HIV Nursing matters

A Magazine of the Southern African HIV Clinicians Society

The psychosocial challenges of HIV positive youth- the silent epidemic

The Sexual and Reproductive Health Needs of Adolescents Living with HIV

Voluntary Medical Male Circumcision and Adolescents

March 2013 Volume 4 No.1

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

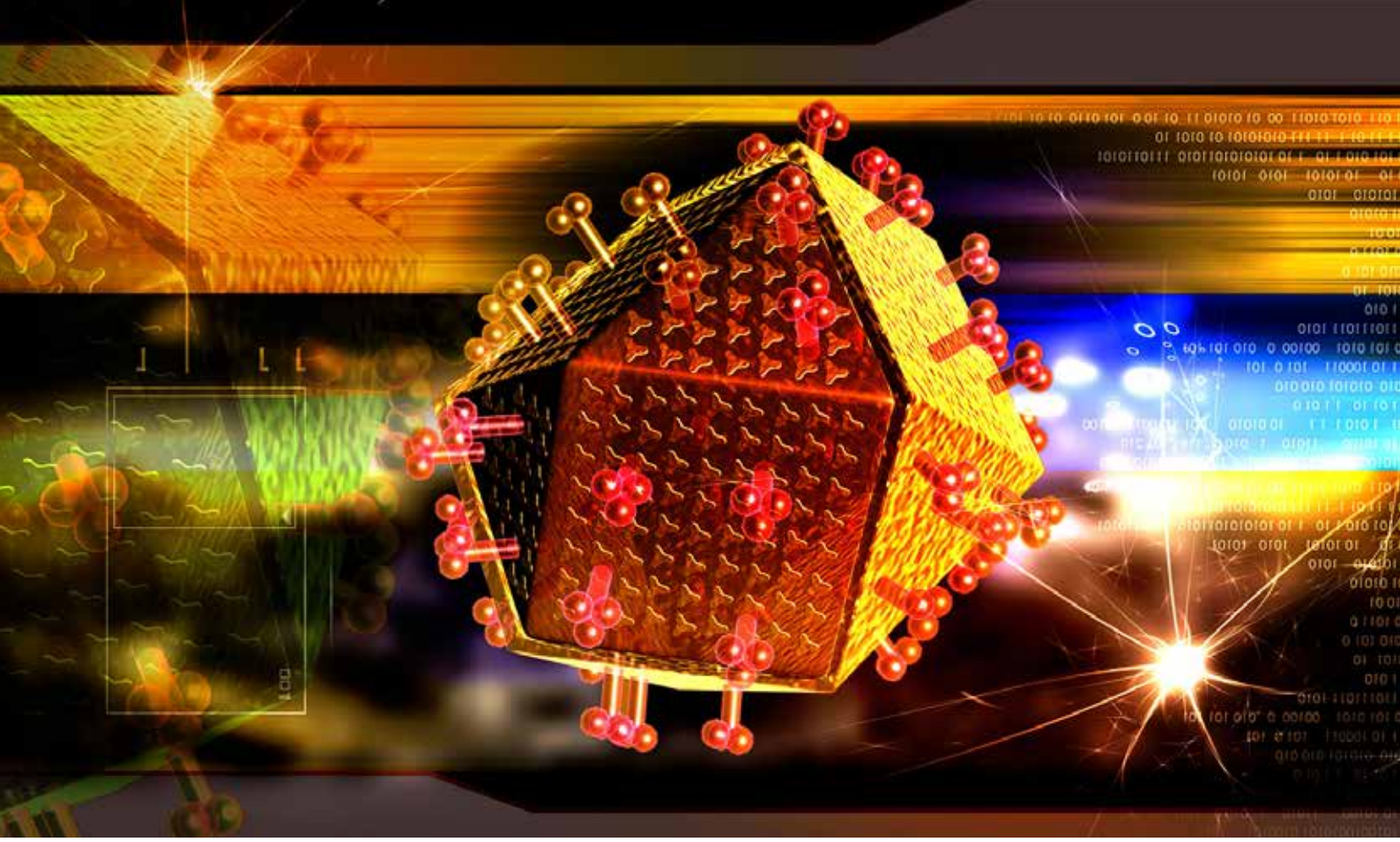
POSITIVE PARTNERSHIPS

Your partner in HIV healthcare

SANOFI

Winthrop Pharmaceuticals (Pty) Ltd,
a sanofi company. Reg. no. 1931/002901/07.
2 Bond Street, Midrand 1685.
Tel. +27 (0)11 256 3700. Fax. +27 (0)11 847 5099.
www.sanofi.co.za. ZA.EFV.13.02.05

SANOFI ARVs
positive partnerships



inside

Guest editorial
Dr Harry Moultrie 4

Message from the president
Dr Francesca Conradie 6

News
What are PMTCT Options 8

Dietician's column
New Year's resolutions with FAD dieting 10

Current issue
Behavioral, Psychiatric, and Cognitive Problems in Adolescents with Perinatal HIV Infection 14
Dealing with stigma within Youth Friendly services 18
The psychosocial challenges of HIV positive youth: the silent epidemic 22

Clinical update
The Sexual and Reproductive Health Needs of Adolescents Living with HIV 26
Voluntary Medical Male Circumcision and Adolescents 30
Tool to aid disclosure for HIV positive adolescents to their romantic partners 34
Improving engagement, retention of care and ARV treatment adherence amongst adolescents 38

Love life report
Youth Friendly Services programme in some public health clinics 42

Profile
CHIVA South Africa Organisation 46

What to do 49

Where to go 50

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

HIV Nursing matters
focuses on Youth & Adolescent Issues

on cover

The psychosocial challenges of HIV positive youth- the silent epidemic

The Sexual and Reproductive Health Needs of Adolescents Living with HIV

Voluntary Medical Male Circumcision and Adolescents

guest editorial

Dr Harry Moultrie

Adolescence is a developmental stage during which children transition into adults through progressively developing their autonomy and taking responsibility for their own lives, including their health. It is a time of intense physical, psychological and emotional change. Risk-taking is part of adolescent development. Many of the important determinants of adult ill health such as harmful alcohol use, tobacco use, unhealthy diet and lack of physical activity have their origins in adolescence. Adolescence is also generally the period in which sexual activity commences and sexual identities are developed. The safe development of healthy sexual identities is particularly challenging for adolescents living in South Africa as a result of the generalised HIV epidemic and generally unhealthy gender norms.

All adolescents need positive adult role models and safe and enabling environments which provide opportunities to exercise healthy choices. Adolescents also require access to adolescent friendly services which address their sexual and reproductive health needs including prevention, diagnosis and treatment. While routine data on adolescent health care utilisation rates are unfortunately limited, the high prevalence of teenage pregnancy and curable STIs amongst school-going children indicate that clinics are not delivering adolescent friendly sexual and reproductive health services.The reintroduction of school health services through the Integrated Schools Health Policy could dramatically improve access to health services for children and adolescents as there are approximately 8 times as many schools as health clinics in South Africa. In order to realise this potential however the ISHP needs to deliver sexual and reproductive health services that are adolescent friendly and which are effectively co-ordinated with clinic services.

The population of South African children with HIV is ageing into adolescence as a result of a maturing HIV epidemic; earlier paediatric diagnosis; provision of antiretroviral therapy (ART) to HIV-infected children and increased coverage of the PMTCT programme with better regimens.In addition to the emergence of adolescents with perinatal HIV-infection, recent estimates indicate that young women aged 15-24 years in South Africa have the highest incidence of HIV of any demographic group in the country, with an estimated incidence of 5.5 (95%CI 4.3-6,6) per 100 women years.

Anecdotal reports suggest that access to HIV Counselling and testing for adolescents remain challenging despite clear guidance from the Children's Act (Act 38,2005) that children 12 years and older with sufficient maturity can independently consent for an HIV test.

ALHIV require access to adolescent friendly services which address their specific needs. These include HIV diagnosis; diagnosis and treatment of complex clinical conditions arising from chronic HIV and/or ART exposure; sexual and reproductive health services including Pap smears and HPV vaccinations and, most importantly, screening, diagnosis and treatment for mental health conditions and psychosocial problems.

Anecdotal reports suggest that access to HIV Counselling and testing for adolescents remains challenging despite clear guidance from the Children's Act (Act 38, 2005) that children 12 years and older with sufficient maturity can independently consent for an HIV test. Slow progressors often remain undiagnosed into older childhood and adolescence.A study of perceptions of risk and acceptability of PICT amongst adolescents and their caregivers concluded that providing information of late diagnosis of MTCT in adolescents could facilitate uptake of PICT as HIV-infection in this population was widely assumed to be exclusively sexually acquired and which carried significant stigma.

Adolescents with perinatal HIV infection (PHIA) often have complex medical conditions related to both long-term HIV and ART exposure. The majority of current PHIAs in South Africa are likely to have been initiated on ART after 5 years of age. As a result of their delayed commencement of ART, many current PHIA would have already had advanced HIV disease at the time of commencing ART. In particular HIV-associated neuro-developmental delay, cognitive deficits, attention disorders and psychiatric disorders are of concern in PHIA. In addition, less common but important renal and cardiac

complications of long-term HIV and ART exposure need to be diagnosed and managed.

Clinical management is often further complicated by HIV drug resistance mutations. As a result of the prolonged high viral loads in children the durability of ART regimens is shorter and the development of drug resistance mutations more likely. A review of outcomes of children on ART in South Africa demonstrated that the three year probability of virological failure in children is 19.3% (95%CI 17.6 – 21.1%). Of concern is that only 38% of children with confirmed virological failure in this study had been switched to second line therapy, with a median time from failure to switch of 5.7 months (IQR: 2.9–11.0). While this delay is partly explained by the previous South African guidelines which advocated for a more conservative approach to switching therapy than current guidelines, ongoing viral replication in the presence of ART is associated with drug resistance.

PHIA face considerable challenges in achieving autonomy as a result of both psychosocial and physical manifestations of HIV as a result of high rates of developmental delay, orphaning, recurrent bereavement, and increased vulnerability to violence and abuse. In particular there is a high prevalence of physical delay, including stunting and sexual maturation in PHIA which can result in internal and external stigma and discrimination. A review of children attending Harriet Shezi Children's Clinic at Chris Hani Baragwanath Hospital in 2010 indicated that more than 50% of children over the age of 5 years had lost at least one parent. Orphaned children are at a significantly higher risk of missing out on schooling, living in households that have less food security, taking on significant caretaking responsibilities, suffering from anxiety and depression, and being exposed to HIV infection. Mental health issues such as depression and traumatic life events have been implicated in adolescent sexual and substance abuse risk behaviours and ability to maintain adherence to medication. In South Africa, nearly a quarter of adolescents reported feelings of sadness, or hopelessness in the preceding 6 months and 21% had attempted suicide, with 29% of these requiring medical treatments. Gender based violence is very common in South Africa, with orphaned and vulnerable children at greater risk. Mental and psychosocial services need to be specifically capacitated to be gender sensitive and to be able to address the psychosocial consequences of gender based violence.

This edition of HIV Nursing Matters is focused on Youth and HIV. Monica Nkwanyana shares some lessons learned on how best to structure HIV and sexual and reproductive health services in order to minimise stigma. Brian Zanoni draws our attention to the importance of screening adolescents with perinatal HIV infection for behavioural, cognitive and mental health problems which can result in poor adherence to ART, loss from care and/or substance abuse.While disclosure of HIV status to older children and adolescents has received considerable attention in recent years, disclosure by adolescents living with HIV to their romantic and sexual partners has received comparatively little attention. Shanaaz Randeira tackles this challenging topic in a superb article which provides guidance on a 5-step process to support disclosure by adolescents to their partners. CHIVA's adolescent programme profile provides inspiration, and there's also an article on circumcision. R

References available on request

HIV Nursing matters

The Team

Guest Editorial: Dr Harry Moultrie

President: Dr Francesca Conradie

Editorial Advisory Board:
Dr Elizabeth Mokoka
Ms Stacie Stender
Dr Natasha Davies
Dr Liezl Smit
Ms Laurie Schowalter
Ms Nelouise Geyer
Dr Michelle Moorhouse

Contributors: Monument Trust

Advertising: Chriss Nyalungu
E mail: Chriss@sahivsoc.org
Tel: (011) 341 0162

Article/Letter submission:
Ms Nonhlanhla Motlokoa
E mail: Nonhlanhla@sahivsoc.org
Tel (011) 341 0162

For more information contact
SA HIV Clinicians Society
Suite 233 Post Net Killarney
Private Bag X2600
Houghton
2041
www.sahivsoc.org
Tel: Tel +27(0) 11 341 0162
Fax: +27(0) 11 341 0161
E-mail: Sahivsoc@sahivsoc.org

The opinions expressed are the opinions of the writers and do not necessarily portray the opinion of the Editorial Staff of HIV Nursing Matters or the Southern African HIV Clinicians Society. The Society does not accept any responsibility for claims made in advertisements.

All rights reserved. No part of this publication may be reproduced in any form without prior consent from the editor.

Message from the president

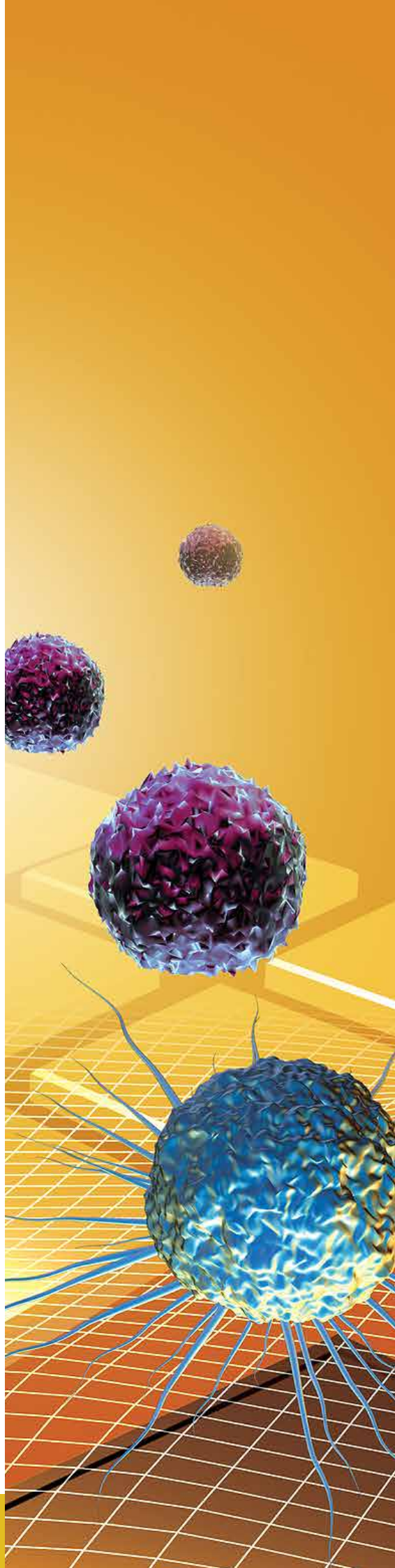
Dr Francesca Conradie:
President Southern African Clinicians Society

2013 is well upon us and exciting times coming up.

As of the 1st April 2013, fixed dose combinations or FDC will be hitting our clinics. And what does that mean to both to our patients and our practice? Firstly, it will make life easier for the patients who are able to take them- one tablet at night. The National Department of Health has designated Priority Groups in order to ensure we have sufficient stock. We do not ever want to have to change from FDC back to the split out medication. All new patients, pregnant and breastfeeding women who can take a tenofovir based regimen with EFV are in the first two groups. Then patients who are on a d4T- based regimen are in the next priority group especially if they have any toxicity. The next priority groups are patients with TB who are stable on a TDF based regimen, then those with other comorbidities and finally those who are on a stable TDF based regimen. The introduction of FDC will make our lives easier but we have to remember, like all medicine, it is not "one size fits all." Some patients will not be eligible, to mention some, those who have renal problems, those who work shifts and cannot take EFV and those who are on second line already. We will have to carefully counsel this group to make sure they do not interrupt their medication.

So our next few months will be hectic but filled with good change.

All new patients, pregnant and breastfeeding women who can take a tenofovir based regimen with EFV are in the first two groups.

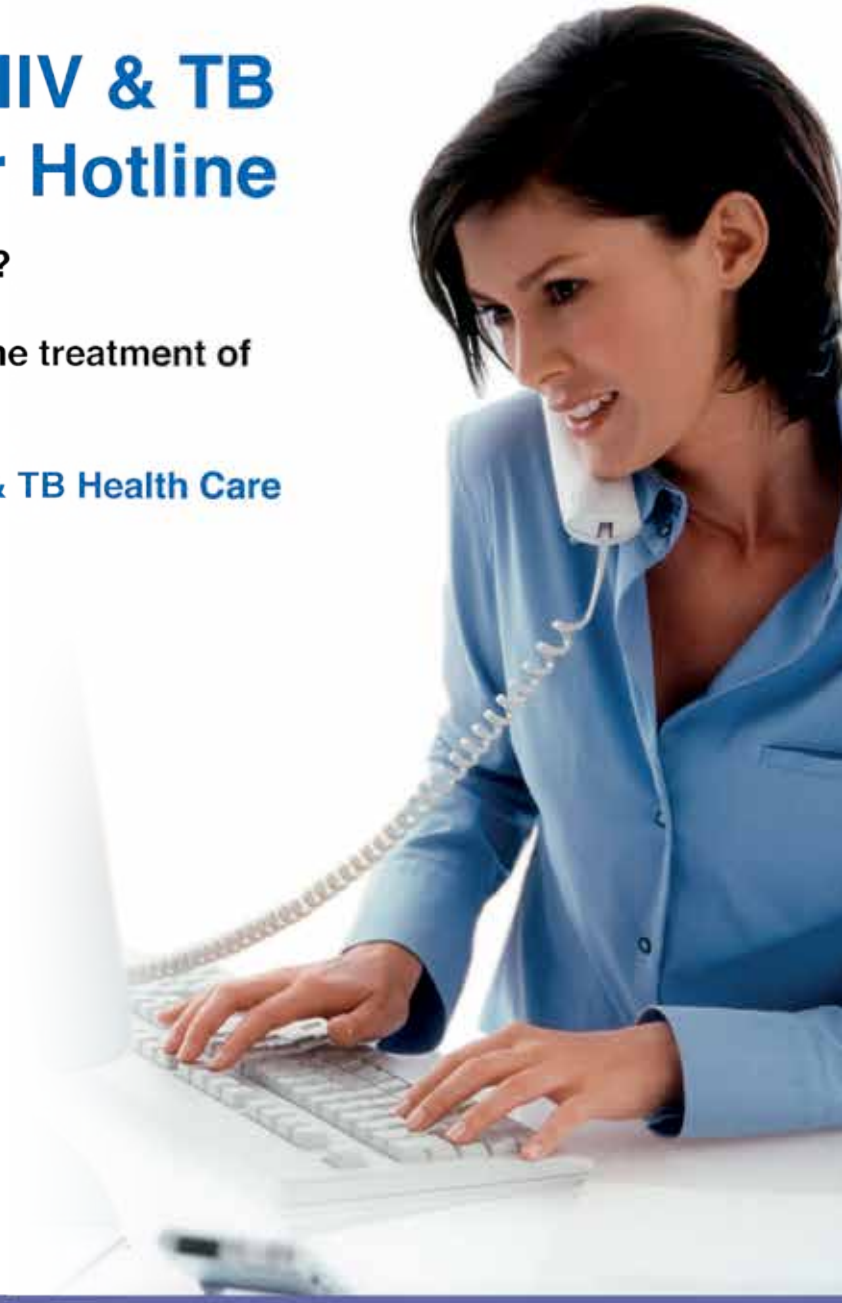


Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

Do you need clinical assistance with the treatment of your HIV or TB patients?

Contact the TOLL-FREE National HIV & TB Health Care Worker Hotline



0800 212 506 / 021 406 6782

Alternatively send an SMS or "Please Call Me" to 071 840 1572

www.hivhotline.uct.ac.za

The Medicines Information Centre (MIC) situated within the Division of Clinical Pharmacology, Department of Medicine at the University of Cape Town is the largest and only clinically-based medicine information centre in South Africa.

In collaboration with the Foundation for Professional Development and USAID/PEPFAR, the MIC provides a toll-free national HIV & TB hotline to all health care workers in South Africa for patient treatment related enquiries.

What questions can you ask?

The toll-free national HIV & TB health care worker hotline provides information on queries relating to:

- HIV testing
- Post exposure prophylaxis; health care workers and sexual assault victims
- Management of HIV in pregnancy, and prevention of mother-to-child transmission
- Antiretroviral Therapy
  - When to initiate
  - Treatment selection
  - Recommendations for laboratory and clinical monitoring
  - How to interpret and respond to laboratory results
  - Management of adverse events
- Drug interactions
- Treatment and prophylaxis of opportunistic infections
- Drug availability
- Adherence support
- Management of tuberculosis and its problems

When is this free service available?

