Elizabeth Glaser
Pediatric AIDS
Foundation

EGPAF's E2A and the AIDSFree Service Delivery Webinar:

Differentiated Service Delivery Models For Children and Adolescents

November 20, 2019

Agenda

- ✓ **Welcome and overview**, Anja Giphart, EGPAF; and Martina Penazzato, WHO
- ✓ **Key policy, evidence and gaps in DSD for children and adolescents**, Anna Grimsrud, IAS
- ✓ **Implementation of DSD models for children and adolescents**, Cathrien Alons, EGPAF
- ✓ **EGPAF-Malawi experience of DSD models for children and adolescents**, Allan Ahimbisibwe, EGPAF
- ✓ **Stakeholder perspective**, Hilary Wolf, PEPFAR
- ✓ **Discussion**: Facilitated by Jennifer Cohn, featuring a member of EGPAF's Committee of African Youth Advisors (CAYA)
- ✓ **Close**: Jennifer Cohn and Martina Penazzato

Webinar Engagement

- Every participant joining remotely is automatically muted to avoid feedback, but we are very happy to hear all of your questions and comments! Here's how to engage:
  - Joining on your computer: a Q&A box should appear at the bottom of your screen – open it up to ask a question at any time during this webinar. Questions for our presenters will be brought to our moderator's attention during the discussion portion. Questions on connectivity/sound quality will be handled immediately.
  - Joining on the phone: press *9 to "raise your hand" this will notify a host to unmute your line. We will unmute calls one at a time, so wait until you hear the "unmuted" announcement to begin speaking.
  - If you have any questions or concerns regarding the Zoom technology you can chat the host, Sarah Denison-Johnston, privately. For any issues rejoining, send a note to publicatons@pedaids.org.

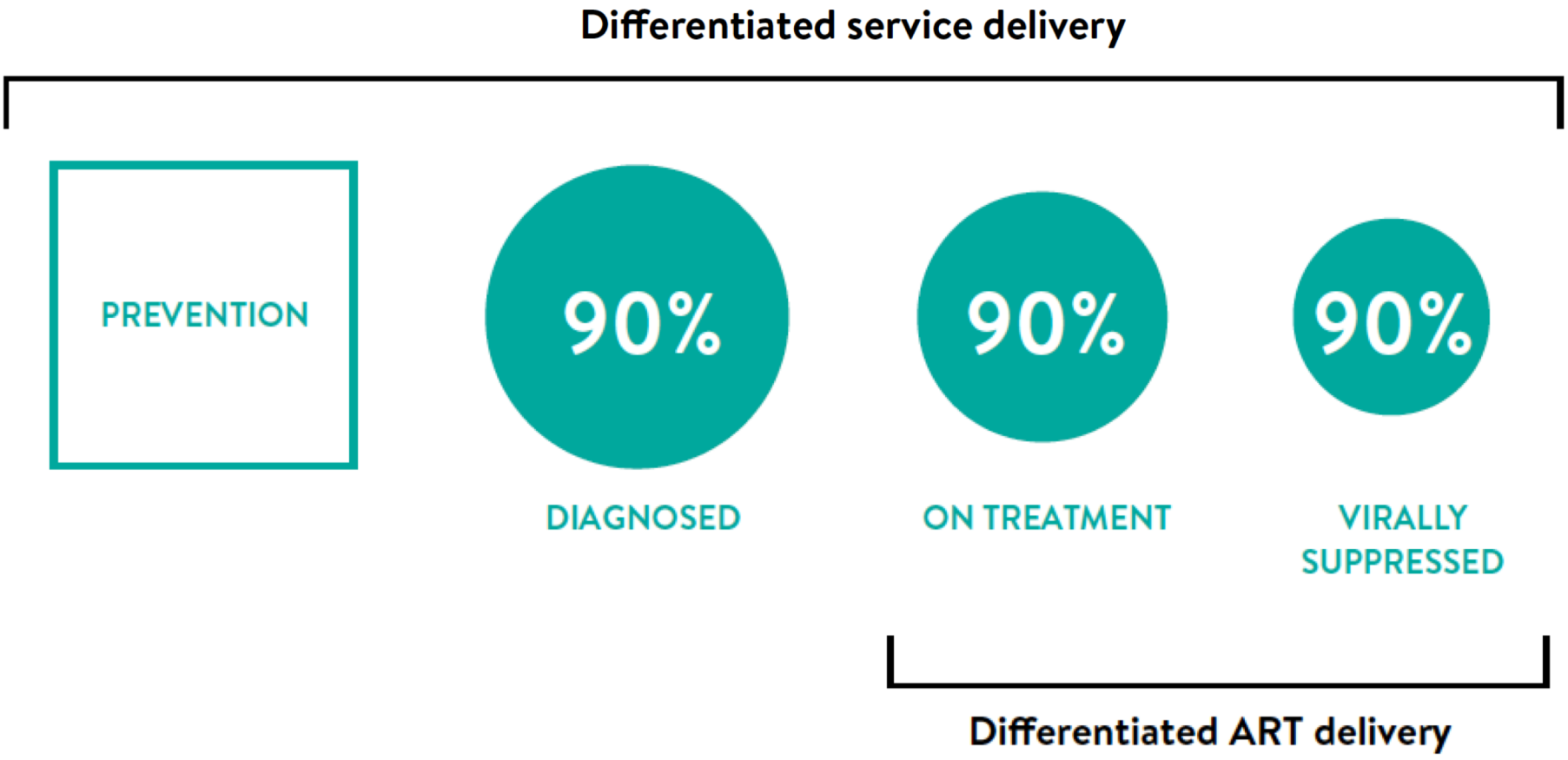
Key policy, evidence and gaps in differentiated service delivery for children and adolescents

Anna Grimsrud, PhD
anna.grimsrud@iasociety.org
WHO-EGPAF AIDS Free webinar
20 Nov 2019

Differentiated service delivery (DSD), or differentiated care, is a **client-centered approach** that simplifies and adapts HIV services **across the cascade**, in ways that both serve the needs of persons living with HIV (PLHIV) better and **reduce unnecessary burdens on the health system.**

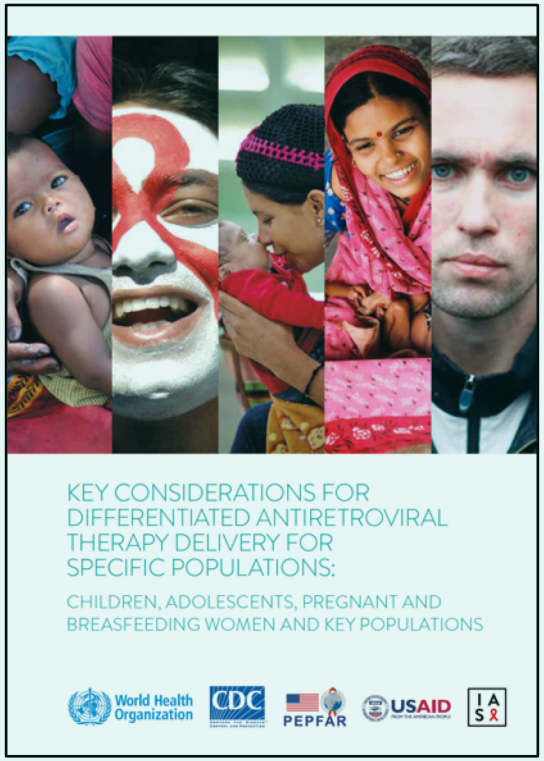
Grimsrud A et al. *Journal of the International AIDS Society* 2016, **19**:21484
http://www.jiasociety.org/index.php/jias/article/view/21484 | http://dx.doi.org/10.7448/IAS.19.1.21484

Differentiated service delivery is applicable across the HIV care continuum



www.differentiatedservicedelivery.org

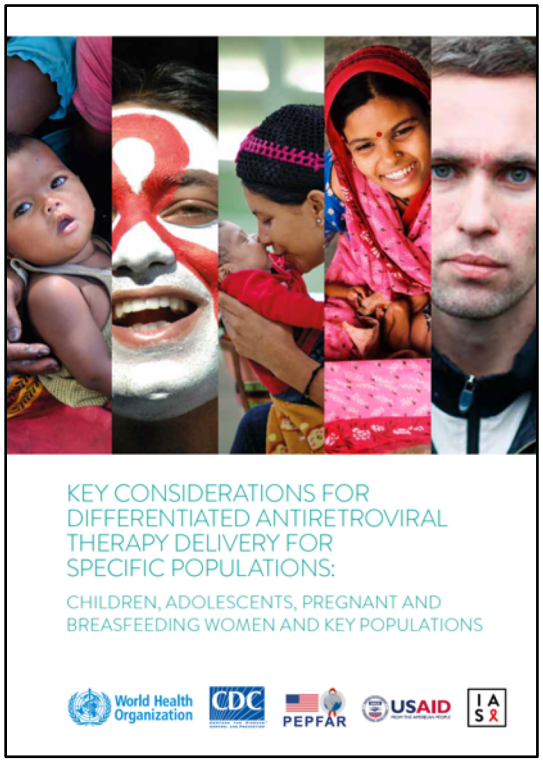
Key Considerations

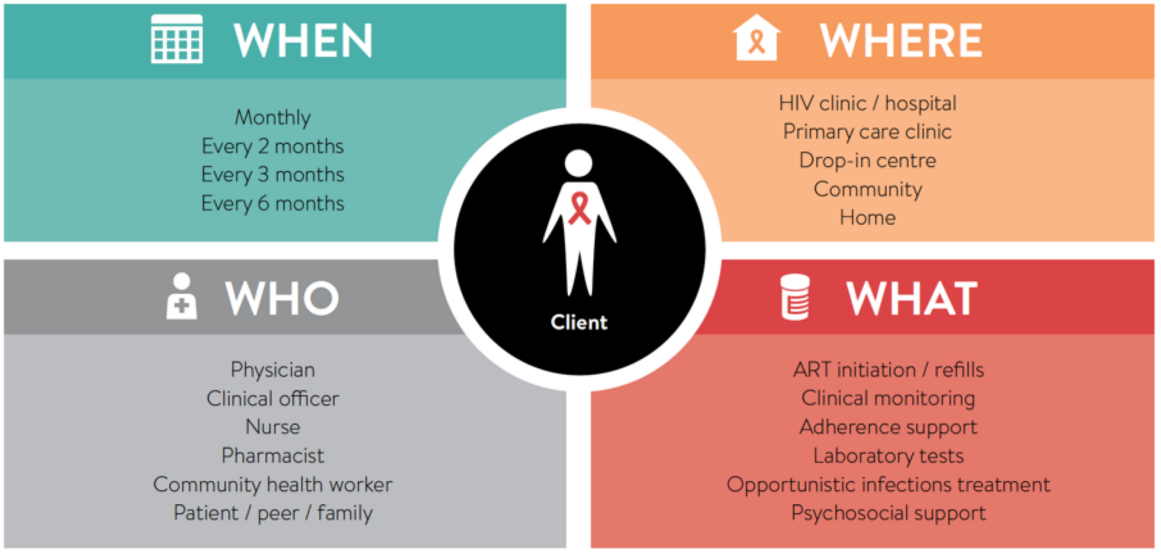


Children, adolescents, pregnant and breastfeeding women and members of key populations **should not be excluded from clinically stable client care based on their population characteristics: age**, pregnancy or breastfeeding status, drug use, occupation, sex, gender identity or sexual orientation. **In principle, services should be tailored to keep families together as much as possible to simplify access and reduce cost.**

