Abstract Book
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2nd HIV & Adolescence Workshop

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Abstracts
Oral Presentations
HIV epidemic projections for adolescents aged 10-19 living in sub-Saharan Africa 2016-2030

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Background: The world has committed to ending AIDS as a public health threat by 2030, but the HIV response for adolescents has been slow. In sub-Saharan Africa, home to 75 per cent of new HIV infections among adolescents, the population aged 10-19 is expected to grow by 32 per cent by 2030 and by 81 per cent by 2050. This rising cohort of adolescents, combined with persistent HIV incidence rates, could threaten global progress in the HIV response for all ages.

Methods: Spectrum's 2017 AIDS Impact Model was used to estimate the number of new HIV infections, number of people living with HIV, incidence and prevalence among adolescents aged 10-19. These output indicators were projected from 2016-2030 based on recent trends of HIV incidence, ART Coverage and PMTCT Coverage in the last five years. Trends were extrapolated into the future using a log-linear curve and coverage rates were held constant once they reached 95 per cent. Output were extracted at the country level and aggregated to four geographic regions of sub-Saharan Africa: central, east, south and west. Output were analyzed by age and sex until 2030.

Results: Given assumptions for incidence rate and population growth, the number of new HIV infections are expected to decline by 46 per cent for both adolescent boys and girls in sub-Saharan Africa between 2010 and 2030. Of the 2.3 million cumulative number of new HIV infections expected to occur among adolescents over the next 13 years, 70 per cent of these infections will occur among girls. Compared to the 1.5 million adolescents living with HIV today in sub-Saharan Africa, a projected 940,000 adolescents will be living with HIV in 2030. However, epidemic projections vary by region. Today eastern Africa accounts for the majority (43 per cent) of new HIV infections among adolescents in sub-Saharan Africa, but by 2030 the majority (35 per cent) of adolescent HIV infections are projected in western Africa. While the number of adolescents living with HIV is expected to decrease in eastern and southern Africa between 2016 and 2030, the number of adolescents living with HIV in western Africa is projected to increase from 220,000 to 240,000.

Conclusion: These findings serve as a warning to plan for an epidemic that is not yet over for young people. By utilizing recent trends in the HIV response in the epidemic model, these results illustrate which populations and regions may need more attention to end AIDS as a public health threat by 2030. While reducing HIV incidence in adolescence is critical to ending the epidemic, it will also be important to plan sustainable and integrated testing, care and treatment programs for this age group.
Committee of African Youth Advisors: A Model for Foundation-wide Youth Engagement

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Background: Meaningful youth participation, leadership, and political advocacy are critical global gaps in the adolescent and youth HIV landscape. To address this in 2017, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) initiated the Committee of African Youth Advisors (CAYA) to ensure access to youth views, insight, and on-the-ground expertise from within current EGPAF country programs. These perspectives inform internal decision-making regarding the design and development of interventions for diverse adolescent and youth sub-groups. CAYA is a partnership between youth and EGPAF programs to accelerate progress toward EGPAF’s mission to end pediatric AIDS.

Methods: CAYA was developed through a consultative process. Global teams identified CAYA representatives, and each participating country identified a staff member (called a CAYA focal point) and two youth volunteers (called CAYA members). Each CAYA focal point facilitated a process to ensure monthly stipends of approximately $42 per month are provided to CAYA members for their active participation in the program. CAYA focal point staff are representatives from each EGPAF country program who act as facilitators and advocates for youth engagement in EGPAF internal discussions and deliverables. All CAYA representatives, members and focal points meet monthly via virtual platforms. During meetings, there are efforts to continuously build capacity for meaningful youth engagement, to update the global CAYA team on progress and tasks, and brainstorm ideas in collaboration. CAYA will present on their activities and deliverables to the EGPAF Board of Directors annually.

Results: Eleven of 12 countries with adolescent programming accepted the invitation to join CAYA (Cameroon, Cote d’Ivoire, DRC, eSwatini, Kenya, Lesotho, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe); only Mozambique declined to join CAYA, citing youth education barriers and language challenges. CAYA focal points identified 21 CAYA members who signed two-year volunteer agreements. CAYA Members are a heterogeneous group of youth (15-29 years) representing both sexes and different experiences (living with HIV, accessing HIV prevention services, pregnant or with children, survivors of violence, in and out of school, working and out of work). CAYA members are predominantly high-performing youth leaders who extend their roles and opportunities within EGPAF programs. At the start, EGPAF developed training modules for the initiative and supported orientation and training of members using online platforms. CAYA members have increased EGPAF youth engagement at international HIV events and developed global disclosure tools, including their voices and experiences in disclosing in school and to partners.

Conclusions: CAYA builds capacity across countries to develop exemplary youth leaders. Country teams have been quick to take up and integrate youth activities and advocacy both at the country as well as the site-level. Despite CAYA still being in the initial implementation phase, this innovative mechanism to ensure adolescent and youth engagement across EGPAF domains has shown considerable potential in filling existing gaps related to EGPAF youth programs. Using technology and virtual systems is possible, but requires support from EGPAF. Language is not a barrier in French-speaking countries but is a challenge in Portuguese-speaking settings.
Sustaining Voluntary Medical Male Circumcision (VMMC) Services and Linkages with Adolescent Sexual and Reproductive Health (ASRH): Lessons learned from the Zimbabwe Smart-LyncAges Project

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Background: Since male circumcision was recommended by WHO and UNAIDS as an additional HIV prevention intervention, adolescent boys have had unprecedented contact with the health system through VMMC services. WHO and UNAIDS recommend that VMMC in HIV programmes be used as a gateway to additional relevant health services for adolescent boys. Currently, VMMC is provided vertically. For future service delivery, integration of ASRH and VMMC services may increase adolescent boys’ access to health services and foster sustained delivery. This project therefore sought to explore the services to deliver and feasible options for sustained service delivery.

Materials & Methods: The Zimbabwe Smart-LyncAges project used a participatory learning and action approach to explore the feasibility of and capacity strengthening interventions to enhance ASRH – VMMC integration and/or linkages and inform transitions needed to sustain VMMC services. Working with national to local level key stakeholders, several interventions were explored including capacity building for service providers and peer educators; joint demand generation; referrals using routine systems; development of resource and IEC materials with age-relevant ASRH and VMMC messages; use of social media and a free messaging platform for information dissemination and gathering adolescents’ opinions. Boys-only forums and mixed group community dialogues discussed VMMC, ASRH and transformative masculinity. Evaluation of the project was conducted using routinely collected data in VMMC and ASRH programs feedback obtained during monitoring visits and end-of-phase assessments.

Results: An increased number of adolescents, parents and community members compared to pre-project months received VMMC and ASRH information through peer educators, community fora and social media platforms. An increased number of adolescent boys were reached with VMMC services. Between March 2016 and March 2017, 11,971 young people were circumcised with an upward trend monthly and a peak of 1,976 in March 2017. Community engagement, sector and partner collaboration brought synergies and contributed to the revision of the national ASRH strategy and the training manuals. The need for comprehensive transformative masculinity interventions was recognised. Extensive lessons were learnt on what works, what does not work, and what should be expanded. Main lessons learnt were: i) partnerships at all levels and community engagement are essential to success; ii) strong linkages require strong health systems; iii) policies such as user fees for adolescents and geographic distance restrict access to services; iv) an already vibrant VMMC program provided a gateway to strong linkages; v) stable funding and dedicated staff are necessary for project success.

Conclusions: This project informs a pathway from the vertical scaling up phase to sustaining coverage phase. A health systems perspective to integration and sustainability is key. Collaboration within the health sector and across sectors is vital. Meaningful and active community engagement strengthens ownership and linkages. Adolescent and youth participation is critical for developing youth centered ASRH – VMMC services. The lessons learned from this project will inform next phase. Key issues must be further explored; research is needed to inform impact and effectiveness; and participatory approaches which involve service users should continue to inform service delivery options and approaches.
Enhancing viral suppression among adolescents, through service delivery quality improvement approach in Western Kenya

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Background: An estimated 18% of 1.5 million people living with HIV in Kenya are aged 15 and 24 years, they contributed 51% of the 77,000 new HIV infections. There's estimated 105,230 HIV infected adolescents 10 to 19 years in Kenya in 2018 and AIDS is the leading cause of mortality in adolescents and young people in Kenya. Studies indicate that approximately 36% of adolescents in Kenya have elevated viral load; hence need for interventions to enhance viral suppression. In December 2016 to May 2018, EGPAF Kenya supported 138 health facilities in 7 Counties in western Kenya to undergo a participatory adolescents HIV services quality assessment and improvement, with intention of improving viral suppression.

Materials and Method: In December 2016 to January 2017, EGPAF led HIV service providers to conduct a baseline assessment on the quality of HIV care for 6,300 adolescents. EGPAF developed quality assessment and improvement tool for adolescents on HIV care. We sensitized the HIV service providers at the sites, and the sub county HIV and TB coordinators on the tool, engaged them in conducting assessment of the quality of adolescents HIV services in their sites using the tool and coming up with action plans to address the care indicators that scored poorly. Providers went through the adolescents files using the tool to assess if the adolescent received the following services in last clinical visit: Nutrition assessment and intervention, TB screening, diagnostic work up for suspected TB, IPT for HIV negative adolescents, correct ART regimen, adherence assessment, usage of adolescent checklist, provision of positive health and dignity services, documented disclosure, STI screening, viral load testing for eligible, viral suppression, and partner testing, pregnancy status, contraception uptake and PMTCT services for eligible adolescents. The team then documented the proportion of adolescents’ that received specific essential HIV care service. EGPAF supported the sites within 4 months to address weak areas; the interventions included providing essential tools to facilities that lacked e.g. the adolescent checklist, disclosure guide, tool for nutrition assessment and documenting nutrition interventions, adherence guide, viral load tracking log. EGPAF also mentored the service providers on latest ART guidelines, managing clients’ appointment and working with schools to support adolescents in boarding schools. We initiated specific support groups and clinic days for suspected treatment failures and adolescent mothers with guiding discussion points. We then conducted a post quality improvement exercise to assess improvement in HIV services and viral suppression rates. We conducted a descriptive analysis of the data on before after the intervention.

Results: Overall viral suppression increased from 63% to 76%, with Migori County having the highest increase in four months (26% increase). Viral load testing uptake increased from 65% to 86%; with Vihiga County leading with 37% increase (from 63% to 100%).

Conclusions: Continuous quality improvement exercise in essential for improvement of HIV service delivery among adolescents to achieve viral suppression. Participatory facility plus county led quality improvement exercise is key for ownership and sustainability. Quality improvement tools need to be available and health workers mentored on their use.
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YBank: financial incentives for improving retention in care and adherence to anti-retroviral therapy amongst adolescents living with HIV in Rwanda

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Background: Although antiretroviral therapy (ART) has shown to be critical in the treatment of HIV by suppressing HIV viral load and sustaining immune function, its adherence has been poorest in adolescents, especially in Sub-Saharan Africa. Financial incentive-based programs have shown early promise in motivating healthy behaviors, however concerns around acceptability remain. This study evaluated the feasibility and acceptability of a multipronged intervention ART adherence and care retention amongst HIV+ adolescents in Rwanda, to adapt the model for scale-up and policy uptake.

Description: Study participants were 72 adolescents (35 female, 37 male, aged 12-19), recruited through random stratified sampling from an urban (n=50) and a rural (n=22) clinic in Rwanda. Inclusion criteria were adolescents aware of their HIV-positive status, enrolled in care at one site for >1 year, and prescribed ART for >1 year. The intervention, called YBank, consisted of: a) short-term and long-term financial incentives for clinic attendance and suppressed viral load; b) monthly life-skills training for financial literacy; and c) peer support from older HIV+ youth. Data collection included: a) baseline and endline survey data on demographic characteristics, clinic attendance, and viral load; b) historical clinical data; and c) semi-structured interviews (30 adolescents, 20 caregivers, and 4 healthcare workers).

Lessons learned: All interviewees found the intervention highly acceptable, and reported emotional benefits associated with the incentive. Key themes expressed by adolescents were feeling rewarded and enhanced future planning. Few caregivers expressed concerns about adolescents accessing mobile money accounts independently. Overall, savings increased and we observed no increase in risky spending behaviors. Although there was no statistically significant reduction in viral load, early results indicate that the intervention may have greater impact on historically vulnerable groups including very young and out of school youth.

Conclusions/Next steps: Financial incentives, combined with a supportive environment and adequate skills-training, shows promise in motivating health behavior change in adolescents. The intervention was deemed acceptable to adolescents and caregivers, however its feasibility was limited by operational challenges, like access to mobile money accounts. The study indicated a need for mixed-methods in designing youth-targeted financial services, and evaluating their efficacy over time using large multi-site RCTs.
Scaling up adolescent responsive services increases HIV testing outcomes among Adolescents and Young people aged 10-24 years in Uganda

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Background: Although 1.8 million Adolescents living with HIV (ALHIV) account for 5% of HIV-infected individuals, they contribute 20% of new infections. Out of 250,000 new HIV infections that occur annually globally among adolescents, 82% live in sub-saharan Africa (SSA). Mortality amongst ALHIV remains high, and they are the only age group in which deaths due to HIV are not decreasing. In SSA, new HIV infections are increasing among adolescents and young people, particularly girls and young women. In Uganda, about 73,000 Adolescents are estimated to be living with HIV; with a prevalence rate of 1.3%. By 2016, coverage of adolescent friendly health services was 37%; with limited access to HIV testing, information, Sexual and reproductive health services, and psychosocial services. As a result, outcomes of adolescents and young people across the 90-0-90 cascade lagged behind compared to the general population.

Intervention/methodology
In 2016, the AIDS Control Program, Ministry of Health rolled out the adolescent friendly program with the purpose of improving care and treatment outcomes. The strategy involved: capacity building for health workers, establishment of adolescent safe spaces, training adolescent peer educators, separate clinic days, and flexible clinic hours. A 5-days national training curriculum and health worker job-aid were developed; Training of trainers at both national and regional levels; training of 2 frontline health workers per health facility from adolescent care entry points such as OPD, Wards, ANC, Maternity, and PNC and one Adolescent peer educator. On-site mentorships were conducted one month and quarterly post training and engagement of health unit management to support the intervention. In 2017, a mixed design cross sectional process evaluation was conducted by MOH to assess the extent to which adolescent responsive services had been scaled up in the country and therefore establish HTS outcomes.

Results: By September 2017, 77.6% health facilities had been trained in Adolescent HIV care, treatment and support. This increased coverage of adolescent friendly services from 37.6% in 2016 to 59.4%. As a result, there was improved entry point testing for adolescents. There was adoption of targeted testing through use of a screening tool at OPD which increased HIV yield among adolescents to 3.1%, from 2.5% observed in 2016, with regional variation. HIV positivity yield in East Central increased from 0.6% to 6.8%, a ten-fold increase; while in Mid-Western it increased from 1.7% to 6.8%. Although Mid-Eastern, had the highest positivity in 2016, the trend changed and had the lowest yield of 0.5% in 2018. Linkage into care for identified positives improved from 44.6% to 74.3%; with variations by age and sex. Males 10-14 years (96.8%) and females 15-24 years (93.7%) were more likely to be linked into care.

Conclusion: Adolescent competent health workers, designation of an Adolescent Care focal person, convenient and flexible working hours (weekends and evenings), presence of Adolescent and Young people Peer Leaders and presence of safe spaces at health facilities are effective in increasing HIV testing yield and aiding early linkage and initiation to HIV care and treatment for adolescents and young people.
Using adolescent peer educators to increase retention at Mnazi Mmoja hospital, Zanzibar

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Background: Quality HIV prevention, care and treatment services provided to people living with HIV entail age specific friendly services that consider unique needs of specific age groups. Retaining children and adolescents in HIV care and treatment services is more challenging compared to other age groups; due to a number of factors including late disclosure, unfavorable school scheduling, peer influence, and lack of family support especially from caregivers because of stigma and discrimination. Adolescent peer education is one of the strategies that provide age specific and friendly services to children and adolescents living with HIV (ALHIV). Tanzania Health Promotion Support (THPS) is an indigenous non-governmental organization supporting Zanzibar HIV Integrated HIV, TB and Leprosy Program (ZIHTLP) to deliver comprehensive HIV prevention, care and treatment services at 11 HIV care and treatment clinics (CTC) in Unguja and Pemba. By October 2016 the hospital had 2,325 current people living with HIV (PLHIV) with 174 being adolescents.

Objective: To increase HIV service uptake and retention of children and adolescents living with HIV through peer education at Mnazi Mmoja Hospital

Methodology: THPS in collaboration with ZIHTLP and Zanzibar Association of People living with HIV and AIDS (ZAPHA+), used the following strategies to improve adherence and retention of ALHIV: a) initiated adolescent club, b) trained 25 adolescents peer educators, c) build capacity of health care workers on adolescents HIV friendly services including supporting disclosure and family therapy through modular training and coaching, d) engaged some ALHIV as ‘young reporters’ in local radio e) used ‘river of life and body mapping’ methodology (established by ZAPHA+) to enhance positive living and f) initiated Saturday clinics for provision of services to adolescents.

Results: Twelve months retention of adolescents at Mnazi Mmoja hospital improved from 70% in 2016 to 94% by March 2018 with 197 adolescents current on ART. Multiple evidence based approaches and interventions used together address challenges encountered in HIV care for adolescents living with HIV. Adolescent peer education is among the pillar interventions that facilitate ease monitoring/follow up of ALHIV. Scaling up this set of interventions is critical to ensure retention of adolescents in HIV care and treatment programs.

Conclusion and Recommendations: Adolescent peer education is among the pillar interventions that facilitate ease monitoring/follow up of ALHIV. Scaling up this set of interventions is critical to ensure retention of adolescents in HIV care and treatment programs.
Long term clinical and psychosocial status of Community Adolescent Treatment Supporters in Harare, Zimbabwe

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Introduction: Young people living with HIV have been recognised as an effective, critical cadre in the delivery of comprehensive HIV treatment, care and support for other children and adolescents living with HIV. Yet young peer supporters living with HIV often experience the same multiple, complex challenges in their lives as their clients. However, there has been limited attention to the impact of this work on the lives of peer supporters, or to their long term clinical and psychosocial outcomes. Since 2009, Africaid and Zimbabwe’s Ministry of Health have been scaling up the Community Adolescent Treatment Supporters (CATS) intervention, a model of peer-led differentiated service delivery for children, adolescents and young people living with HIV.

Methods: A team of former CATS were supported to design a data collection tool for collecting data from other former CATS on a range of clinical and psychosocial domains, including treatment history, viral load, opportunistic infections, relationship and parental status, disclosure and employment status. Under the supervision of Africaid’s research unit, the young researchers were then trained and supported in collecting this data from 50 young people living with HIV who had previously been engaged as CATS in Harare between 2009 and 2017. This data was then analysed.

Results: Of 50 former CATS, 88% (n=40) are currently on 1st line ART regimens and 12% (n=6) are on 2nd line. Virological suppression is high with 92% (n=46) reporting undetectable viral loads while 8% (n=4) have detectable viral loads. Opportunistic infections (OIs) were common with 40% reporting a history of OIs in the previous 9 years. Common among the reported OIs were TB (16%) and Herpes Zoster (16%). Relationships were common with 26% (n=13) married, 14% (n=7) are dating and 98% (n=49) reported having disclosed their HIV status to their partners. 22% (n=11) have children of their own and 100% of these children have been confirmed HIV negative. 54% (n=27) are currently unemployed.

Conclusions: This review confirms high rates of viral suppression, disclosure to partners and prevention of mother to child transmission among former CATS. However, the review confirms high rates of unemployment, presenting future challenges for engagement in services, adherence to treatment and mental health. Mental health data is now being collected and analysed. As peer supporters transition out of their roles in to adulthood, it is critical that they are provided with economic and professional development platforms so that they may continue to develop themselves, both professionally and as young adults. As governments and implementing partners continue to establish and scale up peer support models, it is imperative that investments are made in supporting the clinical, psychosocial and economic needs of this cadre of young people.
Unwavering Voices: Engagement of Youth Champions in policy and advocacy in Mombasa County-Kenya

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Significance/Background: Modifying health policies, systems, and environments are promising strategies for combating new HIV infections among adolescents and youth. There is limited access to youth friendly policy forums and the lack of representation and capacity in high level policy making meetings for adolescents and youth to articulate their sexual reproductive health needs. Creating facilitative health environment through inclusive policies is conducive for service provision among adolescents and youths. Structured voices of adolescents and youths are powerful in influencing the priorities and decisions of policy makers in Kenya. Capacity building on advocacy and policy engagements in sexual reproductive health among the adolescents and youth is key in leadership decision making process. Guidance on standard definition of meaningful engagement of adolescents and youth in advocacy and policy is needed.

Objective: To meaningfully engage adolescents and youth in policy and advocacy for responsive programming.

Program Intervention: Youth Advisory Council has for the last 2 years (October 2016-March 2018) provided technical support to the county of Mombasa with regards to HIV/Sexual reproductive health programming. The council has been involved directly in policies (County integrated development plan, County health bill, and costed implementation plan-FP, budget making processes and several stakeholder meetings). It has played oversight roles in advising the county government in matters of adolescents and youths in HIV/Sexual reproductive health programming and policies.

Methodology: During the implementation period October 2016-March 2018, LVCT Health identified and engaged 15 adolescents and young people aged 15-24 years (6 males and 9 females) in Mombasa County as Youth Advisory Council (YAC). The YAC were recruited from community serving organizations and health facilities. The young people were taken through 2 days training on advocacy and policy engagement to build their capacity in HIV/Sexual reproductive health issues. During October 2016-March 2018, the youth advisory council has focused its efforts in providing solutions addressing HIV/Sexual reproductive health challenges in development of policies and their implementation. The council has been on the forefront in advocating for fully implementation of the National Guidelines for provision of youth friendly services at Mombasa county level.

Results: 15, 6(40%) males and 9(60%) females were enrolled in youth advisory council. The council participated in developing Mombasa Fast Track plan for the cities where adolescence adherences to ART treatment were incorporated. 4(27%) youth participated in shaping adolescent and youth technical working group agenda in the county. 5(33%) have been engaging the Mombasa county in budget making processes through sectoral meetings and public participation year 2017/2018. 3(20%) have actively participated in the development of Mombasa county costed implementation plan-family planning 2018-2022. 2 (13%) have been involved in development of Mombasa county integrated development plan 2018-2022 where they did memorandums addressing allocation of resources in establishments of youth friendly centers within 6 sub-counties of Mombasa. 15(100%) participated in providing inputs for the currently reviewed National youth policy-2006. 5(33%) participated in the development of the AYP SRH/HIV strategy 2018-2023 of Mombasa county, the 1st ever county in Kenya to develop such a strategy.
Defying the odds to mentor and influence the adolescence MSM/MSW to uptake and adhere to comprehensive sexual health services including PrEP

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Background: The Kenyan law, only allow us to reach the young MSM/MSW aged from 18 years and above with health services. We have a lot of them who are below 18 years and it’s Criminal to reach under 18 in Kenya since the law prohibits and the government thinks we are recruiting them into becoming MSM.

29% of all new HIV infections in Kenya were among adolescents and youth. AIDS is the leading cause of death among adolescents in Africa with 17% of all AIDS related deaths in Kenya being among adolescent and youth

We reach the under 18 years with health services but only undercover lest the government arrests us.

YMSM engage in high risk behaviours-anal sex, YMSW are young MSM sex workers who engage in transitional sex very many times and with very many sexual partners of unknown HIV status, they also engage in drug and substance abuse due to peer pressure, which destabilizes their judgment on how to consistently and effectively use condoms.

They are also regarded as Vulnerable populations in that they are susceptible to HIV due to power imbalances in relationships, alienation from family and friends and also health systems ignore or reject them. Thus they face social and legal barriers to accessing HIV prevention and treatment. This hinders their access to health care thus this results to a surge in HIV infections.

Objectives: Use Peer to Peer Approach to influence young and adolescent MSM to take comprehensive services including PrEP. Achieve retention and adherence for the young MSM who are taking PrEP/ARVs

Methods: We create demand for sustained health services uptake through the Use of 70 young peer educator’s age of 18 -24 years, To offer peer education-Health education –BCC, provide condoms Efficacy/lubes, refer for PrEP, PEP, Use digital multimedia platform FB....To promote and scale up health services and disseminate information about HIV/STI

On every Friday, starting from 2pm, we invite a lot of adolescents and young MSM/MSW to come watch movies, we have ISHTAR DOLLS who perform using dances, poems, Vorgeuing and cat walking. We organize a beauty pageant for young MSM.

Results: Over 4000 YMSG and over YMSG 300 have been mobilized by the peer educators; all of them have been offered health educations, STI/HTS Screening. Over 300 are on PrEP, Over 300 are on ART and all of them adhere to ART, and are also given psycho-social support. All these young MSM/MSWs are empowered and they are now healthy thus their lives are enhanced. They are mentored to uptake and adhere to comprehensive health services.

Conclusion: This model should be scaled up and replicated in many health care settings. The government should not bury its head in the sand and should allow all the adolescents access health care and all health commodities like condoms. All health care providers should accommodate all MSMs and provide them with healthcare without stigma and discrimination.
Youth Activist and Advocates Scoping Project (YAASP)

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Background: With young people being the group where globally HIV infection is rising, youth activism/advocacy is a critical component in the global response. This scoping project aimed to strengthen youth HIV activism and leadership by identifying the enabling, supporting and challenging factors faced by YPLHIV entering and sustaining HIV activism/advocacy roles on a local, regional and global level.

Methods: The YAASP Team consisted of three YPLHIV, based in Nigeria, UK and Uganda who were involved in designing the methodology and led on delivery. YAASP engaged global, regional and national leads, including government agencies, global funding organizations, non-governmental organizations, youth-led organizations and the activists/advocates themselves through three different approaches: 1) Semi-structured key informant interviews, 2) An online survey 3) A Twitter Q+A.

The responses were collated and deliberated on by 17 YPLHIV at a 2-day roundtable meeting, where attendees were chosen as global representatives based on their links to advocacy networks in their region. The group were tasked to draw up youth-led recommendations and an action plan. A further consultation was held at the International AIDS Conference, with youth HIV activists and advocates to provide feedback.

24 organisations were interviewed, including 8 youth-led organizations, 4 NGO implementers, 3 NGO networks, 1 funder, 1 NGO involved in capacity building, 1 NGO involved in advocacy, 2 government agencies, 2 UN representatives and 2 researchers representing 6 global regions.

The online survey captured the responses of 69 YPLHIV from 8 global regions. Respondents were aged 13-30, 37.7% female, 59.4% male and 2.9% non-binary.

The Twitter Q&A engaged HIV activists and community advocates in a discussion regarding youth HIV activism/advocacy. Responses came from Africa, Europe and North America, with 44 responses received in total.

Results: At all stages of engagement, participants highlighted the need for improved funding access and transparency to youth-led projects and organizations, improved ethical engagement of YPLHIV in activism/advocacy, providing a logical framework for the inclusion of YPLHIV in all stages of the decision making process, as well as limiting the barriers to entry for YPLHIV in the space of activism/advocacy.

The action plans include:
- A youth-led funding position paper
- Guidance on youth leadership, advocacy and engagement in the HIV response aimed at youth-led movements/networks and stakeholders
- A global youth leaders and advocacy training and mentorship programme to strengthen capacity

Conclusion: This data provides the opportunity for youth-led organisations to mobilise. The gaps identified specifically point to a need for YPLHIV to produce agreed global guidelines in partnership with key stakeholders to address many of the challenges raised. YPLHIV have been clear that the action plan should be youth-led and implemented, which has been reflected in the methodology of this project, and this highlights the need to build capacity in the movement so YPLHIV are able to take leadership roles at all levels of youth activism and advocacy.
Assessing the knowledge and perceptions regarding HIV Testing Services (HTS) and Sexual Reproductive Health & Rights (SRHR) among adolescents in public high schools in Khayelitsha, South Africa: The GAP Year Study

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Background: Adolescents in South Africa are disproportionately faced with sexual and reproductive health and rights (SRHR) challenges such as HIV/sexually transmitted infections (STIs) and access to health care and services. While progress has been made to access HIV testing services (HTS) and other SRHR services by the general population and key populations, the adolescent sub-population in particular have not received the same support and attention in South Africa. As part of a trial we conducted a baseline survey among grade 8 adolescents in 14 public high schools in Khayelitsha to explore adolescents’ knowledge and perception of HTS and SRHR.

Methods: An interviewer led survey was administered to grade 8 learners aged 11–18 years. The survey was reviewed and developed using validated tools and through consultation with experts and community stakeholders. Descriptive statistics were used to summarize data and the Chi-square test was used to test the differences between boys and girls, using STATA version 15 software.

Results: Out of the 1505 that completed the interviewer-led survey, 64.1% (965) were girls. Although less than half of the learners knew they could get HTS without parent consent (38.8% girls and 41.5% boys), the majority knew they could access HTS in any public health care facility (73.5% girls and 76.4% boys) and that they could access health care without being discriminated or stigmatized by health care workers (70.0% girls vs 70.1% boys). The most common source of SRHR information was from the school teacher (63.9% for girls and 49.6% for boys), with healthcare workers contributing a low percentage (7.4% for girls and 2.1% for boys). Only a third of the learners knew and understood their SRHR (36.5% girls and 33.2% boys) and approximately half knew where to access information about SRHR (49.2% girls and 50.8% boys: p<0.001). More than half of the learners had heard about contraceptives, with the percentage higher in girls than boys (60.1% vs 43.7%, p<0.001). The learners also knew that condoms can prevent HIV/STIs (79.9% for girls and 85.7%).

Discussion and Conclusions: The study showed the need to implement innovative channels to improve adolescent knowledge and access to care and services in South Africa since adolescent knowledge is not universal.
He Stands Firm: Cracking the Code on Adolescent Boys’ and Young Men's HIV Testing Behavior

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Background: Against a backdrop of growing concern on boys and men’s poor health and their even poorer health seeking behaviour (UNAIDS Blindspot 2017), He Stands Firm (HSF) is improving HIV testing and related behaviours among adolescent boys and young men (ABYM). The pilot was set around urban and university settings where 16-22 year old males are found. Running for 3 months (May – July 2018), the aim was to get 2000 ABYM to test for HIV and know their status by overcoming barriers that limit men’s uptake of testing services.

Methods: To reach ABYM, HSF found a prototype campus setting Kenyatta University, Nairobi and used:

- Below the line activations – working with peer mobilizers drawn from the institution’s social clubs, in consultation with the university’s AIDS Control Unit (ACU).
- Through the line promotions – working with Triggerise’s ‘t-safe’ platform that connects adolescents and providers by motivating positive behaviour, executing targeted subsidies and giving power to the user through ratings and/or feedback. Subsidies are in the form of Tiko Miles, which are virtual rewards earned through positive behaviour (seeking HIV testing services) and spent on the market at Tiko Trader shops. Triggerise configured the ‘tsafe’ platform to allow the adolescent boys/young men to enrol.
- Above the line promotions – Opening up social media handles (Facebook, Instagram, and Twitter) to target adolescent boys and young men and their communities with captivating hashtags alongside #HeStandsFirm that generated online conversations on positive masculinity & further connect to organizations offering services.

Results and lessons: As a pilot, HSF, has shown that with the right understanding of barriers and motivations to testing, ABYM can be reached with tailored messages to increase their demand for HIV testing, including self-testing. 1367 ABYM from KU & its environs tested for HIV within the pilot period.

Private Public Partnerships (PPPs) worked well to leverage costs. HSF mobilized support from different players the two sided market - activated demand: (KU ACU, NACC), platform management: (Triggerise) and activated supply: (NASCOP, PSK, and LVCT Health).

Being a partner on the “Developing Insights on Young Men and Demand for HIV Self Testing” study by CIFF gave HSF a chance to share lessons at the panel of “Brave New World: Understanding Users to maximize the impact of HIV Self Testing” at a Satellite Session at the 21st International AIDS Conference in Amsterdam in July 2018.

Way Forward: Moving forward, HSF is optimizing with lessons learnt from the pilot and designing a demand generation strategy to increase the number of 15-24 year old ABYM in urban and university settings testing countrywide with 50,000 annually. This will capitalize synergies with the already established set of partners in the pilot phase and those that will be explored in the future.

HSF is informing the first outcome of the newly launched Menstar Coalition’s – and partnering with creative agencies in Kenya to develop Chukua Selfie – a HIV testing campaign aimed at young men, supported by the Elton John Foundation, CIFF and UNITAID in 2019.
Adolescent girls' PrEP uptake from a community-based mobile clinic: early findings from the POWER demonstration project

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Introduction: Achieving an AIDS-free generation critically depends on identifying populations at highest HIV risk and scaling up HIV prevention. HIV pre-exposure prophylaxis (PrEP) is a highly effective and innovative prevention strategy. The World Health Organisation recommends that PrEP be offered to populations at 'substantial risk' of HIV infection, including AGYW in high HIV incidence settings. We evaluated the feasibility of community-based PrEP delivery among AGYW receiving sexual reproductive health services (SRHS) from a mobile clinic.

Subjects and Methods: The objectives of the POWER demonstration project are to determine whether AGYW at risk for HIV are motivated to start PrEP, different models of PrEP delivery, and PrEP uptake, adherence and persistence. HIV prevention options, including PrEP, were offered to sexually active AGYW ages 16-25 accessing SRHS from an adolescent-friendly mobile clinic providing services to high disease-burden townships in Cape Town, South Africa. All young women visiting the mobile clinic were invited to view a promotional video, educating women about HIV prevalence and risks in their community, and the effectiveness of PrEP for HIV prevention. Thereafter, during individual SRH consultations, all eligible young women were screened for STIs with nucleic acid amplification for gonorrhea and chlamydia, and offered enrollment into the POWER cohort, with the option to accept, delay or refuse PrEP.

Results: Between June 2017 - July 2018, 952 AGYW were seen at the Tutu Teen Tester; 66% were 18-22 years old and 270 enrolled in POWER. 95% of the AGYW cohort who enrolled onto the POWER study initiated PrEP on the same day, which translates into 27% of all AGYW visiting the mobile clinic. Among AGYW at enrollment, gonorrhea and/or chlamydia were detected in 42%, 33% were on family planning, and 32% started on family planning at PrEP initiation. 75% of AGYW indicated that their primary partner might have other partners, compared to 11% of AGYW who reported that they had multiple partners at time of enrollment. A majority (76%) of AGYW did not know their partner's HIV status, 6% were in a known serodiscordant relationship, and 83% reported they were not able to consistently use condoms with their regular partner. Most AGYW (77%) who enrolled in POWER reported a high concern about contracting HIV in the next year. At the month 1 follow-up visit, 33% came for PrEP refills.

Conclusions: Among AGYW attending a mobile clinic in Cape Town, PrEP uptake was associated with high HIV risk, based on inconsistent male condom use, having a partner of unknown HIV status, a partner who might have other partners, and high STI prevalence. PrEP uptake was high (95% of those enrolled in POWER and 27% of all AGYW seen at the mobile clinic). PrEP initiation was associated with contraception uptake and continuation, supporting integration of PrEP delivery within sexual and reproductive health services. PrEP delivery to AGYW through a mobile clinic is feasible with high uptake of PrEP. Additional research is needed to understand PrEP persistence and effective support strategies for AGYW.
Combination school- and community-based interventions increase reports of sexual assault in females under 25 years, and provide opportunity for HIV risk mitigation through post-exposure prophylaxis: evidence from rural South Africa

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Background: Statistics South Africa’s 2018 mid-term data estimates HIV prevalence among females 15 – 49 years at 20%. However, UNAIDS measures show promising trends: between 2014 – 2016, incidence among females 15 – 24 years maintained a level of 10,4%, marking a decrease of 0,2% over previous years. To keep the scales tipping in favor of reduction, addressing violence against girls and women (VAGW) as an HIV risk is critical, especially with the availability of post-exposure prophylaxis (PEP).

Methods: For the purposes of this study, we investigate VAGW in the Thulamela Municipality of the Limpopo Province for females under age 25 years. We draw upon the Thohoyandou Victim Empowerment Programme’s (TVEP) database (n= >25 500 records) and highlight the associations between TVEP’s Zero Tolerance Schools- and Village Alliance (ZTSA/ZTVA) interventions and reported rape. We then evaluate clients who accessed PEP to prevent possible HIV infection.

The ZTSA and ZTVA interventions focus on four thematic areas: Gender Equity, HIV, Access to Justice, and Child Rights. The modules are delivered by expert-trained facilitators over the course of nine months with support from key partners (health, social development, justice, police), culminating in a public oath-taking ceremony during which participants pledge to report abuse in any of its forms. This approach results in program ownership and beneficiary accountability. All schools and communities exposed to the interventions are still active in the “Alliance”, some nearly a decade later.

Results: Based on data collected and verified between September 2017 and January 2018, TVEP manages an estimated 35,4 rape victims under the age of 25 years monthly (or 424,8 per annum). On average 25,2 of these are under 19 years, and 20,2 under 16 years, and 10,2 between 19 and 24 years. Given that 10% will report an assault, this translates to approximately 3540 rapes of victims under 25 years – or ±1,95% of females <25 who reside in Thulamela annually (n=180632). During the schools- and community-based interventions, an average 50 of 4450 female participants less than 25 years reported assault, or 1,1%. Assuming the entire population of Thulamela were exposed to the interventions, we estimate reported rape would increase to 2289 per annum – 64,7% of all estimated assaults on under-25 females.

During the same period, 134 of the under-25 female survivors completed PEP of the 147 who were provided the 28-day regimen (91,2% completion). 21 recipients failed to complete the regimen and 70 were ineligible.

Conclusion: Measures from ZTSA/ZTVA paint a clearer picture of how school- and community-based initiatives combine to increase reports of assault, and therefore address HIV risk through provision of PEP. While PEP completion rates among TVEP’s clients far outpace those nationally (±30%), this line of enquiry offers strong support for adopting large-scale expansion of the interventions coupled with referral care. However, the costs associated with the interventions reflect the reach: 6800 beneficiaries at a cost of $97,517.38 per 9-month initiative. Considered against the costs of VAGW and potential new HIV infections, it should be considered an urgent imperative worth the expenditure.
Modified directly administered antiretroviral therapy (mDAART) among HIV-infected adolescents failing protease inhibitor-based second line treatment.

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Background: Sustaining virological suppression among HIV-infected adolescents is challenging. We evaluated a home-based adherence intervention and characterized self-reported adherence, virological response and drug resistance among adolescents failing atazanavir/ritonavir (ATV/r)-based 2nd line treatment.

Methods: HIV-positive adolescents (10-18 years) on ATV/r-based 2nd line treatment with virological failure (viral load (VL) ≥1 000 copies/ml) were randomized to either standard care (SC) or SC with addition of modified directly administered antiretroviral therapy (mDAART) for 90 days. VL was measured and questionnaires were administered at study entry and at 3 months. Genotyping was done for participants with continued failure. Primary outcome was suppression to VL < 1 000 copies/ml.

Results: Fifty adolescents aged 10-18 years on 2nd line treatment for >180 days were enrolled, 23(46%) were randomized to mDAART and 27(54%) to SC. Fifty-four percent were female; mean age was 15.8 years; mean baseline VL was 4.8(log10) copies/ml; 40% reported adherence <80% in previous 1 month at baseline; 40% suppressed (VL <1 000 copies/ml) after follow-up. mDAART resulted in significantly increased self-reported adherence (RR= 0.1; 95% CI=0.02-0.8, p=0.023); closely following dosing schedule (RR= 4.8; 95% CI=1.6-13.8, p=0.004); VL decrease (p=0.031) and modest increase in virological suppression to <1 000 copies/ml (p=0.105). Genotyping in 28/30 participants with continued virological failure demonstrated high level atazanavir resistance (I50L, N88S and I84V) in 6(21%); 3(11%) of whom also had high level resistance to lopinavir and darunavir (V32I, I50L, I54V, 147V and V82A).

Discussion: The mDAART intervention modestly improved virological suppression among adolescents with ATV/r-based 2nd line treatment failure, significantly increased self-reported adherence and decreased viral load. High level ATV/r resistance was demonstrated.

Conclusion: Targeting mDAART to adolescents who are virologically failing PI-based 2nd line treatment decreases viral load and increases self-reported adherence. Early drug-resistance testing could reduce morbidity and mortality.
Effect of gender on virologic suppression among children and adolescents on antiretroviral therapy: Report from a large-scale HIV treatment program

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Introduction: Children and adolescents on antiretroviral therapy (ART) especially in low-resource countries are known to have worse treatment outcomes than other age groups. The role of gender differences in observed outcomes for this subpopulation however remains a subject of controversy.

Objectives: We sought to assess the effect of gender on attaining viral suppression among children and adolescents on ART in a large-scale HIV treatment program in Nigeria.

Methods: We reviewed routinely collected program data for children and adolescents who had been on ART for at least 6 months and received viral load tests between April 2017 and March 2018 in 13 states in Nigeria. Viral suppression was defined as viral load result < 1000 viral copies/ml of serum. We compared viral suppression rates between males and females in children (0-9 years) and adolescents (10-19 years). Data was analyzed using SPSS version 24, statistical significance was assessed using the chi-square test and multivariable logistic regression.

Results: A total of 4517 clients (2409 children and 2108 adolescents) were reviewed with a median age of 9.2 years (IQR; 6.3-12.0 years). Of these, 50.3% (2271) were females and 49.7% (2246) males. Overall, the viral suppression rate was 53.6% (2419) with viral suppression rate higher among females at 56.8% (1290) compared with males; 50.3% (1129) (p < 0.001). There was no difference in viral suppression rates by age (children:53.5% (1289) vs. adolescents:53.6% (1130)). In multivariable analysis females were more likely than males to be virologically suppressed (aOR = 1.30, C.I: 1.16-1.47, p < 0.001) adjusted for age and ART regimen.

Conclusion: Virologic suppression rates among children and adolescents were suboptimal and considerably lower among males. Further investigation into the role of gender in ensuring virologic suppression for this subpopulation of patients on ART is required.
Teens just want to have fun: Association between substance use and weekend ART adherence amongst adolescents living with HIV in South Africa

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Background: As adolescents become adults, they tend to engage in risky behaviours, including the consumption of alcohol and recreational drugs. Despite this, few longitudinal studies have examined the impact of substance use on adherence to antiretroviral treatment (ART) for adolescents living with HIV (ALHIV) in resource-limited settings. This study aimed to examine associations between substance use and weekend ART-adherence amongst the world’s largest cohort of ALHIV.

Materials & Methods: A total of 1065 ALHIV aged 10-19 years (55% female) who ever initiated treatment in 53 governmental health facilities of South Africa’s Eastern Cape were interviewed and followed-up 1 year later (94% retention rate). At each visit, participants reported alcohol and drug consumption, adherence to ART and HIV-related knowledge through standardized questionnaires. Poisson regression with robust variance and marginal effects models were used to estimate the association between substance use and adherence to ART. The potential mediating effect of HIV-related knowledge on this association was also examined.

Results: Baseline self-reported substance use was 9% (n=94) and 21% (n=203) of participants reported at least one missed dose in the past weekend. The prevalence of substance use increased slightly but significantly over time with 12% (n=117) of ALHIV reporting this behaviour at follow-up. Compared to males, more female participants reported substance use at both time points (T1: 12% and 6%; T2: 14% and 9%). In a multivariable logistic regression, adolescents reporting substance use at either time were more likely to be >15 years old (odds ratio [OR]: 3.47, 95% CI: 2.22-5.43), horizontally infected (OR: 2.16, 95% CI: 1.42-3.29) and in a romantic relationship (OR: 2.73, 95% CI: 1.79-4.16).

Substance use is associated with non-adherence on the preceding weekend (incidence rate ratio [IRR]: 1.85, 95% CI: 1.26-2.72) and on the preceding month (IRR: 1.29, 95% CI: 1.15-1.44), but is not associated with non-adherence on the preceding weekday, after adjusting for baseline non-adherence, parental monitoring, age, gender and mode of infection. Marginal effects analysis with covariates held at their mean values showed that substance use increased the predicted probability of non-adherence in the past weekend by 11 percentage points, rising from 14% (95% CI: 0.11-0.16) without substance use to 25% (95% CI: 0.17-0.33) with substance use. We did not find evidence of a moderating effect of HIV-related knowledge (i.e. knowing that you should still take your ARVs after having consumed alcohol or drugs) on this relationship.

Conclusion: These results demonstrate that although substance use levels were not extremely high in this cohort of South African ALHIV, it contributes to the incidence of ART non-adherence, particularly during weekends. Interventions to improve adherence for youth living with HIV may be bolstered by the incorporation of alcohol and drug use prevention components as these adolescents become older and have a more active social life outside their homes and the influence of adults (caregivers, healthcare providers). Alternative approaches taking the lifestyle and behaviours of adolescents into account, such as short cycle therapy, should also be considered, as should intervention components that specifically focus on maintaining ART adherence alongside socialising.
Pregnant and pushed out: Premature transition of pregnant adolescents living with HIV to adult HIV services

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Background: Increased global attention on the growing population of adolescents living with HIV is critical and must be sustained. To ensure that no subgroup is left behind in this momentum, we need a clear focus on equitable treatment access for marginalised and key sub-populations within the larger adolescent group. HIV-infected pregnant and breastfeeding adolescents are especially vulnerable and require careful consideration and responsive care. The limited emerging evidence available suggests that HIV-infected pregnant and breastfeeding adolescents have worse maternal and infant outcomes than HIV-infected adult mothers, including lower prevention of mother-to-child HIV transmission (PMTCT) uptake, higher loss to follow-up and higher mother-to-child transmission of HIV. The extent to which health facilities are providing appropriate treatment and care is unknown.

Materials and Methods: In 2017, Paediatric-Adolescent Treatment Africa (PATA), a network of frontline health providers across sub-Saharan Africa, conducted cross-sectional surveys with n=115 health facilities from 15 countries in Southern, Eastern, West and Central Africa to assess routine facility-level service provision and aggregate patient outcomes. Data were analyzed using descriptive statistics to describe central tendencies.

Results: Most (75%) health facilities were urban or peri-urban. Almost two-thirds (64%) were government services. Just over half (51%) provided primary-level care. Over a third (38%) reported routinely transitioning HIV-infected adolescents who become pregnant out of paediatric or adolescent HIV services due to pregnancy. Detailed analysis of the previous 12 months revealed that of the 71 health facilities reporting pregnancies in their HIV-infected adolescent and young person populations, 68% transitioned ≥1 HIV-infected adolescents or young people prematurely due to pregnancy. Of those pregnant adolescents that remained in paediatric or adolescent HIV services, less than two-thirds had access to PMTCT, antenatal care (ANC) and sexual and reproductive health services (62%, 57% and 55% respectively) at the same time as their HIV services. Less than half had access to support groups (45%) and social service assistance (24%).

Conclusions: The poor integration of PMTCT and antenatal care within dedicated paediatric and adolescent HIV services is of major concern. Results indicate not only the absence of a targeted and enhanced approach for this vulnerable subgroup, but that in many cases, pregnant adolescents lose access to age-responsive services on pregnancy. Those that remain do not receive a full package of services that cater to their unique needs. This is an issue needing urgent attention. Evidence on service delivery models that support pregnant adolescents living with HIV to improve both maternal and child health outcomes is urgently needed. In the interim, this sub-population should be provided access to adolescent-friendly integrated HIV, PMTCT and ANC services, with augmented psychosocial and retention support.
Common mental health disorders, HIV status and HIV intervention uptake among Adolescent Girls and Young Women in rural KwaZulu-Natal

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Background: Despite great reductions in HIV morbidity and mortality following the rollout of antiretroviral treatment, HIV still affects many South Africans. Adolescent girls and young women (AGYW) are at disproportionately high risk of HIV acquisition. The bi-directional association of HIV with mental health conditions, such as depression and anxiety, amongst AGYW suggests that understanding the mental health of AGYW is likely to be vital to the success of efforts to tackle HIV in this population – notably the combination HIV prevention DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) Partnership. We therefore examined the prevalence of psychological distress and the extent to which this was associated with HIV-related risk and service utilization in a cohort of AGYW in an area where DREAMS has been rolled-out.

Materials and Methods: We analysed enrolment data from a representative cohort of AGYW convened to evaluate the impact of DREAMS in uMkhanyakude district, KwaZulu-Natal. Participants aged 13-17 and 18-22 years were selected from the local population using stratified random sampling. Common mental health disorders (CMD) were measured using the validated Shona Symptom questionnaire with a score >9 used as a cut-off for likely CMD. HIV status was ascertained through linked HIV testing performed in the community as part of the Africa Health Research Institute’s ongoing home-based data collection. Exposure to DREAMS was defined as exposure to at least one of the 10 components of DREAMS intervention. We conducted bivariate analysis using χ² tests and multivariable logistic regression analysis to look at factors associated with CMD.

Results: CMD prevalence was high among the 2184 respondents, with 483 (22.2%) scoring above the cut-off. CMD prevalence increased with age, from 10.1% among 13 year-old girls to 33.1% among 22 year-old women. After adjusting for age, those reporting CMD were significantly more likely to be peri-urban/urban dwellers, to report history of food insecurity, to have ever been pregnant and to report ever having experienced physical, psychological and sexual violence. They were also more likely to report knowing their HIV status (55.0% vs 42.0%) and to be HIV-positive (10.6% vs 5.0%). Those with CMD were also less likely to have received DREAMS services (14.7% vs 21.4%), and among those who did receive DREAMS services, those with CMD received fewer. In multivariable analysis, after adjustment for socio-demographic and behavioural factors, those who were HIV-positive were more likely to report CMD (aOR=1.67, 95%CI 1.07-2.62) and there was some evidence that those who had ever taken up any DREAMS intervention were less likely to report CMD (aOR 0.74, 95%CI: 0.54-1.01).

Conclusions: This study shows that among AGYW in rural South Africa CMD is common, is associated both with several risk factors for HIV acquisition and HIV itself, and is associated with less involvement with DREAMS HIV prevention services. Mental health may be a crucial barrier to service access and HIV prevention programmes, thus programme planners need to consider how best to reach AGYW with CMD, as well as incorporating mental health services into HIV prevention interventions, in order to optimize outcomes for AGYW.
Experiences and outcomes of group psychotherapy as an antiretroviral adherence support intervention among young people failing on ART at Newlands Clinic, Harare, Zimbabwe

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Adherence to antiretroviral therapy (ART) is a major challenge faced by young people living with HIV (YPLHIV). We examined the experiences and outcomes of patients who attended an Enhanced Adherence Counselling Group Intervention (EACGI) prior to regimen switch among adolescents failing first line ART. We analysed records for (YPLHIV) aged between 13 and 25 years between 2015 and 2016 with confirmed first line VF who were invited to EACGI. Each patient had a regular nurse counsellor providing ART management who referred patients deemed to require further assistance in adherence counselling and support. EACGI was a 12-week curriculum of weekly 1.5-hour sessions accommodating 8-15 people per group. It was part of routine care, aimed to facilitate readiness to switch treatment to second line ART, and improve adherence through Phenomenological, Motivational Interviewing and Cognitive Behavioural Therapy principles. Viral loads were measured pre and post EACGI and at 3, 6, 9 and 12 months post switch to assess virological outcomes. Fifty-nine patients (57.6% female, n=34) were followed up for 46.8 person-years. Median duration of first line ART was 6 years (IQR: 4–8) at time of invitation to EACGI. Twenty-two patients (37.3%) did not attend any of the sessions, 8/22 being female and 14/22 male. Main reasons for not attending EACGI were a lack of interest and school or work schedules. Main reasons for poor adherence among those who attended were hopelessness, family dysfunction, lack of illness, an aversion to a daily routine attached to stigma, and medication side effects. Among patients who attended >75% of sessions, 76%, 94%, 94% and 100% achieved viral suppression (VL<50 copies/ml) at 3, 6, 9 and 12 months, respectively, of follow up compared to 50%, 55%, 55% and 50% among those who attended at least one but ≤75%. Those who did not attend any session had suppression rates of 32%, 41%, 41% and 39%, respectively. Hopelessness and family dysfunction were major factors negatively affecting treatment adherence among YPLHIV failing on ART. Patients who attended >75% EACGI had better second-line virological outcomes compared to those who attended less or none.
Mental health and socio-economic screening programme in adolescent HIV clinic – outcomes and relation to health indicators

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Background: Mental health and substance abuse disorders are common in adolescents. In the context of a large paediatric HIV clinic at Rahima Moosa Mother and Child Hospital in Johannesburg, South Africa, the adolescent age group (10-19 years) now constitutes the majority of patients in a clinic that started with only younger children two decades ago. We present the outcomes of formal routine mental health and socio-economic screening and the relation of these outcomes to HIV care.

Materials and Methods: At each visit all clinic attendees aged 10-19 were offered screening since February 2018. Socio-economic screening included five questions related to food security, employment, grant receipt, conflict in the home and recent assault. Mental health screening included four pre-screening questions followed by depression (PHQ-A), suicide (AIP handbook), anxiety (GAD-7), trauma (PC-PTSD-5) and substance abuse (CAGE-AID) full screens if pre-screen was positive. We used descriptive statistical methods to highlight screening findings as well as associations of mental health screening positivity with socio-economic and HIV treatment indicators (nadir and current CD4 count, highest and last viral load, starting and current regimen).

Results: Amongst 1618 currently active patients aged 0-24 years, 1032 (64%) were ≥10 years at their last visit and 77% (n=797) of these were screened between February and August 2018. The majority of screens were conducted by counsellors (68%) or nurses (29%). The screened adolescents had a median of 10 years ART treatment experience (IQR: 8-13 years). Socio economic indicators were current food insecurity (experienced by 5%), current unemployment in home (16%), recent conflict in home (12%) and recent assault by other (12%). In total, 39% of screened adolescents had a positive pre-screen for either depression (20%), anxiety (20%), trauma (13%) or drugs/alcohol exposure (5%). Following in-depth screening, 11% (n=87) of 797 screened adolescents required referral due to a positive final screen including 32 for depression, 21 for suicidal concern, 19 for anxiety, 21 for trauma and 12 for drugs/alcohol. Adolescents with a positive screen/referral were older (median age 16 vs. 14, \(p<0.0001\)) than those screening negative, reported recent conflict in the home more commonly (25% vs 10%, \(p<0.0001\)) had lower nadir (median 326 vs 443, \(p<0.0001\)) and last (652 vs 759, \(p=0.0002\)) CD4 counts and were more likely to have a last viral load >50 copies/ml (37% vs 31%, \(p=0.042\)) with no association found with regard to drug regimen containing efavirenz.

Conclusion: Mental health problems requiring referral and further intervention affected one in ten adolescents attending our HIV services and were significantly associated with both socio-economic factors (notably conflict in the home) as well as with HIV treatment indicators. Further work is required to describe outcomes after referral and to investigate the relationship of HIV treatment indicators, particularly viral suppression, and mental health problems. Our findings suggest that mental health screening and pro-active management may be a critical avenue for ensuring better mental, social as well as HIV treatment outcomes.
2\textsuperscript{nd} HIV & Adolescence Workshop

10 - 12 October 2018, Cape Town, South-Africa

Abstracts
Poster
Viral load suppression rates among Zimbabwean Community Adolescent Treatment Supporters (CATS)

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Background: Poor health outcomes and poor suppression rates among AYPLHIV (one Zimbabwean study showing a suppression rate of 48%) have highlighted the need for a holistic approach with this vulnerable age group. Zimbabwe MoHCC therefore introduced peer supporters (CATS) that are providing a link between the health facility and community for AYPLHIV, doing home visits, facilitating support groups and providing psychosocial support. CATS are young people living with HIV aged 18-24 selected by Health Care Workers (HCW:s) at their respective facilities. However, the CATS are also beneficiaries equally in need of support, especially as their CATS duties present a potential extra burden. Therefore, Africaid has set up a robust monitoring program for CATS, following up on CATS health, focusing in particular on viral load monitoring.

Materials and Methods: Programmatic data was collected from programme implementers using a questionnaire requesting a complete ART history and viral load history of all CATS. This was collected directly from the CATS and confirmed with the health facilities. The data was used to supply recommendations for the district, ensuring that all CATS are mobilised for viral load, and that all those with high viral load receive appropriate follow up.

Results: In total 959 CATS from 39 districts were reviewed. Out of these, 870 (90.7%) had a valid viral load result. Out of CATS with a valid viral load result, 681 (78%) had a viral load less than a thousand and 190 (22%) had a viral load more than a thousand. 118 (8%) had not had a repeat viral load. 15 (8%) had not had a repeat viral load in spite of the first viral load being taken 2017 and before. Out of those that repeated, 48 (41%) were above a thousand copies. Out of these, 35 (73%) were switched to second line. In total, 93 (10%) CATS are on second line.

