Adolescent and Youth-Friendly Health Services

Modular Training

Facilitator Manual

March 2017

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Elizabeth Glaser Pediatric AIDS Foundation
Until no child has AIDS.

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This tool began being used in March 2017 as part of the package to train 30 trainers from five districts in Lesotho. This early use enabled the modules to be piloted and refined, with feedback from the Ministry of Health management across sectors.

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Glossary of Terms[1]

Adolescent - aged 10 to 19 years old

Assent – Refers to children's and adolescents' participation in decision-making on health care and research intervention(s) by giving an agreement. Assent is not regulated by law as is consent, and it is sometimes referred to as a moral obligation closely linked to good practice in dealing with patients. It emphasizes that in all cases, whether or not the consent of the parent/guardian is required, the voluntary, adequately informed, non-forced and non-rushed assent of the adolescent should be obtained (see also informed choice, informed consent).

Attitude – A person's views about a thing, process or person, which influence behaviour.

Community health worker – Any health worker who performs functions related to health-care delivery in the community.

Competency – Sufficient knowledge and psychomotor, communication and decision-making skills and the attitudes to enable the performance of actions and specific tasks to a defined level of proficiency.

Confidentiality – The right of an individual to privacy of personal information, including health-care records. This means that access to personal data and information is restricted to individuals who have a reason and permission for such access. The requirement to maintain confidentiality governs not only how data and information are collected (e.g. a private space in which to conduct a consultation), but also how the data are stored (e.g. without names and other identifiers) and how, if at all, the data are shared.

Criterion (of a standard, see also standard) – A measurable element of a standard that defines a characteristic of the service that needs to be in place (input criterion) or implemented (process criterion) in order to achieve the defined standard (output criterion).

Evolving capacity – The capacity of an adolescent to understand matters affecting his or her life and health change with age and maturity. The more an adolescent "knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for him or her can transform direction and guidance into reminders and advice, and later into exchange on an equal footing." In health care it means that as the adolescent matures, his or her views have increasing weight in choices regarding care. The fact that the adolescent is very young or in a vulnerable situation (e.g. has a disability, belongs to a minority group, is a migrant) does not deprive him or her of the right to express his or her views, nor does it reduce the weight given to the adolescent's views in determining his or her best interests, and, hence, choices regarding aspects of care.

Gatekeeper(s) – Adults that have influence over adolescents' access to and use of services, e.g. parents and/or other family members, legal guardians, teachers, community leaders.

[1] WHO/UNAIDS 2015

Health literacy – The cognitive and social skills that determine the motivation and ability of an adolescent to gain access to, understand and use information in ways that promote and maintain good health.

Informed choice – A choice made by an adolescent regarding elements of his or her care (e.g. treatment options, follow-up options, refusal of service for care) as result of adequate, appropriate and clear information in order to understand the nature, risks, alternatives of a medical procedure or treatment and their implications for health and other aspects of the adolescent's life. If there is more than one possible course of action for a health condition, or if the outcome of a treatment is uncertain, the advantages of all possible options must be weighed against all possible risks and side-effects. Also, the views of the adolescent must be given due weight based on his or her age and maturity (see also evolving capacity).

Informed consent – A documented (usually written) agreement or permission accompanied by full and clear information on the nature, risks and alternatives of a medical procedure or treatment and their implications before the physician or other health-care professional begins the procedure or treatment. After receiving this information, the adolescent (or the third party authorized to give the informed consent) either consents to or refuses the procedure or treatment. The procedures and treatments requiring informed consent are stipulated in country laws and regulations. Many procedures and treatments do not require informed consent; however, they all require that the adolescent is supported to make an informed choice and give an assent if so desired (see also assent, informed choice and evolving capacity).

Key populations – Refers to defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. Key populations include men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people. Adolescent members of key populations are more vulnerable than adults in the same groups, and people may be part of more than one key population. Other priority populations at high risk include the seronegative partners in sero-discordant relationships and the clients of sex workers. Also, there is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms.

Outreach (health-care delivery) – Any health-related activity coordinated by the health system that takes place off-site (outside the health facility premises). Outreach activities can be performed by healthcare providers (for example, primary care nurses that perform classroom health education or doctors that perform medical check-ups in schools), or by outreach workers (see definition below). The purpose of outreach activities in adolescent health care is to reach adolescents by bringing services close to where they are: schools, universities, clubs, churches, workplaces, street settings, shelters or wherever young people gather. Examples of outreach activities include health education and distribution of commodities such as condoms.

Rights – Adolescents' health-related rights include at least the following (WHO 2015)

• Care that is considerate, respectful and non-judgemental of the adolescent's unique values and beliefs. Some values and beliefs are commonly held by all adolescents or community members and are frequently cultural and religious in origin. Others are held by the adolescent client alone.

Strongly held values and beliefs can shape the care process and how adolescents respond to care. Thus, each health-care provider must seek to provide care and services that respect the differing values and beliefs of adolescents. Also, health-care providers should be non-judgemental regarding adolescents' personal characteristics, life style choices or life circumstances.

• Care that is respectful of the adolescent's need for privacy during consultations, examinations and treatments. Adolescent privacy is important, especially during clinical examinations and procedures. Adolescents may desire privacy from other staff, other patients, and even family members. Staff members must learn their adolescent clients' privacy needs and respect those needs

• Protection from physical and verbal assault. This responsibility is particularly relevant to very young adolescents and vulnerable adolescents, the mentally ill, and others unable to protect themselves or signal for help.

• Information that is confidential and protected from loss or misuse. The facility respects information as confidential and has implemented policies and procedures that protect information from loss or misuse. Staff respect adolescent confidentiality by not disclosing the information to a third party unless legally required, by not posting confidential information or holding client-related discussions in public places.

• Non-discrimination, which is the right of every adolescent to the highest attainable standard of health and quality health care, without discrimination of any kind, irrespective of the adolescent's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

• Adolescent participation in care processes. Unless the decision-making capacity is delegated by law to a third party, or the adolescent lacks decision-making capacity as assessed by the relevant authority, the adolescent decides about all aspects of care, including refusing care. The adolescent also decides which family member and friends, if any, participate with him or her in the care process. Adolescents' involvement in care is respected irrespective of whether or not the adolescent has a legal capacity for decision-making. An adult's judgement of an adolescent's best interests cannot override the obligation to respect all rights of adolescents as stipulated in the Convention of the Rights of the Child. This includes the right of the adolescent who is capable of forming his or her own views to express those views freely in all matters affecting him or her, and having those views given due weight in accordance with the age and maturity (see also evolving capacities). The facility supports and promotes adolescent involvement in all aspects of care by developing and implementing related policies and procedures.

Standard – A statement of a defined level of quality in the delivery of services that is required to meet the needs of intended beneficiaries. A standard defines the performance expectations, structures or processes needed for an organization to provide safe, equitable, acceptable, accessible, effective and appropriate services.

Support staff – Individuals who provide indirect patient care (for example, receptionists, secretaries) or who are involved in maintaining certain quality standards (e. g. cleaning or security staff)

Transition the purposeful, planned movement of adolescents and young adults with chronic medical conditions from child-centred to adult oriented health care systems.

Very young adolescent aged 10 – 14 years old

Youth aged 15 to 24 years old

Young people 10-24 years of age

Youth friendly service Services that are accessible, acceptable, and appropriate for adolescents. They are in the right place, at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends.

Abbreviations and Acronyms

ALHIV	Adolescents living with HIV
ANC	Antenatal Care
ART	Antiretroviral therapy
AYPLHIV	Adolescents and young people living with HIV
BCC	Behaviour change communication
CHW	Community Health worker/village health worker
CTX	Cotrimoxazole
EFV	Efavirenz
FP	Family planning
HCW	Health care worker
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication materials
IUD	Intra-uterine contraceptive device
LENASO	Lesotho Network of AIDS service organisations
MMSD	Multi-month scripting and dispensing
SRH	Sexual and Reproductive health
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health organisation

1. INTRODUCTION: WHY IS THIS TRAINING IMPORTANT?

Lesotho has multiple health needs but none as serious and burdensome to the healthcare system as HIV and AIDS. In Lesotho, an estimated 314,000 people are living with HIV, including 12,000 adolescents 10-19 years old (5,200 males and 7,200 females) and 32,000 young people 15-24 years old (12,000 males and 20,000 females)[2]. Lesotho has a very high (25%) HIV prevalence among adolescents and adults aged 15-49 years. Starting with 5.1 % positivity rate of males and females aged 15-19 years, the HIV epidemic escalates at slightly older age with a dramatic rise to 14.9% positivity rate for young men and women aged 20-24 years old. Urban areas carry a significantly greater HIV burden than rural regions with prevalence rates of 30% and 22%, respectively, among populations aged 15-49 year olds. Women are disproportionally affected by the epidemic with a prevalence of 30% compared to the prevalence of 19% among men.[3]

An estimated 2,000 new HIV infections occur every year among adolescents 10-19 years old and 6,400 infections among young adults 15-24 years old in Lesotho with approximately 60% of infections occurring in females[4].

These current statistics, while grim, do not reflect significant commitment and country wide responses to the epidemic and youth-friendly services. In 2015, the National Strategy for Adolescent & Young People's Health presented focused efforts to improve access to health care for 10-24 year olds. And in 2016, Lesotho became the first country in the world to adopt 2015 WHO recommendations to initiate all HIV-infected patients on treatment – the Test and Treat approach. New national HIV testing, care and treatment guidelines were developed for roll out and scale up across the country.

Test and Treat is an evidence-based model adopted so that when patients learn their HIV status earlier, their body's respond quicker to ART, have fewer HIV-related complications, and live longer with HIV without transitioning to AIDS. In simpler terms, with this approach the health care system should have fewer visits by sick clients and cater to stable HIV infected patients. This is called differentiated care.

Through a partnership with the Ministry of Health, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Lesotho currently supports over 119,000 clients on ART with 6,622 adolescents 10-19 years old on ART (5.6% of all ART clients) and 6,143 young adults 20-24 years old on ART (5.1% of all ART clients) in the five PEPFAR scale-up districts.[5]

Adolescents and young people represent the key to ending the HIV epidemic in Lesotho, as well as an opportunity to address the existing sexual and reproductive health needs of every generation. Youth are a special group but often underserved in clinics and given insufficient priority. The period of adolescence is associated with significant sexual, reproductive,

[2] UNAIDS AIDSinfo, accessed September 2, 2016. NB: There are no separate estimates for 20-24 year olds.
[3] Lesotho Demographic and Health Survey, 2014.
[4] UNAIDS AIDSinfo, accessed September 2, 2016. NB: There are no separate estimates for 20-24 year olds.
[5] EGPAF Lesotho data for CDC-funded STAR-L districts Berea and Leribe, and USAID-funded CHASE projects as of 6/30/2016. The USAID-PUSH funded districts are Maseru, Mafeteng, and Mohale's Hoek.

cognitive and psychological changes. It coincides with the onset of behaviour that continue to adulthood, including, risk assessment, sexual debut and healthcare use.

This training was designed to capacitate healthcare workers to better manage the care of adolescents and young people living with HIV within the facility and in a team environment, while setting in place services that address the SRH needs of all adolescents & young people.

1.1. Training Objectives

There are main objectives for training health care workers using this guide.

- Increase health care worker awareness about barriers and facilitators to adolescent and youth friendly health services.
- Build health care worker team capacity and skills to address the special needs of adolescents and young people living with HIV within their facility.
- Enhance youth access to sexual and reproductive health services, MCH and HIV, with special clinics, care and/or referrals.
- Introduce health care workers to standards for quality health care services for adolescents which form the foundation of national strategies and the SOP.

Each training module also has a set of learning objectives. These are listed here.

Module 1: Friendly-services for Adolescents & Young People (AYP) in our Facility

- Define the terms adolescent, youth, young person
- Describe the characteristics of adolescents and young people
- Brainstorm barriers to adolescents and young people using health services
- Practice skills to apply professional values to clinic care for adolescents
- Describe the key components of adolescent friendly health services
- Learn about clinical mentoring tools for AYFHS delivery

Module 2: Test & Treat for Adolescents in Lesotho

- Review the epidemiology of Test & Treat
- Describe Lesotho Test and Treat guidelines application to adolescents
- List Differentiated Service Delivery models for 10-24 year olds
- Review clinic patient volume for 10-24 year olds and reflect on facility needs
- Identify effective DSD models that can work in our clinic for adolescents and young people

Module 3: Undetectable Viral Load: Adherence for AYPLHIV Treatment Success

- Understand Viral Load monitoring for adolescents
- Define adherence
- Describe the opportunities and challenges of adherence
- Learn the 5 A's for enhancing adherence for young patients
- Identify team roles through case study and real situations

Module 4: Treatment Support: Disclosure in the family, school and in relationships

- Explain the role of treatment support in ALHIV lives
- Define disclosure and its steps

- Understand the disclosure guidelines in Lesotho
- Identify ways to support patients to determine who, when & how to disclose HIV status
    - At initiation with parents/caregivers
    - At school
    - In sexual relationships and before marriage
- Review case studies on disclosure support for AYPLHIV

Module 5: Aging with HIV: Transitioning Care from Childhood to Adulthood

- Review life expectancy in Lesotho and aging with HIV
- Understand the context for transitions in care for ALHIV
- Explain the differences between child & adult HIV care to reflect on transitional needs of ALHIV
- Look at SOPs for transition used in other settings
- Identify roles of facility staff in support transition and treatment success over life

Module 6: Teen Pregnancy & MCH for Young Women

- Review MCH in Lesotho
- Discuss the differences between young/first time mothers and adult mothers
- Define early pregnancy
- Identify care needs of teen/first time mothers in MCH
- Review facility data to determine local approaches for improving care for teen/first time mothers

Module 7: Sexual & Reproductive Health and Referrals

- Review the sexual & reproductive health (SRH) services available in this facility
- Brainstorm on the SRH needs of adolescents and young people
- Identify non-health services to support youth development
- Clarify integration & the facility-facility referral process
- Create a directory for referrals (across facilities and into the community)

1.2. Target Audience

This capacity building training is targeted at healthcare providers working with adolescents and young people living with HIV, at primary and secondary level healthcare facilities in Lesotho. This includes both clinicians, such as nurses and psychologists, and non-clinicians such as counsellors, social workers and pharmacists. The training is to be done onsite using a modular format.

Facilitators using this guide will undergo a training of the trainers to practice and ensure capacity prior to providing this training in facilities. Trainers have been trained from the Ministry of Health across Lesotho, along with multiple cadres of staff from EGPAF working to support facilities in Maseru, Berea, Leribe, Mafeteng and Mohole's Hoek.

<u>Participant Selection Criteria:</u>

- Provide health services to adolescent patients 10-19 years old anywhere in the facility; OPD, IPD, MCH, FP, TB and more.
- Provide health services to young patients 15-24 years old anywhere in the facility

- HIV care and treatment staff; including PMTCT, pediatric and adult clinic
- Supportive non-clinical staff; social workers, peer and lay counsellors, expert clients/peer educators/peer linkage, community health workers/village health workers, PLHIV networks, PSS providers, partner organization staff/volunteers supporting HIV care & treatment in the facility.

This training may be useful to facility support staff (guards, cleaners and receptionists) but it is recommended that a short orientation on AYFHS be developed specifically for this special role in the facility.

