

The CQUIN Learning Network

Differentiated Service Delivery for Adolescents Living with HIV

Meeting Summary



October 25-27
Johannesburg, South Africa



HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

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Executive Summary

Background

In March 2017, the HIV Coverage, Quality and Impact Network (CQUIN) convened member countries to form a learning network to advance the scale-up of differentiated service delivery (DSD) for HIV. CQUIN is designed to support knowledge exchange and co-creation of resources and tools; it is a demand-driven network responding to participant needs and interests. At the launch meeting in March 2017, DSD for adolescents living with HIV (ALHIV) was among the top three priority areas identified by member countries.

In response, CQUIN convened an ALHIV DSD community of practice (CoP) to foster south-to-south exchange. The ALHIV DSD workshop launched the CoP, which will include post-workshop virtual convenings, south-to-south exchange visits, and ongoing collaborative work to develop shared resources, guidelines and tools.

The ALHIV DSD community of practice is the third CoP launched by CQUIN, following CoPs focusing on monitoring and evaluation (M&E) of DSD and on DSD for patients at high risk of HIV disease progression (P@HR).

Meeting Dates and Objectives

The ALHIV DSD workshop was held in Sandton, South Africa from October 24th to 27th, 2017, with the goal of launching CQUIN's ALHIV DSD community of practice. The main objectives were to:

- Share experiences on the “how” of DSD design and implementation for ALHIV
- Share resources and existing tools on DSDM for ALHIV
- Work together to develop tools and frameworks related to DSD for ALHIV

Meeting Participants

The meeting brought together participants from the nine CQUIN member countries (Ethiopia, Kenya, Malawi, Mozambique, South Africa, Swaziland, Uganda, Zambia, and Zimbabwe) as well as representatives from Côte d'Ivoire. Sixty-nine participants attended the meeting, of whom 51 were from the member countries. Other participants included representatives from ICAP New York, the Bill & Melinda Gates Foundation, the International AIDS Society (IAS), and the Global Fund.

Country teams were led by representatives from the ministries of health and included representatives from the U.S Agency for International Development (USAID), the U.S Centers for Disease Prevention and Control (CDC), Médecins San Frontières (MSF) and implementing partners such as ICAP, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), FHI-360, Baylor University, The Centre for Infectious Disease Research in Zambia (CIDRZ), and University Research Co. (URC), among others. Civil society representation included The AIDS Support Organization (TASO) from Uganda, Family AIDS Care and Education Services (FACES) from Kenya, and six ALHIV.

Key Issues Presented/Discussed

Dr. Elaine Abrams, ICAP senior research director, set the stage for the three-day workshop. She defined adolescence as a transitional stage of physical and mental development that occurs between childhood and adulthood, emphasizing the significant changes that occur, including physical, emotional, and social development. Because of these changes, adolescents are prone to risk taking, which may affect behaviors such as adherence to lifelong treatment. Dr. Abrams explained that HIV creates additional burden and stress to adolescents during a period when they are going through serious transitions in life.

She highlighted the gap in reaching the 90-90-90 targets for adolescents because of these challenges, and the fact that in most settings, community, families and health systems are not aligned to support this transition phase from adolescence to adulthood, particularly for those with HIV.

In conclusion, Dr. Abrams stated that it is critical to optimize outcomes for adolescents and young adults by addressing the legal framework, and providing progressive policies and guidelines; optimal treatment regimens; access to services via differentiated models; well trained, respectful health providers; integrated sexual and reproductive health; integrated behavioral and mental health services; and a service package that is inclusive of family, friends, and peers.

The workshops included five panel presentations, plenary presentations, two country breakout sessions, a vibrant debate on whether or not to offer school-based HIV services for adolescents, and breakout sessions for tool development. Swaziland, Mozambique, South Africa, Zambia, and Ethiopia shared information on national guidelines for adolescents, including the minimum package, challenges, and priorities. Uganda, Zimbabwe, and Malawi shared their legal framework for testing, treatment, DSD, transitioning adolescents to adulthood, and related challenges and priorities. Unfortunately, Kenya's Ministry of Health was unable to join the meeting because of a travel ban for government staff due to elections.

One of the key activities at the workshop was the joint work to co-create tools and resources for adolescent DSD. During breakout groups, participants prioritized four issues: 1) adolescent friendly language for health care workers (HCW) providing youth friendly services; 2) eligibility recommendations for DSD specific to adolescents; 3) a checklist for pre- and post-transition from adolescent to adult treatment services; and 4) M&E tools to track adolescent services and monitor quality.

Common/Cross Cutting Issues and Challenges

- Although adolescents spend most of their time at school, most countries have policies that prohibit provision on HIV-related services in school.
- Countries lack tools for following up adolescents as they move from adolescent services to adult services and there is no way of tracking their outcomes.
- Although most countries have adolescent-specific care models, only Malawi and Zimbabwe have taken these models to scale.
- No country has defined quality measures for adolescent-specific care models, so it is difficult to measure the quality of services in these models.

Key Outputs

- A draft framework was developed for an adolescent and young people’s “bill of rights” and a language framework for healthcare workers to answer sensitive and common sexual health questions
- A draft transition checklist from adolescent to adult care was developed and will be completed after the meeting by the youth technical assistance virtual CoP
- A draft framework was developed on eligibility tools to guide providers in deciding which DSD model is appropriate for ALHIV
- Action plans were submitted by all nine countries on lessons learned and issues to prioritize in order to advance DSD for ALHIV
- The M&E tool development group recommended implementing unique identifiers and creating finer age disaggregation as part of efforts to improve monitoring and evaluation of adolescent DSD models
- A DSD dashboard was submitted from the nine countries on the current status of DSD implementation scale-up in their respective countries

Next Steps

- Convene Adolescent CoP as virtual group to complete the transition checklist
- Share the main issues affecting M&E for adolescent DSD models with the existing M&E CoP
- IAS was tasked with collaborating with youth advocates to finalize a HCW FAQ for youth and adolescent friendly language and the young people’s “bill of rights”
- Follow up with network countries on action plan implementation during CQUIN country visits
- Support countries to engage in south-to-south visits to take adolescent DSD models to scale
- Share key issues from adolescent workshop at the CQUIN annual meeting

Introduction

Background

The Coverage, Quality and Impact Network (CQUIN) was launched by ICAP at Columbia University in March 2017. The Bill & Melinda Gates Foundation funds the network, whose overarching goal is to increase the coverage and quality of differentiated HIV services, leading to enhanced health outcomes and programmatic efficiencies, through demonstration of successful differentiated service delivery (DSD) models and provision of technical assistance to network members. At the launch meeting, DSD for adolescents living with HIV (ALHIV) was one of the areas of interest to country members and was prioritized as a community of practice (CoP).

Countries have made significant progress towards the UNAIDS target of 90-90-90 to achieve epidemic control. However, results from the [Population HIV Impact Assessments \(PHIA\)](#) highlight the disparity in treatment access among adolescents, and the low rates of viral suppression among this age group in all the countries that have published results. In Zimbabwe, Malawi, and Zambia, the PHIA showed that 46.4% of ALHIV knew their HIV status; 82.3% were on antiretroviral therapy (ART); and 79.3% were virologically suppressed, compared to 77.8%; 90%; and 89.8% for adults aged 35-59 years. These results point to the need to optimize treatment for adolescents in order to improve outcomes.

As countries scale up treatment for all, DSD has been proposed as a means to achieve the 90-90-90 goals. DSD models (DSDM) for stable adults have been implemented in multiple countries, but few of these models include adolescents, and most do not address the unique medical and psychosocial needs of ALHIV. In November 2016, WHO convened a group to review DSDM for specific populations including adolescents, noting that the majority of DSDM for ALHIV address the “what” of DSD for ALHIV, not the “how” (*e.g.*, they described the package of services to be delivered, but not the frequency, intensity, location, or health care worker cadres delivering this package).

The WHO review highlighted the fact that most DSDM for ALHIV are pilot or demonstration projects that have not yet been taken to scale. In July 2017, the WHO released [key considerations for differentiated ART delivery for children and adolescents](#), while IAS revised and [launched a decision framework for DSD for ALHIV](#), highlighting a systematic approach to designing adolescent DSD programs for specific contexts and communities.

As a demand-driven network, CQUIN launched this CoP on DSD for ALHIV in response to the priority needs of the CQUIN countries. Priority questions included:

- Which models can be scaled up to attract and retain more adolescents?
- How can existing programs be leveraged to provide adolescent-focused DSD?
- How can programs ensure a smooth transition of adolescents into adult DSDM?
- How can quality adolescent DSD services be maintained?

Objectives

The main objectives were to:

- Share experiences on the “how” of DSD for ALHIV
- Share resources and existing tools on DSDM for ALHIV
- Work together to develop tools and frameworks related to DSD for ALHIV

Meeting Agenda

The workshop was held from the evening of October 24 through October 27. Diverse formats were used to share best practices, common challenges, and areas for co-creation of resources and tools. The methods employed plenary sessions, panel presentations, breakout sessions, and a debate. National programs, implementing partners, and topic experts shared presentations. Adolescents were also given a platform to share their expectations of service delivery, as well as their personal experiences.

Opening Reception

Dr. Batanayi Muzah

Acting Country Director, ICAP South Africa

Dr. Muzah welcomed participants to the meeting, and thanked representatives from all nine CQUIN countries for attending. He told a story about his days as a clinician, when he started an HIV clinic in rural Namibia and established close relationships with several adolescent patients. He talked about the importance of providing the same quality care to adolescents and young people as adults.

Dr. Muzah concluded by explaining the great opportunity everyone had to learn from the adolescents participating in the meeting. He urged participants to deliberate fruitfully, accept feedback, and come up with things that are meaningful over the next three days.

A complete transcript of Dr. Muzah's remarks is available in the Appendix.

Dr. Zukiswa Pinini

Chief Director, HIV/AIDS, STI, National Department of Health (NDOH), South Africa

Dr. Pinini began her remarks by referencing a classic phrase used by people living with HIV – “Nothing about us, without us” – and how it relates to adolescents living with HIV. She explained, “Adolescents and young people are now saying that we must understand them in order to deliver the care they need.”

Dr. Pinini acknowledged the presence of all MOH staff from all nine countries, as well as the leadership from ICAP, USAID, the Bill & Melinda Gates Foundation, PEPFAR, and CDC.

She noted that this meeting comes at a crucial time in South Africa, as the country has just launched its National Strategic Plan (NSP) for HIV, TB, and STIs, 2017-2022 and is working toward reaching the UNAIDS 90-90-90 targets. “There are many adolescents infected with HIV/AIDS, and yet, they are lost between pediatric and adult care,” she said. “I know that some of our partners in South Africa are assisting us in addressing this issue, but we need to scale up our practices.”



A complete transcript of Dr. Pinini's remarks is available in the Appendix.

Dr. Elaine Abrams

Senior Director of Research, ICAP at Columbia University

Dr. Abrams gave an overview of the CQUIN learning network and a preview of what participants would see over the course of three days at the workshop. The focus of Dr. Abram's presentation was to provide an overview of the registration survey and frame the discussion for the workshop. She showed data from the survey, which included 59 responses from 11 countries. Respondents answered questions about policy support for DSD for ALHIV in their countries; the extent to which HIV treatment guidelines addressed DSD for ALHIV; and the extent to which DSD for ALHIV is implemented in their countries, among others.

Dr. Abrams concluded by stating the goal of the workshop: to launch the CQUIN adolescent community of practice by covering the nine CQUIN countries to share experiences on the "how" of DSD for adolescents; share resources and existing tools; and work together to develop tools and frameworks related to DSD for adolescents and young adults.

A complete transcript of Dr. Abrams' remarks is available in the Appendix.

Mr. Prosper Ndlovu

LAS Differentiated Care Youth Champion for South Africa, WITS RHI

Mr. Prosper Ndlovu, WITS RHI

Mr. Ndlovu told his story of being a young person living with HIV, from the time he discovered he was positive in 2006 to the impact he is having as a youth advocate for young people living with HIV.



At first, he said, it was difficult to come to terms with his diagnosis. Taking medication became more difficult as he got older and his family's relationship strained. After his mother and father divorced, he had trouble coping in school, until a social worker invited him to a peer support group where he and fellow adolescents had discussions and educated one another about the issues they were facing living with HIV.

He attended a motivational-educational boot camp, which inspired him to become a motivational speaker and advocate. After matriculation, Mr. Ndlovu became a youth care club facilitator.

"People like me need youth-friendly services in a friendly environment," he said. "I don't define HIV like others do. I define HIV as 'Human Impact to Victory'. I believe that as human beings, it is our responsibility, our impact, to overcome the virus. When we overcome the virus, we become victorious.

HIV lives in me, but it is not in control of me. I am in control of HIV," he concluded.

A complete transcript of Mr. Ndlovu's remarks is available in the Appendix.

Welcome and Opening Remarks

Ms. Mokgadi Phokojoe

Director, Care and Support NDOH, South Africa

Ms. Phokojoe began by encouraging all participants to think back to the challenges they faced when they were teenagers, and to keep in mind what it felt like during that time of their lives throughout the entire week.

“When I was growing up, HIV was not around, and how lucky and fortunate we were,” she said.

“Unfortunately, our children that we are raising are exposed to all of the challenges we faced, on top of the challenge of HIV. We are going to use these three days to deal with how, as a collective of different countries, we will implement strategies to deal with the challenges adolescents face.”

Ms. Phokojoe acknowledged that each country was facing challenges providing care and treatment to ALHIV at all different levels. She stressed the importance of teamwork, and co-creation on the path to effective care and treatment for young people.

A complete transcript of Ms. Phokojoe’s remarks is available in the Appendix.

The CQUIN Learning Network: Communities of Practice

Dr. Peter Preko

CQUIN Project Director, ICAP at Columbia University

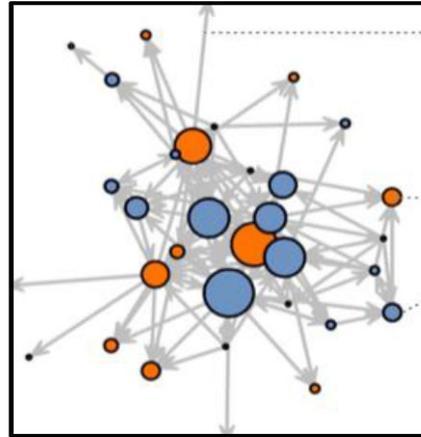
Dr. Preko explained the meaning of a learning network, and its role in the scale up and spread of DSD. He explained that it is more than simply an exchange of information; that CQUIN fosters south-to-south exchange and the ability for members to work together – virtually and in person – to learn and co-create.

Dr. Preko discussed learning exchange and joint-work as a catalyst for the scale up of DSD, collectively moving from pilots to scale up, utilizing the resources needed for success. He spoke about the key element of “just-in-time information” and gave an example from Mozambique, a CQUIN network country that is currently revising its guidelines, and developing a DSD implementation guide. “This network has helped them get information on which models they can add,” he said. “They have visited countries to learn from others what they are doing, and how they are doing it.”

Dr. Preko described the successful traits of learning networks, from focus goals aligning with policy priorities to effective external partnerships. CQUIN, he stated, has strong partnerships with PEPFAR, IAS, WHO, and others.

Expected Outcomes of CQUIN Network

- Access to robust multi-country learning network
 - High volume of knowledge exchange
- Rapid scale up of mixed models of DC by countries
- Increased enrollment of patients into models of preference
- CQUIN countries achieving true universal ART coverage
- Improved health and health system outcomes



Source:
http://www.path.org/publications/files/DHS_analysis_africa_rpt

Dr. Preko concluded by discussing the network’s catalytic projects, as well CQUIN’s achievements ranging from expansion to ongoing south-to-south visits and tool creation. He encouraged participants to visit the [CQUIN website](#) to find information on countries’ DSD activities, and find useful [tools and resources](#).

“CQUIN is about the ‘how’ of DSD,” he said. Looking to 2020, we want robust knowledge exchange, to share what we have with others, and ensure we have universal ART coverage. As a network, I hope we can learn from one another in the coming years so we can reach the 90-90-90 targets for all.”

A complete transcript of Dr. Preko’s remarks is available in the Appendix.

Adolescents Living with HIV: State of the Art

Dr. Elaine Abrams

Senior Director of Research, ICAP at Columbia University

Following up on her opening remarks, Dr. Abrams talked about ALHIV, specifically, who they are and how they are doing with regards to HIV case identification, treatment and viral suppression. Dr. Abrams cited important statistics that highlighted the epidemic among adolescents and young adults, and began to paint a picture of what successful scale up of DSD would look like.

She began by discussing the state of HIV epidemic, including the number of individuals living with HIV globally (36.7 million); the number of new infections (1.8 million); and the number of deaths attributed to HIV/AIDS in 2016 (one million). She also spoke about the success of ART scale up over the last seven to 10 years, noting that much more needs to be done, and that DSD can help make the leap to bend the curve to reach global targets.

Adolescents living with HIV, she stated, are a very heterogeneous population of individuals. Some have acquired HIV through behavioral factors; some have been born with the disease. Adolescents (10- 19 years) are a subset of young people (15-24 years) – those heading into adulthood.



Dr. Abrams noted that adolescence is a transitional stage of significant physical and mental development that occurs between childhood and adulthood, citing definitions of adolescence (WHO defines it as the period of life between 10 and 19 years). She was careful to note that young people are described as those 10-24 years of age, and that although “adolescence” is the term frequently used, we are actually talking about youth and a more inclusive definition of what a young person is. “All of the changes adolescents experience, along with the expectations we have of them are happening in the context of HIV infection and the adolescent brain,” she noted.

“While the prevailing theory is to blame many of the problematic behaviors adolescents exhibit – risky behaviors like substance abuse, unprotected sex, and antisocial acts – on the immature adolescent brain, an emerging and more optimistic theory suggests that this heightened attraction to novel experience is a normal developmental approach,” she said. “The ‘experience-seeking’ theory states that adolescents lack experience so they’re trying things for the first time.”

