

# Adolescents Package of Care in Kenya

A Health Care Provider Guide to Adolescent Care





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This guide contains all the information required by health care providers as they provide services to adolescents with special focus on adolescents living with HIV/AIDS as of the date of issue. All reasonable precautions have been taken by NASCOP to verify the information in this publication. For clarifications contact National AIDS and STI Control Program (NASCOP) on P.O. Box 19361 00202, Nairobi Kenya, Tel: 254 020 2630867, Email: [info@nascop.or.ke](mailto:info@nascop.or.ke), Website: [www.nascop.or.ke](http://www.nascop.or.ke)

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2014



# Foreword

The adolescent in Kenya today faces a myriad of challenges while transitioning from childhood to adulthood. These challenges are closely linked to the physical, emotional, cognitive and social growth and development that occurs during this stage of their life. During this period the adolescent develops new habits, patterns of behavior and relationships. The acquired way of life can have either positive or negative impact on their functioning and opportunities, and can also impact on their quality of life as an adults. Provision of adolescent friendly health services in most health care settings in Kenya has been noted to be suboptimal.

The Ministry of Health through NASCOP and its partners have developed the Adolescent Package of Care; a Health Care Provider Guide which details the essential health services that health care providers should offer to any adolescent who presents to the health facility for services. The package also pays special emphasis to unique services that should be provided to adolescents living with HIV (ALHIV). It is imperative that adolescent friendly service provision is prioritized in all health care settings. This will help in instilling positive health behaviors which will impact on the future quality of life of the adolescents.

This guide has been developed for all health care providers offering services to adolescents in health care settings that includes; counselors, psychologists, nutritionist, nurses, public health officers, clinical officers, medical officers, pediatricians, medical specialists, mental health practitioners and adolescent sexual and reproductive health specialists. The package will give impetus to the provision of adolescent friendly services and ensure there are no missed opportunities to access of comprehensive health services for an adolescent who visits a health facility. In addition it is hoped that local NGOs, implementing partners and other stakeholders will find this guide useful as they engage with the community, health care providers, as well as with the adolescents.

I am hopeful that this guide will be useful for all health care providers involved in the care of the adolescent.



**Dr. Martin Sirengo**

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# Acknowledgement

The development of the Adolescent Package of Care is a result of various efforts by the National Adolescent Technical Working Group, drawn from different organizations and coordinated by NASCOP. This package of care was in part adapted from the ICAP Adolescent HIV Care and Treatment Training Curriculum and AIDSTAR-One Adolescent Transition Toolkit.

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# Abbreviations and Acronyms

ALHIV	Adolescent Living With HIV/AIDS
ART	Antiretroviral Therapy
BMI	Body Mass Index
CIN	Cervical Intraepithelial Neoplasia
CTX	Cotrimoxazole
FP	Family Planning
HBV	Hepatitis B Virus
HCP	Health Care Provider
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV	Human Pappiloma Virus
IGA	Income Generating Activity
KDHS	Kenya Demographic and Health Survey
LSD	Lysergic Acid Diethylamide
MUAC	Mid Upper Arm Circumference
NASCOP	National AIDS And STI Control Programme
OI	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother To Child Transmission
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
SV	Sexual Violence
TB	Tuberculosis
VMMC	Voluntary Medical Male Circumcision
VIA/VILLI	Visual Inspection With Acetic Acid/Visual Inspection With Lugols Iodine
WHO	World Health Organization
YFS	Youth Friendly Service

# Introduction

Adolescence is a transitional phase of growth and development between the ages of 10 to 19 years. It is characterized by physical, psychological, economic and social changes. Youth is globally defined as people between 15 and 24 years of age and young people as those from 10 to 24 years of age. Although 18 years is the legal age of adulthood in many countries in sub-Saharan Africa, adult behaviors are not necessarily fully adopted by then. Therefore, many countries continue to provide youth health and social support programs for people well into their 20s. In 2009, there were 1.2 billion adolescents aged 10-19 years in the world, accounting for 18% of the total world population. Of these adolescents, 185 million live in sub Saharan Africa. In Kenya, adolescents account for over 40% of the total population.

Adolescence is a unique and vulnerable time in the lives of most adolescents. It is a time of rapid physical, emotional, intellectual and social changes as the body matures. It can be characterized as early, middle or late adolescence. Dramatic changes occur during the adolescent years including rapid physical development and further developments in personality, social attitudes, and social skills. It is also during this time that the adolescent experiences separation and individualization from their family/caregiver, further developing a sense of self and creating new relationships with peers. The onset of puberty and greater personal freedom make adolescents acutely vulnerable, and girls especially so. Adolescence is also a period when many young people develop new habits, patterns of behavior, and relationships that not only affect their functioning and opportunities, but also the quality of their future adult lives. It is also during this stage of transition to young adulthood that a normative stage of desire to fit in; psychosocial adjustment; identity development; sexual, alcohol and drug experimentation occurs. This stage of development can lead to challenges at the individual, family, and community level.

Adolescents are particularly vulnerable to HIV infection for social, political, cultural, biological, and economic reasons. They account for approximately 40% of new HIV infections globally. An estimated 2.2 million adolescents are living with HIV, around 60% of whom are girls. Additionally this age group also has the highest rates of sexually transmitted infections. According to the preliminary Kenya Aids Indicator Survey (KAIS) Report 2012, HIV prevalence among 15 to 24 years olds was 2.1%. Among young adolescents aged 12 to 14 years, 7% reported ever having sex, with a median age at first sex reported at 10 years. More than half of youth aged 15 to 24 years ever had sex, some before 15 years of age. Among those sexually-active, 4% of females and 30% of males reported multiple sexual partners.



Adolescents living with HIV (ALHIV) experience particular challenges. ALHIV can be categorized as adolescents who perinatally acquired HIV (vertically acquired HIV infection) and those infected during childhood or adolescence (horizontally acquired HIV infection). Adolescents with perinatally acquired HIV infection are more likely to be experiencing advanced stages of HIV disease including presence of opportunistic infections (OIs) as well as physical and developmental delays. On the contrary, adolescents with horizontally acquired HIV tend to be in the earlier stages of disease; fewer OIs; less likely to have started ART; and less likely to have physical and developmental delays. Many ALHIV experience stigma and other challenges regardless of mode of HIV transmission.

Risk factors for horizontal acquisition of infection amongst adolescents include behavioral and socioeconomic factors such as early sexual debut; multiple sex partners; drug use, alcohol consumption and poverty. Girls who engage in sex with older men and those who drop out of school are also at a higher risk of acquiring HIV. Further, there is low uptake of HIV testing and counseling among adolescents. Adolescents and their caregivers often do not access the health and social services they urgently need due to lack of information; fear of stigma or judgment and barriers in health systems including lack of youth friendly services. Concerted efforts are therefore required to minimize barriers and challenges and improve provision of services for adolescents. In addition adolescents need to be empowered to become active partners in their own health and in the larger response to HIV at the individual, community, national, and global level.

Pregnancy and delivery complications are common causes of death among women aged 15 to 19 years, and by age 20 nearly half of young women in Kenyan have begun child bearing (KDHS 2009). In addition, the 2010 Violence against Children Survey found that prior to age 18, 32% of females and 18% of males experienced sexual violence.

In spite of all these challenges, adolescents in Kenya present a tremendous opportunity for the development of the country. They can be resourceful, courageous and are well aware that their future depends not only on what we can do for them, but also on what they can do for themselves.

Health care workers have an important role to play to support the health of the adolescents. They need to recognize that the adolescents unique growth and development makes them respond or behave differently from other age groups faced with similar health problems. In addition, adolescents have different levels of maturity and responsibilities i.e. in-school or out of school, working or not working, married or unmarried, parents or caregivers to siblings and others are self-reliant or completely reliant on their families and caregivers.

This package of care has been developed as a guide for health care workers to enable them to offer comprehensive preventive, promotive and care and treatment services for adolescents attending their health facilities, irrespective of their HIV infection status.



# Section 1

## STAGES OF ADOLESCENT DEVELOPMENT

Adolescence is characterized by physical and psychosocial developmental changes (detailed in Table 1 below). Psychosocial changes include emotional and cognitive changes as well as relations to family and peers. Development changes can be further divided into 3 stages:

- Early adolescence
- Mid-adolescence
- Late adolescence

### ***Importance of staging adolescent development***

As a health care provider, it is of critical importance to understand the development stages and explain to the adolescent that the changes they are experiencing are normal.

- Understand that vertically HIV infected adolescents may experience stunting compared to their peers
- Assessing an adolescent growth and development is an important entry point for nutrition care and support
- ALHIV in early and mid-adolescence are on pediatric ART regimens
- Towards the end of mid adolescence and in late adolescence, most adolescents are likely to be on adult ART regimens
- Adolescents in late adolescence are more responsible for their own health
- Disclosure to the adolescent infected through vertical transmission should ideally be done before adolescence
  - ▶ *By early and mid-adolescence all ALHIV should know their HIV status*
  - ▶ *Disclosure to others (friends, family, sexual partners) should be discussed/ done by late adolescence, etc.*
- Transition to adult care (self-managed care) should start in mid to late adolescence; Ensure that these adolescents are adherent to their care and treatment before transition.

**Table 1: Summary of adolescent developmental changes and stages**

	Early: 10–13	Middle: 14–16	Late: ≥ 17
Physical			
	Girls -breast bud, downy (fine) pubic hair near labia, peak growth velocity;	Girls-further growth of breasts, increased pigmentation of pubic hair, menarche	Mature physical development
	Boys-darkening and enlarging scrotal sac, testicular growth, downy (fine) pubic hair	Boys – further increase in size of testes, enlargement of penis, growth	
Psychosocial			
Emotional	Wide mood swings, intense feelings, low impulse control, role exploration	Sense of invulnerability, risk-taking behavior	Increasing sense of vulnerability, able to consider others and suppress ones needs, less risk taking
Cognitive	Concrete thinking, little ability to anticipate long-term consequences of their actions, literal interpretation of ideas	Able to conceptualize abstract ideas such as love, justice, truth, and spirituality	Formal operational thought, able to understand and set limits, understands thoughts and feelings of others Sense of responsibility for one's health
Relation to family	Estranged, need for privacy	Peak of parental conflict, rejection of parental values	Improved communication, accepts parental values
Peers	Increased importance and intensity of same-sex relationships	Peak of conformity, increase in relationships with opposite sex	Peers decrease in importance, mutually supportive, mature and

### ***Psychosocial development***

Adolescents may or may not progress through the expected psychosocial (emotional and cognitive) stages of development hence routine assessments should be carried out. Table 1 above will guide you to assess and document the stage the adolescent is currently in. This will help track the adolescents psychosocial development over time, as well as adolescents readiness for transition into adulthood.

### ***Physical development***

Assessment of physical development of adolescents is based on Tanner staging of sexual maturation. This should be carried out routinely in all adolescents. Tanner staging helps to track pubertal development over time. If the adolescent is not developing as expected, consider potential causes and refer as needed. It may also be utilized to assist with ART prescription.

### ***Tanner staging***

Tanner staging is a uniform, accepted method used to describe the onset and progression of pubertal changes. Boys and girls are rated on a 5-point scale. Girls are rated for breast development and pubic hair growth while boys are rated for genital development and pubic hair growth.

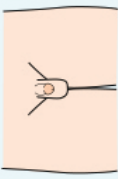
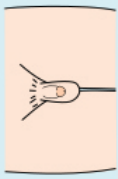
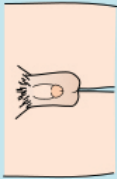

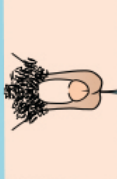
### ***Importance of Tanner Staging***

In HIV treatment, Tanner staging is used to determine which treatment regimen to follow (pediatric or adult). Pediatric ART regimens for early adolescences - Tanner 1 & 2 and Adult ART regimens for mid and late adolescence-Tanner 3 to 5.

Table 2: Tanner staging in girls

Tanner staging in girls			Stage	Age Range (year)	Breast Growth	Pubic Hair Growth	Other Changes
	I		I	0–15	Preadolescent	None	Preadolescent
	II		II	8 or 8½–15	Breast budding, areolar hyperplasia with a small amount of breast tissue	Long, downy pubic hair near the labia, often appearing with breast budding or several	Peak growth velocity often occurs after stage II
	III		III	10–15	Further enlargement of breast tissue and areola, with no separation of their contours	Increase in amount of pigmentation of hair	Menarche occurs in 25% of girls late in stage III
	IV		IV	10–17	Separation of contour, areola and nipple form secondary mound above breast tissue	Adult in type but not distribution	Menarche occurs in most girls in stage IV, 1–3 years after breast budding
	V		V	12½–18	Large breast with single contour	Adult in distribution	Menarche occurs in 10% of girls in stage V

**Table 3: Tanner staging in boys**

Tanner staging in boys	Stage	Age Range (Year)	Testes Growth	Penis Growth	Pubic Hair Growth	Other Changes
	I	0–15	Preadolescent testes ≤ 2.5cm	Pre-adolescent	None	Pre-adolescent
	II	10–15	Enlargement of testes; pigmentation of scrotal sac	Minimal or no enlargement	Long, downy hair, often appearing several months after testicular growth; variable with pattern noted with pubarche	—
	III	10½–16½	Further enlargement	Significant enlargement, especially in diameter	Increase in amount; curling	—
	IV	Variable (12–17)	Further enlargement	Further enlargement, especially in diameter	Adult in type but not in distribution	Axillary hair and some facial hair develop
	V	13–18	Adult in size	Adult in size	Adult in distribution	Body hair continues to grow and muscles to increase in size for several months to years; 20% of boys reach peak growth velocity





# Section 2

## CLINICAL ASSESSMENT

It is important to comprehensively evaluate all adolescents (whether HIV infected or not) who come in contact with health care providers in order to identify and address emerging issues. One needs skills to communicate effectively with the adolescent (Section 3).

This section details the comprehensive services that need to be provided for all adolescents.

The tables below outline the steps for assessment for HIV negative and HIV positive adolescents at every visit.

