Elizabeth Glaser
Pediatric AIDS Foundation
Fighting for an AIDS-free generation

Evidence to Action (E2A) Webinar Series:

Comprehensive Advanced HIV Disease Programming — Lessons From Malawi

August 29th | 9:00 AM EST

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Agenda.

Welcome and Opening Remarks (9:00 — 9:05 AM ET)

Anja Giphart, Executive Vice President of Medical and Scientific Affairs, EGPAF

Introduction (9:05 — 9:10 AM ET)

Appolinaire Tiam, Vice President of Technical Strategy and Innovation, EGPAF

Panelist Presentations (9:10 — 9:40 AM ET)

Eddie Matiya, Project Lead — Advanced HIV, EGPAF

Vincent Tukei, Director of Public Health Evaluation, EGPAF

Judith Kose, Director of Pediatric and Adolescent Services, EGPAF

Moderated Q&A and Take Away Messages (9:40 — 10:00 AM ET)

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2022 INTERNATIONAL AIDS CONFERENCE SATELLITE SYMPOSIUM:

COMPREHENSIVE ADVANCED HIV DISEASE PROGRAMMING

LESSONS FROM MALAWI

August 1, 2022
8:00am – 9:00am | **Room 510/Channel 8**

Webinar 29/08/22
Presenter: Dr. Eddie Matiya, Project Lead, EGPAF

Creative Solutions to Scale Data-Driven AHD Programs in Resource-Constrained Health Systems

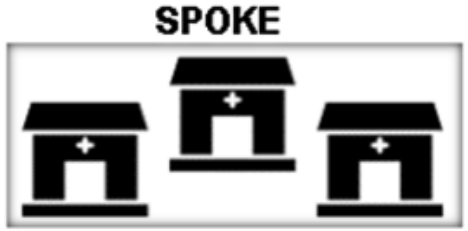
Dr. Eddie Matiya
Project Manager
EGPAF

Project Goals

Goal 1: To improve outcomes of the AHD program by defining and scaling practical models for providing access to AHD services for people living with HIV in Malawi

Goal 2: To disseminate these models as best practices for other countries with similar disease burden and resource constraints via mechanisms such as the CQUIN Advanced

Project Used an Enhanced AHD Hub-and-Spoke Model



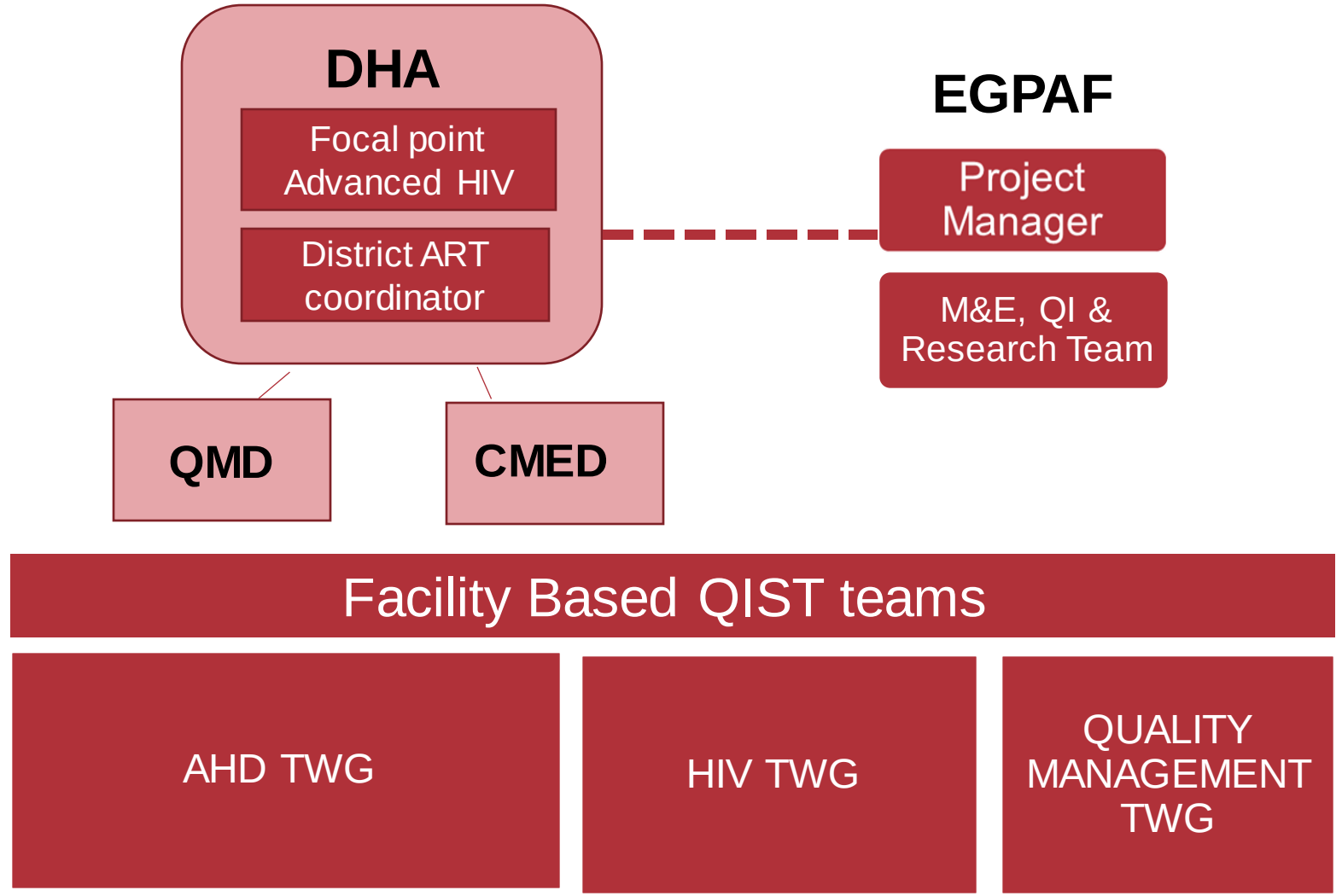
Patient referral where unavoidable but mainly sample transport

	ART	OPD
Screening and diagnosis	Sample referral system to hub • CD4 • CraG-serum • TB LAM, Access to Xpert	• Clinical assessment by AHD clinicians • CD4 • CrAg – blood /CSF • TB LAM, Xpert • LP • Hematology & Chemistry
Prophylaxis & Preemptive Tx	• TPT, CPT • Fluconazole	• TPT, CPT • Fluconazole
Treatment	• TB treatment* • Crypto care (consolidation maintenance phases) • Continuation of OI treatment	• Clinical Expertise • CCM Treatment • TB treatment • Other OI treatment* • Appropriate ART timing
Adherence support	• Counselling • Community-based support/home visit	• Counselling • Community-based support/home visit