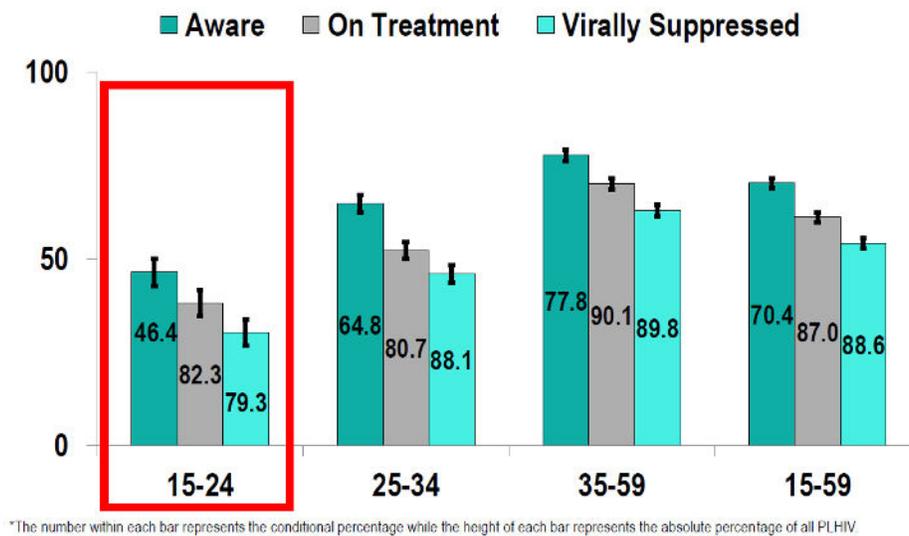
Dr. Abrams shifted focus to how adolescents living with HIV are doing. She cited statistics from the global summary of 2015, showing that an estimated 1.8 million adolescents globally are living with HIV, 90 percent of which are in sub-Saharan Africa. She also noted that of the 4,500 new daily infections, 37 percent are among young people age 15-24.

She also cited that, although there has been a decline in the number of annual new infections in adolescents, they are projected to increase over the next several decades. This is in response to “the

youth-bulge” – a swell in the overall population of young children – which will inevitably lead to more surviving into adolescence, placing them at risk of acquiring HIV infection.

Dr. Abrams discussed the [PHIA survey](#) results from Zambia, Zimbabwe, and Malawi, with rates of knowledge of status on the low end for those 15-24 years of age who tested positive. Overall, the surveys showed higher rates of 90-90-90 targets across the board, but lower rates of testing, knowledge awareness, ART, and viral suppression among adolescents.

Progress Toward 90-90-90 Among Adolescents & Adults 3-Country Combined: Zambia, Zimbabwe, Malawi



Additional data from the U.S. and sub-Saharan Africa also show low rates of viral suppression and ART adherence and among adolescents. Other factors such as psychiatric disorders and adverse childhood experiences can also put young people at increased risk for behavioral and substance use disorders contributing to HIV infection. Data show that a majority of adolescents living with HIV graduate high school, are working, have stable housing, and are in relationships.

“We need to think about the fact that adolescents have sexual lives, so sexual and reproductive health is quite critical,” Dr. Abrams stated. “There is huge demand for modern family planning methods in Africa for young women and it will be critical to consider this in our discussions. As the cohorts of young people living with HIV age in sub-Saharan Africa, we will certainly see many of these young women becoming pregnant.”

Deaths have declined significantly among all age groups with HIV, but somewhat less so for adolescents, she noted. Dr. Abrams concluded by painting a picture of DSD for adolescents living with HIV, and shared her checklist of essentials for effective adolescent DSD, such as good policies, accessible services, and integrated sexual and reproductive health care.

A complete transcript of Dr. Abrams’ presentation is available in the Appendix.

Panel 1: Adolescents Living with HIV: National Guidelines, Minimum Package, Challenges and Priorities

Dr. Gurpreet Kindra from CDC South Africa and Dr. Nicollate Okoko from FACES-Kenya moderated the first panel. Panelists presented overviews on the epidemiology of adolescent HIV, rates of viral suppression, treatment, and transition of care into adulthood. There was a specific focus on access to DSD models and challenges for ALHIV within the country context.

Panelists:

- **Ms. Nobuhle Mthetwa**, Pediatric ART Coordinator, MOH-Swaziland
- **Dr. Irenio Gaspar**, Care and Treatment Chief, MOH Mozambique
- **Ms. Mokgadi Phokojoe**, Director, Care and Support, NDOH, South Africa
- **Dr. Priscilla Lumano-Mulenga**, HIV Technical Advisor, MOH, Zambia
- **Mrs. Alemtsehay Abebe Wolde Micheal**, HIV Program Officer, FMOH, Ethiopia

Key Takeaways

- Adolescent-friendly HIV services should include access to SRH and psychosocial support, with focus on decreasing teen pregnancy and promoting ART adherence and retention.
- Policies and guidelines are in place for adolescent-specific HIV care in all countries, and the majority are in the process of updating adolescent DSD-specific recommendations.
- There is an overall gap in guidelines and policies related to the transition from adolescent to adult care.
- Healthcare provider buy-in and staff capacity is a challenge for the scale up of adolescent friendly HIV services (*e.g.*, resources for training, extra clinic hours).
- Disaggregating age-specific data at the national level will enable countries to track adolescent DSD and other HIV outcomes.

Panel 2: Adolescent and Young Adult Voices: What do they Want?



Dr. Baker Bakashaba, Program Manager at TASO Uganda (pictured left), and Dr. Eduarda P. de Gusmao, Clinical Officer at ICAP New York moderated a panel with five youth advocates from organizations across South Africa. Panelists included four young adults (perinatally and behaviorally infected) who gave personal testimonies of their experiences living with HIV.

Panelists:

- **Bongiwe Zulu**, Aurum, Johannesburg
- **Sharon Siko**, Right to Care, Johannesburg
- **Elihle Dubula**, Y+, Cape Town
- **Saidy Brown**, Y+, Mafikeng
- **Pumeza Runeyi**, MSF, Cape Town

Key Takeaways

- There is a need for different models for adolescent and young people’s HIV testing and care (e.g., some panelists found out their HIV status “on school trips,” in a clinic, or from a peer support counselor).
- Peer support groups and “safe spaces” are a way many of the youth advocates have remained engaged in their care and come to terms with their HIV status.
- Providers should be respectful and patient centered
- Healthcare providers need additional training on how to discuss HIV and sexual health issues with adolescents and young adults.
- Confidentiality and trust of providers are the main determinants for adolescents to return for additional services (HIV or SRH).
- Adolescents want new and innovative approaches to support adherence and peer participation through social networks like WhatsApp, Twitter, and Facebook.

Panel 3: Optimizing Care for Adolescents and Young Adults: Evidence from the Frontline and Recommendations from the Scientific Community

The panel was moderated by Ms. Sharon Siko from Right to Care and Dr. Dalila Zachary from The Global Fund. Panelists discussed how to improve and optimize care for adolescents and young adults living with HIV, providing key recommendations.



Panelists:

- **Dr. Ruby Fayorsey**, Deputy Director, Clinical Unit, ICAP at Columbia: *Exploration of Service Delivery Needs and Preferences of HIV-positive Adolescents: Results of a formative study in Kisumu, Kenya*
- **Dr. Anna Grimsrud**, Lead Technical Advisor, International AIDS Society (IAS): *WHO Key considerations for differentiated ART delivery for children and adolescents & the LAS Decision framework: DSD for adolescents*
- **Mr. Prosper Ndlovu**, Youth Advocate, WITS RHI South Africa: *What do adolescents and young PLHIV want? A summary from the work of LAS Differentiated Youth Champions*

Key Takeaways

- DSDM for adolescents must be client centered to fit diverse adolescent needs.
- Adolescent friendly health services should be integrated into routine HIV care to improve outcomes.
- In addition to ART refills and clinical consultations, psychosocial support is a critical component of care that should be adopted and structured into DSDM.
- DSDM should be flexible and offer a variety of options to meet the needs of each individual client.
- DSDM development should include peer-led models and sensitization trainings for healthcare workers on adolescent- and youth-friendly care.

Country Self-Assessment for DSD Scale-up: the CQUIN Dashboard

Country teams conducted self-assessments of national DSD scale-up using the CQUIN dashboard. These dashboards presented *overall* progress towards scaling up DSD, not adolescent-specific findings. Following the exercise to describe overall DSD progress on the dashboard, countries discussed the status of DSDM for adolescents specifically, identifying best practices, resources, and needs.

	Cote d'Ivoire	Ethiopia	Kenya	Malawi	Mozambique	South Africa	Swaziland	Uganda	Zambia	Zimbabwe
Policies	Light Green	Dark Green	Dark Green	Dark Green	Dark Green	Light Green	Dark Green	Dark Green	Yellow	Dark Green
Guidelines	Yellow	Dark Green	Dark Green	Yellow	Yellow	Dark Green	Dark Green	Dark Green	Yellow	Dark Green
Diversity of DSDM services	Red	Dark Green	Dark Green	Light Green	Dark Green	Dark Green	Dark Green	Dark Green	Light Green	Dark Green

Scale-up plan	Red	Dark Green	Light Green	Yellow	Orange	Yellow	Yellow	Dark Green	Orange	Dark Green
Coordination	Red	Light Green	Yellow	Light Green	Yellow	Red	Light Green	Light Green	Light Green	Light Green
Community	Yellow	Yellow	Dark Green	Yellow	Orange	Orange	Light Green	Yellow	Yellow	Dark Green
Training	Orange	Light Green	Light Green	Orange	Yellow	Orange	Light Green	Yellow	Orange	Yellow
SOPs/job aides	Red	Light Green	Orange	Yellow	Dark Green	Orange	Light Green	Dark Green	Orange	Dark Green
M&E system	Orange	Yellow	Light Green	Orange	Yellow	Yellow	Light Green	Yellow	Orange	Light Green
Coverage	Red	Orange	Yellow	Dark Green	Dark Green	Orange	Yellow	Dark Green	Orange	Yellow
Quality	Red	Red	Orange	Red	Red	Orange	Orange	Orange	Orange	Yellow
Impact	Red	Red	Red	Yellow	Orange	Orange	Orange	Yellow	Orange	Yellow

Cote D'Ivoire does not currently have a national DSD policy or guidelines. Political will and involvement from civil society and implementing partners are needed to scale-up DSD. There is not a specific DSD policy for adolescents.

Ethiopia has only implemented the appointment spacing model which includes adults 18 years and older. The country identifies overall barriers to DSD scale-up as community engagement and M&E systems. The group mentioned that relevant performance indicators should be developed or adapted at the national level to evaluate the HIV outcome of adolescents in support groups.

Kenya has many enablers of DSD including policies, guidelines, diverse DSDM, and a national scale-up plan. Adolescents are identified within this context through national guidelines for youth friendly service provisions. Kenya identified that progress in DSD scale-up could still improve, specifically in the context of adolescents, by increasing coordination efforts through the harmonization and standardization of implementation strategies and M&E structures with finer age disaggregation.

Malawi has national DSD policies and is in the process of updating its DSD guidelines. In particular, Baylor adopted a successful teen club model in all 28 districts. The Malawi team noted that a step towards scale-up could include the adoption of a national standardized toolkit for teen clubs. Further, M&E of DSD for adolescents can be facilitated by disaggregation of HIV M&E data by age.

Mozambique has progressed in its overall DSD scale up via national policies, diversity of DSDM services, and SOPs/job aides. The group identified that DSD scale up can be optimized through efforts to boost community engagement, the adoption of a national scale up plan, and updating the M&E system to illustrate data outcomes for adolescents and populations of patients qualifying for

DSDM.

South Africa has strong DSD guidelines and diverse DSDM that could sustain efforts to increase DSDM access for adolescents. South Africa has many SOP/job aides from IPs and the NDoH, however it identified coordination with partners as a challenge for scale up. Other efforts needed to maximize scale up include national age-disaggregated M&E, strengthening and integration of school-based services, community engagement with CBOs and NGOs, and political will to finance DSD.

Swaziland included adolescents in its national DSD policies and guidelines. The country is currently advancing its DSD scale up plan, as well as expanding its coordination, community engagement, M&E system, and adoption of training materials. Swaziland's efforts to improve DSD for adolescents includes developing quality standards and rolling out population-specific M&E tools.

Uganda advanced national DSD efforts through policies, guidelines, diverse DSDM, a national scale up plan, and incorporating SOPs and job aides into their overall DSDM strategies. The team from Uganda identified national coordination and engagement with adolescents as priorities; community groups could shape the design and boost implementation of DSDM. Uganda also mentioned it would like to update its M&E framework with finer data disaggregation, and update countrywide definitions for DSDM indicators.

Zambia's team recognized that implementing partners support diverse DSDM within the country, but identified that it has yet to adopt DSD-specific national policies and guidelines. Enabling factors for DSD scale up include a national commitment to improving stakeholder coordination and the adoption of national M&E tools to include adolescent-specific data.

Zimbabwe has national guidelines, policies, diverse DSDM and a national scale up plan for DSD. The MoHCC has rolled out adolescent specific DSDM with the Zvandiri/CAT's model, which enabled coordination of job aides, resources, and tools for adolescents, including national SOPs that have specific guidance for multi-month prescriptions. Zimbabwe would like to see VL scale up, better infrastructure for youth centers, training of mentors, and coordination to optimize DSD outcomes for adolescents.

Innovations to Reach the First 90 for Children and Adolescents: Lessons from Swaziland

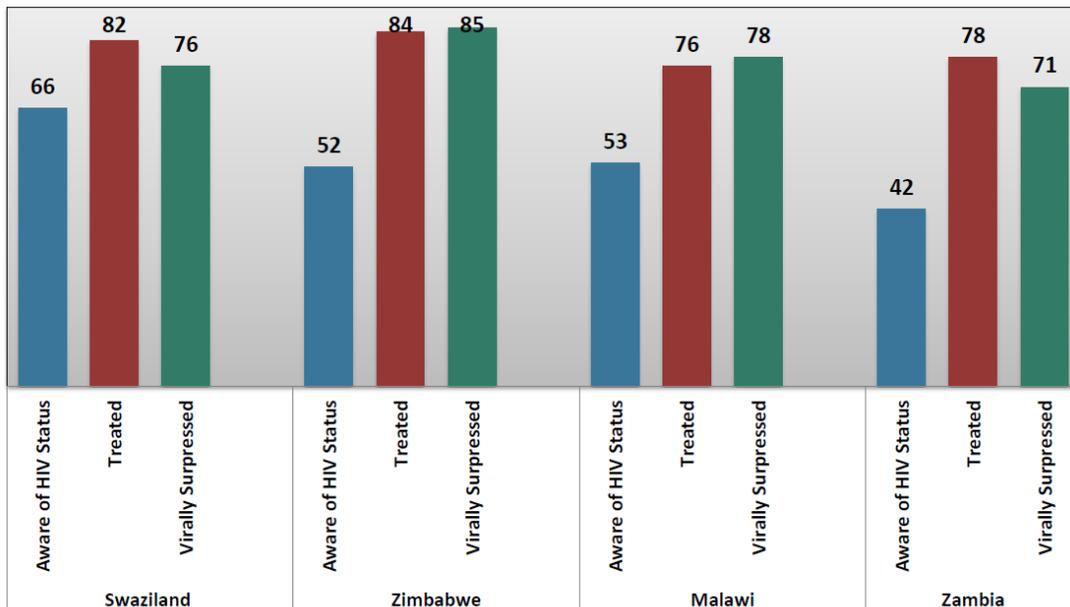
Dr. Lydia Mpango

Senior Clinical Advisor, AIDSFree, Swaziland

Dr. Mpango reinforced Swaziland’s commitment to achieving 90-90-90, citing her country’s strategic framework and plans: strengthening efficiency of pediatric HIV case finding, early linkage to treatment, quality HIV services, and an increase in viral load monitoring. She discussed Swaziland’s success in increasing the number of patients on ART and attaining high coverage rates (84 percent) for the pediatric population.

Referencing the [Swaziland HIV Incidence Measurement Survey \(SHIMS\)](#), Dr. Mpango explained that the disparity in HIV prevalence by sex is most pronounced among young adults. She noted that in Swaziland, only about 66 percent of adolescents and young people are aware of their status, with ART coverage hovering around 82 percent of those aware of their status. Viral suppression is at 76 percent, similar to other sub-Saharan African countries.

Progress towards 90-90-90 in adolescents and young adults 15-24yrs (%)



Dr. Mpango discussed Swaziland's efforts to scale up treatment among children and adolescents, including a policy shift to aggressively test children and adolescents over time, and reducing the age of consent for testing from 16 years in 2010 to 12 years in 2014. Swaziland has worked at different levels of the health system to decentralize HIV testing services, including client- and patient-centered HIV testing and counselling at every point of contact within health facilities, including pediatric HIV testing at all pediatric and adult entry points. There has also been decentralized HIV testing services in community settings, focusing on testing children of index clients.

Other initiatives to increase pediatric HIV testing include the ICAP-Baylor initiative; school debates; and a three-tier initiative to strengthen pediatric intensified case findings, supported by ELMA philanthropies and EGPAF AIDSFree at the national, regional, and community level.

To scale up HIV testing among adolescents, PSI and PACT have implemented the *Dreams on Wheels* program in Swaziland, targeted at adolescents and young people aged 15-24 years. Mobile units are strategically placed near schools in each region, and offer a robust package of care, including HIV risk-reduction counseling, contraception, HIV testing, and CD4 counts. Other services provided include screening and treatment for other STIs, sexual and gender-based violence services, referrals, post-exposure prophylaxis, and family planning counseling. Pregnancy testing, condom distribution, screening for TB and NCDs, and referrals across the whole cascade of care are also part of the initiative. Nearly 20,000 adolescents have been reached.

Dr. Mpango noted that although positivity rates have been low, all of the adolescents identified as HIV-positive have been linked to treatment. Dr. Mpango concluded by sharing lessons learned from Swaziland's approach to reaching the first 90 for children and adolescents. First, home visits are better outside of working hours for index testing. Engaging staff and HCW at different levels – from MOH to the regions and down to the health facilities – to get buy in for pediatric programs is key. There is a need for mentoring and supportive supervision of health care and community workers, and facilities need to plan community outreach at least once per quarter to reach hard-to-reach areas.