**Table 4: Check list for services for HIV negative adolescents**

For all HIV negative adolescents	
1.	Offer HIV testing as appropriate ( <i>see 2.1</i> ).
2.	Take a complete medical and social history including prenatal, birth and family history ( <i>see 2.2</i> ).
3.	Identify concomitant medical conditions (for example, hepatitis B or C infection, diabetes, asthma, pregnancy etc.).
4.	Enquire about concomitant medication, including contraceptive use and traditional therapies.
5.	Assess development as appropriate for age and sex (Use Tanner staging - section 1).
6.	Conduct physical examination, including STI screening if sexually active ( <i>see section 6</i> ).
7.	Review immunization status of adolescent. Ensure that immunization is up to date and educate on HPV (where available) and HBV vaccination.
8.	Prevent, diagnose, and treat concomitant conditions, including TB, diarrhea, malaria, and pregnancy etc. If required refer appropriately.
9.	Carry out mental health screening and refer for additional mental health care if necessary ( <i>see section 4</i> ).
10.	Assess growth and nutrition ( <i>see section 5</i> ).
11.	Provide Sexual and Reproductive Health (SRH) services which includes information, screening, diagnosis, treatment, counseling, and supplies as well as counseling on prevention of HIV ( <i>see section 6</i> ).
12.	Where applicable, carry out a Gender Based Violence (GBV) screening and refer for counseling and care if necessary ( <i>see section 6</i> ).

13.	Conduct psychosocial assessment ( <i>see section 7</i> ).
14.	Advise and guide to seek health services (when to seek medical care, reinforce nutrition).
15.	Provide education, care, and support, for family members and/or partner as appropriate.
16.	Where applicable, schedule next visit, provide flexible follow up dates to accommodate schooling.

## 2.1 HIV Diagnosis

All adolescents should be offered HIV testing and counseling. You should obtain written documentation for the adolescents HIV test result where appropriate. If not available, HIV testing and counseling should be conducted for all adolescents.

### ***Consent for HIV testing in adolescents***

- Testing should only be conducted after consent has been provided by either the adolescent, a legal guardian or parent.
- Consent can either be written or verbal and should be voluntary and not coercive.
- Adequate information should be provided to the clients for proper decision making.
- Adolescents aged over 18 years should provide consent for HIV testing and counseling.
- Adolescents aged less than 18 years may be tested with the consent of a parent or guardian, or may give their own if they are symptomatic for HIV, pregnant, married, a parent, or engaged in behavior that puts them at risk of contracting HIV.

### ***Importance of HTC for adolescents***

- Access to HTC is also important for adolescents.
- Adolescents who test negative for HIV should be supported to reinforce prevention messages and improve their access to prevention services.
- Early diagnosis of HIV infection in an adolescent is important for prompt referral and linkage to care and treatment as well as prevention.
- Due to the increasing availability of ART and prevention interventions, early diagnosis can reduce transmission and improve health outcomes, thereby decreasing HIV incidence, and HIV-related morbidity and mortality in Kenya.

- Adolescents who learn that they have HIV infection can obtain emotional support and learn to reduce the risk of transmitting HIV to others, as well as to obtain HIV treatment and care.
- Early access to care can help them to feel better and to live longer than if they were to present for care when the disease is already at an advanced stage.
- HTC is an essential component of the package of care included in voluntary medical male circumcision (VMMC) programs for HIV prevention.
- Because uptake of HTC by adolescents is currently low and HTC services for adolescents have not been developed in many settings, these guidelines recommend expanded access to HTC for adolescents.

## 2.2 Medical and Social History

When gathering history from the adolescent, start with a number of general, non-threatening questions before moving on to cover the potentially more distressing issues. e.g. What grade are you in at school?, How many brothers and sisters do you have?

Take a complete medical and social history which includes:

- a. The patient's concerns and expectations.
- b. Obstetric and Gynaecological History: Age at menarche, last menstrual period, pregnancy, use of family planning methods, syndromic review of STIs etc.
- c. Family, social and sexual history; sexual partners and children and their HIV status if known;
- d. Occupational history and potential impact of work life and school on treatment options.
- e. Nutritional history.
- f. History of Mental illness.
- g. Inter-current illnesses.
- h. Important co-morbidities (Diabetes, hypertension, kidney disease, tuberculosis etc) and medication history.
- i. Drug allergies.
- j. Alcohol and other drug use.

## 2.3 Physical Examination

### **General Examination;**

Take weight, height, temperature, blood pressure and respiratory rate etc. Carry out detailed general physical examination.

### **Systemic Examination;**

1. Examine all the systems: Respiratory, Cardiovascular, Abdominal, Genital Urinary, Musculoskeletal and CNS.
2. Mental health assessment: Look at the appearance, self-esteem, assess emotions (is the adolescent sad or happy), level of confidence, thought flow- any thought blocks, any suicidal ideations or signs of depression or anxiety. Does the adolescent easily establish a rapport?

**Table 5: Check list for services for HIV positive adolescents**

For all HIV positive adolescents	
1.	Confirm HIV status if newly diagnosed HIV positive. (See 2.1).
2.	Take a complete medical and social history including prenatal, birth and family history. (See 2.2 and 2.4)
3.	Enquire about disclosure of HIV to the adolescent (if perinatally exposed) or disclosure to others (if behaviorally infected) and HIV status of the mother, father, and siblings.
4.	Identify concomitant medical conditions (for example, hepatitis B or C infection, other co-infections or OIs, pregnancy)
5.	Enquire about medication use , including contraceptive use, traditional therapies; Cotrimoxazole and ARVs
6.	Assess development as appropriate for age and sex (use Tanner staging section 2).
7.	Conduct physical examination, including STI screening if sexually active (section 6).
8.	Review immunization status of adolescent. Ensure that immunization is up to date and educate on HPV (where available) and HBV vaccination.
9.	Prevent, diagnose, and treat concomitant conditions and opportunistic infections, including TB, diarrhea, malaria, and pregnancy etc.
10.	Assess WHO clinical stage. If not on ART, determine whether the adolescent meets clinical criteria for ART initiation. If already on ART, determine if any new Stage 3 or 4 events have occurred since ART was initiated.
11.	For those eligible for ART by clinical criteria (WHO Stage 3 or 4), consider preparation for ART initiation (see 2.6).
12.	Schedule indicated laboratory tests e.g. CD4, tests for monitoring toxicities as per the national recommendations.

13.	Carry out mental health screening and refer for additional mental health care if necessary (see section 4).
14.	Assess growth and nutrition (weight, height) as appropriate for age and sex (section 5).
15.	Provide Sexual and Reproductive Health (SRH) services which includes information, screening, diagnosis, treatment, counseling, and supplies as well as counseling on prevention of HIV (see section 6).
16.	Where applicable, carry out a Gender Based Violence (GBV) screening and refer for counseling and care if necessary (see section 6).
17.	Conduct psychosocial assessment (see section 7).
18.	Discuss Positive Living including Prevention with positive (see section 7).
19.	Advise and guide (reinforce and support adherence to ART and/or cotrimoxazole, nutrition, when to seek medical care, medication side effects, adherence to therapy). (see section 7).
20.	Provide education, care, and support, for family members and/or partner.
21.	Continuum of care: Schedule next visit, provide flexible follow up dates to accommodate schooling.

You should take medical and social history and conduct physical examination in all HIV positive adolescents in the same manner as indicated for HIV negative adolescents above. Additional information may be required for HIV positive adolescents as listed below.

## 2.4 Additional Medical and Social History in ALHIV

- a) Opportunistic infections.
- b) History of ARV use including use of ARV drugs for PMTCT.
- c) Identifying important co-morbidities (HBV, diabetes, hypertension, kidney disease, tuberculosis etc) and medication history.
- d) Drug allergies, particularly to cotrimoxazole.
- e) Alcohol and other drug use.
- f) HIV disclosure to the adolescent or disclosure of the adolescents HIV status to others (family members, friends etc). Support the adolescent / family regarding disclosure
- g) HIV status of the mother, father and siblings and whether enrolled in care and on ART if HIV positive.
- h) HIV status of the adolescents sexual partner if any and whether the partner is enrolled in care and on ART if HIV positive.

## 2.5 Additional Physical Examination in ALHIV

General Examination;

- a) Take weight, height, temperature, blood pressure and respiratory rate etc.
- b) Skin examination to look for significant HIV-related skin lesions; particularly PPE, herpes zoster scar, Kaposi sarcoma and fungal infections.
- c) Oral exam to look for candidiasis, Kaposi sarcoma, oral hairy leukoplakia and gum disease.

## 2.6 Preparation for ART

Prior to initiating ART in an adolescent ensure the following;

- a) Acceptance of HIV-status and need to start care and treatment.
- b) Commitment to adhere to lifelong treatment.
- c) Adequate Psychosocial support.
- d) Access to supportive health services.
- e) Meets clinical and/or immunological criteria for initiation.

Please Note:

- Always ensure patients privacy.
- Approach all adolescents with extreme sensitivity and recognize their vulnerability.
- Try to establish a neutral environment and rapport with the adolescent.
- Try to establish the adolescent's developmental level in order to understand any limitations as well as appropriate interactions.
- Stop the examination if the adolescent indicates discomfort or withdraws permission to continue.
- Always identify yourself as a helping person.
- Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted.



# Section 3

## COMMUNICATION AND COUNSELING THE ADOLESCENTS

Communication is the process of transmitting information or thoughts on a particular topic or issue through words, actions or signs, to a recipient aimed at reaching a common understanding. The purpose of communication is to inform with a view of motivating people to act, change, adopt and/or achieve specified desired results.

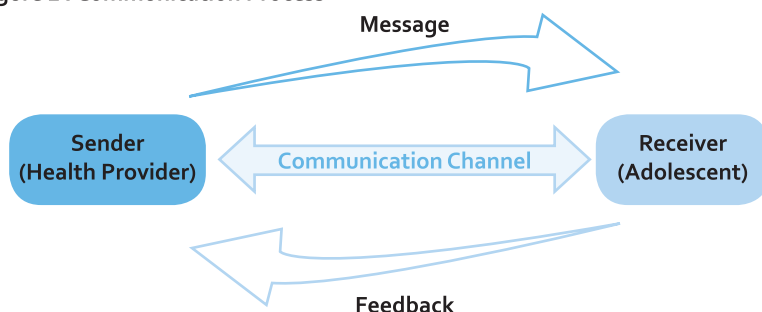
### 3.1 Communication Process

The communication process consists of five components:

1. Sender/communicator - Source of information
2. Message - Packaged message content
3. Media- Channel of communication
4. Receiver of information the audience
5. Feedback/response/reaction

After the sender relays the message, the receiver interprets it, and gives a feedback. Communication occurs when both the sender (source) and the receiver (audience) have the same understanding of the message. The feedback can be in the form of non-verbal communication or verbal responses. The response is based on the perception of the receiver which depends on his/her state of mind, health, attitudes, values & beliefs at the time the message was relayed.

Figure 1 : Communication Process





## 3.2 Types of Communication

There are two major types of communication:

### Verbal: What is heard

Verbal communication should be;

- *Acceptable to the adolescent*
- *Relevant to their current status*
- *Culturally and religiously sensitive.*
- *Delivered in a clear voice and in a language that is easily understood.*

### Non-verbal: What is seen and felt

Non-verbal communication is communication through gestures, body language, facial expressions, eye contact etc.

Adolescents are more sensitive to, and will easily pick up body language cues and facial expressions rather more than the content of verbal communication. You should therefore use observation skills and be aware of your body language in the communication process as well as environmental factors.

## 3.3 Barriers to Effective Communication

You should be aware of some of the common barriers to effective communication and how best to overcome them. These may include:

**Table 6: Barriers to effective communication**

Barriers	How to overcome
Age difference	If possible have persons of similar age to the adolescent (or youth friendly) to communicate.
Education level	Avoid complicated or medical jargon (language).
Language used	Use simple language and diagrams if possible.
Attitude, values, beliefs and perception	Make an effort to understand the perceptions, beliefs, values and attitudes of the clients/patients. Do not impose your values and beliefs on the adolescents.
Environmental factors	Chose a conducive environment, where practical remove any environmental barriers.
One-way communication	Listen more and talk less to pave way for a two way communication process.
Lack of privacy and confidentiality	Ensure there is privacy of work station, security of medical records and confidentiality of information.

### 3.4 Skills of an Effective Communicator

- Establish a good rapport with the adolescents
- Use simple and well understood language
- Listen actively and pick both verbal and non-verbal cues
- Understand the background of the adolescents and maintain privacy and confidentiality
- Communicate with a clear voice and speak in a friendly and polite tone of voice
- Show the adolescents that you have trust and confidence in them in order to gain their trust and confidence,
- Be non-judgmental and do not impose your values on the adolescent
- Ensure there is a conducive environment (quiet, good ventilation)
- Ensure any messages given are appropriate, timely, meaningful and applicable to the situation(s)

#### ***Role of the health care provider in fostering good communication***

As a health care provider you should be able to:

- *Communicate effectively; Help the adolescent to evaluate his/her own behavior and possible solutions to the problem. Respect, trust and give positive encouragement to allow the adolescents take responsibility for their decisions.*
- *Consider the adolescent as an individual, emphasize on their qualities and potential and respect his/her right as a person.*
- *Accept the adolescent as a complete and independent individual with his/her own views, concerns, attitudes and challenges.*
- *Don't be judgmental.*
- *Promote ownership of decisions, greater self-confidence and self-control.*

### 3.5 Counseling Adolescents

Counseling is a person-to-person interaction, in which the counselor supports a client in the exploration and appreciation of their perceived challenges, provides information to help the client to understand their concerns or issues more clearly with a view to assisting the client make more informed choices and/or decisions and develop plans to act on them. Rapport is a key component of effective counseling since it enables the counselor and the client to appreciate each others concerns (the counselor supporting and the client being assisted to develop coping strategies, plans etc) to achieve common agreed upon goals.

Effective counseling approach should include the following:

- Active listening without judgment.
- Respect the adolescent's right to determine how he/she will deal with the situation at hand.
- Provide examples through story telling about similar real-life situations.
- Reduce stigma around sensitive topics by speaking about the topic in a normal manner. (You can do this by speaking about the topic as if it were routine and is not an uncommon occurrence, and by sharing other stories about how people have dealt with stigma in a positive manner. Remember to keep all names confidential when you tell these stories.)
- Ask open-ended questions and avoid direct questions when enquiring on sensitive topics.
- Discuss less sensitive topics before approaching potentially sensitive or uncomfortable topics.
- Link the adolescent to other avenues where he/she can talk about his or her feelings e.g. peer support groups.
- Provide correct information and help the adolescent to make informed decisions.
- Assist the adolescent to identify personal strengths, develop self-confidence and a positive attitude.
- Maintain an open mind
- Trust the adolescent's decisions and feelings.
- Refer for additional religious and spiritual support
- Assist the adolescent to normalize his/her feelings—reassure them about normal, appropriate reactions to the situation.

