G-POWER: Girls—Protected, Optimistic, Wise, Enlightened, Responsible, and Resilient

A comprehensive program to support pregnant and breastfeeding adolescent girls and young women and their infants to achieve and sustain health and well-being

Eric Bond/EGPAF, 2019

Elizabeth Glaser Pediatric AIDS Foundation
Fighting for an AIDS-free generation

SUPPORTED BY

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Table of Contents

INTRODUCTION TO G-POWER . . . 5

STATE OF PBF AGYW IN KENYA AND HOMA BAY . . . 6

- Adolescent girls and young women . . . 6
- The state of the triple threat affecting AGYW globally and in Kenya . . . 6

G-POWER . . . 9

- Rationale for G-POWER . . . 9
- The G-POWER package . . . 9
- Alignment to global recommendations . . . 14

THE AGYW PEER-CENTRIC CASE MANAGEMENT APPROACH . . . 16

- The AGYW peer mentors . . . 16
- How AGYW peer mentors identify and link PBF AGYW into G-POWER . . . 18

HIV-POSITIVE AND HIV-NEGATIVE AGYW CARE AND SUPPORT . . . 24

VALUE ADDED BY THE G-POWER PROGRAM . . . 28

IMPACT OF THE G-POWER PROGRAM . . . 29

- Earlier identification of pregnant AGYW through standardized use of pregnancy screenings and prompt linkage to ANC, PNC, or PMTCT . . . 29
- Implementation of HIV retesting across the ANC and PNC cascade with fidelity, following up on missed opportunities, and rapid identification of seroconversion cases for prompt ART initiation . . . 30
- Reduced rates of seroconversion along the pregnancy and postnatal cascade observed among PBF AGYW in the G-POWER program . . . 32
- Improved skilled delivery . . . 34
- Comprehensive care and support for HIV-exposed infants . . . 35
- Integration of social support and social protection . . . 36
- Facilitating school re-entry for PBF AGYW . . . 38
- Increased identification of GBV cases among AGYW and linkage to care and support . . . 39

CLOSING AND CONTACTS . . . 41

APPENDIX . . . 42

- Training schedule for AGYW peer mentors . . . 43
- Risk Behavior Assessment—PrEP Eligibility . . . 44
- Indicator Reporting Template . . . 45

REFERENCES . . . 48

Acronyms and Abbreviations

AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral therapy
CBO	Community-based organization
CCC	Comprehensive care clinic
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
ECD	Early childhood development
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FP	Family planning
GBV	Gender-based violence
HCW	Health care worker
HEI	HIV-exposed infant
HIV	Human immunodeficiency virus
MBP	Mother-baby pair
MCH	Maternal and child health
MDT	Multidisciplinary team
MOE	Ministry of Education
OVC	Orphans and vulnerable children
PBF	Pregnant and breastfeeding
PNC	Postnatal care
PMTCT	Prevention of mother-to-child transmission
PREP	Pre-exposure prophylaxis
PSS	Psychosocial support
SGBV	Sexual and gender-based violence
SOC	Standard of care
SRH	Sexual and reproductive health
STI	Sexually transmitted infection

Introduction to G-POWER

In recognition of gaps within the cascade of care for pregnant and breastfeeding (PBF) adolescent girls and young women (AGYW) and their infants, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Kenya, with support from The ELMA Philanthropies, designed and implements a tailored, multipronged, and sectoral package of care aimed at providing quality, comprehensive, peer-centric care for improved retention and clinical outcomes among PBF AGYW and their infants. This package, known as G-POWER, refers to girls who will be protected, optimistic, wise, empowered, and resilient through the support of the program. Initiated in 2020, G-POWER is being implemented in 36 facilities in Homa Bay County, Kenya, with 40 trained and capacitated AGYW peer mentors spearheading the approach.

Eric Bond/EGPAF, 2019

State of Pregnant and Breastfeeding AGYW in Kenya and Homa Bay

Adolescent girls and young women

Adolescent girls and young women (AGYW) aged 10–24 are a unique population facing distinct social, economic, health, and developmental risks. Globally, AGYW represent a population disproportionately affected by HIV, gender-based violence (GBV), and pregnancy—also referred to as the triple threat. A number of factors affect their autonomy and agency in preventing transmission of HIV, GBV, and pregnancy: a lack of available, comprehensive sexual and reproductive health education, relationships with older men or with multiple partners, transactional relationships, low condom use, coercion, early sexual debut, and other pressures and stigmas.[1]

The risks, vulnerabilities, and realities that impact the lives of pregnant and breastfeeding (PBF) AGYW and their infants occur at various levels of society. The socioeconomic diagram depicted in Figure 1 outlines the factors, individuals, and entities that PBF AGYW and their infants interact with on a regular basis. Acknowledging the broad social determinants that affect this population creates a demand for programming that target them and address their broader needs in addition to their health and well-being.

The state of the triple threat affecting AGYW globally and in Kenya

The risk and prevalence of HIV, pregnancy, and GBV constitute the triple threat affecting AGYW globally and in Kenya.

HIV

Approximately 1.4 million adolescent girls are living with HIV globally. In sub-Saharan Africa, the prevalence of HIV among AGYW is two to three times that of boys and young men.[2] Despite a global 27% decline in new HIV infections among AGYW between 2015 and 2020, this decline was not uniform nor did it reach global targets.[1] In 2021, roughly 250,000 AGYW acquired HIV worldwide, the majority of them in sub-Saharan Africa.[3] Globally, an estimated 4,900 AGYW (age 15–24) were infected with HIV on a weekly basis in 2021, representing 63% of all new infections.[3] AGYW experience a threefold risk of acquiring HIV compared to boys and young men.[3] The HIV burden in Kenya follows a similar trend. In 2020, over 10,000 new infections occurred among AGYW (age 15–24), more than twice the incidence of new infection among young men in the same age group.[4]

HIV outcomes for adolescents and youth remain suboptimal compared to other populations. Linkage to care and initiation on antiretroviral therapy (ART), sustained retention in care, and challenges with adherence contribute to high adolescent HIV morbidity and mortality.[5,6] Furthermore, for AGYW, pregnancy is among the most vulnerable states for HIV acquisition. Across selected countries, an estimated 66,000 AGYW became HIV positive while pregnant or breastfeeding during 2020; 42% of all women who seroconverted during pregnancy or breastfeeding were aged 15–24.[1]

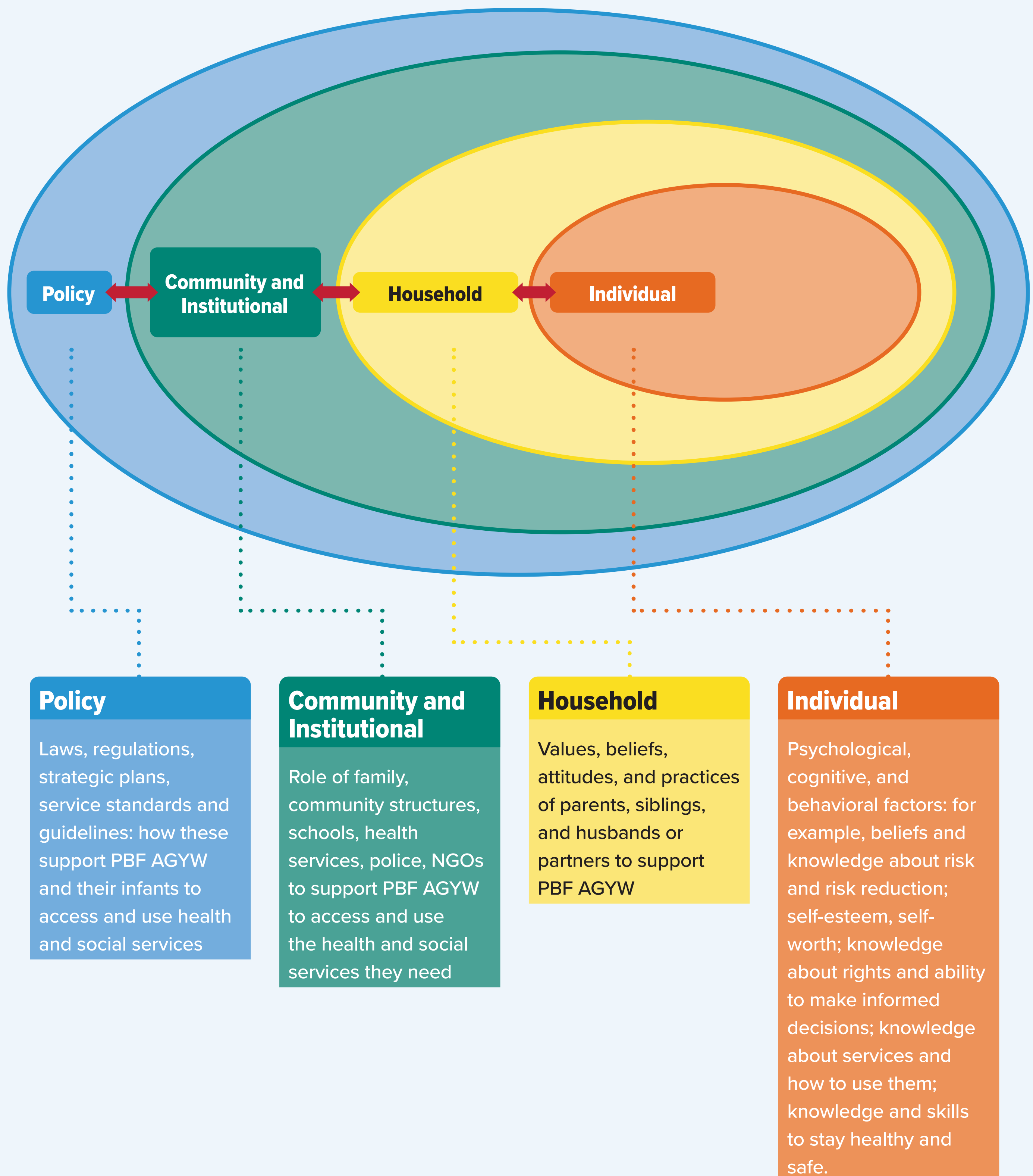


FIGURE 1. Socioeconomic diagram

PREGNANCY

Globally, teenage pregnancy remains a persistent challenge. In sub-Saharan Africa, pregnancy rates have been documented as high as 19%.[7] In Kenya, 18% of adolescent girls aged 15–19 already have a child or are currently pregnant.[8] In 2021, the number of adolescent pregnancies nationally was 317,656, a 23% decline from 2019 when 398,998 adolescent pregnancies occurred.[8] Homa Bay County is among the counties experiencing the highest teenage pregnancy rates at 25%, higher than the national average of 21% in 2021.[8]

PBF AGYW experience higher risks of eclampsia, puerperal endometritis, and poor mental health; moreover, recurrent adverse outcomes among infants from AGYW include low birth weight, early delivery, and neonatal conditions.[9,10,11] Pregnant adolescents are less likely to be retained in care inclusive of antenatal care (ANC) and prevention of mother-to-child transmission (PMTCT) services while also being less adherent to medication if living with HIV.[12] Lower use and later engagement in care contributes to delayed initiation on treatment, lower retention in ANC and postnatal care (PNC) for mothers and infants, and higher transmission of HIV compared to adult women.[13,1,14] Complications related to pregnancy are among the leading causes of mortality for adolescent girls worldwide.[15] Seroconversion risk during pregnancy and breastfeeding puts AGYW and their infants at increased risk and reflects the gap in HIV prevention for this population and the critical need for prioritization.[16]

During the postnatal period, adolescent and young mothers are less likely to use family planning, which can lead to subsequent unintended pregnancies.[17] Becoming pregnant during adolescence has broader implications impacting the social and economic futures of the girls and their children.[18] For instance, cessation of academic engagement among PBF AGYW is a challenge; in Kenya, an estimated 13,000 adolescent girls drop out of school due to becoming pregnant every year.[19]

GENDER-BASED VIOLENCE

Globally, one in every three women has experienced a form of violence.[20] Women who have experienced violence are more prone to HIV infection, with global estimates reporting survivors being three times more likely to be infected with HIV.[21] A 2018 report from the WHO revealed approximately 736 million girls and women age 15 or older experienced physical or sexual violence at least once in their lifetime.[22] In particular, adolescent girls who have experienced violence are more than 3 times as likely to be infected with HIV or a sexually transmitted infection (STI), 3.5 times as likely to experience pregnancy complications, and twice as likely to feel depressed and attempt suicide, according to a study from Eswatini.[23] A study looking at gender-based violence in light of COVID-19 in Nigeria and South Africa found that girls and women living with HIV were more likely to have experienced violence and 3 times as likely to report depression or anxiety-associated symptoms.[24]

In Kenya, an estimated 32% of adolescent girls under age 18 have experienced sexual violence, and 66% have experienced physical violence.[23] Consequently, 30% of girls who experienced sexual violence became pregnant before reaching age 18.[23] Furthermore, school absenteeism, mental distress, child marriage, HIV infection, and social insecurities including food insecurity are reported risk factors related to experiencing violence.[25]

TRIPLE THREAT

HIV, GBV, and pregnancy are linked risks and drivers of one another, particularly among AGYW and PBF AGYW. The cultural, social, and structural factors associated with the perpetration of this threat require a multifactorial response.

G-POWER

Rationale for G-POWER

The G-POWER program is a multidimensional approach that aims to address specific gaps in the care continuum in responding to the triple threat, and to support PBF AGYW and their infants in achieving optimized outcomes and health through a peer-centric case management and multidisciplinary team approach. Although the program is focused on provision of care and support through layered means to all PBF AGYW and their infants, activities focused on the needs of HIV-positive and HIV-negative AGYW are prioritized to ensure continuation of treatment and prevention as well as optimized GBV screening, identification, and linkage as needed.

The G-POWER package

As shown in Figure 2, G-POWER consists of several interwoven activities at structural, biomedical, and behavioural levels. At its core, the program provides a multi-layered, individualized, peer-centric case management approach to support the health of the PBF AGYW and her infant.

Through the support of a multidisciplinary team (MDT) and led by an AGYW peer mentor, the PBF AGYW and her infant are followed and supported throughout the pregnancy, delivery, and breastfeeding period to ensure ongoing engagement with the health facility and to ensure early and rapid response and linkage to services as needed.