Key considerations for differentiated antiretroviral therapy delivery for specific populations: children, adolescents, pregnant and breastfeeding women and key populations. Geneva: World Health Organization; 2017

Specify “Building Blocks” for Children and Adolescents



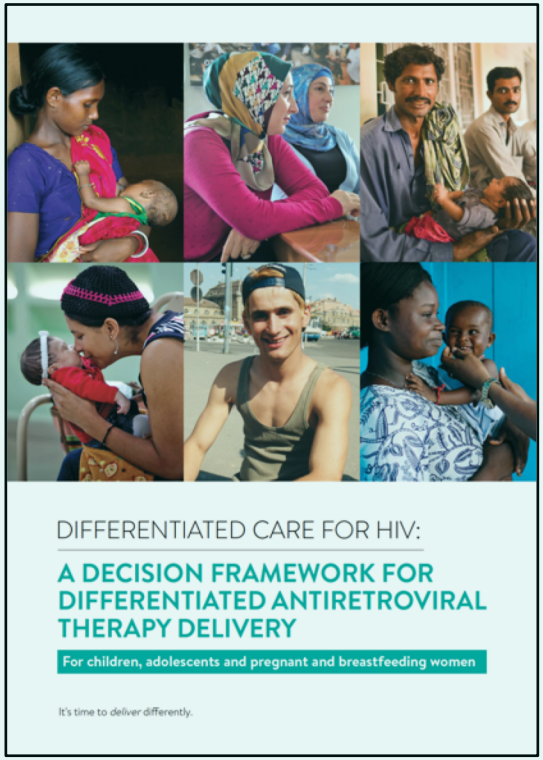


- For ART refills, clinical consultations and psychosocial support
- Children (2-5 years and 5-9 years) and adolescents (10-19 years)

Key considerations for differentiated antiretroviral therapy delivery for specific populations: children, adolescents, pregnant and breastfeeding women and key populations. Geneva: World Health Organization; 2017

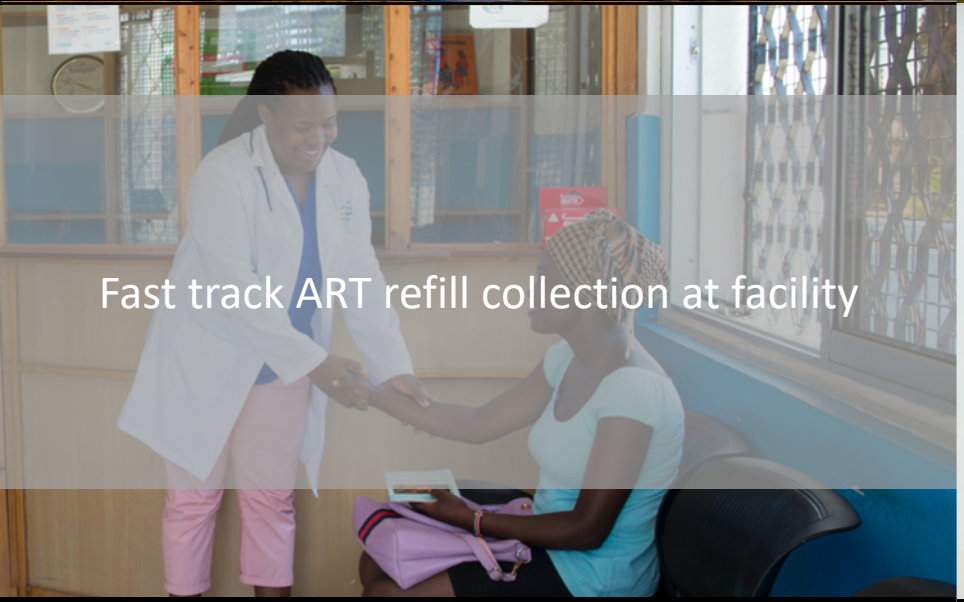
A decision framework for differentiated ART delivery for children, adolescents and pregnant and breastfeeding women

- A **background** to the principles of DSD
- A **menu** of examples of differentiated ART delivery for the specific populations
- **Guidance** on how to adapt or build a differentiated ART delivery model for children, adolescents and/or pregnant and breastfeeding women

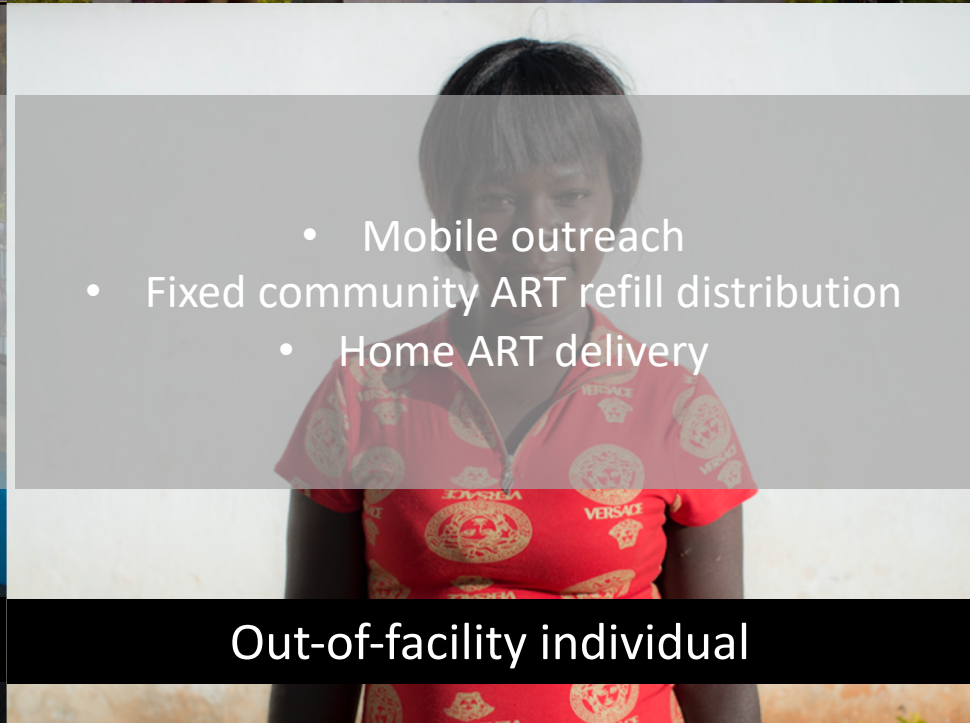


Health care worker-managed group

Client-managed group



Facility-based individual



Out-of-facility individual

An Example – Adolescent Groups in Zimbabwe

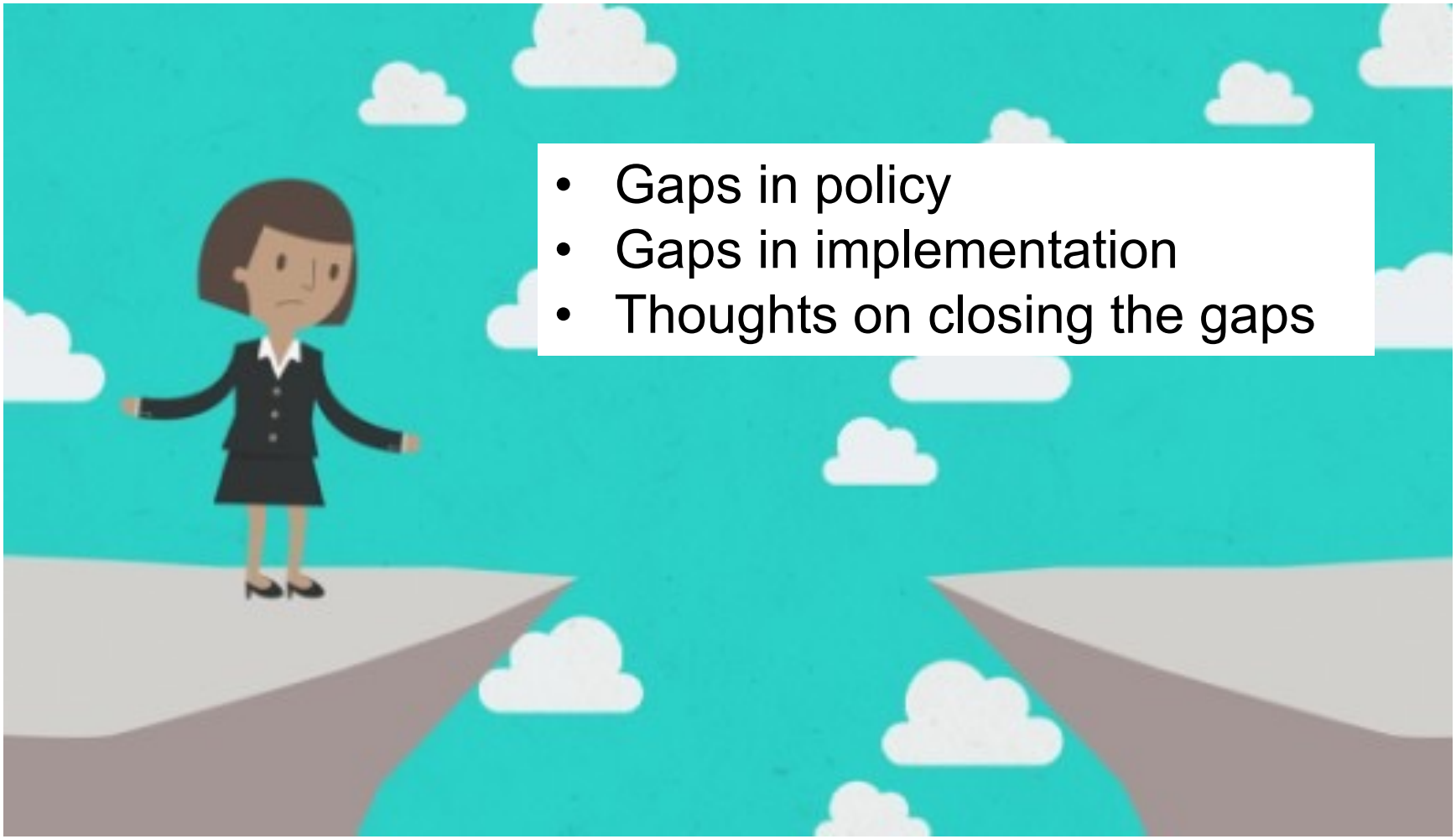
	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	3 monthly	6 monthly	3 monthly*
WHERE	PHC	PHC	PHC with additional visits in the community, outside the health facility
WHO	Primary counsellor/CATS	Nurse	CATS
WHAT	ART and Cotrimoxazole refills Referral check	Clinical consultation SRH services Blood draw (annual if VL)	Peer support SRH education Adherence check Referral check

