Building HIV-positive and HIV-negative pregnant adolescent and young mothers' knowledge, skills, resilience, and problem-solving abilities through a home visiting program using a novel case management approach

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Background

Adolescents (10 to 19 years) continue to be disproportionately affected by HIV, with girls up to 14 times more likely to be infected with HIV than their male counterparts.[1] One in five adolescent girls in sub-Saharan Africa become pregnant by age 18[2] (and face high levels of unintended pregnancy as a result of sexual violence).[3] These girls (especially in high HIV-prevalence settings) face parallel risks of pregnancy and HIV acquisition—and of vertical HIV transmission for their infants. Whether HIV-positive, pregnant, and/or a new mother, adolescent girls and young women experience a host of barriers in their efforts to access and stay in health services. Addressing these structural barriers must be a key component of programming.

The Program

The Kenya AIDSFree HKID Program (June 2017–June 2019), known as the *Jielimishe Uzazi na Afya* (JUA)[4] Program in Kiswahili, was designed to improve HIV and other health and social outcomes for pregnant adolescents (ages 10–19), their children (from birth through 24 months), and adolescent mothers. The program was designed based on lessons from existing home-visiting programs and the global evidence base, adapted specifically for the needs of pregnant adolescents and adolescent mothers. The activity is grounded in existing orphans and vulnerable children (OVC) programming, with strong linkages to OVC and Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) partners and activities as well as clinical and prevention of mother-to-child transmission (PMTCT) services.

As antenatal care (ANC) remains a significant entry point for HIV testing for adolescent women, and provides an opportunity for adolescent-focused HIV prevention for both HIV-negative and HIV-positive adolescents, the program focuses on supporting access to and retention in ANC, including PMTCT services, as well as postnatal care (PNC) services for the mother-baby pair. Building the adolescent's resilience and ability to problem-solve is a key component of the program. The program also focuses on ensuring a strong referral network to critical health and social services—including services to address gender-based violence, opportunities for adolescents to return to school, and livelihood opportunities.

HVT Training Package

- **Module 1.** Context of and Need for this Program
- **Module 2.** Communicating with Adolescents and Adults in Households
- **Module 3.** Empowering Adolescents to Achieve Zero New Infections
- **Module 4.** ANC & PMTCT Services: Supporting Retention and Adherence of Pregnant Adolescents/Adolescent Mothers and their Infants
- **Module 5.** Postpartum Care and Caring for Infants/Toddlers
- **Module 6.** Supporting Adolescent Mothers with Child Development Knowledge and Skills
- **Module 7.** Supporting Adolescents in Developing Life Skills
- **Module 8.** Program Monitoring

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The Model

Given the structural barriers facing pregnant adolescents/adolescent mothers, and the unique needs of these populations, the program employs an individualized case management approach compromised of a Home Visiting Team (HVT) recruited by AIDSFree and community-based organizations:

- **Mentors** offer information and support. They help guide the adolescent client to access and stay in services, care for themselves and their children, and build resilience and life skills.
- **Household Facilitators** are community health volunteers who support the work of the Mentors. The Household Facilitator works with other household members—parents, caregivers, and partners—of the adolescent to help address barriers to care, decrease stigma, and help them understand the importance of supporting their adolescent daughter and her child.
- **Supervisors** are based in the respective county where the intervention is being implemented. They are recruited by the community-based organizations in close collaboration with AIDSFree and support the full HVT. They are available to assist with challenging cases and to provide mentorship, guidance and refresher training on select skills.

Home Visiting Team members are selected through a competitive process and receive comprehensive, 10-day training on the needs of their adolescent clients, the approach and tools used. A *Vulnerability Assessment Tool* is administered to determine pregnant adolescent/adolescent mother eligibility into the program (based on factors such as involvement in programming such as DREAMS, household socioeconomic status, HIV status, and disability). A comprehensive series of standard operating procedures (SOPs), counseling cards/job aids, and monitoring/evaluation tools guide the work of the HVT. Each HVT engages with their clients individually through a comprehensive *Needs Assessment* and continual *Service Planning*. *Case Check-In Meetings* ensure ongoing program adjustment and supervisory support for the HVTs. Community engagement sessions facilitate the commitment and support of community leaders.

