Kingdom of Cambodia

Nation Religion King

Ministry of Health

Standard Operating Procedures for Adolescents Living with HIV: Transition and Retention in Care and Treatment Services in Cambodia

August 2021

National Center for HIV/AIDS, Dermatology

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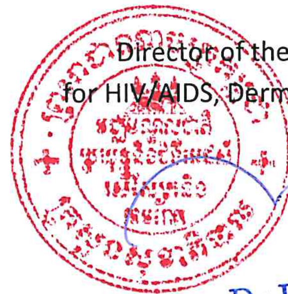
Phnom Penh, 27 August 2021

Director of the National Center
for HIV/AIDS, Dermatology and STD



Dr.LY PENH SUN

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AHC	Angkor Hospital for Children
ARV	Antiretroviral (drug)
ART	Anti-Retroviral Treatment
ALHIV	Adolescents living with HIV
FP	Family Planning
HIV	Human Immunodeficiency Virus
HCP	Health Care Provider
MMD	Multi-Month Dispensing
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	Non-government Organization
PAC	Paediatric AIDS Care
SOP	Standard Operating Procedure
SRH	Sexual Reproductive Health
STD	Sexual Transmitted Diseases
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
U=U	Undetectable = Untransmittable
VH	Viral Hepatitis
WHO	World Health Organization

1. Background & Rationale

Cambodia HIV prevalence is estimated lower than 0.5% for adult of 15-49 years old and 0.1%[1] among adolescents. AIDS is the second of the top ten causes of death and the disability-adjusted life-years lost in adolescents.[2] Transition into adolescence and teenage years is an important stage for human development, which matters everyone to provide them support, especially adolescents living with HIV. There are numerous documented challenges and recommended protocols exist in various settings which help the program implementers, health policy makers and family to minimize the adverse effects on their health outcomes. A number of reports documented an increase in death rate, virological failure,[3,4] non-adherence to treatment,[1,2,5] low-self-esteem, isolation, substance abuse, sexual abuse and suicide around the transition period. In addition, there are also setbacks that a number of HIV adolescents left paediatric clinic unprepared with unclear plan and resulting in an unsuccessful transfer to adult clinics.

The World Health Organization (WHO) suggests that transition of adolescents living with HIV should emphasize preparedness which is determined by adolescents' ability to demonstrate basic health-care awareness, HIV disclosure readiness, understanding their disease, and development of their own health management skills.[6] To achieve an optimal goal of the transition of HIV infected adolescents, the ability to provide health care that is uninterrupted, coordinated, developmentally appropriate, psychosocially sound, and comprehensive must be ensured.

To ensure uninterrupted healthcare and wellbeing of ALHIV in practical and effective ways, the National Centre for HIV/AIDS Dermatology and STD (NCHADS) in consultation with key stakeholders at the national and sub-national levels suggests paediatric and adult ART clinics to consider and apply all stages of transition process: before, during, and after a transition point. Effective interventions for transition of HIV adolescent care, guidance to implementation, and trainings need to be addressed at all levels.

There is limited knowledge about adolescent transitions strategies which have been introduced, implemented, and evaluated in the country, representing a gap of knowledge and transferable models. Therefore, the proposed transition process for adolescent transition in Cambodia is recommended and outlined in Section IV below.

2. Objectives

The objective of this standard operation procedure (SOP) is to provide a step-by-step guidance to ART health care providers, guardians, supporting networks, and ALHIV to successfully transition within the ART clinics or to be successfully transferred-out from Paediatric AIDS Care to adult ART services.

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[1] UNAIDS. HIV and AIDS data hub for Asia Pacific: Data Section: Factsheets: Country Factsheets: Cambodia. 2018. Accessed on 1st Sep 2019 at http://aphub.unaids.org/.

[2] Bekker LG, Hosek S. HIV and adolescents: focus on young key populations. Journal of the International AIDS Society. 2015;18 (2Suppl 1).

[3] Lowenthal ED, Bakeera-Kitaka S, Marukutira T, Chapman J, Goldrath K, Ferrand RA. Perinatally acquired HIV infection in adolescents from sub-Saharan Africa: a review of emerging challenges. Lancet Infect Dis. 2014;14(7):627-639.

[4] Health for the World's Adolescents: A Second Chance in the Second Decade. Geneva, Switzerland:World Health Organization; 2014.

[5] Haynes RB, Sackett DL, Richardson WS, Rosenberg W, Langley GR. Evidence-based medicine: How to practice & teach EBM. Canadian Medical Association. Journal. 1997 Sep 15;157(6):788.

[6] World Health Organization (WHO). HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. Geneva, Switzerland: WHO; 2013.

3. Key Definitions of Terms

- **Adolescent living with HIV:** UNAIDS defines as individuals aged from 10 to 19 years old where adolescence begins with the onset of physiologically normal puberty and ends when an adult identity and behaviour are accepted.[7,8]

- **Adolescent transition** is "the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health-care systems"[9]. It is an important stage for human development, and it is critical to provide effective support to bridge adolescents to the next step, called adult. It is more crucial to smoothly transfer adolescents with chronic conditions or long-term impairments.

- The term **"Transition"** refers *to* the process including evaluation, potential retention, and physical transfer-out. It is regardless of whether an adolescent is physically transferred-out or retained within the same ART care or preparing to be transferred-out. The interventions and process outlined in Section IV further guide heath care providers, NGO workers or volunteers, guardians, and patients throughout the process.

- **Transfer-out** refers to a period when an adolescent starts to experience a new environment of care in which he or she is gradually equipped with certain skillsets & knowledge at the existing care before physically showing up at another ART facility *(See Section 4.2.1).* **The transfer-out** could be either in an individual or in group manner; and could be escorted/facilitated by health care worker/volunteer (i.e. NGOs) depending on the available resources at the site.

- **Retention** refers to a period when an adolescent is still under preparation phase within the same ART facility, recognizing the fact that he or she is not ready to receive care and treatment of another service. It is a state within the transition process. The retention status should be confirmed by a certain assessment performed by heath provider(s) and finally confirm by a guardian together with an adolescent himself or herself *(See Section 4.2.2.).*

- **Transition timeline** refers the start from pre-transition until completed transition. This is a possible range of timeframe that may take to assess and reassess during pre-transition and transition periods. It also gives an idea and mental readiness for the guardians as well as health-care provider about the possible time it may take for successful transition. In this context, the transition begins when adolescent aged from 10 – 14, however, this transition could be flexible based on the readiness of individual ALHIV.

4. Transition Processes

The below framework shows the flow of transition process, starting from pre-transition, during transition and post transition. There are three frameworks which consist of transfer-out strategy (figure 1), retention strategy (figure 2) and summary of ALHIV transition (figure 3). The two figures (figure 1 and figure 2) are the breakdown framework of the SOP.

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[7] AMC. Age limits and adolescents. Paediatric Child Health, 2003; 8(9): 577, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2794325/.

[8] World Health Organization (WHO). HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policymakers and managers. Geneva, Switzerland: WHO; 2013.

[9] Blum RW, Garell D, Hodgman CH, Jorissen TW, Okinow NA, Orr DP, Slap GB. Transition from child-centered to adult health-care systems for adolescents with chronic conditions: a position paper of the Society for Adolescent Medicine. Journal of Adolescent Health. 1993 Nov 1;14(7):570-6.

4.1. Pre-transition process

4.1.1. *Primary Assessments:*

Pre-transition process should be conducted to assess patient eligibility, readiness, and acceptability as described in the below criteria. Knowing their eligibility, HCP consults with both ALHIV and their guardian to ensure they understand and follow the process of the pre-transition. There should be some basic assessment to ensure an adolescent is ready to move to pre-adult stage:

1) **Review eligibility criteria:** age eligibility, two last viral-load results (with undetected VL for the transfer-out option) and HIV status disclosure readiness.
2) **Conduct the primary health education assessment:** child well-being (including ARV regimen) and heath knowledge at baseline assessment and resources needed.

More detail of these processes as follows:

1) Review eligibility criteria

Use the checklist of primary assessment to select eligible patients in each ART site by reviewing ALHIV eligibility criteria, assessing adolescent well-being (**Annex 2-Part I)**, and conducting site assessment as shown in ***Annex 1 - Checklist of primary assessment for pre-transition.***

- **Eligible Age:** Experiences from an NGO dealing with this issue (MAGNA and AHC) suggest the transition should be made according to age group: 1). ALHIV aged between 10 – 14 years old, and 2). aged >15 years old.

  The recommended age to initiate the pre-transition is from 10 years old, and the transfer-out should begin at least when an ALHIV is at least 15 years old. S/He should be evaluated every 3 – 6 months.

- **Last two viral-load results:** The last two viral load results must be evaluated to ensure suppression and good viraemic control. Before proceeding to transfer-out, the ALHIV should have the last two undetected VL results during the last 6 months period *according to Magna's experience in transferring the adolescents and AHC practical experience in transferring stable patients.*

- **ARV regimens:** It is important for clinicians, counsellors, ALHIV and guardians to get updated on the ARV regimen or the future regimen switch based on patients' increased weight bands and changes in the health condition of ALHIV. If the patient has just been recently switched to new regimens and remains unstable, the transfer-out at this time is not recommended, and they should be retained in same PAC service (*Refer to Appendix 1 and 2 for ARV regimen and dosing counselling)*

- **HIV status disclosure:** ALHIV should be aware of their HIV status. If the patient has not yet aware of their HIV status, the health care provider should discuss and collaborate with a guardian to disclose HIV status to the ALHIV before proceeding to the transfer-out. For retention, HCP and guardian should work together to disclose HIV status step by step.

