Step 6: Implement Special Services

describes some special services relevant to pediatric care and treatment of HIV/AIDS which may be appropriate for your clinic. They include community support services, the family unit approach to care, family planning, PMTCT, adolescent services and special considerations with regard to tuberculosis.

Objective

- Implementation of special services according to the clinic’s needs
Effective Delivery of Community-Based Services

In **Step 2** on Program Development, it was explained how to select the community services you would like to provide for your clients. As mentioned, the companion Manual from Secure the Future provides full details of how to implement community support services. The following sections emphasize only those community services which are either essential or which yield the greatest impact in terms of patient clinical outcomes.

**Patient Tracking**

Keeping track of patients and ensuring that they regularly visit the clinic is a major challenge in most resource-limited settings. However, this is an essential activity in order to sustain good clinical outcomes. Patients may default from clinic visits out of fear, related to stigma or because they do not fully understand the importance of regular visits, because they have started taking antiretroviral therapy and are feeling better or because of logistical difficulties related to transport.

Critically, those patients on ARVs risk interruption of therapy if they default by significant amounts of time from scheduled visits, potentially resulting in the development of ARV resistance. An effective tracking system is, therefore, highly recommended. An example of a paper-based tracking system is to be found in **Tool No. 18**. This can also be easily transformed into an electronic system. Irrespective of the system used, it only works if you put in place the physical means of actually tracking down defaulting patients. To this end, the use of mobile phones is increasingly possible, even in very resource-limited settings. However, it is usually also necessary to utilize community resources and personnel, such as community health workers, who can physically go to find the defaulting patient. Although this might seem expensive, it is almost always more cost-effective than dealing with the consequences of non-adherence and the resulting treatment failure. In order to minimize the personnel needed, the personnel utilized for tracking down patients can be the same as those providing home-based care as described below.

**Home-Based Care (HBC)**

It has been convincingly demonstrated that HBC is one of the most impactful community support services, in terms of better clinical outcomes (Mermin J. et al. Mortality in HIV-infected Ugandan adults receiving antiretroviral treatment and survival in their infected children: a prospective cohort study. The Lancet 371:751-755, 2008). It is defined as the care given to individuals in their own natural environment, (i.e. their home), by their families, supported by skilled social welfare officers and communities to meet their spiritual, material and psychosocial needs; with the client herself/himself also playing a crucial role.

HBC has emerged as a key strategy in addressing the HIV/AIDS epidemic in Africa and other developing parts of the world. Some people prefer to receive care at home where they are surrounded by family, friends and a familiar environment. Further, HBC provides an opportunity to inform family members and communities about HIV/AIDS prevention and basic care techniques. Such opportunities are rare for hard-to-reach communities that do not regularly receive prevention and care messages. In this way HBC workers can now play a new role in encouraging community members to come forward for VCT, by explaining the benefit of knowing one’s status and eventually accessing life-saving ARV therapy.

As HIV/AIDS treatment programs are launched and clients begin to regain their health, the job description of an HBC worker changes dramatically. Most HIV/AIDS patients respond well to ARVs and are no longer very sick or bedridden. When this occurs, the HBC worker can assume a new role of helping the improving client live a fulfilling life. This can include assistance with drug adherence, management of side effects and returning to work. Eventually, the HBC worker’s services may no longer be needed.

For patients who are not well or who have mental, physical, emotional and social needs, caregivers provide home-based nursing care. The care provided seeks to promote, restore and maintain the individual’s maximum level of comfort, function and health, as well as helping people to die with dignity.

The HBC worker can also be involved in the critically important job of tracking patients who default from clinic visits as described above.

Although the benefits of HBC have been demonstrated, it is acknowledged that this is not an inexpensive service to provide. It is, therefore, best to target HBC and associated tracking activities at those patients who are deemed by the clinical to be most needy or vulnerable. **Tool No. 14** will help you to identify such patients.

As the job of HBC workers has changed with the advent of widespread ARVs therapy, their training needs
have also changed dramatically. To this end, relevant training resources are to be found in Resource No. 5.