TARGET POPULATION:
PFB AGYW ages 10–24 and their infants until age 24 months

OVERALL AIM:
Provide quality, comprehensive care to PBF AGYW and their infants using a peer-centric, case management approach to optimize their health and well-being

FIGURE 2. The G-POWER project

THE MULTI-DISCIPLINARY TEAM

ROLE	RESPONSIBILITIES
AGYW peer mentor	• Identify PBF AGYW and provide individualized case management, eligibility screening for the triple threat, and subsequent linkage to testing and/or care • Provide comprehensive knowledge, skills, and support to PBG AGYW from pregnancy until 24 months after birth • Mentor PBF AGYW to increase knowledge and support adherence and retention in care for HIV-positive PBF AGYW and enhance risk reduction among HIV-negative AGYW • Improve navigation, bidirectional referrals, and linkage to health and social services as needed • Implement retention and follow-up activities among PBF AGYW and their infants • Facilitate monthly psychosocial support (PSS) and health talks • Address social support of PBF AGYW and their infants in dialogue to change attitudes of parents/caregivers/partners/schools
HIV testing services counselor	• Provide pre- and post-HIV-testing counseling for all PBF AGYW • Provide tailored support and linkage based on HIV result—linkage to ART for HIV-positive AGYW with provision of treatment literacy information • For HIV-negative AGYW—provide prevention messaging and links to AGYW peer mentor to assess for pre-exposure prophylaxis (PrEP) eligibility
GBV focal point (an AGYW peer mentor)	• Based on standardized screening, link suspected cases of GBV to appropriate post-violence care and additional services (police, lawyer)
Clinician	• Provide clinical support for PBF AGYW and their infants in the form of clinical consultations, formal health checks, ANC, and PNC including immunizations • PrEP initiation if eligible for HIV-negative PBF AGYW
Maternal and child health (MCH) Nurse	• Provide clinical support for PBF AGYW and other MCH needs across the continuum of care • Serve as the facility-based supervisor and point of contact for AGYW peer mentors
Adherence counselor	• Conduct adherence sessions for newly diagnosed AGYW or those facing challenges with adherence • Counsel on challenges concerning cases of GBV or other social issues, with referrals made, as needed • Counsel on mental health—depression and other conditions based on the individual
G-POWER program team (project officer, assistant project officer, technical leads, monitoring and evaluation)	• Support the AGYW peer mentors in their roles • Facilitate ongoing trainings, tools, mentorship for project staff • Coordinate with stakeholders for ongoing buy-in and partnership in bidirectional linkages • Support procurement and provision of additional supplies, including dignity kits • Ensure quality assurance in implementation, data input, and day-to-day activities • Support regular collection, review, analysis, and follow-up of individual and aggregate data for real-time decision management and case follow-up

Figure 3 details the inputs, activities, outputs, and outcomes intended for the G-POWER project in responding to the problem statements.

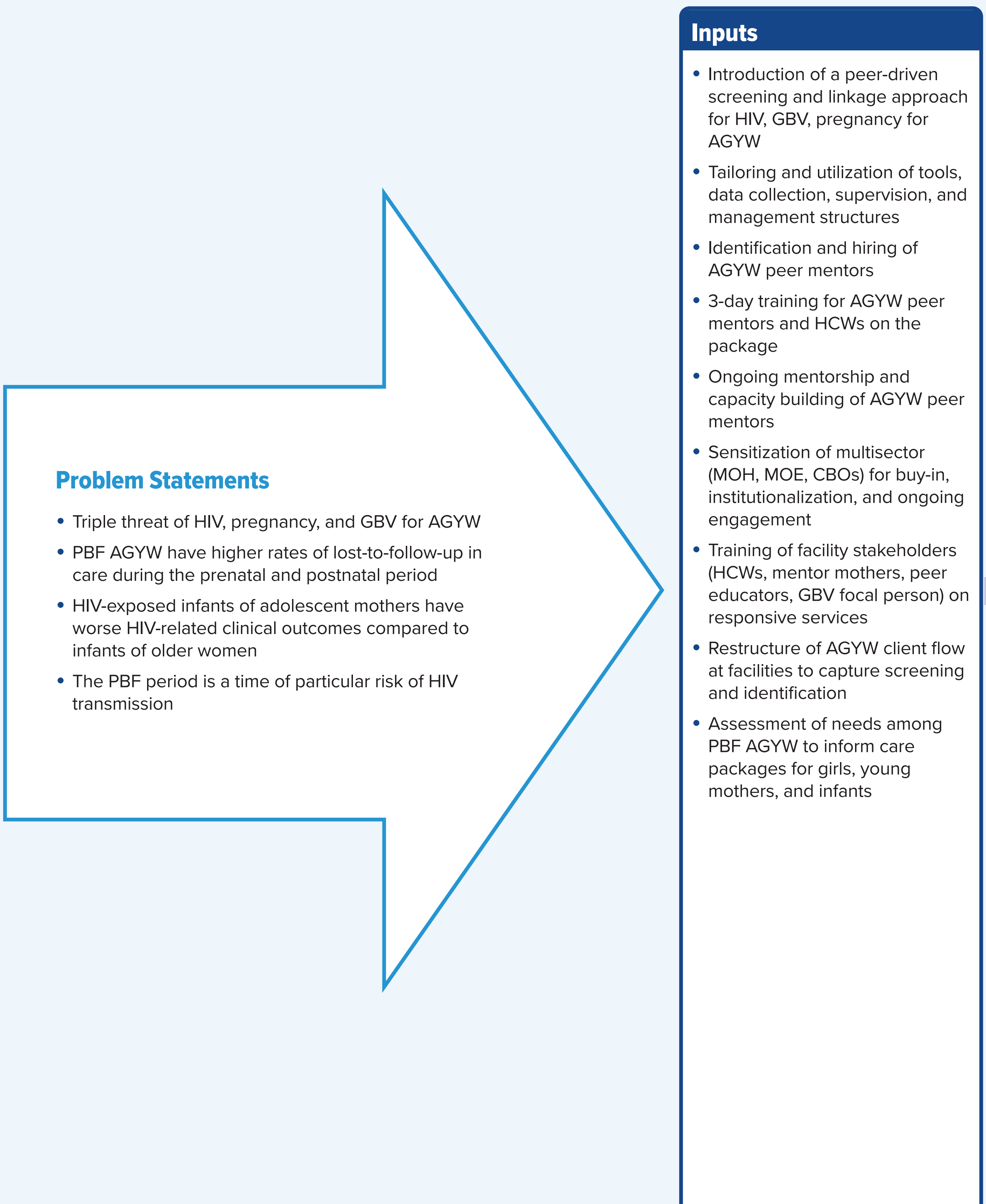


FIGURE 3. Theory of change: inputs, activities, outputs, outcomes

Activities

- Integrate screenings for pregnancy, GBV, HIV for AGYW accessing ANC services
- Introduce the AGYW peer mentor in MCH and integrate into clinic flow for AGYW
- Implement a case management approach for PBF AGYW and their infants led by AGYW peer mentors including counseling, navigation, retention, follow-up, and linkage to other services as needed
- Develop individual birth plans
- Deliver dignity kits and other materials for pregnancy to adolescent and adolescent mother–baby pair
- Equip peer mentors with tablets pre-loaded with tools for screening (pregnancy, HIV, GBV risk), data collection, and reporting (ODK-X and ODK-collect) alongside paper-based tools
- Implement specific ANC clinic and peer-led PSS days for PBF AGYW
- Engage a multidisciplinary team in a case-based approach for PBF AGYW and their infants
- Work with community-based stakeholders for bidirectional linkages (DREAMS, OVC)
- Collaborate with the MOE for retention and re-entry in schools
- Specialized PSS for HIV+ and HIV- AGYW covering health topics including HIV, prevention, STIs, delivery, ECD, infant care

Outputs

- Optimized screening of AGYW for HIV, GBV, pregnancy across entry points
- Comprehensive and individualized case management approach for all PBF AGYW both HIV- and HIV+ and their infants
- Supportive households for PBF AGYW and their infants
- Supportive school environments for PBF AGYW
- Enhanced peer-led navigation, counseling, retention, and follow-up of PBF AGYW
- Improved community linkages including DREAMS for HIV- AGYW, OVC for HIV+ AGYW
- Better access to skilled delivery
- Increased access to dignity kits to facilitate access to needed materials for delivery, postpartum, and infant care
- Improved decision making due to capture and availability of information via digital tools and tablets
- Increased accessibility of tailored PSS (mental health social support) for HIV+ and HIV- PBF AGYW

Outcomes

- Increased number of PBF AGYW/adolescent mothers and their infants receiving the minimum package
- Improved uptake of PMTCT and HIV treatment services among HIV+ PFB AGYW
- Reduction of seroconversion among HIV- PBF AGYW and their infants
- Reduction of unwanted pregnancies through pregnancy and risk assessment and linkage to FP
- Increased access to social protection, education and HES opportunities, and GBV services for PBF AGYW/ young mothers and their infants
- Increased number of PBF AGYW, adolescent mother–baby pairs retained in the ANC/ PMTCT and PNC services
- Increased early identification of PBF AGYW through pregnancy screening, pregnancy testing for suspected cases, and subsequent early enrollment in ANC
- Increased HIV retesting as well as skilled delivery and HEI follow-ups
- Improved developmental outcomes among infants born to adolescent mothers
- Improved knowledge building, skills, and social support for PBF AGYW and young mothers
- Increased school re-admittance among PBF AGYW
- Increased GBV case identification and linkage among AGYW
- Empowerment of AGYW (informed/ agency) and AGYW peer mentors

Alignment to global recommendations

With the intersecting vulnerabilities of HIV, pregnancy and motherhood, and GBV, the response—as indicated by global actors and advocacy messages—needs to provide strategic support and address social, health, economic, and legal barriers. Figure 1.4 depicts key strategic actions for improving services for young mothers living with HIV as outlined in Safeguarding the future: giving priority to the needs of adolescent and young mothers living with HIV.[26] G-POWER systematically addresses each of the strategic actions recommended by global stakeholders.

Fig. 1.4. Key strategic actions for improving services for young mothers living with HIV

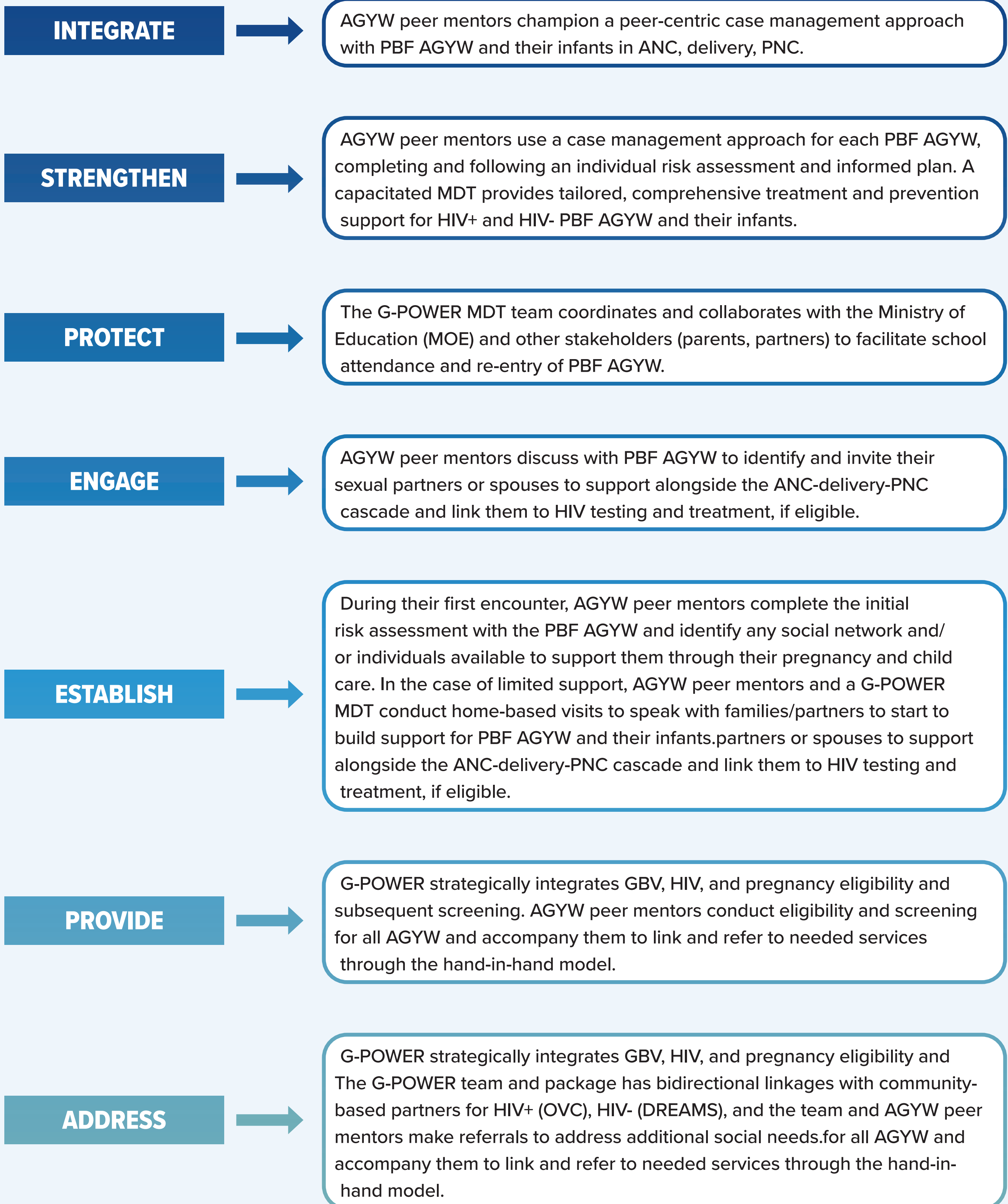


FIGURE 4. Alignment of G-POWER activities with the Safeguarding Framework strategic actions

The AGYW Peer-Centric Case Management Approach

The AGYW peer mentors

AGYW peer mentors form the foundation of the peer-centric case management approach in G-POWER for PBF AGYW and their infants.

WHO ARE AGYW PEER MENTORS?

AGYW peer mentors are AGYW who have been pregnant and/or are young mothers themselves and have been trained and capacitated by program staff and integrated into the client flow at supported facilities.

WHAT DO AGYW PEER MENTORS DO?

It is the role of the peer mentor and health care workers (HCWs) to ensure that PBF AGYW and their infants' access and utilize HIV, ANC, MCH, and PMTCT services throughout the pregnancy, delivery, and postnatal period along with infant and child care.

THROUGHOUT THEIR ROLES, AGYW PEER MENTORS AIM TO →

- Provide comprehensive knowledge and skills to the AGYW on HIV and sexual and reproductive health (SRH);
- Deliver mentoring to increase knowledge and support adherence and retention in care (MCH/HIV services for mother and infant);
- Improve navigation, bidirectional referrals, and linkage to health and social services; and
- Change attitudes of parents/caregivers/partners toward pregnant adolescents/adolescent mothers and their babies.