  For a better outcome, early disclosure of HIV status or sickness to a child living with HIV should be conducted as early as possible by HCP and guardian. Children who delay disclosures of their HIV status might have underline causes of mental, psycho-social issues. HCP might be then reductant or opt to delay for disclosure, it is, in turn, leads to not only performing poorly at school, but also having/triggering some mental health problems. According to a Romanian study, less than half the risk of death over a 3-year

period among children ages 5–17 years who had been disclosed to compared with HIV-positive children who were not disclosed their HIV status.[10]

2) *Conduct health education assessment:*

- **Assessing well-being:** use the child well-being assessment tool to identify and analyse challenges hindering readiness of adolescent transition including nutrition, mental development, health-related issues and socio-economic status (see ***Annex 2**: **Adolescent well-being and Basic Knowledge Assessment tool***)[11].

  Also, paediatric health provider(s) should keep an eye on health, confidence, readiness and resource of a child, especially on HIV status disclosure, and perform the at least 6-month review of the key criteria/questions.

- **Assessing heath knowledge at baseline:** it is important for HCP to know the level of knowledge of his/her patients, mainly basic health knowledge (level 1) before the transition. The level 1 knowledge includes personal hygiene, basic HIV knowledge, anatomy, and preparedness in HIV disclosure. The health progression should be continuously assessed for all knowledge levels.

  After conducting health knowledge assessment, HCP reviews ***resources needed for the transfer-out which includes site and patient capability*** preparing for the next step in the transition period. Reviewing the site capacity involves reviewing an individual patient report or record on weekly or monthly basis (depending on the site routine practice) to select the eligible age of paediatric and other criteria as highlighted in ***Annex 1***. Reviewing patient capability includes health education outcomes. After the review, HCP prepare the summary list of the selected eligible patients and make appointment to discuss during the transition plan and process.

4.1.2. *Providing an overview of the transition plan and process:*

- After the primary assessment, HCP discuss with eligible/selected ALHIV about his/her transition plan whether he/she is willing to be retained or transferred out. The plan can be carried separately or together with their guardians.
  - i. If an ALHIV and his/her guardian are willing to be transferred-out to adult ART, HCP to follow the steps mapped out in B.1 (figure 1).
  - ii. However, if they prefer to be retained in Paediatric ART, HCP follows B.2 (figure 2).
- HCP obtain the informed consent to move to the next stage. If the ALHIV and guardian are to be transferred out, the ALHIV and guardian will be debriefed the about the transfer-out criteria *(Annex **3:** Patient readiness assessment, individual transition plan and information form)*.
- When ALHIV and guardian are not ready for the transition, they will be re-assessed as outlined in A (figure 1), every 3-12 months until they are ready to move to the next phase.

[10] WHO, 2011: Guideline on HIV disclosure counselling for children up to 12 years of age (see Appendix B for Summary of Findings and GRADE Tables comparing children disclosed to with those who are not disclosed to, online at http://www.who.int/hiv/topics/vct/en/index.html)

[11] This tool is adapted from ***Annex 14: Child well-being assessment tool,*** *Chapter 40 of the Cambodian National HIV clinical management guideline for infants, children, and adolescents fifth edition 2019)*.

4.2. Transition phase

4.2.1. Steps for transfer-out to adult ART site

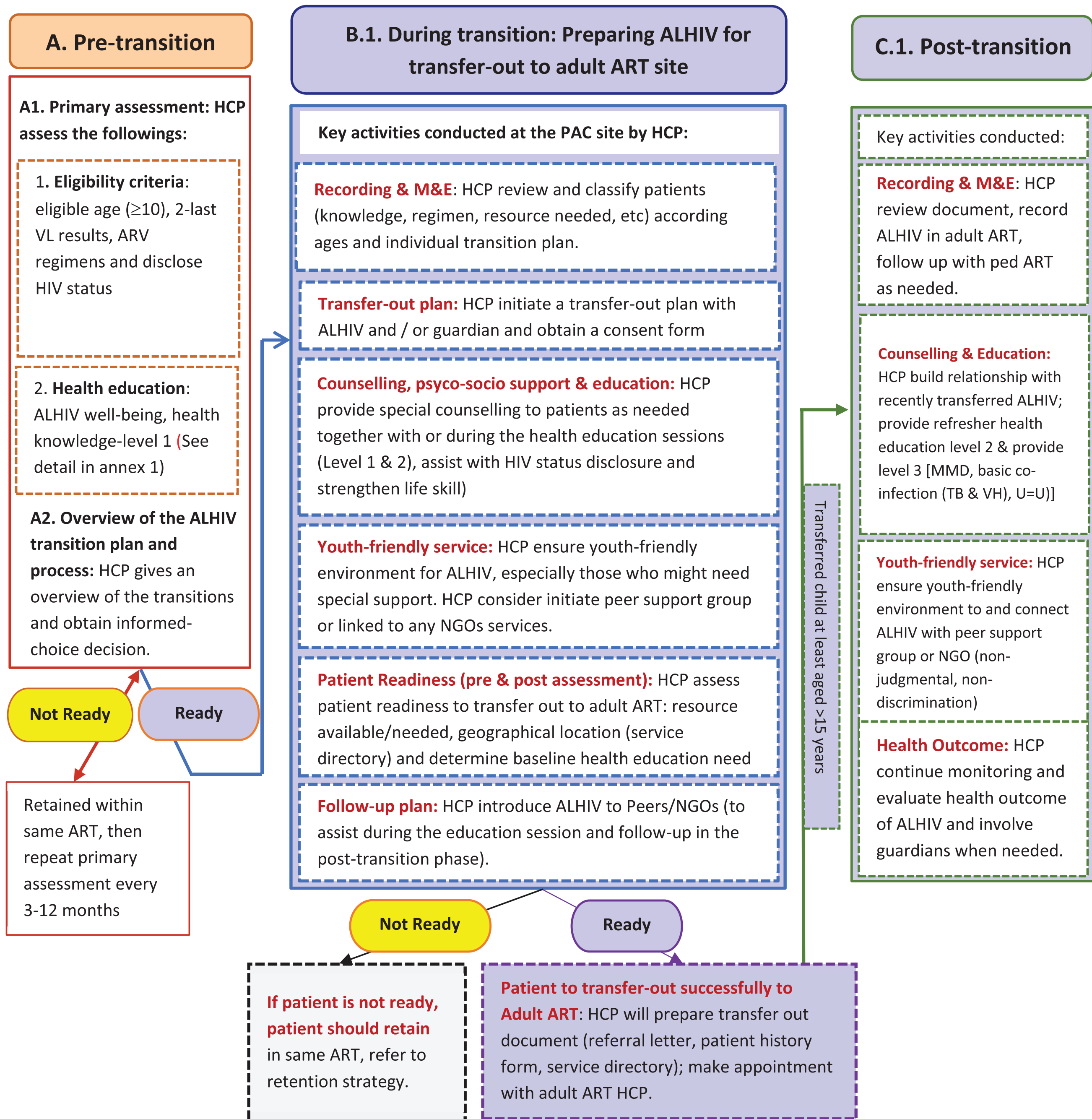

Figure 1: *Flowchart of transfer-out strategy*

In preparation for ALHIV who are willing to transfer out, key activities should be conducted at PAC sites:

1) *Recording & M&E:* HCP review and classify patients (knowledge, regimen, resource needed, etc) according to age and individual transition plan.

2) *Initiate an individual transfer-out plan:* HCP initiates a transfer-out plan with ALHIV and / or guardian and obtains a consent form. The individual transfer-out plan will assist HCP to better understand patient situation, in collaboration with patient and guardian.

3) *Assess pre-patient readiness assessment for transfer-out:* this pre-patient assessment conducts as a baseline for HCP to aide readiness assessment for transfer-out, followings tools will used *(Annex **3:** Patient readiness assessment, individual transition plan and consent form)*

4) *Counselling, psycho-socio support & education:* HCP provide special counselling to ALHIV as needed together with or during the health education sessions (Level 1 & 2), assist with HIV status disclosure and strengthen life skill) *(for details about counselling, refer to chapter 5)*

5) *Youth-friendly service:* HCP ensure youth-friendly environment for ALHIV, especially those who might need special support. HCP consider initiate peer support group or linked to any NGOs services. Youth-friendly services should be offered at all PAC and Adult sites where adolescents are receiving care (both paediatric and adult). Components of youth-friendly services could include: Designing youth-friendly facilities, designing youth friendly services, and adopting youth friendly attitudes *(See chapter #40 of the Cambodian National HIV clinical management guideline for infants, children, and adolescents fifth edition 2019).*

6) *Assess Post-Patient assessment readiness for transfer-out:* In a similar purpose as mention in point 3), HCP should complete the post-patient assessment readiness assessment for transfer-out after the completing the preparation process (*same tool in-pre-patient assessment, refer to Annex 4)*. After the assessment, HCP will understand which patients could be ready or not and act as below:

   i. If ALHIV **is ready to transfer-out to Adult ART**, HCP should use Annex 6: Referral checklist and written consent form for patients and guardian to check all relevant lists that require to complete and sign consent form for agreement. Then, HCP allow ALHIV and his/her guardian to propose adult ART sites, check the updated service directory to find Adult HCP who will be responsible for ALHIV-soon-to be transferred, and make appointment with adult ART HCP. HCP prepares following document to transfer-out:

      a) **Referral letter by hospital**: This is a summary form which provides patients data for the new ART staff. It also consists of individual patient treatment history, VL test results and other tests.

      b) **Summary patient history form:** HCP summarizes all patients who will be transferred out to another ART.

   ii. If ALHIV are not ready to transfer-out, s/he should continue in preparation process and re-assess his/her readiness in the **next 3 to 12 months** *(refer to 4.2.2. Retention Strategy).*

7) *Follow-up plan:* HCP introduces ALHIV to peer support group and/or NGOs to assist during the education session and follow-up in the post-transition phase.

