



Southern African HIV Clinicians Society

3rd Biennial Conference

13 - 16 April 2016
Sandton Convention Centre
Johannesburg

**Our Issues, Our Drugs,
Our Patients**

www.sahivsoc.org
www.sahivsoc2016.co.za

Working with adolescents living with HIV

Tools for healthcare providers

15th April 2016



2016

Who are these adolescents?

- The World Health Organization (WHO) defines an adolescent as any person between ages 10 and 19
- 1 in 5 people in the world are adolescents:
 - 1.2 billion people are aged 10 to 19
 - 85% of them live in developing countries
- Adolescents make up **30%** of the population in SA
- AIDS is the **#1** killer of adolescents in Africa and **#2** worldwide.

WHO (2009); UNICEF(2011); UNAIDS (2013).



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Adolescent HIV: *at a glance*

- According to data from 2012:
 - 2.1 million adolescents are infected with HIV
 - 82% in sub-Saharan Africa, and 58% were females
 - 64% of the 250,000 new HIV infections among older adolescents were among girls
 - 120,000 adolescents died of AIDS
- Globally, AIDS-related deaths increased by 50% in adolescents compared to the 30% decline in all other age groups from 2005 to 2012.



HIV in adolescence: A growing concern

- HIV-related deaths in adolescents have more than tripled since 2000: in the year 2000 HIV was not even among the top 10 causes of death.
 - *WHO (2012)*
- WHO: Young people need to be better equipped to manage their HIV infection and take ownership of their health care
 - *Dr Elizabeth Mason, Director of WHO Maternal, Newborn, Child and Adolescent Health Department*



Adolescents living with HIV

- An inhomogeneous group, consisting of perinatally infected adolescents as well as non-perinatally infected adolescents.
 - HIV Incidence: high in females aged 15 – 24 years
 - Greater background HIV prevalence in adolescents due to longer survival for children initiated on ART
- Clinical characteristics and needs may be very different
- Implications for prevention of transmission

Agwu & Fairlie (2013); Shisana et al. (2013)



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A complex set of issues in HIV+

Specific issues in adolescence

- Timing of infection – viral dynamics, exposure to ART
- Effects of infection/ART on developing organs
- Developmental stage: autonomy, risk-taking
- Family structure and stability; orphanhood
- Peer pressure

Developmental outcomes are altered

- Behavioural issues
- Mental health problems
- Sexual maturity
- Possible learning difficulties
- Stigma which may be detrimental to identity development