Conclusion/discussion: The data suggest that with the assistance of MoHCC and the Zvandiri programme, CATS are doing better in terms of viral load suppression, as compared to existing data about AYPLHIV. However, there was a great variation between districts, with one district (Nkayi) having 100% suppression rate, while another (Chipinge) had 38% suppression rate. This may be an indication of quality of adolescent care in the district, the support from the programme to the CATS, as well as a bias in the selection of CATS.

There is also a surprisingly high number of CATS with two high viral loads that were not switched to second line. According to the programme implementers, there is a lack of confidence among HCW:s to switch to second line. This is an issue that needs further exploration and mentorship within the different districts.
The implementation of a peer led HIV and Disability Impact mitigation project in improving care and support for HIV positive adolescents living with disability.

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Background: Research on the links between HIV and disability is growing. For example, a case-controlled study of 296 HIV positive children aged 2-9 and their HIV negative siblings in Lilongwe, Malawi, found physical, mental and/or sensory disability rates (arising from their infection or treatment) of 33% in the HIV positive children compared with 7% in their HIV negative siblings: a nearly five-fold difference. Children with HIV worldwide are increasingly accessing HIV treatment, resulting in improved survival rates, but there is mounting concern regarding HIV-related disabilities amongst children growing up with HIV. The extent or nature of their disabilities is currently unrecognized, poorly understood and inadequately addressed. Africaid through the ‘HIV & Disability Impact Mitigation’ project aimed to improve the quality of life for adolescents with HIV-related disabilities living in Harare (Zimbabwe), through increased understanding about HIV and disability by strengthening their access to appropriate quality health, rehabilitation and educational services.

Methods: Since 2016 Africaid has been implementing the HIV and Disability Impact mitigation project where Community Adolescent Treatment Supporters (CATS) were trained on identification of disabilities/impairments among children and adolescents in the Zvandiri cohort aged 6 to 16 in Harare. The CATS utilise a simplified disability identification questionnaire which was developed in collaboration with Ministry of Health and Child Care Rehabilitation Department. The identified HIV positive children and adolescents who require further screening for impairments by specialist health care providers are referred for further management. The CATS work closely with the clinics and rehabilitation programme for referrals of cases identified at community level. The CATS continuously offer support to the

children & adolescents with disability through adherence support done through home visits, SMS reminders and support groups.

Results: A total of 1502 CALHIV in the Zvandiri care were screened for disabilities. The identification questionnaires were administered to all the children and adolescents identified at community level. They were all referred for further screening for impairments by specialist health care providers. 808 of the 1502 (54%) children who were assessed were confirmed to be having significant physical and or intellectual disabilities that are interfering with their occupational and social functioning. Below is a summary of the identified impairments.

Conclusions: Programmatic evidence proved that many people living with HIV are developing temporary, episodic or permanent disabilities during the course of their illness. However there is little information regarding the number of children and adolescents with disabilities who have HIV and thus the need for a scientific study so as to come up with concrete evidence and appropriate services for this cohort. The active involvement of CATS is a highly effective model to identify, refer, support and motivate beneficiaries (adolescents and caregivers) to treat infections early and to access HIV and disability related services, as well as for ART adherence and to build self-esteem, confidence and agency.
The power of peers: Multi-country analysis of adolescent viral suppression in sub-Saharan Africa

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Background: UNAIDS fast-track targets require 90% of people on ART to be virally suppressed, but we are far from reaching this goal in adolescents. Limited age-disaggregated data from sub-Saharan Africa reflect viral suppression rates of 33-56% in this age group. Overburdened health facility teams are often unable to offer the psychosocial support and services needed to provide holistic, integrated and comprehensive care to adolescents. Health facility-based adolescent peer supporter programmes have gained recent attention as a promising scaleable intervention. However, we urgently need to examine their effectiveness in real-world settings in sub-Saharan Africa. This is the first known multi-country analysis of the impact of facility-based adolescent peer support on viral suppression.

Materials and Methods: In 2017, Paediatric-Adolescent Treatment Africa (PATA), a network of frontline health providers across sub-Saharan Africa, conducted cross-sectional surveys with 71 health facilities from 13 countries in Southern, Eastern, West and Central Africa to assess facility-level characteristics and past-year adolescent (10-19 years) viral suppression rates. Data were analysed using multivariate logistic regression to measure the impact of ≥1 facility-based adolescent peer supporter on adolescent viral suppression rate, controlling for: country, urban/rural location, public/private facility, level of facility (primary/secondary/tertiary) and physician/non-physician care. UNAIDS Eastern and Southern Africa (ESARO) 2017 data for all people living with HIV were used to define the regional viral suppression rate as 50%.

Results: Health facility respondents were from Southern (35.2%), East (54.9%) and West/Central African (9.8%) regions. Two-thirds (74.7%) of facilities were urban/peri-urban and 57.8% public-only. Half (49.3%) provided primary care and 74.7% physician care. Controlling for these facility characteristics, provision of facility-based adolescent peer support was associated with an almost seven-fold increase in the likelihood of aggregate adolescent viral suppression above that of the ESARO regional rate (adjusted OR 6.95, p=0.02, CI 1.28-37.59).

Conclusions: Provision of health facility-based adolescent peer support was associated with a dramatic increase in the likelihood of higher aggregate adolescent viral suppression. Findings suggest that peer support should be a key service component of the facility-based health response for adolescents living with HIV in sub-Saharan Africa, regardless of geographic setting and various operational variables, including whether facilities are located in urban or rural settings, their level of care or health provider profile. However, further operational research is needed to determine how best to implement and integrate young peer support programmes.
‘They are not responsible enough to use protection’: The blind spot of stigma and discrimination towards young people in healthcare settings

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Background: Efforts to reach the 90-90-90 treatment targets in adolescents and young people living with HIV (AYPLHIV) are failing, with HIV testing, treatment and viral suppression rates worse than adults. The WHO consolidated guidelines list eight global standards for responsive adolescent and youth-friendly health services, one of which is for health providers to respect, protect and fulfil adolescents’ the rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect. UNAIDS warns that HIV-related stigma and discrimination in healthcare settings discourages AYPLHIV from accessing HIV services. Confronting marginalisation in HIV care is critical to ensuring service access and positive treatment outcomes for AYPLHIV.

Materials and Methods: To evaluate health care provider self-perceptions of stigma compared to experiences of AYPLHIV, in 2016-2017, Paediatric Adolescent Treatment Africa (PATA), a network of frontline health workers, conducted semi-structured knowledge, attitudes and practices (KAP) surveys with 54 health providers from 29 health facilities across Kenya, Malawi, Uganda, Zambia and Zimbabwe, and 68 AYPLHIV from Cameroon, Democratic Republic of Congo, Ethiopia, Malawi, Tanzania, Uganda, Zambia and Zimbabwe. Data were analysed using descriptive statistics and thematic coding to describe central tendencies and identify themes.

Results: Health providers were most frequently nurses (41%), predominantly female (67%), and had a mean age of 38 years. Participating AYPLHIV were predominantly female (59%), with a mean age of 22 years. Ninety percent of providers reported having had training on treating, caring for and supporting AYPLHIV. Most providers (85%) reported that AYPLHIV do not receive inferior care, but almost half of AYPLHIV (43%) reported that they did not always get the help they needed at clinic visits. While 98% of providers reported being comfortable talking about sexual and reproductive health (SRH) with AYPLHIV, 59% of AYPLHIV reported not always feeling comfortable asking providers for information about pregnancy and sex, 57% said health providers did not always know the answers to their questions, and 41% reported fear discussing SRH with providers. While two-thirds of providers (76%) reported that they did not scold AYPLHIV for requesting SRH services, 41% of AYPLHIV reported that they had been scolded. Of the health providers surveyed, more than a quarter (26%) said AYPLHIV should abstain from sex.

Conclusions: Results indicate an incongruity between health provider versus AYPLHIV accounts of youth services. Providers seem to have little awareness of AYPLHIV’s experience of services as discriminatory. Fundamentally there remains a blind spot in providers’ insight and willingness to provide services without judgement. To mitigate stigmatizing health provider attitudes and practices, we recommend urgent and intensified health provider education, sensitization and training on people-centred healthcare and the rights of AYPLHIV. Health provider sensitization training should be ongoing and form an integral part of continuing medical education. In addition, integration of AYPLHIV as peer supporters within health facility teams facilitates inter-generational dialogue, breaks down barriers and builds greater understanding and relationship between AYPLHIV and health providers. Finally, routinized and active AYPLHIV patient feedback mechanisms build trust between AYPLHIV and providers, improve AYPLHIV service experiences and increase provider confidence.
Building networks for young people living with HIV (YPLHIV) in Malawi using a multi-disciplinary approach: lessons learned from a peri-urban expansion

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Background: Few evidence-based interventions address the unique needs of YPLHIV during the transition to adult care, and fewer include skill-building in preparation for employment. Baylor College of Medicine Children’s Foundation Malawi (BCM-CFM) and Grassroot Soccer (GRS) designed the Transition Training (T2) program to address these gaps. T2 aims to decrease morbidity and mortality among YPLHIV by building assets, access, and adherence: assets of skills and knowledge related to self-care and employability; access to medical and non-medical networks and resources; and adherence to ART and a healthy lifestyle.

After implementing T2 in an urban setting, BCM-CFM and GRS adapted program design for peri-urban and rural settings. The expanded 20-session, weekly program includes modules on employability skills, self-care, employment opportunities, and computer literacy. The revised T2 program was piloted in urban Lilongwe and the peri-urban setting of Salima District Hospital from October 2017 to April 2018. HIV-positive facilitators were recruited through community-based organizations (CBOs) and trained on program content and youth-friendly facilitation skills.

Materials/Methods: A participatory, mixed-methods evaluation is underway to assess the effectiveness of T2 in improving adherence and employability outcomes among participants. Participants in Lilongwe (n=15, median age=18) and Salima (n=20, median age=19) completed a quantitative pre- and post-intervention survey, and adherence data (pill count as % of expected) was collected at monthly clinic visits. Participants had viral load testing at the inception and Conclusion of the intervention. Qualitative IDIs were conducted with Ministry of Health staff (n=2), and FGDs were conducted with program facilitators. In late 2018, participant-researchers will be trained in youth participatory action research (YPAR) methods in order to conduct participatory focus group discussions.

Lessons Learned: Compared to Lilongwe participants, Salima participants had lower pre-intervention scores in multiple domains, especially HIV & SRH knowledge. Post-intervention adherence in the Lilongwe group was higher than the Salima group (mean 98% vs. 80%), and more Lilongwe participants had an undetectable pre-intervention viral load (11/15 participants in Lilongwe vs 5/11 in Salima); post-intervention viral load testing showed that 11/17 Salima participants were undetectable, demonstrating a positive change. Lower baseline HIV & SRH knowledge in the peri-urban group indicates the need for adaptation of content, session structure, and implementation format as T2 expands.

Salima program facilitators reported positive impacts on participants, indicating that they demonstrated more confidence and improved entrepreneurship skills after the program; for example, several participants are now running businesses of their own, some working together. Facilitators also reported positive impacts on their own lives, including improved counseling and public speaking skills. A major success factor and lesson for expansion was the proactive role local CBOs played in identifying HIV-positive guest speakers to build the social capital and networks of participants.

Conclusions: Conclusions from this evaluation will be used to refine the intervention, prepare for scale, and inform a Ministry of Health working group to create a national minimum package for ALHIV programming. These findings suggest that a multidisciplinary approach to supporting the unique needs of ALHIV can effectively achieve positive, mutually reinforcing employability and treatment outcomes in diverse settings.
Family Planning Services as a service entry point for HIV testing and prevention services for adolescent girls and young women: Reflections from 2 studies in South Africa

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Background and Objectives: In an attempt to curb the spread of HIV in South Africa, the UNAIDS 90-90-90 goal system was implemented which firstly aims to test 90% of the population for HIV. Coupled with the drive for testing, oral pre-exposure prophylaxis (PrEP), has been made available from June 2016 as an effective means of HIV prevention. In order to achieve epidemic control through prevention, service entry points for HIV testing and offering of HIV prevention services to those at risk of HIV need to be identified. Amongst those at risk, adolescent girls and young women (AGYW) (15-24) are disproportionately affected by HIV. Family planning services are often the first entry point for AGYW within the health system, and serve as a potential entry point for integrated health services.

Methods: Reflections are drawn from two studies in South Africa. The first study, conducted in 2016 enrolled female clients, aged 18 and above, attending family planning services at 12 public health facilities in the North West Province and Gauteng. Clients were interviewed using a semi-structured questionnaire about HIV status and contraception use and preferences. The second study, conducted in 2017 enrolled female sex workers (FSW) and men who have sex with men (MSM), aged 18 and above at PrEP implementing facilities. Clients were surveyed about their service utilization, HIV risk and experience with PrEP. Descriptive analysis of data was performed.

Results: The first study enrolled 257 clients, of which 22% (n=56), were between the age of 18-24 accessing family planning services. Out of the AGYW accessing family planning services, 59% (n=33) were HIV negative and 32% (n=18) did not know their HIV status. This highlights opportunities for introducing HIV testing and offer of PrEP. Age at contraception initiation was retrospectively determined for the 257 clients interviewed, of which 22% (n=57) had initiated contraception between the ages of 12 -17 and 49% (n=127) between the ages of 18 -24, highlighting early entry into the health system through family planning services. The second study enrolled 299 clients enrolled for the survey, of which 81 (27%) were between the age of 18 to 24, 52 female and 29 male. Out of the female participants, 62% (n=32) had ever accessed family planning services at the facility and 54% (n=28) were accessing family planning on the day of the interview. Out of the 52 AGYW, 60% (n=31) perceived themselves at risk of HIV of which 68% (n=21) has tested for HIV less than 3 months ago.

Conclusion: The results highlight that the family planning service could be a possible early entry point for HIV testing and offering of prevention services to AGYW, as AGYW as young as 12 are entering into the health system to seek family planning services. Providing integrated family planning and HIV testing and prevention services offers an opportunity to engage AGYW who perceive risk of HIV in care.
Barriers to U=U for adolescents living with HIV: predictors of high HIV-transmission risk from a longitudinal cohort study

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Background: Sub-Saharan Africa is home to over 2 million adolescents living with HIV, a cohort that continues to grow as new infections persist among 15-24 year olds. Eliminating onwards transmission to children and sexual partners in this age groups is paramount. Unfortunately rates of viral suppression hover at around 50%, highlighting the need for supporting adolescents living with HIV to successfully make U=U happen. Adolescents living with HIV who engage in unprotected sex and have detectable viral load risk onwards HIV transmission to their partners and children. However, there is no evidence on predictors of high HIV-transmission risk for this vulnerable population.

Methods: This study investigates risk factors for high HIV-transmission risk among ALHIV in South Africa using data from 1,050 HIV-infected adolescents receiving care in 52 public health facilities in the Eastern Cape. N=979 (94% retention) were re-interviewed in 2016-2017, 1.5% mortality, 1.4% refusals, 3.1% untraceable. Questionnaires measured socio-demographic, HIV-related factors, past-year sexual risk-taking, and relationship factors. Viral load data from medical records were extracted where available (N=870). ALHIV who reported one high-risk sexual practice in the last year and detectable viral load (those without viral loads coded detectable) were categorised as ‘high HIV-transmission risk’. Multivariate logistic regressions tested risk factors associated with high HIV-transmission risk at follow-up, controlling for high HIV-transmission risk and covariates at baseline, and marginal effect modelling for combinations (STATA15).

Results: 16% of ALHIV were in the high-risk of HIV-transmission group at follow-up, compared to 13% at baseline. Participants who reported high HIV-transmission risk at follow up were older (OR=3.3, p<0.001), horizontally-infected (OR=3.4, p<0.001), had disclosed their HIV-status to partners (OR=2.1, p=0.028) and did not know their partners HIV-status (OR=2.3, p=0.01), were unable to negotiate safe sex (OR=1.8, p=0.037) and take ART while in relationships (OR=1.9, p=0.007). Mode of infection moderated the effect of poor relationship dynamics on high HIV-transmission risk: vertically-infected ALHIV in safe relationships reported 6% risk, compared to 42% of horizontally-infected adolescents in relationships with poor dynamics.

Conclusion: Not all adolescents living with HIV are at high risk of passing on HIV to sexual partners and unborn children. Positive prevention efforts should take into account the transitory and vulnerable sexual and romantic relationships that ALHIV navigate. Interventions should support healthy disclosure of HIV-status and safe ART and condom use negotiations as they transition from childhood to adulthood.
Focus on adolescent HIV Care and treatment services by the unfinished business project improves adolescent uptake of HIV services

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Background: UNAIDS estimated that only 17% of the estimated 130,000 adolescents that were in need of care and treatment for HIV were accessing it leaving out 83% of adolescents not accessing care and treatment. According to the UPHIA report 2017; HIV prevalence is almost four times higher among females than males aged 15 to 19 and 20 to 24. HIV prevalence is nearly three times higher in men and women aged 20-24 compared to those aged 15-19. Mildmay Uganda implemented the 2.9 months Unfinished Business Project whose purpose was to "improve earlier diagnosis of children and adolescents with HIV by increasing testing, screening, case finding and linkages to treatment and support" secondly to increase access to quality HIV treatment for children and adolescents.

Materials and Methods: The project was implemented in 25 high volume health facilities located in 6 central districts of Uganda that is Wakiso, Mityana, Mubende, Luweero, Masaka and Mpiigi districts. Personnel recruited included a counselor, 2 peer educators; 1 volunteer tester and an expert client. Testing services were placed at all the entry points that is adult HIV clinic, out patients clinic, inpatients clinic, ante natal care clinic, TB clinics and out reaches. Adolescent youth friendly corners where adolescents are able to receive a whole range of services such as family planning, health education, condom distribution and economic support groups were established. Capacity was built for health care workers in form of trainings in comprehensive HIV care and treatment, HIV testing services, and adolescents as well as data management.

Results: A total of 5013(143%) adolescents out of the 3505 target were identified in the 6 districts. The 25 target facilities contributed 47% to the identification. Linkage improved from 50% in year 1, 75% in year 2, 69% in year 3 to 88.2% in the 3 months of no cost extension period. Viral suppression rate improved from 70.4% in year 1, 71.2% in year 2, 75.7% in year 3 and 71.3% in no cost extension period. While 12 months retention improved to 66%. Retention among adolescents active in the economic support groups was 93% retention as compared to 71% for those not in economic support groups. There was noted improvement in the economic status of care takers and adolescents as they observed to be able to afford basic needs such as food, scholastic materials as well as transport costs to the health facilities for reviews.

Conclusions: The project registered a noteworthy impact with a difference in retention, access to life saving drugs and viral suppression for the Adolescents. Notably, Retention, Access to life saving drugs and Viral suppression among the target facilities was 11%, 9% and 6.3% respectively more than it is in non-target facilities. Specific focus on adolescent health services therefore is key in improving adolescent uptake of HIV services and leads to improved linkage, active on ART and retention in care. Psychosocial support in form of counselors and adolescent youth friendly services greatly improves adolescent take up of health services.
Adolescent Peer Support in Addressing Mental Health and High Viral Load

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Background: Studies have found that adolescents are more at risk of virologic failure than are adults. Yet, there is limited understanding of factors that contribute to or reduce the risk. Further, while the role of adolescents in supporting mental health in peers has been examined, research on the role of peer support for mental health on adolescents with HIV is limited.

Methods: The Peer Support Study (PESU) was a randomized study that examined the efficacy of a peer-led intervention in improving virologic suppression among adolescents and young people (AYPLHIV) (aged 10-24) in Zimbabwe. As part of this study, to gain a deeper understanding of the factors that contributed to high viral load, focus group discussions (FGDs) were conducted with 3 cohorts: adolescents who had an initial viral load >1000 copies/ml; the peer Community Adolescent Treatment Supporters (CATS) of the selected participants, and a group of caregivers.

FGDs began with painting body maps, a therapeutic technique found to be effective with young people living with HIV, including those diagnosed with depression. Guided by scripts, participants represented themselves, their adherence, coping and support. The body mapping was followed by structured discussions of their maps and experiences. The FGDs were conducted in Shona, recorded, transcribed and translated into English for analysis. Transcripts were independently analysed by 3 researchers. Identified themes were compared, consensus of differences was reached through discussion.

Results: Poor adherence was mainly attributed to mental health issues by all three cohorts, with themes of worthlessness, feeling unloved, hopelessness, humiliation, isolation, anger, depression and suicidality. In response, clients defaulted, feeling that life was not worth living. AYPLHIV and caregivers identified support from the CATS as the factor that improved attitude, behaviour and adherence in beneficiaries. Themes included: hope, reduced isolation, having peers/role models, trust and encouragement. Caregivers attributed improved communication between themselves and their children to support received from the CATS. Themes from the CATS reinforced descriptions from clients and the caregivers.

Mental health issues play a significant role in poor adherence and high viral load in adolescents. Hopelessness, related to feeling defective, different from peers and receiving inadequate support result in poor motivation to adhere. When a child is living with non-biological, non-supportive caregivers, adherence is further reduced. Participants directly linked not taking their ARVs to not caring about living.

Peer support was identified by all cohorts as playing a significant role in improved adherence and reduced viral load. Peers can provide a unique role model and credibility with adolescents to counteract negative perceptions. Further research is needed on mental health in AYPLHIV and the role these issues play in adherence. This study supports the premise that programming with adolescents and young people living with HIV needs to attend to mental health if the goal of 90% of those initiated on treatment having a suppressed viral load is to be achieved.
Grief as a mental health Issue: Peer counsellor led bereavement support

Background: Adolescents living with HIV (ALWHIV) face a myriad of challenges that contribute to the high incidence of virologic failure. Orphanhood is a factor affecting large numbers of ALWHIV that contributes to serious psychological distress. The bereavement literature has established that a significant number of children who experience parental death demonstrate lower self-esteem and higher rates of psychological problems than their non-bereaved counterparts. Further, bereaved children living with HIV show a greater incidence of mental health problems compared with other bereaved children. However, because death is not discussed openly with children and grief is often overlooked in the provision of support and efforts to promote resilience, children are deprived of social supports that are central to enabling positive outcomes following significant loss.

Programme: We developed a 6-session bereavement support program within the context of a community based, HIV support program. Ten peer counsellors (18-22 years) from Africaid, in Harare, Zimbabwe, who act as Community Adolescent Treatment Supporters (CATS), and are both HIV+ and bereaved, were trained as peer grief counsellors. The group first participated in an 8-session bereavement support group focused on their own losses. They then participated in a four-day training to learn how to facilitate a 6-session grief support within their ongoing monthly HIV+ support groups. Sessions focused on acknowledging losses, articulating personal experiences, psycho-education on the grief process, expressing feelings and building coping skills to facilitate resilience. The model adapted existing interventions to the local context and multiple losses commonly faced by ALWHIV. An additional session was devoted to caregivers, to support their understanding of grief experience by the children and adolescents in their care and the ways in which it manifests in their behaviours.

Qualitative data was collected following the initial sessions with the CATS and, upon completion of the sessions in the community-based HIV support groups, 5 focus group discussions (FGDs) were held with the CATS and support group participants. Emerging key themes related to their experiences of bereavement were: limited experience in recognizing their losses; confusion and lack of control over a range of feelings; recurrent feelings of hopelessness, depression, fear, sadness, and guilt; feeling isolated and reticent about sharing, believing their feelings were unusual; and shame around ongoing connections felt towards their deceased. Following intervention implementation, members reported relief in learning of shared experiences, greater ability to identify their feelings, link them with specific experiences and employ constructive coping strategies, leading to greater emotional control. Additionally, they recognized their need for connections with the deceased and felt greater freedom in maintaining these.

Lesson Learned: The peer-led grief programme reinforces the need for addressing bereavement with ALWHIV. At the start of the intervention, participants identified issues that contribute to poor mental health. Following, they gave evidence of feeling less alone and a greater sense of self efficacy, as they felt more able to identify and understand their feelings, had more choice in their coping skills, and better ability to talk about their losses with peers and at home.
Taking those drugs! What it takes to adhere to ART among adolescents living with HIV in Kenya.

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Background: HIV/AIDS is the leading cause of morbidity and mortality among adolescents and young people in Kenya. It is estimated that 9,720 adolescents and young people died of AIDS-related causes in 2014. National HIV program data indicates that viral load suppression among adolescents aged 15-19 years is suboptimal. There is little evidence on the factors that contribute to this. Knowledge of these factors will be important for designing HIV programs to prevent poor treatment outcomes among ALHIV in Kenya.

Objective of the study: To explore the factors that influence uptake of anti-retroviral therapy (ART) services among adolescents living with HIV aged 15-19 years.

Methods: LVCT Health conducted a qualitative cross sectional study in three Counties (Mombasa, Kisumu, and Nairobi) between December 2017 and March 2018. Using four focus group discussions (FGDs) with 61 adolescents (26 male, 35 female) and 12 in-depth interviews (IDIs), we collected data on the individual, socio-cultural and health system factors that influenced ART adherence among adolescents. We purposively selected adolescents who had been enrolled in ART programs for at least six months. We deductively coded qualitative data into themes that covered the individual, socio-cultural, drug-related and structural factors that influence uptake of ART services. We analyzed data using Nvivo 11®.

Results: Our participants reported that their perceived health status influenced adherence; most took ARVs when viral loads were high and stopped when viral loads were low. Other individual factors that influenced adherence to ART were fear of HIV related stigma and discrimination from their peers and school staff and lack of knowledge on importance of adherence. Socio-cultural factors that influenced adherence among adolescents were lack of psycho-social support from peers, school staff and caregivers (such as encouragement and picking drugs from ART clinics on adolescent’s behalf). Drug related factors reported by adolescents were non-discreet packaging of ARVs, pill burden due to multiple doses, size of the ARV pills and the unpleasant smell and taste of the pills. Structural barriers that adolescents reported were lack of safe spaces to take ARVs in school.

Conclusion and recommendations: Our findings demonstrate that there are multiple and interrelated factors that influence adherence to ART among adolescents in Kenya. Based on these findings, we have four recommendations. First, ART providers need to invest in building self-management skills among adolescents for them to be responsible for own health. Secondly, it’s important to build capacity of care-givers, relevant school staff and health providers on how to provide psychosocial support to adolescents in ART programs. Thirdly, schools need to invest in stigma reduction interventions as well as providing safe spaces for adolescents living with HIV to take ARVs to improve adherence. Fourth, we recommend differentiated ART care models that are responsive to adolescents’ treatment needs.
The Impact of engaging Guardians in the Care for Adolescents living with HIV and AIDS (ALHIV) through guardian sessions at Baylor College of Medicine’s Centre of Excellence Malawi, May -October 2016

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**Background:** A guardian session is a supportive forum for guardians of Adolescents living with HIV and AIDS to discuss issues that affect and concerns them as guardians. The sessions were introduced due to the challenges reported by guardians for ALHIV on medical care and psychosocial support at their homes as the adolescents try to cope with their illness in addition to typical adolescent struggles. The objectives were; to impart guardians with information on medical and Nutrition care of the ALHIV, and to improve the capability and comfort of guardians in addressing challenging issues which ALHIV are experiencing.

**Methods:** The sessions were conducted on a quarterly basis at Baylor Malawi on a teen club day (gathering of ALHIV for ART refills and psycho social support). Guardians were invited through letters given to all adolescents present in a teen club prior to the session. The topics of discussion are mostly suggested by the guardians and the sessions were facilitated by trained health professionals and mentors. During the sessions we divided the guardians into small groups to ensure active participation, and each group had a health worker to facilitate the discussion. We assessed nutrition status of the adolescents whose guardians were present in the sessions first and assessed them again in their next clinic visit. The guardians gave feedback on the next session.

**Results:** Between the study period two guardian sessions were conducted where a total of 738/772 (114M & 624 F) guardians attended the sessions representing 95.5% of guardians of teens enrolled in Baylor teen club. There were 22 undernourished adolescents, after the nutrition sessions with their guardians, 18 of these adolescents had a normal nutrition status representing 82%.

**Conclusion:** Guardians spend a lot of time with the teens than health workers as such they help to re-enforce the things that the teens have learnt at teen club. The nutrition assessments were done using body mass index (BMI) and the final assessment results showed an improvement in the nutrition status of the adolescents.
HIV infected adolescents on antiretroviral therapy: a retrospective descriptive study of mental health issues documented during routine care

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Background: Mental health of HIV-positive adolescents has significant implications for treatment adherence and retention in care; however few studies have examined the burden of mental health issues in adolescent patients on antiretrovirals (ART) in South Africa.

Methods: A retrospective file review was performed searching for clinical notes describing mental health and/or psychosocial issues in adolescents receiving ART at two clinics in Johannesburg. Patients aged 10-19 must have presented from 1 January to 31 December 2014. Descriptive statistics are reported. Chi squared test ($\chi^2$) was used to test differences of mental illness and psychosocial issues by sex.

Results: In the two facilities, 331 patients were eligible for review and 39/331 (12%) had documented mental health issues. A total of 40 mental health events were documented with two events documented for one patient. The most common mental health problem was depression (n=7/40) and ADHD (n=5/40). Median age for patients with mental health issues was 15 years (IQR: 11–17). 18/40 (45%) events had concurrent psychosocial issues with the commonest issue being death of a parent-caregiver (n=10). Full disclosure of HIV seropositivity was found in 28/37 (76%) of the adolescents with mental health issues. Report of mental illness was not found to be statistically different by sex (p> 0.05). Psychosocial problems were highlighted 36/331 (11%) of the patients.

Conclusion: The prevalence of mental health issues amongst HIV infected adolescents on ART illustrates the burden of mental health problem. The prevalence of mental illness and psychosocial problems highlight the need for appropriate referral and intervention to improve health outcomes.
Abstracts

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Adjustmental Problems among the Children Infected with HIV/AIDS – An Indian Study

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Introduction: Understanding the common psychological problems in HIV-infected children and adolescents is critical for improving their mental health and quality of life as this aspect needs to be explored in India setting.

Objective: Understand common adjustmental and behavioral problems among Adolescents infected with HIV.

Methodology: Cross Sectional Study. 32 Perinatal acquired HIV Adolescents seeking treatment at Asha Kirana Hospital in Mysore were enrolled into the study after Informed consent, Demographics were taken either from parents or guardians. Strengths & Difficulties Questionnaire(SDQ) was administered.

Results: Mean age was 14.41(10 - 17 yrs) with SD of 2.13. 65.5% were boys. 78.1% on HAART and 21.9% were not on ART. 71.9% secondary school, 12.9% in primary school, 9.4% were college going. Mean total score of SDQ of 28.00 ± 4.11. The manifestation of psychological and behavioral problems raged highest in the area of peer relationships (6.72 ± 2.34) and lowest in the area of conduct problems (4.47 ± 2.07). Emotional problems (5.62 ± 1.42); Hyperactivity (5.78 ± 2.07); and prosocial behavior (5.41 ± 2.16) were being in the middle order. ON ART group showed higher psychological and behavioral problems compared to Not on ART group(not Significant). Hyperactivity (r = -0.400; p<0.0), Conduct Problems (r = -0.434; p<0.05), Peer relationships (r = -0.412; p<0.05), were found to be positively correlated with total score of the SDQ (r = -0.503; p<0.05).

Discussion & Conclusion: The study highlighted the need for addressing mental health problems of adolescents with HIV. HIV clinicians should be aware of possible mental health problems. Comprehensive psychiatric, and neuropsychological assessments are critical components in the overall care for Adolescent HIV. Health care professionals should evaluate psychological issues to improve mental health of HIV infected adolescents.
Utilising integration of SRHR in HIV services among Adolescence and Young People Living with HIV to achieve UHC targets in Nairobi County

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**Significance/Background:** Youth friendly Sexual Reproductive Health (SRH) services are services that cater for 10-24-year-old SRH needs. Access to youth friendly SRH services among young people has been wanting in Kenya. According to Kenya Service Provision Assessment Survey KSPA 2010, only 7% of health facilities in Kenya offer Youth Friendly Services (YFS). Total demand for family planning is highest among women age 35-39 (82%) and lowest among women at the beginning age 15-19 (61%), Kenya Demographic Health Survey, (KDHS 2014).

Some of the key factors attributed to the low uptake of FP among adolescents and youths 15-24 years are lack of integrated services, lack of youth friendly services and most importantly lack of a well-defined forum to talk freely on matters affecting utilization of Family Planning and HIV services (Safe Spaces).

**Program intervention/activity tested:** Christian Aid under various programs have sort to contribute to the reduction in unmet needs for Family Planning (FP) among women and girls in Narok County through partnership with various implementer. The Sexual Reproductive Health (SRH) project employed the SASA (start, awareness, support, action) approach to challenge harmful social norms by addressing gender inequalities to improve SRHR outcomes. INERELA+ Kenya; Faith Leaders and Family Planning, engaged Religious Leaders in Family Planning. The introduction of community-based distributors (CBDs) for Family planning by training community health volunteers to offer injectable family planning methods, pills and condoms.

**Methodology:** The program; Addressing Gender Inequalities to Improve Sexual and Reproductive Health Outcomes Assessment Project, was implemented in the rural settings of Narok County in Kenya for a period of 2 years (2015-2017). Female youth aged 15-24 years; male youth aged 15-24 years old were engaged in the 9 areas where the interventions were implemented. A total of 450 respondents were interviewed as anticipated. The main services sought were Family Planning, HIV services and information on SRH.

The Evaluation Team (ET) used themed context analysis in coding the results and findings. A total of 19 KIIs and 11 FGDs were administered at multi-stakeholder levels.

**Results/key findings:** The percentage of young women aged 15-24 reporting use of family planning was 46.7%; (n=42), compared to the baseline only 15.1% of young women reported that they were using modern FP methods. Although the youth are not yet demanding SRH services, only 34.4%; n=31 young women reported seeking SRH services as compared to 25.9%; n=22 of their male counterparts. This data reflect the 23.0% unmet need and 61.4% of young people 15-19 years demanding for family planning, KDHS 2014

**Program implications/lessons learned:** Availability of SRHR services is not sufficient by itself to increase family planning uptake among young people without integration of other services like HIV screening.

Enhancing Healthcare providers capacity on Youth friendly service provision is crucial for family planning uptake among youth 15-24 years Trends show a general increase in the use of injectable and male condoms among young people 15-19 years (Christian Aid End-term Evaluation report 2018).
Descriptive analysis of Emotive and Psychological Status in adolescent and young adult cohort in Italian Setting.

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Background: Recent literature on preventing HIV transmission has shown the importance of working on HIV knowledge and social stigma in infected and non-infected adolescent and young adults. Emotive and psychological status in HIV patients represents an important determinant for patient wellbeing as well as a determinant for ART compliance. HIV patient live with the sustained fear of discrimination and other’s judgement. Researches using SCL-90 test (Symptom Checklist-90-R) to evaluate nosologic personality categories in adolescent and adult HIV patients showed an increase in mean Global Symptom Index (GSI) compared to general population (adults:0.89 versus 0.50, adolescent 1.30 versus 0.80). A study in a brasilian setting showed how adolescent patients have higher scores regarding symptom dimensions as obsessive-compulsive (O-C), interpersonal sensitivity (I-S), depression (DEP), paranoid ideation (PAR) and hostility (HOS). Furthermore, literature shows how HIV patient frequently score “minimal depression” on PHQ-9 (Patient Health Questionnaire-9). For this reason, we structured a cross-sectional study to describe emotive status and adaptative behavior of a HIV adolescent and young adult cohort in an Italian setting.

Methods: We selected a cohort of 47 patients with HIV (45 from birth), aged 14 to 30 (Mean 21.2, SD 4.8), 53.2% female, followed in “Bambino Gesù” Pediatric Hospital in Rome. We performed SCL-90 test, PHQ-9, GAD-7 (Generalized Anxiety Disorder-7) and PM-38 (Raven’s Progressive Matrices for fluid intelligence), usually used to assess emotive status in chronic patients. We performed a descriptive analysis, verifying distribution with normality test (Kolmogorov–Smirnov test and Shapiro–Wilk test). All performed tests were stratified for age categories (adolescent: 14-19, young adults>19), sex, irregular school career and family status (living alone, with one or both parents, adoptive parents, other relatives, foster home). Possible differences in test scores regarding stratification were assessed with ANOVA test for normal values and median test for the remaining. Values p<0.05 were considered significative.

Discussion: PHQ-9 results showed normal values for 48.8% patients, Mild Depression in 37.2%, Moderate Depression in 9.3% and Moderately Severe Depression in 4.7%. GAD-7 showed normal values in 38.1% of cases, Mild Anxiety in 45.2%, Moderate Anxiety in 11.9%, Severe Anxiety in 4.8%.
PM38 resulted to be average value (mean: 98.13 SD 11.05). We observed significant difference in stratification for age and irregular school career. Borderline significance was observed for family stratification.
SCL-90 show higher score in GSI. Regarding symptom dimension, our population shows high scores in obsessive-compulsive dimension, in interpersonal sensitivity dimension, depression dimension, paranoid ideation. We did not observe significative differences in these dimensions by stratification. We did however observe significative differences by stratifying somatization dimension by sex and family status.

Conclusion: It appears important to analyze causes for increase in dimension values for O-C, PAR and how they are related with symptom dimension for DEP and I-S, considering HIV infection, HIV knowledge, socio-cultural context, ART compliance. Further research in this area is desirable.
Accidental disclosure of an HIV-positive status can either build or break you: Experiences of an adolescent girl in Lusaka, Zambia

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Background: Adolescents have been equally affected by the HIV epidemic. They remain vulnerable to emotional distress after knowing their HIV-positive status. I present my experience of “accidentally” knowing my HIV-positive status.

Description: Both my parents died before I was 8 years old and was brought up by my uncle and grandparents. During my childhood, I was in and out of hospital, missed school and looked much smaller and younger than my classmates. My guardians knew of my HIV-positive status but due to stigma around the disease and scarcity and cost of ART at that time did not act upon it. At 15 years old, I was put on medication without being told what it was but told on the effect of taking it. I was never allowed by my guardians to attend hospital appointments without their company. I “accidentally” knew my HIV-positive status at 17 years, after about taking the medication for 2 years, when I attended a hospital appointment alone without the knowledge of my guardians.

Lessons learned: After knowing my HIV-positive status, I was devastated and thought it was the end of the world for me. I defaulted from treatment for more than 2 years. I replaced hospital records with fake address to prevent them from locating me. I kept a bottle of ARVs which my guardians kept seeing. I attempted suicide 3 times. I gave up on everything, and my grades dropped. Eventually the hospital traced me, and provided an opportunity for me to visit them at will. They gave me space to express myself and counselled me over a long period of time. I resisted treatment for over a year, but the hospital staff was patient with me until I started opening up. At that point, they introduced me to other adolescents living with HIV and this helped with acceptance of my HIV-positive status.

Conclusions/Next steps: Timely disclosure of HIV-positive status to adolescents is important, because it may break them, if they found out on their own, as was my case. Good internal and external support systems are important to adherence. Today, am 28, in a relationship and an advocate for ALHIV.
What works: Provision of psychosocial support through clubs and camps for adolescents living with HIV improves adherence, self-acceptance and self-esteem

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Background: Sentebale is a charity organization that was founded in Lesotho in 2006 by Prince Harry (now The Duke of Sussex) and Prince Seeiso aimed at supporting adolescents living with HIV. In 2016, Sentebale was registered as a Trust in Botswana to provide psychosocial support to HIV+ adolescents (10-19 years).

In Botswana, it is reported that 14,000 adolescents (10-19) are living with HIV and the highest number of new HIV infections occurs among 15-24 year olds with females being more affected than males. HIV related deaths are also reported to be high among adolescents.

Working in collaboration with the Ministry of Health and Wellness, Sentebale is supporting over 800 adolescents through 30 network clubs through two psychosocial interventions to address a range of needs and challenges. These are: monthly clubs and annual week-long camps. Caregiver groups are also supported to meet quarterly to address their own challenges within the context of caring for HIV+ children, some of whom are orphaned.

Furthermore, building the capacity of caregivers ensures the creation of a conducive home environment for the children to adhere to treatment. We deliberately focus on hard to reach areas as we continue to roll out the program.

Clubs: HIV+ adolescents are enrolled into clubs that meet once a month on Saturdays to meet other children living with HIV, to get engaged in HIV related and skills building lessons, to play and share personal experiences. The clubs are coordinated by trained volunteers (in some cases youth living with HIV) and some health workers from the local hospitals or clinics. The minimum number of club members is 10. Sentebale provides children with lunch and transport funds.

Camps: During school holidays, Sentebale hosts week-long camps for children. The goal is for every club member to attend camp at least once a year where an intense program is delivered comprising health and HIV related lessons, interactive sessions, play and creative dramatization of experiences. During camp, a medical team administers the children’s medication every morning and evening during strictly set times; through this, cases of poor adherence are noticed and addressed.

Results: At the end of camp, every child is given an opportunity to write their experiences. In 2017, we compiled these testimonies into a pamphlet funded by UNFPA and the reported and recurring themes are:
- Improved self esteem
- Self acceptance and in some cases, abandoning suicidal thoughts
- Improved adherence to treatment; this improvement is also frequently reported by caregivers and health workers saying that Sentebale’s intervention has resulted in significant improvement in adherence whereby children no longer require supervision for taking ARVs
- Improved HIV knowledge
- Improved life skills knowledge e.g., children frequently reported the benefits of discussing Bullying.

Conclusion: The Sentebale model of psychosocial support has been reported as having a positive impact by both the children and their caregivers. Of significant importance is improved adherence and parent child communication which is essential to sustain the gains made on the children. The demand for our service is high and we have chosen to serve remote and hard to reach areas of Botswana.
Understanding the Mental Health of Adolescent who acquired HIV vertically, by creating a safe space to dialogue with Women Living with HIV who self-identify as having or caring for a child living with HIV

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A case study of Children with HIV (CHIVA) Support Summer Camp

Background: Data from the Collaborative HIV Paediatric Study (CHIPS) shows that 2,151 children living in the UK with HIV were reported by March 2018, (91%) acquired HIV vertically. The UK is on its way towards reaching the UN 90 90 90 target, (figures of 87 96 94). It is now important to focus on psychosocial, quality of life & wellbeing issues that significantly affect young people as they journey into adulthood. Young women living with HIV need to be supported in understanding the WHO Sexual, Reproductive Health and Rights recommendations. Young men living with HIV continue to face unmanaged challenges around sex and relationships. Young people in the UK have continuously highlighted the importance of breaking down barriers they face in the home environment around meaningfully discussing living with HIV with their parents or caregivers.

CHIVA host for an annual weeklong residential summer camp for approximately 100 (102 in 2018) young people (ages 11 – 19) living with HIV. They have agreed to incorporate a space for women living with HIV who self-identify as having or caring for a child living with HIV, to have open dialogue with adolescents and young people about the issues they feel they are unable to discuss with their parents or caregivers.

CHIVA is a UK based charity supporting children and young people living with HIV across the UK and Ireland.

Objective: Responding to SDG 3 and the GIPA principals the request from young people living with HIV, who experience barriers in having meaningful conversations with their parents or caregivers will be addressed at the annual CHIVA summer camp.

Material and Methods: A cycle of three (3) workshops which will be repeated three times (total 9 sessions) led by women who self-identify as having a child or caring for a child living with HIV. The sessions will be held in a “fireplace discussion “method, to eliminate any perceptions of power if barriers such as a boardroom table is used.

Results: Qualitative evaluation shows that the intervention is sustainable, enables conversations around mental health, stigma (including self-stigma) and instrumental in breaking the barriers for dialogue in the home environment.

Discussion: Parents and caregivers of children living with HIV have the responsibility of ensuring that young people in their care do not have the burden of isolation, by not being able to share their HIV status. Most young people living with HIV have the desire to use their HIV positive status, to educate breaking down myths about HIV, addressing stigma and discrimination.

Conclusion: Young people living with HIV in the UK do not have access to holistic HIV care that incorporates clinical and psychosocial intervention. Spaces as created at the CHIVA Summer camp need to be funded and be accessible to all young people that need them.
Disclosure patterns for HIV-infected adolescents attending Baylor College of Medicine Clinical Centre of excellence, Lilongwe, Malawi

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Background: With increasing survival of HIV-positive children due to widespread availability of antiretroviral therapy (ART) in developing countries like Malawi, an important challenge faced by caregivers and healthcare professionals is disclosure of HIV-positive status to children and adolescents. Appropriate disclosure of HIV sero-status to HIV infected children is associated with reduced risk of death and better adherence to antiretroviral drugs. WHO 2011 guidelines recommend that most children should be aware of their HIV status by the age they are 12 years old. We assessed the disclosure patterns for adolescents living with HIV at the Baylor College of Medicine Children’s Foundation Centre of Excellence (BCMCF-COE) in Lilongwe.

Methods: This was a cross-sectional study conducted among HIV-positive children attending the BCMCF-COE in Lilongwe, Malawi who were disclosed to by a social worker during their antiretroviral clinic appointment between November 2017 to April 2018. Type of disclosure (partial or full), gender, and age of disclosure were collected from the BCMCF-COE electronic medical records and social work department records. Data were entered into Excel 2013 and descriptive statistics were performed.

Results: Of the 126 clients disclosed to during this six month period at the COE, 94 underwent full disclosure and 32 underwent partial disclosure. Of those undergoing partial disclosure, the average age was 10.7 years for females (95% confidence interval, CI, 9.8-11.6) and 11.3 for males (95% CI 9.3-13.3). Of those undergoing full disclosure, the average age was 12.3 for females (95% CI 10.8-13.8) and 13.1 for males (95% CI 11.7-14.5).

Conclusions: A high proportion of HIV-infected adolescents attending the BCMCF-COE were made aware of their status by the age of 16 years, but many of our clients are being disclosed too late with respect to the WHO guidelines. The delay seen here does raise need for further inquiry. Next steps include (1) sharing the data with clinicians, (2) discussing the causes and implications of the reported delays in disclosure, and (3) developing and implementing strategies to close these gaps.
Harnessing the use of Art in addressing Mental Health issues among Adolescence and Young People Living with HIV to achieve the 3rd 90 targets, in Nairobi County

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Background: The Kenya Mental Health Policy 2015-2030, (2016) states that, Adolescents face behavioral challenges and exposure or pressure to risky behavior, such as use of psychoactive substances; make them vulnerable to mental disorders. Most studies of mental health challenges among adolescents living with HIV in low- and middle-income countries are cross-sectional and do not include comparison groups; however, they do indicate the need to address mental health within care systems addressing HIV or primary care. In a study of 162 HIV-infected children and adolescents in Kenya, 49% were reported to have at least one psychiatric diagnosis or suicidality, with anxiety disorders most common (32.3%), and followed by major depressive disorder (17.8%). Journal of the International AIDS Society, JIAS 2017; 20(Suppl 3)

Program Intervention: Alfajiri under the Safe space programs have sort to contribute to increased viral suppression among Adolescence and young people in three sub-counties within Nairobi. The Safe space program utilised art specifically spoken words and Theater forums approach to address mental health and Sexual Reproductive Health and Rights issue among Young People Living with HIV to improve drug adherence. Alfajiri engaged youth-led groups and Community Health Volunteers during the safe spaces sessions. The use of dialogues and conversational sessions geared towards mental health and HIV increased the outcome of achieving viral suppression among young people.

Methodology: The program; Embracing art for Viral Suppression through Safe spaces by Addressing Mental Health issues among Adolescence and Young People Living With HIV initiative, was implemented in 3 urban slums of Nairobi County in Kenya for a period of 6 months (November 2017- May 2018). Mapping was done to identify health facilities providing HTS, SRHR and Mental Health services within the identified 3 sub-counties. Youths aged 15-24 years were engaged in the 3 areas where the interventions were implemented. A total of 93 Adolescence and Young People were engaged in the safe spaces with 37 being HIV positive but not publicly disclosed. Sessions were held in tertiary institutions and the community to establish the level of young people involvement in mental health and HIV and what social issues they are facing and how they can provide appropriate solutions to them.

Results and findings: The number of young people attaining viral suppression went up based the reports from the identified health facilities by 20% (n=37). Initially with the 37, only 3.7% (n=10) had achieved viral suppression. Out of the 56 young people who were not tested, 27 received tested and 5 turned positive and were initiated on care immediately. From the young people engaged, 13 reported to have experienced anxiety or depression with suicidal ideologies in one point in life with 38.5% (n=5) being young people living with HIV.

Lessons learnt: Although viral suppression depends on ART adherence, Mental Health has a profound impact on adherence among Adolescence and Young People. Creation of safe space in the community as a support system is crucial to Adolescence ownership of their adherence towards attaining viral suppression.
Mental health and HIV disclosure practices for HIV-infected adolescents in Kenya

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Background: Disclosure of HIV diagnosis to HIV-infected adolescents is a critical first step to independent care management and can impact adolescent psychosocial health. Disclosure is often delayed due to caregiver fears and lack of healthcare provider training. Mental health of adolescents pre and post disclosure is not well characterized, and may impact treatment adherence and successful transition to adult care services. However, limited data exits on currently available mental health and disclosure processes. To inform future intervention development, we determined disclosure and mental health assessment and care provision practices and tools currently employed in HIV clinics in Kenya.

Materials and Methods: We conducted in-person facility surveys with clinic managers from a random sample of 46 large (≥300 total patients in care) HIV clinics. Surveys were conducted between January-July 2018. Respondents provided information on challenges caring for HIV-infected adolescents, disclosure processes, and mental health assessment procedures.

Results: Of 46 clinics, 5(11%) were county hospitals, 16(35%) sub-county hospitals, 24(52%) health centers or dispensaries and 1(3%) a mission hospital. The majority (61%) of clinics saw adolescents within adult clinic spaces but provided adolescent services on dedicated adolescent clinic days. The most common adolescent days were Saturdays (46%) and Wednesdays (30%). Almost all clinics (93%) had the same staff providing care for all age-groups.

All clinics reported having disclosure guidelines; the majority (80%) reported having access to disclosure tools. According to clinic policy, median child age for beginning disclosure discussions with caregivers was 7 (IQR: 6-8) and with children was 6.5 (IQR: 6-9). In actual practice, the median child age reported for disclosure discussions with caregivers was 8 (IQR: 6-10) and with children was 9 (IQR: 7-12). In addition to age, clinics reported considering mental health status (79%), adolescent maturity (64%), sexual risk behaviors (45%), adherence (43%), and viral suppression (34%) when evaluating child readiness for disclosure. Disclosure discussions were most commonly initiated by clinical officers, counselors, and peer counselors. The median reported age for completed disclosure was 12 (IQR: 10-15). Most (87%) clinics reported tracking disclosure status using clinic notes (45%), counselor notes (44%), or a Ministry of Health developed tracking form (64%). The majority (89%) of clinics reported assessing mental health in adolescents; 95% reported mental health assessments occurring at every adolescent visit. Twenty-six clinics (63%) reported using the PHQ9 to assess mental health. Clinics reported consistently assessing depression, partner or family abuse, suicidality, and stigma. They less frequently assessed trauma (56%), and postpartum depression (37%). Most clinics (87%) reported immediately treating identified mental health issues, rather than referring participants to receive services elsewhere. For adolescents referred elsewhere for services, approximately half (51%) were referred to services outside the clinic. Those referred externally were most often connected with a clinic social worker (24%) or the caregiver was given information to follow-up (15%).

Conclusion: Better understanding current disclosure and mental health practices for adolescents can inform the development of future interventions to improve clinical practices that leverage already existing infrastructure.
Youth and HIV in Rwanda: a nationwide prevalence and risk factors survey

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Background: Globally there are approximately four million young people aged 15 to 24 living with HIV, and 29% of those are adolescents aged 19 to 24 years. Rwanda like other countries is experiencing a growing share of HIV-positive adolescents aged 15 to 19 years. This study analyzes HIV prevalence and factors associated with high-risk sexual behaviors among young adults (15 to 24 years old) in Rwanda who are not married nor cohabitating with partners.

Methods: We generated relevant summary statistics and used multivariable logistic regression to identify factors associated with inconsistent condom use and factors associated with the early sexual debut. Goodness-of-fit tests, including Hosmer and Lemeshow, Deviance and Pearson’s Statistics, were performed to assess the model diagnostics.

Results: This analysis had a total sample size of 4,843 youths aged 15 to 24 years who participated in the Rwanda AIDS Indicator and HIV Incidence Survey (RAIHIS) study, of which 1,083 (22.36%) were sexually active. HIV prevalence among Rwandan youth aged 15 to 24 years was less than 1 percent (0.56%). Males were less likely than females to inconsistently use condoms (OR = 0.53, 95% CI: 0.38, 0.74). Early sexual debut, defined as intercourse before age 15 years, was more likely among males than females (OR = 1.95, 95% CI: 1.37, 2.78), and among respondents with at least a primary education (OR = 2.31, 95% CI: 1.32, 4.03), with comprehensive knowledge of HIV (OR = 1.99, 95% CI: 1.27, 3.11), and from rich families versus poor families (OR = 1.75, 95% CI: 1.14, 2.67).

Conclusions: The findings provide insights into sexual activity among youth in Rwanda that have concrete implications for current and future HIV response strategies. Early sexual debut and inconsistent condom use among young adults are the two high-risk factors described in this study. Further, this survey found that Rwanda national HIV prevalence is low among youth. We recommend establishing special HIV programs for young adults and adolescent to better lead to an HIV-free generation.
The uptake of sexual reproductive health and rights (SRHR) services among adolescent girls and young women in Kaduna State, Nigeria

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**Background:** Low uptake of Sexual Reproductive Health and Rights (SRHR) services amongst Adolescent Girls and Young Women have created a heavy burden in the tackling of associated health issues. This ranges from unsafe sex, unplanned pregnancy, unsafe abortion and early marriage amongst these population.

This study aims at assessing the knowledge, experience, and exposure of Adolescent Girls and Young Women on sexual education and condom use which results in their poor uptake of Sexual Reproductive Health and Rights (SRHR) services.

**Methods:** An online study comprising of 88 Adolescent Girls and Young Women, age 10-24 of different ethnic background and religion was conducted, from the 25th of February to the 7th of April 2018, in Kaduna state, Nigeria.

Nigeria has a total population of (170 million ) people which Adolescent Girls and Young Women (age 10-24) constituting 31.4% of the country’s population (Source: Global revision of the world population response 2017).

Early exposure and/or high sexual risk amongst Adolescents and Young Persons (AYPs) age 15-24 is seen at 16% for females and 6% for males who had sexual debut before 15 years, but there is a decline for males from 17years to 15 years (2007&2011 SPARC). Condom use during the first sexual intercourse among sexually active Adolescents and Young Persons (AYPs) age 15-24, is seen at 22% for young men and 11% for young women (NDHS 2008).

A mixed method approach was employed for this study, involving the use of self-administered online questionnaires to elicit information on Sexual education and condom use. Data collected was analyzed by Google, and presented graphically, in percentages. https://bit.ly/2HejPPf

**Results:** Sexual Education

- 48.9% of the respondents got their first knowledge about menstrual cycle from their parent, while 35.2% from school, 18.2% from peer group and 5.7% by self discovery.
- 83% of the respondents know how to track their menstrual cycle, while 17% do not.
- Only 37.5% of respondents have knowledge of their safe period, while 62.5% do not have knowledge of their safe period.

Condom

- 76.1% of respondents have heard of female condom, while 23.9% of respondents have not. Of the 76.1% that have heard of female condom, 40% got their knowledge from peer group, 38.5% from School, 27.7% from Social Media, 1.5% from Parent and 1.5% from Religious groups.
- 51.1% of respondents have seen female condom, while 48.9% have not. Of the respondents that have seen a female condom, 53.5% saw it at the health facility/pharmacy, 27.9% saw it with friends, 16.3% saw it in school and 4.7% at home.
- All the respondents have never used a female condom.

**Conclusion:** Sexual Reproductive Health and Rights (SRHR) are services we must provide to Adolescent Girls and Young Women in order to mitigate unsafe sex, pregnancy, unsafe abortion and early marriage among this target populations. It is therefore paramount that efforts aimed at addressing these gaps and challenges are made, as it will greatly impact on the quality of Sexual reproductive health and right (SRHR) services and it’s outcome.
Entry and retention in HIV care: Adolescent experiences with learning their HIV status and psychosocial adjustment to long-term HIV care

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Background: Disclosure of a child’s HIV-positive status is often delayed by family caregivers. Studies in east and southern Africa have documented disclosure rates of 38-62% to adolescents aged 11-15 years. The general recommendation is that the process of disclosure begins around age eight or earlier and is completed before age 12. We explored adolescent experiences entering HIV care; how they learned their HIV status; and characteristics of HIV care settings that helped improve their sense of belongingness and health management.