4.2.2. *Steps for retaining ALHIV in paediatric ART site*

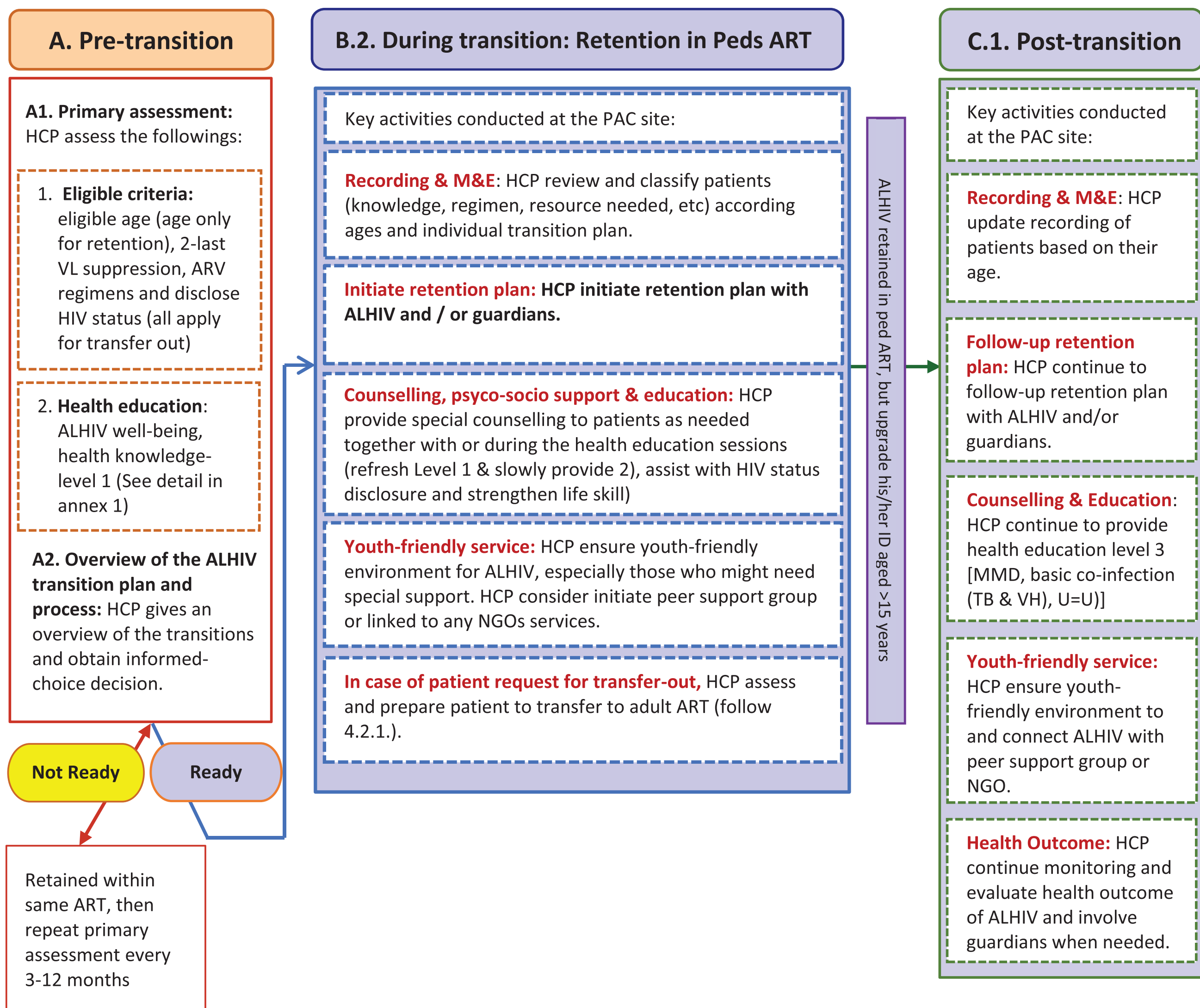

Figure 2: *Flowchart of Retention Strategy*

For retention strategy, key activities conduct at the PAC sites as follow:

1) *Recording & M&E:* HCP reviews and classifies patients based on their knowledge, regimen as resource needed according to age and individual transition plan. The classification of patients helps HCP to prepare plan to support those patients.
2) *Initiate retention plan:* HCP work with ALHIV and /or guardians to initiate retention plan. The retention plan could be a guide for patient, guardian and HCP to understand the need, plan the support, and follow up.
3) *Provide Counselling, Psycho-socio Support & Education*: HCP provides the special counselling to patients as needed together with or during the health education sessions (refresh Level 1 & slowly provide 2) and assist with HIV status disclosure and strengthen life skill).
4) *Youth-friendly service:* HCP ensures youth-friendly environment for ALHIV, especially those who might need special support (e.g. poor-cognitive development, ALHIV with autism, etc.).

HCP consider initiate peer support group or linked to any NGOs services that may be able to provide additional support (e.g. psycho-socio support, transportation, etc).

5) *In case of patient request for transfer-out,* HCP assesses and prepares patient to transfer-out to adult ART *(follow the step in 4.2.1).* If there is no request for transfer-out, ALHIV should continue to be retained in PAC clinics. When ALHIV reaches the age of 15, HCP should upgrade his/her ID and keep their profile in the adult directory.

4.3. Post Transition

4.3.1. *Steps for Transfer-out at Adult ART*

After ALHIV transfer-out to adult ART, there are key steps to do:

a) *Recording & M&E*: HCP at the adult ART reviews documents sent from PAC sites that highlight patient's treatment history. Then, record ALHIV treatment history in adult recording forms. HCP follows up with the PAC for more information as needed.

b) *Counselling & Education:* HCP builds relationship with recently the transferred ALHIV; provides them refresher health education level 2 and level 3 [i.e. MMD, basic co-infection (TB & VH), U=U)].

c) *Youth-friendly service:* HCP ensures a youth-friendly environment ands connect ALHIV with peer support groups or NGOs (i.e. flexible hours, adolescent-only clinics, peer support groups, transportation support, IEC materials, and use of cell phone messaging for support, and linked to other social medias developed by BCC/NCHADS for more information on HIV).

d) *Health Outcome:* HCP continues monitoring and evaluating health outcome of ALHIV and involves guardians when needed.

4.3.2. *Steps for Retention at PAC site*

1) *Recording & M&E*: HCP updates the recording of patients based on their ages. When ALHIV reaches the age of 15, HCP upgrades his/her ID and keeps their profile in the adult directory.

2) *Follow-up retention plan:* HCP continues to follow-up retention plan with the ALHIV and/or guardians.

3) *Counselling & Education:* HCP continues to provide health education level 2 and level 3 [MMD, basic co-infection (TB & VH), U=U)] based on the needed of individual patients / groups (for more detail, *follow Counselling Support-and Roles and Responsibilities of ALHIV, Guardian and Health Care Providers.*

4) *Youth-friendly service:* HCP ensures youth-friendly environment to and connect ALHIV with peer support groups or NGOs (i.e. flexible hours, adolescent-only clinics, peer support groups, transportation support, informational materials, and use of cell phone messaging for support).

5) *Health Outcome:* HCP continues monitoring and evaluating health outcome of ALHIV and involves guardians when needed.

