

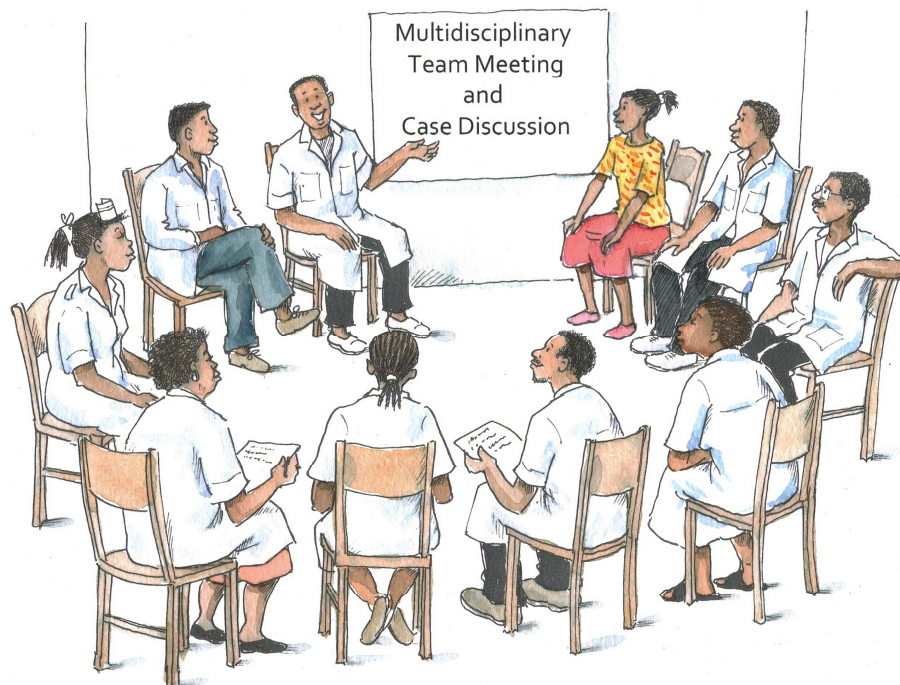
# Module 1 Introduction and Course Overview

Session 1.1:	Welcome and Introductory Activity
Session 1.2:	Training Objectives and Ground Rules
Session 1.3:	Training Pre-Test
Session 1.4:	Values Clarification

## Learning Objectives

After completing this module, participants will:

- Know more about the trainers and other training participants, and will have discussed expectations for the training
- Be able to explain the importance of a training specific to adolescent HIV care and treatment
- Understand the training objectives
- Have set training “ground rules”
- Have completed the training pre-test
- Have explored their own values and attitudes around adolescents and adolescent HIV care and treatment



## Session 1.1

## Welcome and Introductory Activity

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### Session Objective

After completing this session, participants will:

- Know more about the trainers and other training participants, and will have discussed expectations for the training

### Exercise 1: Getting to Know Each Other: Large group discussion and individual reflection

<b>Purpose</b>	<ul style="list-style-type: none"><li>• To provide an opportunity to get to know one another a bit better</li><li>• To create a comfortable learning environment</li><li>• To introduce and understand the role of the adolescent co-trainer/co-trainers (optional)</li><li>• To discuss participants' personal and professional strengths, their concerns about adolescent HIV care and treatment, and their expectations for the training</li></ul>
This exercise consists of 3 parts: <ul style="list-style-type: none"><li>• Part 1: Introductions</li><li>• Part 2: Individual Reflection</li><li>• Part 3: Large Group Discussion</li></ul>	

## Session 1.2

## Training Objectives and Ground Rules

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### Session Objectives

After completing this session, participants will:

- Be able to explain the importance of a training specific to adolescent HIV care and treatment
- Understand the training objectives
- Have set training “ground rules”

### Key Facts about Adolescents and HIV<sup>1, 2</sup>

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#### Global epidemiology

- In 2009, 41% of all new HIV infections (in people aged 15 and over) were among youth 15–24 years of age.
- 2 million adolescents aged 10–19 years are living with HIV (1.5 million of whom reside in sub-Saharan Africa).
- Slightly more than half of all people living with HIV are women or girls. In sub-Saharan Africa, young women aged 15–24 years are 8 times more likely than men to be HIV positive.
- Globally, deaths among children under 15 years of age are declining. An estimated 260,000 children died from AIDS-related illnesses in 2009 — this is approximately 19% fewer deaths than occurred in 2004. This trend reflects the steady expansion of PMTCT services and an increase in access to antiretroviral treatment for children.