**Organizations Providing Home Based Care**

HBC services are provided by non-government (NGOs) and non-profit organizations (NPOs) that are funded by governments and private donors, or by community members volunteering their services through their churches and community organizations. In many countries, NGOs and faith-based organizations (FBOs) implement HBC services unavailable through government programs. Patients who need ongoing care at home upon discharge from a hospital are referred to a primary health care facility in their community. The clinic or primary health center refers the patient to the NPO partner responsible for HBC services in the area. The NPO can then assess the individual’s needs in his or her home, and develop a care plan and assign a caregiver to that person. The structure of an NPO, NGO or FBO providing HBC is variable. At their most developed, volunteers spend time initially perfecting their skills. They may then progress upwards to paid positions of increasing responsibility. This confers the appropriate sense of HBC as a profession.

An individual patient registration form for HBC purposes is to be found in Tool No. 19 and a HBC home visit report form is to be found in Tool No. 20.

**Other Forms of Community Support**

Tracking and HBC are the only two types of community support described in the present Toolkit because they are considered essential to some extent or other in order to ensure good patient clinical outcomes. There are other types of useful community support services, such as patient support groups, food security, income generating activities etc. These are described in detail in the Secure the Future Manual (Resource No. 2).

**Family Unit and Family Planning**

In resource-limited settings, HIV care and treatment programs have traditionally been conceived and implemented as unique clinical services, not integrated with family planning, HIV prevention efforts, or existing primary health care services. In addition, most HIV care and treatment programs approach adults and children as distinct clinical entities, generally with separate provider and support systems for each. Care settings may be disparate in space and time, with little attention given to coordinating care for the different members of a family. This neglects the substantial potential benefits of orienting services toward families.

A family-centered program offers a chance to access HIV-infected family members who may not already be in care. For HIV-infected children, a family-centered approach may have particular importance, as optimal outcomes for HIV-infected children are tightly linked to the health of their caregivers. Additionally, both adult family members’ and children’s access to and retention in care may be optimized in a family-centered program where all family members can be cared for in a single place and at a single time.

Specific clinical benefits may accrue to those able to receive care in a family-centered setting. With provision of HIV counseling and testing to family members, recognition of HIV status may take place at an earlier stage of disease, allowing interventions that may slow disease progression. Late entry into care, associated with poorer responses to subsequent HAART, may be prevented. Disclosure among family members, linked to reductions in depression and improvements in treatment adherence and general support systems, may also be enhanced in family-based care settings.

There is a growing global emphasis on the importance of integrating various HIV prevention, care and treatment services into a comprehensive, longitudinal approach delivered through a single site. WHO’s current model for the prevention of mother-to-child transmission (PMTCT), for example, includes four points encompassing the breadth of consideration from primary prevention of HIV infection among women.

Home based care workers visiting children in their homes in KwaZulu-Natal, South Africa
of childbearing age (point 1) to providing appropriate treatment, care, and support to mothers living with HIV and their children and families (point 4). Family-centered HIV care and treatment programs offer an opportunity for this, allowing natural linkages to and between family planning, antenatal care (ANC), PMTCT, and care and treatment services.

Linking to existing ANC and PMTCT programs may also provide a ready means of establishing a family-centered care and treatment program, as in many resource-limited settings, antenatal care clinics are among the most utilized of services, providing a ready flow of mother-infant pairs, many with additional family members in need of care.

Given that the second point of WHO’s approach to PMTCT is preventing unintended pregnancies among women living with HIV, family planning services are a vital component of a comprehensive family-centered HIV care and treatment program. In many programs, access both to effective means of contraception and to the counseling supporting its effective use is insufficient. In addition, in some settings desire for pregnancy among HIV-positive women (particularly younger women with knowledge of PMTCT and having low numbers of children) has been shown to be appreciable. The inherent complexity these considerations bring to family planning in a comprehensive family-based HIV care and treatment program mandates that a program make available both family planning methods and the supportive counseling services able to ensure their proper uptake and application.

