

FACILITATOR GUIDE

IMAI One-day Orientation on Adolescents Living with HIV



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Facilitator Guide

IMAI One-day Orientation on Adolescents Living with HIV

This course is part of a global commitment and recognition of the importance of addressing HIV and young people. The *Political declaration on HIV/AIDS* adopted at the United Nations General Assembly High-Level Meeting on AIDS (June 2006), states (we):

8. *Express grave concern that half of all new HIV infections occur among children and young people under the age of 25, and that there is a lack of information, skills and knowledge regarding HIV/AIDS among young people;*
23. *Reaffirm also that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the pandemic;*
26. *Commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services.*

www.un.org/ga/aidsmeeting2006/declaration.htm

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Course guidelines

This one-day course has been developed as an additional optional training for the World Health Organization (WHO) Integrated Management of Adolescent and Adult Illness (IMAI) package, focusing on adolescents living with HIV. The target audience for this training are first-level facility health workers who have attended the WHO IMAI-IMIC [Integrated Management of Childhood Illness] Basic HIV Care with ART and Prevention training course and the WHO IMAI Acute Care training course, and are working with adolescent patients.

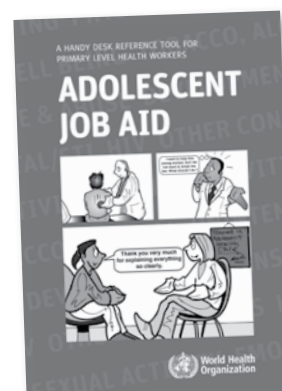
There are two WHO training modules to orient health workers to adolescents and young people living with HIV:

PARTICIPANTS COMPLETE THIS TRAINING AND THEN ATTEND THIS TRAINING THAT FOCUSES ON . . .
WHO IMAI-IMCI Basic HIV Care with ART and Prevention training course and WHO IMAI Acute Care training course	IMAI One-day Orientation on Adolescents Living with HIV	Issues for health workers who provide care to adolescents living with HIV
WHO Orientation Programme on Adolescent Health for Health-care Providers	Module N Young People and HIV	HIV prevention needs of young people in general

Also included, excerpts from the

Adolescent job aid

A desk reference for primary level health workers, which includes 24 algorithms responding to common questions from adolescents and their accompanying adults, including “*Could I have HIV?*”



Course objectives

The objectives of this course are to orient a range of health workers, including medical officers and nurses, to the special characteristics of adolescence and to identify and practice appropriate ways of addressing important issues for adolescents living with HIV.

This course will:

- inform participants of the stages of adolescent development;
- raise participants' awareness of the special needs and challenges facing adolescents living with HIV;
- strengthen participants' skills in providing appropriate prevention, care, treatment and support to adolescents living with HIV.

The day is planned as follows:

8:30–10:30	Sessions 1-3	120 minutes
30 minute break		
11:30–13:00	Sessions 4-6	120 minutes
60 minutes for lunch		
14:00–15:30	Sessions 7-8	90 minutes
30 minute break		
16:00–18:00	Sessions 9-10	120 minutes

A detailed schedule for the day is given at the end of this section of the Guide. Included in Annex 5 of this Guide are three optional sessions (150 minutes) that may be included as part of the training if additional time is available.

READ THE FOLLOWING INFORMATION BEFORE THE COURSE

The course materials include the *Facilitator guide*, *Participant manual* and *IMAI wall chart on the adolescent living with HIV* (hereafter referred to as *Guide*, *Manual* and *IMAI wall chart*, respectively).

Participatory methods used

The training methods used in this course include visualization in participatory programmes (VIPP), brainstorming and buzz groups, group work, role plays, individual exercises, plenary sessions and mini lectures. These methods are described briefly below.

Visualization in participatory programmes

VIPP is a participatory process in which participants are asked to write their ideas and responses to an issue on cards of different sizes and colours. These cards are then displayed to enable participants to see (visualize) the ideas, identify the linkages between them, group similar cards/ideas and develop broad themes. For VIPP to be successful there are some basic rules for card writing.

RULES FOR VIPP CARD WRITING

- 1. Write only one idea per card.**
- 2. Write a maximum of three lines on each card.**
- 3. Use keywords; write legibly.**
- 4. Follow the colour code established by the facilitator for the different categories of ideas.**

These rules are to be reviewed with the participants during Session 1 (Section 1.3.1 of the Manual).

VIPP cards can be used in plenary discussions, small groups or individually for participants to write down and then display their responses to a question. It is important that the question asked is clear and unambiguous. Once the cards have been displayed, the facilitator needs to analyse the cards with the participants and make a quick synthesis of the common themes that they represent. Moving the cards around enables the responses to be organized in a logical manner and shows areas of consensus and disagreement for further discussions.

This methodology allows all participants the opportunity to express themselves, so that even the quieter members of the group are able to participate.

After pinning-up the VIPP cards during an activity, the cards should be stuck with glue onto large sheets of paper to be displayed around the room and referred to by the facilitator during the course. By referring back to the VIPP cards, the participants are reminded of issues that were raised and can better understand the flow of the training and the links between issues.

The VIPP method can also be used to evaluate how participants feel about this course (e.g. at the end of the day, ask all participants to anonymously write one positive and one negative point about the one-day orientation).

If coloured cards are not readily available, as in some countries, use large sheets of plain paper instead and cut them in advance into the different sizes needed for VIPP exercises. Only use black or blue markers to write on the cards as other colours can be hard to read. Other colours can be used to emphasize points.

Participants may be reluctant to apply some of the VIPP writing rules, such as limiting the writing to only three lines per card, or writing in large letters. The facilitator can gently remind them of the importance of adhering to these rules so that their colleagues are able to read the cards, and hence their ideas, from a distance.

Brainstorming / buzz groups / group work

Brainstorming (in plenary discussions or in groups), or working in buzz groups (small groups of 3–4 participants) helps quickly generate ideas, which can be used as a basis for later discussions. They also help the group to cooperate on a task and focus on an issue or a problem.

Brainstorming is often used at the beginning of a session when a new topic is introduced. The facilitator poses a clear question about the new topic and invites the participants to share their ideas. During brainstorming, all the participants' ideas are listed and neither the facilitator nor the other participants should comment on any ideas that have been raised. The responses are written on a flipchart or on VIPP cards, which can be organized to show the issues that emerged from the exercise. Once this has been done, the issues can be examined and discussed.

It is important for the facilitator to decide in advance the reason for asking the participants to brainstorm and plan on how to deal with their responses. Make sure that the initial brainstorming question is clear and well understood. The question should be written on a flipchart so that the participants can read the question when it is introduced. Give the participants clear instructions on the time they have to work together, and do not let the session continue for too long. Ensure that everyone gets an opportunity to contribute.

Role play


Role play can be a valuable method both for teaching and learning. It provides an opportunity for the expression of emotions, which cannot be achieved through discussions alone. Role play has the potential to raise many issues in a much shorter time than would be possible using other teaching-learning methods.

Spot checks

Spot checks are short questions meant for self-evaluation by participants. Participants individually write responses in their Manual at the beginning of the course. They will not be required to share their answers. In the concluding session, the facilitator will review the spot checks and discuss the responses with the participants. At this time participants will be able to evaluate their own knowledge gains and attitude changes.

Adolescent expert patient trainers

This course should include as participants, young people who are trained as expert patient trainers (EPTs), particularly adolescents living with HIV. Their involvement will provide the other participants with a unique insight into adolescents' views on living with HIV. EPTs can assist throughout the day and can be asked to give participants a "true" representation of what it is like to be a young person living with HIV. This Guide mentions when an adolescent EPT can be invited to speak, although it is important that they are adequately prepared beforehand. These occasions are displayed as questions in the format below:



Adolescent expert patient trainer
What do you think about ...?

However, if the adolescents are confident about being involved spontaneously during discussions, it may not be necessary or appropriate to ask them each time a box is indicated.

The facilitators must meet with the adolescent EPTs before the course and prepare them for their role. “Adolescent expert patient trainer” boxes can be used when briefing the adolescents to discuss when their contributions may be particularly useful. The facilitator should discuss with the EPTs which experiences they are willing to share and give clear guidance on when they will be asked to speak and for how long. The facilitator should also discuss with the EPTs how they can decline to answer questions they are uncomfortable with.

During group work, there should be an adolescent EPT in each group, whenever possible. Facilitators must be sensitive to the needs of the adolescent EPTs and assist them in feeling confident to speak to the group by giving them support during the day.

IMAI wall chart on the adolescent living with HIV

A copy of the *IMAI wall chart* (Sheet I and II; Annex 2) should be displayed on a wall where it can be seen throughout the day. There are two boxes on each sheet. At the beginning of the training, each sheet will be covered with two blank flipcharts, one covering each box. During the day the facilitator will lower or remove the flipcharts to uncover each box of information as it is presented to the participants. Instructions on when to uncover the boxes are included in this Guide.

“Come Back to Later” board

The “Come Back to Later” board is a blank flipchart that is put up at the beginning of the day with the title “Come Back to Later” written on the top. Participants are encouraged to “park” on the board those questions, comments and issues that come up during the day but that they feel are not dealt with adequately at the time they arise. This ensures that participants’ questions do not get forgotten or dismissed if they arise when there is no time to discuss or when it is not appropriate to deal with them. The board will be reviewed at the end of the day, during the concluding session, to ensure that all the issues raised have been covered.

Preparation of materials and equipment

The facilitator should review this list before the start of the course.

Planning the course

The facilitator must:

- familiarize themselves with the Guide and Manual;
- ensure there are enough copies of the Manual;
- ensure that participants are asked to bring to the course their copies of two IMAI publications: *IMAI Acute care* guideline module (January 2009) and *IMAI-IMCI Basic HIV care with ART and prevention* guideline module (April 2007);
- pick the three scenarios to use from the eight scenarios that have been prepared for Session 9 (to ensure that they are relevant to your situation);

- decide if the group feedback (Session 9) would be in plenary or as a role play; if it is to be a role play, read “How to conduct a role play” in Annex 5, Optional Session C;
- read local data, local guidelines and other information on HIV and young people; find local information on adolescents and sexuality (e.g. sexual debut, teenage pregnancy, sexually transmitted infection (STI) rates) and determine if there is a national policy on consent to HIV testing and treatment for minors;
- decide whether there is extra time to include any optional sessions; if including:
 - Optional Session A, choose the debate question and write it on a flipchart;
 - Optional Session B, arrange for a guest presenter and prepare them for the presentation; if not included, try to obtain some local data specifically on young people and HIV to use during the day;
 - Optional Session C, read role plays and adapt if necessary; prepare a demonstration role play, if required;
- have the following IMAI and other documents available for facilitators to refer to:
 - *IMAI Acute care guideline module*;
 - *IMAI-IMCI Basic HIV care with ART and prevention guideline module*;
 - *Flipchart for patient education*;
 - *Reproductive choices and family planning for people living with HIV: Counselling tool*;
 - *Adolescent job aid*.

The day before the course

The facilitator must:

- check supplies of markers, tape or blue tack (for sticking up the VIPP cards), glue, large sheets of paper on which to glue VIPP cards, and blank flipcharts;
- prepare flipcharts (from text in this Guide – see below);
- put up the “Come Back to Later” board and make sure that there is a pen available to write on it;
- put up the *IMAI wall chart* Sheets I and II, where these can be viewed easily; cover each half (box) with a blank flipchart (four flipcharts);
- prepare a short icebreaker to use at the start of the course;
- prepare 2-4 energizers (2 minute activities) to use when indicated in the Guide, after long sessions or when participants need a break;
- check the room where the course will be held for sufficient chairs, tables, wall space for sticking up the VIPP cards, and areas for small groups or separate rooms/verandas for group work. If possible, set the desks around the room in a big “U” shape (with the facilitator at the open end of the “U”), to encourage participation;
- decide on how to keep to time (e.g. have a clock, have a time-keeper who uses signals, write the begin and end times of each session in the Guide).

List of flipcharts to be prepared

FLIPCHART

>> The flipcharts that need to be prepared before the course are shown in the *Facilitator guide*, in boxes like this.

Here is a list of the flipcharts and VIPP cards to prepare the day before the course:

1. **“Come Back to Later” board**
2. **Five VIPP cards for Session 1** (Section 1 of the Manual)
3. **Flipchart 1 for Session 2** (Section 2 of the Manual)
4. **Flipchart 2 for Session 2** (Section 2 of the Manual)
5. **Flipchart 3 for Session 3** (Section 3 of the Manual)
6. **Flipchart 4 for Session 3** (Section 3 of the Manual)
7. **Flipchart 5 for Session 4** (Section 4 of the Manual)
8. **Flipchart 6 (plus four VIPP cards) for Session 4** (Section 4 of the Manual)
9. **Flipchart 7 for Session 4** (Section 4 of the Manual)
10. **Flipchart 8 for Session 6** (Section 6 of the Manual)
11. **Flipchart 9 for Session 6** (Section 6 of the Manual)
12. **Flipchart 10 for Session 6** (Section 6 of the Manual)
13. **Flipchart 11 for Session 7** (Section 7 of the Manual)
14. **Flipchart 12 for Session 7** (Section 7 of the Manual)
15. **Flipchart 13 for Session 8** (Section 8 of the Manual)
16. **Flipchart A for Optional Session A1.**

Language

As with all trainings, especially trainings dealing with HIV, consider carefully the language you use. Use of appropriate, non-judgemental and non-discriminatory language by the facilitator can guide participants. The facilitators can also review the *UNAIDS terminology guidelines* ¹ for general guidance on words and terms to be used in talking about issues around HIV.

¹ http://data.unaids.org/pub/Manual/2008/jc1336_unaids_terminology_guide_en.pdf

Here are some general language issues to bear in mind:

- When working with adolescents living with HIV, remember to talk of parents, guardians or caregivers, not just parents, as many adolescents living with HIV are orphans.
- When referring to adolescents who acquired HIV around birth, use the term “adolescents with perinatally acquired HIV” or “adolescents who were infected perinatally”.
- When referring to adolescents who acquired HIV as adolescents, use the term “infected with HIV during adolescence” or “having acquired HIV as adolescents”.

Using the *Facilitator guide*

To help you to use this Guide, a key of the layout is presented below.

Tip for you

These tips, shown in a box like this, are reminders, or provide the facilitator with additional information on conducting an activity.



This symbol is used to mark the main points in a block of text, and will assist the facilitator in covering all the main points.



This symbol is used when it is suggested to include an energizer. Other energizers can be added if the facilitator feels they are needed.



This sign indicates that the facilitator should tell participants to open their Manual.

All sessions (except 1 and 10) begin by stating the learning objectives as shown below. These should be read aloud by the facilitator.

Read aloud:**LEARNING OBJECTIVES**

Key points of a section (or issue) are displayed at the end of each session in the Guide and at the end of each section in the Manual. These are to be read aloud or summarized by the facilitator as a review at the end of each session.

Adolescents and sexual behaviour: An overview

This course does not encourage adolescents to become sexually active but it does recognize that adolescents may already be sexually active. Statistics on adolescent pregnancy and STI rates confirm that many adolescents are sexually active.

For the vast majority of people, sexual activity begins during adolescence. Adolescence includes a wide age range (10–19 years) and during this time many significant developmental and behavioural changes occur. These changes happen at different ages for different adolescents. The particular age at which an adolescent becomes sexually active depends on many individual, social and cultural factors. This means that discussions on sexual behaviour that are appropriate for older adolescents may well be inappropriate for younger adolescents. The implications of this are that the health worker may need to counsel adolescents aged 10–14 years on abstinence and counsel 17-year-olds on safer sex, for example.

Adolescents need to know that abstinence is the safest way to avoid acquiring or transmitting HIV. They need encouragement and support to delay sexual activity until they are physically and emotionally ready. When they are sexually active, they need appropriate information on safer sex (i.e. condom use) so they can protect themselves and their partners. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has reported that when adolescents are provided with correct information on sex, the information does not encourage them to become sexually active, but instead it may help them to make better choices about how and when to become sexually active.

Abstinence may not be possible or acceptable to all adolescents. Adolescents may be forced or coerced into being sexually active, or may be curious about sex and choose to become sexually active earlier than their peers. Some adolescents may change their sexual partners frequently while others may remain with one partner for a long time. As with all people, patterns of sexual activity vary among adolescents, even adolescents within the same peer group. This course encourages health workers to be aware of this and to remain non-judgemental about the sexual choices or preferences that adolescents make.

During this course, the different issues concerning sexuality for two groups of adolescents living with HIV (those who acquired HIV perinatally and those who acquired HIV during adolescence) will be discussed. Adolescents who acquired HIV perinatally are likely to be younger and may never have been sexually active, while those who acquired HIV during adolescence are probably already sexually active. Each group will have their own concerns and questions.

During discussions with adolescents before or during this course, it may be possible to identify culturally acceptable methods for adolescents to find sexual pleasure without the risk of acquiring or transmitting HIV. Health workers could use this information to counsel adolescents and inform adolescent peer counsellors.

Schedule for the day

Sessions	Activity	Page	Time (mins)
Session 1: Introduction to IMAI Orientation on Adolescents Living with HIV <ul style="list-style-type: none"> > Spot checks > Introductions > Course objectives > Participatory methods 	<ul style="list-style-type: none"> > Individual exercise > Group work > Mini lecture > Mini lecture 	15	20
Session 2: Adolescent development <ul style="list-style-type: none"> > Introduction to adolescent development > Participants' experiences of adolescence > Adolescents today 	<ul style="list-style-type: none"> > Mini lecture and plenary discussion > Individual exercise and plenary discussion > Brainstorming 	22	50
Session 3: Adolescence – a unique stage in life <ul style="list-style-type: none"> > How adolescents differ from children and adults > How adolescents differ from each other > Difficult situations for health workers in providing services to adolescent patients living with HIV 	<ul style="list-style-type: none"> > Brainstorming and buzz groups > Mini lecture > Buzz groups and plenary discussion 	32	50
BREAK			30
Session 4: Adolescents living with HIV and health services <ul style="list-style-type: none"> > HIV transmission periods for adolescents: Perinatal or adolescence > Adolescents living with HIV seeking health services > Identifying changes to improve services for adolescents living with HIV 	<ul style="list-style-type: none"> > Mini lecture > Plenary discussion and brainstorming > Individual exercise 	41	45
Session 5: Introduction to using the <i>Adolescent job aid</i> <ul style="list-style-type: none"> > Overview of the <i>Adolescent job aid</i> and its use in providing services to adolescents living with HIV 	<ul style="list-style-type: none"> > Plenary presentation and discussion 	51	30
Session 6: Communicating with adolescents <ul style="list-style-type: none"> > Communicating successfully with adolescents 	<ul style="list-style-type: none"> > Group work and plenary discussion 	53	45
LUNCH			60

...after lunch

Sessions	Activity	Page	Time (mins)
Session 7: Prevention and support for adolescents living with HIV <ul style="list-style-type: none"> > Important questions asked by adolescents living with HIV > Responding to adolescents' questions > Beneficial disclosure > Positive prevention > Consent and confidentiality > Developmental delays 	<ul style="list-style-type: none"> > Brainstorming > Group work > Plenary discussion > Mini lecture and plenary discussion > Plenary discussion > Mini lecture and plenary discussion 	59	45
Session 8: Treatment and care for adolescents living with HIV <ul style="list-style-type: none"> > Clinical status when entering care > Transition of care > Antiretroviral therapy > Challenges in adherence to ART for adolescents > Living with a chronic condition 	<ul style="list-style-type: none"> > Mini lecture > Mini lecture > Plenary discussion > Brainstorming > Mini Lecture 	72	45
BREAK			30
Session 9: The 5 "A"s and the adolescent patient <ul style="list-style-type: none"> > Using the 5 "A"s with an adolescent patient > Feedback 	<ul style="list-style-type: none"> > Group work and plenary presentation (or role play) > Plenary presentation (or role play) 	85	60
Session 10: Concluding session <ul style="list-style-type: none"> > Spot checks > Difficult situations for health workers, "Come Back to Later" board and course objectives > Individual action plan > Key messages and conclusion 	<ul style="list-style-type: none"> > Review > Review > Individual exercise > Review 	98	60

Optional Sessions: The following three activities for the optional sessions are included in Annex 5.

Optional Session A: Debate (60 minutes)

Optional Session B: National situation of HIV and young people (30 minutes)

Optional Session C: Role play (60 minutes)

The facilitator should decide before the start of the course on whether to include some or all of these optional activities, depending on the time available and the needs of the participants.

1

Session 1: _____

Introduction to the IMAI One-day Orientation on Adolescents Living with HIV

Individual exercise / Group work / Mini lecture
(20 minutes)

Welcome the participants after they have seated themselves.

Ask their names and give them each a copy of the Manual.

Individual exercise:

Spot checks



Ask the participants to turn to “Spot checks” in Annex 1 of the Manual.

Say:

- The purpose of the spot checks is to help evaluate your gain in knowledge or changes in attitudes as a result of participation in this course.
- The spot checks will not be collected, graded or checked by any of the facilitators.

Ask them to read the instructions and then complete the spot checks.

Tip for you

- > The spot checks are also in Annex 1 of this Guide.
- > The participants can begin the spot checks once they are seated.
- > Do not wait for all participants to arrive; let those who arrive early begin.

Ask the participants to complete the spot checks to the best of their knowledge. Tell them that they will review the answers at the end of the day.

If necessary, give them a further five minutes to complete this task.

Group work:

Introductions



Start with the prepared short icebreaker.

