Leveraging decentralized drug distribution models to meet the HIV treatment needs of children and adolescents living with HIV

Decentralized Drug Distribution (DDD) Learning Collaborative

May 20, 2021

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EpiC
Meeting Targets and Maintaining Epidemic Control

Session 13: Learning Collaborative Agenda (7-8:30 am EST)

- **Leveraging decentralized drug distribution models to meet the HIV treatment needs of children & adolescents living with HIV**
  Dina Patel | *USAID*
- **Decentralized Drug Distribution for Children and Adolescents Living with HIV: The SIDHAS Project Experience**
  Majeed Adisa | *FHI 360*
- **Improving Multimonth Dispensing for Children and Adolescents Living with HIV**
  Caterina Casalini | *FHI 360*
- **'The pills alone are not enough'**
  Nicola Willis | *AFRICAID*
- **Panel discussion**
  Kiiza Lubega | *Makerere University*
  Joseph Kariuki | *Kenya*
  Claris Tina Awuor | *FACES*

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Leveraging decentralized drug distribution models to meet the HIV treatment needs of children & adolescents living with HIV.

Photo by HealthySunrise Foundation

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Overview

- Children and adolescents living with HIV represent real life superheroes. They are distinct population that requires a unique approach to HIV care. Prevention, testing, initiation of antiretroviral therapy (ART), retention and engagement in care are all critical steps in the care of these youth.
- Each step requires age-specific barriers, so that successful and prolonged viral suppression can occur.
- Adherence to ART, disclosure of HIV-positive status, and stigma are all examples of struggles faced by our youth, their families, and health care providers.
- Multifaceted Differentiated Service Delivery Models (DSD) such as Decentralized Drug Distribution (DDD) and Multimoth Dispensening (MMD) are needed to sustain ART treatment and adherence.
- Youth's living with HIV have true superhero powers and can survive and thrive with the expectation of a normal lifespan.

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1.8 MILLION

Children living with HIV/AIDS globally in 2019

400 children infected with HIV daily!

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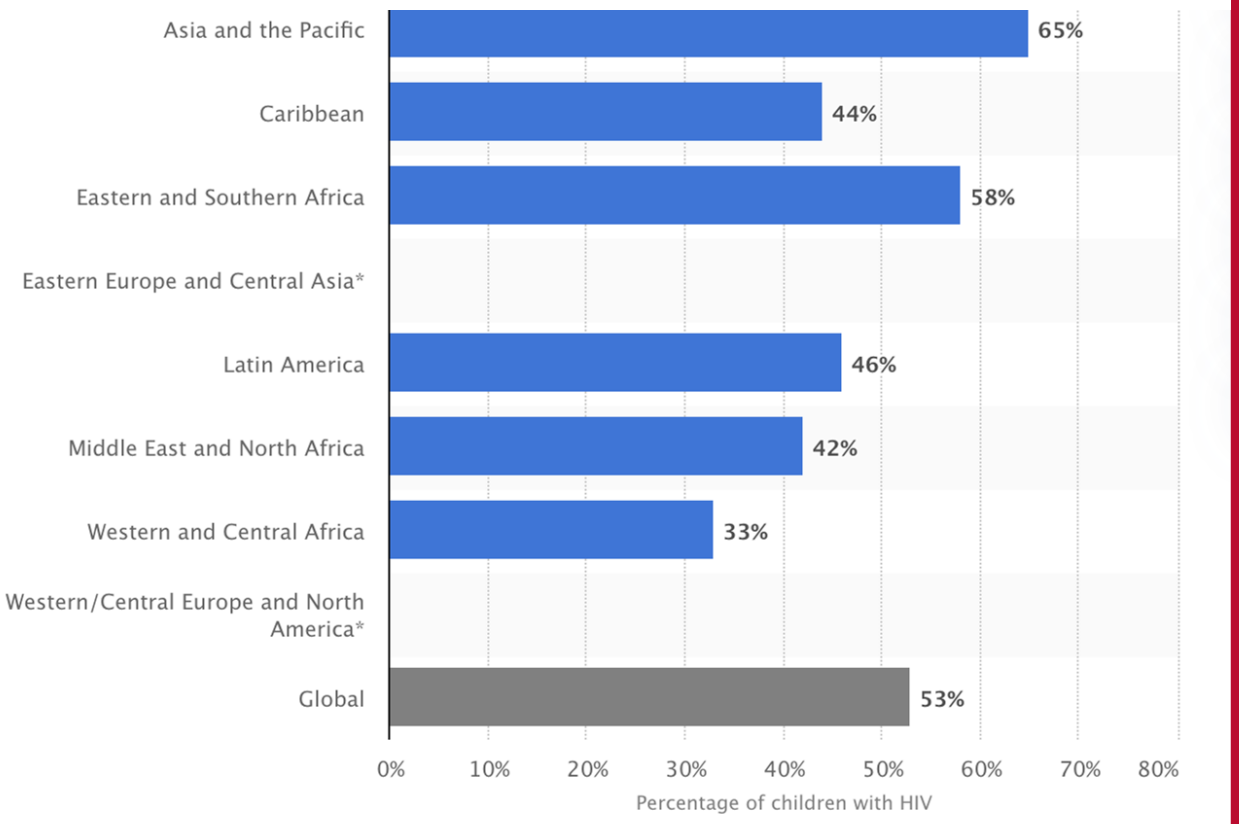
53% of children received ART globally in 2019.

% of children living with HIV (CLHV)receiving antiretroviral therapy (ART) worldwide in 2019, by region.



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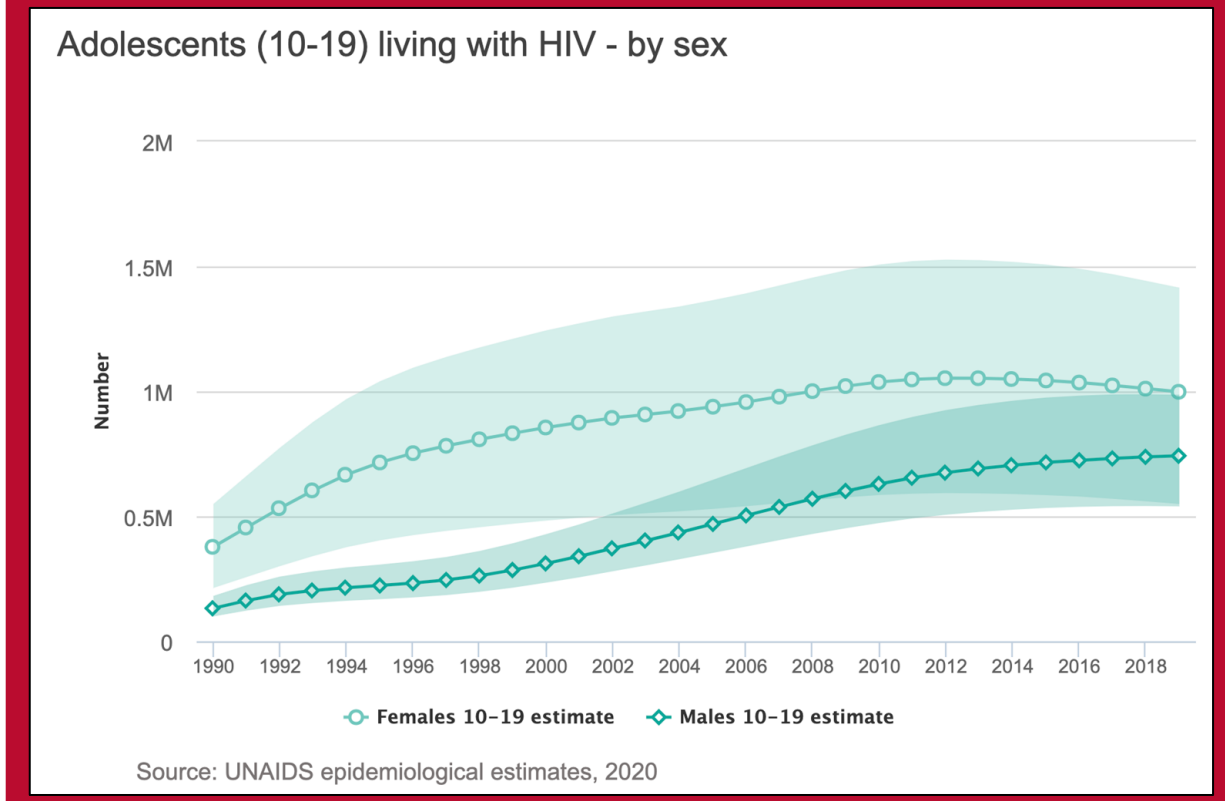
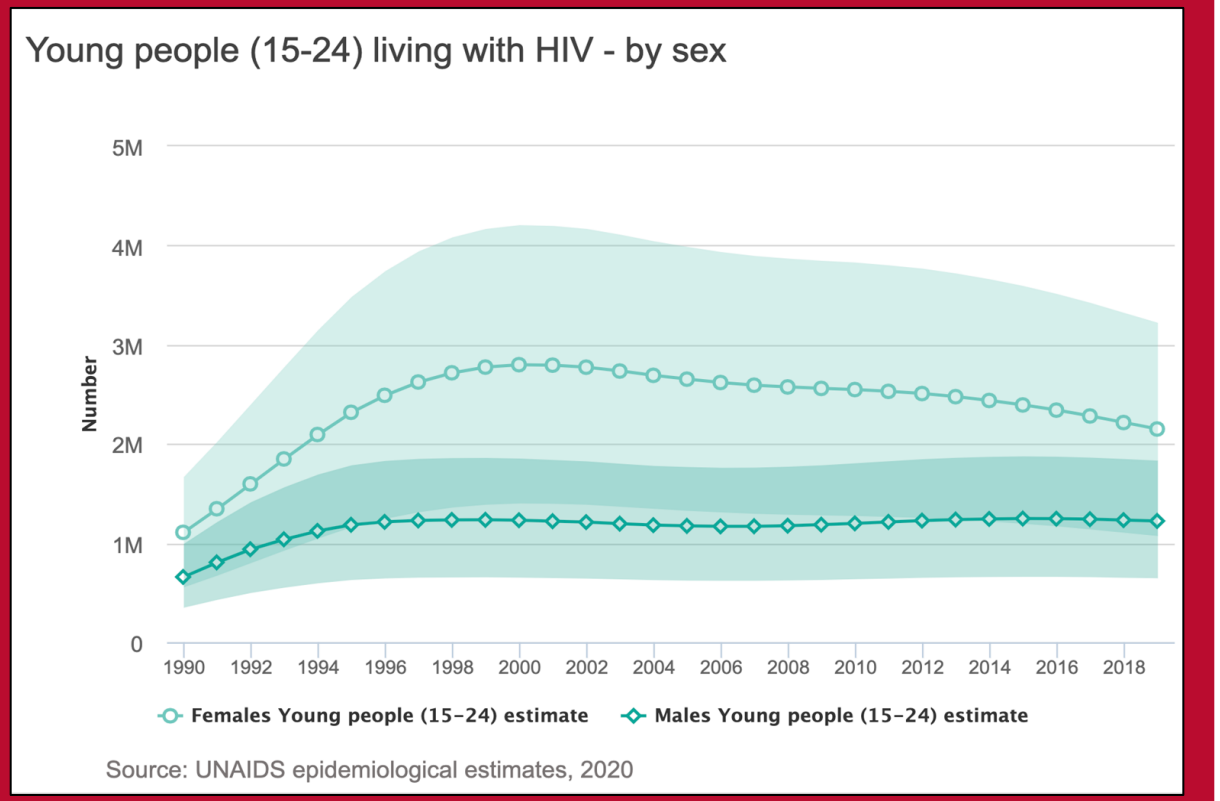
Source: UNAIDS special analysis, 2019.

5.1 Million adolescent and young people living with HIV globally.





~ 1.7 million PLHIV aged 10-19

~3.4 million PLHIV aged 15-24

DSD Models:
DDD & MMD Used to Increase Treatment Coverage

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Wilkinson L et al. *Journal of the International AIDS Society* 2020, **23**:e25482
http://onlinelibrary.wiley.com/doi/10.1002/jia2.25482/full | https://doi.org/10.1002/jia2.25482

JIAS
JOURNAL OF THE INTERNATIONAL AIDS SOCIETY

VIEWPOINT

Children and their families are entitled to the benefits of differentiated ART delivery

Lynne Wilkinson[1,2], George K Siberry[3], Rachel Golin[3], Benjamin R Phelps[3], Hilary T Wolf[4], Surbhi Modi[5] and Anna Grimsrud[1,§]

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Keywords: HIV; ART; differentiated service delivery; children; stable; family-centred

DSD models should be included for clinically stable children above the age of 2.

ART dose adjustments become infrequent, with only three adjustments anticipated between the ages of one to seven years

- DSD should include children/adolescents clinically stable on ART, including children aged two to five years, in differentiated ART delivery models.
- To facilitate adherence for ART countries should consider revising DSD policies, guidelines and/or standard operating procedures to specifically include eligibility criteria for children above two years old and prioritize viral load for children.
- Facilities can then focus on improving family members clinical consultation and ART refill visit alignment and consider enrolment of family members in the same differentiated ART delivery model thereby providing true family centred care.