Even in well-designed family-centered HIV care and treatment programs, there are families and situations for which non-traditional measures will need to be employed. Novel approaches to augmenting the effectiveness of family-centered care are in practice in some settings. The BIPAI-Botswana program utilizes an “In-reach” strategy, wherein patients identified to have a higher risk of difficulty with medication adherence or with significant psychosocial concerns are targeted for home visits. Healthcare teams of varying composition, including nurses, social workers, physicians, and nutritional staff, among others, assess patients in their homes, attempting to understand the patient’s family situation, evaluating multiple variables that affect response to care and treatment, and formulating a plan to broaden the patient’s base of support.

With a goal of optimizing a community’s engagement with and response to HIV care and treatment, comprehensive family-centered services provide an opportunity to reach people where they live, in the context of their family—and to minimize the barriers inherent to separately-provided services.

Prevention of Mother to Child Transmission (PMTCT)

The key to eliminating pediatric HIV infection is an effective PMTCT program (see Resource No. 10: WHO Guideline on PMTCT). This is often established as a separate program from ARV provision because it leverages reproductive and antenatal care settings, but it can also be incorporated into a regular ARV clinic. The regime of ARVs prescribed for PMTCT varies from country to country and changes over time as research yields new results and governments change policies. PMTCT should not be viewed simply in terms of the moments before and after delivery when the mother and newborn child receive the prophylactic medication. It is an extended process starting with community mobilization on PMTCT and continuing with the point when a pregnant woman tests positive in VCT, her pregnancy (i.e., antenatal care), delivery, and postnatal and pediatric care up to the point at 12-18 months when the child’s HIV status is definitively determined. It also entails good counseling of the mother on infant feeding, either breast or artificial. Only by following this entire process can the efficacy of the PMTCT intervention be determined. The services that constitute this continuum of care are not usually integrated so another approach is to coordinate the services and establish a register that tracks the client throughout the process. This continuum of care is illustrated in the diagram below, together with the relevant community services which can support each element of the clinical service.

Another best practice with regard to PMTCT is to obtain a PCR from the newborn infant at 4 - 6 weeks in order to make an early diagnosis of HIV-infection (Antibody based testing such as rapid tests or an HIV ELISA are not valid in a newborn if positive since a positive test at this age may only reflect the maternal status). The test is a little expensive, but a study conducted in South Africa and funded by Secure the Future demonstrated that it was cost-effective, compared to the costs of complications caused by not treating children early enough. As a result, PCR at six weeks of age was adopted by the Department of Health in South Africa as national policy.
The feeding of infants is complicated by the fact that HIV can be transmitted in breast milk. On the other hand, in some resource limited settings, such as Swaziland, access to clean water is limited for most of the population and, therefore, the use of formula feeding brings other risks. Whichever kind of feeding is chosen by a mother, this kind should be used exclusively for the first 6 months of life, because there is clear evidence of a higher risk of transmission of HIV during mixed feeding.

An example of how a coordinated approach to implementing the continuum of care required for effective PMTCT is illustrated in Field Story No 6.1.

**PMTCT Continuum of Care**

![Image of PMTCT Continuum of Care]

Figure 6.1: Illustration of the necessary continuum of care for effective PMTCT

**Field Story No. 6.1: Community Support of PMTCT**

Supplementing the clinical services needed throughout pregnancy and beyond with the community support network described in this toolkit constitutes a best practice. This was the approach taken by the Secure the Future funded project PORECO in Swaziland. The community services did the following:

- Organized extensive community mobilization and education that encouraged pregnant mothers to access VCT
- Monitored women throughout their pregnancies and ensured they received antenatal care either at an antenatal clinic or through home-based care
- Ensured the women took PMTCT medication at the proper time prior to delivery
- If necessary, helped women get to the hospital for delivery or made certain a traditional birth attendant also trained to deliver ARVs was available if the women delivered at home (traditional birth attendants are accepted in many Sub-Saharan countries)
- Continued to track the patients and their newborn babies to ensure they received good postnatal and pediatric care
- Made sure the mother is referred to regular ARV services after delivery

Using this coordinated approach, the project showed that only 2% of the first 200 mothers who were enrolled were lost to follow-up.
Psychosocial Services

HIV affects not only the body but also the psyche of the people who deal with the situation. That is why, every center, hospital and day clinic providing medical services to HIV+ people should offer psychosocial services. The issues are particularly difficult with regard to children and adolescents and special attention is devoted to this subject in the Toolkit, because of the extensive and unique experience gained by BIPAI at the Romanian-American COE in Romania, where over 800 children have been cared for through childhood and adolescence.