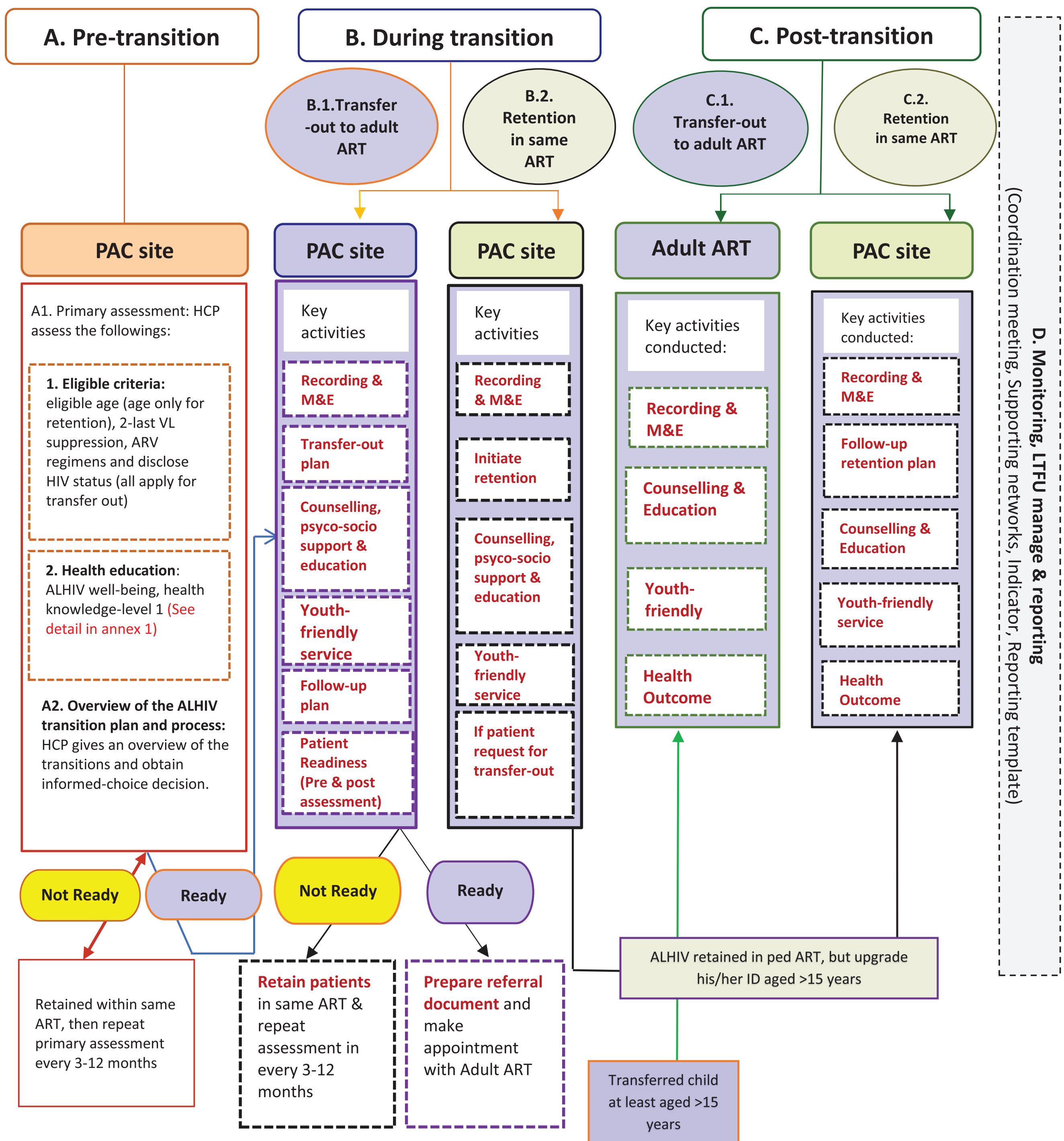

Figure 3: *Summary of ALHIV transition process*

5. Counselling supports

5.1. Steps to conduct counselling sessions

Proper counselling (individual or in a group) should be provided to adolescents and family during the pre-transition period. The counselling should also include assessment of their opinions for transition, when they are ready, who and how to support a transition. Here are the key steps:

Step 1 - Provide counselling to guardians to firstly address the disclosure about HIV status (if not yet disclosed). Another, ARV adherence awareness should be raised as well to support and guide guardians a pathway which help an adolescent to dependently manage the ART appointment by himself/herself at one point. Pre-Transition Assessment is conducted to understand key elements such as how to make ART appointment, identify and seek support from a health provider and others, manage their ARV medication, and take responsible for his/her own health and health of others.

Step 2 - Encourage patients and guardians to follow their roles & responsibility *(refer to VI. Roles and responsibilities of ALHIV, Guardians and HCP).*

Step 3 - Allow ALHIV to identify an adult ART site which he/she finds convenient. So, a paediatric health care provider should provide detail on preferred sites to ALHIV, where necessary additional NGO support should be leveraged (for the transferred-out option, refer to B.2.).

Step 4 - Assess basic HIV knowledge, willingness to disclose HIV and others step by step (*See Annex 3: Knowledge Assessment for Pre-Transition*), then draw a conclusion about it. If an ALHIV and guardian are still not yet ready, repeat the assessment and session every 3 to 6monthly at least. *It is crucial import to note that the assessment should not put pressure on an ALHIV and guardian about transfer-out, it's always about an informed-choice decision made by themselves and under the duty of care of health providers in supporting a smooth transition.*

Step 5 - Engage good support from other stakeholders (the programs or service providers) to address adolescents' readiness should focus on engaging parental support in terms of guardian or foster parents either in community or orphanage as well as family members and friends where it is applicable[12] Experience from ART sites and NGO and finding from community also confirmed similarly evidences.

5.2. Knowledge levels for ALHIV by age-appropriate:

Knowledge categories for possible group sessions or individual sessions and pick a possible calendar suitable for both HCP and ALHIV. **See annex 2, part II.**

1) **Basic knowledge (Level I):** this basic knowledge has been provided by HCP at the PAC before the start of pre-transition. However, the level of understanding could be different from one patient to another. Therefore, is important for HCP to recap and provide the gap knowledge for ALHIV (***Refer to table 1: Suggested knowledge levels for ALHIV by age-appropriate level).***
2) **Secondary knowledge (Level II):** this upper level of knowledge as describe in table 4 should be provided during the preparation to transfer-out as well as retention based on the evaluation by HCP. HCP could decide to choose the sessions appropriate to the patient's acceptability (***Refer to table 1: Suggested knowledge levels for ALHIV by age-appropriate***

[12] Icard LD, Jemmott JB, Carty C, O'Leary A, Sidloyi L, Hsu J, Tyler J, Martinez O. Retention of South African adolescents in a 54-month longitudinal HIV risk reduction trial. Prevention Science. 2017 Jul 1;18(5):534-40.

level). HCP should ensure that the knowledge should well assessed during the pre-transition, within the counselling session.

3) **Tertiary Knowledge (Level III):** this advanced level of knowledge should be appropriate for post transition either for retention or transfer-out. This knowledge should be mainly provided to patients who are 15-year-old and over.

Table 1: Suggested Knowledge Levels for ALHIV by age-appropriate level

Age Categories	Pre-transition	During transition		Post transition	
		Retention	Transfer-out	Retention	Transfer-out
10 - 12 years	I	I or II	-	-	-
13 - 14 years	I + II	II (I+II)	II	II	-
> 15 years*	-	-	-	III (I+II+III)	III
**** must repeat level I, II if they never expose to those levels.***					

Categories

- **Basic knowledge (Level I):** personal hygiene, basic HIV knowledge, prepared for HIV disclosure
- **Secondary Knowledge (Level II):** OIs, HIV disclosure, ARV regimen, EAC (self-adherence), SRH, STI, FP, and positive prevention.
- **Tertiary Knowledge (Level III): MMD, basic co-infections (TB & VH), U=U**

Having addressed the basic knowledge among ALHIV would make the transition more successful. By tailoring knowledge and skills of ALHIV on HIV care, medication management, appointment management, harm reduction behaviours are proved to help them to be ready for transition. Below are key considerations for health providers to follow in addressing health education sessions in PAC setting.

i. Initiate and set up routine meeting sessions, preferably based on ARV appointment schedule (every 2 or 3 months).

ii. Facilitate / create a channel which enables a voluntary-based group counselling. Where possible, help them be prepared for a group transition plan.

iii. Identify self- or group management needs of ALHIV and their caregivers.

iv. Plan the session step-by-step and in an adolescent-friendly manner. Followings are the series of structured core sessions which are necessary for ALHIV, peers and guardians:

It can be culturally sensitive topic for ALHIV. Be sure that basic knowledge on the issues do not imply that ALHIV are caring the any problem at the moment, no judgement on the participants. Be clear to them that it's commonly happening in adults, and they are only equipped with some basic knowledge on the issues.

There might be more sub-set of the topics depending on the age limit group, and various interests. It is recommended that the counsellor should use multiple materials such as printed, audio and video tools to aid the discussion and extend the sessions if necessary. Provide basic knowledge how to browse additional learnings via other social medias and NGO networks.

Encourage peer-mentor among those who are active and trusted by others. For confidentiality, counsellors should give space to peers or individual ALHIV to chat in a private and secured space.

6. Roles and responsibilities of ALHIV, Guardians and HCP

This section outlines the roles and responsibilities of ALHIV, Guardians and HCP in all phases. In addition to HIV care and treatment, HCP should be well-knowledgeable on SRH, STI, FP, positive prevention, life skills, basic co-infection (TB & VH), U=U in order to provide education/counselling to ALHIV from level I to III.

6.1. Pre-Transition

Table 2: Roles and Responsibility Matrix for Pre-transition at PAC Sites

Key Groups	Roles and Responsibilities for Pre-transition at PAC Sites
ALHIV	1) Participate in counselling session as appointed by HCP/counsellors 2) Listen carefully, ask for clarification and understand the transition process either transfer-out to Adult ART or retention in paediatric ART
Guardians	1) Provide physical, mental and financial support to an ALHIV in the pre-transition process (i.e. accompany ALHIV to PAC site, encourage ALHIV to ask question, etc); 2) Listen carefully, ask for clarification and understand the transition process either transfer-out to Adult ART or retention in same ART sites; 3) Encourage his/her ALHIV in pre-transition and help them to understand the transition process; 4) Know the requirement and necessary documents to go to adult ART sites; 5) Understand and prepare the support to their children during the transition
Health Care Providers (HCP)	1) Be knowledgeable about and responsive to all the transition steps and the required tools 2) Ensure an ALHIV is well informed in every step and assisted with necessary individual plan either for the retention and the transfer-out plan 3) Use the eligibility criteria and assessment (baseline & end-line) to determine knowledge, behavior, and ARV adherence before and during the transition process 4) Assess the needs of adolescents and their caregivers, then help them to develop a transition plan for ALHIV based on the needs. Note: the plan must be customized based on an individual adolescent capabilities and resource such physical, mental, social, spiritual and health and wellbeing

6.2. During Transition

6.2.1. Transfer-out Preparation

Table 3: Roles and Responsibility Matrix for Transfer-out Preparation at PAC Sites

Key Groups	Roles and Responsibilities for Transfer-out Preparation at PAC Sites
ALHIV	1) Learn and slowly ask and to provide information in a constructive way:

