



ICASA 2021 & IPHASA 2021

Selected PMTCT/EID, PAEDIATRICS & ADOLESCENT ABSTRACTS

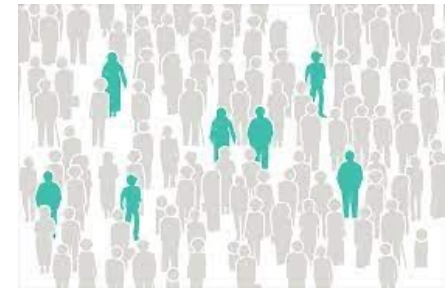
Eleanor Namusoke Magongo
MBChB, MMED



Presentation Layout

- Epidemiology of pediatric HIV
- COVID-19 Impact & service delivery innovations
- DTG, Viral load testing and Suppression
- Patient-Centered Care
- HIV prevention & testing services

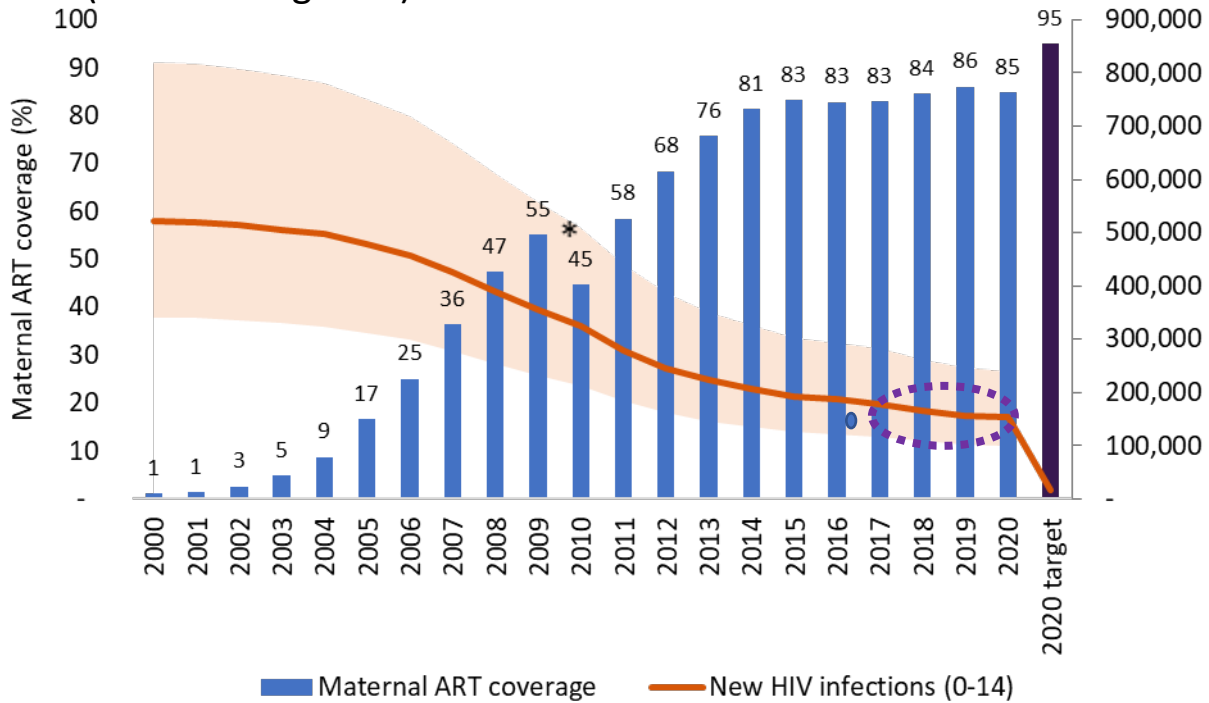
EPIDEMIOLOGY OF PEDIATRIC HIV 2020



Looking back: Reducing new HIV infections and AIDS-related deaths in children

Dr Chewe Luo, UNICEF, ICASA 2021

Global annual new HIV infections and maternal ART coverage (effective regimen)

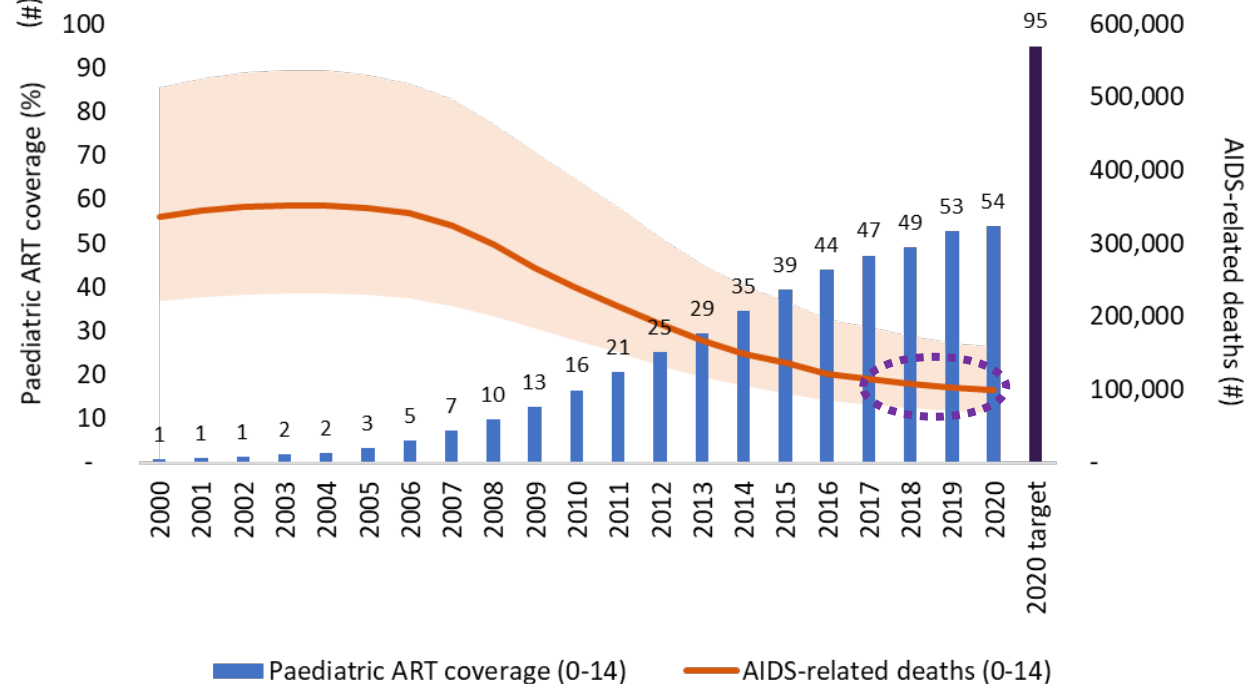


*Drop in ART coverage caused by change in definition of included regimens

150,000 new infections in children in 2020

99,000 AIDS-related deaths in children in 2020

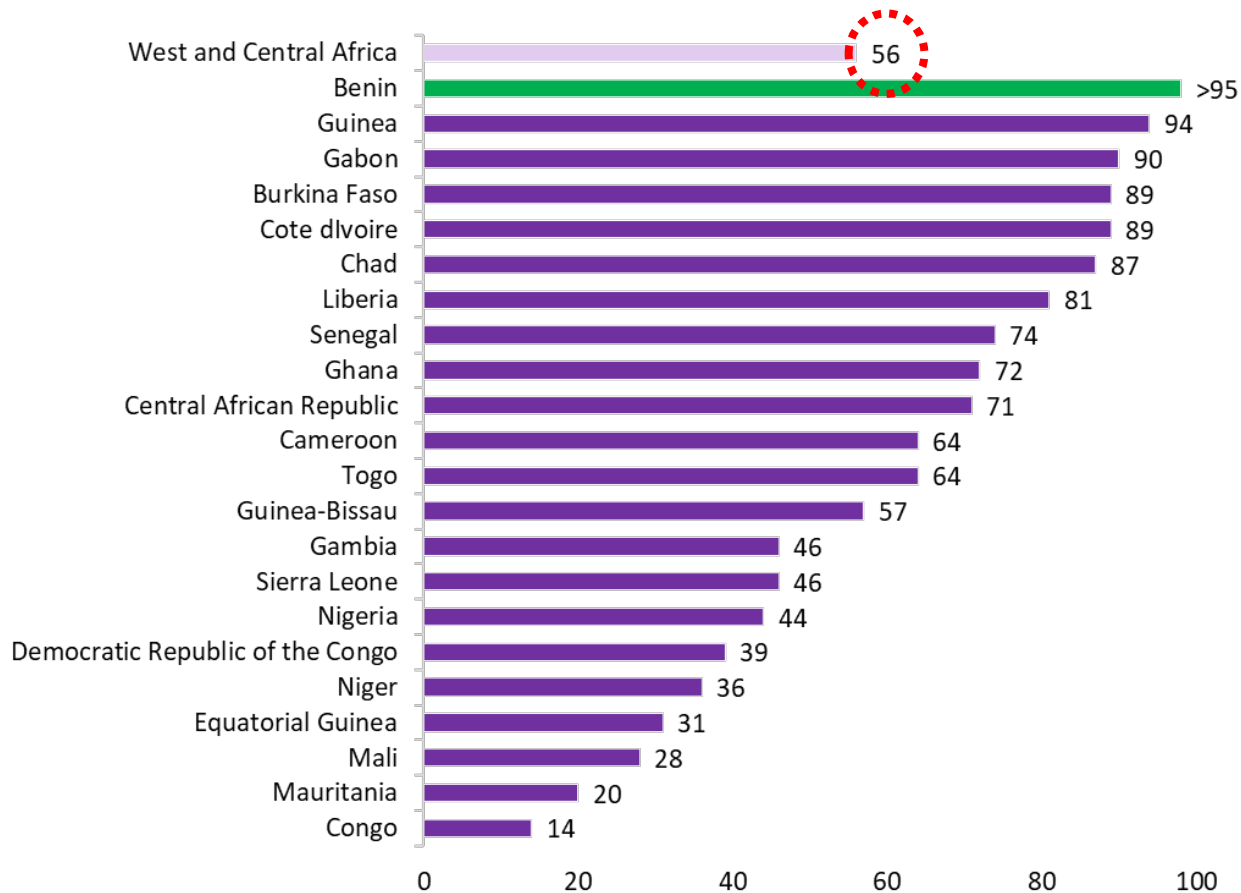
Global AIDS-related deaths and paediatric ART coverage



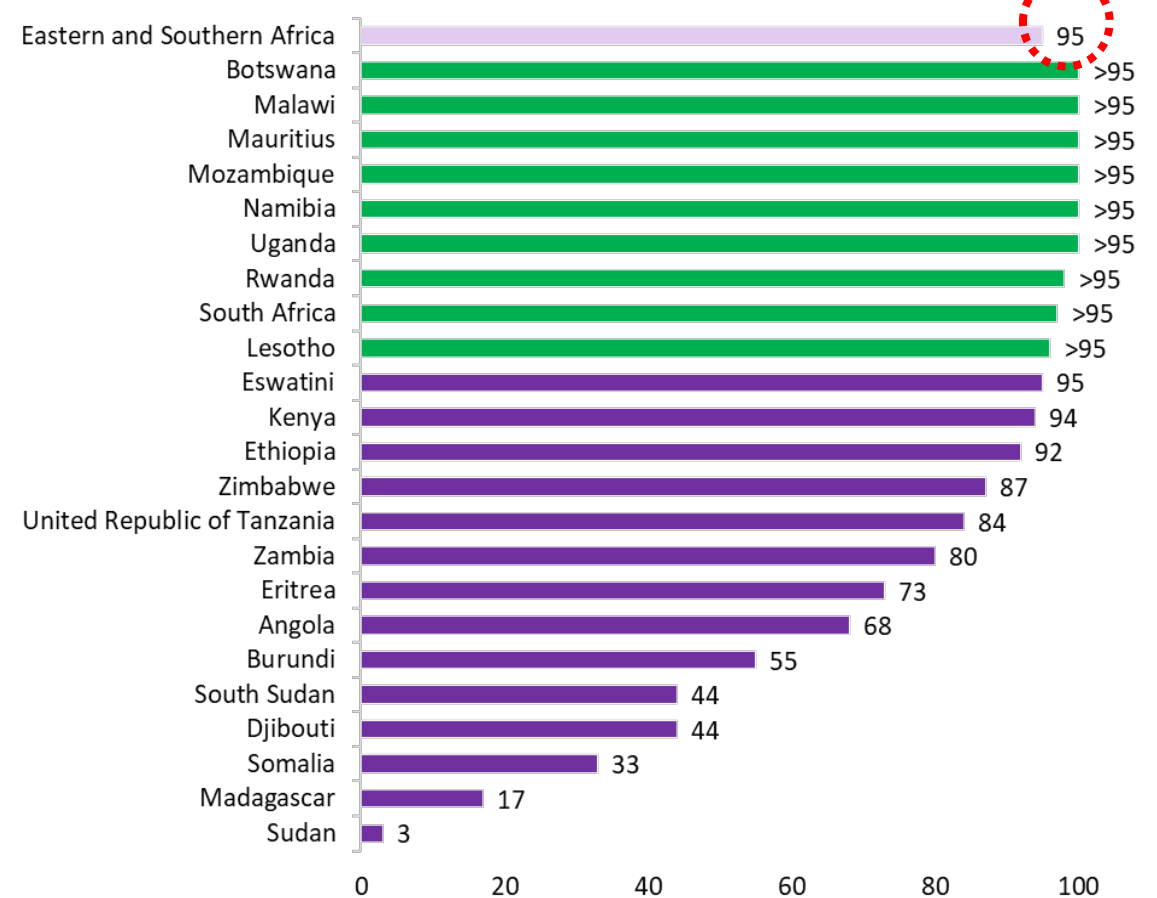
Looking back: Regional and country level disparities in ART coverage in PMTCT (2020)