It is expected that this course will follow other IMAI trainings, and the facilitators and participants will therefore already know each other and not need introduction. However, if participants do not know each other, use an icebreaker. This could include simple

introductions, in which every participant would stand up and say their name and something about themselves. Alternatively, one of the following introduction games could be used:

- Group participants into pairs and ask them to introduce themselves by miming.
- Ask pairs of participants to spend time getting to know one another – the participants can then take turns telling the whole group what they have learned about their partners.
- Get all participants to write a couple of things about themselves on a piece of paper that can be stuck to their chest – the participants will then mingle, reading about each other.

Mini lecture: Course objectives



Focus on adolescents

Tip for you

- > Hold up a copy of *Young people and HIV*, from the Orientation Programme on Adolescent Health for Health-care Providers (WHO 2003), if available.

Say:

In this course, we will focus on the particular needs of adolescents living with HIV. There is another WHO course, *Young People and HIV* – a part of the Orientation Programme on Adolescent Health for Health-care Providers – which is a training on the HIV prevention needs of young people in general.

Although there are aspects of appropriate HIV prevention, care, treatment and support from the IMAI training that are similar to some of the issues covered in *Young people and HIV*, in this course we will consider the particular needs of **adolescents** living with HIV.

Say:



Open your Manual to Section 1.2: Course objectives.

Read aloud:

The objectives of this course are to orient a range of health workers, including medical officers and nurses, to the special characteristics of adolescence and to identify and practice appropriate ways of addressing important issues for adolescents living with HIV.

- inform participants of the stages of adolescent development;
- raise participants' awareness of the special needs and challenges facing adolescents living with HIV;
- strengthen participants' skills in providing appropriate prevention, care, treatment and support to adolescents living with HIV.

Say:

The Manual provides additional information to complement what will be covered during this course. It will be referred to during the day and you are also encouraged to read it later.

During the day, we will also refer to your copies of the *IMAI Acute care* guideline module and the *IMAI-IMCI Basic HIV care with ART and prevention* guideline module.

Tip for you

- > Hold up copies of the *IMAI Acute care* guideline module (January 2009) and the *IMAI-IMCI Basic HIV care with ART and prevention* guideline module (April 2007).
- > Check that all participants have copies or can share.
- > Check that they are using the recent version.
- > Ask the participants to have their copy available in front of them.



Ask the participants to open the Manual to Section 1.4 that provides the schedule of the training course.

Briefly review the session headings to prepare them for the day.

Mini lecture: Participatory methods

Say:

During this course we will use participatory learning methods and everyone will be asked to share their views and perspectives. In this way, everyone (participants and facilitators) will be resource people for the course. There are some ground rules for participatory learning.



Ask the participants to turn to “Spot checks” in Annex 1 of the Manual.

Ask a volunteer to read aloud the rules for participatory learning.

Rules for participatory learning

- Treat everyone with respect at all times, irrespective of sex, age or experience.
- Ensure confidentiality, so that facilitators and participants are able to discuss sensitive issues (such as those relating to sexual and reproductive health and HIV) without feeling concerned about negative consequences.
- Keep track of time; begin and end all sessions on time.
- Ensure that everyone gets an opportunity to be heard.
- Accept and give critical feedback; take care not to hurt anyone’s feelings.
- Draw on the expertise of facilitators, adolescent EPTs and participants in dealing with difficult situations if they arise.

Say:

Adhering to these rules will help to ensure an effective and enjoyable learning environment.

Facilitators and participants may add other rules as appropriate.



VIPP rules and principles

Say:

VIPP stands for visualization in participatory programmes.

VIPP is a participatory process, which involves participants writing their ideas and responses to an issue on cards of different sizes and colours.

Tip > hold up the VIPP cards

VIPP cards are displayed and the linkages between ideas and areas of consensus and disagreement are identified.

For VIPP to be successful there are some rules for card writing.

Take your five prepared VIPP cards, read them aloud and put them up one at a time on the wall where they can be seen by all participants.

>> One idea per card

>> Maximum of three lines

>> Use keywords; write legibly

>> Follow the colour code

>> Do not write lots of words or ideas on one card otherwise no one will be able to read it which defeats the purpose of “visualizing” people’s ideas

Tip > Write the fifth card in small letters to reinforce the point



“Come Back to Later” board

Point out the location of the “Come Back to Later” board and the pen they can use for writing their questions or comments.

Say:

This is where we will “park” questions, ideas or comments that we do not deal with immediately or that need further discussion.

Anyone is free to write a comment or question on the board throughout the day. We will address any unanswered issues at the end of the day.

2

Session 2:

Adolescent Development

Mini Lecture / Plenary / Individual Exercise / Brainstorming
(50 minutes)

Read aloud:

LEARNING OBJECTIVES

- To discuss the stages of adolescence
- To help you reflect on positive and negative experiences in your own adolescence, with a focus on sexual and reproductive health
- To discuss how experiences of today's adolescents compare with those of adolescents 10–20 years ago.

Mini Lecture and Plenary: Introduction to Adolescent Development

Say:

We will begin by clarifying who we are talking about in this course.

Remove the blank flipchart on the top half of Sheet I of the *IMAI wall chart* to uncover the first box as shown below.

According to the World Health Organization (WHO)

- **“adolescents”** are individuals in the 10–19 years age group
- **“youth”** are individuals in the 15–24 years age group
- **“young people”** combine both adolescence and youth and include the 10–24 years age group.

Adolescence has physical, psychological, emotional and socio-cultural dimensions. It is a phase in an individual's life, rather than a fixed age band, and is perceived differently in different societies.

Ask a participant to read the box. **Say:**



- Adolescence is characterized by a period of exceptionally rapid rate of growth and development. During this stage, the body develops in size, strength and reproductive capabilities and the mind becomes capable of more abstract thinking. There is also an increase in emotional control.
- The rate of growth and development during adolescence is only exceeded by the rate of growth during fetal life and infancy. However, in comparison with infancy (when the milestones occur at a similar time for most infants), there is much greater individual variation both in the timing of developmental milestones and in the timing and degree of changes in rates of growth during adolescence. This means that there can be great variations in development among adolescents of the same age.
- During adolescence, social relationships move from a family base to a wider horizon in which peers, other respected adults in the community, and also adults in the media (such as pop music and film stars) play more significant roles.



Stages of adolescence



Ask the participants to look at the Stages of adolescence table in Section 2.1 of the Manual.

This table is shown below.

Stages of adolescence	EARLY 10–15 years	MIDDLE 14–17 years	LATE 16–19 years
Category of change			
GROWTH OF BODY	<ul style="list-style-type: none"> Secondary sexual characteristics appear Rapid growth reaches a peak 	<ul style="list-style-type: none"> Secondary sexual characteristics advance Growth slows down Has reached approximately 95% of adult growth 	<ul style="list-style-type: none"> Physically mature
GROWTH OF BRAIN (Prefrontal cortex)		<ul style="list-style-type: none"> Brain growth occurs Influence on social and problem solving skills 	
COGNITION (ability to get knowledge through different ways of thinking)	<ul style="list-style-type: none"> Uses concrete thinking (“here and now”) Does not understand how a present action has results in the future 	<ul style="list-style-type: none"> Thinking can be more abstract (theoretical) but goes back to concrete thinking under stress Better understands results of own actions Very self-absorbed 	<ul style="list-style-type: none"> Most thinking is now abstract Plans for the future. Understands how choices and decisions now have an affect on the future
PSYCHOLOGICAL AND SOCIAL	<ul style="list-style-type: none"> Spends time thinking about rapid physical growth and body image (how others see them) Frequent changes in mood 	<ul style="list-style-type: none"> Creates their body image Thinks a lot about impractical or impossible dreams Feels very powerful Experiments with sex, drugs, friends, risks 	<ul style="list-style-type: none"> Plans and follows long-term goals Usually comfortable with own body image Understands right from wrong (morally and ethically)
FAMILY	<ul style="list-style-type: none"> Struggles with rules about independence/dependence Argues and is disobedient 	<ul style="list-style-type: none"> Argues with people in authority 	<ul style="list-style-type: none"> Moving from a child-parent/guardian relationship to a more equal adult-adult relationship
PEER GROUP	<ul style="list-style-type: none"> Important for their development Intense friendships with same sex Contact with opposite sex in groups 	<ul style="list-style-type: none"> Strong peer friendships Peer group most important and determines behaviour 	<ul style="list-style-type: none"> Decisions/values less influenced by peers in favour of individual friendships Selection of partner based on individual choice rather than what others think
SEXUALITY	<ul style="list-style-type: none"> Self-exploration and evaluation Preoccupation with romantic fantasy 	<ul style="list-style-type: none"> Forms stable relationships Tests how he/she can attract opposite sex Sexual drives emerging 	<ul style="list-style-type: none"> Mutual and balanced sexual relations Plans for the future More able to manage close and long-term sexual relationships

Adapted from the Orientation Programme on Adolescent Health for Health-care Providers, WHO, 2003 (Handout for Module B, the Meaning of Adolescence)

Read the headings of the columns and the rows aloud to the participants and ensure they understand the stages and categories.

Say:

Adolescence can be grouped into three overlapping developmental stages: ages 10–15, 14–17 and 16–19 years. The overlap of ages is important because the changes are not fixed and happen at different ages for different adolescents.

These age groups roughly correspond with stages in physical, social and psychological development in the transition from childhood to adulthood. The stages provide a basic framework to understand adolescent development.

The characteristics at each stage are normal and part of healthy development.

Say:



Do any of you live with an adolescent aged 10–15 years?

If no one volunteers, ask if anyone knows an adolescent in this age group.

Ask that participant to read the column for that age group.

When they have finished, **Say:**

Do these changes sound familiar to you? Which category of change do you especially notice these days with the adolescent that you know?

Thank the participants and then ask if there is anyone who lives with an adolescent aged 14–17 years. Ask one of them to read the appropriate column.

Finally, ask for a participant who lives with or knows an adolescent aged 17–21 years and ask them to read the appropriate column.

Ask the participants if they notice any particular differences between boys and girls in these different age groups



Brain development during adolescence

Say:

- Brain development continues in the prefrontal cortex during adolescence and well into early adulthood. This area of the brain contributes to developing social and problem solving skills, regulating emotions and moderating moods.
- This is why adolescence is an important time to learn life skills. Life skills complement this phase of brain development, and can help adolescents to deal with the emotional changes and other challenges that they are experiencing and help in the transition to adulthood.

Give them a few minutes to look at the stages of adolescence table. Ask if there are any questions and respond.



Tanner scale

Say:

Another way to assess development during adolescence is by using the Tanner scale. This scale uses physical measurements of development based on external primary and secondary sexual characteristics.



Ask the participants to turn to Annex 2 of their Manual.

Tip for you

> The Tanner scale is in Annex 3 of this Guide.

Say:

This scale is based on observing the development of breasts in girls, development of genitalia in boys and the growth of pubic hair in both sexes. In HIV care, the Tanner scale is used to determine an adolescent's phase of development, in order to decide whether he or she should receive a paediatric or an adult dose of antiretroviral therapy (ART).

The Tanner scale should not be confused with WHO Clinical Staging, which is used to determine if a person needs to receive ART.

We will review this in detail later when we discuss ART.

Individual exercise and plenary discussion: Participants' experiences of adolescence

Show Flipchart 1.

Read aloud:

FLIPCHART 1

>> Write down one memorable episode from your adolescence that relates to feelings or experiences of your sexuality or reproductive health.

Happy 😊

Unhappy ☹️

Give everyone a card of the same colour.

Say:



Each participant should write on the card (in not more than 10 words) one memorable experience from their adolescence that relates to their emerging sexuality.

This may be a positive (happy) or negative (unhappy) memory.

Point out that the responses will be anonymous (participants do not have to write their name on the card), so they need not be concerned about revealing personal or sensitive experiences. Remind them of the VIPP rules.



Be clear about the question and check that everyone has understood that they should identify a specific memory. Give examples, such as your first kiss, first sexual experience, menarche (first menses), an awareness of a change in your body. They can also write about an emotion connected to the memory.

Participants should write down a real memory about one event, and not general feelings during adolescence.

Tip for you

- **The facilitator(s) should also write on card(s), choosing a real experience from their adolescence that will stimulate the discussion (e.g. embarrassment of first night emission, pride of menarche, disastrous first experience while using a condom, shame of getting a sexually transmitted infection).**

When everyone has finished writing on their respective cards, ask them to place their card face down on the table in front of them. Collect the cards, taking care to maintain confidentiality.

Then ask two participants to come forward to help facilitate the activity. Ask one of them to take a card and read it to the group. Then stick the card on the flipchart under the correct heading (happy or unhappy).

Tip for you

- **Generally, the participants will reach a consensus in assigning the cards to the appropriate category (happy or unhappy). However, there may be some disagreement in assigning the cards to one category or the other.**
- **Ask if they would like to name a different category in the middle of happy and unhappy, as sometimes experiences may have both happy and unhappy aspects.**
- **Tell the participants that if they wish they may identify their card and explain their feelings related to this memory.**
- **This is a lively activity with a lot of participation but be careful to keep track of the time.**



Marking turning points

Say:

Some experiences, although negative and painful (such as the ending of a relationship), may have spurred someone to take another direction in their life. These events are remembered as important turning points.

Ask the participants if they would like to identify these turning points and then place a mark (such as a star sign) to highlight these cards.

Brainstorming: Adolescents today

Tell the participants that there will be a brainstorming session now.

Tip for you

- Ensure that the participants understand “brainstorming” or, if necessary explain it to them.
- Brainstorming involves posing a question and inviting participants to share any ideas that come to mind. During the brainstorming, neither the facilitator nor the other participants should comment on any ideas that have been raised. All responses will be written on the flipchart and then discussed.

Show Flipchart 2.

Read aloud:

FLIPCHART 2

- How do adolescents’ experiences of relationships and sex today differ from adolescents’ experiences 10–20 years ago?

Ask anyone to call out a response. Write the participants' responses on Flipchart 2, grouping similar ideas together whenever possible.

After a few minutes, when the flow of ideas slows down, bring the exercise to a close and summarize the responses.



Adolescent expert patient trainer

Do you think your experiences of relationships and sex are different from those experienced by adolescents 10–20 years ago?

Are there any points on the flipchart that you disagree with?

Say:

These different experiences of relationships and sex during adolescence occur because of many factors and are not only about living in a different decade. Other factors that influence these experiences include differences in family environment, peer influences and expectations, socioeconomic conditions, culture and social values, access to information, place of residence, etc.

Say:



How much does our own experience of our adolescence influence how we as health workers deal with adolescents?

Allow a few minutes for discussion and then summarize the main points made by the participants.



Conclude by thanking the participants for sharing their experiences.

Say:

Hopefully, this session has helped us remember some of the feelings and emotions that are connected with being an adolescent. As health workers providing services to adolescents, it is important for us to remember what it was like to be an adolescent and keep in mind how these feelings and emotions affect the decisions and actions of our adolescent patients.



Ask the participants to turn to the Key points at the end of Section 2 in their Manual.

Read aloud (or summarize):

KEY POINTS OF SECTION 2

- 1. WHO defines adolescents as individuals who are 10–19 years old.**
- 2. Adolescence is a period in which an individual undergoes tremendous physical, psychological and emotional changes. There is rapid growth and development of the body and brain, causing physical changes and changes in thinking, problem solving and social skills and relationships.**
- 3. It is important for health workers to understand these changes because they influence how adolescents behave and respond to information that they are given.**
- 4. By remembering our own experiences of adolescence, we may be able to understand better the challenges facing adolescents.**
- 5. The experiences of adolescents today are different from those faced by adolescents 10–20 years ago.**

Ask if there are any questions; respond and/or move on to Session 3.

3

Session 3: _____

Adolescence – a unique stage in life

**Brainstorming / Buzz groups / Mini lecture / Plenary discussion
(50 minutes)**

Read aloud:

LEARNING OBJECTIVES

- to examine ways in which adolescents differ from children and adults, and explore the implications of these differences for providing adolescents with HIV prevention, care, treatment and support;
- to recognize how adolescents differ from each other;
- to identify difficult situations that health workers can encounter when providing services to adolescents living with HIV.

Brainstorming and buzz groups: How adolescents differ from children and adults

Say:



We will now briefly brainstorm about the characteristics that make adolescence a unique stage in an individual's life.

First, we will consider the characteristics of adolescence in general. Later we will consider how these characteristics can influence HIV prevention, care, treatment and support.

Put up Flipchart 3.

Read aloud the statement and question:

FLIPCHART 3

- >> The second decade: *“No longer children, not yet adults”*
- >> What are the characteristics of adolescence that distinguish it from both childhood and adulthood?
- >> Characteristics

Ask the participants to think of a characteristic of adolescence that distinguishes this stage from both childhood and adulthood.

Give one or more examples to get the process started:

- energetic, spontaneous, open or inquisitive
- unruly, lazy, unreliable or disobedient
- desiring independence
- influenced by friends and peer group
- less influenced by family
- looking for role models outside of family (music, movies, etc.)
- embarrassed to talk with an adult about personal issues
- wanting to be different from parents/previous generation.

Tip for you

- > Write the participants' suggestions of characteristics as a list on the *left* of the flipchart (leaving space on the right for the second part of this activity: how these characteristics can influence HIV prevention, care, treatment and support).

Say:

Anyone is welcome to raise a hand and make a suggestion.

Once the flow of suggestions slows down, bring the activity to a close.



Review the characteristics listed by the participants; clarify any characteristics that are not clear and suggest any important characteristics that have been missed.

Allow for some discussion and group similar characteristics together. Write a number beside each characteristic or group of characteristics. This will help in the next stage of the activity.

Tip for you

- > Once the flow of suggestions slows down or you have enough examples, move on.
- > Look at the number of characteristics listed on the flipchart and decide on the number of buzz groups (each of 3–4 participants).
- > Decide how many characteristics (preferably 1–2) to allocate to each buzz group.



Form buzz-groups of 3–4 participants each. Allocate 1–2 special characteristics of adolescence to each group from the list on Flipchart 3.

Say:

Each buzz group should discuss these characteristics and come up with the implications that these characteristics can have on prevention, care, treatment and support for *an adolescent living with HIV*.

Tip for you

- > Write “What this means for HIV prevention, care, treatment and support” on the right of the flipchart.

Say:

Remember that these characteristics are generalizations and may not be applicable to every adolescent living with HIV.



If necessary, give some of the following examples to help the groups start the process:

- **Energetic, open or inquisitive**

Implications: interested in information on HIV, open to changes to reduce risks, however also inquisitive about having sex and other new experiences (e.g. substance use).

- **Unruly, inattentive or disobedient**

Implications: misses appointments, problems with adherence to care and ART, not attentive to their general health.

- **Desiring independence**

Implications: takes responsibility, challenges authority, participates in care agreement, active in self-care, will not listen to health worker.

- **Influenced by friends more than family**

Implications: peer group can be an important source of HIV care and support (importance and advantages of a well informed peer group).

- **Embarrassed to talk with an adult about personal issues and sexuality**

Implications: adolescent may appear inattentive or rude; health workers need training to understand how best to approach and communicate with adolescents.

Tell the participants that they have five minutes to prepare and then one person from each buzz group will present back to plenary.

Ask each group to present their findings. Write keywords from each buzz group's presentation on the right side of Flipchart 3, opposite the relevant characteristics of adolescence that were previously listed.

Tip for you

> Flipchart 3 may look like this:

Characteristics

1. Inquisitive
2. Wants independence
3. Peers are very important
etc...

What this means for HIV prevention, care, treatment and support

- Interested in information, takes risks
- Involve them in care and treatment plan
- Peer group can be informed and give support

If there is time, **Ask:**

How are these characteristics (*pick one or two*) different from children?
How are these characteristics (*pick one or two*) different from adults?

Conclude by summarizing the important points that have been identified by the participants.

Mini Lecture: How adolescents differ from each other

Say:

- Adolescents are different from adults and children.
- Adolescents are also different from each other. Although all people are different from each other, this difference is especially true among adolescents, where there may be a tremendous variation in the phases of development among adolescents of the same age. This is because adolescence is a time of rapid change, and the factors that stimulate the change differ among adolescents. The differences may be physical, psychological (cognitive and emotional) or social.
- Health workers need to understand these differences and take them into consideration in caring for adolescents living with HIV.

Say:



Open your Manual to the box in Section 3.2: “Differences among adolescents and some implications for health workers”

Briefly review each heading (these are examples of differences) and some implications of these differences.

Differences among adolescents and some implications for health workers

- **Age:** minor (e.g. parental/guardian consent may be needed to provide treatment, issues of confidentiality), younger or older adolescent (sexually active or not, the need for age-appropriate prevention information)
- **Stage of development and maturity:** physical and cognitive growth (e.g. whether sexually active, in need of psychosocial and family support, importance of peer group, ability to understand information, understanding consequences of actions, adherence to medication)
- **Gender differences:** different social and cultural influences on boys and girls that affect how they view themselves and relate to others (e.g. sexuality, contraception, condom use, social acceptance of /tolerance for being sexually active, attitudes to same sex preference)
- **Married/unmarried:** (e.g. potential for couple counselling, fertility regulation, consent of partner, other sexual partners)
- **Home situation:** living alone, living with parents/guardians, living on the street, orphan, in school or out of school (e.g. availability of support and care networks, quality and availability of peer support, access to information and services)
- **Education level:** (e.g. literacy level, how to explain health issues, future prospects).
- **Level of information and understanding of risk factors:** for sexually transmitted infections (STIs), HIV, injecting drug use (e.g. able to understand risks of behaviour, knowledge and attitudes of peers)
- **Disposable income:** (e.g. whether the adolescent has money for health care, basic needs and transport costs for accessing health services)
- **HIV transmission pattern:** acquired HIV perinatally or as an adolescent (e.g. how long they have known (or suspected) that they are HIV-positive, implications for mother, clinical status, timing for entering care, new diagnosis, health-risk behaviours)
- **Who else knows they are HIV-positive:** can they control issues of disclosure and confidentiality (e.g. support network, prevention, coping with stigma)
- **Health and stage of HIV disease:** (e.g. asymptomatic or symptomatic, opportunistic infections, needing treatment)
- **Personal and family experience of stigma and discrimination:** (disclosure, support, fear)

Say:

It is important for health workers to remember that adolescents differ from each other. Health workers need to look for these differences and take them into consideration in caring for each adolescent living with HIV.

