# NATIONAL PACKAGE OF CARE FOR ADOLESCENT AND YOUNG PEOPLE LIVING WITH HIV (AYPLHIV)

NATIONAL AIDS/STIs CONTROL PROGRAMME,
FEDERAL MINISTRY OF HEALTH 2022

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**Federal Ministry of Health, Abuja, Nigeria**

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## FOREWORD

Adolescents (10-19 years) are a heterogeneous group and have peculiar needs and challenges which have implications for their health and overall well-being. Adolescents Living with HIV (ALHIV) in Nigeria, often face additional challenges due to loss of parents or other relatives, delayed onset of puberty, difficulties coping with ART adherence, disclosure, stigma, and transitioning from adolescent stage to adulthood, among others. During this period, they undergo rapid physical, emotional, cognitive, and social development leading to new habits, patterns of behaviour and relationships that could either be harmful or beneficial as they grow into adults. Globally, interventions, service delivery models and approaches tailored to the specific needs of adolescents have shown significant improvements in their health outcomes; such interventions are now widely termed Adolescent-Friendly Health Services (AFHS).

In line with the global direction, Nigeria has put in place strategies to scale up services for ALHIV. The National Package of Care recommends interventions for adolescents and a framework for age-appropriate disclosure, transition, psychosocial support, and sexual and reproductive health. It also provides details of effective health services that health care workers should offer to adolescents presenting to health facilities for care.

This guide has been developed by the National AIDS/STIs Control Programme (NASCP) and its partners, for health care workers providing services to adolescents in various facilities. These include medical officers, clinical officers, counsellors, psychologists, nutritionists, nurses, public health officers, paediatricians, medical specialists, mental health practitioners and adolescent sexual and reproductive health specialists. The package will give impetus to the provision of adolescent-friendly services and ensure there are no missed opportunities to access comprehensive health services for any adolescent who visits a health facility.

In conclusion, I believe that our implementing partners, NGOs, and other key stakeholders will find this document useful, as this package of care is standard and instrumental within the Nigerian context while ensuring sustainability and easy replication across the different states of the country.

**Dr Osagie E. Ehanire MD, FWACS**
**Honourable Minister of Health**
**Federal Republic of Nigeria**

## ACKNOWLEDGEMENT

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We equally extend our appreciation to representatives of the following organizations who carefully reviewed the necessary documents and provided invaluable contributions: NACA, WHO, UNICEF, USG/PEPFAR, CIHP, APIN, FHI360, TMEC/RISE, AHF, CCFN, and APYIN.

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Finally, I commend the NASCP staff under the leadership of the National Coordinator, and especially the staff of the Treatment, Care and Support component of the programme that coordinated activities and meetings that ultimately culminated in the successful completion of this document.

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## EXECUTIVE SUMMARY

The 2022 National Package of Care for Adolescent and Young People Living with HIV consists of eight chapters guiding the packages of care for adolescents (10-19) years and young people (20-24) years living with HIV/AIDS in Nigeria.

This document is the product of work by experts and stakeholders in the control of HIV/AIDS, and it offers what the minimum packages of care will be and how these packages can be easily assessed by the targeted population.

The first chapter highlights the gaps in adolescent HIV programming, justification for the National Package of care, challenges facing the adolescent population as well as the pillars of the minimum package of care.

Chapter two provides useful information on novel strategies for reaching Adolescents and Young People with HIV Testing Services and considerations for making HIV testing Adolescent-friendly.

Chapter three focuses on Antiretroviral Therapy: benefits and recommendations of initiating ART, issues on retention in care and viral suppression were also addressed.

Chapter four is about psychosocial support services, their building blocks, importance, and assessment. Other areas covered are Adolescent Peer-Support and the establishment of Youth-Friendly Services.

In the fifth chapter, issues on disclosure, its importance, challenges, and barriers, how to assess readiness for disclosure as well as developing a disclosure plan by health care workers are explained in detail.

The sixth chapter deals with the process of transitioning from adolescence to adulthood which is still a challenge and can lead to significant challenges to health outcome and often results in loss to follow-up if inadequately managed.

Chapter seven covers adolescent sexual and reproductive health relating to rape, pregnancy, sexual violence, and challenges with PMTCT in adolescents.

Finally, the eighth chapter focused on monitoring and evaluation of adolescent services. It also provides basic information on the strategies for monitoring the implementation of services and relevant indicators used for measuring progress.

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## ACRONYMS

| | |
|---|---|
| **AYPs** | Adolescents and Young People |
| **AYPLHIV** | Adolescents and Young People Living with HIV |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ART** | Anti-Retroviral Therapy |
| **ARV** | Anti-Retro Viral |
| **CBOs** | Community Based Organization |
| **CLM** | Community-Led Monitoring |
| **CSO** | Civil Society Organization |
| **CD4** | Cluster of Differentiation 4 |
| **DNA** | Deoxyribonucleic Acid |
| **DSD** | Differentiated Service Delivery |
| **EC** | Emergency Contraception |
| **ECP** | Emergency Contraception Pill |
| **FLHE** | Family Life and HIV Education |
| **FMOH** | Federal Ministry of Health |
| **FSW** | Female Sex Workers |
| **HCW** | Health Care Workers |
| **HIVST** | HIV Self Testing |
| **HTS** | HIV Testing Services |
| **IDUs** | Injecting Drug Users |
| **KP** | Key Population |
| **NASCP** | National AIDS & STIs Control Programme |
| **MSM** | Men who have sex with Men |
| **MDT** | Multi-Disciplinary Team |
| **NACA** | National AIDS Control Agency |
| **NASCP** | National AIDS and STI Control Program |
| **OI** | Opportunistic Infection |
| **OTZ** | Operation Triple Zero |
| **PLHIV** | People Living with HIV |
| **PWID** | People Who Inject Drugs |
| **PLWD** | People Living with Disabilities |
| **PCR** | Polymerase Chain Reaction |
| **PEP** | Post Exposure Prophylaxis |
| **PID** | Pelvic Inflammatory Disease |
| **PMTCT** | Prevention of Mother to Child Transmission |
| **STI** | Sexually Transmitted Infection |
| **SRHR** | Sexual Reproductive Health and Rights |
| **SMS** | Short Messaging Service |
| **STI** | Sexually Transmitted Infection |
| **SNT** | Social Network Testing |
| **TG** | Transgender (person) |
| **TWG** | Technical Working Group |
| **TB** | Tuberculosis |
| **VAPP** | Violence Against Persons Prohibition Acts |
| **WAD** | World AIDS Day |

## DEFINITION OF TERMS

**Adherence to ART:** It is the extent to which a PLHIV behaviour coincides with the ART regimen as agreed through mutual decision-making between the PLHIV and the adherence counsellor.

**Adolescents**: Unless otherwise noted, adolescents are individuals aged 10-19 years. Young adolescents are individuals aged 10-14 years; older adolescents are individuals aged 15-19 years.

**ART:** This is the use of a combination of three or more ARVs to treat HIV to achieve better viral suppression. Highly active antiretroviral therapy (HAART) or Combination Anti-Retroviral Therapy (cART) is used interchangeably.

**ARVs:** These are medicines used to treat HIV.

**Clinical failure in adults and adolescents:** It is the presence of new or recurrent clinical event indicating severe immunodeficiency (WHO clinical stage 4 condition) following 6 months of effective treatment.

**Co-infection:** Co-infection is the spontaneous existence of two or more infections in an individual.

**Co-morbidity:** Co-morbidity is the occurrence of one or more illnesses in an individual with a primary disease.

**Continuum of care:** Is an integrated system of care that guides and tracks clients over time, through a comprehensive range of health services starting from screening for HIV, through to initiation of ART, retention in care and psychosocial support.

**CPT:** Cotrimoxazole preventive therapy is the routine administration of cotrimoxazole in all HIV-positive individuals to prevent the development of a variety of infections.

**Data Quality Assurance:** Data Quality Assurance is a routine measure to ensure the quality of data through a process of validation, reliability, precision, integrity, and timeliness.

**DBS:** Dried blood spot testing (DBS) is a form of bio sampling where blood samples are blotted and dried on filter paper. The dried samples can easily be shipped to an analytical laboratory and analysed using various methods such as DNA amplification.

**Decentralization in the context of HIV:** Decentralization is the devolution of part responsibility for the offer of HIV treatment and care from the tertiary and secondary level ART centres to the primary level health facilities.

**Differentiated care:** Differentiated care is the delivery of a minimum package of HIV/AIDS treatment care and support services according to the diversity of the care needs for people living with HIV.

**Evaluation:** Evaluation in HIV is a systematic assessment that focuses on expected and achieved accomplishments in HIV programmes.

**HIV Data flow:** Data flow is the transmission of HIV data from source (health facilities) through local governments and states data platforms to the Federal Ministry of health as the final data repository.

**HIV Data validation:** Data validation is defined as the checking of all collected HIV data for completeness, thoroughness and reasonableness, and the elimination of errors.

**HIV Re-testing:** This is a second HIV test conducted after a positive first test result. Re-testing is recommended before initiation of ART.



**Immunological failure in adults and adolescents:** This represents CD4+ cell count <= pre-treatment baseline value or persistent CD4 levels below 100 cells/mm3 or 50% decline from on-therapy CD4+ cell count peak level.

**Linkage to HIV prevention, care, treatment, and support:** Proportion/number of individuals who complete a medical visit within 3 months of the diagnosis of HIV.

**Monitoring in HIV:** Monitoring in HIV is the regular observation, recording and process of routinely gathering information about activities taking place in the HIV programme.

**Opportunistic infection:** Opportunistic infections (OIs) are infections that occur more frequently and can become severe in individuals with HIV when their immune system becomes weakened.

**PCR DNA:** Polymerase chain reaction is the use of an enzyme to multiply both HIV DNA and RNA in a blood sample.

**PEP:** Post Exposure Prophylaxis is the use of oral ARVs by individuals exposed to HIV to block the acquisition of HIV.

**Pharmacovigilance in HIV:** This is also known as drug safety. It is the collection, detection, assessment, monitoring, and prevention of adverse effects in patients on antiretroviral drugs and other medicines associated with the management of HIV/AIDS.

**PrEP:** Pre-exposure Prophylaxis is the use of oral ARVs to prevent HIV infection in individuals with a high risk of HIV exposure.

**Retention in HIV care:** Is the number of individuals on ART who are retained in the same facility or another within the HIV programme over a period.

**Sero-discordance:** Sexual relationship in which one partner is HIV positive and the other HIV negative.

**Stable on ART:** These are PLHIV who have received ART for at least one year and have no adverse drug reactions that require regular monitoring, no current illnesses, and have a good understanding of lifelong adherence with evidence of treatment success (i.e., two consecutive viral load measurements below 1000 copies/mL).

**Sustained viral suppression:** This is an optimal response to ART such that the viral load remains below the detection threshold usually at less than 20 copies of HIV RNA/ml.

**Task shifting/sharing:** It is a rational redistribution of tasks among health workforce teams, allowing a wider range of cadres to offer certain services, safely and effectively as a means of rapidly expanding access and improving health care.

**TPT**: TB Preventive therapy is the administration of single or combination anti-tuberculous therapy (including isoniazid) to individuals who may be at risk of acquiring tuberculous infection to prevent the development of TB disease. Active TB must be excluded before administration of TB Preventive therapy.

**Viral load:** It is the number of HIV RNA copies in a millilitre of plasma.

**Virologic failure:** It is a persistently detectable viral load exceeding 1000 copies/ml (that is, 2 consecutive viral load measurements within a 3-month interval, with adherence support between measurements) after at least six months of using ARV drugs.



**Young Persons**: Unless otherwise noted, young persons are individuals aged 20 – 24 years.



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# CHAPTER ONE: INTRODUCTION

## 1.1 Introduction

Globally in 2021, about 1.71 million adolescents were living with HIV, and an estimated 160,000 adolescents were newly infected with HIV, of which 75% were females.[1] In sub-Saharan Africa, adolescent girls and young women aged 15 – 24 are at a higher risk (about 2-4 times) of acquiring HIV infection due to their early sexual debut. Adolescent females (aged 10 -19) account for 85% of new infections in their age group. Knowledge about HIV and STI prevention among adolescent girls and young women aged 15-24 is low with only 15% found to have comprehensive knowledge about HIV[2].

An estimated 255,475 adolescents and young people are living with HIV in Nigeria, of which 47% and 54% are between 10-19 years and 20-24 years respectively. In 2021, there were approximately 21,629 new infections among adolescents and young people, further showcasing the need for strengthened age and context-specific programming in this population.[3]

Adolescents are a heterogeneous group undergoing rapid physical, emotional, and social development. Unique changes that occur during adolescence include emerging autonomy but limited access to resources, a dramatic increase in the number and variety of social relations that could increase vulnerability, development of self and sexual identity, including capacity for self-direction, enhanced but evolving cognitive ability, increased impulsivity, as well as a marked gap between biological maturity and assumption of adult roles. Adolescents, therefore, have peculiar needs and challenges that have implications for their health and well-being.