Response uneven between regions and countries; lower access in WCA

Maternal ART coverage, West and Central Africa



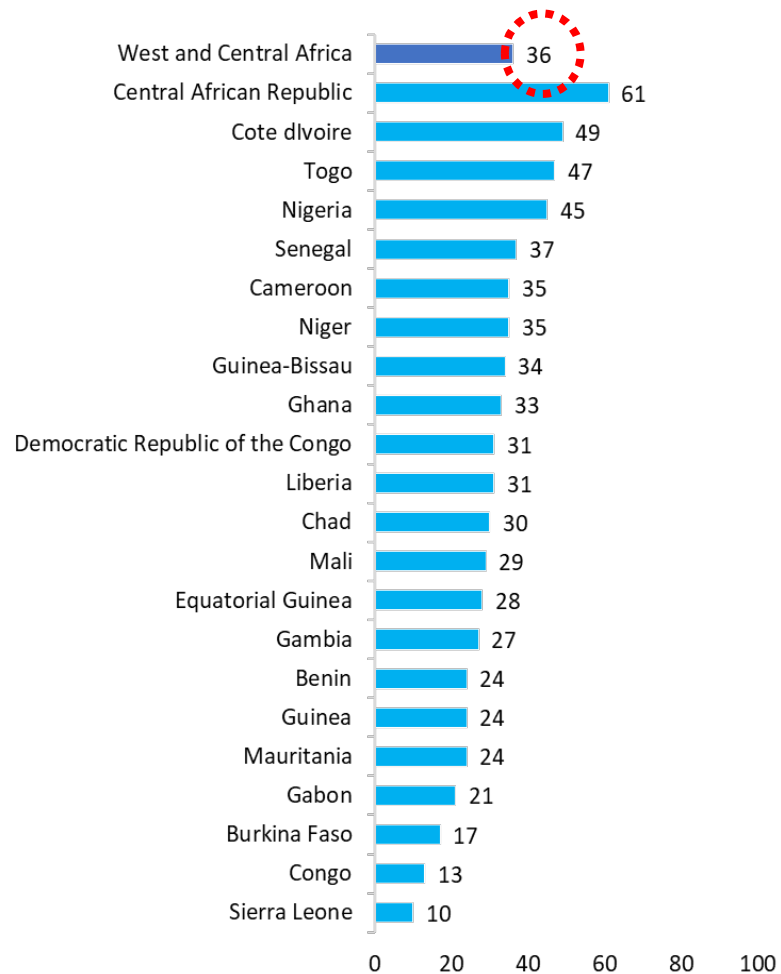
Maternal ART coverage, Eastern and Southern Africa



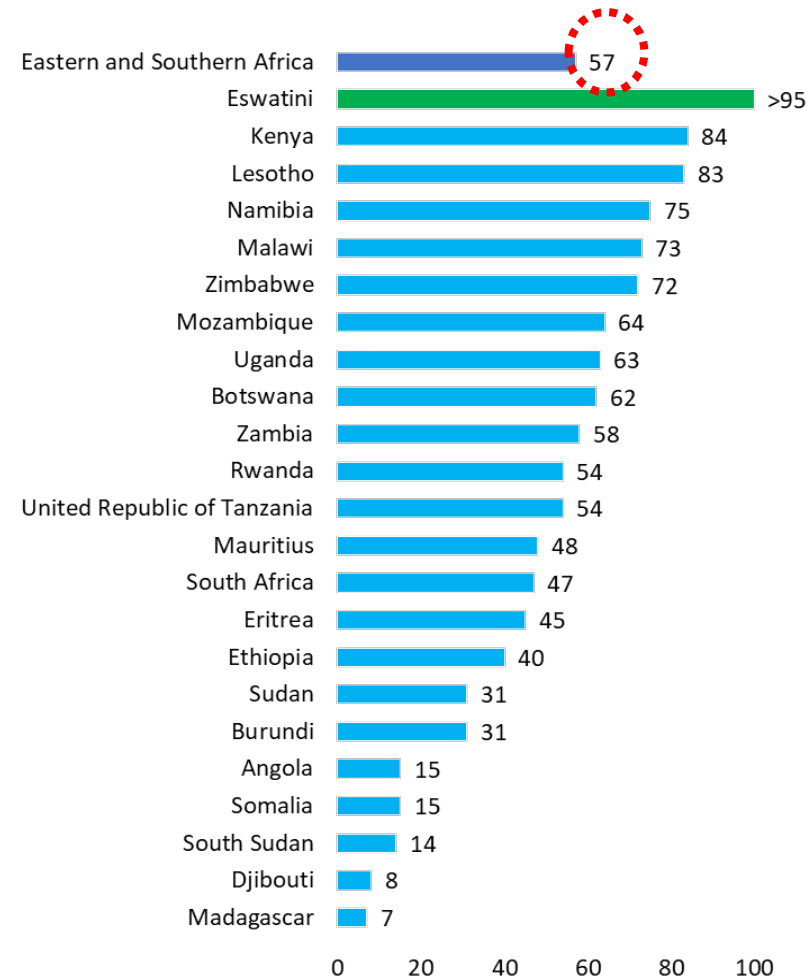
Looking back: Regional and country paediatric ART coverage (2020)

Response uneven between regions and countries; generally low access in both regions

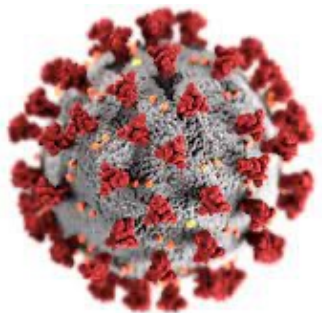
Paediatric ART coverage, West and Central Africa



Paediatric ART coverage, Eastern and Southern Africa

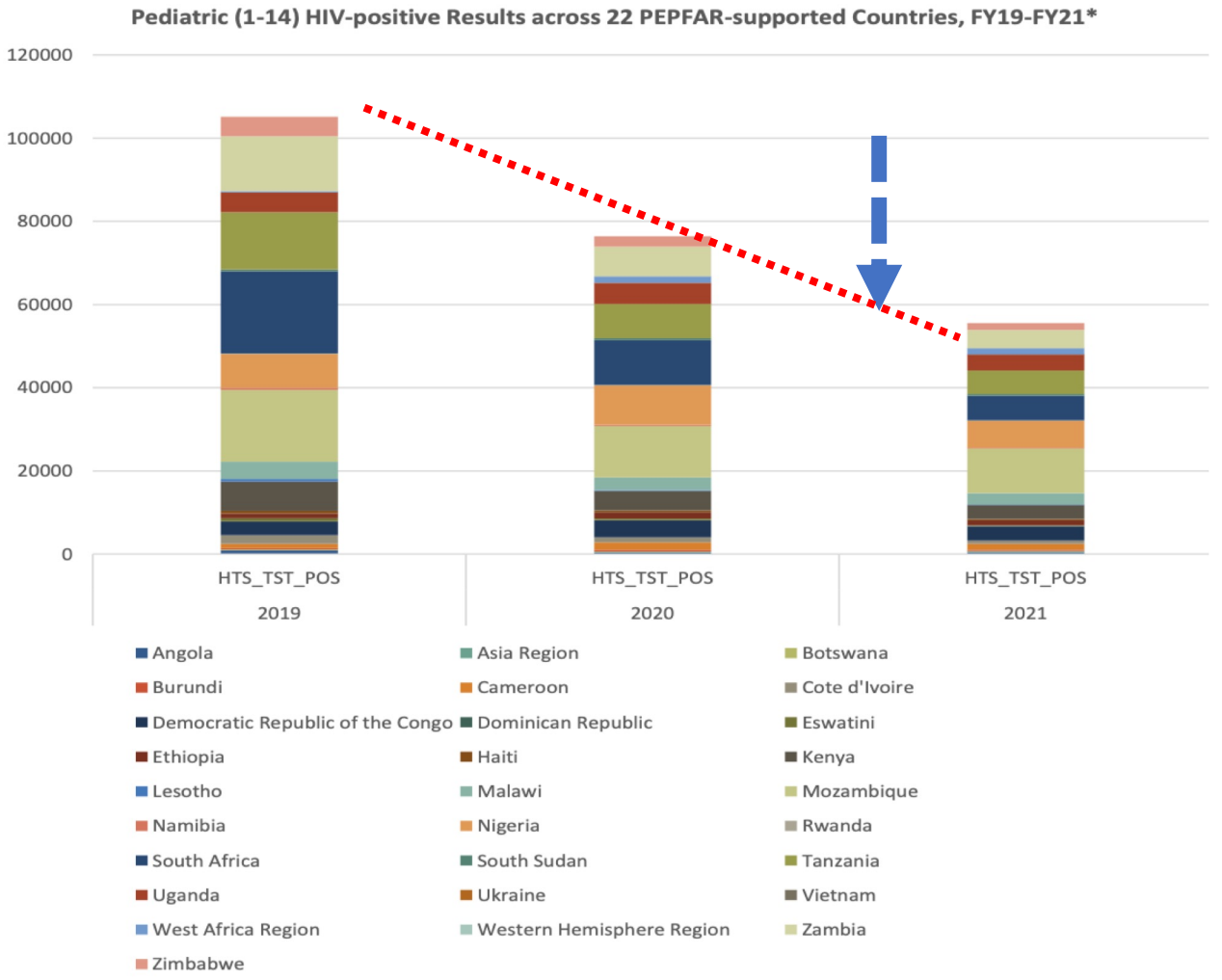
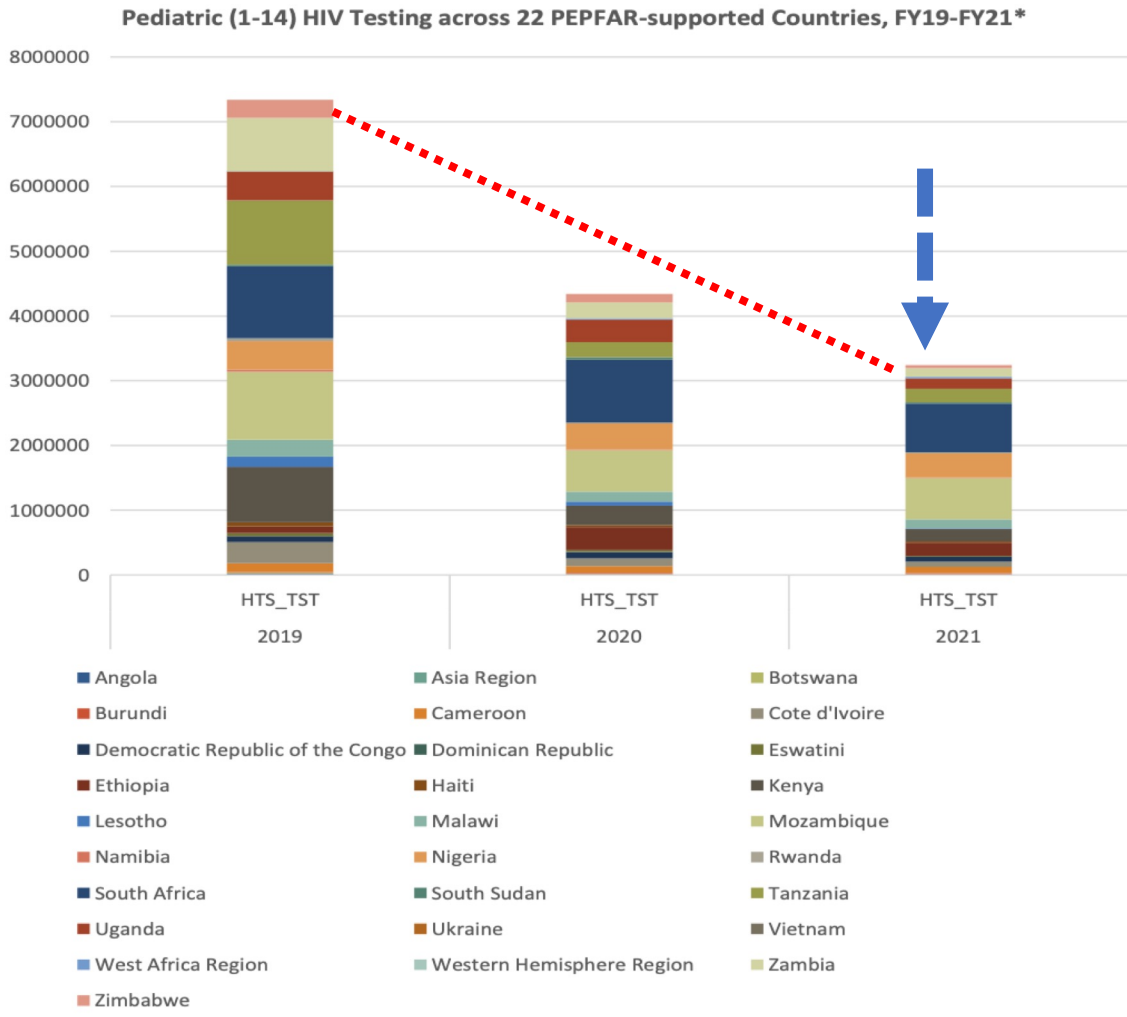