Materials and Methods: From November-December 2017 in six clinics/communities from three regions of Tanzania, adolescents living with HIV (n=19) and health providers (n=6) participated in in-depth interviews. Caregivers (n=25) and community members (n=41) participated in eight focus group discussions. All adult participants and caregivers of participating adolescents under 18 years provided informed consent, and minors provided assent. Discussions were audio-recorded and transcribed into English; data were prepared for analysis in MAXQDA, using a standardized codebook.

Results: Almost half (n=10) of adolescent participants were age 11-17 years; nine were 18-19 years; 11 were female. All of the adolescents described how they first entered HIV care with regard to learning their HIV status, and more than half shared negative experiences. This included disclosure following many years on ART, and/or disclosure by a provider directly, and/or realizing on their own based on their knowledge of HIV obtained from other patients, peers or the general media. Delayed caregiver disclosure was associated with descriptions of feeling angry, irritated, or withdrawn from the caregiver. Provider disclosure was described as either a neutral or positive experience, except in one case where the adolescent was present during testing, and observed the test result turning positive. Provider disclosure was more common for adolescents in care for some time, but whose caregivers had not disclosed to them. Respondents stated how providers were instrumental in helping them to better understand HIV, and making the HIV clinic feel safe and friendly. Adolescents also described the important moments when they first became aware of other adolescents in care, and their appreciation of opportunities to attend adherence clubs or other adolescent-focused activities to gain knowledge, self-confidence and coping skills from their peers.

Conclusions: Delayed caregiver disclosure was generally described negatively by adolescents. Provider engagement of caregivers, particularly on disclosure support, may help to open communication channels between caregivers and adolescents. Enhancing opportunities for peer-to-peer support to adolescents, particularly those newly enrolled, could facilitate the process of adolescent adjustment to HIV care and acceptance of their positive status.
Factors affecting viral suppression in Children and Adolescents living with HIV – A Situational Analysis

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Background: There is a worrying trend of poor viral suppression in Children and adolescents living with HIV (CALHIV). In Kenya, efforts to identify and initiate CALHIV on treatment have borne fruit with 81% and 82% coverage respectively however viral suppression is at 63% with related morbidities due to opportunistic infections. Various hypotheses have been raised to the poor suppression rates. With the lifelong nature of treatment for HIV, it becomes crucial for the CALHIV to achieve viral suppression for better quality of life and to avoid developing resistance to ARV. To address the suboptimal viral suppression, there is need to understand factors that result in optimal and suboptimal suppression rates in CALHIV in Kenya.

Methods:
• 27 health facilities were selected for the analysis based on their optimal and suboptimal suppression rates among CALHIV.
• Upto 20 CALHIV health records per facility, were selected, clinical data abstracted including ARV regimen, ARV Dosing, Viral load results Action to viral loads above 1000 ml3, TB screening, IPT prophylaxis and growth monitoring
• At each facility 2 focus group discussions (FGDs) were conducted; one with caregivers of CLHIV aged 0-9years, and another with adolescents living with HIV
• Facility data was collected about the staffing, availability of HIV related commodities, guidelines related to CALHIV health management.

Results: 4 main categories of factors affecting viral suppression were found: 1) client factors 2) caregiver/community factors 3) ARV formulations 4) health systems

1. PATIENT
• Gap in ownership of HIV status due to late disclosure of status

• Availability of peer mentors and psychosocial support groups result in better suppression rates

2. CAREGIVER/COMMUNITY
• Knowledge gap among caregivers on HIV information as pertains to children and adolescents and lack of understanding of what Viral Load measures
• High level of stigma in the community and at schools result in mental burdens among CALHIV and their caregivers

3. FORMULATIONS
• Bitter taste and pill size of ARVs lead to difficulty in adherence to all doses
• Pill burden and twice daily dosing contributed to missed doses

4. HEALTH SYSTEM
• Strict clinic appointment schedules interfere with school and work schedules
• Lack of national level guidance on psychosocial support models for CALHIV

Conclusion: Multiple factors lead are responsible for optimal or suboptimal viral suppression rates in children and adolescents living with HIV. The National program needs to work in collaboration with the education sector, county governments, health facilities and the community to address these factors. In-addition advocacy is urgently required for development of paediatric and adolescent friendly formulations that take into account their developmental stage and their need to have simplified and reduced dosing frequency due to school schedules and their parents work schedules. The caregivers and the CALHIV require continuous support and education for ownership of HIV status and to help fight stigma and discrimination that is rampant in schools and the community.
Champions For Life (CFL): A faith-based psycho-social support for ALHIV

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Background: The adolescent years are challenging with regards to coping with life changes, ALHIV have to cope with the added challenge of living with a chronic condition associated with life-long medication, stigma and issues of status disclosure among other things.

Description: CFL is a targeted faith-based psychosocial support in the form of Day-seminars and facilitation at Teen Club camps. Participants are adolescent attendees of ARV Clinics, members of the teen clubs who have gone through the full status disclosure programme. Ages are from 12years up. Facilitators are young adults of whom some are students of Health Science and others are young adults living with HIV who have overcome through CFL programmes. Clinic staff including counsellors are present for support where needed.

CFL topics covered to date in Namibia:
- Self esteem
- Overcoming challenges
- Identifying and managing Depression
- Overcoming grief
- Sexuality and relationships
- Skills, Talents and careers
- Leadership training and Team building

Music and dance, Drama, icebreakers, sporting activities, real life stories from Champions and small group discussions with feedback session.

Lessons Learned:
ARV Clinic staff noted teens who go through CFL programs have improved self-esteem and confidence and improved adherence. Champions are better able to identify and articulate problems encountered and offer solutions. They are empowered to mentor and encourage peers. The CFL intervention has had a visible impact on the Teen Club members. This was clearly illustrated at the latest camp facilitated by CFL where the Teens who had had repeated exposure to CFL programmes demonstrated a difference in their social ability which was admired by those having their first exposure to CFL.

The important issues that the Namibian teens identified through group discussion were:
- Alcohol and drugs
- Abuse
- Adherence
- Bullying and discrimination
- Domestic violence
- Family issues
- Relationship issues
- Stigma
- Teen Pregnancy
- The quality of education

Conclusion: The CFL programme of psycho social support improves the lives of ALHIV through addressing specific issues that affect their mental health and providing a platform for discussion and problem solving. These issues are addressed in a teen friendly environment promoting freedom of interaction and openness.
Addressing individual and societal barriers to health, information and justice for adolescent girls in Kisumu, Kenya

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Kenya and Legal Issues Network on HIV & AIDS (KELIN) is a human rights NGO working to protect and promote health-related human rights in Kenya. We do this by: providing legal services, engaging in advocacy campaigns, conducting research and influencing policy that promotes evidence-based change.

Young people contribute significantly to Kenya’s HIV burden with adolescent girls and young women (AGYW) accounting for a disproportionate amount of this burden. The intrinsic connections between HIV and sexual and reproductive health and rights (SRHR) are well established.

Informed by this, KELIN is implementing a project: “Facilitating access to sexual and reproductive justice for orphaned and vulnerable adolescent girls”, aimed at securing sexual and reproductive justice as an avenue to reduce the HIV prevalence among AGYW. The goal is to reduce new HIV infections by 40% through securing sexual and reproductive health justice for adolescent girls and young women in Homabay and Kisumu Counties

The two-year project is structured to address individual and societal barriers of access to health, information and justice through:

a) Increased knowledge and understanding on sexual rights, HIV by AGYW.
b) Addressing structural barriers of access to services and access to justice through engagements with key stakeholders including: elders and widows; the Judiciary and its structures; and policy makers and legislators; and
c) Nurturing AGYW through sports and drama and dismantling stereotypes on what spaces AGYW should or ought to belong in.

In the course of implementation, KELIN found that most adolescents do not have access to legal services, particularly when sexually violated. This is either due to lack of knowledge of the legal process, their rights and where they can get the services. The project raises awareness on the rights of adolescents and young women to their sexual and reproductive health rights. It also facilitates access to justice for vulnerable adolescent girls in Kisumu and Homa Bay Counties.

Adequate safe spaces where young people can go to access information and get youth-friendly sexual and reproductive health services are scarce. The project also works with other partners to provide social protection programmes and services against stigma and discrimination.

Programmatic interventions for HIV fail to explore the intrinsic connection with SRHR leaving a gap in information for AGYW. There has also been a cultural inhibition towards SRH discussions. Most of them are not the decision makers hence without getting the good will of the decision makers the intervention tend to fail.

There is need to replicate intervention models that seek to address both structural and individual barriers. Interventions solely aimed at addressing the individual needs of AGYW fail to address the societal contexts in which AGYWs come from and the areas of vulnerability that individual empowerment cannot shift.

There is need for HIV interventions to make the link with other holistic interventions including access to justice, legal aid and information on contraception.
Implementation of a psychosocial support program for HIV-infected adolescents in Central Africa sub-region context (Cameroon, Tchad)

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Introduction: There is no standardized protocol for psychosocial support of HIV+ adolescents in Central Africa sub-region. The aim of this study is to implement a psychosocial support program for HIV+ adolescents adapted to this sub-region.

Objectives:
- Implement psychosocial support interventions for HIV+ adolescents in some Central Africa health facilities
- Describe mental, cognitive and sexual behaviour profiles in HIV+ adolescents
- Assess the association between evolution of mental, cognitive and sexual behaviours profiles throughout the study process and the types of psychosocial support interventions

Methods: This is a 48 months prospective study conducted in 3 clinical sites of Central Africa: “Centre de Promotion de la Santé (CPS) “, Tokombere, Cameroon, “Centre Djanandoum Naason (CDN)”, Mondou, Tchad and “Centre Mère et Enfant de la Fondation Chantal Biya (CME-FCB)”, Yaounde, Cameroon. We include in this study HIV+ adolescents initiating antiretroviral treatment and adolescent patients not adherent to care (former lost to care, non-adherent to antiretroviral treatment, etc.) and whose parents (or guardians) consent for the study. We describe the frequency of high risk sexual behaviours, depression, and cognitive deficiencies among HIV+ adolescents before any psychosocial support intervention. Using the linear mixed models, we assess the efficiency of the said psychosocial support interventions in reducing the frequency of deficiencies or high risk sexual behaviours among HIV+ adolescents throughout the study process, adjusted to socio-demographic characteristics.

Awaiting profits:
- Implementation of psychosocial support interventions to be standardized in the context of Central Africa
- Data in relation to mental, cognitive and sexual behaviour profiles among HIV+ adolescents in Central Africa
- Data concerning the efficiency of each psychosocial support intervention according to HIV+ adolescents’ mental, cognitive and sexual behaviour profiles
- Scientific publications of study results through doctoral and post-doctoral studies.
Engaging Adolescents and Young People in achieving the first 90 through safe spaces

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Introduction: The International Network of Religious Leaders Living with or Personally Affected by HIV (INERELA+ Kenya) is reaching out to AYPs from different faith communities to raise awareness and disseminate information on HIV and SRHR related issues using the Personal Process Oriented Approach (PPOA) and Safe Spaces (ALFAJIRI). Alfajiri was born out of the need to promote meaningful, efficient and effective young people’s involvement in the designing, planning, implementation, monitoring and evaluation of health programs where they are key stakeholders and partners as well as service beneficiaries through safe spaces.

Background: The initiative began in 2015 in Soweto informal settlement by young people with the help of art crew (Dream of Africa) where sessions were held with teenagers (11-18) years with a focus on social issues leading to school dropout and how the issues could be addressed through art. Later on health issues emerged with more interest on SRHR and HIV, it is for this reason that the safe space was made open for every young person in the community to give their views and challenges. In 2016 ALFAJIRI engaged tertiary learning institutions (Kenyatta University) where most of the new infection rates were high to establish emerging issues on HIV service uptake and enhancing advocacy on scaling up testing activities among youths 18-24 years within the institution and the surrounding community. Some of the key reasons attributed to the increasing new infection rates among adolescents and youths are the lack of awareness of sero-status, poor linkages between testing and treatment services, poor service provision in the health facilities and most importantly lack of a well-defined forum to talk freely on matters affecting them (Safe Spaces).

Objectives:
1. Engaging and identifying issues greasing AYPs vulnerability to HIV infection & fast tracking end of HIV in Kenya.
2. Tackling mental health issues by use of referrals and counselling Dialog between religious leaders and AYPs were held to develop a Call to Action to integrate differentiated care and attitude change communication. Ten youth champions were trained on basic HIV knowledge by INERELA+ Kenya as agents of change in their communities.
3. ALFAJIRI with the help of Kenyatta University AIDS Control Unit (KU-ACU) have been able to strengthen the capacity of youths support group through the safe spaces program. In 2014 the institution had only 5 active students 18-24 living with HIV attending their support group meetings with only 10 students accessing care and treatment, but this number has increased gradually to 23 active and 40 accessing care and treatment at the health center. The group was able to bring youths from the community and students in the university who are both HIV positive and HIV negative aiming at stigma reduction among young people.
4. INERELA have also been able to design youth-effective programs based on what is presented by the young people so as to target adolescents with the best approach

Recommendations: Carry out a study among AYPs in Kenyatta University to establish the social issues facing young people and level of involvement in HIV response.
HIV acquisition and sexual behaviour before and after HIV diagnosis in a youth cohort in Soweto and Durban, South Africa

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Background: In South Africa, youth 15-24 years have the highest HIV incidence of 7.1%. To inform targeted HIV prevention interventions, we measured HIV incidence longitudinally and sexual behaviour before and after HIV diagnosis in youth.

Materials & Methods: Between November 2014-April 2016, 425 (220 Durban and 205 Soweto) youth 16-24 years were enrolled in the AYAZAZI cohort study. HIV status was assessed at each visit using a rapid kit. Interviewers administered a survey measuring socio-demographics, sexual behaviour, and ART initiation (for HIV-positive youth). We analysed data among participants who tested HIV positive during study follow-up visits. Data were analysed descriptively.

Results: Of 425 enrollees with a median age of 19 (IQR: 18-21), 13/425 (3.1%) were HIV+ at baseline and 12/412 (2.8%) seroconverted on follow-up (IR=2.54 [95%CI:1.5-4.4] per 100 person-years). Median time to HIV diagnosis was 11 (IQR: 5-14) months from enrolment. Females comprised of 50% (6/12) of the seroconverters, 42% (5/12) identified as LGBTQ, 83% (10/12) were sexually active, and 60% (6/10) had >1 concurrent sexual partner prior to enrolment. For the time period before and after diagnosis respectively, 83% (10/12) vs. 73% (8/11) reported consensual sexual intercourse; sexually active participants had a median of 2 (IQR 1-6) vs. 1 (IQR 1-1) partners; 70% (7/10) vs. 75% (6/8) had a regular partner; 30% (3/10) vs. 25% (2/8) had a casual partner; 100% (10/10) vs. 88% (7/8) had a male sexual partner; median age of the sexual partner was 23 (IQR 20-24) vs. 28 (IQR 22-33) years; 60% (6/10) vs. 50% (4/8) engaged in vaginal sex, 40% (4/10) vs. 50% (4/8) anal sex, 10% (1/10) vs. 13% (1/8) giving oral sex; 10% (1/10) vs. 0% (0/8) receiving oral sex; 50% (5/10) vs. 75% (6/8) used a condom during last sex; 50% (5/10) vs. 25% (2/8) reported a known HIV-positive partner at the last sexual encounter. 67% (8/12) were taking antiretrovirals 3 months post diagnosis and 17% (2/12) rated that taking antiretrovirals makes the risk of HIV infection lower.

Conclusions: Among youth in a HIV prevention cohort study, HIV incidence was 2.5 per 100 person-years with minimal changes in sexual behaviour after HIV diagnosis. Sub-optimal uptake of ART post diagnosis and low awareness of the HIV prevention benefits of ART, suggest a need for improved education. In addition, biomedical prevention technologies are needed to reduce HIV incidence.
Cause of treatment discontinuation among youth and adolescents living with HIV

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Background: In Burundi, 1.2% of women and 0.6% of men aged 15-49 are HIV-positive among them 0.3% women and 0.1% of men are 15-24 years old according to EDSBIII2016-2017. In 2015, there were 988 adolescents aged 10 to 19 years on TAR treatment and 972 in 2016. According to PNLS / IST baseline data. The RNJ+ in its mission to promote right and care of young people VIH+, it focuses on the retention of young people to TAR framework to contribute to the achievement of 90-90-90 goals specifically on the reduction of viral load up to undetectable stage for youth and adolescents under treatment. For this, RNJ+ has decided to sponsor a survey on the causes of giving up and problems encountered in taking TAR among adolescents and young people living with HIV.

Methodology: In April 2018, 100YPLHIV girls and boys between 15-20 years old participated in the survey made by RNJ + to find out the causes of non-observance and therapeutic abandonment. 1st Identification of participants; 2nd Creation of the group whatsapp (30participants) 3rd Focus group (20participants) 4th Launch of the discussions around the theme: Young people living with HIV and ARV treatment: Why abandonment? What problems did you encounter? 5th Group Work (25 girls and 25 boys)

Results: In the survey, we found that out of 100 participants (girls and boys), 80% have already encountered problems in taking TAR: - Health problem: Physical and chronic disease - Confidentiality issue: preservation, taking medication -Problem of the order and timing: regularity -Treatment for life Case study: "I was 12years old when I started my treatment, after 3years I’m surprised with a breast development like girls and the doctor told me that this is one of the side effects of my treatment" told NA boy of 20 years 65% giving up treatment for: -Causes related to the treatment itself: side effects -Causes related to youth behaviors: Sentimental disorder, Feeling of victimization Case of young people born with HIV/ AIDS, Distraction, Impact of adolescent behaviors (teenagers) -Causes related to the socio-economic and security environment: Discrimination of HIV+, youth imprisonment of key populations, poverty. -Causes related to medical care: Incapacity of health care providers, loss of confidentiality Case study: Case of NS (18years old) during the focus group "How is it that you are sick or need medicine and when you present yourself at the doctor or nurse he tells you to come back tomorrow or that there is no medicine and you will not die anyway and if you die there will not be a big loss."

Conclusion: We were able to make some recommendations: To the Government: - Multiply and support youth-friendly centers - Build the capacity of health personnel - Implement existing laws on the protection of adolescents Towards the support structures - Increase awareness sessions against discrimination and stigmatization of young people from key populations - Multiply therapeutic sessions for teenagers and young people To the NGO: - Support organizations and governments to conduct in-depth studies - Make available TAR with lesser side effects (DTG) for young people over 12years
TB or not TB: A data-driven approach to identify putative pulmonary TB among adolescents in low-resource settings

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Background: Tuberculosis is one of the most common causes of death globally in the era of HIV/AIDS. World Health Organisation (WHO) statistics show that South Africa houses one of the highest global burdens of tuberculosis (TB), with 28% of the world’s cases of HIV-TB co-infection. Recent studies in South Africa indicate that <10% of patients attending clinics for TB-related symptoms were screened for TB and TB screening among people living with HIV is around 80%. Among those tested for TB, availability of results in patient files is limited. Thus, accurate estimates for rates of TB infection remain unknown, particularly for high risk populations. Recently, provider-initiated TB case-finding has become an integral part of HIV care in resource-poor settings. However, studies comparing symptom-based screening with sputum tests suggest that symptom screening has poor sensitivity. We use self-reported symptoms from the second wave of Mzantsi Wakho study – the world’s largest cohort of adolescents living with HIV – to estimate rates of pulmonary TB infection among this high-risk population.

Methods: Total population sampling was used to recruit HIV-positive, ART-initiated adolescents from 52 public health facilities in the Eastern Cape province (n=1058), and 467 HIV-negative adolescents were recruited from the community. Two interviews were conducted with all adolescents using a standardized questionnaire including self-reported symptoms of illness. Latent class analysis was used to empirically identify distinct patterns of self-reported pulmonary TB symptoms from the past 12 months, based on responses in the second-wave interview. Validity of the derived symptom group typologies was tested against self-reported TB test results and medical records using Chi-squared tests.

Results: 93.8% of participants (n=1454) were retained for the second-wave interview and provided self-reported pulmonary TB symptoms, of which 72.4% were HIV-positive (n=1053), 56.8% female, and mean age 15.7 (range 10-23). Our model identified 3 distinct classes of self-reported TB symptoms: putative pulmonary TB (6.9%), other respiratory tract infections (10.5%), and asymptomatic participants (67.7%). A further 14.9% of participants did not meet classification criteria for any groups, demonstrating non-distinct patterns for the analyzed symptoms. The putative pulmonary TB group was characterized by prolonged cough (≥3 weeks), weight loss, night sweats, chest pain, and frequent fever. Other potential respiratory tract infections group was characterized by productive cough, chest pain, and night sweats, which could be indicators of pneumonia. HIV-positive adolescents were more likely to be classified as having putative pulmonary TB (OR 1.62 [95%CI 1.02-2.61], p=0.050) or other respiratory tract infections (OR 5.1 [95%CI 2.84-9.26], p=0.00), with a HIV-pulmonary TB co-infection rate of 5.2%.

Conclusions: We identified 3 distinct symptom profiles for pulmonary TB, using self-reported symptoms from adolescents in South Africa. This analysis suggests high rates of pulmonary TB and respiratory tract infections among HIV-positive adolescents. Given low rates of TB screening and accurate testing in the Eastern Cape, our results suggest a simple symptom-based screening can identify suspect TB cases with high accuracy and the use of a simple checklist may be crucial for more effective case finding and follow-up treatment in high-burden, low-resource contexts like South Africa.
The Association Between HIV and Auditory Brainstem Neural Responses in Young South African Children

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Background: HIV-related central nervous system disease can be a result of untreated perinatal HIV infection (PHIV+); it is possible that antiretroviral therapy (ART) for PHIV could also negatively affect the auditory nervous system. Auditory brainstem responses (ABRs) are used to evaluate the afferent neural integrity of auditory nerve fibers from the cochlea to more inferior portions of the central auditory system. HIV+ children have decreased ABR peak morphology and low peak amplitude suggesting a lack of neural synchrony. In fact, even children with an AIDS diagnosis and normal hearing were found to have impaired auditory neural function. This impairment could result in deficits in speech-in-noise understanding. The purpose of this study is to evaluate ABR data from South African children who are participating in the Auditory Research in Children with HIV: Cape Town (ARCH: Cape Town) study. ARCH: Cape Town is an ongoing study with the purpose of examining the effects of PHIV and ART on various aspects of the auditory system, from the periphery to the auditory cortex.

Materials & Methods: Forty-nine children have ABR data: 38 PHIV+ (22 girls and 16 boys); 9 HIV-unexposed, uninfected (HUU; 5 girls and 4 boys); and 2 perinatally HIV-exposed, but uninfected (PHEU; one girl and one boy). All children were assessed between 11-12 years of age. ABRs were obtained using alternating rarefaction/condensation clicks through insert earphones at a rate of 11.1/sec and at 75 decibels (dB) normal hearing level (nHL). A minimum of 2000 clicks were presented and responses were recorded with surface electrodes attached to the child’s vertex or high forehead, the right and left earlobes, and the center of the forehead (ground). The child was instructed to remain as quiet as possible and that they did not need to respond. ABR latencies, in milliseconds (ms), for peaks I, III, and V were determined.

Results: Hearing loss was defined as a pure-tone average across 0.5, 1, 2, and 4 kHz of greater than 20 dB in the poorer ear. Two children (one PHEU boy and one PHIV+ boy) had hearing loss. For both left and right ears, mean peak I latency was similar between girls and boys (~1.51 ms), but peaks III and V mean latencies were significantly longer in boys (~3.78 ms and ~5.63 ms) compared to girls (~3.65 ms and ~5.46 ms). Because of the small number of PHEU children, PHEU ABR data were included with the HUU ABR data. For left and right ears, mean peak I, III, and V latencies were similar, (~1.5 ms, ~3.7 ms, and ~5.5 ms, respectively) between PHIV+ and the combined PHEU/HUU group.

Conclusions: For these preliminary ABR data from ARCH: Cape Town, there were no differences in peak latencies between PHIV+ and PHEU/HUU children. However, there were three PHIV+ children with poor waveform morphology that is an indicator of a lack of neural synchrony from the cochlea to the level of the brainstem.
Serologic correlates of protection for Expanded Program on immunization (EPI) vaccines in Perinatally HIV-infected (PHIV) Adolescents

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Background: Perinatally HIV-infected (PHIV) adolescents are at risk for under vaccination and poor vaccine response. The aim of this study was to determine the prevalence of antibody levels to Diphtheria, Pertussis, Tetanus, Haemophilus influenzae B (Hib) and Hepatitis B vaccines in PHIV adolescents attending HIV clinic in Cape Town, South Africa.

Methods: Cross-sectional study in which adolescents attending Tygerberg 'pediatric' HIV clinic were enrolled from March through October 2017. Immunity was defined as > 0.01 IU/ml for tetanus and diphtheria, >0.15 μg/ml for Hib and >10 IU/ml for Hepatitis B. Standard descriptive and non-parametric statistical techniques were used to analyse the data.

Results: 54 adolescents, median age 14.2 years (IQR: 12.3-16.4), were enrolled of whom 38 (70%) were female. Two (4%) had confirmation of vaccination status on their Road to Health Card and 34 (63%) had a caregiver that verbally confirmed their vaccinations were up to date. Median CD4 count at assessment was 766 cells/mm3 (IQR: 500-1095) with 42 adolescents being (78%) were virally suppressed. The median age of ART start was 4.8 years (IQR:1.5-10.2) with nadir CD4% of 17.5 (IQR: 12.5-24.2). Half the adolescents were on a PI-based regimen and half on an NNRTI regimen. Median months from time of 6-year vaccination was 86.3 (IQR:30.4-112.63) The geometric mean titer for pertussis toxin (PT) was 3.82 (CI:1.9-7.6) and filamentous haemagglutinin (FHA) 11.2 (CI:7.1-17.4). Forty-eight (89%), 8(15%), 14 (26%) and 12 (22%) had antibodies below the specified thresholds for Hepatitis B, Tetanus, Hib and Diphtheria respectively.

Conclusions: Vaccination status was poorly documented. The majority of PHIV adolescents were not immune to Hepatitis B. Strategies to ensure protection against vaccine preventable diseases are necessary for this neglected population.

Age of starting antiretroviral therapy was not associated with protective antibodies (p= 0.16) but all started much later than current practice.
Knowledge Of Sexually Transmitted Infections And Socio-Demographic Factors Affecting High Risk Sex Among Unmarried Youths In Nigeria

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Background: Despite a relatively high level of knowledge of sexually transmitted infections (STIs), including HIV/AIDS and unwanted pregnancy in Nigeria, 80% yet indulge in unsafe sex such as casual and multiple sexual partnerships, sex without condom, early sexual debut and most of them do not know their HIV status.

Objective: The goal of the study is to identify the factors associated with practice of high risk sex among youths in Nigeria.

Methods: The study employed a secondary data from the 2013 Nigeria Demographic and Health Survey (NDHS). A sample of 7,744 female and 6,027 male aged 15-24 years respondents were utilized in his study making 13,771 altogether. The data were analyzed using frequency distribution and logistic regression.

Results: The results show that both male (92.2%) and female (93.6%) have accurate knowledge of sexually transmitted infections. Nevertheless, the prevalence of high risk sexual behavior is high among Nigerian youths; this is evident as 77.7% (female) and 78.4% (male) are engaging in high risk sexual behavior. Both Socio-demographic and socio-economic factors were statistically significantly related with high risk sexual behaviour among male and female.

Conclusion: The study concludes that there is high level of knowledge of sexually transmitted infections among unmarried youths in Nigeria and the knowledge doesn’t translate to practice. Generally, the practice of high risk sex is high among unmarried youths but higher among male youths. There is need to further examine the factor that is making knowledge about STIs and HIV/AIDS not translate to practice.
Preliminary data on the performance of PHIV+, PHEU and HUU South African children on the Dichotic Digits Test

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Background: Children with perinatal HIV infection (PHIV+) can have a range of neuropsychological problems. However, there are very limited data in children on the effects of HIV on central auditory processing (CAP). Dichotic digit testing (DDT) is a widely accepted measure of CAP. This is a binaural integration task that is sensitive to lesions of the brainstem, corpus callosum or cortex. The aim of this study is to evaluate DDT data from South African children who are participating in the Auditory Research in Children with HIV: Cape Town (ARCH: Cape Town) study, and examine the effects of HIV and antiretroviral treatment on aspects of the auditory system.

Materials & Methods: The DDT is performed by presenting two single-digit English numbers to one ear, and simultaneously presenting two different single-digit numbers to the other ear, under earphones. The individual must repeat all the numbers that they hear. Thirty-seven children have DDT data: 27 PHIV+ (14 girls and 13 boys), 8 HIV-unexposed, uninfected (HUU - 5 girls and 3 boys), and 2 perinatally HIV-exposed, but uninfected (PHEU - one girl and one boy). All children assessed were between 11-12 years of age. The test was administered at 50 decibels (dB) above the child’s speech recognition threshold to ensure a comfortable listening level. The test consisted of 20 stimulus presentations, or 80 total digits (40 per ear). A percentage correct score was obtained for each ear separately. Scores were compared to suggested age-norms for this test. Each child was given practice items before the test was administered to familiarize them with the task.

Results: Because of the small number of PHEU children, PHEU DDT data and HUU DDT data were combined. Normative data reported in the literature suggests that at age 11-12 years, children should obtain scores of ≥88% in the left ear and ≥90% in the right ear. In this study, mean DDT percent correct scores were <70%, which is lower than expected. For the left ear, there was a significant sex-by-HIV status interaction: boys in the PHEU/HUU group had a poorer mean DDT score (55.0%) compared to the other three groups (~63.0-76.3%). Mean DDT scores in the left ear, however, were similar for PHIV+ children (68.8%) compared to PHEU/HUU children (67.8%). But for the right ear, the mean DDT score for boys was significantly poorer (49.4%) compared to girls (71.0%). PHIV+ children had a slightly lower, but not significant, mean DDT score for the right ear (59.3%) compared to the PHEU/HUU children (61.0%).

Conclusions: Children in the current study performed poorer on the DDT compared to normal, and ear dominance differed from other studies. These results may suggest underlying auditory processing difficulties, or may reflect the children’s difficulty in task learning. ARCH: Cape Town is an ongoing study with continued DDT data collection, so further investigation is needed to determine why the percent correct scores are lower than expected, and why some children only concentrate on digits presented to one ear.
Risk factors for the transmission of Hepatitis B virus in HIV positive adolescents in Jalingo, North Eastern Nigeria.

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Background: Report has it that adolescents living with HIV have the tendency of engaging in health-compromising risky behaviors in order to deal with anxiety and gain admission to peer groups. This exposes them to risk of hepatitis B virus infection which is a major public health concern globally and in Nigeria. Many HIV infected patients in sub-Saharan Africa are not routinely screened for hepatitis B virus (HBV) infection. In HIV-infected adolescents, hepatitis B is more likely to progress to chronicity after an acute infection, increasing the risk of liver-related morbidity and mortality has been found to be 2-3 times higher in HIV/HBV co-infected patients than in HIV mono-infected young adults.

Objectives: This study focuses on the predisposing risk factors of HBV infection among adolescents living with HIV.

Method: Using multi-stage sampling method, 260 adolescents were selected from four ARV clinics in Jalingo. Each subject first filled a questionnaire regarding bio data and history of exposure to risk factors. Subsequently, they were screened for HBsAg using enzyme immunoassay-based chromatographic test kit.

Result: Of the 260 adolescents living with HIV, 47 tested positive for HBV, giving a prevalence value of 10.39%.
There was no significant association between gender (p=0.31) or socioeconomic status (p = 0.81) and the seroprevalence of HBsAg among the subjects. Similarly, most of the risk factors studied, including previous history of jaundice (p = 0.26), blood transfusion(p = 0.24), past history of surgery(p = 0.47), scarification marks (p =0.17), sharing of sharp objects (p =0.74) and family history of hepatitis (p =0.79), was significantly associated with HBV infection, except drug injections (p = 1.28), unprotected sex (p = 1.40) that was significantly associated with HBV infection among HIV positive adolescents.

Conclusion: Among the risk factors assessed, drug injection and unprotected sex, which include coercive sex with an older person, played significant roles in the transmission of HBV among HIV positive adolescents in Jalingo and confirms the importance of screening for HBV in among them. Concerted efforts is therefore necessary to educate HIV positive adolescents in Jalingo on safe sex practices and the dangers of drug injection.
Lessons learned: Social Media in research.

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World AIDS Day (2015), SA deputy president, announced a national campaign that focused on young women & girls with 3 specific goals: 1. Keeping girls in school until matric, 2. Decreasing new HIV infections, 3. Decreasing teen pregnancies. Hence the Zimele Project was launched. This 2 year project is currently being implemented in the Klipfontien & Mitchells Plain sub-district, Cape Town, South Africa.

Women of Worth is the research component of Zimele, focused on 18-24 years. Empowerment sessions range from sexual health to CV writing. The aim is to reach 10,000 women for the duration of the project.

Challenges (Women of Worth social media strategy):

1. Implementing a social media strategy for that age group. Keeping in mind that participants predominately come from an economically disadvantaged background. Their needs/wants are different from their peers who are financially ‘stable’.

2. Take mobile data into consideration - how to disseminate information in a relevant & effective way without consuming too much mobile data & choosing the right social media platform.

3. Klipfontien & Mitchells Plain sub-district is quite a large area, what about the human aspect, interacting with their facilitators face-to-face & online?

Addressing challenges:

1. When it came to the social media strategy, it was of vital importance to get the input of the Youth Change Advisory Board (CAB) members as they are ‘target market’. It was concluded that young women & girls are always looking to improve their lives. To break the cycle, but they don’t know where to start. As a result, we regularly post job vacancies that will suit a participant who is looking for their first entry level job. The same applies to a participant that is looking to complete their matric. Cross-posting from various other websites: Choma Mag/She Conquers, gives participants access to more info that is relevant & empowering.

2. Considering mobile data since #DataMustFall is real, posting has been reduced to just text & images only now & then. Since most participants view the content on Facebook free mode (this varies from mobile service provider to the next), images would just be ‘wasted on them’ if not ‘timed’ properly. Instagram may look nice but it takes a lot of data. It was also discovered that most young women and girls are indeed still using Facebook.

3. There are 10 locations where the sessions are held, this is where the participants can meet once/twice a week with their group & chat to their facilitators but a Facebook group was also created where the facilitators are the admins & they are able to interact with their participants as well other participants that don’t living in their area. This is safe space where the young women & girls are encouraged to share and empowered each other.

Conclusions: Incorporating social media within research studies will allow participants to reach information in seconds and give them access to correct information & dispel any myths that they have heard if the message to targeted to them in ‘their voice’.
Mobile Phone usage and Preferences for receiving HIV-related information among HIV positive young adults in urban Uganda.

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Background: Globally, young adults (18-24 years) represent a growing share of people living with HIV. In Uganda, the prevalence of HIV among young adults is estimated at 2.4 percent. HIV programs face many challenges regarding dissemination of health information and retention into care of young adults. Thus need for designing age appropriate interventions to reach them and one such intervention is use of technologies such as mobile phones. We assessed mobile phones usage and preference/willingness for receiving HIV information among HIV positive adolescents attending the Infectious Diseases Institute (IDI) clinic, Uganda.

Methods: A cross sectional survey using semi-structured questionnaires was carried out between March 2014 and January 2016 among adolescents attending the IDI. Participants were randomly selected as they returned for routine clinic visits. Descriptive statistics and frequency distributions were used to describe continuous and categorical variables respectively.

Results: A total of 272 young adults were interviewed, of these, majority were female (75.7 percent), not married (72.1 percent) and on first-line Antiretroviral Therapy (68.8 percent). Median age was 22.3 years (IQR: 20-23) and median CD4 cell count was 481 cell/UL (IQR: 339-666). Ninety-two percent reported owning a personal phone, of these, 36 percent had a smart phone, 90 percent used them for text messaging, 30 percent to search internet, 78 percent mobile money transactions and 50 percent for HIV-related activities like medication reminders. Regarding access to health information, almost three quarters reported ease of access to medical advice and HIV information in general. Majority would like and are willing to receive information by phone call (70.5 percent), text (25.8 percent) and email (3.7 percent).

Conclusions: There is high phone usage (92 percent) and willingness to receive HIV information (96.3 percent) using the phone in this key population. The findings imply that mobile phones can be integrated into the health care systems as a means of communication amongst this highly mobile and transitioning group. This is due to the high phone ownership amongst this key population.
**ADOLESCENCE, HIV ET SEXUALITE**

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**Contexte:** Le Centre National de Référence et de Recherche sur la Prise en Charge des PVVIH est le plus gros site de prise en charge des PVVIH du Bénin avec une importante file active adolescente. En effet, cette cible adolescente autrefois ignorée est depuis quelques années privilégiée en matière de prise en charge vue la recrudescence du nombre de cas reçue et l’absence d’étude réalisée au profit de cette cible alors qu’elle devrait bénéficier d’interventions particulières.

**Objectif général:** Évaluer le profil épidémioclinique et le comportement sexuel des adolescents infectés par le VIH suivis sur site adulte.

**Méthodologie:** Il s’agit d’une étude rétrospective faite sur la file active adolescente suivie au CNRRPEC/CNHU-HKM de Cotonou de 2007 à 2017 soit 10 ans.

**Résultats:** Ont été inclus dans cette étude, 105 adolescents de 15 à 24 ans suivis sous traitement ARV sur le site du CNHU-HKM de Cotonou. La tranche d’âge de 15 à 20 ans représentait 78,02% et celle de 23 à 24 ans représentait 21,98%. Le sexe féminin prédominait dans 92% des cas. Le niveau social était bas dans 68,23% des cas, moyen dans 31,77% des cas. 30% des adolescents ont été transférés du site pédiatrique et 70% venus directement. Les adolescents suivis étaient essentiellement de niveau scolaire primaire (82,42%), 12,58% ont pu atteindre le niveau secondaire et sont actuellement des artisans en apprentissage. 7% d’entre eux poursuivent leurs études supérieures. La quasi totalité des adolescents de 17 à 24 ans soit 98,70% ont déjà connu leur statut et ont tenu au plus de deux rapports sexuels non protégés et ont aussi un multipartenariat. 1,30% essentiellement le sexe masculin sont HSH mais tiennent des rapports protégés. 20,32% des adolescents transférés du site adulte étaient déjà passés en 2e ligne avant leur transfert du site pédiatrique sous LPV/r et 8,90% d’entre eux sont déjà suspects d’échec thérapeutique de 2e ligne.

**Conclusion:** Cette étude a permis d’avoir le profil épidémiologique des adolescents suivis sur le site compte tenu de la rareté des études sur cette cible et d’évaluer leurs attitudes sexuelles afin de prendre des initiatives publiques en matière de santé sexuelle pour une meilleure prévention.
The Use of Adolescent Peer Pressure in HIV/AIDS Prevention: An Integrative Review

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Background: HIV/AIDS has been a threat to global health and development having claimed more than 35 million lives so far and 36.7 million people living with the virus by the end of 2016. Adolescents and young people represent a growing share of people living with HIV worldwide. According to 2016 UNICEF report, there were 2.1 million adolescents living with HIV and 260,000 and new infections in this age group. If current trends continue, hundreds of thousands more will become HIV-positive in the coming years. The reason that adolescents are at increased risk for acquiring HIV infections comes in part from the fact that they are susceptible to peer pressure. Young people want to be accepted by their peers by committing certain activities sanctioned by their peers leading to the phenomena of peer pressure. Peer pressure is defined as an influence of a peer or peer group over an individual or group through interaction that results in change in the attitude, value, practices or behaviors to conform to those of the influencing group or individual. Peer pressure is sometimes considered as the “price of group membership” that could influence the behavior of the young person, leading to projection of drug use, risk-taking behavior as well as dating and sexual attitudes.

Material and Methods: Literature search using words, Adolescents, HIV/AIDS, Peer influence, Peer pressure, Prevention, Youth was conducted through PubMed/Medline, EMBASE, SCOPUS, HINARI, Web of Science, Google Scholar and Google for published and grey literature. The concept of peer pressure as well as its effect on HIV/AIDS prevention was established.

Result: Though it has been used in negative connotation in many ways, peer pressure also has some important positive outcomes and can be used as reinforcement to perform some tasks or development of certain healthy behaviors in HIV prevention. A study conducted to find out drug users’ adherence to HIV treatment showed that peer pressure helped to increase adherence to drug regimens and follow up schedules. It also helped to decrease drug related HIV risk behaviors such as sharing injection equipment. There are evidences showing that peer centered interventions reduce the risky behaviors exposing to HIV/AIDS. For example, some prevention programs teach adolescents skills to counteract peer influences while others use the image of influential young people to promote positive norms. Peer pressure interventions also were effective in increasing knowledge on HIV/AIDS. Though it has been found satisfactory in developed countries, this safe and cost effective intervention is not widely implemented in Africa, a continent stricken the most by HIV with 25.6 million people living with the virus in 2016.

Conclusion: Carefully planned peer centered interventions can reduce new HIV infections among adolescents and this can be accomplished through
- Creating conducive environment for youngsters learn from each other on issues such as alcohol use unsafe sex
- Helping organize youth groups in school or community; giving training and logistic support to such groups
- Including peer pressure resistance strategies in curriculums in areas where new HIV infection is in alarming state

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Accessibility to Sexual and Reproductive Health and Rights Education among adolescents through mass media in selected Districts of Nepal.

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Background: Many normative behaviors of adolescents intersect with risk-taking behaviors. Sexual activity is usually initiated during adolescence. More than half of all young students reported having had sexual intercourse. Males were slightly more likely than females to report having involved in risky behaviors. So, this study was done to find out the accessibility to sexual and reproductive health and rights education among marginalized adolescents through mass media in selected districts of Nepal.

Methods: A cross-sectional study design using mixed methods was conducted among the selected 356 adolescents of Kathmandu, Lalitpur and Bhaktapur districts of Nepal. 56 adolescents were purposely selected for qualitative part. Quantitative data analysis was done using descriptive statistics and chi square test with the assistance of the Statistical Package for Social Science (SPSS) version 21, while qualitative data was thematically analyzed.

Results: There were 356(100%) participants (184 males and 172 females), with a mean age of 18.1 years. The majority (76.4%) of the participants had completed their secondary education, while the remaining were drop outs. Overall 79.2% had SRHR rights knowledge (including HIV and AIDS). Almost 85% of the respondents indicated internet to be the major source of information. Awareness regarding laws and policies related to SRHR was 46%. However, adolescents living with HIV and engaged in drug abuse had more access to SRHR education and services than the other adolescent groups (X2 30.79, p<0.0001). The qualitative study revealed that the participants perceived their parents and teachers to be incompetent in providing SRHR education, and they mostly trusted information on internet to be their true source of knowledge.

Conclusion: Access to SRHR information is quite high but some of the topics have totally been neglected. The validity and reliability of information disseminated though mass media, especially through internet needs to be tested on a thorough basis. The so called marginalized adolescents living with HIV or engaged in drug abuse, should be encouraged in spreading SRHR knowledge through various platforms.
Demographic and sexual risky behavioural factors associated with failing a grade among adolescents attending public high schools in a high HIV setting, Khayelitsha, South Africa.

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Background: South Africa has the highest burden of HIV especially among adolescent girls and young women between the ages of 15-24 years old with 2000 new infections recorded each week. Adolescent learners transitioning from primary to secondary school may find it difficult to cope as this period coincides with significant biological, psychological, and behavioural changes associated with adolescence. Adolescence is one of the most rapid phases of human development. Although the order of changes appears to be universal, their timing and the speed of change vary among and even within individuals. These changes come with difficulties in navigating decisions around dating, safe sex and associated peer pressures ultimately having an impact on school performance. This is important to consider seeing as data indicates that education is a protective factor against HIV acquisition. Therefore, this paper seeks to describe the factors associated with failing a grade among Grade 8 learners attending public high schools in a South African township of Khayelitsha, Cape Town.

Methods: A cross-sectional secondary analysis of baseline data from an ongoing cluster randomized controlled trial (Girls Achieve Power (GAP) Year) which aims to examine the impact of an ecological approach to asset building (health, social, educational, economic) for empowering girls and shifting positive gender attitudes among boys. A survey was conducted with Grade 8 learners aged 11-18 years old from 14 public high schools. Data on knowledge, attitudes, perceptions and beliefs (KAPB) and learner behaviour was collected. Descriptive statistics were used to summarize data and the Chi-square test determined association between risk factors and failing a grade. The p-values were adjusted for clustering within schools.

Results: Out of 1163 learners that participated in the survey, 67% (779) were female, the age ranged from 11-18 years and mean (SD) of 13.7 (1.0) years, and 92.1% (1,070) were Black African. We observed that 27.6% (320) learners repeated a grade; higher among boys than girls (35.4% vs 23.7%, p<0.001). On bivariate logistic regression analysis, older age group [14-18 years vs 11-13 years] (OR 10.5, 95% CI 7.6-14.3), ever having sex (OR 2.2, 95% CI 1.6-3.0), being in a relationship (OR 1.6, 95% CI 1.1-2.4) and being male (OR 1.8, 95% CI 1.3-2.5) were significantly associated with repeating a grade. After adjusting for age and sex on multivariate analysis, ever having sex remained significantly associated with repeating a grade (aOR 1.5, 95% CI 1.0-2.2). Other demographics such as parent employment, parent receiving a grant, having a sibling at the same school, substance abuse and violence were not significantly associated with repeating a grade.

Conclusion: Our findings indicate that sexual behaviour within this cohort of learners, particularly among boys, is an important predictor of poor school performance. Therefore, interventions which address comprehensive sexuality education and its impact on school performance and overall health and wellbeing are critical in the early phases of primary education. Further to this, although recent interventions have targeted adolescent girls and young women, it is important to target boys through programmes which are multicomponent, peer led and enhance communication.
Flipchart-guided and monitored peer support "Clubs" preferred equally by female and male participants for addressing their questions and concerns around substance use: evidence from the FLIPSTER intervention.

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Background: Youth ages 15 – 24 years comprise nearly 18% of South Africa’s 57 million residents, a number estimated to grow over next three decades. It is critical that future leaders are nurtured to foster self-efficacy that will serve as the cornerstone to their future successes. There are, however, few sustainable and salient structured support spaces from which youth can draw upon specialized skillsets – both intellectual and social – to promote thriving. To address this, adolescent health specialists at Right to Care – a South Africa-based public benefit organization working in the adolescent and youth health spaces – developed a low-cost intervention, dubbed “Flipster” that is guided by a graphic and educational Flipchart tool. This program leverages peer support amongst HIV-affected populations who attend youth-friendly health clinics, moderated by experts. The aim of the intervention is to promote peer-to-peer dialogues that address difficult topics, including HIV and STI risk, stigma, and social pressures.

Methods: The intervention was delivered in 60 sites across three provinces: Mpumalanga, Free State and Gauteng. Study participants were selected from a sample of 11 clinics, yielding a total of 86 respondents aged 15 – 24 years. Measures were designed to capture self-reported satisfaction with the intervention design, and to understand preferences in terms of social support for difficult situations. Data were evaluated in SPSS at the aggregate and disaggregate levels, the latter devised to determine female and male intervention effect differences.

Results: The sample represented participating provinces (32.6%, 41.8% and 25.6% for Mpumalanga, Free State and Gauteng, respectively), with equal female and male participation (48.8% to 50.0% ratio; 1.2% no reply). 32.6% selected the Flipster Clubs as their first choice for discussing their substance use issues and questions over family (25.5%); friends (7.0%), church (5.8%), and teachers (4.7%). 9.3% did not know where to seek support. From a gender perspective, 57.1% of females and 42.9% of males preferred Flipster Clubs for the same. There were no notable differences between the two sexes (p>0.05). Odds Ratios enumerate preferences more clearly, demonstrating a generalizable rate (OR 0.78, range 0.30 – 2.01; CI 95%) of seeking substance use support from Flipster Clubs specifically.

Conclusion: The Flipster Tool and Clubs establish promising evidence that speaks to the determination and social investment of youth in addressing and solving peer-related challenges. Of note, the intervention effect impacted female and male subjects equally in three disparate geographic regions, an exciting finding that speaks to its generalizability. Given the low cost of the printed and re-usable Flipchart tool, coupled with the peer-led support framework, Flipster provides the adolescent and youth-friendly health sectors with another evidence-based risk mediation program to bolster an ever-expanding – and much-needed - portfolio of interventions. As findings capture post-intervention findings within a limited timeframe, a follow-on study to investigate prospective, longitudinal impacts – as well as sustained group cohesion after intervention completion – would add value to the evidence base communicated here.
Social Media Impacts to Behavior Change among Adolescents

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Background: In Uganda, 78% of the population are adolescents who face many Sexual and reproductive Health challenges and results from lack of SRH related information. Currently, adolescents are the leading social media users almost at 72% and subscription varies at 81.34% for Facebook, 4.22% Twitter and You Tube 1.79%. Use of social media has become a new trend used for sharing and empowering young people with information. Using social media for Sexual Reproductive Health promotion has successfully impacted on Uganda’s adolescent health behavior.

Materials and Methods: The Internet and the social media are now pervasive and ubiquitous. By the end of 2015, the Internet had been used by 3.2 billion people, 2 billion of them from developing countries, with over 78% of social media users being young people in Uganda, I use Facebook, Twitter, Instagram, WhatsApp and Wordpress to empower young people with SRHR information and this is done through on daily basis by disseminating SRHR information. On Facebook I reach up to 370 young people and Twitter over 150 young people per day, Instagram over 10-15 and on Wordpress over 20-30 per month. This has been achieved through campaigns for example “I KnowKati” campaign which focuses on young people aged 25-35 year olds as these target groups are being affected by reproductive health challenges and HIV largely due to inadequate information. Through the iKnow campaign, we empowered young people with information to seek for SRHR services such as HIV Testing and Counseling closer to them. Through “Know Your Status Afande,” this focused on encouraging police officers to know their HIV status. And finally managed to reach more than 2,058 people per post yet I used to share five posts via twitter. More than 70% of the campaign objectives were been achieved.

Results: The number of young people accessing accurate Sexual and Reproductive Health information and services increased which has helped them to make right choices; the uptake of health services has also increased among adolescents for example family planning use of modern contraceptives has increased significantly since 2000, nearly doubling (from 18% to 26%) between 2000 and 2011 among youth who are sexually active and The proportion of women (ages 15-49) who have tested for HIV and received their results in the past 12 months increased from 47.7% in 2012 to 57.1% in 2014 and from 37.4% to 45.6% among men.

Conclusions: Many young people access health information through social media as shown in the results. There is need to address issues hindering adolescents from using social media. Use of social media and improving access to online accurate information is highly recommended to avert some of the sexual and reproductive health myth among the adolescents. Before health promoters and researchers carry out sexual health promotion interventions they should consider the possible ethical, confidentiality and anonymity issues linked to the use of these media especially to the audience.
The boys diaries - the gender story

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While there is a growing recognition of the importance of including Adolescent Boys and Young Men (ABYM) in Sexual Reproductive Health related programming not much has been done to ensure that ABYM are part of the Sexual Reproductive Health conversations and have access to SRH services. The agenda to abolish the abuse of women appears to have given great attention to the plight of the Adolescent Girls and Young Women AGYW , leaving the boy child relatively vulnerable. SRH interventions, models and strategies have been designed to ensure and secure enabling environments for the girl child to flourish. Today it is widely recognized that improving women’s status and advancing their rights yield benefits for the whole society. The National AIDS Council with support from STEPS For the Future Documentaries to that cause developed a participatory documentary film titled “boys diaries” which celebrates the strengths of young men who share and reflect their own experiences, confront their lives and challenge the values that the society has imposed on them in response to Gender, HIV and Human rights issues. The documentary seeks to share the impact that socialization has had on the boy child and Sexual Reproductive Health. It seeks to expose the vulnerability in men, which for long has been kept silent, only to manifest as certain aggressive behaviors. Boys Diaries highlights the Sexual Reproductive Health issues and challenges faced by young men in a bid to engage programmers and policy makers for attention to the plight of the boy child. The facilitated film screening seeks to give the vulnerable boy child a voice and create a platform for dialogue among young men and women on gender and Sexual Reproductive Health issues affecting them.

The objectives of the film screening are:
1. To create a platform for dialogue among young men and women on gender and Sexual Reproductive Health issues affecting them
2. To engage men as agents of change in order to challenge and dismantle toxic masculinity, patriarchy (and the consequences associated with these) and address the low health seeking behaviors among men.

Expected Outcomes: The learning cycle of the screenings engages the audience to reflect on the issues addressed by the documentaries and is applied to explore issues affecting young vulnerable people and communities and provokes them to engage in practical discourses that influences them and come up with actions for advocacy. therefor the expected outcomes of the activity are as follows;
- engaging in a dialogue with the participants on various Sexual Reproductive Health issues brought out in the film so as to identify and strengthen already existing interventions that are boys and men targeted - sharing of best best practices, experiences and lessons learnt
Cultural practices that spread HIV among adolescents in rural Mulanje

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HIV prevalence among adolescents (15-24) in urban is estimated to as twice as much higher than in rural areas. The spread of HIV in urban areas is attributed to increase in social interaction due to existence of multiple recreational facilities where most youths congregate and celebrate. In rural areas most adolescents undergo various cultural initiation ceremonies to prepare them for adulthood, and this promotes the spread of HIV among them. One harmful cultural practice called "kusasa fumbi," where multiple initiated adolescents were forced to have unprotected sex with a single person, has been abolished in Malawi. The present study was conducted to find out how capable are the remaining initiation ceremonies (Chinamwali and Zoma) of contributing to the spread of HIV among adolescents in Mulanje district.

The study used a triangulation research design where 1 CDSS was selected purposively from which samples of 100 learners and 4 key informants from the surrounding community were obtained randomly. Data were collected through questionnaires, in-depth interviews and observation, and then statistically analysed using Online SSS and tested by Fisher’s exact test to determine the degree of association to which learners agree that initiation ceremony has contributed to the spread of HIV and alternatively not.

It was reported by 75% of the key informants that during the initiation ceremony adolescents are taught sex lessons such as how to handle a sex partner during sexual activity. The adolescents under initiation are also given herbal aphrodisiac to stimulate their sexual desire. Of the learners 68% indicated that initiated adolescents have high sexual desire soon after ceremony are later involved in unprotected sex with experienced partners. However, the Fisher’s exact test value is 0.532285 at α=0.05 implied that the role of initiation ceremonies is not statistically significant in spreading of HIV.

The study study has demonstrated that initiation ceremonies have potential of spreading HIV though at low rate. The use of aphrodisiacs by adolescents increases their sexual drive which culminates in sexual activities. The ultimate principle of the abolished "kusasa fumbi" practices is also embedded in other cultural practices in that they complete their process by act of unprotected sex with an experienced person. The government and relevant stakeholders should take a leading role to encourage traditional leaders to expose and involve youth in only non-harmful cultural practices.

Who's going to tell them?

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Background: This preliminary data comes from the screening and baseline assessment of the AHEAD Study (PACTR20180400332337), a pilot randomised controlled trial of a group hand drumming intervention aiming to improve executive functioning in adolescents with HIV.

Materials & Methods: Adolescents 12-19-years-old with a known HIV status were recruited from three rural primary health care facilities in the Bushbuckridge Municipality, Mpumalanga Province, South Africa. The trial is open to adolescents with any chronic disease. Knowledge of HIV status and willingness to share the status with the study team were assessed as part of screening for study eligibility with adolescents and/or caregivers.

Results: 64 were screened and 56 adolescents recruited to date (88% with vertically transmitted HIV; 12% with horizontally transmitted HIV). Almost a third of those with vertically transmitted HIV who were screened had not yet been disclosed to. There were non-minors who were unaware of their status and were only disclosed to by a caregiver or health care provider during or
immediately after the study screening process. In many of the cases of non-disclosure, there was lack of clarity about the ideal timing and method of disclosure, and whether it was the responsibility of the primary caregiver or the health care provider. Some of the reasons for non-disclosure included: primary caregivers feeling it was the health care provider’s responsibility to disclose; fear of the child’s reaction e.g. potential blame of the caregiver; fear of difficult questions about the source of the infection within the family. Some caregivers had disclosed to the adolescents but expressed concerns about the adolescents’ comprehension of the disease and the full implications of living with HIV. Clinic nursing staff cited adolescents attending clinic alone as a reason for non-disclosure at clinic visits because they felt the adolescent would need support from a family member during and immediately after disclosure. Some health care providers were afraid to disclose without a family member’s permission and/or presence due to anticipated questions about the source of the adolescent’s infection. Some adolescents who were attending clinic independently despite non-disclosure of their status said they were told that they were receiving treatment for a disease they had in the past (e.g. ‘swollen neck glands’) or that the nursing staff had told them that they would explain the disease to them when they were older.