Role of the Psychologist

- Helps parents and children understand events they deal with, both the short and long term consequences
- Helps parents and children find, access or develop the necessary resources for overcoming difficult events
- Listens to the parents or children when they need to talk about their problems
- Helps parents approach the problem of diagnosis and disclosure in relationship to the HIV-positive child
- Helps parents behave properly with the HIV-positive child, avoiding overprotection or neglect of the needs engendered by the new status
- Helps balance the lives of those affected by the disease

Tool No. 21 and Tool No. 22 provide a detailed stepwise approach to psychological counseling for the child, the adolescent and the parent.

Care of Adolescent Patients

As increasing numbers of pediatric patients with HIV/AIDS receive effective ARVs therapy, they are surviving well and many are becoming adolescents. This brings a new dimension and set of challenges to sustaining good clinical outcomes, mainly because of the unique psychosocial needs of adolescents. BIPAI has extensive experience in this area, particularly at its affiliate in Romania, the Baylor Black Sea Foundation in Constanta.

The psychosocial care of adolescent patients should be considered from the beginning of program design. Even if the medical needs might appear overwhelming and most resources should be focused at the beginning in the area of medical services, the psychosocial factors are likely to influence the long term clinical outcomes. A psychosocial service or a psychosocial department should be planned, organized, staffed and trained in accordance with the overall strategy of the HIV center.

Experience shows that psychosocial services take time to become well structured and effectively implemented. This is because the psychosocial service is shaped by the culture of the country and in addition time is required for the team to learn how to function properly, both independently and in interaction with other teams, such as the medical team.

Adolescence Issues

The most commonly used definitions refer to “adolescents” as covering ages 10 to 19 years, “youth” to ages 15 to 24 years and “young people” to ages 10 to 24 years. Regardless of the age interval, adolescents are a very active group, linked with many other societal groups (such as older partners, IV drug users and other subcultures) which may facilitate HIV transmission. In addition, many adolescents worldwide live in poverty, placing them at higher risk of acquiring and spreading HIV.

Adolescence is a significant stage in one’s life, because important growth and maturation characteristics are involved. There are processes of identity formation and acquisition of social roles as well as phases of cognitive, emotional and moral evolution. Age is not always directly linked with these processes, and the professional should be sensitive to the fact that developmental grouping might be more relevant rather than age in establishing a specific health support action for the adolescent.

The most common problems encountered in adolescents accessing care and treatment for HIV/AIDS are:

- Adherence
- Disclosure
- Difficulties in ensuring good transition to care from pediatric to adult care
- Stigma, discrimination and isolation
Needs Assessment and Methods of Assessment

Assessments can be reactive or proactive. A reactive needs assessment is helpful in designing an immediate intervention/action due to the sudden appearance of factors that interfere with the optimal impact of healthcare. **Field story No. 6.2** provides an example.

A proactive needs assessment anticipates needs and helps design interventions in advance, thereby preventing crisis and obstacles and ensuring a better transition through a specific stage. The benefits are both for the professionals that are prepared in advance for a specific issue and for the patients, who feel that the environment is supportive and flexible. An example is shown in **Field story No. 6.3**.

To assist you in performing a proactive needs assessment for adolescents, refer to **Table 6.1**.

Field Story No. 6.2: Example of reaction to a needs assessment

In Romania, children with HIV had early access to antiretroviral therapy. However lack of appropriate food supplies in many households decreased the impact of the medication. In reaction to this the government and the NGOs put together a plan of monthly support to ensure food security. This intervention was not designed in advance; it was only set as a reaction to more and more problems arising from food insecurity.

Field Story No. 6.3: Example of proactive approach to a needs assessment

Recognizing the fact that the children patients from the Romanian American Children’s Centre would soon become sexually interested and sexually active permitted the design of a sexual education program. The program included specific components such as: providing information in support groups, use of experiential methodologies of learning, involvement of peers in education sessions, making condoms available in private clinic spaces, encouraging partner involvement in the patient’s own health care routine etc. As a direct result, four years after the initiation of this program, HIV-infected youth now frequently come with their partners for rapid testing, counseling, condom refills, family planning etc.