#### Global knowledge and behavior

According to UNAIDS (2010):

- Among young people in 15 of the most severely affected countries, HIV prevalence has recently fallen by more than 25%. This decline is due to:
  - Increased adoption of safer sexual practices, including increased condom use
  - Delayed sexual debut
  - Reductions in multiple partnerships.
- Less than half of young people living in 15 of the 25 countries with the highest HIV prevalence can correctly answer 5 basic questions about HIV and its transmission.\*
- Young people aged 15–24 years who live in the 25 countries with the highest HIV prevalence have shown gradually improving knowledge about HIV, but they still fall short of global targets and what is necessary to keep them safe.

\* These countries include: Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d’Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Togo, Tanzania, and Zambia.

## Why a Training on Adolescent HIV Care and Treatment?

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- Young people are at the center of the HIV epidemic. They are particularly vulnerable to HIV infection due to social, political, cultural, biological, and economic reasons.<sup>3</sup>
- With increased access to pediatric HIV care and treatment, perinatally-infected children are living longer and reaching adolescence and adulthood.
- More young people are being tested for HIV because of increased awareness, reduced stigma, greater access and acceptance of testing, etc. In addition, more adolescents who are pregnant are being tested for HIV through PMTCT programs.
- ALHIV face unique health, adherence, and psychosocial issues and challenges.
- Programs and clinical services need to be youth-friendly to attract and retain adolescent clients.
- There are successful models of adolescent HIV care and treatment services in many cities across high-, medium-, and low-prevalence countries. These models can be adapted and scaled-up nationally.
- Health workers need the knowledge and skills to meet the specific needs of adolescent clients.
- Young people are our future!

## Adolescent HIV Care and Treatment Training Objectives

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### By the end of this training, participants will be able to:

1. Describe the stages and characteristics of adolescence and the unique needs and challenges of adolescent clients
2. Implement strategies to make HIV-related services youth-friendly
3. Define and implement the package of HIV-related care and treatment services for adolescents
4. Implement effective communication and counseling skills with adolescent clients
5. Conduct a psychosocial assessment and provide ongoing psychosocial support services to adolescent clients
6. Describe the importance of mental health services for adolescent clients, recognize when a mental health problem may exist, and provide appropriate referrals and support
7. Recognize the signs of and be able to screen for alcohol and substance use disorders among adolescents, and provide support and referrals
8. Provide developmentally-appropriate disclosure counseling and support to adolescents and, where appropriate, their caregivers
9. Provide developmentally-appropriate adherence preparation and ongoing adherence support to adolescent clients and caregivers
10. Support adolescents to live positively with HIV
11. Conduct sexual risk screening and provide non-judgmental, comprehensive counseling on sexual and reproductive health to adolescent clients
12. Provide basic, non-judgmental contraceptive counseling and services to adolescent clients
13. Describe the key components of PMTCT services for adolescents and provide referrals and support along the continuum of PMTCT care
14. Describe ways of linking adolescents with needed facility and community-based support services
15. Describe and implement activities to meaningfully involve adolescent clients in clinical services, such as through adolescent peer education programs
16. Prepare and support adolescent clients throughout the transition to adult care

17. Describe how monitoring and evaluation can be used to support adolescent HIV program improvements
18. Demonstrate core competencies in adolescent HIV care and treatment services in a clinical setting
19. Develop a site-specific action plan for implementing adolescent HIV care and treatment services

## **Adolescent HIV Care and Treatment Core Competencies**

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The “core competencies” are the skills that participants are expected to have mastered by the end of the training (they are listed in *Appendix 15B: Practicum Checklist*). They differ from the objectives (listed in the previous section) in that core competencies focus on specific skills, whereas objectives are sweeping statements that provide a summary of what is to be taught. There are 19 objectives for this course and approximately 60 competencies.

## **Training Syllabus and Agenda**

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The training includes 16 modules, each with its own learning objectives. Each module is divided into a number of sessions.