Buzz groups and plenary discussion:

Difficult situations for health workers in providing services to adolescent patients living with HIV

Say:

We will now identify difficult situations that can occur for health workers providing services to adolescents who are living with HIV.

It will give you an opportunity to identify concerns you may have, and to share real situations that you may have faced or feel concerned about facing.

Form buzz-groups of 3–4 participants each.

Ask each group to think of one difficult and realistic situation at a health centre with an adolescent patient who is living with HIV. This could be:

- a difficult situation that they have experienced
- a difficult situation that they have heard happened to another health worker
- a difficult situation that they imagine or are afraid could happen at a health centre.



Ask them to think about what they, as health workers (not the adolescent), would find difficult when dealing with this situation.

Ask them to focus on a concrete scenario with an adolescent, with the adolescent and the family or with colleagues at the health centre. Remind them to identify situations that are particular to adolescents living with HIV.

Give each group one VIPP card of the same colour and ensure that everyone has a pen.

Give them one example of a short scenario, so they understand that you are looking for real and imaginable situations.

Examples might be an adolescent living with HIV who is:

- telling the health worker not to disclose his/her HIV status to parents or guardians (confidentiality);
- accompanied by a husband who will not let her speak freely to the health worker;
- too shy or afraid to speak, too angry, too ashamed to talk about sex or HIV;
- at the health centre, asking for HIV treatment without a parent/guardian and is under the age of consent.

Say:

You should discuss situations that concern you in your group and then decide on one situation that you will present. Write the situation on your VIPP card, using keywords.

You can choose whether to reveal if the situation is imaginary or real. Remember not to include any information that could identify a real person or location in the situation you describe.

Point out the VIPP card rules on the wall.

When they have completed the task, go around the room asking one person from each group to describe their difficult situation.

Stick the cards on Flipchart 4, grouping similar cards together.

FLIPCHART 4

>> Difficult situations for health workers in providing services to adolescents living with HIV



Summarize the situations described on the cards and allow some time for discussion.

Thank the participants for identifying these difficult situations.

Say:

In the concluding session, we will review this flipchart and decide if these difficult situations have been addressed during the day. If not, we will address them at that time.

Put up Flipchart 4 on the wall in a place where all participants can view it.

Tip for you

- The facilitators need to review the list and decide if these situations or issues will be discussed during the day. When these issues do come up during the day, refer back to the situations that participants have expressed/summarized on Flipchart 4.
- If there are issues that will not come up, plan to add some details to a scenario or check if there is information on these situations in the Manual. These references can be given to the participants in the concluding session.
- If there are difficult situations that will not be addressed during the day or are not addressed in the Manual, plan how you will respond to participants when the list is reviewed in the concluding session.



Ask the participants to turn to the Key points at the end of Section 3 in their Manual.

Read aloud (or summarize):

KEY POINTS OF SECTION 3

1. Adolescents living with HIV differ from adults and children living with HIV because of the rapid changes that occur during this stage of development.
2. Adolescents also differ from each other. Adolescents of the same age may differ in their physical, psychological (thinking patterns and emotions) or social development.
3. There are many developmental differences between a younger adolescent of 10 years and an older adolescent of 18 years, which have implications for their needs and capacities.
4. Health workers need to understand these differences and take them into consideration in the prevention, care, treatment and support of an adolescent living with HIV.
5. Adolescents may behave in ways that health workers can find challenging. Knowing the changes that occur during adolescence can help health workers deal with difficult situations and understand adolescent behaviour in the context of the individual's phase of development.

Say:

We will now have the mid-morning break.

4

Session 4:

Adolescents living with HIV and health services

Mini lecture / Plenary discussion / Brainstorming / Individual exercise
(45 minutes)

Read aloud:

LEARNING OBJECTIVES

- to discuss the different needs of the two groups of adolescents living with HIV;
- to discuss how adolescents living with HIV first come to health services and what may prevent or encourage their return.

Mini Lecture:

HIV transmission periods for adolescents: Perinatal or adolescence

Say:

A number of differences between individual adolescents who are living with HIV have been discussed.

However, it is important to be aware of two specific groups of adolescents living with HIV (defined by the mode of transmission), whose needs may differ significantly. These two groups are:



Adolescents who acquired HIV perinatally, during pregnancy, labour and delivery or postpartum through breastfeeding.

These adolescents may have been attending paediatric services since infancy, may be familiar with health services and have known their HIV diagnosis for many years.

A small percentage of perinatally infected adolescents, the “slow progressors”, may only come to the attention of health services when they are adolescents.

The other group includes:



Adolescents who acquired HIV during adolescence, usually through unprotected sexual intercourse or injecting drug use, or less frequently through an HIV-positive blood transfusion or sharing instruments used for tattooing or skin piercing.

These adolescents may have only recently learnt of their HIV diagnosis and generally have not had long contact with health services.

Most adolescents come to health services because they feel unwell.

Many adolescents who acquired HIV during adolescence would be in WHO Clinical Stage 1 or 2 of the disease and may not yet feel unwell or need treatment. Many of them may not even know that they are infected with HIV.

However, it is important that these adolescents make contact with health services so that they can receive prevention, care, treatment and support education.

Say:

Please open your Manual to the table “Differences between two groups of adolescents living with HIV based on the transmission period (perinatal or adolescence)” in Section 4.2.3.

This table highlights some of the most common differences between the two transmission groups. These are generalizations and may not refer to all adolescents, but they can help us think about differences that have implications for needs and responses.

Go over the table briefly and the “Note” on the following page.

Differences between two groups of adolescents living with HIV based on transmission period (perinatal or adolescence)

Differences relating to:	PERIOD WHEN ACQUIRED HIV	
	PERINATAL	ADOLESCENCE
AGE	<ul style="list-style-type: none"> Younger: early adolescence 	<ul style="list-style-type: none"> Older: usually over 15 years
PHYSICAL DEVELOPMENT	<ul style="list-style-type: none"> Delayed: shorter stature 	<ul style="list-style-type: none"> Normal development
SEXUAL AND REPRODUCTIVE HEALTH	<ul style="list-style-type: none"> Not yet sexually active Thinking about sex Sexual debut 	<ul style="list-style-type: none"> Sexually active Need to change risk behaviour(s) Wanting children
RELATIONSHIPS/MARRIED	<ul style="list-style-type: none"> No/maybe Wanting intimate relationship 	<ul style="list-style-type: none"> Probably in sexual relationship May want marriage
DISCLOSURE	<ul style="list-style-type: none"> To adolescent, if he/she does not yet know the diagnosis Peers 	<ul style="list-style-type: none"> New diagnosis Disclosure to partner, family, peers Asymptomatic, which can reinforce denial
FAMILY SUPPORT	<ul style="list-style-type: none"> Orphan Living with caregivers 	<ul style="list-style-type: none"> Support depends on disclosure Few resources (such as money, information, experience)
ANTIRETROVIRAL THERAPY	<ul style="list-style-type: none"> Yes Adherence may be a problem as an adolescent, not as a child 	<ul style="list-style-type: none"> Probably not yet needed When taking ART: adherence may be a problem
STIGMA/“BLAME” FOR HIV	<ul style="list-style-type: none"> Less likely 	<ul style="list-style-type: none"> More likely

Note: The purpose of this table is to highlight some of the most common differences between the two transmission groups. These are generalizations and may not refer to all adolescents.

Ask if there are any questions and then move on.

Say:



Throughout this course, we will need to consider the different needs of each of these two groups of adolescents living with HIV.

The HIV transmission pattern can determine how and when an adolescent first comes in contact with health services and how this influences their feelings and needs.

Plenary discussion and brainstorming: Adolescents living with HIV seeking health services

Tip for you

- Begin with the warm-up described below to get the participants talking about adolescents living with HIV (of both transmission groups) who attend their health centres.
- Do not spend a long time on this. The purpose is to identify the expertise in the room, to get the participants thinking about the current situation and to understand that the number of adolescents coming to their clinic may increase, and why.
- They may say that they do not have adolescents coming to their clinics. If so, talk about why it is likely that there will be adolescents in the future.

Say:

How many of you had an adolescent patient living with HIV attend your clinic in the past few weeks? Please raise your hand.

Ask one participant:

How many adolescents living with HIV would you estimate attend your clinic?

How many of them acquired HIV perinatally and how many acquired HIV as adolescents?

Ask another participant:

Then **Say:**



We anticipate an increasing number of adolescents living with HIV coming to health centres in the future. This can be attributed to four factors:

1. With successful ART and care, more children with perinatally acquired HIV are surviving to adolescence.
2. More adolescents are being tested for HIV, as a result of factors such as: provider initiated testing, increased awareness, more testing being available, and increasing availability of antiretrovirals (ARVs) providing a reason to be tested.
3. More adolescents who are pregnant are being tested as services for preventing mother to child transmission (PMTCT) become more widely available.
4. As the stigma of living with HIV lessens and the understanding of HIV increases, more adolescents will come for testing, treatment and care.

It is important that we plan for this increase.

Ask if there are any comments and then move on.

Say:

Now we will discuss how adolescents living with HIV seek health services.



Put up Flipchart 5 and ask a volunteer participant to come and help you.

Ask the volunteer to read the question aloud.

Then lead a brainstorming session.

Ask the volunteer to write down the responses from the other participants.

FLIPCHART 5

>> How do adolescents living with HIV make their first contact with health services?

Remind them to consider the needs of the two different groups of adolescents living with HIV (perinatal and adolescent).

Give examples if necessary, such as: voluntary testing and counselling, feeling unwell, pregnant, well but concerned about HIV, brought to the clinic after the death of their mother.

Thank your volunteer.

Then put up Flipchart 6 and ask another volunteer participant to come and help you read the question and write the responses.

FLIPCHART 6

>> What makes it easier for the adolescent living with HIV to return to health services?



Lead a brainstorming session on this flipchart.

>> Adolescent

>> Health worker

>> Health service

>> Other factors (e.g. parents, guardians, peers)

Point to the appropriate cards when participants make a suggestion and

Say:

Yes, that point relates to the adolescent/health worker/health service, etc.

Examples: Health workers trained to respond to the special needs of adolescents, accurate information and materials, peer counsellors and support, support and disclosure to family, community outreach services.

Thank your volunteer and then ask another participant to come and help you.

Put up Flipchart 7

FLIPCHART 7

>> What makes it *harder* for the adolescent living with HIV to return to health services?



Lead a brainstorming session on this flipchart.

Say:

Some of these points can be the opposite of those on Flipchart 6. However, can you think of some that are different?

Examples: Finances, travel distance, lack of support, secrecy of diagnosis, services that are not “adolescent-friendly”, stigma, misinformation, lack of follow-up.

Once again, point to the appropriate VIPP card when participants make a suggestion and

Say:

Yes, that point relates to the adolescent/health worker/health service, etc.

Conclude the activity by summarizing the points made and then asking the adolescent EPT for comments.



Adolescent expert patient trainer

- What helped you return to the clinic?
- What do you think stops adolescents from returning to health services?
- Encourage the EPT to mention the importance of peer support and the involvement of young people living with HIV in service provision.

Say:

We will now review the key points of Section 4 and then do an individual activity to complete Session 4.



Ask the participants to turn to the Key points at the end of Section 4 in their Manual.

Read aloud (or summarize):

KEY POINTS OF SECTION 4

- 1. Based on the transmission period, there are essentially two main groups of adolescents living with HIV:**
 - adolescents who acquired HIV perinatally
 - adolescents who acquired HIV as adolescents.
- 2. There are differences between these two groups that determine how and when an adolescent first visits the health services, and their feelings and needs.**
- 3. Factors related to the health worker or the health services may encourage or discourage an adolescent from returning. It is important to consider how to encourage adolescents living with HIV to return to the health centre for treatment, care and support.**
- 4. Peer support at the clinic is important for adolescents living with HIV. Peers have experience in coping with HIV and can offer practical and appropriate help on how to live positively.**

Individual exercise:

Identifying changes to improve services for adolescents living with HIV

Say:

Now we will do an individual exercise.

Think about the place where you work.

Think about the points identified on Flipcharts 6 and 7.

Say:



Turn to Annex 3 in your Manual.

Ask a volunteer to read the task aloud.

Identifying changes to improve services for adolescents at my health centre

Write down:

1. Three reasons why an adolescent living with HIV may be reluctant to return to my health centre:
 - i.
 - ii.
 - iii.
2. At least three changes that I could *realistically* make that would encourage adolescents to visit/return to my health centre:
 - i.
 - ii.
 - iii.

Give them a few minutes.

Say:

You will not be asked to share what you write, but you can use these ideas in the individual action plan that you will prepare in the concluding session.

Ask if anyone has any comments.

If there is time **Say:**



Are there any changes that have already happened, or are happening at your health centre with the aim of encouraging young patients to visit?

Would anyone like to briefly share these experiences?

Refer participants to the “Characteristics of adolescent-friendly health services” box in Section 4.5 of the Manual.



Use one of the prepared energizers here.

5

Session 5:

Introduction to using the *Adolescent job aid*

Plenary presentation and discussion
(30 minutes)

Read aloud:

LEARNING OBJECTIVES

- to provide an overview of the *Adolescent job aid*
- to outline the section of the *Adolescent job aid* that focuses on HIV.

Turn to Annex 4 of this Guide to the excerpts from the *Adolescent job aid*.

Plenary presentation and discussion:

Overview of the *Adolescent job aid* and its use in providing services to adolescents living with HIV



Ask participants to open their Manual to Annex 4: Excerpts from the *Adolescent job aid*.

Say:

The *Adolescent job aid* has been developed by WHO as a desktop reference for health workers to assist them in dealing with questions that adolescents or their accompanying adult frequently ask, by using algorithms.

We will review this briefly now and you can read it in detail later.

- Look at the table of contents and the types of questions that are included in Part 2. Point out the headings of Part 3 including the section on sexual activity.
- Briefly go over the headings in the Introduction.
- Explain HEADS and read through the questions.
- Turn to the algorithm “Could I have HIV?”
- Lead the participants through the HIV algorithm, beginning with the column headings and explaining how to use this as an algorithm.
- Explain that all the problems in Part 2 have a similar structure.
- Respond to any questions.

Read aloud (or summarize):

THE ADOLESCENT JOB AID

- is a handy desk reference to enable health workers to respond to their adolescent patients more effectively and sensitively;
- has a section dealing specifically with the question “Could I have HIV?” and also includes a number of sections dealing with sexual and reproductive health issues, in general;
- provides health workers with tips about taking a history and examining an adolescent patient;
- includes information that should be provided to adolescents and their accompanying adult.

6

Session 6:

Communicating with adolescents

Group work / Plenary discussion
(30 minutes)

Read aloud:

LEARNING OBJECTIVES

- to review basic counselling skills and discuss the special counselling needs of adolescent patients;
- to identify important points for successfully communicating with adolescents.

Group work and plenary discussion: Communicating successfully with adolescents

Ask the participants to open their *IMAI Acute care* guideline module at the section “Advise and counsel”.

Remind them that basic counselling skills are part of IMAI training and important for successfully communicating with any patient.

Say:

We will now review the IMAI list of basic counselling skills keeping an adolescent patient in mind. Please look at the section “Advise and counsel” and consider what we have discussed this morning about the needs of adolescents.

Read through each of the five sections on your own (clinical situations, elements of basic counselling, useful tools for counselling, the counsellor’s role, and when working with patients). Consider which points are particularly important for an adolescent living with HIV.

Give them a few minutes to work alone.

Put up Flipchart 8 and ask for some examples.

FLIPCHART 8

>> When counselling adolescents living with HIV it is particularly important to:

Allow some time for discussion.

Refer to the other flipcharts when possible if there are links.

Say:

Good communication is a core component of counselling. The health worker's manner of communicating with the adolescent will play an essential part in determining whether the adolescent will listen to or act on the information. Health workers may need to examine their attitudes, values and manner of communicating to work successfully with adolescents.

We will now discuss what health workers should *do* or *avoid* doing to facilitate good communication with adolescents.



Divide the group of participants into pairs.

Give each pair two different-coloured VIPP cards (e.g. one blue and one yellow card if available, or use different coloured pens).

Say:

Discuss together with your partner and then write a “do” that health workers should consider when communicating with adolescents on one colour card (e.g. blue) and on the other card (e.g. yellow) an “avoid”, something that health workers should avoid when communicating with adolescents.

Put up the two cards on two flipcharts, a blue one with “**Do**” written on it and a yellow one with “**Avoid**” written on it to remind them which card to use.

FLIPCHART 9

>> What to do when communicating with adolescents?

Do (on blue VIPP card)

FLIPCHART 10

>> What to do when communicating with adolescents?

Avoid (on yellow VIPP card)

Give them a few minutes to complete the task.

Tip for you

- > If there is time, ask the participants to briefly present their own cards and stick them on the flipchart. Try and get people to group similar cards together.
- > If time is short, you can gather all the cards and present them yourself, or ask two participants to present them with you.

The following table is from Section 6 of the Manual. Participants do not need to look at it now. However, the facilitator should bring up any important points in this table that are missed by participants, at the end of the session.

What to *do* and what to *avoid* when communicating with adolescents

DO	AVOID
<ul style="list-style-type: none"> ■ Be truthful about what you know and what you do not know 	<ul style="list-style-type: none"> ■ Giving inaccurate information (to scare them or to make them “behave”)
<ul style="list-style-type: none"> ■ Be professional and technically competent 	<ul style="list-style-type: none"> ■ Threatening to break confidentiality “for their own good”
<ul style="list-style-type: none"> ■ Use words and concepts which they can understand and relate to. Assess if they understand ■ Use pictures and flipcharts to explain 	<ul style="list-style-type: none"> ■ Giving them only the information that <i>you</i> think they will understand ■ Using medical terms they will not understand
<ul style="list-style-type: none"> ■ Treat them with respect in terms of how you speak and how you act 	<ul style="list-style-type: none"> ■ Talking down to them, shouting, getting angry, or blaming them
<ul style="list-style-type: none"> ■ Give all the information/choices and then help them decide what to do 	<ul style="list-style-type: none"> ■ Telling them what to do because you know best and they “are young”
<ul style="list-style-type: none"> ■ Treat all adolescents equally ■ Be understanding and supportive even if you do not approve of their behaviour 	<ul style="list-style-type: none"> ■ Being judgemental about their behaviour, showing disapproval, or imposing your own values
<ul style="list-style-type: none"> ■ Accept that they may choose to show their individuality in dress or language 	<ul style="list-style-type: none"> ■ Being critical of their appearance or behaviour, unless it relates to their health or well-being

When all the cards are ready, summarize what the participants have identified. Acknowledge that some of these points apply to successfully communicating with *any patient*. Ask them which of the points specifically apply to communicating with an *adolescent patient*. Mark these cards.

Highlight the importance of the attitudes and values of the health worker in effectively communicating with the adolescent.



Refer the participants to the box in Section 4.6 (Characteristics of the health worker in AFHS) of the Manual; ask them to read it later.

Say:

As we saw in Section 5, the *Adolescent job aid* has more information on this, i.e. on how health workers can manage their relationships with adolescents and their parents/guardians and how to organize the clinic.



Adolescent expert patient trainer

- Do you remember a particular occasion when a health worker communicated with you in a manner that helped you to understand or cope with a difficult situation?
- Do you remember a particular occasion when a health worker communicated with you in a manner that was not helpful?
- Again, it will be important to mention the role of peers in communicating with adolescents living with HIV about prevention, treatment and care.



Ask the participants to turn to the Key points at the end of Section 6 in their Manual.

Read aloud (or summarize):

KEY POINTS OF SECTION 6

- 1. Good communication is an essential component of counselling.**
- 2. Health workers may need to examine their attitudes, values and manner of communicating to work successfully with adolescents. As with all people, adolescents need to be treated with respect so that they act on the information given to them.**
- 3. Adolescents may find that their peers are better able to give them support and offer practical and appropriate advice on living with HIV. Health workers should assist in the training of peer educators, and help peer educators to start support groups for adolescents living with HIV.**

Say:

We will now break for lunch.

7

Session 7: _____

Prevention and support for adolescents living with HIV

**Brainstorming / Group work / Plenary discussion / Mini lecture
(45 minutes)**

Read aloud:

LEARNING OBJECTIVES

- to identify questions and discuss issues that are important for adolescents living with HIV;
- to identify prevention priorities and support that health workers can provide to adolescents living with HIV.

Tip for you

- > Remove the blank flipchart on the top half of Sheet II of the *IMAI wall chart* to uncover the first box (Special challenges in providing prevention, care, treatment and support for adolescents living with HIV).
- > Use the wall chart as a prompt during sessions 7 and 8.

Point to the wall chart and **Say:**

In this session, we will discuss the special challenges in providing the two groups of adolescents living with HIV with prevention and support services. These include:

- beneficial disclosure
- positive prevention (including sexual and reproductive health)
- consent and confidentiality
- living with a chronic condition
- development delays
- transition of care
- ART and adherence.

The last three points are particularly important for adolescents with perinatally acquired HIV and are further discussed in the next session.

Brainstorming:

Important questions asked by adolescents living with HIV

Say:

To identify the prevention and support that adolescent's need, we will now think of the questions asked by adolescents living with HIV.