Figure 5 describes the roles of AGYW peer mentors in supporting PBF AGYW and their infants across the pregnancy and postnatal cascade.

ELIGIBILITY CRITERIA FOR AGYW PEER MENTORS

- AGYW age 18–29
- Experience with pregnancy or has a child
- Has a certificate in health or social-science-related field
- Additional training in SRH/HIV fields an added advantage
- Having volunteered/worked in health / social services in health facility or community is an added advantage
- Good interpersonal skills
- Valued attributes: approachable, accessible, friendly, respectful, willing to learn, and open to diversity

INFORM

- Ensure PBF AGYW receive accurate, comprehensive knowledge on all relevant topics concerning health, pregnancy, and motherhood
- Advise PBF AGYW on services available to her and her child
- Facilitate monthly PSS groups—one for HIV+ PBF AGYW and one for HIV- PBF AGYW

ESCORT

- Navigate the health system with the PBF AGYW, escorting her via a hand-in-hand approach to various services, providers, and appointments
- In the case of seroconversion, immediately escort to the comprehensive care clinic or PMTCT clinic for ART initation
- Link to needed services (GBV, ART counseling, PrEP initiation) by physically escorting the PBF AGYW and her infant

SCREEN

- Screen AGYW when presenting for eligibility for pregnancy and HIV testing and subsequently escort to testing if eligible
- Screen AGYW for GBV and make referrals based on suspected cases
- Throughout individual service plans, conduct additional assessments including mental health, alcohol and substance abuse, nutrition
- When HIV-, screen the PBF AGYW for PrEP eligibility and link to the clinician as eligible

BE PROACTIVE

- At enrollment into G-POWER, collect and discuss personal and social contact information to assess risks proactively
- When challenges present, follow up with the clients on the reasons why and engage a MDT to respond accordingly (home, school, family)
- Review client files to identify those due for their next appointment and make reminder calls
- Line list PBF AGYW for retesting to identify those in need at their next appointment

TRACE

- In case a client does not report for an appointment, trace the PBF AGYW and her infant to establish contact and link back to care
- Work alongside the community health volunteers to trace hard-to-track clients and bring them back to care

CONDUCT HOME OR SCHOOL VISIT

- When family or school issues present, conduct home visits to initiate a dialogue to address specific issues for optimized identification, linkage, and care
- When factors present that act as barrier for school re-entry of the PBF AGYW, hold meetings with MOE and school stakeholder to identify a path forward to facilitate re-entry

PLAN SERVICES

- Complete an individual case contact form for each PBF AGYW enrolled in G-POWER
- Identify individual risks, needs, and services
- Outline a service plan for the PBF AGYW and her infant throughout her period of pregnancy, delivery, and the post-natal period, including a delivery plan and retesting schedule as appropriate
- Make referrals to additional services (escort) and to community-based services—OVC, DREAMS

DOCUMENT

- Document the services the PBF AGYW and her infant receive at each visit and list the needed services along with the date for the next visit
- Update the case contact form with messages received after each counseling session
- On a monthly basis, report aggregate data from the pregnancy, HIV, and GBV cascade
- Conduct an audit of any seroconversion cases of PBF AGYW when retested during ANC or PNC to identify the reasons and respond accordingly

FIGURE 5. Roles of AGYW peer mentors

How AGYW peer mentors identify and link PBF AGYW into G-POWER

There are multiple ways in which PBF AGYW are identified and linked into the G-POWER program. Prior to the program, the only individuals who completed a pregnancy assessment were HIV-positive PBF AGYW already in the PMTCT program; this resulted in missed opportunities to identify HIV-positive AGYW and HIV-negative AGYW at risk of pregnancy or those already pregnant but unaware.

Introducing a standardized pregnancy risk assessment for all AGYW presenting to the facility allows identifying suspected, at risk, and confirmed pregnant AGYW and either enrolling them in G-POWER (if pregnant or breastfeeding) or linking them to prevention and FP counseling (if confirmed to not be pregnant).

The role of the AGYW peer mentor is central to the G-POWER package in providing responsive support, accurate messaging, and ongoing mentorship throughout and following pregnancy for PBF AGWY and their infants.

The following section concretely defines the steps AGYW peer mentors take to engage and support PBF AGYW throughout the pregnancy cascade.

HOW AGYW PEER MENTORS ENGAGE WITH PBF AGYW CLIENTS IN G-POWER

1. Once an AGYW presents, with or without a known status of pregnancy or HIV, she is immediately linked with an AGYW peer mentor.

2. The AGYW peer mentor will conduct eligibility screening for HIV, GBV, and pregnancy and respond accordingly. The peer mentor conducts the eligibility screening for pregnancy and HIV and provides an overview of what to expect for testing conducted elsewhere.

3. The AGYW peer educator escorts the AGYW (when eligible) to the lab for pregnancy testing and to the HIV testing and counseling center for HIV testing.

4. After receiving the results and initial counseling, the AGYW peer mentor will provide subsequent messaging based on the results.

    a. All PBF AGYW will be enrolled into G-POWER (HIV-positive and HIV-negative).

    b. Any newly HIV-positive AGYW will be linked immediately to ART initiation through the comprehensive care clinic (CCC) or PMTCT (based on pregnancy status) and connected to the ART counselor.

5. At the same visit, the AGYW peer mentor screens the AGYW based on outlined risk criteria for GBV.

    a. With a suspected GBV case, the AGYW peer mentor will escort the AGYW to the GBV focal point at the facility for counseling, post-violence care, and referrals as needed.

6. Once a PBF AGYW is enrolled into G-POWER, the AGYW peer mentor will complete a case contact form that comprehensively gathers personal details, health information, contact information, risks, school and social support information, appointments, messages, and needs going forward.

   a. The case contact form informs the individualized care for the PBF AGYW throughout her pregnancy and until her infant reaches 24 months.

7. The peer mentor links the PBF AGYW to community-based partners for additional support and social protection.
   a. If under 17 and HIV-positive, she will be linked to partners for orphans and vulnerable children (OVC).
   b. If under 24 and HIV-negative, she will be linked to DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) programming.
8. Throughout the pregnancy, delivery, and postnatal/infancy cascade, the AGYW peer mentors
   a. Provide one-on-one counseling, delivering messages on a safe pregnancy, HIV treatment for prevention, HIV prevention, safe delivery, motherhood, infant health and care;
      i. Document what was discussed in the case contact form during a session and list services (such as retesting) needed at the next visit;
   b. Proactively send appointment reminders to the PBF AGYW and her infant to attend their next appointment;
   c. In the case where any HIV-negative AGYW tests positive, immediately link her to ART and conduct an audit to identify the reason for seroconversion;
   d. Conduct home visits in the case of no-shows or when personal or social challenges arise.
9. Support the transition of the AGYW into transition care after the infant reaches 24 months.

Figure 6 (on the next page) provides an illustrative algorithm to these steps, showing the HIV, GBV, and pregnancy pathways of an AGYW presenting to the facility.

WHAT KIND OF TRAINING DO AGYW PEER MENTORS RECEIVE?

AGYW peer mentors, alongside the HCW teams at facilities, receive a 3-day training that sensitizes them to their roles and responsibilities and provides technical sessions to inform on HIV, PrEP, STIs, prevention, and pregnancy care. Skill-building sessions focus on application of knowledge through case studies, building motivational interview skills, the use of tablets for documentation of data, and tool sensitization. The agenda for the training can be found in the Appendix. The training slides used during the training conducted in Homa Bay can be found linked here.

Additional training on identified needs are implemented as well. For example, facility MDT teams, including AGYW peer mentors, received a GBV-specific training focused on sensitization to forms of GBV, screening for GBV among AGYW clients, referrals, and tools. Motivational interview skills are essential to gather pertinent information on the social, health, and personal information of the PBF AGYW that will inform their individualized case plan.

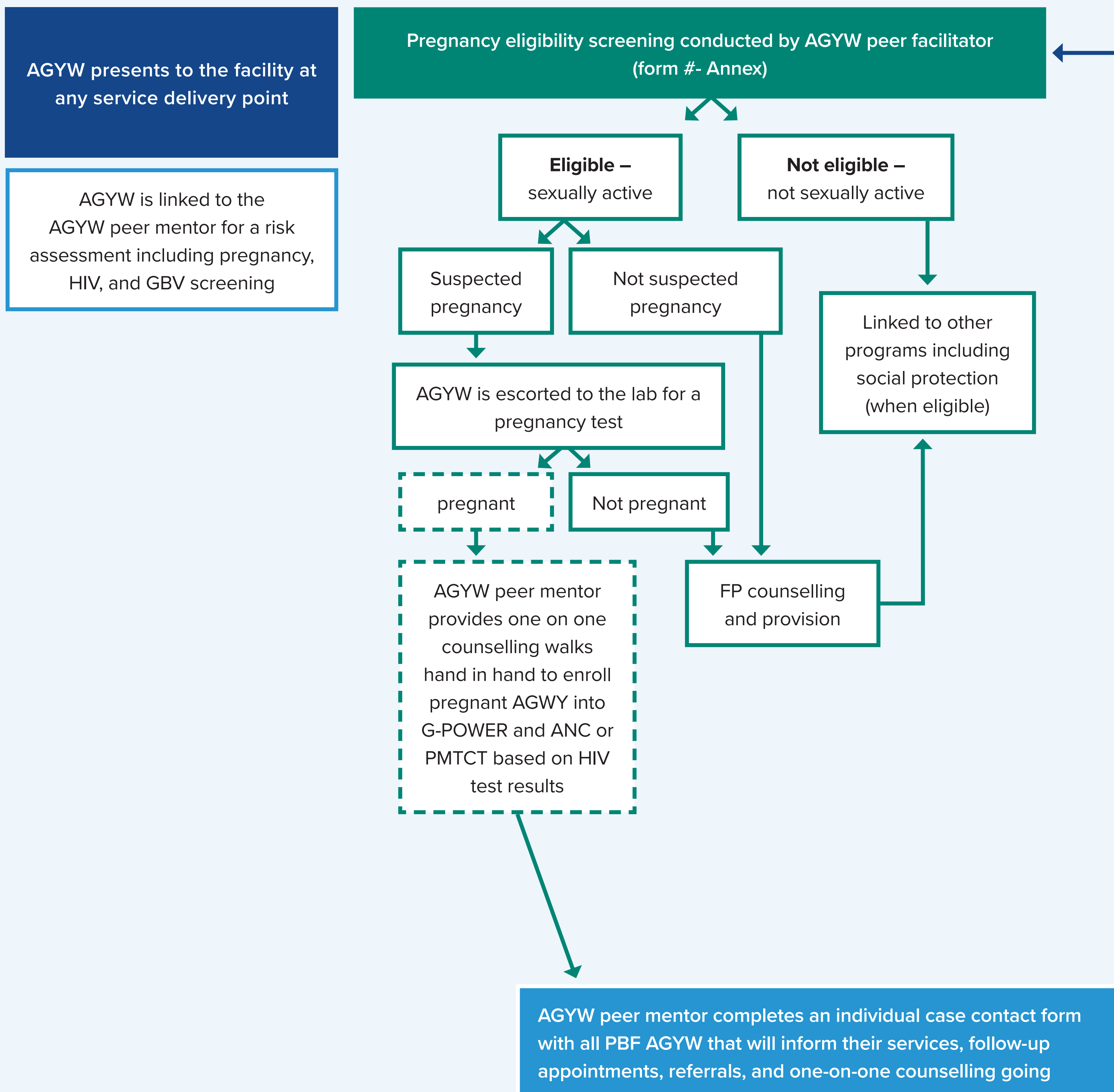
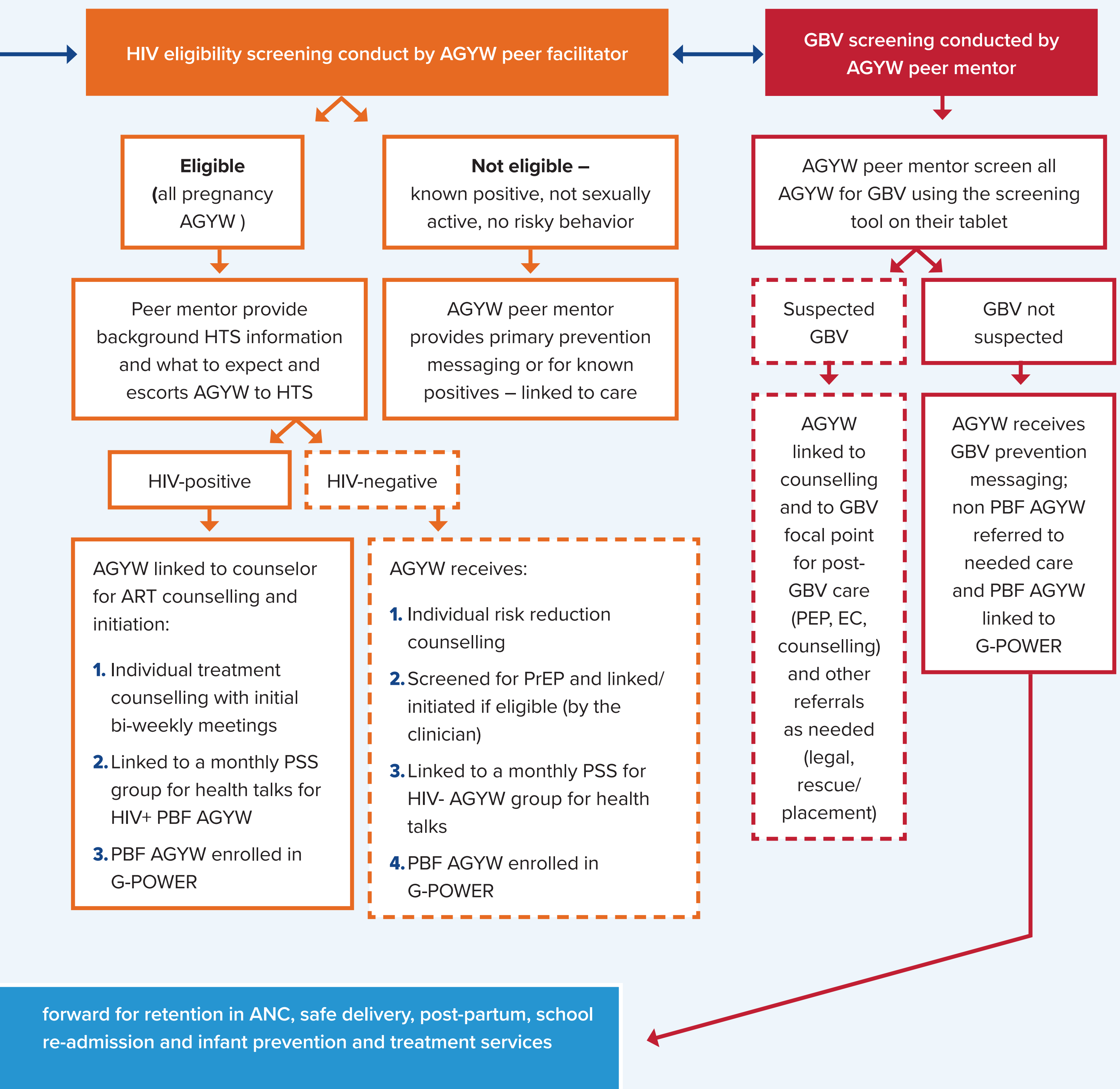


FIGURE 6. Pathways of an AGYW presenting at a G-POWER Facility



forward for retention in ANC, safe delivery, post-partum, school re-admission and infant prevention and treatment services

MOTIVATIONAL INTERVIEW SKILLS UTILIZED TO COMPLETE THE PBF AGYW CASE CONTACT FORM:

- How are you feeling today?
- When did you realize you were pregnant?
- Who can you talk to about stressful things in your life?
- Please describe members of your family, neighbors, or friends who can help you during your pregnancy.
- Is there an adult who can help you with decision making? Who is this adult?
- Have you and the father of the baby talked about how you will together care for the baby—do you anticipate receiving support from him? What type?
- Are you in school?
  - Yes—list the name of the school.
  - No—have you thought about whether or not you will return to school after the baby is born?
- Have you attended your last ANC visit?
- Do you have a birth plan?

