen is very crucial to obtaining good health outcomes for children. Development of tools to support programs and assist health care workers to educate care givers are essential to any future ARV optimization effort.
3. Even with good planning and preparation, drug stock outs can occur and these hinder the implementation of revised guidelines. Careful in-country stock management in phasing the optimization process and tracking facility level stock to inform drug redistributions are important in minimizing the effect of stock outs on patient care.
4. Children who have been exposed to AZT/3TC and ABC/3TC NRTI backbone during their first-line treatment might need HIV drug resistance testing to optimize their second-line ART regimen.
5. It is possible to implement a decentralized national third-line ART program. However, continuous capacity building is key to a successful program.

REFERENCES

1. National Spectrum Estimates, Ministry of Health- 2018
2. Ministry of Health, HIV and AIDS Control/STI Program Annual Report July 2018-June
3. World Health Organization (WHO) HIV Drug Resistance Report 2019

ANNEXES

1. Screening List for Transition to DTG
2. Line Listing Tool for Children & Adolescents
3. SOP for Paediatric & Adolescent ART Optimization
4. PDF version of submitted write-up

27. Uganda

TITLE OF THE PROGRAMME: Sparked Women

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- **Programme is being implemented since:** September 2016 - **End** (if applicable): September 2018
- **Responsible party/parties:** Civil society, Academic institution
- **Population group(s) reached:** Adolescent girls and young women
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Uganda has one of the biggest HIV epidemics in the world. While the epidemic is firmly established in the general population, women are disproportionately affected. Among young people this gender disparity is even worse. HIV prevalence is almost four times higher among young women aged 15 to 24 than young men of the same age (WHO/Uganda Ministry of Health, 'The Uganda Population-Based HIV Impact Assessment 2016-17'). HIV disproportionately affects young women and adolescent girls because of their unequal cultural, social and economic status, especially in patriarchal societies such as Uganda. These dynamics limit women's choices, opportunities and access to information, health and social services, education and employment.

Poverty is an overarching factor that increases vulnerability to HIV and further complicates gender inequalities. Estimates from the Uganda National Household Survey 2016/2017 suggest that the 21 %of the population lives below the national poverty line. Youth account for 60% of the unemployed (FAO 2017), whereby female unemployment is higher than male unemployment. The majority of the women are engaged in non-income generating employment like subsistence agriculture (49.4 percent for women versus 36.9 percent for males) (INCLUDE, Young and female: Double jeopardy for women in Uganda's job market, Gemma Ahaibwe, Anita Ntale, 2016).

Poor women are often economically dependent on men and frequently adopt behaviours that put them at risk of HIV infection. This includes transactional and intergenerational sex, earlier marriage, and relationships that expose them to violence and abuse. Besides increasing vulnerability to HIV, poverty also impacts a person's ability to cope with their HIV infection. For instance, food insecurity, often linked to poverty, acts as a barrier to treatment for women living with HIV. This increases both the risk of HIV advancing and onward transmission.

DESCRIPTION

In 2016, Aidsfonds received a grant under the DREAMS-Innovation Challenge and initiated the Sparked Women project. The aim was to offer an innovative and sustainable intervention for HIV prevention for adolescent girls and young women addressing both access to services at community level as well poverty among AGYW. The idea was also that the project could be scaled up in a short time.

We combined sustainable business models to create job opportunities and sustainable community health service delivery system for young women at risk for and living with HIV. The two business models were:

1. Healthy Entrepreneurs offers a social franchise model where women become small business owners (Community Health Entrepreneurs: CHEs) by selling essential medicines and health products. Moreover, through their tablets, they disseminate information on topics such as HIV prevention and sexual and reproductive health, in particular to AGYW. As such, we aimed to meeting an unmet need for quality health promotion, products, and services such as condoms and family planning products and information, while also strengthening the existing Village Health Team (VHT) structures (focus area 1 Strengthening Capacity of Communities for Service Delivery).

2. Sawa World offers a cost-effective model for self-employment opportunities for young women by teaching 8 different practical solutions¹ (business skills) that require low start-capital as well as providing them with marketing skills (skills in production, packaging, and branding). They are shared through interactive two-day workshops, solution video screenings on the tablets of the CHEs, and step by step solution posters. These educational tools are cascaded widely. As the skills can be easily replicated in an hour or less, instant self-employment opportunities for a large number of AGYW are created.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Together with the Erasmus University in Rotterdam, the Netherlands, the programme was evaluated. the most important outcomes were:

Improved health structures in rural communities:

The Sparked Women project resulted in a network of 914 active CHEs in the six districts with the highest HIV prevalence in Uganda, covering almost all sub-counties per district. On average there are now 3 CHEs present per one sub-county, providing better access to health information and commodities to almost all community members. After one and a half year the CHEs had provided almost 150,000 SRHR and health educational sessions with the videos of their tablets. The CHEs also improved access to health commodities. During the project period, they provided their communities amongst others with over 42,400 treatments for malaria and 15,800 treatments for deworming. The Erasmus research confirmed that the existing health system benefits and is strengthened through the model. It showed that CHEs guaranteed availability of essential medicine and basic equipment, were more motivated, referred twice as many patients and spend more time on health work and compared to

regular VHTs.

Improved SRHR in rural communities:

CHEs have brought contraceptive methods closer to women in their community, by providing easy access for free combined with the necessary SRHR information through the tablets. During the project CHEs handed out 2,990 cycles of the contraceptive pill and 855,000 condoms. They also sold 5,000 reusable sanitary pads. CHEs were especially effective in reaching young girls (with over a third of their health sessions being with AGYW). The impact of this was shown by the Erasmus study, which found communities with a CHE had more comprehensive knowledge of HIV and other STIs, compared to households reached by regular community health workers. Moreover, they saw a doubling in use of modern contraceptives in communities with a CHE compared to those without.

Improved income of AGYW:

Sawa World registered an increased average livelihood score of 6.5 (out of 10) among the AGYW who started businesses, compared to the 4.5 score at the baseline, a 46% improvement. The average monthly income generated by a girl was \$30.40 compared to \$ 3.51 at the baseline, representing an increase of more than 850%. The income was reportedly used for saving, health costs, and reinvesting in their business. Also, the Healthy Entrepreneurs' model was successful in increasing income. The income of Community Healthy Entrepreneurs increased with \$8.96 weekly compared to the control group of regular VHTs. This is USD 35.84 per month. Most women had a family that they were able to support with their income; on average 6 people depended on a CHE's income, of which an average of 2 AGYW. The CHEs used their increased income to improve their family's health and quality of life.

Improved health outcomes

By providing job opportunities to women exclusively, we worked towards equity in access to financial means for both women and men. It is a powerful result of economic empowerment that it increases agency. There is a vast amount of scientific evidence on health benefits for economically empowered women. Our project data confirms how starting a business positively impacted the girls' sexual health behaviour, showing an increase in self-esteem, less sexual partners (74.7% AGYW who started a business reported having a committed sexual partner compared to the 63.6% at baseline) and increased condom use (38.9% at the end of the project, compared to 29.2% at the baseline) and increased HIV counselling and testing (94% of girls took an HIV test in the past twelve months compared to 84.4% at baseline).

LESSONS LEARNED AND RECOMMENDATIONS

In this project we focused specifically on female VHTs, due to the criteria of the DREAMS grant. The added value of this was confirmed as from our experience we noted that men often are able to get the commitment fee that is required to become a CHE more easily, since they often have more sources of income. For the women this was often more difficult since they usually don't have any other income sources. To address this inequity, we enabled them to pay the fee in phases. Through this gender-transformative approach, we managed to increase women's economic participation

ANNEXES

We created beautiful short vlogs showing the journey of the girls in the programme and the impact the programme made on them. They can be found here:

<https://aidsfonds.org/news/vlogumentaries-sparked-women>

28. Zimbabwe

TITLE OF THE PROGRAMME: Sparked Women

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- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** The National Action Plan for Orphans and Vulnerable Children

BACKGROUND

Since 2004, there has been a dramatic shift in the HIV response for children, adolescents, and young people in low resource settings. With the roll out of antiretroviral therapy (ART), children born with HIV have survived beyond infancy and into adolescence. Together with the growing number of new infections among young people, children, adolescents, and young people now significantly shape the HIV epidemic. Yet programs and services have been largely orientated to adults, with limited commitment to the specific needs of children, adolescents, and young people living with HIV (CAYPLHIV).

Despite gains made in numbers on treatment, CAYPLHIV experience late diagnosis and disclosure, higher rates of loss to follow-up, poor adherence, and less viral suppression than adults. A systematic review in resource-limited settings found that, in children 0–10 years initiated on ART, 5%–29% were either lost to follow-up or dead within 12 months. From 2005 to 2012, AIDS-related deaths in adolescents 10–19 years rose 50% while AIDS-related deaths among adults fell by 30%. In addition to opportunistic infections, those born with HIV commonly face growth and developmental delay and other chronic conditions, complex psychosocial stressors and poor mental health. These challenges and their influence on HIV outcomes highlight the need for comprehensive, age, and developmentally appropriate HIV

services.

Increased global awareness has led to a surge of global- and national-level guidance to strengthen service delivery for CAYPLHIV. These inputs have been accompanied by funding initiatives such as the Accelerating Children's HIV/ AIDS Treatment Initiative, which aimed to close the HIV treatment gap for children and adolescents in 9 countries. Global guidance on differentiated service delivery (DSD) recognizes the need to adapt services for children and adolescents. Despite the emerging guidance, insufficient evidence exists on how to take these services to scale.

From 2004, Zimbabwe has scaled up pediatric and adolescent HIV services, culminating in approximately 80% of the estimated 72,887 children and 63,176 adolescents with HIV on ART by December 2017. This scale-up included adoption of the Zvandiri program of Africaid, a local, nongovernment organization (NGO) in Zimbabwe. Zvandiri is a theoretically grounded, multicomponent DSD model for CAYPLHIV that integrates peer-led, community interventions within national service delivery.

DESCRIPTION

Zvandiri is a model of differentiated service delivery for children, adolescents and young people. The goal of Zvandiri (meaning "As I am") is that CAYPLHIV, 0–24, have physical, social, and mental well-being. Zvandiri aims to directly improve young people's experience across the HIV cascade—HIV diagnosis, disclosure, linkages, adherence, retention—and to provide ongoing support for their mental health, social protection, and sexual and reproductive health.

Since 2004, Zvandiri has evolved from one support group in Harare into a comprehensive model, combining community- and clinic-based health services and psychosocial support for CAYPLHIV. At the forefront of service delivery are adolescents and young people living with HIV, 18–24 years old, who are trained and mentored by Ministry of Health and Child Care (MoHCC) and Africaid as peer counsellors known as community adolescent treatment supporters, or "CATS." Their role is to support CAYPLHIV across the HIV cascade through a variety of complementary services integrated within government and private sector clinical care packages, and social protection services.

CATS are attached to health facilities within their own communities and supervised by MoHCC staff, with technical support from district-based Zvandiri mentors employed by Africaid. CATS identify and refer undiagnosed children, adolescents, and young people through index case finding and support pre- and post-test HIV counselling and disclosure. They support the linkage of HIV-negative clients to HIV prevention services while those confirmed as HIV-positive are registered with Zvandiri. CATS manage a caseload of up to 60 CAYPLHIV whom they support through home visits, support groups, clinic visits, and MHealth.

Zvandiri has been scaled up across Zimbabwe through phased expansion, with replication of the model from Harare in 2004, to 6 districts in 2010, and to 3 provinces in 2011. In 2014, the Ministry of Health and Child Care (MoHCC) adopted Zvandiri as a key component of its national accelerated action plan for pediatric and adolescent HIV treatment, whereas the Department of Social Welfare rolled out Zvandiri within its national case management system to strengthen identification of and response to child protection violations against CALHIV.

The support provided by Zvandiri is differentiated according to the clinical and psychosocial circumstances of individual clients. 'Standard care' is provided for CAYPLHIV who are

clinically and psychosocially stable; Enhanced care is provided for CAYPLHIV who are clinically and psychosocially at risk. Over the years, the model has been further differentiated to respond to the specific needs of individual clients with mental health conditions, disability, social protection challenges, TB and for those who are pregnant or breastfeeding.

Zvandiri seeks to support the national response for children, adolescents and young people living with HIV and is therefore implemented in partnership with the Ministry of Health and Child Care, Ministry of Public Services, Labour and Social Welfare, Minister of Primary and Secondary Education and National AIDS Council. It is a multi- donor funded programme with different funding partners funding the same model but with different geographic focus or specific components of the model (e.g Young Mentor Mothers, Disability, Mental Health, Research)

RESIULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Game Changer funding from PEPFAR enabled the national scale up of Zvandiri in 2017. In addition to the support from other funding partners, this resulted in Zvandiri being established in 51 of 63 districts (81%) across all 10 Zimbabwe provinces with 40,213 CAYPLHIV actively engaged in Zvandiri services. Operations research in a rural Zimbabwe district found improved self-reported adherence from 44.2% at baseline to 71.8% at 12 months (P value = 0.008) among adolescents receiving Zvandiri services. They were 3.9 more times likely to adhere to treatment (self-report) compared with the control group receiving standard care (odds ratio 3.934). Additional studies by Zvandiri, the MoHCC, and research institutions have explored the experiences and service delivery needs of different subpopulations of CAYPLHIV, including those with virological failure, disability, mental health conditions, and those who are pregnant or breastfeeding. In another operations research study in 2019, a total of 15,223 contacts and sexual partners with unknown HIV status (linked to 9,353 index CAYPLHIV) were identified and referred for HIV testing. Of them, 12,114 (79.6%) were tested and 1,193 (9.8%) were found HIV-positive. Of the latter, 1,153 (96.6%) were initiated on ART with 99% starting on the same day of diagnosis. Of those on ART, 1,151 (99.8%) were alive on ART at 6 months whilst 2 (0.2%) died. A total of 1,044 (91%) PLHIV underwent viral load testing at 6 months or later, of whom, 1037 (99.3%) were virally suppressed (<1000 copies/ml). A recent cluster randomised trial of the Zvandiri programme found that the Zvandiri programme resulted in 42% lower prevalence of virological failure or death at 96 weeks among participants compared to those only receiving MoHCC standard of HIV care at rural clinics.

https://docs.wixstatic.com/ugd/369a38_4f58376b3aa249d8a3069ed3df5dcd30.pdf

Another trial is currently underway to measure the feasibility and effectiveness of a CATS-led mental health intervention in partnership with the Friendship Bench's evidence-based model of problem solving therapy for lay health care workers.

In partnership with the World Health Organisation, Zimbabwe's Ministry of Health and Child Care, regional Ministries of Health and funding partners, Zvandiri is now being adopted or adapted in the region in 6 countries: Eswatini, Tanzania, Mozambique, Uganda, Namibia, Rwanda and Uganda. Each country is at different stages of implementation, but important lessons are being learned regarding the implementation of this model in different contexts. Programme data will be available early next year regarding the uptake and impact of this model.

LESSONS LEARNED AND RECOMMENDATIONS

Key Lessons Learned in the Scale up Zvandiri include:

Government leadership and coordination were critical in driving scale-up of an integrated,

sustainable, differentiated service for CAYPLHIV

- Packaging Zvandiri as a defined model of care, including joint development of guidance, training curricula, and implementation tools, promoted standardized uptake and implementation of services in line with national plans and systems
- Integration of training, supervision, and mentorship within national systems with TA from an NGO at national, provincial, and district level has been essential for government ownership and support for CATS
- Beneficiary involvement in all aspects of program design and delivery, monitoring, evaluation, and research has been critical, acceptable, and sustainable
- Development of pediatric and adolescent indicators to reflect DSD, as well as the clinical and psychosocial outcomes for this population, has promoted awareness of the need and impact for differentiated services
- Use of programmatic data, together with partnerships with research institutions, has produced robust evidence for informing policy, service delivery, and scale-up, as well as resource mobilization
- Strengthened and scaled-up objective markers, including routine viral load testing and refined measures of mental health, are needed to demonstrate sustained impact
- Basic cost effectiveness and cost-benefit data can strengthen evidence for good practice and sustainable impact.

These principles have remained just as relevant and applicable in the further scale up of Zvandiri beyond Zimbabwe, where the model is being adapted or adopted in other countries. These key lessons learned have formed the basis to the learning, sharing and technical assistance provided by Africaid.

ANNEXES

1. Willis N, Napei T, Armstrong A et al (2019) Zvandiri - Bringing Differentiated Service Delivery to Scale for Children, Adolescents and young people living with HIV, J Acquir Immune Defic Syndr 2018;78:S115–S123; Zvandiri Policy Brief - Cluster Randomised Trial; PEPFAR Solutions: Zvandiri - Peer Counselling to improve adolescent HIV care and support

29. Zimbabwe

TITLE OF THE PROGRAMME: Sparked Women

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- **Programme is being implemented since:** 2015 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, Civil society, Private sector
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

In Zimbabwe, decline of new HIV infections among adolescent and young people (ADYP) has been slow and is projected to remain the same unless innovative, engaging and interactive interventions, including ways of dissemination of prevention information are implemented.