Next steps include strengthening quality HIV testing services and provision both in communities and facilities; implementing evidence-based approaches for testing; and continued implementation of targeted testing strategies focused on high-risk-groups, among others.

A complete transcript of Dr. Mpango's remarks is available in the Appendix.

Panel 4: Adolescents Living with HIV: Legal Framework for Testing, Treatment, DSD, and Transitioning, Challenges and Priorities

The moderators of the panel were Ms. Elihle Dudula from Y+ South Africa and Dr. Herve Kambale from the Swaziland MoH. Panelists discussed the challenges and priorities related to DSD for adolescents.

Panelists:

- **Ms. Teddy Chimulwa**, National Programme Officer, Adolescent Care and Treatment, MOH, Uganda
- **Dr. Clorata Gwanzura**, DSD Medical Officer, MOHCC, Zimbabwe
- **Ms. Dalitso Midiani**, PMTCT Focal Person, Department of HIV/AIDS, Malawi

Key Takeaways:

- HIV testing and counseling should be conducted not only in health facilities and but also in the community to ensure a high proportion of adolescents are aware of their HIV status.
- Age of consent for testing varies throughout countries and is an issue that should be addressed by policy makers to increase access to testing.
- Adolescents should participate in the design, implementation and evaluation of their own DSDM.
- DSDMs should have specific design that meets the needs of every ALHIV subgroup (e.g., KPs, pregnant teens, etc.).
- Youth-friendly health services should include SRH, HIV testing, family planning, and health literacy.
- A DSD transition checklist tool is needed for adolescent transitioning to adult care.

Panel 5: Adolescents Living with HIV: Innovations and Experience

The moderators of the panel were Ms. Saily Brown from Y+ South Africa and Dr. Ruby Fayorsey from ICAP at Columbia University. Panelists discussed innovations and experiences related to adolescent care and treatment.



Panelists:

- **Dr. Ann Sellberg**, Clinical Mentor, Zvandiri -CATS, Zimbabwe
- **Ms. Judith Lungu**, Head of Adolescent HIV Programs, Baylor-COE, Malawi
- **Dr. Maureen Syowai**, Regional Technical Advisor, ICAP-JOORTH, Kenya
- **Ms. Shenaaz Pahad**, Psychosocial Program Manager, WRHI, South Africa

Key Takeaways:

- Adolescent-specific DSDMs such as the Zvandiri/CATS models from Zimbabwe (adopted by the Malawi government) and teen clubs (adopted by the South African government) have been shown to improve retention and adherence to ARTs.
- Adolescent friendly services require strong health systems and buy in from HCWs.
- Language and attitudes of HCWs and community should be adolescent friendly to create environments where adolescents want to access all services, including ANC or SRH.
- Adolescents need enhanced psychosocial support and guidance (e.g., life skills, nurturing environment).
- Parent and guardian involvement in adolescent DSDM activities has been an effective management tactic for sustaining teen clubs in Malawi.
- Adolescent-specific DSDMs have common challenges, including the absence of transition models from adolescent to adult care (e.g., Zimbabwe), lack of resources for model sustainability (bus fare, stipends for peer or youth leaders), and M&E indicators are not aligned with the national system.

Debate: School-based Services for Adolescents Living with HIV: Pro and Con

School-based services have been an ongoing debate in adolescent HIV service delivery. Neither the WHO or ministries of health in the CQUIN network countries have officially endorsed the integration of education and HIV services for adolescents. The growing number of HIV school-linkage programs and the globally contested evidence behind the successful implementation of school-based HIV services paved the way for a debate on this issue.

Workshop attendees were asked to cast a vote prior to the meeting debate on whether or not school-based services for ALHIV should be offered. Prior to the debate, the majority of respondents supported the integration of HIV- and school-based services.

Dr. Justine Jelagat Odionyi from EGPAF Kenya argued “for” ALHIV school-based services. She cited the growing body of implementation science suggesting models such as the Red Carpet Boarding School program in Kenya, which offers convenient and effective services that are demanded by adolescents. Dr. Odionyi mentioned that schools have evolved in recent years and are now a “safe” environment, and with support, can be free from HIV stigma and discrimination.

She explained the potential benefits of offering HIV services in school, as well as what makes schools an ideal place for offering services:

- HIV-positive students would be less likely to drop out of school or care, or miss appointments and school time if access to ART in schools increased.
- HIV/STI awareness and prevention at schools would improve overall health education.
- Discussion forums among students would lead to stigma-free environments.
- Given the right guidance, teachers can provide a supportive environment for students to seek confidential support or disclose their status.

Dr. Baker Bakashaba from TASO Uganda argued “against” school services for HIV-positive adolescents. Dr. Bakashaba suggested that the adolescents that are most at risk of HIV are out-of-school or young key populations. He also emphasized that schools are places for learning and not for receiving quality healthcare. He suggested that schools not offer HIV services because:

- HIV care in school settings is not a cost effective service delivery method and will require upgraded storage space for ARTs, training teachers, safely storing medicines, and providing transportation to clinical appointments.
- Schools are not an effective place to target HIV-positive adolescents since many adolescents are currently out of school (only 24% of students in sub-Saharan African complete upper secondary school).
- Teachers in low-income environments are usually underpaid and overburdened. Educators do not have the training to provide adherence support and counseling for HIV-positive students.

Following the debate, the group voted again, and the responses indicated that many had changed their positions and now opposed offering HIV services in school. Dr. Bakashaba was declared the “winner” of the debate, although all participants agreed that these decisions are contextually specific and not necessarily mutually exclusive.

Friday, 27 October

Optimizing ART for Adolescents Living with HIV in the Context of Changing Treatment Guidelines

Dr. Nandita Sugandhi

Senior Staff Associate, ICAP at Columbia University

Dr. Sugandhi noted the common thread in many of the weeks' presentations: that mortality is not decreasing among adolescents and young adults living with HIV. Referencing Dr. Abrams presentation, she noted that there is more to the challenges practitioners face in treating adolescents than the underdeveloped "adolescent brain". In addition to adolescent-friendly service delivery, she noted additional areas for improvement.

"We know that in the treatment landscape, there is increasing concern about drug resistance and we have very limited data on adolescents in sub-Saharan Africa," she noted. "There are other things aside from the adolescent brain, behavior, and the way we communicate with young people that may be contributing to some of the failures we are seeing in ART and adolescents and young adults."

Dr. Sugandhi restated that there is no "one-size-fits-all" approach; that infants, children, and adolescents are not entering the system at the same time and therefore, should not be given the same treatment.

"Should we continue to harmonize our adolescent regimens with our adult regimens?" she asked. "I want to point out that in 2017; we're paying more attention to the alternative first-line regimens. Two of the alternative first-line regimens include new options that we are calling 'optimized' ARV choices, and that includes the drug dolutegravir, as well as a low-dose of efavirenz."

Optimized treatment includes drugs that are potent, low in toxicity, well tolerated, easy to take and administer for children, and have a high genetic barrier to resistance. They are also durable, improve options for switching or sequencing regimens, can be harmonized across special populations, and are cost-effective or reduce cost. Referencing a recent study, she noted that ARV preferences are actually a multi-sensory experience for adolescents, citing that it's about more than just the quality of the drugs themselves that matter, but the entire experience of taking medication such as convenience and pill size.

Speaking about dolutegravir (DTG), Dr. Sugandhi noted that the drug does not interact with hormonal contraceptives, an important point to consider as adolescents become sexually active. I also want to point out that in several of the presentations this week, we talked about sexual activity, teens having unprotected sex, and unwanted pregnancies. It is important that, as we're trying to increase access to contraception, we also ensure the ARVs we're using don't interact with hormonal contraceptives, and that's not the case for what we're using right now. She noted that multiple countries are now thinking about phasing in the use of DTG singles or DTG fixed dose combinations. According to the WHO guidelines, newly initiating patients are eligible to receive DTG.

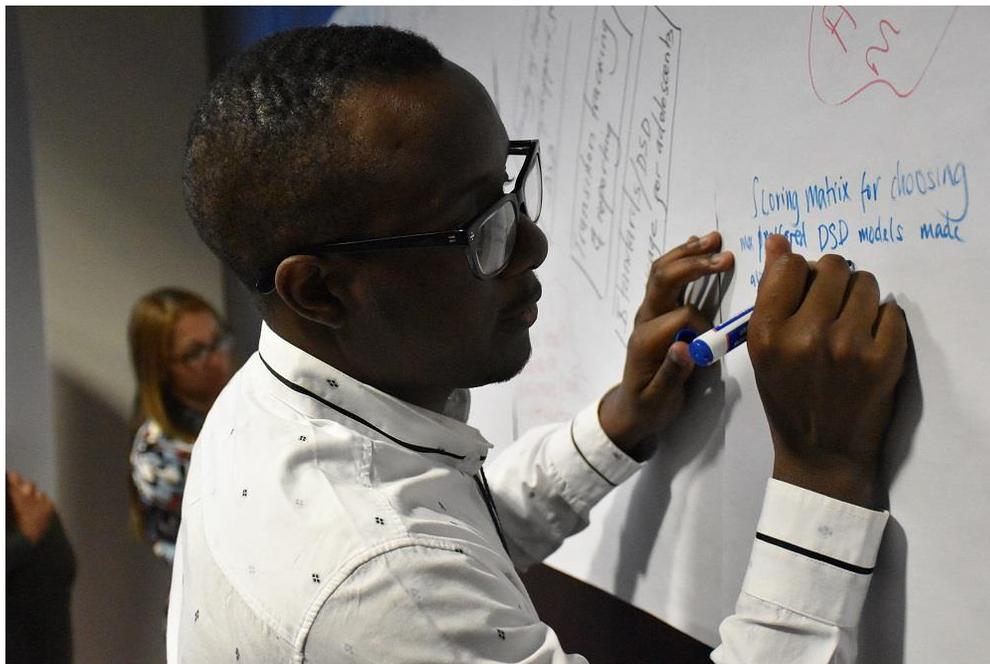
“The important thing to take away here is that dolutegravir is a great drug for newly initiated patients but it can be active even in those who are very treatment-experienced,” she said. “Knowing that we have some options across the spectrum of treatment experience is important.”

She concluded by stating that in order to improve care for adolescents, we must think beyond traditional methods of care and treatment; that optimized ART options (DTG regimens in particular) can provide an opportunity to support more adolescents to reach viral suppression and get to that last 90.

A complete transcript of Dr. Sugandhi’s remarks is available in the Appendix.

Report Back and Update on Tool Development

Participants brainstormed, prioritized and discussed gaps in tools for adolescent DSD. The four topics that received the most interest became small TWGs for tool creation. Each group identified gaps, the type of tool that was needed, and discussed the context in which each tool would be used. A few groups created draft frameworks of tools and others made specific recommendations on how current tools could be adopted and improved to support adolescent-specific DSDM.



Group 1: Adolescent Friendly Language for HCWs and Adolescent/Youth Bill of Rights

The group consisted of youth advocates, pediatricians and public health practitioners. After reviewing the current tools in existence, the group drafted an *Adolescent and Youth Health Care Bill of Rights* for clinics, communities, and other youth-friendly healthcare spaces. The group also drafted FAQs for HCWs and clients to discuss sensitive SRH topics with adolescents and young adults.



Draft Bill of Rights*

Every adolescent and young adult has the right to:

- Access to free/affordable care
- Confidentiality
- Access to the highest attainable health information and care explained in language we can understand
- Access to SRH information and services in a non-judgmental environment
- Examination, information, and treatment whenever I come to a health facility
- Privacy during examination and treatment
- Be seen by health care workers who are identifiable and trained in adolescent- and youth-friendly services
- Provide feedback on the quality of care (including where and to whom)
- Healthy and safe environments
- Participate in decision making as appropriate (country policies)
- To have access to HIV testing and not be judged by our HIV status
- To decide when and with whom we have sex
- Safety from all forms of harm
- Continuity of care including transition

*To be adapted at the country context



The youth advocates in the group suggested the FAQ could be made into pamphlets and posted on social media.

Draft FAQ

- How to disclose to partners, family, and friends?
- Having unprotected sex with suppressed viral load?
- Risks associated with different types of sex?
- Age of consent for:
 - Sex
 - Testing
 - Treatment
 - SRH services
- Mixing drinking/smoking with medication?
- How long will I live?
- Can I get married and/or have children?
- What are the risks of taking ARVs?
- Can I take birth control pills with my ARVs?
- Can I take any other medications with my ARVs?
- What is the difference between different family planning methods?
- What are symptoms of STIs and treatment?

Group 2: Eligibility recommendations for DSD specific to adolescents

The eligibility group consisted healthcare workers and public health practitioners from Swaziland, Mozambique and Uganda. The group identified that healthcare facilities need a pre-existing eligibility criteria for adolescents to join DSDMs. The aim of the tool is to capture minimum standards for DSDM for adolescents, as well as, to have an additional document in patient records and files at health facilities.

	Stable			Unstable			
		Age (<10)	Age (10-14)	Age (15-19)	Age (<10)	Age 10-14)	Age (15-19)
HCW Managed Groups	Adherence Clubs	X	X	X	X	X	X
	YCC/TC		X	X		X	X
Client Managed Groups	CAGs	X	X	X			
	CATS	X	X	X	X	X	X
Out of Facility Individual	Comm Ph Mobile OR						
	Home Delivery	X	X	X			
Facility-based Individual	MMS	X	X	X			
	Fast-track	X	X	X			

	Stable Adolescent Criteria	Unstable Adolescent Criteria
1.	On their current ART regimen for ≥ 12 months	On their current ART regimen for < 12 months
2.	No active OIs (including TB) in the past 6 months	Any active OIs (including TB) in the past 6 months
3.	Adherent to scheduled clinic visits for the past 6 months	Poor or questionable adherence to scheduled clinic visits in the past 6 months
4.	Most recent VL $< 1,000$ copies/mL	Most recent VL $\geq 1,000$ copies/mL
5.	Has completed 6 months of IPT	Has not completed 6 months of IPT
6.	Non-pregnant/not breastfeeding	Pregnant or breastfeeding
7.	BMI ≥ 18.5	BMI < 18.5
8.	Healthcare team does not have concerns about providing longer follow-up intervals for the patient	Disclosure not done
9.	Fully disclosed	Healthcare team has concerns about providing longer follow-up intervals for the patient

Group 3: Transition Readiness Checklist

The group consisted of PEPFAR, MoH, clinicians, and public health practitioners who identified that transition from adolescent to adult care requires systematic screening and preparation in the context of DSDM. The group suggested a checklist could be developed and administered by HCWs for the ages of 19 and above. The checklist could be adopted to measure the transition process at age 17 and would be administered over the course of the next few years. The group developed a draft checklist to assess an adolescent's basic HIV knowledge and ASRH, HIV self-care (adherence, clinic visits, and appointments), psychosocial support, mental health issues, disclosure, knowledge of health system, and arrangement of services.

Group 4: M&E for adolescents

The M&E group consisted of public health practitioners, clinicians, and policymakers including donors, IPs, and MoH. After reviewing existing tools for M&E of DSD and discussing common challenges facing M&E systems in network countries, the group suggested country-specific adolescent DSD outcomes could be illustrated through age disaggregation of data and assigning unique identifiers to adolescents as they advanced through the healthcare system. The group did not develop a specific tool, but suggested countries could refine and update their M&E guidance for AYA DSD through a participatory approach. The group suggested countries could use the WHO Global Standards for Quality Healthcare as a reference when adapting national M&E of DSD for adolescents.

Country Report Back and Way Forward

Countries reflected on their overall engagement in the workshop, the DSD priorities identified, and lessons learned. As a group, each country outlined key steps for post-meeting follow-up.

Ethiopia

- Update the FMOH team and TWG on the outcomes of the workshop
- Develop/customize SRH, transition readiness assessment
- Develop operational plan to ensure provision of comprehensive adolescent friendly services
- Site level data compilation and use
- Ensure reporting and use of data for adolescent age group using national HMIS

Kenya

- Give feedback from meeting to MoH and IPs
- Evaluate the implementation and outcome of the existing adolescent DSDs
- Harmonize and standardize the adolescent DSD models
- Roll out the DSD tools for ALHIV
- Engage adolescents in designing and implementing the DSD models
- Consolidate DSD information in the various national documents

Malawi

- Adapt and standardize teen club materials including M&E tools
- Use the dashboard to assess progress on DSD for adolescents
- Develop DSD service quality assessment tools

Mozambique

- Advocate to include meeting learning points in national program priorities
- Include DSD for adolescents in the national DSD guidelines
- Involve adolescents in the development of the DSD guidelines, IEC, etc.
- Continue discussions about inclusion of DTG as first line for adolescents

South Africa

- Hold a national workshop in mid-January 2018 to plan for adolescent DSD in South Africa
- Recommendation to include youth-friendly staff youth in B Wise clinic rating

Swaziland

- Present lessons learned from meeting in the next care and treatment TWG (November 16)
- Establish DSD Core team to oversee implementation of DSD
- Country review meeting on DSD for adolescents
- Finalize the Draft DSD scale up plan
- Review M&E tools to assess ALHIV coverage
- Finalize the draft tools developed during the CQUIN network meeting

Uganda

- Advocate for DTG for adolescents on treatment as the country develops TLD roll-out/transition plan
- Adapt DSD eligibility matrix to Uganda context (as a job aide)
- Pilot community DSD models for adolescents
- Ensure representation of Uganda team on CQUIN community of practice platforms (virtual)
- Include adolescent representation in the national TWGs and explore/establish mechanisms for enhanced engagement and involvement.

Zambia

- Advocate for reduction in the age of consent for HIV testing
- Advocate for site visits and knowledge exchange between partners related to DSD for ALHIV
- Promote scale-up of DSDM
- Launch of DSD policies for ALHIV in December 2017

Zimbabwe

- Present key takeaways from adolescent meeting to DSD subcommittee
- Continue work on tools from breakout groups in CQUIN meeting
- Implementation of HIMS age disaggregation

- Transition of TLE to TLD (*process*)
- Continued advocacy for:
 - Lowering age of consent for HIV testing to 12 years
 - HIV testing for OVC and children in child-headed families
 - Increasing follow up on technical issues in adolescent care (e.g., disclosure status, ASRH uptake, pregnancy/young mothers)

Closing Remarks

Dr. Elaine Abrams

Senior Director of Research, ICAP at Columbia University

Dr. Abrams concluded the meeting by restating its goals and objectives: to launch the CQUIN adolescent workshop community of practice by convening the nine CQUIN countries to share experiences on the “how” of DSD for adolescents; share resources and existing tools; and work together to develop tools and frameworks on DSD for adolescents and young adults.