We will begin with a brainstorming activity.

Put up Flipchart 11.

FLIPCHART 11

>> Important questions asked by adolescents living with HIV

Say:

What are the questions that an adolescent living with HIV may want to ask a health worker?

Consider questions adolescents may want to ask but may be too afraid or embarrassed to raise.

Also, consider the questions that each group of adolescents may want to ask (those who acquired HIV perinatally and those who acquired HIV as adolescents).

Remember to think of questions that may raise special concerns for adolescents and that are different from adults' questions and concerns.

Think of real questions that relate to how adolescents can live their lives with HIV.

There are no wrong answers.

Give them a few minutes to complete the task.

Tip for you

- > As participants respond, write their questions on Flipchart 11.
- > As you write, decide how many small groups you will have for the next part of the session.
- > Try to group the questions so that there are 6–8 groups of similar questions, depending on the number of groups of participants you will have.

Continues...

Tip for you *(continued)*

- Make sure the participants have raised questions that address most of these important issues:
 - adolescents' sexuality, wanting to have sex, wanting to have a baby, marriage
 - fear of dying, mental health issues, stigma
 - prevention for positives, living with HIV
 - disclosure
 - confidentiality, consent to treatment for minors.
- If these issues are not addressed, prompt participants to think of new questions on these issues. Prompt: "Do you think the adolescent would be concerned about...? What might be their question?"
- When there are no new questions, review the list on the flipchart and give each question (or group of similar questions) a number.
- Circle the question(s) and write a number beside the question or group of questions.

Group work:

Responding to adolescents' questions

Divide the participants into small groups (the same number of groups as you have questions/ groups of questions).

Give each group one question (or a group of similar questions) from Flipchart 11.

Put up Flipchart 12 and read the questions aloud.

FLIPCHART 12

>> Responding to questions from adolescents living with HIV

1. *How can health workers respond to this question?
What can they say and do?*
2. *Who else is needed to respond to this question?
What can they do?*

Say:

Each group should discuss the points on Flipchart 12 and consider how to respond to the question or group of questions that you have been given.

Jot down your responses and choose one person to report back.

You have five minutes.

When the time is up, ask the rapporteur from each group to briefly report back, responding to the points on Flipchart 12.

Give them a few minutes to complete the task.

Tip for you

- **Some questions may provoke a lot of discussion while others may be more straightforward. Allow for some discussion but keep to the time (10–15 minutes) and suggest writing any contentious issues or unresolved questions on the “Come Back to Later” board.**



Adolescent expert patient trainer

- What question(s) did *you* think was the most important to ask the health worker?
- Were you able to ask your question(s)?
- Were you satisfied with the response(s) you got?

After the discussion has come to a close, inform participants that there is more information in Section 7.2 (Important questions asked by adolescents living with HIV) of their Manual.



If there is time, reflect on the similarities of the questions in the Manual and those identified by the participants. If there are any questions included in the Manual that did not come up during the discussion, you can draw the participants' attention to these now. Tell them there is space in their Manual to add any other questions that arise in the discussion.

Plenary discussion:

Beneficial disclosure

Refer to one of the questions on beneficial disclosure identified on Flipchart 11.



Ask participants to turn to the Key points on beneficial disclosure in Section 7.3 of their Manual.

Give them a few minutes to review this section and raise any questions or comments that

Read aloud (or summarize):

KEY POINTS ON BENEFICIAL DISCLOSURE

- 1. Support from family or a guardian is particularly important for adolescents because they are still young, inexperienced and usually still close to their family.**
- 2. Health workers can help adolescents understand the benefits of disclosure and also practice how and when to disclose to selected family members and close friends.**
- 3. Health workers can help adolescents understand the importance of disclosure through counselling and peer support groups.**
- 4. Adolescents with perinatally acquired HIV are able to cope better if they were told about their HIV status at a young age.**
- 5. Health workers need to be aware that there is a risk when disclosing HIV status in an unsupportive setting, in particular for young women who may be at risk of domestic violence.**
- 6. Involving adolescents living with HIV who have already successfully disclosed their status may be helpful in working through the challenges of beneficial disclosure with adolescents thinking about disclosing their HIV status.**

Mini lecture and plenary discussion:

Positive prevention

Say:

Section 11 of the *IMAI-IMCI Basic HIV care with ART and prevention* guideline module (page H67) presents positive prevention for all people living with HIV, including adolescents. We will now focus on the issues that are particularly important for adolescents living with HIV.

Prevention by HIV-positive young people includes all strategies that increase self-esteem, motivation and confidence, with the aim of protecting their own health and avoiding transmission of HIV to others, or becoming re-infected. Successful prevention by HIV-positive adolescents requires their meaningful involvement in the planning and implementation of HIV strategies and policies.

Many of the important issues in prevention for adolescents living with HIV reflect the challenges of everyday behaviour related to adolescent development. One important aspect of adolescent development is sexual development.

This course does not encourage adolescents to be sexually active, and health workers should not assume that adolescents are either sexually active or inactive. This course does encourage health workers to remain non-judgemental on the sexual choices that adolescents make, while strongly promoting “safe sex”.

Statistics on adolescent pregnancy and sexually transmitted infection rates confirm that many adolescents are sexually active.



General points on adolescence and sex

Say:

- Adolescence is usually the time when sexual activity is initiated, as adolescents explore relationships and look for emotional intimacy.
- Globally, puberty is occurring earlier and in many countries adolescents are having sex for the first time at a younger age than previous generations. Worldwide, people are having sex for the first time at an average age of 17.7 years. **(Refer to any national studies/statistics that give information on sexual debut, if available.)**

continues



(continued)

- Social and cultural factors, and not just unavailability or lack of knowledge, influence whether young people use condoms.
- The age difference between adolescent girls and older sexual partners is significantly associated with unprotected sexual activity – the larger the age-gap the less likely it is that condoms will be used.



Adolescents living with HIV and sex

Say:

- People who are living with HIV do not lose their desire to have sex and bear children. Health workers need to be able to respond to the sexual and reproductive health needs of adolescents living with HIV in a non-judgemental manner.
- Peer support groups can help adolescents to access practical and appropriate information on living with HIV and provide them with the support that they need to live positively. Health workers have a role in helping to start such groups, and in linking adolescent patients with existing peer support groups.



The two groups of adolescents (determined by the transmission periods) may have different concerns about sex:

- Perinatally infected adolescents may not yet be sexually active but may be planning to and may have questions related to having sex.
- Those who acquired HIV as adolescents are probably already sexually active, and are now having to consider the implications of their diagnosis on their sexual activity.

Health workers must be prepared to discuss sexual and reproductive health options with these adolescents.



Prevention by positives is especially important with adolescents who are injecting drug users. (See *IMAI-IMCI Basic HIV care with ART and prevention* guideline module (page H62) for special interventions for injecting drug users.)



Education tools for the health worker to use with adolescent patients include:

- *Reproductive choices and family planning for people living with HIV: Counselling tool;*
- *IMAI Flipchart for patient education* – Section 3 on positive living and pages on the adolescent patient (1–12 and 1–13). The images in the flipchart may be more memorable for adolescents;
- Information on counselling on reproductive choices in the *IMAI-IMCI Basic HIV care with ART and prevention* guideline module (page H69).

Tip for you

- Take the paper off the second half of Sheet II of the *IMAI wall chart* and show the “Discussion points on sex for adolescents living with HIV”.
- Ask two participants to read them aloud, one line each.

Discussion points on sex for adolescents living with HIV

1. Do not feel rushed into having sex.
2. If you have not yet had sex, consider delaying it. Do not begin a sexual relationship until you are ready. Talk together and agree on the limits of your physical intimacy.
3. If you are with a new partner, find other safer ways of giving each other pleasure until you are ready to have sex in this relationship. Enjoy other activities together.
4. When you have sex, **use a condom correctly every time**, even if your partner is also HIV-positive. Condoms prevent HIV transmission and also prevent unplanned pregnancy.
5. Drinking alcohol and substance use increase the risk of unplanned and unprotected sex.
6. Avoid situations or people that may put you at risk of unwanted sex.
7. Reduce the number of people with whom you have sex.
8. Consider disclosing to trusted people that you are living with HIV, so that they can support you.

Allow some discussion on these points, but do not let the discussion continue for too long.



Adolescent expert patient trainer

- Do you think these messages are appropriate for adolescents?
- Is there anything you would change or add?
- Do you think adolescents will be able to follow these messages?



Life skills

Say:

Another important part of normal adolescent development is learning life skills. Life skills include problem solving, critical thinking, communication, interpersonal skills, resolving conflict and coping with emotions. These skills help adolescents to develop positive mental health and assist in dealing with the challenges of being an adolescent and living with HIV.

Health workers cannot teach adolescents the full range of life skills but should know where life skills are taught in the community, so that they can refer adolescents living with HIV to them and support the programmes.

Teaching life skills that relate to specific health issues (e.g. discussing how to delay sexual debut, how to negotiate safer sex, the importance of using condoms, and how to use male and female condoms correctly) is part of the health worker's responsibility.



Ask participants to turn to the Key points at the end of Section 7.4 of their Manual.

Read aloud (or summarize):

KEY POINTS ON POSITIVE PREVENTION

Successful prevention for adolescents living with HIV requires their meaningful involvement in the planning and implementing of HIV services and policies.

- 1. Adolescents living with HIV do not lose their desire to have sex and children. Health workers need to be able to discuss sensitive issues with them in an informative and non-judgemental manner.**

- 2. The two different transmission groups of adolescents may have different concerns about sex, depending on whether they are already sexually active or are planning to be sexually active.**
- 3. Prevention is especially important for adolescents living with HIV who are injecting drug users. Adolescent injectors need access to harm reduction programmes and information on safer sex.**
- 4. Peer support groups can help adolescents access practical and appropriate information on safer sex, and provide support for living with HIV positively.**
- 5. Adolescents need access to condoms. They also need information and negotiating skills to ensure that they use condoms correctly and consistently.**
- 6. Adolescents living with HIV may express feelings of anger and depression. The health worker can help them talk about their feelings and refer them to other services as necessary.**

Ask if they have any questions and respond as necessary.

Plenary discussion:

Consent and confidentiality

Point to the questions on Flipchart 11 that relate to consent and confidentiality.

Give them a few minutes to discuss the questions, including any experiences that they have had and any solutions that they would propose.



Ask the participants to turn to the Key points at the end of Section 7.5 in their Manual.

Read aloud (or summarize):

KEY POINTS ON CONSENT AND CONFIDENTIALITY

- 1. Ideally, until the age of majority, an adolescent should be accompanied by a responsible adult who can give their consent for treatment and provide subsequent support. This is not always possible and may also be contrary to the wishes of the adolescent.**
- 2. It is important for health workers to know if there are national or local laws**

on consent to treatment for minors. However, the laws may not explicitly state the age for independent access to HIV treatment or care.

3. In some countries, the law states the age at which adolescents are judged competent to decide for themselves. Where there are no laws, health services may develop their own protocols, based on the best interests of the child and a minor's evolving capacities to make decisions about things that affect their lives.
4. Most legal systems recognize "mature minors" (e.g. married adolescents) as having adult rights for medical consent.
5. Maintaining confidentiality is an essential skill for all health workers and a key component of adolescent-friendly health services. Unfortunately, many adolescents do not think that they have access to confidential care. As for all people, confidentiality for adolescents should be respected.

Say:

There is more information in Section 7.5 of the Manual under "Evolving capacities and competence", and "Best interests".

Mini lecture and plenary discussion: Developmental delays

Say:

Adolescents who acquired HIV perinatally may present with slow skeletal growth and delayed pubertal maturation. This is due to the affect that HIV has on metabolic and endocrine functions. This delay in growth and sexual maturation may also have an impact on the psychosocial development of the adolescent concerned.

These delays are common among adolescents who acquire HIV perinatally, and may cause them feelings of frustration and anger because they look different from their HIV-negative peers.

Provide some brief time for discussion. Ask the participants if any of them would like to share their experiences of responding to adolescents' concerns about developmental delays.



Ask the participants to turn to the Key points at the end of Section 7 in their Manual.

Read aloud (or summarize):

KEY POINTS OF SECTION 7

- 1. Adolescents living with HIV have many concerns and questions that relate to:**
 - acceptance of their diagnosis
 - disclosure of their diagnosis
 - feelings of isolation and stress
 - coping with HIV in addition to the normal challenges of adolescence.
- 2. The health worker should:**
 - listen carefully to their questions and answer them respectfully
 - provide them with support and appropriate information
 - assist them to access existing sources of support through linkages and referrals
 - encourage them to learn life skills that will help them live positively
 - help set up new support groups and services.

8

Session 8:

Treatment and care for adolescents living with HIV

Mini lecture / Plenary discussion / Brainstorming
(45 minutes)

Read aloud:

LEARNING OBJECTIVES

- to present aspects of treatment and care that are of particular importance to adolescents living with HIV.



Adolescent expert patient trainer

- Depending on the experiences of the adolescent EPTs (and the time available), you may ask them to briefly tell participants about their personal clinical story during this session.
- Plan before the course who will speak and when.

Mini lecture: Clinical status when entering care

Say:

The two groups of adolescents (those who acquire HIV perinatally and those who acquire HIV during adolescence) will probably differ in their clinical status when they enter care.

Adolescents with perinatally acquired HIV are likely to have been receiving treatment and care from an early age.

However, those who acquired HIV as adolescence are likely to visit the health centre either because they are unwell and experiencing the symptoms of immune dysfunction, or because they have been referred or have concerns following a positive HIV test, in which case they may still be asymptomatic.

We will discuss these differences in the clinical status of the two groups of adolescents when they enter care.



Perinatally acquired HIV

Say:

Adolescents who acquired HIV perinatally are emerging in increasing numbers, particularly in countries where paediatric services exist and ART for children has been rolled out. As treatment becomes more widely available, there will be a steady growth in the number of babies perinatally infected with HIV who survive into adolescence.

continues



(continued)

They may have begun ART during early childhood because of rapid progression of HIV disease, and may have experienced various ART regimens by the time they reach adolescence.

A small number of the babies who are born with HIV will remain asymptomatic and will survive to adolescence without any treatment (although they are likely to experience developmental delays). These are known as “late progressors”.



HIV acquired during adolescence

Say:

Those who acquire HIV during adolescence are generally asymptomatic for many years following infection, and many may remain unaware of their HIV status.

Asymptomatic period

- For adolescents who acquire HIV after puberty, the infection can remain asymptomatic for a longer period of time than in adults. There appears to be an inverse correlation between age at infection and the length of the asymptomatic period: the younger the age at infection (after puberty), the longer the virus remains asymptomatic.
- They will usually enter care services without symptoms but with moderate immune dysfunction. They may present with problems common to their age group that are occurring more frequently or more severely than expected, for example respiratory tract infections.
- They are more likely to be in WHO Clinical Stage 1 or 2, and therefore not require ART. But they will require care, support and preparation for future treatment.



HIV transmission pattern

Say:

The HIV transmission pattern is an important factor in determining:

- **when** the adolescent enters clinical care (as discussed in Session 4, which dealt with adolescents' initial contact with health services);
- **their clinical status** when they enter care;
- **the health problems** they present with when they enter care.

The HIV transmission pattern is an important factor in determining:

- their general health;
- their nutrition;
- the socioeconomic conditions in which they live;
- other infectious diseases prevalent in their community (e.g. tuberculosis, STIs).

Say:

We will now discuss the other challenges in providing treatment and care for adolescents living with HIV (**point to the wall chart**).

- transition of care
- ART and adherence
- living with a chronic condition.

These are challenges faced by adolescents once they need treatment and care. Although adherence and living with a chronic condition are challenges that apply to all people living with HIV, they may be particularly problematic for adolescents living with HIV.

Mini lecture: Transition of care

Say:

Adolescents who acquired HIV infection perinatally will usually have attended paediatric clinics for many years. These clinics may not be able to provide care for them after they reach a certain age, and this transition from the care with which they are familiar to an adult care setting may be a difficult time for an adolescent. The changes have implications for the health workers and of course for the adolescents and their caregivers, since the adolescents now have to start taking more responsibility themselves for things such as adherence.

There are differences between paediatric and adult care models, and in resource-poor settings there are few health facilities that are set up to specifically serve adolescents living with HIV. However, it is possible for adolescents to receive adolescent-friendly services within adult or paediatric clinics. The success of such services depends on the attitudes of health workers towards adolescents, their understanding of adolescents' special needs and the organization of the clinic.

Tip for you

Remind them they can read more later in:

- ***Adolescent job aid*: Part 1 on organizing the clinic to better meet the needs of adolescents;**
- **Manual: Section 8.2.1 on transition from paediatric care and Section 4.5 on the important characteristics of adolescent-friendly health services.**



Ask the participants to turn to the Key points at the end of Section 8.2 of their Manual.

Read aloud (or summarize):

KEY POINTS ON TRANSITION OF CARE

- 1. Adolescents may not feel comfortable visiting either paediatric or adult clinics. There are few places where adolescent specific HIV clinics are available. However, it is possible for adolescents to receive adolescent-friendly services within adult or paediatric clinics, depending on the attitudes of health workers towards adolescents, their understanding of adolescents' special needs and the organization of the clinic.**
- 2. HIV-positive adolescents who were infected perinatally need adequate preparation and support from health workers while transitioning from the paediatric clinic to the adolescent or adult clinic.**

Plenary discussion:

Antiretroviral therapy

Say:

We will now discuss when to begin ART for an adolescent patient

Ask participants:

Please tell me the seven requirements in IMAI for initiating ART. (*IMAI-IMCI Basic HIV care with ART and prevention guideline module, page H25*)

Refer them to Section 8.3 of the Manual to review these requirements, if necessary.

Say:

With an adolescent patient, the health worker should be especially attentive to their:

- readiness for ART
- adherence preparation
- mental health (*more information in IMAI-IMCI Basic HIV care with ART and prevention guideline module, page H28*)
- needs for support.

Say:

We will now consider the choice of ARV regimen and dosing for the adolescent.

The choice of regimen and dosing (adult or paediatric) of ARVs should be based on the adolescents' physical maturity, using the Tanner scale as a proxy measurement.

Ask the participants to turn to Annex 2 (Tanner scale) of their Manual.

Tip for you

> The Tanner scale is in Annex 3 of this Guide.

Say:

We discussed the Tanner scale earlier during the adolescent development session of this course. We will now review it in more detail.

The Tanner scale defines physical measurements of development, based on external primary and secondary sexual characteristics.



Briefly review the stages and then **Say:**

1. Adolescents who are at Tanner scales 1, 2 and 3 are pre-pubertal, and should be treated with paediatric doses of ARVs. These patients require careful monitoring because this is the time of hormonal changes associated with the growth spurt.
2. Adolescents who are at Tanner scales 4 and 5 are post-pubertal and should be treated with an adult ARV dose.

However, in choosing an appropriate regimen there is a need to go beyond considering physical maturity. Simplification and anticipated long-term adherence are additional important criteria for selecting an appropriate first-line regimen for adolescents.

Ask participants:

What about consent to ART for adolescent minors?

Are there national policies or guidelines on consent to treatment for adolescent minors?

Give them some time for discussion.

Tip for you

- > If possible, know the national policy on consent to treatment for minors.
- > If appropriate, tell participants:
 - In some countries adolescents can give independent consent for reproductive health services if their capacities for understanding the implications of their decisions are considered to be sufficiently developed.
 - The Convention on the Rights of the Child recognizes adolescents' "evolving capacities" to make decisions about things that affect their lives.

Continues...

Tip for you *(continued)*

- The majority of legal systems recognize “mature minors” (e.g. married adolescents) as enjoying adult rights of medical consent.
- This means that most adolescents are able to give consent for the diagnosis and treatment of HIV infection.
- However, in general health workers would like parents/guardians to be involved with their adolescents’ treatment and care.

Ask:

If an adolescent needs to begin ART, can they begin treatment without the consent of their parents or guardian?

Encourage participants to discuss some advantages and disadvantages of entering into lifelong treatment without the knowledge or support of a parent or guardian. Enquire if any of the participants have personal experiences of dealing with consent issues related to adolescent patients that they would like to share with the group.



Ask the participants to turn to the Key points at the end of Section 8.3 of their Manual.

Read aloud (or summarize):

KEY POINTS ON TRANSITION OF CARE

1. There are seven requirements in IMAI to initiate ART at the health centre for all patients living with HIV. The requirements apply equally to adolescents.
2. The choice of regimen and dosing (adult or paediatric) of ART should be based on the adolescent’s sexual maturity rating using the Tanner scale. Those who are at Tanner scales 1, 2 and 3 should be given a paediatric regimen and those who are at Tanner scales 4 and 5 should be prescribed an adult regimen.
3. In choosing an appropriate regimen, there is a need to think beyond the Tanner scale. Simplification and anticipated long-term adherence are

further important criteria for selecting an appropriate first-line regimen for adolescents. With adolescents, the health worker should be especially attentive to:

- **readiness for ART**
- **adherence preparation**
- **mental health**
- **family and other support.**

Brainstorming:

Challenges in adherence to ART for adolescents

Say:

We will now do a brainstorming activity on the particular issues of maintaining adherence to ART for adolescents living with HIV.

IMAI training included the importance of adherence preparation, support and monitoring for ART for adults (if necessary refer them to *IMAI-IMCI Basic HIV care with ART and prevention* guideline module, Section 8.9, “ARV therapy: adherence preparation, support and monitoring”, pages H47–52)

Put up Flipchart 13 and read it aloud.

FLIPCHART 13

>> Factors that may improve adherence to ART for adolescents

Factors about the adolescent
(individual characteristics,
including their stage of
development)

Factors about their environment
(family, peers, health services,
community)

Say:

Think of the factors that could influence adherence to ART for an adolescent. Consider factors that relate to the adolescent (individual characteristics, including their stage of development) and factors that relate to their environment (for example family, peers and community).