- An example of a health care worker-managed group
- Leverages existing model of psychosocial support

*More frequent psychosocial support provided as required

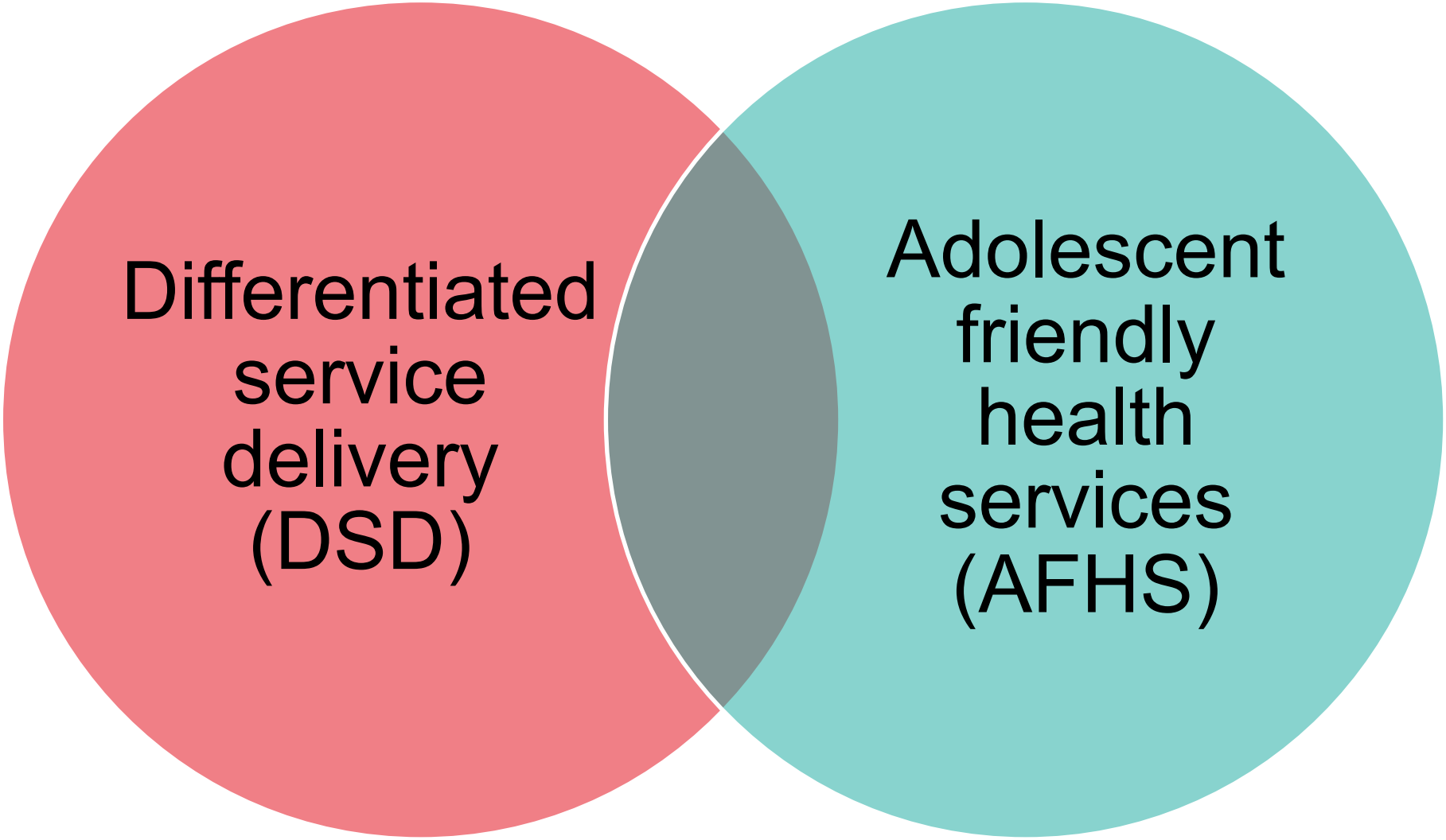
From *A decision framework for differentiated ART delivery for children, adolescents and pregnant and breastfeeding women*

Gaps

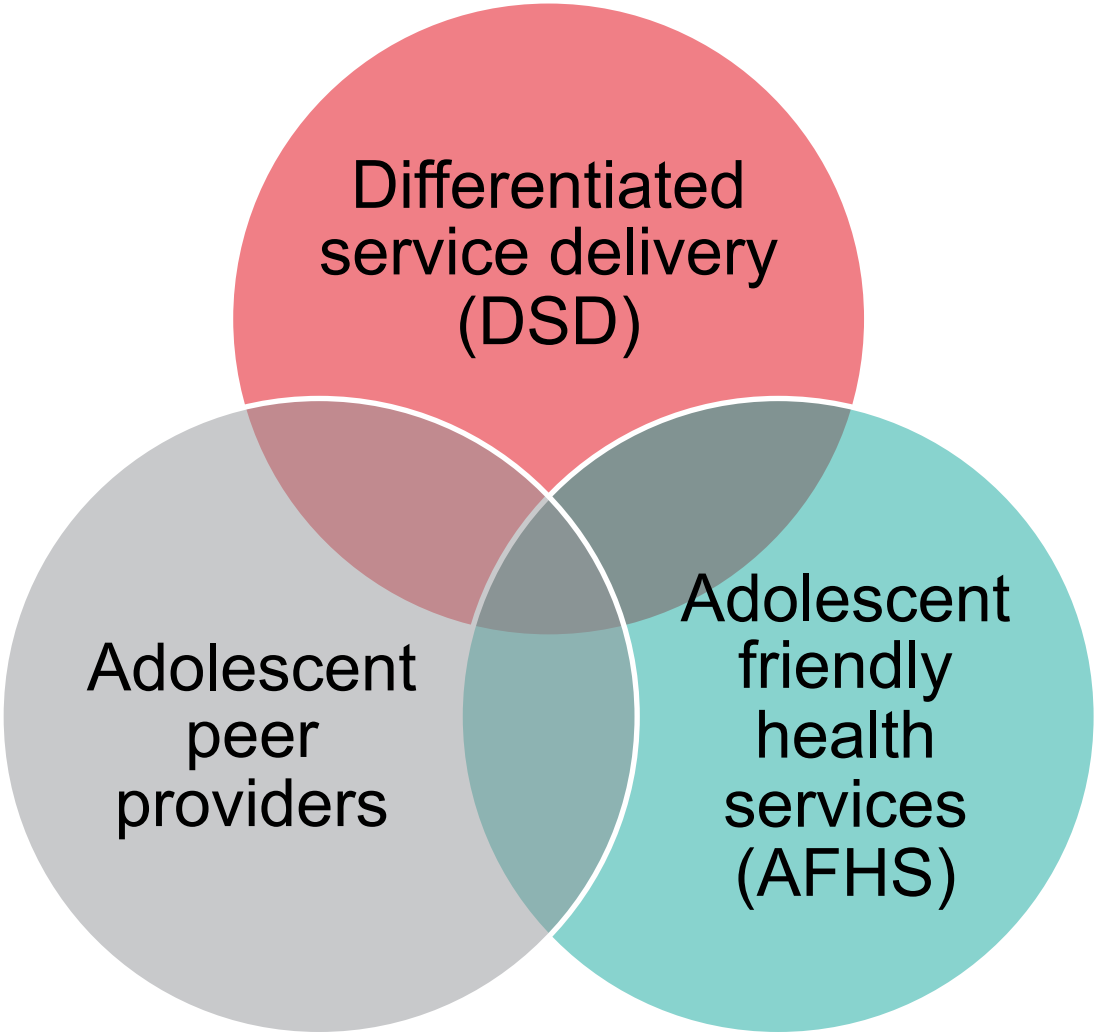

• Gaps in policy
• Gaps in implementation
• Thoughts on closing the gaps

Differentiated service delivery (DSD)

How do these fit together??



How do these fit together??



Gaps from evidence to implementation

Evidence

- Longer ART refills
- Teen Clubs and Youth Clubs
- Family-centered care

Policy

- WHO policy guidance
- Poor uptake in countries

Providing differentiated delivery to children and adolescents
Authors: Child Survival Working Group: IAS, UNICEF, WHO

Implementation

- Provider "trust"
- Mainly through IPs
- Insufficient consideration for families