The hotline operates from Mondays to Fridays 8.30am – 4.30pm.

Who answers the questions?

The centre is staffed by specially-trained drug information pharmacists who share 50 years of drug information experience between them. They have direct access to:

- The latest information databases and reference sources
- The clinical expertise of consultants at the University of Cape Town's Faculty of Health Sciences, Groote Schuur Hospital and the Red Cross War Memorial Children's Hospital

MEDICINES INFORMATION CENTRE

Call us - we will gladly assist you! This service is free.

This service is brought to you as a result of the generous support of the American people through USAID/PEPFAR

news

What are PMTCT Options A/B/B+?

Author: Dr Nicola Wattrus, Programme Advisor, Woman and Child Health Technical Team, Wits Reproductive Health and HIV Research Institute (WRHI)

Co-Author: Dr Vivian Black, Director Clinical Programmes, Wits Reproductive Health and HIV Research Institute (WRHI)
Member of Treatment Care and Support Technical Task Team South African National AIDS Council

ART for all pregnant women irrespective of CD4 cell count could achieve maximum coverage and could potentially lead to elimination of mother-to-child transmission of HIV, eliminating paediatric HIV.

South Africa's current PMTCT guidelines are in line with WHO's 2010 guidelines, offering a similar 'Option A' (see table 1). The current PMTCT programme offers life long antiretroviral therapy (ART) for women with CD4 counts <350cells/mm^3, and AZT (Zidovudine) from 14 weeks gestation followed by AZT 3hrly intrapartum with a single dose of Nevirapine (NVP) and Truvada for women with CD4 counts >350 cells/mm^3. All infants receive NVP daily for the first 6 weeks of life, and this is discontinued if the baby is exclusively formula fed or mom is on ART, and continued until 1 week after cessation of breastfeeding if the mom is not on ART.

WHO's option B suggests that all pregnant women be initiated on to ART as soon as diagnosed HIV positive, and discontinued after cessation of breastfeeding if CD4>350cells/mm^3, or remain on lifelong ART if CD4<350cells/mm^3. All HIV exposed infants would receive AZT or NVP for 6 weeks only irrespective of feeding method.

Option B+ takes things one step further,

Table 1: WHO Guidelines 2010: Three Options for PMTCT Programmes

	Woman receives:		
	Treatment (for CD4 count ≤ 350 cells/mm³)	**Prophylaxis (for CD4 count >350 cells/mm³)**	**Infant receives:**
Option A[a]	Triple ARVs starting as soon as diagnosed, *continued for life*	*Antepartum:* AZT starting as early as 14 weeks gestation *Intrapartum:* at onset of labour, single-dose NVP and first dose of AZT/3TC *Postpartum:* daily AZT/3TC through 7 days postpartum	Daily NVP from birth until 1 week after cessation of all breastfeeding; or, if not breastfeeding or if mother is on treatment, through age 4-6 weeks
Option B[a]	*Same initial ARVs for both*[b]*:*		Daily NVP or AZT from birth through age 4-6 weeks regardless of infant feeding method
	Triple ARVs starting as soon as diagnosed, *continued for life*	Triple ARVs starting as early as 14 weeks gestation and *continued intrapartum and through childbirth if not breastfeeding or until 1 week after cessation of all breastfeeding*	
Option B+	*Same for treatment and prophylaxis*[b]*:*		Daily NVP or AZT from birth through age 4-6 weeks regardless of infant feeding method
	Regardless of CD4 count, triple ARVs starting as soon as diagnosed[c], *continued for life*		

Note: "Triple ARVs" refers to the use of one of the recommended 3-drug fully suppressive treatment options. For the drug abbrviations in the table: AZT (azidothymidine, zidovudine [ZDV]); NVP (nevirapine); 3TC (lamivudine). options.

[a] Recommended in WHO 2010 PMTCT guidelines
[b] True only for EFV-based first-line ART; NVP-based ART not recommended for prophylaxis (CD4 > 350)
[c] Formal recommendations for Option B+ have not been made, but presumably ART would start at diagnosis.

From April 2013, we should have a fixed-dose-combination (FDC) available where Emtricitibine, Tenofovir and Efavirenz are offered as a single tablet to be taken once a day.

and suggests that all pregnant women, irrespective of CD4 cell count, should be initiated on to lifelong ART, and again, all HIV exposed infants would receive either AZT or NVP for 6 weeks only irrespective of feeding practice.

WHO published a programmatic update in April 2012 to the PMTCT guidelines, recommending that Option B or B+ could be programmatically advantageous over option A(1). A single universal regimen would treat all HIV infected pregnant women preventing maternal morbidity and mortality as well as prevent mother-to-child transmission of HIV in-utero, intrapartum and during breastfeeding.

In 2010 the national infant HIV-exposure prevalence in South Africa was 32.0%, and the national mother-to-child transmission (MTCT) rate measured at 4-8 weeks of infant age was 3.5%(2). Although 3.5% transmission rate is quite good, The National Strategic Plan (NSP) on HIV, STI's and TB 2012-2016 has a vision for South Africa: "ultimately zero new HIV infections due to vertical transmission (MTCT), and preventing transmission of HIV to reduce mother-to-child transmission to at least 2% at six weeks and to less than 5% at 18 months by 2016"(3).ART for all pregnant women irrespective of CD4 cell count could achieve maximum coverage and could potentially lead to elimination of mother-to-child transmission of HIV, eliminating paediatric HIV. The sooner the ART regimen is started in pregnancy, the sooner maximal reduction in transmission will occur. With the change to using EFV in pregnancy and no longer using NVP, a universal regimen option has opened up to PMTCT programmes. ART to all pregnant women will help intensify South Africa's PMTCT programme to attain virtual elimination of mother-to-child transmission of HIV, and with the drive to promote exclusive breastfeeding, triple ART for the mother could provide the greatest protection to HIV-exposed infants.

From April 2013, we should have a fixed-dose-combination (FDC) available where Emtricitibine, Tenofovir and Efavirenz are offered as a single tablet to be taken once a day. This is the first step in simplifying the current PMTCT guidelines, as a common regimen for all (adolescents, adults and pregnant women) may be easier to implement and monitor. The same FDC for all adults and adolescents, including pregnant women,does away with multiple and often complicated guidelines.FDC's could contribute to improved treatment adherence(4). This paves the way for a successful PMTCT regimen change to a FDC for all South African pregnant women irrespective of CD4 cell count. R

References:
1. Programmatic Update: Use of Antiretroviral Drugs For Treating Pregnant Women and Preventing HIV infection in Infants. World Health Organisation, 2012.
2. Goga AE, Dinh T-H, Jackson DJ, group ftSs. Evaluation of the Effectiveness of the National Prevention of Mother-to-Child Transmission (PMTCT) Programme Measured at Six Weeks Postpartum in South Africa. South African Medical Research Council, National Department of Health of south Africa and PEPFAR/US Centers for Disease Control and Prevention.
3. SANAC. National Strategic Plan for HIV, STIs and TB 2012-2016. 2011.
4. Connor J, Rafter N, Rodgers A. Do fixed-dose combination pills or unit-of-use packaging improve adherence? A systematic review. Bulletin of the World Health Organization. 2004;82:935-9.

New Year's resolutions with FAD dieting

Written by C Haupt RD(SA) owner of Family Kitchen

Choosing the correct diet for yourself can be very confusing because there is a lot of differing advice available and everybody from your mother to your hairdresser has an opinion on which is the best diet.

Now that the festive season is over, New Year's resolutions have been made and life has returned to normal. Most often the resolutions are about exercising more and losing weight. The question is how do we lose the excess weight gained over the festive period and keep it off in a healthy way. The basic concept of weight is a delicate balance between energy intake and energy expenditure(Saris W, 2006). In order to achieve sustained and effective weight loss it is important that you have a scientific based nutritional education and counselling (Golay A, 2000). Firstly you need to be realistic, work out how much weight you should lose and how fast you should lose it then you need to decide what diet you are going to follow and stick to.

Calculate your ideal weight

To calculate your ideal weight, use the BMI. Your goal weight should give you a BMI between of 18.5 -24.5. If your weight is in the obese range make a more realistic goal of 10% weight loss. Even a small amount (3-5kg) of sustained weight loss has proven health benefits in a person who is obese. This weight loss can help to prevent the incidence of type 2 diabetes by 40 to 60%(Astrup A, 2006). Once you have reached your first goal weight reassess and start with a new goal.

Calculate how fast you should lose weight

Now that you know how much weight you should lose, how fast should you lose it? A common goal set is 10kg in one month but it is not healthy or sustainable. The healthiest way to lose weight is to maintain a steady weight loss over a longer period of time (Mahnan L, 2004). Your aim should be 220g-450g per week for people that are overweight or grade I obese. For people with a BMI of over 35 they should aim to lose 450g – 900g per week. This weight lose should be maintained for 6 months followed by a maintenance diet before starting to diet for weight loss again (Mahnan L, 2004). Workout how long it would take you to get to your goal weight and mark it out in your dairy. Monitoring your weight loss is also a very important set to making sure that you maintain your weight loss(Astrup A, 2006).

To calculate BMI. BMI= weight (kg)/height (m2)
BMI ranges(Mahnan L, 2004):
Underweight <18.5
Normal 18.5- 24.9
Overweight 25- 29.9
Obesity grade i 30-34.9
Obesity grade ii 35-39.9
Extreme obesity ≥40

To calculate your ideal weight
Ideal weight = Desired BMI x height (m2)

The biggest Question is which diet is the best diet to follow?

Choosing the correct diet for yourself can be very confusing because there is a lot of differing advice available and everybody from your mother to your hairdresser has an opinion on which is the best diet.

Use your phone to take photos of the scale. Send your photo to a weight loss friend and help to monitor each other.

There are a variety of different Fad diets that are recommended in the popular media. Example of these are: the Atkins diet, Grapefruit diet, Low carbohydrate diet, Beverley Hills diet, Scarsdale Diet, Guilt-free diet, Chocolate lovers diet, F-Plan diet, Microdiet, The BBC diet, The Biogenic diet, The Rotation diet, Cambridge diet, The Hip and Thigh diet, HPLC diet and the Nibblers diet (Bowyer C, 1991). All of the diets have one aim; that is to reduce the energy intake of the dieter. There are different ways in which to reduce energy intake to achieve weight loss, some are "bad" and others are not. To better understand the FAD diets they can be divided up into different categories of diet: High fat, High protein, High carbohydrate and fibre, Very low energy diets and Dissociated diets.

There are different ways in which to reduce energy intake to achieve weight loss, some are "bad" and others are not.

Before you chose a diet you need to look at the science behind each diet. Below is a short list of some of the most popular diets:

Type of diet	Name	Reason for diet working	What has been reported in scientific literature
High fat, ;low carbohydrate	Atkins (McAuley KA, 2006)	Reduction in amount of energy intake. Produce high ketone production (Mahnan L, 2004).	Initial weightloss is seen in the first 6 months. After 6 months there was an increase in the waist circumference, fat mass, triglycerides and 2 h glucose levels increased. There does not seem to be any benefit for cardiovascular or diabetic risk if the high fat diet is followed compared to the high carbohydrate diet (McAuley KA, 2006).

Before you chose a diet you need to look at the science behind each diet. Below is a short list of some of the most popular diets:

Type of diet	Name	Reason for diet working	What has been reported in scientific literature
High protein	Zone HPLC diet	The total energy intake is reduced, by increasing the protein intake. The energy reduction is the cause of the weight loss. (Astrup A, 2006). Protein has a high satiating effect compared to similar energy amounts of fat and carbohydrates hence the reduction in intake.	After 1 year there was maintenance in the weight loss, waist circumference, fasting triglycerides and insulin. The weight loss was of clinical importance. However there was a poor result for LDL due to the increased intake of saturated fatty acids (McAuley KA, 2006).
High Carbohydrate, high fibre	F-Plan diet Energy % from (McAuley KA, 2006): Carbohydrate 55% Fat < 30% Protein 15% Fibre 25-30g/day	This is closer to a balanced diet approach	Over a 12 month period, there is weight maintenance and a reduction in fasting triglycerides, insulin and waist circumference. Has a role in improving variables found in insulin resistance (McAuley KA, 2006)
Dissociated (low energy) (separating out of food macronutrients)	Beverley Hills diet The Biogenic diet Energy % from the balanced diet (Golay A, 2000): Carbohydrate 42% Fat < 31% Protein 27%	The main principle of the diet is that the macronutrients should be separated out. For example fats and carbohydrates should not be eaten at the same time. The reason given is that the carbohydrate will cause insulin to spike and thus the resulting in fat storage.	When compared to a low energy balanced diet; the resulting weight loss was similar. There did not seem to be any benefit in separating out the macronutrients(Golay A, 2000). It did show an improvement in plasma glucose, insulin and HDL (Golay A, 2000).
Balanced Decreased energy (4218 kJ)	Energy % from the balanced diet (Golay A, 2000): Carbohydrate 42% Fat < 31% Protein 27%	Supplies the body with reduced energy but with adequate macro and micronutrients	The balanced diet had a positive effect on systolic and diastolic blood pressure and an improvement in plasma glucose, insulin and HDL (Golay A, 2000).
Very Low energy diets (1380 kJ)	Slimming supplements or liquid diets Grapefruit diet Microdiet Cambridge diet	Severe energy deficiency.	If more than 1 kg of weight is lost per week it is at the expense of lean body mass which can have effects on metabolic requirements. Often lacking in nutrient adequacy. Not recommended in people with a BMI<25(Bowyer C, 1991)

Recommended diet for healthy and sustainable weight loss

If you want to lose weight in a sustainable and healthy way, a balanced diet with restricted energy is the most sustainable and healthy diet. This means that the diet should be nutritionally complete expect for energy which allows the body to use up excess energy (fat stores). A reduction of about 2100kJ to 4200kJ in energy may be required depending on your age and physical activity. The energy should come from the following split of macronutrients. Energy should come from: carbohydrate 50-55%, protein 15-25%, fat <30% and additional dietary fibre of 25-30g/ day. The carbohydrate should come from vegetables, fruits and whole grain products.

Food should be a part of your life that is enjoyable and social. If you want to be able to sustain your diet make sure that you are able to fit your diet into your lifestyle with a few minor changes. Good luck and enjoy.

Reference

Astrup A, 2006. Carbohydrates as macronutrients in relation to protein and fat for body weight control. International Journal of Obesity, pp. S4-S9.

Bowyer C, 1991. A diet for Slimming. Proceedings of the NUtrition Society, Volume 50, pp. 433-440.

Golay A, A. A. Y. J. B. P. S. S. m. N. G. R. d. T. N., 2000. Similiar weight loss with low energy food combining or balanced diets. International Journal of Obesity, pp. 492-496.

Mahnan L, E.-S. S., 2004. Food, Nutrition, & Diet Therapy. 11th ed. Philadelphia: Saunders.

McAuley KA, S. K. T. R. W. S. M. J., 2006. Long-term effects of popular dietart approaches on weight loss and features of insulin resistance. International Journal of Obesity, 30.pp. 342-349.

Saris W, F. G., 2006. Simple carbohydrates and obesity: Fact, Fiction and Future. International journal of obesity, Volume 30, pp. S1-S3.

to advertise in

HIV Nursing matters

By advertising in HIV Nursing Matters, you reach many partners in the health industry.
Rates for 2012 are as follows:

Size	**Full colour**
Full page/Vol blad	R7200-00
Half page/Half blad	R3850-00
Third page/Derde blad	R2500-00
Quarter page/Kwart blad	R2030-00

Inserts

The same rates as for advertisements applies to inserts
Small advertisements: Available on request
These prices exclude VAT

Digital advertising material formats.

The following are formats by which the magazine can accept digital advertisement:

- Document to be set up to advertising specifications(i.e. Ad specs)
- We don't support zip disks
- Emailed advertising material should not be bigger than 5MB (PDF, Jpeg or tiff)
- All advertising material to be in CMYK colour mode and the resolution 300 dpi
- If pictures are sent, save as high resolution (300 DPI)
- Logos must be 300dpi with a CMYK colour break down
- All advertising material must have a 5mm bleed
- Press optimised PDF's on CD with a colour proof is also acceptable.
- PDFs supplied should include all fonts and in CMYK mode.
- PLEASE SUPPLY MATERIAL IN COMPLETED PDF FORM
- PLEASE ENSURE THE AD INCLUDES CROPMARKS!!!

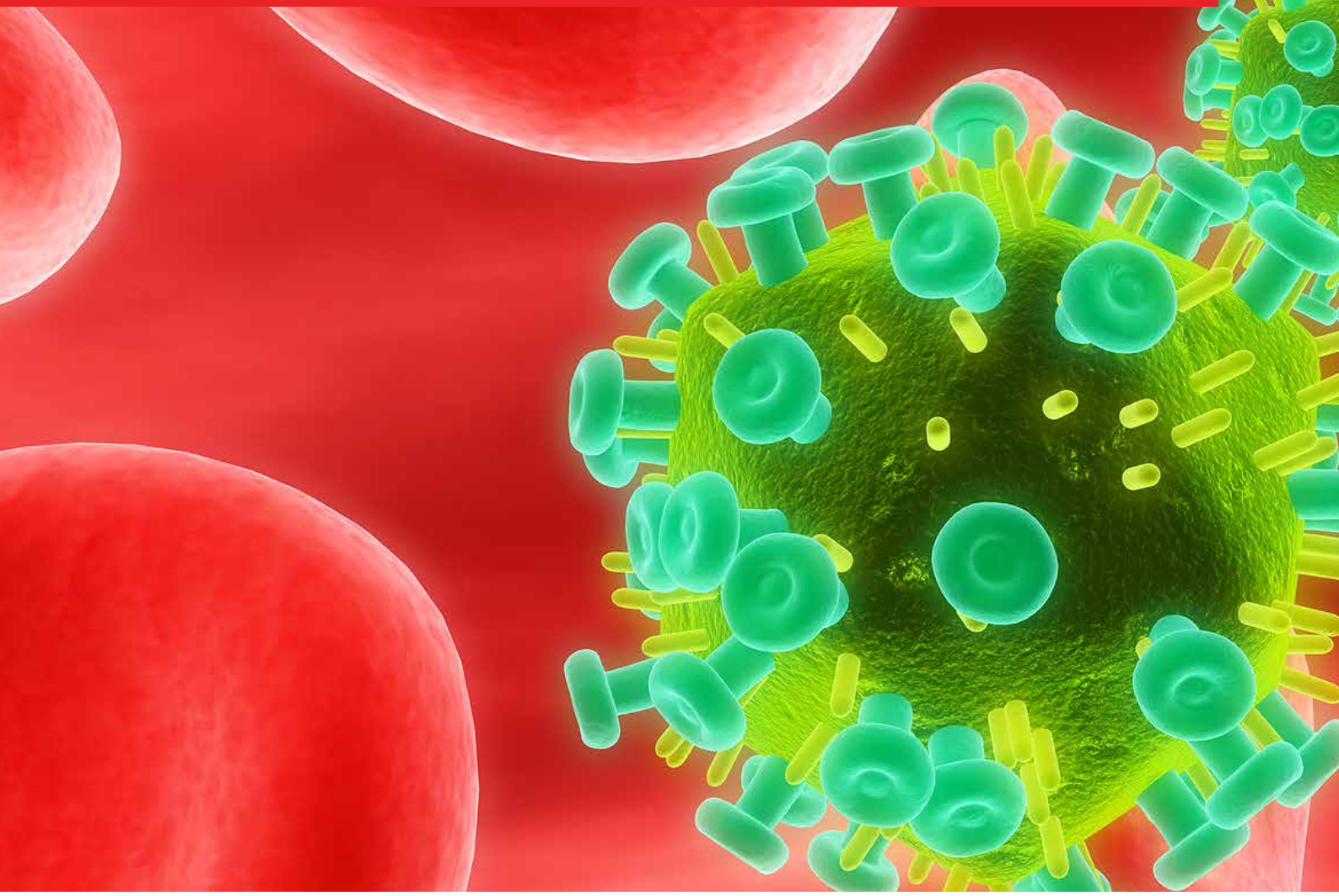
SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

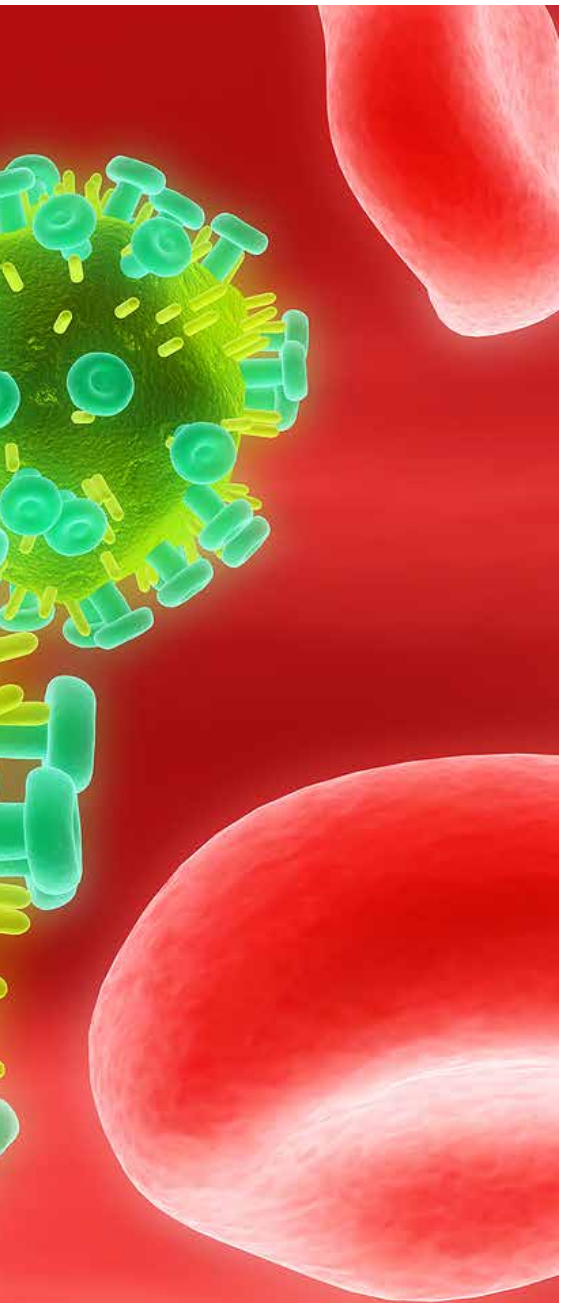
SA HIV Clinicians Society
Suite 233, Post Net, Killarney
Private Bag X2600, Houghton, 2041
www.sahiv.org
Tel: +27(0) 11341 0162
Fax: +27(0) 11341 0161
For advertising submission contact Chriss@sahivsoc.org

Behavioral, psychiatric, and cognitive problems in adolescents with Perinatal HIV Infection: Unrecognized consequences

Brian C. Zanoni, MD, MPH
Ragon Institute of Massachusetts General Hospital, Massachusetts Institute of Technology and Harvard
Harvard Medical School

For perinatally HIV-infected adolescents, undetected cognitive impairments lead to poor academic or occupational performance. Also confounding the problem are frequent disruptions of social, occupational and academic activities because of clinic appointments or hospitalizations.