DESCRIPTION

U-Report was introduced by UNICEF Zimbabwe in 2015 and implemented with line Ministries. It's a free SMS through RapidPro platform to/from 176,238 voluntary registered U-reporters (46% Female; 36% ADYP) for real-time monitoring, community engagement and communication.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

May 2018-July 2019, an average of 27,413 ADYP U-Reporters per poll were reached with 10 polls of 5-11 questions. 7 polls to understand ADYP views and knowledge on HIV-related topics to inform Radio Shows; 2 to assess perceived quality of SRH and HIV prevention services and 1 to assess ARVs impact by Cyclone Idai confirming high lost (63%). Analysis showed wide (14%-95%; 23% average) response rate according to topics; higher among

girls (59%) and 20-24 age group (70%). 72% ADYP (more among girls 74% and in 20-24 73%) reported access to HIV testing services and 66% to ASRH, only 13% to prevention information on condom use and 4% on STI, particularly among the youngest (15-19) and boys. 57% of 15-19 group don't seek health services because "did not feel like going" or 43% "did not feel comfortable going" due to health workers' attitudes. Knowledge on ARV medication was high in terms of definition (73%), what can affect adherence like drugs/substance abuse (92%), poor nutrition (48%) or fear of disclosure status (48%), lack of privacy for storage in school (33%), poor confidentiality (19%). Few ADYP "knew all three definitions of stigma" (36%; 39% girls and 32% boys) and discrimination (33%), but only 37% will not tell family and friends if tested HIV positive. ADYP reported that mobile technology helped them to speak out freely and know that they are not in isolation. In addition, 55,792 ADYP living with HIV were reached through U-report for counselling and 14% were referred to services as needed.

LESSONS LEARNED AND RECOMMENDATIONS

U-report is a game changer for reaching ADYP, especially youngest, with information on prevention and on access to services. U-report can be used for data triangulation and real-time monitoring of ADYP programme, including tracking referral and service utilization. Involvement of ADYP in the preparation of the polls' questions is key to get higher response rate.

II. ASIAN STATES

30. China

TITLE OF THE PROGRAMME: Improving uptake and retention in services through comprehensive innovative measures in college and university settings

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- **Programme is being implemented since:** 2015 - **End** (if applicable): N/A
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Adolescents and young people are at sexual metamorphic and active period, vulnerable and susceptible to high-risk sexual behaviours. They are among key population in HIV response. The Chinese government attaches great importance to the HIV prevention and control, especially for adolescents and young people, taking series of comprehensive innovative measures for HIV response in school settings.

DESCRIPTION

Strengthen collaboration and coordination among different government sectors, provide policy support, establish working mechanism to promote joint action in HIV response in school settings.

The "Outline of China's Children's Development (2011-2020)" issued by the State Council in 2011 clearly included sex and reproductive health education into the compulsory education curriculum system. The National Health Commission(NHC)and the Ministry of Education have jointly issued the "Opinions on Further Strengthening the Education of HIV/AIDS Prevention in Schools", "Notice on Establishing an Epidemic Notification Mechanism to Further Strengthen HIV/AIDS Prevention and Control in

Schools", including the HIV/AIDS education courses in junior middle school and above levels, and the pertaining knowledge requirements at the entrance of universities and secondary vocational schools. The "Contain HIV/AIDS Epidemic Implementing Plan(2019-2022)", approved by the State Council and jointly issued by the NHC and other nine ministries take HIV prevention education for students as one of the six major projects, and has clearly defined the responsibility, actions, and targets for each sector. For those students affected by HIV, NHC, working together with Ministry of Finance, Ministry of Civil Affairs, and Ministry of Education, has provided comprehensive policy, fund, and service in the areas of basic living insurance, medication, education and social service. The stigma and discrimination issues are also addressed. The health sectors are required to avoid disclosing any personal information of the students when informing schools and universities of the HIV epidemic. This helps to alert and enhance the awareness of HIV/AIDS while protecting the privacy of the students.

Strengthen the scientific planning and technical instruction; optimize the services to improve accessibility and specificity.

Experts from health and education sectors have been organized to develop scientific and specified school HIV/AIDS response plan based on local epidemic context, providing technical support for health promotion, test counselling, intervention, and medical care. The layout of HIV counselling and voluntary testing clinics had been adjusted and optimized. Pilot rapid testing kits and condom distribution sites in schools to facilitate students with high-risk behaviours to access counselling and testing actively. For newly diagnosed cases, provide timely notification and psychological counselling.

Strengthen the health promotion, promote AIDS prevention knowledge.

The NHC and the Central Committee of the Communist Youth League jointly organized a national on-site publicity activity entitled "My youth, my choice-Red Ribbon Health Ambassador Campus Tour". China's first lady, Prof. Peng Liyuan was invited to the event as the Goodwill Ambassador for HIV. She stepped into universities together with health experts to perform health promotion on HIV response. This Campus Tour has now covered 7049 colleges and universities and influenced millions of students. The National Health Commission and the Ministry of Education has developed *HIV/AIDS Prevention Knowledge Booklet for Students*, and college courses on HIV/AIDS prevention, which are distributed through internet and new media, more than 100,000 students have taken this course in more than 200 universities and colleges.

Make the full use of student associations to explore the potential of student-initiated HIV response.

It is encouraged to fully utilize student associations and volunteers to carry out comprehensive education on AIDS prevention, drug control, and sex and reproductive health. The College HIV/AIDS Prevention Foundation was established under the joint support of the NHC and the Central Committee of the Communist Youth League, providing funding support for 565 student associations to carry out AIDS prevention activities, include training the peer educators among students, providing sexual health and AIDS prevention knowledge, peer education, comprehensive intervention and testing motivations for the needed.

Strengthen AIDS prevention outside the campus with various measures and methods.

HIV prevention for adolescents and young people out of school has faced great difficulty and challenges. Beside utilizing traditional media such as newspaper, radio and TV, health and educational sectors are now making efforts to explore innovative

Platforms such as internet, dating APPs, videogames, etc. as student-friendly ways to perform health promotion on HIV. Free condom distribution, infection risk online self-evaluation tools, free and commercialized self-test kits are implemented to increase the accessibility and convenience of HIV testing. At the same time, community-based organizations are mobilized to conduct health promotion, high-risk population consulting and intervention, and timely referral of HIV-positive cases to health sectors.

Take Guangzhou City with a population of 14.9 million as an example, the city adopted innovative models and worked with community-based organizations to create four major brand activities for student-led peer education.

Brand Activity 1: *“Hand-in-Hand Red Ribbon HIV Prevention Action: Public Welfare Project among Youth in Guangzhou”*

This activity aims to engage more students and student associations in the HIV response. The project was jointly initiated by the Guangzhou Municipal Centre for Disease Control and Prevention and Social Work Service Centre of the Youth Cultural Palace, Guangzhou Municipal Youth League Committee. From 2015 to 2018, the 4-phase project has supported a total of 124 school association projects, and 114 projects were successfully conducted, 716 ambassadors of peer education for HIV response were trained, with a coverage of approximately 95,372 young students.

Brand Activity 2: *“People together: Red Ribbon Youth Pioneer Program”*

Jointly launched by the Guangzhou Municipal Centre for Disease Control and Prevention, the Guangdong Provincial People's Charity Foundation (a grant-making foundation focusing on youth), and the Lingnan Partner Community Support Centre (the most influential CBO in southern China engaged in health services and sexuality education), this project aims to fill the financing gap in training young peer educators. From 2015 to 2018, this 4-phase project funded 99 projects, through which 147 red ribbon youth pioneers and 4,220 junior peer educators were trained, and supported peer education activities that covered around 86,513 students.

Brand Activity 3: *“A wide variety of choice for advocacy campaigns in HIV response on campus: Micro film+ Sitcom + Peer Education Course +Expert Lecture series”*

Jointly developed by Guangzhou Municipal Centre for Disease Control and Prevention and the Youth Health Companion Association of the Guangdong Teachers College of Foreign language and Arts, a wide variety of choice for advocacy campaigns in HIV response on campus contain three self-directed microfilms and a series of peer education courses and other educational products. Partnered with local schools, this initiative organizes expert lecture series and other activities on campus and now more and more schools are willing to open their doors for courses that are related to HIV response. From 2015 to 2018, 85,917 audiences have been reached during its 150 tours in 135 schools.

Brand Activity 4: *“SUPER PARTNER: peer counselling and testing service project”*

Originally, “SUPER PARTNER” is a group of youth volunteers that focuses on peer HIV counselling and testing service on campus. With the support from UNICEF, China Association of STD and AIDS Prevention and Control, and Guangdong Centre for Disease Control and Prevention, it has expanded its service scope to also provide counselling and testing service for syphilis and other sexually transmitted diseases to young people in school besides HIV. Since 2016, it has held on-campus campaigns for

HIV counselling and testing in 36 schools in Guangzhou city. Approximately 20,000 students have participated in the face-to-face education campaigns, 14,219 received HIV counselling service and over 500 of them got HIV tested (including self-testing).

Output and effect

At present, as one of the important parts of National HIV/AIDS Action plan, China has established a government-led comprehensive school HIV/AIDS prevention system and mechanism, supported by health, education, finance, civil affair sectors and civil society. The fast-rising trend of HIV infection among young students has been preliminary contained at a low prevalence level. Through diligence work in the past decades, China has explored the options that better fits the China's context and accumulated experience on general health education programme for HIV prevention in colleges and universities and intervention for targeted groups with high risk behaviours. As a result, the awareness and knowledge of HIV prevention and treatment among young people have been increased with stronger sense of self-protection. Students have become one of the important powers in HIV response in school.

31. China

TITLE OF THE PROGRAMME: Improve Adherence to Antiviral Treatment to Ensure Children Living with HIV to grow healthy-Practice in Yunnan, China

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- **Programme is being implemented since:** 2004 - **End** (if applicable): N/A
- **Responsible party/parties:** Government, Academic institution
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Children are the future of the country. Children living with HIV should have same happy childhood, receive education and setup their own life goals as ordinary children. Having a healthy body is the premise to meet these needs. Therefore, it is important to provide effective antiviral treatment for children living with HIV at early stage. Yunnan is one of the earliest provinces in China which launched antiviral treatment among children living with HIV and Yunnan AIDS care center have already carried out antiviral treatment for children living with HIV for 15 years with accumulated 200 cases treated and 161 cases being on treatment. Till now, all children having received antiviral treatment here are alive and the center has gained good experience from the practice in children's treatment and management.

DESCRIPTION

Measures

1. Established a professional team specifically in charge of treatment on children living with HIV

The professional team only provides service for children living with HIV and consists of responsible doctors, case managers, and volunteers. The doctors are responsible for treatment, assessment of antiviral effect, monitoring children's growth and development and

instruct the guardians to provide children with reasonable nutrition; duties of case managers include providing training for the guardians on how to help children develop good drug compliance and smoothly communicate with children at different ages so as to build trust between the guardians and children, keeping in touch with guardians closely to get informed about the children's physical condition timely. Volunteers assist case managers to increase the children's drug compliance. Through comprehensive management of ARV treatment for children by professional team, the rate of virus suppression has increased and the rate of drop-out decreased among children on treatment.

2. Provided care and assistance for children living with HIV

Doctors from Care Department in Yunnan AIDS Care Center and volunteers from Yunnan Blue Sky AIDS Prevention and Control Center, a CBO, are also involved in children's anti-viral treatment work. Doctors from Care Department actively organize children living with HIV to participate in a variety of activities, through which they could understand the children's inner thoughts, find children's psychological problems, provide psychological guidance for children with psychological problems as well as care and support. Blue Sky Center provide aids for children in the family with financial difficulties; volunteers buy stationary such as bags for school-age children, care for children's life and learning, and provide care and assistance for children living with HIV as much as possible.

3 Properly resettle AIDS orphans and unsupervised children

Yunnan AIDS Care Center has mobilized CBOs and integrated various resources to help AIDS orphan and children whose guardian cannot afford to raise them. Currently, a total of 20 children on treatment in the center are raised by CBOs, which receive orphans and unsupervised children living with HIV in Kunming, Yunnan. All these children are receiving standardized antiviral treatment and school education, and their drug compliance is very good.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Achievements

1. Significantly effective ARV therapy among Children

The result of antiviral therapy among children in Yunnan AIDS Care Center is leading in the whole Yunnan province. Data analysis of 108 children living with HIV on treatment in 2017 shows as follows: 1) 92.9% of 56 cases on ARV treatment for 1 to 5 years, 97.6% of 41 cases on treatment for 6 to 10 years and 100% of 7 cases on treatment above 10 years have viral suppression; 2) There no opportunistic infection except for one child who developed mycobacteria infection after 2 years of treatment; 3) According to the latest criteria of China's 0-18 years old children' height and weight, 70 of 108 children (64.8%) reached the standard height and 74 cases (68.5%) reached the standard weight; 4) 2 children dropped out of the treatment and the rate of drop out was 1%.

2. Good social adaptability of children living with HIV on ARV treatment

All children living with HIV who have reached school age have received school education, and some of them win good scores in school. In 2018, one child who begun taking antiviral drugs since childhood participated in the college entrance examination and his scores exceeded the admission score line of a key university in China.

LESSONS LEARNED AND RECOMMENDATIONS

While children living with HIV could be nearly convalescent physiologically with the help of successful antiviral treatment, they will still face to many difficulties and challenges in future, such as mental and psychological changes in adolescence and affairs on love, marriage and fertility in adulthood. Therefore, it is necessary to establish a direct referral mechanism for these children between the center and the other medical institution and social organizations to provide a life-long health guarantee. In future, Yunnan AIDS Care Center will continue to

introduce advanced management on children's treatment and promote their successful experience throughout Yunnan province and the country so that more children get the best treatment and care services.

32. China

TITLE OF THE PROGRAMME: National Health Commission-UNICEF Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B Project

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- **Programme is being implemented since:** 2017 - **End** (if applicable): 2020
- **Responsible party/parties:** Government, UN or other inter-governmental organization
- **Population group(s) reached:** Pregnant women and children, Children living with HIV, Adolescents and young people living with HIV, Migrants, refugees or internally displaced children and young people
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Mother-to-Child Transmission (MTCT) is an important contributor to HIV, syphilis and hepatitis B infection in children. The global community has committed itself to eliminating mother-to-child transmission (EMTCT) of HIV, syphilis and hepatitis B as a public health priority to ensure that children remain free from three diseases and their mothers stay alive and well.

In collaboration with UNICEF, the China first-ever prevention of mother-to-child transmission (PMTCT) pilot on HIV was launched in 2001. In past decades, China has successfully embarked on a path of PMTCT with the forward-looking integrated prevention for the three vertically transmitted diseases - HIV, syphilis and hepatitis B, imbedded in the existing maternal and child health (MCH) system. Remarkable progress has been made with MTCT of HIV and the MTCT rate decreased from 34.8 per cent before programme initiation in 2001 to 5.5 per cent in 2017. Similarly, the increasing trend of congenital cases of mother-to-child transmission of syphilis has been reversed since 2011, and the incidence rate of congenital syphilis was 21.9 per 100,000 live birth in 2017. Among children aged 1-4 years, the prevalence of HBsAg declined from 0.96 per cent in 2006 to 0.32 per cent in 2014.

Despite enormous progress achieved in China, the shift from “prevention” to “elimination” is

not an easy task. The number of infected pregnant women detected and reported each year remains high even when measured against China's large population size. Being a long-term and strategic partner with National Health Commission (NHC), UNICEF initiated the Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B Project (EMTCT Project) in 2017, with technical support from WHO and UNAIDS. It will support to the further improvement of the efficiency and quality of PMTCT services, and so that help China to achieve the global goal of EMTCT of HIV, syphilis and Hepatitis B.

DESCRIPTION

Goal

Based on WHO validation criteria, with focus on four prioritized areas, explore and establish management mechanism and service provision model for EMTCT of HIV, syphilis and hepatitis B in different local scenarios, to achieve the EMTCT goals in project sites and serve as a driving force to prepare China for validation of triple elimination after 2020.

Objectives

By the end of 2020, the following objectives are expected to be achieved in project sites:

- (1) MTCT rate of HIV <2%;
- (2) Case rate of congenital syphilis of ≤50 per 100,000 live births;
- (3) MTCT rate of hepatitis B <2%;
- (4) Antenatal care (ANC) coverage ≥95%;
- (5) Proportion of pregnant women received HIV, syphilis and hepatitis B testing ≥95%;
- (6) Proportion of pregnant women received HIV, syphilis and hepatitis B testing in the first trimester ≥80%;
- (7) Proportion of HIV-positive pregnant women received antiretroviral therapy (ART) ≥95%;
- (8) Proportion of syphilis seropositive pregnant women received treatment ≥95%;
- (9) Proportion of children born to women with positive-HBsAg received hepatitis B immunoglobulin (HBIG) ≥95%;
- (10) Proportion of HIV-exposed children received early infant diagnosis (EID) tests ≥90%.