Evidence

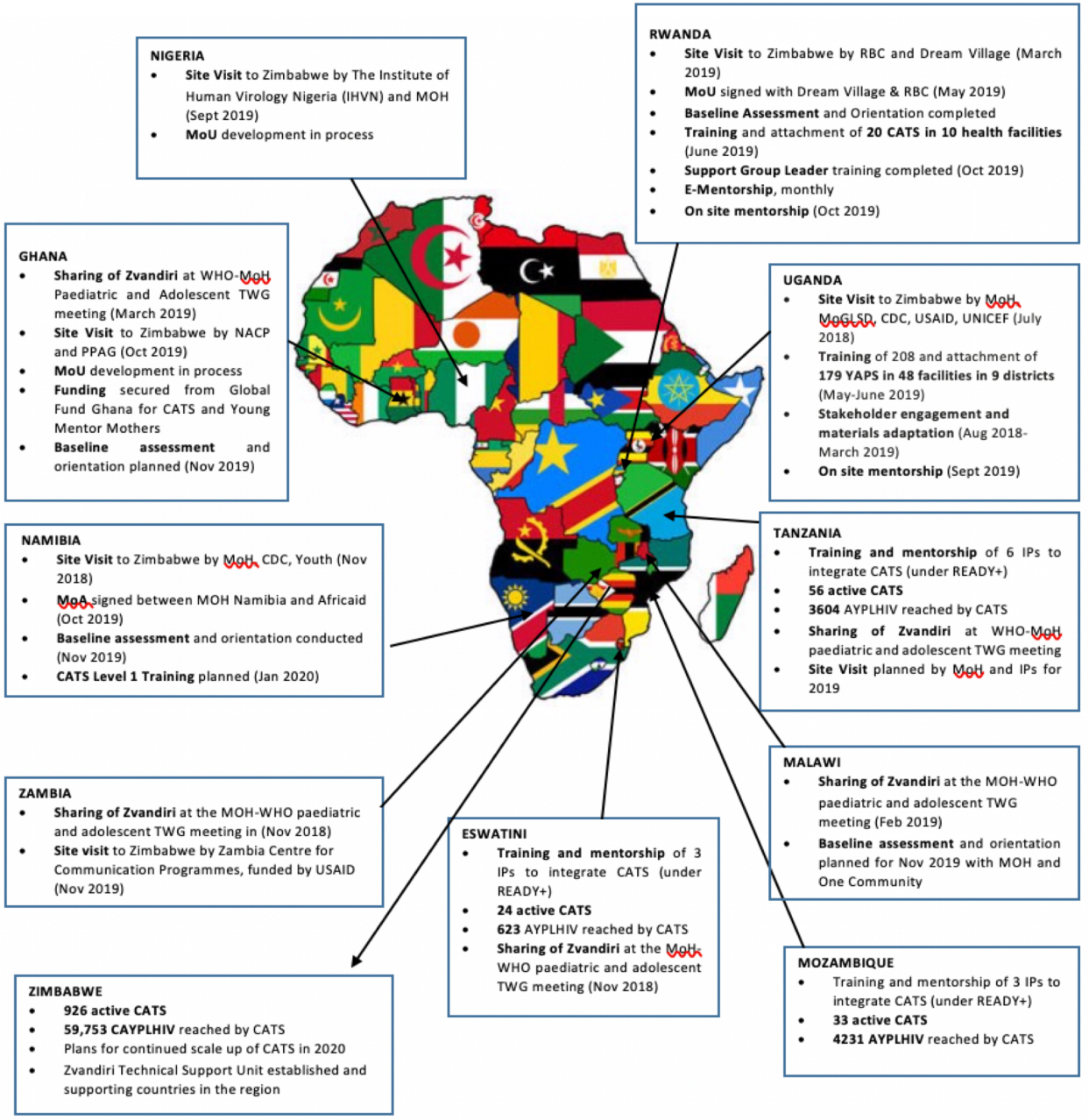
- McBride K, Parent J, Mmanga K, Chivwala M, Nyirenda MH, Schooley A, Mwambene JB, Dovel K, Lungu E, Balakasi K, Hoffman RM, Moucheraud C. ART Adherence Among Malawian Youth Enrolled in Teen Clubs: A Retrospective Chart Review. AIDS Behav. 2019 Sep;23(9):2629-2633. doi: 10.1007/s10461-019-02580-y.
- Kim MH, Wanless RS, Caviness AC, Golin R, Amzel A, Ahmed S, Mhango J, Damba D, Kayabu A, Chodota M, Dlamini S. Multimonth Prescription of Antiretroviral Therapy Among Children and Adolescents: Experiences From the Baylor International Pediatric AIDS Initiative in 6 African Countries. JAIDS, 2018 Aug 15;78:S71-80.
- Bacha JM, Aririguzo LC, Malingoti B, Wanless RS, Ngo K, Campbell LR, Schutze GE. The Standardized Pediatric Expedited Encounters for ART Drugs Initiative (SPEEDI): description and evaluation of an innovative pediatric, adolescent, and young adult antiretroviral service delivery model in Tanzania. BMC infectious diseases. 2018 Dec;18(1):448.
- Willis N, Napei T, Armstrong A, Jackson H, Apollo T, Mushavi A, Ncube G, Cowan FM. Zvandiri-Bringing a Differentiated Service Delivery Program to Scale for Children, Adolescents, and Young People in Zimbabwe. J Acquir Immune Defic Syndr. 2018 Aug 15;78 Suppl 2:S115-S123. doi: 10.1097/QAI.0000000000001737.
- Graves JC, Elyanu P, Schellack CJ, et al. Impact of a family clinic day intervention on paediatric and adolescent appointment adherence and retention in antiretroviral therapy: a cluster randomized controlled trial in Uganda. PLoS One 2018; 13: e0192068.
- MacKenzie RK, van Lettow M, Gondwe C, Nyirongo J, Singano V, Banda V, Thaulo E, Beyene T, Agarwal M, McKenney A, Hrapcak S, Garone D, Sodhi SK, Chan AK, Greater retention in care among adolescents on antiretroviral treatment accessing "Teen Club" an adolescent-centred differentiated care model compared with standard of care: a nested case-control study at a tertiary referral hospital in Malawi. J Int AIDS Soc. 2017 Nov;20(3). doi: 10.1002/jia2.25028.
- Tsondai P, Wilkinson L, Henwood R, et al. Retention and viral suppression outcomes of patients enrolled in family ART adherence clubs in Cape Town, South Africa. 9th International AIDS Society Conference on HIV Science. Paris, France; July 22–27, 2017.
- Wilkinson L, Moyo F, Henwood R, Runeyi P, Patel S, de Azevedo V, et al. Youth ART adherence clubs: Outcomes from an innovative model for HIV positive youth in Khayelitsha, South Africa. 21st International AIDS Conference, Durban, 18-22 July 2016.
- Mwangwa F, Havlir D, Jain V, et al. 48-week outcomes of African children starting ART at CD4>500 with streamlined care. Conference on Retroviruses and Opportunistic Infections; Boston, Massachusetts, USA; Feb 22–25, 2016.
- Decroo T, Mondlane V, Dos Santos N, et al. Early experience of inclusion of children on ART in community ART groups in Tete, Mozambique. 19th International AIDS Conference. Washington, DC, USA; July 22–27, 2012.

Age Restricted Policies:

Children, especially younger children (2-5 years) not eligible

COUNTRY	ELIGIBILITY REGARDING AGE
DRC	Over 15 years of age
Eswatini	Over 18 years Adolescents 10-19 years specifically qualify for Teen Club model
Ethiopia	Over 5 years of age
Ghana	Stable child defined as older than 5 years but allows children 2-5 years to be seen 3-monthly for clinical review with 3-monthly refill
Kenya	Stable above 20 years Children and adolescents can have 3-monthly follow-up
Malawi	Stable adults and children can be given 3-monthly appointments
Mozambique	Stable patient definitions included for age groups 2-4 years, 5-9 years and above 10 years Children <15 years are not eligible for community ART groups
Namibia	Stable patient definition does not include age restriction - note to scrutinize weight and adherence to decide on frequency of visits
Nigeria	Children 0-5 years excluded, requiring more regular monitoring
Rwanda	Children under 15 years excluded (require monthly refills)
Sierra Leone	Stable above 5 years
South Africa	Stable over 18 years
Uganda	Children eligible only for facility-based models, under 5s need to come monthly
Zambia	No age restriction but “all children younger than five years old with HIV are considered as having advanced HIV disease”
Zimbabwe	Children under 2 years should be seen monthly and thereafter 3-monthly until on adult doses.

Scale-up of the Zvandiri programme



Used with permission from Africaid Zvandiri

Advocate!

- Peer-reviewed *push* for family centeredness (Srivastava et al, Grimsrud et al, Mirkovic et al, Richter et al, Srivastava et al)
  - Gains for adults lost if children excluded
- Inclusion (or rather non-exclusion) based on age
- Showcase & spotlight successes


DIFFERENTIATED
SERVICE DELIVERY
Visit www.differentiatedservicedelivery.org
for tools, resources and more.

Elizabeth Glaser
Pediatric AIDS
Foundation

Differentiated Service Delivery Models for Treatment and Care of Children and Adolescents in EGPAF Programs

Cathrien Alons
Associate Director of Technical Leadership and Program Optimization, The Elizabeth Glaser Pediatric AIDS Foundation, Washington D.C.

Methods - Data Collection

Descriptive analysis of differentiated service delivery (DSD) interventions for children and adolescents in seven EGPAF-supported countries between 2017 and 2019

Collected:

- Model descriptions:
  - Patient eligibility for DSD model enrollment
  - Location of care delivery
  - Intervention included in DSD model
  - Health cadre delivering care
  - Frequency/timing of care delivery
- Number of EGPAF-supported facilities implementing each type of DSD model, for each country
- Mapped DSD models against national policies

Eswatini, Kenya, Lesotho, Malawi, Mozambique, Tanzania, and Uganda

DSD Models Implemented

Building Block	Multi-month refills (MMR)	Weekend clinics	School holiday clinics	Child/teen clubs	Family model of care	Community outreach models
Who	Clinicians	Clinicians, lay workers, counselors	Clinicians, lay workers, counselors	Clinicians, lay workers, counselors	Clinicians, lay workers, counselors	Clinicians, lay workers, counselors
What	ART refills	Comprehensive one-stop care-clinical checks, ART refill; groups or individual	Comprehensive one-stop care - clinical checks, ART refill; groups or individual	Comprehensive one-stop care - clinical checks, ART refills; peer groups	Comprehensive one-stop care - clinical checks, ART refills; family groups.	Screening, refills, counseling, clinical checks
Where	Facility	Facility	Facility	Facility	Facility	Community
When	Every 2-3 months	Weekends (frequency may follow refill or clinical check schedule and may be every 2-3 months when combined with MMR)	Scheduled for every 2-3 months during school holidays	Frequency may follow refill or clinical check schedule (may be every 2-3 months when combined with MMR)	Frequency may follow refill or clinical check schedule (may be every 2-3 months when combined with MMR)	Monthly

DSD Models Implemented by EGPAF Country Programs Compared with DSD Policy Landscape

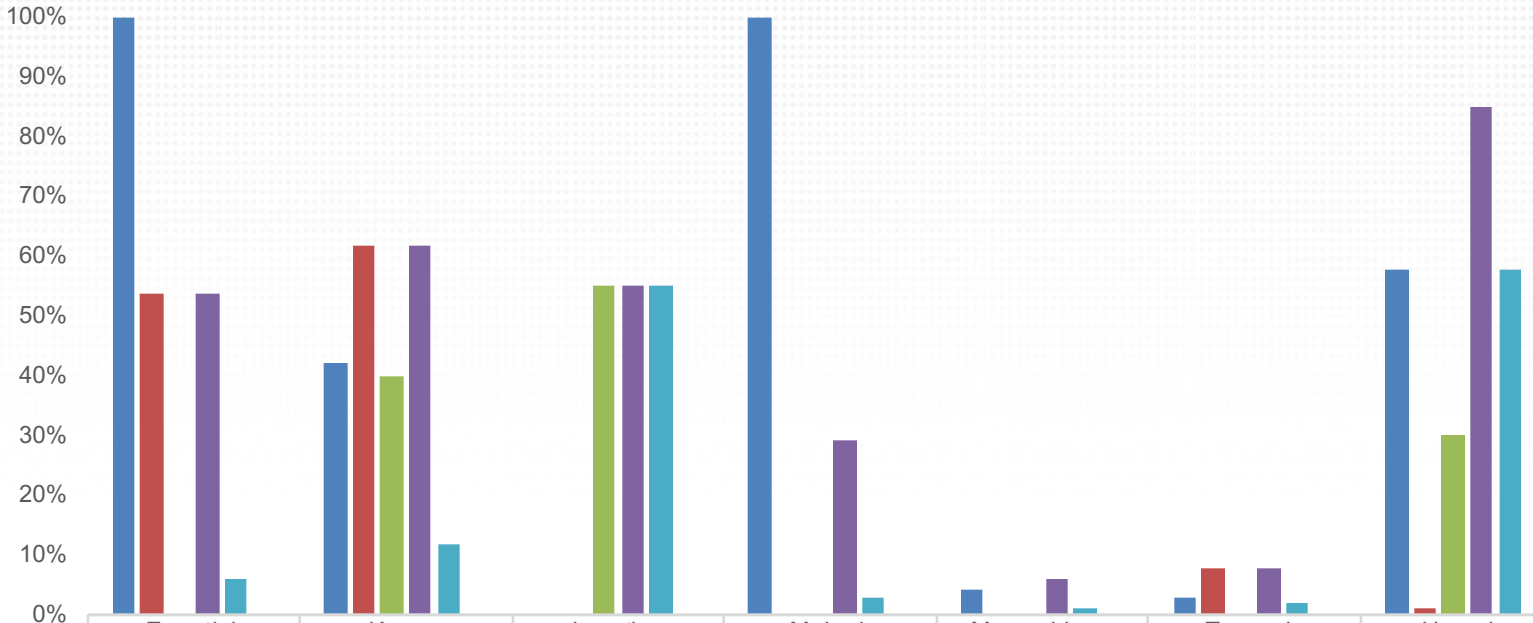
	MMR	Weekend Clinics	School Holiday Clinics	Child/Teen Clubs	Family model of care	Community outreach models
Eswatini	Yes	Yes	No	Yes	Yes	Yes
Kenya	Yes	Yes	Yes	Yes	Yes	No
Lesotho	Yes	Yes	Yes	Yes	Yes	No
Malawi	Yes	No	No	Yes	Yes	No
Mozambique	Yes	No	No	Yes	Yes	Yes
Tanzania	Yes	Yes	No	Yes	Yes	Yes
Uganda	Yes	Yes	Yes	Yes	Yes	No

