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**Elizabeth Glaser
Pediatric AIDS
Foundation**

Until no child has AIDS.

HABA NA HABA

TECHNICAL BULLETIN ■ JULY 2018

SPOTLIGHT ON ADOLESCENTS
AND YOUTH AND HIV



PHOTO: ERIC BOND/EGPAF, 2017

Welcome to *Haba Na Haba*!

This publication provides a dynamic forum for the routine sharing of technical information and promising practices with our fellow colleagues and extended family of partners and like-minded organizations around the world. Each issue of *Haba Na Haba* highlights a topic of particular importance to the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). The topic highlighted in this issue is the diversity of adolescent HIV needs, evidence and programming across EGPAF.

What Does *Haba Na Haba* Mean?

The name of the bulletin, *Haba Na Haba* (“little by little”), is borrowed from the Swahili proverb *haba na haba, hujaza kibaba* (“little by little fills the pot”) and was chosen to reflect the often incremental nature of progress in our field. As the experiences described on the following pages demonstrate, the smaller efforts of every one of us are the essential “ingredients” for mounting a strong and united global response to HIV and AIDS.

Feedback is welcomed from all readers, and contributions are accepted from all EGPAF staff. Please send your questions, comments, or content submissions to publications@pedaids.org.

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ADOLESCENTS AND YOUTH AND HIV



Adolescence is filled with physical, emotional, and social changes that bring new opportunities and challenges. In the context of HIV, adolescence presents further complexities: children living with perinatally-acquired HIV are frequently unaware of their HIV status and, for some, barriers to testing may be experienced. Among those who know their status, but observe HIV-related stigma, identifying as HIV-positive may be a challenge. Children adherent to lifelong medications may experience treatment failure. Among all adolescent and young adults, onset of sexual activity and poor understanding of HIV present major risks. As children grow into adolescence and adulthood, their health and psychosocial needs change, and we, as implementers of HIV prevention, care, and treatment services, must adapt our approaches to prevent, test, treat, and retain these individuals in care. In this issue of Haba Na Haba, we explain why very different approaches are needed for adolescents at risk of contracting or are living with HIV, and we present promising practices within country programs, which have inspired youth populations to thrive.

HIV: A GROWING EPIDEMIC AMONG ADOLESCENTS

Adolescents (10–19 years old¹) and young adults (15–24 years old) represent a growing share of people living with HIV. In 2016, there were approximately 2.1 million adolescents living with HIV worldwide.² Although adolescents living with HIV account for only 11% of the global HIV prevalence, they represent 44% of new infections.² Concerns that adolescents will reignite the HIV epidemic are growing as the number of new infections among adolescents rose to 5.7 million by 2017.² Adolescent girls and young women are particularly vulnerable, with 74% of new adolescent infections occurring among girls and young women in sub-Saharan Africa.³ Without additional investment, the number of new adolescent infections is expected to continue to rise by 13% by 2030.⁴ What's worse is that AIDS-related mortality has decreased in all age groups except among adolescents. In fact, an increase in AIDS-related deaths among adolescents has occurred over the past decade.

The Reasons

Although it is very difficult to characterize and analyze the adolescent HIV epidemic because of the lack of age-disaggregated data across countries, we can examine the existing data to identify several factors propelling the epidemic in this population. One major contributor is sheer young population growth in Africa (Figure 1), frequently referred to as the “youth wave.” Africa is expected to double in overall population size over the next 50 years. Globally, children 0–14 years old make up 26% of the population, and youth 15–24 years old make up 16%. In Africa, however, these percentages are at 41% and 19%, respectively.⁵ Successes in reducing under-five child mortality mean that more and more HIV-positive children are surviving to adolescence.

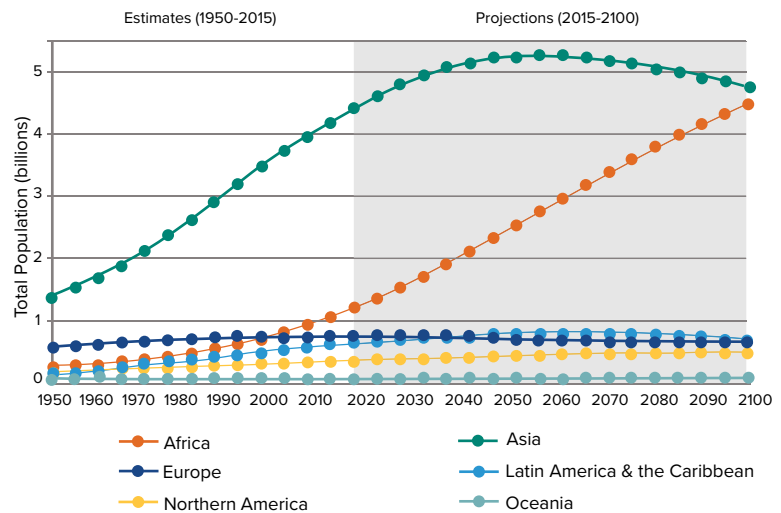


FIGURE 1 Estimated population by region for 1950–2015 and medium-variant projections for 2015–2100⁶

Onset of sexual debut and high teen pregnancy rates are playing an important role in increasing HIV rates among adolescents. Data from five countries (Botswana, Cameroon, Jamaica, eSwatini, and Zimbabwe) reflect HIV prevalence increases in older age groups among young people. In most countries, this increase is consistent with the onset of sexual activity and numbers of adolescents living with HIV (Figure 2).⁷

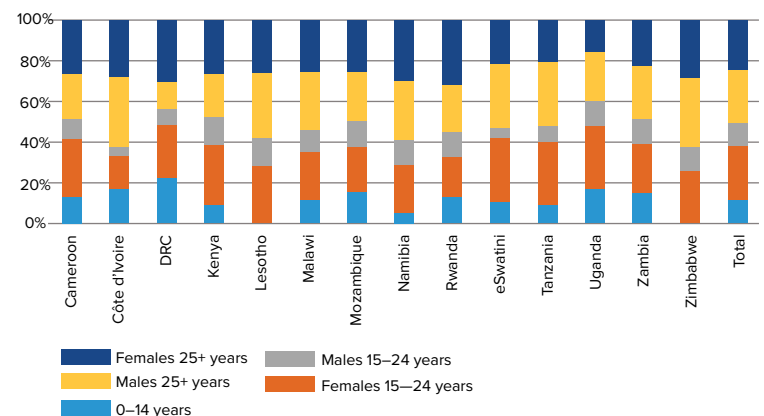


FIGURE 2 Proportion of new HIV infections among demographic groups⁶

Adolescent girls are disproportionately affected by HIV compared to men due to greater risk factors, including physiological differences, gender inequality, unequal gender norms, intergenerational sex, and gender-based violence.⁶ Data on physical, sexual, and emotional violence from 10 sub-Saharan African countries reveal consistently strong associations between male controlling behavior, including physical and emotional violence, and HIV infection among women. Globally, one in 10 girls has experienced sexual violence.

The vulnerability of young women to HIV continues through motherhood. Women are two to four times as likely to acquire HIV through sexual activity during pregnancy and after birth.⁸ Within many countries in sub-Saharan Africa, including the Democratic Republic of the Congo (DRC), Kenya, eSwatini, Tanzania, Uganda, and Zimbabwe, about 15%–29% of adolescent girls 15–19 years old have already become mothers.⁹

The 2030 targets of the Joint U.N. Programme on HIV and AIDS* (UNAIDS) are on track in every age group except adolescents and children. Low rates of HIV testing and diagnosis, insufficient treatment initiation, poor adherence, and lack of viral suppression among adolescents and youth represent serious barriers to controlling the epidemic. In sub-Saharan Africa, only 15% of adolescent girls and 10% of adolescent boys between the ages of 15 and 19 years have been tested for HIV and received their test results in 2017.¹⁰ Available data on viral suppression rates show that people under 24 years of age are consistently lagging behind adults.^{11,12}

EGPAF: WORKING TOWARD 95-95-95 FOR ADOLESCENTS AND YOUTH

Chronic diseases such as HIV put a serious strain on already stressed health systems in Africa. Adolescents living with HIV are smaller in numbers when compared to affected adults, but their health needs are broad, requiring significant investment by clinics and communities to achieve optimal treatment outcomes. At EGPAF, our mission is to end AIDS in children. We work in high-prevalence countries to prioritize the health and well-being of children, women, and families by supporting local health systems to advocate for political action, implement programs, and provide operations research in order to enable the most promising practices to be brought to scale to eliminate the epidemic.

Acknowledging the scope of the adolescent HIV epidemic and their precise needs within health care systems, EGPAF has developed a global adolescent HIV strategy to support our country programs and to scale-up best practices in adolescent HIV prevention, care, and treatment. This strategy, aligned with our three pillars of work (advocacy, program implementation, and research), systematically addresses the complete cascade of integrated client-centered care. It stresses preventing new infections among adolescents, providing quality health care services to adolescents living with HIV (including pregnant and breastfeeding women), connecting adolescents serviced at the facilities with community support to increase demand for services and treatment success, and testing innovative interventions with the potential to successfully retain HIV-positive adolescents and youth in treatment. The EGPAF adolescent strategy has been informed by adolescents, and is designed to serve their needs.

Globally, emphasis has been placed on creating a political environment that better addresses the epidemic in adolescents. We strive to collect,

analyze and disseminate disaggregated adolescent program data, and consistently enhance the political environment to end HIV/AIDS among adolescents. At the country level, EGPAF works in collaboration with national leaders to adapt programs to country contexts. At the community and facility level, EGPAF provides services that cater to the heterogeneity of adolescents.