Key Groups	Roles and Responsibilities for Transfer-out Preparation at PAC Sites
	- how the child would like to do things by his / her own (i.e. take care their own health, manage ARV drug (i.e. # of ARV taken, ARV-taken reminder, ARV safety storage, and drug-side effect monitoring) - how to bring their drug if they go far away from their houses (# travelled days, # ARV-taken plus extra two days, etc.) - how to improve the quality of life (i.e. physical hygiene in daily activities, balance diet, enough exercise, harmful habit avoidance, and stress management) 2) Improve their knowledge by them joining a support group if available to learn other peers who could do better for their medical adherence or listen carefully to counselors or ask question if they wish to learn more 3) Learn how his / her problem-solving skill like how to identify their sickness; who to consult/contact when s/he faces challenges and seek additional advice from the health provider if needed; what to do to deal with their problem/sickness 4) Understand the requirements and necessary documents to go to adult ART sites 5) Access to new adult ART sites on the recommended date/schedule on time 6) Reinforce that they do not wait until they finish all the ARV drug before returning
Guardians	1) Provide physical, mental and financial support to an ALHIV in the transition process – i.e. encourage ALHIV to love his/her health and be responsible for his/her own health and health of a wider community. *Refer to the Enhanced Adherence Counselling and the Undetected=Uninfected counselling materials for more detail messages.* 2) Provide countless support to an ALHIV for his/her daily ARV regimen to ensure no ARV interruption (i.e. what ARVs, daily aide to ARV administration /reminder, ARV storage, monitor drug side effects, planned travel). 3) Remind the date of ART appointment to ensure ALHIV could manage to get the service on time. Use mobile alarm clock if needed and save the contact person just in case of an emergency. 4) Let his/her child know who to seek for support if needed. 5) Ensure available transportation or arrange a timely and safe mean. 6) Know the requirement and necessary documents to go to adult ART sites 7) Understand and prepare the support to their adolescents during the transition 8) Monitor and follow up his/her adolescents' behavior to medical adherence especially during the beginning of transition until they can manage himself/herself successfully.
Health Care Providers (HCP)	1) Be knowledgeable about and responsive to all the transition steps and the required tools; 2) Ensure an ALHIV is well informed in every step and assist with necessary individual plan either for the retention and the transfer-out plan;

Key Groups	Roles and Responsibilities for Transfer-out Preparation at PAC Sites
	3) Manage, in part, by a case manager or play role as a case manager until an ALHIV smoothly settle down in an adult setting; 4) Use the assessment and evaluation tools (baseline & end-line) to determine knowledge, behavior and ARV adherence before and during the transition process; 5) Assess the needs of adolescents and their caregivers, then help them to develop a transition plan for ALHIV based on the needs. Note: the plan must be customized based on an individual adolescent capabilities and resources such physical, mental, social, spiritual and health and wellbeing. **6) <u>For the soon-to-be transferred patient:</u>** ‣ Be a mediator between and within the pediatric and adult ART clinics; ‣ Be sure that an ALHIV visits an adult ART site which he /she wishes to get services; ‣ Ensure a clinician will or prescribe the same ARV drugs to avoid any confusion until they get new drug prescription at a new adult ART service (at least HCP should prescribe ARV drug 3 months; patients should register at adult ART when they have their drug as soon as possible or at least 1 month in hand). Below are key tasks for HCP to prepare for soon-to-be transfer-out patient: **a) Medical Doctors (MD)** ✓ prepare referral letter and summary patient form: ensure that the form completely fill all necessary information including name of peds responsible provider, contact number, and address ✓ Patients need to have viral load undetectable (in the last 2 times - check viral-load based on technical requirement (viral-load result should be valid within 6 months before transfer-out) ✓ work with the data officer/manager to extract patient data to be able to note in summary patient form ✓ send detailed information of patients to registration unit (other sites keep filling in …) ✓ In case of no peer / parental support – group transition is encouraged (at least two adolescents) to go together to support each other **b) Nurse/Counsellor** ✓ Assist doctor to place referral letter & summary patient form into the envelop ✓ Provide counselling to patients/care giver on preparation while transferring to adult ART sites ✓ Inform patients + guardians to bring two handled documents along with them to adult ART clinics ✓ Arrange meeting plan between new health providers and transitional patients in advance of their final appointment ✓ Make appointment with adult ART clinics before transferring

Key Groups	Roles and Responsibilities for Transfer-out Preparation at PAC Sites
	c) NGOs/Adolescent peers ✓ Check with the ALHIV the support needed ✓ Communicate with NGOs/peers at adult ART clinics before visits/transfer-out ✓ Accompany the ALHIV to adult ART sites to get to know the location, available services, and health providers that they may get enroll for ART services ✓ Provide individual or group counselling to encourage the ALHIV to minimize their concern and be ready for their transition

6.2.2. *Retention*

Table 4: Roles and Responsibility Matrix for Retention at PAC Sites

Key Group	Roles and Responsibility for Retention at PAC Sites
ALHIV	1) Join the counselling session with counsellor to plan his/her own transition plan 2) Learn to do things by his / her own based on advice from HCP (i.e. take care their own health, manage ARV drug (set alarm to remind (# of ARV taken, ARV-taken reminder, ARV storage, monitor drug side effects, how to bring their drug if they go far away from their houses, …) 3) Join a support group if available to learn other peers who could do better for their medical adherence or listen carefully to counselors or ask question if they wish to learn more 4) Learn his / her problem-solving skill like how to identify their sickness; who consult/contact when s/he faces challenges and seek additional advice from the health provider if needed; what to do to deal with their problem/sickness 5) Understand the requirement and necessary documents to go to adult ART sites 6) Access to new adult ART sites on the recommended date/schedule on time 7) Understand that they do not wait until they finish all ARV drug
Guardians	1) Provide physical, mental and financial support to an ALHIV during their retention – i.e. encourage ALHIV to love his/her health, responsible for his/her own health and health of a wider community. *Refer to the Enhanced Adherence Counselling and the Undetected=Uninfected counselling materials for more detail messages.* 2) Provide countless support to an ALHIV for his/her daily ARV regimen to ensure no ARV interruption (i.e. what ARVs, daily aide to ARV administration /reminder, ARV storage, monitor drug side effects, planned travel). 3) Remind the date of ART appointment to ensure ALHIV could manage to get the service on time. Use mobile alarm clock if needed and save the contact person just in case of an emergency. 4) Let his/her child know who to seek for support if needed. 5) Ensure available transportation or arrange a timely and safe means.

Key Group	Roles and Responsibility for Retention at PAC Sites
	6) Monitor and follow up his/her behavior to medical adherence especially during the beginning of transition until they can manage himself/herself successfully 7) Know the requirement and necessary documents to go to adult ART sites 8) Understand and prepare the support to their children during the transition
Health Care Providers (HCP)	1) Be knowledgeable about and responsive to all the transition steps and the required tools 2) Ensure the ALHIV is well informed in every step and assist with necessary individual plan either for the retention and the transfer-out plan 3) Manage, in part, by a case manager or play role as a case manager until the ALHIV smoothly settles down in an adult setting 4) Use the assessment and evaluation tools (baseline & end-line) to determine knowledge, behavior, and ARV adherence before and during the transition process 5) Assess the needs of adolescents and their caregivers, then help them to develop a transition plan for ALHIV based on the needs. Note: the plan must be customized based on an individual adolescent capabilities and resource such physical, mental, social, spiritual and health and wellbeing

6.3. Post Transition

6.3.1. *Transfer-out*

Table 5: Role and responsibility matrix of HCP, ALHIV and Guardian at Adult ART Sites

Key Group	Role and responsibility matrix of HCP, ALHIV and Guardian at Adult ART Sites
ALHIV	1) Follow the recommendation/advice from adult ART providers; 2) Learn to manage their schedule/transportation to receive ART service at adult ART sites; 3) Inform/consult with guardians/ peers/ health care providers for support if there are any challenge or change; 4) Learn to adapt to the new environment of ART adult clinic; 5) Monitor and follow up his/her own health and medical adherence after the transfer-out
Guardians	1) Provide physical, mental and financial support to an ALHIV after transfer-out (i.e. encourage ALHIV to love his/her health, responsible for his/her own health and health of a wider community, *Refer to the Enhanced Adherence Counselling and the Undetectable=Untransmittable counselling materials for more detail messages)* 2) Monitor and follow up his/her adolescents' behavior to medical adherence especially after transfer-out they can manage himself/herself successfully. 3) Consult/seek for support to HCP when there are any possible challenges with his/her recent transition adolescent(s)

Health Care Providers (HCP)	**1) Medical Doctor/ Nurse/Counsellors** ▸ Prioritize schedule for new transition patients - make a few separate appointments for their ARV medication; ▸ Monitor / follow up ALHIV health of new transition patients and offer other necessary support. ▸ Enhance adolescent-friendly environment in the way of communication, judgement, relationship building-feel warm and trust to share their personal information, story. **2) NGO/ Peer adolescent network** ▸ Inform already transferring adolescents to seek for support at PAC sites if they need by providing them contact number; ▸ Promote peer adolescent network to encourage in the follow up plan (AHC – peers follow up at least 2 times after the transition to adult ART clinic; ▸ In case of complicated cases (i.e., domestic violence, lack of environmental support at home or family): counselor/peer adolescents keep follow up with transferred adolescents if LTFU 3 - 6 months.