## 1.2 Justification for the National Package of Care for AYPLHIV

Addressing the distinct and diverse needs of adolescents living with HIV (ALHIV) to improve their HIV-related outcomes and reduce new infections among this population, requires comprehensive and integrated approaches if epidemic control is to be achieved. Adolescent HIV services in Nigeria (where available), often have limited integration with other adolescent health services. Surveys and HIV programme results have shown that over the years, ALHIV in Nigeria have been underserved and have significantly worse access to HIV testing, antiretroviral therapy coverage, and viral load suppression

[1] UNAIDS 2022
[2] UNAIDS 2021
[3] Nigeria spectrum estimate, 2022

compared to adults. They are at higher risk of treatment interruption both before and after antiretroviral therapy initiation, with pregnant ALHIV and adolescent key populations being particularly vulnerable.

***Challenges facing AYPLHIV***

It's important to understand that adolescents may have the following challenges:

- Reduced access to HIV Testing and other SRH services
- Delayed disclosure - which may be due to fear, stigma etc.
- Disease denial
- Poor adherence to care and treatment
- Lack of correct information on sexual and reproductive health
- Limited personalized risk perception
- Risky sexual behaviour e.g., having multiple sexual partners, age-disparate relationships, transactional sex, inconsistent condom use which may lead to unplanned pregnancies and sexually transmitted infections (STIs)
- Peer pressure
- Inadequate support systems
- School-related issues
- Alcohol and substance abuse
- Physical, emotional, and sexual abuse
- Preoccupation with body image, and delayed puberty leading to low self-esteem
- Harmful social and gender norms, including gender inequality and gender-based violence

The principles of adolescent-friendly health services and global standards of health care are already integrated into the 2020 National Guideline on HIV Prevention, Treatment and Care. However, this document will build on the minimum package of care stated in the Nigeria National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services (2018) with emphasis on AYPLHIV.

Adolescents and Young People Living with HIV need specific HIV-related services in addition to routine health services. A comprehensive and well-defined package of AYLPHIV service delivery models suiting the country's context must be developed, adopted, and implemented across Nigeria.

### 1.3 Goal

The goal of this document is to provide a description and guidance for the implementation of a standardized package of care for AYPLHIV in Nigeria.

### 1.4 Considerations for a Country-Specific Package of Care for AYPLHIV

Three critical principles considered in developing this package of care include:

- Strengthening health care workers' capacity to address the needs of AYPLHIV
- Use of the family-based approach that integrates parents or caregivers in the care of AYPLHIV
- Integration of psychosocial support, transition support, disclosure, and sexual and reproductive health services



**Pillars of the Minimum Package of Care**

- Strengthened clinical care
- Differentiated Service Delivery
- Psychosocial support
- Sexual and Reproductive Health Services
- Peer Support
- Positive living
- Transitioning to Adult care
- Prevention of Mother-To-Child Transmission
- Community linkages
- Disclosure support
- Retention

### 1.5 Overview of the Package of Care for AYPLHIV

| | |
|---|---|
| **WHAT** | ***Service Delivery:*** The package of care would ensure that AYPLHIV are empowered to make informed decisions about their health and wellbeing. It would enable parents, caregivers, and communities to support their positive living, rights promotion, and enable health care workers (HCWs) to deliver youth-friendly services.<br><br>***Capacity Building:*** This package of care guides the capacity building of health care workers, AYPLHIV champions, parents, and caregivers to deliver appropriate HIV services, steer peer-led support groups, and drive education programs in line with the evidence-based best practices. The HCWs will ensure that AYPLHIV receives peer counselling and psychosocial support alongside routine health services. Adolescent peer supporters/champions will also be trained to lead support groups and engage facility management and the Ministry of Health to routinely review and evaluate adolescent HIV service delivery.<br><br>***Community Engagement:*** At the community level, AYPLHIV peers will work to provide home-based support, and participation in community activities such as community dialogues, enlightenment, outreaches, screening for substance abuse, mental health, educative entertainment, as well as social and sports activities. Through outreaches, peers encourage young people to access HTS and provide linkage to both clinical and non-clinical services. |
| **WHO** | **Target Group**<br><br>Adolescents and young people aged 10-24 years; PLHIV, KP (FSW, MSM, IDUs, TG), PLWD including AYPs living in custodial centres, fragile and humanitarian settings.<br><br>**Stakeholders**<br>• Peer supporters<br>• Health Care Workers<br>• Community-Based Organizations<br>• Civil Society Organizations<br>• Faith-Based Organization<br>• Media Groups |



| | |
|---|---|
| | • Academic and Professional Bodies<br>• Implementing Partners<br>• Development partners<br>• Ministries of Health, other line Ministries, Department and Agencies |
| **WHERE** | Community and the facility with additional virtual support via phone calls/ SMS, WhatsApp, and other social media platforms. |
| **WHEN** | Monthly, quarterly, bi-annual, and annual meetings |
| **HOW (model)** | **The *Federal and State Ministries of Health*** with support from implementing partners will facilitate and coordinate the activities of the peer supporters in the community and facility. These activities include:<br>• Coordinating safe spaces<br>• Coordinating the training of health care workers, parents, caregivers, and teachers on the AYPLHIV package of care<br>• Hosting community dialogues<br>• Supervisory support to the peers<br>***Implementing Partners*** will provide training to service providers on youth-friendly service provision and psychosocial support<br>***The peer supporters/champions*** aged 15-24 years, will be trained to deliver a set of interventions in the community and within the facilities in close coordination with service providers. Specifically, they:<br>• Run the safe spaces which include support groups, teen clubs<br>• Oversee the reception, facilitate bookings, and support peers to navigate services within facilities<br>• Review appointment diaries, send out appointment reminders and follow up with peers who miss appointments<br>• Provide Sexual Reproductive Health and Rights (SRHR) and adherence counselling and information on treatment<br>• Conduct home visits<br>• Support commodity distribution<br>• Strengthen referrals and linkages between community and facility<br>• Lead youth advocacy<br>• Implement community-led monitoring<br>***CBOs*** will provide mentoring and coaching support to the peer supporters |

**1.6 Coordination of Package of Care for AYPLHIV Implementation:**

The National AIDS and STIs Control Programme (NASCP) will provide coordinated leadership for the delivery of high-quality AYPLHIV services. This approach should be fully integrated into quality-of-care policies and strategies within HIV programs. They should also be mainstreamed into existing structures at all service delivery points and supported by mechanisms that facilitate implementation at all levels of

care. A shift is needed from past approaches of building parallel services or implementing project-based models to an approach in which services are integrated into overall health systems.

**NASCP responsibilities**

In this regard, specific responsibilities of NASCP shall include:

I. Engagement of the Paediatric/Adolescent Sub-committee of the National Task Team on ART for programmatic planning and identification of optimal interventions for improved HIV service outcomes
II. Resource mobilization and sustained commodity supply security for a seamless implementation
III. Capacity building of relevant healthcare workers on the implementation of appropriate strategies and interventions
IV. Harmonization, disaggregation and analysis of national and state-level adolescent and young people HIV data for quality and accountability
V. Convening quarterly review meetings for evaluation of AYPLHIV programme implementation

**SASCP responsibilities**

The State's HIV programme is responsible for the state-level coordination of the Package of Care for AYPLHIV including:

I. Engagement for harmonization of state TWGs for improved programmatic planning and identification of optimal interventions
II. Lead state-level implementation of the Package of Care for AYPLHIV in collaboration with the implementing partners and facilities
III. Conduct supportive supervision and mentoring to ensure effective implementation of the package of care
IV. Ensure timely reporting of state-level AYP HIV service delivery data

# CHAPTER TWO: DIAGNOSIS OF HIV INFECTION

## 2.1 HIV Testing Services for Adolescents and Young People

In Nigeria, anyone aged 18 years or above can give their informed consent for HTS. Young people under the age of 18 who are married, pregnant, or sexually active may be considered "mature minors" and can also give consent for HTS. HIV Testing Services (HTS) providers must determine if young people under 18 years are "mature minors" by providing judgment-free counselling that respects the young person's rights, health, and well-being. Young people under the age of 18 years who are not deemed "mature minors" should be tested with the informed consent of their parent or legal guardian. Depending on the age and maturity of the young person, the HTS provider should discuss the reason for testing with the parent/guardian, and possibly also with the young person. If through these discussions, it becomes clear that HTS is also indicated for the parent/guardian, then it should also be offered to them. The HTS provider should work with the parent/guardian to identify the best strategy for disclosing the young person's HIV test result at an age and time that is appropriate, and for ensuring the young person has access to ART and other follow-up services, as needed. When testing children for HIV, the health, safety, and well-being of the child must take priority.

**Consent for HIV testing in adolescents**

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

**Importance of HTS for adolescents**

- Early diagnosis of HIV infection in adolescents is important for prompt referral and linkage to care and treatment as well as prevention
- With the increasing availability of ART and prevention interventions, early diagnosis can reduce transmission and improve health outcomes, thereby decreasing HIV incidence, and HIV-related morbidity and mortality, allowing clients to live longer and happier lives

- Adolescents who learn that they have HIV infection can obtain emotional support with adherence, disclosure, and other needs, obtain HIV treatment and care, and learn to reduce the risk of transmitting HIV to others
- Adolescents who test negative for HIV should be supported to reinforce prevention messages and provided with referrals to prevention services, such as condoms, VMMC, PrEP, and family planning, when appropriate

As uptake of HTS by adolescents is currently low and HTS services for adolescents have not been developed in many settings, these guidelines recommend expanded access to HTS for adolescents.

**2.2 HIV Testing Strategies for reaching AYPs**

1. **PITC**: Provider Initiated Testing and Counselling (PITC) is HIV testing and counselling that is initiated and provided by clinicians to people who visit healthcare facilities. All adolescents and young people attending health facilities, as well as those with symptoms that could indicate underlying HIV illness, should be offered PITC. The program should secure the supply of testing commodities, build HCW capacity, and integrate testing services where applicable to scale up PITC inside facilities in the country.

2. **HIVST:** Adolescents and Young People aged 15 – 24 years are prioritized for HIV Self-Testing (HIVST) to improve overall HTS uptake.

   **Benefits of HIVST among AYPs:**

   I. Promotes access to and creates demand for HTS
   II. It is convenient and discrete
   III. It increases patient autonomy and confidence
   IV. Assures confidentiality
   V. Empowers the individual
   VI. Provides opportunity for other health services

3. **Social Network Testing**: Is aimed at reaching hidden, high-risk networks through a snowball-like approach, expanding HIV case detection potential. Deployed as an integrated part of a differentiated model, it supports the linkage of HIV-positive adolescents to rapid treatment and connects HIV-negative adolescents to services that will help them remain HIV-negative.
   - HIV-positive and/or high-risk HIV-negative persons, particularly from Key Populations are enlisted as recruiters to identify individuals from their social network
   - Social and risk network strategies complement traditional peer outreach by engaging previously unidentified AYP and other high-risk populations like young KPs

4. **Index Testing Services**: Index testing services (ITS) is a focused HTS approach in which the household, family members (including children) and partners of people diagnosed with HIV are offered HTS.



5. **Recency testing**: Recency testing refers to an anti-body-based test to distinguish recent from long-term HIV infection using antibody avidity (binding strength).
    - The recency test kit is used to indicate whether a person's HIV infection was recently acquired i.e., in the last 4-6 months
    - It is a useful tool for disease monitoring and surveillance
    - All kits for this procedure should be evaluated in line with national standards before deployment or public health use after post-market validation
    - This test should be done immediately after the client tests positive using the National testing algorithm

**Considerations for making HTS Adolescent Friendly**

The fast developmental and social changes that occur during adolescence reinforce barriers to healthcare, negatively impacting access, and utilization of healthcare services. A fundamental problem for health care is breaking down barriers and finding effective ways to deliver services that are sensitive to the needs of adolescents. Support for ALHIV's continued engagement in care is critical for their long-term health and well-being, as they require regular—often monthly—appointments.

According to the WHO's 2016 consolidated guidelines on ARV treatment, "adolescent-friendly health services should be implemented in HIV services to ensure engagement and improved outcomes." Adolescent-friendly health services are those that are equitable, accessible, acceptable, appropriate, and effective.

- Equitable: All adolescents have access to the health care they require
- Accessible: Adolescents can easily access the available services, making such services simple to use
- Acceptable: Health services are delivered in ways that meet the needs of adolescent clients, such as by sensitive and non-judgmental health professionals
- Appropriate: Adolescents receive the appropriate, age-sensitive health services
- Effective: Adolescent health is improved when the appropriate health services are delivered in the most effective manner

Some other considerations for making adolescent services friendly include instituting flexible hours (e.g., weekend, evening), dedicated spaces to ensure privacy/confidentiality, and availability of non-judgemental, professionally trained staff.