- Module 1: Introduction and Course Overview
- Module 2: The Nature of Adolescence and the Provision of Youth-Friendly Services
- Module 3: Clinical Care for Adolescents Living with HIV
- Module 4: Communicating with and Counseling Adolescents
- Module 5: Providing Psychosocial Support Services for Adolescents
- Module 6: Adolescents, HIV, and Mental Illness
- Module 7: Providing Disclosure Counseling and Support
- Module 8: Supporting Adolescents’ Retention in and Adherence to HIV Care and Treatment
- Module 9: Positive Living for Adolescents
- Module 10: Sexual and Reproductive Health Services for Adolescents
- Module 11: Family Planning and PMTCT Services for Adolescents
- Module 12: Community Linkages and Adolescent Involvement
- Module 13: Supporting the Transition to Adult Care
- Module 14: Monitoring, Evaluation, and Quality Improvement
- Module 15: Supervised Clinical Practicum
- Module 16: Action Planning, Course Evaluation, and Closure

## Exercise 2: Setting Ground Rules and Introducing Daily Activities: Large group discussion

### Purpose

- To develop and agree on a set of ground rules that will create an environment that facilitates learning
- To introduce the “*Anonymous Question Bowl*” as a safe space for asking questions
- To introduce the “*Morning Rounds*” as a way to start each day of the training off on the right foot
- To introduce the “*How Did it Go*” daily evaluation activity as a way of giving feedback to the trainers so they can make adjustments DURING the training course

This exercise consists of 3 parts:

- Part 1: Develop and Agree on Ground Rules
- Part 2: Introduction of the “*Anonymous Question Bowl*”
- Part 3: Introduction of the “*Morning Rounds*”
- Part 4: Introduction of the Daily Evaluation — “*How Did it Go?*”

## **Session 1.3                      Training Pre-Test**

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### **Session Objective**

**After completing this session, participants will:**

- Have completed the training pre-test

*See Appendix 1B: Pre-Test.*

## Session 1.4

## Values Clarification

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### Session Objective

After completing this session, participants will:

- Have explored their own values and attitudes around adolescents and adolescent HIV care and treatment

### Exercise 3: Values Clarification: Large group exercise

<b>Purpose</b>	To help participants begin to think about their own values, attitudes, and prejudices, as well as how these might either positively or negatively impact their work with adolescents
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The trainer will read a series of statements out loud. After each statement is read, move to the “agree” or “disagree” sign, based on your opinion. If you are not sure whether you agree or disagree with a statement, you can stand somewhere in-between the 2 signs.



## Appendix 1A: Sample Training Agenda

As this curriculum is modular, the training agenda is flexible. Although the curriculum can be completed in 10 consecutive days, it is recommended that the content be taught over a longer period of time. This is preferable because it allows participants to apply what they have learned and to bring those lessons back to the classroom. Teaching the content over a longer period of time also minimizes disruptions to clinical services.

### For example:

- Training could be conducted on 2 or 3 Fridays per month for 4 months, or on 2-3 consecutive days each month for 4-5 months (see sample agenda that follows).
- Alternatively, the training could be conducted 1 module at a time over a period of 15 half-days; for example, every other Friday morning for 30 weeks.

If training modules/days are split up over a period of time, it is recommended that the practical sessions in the clinic also be integrated into each phase of training so participants have opportunities to practice what they have learned shortly after the classroom sessions.

### Month A

<b>Day 1</b>	
Morning Session	<ul style="list-style-type: none"> <li>• Official Opening</li> <li>• Module 1: Introduction and Course Overview (2.5 hours)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Module 2: The Nature of Adolescence and the Provision of Youth-Friendly Services (3 hours, 20 minutes)</li> <li>• “How Did it Go?”</li> </ul>
<b>Day 2</b>	
Morning Session	<ul style="list-style-type: none"> <li>• Recap and “Morning Rounds”</li> <li>• Module 3: Clinical Care for Adolescents Living with HIV (4 hours, 30 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Module 3 (continued)</li> <li>• Prepare for clinical practicum</li> <li>• “How Did it Go?”</li> </ul>
<b>Practicum Session: 1-3 days</b> (practical sessions should be planned based on the availability of participants and preceptors, and the days and times when adolescents receive services)	
Morning Session	<ul style="list-style-type: none"> <li>• Recap and “Morning Rounds”</li> <li>• Clinical practicum, covering knowledge and skills in Modules 1-3</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Debrief on clinical practicum</li> <li>• “How Did it Go?”</li> </ul>