6.3.2. Retention

Table 6: Role and responsibility matrix of HCP, ALHIV and Guardian at PAC Sites

Key Group	Role and responsibility matrix of HCP, ALHIV and Guardian at PAC Sites
ALHIV	1) Follow the recommendation/advice from adult ART providers 2) Learn to monitor and follow up his/her own health and medical adherence 3) Inform/consult with guardians/ peers/ health care providers for support if there are any challenge
Guardians	1) Continue to provide physical, mental and financial support to an ALHIV at PAC site where it is necessary 2) Understand and prepare the support to their adolescent during the transition 3) Monitor and follow up his/her adolescents' behavior to medical adherence especially after transfer-out they can manage himself/herself successfully.
Health Care Providers (HCP)	**1) Medical Doctor/ Nurse/Counsellors** ▸ Follow up ALHIV health income and offer other necessary support as needed ▸ Enhance adolescent-friendly environment in the way of communication, judgement, relationship building-feel warm and trust to share their personal information, story. **2) NGO/ Peer adolescent network:** ▸ Promote peer adolescent network to encourage in the follow up plan (AHC – peers follow up at least 2 times after the transition to adult ART clinic.

7. Monitoring and Reporting

7.1. Monitoring Indicators & reporting

Each site should record the core indicators relevant to the transition, based on each patient record. On quarter basis, counsellor should send the summary record (and individual record) to data clerk, following the ART reporting period, *refer to appendix 3.*

7.2. Monitoring process & LTFU Management

To effectively monitor and facilitate the successful transition, the following activities are proposed:

- Organize quarterly meeting between Peds & Adult ART clinic in the areas or across national levels to track the data of referral and LTFU,
- Also, improve the coordination between Paediatric & Adult ART clinics in the areas,
- In the absence of Peer support group / NGO support: follow-up call is not possible, and
- In term of reporting template, HCP uses to reporting template of re-engagement SOP.

Annexes

Pre-transition Tools

Annex 1: Checklist of primary assessment for pre-transition (for HCP)

Patient Information	
Patient Clinic ID: ………………………………………………	Patient ID (ART number): …………………………………
Sex: ………………………………………………………………	Age: ………………………………………………………………
Counsellor's name: ……………………………………………	Date: ……………………………………………………………

N°	Description	Yes	No	Remark
A.	**Review eligibility criteria**			
I	**Age criteria**			
1.1	Eligible age for pre-transition assessment:			
	‣ ≥ 10-year-old: pass pre-transition assessment			
	‣ 11 – 14-year-old: ALHIV will be in transition phase (either preparing for transfer-out or retention).			
	‣ ≥ 15 -year-old: ALHIV will move to post transition (transfer-out or retention)			
II	**Viral load result**			
2.1	Viral load suppression: last two results suppressed (NCHADS) and most recent result within 6 months			
2.2	1st Viral load result: Date of VL …………………………………… Result of VL ……………………………………			
2.3	2nd Viral load result: Date of VL …………………………………… Result of VL ……………………………………			
III	**ARV Regimens**			
3.1	‣ 1st line regimen (current) ARV regimen……………………………………			
	‣ ARV regimen……………………………………			
	‣ ARV regimen……………………………………			
IV	**Have PLHIV received HIV disclosure?**			
4.1	A. PLHIV and family has not disclosed yet			
4.2	B. PLHIV and family has disclosed			
4.3	C. PLHIV and family plan to disclose			

N°	Description	Yes	No	Remark
4.4	D. Semi disclosure by HCP			

Note: *Child aged >6 (A, B, C); D is for a child aged <6; * a child was informed about an infection in which a child requires a lifelong treatment and continuous VL monitoring for the whole life.*

General conclusion for next steps:

By counsellor (name and date): ____

____

____

By Clinician (name and date): ____

____

____

Annex 2: Adolescent Well-being and Basic Knowledge Assessment

Patient Information	
Patient Clinic ID:	Patient ID (ART number): ....
Sex:	Age: ....
Counsellor's name:	Date: ....

Part I: Adolescent Well-being Assessment			
Description / Statement	**None of the Time**	**Some of the Time**	**All of the Time**
1.1. Nutrition			
I eat at least two meals a day with at least one meal including some meat and vegetables			
I have less to eat than other members of my household			
1.2. Education			
I attend school regularly			
I have the materials I need to do my class work			
I go to school, there is a support person help me to go to school			
I like school			
1.3 Financial situation			
My family has enough money to buy basic needs			
My family can afford for transportation for doctor appointments			

1.4 Physical health and well-being			
I feel strong and healthy			
I worry about my health			
I am growing as well as other kids my age			
I feel like I have the opportunity or luck like other kids			
1.5 Mental health and social connection			
I am as happy as other kids at my age			
There is an adult at home (e.g., parent/guardian) or in the community (e.g., neighbour) whom I trust and who supports me emotionally			
I have at least one friend with whom I can share a secret and whom I trust			
Note: Provider should use K10 tool (Kessler Psychological Distress Scale) see Annex 5, to assess patient's mental health condition.			
1.6 Pressure, harms, and sexual health			
I understand the changes my body goes through during puberty (adolescence)			
I know how a girl can become pregnant and how to prevent that from happening			
I know how to prevent spreading of HIV			
I feel like I can make my own decisions about things that are important to me			
I have people asking for love and marriage, making it very difficult for me to answer them.			
My body is sometimes abused, for example I sometimes experience strong hitting or beating or bad touch.			
I do things that can put me at-risk of getting STD or STIs or getting pregnant (girls)/or making someone pregnant (boys)			

General conclusion for next steps:

By counsellor (name and date): ____

____

____

By Clinician (name and date): ____

____

____

Part II. Basic Knowledge Assessment					
Assessment date	DATE (Pre)		DATE (Post)		
Description / Statement *(Scoring: answer "Yes"=1, "No" = 0)*	**Yes**	**No**	**Yes**	**No**	**Remark**
Education Level I					
a.1. Basic HIV Knowledge					
1) Does the ALHIV understand what HIV is?					
2) Does the ALHIV understand how HIV spreads from one person to other?					
3) Does the ALHIV know how to prevent the spread of HIV from one person to other?					
4) Does the ALHIV understand how HIV affects the CD4 cell count?					
5) Does the ALHIV understand the laboratory tests he/she have?					
6) Does the ALHIV know what viral load is?					
7) Does the ALHIV know what ARV treatment is?					
8) Does the ALHIV know what kinds of drugs he/she are taken?					
a.2. Personal hygiene					
9) Does the ALHIV exercise regularly? If yes, How often per week? (3 times/hours per week is yes, >3 is no)					
10) Does the ALHIV brush his/her teeth regularly? If yes, How often per week? (at least every day "yes", not everyday is "no")					
a.3 Preparing for HIV disclosure-					
11) Does the ALHIV know why he/she are taking medicine every day?					
12) Does the ALHIV know if there's any health consequences if he/she doesn't take his/her medicine as the doctor recommended?					

13) Has the ALHIV's parent(s) or guardian told him/her about why his/her parent(s) or guardians are taking a life-long medication?					
14) Does the ALHIV know the hospital where he/she are picking up his/her regular drugs?					
15) Does the ALHIV feel bad about his/her daily medication?					
Total score a.1 + a.2 + a.3 (For Post assessment: If score 1-6 = poor; 7-11 = average; >11 = acceptable. From score >9, possible for moving to education level II)					
Assessment date	DATE (Pre)		DATE (Post)		
Description / Statement *(Scoring: answer "Yes"=1, "No" = 0)*	**Yes**	**No**	**Yes**	**No**	**Remark**
Education Level II					
b.1. Opportunistic infections (OIs)- Does the ALHIV correctly answer:					
1) What is an OI?					
2) What is an example of common OIs?					
3) How do people get OIs?					
4) What affects can OIs cause to people?					
5) What kind of people who are more likely to get OIs?					
6) How can you prevent getting OIs?					
b.2 HIV Disclosure- Does the ALHIV correctly answer:					
7) Do you know that you are on ART/HIV treatment?					
8) Do you think you can let your friends know that you have HIV?					
9) Would the ALHIV keep HIV status as secret to everyone?					
10) Would you feel bad if your friends know about your HIV status?					
11) Do you know what to do if you were discriminated by your friend or there's any stigma among your friends?					

12) Do you know if peer knows any HCP that could go to for help if there's discrimination?					
13) Do you have any knowledge about HIV disclosure?					
14) Do you have any comments or any suggestions for us so we can help you go through this situation?					
15) Are you able to ask questions to your doctor?					
b.3 ARV regimen- Does the ALHIV correctly answer:					
16) What is ARV and how do they work?					
17) What is the name of your medications /drugs?					
18)What could happen to your health if you don't regularly take your medication?					
19) Why is the CD4 test monitored, and how often?					
20) Why is the VL test monitored, and how often?					
b.4 EAC (Self-adherence)- Does the ALHIV correctly answer:					
21) Why is it important to take medicines every day?					
22) Do you know how to maintain your adherence? OR How do you make sure to take medicines every day?					
23) What could happen to your health if you don't take your medicines every day?					
24) What are reasons why a HCP would switch a regimen?					
b.5 SRH, STI, FP)- Does the ALHIV correctly answer:					
25) Do you understand the basic concept of SRH? (i.e. what health matters are important to think about when having sex (i.e. protection, family planning, STI… etc)?)					
26) Can you describe how to maintain good SRH among people at your age?					
27) Do you know what are good health practices around having sex?					
28)Do you know where and how could you find out more information about healthy sexual behaviour?					
29)Do you know why people contact STI?					
30) Do you know how to prevent from STI?					