Table 6.1: Proactive needs assessment for adolescents

<table>
<thead>
<tr>
<th>Integration of Adolescent Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteers beside a poster displayed at the American-Romanian COE’s candlelight memorial on May 18th. in Constanta, Romania. The captions in English are “Sometimes we hide from the truth” and “We want to be accepted.”</td>
</tr>
</tbody>
</table>

### Table 6.1: Proactive needs assessment for adolescents

<table>
<thead>
<tr>
<th>Problems/ issues in adolescents</th>
<th>Needs in terms of services/ programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infection acquired heterosexually</td>
<td>- sexual and reproductive health (SRH) adolescent friendly services</td>
</tr>
<tr>
<td>HIV infection acquired homosexually</td>
<td>- SRH adolescent friendly services</td>
</tr>
<tr>
<td>- destigmatization support</td>
<td></td>
</tr>
<tr>
<td>- prevention of isolation and vulnerability</td>
<td></td>
</tr>
<tr>
<td>Loss of parents (adolescent orphans)</td>
<td>- psychological support during puberty</td>
</tr>
<tr>
<td>- support for independent life skills development</td>
<td></td>
</tr>
<tr>
<td>- financial security</td>
<td></td>
</tr>
<tr>
<td>- shelter and nutrition</td>
<td></td>
</tr>
<tr>
<td>Loss of parents (adolescent orphans)</td>
<td>- psychological support during puberty</td>
</tr>
<tr>
<td>- support for independent life skills development</td>
<td></td>
</tr>
<tr>
<td>- financial security</td>
<td></td>
</tr>
<tr>
<td>- shelter and nutrition</td>
<td></td>
</tr>
<tr>
<td>Pressure to have children/ pressure to begin sex</td>
<td>- sex education</td>
</tr>
<tr>
<td>- access to contraception</td>
<td></td>
</tr>
<tr>
<td>- self esteem boosting interventions</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse from adults</td>
<td>- link with police authorities</td>
</tr>
<tr>
<td>- practical and legal support</td>
<td></td>
</tr>
<tr>
<td>- trauma counseling</td>
<td></td>
</tr>
<tr>
<td>- non-judgmental attitude from adults</td>
<td></td>
</tr>
</tbody>
</table>
At the BIPAI center in Constanta, Romania, the importance of psychosocial support and importantly, its close integration with other services has been recognized.

“Lack of services offering psychosocial support for HIV infected adolescents has repeatedly been linked with various problems in the process of care and support of these patients. It is not easy for adolescents to be referred from one service to another, from one institution to another; therefore one should try to deliver as many medical and psychosocial services as possible under the same roof.” (Kunins H, Hein K, Futterman D, Tapley E, Elliot AS. Guide to adolescent HIV/AIDS program development. J Adolesc Health 1993; 14:1S-140S).

The field story below illustrates how the BIPAI center tackled this issue.

Partnerships with other providers for adolescent services can also facilitate uptake of new patients and referral of patients for special services, for example:

- As an up-take strategy (e.g., links with night care centres for street children and adolescents might allow HIV screening in those facilities, and thus access to care and treatment). Some of the organizations from this category might be: shelters for victims or homeless, institutions, residential centres, mental health facilities and so on.

- As a referral strategy (e.g., vocational counseling and training might not be a service developed at your centre, but a community NGO or FBO might be specialised in this area). Some of the organizations from this category might be: organizations with literacy and vocational programs, organizations that offer material support and emergency care, higher education centres, spiritual counseling organizations and so on.