Geographical coverage

In 2017-2018, the programme covers six counties of three provinces (sub-national level administrative region), with high epidemic of HIV, syphilis or hepatitis B. Since 2019, the programme scaled-up to cover the whole three provinces.

Beneficiaries

- Women and children: Women of reproductive age (including adolescent girls) and their partners; pregnant women and HIV, syphilis or hepatitis B exposed children and their caregivers.
- Service providers: Maternal and child health service providers at all levels from project areas.
- Government officials: Officials from health and other relevant government sectors at national level and from project areas.

Strategic approach and timeline for national adoption

Building on the results and experiences achieved in the NHC-UNICEF EMTCT project, the government of China will develop national Implementation Plan for EMTCT of HIV, Syphilis and Hepatitis B, conduct internal validation for each province, and prepare for the nation-wide validation, guided by the WHO validation criteria and tools. Step-wise approach is designed for national adoption of triple EMTCT in China:

Phase 1. Preparation phase (2016-2017): National and sub-national level capacity building; gap analysis of national PMTCT programme; adoption of WHO validation criteria and tools;

develop triple elimination framework is completed.

Phase 2. Implementation phase (2017-2020): Pilot and model exercise of triple EMTCT in three provinces, with the new approaches for multiple access points and services to ensure high quality care without gaps, with more reliable data and improved transparency, and increased community engagement, human rights and respecting confidentiality.

Phase 3. National scale-up (after 2020)

Strategies

1. Establish EMTCT working mechanism and national, subnational and local levels
2. Promote equity in PMTCT service utilization and standardize PMTCT service provision
3. Improve information collection and data quality, and conduct monitoring and evaluation
4. Standardize laboratory management for high-quality testing services
5. Promote human rights, gender equality and community engagement

Management and funding support

The project is co-managed by NHC and UNICEF China, with National Center for Women and Children's Health, China CDC provides technical support and daily management. WHO and UNAIDS China offices also provide technical support to this project. A total funding of 2.5 million USD is provided by UNICEF for 2016-2020.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

1. By the end of 2018, the government of three project provinces (Yunnan, Guangdong and Zhejiang) committed to scaling up EMTCT experiences from the six project counties to other regions of the provinces by 2019 and achieving EMTCT targets by 2020 across the whole province.

All project counties/districts have included EMTCT indicators in performance-based evaluation mechanisms for health officials. Governors or vice-governors have taken a leading role in the EMTCT Working Group at provincial and local levels.

After provincial-wide scale up, the project will provide PMTCT-related services to about 3.4 million pregnant women and children born to them on annual basis.

2. Besides financial support from UNICEF, matched funding for EMTCT was also provided by different levels of local government, including 3.7 million RMB (US\$552,000) from provincial governments, and 3.5 million RMB (US\$530,000) from county/district governments in the project areas.

3. In total, 45 training events were held in the project sites, covering 6,222 local health providers and community workers. 92 per cent of the 109 health facilities in the six project sites had trained staff responsible for EMTCT-related information management; 90 per cent had HIV, syphilis and hepatitis B testing records in ANC clinics and 84 per cent had established a data reporting mechanism within their health facility.

4. The results achieved up to date has provided solid evidences and experiences for national PMTCT guidelines and relevant tools update, as well as influenced the PMTCT/EMTCT relevant strategy development and indicators and targets determination within the new National Action Plan for Women and Children Development (2021-2030) .

5. With UNICEF's financial and technical support, the abstract "Challenges of eliminating

mother-to-child transmission of HIV, syphilis and hepatitis B in China: a cross-sectoral survey” was published in The Lancet journal in October 2018.

LESSONS LEARNED AND RECOMMENDATIONS

1. Highest level of political commitment at the Central and sub-national level is key to ensuring high quality services and equitable coverage.
2. A joined-up government led strategy, assigning clear roles and responsibilities for cross-sectoral collaboration within and outside health sector, and closely coordinated among different sectors and levels of government are fundamental to ensure the smooth implementation of project strategies and activities.
3. Triple EMTCT should be embedded within and build on the MCH system for sustainability and universal coverage.
4. Data should drive decision making, and a functional management information system that is linked to the overall health information system is critical to achieving the EMTCT targets.

ANNEXES

The abstract “Challenges of eliminating mother-to-child transmission of HIV, syphilis and hepatitis B in China: a cross-sectoral survey” published in The Lancet journal in October 2018.

33. Indonesia

TITLE OF THE PROGRAMME: Module for PMTCT

CONTACT PERSON

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- **Programme is being implemented since:** 2017 - **End** (if applicable): Ongoing
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization, Academic institution
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** The programme has been included as a key component of the national PMTCT interventions.

BACKGROUND

Indonesia's achievements against the 90-90-90 targets remain low at 50-18-1. This includes the PMTCT coverage at only 17%. Many factors contribute to this low achievement, ranging from gender inequality to other challenges to accessing services. For most women, lack of bargaining power in relationships and a difficulty to talk about sexual and reproductive health exacerbates this situation.

DESCRIPTION

IPPI, the Indonesian Positive Women Network, has developed an innovative job-aid in the form of a comic featuring a character called Arumi. This tool has facilitated greater understanding of the need of positive women around sexual reproductive health rights and PMTCT. Through IPPI's network, and the Mama's Club, the program has been implemented in 16 districts (across 12 of the 34 provinces).

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Use of the tool has made it easier for the community to understand and relate to PLHIV. The training courses on SRH and PMTCT have empowered HIV positive women and provided them with greater bargaining power to manage their own health. The health workers also have been better equipped to discuss sexual reproductive health needs of women living with HIV. The program has also succeeded in disseminating knowledge around SRH and PMTCT among outreach workers and the communities. In the 16 districts where the program has been implemented, there is remarkably higher coverage of PMTCT programs.

LESSONS LEARNED AND RECOMMENDATIONS

Building on this promising result, IPPI would like to expand this program in an additional 16 districts (i.e. through the upcoming Global Fund grant 2021-2023). There has been interest from other countries to adapt a similar tool for their PMTCT programs. It is going to be recommended as the strategy in the upcoming National Strategic Plan.

ANNEXES

IPPI's report on the implementation of the PMTCT program / comic (Arumi)

34. Indonesia

TITLE OF THE PROGRAMME: LOLIPOP (Linkage of Quality Care for Young Key Population)

CONTACT PERSON

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- **Programme is being implemented since:** 2014 - **End** (if applicable): N/A
- **Responsible party/parties:** Civil society
- **Population group(s) reached:** Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Global Fund Country Grant

BACKGROUND

The Integrated Biological and Behavioral Survey (IBBS, Key Population) 2011 showed that the HIV prevalence varied by key population: direct FSWs at 10%; indirect FSWs at 3%; transgender at 22%; FSWs' clients at 0.8%; men who have sex with men (MSM) at 8% and injecting drug users (IDUs) at 41%. The data indicated that one out of three key populations were adolescents and young people between 15-24 years old and have experimented with sexuality or drugs. In addition, the secondary data analysis of IBBS showed that YKPs had a high infection rate and were in the centre of HIV epidemic but they had limited access to information and services.

In response, the then National AIDS Commission (NAC) together with Ministry of Health (MoH) Indonesia, UNICEF Indonesia, Inti Muda (then Fokus Muda), Burnett Institute and Padjajaran University developed a program targeted to YKP in 2014. The YKP was integrated with Layanan Komprehensif Berkesinambungan (Continuous and Comprehensive Service) and SUFA (Strategic Use of ARV) which aimed to increase YKPs' access to HIV services including testing, treatment, and compliance to ARV.

The program was later called HIV LOLIPOP (Linkage of Quality Care for Young Key Population), and was implemented in Bandung as the demonstration site in 2014. Bandung was chosen because it is the capital city of the province that has the third biggest population

in Indonesia. Furthermore, Bandung also had some universities and non-governmental organizations that work around HIV and AIDS issues, which made the city a strategic location for implementing this pilot program. It was hoped that LOLIPOP program could further strengthen HIV programs that already existed in Bandung.

DESCRIPTION

LOLIPOP is a program designed to increase testing, treatment, and adherence, and decrease new infection among young key populations in Indonesia. The four key components of the program include [1] enabling environment; [2] supply side; [3] demand creation; and [4] strategic information.

An enabling environment was needed for developing supportive laws, policies, and providing guidelines to address the structural barriers. Moreover, it could change the behaviour and eliminate the harmful social norms, attitudes, and practices. The National AIDS Commission played a strategic role in creating a conducive and enabling environment for the program. The NAC was in charge of coordinating the support to prioritize YKPs in the policies and programs at the national and district level, including the coordination between the government and YKPs' networks. NAC as the leading government agency on national HIV response was placed at a strategic position to create an enabling environment. The Ministry of Health was the leading agency to fulfil the HIV services in terms of supplies, commodities, and the health workers. It is the supply side of the program. The service commodity included the procurement of condoms, contraception, and drugs for adolescents. They also trained the health workers to be able to provide youth-friendly services followed by the technical assistance and monitoring of the services. Inti Muda, the national YKPs' network, and Indonesia AIDS Coalition (IAC) were responsible for increasing the demand amongst YKPs to seek the services and treatment. Strategies to stimulate demand included the creative use of prevention and promotional materials, unique and youth-friendly branding, face-to-face outreach, mobile SMS information, modelling innovative outreach using digital platform. Furthermore, Inti Muda conducted trainings for the field officer and peer education.

The final component in the LOLIPOP framework was the production of strategic information generated from the program in a scientific manner and was led by Pusdi TB HIV/ Padjajaran University. The data, information would be the basis and evidence for decision-making process, in terms of planning, implementing, evaluating, and developing YKP programs.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

LOLIPOP in Bandung really brought together government, UN agencies, academia, health workers and the YKP for common purpose as envisioned by the program. It was an exemplary coordination for the targeted YKP program in the country. In particular, the equal partnership between young people and adults in this program was an added value.

In less than one year of the implementation of LOLIPOP program in Bandung, there were outputs produced by the LOLIPOP team based on the report developed by LOLIPOP internal team. These outputs were: [1] a baselined data on YKPs; [2] a comprehensive model framework for YKPs-Friendly HIV programming; [3] integrated digital infrastructure to support demand; [4] comprehensive YKPs capacity building package that consisted of resources for friendly services provider, YKP leadership, and for outreach worker; and [5] a model of IEC materials for YKPs.

Due to lack of completed evaluation data, the impact level data could not be presented. After the successful piloting of the LOLIPOP program in Bandung, the team initiated the discussion at the national level to scale up the program in several other provinces. The

scale-up was proposed not only because of the output product of the piloting, but, most importantly, because of the increasing number of HIV cases amongst young people, particularly the young key populations. The stakeholders, including the government, were convinced that LOLIPOP is the innovative approach to address the increasing HIV infections among the young key populations. The possibilities of scale up were explored and Global Fund was one of the promising options for funding. UNICEF led the process in coordination with National AIDS Commission, the Ministry of Health and Inti Muda. Series of coordination and technical meetings were organized to collect the evidence, results of the program in order to determine the strategies and roles of the engaged partners.

On the other hand, Inti Muda, as the representative of YKPs, consistently and actively participated in Country Dialogues during the development of the NSAP and GF proposal development process. Even though Inti Muda faced lots of difficulties in creating their space at the national level, their consistency over time was the game-changer. They also formed alliances with the existing CSOs, national network of key populations, the government and UN agencies for support and to magnify their voices. As a result, NSAP prioritized the YKPs.

In the meantime, Inti Muda conducted outreach and initiated dialogue with Country Coordination Mechanism (CCM) members representing the key populations and demanded to prioritize YKPs needs. They advocated for creating specific achievement indicators for YKPs in the GF concept note. However, the issue on having specific YKP indicators was met with a fierce resistance from the CCM. The counter-argument was that YKPs were already supported with broader KP programs and the modular template of the GF concept note had limitations to include additional indicators disaggregated by age.

UNICEF played a key role in ensuring that the proposed activities of LOLIPOP would not fall off track or get twisted during the grant-making process. They coordinated with SPIRITIA, the Principle Recipient (PR), who was responsible for managing the LOLIPOP activities. Eventually, SPIRITIA became a great ally to YKP and the LOLIPOP program, despite various implementation difficulties. The program was replicated in three provinces of Indonesia, i.e. Denpasar, Surabaya and West Jakarta.

LESSONS LERNED AND RECOMMENDATIONS

LOLIPOP program is a multi-sectoral partnership program targeted for YKP and formulated with the meaningful engagement of YKP. It was initially piloted in Bandung and now has been scaled up in the other three provinces. Inti-Muda, then Fokus Muda, as the national network of YKP played a liaising and coordinating role with the diverse stakeholders and held their ground firmly during the pilot and eventually brought it to the national level for the scale-up. The program provides key lessons and reflection on the meaningful engagement of young people and their leadership leading to impactful and sustainable interventions. Inti Muda played the coordinating role and generated the demand during the pilot while played a key activism role to scale up the program through the Global Fund grant. Numerous challenges were highlighted in question 20.

35. Mongolia

TITLE OF THE PROGRAMME: Hidden Love: A short documentary on young LGBT community in Mongolia

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- **Programme is being implemented since:** 2019 - **End** (if applicable): N/A
- **Responsible party/parties:** Civil society
- **Population group(s) reached:** Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

The LGBT community are bulging in numbers in Mongolia. The recent data says that there are at least 30 thousand of them in the country. Given the conservative and traditional cultures, there is a rampant stigma and discriminations amongst the LGBT community and especially the younger ones are more vulnerable due to lack of coping skills, knowledge and understanding of the issue. There are few outstanding LGBT organizations such as LGBT CentRE, Youth For Health but they don't specifically work on young LGBT. So, Youth LEAD Mongolia (YLM), the national network of YKP has spearheaded the campaigns addressing the issues of younger LGBT. In response, recently in 2019, YLM produced a video titled Hidden Love to address the relationship, sexuality and stigma amongst younger LGBT community. The video won the first place in short film festival organized by LGBT CentRE and second place in Free and Equal campaign by UN Mongolia.

DESCRIPTION

HIDDEN LOVE presents the expectations as opposed to lived realities of the LGBT community particularly of gay men in Mongolia with aim to spread the message of love. Youth LEAD, the regional network, financially supported the production of the movie and was managed by Youth LEAD Mongolia. The movie is inspired by the real life of the current national coordinator of Youth LEAD Mongolia and he has played the leading role in the movie. The script, videography and direction of the movie was done by the young LGBT members of Youth LEAD Mongolia portraying the true youth leadership. The primary focus of the video is to reach out the young LGBT community with the message of relationship,

awareness and sexuality. It was launched through the social media page and broadcasted through public movie theatre, short film festival and the UN platform.

The production team is also looking forward to opportunities to submit the short film as an entry to international LGBT short film festivals.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The video has been viewed by 27K viewers in two months' time with 1000 comments (<https://www.facebook.com/LGBTtuv/videos/374153070144934/>). Similarly, the award won by the video has been published in like-minded regional network's newsletter (<https://apcom.org/2019/09/16/lgbt-short-films-celebrated-during-mongolias-pride-week/>).

The award given to the video can be accessed via this link
<https://www.facebook.com/LGBTtuv/photos/a.791064500957349/2529263027137479/?type=3&theater>.

LESSONS LEARNED AND RECOMMENDATIONS

Youth LEAD Mongolia (YLM) is the only key national organisation working on young key populations with focus on young LGBT community. So, it has been strategically placed to respond to the issues of YKP at the national level. Given the changing context of Mongolia with the increasing use of social media amongst the young people, YLM rightly addressed the issues of young LGBT through video and campaigns.

The video is produced under the leadership of younger LGBT community including the actor, videographer, script-writer and the director. Given the right opportunity, platform and resource the video is the reflection of the true youth leadership.

36. Thailand

TITLE OF THE PROGRAMME: THE TIME IS NOW: Guidance and inspiration for a new era of SRHR and HIV programming for young key populations in Asia-Pacific

CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End** (if applicable): 2019
- **Responsible party/parties:** Civil society
- **Population group(s) reached:** Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Over the last four years, various global, regional and national partners including donors, UN agencies, technical partners and key population networks have collaborated to develop the key population implementation tools for sex workers (SWIT), men who have sex with men (MSMIT), people who inject drugs (IDUIT) and transgender people (TRANSIT). The tools have been referenced as the strategic and guiding document to develop national programs on HIV and key populations and importantly to develop Global Fund proposals relating to programming for key populations. UNAIDS, UNICEF, UNFPA, UNODC, UNDP, and other partners have continued to actively promote and support uptake of the tools at country and regional levels over the last year.