1.3. How to use this facilitator's manual

Facilitators should familiarise themselves with the objectives and content of this training by going through this manual before the training starts. The manual includes a section on adult education tips to help trainers optimise teaching methods in order to effectively relay content to the participants.

Prior to training, facilitators should meet with key facility leadership to explain the training approach, expectations for participants, certification, logistics and schedules. The management of the facility should be aware of the SOP related to this work on adolescent and youth-friendly health services. The SOP provides a summary of the standards expected for quality services to be implemented, which this training will support.

Beyond planning, also ask to see the facility set up and use that opportunity to gather information to understand the current use of services by 10-24 year olds. Review registers to see what services are provided to adolescents and young people; ages 10-14; 15-19; and 20-24 years in this clinic.

Try to complete (or if not possible estimate) the Facility service patient volume table for the preceding 3 months (a quarter) with in each facility conducting trainings:

Health Service	10-14 years	15-19 years	20-24 years
	Male / Female	Male / Female	Male / Female
Out-patient department (OPD) – illness (most common)	/	/	/
	/	/	/
	/	/	/
OPD – injury treatment	/	/	/
Ante-natal care	/	/	/
Post-natal care	/	/	/
Immunizations	/	/	/
Contraceptives/family planning	/	/	/
Injectables (Depo)			
Implants			
Natural family planning methods (2 day)			
HIV testing	/	/	/

HIV treatment	/	/	/
HIV PSS/support groups	/	/	/
STI treatment	/	/	/
Other:	/	/	/
Other:	/	/	/

1.4. Who should provide the training?

Adequately trained and experienced facilitators should provide the training. These may include clinical and mentorship staff, social workers, psychologists, and youth leaders, as appropriate. All trainers must review national policy and guidelines prior to training to ensure that content will meet national standards and achieve intended outcomes.

Facilitators should provide practical training and consultation that fosters ongoing professional development of facility staff to deliver sustainable high-quality care to adolescents and young people. Facilitators should:

- Build relationships with the facility and staff. Facilitators should establish a trusting and receptive relationship by being respectful and displaying good communication skills. They should be sensitive to issues such as workload of mentees, stress and should be flexible enough to tailor sessions to health care worker's situation. The relationships between facility staff and facilitators should evolve and grow over time.
- Identify areas of improvement. Facilitators should have an objective understanding of HCW/facility performance and needs for capacity building in adolescent and young people HIV care. This would have been gained through previous interaction with staff and facility and of assessment records e.g. SIMS reports, Supportive supervisory reports, onsite monitoring reports, PHC reports, ART reports etc.
- Advocate for environments conducive to quality adolescents and young people patient care and provider development. Technical assistance should be offered to support system level changes at health facilities. The facilitator should assess and help to address any issues in system aspects such as infrastructure, patient flow, and privacy of, integrated provision of services at the facility.
- Data collection and reporting. Facilitators should support the utilization and integration of patient data into clinical practice by encouraging documentation practices that promote effective management of AYLHIV. Examples include review of patient tracking records and analysis to identify challenges.
- Minimise disruption of clinical services provided at the facility. Facilitators will schedule modular onsite training session at a time that is convenient to staff and minimises disruption of facility activities. Facilitators should strictly adhere to appointments made and should respect facility staff requests for adjustments.

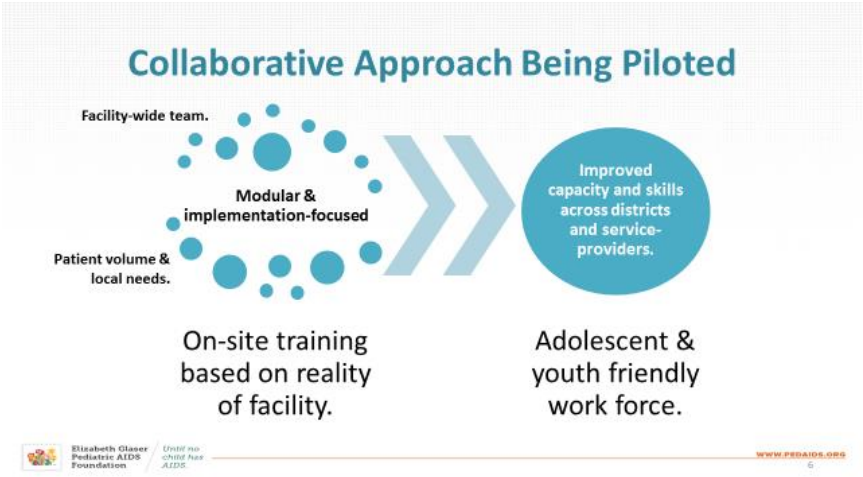
1.5. Evaluation of the Training

The training package includes a pre-test and post-test question papers that will be used to evaluate part of the effect of each training module on participant knowledge and attitudes towards care practices. A Pre-test will be completed by each trainee for each module, scored and recorded. Test answers are in red. At the end of Module 7, a post test will be completed by participants.

Primary success of the training will be seen through the clinic team's response to content, ability to process information, practices skills, and then implement and use them in their clinic. Assessment of these linked outcomes will be done through MOH/EGPAF evaluation activities e.g. Site improvement Monitoring System, data collection and analysis. Additional activities include supportive supervisory visits by DHMTs and the Ministry of Health Adolescent program staff and quality assurance tools.

1.6. Modular Training Sessions

A modular format of training is advised for this training package instead of an off-site integrated training. Modular training can ensure workplace-based skills that will be delivered in incremental sequential units (i.e. modules) of short duration. It includes a process of assessment and follow up on application of skills taught in each model before proceeding to the next module.



Modular training will offer the following advantages:

1. Modular training allows the facility staff to complete sections or modules of training according to an agreed upon time plan and availability.
2. Enables a group of trainees to customize information and discussions directly to the facility reality and patient volume.
3. Empowers staff to be part of planning and implementation of adolescent and youth-friendly services that meet national guidelines and patient needs.
4. Builds a team learning and trusted environment for reflection and growth in the long term, which can be seen directly as service delivery changes and improves.
5. Allows more time to be spent on a module if needed as indicated by staff in the facility.

The training should be done onsite and this will have the following advantages;

1. All facility team members are trained at the same time and this ensures uniformity of skills and knowledge learnt with shared responsibility to act on decisions agreed in training.
2. Supportive supervision findings are incorporated into the beginning of each next module of the training.

3. Helps to ensure cooperative application of principles learnt for a cohort of young clients in care.
4. Minimises time spent away from the facility during training.
5. Allows facilitators to follow up on application of skills and knowledge gained at the facility directly.
6. Encourages team work, facility staff to work together in assessing challenges and addressing them.

2. TEACHING METHODS

The training will use a participatory learning approach that is successful with adult learners. This method focuses on the internal asset building of trainees, so that they can responds to adolescent and young clients, no matter where stationed on the job – within a youth corner or when serving younger clients in adult clinics. Facilitators will guide discussions and help to encourage new thinking, but trainees will decide what to apply in their facility and define the support needed over time. Over time and supportive visits between trainings, facilities will be able to use data and local expertise to improve the service delivery flow and structures to address client's needs and increase provider efficiency.

Since much of the content for SRH and HIV is not entirely new, but specific to an age group, the training will not introduce lots of new information. Instead the training will try to build skills to better apply clinical know-how to younger clients, who may be eligible for services but face attitudes towards care and access. This will also address potential barriers to cares such as negative attitudes, judgement from providers and applying professional values on the job.

2.1. Participatory Training Methods

To keep participants engaged the modules apply a variety of participatory training techniques. This includes:

- Group Discussion: This method allows the participants to discuss a given topic in more detail, to express opinions and to reach a common understanding in a small group setting. The participants' views should be consolidated within the small groups and shared with the large group.
- Case-Study: This encourages participants to think deeply about the situations they might face and decide how they would respond. This method encourages participants to think about problems, options and solutions to challenges they might experience.
- Practical Exercises: A technique used during a training session that permits students to acquire and practice the knowledge, skills, and attitudes necessary to successfully perform one or more training objectives.
- Presentations/Videos: A presentation or video is used to convey new information and to review content from a different angle. This package includes a variety of materials to make the presentations as interactive as possible. The trainer can use other reference materials to augment the presentation.

- Role-Playing: This technique encourages participants to identify real patient issues, document their needs and practice skills. Role-plays are a safe way to practice newly acquired skills and they provide good preparation for real-life situations. They are particularly well suited for counselling and other communication skills.
- Question-and-answer sessions: Participants respond to questions and discuss answer together.
- Brain storming: This is a technique used for finding solutions by means of stimulating ideas. A small group of people with or without conscious knowledge of the subject meets and contributes any suggestion or idea that strikes them, no matter how fantastic or impossible it may sound. All suggestions are encouraged and criticism is not allowed at this stage, although contributors are later invited to explain their ideas. Subsequently, all the ideas submitted are sifted and assessed.
- Learning games: Learning games are seemingly fun activities involving all participants. There are rules and regulations and the games may or may not include a competitive element. After the game, there is need to consolidate, debrief and derive learning.

All participatory learning activities follow a similar process when complete to ensure reflection and application after training as indicated in Figure 1.1 below.

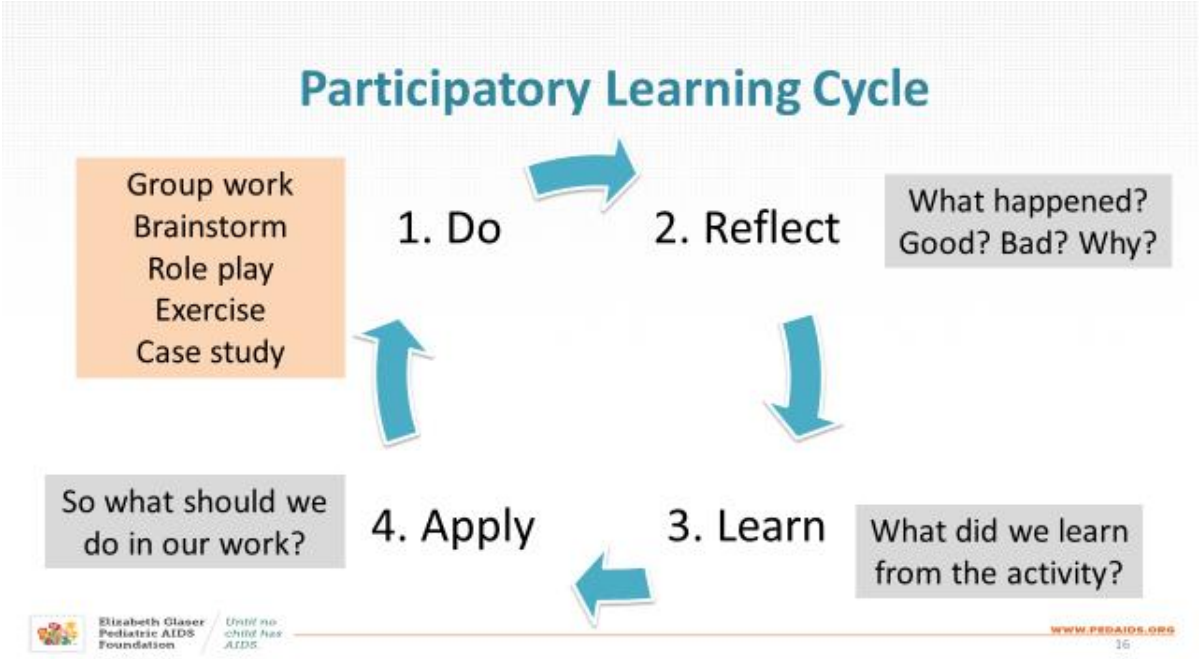


Figure 1.1 The participatory learning cycle

2.2 Tips on Teaching Adults

Teaching adults is a challenging task that requires flexibility, excellent communication and relationship building skills. Most importantly content must be up to date on key national guidelines, tools, clinical knowledge, and teaching skills.

Ensure the following during training sessions to maximise effectiveness of learning:

1 Promote positive self-esteem of participants
- Create a comfortable and safe learning environment and utilise methods that will reassure trainees that their contributions will be received respectfully.
- include small group activities to increase participation
- Help trainees to become more effective and confident through guided discussions and practice sessions

2 Practical and problem centred learning situations
- Include real life scenarios, real cases and case studies to link clinical theory to practice. Encourage trainees to contribute with their own cases and experience in their work.
- Discuss and help your trainees plan for and critique direct application of new information.
- Use content that they can make use of in their current contexts and point out the immediate usefulness of information presented.
- Anticipate problems applying knowledge acquired, so offer concrete and practical suggestions.
- Avoid being too theoretical – confirm which services, tests, and drugs that are locally available and familiar to the trainees.

3 Integrate new ideas with existing knowledge
- Help your trainees recall what they already know from prior experience that relates to the topic being taught
- Ask what else they would like to know about the topic.
- Suggest follow up ideas and next steps for support and implementation after the training

4 Be respectful to each and every trainee
- Never "talk down" to a trainee
- Validate and affirm their knowledge, contributions, and successes.
- Ask for feedback on your work and provide opportunities for input.
- Avoid being judgmental or overly critical.

5 Capitalize on their experience
- Don't ignore what your trainees already know; their experience and expertise are resources for yourself and the whole group.

6 Plan alternate learning activities and choices,
- Allow trainees to adjust the process to fit their experience level e.g. level of detail given, time spent explaining concepts, length of lectures
- Create activities that use trainees ‘experience and knowledge.
- Assess your trainees’ learning needs and understanding before, during, and after any teaching session.

7 Allow choice and self-direction
- Build your plans around the participants ‘needs.
- Share your agenda and assumptions and ask for input on them.

- Ask what they know already about the topic (their perception).
- Ask what they would like to know about the topic.
- Build in options within training plans so you can easily shift if needed.
- Allow time for planning their next steps related to training and ongoing education.

2.3. Recommended training schedule

The amount of time needed to be spent on each model will vary but it is recommended that 3 hours be set aside for each module. The scheduling of modules will depend on availability of the trainer and facility staff but ideally modules should be done not more than 1 month apart.

Ensure continuity of training by keeping records of all activities done and plans that the facility staff agree on. Each new onsite training session should begin with review of progress made on plans made in the last module.

Example:

Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6 …
Planning with facility	Module 1 Training	Site Support Visit to see Module 1 taking place Module 2 Training	Site Support Visit to see Module 2 taking place Module 3 Training	Site Support Visit to see Module 3 taking place Module 4 Training	Site Support Visit to see Module 4 taking place Complete Training Reports
Week 1	*Week 3*	*Week 6*	*Week 8*	*Week 10*	*Week 12 …*

3. COURSE CONTENT

The training consists of the following modules. It is expected that additional modules will be added over time.

Module 1: Friendly-services for Adolescents & Young People (AYP) in our Facility
Module 2: Test & Treat for Adolescents in Lesotho
Module 3: Undetectable Viral Load: Adherence for AYPLHIV Treatment Success
Module 4: Treatment Support: Disclosure in the family, school and in relationships
Module 5: Aging with HIV: Transitioning Care from Childhood to Adulthood
Module 6: Teen Pregnancy and MCH for Young Women
Module 7: SRH and Referrals

Each module includes information to help the facilitator prepare and implement the modules. Within there are:

- Duration, timing of the module's implementation. All are designed to be about 3 hours in length, following more detailed module agenda.
- Learning objectives, which explain the expected outcomes for participants by the end of the module.
- Advance preparation, which describe the steps to be taken for facilitators prior to the training event and materials to carry/have available at the training space.
- Content, with a summary of the module steps and notes to support the training.