Introduction:
Many perinatally HIV-infected children are surviving into adolescence and young adulthood due to increasing potency, durability and access to antiretroviral therapy (ART). Although these tremendous advances have saved many lives and transformed HIV from a fatal disease into a chronic disease, there remain long-term consequences of HIV infection. Despite clinical improvement, high rates of cognitive, behavioral and mental health problems persist in perinatally-infected adolescents (Wood et al., 2009).

Neurologic Effects of Perinatal HIV Infection
HIV inflicts damage on the central nervous system (CNS) by inducing inflammation that results in neuronal cell death. Exactly how this neuronal damage translates clinically depends on numerous factors such as duration of infection, immune control of the virus, severity of disease, genetic factors and mode of HIV transmission (Benton, 2011). One factor in particular - severity of HIV disease - has been significantly associated with lower full-scale intelligent quotient (IQ), learning disorders, and psychiatric diagnoses among HIV-infected adolescents (Wood et al., 2009).

Learning Disabilities
For perinatally HIV-infected adolescents, undetected cognitive impairments lead to poor academic or occupational performance. Also confounding the problem are frequent disruptions of social, occupational and academic activities because of clinic appointments or hospitalizations. Psychological stressors such as loss of parents or family members, social stigma, isolation, or fear related to disclosure might also contribute to poor performances. (Benton, 2011)

HIV-infected adolescents have poor language skills, particularly in reading and vocabulary. This contributes to lower full-scale IQ, higher rates of special education and school failure in HIV-infected adolescents compared to HIV-exposed, HIV-negative adolescents (Wood et al., 2009, Brackis-Cott et al., 2009, Gadow et al., 2010). Those perinatally-infected adolescents with high viral loads or advanced disease at the time of diagnosis have higher degrees of cognitive and learning problems. Unfortunately, the addition of ART treatment only modestly improves language scores in this population (Jeremy et al., 2005, Smith et al., 2012). Higher CD4 percent at ART initiation and longer duration of ART are associated with improved memory and attention control (Koekkoek et al., 2008). Increasing evidence strongly argues for earlier ART initiation in HIV-infected children. Less time with active viral replication could potentially mitigate some of the neurocognitive effects of HIV-infection. However, even clinically and immunologically stable HIV-infected adolescents on long-term ART show more frequent behavioral and learning problems and lower developmental and cognitive scores than established childhood norms (Nozyce et al., 2006, Souza et al., 2010). Early initiation of ART in HIV-infected children as well as early detection and intervention in cognitive impairment could potentially lead to better outcomes for these adolescents.

Mental Health
The manifestation of emotional distress among adolescents can present in many different ways. Psychiatric symptoms, mental health issues, and behavioral problems presenting in the context of HIV infection result from many complex, interacting biological and psychosocial factors. Healthcare workers should recognize that a combination of factors might affect an adolescent's mental health. Medical

factors such as the effect of the HIV on the CNS, opportunistic infections, substance abuse, access to medical care, and family history of mental illness may affect the presentation of emotional stress (Benton, 2011). In addition, environmental and social factors including family and peer relationships, exposure to poverty, violence and abuse all play roles in shaping adolescents response to psychological distress (Benton, 2011).

Feelings of depression, social withdrawal, loneliness, and anger are common among youths struggling to cope with HIV. This often translates into high rates of depression, substance abuse, conduct disorder, social phobia, oppositional defiant disorder and attention deficit hyperactivity disorder among HIV-infected adolescents (Kamau et al., 2012, Pao et al., 2000, Mellins et al., 2006, Musisi and Kinyanda, 2009). HIV disease severity also appears to affect many psychological disorders. A recent study found that adolescents with lower CD4 percent had more severe conduct disorder symptoms (Nachman et al., 2012). The same study found that higher viral load was associated with more severe depression symptoms. Severity of disease and delayed ART treatment impacts cognitive, academic, and social functioning as well as the psychiatric symptoms. Early diagnosis and ART initiation could help reduce some of this burden. For older children, adolescent-friendly HIV medical and psychological support, including mental health interventions, should be integrated into routine medical care to optimize the health and well-being of HIV-infected adolescents.

Adherence

For HIV-infected adolescents on ART, adherence to their medical regimen is critical to their physical, emotional and psychological well-being. Although poor adherence may impact physical and mental health, it might also be a sign of cognitive impairment that leads to a downward spiral. Adolescents with cognitive impairment may find it difficult to regularly adhere to medical therapy. This leads to suboptimal medication levels in the blood, triggering viral replication and drug resistance further increasing the risk for CNS disease (Benton, 2011).
Several studies have shown a clear association between cognitive, psychosocial and behavioral problems in HIV-infected adolescents with substance abuse, sexual risk activities and poor adherence to ART (Kapetanovic et al., 2011, Chandwani et al., 2012). In addition, HIV-infected children with poor adherence have been found to have higher rates of behavioral impairment, including conduct problems, learning problems, somatic complains, impulsivity and hyperactivity (Malee et al., 2011).

Sexual Risk Taking

Perinatally-infected children often experience developmental delay, stunting, and delayed onset of puberty. Perinatally-infected adolescents and HIV-negative adolescents with HIV-infected caregivers are less likely to be sexually active than HIV-uninfected youth from similar environments (Bauermeister et al., 2009, Bauermeister et al., 2012, Elkington et al., 2012). Whether developmental delays lead to delayed sexual activity in perinatally-infected adolescents is unclear. Regardless of HIV status, mental health, substance abuse, and economic factors are associated with sexual risk behavior (Mellins et al., 2009, Williams et al., 2010, Elkington et al., 2012). In addition, caregiver and peer behavior strongly influence risky sexual behavior.

Feelings of depressions, social withdrawal, loneliness, and anger are common among youths struggling to cope with HIV.

Discussion

Perinatally HIV-infected children are living longer, healthier lives as a result of tremendous improvements in early diagnosis and treatment. However, they often suffer with undiagnosed behavioral, cognitive and mental health problems. These issues can manifest as learning disabilities, substance abuse, or adherence problems. It is important for the healthcare team to identify and address these issues immediately. Routine care should include screening that evaluates psychosocial stressors, school performance, and adherence. Currently, there is little data available on effective interventions for these adolescents. Further research is necessary to assist with earlier detection, treatment, and monitoring of these issues to alleviate some of the burden accompanying illness.

The addition of youth-friendly services in many clinical settings is designed to support adolescents through this difficult period of their lives. By offering more convenient hours, peer relationship building, adherence monitoring, educational support, and psychosocial support, these services are equipped to address many of the behavioral issues that develop during adolescence. Diagnosing and addressing

these behavioral, cognitive and mental issues early could result in improved longer-term outcomes for HIV-infected adolescents. ®

References

BAUERMEISTER, J. A., ELKINGTON, K., BRACKIS-COTT, E., DOLEZAL, C. & MELLINS, C. A. 2009. Sexual behavior and perceived peer norms: comparing perinatally HIV-infected and HIV-affected youth. *Journal of youth and adolescence*, 38, 1110-22.

BAUERMEISTER, J. A., ELKINGTON, K. S., ROBBINS, R. N., KANG, E. & MELLINS, C. A. 2012. A prospective study of the onset of sexual behavior and sexual risk in youth perinatally infected with HIV. *Journal of sex research*, 49, 413-22.

BENTON, T. D. 2011. Psychiatric considerations in children and adolescents with HIV/AIDS. *Pediatric clinics of North America*, 58, 989-1002, xii.

BRACKIS-COTT, E., KANG, E., DOLEZAL, C., ABRAMS, E. J. & MELLINS, C. A. 2009. The impact of perinatal HIV infection on older school-aged children's and adolescents' receptive language and word recognition skills. *AIDS patient care and STDs*, 23, 415-21.

CHANDWANI, S., KOENIG, L. J., SILL, A. M., ABRAMOWITZ, S., CONNER, L. C. & D'ANGELO, L. 2012. Predictors of antiretroviral medication adherence among a diverse cohort of adolescents with HIV. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, 51, 242-51.

ELKINGTON, K. S., BAUERMEISTER, J. A., BRACKIS-COTT, E., DOLEZAL, C. & MELLINS, C. A. 2009. Substance use and sexual risk behaviors in perinatally human immunodeficiency virus-exposed youth: roles of caregivers, peers and HIV status. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, 45, 133-41.

ELKINGTON, K. S., BAUERMEISTER, J. A., ROBBINS, R. N., GROMADZKA, O., ABRAMS, E. J., WIZNIA, A., BAMJI, M. & MELLINS, C. A. 2012. Individual and contextual factors of sexual risk behavior in youth perinatally infected with HIV. *AIDS patient care and STDs*, 26, 411-22.

GADOW, K. D., CHERNOFF, M., WILLIAMS, P. L., BROUWERS, P., MORSE, E., HESTON, J., HODGE, J., DI POALO, V., DEYGOO, N. S. & NACHMAN, S. 2010. Co-occuring psychiatric symptoms in children perinatally infected with HIV and peer comparison sample. *Journal of developmental and behavioral pediatrics : JDBP*, 31, 116-28.

JEREMY, R. J., KIM, S., NOZYCE, M., NACHMAN, S., MCINTOSH, K., PELTON, S. I., YOGEV, R., WIZNIA, A., JOHNSON, G. M., KROGSTAD, P. & STANLEY, K. 2005. Neuropsychological functioning and viral load in stable antiretroviral therapy-experienced HIV-infected children. *Pediatrics*, 115, 380-7.

KAMAU, J. W., KURIA, W., MATHAI, M., ATWOLI, L. & KANGETHE, R. 2012. Psychiatric morbidity among HIV-infected children and adolescents in a resource-poor Kenyan urban community. *AIDS care*, 24, 836-42.

KAPETANOVIC, S., WIEGAND, R. E., DOMINGUEZ, K., BLUMBERG, D., BOHANNON, B., WHEELING, J. & RUTSTEIN, R. 2011. Associations of medically documented psychiatric diagnoses and risky health behaviors in highly active antiretroviral therapy-experienced perinatally HIV-infected youth. *AIDS patient care and STDs*, 25, 493-501.

KOEKKOEK, S., DE SONNEVILLE, L. M., WOLFS, T. F., LICHT, R. & GEELEN, S. P. 2008. Neurocognitive function profile in HIV-infected school-age children. *European journal of paediatric neurology : EJPN : official journal of the European Paediatric Neurology Society*, 12, 290-7.

MALEE, K., WILLIAMS, P., MONTEPIEDRA, G., MCCABE, M., NICHOLS, S., SIROIS, P. A., STORM, D., FARLEY, J. & KAMMERER, B. 2011. Medication adherence in children and adolescents with HIV infection: associations with behavioral impairment. *AIDS patient care and STDs*, 25, 191-200.

MELLINS, C. A., BRACKIS-COTT, E., DOLEZAL, C. & ABRAMS, E. J. 2006. Psychiatric disorders in youth with perinatally acquired human immunodeficiency virus infection. *The Pediatric infectious disease journal*, 25, 432-7.

MELLINS, C. A., ELKINGTON, K. S., BAUERMEISTER, J. A., BRACKIS-COTT, E., DOLEZAL, C., MCKAY, M., WIZNIA, A., BAMJI, M. & ABRAMS, E. J. 2009. Sexual and drug use behavior in perinatally HIV-infected youth: mental health and family influences. *Journal of the American Academy of Child and Adolescent Psychiatry*, 48, 810-9.

MUSISI, S. & KINYANDA, E. 2009. Emotional and behavioural disorders in HIV seropositive adolescents in urban Uganda. *East African medical journal*, 86, 16-24.

NACHMAN, S., CHERNOFF, M., WILLIAMS, P., HODGE, J., HESTON, J. & GADOW, K. D. 2012. Human immunodeficiency virus disease severity, psychiatric symptoms, and functional outcomes in perinatally infected youth. *Archives of pediatrics & adolescent medicine*, 166, 528-35.

NOZYCE, M. L., LEE, S. S., WIZNIA, A., NACHMAN, S., MOFENSON, L. M., SMITH, M. E., YOGEV, R., MCINTOSH, K., STANLEY, K. & PELTON, S. 2006. A behavioral and cognitive profile of clinically stable HIV-infected children. *Pediatrics*, 117, 763-70.

PAO, M., LYON, M., D'ANGELO, L. J., SCHUMAN, W. B., TIPNIS, T. & MRAZEK, D. A. 2000. Psychiatric diagnoses in adolescents seropositive for the human immunodeficiency virus. *Archives of pediatrics & adolescent medicine*, 154, 240-4.

SMITH, R., CHERNOFF, M., WILLIAMS, P. L., MALEE, K. M., SIROIS, P. A., KAMMERER, B., WILKINS, M., NICHOLS, S., MELLINS, C., USITALO, A., GARVIE, P. & RUTSTEIN, R. 2012. Impact of HIV severity on cognitive and adaptive functioning during childhood and adolescence. *The Pediatric infectious disease journal*, 31, 592-8.

SOUZA, E., SANTOS, N., VALENTINI, S., SILVA, G. & FALBO, A. 2010. Long-term follow-up outcomes of perinatally HIV-infected adolescents: infection control but school failure. *Journal of tropical pediatrics*, 56, 421-6.

WILLIAMS, P. L., LEISTER, E., CHERNOFF, M., NACHMAN, S., MORSE, E., DI POALO, V. & GADOW, K. D. 2010. Substance use and its association with psychiatric symptoms in perinatally HIV-infected and HIV-affected adolescents. *AIDS and behavior*, 14, 1072-82.

WOOD, S. M., SHAH, S. S., STEENHOFF, A. P. & RUTSTEIN, R. M. 2009. The impact of AIDS diagnoses on long-term neurocognitive and psychiatric outcomes of surviving adolescents with perinatally acquired HIV. *AIDS*, 23, 1859-65.

Dealing with stigma within Youth Friendly services(YFS)

Monica Nkwanyana
Nurse Manager, Youth Friendly Services (2010-2012) WRHI

Youth Friendly Services are important because they provide more age appropriate services for a vulnerable group who may otherwise find it difficult to access necessary health services.

Introduction

According to WHO, adolescents are defined as 10-19-year-olds, youth as 15-24 year olds, and young people as 10-24 year old. This period can also be defined within the cultural context of individual countries; i.e. the age established by a society for the transition to adulthood could be perceived as marking the end of adolescence. **An example is that in the South African National Youth Policy 2009-2014, youth is defined as any person between the ages of 14 to 35.**

In a survey done by the Reproductive Health Research Unit and LoveLife in 2004 on HIV and Sexual Behavior among young South Africans aged15 -24 years,

- HIV prevalence was 10.2%.
- 67% of young people aged 15-24 years reported having had sexual intercourse.
- 24% stated that they had sex while under the influence of alcohol

These statistics indicate a need for more Youth Friendly Services. For such services to succeed, issues of stigma need to be addressed.

Stigma according to Erving Goffman is a mark of disgrace associated with a particular circumstance, quality, or person.Goffman, Erving. (1963). *Stigma: Notes on the Management of Spoiled Identity.* Prentice-Hall.**The three forms of social stigma according to Goffman are:**

1. Overt or external deformations, such as scars, physical manifestations of anorexia nervosa, leprosy (leprosy stigma), or of a physical disability or social disability, such as obesity. Because of loss of weight(wasting) and skin problems which develop at the final stages of AIDS people can associate HIV with this.
2. Deviations in personal traits, including mental illness, drug addiction, alcoholism, and criminal background are stigmatized in this way- because of sex as one of the modes of transmission of HIV and most communities associate that with promiscuity.
3. Tribal stigmas are traits, imagined or real, of ethnic group, nationality, or of religion that is deemed to be a deviation from the prevailing normative ethnicity, nationality or religion – Some of the misconceptions about HIV\AIDS is that the main route of infection for males is via homosexual sex and certain religious sectors do not tolerate issues of homosexuality, it therefore makes it difficult for them to accept a person with HIV/AIDS.

From the above statements it is clear that when a young person comes to the clinic they maybe experiencing one or more of the above-mentioned social stigmas. There is therefore a need for a service that is comfortable, accessible and non judgmental for the youth.

The Essential Service Package for Youth Friendly Clinics, according to The National Adolescent-Friendly Clinic Initiative in South Africa (NAFCI)document

1. Information, education and counselling on sexual and reproductive health.

2. Information, counselling and appropriate referral for violence/abuse and mental health problems.

3. Contraceptive information and counselling, provision of methods including; oral contraceptive pills, emergency contraception, injectable and condoms.

4. Pregnancy testing and counselling, antenatal and postnatal care.

5. Pre and post Termination of Pregnancy(TOP) counselling and referral.

6. Sexually transmitted Infections(STi's) information, including information on the effective prevention of STi's and HIV, diagnosis and syndromic management of STi's, including partner notification.

The environment for the youth should be conducive, clean, and bright with lots of information, especially on health and career guidance.

7. HIV information, pre and post-test counselling, and appropriate referral for voluntary testing if services are not available.

Experiences on how stigmatization in the youth friendly service provided by WRHI was prevented.

I've been a nurse manager,employed by Wits Reproductive Health and HIV Institute (WRHI), in a Youth Friendly Service for 2 years (2010-2012) at 17 Esselen Street. Youth from 12 to 22 years old wereconsulted. Some of them were still attending school, some not attending school,some unemployed and some were from shelters and parks.

Staff Breakdown: Nurse Manager, Community Health Care Worker, 10 peer educators, Community Liaison Officer

The clinic had to be friendly with peer educators that were between 18 to 28 years old and were out of school

Services provided:

- Sexual Reproductive Health Services such as FamilyPlanning, Treatment of Sexually Transmitted Infections, HIV Management, Referral for Termination of Pregnancy and other services like psychologists, hospitals and social worker.
- HCT done at the clinic and at other institutions such as the universities, especially during HIV/AIDS campaigns. For those found to be HIV positive, continuous counseling and support was given.
- Health education was given continuously at the clinic,during workshops and holiday programmes by the youth friendly services team. School going youth at different schools around Hillbrow were trained on peer education, so that they can support their peers at school.
- The youth were first received into the waiting room by the peer educators who gave them health talks as a group or one on one basis. Files were given out and they did not state why a person was there. That ensured confidentiality and removed the stigma of being identified as HIV positive or having STI etc. Each person that came in went to a private counselling room to say why they wanted to be seen, this was done by the community health worker.Stigma was addressed especially when workshops were held or when peer educators were giving talks at schools and the clinic.

I tried to have an open attitude which led to the youth confiding in me especially with the issues of revealing their HIVstatus, sexuality and especially things like date rapes or sexual abuse.