However, these implementation toolkits do not cater and incorporate the unique needs of youth cohorts within the key populations known as young key populations (YKP). YKP technical briefs were developed by WHO in collaboration with various partners and youth-led organizations in 2015. The briefs are great advocacy documents and provide a rationale to invest in the programming of YKP, but they do not provide sufficient guidance to develop interventions on YKP.

To respond UNFPA and IPPF from the EECA region have come up with A Practical Tool for HIV and Sexual and Reproductive Health Programmes with Young Key Populations in Eastern Europe and Central Asia, much similar to the implementation toolkit for YKP. The toolkit, however, is specific to EECA region.

With this backdrop, Youth LEAD developed the regional Implementation toolkit for YKP specific to Asia and the Pacific.

DESCRIPTION

The case study presented aims to present an example of programmes to empower and engage adolescents and youth in the HIV response as beneficiaries, partners and leaders. The YKP Implementation toolkit as explained above is developed by Youth LEAD, the regional YKP organisation, in support with the donor and the technical agencies.

This toolkit takes into account the specific situation of YKP across the Asia-Pacific region, where young people aged 10 to 24 account for thirty-five percent of new HIV infections¹ and where a total of 510,000 young people aged 15 to 24 are living with HIV (220,000 females and 290,000 males).² The literature review for this toolkit has revealed that the needs, issues and priorities of YKP in Asia-Pacific remained the same as those identified through a regional study in 2015 by YouthLEAD:

- SRHR issues of YKP remained overlooked in programming
- Restrictive laws contributed to the continued marginalisation and discrimination of YKP
- Stigma and discrimination remained huge barriers in accessing health services for YKP
- Comprehensive sexuality education, both in and out-of-school remained inaccessible for YKP
- Despite these challenges, there were a number of youth-led organisations in the region implementing and organising innovative approaches to reach YKP

The objectives of the toolkit are:

- to highlight the unique needs of young key populations in the Asia-Pacific region
- to guide and inspire the development of comprehensive regional and national programmes for the SRHR, including HIV, of YKP in the Asia-Pacific region
- to be a guide for developing proposals relating to programming for YKP in the Asia-Pacific region for different donors, including the Global Fund

The toolkit development process was managed and led by Youth LEAD with financial support from UNFPA APRO Robert Carr Fund and the Global Fund (CRG Strategic Initiatives and the TA grant). The process included

- Regional consultation (1 June 2018)
- Desk-based literature review (the team of two technical and two youth consultants)
- Regional survey on YKP
- In-country research in Indonesia, Vietnam and Myanmar
- Case studies on diverse programs of YKP
- Validation workshop (29-30 October 2018)
- Review the YKP peer and the global external experts

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The toolkit has not been implemented in any country until this case study has been submitted. The toolkit itself is the outcome of the youth leadership where Youth LEAD initiated the process, mobilized resources and actively managed the diverse process to develop the toolkit. The process has been explained in question 18. The YKP leaders were the facilitators of the regional consultation, led the research at the countries and actively collected the case studies followed by the review of the draft toolkit.

The Global Fund multi-country grant in Asia and the Pacific has supported the first regional training of the toolkit in the presence of eight countries (Laos, Sri-Lanka, PNG, Timor Leste, Mongolia, Vietnam, Indonesia, and Myanmar) from 17-19 October in Bali which was facilitated by Youth LEAD. The in-country training for PNG and Timor Leste is supported by the same grant and is scheduled for November 2019.

LESSONS LEARNED AND RECOMMENDATIONS

Youth LEAD spearheaded the concept of the YKP toolkit for Asia and the Pacific followed by a similar toolkit in EECA region. UNFPA APRO and the Global Fund CRG- Strategic Initiative jumped in to support the process with the limited amount from which we picky-bagged the first consultation in June 2018. The consultation unfolded the robust process for which the resource was short. Youth LEAD allocated some resource from its existing Robert Carr Fund and started the resource mobilization dialogue with potential donors. Eventually, UNFPA APRO and the Global Fund TA grant added up the financial resource.

The toolkit discussion which started with 10K USD funding ended up spending 100K by the time it was completed. Most importantly since it was led by Youth LEAD, the YKP in the region owned the toolkit and also received further support to implement it at the country level.

ANNEXES

Draft YKP toolkit

III. EASTERN EUROPE AND CENTRAL ASIAN STATES

37. Kazakhstan

TITLE OF THE PROGRAMME: Densaulyk

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- **Programme is being implemented since:** Social assistance of children and adolescents living with HIV since 2013 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify here:** State program for the development of health care of the Republic of Kazakhstan

BACKGROUND

This is a state programme funded by the budgets of the local public authorities to support families affected by HIV and children and adolescents living with HIV with monetary incentives by the age of 16. Additionally, all children born from HIV positive mothers in Kazakhstan receive milk substitutes for free by reaching the age of 12.

DESCRIPTION

In short, the programme consists of social protection under the form of monetary incentives given to families affected by HIV and children and adolescents living with HIV. The programme is managed, coordinated and financed by the local public authorities in cooperation with the district Medical AIDS Centre. The sustainability is being ensured by the government funding. The programme is being implemented in 3 regions of Kazakhstan where the biggest number of children with HIV are registered. Free milk substitutes are funded by the government and covers all children in Kazakhstan born from HIV positive mothers.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The financial support the families receive allowed to ensure that children are staying in families and are not given up and institutionalized. The incentives also allowed to reduce mortality to zero among children and adolescents living with HIV in the regions where social assistance is being delivered because of the improved nutrition.

LESSONS LEARNED AND RECOMMENDATIONS

Developing mechanisms to ensure confidentiality of personal data is very important. The programme should be scaled up nationwide.

ANNEXES

Medical and Social Services for Key Affected Populations 2015 - review by NGO Aman Saulyk, funded by USAID with Technical support from UNAIDS.

IV. LATIN AMERICAN AND CARRIBEAN STATES

38. Antigua and Barbuda

TITLE OF THE PROGRAMME: Prevention of Mother-to-child Transmission Programme

CONTACT PERSON

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- **Programme is being implemented since:** N/A - **End** (if applicable): N/A
- **Responsible party/parties:** Private health institutions, Government
- **Population group(s) reached:** Mothers living with HIV, Children living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

N/A

DESCRIPTION

Antigua and Barbuda employs a community nursing model in which district nurses conduct home visits to encourage women to come in to health centres near the start of their pregnancies and to keep their appointments.

The country takes full advantage of its primary healthcare system, using its 26 community clinics to ensure that every woman had easy geographical access to antenatal care.

The Health Ministry provides free anti-retroviral medication for women who test positive for HIV and free formula.

Mothers living with HIV are encouraged not to breastfeed.

Dedicated counsellors follow up with mothers living with HIV, liaising where necessary with the country's Clinical Care Coordinator at the HIV clinic at the Mount St. John Medical Centre. The Paediatric Unit at the hospital also provides follow-up care to infants through its outpatient clinic.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Antigua was certified by the World Health Organization (WHO) as having eliminated mother-to-child transmission of HIV and syphilis in 2017

LESSONS LEARNED AND RECOMMENDATIONS

The Antigua and Barbuda approach overcomes the barriers of language and migration status. A policy decision to provide healthcare to migrants has been especially important given the country's relatively large Spanish-speaking community.

Using a cadre of health care providers who speak Spanish, the Health Ministry ensured that Spanish-speaking women received quality treatment and care in their native language.

With a population of just over 90,000 and close-knit communities, special care had to be taken to strengthen confidentiality and address stigma and discrimination in healthcare settings. A Human Rights desk at the National AIDS Secretariat and two non-governmental organizations work with the Health Ministry to address any challenges related to stigma and discrimination. In addition, healthcare providers have received anti-stigma and discrimination training to address issues including unconscious bias and confidentiality.

A relationship of trust has been built between the public and private healthcare sectors. Private physicians are assured that there are no issues with confidentiality and that all data will be treated in an appropriate manner.

Key players include nurses supporting Antigua and Barbuda's antenatal care services and the National AIDS Secretariat.

39. Colombia

TITLE OF THE PROGRAMME: Programa de VIH

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- **Programme is being implemented since:** La estrategia para la eliminación de la transmisión materno infantil del VIH y de la sífilis congénita esta implementada desde el 2003, 2016 se unió el componente de hepatitis B y 2017 enfermedad de Chagas. Existe la Cuenta de Alto Costo en VIH inicio en 2011 y da cuenta del seguimiento de la atención en VIH y estado clínico de las personas viviendo con VIH. - **End** (if applicable): Estas estrategias de TMI y programa VIH son estables en el tiempo.
- **Responsible party/parties:** Government, Civil society, Private sector, UN or other inter-governmental organization, Academic institution
- **Population group(s) reached:** población que se encuentre en el país, Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations, Adolescent boys and young men in general population, Migrants, refugees or internally displaced children and young people
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** La estrategia de TMI-Plus forma parte del programa nacional realiza el seguimiento nominal del binomio madre hijo del VIH y da cuenta de cada una de las intervenciones que se suministra a la madre con VIH como a su hijo expuesto y llega hasta la clasificación final del niño ya sea sano o con VIH. El niño con VIH ingresa a un programa de VIH en donde está en forma establece recibiendo atención integral; de igual manera la Cuenta de Alto Costo da seguimiento a la evolución clínica de las PPV sin importar si son niños, jóvenes o adultos y contempla las poblaciones clave como prioritarias. El programa de VIH suministra los datos de la epidemia al país.

BACKGROUND

Respuesta: Colombia tiene un sistema de salud basado en el aseguramiento, lo cual permite que todas las personas con VIH tengan acceso al programa y reciban en forma continua los medicamentos ARV y todos los exámenes y otras tecnologías necesarias para su seguimiento clínico; de igual manera el programa realiza búsqueda, captación y diagnóstico de VIH, esta actividad esta implementado en todo el territorio nacional. De igual manera está presente en Colombia el Fondo Mundial que ha permitido ampliar la oferta de atenciones a las poblaciones clave como la entrega de paquetes educativos (educación, condones, lubricantes y tamizaje). De acuerdo al comportamiento epidemiológico se tiene para el 2017 un porcentaje de TMI del VIH de 2,2%, prevalencia 2018 de 15 a 49 años 0,4%, cobertura de TAR 2017 del 82,9%, porcentaje de personas con diagnóstico temprano de VIH (CD4 mayor de 500) del 23% en el 2017, el comportamiento de la mortalidad por VIH/Sida en los últimos 10 años ha variado entre 5,4 y 5,1 por 100.000 habitantes.

Relaciono el link donde podrá consultar otras publicaciones realizadas por la Cuenta de Alto Costo VIH <https://cuentadealtocosto.org> y en los siguientes enlaces del Ministerio de Salud y Protección Social podrá encontrar datos y publicaciones con referencia al tema

- <https://www.minsalud.gov.co/salud/publica/SSR/Paginas/home-salud-sexual.aspx>
- <https://www.minsalud.gov.co/sites/rid/Paginas/buscar.aspx>

DESCRIPTION

El programa de VIH está dirigido a toda la población que tiene un diagnóstico de VIH sin importar el grupo de edad; Colombia tiene un sistema de salud basado en el aseguramiento de las personas, por lo cual cada Entidad Administradora de Planes de Beneficios tiene los recursos financieros para garantizar la atención a las personas bajo su aseguramiento; de igual manera el Ministerio emite cada año un acto normativo donde se actualiza íntegramente el Plan de Beneficios en Salud con Cargo a la Unidad de Pago por Capitación, el cual es de obligatorio cumplimiento en todo el territorio nacional. De igual manera la Resolución 3280 de 2018 emitida por este ministerio, por medio de la cual se adopta los lineamientos técnicos y operativos de la Ruta Integral de Atención en Salud para la Población Materno Perinatal y se establece las directrices para su operación de obligatorio cumplimiento en todo el territorio nacional. Cabe resaltar que los recursos invertidos por el Fondo Mundial dirigido a impactar en la epidemia de VIH de poblaciones clave son invertidos en el país bajo la asistencia técnica de este Ministerio. Con el proceso migratorio de población venezolana se ha recibido cooperación internacional con referencia a donaciones de medicamentos antirretrovirales y otros insumos que ha permitido la atención humanitaria. De igual manera existen los servicios amigables dirigidos a jóvenes y adolescentes con énfasis en salud sexual y reproductiva, recibiendo una atención diferencial. Existen documentos marco que dan cuenta del alcance programático en VIH como: el Plan Decenal de Salud Pública 2012-2021, el Plan Nacional de Respuesta Ante las ITS, el VIH, la Coinfección TB/VIH y las Hepatitis B y C, Colombia 2018-2022, Guías de práctica clínica basadas en la evidencia para el manejo del VIH. Todos estos documentos los encontraran en los link anteriormente señalados.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Los resultados logrados por el país se encuentran referenciados en el numeral 18. Se anexa cuadro con la inversión realizada en VIH por el Minsalud, entidades territoriales de los años 2016 al 2018. En esta inversión están contemplados la compra de condones y otros insumos.

LESSONS LEARNED AND RECOMMENDATIONS

En la implementación de la respuesta nacional en VIH participan activamente la sociedad civil teniendo representación en varias instancias como el Comité Nacional de Sida, el

Mecanismo Coordinador de País.

Con base en las características de la epidemia de VIH a nivel nacional es necesario fortalecer las medidas de detección temprana y protección específica, que contribuyan a reducir el riesgo de infección en las poblacionales clave y población general.

Es necesario continuar trabajando en el mejoramiento de la calidad de la información reportada al Sistema Nacional de Vigilancia en Salud Pública, de manera que todas las entidades territoriales apliquen el algoritmo diagnóstico de forma correcta.

Teniendo en cuenta la Resolución 3280 de 2018, es necesario fortalecer la captación de casos en la población general, sin discriminar sexo ni orientaciones sexuales, en todas las edades y en todos los momentos del curso de vida.

Se debe fortalecer el entrenamiento del talento humano en salud para la realización de pruebas rápidas, de acuerdo con la establecido en la Resolución 2338 de 2013 y posibles modificaciones.

Implementar y fortalecer las acciones establecidas en la estrategia de prevención combinada, la cual incluye: Autotest, profilaxis pre exposición, profilaxis pos exposición, uso del preservativo, oferta de la prueba de tamizaje y otras acciones orientadas al cambio conductual.

ANNEXES

En los link anteriormente señalados encontrara la información disponible.

40. Venezuela

TITLE OF THE PROGRAMME: Plan de Reducció del Embarazo a Temprana edad y en la Adolescencia. PRETA

CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End** (if applicable): 2019
- **Responsible party/parties:** Government, Civil society, UN or other inter-governmental organization
- **Population group(s) reached:** Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Intersectoral plan that includes government entities and civil society as part of a national effort to reduce adolescent pregnancy

BACKGROUND

Venezuela is suffering a complex humanitarian crisis, that affects the entire population in its availability of health services, education, basic services, sexual and reproductive rights, especially for the most vulnerable groups, including adolescents and youth.

23% of births in Venezuela are of a teenage mother (UNFPA World Population Report), The availability of contraceptives and condoms in public entities is very poor and private pharmacies although have irregular availability, and costs are too high for most of the population. There is a massive emigration of health personnel, deterioration of health centres with failures in basic services such as electricity and water. A significant number of adolescents leave school for caring for younger siblings whose parents emigrated and to work.