WHAT RESOURCES DO AGYW PEER MENTORS RECEIVE?

Following their initial training, AGYW peer mentors are provided with a pocketbook that houses all the information they were trained on as an accessible resource while working at the facilities. The booklet contains information concerning any care and counseling needs of both HIV-positive and HIV-negative PBF AGYW and their infants. A messaging metrics resource exists to provide guidance in counseling the PBG AGYW on a variety of topics. These messages cover:

- STI
- Family planning
- Safe sex
- Safe delivery and birth plan
- Danger signs during pregnancy and infanthood
- Disclosure and adherence of HIV
- Developmental milestones
- Immunizations for infant
- Partner HIV testing
- Condom use
- PrEP
- HIV prevention messages
- Other health messages as needed

One tablet is provided to each facility. In most cases, there is one AGYW peer mentor per facility, and she takes charge of the tablet. In a few high-volume sites, two AGYW peer mentors support the same facility and share the tablet. The tablet contains digital versions of the tools AGYW peer mentors use, including the case contact form, which they complete digitally and can access at any time. The tablets are secure and are linked to password-protected, secure portals where forms are stored, linked to digital management tools.

AGYW peer mentors also receive data bundles to support connection via phone and WhatsApp for retention activities with PBF AGYW clients and their infants. A peer mentor issues appointment reminders by calling or sending an SMS over WhatsApp to the PBF AGYW before their next

appointment. Additionally, the peer mentor often reaches out over the phone or via SMS to ensure the PBF AGYW has all the items she needs for delivery based on their discussed delivery plan as her date approaches. To facilitate home visits, a transportation reimbursement is provided.

A WhatsApp group for AGYW peer mentors was also established following their initial training; this is a very active space. Both AGYW peer mentors and technical staff are included. The group is used to check in with one another, celebrate successes, and gather input on difficult cases. Best practices and lessons are also shared. When difficult cases are discussed, the peer mentors and technical team provide insights and develop a plan to address the challenge, as in the case described in Box 1.

BOX 1. Example of a difficult case shared for consultation with the team

A young girl who recently gave birth to twins was facing severe mental health challenges and abandoned her twins. The peer mentor of her facility reached out to the G-POWER team for support on responding to her situation. In response the team sent a small MDT to the girl's home to meet with the family and identify solutions. The PBF AGYW was followed up for care and the infants were placed with her family for care.

Furthermore, a monthly virtual Zoom call is held with all G-POWER teams, in which two districts report on their performance and share cases for group discussion in leveraging experiences and learnings from other teams and sites.

WHAT IS THE SUPERVISION AND MENTORSHIP STRUCTURE?

At the facility, MCH nurses supervise the AGYW peer mentors. In the G-POWER project, the peer mentors report to the project coordinator, who is always available to support in case management, technical challenges, procurement needs, and so forth.

WHY THE PEER MENTOR APPROACH?

As Rose, an adherence counselor based at the Miru Health Facility put it, "*They [PBF AGYW] need someone to get to their level*."

Peer-based support for PBF women living with HIV has shown to be associated with improved retention throughout PMTCT and postnatal services as well as higher viral suppression rates because of approaches such as the mentor mother model.[27,28] Additional reported impacts include increased disclosure of status and improved adherence to treatment during pregnancy among HIV-positive pregnant women.[29,30]

This evidence is strongly weighted toward pregnant women living with HIV. But the benefit and added value of using AGYW peer mentors allow for structured support of *all* PBF AGYW regardless of HIV status; they can all share and learn from an AGYW who has been pregnant and had a child before, having been through the process herself. The missed opportunity to provide this peer support for HIV-negative AGYW is significant: when an PBF AGYW can relate to someone with comprehensive knowledge and skills who is providing care, this rapport can positively influence the prevention and risk engagement affecting the mother and her infant.

TOOLS AGYW PEER MENTORS USE IN THEIR ROLES

- Case contact form (see Box 2)
- GBV screening tool
- PrEP eligibility tool
- HIV risk screening tool
- Pregnancy risk screening tool

BOX 2. Information collected in the case contact form

- Facility information
- Client information—name, contact information: phone, village, landmark
- Identified needs
- ANC information—expected date of delivery, duration of pregnancy, ANC attendance, existence of a birth plan, nutrition
- School information—attendance, school name, willingness to return
- HIV information—status, last test date, result, retesting eligibility—last result
- PNC information—place of delivery, complications, infant feeding, sleeping / self-care, FP
- School re-entry willingness
- Infant information—name, age, HIV status, feeding, immunizations (done and needed), milestones achieved
- Messages delivered by the peer mentor
- GBV—screening results, linkages, referrals
- Referrals—type of referral, name of provider/facility referred to, date, completion status, any previous referrals
- Services required at the next visit
- Priorities identified for the next visit
- Any restricted food denoted by the provider
- Date of next visit
- Status of the client

HIV-positive and HIV-negative AGYW Care and Support

Both HIV-positive and HIV-negative PBF AGYW enrolled in the G-POWER program receive individualized care determined by their needs as documented by the case contact form filled in during their initial visit at whatever point during ANC or PNC they present. However, as HIV-positive and HIV-negative PBF AGYW also have distinct needs, some of the provisions of services and care are different as outlined in the sections below.

HIV-POSITIVE PBF AGYW

PBF AGYW living with HIV receive tailored, comprehensive support throughout their pregnancy, delivery, and the postnatal period to facilitate their continued adherence on ART, viral load suppression, engagement in care, prevention of transmission to their child, full infant care including immunizations, and support for the healthy development of their child. Figure 7 outlines the key messages and support provided to the HIV-positive AGYW through the peer-centric G-POWER initiative at the facility with intentional community linkages.

HIV-NEGATIVE PBF AGYW

HIV-negative PBF AGYW and their infants receive quality support to ensure optimized pregnancy and infant health outcomes while also prioritizing the prevention of HIV transmission throughout the pregnant and breastfeeding period for the mother and her child.

Figure 8 (on the next page) outlines the key messages and support provided to HIV-negative AGYW through the peer-centric G-POWER initiative at the facility with intentional community linkages.

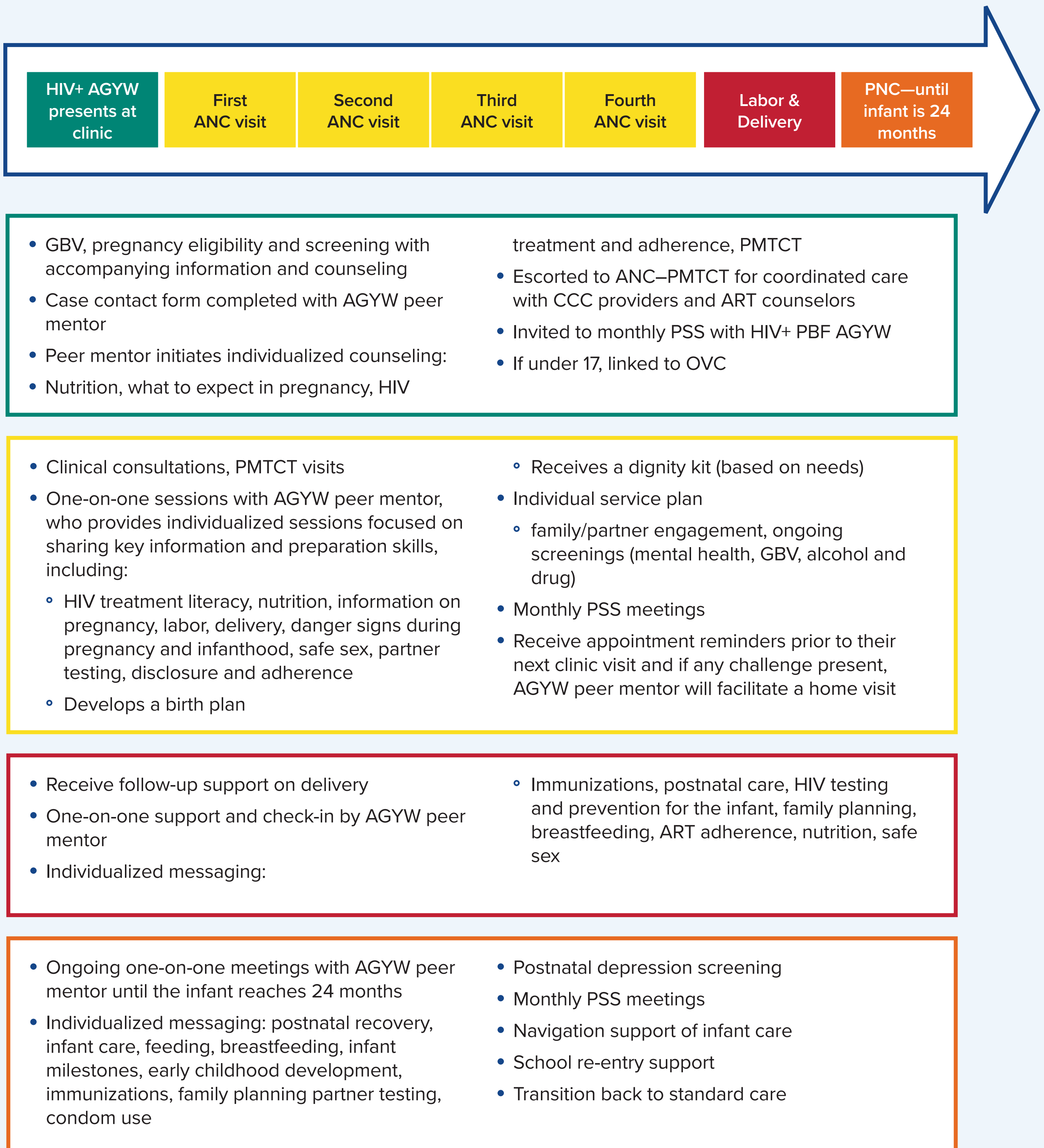


FIGURE 7. Key messages and support provided to the HIV-positive AGYW through G-POWER