### 2.3 Prevention services for AYPs

For Adolescents and Young Persons who test negative for HIV, it is important to provide integrated counselling and preventive services to ensure they remain negative. Adolescence is a period characterized by exploration and an increased likelihood of exposure to high-risk behaviours which must



be addressed. Indeed, national data has demonstrated that 40% of all reported new cases of HIV occur in individuals aged 15-24.

In Nigeria, there are social and contextual factors that make AYP vulnerable to HIV infection. Identification of the prevailing sociocultural factors in a particular community and designing targeted interventions to address them is key to success. However, the common drivers of the epidemic pertinent to Nigerian AYP include multiple and concurrent sexual partnerships, intergenerational sex, sexual coercion, low-risk perception, and transactional sex. Married adolescents and young women may also be exposed to an increased risk of HIV infection from non-faithful husbands.

Cross-cutting factors such as poor socioeconomic background, unemployment or underemployment, gender inequalities and gender-based violence are key exacerbating factors that prevention programs should identify and address. In addition, HCWs must pay attention to traditional, religious, and cultural factors such as child and forced marriage, female genital mutilation, and widow inheritance, to ensure holistic deployment of preventive services.

Effective deployment of prevention services requires efficient collaboration across a Multidisciplinary Team (MDT) including but not limited to primary caregivers, social workers, counsellors, linkage to harm reduction and opioid substitution programs as indicated by key risk factors identified. Additional information on Adolescent and Reproductive Health Services, sexual violence, and risky sexual behaviour assessment can be found in chapter 7.



# CHAPTER THREE: ANTIRETROVIRAL THERAPY

### 3.1 HIV Treatment for Adolescents and Young People

All positive adolescents and young persons tested for HIV utilizing the various strategies described in the previous chapter should be linked to care.

### 3.2 Linkage to care

The intended outcome of HTS and case finding is to ensure all children, adolescents and young people diagnosed with HIV are placed on life-saving antiretroviral treatment, retain them in care and ensure they achieve and maintain viral suppression. The following are some effective strategies for improving linkage for Adolescent and Young People:

**Facility-based strategies**:

- Adhere to the ''Test and Start'' strategy detailed in the 2020 National Guidelines on HIV Prevention, Treatment and Care
- Build the capacity of HCWs to efficiently document patient information in all registers, ensuring adequate availability of information required to facilitate tracking
- Designate a Paediatric & Adolescent focal person to routinely review facility data, ensuring all adolescents and young people not initiated are tracked appropriately

**Community-based strategies**:

- Introduce community-level support groups for parents of HIV-positive adolescents and young persons to educate them on the need to encourage their wards to seek and remain in care
- Provide individual support from community-based peers and/or community health workers (CHWs), community adherence clubs, camps, school-based activities and mHealth initiatives

### 3.3 Treatment of AYPLHIV

Antiretroviral therapy (ART) is the use of a combination of antiretroviral medications (ARVs) to treat HIV infection. All HIV-positive adolescents and young persons identified using the various HTS strategies should be linked to care for ART. If possible, all HIV-infected people, regardless of clinical stage or CD4+ cell count, should have relevant clinical and laboratory evaluation and started on treatment the same day or within 7 days of their HIV diagnosis.

Antiretroviral therapy should be provided comprehensively, with ongoing adherence counselling, baseline and periodic clinical and laboratory testing, prevention, and control of opportunistic infections (OIs), treatment monitoring, and follow-up.

The benefits of antiretroviral therapy for AYPLHIV include:

- Virologic, immunologic, and clinical control
- Prevents the development of ARV medication resistance
- Reduced morbidity from OIs
- Improves the quality of life of HIV patients
- Helps achieve epidemiologic control

**Initiating ART in AYPLHIV: Considerations for Implementation**

Ensuring that AYPLHIV achieves the benefits of ART requires:

- Introducing adolescent-friendly health services
- Providing appropriate provider training and implementing programmes that emphasize support for age-appropriate disclosure, adherence, and retention in care, including peer-to-peer support
- Involving parents and caregivers in developing treatment adherence plans for their wards
- Encouraging healthcare providers to leverage the influence that parents and caregivers exercise on their AYPLHIV to improve adherence to ART

**Recommendations for ART initiation in AYPLHIV**

Early ART initiation in AYP should be prioritized to ensure they benefit from effective age-appropriate counselling techniques which are a key component of the ART package. ART should be initiated in all AYPLHIV, regardless of WHO clinical stage and at any CD4+ cell count.

Nigeria has recommended the use of DTG with NRTI backbone as the preferred 1st line regimen for adolescents including women of childbearing age (TDF + 3TC (or FTC) + DTG). Women intending to get pregnant should however be provided with all necessary information to enable them to make informed choices.

All new AYPLHV for treatment initiation should be screened for Advanced HIV Disease. Those with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and a CD4+ cell count of < 200 cells/mm3 should be managed according to the 2020 National Guidelines for HIV Prevention, Treatment and Care.

### 3.4 Retention in Care and Viral Suppression

Adolescents and young people enrolled in HIV care and treatment need to stay in care to achieve the best possible outcomes. Service delivery models that encourage patient retention should be strengthened and expanded to include all health facilities. Tracking and following up of adolescents and young persons on treatment will aid in the identification of defaulters, those who are not receiving adequate treatment support at home, infants, and children/adolescents who experience treatment failure.



**Barriers to retention and VL suppression among AYPLHIV in care include:**

- Limited number of health facilities providing adolescent-friendly services
- Stigma, discrimination, and lack of disclosure/acceptance of HIV status
- Poor monitoring and tracking of patients on treatment resulting in LTFU
- Inadequate availability of skilled health personnel, jobs aids, limited capacity to manage paediatric HIV/AIDS, especially at lower levels of care
- Non-flexible clinic appointments
- Poor adherence due to pill burden and treatment fatigue
- Financial factors associated with accessing care
- Suboptimal viral load coverage and sample logging for prompt result return and clinical action

**Strategies to improve retention and VL suppression among AYPLHIV in care include:**

- Implementation of age-appropriate and structured disclosure, transition, and psychosocial support for AYPLHIV
- Capacity building for HCWs through regular training (including psychosocial support) and provision of job aids aimed at improving viral load coverage and use of results for decision making
- Strengthen the provision of treatment literacy for patients/caregivers and patient tracking systems
- Differentiated care models for AYPLHIV with multi-month prescription
- Stratified & dedicated clinic hours for adolescents



# CHAPTER FOUR: PSYCHOSOCIAL SUPPORT SERVICES

## 4.1 Introduction

Psychosocial support is critical to the care of AYPLHIV. According to WHO, psychosocial support addresses the ongoing emotional, social, and spiritual needs of AYPLHIV and their caregivers.

HIV-positive AYP face various challenges including disclosure, adherence, cognitive delays, substance abuse, parental bereavement, and other a myriad of clinical conditions. Even when access to treatment and adherence support is available, complex social issues such as stigma, gender-based violence, fear of the unknown, family conflict and caregiver challenges contribute negatively to the health of HIV-positive AYP. In addition, discrimination and disrespect by healthcare providers is a strong disincentive for adolescents and young people to use health services. Other factors that contribute to poor outcomes in this population include disempowering sexual and reproductive health legislation, inaccurate perceptions of HIV-related risk, and poor adherence and interruptions in treatment.

Psychosocial support and counselling increase the ability of AYPLHIV to cope with each stage of infection and enhance their quality of life. Psychosocial support further addresses the ongoing psychological and social problems of AYPLHIV, their families and caregivers, enabling all parties make informed decisions, cope better with stress, illnesses and deal more effectively with discrimination. Lastly, it improves adherence, retention, and viral suppression, thus preventing transmission and contributing to epidemic control.

Psychosocial support services are ideally provided by mental health professionals, such as psychiatrists, clinical psychologists, social workers, counsellors, nurses, etc. These professionals might also refer patients or their families to other needed services. Considering the need for task shifting in complex and busy health facility settings, peer supporters are being trained as lay health workers to provide psychosocial support. Nevertheless, peer supporters have no formal professional or paraprofessional certification to provide standard psychosocial support hence can only provide peer-to-peer support that may include the following services:

- Counselling
- Facilitating peer support group interactions
- HIV health education and treatment literacy
- Peer support activities (e.g., camps, teen clubs, adolescent-friendly corners in the facilities, sports, art, drama etc.)

- Caregiver and family engagement (e.g., home visit)
- Referral for professional mental health support

**Table 4.1 Building blocks for Psychosocial support for AYPLHIV**

| Building blocks | | Considerations |
|---|---|---|
| **When** | Every 1-6 months | • Psychosocial support should be available and accessible either as part of the package of support at ART refills visits or separately<br>• Such support should be available for uptake at a frequency appropriate to the specific need of the adolescents |
| **Where** | ▪ Health facilities<br>▪ Community<br>▪ Virtual environment | • Psychosocial support is ideally provided as close to people's homes as possible<br>• If a low concentration of AYP makes support groups at the community level unfeasible, virtual support could be considered. Alternatively, less frequent attendance at a more centralized location such as a youth-friendly health facility or individual one-on-one home support should be considered<br>• Pregnant and breastfeeding adolescents should continue to be supported within adolescent peer support environments<br>• Virtual environment includes SMS, social media platforms such as WhatsApp and others where applicable |
| **Who** | ▪ Professionally certified mental health specialists<br>▪ Trained lay providers such as adherence counsellors<br>▪ Trained peer supporters | • CBOs including the providers of services for OVC, and lay providers could be considered for providing these services |
| **What** | ▪ Peer group environment<br>▪ Psychosocial assessment<br>▪ Onward disclosure support | • Adolescent benefits from peer support environment such as support group<br>• For adolescents with identified concerns after assessment, a clear referral pathway must be defined |

| | | |
|---|---|---|
| | | • Despite growing independence, adolescents benefit from caregiver support<br>• Psychosocial support packages should consider supporting adolescents to disclose their status to adult support structures and involve such adults in their care |

**Importance of Psychosocial Support**

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

I. Empowers adolescents to gain confidence in themselves, and increases their understanding and acceptance of comprehensive HIV care and support services
II. Empowers caregivers to support AYP in dealing with various health-related and social issues
III. Enhances adherence to HIV care and treatment
IV. Promotes positive self-image and self-esteem
V. Assists AYP make informed decisions, cope better with illnesses and deal more effectively with stigma & discrimination
VI. Improves quality of life and prevents further transmission of HIV infection

**4.2 Psychosocial Assessment**

A psychosocial assessment is an evaluation of an AYP's mental, social, and emotional health. It considers the physical health of the AYP, as well as their self-perception and ability to function in the community. The HEADSS framework is recommended for the assessment of AYPLHIV's psychosocial status (Table 4.2). It is an internationally recognized tool for structuring an adolescent patient's assessment, with sections on Home, Education/Employment, Activities, Drugs, Sex and Relationships, Self-Harm and Depression, Safety and Abuse.

**Table 4.2 Psychosocial characteristics evaluated using HEADSS framework**

| Thematic Area | Content |
|---|---|
| Socio-demographic characteristics | Age, sex, education level, relation to the caregiver |
| **H**ome environment | Relationships with other household members, changing homes in the last 1-year, missing meals, and physical violence |
| **E**ducation | School performance, bullying, repeating classes, inability to pay school fees, change of schools in the last 2 years, and reasons for missing school |
| **A**ctivity and routine | Involvement in extracurricular activities and religious activities |



| | |
|---|---|
| **D**rugs | Use of drugs and substances of abuse |
| **S**ex | Involvement in sexual activity, the practice of safe sex and worry about pregnancy/sexually transmitted diseases. *Questions on sexual activity are restricted to adolescents aged 12 years and above* |
| **S**uicide and depression | Any adolescent with a score of 1 or more on PHQ-9 is considered to have a depressive symptom (Appendix 1) |
| Adherence to ARVs | Any positive response on any of the following 5 questions—do you ever refuse or miss drugs? Do you skip your drugs when in front of others? Do you have problems taking drugs daily or on time? — is taken as an indication of non-adherence |
| Full disclosure of HIV status | An adolescent is classified as having full disclosure if they listed HIV in responding to any of the following 3 questions — Why are you visiting the clinic? Due to which illness? Why are you taking medication? |

### 4.3 Adolescent Peer Support and Youth Friendly Services

Meaningful AYP engagement is one of the standards for high-quality adolescent-friendly health services, and adolescent peer support is a key strategy to achieve this standard. Many health facilities in low- and middle-income countries within sub-Saharan Africa offer some levels of peer-driven activities for AYPLHIV. Such services provide support in a variety of ways, such as individual or group, community or facility-based, and in-person or virtually.

There are many service-delivery challenges and gaps with AYP HIV programmes. Appropriate access to healthcare is often limited by inadequate understanding and sensitization of health providers at all levels of the different clinical and psychosocial needs of AYPLHIV. They have unique needs which require a targeted approach that considers their stage of life and the concomitant challenges that disclosure and transitioning inevitably bring.