**Conclusions:** There were high rates of non-disclosure to adolescents with vertically transmitted HIV even in late adolescence in a small clinic-based sample from rural Mpumalanga, South Africa. This could have negative implications for disease ownership, adherence to treatment, and limiting of high-risk behaviour. Guidance is needed for health care providers and caregivers about suitable methods and timing of disclosure. Increased collaboration between HIV-affected families and primary care facilities is needed to ensure that adolescents are supported during a shared disclosure process and encouraged to take responsibility for their disease and lifestyle as they transition into adulthood.
Gatekeepers are the people who have influence and control over young people’s access to Sexual Reproductive Healthcare. Their support is crucial for young people to understand and increase demand of their Sexual Reproductive Health and Rights including HIV services. We need social and behavior change interventions to enhance community support towards adolescents and young people. From the community dialogue conducted by Youth Advocate Zimbabwe in July 2018, five observations arose:

1. Young people are not a homogeneous group
   Youth Advocate Zimbabwe also works with “peer crowds” who share similar lifestyles and interests. Many of these are outside the mainstream so we realized that we need to ensure our messages also reflect what is important to them.

2. Risk factors tend to cluster, and not in the mainstream group
   There are a lot of protective factors around being in the mainstream peer crowd and most health risk factors are found in other groupings.

3. Zimbabwe has four identified adolescent peer crowds and five among young people.
   Mainstream – more conservative, easy access to alcohol abuse and early sexual debut, high risk of getting HIV
   Popular–stylistic and fun-loving, image-conscious, second-highest rate of early sexual debut.
   Hip hop–relaxed while feeling the system is out to get them, highest rate of alcohol abuse.
   Alternative–don’t want to be seen as mainstream; commonly higher levels of experiencing mental health issues.
   Young People Peer Crowds
   Mainstream–often have kids and are focused on their family, lower risk of contracting HIV.

Partier–lower importance placed on career or families so tend to stay longer in bars; includes University subgroup who share a slightly higher rate of drinking. Second highest rates of alcohol abuse and early sexual debut and high risk of getting HIV

Professional–don’t let their alcohol use get in the way of their career; tend to hang out in the same places as Popular/Partier so could be targeted alongside them.

Hip hop–focused on having overcome challenges, highest rates of alcohol abuse.

Hipster–alternative, see themselves as unique and creative; drink frequently but in smaller amounts.

Note: the descriptors above were used to help the YAZ team identify the groups. They are not self-attributed labels.

4. Behaviours can be the same but reasons and experiences can be different
   Reasons for potential harmful consequences from drinking and sex experienced can vary. For the Popular or Partier peer crowds, consequences that may lead to help-seeking include missing class or work. However, among the Hip hop young adults, the consequences were often more serious, such as involvement with police or child protection services.

5. We need a clear, consistent, and relevant pathway for behaviour change
   We need to be more consistent, with clear calls to action and a nationally consistent menu of options for support for when people recognize they need it.

To reach these groups we need to approach with messages that help them be who they identify themselves as being. Just saying ‘Don’t indulge’ across the board is not engaging with them at the moment.
Designing and delivering PMTCT support services for adolescent girls and young women living with HIV in Malawi

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Background: Malawi’s progress towards achieving elimination of mother-to-child transmission of HIV is impeded by challenges faced by adolescent girls and young women, including high pregnancy rates, suboptimal retention along the prevention of mother-to-child transmission (PMTCT) cascade, and inadequate follow up of their HIV-exposed infants. While the benefits of supporting adult mothers living with HIV are well documented, less is known about the support required for adolescents living with HIV (ALHIV) during and after pregnancy. We conducted formative research to examine ALHIV beliefs, perceptions, and perceived facilitators and barriers to PMTCT services with the aim of adapting the Mothers2Mothers (m2m) program.

Materials & Methods: Focus group discussions (FGDs) were conducted with 71 pregnant and postnatal ALHIV (15-19 years) in four Malawi districts. Four FGDs were conducted in each district: two FGDs with ALHIV who had previous or current experience with m2m and two FGDs with ALHIV who did not have any experience with the m2m mentor mother program. FGDs were conducted with ALHIV using a semi-structured FGD guide that explored their: 1) beliefs, perceptions, social norms and behaviors; 2) perceived needs for, and barriers to, PMTCT care and social support; and 3) preferences for mentor mother characteristics. We used audio-recorders to record all FGDs, and laptops to transcribe the FGD audio files. We developed a codebook and used Dedoose Version 7.6.23 (SocioCultural Consults, LLC) to conduct thematic analysis, which assessed common themes and compared themes between the m2m-beneficiary and non-m2m beneficiary FGD groups.

Results: The median participant age was 18.5 years (interquartile range: 1.5 years). Adolescent mothers living with HIV cited adverse factors that negatively impacted their engagement with PMTCT services and their adherence to treatment, such as poverty-related food insecurity, lack of money for transport to clinics, and the absence of financial support from partners. Stigma, whether within school settings or families, was another barrier to engagement in care. Most ALHIV were motivated to adhere to treatment to protect their infants and young children. Psychosocial support from partners, family members, health workers, teen clubs and mentor mothers facilitated positive healthcare-seeking behavior. ALHIV with m2m experience highlighted the encouragement they received from mentor mothers with partner disclosure, adherence, and home visits. ALHIV were in favor of younger mentor mothers: “I would have loved to have a young [mentor mother] because we are at the same stage and also she has gone through [the same] situation, while [with an] older woman our ways of thinking would be different” [Participant #3].

Conclusion: Pregnant and postnatal ALHIV stated their desire for tailored age-appropriate psychosocial support, resources and economic opportunities. In response, m2m modified its intervention to include Adolescent Champions, who work alongside older mentor-mothers to deliver a core package of HIV, TB, nutrition screening, and sexual and reproductive health services and referral. Support is intensified for sero-discordant couples and early infant diagnosis. Through robust monitoring, m2m hopes to demonstrate that investment in evidence-based interventions can effectively and rapidly diagnose and link adolescent mothers and their partners to HIV treatment and care.
Uptake and utilisation of HIV testing, care and treatment services for HIV positive and pregnant adolescents at ante-natal, maternity and postnatal service points.

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Background: Uganda is one of the countries with a high burden of teenage pregnancy and also HIV infection. We conducted a study to determine the reach and quality of HIV testing, care and treatment services for HIV pregnant adolescents at ante-natal, maternity and post-natal clinics.

Methodology: A cross-sectional retrospective assessment was conducted from July-September 2017 at 140 health facilities across 10 regions. From each region we included a specialized clinic, 1 regional referral hospital, 3 district hospitals, 2 high volume HC IVs and 3 HC IIIIs. Data was abstracted from the HIV testing register, ante-natal clinic, maternity register, post-natal register, HIV care/ART card, and ART register.

Results: The overall proportion of pregnant adolescent mothers 10-19 that attended ANC 1 (within 12 weeks) was 13% and 23%,14%, for 10-14 and 20-24 -year old’s respectively. The proportion of pregnant adolescents and young people attending at least 4 ANC visits is 13%, 36%, and 38% among the 10-14, 15-19, 20-24 years old while the overall ANC 4 attendance was only 37%. Overall proportion of ANC 1 mothers that accessed syphilis testing was low at 38% and 35%, 34% for 10-19 and 20-24 years respectively with lowest access among 10-14-year-old females at 23%. The ANC1 HIV positivity rate across all age groups was 7.6% and varied across age groups; 10%, 4.5%, 5.7% for 10-14, 15-19 and 20-24 year’s old. HIV positivity rate at maternity wards was highest at 3.3% among the young adolescents 10-14 years compared to 1.4% for 15-19 years old. PNC HIV positivity (lactating mothers) averaged 1.1% across all age groups. Overall uptake of ARV’s for adolescents was 79.4% and by age group; 20%, 80%, 88.6% and 82.6% for 10-14, 15-19, 20-24, and > 25 years old respectively. Overall ARV uptake was highest in ANC with an overall uptake 85.8%, followed by maternity at 71.6% and 56.3% for PNC mothers.

Conclusions: Maternal health services for HIV positive adolescents and young people is very low. Strategies to increase timely uptake and utilization of services are highly recommended.
Findings from the first youth-led key stakeholder meeting on child sexual abuse on Kalangala Islands in Uganda.

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Background: Youth engagement is an important catalyst for system changes to improve support for programmatic and policy efforts. However, engaging marginalized youth presents a significant challenge because they are often disconnected from and distrust the systems/environments in which they live. This paper describes processes, outcomes, and lessons learned from engaging youth in program and policy advocacy efforts to address child sexual abuse on Kalangala Island in Uganda. Administrative records and data presented by the district child probation officer indicated that over 47% of children on Kalangala Islands have experienced child sexual abuse, including rape, defilement and sexual trafficking. Kalangala Islands have one of the highest HIV prevalence rates in Uganda (27%).

Materials & Methods: Young people (ages 12 – 24) were mobilized to engage key government representatives and community members in the first stakeholder meeting to raise awareness about the challenge of child sexual abuse on Kalangala Islands, and to develop an action plan to prevent this abuse and address the needs of survivors. Key government representatives included the district chairperson, district police commander, district child probation officer, district director of health services, chief administrative officer and resident district commissioner. Community members included teachers, school administrators, representatives from organizations of people living with HIV, Uganda Red Cross and Human rights. All activities were youth-led. First, participants engaged in a day long dialogue to discuss their challenges, identify priorities and areas in-need of urgent action. The meeting with stakeholders focused on sharing survivor testimonies, discussing the limitations and gaps in current policies and programs, and identifying potential strategies.

Results/lessons learned: Key stakeholders were receptive to the youth’s engagement. Numerous key gaps and challenges in addressing child sexual violence were highlighted: lack of trust in police; re-victimization of survivors by “fit” persons; lack of wrap around health, psycho-social and legal services to mitigate the impact on abuse on survivors; lack of community cooperation with law enforcement to bring perpetrators to justice; and geographical remoteness of the islands that allow for child trafficking and hinders access to services. Among the solutions offered were the need for expanded community education, strengthen law enforcement, create structures and mechanism for identifying and reporting victims; constructing shelters and other wrap around services for survivors; identifying and training of trusted persons in the community. The meeting provided important lessons on the following key concepts related to youth engagement: (1) the importance of strengths-based approach (e.g. providing youth with leadership opportunities); (2) capacity building and collaborative processes to enable promotion of youth’s voices; (3) activating diverse youth voice for social change; and (4) challenges in mobilizing youth.

Conclusion: Youth advocacy holds promise for raising awareness, developing programs, and policy changes to address issues pertinent to the well being of youth. Among the outcomes of this meeting was a follow-up meeting organized by district official to develop an action plan to address child sexual violence and trafficking on Kalangala Island.
Understanding Teen Pregnancy and School Dropout in the Lake Victoria Region: Implications for HIV prevention

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Introduction: Studies have shown that secondary education, especially in single-gender boarding schools, reduces the risk of acquiring HIV by adolescent girls due to, among other factors, better knowledge about HIV, higher level of self-efficacy to abstain from sex or practice safe sex, and the long duration of stay in school thus away from practices that could potentially expose them to HIV. We explored reasons for and consequences of school dropout among girls in four Counties along Lake Victoria, western Kenya.

Methods: We conducted a cross-sectional study with adolescent girls and young women aged 13-21 years who became pregnant while in school. We randomly selected one Sub-County in every County, randomly selected 30% of the Wards in participating Sub-Counties, and randomly selected 50% of the schools in the selected Wards. Principals in the selected schools were requested to share a list of girls who dropped out of school in the last 5 years, and the research assistants obtained direction to their homes from the teachers and students. The assistants then visited the homes of these girls to obtain consent, assess eligibility, and conduct the interview.

Results: We enrolled 289 girls, mean age 18.5 years, average age at sexual debut 14 years and average age at first pregnancy 16 years; 78.6% reported first sex being consensual and 17.3% reported being tricked into having sex. Most (72.7%) were enticed with money or gifts in exchange of sex and 63.5% of sexual encounters took place in the man’s house and 27.1% in a friend’s house. The majority dropped out of school in Form 2 (27.6%) and Class 7 (22.6%) and almost all (92.2%) were learning in mixed day schools. The mean number of sexual partners was 1.7, with whom 82.5% reported not using condoms at all or using only some of the time. On who made them pregnant, 89.1% said boyfriends, of whom 53.5% were boda-boda riders (riders of motorbikes for public transport) and only 9.2% were schoolmates. Most respondents felt sex education (47.9%) and good parenting practices (29.1%) could reduce teen pregnancy and the risk of HIV infection.

Conclusions: Girls who get pregnant in school start sex 2 years earlier than girls in the general population. Mixed day school is a risk factor for teen pregnancy and boda-boda riders are responsible for most teen pregnancies. Interventions for girls should focus on sex education, good parenting skills, and contraceptive use; and for boda-boda riders, the focus should be on legal implications for engaging in sex with minors.
ADDRESSING THE SPECIFIC NEEDS OF ADOLESCENT MOTHERS LIVING WITH HIV

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Background: Adolescent girls and young mothers living with HIV face particular challenges and needs. They remain especially vulnerable to isolation, intimate partner violence, and mental health challenges, and require special attention and enhanced support for healthy outcomes for themselves and their children. They often have poorer PMTCT outcomes, including lower uptake as compared to older women, and may have particular psycho-social support needs. Therefore, tailored information and services about contraceptive options, HIV treatment and prevention methods, and psycho-social support are needed so that they can make healthier choices and protect their own and their children’s health.

Description: READY+ is an International HIV/AIDS Alliance-led consortium delivering HIV/SRHR and PSS services to adolescents and young people living with HIV in Swaziland, Tanzania, Mozambique and Zimbabwe, including adolescent mothers who are part of the programme as peer supporters, also known as CATS (Community Adolescents Treatment supporters) and as clients. In our engagement with adolescent girls and young mothers, we have identified several gaps in existing formal and informal support structures which need to be addressed, including:

- Lack of support from family members and feelings of isolation has contributed hugely to adolescent mothers living with HIV feeling depressed and vulnerable in their ability to be good caregivers
- Adolescent and young mothers living with HIV experience stigma within their communities, and at health care facilities from both health care providers and older mothers.

- There is a lack of tailored psychosocial services to address issues such as post-partum depression and partner abuse within relationships/marriage.

Lessons Learned:
1. AG&YWLHIV who are mothers have specific needs which may be different from other young people and need to be addressed through interventions designed with and for this group.
2. Safe spaces are needed for AG&YWLHIV who are mothers to address specific challenges that they face; including:
   - Competing interests of being a mother and being a young person
   - Multiple responsibilities such as take care of the baby, being a wife and daughter-in-law
   - Non-disclosure to partners affecting adherence for mother and baby
   - Harmful cultural practices and gender norms
   - Isolation from other family members (sisters, mother) and peers who can provide advice and mentorship

3. Strategies that can help AG&YWLHIV who are mothers to achieve better adherence and treatment outcomes include:
   - Provision of enhanced support to pregnant and breastfeeding (e.g. weekly home visits)
   - Reminders for early infant diagnosis and viral load testing for mother and baby.
   - CATS who are young mothers living with HIV trained as mentor mothers to support other adolescent and young mothers with PMTCT.

Next Step: There is sufficient evidence that operational changes are required to address the unique needs of this group. Within READY+, we will be setting up specific support groups for adolescent mothers where they can share concerns in a safe setting. Additionally, it will be critical to engage services providers on the linkages of PMTCT into already existing adolescent and youth friendly service package.
A critical analysis of the falling age of initiation among the injecting drug users and the programmatic response in Manipur India

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Background: Manipur is the first pioneering state in India to implement Harm Reduction (HR) in India. Manipur lies adjacent to the Golden Triangle where the borders of Myanmar, Laos and Thailand meet. Manipur has the third highest rate of HIV Sero-prevalence in India. Out of the 49 highest HIV prevalence districts in India, 4 districts lie in Manipur out of 11. There are about 32,000 injecting drug users (IDUs) in Manipur (Quest 2011). The National AIDS Control Organisation (NACO) classifies Manipur as high-HIV prevalence state. The IDUs in Manipur contributes to 50% of the total HIV infection (NACO HIV epidemiological surveillance 2005). According to Manipur state Aids report 2008, Manipur has shown the highest estimated of adult HIV prevalence 1.4% in India. The HIV prevalence among the IDUs is 12.89% (Sentinel Surveillance 2010–2011)

Material & Method: Literature review using the modified conceptual framework adapted from Andersen and Newman to interrogate the literature and My 7 years of my working experience in Manipur for implementing (HR) project with Project ORCHID funded by Bill and Melinda Gate’s Foundation (BMFG) Avahan AIDS initiative India. Project ORCHID works in selected district of 2 states in north eastern state in India, Manipur and Nagaland, with 31 non – governmental organisations (NGOs). With the target of 18,000 injecting drug users (IDUs), 4000 female sex worker (FSW), and 1450 man having sex with man (MSM) to organise my findings.

Result: The age of initiation of injecting drug use is decreasing in Manipur. Adolescent IDUs are more vulnerable than adult IDUs, as consequences of legal obligation and non-availability of Harm reduction (HR) services. About 94.5% of first injection was usually administered by adult IDUs so , it increases in sharing of needle and syringes, paraphernalia and unsafe sex which increase in HIV, HCV, STIs, overdoses, abscess and premature mortality. While HR for adult IDUs has proved to be effective in Manipur, it has in decrease in HIV prevalence among adult IDUs from 76% in 1997 to 12.8% in 2011.

Conclusions & Recommendations: Acknowledging the decrease in age of initiation and vulnerability, the magnitudes of barrier to utilisation of HR services can facilitate early intervention of HIV prevention programs. The International, National and state Government should urgently revise and update the current Harm Reduction policies to allow the inclusion of adolescents as beneficiaries, also conduct size estimation for adolescents IDUs, and establish adolescent friendly centres, strengthened referral and linkages with other programs.
Adolescent girls and young women in prevention of mother to child transmission of HIV: increased risk for loss to follow up may explain the worse infant outcomes in Kenya

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Background: Growing evidence suggests poor uptake of antenatal and prevention of mother to child transmission of HIV (PMTCT) intervention services, and worse maternal and infant outcomes amongst adolescent girls and young women (AGYW) in Kenya.

Objectives: We sought to characterize women accessing PMTCT interventions, determine infant outcomes, and explore the factors contributing to adverse outcomes.

Methods: This was a retrospective cohort analysis of data on pregnant and post-natal breastfeeding women living with HIV, who sought care at the Kenyatta National Hospital in Nairobi, Kenya, with singleton live infants born from 1st Jan 2013 to 31st Dec 2015. Women were categorized as AGYW (15-24.9 years) and older women (≥ 25 years). We characterized the women and compared loss to follow up (LTFU) and infant HIV transmission in the two groups. LTFU was defined as ≥ 90 days since last missed clinic visit. HIV transmission to infants below the age of 18 months was diagnosed by DNA PCR. Transmission to infants aged 18 months and above was diagnosed by rapid antibody test, and all positive tests confirmed by DNA PCR. Descriptive statistics were used to summarize patient characteristics. Pearson’s chi-square and Fisher’s exact tests were used for comparisons.

Results: Among 607 HIV infected women with singleton live born infants, mean age 34.8 years (standard deviation [SD] 5.4), AGYW comprised 4% (22/607) with mean age 23.2 years (SD 1.5). Overall, in 75% (455/607) of cases the pregnancies were unplanned, only 57% (346/607) had attended antenatal care (ANC) and delivered in the facility, 86% (522) had known HIV status and were on ART at first ANC visit, and 90% (546/573) had not disclosed and were unaware of the partner’s HIV status. The infant outcomes were; 78% (484/607) discharged as HIV uninfected, 2.3% (14/607) transferred out, 17% (101) lost to follow up and 1.3% (8/607) HIV infected. No MTCT of HIV was documented amongst AGYW.

Although characteristics did not differ significantly, unplanned pregnancies were higher amongst AGYW compared to adult women, 82% (18/22) and 75% (437/585) respectively. MTCT rates were comparable between AGYW and the older women (p=1.000). MTCT of HIV was more likely amongst those with unknown HIV status at enrolment compared to those with known status (p= 0.058), and those transferred in regardless of age category (p=0.04). LTFU was significantly higher amongst AGYW compared to adult women (p= 0.002), and significantly lower amongst those whose pregnancy was planned compared to those who did not have pregnancy intention (p =0.008).

Conclusions: LTFU was more likely among AGYW. Evidence informed strategies to improve retention and outcomes such as pregnancy intention screening, with preconception care and family planning provision, are crucial for this group.
Prevention of mother-to-child HIV transmission services for HIV-infected pregnant adolescents: are we doing enough?

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Background: The compounding burden of high HIV incidence and pregnancy among adolescents (10-19 years old) in sub-Saharan Africa makes this group particularly vulnerable. However, little is known about the burden and uptake of prevention of mother-to-child HIV transmission (PMTCT) services and clinical outcomes for adolescents compared to adult women.

Methods: We searched PubMed, Medline, Embase, and Google Scholar for peer-reviewed literature, conducted grey literature search including reviewing published reports from population-based HIV/AIDS surveys and online HIV-related conference proceedings. We included literature published between January 1, 2000 and December 2017 that compared care of HIV-infected pregnant and breastfeeding adolescents with that of adult counterparts in Sub-Saharan African countries. Statistical pooling was not done due to heterogeneity in study designs.

Results: Of the 316 articles reviewed, nine met the inclusion criteria. These nine studies reported data from Western, Central, Eastern and Southern Africa. The PMTCT interventions that were studied included; number of adolescents in PMTCT (n=2), family planning (n=2), ANC attendance (n=6), HIV testing (n=7), maternal ART for PMTCT (n=6), infant ARV use (n=1), retention (n=1) and MTCT rates (n=3). The two studies which assessed the number of adolescents found they accounted for 4-5% of HIV infected pregnant women. Two studies reported on family planning and found that adolescents had lower rates of planned pregnancies compared to adults. Of the six studies that reported on ANC attendance, four concluded that adolescents attended ANC earlier or at a comparable gestational age to adult women. Seven studies assessed HIV testing before and/or during ANC and six found that adolescents were less likely to know their HIV status prior to attending ANC compared to their older counterparts while there were no differences in HIV testing rates between the adolescents and older women in one study. Only one study compared disclosure rates and found that fewer adolescents had disclosed their HIV status (either positive or negative) to their current intimate partner or to their most recent partner if they did not currently have one. All six studies that assessed maternal use of antiretroviral medication for PMTCT reported lower use for adolescents compared to adults. Only one study compared loss to follow-up (LTFU) and found that adolescents had higher rates of LTFU than adult mothers. All of the three studies that assessed infant HIV infection rates found higher infection rates of infants for adolescent mothers compared to adult mothers.

Conclusions: Adolescents represent a substantial proportion of pregnant women living with HIV. There are substantial gaps in PMTCT services for this vulnerable population. To achieve the goals of elimination of mother-to-child transmission of HIV, reasons for suboptimal uptake of HIV-related services and poor clinical outcomes for this vulnerable population need to be urgently addressed.
Access to HIV/sexual reproductive health services for adolescent key populations in Kenya; A Situational analysis.

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Background: AIDS is the leading cause of death and morbidity among adolescents in Africa with 17% of all AIDS related deaths in Kenya being among adolescents and youth. Adolescent deaths resulting from HIV continue to rise despite declines among other age groups in Kenya. The 2012 Kenya AIDS Indicator Survey estimated that 29% of all new HIV infections in Kenya were among adolescents and youth. Limited data exist on adolescents reporting same sex intercourse, drug use and sex work. Consequently, this population has not been adequately targeted resulting in low coverage of interventions, including HIV prevention, treatment and care. Existing programme data collection mechanisms in Kenya do not disaggregate data for this cohort. Similarly, there is lack of adequate research data for this population. We conducted a study in Mombasa, Kisumu and Nairobi Counties of Kenya. In this study, adolescent KPs were defined as adolescents aged 10-19 years who engage in either sex work, same sex relationships or intravenous drug use. Overall aim of the project was to identify enablers and barriers to inform provision of HIV/SRH services to adolescent KPs in Kenya.

Methods: A cross sectional study using qualitative methods was conducted between October 2015 and April 2016. A total of 9 focus group discussions and 18 in-depth interviews were conducted with 108 adolescent KPs in Mombasa, Kisumu and Nairobi City Counties of Kenya. Adolescent key population participants were identified in collaboration with key populations’ organizations working in those counties. The interviews explored issues on access to HIV/SRH services by adolescent key populations by the different groups. Data were recorded digitally, translated, transcribed and coded in NVivo10 prior to a thematic analysis.

Results: Adolescent KPs preferred to access services in private health due to increased confidentiality, limited stigma and discrimination, access to adequate amount of condoms, friendly services and fast tracked services. Negative health provider attitudes made adolescent KPs dislike accessing health care in public health facilities. There was lack of adolescent key population’s policies & guidelines on HIV and sexual reproductive health.

Conclusions: The study has demonstrated existing significant barriers to access of HIV/SRH services for adolescent KP. These results provides a basis for policy and guidelines review and program redesign involving the adolescent KPs to address HIV/SRH service access and uptake issues.
“Motherhood is hard”: exploring the complexities of unplanned motherhood among HIV positive adolescents in South Africa.

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**Background:** For any woman, pregnancy and giving birth are major life-changing experiences. This period is argued to indicate a shift from girlhood into womanhood. However, this experience takes on new meaning when the woman is very young - an adolescent, who is still in school – and learns that she is HIV-positive. For such adolescent, becoming a mother, just like living with HIV/AIDS, involves moving from a known, current reality, to an unknown new reality. In order to understand how HIV positive adolescent mothers grapple with the demands and responsibilities of unplanned motherhood while living with HIV, this study explores the complexities of their experiences in South Africa.

**Materials & Methods:** Drawing on qualitative methods, this study examines HIV positive adolescent mothers’ meaning to motherhood while meeting their personal health needs. Through in-depth interviews, conducted among ten (10) HIV positive adolescent mothers living in Johannesburg, this paper presents an empirical study of their narratives and how they negotiate these complexities in their unplanned new realities. Emerging themes from the interview transcripts were identified, coded and analysed thematically following an interpretivist approach.

**Results:** From the interviews conducted, it is evident that HIV positive adolescent mothers perceive unplanned motherhood as difficult and this negatively affects their future childbearing decisions.

**Conclusions:** Given the importance of motherhood and adolescents globally, this article advocates for feminist policies that would facilitate larger transformative narratives. It also recommends the implementation of relevant policy that would alleviate the difficulties of HIV positive adolescent mothers generally.
Living with a dangerous denial factor and perceptions: A close analysis of the missing link and unmet needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) in as far as HIV/AIDS programming and access to ARVS is concerned in Malawi

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Background: It is a fact that in our communities we have Men who have Sex with Men (MSM), Gays and Women who have Sex with Women (WSW), Lesbians. Though sexual activities by these people in same sex relationship are criminalised under the Malawi Penal Code, LGBTIs are a well known high-risk group with very high incidence as has been evident globally since the onset of the HIV/AIDS epidemic. As one of minority groups issues that are blown out loudly in relation to them are basically in the human rights angle. It is because of this that there are missing links and a lot of unmet needs for these groups which includes their access to ART. It is because of the fact that their sexual orientation is criminalized in Malawi hence these groups have a high prevalence. (NAC2000). It is against this backdrop that a study was conducted to identify specific factors exacerbating high HIV prevalence in LGBTIs.

Methodology: This study was carried out in T/As Mponda and Nankumba in Mangochi district of Eastern Malawi, where numbers of LGBTIs are said to be on the higher side. We used both qualitative and quantitative methods of research with purposive and simple random sampling to draw a total of 63 anonymous respondents comprising 21 LGBTIs, 21 tour guides, tourism industry staff members and 21 Health care workers and traditional healers.

Results: 80% of LGBTIs who freely expressed their sexual orientation indicated that they have limited access to treatment of opportunistic infections and access to antiretroviral medication (ARVs) each time they disclose their sexual orientation, while 40% of Health care workers and traditional healers indicated that MSM and WSW have reduced opportunities to discuss their health status in relation to their sexual orientation for the fear of many public and government reactions like stigma and being arrested.

Conclusion and Recommendation: Because the law in Malawi doesn’t accommodate them of which their sexual activities are done in strict secrecy, LGBTIs face enormous challenges as regards to access to health care services hence this calls for the government of Malawi through the Ministry Of Health to reinvigorate their efforts to formulate inclusive policies that will eventually accomodate LGBTIs, otherwise the current denial factor and perceptions on MSM and WSM will continue /remain making this a high-risk group with very high HIV incidence.
The use of a modern mobile data application (ZVAMODA) by Community Adolescent Treatment Supporters (CATS) in a peer led model, in identifying HIV Positive Adolescents to start and stay on HIV treatment.

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Background: Africaid Zvandiri through the participation of adolescents living with HIV has been developing a globally recognized, peer-led model for supporting children, adolescents and young people living with HIV. This approach centers on Community Adolescent Treatment Supporters (CATS), who are young people (ages 18-24) living with HIV who support 0-24-year-olds living with HIV to begin ART and remain on treatment. The model takes into account adolescents’ broader health and social welfare needs, and differentiates between the needs of individual adolescents. Recently through the participation of adolescents the organization has introduced a mobile data application dubbed the Zvandiri Mobile Data Application (ZVAMODA) which has been developed to track progress of each child, adolescent and young person enrolled in the Zvandiri programme. It is a live mobile database that is compatible to android devices. The Acronym ZVAMODA was named by the adolescents and in their Shona native language literally means “what all of you want”.

Methods: ZVAMODA is a digital application that allows CATS to enter real-time data, collected during every contact with a client. The application is 2.3MB in size and the phone based data automatically synchronizes into the Zvandiri web based database. Data security is ensured through password installations and the devices are kept safely at the health facility. It is also used for sending adherence and clinic visit reminders to adolescents whilst also providing e-mentorship to individual CATS in different locations. It enables one to capture data and access filtered information according to different access levels. Once a CATS has logged into the database, they have access to the clients that are assigned to their facility and community. ZVAMODA has 3 main components of data that are collected by CATS. The first component is the registration of new clients capturing personal history, treatment history, education, referral and caregiver’s details. The second component that is captured on ZVAMODA is the contact which captures information on the counselling and clinical services that were offered by CATS. These would include the home visits conducted, counselling sessions offered and other assessments done. Lastly, there is the Referrals component which captures the clients and the services they have been referred to.

Results: The ZVAMODA App has proved to be an extremely powerful tool for tracking the support for children, adolescents and young people living with HIV with their daily, lifelong medication. As at July 2018, a team of 860 CATS were actively providing adherence support utilising the ZVAMODA App entering and tracking data for more than 45,000 HIV positive children, adolescents and young people in Zimbabwe.

Conclusions: Tracking progress on treatment through the Zvandiri Database, through data synced from ZVAMODA devices is important for measuring the programme and most importantly track treatment progress per particular adolescents. It has been a powerful tool to help measure the impact of a specific interventions provided by the CATS for example, whether adherence improves after a support group or CATS has been introduced per particular adolescent.
Increasing youth leadership and ownership through digital innovation

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Background: The growing number of Adolescent and Young People living with HIV (A&YPLHIV) particularly in East and Southern Africa require innovative thinking about how to engage and support them to make healthy choices about treatment. Taking medication is a daily and life-long reality for A&YPLHIV so tackling this has potential to be disproportionately impactful.

M & C Saatchi are a partner under an International HIV/AIDS Alliance led consortium, READY +, working with A&YPLHIV in Swaziland and Mozambique to develop an innovative digital solution to support them on their treatment.

Description: The approach has been grounded in audience insight and user-centred design. A formative research was conducted through interviews with implementing partners, five exploratory workshops with 40 A&YPLHIV. These workshops were aimed at empowering Community Adolescent Treatment Supporters (CATS) with a tool to aid better conversations with beneficiaries. A digital app was selected as it offered a creative and interactive way to engage the targeted audience, with benefits of recording and standardising data collection over time.

The insights from the initial workshops informed the design of the app through mapping of audience personas and journeys leading into developing a prototype. This prototype allowed CATS to structure conversations and gather key data about client adherence, whilst motivating them by making their adherence journey tangible, via the customisation of a personalised avatar.

The prototype was tested at four workshops with 20 CATS and 20 clients. Their feedback was used to optimise features, functionality and design. With development completed, 20 CATS in Swaziland and Mozambique were trained as early adopters for use during their work as CATS in the communities and health facilities.

Lessons Learned:
1. Youth engagement is essential to maximise relevance: Crucial insights were gained at every stage allowing clear definition of the role of the app, its iteration, and improvement of features, functionality and design. Engagement of A&YPLHIV must also extend to on-boarding to maximise adoption within existing routines.

2. Deep understanding of infrastructure and context is crucial to smooth delivery. Despite care taken to understand the digital market context, lack of consistent mobile phone hardware in each country reduced the speed and agility with which we could respond to audience demands and prevented us getting to a working pilot as fast as we would have liked.

3. To resonate with young people design needs to balance relatability and aspiration. A&YPLHIV wanted to see themselves in their avatars, not non-human characters. Additionally, they wanted rewards to be aspirational items that conferred social currency and allowed them to play with their identity.

Next Steps: We are currently gathering data on usage, perceived usefulness, engagement and impact with CATS who are working in 9 health facilities in Swaziland and Mozambique as part of a pilot phase. Once the data is analysed, the information will be used to optimise the app before scale up in all the targeted health facilities in both countries.
Stay Safe: Mobile Application for HIV Risk Assessment of Young Key Population Groups

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Background: Adolescents and youth are active users of mobile applications (apps). Smartphone is their primary device for internet access. Mobile apps provide a convenient vehicle for reaching a large audience and offer the potential to create personalised and interactive interventions that can be used anonymously and discretely. Therefore, mobile apps can be easily used for health promotion among the youth. The key population groups identified are the men having sex with men, female sex workers, prisoners, intravenous drug uses and transgender people. The youth in the key population groups are highly vulnerable for HIV infections, but they have barriers to access to health facilities due to legal and cultural issues. The universal target of elimination of new HIV infections in 2030 as sustainable development goals could be achieved only by breaking these barriers. Specifically, the youth in key population groups would prefer to know their HIV risk for their sexual acts assessed personally without divulging the information to anyone else. Hence development of a user friendly mobile app to assess HIV risk following a sexual act and to promote HIV testing is a timely requirement.

Materials and Methods: Several consultative meetings were held with relevant stake holders and the mobile application was developed in all three languages of English, Sinhala and Tamil. The risk was assessed for the last sexual activity. The risk levels were categorised as high risk, low risk, very low risk and no risk with a score based on Delphi technique. For the risk categories of high, low and very low, HIV testing was recommended and directed to the closest clinic for Sexually Transmitted Infections in Sri Lanka through GPS location.

Through community based organisations that serve for young key population groups, a diverse sample of 50 young people from key population groups were selected. The mobile application was emailed to the participants with clear instructions of the steps to download the link to their smart phones, along with the feedback form to assess the user-friendliness. The feedback forms were emailed back by the participants and repeated emails were sent to reduce non response rate. A score of 75 or above was considered as excellent, 50 to 74 as satisfactory and below 50 as poor.

Results: The response rate was 98%. The mean age of the participants of the study was 22 years. Of the sample 66% (n=33) were males and 44% (n=17) were females. Out of the users 93.8% (n=46) stated the mobile application was excellent, 4% (n=2) stated as satisfactory and 2% (n=1) stated as poor.

Conclusions: Stay safe is a user friendly mobile application to assess the risk of HIV for the last sexual activity and for promotion of testing for HIV in young key population groups. The application was uploaded to the Google play store and Apple app store for the use of the target groups and for any others interested.
Effects of perinatal HIV infection on metabolic activity are apparent in the peritrigonal white matter at 11 years, despite restored activity in the basal ganglia and midfrontal gray matter

Background: Despite the introduction of antiretroviral therapy (ART), the Human Immunodeficiency Virus (HIV) continues to cause neurological damage in seropositive individuals. The early initiation of treatment in perinatally infected children is vital for reducing child mortality rates. However, the long-term effects of HIV on neurodevelopment, and the neurotoxic effects of the antiretroviral drugs, remain unclear. Proton magnetic resonance spectroscopy (1H-MRS) provides a non-invasive approach for assessing regional metabolic profiles of the brain, providing a mechanistic connection between immunological, structural and cognitive changes that occur during HIV infection.

Within a paediatric cohort, we have previously observed localized metabolic differences in the basal ganglia (BG) and midfrontal gray matter (MFGM) at younger ages in HIV-positive and HIV-exposed-uninfected (HEU) children. This work is an extension of the longitudinal neuroimaging study, providing a cross-sectional examination of the ongoing influence of HIV infection and exposure at age 11.

Materials and Methods: We assessed neurometabolic activity in 11-year-old African children, comparing single voxel 1H-MRS spectra from 28 HIV-positive (13 males, mean age ± standard deviation: 11.50 ± 0.20) and 15 HEU (9 males, 11.45 ± 0.15) children to 8 HIV-unexposed (HU) (4 males, 11.57 ± 0.21) children. The children were scanned with the 3T Skyra scanner (Siemens, Erlangen, Germany) at the Cape Universities Body Imaging Centre (CUBIC), Cape Town. Written consent was provided by the parents, as well as obtaining assent from the children. Absolute metabolite concentrations within the BG, MFGM and peritrigonal white matter (PWM) were calculated using LCModel and compared across HIV status groups, using linear regression models in R. Age at scan, sex and voxel gray/white matter content were controlled for in the analysis. The metabolites of interest include N-acetyl aspartate, choline, creatine, myo-inositol and glutamate.

Results: By 11 years, the metabolic profiles in the MFGM and BG of HIV-positive and HEU children are no different from those of healthy controls. Significant increases in total choline (GPC+PCh) (β= 0.15, p= 0.05) and creatine (β= 0.30, p= 0.03) concentrations are noted in the PWM of HIV-positive children at 11 years. HEU children showed elevated creatine (β= 0.31, p= 0.04) in this region.

Conclusions: Although we cannot differentiate between the effects of HIV and ART, these findings suggest that early treatment of HIV infection may minimise damage and restore metabolic activity in the BG and MFGM by 11 years old, in children either perinatally infected with or exposed to HIV. The effects of HIV in the PWM, however, are only noticed at this later age, with our results indicating that inflammation occurs in this region as a result of HIV infection.
Antiretroviral Prescriptions in Paediatric and Adolescent HIV Infected Patients in terms of Drugs, Dosing and Simplification of Regimens

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Background: In South Africa, most Human Immunodeficiency Virus (HIV) infected adults on antiretroviral therapy (ART) are prescribed one fixed-dose-combination (FDC) tablet daily, whereas children and adolescents require more complicated regimens. Different antiretroviral (ARV) drugs are indicated at different ages, and doses must be adjusted for weight. There are multiple different ARV formulations available including syrups and different size tablets, some of which are poorly tolerated. Certain ARVs can dosed once daily or twice daily, the former is more favourable to most patients. It is important that the correct ARVs are prescribed, at the correct doses and in the simplest, and most acceptable regimen for the patient, to improve adherence and viral suppression, thus decreasing the chance of developing resistance to ARVs.

Materials and Methods: Files of paediatric and adolescent patients on ART were reviewed in Mpumalanga, Free State, and Gauteng provinces in South Africa. A sample of files were selected per facility by one of three methods; randomly, by selecting those with high viral loads (VL) either from TIER.net or the National Health Laboratory System VL report, or, by facility staff identification. Files were reviewed by a doctor from the Right to Care Paediatric HIV department and a facility nurse, if available. The details of the patients’ age, weight, ART regimen, dose and VL results were collected and analysed. ART regimens were considered “not simplified” if they contained poorly tolerated formulations, high pill burdens, or twice-daily dosing, when better-tolerated drugs, fewer tablet, or once-daily dosing regimens were available, acceptable, effective and in keeping with national guidelines.

Results: A total of 381 ART files were reviewed from 17 clinics and 2 hospitals, 54% (n=206) belonged to adolescents aged 10-20 years old and 46% (n=175) to children 0-9 years old. 89% (n=338) of the files had VL results recorded, of these, 48% (n=163) had VL<50 copies/ml, and 52% (n=175) had VL>50 copies/ml. The treatment cascade indicates that 96% (n=365) of the patients were prescribed the correct ARVs, 74% (n=272) were on the correct ARVs and the correct dose for weight, and only 55% (n=207) were on the simplest regimen, the correct ARVs and the correct doses. The results varied greatly between facilities; the best-performing facilities showed 100% of their sample files were on correct dosing and simplest regimens (n=54), while the worst-performing facilities showed 40% of 36 files on incorrect doses and 9% of 11 files on the simplest regimen. Those who were on incorrect ARVs were twice as likely to have a VL>1000 (Odds ratio: 1.96), however those who were on incorrect doses or not on the simplest regimen were just as likely to have VL>1000 as VL<50 (odds ratio:1.02 and 0.99 respectively).

Conclusions: ART prescription for children and adolescents is poorly performed, especially regarding dosing for weight and simplification of the regimen. The appropriateness of ART prescription differs widely between facilities. To ensure equality of care for paediatric and adolescent HIV infected patients, there is a need to improve ART prescriptions for these age groups.
Virologic Response of Treatment Experienced HIV-infected Ugandan Children and Adolescents on NNRTI based first-line regimen, Previously Monitored without Viral Load

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Background: HIV-infected African children have significantly gained access to antiretroviral treatment (ART) through expansion of PEPFAR programs in 2004 and introduction of “Test and Treat” WHO guidelines in 2015. As access continues to increase and children transition from adolescence to adulthood, treatment failure is inevitable over time. Viral load (VL) monitoring in Uganda was introduced in 2016 leaving many years of ART exposure with only clinical monitoring. However, there is limited data on treatment experienced HIV-infected children and adolescents previously monitored without VL in resource limited settings (RLS).

Methods: HIV-infected Ugandan children aged 1-12 years with >1 year of first-line ART were screened in 2010 from HIV-care programs using only immunologic and clinical criteria to monitor response to treatment. Eligible children were stratified by VL > 400 copies/ml and randomized in a clinical trial to compare clinical and immunological (control) versus clinical, immunological plus VL criteria to determine treatment failure with follow-up at 12, 24, 36, and 48 weeks. Plasma for VL was analyzed retrospectively for controls. Logistic regression using General Estimating Equations was used to compare the prevalence (odds) of viral suppression between study arms over time and identify factors associated with viral suppression.

Results: Baseline and follow-up results of 142 enrolled children are presented. At baseline all children were on NNRTI based ART (75% Nevirapine). Mean age was 6 years; with 43% female. Forty-five percent were WHO clinical stage 3 and 4. The median duration on ART was 4 years (IQR 2,5). Thirty-five percent (50/142) had virologic failure (> 400 copies/ml) at baseline, however with a median CD4 absolute count of 1071/ul (IQR 759,1416). The odds of viral suppression did not vary between the study arms over time (arm by week interaction, p=0.63). Overall, the odds of viral suppression were not different between study arms (Clinical, Immunologic & Virologic) vs Clinical & Immunologic: adjusted odds ratio [aOR]: 1.07; 95%CI: 0.53, 2.17, p=0.57 and did not change over time (aOR: 0 vs 24 week: 1.15; 95% CI: 0.91, 1.46, p=0.24 and 0 vs 48 weeks: 1.26; 95%CI: 0.92, 1.74, p=0.15). Longer duration of a child’s ART exposure (aOR: 0.61; 95% CI: 0.42, 0.87, p<0.01) was associated with lower odds of viral suppression. Only 18% (9/50) of children with virologic failure were switched to second-line ART, in spite of access to VL.

Conclusion: One third of treatment experienced children and adolescents on ART had detectable viral load despite good immunologic response. Viral load monitoring is critical for early detection of treatment failure in RLS. However, clinicians urgently needed encouragement to switch failing children and adolescents to second-line ART.
Low HIV viral suppression rates following the Intensive Adherence Counseling (IAC) Program for Children and Adolescents with Viral Failure in Public Health Facilities in Uganda.

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Introduction: The 3rd 90 in the UNAIDS 90-90-90 strategy, is the desired proportion of persons living with HIV/AIDS (PLHIV) on anti-retroviral therapy with a suppressed viral load. The Uganda Population HIV/AIDS Impact Assessment (UPHIA) indicates that pediatric and adolescent clients have low suppression rates (13%) and need special support to achieve viral suppression. The WHO recommends adherence counselling as a means to improve viral suppression. This study set out to determine if adherence support through intensified adherence counselling (IAC) in a program setting leads to suppressed HIV viral load and the barriers that caregivers of adolescents and children face in supporting them to suppress their viral loads.

Methods: This was a mixed methods study. Routinely collected information in a retrospective cohort for all children 9 months to 19 years with an HIV viral load above 1000 copies per ml in 2016 at 15 public health facilities was analysed. The primary outcomes were completion of IAC sessions and repeat viral load results. Focus group discussions (FGDs) were held with caregivers of the children that failed to suppress viral load after adherence counselling. Purposive sampling was used to recruit participants and data was analysed using thematic content analysis.

Results: A total of 449 children had a detectable viral load above 1000 copies/ml, after an average of 3.5 years (SD 5.8) years of ART. 192 (43%) were 10-20 years of age, and 320 (71%) were receiving Nevirapine-based ART regimen. Out of 345 (77%) who completed the recommended three IAC sessions, 62 (23%) achieved viral suppression following IAC. The mean time from 1st to 3rd IAC session was 113 (SD 153) days and 172 (50%) of the children had completed the three sessions within 200 days.

38 caregivers participated in the FGDs. 28 (76%) were also HIV positive, 25 (66%) were biological parents of the children and 29 (78%) were female. The main barriers to viral suppression that were identified were: lack of disclosure, treatment fatigue, lack of food, stigma for the adolescents, drug factors (very frequent dosing, bitter taste, side effects) and limited family support. The caregivers requested for improvement in the quality of counselling and the provision of better drugs that are easier for the children to adhere to.

Conclusion: HIV-RNA viral suppression after 3 IAC sessions was 23% and up to 50% of patient completed IAC within 200 days instead of the recommended 90 days. From the barriers expressed by the caregivers, it is apparent that their challenges have to be addressed if they are to support viral suppression for their children. As we move towards having 90% of ART-treated children with viral suppression, there is need to use differentiated care models to reach the adolescents with the most challenges, provide drugs that are easier to adhere to and to strengthen support for caregivers of children with unsuppressed viral load.
Barriers to adherence among adolescents and young adults on first-line antiretroviral therapy in Johannesburg, South-Africa

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Background: Young people face many challenges in accessing, remaining in, and achieving optimal treatment outcomes in HIV treatment programmes. Adherence to antiretroviral therapy (ART) is essential to suppress viral loads and in turn reduce HIV-related morbidity, mortality and HIV transmission. Patient and provider-related barriers are important to consider when establishing a holistic understanding of ART adherence, particularly among adolescents and young adults (AYAs).

Methods: We conducted a cross-sectional study of HIV positive AYAs (18-35 years) on first-line ART for ≥3 months, returning for a routine viral load test between 07/2015–09/2017 at Themba Lethu HIV Clinic in Johannesburg, South Africa. Eligible patients provided informed consent and completed a standardized questionnaire for self-reported adherence. The adherence assessment tool was conducted on the day of viral load measurement and included structured questions about potential barriers of adherence to ART. Responses were stratified by viral load, with unsuppressed viral loads defined as a viral load ≥400 copies/mL.

Results: A total of 279 patients were included. Participants were predominately female (79%), with a median age of 31 years (IQR: 27-34) and on ART for a median of 42 months (IQR: 18-65). At enrolment 15% (n=41) had unsuppressed viral loads.

One in three patients (n=87; 31%) reported that they never/rarely felt comfortable taking their medication in public. Interestingly, these barriers were similarly reported among patients with an unsuppressed vs. suppressed viral load respectively (32% vs. 31%; Risk Difference (RD): 0.36%; 95% Confidence Interval (CI): -8.64% to 9.36%) and 63% vs. 64%; RD: -0.47%; 95% CI: -9.17% to 8.22%).

Common patient-related barriers included travel costs to the clinic (n=26; 9%) and distance from home to the clinic (n=19; 7%); which were more frequent in those with an unsuppressed viral load (15% vs. 8%; RD: 9.24%; 95% CI: -7.5% to 25.00% and 17% vs. 5%; RD: 23.77%; 95% CI: 1.69% to 45.84%).

In terms of provider-related barriers, slightly more than 10% (n=36; 13%) of patients reported that they did not feel comfortable when collecting their medication from a doctor/nurse/pharmacist, while one quarter (n=70; 25%) reported that they felt judged by health-care workers when collecting their medication. This was more frequent among patients with an unsuppressed viral load (17% vs. 12%; RD: 5.45%; 95% CI: -8.19% to 19.10% and 34% vs. 24%; RD: 7.08%; 95% CI: -3.33% to 17.50%).

Conclusion: Patient- and provider-related factors may act as potential barriers to ART adherence in AYA. These factors should be considered when designing appropriate interventions to improve adherence to ART in this vulnerable population.
Uptake and time to initiation of ART with the treat all and same day initiation guideline; Lessons from the implementation across Nigeria

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Background: The Nigerian antiretroviral therapy (ART) guidelines were changed in 2016 to align with WHO recommendations to treat all persons living with HIV (PLHIV) irrespective of disease staging. This is based on evidence that earlier treatment improves outcomes and decreases transmission. Multiple visits to prepare adolescent patients for initiation of ART contribute to the high rate of attrition and low ART initiation. The Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) with funding from PEPFAR through USAID supported implementation of the guidelines with same day initiation in Nigeria.

Methods: We sought to determine uptake and time to initiation of ART with the test and start + same day initiation guideline in children & adolescents. A retrospective analysis of routinely collected client level program data from PLHIV diagnosed and offered same day ART initiation between October 2017 and February 2018 at 71 health facilities in 11 states was used to determine ART initiation rates and time to initiation.

Findings
Data of 4270 HIV positive clients on the electronic medical records were reviewed with a mean age of 32.86 years (S.D; 12.58). Of these, only 8.4% were children (n=180) and adolescents (n=180). A total of 3724 (97.0%) were diagnosed within the facility and 117 (3.0%) were diagnosed through community outreach. A total of 3,859 (91.2%) had been initiated on ART. Majority (77.5%) of clients were initiated on ART on the same day of HIV diagnosis and 85.5% were initiated within 2 weeks. On average, the time to initiation on ART for adolescents was 6.7 days compared to children (6.0 days) and adults (6.1 days) (K2; 66.13, P < 0.001). Twenty-one (11.7%) children, 10 (5.6%) adolescents and 276 (7.9%) adults were initiated on ART more than 2 weeks after HIV diagnosis (p=0.09). More clients identified in the community (99.1%) were initiated on ART on the same day compared to (76.8%) for clients identified in the facility (p < 0.0001, Fischer’s exact: 47.5).

Conclusion: Implementation of Test and start with same-day treatment initiation policy has shown high uptake of ART in this Nigerian adolescents PLHIV population. Strategies to optimize ART initiation in adolescents and facility settings will be essential. Further study will be necessary to determine if this strategy will improve treatment outcomes.
Delay of announcement of status to Adolescent: an obstacle to the care management to Children Hospital in Senegal

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The Pilot project of PMTCT has began in 2000 to Senegal. in 2005 with the arrival of pediatric ARVs, started the treatment of children. From 2005 to 2015, 218 children followed, 57 reached the Age of Adolescence (16 – 21 years) and are referred to the adult cohort.

In the analysis, we note a delay in the announcement of the HIV status of the child by the refusal of the parents, lack of reliable guarantor for the orphans, lack of training of the social staff. 33 are regularly followed, 10 are died and 14 are lost followed up. There were 34 TAR failures or 60%.

Starting from 2015, we set up a process to accompany the announcement with the training of social staff, organizing group Focus, coaching peer support, strengthening compliance. Now the process of the announcement starts at 7 years and the announcement is obligatory at 12 years. From 2015 to 2018, all 21 transferred teenagers accepted their status and are well attended.
A Rapid Assessment of Facility Based HIV-Adolescent Services in Kenya

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Background: To assess HIV service delivery, the United States President’s Emergency Plan for AIDS Relief (PEPFAR) undertakes periodic but rapid appraisals at supported facilities using a standardized Site Improvement through Monitoring Systems (SIMS) tool. This analysis describes assessment results of HIV support services for adolescents obtained through the SIMS process for the period February 2016 to June 2017.

Methods: SIMS tools 2.0 and 3.0 were used for these assessments. Questions are grouped in progressive scores referred to as ‘Core Essential Elements’ (CEEs) developed by subject-matter experts. Adolescent assessment questions are similar in SIMS 2.0 and 3.0 including in scores. Pre and post assessments were conducted by trained SIMS teams at 70 conveniently sampled sites. CEEs were assigned a ranked color score of 1-4: 1 (red) requiring urgent remediation; 2 (yellow) remediation; 3 (light green), and 4 (dark green) requiring no remediation. CEEs were summarized into 12 SETs based on activities supported by PEPFAR. At the end of each assessment, feedback was provided to stakeholders including facility staff and data summarized through descriptive statistics.

Results: Support services for adolescents living with HIV were assessed at all 70 facilities. Median time between the 2 assessments was 8 (IQR 7-10) months. Majority of sites passed both initial and follow up SIMS assessments; 89% and 93% respectively, with 46% surpassing the SIMS standard at second assessment. By the second visit, no facility required urgent remediation (red score). Improvements were noted in availability of a disclosure policy; institution of adolescent specific peer leaders, extended/weekend hours; availability of sexual and reproductive health services; and provision of services in gender-specific ways; 91%-93%; 91%-94%; 67%-84%; 80%-91%; 50%-64% respectively. The proportion of facilities with a written policy for consent for adolescent HIV testing and treatment decreased from 86% to 79%.

Conclusion: Regular monitoring and follow up using standardized tools at facility level increases both coverage and quality of supported services including support services for adolescents. There is need to apply a similar strategy to improve reach out to adolescents living with HIV in the community.
A modified Intervention Mapping approach to develop an integrated sexual reproductive health curriculum to optimise adolescent health in the Girls Achieve Power trial, in South Africa

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**Background:** Girls Achieve Power (GAP) study is a cluster randomised control trial adopting a multipronged ecological approach to empower adolescent girls as they progress in education, improving their overall health, safety and wellness through an increase in their Educational, Health, Social and Economic Assets, whilst shifting gender attitudes and encouraging positive behaviour among boys. The intervention comprises a sport based, after-school programme with grade 8 learners, parent dialogues and text message platform, school safety intervention as well as linkages to health and psychosocial services. This paper will focus on the design of the GAP Year 2 curriculum (GAP2) that guides the after-school programme which takes place over 2 years.

**Materials and Methods:** The success of an intervention is enhanced by incorporating components which are evidence informed, grounded in theory, and systematically developed. The intervention mapping (IM) approach synthesizes research and integrates it with theory for the design of behaviour change interventions. This IM approach was modified for the development of the GAP 2 curriculum in two key ways i.e. firstly, steps 1 & 2 of the original IM approach include a logic model of the problems surrounding the program as well as the outcomes and objectives. This was modified since the GAP 1 curriculum design process had already included a stakeholder and evidence-informed logic model, programme outcomes and objectives. Secondly, three additional tasks were included in step 2 of the modified process. These tasks were: review of local evidence informed curricula showing impact on behaviour change; assessing GAP2 outcomes against international standards and integrating and mainstreaming findings in the field of adolescent neurological development.

Using the modified IM approach, the development of the GAP2 curriculum took a 6 staged process as follows: 1) Review of GAP Year 1 curriculum and data for continuity and progression; 2) Alignment to international, regional and local policies, strategies, guidelines and practices; as well as to findings in the field of adolescent neurological development 3) Participatory engagement with GAP2 implementers and beneficiaries for practical and context specific implications; 4) Validation of the draft document during a training with implementers; 5) Pilot testing (May to June 2018) and, given the iterative nature of the IM process, refinement of GAP2 based on qualitative and quantitative data collected from beneficiaries, coaches, coach mentors, parents, educators and school principals; 6) Finalisation of GAP2 “Zonke Bonke”, consisting of 21 theory and evidence informed inter-active practice sessions underpinned by grounding principles of cooperative learning, diversity, inclusion and gender transformation as well mainstreaming adolescent neurological development.