Avoid:

- Solving the adolescent's problems (making decisions for him/ her and telling him/her what to do).
- Blaming, judging, and preaching.
- Making promises if they cannot be kept.
- Forcing your own values and beliefs onto the adolescent.
- Providing incorrect information.

### ***Common situations of counseling adolescents***

The following are some situations that require counseling

#### **1. Counseling Adolescents to Postpone Intercourse**

Key messages:

- It is possible, acceptable, practical and normal to abstain from sexual activity.

- Sex should never be forced on any one
- It is better to delay child bearing until after adolescence

## 2. Counseling Sexually Active Adolescents (Includes married and single youths)

Educate and provide information on:

- *Contraception: methods and access.*
- *Prevention and treatment of sexually transmitted infections.*
- *Importance of testing for HIV as couple (to bring their sexual partner).*
- *A HIV infected adolescent can infect his /her sexual partner.*
- *A HIV infected adolescent can transmit HIV to their unborn child.*
- *There is room for secondary abstinence for those who had been sexually active.*

### ***Challenges in counseling the adolescent***

- **Silence:** This can be a sign of shyness, anger, anxiety or non-verbal communication.

*If it occurs at the beginning of a session, the provider can say, "I realize it's hard for you to talk. This often happens to people who come for the first time."*

*If the adolescent has difficulty expressing her/his feelings or ideas, the counselor can use some brochures or posters to encourage discussion or refer to a story or anecdote so the adolescent can talk about others rather than her/him.*

- **Crying:** Try to evaluate what provoked the tears and avoid suppressing the cry. Provide psychological support and refer appropriately
- **Threat of suicide:** All suicide threats or attempts must be taken seriously. It is essential to determine if attempts were made in the past, if s/he is really considering suicide and the reasons for doing so or if it is something said without thinking. It is best to refer the adolescent to a psychiatrist or psychologist.
- **Refusal to be helped:** Adolescent isn't comfortable to discuss their problem, the counselor can say, "I understand how you feel. I'm not sure I can help you, but maybe we could talk for a minute." If not able to communicate plan for a rescheduled visit.
- **Need to talk:** Challenges in counseling may also include a situation where the adolescent is very vocal and wants an outlet to express other concerns that may not be directly related to the immediate counseling need as perceived by the service provider. Give the adolescent the opportunity to express her/his needs and concerns. Refer for relevant services.



# Section 4

## ADOLESCENT MENTAL HEALTH

Most mental health problems emerge in late childhood and early adolescence. Mental health problems and in particular depression is the largest cause of the burden of disease among young people.

Poor mental health is associated with several health and social outcomes such as;

- *Higher alcohol, tobacco and illicit substances use*
- *Adolescent pregnancy*
- *School dropout*
- *Delinquent behaviors.*

Healthy development during childhood and adolescence contributes to good mental health and can prevent mental health problems.

Enhancing social skills, problem-solving skills and self-confidence can help prevent mental health problems such as conduct disorders, anxiety, depression and eating disorders as well as other risk behaviors including those that relate to sexual behavior, substance abuse, and violent behavior.

As a health care provider you need to have the competencies to relate to young people, to detect mental health problems early, and to provide treatments which include counseling, cognitive-behavioral therapy or refer for medication

Mental health refers to the psychological or emotional well-being of an individual. This can be further captured in four main aspects of mental functioning.

These are:

- i. An appropriate awareness of self,
- ii. An awareness of one's abilities,
- iii. An ability to work productively (whether in school or in their own environments),
- iv. The ability to contribute to their communities (social, family or otherwise).

Mental illness is any disease or condition affecting the brain that significantly influences or disrupts a persons thinking, feeling, mood, ability to relate to others and daily functioning.

In addition to the typical emotional changes that occur during adolescence, ALHIV must deal with a number of other stressors such as emotional disorders, adjustment disorders, the potential loss of loved ones, stigma and isolation, gender-based violence, challenges of sexual orientation, and the responsibility of taking care of oneself and/or others in the presence of a chronic illness. Adolescents who suffer from depression are more likely to be non-adherent to their medication and have other self-care issues and thus require extra attention in both assessment and planning of their care.

## 4.1 Mental Health Assessment

As a health care worker you should pay close attention to the adolescents behavior during clinic visits

- Appearance: An assessment of the client's physical appearance, hygiene and grooming
- Mood
- Cognition:
  - ▶ *Orientation – Is the client aware of space, person and time?*
  - ▶ *Memory – short-term, long term*
  - ▶ *Intellect – appropriateness of intellectual functioning for age*
  - ▶ *Concentration*
- Thoughts: Depressive, appropriateness
- Behavior: Appropriateness of behaviour
- Attitude: Cooperative, antagonistic, appropriate
- Speech: Coherence, appropriate
- Perceptions: Abnormal perceptions - auditory, visual, tactile
- Insight: Appropriate appreciation of circumstances
- Judgment: Sound or impaired

## 4.2 Depression

Depression is a feeling of intense sadness, including feeling helpless, hopeless, and worthless that lasts for days to weeks; loss of interest in activities that usually give pleasure.

It is one of the more common illnesses in outpatient clinics but it is often overlooked. You should have a high degree of suspicion at each clinical evaluation.

Always remember that very few adolescents will present with a straightforward complaint of depression. Majority of the adolescents will present with other complaints and may never mention depressed mood unless questioned specifically for the symptoms.

If the adolescent presents with vague somatic (body) complaints or numerous complaints that do not fit any clear clinical pattern consider depression as a diagnosis.

### 4.2.1 Diagnosis of depression

The diagnosis of depression in an adolescent should begin with inquiries of the neurovegetative symptoms. Ask the adolescent if they have noticed any changes in sleeping patterns, appetite, and energy levels. Positive responses should elicit further questioning.

**Table 7: Common Symptoms of Depression:**

SIGECAPS: Give energy capsules	
<b>S</b>	Sleep disturbance
<b>I</b>	Interest/pleasure reduction
<b>G</b>	Guilt feelings or thoughts of worthlessness
<b>E</b>	Energy changes/fatigue
<b>C</b>	Concentration/attention impairment
<b>A</b>	Appetite/weight changes
<b>P</b>	Psychomotor disturbances
<b>S</b>	Suicidal thoughts
Plus depressed mood	

These are the nine symptoms for depressive disorder. Five of these nine must be present to make the diagnosis. See Annex 3 for depression screening tool

Assess all adolescents with depression for suicidal risk.

- Ask the adolescent if they have thoughts of hurting self
- If the response is yes ask the adolescent if they have a specific plan
- If the response is yes consider emergency admission

Always remember that many suicide attempts are apparently made with the



hope of the rescue, which can be useful in assessing how receptive the patient may be to therapy. Bear in mind that even poorly conceived suicidal plans can have a fatal outcome and any suicide risk must be given prompt attention.

Adolescents with suicidal thoughts may still be at risk of suicide even after treatment has begun.

### **Past Medical History/Family Medical History**

Always remember adolescents with a history of depressive episodes are at increased risk of suffering a subsequent episode. Adolescents with depression may have a family history of depression, substance abuse, and/or suicidal attempts. HIV is a chronic disease and ALHIV may often present with depressive symptoms.

### **Social History**

Assess for any emotional and mental stressors in the adolescents life.

Ask about the adolescents family and/or social support structures which are important in determining the adolescents prognosis. Lack of support structures in the adolescents life can increase the risk of suicide and may undermine effective therapy of depression.

Ask the adolescent directly if they are using alcohol or other mood and/or mind-altering substances. In some cases the adolescent may have been self-medicating prior to the diagnosis of depression. Remember that use of such substances may significantly increase the risk of suicide. If the adolescent continues to use these substances after treatment begins, the chances for successful treatment are reduced

### **Physical Examination**

Take a thorough history and conduct physical examination to rule out organic causes of depression.

## **4.2.2 Treatment**

### **Psychotherapy and Counseling**

Psychotherapy is the first line therapy for depression in adolescents and children. Counseling is essential in all age groups but often access is limited. You can conduct some counseling in routine clinical visits although this may require more time.

BATHE technique can be used when counseling a patient in the clinic although this does not replace professional counseling. Use the BATHE technique where options are limited but refer the adolescent if this does not seem to yield expected results.

BATHE is an easy and quick means of allowing adolescents to express their concerns and allows you as a HCP to empathize with the adolescent.

Remember that you are not expected to be able to solve all of your adolescents problems. It will takes you five to ten minutes to complete the questions.

**Table 8: BATHE Technique**

<b>B</b>	Bother/ Background	What is Bothering you the most right now?	This question is meant to elicit any history of current problems. Some will use an alternate form such as "Tell me what is happening right now." This may result in a seeming avalanche of problems. Do not let this overwhelm you. Listen patiently for 3 to 5 minutes and then ask the next question. Asking the patient to identify the most troubling aspect of numerous problems/ stressors can be therapeutic in and of itself for the patient.
<b>A</b>	Affect	How is that Affecting you?	This question is aimed at clarifying the patient's emotional state. An alternative form would be "How do you feel about that?" For some patients this may be the first time they consciously admit that they are affected.
<b>T</b>	Trouble	What is it about this that troubles you the most?	With this question we hope to further focus and clarify the patient's reaction to stressors and identify major areas of concern.
<b>H</b>	Handle	How are you Handling that?	Note the manner of this question. It carries an implicit belief that the patient is handling the situation in some manner. This assists in establishing a working rapport with the patient and may allow opportunity for brief discussion of alternative coping strategies or resources.
<b>E</b>	Empathy	Express Empathy/ understanding of the patient's concerns	For some physicians this can be the most difficult portion of the technique. At the same time it is the most simple. Common statements might be "I can see how that would make you angry." Or "That must be very frustrating." The important point to remember here is that genuine concern can be as therapeutic as offering a detailed plan

## Medications

For adolescents who may not respond to psychotherapy/Counseling refer to a psychiatrist for further assessment and anti-depressants.

## 4.3 Other common mental health disorders

1. Behavioral disorders: violent behavior, aggression, regression, withdrawal and impulsivity (the tendency to do things without adequate forethought).
2. Anxiety: feelings of nervousness, fear, or worry that interfere with the ability to sleep or otherwise function; a lack of appetite; tremulousness, and sweating. In addition, the adolescents may complain of a racing heart, difficulty breathing, headaches, difficulty falling asleep, and difficulty concentrating.
3. Eating disorders: overeating, not eating enough, dieting to the point of starvation (anorexia nervosa), Bulimia nervosa-binge eating and then purging (vomiting).
4. Somatic complaints: complaints relating to the body, not the mind or spirit: Anxiety and depression affect the mind and the body and, when severe, may be accompanied by physical (or somatic) complaints. These may include fatigue, headaches/migraines, abdominal pain/gastrointestinal problems, back aches, difficulty in breathing/chest pain. Somatic symptoms can also occur as indicators of distress in the absence of obvious depression and anxiety. Among ALHIV it is always important to rule out medical causes.
5. Neurocognitive impairments: HIV positive adolescents are at increased risk of loss of memory which includes attention deficit, verbal memory, visual memory, reaction time and complex auditory information processing.
6. Suicidal ideation: thinking about suicide.
7. Drug, alcohol and substance abuse.
8. Problems resulting from side effects of ARVs or negative experiences with medications: some ARVs, like Efavirenz, are known for their effect on the central nervous system, resulting in sleep disturbance, mood changes and perceptual abnormalities including hallucinations. Symptoms usually resolve but clients still need encouragement and support.
9. General problems coping with HIV diagnosis which include social withdrawal, loneliness, anger, confusion, fear and guilt

It is important to work together with the adolescent and his or her care giver to establish a consistent support system. The HCP should offer tips on dealing with anxiety/depression and help the adolescent by referring them to a trained counselor, social worker, psychologist or psychiatrist who is accustomed to treating these symptoms. HCP may also help by referring the adolescent to a community support and/or peer support group.

**Table 9: Tips for Helping the Adolescent**

Offer support	Let the adolescent know that you are there for him or her, fully and unconditionally. Do not ask a lot of questions. Make it clear that you are ready and willing to provide whatever support he or she needs.
Be gentle but persistent	Do not give up if your adolescent shuts you out at first. Talking about issues such as depression can be very difficult. Be respectful of his or her comfort level while still emphasizing your concern and willingness to listen.
Listen without criticizing	Resist any urge to criticize or pass judgment once your adolescent begins to talk. The important thing is that your child is communicating. Avoid offering unsolicited advice or ultimatums as well.
Validate their feelings	Do not try to talk them out of their feelings, even if their feelings or concerns appear silly or irrational to you. Simply acknowledge the pain and sadness they are feeling. If you do not, the adolescent will feel like you do not take his or

NB; As a health care worker you need to be patient, listen, empathize, assure, validate, support and refer the adolescent as necessary.



# Section 5

## NUTRITIONAL CARE AND SUPPORT

Adolescence is a time of rapid change and growth that increases the need for macro and micronutrients. Physical changes that require extra nutrition include rapid changes in weight, height, the onset of menarche for girls, and increases in fat and muscle mass. Growth in adolescence depends on adequate nutrition, including both the quantity and the quality of the food and the ability to digest, absorb and utilize food. Chronic under-nutrition during this period can lead to stunting. Consequently, the nutritional status of the HIV-infected adolescent will have a great impact on overall health, growth, and development and child birth in later adulthood for the girls.

Nutrition care and support for HIV-infected adolescents is a package that should include the following;

- Nutrition assessment
- Nutrition counseling
- Micronutrient supplementation (if needed)
- Food support (if needed)
- Food safety and hygiene
- Psychosocial support
- Referral to other relevant health care services

### 5.1 Nutrition Assessment

The goal of nutritional assessments is to determine if nutritional problems exist and, if so, the severity and probable causes. Health workers should consider the high incidence of food insecurity for families in the region, especially those affected by HIV. Every nutritional assessment should include a discussion of the ability of the client and his or her family to buy or grow enough healthy foods to eat. Nutritional counseling, education, and advice should always be adapted to the realities of a particular clients situation.