There is existing evidence which suggests that peer-to-peer engagement is important and provides an effective mechanism for psychosocial support and improved levels of treatment adherence and health service engagement. AYPLHIV can play an effective role as trainers, counsellors and adherence supporters for their HIV-positive peers and undertake additional task-sharing activities. They serve as positive role models to younger children, relate to their experiences and have a greater appreciation for their concerns and fears. Peer Supporters can also help to identify and link newly diagnosed HIV-positive adolescents and young people to treatment, track interruptions in treatment and improve adherence.

**A peer-to-peer support model provides new evidence in working with AYPLHIV as a cadre of young community and health providers attached to a clinic. They can catalyse effective engagement between younger clients and the clinic, providing child and youth focused projects that improve the overall quality of services for HIV-positive AYP**



**Benefits of the Peer Support Model**

Studies have shown that the use of peer group interventions reduces adolescent risk-taking behaviour and improves decision making. Peer groups are made of adolescents of comparable ages who give psychosocial support, knowledge, and connections with peers who are dealing with similar issues like adherence to treatment, stigma, and disclosing HIV status to others. Participating in peer groups improves adherence, retention in care, and viral suppression, particularly when group sessions are paired with clinical services and the supply of antiretroviral therapy (ART). Asides from peer group meetings, Peer Supporters can improve adherence and treatment outcomes by:

- Implementing appointment reminder and defaulter tracking systems
- Facilitating home visits and community outreaches to reach AYPs who are reluctant to face the stigma of a clinic visit
- Coordinating support group activities, play and health education
- Absorbing some transferrable clinical responsibility from clinic staff, freeing up HCW time to focus on patients, and overall, reducing patient waiting times
- Supporting adherence and disclosure counselling sessions
- Acting as visible members in their communities, serving as role models for other AYPLHIV

The majority of AYPLHIV are not reached by peer groups, and uptake among ALHIV who attend services that host peer groups is often low. Understanding the hurdles to peer group participation, identifying, and applying mitigating strategies to secure accessible, acceptable, and sustainable scale-up is critical.

**Integrating AYPLHIV Into the Healthcare Team as Peer Supporters**

Peer supporters are considered valued members of healthcare teams and participate in weekly staff meetings and team activities. This provides the opportunity for the voice and needs of AYPLHIV to be heard in a clinical context. To carry out their duties, Peer Supporters must be utilized for specific tasks, closely supervised, and mentored by a designated staff member (AYP focal person) who ensures they perform their job description.

Many tasks necessary for the smooth functioning of a busy clinic are performed by health providers that could otherwise be performed by persons with less skill and training. Peer supporters should be trained to perform specific tasks that can free up the time of health providers for more technical tasks, thus ensuring that clinics operate more efficiently.

**Task shifting and sharing lessens the burden on health providers, allowing for greater focus on improving quality of care**



# CHAPTER FIVE: DISCLOSURE

### 5.1 Adolescent HIV Disclosure

Disclosure is the process of informing a client of his/her HIV status. It also involves sharing of HIV status of the caregiver and/or other family members with the child/adolescent (if applicable). It is important that the process of disclosure is initiated by a caregiver with support from a healthcare worker. It is a continuous process and not a one-time event.

Disclosure of HIV status among AYPLHIV and their families and/or support structures is a critically important component of care. However, despite the significance of disclosing an HIV diagnosis, the rate of disclosure globally among children and adolescents remains low.

**Forms of Disclosure**

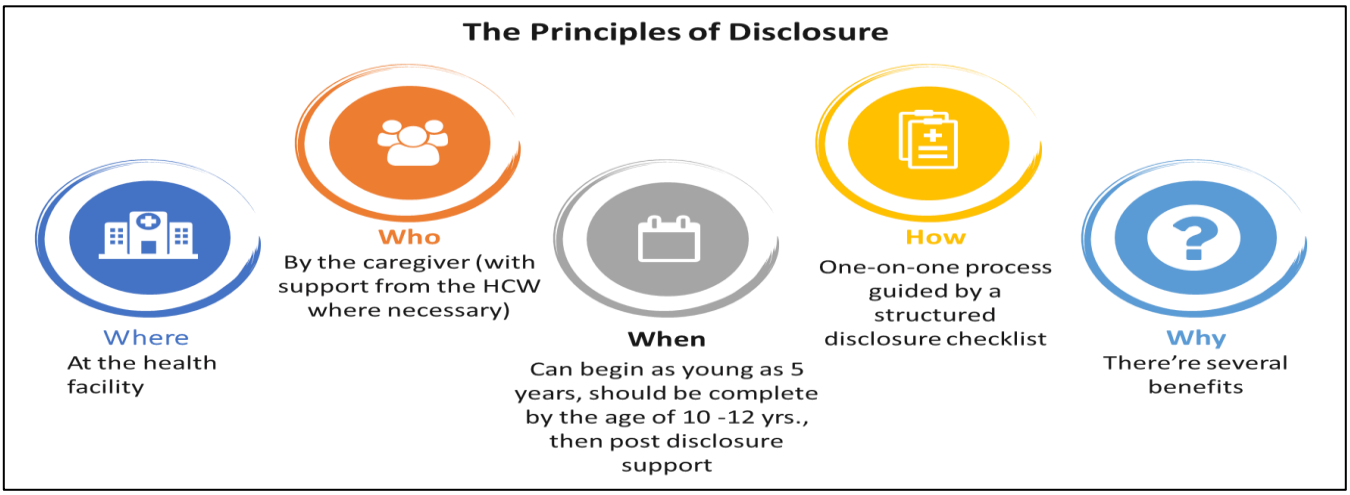
I. **Self-Disclosure**: This is a process in which a person reveals his or her HIV status to another person e.g., family member, sexual partners
II. **Assisted/Supported Disclosure**: The caregiver reveals the HIV status to the child in the presence of the health care provider where both are ready to manage the outcome. There is a checklist available to support the process.
III. **Accidental Disclosure**: Occurs when the child (often traumatically) gets to know their HIV status in an unplanned manner.

### 5.2 Process of Disclosure

The process of disclosure is complex, emotionally, and socially. Caregivers frequently experience uncertainty in revealing an HIV-positive status to their children, which stems from fears of negative consequences from disclosure, such as stigma, psychological problems, unintended disclosure to others, and inability to comprehend and deal with the diagnosis.

Studies, however, suggest that the majority of children who have been told their HIV diagnosis do not experience long-term negative effects, but instead benefit from knowing their status, with a large percentage of children in one study reporting disclosure as a positive event for them. Figure one below details the principles or pillars of disclosure.

*Figure 1: The Principles of Disclosure*




**Disclosure Readiness Assessment**

Disclosure should begin early in childhood from the age of 5 - 6 years with age-appropriate information. The healthcare worker should assess the readiness and willingness of caregivers to disclose HIV diagnosis to the child or adolescent, discuss caregivers' concerns about disclosure and ensure that the disclosure process is not rushed. (Refer to appendix 2 & 3 for the paediatric and adolescent disclosure checklists)

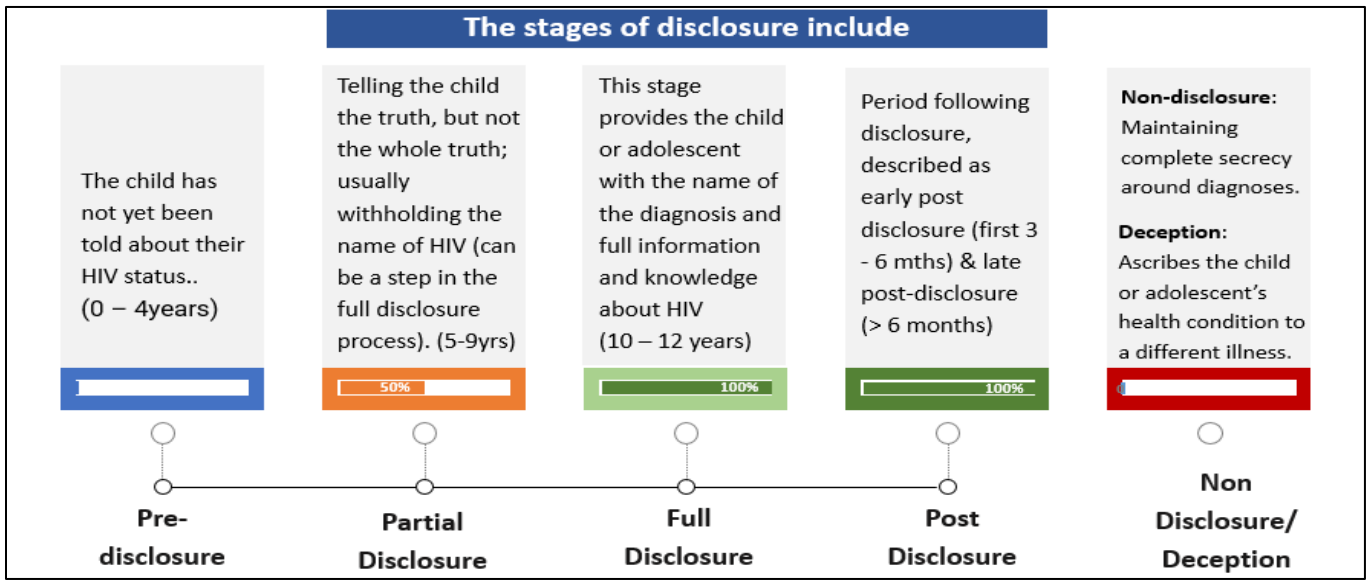
Before initiating the disclosure process, a readiness assessment should be done to evaluate:

- Level of functioning at school
- Family, peer relationships and support
- Interests, activities at school and within the community
- Moods and behaviour patterns on daily bases
- Sexuality and substance use
- Psychosocial assessment.

**Disclosure plan**

The disclosure plan should be developed by the HCW together with their parents or caregivers. The objective of this plan is to outline various stages of disclosure (figure 2), along with all factors which must be considered. The HCW and caregiver must agree on the plan and the caregiver should be prepared to handle the questions of the AYPLHIV.

*Figure 2: Stages of Disclosure*




**Post-disclosure**

The period following disclosure is commonly divided into two parts: early post-disclosure (the first three to six months) and late post-disclosure (greater than six months). The goal of post-disclosure evaluation and follow-up is to identify feelings, perceptions, and level of coping with the diagnosis, as well as to prevent complications after disclosure. (See appendix 4 and 5 for the post-disclosure checklists)

### 5.3 Benefits of Disclosure to Children and Adolescents

Despite being difficult to do, there are many benefits of telling an adolescent about their status. Caregivers need to disclose to adolescents because disclosure:

- **Improves adherence and treatment outcomes:** When AYP know their HIV status, they can be involved in their healthcare, and will be more likely to live positively and adhere to ART
- **Builds trust:** Disclosing to an adolescent shows them that you trust and respect them
- **Builds relationships**: By avoiding secrecy and lies we can help families to build stronger relationships. For AYP to find out they are HIV-positive from someone other than their caregiver can seriously harm the trust relationship
- **Helps adolescents cope better:** Giving AYP accurate information helps them to handle any stigma and discrimination in the community
- **Supports planning:** Once AYP know their status; they and their families can plan together for the future
- **Allows for informed choices:** AYP can make informed choices about sexuality and sex
- **Dispels fears:** AYP often know more than we think or give them credit for. They tend to know when something is being hidden from them, which can lead them to imagine a secret worse than the reality

- **Increases hope**: Disclosure provides opportunities for sharing positive messages with a client
- **Improves access to healthcare:** It is easier for caregivers to ensure that they have consistent care when they can be taken to clinic visits openly and medications can be named and explained
- **Increases ownership:** AYP can begin to take increased ownership over their health and their treatment which facilitates their transition into autonomous adults living with HIV

### 5.4 Challenges/Barriers to Disclosure

| Category | Challenges/Barriers to Disclosure |
|---|---|
| **Health Facility** | • Patient ART care cards do not require documentation of disclosure and lack standardized systems or approaches to disclosure<br>• Lack of training on disclosure<br>• Lack of tools or clear guidance available for disclosure<br>• Need for individualized approaches in addressing disclosure<br>• Constraints for time, space, and confidentiality within health care settings<br>• Limited support (e.g., psychologist and social worker referrals who are available for engagement and follow up |
| **Community** | • Desire to preserve the innocence of childhood, or belief that the adolescent is not ready or is too young<br>• Concern for their emotional or physical health following disclosure<br>• Fear of adverse consequences (e.g., psychological damage, poor self-esteem, etc.)<br>• Concern for being rejected, especially among HIV-positive parents<br>• Need to protect the child or adolescent and their family from stigma and rejection<br>• Culture and religion |
| **Individual** | • Self-blame, denial, anxiety, fear of death<br>• Fear of stigma and discrimination<br>• Feelings of hopelessness<br>• Chronicity of disease |
| **Caregiver** | • Apprehension<br>• Guilt<br>• Denial, self-blame, self-stigma, or stigma against PLHIV<br>• Discomfort among caregivers or family around disclosing an HIV status to their child or adolescent |

# CHAPTER SIX: ADOLESCENT TO ADULT HIV CARE TRANSITION

### 6.1 Adolescent to Adult HIV Care Transition

Transitioning is an intentional, planned process that facilitates and supports the movement of adolescents from adolescent care to adult care while preserving psychosocial and clinical gains. This ensures the coordination and continuity of services from adolescence to adulthood. The goal of the transition is to provide age-appropriate care, sustain or improve clinical status over time, and avoid treatment interruptions.