Guided by this strategy, in 2014, EGPAF began seeking additional resources to expand adolescent HIV programs across supported country programs. Since 2015, EGPAF has scaled up adolescent-focused projects and worked to develop country-specific strategies (country strategies are highlighted in Table 1). These countries mounted a response to a crisis in their adolescent populations that has included creating national technical working groups, providing high-level learning sessions, engaging youth, visiting facilities to enhance adolescent health service delivery, and focused data monitoring. *[Article continues on page 10]*



PHOTO: ERIC BOND/EGPAF, 2016

*The targets are to have 95% of those living with HIV know their status, 95% of those individuals who know their status enrolled on lifelong ART, and 95% of those on ART experience viral suppression by 2030.



PHOTO: ERIC BOND/EGPAF, 2016

Country-Level Focus Within EGPAF Programs

TABLE 1 Country adolescent and youth HIV strategy development to date

	2016		2017		2018	
EGPAF Country	Kenya	Lesotho	Uganda	Malawi	Cameroon	DRC
Strategy Goals	Integrate sexual and reproductive health (SRH) and HIV prevention and treatment for adolescents 10 to 24-years old	95-95-95 for adolescents and young people 10–24 years old; and HIV prevention for uninfected adolescents and young people	Health service delivery, including HIV, TB, SRH, and malaria, among adolescents 10–19 years old	Align adolescent focus with country goals for quality services, increased evidence, and advocacy	Improve uptake of HIV services, quality, and viral load suppression for HIV-positive adolescents	Start Free, Stay Free, AIDS Free initiative for adolescents and young people 10–24 years old
Priority areas for Adolescent and Young Person Subpopulations	In-school adolescent girls and young women and adolescents living with HIV; pregnant and breastfeeding adolescents	Adolescent girls and young women and male sexual partners	Demand creation among all adolescents and young people	Prevention of mother-to-child HIV transmission, HIV prevention, care and treatment, retention and viral suppression support among all adolescents	Referral centers or centers of excellence and all adolescents living with HIV	Adolescents living with HIV and those who need to transition to adult care (20-to 24-years old)



PHOTO: ERIC BOND/EGPAF, 2017

Placing Policymaker Focus on the Needs of Adolescents

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Since the beginning of the epidemic, HIV stakeholders have talked about two age groups affected by the epidemic: children and adults. Yet, as the global HIV response has expanded and evolved, it has become clear that governments need to update national policies and service-delivery models to more effectively address the unique needs of different age groups—particularly, adolescents.

EGPAF has been involved in a number of global and regional efforts to ensure that policymakers are focused on increasing HIV prevention and treatment access and uptake for adolescents, globally. In 2015, EGPAF encouraged the Committee on the Rights of the Child to recognize the unique needs of adolescents living with and affected by HIV and AIDS as the committee prepared a new General Comment on the Rights of Adolescents. Almost all of these recommendations were incorporated into the final General Comment.

Since 2016, EGPAF has been working with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), UNAIDS, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and others to advance the Start Free, Stay Free, AIDS Free framework, a unified road map to end HIV and AIDS in children, adolescents, and young women by 2020. The framework intends to galvanize global momentum and promote national-level action needed to achieve ambitious maternal, pediatric, and adolescent prevention and treatment targets: to reduce the number of new HIV infections among adolescents and young women to fewer than 100,000 and to provide one million adolescents (15–19 years old) with lifelong ART by 2020.

Earlier this year, EGPAF renewed its partnership with the Organization of African First Ladies Against AIDS to advance the HIV prevention and treatment needs of adolescents in Africa. In addition, EGPAF joined the Adolescent HIV Treatment Coalition, a global, collaborative effort to make quality treatment and care available for all adolescents living with HIV. EGPAF has been building global momentum through each of these platforms, creating a louder voice to promote a strong and sustained response to the realities of adolescents affected by HIV. ■



PHOTO: HEATHER MASON/EGPAF 2016

EGPAF STRATEGIES TO IMPROVE HIV PREVENTION, CARE, AND TREATMENT

In resource-limited settings, adolescents face insufficient access to food, education, and housing, as well as high rates of violence—all of which make HIV acquisition risk acute. Yet, perceptions of low risk, low condom uptake, and low rates of HIV testing among youth persist. HIV treatment adherence is low, and treatment failure (e.g. lack of viral suppression) is high among adolescents. EGPAF has scaled up implementation of projects that support adolescents in mitigating HIV acquisition risks, accessing HIV testing sites, receiving SRH counseling, HIV diagnosis, treatment, and retention services, and access to psychosocial support.

Committee of African Youth Advisors

We can only improve access and ensure stable treatment management among adolescents by better understanding the world they face and the impact HIV has on their lives. Creating programs based on their needs, availability, and lifestyle will lead to increased accessibility. In 2018, EGPAF developed the global Committee of African Youth Advisors (CAYA) from supported countries. CAYA is a platform to ensure structured and meaningful youth engagement in HIV program management. This multi-country committee involves adolescent advisors from each supported country who work to inform local program implementation. CAYA members meet regularly to share practices and to review global and national documents and tools to add their perspectives to each. They also attend educational webinars and global technical forums to learn about the progress in treatment, dynamics of the epidemic, and to add youth perspectives to global discourse.

Enabling Health Workers to Manage HIV Among Youth Population

Increasing the capacity of providers, both lay people and professionals, is key to improving adolescent services. Capacity-building initiatives launched by EGPAF in supported settings use a diverse mix of on- and off-site training; on-the-job mentorship; site support; quality improvement exercises; and the development of tools, terms, standard operating procedures, and job aids to ensure sustainability. See page 24 for an example of a large-scale youth care capacity building initiative in Lesotho.

Scaling Up HIV Prevention

A variety of tactics are used to prevent HIV among adolescents in EGPAF-supported programs, from school-based discourse (such as the DREAMS project in EGPAF-Mozambique, see page 32), to HIV risk reduction counseling and increasing access to prevention methods (such as barrier contraception and voluntary medical male circumcision).

The roll-out of Treatment for All (lifelong treatment initiated at the time of HIV diagnosis, regardless of disease status or age) ensures many more adolescents and young adults are eligible for HIV treatment. ART suppresses viral replication and effectively reduces vertical and horizontal HIV transmission (treatment as prevention). EGPAF has been scaling up implementation of Treatment for All guidelines endorsed by the WHO in every supported country.



PHOTO: ERIC BOND/EGPAF, 2018

In addition, EGPAF-Kenya, -Uganda, and -Lesotho are rolling out pre-exposure prophylaxis (PrEP) activities to further facilitate prevention in discordant couples of all ages. These country programs have also been implementing prevention of mother-to-child transmission of HIV (PMTCT) activities specially designed for teen mothers.

Improving Access to Testing and Diagnosis

Young, outwardly healthy adolescents do not often present to test for HIV, mitigate risks, or engage in prevention counseling. EGPAF has implemented multiple practices to recognize patterns of youth behavior and to make testing and risk reduction counseling easier to access. Approaches such as enhanced screening tools, mobile testing, and index case finding have been scaled-up in a variety of settings (a combination of these approaches has been implemented in Kenya, for example; read more on page 28). Targeted mobilization for HIV testing and index case outreach have produced high positivity yields and enabled more than 12,000 new adolescents living with HIV to be successfully identified, linked to care, and initiated on treatment in 2017 alone, in EGPAF programs.¹³

The ART of Adolescents

Compared to adults and young children, adolescents have distinctively different lifestyles, circumstances, and psychosocial needs, and those needs should inform how, when, and where we manage their treatment. Many adolescents are in school and require flexible clinic hours to ensure access to routine HIV care. Many face unrelenting social pressure not to disclose their HIV status, and this lack of disclosure/support has been linked to treatment interruptions and ensuing treatment failure. And some have been on treatment since childhood, have grown tired of it, and need continued monitoring to ensure treatment success.

EGPAF has established school-based mobile testing (through DREAMS, page 32), flexible clinic hours to test and receive

treatment and counseling, and adherence counseling programs to ensure continued access to treatment monitoring and sustained viral suppression (example provided by EGPAF-Malawi, page 36). EGPAF has also created youth-friendly health facilities in several settings (including in Lesotho, page 24) that offer services informed by adolescents for adolescents. HIV testing, care, and treatment; sexually transmitted infection (STI) testing, care, and treatment; PMTCT; maternal and child health (MCH) care; sexual and gender-based violence prevention and counselling, and family planning services are offered in a one-stop model at these centers. These centers also have established psychosocial support programs, such as peer support groups. These interventions have resulted in over 65,000 adolescents living with HIV receiving treatment through all EGPAF-supported projects. *[Article continues on page 14]*



PHOTO: ERIC BOND/EGPAF, 2017



PHOTO: ERIC BOND/EGPAF, 2016

“I Would Be a Madman in the Streets” Michel in Cameroon

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Michel is a fashion-conscious adolescent living in Yaoundé, Cameroon. He is confident and happy today, but he was less so seven years ago when his parents disclosed to him that he is living with HIV. He was 12 years old at the time.

“I was depressed to learn that I am HIV-positive,” says Michel. “But I had been prepared for the news because I had already been attending a psychosocial support group. They kept talking about HIV and AIDS in the support group; so when I was told that I have HIV, I already had a lot of awareness.” After disclosure, Michel moved to a support group for children who know their HIV status.

“Living with HIV is hard. I look at myself, and I look at the others around me—and I wonder what will happen if I tell someone that I am HIV-positive. Will they freeze me out? And it is hard to take drugs every day, especially when you are young. You get up in the morning, and you take drugs. In the middle of the day at school, you take drugs. When you go to bed, you take drugs. When is this going to stop?”

“The counselors help me face these difficulties,” continues Michel. “When I decide to disclose my status to friends and neighbors, and I am afraid of the reaction, they advise me about how to take precautions and how to feel confident. They lift me up, make me feel like I can live like anyone else,” says Michel. “I have a really good relationship

with the support counselors. On a monthly basis, I come here [to the Chantal Biya Foundation's Mother and Child Center, which is supported by EGPAF]. They ask me how I am feeling. Have there been side effects to the drugs I am taking? How is my life at home? If there are problems, they try to help me sort them out. If I have a problem that requires a doctor, they refer me."