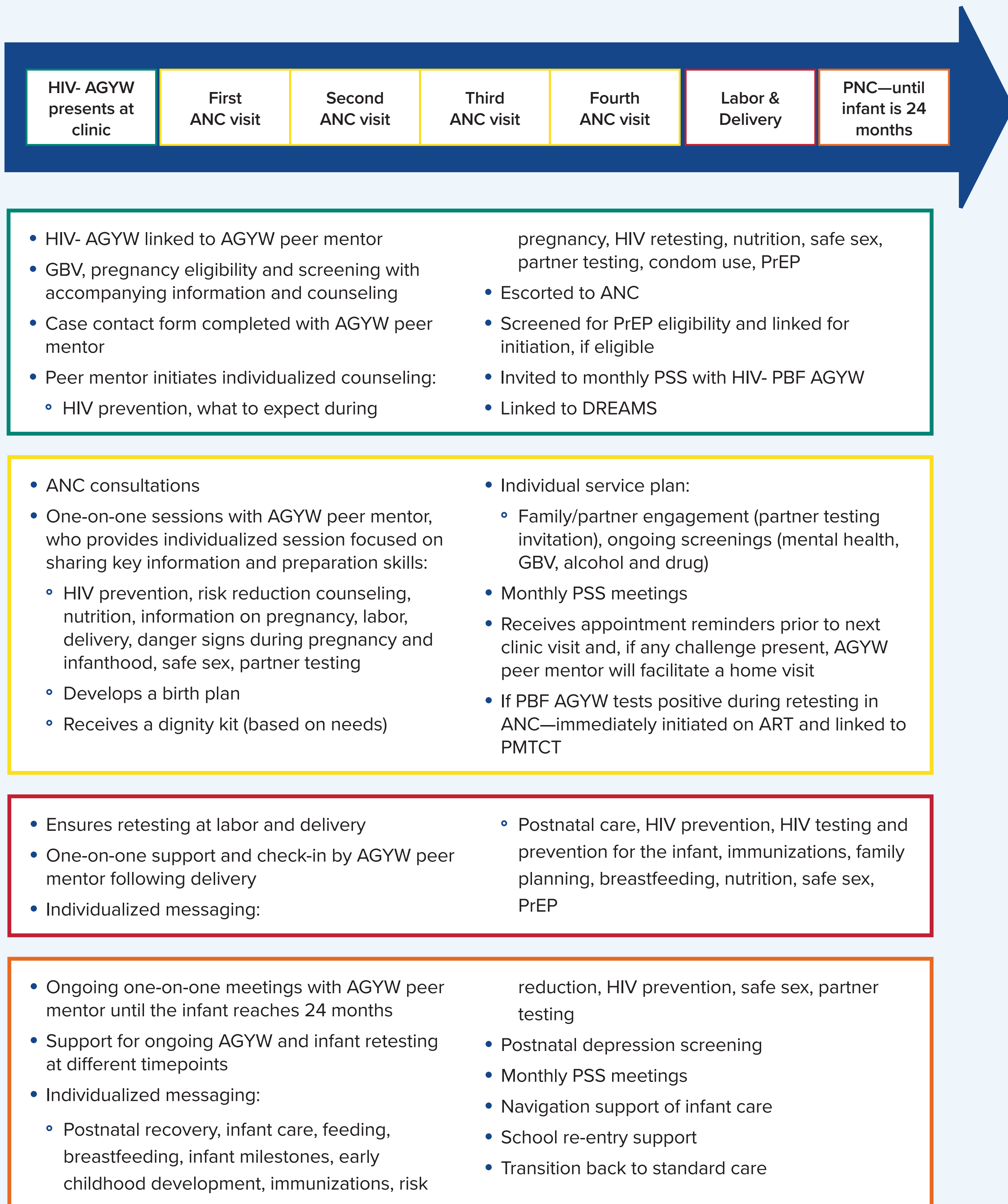
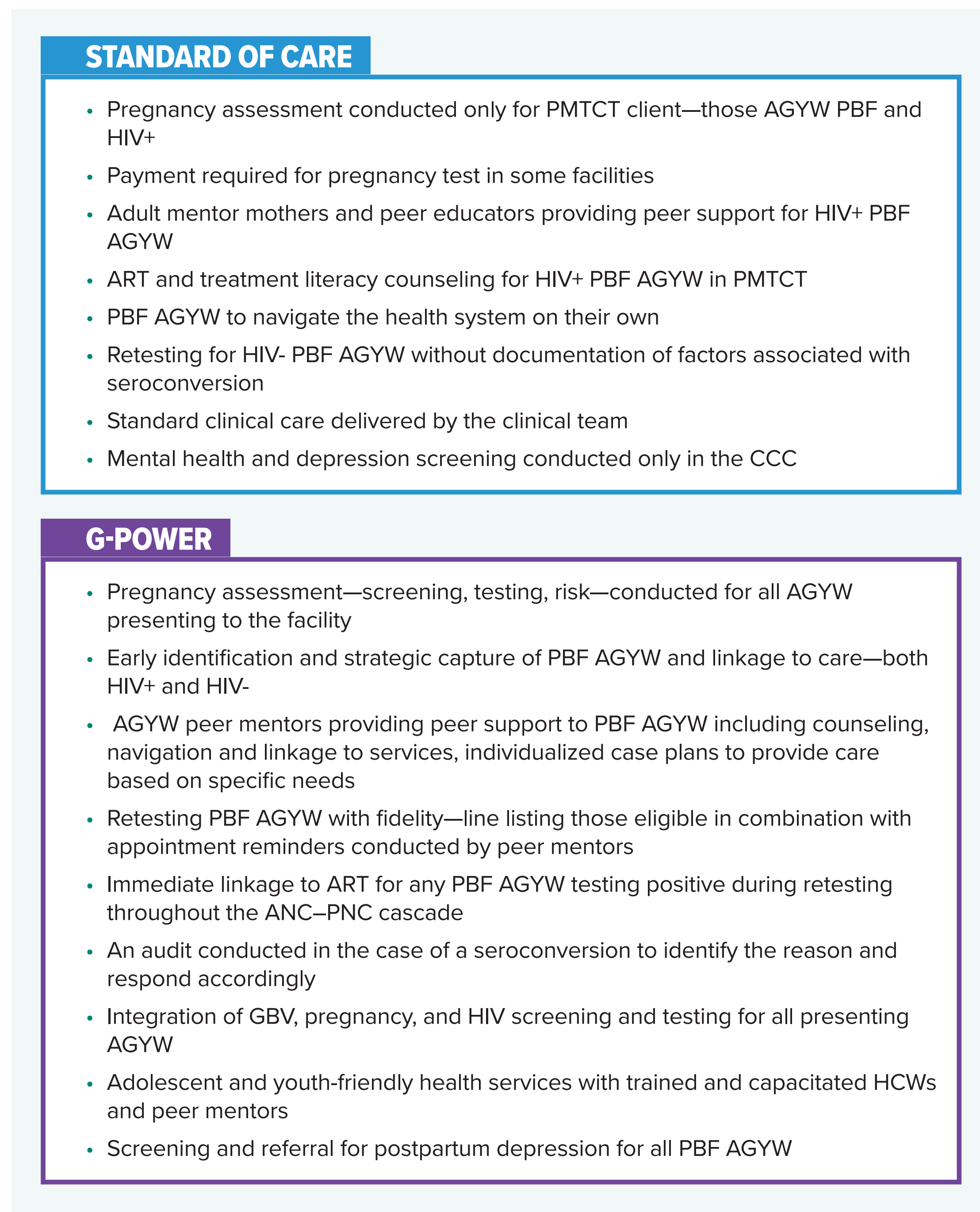


FIGURE 8. Key messages and support provided to the HIV- AGYW through G-POWER

Value Add of the G-POWER Program

The significance of the G-POWER program should not be understated. The elements that allow the G-POWER package to optimize outcomes, reach and impact across all service points include specifically integrated activities in addition to the standard of care (SOC) executed by capacitated teams. Figure 9 elucidates these specific elements that provide tangible value over SOC.



STANDARD OF CARE

- Pregnancy assessment conducted only for PMTCT client—those AGYW PBF and HIV+
- Payment required for pregnancy test in some facilities
- Adult mentor mothers and peer educators providing peer support for HIV+ PBF AGYW
- ART and treatment literacy counseling for HIV+ PBF AGYW in PMTCT
- PBF AGYW to navigate the health system on their own
- Retesting for HIV- PBF AGYW without documentation of factors associated with seroconversion
- Standard clinical care delivered by the clinical team
- Mental health and depression screening conducted only in the CCC

G-POWER

- Pregnancy assessment—screening, testing, risk—conducted for all AGYW presenting to the facility
- Early identification and strategic capture of PBF AGYW and linkage to care—both HIV+ and HIV-
- AGYW peer mentors providing peer support to PBF AGYW including counseling, navigation and linkage to services, individualized case plans to provide care based on specific needs
- Retesting PBF AGYW with fidelity—line listing those eligible in combination with appointment reminders conducted by peer mentors
- Immediate linkage to ART for any PBF AGYW testing positive during retesting throughout the ANC–PNC cascade
- An audit conducted in the case of a seroconversion to identify the reason and respond accordingly
- Integration of GBV, pregnancy, and HIV screening and testing for all presenting AGYW
- Adolescent and youth-friendly health services with trained and capacitated HCWs and peer mentors
- Screening and referral for postpartum depression for all PBF AGYW

FIGURE 9. G-POWER and Standard of Care Contrasted

Impact of the G-POWER Program

As a result of the G-POWER program, several outcomes across the pregnancy and postnatal cascade for the PBF AGYW and her infant have improved.

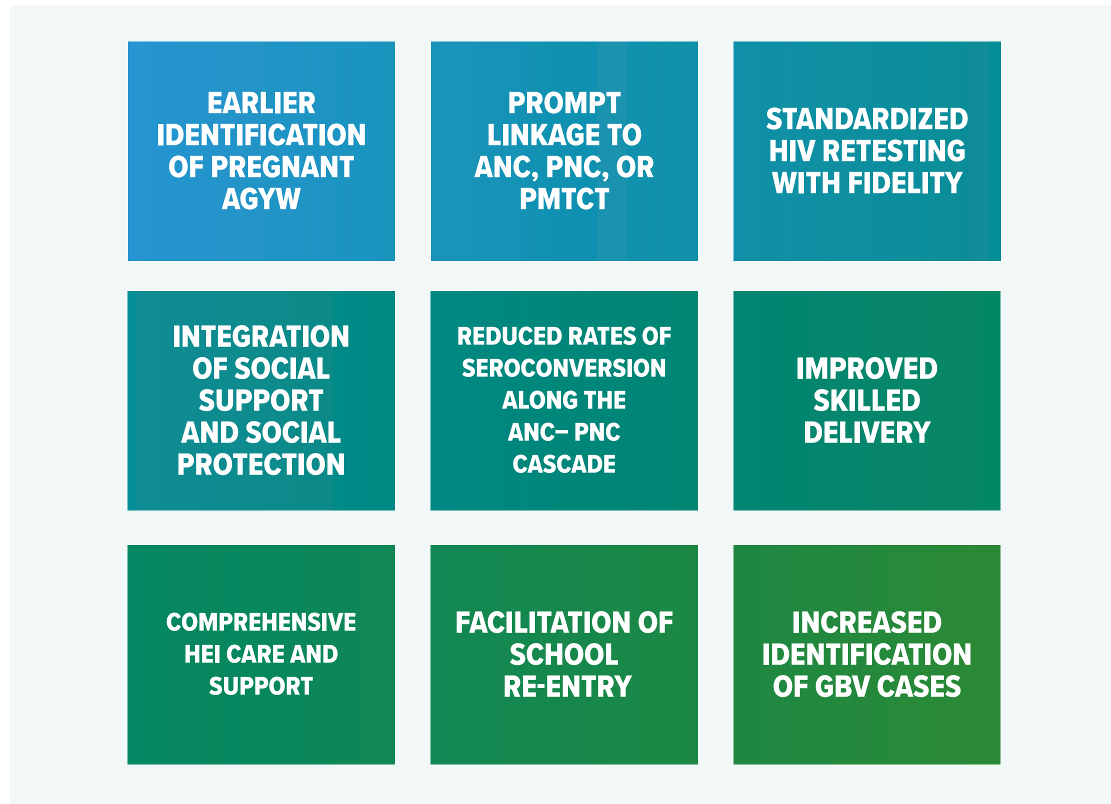


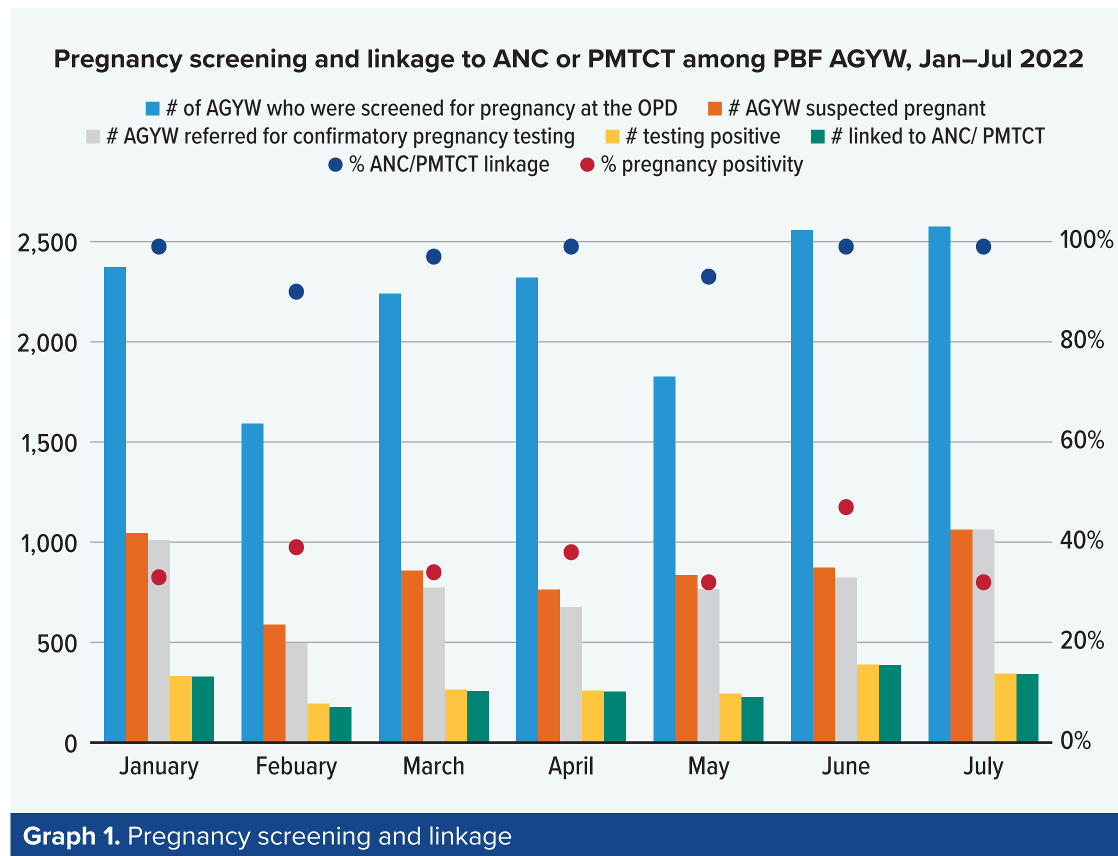
FIGURE 10. Outcomes across the G-Power Program

Earlier identification of pregnant AGYW through standardized use of pregnancy screenings and prompt linkage to ANC, PNC, or PMTCT

Through the standardized use of pregnancy screening for all presenting AGYW at G-POWER facilities, the ability to consistently screen and test those suspected pregnant allows for the rapid linkage to needed care. *This contrasts the SOC where only PMTCT clients are screened for pregnancy or pregnancy intention, resulting in missed cases that often only surface in the second or third trimester, where the opportunity to prevent seroconversion has been missed.* Furthermore, having AGYW peer mentors conduct the screenings and linkage provides an additional avenue to building responsive connection and support for AGYW. The hand-in-hand approach, where AGYW peer mentors physically navigate PBF AGYW to ANC, PNC, or PMTCT, supports rapid engagement in appropriate care.

PROJECT IMPACTS:

- From January to July 2022, all 11,515 AGYW presenting to a G-POWER facility received a pregnancy risk assessment; 4,101 were tested and 1,500 were confirmed pregnant (37%).
- 99% of pregnant AGYW were linked to ANC or PMTCT (see Graph 1).



Graph 1. Pregnancy screening and linkage

Implementation of HIV retesting across the ANC and PNC cascade with fidelity, following up on missed opportunities, and rapid identification of seroconversion cases for prompt ART initiation

Retesting at ANC and PNC intervals is critical for prompt identification of seroconversions and rapid initiation of ART for the PBF AGYW and prophylaxis of the infant. AGYW peer mentors monitor needed HIV retesting for PBF AGYW via the case contact form. Peer mentors line list PBF AGYW who require retesting and prioritize those at certain points in the case of low stock of tests, which is an ongoing challenge. For example, testing at first ANC is prioritized as it is often the first test for the PBF AGYW to inform her care moving forward. The risk assessment and risk counseling is continued at every encounter with HIV-negative PBF AGYW to emphasize, build, and reinforce messaging and prevention behavior.

AGYW peer mentors proactively review PBF AGYW client files to identify any missed re-test opportunities. In those cases, the clients are followed up and, when possible, a retest is completed. In some cases—for instance during labor and delivery, a onetime event—this is not possible, particularly if the AGYW delivered at a different facility. The reasons associated with missed

opportunities are documented. In most cases, low stock or unavailable test kits are the primary factors. When a client does not attend a visit, a follow-up call or home visit is conducted, and the retesting is conducted at the subsequent visit.