The period of transition may be challenging for the adolescent who may not have experience in managing his or her health. Globally, transitioning poses significant challenges to health outcomes and often results in Loss to Follow Up if inadequately managed. It is worthy of note that disclosure is key to a successful transition. Family/caregivers should be supported to conduct age-appropriate disclosure as described in Chapter 5.

This chapter provides concise guidance to programme managers and service providers on the phases and steps required to ensure adolescents living with HIV are thoroughly assessed for eligibility and provided adequate support pre- and post-transition to adult ART clinics. Table 6.2 provides comprehensive guidance on the activities to be conducted to ensure a smooth transition process.

### 6.2 Adolescent to Adult HIV Care Transition Pathway

| Phase | Steps | Considerations |
|---|---|---|
| **Pre-Transition** | Planning and Preparation | a. Build the capacity of HCWs to adequately prepare and support clients through the process of transition<br>b. Plan the transition process with the client, caregiver/treatment supporter, and any other persons required<br>c. Transition planning and preparation should start as early as 10 years or, latest at 14 years with the client and their caregiver and/or once disclosure to the child or adolescent has been fully completed<br>d. Transition plan should be a continuous process rather than a one-off event and should be tailored to adolescent capacities, readiness, and developmental age |

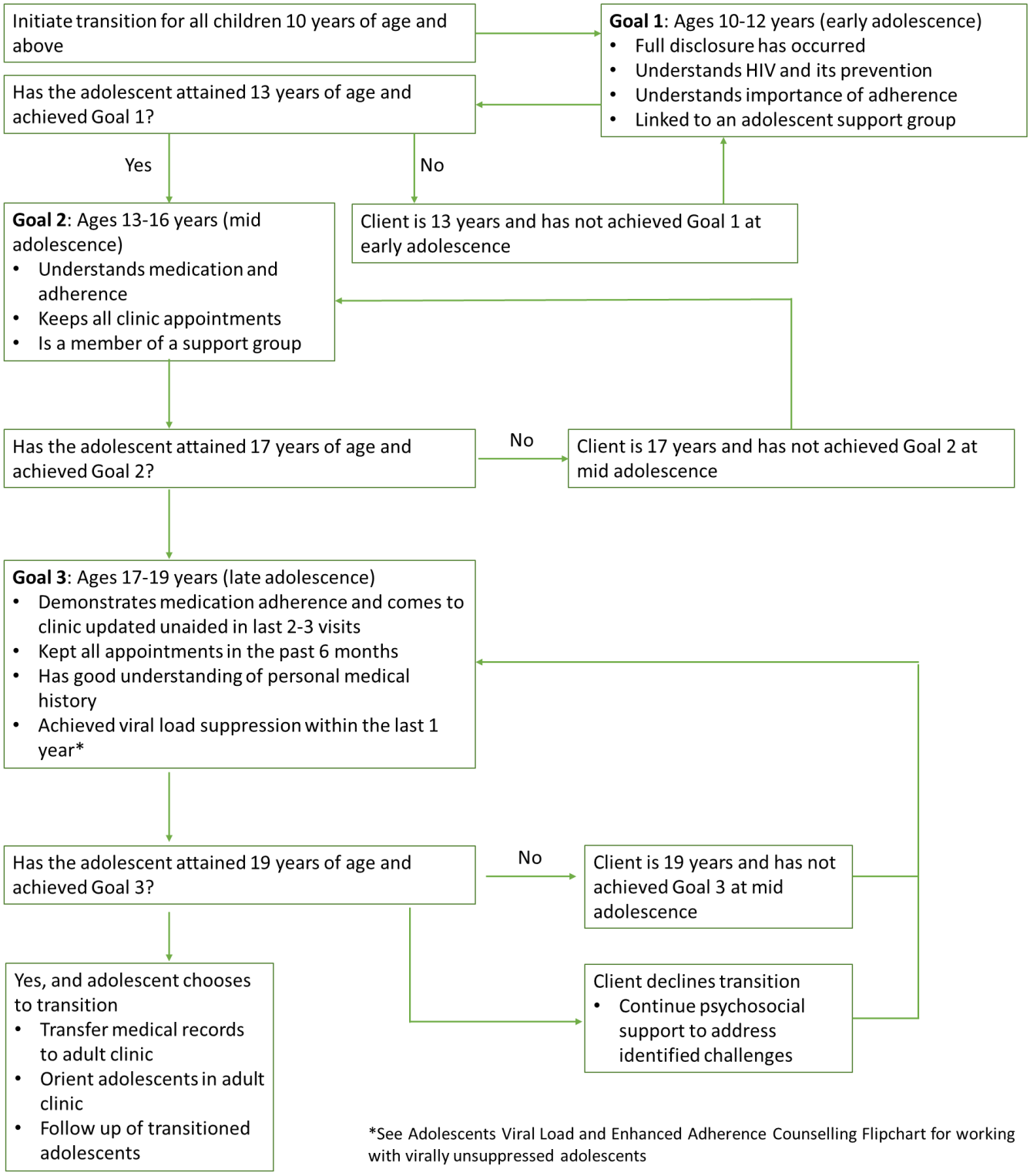
| | | |
|---|---|---|
| | Client (and Caregiver/Treatment Supporter) Case Review and Assessment | a. Agree on the location in which they will be receiving future services (different facilities, same facility but different day or providers), and the preferred service delivery model<br>b. A Client Case Review Assessment checklist should be completed by both client and HCW<br>c. Clinical transition forms should be completed and stored in client files |
| **Transition** | Transition Tasks | a. Draw a timeline for achieving the desired milestones during transition (figure 3)<br>b. The receiving provider or facility should be notified of the transitioning client<br>c. When feasible, a peer supporter should accompany the client to the new provider or facility for the first appointment there<br>d. The transition to a new HIV service delivery model could occur at the facility or community level<br>e. Support the client (and caregivers/treatment supporters) to develop a plan of action for individual self-management<br>f. Ensure proper transition documentation using a transition checklist and other relevant tools<br>g. Conduct monthly or quarterly multi-disciplinary team (MDT) meetings |
| **Post-Transition** | Follow-Up | a. A follow-up discussion is an opportunity to talk through the client's experience and address any concerns or questions they may have<br>b. Follow-up discussions should occur a month after transition and quarterly thereafter, based on need, for the next 6 - 12 months<br>c. Discussions can be conducted with a counsellor, peer mentor, or PSS facilitator, face-to-face at the new facility, over the phone, or via home visits and should be recorded in the client's folder<br>d. Client satisfaction throughout the transition process should be evaluated and discussed by the multi-disciplinary team |
| | Tracking and Reporting | a. Track clients' clinical outcomes and attendance at care and treatment appointments following the transition to identify any needs<br>b. Monitor the viral loads as stipulated in the national HIV treatment guideline<br>c. Document attendance, clinical information, and updates in the client record or folder, including VL, ARV regimen changes, referrals, and other follow-up items |



| | | |
|---|---|---|
| | | d. Follow up with any clients (and caregivers/treatment supporters if appropriate) who are lost to follow up to ensure re-engagement to care<br>e. Ensure that outcomes of tracking are communicated to the appropriate HCW in the transitioned setting |

As transition is a multi-step process occurring over multiple years, figure 3 provides a framework to stage client progress. Appendix 6 further provides a checklist to document transitioning.

*Figure 3: Transition Stages and Milestones*



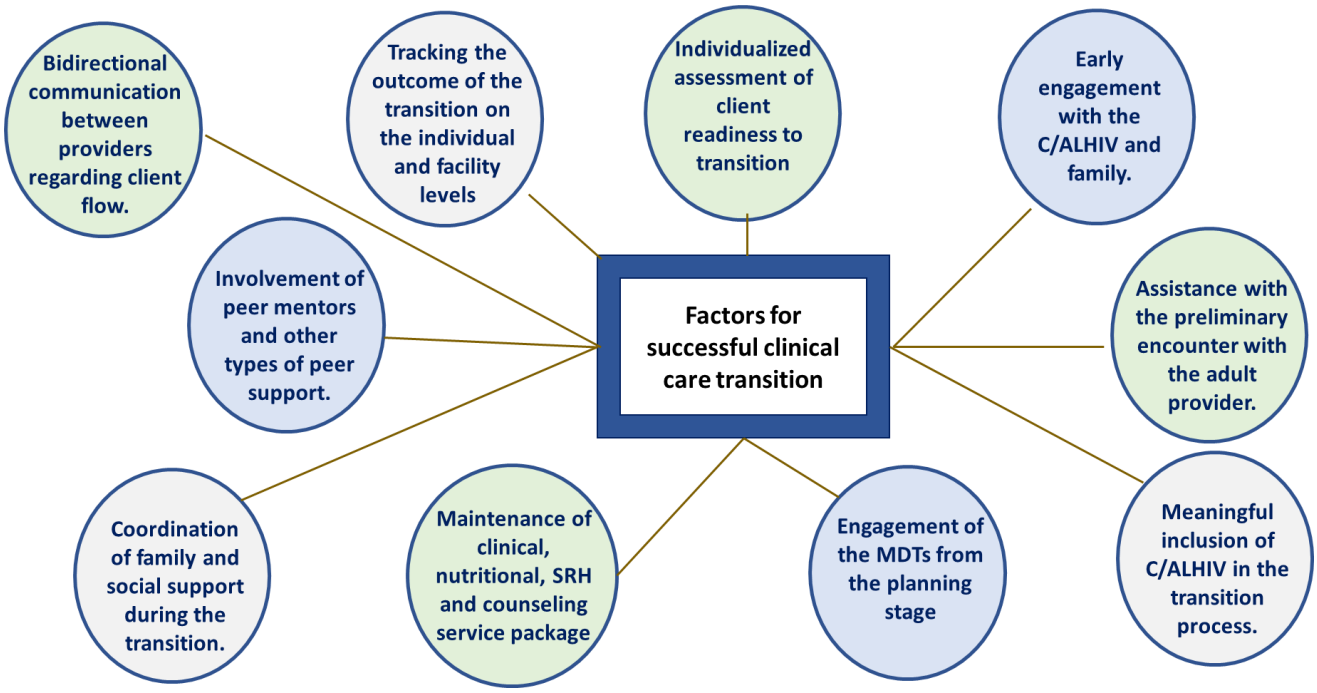

*See Adolescents Viral Load and Enhanced Adherence Counselling Flipchart for working with virally unsuppressed adolescents

### 6.3 Elements of an Effective Transition Process

- Utilization of a checklist to guide transition/development of a written transition plan (appendix 6)
- Coordination by a trained individual who addresses the psychosocial and educational/vocational needs of the adolescents
- Commencement from early adolescence
- Due consideration to adolescents' opinions and allowance for informed decision making
- Involvement of family/caregiver, with allowance for privacy if so required
- An interested and capable adult clinical service with administrative support
- A coordinated transfer process with a designated HCW to ensure continuity
- Capacity of the facility to provide multidisciplinary care
- Access to life skill acquisition and support

Figure 4 below provides a pictorial snapshot of the key elements required for a successful transition programme.

*Figure 4: Elements of an Effective Transition Process*



# CHAPTER SEVEN: ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

### 7.1 Adolescent Sexual and Reproductive Health

Adolescents face several critical health issues, including those related to sexuality and reproductive health which have a significant impact on their current and future health. It is important to note that adolescence is a period of self-discovery, exploration, and continued sexual development. Therefore, it is important to remember that:

- All adolescents have the right to a healthy sex life
- Adolescents should be equipped with the knowledge and skills to protect themselves and their partner(s) through comprehensive family life and HIV education (FLHE) and outreaches.
- Adolescents should be able to access and utilize sexual and reproductive health services which are offered in an integrated manner
- Discussions on issues of sexuality should be made in a constructive and non-judgmental manner
- Health care providers should be sensitive to the diverse sexual orientations of AYPLHIV and should work together with families/caregivers to reinforce accurate messages and education

**Key Terminologies**

**Abstinence**: This means not having sex. It is the only guaranteed method of avoiding STIs and pregnancy

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

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

- Having unprotected oral, vaginal, or anal sex
- Not using a birth control method or using birth control inconsistently
- Having more than one (multiple) sexual partners
- Changing sexual partners frequently
- Having unprotected sex with a partner of unknown HIV status
- Having sex under the influence of alcohol or drugs
- Having sex under coercion
- Having intergenerational sex

**Rape**

Rape is when a person intentionally penetrates the vagina, anus, or mouth of another person with any other part of his /her body or anything else without consent or with incorrectly obtained consent (by force, threats, intimidation, false and fraudulent representation, use of substances capable of taking away the will of that person or by a person impersonating a married woman's husband to have sex) (VAPP Act).