Refer to the Kenya National Nutrition guidelines

- Conduct anthropometric assessment: weight, height, BMI or MUAC where applicable
- Clinical assessment : Look out for stunting, wasting/ obesity, anemia etc

- Biochemical assessment: e.g. Blood sugar, Lipid profiles, Hemoglobin levels etc where available
- Dietary assessment

## 5.2 Nutritional Counseling

Adolescents require adequate dietary intake with increased calories to support hormonal and physical changes that come with this stage of development. Their energy needs further increase with the stage of HIV infection.

Points to emphasize regarding dietary intake for adolescents include:

- *Adequate food intake*
- *Adherence to medication, including ARVs*
- *Consumption of a variety of foods*
- *Prompt treatment of opportunistic infections and any ailments such as malaria*
- *Girls to have iron and folic acid supplements to compensate for loss in menses*
- *Pregnant adolescents needs additional energy and nutrients to support their growth and that of the developing foetus*

*NB: Support adolescents to reduce stigma from peers*

### **Key points to consider**

1. As a health care provider you should keep a list of locally available and affordable foods. This will help you in providing nutrition counseling as it is always best to eat foods grown at home or produced locally which are often cheaper and more nutritious.
2. Provide nutritional education and counseling to the adolescent along with their caregivers as a part of all HIV care appointments.
3. Link the adolescent with a community provider for nutritional counseling services and programs for adolescents who need food assistance in the community.
4. Advise the Adolescents to:
  - *Eat a variety of foods from all food groups based on what is locally available and affordable and be sure to eat sufficient amounts of food every day.*
  - *Eat adequate amount of "energy giving foods" (starches) e.g. Ugali, arrowroots, rice etc.*
  - *Eat "body building foods" (proteins) with every meal. These could be animal proteins like meat, fish, and milk and eggs or plant proteins such as beans, peas, soya beans, and nuts which also provide good quality protein.*

- Eat plenty of fresh fruits and vegetables every day.
- Drink plenty of water (up to 2 liters) each day.
- Eat foods that contain fat and oils in moderation.
- Eat sweets sparingly.
- Avoid junk and processed foods which are often unhealthy and lacking in nutrition value e.g. soda pops, sugary foods, and potato chips
- Advise the adolescent to:
  - ▶ Eat 3 main meals in a day and 2 snacks in between
  - ▶ To eat small meals frequently and have a regular meal schedule.
  - ▶ If busy during the day, they should carry a healthy snack (boiled maize, arrow root banana or an apple) with them.
- Provide daily multivitamin supplement as a routine part of care for ALHIV

5. Counsel the Adolescent with the following tips for Preparing Food Safely

- a) Always wash hands before handling any food.
- b) Wash all surfaces well before cooking.
- c) Wash fruits and vegetables well before eating.
- d) When eating meat, make sure that it is fully cooked.
- e) Store foods in a cool place and do not eat foods that have been sitting out for prolonged periods.

## 5.3 Nutritional Requirements for ALHIV

- HIV-infected adolescents with no AIDS-related symptoms (WHO stage I): 10% more energy (about 210 additional kcal/day, equivalent to 1 cup of porridge)
- HIV-infected adolescents with AIDS-related symptoms (WHO stages II, III and IV): 20-30% more energy (420-630 kcal/day, depending on severity of symptoms)
- HIV-infected child with no AIDS-related symptoms: 10% more energy than HIV-negative children
- Child with AIDS-related symptoms but no weight loss: 20-30% more energy than HIV-negative children
- HIV-infected child experiencing weight loss: 50-100% more energy
- The requirements may even be higher if the HIV-infected adolescent suffers from opportunistic infections or is pregnant or lactating



## How to increase energy intake

- Eat at least 3 meals/day (breakfast, lunch, dinner).
- Have nutritious snacks between meals.
- Increase amounts of food consumed.
- Improve energy and nutrient content of foods by enriching them with energy/nutrient-dense foods (oil, ground nut paste, sugar, eggs, and milk).

## Maternal Nutrition for ALHIV

Good nutrition is important for pregnant and lactating ALHIV as it improves health and infant survival

Support optimal nutrition for pregnant and lactating ALHIV considering the increased nutrient needs

Support lactation management for lactating ALHIV through the following:

- Identify safer infant-feeding practices in the context of HIV
- Demonstration of proper breastfeeding techniques

### 5.3.1 Dietary recommendations for common signs and symptoms associated with HIV

It is important to counsel the ALHIV to seek prompt treatment for all opportunistic infections and other diseases, and manage symptoms with dietary practices, especially for illnesses that may interfere with food intake, absorption and utilization. Refer table xxx .

**Table 10: Dietary recommendations for common signs and symptoms associated with HIV**

Sign/ Symptom	Dietary Recommendations	Care Practices
Anorexia	<ul style="list-style-type: none"><li>■ Try to stimulate appetite by eating a variety of foods</li><li>■ Eat small frequent meals</li><li>■ Select foods that are more energy dense</li><li>■ Avoid strong-smelling foods</li><li>■ Drink plenty of fluids, soups, diluted fruit juices, boiled water</li><li>■ Avoid strong citrus fruits</li><li>■ Consume food rich in soluble fibres</li><li>■ Consume fermented foods such as yoghurt and porridges</li></ul>	<ul style="list-style-type: none"><li>■ If the appetite is lost as a result of illness, seek medical attention for treatment</li></ul>

Taste changes	<ul style="list-style-type: none"> <li>■ Use flavor enhancers such as salt, spices, herbs, and lemon</li> <li>■ Chew food well and move it around in mouth to stimulate taste receptors</li> </ul>	
Diarrhoea	<ul style="list-style-type: none"> <li>■ Drink plenty of fluids (boiled/treated water)</li> <li>■ Boil or steam food if diarrhoea is associated with fat malabsorption</li> <li>■ Reduce or avoid intake of milk and milk products, coffee, tea, alcohol, fatty foods and gas forming foods such as cabbages and carbonated soft drinks</li> <li>■ Eat small frequent meals such as porridge, yoghurt, vegetables and fermented milk</li> <li>■ Eat foods rich in potassium such as bananas and pumpkins</li> </ul>	<ul style="list-style-type: none"> <li>■ Drink clean boiled water always</li> <li>■ Wash hand with water and soap before handling, preparing, serving, or storing food, and after visiting toilet</li> <li>■ Drink more fluids to prevent dehydration</li> <li>■ Use ORS as recommended in the guidelines</li> </ul>
Fever	<ul style="list-style-type: none"> <li>■ Drink plenty of soups</li> <li>■ Eat foods rich in energy and nutrients such as groundnuts, maize, potatoes and carrots</li> <li>■ Drink plenty of healthy fluids</li> <li>■ Eat small frequent meals</li> </ul>	<ul style="list-style-type: none"> <li>■ Drink fluids to prevent dehydration, particularly clean boiled water</li> <li>■ Bathe in cool water</li> <li>■ Rest more</li> <li>■ Seek specific treatment</li> </ul>
Nausea and vomiting	<ul style="list-style-type: none"> <li>■ Eat small frequent meals</li> <li>■ Drink plenty of fluids like soups, unsweetened porridge and fresh fruit juice</li> <li>■ Eat lightly salted and dried food such as crackers</li> <li>■ Avoid spicy and fatty foods</li> <li>■ Avoid caffeine and alcohol</li> <li>■ Avoid oily fried foods and foods with strong smells</li> </ul>	<ul style="list-style-type: none"> <li>■ Avoid skipping meals (nausea is worse on an empty stomach)</li> <li>■ Avoid lying down immediately after eating</li> </ul>
Mouth sores and oral thrush	<ul style="list-style-type: none"> <li>■ Eat cold or room temperature food</li> <li>■ Eat soft mashed warm foods such as mashed potatoes</li> <li>■ Avoid spicy, salty or sticky food</li> <li>■ Avoid sugary food and acidic foods</li> <li>■ Avoid alcohol</li> <li>■ Clean the mouth with warm salty water at least twice daily</li> </ul>	<ul style="list-style-type: none"> <li>■ Tilt head back when eating to help swallowing</li> <li>■ Rinse mouth with boiled warm water after eating to reduce irritation and keep infected areas clean</li> </ul>

Constipation	<ul style="list-style-type: none"> <li>■ Maintain a regular eating schedule and don't skip meals</li> <li>■ Eat more foods that are high in fibre such as cereals, oats, nuts, and whole meal bread</li> <li>■ Drink plenty of liquids</li> <li>■ Avoid processed or refined foods</li> <li>■ Exercise as much as possible</li> <li>■ Avoid laxatives as they cause loss of fluids</li> </ul>	<ul style="list-style-type: none"> <li>■ Drink plenty of fluids including boiled water</li> <li>■ If dietary fibres do not resolve the problem you may prescribe fibre supplements</li> </ul>
Anaemia	<ul style="list-style-type: none"> <li>■ Increase intake of iron-rich foods such as animal products, eggs, green leafy vegetables; fruits rich in vitamin C such as oranges, citrus and mangoes; legumes, nuts; oils seeds and fortified cereals</li> <li>■ Take iron supplements as per prescriptions</li> <li>■ Reduce intake of teas and coffees</li> </ul>	<ul style="list-style-type: none"> <li>■ Drink fluids to avoid constipation</li> <li>■ Treat malaria</li> <li>■ Ensure deworming every 4 -6 months</li> <li>■ If taking zidovudine, check hemoglobin concentration</li> </ul>
Muscle wasting	<ul style="list-style-type: none"> <li>■ Increase food intake by increasing quantity of food and frequency of consumption</li> <li>■ Improve quality and quantity of foods by consuming a variety of foods</li> <li>■ Increase protein in diet</li> <li>■ Increase intake of starchy foods such as cereals and other staple foods</li> <li>■ Eat small, frequent meals</li> </ul>	<ul style="list-style-type: none"> <li>■ Do regular weight bearing exercise to build muscles</li> </ul>
Loss of appetite	<ul style="list-style-type: none"> <li>■ Eat small amounts of nutritious food frequently</li> <li>■ Take nutritious snacks between meals</li> <li>■ Drink plenty of boiled or treated water, and other fluids</li> <li>■ Use favorite foods and natural spices</li> <li>■ Avoid smoking and alcohol consumption</li> <li>■ Eat in the company of friends or relatives</li> <li>■ Conduct simple exercises</li> <li>■ Use multivitamins</li> <li>■ If related to depression, refer to a counselor</li> </ul>	
Respiratory diseases	<ul style="list-style-type: none"> <li>■ Take plenty of fruits and vegetables, especially those rich vitamin C, A, and zinc</li> <li>■ Take high energy, high protein meals to meet caloric requirements</li> </ul>	

### 5.3.2 Dietary Recommendations for Common Chronic Illnesses

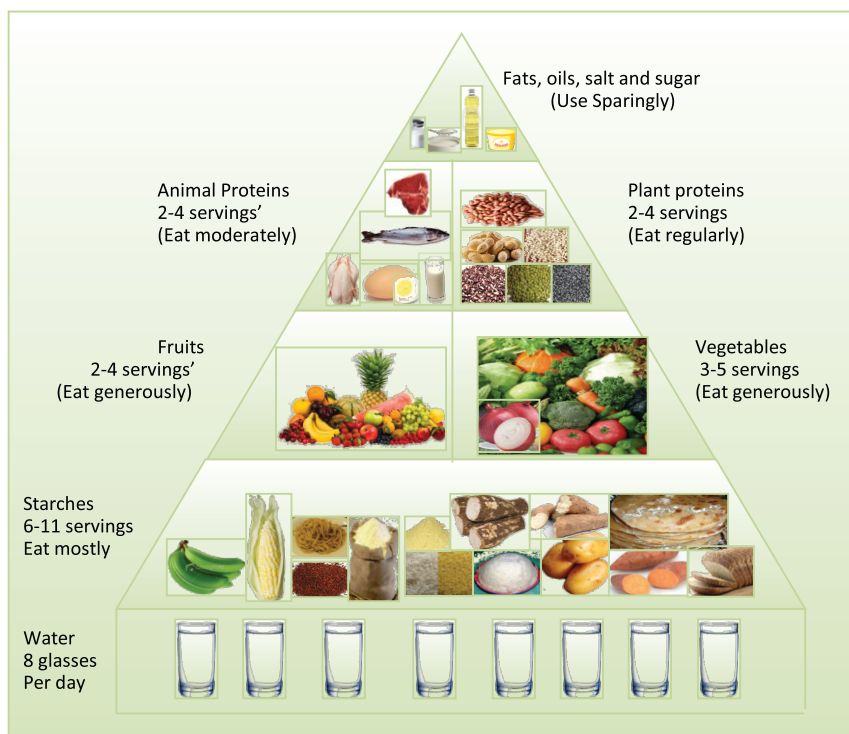
Now we will look at dietary recommendations specifically for some of the common chronic illnesses among our patients with HIV (Table 11).

**Table 11: Dietary recommendations for common chronic illnesses**

Chronic Illness	Dietary Recommendations	Care Practices
Diabetes	<ul style="list-style-type: none"> <li>■ Lower intake of sugary drinks</li> <li>■ Reduce the use of fat for flavoring</li> <li>■ Reduce the consumption of fried foods</li> <li>■ Avoid fatty foods</li> <li>■ Take fruits every day</li> <li>■ Eat more whole grains, vegetables, beans</li> <li>■ Eat less meat and meat products, dairy and baked goods</li> </ul>	<ul style="list-style-type: none"> <li>■ Unprocessed foods and foods high in fiber give satiety and are associated with lower body weight, hence they are highly recommended</li> </ul>
Cardiovascular disease	<ul style="list-style-type: none"> <li>■ Reduce salt intake</li> <li>■ Consume a variety of fruits and vegetables</li> <li>■ Consume whole grains and cereals</li> <li>■ Diet rich in fibre</li> <li>■ Low cholesterol diet</li> <li>■ Simple exercises</li> </ul>	<ul style="list-style-type: none"> <li>■ Weight management and dietitians follow up</li> </ul>
Renal failure	<ul style="list-style-type: none"> <li>■ Limit protein intake</li> <li>■ Reduce salt intake</li> <li>■ Adjust fluid intake</li> </ul>	<ul style="list-style-type: none"> <li>■ Close monitoring of edema and follow up with a dietitian</li> </ul>
Chronic under nutrition	<ul style="list-style-type: none"> <li>■ Eat balanced meals</li> <li>■ Improve nutrient density</li> <li>■ Consume nutrient-rich snacks</li> <li>■ Eat favorite foods</li> <li>■ Admit in therapeutic feeding program</li> <li>■ Manage underlying infections and micronutrient imbalance</li> </ul>	<ul style="list-style-type: none"> <li>■ Advice on simple exercises</li> <li>■ Weigh patient at least every 2 weeks</li> </ul>
Obesity	<ul style="list-style-type: none"> <li>■ Eat balanced meals</li> <li>■ Eat more whole foods and fibre as they give a feeling of satiety</li> <li>■ Drink plenty of water 8 glasses of clean safe water. 2.5 liters per 24 hour day</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase physical exercises</li> <li>■ Monitor weight every month</li> <li>■ Correct any psychological</li> </ul>

NB: For further management of chronic illnesses consult a clinician (Refer to guidelines on ART 2011 - NASCOP)

**Figure 2: Food Pyramid for Adolescents**



This Food pyramid guide serves as a general guide to food choices for adolescents. It is a healthy guide divided into sections to show the recommended intake for each food group.