Ask the participants to suggest factors; write them on the flipchart.

When the flow of suggestions slows down ask the participants for any comments.

Say:



Look at the lists and identify which of these factors health workers can address with adolescents.

Can you suggest any practical actions that health workers can take to address this and assist the adolescent with adherence to ART?

Write their suggestions beside the factors using a different colour pen.

Tip for you

Here are some factors that the participants may identify. They are in Section 8.4 of the Manual, but it is not necessary for participants to look at them now.

Factors that may *improve adherence* to ART for adolescents living with HIV

> The adolescent (individual characteristics and stage of development)

- access to information that corresponds to the adolescent's maturational stage;
- treatment tailored to the adolescent's stage of development;
- information communicated in a straightforward way;
- a relationship of trust and respect with health workers;
- ART adapted to the adolescent's lifestyle (e.g. will the adolescent take medication in school?);
- adolescents involved with and consulted on changes in treatment (therapeutic alliance).

Continues...

Tip for you *(continued)*

- > **Their environment (family, peers, health services, community)**
 - support of siblings, parents/guardians, peers, support group, treatment supporter;
 - consistent care and support from a range of sources over time;
 - regular assessment for side effects and adherence in an appropriate manner;
 - simplified therapeutic regimen;
 - access to support groups led by peers who have successfully implemented and adhered to ART themselves.

Mini lecture:

Living with a chronic condition

Say:

Health workers who care for adolescents with chronic conditions other than HIV (e.g. diabetes, asthma or haematological conditions such as sickle cell anaemia) find that the developmental changes that occur during adolescence can influence the course and management of these chronic conditions. These include poor adherence, disease control, planning and nutrition.

There are parallels between adolescents living with HIV and adolescents living with other chronic conditions, such as asthma or diabetes. For example, chronic conditions may be having or have already had an effect on the adolescents' development, such as on their growth and pubertal changes, and on their psychological development and socialization processes.

Health workers often find that young people who have been managing well with a chronic condition in childhood (when their parents or guardian took primary responsibility for their treatment and care) become "out of control" during adolescence. It can be the same for children who were infected with HIV perinatally – when they reach adolescence their adherence to care and treatment can deteriorate.

Those who acquire HIV as adolescents have problems coping with their new HIV diagnosis and the normal developmental challenges of adolescence. The normal stages of adolescent development and the adolescents' understanding and acceptance of their chronic condition will have an impact on how they manage their treatment and care.

Say:

As we have said before, adolescence is a time of rapid growth and significant psychological change. The management of any chronic condition during this time constitutes a major challenge for the individual, their family and the health-care team.



Ask the participants to turn to the Key points of Section 8.5 on living with a chronic condition in of their Manual.

Read aloud (or summarize):

KEY POINTS ON LIVING WITH A CHRONIC CONDITION

- 1. As with other chronic conditions (e.g. asthma, diabetes), normal developmental changes during adolescence can have an impact on the course and management of HIV (e.g. poor adherence, disease control, planning and nutrition).**
- 2. HIV may also have an effect on the adolescents' development, especially growth and pubertal changes, psychological development and socialization processes.**
- 3. Adolescents who had been managing well with HIV in childhood (when they were more compliant and under the care of their parents or guardian) may appear "out of control" during adolescence, when their adherence to care and treatment may get worse.**
- 4. Those who acquired HIV as adolescents, have the complication of coping with the new diagnosis of a chronic condition in addition to the normal developmental challenges of adolescence.**

Say:

We will now have the mid-afternoon break.



When you resume, use one of the energizers that you have prepared before starting the next session.

9

Session 9:

The 5 “A”s and the adolescent patient

**Group work / Plenary discussion (or role play)
(60 minutes)**

Read aloud:

LEARNING OBJECTIVES

- to review the 5 “A”s from IMAI and identify those issues that are particularly important for the adolescent patient living with HIV.

Tip for you

- > Decide whether you will ask the working groups to report back in plenary or as a role play. Note: the role play may take a little longer.
- > Your decision will depend on the time available and whether this course will include Optional Session C, which is also a role play activity.

Say:

Can you tell me the 5 “A”s? (*Assess, Advise, Agree, Assist, Arrange*).

Group work and plenary presentation (or role play): Using the 5 “A”s with an adolescent patient

Remove the second blank flipchart on Sheet I of the *IMAI wall chart* to uncover the second box. (The 5 “A”s and the adolescent patient living with HIV).

Say:

Remember, this is about the adolescent patient. The 5 “A”s are familiar to you but please think of all we have discussed today as we read through them. Use your adolescent perspective to see the importance of each bullet point.

Ask five participants to each read through one of the 5 “A”s on the *IMAI wall chart*.

Say:

Refer to Section 9 in your Manual, where there are more details on the steps of the 5 “A”s.

Ask if there are any questions or comments.



Divide the participants into groups of three. You can use an interesting method for grouping (e.g. by birth months, favourite food, colour of clothes).

Ask them to turn to Annex 5 of the Manual: “Scenarios using the 5 “A”s with an adolescent patient”.

Ask a volunteer to read the instructions in Annex 5.

Tip for you

> Instructions for group exercise for “Scenarios using the 5 “A”s with an adolescent patient”

Say:

For their specific scenario, each group should:

- identify the important issues in relation to each of the 5 “A”s that the health worker needs to consider for the adolescent patient in their scenario;
- keep the particular needs and challenges of the adolescent patient in mind while working on the scenarios;
- use the 5 “A”s on the *IMAI wall chart* for guidance;
- write the important issues on the flipchart under each “A”. For some “A”s there may not be a particular issue to address in your scenario;
- remember to focus on what is different because the patient is an adolescent

You have 15 minutes to work together and write your responses on a flipchart.

The facilitator will tell the groups to either report back to plenary, as a presentation (with a participant using the flipchart) or as a role play (with two participants in a role play).

Each group should prepare a flipchart regardless of the method they will use to report back.

Allocate one scenario to each of the three groups (choose three from the eight available scenarios – selection can reflect the difficult situations identified in Section 3.3).

Ask the participants to choose a presenter in each group. Or, if reporting as role play, they should choose two people to do the role play in each group, involving the adolescent EPT if possible.

Scenario 1: Mary

Mary is 17 years old. She has been married for one year. She went to the health centre two weeks ago for a follow up visit for contraception. The nurse told her that HIV testing was available at the clinic and asked her if she wanted to be tested. Mary talked with the nurse and decided she wanted to discuss HIV testing with her husband, Peter, who is a 25-year old farmer.

Last week Mary and Peter came back to the clinic for testing. Both Mary and Peter had positive HIV test results. They are both asymptomatic. Mary says she has come to the clinic today because she has been having bad headaches. After examination and discussion, it is clear to the health worker that the headaches are most likely related to the stress that Mary is feeling since she learnt about her diagnosis.

Tip for you

> Important issues that need to be addressed in Scenario 1

Mary needs post-test counselling and continued support to help her understand and cope with her diagnosis. The health worker could use the *Flipchart for patient education* to explain basic information about HIV.

Mary needs to understand what is available for chronic HIV care (see *IMAI-IMCI Basic HIV care with ART and prevention guideline module*, pages H80–H84)

- Assess Mary’s headaches.
- Assess her understanding of the diagnosis.
- Assure confidentiality – she may need reassurance of this.
- Advise on fertility (see *IMAI-IMCI Basic HIV care with ART and prevention guideline module*, page H69): She is very young and has no children (is there pressure on her to have children?).
- Offer partner counselling: Is it a supportive relationship or is there concern of domestic violence?
- Agree on disclosure: Discuss the benefits of telling family or friends her concerns.
- Assist with positive test counselling, positive living and dual protection (see *IMAI-IMCI Basic HIV care with ART and prevention guideline module*, pages H73–73).
- Arrange a follow-up visit, and referral to a support group.

Scenario 2: Franco

Franco is 15 years old. He has lived on the streets ever since he left home three years ago. He works with a small bus company. He likes his life and often hangs out with a group of friends. They like to drink cheap alcohol together and occasionally inject drugs. When they have the money they pay women for sex.

He came to the clinic because he had heard of AIDS and is concerned for his health. Today his test result shows that he is HIV-positive.

Tip for you

> Important issues that need to be addressed in Scenario 2

Franco's social situation (living on the street, substance use, client of commercial sex worker) is a major factor in planning his support and care. His situation and behaviour will not necessarily change with his HIV diagnosis. The attitude of the health worker is key to successfully communicating with Franco (such as being non-judgemental, not telling him what to do). He is a minor without a parent or guardian present.

Franco's personal concern for his health is an important entry point for behaviour change.

- **Assess his reaction to the new diagnosis of HIV.**
- **Assess his knowledge of HIV, his support network and his concerns about his health.**
- **Advise on positive prevention, relating to substance use, safe injecting and condom use.**
- **Agree on positive prevention.**
- **Assist with HIV information and support services, referring as necessary.**
- **Arrange a return visit.**

Scenario 3: Shanaz

Shanaz is 13 years old. She was born HIV-positive. Her mother died of AIDS when Shanaz was four years old and she went to live with her grandmother. Her grandmother now looks after eight children.

Shanaz knows she is HIV-positive and has been visiting the paediatric clinic since she was a baby, and is well known as a patient. She is still on first-line treatment and is doing well. Generally, she is quite healthy although she gets infections easily.

She has come to the clinic today because she woke this morning with blood between her legs and this frightened her. After examining Shanaz, the health worker can reassure her that this is her menarche.

Tip for you

> Important issues that need to be addressed in Scenario 3

Shanaz does not realize this is her menarche. She needs reassurance and practical information about reproduction. She needs to be prepared for her emerging sexuality. Her support network needs to be assessed (other family members, peer support).

Shanaz has come as an unaccompanied minor. Consider the best interests of this adolescent and encourage involvement of other supportive adults.

- Assess her knowledge of reproduction and sexuality.
- Assess adherence.
- Assess her support network, and encourage involvement of grandmother or others, as Shanaz wishes.
- Advise on maintaining general health (nutrition, hygiene, exercise, etc.).
- Advise on preparing for transition of care.
- Agree on disclosure; who else could/should know of her HIV diagnosis and can offer support.
- Assist with support network (e.g. peer group, school).
- Arrange a follow-up visit.

Scenario 4: Cheng

Cheng is 19 years old. He has completed his high school certificate and has been working in a bank for a year. He says he enjoys parties and admits he has had many sexual partners.

He applied for a scholarship to study abroad and has been accepted. The scholarship is dependent on a medical examination and includes an HIV test. He has come to the clinic today for the results of his medical examination.

He was asymptomatic, but the HIV test result showed that Cheng has antibodies to HIV.

Tip for you

> Important issues that need to be addressed in Scenario 4

Cheng is asymptomatic and has received his HIV diagnosis today. His HIV test could prevent him from being able to accept the scholarship. He needs support at this time to cope with his new diagnosis, and follow-up care to assess his mental state. (Inform participants that there is an algorithm in the *Adolescent job aid* that deals with anxiety and depression.) This was a mandatory HIV test that will influence Cheng's immediate and future plans, and opportunities.

Whether his sexual partners are male or female may determine the peer support Cheng will need. Health workers should not assume sexual orientation and need to take care not to be judgemental in their words or attitudes when caring for patients of a different sexual orientation.

- Assess his reaction to the diagnosis.
- Assess his understanding of HIV.
- Assess his support network and mental state, and discuss disclosure.
- Advise on positive prevention including condoms.
- Agree on disclosure (to whom, how and when).
- Assist with referral to support services.
- Arrange a follow-up appointment with a health worker.

Scenario 5: Benton

Benton is a 14-year-old boy with perinatal HIV. He has been brought to the health centre by his uncle. He is an orphan and lives with his uncle and his family. He is enrolled in school but rarely attends. His uncle says that Benton is often out all night and comes home drunk.

His family knows he is HIV-positive and they accept his diagnosis. His uncle is also HIV-positive. The family is upset with his behaviour and are afraid for him.

The uncle says that Benton used to be a good student and did well in school. Recently he has not even been taking his ARVs regularly. His uncle is angry with his nephew and says that he found medication thrown away in the outhouse. He wants the health worker to frighten Benton into taking his medication.

Tip for you

> Important issues that need to be addressed in Scenario 5

These important issues should be discussed either alone with Benton or with his uncle present, as appropriate. If discussed with Benton alone, the health worker needs to also talk later with the uncle present (having obtained Benton’s agreement to this).

The health worker needs to give Benton information on how his behaviour will affect his health. The health worker also has to understand why Benton is not taking his ARVs, assess whether he would take his ARVs if the obstacles to his adherence were addressed, and give him the support he needs to maintain adherence.

The health worker also needs to address the concerns and the supportive role of the uncle and the family.

- Assess treatment and non-adherence.
- Assess Benton’s understanding of ART and his reasons for not taking his ARVs.
- Assess options for peer support to improve adherence.
- Assess risk factors (e.g. sexual activity, substance use) – this should be done with Benton alone.
- Advise on adherence.
- Advise on positive prevention – with Benton alone.
- Agree on positive prevention (if sexually active, offer condoms and demonstration of use).
- Agree on the treatment plan and Benton’s role in maintaining adherence.
- Assist with Benton’s obstacles to adherence and discuss possible future obstacles to adherence.
- Arrange links to peer support services or an adherence buddy.
- Arrange the next appointment.

Scenario 6: Lisbeth

Lisbeth is 19 years old. She tested positive for HIV when she was 16 years old. Lisbeth has been living with HIV for three years, has not been unwell during this time and has not begun ART. She did well in school and now has a good job. She lives at home.

Her family and a few close friends know that she is HIV-positive and she feels well supported. She has had a few boyfriends over the years and she says they always used a condom during penetrative sex. She has not told her boyfriends that she is living with HIV.

Lisbeth has come to the clinic today with a cold. The cold is not serious and it is clear to the health worker that Lisbeth's real reason for coming is that she wants to talk. Lisbeth says she wants to get married in the future and is afraid she will never be able to get married or have children because of her HIV status.

Tip for you

> Important issues that need to be addressed in Scenario 6

Lisbeth wants reassurance from the health worker that she will be able to marry, even if she is living with HIV. Lisbeth reports that she has been practicing safe sex and preventing the transmission of HIV to her boyfriends. She appears to be behaving responsibly and needs recognition for this and encouragement to continue.

The health worker can discuss the benefits of disclosing her HIV status to future boyfriends. If Lisbeth is looking for a husband, the relationship will need to be based on mutual trust from the beginning. Many people living with HIV get married to others who are also living with HIV, to those who are HIV-negative or to people who do not know their HIV status.

She may benefit from a support group where she can discuss these issues with peers who are also living with HIV.

- **Assess her support structure.**
- **Assess contraception (prevention of HIV transmission and pregnancy).**
- **Assess her understanding of HIV transmission routes.**
- **Advise attending an HIV support group.**
- **Discuss when and how to disclose her HIV status.**
- **Assist in skills to negotiate safer sex.**
- **Arrange a return visit and for couple counselling if she wishes in the future.**

Scenario 7: Georgio

Georgio is a thin, unwell-looking young man of 18 years. He comes to the clinic angry and upset. He tells the health worker that someone at the clinic must have told his mother that he is HIV-positive.

He shouts and bangs the desk. When he is calmer, the health worker asks him to say what actually happened. Georgio says that last night when he returned home from work his stepfather shouted at him to “take his filthy AIDS body away” and threw him out of the house. His mother was crying inside the house.

Georgio says he has not told anyone that he is HIV-positive since he was tested here at the clinic six months ago. So he feels that someone at the clinic must have told his mother or his stepfather.

Tip for you

> Important issues that need to be addressed in Scenario 7

Georgio is angry at his situation and blames the staff at the clinic. The health worker may not know if his blame is justified, and should tell Georgio that “we do not know”. The health worker can suggest that they discuss Georgio’s situation now that his family knows his HIV status, rather than discuss blame. It is possible that his appearance may have alerted his family to his HIV status.

Later the health worker may need to discuss with the clinic staff whether there could have been a breach of confidentiality.

- **Assess Georgio’s physical and mental health today.**
- **Assess his options for shelter and support today.**
- **Assess his health-risk behaviours.**
- **Advise on positive prevention and living with HIV.**
- **Agree on confidentiality and beneficial disclosure.**
- **Agree on an immediate action plan for the social situation.**
- **Assist with referral to social support and peer support.**
- **Arrange a follow-up visit.**

Scenario 8: Lena

Lena is 18 years old and has perinatally acquired HIV. She has been married to David for two years. He is also living with HIV. Lena is well. She has been taking ARVs for many years. She has come to the clinic today because she wants to have a baby.

Tip for you

> Important issues that need to be addressed in Scenario 8

All people, including people living with HIV, have the right to reproductive choice (to choose to have or not have a baby). The health worker's role is to explore and explain the risks for Lena and for the baby. If there is a PMTCT service, the health worker can refer Lena to the appropriate clinic.

- Assess Lena's health and ART adherence.
- Advise Lena on the risks of becoming pregnant.
- Advise on the risks for babies of HIV-positive mothers.
- Advise on current recommendations for pregnant women living with HIV, including breastfeeding.
- Advise Lena to discuss this information with David.
- Assist with couple counselling if Lena wishes.
- Arrange referral to a support group.
- Arrange referral to a PMTCT clinic, if available.

Give the groups a two-minute warning and then tell them when their time is up.

Plenary presentation (or role play): Feedback

Choose which group will report back first. You can relate this to the method you chose to divide the groups (e.g. the wettest birth months first).

Say:

A member of the group will read their scenario aloud before each presentation (or role play).

If feedback is by reporting back:

One representative will present from each group. After each presentation the other participants will have an opportunity to raise questions to the group or comment.

When all three presentations are complete, ask if any participant would like to add any other important points that have been missed.

If feedback is by role play:

Follow the guidelines in Optional Session C: How to conduct a role play.

Place two chairs in the middle of the room. Invite the two players from the first group to come up. Remind them to speak loudly, and that this should not be a long role play.

When the activity is completed, thank the participants.

Say:

Many of the adolescents in the scenarios were asymptomatic. Most adolescents who acquire HIV during adolescence will remain asymptomatic for longer than adults, and with greater access to testing, health workers are likely to see more adolescents who are asymptomatic and who know that they are living with HIV. When adolescents become symptomatic, the clinical management of their HIV is generally the same as that for adults, although aspects of care and support may differ.

Read aloud (or summarize):

KEY POINTS ON THE 5 “A”s AND THE ADOLESCENT PATIENT

- 1. The 5 “A”s are as relevant to responding to the needs of adolescents living with HIV as they are to responding to the needs of small children and adults**
- 2. When thinking about the 5 “A”s with an adolescent patient, it is important to take into account specific issues, such as:**
 - **stage of development, including sexual development;**
 - **knowledge and capacities (e.g. life skills);**
 - **mode of transmission (i.e. during the perinatal period or during adolescence);**
 - **needs for care, support and treatment preparedness for adolescents who are living with HIV but do not yet require treatment;**
 - **consent and confidentiality;**
 - **problems that may require specific attention, such as adherence, disclosure, discrimination and emerging sexuality;**
 - **available support structures.**

Wrap up the session by thanking the groups for their hard work.

Tip for you

- **Review the questions on the “Come Back to Later” board and prepare responses for the concluding session.**

10

Session 10: _____

Concluding session

Review / Individual exercise
(40 minutes)

Read aloud:

LEARNING OBJECTIVES

- to review the spot checks, the VIPP cards on “Difficult situations with adolescent patients”, the “Come Back to Later” board and the course objectives;
- to complete an individual action plan.

Review: Spot checks

Go over the spot checks with the participants.

Tip for you

> Here are responses to the spot checks.

1. How confident do you feel about providing treatment, care and support to adolescents living with HIV?

Tell participants that there are no right or wrong answers here. Ask them to look at their responses at the beginning of the course and reflect on any changes they would make now. Ask if anyone is willing to share how his/her views have changed.

Uncomfortable Not very confident Confident Very confident

2. There are three stages of adolescent development. Can you name them and give the approximate ages to which they correspond?

- i. Early adolescence: 10–15 years
- ii. Middle adolescence: 14–17 years
- iii. Late adolescence: 16–19 years

These periods roughly correspond with stages in physical, social and psychological development in the transition from childhood to adulthood. These stages provide a basic framework in which to understand adolescent development.

The overlap of ages is important because the changes are not fixed and happen at different ages for different adolescents

3. Essentially, because of the mode of transmission, there are two groups of adolescents living with HIV. These two groups are:

- i. **Adolescents with perinatally acquired HIV** (during their mothers' pregnancy, labour and delivery, or postpartum through breastfeeding).
- ii. **Adolescents who acquired HIV during adolescence** (usually through unprotected sexual intercourse or injecting drug use, and less often as a result of an HIV-positive blood transfusion or sharing of instruments used for tattooing or skin piercing).

4. What do you think are the three most important questions that may be asked by an adolescent living with HIV in your community?

Tell participants there are no right or wrong answers here.

Remind them of the list of questions developed earlier about what adolescents ask.

Ask them to look at their responses at the beginning of the course and reflect on any changes they would make now. Ask if anyone is willing to share his/her changes.

5. What is particularly important in counselling adolescents?

- Be truthful and honest about what you know and what you do not know.
- Be professional (ensure privacy and confidentiality).
- Give all the information/choices, and then help them decide what to do.
- Treat adolescents with respect in terms of words and actions.
- Treat all adolescents equally.
- Be accepting that adolescents may choose to show their individuality in dress or language.
- Be accepting of sexual orientation.
- Use words and concepts which adolescents can understand and to which they can relate.