"If it were not for the psychosocial support and counseling, I would be a madman in the streets," Michel says. Now Michel looks forward to adulthood. "I am in love," he says. "I have a very nice girlfriend, and the counselors have told me that I can have a family if I want." Michel, who remains active on treatment, has reduced his viral load to an almost undetectable level, giving him an opportunity to use "treatment as prevention" and limiting risk of transmission to his girlfriend. ■



PHOTO: ERIC BOND/EGPAF, 2016

Retention in Care, Viral Monitoring, and Viral Suppression

We are learning more and more about how to ensure better access to viral monitoring and sustained viral suppression. Identifying all adolescents in care and following each to ensure routine adherence counseling and viral load monitoring have been scaled-up in Malawi (see page 36); this project is improving our ability to successfully treat adolescents over time.

To support adolescents and youth in treatment, EGPAF has scaled up implementation of over 500 peer support clubs across eight countries. Combined, these clubs boast more than 10,000 members. They provide assistance in disclosure and create an environment for open discourse about lifelong treatment, stigma and discrimination. This peer support model (exemplified in EGPAF-Lesotho, page 24, and Michel's "life story," page 12) has been associated with increased disclosure and retention within our programs.

Novel approaches to stock second- and third-line regimens for adolescents with treatment failure are also needed. Currently, EGPAF is working with the New Horizons Collaborative to provide advanced treatment management in several country settings (see page 16 for more details).

PMTCT and Care of New Teen Mothers

Between 20% and 30% of PMTCT services are provided to young women. Because youth pregnancy and HIV risks are intertwined, our PMTCT programs focus on addressing the complex needs of teenage mothers living with a chronic condition that affects both herself and her child. EGPAF has increased health worker capacity to support young girls and adolescent women. In Kenya, a home-based program was launched to ensure that teen mothers have access to health and social services (see page 28). In Mozambique, school groups and mobile services take into account the needs of adolescents and young women in pregnancy and early motherhood (see page 32).



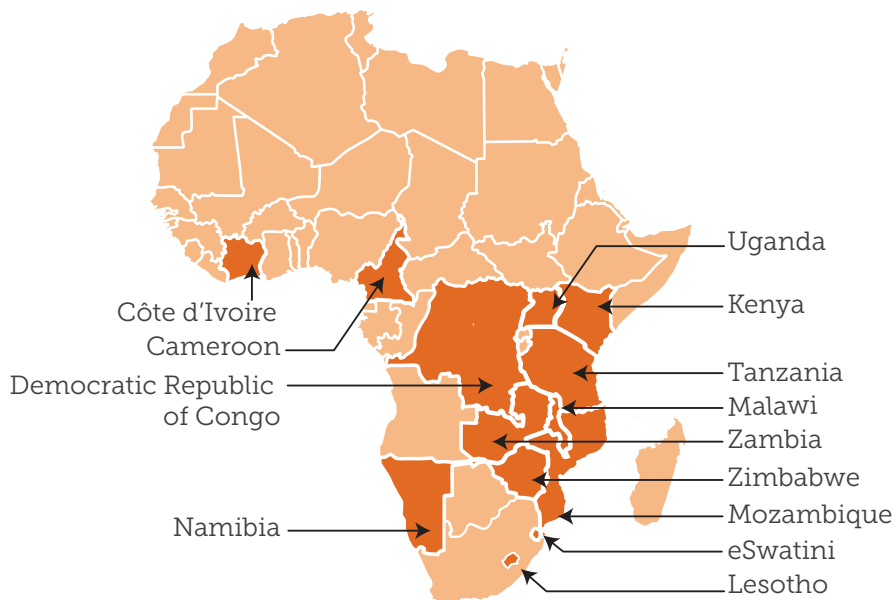
PHOTO: ERIC BOND/EGPAF, 2016

Accomplishments to Date

As of June 2018, EGPAF has implemented programs that have:

- enrolled more than 65,000 adolescents on ART;[†]
- initiated 12,000 adolescents on ART in the preceding 12 months alone;
- increased access to viral load tests, with a focus on improving virologic suppression rates; and
- created more than 500 psychosocial support groups for adolescents and youth, with new evidence-based approaches adapted across country contexts.[‡]

Countries Where EGPAF Supports Adolescent HIV Programs



THE WAY FORWARD

EGPAF, continuing to ensure the elimination of perinatal HIV transmission, maintains an even focus on children, adolescents, and young adults living with or affected by HIV. We will continue to learn from the individuals we strive to serve better. EGPAF will maintain its commitment to using differentiated service-delivery models that cater to the needs of adolescents in health settings, build the capacity of providers and policies to deliver youth-friendly services, integrate services to improve HIV treatment success among adolescents, and build evidence to document progress and successful practices, such as those highlighted in the articles below and in summary on page 19.



PHOTO: ANDREW MARINKOVICH/EGPAF, 2017

[†] Aggregate program data for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Children's Investment Fund Foundation (CIFF) Accelerating Children's HIV and AIDS Treatment (ACT) Initiative supported sites in 12 countries over the 12-month period of October 1, 2016, to September 30, 2017.

[‡] EGPAF-Tanzania Ariel Adherence Clubs are featured on the PEPFAR Solutions Database (<https://www.pepfarsolutions.org/>).

New Horizons Collaborative: Scaling Up Antiretroviral Access for Treatment- Experienced Children and Adolescents

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Background

Long-term treatment, however effective at its onset, can become ineffective over a lifetime, especially when treatment interruptions take place. With more and more children and adolescents diagnosed and enrolled on lifelong ART, demand for second- and third-line treatment is expected to increase in coming years. Prevention and management of treatment failure in children and adolescents living with HIV must be prioritized to achieve and maintain viral suppression and prevent drug resistance in a population suffering from increasing HIV-related morbidity and mortality.

In response to limited availability of second- and third-line pediatric and adolescent treatment options in resource-limited settings, Johnson & Johnson's, EGPAF, and the Partnership for Supply Chain Management launched the New Horizons: Advancing Pediatric HIV Care Collaborative in 2014. Since, Right to Care, The Relevance Network, and the International AIDS Society's Collaborative Initiative for Paediatric HIV Education and Research have joined. Countries participating in New Horizons include Ethiopia, Kenya, Lesotho, South Africa, Rwanda, eSwatini, Uganda, Zambia, and Zimbabwe. Key objectives of the Collaborative include:

- Addressing gaps between pediatric and adult care and treatment
- Targeting challenges to sustainable ART service delivery for children and adolescents
- Building awareness of and confronting challenges faced by adolescents around disclosure, adherence, psychosocial support, retention in care, and transition to adult care

Darunavir/Etravirine Donation Program

The heart of the Collaborative is a darunavir (DRV)/etravirine (ETR) donation program, which increases access to third-line pediatric and adult ART for children and adolescents failing second-line treatment. Johnson & Johnson donates its antiretroviral medicines—PREZISTA® (DRV, TMC114) and INTELENCE® (ETR, TMC125)—to national HIV and AIDS programs for use in children and adolescents up to age 19.

Fostering Technical Leadership and Partnerships

EGPAF provides technical assistance for Collaborative members, including ministries of health, and has developed a number of tools and resources to improve pediatric HIV care and treatment. We have provided capacity building to supported ministries of health on the following topics:

- Facilitating timely regulatory approvals for introducing the donated drugs
- Developing approaches to resolve supply chain management issues
- Sequencing pediatric regimens, with a focus on third-line ART

EGPAF has also coordinated learning platforms to share best practices among Collaborative members through an annual workshop. Young advocates living with HIV have participated in these workshops to ensure that their voices are informing areas for improvement in the work of the Collaborative.

Building the Evidence Base

EGPAF developed a multicountry collaborative research project, based on 2015–2016 New Horizons pilot data in Kenya, Lesotho, eSwatini, and Zambia, that will assess early results of the Collaborative. A research protocol is in its final stages of approval for prospective data collection among a cohort of patients receiving donated products across New Horizons countries. Pediatric patients will be enrolled in the cohort through the end of 2020 and will be eligible to receive donated products through 2039.

EGPAF supports the New Horizons expression of interest (EOI) application process and convenes an expert review committee to ascertain the readiness of countries willing to participate in this donation program. EOI applications may be submitted by ministries of health or by a designee from countries considered to be least developed by the United Nations. New Horizons accepts applications on a quarterly basis, with the following remaining deadlines this year: August 21, 2018, and November 21, 2018. Application materials can be found on EGPAF's website:

<http://www.pedaids.org/new-horizons-advancing-pediatric-hiv-care-collaborative/> ■

New Horizons Collaborative Country Map





PHOTO: ERIC BOND/EGPAF, 2016

Best Practices Highlighted in this Issue of Haba Na Haba



Through our experiences in reaching adolescents, we know that listening and applying youth voices to program design and implementation can lead to success in access to testing, counseling, and support.



Mobile clinics (and their use in male-dominated industry settings, in particular) and school-based education are effective approaches in enhancing testing and awareness of HIV.



A simple screening tool to help health workers identify risks among adolescents and counsel and test as needed, can go a long way in ensuring HIV testing, prevention, and care are provided to those most at risk.



Index client testing, especially among family members of deceased people and sexual partners of adolescents, is very effective in enhancing HIV identification in harder-to-reach populations.



Adolescents benefit not only from integrated services, but from specialized stand-alone adolescent-only service that cater to their specific needs, involve their peers, and offer a range of differentiated services, including linkage to social services and caregiver education for less adherent teens and youths.



We cannot provide adolescent services in a silo: adolescents living with HIV in resource-limited settings face many pressing issues, including food scarcity. We need to make sure we address all needs of the adolescents we serve.