## Month B

Day 1	
Morning Session	<ul style="list-style-type: none"> <li>• Introductions (if there are any new participants), recap, and “<i>Morning Rounds</i>”</li> <li>• Discussion of lessons learned since we last met</li> <li>• Module 4: Communicating with and Counseling Adolescents (4 hours, 15 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Module 4 (continued)</li> <li>• Module 5: Providing Psychosocial Support Services for Adolescents (3 hours, 35 minutes)</li> <li>• “<i>How Did it Go?</i>”</li> </ul>
Day 2	
Morning Session	<ul style="list-style-type: none"> <li>• Recap and “<i>Morning Rounds</i>”</li> <li>• Module 6: Adolescents, HIV, and Mental Illness (3 hours, 30 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Module 7: Providing Disclosure Counseling and Support (3 hours, 50 minutes)</li> <li>• Prepare for clinical practicum</li> <li>• “<i>How Did it Go?</i>”</li> </ul>
<b>Practicum Session: 1-3 days</b> (practical sessions should be planned based on the availability of participants and preceptors, and the days and times when adolescents receive services)	
Morning Session	<ul style="list-style-type: none"> <li>• Recap and “<i>Morning Rounds</i>”</li> <li>• Clinical practicum, covering knowledge and skills in Modules 4-7</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Debrief on clinical practicum</li> <li>• “<i>How Did it Go?</i>”</li> </ul>

## Month C

Day 1	
Morning Session	<ul style="list-style-type: none"> <li>• Introductions (if there are any new participants), recap, and “<i>Morning Rounds</i>”</li> <li>• Discussion of lessons learned since we last met</li> <li>• Module 8: Supporting Adolescents’ Retention in and Adherence to HIV Care and Treatment (4 hours, 10 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>• Module 8 (continued)</li> <li>• Module 9: Positive Living for Adolescents (3 hours, 15 minutes)</li> <li>• “<i>How Did it Go?</i>”</li> </ul>

<b>Day 2</b>	
Morning Session	<ul style="list-style-type: none"> <li>Recap and “<i>Morning Rounds</i>”</li> <li>Module 10: Sexual and Reproductive Health Services for Adolescents (4 hours, 30 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>Module 10 (continued)</li> <li>Module 11: Family Planning and PMTCT Services for Adolescents (2 hours 35 minutes)</li> <li>Prepare for clinical practicum</li> <li>“<i>How Did it Go?</i>”</li> </ul>
<b>Practicum Session: 1-3 days</b> (practical sessions should be planned based on the availability of participants and preceptors, and the days and times when adolescents receive services)	
Morning Session	<ul style="list-style-type: none"> <li>Recap and “<i>Morning Rounds</i>”</li> <li>Clinical practicum, covering knowledge and skills in Modules 8-11</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>Debrief on clinical practicum</li> <li>“<i>How Did it Go?</i>”</li> </ul>

## Month D

<b>Day 1</b>	
Morning Session	<ul style="list-style-type: none"> <li>Introduction (if there are any new participants) and recap</li> <li>Discussion of lessons learned since we last met</li> <li>Module 12: Community Linkages and Adolescent Involvement (2 hours, 45 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>Module 13: Supporting the Transition to Adult Care (1 hours, 40 minutes)</li> <li>“<i>How Did it Go?</i>”</li> </ul>
<b>Day 2</b>	
Morning Session	<ul style="list-style-type: none"> <li>Module 14: Monitoring, Evaluation, and Quality Improvement (2 hours, 15 minutes)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>Module 15: Supervised Clinical Practicum (2–2.5 days)</li> <li>“<i>How Did it Go?</i>”</li> </ul>
<b>Practicum Session: 1-3 days</b> (practical sessions should be planned based on the availability of participants and preceptors, and the days and times when adolescents receive services)	
Morning Session	<ul style="list-style-type: none"> <li>Recap and “<i>Morning Rounds</i>”</li> <li>Clinical practicum, covering knowledge and skills in Modules 12-14 (or all modules if practical sessions have not been incorporated throughout the training so far)</li> </ul>
LUNCH	
Afternoon Session	<ul style="list-style-type: none"> <li>Debrief on clinical practicum</li> <li>Module 16: Action Planning, Course Evaluation, and Closure (3 hours, 10 minutes)</li> </ul>



## Appendix 1B: Pre-Test

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Participant identification number: \_\_\_\_\_ Score: \_\_\_\_/25

- 1) Which of the following statements are factors to be considered in the scale up of adolescent HIV care and treatment services? (select all that apply)
  - a) Young people are no more vulnerable to HIV than adults.
  - b) Youth living with HIV face unique health, adherence, and psychosocial issues and challenges.
  - c) Health workers need specific knowledge and skills to meet the needs of adolescent clients.
  - d) Programs and clinical services need to be youth-friendly to attract and retain adolescent clients.
  