In designing your program for adolescents, your team should come together and discuss how adolescents living with HIV usually come to the attention of health workers in your specific country setting. Some of the psychosocial barriers that might be considered are:

- Lack of skills among health professionals in working with adolescents in some clinical settings can lead to missing opportunities to identify care for vulnerable populations (e.g., emergency care clinics, SRH centres)

- Cultural tendency to focus on sexual and reproductive health services on females and disregard

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**Table 6.1: Proactive needs assessment for adolescents (continued)**

<table>
<thead>
<tr>
<th>Problems/ issues in adolescents</th>
<th>Needs in terms of services/ programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug use</td>
<td>- links with harm reduction services</td>
</tr>
<tr>
<td>ARV initiation and life style changes linked with it</td>
<td>- pre-ARV initiation counseling - adherence counseling - therapeutic alliance - adolescent involvement in the process of decision making</td>
</tr>
<tr>
<td>Lack of appropriate information about the disease, myths about transmission and course of the disease</td>
<td>- education services and materials adapted to the cognitive level of the client</td>
</tr>
<tr>
<td>Diagnosis disclosure to partners and significant others</td>
<td>- planning of the disclosure process - evaluation of risks of rejection/ and safety implications such as harassment and violence - empower client and provide education about rights and responsibilities</td>
</tr>
<tr>
<td>AIDS disease symptoms or prolonged illness</td>
<td>- psychological support - practical support</td>
</tr>
<tr>
<td>Issues with death and dying</td>
<td>- counseling focused on the meaning of life - introduce spirituality issues that are acceptable to the adolescent - family counseling &amp; education about the dying process</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>- psychiatric care - psychological support</td>
</tr>
<tr>
<td>Transition to adult care system</td>
<td>- planning for transition - involve team from adult care system - communicate the plan of intervention with the adolescent and family</td>
</tr>
<tr>
<td>Sexual and reproductive issues</td>
<td>- normalization of discussions about sexual issues - access to contraceptives and condoms - inclusion of SRH service in the overall care provided by the clinic</td>
</tr>
<tr>
<td>Need to protect partner of HIV</td>
<td>- access to rapid VCT that is sensitive to adolescent issues</td>
</tr>
<tr>
<td>Unfriendly services</td>
<td>- education and sensitization of professionals - feedback system regarding adolescents' satisfaction with services provided</td>
</tr>
</tbody>
</table>
Field Story No 6.4: Analysis of factors that influence outcome of HIV services in Constanta, ROMANIA

In 2006 a number of key stakeholders in Constanta, Romania met at a consultative workshop to analyze the level of existing services for HIV infected adolescents, 18 years after the epidemic took root in the county. One of the conclusions of the meeting was that lack of an initial design of comprehensive services (such as medical, psychosocial, educational) leads to malfunctions (most of them communication and systemic ones between different parties involved in the multidisciplinary care), ultimately generating long term effects such as: problems with adherence, perpetuation of sexual HIV transmission, family planning and STI problems.

Factors of success:

- **Strongest developed factors**
  - Clinical experience with HIV of health care providers
  - Existence of different local services for HIV infected adolescents provided by various institutions (medical, psychosocial, educational)
  - Quality of the specialized care interventions
- **Medium developed factors**
  - Existence of alternative services (such as those provided by NGOs or private funders)
  - Existence of standards of care
  - Efficiency in implementing PMTCT
  - Existence of national HIV programs
- **Poorly developed factors**
  - Multidisciplinary team work
  - Legal rights for HIV infected persons
  - Easy access to rapid HIV testing in various areas

Barriers identified:

- **Strongest barriers**
  - Low impact of adolescent education and prevention programs in both urban and rural populations
  - Inefficient communications between different HIV programs and departments
- **Medium level barriers**
  - Communication barriers between different healthcare practitioners
  - Non-professional attitude of health care providers in relationship with HIV infected patients
  - Legislative issues insufficiently specified lead to ambiguity in interpretation and behavior
- **Other barriers**
  - Insufficient funding for all services needed
  - Lack of wide access to contraceptive education among HIV infected adolescents
  - Inconstant/ inefficient level of involvement of key persons from various institutions

Outcomes

The meeting allowed understanding of different implications of the disease at the community level and reciprocal understanding of roles, responsibilities and limits of the local institutions in managing the problems.

