

The Design, Implementation, and Effectiveness of Teen Models of Care:

Lessons from Teen Models of Care for Adolescents living with HIV in Uganda and Malawi

The Problem

In 2017, high rates of treatment failure among adolescents in Arua and Chiradzulu spurred MSF into action.

THE MAIN GOAL

To empower teens and adapt the delivery of care to local contexts.

through

Enhancing medical care with:

- ▶ More frequent viral load monitoring.
- ▶ Optimizing treatment regimens for better control.

Reducing adherence issues by:

- ▶ Providing comprehensive psychosocial and educational support and facilitating peer interactions.
- ▶ Applying a coherent disclosure process for younger teens and a comprehensive multidisciplinary approach for complex cases.

WHAT WE DID

We used :

- ▶ **qualitative methods** to describe in-depth the implementation process.
- ▶ **quantitative methods** to assess the effectiveness of the models of care.

Treatment outcome trends were analysed for 5 reporting quarters in Arua and 24 reporting quarters in Chiradzulu (2016-2020).

Recommendations for policymakers and healthcare professionals

1.

SCHEDULING

Schedule the teens appointments on the same day.

- Same day appointments foster peer interaction, a critical element for the adolescents' well being.
- Full disclosure before engaging in group participation is crucial.
- Saturdays are ideal, but weekdays during school holidays may be more feasible.
- Age-specific groups allow better socialization and tailored services such as Sexual and Reproductive Health and Rights education.
- Caregiver involvement benefits younger teens, especially before full disclosure.

2.

VIRAL LOAD TESTING

Frequent testing can identify treatment issues and address them swiftly.

- Testing every six months drives the rapid detection and management of patients.
- Point-of-care (POC) testing offers faster results and earlier intervention for the most at-risk when national systems are overloaded.
- Combining annual regional testing with additional POC measurements for high-risk individuals allows for efficient monitoring and swift action.

3.

DISCLOSURE

A continuous disclosure process updated to align with patients' developmental and social needs.

- Sensitize staff to the teens' need for additional age-appropriate information.
- Accurate information empowers teens to manage HIV effectively, boosting long-term treatment success.

4.

ADOLESCENT PEERS

Interaction with peers, facilitated by peer mentors (PMs) empower teens living with HIV.

- Clearly define PM roles to avoid overlap with healthcare professionals.
- PMs transitioning to young adulthood can mentor newly trained PMs; normalize HIV and reduce self-stigma, demonstrate successful pathways like marriage, parenthood, and achieving goals; champion the "Undetectable = Untransmissible."

5.

ADDRESS POOR ADHERENCE

Adolescents with suspected failure or poor adherence should be investigated.

- Treatment dropout among teens is often linked to psychological and social challenges.
- Psychological factors: depression, secondary denial of illness, refusal of treatment, rejection of care, risky behaviour, neurological delay.
- Social factors: poor economic conditions/ lack of family support/ psychological or physical abuse.
- A multidisciplinary team including clinicians, counsellors, peer mentors, mental health professionals, and social workers can lead to better outcomes.

6.

MENTAL HEALTH ASSESSMENTS AND CARE

Screening and caring for adolescents with mental health issues is essential.

- Collaborate closely and communicate information on the evolving concerns of teens between clinicians and psychological services.

7.

TRANSITION TO ADULTHOOD

Continue to schedule appointments for recently transferred young adults on the same day and encourage the creation of auto-support groups with the help of former PMs.

OUTCOMES

Both projects achieved high retention rates.

CHIRADZULU
experienced a significant increase in viral load suppression and re-suppression.

ARUA
started from a strong baseline, saw positive but smaller gains.

The following table presents the observed changes in treatment outcomes at each location at the start and at the end of the observation period. Different periods were employed to accommodate the availability of data for analysis.

	Arua		Chiradzulu	
	Treatment trends tracked across five reporting quarters (2016-2020)		Treatment trends tracked across 24 reporting quarters	
	2016-Q1	2019-Q3	2014-Q1	2019-Q4
Seen ¹	376	371	1,045	2,070
Still in care ²	87%	91%	93%	93%
VL Coverage ³	75%	82%	6%	91%
VL suppressed ⁴	77%	76%	49%	83%
VL re-suppressed ⁵	41%	76%	16%	76%

1. Seen : The number of adolescents with either a recorded clinical visit, ART prescription or refill or lab test in the reporting quarter.

2. Still in Care : The number of adolescents with a repeat visit 9 to 15 months in the reporting quarter.

3. Viral Load (VL) Coverage : The number of adolescents with a VL test in the 12 months prior to first visit in the reporting quarter among adolescents in the Seen category.

4. VL Suppression : The number of adolescents with VL<1,000 copies/ml amongst adolescents in the Seen category with a VL test in the reporting quarter.

5. VL Re-suppression : The proportion of adolescents with VL<1,000 copies/ml at the repeat VL test among individuals with a high VL >1,000 copies/ml in the reporting quarter.

Access the full report for the detailed overview of the implementation process and full quantitative insights on the effectiveness of the teen model of care.