3.1. Module 1: Friendly services for Adolescents and Young People in our Facility

Duration: 3 hours

Learning objectives
Define the terms adolescent, youth, young person
Describe the characteristics of adolescents and young people
Brainstorm barriers to adolescents and young people using health services
Practice skills to apply professional values to clinic care for adolescents
Describe the standards of adolescent and youth friendly services
Learn about clinical mentoring tools for AYFHS delivery

Advance preparation:

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Edit slide 27; Take data collected prior to the training and add it to slide 28; there will be a reflection on the patient care needs in the facility.
3. Review the questions and activities for this module and take note of the expected responses from the participants.
4. Prepare facility data that can be referenced in discussions.
5. Review the National Health Strategy for Adolescents and Young People 2015-2020
6. Review the SOP for adolescent and youth-friendly health services
7. Prepare flipcharts with titles as shown in slides.
8. Prepare printed PPTs for participants, pre-tests, and handouts for module 1

You will need the following materials

- Copies of the pre-test (enough for each participant)
- Laptop and projector with module slides
- Flipchart and tape/gum to stick sheets to the wall
- Post it notes/small cards for each participant to write on
- 3 different coloured markers
- An attendance register for the group
- A module reporting form

Content:

Introduce the module and training about Adolescent and Youth-Friendly Health Services.

Agenda for Module 1

TIME	TOPIC
15 min	Welcome & Opening
10 min	Pre-test
60 min	Introduction to Adolescents & Young People aged 10-24 years old
5 min	Break
60 min	Adolescent & Youth-friendly services
20 min	Applying Training Topics in our Facility
15 min	Post-test
5 min	Closing & Next Training Topic

Teaching methods

Lecture, discussion, brainstorming session, role playing data review, action planning.

Trainer instructions

Slides 1 -5

Use the slides to appreciate those who are sponsoring this training and commitment of participants.

Introduce the 7 modules and schedule with trainees. If a schedule has been set already, update the slide to reflect the schedule for this facility.

Review the qualifications for certification; that is each trainee will be eligible for certification showing that both knowledge and skills from this work are being used in the facility once he/she has:

- Attended and participated fully in the training modules
- Completed a pre-test with some improved knowledge on the topic
- Site visits and support demonstrate that there is use of information and skills on the job.

Slide 6

Ensure that introductions are done so everyone knows each other and the group they will be learning and working with over the next few months.

Review basic ground and confirm if these ground rules are okay. If the group would like to add more, allow the group to do that to set an environment of learning.
Common ground rules include:

- Raise hands and one speaker at a time.
- Be respectful
- Critique ideas, not people.
- Do not offer opinions without supporting evidence.
- Avoid put-downs (even humorous ones).
- Take responsibility for the quality of the discussion.
- Build on one another's comments; work toward shared understanding.
- Do not monopolize discussion (or talk too much).
- Speak from your own experience, without generalizing or sharing confidential information.

Slide 7

Handout a pretest for the first module and numbers to be used as ID numbers. Let the group know they will have about 10 minutes to read the test and answer. Each person should be sure to include their ID. The scores will be kept by the facilitator and analyzed as a group (not by individuals).

As a pretest they may not know all the answers yet. If not sure of the response, they can leave a question blank.

At the end of all seven training modules, we will see if they can answer all the questions.

Collect the pretests.

Slide 8

Explain that there are two guiding policies which will inform our content in this module. Read the titles.

See if the group is familiar with these tools by holding up examples. If so, ask for help to explain the role of policy in our work.

Slide 9

Set the foundation for discussions about these audiences through the modules.

Read the content.

Ask the group what they think about this vision for adolescents in Lesotho? Appreciate responses as the group participates with responses, either a positive effect or negative effect.

Slide 10

Explain that throughout these trainings we want to be sure to talk about real youth – youth who live in this community and use these services. In order to do that we need to think about who they are and what are their characteristics.

Post three flipcharts around the room. Each one with an age grouping as shown on the slide. Leave a marker by each flipchart and ask for participants to move form station to station adding their thoughts about males and females in this age group. All answers are welcome.

As the trainees get up; make sure they are clear on the instructions. They can write anything that describes this young person: status, likes/dislikes, attitudes, hobbies … By the end we want to have a picture of who these youths are from this community and who could (and do) use this facility for services.

After 5 minutes, ask the person standing next to the full chart to read the responses.

Thank the group for their input and appreciate their insight into the community which they serve.

Slide 11

Reference the slide in their handouts, which gives a text book description of the stages of adolescent development which are going on in the lives of the youth described on the flipchart.

If there are questions about Tanner staging, explain that is a clinical process for nurses and doctors.

Slide 12 -15

With a foundation of our potential clients and patients, we need to understand the context for our training today and throughout the weeks.

Review the content on each slide.

To get participants discussing among themselves; print out the 8 standards. Split into 8 groups using a fun way. Ask the group to line up by month and day of birthday without talking. They should communicate without talking to each other but find out who was born in January at the start of the line all the way to December at the end of the line.

Give each pair/small group their own slip of paper that includes a standard and break up the groups to discuss them and then present to the group.

On slide 13

Invite a discussion to have the group share their thoughts and opinions about AYFHS locally?

Slide 16-18

In this section the facilitator works to guide reflection of trainees, so that they can focus on personal changes in their own work. It is important to acknowledge the many influences that affect friendly services in a positive or negative direction, however the point of bringing trainees together is to focus on what they can do from their role every day on the job.

If a group member starts to blame a patient or the system, try to direct the conversation back to personal choices and work.

Common barriers to patient care are:

- Patient; money, distance to facility, unaware of services or health needs, fear of lack of confidentiality;
- Facility level; supply chain, lack of staff, long waiting time, expensive services, corrupt/unmotivated management, poor reputation of facility “where people die”,
- Provider level; include judgmental attitudes, refusal to serve young clients, long waiting times, mean/rude/unqualified staff

Common facilitators to care:

- Patient; can afford services/free, proximity to facility, aware of services or health needs, confident in services
- Facility level; supply chain, staff available, shorter waiting times, strong management, reputation of facility “where people get care”,
- Provider level; include friendly, caring staff, able to do their job and help patients, can assess issues and support care and prevention

Use the slides to enable the group discuss about their ideas which help youth to access and use health services, vs those things which inhibit or block youth from accessing or taking up services they need. These can be from any perspective; personal, provider, or health care system.

Slide 18

Guide the group to reflect on their discussion from a provider perspective; which areas do trainees have control over in their work?

Reflect on the thoughts making sure it’s true;

a. What does our analysis show us? Is this the reality?
b. How does it make you feel to think about this?
c. What can we learn from this exercise about how we focus our efforts on the job?

Give each trainee a post it/sticky note.

It will be common to hear about two key issues in facilities: provider attitudes and lack of motivation by staff themselves. Motivation infers some level of lack of interest in adolescent health, which may be influenced by culture or unhappiness in the post and pay.

Organize the thoughts by shared area on a flipchart and review with the group.

Slides 20-23

Explain that the primary barriers to quality care for adolescents are provider’s feelings about what adolescents should be doing from a cultural context.

Summarize the main points, that:

a. Imposing person values on patients

b. Judgmental attitudes towards behaviours, such as early sexual activity

Define values:

- *The regard that something is held to deserve; the importance, worth, or usefulness of something.*
- *Consider (someone or something) to be important or beneficial; have a high opinion of.*

Describe that values are important but not fixed – they can change over time and within a person's role – especially between home and work. On a personal level, *values are a person's principles or standards of behaviour; or one's judgment of what is important in life*. Pass out the Values Boxes Handout; giving one copy to each participant. Explain that together we will complete the work section; then each person will have time to complete the other boxes independently.

a. Using the definitions brainstorm on flipchart possible values in health care and at the facility. List those such as: accountability, efficiency, hard work, quality services, access for all, customer service, teamwork, accurate reporting & record keeping, adhering to national policy and SOPs, treatment success, and more.
b. Explain that from this list, each person should write the top/key values of their facility to be in the blank space.
c. Within that box, a smaller box should be the values for their role. This should vary by position and responsibilities.
d. When complete they should rotate the paper to do the same from an individual perspective; listing their family values and personal values. These can represent culture, religion, clan and more.

When done, ask the group to fold the paper along the diagonal line, so that each set of values for work or family will show when flipped over.

a. Reflect on the responses; are the sides the same or different? Why?
b. What did notice as we were filling the spaces on the handout? How did it feel to think about these things?
c. What did you learn about yourself?
d. How do we make sense of these differences at home and work?
e. Should values change in different places? Why or why not?

Slide 24 - Let's look at a role play to demonstrate the effects of applied values for a patient.

Introduce the role play forms to fill out together. Ask for four volunteers to help fill out the sheets with information listed: age, sex, history (background on the client if they've ever come in for care before), health need.

a. The provider is wearing his personal values (as a hat) and applying this in his/her care for the patient.

b. The teen patient is coming to the facility because – use role play form from trainees.

Slide 25 - After a few minutes; enough to show the interaction and response with personal values; that will judge the girl, assuming she has had early and unprotected sex.

a. Reflect on the interaction; what happens to the patient? How does she feel? Can she receive the appropriate care? Why or why not?
b. Can this interaction influence the patient's decision to listen to the provider? Return to the facility? Why or why not?
c. What else do we learn from watching the role play?

Now ask for 2 more volunteers; one will play a patient and the other a provider. Explain the situation this time:

a. The provider is wearing his/her work values (as a hat) and applying this in his/her care for the patient.
b. The teen patient – using the role play cards.

After a few minutes; enough to show the interaction and response with professional values; that will listen, counsel the patient on available contraceptive methods and screen for sexual activity, to facilitate HIV testing.

a. Reflect on the interaction; what happens to the patient? How does she feel? Can she receive the appropriate care? Why or why not?
b. Can this interaction influence the patient's decision to listen to the provider? Access services? Return to the facility? Why or why not?
c. What else do we learn from watching the role play?

Reinforce to participants that it is normal for all providers to have both personal and professional values; but that they should not be mixed up when providing care. If we use the hat analogy, we wear our personal values outside of work, at home and in our personal lives. We wear our professional values on the job and when serving patients.

Slide 26 - Thank the group for doing both activities. Now explain that the last step in the module to think about how we will apply these lessons of the module in their work.

Slide 27 – Share the slide with data that reflects some pre-training activities to pull data from clinic registers for the last quarter for their facility.

What does the group notice? Is it what was expected? How many clients need adolescent-friendly providers? How many clients need youth-friendly providers?

Slide 28 - Handout a tool that could be used by providers to consider how they provide care that meets the national standards in the provision of health services. Review the tool and discuss its relevance. The tool is optional, if useful.

If the tool is deemed relevant, discuss how it could be used in the clinic.

Slide 29 – Handout another tool that could be used at the facility to collect patient feedback on the services provided. Feedback on their satisfaction with available services and how they are provided. These could be collected in a box or envelop anonymously.

The key for facilities is to request for feedback to clients and then review feedback to make changes as relevant.

Slide 30 – Appreciate the work done for this module. Explain that we're about done. The last step for each module is deciding what to do next – in this facility.

Let the group decide what is the priority and what immediate next steps can be done.

Explain that for every training, the facilitator will record the discussion with attendance and share a copy of the report with the facility leadership and team supporting the site. The idea is that discussions do not stay in the room, but have chances to grow and get support from here on forward.

Slide 31

Confirm that the training objectives have been met using this slide. Ask for each learning objective; did we do it? If not, find out what needs to be completed and set a plan for that on-the-job.

Slide 32

Use this last slide to guide closing of the first training module.

Use the attendance sheet and reporting tool to help complete the module. Post tests will be done after Module 7.

Key sources

Lesotho Ministry of health. 2016. *The National Health strategy for Adolescents and Young People 2015-2020*. Maseru Lesotho

Name: _____ District: _____

Thank you for attending this Training. The summary form is given at the beginning of each training and is compared with an evaluation at the end of the training. It will be used to determine the usefulness of this training. Please attempt to answer ALL of the following questions.

Please circle all statements that represent your experience BEFORE this workshop.

1. Trainer of adolescent (10-19) health care and HIV services.
2. Trainer of youth friendly services and sexual and reproductive health for 10-24 year olds.
3. Trained in adolescent (10-19) and/or young people's (15-24) health and provision of services.
4. Trained in adolescent (10-19) and/or young people's (15-24) health but not providing services.
5. Not trained in adolescent (10-19) and/or young people's (15-24) health or provision of services.
6. Not trained in providing youth (10-24) health care and not providing youth services.

1. Providing Adolescent and youth-friendly services

A person aged 10- 24 years old is defined as a youth	True	False
The Lesotho national vision is that All adolescents in Lesotho enjoy the highest standard of health, develop in a well-balanced manner and are adequately prepared to enter adulthood and assume a constructive role in communities and in society at large.	**True**	**False**
There are 8 standards for youth friendly services and for Lesotho these include: *Youth are actively involved in designing , implementation, monitoring and evaluation of services*	**True**	**False**
A characteristic feature of early adolescence (age 10- 14 years) is a clear understanding that present choices affect the future and an ability to plan for the future	**True**	**False**
Youth friendly services need to meet the standard of being accepted by young people due to the friendly attitude of health care providers, reasonable waiting time, and because confidentiality and privacy are maintained	**True**	**False**
If a facility meets youth friendly services standards, young people will be able to access information and services in convenient working hours irrespective of ability to pay	**True**	**False**

A 13-year-old

is an adolescent, a young person and a youth	**True**	**False**
should be aware of services provided outside the facility and can be involved in designing, implementation, monitoring and evaluation of health services if the facility meets global standards for quality health care services for adolescents	True	False

A 20-year-old

Is a young person but not an adolescent	**True**	**False**
Typically is mature enough to plan for the future and understands how present choices affect the future	**True**	**False**
Typically has same sex friends from whom he has strong peer influence	**True**	**False**

3.2. Module 2 Test & Treat for Adolescents in Lesotho

Duration: 3 hours

Learning objectives

Review the epidemiology of Test and treat
Describe Lesotho Test and treat guidelines application to adolescents
List the differentiated service delivery models for 10 to 24 year olds
Review clinic patient volume for 10 to 24 year olds and reflect on facility needs
Identify effective DSD models that can work in our clinic for adolescents and young people

Advance preparation

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Review the questions and activities for this module and take note of the expected responses from the participants.
3. Assess the facility data before the module and update slide 10
    - Alternatively have a member of the facility prepare the data beforehand and share it with you for updating.
4. Collect data on time from diagnosis to ART initiation for a sample of 5 adolescents or young people.
5. Assess and take note of differentiated service delivery models currently being implemented in the facility and which ones are being applied for adolescents and young people.

You will need the following materials

- Laptop and projector
- Flipchart
- 2 different coloured markers
- Module 2 handouts
- Facility data on test and treat for adolescents – ART initiations/ time to ART initiation
- 2016 National ART guidelines on the use of antiretroviral therapy for HIV prevention and treatment.

Content

This module gives guidance on application of 2016 National ART guidelines on the use of antiretroviral therapy for HIV prevention and treatment and HIV testing services guidelines for adolescents and young people. Module includes HIV testing and counselling, ART initiation and monitoring. The module includes assessment of existing services in the facility and data review as well as action planning to improve services offered.