DSD Supporting Policies – Population and Models Included in National Guidelines

- Included in the guidelines without specifications (except Uganda >2 years)
- Specified for adolescent clients (10-19 years)
- Specified for stable, adolescent clients (10-19 years)
- Specified for stable clients (Malawi >2 years; Mozambique/Tanzania >5 years)
- Not included in the national guidelines

- 0-19 years and caregivers
- 0-10 years and caregivers

Coverage of DSD Models at EGPAF-supported Sites Across Seven Countries



	Eswatini	Kenya	Lesotho	Malawi	Mozambique	Tanzania	Uganda
MMR	100%	42%	yes*	100%	4%	3%	58%
Weekend Clinics	54%	62%	yes*			8%	1%
School Holiday Clinics		40%	55%				30%
Child/Teen Clubs	54%	62%	55%	29%	6%	8%	85%
Family model of care	6%	12%	55%	3%	1%	2%	58%
Community outreach models							

* EGPAF supported sites are implementing, but no data obtained on % of sites supporting this model

Family Care Model (FAM-CARE) - Eswatini

Who eligible –
- Children/adolescents <19 living with HIV and their families

Who -
- Expert clients
- Health care workers

Where -
- Health Facility

When -
- Eswatini National Guidelines – standard for HIV-positive pediatric patients on ART to be seen monthly for visits and ART pickup
- Viral load testing every 6 months

What -
- Families registered and seen as a family unit (files in family folder) by same health worker
- Designated health worker reviews family folder prior to scheduled facility visits
- Designated expert client leads family to consultation room; prioritized to reduce time spent at facility
- Expert client consults with family – provides pre-packaged medication if no members are ill
- VL tests for each member every 6 months
- If stable – only one member is required to pick up refills
- SMS appointment reminders
- Follow-up system in case of missed appointment

Impact –
- Reduced workload for health workers
- Decreased time spent at facility for families
- Foster familial support for treatment success
- Evaluation underway

Ariel Adherence Clubs (AAC) –Tanzania

Who is eligible–
- HIV-positive children and adolescents 5-19 yrs and their caregivers
  - Children's Clubs for ages 5-14 years; if partial disclosed.
  - Adolescent Clubs for ages 10-19; must be aware of HIV status and viral load

Who -
- Peer facilitators
- Clinicians, lab and pharmacy staff

Where -
- Higher volume health facilities, dedicated space

When -
- Monthly (Saturday)

What -
- Club meetings, PSS, individualized counselling, with caregiver
- Integrated clinical service delivery (ART refill, labs, clinical care) on same day as monthly support group

IMPACT –
- Adolescents attending AAC were more likely to be retained in care at 6 months (91% vs 76%)
- Adolescents attending AAC were more likely to have HVL performed (67% vs 39%)
- In context of suboptimal VL coverage, no difference in VLS observed between those attending and those not attending


PHOTO: ANDREW MARINKOVICH/EGPAF,2017

ViiV Red Carpet Services –Kenya

Who is eligible–
- HIV-positive adolescents 15-21 years

Who -
- Red Carpet Coordinators
- Multi-disciplinary teams
- School engagement and support

Where –
Health facility; secondary schools

When -
- Weekend and extended clinical hours

What -
- Intensive adolescent involvement in project design and implementation
- Peer counselling and PSS provided at facilities and schools
- VIP services: fast-tracked services for 15-24 year-olds
- School-based support for clients
- One2One telephone hotline (with LVCT)

IMPACT –
- Enrolled 560 adolescents (15-19) and youth (20-21 years) in 6 months
- Statistically significant results comparing pre- and post-intervention patient records
  - Increased linkage to HIV care:
    - From 56% to 97%
  - Increased retention on treatment
    - 3 month: from 66% to 90%
    - 6 month: from 54% to 98%
- All patients received peer counseling and psychosocial support

Kuria et al. AIDS 2017, 31 (Suppl 3):S253–S260

Lessons learned

- Need for adapted M&E systems
  - M&E systems to track children and adolescents living with HIV across DSD models
  - Availability of quality, disaggregated data
  - Need for intentional evaluation of different models
- Scale up models that work
- Incorporate client feedback to inform adolescent DSD
  - Design models that take the perspective of young people into account
- Remaining policy gaps
  - Gaps for endorsing specific models (e.g. school holiday clinics)
  - Age range for eligibility to be more inclusive
  - Lack of community-based models for children and adolescents
  - Addressing specific needs of pregnant adolescents

Conclusion

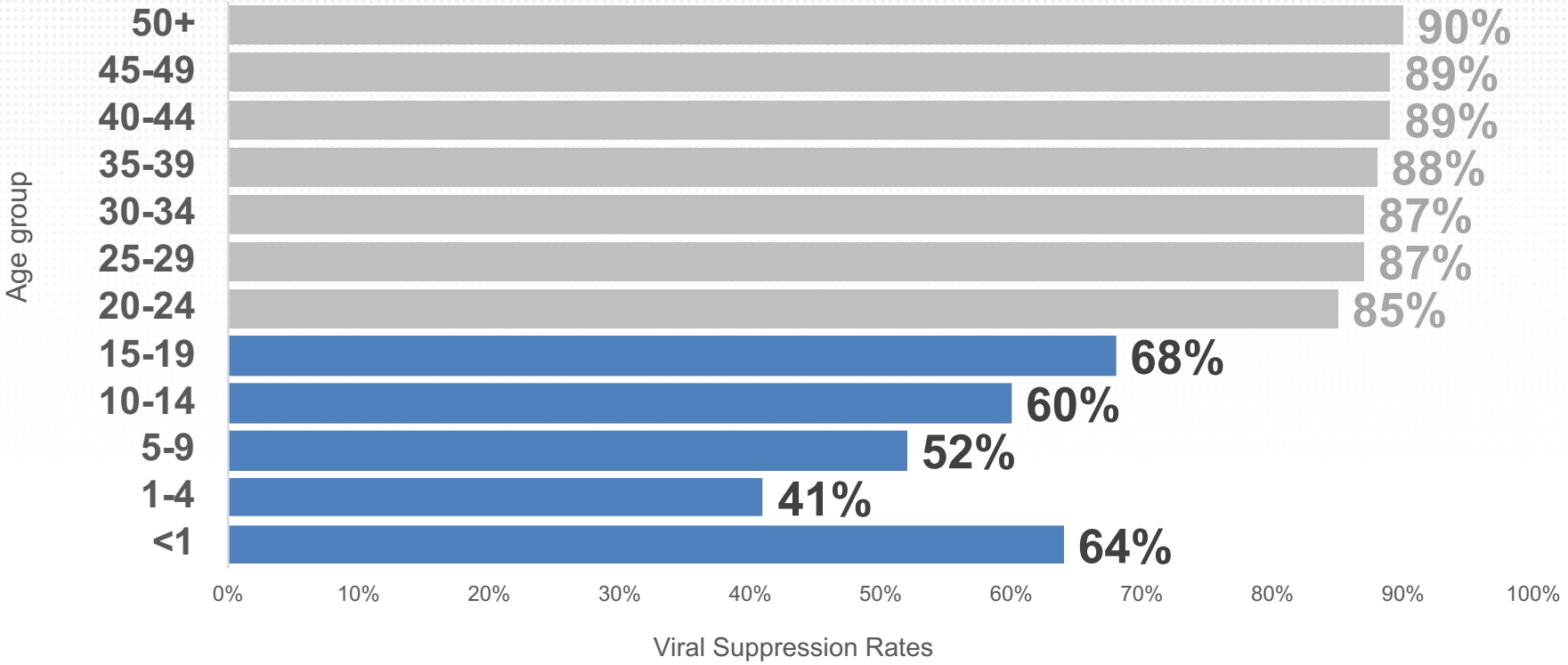
- DSD models are varied and aim to meet the needs of different populations
- Findings suggest the feasibility of implementing DSD models across LMICs countries for children and adolescents
- DSD show potential to reduce various burdens for patients, caregivers, and providers
- DSD models for children and adolescents are critical to improving the quality of HIV care and outcomes for children and adolescents

Elizabeth Glaser
Pediatric AIDS
Foundation

EGPAF-Malawi's Experience with DSD Implementation for Children and Adolescents

Allan Ahimbisibwe
Technical Director, The Elizabeth Glaser Pediatric AIDS Foundation, Malawi

Low Levels of Viral Suppression Reported in Children and Adolescents in Malawi



- Attributable to use of less efficacious regimens in these populations (about 70% of children are on NNRT-based regimen)
  - regimens with known resistance and without easy transition to second line
  - Inadequate adherence for the age, especially in adolescents