Programs that provide caregiver education and enhance home-based support of adolescents, can deliver better treatment outcomes.



Treatment peer coordinators who use their own life experiences to inspire adolescents and youth to stay on treatment and attain their goals can be a powerful force. Relatability to the individuals who serve their needs is key for adolescents (see our interview with adolescent coordinator Leonarda Pastory on page 20 for more).



Specialized psychosocial support can improve retention in care and virologic suppression rates, especially among pregnant adolescents and young mothers.



Routine audits of viral suppression data can be crucial in developing well-informed outreach projects; bringing us closer to that third 95.

Q&A with Leonarda Pastory, Adolescent Coordinator for EGPAF-Tanzania

Leonarda Pastory lives and works in Tanzania. She is an adolescent program coordinator who works on the implementation of the ClIFF-funded Accelerating Children's HIV and AIDS Treatment (ACT) Initiative (see article on page 23). Through use of her own life experiences as an adolescent living with HIV, Leonarda applies promising practices to scale-up this initiative, reaching as many children and adolescents as she can with lifesaving prevention, treatment, and retention strategies.



LEONARDA PASTORY

Why did you choose a career in HIV? What did it take for you to get to this point in your career?

I chose a career in HIV because I've lived my whole life with the disease. I was born with HIV, lived my childhood, grew into an adolescent, and now I'm a young woman with HIV. It took courage and a great deal of strength to get to this point. There was a time where I nearly dropped out of school to become a maid. But I mustered the strength, and here I am, with a master's degree in public health, doing something I feel I was born to do. I can speak firsthand to the benefits of ART and retention on treatment. I've transitioned from being a vulnerable little girl with a CD4 count at first initiation of just "3" to a dependable 30-year-old wife (to husband Erick, also living with HIV) and mother to a HIV-negative son (just 18 months old) with an undetectable viral load. I have a career with EGPAF-Tanzania that I am extremely passionate about.

Why is working with adolescents an important element of your work?

Most new HIV infections occur among adolescents. Most unplanned pregnancies occur among adolescents, as well. At the same time, adolescents are the most likely to be lost to follow-up, both within the treatment cascade and while enrolled in

antenatal care services. Adolescents are more often living with unsuppressed viral loads, and that is just unacceptable—we need to do more for this group. Working with them and strengthening psychosocial support and counseling ([through Ariel Adherence Clubs](#)) is an important part of my job at EGPAF.

What is the most challenging element of your work with adolescents, and how can you picture our overcoming it?

Most adolescents feel insecure and have not accepted their HIV status. Many of those I work with are orphans (like me), and they don't believe they have important dreams to achieve; they have this negativity in their hearts. This makes it a challenge to counsel them, and it complicates their treatment adherence. I believe it is most important to counsel all children from a very young age that HIV is not a death sentence; rather, it is a chronic illness with which one can live competently. I believe that, as adults, we need to ensure all children grow up with hope; that they will always be able to grow up to be healthy and responsible for their lives and future success.

What is the greatest accomplishment you've witnessed to date in reaching this group?

Acting as a role model and sharing my own status, life experiences and accomplishments have gone a long way. I've seen children who had given up on life, contemplating suicide, become hopeful. They now take their medication and are focusing on future careers. Relatability to treatment coordinators is key.

What should be prioritized to address the gaps in achieving 95-95-95 targets among youth and adolescents by 2030?

We need to strengthen differentiated service delivery models to treat each adolescent and youth as an individual client. Adolescents living with HIV might have similar challenges; however, ways of successfully addressing each of them is quite different, since they have different contexts and thoughts on care. We also need to work closely with parents, caregivers, and

teachers on treating the adolescents and youths they/we care for. Clinical services is one part of treatment, but family life and relationships among parents, caregivers, teachers, and the children they care for has a great impact on treatment success. I also think we need to strengthen sexual and reproductive education health education and services (especially family planning needs of adolescents and youth) and psychosocial support for both adolescents/youths and caregivers. Emotional well-being is critical to long-term care.

What is your hope for all adolescents living with HIV being served by EGPAF?

My hope for all children is that they realize and truly appreciate that it is possible to live positively and achieve their goals. I want the children I work with to see their challenges and turn them into opportunities. These children are our future, and they can become a responsive and responsible force that leads us to an HIV-free generation. ■



PHOTOS: LEONARDA PASTORY



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Project Overview

CIFF awarded EGPAF a two-year project to address the growing needs among adolescents in HIV prevention, care, and treatment in 2016. The ACT Adolescent Project now encompasses three separate country-specific projects in Kenya, Tanzania, and Zimbabwe, all of which are focused on quality adolescent HIV services. In Tanzania, EGPAF collaborates with the Ministry of Health, Community Development, Gender, Elderly and Children, and partners, including Ariel Glaser Pediatric AIDS Healthcare Initiative (AGPAHI), our local affiliate, with technical assistance to provide direct support to 50 facilities (25 supported by EGPAF and 25 by AGPAHI), in five regions.

Project Objectives

- Improve and scale-up adolescent-friendly HIV screening services in select health facilities
- Increase the proportion of HIV-positive adolescents initiated on ART and improve retention and adherence to care and treatment services
- Expand the evidence base to improve existing and new adolescent models of service delivery and strengthen monitoring and evaluation frameworks and systems to improve services

Key Activities and Services Supported by the ACT Initiative

- Full spectrum of adolescent HIV testing, ART, and viral load services at supported sites
- Teen clubs (adolescent psychosocial support groups) at supported sites
- Integrated adolescent SRH services implemented in each supported site
- Health education outreach to communities and schools
- Health care worker training, supervision, and mentorship
- Quality improvement interventions

Progress to Date

Through targeted support at these 50 facilities, the project provided HIV testing among 96,243 adolescents aged 10–19, as of the end of March 2018. Of these adolescents, 1,174 were identified as HIV-positive, and 1,075 (92%) were initiated on ART. Retention at 12 months after ART initiation was 81%. From October 2017 to March 2018 908 received viral load testing, and of these 575 (63%) had achieved viral suppression. Over 3,000 adolescents 10–19 years of age were currently accessing ART at these project-supported sites, at the end of March 2018. EGPAF and AGPAHI trained 250 health care workers on adolescent-friendly health services and established 50 teen clubs (one at each facility). Project staff members provide supportive supervision on service delivery and on quality improvement, with an intensive focus on quality improvement for viral load service improvement.

At the national level, EGPAF is providing support to revise the national adolescent sexual and reproductive health strategy and to develop a guide for health workers on adolescent HIV services. Under this project, EGPAF is also conducting an evaluation of adolescent- and youth-friendly services in Tanzania to further inform future adolescent HIV service delivery. ■

IN LESOTHO...

EGPAF-Lesotho's Customized Adolescent Program: Reaching a Priority Population



- USAID-funded districts
- CDC-funded districts



PHOTO: ERIC BOND/EGPAF, 2017

Since 2004, EGPAF has been supporting Lesotho with technical assistance and advocacy at the national level, as well as with direct service delivery and operations research activities. Currently, EGPAF supports 175 sites in 10 districts, implementing a comprehensive package of TB and HIV services.

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Background

Lesotho has one of the highest national HIV prevalence rates in the world, at 25%.¹³ The prevalence of HIV among adolescents 15–19 years old is 5.1%.¹⁴ Driving the epidemic in this demographic is early onset of unprotected sexual activity (about 46% of young women and 60% of young men 15–19 years of age have had sex at least once, and an estimated 20% of women have given birth before age 20¹⁵), intergenerational sex, and low HIV knowledge (among adolescents, only 35% of females and 30% of males are estimated to report having a comprehensive HIV knowledge).¹³

Strategy

EGPAF-Lesotho developed and launched an adolescent and young people (AYP) HIV strategy to ensure all AYP living with HIV who are accessing EGPAF services live healthy lives and that all HIV-negative AYP are empowered to remain so. The strategy aims to reduce the number of new infections among AYP by 50% by 2020, driving progress toward UNAIDS 95-95-95 targets.¹⁶



Creating Adolescent-Friendly Health Sites

EGPAF developed a seven-part [modular training manual](#) and rolled-out this training in 118 PEPFAR-supported sites beginning in April 2017 (using an on-site training methodology, with one module delivered per month). Each of the seven modules aims to provide health workers with the knowledge and skills to counsel, test, treat, and retain adolescents. Since the training, EGPAF has provided on-site mentorship and supportive supervision.

Beginning in January 2017, EGPAF, with PEPFAR funding and in collaboration with Lesotho's Ministry of Health, established eight adolescent centers at Berea Hospital, Motebang Hospital, Queen Elizabeth II Hospital, Scott Hospital, Maluti Adventist Hospital, Ntsekhe Hospital, Mafeteng Hospital, and (through support to an existing center) the Lesotho Planned Parenthood Association (LPPA). These centers offer HIV and STI risk-reduction counseling; HIV testing, care, and treatment; disclosure and adherence support; TB screening and treatment; peer-led psychosocial support; social services to enable transition to adult care; and referrals to other services (e.g., antenatal care for pregnant teenagers; SRH services, including STI and cervical cancer screening and treatment; family planning; post-exposure prophylaxis [PEP]; post-rape

care and counseling; and, as of October 2017, PrEP). Services are not integrated within other adult or pediatric HIV and MCH services; rather, they are catered only to the AYP population and are found entirely within their own separate clinics. These services are offered throughout the week, on weekends, in the mornings, and after school for increased accessibility. EGPAF deployed adolescent health teams (one pediatrician, six psychologists, six social workers, and six adolescent HIV clinical nurses) to each of the eight centers; the team also supports other health facilities in the hospital catchment areas. These teams are managed by the adolescent and priority population advisor at EGPAF's office in Maseru.

