Training course in adolescent sexual and reproductive health 2019

HIV prevention and care

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Question 1:

Name 3 reasons why there is increased risk of adolescent girls acquiring HIV and of the consequences of HIV infection?

UNAIDS 2018 estimate reports that, HIV infections among adolescent girls 10-19 years old between 1990 -2017 are significantly higher than males of the same age with 61% of all adolescents living with HIV aids being girls. The three risks factors of HIV in adolescent girls among others are:

a) Low levels of economic independence
b) Poor access to education
c) Gender inequalities

Harmful social and gender norms in the society, gender inequalities, unequal power relations, in ability to negotiate for safer sex due to low levels of economic independence and limited access to resources entrenches gender inequality leaving girls vulnerable to HIV infection and impact.

Due to lack of education, most adolescents lack basic knowledge on prevention of HIV: only 34% of young men and 28% of young women in sub-Saharan Africa between 2012 and 2017 had comprehensive knowledge on how to prevent HIV [1]

One major consequence of HIV infection among adolescent girls is increased AIDS related mortality.

Question 2:

Name 3 reasons why we have to do more to address HIV in adolescents than we are doing now?

Globally, the number of adolescents infected by HIV compared to other age groups has not declined. For example, in 2017 adolescents acquired 190,000 new infections of HIV globally. Based on the 2018 estimate of the UNAIDS, the number of new HIV infections between the years 2000-2017 has not declined, instead it has flattened. Additionally, the number of AIDs-related deaths among adolescents between 10-19 years old have not declined but also flattened.

Report from UNICEF 2018 HIV estimates from 40 countries suggests that only 37% of adolescents aged between 15-19 years (41% girls and 31% boys) accessed antiretroviral therapy. This information shows that largely, adolescents living with HIV receive inadequate access to antiretroviral therapy. There is need to focus on adolescents if we are to achieve epidemic control by 2030.

Question 3:

Name 2 ways in which service organization of medication refill visits could be differentiated to make them more friendly to young people living with HIV.

Most young people who live with HIV are still accessing education. Unrealistic schedules for clinic refill visits and missing school may discourage adolescents from following up with treatment. Extending ART refills to accommodate school calendar and hours will be

friendlier to young people. Additionally, it will be prudent to use lay adolescent friendly service providers who would be able to provide privacy and be flexible enough to see all adolescents seeking the services.

Question 4

What is the DREAMS initiative? What is layering in the context of the initiative? What challenges has the initiative experienced in layering interventions?

DREAMS initiative is a Public-Private Partnership HIV prevention program aimed to break the cycle of HIV infection among adolescent's girls and young women, by creating opportunities for them to live Determined, Resilient, Empowered, AIDS –free, Mentored and Safe (DREAMS) lives. In addition, it provides a combination of HIV prevention packages designed to target multiple root causes of risk for adolescent's girls and young women with the aim of reducing vulnerability against HIV.

Layering in DREAMS means providing each adolescent girl and young woman with multiple interventions and services from the DREAMS core package as opposed to singular standalone interventions. It includes existing contextual level interventions that are not directly delivered to adolescent's girls and women but from which may benefit from.[2]

While implementing DREAMS project in Kenya, Zimbabwe and South Africa, the following challenges in layering interventions were observed.

- It was challenging to layer services in the DREAMS Core Package–at individual AGYW level. From the report, there were cases where targets were also perceived to impede the layering and referral of services as IPs 'chased' their own targets, rather than refer to other IPs.

- Tracking the layering of services was difficult. During implementation, South Africa and Zimbabwe faced challenges in tracking of referrals to facilitate layering since implementing partners lacked enough time to plan and experienced poor coordination strategies that would have broadened the focus to deliver integrated services across partners.

- The monitoring and evaluation databases used to consolidate routine/ programme data differed across countries and were not comparable and defined and counted services differently. In South Africa, the database did not capture referrals and therefore could not be used to show degree of layering between partners or the number of services AGYW had received which was a missed opportunity to better understand risk and vulnerability while in Zimbabwe, their information system had failed to track primary packages by age and circumstances of adolescents girls and young women and had planned to further modify their DHIS2 in Year 3.A 'new way of working' was difficult given lack of existing systems, structures or incentives for organizations to link their services for AGYW. Some sectors had no history of working together yet were expected to co-ordinate the delivery of targeted and layered interventions, effectively and rapidly.

In conclusion it would be important to ensure good collaboration, cooperation, and networking among DREAMS players.

Question 5.

What is the rationale for PrEP? What is WHO's recommendation on the use of PrEP? Name three attributes of the recommendation?

Despite scaling up HIV treatment, new number of HIV infections among adults has not decreased. Instead, it has flattened. Evidenced based interventions such us prevention of mother to child HIV transmission in pregnant women has demonstrated that prevention and treatment go together if reduction in HIV transmission is to be realized. AIDS-related deaths among young adolescents aged 10–14 years have declined since 2010 to approximately 20 000 deaths globally during 2015, due largely to the impact of prevention of mother-to-child transmission [3]

WHO recommendation in September 2015 states that "oral pre-exposure prophylaxis (containing TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches"[4]

Firstly, prep should be availed to people who are at a substantial risk of HIV such as those who inject drugs and women who have bisexual male partners.

Secondly, Prep should be an additional prevention choice and should not replace or compete with effective and well-established HIV prevention interventions, such as comprehensive condom use, HIV testing and links to ART programming for sex workers and men who have sex with men and harm reduction for people who inject drugs.

Lastly, people receiving PrEP should be given comprehensive support such as adherence counselling, legal and social support, mental health and emotional support and contraception and reproductive health services.

References

1. United Nations Population Division. Population facts. New York: United Nations; 2014. http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2014-6.pdf

2. PEPFAR. Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR Country Teams on the DREAMS Partnership, 2015. http://ghpro.dexisonline.com/sites/default/files/2015-03-09%20%20FINAL%20DREAMS%20Guidance.pdf

3. Slogrove AL, Mahy M, Armstrong A, Davies MA. Living and dying to be counted: what we know about the epidemiology of the global adolescent HIV epidemic. J Int AIDS Soc. 2017;20 (Suppl. 3):2152.

4. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015.