31) Do you know where to get STI knowledge and service?					
32) Do you know why people need family planning?					
33) Do you know where to get family planning knowledge and service?					
b.6 Positive prevention- Does the ALHIV correctly answer:					
34) Can you tell what positive prevention is?					
35) Do you know who are at risk of infection?					
36) Do you know how to prevent people from infections of any sexual related disease?					
Total score b.1 + b.2 + b.3 + b.4 + b.5 + b.6 **(For post assessment: If score 1-15 = poor; 16-24 = average; >24 = acceptable. From score >20, possible for moving to education level III)**					
Assessment date	DATE (Pre)		DATE (Post)		
Description / Statement *(Scoring: answer "Yes"=1, "No" = 0)*	**Yes**	**No**	**Yes**	**No**	**Remark**
Education Level III					
c.1 MMD- Does the ALHIV correctly answer:					
1) How often you come get your ARV? (e.g 2, 3 or above months)					
2) Do you know what MMD is? And its purpose? **Note:** If yes, continue to question 3. If no, skip question 3 and provider should introduce MMD to the patient.					
3) Can you tell what the eligibility criteria of MMD are?					
c.2 Basic Co-infections - Does the ALHIV correctly answer:					
4) **General:** Have you ever heard of HIV-co-infection?					
5) If yes, what are the possible main co-infections that deteriorate PLHIV health condition?					
6) **TB:** Have you ever heard of TB?					
7) If yes, do you know why you need TB Preventative Therapy?					

8) If yes, do you know where and when to get treatment?					
9) **HCV:** Have you ever heard of HCV infection?					
10) If yes, do you know why PLHIV are at risk of getting HCV co-infection?					
11) If yes, do you know what the elevated risks are associated with HIV?					
12) If yes, do you know where and when to get treatment?					
c.3 U=U - Does the ALHIV correctly answer:					
13) Do you know how to prevent HIV transmission to a partner or infant?					
14) Do you know how to stabilize your health just like the other non-HIV infected people?					
Total score c.1 + c.2 + c.3 **(For post assessment: If score 1-6 = poor; 7-9 = average; >9 = acceptable)**					

Transition for transfer-out for ALHIV aged 15 and above

Annex 3: Patient readiness assessment before transfer-out/retention strategy, individual transition plan and information form

Part I: Patient Readiness Assessment			
B1. Understanding HIV Status **(Scoring: answer "Yes"=1, "No" = 0)**	**Patient response**		**Remark**
	Yes	**No**	
1) Have you been disclosed your HIV status?			
2) Understanding HIV basic knowledge			
3) Understanding CD4 test purpose			
4) Understanding VL test purpose			
5) Understanding of evolution of HIV interacting with CD4 T cells?			
B2. Knowledge of his/her health:	**Yes**	**No**	
6) Do you understand what caused the change of your medical condition?			
7) Do you manage your daily treatment needs and understand the important of the medications you take?			

8) Do you have any problems with your daily treatments?			
9) Do you know/understand the results of your latest blood test?			
B3. Understanding how to keep healthy	**Yes**	**No**	
10) Do you use alcohol, drugs, and cigarettes and/or of risk reduction behaviours?			
11) Should you continue to take ART even if you feel sick?			
12) Do you know when you're getting sick such as a cold and you know what to do?			
2.4 Know their life skills	**Yes**	**No**	
13) Do you have a phone to use in case of an emergency?			
14) Do you have phone numbers of friends and family to call in case of an emergency?			
15) Are you responsible for making appointments with your providers?			
16) Are you responsible for refilling your medications?			
17) Do you have an attendant, home health aide?			
2.5 Know how to communicate effectively	**Yes**	**No**	
18) Are you able to ask questions of your health providers?			
19) Are you able to contact teen/young adult support groups?			
Level III			
2.6 Demonstrates responsible sexual activities:	**Yes**	**No**	
20) Do you understand of diagnosis of pregnancy?			
21) Do you understand the link between HIV and pregnancy?			
22) Do you understand the risk of abortion and the impact of early pregnancy?			
23) Are you able to avoid sexual harassment and way to seek for support when needed?			
24) Do you know what a STD is and how it can affect you and how to prevent STDs?			
2.7 Information regarding reproductive health	**Yes**	**No**	

25) Do you know about contraception and know when to seek birth control counselling?			
26) Do you understand the problems associated with teenage/unplanned pregnancies?			

Conclusion of the readiness assessment and information form

Checklist #01: ALHIV Transition (for Adolescent)

The purpose of this adolescent transition checklist is to check adolescent their knowledge and acceptance to transfer out from pediatric ART to adult ART sites. Your transition could change your health care provider and your health care, and you should talk to your health care provider and guardian to ensure that you will be well-prepared before your transition. In order to have a smooth transferred out, you need to do the following tasks as list below. This information checklist will assist adolescent to think about their self-care.

Based on the score, HCP will tick followings to understand the ALHIV's understand them before the transition:

- ☐ Understand about HIV/AIDS and their health care;
- ☐ Understand about sexual and reproductive health;
- ☐ Know their ARV regimens and take adherence medication and if they forget to take their ARV, they will know how to deal with it;
- ☐ Know how to prepare their ARV based on doctor/HCP's prescription;
- ☐ Participate in all appointment with their HCP and community health care
- ☐ Can solve any problem when they face health challenges;
- ☐ Be able to seek for support from other health care facilities and community.
- ☐ Can prepare their transition plan before transferring out

Checklist #02: ALHIV transition (for Guardians)

The purpose of this information checklist is to provide information about the ALHIV enrolment in pre-transition process to guardians of ALHIV. In addition, this checklist also intends to inform guardians how to support ALHIV in the process of this pre-transition from pediatric ART site until successful transition to Adult ART sites. The adolescent transition is the process of changing to be self-caring which are quite challenging for adolescent patients. It is because the adolescents will need to solve many challenges they may be facing. Besides these, they need to learn how to manage HIV. This period may be also a critical period to ALHIV's families due to ALHIV patients may take the right in self-management and decision making. In this pre-transition, health care providers, guardians and community encourage ALHIV to take their own high responsibility for their health.

Please use information checklist below to confirm that patients in the monitoring for pre-transition and as guardians they will support ALHIV to take high responsible in caring their health.

Ability of ALHIV in doing the followings, with support from guardian:

- ☐ Follow HCP's advice, get ARV on themselves and properly use ARV by themselves;
- ☐ Make appointments with health care providers by themselves and be on time at their appointments;
- ☐ Prepare their own transportation for their appointments;
- ☐ Record or note any appointment time to meet health care providers and other appointments;
- ☐ Can receive other social services in their community and health facilities / other health care services;
- ☐ Can tell / discuss about their health problems with health care providers and counsellors.

(Optional) Date: ………………../…………………./…………………

Signature / Thump print

Name of guardian: ……………………………………

Checklist #03: ALHIV Transition (for Health Care Provider)

The purpose of this information checklist is to remind and use other important tools that should be helpful for health care provider to assess the readiness of ALHIV for their transition or not yet.

Below is necessary to properly check by counsellor before transferring ALHIV to Adult ART services:

- ☐ Adolescent and their guardian are well prepared for the transition;
- ☐ Pediatrics care provider has contacted to adult care providers to inform adolescent transition before transferring them out;
- ☐ HCP already completed patient summary form (Transition for transfer-out for ALHIV aged 15, Annex 3) for 1 copy and referral letter (Depending on hospital administration);
- ☐ Adolescent has completed all tasks as in adolescent checklist;
- ☐ Adolescent has at least 50% correctly answered all questions in HIV/AIDS knowledge;
- ☐ Adolescent can maintain enhanced adherence medication and have plan in the future;
- ☐ Adolescent can communicate with health care provider in the time of changing health and inform when they need emergency support;
- ☐ Need psychological support that have been solved by social team of the hospital;
- ☐ Adolescent has visited adult ART sites before the transition;
- ☐ Adolescent / guardian have understood the process and accept to transfer to adult ART sites.

(optional) Date: …………………………. /…………………/…………………….

Signature / Thump print

Name of Counsellor: …………………………………………..

Post-transition Tools

Annex 4: Evaluation for Post transfer-out (HCP/NGO/Peer Counsellor)

Note:

- *The follow-up should be done between 3-12 months; and after the ALHIV maintaining 2 ARV appointments with stable results.*
- *If the follow-up of the 2nd appointment with 2 stable results, the follow-up could be stopped and the ALHIV should continue ARV follow-up as other adult's appointment.*
- *If the ALHIV's 1st or 2nd appointment did not show good/unstable result at the new Adult ART service; the counsellor should continue addressing the ALHIV concerns. There should be at least 2 additional follow-ups to be conducted.*

Patient Information	
Patient Clinic ID: .... Sex: .... Counsellor's name:	Patient ID (ART number): .... New Adult ART name: .... Age: .... Date: ....

1. Do you remember your last appointment date? ☐ Yes Specify: .... ☐ No
2. Do you ever miss your appointment date? ☐ Yes ☐ No
3. What are the reasons for your miss follow up?
   - ☐ Forget
   - ☐ Was not aware of appointment
   - ☐ Too sick to come in
   - ☐ Work related
   - ☐ Other..............................
   - ☐ No transportation
   - ☐ Feel not good to come in
   - ☐ Feel shy
   - ☐ Feel bored
4. Do you have next appointment date? ☐ If yes, when? .... ☐ No
5. How do you feel about the adult service?

   ....

   ....
6. Do you know your doctor's name? ☐ Yes Specify: .... ☐ No
7. Do you know your counsellor's name? ☐ Yes Specify: .... ☐ No
8. Do you have the contact number of your care provider or the clinic?