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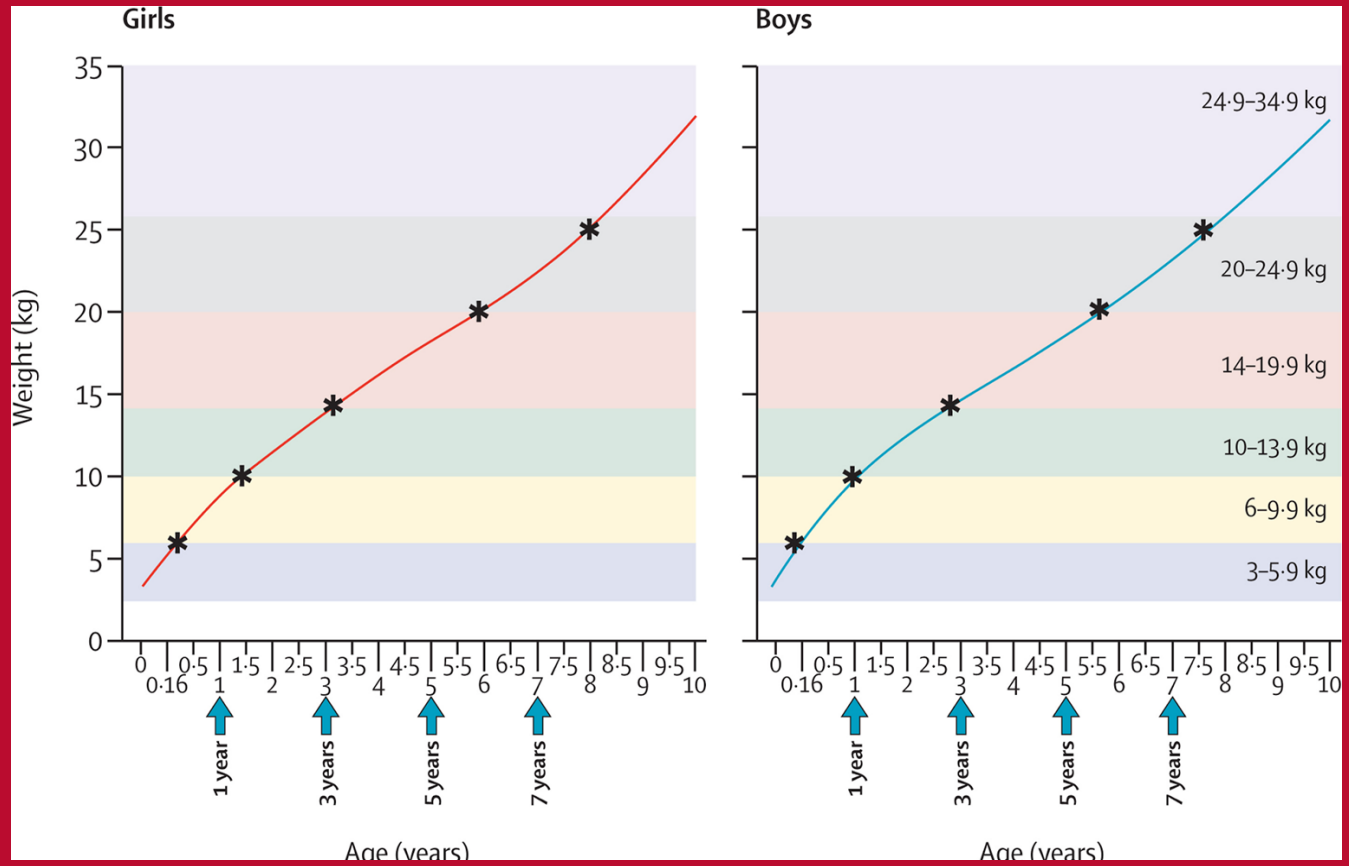
ARV dose changes for children are infrequent beyond infancy
Srivastava et al *Lancet HIV* 2019



Only three dose changes are anticipated between 1 year and 7 years of age and adult ART dose can be reached before the child reaches 10 years of age.

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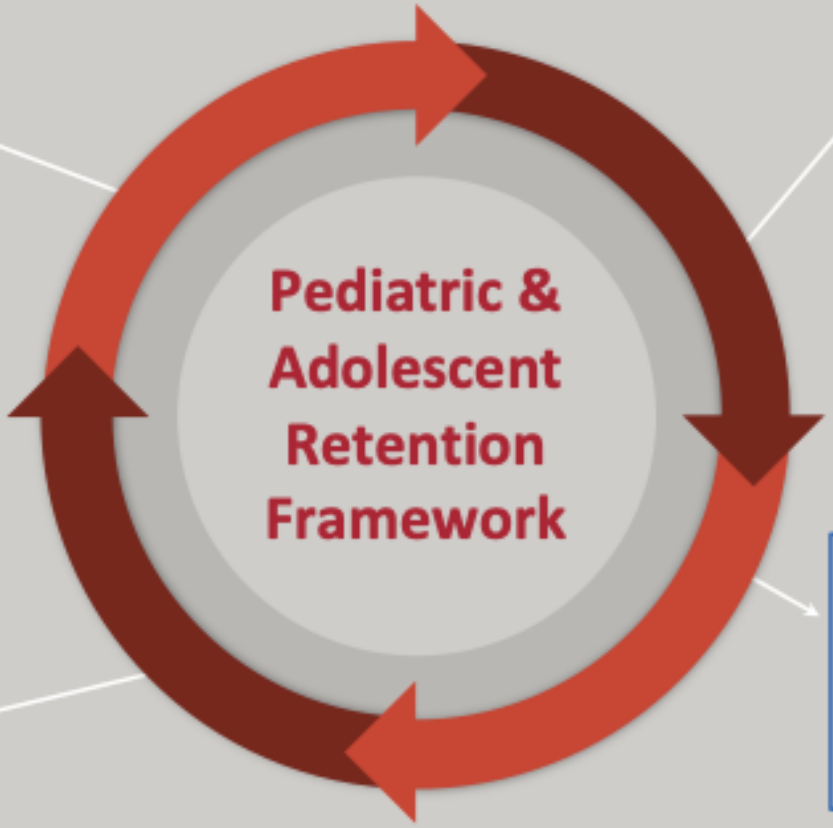
Improving C/ALHIV retention requires a mix of preventive and responsive strategies

DSD Models

- MMD
- Adolescent peer support
- Fast-track ART refills
- Family drug pick-up
- **Community-based models**

Trained HCWS

- High quality pediatric care
- ART Optimization
- Adolescent-friendly services



Active Patient Tracing

- Prompt identification of missed appointments & rescheduling
- **Active community tracing efforts**
- Additional support for those who return to care for adherence & AHD screening

Supportive Services

- Increase enrollment of C/ALHIV into OVC programs
- **Virtual support**

This framework should be implemented within the context of client/family-centered care

Pediatric MMD
Policy & USAID Performance

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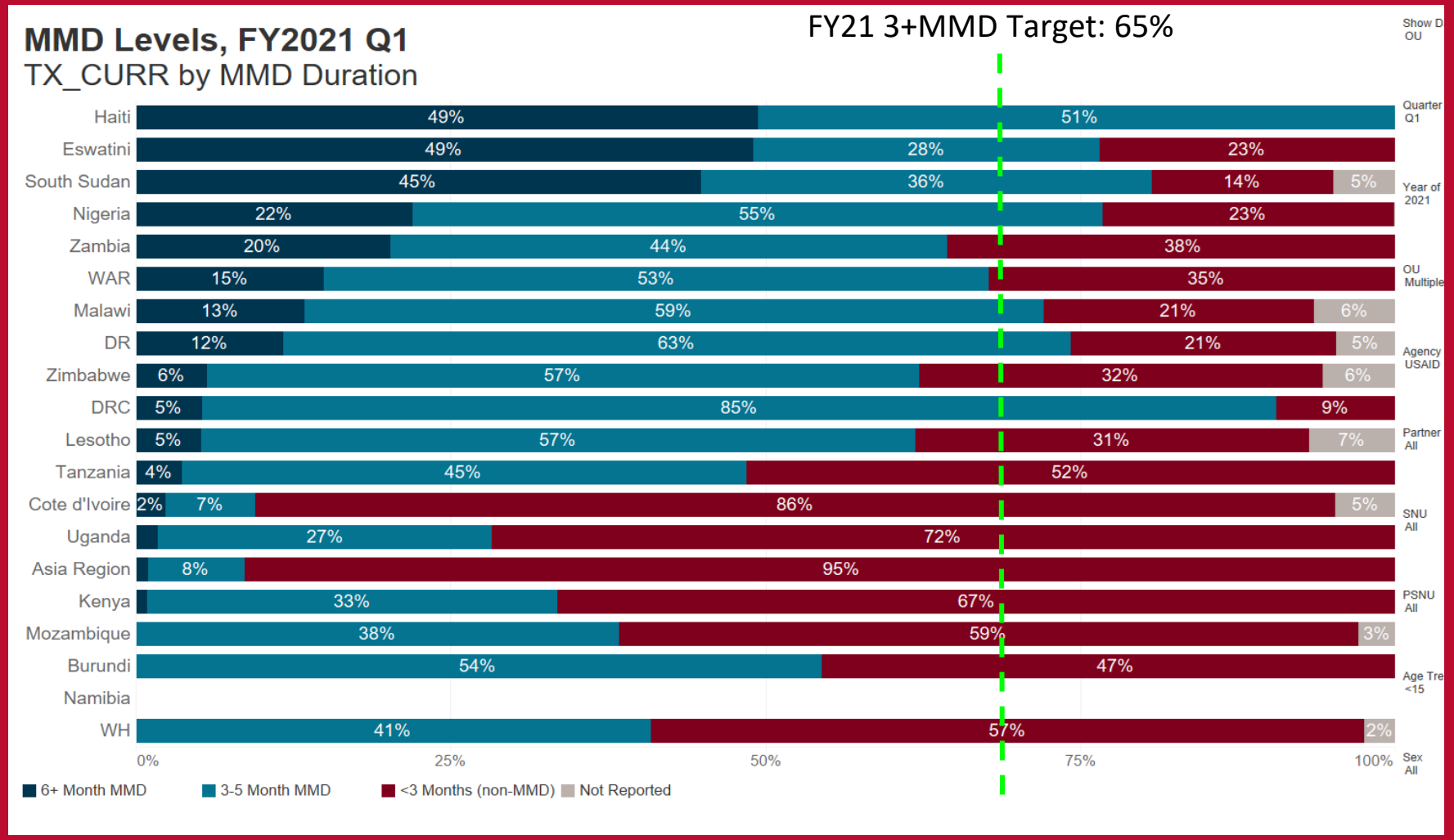
Pediatric MMD Policy

MMD Age Limit	Country
Children ≥ 2 years	Burma, DRC, Haiti, Kenya, Lesotho, Mozambique, Namibia, Rwanda, South Sudan, Uganda, Zambia, Zimbabwe (3MMD)
Children ≥ 5 years	Haiti (6MMD at 20kg); Togo (3MMD at 20kg); Angola, Botswana, Eswatini, Ethiopia, Ghana, Malawi, Nigeria, Tanzania (3MMD)
Other	Burkina Faso (6MMD ≥ 12), Burundi (3MMD ≥ 10), Cameroon (3MMD for adolescents), Zambia (6MMD ≥ 10)
COVID adaptations	Burundi (3MMD ≥ 2); Eswatini (3MMD ≥ 2); Malawi (6MMD for peds 20kg); Zambia formally adopted pediatric COVID adaptations; Zimbabwe (6MMD for adolescents); Mozambique allowed 3MMD for peds but did not accelerate implementation until COVID
Policy unknown but peds MMD implemented	Cote d'Ivoire, Dominican Republic, India, Indonesia, Laos, Mali, Nepal, Senegal, Thailand

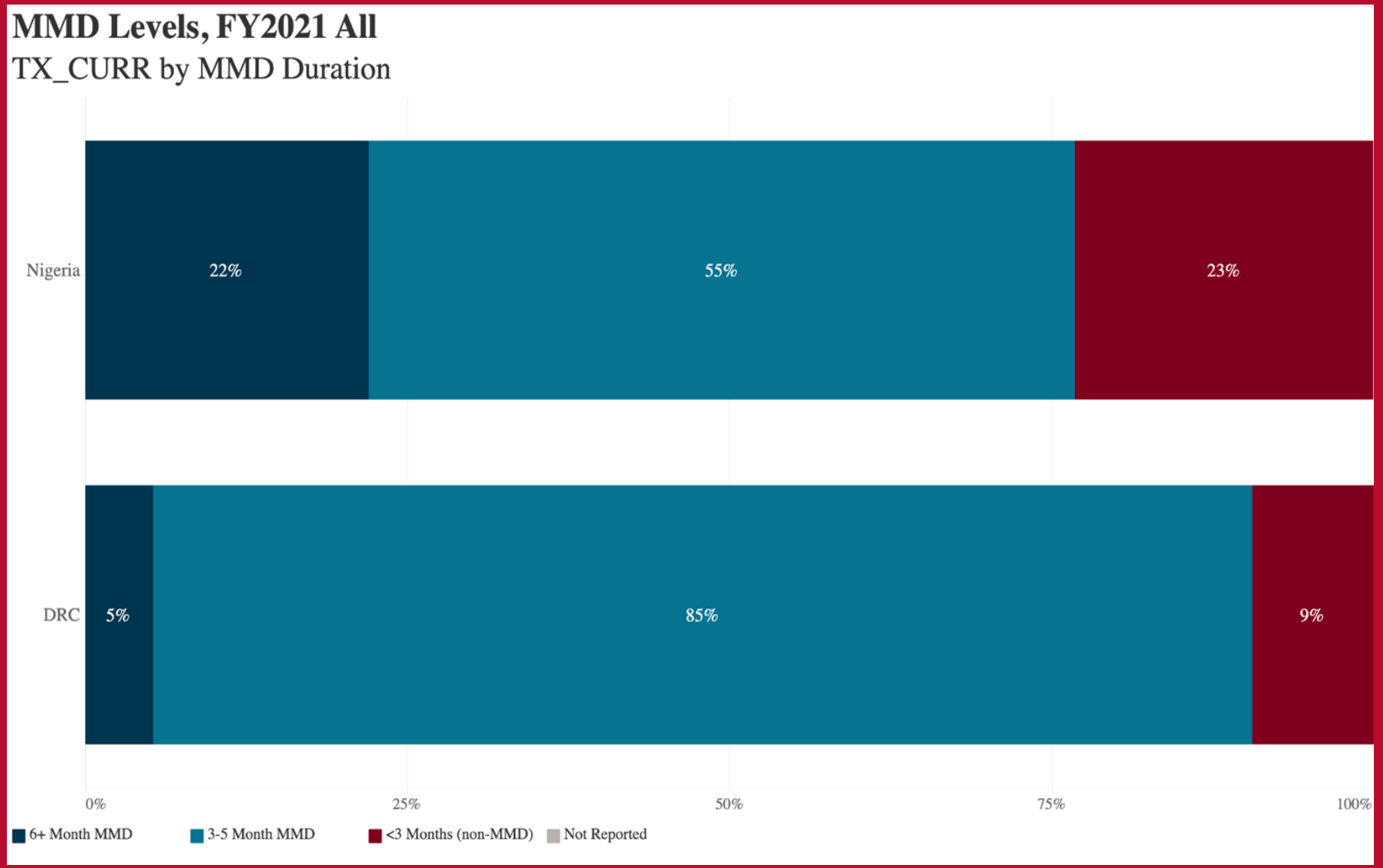
FY21 country level pediatric MMD analysis