#### Remember

- *Good nutrition is an important component of positive living. Health workers should provide regular weight and nutritional monitoring and counseling as part of ALHIV's routine care.*
- *Health workers should support adolescent clients with nutritional problems and work with them and/or their caregivers to address these problems with home-based nutrition interventions. Prompt treatment of symptoms can support clients to adhere to their care and treatment plan, including ART, which in turn can prevent or reduce many symptoms.*



# Section 6

## ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Among the critical health problems adolescents face are those associated with sexuality and reproductive health such as early and unprotected sexual activity. These have a significant bearing on both their current and future health status. Adolescents sexual and reproductive health is often determined by their age of first sex. Although trends have improved over time, in 2009 there were a significant number of girls (11 per cent) and boys (22 per cent) who had their first sexual intercourse before the age of 15 years (KDHS 2009).

Adolescence is a period of self-discovery, exploration, and continued sexual development, it is also a period when sexual initiation usually occurs. Therefore its important to remember that:

- All adolescents have the right to a healthy sex life
- Adolescents should be equipped with the knowledge and skills to protect themselves and their partner
- Adolescents must be able to access and utilize sexual and reproductive health (SRH) services which are offered in an integrated manner as part of regular routine services
- Always avoid negative constructs of sexuality that emphasize disease and fear instead focus on the positive aspects of sexuality, which may help adolescents commit to safer sex practices
- Be prepared to discuss issues of sexuality in a nonjudgmental and constructive manner
- Be sensitive to diverse sexual orientations (homosexual, heterosexual, bisexual)
- Remind the adolescent that questions, desires, and thoughts about sex are normal for any adolescent and offer them your support
- Work together with families/caregivers to reinforce accurate messages and education
- Understand that adolescents are up to three times more likely to experience pregnancy related complications than older women. High fertility levels as well as high teenage pregnancy rates have serious negative consequences. Early childbearing disrupts the pursuit of education and limits future opportunities for social and economic development
- Sexual and reproductive health (SRH) services should be made available in all adolescent clinics

## Definitions of key terms

**Sexual Activity:** Sex can be a normal part of life for many older adolescents and adults. Sex means different things to different people;

- *Vaginal sex or penile vaginal sex*
- *Anal sex or penile anal sex*
- *Oral sex (when a person kisses or licks his or her partner's penis, vagina, or anus)*
- *Inserting fingers or objects into the vagina or anus*
- *Masturbating (touching ones genitals alone or with a partner)*

In many places, sex is often thought to mean only penis-vagina sex between a man and woman; however it could also mean sex between a man and a man or sex between a woman and a woman.

**Sexual Orientation and Identity:** Adolescence is a time of sexual experimentation and defining ones sexual identity. As a health care provider its important to know that an adolescent sexual identity may change later in life. Discuss the adolescents sexual orientation in a non-judgmental way. Bear in mind that male adolescents who have sex with other men are at increased risk of HIV and STIs. Counsel them on safer sexual practices and provide any necessary referrals.

**Safer Sex:** Safer sex refers to sexual practices that do not expose a person to sexually transmitted infections, HIV or pregnancy.

**Risky sexual behaviors:** Risky sexual behaviors are those which increase the chance of the adolescent contracting or transmitting disease (HIV infection and other sexually transmitted infections (STIs) or increase the chance of the occurrence of unwanted pregnancy. They include;

- *Having oral, vaginal or anal sexual contact without a condom.*
- *Not using a birth control method or using birth control inconsistently*
- *Having more than one (multiple) sexual partners*
- *Changing sexual partners frequently*
- *Having unprotected sex with a partner of unknown HIV status*
- *Having sex when under the influence of alcohol or drugs*
- *Having sex under coercion*
- *Having sex with an older man or woman*

As a health care provider you should counsel the adolescent to avoid risky sexual behaviors and emphasize on the need to practice safer sex and refer appropriately



**Rape:** According to the Kenyan Sexual Offences Act the offence of rape is when a person:

- (a) Intentionally and unlawfully commits an act which causes penetration with his or her genital organs;
- (b) The other person DOES NOT consent to the penetration; or
- (c) The consent is obtained by force or by means of threats or intimidation of any kind.

## 6.1 Sexual Risk Screening and Counseling

Following section explains how to carry out steps to assess the risk related to sexuality activity of your adolescent client:

- *Create trust between you and your adolescent client to make him or her feel comfortable asking questions and raising concerns.*
- *Explain that you will keep the information confidential unless there is an emergency or a health risk that requires intervention.*
- *Use good communication and counseling skills and avoid making assumptions or judgment about the adolescent client, including about his or her knowledge, behaviors and sexual orientation.*

### ***Conducting a risk assessment***

Questions which you should ask as part of the risk assessment include:

- Do you have a boyfriend/girl friend?
- Have you ever had sex with your boyfriend/girlfriend?
- Are you having sex with males, females or both?
  - 1. *For girls ask if they are having sex with a boys or girls*
  - 2. *For boys ask if they are having sex with girls or boys.*
- How many partners do you have right now? How many partners have you had in the past year?
- Do you have vaginal sex? Oral sex? Anal sex?
- Did you use a condom (and lubricant for anal sex) last time you had sex? Do you use a condom every time you have sex (and lubricant for anal sex)?
- Are you currently taking any contraceptives? Which ones? Did you use other contraceptives last time you had sex?
- Have you had any abnormal vaginal discharge (colour, amount or smell), pain when urinating or any sores or bumps in or around your genitals or anus?
- Have you ever experienced sexual contact against your will?

- For girls, have you ever been pregnant? What were the pregnancy outcomes? For boys, ask, do you have a child?
- Have you had your first menstrual period? If yes, when was your last period?
- Do you know your own HIV status? If so does your partner know? Do you know the HIV status of your partner(s)?
- Have you ever used alcohol or drugs? If so, how often in the last week have you used alcohol or drugs

### ***Risk reduction counseling***

Risk reduction counseling is an important role of a health care provider. It includes that you understand if the adolescent has correct knowledge and discuss options for sexual risk reduction. Below are suggested questions to initiate and guide the counseling process.

- How is HIV transmitted from one person to another?
- How can a person prevent transmission of HIV during sex?
- What is your plan to protect your partner from getting HIV when you have sex?
- Did you know that even if both partners have HIV, it is important to practice safer sex and use condoms? Do you know why?
- There are a number of ways to reduce your risk of HIV, other STIs, and unwanted pregnancy, including:
  - Abstinence
  - Being faithful to one sexual partner and knowing the HIV status.
  - Correctly and consistently using condoms.
  - Disclosing your HIV status and negotiating safe sexual practices: Encourage disclosure of HIV status to partners, work with clients to facilitate the disclosure process, and offer the possibility of meeting with the client and partner together to help the client disclose.
  - STI screening and treatment (HIV is transmitted more easily in the presence of other STIs).
  - Avoid alcohol, marijuana, drugs, and other substances that impair good judgment and prevention discuss abstinence.

**Abstinence** means not having sex. Explain to the adolescent that abstinence is the only way to avoid getting STIs/ HIV and pregnancy.

## 6.2 Adolescent Contraception

Adolescents are medically eligible to use any method of contraception and must have access to a variety of contraceptive choices. Age alone does not constitute a medical reason for denying any method of contraception to adolescents. While some concerns have been expressed regarding adolescents use of contraceptives methods (such as DMPA by adolescents under 18 years) this concerns must be balanced against advantages of avoiding pregnancy.

You should encourage sexually active adolescents to use contraceptive services by adopting a positive attitude, ensuring privacy, confidentiality, and providing convenient hours of services.

Consider important Social and behavioral issues in the choice of contraceptive methods by adolescents:

- In some settings adolescents may be at high risk of STI, including HIV.
- Methods that do not require a daily regiment maybe preferred by some adolescents
- Adolescents have been shown to be generally less tolerant of side effects than older adults, which is one reason why they have a higher discontinuation rates.
- Method of choice may also be influenced by factors such as sporadic patterns of intercourse, need to conceal sexual activity and contraceptive use.

NB: Always follow the national “Family Planning Guidelines” when providing contraceptive counseling and support and when prescribing a contraceptive method.

*Please consider the following when you discuss contraceptives with your adolescent client.*

**Table 12: Contraceptive Options for adolescents**

Method	Considerations
Male and female condoms	<ul style="list-style-type: none"> <li>• Good methods for adolescents to protect against HIV, STIs, pregnancy.</li> <li>• Are readily available, affordable and convenient.</li> <li>• Requires demonstration on proper use.</li> <li>• Counsel on correct and consistent use all adolescents.</li> <li>• Adolescents living with HIV should always be supported to use condoms when sexually active.</li> </ul>
Combined Oral Contraceptive (COC) pill/ progestin only pill	<ul style="list-style-type: none"> <li>• Young women may have less control than older women over having sex and using contraception.</li> <li>• Need to be taken daily.</li> <li>• For adolescents living with HIV emphasis should be placed on the use of condoms together with oral contraceptives.</li> <li>• Progestin only pills are recommended for breastfeeding mothers with babies less than 6 months old.</li> </ul>
Injectables	<ul style="list-style-type: none"> <li>• Can be used by all adolescents without restrictions.</li> <li>• Does not protect against STIs and HIV.</li> <li>• Counsel on schedule of injections.</li> <li>• For adolescents living with HIV emphasis should be placed on the use of condoms together with injectable.</li> </ul>
Implants	<ul style="list-style-type: none"> <li>• Provides long term and safe protection against pregnancy.</li> <li>• Does not protect against STIs and HIV.</li> <li>• For adolescents living with HIV emphasis should be placed on the use of condoms together with implant provide counseling to prepare client for possibility of irregular bleeding.</li> </ul>
Emergency contraceptive pills (ECP)	<ul style="list-style-type: none"> <li>• Emergency contraception should be made available whenever an adolescent client has had unprotected sexual intercourse, including sex against her will or after contraceptive failure.</li> <li>• Provide counseling on adopting a regular contraceptive method, as well as on condom use for dual protection.</li> </ul>
Intra uterine devices	<ul style="list-style-type: none"> <li>• Can safely be used by all adolescents including adolescents living with HIV on ART.</li> <li>• Initiation is not recommended for ALHIV with advanced HIV disease or AIDS.</li> </ul>
Male and female sterilization	<ul style="list-style-type: none"> <li>• They should be provided with great caution since adolescents are among the most likely to regret sterilization.</li> </ul>
Fertility awareness methods (Natural)	<ul style="list-style-type: none"> <li>• A difficult method for most adolescents to implement correctly and consistently.</li> <li>• Not reliable for pregnancy prevention.</li> <li>• Do not recommend.</li> </ul>

## 6.3 Considerations for Adolescent Pregnancy

Adolescents need to know that their bodies are capable of reproduction. Girls can get pregnant even before their menstrual period becomes regular and most girls usually begin menstruating between the ages of 9 and 16 years. Many adolescents believe they cannot get pregnant until they have had intercourse several times. Therefore, adolescents need to know that each and every act of unprotected sex represents the possibility of pregnancy and/or acquiring an STI or HIV.

If your adolescent client is pregnant, consider following:

- Ensure that she attends at least four ANC visits, management of infection, including syphilis, HIV and other STIs, HIV testing and counseling, and nutritional assessment
- Support her to develop an individual birth plan
- Management of pre-existing conditions and pregnancy complications
- Malaria prevention where applicable
- TB screening
- Safe delivery with skilled birth attendant
- If she has not completed her education, encourage the adolescent girl to go back to school after the pregnancy and delivery
- Offer or refer for crisis pregnancy counseling; Crisis pregnancy counseling is provided for adolescents with unplanned pregnancy. Counseling is provided to help the adolescent make an informed choice regarding parenting or adoption
- Counsel appropriately on the risks associated with abortion
- Liaise with the Community Health Worker to identify and link the pregnant adolescents to the health services and provide follow up support
- Offer and encourage psycho-social support and counseling for all pregnant adolescents and their caregivers

### ***Counseling for planned pregnancy for adolescents living with HIV***

Provide education on the risks of pregnancy during adolescence, especially early adolescence.

When counseling ALHIV on future planned pregnancies, ensure that you cover the following:

- *It is safest to wait until adulthood to become pregnant and have children.*
- *It is important for adolescents to know the facts about pregnancy and preventing mother to child transmission (PMTCT) before they become pregnant. The safest time to get pregnant is when the adolescent:*
  - ▶ *Has CD4 cell counts > 500*
  - ▶ *Is healthy: they do not have any opportunistic infections (including TB) nor do they have advanced AIDS*
  - ▶ *Is taking and adhering to their ART regimens*
  - ▶ *Has undetectable viral loads if on ART*
  - ▶ *Is in a stable relationship*
  - ▶ *Is financially stable*
- *It is healthiest for a mother to wait until her child is at least 2 years before getting pregnant again.*

### ***Considerations for HIV positive pregnant adolescents***

You should follow the national PMTCT and ART guidelines when providing services to pregnant adolescents living with HIV, their partners, and their families.