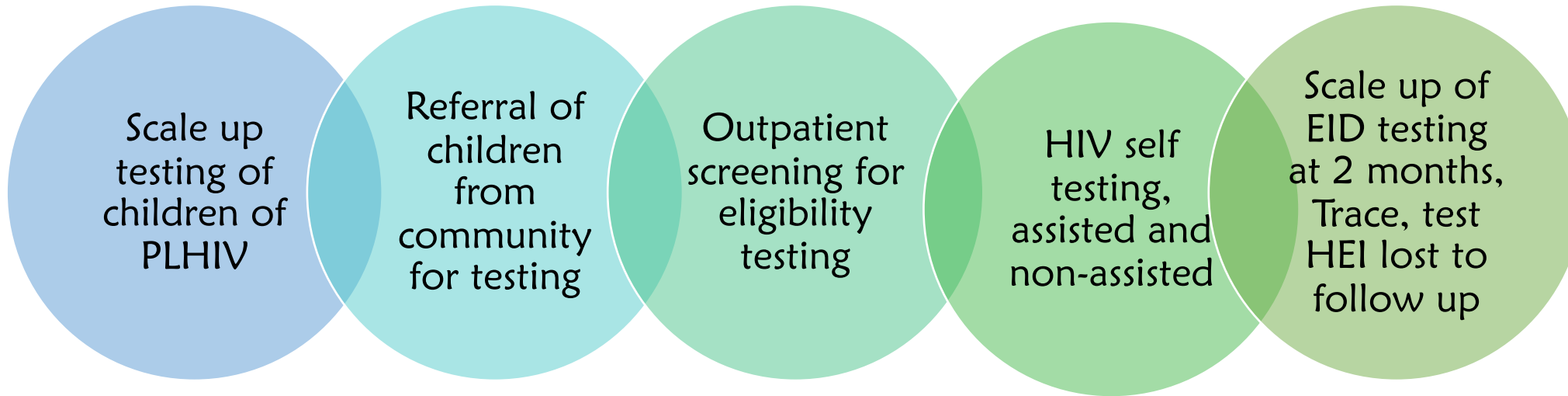
COVID-19 IMPACT & SERVICE DELIVERY INNOVATIONS



HIV testing and positives identified in PEPFAR countries

*Dr Immaculate Mutisya , Public Health Specialist [pediatrics & adolescents]
Centers for Disease Control and Prevention, Nairobi, Kenya, IPHASA*





Multidisciplinary COVID 19 adaptation approaches:

- ❖ Test untested children of PLHIV
- ❖ Leverage on OVC programs to refer eligible children from the community
- ❖ HIV self testing (HIVST)
- ❖ Optimize EID testing and tracing HEI disengaged from care , test and link to services
- ❖ Efforts should be made to track missed opportunities during the pandemic at country level

Four areas of synergy created between the HIV and COVID-19 responses

Laurie Gulaid, UNICEF ESARO, ICASA



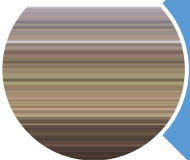
Bringing services closer to communities



Maximizing investments in the HIV infrastructure



Catalyzing use of digital platforms



Strengthening a multisectoral response

Bringing HIV and COVID-19 services closer to communities

- Differentiated service delivery
- Peer led models

Leveraging investments in HIV infrastructure for the COVID-19 response

- Strengthen laboratory systems
- Utilize training approaches used during COVID-19 to scale up trainings
- Strategic information; building on COVID-19 monitoring systems
- Robust supply chain systems

Use of digital platforms: disseminate correct information through social media, tele-mentoring and virtual trainings

Strengthen a multi-sectoral focus

Multi-month Dispensing of ART & VLS for children living with HIV before & during the COVID-19 Pandemic in Nigeria, Tanzania & Zambia

Stephanie Dowling et al, ICASA 2021

- Country expansion of MMD eligibility criteria during COVID—19 pandemic
- FASTER, a PEPFAR-funded project assessed MMD & VLS to monitor impact of programmatic shifts on ART service delivery
- Age: 0-14 years
- MMD duration: < 3 months, 3-5 months & 6 or more months
- Baseline period: October-December 2019 (before COVID)
- Endline: October-December 2020 (during COVID).

Study sites

- Nigeria: 58
- Tanzania: 48
- Zambia: 50

Outcomes of interest

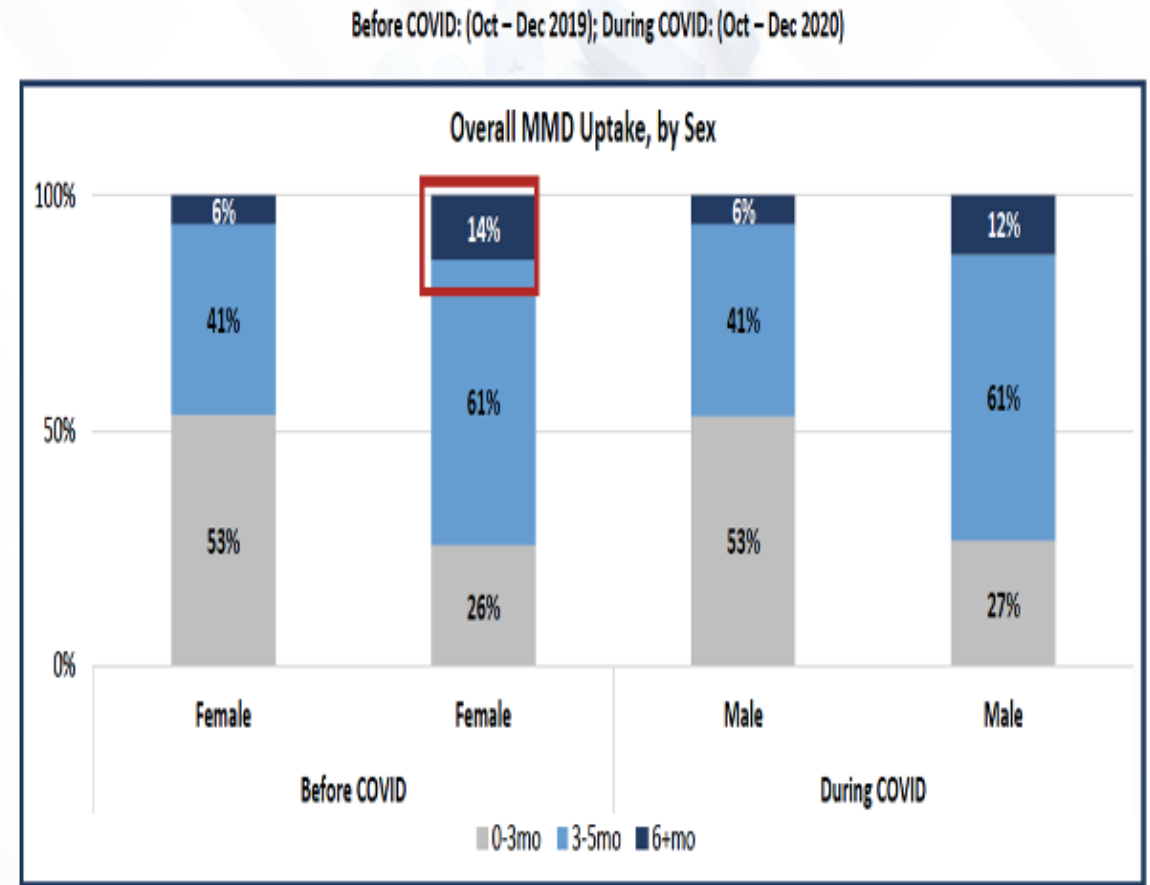
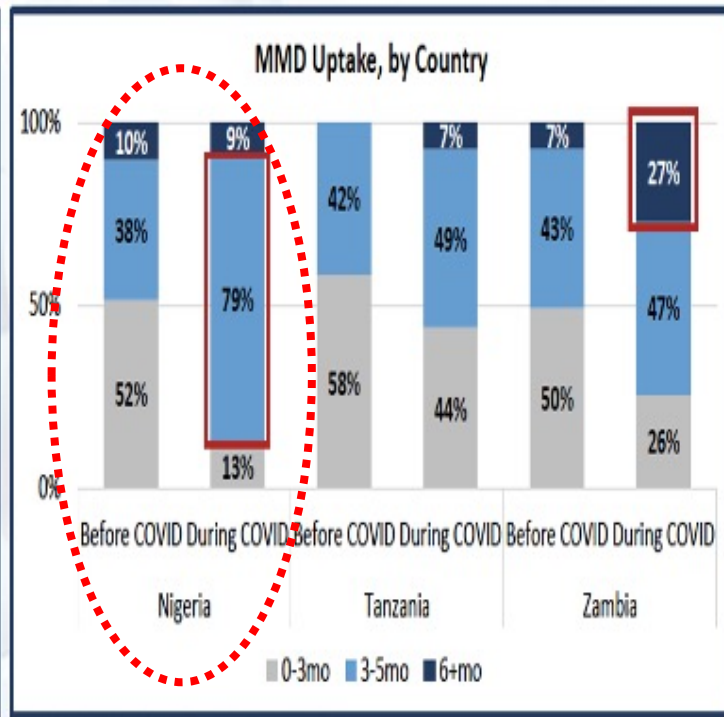
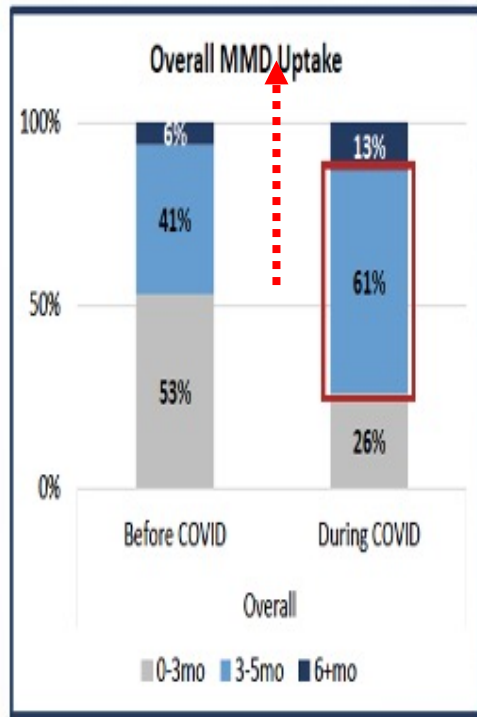
% change in overall proportion of ART dispensed as MMD, MMD category & sex

Difference in median VLS rates across facilities, countries & sex

% change in proportion of facilities with overall VLS above 80% (threshold for good performance)

Multi-month Dispensing of ART & VLS for children living with HIV before & during the COVID-19 Pandemic in Nigeria, Tanzania & Zambia

Stephanie Dowling et al, ICASA 2021

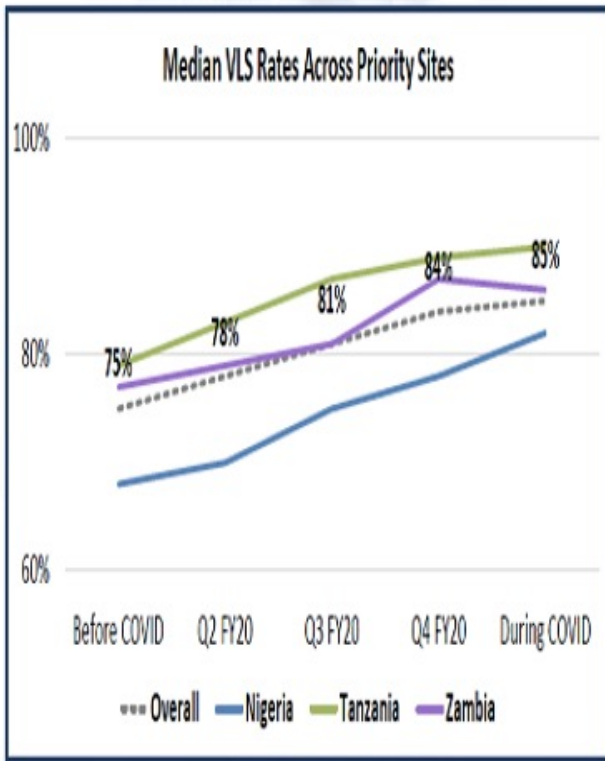


Before COVID: (Oct – Dec 2019)
During COVID: (Oct – Dec 2020)

Note: Facilities included in analysis of each MMD category due to data availability: 0-3MMD (153 facilities), 3-5MMD (154 facilities), 6+MMD (95 facilities).