   ☐ Yes Specify: .... ☐ No
9. What would you do when you want to see your doctor before your appointment date?

   ....

   ....

10. When you get sick before your appointment date, what would you do?

……
……

11. Do you have friends at the adults' services? ☐Yes Specify: …………………………………… ☐ No
12. Do you recently test for CD4 or VL or both? ☐ Yes Specify: …………………………………… ☐ No
13. Do you know your CD4 or VL result or both? ☐ Yes Specify: …………………………………… ☐ No
14. Do you know the name of your ARV treatment? ☐ Yes Specify: …………………………………… ☐ No
15. Do you know the dosage and its use? ☐ Yes Specify: …………………………………… ☐ No
16. In the past 3 days, on how many days have you missed taking all your pills?

    ☐ None
    ☐ One day
    ☐ Two days
    ☐ Three days

17. Do you ever have side effects since your transfer into adult service?

    ☐ Yes Specify: …………………………………… ☐ No

18. Do you have a partner? ☐ Yes (go to question 19) ☐ No (skip to question 22)
19. Do you ever have sex with her/him? ☐ Yes (go to question 20) ☐ No (skip to question 21)
20. Do you use the condom every time you have sex?

    ☐ Yes ☐ No

21. Do you understand about the important of condom? ☐ Yes ☐ No
22. Do you have plan to get married with someone? ☐ Yes ☐ No
23. Do you have any idea about family planning? ☐ Yes ☐ No
24. Do you have a job? ☐ Yes Specify: ………………………… ☐ No

Annex 5: Kessler Psychological Distress Scale (K10)

រង្វាស់ Kessler វាស់វែង ទុក្ខព្រួយ (K10)

Kessler Psychological Distress Scale (K10)

ប៉ុន្មានដង ដែលអ្នកធ្លាប់មាន រោគសញ្ញា ដូចខាងក្រោមៈ នៅក្នុងរយៈពេល ៤ សប្តាហ៍ ចុងក្រោយ អ្នកមានអារម្មណ៍ថាៈ How often have you experienced the following symptoms? In the last 4 weeks,		មិនដែល Never 1	មានពេល តិចតួច A little of the time 2	មានពេល ខ្លះ Some of the time 3	មានសឹងតែរាល់ ពេល Most of the time 4	មានគ្រប់ ពេល All the time 5
K1	អស់កំលាំងខ្លាំង ដោយគ្មានមូលហេតុ Did you feel tired out for no good reason?					
K2	ភ័យខ្លាច Did you feel nervous?					
K3	ភ័យខ្លាច ដែលគ្មានអ្វី អាចជួយអោយធូរបាន Did you feel so nervous that nothing could calm you down?					
K4	អស់សង្ឃឹម Did you feel hopeless?					
K5	ខ្វល់ខ្វាយ អន្ទះសារ Did you feel restless of fidgety?					
K6	រសាប់រសល់ នៅមិនស្ងៀម Did you feel so restless you could not sit still?					
K7	ពិបាកចិត្ត Did you feel depressed?					
K8	ត្រូវការខិតខំប្រឹងប្រែងយ៉ាងខ្លាំង ក្នុងការធ្វើអ្វីមួយ Did you feel that everything was an effort?					
K9	មានទុកព្រួយខ្លាំង ដែលគ្មានអ្វី អាចអោយអ្នករីករាយបាន Did you feel so sad that nothing could cheer you up?					
K10	ខ្លួន គ្មានតម្លៃ Did you feel worthless?					
បូកសរុបពិន្ទុ ពី K1 ដល់ K10 Sum scores from 1 to 10						

ការបកស្រាយ (Score Interpretation):		
ពិន្ទុ Score <20	សុខភាពផ្លូវចិត្តល្អ (Likely to be well)	កំណត់សំគាល់: មិនមែនសំរាប់ប្រើ ចំពោះអ្នកជំងឺសរសៃប្រសាទនោះទេ
ពិន្ទុ Score 20-24	កំរិតមានទុក្ខព្រួយ តិចតួច (Mild level of distress)	
ពិន្ទុ Score 25-29	កំរិតមានទុក្ខព្រួយ មធ្យម (Moderate level of distress)	
ពិន្ទុ Score >30	កំរិតមានទុក្ខព្រួយ ធ្ងន់ធ្ងរ (Severe level of distress)	

Appendix

Appendix 1: Preferred regimens for adolescent

First-line ART	Preferred 1st line	Alternative 1st line	Special circumstances*
Adults + adolescents + weight 20 kg – 30 kg	ABC + 3TC + DTG*	ABC + 3TC + EFV 400	AZT + 3TC + DTG AZT + 3TC + EFV 400 AZT + 3TC + LPV/r ABC + 3TC + LPV/r
Adults + adolescents + weight > 30 kg	TDF + 3TC + DTG*	TDF + 3TC + EFV 400**	ABC + 3TC + DTG ABC + 3TC + EFV 400 AZT + 3TC + DTG AZT + 3TC + EFV 400 TDF + 3TC + ATV/r (or LPV/r)*** TAF****+ 3TC + DTG

* Effective contraception should be offered to adult women and adolescent girls of childbearing age or potential. DTG can be prescribed for adult women and adolescent girls of childbearing age or potential who wish to become pregnant or who are not otherwise using or accessing consistent and effective contraception if they have been fully informed of the potential increase in the risk of neural tube defects (at conception and until the end of the first trimester). If women identify pregnancy after the first trimester, DTG should be initiated or continued for the duration of the pregnancy. Dolutegravir (DTG) is part of a new class of ARVs: the integrase strand transfer inhibitors (INSTIs). DTG offers clinical and programmatic advantages over efavirenz (EFV) for use in first-line therapy.

** EFV 400 mg is expected to be safe for pregnant women to use, like EFV 600 mg. EFV 400 mg can be co-administered with rifampicin containing anti-TB treatment, with co-administration well-tolerated and plasma concentrations maintained above the levels considered to be effective.

*** ATV/r is given when weight is ≥ 35 kg.

****TAF may be considered for people with established osteoporosis and/or impaired kidney function if it is available.

Appendix 2: ARV dosing

Regimens	Paediatric Dosage by Weight Band (Kg)								
ARV Products	**3 - 3.9**	**4-5.9**	**6 - 9.9**	**10 - 13.9**	**14 - 19.9**	**20 - 24.9**	**25 - 29.9**	**30 - 34.9**	**35 - 39.9**
AZT/3TC/NVP 300/150/200 mg							2	2	2
AZT/3TC/NVP 60/30/50 mg	2	2	3	4	5	6			
AZT/3TC 300/150 mg							2	2	2
AZT/3TC 60/30 mg	2	2	3	4	5	6			
TDF/3TC/EFV 300/300/400 mg								1	1
TDF/3TC 300/300 mg								1	1
ABC/3TC 600/300 mg							1	1	1
ABC/3TC 120/60 mg	1	1	1.5	2	2.5	3			
NVP 200 mg				1	1.5	1.5	2	2	2
NVP 100ml susp - bottles	10	10	16						
EFV 600 mg									
EFV 200 mg				1	1.5	1.5	2	2	2
ABC 300 mg					1	2	2	2	2
ABC 60mg	2	2	3	4					
TDF 300 mg								1	1
ATV/r 300/100mg							1	1	1
LPV/r 200/50 mg							4	4	4
LPV/r 100/25 mg				3	4	4	6		
LPV/r 40/10mg Granules	4	4	6	8	10	12			
LPV/r 80+20 ml - in ml	2	3	3	4	5	6			
DTG 50mg						1	1	1	1
TDF+3TC+DTG (300/300/50) - 30 tab								1	1

Appendix 3: Monitoring Indicators for ALHIV transition

Year		Quarter			
Total Provinces/Cities		**25 provinces/cities**			
Source of ART sites		**PAC sites**		**Adults ART sites**	
Category		**Age**	**Sex**		**Total**
			Male	**Female**	
A. # ALHIV reported in the pre-transition	# ALHIV patients who are eligible for pre-transition	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV patients who enrol in transition process	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV patients who have been assisted with HIV disclosure through counselling sessions	10 - 12			
		13 - 14			
		15 - 19			
B. #Reported ALHIV during the transition period					
B. 1 – transfer-out	# ALHIV patients who are ready for transfer-out to adult	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV patients who have been assisted with HIV disclosure through counselling sessions	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV patients who received education (level I, II, & III)	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV who loss (in the time of transfer-out/retention) to follow up (suggest classifying loss and dead)	10 - 12			
		13 - 14			
		15 - 19			
B. 2 - Retention	# ALHIV patients who are retained in the same ART sites (to be moved to B.2 - retention)	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV patients who have been assisted with HIV disclosure through counselling sessions	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV patients who received education (level I, II, & III)	10 - 12			
		13 - 14			
		15 - 19			
	# ALHIV who loss (in the time of retention) to follow up (suggest classifying loss and dead)	10 - 12			
		13 - 14			
		15 - 19			
C. # ALHIV reported during post transition	# ALHIV successfully transferred from PAC and enrolled in adult ART (after 3-6 months)	15 - 19			
	# ALHIV retained in PAC	15 - 19			

	# ALHIV who lost to follow up (including #ALHIV who died)	15 - 19			
	# **Total** ALHIV patients who successfully received education (Total = level I+ II+ III)	15 - 19			
	a. Education level I				
	b. Education level II				
	c. Education level III				

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ឧបត្ថម្ភបោះពុម្ពដោយ

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