Key PMTCT concepts include:

- *Keeping the mothers healthy*
- *Reduce risk at every stage: during pregnancy, labor, delivery and breastfeeding.*
- *All HIV positive pregnant and lactating mothers require ARVs*
- *All babies of HIV infected mothers, require cotrimoxazole and ARV prophylaxis*
- *HIV exposed infants need to have HIV DNA PCR testing at 4 to 6 weeks of age*
- *Encourage partner testing and disclosure*

### ***Challenges adolescents may face with PMTCT***

Pregnant adolescents and new adolescent mothers (and their partners) face many of the same challenges adults face with PMTCT. However, you should keep in mind particular challenges that could constitute barriers to adolescent clients in PMTCT programs, including:

- *Difficulty adhering to ART or ARV prophylaxis.*
- *Difficulty giving the infant medicines every day.*

- *Challenges with safe infant feeding, especially exclusive breastfeeding for the first 6 months of life.*
- *Fears about having a baby who is HIV-infected and guilt about possibly passing HIV to the infant.*
- *Facing stigma for having HIV and becoming pregnant — and for being pregnant at a young age (especially if unmarried).*
- *Difficulty foreseeing the future adhering to lifelong HIV care while also caring for a child.*
- *Lack of emotional and financial support from family and/or the child's father.*
- *Financial instability and the possibility of dropping out of school.*
- *Inadvertent disclosure of HIV-status to others.*
- *Lack of access to youth-friendly PMTCT information and services.*

## 6.4 Sexually Transmitted Infections

Adolescents who are sexually active may not practice safer sex and as such are at increased risk of contracting sexually transmitted infections (STIs). You should assume that all adolescents clients are sexually active or will be sexually active soon.

At every visit, ask adolescent clients about STI symptoms.

For females adolescents ask about:

- *Vaginal discharge that is not normal (color, amount, smell)?*
- *Pain during urination (pee)?*
- *Sores or bumps in or around the genitals?*
- *Pain in the lower abdomen?*

For males adolescents ask about:

- *Discharge from the penis (urethral discharge)?*
- *Pain during urination?*
- *Sores or bumps around the genital area or anus?*

Note:

- *Conduct a thorough physical examination if the adolescent has any of the above symptoms.*
- *Ensure that there is privacy during all physical examinations.*
- *Offer to have the exam performed by a health care professional of the same sex if possible or have someone of the same sex (chaperon) in the room during examination*

- Give feedback in a non-judgmental manner. For example, "I see you have a small sore here, does it hurt?"

### ***Diagnosis and treatment of STIs***

You should use information from the physical examination in combination with the client's history to make a syndromic diagnosis and manage the client as per the National STI treatment guidelines.

Treat clients diagnosed with an STI syndrome for all of the possible STIs that could cause that syndrome. In addition:

- *Counsel adolescent clients to avoid sex while being treated for STIs until they are completely cured.*
- *Counsel adolescent clients diagnosed with STIs to inform their sexual partner(s) to seek medical care so that they can be evaluated and treated for STIs as well.*
- *Conduct risk reduction counseling to help adolescent clients avoid STIs in the future including counseling on safer sex and consistent condom use with every sexual encounter.*
- *Counsel the adolescent to complete their medications even if they may feel better.*

## **6.5 Cervical Cancer Screening**

Cervical cancer is rare before the age of thirty. Women between 25-49 years are the primary target for screening according to the National guidelines for prevention and management of cervical cancer. Women below the age of 25 should only be screened if they are at high risk of the disease (early sexual exposure, multiple sexual partners, previous abnormal screening or CIN or are HIV positive).

All adolescent girls at high risk of cervical cancer should be screened regularly as per the national guidelines.

Common cervical cancer screening methods include:

- *VIA/VILI*
- *Pap smear*
- *HPV testing*

### ***Vaccines***

Where available, offer Human papilloma virus (HPV) vaccine against cervical cancer (Gardasil or cervarix) and hepatitis B vaccines.



## 6.6 Sexual Violence

Considerations for the medical management of survivors of violence

- It is critical that health care providers have a high index of suspicion for any form of violence amongst adolescents.
- Note that most survivors of sexual violence do not disclose their experiences to service providers, families or friends.
- Survivors of sexual violence make frequent visits to health care services because they are experiencing the physical and psychological effects of sexual violence, which can manifest as headaches, gastrointestinal distress and/or the physical effects of the violence such as Pelvic Inflammatory Disease (PID) and Sexually Transmitted Infections (STI's) or Human Immunodeficiency Virus (HIV).
- Health care visits are the gateway to care for many survivors of sexual violence and providers are central in improving the outcomes of survivors of violence if they screen, educate and refer their patients appropriately.
- When you confirm that your patient has undergone any form of sexual violence ensure to urgently provide comprehensive services for management of sexual violence as per the national guideline

The essential components of medical care after a rape include:

- Management of any life threatening injuries and extreme distress. This should take precedence over all other aspects of post-rape care.
- History and clinical examination
- Management of physical injuries
- HIV testing and provision of PEP Survivors who are found to be HIV negative( within 72 hours of incident) and effective linkage to care and treatment of those who are positive
- Collection of forensic evidence and presentation to court
- Empirical STI prophylaxis to ALL survivors
- Provision of ECP to eligible clients (EC should be given within 120 hours/ 5 days of sexual violence; ideally as early as possible to maximize effectiveness)
- Trauma counseling and mental health assessment
- Referrals to/from police and support services- Survivors of sexual violence should be encouraged to report to the police immediately after medical treatment. It is however an individual's choice and he/she should not be forced.

*NB: Informed written consent must be obtained from the survivor/guardian before beginning of the consultation.*

### ***PEP management for SV***

All HIV exposures through sexual violence should be treated as per the Kenya ART guidelines

## **6.7 Voluntary Male Medical Circumcision (VMMC)**

For HIV-negative male adolescents provide or refer for voluntary male medical circumcision services to decrease the likelihood of HIV acquisition. Male circumcision is a proven intervention that offers partial protection against sexually acquired HIV in men. VMMC should always be considered as part of a comprehensive HIV prevention package which includes:

- *HIV testing and counseling*
- *Provision and promotion of correct and consistent use of female or male condoms*
- *Active exclusion of symptomatic STIs and syndromic treatment as indicated*
- *Counseling on risk reduction and safer sex*



# Section 7

## PSYCHOSOCIAL SUPPORT FOR ADOLESCENTS LIVING WITH HIV

As a health care provider, you should understand that psychosocial support is critical to the care of adolescents living with HIV. According to WHO psychosocial support addresses the ongoing emotional, social, and spiritual concerns and needs of adolescents living with HIV and their caregivers. The ultimate objective of psychosocial care is to prolong survival of patients, assist them to attain quality of life, and enable them to reintegrate back to society.

### 7.1 Importance of Psychosocial Support

HIV is often associated with a series of family adversities for which emotional and material support are needed to achieve good health outcomes for adolescents. ALHIV are less likely to develop serious mental health problems when offered psychosocial support.

Psychosocial support:

- i. Empowers adolescents helping them gain confidence in themselves and increases understanding and acceptance of HIV comprehensive care and support services
- ii. Empowers caregivers to support adolescents in dealing with various health related and social issues
- iii. Enhances adherence to HIV care and treatment
- iv. Promotes positive self-image and self-esteem as all adolescents need to feel normal and fit in with peers
- v. Assists adolescents make informed decisions, cope better with illness and deal more effectively with stigma & discrimination
- vi. Improves quality of lives and may prevent further transmission of HIV infection

#### ***Challenges facing adolescents***

Its important to understand that adolescents may have the following challenges:

- *Delayed disclosure- which may be due to fear, not knowing status, stigma etc*
- *Denial of the disease*

- *Poor adherence to care and treatment*
- *Lack correct information on sexual and reproduction health*
- *Risky sexual behavior e.g. having multiple sexual partners, inconsistent condom use which may lead to unplanned pregnancies and Sexually transmitted infections (STIs)*
- *Peer pressure*
- *Inadequate support systems*
- *School related issues*
- *Alcohol and substance abuse*
- *Physical, emotional and sexual abuse*
- *Preoccupation with body image, delayed puberty leading to low self-esteem.*

## 7.2 Psychosocial Assessment

When dealing with an adolescent, you will need to conduct a psychosocial assessment to help create a care and treatment plan.

A psychosocial assessment is an evaluation of an adolescents mental, social and emotional health. It takes into account not only the physical health of the adolescent, but also the adolescents perception of self and his or her ability to function in the community.

In the assessment, you may need to ask about:

**Table 13: Psychosocial assessment**

Assessment	Concerns
1. The adolescent health	Optimal or suboptimal physical and psychological health
2. Family status	Primary caregiver, parents status
3. Living situation	Where do they live, With whom
4. School performance	Which school, grades
5. Knowledge on HIV	Awareness of status, ART
6. Adherence	Challenges
7. Disclosure status	To whom, when
8. Physical and sexual abuse	Evidence
9. Drug and substance abuse	Evidence
10. Sexuality concerns	Developmental concerns
11. Support systems	Family, school, community

Under psychosocial support we will discuss the following sub topics

- *Disclosure*
- *Loss Grief and bereavement*
- *Stigma and discrimination*
- *Alcohol and substance abuse*
- *Life Skills*
- *Peer pressure*
- *Self esteem*
- *Vulnerable adolescents*
- *Positive Living*

### **7.2.1 Disclosure**

To disclose is to reveal, to make known, to make public, or to share personal information with someone. HIV Disclosure occurs when the adolescent is told his/her HIV status or the adolescent tells a family member or a buddy/friend about their HIV-status. Disclosure is not a onetime event and may require several conversations overtime.

#### ***Disclosure process***

It is important as a HCP to ask the parent/ caregiver questions about their ideas, feelings, beliefs and knowledge regarding disclosure and their disease. Find out what they think about the importance of disclosure, the appropriateness of the age at disclosure, who should disclose and how the process would be best supported. Similar discussion also should take place with an adolescent for them to disclose their status to others.

- i) Partial disclosure: Generally this occurs when the HCP or the caregiver tells the young person that they have a chronic illness and that they have to take medicine, without naming disease or using the actual words HIV or AIDS.

Advise the caregivers that partial disclosure should preferably start at age of 6 years

- ii) Full disclosure

*This takes place when a child /adolescent is specifically told that he/she is HIV infected and may be given more HIV-related details, e.g. how it's transmitted and how the child might have contracted it.*

*Full disclosure should occur when the child is developmentally ready, but ideally before adolescence typically the age 10 years. Full disclosure is easier for the adolescent who has been partially disclosed to and understands some basics about his/her health, care and medicines.*

- iii) Accidental disclosure: this is when someone talks about HIV status without knowing that the child is not aware of their own status. This could be in the community or in the facility. The HCP should find out how, where and when the child/adolescent was accidentally disclosed to and provide facts to correct any misunderstanding that the young person may have.

Encourage and support HIV infected adolescents to disclose their status to their sexual partner, parents, friends or a close relative.

### ***Advantages of disclosure***

- It helps improve the self-care and self-esteem.
- Helps to avoid anxiety of accidental disclosure
- Enables adolescent to access psychosocial support from peers or family
- Easier access to health care hence this may help in access knowledge for prevention measures.
- Enhances good adherence to care and medications
- Assists most children to cope with the diagnosis, open up, minimize anxiety, reduce self-stigma and depression
- Enables one to discuss safer sex and family planning choices with one's partner(s)
- Empowers one to refer a partner for HIV counseling and testing and to care and treatment if needed.
- Gives one freedom to ask a friend or a relative to be a treatment buddy
- Enables one to access peer support groups and community organizations
- Empowers one to serve as a role model for other people on disclosure

### ***Disadvantages of disclosure***

- Assumptions made about sexuality, promiscuity or lifestyle choices
- Children may blame parents for infidelity and knowingly infecting them
- Discrimination by family, school and community
- Discrimination at work including possible loss of a job

- Distancing, fear, rejection or abandonment by partner, family or friends/ classmates
- Blame by partner/ family for “bringing HIV in to the household”
- Physical, emotional and sexual abuse
- Self-stigma
- May lead to anxiety, self-blame depression and suicidal ideations
- Poor adherence in some instances (due to loss of hope)
- Loss of economic/subsistence support from family members

### ***Role of a HCP***

- Understand that most adolescents prefer disclosure by a family member if perinatally infected while non-perinatally infected adolescents can choose who to disclose to
- Empower care givers to develop a disclosure plan considering the needs, feelings and beliefs of the adolescents, care givers and the whole family
- Explore with the caregiver what they will say, how and where they will disclose
- Anticipate the young person’s fears and concerns
- Ensure that confidentiality is maintained at all times
- Empower the adolescent to disclose to caregivers, sexual partners and schools teachers or matrons when necessary
- Be present if requested as the care giver talks and discloses to the child/ adolescent

### ***7.2.2 Adherence***

Adherence refers to how faithfully a person sticks to and participates in his or her HIV prevention, care and treatment plan. It includes adherence to both medications and care. This means taking the correct dosage of drugs at correct times while observing any dietary restrictions. As a health care provider you should ensure that:

- The adolescents enter and continue on a care and treatment plan
- Take medicines to prevent and treat opportunistic infections
- Participate in ongoing education and counselling
- Attend appointments and tests (like regular CD<sub>4</sub> tests) as scheduled
- Pick up medications when scheduled and before running out
- Modify lifestyle, nutrition and avoid risky behaviours



- Make a commitment to prevent new HIV infections
- Explore factors affecting adherence and support appropriately

### 7.2.3 Loss, Grief and Bereavement

Grief is defined as a biological, psychological, and social reaction to loss. It is manifested as intense sorrow due to either death of a loved one, separation, divorce, or natural disaster.

Mourning is an external expression of loss. Bereavement is defined as the state of having lost someone special such as a family member or a friend. Many ALHIV have lost one or more family members or caregivers, resulting in potential depression and relationship problems with peers, Post Traumatic Stress Disorder (PTSD), and behavioral problems (Cluver et al. 2009).

For the ALHIV, HIV brings grief around a variety of losses like health, relationships, sex, future, certainty, life, jobs, family, self-image, independence etc.

Often, the grief experienced by ALHIV is multilayered and is referred to as complicated grief. This means that the adolescent might take a longer time to work through his or her issues related to grief and might even be vulnerable to other mental health conditions.

As a health care Provider:

- *Understand that children and adolescents grieve differently at different ages. The kind of support provided should be age-based*
- *Acknowledge it and monitor it, taking note of the adolescent's emotional state*
- *Encourage the bereaved to express feelings of loss without being judgmental*
- *Work with the adolescent and his or her family/caregiver to build upon existing strengths during the grieving process*
- *In the event of impending death, work with an ill caregiver to offer love and care to the adolescent*
- *Routinely monitor for grief symptoms, which may include sadness, poor appetite, weight loss, difficulty sleeping, crying, guilt, rage, numbness and disorganized thoughts*
- *Provide an open environment where the adolescent can discuss his or her experiences in an unrushed manner and be sensitive to the adolescent's needs as this will help him or her to express the feelings of grief*
- *Allow the adolescent to grieve at his or her own pace, encouraging routine behavior such as school attendance or work*
- *Encourage the adolescent to be proactive in finding help to address his or her loss*

- Refer ALHIV who display grief symptoms for counseling as well as to peer support groups to reinforce their resilience and to provide support throughout the grieving process

#### 7.2.4 Stigma and Discrimination

Stigma is defined as negative attitude toward people that we think are not normal or right while discrimination is defined as treating someone unfairly or worse than others because they are different in some way (for example, because a person has HIV). Discrimination is the action that often follows stigma. Stigma and discrimination prevent good access to HIV prevention, care, and treatment services for many people. They can also prevent ALHIV and their families from living healthy and productive lives.