The module also includes a section on differentiated service delivery models as they apply to adolescents.

Agenda for module

TIME	TOPIC
15 min	Welcome & Opening
10 min	Pre-test
30 min	Introduction to Test & Treat
30 min	Review Test & Treat Guidelines for Adolescents
5 min	Break
30 min	Facility Volume and Differentiated Care Models
45 min	Applying Training Topics in our Facility
15 min	Post-test
5 min	Closing & Next Training Topic

Teaching methods
Lecture, discussion, group work, action planning

Facilitator instructions

Slide 1-5 Welcome and opening:

Use the slides to appreciate those who are sponsoring this training and commitment of participants.

Review progress since module 1 and remind facility staff about the schedule of remaining modules. Share updated slide to reflect the schedule for this facility.

Review the qualifications for certification; that is each trainee will be eligible for certification showing that both knowledge and skills from this work are being used in the facility once he/she has:

- Attended and participated fully in the training modules
- Completed a pre-test with some improved knowledge on the topic
- Site visits and support demonstrate that there is use of information and skills on the job.

Review the objectives and agenda of the module with the participants.
Share the learning objectives.
Review ground rules

Slide 7

Handout a pretest for the module and numbers to be used as ID numbers. Let the group know they will have about 10 minutes to read the test and answer. Each person should be sure to include their ID.

The scores will be kept by the facilitator and analyzed as a group (not by individuals).

Slide 8

Distribute the references handouts. Explain that the 2 handouts are extracts from the

I. HIV testing services guidelines
II. National guidelines on the use of antiretroviral therapy for HIV prevention and treatment

The handouts highlight guidance on HIV diagnosis, care and treatment for adolescents and young people specifically as indicated in the 2 guidelines.

Slide 9

Lesotho HIV estimates (UNAIDS 2015)
Discuss these estimates with participants and highlight any updates.
Emphasize that Lesotho currently has the 2nd highest HIV prevalence in the world

Slide 10

Ask participants why there is need to focus on adolescents.
Guide the participants' responses towards discussion of standard answers on the slides:

- Population sub group with higher mortality than others; indicating they are not accessing care or being lost in care.
- Group with low service access and retention on treatment.
- Rising HIV incidence; and key to stopping the epidemic.

Slide 11

Invite responses from trainees to get an understanding of the starting point for the module. Assess participant knowledge on test and treat and how this new approach has impacted on service delivery in the facility.

Slides 12-13

Discuss the definition of test and treat.

Ask if the facility staff are following this guidance.
Stress that adherence counselling is still an essential part of ART initiation even with the test and treat guidance. The same as readiness assessment which should be done and documented for all clients.

Depending on the audience you may need to give more detail on actual benefits shown by the studies. See notes below

Slide 14
Video

Explain that you are about to play a simple Video on how HIV affects the immune system. It gives simple explanation on how ARVs work from Help stop the virus.

Slide 15

Discuss the underlying evidence. Refer to notes below for further guidance on the START and TEMPRANO studies. These are the 2 major studies that support the test and treat approach.
START Study

- Which stands for Strategic Timing of Antiretroviral Therapy. It was conducted in over 30 countries in Africa, Asia, Europe, North and South America. It was conducted from 2009 to 2015.
- Cardiovascular endpoints included myocardial infarction, stroke, or need for coronary revascularization
- Secondary end points included serious AIDS related events, serious non–AIDS-related events, death from any cause, grade 4 events, and unscheduled hospitalizations for reasons other than AIDS. Grade 4 events were defined as potentially life-threatening symptomatic events not attributable to AIDS that required a medical intervention.

TEMPRANO Study
A trial of early antiretroviral and isoniazid preventive therapy in Africa done in Ivory coast
Major differences from START: one country, 4 arms (start ART immediately/defer ART and +/- IPT), and slightly diff endpoints
The CD4 cutoff for initiation increased twice during this study. Once in December 2009, it was increased to 350, and again in August 2013, it was increased t CD4 < 500.

The primary study endpoint was a combination of all-cause deaths, AIDS diseases, non-AIDS malignancies, and non-AIDS invasive bacterial diseases. The risk of primary events was lower with immediate ART than with deferred ART, with a hazard ratio of 0.56 in favour of early ART (CI, 0.33–0.94). On the basis of these results, the study team concluded that early ART is beneficial in reducing the number of these clinical events.

Also discuss treatment as prevention. Indicate that viral suppression reduces risk of HIV transmission by 96% as indicated in the HPTN052 study.
The HPTN052 study was done in 9 countries - HIV-infected partners were assigned to start ART at the beginning of the study, called the “early” arm (CD4 count at ART initiation 350-550 cells/mm3), or later in the study, called the “delayed” arm (CD4 count at ART initiation 350-550 cells/mm3). Those on the delayed arm started ART based on eligibility criteria – clinical and immunological criteria.
96% reduction of HIV transmission within the couples assigned to early ART noted.

Slide 16

Video on test and treat benefits.

Explain you are about to play a simple video on the benefits of test and treat. This video is based on the findings of the HPTN052 study which is explained above.

Ask for comments about the video and whether there are any questions.

Slide 17

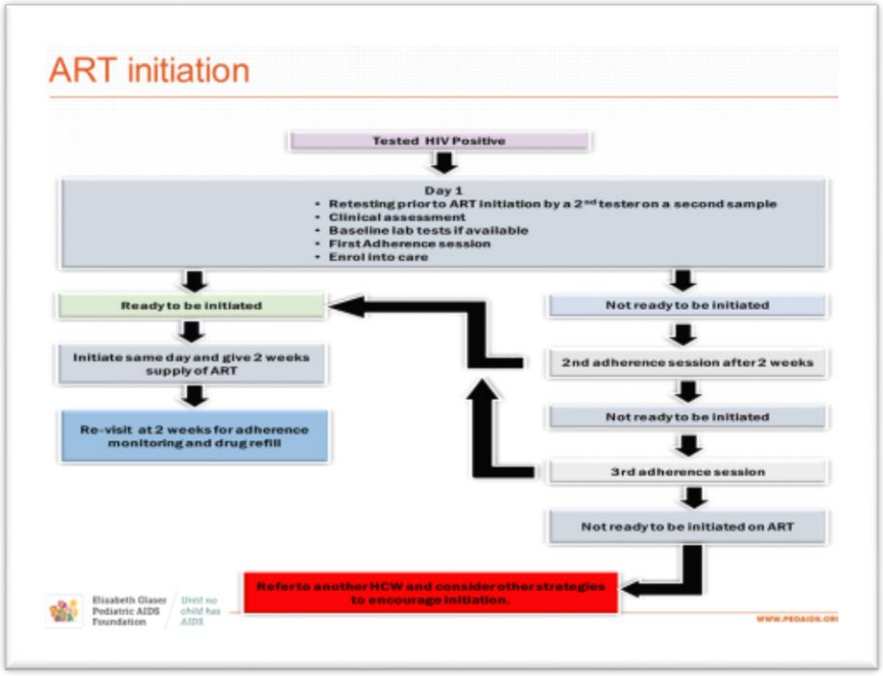
This slide links Test and treat to other existing methods of public health approaches to control the spread of HIV.

Remind the participants about the Positive health and dignity prevention package which is the comprehensive package of services aimed at prevention of HIV transmission for people living with HIV. This package includes;

1. Continuous adherence monitoring and support for PLHIV on ART
2. Prompt identification of pregnancy and provision of family planning services to PLHIV not currently desiring pregnancy
3. Referral to and from relevant community-based programs for non-clinical support and services
4. Encourage consistent condom use through education and condom and lubricant
5. provision
6. Reduction in high risk behaviours, including unprotected sex and multiple sexual partners
7. Routine screening and treatment of STIs
8. Mental health and substance abuse screening with referral to appropriate services for individuals, including Blue Cross and Alcoholic Anonymous groups
9. Support for disclosure of HIV status to partners and partner testing with appropriate referral to prevention services for HIV-negative partners, such as PrEP and VMMC

Slide 18

Revisit the test and treat initiation cascade based on the 2016 ART guidelines.



Stress the need for

- Retesting – for initiation
- Baseline clinical assessments
- Baseline blood tests – these should not delay initiation if client is clinically stable
- TB screening
- Adherence sessions
- Enrolment

Also discuss the need for repeat adherence sessions for those not ready for ART as indicated in the algorithm.

Slide 19-20

Discuss the participants' experience with test and treat for the various age group and whether age has any impact on patients' acceptance of the approach.

Discuss the effect of physical development on ARV selection.

Discuss the differences between adult and adolescent clients and how adolescents should be catered for.

Slide 21

Discuss cascade of HIV Care as it applies to adolescents and the need for age specific psychosocial support.

Slide 22- 25

Case discussions to highlight potential test and treat challenges and opportunities for 3 different young people.

Consider doing separate group discussions if time allows.

Guide the discussions by explaining the questions

I. Challenges are difficulties that may arise for this particular client e.g. religious school may have negative attitude to the child's status, the child's age means she may have to be reliant on a caregiver, she may not have been disclosed to at that age, restrictions if in boarding school.
II. Opportunities are characteristics of the client/context that may make it easy to test and treat them.

Conclude by reflecting on the discussion on slide 25. Guide the discussion to highlight that adolescents and young people are a heterogeneous group with a variety of challenges and also opportunities that can be taken advantage of to provide test and treat services.

Participants should conclude by indicating how they will apply what they have learnt into their work.

Slide 26

Inform participants that you are now going to discuss the facility's data. If you have a picture of the facility you can insert this on the slide to emphasize that this information is about their facility.

Slide 27

Explain the various indicators you have collected and how you disaggregated them and why if there is need.

Slide 28

Review of facility data

*Assess the facility data before the module and update slides 28 and 30. Alternatively have a member of the facility prepare the data beforehand and share it with you.
To update graph

i. Click on the graph
ii. Select edit data
iii. Enter numbers of adolescents and young people diagnosed, enrolled into care and initiated on ART.

- Discuss the pattern of the graph and possible reasons
- Guide the discussion based on facility performance

Maintaining performance if doing well
Improving performance if suboptimal performance. Remember to include positive comments with any comments indicating suboptimal performance.

Slide 29

Collect data on time from diagnosis to ART initiation for a sample of 10 adolescents or young people before the training and update the excel sheet.

To do this

- Click on the pie chart
- Select edit data
- Enter numbers of adolescents for each time delay to ART initiation i.e,1 day, 2-4 days etc. since test and treat was introduced in the facility
- Include at least 10 adolescents – this will depend on volume of ALYHIV being managed at the facility and may have to be less.
- Include preART patients from before implementation of test and treat

Discuss the distribution and possible reasons

Also assess health care worker motivation and feelings about improving performance.

Agree on targets for shortening time from diagnosis to initiation. This is particularly important if the reasons for delayed initiation are facility/HCW- related and can be fixed e.g.

- if facility only initiates clients on specific days of the week.
- Delays due to incorrect belief that CD4 results have to be available first.

Please note - the guidelines do not have target time to initiation but all clients who are ready to initiate ART can be initiated on the day of diagnosis.

Discuss the major bottlenecks and challenges with ART initiation. If the facility is doing well, focus on maintaining the trend.

Slide 31

Introduce differentiated service delivery to the participants by asking what they know about differentiated service delivery. Also ask which models have been implemented in their facilities. Below is a summary on differentiated service delivery for your information.

Differentiated care is a movement away from a “one-size-fits-all” approach as we push towards 90-90-90

- Need to adapt to patient and health system needs and barriers
- Ensure we are not only addressing stable patients’ needs!

Differentiated care is not novel, just re-packaged

- Many of these ideas are already happening, but not in a comprehensive & systematic way

Remind participants that differentiated service models also include models for HIV testing not just delivery of drugs.

Slide 32

Help participants to understand that Differentiated service delivery models are all about helping clients overcome barriers to care. In this way service delivery is tailored to clients’ needs.

Ask participants what some of these barriers are for adolescents. Refer to slide for standard answers.

Slide 33

Explain to participants that after having identified the barriers to accessing services for adolescents and young people, consider the following four questions:

1. When will HIV services be provided? (will ART services be provided daily or limited days/hours? Do ART clients have to return every month for ARV refills or can stable patients come back every 3-6 months?).

2. Where will HIV services be provided? (community versus facility).

3. Who will provide HIV services? (doctor, nurse, pharmacy personnel, lay worker, HIV client themselves, peer leader).

4. What HIV services will be differentiated?

Ask whether the participants understand this and explain to them that they will use this process in the coming slide to determine how to differentiate services for examples of adolescents and young people.

Slide 34

Group work on differentiating care for adolescents and young people.
Assign a client to each group and give each group 10 min to come out with possible DSM to cater for the client.
Go around the room with other facilitators to assess understanding of the tasks and explain with examples as needed.
Remind participants to go through the WHEN, WHY, WHO & WHAT process
Guide participants to assess

i. Stability of the client
ii. Additional need for more frequent visits – pregnancy, stage 3/4, poor adherence, high viral load etc.
iii. Community versus facility based care.
iv. Eligibility for various existing differentiated service delivery models.

Slide 35

Examples of differentiated service delivery models. Refer to current guidance on eligibility of adolescents and young people for these.

See slide notes for explanation on fast track refills.

Slide 36 & 37

In conclude the module, facilitate the discussion on action plan based on challenges highlighted during the presentation. Ask one of the participants to document the plan on flip chart paper.

Remind the facility staff that you will be reviewing progress on this plan with them at your next visit.

Guide the participants to keep their action plan specific, achievable, time bound, measurable and realistic.

Slide 38

Hand out post-test papers and conduct test.
Record attendance and give comments as needed. Applaud good attendance and highlight any gaps.

Inform participants about next module date and topic.

Key points

Recap key points and reemphasize targets agreed upon by the facility.

ART should be initiated among all adults with HIV regardless of WHO clinical stage and at any CD4 cell count.

- ART should be started as soon as possible after diagnosis for all HIV positive patients regardless of age, clinical status or CD4 count.

- HIV patients should still receive standard package of care including clinical assessments and baseline blood tests with test and treat approach.

- Allow time for questions and comments at the end.

Key sources

Fick C, Fairlie L, Moultrie H, Woollett N, Pahad S, Thomson K, Pleaner M. *Working with adolescents living with HIV: A handbook for healthcare providers*. Johannesburg: Wits RHI and Southern African HIV Clinicians Society, 2nd edition 2016

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Lesotho Ministry of health. 2016. The National HIV Testing Services Guidelines. Maseru Lesotho.

Temprano ANRS 12136 Study Group. A trial of early antiretrovirals and isoniazid preventive therapy in Africa. N Engl J Med. Jul 20 2015. Available at http://www.ncbi.nlm.nih.gov/pubmed/26193126.