6. Read each statement and tick the box (Agree or Disagree) that reflects your point of view.

“Adolescents are not at risk of HIV in my community.”

“Adolescents are at risk of HIV in my community.”

“An adolescent with a positive HIV test result who is still asymptomatic does not need any services.”

All adolescents living with HIV need support to:

- **deal with their diagnosis**
- **live positively**
- **understand the importance of positive prevention**
- **understand the benefits of disclosing their HIV status to trusted people**
- **link up to support in their family, with their peers and in the community.**

Adolescents especially need this support because of their stage of development (no longer a child, not yet an adult).

“Health workers must tell adolescents living with HIV how they should behave.”

Telling an adolescent how to behave does not mean that they will behave as you prescribe.

Health workers can give adolescent clear information on the benefits and problems of certain actions and answer the adolescent’s questions. However, the adolescent will need to decide how to behave.

“If a boy of 14 years came for HIV care I would tell him I could not help him unless he comes back with a parent or a guardian.”

“If a young person tests HIV positive, it is my duty to tell their parents.”

“If a married adolescent who is living with HIV comes to my clinic, I am not obliged to tell their partner.”

Adolescents living with HIV can feel very isolated. A health worker can encourage the adolescent to see the benefits of having trusted people know their diagnosis, so they can feel supported. However, it is for the adolescent to decide whom to tell.

The issues around consent, confidentiality and disclosure are complex and differ between countries and communities.

Today we have discussed some of these issues: issues of best interests of the child, evolving capacities and competence. There is more information in the Manual. We hope that this has stimulated you to examine and discuss what happens in your community in relation to beneficial disclosure and consent for minors to access HIV testing, care and treatment.

“I find adolescents today very hard to understand because they behave so strangely.”

Statements like this are saying that adolescents are all the same. As we have discussed, adolescents are not all the same.

The way adolescents behave can feel challenging. This is part of their normal development.

We hope that after today you may feel a little more knowledgeable about, and tolerant of what makes adolescents seem so different.

“Prevention, care, treatment and support for adolescents living with HIV is no different from that for children or adults.”

As we have discussed today, there are issues that relate to adolescent development that indicate that there is a need for a different approach to the prevention, care, treatment and support for adolescents living with HIV. This approach can help them live positively and protect their health during the years before they become symptomatic. This approach also recognizes their right to decide about sexual activity and reproductive choices. The health worker can provide them with support and guidance on how to do so with minimal fear of passing on their infection or becoming re-infected.

Ask if anyone has any comments on the brief scenarios.

Say:

These scenarios help to examine our attitudes towards adolescents. If we are too judgemental towards adolescents, we will miss the opportunity to help them. Adolescents living with HIV need health workers' support to cope with the many difficulties that they face.

7. Read the following brief scenarios. Consider your personal and professional feelings and reactions to each one and write some comments. You will not have to share these comments with other participants so try to be honest and explore how the adolescents in the scenarios make you feel and react.

- a) Jay, a 14-year-old boy, comes to the clinic alone with a cut on his head. He will not look at you. When you question him he answers with short responses in an angry voice.

Your comments:

- b) Mai is a 15-year-old girl who comes to the clinic with her mother. The mother says that Mai has been missing school, sleeping late, shouting at her parents and staying out late with her boyfriend. They have tried punishing her and locking her in her room. Mai does not say anything, just keeps looking at the floor with her arms crossed while her mother speaks.

Your comments:

- c) Pasco, a 15-year-old boy who is HIV-positive, comes to the clinic and asks for condoms.

Your comments:

- d) Shaana, a 17-year-old girl, comes to the clinic and asks for contraception. She is not married and says she has had a sexual relationship with her boyfriend for two months.

Your comments:

- e) A noisy group of young boys are standing at the clinic door talking and laughing loudly. They seem to be trying to make one of the boys in the group enter the clinic, pushing and joking with him.

Your comments:

Ask participants to look at their comments and reflect on any changes they may have in attitude now compared to this morning.

Ask if anyone would like to share any of his/her comments or changes.

Ask if there are any further comments or questions.

Review:

“Difficult situations for health workers in providing services for adolescent patients living with HIV”, “Come Back to Later” board and course objectives

Go to Flipchart 4 with the VIPP cards on “Difficult situations for health workers in providing services for adolescent patients living with HIV”.

Read through the difficult situations that were identified by the participants.

Review with the participants where in the course or the Manual each “difficult situation” was addressed.

If there are situations that were not addressed in the course, give the participants the information or a reference that you have already prepared (see “Tip for you” box at the end of Session 3) that will assist them in dealing with this situation in their work.

If there are questions or situations that you cannot answer, acknowledge this. Ask if anyone else can help. Suggest other sources.

Ask if there are any questions and then move to the “Come Back to Later” board.

Respond to any points on the board that have not already been covered.

Ask the participants to turn to the “Course objectives” in Section 1.2 of their Manual that were discussed in Session 1.

Ask if they think we achieved these objectives or if there any areas or objectives that we did not accomplish.

Ask if there are any comments on the course objectives or about this training in general.

Individual exercise:

Individual action plan

Ask the participants to look at the “Individual action plan” in Annex 6 of the Manual.

Go over the plan and explain the five columns to them.

Column 1:

What changes do I plan to make in my everyday work with/for adolescents living with HIV?

Say:

Each change could relate to anything you have learned during this course.

Column 2:

Why do I believe this change is important and who or what will benefit and why?

Column 3:

How will I know if I have been successful and when will I know this?

Say:

As it is likely that you will only see the effect of the change after some months, how will you know how effective the changes have been?

Column 4:

What personal or professional challenges do I anticipate in carrying out these changes?

Say:

It is not always easy to make even simple changes, so it is important to be ready for the difficulties that may arise and the need to overcome them.

Column 5:

What help am I likely to need and who could provide me with this help?

Ask if there are any questions. Respond.

Ask them to now consider what they would put in their own action plan.

Remind them that they can refer back to the points they noted down in Annex 3 of their Manual.

Give them time to complete this task.

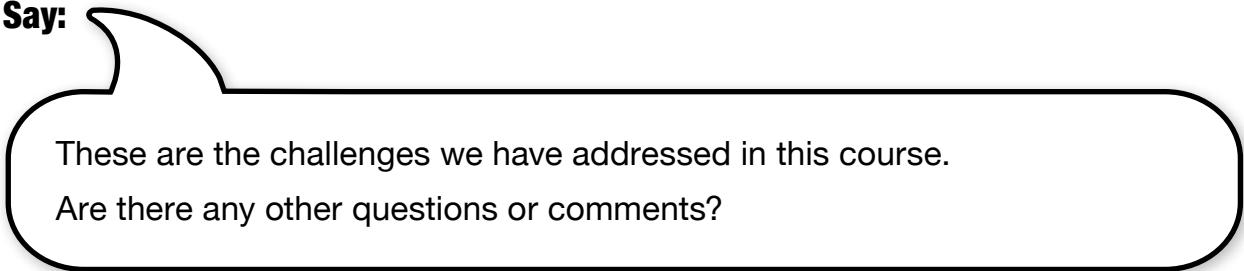
Review:

Key messages and conclusion

Point to the *IMAI wall chart* Sheet II box on “Special challenges in providing prevention, care, treatment and support for adolescents living with HIV”.

Review the seven challenges listed here with the participants.

Say:



These are the challenges we have addressed in this course.
Are there any other questions or comments?

Tell them that this is the end of the IMAI One-day Orientation on Adolescents Living with HIV.

Thank the participants for their hard work.

Additional reading

Adolescent health and development in the context of the Convention on the Rights of the Child. Committee on the Rights of the Child, General comment No. 4 (2003).

Adolescent job aid: a handy desk reference for primary level health workers. Geneva, World Health Organization, 2009.

Antiretroviral therapy of HIV infection in infants and children in resource-limited settings: towards universal access. Recommendations for a public health approach. Geneva, World Health Organization, 2006.

IMAI Acute care: Guidelines for first-level facility health workers at health centre and district outpatient clinic. WHO/CDS /IMA I/2004.1 Rev. 3. Geneva, World Health Organization, 2009.

IMAI-IMCI Basic HIV care with ART and prevention guideline module. Geneva, World Health Organization, 2007 (<http://www.who.int/hiv/topics/capacity/en/index.html>, accessed 30 May 2009).

Impact of HIV and sexual health education on the sexual behaviour of young people: a review update. Joint United Nations Programme on HIV/AIDS, 1997.

More positive living: strengthening the health sector response to young people living with HIV, Geneva, World Health Organization/United Nations Children's Fund, 2008 (http://www.who.int/child_adolescent_health/documents/9789241597098/en/index.html, accessed 30 May 2009).

Orientation programme on adolescent health for health-care providers. Geneva, World Health Organization, 2003.

Reproductive choices and family planning for people living with HIV: counselling tool. Geneva, World Health Organization, 2006.

UN Committee on the Rights of the Child (CRC), *CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4 (<http://www.unhcr.org/refworld/docid/4538834f0.html>, accessed 30 May 2009).

UNAIDS. *UNAIDS terminology guidelines (February 2008). Summary of preferred terminology* (http://data.unaids.org/pub/Manual/2008/jc1336_unaids_terminology_guide_en.pdf, accessed May 31, 2009).

Annex 1: Spot Checks

The purpose of the spot checks is to help you assess your gains in knowledge and understanding as a result of participating in this course.

The spot checks will not be collected, graded or checked by any of the facilitators. This is merely for your personal use at the beginning of the day.

The responses will be discussed at the end of the day.

Respond to the following questions to the best of your knowledge and understanding.

For many of the questions there is no right or wrong answer.

1. How confident do you feel about providing treatment, care and support to adolescents living with HIV?

☐ Uncomfortable ☐ Not very confident ☐ Confident ☐ Very confident

2. There are three stages of adolescent development. Can you name them and give the approximate ages to which they correspond?

i. _____

ii. _____

iii. _____

3. Essentially, because of the mode of transmission, there are two groups of adolescents living with HIV. These two groups are:

i. _____

ii. _____

4. What do you think are the three most important questions that may be asked by an adolescent living with HIV in your community?

i. _____

ii. _____

iii. _____

5. What is particularly important in counselling adolescents?

6. Read each statement and tick the box that reflects your point of view.

	I agree	I disagree
“Adolescents are not at risk of HIV in my community.”		
“An adolescent with a positive HIV test who is still asymptomatic does not need any services.”		
“Health workers must tell adolescents living with HIV how they should behave.”		
“If a boy of 14 years came for HIV care I would tell him I could not help him unless he comes back with a parent or guardian.”		
“If a young person tests HIV positive, it is my duty to tell their parents.”		
“If a married adolescent who is living with HIV comes to my clinic, I am not obliged to tell their partner.”		
“I find adolescents today hard to understand because they behave so strangely.”		
“Prevention, care, treatment and support for adolescents living with HIV is no different from that for children or adults.”		

7. Read the following brief scenarios. Consider your personal and professional feelings and reactions to each one and write some comments. You will not have to share these comments with other participants so try to be honest and explore how the adolescents in the scenarios make you feel and react.

- a) Jay, a 14-year-old boy, comes to the clinic alone with a cut on his head. He will not look at you. When you question him he answers with short responses in an angry voice.

Your comments:

- b) Mai is a 15-year-old girl who comes to the clinic with her mother. The mother says that Mai has been missing school, sleeping late, shouting at her parents and staying out late with her boyfriend. They have tried punishing her and locking her in her room. Mai does not say anything, just keeps looking at the floor with her arms crossed while her mother speaks.

Your comments:

- c) Pasco, a 15-year-old boy who is HIV-positive, comes to the clinic and asks for condoms.

Your comments:

- d) Shaana, a 17-year-old girl, comes to the clinic and asks for contraception. She is not married and says she has had a sexual relationship with her boyfriend for two months.

Your comments:

- e) A noisy group of young boys are standing at the clinic door talking and laughing loudly. They seem to be trying to make one of the boys in the group enter the clinic, pushing and joking with him.

Your comments:

Annex 2: IMAI wall chart on the adolescent living with HIV

Sheet I

According to the World Health Organization (WHO)

- **“adolescents”** are individuals in the 10–19 years age group
- **“youth”** are individuals in the 15–24 years age group
- **“young people”** combine both adolescence and youth and include the 10–24 years age group.

Adolescence has physical, psychological, emotional and socio-cultural dimensions. It is a phase in an individual's life, rather than a fixed age band, and is perceived differently in different societies.

THE 5 “A”S AND THE ADOLESCENT LIVING WITH HIV

NOTE: With a minor, understand your legal obligations in terms of consent and confidentiality, bearing in mind the best interests of the adolescent and their evolving capacities.

When providing treatment, care, support and prevention for adolescents, use appropriate language and attitudes.

ASSESS

- Physical and psychological status and support structures
- Current treatments and adherence
- Sexual activity (current and intended), pregnancy, health-related risk behaviours.

ADVISE

- Relationships, couple counselling, sexual activity, condom use, contraception
- Treatment plan: dose (use Tanner scale), simplest regimen, evaluate confidence and readiness
- Prevention plan: dual protection, consider mode of transmission and sexual activity.

AGREE

- Disclosure: Who? How? When? What support?
- Role of adolescents and others in treatment and prevention plans
- Goals: clear, measurable, realistic, under patient's control, limited in number.

ASSIST

- Summary of plan, referrals, links
- Provide medication and contraceptives/condoms
- Skills and tools for self-management, adherence, safer sex.

ARRANGE

- Record visit and arrange next appointment date, including parents and partner (as appropriate)
- Activities/support between visits
- Referral as necessary, links with peers

Sheet II

SPECIAL CHALLENGES IN PROVIDING PREVENTION, CARE, TREATMENT AND SUPPORT FOR ADOLESCENTS LIVING WITH HIV		
CHALLENGES	Adolescents who acquired HIV perinatally (often younger age: early adolescence)	Adolescents who acquired HIV during adolescence (usually older age: 15 plus years)
BENEFICIAL DISCLOSURE	<ul style="list-style-type: none"> ■ If not yet discussed, disclosure to adolescent ■ Peers 	<ul style="list-style-type: none"> ■ Need support to tell chosen family and friends ■ Will benefit from others knowing so they can get support ■ Fear of stigma/blame
POSITIVE PREVENTION	<ul style="list-style-type: none"> ■ Not yet sexually active ■ Preparing for sexual activity ■ Wanting sexual relations and pregnancy in the future 	<ul style="list-style-type: none"> ■ Already sexually active ■ Changes in health risk behaviour(s) ■ Wanting marriage and children ■ Need life skills, peer support
CONSENT AND CONFIDENTIALITY	<ul style="list-style-type: none"> ■ Living with family/guardian ■ No longer a compliant child ■ Needs to start taking responsibility for own treatment 	<ul style="list-style-type: none"> ■ Legal position on age of consent ■ Concern about confidentiality ■ Desire for independence and need for support
DEVELOPMENTAL DELAYS	<ul style="list-style-type: none"> ■ Delays in skeletal growth and puberty 	<ul style="list-style-type: none"> ■ Normal development
TRANSITION OF CARE	<ul style="list-style-type: none"> ■ Paediatric to adolescent 	<ul style="list-style-type: none"> ■ Adolescent to adult
ART AND ADHERENCE	<ul style="list-style-type: none"> ■ Choice of regimens ■ Adherence: no longer a child 	<ul style="list-style-type: none"> ■ When to begin ART ■ Choice of regimen ■ Adherence
LIVING WITH A CHRONIC CONDITION	<ul style="list-style-type: none"> ■ May be an orphan ■ Acceptance of the condition may change as the adolescent develops 	<ul style="list-style-type: none"> ■ New diagnosis ■ Depression and anger ■ Lack of experience and resources

DISCUSSION POINTS ON SEX FOR ADOLESCENTS LIVING WITH HIV

1. Do not feel rushed into having sex.
2. If you have not yet had sex, consider delaying. Do not begin a sexual relationship until you are ready. Talk together and agree on the limits of your physical intimacy.
3. If you are with a new partner, find other safer ways of giving each other pleasure until you are ready to have sex in this relationship. Enjoy other activities together.
4. When you have sex, use a condom correctly every time, even if your partner is also HIV positive. Condoms also prevent unplanned pregnancy.
5. Drinking alcohol and using substances increase the risk of unplanned and unprotected sex.
6. Avoid situations or people that may put you at risk of unwanted sex.
7. Reduce the number of people with whom you have sex.
8. Consider telling trusted people that you are living with HIV so they can support you.

Annex 3: The Tanner scale










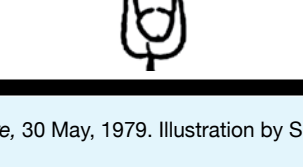
The Tanner scale (or Tanner staging) provides a measure of physical development in adolescents. The scale defines physical measurements of development based on external primary and secondary sex characteristics. The scale is based on observing the development of the breasts in girls, the development of the genitalia in boys, and the growth of pubic hair in both sexes.

Due to natural variations, individuals pass through the Tanner stages at different rates. The Tanner scale cannot measure the entire course of puberty because the changes in internal reproductive organs begin much earlier and finish much later than the changes in visible external characteristics.

In ART, the Tanner scale is used to determine which treatment regimen to follow (paediatric or adult). Adolescents at Tanner scale 1, 2 or 3 should be started on a paediatric regimen, while adolescents at scale 4 or 5 should be put on the adult regimen.

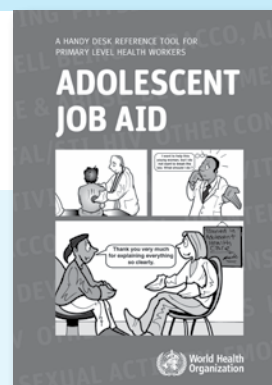
Tanner scale: Female breast	
Scale 1: no breast tissue with flat areola	
Scale 2: breast budding with widening of the areola	
Scale 3: larger and more elevated breast extending beyond the areola	
Scale 4: larger and even more elevated breast. Areola and nipple projecting from the breast contours	
Scale 5: Adult size with nipple projecting above areola	

Tanner scale

Male and female pubic hair	Pubic Hair
Scale 1: none	
Scale 2: small amount of long hair at base of male scrotum or female labia majora	
Scale 3: moderate amount of curly and coarser hair extending outwards	
Scale 4: resembles adult hair but does not extend to inner surface of thigh	
Scale 5: adult type and quantity extending to the medial thigh surface	
Male genitalia	Male genitalia
Scale 1: testes small in size with childlike penis	
Scale 2: testes reddened, thinner and larger (1.6–6.0 cc) with childlike penis	
Scale 3: testes larger (6–12 cc), scrotum enlarging, increase in penile length	
Scale 4: testes larger (12–20 cc) with greater enlargement and darkening of the scrotum; increase in length and circumference of penis	
Scale 5: testes over 20cc with adult scrotum and penis	

Annex 4: Excerpts from the *Adolescent job aid*

Table of Contents



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How does the *Adolescent job aid* relate to other WHO guidelines?

How is the *Adolescent job aid* organized?

How is the *Adolescent job aid* to be used?

PART 1: The clinical interaction between the adolescent and the health worker

1. The special contribution that you could make to the health and development of your adolescent patient
2. Establishing rapport with your adolescent patients
3. Taking a history of the presenting problem or concern
4. Going beyond the presenting problem or concern
5. Doing a physical examination
6. Communicating the classification, explaining its implications, and discussing the treatment options
7. Dealing with laws and policies that affect your work with your adolescent patients

PART 2: Algorithms, communication tips and frequently asked questions

DEVELOPMENTAL CONDITIONS

Delayed puberty: Male

Delayed puberty: Female

MENSTRUAL CONDITIONS

“I have a lot of pain during my periods”

“I bleed a lot during my periods”

“I have irregular periods / my periods have stopped”

PREGNANCY-RELATED CONDITIONS

“I do not want to get pregnant”

“Could I be pregnant?” (suspected pregnancy)

“I am pregnant”

GENITAL CONDITIONS (INCLUDING SEXUALLY TRANSMITTED INFECTIONS)

“I have a problem with the skin at the tip of my penis” (foreskin problems)

“I have pain in my scrotum/I have injured my scrotum”

“I have discharge from my penis/pain on urination”

“I have a sore on my genitals”

“I have a swelling in my groin”

“I have an abnormal discharge from/burning or itching in my vagina”
(for non-pregnant women)

HIV

“Could I have HIV?”

OTHER COMMON CONDITIONS

“I have abdominal pain”

“I am too pale”

“I am tired all the time”

“I have a headache”

“I have acne”

“I am too thin/too fat”

“I am too short”

“I have been attacked”

“I cannot see very well”

Part 3: Information to be provided to adolescents and their parents or other accompanying adults

Healthy eating

Physical activity

Sexual activity

Emotional well-being

The use of tobacco, alcohol and other substances

Unintended injuries

Violence and abuse

Introduction

What is the *Adolescent job aid*?

It is a handy desk reference.

Who is the *Adolescent job aid* intended for?

It is intended for health workers who provide primary care services (including promotive, preventive and curative health services) to adolescents.

These health workers include doctors, midwives, nurses and clinical officers. The *Adolescent job aid* takes into account the fact that in most settings health workers provide health services to children and adults in addition to adolescents.

What is the purpose of the *Adolescent job aid*?

Its purpose is to enable health workers to respond to adolescents more effectively and with greater sensitivity. To do this, it provides precise and step-wise guidance on how to deal with adolescents when they present with a problem or concern regarding their health and development.

What does the *Adolescent job aid* contain?