Peer-Driven Support

EGPAF recruited and trained 24 youth ambassadors who focus on sensitizing and mobilizing their peers to engage in health services, providing HIV testing services, and organizing peer support groups. Youth are mobilized from schools, district youth resource centers, youth clubs, and community forums. The ambassadors also work with village health workers to encourage young people to access services at the adolescent centers.

EGPAF developed a [Peer Support Group guide](#) for leaders to develop groups and to ensure standardization of support group activities. Peer support groups are organized

by age (e.g., 10–14, 15–19, and 20–24 years of age). Some groups are further divided by gender, and 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. They discuss fighting discrimination, and they talk about AIDS-free living and sexual health. Strategies are developed for youths at 23 years of age to prepare for transition to adult HIV care and treatment.

Applying Differentiated Care to Address the Needs of All Adolescents

AYP visiting each of the 126 facilities (118 sites where health workers were trained and the eight adolescent-specific centers combined) have a wide range of needs. Some are stable on treatment; some are lacking food or warm clothes; some are not supported by their families or have been orphaned; and some have been the victims of sexual assault. When higher-risk patients such as these present at a supported site, triage nurses refer their cases to EGPAF's team of adolescent social workers, who then conduct home visits to learn more about the home environment, to ensure that social challenges are addressed, and to make efforts to retain all in care. EGPAF social workers also organize caregiver days at supported sites to counsel and empower guardians to accept and support their adolescents.

Achievements from the Implementation of Adolescent Strategy

To date, 1,432 health workers (20 doctors, 481 nurses, 312 counselors, 57 pharmacy technicians, and 562 support staff) completed trainings on adolescent and youth-friendly services across the 118 sites. By

early 2018 in all 118 sites, 192 adolescent peer support groups were established with 3,628 AYP engaging in them. The positivity yield from HIV testing of 188,801 AYP across all the adolescent sites is 3% as of December 2017.

TABLE 2 Compiled statistics from 118 EGPAF supported sites for youth aged 10-24, January-December 2017

Districts	Number tested	Number (%) test- ed HIV-positive	Number (%) ini- tiated on ART	Number current on ART	Number with documented viral load	Number (%) virally suppressed	Peer support groups established
Berea	35,726	899 (3%)	961 (107%)	2,956	943	760 (81%)	62
Leribe	50,561	1,092 (2%)	1,197 (110%)	4,333	1,284	1,042 (81%)	29
Mafeteng[§]	26,925	698 (3%)	801 (115%)	2,021	712	631 (89%)	13
Maseru	58,792	2,219 (4%)	2,462 (111%)	6,685	2,992	2,769 (93%)	61
Mohale's Hoek	16,797	487 (3%)	522 (107%)	1,479	610	387 (63%)	27
TOTALS	188,801	5,395 (3%)	5,943 (110%)	17,474	6,541	5,589 (85%)	192

TABLE 3 Compiled statistics from each of the eight adolescent centers, January-December 2017

Adolescent Centers	Number tested	Number (%) tested HIV-positive	Number (%) initiated on ART	Number current on ART
Berea Hospital	2,962	93 (3.1%)	106 (114%)	429
Motebang Hospital	5,537	164 (3%)	128 (78%)	214
Queen II Hospital	4,947	252 (5%)	231 (92%)	336
LPPA	1,032	48 (4.7%)	41 (85%)	50
Scott Hospital	1,817	46 (2.5%)	47 (102%)	281
Mafeteng Hospital	454	18(3.9%)	18(100%)	280
Maluti Hospital	2,478	59 (2.4%)	63 (107%)	233
Nts'ekhe Hospital	2,053	79 (3.8%)	55 (70%)	169
TOTALS	21,280	759 (3.6%)	689 (92%)	1,992

[§] The Mafeteng adolescent corner started in November 2017. During December schools were closed and children were coming in large numbers after mobilization. A total of 13 psychosocial support groups were established.

At the eight adolescent centers, more than 21,000 AYP were tested for HIV (all were counseled on risk reduction of HIV and STIs and on the importance of care and treatment); of these, nearly 760 were HIV-positive, of which 689 (92%) were initiated on ART. These adolescent centers provide HIV services to 11% of the population on ART in the country (1,992/17,474). They also address the complete SRH needs of pregnant and sexually active young populations. Of all AYP accessed through the eight adolescent centers, 6.8% were treated for STIs. The overall HIV positivity yield for all pregnant AYP was 18.8% (PMTCT was offered to all).

Challenges

Incomplete linkages to HIV treatment and suboptimal ART adherence in HIV care continue to affect AYP living with HIV in Lesotho. Causes include poor care and support from families; non-acceptance of long-term treatment; and nondisclosure of HIV status to friends and family, leading to challenges in consistently taking medications. EGPAF is providing continuous adolescent- and youth-friendly health service training and mentorship to health workers. Support groups and involvement of AYP in program management will continue to drive progress in minimizing discrimination and stigma facing this community.

Viral load monitoring has been crippled by long turnaround times in Lesotho, caused by a shortage of lab personnel to manage a larger inflow of tests and the occasional stock-out of lab reagents or consumables to facilitate tests. EGPAF is working with Lesotho's Ministry of Health to advocate for solutions to this problem. Currently, about 65% of AYP living with HIV who are eligible for a viral load test have received one. EGPAF is working with AYP and their caregivers to ensure that all are monitored and virally suppressed.

Conclusion

EGPAF-Lesotho's adolescent program model has been hailed by the Ministry of Health and donors for providing critical HIV prevention, care, and treatment services to the future generation. Applying a strategy that meets the myriad needs of adolescents has shown promise, as this group may benefit not only from integrated services, but from unique environments that cater to their needs, involve their peers, and offer a range of differentiated services. Moving forward, EGPAF will scale-up this model to the five PEPFAR sustained-response districts, so that youth-friendly health care services will be available in all facilities across the country. ■



PHOTO: ERIC BOND/EGPAF, 2017

IN KENYA...

Special Projects Innovate and Build Evidence in Kenya

EGPAF began working in Kenya in 2000. The program, which started as a small, privately-funded PMTCT initiative, has since grown into one of the largest HIV prevention, care, and treatment programs in the country, with special focus in two geographically unique areas: Western Kenya and Turkana.

Over the past several years, EGPAF-Kenya has developed several initiatives to increase access to HIV prevention, testing, treatment, and retention services among adolescent and youth populations across the country. Herewith is a glimpse into three major initiatives showing promise in reaching this vulnerable population with needed HIV services, while generating evidence along the way.

ELMA Project

In 2015, the ELMA Foundation and EGPAF launched a project in Kenya to increase access to HIV testing and linkage to ART among children and adolescents (from 18 months to 19 years of age). The project has been implemented in 78 sites in Homa Bay, Migori, and Kakamega counties from November 2015 to October 2018. The project uses innovative strategies for intensive case finding, including “smart” testing, targeted community testing, and index client testing.

Smart Testing

Smart testing involves the use of a screening tool to identify children and adolescents who are eligible for HIV testing based on national testing guidelines. Eligibility criteria include children under nine years of age and never tested for HIV; those with HIV-positive mothers, children who appear malnourished, symptomatic of HIV or TB, have been hospitalized in the past six months, or have abused drugs or alcohol; adolescents with a history of sexual abuse or sexual activity, or

have been exposed to condom malfunction; and all victims of rape. Trained triage assistants structure client flow in 16 sites to ensure that all clients are screened using this tool before being seen by a clinician. Clients with any of these characteristic are counseled and linked to HIV testing services before seeking other health services. Retesting, especially among older adolescent key populations (e.g., a negative partner in discordant relationship and those on PrEP), and annual testing for all adolescents is encouraged during counseling and testing. The positivity yield among clients in the 16 sites increased from an average of 0.6% in May 2017 to 2.0% in July 2017. The intervention was expanded to all EGPAF-supported sites in Kenya as of May 2018.

Targeted Community Testing

Targeted community testing, including testing at social and industry settings where adolescents (and, in particular, harder-to-reach male adolescents) frequent, such as fishing beaches and soccer games, enabled further identification of HIV cases. Peer educators were recruited from the community and were sensitized on HIV testing and linkage to care and treatment. These educators set up testing tents on beaches and on the sidelines of soccer games, testing individuals and offering supportive counseling and care and treatment linkage services. A total of 385 adolescent young boys were tested at two fishing beaches, with 14 testing positive (3.64% positivity). From January to February 2018, 72 adolescent



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TABLE 4 Positivity Across Types of Index Cases

Index Client Case	Tested	HIV-Positive	Positivity
ART client's children testing	22,019	332	1.5%
Deceased index family testing	861	30	3.5%
Adolescent sibling testing	1,389	39	2.8%
Adolescent partner testing	290	8	2.8%

boys were tested during the National AIDS Control Council “Maisha League” in 2017; two were diagnosed positive (a positivity of 2.8%).

Index Client Testing

The project also scaled-up testing of children of deceased ART clients, adolescent siblings, and sexual networks. EGPAF created an index clients contact register and tracing forms, and HIV testing service providers were recruited and trained on their use. Health care workers were sensitized on adding contact information to the tracing register through information provided on facility-based patient treatment cards (used by health facility staff to manage patients on ART). Health workers were also mentored on the importance of providing family testing, when possible. See results in Table 4.

Adolescent Girls and Young Women Project

This Johnson and Johnson (J&J)–funded project in Kenya targets pregnant or breastfeeding adolescent girls and young women aged 15–24 years in 32 health facilities in Kakamega County. It is a peer-led project, which aims to support existing PMTCT with enhanced psychosocial support groups, providing a forum for adolescent and young girls to support each other in care, treatment, and motherhood. All adolescent girls attending antenatal and postnatal clinic services are invited to join psychosocial support groups across the 32 sites. The peer educators are clients actively enrolled on treatment who are recruited from these sites by EGPAF staff

and trained on HIV, SRH, gender-based violence care, and infant care in a three-day on-site training. The educators coordinate with MCH nurses and use home visits and increased counseling to help young women manage their HIV treatment, viral load, and suspected treatment failure. In 2017, the project enrolled 3,922 adolescents and young girls; the number of participants is expected to double this year.