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Pre-test/Post test

Module 2: Test & Treat for Adolescents in Lesotho

15 minutes
Circle the correct answer

7. Amohelang is an 18-year-old who has just tested positive today. The following should be done on the day of diagnosis

Repeat HIV test with Unigold rapid test kit only	True	False
WHO clinical staging	True	False
Isoniazid preventive therapy initiation	True	False
Initiation on ART without adherence counselling if Amohelang declares he is ready for ART	True	False
If Amohelang is not ready to start ART, he should be given appointment for another adherence session	True	False
Offer partner testing, STI screening and offer other preventive measures in the PHDP package	True	False

8. Benefits of test and treat

Studies have shown that 96% reduction of HIV transmission within the couples assigned to early ART as opposed to delayed ART	True	False
Treating HIV-infected persons to improve their health and to reduce the risk of onward transmission—sometimes called treatment as prevention *is an effective public health strategy for controlling the spread of HIV*.	True	False
Although research studies that have shown benefit of test and treat (TEMPRANO, START, HPTN 052 studies) were done in adults and not in adolescents, recommendations have been extrapolated to adolescents based on the expectation that they will derive benefits from early ART similar to those observed in adults	True	False

9. *ART initiation in adolescents*

If a client is still not ready to start ART after 3 adherence sessions, refer to another HCW and consider other strategies to encourage initiation	True	False

10. *Mpho is a 14-year-old boy who has been diagnosed HIV positive. He has come with his grandmother who is his primary caregiver and is not ready for him to start ART today in spite of counselling done*

Mpho should be started on ART if he says he is ready to start ART	True	False
Mpho is eligible for CTX if he has herpes zoster and the CD4 count is not yet available	True	False
He should have CD4 count done today and then annually until he is ready to start ART	True	False
Mpho and his grandmother should be given an appointment for adherence counselling and ART preparation	True	False

3.3. Module 3: Undetectable Viral Load: Adherence for AYPLHIV Treatment Success

Duration: 3 hours

Learning objectives

At the end of this module participants will

- Understand viral load monitoring for adolescents
- Define adherence
- Describe opportunities and challenges of adherence
- Learn the 5 A's for enhancing adherence for young patients
- Identify team roles through case study and real situations

Advance preparation

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Review the questions and activities for this module and take note of the expected responses from the participants.
3. Print copies of handouts, if not done already.
4. Confirm that video links can play properly.
5. Have a blank copy of the reporting form for this module.

You will need the following materials

- Laptop and projector
- Speakers - optional
- Flipchart
- 2 different coloured markers
- Facility data on viral load testing and suppression rates for adolescents – ART initiations/ time to ART initiation
- 2016 National ART guidelines on the use of antiretroviral therapy for HIV prevention and treatment.
- Pre and post-test forms
- Handouts

Content

This module focuses on disclosure and aspects of treatment support for AYLHIV. It includes definition of disclosure, classification, barriers to disclosure in adolescents and young people. The module also includes sections on role of the healthcare worker in the disclosure process including post-disclosure support.

Agenda

TIME	TOPIC

15 min	Welcome & Opening
10 min	Pre-test
45 min	Introduction to Viral Suppression & Treatment Goals for Adolescents and Young People
15 min	5 A's of Adolescent Adherence
5 min	Break
15 min	Case Studies – ALHIV with detectable viral load results
60 min	Identifying Team Roles for Adherence in our facility
15 min	Planning for Increased Viral Suppression for AYP clients
5 min	Closing & Next Training Topic

Teaching methods
Lecture, videos, group work, discussions, case study

Facilitator instructions

Slide 1 -6: Welcome and opening:

Introduce Module 3 and appreciate the support for holding this training today.

Remind the group about the certification and then review progress made. Find out how the participants are applying their learning and improving services. If there are delays in changes, find out the reasons and consider postponing more training if necessary.

Attempt to ensure site progress by raising delays with participants, facility heads and district leaderships. However, with serious delays or issues, raise these to EGPAF Maseru leadership supporting the adolescent programming.

Review the objectives and agenda of the module with the participants.

Share the relevant key references.

Discuss learning objectives.

Slide 8

Handout a copy of the pretest for each participant. Each participant should have a number that Vcan assist with tracking their progress. Collect when completed.

Slide 9 Play video explaining the goal of undetectable. Confirm understanding, playing a second time if needed to ensure English language is understood.

Slide 10-11

Discuss what viral load is as explained in the video. Ask participants what viral load measures-
Viral load test is a lab test that measures the number of HIV virus particles in a milliliter of blood. These particles are called "copies.

A viral load test helps provide information on the patient's health status and how well antiretroviral therapy (ART – treatment with HIV medicines) is controlling the virus.

According to the 2016 National ART guidelines adolescents should undergo viral load testing every 6 months. Refer participants to page 51 of the guidelines. Highlight that the 6 monthly test is only for those who remain viraly suppressed. If the viral load is high then the algorithm for high viral load should be followed.

Slide 12

Discuss the need for adolescents and young people to set the treatment goals and achievement of undetectable viral load should be one of these.

Slide 13

Emphasize the need for HCW to support clients to achieve 3 zeros –
Zero viral load
Zero missed doses
Zero missed appointments

Slide 14

Introduce participants to the section on adherence and ask to get their own understanding of the term adherence. Prompt participants and guide them to the standard answer as needed.
Discuss the importance of good adherence with participants.

Slide 15

Share the standard definition according to our guidelines
Emphasize that good adherence goes beyond just taking medications correctly but also includes

- Following an agreed upon care plan
  - Physical and mental health
- Attending scheduled clinic appointments
- Picking up medications on time (refills)
- Getting regular required lab tests

Slide 16

Discuss the challenges of adherence. Ensure a rounded discussion by encouraging participation and highlight challenges such as treatment fatigue for vertically infected adolescents.

Slide 17

Discuss evidence indicating that adolescents are generally less adherent and have lower suppression rates than other age groups.

Explain that the same trend applies to adolescent adherence to medication for other chronic conditions. Ask participants for their experience with this.

Slide 18
Implications of poor adherence. This is an animated slide that shows the progression of patient's condition when poorly adherent.

Explain that non-adherence has a number of implications for the health outcome of patients.
A patient who is not taking drugs correctly will have poor health and get ill with opportunistic infections frequently.
They may also end up developing resistant strains of HIV that will be difficult to treat with the conventional treatments available in the country.
Therefore, you need to help and actively advise patients to strictly adhere to all of the services they receive from the health facilities.

Slide 19

Resistance video
Explain that you are about to play a video on drug resistance.
Ask if participants understood the video and whether there is need for additional explanation.

Slide 20

Explain that there are spheres of influence I.e. people and environments which both push and pull adolescents access and use of HIV, testing, care and treatment.

Slide 21

Explain that you are about to play video on importance of staying on treatment for AYLHIV. Ask for comments at the end of the video.

Slides 22 to 26

Assign groups to reflect on challenges and opportunities for adherence for the various cases.

Ensure you display slide 25 to guide the participants on how to do the task.

Give groups 10-15 minutes depending on the number of questions they need to answer. Allow each group to present and allow the rest of the participants to comment and add.

Go through reflection on slide 26 with the participants. Take time to discuss how the participants will apply what they have learnt to their work.

Slide 27

If available share the job aide on the 5As.
Go through each A and discuss what should be done.

- Assess-
    - Assess patient and caregiver's goal for consultation
    - -Clinical status
    - -Risk factors
    - -Knowledge & beliefs

- Advise
    - Use neutral and non-judgemental language
    - Correct inaccurate knowledge
    - Discuss options available, evaluate readiness for treatment plan

- Agree
    - Negotiate selection of adherence support options.
    - Agree on goals that reflect patient's priorities.
    - Ensure goals are
        - Clear,
        - Measurable
        - Realistic
        - Under the patient's direct control
        - Limited in number
- Assist
    - Provide treatments, medication, adherence tools and skills, address obstacles,
    - Provide Psychosocial support as needed.
    - Link to available support
- Arrange
    - Provide treatments, medication, adherence tools and skills, address obstacles,
    - Provide Psychosocial support as needed.
    - Link to available support

Slide 28
Ask participants methods they are using for measuring adherence and the advantages and disadvantages of each method.
Discuss which method they feel works best for adolescents.
Refer to notes for additional information for each method.

Slide 29

Discuss available job aides for 5As. Emphasize the need for appropriate referrals

Slide 30 -32

Discuss tips to enhance adherence for adolescents and young people. Section includes discussion on effective adherence counselling.

Ask participants for their own impression of this and how practical the tips are. Keep the discussion open and ask for their own experiences and tips.

Slide 33-35

Hand out case study forms.
Ask participants to fill these detailing any difficult cases relating to adherence to treatment that they may have come across that they would like to discuss.
Redistribute slips to groups after quickly checking for relevance and clarity.
Allow the groups 10 minutes to come up with a management plan for the clients.
Advise them to include available cadres in the facility.

After each team presents do a reflection exercise on Slide 34.

Display Slide 35 to remind the teams of potential cadres that can be involved.

Slide 36

Discuss next steps for the facility based on what has been learnt during the model. All of this should be documented on the module report. Emphasize the need for SMART goals.

Slide 37

Review module and discuss with participants whether training objectives have been achieved.

Slide 38

Conduct post-test.
Review attendance and comment accordingly.
Inform participants about next module topic and agree on dates.

References

Aidsinfo.2017. *Considerations for Antiretroviral Use in Special Patient Populations HIV-Infected Adolescents and Young Adults*. From https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/21/hiv-infected-adolescents-and-young-adults

Fick C, Fairlie L, Moultrie H, Woollett N, Pahad S, Thomson K, Pleaner M. *Working with adolescents living with HIV: A handbook for healthcare providers*. Johannesburg: Wits RHI and Southern African HIV Clinicians Society, 2nd edition 2016.

Claborn, K. R., Meier, E., Miller, M. B., & Leffingwell, T. R. 2015. A Systematic Review of Treatment Fatigue among HIV-infected Patients Prescribed Antiretroviral Therapy. *Psychology, Health & Medicine*, 20(3), 255–265. http://doi.org/10.1080/13548506.2014.945601

Tadde, D., Egedy, M., & Frappier, J.-Y. (2008). Adherence to treatment in adolescents. *Paediatrics & Child Health*, *13*(1), 19–24.

Pretest/Posttest

Module 3: Undetectable Viral Load: Adherence for AYPLHIV Treatment Success

15 minutes
Circle the correct answer

1. ***Adherence and AYLHIV***

Adherence includes not only adherence to treatment but also adherence to care e.g. keeping appointments	**True**	**False**
The standard clinical definition of adherence is taking 95-105% of medications the right way at the right time (the 4 R's: Right drug, Right dose, Right time, and Right way). • *Following an agreed-upon care plan* • *Attending scheduled clinic appointments* • *Picking up medications on time* • *Getting regular required laboratory tests*	**True**	**False**
HIV-positive adolescents on ART generally have higher viral suppression rates than either adults or younger children.	**True**	**False**
One of the implications of poor adherence is development of resistance stains which may limit future ART regimen options	**True**	**False**
Inability to accept HIV status can impact negatively on ART adherence	**True**	**False**
5 As of Adherence include Assess where HCW should: • *Ask about and assess the client's knowledge, attitudes and concerns about ART and adherence*	**True**	**False**
Pharmacy records can be assessed to measure adherence	**True**	**False**
Making a treatment plan includes the following only • Treatment regimen • Follow-up plan •	**True**	**False**

2. **Ongoing adherence**

Is not necessary if the client has accepted their status and is willing to take their medication.	**True**	**False**
Is necessary as barriers to adherence can change over time	**True**	**False**
In the case of missed doses clients should not take double dose when they realize they have missed a dose	**True**	**False**

3. ***Mapule is a 16-year-old client whose mother reports she has not been taking her medications well for the past month*.**

Her ARVs should be stopped immediately to minimize the risk of resistance to ART	**True**	**False**

Discrimination in the community may be a contributing factor		
If this is related to pill fatigue the facility team should; • Counsel, support the patient • Manage side effects • Enlist family support	**True**	**False**
When asking a client about their adherence it is best to ask close- ended questions e.g. Are you taking your medication well? as opposed to open ended questions e.g. How often did you take your medication at the right time this past week?	**True**	**False**
You should equip the mother with skills to force Mapule to take her medications against her will.	**True**	**False**
Mapule reports she is has stopped taking her medication because she has been healed at church and she believes that God would not let her suffer. You should give her information, counseling and support whilst respecting her choice and beliefs.	**True**	**False**

3.4. Module 4: Treatment Support: Disclosure in the family, at school and in relationships

Duration :3 hours

Learning objectives

Define disclosure and its steps
Understand the disclosure guidelines in Lesotho
Identify ways to support patients to determine who, when & how to disclose HIV status
At initiation with parents/caregivers
At school
To boy/girlfriends and before marriage
Practice disclosure sessions on real cases

Advance preparation

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Review the questions and activities for this module and take note of the expected responses from the participants.

You will need the following materials

- Laptop and projector
- Flipchart
- 2 different coloured markers
- Pre-test question papers
- 2016 National ART guidelines on the use of antiretroviral therapy for HIV prevention and treatment.
- National HIV testing services guidelines
- Pre and post-test forms
- Handouts

Content

This module focuses on disclosure and aspects of importance in AYLHIV. It includes definition of disclosure, classification, barriers to disclosure in adolescents and young people. The module also includes sections on role of the healthcare worker in the disclosure process including post-disclosure support.

Agenda

TIME	TOPIC
15 min	Welcome & Opening

10 min	Pre-test
30 min	Introduction to Aging with HIV
30 min	National Guidance on the Disclosure Process & Steps
5 min	Break
15 min	Overcoming Barriers to Disclosure for Young Patients
60 min	Practicing Skills to Support Disclosure Using Role Play
15 min	Next Steps: Improving disclosure support in our facility
5 min	Closing

Teaching methods

Lecture, discussion, role playing data review, case study.

Facilitator instructions

Slide 1 -5

Review and summarize progress with whole training package.

Review the objectives and agenda of the module with the participants

Use the slides to appreciate those who are sponsoring this training and commitment of participants.

Review progress since module 3 and remind facility staff about the schedule of remaining modules. Share updated slide to reflect the schedule for this facility.

Review the qualifications for certification; that is each trainee will be eligible for certification showing that both knowledge and skills from this work are being used in the facility once he/she has:

- Attended and participated fully in the training modules
- Completed a pre-test with some improved knowledge on the topic
- Site visits and support demonstrate that there is use of information and skills on the job.

Review the objectives and agenda of the module with the participants.
Share the learning objectives.
Review ground rules

Slide 6

Handout a pretest for the module and numbers to be used as ID numbers. Let the group know they will have about 10 minutes to read the test and answer. Each person should be sure to include their ID.

The scores will be kept by the facilitator and analyzed as a group (not by individuals).

Slide 7
Define treatment supporter

Slide 8-9

Introduce the video and tell participants to pay attention to the subtitles.
Video of Tanzanian adolescent highlighting challenges around adolescent disclosure. Use this video to start discussion on disclosure.
Speakers may not be necessary unless Sotho translation is available.

Ask participants about how they felt about the video and to share their observations. Jot these down on flip chart paper.
Discuss the issues that come out in the video. Check that these issues are relevant in the context of Lesotho.

Possible issues that participants will bring up

Grade 3/Age that client finds out status
Disclosure by others not caregiver/HCW
Unexpected disclosure in other settings outside of health facility
Discrimination and stigma related to others knowing status
Feelings of betrayal
Parents not disclosing because they are

- Scared
- Guilt
- Not sure how
- Not supported to
- Cultural factors

Adolescent partner disclosure
Fears- acceptance by future partners

Slide 10

Define disclosure and highlight that it should be an ongoing process and not a one off event.

Slide 11

Highlight the guidance according to the National ART guidelines. Discuss how participants feel about the recommendation to have full disclosure by the age of 10 years.