Strategies for dealing with different forms of stigma at a clinic or hospital:

- *Make sure young people and ALHIV, such as Peer Educators, are part of the care team*
- *Make sure young people help evaluate the clinical services that are being offered and that feedback is formally reviewed by managers and health care workers*
- *Link the clinic with youth groups and ALHIV support groups in the area*
- *ALHIV should talk openly about their attitudes, feelings, fears, and behaviors with other health care workers and support each other to address fears*
- *Report any discrimination at the clinic toward ALHIV and families to a manager*
- *Empower ALHIV to deal with stigma by standing up for themselves and educating people on HIV, ignoring people who stigmatize them, joining support groups and taking and adhering to medicines which restores their health and allows the community to see HIV as a chronic disease. People who openly take ART can reduce stigma around the disease but this should not be used to demand that young people take medication openly. Stigma has to be addressed gradually and in a supportive manner to allow the adolescent to be comfortable with him/her self before disclosing to others.*

#### 7.2.5 Alcohol and Substance Use

ALHIV may also use alcohol or other substances as a coping mechanism to deal with feelings of sadness or hopelessness around their diagnosis, especially after disclosure, or with parental loss. It is considered abuse when there is excessive use of either alcohol or substances that alter the mind. For HIV positive

adolescents on ARVs, there are no safe drinking levels.

It is important to always ask the adolescents about alcohol/ drug use and refer appropriately.

Commonly abused drugs/substance

- Medical drugs e.g. Tranquilizer, ketamine, amphetamines, barbiturates, diazepam, artane
- Alcohol – chang'aa, busaa, beer, wine
- Nicotine -Tobacco
- Inhalants- Glue, petrol
- Miraa (khat)
- Cannabis (bhang)
- Opiates e.g. Heroin (brown sugar), morphine, cocaine
- Caffeine
- Hallucinogens- e.g. LSD

As a HCP:

- *Watch for signs of alcohol misuse and substance abuse among adolescent and provide education on risk reduction and referrals for counseling and treatment*
- *Counsel on effects of alcohol and substance use in increasing risky sexual practices such as not using condoms, which can increase possible HIV or other STI transmission*
- *Alcohol or substance use may lead to skipping antiretroviral medication. Inform the adolescent about the risks of non-adherence and what consistent non-adherence could mean for his or her long-term health outcomes*
- *May cause harmful reactions when consumed with ARV medications- EFZ,3TC,d4T, ABC, ZDV/AZT*
- *It may cause them to neglect their overall health and self-care*
- *Refer adolescents to relevant support groups and other facility departments*
- *As with sexual activity, adolescents may not feel comfortable discussing alcohol and other substance use with parents or other caregivers present, so you may request to speak with the adolescent in private*

### 7.2.6 Life Skills

Life skills can be defined as the abilities a person possesses that enable him or her to deal effectively with the demands and challenges of everyday life and

to maintain a mental wellbeing that is demonstrated in adaptive and positive behaviour while interacting with others, his/her culture and environment (WHO/MNH/PSF/93.7 A. Rev 2).

Life skills enable individuals to translate knowledge, attitudes and values into actual abilities i.e. what to do and how to do it. Life skills help young people identify goals, take greater responsibility for their own lives and build a good and healthy future for themselves.

**Table 14: Categories of Life Skills**

Skill of knowing and living with oneself	Skills of knowing and living with others	Skills of making effective decisions
<ul style="list-style-type: none"> <li>• self-awareness</li> <li>• self esteem</li> <li>• assertiveness</li> <li>• coping with emotions</li> <li>• coping with stress</li> </ul>	<ul style="list-style-type: none"> <li>• interpersonal relationships</li> <li>• friendship formation</li> <li>• empathy</li> <li>• peer pressure resistance</li> <li>• negotiation</li> <li>• non-violent conflict resolution</li> <li>• effective communication</li> </ul>	<ul style="list-style-type: none"> <li>• critical thinking</li> <li>• creative thinking</li> <li>• decision making</li> <li>• problem solving</li> </ul>

### ***Role of the healthcare provider***

- Enhance the adolescents self-esteem and assertiveness in their relationships with peers and adults
- Empower the adolescent develop attitudes, values and skills that promote positive, responsible and healthy life styles
- Encourage the adolescent to recognize themselves as responsible members of the society, with a contribution to their development and well-being

Therefore as a Healthcare worker you should work with ALHIV to strengthen their

- *Communication and negotiation skills*
- *Decision making skills*
- *Dealing with peer pressure*

### ***7.2.7 Peer Pressure***

Peer pressure is social pressure by members of ones peer group or age group to take a certain action, adopt certain values, or otherwise conform in order to be accepted there is positive and negative peer pressure.

Peer pressure is POSITIVE when it encourages one to:

- *Adhere to care and treatment plan hence act as buddies*
- *Strive for better grades in school*
- *Eat well, exercise and have enough sleep or rest*
- *Join after-school and community programs such as being part of a psychosocial support group*
- *Develop positive self-esteem, positive attitude, healthy values and habits*
- *Respect others*
- *Try new positive activities in a safe environment –e.g. a sport or drama club*
- *Work hard at something*
- *Teamwork*
- *Say no to dangerous activities such as taking drugs or alcohol, having sex*
- *Develop social skills necessary for adulthood*

Peer Pressure is NEGATIVE when:

- *Makes one miss taking drugs*
- *Do not attend clinic regularly*
- *One is lured into skipping classes & missing school*
- *Experimenting with drugs and alcohol*
- *Becoming sexually active*
- *Develop bad habits and attitudes such as drinking, smoking*
- *Bully or alienate others*
- *It leads to anxiety and depression which may also lead to suicide*

Negative peer pressure can hinder an adolescent to adhere to care and treatment

Therefore as a health care provider explain what peer pressure is and how to address it

- Help adolescents identify factors that would lead them to fall into negative peer pressure
- Appropriately refer an adolescent who is faced with negative peer pressure
- Encourage open communication for those affected
- Empower adolescents to learn to say no to things that do not add value to them

As a health care provider it is important to support positive peer pressure and guide adolescents on its consequences.

### **7.2.8 Self Esteem**

Self-esteem refers to how much one values himself or herself. It is how one sees and feels about themselves and their achievements.

#### ***Why positive self-esteem is important?***

Good/positive self-esteem is important because

1. It helps ALHIV to hold their head high and feel proud of themselves
2. It gives one the courage to try new things
3. Gives one the power to believe in themselves
4. It allows adolescents respect themselves even when they make mistakes.
5. It helps young people make appropriate choices and decisions in life

#### ***Low self esteem***

- Refers to when one does not think highly of themselves, don't feel good about themselves or think one is not important – may be because of what people have said
- Low self-esteem can destroy one's confidence
- If not handled well low self-esteem can affect one till adulthood

#### ***What Influences a Persons Self-Esteem?***

- Puberty and development. Some teens struggle with their self-esteem when they begin puberty because the body changes they undergo. These changes, combined with a natural desire to feel accepted may make the adolescents compare themselves with others.
- Eating disorders
- Media images and other outside influences. Adolescents may compare themselves with the people around them or with actors and celebs they see on TV, in movies, or in magazines.
- Families - children who are constantly criticized by their parents may develop low self-esteem
- Schools – teasing from classmates and peers

As a health care provider encourage adolescents to:

- ▶ Give themselves three compliments every day
- ▶ Appreciate the fact that their body is their own no matter what shape, size, or color
- ▶ Appreciate themselves and identify which aspects they can realistically change and which they can't

- ▶ *Remain focused in their life*
- ▶ *Read motivational books*

### **7.2.9 Vulnerable Adolescents**

A vulnerable adolescent is one who is in need of protection. Many ALHIV may have lost one or both parents to AIDS, or have a caregiver who is also living with HIV. Losing a parent to AIDS increases the chance a child will experience stigma, rejection, and a lack of love and care. Being an AIDS orphan or having a caregiver living with HIV is also associated with an increased likelihood of being emotionally or physically abused. Children made vulnerable by HIV are at greater risk of being neglected and exploited through forced labor or trafficking. Adolescents living with HIV are more likely to experience gender based violence (GBV) than their uninfected peers due to their vulnerability. For adolescents, GBV may include sexual/physical/emotional/ abuse, trafficking, neglect, and domestic violence

The other vulnerable adolescents that will require more care and support are teenage parents, adolescents with all forms of disability, child sex workers, and child laborers.

As a health care provider, look for:

- *Signs of abuse, including physical marks (e.g., bruises, cuts, and burns)*
- *Symptoms of STIs or early pregnancy in young adolescents*
- *Chronic yet unexplained health problems*
- *Changes in behavior or mood, and academic problems.*
- *Where necessary, talk to the adolescent about what is going on in his or her home, community, and school .You may ask to speak to the adolescent privately, as the abuse or mistreatment could be from the family/caregiver.*
- *Reinforce the confidential nature of your discussion as adolescents may be reluctant to betray family/caregivers or authority figures, or their spouses*
- *Inform the adolescent that you may bring in additional providers, such as those involved with law enforcement, if necessary.*
- *Adolescents may be involved in sex for money in order to meet their basic needs such as food, shelter, clothes and school fees. Review the risks associated with transactional sex, and try to work with the adolescent and the family/caregiver to identify resources to help them their meet needs.*
- *Coordinate with social workers and law enforcement agents to ensure the adolescent is protected.*

### **7.2.10 Positive Living**

Positive living is a way of life adopted by persons living with HIV (PLHIV) aimed at improving their quality of life and that of those around them. The appropriate recipe for positive living includes correct knowledge and practices in HIV prevention, care and treatment, determination to live, deliberate actions for healthy mind, body and soul all leading to a healthy life. The components of positive living therefore include;

- *Prompt medical care*
- *Proper nutrition and nourishment*
- *Relaxation, appropriate physical exercises and avoiding idleness*
- *Avoiding alcohol and cigarette smoking*
- *Personal, general and environmental hygiene*
- *Avoiding unprotected sex*
- *Access to psychological care*
- *Access to spiritual counseling*
- *Developing a positive attitude towards life, the illness and those around*





# Section 8

## COMMUNITY LEVEL CARE AND SUPPORT SYSTEMS

It's important to link health facility services and services offered at the community level to enhance the care of adolescents. To facilitate this linkage the health worker/provider should understand the community services that are available within the catchment area. As a health care provider, you may not know all the organizations providing adolescent care services at the community level. However, you can achieve this by organizing meetings for organizations in your community to meet on a routine basis to identify, coordinate and enhance the available package of services for adolescents. This can enhance strong facility/community linkages and a coordinated referral system.

Examples of services and groups that may be available at the community level include:

### 8.1 Community Services

- Food support
- Home and community based care
- Income generating activities (IGA)
- Transportation to clinic appointments
- Adherence support
- Information, education and communication
- Legal support services
- Spiritual support

## 8.2 Community Groups

- Family and care giver support group
- Peer support groups for the Adolescents living with HIV
- Vocational support groups
- Adherence educational support group
- Agriculture youth clubs
- Religious youth group
- Post test clubs

Within these groups members are able to:

- *Share experiences to ease fears, anxiety and doubts*
- *Learn more about body changes*
- *Share experiences in coping with a HIV positive status*
- *Acquire life skills and abilities or psychological competencies that help them deal or cope effectively with the challenges of being an HIV infected adolescent*
- *Identify personal goals*
- *Go through the process of Self-awareness, which is the ability to understand who they are as well as their strengths and weakness. This enables the adolescent to work on his/her weakness and build on his/her strengths*
- *Appreciate the role of Critical thinking in their lives. This enables adolescents to analyze a situation, make decisions and give their own opinion even if it differs from others*
- *Build their self-esteem. This will enable adolescents to feel confident about themselves and their decisions*

As a health care provider you need to know the general characteristics of the community support structures that you will link the adolescents to, so that you avoid rejection or conflict of interest

## 8.3 Type of Support Groups

### ***Family and Care Giver support***

As with HIV care and treatment for clients of any age, it is important to provide family-focused care to adolescents to address issues of self acceptance,

self care, and holistic family support. Ask the adolescents about their living condition at home and involvement of the family in their care and treatment. When appropriate, ask the adolescent about their sexual partners and encourage their partners to come to the clinic for education and testing.

### ***Schools/institutions support***

Adolescents living with HIV (ALHIV) need to be enrolled and retained in school just like other HIV negative adolescents, however some ALHIV may have learning disabilities, and their schooling can be interrupted for various reasons. Enquire about schooling at each visit ask:

- a. If the adolescent is in school and the level of education.*
- b. If they have ever missed school due to the illness and what was the illness.*
- c. If Anyone at school knows the adolescent's HIV status and whether they have a treatment buddy at school*
- d. How ARVS/CTX are stored and taken while at school*
- e. If the adolescent has friends at school*
- f. If they experience any form of stigma or discrimination e.g is there anyone at school that bullies you, that makes fun of you, hits or threatens you?*

Health facilities should work with neighboring schools and institutions to;

- *Promote HIV information awareness*
- *Establish a supportive environment for ALHIV in schools*
- *Elimination of stigma in schools*
- *Ensure comprehensive sexuality education (FP methods and condoms) and facilitating access to services if needed.*
- *Provide teacher sensitization and training.*
- *Provide outreach programs to schools and institutions*
- *Support ALHIV in adherence medication while in school especially boarding schools*
- *Encouraging HTC in schools and colleges*
- *Support peer groups clubs in schools*

### ***Youth Groups/Clubs/Adolescent village groups***

Very often people living with HIV feel isolated and alone. Support groups can help;

- *Increase the uptake of healthcare services such as HIV testing, PMTCT, HIV care and treatment.*
- *Understand clinical services and importance of adhere to care and treatment.*
- *Environment for sharing experiences*

- Link its members to healthcare services and community-based services. For example, healthcare workers or leaders of community-based organizations can talk about the range of services their organizations offer during support group meetings.