One concrete result of the meeting was that some specific partnerships materialized. For example, the partnership between the Infectious Diseases Hospital and Baylor Black Sea Foundation allowed the setting up the BIPAI Romanian Centre of Excellence that offers under the same roof a large number of medical and psychosocial services. Another concrete partnership was with the Local Employment Agency that offers counseling and professional integration for various categories, including persons with HIV. This partnership was further financed as a special project by the Global Fund. The low impact of adolescent education and prevention programs in urban and rural populations guided the strategic educational plan of Baylor Romania through using new approaches and ways of transmitting impact information. Some of the initiatives were school education campaigns called “Sexiest Survivor” that used edutainment as a teaching method. Other initiatives include a photographic project that offered the world seen through the eyes of HIV positive adolescents as a starting point for sessions regarding HIV and reproductive health.

A new approach included strengthening partnerships with county and regional hospitals in order to improve uptake of positive patients through rapid testing screening. This allowed also an opportunity to educate health professionals about HIV, best practices and standards of care.
adolescent boys and males that might be exposed to HIV as well

Poverty and living in marginal groups are factors usually associated with untimely healthcare support. Links with community services in remote or particularly vulnerable areas should be considered.

An example of how a team of different disciplines analysed the outcomes and achieved for adolescents under their care in Romania and proposed new ways forward is illustrated in Field Story No. 6.4.

Selecting Types of Adolescent Services To Be Delivered as Part of the Site’s Program

You may want to consider inclusion at your site of relevant psychosocial counselling services for HIV infected clients, their partners and families from among the following:

Routine Counseling Services:
- Pre and post-test counseling
- HIV diagnosis disclosure counseling
- Long-term support for acceptance of HIV diagnosis
- Counseling before initiation of ARVT and for maintaining ARVT
- Implementation of behavioural changes
- Support for accessing legal rights
- Practical help to overcome social obstacles

Emergency support
- Funeral support
- Nutritional support
- Coverage of transportation costs for clinic visits (for special cases)
- Referrals in emergency situations (medical emergencies, need for guardianship in a residential centre)
- Improvement of living conditions (support with access to clean water, support for temporary loans and coverage of debts)

Support group for HIV positive young women
- Monthly meeting dealing with acceptance of HIV diagnosis

Vocational counselling and support
- School and professional integrations
- Activities to limit occupational deficit

Health education
- Interventions designed to decrease risk behaviours

Evaluation of adherence to ARVs

Pregnancy
The issue of pregnancy among HIV infected adolescents is of particular importance. PMTCT programs as well as links with abortion care services might identify many such cases. Therefore, females should be included in your program as a specific focus. HIV services may serve as entry points for family planning services and later for PMTCT.

Creating an Adolescent Friendly Setting
An adolescent friendly setting may encourage the adolescent to come forward with his/her partner in order to take some health decisions.

Below we have included criteria for adolescent friendly services, defined from the point of view of the patient himself/herself. This is the result of a support group with adolescents organized in Romania in 2007.
- Independence in choosing the needed service is allowed
- Direct involvement in decisions that impact adolescent quality of life are part of day to day routine;
Unconditional access to services is offered
The personnel displays an open attitude and has the following skills:
- Empathy
- Ability to communicate and negotiate both with the adolescent and his/ her parents
- Encouragement
- Honesty
- Sensitivity to age specific issues and personal idiosyncrasies
Work/consultation environment ensures confidentiality, trust, psychological comfort and enough time for each patient

Adherence Issues
Adherence issues are even more common in adolescents than children and adults.
The following points are particularly worthy of consideration in regard to adherence to ARVs among adolescents:
- Need to facilitate participation of adolescents in treatment decisions and adherence
- Need to carefully assess the moment of initiation of ARVs
- Need to educate professionals about stages of motivation and build skills that allow identification of stage in which the patient is (pre-contemplation – contemplation – decision making, etc.)

Lessons Learned
- Community support services are critical to achieving the best outcomes for pediatric HIV care and treatment programs in resource-limited settings.
- Home-based care and effective patient tracking are the most impactful community services in relation to patients’ clinical outcomes.
- A family-based program offers a chance to access HIV-infected family members who may not already be in care.
- For HIV-infected children, a family-based approach may have particular importance, as optimal outcomes for HIV-infected children are tightly linked to the health of their caregivers.
- HIV has profound psychosocial implications and you should incorporate psychosocial services in your program.
- Adolescents need particular attention from a psychosocial perspective because of the unique world they inhabit and the serious implications the disease has for the whole of their life.