The CQUIN Learning Network

Adolescents Living with HIV: National Guidelines, Minimum Package, Challenges and Priorities Swaziland

Ms Nobuhle Mthethwa
MOH- SWAZILAND
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Presentation Outline

• Epidemiology of ALHIV
• Viral suppression in adolescents living with HIV
• Treatment for adolescents living with HIV
• Transitioning to adulthood
• Referrals
• DSD Models
• Challenges for ALHIV
Kingdom of Swaziland

- Population – 1.2 million
  - 52% Population <20yrs
  - 79% lives in rural areas
  - Teenage pregnancy rate 16.7%
  - Number of adolescents living with HIV 10-19yrs are 8,213

- 4 Administrative Regions
  - 55 Constituencies
  - 360 Chiefdoms (basic unit of the community.)
Adolescents in Swaziland

1.5 billion people in the world are between the ages of 10-25.

Swaziland’s population is relatively young with 39.6% under 15 years of age and 52% younger than 20 years.

Approximately 14% of girls aged 15 – 24 years had HIV with females more infected than men (22.9% vs 5.9% respectively).

3.8% of young girls started sex before their 15th birthday compared to boys at 2.6%.

22% of women 20-24 years of age reported to have had their first live birth before their eighteenth birthday.

All adolescents and young people require safe, effective, affordable and acceptable access to a range of services – particularly services related to pregnancy, HIV and STI prevention, testing and treatment.

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Task shifting to scale up access to care and treatment services for ALHIV

- Guiding principles
  - Quality of care
  - Access to services (Universal Access)
  - Integration of Health services
  - Strengthening of HR capacity

Cadres:
- HTS by Lay Counsellors
- ART initiation by nurses
  - > 70 % in PHC
- M2M, ECs
  - Adherence counselling, support, defaulter tracing & linkage to care
- MNCH Promoters
  - ANC, FP, EID, BF etc.
HTS Volume, Positivity Rates and Yield by Age/Sex, National, Q2 2017

Sources: HMIS HTC Data, 2017 Q2.
## Pediatric New ART Initiations (Q2-2017) < 19 yrs.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Hhohho</th>
<th>Shiselweni</th>
<th>Manzini</th>
<th>Lubombo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>&lt;1yr</td>
<td>6</td>
<td>10</td>
<td>10</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>1-4yrs</td>
<td>12</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>5-9yrs</td>
<td>10</td>
<td>6</td>
<td>15</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>10-14yrs</td>
<td>15</td>
<td>15</td>
<td>19</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>15-19yrs</td>
<td>72</td>
<td>15</td>
<td>53</td>
<td>6</td>
<td>83</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>53</td>
<td>103</td>
<td>25</td>
<td>150</td>
</tr>
</tbody>
</table>

**Sources:** HMIS PMTCT Data, 2017 Q2.
Current on ART Children and Adolescents < 19yrs (n= 13815) Q2,2017

- <1 yrs: 323 (2.30%)
- 1-4 yrs: 1735 (12.60%)
- 5-9 yrs: 3544 (25.70%)
- 10-14 yrs: 4276 (31%)
- 15-19 yrs: 3937 (28.40%)
- Grand Total: 13815 (100%)

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Current on ART Children and Adolescents < 19yrs (n= 13815) Q2,2017

Current on ART Children and adolescent (<19 yrs) 2017

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Viral Load Testing by Age-Group Q2 2017

VL testing by Age Group

- # of VL Tests
- # of suppressed VL Tests
- % of VL tests
- % VL suppressed

(a) <1
(b) 1-4
(c) 5-9
(d) 10-14
(e) 15-19

- 6089
- 5377
- 702
- 79%
- 77%
- 73%
- 79%
- 80%
- 5%
- 2%
- 3%
- 2%
SHIMS 2, 2016 Population of PLHIV with Viral Load <1000 cp/mL by Age and Sex

* Denominator is all PLHIV with viral load results (irrespective of awareness of HIV positive status and ART status.)