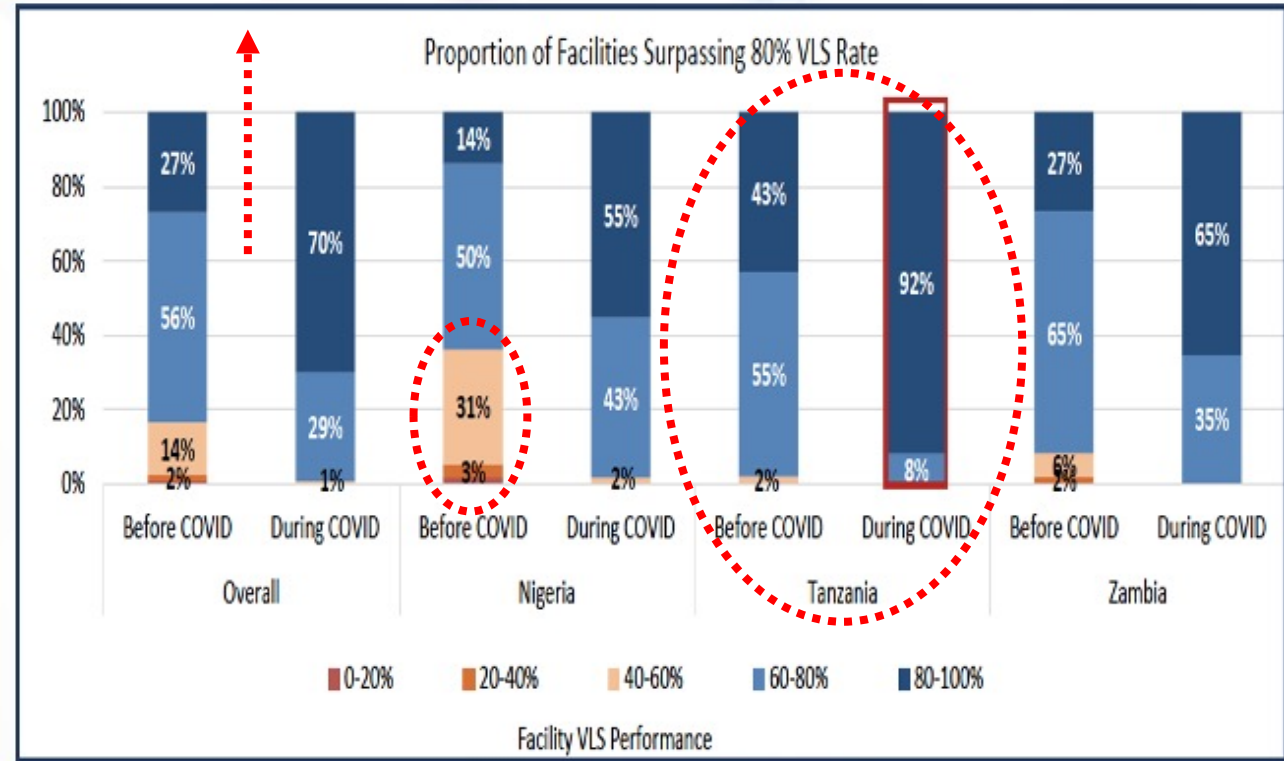
Multi-month Dispensing of ART & VLS for children living with HIV before & during the COVID-19 Pandemic in Nigeria, Tanzania & Zambia

Stephanie Dowling et al, ICASA 2021



Before COVID: (Oct - Dec 2019)
During COVID: (Oct - Dec 2020)

Note: Facilities included in analysis of median VLS (156 facilities), and number of facilities with VLS above 80% in Q1 FY21 (109 facilities).



Note: Facilities included in analysis of median VLS (156 facilities), and of number of facilities with VLS above 80% in Q1 FY21 (109 facilities). Some data labels for values ≤2 not shown in chart.

Key Take Aways

- **The expansion in the MMD criteria for children lead to an increase in the proportions of children accessing MMD**
- **This reduced some of the structural barriers**
- **Leading to improvement in viral load suppression**
- **Need to assess impact of MMD on VLS with ART optimization, especially in the era of DTG**

DTG, VIRAL LOAD TESTING & SUPPRESSION



* Manufacturers may change the packing design without notice.

Virologic outcomes & risk factors for non-suppression during VL scale up in Zimbabwe

Makurumidze et al ICASA 2021

- Zimbabwe started implementing VL testing in 2013
- Limited evidence on performance of VL & groups at risk of non-suppression
- **Aim:** Estimate VLS for routine & repeat tests after Enhanced Adherence Counselling (EAC) & to identify factors for non-suppression
- Retrospective cross-sectional study
- Using data collected from 2014 to 2018
- VL non-suppression was >1000 copies/ml
- Bivariable & multivariable logistics regression done to determine factors associated with non-suppression

Table 1. : Overall viral load suppression for routine and repeat viral load after enhanced adherence counselling

Reason for test	Total	Suppressed (%)
Routine viral load test	101725	87705 (86.2)
Repeat after EAC viral load test	1884	888 (47.1)

Factors associated with viral non-suppression for routine viral load tests

- Males (vs females, adjusted odds ratio (aOR) = 1.19, [95% CI: 1.14 - 1.24])
- **Adolescents (vs adults, aOR = 3.11, [95% CI: 2.9 - 3.31])**
- Tertiary level (vs primary, aOR = 1.63, [95% CI: 1.44 - 1.85])
- Commenced ART in 2014-2015 (vs <2010, aOR = 0.83, [95% CI: 0.79 - 0.88]) and from 2016 (vs <2010, aOR = 0.84, [95% CI: 0.79 - 0.89])
- Confirmed pregnant (vs unconfirmed women, aOR = 0.79, [95% CI: 0.70- 0.90])

Factors associated with viral non-suppression for repeat viral load tests after enhanced adherence counselling

- **Young adults (vs adults, aOR =3.48, [95% CI 2.16 - 5.83]), adolescents (vs adults, aOR = 2.76, [95% CI: 2.11 - 3.72]) and children (vs adults, aOR=1.51, [95% CI: 1.03 - 2.22])**

There is need for more focus on sub populations at highest risk of non-suppression; adolescents & young adults

Ensuring Viral Load Suppression among Children on ART Enrolled in South Sudan's Orphans and Vulnerable Children's Program

P. Mawora et al, Poster PEB017, South Sudan, ICASA

- ACHIEVE, a PEPFAR-USAID funded organization provides OVC care at 8 facilities
- Services:
 - Clinical; treatment literacy, HIV disclosure, PSS
- Non-clinical: education support, hygiene counselling, WASH, parenting & violence prevention
- Follow-up; twice a quarter through phone call and home visit
- 449 OVCs enrolled between 1st April 2020 & 30th March 2021
- ACHIEVE staff monitored ART regimens, VLS & MMD

Figure 1: Viral load suppression and MMD over time – COP19Q4 to COP20Q4

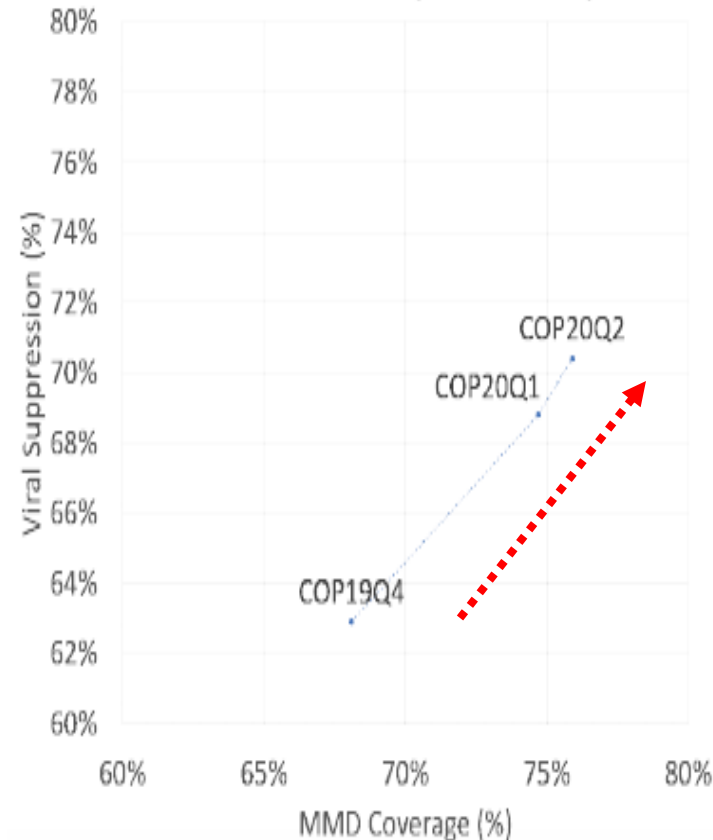
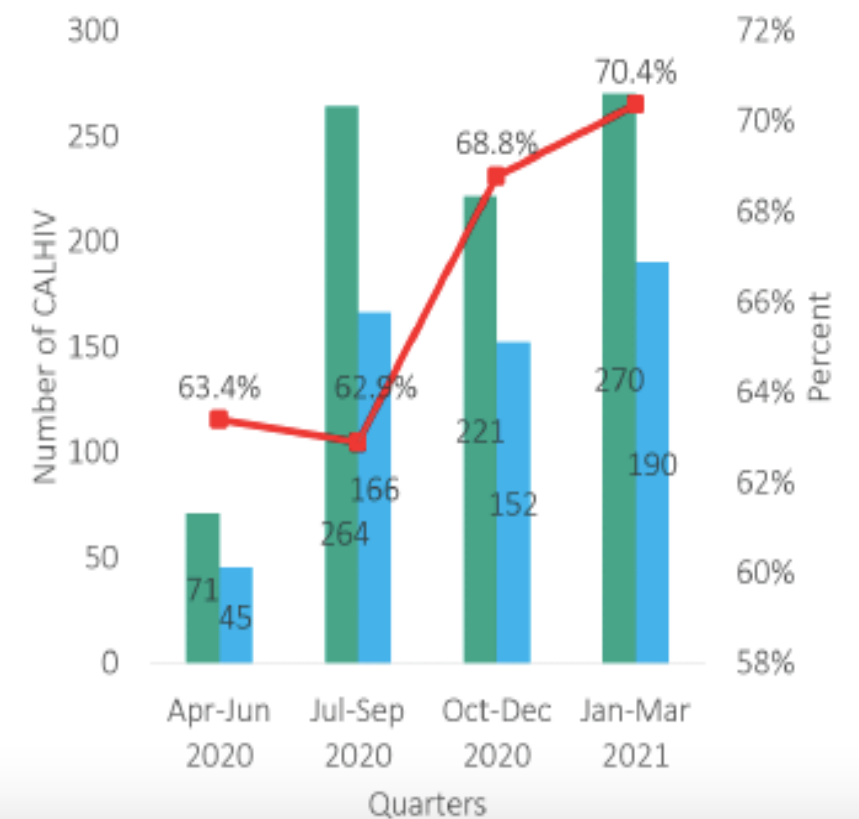


Figure 2: Viral load suppression over time, for CALHIV in the OVC Program April 2020 to March 2021



Viral suppression among children & adolescents with high viral load following implementation of a standardized enhanced adherence counselling (SEAC) package

Rose Masaba et al, Abstract number, Kenya, ICASA

- Pre-post study
- Study popn: children & adolescents with a VL > or equal to 1000 copies/ml
- Retrospective patient-level data abstracted from medical records who received care between October 2016-September 2018
- SEAC data prospectively abstracted for patients receiving care from February 2019-September 2020
- SEAC Package: SOPS in SEAC, Training, mentoring on SAEC and individualized case management

Characteristics		Pre-standardization (N=595) n (%)	Post-standardization (N=146) n (%)	Total (N=741) n(%)
Sex	Female	300 (50.4%)	70 (48.0%)	370(49.9%)
Age (years)	Mean (SD)	10.9 (4.5)	11.3 (4.1)	
	0-9	227 (38.1%)	44 (30.1%)	271(36.6%)
	10-14	229 (38.5%)	67 (45.9%)	296(39.9%)
	15-19	139 (23.4%)	35 (24.0%)	174(23.5%)
Viral load at EAC enrolment	N, Median (IQR) copies/ml	593, 9,560 (2,580-42,410)	146, 3,481 (1,666-20,162)	739, 7970 (2,150-37,700)
ARV regimen before EAC	NNRTI-based	420 (70.6%)	65 (44.8%)	485(65.4%)
	PI-based	175(29.4%)	77 (53.1%)	252(34.1%)
	Other	0 (0%)	3 (2.1%)	3(0.4%)
ART duration prior to EAC	N, Median (IQR), years	6.3 (3.2-8.9)	7.4 (4.3-9.4)	6.6 (3.4-9.1)
Facility	County referral hospital(Level 5)	377 (63.4%)	87 (60.0%)	464(62.6%)
	Sub-county hospitals(level 4)	19 (3.2%)	4 (2.8%)	23(3.1%)
	Health centers(Level 3)	199 (33.4%)	54 (37.2%)	253(34%)

IQR-interquartile range

SEAC reduced days to completion of the minimum sessions by 270 days, increased proportions completing EAC by 10%

Characteristics	Pre-SEAC period (N=595) n (%)	Post-SEAC period (N=146) n (%)	p-value
EAC uptake			
Attended 1 st EAC	497 (83%)	146 (100%)	<0.001 ^a
EAC uptake by sex:			
Male	254/295 (86%)	76/76 (100%)	0.001 ^a
Female	243/300 (81%)	70/70 (100%)	<0.001 ^a
EAC uptake by age:			
0-9 years	193/227 (85%)	44/44 (100%)	0.006 ^a
10-14 years	184/229 (80%)	67/67 (100%)	<0.001 ^a
15-19 years	120/139 (86%)	35/35 (100%)	0.020 ^a
Time to EAC uptake, median (IQR) days			
	49.0 (23.0-102.5)	41.0 (20.0-67.0)	0.006 ^b
Three EAC sessions completed	n=497 403 (81.1%)	n=146 133 (91.1%)	0.004 ^a
<Three EAC sessions completed	94 (18.9%)	13 (8.9%)	<0.001 ^a
Time to complete minimum three EAC sessions, median (IQR) days	n=403 59.0 (3.06-91.0)	n=133 47.0 (33.0-63.0)	0.002 ^b

^a Chi-square test (difference in proportions). ^b Wilcoxon Ranksum test (difference in medians)

Characteristics	Pre-SEAC period (N=595) n (%)	Post-SEAC period (N=146) n (%)	p-value
VL after three EAC sessions	373/403 (92.6%)	122/133 (91.7%)	0.756 ^b
VL results after three EAC sessions:	n=373	n=122	
median (IQR) (copies/ml)			
	2,637 (363-21,996)	1,250 (245-6,000)	0.010 ^b
VL outcome after three EAC sessions	n=373	n=122	
Suppressed (<1,000 c/mL)			
Unsuppressed (≥1,000 c/mL)	145 (39.6%)	67 (54.9%)	0.023 ^a
Results not available	221 (60.4%) 7 (1.9%)	55 (45.1%) 0	

^a Chi-square test (difference in proportions). ^b Wilcoxon Ranksum test (difference in medians)

2 EAC more effective in VLS than the recommended minimum of 3 sessions

Variable	Unadjusted/Crude OR (95% CIs)	Adjusted/AOR* (95% CIs)
Pre-SEAC(Ref)	-	-
Post-SEAC	1.6 (1.0-2.3) [†]	1.7 (1.2-2.7)
EAC sessions completed		
<3 Sessions	1.8 (1.1-2.9) [†]	2.2 (1.3-3.5)
3+ Sessions (Ref)	-	-
Facility County:		
Turkana (Ref)	-	-
Homa Bay	2.3 (1.3-4.1) [†]	2.2 (1.2-4.1)
Time on ART Prior to EAC (years)	1.1 (1.0-1.1) [‡]	

[†]significant bivariate, so included in multivariate analysis. [‡]ART time was dropped from multivariate model, as it did not retain significance in full model

This analysis included all participants who had data in at least one bivariate association.