Each HVT has five to eight adolescent clients, depending on the catchment area

Two household facilitators (HFs), one female and one male, largely pulled from existing community health volunteer (CHV) cadres (age ~31–45)

Mentor (case manager), sensitive to the issues of pregnant adolescents/adolescent mothers and their infants (age ~19–30)

Supervisor (two per ward), at least three to four years of work experience in relevant community work

Current Status

The program is implemented through two community-based organizations in Kisumu and Homa Bay counties, Kenya: Make Me Smile and Kagwa, respectively (and is expanding to Nairobi as of June 2018). In January 2018, AIDSFree trained 24 HVT cadres (total of 80 participants). Through outreach, the HVTs screened 480 pregnant adolescents/adolescent mothers in their catchement areas, and enrolled 191 clients (an additional 192 will be enrolled in Nairobi).

Emerging Issues (Early Implementation)

- High number of pregnant/lactating girls
- Severe issues emerging (deaths, suicide fears, abandonment)—*care for the caregiver*
- Disabilities
- Non-supportive parents and guardians; school teachers and administrators and principals
- Competing tasks facing adolescent girls
- Benefits of program being felt with an increased number of adolescents willing to return to school
- Escorted referrals enhancing access to service delivery
- Health facilities reporting increased new ANC visits after pregnancy mapping
- Complexities around child rights and gender-based violence
  - Married adolescents
  - Action against perpetrators

Tools Developed

- Facilitator's Training Guide & Slides
- Home Visiting Team Counseling Cards (Job Aids)
- SOP 1: Ethical Procedures and Code of Conduct
- SOP 2: Case Management
- SOP 3: Supportive Supervision
- SOP 4: Program Monitoring

Photo: Shehbal Nizamy, John Snow, Inc.

Case Management Flowchart

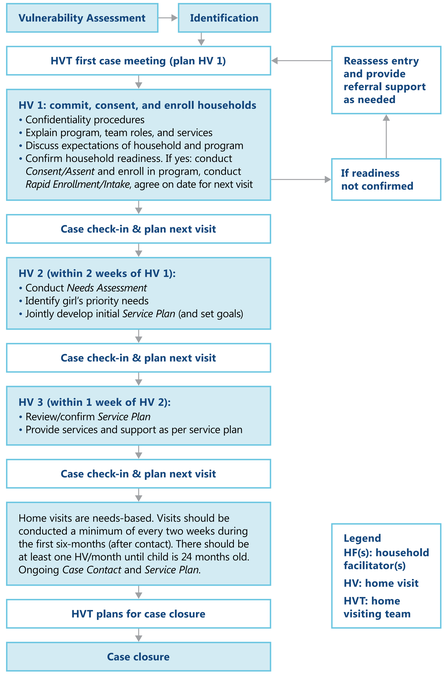

Photo: Mercy Ariyo, John Snow, Inc.

References

[1] U.S. President's Emergency Plan for AIDS Relief (PEPFAR). 2018. "FY2018 Country Operational Plan (COP) Guidance for Standard Countries." https://www.pepfar.gov/documents/organization/276459.pdf.

[2] K. G. Santhya and S. J. Jejeebhoy. 2015. "Sexual and Reproductive Health and Rights of Adolescent Girls: Evidence from Low- and Middle-Income Countries." *Global Public Health.* 10:189–221.

[3] Data from Together for Girls, Washington, DC; rates: Tanzania 31 percent; Kenya, 30 percent; Zimbabwe, 34 percent; Malawi, 33 percent; and Nigeria, 15 percent.

[4] Translated to mean "take pride in parenthood and health."

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