Viral load testing and viral load suppression rates were measured before and after implementation of the peer support model in these sites. Results indicate marked improvement in viral load testing, from 83% at six months post-ART initiation to 96%, and in viral suppression, from 78% to 96% at six months on treatment. These findings underscore the importance of peer support on critical treatment outcomes.

Adolescent PMTCT: Home Visits for Case Management

EGPAF-Kenya is implementing a home visiting program to link adolescent girls (10–19 years of age), young mothers, and their children to health and social services. The program uses a case management approach. This one-year intervention, which runs from January 2018 to December 2018, uses community mapping in Kisumu and Homa Bay counties to collect information on pregnant, breastfeeding, or teen mothers of infants. A home visiting team provides mentorship to offer support in care, retention, PMTCT, and follow-up on postpartum services of mother-baby pairs to each adolescent girl's home. Linkage to health and social services is offered during

these visits. Recognizing the economic hardship experienced by adolescent mothers, this intervention is also piloting a “Cash plus Care” package in which eligible at-risk pregnant adolescents and adolescent mothers will receive cash transfers to stay in school (or be readmitted after delivery), for school uniforms, for clinic fees to ensure safe and skilled delivery, and for daycare support for infants when the young mothers rejoin school.

As of April 2018, 192 at-risk adolescents have been enrolled in the program. Nearly 500 adolescents have been identified; all of them were invited to enroll in the program in the coming months.

Lessons Learned:

- Providers need help making HIV testing for adolescents a routine process, with easy-to-use tools.
- Index case testing works, but we need to look beyond current clients in care. Deceased clients may link us to more unidentified cases.
- Antenatal care continues to be a source of new case identification and a place to address HIV prevention and treatment needs.
- Specialized psychosocial support can improve retention and viral suppression rates, especially among pregnant adolescents and young mothers.■

Maureen Overcomes Hunger in Turkana County, Kenya

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PHOTO: ERIC BOND/EGPAF, 2016

Maureen Esekun, 15, knows well the gnaw of hunger. She knows the lightheadedness that comes when she gathers firewood in the sweltering heat. She knows about the weak knees that make each step a struggle as she walks the dusty paths to school. “Sometimes I would go three days without eating because of lack of food,” says Maureen. “When I wake up in the morning, I feel weak, and it is hard to start my day.” Food scarcity of this scale would be a challenge for any growing adolescent, but it is particularly difficult for Maureen because she is living with HIV, and she is supposed to take her ART with food.

“When I feel dizzy, I sleep, and I persevere,” says Maureen. “But I always take my medicine.” With 90% of the population living below the poverty threshold, Turkana County is the poorest region in Kenya. Cut off from the rest of the country by poor roads and a harsh climate, Turkana County frequently faces drought, which threatens livestock—the main source of sustenance and income. Crop cultivation is limited.

“Data from our Turkana program show that more than half of our clients have either moderate or severe forms of malnutrition,” says Lazarus Momanyi, M.D., a manager of EGPAF’s Timiza 90 project. “Malnutrition in HIV weakens the body’s immunity and hastens disease progression.

In response, EGPAF is using a multisectoral approach working with partners, such as World Relief and the World Food Programme, to connect children and their families to nutritional

and livelihood support,” says Dr. Momanyi. With support from EGPAF, the Lodwar County Referral Hospital has linked Maureen to nutrition support, providing her with Food by Prescription Prescription, a fortified flour for a porridge that meets the energy needs of a growing adolescent. EGPAF also supports the distribution of wet foods like githeri (beans and corn) during pediatric and adolescent clinic days at the facility. “Porridge is prepared and provided for the children and adolescents as they wait to see the clinician,” says Carol Mukami, the project officer for EGPAF’s nutrition component. “Apart from providing additional nutrition, this led to improved appointment-keeping at the facility.”

Although Maureen has missed several years of school because of illness, now she is in Class 5 in her primary school. She is determined to continue on to secondary school and graduate. “I faithfully go to school because I know that education is my future,” says Maureen. “I want to go to the university in Nairobi. I want to get married and have five kids.” ■



PHOTO: ERIC BOND/EGPAF, 2016

IN MOZAMBIQUE...

Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS)

In 2004, EGPAF began implementing a PMTCT program in the Nampula, Cabo Delgado, Maputo, and Gaza provinces in Mozambique. Currently, EGPAF-Mozambique supports the Ministry of Health in providing HIV services at 137 health facilities in Gaza; it also supports performance-based financing efforts in Nampula and Gaza. A key priority population in Mozambique is adolescent girls and young women; EGPAF has been involved in a partnership to enable support for this population.

HIV prevalence is more than four times higher in adolescent girls and young women than in men of the same age in Mozambique.** Drivers include early sexual debut (25% of women and 24% of men are sexually active before age 15), early marriage (48% are married before age 18), having older sexual partners (11% of women 15–19 years old have had sex with a partner who is at least 10 years older), and early pregnancy (46% of adolescent girls between ages 15 and 19 are pregnant or have become mothers).¹⁷

The three-year DREAMS partnership project delivers a core package of evidence-based approaches that help adolescent girls and young women (ages 10–24) remain free of HIV. DREAMS is supported by PEPFAR, the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences, and ViiV Healthcare in 10 countries with the highest adolescent HIV burden, including Mozambique. By increasing availability of and access to quality health services and addressing the factors that put girls at increased risk of acquiring HIV, including poverty, gender inequality, sexual violence, and a lack of education, DREAMS works to empower girls and mobilize communities to invest in girls and young women.

DREAMS is implemented in the six districts in Mozambique with the highest

burden of HIV infection. Alongside World Education, Nweti, Rede CAME, Jhpiego, and Nucleo Provincial de Combate ao SIDA, EGPAF works to implement a multilayered intervention. EGPAF's role within this partnership is to implement clinical interventions within 52 facilities. Our comprehensive clinical package includes prevention of new HIV infection, prevention of unintended pregnancy, STI screening and treatment, postsexual and gender-based violence treatment, PMTCT, and postnatal care for girls and adolescents. Partners have been implementing complementary community- and school-based activities.

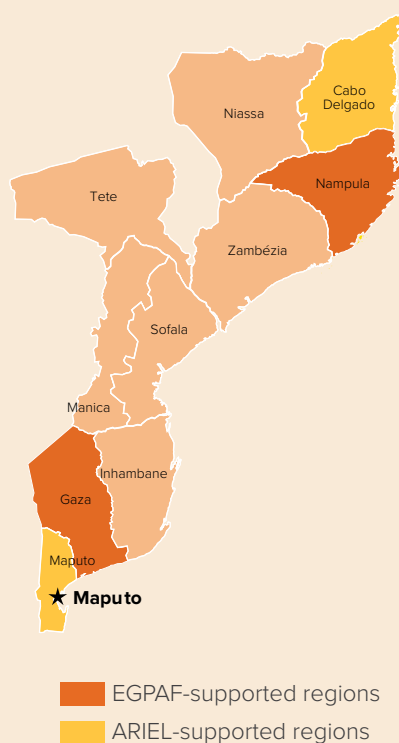
Scaling Up Capacity

EGPAF trained health providers in the 52 sites, including in stand-alone youth-friendly clinics, as well as providers operating mobile clinics. Peer educators were trained to provide education on SRH and HIV, refer adolescents to clinical services, mobilize adolescents living with HIV to form and attend support groups, and facilitate these groups.

Youth-Friendly Services and Clinics

Youth-friendly services were established in all 52 facilities. In four health facilities, youth-friendly services are provided in separate stand-alone clinics for youth; and

** Among women ages 15–19, HIV prevalence is an estimated 6.5%; among men in this age group, the estimated rate is 1.5%. Among women ages 20–24, HIV prevalence is estimated at 13.3%; among men of this same age: 5.3%.



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in 48 health sites, youth-friendly services are integrated into existing clinical services. Providers in all clinics were trained to respond to the specific SRH needs of adolescents in an open and thoughtful manner. Services provided in all of these settings include HIV prevention, care, and treatment; family planning; STI screening and treatment; and antenatal care services. Clinic schedules are adapted to ensure that school-going adolescents can visit after school hours.

Mobile Health

Mobile clinics are being used to provide adolescent girls and boys with SRH/HIV services in close proximity to secondary schools and sports stadiums. In the mobile clinic, HIV testing and counseling are offered in addition to other SRH services. All adolescents in need

of further clinical services are referred to their closest health facilities for ongoing care. Those testing HIV-positive are linked to treatment.

School-Based Education Corners

To increase access to SRH/HIV information, EGPAF established youth corners in six secondary schools. After school, peer educators meet with students to provide SRH/HIV education or referral to a health facility for related services. These educators also provide health and HIV education during graduation ceremonies and in class meetings during regular school hours. The after-school meetings include discussions and films (to frame discussions) on HIV, SRH, pregnancy, and gender-based violence.

