Training course in adolescent sexual and reproductive health 2021

HIV prevention and care

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Question 1

Name three factors that increase adolescent girls' risks of acquiring HIV and of the consequences of HIV infection?

Adolescent girls continue to be more at risk of acquiring HIV, based on the UNAIDS 2018 estimates report, they found that between 1990-2017 HIV infections among adolescent girls aged 10-19 are significantly higher than males of the same age. 61% of all adolescents living with HIV aids being girls. **Three factors** that increase adolescent girls' risks of acquiring HIV are **(1)** gender inequalities and harmful masculinities, **(2)** violence, **(3)** poor access to education and employment opportunities, and low levels of economic independence. Most adolescents lack basic knowledge on the prevention of HIV. The data shows that 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. Besides, adolescent girls especially may face more obstacles because they are unable to negotiate the use of preventive methods such as condoms due to low levels of economic independence, interpersonal violence, and power differentials related to age and gender. Also, adolescents are less likely than adults to be tested for HIV, and almost 60% of the 107 reporting countries mentioned that parental consent was required for adolescents to access HIV treatment. Finally, adolescents living with HIV are underserved by HIV services and have poorer retention in care and lower rates of viral suppression compared with children and adults living with HIV. **The consequences of HIV infection** if left undiagnosed and untreated will lead to mortality. Due to the impact of prevention of mother-to-child transmission, AIDS-related deaths among young adolescents aged 10–14 years have declined since 2010 to approximately 20 000 deaths globally during 2015. However, AIDS-related deaths among adolescents aged 15–19 years have continued to rise, with an estimated 20 800 deaths during 2015, due in part to the unique characteristics, especially increasing autonomy, of older adolescents and the effects of these characteristics on adherence to treatment and retention in care. Compared with children and adults living with HIV, adolescents living with HIV have higher rates of mortality. Adolescents comprise the only age group for which AIDS-related mortality did not decline between 2000 and 2015 worldwide; instead, AIDS-related mortality among adolescents more than doubled during this period.

Question 2

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

Three reasons why we have to do more to address HIV in adolescents than we are doing now because based on the UNAIDS estimates reported that 1.6 million adolescents living with HIV, 61% of them being girls. **(1)** Generally, new HIV infection is higher in adolescents compared to other age groups, there is a decline from 320 000 new cases in 2008 to 250 000 new HIV infection among adolescents compared to 180 000 among younger children in 2017. However, the decline of new HIV infection among adolescents has almost flatlined. **(2)** AIDS-related deaths continue to decrease for all age groups except also for adolescents the decline has flatlined. **(3)** Adolescents living with HIV receive inadequate access to antiretroviral therapy, statistics from 40 countries showed that only 37% of adolescents aged between 15-19 years (41%

girls and 31% boys) accessed antiretroviral therapy. Hence, we still have more to do to address the HIV infection in adolescents.

Question 3

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

The two ways in which service organization of medication refill visits could be differentiated to make them more friendly to young people living with HIV are: **(1)** medication refill visits for adolescents should not be more frequent than every three months, so the burden of frequent appointments for adolescents will be decreased and they have enough time for studying and doing other activities. **(2)** these visits can be in a PHC and also out of facility individual or group collection can be a good option. It could be great to consider ART delivery models, especially for pregnant or breastfeeding adolescents that should be supported within differentiated ART models for clinically stable adolescents. **Additional ways** to make these visits more friendly, those visits are generally provided by nurses and doctors, trained lay providers with AFHS can be added and they can be more friendly and flexible with adolescents. Also, in the case of oral contraception provided refills could be distributed along with ART refills. It is essential to include in these visits adherence check, disclosure process check-in and referral check with a clear pathway to identify needs for referral to clinicians.

Question 4

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

The DREAMS initiative is a public-private partnership aim to stop the persistent pattern of HIV infection among Adolescent Girls and Young Women (AGYW) by creating opportunities for them to live Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe lives (DREAMS). This initiative is designed to provide a combination of HIV prevention packages to target multiple sources of risk for AGYW such as the economic, social, cultural, behavioral, and biomedical factors that increase their vulnerability to HIV infection. The initiative core package includes interventions that aim to reduce the vulnerability of the target group to HIV and enhance individual agency, with additional funding to strengthen HIV testing and treatment programmes for male sexual partners of young women.

Layering in the context of the DREAMS initiative means providing multiple interventions or services from the DREAMS core package to each AGYW. The combination of interventions that should be layered depends on several factors such as, which interventions and services are included in the country's DREAMS programme: age of the AGYW, and specific circumstances of individual AGYW. Layering also comprises contextual level intervention. DREAMS activities are intended to be integrated within government-supported systems and this is to build on the existing infrastructures. **The challenges** that the initiative experienced in layering interventions are: **(1)** Layering services in the DREAMS Core Package at individual AGYW level which include challenges related to a need for better integration of services. This is can be done by

applying tested models to other population groups and services (beyond adolescents and young girls). In this case, there is a great need to strengthen and improve screening and referral protocols, the formal linkages between organizations to ensure that the programme applied smoothly also the importance to use passports, and badges. The evaluation mentioned that, it is necessary to identify the high-risk populations and appreciate the unique and comprehensive needs of AGYW. **(2)** Tracking the layering of services, which can be done by using a unique ID that strengthens the information system to monitor DREAMS services and it could be improved to track layering and primary packages, and services by individual risk profiles.