Slide 12

Distribute the handout and review in full together.

Slide 13

Allow the participants to volunteer the benefits they have noted before sharing information on slides.
Make use of animation to allow participants to respond first before showing them the benefits.

Slide 14

Discuss potential challenges of disclosure.
Highlight benefits by far outweigh potential negative impacts of disclosure but it is necessary to prepare for the potential occurrence of these.
Allow participants to share any experiences they may have of negative outcomes.
Specify that these can be minimised by social support.

Slide 15-17

Go through the National ART guidelines guidance on disclosure for young children as well as adolescents.

Slide 18

Discuss disclosure in the school setting.
Highlight the need to identify ways to support patients to determine who, when & how to disclose HIV status.
Make this as much a discussion as possible and allow participants to share their experiences.

Slide 19-20

Discuss disclosure to partners.
Highlight the need to identify ways to support patients to determine who, when & how to disclose HIV status.
Make this as much a discussion as possible and allow participants to share their experiences.

Define the role of the HCW in the disclosure to partners. Discuss participants' own experiences and roles of different cadres in the disclosure process.
Emphasize on methods of equipping patients to disclose through role playing etc.
Also highlight the need for HCW to prepare clients for possible reactions and how to respond to them.

Slide 21

Emphasize that normalizing HIV in a hyper-endemic country reduces stigma for the large proportion of the population infected.

Slide highlights IEC materials that educate youth on how to respond when being disclosed to.

Slide 22-24

Basket role play.
Handout the case study forms. Ask participants to fill in highlighting any difficult cases they may have come across.
Allow participants to role play disclosure situations based on the cases they have been given.

Groups then give feedback on how the process went.
Process role play and ask each group how the role play went.
Find out what participant learnt from the exercise.
Discuss what lessons participants can take to their work in the facility.

Slide 25
This slide is on management of cases where caregivers feel that they are not ready for disclosure.

Stress that the HCW should not go against the will of the caregiver but should continue to provide support. They should regularly assess how much the child knows to check whether disclosure may have been done subsequently.

Stress that just because a child/adolescent says they know they have HIV does not mean they necessarily understand the implications of this. The healthcare worker has to explain this clearly.

Slide 26

Discuss next steps for the facility. Guide the discussion to help the facility consider incorporating the following;

Mop up of ALHIV files without documented disclosure.
Clarify provider role in disclosure for AYPLHIV in care.

Slide 27
Review objectives and discuss with participants whether these have been achieved.

Slide 28

Hand out post-test papers and conduct test.
Record attendance and give comments as needed. Applaud good attendance and highlight any gaps.

Inform participants about next module date and topic.

Key sources

- Calabrese SK et al. *Diagnosis disclosure, medication hiding, and medical functioning among perinatally infected, HIV-positive children and adolescents*. AIDS Care, 2012, 24(9):1092-1096. DOI:10.1080/09540121.2012.699670.

- Fick C, Fairlie L, Moultrie H, Woollett N, Pahad S, Thomson K, Pleaner M. *Working with adolescents living with HIV: A handbook for healthcare providers*. Johannesburg: Wits RHI and Southern African HIV Clinicians Society, 2nd edition 2016

- The wall street journal. 2014. *Little Children and Already Acting Mean*. From http://www.wsj.com/articles/SB10001424052702304811904579586331803245244

- United Nations International Children's emergency Fund. 2016. *Tanzania: the journey of an adolescent living with HIV*. From https://blogs.unicef.org/blog/tanzania-the-journey-of-an-adolescent-living-with-hiv/

- Vreeman RC et al. 2013. Disclosure of HIV status to children in resource-limited settings: a systematic review. Journal of the International AIDS Society 16:18466 5.

- World Health Organisation. 2013. *HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policymakers and managers*. Geneva: World Health Organization.

Pre-test

Module 4: Treatment Support: Disclosure in the family, school and in relationships

15 minutes
Circle the correct answer

1. **Disclosure**

Disclosure involves age-appropriate information which will enable them to understand their HIV diagnosis, how it was acquired and to come to terms with living with HIV.	**True**	**False**
Disclosure may be to the adolescent or by the adolescent to a third party	**True**	**False**
The healthcare worker should be the one to disclose to an adolescent with the support of the parent/care giver	**True**	**False**
Children/Adolescents often know the truth before we expect or think they do	**True**	**False**
Disclosure has multiple disadvantages to the adolescents that outweigh the benefits	**True**	**False**
Reassurance and empowering adolescents are ways we can help adolescents cope with their status	**True**	**False**
The health care worker should decide who the adolescent should disclose to as they are too young to make this decision	**True**	**False**
The HCW has no role to play in how adolescents cope with their HIV diagnosis and this should be the caregiver/parent's responsibility	**True**	**False**
After disclosure, adolescents may be shocked, angry, sad, afraid, confused or feel rejected	**True**	**False**

2. *Mamello is a 16-year-old who has just been diagnosed HIV positive but her mother does not want her to know her status.*

Mamello has the right to know her HIV status	**True**	**False**
Disclosure cannot be done without the parent's consent	**True**	**False**
The nurse should be the one to disclose to Mamello.	**True**	**False**
You know her boyfriend who is your neighbour's son. It is your responsibility to inform him so he can also come for testing and if negative be advised on preventive measures such as PrEP	**True**	**False**
You should counsel the mother of Mamello's right to know her status and the benefits of her knowing her status as well as exploring her fears about disclosure	**True**	**False**

3. **Atang is a 13-year-old HIV positive client who has just had full disclosure of his status. He has adjusted well to the disclosure and has accepted his status.**

This is the end of the disclosure process	**True**	**False**

4. **Atang would like to disclose to his 10-year-old cousin who stays in another town.**

You should discuss this with his caregiver	**True**	**False**
It is Atang's right to choose who else knows his status	**True**	**False**
You should encourage him and his caregiver to disclose to people they trust to support him but in the end you need to respect his wishes	**True**	**False**

5. **Rorisang is an 18-year-old adolescent who came with her fiancée to the clinic on advice of their church marriage counsellor for premarital HIV testing. You have just disclosed to her that she is HIV positive. She does not want to disclose to her results to her partner.**

It is not necessary to counsel and guide her as she has already made her decision	**True**	**False**
It is the counsellor's responsibility to support, inform, guide, assist and equip her to prepare for and manage disclosure	**True**	**False**
The counsellor should explore the benefits and potential adverse effects of disclosure to her partner	**True**	**False**
The counsellor should assist her in developing coping mechanisms	**True**	**False**
The counsellor should inform her partner in spite of Rorisang's wishes as they may be sued by the partner.	**True**	**False**

Module 5: Aging with HIV: Transitioning Care from Childhood to Adulthood

Duration: 3 hours

Learning objectives
Review life expectancy of PLHIV and aging with HIV
Understand the context for transitions in care for ALHIV
Explain the differences between child & adult HIV care to reflect on transitional needs of ALHIV
Look at SOPs for transition used in other settings
Identify roles of facility staff in support transition and treatment success over life

Advance preparation

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Review the questions and activities for this module and take note of the expected responses from the participants.

You will need the following materials

- Laptop and projector
- Flipchart
- 2 different coloured markers
- Facility data on test and treat for adolescents – ART initiations/ time to ART initiation
- 2016 National ART guidelines on the use of antiretroviral therapy for HIV prevention and treatment.
- Pre and post-test forms
- Handouts

Content

This module is on transition of adolescents in care as they move from paediatric care to adolescent care as well as adolescent care to adult care. It includes guidance and discussion on transitioning adolescents into relevant adult models of differentiated service delivery.

Key Considerations for the Transition to Adult Care

As HIV-infected adolescents grow into adulthood, it becomes necessary for them to transfer to adult care settings and take responsibility for their own health and disease management. Transition has been defined as the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health-care systems (Shaw, TM & DeLaet, DE. 2010.)

Alternative definition is a multifaceted, active process that attends to the medical, psychosocial, and academic or vocational needs of adolescents as they move from the child- to the adult-focused healthcare system. (HIV clinical resource 2016).

ALHIV may face challenges in their transition to adult care and in learning to independently manage their own care.

These challenges affect both health workers in pediatric and adult clinics as well as adolescents and their caregivers.
The role of the health worker is to provide ALHIV and their caregivers with adequate support and to help ALHIV increase their capacity to manage their own care and to advocate for themselves in the clinical setting.

Some key challenges for ALHIV during the transition process may include:

- Balancing complicated care: Adolescents have to manage multiple medications and appointments and must deal with many different health workers and health services.

- Leaving a familiar care network: Adolescent clients may feel reluctant to leave a familiar care setting, which often means losing contact with support networks and friends there. They may also be fearful and uncertain about how to manage a new clinic setting with new providers.

- Psychosocial and developmental challenges: Adolescents are coping with the typical changes, feelings, and worries of adolescence (which may include relationships, employment, education, etc.) and they may be struggling with disclosing their HIV-status to peers and family. Given the number of life changes happening all at once, adherence to ART and visits to the clinic may become less of a priority. Health workers need to work closely with ALHIV who are about to transition to adult care to ensure that they continue to adhere to their ART regimen and to their care.

- System challenges: Adult clinics typically lack specific, youth-friendly services for adolescents as well as an understanding of and appreciation for adolescents' needs and issues

Transition is applicable to every ALHIV as they mature into adulthood — all adolescents require support both within and outside of the clinic setting to take greater ownership over their health care, behaviour, lives, and adherence to care and treatment.

- The transition to adult care generally occurs in parallel with an adolescent's emotional and physical maturation into adulthood. Effective transition must allow for the fact that adolescents are undergoing changes that impact much more than just their clinical care. Adolescents' psychological maturation may be influenced by how and when they assume responsibility for their own care and vice versa.

• Health workers should help ALHIV set and achieve goals for independence and self-management of care as a way of recognizing their increasing maturation, capacity to make choices, and independence.

• Leading up to the transition, health workers should encourage ALHIV to develop as much independence as possible, both from their families and from health workers. This will help bridge the gap to adult services and help adolescents make informed decisions about their own care.
• Reaching the overall goal of helping adolescents achieve independent management of their own care is a gradual process and should, whenever possible, involve the caregivers and family.

• Some caregivers will need assistance understanding their changing role as the focus of care moves away from always having a caregiver present at appointments, and toward a confidential relationship between the adolescent and the health worker.

Agenda for Module 5

TIME	TOPIC
15 min	Welcome & Opening
10 min	Pre-test
30 min	Introduction to Aging with HIV
30 min	Brainstorming of AYP Life Stages and impact of HIV
5 min	Break
15 min	Facility Analysis – Transition, LTFU and transfers
60 min	Reviewing SOPs for Transitioning ALHIV to adult ART Clinic
15 min	Planning for our Facility's Clients Living with HIV
5 min	Closing & Next Training Topic

Teaching methods
Lecture, group work, discussion

Facilitator instructions

Slide 1-6 Welcome and opening

Use the slide 2 to appreciate those who are sponsoring this training and commitment of participants.

Review and summarize progress with whole training package.

Review the agenda and objectives of the module with the participants.

Re-emphasize the qualifications for certification; that is each trainee will be eligible for certification showing that both knowledge and skills from this work are being used in the facility once he/she has:

- Attended and participated fully in the training modules
- Completed a pre-test with some improved knowledge on the topic
- Site visits and support demonstrate that there is use of information and skills on the job.
- Revisit ground rules.

Slide 7

Handout a pretest for the first module and numbers to be used as ID numbers. Let the group know they will have about 10 minutes to read the test and answer. Each person should be sure to include their ID. The scores will be kept by the facilitator and analyzed as a group (not by individuals).

As this is a pretest, participants may not know all the answers yet. If not sure of the response, they can leave a question blank.

At the end of all seven training modules, we will see if they can answer all the questions.

Collect the pretests.

Slide 8

Begin the discussion by introducing aging with HIV and the inherent need for health systems to accommodate more HIV positive patients that will transition through age appropriate care.

Slide 9

Discuss graph on life expectancy in Lesotho and ask participants to comment. Ask how this might apply to AYLHIV.

Slide 10-11

Slide with an example of an adult infected perinatally who has lived for 26 years. Josephine was infected from MTCT. She is now 26 years old and completing her tertiary studies in Uganda. She uses her story to speak out on behalf of adults around the world. She is 26+ years on ART; and she is not alone.

Ask if the participants have any similar local examples of people who have survived through childhood to adolescence to adulthood with HIV.

Slide 12

Define transition.

Highlight the different levels at which transition can occur:

- Within a facility with defined pediatric, adolescent and adult clinics

- Between facilities with age defined clinics; ex. home to work setting
- Through care process; moving from provider-led to patient-led disease management

Slide 13 - 14

Guide participants to brainstorm on the differences between child-centred and adult-centered care.

Ask one/two of the participants to document on flip chart paper.

On slide 14 highlight any differences the participants may have missed.

Ask where adolescent- centred care fits in.

Slide 15

Bring the discussion to the context of the facility and ask about how transition occurs for clients from the age of 10 to the age of 24 years. Remind participant about the different levels that transition occurs

Slide 16

Ask the questions;

- What team exists in this facility?
- What can be accessed at district level to assist with transitioning clients?
- What are the roles of the team members in preparing and supporting transitions?

Slide 16

Ask about transitioning challenges in the context of the facility and discus possible solutions. Allow the participants to discuss among themselves in groups if time allows.

Review sample SOPs on transition with the participants and discuss which guidance would be relevant to their context.

Slide 19

Discuss next steps for the facility regarding transition.

Ask about patient volume, action points to streamline transition and support required.

Document this on the module report.

Slide 20

Review learning objectives and whether these have been achieved.

Slide 21

Hand out post-test papers and conduct test.
Record attendance and give comments as needed. Applaud good attendance and highlight any gaps.

Key sources

Fick C, Fairlie L, Moultrie H, Woollett N, Pahad S, Thomson K, Pleaner M. *Working with adolescents living with HIV: A handbook for healthcare providers*. Johannesburg: Wits RHI and Southern African HIV Clinicians Society, 2nd edition 2016.

HIV Clinical resource. 2016. *Adolescent HIV care*. From http://www.hivguidelines.org/adolescent-hiv-care/transitioning-to-adult-care/#tab_0

International Centre for AIDS Care and Treatment Programs. 2014. *Adolescent HIV care and treatment - participant manual.* From http://files.icap.columbia.edu/files/uploads/Module_13_-_PM_Adolescent.pdf

Lesotho Ministry of health. 2016. The National HIV Testing Services Guidelines. Maseru Lesotho.

Lesotho Ministry of health. 2016. National Guidelines On the Use of Antiretroviral Therapy for HIV Prevention and Treatment. Maseru Lesotho.

Shaw, TE & DeLaet, DE. 2010. Transition of Adolescents to Young Adulthood for Vulnerable Populations.*Pediatrics in Review* 31 (12) 497-505; DOI: 10.1542/pir.31-12-497

Pre-test

Module 5 Aging with HIV: Transitioning Care from Childhood to Adulthood

15 minutes
Circle the correct answer.

