POLICY BRIEF PREPARED FOR THE PARLIAMENT OF UGANDA

A Youth-Focused Economic Empowerment Approach to HIV Treatment Adherence among Youth Living with HIV in Uganda

This report was developed by the International Center for Child Health and Development (ICHAD) and Strengthening Mental Health and Research Training in Sub-Saharan Africa (SMART Africa Center) at the Brown School at Washington University in St. Louis, and AfriChild Center in Uganda.

Currently, 98,000 children below the age of 15 are living with HIV in Uganda[1]. Additionally, the HIV prevalence rate among persons aged between 15 and 49 years is 5.4%[1]. Despite wider access to antiretroviral treatment (ART), young people aged between 15 and 19 are the only age group with increased mortality rates due to HIV/AIDS in sub-Saharan Africa (SSA)[2]. This trend can be partially explained by the fact that adolescents are less likely to adhere to ART compared to younger children and adults[3], as well as higher attrition rates from HIV treatment and care[2]. People living with HIV who adhere to HIV treatment live longer and healthier lives[4,5]. Moreover, when virally suppressed, they are considerably less likely to transmit the virus[6,7]. Yet, in Uganda, the prevalence of viral load suppression is distinctly lower among adolescents and younger adults (15-24 years) at 42.5%, compared to 83.7% for adults[8]. Hence, addressing ART non-adherence among youth in Uganda is critical.

Poverty and its associated stressors are significantly associated with poor adherence to HIV treatment[9].

Research has demonstrated that once adolescents are financially stable and able to meet their basic needs, they would prioritize HIV treatment[10]. Thus, innovative asset-based economic interventions that provide economic strengthening opportunities to youth and their families are essential to improve the economic and health outcomes of Youth Living with HIV (YLWHIV). A family economic empowerment intervention, titled Suubi+Adherence, was implemented across five districts in Uganda with YLWHIV and their families, by providing incentivized matched savings accounts in the form of Child Development Accounts (CDA) and microenterprise development workshops[9]. Using rigorous methodologies, the Suubi+Adherence intervention has been shown to improve HIV treatment outcomes, including ART adherence and viral suppression among YLWHIV, as well as mental health functioning[9,11,12]. The study results also showed that financial incentives to improve ART adherence in low resource settings are not only effective, but can also be cost-effective in suppressing viral load[13].

RECOMMENDATION #1

Incorporate Economic Empowerment (EE) into Routine Healthcare Delivery to ALWHIV

Poverty and its associated stressors have been documented to be a major barrier to HIV treatment adherence among YLWHIV[9]. To increase ART adherence among YLWHIV, it is essential to ensure they are financially stable. Economic empowerment interventions must be incorporated into routine HIV healthcare delivery, where clinics can partner with financial institutions to provide financial assistance in addition to ART for YLWHIV. Combining clinical care with economic empowerment can simultaneously address the economic needs of YLWHIV such as financial instability and food insecurity, while enabling them to prioritize their HIV treatment[9]. This provides an actionable step for effectively implementing Section 3(4) of the current Uganda National HIV and AIDS Policy[14], which aims to "*provide economic support to all those infected and directly affected by HIV and AIDS*[14]."

RECOMMENDATION #2

Build the Capacity of Healthcare Personnel and Peer Counselors to Effectively Deliver Economic Empowerment Interventions in Combination with ART

A key element of quality service delivery and demand is a well-trained health workforce[16]. To ensure the effective and centralized delivery of economic empowerment interventions together with ART, the

intervention delivery can be task-shifted to Health Care Workers (HCWs) who will be trained in key components of economic empowerment interventions. However, there is a shortage of healthcare personnel in Uganda. Only 73% of healthcare staff positions are filled in healthcare facilities across the country[17]. Hence, the existing lay workforce of peer counselors can be leveraged to further support the efforts of HCWs to adequately implement these combined services for YLWHIV in clinic settings. It is worth noting that clinics across the country already utilize peer counselors in ART adherence counseling[9,16]. Hence, mobilizing HCWs and peer counselors in delivering these combined services provides an optimum solution for effective implementation.

Endnotes

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