DESCRIPTION

The objectives of the program are to offer comprehensive health services to the most vulnerable adolescents with emphasis on preventing the transmission of HIV and other STIs. The funds are those corresponding to UBRAF (UNAIDS) and UNFPA worked as a leader of the common project. Work is being carried out in the Carabobo State, within the State that is geographically large and with remote and difficult access areas. Vulnerable locations were selected, such as a settlement of precarious homes without public services call, In the

project, the MOH is involved as governing body since the opening of the differentiated services of adolescent attention are part of a national policy, the state health authorities with which an agreement was signed, the state education authorities, civil society, Venezuelan Infectious Medicine Society who provides technical support and the possibility of private care for adolescents with HIV diagnosed in the framework of the project. A non-governmental organization specializing in adolescents and young girls, "Niña Madre" acted as an IP for operational execution. Sustainability is supported by the generation of local capacities, the first year it was necessary that the facilitation to health personnel, community, adolescents and teachers were in charge of specialists from outside the state. For the opening of the next two centres, the workshops were facilitated by the already trained local staff. The local health authorities involved have made other centres open with technical support and with local funds.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Three centres of differentiated attention for adolescents in populations totalling 380,000 inhabitants. Health care that includes HIV diagnostic testing, education, condom delivery, dispensing of contraceptive methods, comprehensive evaluation, referral and treatment. Training of 60 health personnel in comprehensive care for adolescents, training in comprehensive sexuality education with emphasis in HIV prevention to 90 teachers, sensitization to 150 community leaders, continuous educational activities for adolescents, to date around 1000 participants

LESSONS LEARNED AND RECOMMENDATIONS

- Importance of including national and local authorities to allow sustainability
- Importance of multisectoral work such as health, education, protection, civil society
- In spite of very adverse social and economic circumstances when there is a motivated work team with technical and resource support, it is possible to achieve goals with significant impact
- Include community leaders and adolescents in decision making allows a better adaptation to each reality to better achieve the objectives
- Joint work among UN agencies facilitates actions

IV. WESTERN EUROPEAN AND OTHER STATES

41. The Netherlands

TITLE OF THE PROGRAMME: Multidisciplinary transition clinic for perinatally HIV infected adolescents in the Amsterdam UMC

CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End** (if applicable): N/A
- **Responsible party/parties:** Academic institution
- **Population group(s) reached:** Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

As a result of potent combination antiretroviral therapy (cART) a growing number of perinatally HIV infected children survive into adulthood. Therefore, the transitioning process, defined as the planned movement from paediatric to adult health care centres, has become increasingly important. This process of transition can be challenging in chronically ill adolescents and young adults (AYA) due to social and developmental issues (1), that can lead to loss to follow up and adherence problems (2). Further, insufficient communication between health care workers possibly leads to discontinuity of care. For HIV infected AYAs, the transition process, characterized by development and recognition of sexuality and increased awareness of HIV-related stigma is even more challenging. Indeed, in AYA living with HIV, several studies reported on problems after transition like risk of non-adherence, loss to follow up and lack of autonomy (3,4). Currently, there is consensus on the importance of early initiation of the transition process and utilisation of a transition protocol that may improve patient outcomes. The tools and processes that facilitate this transition process are unidentified. Although the utilisation of a transition protocol is recommended, a standardized or validated transition protocol is yet unavailable.

In 2016 we performed a study in the Netherlands on virological outcomes of perinatally infected AYA before and after transition. We found that these AYA were vulnerable to virological failure due to non-adherence during the transition period. Those who were at increased risk were AYA with a low education level and those with insufficient knowledge regarding HIV. Of 58 AYA, 8 were loss to follow up after transition (5). However, problems did not become apparent uniquely after transition to adult care, in the Netherlands usually at

the age of 18 years, but almost equally often while still in paediatric care, around the age of 17 years. Recent evaluation of viral suppression of those diagnosed with HIV before the age of 18 years, show suppression rates of only 83% in perinatally HIV infected young adults who were prescribed cART (aged 20-24) (6) .

These findings made us review our then operational transition protocol consisting of focus on disease specific knowledge, self-support and autonomy from the age of 12 years until the moment of transition to adult care and included one meeting with future health care providers before the actual transition to adult care at 18 years of age.

Positive experiences from a multidisciplinary transition clinic for AYA living with cystic fibrosis (7) convinced us to change our approach and offer this more intensive collaborated care to the AYA population in care at the paediatric HIV treatment centre.

DESCRIPTION

We adjusted the previous version of transition protocol to its current form. Since April 2018, we initiated a monthly multidisciplinary transition clinic for perinatally HIV infected adolescents in the Amsterdam UMC. This multidisciplinary transition clinic consists of both paediatric and adult healthcare providers (paediatric and adult HIV treating physicians, HIV specialist nurses, child psychologists and social workers). From the age of 16 to 18 years, the adolescent in transition meets every 3 to 6 months with the whole multidisciplinary transition team. The main objective is to offer medical as well as social and psychological care during a joined venture of paediatric and adult health care providers, to achieve the following goals; early detection of psychologic problems, improvement of clinical outcomes and retention in care.

Different stages of the transition process are described below:

Transition from 12 to 15 years:

- Patient and parent(s) are informed about the start of the transition process by their HIV treating paediatrician and HIV specialist nurse. Between the age of 12 and 15 years, adolescents will be stimulated to discuss their physical wellbeing and medication use with their health care providers. To detect and encounter psychosocial problems at an early stage, adolescents are invited to fill in a web based validated questionnaire on quality of life before each visit (www.hetklikt.com).
- Adolescents will be invited in the consultation room without their parents, who will join after the first half of the consult.
- Between the age of 15 and 16 years, patients have a meeting with the child psychologist and their HIV specialist nurse. In this one hour meeting an inventory of areas that need attention at the transition clinic is drawn up. We use an Individual Transition Plan (ITP) to discuss the following subjects: general health, disease specific knowledge, sports, sexuality, substance use, living circumstances, education, work, insurance and social relations.

Transition clinic 16-18 years:

- Shortly before their 16th birthday adolescents and their parents will receive a letter to inform them on the start of the multidisciplinary transition clinic.
- From the age of 16 years until the actual transfer at 18 years of age, patients will have regular outpatients medical check-ups with both their treating paediatric and adult infectious disease specialist. This is followed by a paediatric and adult HIV specialist nurse appointment. By meeting the adult HIV care providing health team a safe environment is provide to the adolescent patient. Additionally, the adult health care providers will be informed on specific issues regarding the AYA care.
- During their visit at the transition clinic, adolescents and their parents will meet different health care providers in a so-called carrousel clinic. A visit will take 1,5 hour and consists of three sessions of 30 minutes. The adolescent talks to the team of doctors, nurses and the

child psychologist consecutively. A social worker is available for parents to support them in their changing role. It is important that parents realise that their support is still needed, although their child has to develop independency.

To measure psychological outcomes, we use anxiety and depression scores (Patient Health Questionnaire (PHQ), Generalized Anxiety Disorder (GAD)) and KLIK (www.hetklikt.nu). KLIK is a Patient Reported Outcome Measure (PROM) portal used in clinical care. Patients and/or parents complete PROMs (HRQOL, symptoms or psychosocial functioning) online at home, prior to the outpatient consultation. The answers are converted into an electronic KLIK PROfile and are directly available for the healthcare professional. The healthcare professional discusses the KLIK ePROfile during the consultation, to monitor well-being over time, detect psychosocial or HRQOL problems or symptoms early and provide tailored advice and interventions.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

An evaluation of the transition clinic will be done, once the transition clinic runs for 4 years. In this way structures and routines of the transition clinic are expected to be more or less standardized (8). Outcomes of interest will be retention in care, HRQoL, detection of psychological problems and improvement of clinical outcomes.

In the Netherlands, 192 children < 18 years receive care at one of the 4 paediatric HIV centres. The transition clinic program will potentially be rolled out to the other 3 centres and could set an example for other developed countries.

From April 2018 on, 14 adolescents started at the transition clinic of whom 13 participated in the one-hour meeting with the child psychologist. Currently, 4 adolescents who participated in the project receive care at the adult clinic and had at least one visit there.

LESSONS LEARNED AND RECOMMENDATIONS

The program could not have been implemented without the willingness of participating disciplines to step away from their regular way of working. The time spent at the adolescent clinic by the adult providers, is not declarable. We started this project with a very motivated team, who all are devoted to improving the care for this special group were possible. The major challenge at this stage is of logistic matter. It is important that everybody arrives in time since there are three patients arriving together and start simultaneously with their consult at one of three disciplines. After 30 minutes patient switch to another room. In this way, 3 patients can finish the complete consult in 1,5 hours. Further, there have to be enough consultation rooms available close to each other.

A recommendation we would like to make is the possibility of evening opening hours, as the majority of AYA visits school during the daytime. This would also require flexible opening hours of other facilities like the outpatient clinic hospital laboratory.

ANNEXES

Please contact responsible person for more information about this project.

42. Puerto Rico (United States)

TITLE OF THE PROGRAMME: Peer support

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- **Programme is being implemented since: 2019 - End** (if applicable): ongoing
- **Responsible party/parties:** CBO
- **Population group(s) reached:** Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Ryann White

BACKGROUND

Among Latinos in the United States, YMSM are heavily affected by HIV/AIDS. CDC 2017 data indicates that Latino men accounted for 9,908 of all estimated new HIV infections among Latinos with 25,748 of these new estimated infections among MSM. The goal of this intervention who is targeting Latino YMSM are to: (1) increase access to HIV medical care services to underserved Latino YLWH, (2) increase adherence among Latino HIV positive Youth who are coming in and out of care,(3) obtain viral load suppression, (4) have Latino YPLWH access Peer Support Services in order to reduce health disparities and increase treatment retention and adherence, (5) increase recruitment, engagement and retention among Latino HIV positive Youth along the HIV, linkage to care and treatment continuum by the use of innovative adaptations and approaches, and (6) increase knowledge of HIV/AIDS and Treatment and reduce HIV stigma in the targeted population.

DESCRIPTION

Peer Support (PS) is an individual- and group-level intervention strategy that can be implemented with patients who are either ART-experienced or ART-naïve. Patients who are HIV-positive, taking ART medicines and adherent to their treatment are trained to serve as "peers". Peers provide medication-related social support through group meetings and weekly individual telephone calls. PS at PRCONCRA focuses on increasing access to HIV medical

services for Young Latino MSM by having a Peer accessible through phone or in person at the convenience of the participant. PS also focused on educating on HIV 101, Adherence, Risk Reduction Strategies like PrEP for negative sexual partners, testing and safer sex negotiation skills in order to increase Empowerment among HIV positive Latino youth towards their HIV treatment. In order to increase accessibility of the Peer in non-traditional hours, there is a cellular phone assigned to each Peer. Participants enrolled in PS undergo a questionnaire to know their communication preferences, such as: days, hours and mechanisms they better like. These adaptations help staff reach participants in order to maintain communication and work any barriers that are impeding them to access care and achieve viral load suppression. Weekly individual peer phone calls provide more in-depth personal attention and feedback to answer any questions the patient may have felt uncomfortable asking during group meetings. For group meetings PRCONCRA has implemented cultural competency by selecting a venue where participants feel comfortable and safe visiting. Food is always part of group meetings. During the group encounter, Peers talk about the social determinants of health that commonly are issues among the participants, affecting their adherence and viral load suppression. Some Issues can be: transportation, work, studies, stigma towards being gay or HIV positive, acceptance of serostatus, disclosure to others, mental health issues. During the conversation at the group meeting Peers will guide the topic towards bringing up experiences and alternatives in how to overcome barriers that affect adherence and viral load suppression. Based on issues identified by group members, peers may work with program staff to schedule speakers (e.g., nutritionist) to present during group sessions.

For over 10 years, PRCONCRA has implemented Peer based projects to expand HIV testing, linkage to care, increase retention and adherence to treatment and empower Latino YMSM in Puerto Rico. PRCONCRA increased and targeted HIV testing among high-risk Latino Youth and their partners by incorporating a series of innovative culturally a linguistically sensitive strategies to engage Latino Youth in Puerto Rico. Implementing adaptations to locally developed interventions and EBI's implemented, helped increase accessibility to HIV testing by mobilizing PRCONCRA staff to local bars, venues and locations where YMSM gather during non-traditional hours in order to reach Latino Youth. Staff engage via text messaging, email, phone calls, social media and mobile applications with target population through each step of the navigation of HIV testing and linkage to care. PRCONCRA's success since 2011 is the unique strategy of providing same day preliminary testing, confirmatory, and to continue to communicate and engage via mobile text messaging with Youth. Throughout all the HIV continuum the Peer Support strategy has been a success. This innovative engagement approach has lead to obtain a 75% viral load suppression in less than 3 months.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Since Peer Support intervention was implemented, in less than a trimester it has proven successful in increasing the percentage of viral load suppressed participants identified under HIV positive Youth between 13-24 years of age in PRCONCRA clinic in 2019. A total of 25 participants were identified under the target population with a 65% of viral load suppression rate in December 2018. After the implementation of the program began in January 2019, over 75% of individuals were contacted through phone or text by Peers in the first 30 days of the program. Participants received an initial overview of the program and achieved an appointment at the clinic. By the end of September 2019, viral load suppression rates had increased to a 93%. More than 3 contacts through phone calls and text messages a week were made to participants to maintain communication with participants who are in the program and recruit for other risk reduction strategies taking place like: Healthy Relationships retreat and WICY clinics.

LESSONS LEARNED AND RECOMMENDATIONS

This evidence based intervention targeting Latino HIV positive Youth supports the National HIV/AIDS Strategy's call to End the Epidemic goals, which cites treatment as prevention as the most effective prevention strategy, as well as targeting ethnic and racial minority populations most at high-risk of HIV/AIDS as are Latino YMSM in Puerto Rico. Through strong leadership, innovative engagement and follow-up strategies, PRCONCRA is able to engage and immediately link to treatment and HIV medical care, increase adherence and achieve viral load suppression in a large percentage of Latino HIV positive Youth in less than three months. Peer Staff at the Prevention Center contact target population at their convenience using cultural adaptation to increase accessibility of services. Through the use of phone Apps Peer staff engages this population since youth in Puerto Rico are more interested in texting than speaking through phone. This adaptation was able to demonstrate the effective strategies to recruit, engage for medical care and follow-up during the HIV treatment process to increase percentage of Latino YMSM linked to treatment, adherence and viral load suppression in Puerto Rico. As a result, PRCONCRA continues to lead in efforts to provide recruitment, HIV testing, engagement, and medical care services tailored to Latinos in Puerto Rico.

ANNEXES

Peer Support Presentation

43. United States

TITLE OF THE PROGRAMME: E-VOLUTION

CONTACT PERSON

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- **Programme is being implemented since:** Project ARK founded in 1995 and the E-VOLUTION programme funding started on 9/1/15 - **End** (if applicable): N/A for Project ARK and the E-VOLUTION programme will end on 8/31/20
- **Responsible party/parties:** Academic institution
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify here:** Special Project of National Significance, Ending the Epidemic, end + disparities ECHO collaborative

BACKGROUND

The E-VOLUTION program was developed by researchers within Project ARK (AIDS Resources and Knowledge) at Washington University School of Medicine, in Saint Louis, Missouri, to address disparities in health outcomes for persons living with HIV. While national HIV infection rates have begun to decline, certain populations, including people of colour, young adults, and men who have sex with men, still experience disproportionate rates of infection (i). In addition, youth have the poorest HIV care continuum outcomes including lower rates of linkage to care, retention and Viral Load Suppression (VLS) (ii). In an alarming trend, during the period of 2010-2013, youth represented both a growing number and proportion of new HIV/AIDS cases within the St. Louis region. In 2013, there were 332 new diagnosed HIV/AIDS cases in the St. Louis MSA. In 2013, youth ages 13-24 represented 33.7% (n=112) of the total 332 new HIV/AIDS cases in the region. In addition, this population was found to have the poorest HIV care continuum outcomes. These disparities highlight a need to implement a novel approach, specific to the young adult

population that supplements existing services available to those living with HIV/AIDS.

Using text messaging to provide support for people living with HIV can be an effective tool to improve patient outcomes along the HIV care continuum (x). In a randomized clinical trial of HIV-infected adult patients, those who received text-messaging support had significantly improved antiretroviral adherence and rates of viral suppression compared with the control group (iii). Text messages have also been used as appointment reminders to increase attendance rates at HIV clinics (iv). and are a feasible way to deliver personalized affirming or reminder messages for HIV medical care (v). Studies have also shown that automated systems that go beyond the single message or “push” message and utilize a two-way communication method improved results in affecting the desired behaviour (vi,vii)

i Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2019).
<https://www.cdc.gov/hiv/statistics/overview/ata glance.html>

ii Griffith DC & Agwu AL. Caring for Youth Living with HIV across the Continuum: turning gaps into opportunities, *AIDS Care*. 2017 Feb. 29;10, 1205-1211.

iii Lester RT, Ritvo P, Mills EJ, Kariri A, Karanja S, Chung MH, Jack W, Habyarimana J, Sadatsafavi M, Najafzadeh M, Marra CA, Estambale B, Ngugi E, Ball TB, Thabane L, Gelmon LJ, Kimani J, Ackers M, Plummer FA. Effects of a mobile phone short message service on antiretroviral treatment adherence in Kenya (WelTel Kenya1): a randomized trial. *Lancet* 2010 Nov; 376 (9755):1838–45.

iv Da Costa TM, Salomão PL, Martha AS, Pisa IT, Sigulem D. The impact of short message service text messages sent as appointment reminders to patients' cell phones at outpatient clinics in Sao Paulo, Brazil. *Intl Med Informatics* 2009 Sept; 79 (2010):65-70.

v Ingersoll K, Dillingham R, Reynolds G, Hettema J, Freeman J, Hosseinbor S, Winstead-Derlega C. Development of a personalized bidirectional text messaging tool for HIV adherence assessment and intervention among substance abusers. *J Subst Abuse Treat*. 2014 Jan; 46(1):66-73.

vi Murray MC, O'Shaughnessy S, Smillie K, Van Borek N, Graham R, Maan EJ, WelTel BC1 Study Team. Health care providers' perspectives on a weekly text-messaging intervention to engage HIV-positive persons in care (WelTel BC1). *AIDS Behav* 2015 Oct; 19(10):1875-1887.

vii Saberi P, Johnson MO. Technology-based self-care methods of improving antiretroviral adherence: a systematic review. *PLoS One* 2011; 6(11):e27533.

x Uhrig JD, Harris J, Furberg R, et al. Communication-Focused Technologies: Health Messages for HIV-Positive Men Who Have Sex with Men – Final Report. (Prepared by RTI International, under Contract No. HHSA290200600001I #7). AHRQ Publication No. 11-0063-EF. Rockville, MD: Agency for Healthcare Rese

DESCRIPTION

What is E-VOLUTION: The E-VOLUTION program focused on and succeeded in improving HIV health outcomes for youth, especially African American young men who had sex with men. Specifically, the initiative improved-- viral suppression rates, HIV medical visit show rates, and communication with medical case managers, all the while removing barriers and responding to needs through the use of mobile health (mHealth) programming. The E-

VOLUTION texting intervention included two components: an automated two-way text messaging system coupled with live text messaging between medical case managers (MCMs) and their clients, youth/young adults living with HIV. Utilization of the automated 2-way text messaging system offered the ability to alert members of the care team, in real-time, allowing for expedited intervention. Then, person to person text messaging between the participant and their MCM provided follow-up of participant needs identified by the automated system. Washington University School of Medicine purchased a two-way text messaging system from Epharmix, Inc. for the E-VOLUTION program to collect condition-specific data.

