Barriers and facilitators for transitioning of young people from adolescent clinics to adult ART clinics in Uganda: Unintended consequences of successful adolescent ART clinics

Scovia Nalugo Mbalinda (snmbalinda@gmail.com)
Makerere University College of Health Sciences https://orcid.org/0000-0002-4945-130X
Sabrina Bakeera-Kitaka
Makerere University College of Health Sciences
Derrick Lusota Amooti
Makerere University College of Health Sciences
Eleanor Namusoke Magongo
Ministry of Health
Philippa Musoke
Makerere University College of Health Sciences
Kaye K Dan
Makerere University College of Health Sciences

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Abstract

Background

There is a growing number of adolescents and young adults with HIV who require transfer of care from pediatric/ adolescent clinics to adult ART clinic. Currently, adolescents are largely in the care of pediatricians; but as they grow, they transition to adult HIV clinics. The purpose of this study was to explore the facilitators and barriers of transitioning among adolescents from adolescent clinics to adult ART clinics.

Method

An explorative qualitative approach was utilised for this study. Eighteen focus group discussions were held in nine health facility with (191) adolescents and young people in order to capture their experiences, barriers and facilitators regarding transitioning to adult clinics. The focus group discussions were audio recorded and transcribed. The Silences Framework using thematic approach guided the analysis.

Results

The key emerging issues were: Care provided in the adolescent clinics, Unfriendly adults, stigma and discrimination, Congestion and long waiting time, health providers in adult clinics were barriers to transitioning. Moving as a cohort, Transition preparation, care in clinics, positive living, support from the guardian and Young adolescent program Support (YAPS) could facilitate readiness and transitioning.

Conclusion

Adolescents and young people expressed fear to transition to adult clinics mainly because of the perceived better care provided in adolescent clinic, thus constituting a barrier to smooth transition A range of individual, social and health system and services-related factors hindered transitioning. Expectation of transitioning as a group, assurance of similar care as in the adolescent clinic, and guarantees of confidentiality, privacy and autonomy in decision-making for care were perceived as facilitators. There is need to strengthen implementation of age-appropriate care and individualized case management during care transition at all health facilities. Furthermore, the findings suggest the need to create supportive family, peer, and healthcare environments for adolescent transition.

Background:

Perinatally or behaviorally HIV-infected adolescents (10–19 years) and young adults (20–24 years) are an increasing proportion of the HIV-infected population in Uganda [1], with over 110,000 HIV-infected adolescents in Uganda in 2012. There is a growing number of adolescents and young adults with HIV who require transfer of care from pediatric to adult providers[2]; yet, globally, many young people experience barriers (e.g., infrastructure, staff training) that complicate this process. Attention to this transition is critical to ensure continuity of complex care and can help mitigate potential adverse physical

and psychological complications resulting from their HIV-infection or use of long-term medication therapies. Adolescent transition outcomes have been reported in high- and middle-income countries in North America, Europe, and Asia [3–8]. These studies do not reflect the challenges of HIV care in sub-Saharan Africa, given the limited-resource context increases the complexity of transition and its evaluation. In high-income countries, transition from paediatric to adult care services usually involves a change of clinic and /or providers, largely because care is provided as a specialized service and transitional models of care are available [9, 10]. The lack of structured transition programmes reflects a broader gap in bridging from paediatric- and adolescent- to adult-oriented services for chronic illness in general, and for HIV care specifically [1]. The model of care in sub-Saharan Africa is predominantly non-specialist, comprising integrated clinics where adults, adolescents and children living with HIV are seen by the same staff in the same place [1]. However, adolescent-friendly services, usually in the form of a dedicated adolescent clinic day, are increasingly being implemented [1, 8]. Although specific services that address the unique needs of adolescents may be available, practices vary in many of the clinics.

Despite progress in reducing perinatal HIV transmission, there is a growing number of youth people with HIV/AIDS (YPLHIV) who will require transfer of care from pediatric to adult providers [1]. According to the United Nations Population Fund (UNFPA, 2017) 1.5 million Ugandans currently live with HIV. HIV prevalence among adults 15–49 years is 8.3% with HIV prevalence of youth age 15–24 at 3.2% (female) and 1.9% (male) (UNPF, 2017). It is estimated that 567 young people aged 15–24 years old are infected with HIV every week (Government Citizen's Interaction Centre [GCIC], 2017). HIV prevalence is four times higher among young women compared to young men [11] increasing the risk for perinatal transmission. Consequently, an increase in the number of YPLHIV who are in need of HIV care and treatment services is expected.