Data source: Analyzed MOH Data

A Clear Need for Support

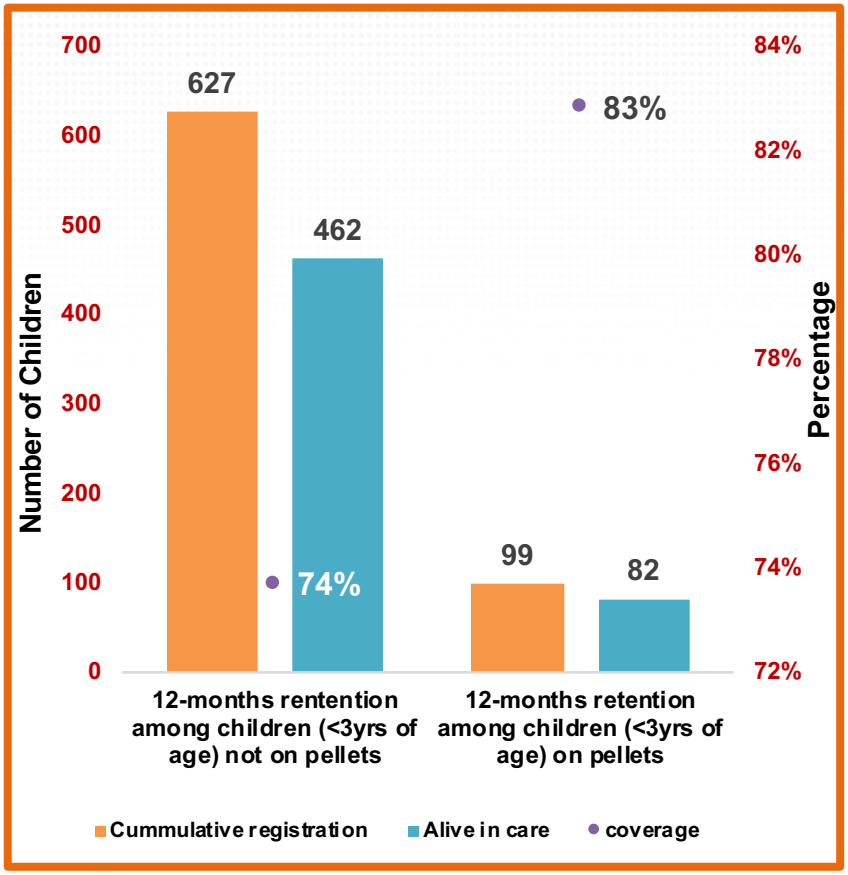
- **Increased accessibility and utilization of effective drug regimens**
  - Prompt switching of children to efficacious regimen: first- and second-line regimens, as appropriate

- **Tailored case-management for children and adolescents, involving guardians**

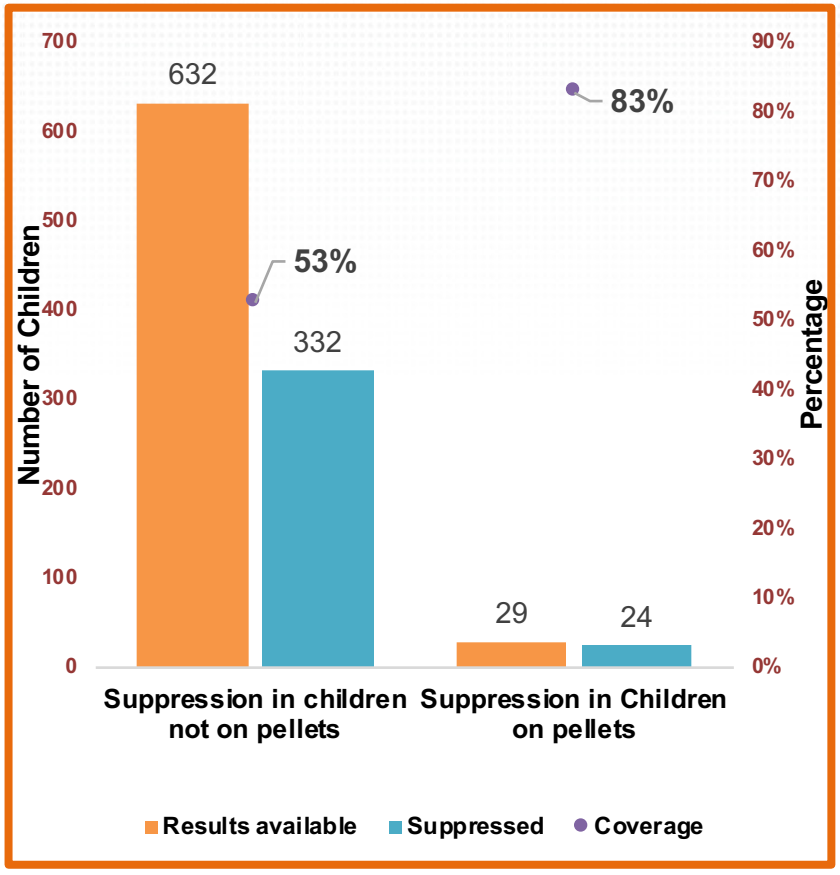
- **DSD models considered:**
  - Mother-infant pairs
  - Pediatric-specific ART clinic days
  - Family clinic days
  - Teen clubs

Higher Retention and Viral Suppression among Children on Pellets Compared to Other Regimen

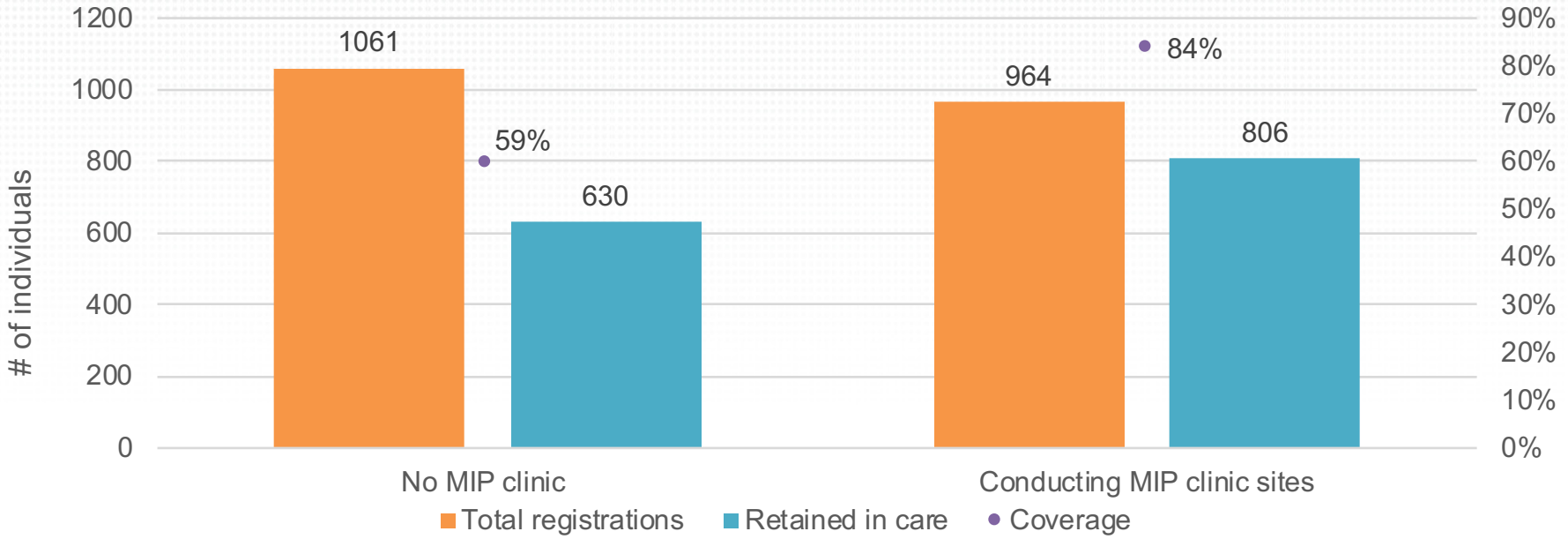
Retention at 12-months for children < 3 years old on pellets in EGPAF-supported districts April-June 2019



High viral suppression rate among children < 3 years on pellets in EGPAF-supported districts April-June 2019



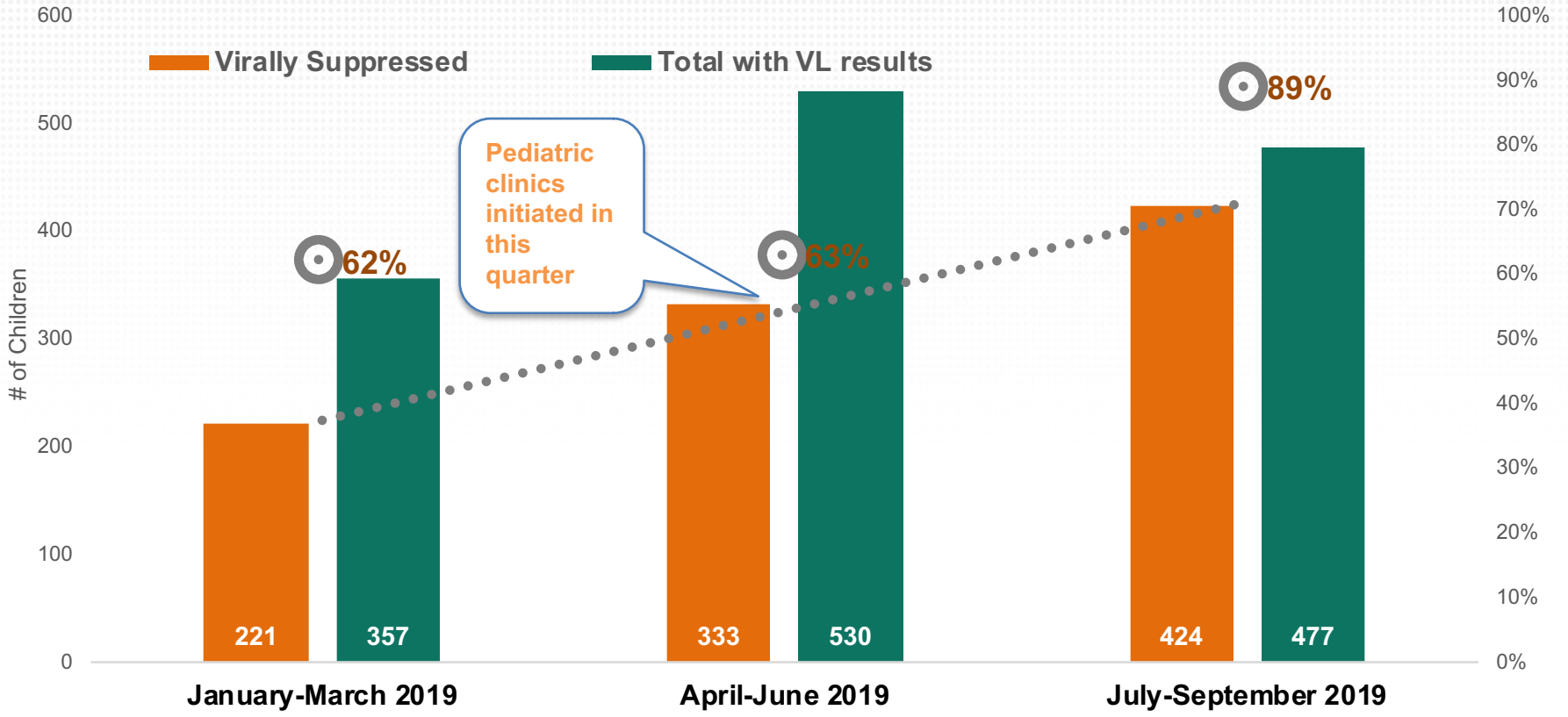
High Retention Rates among Mother Infant Pairs (MIP) in 16 Health Facilities in Blantyre and Zomba Districts (April-June, 2019)