**Conclusion:** The modified IM approach provides a systematic, participatory process for curriculum development that can be replicated within cost and time effectively. It allows for data informed, local context driven curriculum-based interventions that are aligned to international best practice standards to facilitate risk reduction and behaviour change. Integrating findings in the field of adolescent neurological development in GAP2 made this modified IM approach particularly suited to designing interventions that aim to advance adolescent sexual and reproductive health.
Caring Fathers: A synopsis on male involvement in the care for Adolescents Living with HIV (ALHIV) in Malawi

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Background: Male involvement in caring for people living with HIV in general has been a challenge in many of the sub-Saharan countries. Children or Adolescents living with HIV have also become victims to this way of living in Africa. This lack of support from male partners has left women caring for the sick children in hospitals while also economically struggling to feed their households. In the process, sick children have been abandoned in most facilities where Baylor Malawi supports as these women are tired of the solo responsibility. Baylor Malawi then introduced an intervention called ‘caring fathers’ including biological, step or common-law fathers who have physically abused, emotionally abused or neglected their children, or exposed their children to domestic violence or who are deemed to be at high-risk for these behaviors.

Materials & Methods: The program consisted of 5 sessions, 1 session per month of about 4 hours of group parenting for fathers. The sessions combined elements of parenting, fathering, battering and child protection practices and supporting medication adherence of children to enhance the safety and well-being of children. Other topics in the 5 sessions included knowing your child, viral load understanding, supporting child disclosure processes, fathers’ roles in families, stigma and discrimination, human basic needs and child development stages.

Results: The caring father’s initiative managed to recruit 30 fathers in the 5 sessions. 84% (25) of these fathers failed to take care of their homes while 16% (5) were involved in the programme as role models. Initially, the group started with 25 fathers (20 offenders and 5 role models). The additional 5 were invited by some of the offenders who had learned of the importance of caring for their sick children. As a grouping of fathers with others as role models, it managed to reach to other men who had difficulties being in the forefront of their children’s adherence to medication and respecting clinic appointment dates. The program managed to bring the fathers to share their experiences as fathers caring for children living with HIV and learn from each other. These fathers are now able to know the medication of their children and know their children well. We have also observed good collaboration within the family on the care of children living with HIV and remarkable financial support for children coming to clinic by the fathers. Attitude on testing for HIV among these fathers has also changed as those that did not know there status tested after learning from others.

Conclusions: Role modeling among fathers is one way of encouraging male involvement in the care for children and adolescents living with HIV. Further research needs to be done to observe the improvements in ART adherence among children with fathers in such programs.
Addressing adolescent boys’ unique sexual and reproductive health needs in Nigeria: Baseline findings from a sport-based program evaluation

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Background: In Nigeria, and globally, a gap exists in addressing the unique sexual and reproductive health (SRH) needs of adolescent males. School curricula in Nigeria include a Family Life and HIV Education component, but it has limited sexual health information and fails to reach out-of-school youth. SKILLZ Guyz (SG) is an 11-session, sport-based intervention for in-school and out-of-school adolescent boys ages 13-19 that uses soccer language, metaphors and activities as a unique entry point to increase demand for health services and address harmful gender norms, violence and substance use. An external, mixed-methods evaluation was conducted aiming to: a) assess participant knowledge, attitudes, and beliefs related to SRH, HIV, gender equity, and positive identity formation; b) assess and compare effectiveness of the program among in-school and out-of-school youth; and c) identify critical components to implementation fidelity and delivery.

Materials/Methods: Quantitative pre-tests were administered in February 2018 to in-school and out-of-school participants aged 13-19 (n=258, mean age=14.8 years), including measures of SRH knowledge, gender equitable attitudes, and health-seeking behaviours. Qualitative data was collected from February - April 2018 and included FGDs (n=2) with trained ‘Coaches’ who facilitate the program and IDIs with program staff (n=8). Descriptive statistics were calculated and qualitative data were reviewed for emergent themes, then merged for triangulation. While endline quantitative data analysis is being finalised, baseline quantitative and qualitative data were analysed in March and April 2018 and presented below.

Results: Key baseline survey results indicate low levels of HIV knowledge and very high levels of alcohol use (92%; n=237). About one-third of participants correctly identified HIV prevention techniques (34%; n=87), drivers of HIV risk (33%; n=85), and contraceptive methods (34%; n=87), and only 24% (n=61) correctly identified modes of HIV transmission, highlighting the urgent need for accurate information on HIV transmission and prevention, and contraception. About 29% of participants reported ever having had sexual intercourse (n=76), and among those, only 31% (n=23) report having used a condom at last sex. These findings confirm the need and opportunity to intervene early and engage boys before sexual debut, which often occurs around age 15-16 (national median age = 15.9; 2013 DHS).

In post-intervention qualitative data from FGDs, Coaches reported positive behaviour and attitude changes in participants, even among those who had previously engaged in unhealthy behaviours such as bullying and substance use. Coaches reported that their participation in the program caused them to reflect on and change their own negative SRH and gender attitudes, making them better role models. In interviews, program staff expressed that participants reported use of intervention techniques to improve anger management and reduce use of physical violence against peers.

Conclusions: Preliminary results demonstrate a need for accurate HIV and SRH information and life skills building among participants, supported by pre-intervention quantitative findings. Continued advocacy around access to accurate SRH information in forms appropriate for adolescent boys is necessary. Qualitative findings demonstrate initial positive program effects on both participants and facilitators, indicating the promise of this soccer-based intervention in addressing the SRH needs of adolescent boys.
Describing the feasibility and acceptability of delivering an intervention designed to increase adolescent mothers return to school postpartum

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Background: School dropout and poor attendance have each been associated with incident HIV infection; yet adolescent mothers face significant challenges to returning to school after giving birth. Although the South African Department of Basic Education has progressive policies supporting young mother’s ability to return to school, evidence suggests that a majority of adolescent girls do not return to school after giving birth. The Mentoring Adolescent Mothers at School (MAMAS) is a DREAMS Innovation Challenge intervention funded by PEPFAR and managed by JSI Research & Training Institute, Inc. MAMAS is a peer-led participatory intervention and is designed to mentor and support adolescent mothers in their return to and retention in school following birth. Peer mothers (who themselves had given birth during their schooling years and returned to and completed high school) were recruited and trained to deliver the intervention to adolescent mothers 6 weeks postpartum until 6 months postpartum. The intervention involved weekly sessions focusing on such areas as Human Rights, Staying in school, accessing the child support grant, and others. We use qualitative and routine data to reflect on the lessons learned from implementing the intervention.

Materials & Methods: Adolescent mothers (n=120), who were living in a Durban township, were six weeks postpartum, and were between 14-19 years old were recruited to participate in MAMAS. Adolescents mothers were allocated to an intervention (n=68) and a comparison arm (n=52). We use baseline quantitative data to describe the demographics and social contexts of our participants’ lives (n=120), screening data to describe uptake of the intervention, and qualitative data to describe acceptability of the intervention among active participants (n=7).

Results: Nearly two-thirds of the participants attended at least one intervention session (57%, or 39 out of 68). The other 40% of participants who enrolled did not attend a single intervention session. Baseline quantitative data collected within the first 6 weeks postpartum reveals significant challenges in adolescent mothers’ lives in the early postpartum period. For example, 50% of girls reported food insecurity, 21% tested positive for sexually transmitted infections and 40% reported intimate partner violence. These challenges may prevent adolescent mothers from initiating and attending intervention sessions. Nonetheless, the adolescent mothers who actively participated in MAMAS reflected positively on the intervention. Specifically, during in-depth interviews, participants described how the group sessions and their relationships with the peer mothers substantially improved their well-being in the postpartum period. They described how the advice they received from the peers helped them address barriers they faced to returning to school after giving birth.

Conclusions: Adolescent mothers face significant challenges to returning to school and staying in school. Interventions, like MAMAS, may facilitate better school outcomes and reduce risk of HIV infection. Adolescent mothers who participated in the intervention described multiple ways the intervention positively affected their well-being. Alternative strategies to engage and support adolescent mothers postpartum, including meeting them at home or in the clinic during their routine visits may increase attendance at intervention sessions.
The impact of the layering of services on the health outcomes of adolescent girls and young women living with HIV under the DREAMS Project in Gweru, Zimbabwe.

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Background: Layering of services by Determined, Resilient, Empowered AIDS-free, Mentored, Safe (DREAMS) partners in Gweru district has impacted positively on the outcomes of Adolescent Girls and Young Women (AGYW 10 – 24) living with HIV. Africaid has been implementing the DREAMS project since October 2015 with other DREAMS partners in the six districts of Zimbabwe, namely Bulawayo, Mazowe, Makoni, Chipinge, Gweru and Mutare. DREAMS, a USAID funded innovation which seeks to reduce new HIV infections in AGYW, other young people and other vulnerable populations in Zimbabwe by strengthening HIV and Gender Based Violence (GBV) prevention. Services being provided include HIV prevention, education support, GBV response, cash transfers to AGYW households, Income Savings and Lending Schemes (ISALS) for AGYW as well as sexual reproductive health services which include family planning and Pre-Exposure Prophylaxis (PrEP).

Materials and Methods: District DREAMS referral task force team was set up and met on weekly basis to track referrals and ensure referral completion. Focus group discussions with AGYW who were referred for services were conducted in June 2018.

Results: A total of 1068 AGYW living with HIV were linked to other DREAMS partners (referral-out) by Africaid Community Adolescent Treatment Supporters (CATS) through a district referral system between October 2017 and June 2018 in Gweru district. Out of the 1068 referred for various services, 695 managed to access the services giving a referral completion rate of 65% (DHIS2). A total of 405 AGYW living with HIV were also referred to Africaid (referral-in) by other DREAMS partners such as World Education, Youth Advocacy Zimbabwe, Family Health International 360/SAF AIDS, and they all received peer-led adherence and treatment services. 67% of the 405 adolescent girls referred for CATS services who had a viral load test between October 2017 and June 2018 had a suppressed viral load result. 30 adolescent girls and young women were linked to economic strengthening services and 10 have since started their own income generating projects. Increased awareness on Sexual Reproductive Health (SRH) issues among AGYW was also noted with AGYW empowered to make independent Sexual Reproductive Health choices. Based on focus group discussions conducted with 30 of the girls, confidence to disclose their status to partners increased significantly with their HIV negative partners being linked to HIV prevention services which include Pre-exposure Prophylaxis and Voluntary Medical Male Circumcision (VMMC).

Conclusion: Layering of services is key to ensuring successful outcomes among adolescent girls living with HIV. Strengthening of referral pathways key for comprehensive service delivery. Good adherence and SRH awareness among adolescents living with HIV key for prevention of new HIV infections.
Optimizing treatment for adolescents: A case study of implementation of OTZ (Operation Triple Zero) in a high volume urban facility in western Kenya.

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Background: Adolescents and other young people (AYP) continue to bear a disproportionate burden of HIV infections in Kenya; in 2016, AYPs ages 15-24 years accounted for nearly half of all new infections. Moreover, AYPs living with HIV record poorer treatment outcomes. AYPs accounted for 10,000 HIV-related deaths and only 61% of those on treatment achieved viral suppression (VL). Thus, innovative strategies are needed to improve HIV care and treatment services for AYPs if desired outcomes are to be realized.

Operation Triple Zero (OTZ), an initiative of Kenyatta National Hospital, empowers AYPs to be in charge of their own treatment and to commit to the “triple zero outcomes” – zero missed appointments, zero missed drugs and zero viral load. AYPs who achieve these outcomes are dubbed “heroes” and are engaged to inspire others through a variety of creative activities. OTZ, grounded in the tenets of the asset-based approach, is implemented in five components; treatment literacy, social groups and peer support, addressing self-stigma, transition to adult care and, life skills.

Description: PATH initiated implementation of OTZ in western Kenya through sensitization of health care providers in November 2017. Thereafter HIV positive adolescents between 10-19 years were enrolled in OTZ across multiple facilities. In Migosi Sub County Hospital, located within Kisumu City, a total of 42 adolescents were enrolled in December 2017 after obtaining consent from them; 22 (52%) of these adolescent were 10-14 years old while 20 (48%) were 15-19 years old. Majority 64% (27) were female.

At enrollment the baseline VL suppression was 74% with a retention rate of 82%. During the 7 month period of OTZ implementation, the VL suppression rate improved to 88% with a corresponding increase in retention rate to 90%.

During the same period, enrolled adolescents were engaged in various OTZ related activities such as exchange visits with other adolescent groups in other facilities, participation in drama and art clubs, educative video and shows on adherence and stigma discrimination, and adolescent support groups.

Lessons learnt and Conclusion: OTZ provides a focus approach to optimizing treatment outcomes for adolescents and empowers adolescents to be able to do self-health management. Similarly, OTZ strengthens positive living and planning for the future, and empowers adolescent not to give up on life through development of individual health plans for each adolescent. Adolescent clients expressed satisfaction with the OTZ services; specifically they were happy about the greater attention from service providers during consultation and the improved communication with other clients through the WhatsApp support group.

Next steps: Based on the successful pilot of OTZ at select facilities, we will scale up to reach more adolescents. Further, we will conduct qualitative individual and group interviews with adolescents and other stakeholders to better understand their experiences with OTZ and strategies for improving their HIV care services. Finally, we will constitute a technical team to consider implementing OTZ at community level and document lessons.
Accelerating HIV testing targeting young people within Sex workers through community based: Outcomes and perspectives

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Background: Female sex workers (FSW) are disproportionately affected by the HIV epidemic in Rwanda with an overall HIV prevalence exceeding 45% among them. The focus of the country over the last years has been to identify the maximum number of HIV positive FSW and link them to care through community outreach activities around the country. We describe the lessons learned and results of this program in 2016 and 2017.

Methods: Health care Providers under Rwanda Ministry of Health’s supervision conduct community outreach activities in selected sex work hotspots every 3 months. These hotspots were identified through a national mapping exercise conducted in 2015. During these outreach activities, HIV testing services are offered and linkage to care and treatment services is ensured by trained peer educators.

Results: From January 2016 – December 2017, 2812 FSW were tested for HIV during these quarterly outreach activities in 10 hotspots around the country. Among them, 214 new HIV positive cases were identified and 96% (205/214) were linked to care and treatment services with the help of peer educators in public health centers. In addition, identified HIV negative FSWs in hotspots were offered HIV prevention services including risk reduction counseling, condom and lubricant distribution, sexually transmitted infections (STIs) screening and treatment and sexual and reproductive health services (SRHR) including family planning services.

Conclusion: These results show that community outreach HIV testing services targeting young people within FSWs are effective in identifying new HIV positive cases and linking them to care using the peer educator approach. They are a good strategy to supplement HIV testing services that are offered in healthcare facilities and serve as entry point for others recommended package of services for FSW.
Integrating life skills to care and treatment of Adolescents living with HIV(ALHIV) - A practical Example from rural Kenya.

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Background: Adolescents and youth have challenges that hinder them to quality HIV prevention, treatment and support services. Challenges they experience are Non-disclosure of HIV statues, poor adherence to ART, stigma and discrimination, sexual and reproductive health issues, drug and substance abuse, unemployment and inadequate social support.

Description: Youth and adolescents development is promoted through activities and experiences that help them develop social, ethical, emotional, physical, and cognitive competencies. Life skills have been part of the youth and adolescents development process and supports the young person in developing: The ability to analyze their own strengths and weaknesses, set personal goals, and have self-esteem, confidence and motivation. The skills also facilitates the ability to establish support networks in order to fully participate in community life and effect positive social change. The youths and adolescents are empowered with the ability to guide or direct others on a course of action by influencing their opinions and behavior of others and serve as a role model. The Life skills model is a comprehensive set of universal cognitive and non-cognitive skills and abilities, connecting behavior, attitudes, and knowledge, which youth develops and retains throughout their lives. This increases the young people’s well-being and help them to develop into active and productive members of their community. The skills Changes personal behavior and social attitudes of youth, allowing them to create a life plan and equip them to take steps toward achieving their goals. The young people are helped to better understand healthy personal behavior, thus decreasing outcomes such as poor adherence, teen pregnancies, drug and alcohol use and enhances interpersonal relationships and expectations for their future and the future of their generations.

The life skills activities they are involved in include:
1. Greenhouse farming(#farmingiscool)
2. Bead making(#beadsforhealth)
3. Soap Making
4. Yoghurt making
5. Wheel of knowledge (#tubonge) to learn and understand on adolescent care package.
6. Adolescents led initiative for example home visits for adolescent facing challenges by the youth champions.

Lessons learned: 1. Adolescent led meetings planning and organization has built their esteem and empowered them in leadership. 2. Viral suppression from 79% to 95% among ALHIV in the last three years. 3. Teamwork and Interpersonal skills that involves Critical and creative thinking, problem solving and Decision-making 4. Multicultural sensitivity and awareness that has enhanced Professionalism that is grooming with Self-assertiveness.

Conclusions/Next steps: Youths and adolescents living with HIV needs to have a positive development framework that unites them towards building a strong relationship for growth through ideas they share from the platforms as a guide on improving on their treatment outcomes.
Formative Assessment of Antenatal Care, Prevention of Mother-to-Child Transmission, and other HIV services for Pregnant Adolescent Girls and Young Women in Kakamega County, Western Kenya.

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Background: In Kenya, adolescent girls and young women (AGYW) face significant barriers in accessing health services and protecting their health. Prevention of mother-to-child transmission (PMTCT) programs are a major entry point for identifying HIV-positive AGYW, yet PMTCT services are not currently structured to support this population. This assessment aimed to identify the barriers and facilitators to the provision of antenatal care (ANC), PMTCT, and other HIV services for AGYW in an effort to scale-up AGYW-focused ANC in Kakamega County.

Materials & Methods: In June 2017, we conducted focus group discussions (FGDs) with AGYW aged 15-24 years who were either pregnant or lactating and receiving services at one of the eight selected facilities in Kakamega County. Health care workers recruited participants using a script and referred those interested in study participation to the study team. Participants were purposively selected. All participants provided written informed consent. FGD topics included barriers and facilitators to accessing ANC/PMTCT services and community and health facility barriers to initiating and adhering to PMTCT services. Individual demographic data were also collected from FGD participants. Trained moderators conducted the FGDs with AGYW in English and Kiswahili. FGD audio recordings were simultaneously transcribed and translated into English (for Kiswahili transcripts). A qualitative analyst applied content codes to the transcripts using NVivo 9. Thematic content analysis was used to identify major themes within each code.

Results: Eighty-four AGYW participated in eight FGDs. Participants' average age was 21 years: 15-19 years (33%), 20-24 years (67%). Few AGYW (n=9, 11%) were still attending school and only 23% had completed secondary school. About half (n=40, 48%) reported being HIV-positive and 78% had disclosed their status. One-quarter were single, 45 (54%) were either married or in a partnership. Long queues, inconvenient hours, poor organization of services, uncomfortable waiting areas and limited physical space for ANC, use of demeaning and unpleasant language by provider, and lack of privacy were key barriers to accessing ANC services. Adolescents also reported lack of emotional and financial support from family, difficulty being a first-time mother, having an unstable partner, being blamed for the pregnancy, and stigma from the community as other barriers to accessing ANC. Strategies identified to improve service access and adherence included reducing wait times, flexible facility service hours, family support such as providing transport to facilities, and reducing discriminatory provider attitudes. Design and layout of the health facility, assurance of privacy during consultation, friendly attitude and respect from health care personnel, availability of all necessary tests, and ease of physical access were mentioned as facilitators to ANC/PMTCT access.

Conclusions: Barriers and facilitators to ANC/PMTCT uptake were identified across the individual, family, community, and health system level. Findings from this formative assessment have been used to design a package of AGYW responsive services including; support for monthly AGYW psychosocial support group meetings, weekend clinics to reinforce the importance of school-attendance and return during postnatal period, purchase of curtains to ensure privacy in ANC and inclusion of signage on doors for ease of identifying different service areas.
Adolescent Pregnant Women Living with HIV in Kenya: Who Are They and How Do We Reach Them?

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**Background:** Despite widespread access to antiretroviral therapy (ART) for pregnant HIV-infected women, adolescents have lower engagement in PMTCT, lower rates of viral suppression, and higher rates of mother-to-child transmission compared with adults. Very limited data exist on characteristics of adolescent HIV-infected pregnant women in sub-Saharan Africa, and how they can be reached to support their engagement in care. Mobile health (mHealth) interventions are promising strategies to support adolescents living with HIV, but little is known about this group’s access to mobile phones. The goal of this analysis is to compare the sociodemographic and technology access characteristics of adolescents and adults in a cohort of pregnant women living with HIV in Kenya.

**Methods:** A cross-sectional analysis was performed using screening and enrollment data from participants in the Mobile WACHX trial (NCT02400671), which examines the effect of SMS messaging on ART adherence among pregnant HIV-infected women in Kenya. All HIV-infected pregnant women aged 14 attending antenatal care at 6 public facilities were screened for study participation. Those who had daily access to a mobile phone were eligible for enrollment in the trial. Phone access at screening and sociodemographic characteristics at enrollment were compared between adolescent and adult pregnant women. Chi-square or Fisher’s exact tests were performed to compare proportions of categorical variables. Welch two sample \(t\)-tests were performed to compare means of continuous variables.

**Results:** Of 825 HIV-infected pregnant women enrolled in the trial, median age was 27 years (IQR 23-31), and 33 (4.0%) were adolescents (14-19 years old). Compared with adults, adolescents had lower household monthly income (median US$50, IQR $22.5-75.5 vs. US$80, 40.0-150.0, \(p=0.001\)). A smaller proportion had a current partner (69.7% vs. 90.0%, \(p<0.0001\)), and among those who did, a smaller proportion received financial support from their partner (82.6% vs. 92.5%, \(p=0.01\)). Among adolescents age 18, who would be expected to be in secondary school in the Kenyan education system, a minority was in school (3/22, 12.0%). A smaller proportion of adolescents had been diagnosed with HIV prior to pregnancy (45.5% vs. 60.4%, \(p<0.0001\)) and had ever used family planning (40.6% vs. 69.3%, \(p<0.0001\)). The proportion who had disclosed their HIV status to others did not differ by age group.

Mobile phone access was lower in adolescents than adults: among 1,290 pregnant HIV-infected women screened, 81 (6.3%) were adolescents; 80.2% of adolescents had daily mobile phone access vs. 93.3% of adults (\(p<0.0001\)). Among 825 enrolled participants with daily phone access, a larger proportion of adolescents used SMS as their primary mode of communication than adults (25.0% vs. 7.0%, \(p=0.01\)).

**Conclusions:** These data highlight pregnant HIV-infected adolescents’ low economic support, low school attendance, unmet need for family planning, and recent HIV infection. These unique characteristics require tailored support. Although most HIV-infected pregnant adolescents are reachable through mobile phones, mHealth interventions in this group should take into account lower access than in adults.
Factors associated with self-reported HIV testing among adolescents participating in the Girls Achieve Power (GAP Year) cluster randomised trial, Khayelitsha, Cape Town, South Africa

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Background: HIV/AIDS remains a major public health problem in South Africa, especially among adolescent girls (10-19 years) where prevalence is higher than adolescent boys. Countries under the UNAIDS guidance have now adopted the 90-90-90 strategy to combat HIV/AIDS globally. However, HIV testing among adolescents remains low despite increasing efforts to ensure HIV testing services (HTS) are youth friendly and the existence of a policy allowing children 12 years and older to test without parental consent. In South Africa, a cross-sectional study found that 49% of female and 30% of male adolescents had tested for HIV. We determined factors associated with self-reported HIV testing among in-school adolescents enrolled in the GAP Year Trial in Khayelitsha, Cape Town.

Methods: We conducted a cross-sectional analysis utilizing baseline data from Girls Achieve Power (GAP Year) programme, an ecological intervention that empowers adolescent girls’ agency and safety while shifting gender attitudes and encouraging positive behaviour change among adolescent boys. We collected baseline data from grade 8 learners utilising two structured surveys i.e. an interviewer-led survey that captured data on knowledge, attitudes, and perceptions, (KAP), and an Audio Computer-Assisted Self-Interview (ACASI) which captured information on experiences of violence, drug use, access to sexual and reproductive health services including HTS and risky sexual behaviour. We applied multivariate logistic regression model to determine factors associated with self-reported HIV testing among adolescents, while adjusting for clustering within schools.

Results: A total of 1,163 Grade 8 learners from 14 study schools completed both surveys, with 67.0% (779) girls and age from 11-18 years with mean (SD) of 13.7 (1.0) years. Forty-four percent of learners (504) were living with both parents, 36.5% (417) with a single parent, 18.7% (213) with relatives or guardians, and 0.7% (8) were child-headed households. Violence was experienced by 28.9% (337) of learners: 47.8% (161) physical, 30.9% (104) psychological, 10.0% (34) sexual, and 11.3% (38) other types of violence. In terms of risky sexual behaviour, 24.6% (286) had sex before with 45.3% (129/286) having had sexual debut at 13-14 years. Almost half of the learners 49.3% (573) were in relationship. Self-reported HIV testing was 43.8% (509): higher in girls compared to boys (48.4% vs 36.6%, p<0.001). In multivariate logistic regression, girls (adjusted Odds Ratio [aOR] 2.08, 95%CI: 1.52 to 2.83, p<0.001), older learners [14-18 years versus 11-13 years] (aOR 1.67, 95%CI: 1.19 to 2.35, p=0.006), those who ever had sex (aOR 1.78, 95%CI: 1.13 to 2.79, p=0.016), and those experiencing violence (aOR 1.50, 95%CI: 1.15 to 1.96, p=0.005) had significantly higher odds of self-reported testing for HIV.

Conclusions: Our findings indicate that a combination of risky sexual behaviours and violence are important predictors of self-reported HIV testing, particularly among adolescent girls. Therefore interventions should be tailored to address both structural and biomedical factors associated with increased risk to HIV acquisition and violence. Further to this, our findings indicate that an increased perception of risk is also important in driving HTS uptake and therefore risk screening to inform linkage into prevention methods such as PrEP is critical.
Enhanced Psychosocial Care for HIV-Infected Children – The BOMU Hospital Kenya Experience

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Introduction: Achieving the UNAIDS goal of the third 90 requires a comprehensive approach to care and treatment that would include palliative care. Palliative care includes addressing physical and psychosocial health. There is limited data on the impact of integrating palliative care with standard HIV care and treatment in children. We measured the effect of palliative care on health status in HIV-positive children on antiretroviral therapy (ART) in Bomu Hospital, Mombasa, Kenya.

Methods: Two hundred and seventy seven children aged between five and 15 years receiving ART at an outpatient center were offered palliative care with an opt-out option. Of these, 97 children accepted and received palliative care for at least 6 months and 180 received standard ART care opting out of palliative care. Physical and psychosocial health of all children was determined using the Pediatric Quality of Life tool after three months on palliative care. Physical health was determined from the physical health score and psychosocial health was calculated as an average of emotional, social, and school functioning scores. Data abstraction took place from April 2016 to June 2016 and analysis was conducted using the Mann Whitney U test.

Results: There was no statistically significant difference between the two groups in nadir CD4, age, duration on ART, and gender. The two groups had comparable baseline physical and psychosocial health scores. Children receiving palliative care alongside ART have better psychosocial and physical health compared to children receiving only ART (p < 0.00) and (p < 0.00) respectively. Emotional, social, and school functioning were significantly higher (p = .00, p = .014, and p = .00 respectively) in children who received palliative care in addition to ART compared to children who received ART alone.

Conclusion: Physical and psychosocial (emotional, social, and school) functioning are important factors that determine treatment outcomes in children on ART. Addressing these factors through palliative care will create a positive social change by improving treatment outcomes, quality of life, and longevity.
Introduction: HIV infection causes nutrient losses that increase nutritional requirements and the risk of malnutrition. Adolescence is a period of biological, physical, and psychological changes which requires adequate and balanced healthy diet during all phases of growth and development from infancy, childhood and puberty in both HIV-infected and uninfected individuals. For perinatally-infected HIV positive adolescents, the negative effects of malnutrition cannot be overstressed. Evidence shows that a well-nourished individual has a stronger immune system to cope with HIV and fight illness from infancy through to adolescence. This paper describes interventions conducted through the support of Partners and the Government to strengthen Infant and Young Child Feeding (IYCF) practices with the aim of reducing the risk of malnutrition among HIV-infected mothers and their perinatally infected children during the first 1000 days of life.

Methodology: Pregnant women registered for antenatal care (ANC) in seven (7) facilities in Kosofe LGA in Lagos state, Nigeria were assessed for their HIV and nutritional status from December 2017 to June 2018. They were followed-up with HIV and nutritional services every 6 weeks through ANC, delivery, post-natal care (PNC) and during child welfare clinics for their infants. Health Care Worker’s (HCWs) at these facilities were trained to provide HIV counselling and testing, interpersonal counselling (IPC) and targeted education on comprehensive IYCF practices for the pregnant and breastfeeding mothers. A major aspect of IPC support includes counselling of pregnant women and mothers of children under 2-years on adequate maternal and child nutrition practices in terms of physical, mental and economic growth and development. Demonstration classes were conducted to depict correct positioning and attachment for mothers of infants. Food demonstration classes and consultation sessions with IYCF-trained nutritionists were carried out monthly. Pregnant women and mothers of children under 2 years of age were given IYCF cards in addition to their regular health facility cards which holds records of their HIV status and nutritional status through routine checks. High-risk HIV-positive pregnant women and perinatally infected children get additional support from HCWs in terms of more intense nutrition counselling, monitoring and tracking for infants 6-24 months.

Results: A total of 9,020 pregnant women were provided with HIV testing services (HTS) during their ANC visits. Of the total number who got tested, 3.2% (n=289) of them tested HIV-positive. All the HIV-positive pregnant women were counseled on comprehensive IYCF practices and are being followed up with prevention of mother to child transmission (PMTCT) and IYCF services through delivery and PNC.

Conclusion: Targeted interventions to break the intergenerational cycle of malnutrition starting in-utero may improve health outcomes especially for children and adolescents infected with HIV by their mothers. Ensuring the scale-up of IYCF services will play a key role in improving the nutritional status of children, adolescents and women in Nigeria and consequently help the HIV-infected adolescent fight the disease during puberty and rapid growth.
Early lessons from a combination HIV prevention programme that includes a conditional cash transfer for young women 19-24y in Cape Town, South Africa

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Background: Social determinants in South Africa drive the gender differential in HIV vulnerability. Young women aged 19-24y are 3.5 times more likely to have HIV than their male counterparts. Combination HIV prevention interventions that address bio-, psycho-, social, and structural risk factors have the greatest impact on HIV outcomes. Social protection instruments such as conditional cash transfers have been used to minimise risk exposure by reducing poverty; keeping children, especially girls, in school; reducing risky sexual behaviour and enhancing capacity for health and wellness. Women of Worth (WoW) is a trial of a combination HIV prevention intervention that includes a conditional cash transfer for young women 19-24y in two sub-districts in the Cape Town Metro in South Africa. This trial is part of a broader Zimele project consisting of integrated, multi-sectoral, multi-setting interventions for young people aged 10 to 24 years in the same sub districts. The project is funded by the Global Fund for Malaria, HIV and TB and is sub-contracted to the Desmond Tutu HIV Foundation as an implementation partner of the Western Cape Department of Health. The aim is to share early implementation lessons from the trial.

Materials & Methods: WoW is a single-blinded, double arm, randomised control trial. The aim of the trial is to assess the impact of an incentive plus empowerment (“care”) vs “care” only intervention targeted at 10’000 19-24y old young women: half the participants are randomised to a conditional cash transfer plus care and the other to care only. Care received by all participants includes Adolescent Youth Friendly fixed and mobile services, a 12 session empowerment programme, and other support services. The incentive of ZAR300 ($20.44) is received by half the sample upon successful attendance of an empowerment session. Due to implementation challenges, participant and staff feedback, the study procedures were reviewed and amended from version 1.0 used from May 2017 to Dec 2017, to version 1.1 used from March 2018 to July 2018. Adaptations from version 1.0 to 1.1 included augmenting the demand generation with a respondent driven recruitment strategy, weekly instead of monthly empowerment sessions, flexibility in session attendance, further training and ongoing coaching of facilitators, and the use of QR codes, scanner technology to monitor linkage to health facilities.

Results: There were 2352 enrolments as at 30 July 2018. Enrolments on average per month increased from 120 in version 1.0 to 277 in version 1.1. Successful enrolment rate post registration improved from 65% to 76% reducing early drop out rate from 35% to 24%, 241 participants graduated and 325 were successfully linked into care.

Conclusion: Early findings suggest that respondent driven recruitment techniques, flexible weekly sessions with better capacitated & supported facilitators and the use of scanner technology improved the uptake of the intervention.
The Challenges and Successes of Transitioning from Pediatric to Adult Care in an Academic Urban setting in Canada: It takes more than free pizza

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Transitioning from pediatric or adolescent HIV care to adult HIV care involves many challenges. Many children and youth growing up with HIV are used to family-centered, child-friendly, multidisciplinary primary care teams that might involve pediatricians, pediatric nurse practitioners, nurses, social work case managers, psychologists, nutritionists, chaplains, and other dedicated caregivers. Long-term bonds often exist between these care providers, patients, and families.

In contrast, the adult care model is more fragmented – with medical care, mental health care, and social services being offered separately – and requires more independent navigation of the healthcare system. Youth in transition must also confront the possibility of discrimination and stigma when disclosing their HIV status to new providers and other patients.

Youth living with HIV, in general, are also the least likely of any age group to be linked to care, which is defined as visiting a health care provider within 90 days of learning their HIV status. Retention in care and viral suppression are also low in this age group – according to data from 2012, only 21% of 18 to 24 year-olds living with HIV in the U.S. had been prescribed antiretroviral treatment, and only 16% were virally suppressed.

Successful transition is a process that takes time and requires a coordinated system-based approach. We will discuss an approach to care of transitioning from an Urban-based Academic Pediatric/adolescent centre in Toronto to an adult-based Academic interdisciplinary Family Health Team, also based in Toronto.

Successes and challenges will be discussed including keys such as:

1) Adequate preparation: Transition discussions should begin with youth living with HIV and their families in early adolescence, so that young people can acquire the independence, organizational, and communication skills they will need in adult care,

2) Timing: Transition should be a long and planned process, allowing young people sufficient time to adjust to the concept and prepare for the change, essential communication.

3) Choice: Youth should be provided with options, such as choosing their preferred adult care clinician and timing of the transition.

4) Communication across the HIV care systems: It is very important for pediatric and adult clinicians to communicate well when exchanging medical and psychosocial information. Some youth living with HIV may have concerns about disclosing information again to a new clinician, so collaboration between clinicians is essential.

5) Social and psychological support: Youth living with HIV can benefit from meeting peers who have already transitioned into adult care, or from touring adult clinics with peers, case managers, or family members. Providing psychosocial support for youth is also helpful, particularly in relation to housing, transport, access or referral to mental health services and sexual health education.

6) Flexibility: Youth are provided with walk in hours and flexible scheduling in the evening to suit their needs enabling better follow up care and trust with their various care providers.

Challenges to transitioning planning will be discussed including concerns about confidentiality, stigma, adjustment to an adult health-care setting, issues with adherence and retention in care.
Community Safe spaces are a model for risk Avoidance for Young Teens

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Background: HIV prevalence in Uganda is almost four times higher among Adolescent and young women aged 15 to 24 than young men of the same age. (UPHIA 2016-2017). The issues faced by AGYW include gender-based violence (including sexual abuse) and a lack of access to education, health services, social protection and information about how they cope with these inequities and injustice (UAC 2015). Catholic Relief Services and the AIDS Support Organization (TASO) are implementing an Orphans and vulnerable children project as part of SOCY they are 2 year DREAMS (Determined, Resilient, Empowered, AIDS free, and Mentored and Safe women) initiative targeting Adolescent Girls and Young women (AGYW) 10-24 years in three districts of Uganda. The goal of DREAMS is to reduce HIV incidence among AGYW. One of the core interventions is implementation of the safe spaces model where the girls meet at regular times to build their social, health, human assets, receive services and be linked to community resources. Safe spaces are easy and safe to access places approved by AGYW and their caregivers.

Methods: SOCY is implementing the safe spaces model to support teens 10-17 years to stay HIV free. We work with teens and caregivers to select safe spaces in the community where teens receive social asset building interventions and access HIV prevention services. The AGYW select possible community provided safe spaces like schools, respected community members home, churches, health facilities. We seek permission from the authority to use these spaces, negotiate terms of using the safe spaces, meeting time, days and inaugurate the safe spaces. The project has 200 safe spaces that are community provided and for the period June 2016-September 2017; 9144 AGYW accessed these spaces.

Results: Community members have provided 200 safe spaces where teens access HIV prevention services from Health service providers. Teens are provided a safe space to talk about HIV, sex, violence prevention and risk reduction behaviors with community resource persons. Teens are able to freely express themselves. Strengthened Community engagement in teens risk reduction programs.
Improving knowledge of HIV management and health outcomes among Adolescents Living with HIV in Nigeria through support group activities

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Introduction: Lack of knowledge on HIV-management, lack of self-care skills and unavailability of youth friendly services and safe spaces are major barriers preventing access to HIV care and treatment among Adolescents Living with HIV (ALHIV) in Nigeria. The lack of these knowledge and skills affects HIV clinical outcomes for them (e.g. affects their ability to adhere to medications and also to remain in HIV care and treatment.) These barriers to health care and treatment often lead to poor ART adherence and poor retention rates among ALHIV. In the context of the HIV epidemic, enrolment and participation of ALHIV in support group (SG) activities have proven to be an effective mechanism not only for sharing experiences and mutual support for participants, but also for learning and gaining new knowledge and skills. This paper describes the result of a SG intervention that aimed to empower ALHIV with knowledge and skills to improve their ability to adhere to ART treatment and remain in care.

Methodology: A pre and post-intervention assessment of ALHIV (10 – 19 years) enrolled in SGs established by the USAID-funded SIDHAS project in 6 PEPFAR-priority LGAs in Nigeria between October 2016 to June 2018. A SG is a small group of people with common experiences or concerns who provide each other with encouragement, comfort, and advice. Trained case-managers facilitated SG meeting activities once every month for these ALHIV. With 14 interactive sessions of the “Positive Connections Guide – Leading Information and Support Groups for Adolescents Living with HIV”, the ALHIV were empowered with knowledge and skills on HIV-management including; knowledge on benefits of HIV status disclosure, lifelong ART adherence, retention in care, Sexual and Reproductive Health, post Gender-Based Violence Care, Mental Health, Life Building Skills, Positive Health Dignity and Prevention (PHDP), Self-Care Management Skills etc. A referral network was also set-up to strengthen the referral system of health facilities and other social services where the ALHIV can access services. A standardized checklist (14-part questionnaire) was used to assess the ALHIV who completed the 14 sessions of the guide.

Results: Of the 145 ALHIV that participated, 63% were females with mean age of 13.3 years (SD=2.90). The mean score for pre-test assessment was 9.7 (SD= 1.69) while the mean score for post-test assessment was 14 (SD= 1.84). This finding was statistically significant (p-value<0.001). ALHIV acquired the most knowledge in the areas of importance of disclosure, consistently taking their HIV medications exactly as the doctor tells them to and knowing where to find other services relevant to their health, as there was a mean increase of 72% from the pre-test to the post-test. The least knowledge gained was in knowing where to get treatment for HIV as 98% of them already knew that they get their ARVs from the facilities in both pre and post-tests. Retention rate improved from 61.8% to 73.5%.

Conclusion: Targeted interventions including awareness creation, teaching, mentoring and coaching through support group activities may improve HIV management knowledge, skills and consequently positive health outcomes including increased retention-rates for ALHIV.
Reaching the older adolescents through provision of friendly services in Mityana hospital a public Hospital.

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Introduction: In order to achieve the first UNAIDS 90, the older adolescents 15-19 years cannot be left out in the struggle due to their nature of being inquisitive to explore what nature has brought upon them, the rapid physical development and emotional changes.

Program description: Between October 2015 and March, 2018, 158 adolescents 15-19 years were identified as new HIV positive in Mityana Hospital. The aim of the project was to fast truck 128 older adolescents between the ages of 15-19 years. One know your child’s status counsellor was recruited in Mityana hospital to support in counselling and improving adolescent friendly services to increase early diagnosis for the adolescents. Adolescent friendly services ranged from offering HIV testing and counselling to all adolescents at the teenage clinic and at the ANC clinic, providing drugs at the clinic for OIs, daily and continuous health education at the clinic on importance of having a HIV test and basic information on HIV and AIDS, provision of games, sexual reproductive talks, training and on job mentorship for peer educators who give support to increase adolescent attendance and life skills talks every single clinic day.

Lessons learned: Provision of adolescent friendly services is an effective strategy in encouraging the older adolescents to take an HIV test and involvement of every member of staff. Friendly services provide a conducive environment for an adolescent which translates into improved early diagnosis.

Conclusion: Implementation of friendly services such as daily health education, indoor games, provision of OI drugs, showing good and positive attitude can increase the number of adolescents receiving HTS services.
A baseline assessment for HIV prevention campaign among young People in Nigeria: Lessons learnt

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Background: Despite advancement in HIV treatment, prevention still remains an essential part of the global HIV response. The 2018 UNAIDS report states a prevention crisis, with a number of new infections compared to number of AIDS related deaths prevented. Young people ages 15-24 particularly women bear the brunt of this inadequate response. The National Agency for the Control of AIDS, Nigeria with the support of United Nations Children’s Fund (UNICEF) proposed a National HIV prevention campaign targeted towards Adolescent and Young People (AYPs) to increase access to HIV information and services among this population. A baseline assessment was conducted in four states of the country to inform a proper campaign.

Intervention: Through Focus group discussion (FGDs) and Key informant interviews (KIIs)—40 AYPs per state (Lagos, Kaduna, FCT and Benue) ages 15-24 were interviewed. They were drawn from both the general and key populations within rural and urban settings. The FGDs were organised into two groups of ages 15-19 and 20-24 with 10 participants in each group. Issues explored included knowledge, risk perception, age of sexual debut, condom use, HIV testing services (HTS), gender based violence and appropriate messaging for AYPs. KIs using a structured questionnaire were conducted among key influencers such as teachers, brothel owners, healthcare providers and community leaders. Major themes explored included areas of congregation for AYPs, communication channel preferences.

Lessons learnt: The baseline assessment showed a high level of awareness and risk perception towards HIV, multiple sexual partners/transactional sex, and stigma limiting uptake of HTS. Assessment revealed limited knowledge of gender based violence and youth friendly HIV messages. Most of the participants recommended that HIV messaging should start as early as 10 years of age and address issues on misconceptions, prevention and management of HIV. The preferred mode of delivery of messages was social media specifically Facebook and Whatsapp in addition to traditional methods. Use of celebrities as ambassadors was also advocated. Service should be delivered both in facilities and communities (areas of residence, barber’s shop, relaxation spots, sport centres and place of worship).

Next Steps: Appropriate messages based on this have been developed with the roll out of the campaign to commence soon.
Optimizing viral load services for adolescents through Recreation Adolescent Support Clinics (RASC) in Zambia Defense Force (ZDF) facilities.


Background: Viral Load (VL) monitoring is important to ensure treatment efficacy, monitor drug resistance to the prescribed HIV therapy and can be used to identify people in need of adherence support. However, children and adolescents aged 10-19 years associate VL sample collection with pain and discomfort. Some of the 3,800 children and adolescents from the 57 Zambia Defense Force (ZDF) supported sites were not keen to undergo VL sample collection. To address this challenge, Recreation Adolescent Support Clinics (RASC) were introduced as a way of distracting them from pain associated with sample collection. RASC uses play time for sports, poems, singing, drama and toys to accomplish the implementation of health interactions and services such as VL sample collection, drug pick-up, adherence counselling and clinical evaluation in a negotiated environment without compromising health care worker and adolescent relationship. To establish the relationship between VL sample collection and RASC implementation, a descriptive study to show correlation on the number of adolescent VL samples collected during RASC months and those collected during non-RASC months among the ZDF supported sites was undertaken.

Material and Methods: Facility VL monthly reported data from January to June 2018 from eleven facilities purposely selected basing on high volume of ART clients was analyzed. Number of VL samples collected in months of RASC implementation and those collected in non-RASC months were analyzed. VL sample collection was guided by the eligibility criteria stipulated in the national guidelines. To determine if correlation exists between the number of VL samples collected among children and adolescents and month of RASC implementation, Pearson Correlation Coefficient (r) was calculated.

Results: 367 VL samples were collected from eligible children and adolescents on ART between January and June 2018. Of these, 191 (52%) samples were collected during months of active RASC implementation while 176 (48%) were collected in months of non-RASC implementation. The correlation between the number of VL sample collected and month of RASC implementation was calculated at r= 0.8 (p<0.05) while the correlation between the number of VL samples collected and non-RASC implementation month was -0.003 (p>0.05).

Conclusions: There is a strong positive relationship between the number of VL samples collected from children and adolescents (10-19 years) and months of RASC implementation (r=0.8. P<0.05. With the children and adolescent population on ART in ZDF supported facilities standing at 3,800 (13.8%) of patients on ART, active RASC implementation is an important strategy for VL services access and coverage which can contribute significantly to desirable treatment outcomes.
The emotional impact of an educative intervention on HIV risk of infection in adolescent with and without HIV infection. Identifying and training “Peer Supporters”.

SMAC study

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Background: Even though the progress of ART, HIV infection incidence remains constant in young adults and new cases are still occurring in European Pediatric Population. The low level of risk perception on HIV in young people amplify this problem. Epidemiological analysis of data show how low level of risk perception and information on HIV in adolescents and young adults amplify this problem. The PARTNER study documented how suppressive ART become the best preventive strategy to avoid viral transmission. Patient’s emotional status represent an important parameter for the patient’s health as well as a determinant for ART compliance. Emotional frailty in HIV patients is sustained by fear of discrimination, bringing patients to take not properly ART. It appeared imperative to analyze emotional status as a infection’s marker and investing in educational strategies on improving knowledge in infection and non-infected population. Recent local experiences in other chronic diseases showed the importance to invest in Peer-Supporter strategies.

Methods: 1)90 infected HIV patient and relatives followed in “Bambino Gesu” Pediatric Hospital in Rome was interrogated to structure a prospective cohort study with evaluation pre-post an educational intervention.
2)We then structured a prospective cohort study with evaluation pre-post intervention

a.)In a preliminary phase emotive status, cognitive level and adaptive behavior will be assessed in our cohort using tests as PM-38, CPM-47, SCL-90R, SDQ-Ita, PHQ-9 and GAD-7, SF12.

b.)50 patients over 14 in two age groups (14-18 yrs, 18-30 yrs) will receive an educational intervention on general hygiene and health care topics, disease transmission and HIV specifics.

c.)An specific evaluation test will be administered before and after the intervention to assess general knowledge on main health topics, using Google Forms platform.

d.)Item b. and c. will be offered to a high school cohort in Rome including only adolescents.

e.)Selection criteria for creating “Peer-Supporter” group of patients will be discussed and testes at the end of the educational intervention.

Results: 100% of patients expressed the need for educational programs concerning infectious diseases general topics, transmission routes, health issues particularly about HIV research. It is to be noted that while putting together this protocol, a greater empowerment regarding the disease was observed in our cohort. The idea of “being taken care of” outside routine visits is already resulting in an
Adolescent Girls and Young Women and HIV Prevention in sub-Saharan Africa: A review of ongoing and planned research to inform introduction of HIV prevention products and services

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Background: New HIV prevention products are needed and existing ones need to be successfully introduced to begin to address the disproportionate number of new HIV infections among adolescent girls and young women (AGYW) in sub-Saharan Africa. For successful introduction of products, a thorough understanding of the factors that may influence AGYW’s awareness, acceptance, uptake, adherence and championing of HIV prevention is essential. The landscape of research on AGYW and HIV prevention is highly saturated, and there is a need identified a need to map research along the HIV prevention journey framework to discover what is known, will be known and gaps in understanding that exist. Starting in 2017, the HIV Prevention Market Manager began tracking ongoing and planned work, and this mapping builds on a previously published analysis by identifying the full scope of work in this area and mapping research questions under investigation to the journey framework.

Methods: A review of ongoing and planned research on HIV prevention and AGYW ages 15-28 in sub-Saharan Africa was conducted. The review maps the research by study type, country and questions along the HIV prevention journey framework—awareness, acceptance, uptake, adherence and championing. Structured interviews with stakeholders, meetings with product developers, researchers, marketing agencies and program implementers, and surveys informed the mapping.

Results: The review identified 84 organizations working on 104 ongoing and planned projects in 18 countries across sub-Saharan Africa. The majority of the research focuses on acceptability and adherence, with oral PrEP the primary product under study. The mapping found that South Africa, Kenya and Zimbabwe are the primary locations for research. Only 19% of all projects in sub-Saharan Africa gather information on influencers, with 70% of these projects including a focus on male partners, and only 4% including a focus on the provider as influencer.

Conclusion: The mapping brought to light several gaps in research on AGYW as end users of HIV prevention products, such as the lack of research focused on providers as influencers. The mapping intends to be a living document, updated with new research on an ongoing basis, and can inform collaborations and act as a guide to funders and implementers when considering what is already happening, what gaps might exist and what new work is needed to understand AGYW and HIV prevention.
Impact of DREAMS Initiative: Intervention layering core to reduction of HIV incidence among Adolescent Girls and Young women in Uganda 2016 -2017

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Background: The Ministry of Health Uganda Coordinates the “Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe” (DREAMS) Initiative, now in 15 Districts with support from PEPFAR, to reduce new HIV infections in adolescent girls and young women (AGYW) aged 10-24 by 40% over 2 years. DREAMS employs a tool kit of evidence-based structural, behavioral and biomedical prevention interventions targeting high risk HIV-negative AGYW, their male partners, and communities, Beneficiaries were enrolled and followed longitudinally.

Methods: The program uses service layering a core principle of DREAMS Model of Implementation where multiple interventions/services are provided to AGYW, according segments. From October 2015 to September 2017, 144,465 eligible AGYW were enrolled in 10 high HIV prevalence districts, selected for high HIV treatment unmet need and a large number of AGYW. All AGYW, confirmed HIV negative within 12 weeks of enrolment, were followed in an open cohort design. They received an intensive prevention package of interventions described in the DREAMS service package.

Results: All AGYWs enrolled were exposed to same interventions and we observed about 22 new infections after follow up of about two years. This computes to an incidence rate (IR) of 2.69 per 10,000PY, which is significantly lower than rates earlier described within all women in studies prior to DREAMS implementation, (IR=83 per 10,000PY), IR Ratio, 0.03, CI,0.02 to 0.05. Most new infections occurred within six months of enrolment, among age-group 20-24, with 32% (7) among AGYW in transactional sex segment over 8,765PY. (IR 7.99 per 10,000PY). This segment showed a decrease in those reporting to have 3 or more sexual partners, from 43% (2393) at enrolment to 6% over observation period. There was no geographic difference in rates of new infections after controlling for regional prevalence.

Conclusion: Layering supports prevention especially in reduction of HIV incidence among population with High risk of HIV infection, demonstrates OVC support and Follows evidence that comprehensive care is more effective than standalone services. This should therefore be scaled up more in Uganda and other Countries.
Adolescent Female Sex Workers are most vulnerable, hidden and extremely hard to reach for providing HIV prevention services in Bangladesh

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Background: Save the Children in Bangladesh (SC) is implementing HIV Prevention project in Bangladesh under the support from the Global Fund. This project is providing essential services among female sex workers for HIV prevention which is not specific to adolescent FSW focused yet. Currently, about 18,500 Female sex workers are receiving HIV prevention services among them 1269 are adolescent which is 6.85% of total listed FSWs.

Materials & Methods: From programmatic experiences, it has been found that a significant proportion of adolescent FSWs was reached by HIV intervention later than (eg. months/years) their exposure to the sex trade. This is a missed opportunity to address their essential needs as their physics started to mature, consume secondary sexual characteristics and ready for sexual intercourse. And this led every possibility to get pregnant at an early stage and risk to forceful abortion. In a low socio-economic condition of Bangladesh, many families had to stand to take hard decision to let their early adolescent daughters married. Instant reduction of family burden in such a way and social disruption lead these females to make vulnerable to illegal act like sex trade. They were somehow forced to such situation and prone to a deprived health condition. There is a very little country experience of Adolescent FSW programming and no specific mechanism established to address their need. Same services are offered to all FSW including Adolescent groups through the common platform (DICs and outreach).

Results: By analyzing listed (1269) Adolescent female sex workers it has been found that they are engaging sex trade in 3 setting, 51% are Residence based, 12% are Hotel based and 37% are Street based. Data shows that 16% of them are up to 15 years of age and 84% are between 16 to 19 years of age. 52% of them has exposure with commercial sex trade before they completed their age 15 years. Among the listed adolescent FSWs 9% of them are student, 6% are engaged in services, 6.5% are engaged with any types of business and 11.5% of them are housewife. 31% of adolescent FSWs are single, 47% of them are married, 13% of them are separated, 4% of them are Divorced and 3% of them are widow. 46.5% of them have at least one children. A qualitative assessment on Adolescent FSWs shows that they are scattered and they have some specific service demand including Reproductive health care, Family planning, STI management, Psycho-social counseling, Education, linkage with government social safety net, etc.

Conclusions: Considering the context, Save the Children and Unicef have jointly designed a project and started implementation from June 2018. A new reaching strategy for adolescent female sex workers will be piloted. The community-based adolescent group will be formed under this project. To enable national ability, this project will work to address favorable political will, legal environment, effective multi-sectoral collaboration and coordination, advocate for appropriate resource allocation, knowledge management and comprehensive intervene to ensure the continuum of care for the most at-risk female adolescents.
Emerging Evidence on Adolescent HIV Prevention Behavior: Qualitative Results from a human-centered approach to increase adoption and adherence to HIV prevention among high-risk adolescent girls and young women

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Background: The HIV Prevention Market Manager (PMM) project is undertaking a collaborative research project to provide in-depth understanding of the HIV prevention needs, wants, challenges and opportunities among adolescent girls and young women (AGYW) aged 15-24 in South Africa, especially those at particularly high risk of acquiring HIV. Funded by the Bill & Melinda Gates Foundation, the PMM seeks to facilitate the efficient and effective development and rollout of HIV prevention interventions. The research aims to improve understanding of factors that impact uptake and effective use of HIV prevention products and services and will produce outputs that are actionable and sustainable for a range of implementation partners.

Methods: The project is integrating several different research techniques, including ethnographic research, journey mapping, human-centered design and discrete choice experiments. The research is focused in two districts each in KwaZulu-Natal and Mpumalanga, South Africa with AGYW aged 15-24. In the qualitative research phase, influencers of AGYW were included. The qualitative research mapped the pathways to individual decisions and behaviours made by AGYW, identified key prevention drivers and identified uniform behaviors, attitudes and motivators among AGYW to serve as inputs into quantitative research.

Results: PMM’s qualitative research found that in order to create an HIV prevention strategy that will resonate with AGYW, a framework of understanding that aligns with the adolescent perspective is needed. AGYW are not focused on HIV prevention, rather the feeling of being at risk of HIV is isolated to momentary “blips”. Their focus is on balancing healthy sexual behaviors, i.e. preventing pregnancy, avoiding STIs and HIV, and successfully navigating their relationship(s), with the relationships most often winning out.

Conclusions: Building a successful strategy for HIV prevention needs to support an AGYW’s journey navigating their current context of sexual behaviors and relationship management. Quantitative research will build on these findings, with finalization of unique AGYW segments and their decision pathways allowing an understanding of the differences between groups and distribution across geographies to inform targeting and roll-out strategies of HIV prevention products and services.
The dangerous trend of Adolescence HIV infection in Nigeria

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Background: Age limit of 10-19 years is so delicate that whatever happens at this age may remain in the life of such individuals and health challenges such as HIV infections are inclusive. This writes up reports the dangerous trend of adolescence HIV infections in Nigeria.

Materials and methods: This was a descriptive cross-sectional study which spanned 6 months. The study was carried out in the two regions of Nigeria the northern region and Southern region. Internally displaced camps, commentaries from cases in the police, personal accounts of events from adolescence and knowledge from our intervention processes were used as data for this study. A total of 67 consecutive adult male and female adolescence aged Ten to Twenty years were recruited listening to their history after obtaining consent (which was in most cases difficult) and were tested for HIV and other viral diseases. Consent form and interviewer-administered, structured questionnaires were used as study tool. Screening and confirmatory test were performed free of charge in the teaching hospital. Data were analyzed using SPSS 19.0 software. p-values of <0.05 was considered as statistically significant.