Asire and colleagues [12] assessed both private and public clinics in Uganda caring for YPLHIV and found that only 3% of healthcare facilities had a specific health transition clinic (HTC) to support the transition from paediatric providers to adult providers. Additionally, Nyabigambo and colleagues [13]found that HTC use is less common in those who are older (age 20–24), male, live in rural locations, acquired HIV behaviorally, are not on antiretroviral therapy (ART), and have CD4 counts > 250. Therefore, those at highest risk for health complications and transmission of HIV to others do not have the HTC resources to support a successful transition. Efforts have been made by Ministry of Health to expand the 3% availability to 100% so that the Transitioning process is prioritized at a National Level. The Young Adolescent Programme Support (YAPS) Project which started in 2019 is attempting to empower adolescents and young people

Transition is “a planned process by which HIV-infected adolescents and young adults, and their caregivers, are empowered with knowledge and skills to enable them to independently manage their health.” [14]. The main goal of transitional care is for YPLHIV to develop confidence, autonomy, and responsibility for their HIV care by the time they are required to attend adult clinics. A good transition process builds life-skills and reduces risk-taking behaviors that can interfere with adherence to treatment and retention in care. Additionally, keeping YPLHIV on ART continuously and preventing transmission to

others is critical to any transition program [1, 13]. Adolescents have expressed the need for an improved transition process. Assessment of adolescent HIV care found “the need for better planning and preparation for clinical providers and adolescents to improve the transition process, with a focus on improving both clinical and psychosocial support throughout the process”[1]. However, there is no clear process of transitioning to adult care in Ugandan health clinics. The purpose of this study was to explore the facilitators and barriers of transitioning among adolescents from adolescent clinics to adult ART clinics. Ensuring effective transition from pediatric/adolescent to adult care is a national priority for optimizing the health of YPLHIV, and also critical for prevention of HIV transmission to wider communities.

Methods

Setting and participants

The study was conducted from August 2019 to January 2020 in 9 facilities s at various health care system levels Regional hospital will include; Lira RRH, Mbale RRH and Kabale RRH, District hospital will include Mityana Hospital and Lacor Hospital, Health Center IV will include; Kisenyi HCIV and Bugembe HCIV and HC III will include TASO Mbarara and Nsambya Home Care. Data was collected through 18 focus group discussions with young people living with HIV in Nine facilities.

Socio demographic data

Majority of the respondents were aged 20-24 years, in school, female and had got HIV through perinatal transmission. (Table 1)

Data collection and analysis

An explorative qualitative approach was utilised for this study using eighteen (18) focus group discussions. Data was collected from 9 health facilities in all the four regions of Uganda. The study participants were selected through purposeful sampling based on sex and age. Eighteen focus group discussions were held, nine for the females and nine for males with an average of 10 young people in each focus group.

These participants were identified through the peer educators who were approached at the beginning of the study. All participants gave verbal informed consent and were assured that the information given was confidential, that they were not obliged to join the study, and that their views would be anonymous.

Participants were selected purposefully by maximum variation sampling to represent a variety of age group, education level, and socioeconomic status. All the interviews were conducted in one of the private offices on the ward by the first Author (SNM). We explored the following issues concerning transitioning of adolescents to adult clinics. (Responsibility of their own health, Knowledge about their health, responsible behavior, introduction of transitioning process, experiences of adolescents who had transitioned and now they were back in the adolescent clinics, facilitators and barriers in transitioning to

adult clinics). The interview guide was developed using literature and Ministry of Health (MOH) guidelines on transitioning.

Interviews lasted for 60-90 minutes and were conducted in English and other local languages depending on the location. The proceedings were tape recorded. At the end of each interview, the key points were summarised to the participants in order to verify the data. Handwritten notes were taken during interviews.