OR-Odds ratio

AOR-adjusted odds ratio

Key Take Aways

- **In this era of DTG, it is still important to continue with the standard practices like PSS including adherence monitoring & peer to peer support in order to maximize DTG benefits**
- **Additional studies are needed to explore the impact of MMD on viral load access & viral load suppression**
- **Patient–centered care is critical to achieving the 3rd 95**

PATIENT CENTERED CARE



Defining Person Centered Care within HIV Treatment Continuum in SSA

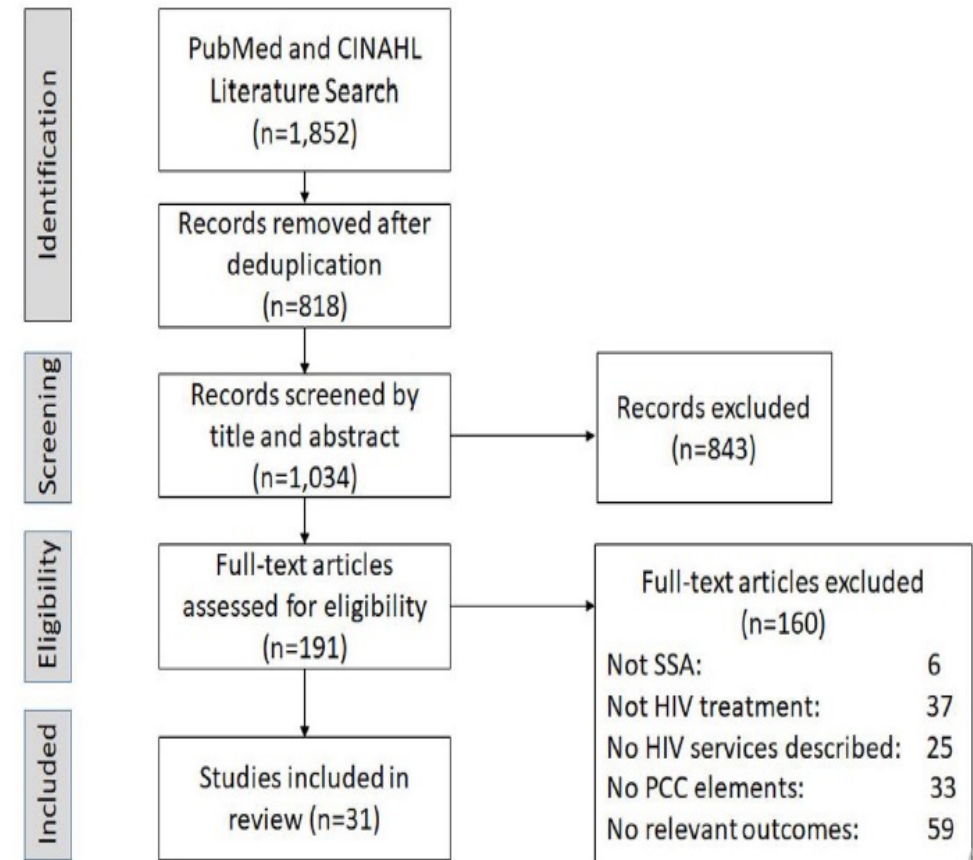
Jessica Posner et al, ICASA

PCC Interventions

PICOs (framework for study inclusion)

- **Person:** Clients accessing HIV treatment services or HCWS providing HIV treatment services
- **Intervention:** Described HIV treatment program or elements of PCC that contributed to HIV treatment uptake, retention, and/or viral suppression
- Compared different models of PCC
- **Outcomes:** Included health outcomes related to PCC interventions
- **Study design:** Any study design other than reviews & study protocols
- Methodological quality of the included studies with quantitative components was scored using effective Public Health Practice Project (EPHP) quality assessment

PRISMA Flow Diagram for PCC



PCC Interventions

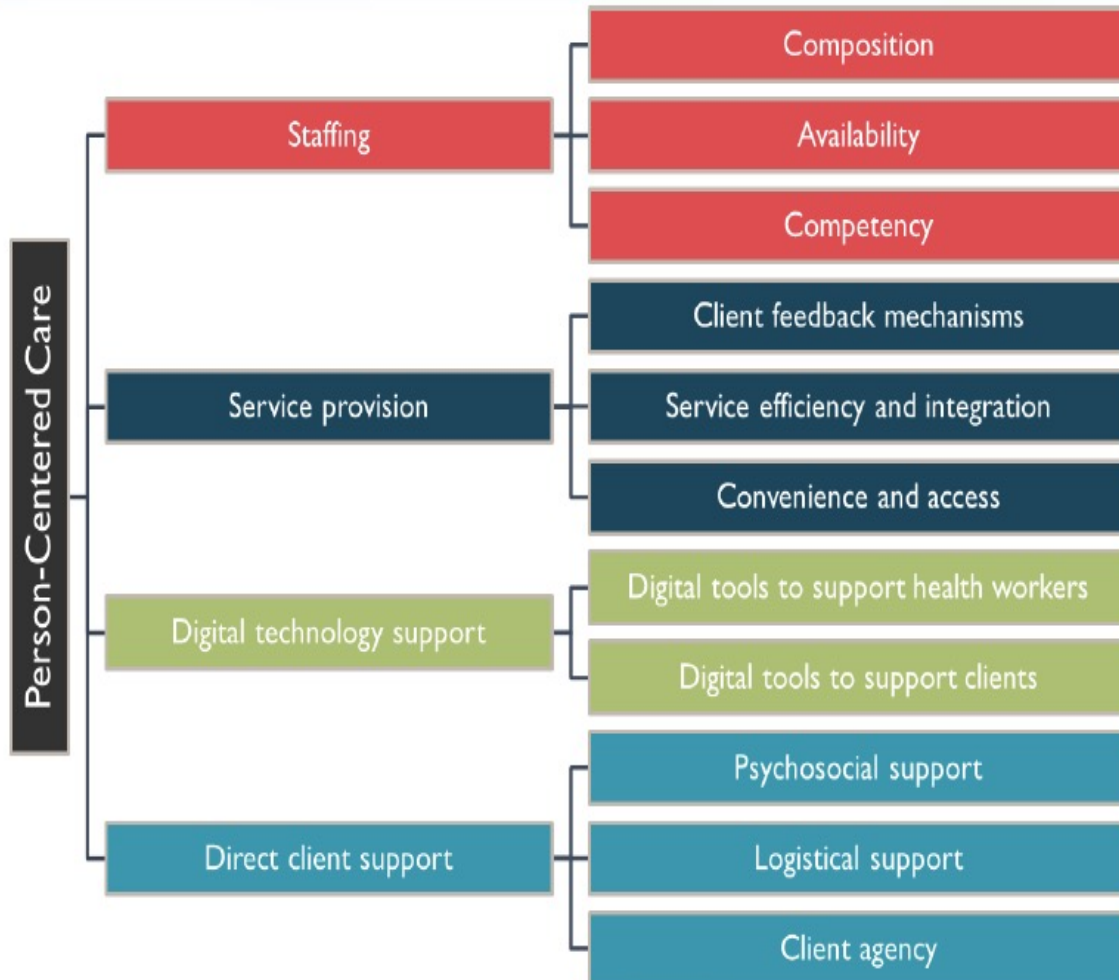
Population	Person-centered interventions	Outcomes reported		
		Linkage	Retention	VL suppression
Adolescents	<ul style="list-style-type: none"> ● Appointment reminders and missed appointment notices ● Adolescent-only clinic, support groups for adolescents and parent/caregiver 		✓	
	<ul style="list-style-type: none"> ● Community adolescent treatment supporters facilitate support and ART refill groups & provide counseling, home visits, & missed appointment follow up ● Saturday clinics with pre-packaged ART ● Group activities including counseling and sports ● HCW use MOH checklist to provide adolescent-friendly services during adolescent clinic 		✓	✓
	<ul style="list-style-type: none"> ● Boarding school students offered HIV & SRH counseling, ART storage, health clubs, and treatment linkage 	✓	✓	
Pregnant or postpartum women, and their exposed infants	<ul style="list-style-type: none"> ● Lay health workers provide clinic- and home-based education, texts with appointment reminders and missed visit follow-up ● Postpartum women receive HIV care at MCH clinic until breastfeeding cessation and final infant HIV test ● Individual counseling to pregnant and postpartum women provided via telephone 		✓	

PCC Interventions

Population	Person-centered interventions	Outcomes reported		
		Linkage	Retention	VL suppression
Women and men	<ul style="list-style-type: none"> ● Expert patients provide education/counseling, phone calls and home visits ● Community ART refill groups, fast-track, club refills, family refills 		✓	
	<ul style="list-style-type: none"> ● Expedited ART initiation for people with CD4<350 ● Text appointment reminders with integrated health messages ● Cellular airtime to offset clinic visit costs 	✓	✓	
	<ul style="list-style-type: none"> ● Adherence clubs in facilities/communities with ART dispensation ● Enhanced adherence counseling for clients with VL>400 ● EMR reports to follow-up missed visits 		✓	✓
	<ul style="list-style-type: none"> ● Cash transfers to cover clinic transport costs ● Flexible hours, reduced waiting time, and friendly staff ● Education workshops and treatment preparation for clients and family members with directly observed therapy 			✓
Men	<ul style="list-style-type: none"> ● Flexible clinic hours & reduced clinic visits ● 24-hour question hotline & telephone appointment reminders ● Differentiated ART distribution in community settings 		✓	✓
Families	<ul style="list-style-type: none"> ● Family clinic days scheduled ● Individual counseling for parents and adolescents 		✓	

PCC Interventions

PCC Framework



Next Steps

- Share and Validate framework among implementers
- A facility based tool that assess the degree to which PCC services are implemented and identifies gaps to enhance PCC
 - Through implementation understand if the framework meets the PCC needs of diverse populations including Kps who were neglected in the literature
 - Engage with community led monitoring groups to ensure complementarity of facility vs client directed tools
- Consider if a modified version of this framework will be beneficial within the prevention and HIV testing realms

Does a Youth Intern Program Strengthen HIV Service Delivery in South Africa: A Time Series

Deanna Tollefson et al, South Africa, ICASA

Place unemployed young adults (18-29 y.o.) in South Africa with secondary education but no work experience in one-year internships at health facilities

Dual Purpose



(1) **Improve employment prospects** for youth by providing them with job experience and training



(2) **Support health facilities** by providing them with extra temporary staff, specifically for HIV-related services

Program Interns

- HIV Testing & Counseling (HTC)
- Patient Navigating
- Tracing

Admin Interns

- Filing
- Data Capture
- Clerk

Routine Data Sources

- *Intern Data*: Location, dates, type of placements (YHA program)
- *Facility Data*: Facility-level data on HIV services (TIER.Net as reported to Aurum)

Outcomes for Analysis: 7 outcomes of interest

Testing	Treatment Initiation	Retention in Care
<ul style="list-style-type: none"> • Tested for HIV (<i>hts_tst</i>) • Positive for HIV (<i>hts_pos</i>) 	<ul style="list-style-type: none"> • Newly initiated on treatment (<i>tx_new</i>) • Initiated within 14 days on treatment (<i>initiated_14days</i>) 	<ul style="list-style-type: none"> • Lost to follow-up (<i>outcome_ltf</i>) • Completed viral load testing (<i>vl_completed_6mth</i>) • Virally suppressed at 6 months (<i>vl_supp_6mth</i>)

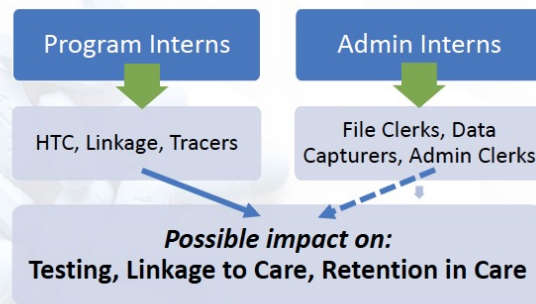
Did HIV service indicators improve after YHA interns placed at facilities?