In the case of a PBF AGYW testing positive, **an audit is immediately conducted to identify the factors associated with the seroconversion** (see Box 3). This occurs in a one-on-one conversation between the AGYW peer mentor and the PBF AGYW. Factors affecting access and uptake to HIV testing and retesting that have been documented include:

- A husband who has not shared his status with his wife and refuses to allow her to get an HIV test;
- Lack of disclosure from a husband (before marriage) or partner (before or during the relationship);
- Being in denial about being HIV positive; and
- Forced relationships with a superior without disclosure.

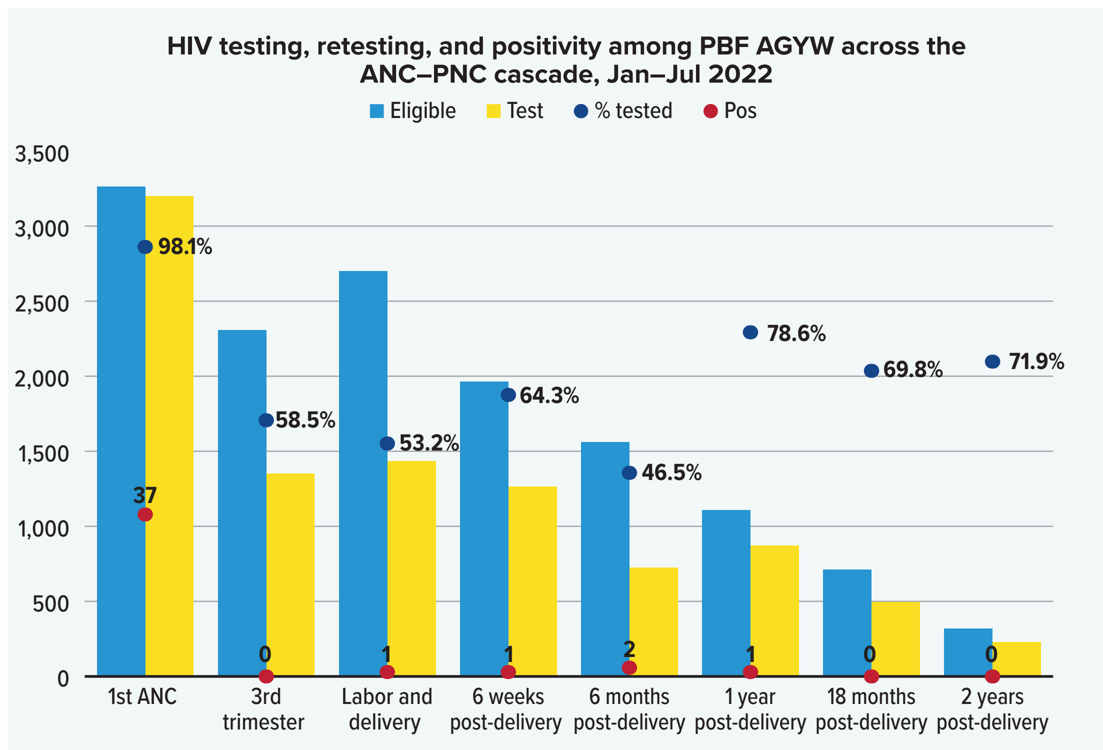
Identifying and documenting these factors enable the peer mentor and the G-POWER MDT to respond accordingly. Each PBF AGYW testing HIV-positive is immediately initiated on treatment and receives ongoing counseling and engagement. When feasible, their partner is engaged for re-initiation of ART or screening for PrEP.

BOX 3. The seroconversion audit

AGYW peer mentors hold an in-depth discussion with the PBF AGYW who became infected with HIV to pinpoint the factors related to the seroconversion. These reasons are documented every month to establish understanding of factors contributing to this challenge. On a case-by-case basis, an MDT team including the peer mentor will intervene. For instance, one case occurred as the AGYW did not know her husband's status; he was HIV-positive, had not accepted his status, and had stopped taking his medication. The MDT conducted a home visit with the family to provide education and bring him back to care.

PROJECT IMPACTS:

- From January to July 2022, 69% (9567/13927) of eligible PBF AGYW received a retest across the pregnancy and postnatal cascade.
- The main challenge in testing is stock-outs of test kits.
- The overall positivity was .4% (42/9567) across the cascade; however, positivity was highest at the first ANC visit at 1.2% (see Graph2).
- There was 100% linkage to ART of any PBF AGYW who newly tested HIV-positive during HIV retesting.



Graph 2. HIV testing among PBF AGYW

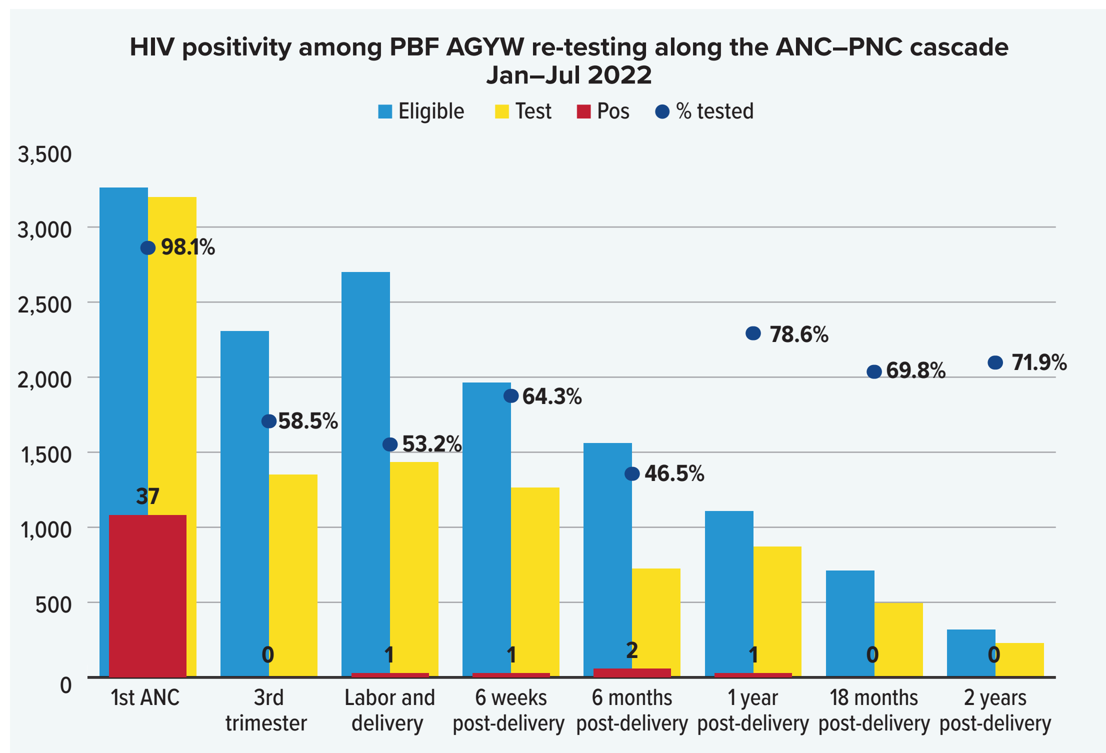
Reduced rates of seroconversion along the pregnancy and postnatal cascade observed among PBF AGYW in the G-POWER program

AGYW peer mentors provide continuous, tailored support to each PBF AGYW throughout their ANC, delivery, and PNC journey. Immediately following a positive pregnancy test, the PBF AGYW receives individual counseling from the peer mentor and ANC or PMTCT provider. For HIV-positive PBF AGYW, adherence to ART and retention in care is emphasized alongside the additional information and skills for pregnancy and motherhood; for HIV-negative PBF AGYW, PrEP initiation and retention for those eligible as well as risk reduction counseling and prevention dialogue are prioritized. Appointment reminders and retesting with fidelity for HIV-negative PBF AGYW at each opportunity, in conjunction with continuous prevention messaging and partner engagement, allow for ongoing support and monitoring to limit the risk of seroconversion.

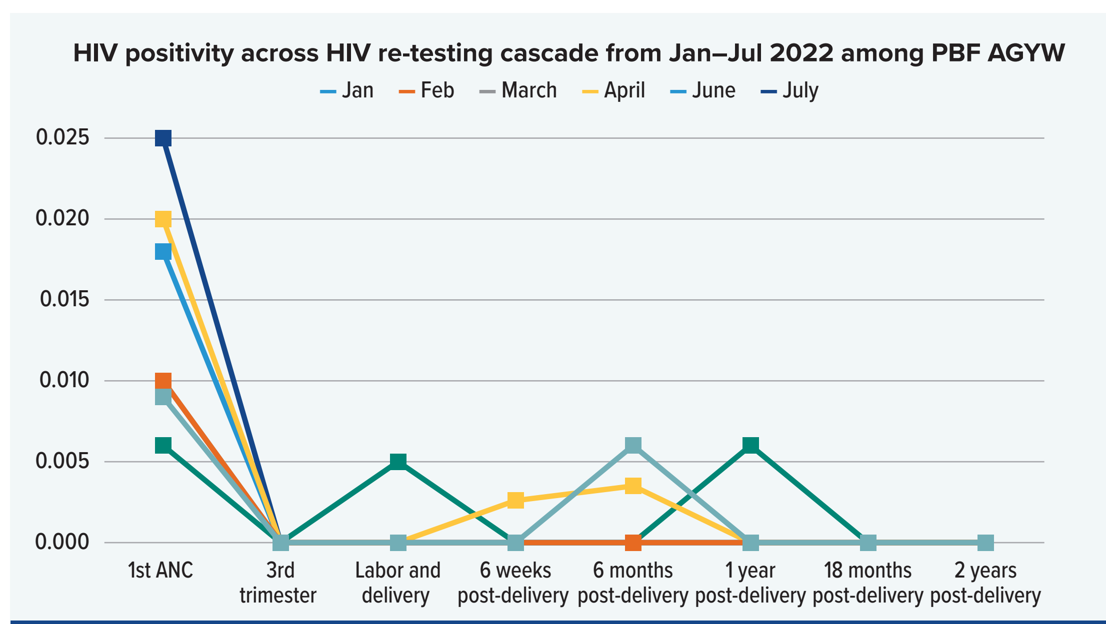
The majority of PBF AGYW test positive at their first ANC when first being linked and enrolled in the G-POWER program. Continued exposure to prevention messages and additional support facilitate risk reduction measures by PBF AGYW. From January to July 2022, there were five seroconversions. **Each seroconversion case initiates an audit.** Reported factors contributing to seroconversions include lack of disclosure between partners, unknown status of a partner or spouse, and being in denial of having HIV. All AGYW testing positive are linked to ART, receive treatment preparation and treatment literacy sessions, and are enrolled in PMTCT.

PROJECT IMPACTS:

- The majority (88%) of PBF AGYW who test HIV positive do so at their first ANC—often the first entry point into the G-POWER program.
- Seroconversion at subsequent retesting points is consistently much lower and at 0% at several points for PBF AGYW across the cascade with a mix of the messaging matrix, patient-centered support, addressing barriers, and facilitators (see Graphs 3 and 4).



Graph 3. HIV positivity among PBF AGYW re-testing



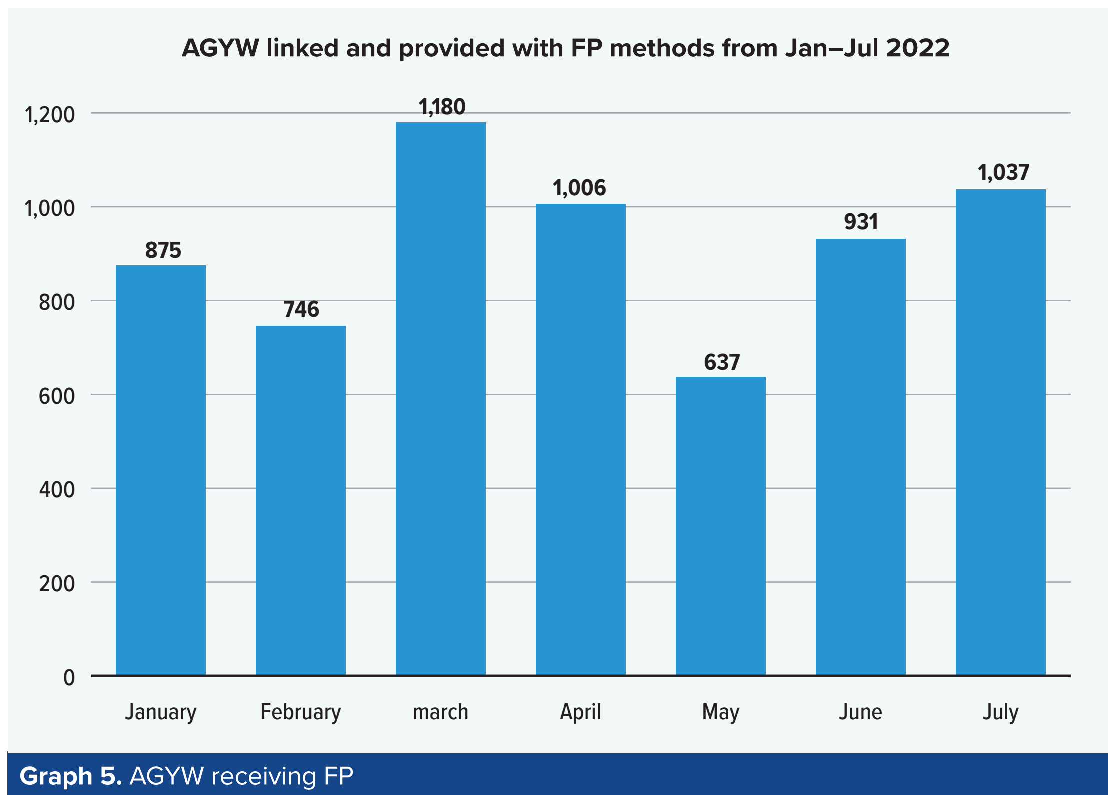
Graph 4. HIV positivity across HIV re-testing cascade

FAMILY PLANNING INTEGRATION TO AVOID UNINTENDED PREGNANCIES

The provision of family planning (FP) counseling and services for sexually active AGYW not pregnant as well as those in G-POWER who are in postnatal care is critical for empowering AGYW to prevent unintended pregnancies in the future. Mentorship is provided to these clients at the outpatient department (OPD) and in PNC clinics through counseling on FP methods and provision of services (see Graph 5).

PROJECT IMPACTS:

- From January to July 2022, 6,412 AGYW received FP following counseling and mentorship.