The focus group interviews were initially reviewed to by the first author during data collection to assess point of data saturation. After data collection, all the FGDs were transcribed verbatim. The transcribed text was then translated from local language into English. As the researchers aimed at exploring experiences, barriers and facilitators to transitioning. A manifest thematic analysis approach was chosen [15]. The interviews were read through several times by all authors and the different statements were grouped, resulting in the construction of a map, in accordance with the description by Braun and Clark [15]. Different themes and sub themes were identified and discussed and rearranged until a final pattern was distinguished. The themes that were relevant to our research questions were considered and reported.

The Silences Framework [16]guided this research. The Framework asserts that reality is not objective or fixed but rather human beings scripts the social world in communities at a particular time[16]. The Framework put an emphasis on the 'Screaming Silences' in individual and group interpretations of experiences that can be qualified as 'truth'. In this paper silences are explored in relation to facilitators and barriers of transitioning among the adolescents in ART clinics in 9 facilities (3 regional referral hospitals, 2 District hospital, 2 Health Center IV and 2 private facilities). in Uganda. The Screaming Silences in relation to facilitators and barriers with in adolescents were explored to ascertain barriers and facilitators for transitioning of adolescents into adult clinics in 9 health facilities in Uganda.

The focus group discussions with the research participants lasted for one hour. All focus group discussions were audio tapped and transcribed verbatim and the transcribed data was subjected to the four phases of the Silences Framework shown below [16] .

- **Phase 1 -** After transcription, the outputs from the focus group discussions were analysed by the researcher and recurrent themes were identified as the preliminary findings from the study.
- **Phase 2 -** The preliminary findings from phase 1 were reviewed by the research participants. Reflections on the early findings from the participants were used to enhance further critique, confirming or refuting the findings from phase 1. A discussion of the silences (Findings) was formulated.
- **Phase 3 –** A further analysis of the findings from phase 2 was undertaken in this stage by research participants. The participants in this phase were drawn from the ART clinics that had not taken part in the focus group discussion with a critical indirectly associative eye.

- **Phase 4 -** Finally the researcher reflected on the findings from phase 3, revisiting, reviewing and developing emerging themes which formed the final output of this study.

Ethical approval Ethical reviews and approval were obtained from the Research Ethics Committee of School of health Sciences, College of Health Sciences at Makerere University University #SHSREC REF NO: 2019-029 and Uganda National council of Science and Technology (SS5063) Administrative clearance and permissions were also obtained from the management of each of the health facilities. Written informed consent was obtained from young people above 18 years. For adolescents below 18 years assent from the adolescents and consent from parents or guardians was obtained. Participation was voluntary and all the interviews were conducted in private settings to ensure participant's confidentiality.

Results

In Uganda, all ART service delivery they created an adolescent clinic or a day which provided Adolescent living with HIV (ALHIV) a comprehensive Service package in addition to adolescent friendly services. This is because they are a unique group and require additional support. While the components of the adolescent package of HIV care closely resemble those of the adult package of care, how they are delivered has an impact on uptake and success. To be effective, the adolescent package of care ensured: Integration of services, that services are age and development age appropriate, responsive to the needs of both perinatally infected adolescents, as well as those infected later in childhood or adolescence, emphasis on both care and treatment, and services are family-centred. Components of the HIV Care and Treatment service package for adolescents include the following: HIV Counselling and Testing, HIV prevention service, Growth and development monitoring, nutritional counselling and support, opportunistic infection screening and management, Sexual and reproductive health, Counselling and Psychosocial support, ARV preparation, initiation and monitoring, Adherence and retention into care and mental health.

Following transcription, coding and analysis of the focus the following themes on barriers and facilitators to transitioning to adult ART clinics. Barriers identified in this study included; unfriendly adults in the adult clinics, care provided in adolescent clinics, health care providers in adult clinics, congestion and long waiting lines in adult clinics, stigma and fear to disclose their HIV status, preparation to transition and fear to loose friends and the facilitators identified were; Move as a cohort, transition preparation and care in adult clinics.