Case Scenarios

- One of the cases was about a girl that came wanting to be checked if she had an STI or not. She was reassured because there were no signs of infection. She kept coming until I had to really enquire if there was anything more that she wanted to talk to me about. She revealed that she was raped a few months ago on her way home, and she never spoke to anyone about it, and she expressed that she needed help. She was subsequently referred for further counselling and pregnancy testing, HIV was excluded.
- Another case was about a 19 year old boy who was staying with four girls and having a sexual relationship with all of them, apparently he was owning a flat (Left to him by his late mom) and the girls wanted a place to stay, so they had to pay by having sex with him. The boy had an STI, which he got treatment for, extensive health education was given and he was encouraged to bring the girls for STi treatment. Condom usage and HCT was encouraged.

The abovementioned scenarios show how important it is to provide a comfortable and conducive environment for the youth because they are able to offload some of their heavy burdens they are carrying and confide in someone who cares.

Lessons learnt

- Peer education programme is helpful because peer educators are within the age group, so it becomes easy to identify with them and seek advice and confide in them.
- The environment for the youth should be conducive, clean, and bright with lots of information, especially on health and career guidance
- Introducing peer education programmes at schools is very important. Because the peer educators are within reach,other students can consult them when they have problems and they will be referred to the clinic accordingly.
- Health care providers should have a non-judgmental attitude and be able to pick up key points during the consultation.The service provider should be helpful.
- The nurse should be competent enough to recognize some of the underlying issues.
- Liaising with other community based organizations such as SANCA(SouthAfrican National CouncilonAlcoholism and Drug Dependence), shelters, churches and universities. Other NGO's such as LoveLife provide a good source of referral

Challenges

- Problems with clinic security after hours. The school going youth cannot access the service after 16h00 and that's the time they come back after school.
- Some of the health care provider's negative attitudes from other programmes might prevent youth from coming to the clinic when they have problems.
- Some consultations are long, especially if it is a difficult case, and that leads to long waiting times.
- Hillbrow community is known to be very mobile and that makes it very difficult to do follow up because many youth either give wrong or old addresses.
- Youth prefer to come to the clinic in large groups which poses a challenge when one of them is found to be HIV positive, it becomes obvious by their sudden change of mood.
- Lack of communication between youth and their parents, this makes them very scared to tell their parents if they are having difficulties.
- ARV drug stock outs are a major problem because it promotes lack of adherence.

Recommendations:

- Comprehensive services to be given as this will help minimize the issues of the youth being stigmatized.
- Separate waiting area from the adults is very important.
- Training of the staff from the cleaner to the security guard is important so that they can be able to understand what issues the youth are dealing with and avoid making comments that would stigmatize the youth.
- Extension of hours should be encouraged and the security made available.
- Avoidance of drug shortages is important. This will promote adherence amongst the youth, especially with regards to ARVs.
- Lots of parenting workshops to be held, to minimize issues of communication between parents and the young people

Conclusion:

Youth Friendly Services are important because they provide more age appropriate services for a vulnerable group who may otherwise find it difficult to access necessary health services.

References:

Melanie Pleaner (NAFCI/RHRU) through a collaborative process Survey on: HIV AND SEXUAL BEHAVIOUR AMONG YOUNG SOUTH AFRICANS (2004) (RHRU and Love Life).

South African National Youth Policy 2009-2014

Goffman, Erving. (1963). Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall.

The psychosocial challenges of HIV positive youth: the silent epidemic

Nataly Woollett, M.A.
Technical Head: Psychosocial; Wits Reproductive Health & HIV Institute (WRHI)

HIV positive patients have to endure the stigma and discrimination they feel from the community or service providers, but also, especially during adolescence, experience 'self-stigma'(or 'internalized stigma') where an individual takes on the perceived stigma of others and stigmatizes themself.

Today, 1.2 billion adolescents stand at the challenging crossroads between childhood and the adult world (UNICEF, 2011). Nine out of ten of these young people live in the developing world and face especially profound challenges, from obtaining an education to simply staying alive. Adolescents are vacillating in a developmental stage that bridges childhood and adulthood; a time of increased flux. At no other time except infancy do human beings undergo so much development in such a short period. During adolescence, children gain 50% of their adult body weight, become capable of reproducing, and experience an astounding transformation in their brains (UNICEF, 2011). All these changes occur in the context of rapidly expanding social spheres. Although most adolescents navigate this challenging developmental stage successfully, it can be especially difficult if there are other stressors to overcome, including HIV. HIV adds a significant burden to adolescent development, including issues of stigma, orphan hood and bereavement, increased poverty and food insecurity, high mobility and inconsistent schooling, increased risk for teen pregnancy and exposure to violence, high sexual risk taking behaviour, and especially, increased risk for poor mental health outcomes.

Research with adults indicates that people living with HIV in both developed and developing countries have higher levels of mental disorder than non-HIV-infected populations (Freeman et al., 2007). The reasons for this are complex but include pre-morbid mental conditions, the effects of the virus on the central nervous system, the psychological impacts of living with HIV/AIDS, side-effects of medication and results of social stigma and discrimination (Freeman et al, 2007). Mental health disorders have been shown to occur with increased frequency among HIV-positive children and adolescents. Studies conducted primarily in the United States have shown that HIV-positive children and adolescents display a higher rate of behavioural, social, and emotional problems, such as attention-deficit hyperactivity disorder, depression, oppositional defiant disorder, adjustment disorder, post-traumatic stress disorder and anxiety, relative to their uninfected peers. These problems are also evident in adolescents but in addition include suicidality and alcohol abuse later in development. While the virus itself or an opportunistic infection, such as one causing meningitis or encephalitis, may lead to neuro developmental impairments that affect mental and psychomotor development, it appears that the social context of HIV (such as familial disruption, poverty, and stigmatization) may play a greater role in the higher prevalence of mental health problems among this population(Domek, 2009).

A major distinction between HIV/AIDS and other chronic or terminal illnesses is the stigma associated with the disease. This stigma often stems from lack of knowledge about HIV and how it is transmitted. Stigma can adversely affect adolescents and their caregivers in ways that have long-term negative psychological and social consequences (Close, 2003). HIV positive patients have to endure the stigma and discrimination they feel from the community or service providers, but also, especially during adolescence, experience 'self-stigma'(or 'internalized stigma') where an individual takes on the perceived stigma of others and stigmatizes themself. Internalized stigma has a large effect on the paediatric population through its influence on parents' decisions to disclose. If parents or caregivers have internalized the stigma and negative views of HIV/AIDS, their likelihood of telling the child about his or her diagnosis decreases significantly. If adolescents internalize the stigma regarding their diagnosis, they are more likely to become depressed and engage in denial regarding their HIV status (Close, 2003). Adolescents may fear disclosing their status to others and feel shameful regarding their condition. Obviously, these factors have an enormous influence on interpersonal relationships, self-esteem and the practice of safe sex where honestly talking about sexual transmission and protection is crucial.

To safeguard a child from experiencing stigma, caregivers often practice 'stigma management' and delay disclosing the child's diagnosis to the child as a result of shame and guilt, fears of inadvertent disclosure to community etc.As a result, between 25%-90% of school-aged HIV positive children are unaware of their own status (Close, 2003) regardless of going to the clinic every 3 months to pick up treatment.However, many children are being sensitized to HIV and ART through life orientation classes at school and through the media, so inadvertently they start to 'figure it out' on their own. Unfortunately, as the family system has not been honest, stigma leads to an atmosphere of secrecy within the family that the child often senses. Children become acutely aware of their family's feelings towards their diagnosis, through observing interactions with other adults and how they discuss or avoid the topic in their presence. Labelling the diagnosis as a secret that cannot be discussed only serves to increase the stigma and by adolescence, many of these HIV positive children have internalized that stigma to a degree that disastrously impacts their self-esteem and identity formation.

Healthcare providers play a significant role in assisting families with the disclosure process. Many families choose to disclose in the clinic setting so they can receive the educational support of the facility staff there. It is important to note that disclosure is a process rather than a one-time event; caregivers need to be aware of their responsibilities and create an atmosphere of asking and answering questions about the virus and living with it with an attitude and pace of information giving that is comfortable to the child/adolescent. Caregivers might also be asked to

disclose their own status, which they should be prepared for. Through basic education about the virus, how it is transmitted, and treatment options, much of the stigma surrounding HIV/AIDS can be dispelled. Through educating communities at large, families and children infected or affected by HIV/AIDS can receive much-needed support and will no longer feel alone in their struggle (Close, 2003). Obviously, if this is done satisfactorily, adolescents can learn how to disclose to their friends, and later their sexual partners in ways that do not disadvantage them or their sexual partner. HIV incidence remains highest among 15-24yr olds, with approximately 40% of horizontal transmission occurring within this age group (UNAIDS, UNICEF, WHO, 2008).

Timing and mode of transmission may be important factors to consider as perinatally/vertically infected adolescents may experience different psychological challenges given that they have lived with HIV for a significantly longer period, compared with adolescents infected behaviourally/horizontally. Many adolescents who contracted the virus from their mothers are orphaned by the time they reach adolescence. Resultantly, at a tender age, they have had a fair dealing with death and grief. Much of the grief surrounding HIV/AIDS is quite normalized in communities and these children/adolescents often do not receive much support with their losses (which are enduring). Adolescents might miss their parent who died for the remainder of their lives and have complex and unresolved feelings about the loss, the family disruption, and their HIV status that have never been adequately or compassionately managed by the adults around them. Unresolved grief can lead to traumatic bereavement symptoms (such as post-traumatic stress disorder (PTSD) – hypervigilence, avoidance, dysregulation, re-experiencing, increased stress and hyperarousal etc.) and depression if not dealt with.A recent study reports that children and adolescents orphaned by AIDS were 117% more likely to be suffering from post- traumatic stress disorder than children/adolescents whose parents were alive, and also 67% more likely than children/adolescents orphaned by other causes, including homicide, suicide and cancer (Cluver, 2011). Orphans and vulnerable children are at increased risk for mental health problems as a result of the typical contexts of emotional deprivation and stigma of their upbringings; and lack of attention given to their mental health outcomes.

Unfortunately, youth friendly services are not widely available in the public health sector in South Africa (SANAC, 2011), and adolescents tend to get lost in adult systems of care or fall out of care as a result of their needs not being met. Better information on adolescents is needed if health-care providers, community-level stakeholders, caregivers, and policy-makers are to respond effectively to the specific needs of this group. For adolescents living with a chronic illness, transitioning into adulthood includes an important shift toward medical independence. Youth need assistance from healthcare professionals in taking charge of their medical care and utilizing the healthcare system to their advantage. Unfortunately, healthcare service involvement decreases in adolescence at the same time that family involvement in youth's health care also declines which has serious implications for future health. As long as this population is overlooked and their clinical, psychological and social needs remain poorly understood, adolescents (including those on ART) will remain one of the most vulnerable populations affected by the HIV pandemic. Our failure to address this vulnerability threatens the lives of these youth and jeopardizes the successes of paediatric HIV treatment efforts to date.

As access to highly active antiretroviral therapy (HAART) improves globally, the population of vertically infected adolescents is expected to grow (Ferrand et al, 2009). While youth aged 10-19 accounted for 1% of the total number of patients receiving HAART in South Africa in 2008, this proportion is expected to grow to approximately 5% by 2020, mainly as a result of vertically infected children surviving into adolescence (Jaspan et el, 2009). Adherence to HAART remains problematic with this population as adolescents are often challenged with maintaining strict routines and this is often linked to mental health problems (Ferrand et al, 2010; Mellins et al, 2004; Merzel et al, 2008). Furthermore, South Africans between 13-19 years comprise roughly 30% of the population (STATS SA, 2010), so treatment and care for HIV-positive adolescents will become increasingly important over the next decade as more adolescents will require access to healthcare. Being mindful of and addressing some of the psychosocial stressors of this population would go a long way in improving the lives of adolescents and strengthening the healthcare system response to an important population. ®

Healthcare providers play a significant role in assisting families with the disclosure process, many families choose to disclose in the clinic setting so they can receive the educational support of the facility staff there.

Ways to address the challenges of caring for the HIV+ adolescents:

- If you don't like adolescents, it is probably best not to work with them.
- Remember adolescents who are having a particularly 'hard time' may present with increased 'attitude'. This is a good defence to getting others to 'back off'... don't be misled! Know that if an adolescent presents this way, they need an especially patient and kind approach.
- Be open to engaging in conversations of disclosure and give support on how to manage this process.
- Adolescents may say they know when they don't (especially around sexual reproductive health issues) – make sure you explain every time.
- Intergenerational sex (sugar daddy) is abundant in our culture...just because she appears to be okay with it does not mean it is consensual (non-exploitative) or that she has made informed choices and can negotiate safe sex.
- Adolescents talk to other adolescents – if one adolescent has a bad experience with you, they won't come back and neither will their friends!
- Adolescence is a time of experimentation...just because they do it now doesn't mean they will do it always...opportunities to educate are important.
- To be of most benefit to the growing adolescent, an adult needs to be a constant and consistent
- figure, available as a sounding board for the youth's ideas without dominating or overtaking the emerging, independent identity of the young person – don't get caught up in power struggles with youth, you will lose!
- Adolescents have RIGHTS and we need to uphold them.

References:

Close, K.L. (2003). Psychosocial aspects of HIV/AIDS: children and adolescents. In HIV Curriculum for the Health Professional. Baylor International Pediatric AIDS Initiative, Baylor College of Medicine.

Cluver, L., Orkin, M., Gardner, F. & Boyes, M.E. (2011). Persisting mental health problems among AIDS orphaned children in South Africa. Journal of Child Psychology and Psychiatry, 1-8.

Domek, G.J. (2009). Facing adolescence and adulthood: The importance of mental health care in the global pediatric AIDS epidemic. Journal of Developmental and Behavioural Pediatrics, 30: 14,150

Ferrand, R.A., Lowe, S., Whande, B., Munaiwa, L., Langhuang, L., Cowan, F., Mugurungi, O., Gibb, D., Munyati, S., Williams, B.G. & Corbett, E.L. (2010). Survey of children accessing HIV services in a high prevalence setting: time for adolescents to count? WHO Bulletin, 88, pp428-434.

Ferrand, R.A., Corbett, E.L., Wood, R., Hargrove, J., Ndhlovu, C.E., Cowan, F.M., Gouws, E. &Williams, B.G (2009). AIDS among older children and adolescents in Southern Africa: projecting the time course and magnitude of the epidemic. AIDS, 23, pp2039-2046.

Freeman, M., Nkomo, N., Kafaar, Z. & Kelly, K. (2007). Factors associated with prevalence of mental disorder in people living with HIV/AIDS in South Africa. AIDS Care, 19(10), pp1201-1209

Jaspan, H.B., Li, R., Johnson, L., & Bekker, L.G. (2009). The emerging need for adolescent-focused HIV care in South Africa. The Southern African Journal of HIV Medicine, Dec Opinion Piece, pp9-11.

Mellins, C. A., Brackis-Cott, E., Dolezal, C., & Abrams, E. J. (2004). The role of psychosocial and family factors in adherence to antiretroviral treatment in Human Immunodeficiency Virus-infected children. The Pediatric Infectious Disease Journal, 23, 1035-1041.

Merzel, C., vanDeventer, N. & Irvine, M. (2008). Adherence to antiretroviral therapy among older children and adolescents with HIV: A qualitative study of psychosocial contexts. AIDS Patient Care and STDSs, 22(12), pp977-987

Pettifor, A. E., Rees, H. V., Kleinschmidt, I., Steffenson, A. E., MacPhail, C., Hlongwa-Madikizela, L., Vermaak, K. & Padian, N. S. (2005). Young people's sexual health in South Africa: HIV prevalence an sexual behaviors from a nationally representative household survey. AIDS, 19(14), 1525 1534

SANAC (2011). Getting to success: improving HIV prevention methods in South Africa. South African National AIDS Council; HIV epidemic, response and policy synthesis.

Thurman, T.R., Brown, L., Richter, L., Maharaj, P. & Magnani, R. (2006). Sexual risk behaviour among South African adolescents: is orphan status a factor? AIDS and Behaviour, 10 (6), 627-635.

UNAIDS, UNICEF & WHO (2008). Children and AIDS: Second Stocktaking Report. Geneva

UNICEF (2011). State of the World's Children: Adolescence an Age of Opportunity. Geneva

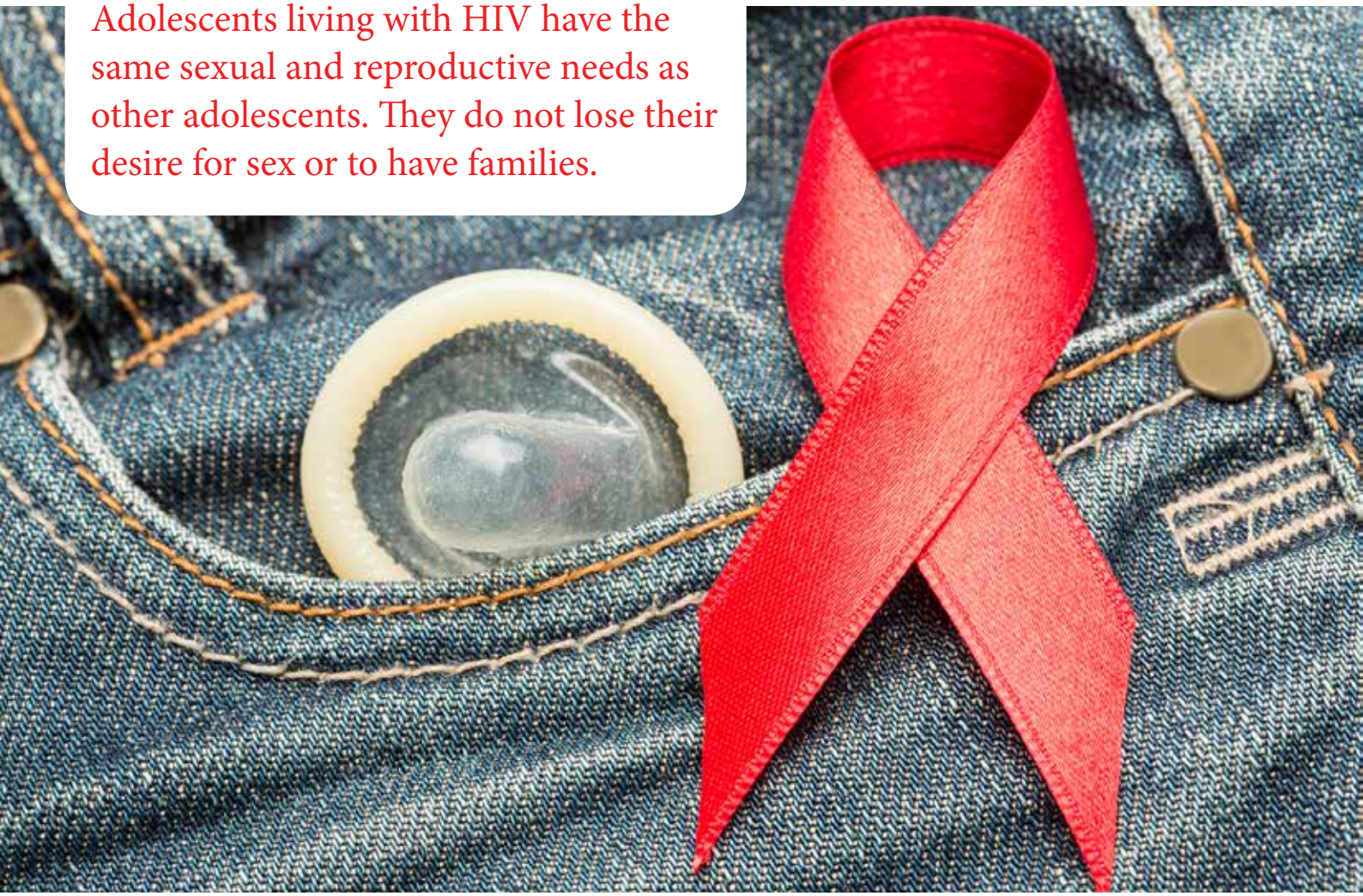
‘Vaku vaku’. ‘Iturr nash’. ‘Spaka paka’.

The Sexual and Reproductive Health Needs of Adolescents living with HIV

By: A Armstrong[1], B Pungula[2], Z Sobantu[1], E Cheserem[3], K Moshal[1,4]
[1]CHIVA SA, KwaZulu Natal, South Africa; [2]YAFS Clinic, Nseleni Community Health Centre, KwaZulu Natal, South Africa; [3]Caldecot Centre, Department of Sexual Health and HIV, King’s College Hospital, London, United Kingdom; [4]Department of Infectious Diseases, Great Ormond Street Hospital for Children, London, United Kingdom.

A Armstrong – BNS, RGN, NMP, DipTN, DTM+H, MSc Int. Health
B Pungula – DipN, RGN, RGM, CHN, DipPHC, DipHIV,
Z Sobantu – BCUR (Hons), RGN, RGM, CHN, Occ.HN
E Cheserem - MBChB, MRCP, DipHIV
K Moshal - MBChB, MRCP(UK), MRCPCH, DTM+H

Adolescents living with HIV have the same sexual and reproductive needs as other adolescents. They do not lose their desire for sex or to have families.