Changes implemented:

- Introduced registers with longitudinal follow-up of infants
- Assigned care and treatment officers as focal persons to facilitate clinic activities to improve coordination
- Accessing Laboratory Information Monitoring System (LIMS) for results follow-up at facilities

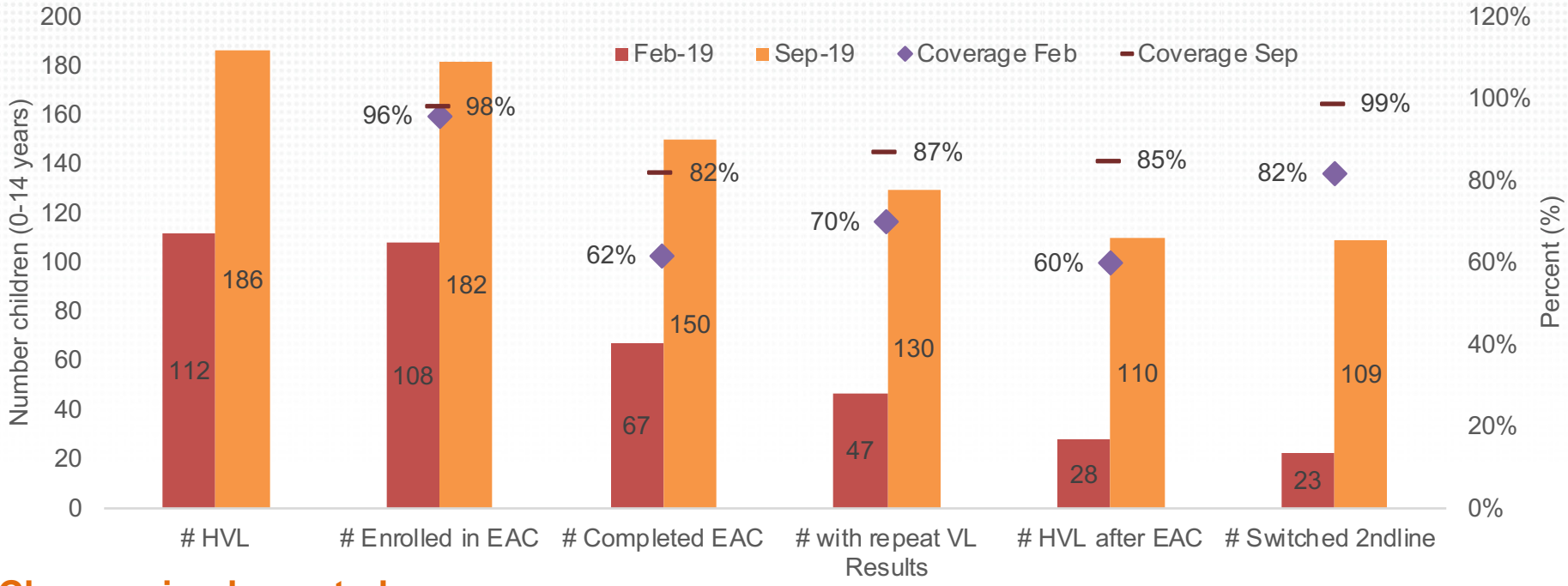
Pediatric Clinic: Increase in Viral Suppression among Children Attending Pediatric Clinics



Changes implemented:

- General clinic for children, but scheduled on a dedicated day
- Clinician provides targeted case management of children

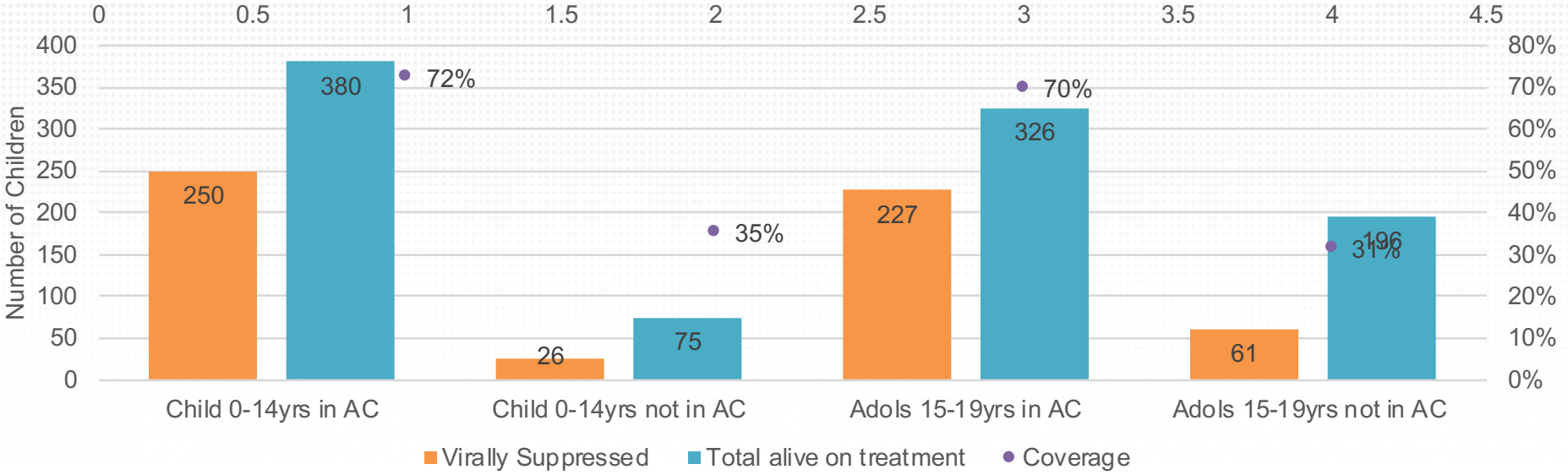
High Viral Load (HVL) Management for Children (ages 0-14 years) through Family Model Clinics (N=6)



Changes implemented:

- Special clinic day for children with HVL and their families, seen together by a specialty team of nurses, CTO, DTO, HDAs, Clerk and PSS counselors
- Provides ample time for thorough clinical consultation/assessment
- PSS services through individual and group counseling on disclosure, adherence and socio-emotional support to both children and adults (3 enhanced adherence counseling [AEC] session recommended per family)
- A targeted VL test is done, then a second VL test, switched to second line ARVs, if HVL persists

Viral Suppression Higher among Children Attending Ariel Clubs (AC), Five Facilities in Blantyre



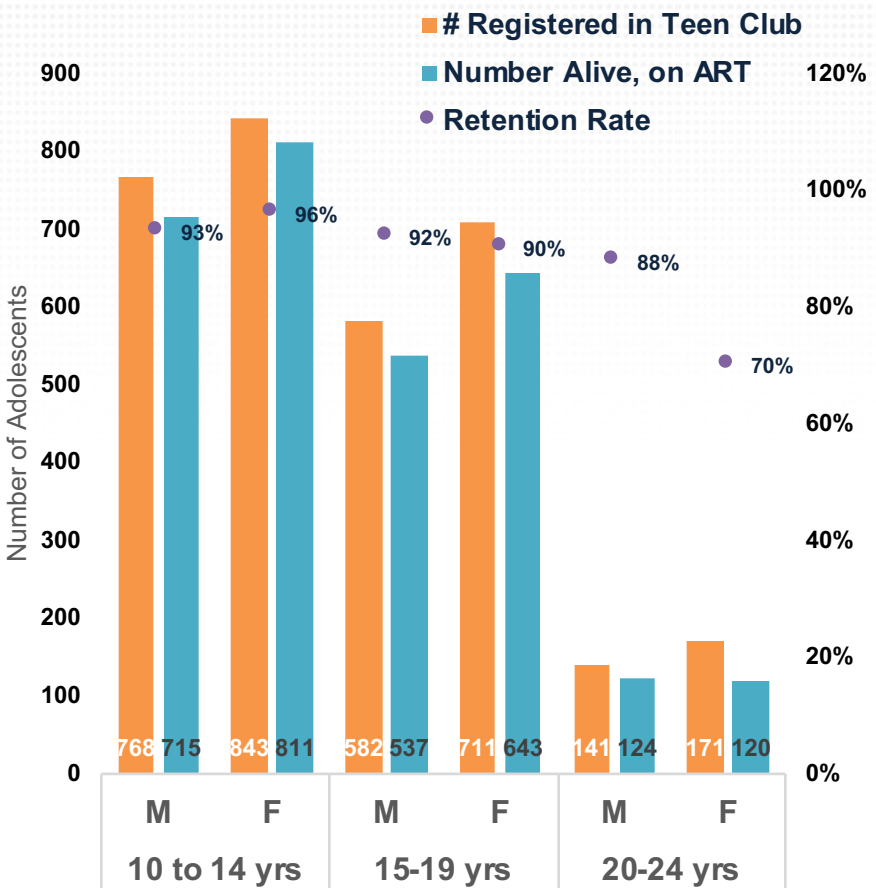
Changes implemented:

- A peer support group for adolescents (10 to 19 years), meets once per month (Sat or Sun)
- Services offered to group include clinical consultations, refills, VL monitoring
- Quarterly guardian sessions on ART, and positive parenting for enhanced guardian support
- Home visits and family/guardian sessions for adolescents with identified specific issues
- Food provided for the day

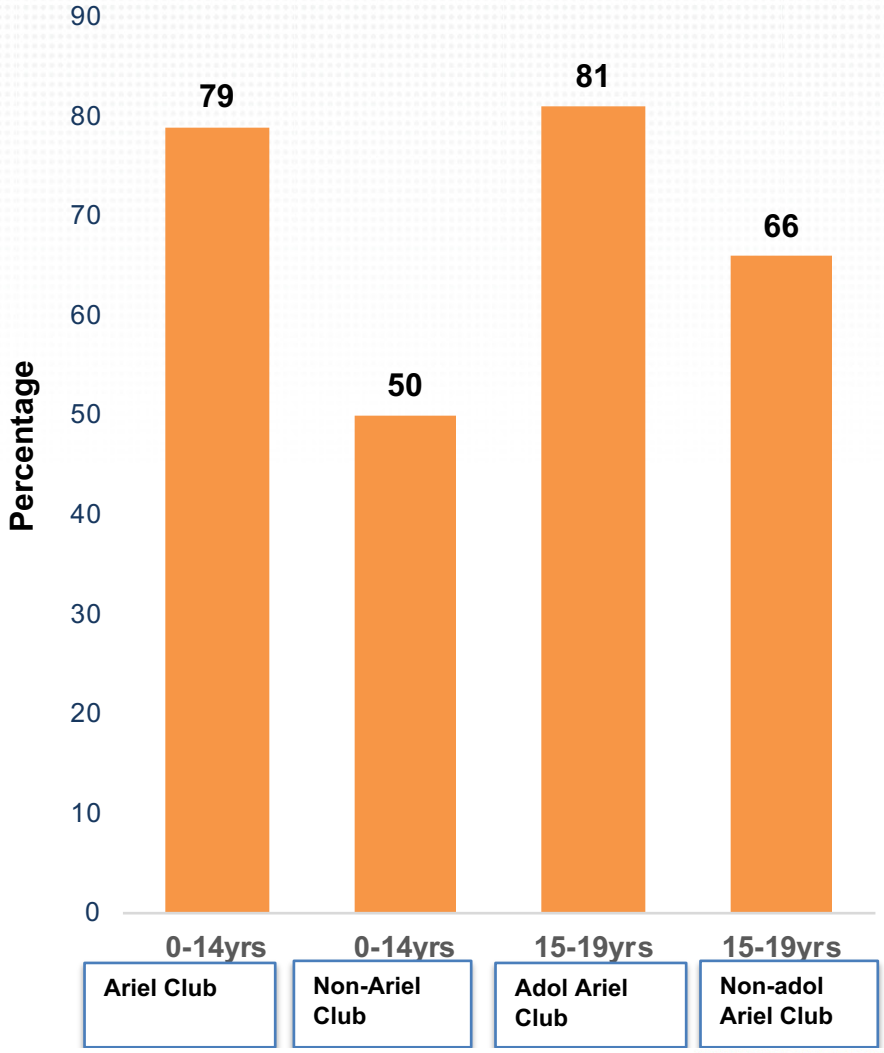
PSS services offered: PSS assessment; group ART and HIV and AIDS education; individual and group counseling for adolescents with HVL / defaulted/ missed appointments; recreational activities; transitioning to adult care.