Barriers to transitioning

Unfriendly adults in the adult clinics

There was an attempt to transition the adolescents to adult clinics but most of them came back to adolescent clinics. The adolescents stated that one of the barrier for them to transition to adult clinics is

the judgmental, unfriendly nature of the adults in the clinics. The adolescents found it hard to talk to adults because they are so serious and talk adult stuff, they feared to be discriminated against them

"…. the adult people are so judgemental, you hear them saying, "how did he get the HIV? such a young child! yet sometimes, you got it from your mother, like me I got it from my mother and they don't end only here, they again take them to the community and the whole village knows and then you reach there when everyone has known" (male, 20-24 years)

"*…..when you go to the adult clinic, it may be so difficult to comfortably associate with the adults. So, it may not be easy for us. They have parental thoughts, yet for me I have adolescent thoughts. I don't know if there are adults, that I will be able to converse with like it is here. So, I think it may be so hard for me to comfortably converse with them or fit in them. But maybe if I get a child, I will be able to fit in them knowing am a fellow parent." (Female ,20 -24 years)*

Care provided in adolescent clinics

The adolescents have been in the adolescent clinics since they were 10 years. They have developed a routine, found friends and care in adolescent clinic is different and it favors them and they like it. A typical adolescents' clinic starts off with a reminder from the peer a day before the clinic. Those who confirm will be expected to attend the clinic and those who are not able reasons are given and if it is within the reach of the facility they are facilitated like transport. On the real day they start off with education session either from the peer, health providers or counselors depending on the schedule and experience. After the session if they are suppressed they are fast tracked to the pharmacy and send a maximum of 30 minutes. If they are not suppressed they are taken to the counselors and then to clinician and finally to the Pharmacy for refill. The provide porridge and a bite every time they come to the clinic, they do hold psychosocial events quarterly for all the adolescents mainly to share experience, have talks, dance eat and play. They also have health education sessions with peers. The adolescents felt that they been favored in this adolescent clinic which they know won't happen in the adult ART clinics because some have experienced the adult clinic

….at a certain point it comes back to the health workers. Health workers tend to treat adolescents and young people in a different way while in the adolescent clinic and therefore the adolescents don't wish at any one point to leave their clinic to go to the adult clinic where they will not be treated the same way" (female, above 24 years)

like another reason why we might be scared to leave this adolescent clinic, we think that our clinic is more confidential and secure than the adult clinic because we feel like our secrets are safe in the adolescent clinic than in the adult clinic. Yah, we feel that and we think that's what works for us because we feel we are the same age it's easy to understand each other but in the adult clinic adolescents fear to meet there their relatives, their aunts their uncles, who may expose their status outside. It's not okay because stigma is high, discrimination, some of us are still in school so, we fear those, so we find that it's hard for someone to be exposed outside in the adolescent clinic than in the adult clinic. (female, 15-19 years)

The health care providers in adult clinics

The adolescents expressed fear for the health care providers in the adult clinic. The adolescents thought that working with the new providers would not be favourable to them and providers in the adult clinics may not be friendly and kind like those in adolescent clinics

"I fear to find different and new health providers in the adult clinic who do not know me and they don't know my story". (female, 15-19 years)

"Fear that the health workers in the adult clinic are not kind and caring as those in the adolescent clinic". (female, 15-19 years)

Congestion and long waiting lines

Some of the adolescents who had visited the adult clinic expressed that adults spend a lot of time in the clinic from morning to evening, whereas in adolescents' clinic they are seen very fast and they leave. The adult clinics have so many clients and are congested, Adolescents don't want to spend a lot of time in the clinics

"when I come putting on my uniform, they give me the medicine but there you have to wait until they finish those who came first but here, if I come putting on my uniform or even if I am not putting it on, I get my medicine fast". (Male, 15-19 years)

some of us are schooling going children, some are working so, someone will escape from school to come pick medications, some will escape from work to come pick medications, so, when we are transitioned for real, remember when you join adulthood, then, for them they know ounce I am going for medication I am going to make all that day for medication but for us we are always on a quick schedule. As you come you left school when having a test in the afternoon, you come rushing you say, aya ya ya, I am going for a test, they give you your medicine and you move but the adults stay here the whole day. We see, some of our parents we come with them and they expect to spend the whole day and you find you came with the parent for you you're done but she is still there. (female, 20-24 years)

Fear to lose friends

The adolescents expressed that if they are transferred to adult clinics they will lose their friend since they will be given different appointments where as in adolescent clinics they had a special day when they met as adolescents, this scares them a lot

"I don't want to go to the adult clinic because they will miss their age mates since they usually come to the clinic and share their experiences". (female, 15-19 years)

"I would not wish to go to the adult clinic, is because I will miss my friends. When you come here, you chat with this one and you have totally a different conversation with another person". (male, 15-19 years)

Stigma and fear to disclose their status

The adolescents expressed fear that if they went to the adult clinics, the adults would disclose their sero status and this would create stigma in the communities they live in

“I fear to find relatives and village mates in the adult clinic who might disclose my HIV status back in the village to their children and other people in the village” (female, above 24 year).