WHO Received E-VOLUTION: E-VOLUTION was designed for youth and young adults, ages 18-29, living with HIV who utilize text messaging, are enrolled in clinical care, and require support in remaining adherent to HIV care. Project ARK developed this digital media-based intervention to address gaps in the regional HIV Care Continuum for underserved, underinsured and hard-to-reach youth, who utilized mHealth.

WHERE Did E-VOLUTION Take Place: The E-VOLUTION program was implemented at infectious disease clinics that are part of Project ARK in St. Louis, Missouri. Project ARK, a program of the Washington University School of Medicine, has served as the St. Louis region's only Ryan White Part D recipient since 1995. Project ARK provides a comprehensive continuum of HIV care and prevention services including HIV testing, linkage to care, medical & behavioural health services and MCM and serves the vast majority of youth in care within the region. At the start of this program, in 2014, Project ARK served 332 youth, of which 86% were African American. HIV-infected youth had lower rates of linkage to care, retention and viral suppression compared to other age groups served in the program. These disparities highlighted a need to implement a novel approach specific to the young adult population.

WHO Delivered E-VOLUTION: The automated text-based intervention was implemented by existing Ryan White funded MCMs to provide them additional tools to assess and address the needs of their clients. The MCM staff was instrumental in integrating the texting intervention into the existing Washington University clinical sites. Case managers serving youth and young adults ages 18-29 implemented the project.

HOW Did E-VOLUTION Work: E-VOLUTION staff enrolled patients into the Epharmix, HIV-specific intervention. Once enrolled in the automated system, participants began receiving the automated text messages, which asked medically relevant questions and prompted recipients for a response. Patients answered the text prompts on their personal mobile phones, sending in data that is relevant to their clinical team. When a client reported challenges via response to automated texts, the system triggered action alerts to the MCMs. They then responded in timely, live two-way text messaging with their client.

HOW MUCH Did E-VOLUTION Cost: Estimated key costs related to implementing text-based interventions are summarized in Table 1 of the annex. Primary costs included: 1. Purchasing technology platforms/applications that assist in the delivery of the program; 2. Purchasing smartphones for staff and/or clients to interact with the technology; 3. Monthly costs for staff cellular phone service; and 4. Allocation of resources to provide assistance for phones, however E-VOLUTION relied on participants use of their own cell phones.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

A total of 100 youth were recruited into the E-VOLUTION program, 87 were retained for at least 6 months and 74 for at least 12 months. The majority of participants were Black (95%), MSM (81%), and the average age was 22.33 years (SD=2.08). These young people faced a

tremendous amount of adversity including high rates of experiencing intimate partner violence, jail time and sexual assault. Many reported symptoms of depression and used substances. See Table 2 in the annex "Intervention Participant Risk Factors at Enrollment (n=100)."

The intervention resulted in 450 triggered alerts. The most common alerts were missed medication doses for the day (n=162), requests to discuss housing (n=94) and missed appointments (n=83). Most intervention participants (n=98) engaged in live text-message conversations with their case managers. McNemar exact tests determined a significant difference in the number of participants with suppressed viral loads at both 6 and 12-months compared to participants VL at enrollment. Results indicated that a significantly greater proportion of participants were virally suppressed at both 6 (p=.003) and 12-month (p=.038) follow-ups.

There was a significant positive association between texting frequency and medical visit attendance in which those who texted with their case manager at least once per month were more likely to attend their 12-month medical appointment.

Outcome/Impact Indicators

Outcomes indicators used to determine the success of this project are specific to performance measures along the HIV Care Continuum and were specifically defined by the HIV/AIDS Bureau. See the Performance Measure Portfolio on the HAB website for definitions for viral suppression, <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/coremeasures.pdf>.

- Viral Load Suppression Improvement: Automated and live two-way text messaging with a case manager improved and sustained HIV viral load suppression rates at 6 months and at 12 months in a population of young, mostly black, MSM with high rates of significant social risk factors of depression, substance use, trauma and time in jail.
- Attendance at Medical Visits: Those who texted with their case manager at least once per month were more likely to attend 12-month medical visits.
- Text Messaging Improved Case Managers and Clients Communication: Case managers reported improved work effectiveness and participants felt supported as a result of implementing text messaging. Texting access ameliorated barriers to care including arranging appointments, transportation providing community resources and managing real time logistics. With the time saved, case managers were able to engage more intensively with clients, providing more support and resources and helping them solve problems in real-time.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons from the Field

Several lessons were learned during program implementation. Below is a list of activities that were incorporated into E-VOLUTION that aided successful program deliver:

- It is crucial to have engagement and support from the case management and medical teams for the success of the program.
- Work closely with case managers and support staff to maintain updated contact information for the participants. Collect a second method of contact in case phone is out-of-service.
- Establish a thorough informed consent process that clearly explains the risks associated with text messaging and application use to ensure information security and legal reviews go well.
- Allow for nonspecific labelling of sensitive topics, for example in the message "did you take your medication today" allow the participant to choose an alternative, innocuous word to it saying "medication," for example "vitamins" or "walk."
- Provide staff with thorough training opportunities on incorporating new technology with

clients to include topics such as emergency procedures, self-care, boundaries, and safety.

- Promptly follow-up on alerts and provide feedback on utilization of the messaging application. Knowing there is a real person following texts and alerts increases accountability. Participants may even be surprised and say things like “Someone really checks these?!”
- Addressing challenges to daily living such as access to transportation and food insecurity provides an opportunity to change existing care structures and allowed youth to become successful in attending clinic appointments, updating appointments, and managing their health.
- Establishing a good working relationship with the vendor(s) allows teams to address changes in the program (update messages, optimize feedback loops, customize product functions to meet program needs), implement reporting mechanisms for program monitoring, and receive prompt technical support when needed.

Considerations for Replication

A set of replication considerations were identified that may help in future implementation:

- Two-way text messaging necessitates an evolution of staff practice, such as:
 - Defining crisis intervention protocols and ethical boundaries
 - Identifying best practices for resource sharing via text message, self-care, and guarding clients’ privacy.
- Suggestions for improving automated medication reminder and check-in text messages.
 - Offer a more comprehensive list of response options for clients to indicate reasons why they have not taken their medications.
 - Clarify that automated appointment reminder messages are not coming from health care providers’ offices and note that clients must contact their providers to cancel appointments.
 - Create functionality to more easily identify and document that an alert has been resolved.
 - Give messages a more relatable, warmer feel.
 - Give messages a more supportive tone and make them feel like someone cares.

ANNEXES

Table 1: E-VOLUTION Costing Estimate; Table 2: Intervention Participant Risk Factors at Enrollment (n=100); Intervention Manual; Intervention Monograph

44. United States

TITLE OF THE PROGRAMME: Atlanta Family Circle HIV/AIDS Network for Women, Infants, Children and Youth (Ryan White Part D)

CONTACT PERSON

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- **Programme is being implemented since:** 2006 - **End** (if applicable): N/A
- **Responsible party/parties:** Non-profit hospital system
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Georgia, along with 15 other Southern states and the District of Columbia, make up 38% of the U.S. population, but according to the Centers for Disease Control (CDC), bear the highest burden of HIV infection. The South accounts for 50% of undiagnosed HIV infections, 51% of annual HIV infections, and 45% of persons living with HIV. (<https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-prevention-south.pdf>) CDC data also ranks Georgia 5th highest in the country in total number of new HIV infections among adolescents and adults and for the number of persons living with HIV infection. Georgia ranked 1st in rate of HIV diagnosis among adults and adolescents.

The state's HIV epidemic is located primarily in the 20-county Metropolitan Atlanta which is home to 55% (5,705,071) of Georgia residents and is the ninth largest Metropolitan Statistical Area (MSA) in the nation. (<https://www.statista.com/statistics/183600/population-of-Metropolitan-areas-in-the-us>) Further, of the 48 U.S. counties identified by the "End the HIV Epidemic: A Plan for America" as having the highest HIV burden in the country, four (Cobb, DeKalb, Fulton, and Gwinnett) are located in Georgia and make up four of the five Metropolitan Atlanta core counties.

The HIV epidemic in Metropolitan Atlanta is concentrated primarily in one downtown geographic area that includes portions of Fulton and DeKalb Counties – the largest counties by population. The prevalence rate of HIV within the cluster is 1.34% and is compatible with

what the World Health Organization (WHO) would describe as a “generalized epidemic”. (<https://blackdoctor.org/488961/atlanta-hiv-rates-2016>)

According to CDC HIV surveillance data for 2016 and released in 2018 (the most current year for which data are available), Metropolitan Atlanta had the 4th highest rate of new HIV diagnoses; among males, the 3rd highest rate; among Black males, the 1st highest rate; among males ages 25-34, the 2nd highest rate; and, among males 45-54, the second highest rate. The epidemic is primarily among Black males particularly Men who have Sex with Men (MSM). Despite medical advances HIV-related deaths continue, and the EMA ranked 9th among males, and 11th overall (Centers for Disease Control and Prevention. Diagnoses of HIV infection among adults and adolescents in Metropolitan statistical areas—United States and Puerto Rico, 2016. HIV Surveillance Supplemental Report 2018;23(No. 2). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2018. Accessed [7/26/2018]).

A primary resource for the Atlanta EMA in providing care for youth and young adults is the Grady Ponce de Leon Center’s Family and Youth Clinic (FYC) which serves as the outpatient HIV/AIDS facility of Grady Health System, the largest public hospital-based health system in the Southeast. Grady Ponce Center has been part of the state’s efforts to address the HIV burden since 1988 when Georgia received one of the first 13 Pediatric AIDS Demonstration Projects in the country. The project, which included Grady as the primary provider for pregnant and postpartum women and their children as part of its network of providers, was housed at what is now the Georgia Department of Public Health (DPH). With the creation of the federal Ryan White HIV/AIDS Program, Georgia was one of the original Part D grantees with DPH overseeing implementation of Part D services by what is now known as the Atlanta Family Circle HIV/AIDS Network. In 2006, Grady Ponce Center became the Ryan White Part D grantee to support the Atlanta Family Circle provider network. Through the Grady Hospital System, the Grady Ponce Center, and the Part D Network, HIV WICY patients in the EMA are currently able to receive an integrated, coordinated and comprehensive system of care.

DESCRIPTION

In addition to the Grady Ponce Center’s Family, Youth and Women’s Clinics, the Atlanta Family Circle Network includes Grady Women’s Health Services and Equality Foundation of Georgia. Originally funded as a Pediatric AIDS Demonstration Project in 1988, for over 30 years the Network has provided services for the majority of Atlanta women, children, youth and families living with HIV. The primary purpose of the Part D Network continues to be to create an integrated, coordinated system of comprehensive, culturally competent, family-centred, community-based services for HIV positive women, children, adolescents and families residing in the Atlanta Eligible Metropolitan Area (EMA) covering 20 (five core counties and 15 surrounding counties). As the Part D grantee and primary care provider, Grady Ponce Center has played a lead role in ensuring that eligible infants, children, youth and women have access to quality primary care and HIV/AIDS specialty care as well as the essential support services needed to remain in care. In addition to primary and subspecialty adult and paediatric medical care, peer counselling, mental health care, substance abuse services, and oral health care, the IDP provides space for several partner agencies delivering services on-site including housing assistance, legal counselling, and food pantry. Network partner Grady Women’s Health provides prenatal and postpartum care in the Grady OB High Risk Clinic for pregnant women who are living with HIV along with one-on-one adherence counselling for women attending the clinic and linkage to social work case management and to infectious disease care after delivery. The Equality Foundation of Georgia (EFG) is responsible for facilitating linkage of newly diagnosed or out of care youth and transgender women living with HIV identified through EFG program “The Spot” to the

Ponce Center, conducting monthly youth advisory committee meetings, conducting training for Part D clients and staff, and other services.

The objective of the Grady FYC system of care for children and youth is to provide comprehensive care for a minimum of 600 infants, children, youth and young adults ages birth through 24 each year. The Ponce de Leon Center's Family and Youth Clinic is supported through its direct HRSA Ryan White Part D award as well as a subrecipient award from Ryan White Part A and state funding from the Georgia Department of Public Health (DPH). Part D funds are used to fill in the gaps in services to Atlanta's HIV affected and infected children, youth, and women and their families. Implementation of the Part D program is coordinated by a project director and part-time project coordinator along with other key staff including Medical Director. The Part D grantee communicates on an on-going basis with Atlanta EMA Ryan White Part A staff to ensure funding does not duplicate other Ryan White supported area services.

The Grady Ponce Family, Youth and Women's Clinics (FYWC) deliver community-based mother- and child-centred comprehensive care within the medical home of the Ponce Center. Comprehensive services offered include family-centred, multidisciplinary HIV-specialty care services in an ambulatory setting; social work case management; family advocacy; in-clinic support groups; support with adherence to antiretroviral therapy with a nurse educator; nutritional counselling and support; psychological counselling and testing, childcare and patient navigation.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The Network includes a primary service area of five metro counties and 15 surrounding Atlanta counties. Due to state funding the Network also serves clients from 15 of the 18 Georgia DPH districts where infant and youth services are limited. The network served 695 clients ages birth to 24 years old in 2018. In a recent comparative review of viral suppression data for the Atlanta EMA, the Grady Ponce Center had higher viral load suppression rates than the same race/age/gender populations served in the EMA as a whole. For example, Grady Ponce Center patients who were Black men who have sex with men ages 13-18 had a viral suppression rate of 78% while the same demographic served in the EMA had a 71% viral suppression rate. The higher viral suppression rates for Ponce Center youth and young adults demonstrates the importance of the wrap-around services for this vulnerable population.

LESSONS LEARNED AND RECOMMENDATIONS

Provision of an evidence-based multidisciplinary intervention leads to improved patient outcomes. The extensive wrap-around services available at the Grady Ponce Center also provide the support needed for youth and young adults to remain in care and ultimately achieve viral suppression. Due to the developmental needs and challenges that youth and young adults have that continually change as they age it is important that staff providing services to this population have the training and experience to effectively support patients to remain in care.

A continuing challenge is keeping young adults in care after they age out of the Family and Youth Clinic and begin care at the Ponce Center's Adult Clinic where there are fewer supportive services due to the significantly higher volume of patients.

45. United States

TITLE OF THE PROGRAMME: Comprehensive Family AIDS Program

CONTACT PERSON

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- **Programme is being implemented since:** 1991 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government
- **Population group(s) reached:** Children living with HIV, Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- Funding through Ryan White Part D

BACKGROUND

Children's Diagnostic and Treatment Center is an outpatient facility which has provided early intervention, medical care and other services to children and families with special needs living in Broward County, Florida since 1993. Comprehensive Family AIDS Program (CFAP) is one of six programs at CDTC which provides a one stop family centred medical care for women, infants, children and youth since 1991. CFAP staff have worked an average of over 13 years in the program. The Care Coordinators works closely with the Department of Health as the rates of HIV infection increases within Broward County. CFAP continues to be needed in Broward County due to the increasing rates of HIV infection among women and youth who are predominately racial and ethnic minorities, medically underserved, economically disadvantaged and often disenfranchised. Some of the problems identified within the program are Youth/Young Adult specific services have shown to be more effective in engaging and retaining this population in care. Community providers that have begun to see more HIV patients in this age group typically only provide primary medical services. Youth have multiple psychosocial needs and often lack parental or community support needed to be successful in manoeuvring complicated health systems without intensive case management. Additional issues for the youth are lack of qualifying for the insurance problems and lack of substance abuse and mental health services. Often, the streets and their peers become their safe heaven. CFAP Care Coordinators provide a supportive network to remove some of these barriers.