Trainings
Patient consultation
Mentorship
QI

	ART	IPD	OPD	LAB

Collaboration Under MOH-DHA Leadership



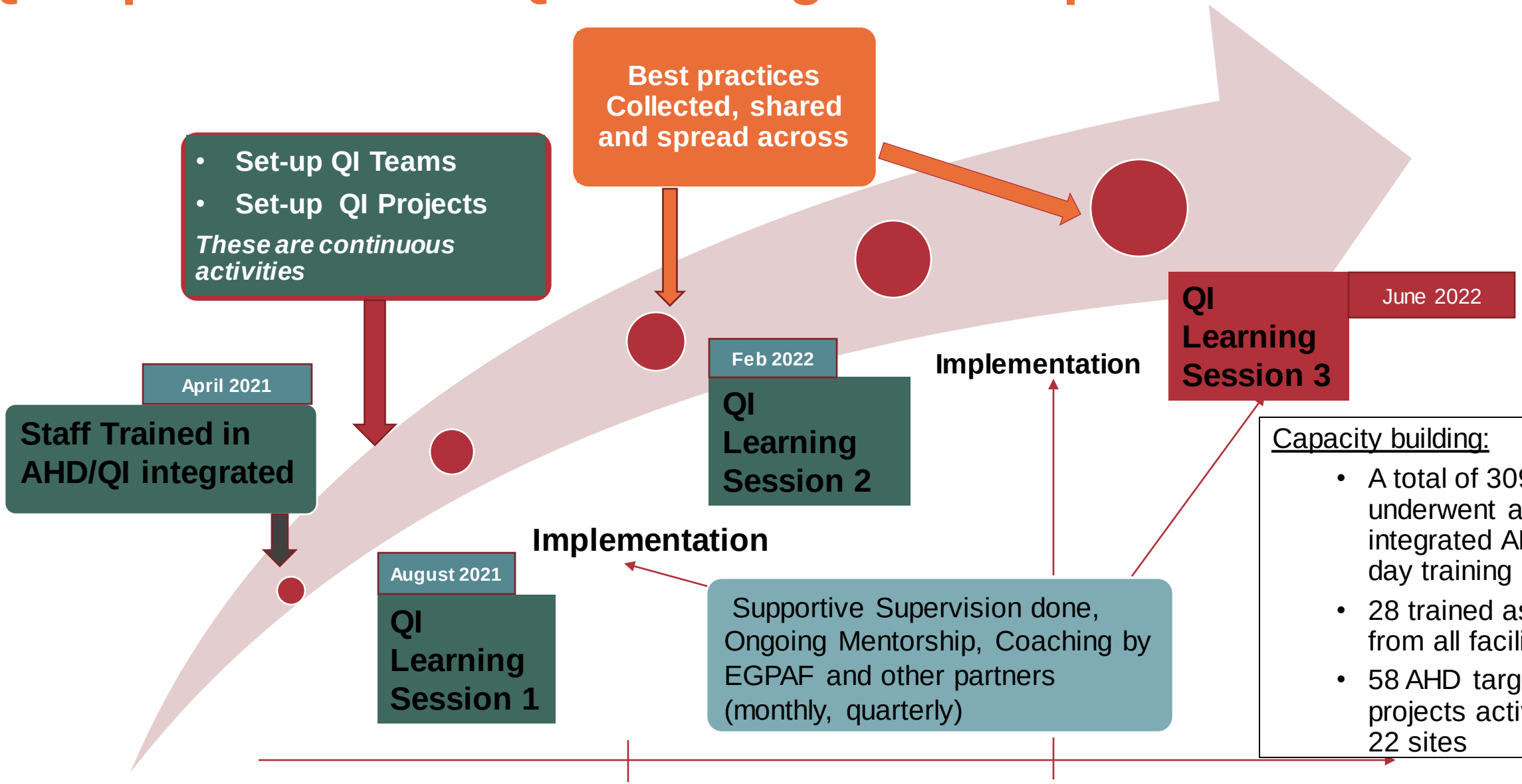
- DHA responsible for district and site selection
- DHA leading in finalizing job aids, SOP, M&E tools
- Project supports training, mentorship, QI trainings and collaboratives
- IPs – relevant staff trained in QI, support QI activities at facility levels and participate in collaborative learning sessions

Overall performance indicators (Jan. 2021 – March 2022)

	Indicators	num	den	percentage
AHD Screening				
1	# (%) patients newly diagnosed HIV	3745	7235	52%
2	# (%) patients newly diagnosed HIV with WHO staging performed	3745	3745	100%
3	# (%) patients newly diagnosed with HIV with CD4 count performed	2783	3745	74%
4	# (%) other PLHIV (returning to care after ART interruption, HVL, Stage 3/4, admitted)	3490	7235	48%
5	# (%) other PLHIV with WHO staging performed	3490	3490	100%
6	# (%) other PLHIV with CD4 count performed	1880	3458	54%
7	# (%) PLHIV with CD4 performed	4663	7235	64%
8	# (%) of PLHIV WHO Staging performed (no CD4)	2572	7235	36%
AHD Classification				
9	# (%) PLHIV with CD4 count <200 cells/mm3	1140	4663	24%
10	# (%) PLHIV with WHO clinical stage 3 or 4 (no CD4)	487	2572	19%
11	# (%) PLHIV classified as presenting with AHD	1627	7235	22%
Retention				
12	# (%) PLHIV with AHD alive and on AHD care	1402	1563	90%
13	# (%) PLHIV with AHD alive at 6 months AHD enrolment	813	935	87%
14	# (%) PLHIV with AHD who died within 6 months of AHD enrolment	86	935	9%
15	# (%) PLHIV with AHD who interrupted treatment within 6 months of AHD enrolment	36	935	4%
Viral load management				
26	# (%) of PLHIV with AHD who had a documented VL result	143	1627	9%
27	# (%) of PLHIV with AHD who had a documented Suppressed VL result	107	143	75%
TB Screening, diagnosis and treatment				
12	# (%) PLHIV with AHD who tested for TB using Urine TB LAM	1699	1627	104%
13	# (%) PLHIV with AHD diagnosed with TB	393	1699	23%
14	# (%) PLHIV with AHD diagnosed with TB initiated on TB treatment	388	393	99%
16	# (%) PLHIV with AHD who were diagnosed with TB in the previous reporting period who died	32	393	8%
CI Screening, diagnosis and treatment				
17	# (%) PLHIV with AHD tested for cryptococcal infection (CI) using Serum CrAg LFA	1462	1627	90%
18	# (%) PLHIV with AHD who tested positive for CI using Serum CrAg LFA	92	1462	6%
19	# (%) PLHIV with AHD who tested positive using CSF CrAg LFA	35	91	38%
20	# (%) PLHIV with AHD treated for Cryptococcemia	57	57	100%
21	# (%) PLHIV with AHD diagnosed with CM initiated on CM treatment	33	35	94%
23	# (%) PLHIV with AHD who were diagnosed with CCM in the previous reporting period who died	11	35	31%
24	# (%) PLHIV with AHD who were diagnosed with CI in the previous reporting period who died	4	57	7%