Result: There were 67 adolescence who consented to participate with a mean age of 16 ± 12.8 years. The infection rate (with viral and bacterial) was 94.0% (63 Vs 67). There were 44 adolescence who were positive to HIV with infection rate of 65.7%. There were 28 males (41.8%) and 39 females (58.2%) of this five males (11.4%) and the entire female subjects (88.6%) were HIV positive (17.9 and 100.0% infection rates respectively). There were 9 (13.4%) aged 8-10 years, 22 (32.9%) age 11-15 years and 36 (53.7%) age 16-20 years in the study with HIV infection rate of 4.5%, 43.2% and 52.3%. In terms of awareness, 29 (65.9%) knew about the virus and 15 (34.1%) knew nothing about the virus. Conversely, 45 (67.2%) among the total population study did not use condom while 12 (27.2%) use it.

Discussions: This high HIV infection rate among the adolescence in this study calls for cause of alarm. In the last eight years several internally displaced camps were open to accommodate people who had lost their live hood. Some of the respondent complained of sex for food in the IDP camps and adolescence are the main targets of camp officials. Increase incidence of unreported cases of adolescence rape in the northern region of the country. Trafficking of adolescence in the southern region where adolescence age are “sold out” for house help and later brutalized and sexually abused. Increased rate of adolescence hawking and abused.

Future study: The expansion of this study will look at the effect of Drug abuse, Key populations and HIV infection. Expansion of study coverage to include 80% of secondary schools and Universities is desirable.

Limitation: Small sample size.

Conclusion: From this study, both the rich and the poor in our society are involved but poverty, flooding and insecurity leading to creation of IDP camps and bad cultural mindsets predisposes adolescence infections including HIV.
Implementing Soul Buddyz Clubs in Klipfontein-Mitchell’s Plain: “Educators Perspective”

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The Desmond Tutu HIV Foundation in partnership with the Western Cape Government launched The Zimele Project in 2017. The project is a multi-dimensional intervention programme for the youth of the Mitchell’s Plain/Klipfontein health district and aims to bring effect on issues relating to health and social matters. The Soul Buddyz Club (SBC) programme is a school-based intervention programme, which targets 10-14 year old boys and girls. The programme focuses on educating learners on health and social related issues and allows these learners not only to learn about these issues but allows for an open discussion on personal experiences. Currently, the programme is being implemented in 52 primary schools within the Mitchell’s Plain and Klipfontein district and over 1000 learners have being impacted.

An educator’s perspective:
Educators have noted that the SBC has had a positive impact on the learners. Learners are participating in projects and doing their own research. Learner’s behaviour has changed after being exposed to the SBC, they are taking a positive role in their community and school environment. The club has allowed for a safe space, where learners are allowed to speak their minds and provided a platform where there is no judgement. The club has allowed learners to grow and built their self-confidence and the public speaking skills has since improved. The club and the sessions has broken the chain of fighting and labelling as learners are being educated about effects and consequences thus changing their mind-set. The activities completed has empowered the learners with information. Through special projects, these learners are making a difference within their community and school environment. Learners have engaged in local protests against rape and crime.

As there are many successes, these educators have also experience a number of challenges, the programme is highly reliant on the teacher to facilitate the club session, this has been proven highly challenging as the teaching scheduling and other obligations are in conflict with the club session. Schools are situated in areas where there are high rate of gang violence in and around the schools. This has influenced club meeting as it is unsafe for learners to attend sessions after school and in some cases; schools have closed for a few days due to the violence. Staff members/SBC Supervisors are affected as they are unable to enter the school or community as certain areas are unsafe. Learners are demotivated to attend club meetings after schools as the sessions can be very theoretical and learners are more in favour of doing artsy/practical work. The Soul Buddyz programme introduced the SBC App to all schools. The app aimed to assist the teacher/facilitator with capturing meetings and easy access to obtaining points. The app has been proven problematic as teachers are unable to log any club meetings or gain any access to the app.

In summary
Maintaining a good relationship with all relevant stakeholders has allowed the programme to flourish and has impacted a large amount of learners.
Male and female condom and other physical barriers

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Background: Low use of condoms has created a heavy burden to mitigating the spread of new HIV infection Among Adolescent and Young persons. This study aim at assessing the factors that contribute to low use of condoms among adolescents and the associated barriers.

Methods: A study comprising of 115 young person's age 15-20 years (65 males and 50 females) of different ethnic background, was conducted in November 2017, in Kaduna South LGA of Kaduna state, North west Nigeria. HIV Prevalence in Kaduna state is seen at 2.2 which makes it the state with the highest prevalence in north west zone of Nigeria in 2017.

Early exposure and/or high sexual risk amongst Adolescents and Young Persons (AYPs) age 15-24 is seen at 16% for females and 6% for males who had sexual debut before 15 years, but there is a decline for males from 17 years to 15 years (2007&2011 SPARC).

Condom use during the first sexual intercourse among sexually active Adolescents and Young Persons (AYPs) age 15-24, is seen at 22% for young men and 11% for young women (NDHS 2008).

A mixed method approach was employed involving the use of self-administered questionnaires and in-depth interview to elicit information on the use of condoms. data were analyzed using descriptive statistic.

Results: - 80% of males and 70% females, age 15-20yrs were found to be sexually active
- High sexual risk was observed at 75% in the females and 40% in the males.
- Comprehensive knowledge of male and female condoms: only 50 % of males have seen a male condom and 18% of females have ever seen a female condom.

- Condom use among sexually active: only 20% of males have use condom in the last 3 month and only 4% females have use female condom in the last 3 month.

Factors associated with findings were:
Poor condom awareness, condom access not youth friendly, female condom not pleasurable and good in sight, size of condom not friendly to some males, religious belief, fear of been stigmatize by partners, peer pressure, inadequate sexual education, lack of parental advice towards condom, and emulation from knowledge gotten through pornography.

Conclusions: Male and female condoms are services we most provide to the young ones in other to reduce New spread of HIV infection, Low access and use of condoms will create more burden rather than solution to health of our young ones. Therefore efforts aimed at addressing the above factors will greatly impact on quality of HIV prevention of adolescents and young people.
Lessons Learnt: Implementing the Keeping Girls in School Program in the Klipfontein-Mitchell’s Plain Sub-Districts, Cape Town

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The South African National Strategic Plan on HIV, STIs and TB (2012–2016) (NSP) has as a key activity the focus on Young Women and Girls (YW&G). In line herewith, the Zimele Project rolled out the Keeping Girls In School (KGIS) in the Klipfontein-Mitchell’s sub-district. The program seeks to decrease new HIV infections in YW&G, decrease teen pregnancies and to retain girls in school until matric, being HIV protective. From Jan 2017 to date we implemented the comprehensive package of health, education and support services in 44 secondary schools between the ages 15-19 with >7000 learners impacted.

Challenges
1. Stakeholder engagement: While the programme was agreed to by the Department of Education and Department of Health, not all Principals agreed to the program, or delayed the implementation at their schools. Some schools only signed on in quarter 4 – this impacted program delivery.
2. Schools challenges: Some Educators found it difficult to do suitable work with the boys while the girls were in the health education sessions. Some Educators wanted learners to attend life orientation lessons to meet the demands of their curriculum, instead of attending the health sessions. Some schools did not have an extra class room for health education sessions.
3. Implementation challenges: The new program required ongoing staff training. When this was conducted during school times, it impacted delivery of the programmes because of the prior arrangements made with the schools. Safety in the area made home visits and afterschool programmes an implementation challenge. Homework tuition was not well attended.
4. Data challenges: The biometric system was set up to capture the fingerprints for the database. Registration was time consuming especially if the device is slower due to network or user error. Data was paper-based because of this, which resulted in process challenges.

Best practices to address challenges
1. Stakeholder solutions: Coordinator and Supervisor met each Principal to establish a relationship and provide clarity on the full KGIS. Strengthening relationships i.e. DTHF and Education Department allowed for trust relations to be established. Linking Principals and NGOs who offered programs to the boy learners while girls are busy proved beneficial.
2. Staff solutions: Coordinator and Supervisor started weekly one-on-one staff meetings identifying challenges in real time. Supervisor visit the schools the following week to address the challenges to minimise risk. Homework tuition offered via the exams periods provided learners with a safe space to study proved beneficial.
3. Implementation solutions: Issuing sanitary towels to learners saw numbers of absenteeism decrease. Having Nursing staff join health sessions to answer questions and improve referrals. Arranging transport for Home visit days, in order to minimize safety threat.
4. Data Solutions: Have learners complete a registration form first. Data team capture information onto a spreadsheet which is uploaded onto the Broccoli system. At the next session only fingerprints was needed. Staff being moved around to assist with biometric capturing and working with the Data team to clean up the database.

In summary: A solutions-driven approach to stakeholder collaboration was key to program implementation.
Perceptions, Utilization and Expectations of Youth Friendly Services (YFS)

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Background: The delivery of health care services directed to young people has become a topic of increasing interest especially in the context of sexual and reproductive health (SRH). According to WHO (2011), services must be friendly for them to be accessible to adolescents. The national adolescent friendly clinics initiative (NAFCI) in South Africa based its development and implementation on the fact that offering services through public sector is the accessible and sustainable approach. The study moves from the premises of IPPF (International Planned Parenthood Federation) which defines YFS as ‘those services that attract young people, respond to their needs and retain young clients for continuity care (IPPF, 2007).

Objective: Using unintended pregnancy as an outcome of measure the study seek to explore teenage boys and girls perceptions, experiences and expectation of the support provided by YFS.

Methods: Data is draw from a mixed method study which was looking at the experiences with unintended teenage pregnancy in a location that has NAFCI clinic. Six focus groups and 198 surveys were conducted with teenagers aged 13 -19 years (13-15 younger and 16-19 older), 15 narratives were conducted with pregnant teenagers. The data set were analyzed separately and some quantitative variables were applied to interpret the result on whether quantitative result support or contradict qualitative result and vise versa.

Results: Three themes emanating from the study findings are; teenager’s experience with health care services; the obstacles to using the YFS s; and the teenager’s expectations of YFS responsiveness to their needs. Participants had no knowledge of existing NAFCI/YFS clinic in their township. They seem not restricted to or enticed by the impressive concepts such as; YFS, adolescent youth friendly services (AYFS), NAFCI etc. The study noted factors that impacted on non-use of existing YFS and factors contributing to unintended pregnancy. The social roles of different key role players such as parents, health care providers and teachers are ambiguous thus leading to teenager’s confused identity, lack of knowledge of health care facilities designed specifically for them, negative perceptions and experiences with health care system, young people are sexually aware and thus have a certain level of curiosity, they have knowledge but lack life skills as a result there is not much discussion happening in their social-sexual relationship but the action of engaging in sex is happening, dissatisfaction with parental input, and impulsive approach to intimate encounters.

Conclusion: Results of this study suggest several possibility approaches that could be implemented to improve provision of sexual and reproductive health, and these approaches are more towards the non-conventional approach. This includes community involvement in supporting young people, heightened parental involvement and roles and services that are brought to where young people e.g. schools and shops. The developmental approach recognizes human being as a resource that can be utilized and focus on interrelationships due to their influence on social roles.
HIV self-testing to male partners through PMTCT mothers; Sprint to 90.90.90

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Introduction: According to UNAIDS, 90% of the population living with HIV should know their status by 2020. With the multi pronged approaches by stakeholders statistics indicate that Kenya has not yet archived the first 90, and according to DHIS2 in the previous quarter, Nairobi County was at 66% with a gap of 24% as much as PEPFAR is tremendously funding Kenya to beat this epidemic, it is glaringly obvious that people are still at large living with HIV. Immediate actions such as self-testing have been introduced to boost the identification of PLHIV.

Problem Statement and Objective: Pregnancy present unique opportunity to test the partners, but this has not been fruitful as most male are hard to reach during clinic hours. According to the new guideline on use of ARVs, partners of pregnant women attend ANC (Antenatal Clinic) are a target of self test. the concept works in the a way that women visiting ANC delivers self-testing kits to their partners in consensus with the SOPs. This potent strategy will benefit both the mother and the baby.

Methodology: At ACK health center in Kibera slum, Nairobi County, pregnant young mothers attending attending to ANC were convinced and given self-testing kits with package of information during the health talk by HTS(HIV Testing Services) counselors so as to administer to their partners. The mother seemed to b happy with the advent of Self-testing as their partners would not feel the shame of walking to the facility and sitting on the waiting benches initial.

Findings: Delivering the self-testing kits to male partners was highly accepted to both the partners. In the last quarter of 2017, reports from the young mothers were positive as most males had consented to the kit orally and got to know there HIV status. 40 young mothers where given self-test kits, 30 said that there partners tested themselves in their presence. The tests mostly took place after the evening meal. no client seroconverted and 8 male partners rejected the idea.

Way forward: it is glaring that most male partners do not accompany their pregnant partners to the clinic during ANC visits for various reasons such as been committed to work. With this strategy role to other sites, many male partners are going to be reached with the testing services hence leading to archiving the 90.90.90.
Standout 22285: Social media the game changer

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In the 21st century, Information Communication Technology has dominated all aspects and models of communication due to convenience and privacy. Family Health Options Kenya (FHOK) launched a youth led project named Standout 22285 aimed at Linking young people with HIV/AIDS and sexual reproductive health information and services through TEXTING (SMS) the word SRH to 22285 SMS, Use of the twitter handle (#standout 22285) and Facebook page (YAM-Kenya).

Methods: The project has been conducted in five identified districts adjacent to an FHOK clinic. The methods/activities undertaken focused on the 360° Approach (i.e. media, internet)

Through the use of Objectives
• To ensure young people are accessing RH information through the use of social media and the TEXT platform.
• To Increase advocacy on youth friendly services and other sexual reproductive health services & Rights.
• To increase the demand of SRH services, counseling and treatment among the young people
• TEXTING (SMS) the word SRH to 22285 SMS, Using of the twitter handle (#standout 22285) and Facebook page (YAM-Kenya, Standout project conduct
• Open forums and disclosure sessions
• Sexual Reproductive Health challenge competition
• Social media drive(creating #tag or trends and engaging in different discussions online)
• Publicizing SRH services

Results: (January to December, 2015)
The SMS services proved to be effective, they accounted for the 85% of the total responses. Of 39600, 33500 were records from the SMS system and 6100 from the other social media platforms, of the 33500, 48% were male and 52% were females and the age of 15-24 accounted for 55%. HIV/AIDS related questions accounted for 35% of the total of (39600) making it popular among the rest of the questions on the chart

Conclusion and recommendations: The findings from the period of 12 months indicated clearly that people still need information beyond the walls of a facility, regardless of the distance, gender and age which could be accessed from social media which is readily available to the wider population. Social Media is effective in targeting young people; the 55% reached were young
The majority reached (52%) was females; evidence suggests that females have a higher health seeking behavior than males. Therefore, as the project aims to stimulate service demand, extensive publicity and systematic recording systems need to be enhanced
Sustainable options for Adolescent Health Access

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Background: Uganda has a predominantly youthful population with more than 70% under 24 years. Sexual Reproductive Health has been identified as a priority area for young people. About 25% of young girls give birth to their first child before the age of 19. (UDHS 2016). This makes it challenging for them to pursue further education and live the lives they desire. HIV prevalence is almost four times higher among females than males aged 15 to 24 and 20 to 24. The prevalence of Viral Load Suppression is distinctly lower among younger adults: 44.9% among HIV-positive females and 32.5% among HIV-positive males aged 15 to 24 compared to 80.3% among HIV-positive females aged 55 to 64 and 70.2% among HIV-positive males aged 45 to 54. (UPHIA 2016) This raises a gap on top of the already existing SRH challenges and needs among young people. However, the gaps have been identified in relation to stigma and countless times the unfriendly youth services and health worker attitudes. New infections were also noted to be higher among the adolescents than in the adults. This undoes the very intensive EMTCT program and therefore the need to address the gap.

Mama’s Club Uganda a psychosocial non-government organization came into play to address these needs to achieve the 90-90-90 strategy, reduce the rate of teenage pregnancy that is standing at 25%, and as well reduce the knowledge gap concerning Sexual Reproductive Health and HIV. Youth friendly corers were established and some strengthened with human resource, IEC, recreation to attract young people and to share with them age appropriate information. A volunteer/ peer was placed at each of the sites with a health worker trained in adolescent health to provide accurate age appropriate information and services. In addition, IEC including educative videos, t-shirts were provided to guide the health education sessions and promote behavioral change. The games and sports were used to attract young people and were a strategy to integrate services and information for young people.

Results/ Findings:
1. Young people are more open to accessing services and information at the youth friendly corners
2. Peer led interventions yield more response than any other strategy. 3. Through the project, we reached over 9,000 youth because of he peers mobilizing youth to come for services
4. Due to transport constraints, outreaches are a good strategy to reach the young people.

However, 1. Human resource is a constraint and therefore integration of adolescent friendly services in the already existing structures and systems is a requirement for sustainability of the adolescent friendly services.
2. Peer led clubs especially for adolescents living with HIV serve as strong support groups for adherence, retention and viral suppression especially in facilities without adolescent HIV clinics.

In conclusion, adolescents may not be reached with only one mode of intervention because of their diversity and needs. It is therefore important to explore innovative, peer-led, adolescent oriented and sustainable models to reach the adolescent and cover the health gap.
The need for sufficient funding to offer quality paediatrics & adolescent HIV/AIDS & TB services at the national paediatrics and adolescent (NAPAC) call centre

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Background: While the Uganda HIV/AIDS prevalence has reduced to 6.2%, there is still need to give quality health care to achieve 95:95:95 targets. In order to achieve quality paediatric HIV/AIDS & TB care, funding is needed to have real life solutions that offer information to enable frontline healthcare workers deliver quality Pediatric HIV/AIDS & TB treatment. However, if resources allocated are insufficient, this may have a direct impact on the quality of healthcare delivered. It is on this note that Baylor-Uganda with funding from Center for Disease Control and Prevention established the National paediatric and adolescent HIV and TB call centre (NAPAC) to enable health workers across the country consult and receive technical assistance regarding HIV/TB management in children and adolescents.

Description: For the first two months into the new project, the call centre was affected in terms of performance, consultations from health workers have reduced to an average of 136 as opposed to 250 monthly target (a 45% reduction). This decline has been largely due to failure to replace the call centre Doctor and Pharmacist who offered instant solutions in real time when consulted. This further led to an increase in waiting time which makes the consulting process time consuming and irritating for the health workers. FAQ dissemination and stakeholder engagements aimed at addressing knowledge gaps have also halted. The current clinic staff receiving Call Centre consultations are unable to provide adequate call resolution due to heavy clinic workload which has affected our client retention. There is need to train and refresh the clinic health workers in customer relations, first call resolution and refresher training in the latest national HIV/TB guidelines so as increase customer satisfaction, retention and promotion of NAPAC by word of mouth hence reducing future costs on marketing

Lessons Learnt: NAPAC has immensely helped ease the work of health workers especially in the lower level health facilities where specialist are hard to find. More than 5994 health workers have consulted the helpline on paediatric and adolescent HIV/TB issues and technical responses provided. Every month, TB management takes up over 20% of the calls from health workers followed by consultations on eMTCT, HIV related cases like regimen, and adverse drug reactions counselling, drug stock outs and also PEP cases due to rape. As a result of funding

Conclusion/Next steps: Health call centres can help in increasing the knowledge of health workers especially the lower level cadres in the remote areas. NAPAC as a portal for real-time knowledge transfer to health workers should be given funding priority hence making the treatment and care of HIV/TB easy. There has been decrease in the number of calls since funding reduced to the call centre from 250 calls to 136 calls (45% reduction)
Age at first HIV test and sexual risk behavior among adolescents and young people in Abia and Taraba: Implications for HIV prevention

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Background: Over 80% of adolescents living with HIV globally, live in Sub-saharan Africa with limited access to care and treatment. As efforts are ongoing to improve treatment coverage, it is agreed that prevention remains crucial in winning the battle against HIV/AIDS. In this abstract, we present findings from a review of data on adolescents and young people attending facilities in Abia and Taraba states to improve prevention programme.

Methodology: Programme data from 2014-2017 was reviewed for adolescents and young people, accessing services from 6 facilities, located within both urban and rural settings, from Abia and Taraba states in Nigeria. Data was extracted on clients’ demographics, HIV testing history and HIV risk assessment.

Results: Two thousand, two hundred and fifty one (2,251) case records were retrieved, 720 records were incomplete. Sixty percent of the clients were from Taraba state. 34% were males and the rest females. The mean age of the clients were 19.7 years, range 10 - 24 years. 54.5% were first time testers for HIV. The mean age of first time testers was 19.5 years while the mean age of re-testers was 20.5 years (p=0.01). 54% of the total population were sexually active. About a third of them were not sexually active with a mean age of 18 years. 10.6% had unprotected sex with a casual partner in the last 3 months and about 35% had unprotected sex with a regular partner within the last 3 months. 2.5% had a history of STI and 11.6% had more than one sexual partner in the last 3 months. At the time of testing, 6.6% were identified HIV positive.

Among first time testers - 62% were sexually active compared to 74% of re-testers (p=0.002). 21.2% of re-testers compared to 12% of first time testers had unprotected sex with a casual partner (p=0.000). While 31% of re-testers as opposed to 10% of first time testers, had more than one sexual partner in 3months (p = 0.000). About 35% of both groups had unprotected sex with a regular partner (p = 0.354).

Conclusion: This review reveals a high level of misconceptions and unsafe sexual practices about HIV among AYPs. About a third engage in unprotected sex with regular partners assuming faithfulness and re-testers are two times more likely to have unprotected sex with a casual partner and three times more likely to have more than one sexual partner. Thus HIV prevention messages and programmes targeted at AYPs need to prioritize sexual risk behaviour modifications, emphasizing the need to stay negative, having tested negative.
Enhancing Psychosocial and ART support among children living with HIV at Baylor College of Medicine Children’s Foundation Malawi (BCM-CFM) Clinic through HIV disclosure

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Background: Disclosure is the process of sharing information about a person HIV status with others. As adolescents living with HIV (ALHIV) gain independence over their self-care and begin to engage in sexual relationships, their experiences of being informed about their HIV status and of telling others about their HIV status may affect their ability to cope with having the disease. As one way of enhancing self-care and adherence to ART among ALHIV, BCM-CFM realised the need for a formal disclosure process.

Method: Disclosure is Process not an event and is done by psychosocial workers, peer supporters and social workers using little soldier books. There are two types of disclosure, partial and full disclosure. Partial disclosure is appropriate for the younger children between 6 to 9 years where information about their condition is given without using the words HIV or AIDS and is an effective strategy to help caregiver who do not feel ready for full disclosure. Full disclosure usually happens by the time a client is 10 years or above, this is when a young adolescent is told that he or she is HIV positive and given further HIV related details.

Results: From January 2016 to December 2017, teens were 1772 (834F 938M) fully disclosed at BCM-CFM and teens were 940 (420M 520F) partially disclosed within the same period. This has increased the number of teen club enrolment at BCM-CFM with as 90% only fully disclosed teens are eligible for teen club enrolment hence majority of the teens have access to comprehensive psychosocial service offered during teen clubs.

Conclusion: Disclosure also reduces level of anxiety, depression, and low self-esteem in adolescents hence this promotes adherence to ART and it is greatly powerful as it assist adolescent to improve access to treatment, care and positive living.
A Stakeholder Mapping Plan for Implementing an Adolescent Programme in a Low Socio-Economic Community in Cape Town

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The Good Participatory Practice (GPP) guidelines provide a framework for development of effective stakeholder engagement programmes. The goal of effective stakeholder engagement programmes is to build mutually beneficial, sustained relationships between trial funders, sponsor and implementers and their stakeholders. Stakeholder mapping is a key part of successful stakeholder engagement for a project of this magnitude, with maximum impact. In partnership with the Western Cape Department of Health (WCDoH) and funded by the Global Fund to Fight Aids, Tuberculosis and Malaria, the Desmond Tutu HIV Foundation launched The Zimele Project, a unique multi-dimensional health and social intervention programme for our youth aged 10-24 years. The programme is designed for 20 000+ participants in and out of school and will run for 2 years in the Mitchell’s plain/Klipfontein health sub-district. The four steps below outlines the stakeholder mapping plan used for the Zimele Project.

Identify. Step one is stakeholder identification. A stakeholder is identified as anyone that has an interest in the outcome of a project or process. Projects can be delayed or sidetracked if key stakeholders are not identified, so at the outset of a project it is important to identify stakeholders. This project generate a large community of interest and their impacts can be far reaching. Stakeholders fall into two main categories – those who contribute to a project, and those who are affected by a project. The key Contributing Stakeholders (CS) identified are the Global Fund, as the funder and the WCDoH as the principal recipient who in addition provided the M&E and support functions. Additional CS partners are the Western Cape Education Department, via the 90 schools and the City of Cape Town via the 24 health facilities and community amenities used to host events. The Affected Stakeholders (AS) were the more than 10 000 beneficiaries to date. In addition, multiple community partners and service providers, who were identified to implement specialised components of the programme, are both CS and AS.

Analyse. The next step is stakeholder analysis which involves defining stakeholders’ roles and expectations. Some CS and AS stakeholders had the potential to generate a much greater impact on the project than others. For the Zimele Project, we used an Influence-Interest Matrix (IIM) allowing us to logically map stakeholders according to their influence and interest in the project.

Prioritise. The third step is prioritisation of stakeholders. Once we analysed our stakeholders according to the IIM, we could prioritise their needs. By categorising stakeholders we were able to map them into appropriate engagement levels (e.g.) did we need to Manage them closely; Keep them Satisfied; Keep them informed or Monitor them?

Engage. The final step in the process was the actual engagement with our key stakeholders and to win their support and understanding. This took on different forms and became the basis of our Communications and Reporting Plans with all concerned.

We understood that our stakeholder status changed, we therefore reviewed and updated our analysis and prioritisation needs to be regularly for the duration of the project.
Engaging AYP’s through the provision of comprehensive HIV prevention services

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Background: Globally, there are over 1.8 billion Adolescents and Young People (AYP). In 2012, the global estimate of AYP living with HIV was 5.4 million. In 2012, an estimated 780,000 youth aged 15–24 were newly infected with HIV. In Nigeria by 2014, about 19,000 AYPs did not know their HIV status. To address this gap, the Federal Ministry of Youth Social Development (FMYSD), State Agencies for the Control of AIDS (SACAs) and Civil Society Organizations (CSOs), were engaged by National Agency for the Control of AIDS (NACA) through the World Bank HIV Prevention Development Project (HPDP II), to provide comprehensive HIV services for AYPs.

Method: The World Bank HPDP II, through NACA supported FMYSD to provide comprehensive HIV prevention services to young persons. The Federal and State Ministries of Youth and Sports provided HTS to out-of-school populations and also supported (NYSC members on establishing anti-HIV/AIDS Community Development Services (CDS). The ministry conducted outreaches and 203,131 youths were counselled and tested for HIV. 2,555,685 condoms were also distributed (1,919,345 male and 557,308 female). 12,941 NYSC members were trained on HTS in 32+1 states. Eighty-four (84) state HIV desk officers of Ministry of Youths (MOY) received training on reviewed HTS tools. 22 NYSC & State Ministry of Youth HIV schedule officers were trained on coordination of out-of-school youths HIV prevention activities. SACAs and CSOs also provided HIV Testing outreaches in states for out-of-school youths. During these outreaches, 246,788 youths got counselled, tested and received result from Anti-HIV/AIDS CDS groups. Out of these outreaches, 1,835 positive cases were identified and referred to healthcare facilities for treatment and retention in care services. 20 out-of-school youths were trained as counselors and testers in the FCT.

Lesson Learned: There was strengthened coordination mechanisms between FMYD & NYSC for effective coordination of out-of-school youth and other youth related activities. Positive AYPs were linked to care and capacity building was provided to peer leaders and health care workers to mitigate stigma and discrimination. Involvement of AYPs in planning activities resulted in increased uptake of services. Mechanisms were strengthened between Engagement with government, health care workers, and peer leaders resulted in a successful AYP program.

Next step: It is presumptuous to think that HIV interventions targeting the general population will meet the needs of the AYPs. Adolescents need appropriate and accessible services that recognise and support their needs as they transition from childhood to adulthood. Improved patients’ quality of life and optimal adherence are crucial to ART program success and achieving HIV epidemic control. NACA to increase efforts in providing services that seek to empower adolescents and young people thereby creating a ripple effect that will decrease their vulnerability to HIV risk factors and increase their access to HIV prevention, testing, treatment and adherence thus improving the quality of life of AYP PLHIVs.
The role and benefits of peer support in Mityana hospital a public hospital

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Introduction: Peer educators are key people in the support and provision of service to adolescents and young people that are living positively, this helps ALHIV to come together and share experiences that assist them manage their lives responsively. This is to help describe the benefits of having peer educators in Mityana Hospital.

Program description: After a training that was carried out in Mityana for 4 peer educators by Mildmay Uganda under the unfinished business, the peer support services were strengthened to include adherence support groups both in and outside that hospital, involvement of adolescents living with HIV to make informed decisions about their health. Adolescent clinic days were streamlined and appointment days given according to age groups for; example those between the age of 10-14 years come for their appointments on the second Thursday of the month and the older adolescent come for their appointments on the last Thursday of the month, they are then added into the adherence groups/club of their choices by the peer educators who also mentors other adolescents to take on the roles of leading the different clubs, these clubs/groups have members that are fully aware of their status, that is to say they have been fully disclosed to, these groups normally have a joint meeting every holiday depending on the program. Topics and themes are normally chosen with the support of the peer educators, well recorded on top of the daily attendance book and pined-up for all health workers to be aware of the programs, Entertainment include educative storytelling, sharing experiences and songs, the in facility club meetings are scheduled according to the clinic days; adolescents are selected to give health education and act as role models during counselling sessions, they are actively involved to encourage good adherence and reduce stigma and discrimination through giving testimonies.

Lessons learned:
• Most adolescents are actively involved in their own health for example, they are able to personally ask for their viral load results which was not the case before unfinished business.
• Older adolescents have really benefited from the sexual reproductive health education by getting honest answers to their questions.
• Peer support activities lead to adolescents having responsibility about their lives and making informed decisions.

Conclusion: Peer supporters have significant roles to ALHIV. They could be in position to assist in fighting stigma, assist in supported disclosure, improving adherence to drugs among ALHIV and better health outcomes.
Improving ART initiation in adolescent and young men with same-day ART in KwaZulu Natal, South Africa


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Background: In South Africa, research has demonstrated that young men are less likely to get tested for HIV, start antiretroviral therapy (ART) or remain on ART compared to women. According to the Thembisa model, data from KwaZulu Natal shows that an estimated 84.5% of men knew their status (vs. 90.6% of women) and 47.9% of men who know their status were on ART (vs. 59.3% of women) in 2015. Interventions to increase access to and uptake of HIV testing and ART in HIV-infected young males are needed in South Africa. Providing same-day ART may increase access to ART for young men who may not return for multiple pre-ART sessions, however, retention in care may be lower in men following same-day ART.

Methods: BroadReach has supported the Department of Health in KwaZulu Natal Districts of Harry Gwala, King Cetshwayo and Ugu to offer same-day ART since September 2016. We evaluated the impact of same-day ART on improving access to ART for young men <35 years old by comparing the proportion of young men initiating ART through same day ART vs. non-same day ART and the association between same-day ART and loss to follow-up (LTFU) and viral suppression (<400 copies/mL) in young men who initiated same-day ART between January and December 2017 who had a diagnosis date on file.

Results: In total, 4138 men initiated ART in the three Districts in 2017, of whom 2357 were younger than 35 years old (57%). Overall, 1780 men initiated on the same day as diagnosis (43%); the highest proportion of same-day ART was in 15-24-year-old young men (46%) and the lowest proportion was in the <15 year group (37%). Overall LTFU was significantly higher in men <35 years old who initiated same-day ART vs. non-same day (17.4% vs. 14.5%; p=0.001). Viral suppression was higher in the same-day ART group of young men <35 years compared with the non-same day ART group (90% vs. 85%; p<0.05); there was no difference in young females. When comparing with the previous year, more young men initiated ART following the introduction of same-day ART. In 2016 only 1203 men <35 years old initiated ART in these three Districts, compared with 2261 in 2017, an 88% increase (vs. 52% in young females in same time-period).

Conclusion: Same-day ART initiation was one of the key interventions and was an instrumental factor in increasing access to ART in young men and resulted in a improvement in viral suppression. Same-day ART should be actively scaled up in all other facilities in KwaZulu Natal and beyond. Same-day ART initiation has improved access to ART in young men, though more work is needed to improve retention in care in high-risk, mobile men in KwaZulu Natal and other high HIV prevalence communities.
Identification of HIV infected children and adolescents through support to private health facilities in Rwenzori region, Uganda

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Background: The private sector has increasingly become a popular source of health care in Uganda yet HIV counseling and testing interventions are majorly supported in the public health sector. Baylor Uganda set out to provide high quality HIV counseling and testing services (HTS) at private for profit health facilities (PFPs) to increase the opportunity for identification of HIV infected children and adolescents.

Methods: In the period July – December 2016, Baylor-Uganda identified 18 PFPs in four districts in Rwenzori region Uganda where the following interventions were put in place: Free HTS for children and adolescents 2-19 years, orientation of Health workers at the PFPs on national standards for testing children including use of the national HTS eligibility tool and facilitation of referrals through phone calls to referral Antiretroviral treatment accredited sites. The PFPs were supported to report their HTS data through the national HMIS. Baseline data on paediatric and adolescent HTS from the 18 PFPs for the period before the intervention (October 2015 – March 2016) was obtained from the national HMIS and compared with data in the intervention period (July 2016-December 2016).

Results: A total of 345 children (45% female) and 1074 adolescents (57% female) received HTS between October 2015 and March 2016 compared to 2463 children (50.1% female) and 2496 adolescents (61% female) during the intervention period. Three children (33% female) and 20 adolescents (60% female) tested HIV positive between October 2015 and March 2015 compared to 28 children (71% female) and 31 adolescents (85% female) during the intervention period. This correlates to a 156% increase in the number of children and adolescents that tested HIV positive between the two periods. The positivity was 1.6% before the intervention period and 1.2% in the intervention period. Linkage into care in the intervention period was at 97% compared to 74% before the intervention period.

Conclusion: Identification of HIV positive children and adolescents more than doubled using simple innovative approaches of HTS at private for profit health facilities. An improvement in linkage into care was also observed. The PFPs however need to be supported to provide sustained quality HTS.
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Lessons from service delivery: The nuts and bolts of providing adolescent peer support in low-resource settings

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Background: WHO recommends peer support for adolescents and young people living with HIV (AYPLHIV). Peer support enables providers, programmes and services to be more responsive, acceptable and sustainable, encouraging AYPLHIV to seek and remain in care.

Materials and Methods: Since 2015, Paediatric-Adolescent Treatment Africa (PATA) has implemented the Re-Engage Adolescents and Children with HIV (REACH) programme, which supports young people living with HIV age 18-24 years to task-share HIV service provision with professional health providers for their AYPLHIV peers. REACH is implemented in 20 health facilities across six sub-Saharan African countries. Each facility manages implementation according to the particular needs of its adolescent population, operations and national policies. Since REACH’s inception, PATA has monitored service delivery and aggregate patient outcomes at REACH facilities, as well as facility-specific implementation models. We have systematically gathered qualitative acceptability data from providers, peer supporters and adolescent patients. The lessons drawn from these multi-year analyses are presented here.

Results: Peer supporters support age-matched AYPLHIV and/or serve as near-peers to younger patients. In all cases, the aim is to ensure empathic support and share positive coping strategies. Most effective peer supporter duties include peer education, basic psychosocial and adherence counseling, and recognizing signs of poor coping and trauma requiring referral to professional support. Peer supporters require training on HIV treatment literacy, sexual and reproductive health and rights, counseling, group facilitation, communication and documentation.

Oversight and management are critical for quality assurance including in-service supervision, performance review and mental health support. Access to job aides, supportive materials and feedback from health providers and patients are necessary. Peer supporters’ meaningful engagement with health providers helps providers to appreciate the value of the peer supporter role, and proactively facilitates its integration into health facility structures and activities while advocating for adolescent-friendly health services.

Policies barriers in several countries limit lay providers’ role in HIV service provision and thus potential scale-up. Where not a formal cadre, peer supporters must have clear role descriptions, defined accountability, compensation and workplace protections. Conditions of service should be harmonized with the most comparable cadre. Their scope of work and supervision require clear boundaries that respect their limited training, young age and heightened vulnerabilities.

Peer supporters gain leadership and capacity-building opportunities, helping to combat self-stigma. However, because young peer supporters age out of the youth category, it is important to link them to skills-building, livelihood strengthening, career development and mentorship opportunities throughout their service term.

Conclusions: Peer support programmes are a critical strategy to improve adolescent-friendly health services. Young peer supporters can fulfil an important role in raising awareness and challenging stigma within health facilities, enhancing quality of AYPLHIV services, and contributing to a responsive environment for improved outcomes for AYPLHIV.

Policy and operational complexities are inherent in integrating lay cadres of AYPLHIV into health systems. While it may not be possible to establish a professionalized peer supporter cadre in all national systems, ensuring basic needs are met and implementation standards upheld will help to ensure quality at scale.
Monitoring viral load coverage and viral suppression rates in contributions to reaching the 3rd 90 among adolescents living with HIV in Nigeria; The FHI 360 Nigeria Experience

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Introduction: Viral load (VL) coverage and viral suppression (VS) rates are much lower in children and adolescents compared to adults. These poor indices are usually due to low uptake and demand of VL-services by clients or poor service delivery by care-providers. In Nigeria, an analysis of factors contributing to low VL coverage and VS rates among adolescents living with HIV (ALHIV) were attributed to client-related factors; poor VL-literacy among ALHIV and their caregivers, poor ART-adherence, religious/cultural biases, inaccurate client contact-details, and health-facility/reference-laboratory factors; inefficient triage systems for VL-eligibility determination, suboptimal awareness for VL-prescription among care-providers, inadequate human-resource capacity for sample-collection, preparation, and transfer to laboratories for analysis, reagent stock-out, equipment-downtime, power-outages, inadequate sample storage-capacity and short duration of lab-uptime leading to long turnaround time (TAT) from sample-collection to availability of VL-results for decision making by care-providers. Evidence shows that differentiated-care and efficient data-use improves health-outcomes for ALHIV. This paper describes lessons learned (challenges and solutions) from implementing VL-services among ALHIV enrolled on the Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) project, for HIV-care and treatment in 13 Nigerian states.

Methodology: The SIDHAS project, implemented by FHI 360, is a PEPFAR/USAID-funded project whose goal is to sustain cross-sectional integration of quality HIV/AIDS/TB services in 13 Nigerian states. A total 7435 (4454 females; 2981 males) ALHIV (10-19 years) were identified, linked to HIV-care and treatment and monitored for improved VL-coverage and VS-rates between October 2016 and September 2017. ALHIV were provided with differentiated-care by trained case-managers and counsellors who provided targeted/focused client-education and treatment-support to clients/caregivers. Case-managers tracked through phone-calls, SMS-reminders, home-visits, and provided intensified adherence-counselling support at treatment-initiation and for ALHIV with unsuppressed VL-results. Specific ART-adherence challenges e.g; inability to take medications while in boarding-schools, due to bad-taste and forgetfulness/playing were addressed for younger-ALHIV (10-14years) and concerns of transition to adulthood for older-ALHIV (15-19years). ALHIV were linked to HIV Support-Groups and with ‘Positive Connections Guide’ empowered with knowledge and skills on HIV-management. Conducted clinical-audits to determine coverage rates, colour-coded client’s folders for differentiated-care, optimized the triage-process, leveraged on electronic management records to optimize eligibility assessments, mentored care-providers on VL-services and published VL SOPs to clarify roles and encourage standardized care by care-providers. Reference-laboratories were supported with sample-collection, mitigated human resources issues, procured high-capacity centrifuges and solar-freezers, ensured efficient sample-transfer and continuous reagents supply. Facilitated effective VL-result documentation, alerting care-providers promptly for clinical decision making thereby reducing long-TAT. Facilitated drug switches for ALHIV with unsuppressed VL-results.

Results: VL coverage increased from 8% in October-2016, to 26% in March-2017, and to 43% in September-2017. VS rates (VL-results ≤ 1000 copies/ml) improved from 55% (n=179: 102-females; 77-males) of total 324 ALHIV tested for VL at baseline, to 78% (n=667: 360-females; 307-males) of total 853 ALHIV tested at end-line. TAT for VL-services improved from 8 to 3 weeks.

Conclusion: Program data showed improvement in VL coverage and VS rates among ALHIV enrolled on the SIDHAS project. The identified interventions that work best should be scaled-up in contribution to the HIV continuum of care for ALHIV in Nigeria.
Innovations to increase identification of HIV-infected adolescents in Nyanza, Kenya

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Background: Improving HIV diagnosis among adolescents is critical in enhancing their access to HIV treatment. In 2015 in Kenya, only 49.8% adolescents knew their status, young people 15-24 years contributed 51% of new adult HIV infections. Studies have shown that some unidentified, untreated HIV-infected children may survive beyond 10 years; and AIDS related ailments is the leading cause of death among adolescents in Kenya. Limited data exists on best strategies to identify HIV-infected adolescents. Between September 2017 and March 2018, EGPAF Kenya piloted 4 HIV testing strategies targeting some vulnerable groups of adolescents in 36 sites. Those targeted included: adolescent children of deceased adults with known HIV status, adolescent siblings of adolescents on ART, adolescent sexual partners of adolescents on ART and adolescents in fish landing beaches.

Materials and Method: EGPAF trained 144 (HTS) providers, sensitized the other HIV service providers and HIV coordinators on the approaches. We developed index case contacts’ registers for active and deceased clients. HIV service providers were instructed to pull records of clients who died in the past 2 years and document eligibility of their adolescent children. The Providers also collected information on adolescents’ sexual partners and siblings and documented eligibility. EGPAF supported HIV testing for eligible contacts at facility or at home with consent. EGPAF dedicated trained HTS providers in 3 fish landing beaches, mobilization was during beach management unit (BMU) meetings by HTS providers, peer educators and beach management officials. Testing was done at the beach. Close to 100% of the adolescents tested HIV positive through the above strategies were initiated on ART. We conducted a descriptive analysis of data on HIV tested and positivity by strategy. We also collected information for adolescent positivity through PITC in the same sites.

Results: 547 adolescent children of deceased index clients were tested with 25 testing positive (4.6% positivity). 258 of them were male and 289 female, with 12 male positives and 13 female positives (4.7% and 4.5% positivity respectively), no significant difference by gender. 794 siblings of adolescents on ART were tested with 23 testing HIV positive (3%); 278 of them were male and 4 tested positive (1.4% positivity), 516 were female with 19 testing positive (3.7%); big difference by gender. 303 adolescent sexual partners of HIV infected adolescents were tested with 8 positives (2.6%). And 383 adolescents were tested at the beaches, 14 tested positive (3.7% positivity); no big difference in positivity by gender (boys had 3.9% positivity and girls 3.5%). Adolescents PITC in the same sites was 0.9%

Conclusions: We hypothesize that deceased index cases may have presented with advanced HIV disease, and less likely to have disclosed their status, hence high positivity amongst their adolescent children and their children missing testing early. Adolescents have not been traditionally used as index clients; testing adolescents’ siblings and sexual partners yielded higher positivity compared to testing of children of adults on ART gave 1.5% positivity. Beach testing is an opportunity for reaching adolescent girls and boys, at risk of HIV acquisition, beyond the health facilities.
Lessons Learned from Partner Notification Services as a Window of Opportunity in reaching UNAID’s First 90 among Adolescents in Nigeria

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Introduction: The prevalence of undiagnosed HIV among adolescents is high and therefore still poses as a barrier to reaching the first 90 of the UNAIDS 90-90-90 targets among this sub-population. Partner notification services (PNS) are part of a comprehensive HIV testing service (HTS) package and hence a critical approach for HIV identification and subsequent linkage of positives into the HIV care and treatment cascade. Evidence shows that contact tracing through sexual network testing is an effective mechanism for HIV identification. This paper describes the pattern of HIV identification and linkage to ART among adolescents offered PNS in a USAID-funded project - Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS), implemented by FHI 360 in Nigeria.

Methodology: A descriptive retrospective study of PNS implemented among HIV-positive adolescents in 202 PEPFAR supported health facilities across 13 states in Nigeria. The period of study was from October 2016 to June 2018. PNS was offered to HIV positive adolescents (15 – 19 years) who were identified as index clients in SIDHAS supported facilities. Case managers were engaged and trained by the project to work with facility staff to track sexual contacts of the identified HIV-positive index clients in the communities. Sexual contacts of these index clients who were successfully reached either through home visit or by phone call, were offered HTS as part of the comprehensive package. Those identified as HIV-positives were linked to care and HIV treatment in supported facilities.

Results: A total of 446 (Males =68; Females=378) adolescents living with HIV (ALHIV) were identified as index clients. Out of the total index cases identified, 74.8% (n=334; Males=60; Females=274) agreed to partner notification. With a partner elicitation quotient of 1:0.5 (i.e. less than one sexual contact elicited from an ALHIV index case); 277 (Males-99; Females-178) sexual contacts elicited, were in the adolescent age group (15 – 19 years). Of these, 151 (Males=100; Females=51) of the adolescent sexual contacts accepted HTS, with a HIV testing uptake of 55%, and a yield of 24.5% (n=37) The adolescent partners of the index cases who tested HIV positive were all successfully linked to ART.

Conclusion: The study results indicate that a high yield of HIV-positive adolescents was elicited from HTS and PNS services offered to sexual contacts of HIV-positive index cases. Though there are yet to be defined programs with respect to Partner Notification Services targeted at adolescents, a big opportunity exists in using PNS to increase HIV identification and subsequent linkage of HIV-positives to treatment among the adolescent age group.
Promising practices for adolescent’s HIV services: Experience from Tanzania

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Background: Tanzania is among the 23 global priority countries to scale up HIV prevention and treatment access for adolescents and young people, and is also a home to an estimated 200,000 adolescents living with HIV (ALHIV). National data suggests low rates of ART initiation for adolescents and young people living with HIV (50 per cent), low ART retention (60 per cent) with high loss to follow up (32 per cent). Furthermore, data from the THIS 2017 shows low access and uptake for HIV testing among adolescents and young people (39 per cent), and a 2 times higher HIV prevalence in adolescent’s girls, (1.0) than their male counterparts (0.4) for age group, 15-19 yrs.

In Tanzania, there are several organizations which are providing HIV testing, care, treatment and support for ALHIV. However, most of these efforts are done at a smaller scale and are not well analyzed or documented. An analysis and documentation of promising interventions for ALHIV is needed to inform local efforts for program managers and policymakers to support the scale up of interventions that work and inform investments to achieve 90-90-90 targets for accelerated HIV services for adolescents living with HIV.

Materials and Method: UNICEF supported the identifications and documentation of the promising practices for ALHIV between November, 2017 and April, 2018. ALHIV programs with at least 5 out of the following criteria; 1) Effectiveness 2) Applicability 3) Sustainability 4) Replication 5) Ethical Consideration 6) Political Obligation 7) Community/Beneficiary engagement, were included. Interviews with ALHIV were also conducted to get their opinions and experiences on services for ALHIV.

Results: Case finding for ALHIV: Targeted peer supported and community engagements maximizes identification of ALHIV:
1) PEER Supported testing initiatives in the lake zone regions (medium prevalence) identified 3,277 (1.7% yield) among 187,409 adolescents tested for HIV from Oct 16 – Sept 17.
2) Targeted community testing in the Southern Highland (High prevalence regions) identified 1,184(5.6% yield) among 21,234 adolescents who were tested for HIV, all were linked to care and 1,065(95%) were started on ART.
3) School based testing identified 12 (2%) HIV infected adolescents among 599 adolescents tested through school’s health events, all were referred and started on treatment.
4) Community testing for vulnerable population adolescent’s girls in (medium prevalence regions) identifies 357 (1.6%), 66% (236) were linked to care and (231)97% were started on treatment.

Psychosocial Support Clubs (PSS): Health facilities with adolescent clubs improved retention, wellbeing and viral load outcomes for ALHIV. Facilitated active participation of ALHIV, generated demand for improved SRH/HIV services and they wanted to be involved in service delivery.

Conclusion: Several promising interventions are ongoing for ALHIV in Tanzania; the right mix combination of community, facility and peer led intervention is needed to inform the best approach for increased enrollment and retention in HIV programs. More nuanced approaches are needed for young, older and adolescent’s key population. Costing information on the interventions is needed to inform governments standardization, adaptation and scale up to improves ALHIV services for adolescent boys and girls.
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Optimizing targeted testing to improve HIV case finding among adolescents in Rwenzori region, Uganda.

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Background: The national Anti-retroviral therapy (ART) coverage among adolescents (10 – 19 years) is low as only 40% of those eligible are on ART. This is attributed to the low identification through HIV testing services (HTS) as well as low linkages into HIV care. Finding these adolescents is critically needed to meet the country’s 95-95-95 goals by 2020. To address this gap, Baylor Uganda implemented targeted facility and community interventions to improve case finding for adolescents living with HIV in 5 districts of Rwenzori region. We determined the HIV yield from these models.

Methods: In the period April 2016 – March 2017, we implemented the following targeted HTS interventions; provided capacity building for health workers to strengthen provider initiated HIV testing and counselling (PITC) at key entry points (i.e. outpatient department, inpatient wards, Tuberculosis, malnutrition, index client testing, young child clinic (YCC)), strengthened use of a screening tool for HTS eligibility, provided HTS at convenient hours for the adolescents (evening and weekend HTS), provided HTS for adolescents at private for profit health facilities. Data in the pre intervention (April 2015 – March 2016) was compared to data in the post intervention period (April 2016 – March 2017).

Results: A 35% increment in HTS uptake for adolescents (15 – 19 years) from 43,051 to 58,217 was observed during the implementation period. Similarly, a 109% increment was obtained in the number of adolescents identified from 420 to 880 in the implementation period. The overall yield was 1.5% (880/58,217) in the implementation period, an improvement from 0.9% before the interventions. Testing yields from the different interventions included: PITCT from key entry points (inpatient department 1.1% (21/1934), Outpatient department 3.4% (621/18075), Nutrition unit 2.9% (4/140), index client testing 1.9% (9/475), tuberculosis unit 12.5% (1/11), YCC 0.9% (19/2209), Outreaches 0.7% (38/5043)), Flexi hour testing for adolescents 0.8% (85/10,604), testing at private health facilities 1% (33/3300).

Conclusion: Identification of adolescents living with HIV more than doubled through strengthened HTS both at health facility and community level. Although the highest yield was obtained from the tuberculosis unit, the highest absolute numbers identified were obtained from outpatient department while the lowest yield was from outreaches. There’s need to strengthen screening for HTS eligibility during these outreaches to improve yield.
Retention of HIV-Positive Adolescents in Care: A Quality Improvement Intervention in Mid-Western Uganda

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Background: Low retention of HIV-positive adolescents in care is a major problem across HIV programs. Approximately 70% of adolescents were non-retained in care at Katooke Health Center, Mid-Western Uganda. Consequently, a quality improvement (QI) project was started to increase retention from 29.3% in May 2016 to 90% in May 2017.

Methods: In May 2016, we analyzed data for retention, prioritized gaps with theme-matrix selection, analyzed root causes with fishbone diagram, developed site-specific improvement changes and prioritized with countermeasures matrix, and implemented improvement changes with Plan-Do-Study-Act (PDSA). Identified root causes were missing follow-up strategy, stigma and discrimination, difficult health facility access, and missing scheduled appointments. Interventions tested included generating list of adolescents who missed scheduled appointments, use of mobile phone technology, and linkage of adolescents to nearest health facilities (PDSA 1), Adolescent Only Clinic (PDSA2), and monthly meetings to address care and treatment challenges (PDSA 3).

Results: Retention increased from 17 (29.3%) in May 2016 to 60 (96.7%) in August 2016 and was maintained above 90% until May 2017 (with exception of February and May 2017 recording 100% retention levels).

Conclusion: Context specific, integrated, adolescent-centered interventions implemented using rigorous QI initiatives significantly improved retention in Mid-Western Uganda. In particular, tracking adolescents who missed clinic appointments, linkage of far adolescents to nearby health facilities, startup of adolescent only clinic, and tackling of adolescent HIV care challenges via meetings improved retention. We recommend the replication of these interventions at health facilities facing similar challenges in Uganda and beyond.
Building capacity for sub-national data driven programming.

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Background: To better understand and improve the HIV response for adolescents and young people, Botswana initiated the ALL IN country assessment in 2015. The initial phase I rapid assessment identified priority populations, interventions and districts for accelerated action and supported the development of a new Programming Framework for Adolescents and Young Adults. Given the limited available data and the geographic disparities across HIV, social, demographic and service delivery indicators, a better understanding of the gaps in planning and programming for adolescents and young people (AYP) in each of the selected districts was needed to not only strengthen sub-national planning but to also ensure successful implementation of programmes and outcomes for adolescents.

Methods: The ALL IN phase II in-depth bottleneck analysis was carried out in four districts selected based on the basis of HIV prevalence, socio-economic and other contextual factors and past performance on priority interventions (HIV testing and counselling; anti-retroviral treatment; condom access and use; VMMC; gender based violence; alcohol and drug abuse and other psychosocial issues). Data on key indicators related to supply, demand and quality of these interventions was collected and analysed. A causality analysis was undertaken to further identify and understand bottlenecks and performance gaps and key actions for programmatic acceleration.

Results: Large gaps exist in AYP accessing HIV testing services (HTS), treatment and condom use. However, those identified as having HIV are successfully on ART, while limited adherence data is available. Across all districts gender gaps exist with young men not accessing HTS and therefore not starting treatment. Bottlenecks identified by stakeholders included limited access to adolescent sexual reproductive health services (ASRH), low utilization of HTS services, especially among young men and a high proportion of AYP living with HIV not yet identified and put on treatment. Key actions identified to address existing barriers and bottlenecks include development and delivery of quality HIV and SRH services targeted to AYP, meaningful engagement and participation of AYP in policies and programmes, strengthened partnerships with community based organizations, making schools work for adolescent health and well-being and strengthened strategic information. Phase II additionally strengthened the capacity of planners, programmers and service providers to implement data-driven HIV programming through improving understanding of AYP programming and importance of age, gender and sub-national data.

Conclusions: The in-depth bottleneck analysis provided valuable evidence and insights to inform future sub-national level and national HIV programming for AYP. Four key areas were identified as broad pathways to a more equitable and effective response: information, integration, investment and involvement. Working together, guided by the evidence and district level analyses and solutions, Botswana can accelerate progress in preventing new HIV infections and AIDS related deaths among adolescents and young people and achieve its goal of ending AIDS.
Adolescent after hours and weekend “happy hours” contribute to increases HIV testing, yield and ART initiations in KwaZulu Natal clinic

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Background: South Africa has the highest number of HIV infected adolescents worldwide, most of whom acquired the virus through a combination of vertical and horizontal transmission (1). Adolescents, particularly girls and young women aged 15 – 24, have a high incidence of new HIV infection (2). The South African National Adolescent and Youth Health Policy of 2017 recommends HIV treatment services to provide creative ways to support the health and wellbeing this population. The District Health HIV&AIDS Disclosure Programme in KwaZulu-Natal Province programme focuses on diagnosing and treating HIV positive adolescents living with HIV or already on ART to improve how they navigate challenges of living with HIV by providing holistic interventions.

Methods: BroadReach supports the Department of Health in King Cetshwayo District in KwaZulu Natal, South Africa. This adolescent and youth programme is run in health facilities after-hours, on weekends, and during school term breaks to improve access to HIV testing and treatment. This evaluation measured the impact of adolescent interventions in one public health clinic in King Cetshwayo by comparing results before the intervention (January - June 2017), during the intervention (July - December 2017), and after the intervention (January - June 2018). Adolescents aged 13-19 years were given opportunities to get tested for HIV after-hours during youth “happy hours” and those on ART were reached through the facility’s list of patients on ART to invite them to adolescent-friendly adherence clubs. A participatory approach involving group discussions, role plays, and ice breakers was employed. We evaluated HIV testing, treatment, and retention in care before and after the intervention in adolescents.

Results: Before the adolescent intervention, the health facility tested approximately 46 adolescents 13-19 years old in 6-months. HIV testing services to adolescents increased significantly and quadrupled after the intervention to testing 184 adolescents in 6-months (p<0.001). The yield of HIV positive adolescents also increased from n=5 (11%) in 2017 to n=23 (13%) after the intervention (p<0.05). However, ART initiation declined over time but was >100% of case finding indicating that there were pre-ART adolescents that needed to be initiated on ART. They initiated 31 HIV+ adolescents before the intervention and 38 HIV+ adolescents during and after the intervention. Proportion of adolescents on ART who were virally suppressed (<1000 copies/mL) increased from 75% before the intervention to 85% after the intervention. Retention of adolescents on ART improved from 37% being lost to follow up or transferred out after 12 months on ART to 22% a year later following the intervention.

