From global to regional: Science, youth and community in the HIV response in East Africa

SCIENTIFIC SYMPOSIUM

Rwanda, 30 November 2019
HIV testing, linkage to treatment and retention in care of adolescents and young adults

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Zvandiri Overview

- Differentiated HIV service delivery model for children, adolescents and young people, adopted by MoHCC, Zimbabwe. Zvandiri’s DSD model is more than the where and when of ART, but it provides differentiated support to ART adherence and quality of life.
- Implemented primarily by Community Adolescent Treatment Supporters (CATS)

**CATS**

- HIV positive 18-24 year olds
- On ART; adhering well
- Willing to engage as a CATS
- Able to read and write
- Completed school
- Consent from caregivers
CATS Across the Cascade

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| **Targeted HTS Mobilisation**  
Index case finding  
Self Testing  
Linkage to confirmatory testing  
Linkage to prevention services for those testing negative | **Linkage to ART**  
ART readiness counselling  
Disclosure counselling | **Information, counselling, monitoring and support**  
HIV  
ART and Adherence  
Viral Load  
OIs including TB  
Mental health  
SRHR  
Prevention  
Disclosure  
Young KPs | **Identification of red flags and referral**  
OIs incl TB  
VL Monitoring  
Child protection, Mental health Conditions  
SRHR  
Disability  
PMTCT | **Tracing LTFU and linkage back to care**  
WhatsApp clinic and adherence reminders and Check ins  
Groups  
Support Groups  
Refill groups  
E Support groups  
Young Mother Groups  
Boys and Young Men | **PMTCT**  
Young Mentor Mothers  
PrEP for partners  
Disclosure counselling  
ISALS  
Transition to adult support |

- Training, mentorship and supervision for health workers, social welfare, teachers and caregivers
- Linkage and bidirectional referrals with clinics, social workers, teachers, communities, families
- Services are differentiated to **Standard** and **Enhanced** Levels of support
- According to the clinical and psychosocial needs of individual CAYPLHIV
- Enhanced Care includes additional support from Zvandiri Mentors, MoHCC and MoPSLSW clinic and community cadres

www.iasociety.org
The Zvandiri model started in Zimbabwe in 2004. Currently there are 1,114 CATS providing differentiated care and support to 59,753 children, adolescents and young people living with HIV across 51 districts in the country.
Scale up of the Zvandiri Model in the Region

Zvandiri and the CATS model now adopted or adapted in Eswatini, Ghana, Mozambique, Namibia, Rwanda, Tanzania and Uganda. There are 328 CATS/YAPS providing DSD to 10,543 CAYPLHIV in the region.
Zvandiri Outcomes and Data

1st 90
90% acceptance rate
7% Positivity

2nd 90
97% initiated on ART post-testing

3rd 90
99% suppression after 12 mths on ART
77% viral suppression across 52 districts

4th 90
Improved psychosocial well-being among those receiving Zvandiri

56% CALHIV living with disability
ALHIV attribute virological failure to poor mental health and relationships in their lives
65% of ALHIV at risk of common mental disorder, correlating with poor adherence

CAYPLHIV receiving Zvandiri were 42% more likely to be virologically suppressed than adolescents receiving Standard Care alone
High levels of resistance amongst ALHIV with virological failure
Zvandiri – Lessons Learned

- **We learned that this works** – Evidence from trial data and programmatic outcomes
- **A multicomponent layered peer led intervention is effective for both HIV and quality of life outcomes**
- **Government leadership and coordination** - Critical in driving scale up of an integrated, sustainable, differentiated service for CAYPLHIV
- **Packaging Zvandiri as a defined model of care** - Standardised uptake and implementation of services in line with national plans and systems
- **Integration of training, supervision and mentorship** - Within national systems with TA from Africaid at national, provincial and district level essential for government ownership and support for CATS
- **Beneficiary involvement** - In all aspects of program design and delivery, M&E and research has been critical, acceptable and sustainable
- **Development of paediatric and adolescent indicators** - To reflect DSD, as well as clinical and PSS outcomes promoted awareness of need and impact for DSD
- **Use of programmatic data, together with partnerships with research institutions** - Has produced robust evidence for informing policy, service delivery, and scale up, as well as resource mobilization
- **Basic cost effectiveness and cost-benefit data**
Thank you!