Rationale

- YHA Program in place since Q4 2018, but impact is unknown
- Routinely collected program data available for analysis

Goal: Conduct interrupted time series analysis to explore impact of YHA as implemented on HIV services

- Testing
- Linkage to care
- Retention in care



Eligibility Criteria

1. YHA interns placed between Nov 2018-Oct 2019 (first year of program)
2. Aurum is PEPFAR Implementing Partner
3. Located in:
 - Ekurhuleni District (EKN)
 - North West Province (NW)



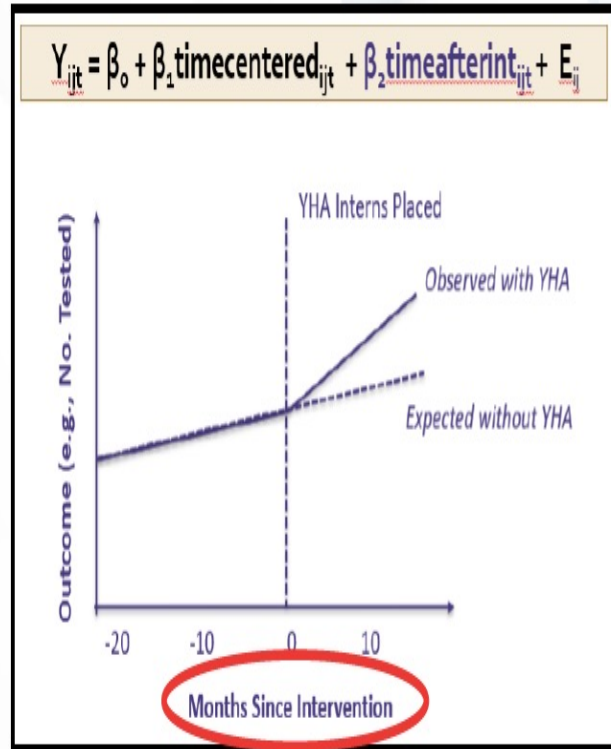
Facility Characteristics

- **207 facilities**
 - 35% in EKN, 65% in NW
- **604 interns placed**
 - 60% in EKN, 40% in NW
 - 43% program interns
 - 1 to >10 interns per facility

Per Facility	EKN Mean (SD)	NW Mean (SD)
No. Interns	4.9 (3.7)	1.8 (1.3)
No. Prog. interns	2.7 (2.3)	0.4 (0.6)

YHA Intern Program Increased number tested, initiating treatment, accessing VL & clients with VLS

Did the trend (slope) change after interns were placed?



n=217 facilities, calendar time: Oct 2017 to March 2020*

*Viral load indicators: Oct 2018-March 2020

7 analyses (1 per outcome)

(e.g., number tested for HIV)

Interested in: Difference in slope between intervention and pre-intervention (β_2)

Modeling

- Linear, multilevel model in r (*nlme*)
- Uncontrolled time series
- Adjusted for autocorrelation (AR1)
- REML estimates
- Random intercepts
- Random intercept & slope sensitivity analysis

- Significant Increase in number tested: **slope +24.5 (18.4, 30.5)***
- No significant change in number of HIV positives identified: Slope +0.13(-0.11, +0.37)
- Significant increase in number initiating treatment: **Slope +0.5(0.37, 0.80)***
- No significant change in number initiated in 14 days: slope -0.20 (-0.49, 0.10)
- Significant decrease in number LTFU: **slope -0.37 (-0.56, -0.18)***
- Significant increase in number with VL testing: **slope +0.78 (0.45, 1.11)***
- Significant increase in number with VLS: slope +0.70 (0.39, 1.00)*

Integration of Differentiated Model of Care (DMOC) on HIV/AIDS & NCDs treatment refills in and out of health facilities in South Africa during COVID-19

Musa Manganye, Department of Health SA, ICASA

Number of clients remaining on ART

5 206 102 Mil (DHIS Sept, 2021)

- 93% - 72% - 89% Towards achieving UNAIDS 90-90-90 targets
- Largest Treatment Program in the world

Diabetes Prevalance

- 3.3% in 2005
- 2.8% in 2008
- 3.2% in 2017 (Chiwandire et.al.2021)
- Stagnant trends over years

Total Population
58,78 Million
(2019-StatSA)

PLHIV Prevalence

7.7 Million PLHIV
(95% CI: 7.1 – 8.8 Million)
(THEMBISA,2019)

Hypertension Prevalence

- 11.8% in 2005
- 9.5% in 2008
- 14.3% in 2017
- Increased trends over years (Chiwandire et.al.2021)

Adherence to HIV, TB, and NCD treatments is an increasing challenge, and non-adherence to long-term therapies results in poor health outcomes.

The massive expansion of the ART programme in recent years and the rising burden of NCDs in South Africa is placing considerable strain on health care services, which presents challenges of maintaining high quality public health services

- The DMOC Model **redefine the convenience for patients of Chronic Care** stable on ART and living with HIV and/or hypertension and/or diabetes.
- **There are no more queues**
- Makes provision for the three differentiated models of care:
 - **Facility Pick Up Points (FAC-PUP)** - The treatment can be pre-dispensed by the facility pharmacy or by a Central Dispensing Unit (CDU) or Centralized Chronic Medicines Dispensing and Distribution (CCMDD)
 - **External Pick-Up Points (EXT-PUP)** – It includes private pharmacies, smart lockers, community points, etc.
 - **Adherence Clubs (ACs)** – facility and community-based.



Community Adherence Club in session – Eastern Cape – Amathole District

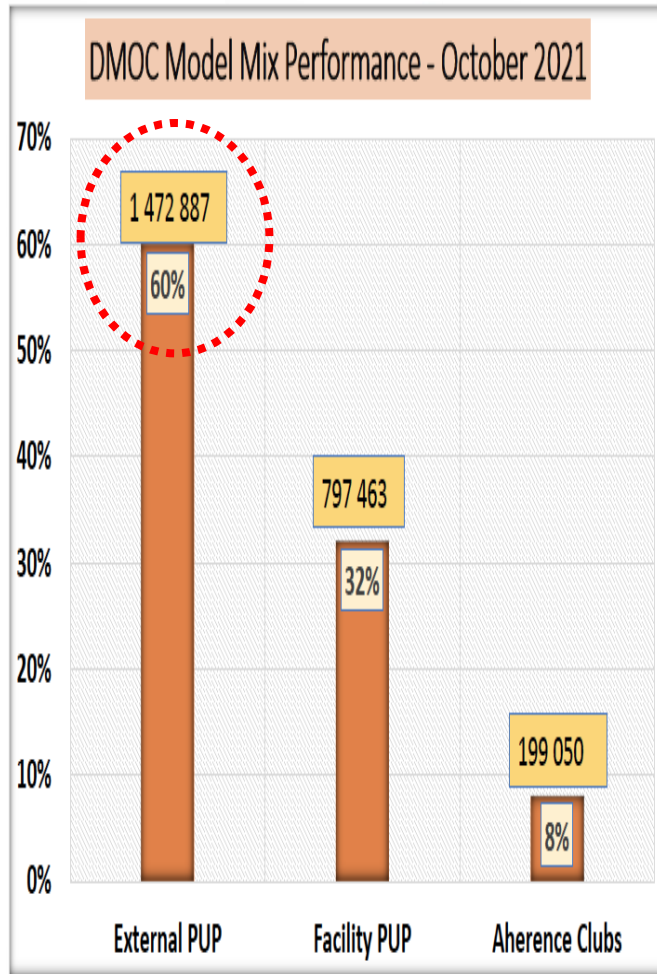


Pelebox Smart Lockers creates easy access for chronic medication – Example of External Pick-Up Points

Same eligibility for all options

- 18 years & above
- On treatment for at least 6 months
- Most recent assessments normal
 - VL in past 6 months < 50-999 copies/ml
 - HbA1c in past 6 months < or equal to 7% for diabetic patients
 - 2 consecutive BP < 140/90 mmHg
- Clinician confirms patients eligibility for RPCs
- Patient voluntarily opts for RPC options
- No current TB or medical condition requiring regular consultations

It is possible to integrate HIV & NCD service delivery at both facility & community level.



Source: CCMDD, October 2021

- All three models are supported by pre-packed medications. Many clients receive their medicines via CCMDD (Central Chronic Medicine Dispensing and Distribution)
- 60% of patients at Ext-PuP has reached the target of 60%
- FAC-PUP achieved its target with most clients from AC collecting medication through FAC-PUP due to limitations of Covid-19 lockdown regulations discouraging social gatherings

Type of Data Element	Facility pick-up point (FAC-PuP)	Adherence club	External pick-up point (Ex-PuP)	TOTAL
ART + other chronic meds <i>(CCMDD, October 2021)</i>	658 671	500 590	1 486 684	2 645 945
Chronic meds only <i>(CCMDD, October 2021)</i>	144 747	186 513	225 365	556 625
TOTAL	803 418	687 103	1 712 049	3 202 570

South Africa progressed from 36% (800 000) patients in Jan 2020 to 60% (over 1 700 000) patients in the external pick-up points 2020/21

Key Take Aways

- **Need to integrate NCD services into HIV services, and to integrate NCD/HIV services into routine primary health care activities**
- **This integration should occur both at facility & community level to bring services closer to the clients**
- **We need to continue to innovate on how to further bring these services closer to the clients**
- **Continue to empower clients to take charge of their health**

HIV PREVENTION & Testing Services



Factors associated with sexual exploitation & transactional sex among adolescent girls & young women: VAC survey 2017

Alex, Sciarratta, Zimbabwe, ICASA

Characteristic variable	Ever had transactional sex (weighted)
Total in study population	4.2%
Islamic/traditional/no religion/other	6.6%
Engaged in work for at least one hour during the previous week	5.9%
Never married	7.7%
Never pregnant	5.8%
Early sexual debut (before age of 15)	7.8%
Ever drank alcohol in lifetime	10.9%
Drunk in the previous 30 days	11.5%
Mental health distress in the previous 30 days	6.8%
Infrequent condom use in the previous 12 months	12.7%
Had multiple sexual partners in the previous 12 months	38.1%
Ever had symptoms of or diagnosed with a sexually transmitted infection (STI)	7.9%
HIV-positive	11.2%
Experienced any violence in lifetime	8.0%
Experienced sexual abuse or violence in lifetime	9.7%

Characteristic variable	Adjusted Odds Ratios (95% CI)
Islamic/traditional/no religion/other	1.83 (1.06-3.16)
Engaged in work for at least one hour during the previous week	1.90 (1.16-3.11)
Ever drank alcohol in lifetime	2.21 (1.14-4.29)
Mental health distress in the previous 30 days	1.70 (1.09-2.66)
Infrequent condom use in the previous 12 months	3.41 (1.79-6.49)
Had multiple sexual partners in the previous 12 months	5.83 (3.00-11.33)
HIV-positive	2.65 (1.21-5.81)
Experienced any violence in lifetime	2.61 (1.49-4.59)

There is need to scale up & strengthen HIV prevention interventions for AGYW, with focus on those with multiple sexual partners, infrequent condom use, and those experiencing violence of any form

HIV & Key populations in WCA; experiences, service provisions, policies & best practices

J Roma-Reardon et al, ICASA

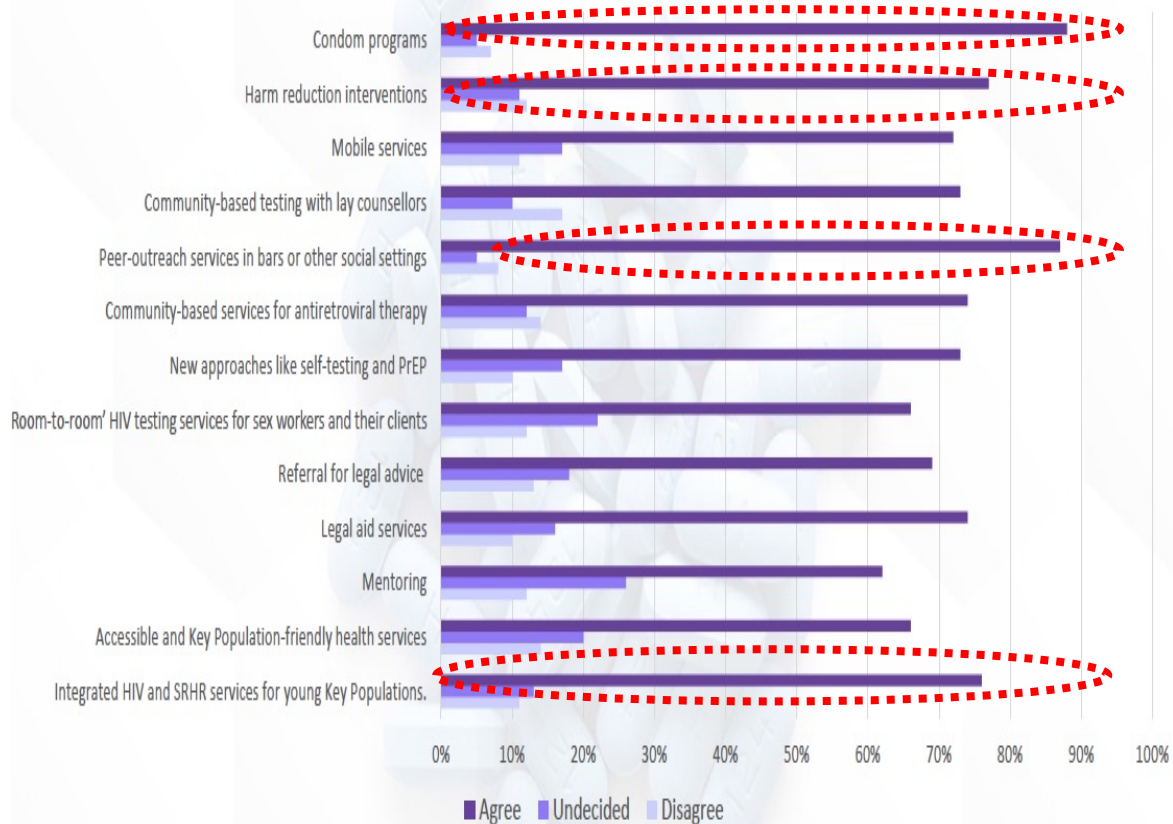
- **Objective:** Capture a realistic picture of experiences of Key populations & efforts to provide HIV/STI/, SGBV & SRHR services in 23 countries in WCA
 - Theme 1: Experiences, needs, barriers & enablers, data & information
 - Theme 2: Service provision-roles of KP CSOs, gaps in service provision, KAPs, law enforcement & funding
 - Theme 3: Policies, strategies and plans
 - Theme 4: Best practices to support service delivery