- High AHD screening uptake through either CD4 or WHO clinical staging
- High proportion of clients presenting with AHD (22%)
- AHD 29% New Pos, 22% BB2C
- Observed a high proportion of deaths (9%) within 6 month enrollment. Higher mortality in unstable AHD inpatients
- Retention (90%) Low AHD treatment interruption (4%)
- Suboptimal viral load uptake
- Optimal TB and CI screening

QI Implementation: QI Learning Roadmap

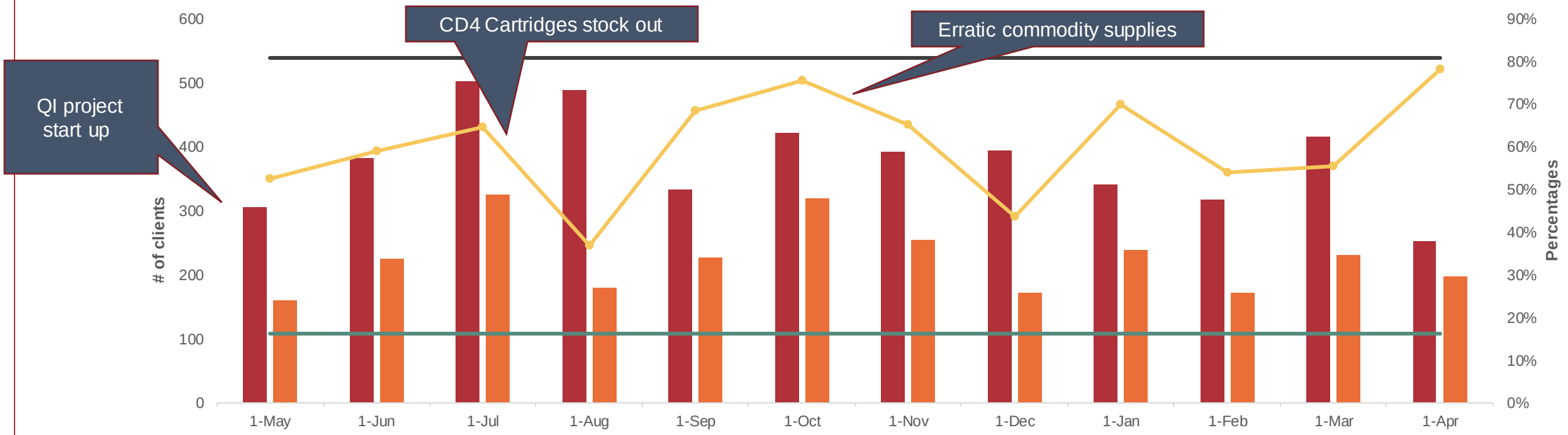


Capacity building:

- A total of 309 HCWs underwent an integrated AHD/QI 6-day training
- 28 trained as mentors from all facilities
- 58 AHD targeted QI projects active in all 22 sites

Using Quality Improvement Initiatives to Strengthen Screening for AHD

Availability of commodities impacted screening in all 22 facilities (August 2021 and early 2022)



	1-May	1-Jun	1-Jul	1-Aug	1-Sep	1-Oct	1-Nov	1-Dec	1-Jan	1-Feb	1-Mar	1-Apr
Total PLHIV	305	382	503	489	332	422	391	394	341	318	416	253
# of clients screened	160	225	325	180	227	319	255	172	238	171	230	198
Coverage	52%	59%	65%	37%	68%	76%	65%	44%	70%	54%	55%	78%
Baseline	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%	16%
Target	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%

Period

Total PLHIV # of clients screened Coverage Baseline Target

Lessons Learned

Strengthen systems to increase diagnostic and treatment capacity at sites and/or optimize hub – spoke model with SOPs/job aids to better support HCWs	• Decentralization of tests to spokes and service delivery points (rather than labs) has improved uptake in sites (POC testing) • Need to further decentralize and scale up POC CD4 • Possible to diagnose TB and crypto for the spokes • Proportion of AHD is high and yield of especially LAM is significant
Need for capacity building (trainings, systematic mentorship)	• Important to train clinicians and nurses to adequately act upon the results • Dedicated focal person for the program within the facilities has been key
Need for M&E tools	• Data collection and tracking is complex • Utilization of AHD register has made client and service tracking easy to follow within AHD clinics though labour intensive and significant gaps in service provider documenting key variables • Need to balance M&E demands with service provision. Is it time to have AHD indicators in EMR for easy monitoring of patients and AHD services?
AHD developed that is easily adaptable	• The project has developed packages that can easily be further scaled-up at national level in addition to being used to support other countries

Adaptation of quality improvement tools in AHD service delivery	• Use of quality improvement tools/approaches increased identification of all eligible patient groups for AHD screening at both hub and spokes through:
	  • Creation of AHD work improvement teams in key service delivery points
	  • Integration of AHD into existing MOH district quality improvement support team activities

Overview of Quantitative and Qualitative Project Evidence and Data

Dr. Thulani Maphosa
Public Health Research and Evaluation Director
EGPAF Malawi

Aim and Objectives

- **Aim of the evaluation:** assess the introduction of an optimized AHD package including:
  - Differentiated service delivery (DSD) hub-and-spoke model
  - Use of QI to support the scale-up of AHD patient care
- **Objectives:**
  - Determine the effect of implementing the optimized AHD package in intervention sites versus control sites
  - Qualitative (acceptability and feasibility) and costing components

Methods

Mixed methods study

Non-randomized controlled cluster study comparing intervention and control sites for outcomes evaluation (quantitative)