Health care providers should conduct a risk assessment (Appendix 7), provide information and counsel the adolescent to avoid risky sexual behaviours and emphasize the need to practice safer sex and refer appropriately (appendix 8).

### 7.2 Considerations for Adolescent Pregnancy

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

A pregnant adolescent client should be provided access to the following services:

- Abortion and associated risk counselling
- Antenatal services and development of a birth plan
- Malaria preventive therapy
- Management of infections including syphilis, and other STIs
- Nutritional assessment
- Management of pre-existing conditions and complications of pregnancy
- TB screening
- Safe delivery with a skilled birth attendant
- Crisis pregnancy counselling to adolescents with an unplanned pregnancy and their families to inform the choice of parenting or adoption
- Educational, vocational, and psychosocial counselling; encouragement to finish school after delivery if uncompleted.

### 7.3 Counselling for Planned Pregnancy for Adolescents Living with HIV

Adolescents must be properly counselled on the risks of unplanned or unwanted pregnancy during adolescence, especially early adolescence. Counselling should emphasize the following:

- Safety and benefits of waiting till adulthood to commence pregnancy and motherhood
- Prevention of Mother to Child Transmission strategies. The safest time to get pregnant is when the adolescent:
    - Has CD4 cell counts > 500cells/mm3



- Is healthy: without opportunistic infections (including TB) or advanced AIDS
- Is taking and adhering to her ART regimens
- Has undetectable viral loads if on ART
- Is in a stable relationship
- Is financially stable

- Recovery period of 2 years before the next pregnancy
- Treatment considerations in pregnant adolescents as defined in the National guidelines for HIV Prevention, Treatment and Care, 2020; chapter 6, pages 90-91.

### 7.4 Challenges with PMTCT in Adolescents

Pregnant and breastfeeding adolescents (and their partners) in addition to facing similar challenges as that of adults also have their peculiar challenges which constitute barriers to PMTCT programs. These include:

- Difficulty in adhering to ART
- Difficulty in the daily administration of medication to infants
- Non-adherence to recommended infant feeding practice in the first 6 months of life
- Fears and guilt of possible mother-to-child transmission of HIV
- Stigma and discrimination
- Lack of emotional and financial support from partner/ family members
- Possibility of dropping out of school
- Inadvertent disclosure of HIV status to others
- Lack of access to youth-friendly PMTCT information and services

### 7.5 Sexual Violence

Health care providers must have a high index of suspicion for any form of violence amongst adolescents, considering that most survivors of sexual violence do not disclose their experiences to service providers, families, or friends. Survivors of sexual violence make frequent visits to health care services because they are experiencing the physical and psychological effects of sexual violence, which can manifest as headaches, gastrointestinal distress and/or the physical effects of the violence such as Pelvic Inflammatory Disease (PID) and Sexually Transmitted Infections (STIs).

**Considerations for the Medical Management of Survivors of Violence**

Health care visits are the gateway to care for many survivors of sexual violence and providers are central to improving the outcomes of survivors of violence if they screen, educate, and refer their patients appropriately. Survivors of sexual violence must be offered essential medical care including:

- Management of any life-threatening injuries and extreme distress. This should take precedence over all other aspects of post-rape care.
- History and clinical examination

- Empirical STI prophylaxis to all survivors
- Collection of forensic evidence for presentation to the court
- Provision of Emergency contraception (ECP) to eligible clients (EC should be given within 5 days of sexual violence; ideally as early as possible to maximize effectiveness)
- Trauma counselling and mental health assessment
- Survivors of sexual violence should be encouraged to report to the police immediately after medical treatment.

# CHAPTER EIGHT: MONITORING AND EVALUATION

## 8.1 Monitoring and Evaluation

The HIV Monitoring and Evaluation (M&E) system tracks and ensures adequate documentation of HIV and related health services provided for People Living with HIV (PLHIV). It measures programme performance and informs improvement at every stage along the continuum of care; diagnosis, linkage to care, treatment, and retention in care. For continuity and efficiency, it is important to align the HIV M&E of the AYPLHIV Package of Care to the existing National M&E system.

## 8.2 Data Collection and Flow

As the National HIV/AIDS Health Sector Response indicators are disaggregated into different age bands which allows the derivation of AYP data, and indicators applicable to diagnosis, linkage to care, treatment, and retention be drawn from national systems. However, with regards to the nascent thematic areas i.e., psychosocial support, disclosure, transition support and ASRH services, this chapter proposes new and concise indicators to track implementation, improve programming and inform further revision as may apply. As with all national health sector data, data collection sources will include facility reporting systems/tools for programme data.

The National Data management process spans data collection, collation, validation, harmonization, and reporting. The process commences with health facility level collection and collation of programme data utilising the national data reporting forms and registers, as well as Electronic Medical Records (EMR) where available. The Local Government Area (LGA) M&E HIV/AIDS focal persons are tasked with monthly data collation from all health facilities offering HIV services within their jurisdiction and submitting summaries to the State HIV/AIDS and STI Control Programme (SASCP). SASCP is tasked with reviewing and validating reports, as well as submitting them to the National HIV/AIDS AND STI Control Programme (NASCP), and a copy shared with the State Agency for the Control of AIDS (SACA) for onward submission to the National Agency for the Control of AIDS (NACA). Furthermore, NASCP further reviews and validates state data, and submits to NACA and the Department of Health Planning and Research (DPRS), Federal Ministry of Health every quarter. Reporting to national leaders and donors occurs at this level.

The progress of specific indicators vis-a-vis targets will be reviewed and reported by the M&E officers, state paediatric and adolescent focal persons, and SASCP leads. Progress, challenges, and quality improvement are to be addressed at weekly situation room meetings, monthly or quarterly LGA, state or National review meetings/TWG meetings.

In addition to the above, most comprehensive health facilities have Electronic Medical Recording (EMR) system through which patient information is onboarded into the National Data Repository (NDR). The District Health Information System (DHIS) has been developed to facilitate direct real-time data entry by facility M&E officers thus reducing transcription errors and improving data quality.

### 8.3 HTS and ART data flow pathways

Figures 5 and 6 details the reporting pathways for HTS & ART data respectively. Data from the individual Patient Management and Monitoring tools (PMM) is aggregated into the Program Monitoring and Evaluation (PME) tools. Aggregated data is shared to higher levels through the EMR/NDR pathway and the DHIS pathway. The data should be reported on the NDR or DHIS by the 14th of every subsequent month as seen in figure 7 below.

*Figure 5: Workflow for HTS Data Collection Tools*

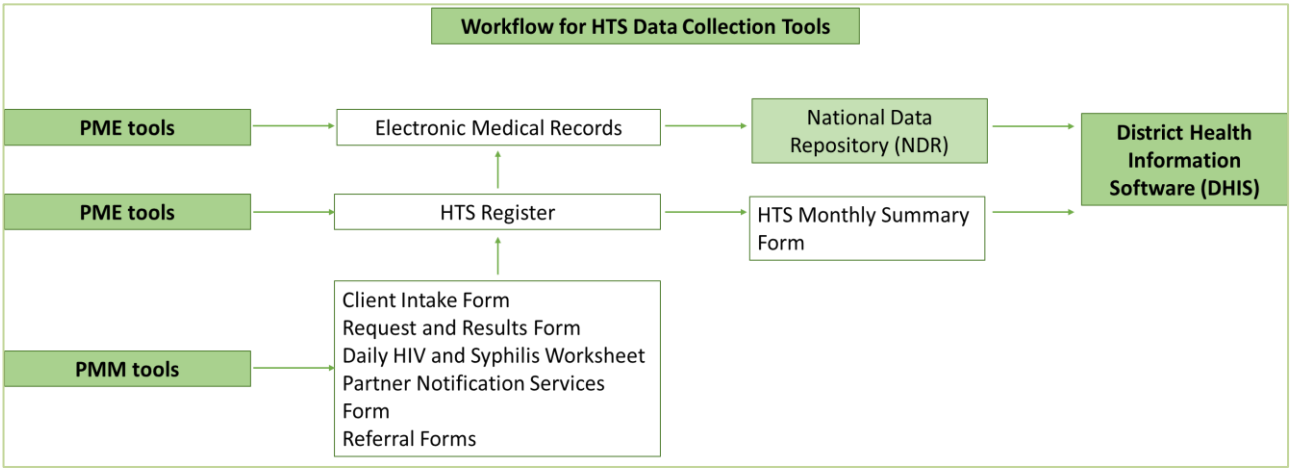



*Figure 6: Workflow for ART Data Collection Tools*

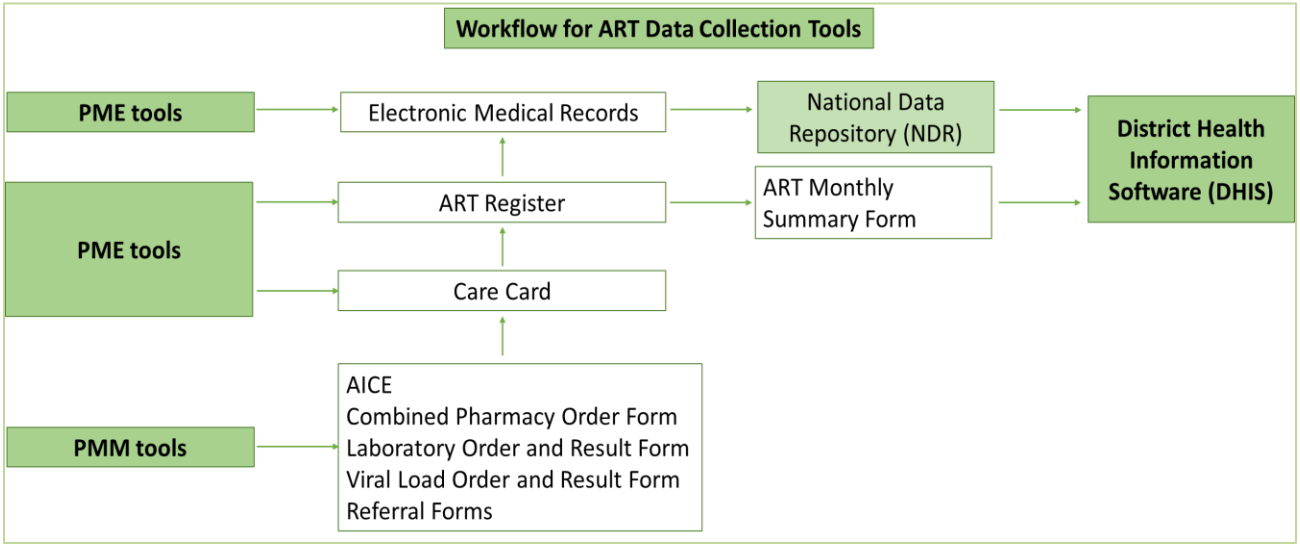
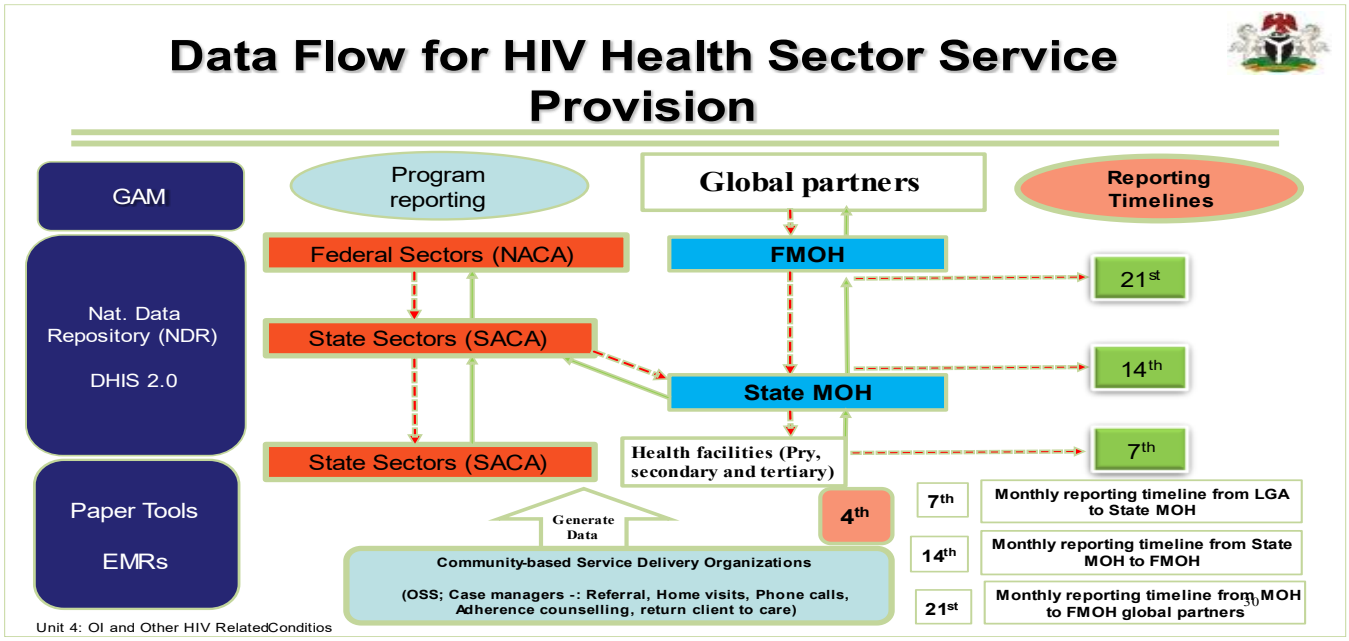