Conclusion: Interventions to improve access to HIV testing and treatment services, especially after-hour and youth-friendly services are essential to reach at risk youth. Our interventions in KwaZulu Natal demonstrated effectiveness in significantly increasing testing and case finding as well as improving viral suppression in at risk adolescents.
Barriers and motivators of adolescents participating in DREAMS interventions in rural KwaZulu-Natal, South Africa: Perspectives of the adolescents, their grandparent carers and programme facilitators

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Background: Adolescent girls and young women remain very vulnerable to new HIV infections, despite the widespread availability of HIV testing, counselling and antiretroviral therapy. The Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) initiative, (a global partnership between the U.S. President’s Emergency Plan for AIDS Relief, Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, ViiV Healthcare and Gilead), was conceived to reduce new HIV infections in adolescent girls and young women in 10 sub-Saharan African countries including South Africa. We investigated the barriers and motivators for participation in DREAMS interventions among adolescents in the care of grandparents from the perspectives of the adolescents, their grandparents, and programme facilitators in rural KwaZulu-Natal, South Africa.

Materials and Methods: Drawing from a social ecological model (SEM), data were collected in three phases, from October 2017 to July 2018, using participant observation and repeat ethnographic interviews with DREAMS adolescent recipients aged between 13 and 19 years, their grandparent carers aged 50+ and programme facilitators. Adolescents were recruited through a DREAMS implementing partner offering individual and family HIV prevention programmes. Individuals were asked to share their perceptions and experiences regarding adolescents’ participation in DREAMS programmes. Written informed consent or child assent was obtained from all individuals before participation. All data were collected in isiZulu and audio-recorded, transcribed verbatim and translated into English. Analysis was conducted thematically.

Results: Forty interviews were conducted with 14 participants (6 DREAMS adolescent recipients, 6 grandmothers and with 2 programme facilitators). All the adolescents were recipients of one or two HIV prevention programmes from the DREAMS implementing partner. We identified individual, family/caregiver, community, and institutional-level barriers and motivators associated with adolescents’ participation in DREAMS interventions. Barriers identified include: (1) fear of sharing personal information in a group setting, (2) parental refusal, (3) community misconceptions, (4) competition between programmes, (5) exclusion of boys and older people, (6) peer pressure to withdraw, (7) timing for programme delivery, (8) dislike writing activities, and (9) ineffective recruitment strategies. On the other hand, motivators include: (1) enabling spaces to discuss HIV and sexual health issues between adolescents and their carers, (2) family support, (3) opportunity to test for HIV, (4) incentives, (5) accessibility, (6) trust in programme facilitators, (7) space for adolescents to meet away from home, (8) perceived positive behavioural changes, and (9) gaining HIV and sexual and reproductive health information.

Conclusions: Mitigating barriers and strengthening motivators could enhance adolescents’ participation in HIV prevention programmes. Findings offer valuable insights into implementing DREAMS interventions and inform future investments in adolescents’ health.
Improving ART Initiation among Adolescents in APIN supported health facilities in Lagos State, Nigeria.

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Background: Trends in new HIV infections have shown a decline in all age groups except adolescents aged 10-19 years. More alarming, AIDS has been identified as the number one cause of death among adolescents in Africa despite improved access to antiretroviral therapy. Nigeria has an estimated 240,000 adolescents living with HIV (ALHIV). This represents 13% of the global ALHIV burden, and is the second highest globally. In 2016, Nigeria had 220,000 new HIV infections with adolescents accounting for 16%. There is no current data on linkage to ART amongst HIV positive adolescents in Nigeria. A 2014 assessment of HIV positive children aged 0-14 years in Nigeria, reported an ART uptake of 20.5%. Condom use at last sex among girls was 38.1% and 46.1% among boys, with multiple sexual partners demonstrating an increased risk of HIV transmission. This paper seeks to determine the effect of strategies aimed at improving adolescent ART uptake as implemented in the APIN HIV program in 24 facilities in Lagos State.

Methodology: The strategies involved engagement of focal persons for the adolescent program in each facility, establishment of specialized adolescent HIV clinics or dedicated clinic days in facilities with high numbers of adolescents in care, identification, training and deployment of adolescents who were stable on treatment as peer educators, as well as establishment of adolescent clubs. Youth-friendly healthcare workers who are passionate about adolescent health were identified to act as focal persons for adolescents accessing care. They helped newly identified HIV positive adolescents to navigate the clinics, facilitated enrollment into care and treatment, and fast-tracked clinic visits. The specialized clinics and clinic days created a friendly environment focused on adolescent-specific issues. The peer educators supported health talks, linkage to ART and other services, coordinated adolescent support groups on site and via social media, and tracked those who had defaulted on clinic visits, drug pick-up, or viral load monitoring. Newly identified HIV-positive adolescents were followed up to ensure linkage to ART by dedicated peer educators and youth-friendly healthcare workers who utilized a client level linkage tracker tool to account for all clients. Monthly adolescent club meetings were coordinated and co-facilitated by the peer educators and youth-friendly healthcare workers to provide social and psychological support.

Results: Over a 6-month period (December 2017 to May 2018) of implementation of these strategies, there was a steady increase in ART linkage amongst ALHIV across the facilities from 75% in December 2017 to 89% in May 2018. However, in March 2018, there was a nationwide healthcare workers’ industrial action which had a significant impact on ART linkage dropping it to 64%. Following resumption of work, the linkage rose to 81% in April.

Conclusion: Improving linkage to ART among adolescents requires a multi-pronged approach and deliberate deployment of human, financial, and infrastructural resources. These should be tailored directly towards adolescent programs in order to increase ART uptake and improve HIV outcomes in this age group. The success of the adolescent HIV program will have a great impact on achieving epidemic control.
Improving retention and Viral suppression among HIV-Positive Adolescents in Care and Treatment

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Introduction: Adolescents living with HIV are a critical population having a high incidence of HIV, low retention and viral suppression, and high mortality, yet an underserved. This calls for targeted interventions for this group to turn the tide. Access to quality HIV care and treatment is critical to achieving viral suppression. Low retention of HIV-positive adolescents in care is a major problem across HIV programs. A variety of factors may facilitate or create a barrier for retention in care or becoming virally suppressed. The FHI360 project funded by USAID in Kenya had an average retention rate of 57% and viral suppression of 60% in select six high volume facilities. The project implemented a continuous quality improvement (CQI) to improve the retention and viral suppression to over 80% by June 2018.

Methods: In July 2017, we analyzed data for retention and Viral suppression in the six sites, identified and prioritized gaps along the 90-90-90 cascade, analyzed possible root causes through the fishbone diagram, developed site-specific improvement action plans in order of priority, and implemented improvement changes through the Plan-Do-Study-Act (PDSA) cycle. Some of Identified root causes from file reviews, and discussions with clients and providers were missing scheduled appointments, health care provider attitudes, stigma and discrimination, patient flow, having all age/sex populations seen together, and unavailability of services on weekends. The interventions undertaken by the project were; enlisting an adolescent champion to spearhead the change process in the facilities and training the adolescent champions and health providers on adolescent package of care, Establishment of Adolescent Only Clinic days or spaces, and establishment of adolescent support groups.

Results. Retention increased from 57% in July 2017 to 88% in June 2018, while the viral load suppression increased from 61% to 73% in the same time period. Viral suppression was even better among those who enrolled in psychosocial support groups at 91%.

Conclusion: Provision of integrated adolescent centered and friendly interventions using the continuous quality improvement model significantly improved retention and viral suppression among this population. Further studies are needed to prospectively assess the impact of adolescent-friendly services on these outcomes.
Getting to the 3rd 90: Adolescent HIV services and treatment outcomes in Lesotho

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Background: In 2016, the Joint United Nations Programme on HIV and AIDS estimated 1,800 adolescents were newly infected with HIV, in addition to the 12,000 aged 10-19 years olds already living with HIV. Lesotho has HIV prevalence of 25.6 % among adolescents and adults aged 15-59 years and lower viral suppression among younger adults (50.9% for females and around 52 % males aged 15 to 24 years LePHIA 2017). The Elizabeth Glaser Paediatrics AIDS Foundation (EGPAF) supported Lesotho Ministry of Health (MOH) in 2017 to establish adolescent and youth friendly services (AYFHS) in five supported districts to improve HIV services uptake among adolescents and young people (AYP).

Method: EGPAF recruited and trained 45 adolescent-specific staff; young nurses, psychologists, social workers, and Youth Ambassadors (YA) to provide mentorship and support to 118 health facilities (Sites have a combination of government staff alongside EGPAF-seconded staff).

At these sites, AYP are tested for HIV, initiated on ART and monitored for viral load by clinician trained on AYFHS. Psychologists and social workers manage adolescents facing treatment challenges, provide disclosure support to adolescents and jointly manage AYP who are found to be unsuppressed at their last viral load test. YA are a lay cadre that provide peer-demand creation, HIV testing, support group management, and non-professional clinical support. Services are provided on weekends or on dedicated adolescent days. Routine program data from 118 MOH-supported sites was analysed for AYP 10-24 years old from June 2015 to December 2016 before implementation of AYFHS and January 2017- June 2018 after implementation of AYFHS.

Results: Before implementation of AYFHS from June 2015- December 2016, 179,902 AYP aged 10-24 year tested for HIV , 7642 found to be HIV positive and 6,838 (89%) initiated on ART. 14,436 were AYP currently on ART, 1231(9%) AYP who completed a viral load test and 949 (77%) were viral suppressed.

After the implementation of AYFHS from January 2017- June 2018, 304,034 AYP tested for HIV, 7,678 found to be HIV positive and 9004(117%) initiated on ART. 19,827 AYP were currently on ART, 9317(47%) AYP who completed a viral load test and 7666 (82%) were virally suppressed.

Lessons Learned: More AYP were HIV tested since implementation of AYFHS (number of AYP’s HIV-tested nearly doubled between pre- and post-intervention measurements). Linkage to ART rates surged above 100% with overall of 117% after the implementation (numerator includes clients found to be HIV positive, clients with known positive status who had been lost to follow-up and are now being initiated on treatment and these have become greater than the number of people tested HIV-positive). Viral load uptake improved after implementation of AYFHS with suppression rates of 82% post-, from 77% pre-implementation of AYFHS.

Conclusion: Special models of care that are adolescent-friendly and include young people in service delivery can provide HIV services at scale successfully. HIV treatment is a long-term investment, requiring provider capacity, meaningful engagement of young people in their treatment, and strong monitoring systems to ensure that all gaps are filled and success is maintained.
Becoming men: HIV-positive adolescent boys’ adherence to ART during initiation/circumcision in the Eastern Cape Province of South Africa

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Background: Adolescent AIDS-related deaths in Southern Africa have tripled since the year 2000, while decreasing in all other groups. Girls and women are more likely to contract HIV, while men are more likely to die of AIDS-related illness due to harmful hegemonic masculine norms. Little is known about HIV-positive adolescent masculinities and how adolescent boys living with HIV engage with traditional and biomedical health services. Amongst Xhosa boys in the Eastern Cape Province of South Africa, traditional circumcision/initiation is a crucial rite of passage with myriad social, gendered, familial and spiritual meanings. Traditionally, during this time of initiation/circumcision, biomedicine taking is forbidden - posing a potential challenge for boys who rely on chronic medication.

Objectives: To explore the ways in which HIV-positive adolescent boys navigate medicines-taking during, and after, traditional initiation/circumcision in the Eastern Cape.

Methods: Conducted as part of the largest-known study of adolescents living with HIV (n=1059), this research engages life-course narratives and semi-structured interviews to explore participant beliefs, experiences and health behaviours, including medicines-taking during and after traditional initiation/circumcision.

Results: During a time when medical male circumcision is being scaled up as an HIV prevention intervention in Southern Africa, traditional initiation/circumcision (Ulwaluko) is commonly practiced among the amaXhosa, and is a powerful organizing factor in constructions of masculinity.

This time presents a challenge to boys living with HIV, where the imperative of HIV medicines-taking clashes with perceived expectations of not engaging with biomedical care or treatment. This dilemma is compounded by HIV-related stigma and secrecy, which deters boys from disclosing their HIV-positive status. Boys engage a range of strategies including disclosing to one trusted person at the circumcision school, hiding medicines without telling anyone, and in some cases ceasing medicines taking without alerting health providers of their decision.

The three months following traditional initiation/circumcision also represents a time when adolescent boys and young men disengage from care for fear of being seen at the clinic. Recent initiates (kwala) wear clothing that distinguishes them as ‘new men’ and are highly visible and surveilled. Participants disclosed not engaging with health services at this time for fear that people will think that their circumcision was botched, or that they took biomedicine while at initiation. Caregiver pick-ups were a strategy that some boys used in order to obtain ART.

Conclusions and Recommendations: While respecting the confidentiality of this longstanding tradition, greater policy and programmatic attention is required to support medicines-taking during and post-initiation. The period of traditional initiation/circumcision is a context in which boys are struggling to take HIV medicines and be retained in HIV care and may have long-term health implications for adolescent boys, their sexual partners and communities.

Understanding social contexts is crucial to rolling out evidence-based, highly relevant policy and programmatic responses. It is for this reason that it is important to understand the context-specific gendered contours of the HIV epidemic, including the spaces in which gendered social identities and behaviours are constructed.
Prevalence and Determinants of Viral Suppression among Adolescents on ART in five High volume HIV treatment sites in the SWR, Cameroon.

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Background: Due to children’s dependence on caregivers and given the unique behavioral characteristics of adolescents, they may suffer worse antiretroviral treatment (ART) outcomes. There is, very little or no data in Cameroon assessing viral suppression (VS) of adolescents on ART and the risk factors of poor suppression. We determine viral suppression, treatment adherence and risk factors of poor suppression in adolescents accessing ART in five high volume HIV management units in South West region (SWR) of Cameroon.

Materials and Method: In a retrospective cohort and facility based survey, 410 adolescents were recruited through a non-probability convenient sampling method. Adolescents on ART for more than six months with viral load test results were eligible for the study. Viral load (VL) was measured for any adolescent on ART for six months or more. VS was defined as any VL<1000 copies/mL. Adolescents with unsuppressed first VL received enhanced adherence supports and a second VL was measured after 6 months. Adherence was measured using the visual analogue scale (VAS) and optimal adherence was defined as adherence > 90%. Our data was analysed using SPSS. VS, adherence were compared with different socio-demographic and clinical variables and risk factors of poor adherence and VS determined.

Results: The prevalence of VS was 56.1% (230/410) in first VL test and 25.5% (39/153) in the second VL test among adolescents on ART for at least six months with mean duration of 65 months. The overall VS among adolescents was 65.6% (269/410) and ART failure rate of 27.8% (114/410). A 54.6% (221/405) of adolescents reported optimal adherence to ART. Poor (<80, VAS), [aOR=3.3, (95%CI, 1.8-5.9); p = 0.000] and moderate adherence (80<90, VAS), [aOR=2.9, (95%CI, 1.3-6.2); p = 0.007] were the lone factor which significantly associated with poor VS. Poor adherence was positively associated with non- and partial disclosure; [aOR= 11.1, (95%CI, 2.0-61.6); p = 0.006], WHO stage III and IV [aOR = 0.2, (95%CI, 0.1-0.4); p = 0.000], lack of medication partner [aOR = 0.3, (95%CI, 0.2-0.6), p = 0.000] and insufficient food per day; [aOR = 0.3, (95%CI, 0.2 - 0.6), p = 0.000]

Conclusion: The prevalence of viral suppression was low among adolescents on ART in the SWR. Sub-optimal adherence to ART was the major factor associated with poor VS. Factors associated with poor adherence were non-disclosure, advanced disease, lack of medication partner and insufficient food. Interventions to strengthen adherence to ART and improve VS in adolescents be developed urgently.
Lessons learned from an adolescent friendly HIV management program and reproductive health service in Soweto, South Africa

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Background: HIV counseling and testing identified as an entry point to care in an endeavor to deal with HIV infection and management. It is important to normalize HIV testing and use testing to assist people in getting onto treatment and care. Kganya Motsha Adolescent Centre KMAC), is a program specifically established to provide voluntary counseling and testing as well as management of HIV-positive young people in Soweto, South Africa. This paper aims to describe the proportions of HIV testing and prevalence of HIV among young people accessing KMAC and describe the lessons learned from setting up and running an HIV management clinic for adolescents.

Methods: A retrospective cross-sectional analysis, using clinic records of young people accessing services from 2008 to 2012.

Results: A relatively higher uptake of HIV testing and HIV prevalence among females than males, of the 11,522 who tested, 7689 (67%) were females. The total number of HIV infections was 410, with an HIV prevalence of 3.6% (95% CI 3.2–3.9%). It was possible to set up and run an HIV programme for young people, the programme was successful in reaching adolescents to test for HIV. There was however a notable discrepancy by gender regarding the point of contact and accessing the services, with girls reached both at the clinic and through outreach while boys were mainly reached through outreach. Uptake of service by males increased every year with less than 500 males in the first year and above a 1000 in the fifth year. The females started at over 800 to over 7000 in five years. There was lot of demand for other sexual and reproductive health services such as pregnancy testing and request for contraceptives. The primary health nurses were able to source the contraceptive and these were provided at the clinic. The programme demonstrated that young people are in need of a service that will provide HIV services and other reproductive health services, however for the service to be accessible it should not be restricted to clinics and centres.

Conclusions: KMAC in Soweto seemed effective in reaching more young men to test for HIV through community outreach. These data reflect that there is still a great need to scale-up HIV testing services to reach young men in South Africa. There is a need to make HIV-testing centers more attractive to young men and take the services to the where the young people are. Mobile services have a great role to play in providing services to young people.
An assessment of assisted HIV self-testing for children and adolescents living in households with an HIV positive individual in Zimbabwe.

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Background: HIV testing and counselling (HTC) is the critical first step in accessing lifesaving antiretroviral therapy, however several barriers to accessing HTC have been identified particularly among children and adolescents. These include distance to travel to health care facilities, cost of travel, user fees at facilities, fear of disclosure of HIV status from parents/caregivers to their children and inconvenient opening times of facilities. We investigated the feasibility of assisted HIV self-testing whereby caregiver should test their children using oral mucosal HIV tests.

Methods: HIV positive individuals attending 6 primary healthcare facilities were approached by research assistants from March-July 2018 in Bulawayo (urban) and Mangwe (rural) districts in Zimbabwe. They were offered HIV testing of children and adolescents aged 2-18 in their households using facility testing, community-based testing or assisted self-testing. Indexes opting for assisted self-testing were shown how to perform and interpret the test result and completed a brief competency assessment before taking a test kit home. They also completed a short questionnaire on why they selected this option. To assess accuracy, the first 15 participants at each facility were accompanied by a research assistant to their home where they performed the test on their children while the research assistant observed. All indexes were followed up by telephone call or home visit to ascertain the test outcome and to collect the used test kit.

Results: 56 index cases took up assisted HIV self-testing (86% female, median age 40 years). 111 children (median age 9 years) were to be tested. The main reasons for uptake of assisted self-testing included convenience of access (93%), privacy (77%) and the fact that the test is not painful (50%). Most indexes (69%) were biological parents of the children and the second largest group were grandparents (16%) followed by biological aunts/uncles (14%). All the indexes who opted for assisted HIV self-testing passed the competency assessment. Test outcomes were received for 85 children (77%) and none tested HIV positive. Among the 79 participants who underwent an accuracy assessment 70 (89%) performed the test themselves with no assistance from the research assistant and 77 (98%) accurately read the results of the HIV test. 57 (72%) indexes disclosed the test results to the child without assistance from research assistants. The research assistants assisted with disclosure for 7 (9%) participants.

Conclusions: Assisted HIV self-testing is a feasible method to increase uptake of HIV testing among children and adolescents, a group that is often difficult to reach and has lower uptake of HTC particularly in rural settings where costs of travel and distance is higher. This method will be particularly useful in settings where clinical staff are limited and in rural settings where distances to travel to facilities are long.
All In to #EndAdolescentHIV: Leveraging data to achieve Results for adolescents in Eastern and Southern Africa

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Background: Launched in February 2015, All In to End Adolescent AIDS (All In) aimed to inspire collaboration across sectors to accelerate gains towards ending the AIDS epidemic by 2030, by ensuring that no adolescents are left behind in the HIV response. In 14 high-burden countries in Eastern and Southern Africa (ESA), UNAIDS and UNICEF supported governments to convene key stakeholders to take stock of the health and well-being of adolescents. Using the Adolescent Assessment and Decision Making tool, countries conducted data assessments and consultation at both national and sub-national levels to identify critical data gaps and discuss strategies to address the unique needs of adolescents living with and at risk of HIV. A regional review was undertaken to explore the implemented actions and changes to HIV programming that followed All In country assessments undertaken between 2015 and 2017.

Methods: This regional review appraised All In influence on five key areas: stakeholder engagement and collaboration, strategic information, policies and plans, implementation, and resource mobilization. Qualitative in its approach, the review entailed: 1) desk review of All In assessment reports; 2) country visits; 3) in-person and virtual interviews with 43 key stakeholders including government officials at both national and subnational levels, representatives of UN agencies, youth-led networks, funding partners and implementing organizations.

Results: The review found that All In has generated changes across multiple aspects of HIV programming for adolescents. In the literature and through interviews, it was noted that All In made adolescents more visible, calling attention to their HIV, health, and wellbeing. The strategic information gathered by country assessments informed national HIV responses and served as a critical advocacy tool. All In facilitated collaboration amongst stakeholders within and across HIV, health and other sectors. Technical working groups (TWGs) on adolescents were established or strengthened at national and sub-national level. Through All In, adolescents were engaged as critical stakeholders through youth-led consultations, the use of mobile technology and as members of TWGs. Strategic information for adolescents has been strengthened through changes to data collection tools to allow for age disaggregation, improved HIV estimates and the introduction of implementation science projects to inform scale-up. All In facilitated inclusion of adolescents in relevant policy changes and planning. The assessment outcomes informed adolescent components of national strategic plans and sparked the development of separate adolescent-focused national and sub-national work plans. Changes in programme implementation included: more targeted programming for adolescents as a distinct population group; expansion and scale-up of adolescent interventions; and increased capacity of sub-national implementers. Additional international and domestic investment for adolescent HIV programming was also noted, including for work plan implementation, scale-up of interventions and dedicated personnel.

Conclusion: All In data assessments catalyzed the HIV response for adolescents, elevating attention to their needs and inspiring tailored-action. All In has demonstrated that collating available adolescent-specific data is possible and a powerful tool for change. Documenting the full impact of these policy and programmatic changes on HIV and related outcomes for adolescents will require repeated All In assessments, ideally embedded into country programming.
Early lessons learnt from developing a peer navigator program to improve uptake and retention in HIV prevention programs

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Background: HIV incidence remains high among adolescent girls and young women (AGYW) in South Africa (SA). Effective HIV and pregnancy prevention interventions in young people require long-term engagement with healthcare systems. However, engagement of AGYW in facility-delivered care programs for socially stigmatised conditions such as HIV and sexual health remains a challenge for HIV prevention. Community delivery of care programs by respected peers may overcome these social and structural barriers. We describe early lessons from our work to co-create a peer-delivered adaptive intervention to improve uptake and retention of HIV prevention modalities, and sexual reproductive healthcare to AGYW.

Materials & Methods: We conducted a mixed-methods study using participatory action research to develop and implement peer-delivered support for young people to uptake and remain engaged in existing effective HIV prevention interventions in UMKhanyakude district, KwaZulu-Natal, SA. Our aim was to identify and train 21 pairs of geographically-based peer navigators to work within catchment areas of approximately 500 AGYW. We identified 108 men and women aged 18-30 years to allow for loss to follow-up who underwent training for 6-8 weeks including research methods, good clinical practice and HIV/AIDS testing and counselling. We then conducted one facilitated participatory workshop (42 attendees). We portrayed epidemiological and social science evidence regarding HIV and sexual health through interactive vignettes, then brainstormed solutions for use in the community in facilitated groups.

Results/Lessons learnt: The recruitment of peer-navigators was community-based through traditional leadership structures and the Africa Health Research Institute community engagement unit. Traditional leadership knew their community members and their involvement encouraged buy-in and engagement early in the project. Working part-time seemed attractive to peer navigator recruits and free training was seen as essential exposure to research and capacity building. We trained more females than males which might affect the gender-balance of pairs. The planned training schedule evolved as we progressed, to include topics generated by peer navigators, including: contraception; sexual reproductive health (SRH); modes of HIV transmission (young people were more worried about this than prevention methods); pre-exposure prophylaxis (availability and possibility of replacing condoms). We learnt young people are more worried about fertility than HIV. Despite much past HIV programming locally, myths around HIV transmission and fertility persist, that using marijuana or men taking female oral contraception can prevent pregnancy. Judgemental attitude of healthcare providers and being seen in clinic were viewed as barriers to access and uptake of HIV testing, care and contraception. Young people were able to critically appraise evidence through vignettes and actively engaged in the participatory workshops, to develop innovative ideas to tackle the health and social issues facing them.

Conclusion: Early lessons from developing this peer-navigator program highlight ongoing gaps in information, knowledge and education around HIV transmission and SRH in young people. However, young people are enthusiastic and able to creatively engage with these issues in their community. Furthermore, there was community buy-in, and training and developing peer-led programs to support young people was acceptable and feasible. Extensive adaptive training and ongoing supervision are needed for program success.
Organised Chaos?: Patterns of Transition to Adult Care for Adolescents Living with HIV

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Background: Existing research in sub-Saharan Africa has focused on adolescents’ transitions from paediatric to adult wards within single facilities. However, real-life experiences of paediatric-to-adult care transitions are more complex. Within decentralised healthcare systems, such as South Africa’s, adolescents simultaneously transfer across healthcare facilities and facility types (hospital, community health centre, or clinic). This study first characterises the multiple types of transitions experienced by a large cohort of HIV+ adolescents in South Africa and subsequently tests whether these transitions predict viral suppression.

Methods: Data was extracted from electronic and paper-based medical records for 956 ART-initiated adolescents (10-19 years old) recruited from 52 urban and rural healthcare facilities in the Eastern Cape. Data collection included records in multiple facilities through January 2018. Experiences of different forms of transition were tested as predictors of viral suppression (<1000 copies/mL) using sequential multivariate logistic regression, entered simultaneously with age (10-14/15-19 years), sex, urban/rural residence, mode of infection, and time on ART.

Results: One-third of adolescents (29.7%) had received care at ≥2 facilities, and 21.3% had ever been down-referred in care. Of those attending multiple clinics, 9.5% had silently transferred care, without record in patient files. We identified 4 paediatric-to-adult transition categories among the 16.3% of adolescents who had ever transitioned. First, 34.6% experienced cyclical transition, characterised by bi-directional transfers between adult and paediatric care. Second, only 20.5% experienced classical transition, or transition across wards within the same facility. By contrast, 79.5% experienced implicit transition, or de-facto transition resulting from down-referral to a lower-level facility. By attending antenatal clinics, 55.6% of adolescent mothers were identified as having experienced maternal transition. Because only 27 of the 69 pregnant adolescents in our sample had patient files at an antenatal clinic, many maternal transitions were likely undocumented. Clinic observations suggest that pregnant adolescents bring their patient files from paediatric facilities to antenatal clinics—then out of them post-partum. Median age of first transition from paediatric to adult care was 12 years (IQR 10-15). In multivariate regression, adolescents who transitioned were more likely to be on ART for ≥2 years (OR 4.2 [95%CI 1.7-10.5], p<0.01). Transition to adult care did not significantly predict viral suppression. Adolescents who had ever been down-referral were more likely to achieve viral suppression (OR 1.8 [95%CI 1.2-2.8], p<0.01). Those who had silently transferred were less likely to achieve viral suppression (OR 0.4 [95%CI 0.2-0.9], p=0.04).

Conclusions: Among HIV+ adolescents in South Africa, transition to adult HIV care is not a singular event. Often, it is a cyclical movement between paediatric and adult care across facility types that begins in early adolescence, likely due to down-referral within a decentralised care system. Interventions to improve post-transition outcomes must consider simultaneous transitions out of tertiary care and undocumented transitions for adolescent mothers. Future studies should explore longitudinal health outcomes before and after these types of transitions.
Predictors of HIV positive status of Adolescents and Young Persons with HIV positive indexes

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Objective: To determine predictors of HIV status of Adolescents and Young Persons (AYP) who were family members of HIV positive index cases in Nigeria.

Method: This is a secondary data analysis. The primary data were collected through index case finding of AYP living with HIV identified via index adults and OVC living with HIV resident in Lagos State, Benue State and the FCT, Nigeria. Adults living with HIV mobilized their children aged 10-24 years, while HIV positive OVC mobilized their siblings to be tested for HIV. Each mobilized AYP was tested for HIV, and asked questions to assess their HIV risk profile (history of sexual risk behavior, history of STI symptoms and TB related symptoms). Information on sociodemographic profile (age, sex and marital status) was also obtained. The association between their HIV status (positive or negative), sociodemographic profile and HIV risk profile was determined using chi square test. Predictors of HIV positive status was determined using logistic regression. All dependent variables with p values < 0.4 were entered into the logistic regression model.

Results: The data of 14,205 AYP (90% aged 10-19 years) who were wards or siblings positive index cases were extracted. 79 (0.6%) AYP were HIV positive; 57% of all positives were aged 10-19 years. A significantly higher proportion of AYP who were HIV positive had one or more HIV sexual risk behaviour (p<0.0001), one or more TB symptom (p<0.0001), history of one or more STI symptoms (p<0.0001), were married (p<0.0001), and were 20-24 years old (p<0.0001). Predictors of a HIV positive result were: marital status (OR: 13.53; p<0.0001), having TB symptoms (OR: 2.83; p=0.011), a history of STI symptoms (OR: 4.37; p=0.001), and age (OR: 2.18; p<0.0001).

Conclusion: Testing to identify AYP living with HIV should focus on those who are married, had a history of STI, had TB symptoms and 20-24 years olds. Also, those with one or more HIV risk behaviours who are HIV negative should be prescribed PrEP.
HIV status and HIV sexual Risk taking Behavior of Adolescents and Young Persons in Nigeria

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Objective: To determine the HIV sexual risk behaviour and practices (unprotected sexual intercourse, transactional sex, sexual assault, multiple sex partners) of adolescents and young persons (AYP); and the HIV sexual risk behavior of AYP Living with HIV

Method: This was a secondary analysis of a dataset collected from AYP linked to parents/siblings who are HIV positive index cases resident in Lagos, Benue and the Abuja, Nigeria. Data on HIV status and HIV sexual risk behavior (age of sexual debut, unprotected sexual intercourse, multiple sex partners, transactional sex, history of sexual assault) were extracted. Association between HIV status and HIV risk behavior was determined. The HIV sexual risk behavior associated with HIV positive status was determined using logistic regression.

Results: There were 4,816 HIV negative and 110 HIV positive AYP. More HIV negative (65.9%) than HIV positive (47.3%) respondents were not sexually active (χ2=16.44; p<0.001). Most of the sexually active respondents started sex as young adolescents (15-19 years). Significantly more HIV negative AYP practice protected vaginal sexual intercourse (p=0.01). There was no significant difference in the proportion of HIV negative and HIV positive AYP who practice unprotected anal sexual intercourse (p=1.00) and transactional sex (p= 0.17). Significantly more AYP who gave no response to question on HIV status had a history of sexual assault when compared with AYP who were HIV negative and HIV positive (15.2% vs 6.1% vs 4.5%; χ2=56.86; p<0.001). Using a multivariate logistic regression, the only significant predictors of HIV positive status was unprotected vaginal sexual intercourse (Coef: -0.03; 95% CI: 0.009 - 0.04; p=0.003).

Conclusion: AYP are sexually active beings and practice multiple forms of high risk sexual activity irrespective of their HIV status. Higher proportions of AYP who practice unprotected sexual intercourse are HIV positive. This implies that a lot more needs to be done with respect to comprehensive information and services on safer sex to all AYP with special emphasis on HIV positive AYP. A history of sexual assault may trigger withdrawal from AYP during intimate questioning on HIV status. The association between sexual assault and HIV positivity makes it imperative for researchers not to treat none responses on questions about HIV status with levity.
Viral load status among adolescents in 13 SIDHAS-supported states in Nigeria

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Background: The number of people accessing antiretroviral therapy (ART) has gradually increased in the recent years. Establishment of the HIV viral load suppression status among patients enrolled on ART is critical for timely detection of treatment failures, identification of patients in need of more intensive adherence support and minimizing development of drug resistance. Achieving virologic suppression is important to ensure best outcomes and prevent transmission among people living with HIV. Globally adolescents and young people are far from reaching the UNAIDS fast-track targets that require 90% of people on ART to be virologically suppressed. We investigated the HIV viral load suppression status among adolescence (ages 10-19 years) on ART in Strengthening Integrated Delivery of HIV/AIDS Services/SIDHAS (a USAID funded Comprehensive HIV and TB project) supported health facilities in Nigeria.

Materials & Methods: A cross sectional study using routinely collected service data from 13 SIDHAS supported States in Nigeria (Adamawa, Akwa- Ibom, Anambra, Bauchi, Bayelsa, Borno, Cross River, Edo, Jigawa, Kano, Lagos, Rivers and Yobe). Data on demographic factors, clinical factors and viral load testing was extracted. The outcome variable viral load suppression was defined as having less than 1000 RNA/ml of blood. Bivariate analyses were conducted to assess the associations of demographic characteristics with HIV viral suppression. These analyses were computed with viral load as a dichotomous variable (suppressed /<1000 copies/mL or unsuppressed/≥1000 copies/mL). Chi-square analysis was used to determine if there is a significant relationship between viral load and study factors.

Results: All 2347 participants were started on ART between the ages of 10 and 19 years. The median age at ART initiation was 15 (IQR 13-17) years. The median duration on ART was 4 (IQR 2-6) years. Over half (n=1673; 71%) were female and proportion of respondents aged 15-19 years old was 66%. Over half the participants (n=1465; 62%) were virally suppressed. Adolescents who were female and 15-19 years were more likely to have virologic suppression than those 10-14 years old (aOR=1.71; 95%CI 1.09-4.32).

Conclusions: Adolescents need targeted strategies and interventions to adhere and manage their HIV infection.
A critical analysis of strategies aimed at addressing HIV and AIDS in the Makana Municipality: a case study of the HIV and AIDS agenda in Grahamstown

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The relatively contemporary framing of HIV and AIDS into a development issue has compelled the different spheres of government (the national, provincial and municipal) to identify with the notion of HIV/AIDS agenda setting as part of their Constitutional mandate.

The aim of this research paper was to unpack the local HIV/AIDS agenda for Grahamstown, through an analysis of the Integrated Development Plan (IDP) of Makana Municipality (MM) - of which Grahamstown falls under- in contrast with that of the renowned Steve Tshwete Local Municipality (STLM). Engagement with the two aforementioned as well as qualitative interviews, uncovered the various agendas carried out by different entities within the community of Grahamstown in addressing HIV/AIDS. The relatively isolated nature of these agendas pointed to a plurality of approaches and lack of cohesion in addressing HIV/AIDS and its related issues in Grahamstown.

The qualitative approach: Interpretive Phenomenological Analysis (IPA), was elected to drive the research study and can be explained as, “a recently developed approach in the field of qualitative research, especially in the cognate disciplines in the human, health and social sciences” (Smith et al., 2009: 5 cited in Agbedahin, 2012: 125). The IPA shares certain factors with three other theoretical frameworks namely, phenomenology, hermeneutics as well as idiography.

My study illuminated the fact that there is more than one agenda for HIV/AIDS in Grahamstown. One can be seen as ‘mainstreaming’ as endorsed by the municipality and multiple others are driven by individuals working either as activists or members of civil society with a great affinity with the community.

The lack of sufficient knowledge on the municipality’s ‘mainstreaming’, however, is an example of the lack of impact of Makana IDP; it is also evident that this lack of (knowledge on) a defined local strategy for HIV and Aids in Grahamstown, is essentially detrimental. Niches are, however, occupied by organisations and people in various capacities in the community, which is in line with the National Strategic Plan (NSP) which aims at, “strengthen[ing] the multi-sectoral response to HIV, TB and STIs as a contribution to the overall social and economic development of South Africa” (SANAC: 2017). Perhaps the second part to that aim: “policy review, programme management and co-ordination, technical assistance and capacity building and sectoral support” could still be improved.

The aim of the NSP and the reality at the district and local levels show that there is a gap between the government and the entities which-government is aware-share greater contact with the Grahamstown citizens. This awareness does not translate to support and unified interaction; instead, the local government continues silo-type efforts which although important, do not foster inter-sectoral communication.

The development of a better IDP, one that actually makes explicit mention of comprehensive and effective strategies to address HIV/AIDS in Grahamstown, would contribute towards a cohesive HIV/AIDS agenda. One that would harness the experiences of each micro-collective in developing agendas informed by the plurality of realities in Grahamstown; ensuring more than HIV/AIDS being addressed in a healthy and cohesive manner.
Retention in care among adolescents on ART: an overview in the center region, Cameroon.

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Background: Today, AIDS is the leading cause of death among adolescents worldwide and the second most common cause of death among adolescents globally. In Cameroon, the retention rate in care about adult is 76% compared to adolescents living with HIV (10 – 19 years) and their associated factors that remains unknown, because epidemiological data are not disaggregated by age group. This study aimed to generate information about retention in care for adolescents (10-19) and associated factors among adolescents living with HIV in the Center region of Cameroon to improve on strategies that promote adolescents retention.

Methods: We conducted a retrospective study in 13 health facilities in the Centre region of Cameroon. A total of 272 adolescent that were initiated on ART Between April 2015 to April 2017 were reviewed in ART register. This record was retrospectively followed up for duration of one year to determine their retention rate in 12 months in treatment care. We eliminated those who are transferred out and who were dead and also come out with the number of Loss To Follow up (LTFU). Associated factors were identified according to clinical, sociodemographic and health facility aspects.

Results: The mean age of these adolescents was 14.78 (SD 3.22) years. The retention rate in care was 73.5% the third month of initiation, 64.3% during the sixth month while 70.6% of adolescents were retained at the twelfth month. The total number of LTFU at the 12th months was 24.3%. Adolescents receiving treatment in the first and second category health facilities were about 3 times significantly more likely to be retained in care at the 12th month compared to those receiving treatment in the fourth, fifth and sixth category health facilities (OR 3.23; 95% CI: 1.71-6.13; p=0.000). Adolescents in urbanely located health facilities were about 5 times significantly more likely to be retained in care at the 12th month into treatment compared to those in rurally located health facilities (OR 4.77; 95% CI: 2.60-8.74; p=0.000). The younger adolescents (10-14 years) were about 3 times significantly more retained in care than the older adolescents (15-19 years) (OR 2.92; 95% CI: 1.60-5.35; p=0.000).

Discussion: Retention in care among adolescents is poor within 12 months (less than 75%) of ART initiation. However, the higher retention rate among children under the age of 15 may be due to the fact that their ARVs are most often collected by their parents or caregivers compared to those over the age of 15 who sometimes come to collect themselves. These results will better help to put in place some strategies that will increase adherence among adolescents. Interventions focusing on the healthcare environment, particularly third, fourth and fifth category may help to further improve retention and reduce the number of LTFU and improve health outcomes.
Improving retention in HIV care of adolescents through a peer to peer approach in western Uganda

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Background: Adolescents living with HIV are an underserved population and lack specific programs targeting their needs. Poor retention in HIV health care services and high mortality rates due to HIV have been reported in this age group. Adolescents are the only age group in which deaths due to AIDS are not decreasing. In Rwenzori region, twelve-month retention in HIV care for adolescents was at 73% (October 2015 – March 2016). Baylor Uganda implemented targeted a peer to peer approach to improve retention in HIV care for adolescents. We describe best practices learnt in improving retention in HIV care for adolescents.

Description: From February 2016 to March 2018, the following interventions were implemented to strengthen retention in HIV care for adolescents in 5 districts in Rwenzori region:
In February 2016, selected health workers were trained to provide adolescent friendly services at health facilities. These became adolescent focal persons and played an oversight role in provision of adolescent friendly services at the health facilities.
In April 2016, trained adolescent focal persons were supported to establish adolescent-only clinics for HIV care. Previously adolescents had been obtaining HIV services on the same clinic day as adults. In the same period, health facilities were supported to conduct adolescent peer support meetings once every 2 months at which peer to peer psycho social support was provided.
In September 2016, adolescent peer leaders were trained and engaged in planning and provision of adolescent HIV services including peer to peer health education talks, counselling, file running, routine follow up and follow up of lost adolescents through home visits.


Lessons learnt: Between April 2016 and March 2018, adolescent-only HIV care clinics increased from 12 to 57 clinics with all the clinics having adolescent peer leaders. Before the intervention, 12-month retention in HIV care for adolescents was at 73% (October 2015 –March 2016) and it dropped to 66% for the April 2016 – September 2016 cohort at the beginning of implementation of the intervention. Progressive increase in 12-month retention was achieved in the cohorts of October 2016 – March 2017 (80%), April 2017 – September 2017 (85%) and October 2017 – March 2018 (93%) following training and engagement of adolescent peer leaders.

Recommendations: Deliberate efforts should be made to train and engage adolescent peer leaders within adolescent-only friendly HIV care clinics as a strategy of improving retention in HIV care for adolescents.
Tracking children and adolescents in the HIV cascade – challenges using routine program data

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Background: Children and adolescents living with HIV (CALHIV) are falling short on achieving the UNAIDS 90-90-90 goals for HIV testing, treatment, and virologic suppression. Health systems interventions including the Systems Analysis and Improvement Approach (SAIA) have been effective in improving the HIV care cascade for adults living with HIV, and especially in prevention of mother-to-child transmission of HIV. SAIA relies heavily on publicly available routine program data to characterize implementation gaps in the HIV cascade and to track serial improvements. It is not known whether routine program data sources are able to support similar activities for children (0-9 years), adolescents (10-19 years), and young adults (20-24 years).

Methods: The SAIA-PEDS pilot study collected data about the children and adolescent living with HIV (CALHIV) cascade (0-24 years), including: 1) uptake of HIV testing, 2) linkage to care, 3) antiretroviral therapy (ART) initiation, 4) viral load (VL) monitoring, and 5) VL suppression. Three data sources were considered at 6 pilot facilities in Kenya of differing sizes: A) monthly aggregated, clinic-level count data from DHIS II; B) abstracted individual-level, cross-sectional facility paper registers (register data), and C) individual level, longitudinal or cross-sectional electronic medical records (EMR).

Results: No single data source was sufficient to cover the 5 steps of the CALHIV cascade; numerator and denominator data for the indicators were often not available within the same data source. Uptake of testing, linkage to care, and ART initiation were also collected in EMRs, when available; VL data was available in either registers and/or EMRs. There were inconsistencies in the source documents for the EMR data. Strong heterogeneity existed between the 6 clinics.

DHIS II data had different age bands of aggregation for the 5 indicators of interest, prohibiting use of this data source to characterize the CALHIV cascade. Outpatient data was split above and below 5 years; inpatient data was split above and below 12 years; HIV testing data was split above and below 15 years; HIV linkage to care, and treatment data was not age disaggregated.

Abstracted registry data enabled aggregation to age bands of choice, but were slow to collect, prone to abstraction errors, and challenging to access given regular use for clinical activities.

EMR data was only available for CALHIV once they were diagnosed and linked to care at select facilities.

Conclusion: Accurately characterizing gaps in CALHIV service delivery will require harmonization of routine program data aggregation approaches. Currently, abstraction of paper registers is the only approach that allows appropriate age aggregation for CALHIV.
Towards 90-90-90: Increasing Viral Suppression at Kimbimbi Sub-County Hospital Kenya through Pediatric and Adolescent Viremia Clinics

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Background: Stigma, non-disclosure, toxicities, substance abuse, mental health disorders, religious beliefs, inadequate treatment preparation, weak social support, poor client-provider relationship and minimal caregiver involvement all cause poor adherence to ART among paediatrics and adolescents. Sub-optimal utilization of Viral load (VL) further negates efforts towards achieving 90% VL suppression.

Objective: In June 2016, Kimbimbi SCH in Kirinyaga County recorded a VL suppression rate of 76% among pediatrics and adolescents. Our aim was to increase VL suppression to at least 90% within 12 months.

Methods: Through the formation of adolescent-pediatric viraemia clinics, comprising ‘one-stop health shops’ staffed by a multi-disciplinary team of peers and healthcare practitioners (HCPs), we were able to identify individual barriers to viral suppression amongst clients and caregivers, discuss remedial measures and collectively agree on corrective action. Upon completion of planned enhanced adherence counselling (EAC), clients were fast-tracked for repeat VL testing to minimize interruptions to adolescents’ busy schedules. Non-suppressors were promptly referred to the multi-disciplinary team for consideration of regimen change.

Results: In June 2017, the facility reported a suppression rate of 89% in the same group. By April 2018, the facility had sustained suppression rate of 97%. Disclosure amongst pediatrics improved dramatically and more caregivers were positively engaged. The approach has since been scaled up to Kerugoya CRH, Kagumo Health centre and Sagana Sub-county hospital.

Conclusion, recommendations and implication: Pediatric and adolescent-focused Viremia clinics are feasible, scalable and can help achieve the 90-90-90 targets. They allow for patient-centred care delivery and can be optimized to incorporate more adolescent-specific services.
Viral load access and suppression among adolescents living with HIV in Uganda

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Background: By end of 2017, an estimated 73,000 adolescents were living with HIV in Uganda and only 28% were on ART in 2013. Maintaining sustained high levels of adherence to ART is crucial to achieving viral suppression. And yet, adolescents often have challenges adhering to treatment and remaining in care. The viral load suppression rate among adolescents in 2015 was 70.5% which was below the UNAIDS-90% target. To address this, a ten-point viral load program was implemented. This includes; Sorting of results (suppressed vs non-suppressed) for rapid action, use of viral load tickers to flag non-suppressed files, first IAC within 30 days of result return, Intensive adherence counseling (IAC) forms to support completion of 3 IAC sessions, viral load focal teams with clinical–lab interface for routine review of non-suppressed files, utilization of non-suppressed registers, multidisciplinary switch team, integrated viral load testing into morning health education sessions, linkage with community structures for peer support and client tracking, and viral load continuous quality improvement site-level initiatives. We conducted an assessment to determine the current coverage for viral load tests and proportion of active adolescents and young people who have achieved viral suppression at the last scheduled viral load test within the last 12 months.

Methodology: A cross-sectional retrospective assessment was conducted from July-September 2017 at 140 health facilities. Ten health facilities (10) were selected from each region and these included a specialised clinic, 1 regional referral hospital, 3 district hospitals, 2 high volume HC IVs and 3 HC IIs. An orientation meeting was held for data collectors. Data was collected by district-based teams and Implementing Partners with supervision from the Ministry of Health teams. Data was abstracted from the HIV care/ART card, ART register and the non-suppressed viral load register. Data collection tools were de-identified to ensure privacy.

Results: Of 28,524 active adolescents and young people whose records were assessed, only 56% (15,834) accessed viral load testing, 77% of those were virally suppressed as compared to 70.5% in 2015. Access to a first viral load test was 57.1% (471/825) with a first viral load suppression rate of 86.2. Viral load access by age groups 10-14, 15-19 & 20-24 years was 68%, 54% and 51% respectively while viral load suppression by the same age groups was 73%, 71% and 81% respectively.

Conclusions: The ten-point package for improving viral load suppression registered increase in the proportion of adolescents with suppressed viral load. However, in order to achieve the UNAIDS 3rd-90 target by 2020, intensified efforts as well as game-changer strategies are needed to increase viral load test access and suppression for adolescents and especially young people. Psychosocial support to help HIV positive adolescents adhere to treatment and clinic appointments with focus on the older ones is crucial.

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Background: Nigeria has a large population of over 173 million people. Of these, 28% are young people (aged 10–24 years). The national prevalence of HIV is 3.4%. Among young people aged 15–19, the HIV prevalence is estimated to be 2.9% and 3.2% among those aged 20–24 years. Among 20–24 year olds, young women are more affected by HIV than young men in Nigeria (Women: 3.7% Vs Men: 2.4%). The HIV response for adolescents and young people (AYP) in Nigeria has improved in recent years, evident in the development of the National HIV strategy for AYP. Notwithstanding, tracking of progress has been hindered by inadequate data disaggregation (age) of the national monitoring system. In response, the National Agency for Control of AIDS conducted a data collection exercise to generate longitudinal, individual-level data across all stages of HIV service delivery cascade for AYP in Abia and Taraba States.

Description: National Agency for the Control of AIDS (NACA) in collaboration with UNICEF conducted a research to establish the uptake of HIV service cascade and retention in care in Abia and Taraba from September 2014 to March 2017. The study population were AYP aged 10 to 24 years receiving HIV/AIDS services from 23 comprehensive service sites (11 in Taraba and 12 in Abia). The study involved data abstraction from programme and administrative records and outreach data.

Results:
• A total of 10,087 clients counseled and tested- 67.8% females and 32.2% males.
• HIV prevalence was 10.7% among females and 6.5% among males.
• A total of 943 AYPs tested HIV positive between 2014-2017, 78% females and 22% males. About 64% of females and 31% males were initiated and retained in care from 2014-17

Conclusion: The results demonstrate a trend of lower HIV service uptake among males compared to females including enrollment on treatment. In line with 90-90-90, viral suppression is a key prevention component in elimination of HIV, which will ultimately be impossible if positive males are not tested and placed on treatment. It is crucial to begin to design HIV prevention programmes with gender responsive approaches to effectively address the epidemic. Otherwise, the males may soon become left behind.
Enablers and Barriers to ART Treatment Adherence among Adolescents Living with HIV (15-19yrs) in Goa, India

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Background: The arrival of anti-retroviral therapy (ART) has been a major respite for those infected with HIV, but optimal adherence is needed for best outcomes. Non-adherence adversely affects clinical, immunological, and virological outcomes of patients. Adherence to ART was found to most challenging among those ALHIVs in their late adolescents, i.e. 15-19 years in Goa, prompting a study to identify enablers of and barriers.

Methods: The data collection was carried out by Human Touch Foundation, among adolescents (aged 15-19 years) who were on treatment since last five years through a cross-sectional qualitative study using semi-structured interviews at the main ART Centre at Goa Medical College, Bambolim and Link ART Centres at District Hospital, Mapusa and Margao. Open-ended questions were used to conduct 63 interviews in their mother tongue (Konkani). The interviews were audio-taped, transcribed verbatim and translated into English. The data were analyzed manually using the thematic content analysis method.

Results: The barriers identified included, individual, i.e perception about ART, misuse of alcohol which caused difficulty in remembering medication routine and dating and relationships. Simply forgetting and being busy due to work and schooling schedule was most frequently mentioned. Sociocultural barriers included lack of supportive family and friends and perceived stigmatization after disclosure. Distance, long waiting lines, delay in taking samples for investigations on fasting and a short period of medicine prescription featured as a barrier in healthcare provision and system. Most drug-related barrier, i.e side-effects and emotional distress, i.e. the ability to concentrate on taking ART were also reported. There were few enablers as compared to the barriers expressed which included support from health care providers, peers, and parental support, knowledge of disease and self-motivation. Perceived positive outcomes of ART was the most important enabler reported by older adolescents.

Conclusions: Understanding barriers and enablers among ALHIV is important for the design of appropriate interventions. Healthcare providers should address these through their engagement and participation, which may include peer or buddy treatment approach. Further, policymakers should revisit their treatment policy and include the newly identified emerging treatment barriers.
Meeting the Emotional and Psychological well-being of Adolescent and Young people Living with HIV; A Relevant tool for Adherence And Retention in Care

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Background: Adolescent and young people (15-24) living with HIV not only deal with their physical health but also their emotional health, psychological stability, disclosure and stigma. Although some Adolescent and young people living with HIV are able to surpass this, but when this challenge interjects with Romantic Relationship, self-stigma and discrimination, depression and anxiety. Adherence and retention in care is threatened.

Description: In Lagos Nigeria as at 2017, more than sixty percent (60%) of Adolescent and young people living with HIV in our Network and Support Groups had decline in adherence and clinical appointment, which is a big threat to retention; all of which can be traced to emotional and mental instability, resulting from self stigmatization, inability to disclose their status and poor negotiation skill in terms of sex, Stigma among same sex relationship.

A four weeks peer education interventions with the aim of meeting emotional and mental well being of AYPLHIV accessing care in four ART centers in Lagos State Nigeria. The interventions extensively addressed optimum adherence strategies, negotiation skill in terms of sex and managing relationship and life skills, self esteem, goal setting and adaptation strategies for disclosure. The participant were closely monitored for another three month to note any improvement in their viral load and retention in care and results achieved were amazing as improved adherence ranging from 65% to 75%, 60% disclosed status, 85% negotiated condom use with their partner consistently through the results were amazing but more could still be achieved.

Lesson Learned: Adolescent and young people living with HIV are diverse with different issues at different ages, more like the different stages in life, Adherence for young people is a big issue so also is starting and retaining them on treatment; one way is to tackle this issue is to get a peer-educator to help them to fully understand how to go about their treatment and to better understand themselves as well as the Undetectable = Untransmittable; This would help them focus well on adhering to treatment of which will strengthen the realization of their abilities, coping with normal stresses of life, productive contribution to their community, clinical adherence as well as taking responsibility for their health.

Next Step: Inclusion of Peer-to-peer mentors and young Emotional and Psycho-social experts in Adolescent and young people HIV response cannot be over emphasized. Furthermore the Undetectable = Untransmittable concept should be promoted targeting Adolescent and Young People who are negative which would help in changing their perspective on stigmatization and discrimination so as to reduce pressure from discrimination from the environment on Adolescent and young people living with HIV.
Characteristics of a Nationwide Cohort of Nigerian Adolescents Living with HIV on Treatment

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Background: At an estimated 240,000, Nigeria has the second highest number of adolescents living with HIV (ALHIV) globally. Treatment outcomes for ALHIV have been poorer than for adults and younger children living with HIV. In order to improve outcomes for this population, comprehensive profile information is needed for programming innovations and differentiated care. We collated patient-level data from a large cohort of Nigerian ALHIV on ART to facilitate high-level decision-making for better outcomes.

Methods: Between April and September 2017, data from all sites supported by six of the largest member organizations of the Nigeria Implementation Science Alliance were collected from the relevant State Health agencies. These 6 PEPFAR-implementing partners supported healthcare facilities across all 6 of Nigeria’s geopolitical zones. Data from 10-19 year old ALHIV enrolled in care and on ART during the review period were targeted. Data collected were extracted from de-identified programmatic databases that included socio-demographic and clinical treatment information. Data from each partner were merged into a single Microsoft Excel database and descriptive analysis conducted using STATA 13.

Results: A total of 22,551 unique ALHIV entries were identified, from 29 of Nigeria’s 37 states and the Federal Capital Territory. The highest proportion of ALHIV (34.1%) came from the North-Central Zone, and the lowest proportion (9.3%) from the South-West. ALHIV in this cohort comprised 13,473 (59.7%) females, and were spread at 30.5%, 33.5% and 36.0% across early (10-13 yrs), mid (14-16 yrs) and late (17-19 yrs) adolescence, respectively. The greatest proportion of females (77.5%) was in the 19 year age group, with the lowest proportion (~50%) across the 10-14 year age group.

After excluding 4% missing data, approximately 91% of adolescents in the cohort were documented as being currently on first line NNRTI-based adult or pediatric combination ART. The remaining 5% of ALHIV were on PI-based second-line regimens. Facility-based ART refills for the majority (59.4%) of this cohort were on a two-monthly cycle; 29.7% on a one-monthly cycle and 10.2% on a three-monthly schedule.

There were significant data gaps, with little to no information available on source of HIV infection and point of service entry into care, marital or sexual activity status, HIV disclosure status, or viral suppression.

Conclusions: This ALHIV cohort represents nearly 10% of the estimated 240,000 ALHIV in Nigeria, and offers an opportunity to understand and program for impactful differentiated ALHIV care in the country. Questions remain on the relative absence of older adolescent males in care, regimens adjustments and switching based on weight and viral load data, and the best schedule and approach for delivering ART to this challenging population. Missing and non-prioritized data is an issue, specifically that needed to provide adherence support and comprehensive sexual and reproductive health services, including PMTCT and partner notification. Data collection for relevant indicators need to be incorporated into routine programming for improved service delivery. Longitudinal monitoring for this cohort can potentially yield valuable data to improve treatment outcomes.
Uptake and yield of index linked HIV testing for children and adolescents aged 2-18 years in Zimbabwe.

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Background: We evaluated the effectiveness of index linked HIV testing for children and adolescents aged 2-18 years in rural and urban Zimbabwe where the adult HIV prevalence in 2016 was high at 14%.