Qualitative component evaluating acceptability and feasibility

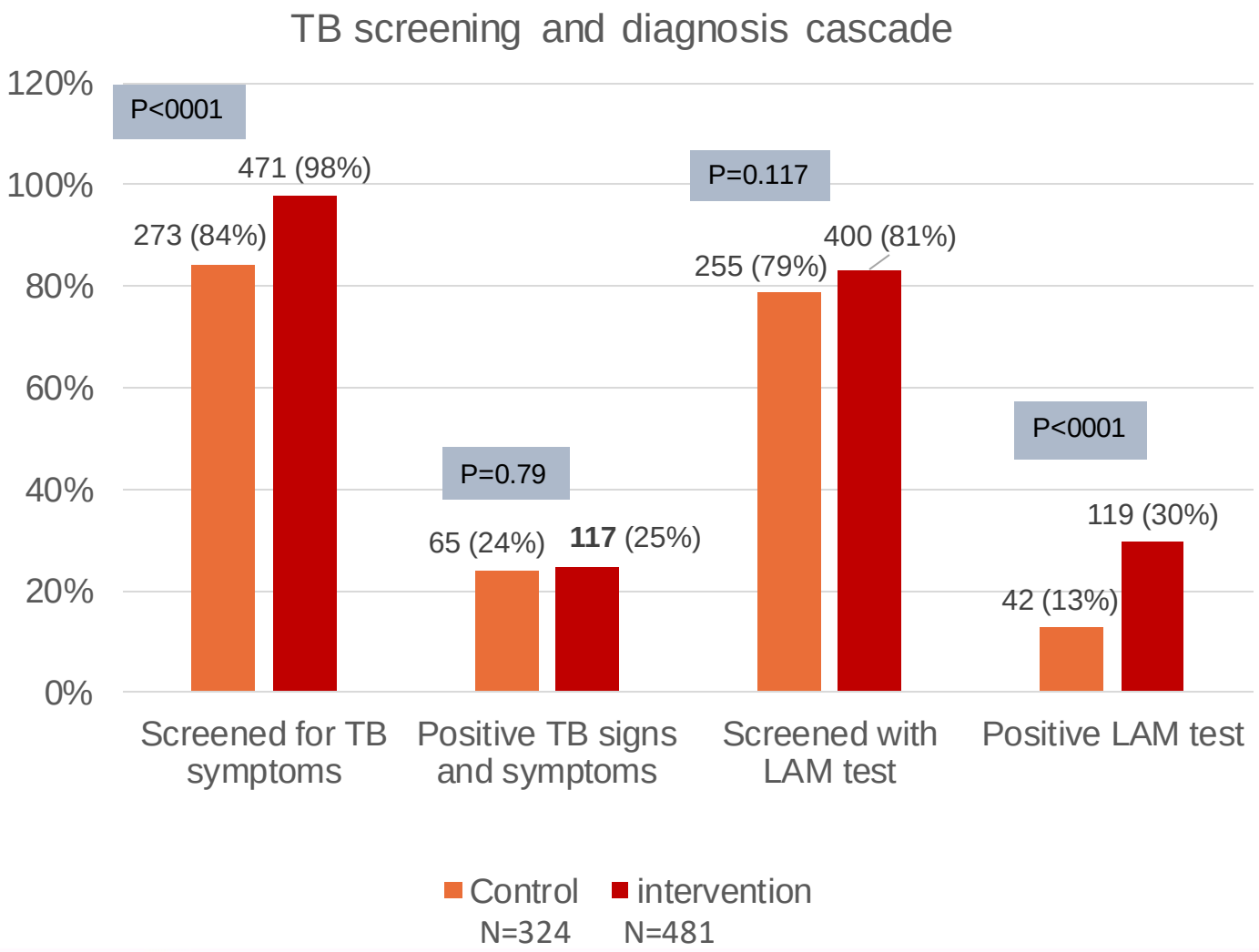
Study Sites	**Study Population:** PLHIV who are diagnosed with AHD	Individual-level data abstraction from routine clinical records of clients meeting the WHO AHD definition.
22 Intervention sites (8 hospitals and 14 Health Centers) in 3 districts 13 control sites (5 hospitals and 8 Health Centers) in 4 districts	1. Adults, adolescent & Children > 5 years with CD4 <200 cells/ml 2. WHO clinical stage 3 or 4 event. 3. All children <5 yrs old < 1yr on ART or unstable on ART	**Primary endpoint of the evaluation:** Risk of death while on AHD care and support

We present preliminary analysis of the study finding this far, **while 12 months outcome follow-up of the study participant is still ongoing.**

Study Enrollment

- Overall enrollment: 805 completed (target of 700)
- Intervention sites enrollment: 481 (60%) compared to control sites enrollment: 324 (40%)
- 50.6% were male
- Median age was 37 years (IQR [28-45])
- 33 (4.9%) were children under 5 years old
- Overall, 508 (63%) were newly diagnosed and 297 (37%) had started ART more than six months ago, among whom 77/237 (32%) had documented treatment interruption for more than six months
- The median CD4 count was 122 [73-172] cell/mm3