Preparation for transitioning

The adolescents expressed that preparation is paramount for them to transition and it may hinder them from transitioning because they don’t know what to expect to do there and what is expected of them. This could be that they are not prepared well or they don’t know what to expect in adult clinics Some adolescents think they are still young and that they have not reached that age of going to the adult clinic. Initially the Ugandan guidelines said that the age of transitioning was 18 years and later moved it to 24 years. However, there are clients who are above 24 years still seen in the clinic.

“We don’t want to go to the adult clinic because they think they will be treated like adults yet they are still those vulnerable people who still need that care like that in the adolescent clinic”. (female, 15-19 years)

“I didn’t want to go to the adult clinic because they didn’t know what they are going to do there”. (male, 15-19 years)

Facilitators to transitioning

Moving as a cohort

Adolescents expressed that taking them as a cohort to the adult clinic so that they move with their friends whom they have been with and are familiar with would facilitate the transitioning process instead of distributing them in the different adult clinic days Creating a different day for the transitioned adolescents in the adult clinic and not mixing them with the adults.

“If they are to change us to the adult clinic, they should take us as a group because now you are able to see your friends and age mates maybe they get like 10 adolescents and they take them there as a group but when you have been knowing each other. So, that helps”. (Male ,20-24 years)

“like all of us as we are here, all of us should go at once because as we are here, we know our selves and we associate. So, even if they give us one day in a month, but we are as we are here when we are age mates but not sitting here next to a 70 year, grand mum ” (Female 15-19 years)

Transitioning preparation

Preparing the adolescents earlier before being transitioned to the adult clinic, like first talking to them about transitioning and telling them everything about the adult clinic would facilitate transitioning.

"We should be having sessions with parents and the health workers and discuss with them to on how to treat the adolescents well when they are transitioned to the adult clinic, not to be judgemental, not to disclose their status in the village, not to talk about them, not to discriminate the adolescents among others such that the adolescents feel comfortable when they go to the adult clinic" (female, 15-19 years)

"I think transitioning should be introduced to us from the point we step in and become their client so that we grow up with that in mind, it's not like an ambush, like the way they are doing it now. But if at a point we steeped in here during counselling, they added that point of transitioning each time I have a counselling session they tell it to me, it wouldn't be new to me and I will be feeling comfortable going there because they will be telling me the advantages and why but now it's had for someone." (Female, 20-24 years)

Care in adult clinic

The adolescents want to be treated the way they have been treated in the adolescent clinics as they move to adult clinics that could facilitate their transitioning like one of the adolescent who said

"They should provide patients in adult clinic with the same privileges like those in the adolescent clinic for example giving them porridge, having adequate counsellors, short waiting time among others" (female 18 years)

"Treating adolescents well like children even when they are transitioned to the adult clinic, like being caring and kind to them while in the adult clinic" (Male ,15-19 years)

"Moving with the same health providers to the adult clinic whom the adolescents are used to and who know more about them". (Female, 15-19 years)

Some adolescents were ready to move to the adolescent clinics because of some of the benefits they will get the moment they as in adult clinics as compared to adolescent Clinics like

"For me, I would love to go to the adult clinic, such that I be able to meet adults with beneficial ideas and knowledge, and also to have sensible and mature conversations with them" (female, 20-24 years)

"I would love to go to the adult clinic because now when I get there obviously there are packages that are given in the adult clinic that I can't get here like practicing safer sex, family planning and by that time I will be engaged so they will be beneficial to me" (Female ,20-24 years).

"Differentiated Service Delivery model, they have privileges of getting drugs from home, in the community they don't have to come here and for the adolescents, it's the clinic and I would also love to be on those groups where you don't have to come to the clinic, I only have to come to the clinic when I have issues" (Male ,20-24 years)

All the ART clinic had peer support group and some of the facilities were implementing the new program from Ministry of Health. In peer support groups adolescents to help each other to improve and better

manage their situation, share challenges and discuss solutions. Members support each other to implement decisions made to meet their psychological, social, physical and medical needs

I feel like they still need more help in the adolescent clinic from my peers (peer support) through their support groups and also from health care providers especially their counsellors and social support on adherence to medication among other challenges they face (Female, 20-24 years).