DESCRIPTION

Broward Health Hospital District is the parent company for CDTC. CDTC is a patient centred medical home and youth are often referred through different avenues such as paediatric offices, Broward County Health Department, OB/GYN, other community base agencies and self-referrals. Each Care Coordinator is trained to assist the youth by using motivational interview technique to engage the youth. Once a paediatric referral is received, intake is conducted, linkage to medical care and case management. Broward County Health Department has selected CDTC for the Test and Treat program which allows new HIV positive clients or clients lost to follow or out of medications to be seen immediately by the provider the same day and start their antiretroviral therapy. The clients are eligible for services through Ryan White Part A program for 30 days. CDTC offers same day appointments and evening clinics are available for our youth to attend their appointments. CDTC provides a on call daily, including holidays and weekends. The Care Coordinators develop a relationship with each client and address their medical care and basic needs. CFAP receives our funding from HRSA, however it has been at level funding for many years. Therefore, financial stability has been maintain by community donations, and major fund raising which is supported by our development department. CDTC major partners are HRSA, Broward Regional Planning Council and the county Health Department.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

CFAP serves all of Broward County, Florida, an urban community of approximately 1200 square miles on the southeast coast of Florida, bordered by Miami-Dade County to the south and Palm Beach County to the north. Broward is the second largest and one of the fastest growing metropolitan areas in the state with 1.9 million residents. The Broward Eligible Metropolitan Area (EMA) has ranked among the top communities with the highest HIV/AIDS prevalence for the past two decades. Broward ranks second in the state of Florida in the paediatric AIDS epidemic. and CFAP's successful implementation of medical care, adherence education, and case management, the Part D target populations have been able to live longer and healthier lives. The majority of CFAP clients live at or below 100% FPL, often with substance abuse and mental health issues. Adolescents and young adults with children frequently work, and have little support, no child care, and no transportation. Consequently, they neglect their own medical care in order to ensure that their children receive care. Medical successes over thirty years have allowed children born with HIV to continue to survive well into adolescence and adulthood. There are no HIV positive babies for the last two years. Perinatally infected children are nearly all reaching into adulthood and mother to child transmission has been reduced to less than 1% in Broward. CFAP is largely responsible for the successful outreach, identification and care of children with HIV in the Broward Community. CFAP also provides primary and specialty care to all youth with HIV/AIDS, as well as providing secondary prevention education to the entire community, especially youth, ensuring access to research for all patients. CFAP has pioneered the Medical Home in Broward, through provision of family centred, comprehensive, coordinated, linguistically and culturally appropriate medical care and supportive services, providing a one-stop delivery model for HIV positive women, infected and exposed children and adolescents. No other organization in this County provides comprehensive, family centred HIV medical management and coordination of care for all these populations. CFAP has achieved servicing approximately 200 youth by providing medical services and intensive case management. In addition, for this calendar year the viral load suppression is 70%.

LESSONS LEARNED AND RECOMMENDATIONS

The factors that have made our program successful are, having daily huddles with our medical team and care coordinators. We have a medical staff meeting biweekly to review all patients with high viral load and get recommendations from the team. We also monitored our HIV exposed infants and provide education to the parents about medications and HIV testing. Once referred, youth are contacted by a Care Coordinator within 24 hours and linked to care as quickly as possible, oftentimes that same day. It is CFAP's experience that the first connection with youth is the most important to their retention in care. CFAP staff 84% of whom are minority will place special emphasis on linking and retaining all women and youth to care and newly identified or aware of their diagnosis but not into care. This calendar year CFAP serve have provided services to over 200 youth and children. CDTC Research Program assist with our youth by with reducing their viral load by decreasing their viral load with various studies, such as adherence study. The programs have successfully addressed a number of challenges through its history. Recommendation that we are currently working on are identifying newly diagnosed youth, addressing the needs of client with comorbidities, encouraging patients to successfully adhere to treatment and reach viral suppression, encouraging and accessing patients to dental care. To enhance staff abilities to effectively worked with client we have implemented a chronic disease self-management program. CFAP staff have ongoing motivational interviewing booster session to maximizes their ability to support client with engaging in care, keeping medical appointment and achieving a viral load suppression. Broward county is the second in the nation with newly infected and high HIV cases. Women is amongst the highest infected population in Broward County, therefore WICY plays an important role in legislative and policy to fund HIV medical care, due to legislative changes there have been several changes that impact the youth such as no Medicaid expansion in Florida and limited access to medical care and specialty providers. Legislator needs to consider WICY population when making certain policy changes because they negatively impact this population.

V. MULTIPLE COUNTRIES

46. Angola, Madagascar, Mozambique, Zambia, Zimbabwe

TITLE OF THE PROGRAMME: Linking Policy to Programming Strengthening Legal and Policy Environments for Reducing HIV Risk and Improving Sexual and Reproductive Health for Young Key Populations in Southern Africa

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- **Programme is being implemented since:** 2017 – **End:** 2020
- **Responsible Parties:** Government, Civil society, UN or other inter-governmental organization, Academic institution
- **Population Group(s) reached:** Adolescent girls and young women, Adolescent boys and young men in general population
- **Has the programme been evaluated/assessed?** Yes
- **Is the programme part of the national AIDS strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Key populations i.e. sex-workers, men who have sex with men, people who inject drugs, people in prison, lesbians, gay-identified men, bisexual, transgender and intersex people are extremely diverse groups who have much higher rates of HIV and STIs than the general population. Young people, who are also members of key populations, are an often neglected or invisible subset of this bigger group, that face a complex set of legal, policy and structural barriers to access to HIV and SRH services, because they are adolescents or young adults. The linking Policy to Programmes initiative, a project funded by the Netherlands Government implemented in five countries namely Angola, Madagascar, Mozambique, Zambia and Zimbabwe aim at augmenting legal and policy issues related to access to SRHR for young key populations people in the project countries and SADC level.

High rates of HIV infection and limited access to sexual and reproductive health and rights amongst key populations in Southern Africa is well documented. Statistics from the project countries show for example, that: HIV prevalence among MSM in Zambia is 17.5 compared to 12.4 %, among the adult population (UNAIDS, 2015) ; in Angola HIV prevalence among female sex workers is estimated to be 7.2% against 2.4% among the general population; HIV prevalence among female sex workers in Mozambique is 27.5% compared to 10% among the general population, while prevalence among sex workers in Zimbabwe is 50% compared to the 14% national average. In Madagascar, HIV prevalence among people who use drugs and MSM stands at 7.2% and 14.1% compared to the national average of 0.4% (Baggaley et al, 2015) . In Zambia, HIV prevalence among people in prison is estimated at

27.4%(UNAIDS, 2014) compared to 12.4% for the general population. Transgender people are largely invisible in research in Southern Africa but the few epidemiological studies that have been conducted in the region have shown disproportionately high HIV prevalence ranging from 6% to 68% (WHO, 2011) . It is also worth noting that issues facing intersex people are not well understood or acknowledged in Southern Africa.

Although there is less data specific to young key populations, there is evidence that they are equally, if not more at risk of poor SRH outcomes in Southern Africa. For example, a study in the Republic of the Congo found that HIV prevalence among MSM aged 15–19 years in 2012 was 4.5% compared to 1% among the general population. In Zimbabwe, prevalence of herpes simplex virus 2 was found to be around 50% among young females under 20 years selling sex, rising to 80% by the time they reached 25 years. Another study in Madagascar showed that young people aged 16–19 years who sell sex were at higher risk of chlamydial and gonococcal infection than those aged 20 or older (WHO, 2015)

The political, legal and policy context in many parts of Africa remains restrictive for young people to access equitable access to HIV prevention and SRHR services. Most countries in Southern Africa do not provide for the age at which adolescents can independently consent to specific SRH services, such as HIV testing, contraception, and abortion, if lawful. For instance, Zambia does not, under law, provide for the age at which adolescents can independently consent to obtaining contraception and this lack of specific provisions in the law has resulted in part in the low rates of contraceptive use by adolescents in Zambia (UNICEF, 2015) . In addition, conflicting laws regarding the age of consent to sex marriage and access to sexual and reproductive health and rights (SRHR) create uncertainty amongst service providers, creating further barriers to access to services for young people.

Even where there are adequate legal protections, young people are not aware of the legal protections and government officials often fail to implement and enforce the legal protections. For instance, Swaziland legally provides for abortions in cases of rape under

DESCRIPTION

The overall objective of the project is to improve SRH outcomes for young key populations by strengthening HIV/SRH related rights of young key populations in law, policy and strategy in 5 SADC Countries (Angola, Madagascar, Mozambique, Zambia and Zimbabwe).

Specific Objectives include:

1. Strengthening the capacity of national governments to put in place HIV/SRH-related legal, policy and strategy environments that respect the rights of young key populations
2. Strengthening the capacity of regional and national civil society organisations including community-based groups to claim rights and advocate for strengthened national HIV/SRH-related legal, policy and strategy environments and improved HIV/SRH service provision for young key populations
3. Strengthening the capacity and leadership of SADC to facilitate Member States to put in place legal, policy and strategy environments that respect the rights of young key populations and promote regional learning
4. Strengthening the understanding of appropriate indicators and monitoring and evaluation processes that help promote accountability for implementation of human rights enabling activities that arise from law, policy and strategy assessments, advocacy and research activities

The project focuses on young key populations (YKPs) i.e. young sex workers, young men who have sex with men, young people who use drugs, young lesbian, gay, bisexual, transgender and intersex and young people in prisons.

The project is implemented by a consortium comprised of the UNDP Regional Service Centre for Africa (lead), in partnership with the African Men for Sexual Health and Rights (AMSHeR), and the Health Economics and AIDS Research Department of the UKZN University (HEARD). UNDP is responsible for the overall coordination and financial management of the project which is funded by the Leave No One Behind initiative of the Netherlands Government on improving sexual health and rights of young people in the SADC region.

Strategies to ensure sustainability of the project include:

- National ownership of the project design and implementation at national and regional levels,
- Building on existing work currently being done at both national and regional levels to strengthen legal and regulatory frameworks,
- Strengthening capacity and providing support to duty-bearers at both national level (e.g. national governments) as well as regional level on issues of HIV/SRH, human rights and law.
- Supporting the development of national Young Key Populations Experts to ensure ongoing expertise and support for HIV/SRH, law and human rights issues in the region.
- Promoting linking, sharing and learning across countries and across the region to increase long-term national and regional knowledge and capacity in HIV/SRH, law and human rights and efforts to strengthen legal and regulatory responses.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The project is among the first in the region to open up the space for YKPs to voice their concerns and for duty bearers to receive their inputs. Partnerships have been established involving government, parliamentarians, civil society, and research institutions to understand the challenges faced by YKPs holistically and design effective interventions. These partnerships rely on structures that the project has created or reinforced, along with interventions to develop the required set of skills for YKPs or organizations representing their interests.

The project has achieved significant results which include undertaking Legal Environment Assessments (LEAs) on HIV prevention and SRHR in the five countries with full engagement and participation of all stakeholders including YKPs. The project developed the Civil Society Engagement Scan which is a tool designed to provide CSOs and KP groups with the necessary information on the main law and policy formulation and reform processes such as how a bill is drafted, how a draft bill becomes a law, how policy is drafted or amended and how different stakeholders are engaged at different stages of these processes is produced for all five countries. Advocacy working groups established in each of the project countries are coordinating participation of young key populations in the design and implementation of important strategies in the different countries.

One of the major achievements of the project is development of the SADC key population strategy which was approved by the SADC Member States (MS) Ministers of Health in November 2017. The strategy is a significant milestone for HIV prevention and Sexual and Reproductive Health and Rights (SRHR) of key populations including for young key populations (YKPs), as it will serve as a guide to SADC MS in designing and implementing appropriate SRH and HIV prevention, treatment and care programmes for Key Populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels.

While higher level development results such as legal reviews and policy reforms require longer term intervention and action by several stakeholders, the project is already contributing to some significant changes in the legal and policy environment in the project countries. For instance, young key populations that have been involved in the project directly participated in and contributed to the advocacy and national dialogue which led to the decriminalization of same sex relationship in Angola. In Zimbabwe young key populations are interacting with parliamentarians in the work around the revision of age of consent for marriage and access to health services.

LESSONS LEARNED AND RECOMMENDATIONS

A mid-term review of the LPP project has been undertaken in 2019. The review findings as well as the annual reports indicate that the project is addressing a complex, challenging and often controversial issue of key populations which is further compounded by the dimension of the age group of the population that the interventions focus on. Despite the challenges, however, the project is significantly contributing to the creation of conducive policy and legal environment at the country as well as regional level by introducing innovative mechanisms that bring together young people, civil society, and policy makers including Parliamentarians to address the SRHR related challenges of an often neglected and difficult to reach community. It has also generated considerable expectation and interest among the young key populations to participate in and benefit from the various interventions. During this project period approximately 400 young key populations capacities have been strengthened in policy and law reform including providing a platform for engagement with policy makers at national, regional, continental and global levels. By working closely with government, key population communities and civil society the project helps countries identify legal and policy frameworks (LEAs) in need of reform, strengthening or enforcement for better, equitable and effective access of YKPs to services and information and protection of their rights. The project demonstrated the considerable potential within the implementing partners, the YKP community, civil society, national and regional government structures and development partners to promote the SRHR of YKPs. These innovations, experiences and potentials can be leveraged to expand, strengthen and sustain the purpose and goals beyond the current project phase and the current focus countries.

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47. Botswana, Cote d'Ivoire, Haiti, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zambia, Zimbabwe

TITLE OF THE PROGRAMME: DREAM Partnership: Combination HIV prevention for adolescent girls and young women

CONTACT PERSON

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- **Programme is being implemented since:** 2015 - **End** (if applicable): ongoing
- **Responsible party/parties:** Government, civil society, private sector
- **Population group(s) reached:** Adolescent girls and young women
- **Has the programme been evaluated/assessed:** Yes (Evaluation in progress)
- **Is the programme part of the national aids strategy** No
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify here:** In select countries, DREAMS is included in and has informed national strategies for AGYW

BACKGROUND

Despite substantial declines in the number of new HIV infections, the epidemic among females aged 15-24 in sub-Saharan African countries remains significant. In 2018, adolescent girls and young women (AGYW) accounted for 71% of new infections in young people in sub-Saharan Africa (UNAIDS 2018). AGYW in sub-Saharan Africa remain up to 14 times more likely to be infected with HIV than their male peers (PHIA multiple countries). The recent ECHO trial, enrolling women requesting contraception in Eswatini, Kenya, South Africa, and Zambia, demonstrated, incidence rates over 3/100 women years despite inclusion of prevention education at each visit. Incidence rates over 5/100 women years were seen in several South African sites, with the highest rate being 6.8/100 women years despite intensive prevention education.

Girls' lives are complex and full of challenges. Many of these challenges put them at greater risk for HIV, including the startling statistic that one in three girls will experience gender-based violence at a very young age, often leading to a lifetime of

violent experiences (VACS). Such violence increases a girl's likelihood of HIV acquisition and many other negative outcomes.

DESCRIPTION

To respond to these challenges and control the epidemic among adolescent girls and young women, PEPFAR in 2014 partnered with the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences, and ViiV Healthcare to launch the DREAMS public-private partnership. DREAMS is a comprehensive prevention programme addressing the multidimensional circumstances that place young women at increased risk of contracting HIV. DREAMS aims to reduce new HIV infections among adolescent girls and young women in the highest HIV burdened geographic areas of 15 countries

To respond to the realities of the lives of adolescent girls and young women, the DREAMS Partnership requires a multi-faceted, integrated response from the health, education, psychosocial, economic and civil society/community sectors. Not only is DREAMS an effort to reduce new HIV infections, but it also aims to reduce other critical vulnerabilities such as lack of school completion, early pregnancy and gender-based violence. The DREAMS core package of interventions (Saul, 2018) includes interventions that: (1) empower adolescent girls and young women and reduce their risk (economic strengthening, safe spaces, and HIV-related health services such as HIV testing services, condoms, PrEP, and voluntary family planning); (2) strengthen the families of adolescent girls and young women (parenting/caregiver programs); (3) mobilize communities for change (community mobilization and norms change programs, school and community based HIV and violence prevention); and (4) reduce the risk of men who are likely to be male sex partners of adolescent girls and young women (linkages to HIV testing services and VMMC).