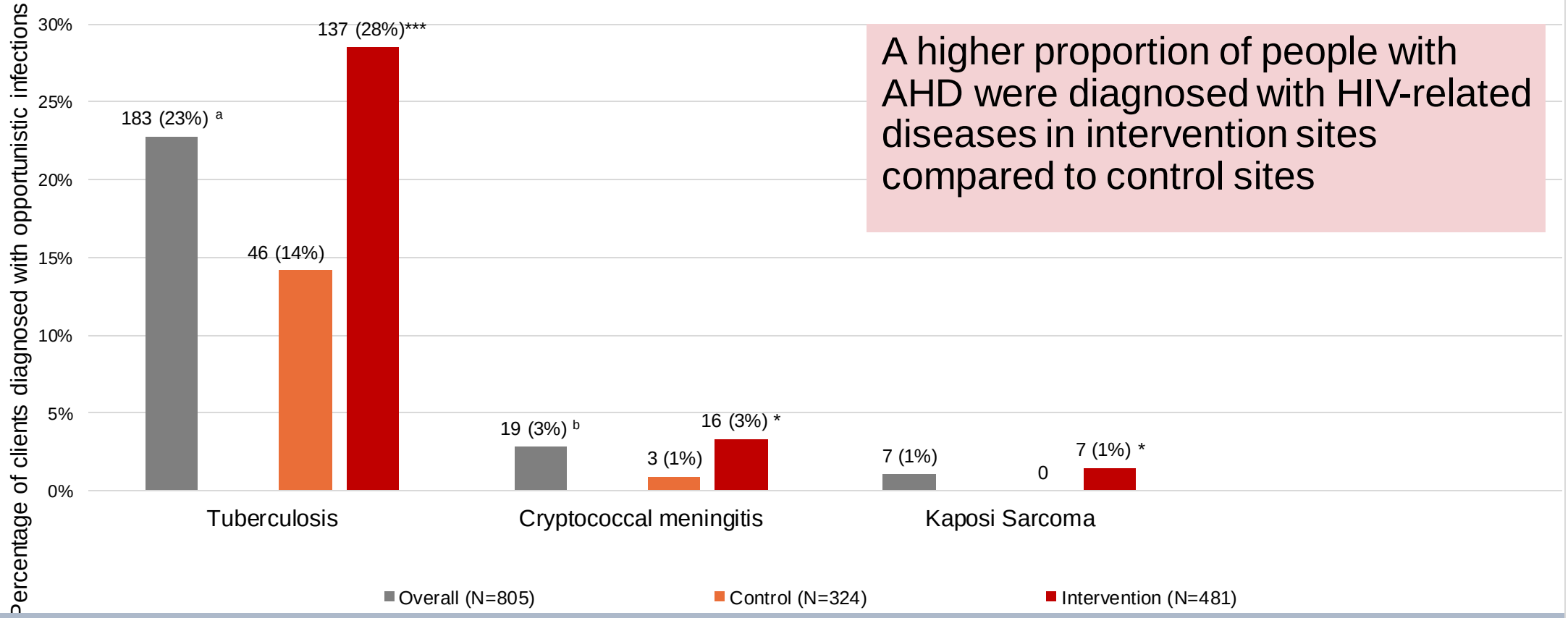
TB Screening and Diagnosis Cascade



- More clients screened for TB signs and symptoms in intervention sites (98% compared to 84%)
- Same proportion of clients screened positive on TB symptoms (24%)
- Similar proportion of clients screened with TB LAM in control and intervention (81%), however, there was a higher positivity of the LAM test during the intervention (30% compared to 13%)
- Higher uptake of clinical and biological TB screening in intervention sites

Same trend were observed for CrAg screening (serum antigen, clinical screening for signs of meningitis)

HIV-Related Diseases Diagnosed Among 805 Clients Enrolled in AHD Care



A higher proportion of people with AHD were diagnosed with HIV-related diseases in intervention sites compared to control sites

(a) TB symptoms were present in 182 (28%), positive TB-LAM **161 (85%),** positive Xpert in **14 (10%)** and chest Xray in **8 (6%)**
(b) Neurological signs were present in 9 (1%), positive serum CrAg in 26 (3%) , and positive CSF CrAg in 5 (0.6%)
*** P<0.0001 for the comparison of TB diagnosis between control and intervention
• P<0.05 for the comparison of cryptococcal meningitis diagnosis and Kaposi sarcoma diagnosis between control and intervention (P=0.032 and 0.046) respectively)

Conclusion

- We observed an increased diagnosis of TB, crypto, and Kaposi sarcoma in the intervention sites compared to the control sites (very likely in link with enhanced screening capacity)
- TB LAM positivity rate was higher in intervention sites and the cause for this is unclear
- Ensuring parallel access to TB-LAM, Xpert testing, and CXR is needed to improve the certainty of TB diagnosis
- Acceptability is good (the challenges identified through the qualitative component are used in the QI model)
- Positive health systems impact of QI-based collaborative being observed in the intervention sites while intervention costs remain high

Implementation and Evaluation of Differentiated HIV Care and Treatment for People with Advanced HIV Disease in Lesotho

Vincent Tukei

Project Description

- Aim: To strengthen and assess health service delivery for PLHIV with advanced disease who receive a package of care per the Lesotho ART guidelines.
- Record abstraction of routinely collected program data
- Evaluation sites: Two district hospitals in Leribe and Berea districts.
- Participants: HIV-positive patients (≥15 years) with advanced HIV disease at the time of entry/re-entry into HIV care and treatment.
- Evaluation period: November 2018 – December 2019.
- Six months data from time of enrolment to care
- Objectives focused on key processes and selected patient outcomes

Key Process Objectives

1. Same-day CD4 cell count testing and WHO clinical staging on day of enrollment into HIV care (≥90%).
2. Rapid initiation of ART within 7 days, if no OI requiring delay of ART (≥90%).
3. Same-day serum CrAg screening test for patients with CD4 ≤100 cells/mm^3, or clinical stage 3 or 4 (≥95%).
4. TB screening (at every clinical visit) followed by prompt initiation of TB treatment within 3 days of TB diagnosis for those co-infected with TB (95%)

Key Process Objectives

5. Prompt initiation of TPT within 3 days of a negative TB symptom screen (≥95%).
6. Same-day initiation of co-trimoxazole on day of enrolment (≥90%).
7. Documented clinical exam at every visit to evaluate for signs of OIs (≥90)
8. Intensive follow-up which included weekly phone calls for the first 4 weeks after enrolment (≥90%) and active tracking of missed appointments (≥90%).

Key Outcome Objectives

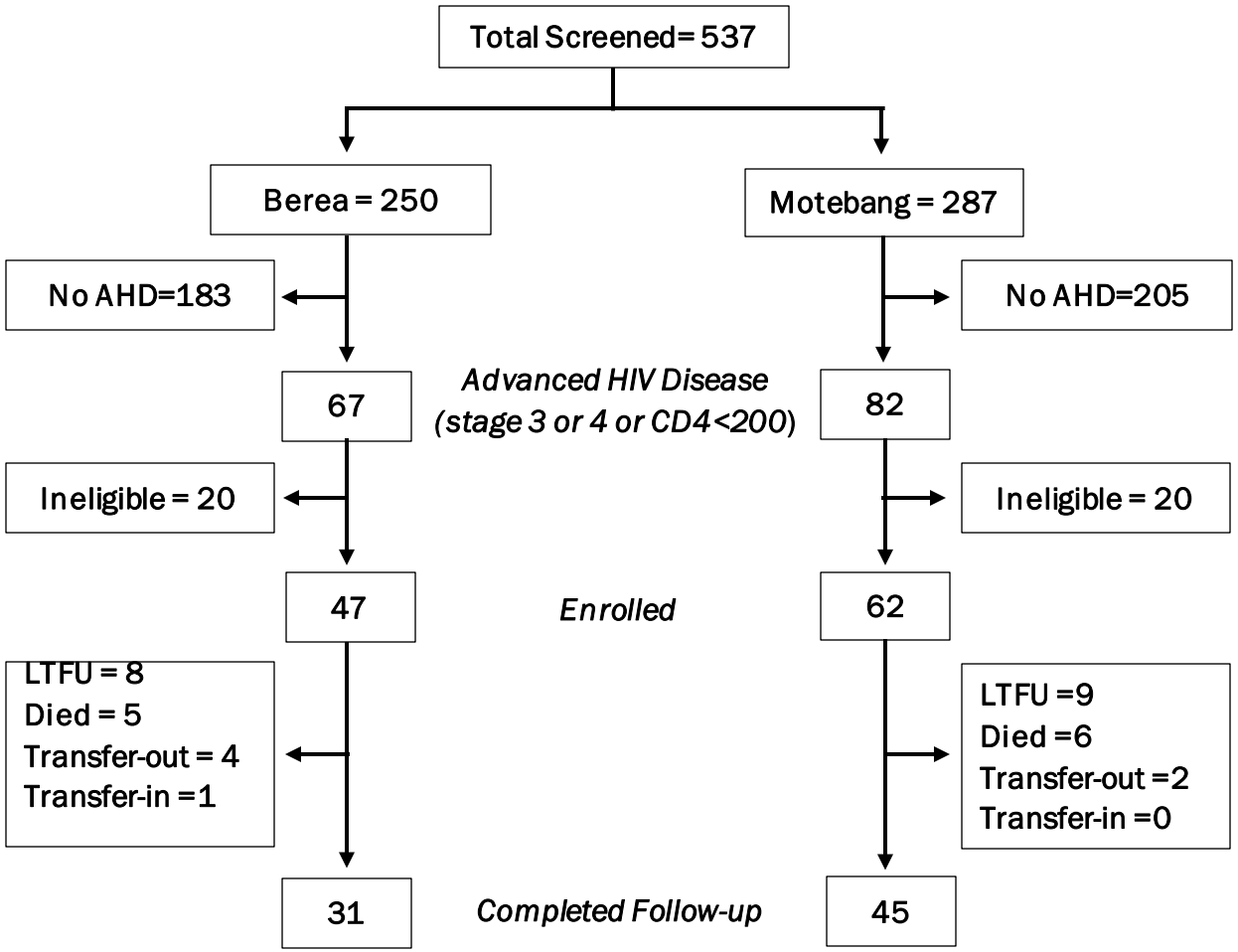
Survival	Retention	Adherence	Viral Suppression
Determine the proportion of PLHIV with advanced disease who are alive 3 and 6 months following ART initiation. (>90%).	Determine the proportion of PLHIV with advanced disease retained in care at 3 months and 6 months after initiation on treatment (≥90%).	Assess the proportion of PLHIV with advanced disease who achieve adherence rates of 95-100% based on pill counts during first 3 months and 6 months on ART (≥90%).	Determine the proportion of PLHIV with advanced disease with documented viral load (VL) results who achieved viral suppression (<1000 copies/ml) 6 months after ART initiation