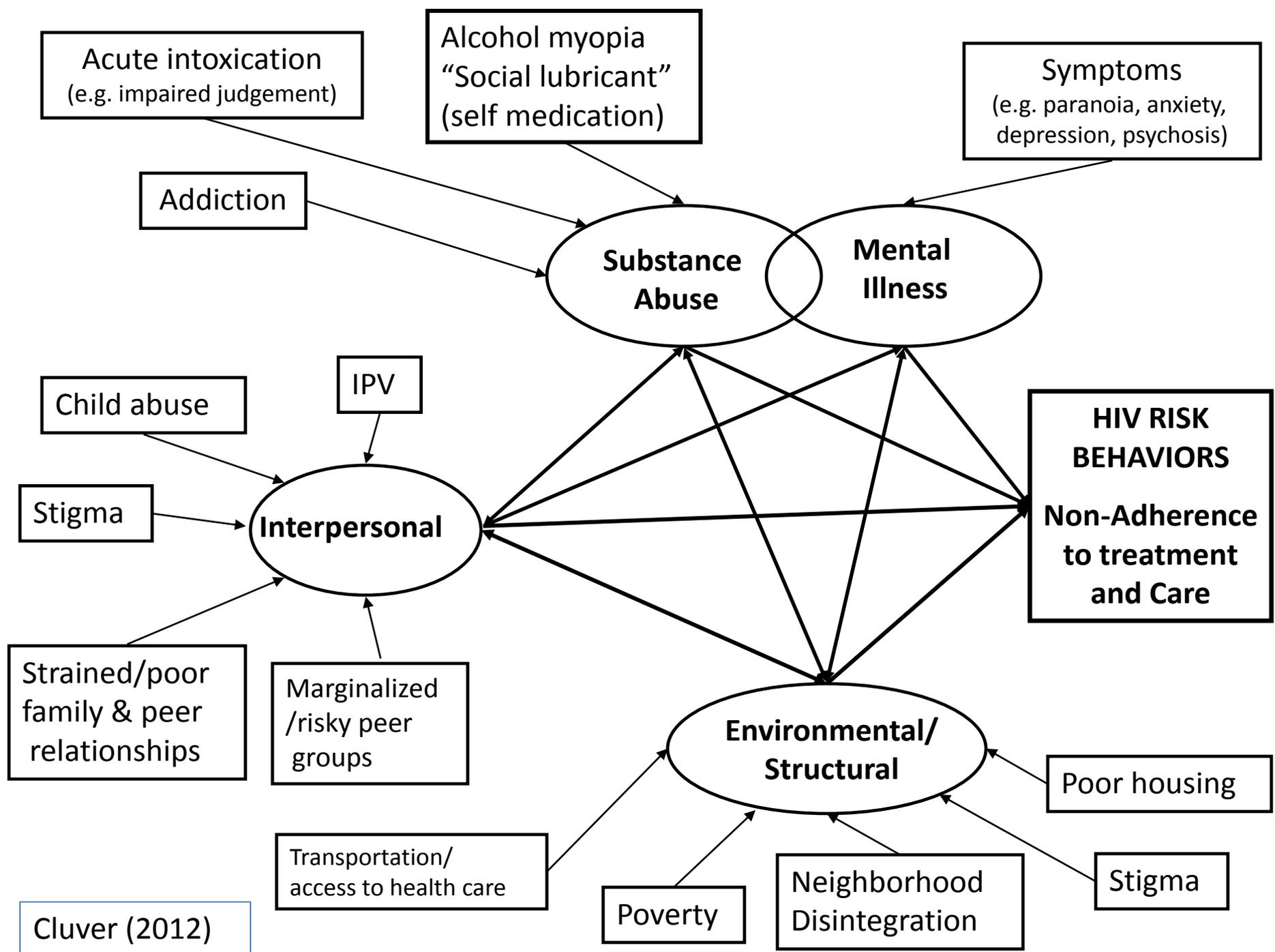
May impact on behaviours in adolescence

- Adherence
- Disclosure
- Substance use, violence
- Sexual behaviour, risk-taking

Secondary transmission



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Results from the National Youth Risk Behaviour Surveys

- At least 18.5% of adolescents attempted suicide
- Sexual risk behaviour:
 - 36.3% had ever had penetrative sex
 - 12.0% first had sex before 14 yrs old
 - Among those who have ever had sex, 58.0% had ≥ 1 sexual partner(s) in the past 3 months
- Condoms were the most frequently reported form of contraception used, at **46.8%**. The second highest response was “no method used” (**17.5%**).
- Prevalence for consistent condom use was **32.9%**



Teen pregnancy

- Nationally, **18.0%** of sexually active learners reported that they had either been pregnant or made someone pregnant
- Nationally, **14.0%** of learners who reported ever having had sex reported having a child/ children
- Of learners who had ever had sex, **8.4%** reported having had an abortion
 - 39.4% took place at a hospital/clinic
 - 27.0% reported using a traditional doctor/healer
 - 11.4% reported ‘another place’ and
 - 8.0% reported that they did not know where the abortion took place.



Substance Abuse

- Drug use in South Africa is twice the world norm.
- United Nations World Drug Report recently named South Africa as one of the drug capitals of the world
 - abuse of alcohol and usage of dagga
- Drug abuse could pose a bigger threat to the country's future than the Aids pandemic.
- Studies show that the average age of drug dependency in South Africa to be 12 years old, and dropping. (CDA – Bayever 2009)
- 1 in 2 schoolchildren admits to having experimented with drugs.
- By the age of 18 more than 60% of teenagers has become drunk. 30% had used school time or work time to drink.

Demands placed upon the healthcare provider treating ALHIV

- Knowledge and understanding of adolescent health, health concerns and development
- Specific knowledge on the management of adolescent health concerns in the context of HIV
- The ability to deal with psychosocial and mental health issues of adolescents
- Communication skills to engage with adolescent clients



Companion resources

Working with adolescents living with HIV

A handbook for healthcare providers



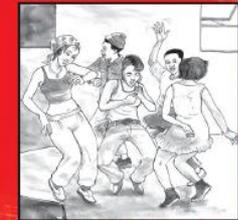
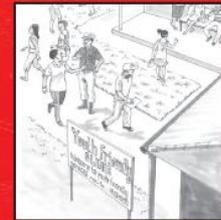
TOOLKIT: Version 7/9/2013

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Working with adolescents living with HIV

A toolkit for healthcare providers



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Working with adolescents living with HIV

**PART A:
Clinical
management
of adolescents
living with HIV**

**PART B:
Management
of the
psychosocial
wellbeing and
mental health**



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**SECTION 1: AN INTRODUCTION TO
WORKING WITH ADOLESCENTS**

**SECTION 2: CONSULTATION, SCREENING
AND HISTORY-TAKING**

**SECTION 3: CONTINUUM OF CARE: HCT
AND ART**

**SECTION 4: MANAGEMENT OF
OPPORTUNISTIC INFECTIONS AND OTHER
HIV-RELATED CONDITIONS**

**SECTION 5: SEXUAL AND REPRODUCTIVE
HEALTH**

PART A: CLINICAL MANAGEMENT OF ADOLESCENTS LIVING WITH HIV

Understanding adolescents

- 4 fundamental developmental tasks of adolescence: “Identity vs Role confusion”
 - Formation of a personal, integrated identity
 - Formation of a school/occupational identity
 - Formation of a sexual identity
 - Pondering the roles they will play in the adult world

Erikson, Erik H. (1968) Identity, Youth and Crisis. New York: Norton.