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

In FY2019, the DREAMS partnership reached over 1.5 million AGYW with critical comprehensive HIV prevention interventions. Recent modelling data announced on WAD 2019 shows that there have been reductions in new HIV diagnoses among adolescent girls and young by 25% or more in nearly all of the DREAMS districts.

The Bill and Melinda Gates Foundation funded Population Council to conduct research on barriers and facilitators of successful program implementation and the London School of Hygiene and Tropical Medicine to conduct impact evaluation in three DREAMS countries (Kenya, South Africa, and Zimbabwe). Analysis is ongoing with further results expected in 2020.

LESSONS LEARNED AND RECOMMENDATIONS

Broad Stakeholder Involvement: PEPFAR understood early on that DREAMS would require meaningful engagement and partnership with the right stakeholders to truly impact the lives of AGYW. From the beginning, DREAMS required the establishment of a multisectoral, multidisciplinary steering committee to ensure the comprehensive needs of AGYW are met in a manner that promotes local ownership and

sustainability. At both headquarters and the country level, PEPFAR has cultivated partnerships with the private sector, civil society organizations, multilateral organizations, host country governments, and most importantly AGYW themselves. These relationships provided critical expertise, funding, and guidance to better position DREAMS for success.

Data Use: Data have guided every step of DREAMS planning and implementation. From the creation of the DREAMS guidance to the program and outcome data that PEPFAR collects from DREAMS implementation, DREAMS is shaped by the needs of AGYW. Currently, several sources of data are used to monitor the implementation of DREAMS, as well as changes in outcomes at the district level. These data sources include PEPFAR program indicators disaggregated by age and sex, findings from DREAMS implementation science, observational visits by PEPFAR headquarters staff, modelling of new HIV diagnoses among AGYW in DREAMS districts over time, and survey data including PHIA and VACS. Findings are being used to improve DREAMS programming on an ongoing basis.

DREAMS has shown that implementing a comprehensive package of services to prevent HIV in AGYW is possible and successful. Approaches for AGYW prevention must be multi-faceted in order to address the multiple, layered needs and vulnerabilities of AGYW.

ANNEXES

Dreaming of an AIDS-Free Future: <https://www.state.gov/wp-content/uploads/2019/08/Dreaming-of-an-AIDS-Free-Future.pdf>

DREAMS PLOS collection: <https://collections.plos.org/dreams-ecollection>
What is the DREAMS Core Package?:
<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0208167>

48. Côte d'Ivoire, Eswatini, Lesotho, Mozambique and Zimbabwe

TITLE OF THE PROGRAMME: Securing Pediatric ARV Access Now (SPAAN)

CONTACT PERSON

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- **Programme is being implemented since:** 2019 - **End** (if applicable): 2020
- **Responsible party/parties:** Civil society
- **Population group(s) reached:** Children living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy:** No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

In 2018, 937,000 children living with HIV were receiving antiretroviral therapy globally. Only 56% of children living with HIV are receiving treatment, lagging behind adult treatment coverage. In addition to this treatment coverage gap, there is also a treatment quality gap. Currently, the paediatric antiretroviral market faces significant quality, demand/adoption and supply/delivery barriers that hinder the rapid and sustainable uptake and use of effective, child-friendly formulations. While clinical trials have demonstrated the benefits of newer antiretrovirals such as Lopinavir-Ritonavir (LPV/r) over nevirapine (NVP)-based regimens, many children – in some countries the majority of children – are still on NVP-based regimens. NVP is no longer recommended by the World Health Organization for first-line treatment in children due to its increased risk of drug resistance and inferior clinical outcomes. Even when LPV/r syrup is available, it is poorly tolerated by children and difficult to store due to the cold chain requirement. The long-term treatment and care of HIV-infected infants will only be successful if children and health systems have immediate and sustainable access to child-friendly formulations of antiretrovirals that are safe, effective, affordable, and palatable.

DESCRIPTION

Several new, child-friendly ARV treatments and formulations, which are better tolerated by children under three years of age and do not require cold chain, are available and approved

for use, with more on the horizon. However, as new, optimal paediatric ARV formulations become available, significant barriers to their rapid and sustainable uptake need to be removed.

These barriers include:

- Delays in uptake and transition to newer formulations,
- Risk of unstable supply and stock-outs during the transition,
- Supply-demand mismatch
- High prices lead to significant opportunity costs
- The complexity of health worker and patient training

To overcome these barriers, EGPAF, with funding and support from Unitaids, will work in five implementing countries – Cote d'Ivoire, Eswatini, Lesotho, Mozambique and Zimbabwe – to accelerate sustainable access to optimal paediatric ARV formulations. The goal of this project is to streamline and accelerate the introduction of new, child-friendly ARV formulations, focusing on current plans for solid formulations of LPV/r and the DTG 50 mg tablet as well as future plans to introduce DTG dispersible formulations.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

This initiative will greatly contribute to achieving the UNAIDS 95-95-95 targets in the five focus countries (Cote d'Ivoire, Eswatini, Lesotho, Mozambique and Zimbabwe). Rapid introduction of optimal paediatric ARV formulations is expected to not only achieve cost savings and efficiencies in terms of decreased drug resistance and increased viral load suppression, but also improved survival among HIV-infected infants and children.

By July 2020, the initiative is expected to achieve the following:

- At least five countries with approved formulations, quantification, updated treatment guidelines, revised essential medicines lists, and funding commitments to accelerate and sustain access to optimal paediatric ARVs.
- 244 project sites in five focus countries with access to child-friendly formulations, and with at least one health care worker trained per site in the use of new formulations.
- At least 26,000 HIV-positive children prescribed new formulations across 244 project sites, and more than 150,000 children prescribed new formulations across the five focus countries.

LESSONS LEARNED AND RECOMMENDATIONS

As the program has just started this year, the lessons learned are still to be determined.

ANNEXES: N/A

49. Mozambique, Eswatini, Tanzania and Zimbabwe

TITLE OF THE PROGRAMME: READY +

CONTACT PERSON

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- **Programme is being implemented since:** 2016 - **End** (if applicable): 2020
- **Responsible party/parties:** Government, Civil society, Private sector
- **Population group(s) reached:** Adolescents and young people living with HIV, Adolescent girls and young women, Adolescents and young people among key populations
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify here:** national SRHR strategy

BACKGROUND

In many countries around the world, adolescents and young people lack access to youth-friendly sexual and reproductive health (SRH) services and accurate information. According to UNAIDS 2019 brief on women and HIV, seven out of ten young women in Africa do not have comprehensive knowledge about HIV. Parents, communities and policymakers may be reluctant to discuss young people's sexuality. Gender roles and expectations restrict how young women and men should behave and act. And young people are often excluded from programmes and decisions about their own sexual and reproductive health and rights (SRHR).

This is difficult for all young people in their diversity, even more so for adolescents and young people living with HIV who face stigma, discrimination and violence. As they explore their sexuality and get into relationships, adolescents and young people living with HIV face many challenges. These include disclosing their HIV status, adherence to anti-retroviral therapy (ART), mental health challenges, practising safer sex and understanding options for effective contraception while on ART and coping with the side effects. These are pressing challenges: according to the UNAIDS 2019 fact sheet, every week about 6,200 young women aged 15-24 become infected with HIV and more than 90% of deaths worldwide from AIDS-related illnesses among adolescents occurred in sub-Saharan Africa (UNAIDS 2019, Women and HIV: a spotlight on AG & YW).

In response, READY, a portfolio of youth programmes aims to promote Resilient, Empowered Adolescents and Young People so that they can make the changes needed to lead healthy lives. READY stands for Resilient, Empowered Adolescents and Young People. The projects are designed, delivered and monitored with and by adolescents and young people living with and most affected by HIV. This case study will focus on how READY +, a project implemented in four countries in the SADC region has empowered, engaged adolescents and youth living with HIV as beneficiaries, partners and as leaders.

DESCRIPTION

READY+ aims to reach 30,000 adolescents and young people living with HIV in eSwatini, Mozambique, Tanzania and Zimbabwe. Supported by the Embassy of the Kingdom of the Netherlands, in Maputo, the four-year programme (2016-2020) aims to increase access to holistic care and support, promoting not only SRHR but also mental health in order to foster resilience. READY + is implemented by a multi-disciplinary consortium of youth, SRHR, HIV and communication partners led by Frontline AIDS, including: Africaid Zvandiri ; the Coordinating Assembly of Non-Governmental Organisations (CANGO); the Global Network of People Living with HIV (GNP+); the Global Network of Young People Living with HIV (Y+); M&C Saatchi World Services; Paediatric AIDS Treatment for Africa (PATA) and the Regional Psychosocial Support Initiative (REPSSI) and local implementing partners and health facilities.

READY+ works with a wide range of target groups so that:

- Adolescents and young people are ready to make informed decisions about their health and rights.
- Parents and caregivers are ready to support adolescents and young people to talk about their sexuality.
- Service providers are ready to provide youth-friendly services.
- Decision-makers are ready to champion access to information, services and commodities for adolescents and young people living with HIV.

Community Adolescents Treatment Supporters (CATS) are at the heart of the programme. These are adolescents and young people living with HIV aged 18 – 23 years old trained to provide care and support to their peers by Africaid. Training focuses on HIV, SRHR and how to provide support to their peers in the communities as well as in the facilities. Africaid work closely with the Paediatric Adolescent Treatment for Africa (PATA) who facilitate the delivery of holistic adolescent and youth friendly health services through 26 health facilities. They are also the link to the national Ministry of Health with whom READY + engages with. PATA lead in all health provider training, sometimes jointly hosted by the relevant MoH, and host the regional peer-to-peer learning summit to provide space for health providers and CATS to engage in learning and to improve the quality of support provided to young people.

Trained CATS provide information, counselling and support their peers and encourage adherence to treatment. M & C Saatchi World Services have worked with CATS in eSwatini and Mozambique to develop a mobile application (also known as the CATS App) that they use in their day to day interaction with their clients. The App is designed to open up dialogue on adherence, difficulties in taking and staying on treatment and mood. REPSSI provides training to CATS and IPs on how to provide psychosocial support and have dialogue around mental wellbeing, adherence and disclosure. CATS run safe spaces in the community, providing SRHR and adherence counselling. Within facilities, they receive A & YPLHIV and support them to navigate services, ensuring that adequate follow up is provided by a community-based CATS.

At the local level, CATS receive support from the implementing partners who facilitate READY + activities in the community and coordinating READY + safe spaces, providing supportive supervision, and provide training for parents/caregivers. In all four countries, there is one READY + entry point also known as the Lead Organisation (LO): REPSSI is the LO in Tanzania, Zimbabwe and Mozambique while CANGO is the LO in eSwatini. Their role is to support, manage and implement the programme. Frontline AIDS manages the consortium and leads on M & E and communication.

The Global Network of Young People living HIV (Y+) plays the vital role of promoting the involvement of adolescents and young people living with HIV in decisions that affect their health and wellbeing, which is the heart of READY+. They represent the consortium in strategic regional and international platforms amplifying the voices of A & YPLHIV.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

Since the beginning of the project in October 2016, READY+ has reached 22,723 A&YPLHIV with SRHR and HIV information in safe spaces in health facilities and community settings. A total of 353 community adolescent treatment supporters (CATS) have been trained; and CATS reached 20,268 A&YPLHIV through one-to-one visits. Within health facilities, 122 health providers have been trained on how to provide integrated SRHR, HIV and psychosocial support services; and with the help of CATS, 20,354 A&YPLHIV were reached with integrated facility-based services.

In 2017, Y+ focal points conducted interviews in their communities and spoke to their peers to understand the experiences, perspectives and needs of adolescents and young people living with HIV, as well as the communities around them.

Main issues that came out from these discussions are now the basis of A & YP led advocacy within the community, within the facilities and nationally in relevant spaces, particularly the Ministry of Health. These issues, pertinent to young people living with HIV, include treatment adherence, access to comprehensive sexual and reproductive health services and disclosure.

From the mid-term review conducted in 2019, including a CATS assessment conducted in June 2019, key findings on the impact of the programme included:

- Adolescents and young people living with HIV have been trained and taken the lead in service delivery, developing successful advocacy and accountability initiatives in each of the four countries. For example, through Y+ leadership, the young people have developed the READY to Care toolkit which is a advocacy tool targeting health care providers. In this brief booklet, they learn how to support A & YPLHIV to feel more comfortable and supported while in health facilities. At the same time A & YPLHIV in the programme use it to accredit health facilities.
- Adolescents and young people living with HIV report that they feel empowered with increased knowledge, skills and confidence. Y+ have represented the consortium in strategic regional and international platforms and or forums amplifying the voices of A & YPLHIV as well as influencing change at policy levels. For example, several Y+ advocates were featured as speakers on adolescents and youth centred approach in the AIDS 2018 opening and closing ceremonies, and others will represent their peers in the upcoming Nairobi Summit to mark the 25th anniversary of the International Conference on Population and Development as well as hold significant leading roles at ICASA 2019 in Kigali.
- CATS have gained confidence, knowledge and self-esteem. This has enabled them to support their peers, improve their own health and promote adherence to ART in their peers.
- Almost 92% of the target for the number of adolescents and young people living with HIV trained as CATS has been met. The target for the number of adolescents and young people

living with HIV accessing one-to-one peer support from CATS in the community has been surpassed (184%).

- The vast majority (96%) of CATS would recommend being a CATS to their friends.
- Just over three-quarters (76%) of CATS said they felt supported in their roles by implementing partners and health workers. Perceptions varied as to the level and quality of support.
- Parents and caregivers have accessed information and gained skills that have empowered them to talk openly to their children about HIV and SRHR, safer sex, ART adherence and disclosure.
- Evidence from the Youth Summit, an annual gathering of young people, healthcare providers and READY + held by PATA in 2018 shows that service provider attitudes matter to young people. The number of service providers taking part in peer learning has been surpassed (173%). There has, however, been mixed progress in the number of referrals.

LESSONS LEARNED AND RECOMMENDATIONS

Young people leading the way in service delivery and linkage: Working with CATS has proven that reaching young people through their peers and friends is the best way to empower with accurate information, to improve their treatment adherence and provide them with safe spaces to talk about health issues.

Young people advocating for their needs: In the country where READY+ is implemented, young people living with HIV gathered in their respective networks have been able to develop their priority issues and advocacy strategies to address those issues. In Tanzania and Zimbabwe, young people living with HIV have been able to mobilize parliament to listen and to make commit to address their issues, for example the latest issue with access to DTG for young women living with HIV or access to paediatric drugs.

The following recommendations have been identified, based on the challenges, lessons learnt, and gaps outlined in the mid-term review and CATS survey:

Vocational training for young people

1. Explore and create new opportunities to develop young people's skills, knowledge and competencies so that they can get jobs.
2. Broaden CATS' 'job shadowing' opportunities (where they observe implementing partner counselling sessions) beyond the actors involved in the programme to include other professions. This could amplify livelihoods options and open up economic spaces for CATS.
3. Explore innovative ways to develop the knowledge and social capital gained by CATS into employment opportunities, beyond healthcare.

Young People Enhancing community awareness

4. Intensify activities that young people design and implement aimed at creating community awareness and addressing HIV-related stigma and discrimination.
5. Scale up efforts to work with schools to increase awareness, reduce stigma and discrimination and create environments for adolescents and young people living with HIV to thrive.
6. Link adolescents and young people living with HIV and parents/caregivers with partners that provide nutritional support.

Transforming service providers' attitudes towards supporting adolescents' sexuality and SRH

7. Continue to invest in building the capacity of health workers and shifting their attitudes so that they can provide quality services that are sensitive to the unique needs of adolescents and young people living with HIV.

Caring for CATS as leaders

8. Continue to improve relationships between CATS, and with implementing partners and health workers.

9. Consider establishing a peer review mechanism for implementing partners. The peer review should be linked to a process through which implementing partners can learn from others' experiences of how best to operationalise and support CATS.

10. Ensure more support for health workers to provide supportive supervision to CATS.

11. Consider innovative, practical ways to develop CATS' interpersonal 'soft skills' in effective communication, empathy, cooperation, conflict management and resolution. This will help reduce areas of conflict among CATS, and between CATS and other stakeholders.

12. Invest more in capacity building, mentorship and fair remuneration for youth leaders, youth networks and CATS.

13. Develop CATS' social capital and create more opportunities for CATS to share experiences and build relationships to ensure they are retained.

Young people's capacity building and meaningful engagement

14. Ensure adolescents and young people living with HIV are meaningfully involved in designing, monitoring and accrediting health services.

15. Invest further in youth leadership in advocacy and accountability.

Data

16. Invest in data collection so that all advocacy and accountability efforts are documented in future.

ANNEXES

1. RCT on effectiveness of the CATS model (2) READY + Newsletter on the READY Movement and leadership (3) READY to Care Toolkit and Accountability Scorecard