Methods

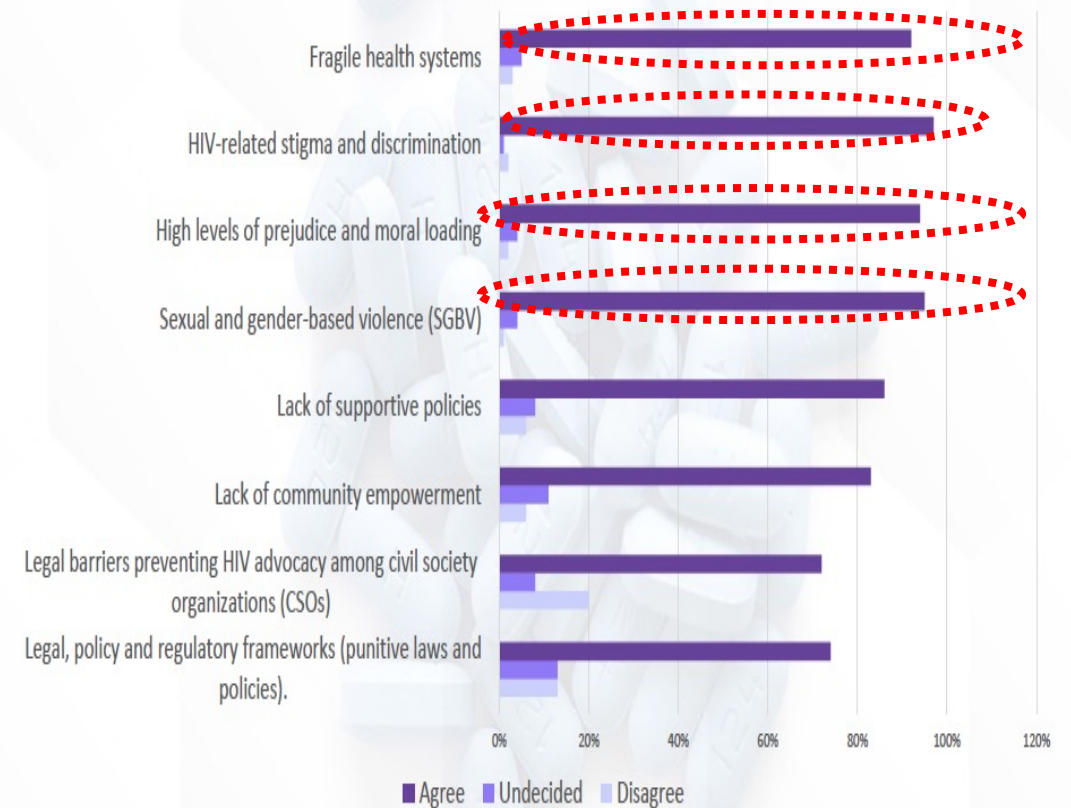
- Conduct a desk review
- Online questionnaire focused on the 4 themes in English, French & Portuguese
- Questionnaire was sent to 377 key stakeholders working with KPs in 23 WCA countries
- Cape Verde, Central African Republic, Gambia, Niger, Sao Tome & Principe did not participate

Needs and key barriers for Key Populations in WCA

Needs of key populations in terms of HIV/STIs, SGBV and SRHR programs and services

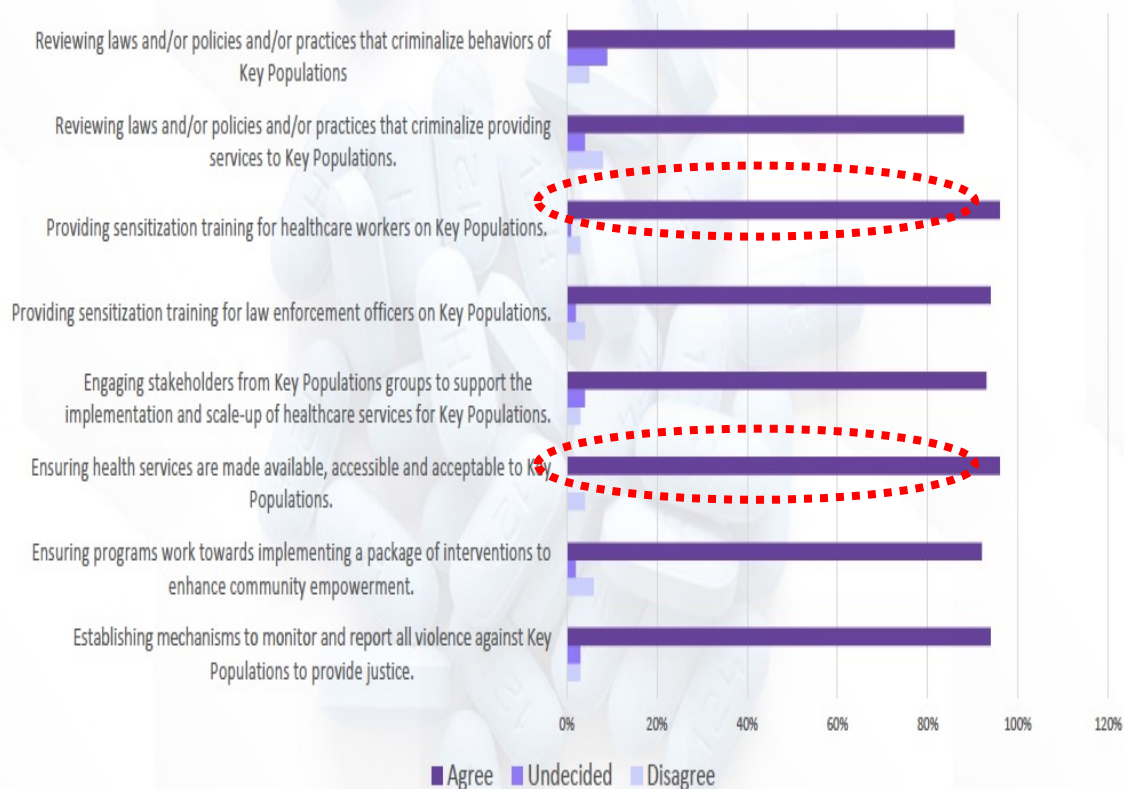


Barriers affecting the responses of key populations to HIV/STIs, violence and other human rights abuses

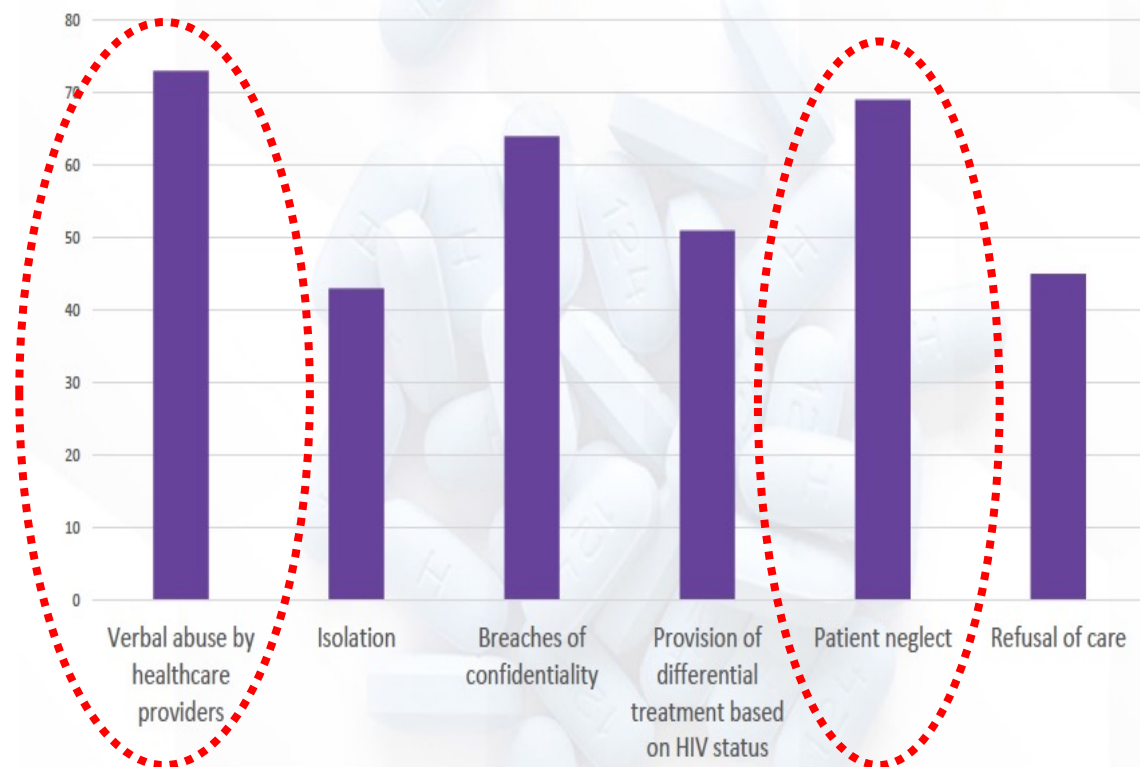


Sensitization training for health workers & providing access to services were the main enablers

Enabling factors affecting the responses of key populations to HIV/STIs, violence or other human rights abuses



Issues experienced by key populations in healthcare settings



Pink Day Youth Friendly Services: Promoting Uptake of SRH/HIV services among AGYW in Zambia

Kawina Paul Poho et al, Zambia, ICASA

- 32% of adolescent girls aged 15-17 years & 60% of those 18-19 years are sexually active
- 40% condom use at last encounter
- Charles Drew University implementing the Rise up project to identify root causes of HIV risk behaviour among AGYW
- Project implementing a Pink Day where AGYWs come in to access SRH, HIV & PSS services through peer-peer sensitization & FGDs

Characterisitc	Results
Enrolments & screening for HIV for negative or with unknown status	9,602 to 15,811
Eligible for testing	8,506
Tested positive	3,309 (39% yield)
Virally suppressed	3,189 of 3,309 (96%)

Lessons Learned

1. Demand creation increases uptake of SRH/HIV services
2. Need for a one-stop SRH/HIV centers
3. Need for capacity building to expand youth friendly services at the grass roots

Preferences & Uptake of Oral PrEP among AGYW in Kampala, Uganda

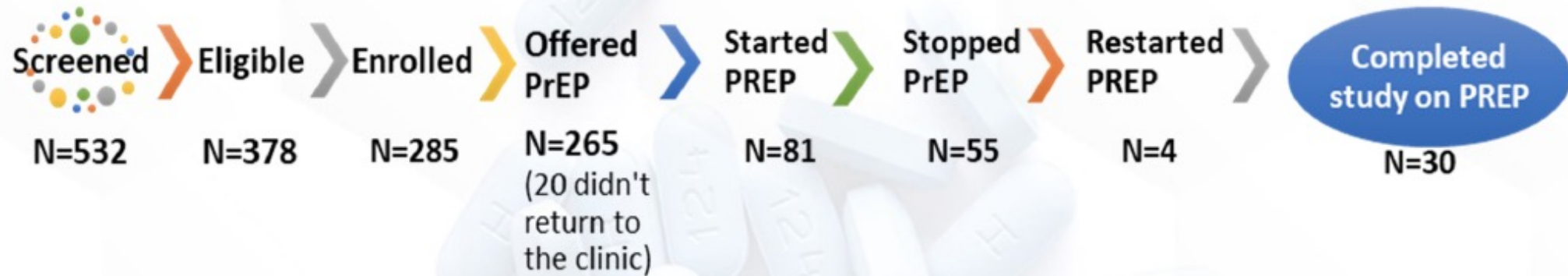
Yunia Mayanja, Uganda ICASA

- 24 months prospective cohort among AGYW 14-24 years
- Enrolled 285 HIV negative AGYW who reported sex work
- Active recruitment for 9 months using project mobilisers & peer-led approach
- Quarterly f/up visits: each volunteer f/up for 12 months
- Quantitative & Qualitative data collected
- Volunteers educated on biomedical product & thereafter assessed for preference
- Product rank: 1 – most preferred & 5 – least preferred
- Optimal adherence > or equal to 90%; missing up to 3 pills a month

Characteristics	Results
Mean age	20 years (SD+/- 2.2)
Reported paid sex	92.2%
Reported = or > 10 sexual partners in past 3 months	20.4
Used hormonal contraceptives (Injectables or implants)	38.5%
Had chlamydia, gonorrhoea &/or active syphilis	26.9%
Volunteer preference for oral PrEP among top 2 scores	47.6%
Uptake of oral PrEP	81 of 265 (30.6%)

These results highlight a great need for HIV preventive services tailored to the needs of AGYW

Oral PrEP Cascade



184 declined PrEP due to: low HIV risk perception (**33.7%**); dislike for daily pills (**27.2%**); not being ready (**21.7%**); preference for other methods (12.5%) e.g., condoms, concern about side effects (2.7%) and stigma (2.2%).

