At the Precipice: Demographics and the Risk of Losing Control of the HIV Epidemic

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Congratulations!!

• **You** have achieved “the impossible”
• MDG – initially no ART goal
• <50,000 to ~13.8 million on ART
• 50% reduction in death
• 30% reduction in new infections

• **THANK YOU!!**
The Challenge
This century, Africa’s population will quadruple

- By the end of the century there are projected to be 3.7bn more people in the world of which 84% will be in Africa.

- Africa’s population is just over a billion. By 2050 this will be nearly two and a half billion, and by the end of the century over four billion.

- Africa’s population is young, with 61% under 25 (compared to 33% in North America). In Uganda, Chad and Niger half the population is under 16.
**Youth Bulge in Zambia**

**At the beginning of the Epidemic**

- **Zambia - 1990**
  - Male
    - Young Men Population: 781,000
    - Young Men PLHIV: 38,000
  - Female
    - Young Women Population: 772,000
    - Young Women PLHIV: 66,000

**Today**

- **Zambia - 2016**
  - Male
    - Young Men Population: 1.6 million
    - Young Men PLHIV: 48,000
  - Female
    - Young Women Population: 1.6 million
    - Young Women PLHIV: 77,000

23 fold increase in GDP per person
Achieving Epidemic Control
Progress toward 90/90/90 in Adults

Figure 1 – Progress to 90-90-90 in Adults

<table>
<thead>
<tr>
<th>Country</th>
<th>Aware of HIV Status</th>
<th>Treated</th>
<th>Virally Suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swaziland 15+ (2016)</td>
<td>85</td>
<td>87</td>
<td>92</td>
</tr>
<tr>
<td>Lesotho 15-59 (2017)</td>
<td>77</td>
<td>88</td>
<td>90</td>
</tr>
<tr>
<td>Zimbabwe 15-64 (2015)</td>
<td>74</td>
<td>87</td>
<td>86</td>
</tr>
<tr>
<td>Malawi 15-64 (2015)</td>
<td>73</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>Zambia 15-64 (2015)</td>
<td>67</td>
<td>85</td>
<td>89</td>
</tr>
<tr>
<td>Uganda 15-64 (2017)</td>
<td>66</td>
<td>88</td>
<td>83</td>
</tr>
<tr>
<td>Tanzania 15-64 (2017)</td>
<td>52</td>
<td>91</td>
<td>88</td>
</tr>
</tbody>
</table>

Age Groups (years)

PEPFAR U.S. President's Emergency Plan for AIDS Relief
Focus on Young People

Progress to 90/90/90 in 15 to 24 year olds

Note: Results based on self-report of HIV awareness and ART status (plus ARV testing in Malawi and Zambia), and on viral load testing.

Source: PEPFAR PHIA
Viral load suppression at the community level after 15 years

<table>
<thead>
<tr>
<th>Aged 15-64</th>
<th>Aged 15-24</th>
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<tbody>
<tr>
<td>Swaziland 68%</td>
<td>Swaziland 42%</td>
</tr>
<tr>
<td>Lesotho 61%</td>
<td>Lesotho 42%</td>
</tr>
<tr>
<td>Zimbabwe 55%</td>
<td>Zimbabwe 34%</td>
</tr>
<tr>
<td>Malawi 59%</td>
<td>Malawi 34%</td>
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<tr>
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Adolescent Girls and Young Women: Who is Infecting Whom?

Africa Centre identified phylogenetically linked HIV transmission networks in Hlabisa

High HIV incidence men
mean age 27 years
(range 23-35 years)

High HIV risk women
Mean age 18 years
(range 16-23 years)

Men and women < 24 usually acquire HIV from similarly aged partners

High HIV prevalence women
Mean age 26 years
(range 24-29 years)

Very young women acquire HIV from men who are on average 8 years older

When teen girls reach their mid-20s they perpetuate the cycle

Gender gap

• Adolescent girls/young women up to 14-times more like to be infected than adolescent boys/young women (PEPFAR)
• Cannot forget the males: the ones we miss when young are likely the most at risk of contracting and spreading HIV

• Gender gap is driven by gender inequality!
Largest Generation in History Reaching an Age When They Are Most at Risk of HIV

The Opportunity
Our Priorities for Adolescent Girls and Young Women

Keep them HIV FREE

Also, help them:
• Stay in school
• Prevent early pregnancies
• Prevent sexual violence
• Post violence care

Photo credit: USAID/Carole Dougis
What do adolescents want?