It contains guidance on commonly occurring adolescent-specific problems or concerns that have not been addressed in existing World Health Organization (WHO) guidelines (e.g. delayed menarche). It also contains guidance on some problems and concerns that are not adolescent specific but occur commonly in adolescents (e.g. sexually transmitted infections) and highlights special considerations in dealing with these conditions in adolescents.

How does the *Adolescent job aid* relate to other WHO guidelines?

It is consistent with and complementary to other key WHO guidelines including:

- *Integrated management of adolescent and adult illness*
- *Integrated management of pregnancy and childbirth*
- *Decision-making tool for family planning clients and providers*

How is the *Adolescent job aid* organized?

Following this introductory section, it contains three parts:

Part 1: The clinical interaction between the adolescent and the health worker

Part 2: Algorithms, communications tips and frequently asked questions

Part 3: Information to be provided to adolescents and their parents or other accompanying adults

How is the *Adolescent job aid* to be used?

Firstly, familiarize yourself with its contents.

Part 1: Go over the guidance that this part contains, carefully, thinking through its implications for your work. Where possible, discuss this with your colleagues.

Part 2: Go over the list of algorithms that it contains. Choose one presenting complaint that you commonly encounter in your work and go through the algorithm carefully, thinking through what it guides you to in the “Ask” and “Look/Feel/Listen” columns, in order to classify the condition. Then, go through how it guides you to manage each classification. After that, go over the information to be provided to the adolescent and the accompanying adult as well the responses to frequently asked questions.

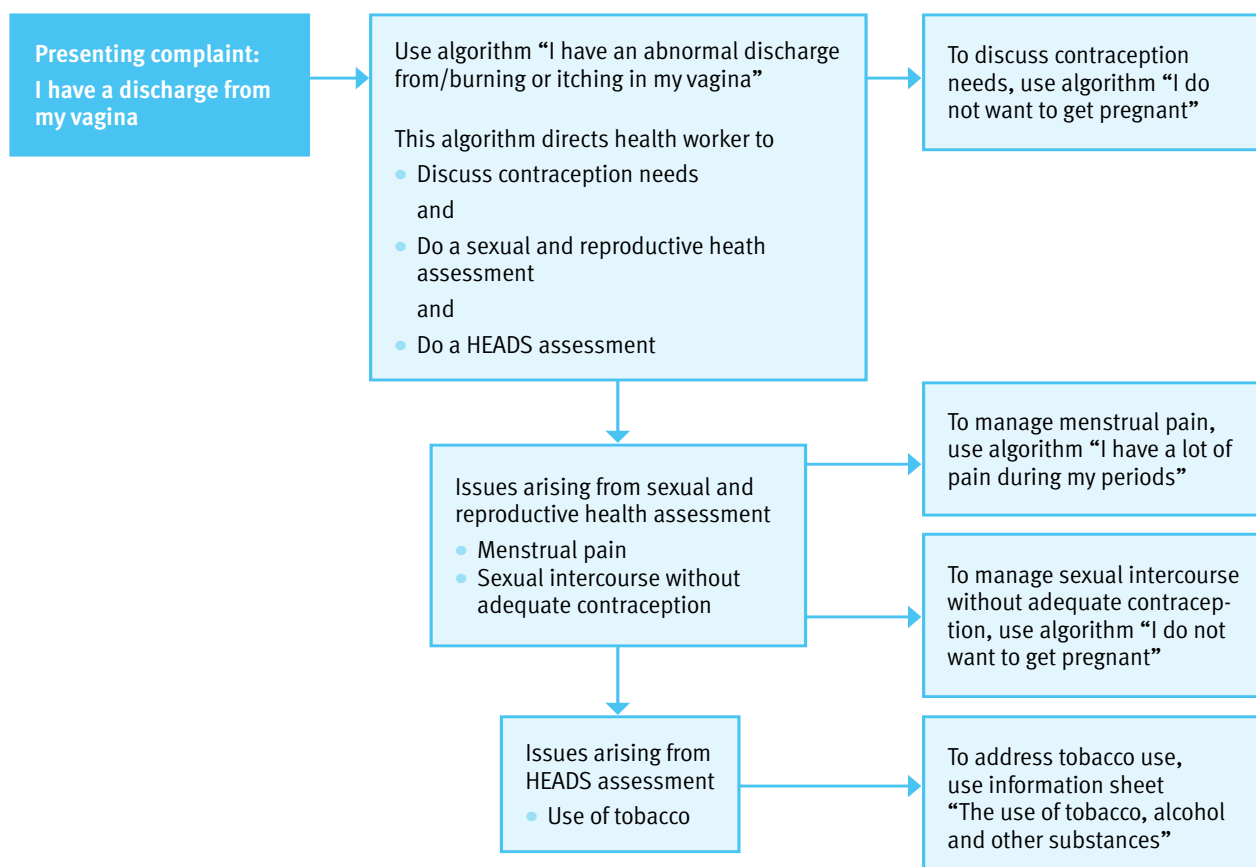
Part 3: Go over the list of topics that it contains. Choose any one topic and go over the messages it contains for adolescents and for their parents.

Secondly, begin using it in your work.

The starting point for each algorithm is the presenting complaint, either by the adolescent or by his/her parents. As you go through the “Ask” and “Look/Feel/Listen” columns, you are likely to be pointed to other algorithms to use. Go to them after you have completed the classification, defined the management approach to be used, provided information, and responded to questions, if any. In this way, the *Adolescent job aid* guides you to go beyond the presenting complaint to identify and deal with other problems that were not raised by the adolescent or his/her parents.

This is illustrated in the following chart.

Example of entry points for use of algorithms, accompanying communication tips and information sheets in the *Adolescent job aid*



When you start using the *Adolescent job aid*, take the time to go through each algorithm and the accompanying communication tips carefully. With practice, you will be able to do this faster. You will also learn which issues you will need to spend time on, and which ones you could go through quickly or even skip altogether.

Lastly, although the *Adolescent job aid* contains 24 algorithms and communication tips on commonly occurring presentations, it does not cover all the presenting complaints that adolescents come with. This means that from time to time you will need to manage adolescents using other guidelines.

Part 1

The clinical interaction between the adolescent and the health worker

This part of the *Adolescent job aid* addresses the following issues:

1. The special contribution that you could make to the health and development of your adolescent clients/patients
2. Establishing rapport with your adolescent clients/patients
3. Taking a history of the presenting problem or concern
4. Going beyond the presenting problem or concern
5. Doing a physical examination
6. Communicating the classification, explaining its implications, and discussing the management options
7. Dealing with laws and policies that affect your work with your adolescent clients/patients

1. The special contribution that you could make to the health and development of your adolescent clients/patients

What you should be aware of:

1. Adolescence is a phase in life during which major physical, psychological and social changes occur. As they encounter these changes, adolescents have many questions and concerns about what is happening to their bodies. In many places, adolescents are unable to share their questions and concerns, and to seek answers from competent and caring adults.

2. While adolescence is generally considered as a healthy time of life, it is also a period when many behaviours that negatively affect health both during adolescence and later in life, start. Furthermore, many adolescents die every year – mostly from unintentional injuries (e.g. car crashes), intentional injuries (suicide and interpersonal violence) and pregnancy-related causes.

3. Health workers like you have important contributions to make in helping those adolescents who are well to stay well, and those adolescents who develop health problems get back to good health. You can do this through:

- providing them with information, advice, counselling and clinical services aimed at helping them maintain safe behaviours and modify unsafe ones (i.e. those that put them at risk of negative health outcomes);
- diagnosing/detecting and managing health problems and behaviours that put them at risk of negative health outcomes; and referring them to other health and social service providers, when necessary.

Health workers like you have another important role to play – that of change agents in your communities. You could help community leaders and members understand the needs of adolescents, and the importance of working together to respond these needs.

2. Establishing rapport with your adolescent clients/patients

What you should be aware of:

1. Some adolescents may come to you of their own accord, alone or with friends or relatives. Other adolescents may be brought to see you by a parent or another adult. Depending on the circumstances, the adolescent could be friendly or unfriendly with you. Also, depending on the nature of the problem or concern, the adolescent could be anxious or afraid.

2. Adolescents may be reluctant to disclose information on sensitive matters if their parents or guardians, or even spouses are also present.

What you should do:

1. Greet the adolescent in a cordial manner.

2. Explain to the adolescent that:

- you are there to help them, and that you will do your best to understand and respond to their needs and problems;
- you would like them to communicate with you freely and without hesitation;
- they should feel at ease and not be afraid because you will not say or do anything that negatively affects them;
- you want them to decide how much they would like to involve their parents or others;
- you will not share with their parents or anyone else any information that they have entrusted you with, unless they give you the permission to do so.

3. If the adolescent is accompanied by an adult, in their presence, explain to the accompanying adult that:

- you want to develop a good working relationship with the adolescent. At some stage you may need some time to speak to the adolescent alone.

3. Taking a history of the presenting problem or concern

What you should be aware of:

1. Many adolescent health issues are sensitive in nature.
2. When asked by health workers about sensitive matters such as sexual activity or substance use, adolescents may be reluctant to disclose information because of fears that health workers may scold or mock them.

What you should do:

1. *Start with non-threatening issues:* Start the clinical interview with issues that are the least sensitive and threatening. The *Adolescent job aid* algorithms contain many direct questions that health workers need to ask to determine classification and subsequent management. However, if you were to ask an adolescent, “*Are you sexually active?*” without first establishing rapport, the likelihood of obtaining any answer, let alone a true answer will be low. It is usually best to start with some introductory questions (e.g. about the adolescent’s home situation) before proceeding to more sensitive topics such as sexual and reproductive health. Then when one is ready to commence questioning about sexual and reproductive health, it is best again to start with the most non-threatening questions before proceeding to the more sensitive ones.
2. *Use the third person (indirect questions)* where possible: It is often best to ask first about activities of their peers and friends rather than directly about their own activities. For example, rather than ask an adolescent directly, “*Do you smoke cigarettes?*” you could ask, “*Do any of your friends smoke?*” If the adolescent replies, “*Yes*”, you could then ask, “*Have you ever joined them?*” This can lead to other questions such as, “*How often do you smoke?*” etc.
3. *Reduce the stigma around the issue by normalising the issue:* An adolescent who has an unwanted pregnancy or a sexually transmitted infection may feel embarrassed or even ashamed. You can reduce the stigma around the issue by saying to the adolescent that, “*I have treated a number of young people with the same problem you have*”.

What you should be aware of:

Even with adequate training, many health workers are uncomfortable discussing sensitive matters with anyone, whether adults or adolescents.

What you should do:

1. The first step in dealing with this is being aware of the issue, and then trying to overcome it. It may be useful to reflect that your discussions with the adolescents, although uncomfortable, will help you identify their needs and address their problems. It may also be useful to discuss your thoughts and feelings with a colleague.

2. Learn as you go along. In the beginning, you may use the questions listed in the *Adolescent job aid* as they are written. With time you may choose to modify them, using words and phrases that you are more comfortable with and a more relaxed conversational style. You will also find that you will get faster with practice, and will learn which issues to spend time on, and which other issues you can address quickly.

4. Going beyond the presenting problem or concern

What you should be aware of:

1. When adolescents seek help from a health worker, they tend to volunteer information about the health problem that seems most important to them (i.e. the presenting complaint). They may have other health problems and concerns but may not say anything about them unless directly asked to do so. In such a situation, the health worker is likely to deal with the presenting complaint only (e.g. fever and cough) and go no further thereby missing other existing problems.
2. Further, adolescents may not volunteer information about a health problem or concern because they may be embarrassed or scared to do so, or because they may not be comfortable either with the health worker or the situation they are in.

What you should do:

You could consider using the HEADS assessment, which could assist you to:

- detect health and development problems that the adolescent has not presented with;
- detect whether the adolescent engages in behaviours that could put one at risk of negative health outcomes (such as injecting drugs or having unprotected sex);
- detect important factors in their environment that increase the likelihood of their engaging in these behaviours.

In this way, you would get a full picture of the adolescent as an individual and not just a case of this or that condition. It would also identify the behaviours and the factors in the adolescent's environment to address – yourself and in conjunction with other health and social service providers.

HEADS is an acronym for

- **H**ome
- **E**ducation/Employment
- **E**ating
- **A**ctivity
- **D**rugs
- **S**exuality
- **S**afety
- **S**uicide/Depression

The HEADS assessment is structured so that you can start the discussion with the most non-threatening issues. It starts by examining the home and the educational/employment setting. It then goes on to eating, and then to activities. Only then does it deal with more sensitive issues such as drugs, sexuality, safety and suicide/depression.

See the listing of “Information that can be obtained from a HEADS assessment” towards the end of this part of the *Adolescent job aid*.

If time does not permit you to do a full HEADS assessment, you will need to prioritize which sections of the HEADS assessment to do. You may choose to prioritize the sections which are most related to:

- Presenting complaint:

If an adolescent presents with an injury after a fall while drinking alcohol, you may prioritize the “Drugs” section of the HEADS assessment.

and / or

- Important health issues in your local area:

If you are working in an area of high HIV prevalence you may prioritize the “Sexuality” section of the HEADS assessment.

5. Doing a physical examination

What you should be aware of:

1. In order to make a correct classification, all the signs listed in the Look/Feel/Listen column of the algorithms need to be carefully checked for.
2. Some items in a physical examination are unlikely to cause embarrassment (e.g. checking the conjunctivae for anaemia); however, some other items are likely to do so (e.g. checking the vagina for the presence of abnormal discharge).

What you should do:

1. Before doing a physical examination:

- If the adolescent is with an accompanying person, reach an agreement as to whether they want this person to be present during the examination.
- Inform the adolescent about what examination you want to carry out and the purpose of the examination.
- Explain the nature of the examination.

As part of the physical examination check the following things:

- Temperature
- Pulse rate
- Presence of anaemia
- Presence of jaundice
- Presence of lymphadenopathy
- Presence of obvious over/under-nutrition
- Any abnormal health and lung sounds
- Any evidence of swellings or tenderness in the abdomen
- Presence of teeth and gum problems
- Presence of skin problems

- Obtain the consent of the adolescent. (If the adolescent is below the legal age of being able to give consent, you will need to obtain consent from a parent or guardian. However, even if you have obtained consent from a parent or guardian, you should not proceed with the examination unless the adolescent agrees).

2. During an examination:

- Respect local sensitivities regarding gender norms (e.g. whether it is appropriate for a male health worker to examine a female patient). If needed, ensure the presence of a female colleague during the examination.
- Ensure privacy (e.g. make sure that curtains are drawn, doors are shut and that no unauthorized person enters the room during the examination).
- Watch for signs of discomfort or pain and be prepared to stop the examination if needed.

6. Communicating the classification, explaining its implications, and discussing the treatment options

What you should be aware of and do:

1. Informing your adolescent patients about the classification and explaining its implications for their health can help them become active partners in protecting and safeguarding their health.
2. Informing them about the different treatment options and helping them choose the one that matches their preferences and circumstances will increase the likelihood that they will adhere to the treatment.

What you should do:

1. When you have made a classification, you will need to communicate it and explain its implications to the adolescent.

Before doing so:

- check whether they want to have the parent or other accompanying person present.

While communicating:

- demonstrate your respect and empathy to the adolescent through your speech and your body language (e.g. if the adolescent is with a parent or another accompanying person, address them);
- use language and concepts that they are likely to understand;
- periodically assess their understanding (e.g. by asking them to say in their own words what they understand about an issue).

2. Provide information on the implications of each treatment option and help the adolescent choose the one best suited to his/her needs.

While doing this:

- present all the relevant information;
- respond to questions as fully and honestly as you can;
- help them choose;

- respect their choice even if it is not the one you would have wanted them to make.
3. When providing medication, explain why they need to take it, and when and how they need to do so. If prescribing medication, make sure that they will be able to find the money to buy it.

7. Dealing with laws and policies that affect your work with your adolescent clients/patients

What you should be aware of and do:

1. Ensure that you are fully aware of the national and local laws and policies.
2. Where appropriate, help your adolescent patients and their parents become aware of them.
3. As a health worker, just like all other citizens of your country, you have the responsibility to respect these laws and policies. As a health worker, you have an ethical obligation to act in the best interests of your adolescent patients. In your work with adolescents, you may find that in some situations, prevailing laws and policies may not permit you to do what is in the best interests of your adolescent patient (e.g. in some places, the provision of contraceptives to unmarried adolescents is illegal). In such situations, you may need to draw upon your experience and the support of caring and knowledgeable people to find the best way to balance your legal obligations with your ethical obligations.

Information that can be obtained from a HEADS assessment

Home	Where they live With whom they live Whether there have been recent changes in their home situation How they perceive their home situation
Education/ Employment	Whether they study/work How they perceive how they are doing How they perceive their relation with their teachers and fellow students/employers and colleagues Whether there have been any recent changes in their situation What they do during their breaks
Eating	How many meals they have on a normal day What they eat at each meal What they think and feel about their bodies

Activity	<p>What activities they are involved in outside study/work</p> <p>What they do in their free time – during week days and on holidays</p> <p>Whether they spend some time with family members and friends</p>
Drugs	<p>Whether they use tobacco, alcohol, or other substances</p> <p>Whether they inject any substances</p> <p>If they use any substances, how much do they use; when, where and with whom do they use them</p>
Sexuality	<p>Their knowledge about sexual and reproductive health</p> <p>Their knowledge about their menstrual periods</p> <p>Any questions and concerns that they have about their menstrual periods</p> <p>Their thoughts and feelings about sexuality</p> <p>Whether they are sexually active; if so, the nature and context of their sexual activity</p> <p>Whether they are taking steps to avoid sexual and reproductive health problems</p> <p>Whether they have in fact encountered such problems (unwanted pregnancy, infection, sexual coercion)</p> <p>If so, whether they have received any treatment for this</p> <p>Their sexual orientation</p>
Safety	<p>Whether they feel safe at home, in the community, in their place of study or work; on the road (as drivers and as pedestrians) etc.</p> <p>If they feel unsafe, what makes them feel so</p>
Suicide/ Depression	<p>Whether their sleep is adequate</p> <p>Whether they feel unduly tired</p> <p>Whether they eat well</p> <p>How they feel emotionally</p> <p>Whether they have had any mental health problems (especially depression)</p> <p>If so, whether they have received any treatment for this</p> <p>Whether they have had suicidal thoughts</p> <p>Whether they have attempted suicide</p>

Sexual and reproductive health assessment

Here is an example of how a health worker may do a sexual and reproductive health assessment.

Menstrual history

- Have your periods started yet? If so, how old were you when your periods started?

Pain during the periods

- Do you have pain with your periods?
- Does the pain prevent you from carrying out your daily activities?
- What do you do to ease the pain?

Excessive bleeding during the periods

- How many days do your periods last when they come?
- How many pads (or equivalent) do you use a day?

Regularity of the periods

- Are your periods regular? Do your periods come at the same time every month?
- How many days are there normally between your periods?

Knowledge about sexuality

- Have you learned about sexuality at school, at home or elsewhere?

Note: Probe to find out whether the adolescent is knowledgeable about basic anatomy and functioning, menstruation, pregnancy and contraception, and sexually transmitted infections. Do this using questions tailored to the age, level of development and circumstances of the adolescent.

Sexual activity

- Depending on the context, ask whether their friends have boyfriends/girlfriends, and then whether they do so themselves.
- Again depending on the context, ask whether their friends have had sex, and then whether they have done so themselves. (Be aware that the word “sex” may mean different things to different adolescents. Probe about penetrative sex, e.g. “Does he touch your genitals only?” and “Does he put his penis in your vagina/mouth?”)

Pregnancy and contraception

- Do you know how one could get pregnant?
- Do you know how one could avoid getting pregnant?
- Are you currently trying to get pregnant?
- Are you currently trying to avoid getting pregnant?

- If so, what do you do to avoid getting pregnant?
- Do you know about contraceptive methods?
- If so, do you use any contraceptive method?
- Have you had sex in the last month?
- Is your period delayed? Have you missed a period?
- Do you have any of the following symptoms of pregnancy: nausea or vomiting in the morning, and swollen and sore breasts?
- When was the last time you had sex?

If sexually active... Sexually transmitted infections

- Do you know what a sexually transmitted infection is?
- Do you do anything to avoid getting a sexually transmitted infection?
- Do you know about condoms? Do you use them when you have sex? If so, do you use them always? If not, why not? Where do you get condoms?
- How many sexual partners have you had in last three months?
- Have you ever had an infection: genital sore, ulcer, swelling or discharge?
- If so, have you received any treatment for this?

I. Laws and policies that govern health service provision:

- laws and policies that specify the age at which diagnostic tests (e.g. an HIV test) or clinical management (e.g. provision of contraception) can be done with the independent consent of the adolescent;
- laws and policies on requirements to report infections (e.g. HIV) or assault (e.g. physical or sexual assault);
- laws and policies that require partner notification (e.g. in the context of a sexually transmitted infection);
- laws and policies that require a health worker to use government-approved standards and guidelines for clinical management.

II. Laws and policies on social issues that could affect your work with adolescents:

- laws and policies on protecting and safe-guarding minors;
- the stipulated age of consent for sex and the stipulated age of marriage (and any discrepancies between the two);
- the stipulated age at which tobacco and alcoholic products can be sold or purchased;
- laws and policies on the possession and use of psychoactive substances;
- laws and policies on homosexuality.

Part 3

Information to be provided to adolescents and their parents or other accompanying adults

3. Sexual activity

Sexual activity often begins during adolescence, within or outside marriage. Many adolescents become sexually active before they know how to protect themselves from unwanted pregnancies and sexually transmitted infections.