Factors Associated with PrEP Uptake

Variable	Categories	n (%)	Unadjusted RR (95% CI)	LRT p-value	Adjusted RR (95% CI)
Age at enrolment (years)				0.382	
	14-19	28 (27.5)	1.00		1.00
	20-24	53 (32.5)	1.18 (0.81-1.74)		1.07 (0.74-1.54)
Marital status				0.009	
	Single (never married)	45 (29.6)	1.00		1.00
	Married	17 (22.4)	0.76 (0.46-1.23)		0.88 (0.56-1.39)
	Separated / divorced	19 (51.4)	1.73 (1.16-2.58)		1.55 (1.04-2.33)
Number of sexual partners in past 3 months				<0.001	
	1	9 (11.0)	1.00		1.00
	2-9	39 (30.2)	2.75 (1.41-5.39)		2.36 (1.20-4.63)
	≥10	33 (61.1)	5.57 (2.90-10.7)		4.70 (2.41-9.17)
Condom use with sexual partners in past 3 months				0.001	
	No	11 (15.5)	1.00		
	Yes	70 (36.1)	2.33 (1.31-4.14)		
Frequent travel from home in past 3 months				0.024	
	No	39 (25.2)	1.00		-
	Yes	42 (38.2)	1.52 (1.06-2.18)		
Preference for oral PrEP				0.002	
	Not preferred (score 3, 4 or 5)	31 (22.3)	1.00		1.00
	Preferred (score 1 or 2)	50 (39.7)	1.78 (1.22-2.60)		1.53 (1.08-2.19)
Had STIs (chlamydia, gonorrhea, active syphilis)*				0.652	
	No	57 (29.5)	1.00		-
	Yes	23 (32.4)	1.09 (0.73-1.63)		

Summary of PrEP Adherence

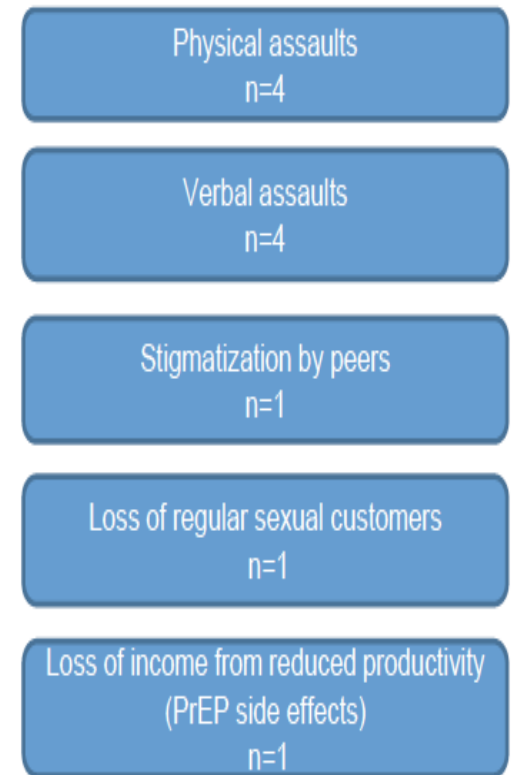
Plasma TDF levels and self-reported adherence	Time on PrEP (months)			
	1-3 months	4-6 months	7-9 months	10-12 months
	n (%)	n (%)	n (%)	n (%)
Total Persons on PrEP	45	33	27	30
Total persons tested	42	24	18	16
Assay results				
Below detection threshold ($\leq 10\mu\text{g/L}$)	31 (73.8)	18 (75.0)	19 (94.4)	15 (93.8)
Quantifiable; not protective ($>10\mu\text{g/L}$ to $\leq 40\mu\text{g/L}$)	8 (19.1)	6 (25.0)	1 (5.6)	1 (6.2)
Quantifiable; protective ($>40\mu\text{g/L}$)	3 (7.1)	0 (0)	0 (0)	0 (0)
Self-reported adherence				
Sub-optimal adherence ($<90\%$ score)	9 (21.4)	3 (12.5)	3 (16.7)	4 (25.0)
Optimal adherence ($\geq 90\%$ score)	33 (78.6)	21 (87.5)	15 (83.3)	12 (75.0)

Social Harm related to PrEP use among AGYW in a PrEP demonstration project in Uganda

Winfred Nasalire et al, ICASA

- Prospective cohort between Dec 2017 & July 2019
- Enrolled AGYW sex workers aged 18-24 years
- Initiated on oral PrEP (TDF/3TC)
- F/UP: Every month for first 3 months, thereafter every 3 months
- Data collected: adverse events, adherence, sexual behavior & social harm (during scheduled or unscheduled visits or calls)
- Of 848 enrolled participants, 11 reported PrEP-related social harm (3.10 per 100 person years, 95% CI, 1.72, 5.60)
- 10 events were as a result of mistaking PrEP for ART & suspecting the participants as HIV positive
- An additional event involved loss of income due to PrEP side effects
- 45% (5/11) who experienced social harm chose to exit the study, 6 continued without further event
- All participants were provided with counselling services

Figure 3: PrEP-related social harms observed among participants initiated on oral PrEP



Successful return of Clients Results after an HIV-Self test: The role of peers in southern highlands, Tanzania

Abele Ngwalle et al, ICASA

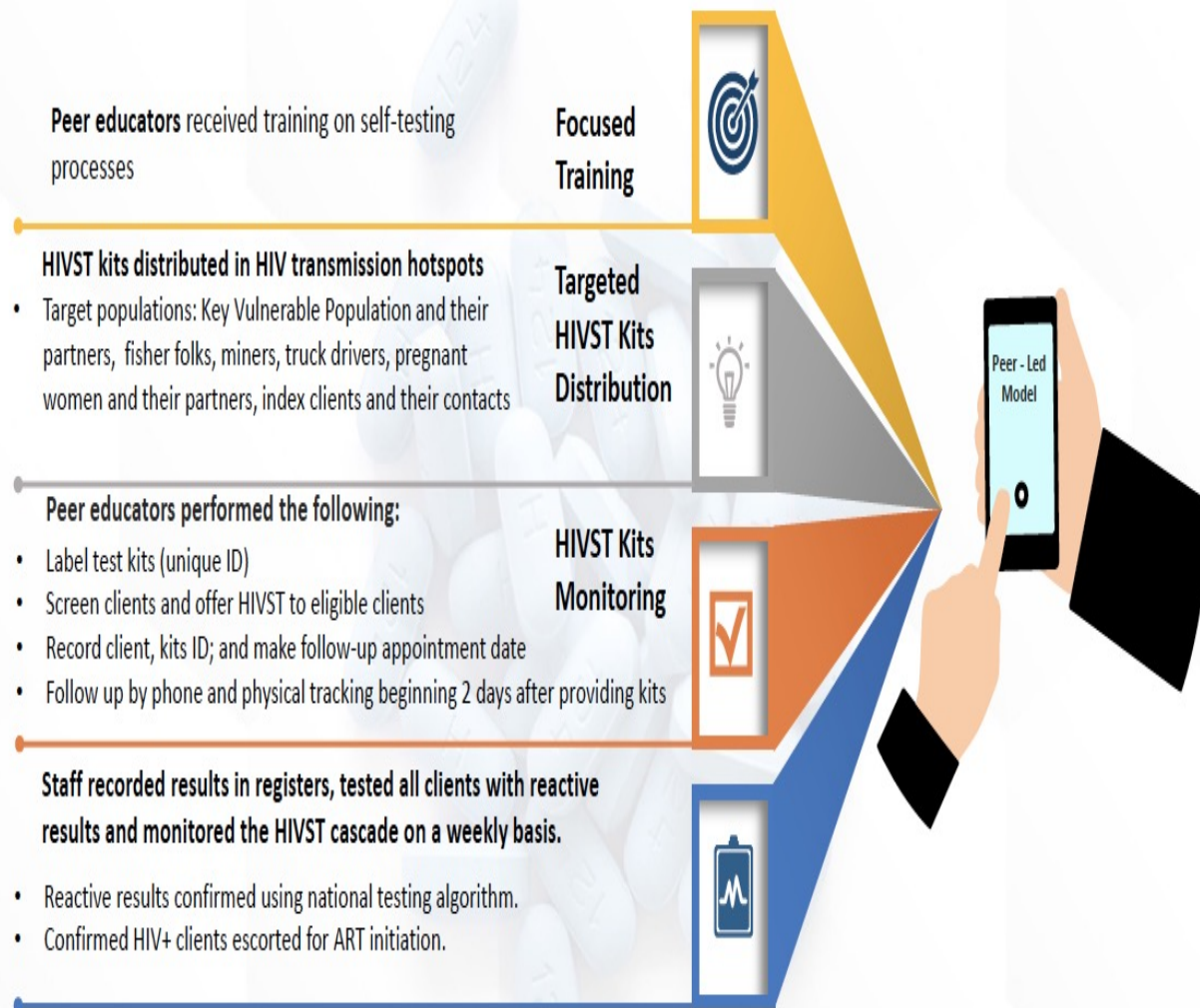
Challenge: How can HIV programs track the use of HIVST kits?



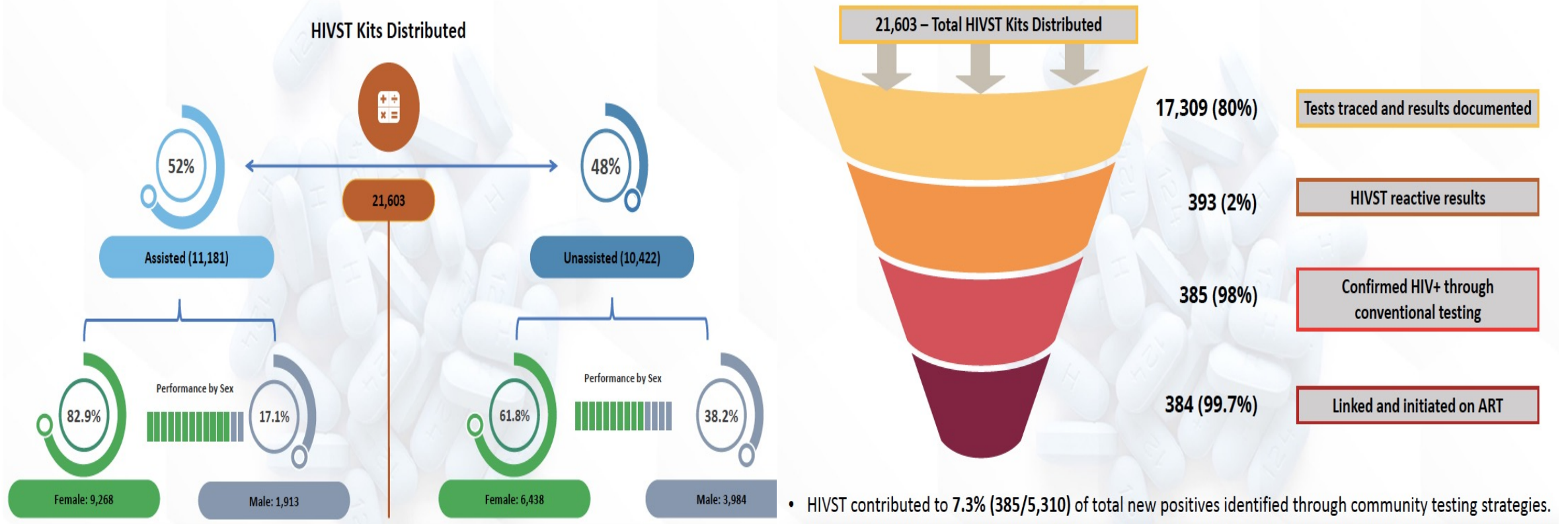
The inherent challenge of HIVST

“Distributing HIV Self-Tests is easy... we know that people want these tests. What is difficult is trying to piece together what happens to a test and to a tester once they have left and test in private”

Source: HIVST monitoring and evaluation guidance for HIV programmes, September 17th, 2020



98% successful return rate for HIV status confirmation following peer distribution of kits and 99.7% linked and initiated on ART



Peer-led HIVST kit delivery should be considered at facility level & may further increase identification of undiagnosed PLHIV who may be missed by the conventional HIV testing approaches

Key Take Aways

- **Strengthen the integration of SRH/HIV services and to strengthen adolescent friendly services to make services more accessible to adolescents**
- **Uptake of oral PrEP remains low among AGYWs at risk of acquiring HIV infection. New strategies to address this gap are required**
- **Need strategies needed to address low PrEP uptake including addressing PrEP-related social harm**

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Thank You