Retention and Viral Suppression in Ariel Clubs

High retention in care for adolescents in Ariel Clubs, by June 2019



Adolescent viral suppression in Ariel Club sites vs sites without clubs



Lessons Learned

- Optimize drug regimens
- Dedicated, skilled cadres and team approach are critical for successful implementation
- Teens in clubs have higher VL suppression rates compared to teens not in clubs
- Continuous improvement/exploration may be needed
  - Revisit DSD for teen clubs-fast track for stable adolescents and slow model for unstable
- Scalability possible
  - FMC initiative has now been scaled-up to 32 health facilities

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Differentiated service delivery for children and adolescents

Hilary Wolf | November 20, 2019

16 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

DSD to Improve Retention and Adherence

- Barriers include issues of access/convenience, stigma and confidentiality, as well as deeply held belief systems
- Untangling the specific issues for each family and addressing them directly improves patient outcomes
- DSD models provide a critical solution to retention and adherence barriers

Principles of Family-Centered Care

- Aligning parent and child:
  - Clinical appt dates
  - ARV pick-up dates
  - VL/lab dates
  - Preventing/treating coinfections/comorbidities
  - Psychosocial support needs
- Utilize OVC and community programs to provide comprehensive support to the whole family

Family Centered Care: Considering Adolescents

- As children age into adolescence, families continue to play an important role in adolescents' transition to self-health management
- Facility and community programs should support caregivers on age-appropriate disclosure to the child
- Once the child/adolescent is disclosed, they can be enrolled in adolescent-focused DSD models that include adolescent peer support – with choice about alignment with family visits
- Even after disclosure and enrollment into adolescent DSD models, caregivers should be engaged to support post-disclosure and adherence until the adolescent is successfully transitioned to HIV self care
- Families of adolescents should also be screened for eligibility into OVC programs or other community services

Family Centered Care: Viral Load Coverage (VLC)

- VL monitoring is essential for all family members
- VL results are the key to differentiated care
  - reduced intensity of care if suppressed
  - Increased intensity of care if not suppressed
- VLC should be monitored separately by age group
  - Children at higher risk of poorer coverage
  - Address barriers to lower VLC coverage in children than in adults

Family-centered DSD When Not All Family Members are "Stable"

Some DSD programs serve the needs of all families and others specifically support them when one or more member is unsuppressed

Stable

- Multi-month dispensing
- PAMA care (Kenya)
- Mentor mothers for children <5 (Mozambique)
- Family adherence clubs (South Africa)
- OVC Programs
- Family CARGs (Zimbabwe)
- Adolescents:
  - Operation Triple Zero (Kenya)
  - Zvandiri (Zimbabwe)
  - Teen Club (multi-country)
  - ARIEL Clubs (multi-country)
  - CAMARA groups (Lesotho)

Unstable

- PAMA Care (Kenya)
- Family viremia clinics (Malawi)
- Adolescents
  - Operation Triple Zero (Kenya)
  - Zvandiri (Zimbabwe)
  - CAMARA adolescent clubs (Lesotho)
- OVC Programs

Draft COP20 Guidance on MMD in Children

- **Eligibility Criteria**:
  - children need to be on optimal ART, with no dose or formulation changes for at least 3 months.
  - Children should have no intercurrent illness, including malnutrition
  - Caregivers should be counselled and oriented on age-appropriate disclosure processes, but disclosure should not be a requirement for MMD
- **Cotrimoxazole** should be provided with ART refills

Draft COP20 Guidance on MMD

Children 2-5 years

- 3 monthly refills (including co-trimoxazole refill, disclosure process check-in) and clinical visits *(one visit for refills and clinical consultations)*
- Suppressed and on the same regimen for 3 months without serious intercurrent illness

Children 5-10 years

- 3 monthly ART refills-delinked from clinical consultation visits, can be managed by lay providers
- 6-monthly clinical visits with family friendly scheduling Nurses can carry out clinical consultations and reissue prescriptions
- Consideration given to selecting times and dates that suit children attending school such as scheduling visits during school holidays

Adolescents

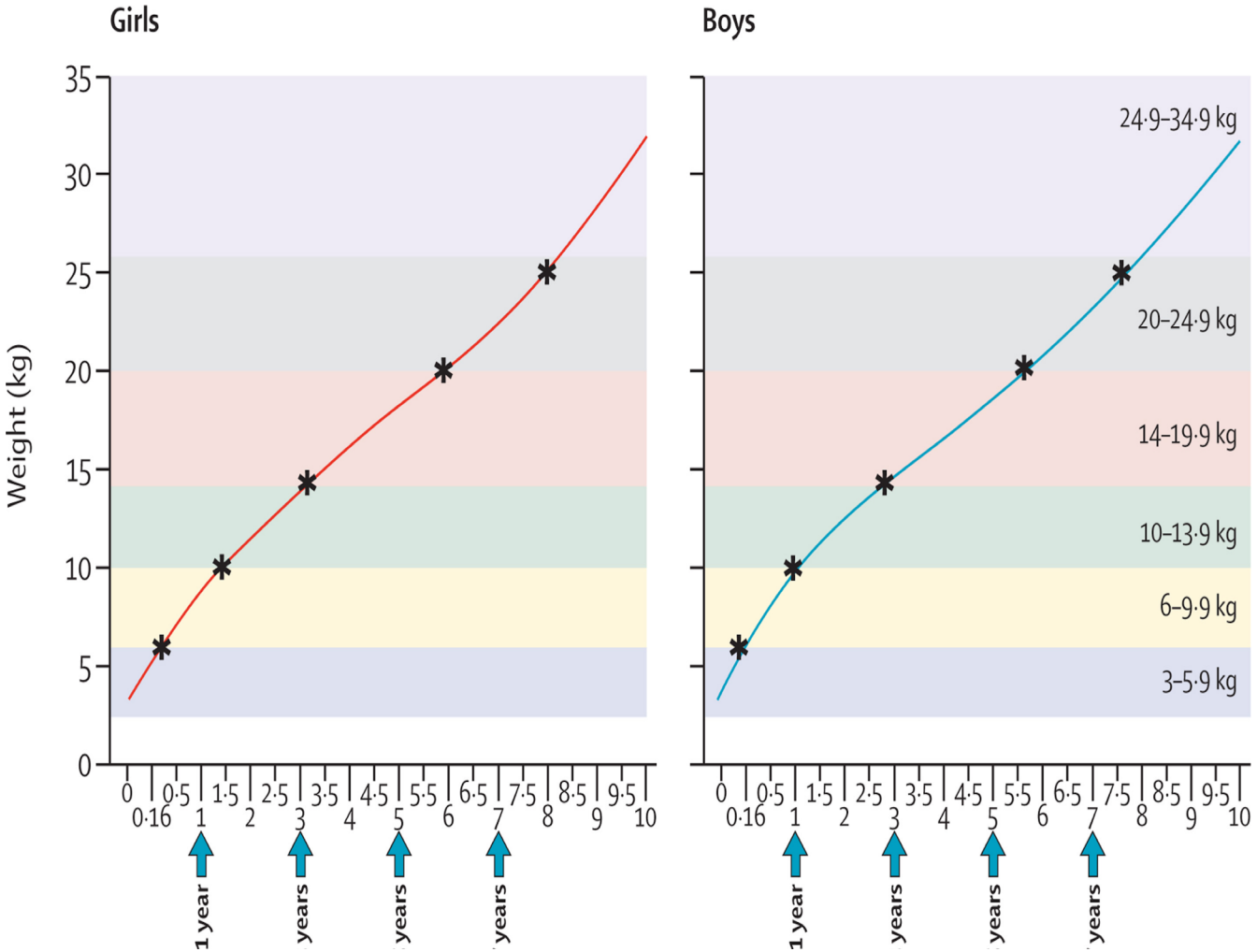
- Similar clinical criteria used for adults in determining eligibility for MMD with consideration for psychosocial support outside of the clinical setting

Challenges in Country with MMD among kids

- Concerns that have emerged from MMD guideline discussions
- Concerned about fewer clinic consultation visits for children <5 years
- Insisted on alignment with Immunization clinic monthly visits to monitor their weights and health in general
- Cited the WHO advanced disease guidance saying ‘All children younger than five years old with HIV are considered to have advanced HIV disease’

ARV dose changes for children are **infrequent** beyond infancy

Srivastava et al *Lancet HIV* 2019



Only three dose changes are anticipated between 1 year and 7 years of age and adult ART dose can be reached before the child reaches 10 years of age.

Opportunities to Address Challenges

- Frequency of **weight checks**, **immunization visits/schedule**
- **Advanced disease** category pertains to management around ART initiation (or re-initiation or treatment failure) - not ongoing successful treatment
- **Training and guidance materials** 1. address provider negative attitudes/concerns about DSD/MMD for children 2. illustrate how family-centered DSD/MMD could be planned, implemented and managed including clinical scenarios with adolescents and when one family member is “unstable”
- **M&E** 1. need to ensure tracking of missed clinic visits and med pick-ups for all family members 2. develop tools to promote/monitor/report on uptake of family-centered DSD/MMD
- **Political will** – i.e. country guideline changes


Thank
you!

Questions?

On computer or via the Zoom app

- Ask a question in the Q&A chat; or
- Click "Participants" on the Zoom Menu Bar (top of page) and then click "Raise Hand" to be un-muted.

On your phone/dialed in

- **Click *9** to "raise your hand“. You will be notified as you are unmuted. Feel free to speak up as soon as you hear this unmuted announcement.

Please state you name before asking your question