“I think we can say unconditionally that we have met these goals and objectives,” she said.

Dr. Abrams stated how much of a privilege it was to have the time devoted to bringing everyone’s expertise and experiences together to consider these different issues, all focused on trying to improve the outcomes for adolescents and young adults living with HIV. “For me and others, this has been an opportunity to learn about incredible work that’s happening. Every single program and presentation has demonstrated innovation and exciting, thoughtful, meaningful work in the field.”

She concluded by recognizing that, although we are not yet at scale, we are moving toward scale up of DSD for adolescents living with HIV with the hope that we can measure impact in the coming years. Dr. Abrams recognized the contribution of the adolescent participants, and others who participated and made the meeting possible.

A complete transcript of Dr. Abrams’ closing remarks is available in the Appendix.

APPENDIX

Agenda

Tuesday, October 24

Participant Introductions

Dr. Batanayi Muzab, Acting Country Director, ICAP South Africa

Dr. Zukiswa Pinini, Chief Director, HIV/AIDS, STI, National Department of Health (NDOH), South Africa

Dr. Elaine Abrams, Senior Director of Research, ICAP at Columbia University

Mr. Prosper Ndlovu, LAS Differentiated Care Youth Champion for South Africa, WTTS RHI

Wednesday, October 25

Welcome and Opening Remarks

Ms. Mokgadi Phokojoe, Director, Care and Support NDOH, South Africa

The CQUIN Learning Network: Communities of Practice

Dr. Peter Preko, CQUIN Project Director, ICAP at Columbia University

Adolescents Living with HIV: State of the Art

Dr. Elaine Abrams, Senior Director of Research, ICAP at Columbia University

Q&A

Panel 1: Adolescents Living with HIV: National Guidelines, Minimum Package, Challenges and Priorities

Moderators: Dr. Gurpreet Kindra, CDC - South Africa and Dr. Nicollate Okoko, Faces-Kenya

- Ms. Nobuhle Mthetwa, Pediatric ART Coordinator, MOH-Swaziland
- Dr. Irenio Gaspar, Care and Treatment Chief, MOH Mozambique
- Ms. Mokgadi Phokojoe, Director, Care and Support, NDOH, South Africa
- Dr. Priscilla Lumano-Mulenga, HIV Technical Advisor, MOH, Zambia
- Mrs. Alemtsehay Abebe Wolde Micheal, HIV Program Officer, FMOH, Ethiopia

Panel 2: Adolescent and Young Adult Voices: What do they Want?

Moderators: Dr. Baker Bakashaba, TASO Uganda and Dr. Eduarda P Gusmao, ICAP-NY

- Bongwiwe Zulu, Aurum, Johannesburg
- Sharon Siko, Right to Care, Johannesburg
- Elihle Dubula, Y+, Cape Town
- Saily Brown, Y+, Mafikeng

- Pumeza Runeyi, MSF, Cape Town

Panel 3: Optimizing Care for Adolescents and Young Adults: Evidence from the Frontline and Recommendations from the Scientific Community

Moderators: Ms. Sharon Siko, Right to Care and Dr. Dalila Zachary, The Global Fund

- Dr. Ruby Fayorsey, Deputy Director, Clinical Unit, ICAP at Columbia: *Exploration of Service Delivery Needs and Preferences of HIV-positive Adolescents: Results of a formative study in Kisumu, Kenya*
- Dr. Anna Grimsrud, Lead Technical Advisor, International AIDS Society (IAS): *WHO Key considerations for differentiated ART delivery for children and adolescents & the LAS Decision framework: DSD for adolescents*
- Mr. Prosper Ndlovu, Youth Advocate, WITS RHI South Africa: *What do adolescents and young PLHIV want? A summary from the work of LAS Differentiated Youth Champions*

Country Breakout Sessions

Country teams will review the CQUIN staging dashboard for differentiated service delivery models (DSDM), conduct self-assessment and discuss the status of DSDM for adolescents, identifying best practices, resources, and needs.

Report Back from Breakout Sessions

Moderators: Dr. Jacqueline Balungi Kanyma, Baylor-Uganda and Dr. Tendai Nyagura, USAID, Zimbabwe

Wrap-up and Plans for Day Two

Thursday October 26

Welcome and Recap of Day 1

Innovations to Reach the First 90 for Children and Adolescents: Lessons from Swaziland

Dr. Lydia Mpango, Senior Clinical Advisor, AIDSFree, Swaziland

Panel 4: Adolescents Living with HIV: Legal Framework for Testing, Treatment, DSD, and Transitioning, Challenges and Priorities

Moderators: Ms. Elible Dudula, Y+ South Africa and Dr. Herve Kambale, MoH, Swaziland

- Ms. Teddy Chimulwa, National Programme Officer, Adolescent Care and Treatment, MOH, Uganda
- Dr. Clorata Gwanzura, DSD Medical Officer, MOHCC, Zimbabwe
- Ms. Dalitso Midiani, PMTCT Focal Person, Department of HIV/AIDS, Malawi

Panel 5: Adolescents Living with HIV: Innovations and Experience

Moderators: Ms. Saily Brown, Y+ South Africa and Dr. Ruby Fayorsey, ICAP at Columbia University

- Dr. Ann Sellberg, Clinical Mentor, Zvandiri -CATS, Zimbabwe
- Ms. Judith Lungu, Head of Adolescent HIV Programs, Baylor-COE, Malawi

- Dr. Maureen Syowai, Regional Technical Advisor, ICAP-JOORTH, Kenya
- Ms. Shenaaz Pahad, Psychosocial Program Manager, WRHI, South Africa

Prioritization of Tools to Develop – Consensus Building on Tools to Develop

Moderator: Dr. Maureen Syowai, Regional Technical Specialist, ICAP Kenya

Debate: School-based Services for Adolescents Living with HIV: Pro and Con

Moderators: Dr. Nandita Sugandhi, ICAP-NY and Dr. Anna Grimsrud, IAS

Panelists:

- **Pro:** Dr. Justine Jelagat Odionyi, Senior Technical Advisor, EGPAF, Kenya
- **Con:** Dr. Baker Bakashaba, Regional Project Manager, TASO, Uganda

Breakout Sessions – Tool Development

Breakout into 3 or 4 groups to work on priority tools or resources needed to scale up DSDM for ALHIV

Wrap-up and Plans for Day Three

Friday, October 27

Welcome & Recap of Day Two

Optimizing ART for Adolescents Living with HIV in the Context of Changing Guidelines

Dr. Nandita Sugandhi, Senior Staff Associate, ICAP at Columbia University

Breakout Sessions: Tools and Resources

This breakout session will focus on finalizing resources needed to scale-up DSDM for ALHIV

Report back/Update on Tool Development

Moderators: Ms. Gertrude Matshimane, NDOH, South Africa and Dr. Kayira Dumbani, CDC-Malawi

Country Breakout Groups

Country teams will work to identify next steps and priorities to support DSD scale up for ALHIV

Report Back from Country Breakout Sessions

Moderators: Dr. Theresa Simione Beatriz, Ariel Glazer Foundation, Mozambique and Dr. Pido Bongomin, ICAP-Swaziland

Meeting Wrap-up

Survey

Next Steps and Closing Remarks

Participants



Elaine J. Abrams, MD, is the Senior Research Director at ICAP and professor of Epidemiology at the Mailman School of Public Health, and professor of Pediatrics at Columbia at the College of Physicians and Surgeons, Columbia University, in New York City. She has dedicated her career to improving health outcomes of children and families living with HIV disease. She began her work in central Harlem, New York City, at the Family Care Center, where she developed a comprehensive research and care program for children and families with HIV, and she has worked tirelessly over the last decade to bring much of the learning from NY to inform global health initiatives. Her research has primarily focused on the prevention and treatment of pediatric HIV infection.

Her work contributed to the evolution of highly effective multi-drug antiretroviral treatment (ART) regimens for infants and children and to a greater understanding of the behavioral and psychological aspects of living with HIV infection during childhood. She has been at the forefront of efforts to optimize approaches to prevention of perinatal HIV prevention, including recommending ART for all HIV-infected pregnant and breastfeeding women. She conducted implementation science research in sub-Saharan Africa and elsewhere, which benefited hundreds of thousands of HIV-infected mothers and their children around the world.

A committed teacher and mentor, Dr. Abrams has been highly committed to mentoring young clinicians and researchers and nurturing the next generation of researchers and clinicians. She has written more than 200 articles published in peer-reviewed journals, lectures widely, and chaired the 2015 WHO ART Guidelines Committee, which endorsed universal treatment for all individuals living with HIV infection.



David Allen is Deputy Director, HIV, Southern Africa for the Bill & Melinda Gates Foundation. Dr. Allen received his MD from the New York University School of Medicine and his MPH degree from the Johns Hopkins School of Public Health. He worked as a pediatrician in Washington D.C. before joining the Centers for Disease Control and Prevention (CDC) for a twenty-year career. At CDC, Dr. Allen worked in a variety of public health areas including infant mortality, homeless health, community health, epidemiology training, and HIV/AIDS. He served as an advisor to the South African Department of Health, Director of the CDC Global AIDS Program for South Africa, the Regional Director of the Global AIDS Program for Southern Africa, and the Director of the Global AIDS Program, Caribbean Regional Office.



Dário Aly trained in medicine at Eduardo Mondlane University in Maputo. He has worked ICAP Mozambique for eight years and he has experience in health system strengthening at the district, provincial, and national levels. He has expertise in public health, HIV program management, HIV program polices, HIV program planning, HIV M&E, nutrition, HIV training tools development, MCH M&E tools development, Integrated HIV/AIDS care, support, treatment and adherence (including: ART, TB, and pediatric treatment), maternal health, and health services management.



Baker Bakashaba is a medical doctor, with a Bachelor of Medicine & Surgery Degree from Makerere University; he is currently pursuing an MSc. in Project Management at the University of Salford, UK. During his seven years at TASO Uganda, he managed HIV/AIDS programs, focusing on design and implementation of facility and community-based client centered projects and health systems strengthening. He has had the opportunity of contributing to the design of community ART models in TASO, such as Community Drug Distribution Points (CDDP) and Community Client led ART Delivery (CCLAD), as well as other national level differentiated service delivery models. He is currently the Regional Project Manager for the “Accelerating HIV Epidemic Control in Soroti Region” project – a regional HIV/AIDS project funded by PEPFAR via CDC.



Theresa Simone Beatriz is a medical doctor specializing in general paediatrics. She attained her degree from Eduardo Mondlane University in Maputo, Mozambique and currently works as a Senior Technical Adviser in Paediatric HIV Care and Treatment at the Mozambique Ministry of Health. Prior to her current role, she spent four years as the PMTCT Senior Technical Adviser at the Ariel Glaser Paediatric AIDS Foundation. During this time, she worked as a PMTCT consultant to AIDS Free program in Angola. She has more than 10 years of experience as a clinician and hospital administrator.



Pido Bongomin is a medical doctor and the current Deputy Country Director for Programs at ICAP Swaziland. He was trained in medicine at Makerere University and previously worked as the Uganda Country Director at the Institute of Human Virology for the University of Maryland.



Saidy Brown is a 22-year-old youth advocate living with HIV. Saidy was born with HIV and has embarked on a journey of to end HIV stigma. Saidy is an inspirational speaker and uses social media to share her story. She has a passion for educating and inspiring other people living with HIV. She is a member of the SA Y+.



Jacqueline Calnan is a Technical Advisor at USAID Uganda. She has 17 years of experience in public health practice in the areas of HIV prevention, care, and treatment, as well as a successful track record in quality management/quality improvement of health care, policy development, program design and management. Ms. Calnan holds two Master's Degrees in Development Management and Public Health. Since 2009, Ms. Calnan has co-chaired the PEPFAR Uganda Care and Treatment Technical Working Group and provides leadership and technical guidance on a number of strategic directions and actions in order to achieve PEPFAR goals. Ms. Calnan serves as a core member on national HIV care and treatment technical committees and has supported the Ministry of Health/AIDS Control Program to develop a national rollout plan for the revised national antiretroviral treatment guidelines, including differentiated service delivery models. She has also supported the rollout of the national viral load-testing program; development of national pediatric treatment scale up plan; the rollout of the PMTCT Option B+ program; and participates in the national ART supply chain task force to ensure commodity security and plan for ARV optimization.



Teddy Nabwire Chimulwa is the National Programme Officer, Adolescent Care and Treatment, working with the Ministry of Health in Uganda. She has 20 years of experience and holds a bachelor's degree in Social Sciences and a Master's Degree in Social Sector Planning and Management, as well as a Post-graduate certificate in Child Protection from Makerere University in Kampala, Uganda. Ms. Chimulwa is a Senior National Resource Person in HIV prevention, counseling and testing, child protection, psychosocial programming, and capacity building. She serves as a member of several national Technical Working Groups, including Adolescent Health, HIV Testing Services, Care and Treatment, Third-line ART Implementation, DSDM, and Key Populations.

Not Pictured

Crispin Moyo is the Country Director at EQUIP Zambia.

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Nonhlanhla Dlamini is the Chief Director of Child, Adolescent, and School Health at NDoH, South Africa.



Elihle Dudula is a 20-year-old youth advocate at Y+ in Cape Town. She has been living with HIV for four years and is mother to two boys: Iwiwe, four years old, who is currently on treatment and living with HIV and Samuel, who is one-year-old and negative.



Lillian Diseko is a Program Manager in the HIV, AIDS and STI Cluster at the National Department of Health, South Africa. She worked for 10 years as a professional nurse/ midwife and HIV coordinator in Johannesburg before joining the Gauteng provincial office as a TB/HIV integration manager. She provides all provinces with logistical and technical support to efficiently implement the National Strategic Plan and other relevant policies aimed at improving the delivery of quality HIV and TB services in the public sector. Her passion is to improve the quality of life and health outcomes for persons living with HIV and TB. She has a degree in Nursing Sciences (UNISA), postgraduate diplomas in Community Health Nursing (Wits Tech) and Health Management (UCT), as well as a Certificate in Project Management from UNISA Business School.



Ashiono M Everline is a medical doctor with over 10 years in clinical service. She has a master's in Child Health and Pediatrics from Moi University and has practiced as a pediatrician for six years. Dr. Everline lectures at Egerton University, Department of Child Health and Pediatrics. She led the design and implementation of clinical technical strategies for the USAID-funded programs covering HIV, maternal, and child health, including Malaria, for the last five years. She is currently Deputy Chief of Party, and Technical Lead providing technical and managerial oversight to a seven-year USAID regional technical assistance, integrated HIV/AIDS TB, reproductive health and family planning, maternal-child health, and malaria program working with the Ministry of Health and other implementing partners in five counties in Kenya.



Ruby N Fayorsey, MD, MPH is a pediatric infectious disease specialist, and Deputy Director of the Clinical and Training Unit at ICAP, Mailman School of Public Health, Columbia University. She provides both clinical and programmatic support to ICAP programs in sub-Saharan Africa including Kenya, Tanzania, Democratic Republic of Congo, Ethiopia, and South Sudan. She has over 18 years of experience working with women, infants, children, adolescents, and young adults with HIV and families in impoverished environments in the US and sub-Saharan Africa. Dr. Fayorsey has served as a consultant to the WHO on several topics including IMCI, pediatric HIV disclosure, HIV diagnosis in infants, and child and adolescent HIV. She is also involved in implementation science research to improve retention of HIV-infected pregnant and breastfeeding women. Dr. Fayorsey is an attending physician at Harlem Hospital, NYC, where she provides HIV prevention, care, and treatment to infants, children, adolescents, and young adults at the Family Care Center.



Mariana Garcia is a Brazilian clinical psychologist with a background in humanitarian aid working with Doctors without Borders/Médecins Sans Frontières (MSF). Based in Cape Town, South Africa, at Southern Africa Medical Unit (SAMU), she started working with MSF in 2009 in different contexts (Colombia, Gaza Strip, India, Zimbabwe, etc). She completed a Master's in International Cooperation and Development at University of Cantabria Spain in 2009. She joined SAMU in March 2016 as Patient Community Support advisor providing technical and strategic support to HIV/TB programs on health promotion and mental health activities in different projects in the southern African region (Zimbabwe, Malawi, Mozambique, South Africa, DRC, and Guinea).



Irénio Gaspar is a medical doctor, qualified at Eduardo Mondlane University and currently working as the STD and HIV/AIDS Programme Supervisor at the Maputo City Branch/Directorate of the Ministry of Health since 2015. Due to the nature of his work, as well as the country's high HIV prevalence, he works mostly with the general population, with special focus on high-risk groups: the LGBT community, prisoners, and sex-workers.



Nathalie Grah is a medical doctor, with a Diploma of Specialized Studies in Pediatrics, and holds Master's in Public Health. She is currently the HIV Pediatric Care and Treatment Senior Advisor at ICAP at Columbia University. Dr. Grah also holds Certificate in Project Management from Ecole Centrale de Lille in France.



Anna Grimsrud, PhD, is the Lead Technical Advisor for the International AIDS Society (IAS). Dr. Grimsrud's project focuses on supporting the implementation of differentiated models of antiretroviral therapy delivery in sub-Saharan Africa. She holds a Master of Public Health and PhD from the University of Cape Town, and has been involved in research with IeDEA-Southern Africa Collaboration, the Desmond Tutu HIV Foundation, and Médecins Sans Frontières (MSF).

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Yoseph Gutema is a medical doctors and the Pediatric Technical Advisor at ICAP Ethiopia.