- 2) Adolescence is a unique stage of life that is characterized by:
  - a) Challenging caregivers or elders
  - b) A focus on body image
  - c) A sense of immortality
  - d) Significant physical, emotional, and mental changes
  - e) All of the above
  
- 3) Which of the following are characteristics of “youth-friendly” services? (select all that apply)
  - a) There are special days/times set aside for young people to receive services.
  - b) Young clients can only come to the clinic when they have a scheduled appointment.
  - c) Young people are involved in designing and monitoring programs.
  - d) Multiple services are available in one clinic, known as “one-stop shopping.”
  - e) Health workers mainly use group counseling sessions in order to save time.
  
- 4) To be effective, the adolescent package of care must ensure: (select all that apply)
  - a) The integration of services
  - b) That services are age- and developmentally-appropriate
  - c) That the needs of both perinatally infected adolescents and those infected later in childhood or adolescence are met
  - d) That services encourage adolescents to take responsibility for their own health
  - e) That adolescent clients receive care in the pediatric clinic for life
  
- 5) The adolescent package of HIV care closely resembles the package of HIV care for adults; however, the way services are delivered can impact their success among adolescents.
  - a) True
  - b) False
  
- 6) Adolescent clients should be started on ART when their CD4 cell count is:
  - a) 200 or less
  - b) 250 or less
  - c) 300 or less
  - d) 350 or less
  - e) None of the above

- 7) How frequently should CD4 cell count be monitored in adolescent clients?
- Every 12 months; but 6 monthly as CD4 count approaches threshold (to initiate ART)
  - Every 9 months; but 4 monthly as CD4 count approaches threshold
  - Every 6 months; but 3 monthly as CD4 count approaches threshold
  - Every 4 months; but 2 monthly as CD4 count approaches threshold
  - Every 2 months; but monthly as CD4 count approaches threshold
- 8) Counseling includes which of the following? (select all that apply)
- Solving another person's problems
  - Helping another person make informed decisions
  - Telling another person what to do
  - Respecting everyone's needs, values, culture, religion, and lifestyle
  - Recording key points of the counseling session in the client's clinic file
- 9) Family-focused care means that health workers can talk openly with caregivers about any information shared by the adolescent client.
- True
  - False
- 10) Which of the following are coping strategies that health workers should suggest to adolescent clients to help them reduce stress and promote their psychosocial well being? (select all that apply)
- Talking with a Peer Educator
  - Joining a support group
  - Exercising
  - Disclosing their HIV-status to all of their friends
  - Participating in recreational activities, like sports or youth clubs
- 11) Which of the following statements about mental illness are correct? (select all that apply)
- Mental health problems are very rare among adolescents living with HIV.
  - Mental illness and substance abuse are closely related.
  - Only trained psychologists and psychiatrists can recognize the signs of possible mental illness in adolescents.
  - Adolescents are susceptible to depression, anxiety disorders, behavioral disorders, and alcohol/substance use disorders.
  - All clinics should have standard procedures on how to manage adolescent clients with possible or confirmed mental illness.
- 12) Disclosure to a child or adolescent is a one-time event for which the caregiver must be well-prepared.
- True
  - False

