

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?

While prevention strategies have sought to address issues surrounding HIV, adolescent girls continue to be at an increased risk of getting infected. In eastern and southern Africa, girls made up two out of three new infections among adolescents in 2017. Adolescent girls are disproportionately affected by HIV infections, with their number rising to 1 million in 2017, compared to 0.6 million boys. This means that roughly 61% of new infections affect young women.

This is partly attributed to a lack of knowledge among young people. Statistics show that only 28% of young women in sub-Saharan Africa (2012 to 2017) had sufficient knowledge on HIV prevention. These women and girls face further obstacles to implement safe protection measures as the use of condoms may be hard for them to ensure. This is largely due to pressures faced from a lack of economic independence, intimate partner violence, poor education access, lack of employment opportunities or other power structures in regards to sex and gender which limit their self-autonomous decision-making.

Young women are further exposed to the risk of contracting HIV as, in many countries, adolescents are less likely to be tested and diagnosed, further increasing the risk that they may pass on the illness to others. This is partly due to the fact, that some countries require parental consent.

An HIV infection has significant consequences and if left untreated is likely to result in death. While numbers among younger adolescents from 10 to 14 have declined, as successful medical treatment can now prevent the transmission from mother to child, numbers for young people from 15 to 19 have increased, resulting in 20 800 deaths in 2015. Adolescents living with HIV have a much higher rate of mortality than adults and they are the only age group for which the number of deaths related to HIV did not decline from 2000 to 2015, instead it actually doubled.

Question 2

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

It is of crucial importance to increase efforts in regard to HIV prevention in adolescents. From 2000 to 2017, there has been a significant decrease of infection for children aged 0 to 4 from 420,000 to 180,000. While the number of adolescent infections for ages 15 to 19, has declined from 420,000 to 250,00, no significant progress has been made in the last 10 years and the decline has all but stagnated. This shows that while some progress has been made, efforts need to be renewed to ensure that the number of new infections continues to decrease. Statistics show promising results namely that AIDS related deaths have largely decreased for all age groups, most significantly for children from age 0 to 14, where the death rate is now at just over 100,000 in 2017. From the early 90s to the late 2000s, the rate of death for adolescents, however, actually increased. While a sharp decline was visible from 2010, it has all but flatlined, further highlighting the very real and evidence-based need that HIV infection among adolescents continues to be a very real issue, that could even worsen if left unattended. Statistics from 40 countries also show that adolescents who have contracted HIV do not have sufficient and adequate access to the necessary antiretroviral therapy. In 2017, 61% of

adolescents aged 10 to 14 were on ART, compared to only 37% of adolescents aged 15 to 19. Adolescents continue to be at a high risk of contracting HIV and dying from HIV as they, for various reasons, are not able to access the services, or may not be aware of their infection. While many other groups, have seen improvements, adolescents remain at risk, signalling how crucial further intervention is.

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.

Medication refill visits offer some potential to make services more adolescent friendly. For example these visits should not take place more than every three months which decreases the burden of frequent appointments on young people. The visits could take place in a PHC, but also individual or group collections outside of official facilities could be an option. It could also be useful to consider different ART delivery models, especially in regard to pregnant or breastfeeding adolescents which should be supported with adapted ART models if they are in a stable condition. The person in charge of medication refills visits are generally doctors and nurses, this could be supplemented with lay providers who are trained to increase the number of available and capable personnel.

In case of an oral contraception, the refill could be timed in line with ART refills. It is crucial to also include an adherence check, alongside a disclosure check-in to improve the services for adolescents. Lastly, provisions should also include a referral check to identify if the person in treatment requires further medical support.

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?

The DREAMS initiative is coordinated by the US Office of the Global AIDS Coordinator and partners from the private sector, with funding from the US President's Emergency Plan for AIDS Relief. The partnership has designed a far-reaching programme to put a stop to the persistent pattern of HIV among adolescent girls and young women. It aspires to do so by building opportunities for them to live Determined, resilient, Empowered, AIDS-Free, Mentored and Safe lives (DREAMS). The initiative delivers its programme through a combination of HIV prevention packages, a so-called core package, which address multiple risk sources. These include generally speaking, cultural, economic, social, behavioural and biomedical factors that lead to an increased risk of contracting HIV among the target group. Through this core package, DREAMS hopes to decrease vulnerability of its target group in relation to HIV, while also further strengthening individual agency. Additional funding also goes into supporting the male partners of young women in relation to testing and treatment. DREAMS applies a multi-sectoral approach which aims to 'layer' services. This means that young women and adolescent girls are offered multiple interventions and/ or services from DREAMS' core package. How the combined interventions, that should be provided through layering, are designed depends on the type of interventions and service that are part of the country's DREAMS programme, the age of the target group, and other individual and specific circumstances of the individual in question, such as abuse or sexual assault. Layering also comprises contextualization of different level, such as the inclusion of community-based

interventions, which go beyond the individual. Rather than creating additional services, DREAMS seeks to integrate its programme into existing government support systems. While the layering initiative offers promising results, its implementation has not been without its challenges. Some of these challenges are related to a need for a better integration of the provided services. In order to do so, one needs to devise tested model that can then be used for other population groups, beyond young girls and adolescent women, and also for other services, beyond HIV treatment.

This also means that there is a great need for improved screening and referral protocols in institutions. The formal linkage between the different organisations has to be improved to ensure smooth running of the programme. Assessments further recommend the use of passports and badges. These approaches presented themselves as useful innovations as a result of the DREAMS programme.

The analysis additionally identified the necessity of recognising populations with the highest risk alongside an appreciation for the very special, unique and complex needs of young women and adolescent girls.

Lastly, some challenges referred to the tracking of the service layering. By using unique IDs information services were able to improve the monitoring of DREAMS services. Nevertheless, some areas of improvement relate to the tracing of layering and primary packages, as well as services by individual risk profiles.

Question 5

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

PrEP is a way for people who don't have HIV to prevent HIV infection by taking a pill every day. "PrEP" stands for Pre-Exposure Prophylaxis. The word "prophylaxis" means "to prevent or control the spread of an infection or disease". PrEP is essential as there is still no decrease in HIV infection among adults on a global scale. While there are increased treatment opportunities, it is also important to build on prevention as these two measures go hand in hand. In order to fast-track HIV services to address the needs at global, regional, national and local levels until 2020 and 2030, there is a strong need to offer measures for HIV preventions which are devised on solid evidence.

The WHO recommends using oral PrEP which contains TDF, as additional prevention choice. This means that it does not substitute the use of other prevention measures such as safe sex practices. It is recommended for those who are at a very high risk of contracting HIV and is a part of different combination prevention approaches.

PrEP comes with a very high recommendation from the WHO and has different aspects. On the one hand, it is classified as enabling. This means that it is not specific to any population and sensible for people at substantial risk (the latter is defined as an HIV incidence of more than 3 out of a 100 people per year in the absence of PrEP). Furthermore, it provides an additional prevention choice but should be combined with condoms and lube, harm reduction as well as HIV testing and links to ART. The last attribute refers to the fact that the provision of PrEP should be linked to comprehensive support. This could entail adherence counselling, legal and social support, mental health and emotional support, alongside contraception and reproductive health services.