Eduarda P Gusmao is a Clinical Officer, Pediatric HIV Care and Treatment, and PMTCT for ICAP at Columbia University. Dr. Pimentel de Gusmao is a pediatrician with specialization in infectious diseases and provides clinical and programmatic support to ICAP programs in sub-Saharan Africa, including Mozambique, Angola, Tanzania, Sierra Leone, Swaziland, and Kenya. She has over 15 years of experience in clinical and public health work in maternal child health (MCH), HIV-infected children and adolescents, and PMTCT in low- and middle-income settings in Brazil and sub-Saharan Africa.



Sthembile Gombarume joined USAID on in 2014 as a Project Development Specialist – Care & Support. She has 18 years of experience managing HIV and AIDS Programs in the Southern African region and has worked in Malawi, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe supporting community development. She has worked for regional and international NGOs, including FHI-360, Save the Children UK, World ORT International Cooperation, and the Southern African AIDS Trust in various capacities, namely program management, capacity building, and monitoring and evaluation. Sthembile holds a Master's Degree in Development Studies from the University of the Free State, a Master's Degree in Business Administration from Nottingham Business School, and a BSc. (Honours) from the University of Zimbabwe.



Clorata Gwanzura, is the Differentiated Care Medical Officer, HIV Care and Treatment, at MoHCC Zimbabwe. With support from the CQUIN project, she supports differentiated care projects in the AIDS and TB Unit. She recently joined ICAP in Zimbabwe and has five years' experience working at various levels in the Zimbabwe Ministry of Health, implementing and managing health programs including HIV programming. Key areas of interest include health systems strengthening and program management. Dr. Gwanzura is a medical doctor and holds an MPH degree.



Joseph Kabanda is a Public Health Specialist who received his medical degree from Makerere University College of health sciences in Uganda and earned a Master of Science in Public Health degree at Makerere University, school of public health in Uganda. For the past 10 years, Dr. Kabanda has served in various capacities at various levels of service delivery to improve HIV/AIDS services in Uganda to achieve epidemic control. Currently, Dr. Kabanda is working at Centers for Disease Control and Prevention (CDC)-Uganda, in the health services branch as the HIV Care and Support specialist. He provides national-level technical assistance and supports the Ministry of Health, implementing partners, and health facilities about HIV/AIDS care and support issues including development of guidelines for the differentiated service delivery models (DSDM) for Uganda. Currently, Dr. Kabanda is continuing to make contributions and input into the implementation manual, job aides, and SOPs for implementation of DSDMs in Uganda.



Jacqueline Balungi Kanywa is the Manager of Medical Care at Baylor College of Medicine Children's Foundation, (Uganda BCMCF-U). Dr. Kanywa began her health career 16 years ago when she worked as a primary healthcare provider for six years at St. Mary's Lacor Hospital in the formerly war-torn Northern Uganda. She then joined BCMCF-U as a researcher in the field of HIV/ AIDS with the multi-country Anti Retro Viral Research for Watoto (ARROW) trial, a research project that influenced the WHO 2013 ART guidelines. Dr. Kanywa is an epidemiologist and general practitioner. She is a graduate of the University of Texas School of Public Health and Makerere College of Health Sciences, formerly known as Makerere Medical School. She has been engaged in various local, national, and international guidelines development meetings with the Uganda Ministry of Health, Jansen Pharma (Johnsons & Johnsons), New Horizons, and World Health Organization headquarters in Geneva.



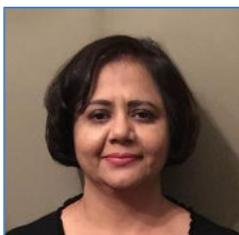
Hervé Nzereka Kambale is a Differentiated Care Advisor for the Swaziland National AIDS Programme (SNAP). He is dedicated to scale up the implementation of differentiated care for patients at high risk of advanced HIV disease progression in Swaziland. Dr. Kambale has eight years' experience in HIV clinical and program management, as well as five years' of clinical experience in general medicine. His major contributions include successfully raising standard of care through health education and capacity building, mentoring and supervision, and effective collaboration with the Ministry of Health and other NGOs in palliative care, cancer management, PMTCT, HIV/AIDS, and maternal-child care. Dr. Kambale graduated with an Mphil in HIV/AIDS Management from Stellenbosch University in 2013, and an MBChB from the Catholic University of Bukavu in 2005. He has previously worked in Rwanda, DR Congo, Botswana, and Swaziland.



Wamaka Kaminyoge is the Senior Technical Officer for Care and Treatment for the Elizabeth Glaser Paediatric AIDS Foundation (EGPAF)-Malawi. He is responsible for rolling out differentiated service delivery models while monitoring and documenting their promising practices. He is also responsible for providing input and coordinating all HIV-related care and treatment activities for both adults and paediatrics including EID, PMTCT, VL scale up, monitoring of treatment failure, and patients initiated on second line treatment. Dr. Kaminyoge holds a Bachelor's Degree of Medicine and Surgery from University of Malawi.



Dumbani Kayira is a pediatrician with program, research, and clinical experience in maternal and child health, HIV/AIDS, and TB. Dr. Kayira is currently responsible for planning, implementation, and evaluation of pediatric and adolescent HIV and PMTCT programs for The U.S. Centers of Disease Control and Prevention (CDC)-Malawi. Previously, Dr. Kayira conducted HIV/AIDS, TB, and malaria clinical trials with University of North Carolina in Malawi. Dr. Kayira received his medical degree at University of Malawi's College of Medicine and completed his pediatric residency at the University of the Witwatersrand in South Africa.



Gurpreet Kindra is a medical doctor and a Health Specialist, Pediatrics for Care and Treatment at the U.S. Centers for Disease Control and Prevention (CDC)-South Africa.



Sophia Ladha is an international public health professional with extensive management, technical support, and research experience in Africa on sexual reproductive health and rights, family planning, youth, HIV/AIDS, maternal and child health, and strengthening health systems. She enjoys being involved in projects at different stages, from inception to evaluation. Ms. Ladha is dedicated to improving health and development outcomes for women, youth and families in Africa. Over the past six years, Ms. Ladha has led and managed multiple donor-funded projects concerning adolescent sexual and reproductive health (ASRH), including HIV prevention, care, and treatment, as well as comprehensive abortion care (CAC) implemented through close collaboration with the National Department of Health (DoH) and Provincial DoH.



Sheena Lott is a Deputy Country Director that has worked in the field of development at both a community and facility levels with particular interest and experience related to the implementation of HIV health systems strengthening programmes. Sheena believes that health systems strengthening projects should encompass delivery at both a community- and facility-level that are complementary, but have traditionally been implemented in isolation from each other. A facility provides curative services to those in need of health care, however, there is a need to incorporate the larger community and household to ensure a positive health outcome especially in the arena of HIV. Sheena believes in a “whole-system change”, which incorporates the engagement of community structures and support for holistic patient care at a household level resulting in enhanced health outcomes of individuals. This change requires a much broader number of role players and the need for localized political support.

Sheena was responsible for the successful implementation of a PEPFAR-funded health systems project that resulted in a strengthened referral network between the district hospital and surrounding primary healthcare clinics. This project included the successful down-referral of patients to primary health care facilities at a time when hospital care for HIV patients was the preferred model. Sheena’s community-based experience mentoring organizations and implementing OVC and adherence programmes for people living with HIV has cemented her belief in a “whole system approach” to public health care. Sheena holds a B. Soc. Sc. Degree from the University of Natal – PMB.



Judith Lungu is the Head of HIV Adolescent Psychosocial Programmes for Baylor College of Medicine Children’s Foundation Malawi (BCM-CFM). She has helped develop the Adolescent Programme by piloting interventions for teens transitioning from teen clubs, pregnant teens, and also facilitated scale up of the working ‘teen club’ model across Malawi. As a BCM-CFM representative, she is working with the Ministry of Health (MoH) in coming up with a minimum teen club package that will be included in the 2018 HIV Management Clinical Guidelines. Ms. Lungu has a background in psychology and is currently pursuing her MPH.



Victoria Masuku is a URC Senior Advisor for Community Grants and Partnerships. She is a public health specialist with 27 years' experience in clinical and community health care settings. She currently oversees the implementation of differentiated care models in collaboration with community-based organizations to rollout patient-centered HIV care. She participates in various national technical working groups and has supported development of key national guiding documents. Mrs. Masuku recently participated in the development of the Swaziland National Differentiated Care Guidelines and Standard Operating Procedure Manual and support capacity building for health care facilities and community partners to implement these ART service delivery models.

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Getrude “Getty” Matshimane is the Deputy Director, HIV Youth Prevention Manager for the National Department of Health, South Africa.



Zenebe Melaku is ICAP's country director in Ethiopia. He has over 20 years of clinical, academic, programmatic, and managerial experience in medicine and public health in Ethiopia. In his current role, Dr. Melaku oversees the planning and implementation of comprehensive and high quality HIV/AIDS care and treatment services at ICAP-supported sites in eight regions of Ethiopia. He provides technical and managerial oversight to program activities at the national, regional, and site-levels and liaises with the Federal Ministry of Health and other project partners and collaborators.

Before joining ICAP, Dr. Melaku was an Associate Professor of Internal Medicine at Addis Ababa University and served as the Technical Advisor for HIV/AIDS Care and Treatment at the U.S. Centers for Diseases Control and Prevention (CDC) in Ethiopia. His areas of expertise include HIV/AIDS, TB, health systems strengthening, program management, organizational development, and strategic planning. Dr. Melaku holds a medical degree with a specialty in internal medicine from Addis Ababa University, a Certificate of Fellowship in Neurology from the University of Limoges (France), as well as Certificates in Rheumatology, Advanced Epidemiology, and Research Methodology and Clinical Field Trials from the University of Bergen (Norway).



Priscilla Lumano-Mulenga, BScHB, MBChB, MScID, is an Infectious Disease Specialist who is currently working as the Technical Advisor to the HIV unit at the Ministry of Health, Zambia. She has been involved with the National Anti-Retroviral (ARV) Program since its inception in 2002. In 2005, she joined a local USG Care and Treatment Implementing Partner called the Centre for Infectious Disease Research in Zambia (CIDRZ), where she held various positions including Head of Quality Assurance/Quality Control (QA/QI) before moving to the Elizabeth Glaser Paediatrics AIDS Foundation (EGPAF) as the Technical Director.



Alemtsehay Abebe Wolde Micheal is an HIV Program Officer for the Federal Ministry of Health in Ethiopia. She holds a Master's in Public Health.



Dalitso Midiani is the PMTCT Early Infant Diagnosis Program Officer at the Malawi Ministry of Health. She has a Bachelor of Science degree in Nursing and Midwifery and has a Master's Degree in Public Health. Ms. Midiani has worked in the HIV and AIDS program for the past 15 years as a medical and public health practitioner. She serves on various HIV Technical Working Groups within the Ministry of Health, including the SPARK Health Initiative, in collaboration with the University of Cape Town.



Munamato Mirira, MBBS, MBA, MSc., is a Senior Clinical Advisor at USAID Swaziland. He received Bachelor of Medicine & Bachelor of Surgery degrees from the University of Zimbabwe, a MSc. in Biostatistics and Epidemiology from the University of the Witwatersrand, and an MBA from Heriot-Watt University.



Musonda Musonda has over six years' of experience in the public health sector, particularly in HIV prevention and community mobilization. Currently, Musonda is the Head of Community Programs at Centre for Infectious Disease Research in Zambia (CIDRZ), where she provides oversight for several community-based programs, including two adolescent-focused programs. She also promotes community ownership and commitment to enhance sustainability. Musonda holds a Master's Degree in International Relations from London Metropolitan University, where she focused on the various efforts made to achieve justice and reconciliation in post-genocide Rwanda. As a 2016 Mandela Washington Fellow, Musonda is working to build upon her experience in community engagement and focus on the incorporation of behavioral change into existing and future HIV prevention programs. She is especially passionate about providing comprehensive sexual and reproductive health services to adolescents in Zambia, including DSD models for adolescents.



Lydia Mpango is a Senior Clinical Services Advisor Care and Treatment AIDSFree Project Swaziland, providing technical assistance to the Swaziland National AIDS Program (SNAP) to improve pediatric and adult care and treatment access and psychosocial support. She also provides support in the planning, coordination, implementation, and quality improvement of comprehensive HIV/TB/PMTCT activities at the regional (Hhohho) and facility level. Lydia has a special interest in implementation differentiated HIV service delivery and improving long-term health outcomes of children, adolescents, and their families.



Nobuhle Happiness Mthethwa is the National Pediatric HIV Care and Support Advisor for the Swaziland National AIDS Program (SNAP).



Batanayi Muzah is the Acting Country Director for ICAP South Africa. Dr. Muzah possesses a medical degree diploma in HIV management and MSc. in Epidemiology and Biostatistics. He has extensive HIV and TB clinical medicine experience from Zimbabwe and Namibia before starting a career in Public Health in South Africa. Dr. Muzah has held management positions with several institutions in South Africa. He spent much of his time at ICAP working as the Senior Technical Advisor working closely with the South Africa National Department of Health on various projects.



Anne Nakirijja is the Deputy PEPFAR Program Manager at Makerere University Walter Reed Project (MUWRP). She supervises and supports program teams to implement the HIV prevention, care, and treatment program activities in line with the Ministry of Health and PEPFAR guidelines throughout four districts in Uganda. The programs provide prevention (HTS, VMMC, DREAMS, eMTCT, KP/PP programming), care and treatment (pediatric, adolescent, and adult TB and HIV services), adopting the health systems strengthening approaches.



Prosper Ndlovu, is a 22-year-old youth advocate for HIV positive adolescents from South Africa. He was the IAS Youth Champion for South Africa and is currently a Counselor and Youth Club Facilitator for Wits Reproductive Health and HIV Institute.



Tendai Nyagura has worked with USAID Zimbabwe since 2015 as a Public Health Specialist (HIV Care and Treatment). Previously, she worked in the Ministry of Health in various portfolios which include District Medical Officer, Provincial Epidemiology and Disease Control Officer, and Medical Officer for ART within the AIDS & TB Unit, MOHCC HQ. Tendai is a qualified medical doctor with a Master's in Public Health from the University of Zimbabwe. She is an active member of the Zimbabwe Public Health Physicians Association. She has interests in epidemiology and enjoys teaching public health topics.

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Heidi O'bra works at USAID Zambia.



Justine Jelagat Odionyi is a Consultant-Paediatrician with a vast experience in provision of Quality HIV care with special interest in pediatric and adolescents health. She is a graduate of the University of Nairobi - Bachelors in Medicine and Bachelors in Surgery, and has a Master's in Paediatrics and Child Health (M.MED). Dr. Justine joined Elizabeth Glazer Pediatric Aids Foundation (EGPAF) as a Senior Pediatric and Adolescent Technical Advisor in 2016. She coordinates and provides technical, leadership, and management support to implementation of high-quality PMTCT, paediatrics, and adolescents HIV care and treatment services across EGPAF Kenya projects.

Before joining EGPAF, Justine worked with the Partnership in Advanced Care and Treatment – Centre of Excellence (PACT-COE), University of Nairobi as the Project Paediatrician where she had varied responsibilities including provision of technical support for the PMTCT program at Kenyatta National Hospital (KNH) and Pumwani Maternity Hospital. She led provision of high-quality paediatric and adolescent HIV care and treatment at KNH; supervision and mentorship of paediatric and child health postgraduate residents rotating in KNH HIV clinic; and developed capacity of health workers in PMTCT and paediatric and adolescent HIV prevention, care, and treatment services. She was also focal person for Accelerating Children's Treatment (ACT) Initiative's Rapid Results initiative in KNH and Pumwani Maternity Hospital. Previously, Justine worked with Ministry of Health as a Senior Medical Officer - Paediatric HIV Clinic - Coast Provincial General Hospital, Mombasa before joining Eldama Ravine District Hospital (Baringo County) as the Consultant Paediatrician.



Nicollate Awuor Okoko is the Technical Lead – Pediatrics and Adolescents at the Family AIDS Care and Education Services (FACES) and Kenya Medical Research Institute (KEMRI). She has nine years of experience in leadership and management in pediatric adolescent HIV/AIDS care and treatment, TB, PMTCT, HTC, and community-related health service supervision and provision. Dr. Okoko undertook medical training at Kenya Medical College and attained a BScPH in Public Health from Jomo Kenyatta University. She holds certificates in HIV Management

and Leadership from the University of Washington and the University of California, San Francisco.



Shenaaz Pahad is a Psychologist and Psychosocial Programme Manager of Adolescent Innovation Project at Wits RHI, and supports oversight of Bwisehealth.com. She has expertise in adolescent adherence and disclosure, mental health, gender-based violence, substance abuse, and HIV treatment and prevention strategies, addiction (especially eating disorders), psychological testing, migration, and resilience. She is the editor of *I ACT for Adolescents* and co-author of *Working with HIV-positive Adolescents*, multiple guidelines and research papers, technical advisor and researcher.



Mokgadi Phokojoe is the Director of Care and Support at the National Department of Health in South Africa. Ms. Phokojoe is a social scientist with 39 years of experience and over 25 years in the South African HIV and AIDS public health sector. She has held various leadership positions ranging from Marketing and Health Consultant at Johnson & Johnson, Social Worker for Randfontein Estates Gold Mine, Chief Community Liaison Officer for a National Nutrition School Program, Assistant Director: Health Promotion, and Deputy Director: Care and Support HIV and AIDS Program. She is currently serving as Director: Care and Support in the HIV and AIDS Cluster at the National Department of Health.

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Zukiswa Pinini is a medical doctor and the Chief Director of HIV/AIDS at the National Department of Health in South Africa.



Peter Preko is the Project Director for ICAP's CQUIN HIV Learning Network. Dr. Preko started his career in HIV work as the CEO and co-founder of AIDS ALLY, a local NGO that provided care and treatment in Ghana before national HIV treatment programs started in Africa. Prior to his current role, he was with ITECH – University of Washington, seconded to the Malawi Ministry of Health as the Senior Care and Treatment Advisor. Dr. Preko worked with CDC Swaziland from 2011 to 2016 as the PEPFAR Swaziland Care and Treatment Lead. Before joining CDC, he was the Senior Care and Treatment Specialist at ICAP in Swaziland. In Ghana, before moving to Swaziland, Dr. Preko was the Senior Program Manager (HIV/AIDS) at AED-SHARP and Engender Health. Dr. Preko obtained his BSc. Human Biology and medical degrees from the Kwame Nkrumah University of Science and Technology and a Master's of Public Health from the University of London School of Hygiene and Tropical Medicine.