Specific adolescent preferences for sexual and reproductive health services

Adolescent Friendly Services
- Appropriate info and services tailored to them
- Confidentiality and privacy

Flexibility:
Opening times that suit them, is close to them & adapts around their school obligations

Comprehensive services of high quality
- Counselling & education
- SRHs
- Links to specialist services

Phil Smith, SAMJ 2017
Youth Clubs in South Africa

- Pilot data from MSF supported project in Khayelitsha, South Africa between March 2012-May 2015
- Clubs met monthly for the first 6-12 months, thereafter two monthly at the clinic
- ART refills, HIV clinical management and FP were integrated
- Youth Clubs included ART ineligible youth (21.7%), newly ART initiated youth (52.8%) and stable on ART youth (25.5%)
- School going and out of school Clubs
- 12-month retention was 81.7% (95% CI 76.4-86.0%)
  - 86.4% among newly initiated
  - 94.3% among stable on ART

Wilkinson et al, AIDS 2016, TUPEE490
Zvandiri and the CATS model in Zimbabwe

• Started in 2004 as one support group of ALHIV
  • “Zandiri” – “As I am” in Shona
• Provides differentiated care for children, adolescents and young people with HIV, 0-24 years of age
• Implemented by Community Adolescent Treatment Supports (CATS)
  • HIV positive 18-23 year olds
  • Trained and mentored to provide support across the HIV cascade
• Adopted by the Government of Zimbabwe
• Recommended for scale up by WHO, UNAIDS, AIDStar One, UNICEF, SADC
The Programme: geared towards those in their 2\textsuperscript{nd} decade of life

- **Ujamaa Program**
  - In Addition: & Soul Buddyz + Parent support

- **Adolescent-tailored health services**

- **Support Auxiliary Social Workers**

- **Soul Buddyz Clubs:**
  - In School

- **Keeping Girls in School:**
  - Health Education in School

- **Skillz Grassroots Soccer**
  - In Addition: Rise Clubs, Teen Parenting & PrEP

- **Mens' Services**
  - In Addition: Rise Clubs & Community dialogues with men

- **Women of Worth:**
  - Incentive & Care Programme

- **Foot in The Door**

**Impact evaluation**

**Service utilisation**

- 10 years
- 14 years
- 19 years
- 24 years
Hub and Spokes Community Model

- **Hub**: AYFS Clinic
- **Spokes**: Schools, Mobile Units, School Health RNs, WOW, TPP
- **Model**:
  - Walkable services
  - Linking services to health facilities
  - Health utilisation

**Operational Footprint**:
- 50 Primary Schools
- 45 Secondary schools
- 24 Health facilities
- 10 Community Venues
Global Fund and EJAF embraced HCD because new approaches were needed to design HIV programs that address the needs of young people.

HCD can increase our understanding of youth’s perspectives on sexual and reproductive health, by:

- **Bringing a human angle to technical systems**
  
  Enhancing the traditional thinking that happens in controlled clinical environments and with the technical language of public health.

- **Getting to the root of decision making**
  
  Deepening our understanding of social and behavioural drivers of people’s decision-making around health, particularly those that sit outside the formal health system.

- **Uncovering needs and values**
  
  Unearthing and testing solutions that more acutely reflect the needs and local realities of youth, and are thus more relevant and scalable in their design.
Putting it all together?
Network Model to link Communities of Practice to Policy Making:
Data and innovation feedback loops systematically harness the power of communities of practice to improve outcomes and change policy

The Council for Health Impact will be driven by the Head of State, will include development partners, and will coordinate all of the partners to drive policy, funding decisions, and performance. FBO, NGO, and private sector will be included at all levels, as appropriate for the setting.
• Time great flux: challenge and opportunity
  o inward, backward with fear/hate
  o outward, forward with hope/love

• Most exciting time for Development, Global Health – the human family

• Achieving the “impossible” - again

• “The arc of .....history bends towards justice” - MLK (Theodore Parker)