1. Transition

The goal of transition is to ensure the provision of uninterrupted, coordinated, developmentally and age-appropriate, and comprehensive care before, during, and after the transition	**True**	**False**
Transition can be defined as the purposeful, planned movement of adolescents and young adults with chronic medical conditions from child-centred to adult oriented health care systems.	**True**	**False**
Transition needs to be managed to ensure that the medical, psychological and social needs of the young person are addressed	**True**	**False**
Caregivers should not be involved in the process to ensure autonomy and independence of the adolescent	**True**	**False**
Transition may be from • *Paediatric or child-orientated services into adult care* • *Paediatric into dedicated adolescent care* • *Adolescent services into adult care.*	**True**	**False**
There is no need to discuss transition if child-centred, adolescent and adult HIV care is done in the same consulting room by the same health care worker	**True**	**False**
Transition from adolescent care to adult care should be based on age alone	**True**	**False**
Responsibility of the young person as well as developmental readiness are some of the factors that should be considered before transitioning adolescents to adult care.		

2. The process of transition

Transition needs a supportive health system including • *Copies of clients' files/records/test results and medical history,* • *Handover and referral procedures* • *Identifying most at-risk or complex cases where* • *additional care may be required (clinical and/or psychosocial).*	**True**	**False**
Current and future healthcare providers as well as parents and caregivers need to be included in the transition process	**True**	**False**
The involvement of the parent /caregiver varies but the underlying objective of encouraging the young person to take responsibility for their health and management of HIV should be maintained	**True**	**False**

3. *Stable care options for adolescents transitioning into adult care*

Differentiated service delivery is a movement away from a "one-size-fits-all" approach as we push towards 90-90-90	**True**	**False**
Out of facility HIV testing (campaigns) and Integrated out of facility testing (outreach) are examples of differentiated service delivery models for HTS	**True**	**False**
A mature 16 year old is eligible to join a Community ART group	**True**	**False**

Module 6: Teen Pregnancy & MCH for Young Women

Duration: 3 hours

Learning objectives
At the end of this module participants will
Have reviewed MCH services in Lesotho
Discuss the differences between young/1st time mothers and adult mothers
Define early pregnancy
Identify care needs of teen/1st time mothers in MCH
Review facility data to determine local approaches for improving care for teen/1st time mothers

Advance preparation

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Review the questions and activities for this module and take note of the expected responses from the participants.
3. Print copies of handouts, if not done already.
4. Have a blank copy of the reporting form for this module.
5. Collect data on teen pregnancy in the facility for the past quarter/6 months and update Slide 22. Use the ANC register to get these details.

You will need the following materials

- Laptop and projector
- Speakers - optional
- Flipchart
- 2 different coloured markers
- Facility data on viral load testing and suppression rates for adolescents – ART initiations/ time to ART initiation
- 2016 National ART guidelines on the use of antiretroviral therapy for HIV prevention and treatment.
- Pre and post-test forms
- Handouts

Content
This module focuses on maternal and child health services as well as teen pregnancy in the local context. It highlights the special needs of first time mothers and adolescent pregnant women.

Agenda for Module 6

TIME	TOPIC

15 min	Welcome & Opening
10 min	Pre-test
30 min	MCH Review
30 min	Teen Pregnancy
5 min	Break
30 min	Facility Analysis – Teen PMTCT, Teen MCH and Young Moms
45 min	Group Work
15 min	Planning for Services for Pregnant Teens & Young Mothers
5 min	Closing & Next Training Topic

Teaching methods
Lecture, group work, discussions, case study

Facilitator instructions

Slide 1 -7: Welcome and opening:

Introduce Module 6 and appreciate the support for holding this training today.

Remind the group about the certification and then review progress made. Find out how the participants are applying their learning and improving services. If there are delays in changes, find out the reasons and consider postponing more training if necessary.

Attempt to ensure site progress by raising delays with participants, facility heads and district leaderships. However, with serious delays or issues, raise these to EGPAF Maseru leadership supporting the adolescent programming.

Review the objectives and agenda of the module with the participants.

Share the relevant key references.

Discuss learning objectives.

Slide 7

Handout a copy of the pretest for each participant. Each participant should have a number that Vcan assist with tracking their progress. Collect when completed.

Slide 8

Inform participants about key references.

Slide 9-10

Group work on Maternal and child health.
Split into 4 groups – to complete each section on a piece of flipchart.
Display slide 10 which explains what is required in the task.
Then let each group present – this should not be challenging.

Slide 11

Define preconception care
Discuss advantages of of preconception care.
Explain that preconception care aims to;

- Improve their health status of females before they conceive
- Reduce behaviours and individual and environmental factors that contribute to poor maternal and child health outcomes.
- Its ultimate aim is to improve maternal and child health, in both the short and
- long term.

Slide 12

Give further details on benefits of preconception care as indicated on the slide.

Slide 13

Issues to be discussed through preconception care

Nutritional conditions

- Screening for anaemia and diabetes
- Supplementing iron and folic acid
- Information, education and counselling
- Monitoring nutritional status
- Supplementing energy- and nutrient-dense food
- Management of diabetes, including counselling people with diabetes mellitus
- Promoting exercise
- Iodization of salt

Tobacco use

- Screening of women and girls for tobacco use (smoking and smokeless
- tobacco) at all clinical visits using “5 As” (ask, advise, assess, assist, arrange)
- Providing brief tobacco cessation advice, pharmacotherapy (including
- nicotine replacement therapy, if available) and intensive behavioural
- counselling services
- Screening of all non-smokers (men and women) and advising about harm of
- second-hand smoke and harmful effects on pregnant women and unborn
- children

Genetic conditions

- Taking a thorough family history to identify risk factors for genetic conditions
- Family planning
- Genetic counselling
- Carrier screening and testing
- Appropriate treatment of genetic conditions

- Community-wide or national screening among populations at high risk

Environmental health

- Providing guidance and information on environmental hazards and prevention
- Protecting from unnecessary radiation exposure in occupational,
- Environmental and medical settings
- Avoiding unnecessary pesticide use/providing alternatives to pesticides
- Protecting from lead exposure
- Informing women of childbearing age about levels of methyl mercury in fish
- Promoting use of improved stoves and cleaner liquid/gaseous fuels

Infertility/sub-fertility

- Creating awareness and understanding of fertility and infertility and their
- preventable and unpreventable causes
- Defusing stigmatization of infertility and assumption of fate
- Screening and diagnosis of couples following 6–12 months of attempting
- pregnancy, and management of underlying causes of infertility/sub-fertility,
- including past STIs
- Counselling for individuals/couples diagnosed with unpreventable causes of
- infertility/sub-fertility

Psychoactive substance use

- Screening for substance use
- Providing brief interventions and treatment when needed
- Treating substance use disorders, including pharmacological and
- psychological interventions
- Providing family planning assistance for families with substance use
- disorders (including postpartum and between pregnancies)
- Establishing prevention programmes to reduce substance use in adolescents

Vaccine-preventable diseases

- Vaccination against rubella
- Vaccination against tetanus and diphtheria
- Vaccination against Hepatitis B

Too-early, unwanted and rapid successive pregnancies

- Keeping girls in school
- Influencing cultural norms that support early marriage and coerced sex
- Providing age-appropriate comprehensive sexuality education
- Providing contraceptives and building community support for preventing
- early pregnancy and contraceptive provision to adolescents
- Empowering girls to resist coerced sex
- Engaging men and boys to critically assess norms and practices regarding
- gender-based violence and coerced sex
- Educating women and couples about the dangers to the baby and mother of
- short birth intervals

Sexually transmitted infections (STIs)

- Providing age-appropriate comprehensive sexuality education and services
- Promoting safe sex practices through individual, group and community-level
- behavioural interventions
- Promoting condom use for dual protection against STIs and unwanted
- pregnancies
- Ensuring increased access to condoms

- Screening for STIs
- Increasing access to treatment and other relevant health services

HIV

- Family planning
- Promoting safe sex practices and dual method for birth control (with
- condoms) and STI control
- Provider-initiated HIV counselling and testing, including male partner testing
- Providing antiretroviral therapy for prevention and pre-exposure prophylaxis
- Providing male circumcision
- lifelong antiretroviral therapy

Mental health

- Assessing psychosocial problems
- Providing educational and psychosocial counselling before and during pregnancy
- Counselling, treating and managing depression in women planning pregnancy and other women of childbearing age
- Strengthening community networks and promoting women's empowerment
- Improving access to education for women of childbearing age
- Reducing economic insecurity of women of childbearing age

Slide 14

Discuss the standards for ANC in Lesotho

Page 30 HTS guidelines HTS for all ANC women at confirmation of pregnancy
Retest every 3 months

At 36 weeks at delivery if previous test is more than 4 weeks old.
3 monthly post partum

Basic laboratory investigations
• VDRL to screen for syphilis
• Hb to screen for anaemia
• Blood group and Rh factor (if not known)
• Urine tests to detect urinary tract infection and protein
• HIV test if status is not already confirmed (for all pregnant women)
• CD4 cell count for immunologic staging (for all HIV-infected pregnant women)
• ALT and creatinine – for all HIV-infected women at first ANC visit (both for patients initiating ART and for those already on ART)
• HBsAg to screen for Hepatitis B infection
• Hepatitis C serology

Slide 15

Ask about screening in ANC and compare with the standard.

Screening and management of anaemia
• HIV infected pregnant women are at particularly high risk for anaemia – Hb screening should be performed at the first visit (and monthly thereafter)

• Women with severe anaemia (Hb < 8 g/dL) should be started on haematinics immediately, while the cause of anaemia is investigated.
o Those who fail to respond within one month should be referred for further management.
o Severe unexplained anaemia (normocytic, normochromic) is a WHO Clinical Stage 3 condition

• **Nutritional assessment and counselling**
• Assess adequacy of caloric and nutrient intake
• Provide folic acid, multivitamin and other micronutrient supplementation in the first trimester as per national guidelines
• Provide iron starting from the second trimester
• Counsel on proper diet based on available local resources
• Provide nutritional support if indicated

• **STI screening**
• Assess risk for STIs
• Diagnose and treat early according to national guidelines
• Counsel about STIs, their signs and symptoms and how STIs increase the risk of HIV transmission
• Educate about avoiding transmission or re-infection

Tuberculosis
• Screen all women for TB who have had a cough, or any other symptoms suggestive of TB regardless of HIV status (see national TB guidelines for further details)
• Specific TB treatment regimens are recommended for women infected with HIV, pregnant women and women already receiving ART (see National TB guidelines)
• All HIV-infected women, including those who are pregnant, should receive six months of Isoniazid Preventive Therapy (IPT) once active TB disease has been excluded (see National TB guidelines and TB/HIV guidelines for details).

Slide 16

Discuss standard postpartum care as it applies to AYHIV. Refer participants to PMTCT guidelines for standard post partum care.

Slide 17

Refer to participants' presentation on infant care and fill in any gaps. Als refer participants to PMTC guidelines
Appoint mother and baby together

- 7 days
- 6 weeks
- weeks
- 14 weeks
- monthly until 1 year old
- 6 weeks after cessation of BF

- 2-3 monthly after 12 months of age

Do Early infant diagnosis according to the guidelines
Family planning services
Infant feeding advice
Social services
Interventions for the infant
Routine care – immunisation, Vit A, deworming, growth monitoring, screening
CTX if HIV exposed.
NVP if HIV exposed

- History
    - o Was the infant immunized at birth?
    - o Are there danger signs for the new born?
    - o Nevirapine prophylaxis.

- Physical examination
    - o Check respiratory rate, pulse, and temperature
    - o Check the infant's weight
    - o Check the infant's general condition (respiratory effort, alertness, tone, nutrition, hydration, pallor, reactivity, cry)

Counsel on:
- Birth spacing plan and family planning
- Nutrition
- Infant feeding
- Safer sex
- Begin co-trimoxazole prophylaxis for the infant
- Infant follow-up: growth, development, clinical monitoring, immunizations
- Perform early infant diagnosis of HIV using DNA PCR test

<u>Slide 18</u>

Review MCH servives availabe in the facilities and woirk with the team to identify and analyze challenges.

<u>Slide 19</u>

Discussion on maternal and child mortality in Lesotho and how it links to service coverage. Slide highlights Lesotho's successes including;

- Reduction in under 5 mortality from 117 per 1000 live births to 90 deaths per 1000 live births (UNICEF 2015)
- Increase in facility delivery to 78%

Challenges include
- A high maternal mortality 1,024/100,000 live births
- A high neonatal mortality 33/1000 live births
- High HIV prevalence - 25% of the adult population(2014 DHS)

Highlight that these figures highlight a lingering gap in quality of care for implementation and delivery of key life-saving interventions and MNCH services.
Ask participants to say where they feel the challenges are and the possible interventios required.

Slide 20

Discussion on teen pregnancy.
Ask participants about their experiences with this in the facility. Ask about possible contributing factors.

- Lack of knowledge on SRH
- Contraceptive provision and knowledge
- Improper use of contraceptives
- Developmental issues
- Sexual abuse
- Socioeconomic issues
- Early marrriage
- Permissive culture and traditions

Slide 21

Handout WHO contraceptive factsheet.

Ask participants to highlight what strikes them on the fact sheet.

- 0.5 million adolescents – One quarter of the population of Lesotho
- Average age of onset of sexual activity for boys at 15.9 years as compared to 16.4 years for girls with sexual debut below 20 years.
- Average age at first birth for those who become parents before 20 is 17.8 for girls which is younger than the average age for boys which is 18,2 years.

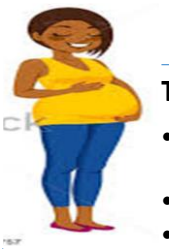
Slide 22

You should have acollected data on teen pregnancy for the past quarter for the facility and updated slide 22 before starting the module. If the facility sees very few patients consider collecting data over 6 months instead.
Review the data with facility staff and ask for comments.

Slide 23

Discuss the differences between adult and teen pregnancy. Request 2 participants to highlight the different characteristics on separate flipcharts.

Potential answers include:



Teen pregnancy

- Inadequate prenatal care - concealed pregnancy, financial support, lack of knowledge, limited decision making
- less likely to attend /access prenatal care
- More likely to delay ANC
- Increased the risk of adverse birth outcomes preterm delivery, low birth weight,
- Increased maternal complications preeclampsia,
- Low socioeconomic status
- Inadequate weight gain during pregnancy
- Limited decision making ability
- More impressionable and may take advice outside of the MCH setting
- Inability to think abstractly and plan ahead,
- adolescent feelings of invulnerability
- Difficulty understanding instructions
- Need more support - psychosocial, financial.

Adult pregnancy

- More financially independent?
- More autonomous
- More likely to be experienced and set in their ways.

Slide 24

How do services differ for teen mothers and adult pregnant women. Ask why and whether more can be done above what is existing currently.
Link this to the challenges of teen mothers.

Slide 25

Group work for teams to design package for teen mothers. Give participants 15 minutes and handout flip chart paper and markers.
Encourage teams to have a holistic approach to this task and to consider the following;

The pregnants teen's life
Physical factors & HIV risk
Emotional factors
The baby's father/partner
The client's family

Slide 26

Reflect on the presentations

Facilitate th ediscussion on key needs oof clients, what is currently available, required resources and expertise.

Slide 27

Identify gaps, next steps to be taken and and assign roles.
Encourage participants to highlight support needed.

Document this part of the training on the module report.

Slide 20

Review learning objectives and whether these have been achieved.

Slide 21

Hand out post-test papers and conduct test.
Record attendance and give comments as needed. Applaud good attendance and highlight any gaps.