*Figure 7: HIV Health Sector Data Reporting Structures and Timelines*



### 8.3 Monitoring & Evaluation Framework

| Indicators | Definition | Level of measurement | | | | Disaggregation | How to measure | Unit of measurement | Frequency of Reporting | Data Source | Responsible person |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Input | Output | Outcome | Impact | | | | | | |
| Total number of people tested for HIV and received results. (Age 10-24 years) | This indicator measures the total number of persons aged 10-24 years, tested for HIV, and received their test results as either positive or negative within the reporting period. It is intended to monitor the uptake of HTS within the country | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**Test result**: Positive, Negative<br>**Service delivery points**: In-patient, Out-patient (C&T, TB, FP, STI), PMTCT, Community (OVC, Index, Outreach) | As contained in the National HTS Indicator Reference Sheet | | | | |
| Total number of persons tested negative for HIV, who were linked to preventive services (Age 10-24 years) | This indicator measures the number of persons aged 10-24 years who tested negative for HIV and linked to preventive services | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**Service**: PrEP, VMMC, condom use, PMTCT | Count the number | Number | Monthly | Client intake form/register | Facility M&E Officer |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of People living with HIV newly started on ART during the reporting period. (Age 10-24 years) | Number of PLHIV aged 10-24 years who were newly initiated on ART | | | | | **Sex**: Male, Female **Age**: 10-14, 15-19, 20-24 | As contained in the National ART Indicator Reference Sheet | | | | |
| Number of PLHIV who are currently receiving ART during the reporting period. (Age 10-24 years) | Number of PLHIV aged 10-24 years who are currently receiving ART | | | | | **Sex**: Male, Female **Age**: 10-14, 15-19, 20-24 **Regimen**: First line, second line, third line **DSD**: Facility (MMD, others) based, community-based | As contained in the National ART Indicator Reference Sheet | | | | |
| Percentage of PLHIV who are on optimal ARVs for their weight (Age 0-24 years) | Percentage of PLHIV aged 0 - 24 years who are on optimal ARV regimen for their weight during the reporting period | | | | | **Sex**: Male, Female **Weight**: 3-5.9kg, 6-9.9kg, 10-19.9kg, 20-24.9kg, 24-29.9kg, >30kg | Count the number | Proportion | Monthly | Facility EMR | Facility M&E Officer |
| Percentage of PLHIV currently receiving ART who are retained in care (Age 0-24 years) | This indicator provides a measure of the overall gain or loss in PLHIV in care compared to the expected number of PLHIV in care | | | | | **Sex**: Male, Female **Age**: 0-4, 5-9, 10-14, 15-19, 20-24 **DSD**: Facility (MMD, others) based, community-based | Count the number | Proportion | Monthly | Facility EMR | Facility M&E Officer |



| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Number of PLHIV on ART who received clinical TB Services | This indicator measures the number of PLHIV aged 10-24 years on ART who received TB screening services and are placed on appropriate management | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**ART status**: (New/Prior)<br>**Screened**: (Yes/No)<br>**Presumptive**: (Yes/No)<br>**Received TPT**: (Yes/No, Started/Completed)<br>**Tested for TB**: (Yes/No)<br>**Test results**: (Positive/Negative)<br>**Treated for TB**: (Yes/No) | As contained in the National ART Indicator Reference Sheet |
| Number of PLHIV on ART who were newly diagnosed with viral Hepatitis during the reporting period. (Age 10-24 years) | Number of PLHIV aged 10-24 years on ART newly diagnosed with viral hepatitis (B or C) via Rapid Screening Tests (RTKs) | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**Type**: HBV/HCV | As contained in the National ART Indicator Reference Sheet |
| Percentage of PLHIV on ART (for at least 6 months) with VL test result. (Age 10-24 years) | Percentage of PLHIV aged 10-24 years on ART for at least 6 months with VL test result within the reporting period | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**DSD**: Facility (MMD, others), community-based | As contained in the National ART Indicator Reference Sheet |



| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Percentage of PLHIV on ART (for at least 6 months) who have virologic suppression. (Age 10-24 years) | Percentage of PLHIV aged 10-24 years for at least 6 months who have suppressed viral load (<1000copies/ml) during the reporting period | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**DSD**: Facility-based (MMD, others), community-based | As contained in the National ART Indicator Reference Sheet |
| Number of annual AIDS deaths among PLHIV during the reporting period. (Age 10-24 years) | Number of PLHIV aged 10-24 years who have died of AIDS-related illnesses during the reporting period | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24 | As contained in the National ART Indicator Reference Sheet |
| Number of newly diagnosed PLHIV with CD4 Test Result. (Age 10-24 years) | Number of newly diagnosed PLHIV aged 10-24 years who received CD4 test and have results | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**CD4 Test Result**: < 200cells/mm3, >200cells/mm3 | As contained in the National ART Indicator Reference Sheet |
| Number of newly enrolled PLHIV presenting with CD4< 200cells/mm3 screened for Cryptococcal Antigen (CrAg) before ART | Number of newly enrolled PLHIV aged 10-24 years presenting with CD4<200cells/mm3 screened for Cryptococcal Antigen before ART initiation | | | | | **Sex**: Male, Female<br>**Age**: 10-14, 15-19, 20-24<br>**CrAg Result**: Positive, Negative | As contained in the National ART Indicator Reference Sheet |



| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| initiation. (Age 10-24 years) | during the reporting period | | | | | | | | | | |
| Number of newly enrolled PLHIV presenting with CD4 <200cells/mm3 with Cryptococcal meningitis who were started on treatment for Cryptococcal Meningitis before ART initiation. (Age 10-24 years) | Number of newly enrolled PLHIV aged 10-24 years presenting with CD4 <200cells/mm3 with Cryptococcal meningitis who were started on treatment for Cryptococcal Meningitis before ART initiation | | | | | **Sex**: Male, Female **Age**: 10-14, 15-19, 20-24 | As contained in the National ART Indicator Reference Sheet | | | | |
| Number of PLHIV on ART who were newly devolved into a Differentiated Service Delivery (DSD) model during the reporting period. (Age 10-24 years) | Number of PLHIV aged 10-24 years on ART who were newly devolved into Differentiated Service Delivery (DSD) model. During the reporting period | | | | | **Sex**: Male, Female **Age**: 10-14, 15-19, 20-24 **DSD Model**: Facility-based (MMD 3, MMD6, others), Community based (home service, community pharmacy, others) | As contained in the National ART Indicator Reference Sheet | | | | |
| Number of AYPLHIV who received psychosocial | Number of AYPLHIV aged 10-24 years who received psychosocial support | | | | | **Sex**: Male, Female **Age**: 10-14, 15-19, 20-24 **Depression Severity**: | Count the number | Number | Monthly | Psychosocial Support Register | Facility M&E Officer |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| support services during the reporting period. (Age 10-24 years) | services during the reporting period using the HEADSS framework | | | | | Minimal, Mild, Moderate, moderately severe, severe using the PHQ-9 questionnaire<br>**Peer Group**: Enrolled, not enrolled<br>**Mental health**: support groups: Enrolled, not enrolled | | | | | |
| Number of AYPLHIV who have undergone age-appropriate disclosure during the reporting period. (Age 5-24 years) | Number of AYPLHIV aged 5-24 years who have undergone age-appropriate disclosure during the reporting period | | | | | **Sex**: Male, Female<br>**Age**: 5-9,10-14, 15-19, 20-24<br>**Type of Disclosure**: Full, Partial, Accidental | Count the number | Number | Monthly | Disclosure Register | Facility M&E Officer |
| Number of AYPLHIV who were successfully transitioned into adult HIV care during the reporting period. (Age 15-24 years) | Number of AYPLHIV aged 15-24 years who were successfully transitioned into adult HIV care during the reporting period | | | | | **Sex**: Male, Female<br>**Age**: 15-19, 20-24 | Count the number | Number | Monthly | Transition Register | Facility M&E Officer |

*Figure 8: Combined Data Flow with Timelines*

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of AYPLHIV who received SRH education during the reporting period. (Age 10-24 years) | Number of AYPLHIV aged 10-24 years who received SRH education during the reporting period. | | | | | **Sex**: Male, Female **Age**: 10-14,15-19, 20-24 | Count the number | Number | Monthly | SRH Register | Facility M&E Officer |
| Number of AYPLHIV who received SRH services during the reporting period. (Age 10-24 years) | Number of AYPLHIV aged 10-24 years who received SRH services during the reporting period. | | | | | **Sex**: Male, Female **Age**: 10-14,15-19, 20-24 **Type of Services**: FP, STI, cervical cancer screening, Others | Count the number | Number | Monthly | SRH Register | Facility M&E Officer |
| Number of AYPLHIV who reported any form of sexual violence during the reporting period (Age 10-24 years) | Number of AYPLHIV aged 10-24 years who reported any form of sexual violence during the reporting period | | | | | **Sex**: Male, Female **Age**: 10-14,15-19, 20-24 **Type of violence**: Rape, GBV | Count the number | Number | Monthly | GBV tools | Facility M&E Officer |
| Number of AYPLHIV who received post GBV services during the reporting period (Age 10-24 years) | Number of AYPLHIV aged 10-24 years who received post GBV services during the reporting period | | | | | **Sex**: Male, Female **Age**: 10-14,15-19, 20-24 **Service delivery**: Received services, Referred for services | Count the number | Number | Monthly | GBV tools | Facility M&E Officer |

## Appendix 1: Patient Health Questionnaire-9

| **Patient Health Questionnaire-9 (PHQ-9)**<br>The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression | | | | |
|---|---|---|---|---|
| **Date:** | | **Patient ID:** | | |
| Over the last 2 weeks, how often have you been bothered by the following problems?<br>*Tick "✓" the appropriate answer* | Not at all | Several days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling asleep, staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |
| Column totals | | | | |
| Total score | | | | |
| 10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?<br>□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult | | | | |

| PHQ-9 Questionnaire Interpretation | | |
|---|---|---|
| **PHQ-9 Score** | **Depression Severity** | **Proposed Treatment Actions** |
| 0 - 4 | None - minimal | None |
| 5 - 9 | Mild | Watchful waiting, repeat PHQ-9 at follow up |
| 10 - 14 | Moderate | A treatment plan, considering counselling, follow-up and/or pharmacotherapy |
| 15 - 19 | Moderately severe | Active treatment with pharmacotherapy and/or psychotherapy |
| 20 - 27 | Severe | Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management |
| **Key Notes** | | |
| **Consider major depressive disorder** if there are at least 5 ✓ responses one of which corresponds to question #1 or #2. **Consider other depressive disorders** if there are at least 2 - 4 ✓ responses one of which corresponds to question #1 or #2<br><br>This diagnosis also requires impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a manic episode (bipolar disorder), and a physical disorder, medication, or another drug as the biological cause of the depressive symptom | | |
| **A response to question #9 needs further assessment for suicide risk** by trained personnel, regardless of the total score | | |
| Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis must consider how well the patient understood the questionnaire. | | |

## Appendix 2: Paediatric Disclosure Readiness Assessment Checklist

Assessment of Family and Child Readiness for full HIV disclosure

**Paediatric Disclosure Readiness Assessment Checklist**

| | |
|---|---|
| Name of the child: | Facility Name: |
| Gender: | LGA: |
| Age/Date of Birth: | State: |
| Caregiver's Name: | Hospital Number: |
| Caregiver's Phone Number: | |