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Pumeza Runeyi is a MSF Youth Club Supervisor from Khayelitsha, Cape Town, South Africa.



Ann Sellberg is a Swedish medical doctor who has been working as the clinical mentor for the Zvandiri Program in Harare since January 2017, focusing on peer-to-peer support for HIV-positive children, adolescents, and young people. Before joining Zvandiri, Ann worked with Doctors without Borders/ Médecins Sans Frontières (MSF) in Harare, setting up an adolescent program, and in Chipinge, conducting on-the-job training for health care workers in viral load monitoring and second line switch. She has been practicing in Zimbabwe since 2014.



Sharon Siko is a Youth Advocate for Y+ in Johannesburg.



Suilanji Sivile is an infectious diseases physician working at University Teaching Hospital in Lusaka, Zambia. He attends to adults and adolescents with advanced HIV at the UTH Center of Excellence. He is a member of the Ministry of Health Differentiated Service Delivery Steering Committee and participates in different HIV-related programs at the Ministry. His interests include immunologic and metabolic outcomes in patients on long-term HIV treatment.



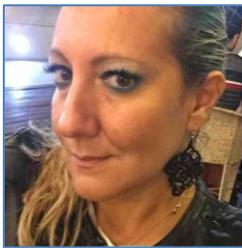
Nandita Sugandhi is a pediatrician with over 10 years of experience working in pediatric HIV care and treatment. After completing her training in New York in 2006, she spent four years working as a Pediatric AIDS Corps Doctor with the Baylor International Pediatric AIDS Initiative (BIPAI) in Swaziland, Botswana, Tanzania, and India. She then went on to work with the Clinton Health Access Initiative (CHAI) as a Clinical Advisor to improve access to essential drugs and diagnostics for HIV Prevention and Treatment in resource-limited settings. She joined ICAP at Columbia University as a Senior Staff Associate in 2017. She is also a practicing pediatrician providing care to HIV-infected and affected infants, children, adolescents, and young adults in New York City. She leads the Technical Advisory Panel for Pediatric AIDS Treatment for Africa (PATA), a network of over 250 clinics in sub-Saharan Africa dedicated to providing high-quality pediatric HIV care. She is also an active member of the IATT Child Survival Working Group, which provides technical assistance and coordination across multiple stakeholders and national programs to ensure policy and practice effectively fit country-specific patient needs.



Dr. Maureen Syowai is a Regional Technical Specialist at ICAP Kenya, where she works on the Optimize and CQUIN projects.



Wondimu Teferi is a public health specialist working with the U.S. Centers for Disease Control and Prevention (CDC) in Ethiopia since 2008 as a Pediatric HIV Care and Treatment Program Advisor. Dr. Wondimu is responsible for providing guidance and oversight for planning, implementation, and monitoring of pediatric HIV care and treatment activities by CDC Ethiopia partners. As a lead for CDC Ethiopia Pediatric HIV program support, Wondimu is involved in the design and implementation of projects related to pediatric HIV and other child health issues involving numerous partners and the Federal Ministry of Health. Prior to this, Wondimu was a clinician and instructor in the University of Gondar for five years. Wondimu earned medical degree from Jimma University, specialty Certificate in Pediatrics and Child Health from Addis Ababa University, and Public Health Degree from Gondar University.



Marilena Urso is the HIV Treatment Teal Lead at CDC Mozambique.



Marnie Vujovic is a clinical psychologist with considerable experience in the development and implementation of psychosocial programmes for children and adolescents infected with HIV. Dr. Vujovic has been actively involved in strengthening psychosocial support for adolescents attending healthcare facilities in provinces across South Africa and was instrumental in developing adolescent- and youth-friendly services for the Harriet Shezi Adolescent HIV clinic at Chris Hani Baragwanath Hospital. As a consultant in the children's sector for four years, she was involved in the development of tools and resources for healthcare providers working with HIV-positive teens and has led studies looking at adolescent sexual and reproductive health and other aspects of adolescent development including the mental health of HIV-positive adolescents on antiretroviral therapy. In 2013, Marnie joined Right to Care as a Psychosocial Programme Manager and is heading its Paediatric and Adolescent HIV Programme.



Dalila Zachary is currently a consultant HIV Advisor for the Technical and Advice and Partnerships Department at the Global Fund. Dr. Zachary studied medicine at Johns Hopkins School of Medicine in Baltimore, Maryland. She trained in internal medicine at Temple University Hospital in Philadelphia and infectious diseases at Brown University in Providence, Rhode Island. She spent three years in Zambia performing HIV and TB research, teaching post-graduate students in HIV and infectious disease programs, and helping to set up the first third-line ART clinic at the University Teaching Hospital in Lusaka. Since 2014, she has worked with the Global Fund as a Technical Advisor to support timely identification of opportunities for existing HIV grants, and for programming of new funding with an increased focus on program quality, efficiency, and improved innovative differentiated service delivery models. Her work has focused on support to streamlining of strategic priorities including gender, adolescents, women and girls, key populations, and human rights investments.



Simukai Zizhou is a medical director working in Mashonaland East Province of Zimbabwe for the Ministry of Health and Child Care. Dr. Zizhou is a public health specialist with a Master's of Public Health, a Certificate in Monitoring and Evaluation, and a Certificate in Applied Epidemiology.



Gerald Zomba joined USAID Malawi in 2016 as a Pediatric HIV Specialist after he worked briefly with Action Aid Malawi as an HIV Technical and Advocacy Coordinator for the TB/HIV Global Fund Project. He is a member of USAID Malawi HIV Treatment and Care Team responsible for Pediatric and Adolescent Portfolio. His professional career started in 2003 as an ART Clinician for Médecins Sans Frontières (MSF) in Chiradzulu HIV Project. Two years later, he was appointed as a TB Program Manager, a position he held for five years. In July 2011, he joined the Department of HIV and AIDS for Malawi Ministry of Health to do a two year HIV fellowship program jointly offered by CDC, I-TECH Malawi, and the Ministry of Health. Upon completion, he was offered a position of HIV Program Officer. He left the Department of HIV and AIDS in March 2016 for ActionAid Malawi. He holds a Master's of Public Health (Malawi), Bachelor of Science (Namibia), and Clinical Medicine Diploma (Malawi).

Not Pictured

Bongiwe Zulu is a Youth Advocate at Aurum in South Africa.

Full Transcripts

Tuesday, October 24th

Participant Introductions

Dr. Batanayi Muzah, ICAP South Africa

“Good evening everyone, and welcome to South Africa. I would like to take this opportunity to welcome representatives from Ethiopia, Kenya, Malawi, Mozambique, Swaziland, Uganda, Zambia, and Zimbabwe to this very important meeting. This meeting is very close to my heart. In my last years as a clinician, I started an HIV clinic in rural Namibia. I had teenage patients, one of which – a 16 year old girl – I grew very close with. One day, she told me she had a boyfriend, and that this boy wanted to have unprotected sex – it was a very difficult time for her.

Another patient, who was 15 at the time, always came to the clinic with her mother. One day, I asked for her mother to step out so she could talk to me privately. She told me she was angry with her mother, because she had not disclosed to her why she was taking pills ever since she was a child. I took initiative to start an adolescent clinic, and to this day, it is still functioning.

The reason we are here is to talk about scaling up DSD for adolescents and young people living with HIV. The reason we are doing this is that we feel if we do not provide the same care to these young patients as we provide to others, we’re going to miss an opportunity to keep future generations healthy.

I was going to come to this podium with a song but my backup vocalist is not here. The song I wanted her to sing was *What Have We Done?* I wanted her to sing this song because it is relevant to this meeting: What have we done...for adolescents? We concentrate a lot of our time providing care for adults, but we forget about the gap in between and we think about it as an afterthought. I spent a lot of time at the South Africa NDOH, and I can tell you that when we plan for anything, we plan for adults. When we speak in public, we talk about inclusive planning, but we never consult. We have adolescents here with us because this time, we are going to plan and consult with you.

This is an opportunity we should take to learn from the adolescents participating in this meeting and make sure that in the next three days we deliberate fruitfully, and come up with things that are meaningful, and respond to the needs of adolescents. I am very confident that we are going to have very positive outcomes. All I ask is that you be open and accept the criticism and feedback that comes from the adolescents. Thank you very much, and enjoy your stay in South Africa.”

Dr. Zukiswa Pinini, South Africa NDOH

“Good evening ladies and gentlemen, and welcome to South Africa. Good evening, for those who speak English; Bonjour, for those who speak French; and Sawubona, for those from South Africa. I want to thank the adolescents who are here tonight. As Batanayi said, this is the first time we are really planning with them.

In the older days, people living with HIV used to say “nothing about us, without us”. I now think the adolescents and young people are saying something similar to us: that we must understand them in order to deliver the care they need, and ultimately win the fight against HIV.

I would like to acknowledge the presence of all the staff from the MOH of all nine countries here tonight. I would also like to acknowledge the leadership from USAID South Africa and ICAP at Columbia University; the representatives from the Bill & Melinda Gates Foundation, PEPFAR, CDC, and USAID; all of my fellow South Africans; and all of the organizers that are here today that are helping us have this workshop.

I would also like to thank ICAP, under the leadership of Dr. Muzah, for organizing this meeting. It is coming at a crucial time here in South Africa, as we have just launched our National Strategic Plan (NSP) for HIV, TB, and STIs, 2017-2022. We also know we must meet the UNAIDS 90-90-90 targets. There are many adolescents infected with HIV/AIDS, and we don't have concrete programs for this population, as they are lost between pediatric and adult care. I know that some of our partners in South Africa are assisting us in addressing this issue, but we need to scale up our practices.

South Africa is the epicenter of HIV. We have the highest rate of infections in the age group 15-24, especially among young girls. As a government, we have launched a campaign focused on adolescents (mainly girls) that helps to ensure they complete school through matriculation; prevents teen pregnancy; educates them about HIV/AIDS; and reinforces independence so they can fend for themselves and not depend on other people. Through this program, we are trying to address the problem of the “blessers” – older men who have relationships with young girls and at times, infect them with HIV. We also offer services for males with this program, and we have a website that fosters communication amongst youth.

The South African Government is working on prevention programs for adolescents. As we know, UNAIDS has said that by 2020, we must reduce new HIV infections to around 88,000 per month, and currently that number is quite high at 270,000 new infections. The hardest hit age group is 15-25; we must look at DSD for adolescents and explore ways to prevent new infections. So once again, thank you for coming, and I thank ICAP for organizing this workshop. I hope that we can all learn some new things, including best practices from other countries.”

Dr. Elaine Abrams, ICAP at Columbia University

“Good evening everyone, and welcome. I am so excited about this workshop and the opportunity to have all of these great minds together to do the work. The CQUIN learning network includes nine countries, and the focus of the network is on joint learning toward the scale up of DSDM in order to improve coverage, quality, and efficiency. It is a form of knowledge exchange and co-creation, especially in an area where models, tools, and resources are scarce.

This workshop is one of a series of workshops aligned with CQUIN's ‘communities of practice’, which were selected at the launch meeting in March of this year. They identified five domains: stable patients, with a particular focus on M&E and QI; patients at high risk of disease progression; adolescents; men; and HIV and NCDs.

At this workshop, there will be a series of plenary presentation; you will learn about the network; and there will be talks on the state of the art for adolescents living with HIV, innovations to reach the first 90 for children and adolescents, and optimizing ART for this group. There will also be a series of

panel discussions covering a variety of issues, such as national and guidelines and priorities. We are going to have a great opportunity to hear the voice of young people and adolescents. We will also discuss optimizing care and bringing evidence from the field, a legal framework for a variety of issues that are particularly important for this population, and discuss innovations and experiences based on the work that's already ongoing for DSDM for adolescents.

We are also planning a debate; we use this format in a number of meetings and it's a fun, exciting, and interesting way to exchange information and learn new things. Most importantly, there will be breakout groups where you will all get to work with knowledge exchange, co-creation, and tool development.

The CQUIN group typically sends a survey out to help participants prepare for the meeting and think ahead about the work they will be doing. For this meeting, we sent a survey and received 59 responses from people from 11 countries. The survey is in line with our meeting objectives, and it's intended to help identify challenges and opportunities among the countries and frame the discussions. I am going to give an overview of the results of the survey and I hope it will influence the discussions over the next several days.

First, we asked to what extent is DSD for adolescents supported at the policy level in your countries. Surprisingly there was a lot of support, with 53 percent of the countries saying DSD is somewhat supported at the policy level, and 30 percent saying it is strongly supported. That is wonderful news and a great starting point for the work we'll be doing.

Next, we asked: Do HIV treatment guidelines in your countries address DSD for adolescents? At least 50 percent said yes but we see there is a long way to go in several countries before we see DSD included in the guidelines.

Are you aware of pilot projects of DSDM for adolescents? We probably have a select group of people participating in the meeting, but almost two-thirds said yes, they were aware of some pilot projects or activities, while only 22 percent said no. When asked to describe the pilot projects, you'll see that respondents mentioned community-based support groups; fast-track for adolescents in Zimbabwe combined with school schedule and peer support; youth care WHAT group HIV management approach; integrating clinical care and psychosocial support; and teen club models in Swaziland. I think you'll hear more about the particulars of these projects and others over the course of these three days.

We asked what services you feel should be included in a minimum package of DSD for adolescents. I found this quite interesting. It started with a human resources training and supervision to ensure youth-friendly services could be provided. Also mentioned were peer counseling support groups; adolescent days; and information and sharing-sessions at a clinical level. There was a lot of attention to multi-month ART prescribing and other aspects of clinical services; psychosocial support and contraceptive services; and convenient hours for adolescents to access services, including weekends. We will likely see this list shuffle and grow as we spend these three days together.

Next, we asked if you were aware of any training curricula in your country for DSDM for adolescents. About 45 percent said yes, while close to half said they were not. There were several examples of various training curricula, I imagine for specific programs, including youth clubs in Khayelitsha that have been rolled out at the national level; operation triple-zero and APOC

curriculum; the WITS RHI toolkit for adolescent programs; and the teen club model led by the Baylor Pediatric AIDS Initiative that's been implemented in several countries.

To what extent is DSD for adolescents implemented in your country? Over half of respondents said there were programs implemented 'to some extent' – likely at the pilot level; over 30 percent said implemented at scale – in more than 50 percent of districts; and a small number of you said nothing is being implemented.

So what would make it easier to deliver DSD for adolescents in your country? Answers to this question included integration with primary health care, maternal and child health services; enforcement of existing policies at a district level; child-friendly clinics with incentives such as Wi-Fi access, free data, and reminder gadgets; collaboration with youth-friendly organizations; and staffing and infrastructure improvements. I was struck by how many of these were systems issues.

We asked what the most significant barriers were to DSD for adolescents. Not surprisingly, we see weak health systems, stock outs, and loss-to-follow up as an answer. Also, absence of policies, inadequate manpower and resources, insufficient local data on adolescent DSD models, a lack of adolescent empowerment, poor training of health care workers, and insufficient viral load monitoring. So there's really a variety of barriers and challenges at the local level as we think about putting DSD models into place for adolescents.

Finally, what would you like to learn from other countries about this approach to adolescents? We saw answers such as how to sustain adherence; successful models and how they were sold to adolescents to ensure uptake; how programs initiated and scaled up; how to address M&E issues or apply them to DSD models; and how to utilize community platforms for success.

There were a number of questions that came through from participants as well in the survey, and I think everyone here is enthusiastic about listening and learning from everybody. I hope that survey is provocative and helps people think about what they are going to share over the next few days. Our goal here is to launch the CQUIN adolescent community of practice by covering the nine CQUIN countries to share experiences on the 'how' of DSD for adolescents; share resources and existing tools; and work together to develop tools and frameworks related to DSD for adolescents and young adults.

This is a unique opportunity to talk to each other, learn from one another, and be creative and think ahead to how we can make services for adolescents as strong as they can be. It is an opportunity to be innovative and work with these young people to ensure the best health outcomes possible. Thank you again for being here, and we'll see you tomorrow."

Mr. Prosper Ndlovu, WITS RHI

"Good afternoon everyone. My name is Prosper. I am a youth care club facilitator from WITS RHI, an IAS youth champion, and an advocate for young people. First, I want to share with you my story. I discovered I was HIV positive in 2006, so I've been living with HIV for most of my life. I've been taking ARVs for 12 years, since 2005.

At first, it was normal to start medication, but as I grew up and started to understand the process of living with HIV, it became too difficult for me. My family used to fight a lot, and my father hated me. I used to be the outcast of my family, so I had low self-esteem and couldn't believe in myself. When I was in the seventh grade, my mother and father divorced. When they divorced, my father denounced

me, which affected me psychosocially. I could not cope at school and failed my classes – my life was miserable. I was invited to a peer support group by my social worker, where I met with people my age. We had discussions, engaged, and educated one another about the issues we were facing.

One day, I attended a motivational-educational camp, and it built me up. When I came out of the camp, I realized my dream – that one day, I would become a motivational speaker to inspire young people. As I engaged with young people, I told my social worker, that I have this passion in me that I want to help and motivate people. So the social worker helped me to join a community advisory board, where me and my peers advices on studies to distribute medication to young people. Once I passed my matriculation, I became a youth care club facilitator, which is my post right now. I run sessions with young people – those newly initiated on treatment and virally suppressed, and those who are not virally suppressed.

We meet on a monthly basis and discuss health issues, including teenage pregnancy. Being amongst young people makes me realize that the best services for my peers and me are youth-friendly services. The reason I am standing here today is the support I have got over the years from young people, as well as the staff that treated me in the clinic. If I had received bad service from unfriendly staff, I would be bitter, and would not be here today.

I am proud to be an advocate for young people. I remember when my father denounced me, I defaulted from my medication and I became drug resistant, and they had to switch my regimen. It was all just so complicated, and I wanted to end my life. The dream that was built inside of me gave me hope. People like me need youth-friendly services in a friendly environment. I do not define HIV as others do. I define HIV as “Human Impact to Victory”. I believe that as human beings, it is our responsibility, our impact, to overcome the virus. When we overcome the virus, we become victorious.

