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
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).
**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.

Idele at al (2014); UNAIDS, (2013); WHO (2013)
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)
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
HIV RISK BEHAVIORS

Non-Adherence to treatment and Care

Symptoms (e.g. paranoia, anxiety, depression, psychosis)

Mental Illness

Substance Abuse

Addiction

Alcohol myopia “Social lubricant” (self medication)

Acute intoxication (e.g. impaired judgement)

Environmental/Structural

Poor housing

Stigma

Transportation/access to health care

Poverty

Neighborhood Disintegration

Mental Illness

Symptoms (e.g. paranoia, anxiety, depression, psychosis)

Substance Abuse

Addiction

Alcohol myopia “Social lubricant” (self medication)

Acute intoxication (e.g. impaired judgement)

Environmental/Structural

Poor housing

Stigma

Transportation/access to health care

Poverty

Neighborhood Disintegration

Stigma

Marginalized/risky peer groups

Strained/poor family & peer relationships

Child abuse

IPV

Interpersonal

Cluver (2012)
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%

YRBS (2011); Shilubane et al. (2013).
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.

SA YRBS 2011
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. (The Lancet medical journal, 2009)
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

Working with adolescents living with HIV
A toolkit for healthcare providers
PART A: Clinical management of adolescents living with HIV

PART B: Management of the psychosocial wellbeing and mental health

Working with adolescents living with HIV
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

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

<table>
<thead>
<tr>
<th>Scale 1: None</th>
<th>Scale 2: Small amount of long hair at base of male scrotum or female labia majora</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 3: Moderate amount of curly and coarser hair extending outwards</td>
<td>Scale 4: Resembles adult hair but does not extend to inner surface of thigh</td>
</tr>
<tr>
<td>Scale 5: Adult type and quantity extending to the medial thigh surface</td>
<td></td>
</tr>
</tbody>
</table>

#### Tanner scale: Male genitals

<table>
<thead>
<tr>
<th>Scale 1: Testes small in size with childlike penis</th>
<th>Scale 2: Testes reddened, thinner and larger (1.5–6.0 cc) with childlike penis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 3: Testes larger (8–12 cc), scrotum enlarging, increase in penis length</td>
<td>Scale 4: Testes larger (12–20 cc) with greater enlargement and darkening of the scrotum; increase in length and circumference of penis</td>
</tr>
<tr>
<td>Scale 5: Testes over 20 cc with adult scrotum and penis</td>
<td></td>
</tr>
</tbody>
</table>

#### Tanner scale: Female breast

<table>
<thead>
<tr>
<th>Scale 1: No breast tissue with flat areola</th>
<th>Scale 2: Breast budding with widening of the areola</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale 3: Larger and more elevated breast extending beyond</td>
<td>Scale 4: Larger and even more elevated breast, Areola and nipple projecting from the breast contours</td>
</tr>
<tr>
<td>Scale 5: Adult size with nipple projecting above areola</td>
<td></td>
</tr>
</tbody>
</table>

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*Source: Participants' manual: IMAI one-day orientation to adolescents living with HIV (Annes), WHO, Geneva, 2000.*
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
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
- Don’t lose your temper, judge or threaten the client. Good communication is necessary to identify barriers to adherence.
- 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.
- 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.
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
- Provide accessible, non-judgemental services to gay, lesbian, bisexual and transgender youth and to ensure that they have access to SRH services
- Engage adolescents in conversation about sexuality and sexual health
- Communicate potential positive outcomes of actions and not just the down-side risks
- Inform clients of their right to confidentiality, and that information may be shared with other healthcare providers on a need to know basis
- Provide clear, accurate information in a natural and comfortable manner: this will help the adolescent to feel less embarrassed
- 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

Working with adolescents living with HIV: A toolkit for healthcare providers
## 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)

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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

Contraceptive options in young HIV + women

- WHO:

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

MEC = Medical Eligibility Criteria for Contraception

WHO (2014)
### Summary of options for contraception for adolescents living with HIV