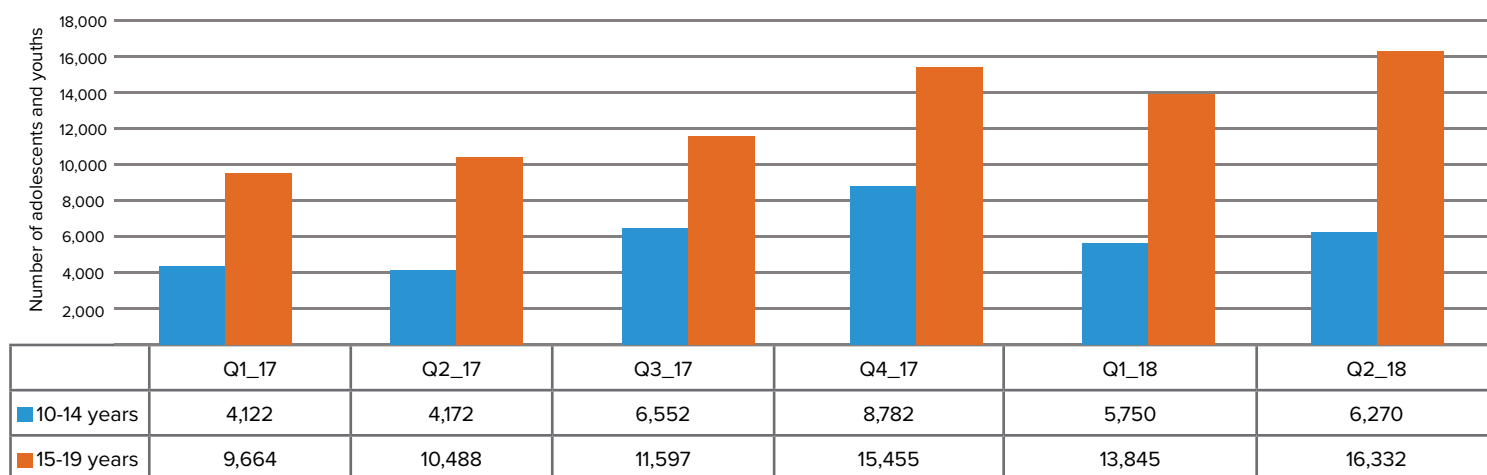


FIGURE 3 HIV testing among adolescents in DREAMS districts

TABLE 5 Positivity rates across sites between early-2017 and mid-2018.

	DREAMS	Non-DREAMS	DREAMS	Non-DREAMS	DREAMS	Non-DREAMS	DREAMS	Non-DREAMS
	M (10-14 years)	M (10-14 years)	F (10-14 years)	F (10-14 years)	M (15-19 years)	M (15-19 years)	F (15-19 years)	F (15-19 years)
Q1_FY17	2%	2%	2%	4%	3%	6%	5%	5%
Q2_FY17	2%	3%	2%	4%	3%	2%	4%	4%
Q3_FY17	1%	2%	1%	2%	1%	2%	3%	4%
Q4_FY17	2%	2%	1%	1%	1%	1%	3%	3%
Q1_FY18	1%	1%	1%	1%	1%	1%	2%	3%
Q2_FY18	2%	1%	2%	1%	1%	1%	2%	4%

One-Stop Model for Gender-Based Violence Services

Comprehensive post-violence care, including PEP, emergency contraception, STI screening, injury care, psychosocial support and counseling, and ongoing support (for four months), is offered to any client post-violence in eight of the 52 sites, along with consented forensic collection and submission to police. Gender-based violence counseling and care are provided using a one-stop model, where services are provided in a single, private room so that clients can receive integrated care from one health staff member without having to transfer to other departments, clinics, or the police department.

Results

In the DREAMS districts, an increasing number of adolescents has been tested and know their HIV status (see Figure 3). Positivity yields were calculated and compared between DREAMS and non-DREAMS sites and the results are varying; with an overall positivity yield spike seen in boys and even more drastically in young women, 15-19 years of age (Table 5).

Next Steps

To date, DREAMS has demonstrated an increase in the number of adolescents knowing their HIV status, and access to information and services. In the coming year, EGPAF will expand SRH/HIV service delivery at secondary schools and health facilities. In addition to SRH/HIV education, a full-time MCH nurse will provide clinical SRH/HIV services within youth corners at selected secondary schools. MCH nurses based at schools will also create awareness among teachers regarding adolescents and SRH/HIV, with the aim to reduce stigma and discrimination faced by adolescents living with HIV. The mobile clinics will continue to provide youth-friendly services at schools without permanent youth corners, as well as places where youth gather on weekends so that out-of-school adolescents can be reached.■





PHOTO: ERIC BOND/EGPAF, 2017

IN MALAWI...

Increasing Access to Viral Load Monitoring Among Adolescents Living with HIV to Improve Treatment Outcomes

EGPAF began supporting operations in Malawi in 2001. Currently, EGPAF-Malawi provides technical assistance in the provision of adult and pediatric HIV prevention, care, and treatment services to more than 130 Malawian Ministry of Health and faith-based facilities, district-level health teams, and community-based organizations.



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In Malawi, there are an estimated 90,000 adolescents (10–19 years of age) living with HIV, with 4,800 new infections each year.²³ With funding from PEPFAR and the U.S. Centers for Disease Control and Prevention, EGPAF supported Malawi's Ministry of Health in providing 2,300 adolescents living with HIV with a package of care at 21 high-volume facilities across seven districts. Routine clinic hours were extended to one Saturday per month to ensure adolescent participation without affecting school attendance. The package of services includes communication and counseling, HIV testing and viral load monitoring, ART, SRH services, nutritional care and support, and psychosocial support. EGPAF-trained nurses, clinicians, and teen mentors provide these services at all 21 sites. Health care workers were trained by EGPAF and the African Network for Care of Children Affected by HIV/AIDS in December 2015 and February 2016.

In 2016, Malawi's national HIV program launched guidelines to ensure that all clients on ART are monitored for treatment success and reach optimal viral suppression. The Malawi national guidelines recommend routine viral testing at six months post-ART initiation and every two years thereafter. Clients with a high viral load (> 1,000 copies) are assessed and receive intensive adherence counseling for three consecutive months before having a repeat viral load test. Treatment-adherent clients who have high viral load after a repeat test are switched to second-line ART.

From April to May 2017, EGPAF-Malawi conducted an assessment of viral load monitoring among adolescents. The assessment involved auditing ART master cards (a facility-based treatment register used by health workers to facilitate clinical monitoring of each HIV-positive patient) to determine whether viral load testing was performed according to guidelines among adolescents (10–19 years of age). The audit identified eligible adolescents who missed their viral load test; these adolescents were traced through home visits and offered a viral load test. Out of 1,013 adolescents registered and assessed in 21 supported facilities, 957 were eligible for viral testing, and 814 had received at least one viral load test. Of the 814 teens with a viral load result documented at the time of the audit, 22% had received the test as per milestones (at six months post-ART initiation and again at two years post-ART initiation), and 88% were offered a test. Of the 143 adolescents who had never received a viral load test, 25 were at boarding school during follow-up activities, 22 were absent but eventually tracked, 28 defaulted, three had died, and 17 did not receive a test for unknown reasons.

Of the 814 tested, 80% (651/814) were virally suppressed and 20% (163/814) had a high viral load. Of the 163 with a high viral load, 124 (76%) completed intensive adherence counseling, per national guidelines, and 72 had a repeat test (52 still had poor adherence despite intensive counseling; these adolescents are still followed, counseled, and managed, and



attempts to reach them for viral monitoring are ongoing). After repeat testing, 45% (33/72) still were not virally suppressed; 90% (30/33) of these individuals were switched to second-line ART, while 9% (3/33) had died by the time results came back. Of those who had died, such conditions as poor nutrition and unsupportive families were seen. EGPAF is working to scale up peer/community support activities to further reduce mortality risks.

Through the viral load audit, EGPAF-Malawi identified key focus areas for health care providers and adolescent mentors to better manage HIV treatment in adolescents. These areas include timely identification of eligible adolescents for viral load testing, routine

viral monitoring audits, and adolescent-focused adherence counseling through use of lay health workers (i.e., recruitment of “expert teen clients,” who are selected by health sites to remind clients, provide role modeling, and lead youth outreach activities). Differentiated models of care will further allow health workers to reach children at highest risk of mortality with needed support services. A teen club approach was recently adopted nationally and is currently being rolled-out across EGPAF sites within Malawi. EGPAF-Malawi teen clubs will offer a clinical package to more than 11,000 adolescent living with HIV, who will be tracked across the care and treatment cascade. The aim of the package is to ensure that all adolescents living with HIV are both retained in care and virologically suppressed as they transition to adult care.

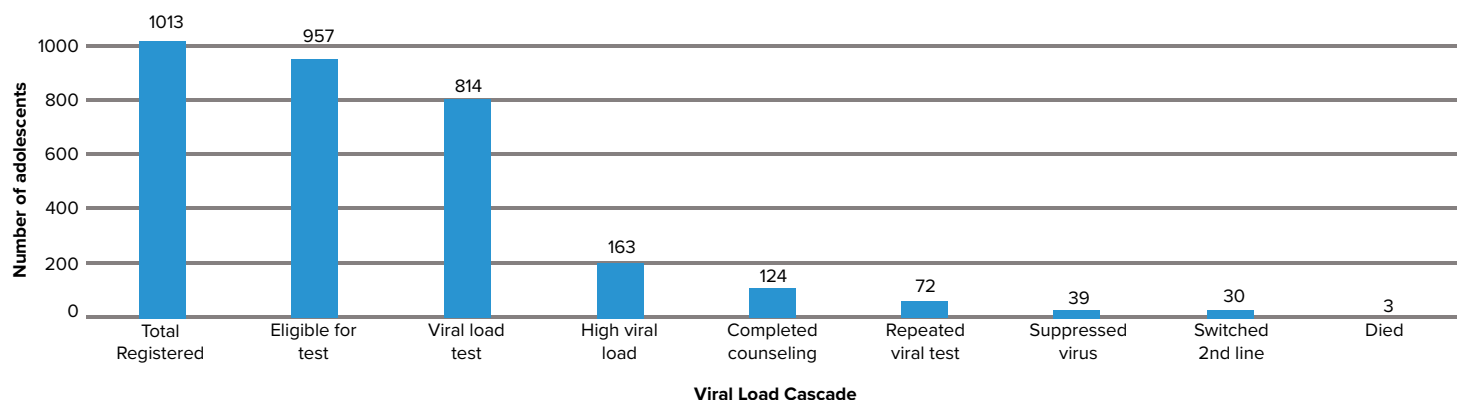


FIGURE 4 Viral load cascade in EGPAF-supported adolescent clubs (10-19 years of age)

EGPAF Research Zeros in On Adolescents

30 years ago, EGPAF was founded to catalyze support and research to end AIDS in children and our focus in this area remains. In recent years, EGPAF has expanded its research lens to better understand HIV risk factors among adolescents, who are transitioning through childhood. Operations research has been conducted to understand how best to provide HIV services, especially PMTCT services, to adolescents and young women; to identify and better retain young HIV-positive clients on treatment; and how to manage drug resistance and suspected treatment failure.