My motto is this: HIV lives in me, but it is not in control of me. I am in control of HIV. Thank you.”

Wednesday, October 25th

Welcome and Opening Remarks

Ms. Mokgadi Phokojoe, South Africa NDOH

“Good morning colleagues. Yesterday, as I was reflecting on what I should say this morning, I started thinking of the challenges I faced when I was a teenager. I encourage you all to do the same. We are all now adults. Some of us are technocrats, technical advisors, managers, project leaders, support partners; it’s our responsibility to come up with strategies to help those who are now teenagers. When we were teens, we were in a world of our own and did not want to listen to anyone, and when we look at our data on adolescent HIV/AIDS...oh my word, it’s as if we are not listening to what these young people need.

When I was growing up, HIV was not around, and how lucky we were. Unfortunately, our children that we are raising are exposed to all of the challenges we faced, on top of the challenge of HIV. We are going to use these three days to deal with how, as a collective of different countries, we will implement strategies to deal with the challenges adolescents face. May I also take this opportunity to welcome all countries represented here today. You have all come to share best practices, challenges,

and the solutions you have put together to ensure that we, as Africans, and others around the world can deal with these challenges.

Ladies and gentlemen, we are facing these challenges at different levels, and therefore we need each other to help lift one another to the next level, especially within the context of the 90-90-90 goals. There is a passage in the bible that says, ‘When your heart is overwhelmed, lead me to the rock that is higher than I.’ I am sure in one way or another as parents, technocrats, managers, as aunts and uncles, grandfathers and grandmothers, that we are overwhelmed by the responsibility of looking after these adolescents. Some of us are even managing this in our own households.

We need help, and it has to come on strong. I am hopeful that among us, we will find strategies that will help one another emulate, learn from, and implement in our countries. Lo and behold, all of the things we’re learning will also require resources – be it human resources, financial, or technical support. We need these things so we can create capacities in our countries to ensure we deal with the challenges facing adolescents on HIV/AIDS-related matters.

On that note, I am hoping that we can come up with solutions. I hope that at the end of the day, as individuals and countries, that we can say we did all we could, so that the generations that come after us can say we did our best; and that our best was sufficient to take us to another level.

I am a very purpose-driven person. The fact that you are here and you came from your different countries means that there was a reason for you to come here, to network, socialize, and cross-pollinate. Having said that, I wish you all the best over the course of three days. Welcome, welcome, welcome.”

The CQUIN Learning Network: Communities of Practice

Dr. Peter Preko, ICAP at Columbia

“My job is simple. I am the ambassador for CQUIN, the marketing director, and I am here to let you know what this network is all about. In Uganda, they say that ‘One person is a thin porridge, two or three people is a lump of Ugali.’ This simply means that if more people do things together, they are better off – stronger. Ugali is heavy, so it can sustain you through the day; it gives you energy and sustainability so you can accomplish more together.

So what is a learning network? I am sure we have all been part of learning groups in school where we study together. When you are in a group, you realize that sometimes you do not have to learn everything. Someone learns something, and even if you all learn, some may learn or understand certain things better. If you have a group, they can explain things to you so you can better understand. A learning network is a structure that facilitates joint learning.

It is not simply an exchange of information – I could send you emails and publications, but you will not learn much. However, if we sit together and we discuss how I was able to do something, and I take you through the step-by-step, including the challenges I went through, then you can learn how I did it. It is also an approach that allows for co-creation of resources, which we will participate in over the next three days.

Doing work together is a way of catalyzing scale up. We talk about DSD and most of us have pilots in our countries. We are at a point that we want to scale up, but how do we do it? The skills and resources for piloting something are different from those needed for taking something to scale. A network like this gives us an opportunity to discuss things and even learn from those who have done it better.

The key element is to have this just-in-time information and knowledge at the point you want to scale up. For example, Mozambique is revising its guidelines, and developing a DSD implementation guide. This network has helped them get information on which models they can add and they have visited countries to learn from others on what they are doing, and how they are doing it.

For a network to be successful, it must have certain characteristics. One of them is to have focus goals align with policy priorities. For us, the network's focus goals are scaling up DSD. You must have people who are experienced and are champions in that area. Looking around we have a lot of champions here, people who are very experienced in this network and will share their experience with us. A learning network also has to be participant driven. Yesterday I was at the PATA conference and people were asking about CQUIN in their countries and I said it is demand-driven, but it is also participant-driven. For example, the decision to have this workshop on DSD for adolescents living with HIV was made by participants at the CQUIN launch in March in Durban.

You also need an effective external partnership. We have strong partnerships; we have PEPFAR strongly behind us, along with IAS, WHO, and others. ICAP is the convening body, so we have all of the key elements in place for our network to work.

CQUIN stands for HIV Coverage, Quality, and Impact Network. These words were chosen deliberately, because we believe that in order for DSD to have impact, it needs to be taken to scale – the coverage has to be good. Without good coverage, you cannot measure impact. Again, quality is important; many countries are hesitant to roll out adolescent models because they are skeptical about the quality. As we roll out DSD, we need to ensure that the quality is moving with us, and that is why for some of the countries we have started quality improvement projects.

CQUIN is funded by the Bill & Melinda Gates Foundation, and focuses on the 'how' of DSD. If you look at the decision framework, it talks about what we need to do, when we need to do it, where, and who should do it. This is the focus of our network. As we come together, you should be asking countries is about the 'how'. This is very important for the learning process. Overall, we want to be sure we can increase coverage and quality of DSD to have an enhanced health outcomes and programmatic efficiencies. We want to do this by demonstrating best practices – things that are working well to increase demand and generate interest from MOH, and measure what is working and not working. Our focus is on knowledge exchange, joint learning, and sharing of innovations.

Specifically, we want to ensure we work with you to identify cross-country barriers and joint challenges so we work together to solve them. We want to make sure that in each country, we try to implement some small project, so we can learn something that we can take to scale and share with other countries. We call these catalytic projects, and we have them happening in several countries.

What have we achieved so far? We are now in nine countries (we started with six). We have developed a dashboard that we have used to collect baseline information from the countries, and you can see there is an opportunity for learning, because we are not all at the same level. Even countries that are proficient in some areas are not in others. We have had ongoing south-to-south visits and

have engaged in tool creations. We have our M&E technical assistance to develop M&E tools, and are forming a tool-development task team that came out of the Harare workshop for patients at high risk.

We launched a [website](#), which I encourage you to visit, there is a lot of information on what countries are doing with DSD, and there are links to other important networks and organizations here. We have also exchanged information through webinars, journal clubs, and other publications. We just wrapped up a study in Zimbabwe looking at men and their preferences on DSD. We also have a formative study in Kenya that is going to be presented here, and we're going to have a study in Swaziland focused on self-monitoring of blood pressure. We also have workshops based on the communities of practice that you – our network members – prioritized at the launch. There are also virtual communities of practice such as M&E.

At the country level, we have seconded coordinators to some countries, and we've advocated for PEPFAR to support DSD coordinators in others. We have supported countries like Swaziland and Zimbabwe to revise their M&E tools so they can collect the right data.

Looking to the future, in 2020, we want robust knowledge exchange, to share what we have with others, and to be sure that we have universal ART coverage. I want to conclude by saying that every comet, once upon a time, was just a couple of years old, not very strong, and couldn't go far. That may be where we are at this point. As a network I hope we can learn from one another in the coming years so we can reach the 90-90-90 targets for all. Thank you very much.”

Adolescents Living with HIV: State of the Art

Dr. Elaine Abrams, ICAP at Columbia

“I'm delighted to be here this morning and very excited about the work ahead. I am going discuss adolescent living with HIV and precision public health to improve health outcomes. I will talk a little bit about who these adolescents living with HIV are, how they are doing, and then begin to paint a picture of what differentiated service delivery for adolescents looks like.

Everyone is aware that there are an estimated 36.7 million people living with HIV. In 2016 it was estimated that there were 1.8 million new infections, and close to one million deaths attributed to HIV/AIDS. We have had enormous success with scale up of ART with close to 20 million people now accessing ART services, and this really scaled up over the last seven to 10 years. Many people in this room were part of this, and we have seen a drop in the number of deaths, though still far too many, attributed to HIV/AIDS. With this, we've also seen an improvement of life expectancy at birth. There are an estimated 5,000 new infections each day in adults and children, about two thirds of which occur in sub-Saharan Africa. There are around 400 new infections each day in children less than 15 years of age, and we've seen that drop dramatically over the last five years.

Among the 4,500 new infections in those ages 15 and older, 43 percent are among women, 37 percent among young women 15-24 years of age, and 22 percent among young men. We have to keep all of this in context as we think about the work for this particular group of people. We have some very large targets, and we are hoping to end AIDS as a public health threat by 2030. Despite all of the accomplishments, we have a long way to go.

A little more than half of the estimated total number of people living with HIV are receiving ART and we have a very ambitious set of program coverage targets to be achieved by 2020. Everyone is

familiar with the three 90's: 90 percent of people living with HIV knowing their status; 90 percent with known status on treatment; and 90 percent on ART virally suppressed. The fourth 90 that we do not hear much about is to have comprehensive HIV prevention available to 90 percent of people in need. There are targets that are even more ambitious for 2030 that we should think about over the next three days, and those are the three zeros: zero new HIV infections; zero discrimination; and zero AIDS-related deaths.

We have a long way to go, and we see DSD as coming to the rescue to help us make the big leap and bend the curve to reach these targets. DSD is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV, while reducing unnecessary burdens on the healthcare system. It is DSD that will allow us to reach full coverage, with high quality and impactful services. So let's think about adolescents and providing tailored services to adolescents living with HIV.

First off, who are they? They are your children, friends, neighbors, and cousins. They are the kids you see driving to work, they're pregnant young women, young men who have sex with men, young girls who sell sex, young women and men who are caught up in war and turmoil, those who use drugs, the boys playing soccer, transgender individuals, and just the kids and young people who surround us and are part of our lives. They are who we were, and they are sitting in this room. When we recognize adolescents living with HIV, we need to recognize it is a very heterogeneous population of individuals. Some have acquired HIV through behavioral factors; some have been born with the disease. Adolescents includes young people aged 10-13 and older – people heading into adulthood.

Adolescence is a transitional stage of physical and mental development that occurs between childhood and adulthood. WHO defines it as the period of life between 10 and 19 years. Early adolescents can be from 10-13 or 10-15 years of age. Youth are defined by their age group, with WHO defining youth as the period of life between 15 and 24 years. Young people are also described as 10-24 years of age. We are going to use the term adolescents in this meeting, but we are actually thinking about youth and a more inclusive definition.

Adolescents is a time characterized by enormous change. It is a time of physical growth, puberty, and sexual maturation. A time of psychological and neurocognitive development, as well as separation and individuation. These trajectories do not necessarily happen simultaneously; sometimes they happen at different times, rates, or they start and stop. In the end, we hope that all of these changes bring us wonderful, well-formed, talented adults.

While childhood is characterized by dependence on parents, family, and adult caretakers, adolescence is a period of emotional growth and development. It requires adult supervision and decision-making. Your main job is education and learning. You are not supposed to be having sex or using bad substances, and in particular, for our purposes, your healthcare is generally supervised and then you emerge into adulthood when you are independent. As an adult, your education is expected to be complete or completing; you're looking for things like employment and residential independence; dating, partnership, and marriage are all normal aspects of adulthood along with pregnancy, parenthood, and sexual relationships. For the population of interest, all of these things are happening in the context of HIV infection and the adolescent brain.

Many of us have come to think of the adolescent brain as somewhat different from the adult brain. In addition, we have come to think of adolescence as a problematic time, and the prevailing theory

blames it on the brain and says because of this period of development, adolescents do stupid things and are difficult to work with.

It is a time when we see increase in morbidity and mortality associated with risky behaviors like substance abuse, unprotected sex, antisocial acts, and reckless driving. It has been proposed that it's because the brain is immature, the neural system and prefrontal cortex are slow to mature while you have a lot of maturation in parts of the brain that are easily excited. The brain's inhibitory system does not match the demands of the sensation-seeking system, resulting in increased participation and risky behaviors. This is more or less where we've landed thinking about adolescents, but there's an emerging theory that is much more optimistic, which may give us a more positive outlook on adolescents. This theory suggests that this heightened attraction to novel, exciting experience known as 'experience seeking' which peaks during adolescence, is actually a normal mental approach. It states that adolescents lack experience so they are trying things for the first time, like driving, figuring out what to wear, or using drugs. For most youth, this period passes without major catastrophe.

There are a smaller subset of teens who exhibit this impulsive behavior and have weak cognitive control – they are at most risk for unhealthy outcomes. But if we think about this time and increase in risk-taking as an adaptive need to gain experience required to assume adult roles; that teens are doing things and making decisions to learn and grow; if we frame the approach that way, we may understand their behavior and better-engage with them.

There are a number of enormously successful people who dropped out of college (Bill Gates, Oprah Winfrey), and you can imagine what their parents thought when they called them and told them they had enough of school...who would have guessed?

So how are adolescents living with HIV doing? Let's look at the numbers. According to the global summary from 2015, an estimated 1.8 million adolescents globally are living with HIV (90 percent in sub-Saharan Africa). There are an estimated 250,000 in this age group and there were 41,000 deaths in 2015. Of the 4,500 new infections every day, 37 percent are among young people age 15-24; 22 percent among women; and 15 percent among young men. New infections among 15-19 year olds have declined but more slowly than children less than 15 years of age. PMTCT has been successful, and we have seen a drop in the annual number of new pediatric infections. There has also been a drop in the number of annual infections for 15-19 year olds, however, it has not dropped as quickly or as much as we would like.

There are some worries about the future. There was a peak in the late 1990s among adolescents 15-19. We have seen a decline in the number of annual new infections in the age group, but it is projected to increase over the next several decades. This is in response to the 'youth bulge'; we've done such a good job protecting the lives of young children that we're inevitably going to see more and more survive into adolescence. In 2000 there were 40 million adolescents globally; in 2010 there were 210 million adolescents; and in 2050 it's estimated there will be 450 million. So just by virtue of the numbers, many more individuals will be at risk of acquiring HIV infection.

How are we doing with the 90-90-90 targets among adolescents living with HIV? I think many of you are familiar with [PHIA surveys](#). These were nationally representative surveys, and we now have data from three countries: Zambia, Zimbabwe, and Malawi. Looking at the data, we see that of those age 15-59 years who tested positive for HIV, 70 percent were aware of their status, 87 percent were on treatment, and 89 percent were virally suppressed.

If we look specifically at the adolescent group of 15-24 year olds, we see the rate of knowing their status is quite low. Only half of those infected knew they had HIV, and of those 82 percent were on treatment, with 80 percent virally suppressed. Those rates of suppression were lower than in the older populations, but are actually remarkable for this age group. We also see similar patterns from the PHIA surveys in Swaziland. Overall, higher rates of 90-90-90 across the board, but lower rates of testing, knowledge awareness, ART, and viral suppression among adolescents.

This is not particular to sub-Saharan Africa; here we see data from the U.S. among youth with behaviorally-acquired HIV who were taken care of at adolescent-specialty centers. Rates of viral suppression among this group are quite low. This includes those adolescents who are on treatment for over five years, with viral suppression rates at around 50 percent. A parallel study at these sites among youth with perinatal infection shows even lower rates of suppression. If we look at the oldest group who knew their status for a long time, viral suppression rates were only around 40 percent, so by comparison, at least with these data, youth in sub-Saharan Africa are doing quite well.

One interesting study from New York City looked at the outcomes of viral suppression of people living with perinatal-acquired HIV. In this group, there were around 1,600 youth with perinatally-acquired HIV, and the median age is somewhere around 22. Most of these individuals are in their 20s and 30s, and about 62 percent are 20-29 years of age. We've reached elimination of perinatal MTCT in New York City, so researchers could then shift focus to viral load of these individuals by age. We see similar data across ages, with about 60 percent viral suppression; these are long-term outcomes of viral suppression of individuals growing up with perinatal HIV infection in a part of the world with good health services and access to ART.

Let's look at a couple of other outcomes. Adherence data from a Malawi study showed 30 percent of a cohort of 500 HIV-positive adolescents 12-18 years of age on ART reported missing ART doses within the last week, with 45 percent reporting missing ART doses within the last month. I have generally found adolescents to be quite upfront about their medication-taking patterns. When researchers looked at the various factors associated with missed doses, you can see that those with missed clinic appointments in the last six months were at higher risk of missing doses, and those who were not extremely sure about their medication and self-efficacy were at higher risk. There is also inadequate adherence among adolescents who witnessed and experienced household violence in the past year – something we don't commonly ask about – as well as those who reported alcohol use.

I'm going to switch back to the U.S. again, back to a New York cohort of youth with HIV infection we're following. Most of these youth are around 22 years old with perinatal HIV infection and I want to use this data to talk about other outcomes. We've been looking at behavioral health outcomes among this group, and comparing them with an HIV-exposed uninfected cohort (kids from similar communities and households). About a quarter of kids in this cohort have evidence of psychiatric disorders such as anxiety or depression; about a quarter report substance use; and seven percent report having been incarcerated.

Interestingly, these rates are not any different in our exposed cohort compared to those living with HIV infection, but overall these rates are a little higher than the norms or from studies of adolescents in the U.S. in the same age range. We are not seeing that HIV is conferring increased risk, but these kids – the lives they lead and the families they are from – may put them at increased risk for behavioral and substance use disorders.

When we looked at transition milestones (the adult activities we want these adolescents to reach), we found they were doing quite well. Over 75 percent of those living with HIV completed high school (or received an equivalent degree). Over half are working or in school; most have stable housing, with some paying rent; almost all have been in a relationship with a man or woman; and 50 percent were currently engaged in a partnership.

That brings up another issue that I hope we talk about, and that is that adolescents have sexual lives. We need to think about that and embrace it in our services, because thinking about sexual and reproductive health is quite critical. There is huge demand for modern family planning methods in Africa for young women and it will be critical to consider this in our discussions. In the north, we have also seen many young women growing up with HIV, having pregnancies. Close to 800 pregnancies have been reported and 1,200 perinatally-infected girls primarily from the north. As the cohorts of young people living with HIV age in sub-Saharan Africa, we will certainly see many of these young women becoming pregnant. We also know the ANC is a very common place for young women to learn they are HIV infected.