Results

Characteristics of Patients Screened for Advanced HIV Disease

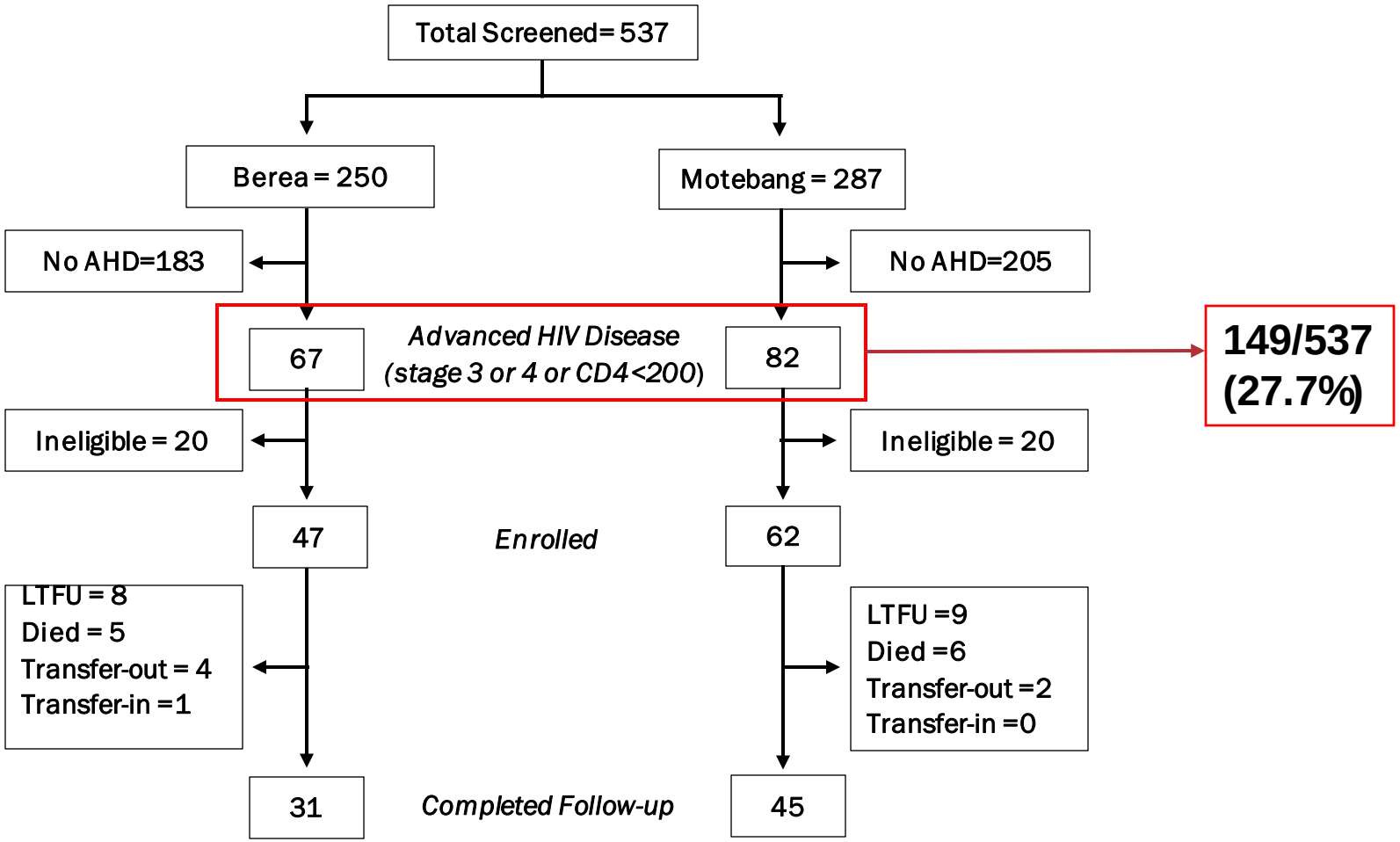
Characteristic	Hospital		Total (N=537) n (%)
	Berea (n=250) n (%)	Motebang (n=287) n (%)	
WHO Clinical Stage			
Stage 1	146 (58.6)	168 (58.5)	314 (58.6)
Stage 2	57 (22.9)	40 (13.9)	97 (18.1)
Stage 3	44 (17.7)	78 (27.2)	122 (22.8)
Stage 4	2 (0.8)	1 (0.3)	3 (0.6)
CD4 Test Done?			
No	166 (66.4)	221 (77.3)	387 (72.1)
Yes	84 (33.6)	66 (23.0)	150 (27.9)
CD4 Results (cells/mm^3)			
≥200	50 (59.5)	30 (45.5)	80 (53.3)
<200	34 (40.5)	36 (54.5)	70 (46.7)
Danger signs present?			
Yes	3 (1.2)	18 (6.3)	21 (3.9)
No	246 (98.8)	267 (93.7)	513 (96.1)