Question 5.1

Explain what Theory of Diffusion of Innovation is?

The Theory of Diffusion of Innovations is considering that innovation can be new information, an attitude, a belief or practice, or any other object that is perceived as new by the individual or the community and can be diffused to a specific group. An innovation is communicated through certain channels over time amongst members of a social system such as schools.

Question 5.2

Who are "Change Agents"?

"Change Agents" are opinion leaders. The use of opinion leaders is a central point in this theory. Peer educators are assumed to have this role by influencing not only those for whom the activities are organized but also others of relevance in the peer's environment such as family, friends, etc. through an informal diffusion.

Question 5.3

Statistically speaking, what impact did the peer education intervention have on students' knowledge, as compared to students who were not exposed to the intervention?

68% of students targeted by peer education had good knowledge scores compared to 43.3% of students not targeted by peer education. Students targeted by peer education had statistically fewer misconceptions and better knowledge on the modes of transmission and prevention. The only exception was the knowledge on having sex with an infected person, which was not statistically significant.

Question 5.4

In your country, what role do you believe that peer educators could play in a project/ programme to address HIV among adolescents or young people? Please provide a relevant reference or example.

In Egypt, approximately 61% of the population is under the age of 30, and 40% is between the ages of 10 and 29 (Roushdy et al., 2015). They are the majority; they must have a role. Peer

educators could play an important role in projects and programmes to address HIV among adolescents such as spreading awareness on HIV and AIDS and tackle stigma and discrimination among their peers through a youth-friendly message and approach. Peer educators have a lot of advantages for example they have physical and sociocultural access to intended audiences in their natural environments without being conspicuous because the target populations have the feeling that those peers are from the same socio-cultural environment. Also, they can affect people's behaviors because they gain people's trust if they are well trained and they act as persuasive role models for change. Also, they are effective and credible communicators, they use appropriate language/terminology as well as non-verbal gestures to allow their peers to feel comfortable when talking about issues of sexuality and HIV/AIDS (UNAIDS, 1999). The Egyptian Family Planning Association (EFPA) gave a good example of the role of peer educators in HIV programs, they used outreach as an extension of their clinical services to engage with young people who are most at risk of acquiring HIV. They used volunteer peer educators to provide comprehensive, gender-sensitive, rights-based sexual and reproductive health education. Each clinic had two young males and females' educators aged 18-24 trained in comprehensive sexual and reproductive health education, HIV and other STIs, and communication skills; they are supervised by clinic staff and by an EFPA reproductive health officer and youth officer. The peer educators conduct outreach sessions with young people less than 18 years of age, primarily at government institutions for street children and orphanages. They offered sessions away from the clinics to provide confidentiality for young people, they explained the services offered by the clinics. They realized a lot of success for example in 2012, 81 peer-to-peer sessions reached almost 2,300 people, one-third of whom were young men who have sex with men or young people who inject drugs (WHO, 2017).

Question 6.1

What are the five principal components of the regional strategy for the health sector response to HIV's priorities?

The five principal components of the regional strategy for the health sector response to HIV's priorities are: **(1)** Strengthening health information systems for HIV and operational research, **(2)** adopting political will, broad participation, and increased financing for a coordinated and sustained national response to HIV, **(3)** providing quality HIV prevention, care, and treatment services and enhancing their utilization, **(4)** strengthening the capacity of health systems for effective integration of HIV services, **(5)** promoting a supportive policy and legal environment to facilitate the health sector response.

Question 6.2

In your opinion, which of the five principal components of the regional strategy for the health sector response to HIV's priorities is most needed in your country? Please provide a relevant reference or example.

I think that "Providing quality HIV prevention, care and treatment services and enhancing their utilization" and "Strengthening health information systems for HIV and operational research" are the priority components that are needed in Egypt. Based on the Global AIDS Response Progress

Report done in Egypt in 2014, the major challenges faced by people living with HIV (PLHIV) are: **(1)** the lack and disparity of geographical coverage of HIV prevention, care, and support services and programmes remain a big challenge in Egypt. While PLHIV faces different challenges and marginalization especially in upper Egypt, this remains a gap that needs to be addressed in plans. **(2)** Integration of HIV services in the health system remains a key challenge for the national response. While there is a consensus both on government and non-government sectors that this remains a key gap that requires programmatic interventions, further advocacy efforts are needed. **(3)** The government of Egypt's (GOE) logistics for and supply chain management of Antiretroviral and other medical supplies require strengthening. (4) Finally, GOE faces a major challenge in conducting high-quality M&E activities. The GOE does not have an automated system for data collection. In some cases, government employees trained in M&E have left their posts. Finally, the GOE does not have a specific mechanism for the dissemination of M&E data. These challenges menace the ability of the GOE to provide high-quality reporting on its efforts in the area of combating HIV/AIDS. The GOE must develop a standard national M&E mechanism and protocol and make progress against these other challenges to combat HIV/AIDS in Egypt (The Ministry of Health and Population, 2014).

References

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