Adolescents, defined as those aged 10 – 19, contribute significantly to shaping the future course of the HIV epidemic. An estimated 2 million adolescents are living with HIV globally.[1] In South Africa, data from 2009 estimates that between 264 000 – 322 000 10 – 19 year olds and between 840 000 – 1 030 000 young people (15 -24 year old) are living with HIV.[1] Evidence shows that risk of sexually transmitted infections (STIs) and pregnancy clusters at adolescence and young adulthood.[2,3] The average age of sexual debut for a South African adolescent is 15.[4] Only 13% of those who have had multiple partners report condom use during their last sexual contact, and 31% of males between 15 - 24 years report more than one partner in the last 12 months.[4]

The increase in access to antiretroviral therapy (ART), means more children who were infected through mother to child transmission are surviving into adolescence and adulthood.[5,6,7] Likewise, the increased availability and uptake of HIV testing and counselling (HTC) has allowed more adolescents with vertically transmitted infection to know their status.[8] Additionally, concerted efforts in HTC have also assisted in the identification of 'slow progressors' – vertically infected HIV positive patients who are diagnosed in adolescence, as, due to the slow decline of their immune systems, they do not present unwell, or earlier in life.[9,10]

Adolescence is a period of transition between childhood and adulthood.[11] It is a developmental stage characterized by physical, psychological, social and emotional growth and change.[11] It is also a time of sexual exploration, taking sexual risks, the forming of sexual identity and development of relationships. Adolescents living with HIV must learn, not only to live with a chronic illness, but also to deal with the emotional and psychological issues associated with the knowledge that this is a highly stigmatised transmissible infection.[12] This often has an enormous impact on their sexual health, relationships and emotional wellbeing. [12]

Adolescents living with HIV have the same sexual and reproductive needs as other adolescents.[13] They do not lose their desire for sex or to have families.[13] Many have had sex, or intend to in the future, and have numerous unanswered questions relating to sex.[13,14] They have concerns about infecting others, having children safely, and disclosing to partners.[12,13,14] In a Ugandan study of young people living with HIV, only one-third of the respondents had never had sex, and of these, 86% intended to have sex in the future.[14] The desire to have children and a family has also been extensively documented.[12,13,14] In a Kenyan study, three quarters of participants wanted to have children in the future, although most aimed to delay this to later in life.[13] Despite this, low rates of contraceptive use (66%) were reported, 68% of sexually active female respondents had already been pregnant and three quarters of those were unintended pregnancies.[13] Similarly, in a study from the United Kingdom of young women born with HIV, one-fifth had been pregnant and 75% of these were unplanned pregnancies.[15]

This population brings unique challenges.[11,12,16] Health professionals working in pediatric and adult services have limited experience with, and feel under-equipped to address them.[16,17] Healthcare workers often feel constrained by lack of human resources, time or space to provide care.[18] However the greatest challenge they face is communicating effectively with adolescents, particularly when discussing sex.[19,20,21] Qualitative studies involving adolescent living with HIV have documented their concerns regarding the judgmental attitudes of healthcare workers.[12,21,22,23] At the 2006 Global Consultation of young people living with HIV, participants voiced their concerns and called for healthcare workers to 'Stop being mothers and fathers, be health providers'.[23] Healthcare workers' personal views about adolescent sex are shaped by societal and cultural norms and taboos. Unfortunately these views often create a barrier to discussions around sex, relationships and other issues important to adolescents. This results in missed opportunities for thorough sexual and reproductive health (SRH) assessments and the effective provision of pertinent information to promote healthy and safe sexual practices.[24]

There are a growing number of studies that have documented the sexual and reproductive health needs of adolescents living with HIV, with many emphasising the gaps that exist within health services to address them.[13-15,25-27] The individual and public health consequences of not addressing these needs, namely new HIV infections, unwanted pregnancies and sexually

Consultation of young people living with HIV, participants voiced their concerns and called for healthcare workers to "Stop being mothers and fathers, and be health providers"

transmitted infections and their impact on mortality and morbidity, further highlights the importance of strengthening health services.[24,28] In a study of barriers to sexual and reproductive health programming for young people living with HIV in Uganda, Obare and colleagues suggest that programming gaps are due to the lack of clear guidelines and policy, as well as a limited capacity to offer the services required. [20] As South Africa moves from treatment initiation to long-term treatment and care, health services need to adapt to provide the long-term care and support her population needs: this includes SRH for adolescents. Adolescents are more likely to reduce their risk behavior when the relevant information, skills and services are provided in an enabling and protective environment.[29] Young people living with HIV attending the Global Consultation also expressed frustration with the inadequate and inaccessible information specific to the needs of young people with HIV, especially with regards to SRH.[23] Similarly, the Ugandan study showed a disconnect between the information provided by services and the actual needs and desires of the young people.[13]

Adolescents living with HIV need respectful, non-judgmental, caring health care workers who create a platform for them to discuss issues around SRH. Such healthcare workers would provide them with health promotion information, guide them in developing harm-reduction skills and assist them in making informed decisions. They need the ongoing provision of accurate information before their sexual debut. This includes information on: puberty; understanding their bodies; condom use; condom negotiation; STI signs and symptoms; types of sex and HIV/STI transmission risk; available family planning methods; pre-conception advice; how to, when to and whom to disclose their status to; as well as their rights and responsibilities concerning disclosure at work, school and in sexual relationships.

They need health services that are accessible at appropriate times – for example, after school and weekends. These services should be safe, confidential, and provide access to condoms, lubricants and a choice of family planning methods. Adolescents living with HIV also need services which provide easy access to support groups and peer support workers at community and clinic level: having peers they can relate to is an important source of support.

For health services to be able to properly address the SRH needs of adolescents and support the implementation of the strategies outlined above, an integrated model of service delivery, which includes the long-term management of HIV, and SRH, needs to be developed. Integral to the success of this is the development of the clinical and communication skills and knowledge of the healthcare workers, through training and mentorship. Ongoing operational research, which involves the adolescent population it is being designed to serve, is vital to build clear evidence based care. Actively engaging adolescents living with HIV and civil society is imperative for ensuring that services are responsive to their needs as well as building meaningful partnership. Ultimately, clear and comprehensive national guidelines, policies and leadership are essential to sustain and support this process.

For more information about CHIVA South Africa's Adolescent Programme visit: http://www.chiva-africa.org/

Or contact the Adolescent Programme Coordinator at: alice.armstrong@chiva-africa.org

Adolescent Resources available at: http://www.chiva-africa.org/

adolescent-programme.html

Acknowledgement – Special thanks to the peer support workers from the YAFS Clinic at Nseleni Community Health Centre in KwaZulu Natal for taking the time to share their views regarding important aspects of SRH care for adolescents living with HIV.

Reference:

1. United Nations Children's Fund. Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood. New York: United Nations Children's Fund, 2011.

2. Santos R. Young People, sexual and reproductive health and HIV. Bulletin of the World Health Organization 2009, 87: 877-879.

3. Gore F, Bloem P, Patton G, Ferguson J, Joseph V et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet 2011, 377(9783): 2093-2102.

4. Shisana O, Rehle T, Simbayi LC, et al. South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? Cape Town: HSRC Press, 2009.

5. Joint United Nations Programme on HIV/AIDS. Report on the Global AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS, 2008.

6. Coovadia H, Mantell J. Adolescents and HIV in Sub-Saharan Africa: A timely Issue and Missed Opportunity. Clinical Infectious Diseases 2010, 51(7): 852-854.

7. Gray G. Adolescents HIV - Cause for Concern in Southern Africa. PLOS Medicine 2009, 7(2).

8. World Health Organization, Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Geneva: World Health Organization, 2009.

9. Ferrand R, Leuthy R, Miller R, Corbett E. HIV Infection Presenting in Older Children and Adolescents: A Case Series from Harare, Zimbabwe. Clinical Infectious Disease 2007, 44: 874 - 878.

10. Ferrand R, Corbett E, Wood R, Hargrove J, Ndhlovu E, Low S, Whande B, Cowan F, Gouws E, Williams B. AIDS among older children and adolescents in Southern Africa: projection the time course and magnitude of the epidemic. AIDS 2009, 23(15): 2039-2046.

11. Campbell T, Beer H, Wilkins R, Sherlock E, Merrrett A, Griffiths J. "I look forward. I feel insecure but I am ok with it". The experience of young HIV+ people attending transition preparation events: a qualitative investigation. AIDS Care 2010, 22(2): 263-269.

12. Li R, Jaspen H, O'Brien V, Rabie H, Cotton M, Nattrass N. Positive futures?: a qualitative study on needs of adolescents on antiretroviral therapy in South Africa. AIDS Care 2010, 22(6): 751-758.

13. Obare F, van der Kwaak A, Adieri B, Owuor D et al. HIV-positive adolescents in Kenya: Access to sexual and reproductive health services. KIT Development Policy & Practice 2010, 33.

14. Birungi H, Obare F, Mugisha J, Humphres E, et al. Preventative service needs of young people perinatally infected with HIV in Uganda. AIDS Care 2009, 21(6): 725-731.

15. Williams B. Pregnancy outcomes in women growing up with HIV acquired perinatally or in early childhood. HIV Medicine 2010, 11(1): 144.

16. Miles K, Edwards S, Clapson M. Transition from paediatric to adult services: experiencesof HIV-positive adolescents. AIDS Care 2004, 16(3): 305-314.

17. Maturo D, Powell A, Major-Wilson H, Sanchez K, et al. Development of a protocol for transitioning adolescents with HIV infection to adult care. Journal of Pediatric Health Care 2011, 25(1): 16-23.

18. Coovadia H, Jewkes R, Barron P. Health in South Africa 1, The health and health system of South Africa: historical roots of current public health challenges. Lancet 2009, 374: 817-834.

19. Global Network of people living with HIV. Priorities and Recommendations coming from the Young People Living with HIV Consultation. Amsterdam: Global Network of people living with HIV, 2010.

20. Obare F, Birungi H, Kavuma L. Barriers to Sexual and Reproduction Health Programming for Adolescents living with HIV in Uganda. Population Research Policy Review 2011, 30: 151-163.

21. Hodgson I, Ross J, Haamujompa C, et al. Livingas an adolescent with HIV in Zambia – lived experiences, sexual health and reproductive needs. AIDS Care 2012, 24(10): 1204-1210.

22. Pediatric AIDS Treatment for Africa. Planning HIV/AIDS Care for Adolescents in the Western Cape Province. Cape Town: Pediatric AIDS Treatment for Africa, 2010.

23. World Health Organization, United Nations Children's Fund. Global Consultation on Strengthening the Health Sector Response to Care, Support, Treatment and Prevention for Young People Living with HIV. Geneva: World Health Organization, 2008.

24. World Health Organization/United Nations Children's Fund. Strengthening the Health Sector Response to Care, Support, Treatment and Prevention for Young People Living with HIV. Geneva: World Health Organization, 2008.

25. Koeing L, Pals S, Chandwani S, Hodge K, Abramowitz S et al. Sexual Transmission Risk Behaviours of Adolescents with HIV Acquired Perinatally or Through Risky Behaviour. Journal Acquired immune Deficiency Syndrome 2010, 55(3): 380-390.

26. Fernet M, Wong K, Richard M, Otis J et al. Romantic relationships and sexual activities of the first generation of youth living with HIV since birth. AIDS Care 2011, 23(4): 393-400.

27. Marhefka S, Valentin C, Pinto R, Demetriou N et al. "I feel like I'm carrying a weapon." Information and motivations related to sexual risk among girls with perinatally acquired HIV. AIDS Care 2011, 3: 1-8.

28. World AIDS Campaign. Briefing Paper, Youth Positives: Living their Rights. Cape Town: World AIDS Campaign, 2010.

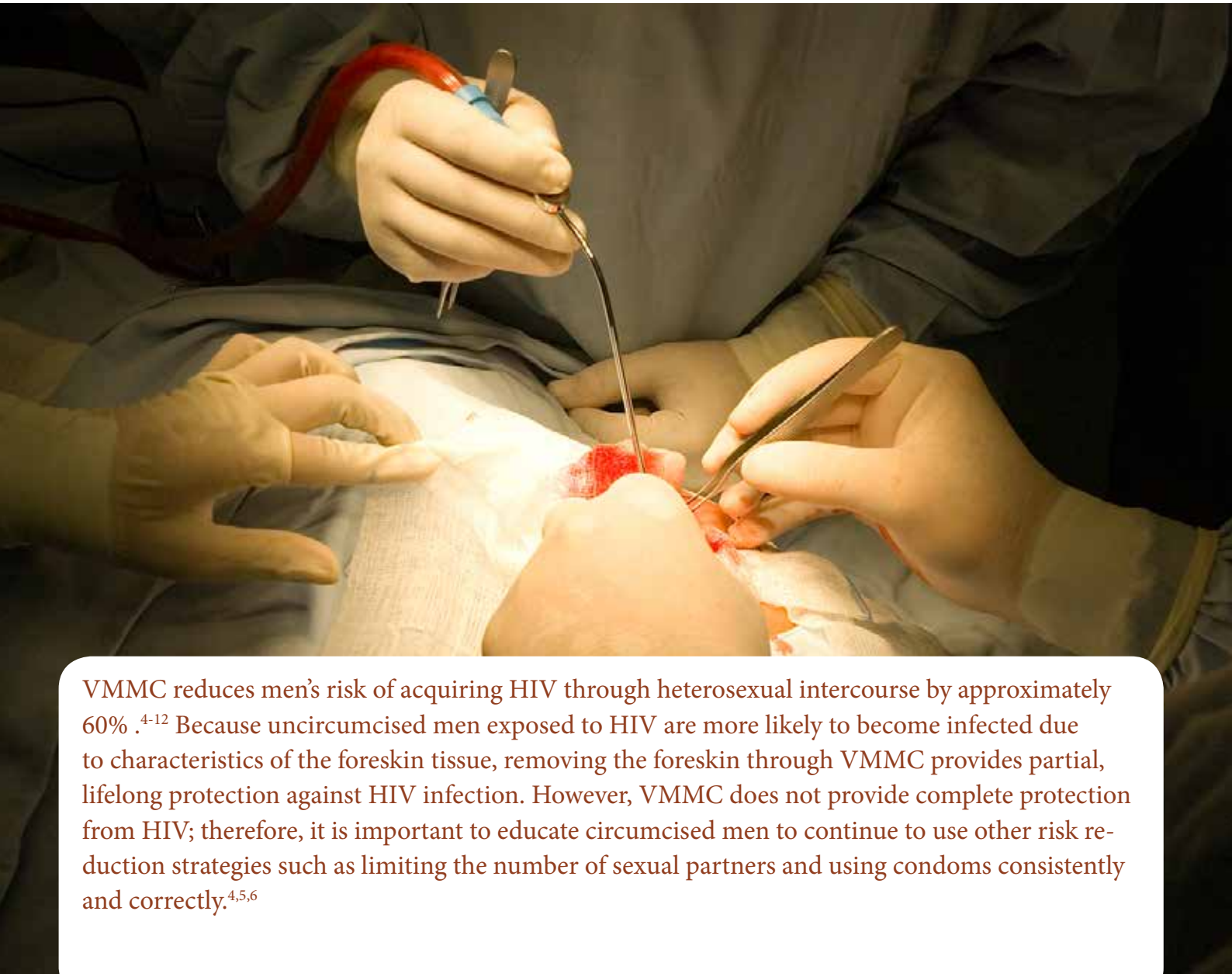
29. Dick B, Ferguson J, Chandra V, Brabin L, Chatterjee S, Ross D. Review of the evidence to increase young people's use of health services in developing countries. World Health Organization Technical Health Series 2006, 938: 151-204.

Voluntary Medical Male Circumcision and Adolescents:

An opportunity for nurses to contribute to an HIV free generation

A Christensen, MS, CNS, T Adamu Ashengo, MD, MPH, D Bossemeyer, BSN,
A Hellar, MD, MMed, MBA, H R Mahler, MHS, E Necochea, MD, MPH, K A Curran, MHS.

1 Jhpiego, USA
2. International Health Department, Johns Hopkins Bloomberg School of Public Health.
3. Jhpiego, Mozambique
4. Jhpiego Tanzania



VMMC reduces men's risk of acquiring HIV through heterosexual intercourse by approximately 60% .[4-12] Because uncircumcised men exposed to HIV are more likely to become infected due to characteristics of the foreskin tissue, removing the foreskin through VMMC provides partial, lifelong protection against HIV infection. However, VMMC does not provide complete protection from HIV; therefore, it is important to educate circumcised men to continue to use other risk reduction strategies such as limiting the number of sexual partners and using condoms consistently and correctly.[4,5,6]

Introduction

Preventative health care is dependent on engaging healthy individuals to take charge of their health care decisions and make informed choices to prevent disease. All too often, we perform under crisis management conditions—diagnosing, educating and treating patients once disease has already taken hold. Voluntary Medical Male Circumcision (VMMC) provides an ideal platform for nurses and other health workers to educate and counsel healthy individuals and counteract this trend.

Women are generally easier to engage in health care, as they are seen in family planning, antenatal and postnatal care, and in preventative care for their children such as vaccination clinics. Voluntary HIV counseling and testing is another platform where there is the potential to reach healthy individuals, but a recent UNICEF report indicates most youth in sub-Saharan Africa are not taking advantage of these VCT services.1 Adolescents, particularly male adolescents—a notably hard to reach population—have little reason or desire to engage in the health sector.2 Occasions that bring male adolescents and health care workers (HCWs) together must therefore be maximized to allow for discussion of preventive health practices, education and counseling.

Voluntary Medical Male Circumcision (VMMC) services, which are targeted to healthy, HIV negative males, provide one such opportunity. Adolescents make up 23% of the total population in sub-Saharan Africa, and are an extremely vulnerable group for HIV infection due to age, biology and legal status.1 While HIV prevalence rates have been on the decline in the younger population,3 a recent UNICEF report suggests that only 33% of adolescent males in sub-Saharan Africa have a comprehensive knowledge of HIV.1 VMMC is a chance to offer these young men HIV education, testing and counseling, and sexually transmitted infection (STI) screening and treatment, and to present positive sexual norms and behaviors before they enter into the prime of their sexual lives.

VMMC Overview

VMMC reduces men's risk of acquiring HIV through heterosexual intercourse by approximately 60% .[4-12] Because uncircumcised men exposed to HIV are more likely to become infected due to characteristics of the foreskin tissue, removing the foreskin through VMMC provides partial, lifelong protection against HIV infection. However, VMMC does not provide complete protection from HIV; therefore, it is important to educate circumcised men to continue to use other risk reduction strategies such as limiting the number of sexual partners and using condoms consistently and correctly.[4,5,6] Adolescents and men who undergo VMMC are educated and counseled regarding the partially protective effect of VMMC the day of the procedure, with ongoing reinforcement at all follow up visits.

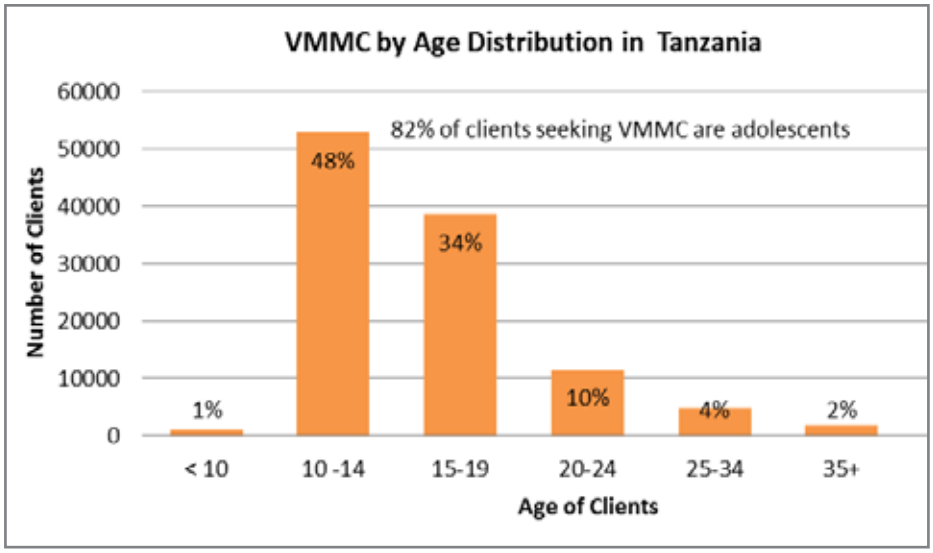
The World Health Organization (WHO) recommends a minimum package of services to be offered in combination with the VMMC procedure. These services include: provider initiated counseling and testing with linkages to HIV care and treatment for clients who test positive; screening and treatment for STIs; provision of male and female condoms (including promotion of their correct and consistent use); and provision of risk reduction counseling.