Discussion

The barriers for transitioning included; supportive care provided in the adolescent clinics, Unfriendly adults, stigma and discrimination, Congestion and long waiting time, health providers in adult were barriers to transitioning. Moving as a cohort, Transition preparation, care in adult clinics, positive living, support from the guardian and Young adolescent program Support (YAPS) Could facilitate readiness and transitioning.

Adolescent-friendly services are accessible, acceptable, appropriate, effective and equitable [17]. Providers of these services are sensitive to their young clients' needs, they encourage autonomy and demonstrate respectful and non-judgmental attitudes. In this study one of barriers to transitioning was creation of adolescent's clinics. The care provided in the adolescent clinics was very satisfactory to the adolescents and they didn't see the need to transfer to adult clinics. Adolescent HIV care is characterized by an emphasis on multidisciplinary on-site care with a youth friendly environment, a family-centred focus, and psychosocial support which attends to adolescent developmental needs [18]. Many adolescents with HIV (both perinatal and behaviourally acquired) develop strong and longstanding relationships with their care team, often seeing them as members of their family, especially in the context of parental loss[19, 20] As such adolescents may be reluctant to disengage from health care providers in the adolescent clinics and likewise. Integrating adolescent friendly days or clinics in ART care has shown to improve retention in care [21] which improves health outcomes. However, most of these adolescent and young people have grown and need to move to adult clinics to create space for those patients in pediatrics clinic. This poses a question could creation of adolescent clinics hinder their transitioning.

Engagement of adults in the adult ART clinics to support adolescents in transitioning cannot be underestimated. In this study most of adolescents saw the unfriendly adults in the adult clinics as a barrier to transitioning. It is important to explain the transitioning process and its importance to the adults in adult clinics so that they can support these adolescents. The role of care givers and adults has been documented in many studies family caregivers wanted early knowledge about transition; these individuals are important resource to find potential solutions to guide the transition process [22, 23]. It is important to ensure that the adolescents can be accommodated in the clinic they are being transferred too. This includes the setup of the clinics including the adults Psychosocial support can help adolescents as well as their caregivers gain confidence in themselves and their coping skills. It can increase patients' understanding and acceptance of comprehensive HIV care and support services, encourage adherence to

HIV treatment, and equip them with skills to make informed secondary prevention decisions. Such support can also help prevent adolescents living with HIV adopting risk-associated behaviours or from developing more severe mental health problems. Caregivers and adults also benefit from support that acknowledges the stress they are under and validates their concerns about their children or charges, while enabling them to learn how to cope with the adolescent's developmental and health needs.

HIV is a highly stigmatized illness and many adolescents and young people living with HIV face HIV-associated stigma and disclosure to sexual partners, friends, and family is a barrier to engagement in adult care [24, 25] In this study adolescents expressed fear that if they went to the adult clinics, the adults would disclose their sero status and this would create stigma in the communities they live in. Adults, parents and care givers need to understand that stigma can affect an adolescent's ability to live positively with HIV and affects an individual's sense of self-worth and self-esteem, the ability to seek emotional and psychosocial support through disclosure to others, the confidence to adhere to treatment at school or in the workplace, and the willingness to seek health services on a continual basis [26]. Understanding and learning how to deal with stigma is one of the skills that adolescents living with HIV need to acquire as they move into adulthood. There is need to address stigma by creating clinic wide strategies to eliminate stigma towards adolescent patients in the clinical setting[26].

One of the barriers mentioned was congestion and long waiting hours in adult clinics. The HIV service delivery approach for adolescents usually Fast-track drug pickup and has flexible clinic hours that take care of both in-school and out of school adolescents so they don't wait a lot. Adult HIV clinics are often more formal with limited scheduling flexibility, more patient- and disease-focused care, less co-located specialty care, and fewer youth-friendly services [5] These characteristics may explain the poor outcomes of ALHIV seen in adult care[27]. Adolescents and young people transitioning to adult clinics have identified fear of the adult clinic environment as a barrier to smooth and proper transition and have described difficulties after transfer to adult clinics in dealing with congestion and longer wait times [20, 22].. Engaging and training adult providers in adolescent -friendly HIV care models may be useful as many adult providers lack the expertise or will to provide youth-friendly services in the adult setting[19, 28].