Adolescents need help to understand the changes that their bodies are going through. They also need support to deal with the thoughts and feelings that accompany their growth and development, and to make well-informed and well-considered decisions on beginning sexual activity. They also need advice and support to resist pressure to have sex against their will. Adolescents need to be well aware of the problems they could face through too-early and unprotected sexual intercourse, and about what they could do to avoid unwanted pregnancies and sexually transmitted infections. They also need to be able to obtain the health services they need to avoid health problems, and to get back to good health, if and when they experience health problems.

Messages for adolescents

1. Many adolescents, including older adolescents, have not started having sexual intercourse (i.e. the insertion of the penis into the vagina, mouth or anus). The decision to start to have sexual intercourse is an important one. Wait until you feel ready to do so. Do not start just because other people want you to do so.
2. Even if you have had sexual intercourse in the past, you could decide to stop doing so until you feel truly ready for it.
3. Talk to your parents or other trusted adults about how to make decisions about sexual activity, and about how to resist pressure from others to have sex.
4. As far as you can, avoid being with people or in places where you could be forced to have sex against your will.
5. Be aware that there are ways of having and giving sexual pleasure that carry no risk of becoming pregnant or getting a sexually transmitted infection. This includes kissing, caressing and touching or rubbing the genitals. (Contrary to popular belief, handling your genitals does not lead to any negative effects.)

6. If you decide to have sexual intercourse, always use a condom from start to finish.
7. If you have had sexual intercourse without a condom or other form of contraception, it is possible that you could get pregnant or a sexually transmitted infection, including HIV. You should seek help from a health worker as soon as possible. With prompt action after sexual intercourse without a condom or other form of contraception, a possible pregnancy or HIV infection may be prevented. Most sexually transmitted infections can be treated with simple medicines.

Messages for parents

What you should know:

1. While many adolescents wish that they could talk to their parents about their changing bodies and about sex, they feel uncomfortable to do so. So, they turn to other sources for information. Unfortunately, much of what they learn from other sources is misleading and incorrect.
2. Some people believe that talking with adolescents about sex will lead them to have sex. This is not true. In fact, adolescents who talk with their parents are more likely to postpone sex until they are ready, and to protect themselves and others when they do begin.





What you should do:

1. As your son or daughter grows and develops from childhood into adolescence, provide them with information on an ongoing manner about their changing bodies and about sex. Ask them if they have any questions or concerns. Show them that you are open to talk to them about this and other subjects.
2. Explain that sexual feelings are normal, but that having sex should be a well-thought through decision.
3. Explain that abstaining from sex is the only completely sure way to prevent pregnancy and sexually transmitted infections.
4. Talk to your son or daughter about how to prevent pregnancy and sexually transmitted infections, even if you have stressed the importance of abstaining from sex until they are ready. Explain that while there are different options for contraception, only condoms, if used properly, can reduce the risk of both pregnancy and sexually transmitted infections.
5. Discuss the pressures that they could face to have sex before being ready for it. Discuss how they could resist such pressures.
6. Encourage them to seek help from a health worker for advice and support, if and when they need to do so.

Notes


[illegible]

“Could I have HIV?”

Ask	Look/Feel/Listen	Symptoms & Signs
<p> TIP for the health worker: Say that you are now going to ask him/her some personal questions and reassure him/her that information will be kept confidential.</p> <p>Why do you think you could have HIV?</p> <p> TIP for the health worker: Allow the adolescent to speak without interruption. This is an opportunity to learn about his/her understanding of how one could get HIV.</p> <p>Symptoms associated with HIV infection</p> <ul style="list-style-type: none"> • Do you have/have you had recently <ul style="list-style-type: none"> – Noticeable weight loss – Prolonged diarrhoea – Prolonged cough – Prolonged fever – Painless purple bumps on your skin or in your mouth – White patches in your mouth – Painless swellings in your glands <p>Illness associated with HIV infection</p> <ul style="list-style-type: none"> • Have you ever been diagnosed with tuberculosis? <p>Risk factors for HIV infection</p> <ul style="list-style-type: none"> • Do you use a condom every time you have sex? • Do you have/have you had many sexual partners? • Does your partner have/has your partner had other partners? • Have you had unprotected sex in last 72 hours? • Do you/have you inject(ed) drugs? <p>Symptoms of STI syndromes</p> <ul style="list-style-type: none"> • Do you have/have you had? <ul style="list-style-type: none"> – Sore/ulcer on your genitals – Discharge from your vagina – Discharge from your penis – Scrotal pain/swelling <p>Do a Sexual and Reproductive Health Assessment</p> <p>Do HEEADSSS Assessment</p>	<p> TIP for the health worker: Say that you are now going to examine him/her. Ensure privacy of the examination setting. For young women, have a female colleague present if needed.</p> <p>Signs associated with HIV infection</p> <p>Check for</p> <ul style="list-style-type: none"> • Weight loss of more than 10% (if previous weight is available) $\% \text{ Weight Loss} = \frac{(\text{Old Weight} - \text{New Weight}) \times 100}{\text{Old Weight}}$ <ul style="list-style-type: none"> • Kaposi lesions (painless purple lumps on the skin of the palate in mouth) • Fungus infection in the mouth • Generalized lymphadenopathy • Evidence of serious infection (e.g. respiratory infection) <p>Signs of STI syndromes</p> <p>Check for</p> <ul style="list-style-type: none"> • Genital ulcer • Swelling in the groin • Discharge from the vagina • Discharge from the penis • Scrotal swelling <p> TIP for the health worker: Current or past STI constitutes a risk factor for HIV infection</p> <p>Do a General Physical Examination</p>	<p>Any symptom associated with HIV infection or Any sign associated with HIV infection or Any illness associated with HIV infection (With or without identified risk factors)</p> <p>Any risk factor for HIV infection and No symptoms associated with HIV infection and No signs associated with HIV infection and No illness associated with HIV infection</p> <p>No risk factor for HIV infection and No symptoms associated with HIV infection and No signs associated with HIV infection and No illness associated with HIV infection</p>

Adolescent: I had sex last week and I am worried that I may have HIV. I have had this cough for two weeks. Could it be AIDS?

Parent: My son/daughter has been ill for sometime. Could he/she have HIV ?

Classify	Manage	Follow-up
Possible HIV infection causing symptoms, signs or illnesses commonly associated with HIV infection	<p>Explain the classification</p> <p>If available on site, provide HIV testing and counselling</p> <p>If not available on site refer to a facility that offers HIV counselling and testing</p> <p>Provide counselling on safer sex/HIV risk reduction</p> <p>Treat any HIV related illness that have been identified (Refer to AMAI Guidelines)</p>	Agree on a follow-up visit or refer the adolescent elsewhere
At risk for HIV infection	<p>Explain the classification</p> <p>Provide counselling on safer sex/HIV risk reduction</p> <p>If available on site, provide HIV testing and counselling</p> <p>If not available on site refer to a facility that offers HIV counselling and testing</p>	Agree on a follow-up visit or refer the adolescent elsewhere
HIV infection unlikely	<p>Explain the classification</p> <p>Provide counselling on safer sex/HIV risk reduction in all cases</p> <div data-bbox="477 1675 1117 1962"> <p> TIPS for the health worker:</p> <p><i>Treat all classified STI syndromes using the appropriate algorithm.</i></p> <p><i>Encourage the adolescent to ask all partner(s) within the last two months to have themselves checked by a health worker whether they are symptomatic or not.</i></p> <p><i>Counsel regarding contraception and safer sex.</i></p> </div>	

Information to be given to adolescents and accompanying adults

Information to be provided and issues to be discussed before an HIV test is carried out:

1. Check the adolescent's understanding of key information on HIV.

- What is HIV?
- How is HIV spread (and how it is not spread)?
- How could HIV infection be prevented?
- What are the effects of HIV on the body?
- What is it that health workers can offer to people who have been found to have HIV?

(If necessary, fill knowledge gaps and correct misconceptions.)

2. Provide key information about the HIV test.

(i) What is an HIV test?

An HIV test is a blood test which detects the presence of natural chemicals (antibodies) that the body produces in response to the presence of HIV germs in the body. These antibodies are produced by the body 8–12 weeks after being infected with HIV.

(ii) What does a positive or a negative HIV test result mean?

An HIV-positive test result means that the person who has been tested has HIV infection. An HIV-negative test result means that the person who has been tested does not have HIV infection. However, as mentioned above, the antibodies that are detected by the HIV test are not produced by the body until 8–12 weeks after infection with HIV. Therefore, in the three months after infection occurs, the HIV test can still be

negative although the person tested has HIV infection.

(iii) What are the reasons for having an HIV test?

There are at least four good reasons for having an HIV test:

- Health workers can provide effective medicines to prevent HIV germs from multiplying in the body.
- Health workers can provide medicines to prevent or treat other illnesses resulting from the effects of HIV on the body (e.g. tuberculosis).
- If a woman who is infected with HIV wants to have a baby, she can be given medicines to reduce the likelihood of the HIV infection passing from her body to that of the baby (in her womb).
- Knowing whether one is HIV infected or not can help one to take the necessary steps to protect both oneself and others from infection.

3. Assure confidentiality and ongoing support.

Firstly, assure the adolescent that the test results will not be shared with anyone. Secondly, assure the adolescent that if he/she is found to have HIV infection, every effort will be made to provide him/her with the needed care and support either on the spot or from other sources of care and support.

4. Confirm the willingness of the adolescent to proceed with the test, and if so, obtain his/her informed consent to undertake the test.

Informed consent means that the adolescent has been provided with key

information about HIV and about HIV testing, has fully understood it and has agreed to undergo the test. Ask the adolescent if he is willing to take the test and if so, ask him to clearly say that he consents to undergoing the test. Remember that the patient has the right to refuse an HIV test.

Information to be provided and issues to be discussed before the HIV test results are disclosed:

- recall the discussion on the meaning of a positive and negative test result;
- enquire whether the adolescent has considered whom to share the result with;
- empathize with the adolescent, saying that you are aware that waiting for the test result must have been hard. Assure him/her of your support.

Information to be provided and issues to be discussed if the result is positive (i.e. it confirms that the person has HIV infection):

- share the test result;
- appreciate that the ‘bad’ news is likely to trigger a strong reaction; empathize with and comfort the adolescent;
- check the adolescent’s understanding on the implications of the test result and provide further explanation if needed;
- discuss whom they would share the result with;
- explain what support services could be provided;
- explore what immediate support they need;

- indicate when they could come back for further discussion.

Support disclosure:

Tell the adolescent that it would be useful to consider whom he/she would inform if found to have HIV. Parents, other members of the family, as well as friends could be a valuable source of support.

Ask the adolescent to identify one or two people whom he/she likes, trusts and could turn to for help.

Information to be provided and issues to be discussed if the test result is negative (i.e. it confirms that the person does not have HIV infection):

- share the test result;
- appreciate that even hearing the good news is likely to trigger a reaction in the young person; give the adolescent some time to calm down;
- check the adolescent’s understanding on the implications of the test result and provide further explanation if needed;
- Stress the importance of taking steps to continue staying HIV-negative by protecting himself/herself and indicate what support you could provide for this.

Tip for the health worker:

In case the exposure occurred less than three months prior to the HIV test, explain that a negative result could mean either that the adolescent is not infected with HIV, or that infection has occurred but that antibodies to HIV have not yet been produced by the body. Advise a repeat HIV test in 6–8 weeks.

Annex 5: Optional sessions

Optional Session A: Debate (40 minutes)

Tip for you

- > This session can be included at any time in the course after Session 5 has been dealt with.
- > Decide which one of the following statements you will use for the debate.
 1. “Health workers should be able to provide care and treatment to an adolescent minor living with HIV without obtaining the consent of his/her parents or guardian.”
 2. “An adolescent living with HIV should be supported to have a baby, if this is what they choose to do.”
 3. “A health worker should never break confidentiality by telling other people that an adolescent minor is living with HIV.”

Read aloud:

LEARNING OBJECTIVES

- to identify important issues relating to consent, reproductive choice or confidentiality when providing care and treatment to adolescents living with HIV;
- to debate these issues.

Group work and plenary:

If you are using debate questions 1 or 3, before putting up the debate statement first ask:
Who is considered to be a minor in your country for accessing health services?

Tip for you

- > As this question may lead to a heated discussion, the following information is given to assist you.
 - A **minor** under the law is a person who is not yet a legal adult (reaching the legal age of majority). This is usually determined by age, but can sometimes be defined by other factors, such as marital status.
 - National or local laws may or may not stipulate the age of majority for independent access to HIV care and treatment.
 - Article 3 (1) of the Convention on the Rights of the Child states that: “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, **the best interests of the child** shall be a primary consideration”.
- > Allow some discussion, and if consensus is not reached:

Say:

As a group, we may not be able to fully agree on who is a minor. However, even though we cannot agree on the exact definition of a minor for all situations, we will still hold this debate because it will allow us to explore some important issues.

Divide the group of participants into two and allocate one group “for” (i.e. they agree with the statement) and the other “against” (i.e. they disagree with the statement).

Explain that you would like to ask the participants to debate an important statement. Pin up Flipchart A.

FLIPCHART A

>> Debate statement:

(Write the statement you have chosen to debate here)

Say:

Each group must prepare a set of arguments for or against this debate statement (depending on which group you have been allocated to).

You will then argue the statement from the viewpoint of the group you are with (for or against), even if this is not your personal view.

You will have 10 minutes to prepare at least three strong arguments in your group and to write them on VIPP cards. Then you will ask a representative from your group to present the arguments and to argue your case.

Give different colour cards and a pen to each group (“for” and “against”).



When the time is up and everyone is ready, ask the representative from the “for” group to come forward and present. The presenter pins up one card at a time, and defends its contents. When all the cards are up from the “for” group, ask the “against” group to offer one effective argument against the statement on each card.

The facilitator will note down the counter arguments on the flipchart.

Then ask for the representative from the “against” group to put up cards and explain their arguments. Immediately after the presenter has finished speaking, encourage the other group to debate the points on the cards.

When all the arguments from both sides have been presented and countered, summarize the debate and stress that there will always be opinions from both sides.

Debates may not only be heated but also go on for a long time. It is therefore important to keep track of the time allocated to this session.

Optional Session B: National situation of HIV and young people

Mini lecture by guest presenter

(30 minutes)

Tip for you

> This section can be included any time after you have completed Section 3.

> Preparation

The facilitator should arrange for a guest presenter or an adolescent EPT to give a 20-minute presentation (plus 10 minutes for questions) on the national situation of HIV and young people in the country. If possible, the facilitator should choose a youth presenter or a person with experience of working with young people. The facilitator should meet with the presenter beforehand and discuss the presentation. The suggested content for the presentation is shown below.

If an adolescent EPT is presenting this section, he/she may need assistance beforehand, from the facilitator, to prepare the presentation. If it is not possible to have a guest presenter or an EPT, the facilitator should prepare and present this section.

SUGGESTED CONTENTS FOR PRESENTATION BY THE GUEST PRESENTER:

- national HIV prevalence rates among young people (where possible by mode of transmission) –check the UNAIDS website if data are not easily available;
- estimates of most common periods of transmission for young people living with HIV (perinatal or adolescence);
- national studies of knowledge, attitudes and behaviours relating to HIV among young people;
- consent to and confidentiality for care and treatment for minors (national laws and policies, and what happens in practice);
- availability of HIV treatment, care and support services for young people.

IF TIME PERMITS, INFORMATION ON:

- male and female condom use and availability to young people;

- estimates of most common periods of transmission for young people living with HIV (perinatal or adolescence);
- STI rates among young people;
- pregnancy rates and abortion rates among young people;
- situation regarding HIV stigma, discrimination and denial;
- sexual behaviour and injecting drug use behaviour rates among young people;
- availability of peer support for adolescents living with HIV (for example through non-government organizations);
- other available data, studies or national guidelines on young people and HIV.

Read aloud:

LEARNING OBJECTIVES

- **to provide participants with an overview of the current national situation of HIV and young people – problems and response;**
- **to provide information on the national situation on related sexual and reproductive health issues and young people.**

Mini lecture:

By guest presenter



Introduce the guest presenter.

Tell the participants that the presentation will last for 20 minutes with 10 minutes for questions

The guest will deliver the presentation.

Thank the guest presenter.

Invite the participants to ask questions and let the guest presenter respond.

Write any unresolved points on the “Come Back to Later” board.

Thank the presenter again and close the activity.

Optional Session C: Role play demonstration and practice on the 5 “A”s

Role play and plenary

(60 minutes)

Tip for you

➤ This session can be included after completing Session 9.

➤ **How to conduct a role play session**

A role play can be a valuable method of teaching and learning. It provides an opportunity for the expression of emotions, which often cannot be achieved through discussions alone. A role play can raise many issues in a much shorter time than other teaching–learning methods and can be used by:

- facilitators, adolescent EPTs and/or participants to demonstrate “good practice”;
- participants, as a problem-identification tool using prepared or spontaneous role play. This can occur in plenary or in small groups as a means of developing problem-identification skills.
- small groups of three members (in the role of health worker, adolescent and an observer), with rotating roles, which enables each person in turn to practise health worker skills, such as communication.

It is important to follow the rules of the role play. The facilitator should read the role plays before the course and adapt them if necessary to make them appropriate to the cultural situation. This may include changing persons’ names, the names of the location/site, or the circumstances of the event.

To ensure maximum spontaneity, the facilitator should reduce initial discussion of the role play to a minimum. If the role play is to take place in a plenary, place two or more chairs at the front of the room – one for the health worker, one for the adolescent and additional chairs for any others who are meant to be present in the role play, such as family members.

Ask for volunteers or adolescent EPTs to play the roles, explaining exactly their task. Explain that they will be expected to demonstrate a “typical” reaction between an adolescent and a health worker, not an ideal one. Start the first role play with the arrival of the adolescent to see how he or she is greeted by the health worker.

Let the role play run for 3–5 minutes. The facilitator and other participants should observe, especially focusing on what the health worker does or says that makes a difference to the way the adolescent reacts, what kind of body language is used by both the health worker and adolescent, what attitude the health worker displays towards the adolescent and any family members, and any difficulties the health worker experiences.

Afterwards, ask the role players to stay where they are until the discussion is over. Be sure to thank and praise the role players, and then ask them to come out of their roles, i.e. say who they really are. Explain to the group that this is important to diminish the surprisingly powerful effect role plays can have on the players afterwards.

Next, ask that participants to focus their comments on what happened in the role play, not on general issues that can be taken up later. Begin by asking each of the role players how they *felt* in their role (in addition to what they thought). When they have finished, ask the group for their reactions. If necessary, refer to any behaviour that was significant and ask people to comment on it. Demonstrate that you expect people to give helpful positive and negative feedback. When the group has finished commenting, go back to the role players to give them the “last word”.

The facilitator should decide who will do the demonstration role play in C1 and ask them to prepare. For the demonstration, select people who are experienced and confident, such as adolescent EPTs.

Read aloud:

LEARNING OBJECTIVES

- to bring together the information of this one-day course as a demonstration role play between an adolescent patient and a health worker;
- to give participants an opportunity to practice their skills in a role play;
- to provide participants with an opportunity to gain experience of using a role play in a participatory learning situation.

Role play:

C1 – Demonstration

Tell participants there will now be a demonstration role play. Place two chairs in the middle of the room and ask participants to sit where they can see and hear the demonstration.

Ask participants to take notes during the role play on the 5 “A”s, and the content and process of the interview.

Tip for you

- A facilitator and an adolescent EPT will present a prepared role play for about 3–5 minutes. They should have developed it together and prepared it before the course.
- They should include the following elements:
 - 16-year-old adolescent;
 - sexual transmission of HIV;
 - positive HIV test two weeks ago without parental consent or knowledge;
 - discuss issues of confidentiality, benefits of disclosure, accessing support networks, positive prevention (including positive living and condom use);
 - refer to peer group, plan for return visit.



Adolescent expert patient trainer

Ensure that the role play (3–5 minutes) is prepared in advance.

Allow some time for discussion and comments after the demonstration role play.

Role play:

C2 – Participants’ practice

Tell participants that now it is their turn.

Divide the participants into four groups.

In each group, they should decide who would play the role of the health worker.

An adolescent EPT or another participant can play the role of the adolescent patient.

The other participants will be observers.

Ask the participants to turn to the Scenarios for role play in Annex 7 of their Manual.

Review the instructions with them.

Tip for you

> (Annex 7 in the Manual)

Scenarios for role play

> Scenario One

Yugo is a 16-year-old boy who tested positive for HIV three weeks ago. He has come alone to the clinic today and appears distressed. He says he has not told anyone that he is HIV-positive and has felt both sad and angry much of the time since his HIV diagnosis. His girlfriend is upset with him because of the way he is behaving. His school work is getting neglected. His parents are worried and have tried to talk with him. He does not know what to do.

> Scenario Two

Janine is a 15-year-old girl who acquired HIV perinatally. She has known that she is HIV-positive for many years and has been coming to the health centre since she was a baby. She has been taking ARVs and generally feels well. She has had few problems with her health over the years.

Her mother died when Janine was seven and she has been living with her grandmother ever since. Her grandmother knows that Janine is HIV-positive but does not like to talk about it. Janine does not know her father. She has a close group of friends but none of them knows she is HIV-positive.

She has come today because she wants to talk about her friend Marco. He is a boy she likes very much and she knows that he likes her. She is worried because she does not want to put him at risk of acquiring HIV. She has strong feelings for him.

They have been arguing recently because she has been putting off having any physical contact with him. He has been trying to kiss her.

She has come today to ask your help to decide what to do.

The facilitator should keep track of time.

Remember to allow 10 minutes at the end of the session for plenary feedback.

Plenary:

C3 – Feedback

When the time is up, bring the groups back together.

Ask for general comments on the role play.

Ask what issues came up for each scenario.

Ask what went well and what was difficult.

Ask what the participants learnt.

Bring the activity to a close.

Notes

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