Adolescents and VMMC

In many countries, the majority of demand for VMMC services is coming from adolescents (see Figure 1) possibly due to its association with the rite of passage to adulthood.[13,14] In Tanzania and Mozambique, for example, 82% and 75% of males respectively, who sought VMMC were aged 10-19.[14,15] To ensure age appropriate, ethical and high-quality care, adolescents seeking these services require special considerations.

Demand for VMMC services is created through a variety of avenues. First must be the provision of high-quality care, as adolescents that are satisfied with their service will be more likely to recommend VMMC to their peers. Countries are also increasing the demand for VMMC services through traditional media sources such as radio, print ads (billboards) and branding (such as t-shirts). The use of community mobilization and active referral programs—referring males to VMMC from HCT sites and other health services—also aids in creating demand. In Tanzania, a

Figure 1: Age Distribution Data of VMMC Clients in Iringa and Njombe Regions in Tanzania (as of December 2012, Jhpiego).



research study found that adolescent males seem to be attracted by a "campaign" mode of service delivery.[17] The campaign approach provides VMMC services in high volume at specific periods in time. Campaigns are often designed to target certain populations (e.g., during school holidays to provide VMMC to adolescents). Strategies adopted by the campaign to generate demand included the widespread dissemination of messages focused on the provision of free VMMC and mobilization of the community by specially trained community mobilizers.

Age appropriate care - VMMC is currently provided in a variety of setting, including hospitals, clinics and mobile sites. And while it is offered to men of all ages, adolescents must receive counseling and messaging appropriate for their age. Some facilities offer "youth days" for VMMC, while others triage patients by age, and offer specific group education and individual counseling tailored to different age categories. While preteens may only need basic information about how to care for their sexual organs, young teens should be introduced to broader HIV and other STI prevention concepts—including delaying sexual debut—and should be educated on correct and consistent condom use. Older, sexually experienced adolescents need more in-depth information about HIV and other STIs, and counseling on risk reduction strategies. At all ages, positive gender and age appropriate norms should be addressed.

Table 1 displays adolescent norms along with recommendations about age-specific care and the implications for VMMC.

High-quality Care - Nurses and other HCWs offering VMMC have a fantastic forum to provide health services to adolescents seeking VMMC; however, they need to ensure that they employ high-quality care practices tailored to these adolescent clients. This age group, especially those on the younger end of the spectrum, may need reassurance, as they can be fearful of providers and the impending procedure. Individual counseling for younger adolescents must involve the provider assessing if the adolescent understands what he is about to undergo. Ensuring that patients have a clear understanding of what to expect during and after the procedure—including pain expectations and management—helps to appease fear.

Referral for VMMC – Adolescents who are HIV negative and enter the health care system through other entry points (such as voluntary counseling and testing, or outpatient services) also need to be educated and referred to VMMC services. Communities play a vital role in referring young men for VMMC as well, through schools, churches, home health and other community organizations. It is also essential to educate parents and guardians on the benefits of VMMC, so they can encourage their sons or wards to seek the services. Ultimately, adolescents of both sexes should be educated on the health benefits of VMMC, as older adolescent girls can be encouraged to promote VMMC and choose circumcised partners. Mother, grandmothers and caregivers are also essential to

Table 1: Adolescents and VMMC - Norms and Recommended Care.17

Adolescent Norms	Age-Specific Care	VMMC Implications
Fears separation from peer group	Encourage social interaction with peers	Provide age-specific VMMC group counseling to keep adolescents within their peer group
		Provide VMMC services or days that are youth specific
		Use terms such as "many young people" to indicate attendees are not alone or different
Fears loss of control	Collaborate with the adolescent	Explain VMMC and follow up procedures carefully and ensure understanding
	Encourage participation in self-care activities	Engage the adolescent with the necessary follow up procedures to have them take charge of their own care
	Allow choices whenever possible	
Desires independence	Treat more as an adult than a child	Educate and counsel the adolescent regarding VMMC (not just the parent/guardian)
	Avoid authoritarian controls	Ensure the provision of the adolescent's assent (not just parent/guardian consent)
	Be honest and encourage open communication	Provide empathetic care and counseling prior to the VMMC procedure
	Show respect	

educate, as they play a vital role in informing their sons, grandsons and males in their community about the benefits of VMMC.

Consent and Assent - VMMC is a surgical procedure that requires the appropriate consent procedure as defined by law. Although adolescents under age 18 generally do not have the legal right to give informed consent, they have the right to participate in decisions affecting their health, and therefore should provide assent for the surgical procedure. If an assent is given, parents or guardians are responsible for providing consent, and should be informed of the risks and benefits of the procedure. Providers should defer circumcision in adolescent clients who do not provide assent for the procedure, even if the parent or guardian has provided consent.

The Role of Nurses in VMMC in sub-Saharan Africa

Nurses play a vital role in VMMC implementation and scale up in the WHO identified 14 VMMC priority countries.* In addition to working as VMMC educators, HIV counselors, triage nurses, surgical assistants, and post-op caregivers, in countries such as Tanzania, South Africa (Eastern Cape), Zambia, Kenya, and Mozambique, nurses are also performing the VMMC procedure. Data show that there is little difference in VMMC adverse event rates of nurses compared to other VMMC providers.[15] As nurses continue to provide these services to men, particularly adolescents, they need to take advantage of this unique opportunity to engage with this younger generation. Nurses can play a pivotal role in ensuring that adolescents have a positive experience with VMMC and the health sector as a whole.

Table 2 presents VMMC facts for health professionals working with adolescents.

Table 2. VMMC Fast Facts for Nurses and Providers Working with Adolescents.

VMMC reduces the risk of female-to-male sexual transmission of HIV by approximately 60%. Adolescent males and females should be informed that VMMC is only partially protective against HIV and, therefore, patients need to continue to use risk reductions strategies (such as reducing the number of sexual partners and using condoms correctly and consistently).[4, 5, 6]
VMMC should be offered as a package of sexual health services, including: HIV testing and counseling and linkages to care and treatment; provision and promotion of correct and consistent use of male and female condoms; screening and treatment for STIs; and risk reduction counseling.
A one-time health intervention, VMMC provides life-long partial protection against HIV as well as some other STIs. [7, 8, 9]
Evidence shows that VMMC reduces some STIs, particularly ulcerative STIs, including chancroid, herpes and syphilis, as well as balanitis, phimosis, and penile cancer. [18, 19]
VMMC also benefits women. Circumcision has an association with a reduction in penile human papilloma virus, which is associated with cervical cancer in female partners. Female partners of circumcised men also have lower rates of bacterial vaginosis. [20, 21]

Conclusion

The demand for VMMC from adolescents in many countries is high, bringing this hard to reach population in contact with the health system. Adolescence is a formative time for young males; they are broaching adulthood and the sexual and reproductive responsibilities that come with transition. Nurses can play a vital role in VMMC services by creating demand for and providing high-quality, age appropriate VMMC services to this next generation. VMMC is a proven biomedical intervention that has the potential to avert millions of HIV infections and directly contribute to the world goal of creating a HIV free generation. ℞

Reference List

UNICEF. Progress for Children: A report card for adolescents. 2012. http: http://www.unicef.org/publications/files/Progress_for_Children_-_No._10_EN_04272012.pdf (accessed 11 February 2013)

Barker G. Adolescents, Social Support and Help Seeking Behavior. 2007. WHO Discussion Papers on Adolescents. WHO Department of Child and Adolescent Health and Development. http: http://whqlibdoc.who.int/publications/2007/9789241595711_eng.pdf (accessed 11 February 2013)

WHO UNAIDS. Young people are leading the HIV prevention revolution. 2010. http: http://data.unaids.org/pub/outlook/2010/20100713_outlook_youngpeople_en.pdf (accessed 11 February 2013)

Bailey RC et al.. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomized controlled trial. Lancet 2007, 369(9562): 643–656.

Gray RH et al. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomized trial. Lancet 2007, 369(9562): 657–666.

Auvert B et al.. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. PLoS Medicine 2005, 2(11): e298.

Auvert B et al. 2011. "Effect of the Orange Farm (South Africa) Male Circumcision Roll-out (ANRS-12126) on the Spread of HIV." IAS Conference, Rome, 17–20 July.

Kong X et al. 2011. "Longer-Term Effects of Male Circumcision on HIV Incidence and Ris

Tool to aid disclosure for HIV-positive adolescents to their romantic partners

By: Shanaaz Kapery Randeria
Psychosocial Case Manager -Adolescent ProjectWRHI

Adolescents in the working group who had disclosed their status to their partners mentioned feeling relieved, 'like a burden had been lifted off their shoulders' and that their partners were supportive and their relationship stronger than before the disclosure.

"HIV is not just a virus. It is also a disease of society and human relationships …" Mark Heywood (2009)

Introduction:

Disclosure of HIV status is a voluntary process as indicated in the South African Constitution as well as the Children's Act 38 of 2005. This means that no person should be coerced into disclosing HIV status; special circumstances however may require disclosure without consent. The time at which disclosing one's HIV-positive status occurred as well as to whom was therefore at the discretion of the HIV-positive individual.

Adolescents are particularly vulnerable both for infecting and being infected with HIV as a result of drug and alcohol abuse and sexual debut at this stage of development (Augustine, 2008).

Disclosure of HIV status:

A facility in Soweto runs psychosocial programs, which are youth-friendly, rights-based and developmentally informed in an attempt to normalize living with HIV by regarding it as a long-term condition and not an illness. When discussing HIV, words like 'secret' and being 'sick because I am HIV-positive' which have negative connotations, are replaced with words such as 'confidentiality' in which the individual has a sense of control over who learns about my status' and 'I am an adolescent who knows my HIV status'-so that the adolescent is not defined by the virus but instead has a sense of accomplishment and control.

Disclosure can contribute to the reduction of HIV-transmission through negotiating safer sex practices, increase in adherence to ARV's and accessing important services and treatments, such as treatment for sexually transmitted infections, termination of pregnancy, psychosocial support, counselling and youth groups for example (Serovich, 2001).

The advantages of disclosing one's HIV status, as noted by adolescents from the 'Disclosure Tool' working group include a feeling of relief, increase in self-esteem, less anxiety, obtaining support from family and romantic partners, a deeper romantic relationship (which does not necessarily imply a sexual relationship) encouraging partners to get tested and feelings of accomplishment and pride.

Disadvantages of disclosure include the fear of abandonment (friends, family and community) and consequent isolation (self-imposed or external), violence, stigma and discrimination (experienced, vicariously or perceived), being accused of promiscuity and loss of social and economic support.

Health professionals should always encourage disclosure, bearing in mind that each individual's circumstances are unique and being mindful of the disadvantages of disclosure.

Steps in the disclosure process:

A group of HIV-positive adolescents from the facility in Soweto mentioned above have embarked on a groundbreaking task to identify the steps in the process of disclosing their HIV status to their romantic partners.

Disclosure was defined as a 'process of telling someone of choice, something very personal'. HIV disclosure specifically was the process of telling someone about one's HIV-positive status. The need to prepare one's partner to be informed about one's HIV status was found to be a process involving many steps before the person could be trusted with the information.

The 'Disclosure Tool' working group identified 5 steps to be followed for disclosure of one's HIV status to romantic partners.

Step 1: Accepting one's HIV-positive status
Step 2: Gaining as much information and knowledge about HIV/AIDS (including rectifying mis-information and myths)
Step 3: Assessing partner readiness
Step 4: Disclosing HIV status
Step 5: Post-disclosure support

Step 1: Accepting one's HIV-positive status

The most important step in the disclosure process was accepting one's HIV-positive status. Acceptance was not just about telling a trusted person that one was HIV-positive; it was the feeling of truly believing in oneself, acknowledging and being confident that 'I have a future that I can work towards' and as one adolescent said 'a person has to be happy inside to appreciate what you have around you-a sense of value.' The future gaze of believing that 'I will not die soon...' and 'that I can have a career, a family and material things ...' was important in accepting one's HIV-positive status.

Step 2: Gaining correct HIV/AIDS information

Steps 2 and 3, were interchangeable and did not necessarily follow on from

Adolescents are particularly vulnerable both for infecting and being infected with HIV as a result of drug and alcohol abuse and sexual debut at this stage of development (Augustine, 2008)

each other. Step 2 included obtaining sexual reproductive health information, where to access services and a comprehensive knowledge and understanding about HIV. Support groups, the internet, peer groups, counselling, school, trusted adults like teachers and caregivers or older siblings, and health facilities were the main source of information. The adolescents mentioned that it was important to find someone whom they could trust and confide in in order to feel comfortable with them.

Step 3: Assessing partner readiness:

Adolescents in the working group felt the need to 'test' whether they could trust their partners with the knowledge of their HIV-positive status first before disclosing their status. This finding is different to the findings from a group in the Unites States which states that after disclosure the partner can be educated about HIV (Velasquez, 2012).

The romantic partners, not necessarily sexually active, were asked on more than one occasion how they felt about HIV; how they felt about HIV-positive people; how they felt about having an HIV-positive partner as well as observed for their behaviour and reactions when HIV discussions occurred. The decision to disclose was heavily dependent on the responses of partners.

The extent of the anxiety accompanying disclosure was evidenced even when it was found that the partner accepted HIV-positive people and would continue dating an HIV-positive partner. The fear of rejection and subsequent stigma and discrimination from the partner because of HIV was implicated in the reluctance to disclose.

Stigma:

Literature (Erku, 2012) and the 'Disclosure Tool' working group indicate that stigma and discrimination are important deterrents to disclosure. Many and varied interventions are required to ward off the damaging and debilitating effects of stigma and discrimination post- disclosure in adolescents. The working group adolescents mention that youth –groups, regular support groups in health-care facilities and strong condemnation,(from the top down), of stigma and discrimination are ways to address the challenge. The fear of stigma and discrimination in adolescence is markedly amplified as compared to that experienced by adults. This is particularly difficult for the adolescent because of the need to 'fit-in' and the desire for a sense of belonging while disconnecting from significant adults.

Step 4: Disclosing

Disclosure is an anxiety-provoking experience (Kardas-Nelson, 2010). Adolescents mentioned that they would only disclose their status to long-term partners when a commitment to sharing a future, getting married, was established. Long term relationships were those that lasted 2 years or longer.

Lack of communication skills and about how to broach the topic were two additional obstacles identified that prevented the actual disclosure of one's HIV status to partners.

Learning to convey the intended message as well as being able to withstand negative responses was essential in attempting to disclose one's status. The benefits of accepting one's status was crucial during this stage of the process, especially if the partner's response to the disclosure was negative.

Adolescents in the working group who had disclosed their status to their partners mentioned feeling relieved, 'like a burden had been lifted off their shoulders' and that their partners were supportive and their relationship stronger than before the disclosure.

The timing and place of disclosing was important. Choosing a quiet, safe place rather than a public one where others could witness the partner's reaction, if it was negative, or where they could hear your conversation was important. Ensuring your safety was essential, preferably where one could call on someone for help if the situation turned violent. A room in one's house where the door could be shut for privacy but with other people at home was a suggestion.

The disclosure should preferably be done when both you and your partner are relaxed, over a weekend as an example. Times which were not suitable for disclosure included exam time, after work or when you know your partner is experiencing a stressful time or experience.

Role-playing the disclosure as well as positive and negative outcomes of the process is a good way to be prepared for possible outcomes. In this way both expected and the unexpected aspects that can occur during the process can be explored.

Step 5: Post-disclosure support

Post-disclosure support is important regardless of whether the outcome of the disclosure is positive or negative.

If the outcome is positive, then the need to support the partner is important. The partner may want detailed HIV/AIDS information from a 'professional' rather than hearing it from his/her HIV positive partner. The need to be tested, if he/she has not already done so, fear of being HIV-infected or how to stay negative (if he/she is not HIV-positive), sexual reproductive health while living with HIV, finding ways of supporting the HIV positive partner are some of the possible concerns and factors that will require support after disclosure.

If the outcome of disclosure is negative, the partner will need support to deal with it. There might be a need for a safe place to go to or to live in for a while if violence or the threat occurs. Emotional and psychological counselling and support may be necessary to deal with the rejection and possible

stigma and discrimination that follow or even joining a support group for HIV-positive adolescents to share similar experiences.

The experience of joining a support group, at the above-mentioned facility, has been cited as a useful tool in dealing with living with HIV as an adolescent as well as how to buffer oneself against negative experiences like stigma and discrimination. Adolescents from the group say that they learnt from the group that 'If you are HIV-positive it is not the end of the world, it is just the beginning' and '... it helps me to feel good about myself and they don't judge... the main reason is to get support'.

Discussion:

Research indicates that AIDS orphans are more at risk for mental health challenges than non-orphaned children (Cluver et al, 2008). Anger, guilt, depression and anxiety are feelings commonly experienced by adolescents, regardless of HIV status.

The need for good mental health amongst adolescents is vitally important at this developmental stage since it impacts on the formation of a healthy personal and sexual identity, and creates a buffer against negative peer pressure.

Disclosure can therefore be seen to contribute to positive mental health outcomes by reducing stress and anxiety in HIV-positive individuals (Serovich, 2001).

While statistics indicate reductions in HIV transmission, globally we are still faced with the challenge of high HIV transmission rates in the 15-24 year old population (Nicholson, 2012). HIV infections amongst adolescents 15-24 years old account for 40% of new infections in adults (UNAIDS 2012). In South Africa in 2009 had an HIV prevalence of 17.8% amongst adults (15-49 years old) of which 9% was young people (15-24 years). The USA in comparison had an adult HIV prevalence rate of 0.6% of which 0.2% was young people (UNICEF, n.d.)

In order for adolescents to disclose their HIV status to their partners, they have to perceive that doing so would reap positive benefits that outweigh the perceived negative outcomes (Serovich, 2001). This translates into being accepted and valued as a partner and creates sense of belonging, despite being HIV-positive.
A positive effect of disclosing one's HIV status to partners is the possibility of negotiating safer sex practices. In the presence of greater access to ARV's and a change in behaviour the high HIV prevalence rate in the 15-24 year old age group can potentially be decreased.

Conclusion:

The South African Constitution and the Children's Act 38 of 2005 give children and adolescents the right to confidentiality and privacy. This applies to their HIV status as well.
An adolescent cannot be forced to disclose his/her HIV status, and should disclose only after being prepared to do so. However, given the high HIV prevalence amongst adolescents and the advantages of disclosure to their well-being, mental health, support and treatment, disclosure should be encouraged. The steps identified above to prepare adolescents for disclosure to their romantic partners is a guideline developed by HIV-positive adolescents to assist with the daunting task.
Health workers occupy an important place in the HIV arena, as a point of contact for adolescents; their role in the reduction of HIV infection cannot be emphasized enough. The process of disclosure is not easy-not for the adolescent or for the health worker equipping the adolescent for the disclosure process! ℞

References are available on request

The struggle addressing HIV in adolescents will continue for quite some time. However, there are many people and organizations attempting to battle the major issues that prevent us from eliminating HIV.

Improving engagement, retention of care and ARV treatment adherence amongst adolescents through the WhizzKids United programme introduced by The Africaid Trust in Edendale, Umgungundlovu District, KwaZulu Natal

By Marcus McGilvray, RN (Greenwich University), BA (HONs) in Health Management (Brighton University), CEO & Founder The Africaid Trust,Dr N Madlala, MBCHB (Limpopo University), BSc (Limpopo University), & Michael Brown Woliver MIPH (University of Sydney), BA (East Carolina University)

The South African Government 'roll out' of Highly Active Antiretrovial Therapyies (HAART) in 2004 successfully transformed HIV infection into a chronic disease managed in primary care. In well-resourced countries, antiretroviral therapy (ART) has made survival of HIV-infected children into adolescence and adulthood the norm (Gortmaker SL, Hughes M, Cervia J, et al, 2001). This can now be expected in low and middle-income countries with functioning HIV treatment programmes. Adolescent HIV patients include surviving perinatal infected children, those who are 'behaviourally infected', usually through consensual sex or drug use (CDC, 2011), and those who are victims of sexual assault (Meel BL, 2005).

Successful management of HIV and AIDS through the use of ARV's requires an adherence rate of not less than 70 - 95%, which will prevent the emergence of resistant strains of HIV and reduce viral load to undetectable levels (Chesney, 2004; WHO, 2006). ARV's must be taken in the right dosage, at the right time, everyday for a lifetime. Essentially, this can equate to an adolescent having to take up to 240 tablets per month, typically twice per day.

Effective adherence support among adolescents may be regarded as being decisive in primary care if the young person is to enjoy a healthy life and longevity. One must also note that non-adherence has devastating implications that go well beyond that of the individual alone. Not only can sub-optimal adherence result in virologic failure and the development of drug-resistant forms of HIV that can undermine the effectiveness of HAART and limit future treatment options for individuals, but on a societal level this can lead to an increased prevalence of HIV resistant strains in communities, which can severely compromise South Africa's fight against HIV and AIDS (Laurence, 2004; WHO, 2006). These outcomes are particularly devastating in resource-limited settings and developing countries where treatment options are severely limited and second line ARV regimens are extremely costly (Nam, Fielding, Avalos, Dickinson, Gaolathe, Geissler, 2008).