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Adolescent development

- **Physical:** characterized by dramatic physical changes incl. appearance of secondary sexual characteristics (menarche, night emissions); rapid growth in height; voice changes; sexual relationships and interest.
- **Emotional:** infusion of hormones; erratic moods; impulsivity; feeling 'indestructible' (won't happen to me); peer group central (and highly influential); idealistic thinking; individuating and identity key developmental milestone to achieve.
- **Behavioural:** self-consciousness; sensitivity and concern over one's own body changes (and excruciating comparisons between oneself and one's peers); strong need for peer approval; high risk taking behaviours; role confusion and definition central.
- NOT adults, NOT children – vacillate between both.



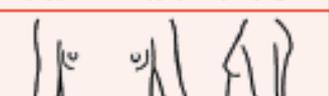
Adolescent health and development

3.3 Tanner scale for male and female development

tanner scale: Male and female pubic hair	
scale 1: none	
scale 2: small amount of long hair at base of male scrotum or female labia majora	
scale 3: moderate amount of curly and coarser hair extending outwards	
scale 4: resembles adult hair but does not extend to inner surface of thigh	
scale 5: adult type and quantity extending to the medial thigh surface	

tanner scale: Male genitalia	
scale 1: testes small in size with childlike penis	
scale 2: testes reddened, thinner and larger (1.5-6.0 cc) with childlike penis	
scale 3: testes larger (6-12 cc), scrotum enlarging, increase in penile length	
scale 4: testes larger (12-20 cc) with greater enlargement and darkening of the scrotum; increase in length and circumference of penis	
scale 5: testes over 20cc with adult scrotum and penis	

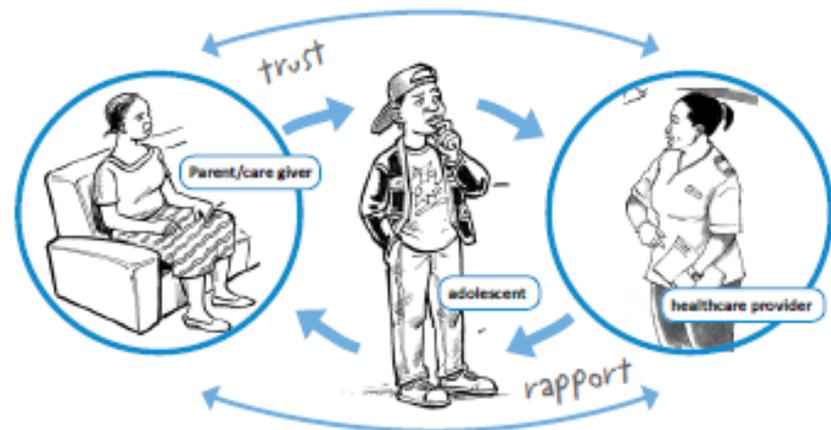


tanner scale: fe male breast			
scale 1: no breast tissue with flat areola		scale 4: larger and even more elevated breast. Areola and nipple projecting from the breast contours	
scale 2: breast budding with widening of the areola		scale 5: Adult size with nipple projecting above areola	
scale 3: larger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

Source: Participants manual: IMAI one-day orientation to adolescents living with HIV (Annex), WHO, Geneva, 2010.

Important skills for adolescent care

- A different approach for the consultation
- Communication skills around sex and sexual reproductive health
- Managing dynamics: caregiver, adolescent, healthcare provider



FOUNDATION OF GOOD COMMUNICATION

Positive encounters are based on the building of trust and rapport.



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Management challenges for ALHIV

- Important challenges for HIV management in adolescents
 - Evolving need for counselling, education and support
 - Challenges with adherence – this potentially leads to virological failure and ART resistance
 - Disclosure – multi-faceted effects on adherence and retention in care
 - Potential for comorbidities and long term side effects of ART (especially if perinatally infected)
 - Management of adolescent health issues in the context of HIV – SRH, mental health, etc.