The most important outcome, of course, is mortality. Deaths have declined significantly among all age groups with HIV, but somewhat less so for adolescent in the 10-19 year age group, which you can see represented. It's also important to realize that there are other causes of death amongst the 10-19 year old age group such as road traffic incidents, interpersonal violence, lower-respiratory infection, self-harm, and pregnancy-related complications for young girls.

To close, I would like to paint a picture of DSD for adolescents living with HIV. HIV creates additional burdens and stresses for individuals living with HIV, regardless of age. We are asking infected individuals to take lifelong, daily regimens of medications; make frequent medical visits; disclose their status to partners; use condoms; and the list goes on. In many settings communities, families, and health systems are not aligned to support adolescents as they transition to adulthood, particularly adolescents living with HIV. This is because of stigma, bad policies, inadequate guidelines, and poor health and educational services. We want to optimize outcomes for adolescents and young adults living with HIV. In order to address the needs of these adolescents, it will be critical to address their needs as adolescents and young people, not just adolescents and young people living with HIV.

My list of essentials to do that include good policies; good drugs (at least until we find a cure); accessible services; well-trained, respectful, non-judgmental health care providers; integrated sexual and reproductive health care; integrative behavioral and mental health services; and inclusive family, friends, and peers.

Get your pastels and paint brushes out. It's time to listen, learn, and co-create. Everyone in this room should think like an adolescent: take risks, try new things, be bold, rely on the people around you – your peers, friends, and your network – employ technology, have fun, and let's achieve some great things over the next three days. Thank you.”

Thursday, October 26th

Innovations to Reach the First 90 for Children and Adolescents: Lessons from Swaziland

Dr. Lydia Mpango, AIDSFree, Swaziland

“Good morning everyone and welcome. The MOH in Swaziland is very committed to achieving the ambitious 90-90-90 goals for adults and children set forth by UNAIDS. Even their strategic framework is in line with this commitment to drive these efforts. Strengthening efficiency of pediatric HIV case finding, early linkage to treatment, quality HIV linkage services, and an increase in viral load monitoring are some of our key strategies. Our data on ART for pediatrics from 2011 shows a gradual increase in the number of patients who are on ART. According to our projections, we are expected to be at around 16,812. We are at about 84 percent in terms of coverage of our pediatric population on ART, so we still have some way to go to reach the 90.

Looking at trends in testing of our adolescents less than 15 years from 2011-2016, we see that we have still increased our testing over time, and we are finding quite a bit of positives to initiating them on treatment. I am going to talk about some things that are helping to drive this.

The [Swaziland HIV Incidence Measurement Survey \(SHIMS\)](#) is something that I hope we all have seen. We are quite proud of it, because it shows that we were able to reduce HIV incidence among adults in half, from 2.5 to 1.4 percent. We are still struggling with our children under the age of 19, however, so we still have a lot of work to do. When it comes to the 90-90-90 targets, our performance is comparable to other countries when we look at our adults. We have relatively high rates of awareness of HIV status, as well as ART coverage rates and viral suppression among adults over the age of 15. This is not the case with adolescents, however. In Swaziland, only about 66 percent of our adolescents and young people are aware of their status, and we have coverage of 82 percent of those. Viral suppression is at 76 percent, and you can see from other countries that the trend remains the same across our different countries.

So, what are some of the things we have done to scale up treatment among children and adolescents? We have had a policy shift to aggressively test children and adolescents over time. We can look as far back as 2010, where, according to our guidelines, HIV testing was only for our HIV-exposed children. In 2014, we began testing more aggressively, and we introduced nine-month testing and exit testing at 18-24 months. We also pushed for testing after cessation of breast-feeding regardless of status of the parents, and of course upon the presumptive diagnosis of HIV.

Back in 2010, our age of consent for testing was 16. In 2014, we reduced the age of consent to 12 years and we tried to sensitize our health care workers so in the event a child is less than 12 years, the health care worker is empowered to take consent for that child in order to ensure they have access to testing.

In terms of policies and guidelines, we have worked very hard among the different levels of our health system to decentralize HIV testing services at every point of contact within our health facilities, and we are doing both client and patient-centered HIV testing and counselling. We've also decentralized HIV testing services to our community settings are offering services universally at the community level to all those who do not have a known status. We're conducting pediatric HIV testing at all of our pediatric entry points, as well as our adult entry points because we know adults

come to our facilities or to community events with children. We have begun HIV self-testing; our age of consent of our pilots in Swaziland is 16 in order to avail this opportunity for our adolescents to test.

In terms of strengthening HIV infection identification to children, there have been several things done in Swaziland, including the ICAP-Baylor initiative to scale up pediatric HIV testing, using index cases of adults and children who were found to be positive. Our positivity rates among children 0-14 were quite low, at one percent, and we were able to link 83 percent of those children to treatment.

We are also doing an initiative to strengthen pediatric intensified case-findings, supported by ELMA philanthropies and EGPAF AIDSFree. The initiative is being conducted at three levels. At the national level, we have developed IEC materials such as an adolescent adherence tool for many health facilities. At the regional level, we're working with our regional management teams to map, select, and sensitize civil society organizations to raise awareness and demand for pediatric HIV testing services at 25 sites in two regions. Finally, at the community level, we've done community sensitization days where we provide a service package that includes testing, ART-initiation, and referrals.

We are also trying to engage schools. We have had two successful school debates to raise awareness of and increase pediatric testing, and have sensitized teachers on this initiative. We even award prizes to the children who participate in these debates. Topics range from whether HIV/AIDS should be treated as a standalone subject in primary school to the cultural beliefs that discourage children to go for testing. Testing scale-up was quite slow initially. Our donors helped us place some lay counselors in the schools to discuss task shifting, and support the nurses and clinicians for testing. We were able to then see an increase in testing from October to December of 2016.

Now part of the initiative is raising awareness; we found it interesting that we were able to initiate more children than we were finding, so we feel this kind of engagement with the community and the children within schools and the community is helping. We initiated more than double the number of children we found.

Another initiative we are doing in Swaziland to scale up HIV testing among adolescents is called *Dreams on Wheels*. This is being done by PSI and PACT, and it is targeted at adolescents and young people aged 15-24. They have been able to secure four mobile units and have placed one in each region. In Swaziland, we cannot test in schools, so we engage the community to find out where we should put the mobile van, which can be near a shop or community structure near the school, but not in the school itself.

Dreams on Wheels has a package of care, including HIV risk-reduction counseling, contraception, testing, and CD4 counts. There is also a point of care machine where we conduct screening and treatment for other STIs. They also provide sexual and gender-based violence services, referrals, post-exposure prophylaxis (within 72 hours of assault), and family planning counseling.

Pregnancy testing, condom distribution, screening for TB and NCDs, and referrals across the whole cascade of care are also part of the initiative. Through this program, we have reached 19,068 adolescents. Positivity rates have been rather low, but all of our identified positives have been linked. This initiative also saw older age groups in terms of access of services in our communities. In order to scale up testing, we introduced point of care early-infant diagnosis supported by UNITAID and EGPAF. To date, we have managed to test 325 children. We were able to test, and get results to

caregivers in less than 24 hours through facilities that have direct access to the point of care machine and implementation of a hub-and-spoke mode of testing.

So far, we have identified nine positive children and have managed to start six of them on ART. Unfortunately, we lost one and one parent refused. Swaziland has also moved to birth testing, which we are piloting in three maternities. We are still using point of care and this is being supported by UNITAID and EGPAF as well. We want to see if this can be done even without point of care. We are doing this using conventional testing with the support of ICAP and hope to share some of our preliminary results next session.

So what have we learned in terms of innovations for reaching the first 90 for children and adolescents? In terms of index testing, home visits are better outside of working hours. We do them in the afternoons on Saturdays and on holidays. In addition, we find that many parents don't live with their children, which makes access to testing a bit challenging at times. Some clients are hard to access because they are away at work and when they are off duty they migrate to other regions – we live in a very migratory society. Some male index cases had children from different mothers, making it difficult to map and reach them.

In terms of pediatric testing, a proper entry process enhances the buying in and support of the project, so we've engaged all different levels, from the MOH to the regions, down to the programs in order to get buy-in. There is a need for mentoring and supportive supervision of health care and community workers. Facilities need to plan community outreach at least once per quarter to reach hard-to-reach areas, and there is a need to engage children concerning testing. Our concept for testing being reduced to 12 years has really played a very great role in increasing access, though when it comes to getting results, we're still trying to empower health care workers to do assessment before they disclose results, because we've got some children who are 12 years old, but are developmentally much younger.

So what are our next steps? We would like to strengthen quality HIV testing services and provision both in communities and facilities, so we are doing quality assurance assessments at facility-based and community-based sites. We are providing feedback on mentoring support, implementing evidence-based approaches for testing among all groups, and that's routine reporting on index-testing report approaches and implementing HIV self-testing in those adolescents older than 16 years.

We also would like to continue to implement targeted testing strategies focused on our high-risk groups, of which adolescents form a major part. We are scaling up point of care and EID birth testing and are strengthening forecasting and HIV testing services rapid-test stock ordering at all levels; mapping of underserved communities and providing HIV testing services; and conducting research assessments to inform evidence-based pediatric approaches. Thank you to our MOH, SNAP, our reproductive sexual unit, PEPFAR, all implementing partners, and the communities and facilities across Swaziland.”

Friday, October 27th

Optimizing ART for Adolescents Living with HIV in the Context of Changing Guidelines

Dr. Nandita Sugandhi, ICAP at Columbia

“The reason we are here is to talk about the challenges adolescents are facing, and we talked a lot about it this week. We don’t see decreasing mortality in our young people. We see from the [PHIA data](#) that the lowest rates of viral suppression are in our younger adults and adolescents, as well as young children and there are many reasons for this. As Elaine stated earlier in the week, we like to blame many things on the adolescent brain, but there is more to it than that and we are trying to come up with ways to address this. We have been looking at adolescent-friendly services for counseling, testing, and providing treatment. We are here to talk about adolescent DSD models, and to overcome some of the issues we’re finding, but I don’t think we are going to get to everything we need to with just this alone.

We know that in the treatment landscape, there is increasing concerns about drug resistance and we have very limited data on adolescents in sub-Saharan Africa. Most of this data we have in pediatric populations is from children, but we do have some limited evidence – a small sample size from the U.S. – demonstrating that there are sexually active young adults and youth who do develop drug resistance. There are other things aside from the adolescent brain, behavior, and the way we communicate that may be contributing to some of the failures we are seeing in ART and adolescents and young adults.

We also have to recognize that there is no ‘one-size-fits-all’ approach and that infants, children, and adolescents are not coming into the system at the same time. There are infants and young children that are diagnosed and start ART in childhood; then there are others that are tested, diagnosed, and initiate treatment as adolescents. We have the young adult population as well, and on top of them, the population we refer to as ‘old people’ – anyone over 25. Meanwhile, as healthcare workers, we have been raining down all of these different ARVs on our patients – on young infants, children, and adolescents. We have had all of this treatment experience and we are still at the point we are today. We spend a lot of time talking about the issues around pediatric drugs. We ask questions about what we are going to give infants, and how are we going to deal with all of these tablets for these young kids’ multiple formulations. All the while, we treat adolescents like adults.

Our 2010 WHO guidelines for adults and adolescents had the same initiation criteria, and the same regimen recommendations. In 2013, it was the same. We had consolidated guidelines, but we still grouped adolescents and adults together. There was some recognition that we needed to start tailoring to adolescent-friendly services but our regimens themselves stayed the same. There was some thought on how we could better provide ART and what strategies we could use for adolescents.

I want to reference the BREATHER trial, which was a ‘weekends off’ study. It followed a group of very adherent, stable young people on an efavirenz-based regimen. This type of intervention is great for those highly adherent adolescents, but it doesn’t solve the issue for those that are not adherent or are having difficulty; two days off is also not a lot of time. We know that many times, our young people who are in school are skipping their medications during exam time, because they need to stay up at night and study. Also, last I checked, exam season lasted longer than two days. So this was a nice strategy for some but it doesn’t fit the needs of many adolescents.

The 2016 guidelines recommended the same preferred regimen for adults and adolescents. Is this the best we can do? Should we continue to harmonize our adolescent regimens with our adult regimens? I want to point out that in 2017, we are paying more attention to the alternative first-line regimens. Two of the alternative first-line regimens included some new options that we are calling ‘optimized’ ARV choices, and that includes the drug dolutegravir, as well as a low-dose of efavirenz.

When we talk about optimization, we mean drugs that are potent, low in toxicity, well tolerated, easy to take and administer for children, and have a high genetic barrier to resistance. They are also durable, improve our options for switching or sequencing regimens, can be harmonized across special populations like pregnant women and children being treated for TB, and are cost-effective or reduce cost.

Adolescents also have their own ideas about what’s optimal. There was a study called ‘Yummy or Crummy’ and it looked at the preferences that adolescents, young adults, and children have for their ARVs. What they found is that it is really a multi-sensory experience; it’s about more than just the quality of the drugs themselves that matter. One thing that was discovered as very important was pill size. Medicines that were discreet and easy to swallow were highly preferred by adolescents.

I also want to point out that in several of the presentations this week, we talked about sexual activity, teens having unprotected sex, and unwanted pregnancies. It is important that, as we’re trying to increase access to contraception, we also ensure the ARVs we’re using don’t interact with hormonal contraceptives, and that’s not the case for what we’re using right now. One of the drugs we’re talking about using is dolutegravir. It is one of the best-in-class integrase inhibitors, and it’s a new class of drugs that is very well tolerated and has low toxicity. It also has a low genetic barrier to resistance, it’s dosed once-daily, and it’s a very small tablet. Even for those patients on TB treatment, we can dose it twice daily so it can be used in that population, and there is more data now saying it can be used in pregnancy.

Right now, dolutegravir is available as a 50-milligram single tablet, and is available in combination with tenofovir and 3TC (TLD). It’s also available in combination with abacavir and 3TC. Right now, the TLD that we are looking at is actually a lower cost than the preferred regimen we’re using, which is TLE. Recently, there are two new suppliers who developed this and they’re selling it at lower costs.

Another option mentioned is reduced-dose efavirenz. There was a study looking at using 400 milligrams instead of 600 milligrams, and it’s not inferior in those patients who are initiating treatment. The idea was that a lower dose of a medication would lead to decreased costs for the program, but there’s also the hypothesis that if you’re using a low dose of a medication that you’ll also have fewer side effects from it. At this point, we don’t have enough evidence to use this in pregnant women or TB patients, and unfortunately, this still interacts with hormonal contraceptives.

As a result, we’re moving toward dolutegravir. Multiple countries are now thinking about phasing in the use of dolutegravir singles or dolutegravir FTC. So, this is something that in your programs you might start hearing about or seeing. We might ask ourselves: Who is eligible for dolutegravir? Well, newly initiating patients in the WHO guidelines, this is included as an alternative for ‘WHAT to start’.

There is evidence in treatment-naïve patients that dolutegravir-containing regimens are superior to those containing efavirenz or darunavir/ritonavir or raltegravir. We have many of our patients that are already on ART, so there is evidence that those first-line stable patients could be switched safely to dolutegravir. There is emerging evidence now (it’s very new) that suggests dolutegravir could be

superior to lopinavir/ritonavir if it's combined with another active NRTI. There is much more work to be done on this side, but we're learning it could be a good second-line choice. Then for a third-line patients, there's evidence it can be used when combined with 1-2 other fully active drugs, and even in those patients that may have had an older integrase inhibitor like raltegravir, it could be dosed twice daily to overcome integrase inhibitor resistance.

The important thing to take away here is that dolutegravir is a great drug for newly initiated patients but it can be active even in those who are very treatment-experienced, and that is many of the perinatally infected young people we're seeing in our clinics today. I think that's important when we talk about transition as a difficult time. We send our young adults to the adult health care worker in the adult clinic and regardless of what treatment history they have, they're seen as an adult, so they may not take the same care and look back at the treatment history to see if this is someone who started a year ago, or fifteen years ago. Knowing that we have some options across the spectrum of treatment experience is important.

To conclude, we need to move beyond this idea that adolescents are just poorly adherent adults, because there is more than that. We are looking at adolescent-friendly health service delivery models but that is not going to solve all the issues we have. We now have these optimized ART options, and dolutegravir regimens in particular can give us this opportunity to support more adolescents to reach viral suppression and get to that last 90. Thank you."

Closing Remarks

Dr. Elaine Abrams, ICAP at Columbia

"I want to take us back to the goals and objectives of this meeting: to launch the CQUIN adolescent workshop community of practice by convening the nine CQUIN countries to share experiences on the 'how' of DSD for adolescents; share resources and existing tools; and work together to develop tools and frameworks on DSD for adolescents and young adults. I think we can say unconditionally that we have met these goals and objectives.

More specifically, I found it to be a real privilege to have the time devoted to bringing our respective expertise and experiences together to consider these different issues, all focused on trying to improve the outcomes for adolescents and young adults living with HIV. We should all feel good about having that time and devoting it to this particular topic. For me and others, this has been an opportunity to learn about the incredible work happening already. Every single program and presentation has demonstrated innovation and exciting, thoughtful, meaningful work in the field.

I do not think we are quite at scale yet, but in some of this work, we are seeing things move to scale, and I think we can be very hopeful that over the years we will be able to measure impact. We've had the opportunity to do a lot of good south-to-south learning right here in this room, which sets the precedent for Peter's vision of a complex network. I hope that you are all able to travel around sub-Saharan Africa to see how others are doing this work.

One of the best parts of this workshop was hearing the voices of adolescents and young people who are living this experience and recognizing the importance of their partnership – your partnership – as we think about how to maximize service, develop these models and put them in place. It has been such a privilege to be in this room with all of these leaders, advocates, and people who are doing this work that care deeply about a group of humans who so often get negative press. Adolescence is a

difficult time, but it's a wonderful time, and everyone in this room thinks that way and will spread that word when they get back. I thank you all personally and hope you have gotten as much out of this experience as I have."

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