Cohorts studies in sub-Saharan Africa have shown that adolescents are less likely to adhere to ARV's than adults (Nachega JB, Hislop M, Nguyen H, Dowdy DW, Chaisson RE, Regensberg L, Cotton M, Maartens G., 2009), and have lower survival compared to younger children (Bakanda C, Birungi J, Mwesigwa R, Nachega JB, Chan K, Palmer A, Ford N, Mills EJ., 2012). Despite increasing research in developed countries, studies on the special needs of HIV-infected adolescents in sub-Saharan Africa are scant.

Two key predictors of well-being, viral suppression and survival have been identified among HIV-infected patients since the advent of ARV's:

1) Engagement and retention in care (Mugavero MJ, Lin HY, Willig JH, Westfall AO, Ulett KB, Routman JS, Abroms S, Raper JL, Saag MS, Allison JJ, 2009)
2) Adherence to ARV's (Kahana SY, Rohan J, Allison S, Frazier TW, Drotar D, 2012).

With regard to point one, in South Africa patients aged 13 years or more are typically seen by generalist or adult medicine providers, in an environment where multi-disciplinary care is currently unavailable for the vast majority of patients. With regard to the second point, adherence is a complex dynamic behaviour influenced by characteristics of the individual, the clinical setting, the relationship between the clinical provider and individual, the treatment regime, the disease, and the surrounding context in which the individual lives, and the health care system. These relationships can be reciprocal and reinforcing and, as a result, an individual's level of adherence can change over time (Ammassari et al., 2002; Ickovics & Meade, 2002; Kagee, 2008). According to Skhosana, Struthers, Gray, and McIntyre (2006), adherence is a process that requires adjustment over time and across different aspects of an individual's lifestyle.

South Africa is currently home to the highest number of HIV-infected people (5.7 million) in the world (UNAIDS, 2009). According to antenatal clinic data, KwaZulu-Natal (KZN) has the highest HIV prevalence of any province in South Africa (National DoH, 2008). Most of these individuals acquire HIV in the second or third decades of life, with young females at highest risk; approximately 10% of adolescent girls aged 15-19 years are infected, rising to 50% in the 25-29 year age range (Welz T, Hosegood V, Jaffar S, Batzing-Feigenbaum J, Herbst K, Newell ML., 2007).

The Greater Edendale Area (GEA) on the outskirts of Pietermaritzburg sits in the heart of this epidemic, home to approximately 300,000 people and high levels of poverty, unemployment and violence. Edendale hospital (EDH) is an 860-bed district and regional facility located within the GEA. Although HIV counselling and testing (HCT) is offered through this facility, resources to meet the specific needs of adolescents living with HIV are sparse. In response to meeting the sexual and reproductive health needs of adolescence in the GEA, The Africaid Trust launched the WhizzKids United (WKU) programme in 2006 and launched its WKU Health Academy within the grounds of EDH in 2010.

The WhizzKids United programme is designed to engage youth in HIV & AIDS prevention, care, treatment and support through the universal language of football. Engagement of youth in GEA begins in school life orientation lessons with WKU's 'On the Ball' life

skills curriculum which uses each facet of 'the beautiful game' to interpret and illustrate valuable life skills. The programme strives to overcome the motivational problems of 'conventional HIV prevention programmes' by harnessing the youth's passion for football to establish essential skills in their daily life behaviour. Understanding a goal in football is easy but what about a goal in life? To score a goal in football you have to beat the defenders and the goalkeeper but what obstacles do you have to overcome in life to achieve your goals? How do you prevent HIV infection becoming your biggest obstacle in life? Without rules in football the game isn't fun but does the same apply to life? These are some of the questions that are explored by boys and girls. On completion of the 16 session curriculum youth are encouraged to attend the WKU Health Academy for one-on-one three monthly sexual health risk assessment and HIV counselling and testing, HCT. First however, they take part in a graduation ceremony - a World Cup football tournament with each team of six (three boys and three girls) representing one of the thirty two teams which played in the FIFA 2010 World Cup™!

WKU Health Academy is a stand-alone 'youth friendly' clinic built within the grounds of EDH. The word 'academy' resonates far more positively with youth than the word 'clinic'.

The WKU Health Academy has a staff compliment of 1 part-time Doctor, 4 Nurses, 4 Lay Counsellors, 4 Community Life Skills Trainers/Counsellors, 1 orphan and vulnerable (OVC) cook and 3 Admin Clerks. The Professional staff contingent is salaried by EDH whilst managed by The Africaid Trust. In promoting a 'youth friendly' culture, staff not only meet and converse with adolescents and their families on their own level, but also dress in Liverpool FC or Nike shirts, both partners of the programme, creating a more informal atmosphere. Uniforms are regarded as to formal and "off putting" by the youth.

Youth attending sexual health risk assessment are at the same time evaluated for OVC status according to UN guidelines on OVC determinants. Through these regular assessments and counselling sessions the required health services are then identified and provided to the young person within the Health Academy. These comprehensive services offered under one roof include amongst many others, one-on-one counselling, couple counselling, rape counselling, adherence support group using football and individual counselling, family planning, treatment and management of sexually transmitted diseases, ARV treatment, management and support.

On entering the Health Academy youth are put at ease by the welcoming and warm staff coupled with bright coloured surrounds. Age and interest-appropriate magazines, pop corn and TV occupy the short waiting times.

Recreational and educational activities help to draw youth into the Academy. Such activities including homework clubs, internet centre, drama, arts and crafts, dance, choir, sports and mixed gender football league not only help retain youth, but they also allow staff to develop a more complete understanding of patients. Regular rapport helps build up trust allowing staff to optimise the bio-psychosocial aspects of the youth's lives which helps improve adherence in HIV positive youth.

On-going weekly internal training for staff including adolescents , their behaviour, biological, physiological, social and psychological changes and adolescence adherence counselling encourages the unique needs of youth to be central in all services offered.

Sipho (name changed) is typical of so many youth receiving ARV treatment. Sipho, 15 years of age was referred to the Health Academy from a local hospital as he relocated to live with his Grandmother due to the loss of his Mother to HIV. He has been on ARV's for 7 years and for the first 4 years responded well to treatment, notably due to his caregiver giving him his medication. Last year his viral load fluctuated due to challenges with adherence as an adolescent responsible for taking his own medication. He was still not informed of his status and was experiencing treatment fatigue. During home visits to assess need for support, a WKU lay ccounsellor would meet with the Grandmother to discuss the need for full disclosure to Sipho. After much counseling with the grandmother, the counsellor disclosed Sipho's status to him. Like so many adolescents faced with the same news, he defaulted on his treatment. Coming to terms with the resentment of not being told his status by his mother, coupled with anger, guilt, stigma, the permanency of HIV and embarrassment were challenges Sipho faced. The counsellor had to support Sipho during a time when he was tired of the responsibility of caring for himself when his peers appeared to be leading carefree lives.

Successful management of HIV and AIDS through the use of ARV's requires an adherence rate of 70-95%, which will prevent the emergence of resistant strains of HIV and reduce viral load to undetectable levels.

Since the beginning of ARV treatment in October 2011, of the approximately 300 regular defaulters to treatment that have been transferred for treatment at the Health Academy, there has been a marked improvement in adherence in 87% of cases.

As the Health Academy develops with its very limited funding supply the hope is that this model will be replicated in partnership with the Department of Health. ℞

References

1) Gortmaker SL, Hughes M, Cervia J, et al. Effect of combination therapy including protease inhibitors on mortality among children and adolescents infected with HIV-1. New Engl J Med 2001;345:1522-8.

2) Centers for Disease Control and Prevention. HIV among Youth. Atlanta: US Department of Health and Human Services; 2011. Available at www.cdc.gov/hiv/youth/pdf/youth.pdf.

3) Meel BL. Incidence of HIV infection at the time of incident reporting, in victims of sexual assault, between 2000 and 2004, in Transkei, Eastern Cape, South Africa. Afr Health Sci 2005;5:207-12.

4) Chesney, M. (2004). Review – adherence to HAART regimes. In J. Laurence, Medication adherence (pp. 17-26). New York: Mary Liebert, Inc.
Bangsberg DR. Less than 95% adherence to nonnucleoside reverse-transcriptase inhibitor therapy can lead to viral suppression. Clin Infect Dis. 2006;43:939-941

5) Laurence, J. (2004). Introduction: The challenge of medication adherence in HIV/AIDS and the consequences of adherence failure. In J. Laurence, Medication adherence (pp. 1-10). New York: Mary Liebert, Inc.

6) Nam, S. L., Fielding, K., Avalos, A., Dickinson, D., Gaolathe, T., Geissler, P. W. (2008): The relationship of acceptance or denial of HIV-status to antiretroviral adherence among adult HIV patients in urban Botswana. Social Science & Medicine 67, 301–310.

7) Nachega JB, Hislop M, Nguyen H, Dowdy DW, Chaisson RE, Regensberg L, Cotton M, Maartens G. Antiretroviral therapy adherence, virologic and immunologic outcomes in adolescents compared with adults in southern Africa. J Acquir Immune Defic Syndr 2009;51:65–71.

8) Bakanda C, Birungi J, Mwesigwa R, Nachega JB, Chan K, Palmer A, Ford N, Mills EJ. Survival of HIV-infected adolescents on antiretroviral therapy in Uganda: findings from a nationally representative cohort study in Uganda. PLoS ONE 2011;6:e19261.

9) Mugavero MJ, Lin HY, Willig JH, Westfall AO, Ulett KB, Routman JS, Abroms S, Raper JL, Saag MS, Allison JJ. Missed visits and mortality among patients establishing initial outpatient HIV treatment. Clin Infect Dis 2009;48:248-56.

10) Kahana SY, Rohan J, Allison S, Frazier TW, Drotar D. A meta-analysis of adherence to antiretroviral therapy and virologic responses in HIV-infected children, adolescents, and young adults. AIDS Behav 2012. DOI 10.1007/s10461-012-0159-4.

11) Ammassari, A. et al., (2002). Correlates and predictors of adherence to highly active antiretroviral therapy: Overview of published literature. Journal of Acquired Immune Deficiency Syndrome, 31, S123-S127.

12) Skhosana, N. L., Struthers, H., Gray, G. E., & McIntyre, J. A. (2006). HIV disclosure and other factors that impact on adherence to antiretroviral therapy: The case of Soweto, South Africa. African Journal of AIDS Research, 5, 17-26.

13) UNAIDS. AIDS epidemic update. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO); 2009.

14) National Department of Health. The National HIV and Syphilis Prevalence Survey, South Africa, 2007. Pretoria: National Department of Health; 2008

15) Welz T, Hosegood V, Jaffar S, Batzing-Feigenbaum J, Herbst K, Newell ML. Continued very high prevalence of HIV infection in rural KwaZulu-Natal, South Africa: a population-based longitudinal study. AIDS 2007;21:1467-72.

Youth Friendly Clinics

In partnership with the Department of Health, loveLife is running its Adolescent and Youth Friendly Services Programme in some public clinics in South Africa. Through the programme, a variety of health services are made more easily accessible to young people, writes Thandiwe McCloy

Young people have also been too afraid to access sexual and reproductive health (SRH) services at clinics, fearing judgmental attitudes from staff. Included in the training provided by love Life is the importance of all clinic employees treating young people with the utmost respect, non-judgmental attitudes and professionalism as well as keeping sensitive issues they discuss confidential.

In line with its efforts to encourage young people to take a holistic approach to caring for their health, loveLife is running its Adolescent and Youth Friendly Services (AYFS) programme in 479 primary health care clinics throughout South Africa.

The overall objective of AYFS is to provide a package of services that is primarily moulded to maintain optimum health and good lifestyle practices among youth and adolescents.

As South Africa's largest HIV prevention programme for young people, loveLife implemented its AYFS initiative in 2000 to ensure that health services are acceptable, accessible, affordable, available and effective for youth through on-going mentoring and support.

Dr Memory Muturiki, the Executive Manager of AYFS, explains that the programme endeavours to optimise the use of available community resources in providing a comprehensive health services package to young people. "Other objectives of the programme are integrating health promotion information, including HIV prevention messaging in all settings where young people live, work and engage in sports and other recreational activities," adds Dr Muturiki.

In striving to encourage youth to access clinic services, AYFS includes loveLife Senior Technical Advisors training Master Trainers at clinics at the Provincial and District level. As part of the training is how to develop attitudes, values and perceptions that are more friendly and supportive to young people accessing health services. These Master Trainers then go on to impart this information to all clinic employees – including health care workers, grounds men, clerks and cleaners, and all those who come into contact with young people at clinical projects. The reason for this training is that there have been cases of clinic staff not giving young people the services they need because they believe it's more important to turn their time and attention to older patients who tend to suffer more ailments.

Young people have also been too afraid to access sexual and reproductive health (SRH) services at clinics, fearing judgmental attitudes from staff. Included in the training provided by loveLife is the importance of all clinic employees treating young people with the utmost respect, non-judgmental attitudes and professionalism as well as keeping sensitive issues they discuss confidential.

"In this way, a welcoming and supportive environment is created for youth, increasing their chances of coming to clinics for information and services, returning when they need to and recommending these services to friends," says Dr Muturiki.

The AYFS Programme at clinics offers a range of SRH services, including condoms, contraceptive education and provision, various contraceptive methods, with an emphasis on dual method protection as well as male and female condom demonstrations.

Through AYFS, young people can also access HIV Counselling and Testing (HCT), pregnancy testing and counselling, and antenatal and post natal care. In some clinics, antiretrovirals are dispensed. Available services also include treatment and education on sexually transmitted infections (STIs), pre and post counselling for Termination of Pregnancy (TOP) and referrals for TOP. Referrals to organisations offering support for drug and substance abuse as well as advice on oral health are also part of the package. By using these amenities, young people reduce their risk of unplanned pregnancy, contracting HIV and other STIs. They are also able to benefit from loveLife's brochures and publications supplying a wealth of positive lifestyle and healthy sexuality information.

Aside from offering SRH services and information, AYFC provides treatment for tuberculosis, chronic diseases, disability and injuries. As part of AYFC are also general health tests, such as glucose and anaemia tests. Education, counselling and appropriate referral for sexual exploitation, violence and abuse as well as various other mental health issues are also available.

Dr Muturiki adds that through AYFS, young people are able to access services in separate rooms from adults, so

contributing to greater confidentiality for them.

In promoting a holistic approach to health, AYFC staff also provide youth with information on the importance of a balanced diet and regular exercise.

To give young people the information and motivation they need to make healthy lifestyle choices, loveLife groundBREAKERS (gBs) and Mpintshis - peer motivators and community mobilisers - implement loveLife's healthy sexuality and positive lifestyle programmes at clinics running the AYFC initiative. These programmes are also available in schools, community-based organisations and loveLife Y-Centres (youth centres) throughout South Africa.

Young people can also benefit from valuable information in health talks delivered by gBs and Mpintshis through the AYFC initiative.

This comprehensive package of AYFC services focus on priority areas of adolescent and youth health decided on through consultations between the Department of Health, loveLife, the World Health Organisation and other key stakeholders.

To be registered as an AYFC, clinics need to provide health services in these priority areas. They have to meet five minimum standards which include Management System Support for effective provision of adolescent and youth programmes through capacity development of the manager and service providers. They have to be appropriate to the needs of adolescents and youth, accessible and available to them at times that are convenient. Staff also needs to have been trained on the importance of embodying attitudes, values and perceptions that are friendly towards young people accessing SRH services. Clinics need to have the drugs, medical supplies and equipment to provide the essential service package and ensure that proper referral systems are in place at different settings and at all levels of health care.

Due to the success of AYFS, mechanisms are currently being put in place to ensure that the programme is implemented across South Africa with quality, consistency and sustainability.

Clinics achieving these minimum standards will be recognised as implementing AYFS. However, they are still expected to commit to eventually achieving all 10 norms and standards of AYFS, which include healthcare workers providing relevant health and wellness information to young people in various settings, such as schools, youth centres, places of safety and workplaces.

"Many young people tend to only come to the clinic when they are ill," explains Dr Muturiki. "By healthcare workers providing health education to

youth in the broader community, they can play a powerful role in promoting preventative care. They also decrease the number of youth coming to clinics, so reducing the burden on our health systems."

As part of AYFC, loveLife trains healthcare workers in primary health care clinics to carry out periodic re-assessments that determine the extent to which their facility has improved its youth friendliness.

Due to the success of AYFS, mechanisms are currently being put in place to ensure that the programme is implemented across South Africa with quality, consistency and sustainability.

Aside from being available in public health clinics, AYFS is also implemented at clinics in seven loveLife Y-Centres (youth centres). In total, loveLife has 20 Y-Centres across South Africa which offers young people healthy sexuality and positive lifestyle information, sports activities and skills development opportunities.

Y-Centre clinics are called Vitality Rooms and offer services similar to those at AYFS.
Botlhale Mokwape is a nurse and line manager at the Vitality Room in the Royal Bafokeng Y-Centre, situated in Luka in the North West Province. She explains that young people mostly visit the Vitality Room for HCT, contraceptives and treatment of STIs. In future, she would like to do more school visits and door-to-door campaigns to make young people more aware of Vitality Room services and encourage them to use the facility. "There are still perceptions among youth that if you go to a clinic for SRH services, the nurse will judge you," says Botlhale. "Some believe myths about contraceptives making you infertile. I want more young people to come to the Vitality Room so they can receive correct health information. I want them to know that they will be treated with respect and receive the help they need."

While she enjoys her work, she says it can be difficult to get older youth to use condoms. "Some of them say they can't use condoms with their baby's father as they've been together for a long time. I tell them that HIV and STIs don't discriminate between long and short term relationships and there is no measuring stick to check if your partner is cheating on you."

But Botlhale gets a great sense of satisfaction when young people comply to contraceptives, adding that she always reminds them to use dual method contraception.

"I also really enjoy informing young people about healthy lifestyle living, such as the dangers of drinking and smoking and the importance of good nutrition and regular exercise," she says. "In this way, youth are taught about the huge value of leading positive lifestyles from a young age and will hopefully put their knowledge into practice throughout their lives. This way, we help to prevent levels of morbidity and chronic disease in our country."

Mpho Mokuoa (24) is just one of the young people who benefits from the Vitality Room at the Bafokeng Y-Centre. "I mostly go for HCT, while some of my friends go there for contraceptives," she says. "Whenever something isn't right with my body, like when I sometimes get pimples during my period, I come to the room for treatment.

"The nurse there is friendly, easily approachable and answers any questions I have. The service is good and it's great that it's free. At the Vitality Centre, the service is quicker than at clinics, where you often have to wait in long queues." R

CHIVA South Africa

By: A Armstrong[1], Z Sobantu[1], J Houghton[1], K Naidoo[1,2], K Moshal[1,3]

[1]CHIVA SA, KwaZulu Natal, South Africa; [2]Department of Paediatrics, University Of KwaZulu Natal, South Africa; [3]Department of Infectious Diseases, Great Ormond Street Hospital for Children, London, United Kingdom; CHIVA Africa, United Kingdom.

A Armstrong – BNS, RGN, NMP, Dip TN, DTM+H, MSc Int. Health
Z Sobantu – BCUR (Hons), RGN, RGM, CHN, Occ.HN
J Houghton – RGN, RSCN, Dip TN, MsC Soc Anth
K Naidoo – MBcHB, DCH, FC (Paeds)
K Moshal - MBChB, MRCP (UK), MRCPCH, DTM+H

Our mission is to improve the skills and confidence of healthcare professionals caring for and treating children and adolescents with HIV and their families, allowing them to scale up their services and provide long-term quality care to their patients.

CHIVA South Africa is a non-government organisation that facilitates the sharing of knowledge, skills and experience in the treatment of HIV-infected children and adolescents with government healthcare professionals. In providing practical support, mentorship and teaching we work with all disciplines of healthcare staff to assist with task shifting and role development. CHIVA South Africa started in September 2004, as a collaborative project between CHIVA (Children's HIV Association of the UK and Ireland), the University of KwaZulu-Natal and the Department of Health (DoH) of KwaZulu-Natal (KZN). Since then the programme has expanded to the Eastern Cape Province (2008) and the North West Province (2010).

Our mission is to improve the skills and confidence of healthcare professionals caring for and treating children and adolescents with HIV and their families, allowing them to scale up their services and provide long-term quality care to their patients.

Our main objectives are:

1) Teaching

- To provide practical and technical support for all members of the multi disciplinary team.
- To produce relevant, comprehensive, practical teaching resources based on local guidelines.

2) Partnering

- To work closely with the provincial Departments of Health to assist them in the implementation of local and national policies for paediatric and adolescent health care delivery.
- To support key staff at provincial hospitals and associated health facilities on a regular basis.
- To increase our in-country volunteer base from within South Africa's health and NGO sectors, for the benefit of both the volunteers themselves, the health professionals they teach and mentor, and to ensure the quality and sustainability of our programmes.

3) Replicating

- To expand to other provinces of South Africa and elsewhere in Africa.
- To promote continued learning through provision of free teaching resources.