Goal for FY21 is for each OU to reach 65% pediatric MMD coverage

- 8 countries have already achieved this
- We have low coverage in several large countries driving down aggregate coverage: Uganda, Kenya, Mozambique and Tanzania
- Need to continue to monitor pediatric 6MMD policy and uptake

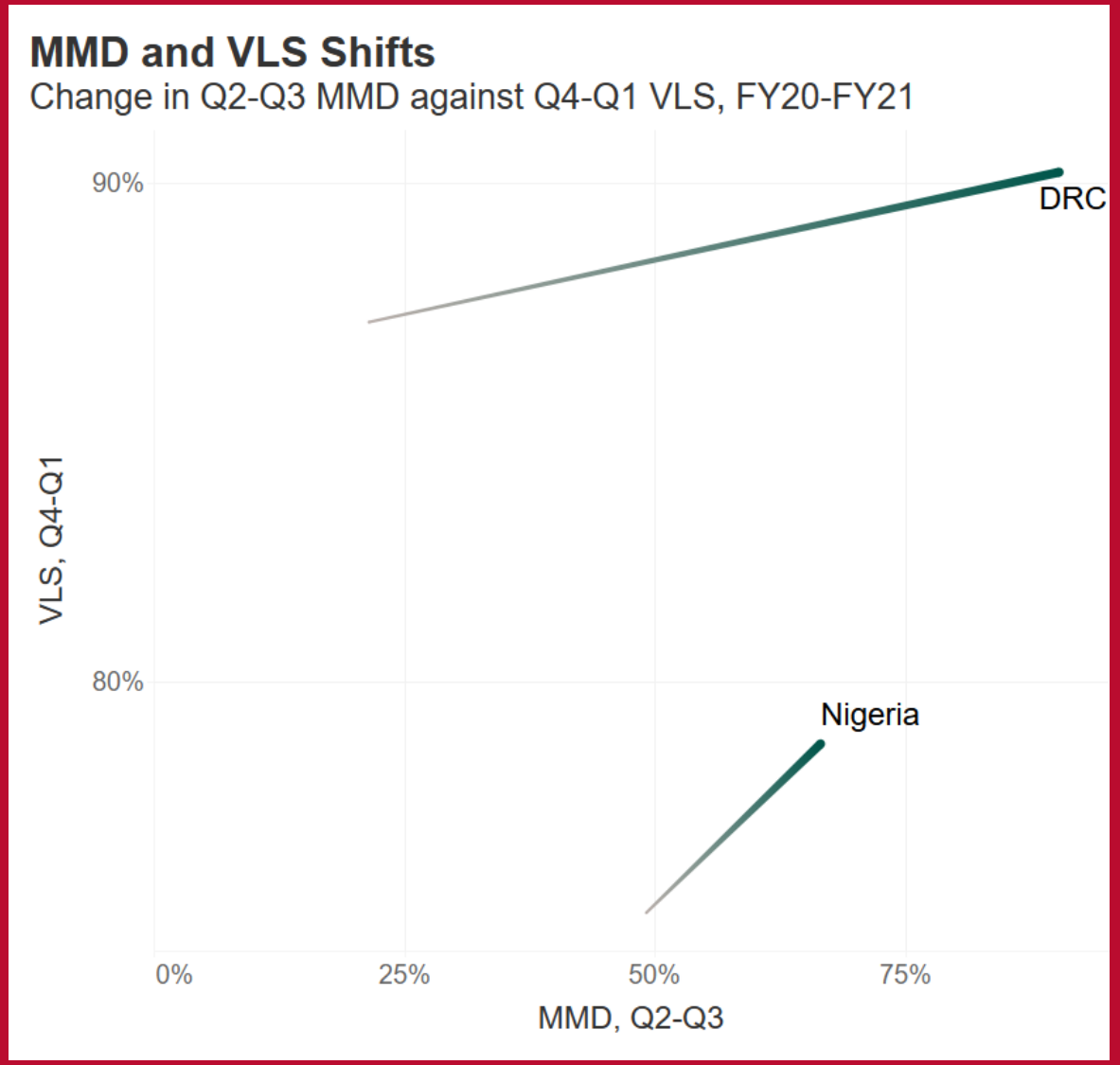
Nigeria & DRC



Nigeria has 77% coverage for their pediatric population on at least 3 MMD

DRC has 90% of coverage for their pediatric population on at least 3 MMD

MMD & VLS SHIFTS Nigeria & DRC



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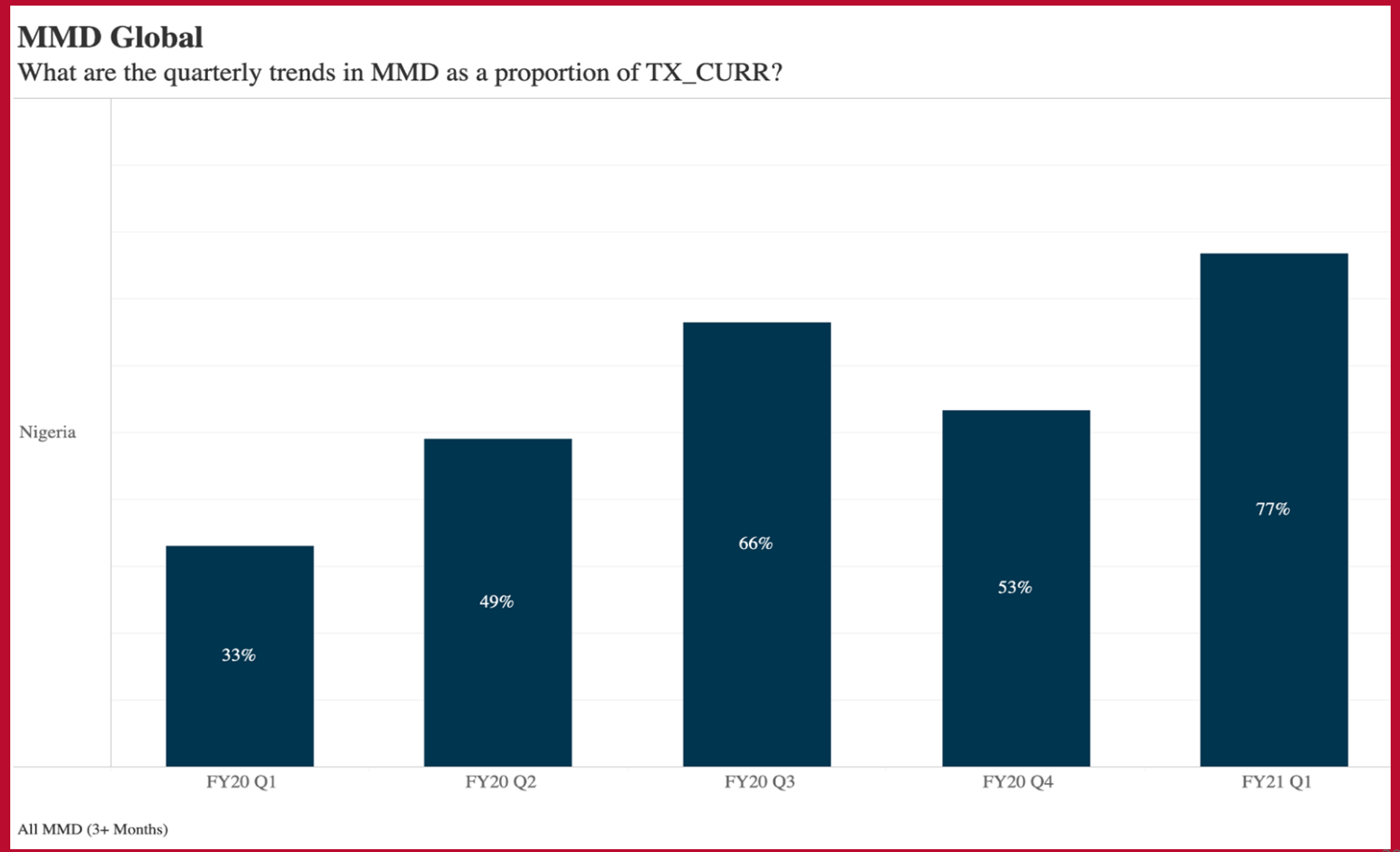
Country Example: Nigeria

- Change and support in policy and guidelines
- Incorporation of MMD into Tx Surge plan
- Monitored drug availability to avoid stockouts
- Paired mothers/children for drug refills
- Procuring TLD 90- and 180-count bottles to scale-up MMD for ART. Reduced barriers to treatment for patients

Nigeria increased pediatric 3+MMD coverage from 33% in FY20 Q1 to 77% in FY21 Q1

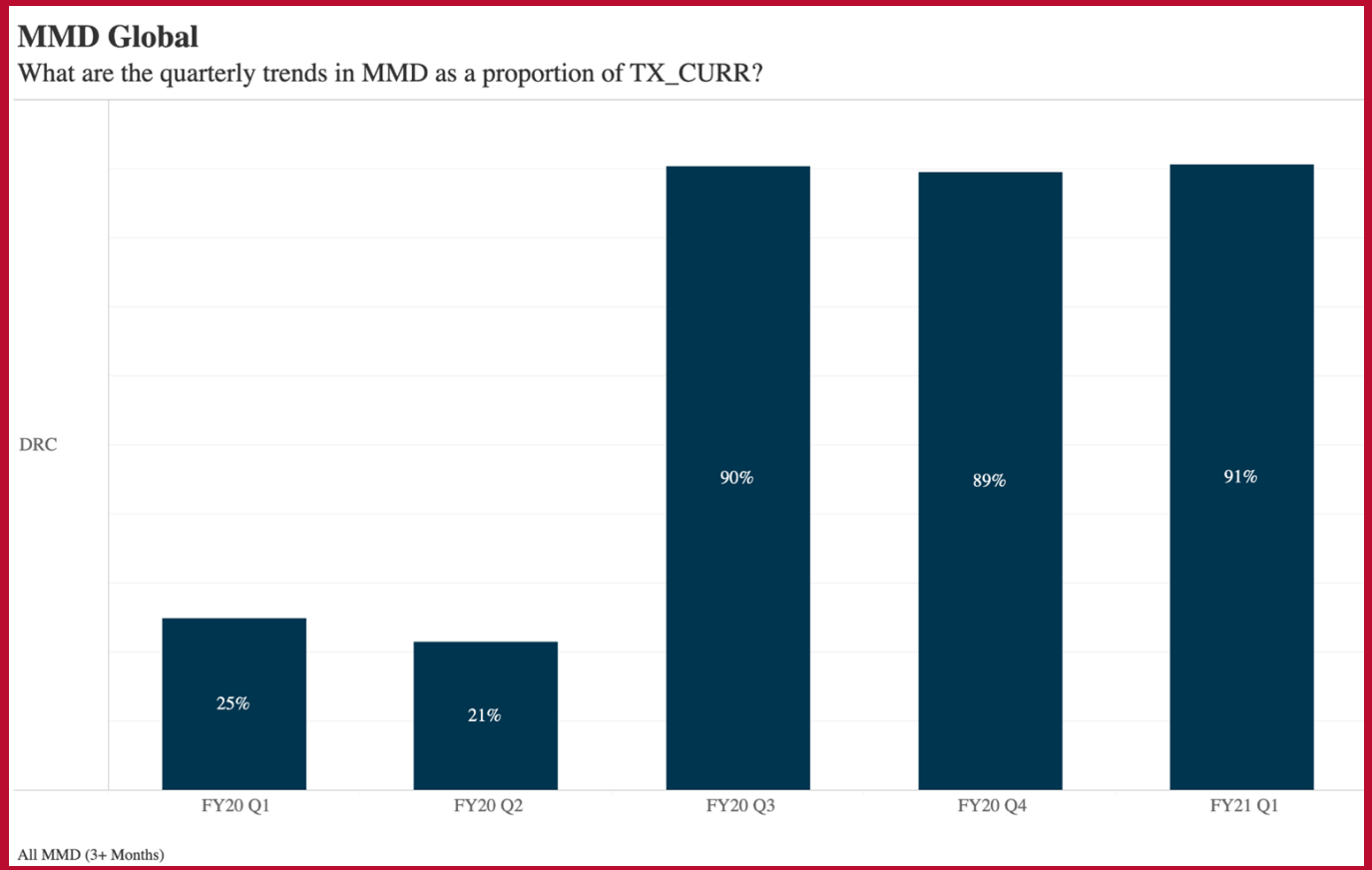


Country Example: DRC

Push to include children in differentiated service delivery during COVID response

- PNLS, in collaboration with USAID, issued directive to extend MMD to peds
- Sensitized facility staff
- Prioritized sites with high volume of children
- Used clinical records, registers and tier.net to identify eligible patients
- Monitored drug availability to avoid stockouts
- Paired mothers/children for drug refills
- Used CHWs and psychologists to improve treatment literacy

DRC increased pediatric 3+MMD coverage from 25% in FY20 Q1 to 91% in FY21 Q1



Pediatric & Adolescent DDD Overview

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Examples of Adult DDD Models:

Private Clinics & Hospitals

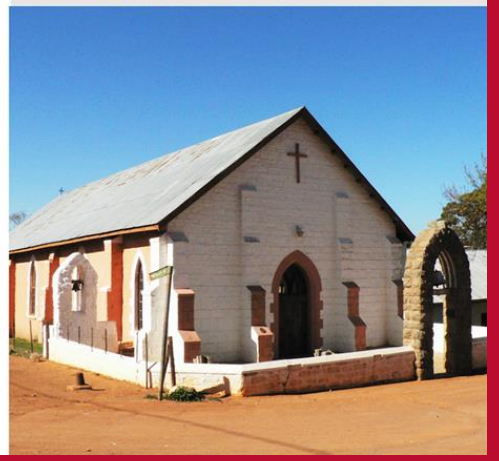
Private Pharmacies

Pop-up Pharmacies

Automated Lockers

Home Delivery

Community-based



Examples of Decentralized Distribution of ART (Adult)	
Home Delivery program	Nigeria, Kenya & Nepal
Delivery from private pharmacies to patients homes	Uganda & Kenya
Provision at KP-led community-based drop in centers	Malawi, Kenya, DRC, & Haiti, Nigeria
Apps and online appointments	Kenya & Nigeria
Use of the online reservation app	Multiple countries

DDD Implementation progress in COP19 and 20

- At least **19 countries** in Africa and Latin America and the Caribbean are implementing DDD in COP20 (up from 7 in COP18)
- 17 are distributing ARVs through **private pharmacies and clinics**
- Majority through **community groups** (CAGs, PODIs, CDPs)
- 6+ countries with **home delivery** programs
- 4+ countries using **e-lockers**
- 3 countries with **centralized dispensing**

Integrating MMD & DDD to Increase Coverage

- What additional benefits does DDD give to MMD?
  - Where 6MMD isn't feasible, DDD is a necessary adaptation
  - Patient choice: Some patients may refuse 6 MMD, easier pickup and more discretion
  - Decreasing burden on public sector for 3 month refill visits
  - Increasing convenience and decreasing costs for patients
  - Facilitates social distancing
  - Potential for other chronic medicine pickup integration
- Countries that have successfully integrated MMD and DDD
  - Haiti: leveraging community-based drug distribution using peer navigators to increase 6MMD
  - Lesotho: incorporating 3MMD into Community ART Groups (CAGs)

Different Approaches to Implement MMD or DDD

Utilizing Family-Centered Models and MMD Care Coordinators

- To optimize DDD & MMD, we want to take a family-centered approach that aligns MMD schedules/ART pickups across household members
- Discuss adoption of MMD care coordinators who facilitate family-members clinical schedules and MMD/ART pick up schedules. These individuals can also provide or assign adherence counseling for clients newly enrolled on MMD.
- Evaluate where and how family-centered approaches to MMD are being implemented?
- How is this being planned, scaled and evaluated?
- What tools and resources can be used to support implementation and scale-up of family-centered MMD?
- Identify where family-centered MMD is being implemented and document best practices to be shared across program

Key Takeaways & Action Items

- DSDM, DDD, MMD are needed to sustain ART treatment and adherence for children globally.
- Integrating **MMD & DDD does not mean they are mutually exclusive**. You can have MMD coverage without DDD and vice versa. But there are **benefits of integrating MMD & DDD to optimize client-centered continuity of treatment and VLS.**
- Need to continue to **push for policy changes** to permit DDD & 3MMD for children > 2 and 6MMD for children 5 and older
- Support countries to ensure they are following a family-centered approach to DDD & MMD and share best practices of their approach

Other Considerations….

- How often should ART assessment be made as kids transition from preteens to adolescents?
- How will ARV dispensing preference change in terms of DDD or MMD models for children that transition to adolescents?
- Which community distribution model will work best for children, family or adolescents?
- How does HIV status disclosure (known or unknown HIV status) play into which MMD/DDD models would be preferred?
- How does gender or different cultures play a role for MMD and DDD model preference?
- How to track which models are being utilized?

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Decentralized Drug Distribution for Children and Adolescents Living with HIV: The SIDHAS Project Experience

Majeed Adisa, FHI 360

May 20, 2021

Strengthening Integrated Delivery of HIV/AIDS Services

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fhi360 THE SCIENCE OF IMPROVING LIVES

NIGERIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

Funded by the President's Emergency Plan for AIDS Relief through U.S. Agency for International Development

SIDHAS Project Overview

- The USAID funded Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) project is a10-year project (2011 – 2021) initially implemented across 13 states in Nigeria and now being implemented in two states including Akwa Ibom.
- The SIDHAS project supports comprehensive HIV and TB/HIV integrated programs with focus on HTS, PMTCT, TB/HIV, ART for pregnant women and general population, as well as FP, PrEP and cervical cancer screening services for target populations.

- **Goal:** To sustain cross sectional integration of HIV/AIDS and TB services by building Nigerian capacity to deliver sustainable high quality, comprehensive, prevention, treatment, care and related services.

Akwa Ibom

- 102 Supported Facilities
- 125,485 Total PLHIV

Cross River

- 53 Supported Facilities
- 29,652 Total PLHIV

KR 1 - Increased access to high-quality comprehensive HIV/AIDS and TB prevention, treatment, care and related services through improved efficiencies in service delivery

KR 2 - Improved cross sectional integration of high-quality HIV/AIDS and TB services

KR 3 - Improved stewardship by Nigerian institutions for the provision of high-quality comprehensive HIV/AIDS and TB services

2nd and 3rd 95 Strategies

CALHIV – Specific Strategies

- Line listing of CALHIV for pre-appointment tracking
- Pre-emptive tracking of CALHIV to reduce default rate and improve retention and treatment outcome.
- Routine weight and drug regimen monitoring for review during clinic visits to ensure regimen optimization and maximal dosage and efficacy
- Nutritional status assessment and rehabilitation
- Psycho-social support for CALHIV and their guardian/parents
- Leveraging on Starter Pack Initiative to refill CALHIV across unsupported sites
- Focused pediatric case management
- Operation Triple Zero (Asset-based Program)
- Hub and spoke virtual mentorship program (via use of clinical mentors)
- Use of adolescent-specific case managers/champions
- **Implementation of DSD and DDD models**

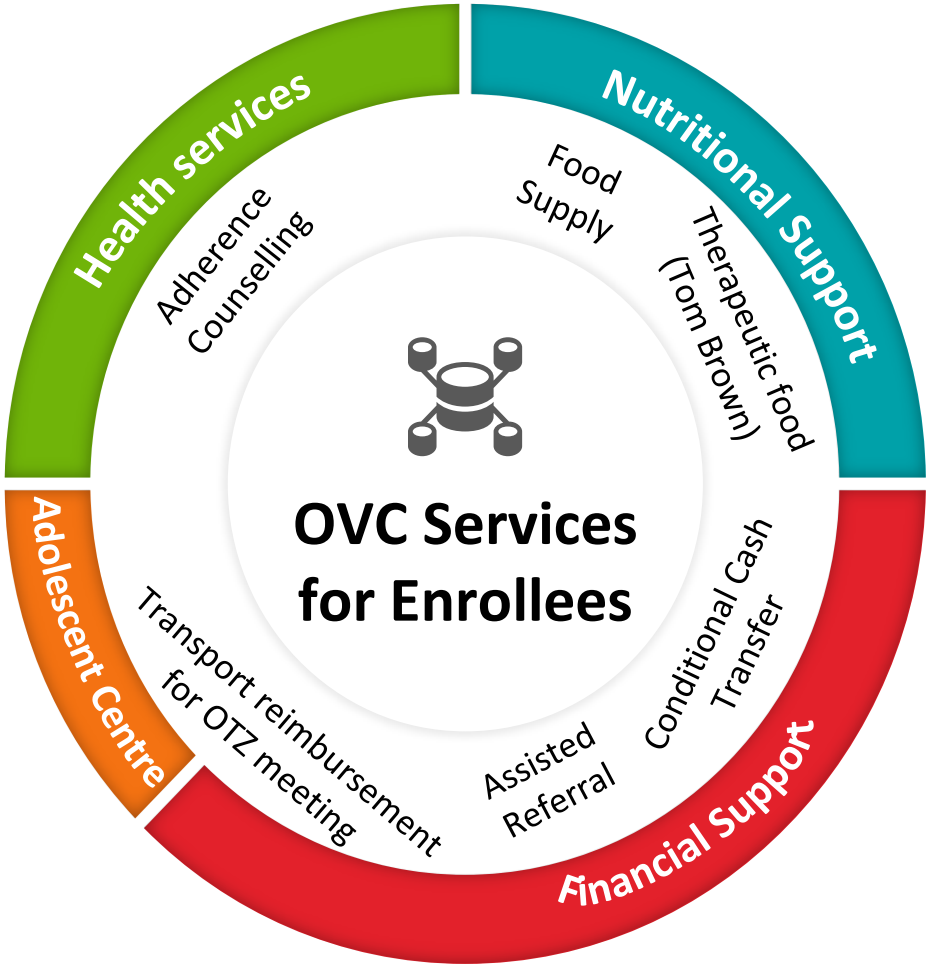
Standardized Package of Services offered as part of DDD for CALHIV

- Vital signs; weight, height / BMI
- Prepacked ARV medications
- Prepacked TB Preventive Therapy
- Disclosure Counselling
- Nutritional assessment
- ART / TPT/TB adherence counseling
- COVID19 screening and information leaflets
- Condoms to sexually active CALHIV
- Viral Load sample collection

OVC Collaborative Effort (CCCRN)

Emergency medical services provided to CALHIV

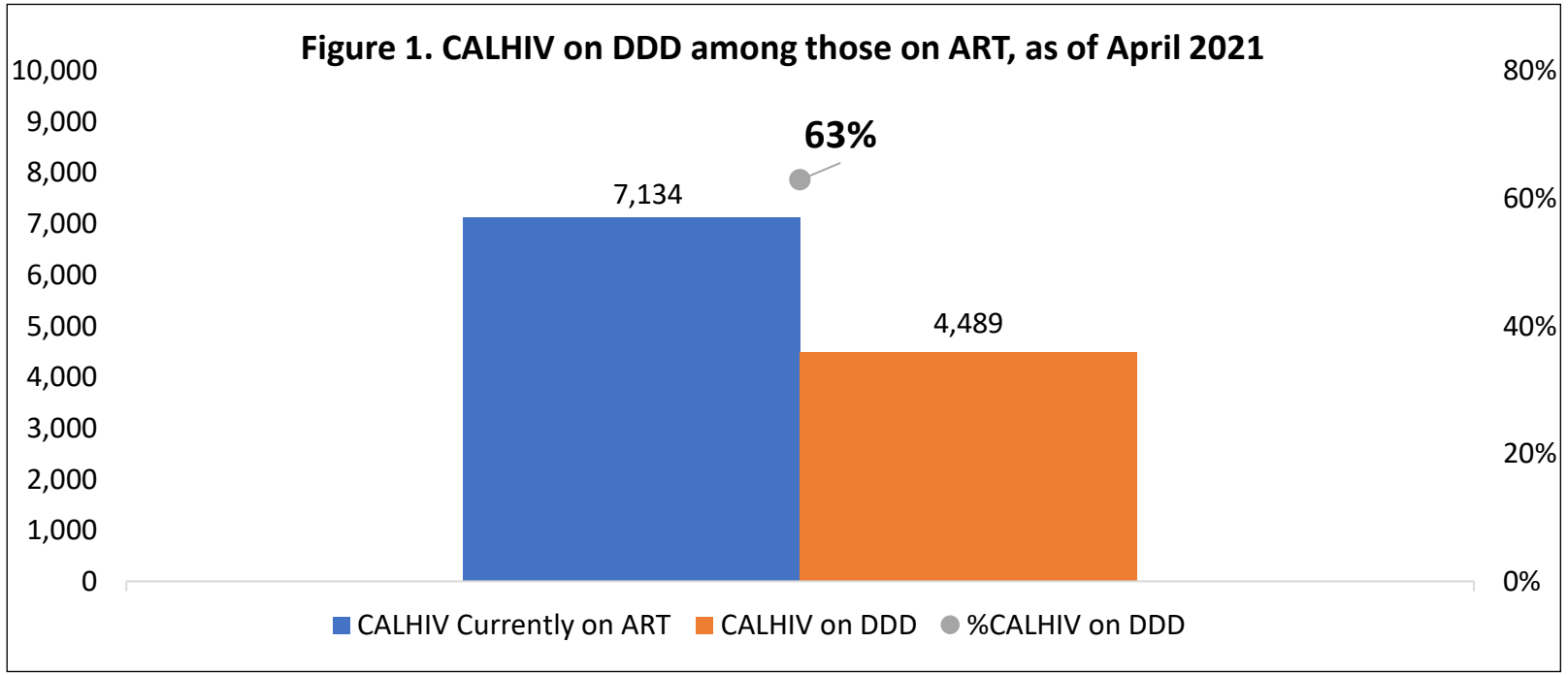
Nutritional support provided to malnourished CALHIV