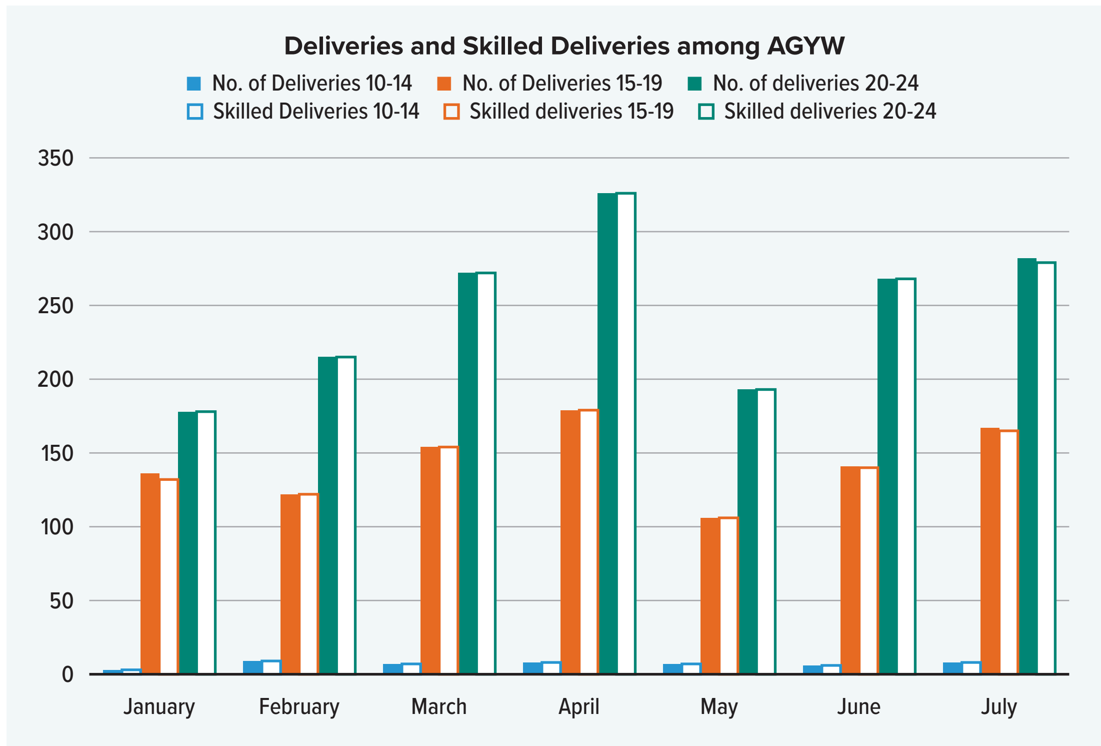
Graph 5. AGYW receiving FP

Improved skilled delivery

Throughout ANC, AGYW peer mentors support pregnant AGYW in developing delivery plans to facilitate their preparation, including transportation to the facility, social support, and the required materials to bring to the facility for delivery.

PROJECT IMPACTS:

- From January to July 2022, among the 2,787 AYGY who delivered, 2,777 (99.6%) AGYW had a skilled delivery. (see Graph 6)



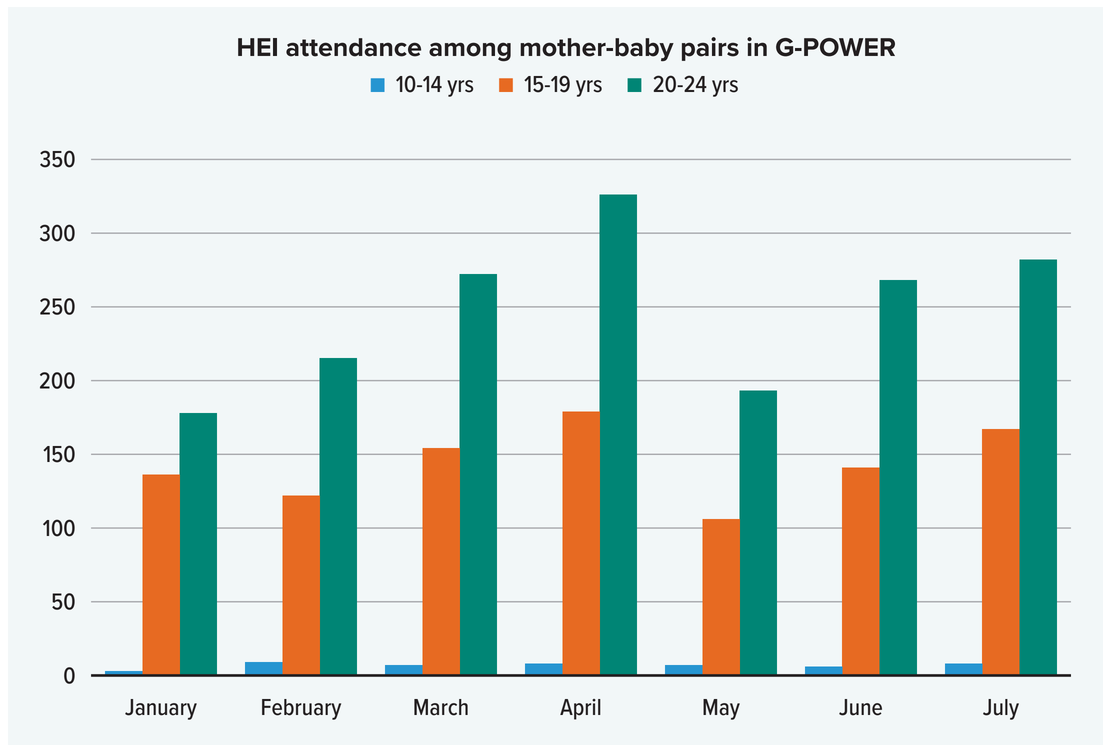
Graph 6. Deliveries and Skilled Deliveries

Comprehensive care and support for HIV-exposed infants

Following the delivery of their infants, AGYW in PNC continue to receive support and follow-up by the AGYW peer mentors and the G-POWER team through proactive engagement. The mother-baby pairs (MBPs) receive guided support for HIV testing, prevention, and immunizations until the infants reach the age of 24 months. The infant's information is collected in the child welfare clinic in the mother-baby booklet, and the AGYW peer mentor follows up with the MBPs with fidelity, providing appointment reminders, individualized messaging, and home visits when necessary.

PROJECT IMPACTS:

- From January to July 2022, 2,978 AGYW and their infants who were identified as HIV-exposed infants (HEIs) had their diagnostic samples collected at the facility (see Graph 7).



Graph 7. HEI attendance

Integration of social support and social protection

The G-POWER package intentionally created linkages to social support including PSS, early childhood development (ECD), and social protections through OVC and DREAMS partnerships, ensuring the availability of critical care and services to support the health and well-being of AGYW and their infants.

INTEGRATION OF SOCIAL PROTECTION

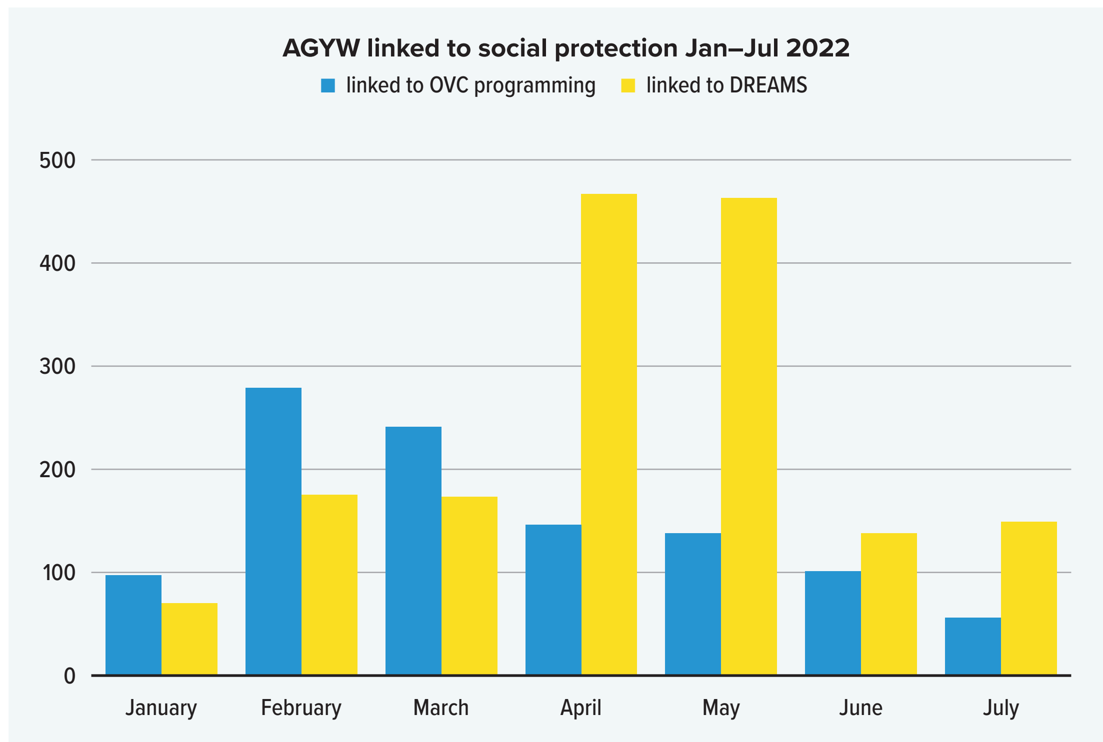
As the evidence shows, social protection can address structural barriers that are associated with risky behaviours and risk of HIV acquisition.[31] These structural barriers include social (gender inequalities, lower education completion) and economic (poverty) factors. G-POWER intentionally integrates linkages with OVC and DREAMS partners to ensure PBF AGYW receive additional social protection services.

The community partners to which AGYW are linked provide opportunities for building and engaging in life skills, such as making soap and fabric softener, and economic empowerment skills. Other facilities, including Nyandiwa Level IV Hospital, can link PBF AGYW to Caritas for school fees, stationery, uniforms, and economic empowerment skills.

Dignity kits and mama-baby care packs are provided to PBF AGYW and their infants on a case-by-case basis depending on need. These consist of various items including sanitary pads, panties, infant diapers, and materials the pregnant AGYW need when presenting to the facility for delivery. Nutritional packs are also provided as needed through food rations during PSS meetings.

PROJECT IMPACTS:

- From January to July 2022, 2,693 PBF AGYW were linked to social protection partners—1,058 to OVC programming and 1,635 to DREAMS partners (see Graph 8).



Graph 8. Social protection

PSYCHOSOCIAL SUPPORT (PSS)

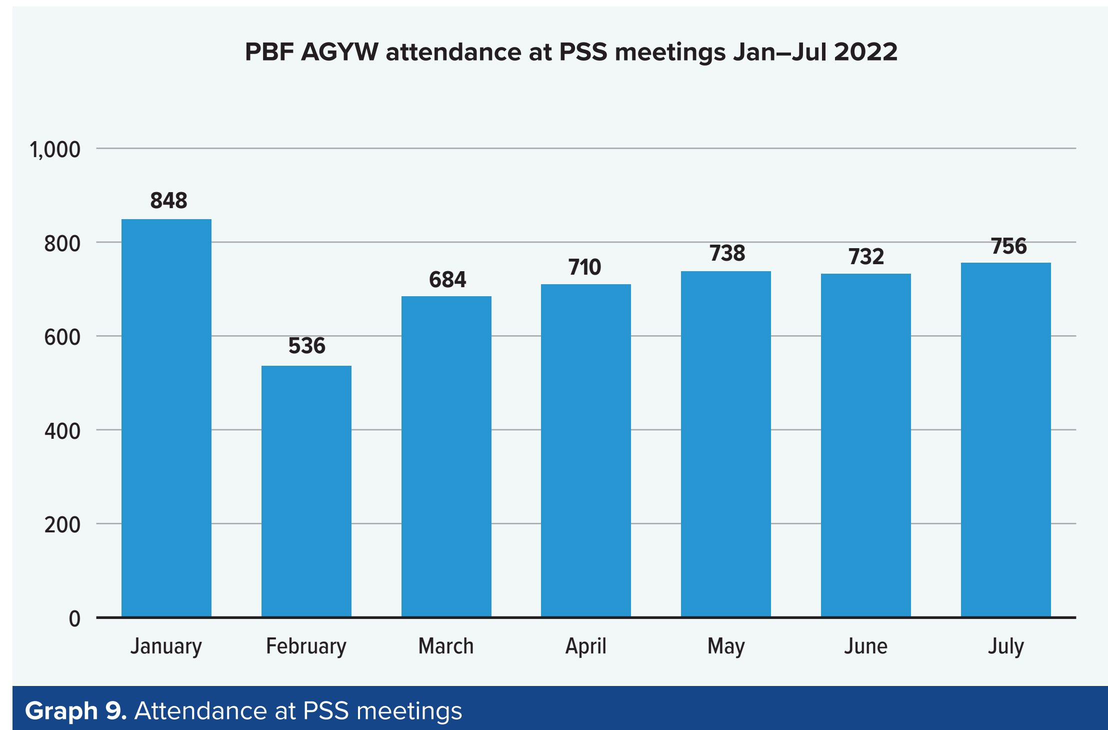
Peer-mentor-led PSS groups for both HIV-negative and HIV-positive PBF AGYW are conducted monthly. Separate groups are held for PBF AGYW who are living with HIV to include additional topics related to PMTCT and treatment literacy and for confidentiality reasons. **G-POWER shifted programming of PSS groups to engage not just clients who are unsuppressed but *all* PBF AGYW facing various vulnerabilities and risks (newly enrolled, facing GBV, new positive, PBF)**. Both groups are facilitated by peer mentors, who receive support from facility staff, and cover a variety of topics including:

- Pregnancy
- Childbirth
- Child care
- Infant feeding methods
- FP
- Signs of STIs
- HIV treatment
- HIV prevention and risk reduction
- The importance of attending ANC and PNC
- GBV
- COVID-19 prevention

In the case of topics requiring additional expertise, health providers attend. Refreshments are also provided.

PROJECT IMPACTS:

- From January to July 2022, 5,004 PBG AGYW, both HIV-positive and HIV-negative, participated in PSS meetings (see Graph 9).



Graph 9. Attendance at PSS meetings

EARLY CHILDHOOD DEVELOPMENT (ECD)

Providing the knowledge and skills for PBF AGYW around motherhood, infancy, and development is a critical element in the G-POWER program. ECD project elements were informed by the nurturing components of care consisting of health, nutrition, responsive caregiving, security, safety, and sufficient opportunities for early learning.[32] ECD elements are integrated into one-on-one and group activities for PBD AGYW and their infants; messages are often provided in both settings and meant to be complementary.