Adolescent virological failure

Tips to manage adolescents with virological failure

- Other causes of an elevated viral load need to be investigated, and could include:
 - incorrect dosing
 - drug interactions
 - poor absorption
 - drug resistance

- Be aware of potential underlying issues affecting adherence, such as social problems, non-disclosure, pill fatigue, mental health concerns. These need to be addressed

- DOT can be arranged with the client's consent. A caregiver or treatment supporter can fulfil this role, remind them that their job is to remain supportive

- Don't lose your temper, judge or threaten the client. Good communication is necessary to identify barriers to adherence

- Ask if the client is able to tolerate the current drug formulations: adolescents may say they cannot swallow larger tablets. Side effects may also be affecting adherence

- Review the treatment time: Is this still the optimal time for the client? If their treatment time has passed, do they still take treatment?

- Review the use of treatment reminders: pillboxes, alarms and others

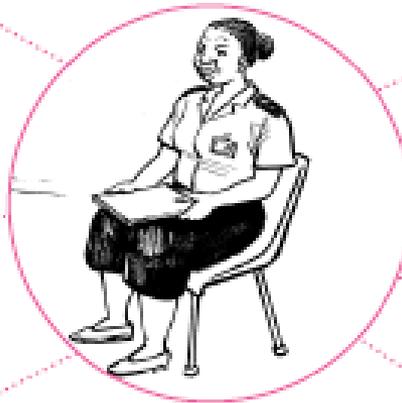


Tips to manage adolescents with virological failure

Adolescents and Sexuality

19.3 Guidelines and tips for consultations

Adolescents need accurate, understandable and age-appropriate information to make informed decisions about sexual and reproductive health.



- Avoid making assumptions about the adolescent's sexual orientation, behaviour and knowledge

- Inform clients of their right to confidentiality, and that information may be shared with other healthcare providers on a need to know basis

- Provide accessible, non-judgemental services to gay, lesbian, bisexual and transgender youth and to ensure that they have access to SRH services

- Provide clear, accurate information in a natural and comfortable manner: this will help the adolescent to feel less embarrassed

- Engage adolescents in conversation about sexuality and sexual health

- Communicate potential positive outcomes of actions and not just the down-side risks

- Routinely ask questions, even of adolescents who report that they are not sexually active, this provides an opportunity to identify and discuss any issues/challenges they may have

Contraception for adolescents

Recommended contraceptive methods for adolescents

- Abstinence (including secondary abstinence)
- Delay sexual debut, *or*
- Barrier method (strong reinforcement of condom use) with:
 - highly effective contraception:
 - combined hormonal contraception
 - progestogen-only injection
 - Cu IUD
 - LNG-IUS
 - progestogen-only implant
- Emergency contraception to be promoted and accessible in the event of unprotected intercourse, method misuse or failure. Emergency contraception includes Cu IUD insertion and emergency contraception pills (within 120 hours after unprotected sex- the sooner, the more effective)



Abstinence as an option

- Abstinence is the only contraceptive method guaranteed to be 100% effective, as well as preventing STIs,

BUT

- Abstinence-only approaches have been shown to be ineffective
- “Abstinence-plus” methods of sexual health education have been found to delay sexual debut and increase condom use amongst youth

Oringanje C et al (2009), NDOH (2013).



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Contraceptive options in young HIV + women

- WHO:

MEC categories for contraceptive eligibility	
1	A condition for which there is no restriction for the use of the contraceptive method
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition which represents an unacceptable health risk if the contraceptive method is used.