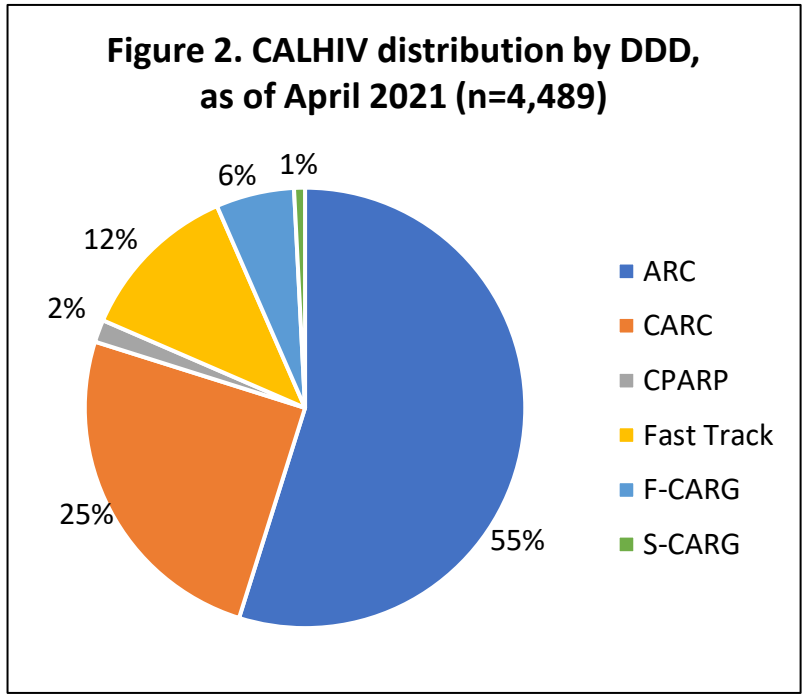


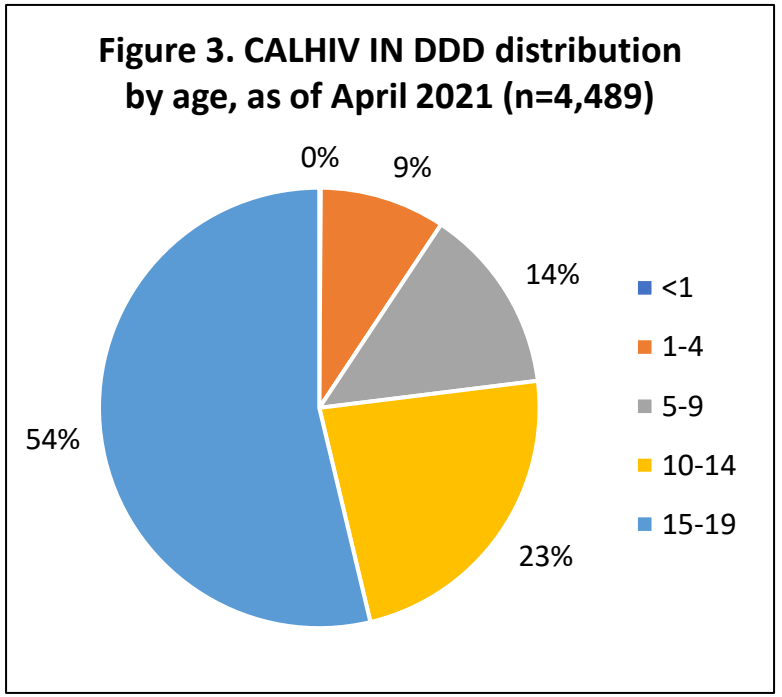
DDD Models for CALHIV

Type of DDD	Target Age group	Eligibility Criteria	Where DDD is offered	Who offers DDD
Fast Track Clinic (FTC)	Stable Adults and CALHIV	Stable clients (Virally suppressed), >95 % adherence, no OIs	Facility	Health Care Workers
Community ART Refills Clubs (CARC)	Adults and CALHIV	Stable clients (virally suppressed), >95 % adherence, no OIs	Community	Community Pharmacist (Health Care Worker)
Adolescent Refill Club (ARC)	Adolescents and Young Adults (10 – 24 Years)	Adolescents (10-19 yrs)	Community	Health Care Workers
Family-Centered ART Refill Group (F-CARG)	Family Members (Adults and CALHIV)	Partners in family context regardless of clients' clinical/virological status	Community	Members (PLHIV)
Self-forming ART Refill Group (S-CARG)	Adults	Clients with mutual agreement	Community	Members (PLHIV)
Community Pharmacy ART Refill Program (CPARP)	Adults and CALHIV (But alongside their parents)	Stable clients (Virally suppressed), >95 % adherence, no OIs	Community	Community Pharmacists (Health Care Worker)

Devolvement of CALHIV into DDD models

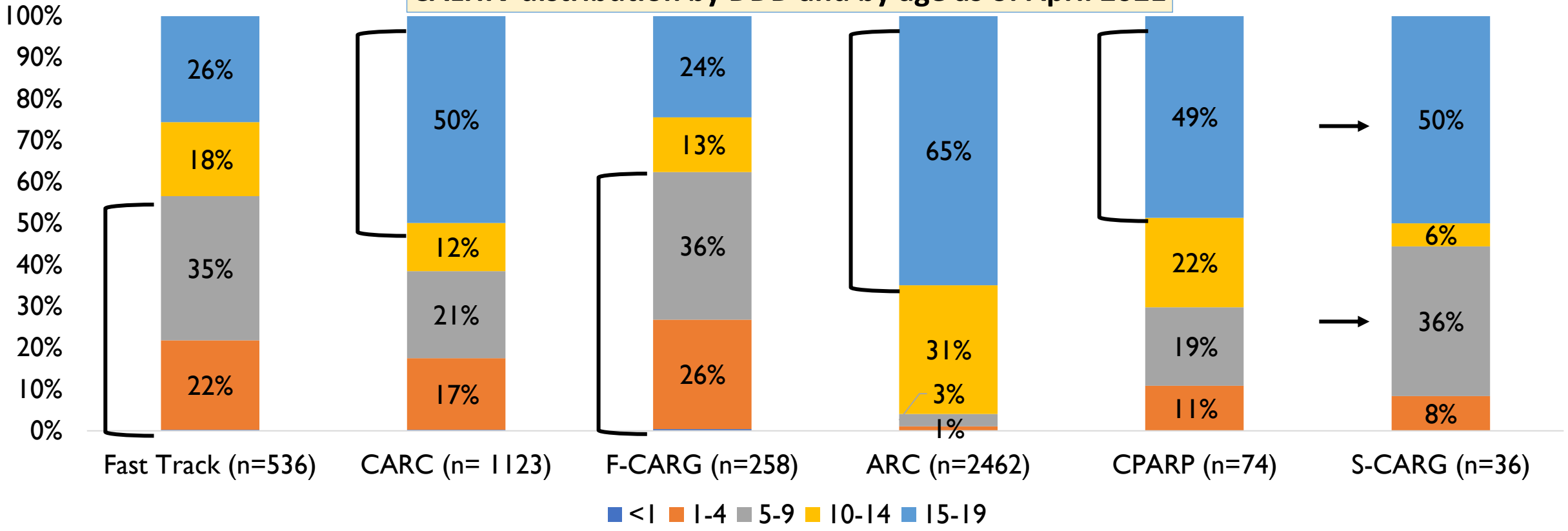






- As of April 2021, 63% of the CALHIV were devolved to a DDD model (Figure 1)
- 80% of the CALHIV devolved to a DDD model were enrolled into CARC and ARC models (Figure 2)
- 77% of the CALHIV devolved to DDD were from ages 10-19 years (Figure 3)

CALHIV distribution by DDD and by age as of April 2021



Over 50% of the CALHIV in Fast Track and F-CARG models, were ages 1 to 9 years

While ages 15 to 19 years accounted for 50% and 65% of the CALHIV in CARC-CPARP and ARC models, respectively

The S-CARG model had 86% of the CALHIV from ages 5 to 9 years and ages 15 to 19 years

CALHIV and DDD impact on Optimized regimen, MMD, Viral load

- Among the CALHIV on DDD, **99%** were on Optimized regimen

Optimized regimen	0-3 yrs	4-5 yrs	6-9 yrs			10-19 yrs	
	<14kg	14-20Kg	<20Kg	20-29kg	>29kg	<=30Kg	>30Kg
ABC/3TC/LPV/r	√	√	√				
TDF/3TC/DTG					√	√	√
ABC/3TC/DTG				√		√	

- **91.4%** were on MMD (≥ 3 months)
- **90%** Viral load coverage
- **94%** Viral load suppression

Lessons learnt

- DDD increased access to ART
- Steady but gradual improvement in refill rates
- Opportunity for services integration (Nutrition, Psychosocial, client education, VL)
- Improved parental/caregiver support

Challenges

- Disclosure concerns among some caregivers
- Pill burden/treatment fatigue for some caregivers and CLHIV despite DDD
- Issues surrounding caregiver's full participation

Recommendations

- Implementation of age-appropriate disclosure packages for CLHIV 5-9yrs in pre-OTZ club
- Strengthening caregivers' forum for enlightenment on DDD and home-ART support
- Use of genealogy champions approach to scale up DDD for acceptance among CALHIV age group and their caregivers
- Use OTZ platform to provide mental health support for caregivers and their wards

Thank You

Strengthening Integrated Delivery of HIV/AIDS Services

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Improving Multimonth Dispensing for Children and Adolescents Living with HIV

Decentralized Drug Distribution (DDD) Learning Collaborative

Caterina Casalini
Senior Technical Advisor, FHI 360 Netherlands

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EpiC
Meeting Targets and Maintaining Epidemic Control

Objectives

- Improve the enrollment of children and adolescents living with HIV (C/ALHIV) eligible for multimonth dispensing (MMD) in selected sites in Nigeria and Burundi to improve adherence to treatment, retention in care, and sustained viral suppression.
- Build on case management approach to foster collaboration between HIV treatment programs and platforms for orphans and vulnerable children (OVC), aligning with the pivot toward including C/ALHIV in PEPFAR-supported OVC programs.
- Support optimization of pediatric ARV regimens and dosing to ensure that CLHIV receiving MMD are on optimized ART regimens.

Deliverables

1. Quantitative and qualitative assessment on MMD among C/ALHIV (ACHIEVE, RISE, EpiC)
2. Policy brief to help advocate with ministries of health (MOHs) and facility management/providers (ACHIEVE)
3. Technical guide for health providers and people who work with OVC to support scale-up of MMD among C/ALHIV (RISE, ACHIEVE)
4. Key messages on treatment literacy and self-efficacy for C/ALHIV and caregivers (EpiC)

Qualitative Assessment

Major challenge related to enrollment of C/ALHIV on MMD	Burundi (n=4)	Nigeria (n=10)
	EpiC	EpiC
By provider		
Stockout or shortage of ARVs for 3 and/or 6 months MMD	8	6
Frequent dose adjustment needed	6	12
Uncomfortable prescribing MMD for C/ALHIV	15	27
Lack of training to prescribe MMD/mentoring or supervision on MMD	10	21
Unavailability of viral load (VL) test results	15	16
Unable to identify C/ALHIV eligible for MMD	6	11
Lack of time to identify eligible CC/ALHIV	9	32
Challenges related to beneficiaries (from providers' perspective)		
C/ALHIV/caregiver unable to adhere/manage ARVs as prescribed	12	31
Child is ill and needs to be followed more frequently	8	35
Non-disclosing C/ALHIV/caregiver fail to store a large supply of ARVs	11	2
C/ALHIV/caregiver want to see provider more frequently	11	12
Worried C/ALHIV/caregiver will sell ARVs	17	12
Lack of storage (space) for ARVs at home	15	11
Challenges related to health system (from providers' perspective)		
Limited stock of ARVs for C/ALHIV in the health system	10	31
Lack of clear national MMD policies, SOPs for C/ALHIV	8	12
Policies requiring viral loads (VLs) as MMD eligibility	8	17

- Focus group discussions with clinicians, nurses, counselors, case managers, and pharmacists (21 Burundi; 36 Nigeria)
- From the qualitative assessment and a landscape analysis, we learned that there weren't MMD literacy materials available

Burundi	Nigeria	Challenge
5-8	0-11	Low
9-12	12-22	Medium
13-17	23-35	High

Development of Literacy Materials

- Reviewed existing MMD literature
- Extracted information from qualitative assessments

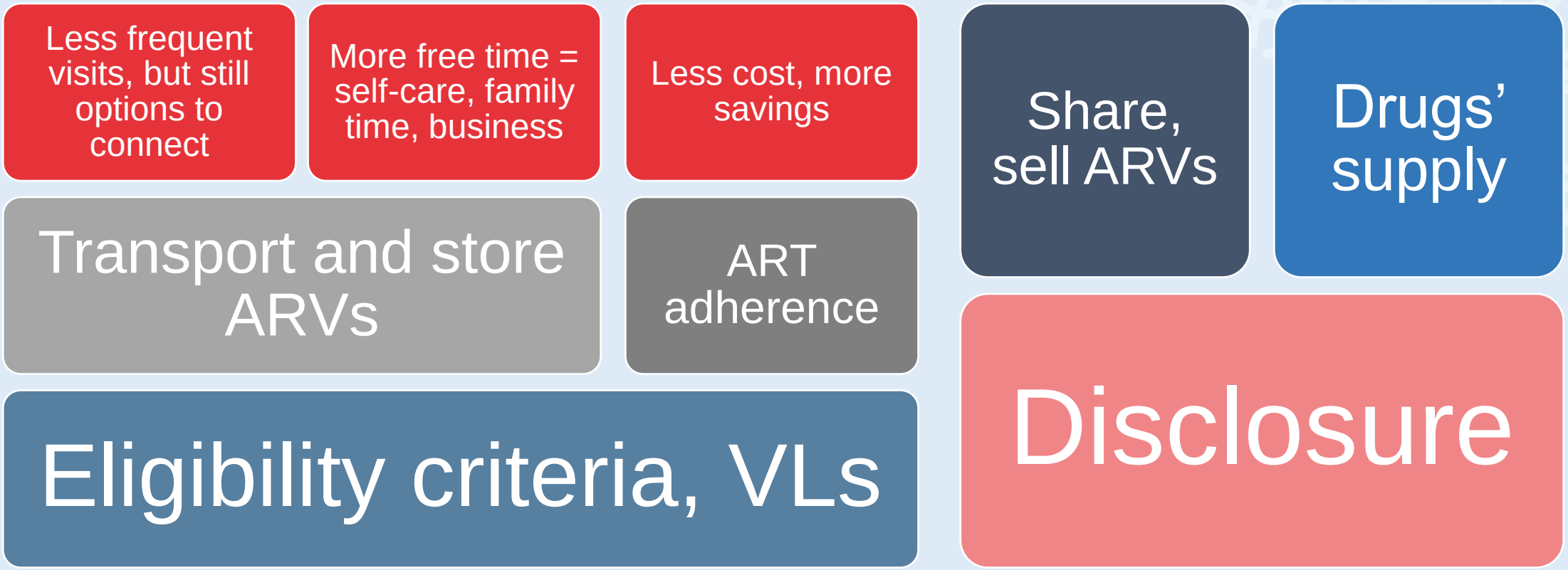
- Developed messaging framework
- Drafted job aid, client brochures; translated in English, French, and Kirundi