Facilitating school re-entry for PBF AGYW

Attending school is a protective factor for AGYW in reference to the triple threat (HIV, pregnancy, and GBV). School dropout is also attributable to teenage pregnancy among PBF AGYW and young mothers, which affects their social and economic futures. For this reason, school attendance and re-entry were integrated into AGYW peer mentor responsibilities in the G-POWER program.

At their first interaction, AGYW peer mentors document on the case contact form whether the PBF AGYW is currently attending school and, if so, which school she attends. If she does not attend school, the reasons are recorded. The PBF AGYW is also asked about her interest in re-entering school following the birth of her child.

The AGYW peer mentor supports ongoing school attendance through pregnancy, as supported by the school re-entrance policy. If the AGYW faces a challenge in attending or returning to school,

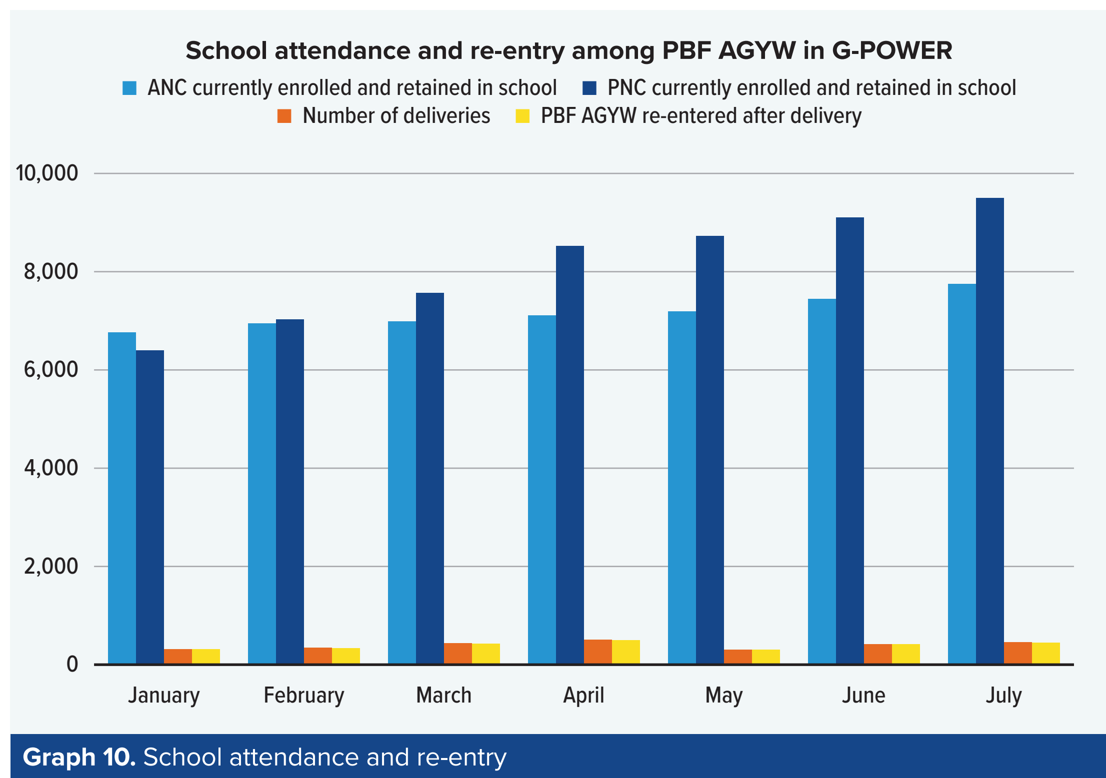
the peer mentor contacts the school. With support from the G-POWER team, the peer mentor will facilitate a solution when possible, to ensure re-entry of the BPF AGYW (see Box 4).

BOX 4. A school re-entry example

An adolescent girl who gave birth to her child was unable to return to school to finish her exams because she lived far from school and was still breastfeeding her child. Her AGYW peer mentor talked to the school matron, who was able to provide a place for the girl and baby to stay at the school, with someone to watch the baby while she took her exams.

PROJECT IMPACTS:

- From January to July 2022, 2,753 PBF AGYW re-entered school following delivery (see Graph 10).



Graph 10. School attendance and re-entry

Increased identification of GBV cases among AGYW and linkage to care and support

AGYW peer mentors, along with G-POWER facility-based staff, received a comprehensive multiday training on sexual and gender-based violence (SGBV) that included building knowledge and skills around the different types of SGBV, risk factors, screening for suspected cases, and linkages and referrals based on screening outcome. For example, time during the training was focused on identifying forms of GBV including female genital mutilation, child abuse, deprivation of food or water, financial control, and controlling behaviors.

AGYW peer mentors screen every AGYW that enters their facility using a screening tool on their tablet. AGYW with a suspected case are immediately linked with the GBV focal point at the facility by the peer mentor physically accompanying the AGYW to meet with them. Over a five-month period, over 15,000 AGYW have been screened and over 1,900 were linked to care and support (see Graph 10). Referrals are documented in the case contact form (see Box 5), as are the details of the providers or facility to ensure follow-up to confirm completion of the needed service. Referrals for GBV cases can include linkages to police, legal, social, and health services.

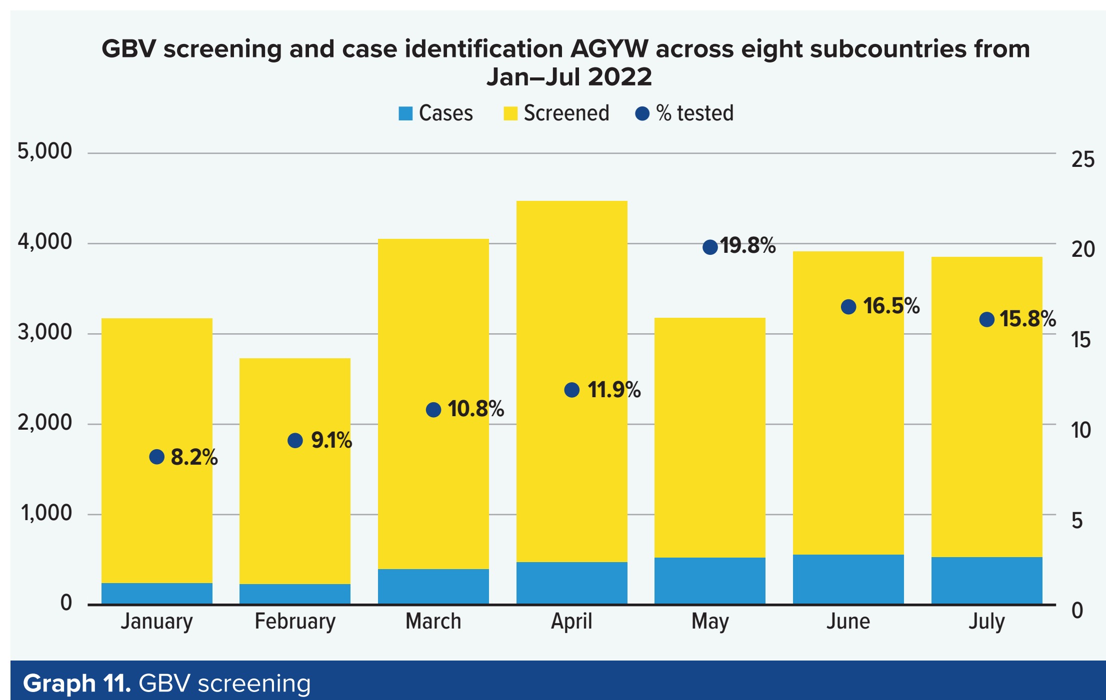
BOX 5. Example questions in the case contact form used by the peer mentor with each PBF AGYW

- In the past, have you been hit, slapped, kicked, or physically hurt by someone?
- Are you in a relationship with a person who physically hurts you?
- Are you in a relationship with a person who threatens, frightens, insults, or treats you badly?
- Are you in a relationship with a person who forces you to participate in sexual activities?
- Have you ever experienced any of the above with someone you do not have a relationship with? That makes you feel uncomfortable?

**A yes to any of the posed questions confirms eligibility for a referral*

PROJECT IMPACTS:

› From January to July 2022, 22,417 AGYW were screened for GBV and 2,944 cases (13.1%) were identified and linked to care and support



Graph 11. GBV screening

Closing

The G-POWER project demonstrates significant promise in providing solid evidence for establishing a comprehensive, peer-centered case management approach to support HIV-positive and HIV-negative PBF AGYW and their infants in achieving and maintaining health and well-being throughout and after pregnancy.

Contacts

If interested in learning more about the program, support for adaptation, or additional insights, please see the following contacts:

- Dr. Eliud Mwangi—country director EGPAF Kenya: emwangi@pedaids.org
- Job Akuno—senior project manager EGPAF Kenya: jakuno@pedaids.org

Appendix

The following tools and resources are available in the appendix.

- Training schedule for AGYW peer mentors
- Risk behavior assessment—PrEP eligibility
- Indicator reporting template

Training schedule for AGYW peer mentors

TIME	TOPIC
9:00–9:30 a.m.	Registration, prayers and introductions, house rules, roles and responsibilities (rapporteurs, timekeeper, class rep)
9.30–9:35 a.m.	Review of agenda and modules
9:35–9:45 a.m.	Exercise
9:45–10:15 a.m.	Welcome remarks Brief background and introduction of the AGYW program
10:15–10:45 a.m.	Tea break
10:45–11:30 a.m.	Multiple pathways
11:30–1:00 p.m.	AGYW and risks for HIV/STIs (prevention) PrEP and considerations for AGYW
1:00–2:00 p.m.	Lunch break
2:00–4:00 p.m.	ANC care for AGYW Management of labor, delivery, and postpartum care for AGYW Understanding and utilization of PMTCT services by AGYW and HEI Early infant diagnosis testing protocol in Kenya
4:00–4:30 p.m.	Tea break and end of day 1
	DAY 2
8:45–9:00 a.m.	Registration and recap
9:00–9:45 a.m.	Postpartum depression
9:45–10:30 a.m.	GBV and AGYW
10:30–11:00 a.m.	Tea break
11:00–12:00 p.m.	Skills for maintaining interactions with AGYW
12:00–1:00 p.m.	Case management approach for PMTCT clients
1:00–2:00 p.m.	Lunch break

2:00–3:00 p.m.	Monitoring and evaluation of AGYW program Documentation and reporting.
3:00–3:20 p.m.	EGPAF Code of Conduct
3:20–3:50 p.m.	Timesheets, managing advances for PSS / home visits
3:50–4:10 p.m.	Summary of workshop
4:10–4:30 p.m.	Way forward and closure
4:30–5:00 p.m.	Tea break and departure
	END

Risk Behavior Assessment—PrEP Eligibility

PrEP eligibility is determined by answering yes to one or more of the following questions.

In the last 6 months:

- Have you been sexually active?
- Have you had more than one sexual partner?
- Have you had sexual contact where neither you nor your sexual partner was wearing a condom? How many of your sexual partners were HIV-positive or of unknown HIV status?
- Have you had sex with HIV-positive partner(s) or persons of unknown HIV status without a condom?
- Have you been treated for a sexually transmitted infection?
- Have you injected drugs that were not prescribed by a health care provider? If yes, did you use syringes, needles, or other drug preparation equipment that had already been used by another person?
- Have you had sex while you or your partner was under the influence of alcohol or drugs? History of sexual and gender-based violence / intimate partner violence?
- Are you in an HIV-discordant relationship newly diagnosed?

Indicator Reporting Template

FACILITY NAME:	MONTH/YEAR:		
	10–14 Yrs	15–19 Yrs	20–24 Yrs
Number of AGYW done for pregnancy risk assessment			
Number with suspected pregnancy risk			
Number tested for pregnancy			
Number positive for pregnancy			
Number of pregnant AGYW linked to ANC			
Number provided with FP			
Number of AGYW newly enrolled in ANC			
Number of AGYW newly enrolled in PNC			
Number current enrolled in ANC			
Number current enrolled in PNC			
HIV testing and retesting at ANC and maternity			
Number eligible for testing at 1st ANC			
Number tested for HIV at 1st ANC			
Number newly identified HIV-positive at 1st ANC			
Number newly initiated on ART at 1st ANC			
Number eligible for HIV testing at 3rd trimester			
Number tested for HIV at 3rd trimester			
Number newly identified HIV-positive at 3rd trimester			
Number newly initiated on ART at 3rd trimester			
Number eligible for HIV testing at labor and delivery			
Number tested for HIV at **labor and delivery**			

FACILITY NAME:	MONTH/YEAR:		
	10–14 Yrs	15–19 Yrs	20–24 Yrs
Number newly identified HIV-positive at **labor and delivery**			
Number newly initiated on ART at **labor and delivery**			
HIV testing and retesting at PNC			
Number eligible for HIV testing at 6 weeks PNC			
Number tested for HIV at 6 weeks PNC			
Number newly identified HIV-positive at 6 weeks PNC			
Number newly initiated on ART at 6 weeks PNC			
Number eligible for HIV testing at 6 months PNC			
Number tested for HIV at 6 months PNC			
Number newly identified HIV-positive at 6 months PNC			
Number newly initiated on ART at 6 months PNC			
Number eligible for HIV testing at 12 months PNC			
Number tested for HIV at 12 months PNC			
Number newly identified HIV-positive at 12 months PNC			
Number newly initiated on ART at 12 months PNC			
Number eligible for HIV testing at 18 months PNC			
Number tested for HIV at 18 months PNC			
Number newly identified HIV-positive at 18 months PNC			
Number newly initiated on ART at 18 months PNC			
Number eligible for HIV testing at 24 months PNC			
Number tested for HIV at 24 months PNC			
Number newly identified HIV-positive at 24 months PNC			

FACILITY NAME:		MONTH/YEAR:	
	10–14 Yrs	15–19 Yrs	20–24 Yrs
Number newly initiated on ART at 24 months PNC			
ART cohort analysis			
Number of AGYW started on ART 12 months ago (ANC and PNC)			
Number active on care			
Number with a viral load done			
Number who are virally suppressed			
ANC AGYW scheduled to attend the clinic			
PNC AGYW scheduled to attend the clinic			
HEI scheduled to attend the clinic			
ANC attended clinical monitoring visit			
PNC attended clinical monitoring visit			
HEI attended clinical monitoring visit			
Number of clinical visit defaulters line listed			
Number of clinical visit defaulters traced			
Service-planning clients profiled and listed for support			
Service-planning-profiled			
Service-planning-supported			
GBV services			
Number screened for GBV			
Number of GBV survivors identified			
Number of survivors referred for support			

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