MEC= Medical Eligibility Criteria for Contraception



Summary of options for contraception for adolescents living with HIV

	Method	Common side effects	Common contraindications (not all-inclusive)	Drug interactions: TB Rx	Drug interactions: ART	Prevention		Comment/recommendation
						STI	HIV	
	Male condom	None	None	None	None	-	-	Promote condom use for all adolescents. Consistency, correct use and with confidence
	Female Condom	None	None	None	None	-	-	Promote condom use for all adolescents. Consistency, correct use and with confidence
	OCs	Nausea, inter-menstrual bleeding, mild headaches, breast tenderness	History of thrombosis, hypertension	Rifampicin - do not use together (WHO MEC 3)	RTV-coated PIs – do not use together (WHO MEC 3) NNRTIs – generally can use, add condom (WHO MEC 2)	x	x	Client-dependent contraception; adherence essential. Can be used where adherence ensured. Combine with condom use
	Injectable (DMPA/ NET-EN)	Changes in menstruation (irregular, prolonged, heavy, amenorrhoea) and weight gain	Undiagnosed vaginal bleeding	DMPA: none. (WHO MEC 1) NET-EN: mild interaction with rifampicin. To add condom (WHO MEC 2)	DMPA: none. WHO MEC 1) NET-EN: mild interaction with PIs and NNRTIs. To add condom (WHO MEC 2)	x	x	Recent studies have shown that DMPA may increase HIV transmission risk (until further research has been conducted, WHO stance: condom use is strongly recommended (WHO MEC 1). Client-independent contraception
	Cu IUD	Menstrual changes (bleeding may be heavier, longer and more crampy)	Current AIG and unwell, current cervicitis/PID	None	None	x	x	Reliable, long acting reversible contraceptive method. Client-independent method. May be used as emergency contraception. Combine with condom use. Can be inserted if client is well (WHO MEC 2). Note: Unwell HIV positive – WHO MEC 3.
	LNG IUD	Irregular and infrequent bleeding initially with development of amenorrhoea later	Current AIG and unwell, current cervicitis/PID	None	None	x	x	Not currently available in the FHC setting. Reliable, long acting reversible contraceptive method. Client-independent method. Cannot be used for emergency contraception. Combine with condom use. Can be inserted if well (WHO MEC 2). Note: Unwell HIV positive - WHO MEC 3
	Progestogen-only implants	Irregular bleeding and amenorrhoea, but less pronounced than with injectables	Undiagnosed vaginal bleeding	Mild interaction with rifampicin. Avoid concurrent use. (See comment)	Mild interaction with PIs and NNRTIs. Avoid concurrent use. (See comment)	x	x	Note: recent evidence has shown that EFV, rifampicin and certain anticonvulsants should not be used with the implants due to reduced contraceptive efficacy. If already inserted, it may be removed and an alternative method used, or an additional non-hormonal method should be added (such as IUD or condom use).
	Emergency contraceptive pills	Nausea, vomiting, headaches, fatigue, cycle irregularities	Incident occurred more than 120hrs ago	With Rifampicin. No dose adjustment recommended	With PIs. No dose adjustment recommended	x	x	All clients should be aware of the availability of this method. Consider emergency IUCD use where pill use is inappropriate

Gender-based violence, sexual assault and sexual abuse

Box 24: Interventions to manage sexual assault

Any episode of sexual assault should be followed up by the following interventions:⁴⁵

- ✓ HIV testing and post-exposure prophylaxis (PEP), following national guidelines (note that if the adolescent is already known to be HIV-positive and on ART, this is not necessary).
- ✓ Medical examination that includes the collection of forensic evidence.
- ✓ Prophylaxis for STIs including HIV if the adolescent is HIV-negative.
- ✓ Pregnancy testing and the provision of emergency contraception (for females).
- ✓ Provision of other medical treatment as necessary.
- ✓ Counselling and support.
- ✓ Temporary place to stay, if needed for safety.
- ✓ Link to the police for an investigation of the assault.

SECTION 6: PSYCHOSOCIAL WELLBEING

- Psychosocial support and communication
- Adherence
- Disclosure
- Transition
- Support groups for adolescents

SECTION 7: MENTAL HEALTH

- Management of common mental health conditions in adolescents living with HIV

PART B: MANAGEMENT OF THE PSYCHOSOCIAL WELLBEING AND MENTAL HEALTH



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Effective support: communication and the relationship

- See the adolescent as a an individual
- Respecting confidentiality
- Respecting privacy
- Involve the client in the care process
- Show respect
- Be encouraging and patience
- Displaying patience and encouraging clients to speak for themselves
- Involve parents/caregivers when appropriate

Adherence

- Adolescence is increased risk period for poor adherence - poor adherence in adolescents *not restricted to HIV*
- Adherence is the single most challenging aspect of successful HIV care
- Non-adherence may be caused by any combination of structural, patient-related, provider-related, medication-related, disease related and psychologically-related factors
- Adherence is not stagnant and requires continuous reassessment



Predictors of poor adherence

- Poor clinician/patient relationship
- Lack of understanding
- Low literacy – creative counselling needed
- Medication side effects
- Lack of reliable access to primary healthcare
- Domestic violence
- Religious and traditional beliefs
- Stock outs
- Discrimination
- Mental Illness and common mental health difficulties
- Supporting other sick family members
- Active drug and alcohol use
- Mobile lifestyle
- Travel away for holidays
- Inadequate water
- Knowledge of HIV
- Housing
- Undiagnosed OI



20. Adherence

Tips for improving adherence

- 😊 Build on strengths and praise good adherence
- 😊 Always explore the underlying reasons for poor adherence. Encourage the young client to weigh up the pros and cons, benefits and possible consequences of good and poor adherence
 - 👉 *Remember that this needs to be revisited as they grow older*
- 😊 Discuss treatment and logistics of getting to the clinic – with client, and parent/caregiver where appropriate
- 😊 Provide adolescent-friendly services, including accessible, acceptable and appropriate services, so that young clients feel welcome at the clinic
- 😊 Create an environment for both parents/caregivers and adolescents to be honest about adherence, by being non-judgemental and building a relationship based on trust, respect and openness
- 😊 Check in with clients frequently after they start or change medicines – if not during clinic visits, by phone or outreach workers going to their homes
- 😊 Ensure systems are in place (with consent granted) to contact adolescent clients (SMS, phone call, outreach) who miss clinic appointments or prescription refills
- 😊 Where possible simplify treatment and dosing