- Solicited feedback from EpiC, RISE, and ACHIEVE staff in Burundi, Nigeria, and headquarters
- Updated materials based on feedback

- Developed pre-test protocol and instrument
- Supported EpiC and ACHIEVE staff in Burundi and Nigeria to pre-test materials with health care providers, people who work with OVC, workers, of CALHIV and ALHIV

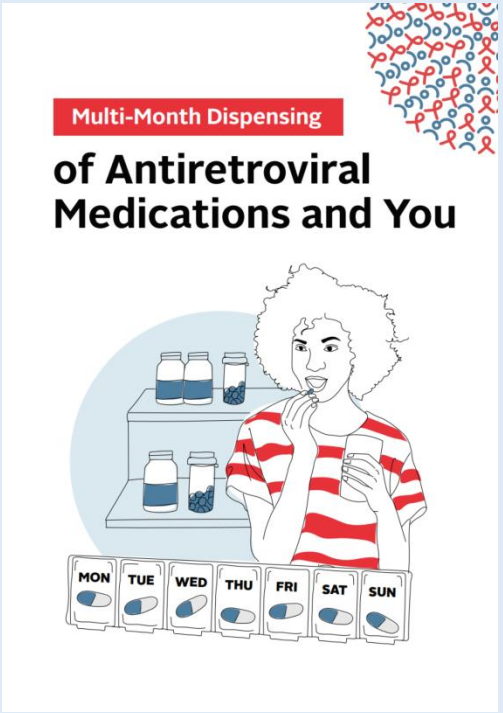
- Solicited USAID feedback
- Updated materials based on pre-test results and USAID feedback

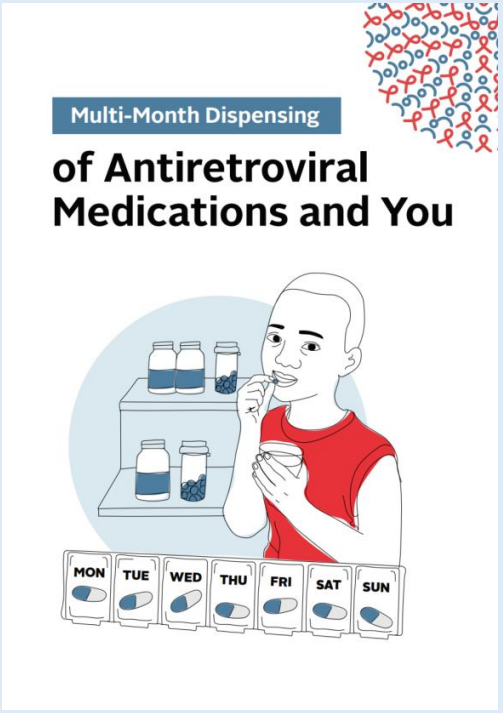
Themes Guiding Development of Content for Literacy Materials



Job aid

Client brochures





Literacy Material is available in **English and French**

https://www.fhi360.org/resource/multi-month-dispensing-antiretroviral-medications-adolescents-and-children-living-hiv

Technical Assistance

- Monthly site-level data reports on MMD and VL by age group
- Teams' discussion; including issues related to optimized regimen and Supply Chain Management (SCM)
- Sites' prioritization for targeted technical assistance

	MMD <18				
site	Jun	Jul	Aug	Sep	Oct
1	30%	35%	40%	50%	55%

Example #1: Sites with particularly low MMD coverage were prioritized through more frequent visits/meetings and technical assistance to identify and address bottlenecks; track C/ALHIV missing the VL test; line list C/ALHIV eligible for MMD

	MMD <18				
site	Jun	Jul	Aug	Sep	Oct
2	50%	55%	50%	70%	79%

Example #2: As soon as sites graduated into the next level, they were supported to prioritize the age groups in which they were still scoring below the PEPFAR benchmark

	MMD <18				
site	Jun	Jul	Aug	Sep	Oct
3	60%	70%	79%	85%	90%

Example #3: And as soon sites met the PEPFAR benchmark, the technical assistance was reduced, though not entirely in order to still support the site sustaining the effort over time

EpiC Project - MMD Monthly Trend, Nigeria SIDHAS Project (36 sites)

Figure 1. Sites reporting MMD among TX CURR CALHIV >80%, June 2020 versus March 2021, SIDHAS Project, Nigeria

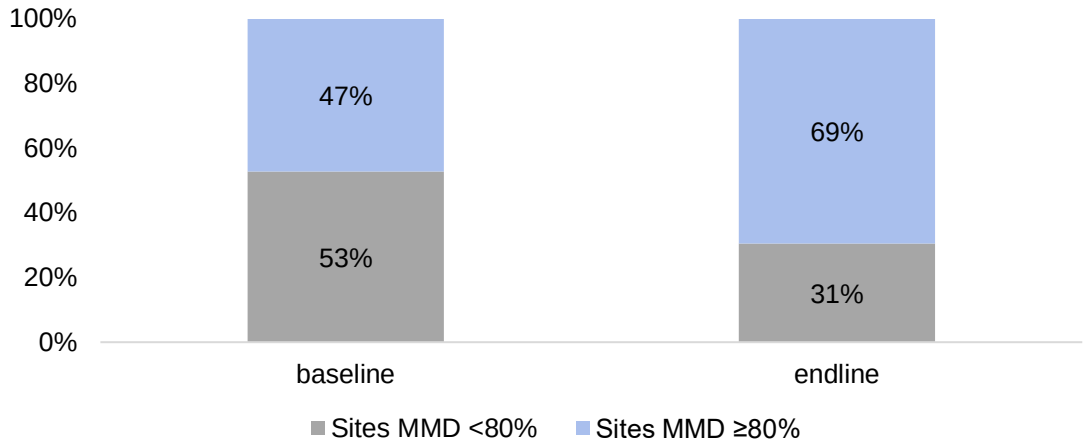
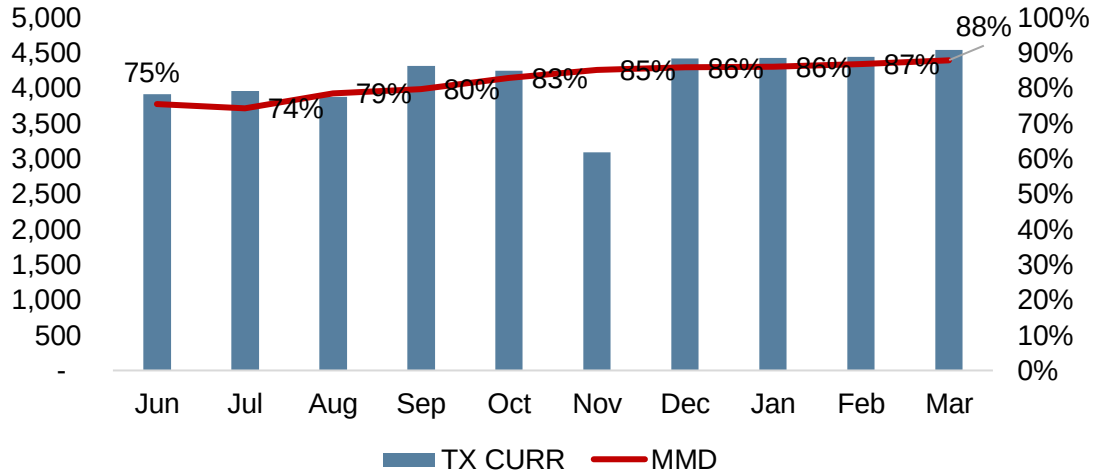
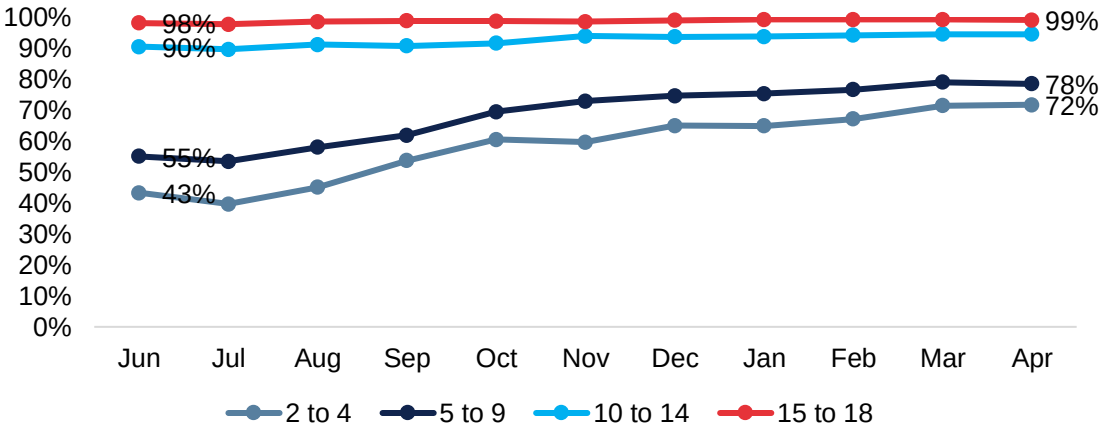


Figure 2. MMD among TX CURR CALHIV ages <19, by month FY20-21, SIDHAS Project, Nigeria

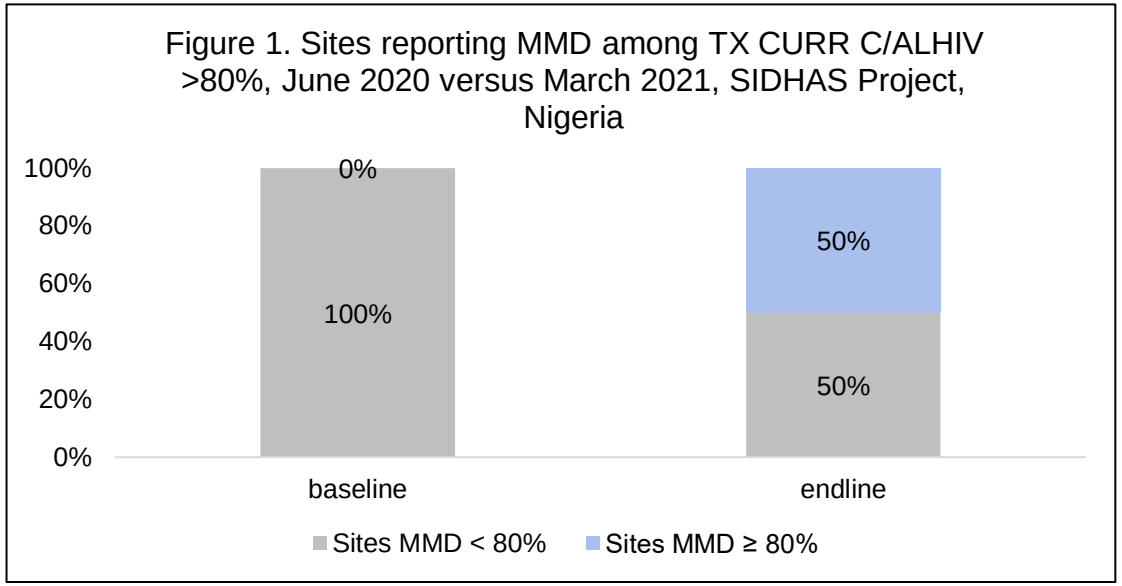


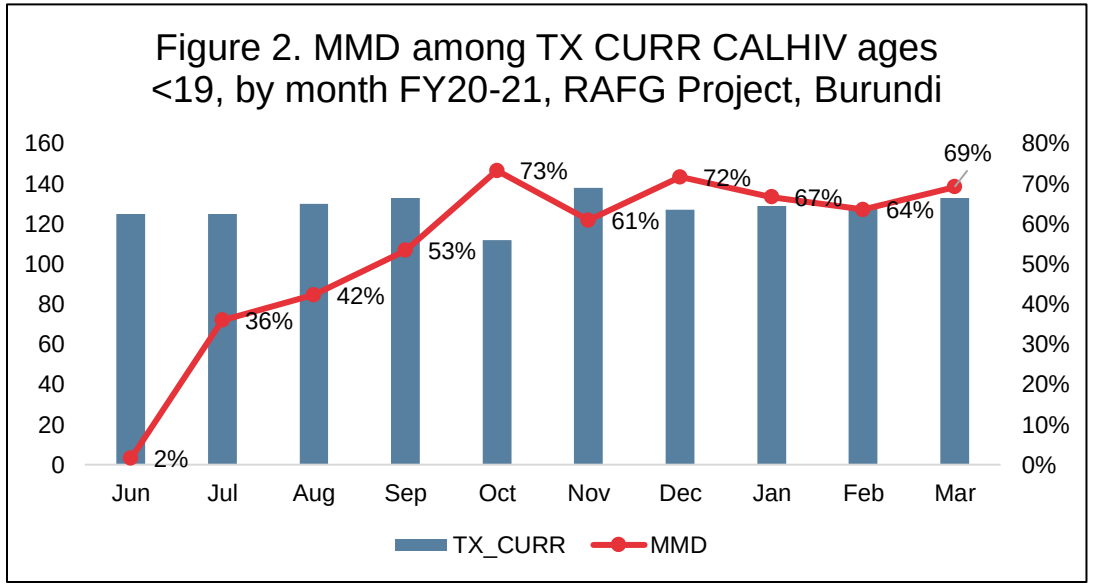
- An increase in the number of sites reporting MMD >80% was observed (Figure 1)
- Overall, the PEPFAR benchmark was achieved (Figure 2)
- C/ALHIV ages 10+ who already reported higher MMD coverage compared to ages <10 were able to sustain such effort
- A 23% increase in ages 5-9 years and a 29% increase in ages 2-4 years were reported when comparing baseline to endline; age 5-9 years is approaching the benchmark (Figure 3)