Multiple journal articles have been published by EGPAF in recent years that expand our understanding of adolescent and youth subpopulations. These include:

[Preventing Human Immunodeficiency Virus Acquisition in Youth](#)—Generations at Risk, Authored by Lynne Mofenson, EGPAF Senior HIV Advisor in Research and published in the Journal of American Medical Association, Pediatrics in 2017 (71[9]:829–830).

[The Epidemiology of Adolescents Living with Perinatally Acquired HIV: A Cross-Regional Global Cohort Analysis](#). Co-authored (alongside the CIPHER study team) by Lynne Mofenson and published in PLoS Med in 2018 (15[3]:e1002514).

[In Search of the Right Time and Right Place: Screening Adolescents and Youth for Human Immunodeficiency Virus in the United States](#), co-authored (alongside with George Siberry, PEPFAR) by Natella Rakhmanina, Senior Advisor in EGPAF's Technical Assistance & Sustainability Unit, and published in the Journal of Adolescent Health in 2018 (62[3-4]).

[PMTCT Service Uptake among Adolescents and Adult Women Attending Antenatal Care in Selected Health Facilities in Zimbabwe](#), co-authored by Reuben Musarandega, EGPAF-Zimbabwe Senior Strategic Information & Evaluation Officer, et al. and published in the Acquired Immune Deficiency Syndrome in 2017 (75[148-155]).



[Optimizing Linkage to Care and Initiation and Retention on Treatment of Adolescents with Newly Diagnosed HIV infection](#), co-authored by Eva Ruria, EGPAF-Kenya Program Officer, et al. and published in AIDS in 2017 (31[253-260]).

[Youth Engagement in Developing an Implementation Science Research Agenda on Adolescent HIV Testing and Care Linkages in sub-Saharan Africa](#) by Lynne Mofenson in 2017 in AIDS in 2017 (31[195-201]).

More studies that include adolescents are underway and additional evidence will be published. Visit the [EGPAF resource library](#) for a current update.





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IN eSWATINI...

Reaching Current and Future Generations of Adolescents with HIV Testing Services and Comprehensive HIV Services in eSwatini

Since 2003, EGPAF-eSwatini has provided support to the Ministry of Health to improve health systems through trainings, mentorship, and procurement of essential HIV drugs and commodities. Currently, EGPAF-eSwatini provides PMTCT, ART, and TB-related services in 56 sites in the Hhohho and Shiselweni regions.

eSwatini has one of the highest adolescent and adult HIV prevalence rates in the world, at 27% for people 15–49 years old. Despite major achievements in epidemic control among adults, only 32% of adolescents living with HIV know their status.¹⁹ EGPAF-eSwatini developed, implemented, and examined school debates to expand access to HIV knowledge and testing services among adolescents.

School Debates

Through ELMA Foundation funding, EGPAF-eSwatini collaborated with the Ministry of Education to conduct debates targeting primary school children under 15 years of age and referring them for HIV testing at nearby health facilities. The debates were conducted in schools in April and May 2017. Ministry of Education staff moderated, and a facility nurse was assigned to clarify misconceptions during the debate. Because HIV testing is not allowed in schools in eSwatini, children interested in testing were given referral forms (which they had signed by caregivers and then handed over to facility staff before testing for HIV), and an invitation letter was sent out to formally request that parents/caregivers accompany the children for HIV testing.^{††} Nearby facilities monitored referred patients for three months after the debates. A total of 1,124 adolescents (506 boys and 618 girls) attended the debates. Of these, 269 (47.3%) males and 300 (52.7%) females arrived at a nearby clinic for testing, using their referral forms. Two children were found to be HIV-positive (a boy and a girl), and both were initiated on ART.

Lessons Learned

We learned that engaging children at schools is feasible and enhances use of services, though could be bolstered in settings where testing is not allowed on campuses by mobile testing opportunities. This activity did not result in a high positivity yield, but it did expose a greater number of youths to HIV education and testing information and services.

[†] Among women ages 15–19, HIV prevalence is an estimated 6.5%; among men in this age group, the estimated rate is 1.5%.
^{††} Among women ages 20–24, HIV prevalence is estimated at 13.3%; among men of this same age: 5.3%.

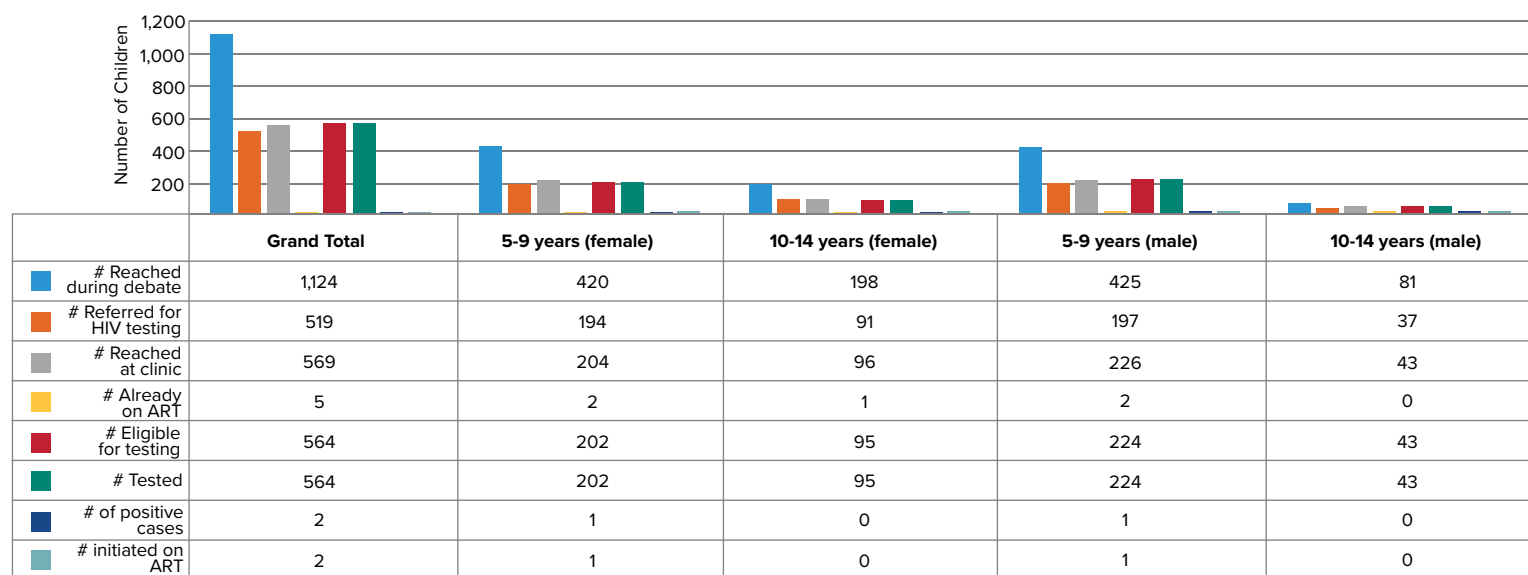


FIGURE 5 Referrals and linkages for pupils reached during school debates by age and gender



PHOTO: ERIC BOND/EGPAF, 2015

EGPAF Ambassador, Brian Ahimbisibwe

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For more about our EGPAF ambassadors, please email media@pedaids.org.

While growing up in Rutooma, a village in south-western Uganda, Brian Ahimbisibwe did not know that he had been born with HIV. His father died when he was only nine months old, and his mother passed away when he was 10 years old. His aunt, who assumed responsibility for his care after his parents died, did not tell him about his status, nor did she explain why he needed to take daily medication—leaving him unaware for years.

In 2006, when he was 16, a friend noticed him taking medications and asked if they were for HIV. Brian was confused and shocked, denying the possibility. However, his friend's question planted doubts in his mind. He looked into his prescription and realized it was, in fact, an antiretroviral drug.

HIV- and AIDS-related stigma, engrained in Brian's community, filled him with shame and fear. Brian stopped taking his medications reliably and skipped a few doctor's appointments. Soon, his health began to deteriorate. Eventually, returning to the clinic where he sought treatment, he recognized three fellow students from school. They acknowledged each other, mutually recognizing their shared status. Finding solidarity in this way was comforting to Brian and to his classmates.

Brian was among the first members of an Ariel Club—a peer-led psychosocial support group for youths living with HIV—started at Kabale Regional Referral Hospital in 2007. He also began to help register other children at the clinic and to follow up with those who missed meetings. In 2008, he and a small number of other Club members were invited to an Ariel Camp in Kampala. At the camp, he and his peers engaged meaningfully in diverse topics such as adherence, sexual and reproductive health and rights, and the transition to adulthood. He notes that this was a once-in-a-lifetime experience that solidified his passion for and dedication to advocating for HIV and AIDS issues.

In addition to his role as an EGPAF ambassador, Brian continues to be a peer mentor to young people in his community and throughout Uganda. Outside of his work with EGPAF, he is pursuing a master's degree in public health. ■



PHOTO: KATHLEEN BORQUETA/EGPAF, 2018

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