Participant screening, enrolment and follow-up



AHD = Advanced HIV Disease; LTFU = Loss to follow-up

Participant screening, enrolment and follow-up



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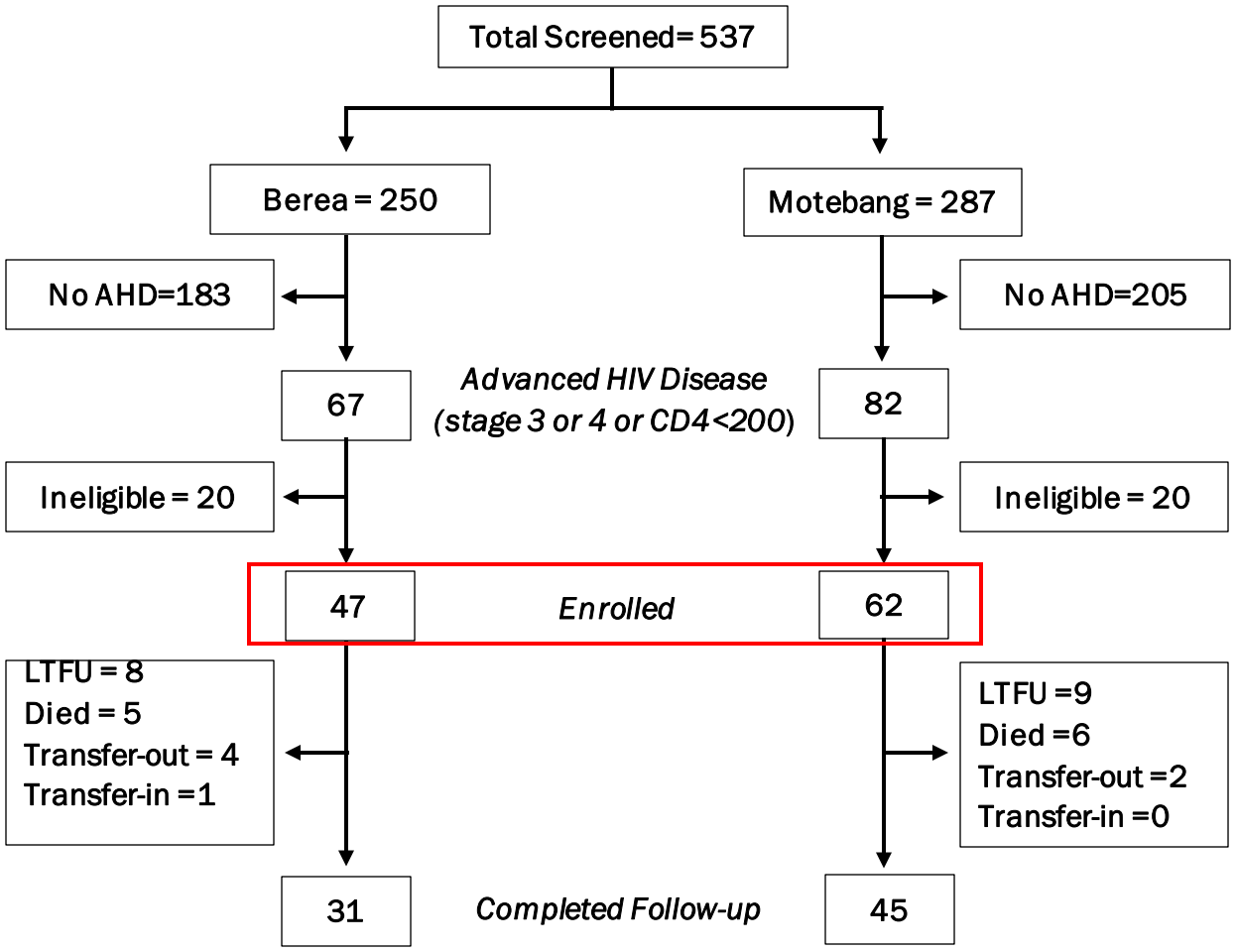
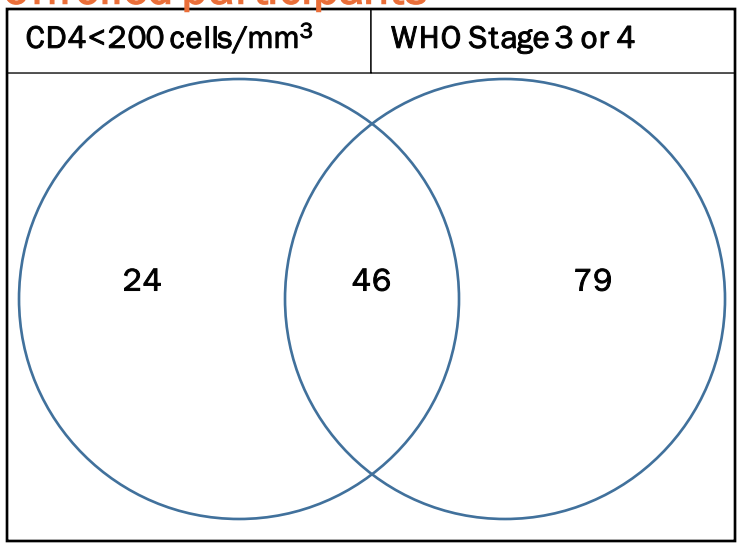


AHD = Advanced HIV Disease; LTFU = Loss to follow-up

Immunologic and clinical status of enrolled participants



Timing of service provision to patients with advanced HIV disease

Timing of service provision	Hospital		Total (n=109) N (%)
	Berea (n = 47) N (%)	Motebang (n = 62) N (%)	
ART Initiation			
Initiated before enrolment visit	18 (38.3)	4 (6.9)	22 (23.0)
Day of enrolment	20 (42.6)	35 (60.3)	55 (52.4)
2-7 days after enrolment	0	4 (6.9)	4 (3.8)
> 7 days after enrolment	9 (19.2)	15 (25.9)	24 (22.9)
Not Initiated	1	3	4
TB Screening			
On day of enrolment	47 (100.0)	62 (100.0)	109 (100.0)
After enrolment	0 (0.0)	0 (0.0)	0 (0.0)

Timing of service provision to patients with advanced HIV disease

Timing of service provision	Hospital		Total (n=109) N (%)
	Berea (n = 47) N (%)	Motebang (n = 62) N (%)	
TPT Initiation			
Before enrolment	8 (17.0)	3 (4.8)	11 (10.1)
At or within 3 days of enrolment	15 (31.9)	2 (3.2)	17 (15.6)
After 3 days of follow-up	10 (21.3)	32 (51.6)	42 (38.5)
Not initiated/on active TB treatment	14 (29.8)	25 (40.3)	39 (57.8)
GeneXpert Test (n=45)			
Before initial visit	9 (50.0)	11 (40.7)	20 (44.4)
At initial visit	7 (38.9)	14 (51.9)	21 (46.7)
During follow-up	2 (11.1)	2 (7.4)	4 (8.9)