Key sources

UNICEF. 2015*. Levels & Trends in Child Mortality Report 2015 Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation United Nations.* New York USA.

WHO. 2013. *Preconception care: Maximizing the gains for maternal and child health.*
Ministry of health. 2013. *National guidelines for the prevention of mother to child transmission of HIV.* Maseru Lesotho.

Xi-Kuan Chen, Shi Wu Wen, Nathalie Fleming, Kitaw Demissie, George G Rhoads, Mark Walker; Teenage pregnancy and adverse birth outcomes: a large population based retrospective cohort study. *Int J Epidemiol* 2007; 36 (2): 368-373. doi: 10.1093/ije/dyl284

Pretest /Post-test - Teen pregnancy and MCH for young women

Trainee ID: _____ Date _____

Tick appropriate test

Pretest		Post test	

1. ***Regarding preconception care***

Preconception care is the provision of biomedical, behavioural and social health interventions to females and couples before conception occurs.	**True**	**False**
Preconception care has no positive impact on maternal and child health outcomes.	True	False
There is no need for preconception care for adolescents	**True**	**False**
Preconception care for adolescents and young people includes addressing issues such as • *HIV* • *Unwanted pregnancies* • *Rapid successive pregnancies* • *Subfertility*	**True**	**False**
Conception should be deferred until the HIV positive partner is virally suppressed in a sero-discordant couple	**True**	**False**

The standard ANC care package in Lesotho includes

At least 4 ANC visits for all pregnant Adolescents and young people	**True**	**False**
Lifelong ART only for pregnant adolescents with stage 3 or 4 disease or CD4 count below 500 cells/ml	True	False
TB screening should be done for HIV positive clients only as they are the ones at risk of contracting TB	**True**	**False**
Pregnant AYLHIV should receive integrated antenatal care services, and may require more than four antenatal visits and services to be offered in adolescent/youth-friendly setting.	**True**	**False**
According to the PMTCT guidelines, basic Laboratory ANC Tests include 1. *VDRL to screen for syphilis* 2. *Hb to screen for anaemia* 3. *Blood group and Rh factor (if not known)* 4. *Urine tests to detect urinary tract infection and protein* 5. *HIV test if status is not already confirmed (for all pregnant women)*	**True**	**False**

6. *CD4 cell count for immunologic staging (for all HIV-infected pregnant women)*
7. *ALT and creatinine – for all HIV-infected women at first ANC visit (both for patients initiating ART and for those already on ART)*
8. *HBsAg to screen for Hepatitis B infection*
9. *Hepatitis C serology*

Regarding teen pregnancy

Among adolescents who become parents before age 20, the average age at first birth is 17.8 years for adolescent girls	**True**	**False**
Every infant born to an HIV infected mother should receive a DNA PCR test to determine their HIV infection status at 6 and 14 weeks of age.	True	False
Adolescents have higher rate of antenatal and obstetric complications than other women of reproductive age	**True**	**False**
Among adolescents who had sex before age 20, the average age at first sex is 16.4 years	**True**	**False**
Adolescents who are newly diagnosed with HIV on postnatal follow-up need to access ART on the same day if they are breastfeeding, as part of PMTCT	**True**	**False**

Module 7: Sexual Reproductive Health & Referrals for Young Clients

Duration: 3 hours

Learning objectives
At the end of this module participants will

Review the sexual & reproductive health (SRH) services available in this facility
Brainstorm on the SRH needs of adolescents and young people
Identify non-health services to support youth development
Clarify integration & the facility-facility referral process
Create a directory for referrals (across facilities and into the community)

Advance preparation

1. Read through the entire module and ensure that you are prepared and comfortable with the content and methodologies.
2. Review the questions and activities for this module and take note of the expected responses from the participants.
3. Print copies of handouts, if not done already.
4. Have a blank copy of the reporting form for this module.

You will need the following materials

- Laptop and projector
- Flipchart
- 2 different coloured markers
- Facility data on referrals and sexual reproductive health services available.
- Handouts –
    - referral forms (not necessarily to give to each participant)
    - referral directory
    - Contraceptive options for adolescents(WHO)
- Pre and post-test forms
- Pre and post-test forms
- Handouts

Content
This module focuses on sexual and reproductive health for adolescents and young people with a focus on services existing in the facility and how these can be improved. The second section deals with both inter and intra-facility transfer and associated documentation. One of the main expected outcomes of this module is that facilities will come up with a facility specific directory of referrals.

Agenda

TIME	TOPIC
15 min	Welcome & Opening
10 min	Pre-test
25 min	SRH Services Available
30 min	Services available to young people & additional needs
5 min	Break
45 min	Developing a referral directory
15 min	Planning to improve SRH services and completed referrals
30 min	Post test
15 min	Official Closing Training Evaluation

Teaching methods
Lecture, group work, discussions, quiz.

Facilitator instructions

Slide 1 -7: Welcome and opening:

Introduce Module 7 and appreciate the support for holding this training today.

Remind the group about the certification and then review progress made. Find out how the participants are applying their learning and improving services. If there are delays in changes, find out the reasons and consider postponing more training if necessary.

Attempt to ensure site progress by raising delays with participants, facility heads and district leadership. However, with serious delays or issues, raise these to EGPAF Maseru leadership supporting the adolescent programming.

Review the objectives and agenda of the module with the participants.

Share the relevant key references.

Discuss learning objective.

Slide 8

Handout a pretest for the first module and numbers to be used as ID numbers. Let the group know they will have about 10 minutes to read the test and answer. Each person should be sure to include their ID. The scores will be kept by the facilitator and analyzed as a group (not by individuals).

As this is a pretest, participants may not know all the answers yet. If not sure of the response, they can leave a question blank.

At the end of all seven training modules, we will see if they can answer all the questions.

Collect the pretests.

Slide 9

Ask participant to recap on relevant standards with the participants. Ask them which sandards they feel are relevant to provision of SRH services to adolescents.

Highlight that the ones on the slide are the most relevant but the other ones do still apply. Below is a list of the standards according to the Lesotho National Health strategy for adolescents and young people.

Standards 1: All young people have access to health services, including those who request abortion, mentally and physically challenged, drug users, gays and lesbians, sex workers and very young adolescents

Standard 2: Young people can access information and services in convenient working hours irrespective of ability to pay

Standard 3: Health services are accepted by young people due to the friendly attitude of health care providers, reasonable waiting time, and because confidentiality and privacy are maintained

Standard 4: Young people get all the relevant services that they need from trained health professionals with knowledge and skills in reproductive health, sexuality and care, treatment of STIs, mental health, domestic and sexual violence

Standard 5: Services provided to adolescents are provided by well trained health workers and there is enough and appropriate medication and equipment at the delivery points

Standard 6: The services provided are supported by parents and other community members, and young people are aware of the services provided outside the facilities

Standard 7: Young people are actively involved in designing, implementation, monitoring and evaluation of the services

Standard 8: Quality assurance mechanisms, HMIS and financial plans support the provision of services to young people.

Slide 10

Share the handout for this module

Ask participants to define SRH as they understand it

Within the framework of the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, RH addresses the reproductive processes, functions and systems at all stages of life. RH implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

According to the WHO working definition
sexual health is "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006).

List the SRH services available at the facility
Examples can include

- Antenatal services
- New-born and maternal services
- HIV/AIDS services
- STI services
- Postpartum/post-abortion services
- Family planning
- Gender based violence services
- Sexual abuse/assault services – PEP etc.
- Psychosocial services related to SRH.
- Voluntary male medical circumcision.

After all the services have been listed indicate which ones are for females and which ones are for males by putting marks as indicated on the slide.

<u>Slide 11</u>
Reflect on the discussion with the team.
Bring up the issue of how age affects SRH service provision.
Analyse SRH services in the facility and bring out the positives as well as potential areas for improvement.
Also discuss how personal values influence professional decisions.

<u>Slide 12</u>

Discuss female reproductive health needs
Ask participants to add any more that they feel are relevant for the Lesotho setting.

<u>Slide 13</u>

Discuss male reproductive health needs
Ask participants to add any more that they feel are relevant for the Lesotho setting.

Slide 14

Discuss roles of different cadres in SRH service provision.
The recommendation is to start early especially when signs of puberty start. Discuss participants' views and whose role they feel it is to discuss SRH with clients.
Also discuss the advantages of using peer educators/leaders/expert clients etc.

Slide 15

Discuss the subject of sex education and ask for participant options.
Highlight that it is especially important to educate adolescents by the time they begin puberty.

Ask participants about their personal values regarding this and how this may impact on them providing sex education to clients. Do they feel it is their responsibility to give sex education to young patients?

Also emphasize the need to normalise the conversation.

Use should be made of resources such as peer educators etc.

Slide 16

Contraceptives for adolescents. Conduct this portion using quiz format if time allows.

Use each point to expand further on contraceptive use for adolescent and give examples.

In general, with the exception of male and female sterilization, all methods that are appropriate for healthy adults are also potentially appropriate for healthy, post-pubertal adolescents.

- **True**

Once puberty has been achieved, methods that are physiologically safe for adults are also physiologically safe for adolescents.

- **True**

No method of contraception should be excluded based on adolescent age alone.

- **True**

The provision of contraception to adolescents should be
holistic
take their sexual and reproductive health needs into account
consider all medically appropriate options

- **True**

Adolescent women only need education on the method of contraception they request

- **False - Adolescent women need accurate information about all contraceptive methods.**
- **Information on efficacy, appropriate use, limitations, risks, side effects, mechanism of action and non-contraceptive benefits of method**

- **Information to pro-actively address common misconceptions, e.g. about the need for a 'pill-break'**
- **Increase awareness about all available alternatives and facilitate informed choice.**

Family planning methods for male adolescents include condoms, vasectomy and withdrawal that males use directly, and the Standard Days Method (SDM) that requires their participation.

- **False – vasectomy which is a permanent method is generally not suitable for adolescents**

Contraceptive choices for adolescents and young people cases. All cases are HIV positive unless indicated otherwise
Ask participants to refer to the relevant handout for guidance.

Ask about

- Holistic care for the clients
- What the key considerations would be for each case
- Allow for discussion and help the participants realise the need to consider each client individually.
- Ask about legal issues that may be related to each case
- Any social issues.
- Personal values and how they may impact decision making.

Slide 19

Ask participants to give their definitions of these before displaying

1. **Integrated services**

"the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."

Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

2. **Referral**

is when a provider (lay or professional) reviews a client's needs, discussed options, and provides advice on a service not available in that space.

the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency or department/facility for services.

3. **Non-health services**

Refers to assistance and **services** provided by persons who are **not** nurses, doctors, or other licensed medical personnel.

Slide 20

Explain that integration of services can be of different forms.

Slide 21

Discuss suitable options for referrals for adolescents and young people and the pros and cons of each method.

Slide 22

Discuss examples of referral forms available or that should be available at the facility. Have these available if possible. If some are not available ask for reasons why not and facilitate the facility receiving copies.

Slide 23

Highlight that we have so far discussed a lot on health-related services for adolescents e.g. SRH, ART but there is also need for referral for non-health services.

Slide 24

Discuss available on-site and offsite non health services at the facility's disposal.
Discuss available facility-community linkages.
Also enquire about and discuss patient awareness of these non-health services.
Possible non-health services can include;

- Youth centres
- Social welfare
- Blue cross – rehabilitation
- Legal services
- Police

Ask participants about ease of access and frequency of use of the available resources.

Slide 25

Work with the facility to start drafting the 2 directories.
Ideally this should be type written. Facilitate the process and assist with printing.
Details may have to be completed after the module is completed.

Slide 26

Review learning objectives and whether these have been achieved.

Slide 27

Hand out post-test papers and conduct test.
Record attendance and give comments as needed.

Inform participants that the training is now complete and review achievements. Review progress together and agree on further supportive supervision and mentoring.

Slide 30

- Training Representative
  - Reflections on the training and participation
- Facilitator
  - Summary of achievements
- Facility head
  - Appreciation
  - Thanks
  - Moving Forward

If progress made is satisfactory, award certificates.

Pretest /Post-test - SRH and referrals for young clients

Trainee ID: _____ Date _____

Tick appropriate test

Pretest		Post test	

2. Regarding SRH and referrals for adolescents and young people

On average, among adolescents who had sex before age 20, adolescent girls first have sexual intercourse at age 16.4 years and adolescent boys at 15.9 years.	**True**	**False**
When it comes to discussing sex with adolescents start early; when signs of puberty start and clients see changes and may have basic questions.	**True**	**False**
A referral is when a provider (lay or professional) reviews a client's needs, discussed options, and provides advice on a service not available in that space.	**True**	**False**
The World Health Organization's (WHO) Medical Eligibility Criteria states that age on its own cannot be a contraindication for any contraceptive method	**True**	**False**

3. Mpho is a 16-year-old adolescent who requests contraceptive advice from you because she has a new boyfriend with whom she plans to be sexually active.

You tell her to abstain from sex as she is still too young and ask her to bring her parents	**True**	**False**
You should refer her to a clinic that offers contraception if they are not available at your facility	**True**	**False**
You should discuss all options for contraception and guide her to select a suitable method	**True**	**False**
You could offer her emergency contraceptive methods if she presents up to 5 days following unprotected sexual intercourse	**True**	**False**
Always recommend condoms to prevent STIs/HIV transmission		
Offer her an HIV test	**True**	**False**

APPENDIX I: FACILITY HEALTH SERVICES PATIENT VOLUME LIST

Health Service	10-14 years	15-19 years	20-24 years
	Male / Female	Male / Female	Male / Female
Out-patient department (OPD) – illness (most common)	/	/	/
	/	/	/
	/	/	/
OPD – injury treatment	/	/	/
Ante-natal care	/	/	/
Post-natal care	/	/	/
Immunizations	/	/	/
Contraceptives/family planning	/	/	/
Injectables (Depo)			
Implants			
Natural family planning methods (2 day)			
HIV testing	/	/	/
HIV treatment	/	/	/
HIV PSS/support groups	/	/	/
STI treatment	/	/	/
Other:	/	/	/
Other:	/	/	/

APPENDIX II: ADOLESCENT & YOUTH-FRIENDLY SERVICES TRAINING ATTENDANCE & MENTORSHIP SCHEDULE

Facility: _____
Contacts:

1. Name _____ Phone _____
2. Name _____ Phone _____

7 Core Modules	1: Adolescent & Youth-friendly Services	2: Test & Treat for Adolescents	3: Adherence Counselling for Adolescents & Young People	4: Disclosure Support for Parents & Young Patients	5: Transitions: Stable & Adult Care Options	6: Teen Pregnancy and MCH for young mothers	7: SRH and referrals
Training Date							
Time							
Location							
Training invitees							
Mentorship site visit							
Date							
Time							
Mentorship site visit							
Date							
Time							

APPENDIX III: AYFHS ATTENDEE TRACKING

Name, title	Phone What's App Email	Date of Attendance at Training Modules			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			
		1	2	3	4
		Pre/Post test score			

APPENDIX IV: AYFHS MODULE TRAINING REPORT

Date of Training: _____
Time of training: From _____ to _____
Facilitator: _____
Number of attendees: _____
Please complete the following and provide a copy to the facility and another copy to EGPAF.

Describe the module # and content completed:
Describe the plans made by the trainees as a result of the training:
List any support that is requested from trainees:
The next training modules is number ___ and planning for Date _____ Time _____
The next site support is planned for Date _____.