Disclosure

- Strong link between Adherence and Disclosure
 - Disclosure of the HIV diagnosis is necessary as children age
 - Establish whether the adolescent has been disclosed to?
- Disclosure may:
 - Improve adherence to treatment
 - Improve clinical outcomes
 - Encourage adolescents to take more responsibility and participate in their healthcare
 - Improve access to support
 - Improve retention in care

WHO (2011), Arrivé et al. (2012), Vreeman et al (2013).



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21. Disclosure

Preparing for disclosure in partnership with parents/caregivers

The role of parents/caregivers

It is recommended that the *parent/caregiver is encouraged to assume responsibility for ensuring that disclosure takes place.* Therefore, to ensure successful outcomes it is important to ensure that they are ready for the process of disclosure.



Checklist for parent/caregiver readiness for disclosure

The parent/caregiver:

- ✓ Is in reasonably good health, and the adolescent has family or other sources of support following disclosure
- ✓ Has a relatively good relationship with the adolescent
- ✓ Has accepted and disclosed their own HIV positive status, if HIV-positive
- ✓ Has accepted the adolescent's HIV positive status
- ✓ Has good knowledge and information about HIV as well as treatment and support
- ✓ Is able to talk about HIV and related matters
- ✓ Has a support system
- ✓ Wants to protect the adolescents and/or family from stigma, discrimination and rejection



Note:

If the parent/caregiver is not ready to disclose, the process cannot be forced but follow-up with counselling and discuss their fears and anxieties around disclosure.

The role of healthcare care providers

HIV-positive adolescents, as well as caregivers, need the support of the healthcare team and other support from schools and religious institutions (or any relevant social structure), to initiate and sustain the process of disclosure. The healthcare provider and those who work with the child/adolescent should play a supportive role in facilitating the process.



- ✓ Tailor the disclosure process to meet the developmental needs and understanding of each adolescent, as well as their parent/caregiver
- ✓ Manage the barriers to disclosure with the support of institutions that form the immediate social environment of the adolescent as well as the caregiver
- ✓ Be accessible and open to answer queries that may arise from the adolescent or caregiver pre-disclosure, during the disclosure process and post-disclosure

At every visit, check if the child or adolescent has been disclosed to?

Ask:

1. Do you know why you come to this clinic?
OR Do you know why you take these tablets?
2. Ask what is HIV?

Use this is an opportunity for you to provide HIV education



Adolescents living with HIV are more likely to develop mental health problems

Adolescents with mental health problems are more likely to acquire HIV

Possible causes:

- Social stressors such as stigma, financial difficulties and relationship difficulties.
- Lack of adequate support structures.
- May also be associated with certain medications or with the direct effect of the virus on the brain.



Possible causes:

- Vulnerable and are more likely to engage in risky behaviours such as unprotected sex and substance abuse.
- Also at risk of being sexually abused.

25. Management of common mental health conditions in adolescents living with HIV

25.2 Grief, bereavement and depression

- Many adolescents living with HIV have lost significant loved ones.
- Some adolescents have endured multiple losses over time. These losses could have led to significant grief that has not been addressed. Grief is not a mental disorder as it is an expectable and culturally accepted response to the event of loss or death of a loved one. However, the manner in which some individuals react to grief may present with symptoms characteristic of depression.

Differences between grief/bereavement and depression	
Grief/bereavement	Depression
Guilt is focused on aspect of loss.	Guilt is preoccupied with a negative self-image.
Have moments of pleasure or happiness.	Feelings of emptiness and despair are constant.
Preoccupation with deceased.	Preoccupation with self.
Not demoralising or humiliating.	Demoralising and humiliating.
Overt expression of anger.	Anger not as pronounced.
Diminishes in intensity over time.	Consistent sense of depletion.
Suicidal gestures are rare.	Suicidal gestures are not unusual.
Responsive to support.	Unresponsive to support.
Elicits sympathy, concern and desire to embrace.	Elicits irritation, frustration and a desire to avoid.
Usually functions at work, home and/or school.	Inability to function at work, home, and/or school.