<table>
<thead>
<tr>
<th>Method</th>
<th>Common side effects</th>
<th>Common contraindications (not all-inclusive)</th>
<th>Drug interactions: TB Rx</th>
<th>Drug interactions: ART</th>
<th>Prevention</th>
<th>Comment/recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Condom</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>STI: -</td>
<td>Promote condom use for all adolescents. Consistency, correct use and with confidence</td>
</tr>
<tr>
<td>Female Condom</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>HIV: -</td>
<td>Promote condom use for all adolescents. Consistency, correct use and with confidence</td>
</tr>
<tr>
<td>COC</td>
<td>Nausea, intermenstrual bleeding, mild headaches, breast</td>
<td>History of thrombosis, hypertension</td>
<td>Rifampicin – do not use</td>
<td>RTV-boosted PIs – do not</td>
<td>STI: -</td>
<td>Client-dependent contraception: adherence essential. Can be used where adherence</td>
</tr>
<tr>
<td></td>
<td>tenderness</td>
<td></td>
<td>together (WHO MEC 3)</td>
<td>together (WHO MEC 3)</td>
<td>HIV: -</td>
<td>is ensured. Combine with condom use</td>
</tr>
<tr>
<td>Injectable (DMPA/NET-EN)</td>
<td>Changes in menstruation (irregular, prolonged, heavy,</td>
<td>Undiagnosed vaginal bleeding</td>
<td>DMCPA: none,</td>
<td>DMCPA: none,</td>
<td>STI: -</td>
<td>Recent studies have shown that DMPA may increase HIV transmission risk (until further</td>
</tr>
<tr>
<td></td>
<td>amenorrhea) and weight gain</td>
<td></td>
<td>(WHO MEC 3) NET-EN mild interaction with rifampicin.</td>
<td>(WHO MEC 3) NET-EN mild interaction with PIs and NNRTIs. To add condom (WHO MEC 2)</td>
<td>HIV: -</td>
<td>research has been conducted, WHO stands: condom use is strongly recommended (WHO MEC 2). Client-independent contraception</td>
</tr>
<tr>
<td>Cu IUD</td>
<td>Menstrual changes (bleeding may be heavier, longer and</td>
<td>Current AIDS and unwell, current cervicitis/</td>
<td>None</td>
<td>None</td>
<td>STI: -</td>
<td>Reliable, long acting reversible contraceptive method. Client-independent method. May</td>
</tr>
<tr>
<td></td>
<td>more cramps)</td>
<td>PFD</td>
<td></td>
<td></td>
<td>HIV: -</td>
<td>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 2.</td>
</tr>
<tr>
<td>LNG IUD</td>
<td>Irregular and infrequent bleeding initially with</td>
<td>Current AIDS and unwell, current cervicitis/PFD</td>
<td>None</td>
<td>None</td>
<td>STI: -</td>
<td>Not currently available in the PHC setting. Reliable, long acting reversible</td>
</tr>
<tr>
<td></td>
<td>development of amenorrhea later</td>
<td></td>
<td></td>
<td></td>
<td>HIV: -</td>
<td>contraceptive 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 2.</td>
</tr>
<tr>
<td>Progestogen-only</td>
<td>Irregular bleeding and amenorrhea, but less pronounced</td>
<td>Undiagnosed vaginal bleeding</td>
<td>Mild interaction with rifampicin. Avoid concurrent use. (See comment)</td>
<td>Mild interaction with PIs and NNRTIs. Avoid concurrent use.</td>
<td>STI: -</td>
<td>Note: recent evidence has shown that EFV, rifampicin and certain antiretroviral</td>
</tr>
<tr>
<td>Implants</td>
<td>with injectables</td>
<td></td>
<td></td>
<td></td>
<td>HIV: -</td>
<td>medications should not be used with the implants due to reduced contraceptive efficacy. If</td>
</tr>
<tr>
<td>Emergency contraceptive</td>
<td>Nausea, vomiting, headaches, fatigue, cycle</td>
<td>Incident occurred more than 120hrs ago</td>
<td>With Rifampicin. No dose adjustment recommended</td>
<td>With PIs. No-dose adjustment recommended</td>
<td>STI: -</td>
<td>already inserted, it may be removed and an alternative method used, or an additional</td>
</tr>
<tr>
<td>pills</td>
<td>irregularities</td>
<td></td>
<td></td>
<td></td>
<td>HIV: -</td>
<td>non-hormonal method should be added (such as IUD or condom use).</td>
</tr>
</tbody>
</table>

**Working with adolescents living with HIV: A toolkit for healthcare providers**
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.
PART B: MANAGEMENT OF THE PSYCHOSOCIAL WELLBEING AND MENTAL HEALTH

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
Effective support: communication and the relationship

- See the adolescent as 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

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

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 providers 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

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.

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.

Working with adolescents living with HIV: A toolkit for healthcare providers
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.

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

- questioning faith and the meaning of life
- lack of energy
- withdrawal
- disbelief
- lack of concentration
- confusion
- shock
- feeling worthless
- anxiety about death
- anger
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.

<table>
<thead>
<tr>
<th>Preferred</th>
<th>To be avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low dose atypical antipsychotics such as risperidone are preferred. These may not be available at all levels of care.</td>
<td>• 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</td>
</tr>
<tr>
<td>• Depot (injectable) antipsychotics may be used where clients have no other contraindications and are agreeable with this</td>
<td></td>
</tr>
</tbody>
</table>

Use with caution
• 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).

<table>
<thead>
<tr>
<th>Preferred</th>
<th>To be avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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.</td>
<td>• St John’s Wort (Hypericum perforatum) – a herbal, OTC preparation with antidepressant properties – should not be used with ART</td>
</tr>
<tr>
<td>• These drugs may not be available at all levels of care. Referral may be required</td>
<td></td>
</tr>
</tbody>
</table>

Use with caution
• *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*
• 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
• *Amitryptiline* 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
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.

Discuss the client’s eventual transition into adult care
- Discuss the transition with both the adolescent and the parent/caregiver in advance
- Address fears, hopes, risks, opportunities and plan together
- Revisit the topic periodically

Ensure the adolescent is ready for the transition
- Adequate preparation is needed to ensure successful transition and good adherence
- Transition should be based on the maturity, developmental readiness and responsibility of the young person rather than chronological age

Transition requires life skills
- Adolescent clients moving into adult care need:
  - to learn to take responsibility for adherence, making and keeping appointments and seeking care
  - essential knowledge of HIV and related health issues, and how to access the relevant health services
  - insight and an understanding of the psychosocial related issues affecting them

Link paediatric and adult care
- Identify adolescents/peer educators in the adult clinic who can provide support
- Arrange a handover discussion/meeting with the new healthcare provider

Working with adolescents living with HIV: A toolkit for healthcare providers
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THANK YOU