Most of the adolescents have grown in these ART clinics and they are very comfortable in these clinics with their peers and their providers. The study showed that the adolescents wanted to be moved as a cohort or at least 10 of them on a specific day in the adult clinic. Separation from the group they have known is a challenge a study done in US found out that most of the adolescents felt like they had lost a family when they talked about transitioning[23]. It is important to assist adolescents identify barriers (real or perceived) to transitioning process so that the providers, care givers and adolescents can explore potential strategies to overcome them.

Transition needs to be carefully planned and managed, taking into consideration the adolescent's medical, psychological and social needs. Transition should be a gradual process of preparing and supporting the adolescent to make the shift from dependence on caregivers to self-management and

autonomy, and into more developmentally and medically appropriate care. Carefully planned transition recognizes the evolving developmental, medical, emotional, educational and social needs. In this study it showed that transition preparation acted as a barrier for effective transitioning if it was not done well and a facilitator if it was done well.

Peer support is about giving and receiving help to others with respect, shared responsibility, and mutual agreement. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. Peer support groups are groups of people who come together because they share a common situation. In this study adolescents found the Young adolescent program Support (YAPS) Could facilitate readiness and transitioning. In peer support groups adolescents found out that they help each other to improve and better manage their situation, share challenges and discuss solutions. Members support each other to implement decisions made to meet their psychological, social, physical and medical needs. There is need to use peer and young groups in transitioning and may be they could be used to receive these young people in the adult clinics so that when they transition they see familiar faces that could improve the transitioning process.

Study limitations

The participants were selected by the peer leader from the ART clinic this could have posed a selection bias but we overcame this by asking the peer leader to select both females and males and also to have a representation of young people aged 10-19 and 20-24

Conclusion

Adolescents and young people did not want to transition to adult clinics mainly because of the supported care provided in adolescent clinic. A range of individual, social and health system and services hinders transitioning readiness and transitioning. There is need to strengthen implementation of age-appropriate and individualized case management transition at all sites. Furthermore, the findings suggest the need to create supportive family, peer, and healthcare environments for adolescent transition.

Abbreviations

ALHIV Adolescents living with HIV

ART- Anti retro viral Therapy

PHIV Perinatally HIV

HIV Human Immunodeficiency Virus

HC Health Center

HTC Health Transiting Clinics

MOH Ministry of Health

PNFP Private Not for Profit

RRH Regional Referral Hospital

YAPS Young adolescent Program Support

YPLHIV Young people living with HIV

Declarations

Ethics approval and consent to participate

Ethical review and approval were obtained from the Higher Degrees and Research Ethics Committee of the College of Health Sciences at Makerere University #SHSREC REF NO: 2019-029 and Uganda National council of Science and Technology (SS5063). The administrative clearance and permissions were obtained from the nine health facility. Written informed consent was obtained from the adolescents and young people. Participation was voluntary and all the interviews were conducted in private settings to ensure participant's confidentiality.

Consent for publication

Not applicable

Availability of data and materials

The acquired and/or analyzed data are not publicly available because of the lack of authorisation from the children's legal guardians, and the agreement with the Research Ethics Committee that the database would remain with the corresponding author only. However, all data can be made available by the corresponding author upon reasonable request.

Competing interests

The author(s) declare that they have no competing interests.

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Authors' contributions

SNM designed the study, collected and analysed the data, drafted the paper; SBK contributed to the design the study and reviewed the paper. LD contributed to the collecting data, analysis, and reviewing the paper; EM contributed to the reviewed the paper PM contributed to the reviewed the paper and DKK contributed to the design the study, analysed the data and reviewed the paper. All the authors approved the final draft of the paper.

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Tables

Table 1: Socio demographic data

Variable	Numbers
Age	
15-19	49
20-24	72
Above 25	53
Education status	
In school	102
Out of school	72
Sex	
Male	84
Female	90
Mode of transmission	
Perinatal	127
Horizontal	56
Don’t know	8
Living status	
Alone	30
Parents	52
Guardian	109

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