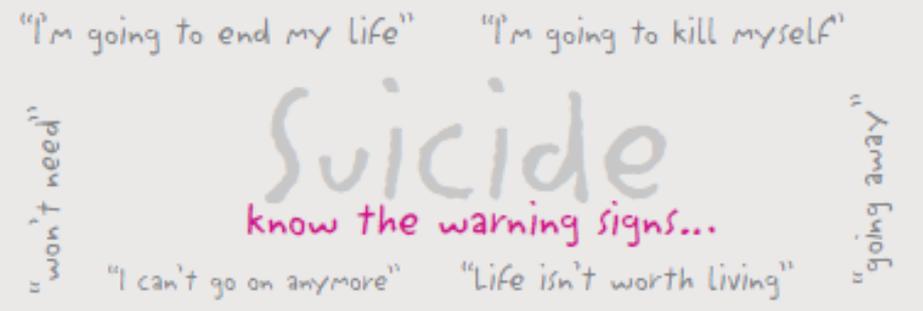


Identifying adolescents at risk of suicide

- Important screening questions to ask:
 - Do you ever have thoughts of hurting or killing yourself?
 - Are you currently thinking of killing yourself?
 - Have you ever tried to kill yourself?

Know the warning signs...

- ✓ Talking about suicide or death in general. "I'm going to end my life" or "I'm going to kill myself"
- ✓ Talking about "going away"
- ✓ Referring to things they "won't need," and giving away possessions
- ✓ Talking about feeling hopeless or feeling guilty. "Life isn't worth living" or "I can't go on anymore"
- ✓ Pulling away from friends or family and losing the desire to go out
- ✓ Having no desire to take part in favorite things or activities
- ✓ Having trouble concentrating or thinking clearly
- ✓ Experiencing changes in eating or sleeping habits
- ✓ Engaging in self-destructive behavior (drinking alcohol, taking drugs, or cutting, for example)
- ✓ Having attempted suicide in the past



Management of an adolescent suicide

- Explore the suicidal statements further as well as their reasons for wanting to die
 - Review the risk: is this person low, medium or high risk?
- Be kind, empathetic and non-judgemental when assessing the risk for suicide but also objective.
 - If the patient suffers from mental illness or is currently engaging in substance abuse, this automatically increases their risk!
 - If you have access to a psychologist or mental health professional, please refer the patient for further screening and intervention
- Contract a safety plan
 - Which could include drawing up a suicide contract with the suicidal adolescent
 - Discuss your legal requirement as a healthcare provider to break confidentiality to parents or other support services
- Make a relevant referral
 - Psychologist or other mental health professional
 - NGO or CBO
 - Hospitalisation if the patient is high risk



25. Management of common mental health conditions in adolescents living with HIV

25.7 Psychotropic drugs and HIV *continued*

Antipsychotics:

These drugs are for the management of psychosis or psychotic features.

Preferred	To be avoided
<ul style="list-style-type: none">• Low dose atypical antipsychotics such as risperidone are preferred. These may not be available at all levels of care• Depot (injectable) antipsychotics may be used where clients have no other contraindications and are agreeable with this	<ul style="list-style-type: none">• Clozapine should be avoided, unless in consultation with a specialist. With use of PIs, could precipitate seizures and other adverse effects. Neutropenia may also occur as a side effect
Use with caution <ul style="list-style-type: none">• Older “typical” antipsychotics, such as haloperidol, have a higher risk of neurological side effects in HIV-positive clients. These drugs may be used but the healthcare provider should remain alert for possible side effects, and low doses should be initiated and increased slowly	