Figure 3. MMD among TX CURR CALHIV ages <19, by month FY20-21, SIDHAS Project, Nigeria

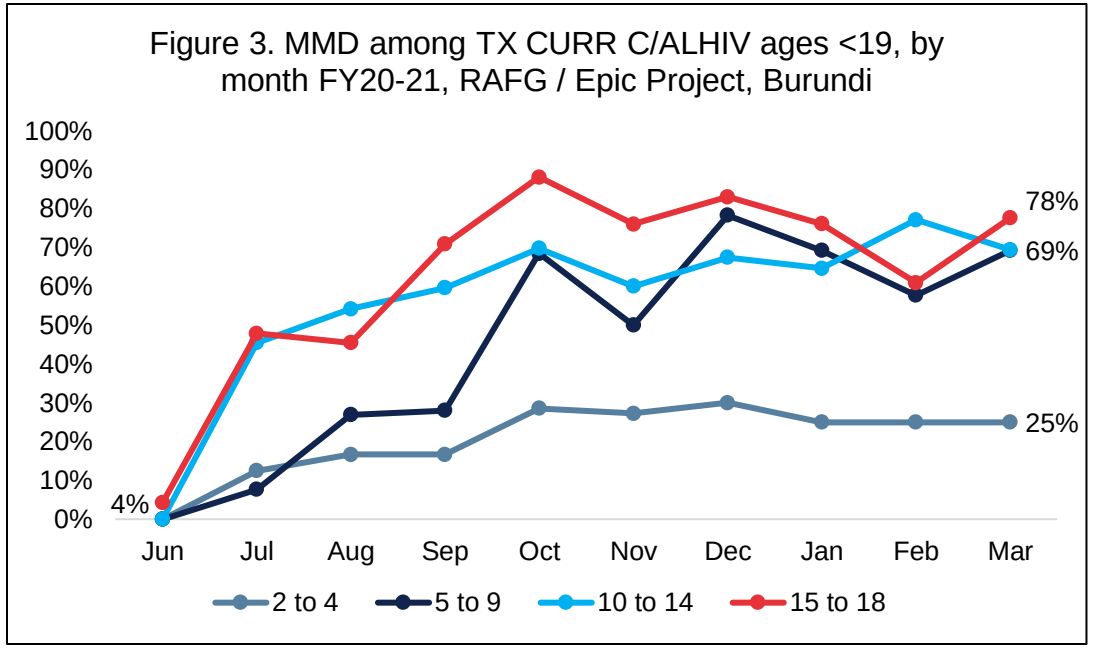


EpiC Project - MMD Monthly Trend, Burundi RAFG Project (6 sites)





- In Burundi, policy (May 2020 and only ages 10+) and SCM negatively affected the ability to reach the MMD PEPFAR benchmark
- However, the MMD benchmark was reached at 50% of the sites (Figure 1) and scale-up across all age groups has been impressive (Figure 2)
- Improvement in MMD was observed also when disaggregated by age, but remained very low at endline for ages 2-4 years; it is approaching the benchmark for ages15-18 years (Figure 3)



What drove the MMD success?

Intervention	Nigeria	Burundi
Weekly and monthly data analysis and review	√	√
Sites visit to assess the progress on the following viral load (VL) and MMD indicators	√	√
Mentoring to the health care providers in person and remotely (via phone, WhatsApp and other virtual platforms)	√	√
Regular line listing of CALHIV eligible to receive VL testing and MMD at each site	√	√
Roll out of the Pediatric Regimen Calculator	√	
Provision of Optimized Pediatric Regimen	√	√
Provision of Community ART Distribution	√	√
Provision of Pediatric and Caregivers Groups	√	√
Partnership with OVC programs		√

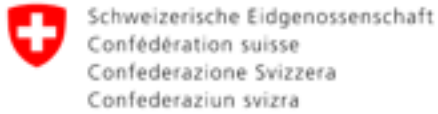
Lessons Learned

- The qualitative assessment provided complementary information to the routinely collected data and guided content development of the literacy material
- The content of the literacy material was designed to respond to needs of clients and providers, and to address misunderstandings and concerns from the qualitative data and the literature
- The use of quantitative data informed targeted TA to the providers on how to fast-track MMD
- The rapid scale-up of MMD through intensified TA is feasible, though policies and SCM are key to its success

‘The pills alone are not enough’

N Willis, 20 May 2021

ZVANDIRI: ONE MODEL, MULTIPLE PARTNERS



ZVANDIRI - PEER-LED, DIFFERENTIATED SERVICES FOR CHILDREN, ADOLESCENTS AND YOUNG PEOPLE

2400

Community Adolescent Treatment Supporters (CATS)

and **Young Mentor Mothers** (YMMs)

supporting

64,000 children, adolescents and young people living with HIV

IMPROVED

HTS

ART ADHERENCE

VIRAL SUPPRESSION

RETENTION

MENTAL HEALTH

SRHR

PROTECTION

PREVENTION

WHAT DO YOUNG PEOPLE SAY?

Youth Perceptions and Experiences with MMD and Scripting in Zimbabwe, 2019

- 25 FGDs with 282 youth, 18-24 years of age

Advantages

- Fewer clinic visits; saving time and money
- Fewer disruptions to life
- Fewer opportunities for inadvertent disclosure
- Incentivises adherence and viral suppression

Disadvantages

- Fear of poor adherence through reduced support
- Storage challenges
- Less frequent interactions with peers

Young People want…

Intensified, friendly, and confidential support from CATS, peer counsellors (PCs), and nurses

- Home visits
- Phone Reminders
- Monthly support groups
- Family support
- Support from community members

USAID FROM THE AMERICAN PEOPLE PEPFAR U.S. President's Emergency Plan for AIDS Relief YOUTH POWER LEARNING

WHAT DO YOUNG PEOPLE SAY?

WHO Global Consultation, 2020

- 388 adolescents and young people
- 45 countries

Young people told us that Psychosocial Support:

- Is transformative across all HIV outcomes
- Should be multi component, differentiated
- Must be sustained over time
- Should be delivered by peers, supportive health care workers and trusted adults

https://www.youtube.com/watch?v=kys44Xx2tyA&t=12s

ZVANDIRI – SUSTAINED ENGAGEMENT AND SUPPORT

CLINIC	ART REFILL	COMMUNITY

HIV, ART, VL Literacy
CAYPLHIV and Caregiver

Counselling
Disclosure, ART and adherence, TLD, VL, EAC, mental health, TPT, SRHR

Identification of 'red flags' and referral
Clinical, mental health, protection
|
Mobilisation
ART Refill, VL, TPT, TLD

Defaulter Tracing

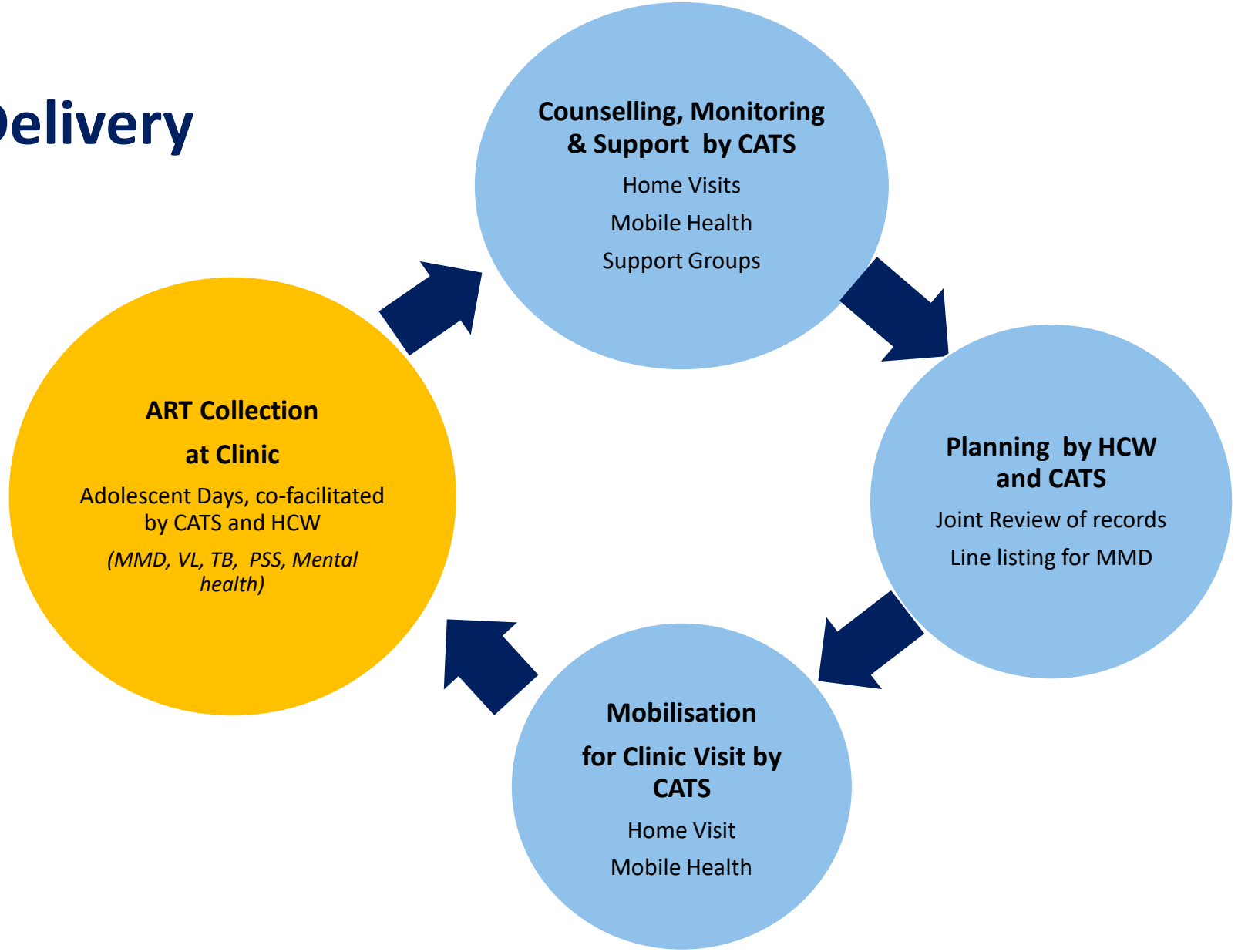
HTS *(index and HIVST)*

FACILITY-BASED ART Delivery

WHO?

Most children and adolescents (national guidelines)

Monthly refills
MMD

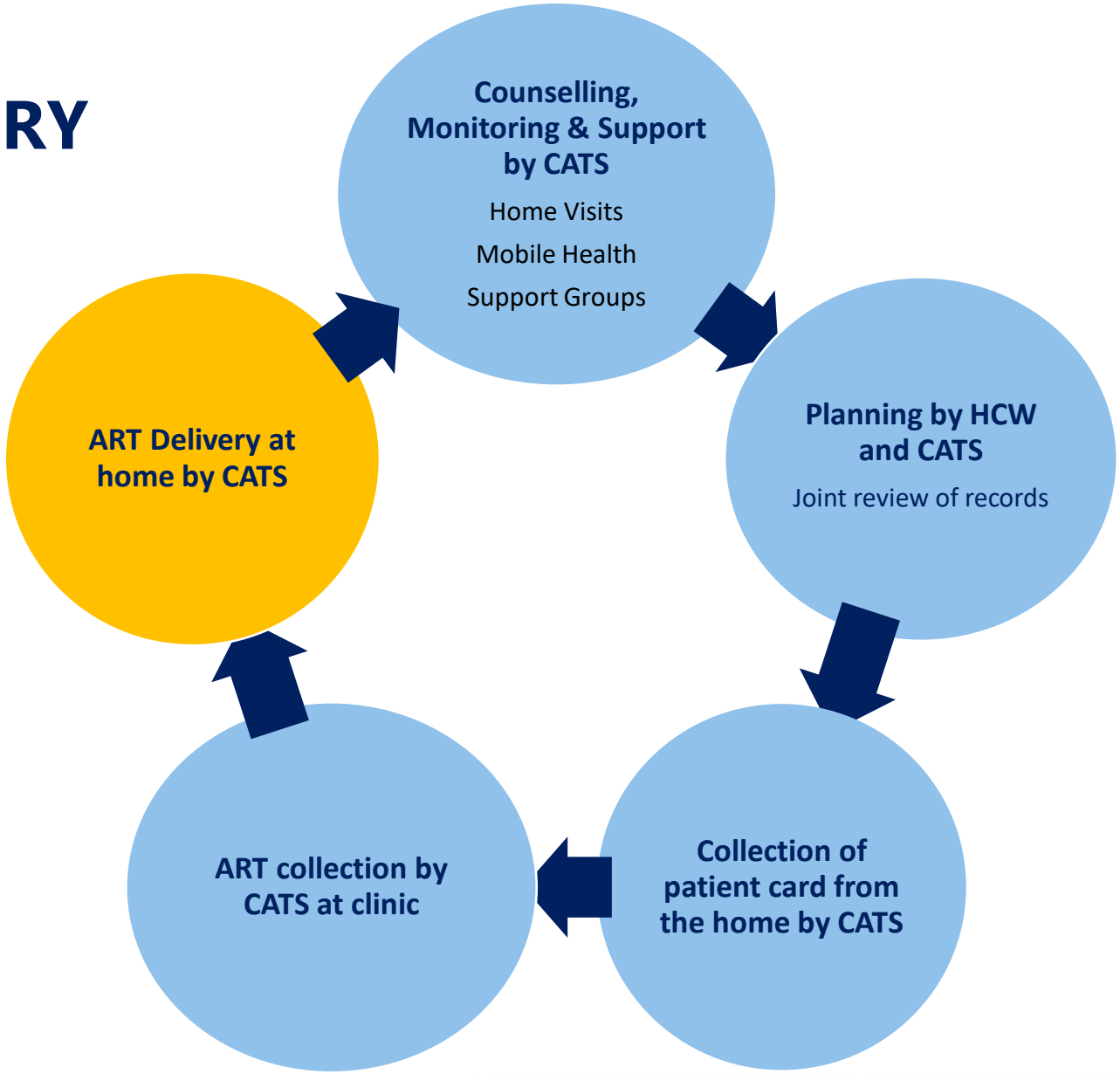


HOME-BASED ART DELIVERY

WHO?