### ***Adolescent support groups:***

ALHIV may want to form their own support groups to discuss some of the special challenges. During the support group meetings adolescents may be involved in activities such as; sports, crafts, drama as well as discussion on different health topics. These adolescent activities are best led by an adolescent peer educator. Peer educators play an important role in initiating; organizing, facilitating and mentoring support groups.

Adolescent peer educator should be;

- *Older adolescent*
- *Living positively with HIV*
- *Adherent to care and medications*
- *Open-minded and non-judgmental attitude (respectful and tolerant of different perspectives, cultural backgrounds, and lifestyles)*
- *Good interpersonal and oral communication skills*
- *Commitment to working with other ALHIV*
- *Availability to work at clinic (which does not conflict with school or work attendance)*
- *Represent age, ethnicity, socio-economic status, gender, language preference/abilities, and other characteristics of adolescent clients at the clinic*

### ***Positive (Young) Mothers support groups***

These are support groups for adolescents who are also mothers and are living

with HIV. These support groups provide psychosocial and emotional support and help the young mothers understand and access key HIV and PMTCT services. These groups also address concerns specific to HIV positive mothers such as safe infant feeding, care of HIV-exposed babies, and the importance of adherence to PMTCT and ART services.

## 8.4 Support Groups Topics

- Positive living
- Disclosure
- Coping with school
- Relationships and sexuality
- Dealing with stigma
- Adherence
- Preventing opportunistic infections
- Nutrition
- Domestic violence
- Family planning and dual protection
- Preventing new HIV infections
- Dealing with death and dying of a friend or family member



# Section 9

## YOUTH FRIENDLY SERVICES

Even when they know of their HIV infection, many adolescents do not receive the care they need. Many HIV-positive adolescents experience denial about their HIV disease, sometimes as a coping mechanism. Overwhelmed with the demands of school, work, chaotic home lives, depression, substance use, or homelessness, young people may decide that they cannot focus on their HIV disease until some point in the future (e.g., when school is over, or after they move away from home, or after they find a home). Adolescents typically are inexperienced and unfamiliar with the medical system, and often have difficulty navigating the complex systems of care associated with HIV. In addition to a lack of skills, a significant fear and a mistrust of the health system prevent many adolescents from seeking care. In some places, adolescents may be unable by law to consent to medical services on their own.

To provide care to adolescents with HIV, the barriers that separate them from medical services must be overcome. Individual clinics and providers can make a difference by offering care that is as youth-sensitive as possible.

Youth Friendly Services (YFS) are those that provide an open and safe environment for ALHIV open up to the health care provider and discuss freely the issues they are facing in their life without fear of being judged. A youth friendly environment allows the adolescent to talk about sex and sexuality, sexual feelings and desire for a sexual partner or children. This allows the adolescents to disclose to you if they are sexually active or intending to have sex. Sexually active adolescents are hence able to access condoms and contraceptives while



pregnant adolescents are able to access PMTCT services.

Every health facility should endeavor to provide youth friendly services; this may be a separate day, a room or a separate time when adolescents are seen at the health facility. Other than provision of sexual reproductive health services a youth friendly environment allows for the provision of alcohol and drug abuse services, disclosure and psychosocial support for the adolescents.

The YFC should have the following characteristics:

### ***Health Facility***

- Welcoming attractive, clean, spacious, well lit and allows for privacy.
- Convenient hours ( afternoons, Saturdays) and location
- Short waiting time with or without an appointment and swift referrals
- Comfortable surroundings and friendly to both genders
- Well equipped with information and education materials as well as provide activities that keep the youth occupied e.g. posters, leaflets, booklets, magazines, brochures, flyers, pool table, TV/ video games, movies, music etc
- Adolescents should be well informed of the range of services available and how to obtain them.
- Adolescents are actively involved in the assessment and provision of health services
- Necessary equipment, supplies and basic services are available to deliver the required health services for the adolescents

### ***Health care providers***

- Health care providers who are especially trained/oriented on adolescent sexual/reproductive health issues and communication.
- Health care provider should be friendly, respectful, non-judgmental and ensure complete confidentiality and privacy
- Adequate time allocated for client and provider interaction

### ***Program Design***

- Youth involvement in program design and monitoring
- Drop-in clients welcome
- Short waiting times

- Appointment systems in place and tracking systems for clients who miss appointments
- Affordable or no fees for services
- Integrated services available — “one-stop shop”
- Provide comprehensive SRH information in a youth-friendly language.
- Allow for regular activities like outings and retreats
- Provide outreach services e.g. school health program
- Non-medical staff oriented on youth friendly services
- Youth support groups established
- Peer educators available
- Partner with and refer ALHIV to community based support services which help with adherence, retention and overall wellbeing.
- Provide support around disclosure of HIV status to sexual partners. Recognize sexual and intimate partner violence among ALHIV, including information about appropriate referral pathways for support.



# Section 10

## TRANSITION OF ALHIV FROM PEDIATRIC TO ADULT SERVICES

Transition is the process of supporting ALHIV to graduate into adult services when she/he ages out of pediatric clinic. The period of transition may be a vulnerable period for the adolescent because he or she may not have a lot of experience or practice in managing his or her own health care. It is important to work with adolescent clients to encourage them to routinely attend their appointments, adhere to their medications, recognize and utilize additional sources of support such as other community-based services, and abstain from drugs and alcohol that may negatively impact their health.

Transition to self-care should be individualized and client-centered based on the physical development, emotional maturity, and health status of the client. The goal of transition is to ensure that health care providers facilitate the transition process through provision of uninterrupted, coordinated, age and developmental appropriate and comprehensive care before, during and after the transition.

### ***Process of transitioning an adolescent to adult care***

Transition is a process, not an outcome. It begins early in adolescence. It should be an age and developmental centered approach. It is not a onetime event. ALHIV may face challenges in their transition to adult care and in learning to independently manage their own care. The transition process should therefore enhance the adolescents autonomy, cultivate a sense of personal responsibility, facilitate self-reliance and self-efficiency and boost the adolescents capacity for self-care and self-advocacy.

The following should be taken into account during the transition process;

- *Disclosure of HIV status is a prerequisite for transition; Support the family/ caregiver to disclose if the adolescent does not yet know his or her status*
- *Develop a transition plan; Multidisciplinary team should develop a facility transition plan with inputs from the adolescent and their caregivers; plan should be reviewed on a regular basis*
- *Review the clients medical history, encourage them to raise their fears and concerns on their care and medicines and discuss any future changes*
- *Ensure adolescents understands medication use and importance of adherence*
- *Promote linkages to peer support groups*
- *Organize health talks for transitioning adolescent clients; consider having health talks led by an older adolescent who has successfully transitioned to adult care.*
- *Encourage older adolescents to take responsibility of their care and clinic appointments (for example having a clinic appointment and medication diary)*
- *Consider transitioning adolescents to adult care in cohorts or groups, if possible, so that the adolescents can support one another.*
- *Always assess patient readiness before transitioning.*
- *Involve parents and caregivers during the transition process*

*Note: To ensure that the transition process is smooth, it is essential to screen for and treat mental health issues.*

### **Guide for age specific transition plan**

The following is a guide for developing an age specific transition plan;

#### **Early adolescence (10-12 years)**

- Encourage caregiver to fully disclose to the child
- Increase one on one meetings and counseling session with the adolescents
- Begin to explain medication use and adherence
- Link adolescents to support groups
- Introduce transition to adolescent and caregiver

#### **Mid adolescence (13-16 years)**

- Continue counseling on transition to the adolescent and caregiver
- Ensure full disclosure has been done
- Knows importance of adherence and positive living
- Encourage appointment keeping and adherence to medication
- Encourage self-expression of fears and concerns
- Member of a support group

## **Late adolescence (17-19 years)**

- Arrive to appointments on time
- Know when to seek medical care for symptoms or emergencies
- Knows how to express their fears and concerns
- Knows their HIV status, knowledge on HIV and mode of transmission
- Can give medical history independently
- Can independently take medication
- Able to understand the medication they are taking and its importance
- Attendance of peer/other support groups
- Linked to home and community-based support services

## ***Transferring an adolescent to adult clinic***

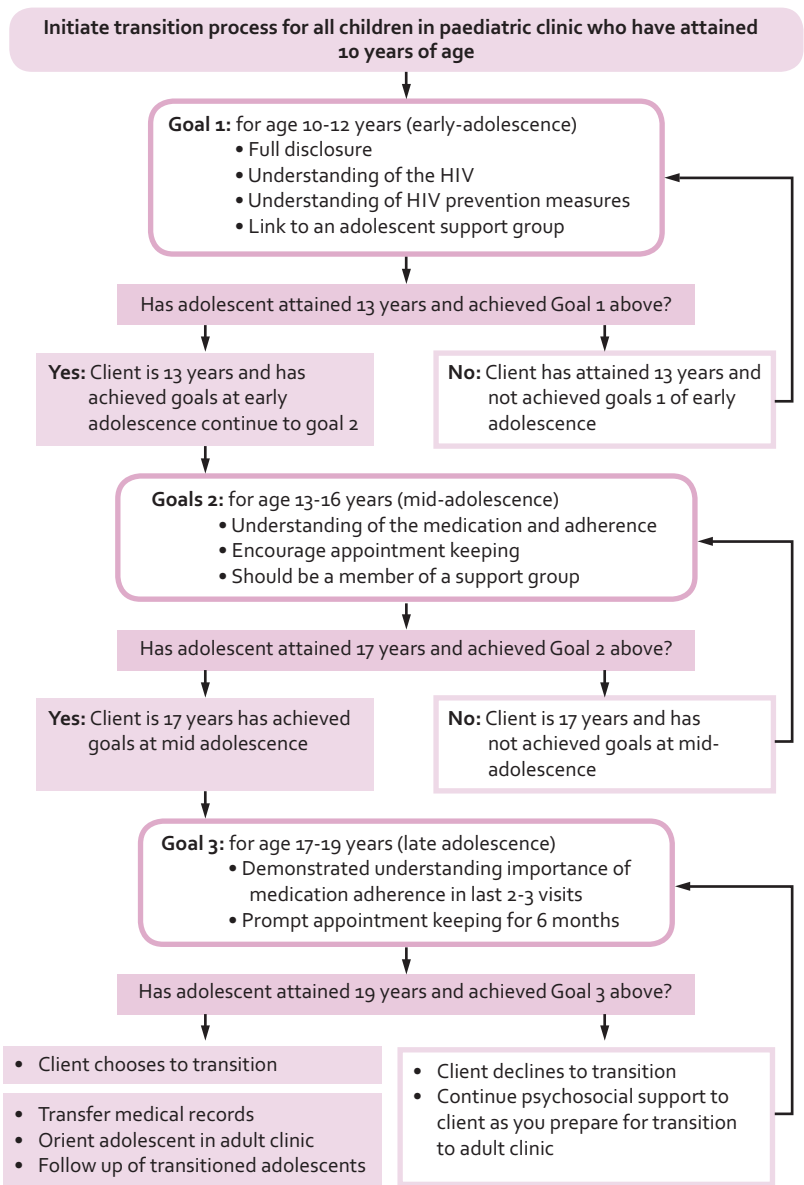
In order to transfer the adolescent to adult clinic the following should be taken into account;

- Willingness to transition to adult care
- Age : should be at least 19 years of age
- Should have completed basic education (primary /secondary school)
- Pregnant adolescents and married adolescents should be prioritized
- Follow up plan for transitioned adolescents
- Transitioned adolescents should be in a support group
- Schedule a visit to the adult clinic, so adolescents can learn more about the services and the healthcare providers before the transfer takes placeInitiate transition process for all children in paediatric clinic who have attained
- Meet with an adolescent client who has transitioned to adult care
- Attend a support group session with other transitioning adolescents

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# Annex 1: Adolescent Transition Algorithm





## Annex 2: Transition Template

	Steps to facilitate transition process	Suggested activities to facilitate the transition process	Comments
1	Introduce the transition	Discuss transition during adolescent support group meetings and group health education sessions	
		Discuss transition during clinical checkups and individual counseling sessions with adolescent clients	
		Discuss transition with caregivers, during group or individual sessions	
2	Encourage increasing responsibility for his or her own health care management	Ensure the adolescent understands his or her own health condition, care plan, and medications	
		Talk about transition and transfer to the adult clinic, discuss expectations, and answer any questions	
		Talk to adolescents about general coping, positive living, and building supportive relationships	
		Give caregivers an opportunity to discuss their feelings about transition and any concerns about having a less active role in the adolescent's care	
3	Assess client's ability to make independent health care decisions, assess readiness for the transition and determine additional support needs	Assess <i>client's</i> understanding of own care and transition process	
		Assess <i>caregiver's</i> understanding of clients care and transition process	
		Encourage the adolescent to make their next appointment and to refill their medications on their own	
		Initiate any needed referrals, including to support groups	
4	Provide continuing guidance during the transition process	Review plans for continued adherence to care	
		Review adherence to medicines and ensure the client has, and knows how to use, and keep track of doses	
		Ensure client knows where to access help/assistance, if he or she has questions about the adult clinic	

5	Implement the transfer to an adult clinic	Transfer medical records to adult clinic	
		Transfer the adolescent to the adult clinic (where applicable)	
		Discuss the adolescent's care with healthcare workers at the adult clinic, (where applicable)	
		Provide orientation to the adolescent in the adult clinic	
		Follow up after the transfer <ul style="list-style-type: none"> <li>• Schedule a follow-up visit with the adolescent,</li> <li>• Encourage Peer Educators to visit the adult clinic and talk with newly transitioned adolescents</li> </ul>	

# Annex 3: PHQ questionnaire

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Over the last two weeks, how often have you been bothered by any of the following problems?  
(use '✓' to indicate your answer)

1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you could be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: for interpretation of TOTAL , please refer to accompanying score card). **TOTAL**

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_  
Somewhat difficult \_\_\_\_\_  
Very difficult \_\_\_\_\_  
Extremely difficult \_\_\_\_\_

## PHQ-9 Patient Depression Questionnaire

### For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

### **Consider Major Depressive Disorder**

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

### **Consider Other Depressive Disorder**

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

### **To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

### **Scoring: add up all checked boxes on PHQ-9**

**For every ✓** Not at all = 0; Several days = 1;  
More than half the days = 2; Nearly every day = 3

### **Interpretation of Total Score**

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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