Methods: Individuals living with HIV attending primary healthcare facilities for treatment in Bulawayo (urban, 4 clinics) and Mangwe (rural, 2 clinics) were approached by trained research assistants over 5 months (Feb-July 2018) and asked whether they had children or adolescents of unknown HIV status living in their households. If they did, 3 options were offered for their children to access HIV testing and counselling (HTC):
1) Clinic-based HTC
2) Home-based HTC performed by community health workers.
3) Testing performed by caregivers using an oral mucosal test (assisted HIV self-testing) [*March-July2018]

Participants who consented to participate were followed up to assess the HIV testing outcomes.

Results: From February to July 2018; 7819 HIV positive individuals were screened in 6 primary care clinics (64.9% female, median age 42 years) after eliminating ineligible indexes for various reasons e.g. no guardian if <18 years, previously screened, no children, no consent; 2806 indexes consented to take part in the study. Among consenting indexes, there were 5837 children and adolescents identified. Among them 2118 (36.3%) children aged 2-18 years living in their household were of unknown (never tested) HIV status (mean age 7 years), 2080 (35.6%) children were last tested negative over 6 months ago, 1258 (21.6%) were known negative <6 months, 375 (6.4%) were known positive on ART and 6 children (0.1%) were known HIV positive not registered in care. All children of unknown HIV status and known negative >6 months were offered an HIV test. The offer for an HIV test was accepted for 3524 (83.9%) eligible children. While 2 testing options were available, 81.6% of indexes opted for facility-based testing, while 18.4% preferred community-based testing. When assisted self-testing was introduced in March 74.7% of indexes selected facility-based testing, 19.2% community-based testing and 6.1% assisted self-testing. This trend was similar in both urban and rural settings. Among those that accepted testing 71% were tested within 60 days and 28 children were diagnosed HIV positive (median age 11 years, HIV prevalence 1.4%, HIV yield 0.7%). 81% of children newly diagnosed were over 7 years of age. 31 (91.2%) eligible children were linked HIV to care.

Conclusion: Index linked HIV testing is an acceptable HIV testing strategy for children and adolescents in Zimbabwe, but yield is low and facility-based testing is more popular. The majority of undiagnosed children are older than 7 years and strengthening of HTC strategies to target this age group are required.
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Improved utilization of the national pediatrics and adolescent HIV/AIDS/TB call center through targeted marketing: Lessons from Baylor-Uganda

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Abstract

Background: Real time consultation between health specialists and lower cadre health care providers who are frontline in the communities through call centers can improve HIV/AIDS/TB clinical management to achieve the 90:90:90 goals in developing countries like Uganda. There is limited documentation on utilization and strategies used to improve access by health workers in periphery health facilities. In 2015, the National pediatric and adolescent HIV/TB call Centre was set up to offer consultative services to the health workers eliminating the prohibitive communication costs. Review of data in 2016 using the customer relations management system showed that the toll free line received about 23 calls per month from health workers. We describe best practices in acceleration of utilization of the National Paediatric and Adolescent Call Center from 2015 to 2017.

Description: Baylor-Uganda is responsible for managing the call center. As such, we implemented interventions to marketing the call centre including: visits to the health facilities providing HIV treatment services covering 114/121 (94%) of the districts where education sessions on the centre were provided; weekly text reminders sent out to individual health workers; print material about call centre like posters and T-shirts at the facility. Monthly summaries of total calls received by the centre were made and monthly feedback on the calls tracked through client satisfaction surveys using the Likert scale (0-10). Responses were categorized into promoters, passives and detractors after which, the Net promoter score was calculated.

Lessons learnt: Overall, calls from health workers increased from an average of 23 to 301 per month from March 2016 to March 2017. The NPS improved from 60% to 73.3% in 2016 and 2017 from a sample of 187 feedback calls made. The National coverage in terms of calls per district rose from 40% in September 2016 to 94% in September 2017 with 114 out of 121 districts calling. Strategies including facility based marketing to ART facilities and SMS texts among others improved utilization of the National Call.

Next steps: Deliberate efforts should be made to market toll-free centers targeting health workers in order to improve utilization of the service thus improving especially Pediatric HIV and TB care.
Point of Care for Viral Load Testing; a solution to integrated HIV care for Adolescents living with HIV in Kenya

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Background: In Kenya, more than half of all new HIV infections are among adolescents and has largely contributed to the significant increase of adolescents living with HIV. The standard of care for ALHIV include among others monitoring of their viral loads and additional services such as STI screening and adherence counselling. The viral load monitoring is done through a referral system where samples are collected and shipped in cold chain to centralized labs for testing. While Kenya has a robust HIV VL laboratory network, this referral system is marred with lots of challenges including less uptake of the viral load service and loss to follow up of the ALHIVs due to the long turn-around times. In view of this, HIV POCT has been identified as helpful in implementing the much needed integrated models of primary care that will allow the ALHIV to get the viral load results and other services near the patient or at the service delivery point. In this regard, the National Public Health Labs through partner and stakeholder involvement developed The Key Considerations in Implementing Point of Care in Kenya guidelines that provides a framework on how POC will be implemented for all populations living with HIV among them the ALHIVs. This document is intended for use by various stakeholders including national and county health policy makers and program managers, development partners, investors, implementing partners, logistics and procurement personnel, laboratory and health care service providers.

Methods: Development of key thematic areas in POC programming and a road map necessary for implementation. In addition, mandatory requirements that need to be enforced as a part of a quality management system in compliance with ISO 22870 particular for quality and competency were also developed.

Results: Successful development of a comprehensive national Point of Care business plan in Kenya that now allows for POC implementation even for ALHIV

Conclusion: The newly developed national Point of Care Business plan is a promising government initiative that will better treatment outcomes to ALHIVs with the overall goal in using innovative technology to attain the 3RD UNAIDS 90-90-90 targets among adolescents in Kenya. Their ability to relay results to the ALHIV in a single visit could greatly improve their treatment outcomes, provide better linkage to care and minimized loss to follow ups (LTFUs).
Operation triple zero: An adolescents and young people peer-led model for optimizing treatment outcomes

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Introduction: The Operation Triple Zero (OTZ) initiative is geared towards motivating adolescents and young people (AYP) to take responsibility for their own health and commit to achieving zero missed appointments, zero missed drugs and zero viral load. OTZ empowers AYPs living with HIV (AYPLHIV) by training them on ART treatment literacy and other topics which foster positive living. To this end, age appropriate materials and youth friendly approaches are utilised. The initiative which draws heavily from an asset based model seeks to improve health outcomes, including achieving viral suppression. With its inception back in 2014, the OTZ club at the Kenyatta National Hospital Comprehensive Care Centre (KNH CCC) is the oldest in Kenya. The KNH CCC AYPs have played a leadership role in mentoring budding OTZ clubs around the country, thus positively impacting the lives AYPLHIVs.

Problem Statement: HIV/AIDS tremendously alters the lives of AYPs living with the condition. Psychosocial and other issues influence all spheres of their lives, including adherence which is crucial to attaining viral suppression. It is well known that AYPs value the opinions expressed by their peers. The Global Health Village platform is a perfect opportunity for the KNH CCC OTZ AYPs to showcase their work and talents, with the ultimate goal of motivating AYPLHIV globally to take charge of their health and improve their health outcomes.

Justification: Despite accounting for only 11% of the adult population, adolescent girls and young women aged 15–24 years accounted for 20% of new HIV infections among adults globally in 2015 (UNAIDS, 2016). In Sub-Saharan Africa, adolescent girls and young women accounted for 25% of new HIV infections among adults (UNAIDS, 2016). In Kenya, the total number of Persons Living with HIV in 2013 was estimated at 1.6 million (Kenya MOH, 2014). Among the youth (15-24 years), HIV prevalence was higher among females than males (2.7% v/s 1.7% ) (Kenya MOH, 2014). Of note is that women in this age group accounted for 21% of all new HIV infections in Kenya (Kenya MOH, 2014; NACC, 2014). Centers of Excellence (CoE) project data reflect a five-fold increase in the proportion of adolescents and youth aged 15-24 years entering HIV care between 2004 and 2015(Mecha et al., 2016). This underscores the importance of exploring innovative, AYP friendly approaches to address the unique needs and challenges faced by AYPs. The Global Health Village platform presents such an opportunity.

Results:
1. This innovation has resulted in 98% retention rate among a population of 398 adolescents.
2. The viral suppression rate was 83% as of June 2018.
3. 98% of the population keeps their appointments as scheduled.

Objectives/ Expected Outcomes of the OTZ initiative participation in the conference
1. Create a forum for AYPLHIVs to socialise & share experiences at an international forum
2. Sensitize AYPs globally on the existence and benefits of OTZ membership
3. Showcase OTZ work and AYP talent
A study on determinants of art adherence among young people living with HIV in Mangochi and Chikwawa districts, Southern Malawi

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Background: Young people and specifically girls and young women often have poor sexual and reproductive health outcomes compared to adults. Notably 13% and 33% of maternal mortality in Malawi is among adolescents aged 15-19 and young women 20 to 24 years respectively. In Malawi, the Coalition of Women Living with HIV (COWLHA) implements the Get Up, Speak Out (GUSO) programme with support from Aidsfonds and works on improving the access to sexuality information and sexual-health services, including for young people living with HIV. COWLHA, is one of the organisations noticing an increased number of people who are not adhering to treatment, despite the increasing uptake of HIV and Reproductive Maternal and Neonatal Health (RMNH) services.

This research was done to come up with evidence on how YPLHIV can be supported best in COWLHA’s under the following objectives

1. Determining primary reasons for ART defaulting by young people and young people in COWLHA’s implementing areas in Malawi disaggregated by age, gender, socio-economic status, mode of infection (paediatric vs. behavioural-infected) and knowledge about ART
2. Identifying characteristics for triaging young people that need support to adhere to ART;
3. Investigating the relationship between the rising number of ART defaulters and the ‘test-and-treat’ strategy:

Methodology: The study employed a mixed methods approach using qualitative and quantitative research methods and was conducted in Mangochi and Chikwawa Districts where COWLHA is implementing its programmes. Qualitative data analysis involved content, thematic and discourse analytic methods using NVivo software, as appropriate. Qualitative data analysis followed analytic themes based the TDF domains. Quantitative data was analysed using STATA.

Results: Over the entire period under review, 92% of AYPLHIV initiated on ART before the Test and Treat policy were retained on treatment over the review period; 2% defaulted, about 1% died and 5% were transferred out of health facilities to other treatment centres. On the other hand, for AYPLHIV initiated on treatment under the Test and Treat policy, 97% were retained on treatment, 0.5% defaulted, 0.3% died and 2.5% were transferred out. Time to default incident was analysed and revealed that, overall, majority (81%) of AYPLHIV defaulted treatment within the first six months of initiation. The risk of treatment default was lower among YPLHIV initiated on ART after/during the Test and Treat policy than their counterparts who started ART prior to Test and Treat. The results also show than compared to Chikwawa, the risk of defaulting ART for YPLHIV is about ten times higher in Mangochi. The results also show that the risk of treatment default is much lower among YPLHIV initiated on ART in WHO clinical stages 3 and 4 compared to those who initiated in stages 1 and 2.

With regard to risk factors for treatment default among YPLHIV, this study’s findings are consistent with others on various themes including: unfriendly environments that propagate stigma and discrimination in the home and schools; limited social support system, and health system that may not be responsive to the care needs of YPLHIV.
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Using ‘Whatsapp’ In Improving HIV Care For Teens In Kenya

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Background: Adolescents living with HIV are an underserved population, with poor retention in HIV care services and high mortality, who are in need of targeted effective interventions. Adolescence is sometimes characterized by high risk sexual behavior and a lack of engagement with healthcare services that can affect adherence to antiretroviral therapy. We conducted a literature review to identify strategies that could be adapted to meet the needs of adolescents living with HIV.

Methods: HIV positive adolescents in high schools and colleges with smartphones and high viral load with poor retention between 2014 and 2017 were considered for this study. A multidisciplinary team of adolescents HIV volunteers carried out an assessment of clinical and patient factors leading to treatment failures. The team members had defined specific roles and independent task to strengthen adherence and improve retention. Chart abstraction was done and data collected to establish patient factors associated with adherence and retention and any method that can be used to improve adherence and retention. Data was analyzed descriptively using frequencies and proportions.

Results:
1. Treatment files from 135 adolescents, 67(49.6%)females and 68(50.4%)male were reviewed.
2. The median age was 17 years with 85(63%) having secondary education. All adolescents were on ART with 75(55.6%) had failed treatment ( adherence and retention).
3. About 87% of adolescents knew mobile phone application called ‘whatsapp’ and 75% had access to ‘whatsapp’ and joined the newly created ‘whatsapp’ group.
4. About 67% of adolescents who had joined ‘whatsapp’ group were doing well in treatment.
5. 100% of adolescents who had joined the ‘whatsapp’ group got access to sex education, disclosure education and other more educational materials.

Conclusions: There is disparity among adolescents who get access to ‘whatsapp’ in terms of adherence and retention.
With active ‘whatsapp’ groups, hundreds of young people who are born HIV positive can access HIV treatment education, turn their anger and despair into renewed hope, and pursue their dreams again.
Transgender, Male Sex Workers and HIV/AIDS Transmission

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Background: This paper is concentrated with some unreached area of HIV/AIDS transmission. Transgender and male sex worker is a major group of sex work in Khulna but at the same time it is an unrevealed shocking issue for Khulna people. In this research the risky side of male sex workers and transgender is represented with their involvement of spreading out HIV/AIDS. HIV/ AIDS is a very important issue and most of the time people ignore the issue. In case of adolescent transgender and male sex workers people cannot even imagine about their involvement in sex work as well as they can be possibly responsible for spreading out HIV/AIDS. But this is a major issue and a huge number of adolescent transgender and male were found involved in sex work through research and their risk for spreading out HIV/AIDS was another alarming issue came out from the analysis.

Methods: To mitigate the spreading of HIV/AIDS through insecure physical relations JJS, UNICEF jointly running counselling and screening of HIV/AIDS for adolescent transgender, Male Sex with Male and Male Sex Worker.

Result: At the beginning of the project 100 Transgender (TG), Male sex worker (MSW) and Male Sex with Male (MSM) was targeted to take under testing and counselling. At this current time there was 74 TG, MSM and MSW received the testing and counselling facilities. Now the rate of their post counselling consciousness is 92% which is very significant.

Conclusion: At the beginning of the project it came out that the TG, MSM and MSW have very small amount of knowledge on HIV issues. But now through counselling the behavioral change among the target group is very major (according to the statistical analysis of their verbal interview report). Now their risk of HIV/AIDS transmission is declining also. After counselling, the group of most risk TG, MSM and MSW are taking precautionary measures while they are involve in sex work.
Monitoring and reporting psychosocial care and support for PLHIV as part of comprehensive HIV care: Experiences of integration into the national HMIS for Uganda

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Introduction: Adolescents are a unique population with a myriad of psychosocial concerns arising from their stage of development. These directly impact treatment outcomes for Adolescents living with HIV (ALHIV). Although psychosocial care and support (PSS) has been widely documented elsewhere as major determinant of positive HIV care and treatment outcomes, there has been no proactive identification and documentation of PSS issues among adolescents national level. The national guidelines highlight positive health, dignity and prevention (PHDP); including PSS, but its implementation is weak. There has been no national job aide to assist service providers to document psychosocial assessments and track these among adolescents and young people. The ‘test and treat’ strategy adopted in 2016 further underscores the need for structured and well guided psychosocial care and support for PLHIV.

Methods: In 2016, the AIDS Control Program (ACP), Ministry of Health initiated the process of strengthening PSS service delivery. Key strategies were identifying and engaging PSS technical experts; constituted a national TWG comprising of MOH technical staff, PSS experts, academia, implementing partners, Sub-national partners (districts), other line ministries and civil society organizations (CSOs) to discuss and provide guidance for programming, monitoring and evaluation of PSS. Activities included; conducting consultative meetings, writing workshops, and stakeholder engagements. National psychosocial care and support operational guidelines; training materials, standard operating procedures and health worker job-aids developed; national level PSS indicators at process, output, outcome and impact levels determined, data elements to be routinely collected and reported identified and revised national HMIS tools for documenting and reporting HIV services to include PSS.

Achievements: By July 2017, several achievements had been reached. To standardize and guide programming for PSS through the guidelines, a comprehensive service package was developed, PSS standards established, the PSS care cascade documented, delivery approaches clarified, a multi-disciplinary health care team recommended, and guidance for differentiated PSS services provided. To strengthen monitoring and evaluation for PSS services as well as improve patient management, the following has been achieved to date: the national primary data collection tool (HIV/ART Care card) was modified to include PSS aspects, which shall be monitored for all clients on every visit; the ART Register revised to include PSS indicators and a Psychosocial Peer Support group Activity Log developed to track activities of peer support groups.

Lessons Learnt and Next steps: Meaningful engagement of both internal and external stakeholders is the game changer in the integrating psychosocial care data elements and indicators in the national HMIS. Key stakeholders internally include the MOH leadership, technical staff from all HIV program areas and other MOH departments especially Health Information, Reproductive Health and mental health. Critical external stakeholders involved include AIDS Development partners, implementing partners, health facility teams, other relevant line ministries especially education and gender, labor and social development; civil society organizations; the academia and PSS technical experts. In addition, a psychosocial technical officer at national level is central to coordinate the integration process. Next steps are: disseminating the guidelines, training health care providers, rolling out the revised HMIS tools, and monitoring implementation.
Implementing the Good Participatory Practice Guidelines in the Girls Achieve Power (GAP) trial in South Africa

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Background: Stakeholder involvement is a key component of ensuring a study’s acceptability, feasibility, enrolment and outcome assessment as well as the design, implementation and overall quality of the research. Globally, there has been increased advocacy for the involvement and engagement of community stakeholders for clinical trials and health research. Developed by AVAC and UNAIDS to systematically guide stakeholder engagement, the Good Participatory Practice (GPP) guidelines provide a framework for stakeholder engagement within clinical trials, to ensure a study’s acceptability, feasibility, and improving the overall research quality; however, they have rarely been applied beyond this setting, and no literature exists on its application in adolescent research.

Methods: A review of the 2011 GPP guidelines was undertaken to identify which 16 GPP topic areas could be applied and adapted for implementing an ecological asset building intervention i.e. the Girls Achieve Power (GAP Year) cluster randomised controlled trial for reducing school drop-out and increasing reporting of gender based violence in Gauteng and Western Cape province in South Africa.

Results: The 16 GPP topic areas were adapted and implemented to guide stakeholder engagement for GAP Year, identifying specific strategies to adopt for research with adolescents that have been implemented to date.

Conclusion: We show the usability and adaptability of the GPP framework for guiding stakeholder engagement in non-clinical trials like GAP Year. Most of the GPP topic areas were applicable to GAP Year, however, adaptations were required to respond to the unique needs of the beneficiaries, study design, location and tools. Adaptations included using mobile platforms for sharing health information with adolescents, text messaging platform and dialogues to engage parents and focus group discussions with adolescents and workshops with coaches to discuss tool and curriculum development, messaging and IEC material content. Systematically planning and implementing stakeholder engagements using the GPP framework helped elicit feedback and requests for further information from various stakeholders.
Adherence to antiretroviral therapy among adolescents living with HIV: an overview in the center region, Cameroon.

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Background: Today, AIDS is the leading cause of death among adolescents worldwide and the second most common cause of death among adolescents aged 10–19 years. This high mortality is largely attributed to challenges in adhere to Antiretroviral therapy (ART), as well as appropriate transitioning from pediatric to adult ART regimens. In Cameroon, adolescent’s rate of adolescents living with HIV (10 – 19 years) and their associated factors remains unknown, because epidemiological data are not disaggregated by age group. This study aimed to better understand Cameroonian adolescents’ experience to ART in order to implement and evaluate a range of effective adherence management interventions.

Method: We conducted a cross-sectional study in 13 health facilities in the Centre region of Cameroon. A mixed approach (combination of quantitative and qualitative techniques) was used and data collected from April to June 2018). A total of 270 adolescents that were on ART at least six months before the study were involved. Were included in this study only adolescents with a recent viral load count test available. Viral load suppression was used to ascertain if an adolescent was adherent or not. Those with a viral load less than 1000 copies/mL were considered as adherent and those with more than 1000 copies/mL were considered as non-adhering. For qualitative aspect, we conducted fourth Focus Group Discussions (Two with girls, 2, with male) with adolescents who are already disclosed and two FGD with parents/caregivers).

Result: The mean age of these adolescents was 14.57 (SD2.869) years. Among 270 adolescents involved for this study, 228(84.4%) were infected through their mother. 169 (62.6%) were adherent with viral load result less than 1000 copies. Adolescents in urbanely located health facilities were about 4.5 times significantly more likely to be adherent compared to those in rurally located health facilities (OR 4.77; 95% CI: 2.83-7.14; p=0.002). Adolescents who were transmitted vertically were 4.4 times significantly more adherent (OR 4.42; 95% CI: 2.75-7.11; p=0.002) compared to those horizontal transmission. Despite association between adherence and adolescents sexual active (p=0,031), they was not association between adherence and disclosure of the status (p=0, 12). Qualitative result shoes that adolescents described a context of negative societal beliefs about HIV, necessitating a lifestyle of secrecy and minimizing the information shared about HIV or ART.

Discussion: Results of this research on adherence to ART among adolescents living with ARV shows that adherence level is poor. Most of factors influence adherence to ART linked to heath facility and clinical factors. No consistent, predictive socio demographic relationships with adherence to antiretroviral medications were emerged. Development of intervention strategies according to these factors identified may able more accurate monitoring of adherence.
HIV Suppression Outcomes Among Adolescents In Kenya; Retrospective Cross-Sectional Analysis

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Background: Globally, the HIV burden among adolescents by 2010 has substantially increased by over 30%. This is mainly as a result of the HIV Exposed Infants who acquired HIV infection either pre-partum, partum and post-partum (0-18months) before the now readily available Prevention of Mother to Child Transmission (PMTCT), now reaching the adolescent stage because of successful initiatives implemented by the HIV Care and Treatment programs. The current program data in Kenya indicate that there is an increase in adolescents living with HIV, and the country is among the 21 global priority countries that collectively account for 90% of adolescents living with HIV (ALHIV). Several countries have reported non suppression levels among the adolescents mainly because of poor adherence and development of drug resistance due to being on life-long anti-retroviral therapy since infancy. Although Kenya has scaled up viral load testing as a measure to monitor ART treatment outcomes, we do not have granulated data on the suppression levels of ALHIV. In view of this, we sought to do a retrospective cross-sectional analysis of viral load suppression levels among adolescents living in Kenya whose samples are routinely analyzed at the EID/VL network labs, Kenya.

Method: We conducted a retrospective analysis at the National HIV Reference Laboratory, Kenya of viral load outcomes among adolescents aged between 10-19 years using viral load Results from routinely collected samples from ALHIV attending routine care at all facilities in Kenya. The period of analysis was between 2012 to 2017. Statistical analysis was done using SAS version 9.4 to assess the suppression levels.

Results: Adolescents between the ages 10-19 years had a lower suppression rate in 2012 (30%) but reported an increased mean suppression rate of 63.5% by 2017. Upon granulating the data further, adolescents between the age 10-14 years had better suppression rates of 66.9% as compared to their counterparts aged between 15-19 years who had a mean suppression rate of 58.3% in 2017. By gender, the females generally reported a suppression rate of 61% as compared to the males who reported a suppression rate of 55%. Analysis by regions of the country showed that there were no significant differences in suppression rate among adolescents.

Conclusion: The viral load suppression outcomes among ALHIVs, has significantly increased by 2017 due to the initiatives put it place by the HIV care and treatment program in Kenya for the ALHIV population. However, if Kenya is to achieve the 3rd 90 UNAIDS, then more measures and priority activities needs to be given to the adolescents who are living with HIV in Kenya.
Soliciting parental consent amongst adolescent minor mothers does not affect enrollment in HIV prevention intervention study

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Background: There are concerns that having to solicit parental consent for adolescent minors’ participation in HIV prevention research is a barrier to enrollment. To date, there is limited empirical data which has examined whether solicitation of parental consent negatively affects participation among adolescent minors, particularly among adolescent mothers who have recently given birth. The purpose of this study is to describe strategies staff used to enroll adolescent minor mothers into the intervention study. Further, we compare enrollment into an HIV prevention intervention among adolescent mothers who are under the legal age of consent to those who are 18 and older.

Materials & Methods: Adolescent mothers (n=120) participated in a DREAMS Innovation Challenge intervention, Mentoring Adolescent Mothers at School (MAMAS); funded by PEPFAR and managed by JSI Research & Training Institute, Inc. Mothers were screened for eligibility between July 2017 and April 2018 at a public hospital’s maternity ward in a township near Durban. Mothers were eligible to participate in MAMAS if they had given birth in the past six weeks, had attended school in the past year, were between 14-19 years old, and had planned to live in the township for 6 months. Parental consent to participate in the intervention study was sought for eligible adolescents who were under 18 at their home or on the day of discharge. We conducted interviews with MAMAS staff to provide insight on strategies used to solicit parental consent. We use screening and enrollment data to ascertain if there are differences in enrollment between adolescent minors and those who are 18 and over.

Results: Staff implemented three strategies to solicit parental consent so that adolescent minors could enroll in the MAMAS intervention: (1) The staff leveraged the fact that a parent/guardian had to be with the adolescent mother when she was discharged from the hospital. Specifically, staff approached the parent/caregiver immediately after discharge activities to describe the MAMAS intervention. (2) If the parent/guardian could not stay after discharge activities, staff explained MAMAS while transporting the parent/guardian home. (3) Further, staff provided late afternoon and Saturday clinics where parent/guardians could come complete the informed consent process to accommodate busy schedules. Although parental consent was not required for adolescents who were 18 and over, staff attempted to contact their parent/guardian to share information on MAMAS with the adolescent’s permission. From the interviews with staff, they felt that adolescents of legal age whose parent/guardian were informed had better retention than those whose parent/guardian could not be reached. In examining the screening data, there were no statistically significant differences in enrollment rates between adolescent minors (90.9%, n=50) and adolescents who were 18 and over (79.6%, n=70) (p=0.07).

Conclusions: Soliciting parental consent did not negatively affect adolescent minor’s enrollment into MAMAS. Although time consuming, involving parents/guardians by obtaining their consent or simply describing the intervention to them could be beneficial in the uptake of HIV prevention intervention studies among both adolescent minor mothers and those adolescents who are 18 and over.
Abstracts

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Adolescent Female Sex Worker: Case Study on Khulna City

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Background: In our society, sex work is always considered as a disgraceful and dishonored profession. But at the same time we can not deny that a huge number of female especially adolescent girls are involve in sex work either willingly or forcefully. This research aims to find out the life style, mental status and HIV/AIDS risks of adolescent female sex workers in Khulna city.

Methods: A large number of female sex workers were identified and face to face oral conversation was done. Their past life, reason of their involvement in the professions like sex work was studied. They are tested for HIV, STIs and provide free treatment if they needed under this study. Then they are under an ongoing process where these sex workers get knowledge about the harmful consequences of HIV/AIDS and relievent counselling. Their sequential change is also under observation and followed up through this research.

Results: After analyzing the pre and post counselling of the condition of the adolescent female sex worker in this study it is resulted that 85% of the floating sex workers are taking precautionary steps at least. Before counselling and showing the adverse effect of the risk of HIV/AIDS of their unprotected sex work most of them were careless about their life. But now 78% of them are practicing safe precautionary sexual behaviours.

Conclusion: Only counselling and creating awareness among the sex worker make them so conscious that the risk of HIV/AIDS of the target group have been reduced by 88.81% (according to verbal conversation survey) and this amount is very positive achievement for any project. If it can continued in this way the risk of HIV/ AIDS will furthure decreased.
Innovative Youth Led Approach to Address Stigma and Discrimination through Y+ Pageant

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**Background:** Young people have continuously faced frustrations from stigma and discrimination from their families, schools, guardians, potential employers and the general public. This affects their mental health, uptake of HIV services at health facilities, adherence, fear to disclose due to violence and rejections during this critical development stage which exposes them to risky behavioral practices. With this background, Uganda Network of Young People Living with HIV & AIDS (UNYPA) a youth led non-for-profit organization together with partners worked to uplift the plight of all young people living with HIV&AIDS in Uganda, in order to re-echo their voices and build a strong, energetic, creative, and productive generation through a unique event dubbed Y+ Pageant.

**Method:** The Y+ Pageant is a national activity for young people between 16 and 24 years of age. It includes regional auditions for the four regions of the country to ensure that the young people from different regions are represented. The four winners from the regions continue to the bootcamp which is a week-long capacity training done by expert trainers where the four contestants from each region camp together to widen their knowledge on, positive living, economic empowerment, key advocacy, life and hands on skills to make them as competent as the HIV negative young people. The campaign is crowned off with the grand finale which is an advocacy platform where stakeholders, decision makers, Partners and YPLHIV come together to witness and support the 16 contestants to go out and be the voices of their fellow young people living with HIV/AIDS and to front their key asks in relation to SRHR and HIV services. Furthermore, the 16 contestants showcase their advocacy skills, knowledge on HIV/SRHR, and also share their action plans in fighting stigma and discrimination before a high-level jury and audience present. 6 winners are selected (2nd and 1st runners up, and national Miss & Mr. Y+). The ambassadors are provided spaces, opportunities to attend high level meetings. These speak out for their fellows and influence decision making for a full year before the campaign resumes and other ambassadors selected.

**Results:** This campaign has been run since 2014 and over the years, it has managed to reach different people even those on social media. The campaign has so far reached 25600 young people and a pool of decision makers. In regards to empowering youths, this campaign has given confidence to the young people and revived their self esteem as they are supported by a technical team to handle different situations. Due to the plea of the ambassadors, an anti-stigma policy has been drafted and they are now living as champions in the different areas of advocacy.

**Conclusion:** The Y+ pageant not only fosters youth leadership, engagement and advocacy but also supported the young people to overcome the traumatizing stigma and discrimination in their communities.
Improving Service Provision to Adolescent and Young People Living with HIV: “What we want and how to do better”

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Background: In most countries across Africa the health care system is not designed to cater for the health needs of young people especially adolescents and young people living with HIV (A&YPLHIV).

There is world wide support for youth-friendly SRH education and services which also address gender inequality and provide a holistic package of care. However, many services, particularly in the adolescents’ space remains under resourced and not tailored towards the specific needs of this diverse group leaving most of their needs unmet. To succeed services needs to be accessible and user friendly to be effective. Poor quality services discourage most A&YPLHIV from accessing information and services that are needed to make informed decision around healthy living. Judgmental service providers, lack of privacy, inconvenient service schedules and inflexible appointments all are contributing factors that dramatically reduce uptake and retention in services.

The Global Network of Young People Living with HIV (Y+) is a partner in the International HIV/AIDS Alliance led READY+ consortium working in four countries, Zimbabwe, Swaziland, Mozambique and Tanzania to deliver youth friendly HIV/SRHR and psychosocial support to adolescents and young people living with HIV. Y+, through focal points in their respective networks of YPLHIV in these four countries worked with colleagues to develop a tool that provides guidance to service providers on how to work with young people living with HIV.

Methodology: Y+ focal points in the four countries held consultative sessions with over 100 adolescents and young people living with HIV, including at ICASA 2017, to outline the health needs of A&YPLHIV on what really matters to them when accessing tailored, judgement free and user-friendly services. The outputs gathered were collated into a leaflet that outlines what health care providers can do to support adolescents and young people living with HIV, feel more comfortable and supported when accessing the health care system within health facilities.

Result: A tool that guides and supports health care providers in understanding the realities and experiences of young people when accessing services and how they can contribute to providing safe, informed and better quality services. The tool summarizes, ‘the Do’s’ and ‘the Don’ts’ in an easy, simple and honest leaflet. It also includes a Service Charter that promotes and champions good practices of health care providers and a scorecard for young people to rate the level of user friendliness of the facilities attended. The tool also outlines the expectations that young people should have about adult caregivers and their responsibility towards their health needs.

Conclusion and Next steps: A guide to introduce the tool to health facilities is under development and will be piloted within health facilities in the four READY+ countries under PATA and Y+ leadership in 2018. It is expected that the tool, including the Charter and scorecard, will build a bridge and establish better collaboration between health workers and young people living with HIV to improve their access to services.
Behavior change among adolescents in and out of school within six counties in Kenya.

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Background: The Positive Teens Positive Lives project is a 2 year program (2016-2018) funded by UNICEF with the aim of monitoring behavioral change among young people aged between 10-14, 15-19 and 20-24 years and equipping them with information on HIV and AIDS. The key area of operations of positive teen positive lives project is the creation of enabling environment that is intended to enable young people to assert their Sexual Reproductive Health rights through meaningful youth participation (MYP) at all levels of programming.

Description: Positive Teens Positive Lives project is being implemented in 6 counties, Nairobi, Mombasa, Kisumu, Migori, Siaya and Homabay for Sauti Skika, who are “Using the Positive Health, Dignity and Prevention” Framework to Explore the Lived Experiences of Young People Living with HIV in Kenya”. Youth participation guide has been developed with input from YPLHIV, which is currently used to equip Young People Living with HIV with knowledge on active Meaningful Youth Participation in Reproductive Health and HIV/AIDS programming at institutional and programmatic levels.

Lessons learned: Meaningful Youth Participation is achieved by placing young people at the Centre of the Positive Teens Positive Lives project, through active and meaningful participation throughout the program. There is a realization that youths are experts of their own experiences. Experience sharing is critical, leading to opening up of other YPLHIV. Engagement lead to the realization by political leaders that youths are important partners and credible advocates in the fight against HIV/AIDS and SRHR.

Conclusions/Next steps: Program is led and owned by the youth through Sauti Skika network. This was achieved through involvement of young people in the program development and implementation . During the period of implementation, more than 3000 adolescents where trained and equipped with tools to help reduce Stigma among school going adolescents, afterwards there was a change in attitude among the communities and schools that had the adolescents who where trained. This has led to the formation of health clubs in schools and psychological support groups to help disseminate information on Stigma reduction. “Sauti Skika Stigma champions”, meaning our Voices are Heard formed by a group of YPLHIV. So far it has 15,000 members countrywide. One of the young members presented the issues of YPLHIV at the “All in” Campaign launch at UN General Assembly special session, which has led to recognition and commitment by the President of Kenya to fast track the end of new HIV infections among Young people.
We are still here! Sharing our stories to save our lives.

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Background: South Africa has an estimated 7.1 million people living with HIV, or 18.9% of the total population. 10.4% of young women, and 4.0% of young men are believed to be living with HIV. In the Vhembe District of the Limpopo Province — where we live — the prevalence is 20.3%.

There is an increase in HIV prevalence nationally among both the female and male 15 - 49 year age groups, but a reduction in children less than 15 years old. People say this is because reducing mother-to-child transmission, but there is arguments that using different kinds of projects for young people can reduce HIV infections or keep kids infected at birth healthy. We believe that a big part of this is peer support.

Methods: A group of 29 young people living with HIV since birth who reside in the rural areas of the Vhembe District in South Africa have organized ourselves because we saw a need to encourage younger children living with HIV. The problems of living with HIV have made our lives difficult. Nurses are often judging us, and so are the communities where we stay. This happens a lot more if we have lost a parent to AIDS and we are orphans, sometimes raising our little brothers and sisters. Many of us have experienced discrimination in schools because of our status. But we are strong and we want the new children living with HIV to avoid these problems, so we decided to find ways to empower them.

With support from UNICEF to help us reach clinic peer support groups, and a project focussing on young people in South Africa and Ethiopia (EthioSA), we started to use our voices and experiences to break down walls. We speak to groups of 20 - 30 children ages 5 - 15 years every second weekend about health, future goals, the importance of taking safety measures, and the signs of child abuse.

Lessons Learnt: Letting them know that we believe in them - and support them - makes them feel not alone, and less discriminated against. And by talking about our lives, we feel better and encouraged to live healthy lives too because we are role models. We see that after the sessions, they understand living healthy with HIV, and accepting their status knowing that they can survive like we do. They also are proud of their small viral load blood tests, which makes them not a risk to other people.

Discussion: We have learnt that people only die of ignorance, not of HIV. Giving children tools to survive, which is ARV treatment and good advice from people like us who have lived this life, makes them empowered. We respect our elders and the projects they do for us, but we want to be part of the solution. When we talk about our stories, we are saving lives.
A Case For Safe Spaces Towards Positive Youth Engagement In Community Transformation

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Background: Without the existence of safe spaces, youth from different race/ethnicity, gender, religious affiliation or cultural background may feel intimidated to freely contribute to community transformation and development efforts. The features of settings where young people spend their time have been found to decisively impact on a young person’s development.

Materials & Methods: Youth Rising is solving the problem of unemployment among youth who have not gotten a chance to get formal education. In Uganda youth face challenges in making the transition to adulthood, poor educational quality, lack of social safety nets including youth-friendly services, high rates of youth unemployment and underemployment, as well as issues such as child labor and un-purposeful rural to urban migration. At Youth Rising, we believe that the resiliency, creativity and innovation of these very same young people in hardship can power community transformation.

At the centers, we train young people through a three-pronged success curriculum that includes: Vocational Skill Building, creating access to economic opportunities and Youth Health Friendly Services. We create and capture value through our youth-2-youth (Y2Y), service-learning model that encourages network effect where young professionals have the opportunity to mentor their near-peers in life skills, a range of vocational trades and business development on a volunteer basis. The end result is two-fold with our young members paying to study and benefiting from the programs availed to them and become economically and socially empowered young leaders and the volunteers reap the reward of making a difference in other people’s lives, while gaining valuable, hands-on experience working in a professional setting.

Results: It has been realized that the provision of a safe space is an essential component of effective community youth programs that aim to enhance positive youth development by using a multi component approach that focuses on the whole person. Peer programs should aim at creating a safe, supportive and experiential learning environment for at risk youth. It has been further noted that the concept of a safe space can mean different things for different at-risk youth. Peer-based youth programs work through a complex interplay of environment, peer group factors and program factors to deliver short term impacts on the individual.

Conclusions: To ensure that a safe space is promoted a variety of contextual factors and program activities need to be given attention to when providing community services for young people who are considered to be at risk.

- For young people lacking social skills, a safe space is somewhere they can learn and practice new skills and receive constructive feedback.
- For young people who may be subject to bullying, abuse, harassment or negative and unsupportive peer and adult influences, a safe space equates to a type of refuge where they can be assured of physical and psychological safety.
- For young people who are fearful of accessing mainstream support services, a safe space is somewhere they can access information and support without fear of being judged or having to face the consequences of disclosure.
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Developing the Y+ South Africa Network: A Youth-Led National Consultation

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Background: Increasing evidence indicates that young people living with HIV (YPLHIV) are underserved by HIV services. Actively engaging YPLHIV is imperative to ensure that services are responsive and provide sustainable, appropriate solutions. Networks YPLHIV provide structured platforms for engagement, and for members to connect and advocate for change. Currently no formal networks exist in South Africa (SA) for YPLHIV. To develop a Y+ network in SA a youth-led community consultation was conducted. We aimed to ensure that YPLHIV are meaningfully involved from the outset of developing the network and gain insights to inform the identity and strategy of the network.

Methods: A series of workshops, based on participatory learning and action approaches, were conducted in all nine provinces of SA in rural and urban areas. YPLHIV aged between 15-24 years were invited through posters in clinics and social media posts. Conducted by 18 trained YPLHIV, known as provincial leads, the workshops followed standardised guides and reporting tools. The workshops followed ethical principles through consent procedures, measures to ensure confidentiality, provision of transport costs and food as well as appropriate approvals from the Department of Health. The outcomes were analyzed using qualitative content analysis and the key themes identified were presented at a two day national network development meeting for validation and decision making.

Results: In total, 507 YPLHIV participated; 48% were 15-18 years old, 53% were female, 58% lived in rural or township areas, 32% had not disclosed their status and 68% were sexually active. Participants highlighted internal and external stigma, fear of rejections and judgement with many not wanting to disclose. Emotional distress including suicidal ideations were prominent especially when newly diagnosed. Accepting their status took time and was made possible with support especially from others YPLHIV. Poor access to and quality of services were noted with lack of information as a major barrier. Participants requested that the network be youth-led. That it provides information, builds skills, raises awareness and empowers them to live positively. They want a support systems, a safe space to be heard and listened to and a platform that connects them. Ultimately, they want a network that raises their voice, advocates on their behalf and fights for their rights.

Conclusions: A consultation process was imperative to ensure that Y+ SA is responsive to the needs and desires of YPLHIV in SA. The network's identity and work plan have been developed based on these outcomes. Y+ SA's mission is to empower young people living with HIV in South Africa. Our vision is for all young people in South Africa living with HIV to have access to their full human rights. Y+ is a movement that brings together vibrant, diverse, and empowered young people living with HIV. They advance their mission by sharing knowledge, creating safe spaces, building support systems and boldly advocating for change. Y+ SA works through provincial hubs, workshops and dialogues, national advocacy campaigns and social media.
Building Resilience Strategies for Adolescents Living with HIV through Club in Goa, India

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Background: There is a shift of HIV from a terminal illness to a chronic one opening up avenues for building resilience among adolescents to live potentially long and healthy lives. Bloom and Blossom Club, probably the first club of ALHIV in India, rose out of the need for a safe space for those in their late adolescents to discuss living with HIV.

Description: Since 2016, Human Touch Foundation (HTF) promoted engagement of ALHIVs in various programmes, providing them an avenue to advocate for their rights. The club has a membership of 123 adolescents of age group of 15-19 years. They engage in discussing issues, creative therapies, recreation, sports and community outreach. It is a platform to create a social network for mutual support; provide an opportunity to express feelings and needs; reduce the level of depression and loneliness, provide a safe and welcoming environment, emphasize and offer emotional support and practical coping skills and facilitate access to quality treatment and social security schemes.

Lessons learned: 85% report that their confidence level is raised, 87% report that their knowledge of their rights and the social environment is heightened. Further 72% reported that their personal and social development and familial relationships are improved. 53% got access to the social protection scheme and 81% got access for 100% concession in public transport to access treatment services, with the process initiated by the club themselves. Members facilitated access to treatment to 23 lost to follow up cases and access to treatment now 100%. Treatment buddies' is introduced to ensure that 90% of all receiving ART will have viral suppression by 2020. Two adolescents represented the country for the Asia Pacific TeenGen Leadership ToT by Youth LEAD.

Conclusions/Next steps: With late adolescence, a key time for healthy decision-making, skill development, BBC has shown a significant impact on the lives of ALHIVs. It has enabled their participation and engagement as well as raised their awareness of their rights and responsibilities, thus building resilience. HTF has re-envisioned their plan to include more activities, exposure, leadership training and other opportunities to make supportive connections.
The role of youth organizations in the community

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Introduction: The RNJ+ Youth Center opened in 2014. It is a community center; youth friendly, led by young people. Basic services such as: information, counseling, screening, family planning, dialogues, orientations, formalized references are provided. It is an integrated youth center of key populations: YPLHIV, MSM, sex workers, IDU and young people with disabilities.

Description and Results: The youth center is a space run by young people. All staff providing services at the community level and the governing board are from key populations. Services are offered according to the needs of young people. More than 55,000 youth aged 10 to 24 has been served over the past 3 years. The center has developed a partnership with public, community and private health institutions to provide young people with access to a range of SRHR and HIV services not available on site.

Strategies:
- Serve as a link between the communities and the care structures: Through peer educators, they sensitize and give information in the community and refer young people in need to care and management centers.
- Provide quality monitoring and mentoring: Young leaders introduce other young adolescents to advocate and become leaders in governance, technical staff.
- Document and report of rights violation cases of young key populations in health matters or cases of discrimination and stigmatization: REACT tool allowed us to document these cases of violation of the right to young people from key population.
- To serve as a community observatory on access to quality services for young people: Young people are involved in various country programs such as planning, implementation and monitoring of programs (member of Global fund CCM Burundi and CNLS Burundi)
- Strengthen the capacity of young community leaders to be activists and advocate for access to quality services: Young positive leaders testify and help others to access the service and mobilize partners for quality services of young people and adolescents
- Partnerships: Youth organization unite force with various partners in order to fight against HIV and improve SRHR services

Lessons learned: The work done at RNJ+ center proved that:
- Involving youth from key populations in service delivery increases access to peer services
- Planning based on real needs of beneficiaries at the community level is effective.
- Place of youth organizations is important in community and we observe the behavior change of positive youth sensitized in the locality
- Communication among young people is more effective on issues related to sexuality: Young people prefer an environment where they feel free to express themselves and ask for service without fear of judgmental behavior
- Providing integrated SRHR and HIV services to young people therefore requires an appropriate environment
- Working with youth in service delivery can reduce fear of discrimination and increase demand for services.

Conclusion: RNJ + Youth Center has proven the place of community-based organizations, its ability to lead for young people and is a promising practice that can serve as an example to other health institutions, particularly regarding the involvement of beneficiaries in the supply of services.
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Connecting With Adolescents And Youth In The Communities Through Adolescent & Youth Sub Cab

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Background: Baylor-Uganda Clinical Research Site (CRS), an affiliated CRS for Johns Hopkins Kampala Clinical Trial Unit, expanded its Community Advisory Board (CAB) by restructuring it to three (3) Sub-CABs to cater for the different population it serves. The three Sub- CABs are Maternal & Child; Adolescent & Youth, and Key Population/ Priority population. The need arose to have specific targeted CABs to cater and reach the different populations to be served yet it was important that adolescent and youth could be the ideal people to reach their fellow peers As such Baylor -Uganda Adolescent and Youth sub CAB was established in July 2017 with an aim of reaching out to Adolescent and youth in the community, with information on HIV/AIDS Prevention, Care, treatment and research

Description: The Sub CAB act as a strong tool in linking Baylor- Uganda program and research teams to the adolescents and youth in their respective communities and vice versa with objectives of sharing with the community information about various research and programs being conducted at Baylor-Uganda; Mobilize the community to engage in the adolescent programs and research studies being conducted and receive updates from the program and research teams and provide them to the community as needed and required

The Sub CAB compromises of dedicated youth community members with passion for issues related to Adolescents & Youth infected and affected with HIV/AIDS and committed to reaching young people and adolescents with information on HIV/AIDS as well as advocating for better friendly services. The Adolescents & Youth Sub CAB’s vision is to promote community involvement among adolescents, young people, and their families in prevention, care, treatment, and research with a mission of “An adolescent community that is informed, empowered, free from discrimination, with improved quality of life through better health seeking behaviors, for an HIV-free generation

Results: To date six community engagement meetings have been conducted with more than 600 adolescent and youth both in and out of school have been reached with prevention messages, held seven bi monthly Sub CAB meetings, conducted one residential retreat, developed CAB guideline/bilaws, work plan, budgets, SOPs. All Sub CAB members were trained on protocols, Human subject protection, public speaking and skills building.

Lesson Learnt: Improvement in adolescent & youth engagement at the Centre especially in group discussions

Next steps: Visit five high schools who have requested for the Adolescent & Youth Sub CAB to engage their students in HIV prevention education
- Evaluate impact of their work on community engagements
- Mobilize adolescent and youth communities for skills training and HIV education.
Adherence misfits: Divergent perspectives on ART-defaulting among healthcare providers, caregivers, peer-navigators and adolescents living with HIV

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Background: HIV is the leading cause of death for young people (ages 10-24) in Africa. Adherence to antiretroviral treatment (ART) is among the greatest healthcare challenge facing adolescents living with HIV. Terms such as ‘defaulting’ and ‘non-adherent’ delineate non-compliance to ART and dis-engagement from care. A growing literature identifies structural and clinical factors for ART non-adherence among adolescents. Less is known about how adolescents themselves understand non-adherence, and how this differs from their healthcare providers and caregivers.

Methods: This research investigates the disjunctures between how healthcare workers and adult caregivers define poor adherence to ART among adolescents, and how adolescents themselves conceive of poor adherence. It combines the qualitative datasets of the Mzantsi Wakho study and Paediatric-Adolescent Treatment for Africa (PATA). Mzantsi Wakho is the largest longitudinal, community-traced study of ART adherence among adolescents living with HIV (n=1063, 94% retention). PATA constitutes a network of healthcare providers in 24 African countries, collecting data from health providers and HIV-positive peer-supporters within 289 facilities.

Different perceptions of the term ‘defaulting’ were explored through qualitative interviews with HIV-positive adolescents (n=56), caregivers (18) and healthcare providers (n=13), and through clinic observations, in the Mzantsi Wakho study. PATA data constituted semi-structured interviews with peer supporters (n=6), health facility surveys (n=218) and programme reports with those providing adolescent services (n=289). PATA data on peer navigators provided insights into the roles played by young community health workers in supporting and promoting better adherence and retention in care among youth.

Results: Terms for non-adherence are used widely in research and programming for tracking and improving the health of young people with HIV. The term ‘defaulting’ is used by healthcare providers, and by some caregivers, to refer to patients with the worst adherence outcomes and the weakest retention in care. Longitudinal qualitative data demonstrated that adolescent patients did not use or identify with these terms. Adolescent patients understand non-adherence as temporary (‘I'll go back’) and necessary (‘I need a break’). Peer navigators worked as intermediaries between adolescent patients and healthcare providers, aligning adolescents' descriptions of medicines-taking with clinical definitions of defaulting, and promoting better adherence and support for non-adherent adolescents.

Conclusions: Combining qualitative datasets from research studies and HIV programming offers a valuable opportunity for triangulating findings across settings. Through integrating qualitative research between datasets, including with adolescents and healthcare providers, popular and practicable understandings of adolescent ART adherence emerge. To improve adolescent health outcomes, it is crucial to address the disjuncture between adolescent, caregiver and healthcare provider understandings of non-adherence, as well as different approaches to routine clinic visits. Peer navigators provide the potential to bridge gaps in understandings between adolescents and adult healthcare providers, serving as a much-needed link between adolescents, adult caregivers, and healthcare providers.
Strengthening Peer Support Interventions in Uganda to reach Adolescents and key Stakeholders through READY Teens Program

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Introduction: In Uganda, adolescent key population face a lot of stigma and discrimination in families and health facilities, domestic violence and isolation from peers among others which disrupt treatment adherence and attained of the 90 90 90 UNAIDS global targets by 2030.

Background: In Uganda, many adolescent girls and young women face various challenges in regards to accessing SRHR services and information and also access ART. READY Teens addresses Social and structural barriers as well as individual-level behaviors affecting HIV prevention and treatment among adolescent. To further clarify on the actual needs of adolescents in Uganda, With support from International HIV/AIDS Alliance, READY Teens conducted a baseline to ascertain their unique needs among adolescents living with HIV, adolescents using drugs and adolescents selling sex. Findings from the baseline noted that parents / caregivers tended to be more comfortable talking to their children about HIV than about sex/SRHR. Some parents were comfortable talking about sex. Also, there tended to be a higher level of comfort for the parent if talking to a child of the same sex. Respondents in Uganda were noted not to feel more comfortable talking about sex with adolescents compared to other east African countries like Ethiopia and Burundi. 54.6% of adolescents who are both aware of ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Furthermore, only 59.6% of adolescents were found to have used a condom during last sexual intercourse.

While stigma and discrimination has reduced over time in some contexts among adolescents and young people, more programs targeting adolescent should focus efforts on continuing to reduce stigma and discrimination in schools, families and health care settings. There is also need for continued efforts to change gender norms with parents/caregivers, community leaders, and adolescents will be important. Employing a discussion on gender norms may be one way to encourage dialogue on gender and its influence on SRH and HIV. It should further be noted that there is a prevailing belief that teaching adolescents about sex will result in them having sex. Working with parents/caregivers, community leaders, health care providers, and adolescents to understand that this is not the case (e.g., based on research) will be key.

Program description and methodology: PEERU also works with the adolescents’ communities, by engaging with parents, teachers, religious leaders, and local political leaders. Train peer educators, mentors and health workers on how to provide adolescent friendly services. Use edutainment through the use of street theater to mobilize targeted communities to access HCT services and also create awareness and sensitization. PEERU has further engaged policy makers and key stakeholders for greater accountability amongst them to the SRHR/ HIV needs of adolescents in Uganda and beyond.

Lessons learned: More work is still needed in increasing adolescents’ confidence and ensuring they are not easily influenced on issues of SRHR and HIV. This was shown to be incredibly important in terms of sexual behaviour change and should go hand in hand with awareness raising.
Enhancing Support for Adolescents Living with HIV/AIDS

Malisau P1
1Centre for Girls and Interaction (CEGI), Mzuzu, Malawi

Adolescents living with HIV face substantial difficulties in accessing HIV care services and have worse treatment outcomes than other age groups. The objective of this review was to evaluate the effectiveness of service delivery interventions to improve adolescents' linkage from HIV diagnosis to antiretroviral therapy (ART) initiation, retention in HIV care and adherence to ART.

Adolescent Impact, a developmentally targeted behavioral intervention aimed at decreasing risk behaviors and promoting health care adherence, was delivered to 26 HIV-infected youth, aged 10-21 years, receiving care and ARV in six rural HIV centers of Nkhata bay, Rumphi and Mzimba districts. Participants completed a patient satisfaction survey following the 12 part intervention consisting of seven groups and five individual sessions. No differences in satisfaction ratings emerged between perinatally infected adolescents and those who acquired HIV through risk behaviors. However, differences emerged regarding perceived intervention utility and content-specific preferences. Findings suggest that Adolescent Impact participants were satisfied with the intervention and that a heterogeneous group of HIV-infected youth could be advantageously integrated into the same secondary prevention program.

The ‘Fish Bone’ diagram was used as the method to identify and analyze the problems, as well as their causes and effects to the Targeted Districts where the project is to be piloted. Logical framework was used as an analytical tool to plan the Project and will also be instrumental in monitoring and evaluating the project; Three major project components were identified to achieve the project goal and objective:

• Strengthened capacity of adolescent youths living with HIV in Mzimba, Rumphi and Nkhata bay to demand access to support, care and Treatment;

• Improved awareness of target groups (family, peers and community) about the rights of Adolescents living with HIV/AIDS;

• Enhance Adolescents living with HIV/AIDS's role in the community and their involvement in HIV/AIDS prevention; and

• Sustainable community involvement in developing programs and activities for the betterment of Adolescents living with HIV/AIDS.

Therefore CEGI has established 7 teen/adolescents living with HIV/AIDS clubs in the mentioned district with support from HIVOS.
Youth led Initiatives on one to one engagement on advocacy.

Wambura M1
1Maisha Youth, Nairobi, Kenya, 2National Aids Control Council, Nairobi, Kenya

Introduction: For adolescents and young people the challenge continues to be limited access to youth friendly services, lack of policies that speak to their needs, and lack of representation in high level policy making dialogues for adolescents and young people to articulate their HIV/Sexual reproductive needs. For better service provision it is necessary to modify health policies, systems and environment which young people engage in to have more inclusive policies for adolescents and young people. The case is study of Unified and amplified voices in engagement with young people from various part of the country, youth led organizations in advocating for their space in the policy making stages. In Kenya the collaborative voices of adolescents’ and young people are very powerful in influencing the priorities and decisions of policymakers.

Objective: To Advocate for meaningful engagement of adolescents and young people to take up leadership positions, to be included in high level policy meetings for responsive programming, and champion for integration of other services such as (entrepreneurship, entertainment etc) together with HIV Services.

Description: In 2017 during the Maisha Conference, Maisha Youth was mandated to organize a youth pre-conference by the National Aids Control Council. The whole process was given to the young people from planning to execution which turned out to be very successful. This was a clear example of the benefits and rewards of meaningful youth engagement. Similarly, the event resulted in the rise of other youth networks in different organizations championing for Meaningful youth engagement in their spaces.

Lesson Learnt: When young people are given leadership opportunities and meaningfully engaged, among-st themselves they are able to work very well and have a great impact on peer to peer approach. However, success is also guaranteed if there is technical support from the implementing partners, donors and professions.

Conclusion & Recommendations: Capacity building on Leadership, advocacy, and meaningful engagement (Policy engagement) in HIV/Sexual reproductive health among adolescents and young people is key in decision making process. A guidance on standard definition of meaningful engagement of adolescent and youth in advocacy and policy is needed.
2nd HIV & Adolescence Workshop

10 - 12 October 2018, Cape Town, South-Africa

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<td>Zhou, S</td>
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<td>Adolescent after hours and weekend “happy hours” contribute to increases HIV testing, yield and ART initiations in KwaZulu Natal clinic</td>
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<td>Sustainable options for Adolescent Health Access</td>
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Abstract Book
2nd International Workshop on HIV Adolescence - Challenges & Solutions
10 - 12 October 2018, Cape Town, South Africa

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