**Name of Counsellor/Assessor/Facilitator ……**

| **Assess the child for disclosure eligibility** | | **Date** | | **Observations/Note** |
|---|---|---|---|---|
| **1a** | Child has met the age criteria (between 5 and 10 years) | Yes | No | |
| **1b** | Child and caregiver know the benefits of disclosure | Yes | No | |
| **1c** | Caregiver willing to disclose HIV diagnosis to the child | Yes | No | |
| **Note: If the answer to question 1c is no, ask the caregiver if they are willing to continue with the rest of the assessment. If not, stop here, continue counselling, and refer for assessment at a later date.**<br><br>Comments: | | | | |
| **Assess the child and caregiver readiness** | | **Date** | | **Observations/Note** |
| **2a** | Child and caregiver free from severe physical illness, trauma, or psychological illness. | Yes | No | |
| **2b** | The child has consistent family, peer support orsocial support | Yes | No | |
| **2c** | Child demonstrates interest in the environment and playing activities | Yes | No | |
| **2d** | Child already knows about the illness and medicines | Yes | No | |
| **2e** | Functional school engagement by the child (consistent attendance, interacts well with the school community, able to freely discuss schoolactivities) | Yes | No | |
| **2f** | Caregiver ready to disclose to the child | Yes | No | |
| **2g** | Caregiver has communicated with the child to assess readiness | Yes | No | |

| | | | | |
|---|---|---|---|---|
| **2h** | Caregiver and child understand the importance of confidentiality | Yes | No | |
| Comments: | | | | |
| **Execute disclosure: to be guided by the caregiver and supported by a health careworker** | | **Date** | | **Observations/Note** |
| **3a** | Caregiver and the child have been reassured of the importance of disclosure | Yes | No | |
| **3b** | The environment and time are safe for disclosure | Yes | No | |
| **3c** | The depth of the child's knowledge assessed | Yes | No | |
| **3d** | Caregiver supported to disclose using the simplest language the child can understand | Yes | No | |
| **3e** | Immediate reactions of both the child and caregiver observed. | Yes | No | |
| **3f** | Negative reactions and concerns addressed | Yes | No | |
| **3g** | Child allowed to ask questions | Yes | No | |
| **3h** | Benefits of disclosure revisited/reviewed with the child and caregiver | Yes | No | |
| **3i** | Care options available to the child and caregiver explained | Yes | No | |
| **3j** | Concluded the session with reassurance to both child and caregiver. Reiterating the importance of confidentiality of information about one's health with the child and the caregiver | Yes | No | |
| Comments: | | | | |

## Appendix 3: Adolescent Disclosure Readiness Assessment Checklist

**Adolescent Disclosure Readiness Assessment Checklist**

| | |
|---|---|
| Name of Adolescent: | Facility Name: |
| Gender: | LGA: |
| Age/Date of Birth: | State: |
| Phone Number: | Hospital Number: |

**Name of Counsellor/Assessor/Facilitator …….**

| **Assess the Adolescent for disclosure eligibility** | | **Date** | | **Observations/Note** |
|---|---|---|---|---|
| **1a** | Adolescent knows the benefits of disclosure | Yes | No | |
| **1b** | Adolescent willing to disclose HIV diagnosis | Yes | No | |
| **Note: If the answer to question 1b is No, ask the client if they are willing to continue with the rest of the assessment. If not, stop here, continue counselling, and refer for assessment at a rescheduled date.**<br><br>Comments: | | | | |
| **Assess the adolescent readiness** | | **Date** | | **Observations/Note** |
| **2a** | Adolescent free from severe physical illness, trauma, or psychological illness. | Yes | No | |
| **2b** | Adolescent has consistent family, peer support orsocial support | Yes | No | |
| **2c** | Adolescent demonstrates interest in the environment and playing activities | Yes | No | |
| **2d** | Adolescent already knows about the illness and medicines | Yes | No | |
| **2e** | Functional school engagement by the Adolescent (consistent attendance, interacts well with the school community, able to freely discuss school activities) | Yes | No | |
| **2f** | Adolescent ready to disclose status | Yes | No | |
| **2g** | Adolescent understands the importance of confidentiality | Yes | No | |
| Comments: | | | | |

| Execute disclosure: to be supported by the health careworker | | Date | | Observations/Note |
|---|---|---|---|---|
| **3a** | Adolescent has been reassured of the importance of disclosure | Yes | No | |
| **3b** | The environment and time are safe for disclosure | Yes | No | |
| **3c** | The depth of the Adolescent's knowledge assessed | Yes | No | |
| **3d** | Adolescent supported to disclose using the simplest language they can understand | Yes | No | |
| **3e** | Immediate reactions of both the adolescent observed. | Yes | No | |
| **3f** | Negative reactions and concerns addressed | Yes | No | |
| **3g** | Adolescent allowed to ask questions | Yes | No | |
| **3h** | Benefits of disclosure revisited/reviewed with the adolescent | Yes | No | |
| **3i** | Care options available to the adolescent explained | Yes | No | |
| **3j** | Concluded the session with reassurance to the adolescent. Reiterating the importance of confidentiality of information about one's health. | Yes | No | |
| Comments: | | | | |

## Appendix 4: Paediatric Post Disclosure Assessment Checklist

**Paediatric Post-Disclosure Assessment Checklist**

**(To be administered every 3 months for 9 months after disclosure)**

| | |
|---|---|
| Name of the child: | Facility Name: |
| Gender: | LGA: |
| Age/Date of Birth: | State: |
| Caregiver's Name: | Hospital Number: |
| Caregiver's Phone Number: | |

**Name of Counsellor/Assessor/Facilitator …….**

| **Focus on child's reaction to self and family, e.g., anger directed at self, siblings, parents.** | **Date** | | **Observations/Note** |
|---|---|---|---|
| Child school attendance is consistent, interacts well with the school community, able to freely discuss school activities | Yes | No | |
| Family, social, and peer relationships and support after disclosure assessed | Yes | No | |
| Child's perception of their healthcare and outlook assessed | Yes | No | |
| Self-stigmatization issues addressed | Yes | No | |
| Child's mood and negative behaviour addressed | Yes | No | |
| Referred appropriately for psychosocial support | Yes | No | |
| Age-appropriate adherence information given | Yes | No | |
| Child's interest and engagement in children's activities like playing assessed | Yes | No | |
| Comment on self-perception and the child's fears (including if the child understands what is going on), concerns raised by a caregiver, mood changes or reactions. Indicate any subsequent post-disclosure sessionand concerns. | | | |
| Final comments: indicate overall disclosure comment, plans, referrals, pending disclosure issues, support group enrolment and extended post-disclosure support: more than three sessions for children with difficulties. | | | |

## Appendix 5: Adolescent Post Disclosure Assessment Checklist

**Adolescent Post-Disclosure Assessment Checklist**

**(To be administered every 3 months for 9 months after disclosure)**

| | |
|---|---|
| Name of Adolescent: | Facility Name: |
| Gender: | LGA: |
| Age/Date of Birth: | State: |
| Phone Number: | Hospital Number: |

**Name of Counsellor/Assessor/Facilitator ……**

| **Focus on the Adolescent's reaction to self and family, e.g., anger directed at self, siblings, or parents.** | **Date** | | **Observations/Note** |
|---|---|---|---|
| Adolescent school attendance is consistent, interacts well with the school community, able to freely discuss school activities | Yes | No | |
| Family, social, and peer relationships and support after disclosure assessed | Yes | No | |
| Adolescent's perception of their healthcare and outlook assessed | Yes | No | |
| Self-stigmatization issues addressed | Yes | No | |
| Adolescent's moods and negative behaviour addressed | Yes | No | |
| Referred appropriately for psychosocial support | Yes | No | |
| Age-appropriate adherence information given | Yes | No | |
| Comment on self-perception and the Adolescent's fears, concerns raised, mood changes or reactions. Indicate any subsequent post-disclosure session scheduled. | | | |
| Final comments: indicate overall disclosure comment, plans, referrals, pending disclosure issues, support group enrollment and extended post-disclosure support: more than three sessions for children with difficulties. | | | |

**Appendix 6: Transition Checklist**

| Phase | Step | Transitioning Tasks | When | Persons Involved | Completed (Yes/No) | Date |
|---|---|---|---|---|---|---|
| Pre-transition | Planning | Plan and develop a timeline for the transition process with the client, caregiver/ peer or treatment supporter, and any other persons required.<br>*Transition should be a continuous process rather than a one-off event and should be tailored to adolescent capacities, readiness, and developmental age* | Client between ages of 10-14, or once disclosure has been fully completed | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | Client (and caregiver/ treatment supporter) case review and assessment | Complete client case review and assessment to assess readiness and progress against transition stages and milestones | | | | |
| | | ***Goal 1*** | Ages 10-12 (early adolescence) | | | |
| | | Full disclosure has occurred | | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | | Client understands what HIV is and its prevention | | | | |
| | | Client understands the importance of adherence | | | | |
| | | Client interacts with providers and asks questions | | | | |
| | | Client is linked to an adolescent support group | | | | |
| | | ***Goal 2*** | Ages 13- 16 (mid-adolescence) | | | |
| | | Client understands the importance of taking medication and adherence | | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | | Client understands the importance of CD4 and VL testing, and the meaning of the results | | | | |
| | | Client keeps all appointments | | | | |
| | | Client is an active member of a support group | | | | |
| | | Client understands the reasons for disclosure and disclosure methods | | | | |
| | | Client understands how HIV Is transmitted and how to prevent transmission | | | | |
| | | Positive living, health relationships, sexual and reproductive health and family planning have been discussed with the client | | | | |
| | | ***Goal 3*** | Age 17-19 (late adolescence) | | | |
| | | Demonstrates good medication adherence | | Client, caregiver, treatment/peer | | |
| | | Achieved viral suppression within the last 1 year | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Kept all appointments in the past 6 months and came to clinical appointments unaided in the last 2-3 visits | | supporter, MDT and any other persons required | | |
| | | Has a good understanding of personal medical history | | | | |
| | | Client identifies members of the health care team, and their roles and knows how to contact them | | | | |
| | | Client can refill medication prescriptions on their own and without reminders | | | | |
| | | Client knows what to do if they are not feeling well and when/ how to contact their health care provider | | | | |
| | | Client is aware of available community services and can access them independently | | | | |
| | | Client chooses to transition | | | | |
| | **Preparing for transition** | Agree on the location in which the client will be receiving future services (different facilities, same facility but different day or providers), and the preferred service delivery model | Attainment of goal 3, prior first visit to the adult clinic | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | | Support client (and caregivers/ treatment or peer supporters) to develop a plan of action for individual self-management | | | | |
| | | Prepare adolescent to enter adult care- schedule first appointment together | | | | |
| | | Ensure that peer/ treatment supporter is available for additional support | | | | |
| | | Engage adult provider/ notify the adult provider or facility of transitioning client | | Current and future MDT, including adult provider | | |
| | | Complete clinical transition forms and stores them in the client's file | | | | |
| | | Transfer or provide a copy of medical records to the adult clinic | | | | |
| **Transition** | **Implementing transition** | Accompany and orient adolescent during first adult care appointment | First visit to the adult clinic | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | | Ensure proper transition documentation using a checklist and relevant tools | | | | |



| | | | | | | |
|---|---|---|---|---|---|---|
| **Post-transition** | **Follow-up** | Follow-up post-transition to address concerns and assess client satisfaction.<br>*Discussion can be held face-to-face, via phone, or during home visits and documented in the client folder* | After the first appointment, one month and quarterly thereafter for the next 6-12 months, based on need | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | | Ensure continued psychosocial support to address identified challenges | | | | |
| | **Tracking and reporting** | Track clients' outcomes and attendance at care and treatment appointments following the transition to identify any needs and report to appropriate HCW in transitioned setting | After the first appointment, one month and quarterly thereafter for the next 6-12 months, based on need | Client, caregiver, treatment/peer supporter, MDT and any other persons required | | |
| | | Monitor viral loads as stipulated in the national HIV treatment guidelines | | | | |
| | | Document attendance and retention in the client record or folder | | | | |
| | | Document any changes in ARV regimens | | | | |
| | | Document referrals and any other follow-ups | | | | |
| | | Follow up with any clients (and caregiver/s treatment supporters if appropriate) who are lost to follow-up to ensure re-engagement in care and document outcomes | | | | |

**Appendix 7: Risky Sexual Behaviour Assessment**

The following questions may be asked to trigger conversation and assess risk:

| S/N | Question bank |
|---|---|
| 1 | Do you have a boyfriend/girlfriend? |
| 2 | Have you ever had sex with your boyfriend/girlfriend? |
| 3 | Are you having sex with males, females, or both?<br>• For girls ask if they are having sex with boys or girls<br>• For boys ask if they are having sex with girls or boys |
| 4 | How many partners do you have right now? How many partners have you had in the past year? |
| 5 | Do you have vaginal sex? Oral sex? Anal sex? |
| 6 | Did you use a condom correctly (and lubricant for anal sex) last time you had sex? |
| 7 | Do you use a condom every time you have sex (and lubricant for anal sex)? |
| 8 | Are you currently taking any contraceptives? Which ones? Did you use other contraceptives last time you had sex? |
| 9 | Have you ever experienced sexual contact against your will? |
| 10 | For girls, have you ever been pregnant? What were the pregnancy outcomes? |
| 11 | For boys, ask, do you have a child? |
| 12 | Have you had your first menstrual period? If yes, when was your last period? |
| 13 | Do you know your HIV status? If so, is your partner(s) aware of your status? |
| 14 | Do you know the HIV status of your partner(s)? |
| 15 | Have you ever used alcohol or drugs? If so, how often in the last week have you used alcohol or drugs |

**Appendix 8: Risk reduction counselling**

Risk reduction counselling is an important role of a health care provider. Below are suggested questions to initiate and guide the counselling process:

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

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