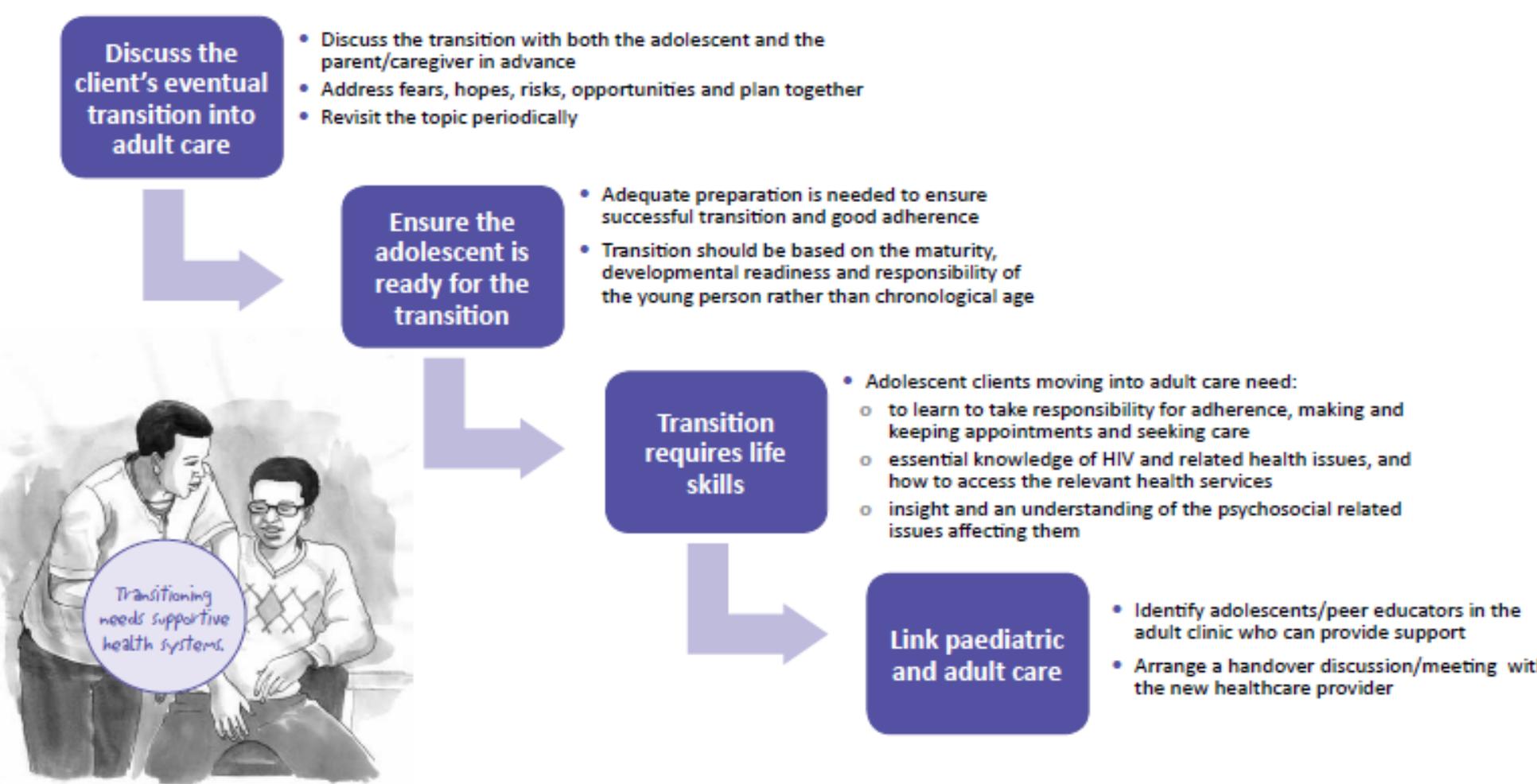
Antidepressants:

These include the SSRIs (usually used for depression and anxiety-related disorders) and the tricyclic antidepressants (TCAs) (usually used to manage neuropathic pain or refractory depression).

Preferred	To be avoided
<ul style="list-style-type: none">• Citalopram or sertraline should be used with preference (these are psychiatrist initiated). Citalopram is preferred as an initial agent in clients on second line ART.<ul style="list-style-type: none">◦ <i>These drugs may not be available at all levels of care. Referral may be required</i>	<ul style="list-style-type: none">• St John’s Wort (<i>Hypericum perforatum</i>) – a herbal, OTC preparation with antidepressant properties – should not be used with ART
Use with caution <ul style="list-style-type: none">• <i>Fluoxetine and paroxetine (both SSRIs) should be used with caution in conjunction with ART – both may interact with PIs and NNRTIs and there is a risk of severe adverse reactions</i>• Fluoxetine can be started at low doses if the client is on first-line ART only. If a dose increase is required this should be done slowly• <i>Amitryptalline</i> is the most frequently used TCA. For clients with HIV, it is usually used in low doses to manage neuropathic pain but it may be used to treat depression. Side effect monitoring is essential	

22. Transition in care

Transition refers to the process through which adolescents living with HIV move from one level of care to another – generally from paediatric services into adult services. Transition in care is accompanied by a range of possibilities and challenges. *Transitioning needs supportive health systems.*



Appendices

OVERVIEW		
APPENDIX 1:	(a) Tanner staging	215
	(b) Growth charts	217
APPENDIX 2:	Five "As" for consultations with adolescents	221
APPENDIX 3:	ARV drug dosing chart for children and adolescents	222
APPENDIX 4:	Managing acute adverse ARV reactions and grading toxicity	224
APPENDIX 5:	TB regimens with dosages for uncomplicated and complicated TB	229
APPENDIX 6:	TB prevention	230
APPENDIX 7:	Distress protocol for managing adolescent rape victims	233
APPENDIX 8:	Medical and legal protocol for adolescent rape victims	236
APPENDIX 9:	Psychosocial assessment tool	237
APPENDIX 10:	Tips for health workers on identifying possible mental illness	241
APPENDIX 11:	Distress protocol and screening tools for managing suicide ideation in adolescents	242
APPENDIX 12:	Distress protocol and screening tools for managing substance and alcohol abuse in adolescents	245

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THANK YOU



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