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Viral Load Monitoring in Children and Adolescents

In 10 – 19 year old patients, VL should be done every 6 months.
Treatment of ALHIV: Guideline recommendations 2017/18

– Test and start
– CTX prophylaxis
  • Discontinue after 1 year on ART
    – WHO T1 & T2, VL < 1000 c/ml, CD4 > 350
– ATV/r recommended for 2\textsuperscript{nd} line regimens
  • LPV/r- alternate
– Transitioning of adolescents to adult care
– Psychosocial issues
  • disclosure, caregiver involvement, SUAC package
– Differentiated care
– 3\textsuperscript{rd} line Regimens (since 2014- “New Horizons”)
Guideline recommendations: 1st line ART 2010-2018

<table>
<thead>
<tr>
<th>UNDER 2 YEARS</th>
<th>2–11.9 YEARS</th>
<th>12 YEARS AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVP-exposed</td>
<td>NVP-exposed</td>
<td>Regardless of NVP exposure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>&lt; 3 Years</th>
<th>3 to &lt;5 years</th>
<th>≥5 to 12 Years And Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>NVP-exposed</td>
<td>Not NVP-exposed</td>
</tr>
<tr>
<td>Preferred</td>
<td>ABC + 3TC + LPV/r</td>
<td>ABC + 3TC + LPV/r</td>
</tr>
<tr>
<td>Alternative</td>
<td>AZT + 3TC + LPV/r</td>
<td>AZT + 3TC + LPV/r</td>
</tr>
</tbody>
</table>

Recommended First line > 12 years (> 40kg) 

**TDF-3TC-DTG**
Transitioning to adulthood

Key components to support for ALHIV during the transition process include:

• Provision of adolescent friendly services
• Support Self-management of medication and appointments
• Understanding results of monitoring (Viral load)
• Provision of Psychosocial support (relationships, employment, education, etc.)
• Supported disclosure (HCWs, peers and family)
• Identification of developmental changes
Referral Services

• Intra facility:
  – Care and treatment services (ART, PMTCT, TB)
  – SRH services (FP, Cacx screening)
  – Peer support (Teen clubs)
  – Services are fully integrated at all levels of the care system.
  – Psychosocial support

• Inter-facility
  – Psychological care
  – Social services
  – 3rd line treatment
Models of ART delivery

1. Mainstream care

2. Fast track/ drug pick up

3. Community based ART groups (CAGs)

4. Facility based Treatment clubs (TCs)

5. Outreach model

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Treatment clubs for adolescents

Inclusion criteria

- Alignment with the age criteria within the groups in each club (10-15 years, 16-19 years)
- Full disclosure
- On the same ART regimen for at least 6 months (first or second line)
- Client has been refilling in the same facility for at least 6 months.
- **No clinical, immunological or virological failure**
- ARV regimen is well tolerated

Exclusion criteria

- Pregnant or lactating adolescent
- Failure to get assent from child and consent from care giver if client <18 years old
- Presence of comorbidities e.g. TB, mental health problems, substance abuse or any condition deemed significant by the medical officer or nurse
Treatment clubs: Teen Clubs

• All children on treatment are registered in the teen clubs
• Meet monthly for Peer support +/- drug pick up
  – 2-3 month drug refills (stable patients)
• Adherence support
• Structured Teen club curriculum
• Integrated services (IPT, FP services)
• Grouping according to age group
• Youth empowerment (Teen champions)
• Care giver engagement
• Social worker support (limited facilities)
Treatment clubs for adolescents

• Similar running as adult groups
  – Emphasis on adolescent dynamics
  – Emphasis on viral suppression
  – Emphasis on prevention:
    • New/re-infections
    • Unwanted pregnancies
Treatment clubs: Family centered care (FCCM)

- An HIV positive child and adolescent (0-19 years) is provided HIV care and treatment services with at least one family member involved in the support for the child.
- The model also promotes family HIV testing through actively offering HIV testing services to all family members of the index HIV positive child.
- A family member is defined as someone who is related to the child either by blood or adoption; or someone residing in the same household with (responsible for the index child).
Priorities of ALHIV

• Optimum Health
• Disclosure
• Adherence
• Simpler Regimens
• Retention
• Continued Counselling
• Psycho social support
• Psychological support
• Hope, career guidance and a vision for the future
Challenges:

- Disclosure
- Pill fatigue
- Poor virological suppression
- Teen age pregnancy
- Stigma and discrimination at home school and community
- Advanced disease
- Longer term options for treatment
  - access to new drugs and formulations
- Transitioning to adult care
CQUIN Network Contribution

• Leveraging from other countries experiences in development of systems and tools to support adolescent differentiated care
• TA in monitoring and evaluation of adolescent differentiated care and supporting parents and caregivers in ongoing care of adolescents
• Sharing experiences in attaining the 95-95-95 Global targets for children and adolescents
• Inclusion of the adolescents in workshops for advocacy purposes.
Siyabonga