- 13) Which of the following statements about disclosure are true? (select all that apply)
- a) Health workers can work with caregivers to develop and implement a disclosure plan; they can also play a supportive role throughout the disclosure process.
  - b) Research shows that disclosing a child/young adolescent's HIV-status often results in psychological problems, emotional harm, and difficulties with adherence.
  - c) There are times when health workers may need to facilitate disclosure discussions with children/young adolescents.
  - d) It is recommended that children/young adolescents be fully disclosed to when they are developmentally ready — typically by the time they are 10–12 years old.
  - e) Health workers should encourage older adolescents not to disclose to their friends because they may face stigma and discrimination.
- 14) Adherence preparation and ART initiation can usually be completed in 1 visit.
- a) True
  - b) False
- 15) The only reliable way to assess client adherence is with pill counts.
- a) True
  - b) False
- 16) Positive prevention includes which of the following? (select all that apply)
- a) Partner disclosure and testing
  - b) Sleeping and resting under an insecticide-treated mosquito net if in a malarial area
  - c) Sexual risk reduction
  - d) Prevention and treatment of STIs
  - e) Washing hands and bathing regularly
  - f) Preventing mother-to-child transmission (PMTCT)
- 17) Which of the following statements is correct?
- a) Health workers need to stress that ONLY heterosexual behavior is normal.
  - b) Health workers should understand different sexual behaviors and sexual orientations and talk openly and non-judgmentally about them with clients.
  - c) Health workers need to stress that homosexual and bisexual behavior is abnormal.
  - d) Health workers need to stress that transsexual/transgendered behavior should not be tolerated.
- 18) The following sexual activities are considered HIGH risk for transmitting HIV: (select all that apply)
- a) Unprotected (no male or female condom) anal or vaginal intercourse
  - b) Using a latex condom during every act of vaginal or anal intercourse
  - c) French/deep kissing
  - d) Mutual masturbation
  - e) Oral sex without a latex barrier
- 19) The adolescent female genital tract is less susceptible to STIs than that of adult women.
- a) True
  - b) False

- 20) What advice would you give an adolescent client living with HIV who wants to get pregnant? (select all that apply)
- a) It is safest to wait until adulthood to become pregnant.
  - b) There are many health, psychological, social, and economical risks of adolescent pregnancy.
  - c) Stop having sex because it is dangerous for you and your partner.
  - d) It is important to continue to talk with health workers to know the facts and risks about getting pregnant and to understand the facts about PMTCT services.
  - e) Switch to or start taking efavirenz before trying to become pregnant.
  - f) Make sure you (and your partner, if HIV-infected) are adhering to your ART regimen and have a CD4 count over 500 before trying to get pregnant.
- 21) Which of the following are usually good contraceptive options for adolescents living with HIV? (select all that apply)
- a) Male and female condoms
  - b) Oral contraceptive pills
  - c) Spermicides and diaphragms with spermicides
  - d) Male and female sterilization
  - e) Injectable contraceptives
  - f) Hormonal implants
- 22) Which of the following statements are true? (select all that apply)
- a) Dual protection and dual method use mean the same thing.
  - b) Condoms provide dual protection.
  - c) Dual protection refers to the practice of taking ART and cotrimoxazole.
  - d) Dual method use should be recommended for sexually active adolescents. This means they use condoms and another method of contraception (such as oral or injectable contraceptives).
- 23) In reference to transitioning to adult care, which of the following statements is true? (select all that apply)
- a) All adolescent clients should be ready to transition to adult care by age 16.
  - b) In helping prepare an adolescent to transition, the health worker should support him or her to develop self-care and self-advocacy skills.
  - c) In preparation for transition, adolescents should visit and tour the adult HIV clinic.
  - d) Adolescent clients should be encouraged to rely more and more on their caregivers to ensure that they adhere to their ART regimen.
- 24) Which of the following statements about adolescent involvement are true? (select all that apply)
- a) Adolescent peer education programs and community advisory boards are useful mechanisms to involve adolescents in services.
  - b) Adolescent peer educators can take on the same responsibilities as adult peer educators.
  - c) Adolescent peer educators can help create a safe clinic environment, improve adherence and positive living among clients, and improve service quality.
  - d) Asking adolescents to help with clinic filing and cleaning are examples of meaningful involvement.
  - e) It is important to have a clear training and supervision plan in adolescent peer educator programs.



- 25) Which of the following are examples of indicators? (select all that apply)
- a) Number of adolescents who initiated ART in the quarter
  - b) Percentage of adolescent clients lost to follow-up in the year
  - c) To ensure that 95% of eligible adolescent clients initiate ART this year
  - d) All adolescent clients should be screened for TB at enrollment
  - e) % of adolescent clients screened for TB at enrollment in the quarter



## References

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<sup>1</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) (2010). *UNAIDS report on the global AIDS epidemic, 2010*.

<sup>2</sup> UNICEF. (2011). *Opportunity in crisis: Preventing HIV from early adolescence to young adulthood*. Available at: [www.unicef.org/media/files/OiC\\_FactSheet.pdf](http://www.unicef.org/media/files/OiC_FactSheet.pdf)

<sup>3</sup> United Nations Population Fund. *Young people: The greatest hope for turning the tide*. Available at: <http://www.unfpa.org/hiv/people.htm>