Children and adolescents who are unable to travel to clinic

Poor health
Disability
Child headed household
Long distances
Cyclone Idai
COVID-19

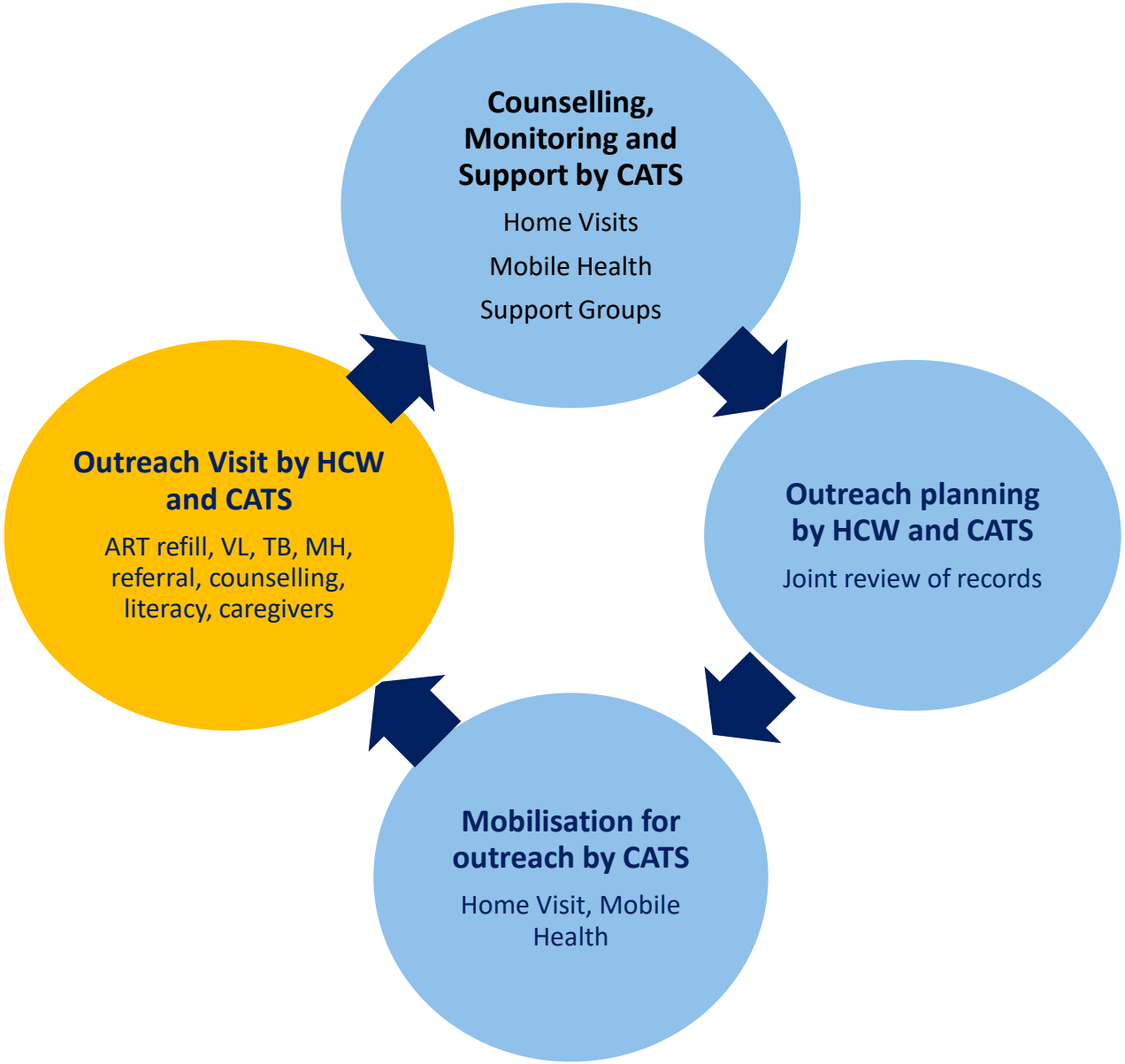


COMMUNITY OUTREACH

WHO?

Children and adolescents who are Unable to travel to clinic

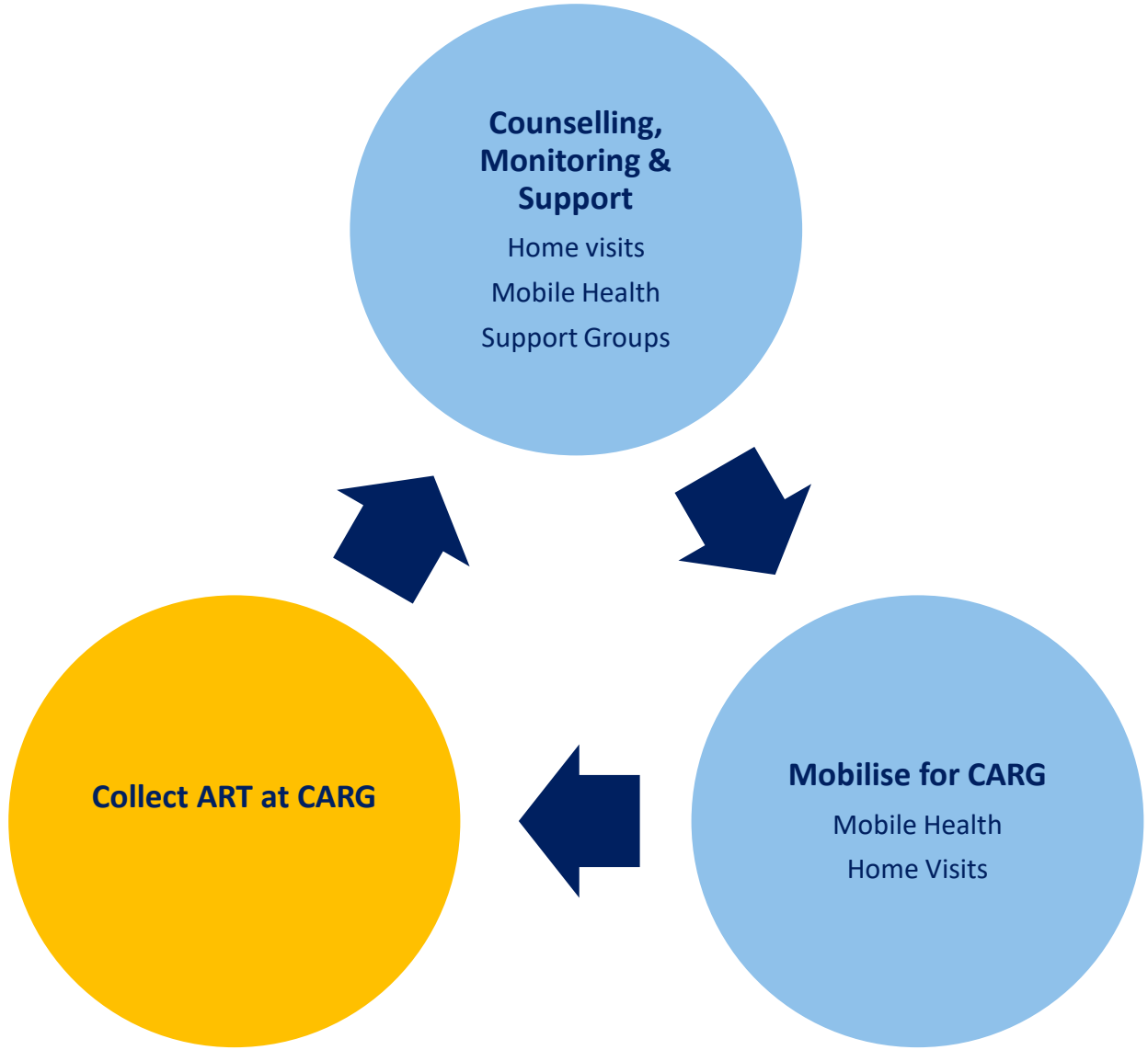
Poor health
Disability
Child headed household
Long distances
Cyclone Idai
COVID-19



CARGS

WHO?

Stable adolescents although
not routinely done for this age group



RESULTS

2020 PROGRAM DATA

AND RESEARCH DATA

1st 95

5,422 children, adolescents and young people mobilised through contact tracing and referred for HIV testing services;

15% confirmed HIV positive.

2nd 95

95% CAYP who tested positive for HIV were linked to HIV treatment and care.

3rd 95

98% viral suppression among CATS

97% of young mothers in Zvandiri were virally suppressed

90% of young people in Zvandiri were virally suppressed

ALHIV in Zvandiri **42% more likely** to be virally suppressed[1]

4th 95

Reduction in common mental disorders among adolescents living with HIV from 68% to 2% among those receiving enhanced counselling from CATS[2]

[1] Mavhu W, Willis, N., Mufuka, J., Bernays, S., Tshuma, M., et al (2020) Effect of a differentiated service delivery model on virological failure in adolescents with HIV in Zimbabwe. Lancet Glob Health 2020; 8: e264-75

[2] Willis N, Simms V, Mutsinze A, Chinoda S, Wogrin C et al (2020) Effect of a peer-led mental health intervention on virological suppression and mental health among adolescents living with HIV in Zimbabwe (Zvandiri-Friendship Bench): a cluster-randomised controlled trial. Oral presentation, International Workshop on HIV & Adolescence 2020

SUCCESSES

- **Jointly** planned, implemented, monitored and evaluated with MoHCC
- Full **integration** of trained, mentored peers and Zvandiri Mentors within health facility and community teams and national mentorship program
- **Standardised** implementation of evidence-based package of services
    - Differentiated, across clinic and community
- **Sustained** on site and virtual **training and mentorship** of:
    - CATS and YMMs
    - Health Care Workers, Social Welfare Officers
- Strengthening of **families and communities**
- Child and adolescent friendly literacy and counselling tools
- Guided by WHO Standards for **Quality** Adolescent Health Services
- **Adopted** or **adapted** in 8 countries

WAY FORWARD

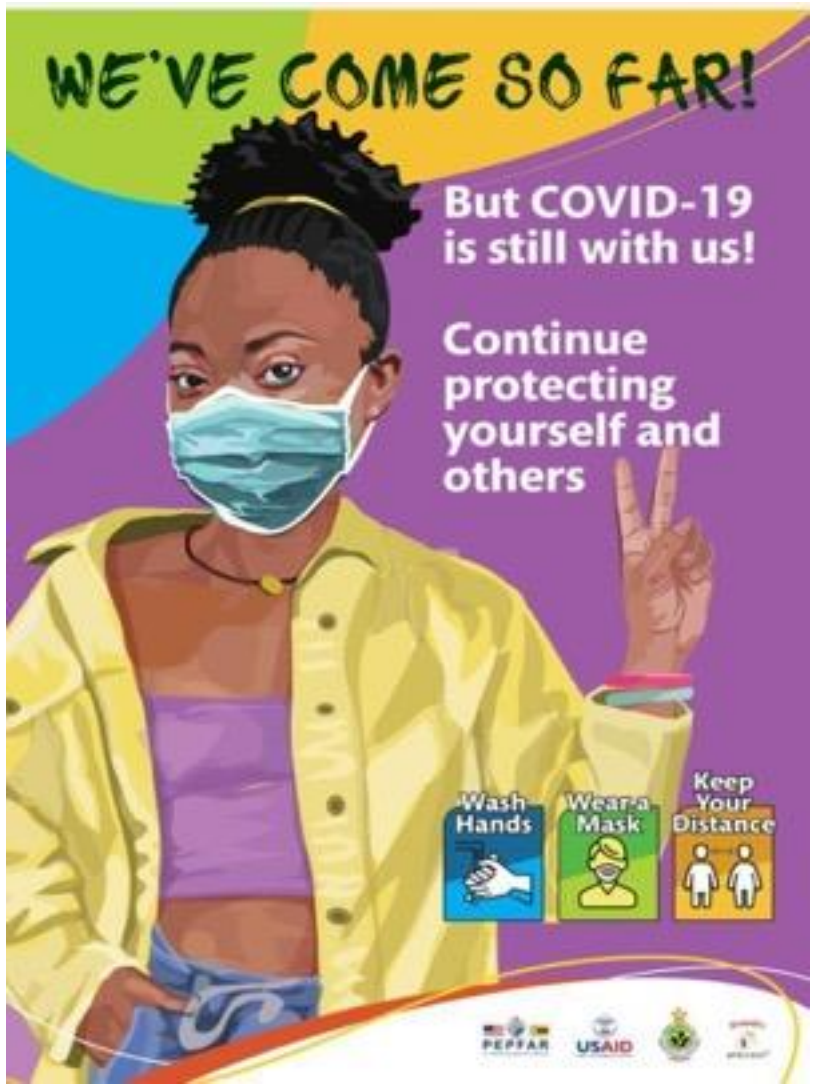
- **Listen to young people**
  - Differentiated - what works for some may not work for others

- **Sustain support and engagement**
  - Wherever, whenever ART is delivered, continued literacy, counselling and support services are wanted and needed
  - Peers, HCWs, trusted adults
  - Invest in their training, mentorship and support

- **Systems Strengthening**
  - Viral Load Monitoring
  - Documentation

THANK YOU

www.africaid-zvandiri.org



Moderator

Sabrina Bakeera-Kitaka

Senior Lecturer

Makerere University

Panelists

Kiiza Lubega

Adolescent Program Coordinator

Makerere University

Joseph Kariuki

Naivasha

Kenya

Claris Tina Awuor

Community Health Assistant

FACES

Q&A

Upcoming Session

Virtual case management and support for patients on DDD and MMD

Thursday, June 17, 2021

7:00 AM-8:30 AM ETD | 13:00-14:30 EAT

Register here