Adolescent Programme

In 2008, in response to the observed growing needs and on the request of health care professionals involved with the pediatric programme, CHIVA South Africa launched their dedicated Adolescent Programme. Adolescents living with HIV need to be able to access, and be retained in, services. This impacts their quality of life and life expectancy, as well as aiding the prevention of new HIV infections. The requirement for health services to address adolescents' needs creates unique challenges for health professionals who are committed to providing adolescents living with HIV the highest quality support and the most effective health services. Health services need to make a concerted effort to reduce barriers to, and challenges within, services to ensure delivery of quality HIV care. To address the needs of this growing cohort and the health professionals who look after them, further teaching, mentorship and health system strengthening is required.

The CHIVA SA adolescent programme develops and delivers workshops, seminars and master classes aimed at healthcare professionals treating adolescents in KwaZulu Natal, as well as supporting potential strategies to address the health system challenges in providing services to adolescents living with HIV. The 2012/2013 workshop series is being held in all districts of KwaZulu Natal. All healthcare professionals working with adolescents (aged 10 -19 years old) living with HIV, whether based in adult, pediatric or primary health care settings are invited to attend. District HIV, AIDS, STI's and TB (HAST) coordinators and operational managers, assist in identifying the multidisciplinary team members who would most benefit from these workshops. Already in 2012, our current workshop series has been delivered in 6 districts of KZN with over 900 participants attending from all healthcare disciplines.

Our current workshop series is based on participatory learning and action approaches to engage the experience of health care professionals that are attending. It includes four workshops covering adherence, disclosure, sexual and reproductive health and adolescent friendly services, which incorporate themes of multidisciplinary working, collaboration and counselling. Each workshop gives participants the opportunity to explore challenges, identify key guiding principles and put into practice the skills they have learnt.

Each year the programme is modified following analysis of participant feedback and identification of priority areas for future support. This has allowed for each series of teaching to build upon the previous, ensuring continuous learning and ensuring that we are responsive to the learning needs of healthcare professionals and the adolescents they serve.

Although adolescent HIV care is a growing healthcare focus in South Africa, other countries that have had access to ART for longer periods have been managing the care of adolescents living with HIV for over a decade. To draw upon their experiences and to learn from their challenges, CHIVA South Africa invites both local and international multidisciplinary experts in the field to volunteer their time

to facilitate teaching and mentoring. Additionally, in partnership with love Life we have the privilege of having the expertise and insight of local young South African ground BREAKERS to facilitate our youth friendly services workshops.

In addition to our current workshop series, in 2013 we will be:

- Hosting a master class on the Clinical Management of Adolescent HIV
- Working with key stakeholders to develop provincial strategies for service provision to adolescents living with HIV
- Providing support to clinics in their development of adolescent HIV services and support services.

Below, in their own words, participants in 2012, share their experience of the CHIVA South Africa adolescent programme:

- *'With youth friendly service I learnt that simple changes with no money make dramatic effect. My attitude being the first thing to change'*
- *'This workshop empowers people in area that needs more attention!'*
- *'As a school nurse I will be more aware of adolescents living with HIV issues. This workshop will help me to assist them especially with adherence'*
- *'I have not thought about how to empower an adolescent to adhere to treatment rather than just tell them what to do! This will now change'*
- *'I will be more respectful to my patients and listen more plus understand adolescents more'*

Quotes from facilitators in 2012:

- *'It has been a super week! It has really improved my facilitations skills. It was nice to have healthcare workers value our views as young people despite their age or profession'*
- *'The workshops were very informative. It was great to interact with other volunteers from around the world. Also as a young person it was a great opportunity to advocate for other young peoples service delivery needs'*
- *'Being part of this experience made me realised how much I love my job and reinforce the reason why I'm doing it'*
- *'The workshop was more of facilitation than it being a lecture, that gave people a chance to give their participation and it served also as a platform for facilitators to learn from participants'*

Adolescents living with HIV need to be able to access, and be retained in, services. This impacts their quality of life and life expectancy, as well as aiding the prevention of new HIV infections.

- CHIVA South Africa resources, as well as links to other helpful resources, are available through our web site – **www.chiva-africa.org**
- Visit our Facebook page which is updated regularly with resources, workshops and recent research on paediatric and adolescent HIV – **www.facebook.com/CHIVAAfricaPage**
- From more information regarding adolescent HIV and provision of services contact alice.armstrong@chiva-africa.org
- For the paediatric programme contact juliet.houghton@chiva-africa.org or zameka.sobantu@chiva-africa.org R

Test your knowledge Quiz

1. By what percentage does VMMC reduce a man's risk of acquiring HIV infection?

2. VMMC can only be performed in a hospital set up. True or False

3. Successful management of HIV and AIDS through the use of ARV's requires an adherence rate of 70%-95%, to prevent the emergence of resistant strains of HIV. True or False

4. The increase in access to antiretroviral therapy (ART) means more children who were infected through mother to child transmission are surviving into adolescence and adulthood.True or False.

5. According to the National DoH, 2012, which province in South Africa has the highest HIV prevalence?

6. Between 25%-90% of school-aged HIV positive children are unaware of their own status, regardless of going to the clinic every 3months to pick up treatment. True or False.

7. In children, severity of HIV disease and delayed ART treatment impact cognitive, academic, and social functioning as well as psychiatric symptoms. True or False.

8. According to the Children's Act (Act 38, 2005), at what age can a child consent for an HIV test?

9. According to current PMTCT guidelines, HIV positive pregnant women in South Africa are being given Option B+. True or False.

10. Which patients are prioritised to be the first group to receive fixed dose combination(FDC)?

Get all the answers on the next page (Page 50)

Answers to the Quiz questions

1. VMMC reduces men's risk of acquiring HIV through heterosexual intercourse by approximately 60%. From this Article *"Voluntary Medical Male Circumcision and Adolescents: An opportunity for nurses to contribute to an HIV free generation"*

2. False: **Age appropriate care** - VMMC is currently provided in a variety of setting, including hospitals, clinics and mobile sites. From this article *"Voluntary Medical Male Circumcision and Adolescents: An opportunity for nurses to contribute to an HIV free generation"*

3. True: Successful management of HIV and AIDS through the use of ARV's requires an adherence rate of 70 - 95%, which will prevent the emergence of resistant strains of HIV and reduce viral load to undetectable levels (Chesney, 2004; WHO, 2006; Bangsberg, 2006). From this article *"Improving engagement, retention of care and ARV treatment adherence amongst adolescents through the WhizzKids United programme introduced by The Africaid Trust in Edendale, Umgungundlovu District, KwaZulu Natal"*

4. True: The increase in access to antiretroviral therapy (ART), means more children who were infected through mother to child transmission are surviving into adolescence and adulthood. From this article *" 'Vaku vaku'. 'Iturr nash'. 'Spaka paka'.* The Sexual and Reproductive Health Needs of Adolescentsliving with HIV"

5. According to antenatal clinic data, KwaZulu-Natal (KZN) has the highest HIV prevalence of any province in South Africa (National DoH, 2012). From this article *"Improving engagement, retention of care and ARV treatment adherence amongst adolescents through the WhizzKids United programme introduced by The Africaid Trust in Edendale, Umgungundlovu District, KwaZulu Natal"*

6. True: As a result, between 25%-90% of school-aged HIV positive children are unaware of their own status (Close, 2003) regardless of going to the clinic every 3 months to pick up treatment. From this article *"The psychosocial challenges of HIV positive youth: the silent epidemic"*

7. True:Severity of disease and delayed ART treatment impacts cognitive, academic, and social functioning as well as the psychiatric symptoms. From this article *"BEHAVIORAL, PSYCHIATRIC, AND COGNITIVE PROBLEMS IN ADOLESCENTS WITH PERINATAL HIV INFECTION: UNRECOGNIZED CONSEQUENCES"*

8. Anecdotal reports suggest that access to HIV Counselling and testing for adolescents remains challenging despite clear guidance from the Children's Act (Act 38, 2005) that children 12 years and older with sufficient maturity can independently consent for an HIV test. From the *"Guest Editorial comments."*

9. South Africa's current PMTCT guidelines are in line with WHO's 2010 guidelines, offering a similar 'Option A' From the *"NEWS articleWhat are PMTCT Options A/B/B+?"*

10. All new patients and pregnant and breastfeeding women who can take a tenofovir based regimen with EFV are in the first two groups. From *"The President's comments"*

FIDSSA 5

Changing Attitudes

5th FIDSSA CONFERENCE
Champagne Sports Resort Drakensberg
KwaZulu Natal, South Africa

- Antibiotic stewardship
- HIV and TB
- Multi-resistant Gram negatives
- Insights from the microbiome
- Infectious Diseases in marginalised populations and mass gatherings
- Current vaccination challenges and controversies
- New therapeutics
- Frontiers in diagnostics
- Workshops and training

For further information contact the FIDSSA Conference Office
Tel: +27 (0)11 463 5085 Fax: +27 (0)11 463 3265
email: erna@soafrica.com, janice@soafrica.com
www.fidssa.co.za

NDOH/SANAC Nerve Centre Hotlines

- Any HCT concerns from facility and district managers should be reported to the NDOH/SANAC

Nerve Centre Hotline and, specific emails for each province:

- **Western Cape:** 012-395 9081 sanacwesterncape@gmail.com
- **Northern Cape:** 012-395 9090 sanacnortherncape@gmail.com
- **Eastern Cape:** 012-395 9079 sanaceasterncape@gmail.com
- **KZN:** 012-395 9089 sanackzn@gmail.com
- **Free State:** 012-395 9079 sanacfreestate@gmail.com
- **Mpumalanga:** 012-395 9087 sanacmpumalanga@gmail.com
- **Gauteng:** 012-395 9078 sanacgauteng@gmail.com
- **Limpopo:** 012-395 9090 sanaclimpopo@gmail.com
- **North West:** 012-395 9088 sanacnorthwest@gmail.com

AIDS Helpline 0800 012 322

The National Toll free AIDS Helpline was initiated in 1991 by the then National Department of Health's (NDoH) "HIV/AIDS, STD's and TB Directorate". The objective of the Line is to provide a national, anonymous, confidential and accessible information, counselling and referral telephone service for those infected and affected by HIV and AIDS, in South Africa.

In 1992, LifeLine was requested by NDOH, to take over the management of the Line by rotating it between the thirty-two existing community-based LifeLine Centres, and manning it with volunteer counsellors. In 2000, in response to an increasing call rate, a centralised Counselling Centre was established in Braamfontein, Johannesburg, to house the AIDS Helpline

The AIDS Helpline a national toll-free, operates on a 24/7 basis and is utilized by people from all walks of life in urban and rural areas, in all eleven languages at no cost from a landline telephone.

Annually, the Line provides anonymous, confidential and accessible telephonic information, counselling and referrals to over 300 000 callers.

The AIDS Helpline plays a central role in providing a deeper preventative and more supportive service to those infected and affected by the disease, but also serving as an entry point in terms of accessing services from government, private sector and other NGOs/ CBOs

Cases presented to the range from testing, treatment, transmission, TB, Medical Male circumcision, etc.

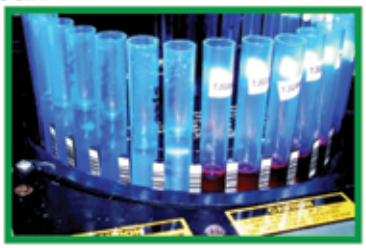
The AIDS Helpline incorporates the Treatment line. The treatment support services were included to complement the services provided by lay counsellors on the line. The Treatment Line is manned by nurses who provide quality, accurate, and anonymous telephone information and/or education on antiretroviral, TB and STI treatment

NATIONAL HEALTH
LABORATORY SERVICE

RESULTS HOTLINE

0860 RESULT 737858

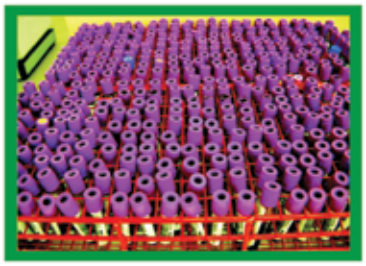
This line is dedicated to providing results nationally for HIV Viral Load, HIV DNA PCR and CD4 to Doctors and Medical Practitioners, improving efficiency in implementing ARV Treatment to HIV infected people. This service is currently available to members of Health Professionals Council of the South Africa and the South African Nursing Council. The hotline is available during office hours from 8am to 5pm Monday to Friday.



Register to use the RESULT HOTLINE

Follow this simple Step-by-step registration process

Dial the HOTLINE number 0860 RESULT (737858)
Follow the voice prompts and select option 1 to register to use the hotline
A hotline registration form will be sent to you by fax or e-mail.
Complete the form and return it by fax or e-mail to the hotline to complete your registration process.
Once you are registered, you will be contacted with your unique number. This number is a security measure to ensure that the results are provided to an authorized user.



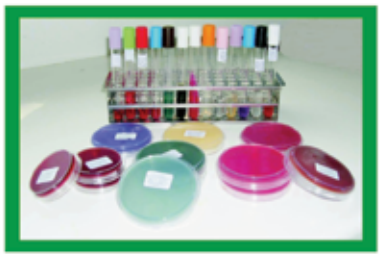
To use the hotline dial 0860 RESULT (737858)

Select option 2 to access laboratory results.

- You will be asked for your HPCSA or SANC number by the operator.
- You will be asked for your Unique Number.
- Please quote the CCMT ARV request form tracking number (bar coded) and confirm that the result requested is for the correct patient.

Should the results not be available when you call, you will be provided with a query reference number which must be used when you follow up at a later date to obtain the result.

Once you have a Reference number



Select option 3 to follow up on a reference number
Should the requested results not be available, a query reference number will be provided to you.
A hotline operator will call you within 48 hours of receiving the laboratory results.

Registering for this service from the NHLS, will assit in improving efficiency, providing improved patient care and streamlining clinic processes. Call now and register to access results for HIV Viral Load, HIV DNA PCR and CD4.

9th Public Health Association of South Africa (PHASA) conference and the inaugural conference of the African Federation of Public Health Associations (AFPHA)

Africa's Public Health Legacy - Beyond the MDGs

24 - 27 September 2013

The 9th Public Health Association of South Africa (PHASA) conference and the inaugural conference of the African Federation of Public Health Associations (AFPHA) will be held jointly in Cape Town at the International Convention Centre.

CONFERENCE DATES

24 September 2013	Student Assembly
	World Federation of Public Health Association's Workshop
25 September 2013	Skills-building Workshops
26-27 September 2013	Main Conference

CALL FOR ABSTRACTS *(Conference official language is English)*

PHASA & AFPHA are now calling for abstracts for the 2013 Conference. Authors should submit abstracts online by no later than **21 May 2013.**

Track 1: Leadership for a lasting legacy
Track 2: Social determinants of health
Track 3: Burden of disease, disability and population health
Track 4: Improving the performance of the health system
Track 5: Policy advocacy and Community action for public health
Track 6: Public Health Education, Teaching and Training

SPECIAL CONFERENCE FEATURES

- Abstract Mentorship Programme
- Student assembly
- Satellite sessions
- Saving our planet-climate change focus
- Taking stock - Thinking futures – A moderated panel discussion

REGISTRATION

Early registration:	5 March – 30 July 2013
Late registration:	1 August – 13 September 2013

EXHIBITION

Do not miss the opportunity to network with industry innovators. Get in touch to learn more about exhibition opportunities at this event.

For more information, please visit the website at www.phasaconference.org.za

CONTACT DETAILS

MRC EVENT MANAGEMENT OFFICE
TEL: +27 21 938 0237
EMAIL: deon.salomo@mrc.ac.za

Right to care
TREATING AIDS SERIOUSLY

FOR YOUR CALENDAR: 21-24 May | Johannesburg | Sandton Sun Hotel

2013 Disability Summit

Disability & HIV/Aids

BEST PRACTICE

Policy Development and Integrating Disability & HIV/Aids Programmes in the workplace

Private & Public Sector

Who Should Attend?

- Occupational Health Care Practitioners,
- Peer Educators,
- Hiv/Aids Coordinators,
- Nurses/Doctors,
- Researchers,
- Special Programs Managers/Officers,
- Eap Managers/Officers And Service Providers,
- Psychiatrists,
- Training Managers/Officers/Coordinators,
- Care Givers,
- Social Workers,
- Hiv/Aids Researchers,
- Hiv/Aids Volunteers,
- Administrative Policy Coordinators,
- Hiv/Aids Counselors,
- Hr Managers/Officers,
- Vct Counselors,
- Wellness Practitioners,
- Government, Municipalities,
- Employment Equity Practitioners,
- Diversity Practitioners,
- Heads Of Departments/ Team Leaders
- All Relevant Personnel

Dr. Ali Bacher
Keynote Speaker
Opening Address

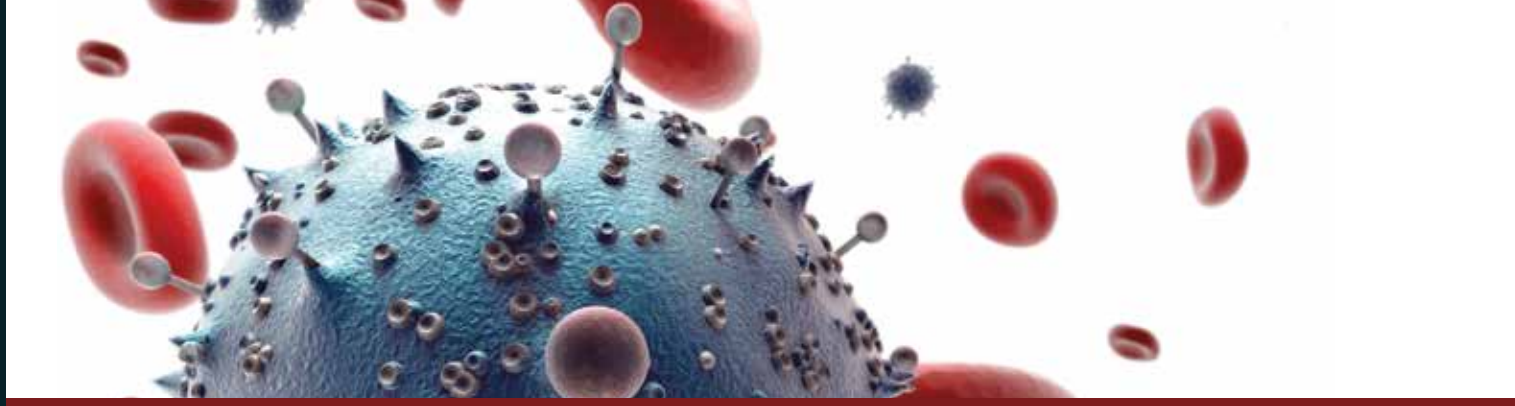
Right to care
TREATING AIDS SERIOUSLY

ROLLING
LIFELAB
SAFOD
USAID | SOUTHERN AFRICA
CDDRLP
HEARD
eafod

Includes
Special Educational tour of The Apartheid Museum, on the 24th of May

KasWare
Conferences and Trade Shows

Information: Conference solutions +27 11 791 4795 (Reception) | +27 11 075 4535
Fax: +27 (0) 86 588 1511 | +27 11 791 4965
info@kaswaretrade.com | www.kaswaretrade.com
145 Republic Road, Coll House, Fontainbleau, Johannesburg, Gauteng, South Africa



UNITING NURSES IN HIV CLINICAL EXCELLENCE, BECOME A MEMBER.

Who are we?

We are a member-based Society that promotes quality, comprehensive, evidence-based HIV health care, by:

1. **LEADING • PIONEERING**
   We are a powerful, independent voice within Southern Africa with key representation from the most experienced and respected professionals working in the fight against HIV.

2. **CONNECTING • CONVENING • ENGAGING**
   Through our network of HIV practitioners, we provide a platform for engagement and facilitate learning, camaraderie and clinical consensus.

3. **ADVOCATING • INFLUENCING • SHAPING**
   With our wealth and depth of clinical expertise, we can help health care workers take their practice to a new level. We are constantly improving and expanding our knowledge, and advocating for clinical and scientific best practice.

Member Benefits

Join today and gain instant support from a credible organisation. The Society helps connect you with the best minds in HIV health care. Build your knowledge, advance your profession and make a difference by getting involved now!

- Free quarterly subscriptions to the *Southern African Journal of HIV Medicine*
- Free monthly subscription to the Society's e-newsletter, *Transcript*
- E-learning through CPD-accredited clinical case studies and on-line discussion group forums
- Free quarterly subscriptions to *HIV Nursing Matters*
- Weekly SMS clinical tips for nurse members
- Free CPD-accredited continuing education sessions
- Listing in the Society's online HIV provider referral network

SOCIETY CONTACT DETAILS:

Tel: +27 11 341 0162 • **Fax:** +27 11 341 0161
Email: sahivsoc@sahivsoc.org

Post: Suite 233, Private Bag X2600, PostNet, Killarney, Houghton, 2041

www.sahivsoc.org