Timing of service provision to patients with advanced HIV disease

Timing of service provision	Hospital		Total (n=109) N (%)
	Berea (n = 47) N (%)	Motebang (n = 62) N (%)	
Cotrimoxazole Prophylaxis			
Initiated before enrolment	12 (26.1)	14 (22.6)	26 (24.1)
Day of enrolment	33 (71.7)	48 (77.4)	81 (75.0)
Not initiated	1 (2.2)	0 (0.0)	1 (0.9)
Missing	1	0	1
Serum CrAg if CD4 ≤ 100cells/mm^3 or stage 3 or 4 (n=97)			
Same day (enrolment)	14 (36.8)	25 (42.4)	39 (40.2)
During follow-up	5 (13.2)	1 (1.7)	6 (6.2)
Not done	19 (50.0)	33 (55.9)	52 (53.6)

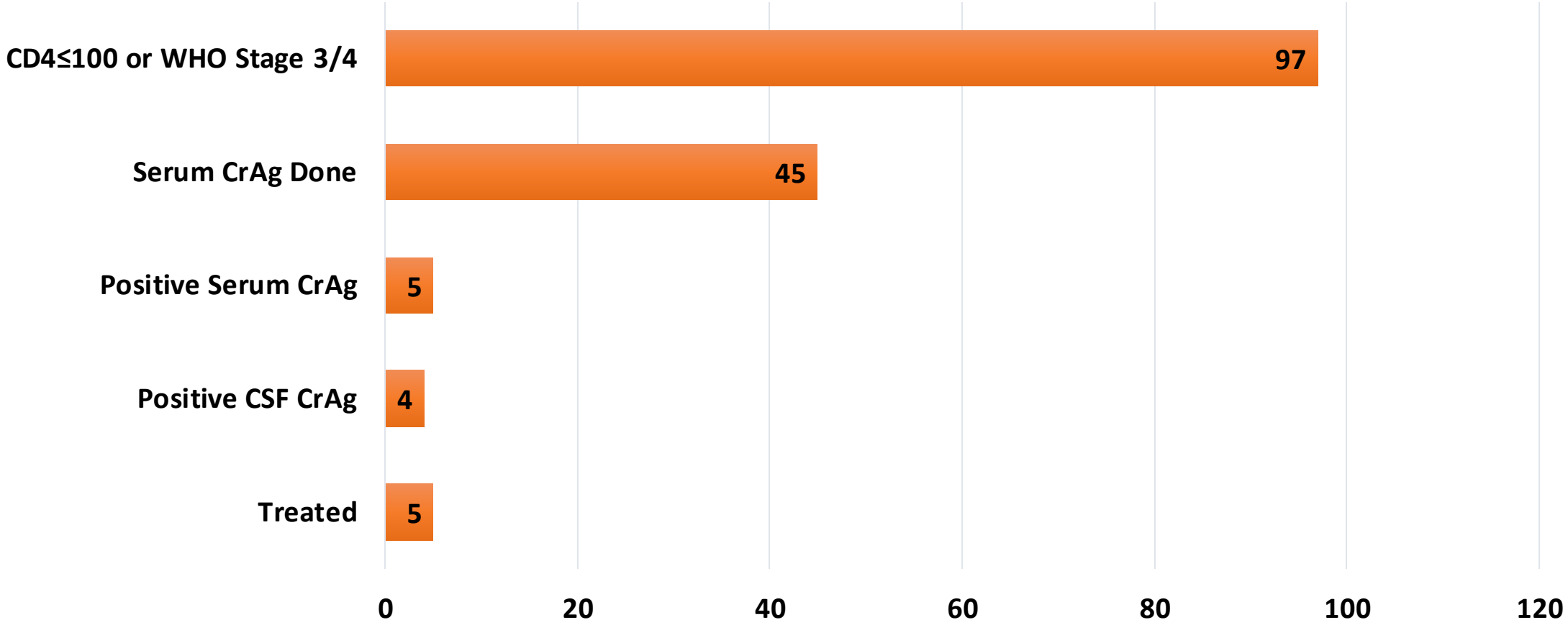
Follow-up Information for Enrolled Participants

Follow-up Visit Type	Period after enrolment	# Expected at facility visit	# Seen at facility (%)	Died before follow-up visit	# Missed Visits
#1	2 Weeks	107	92 (86%)	2	15
#2	4 Weeks	104	89 (86%)	3	13
#3-Additional	8 Weeks	101	85 (84%)	3	13
#4	12 Weeks	100	69 (69%)	1	30
#5-Additional	18 Weeks	99	62 (63%)	1	36
#6	24 Weeks	98	68 (69%)	1	29

TB Treatment Outcomes at 6 months of Follow-up

TB Treatment	Hospital		Total (n = 34) N (%)
	Berea (n = 12) N (%)	Motebang (n = 22) N (%)	
TB Treatment Outcomes			
Completed	1 (8.3)	5 (22.7)	6 (17.6)
Cured	5 (41.7)	6 (27.3)	11 (32.4)
Defaulted	0 (0.0)	1 (4.5)	1 (2.9)
Died	3 (25.0)	5 (22.7)	8 (23.5)
Still on Treatment	3 (25.0)	3 (13.6)	6 (17.6)
Transferred out	0 (0.0)	1 (4.5)	1 (2.9)
Treatment Failure	0 (0.0)	1 (4.5)	1 (2.9)

Cryptococcal Disease Screening and Treatment



Final Outcomes at End of Follow-up (n=109)

Outcomes at 6 months	Hospital		Total (n=109) N (%)
	Berea (n = 48) * N (%)	Motebang (n = 61) N (%)	
Final Outcome			
Completed follow-up	31 (64.6)	45 (73.8)	76 (69.7)
Died	5 (10.4)	6 (9.8)	11 (10.1)
Transferred Out	4 (8.3)	1 (1.6)	5 (4.6)
Lost to Follow-up	8 (16.7)	9 (14.8)	17 (15.6)
Viral suppression (n = 76)			
< 1000 copies/mm3	27 (87.1)	36 (83.7)	63 (85.1)
≥ 1000 copies/mm3	4 (12.9)	7 (16.3)	11 (14.9)
Missing			2

WHO Package of Care for Children and Adolescents with Advanced HIV Disease to STOP AIDS

Box 1. Screen, Treat, Optimize and Prevent AIDS

Screen[a]

TB
- Screen for TB using a clinical algorithm[b] followed by X-ray when indicated and if available
- Use the following diagnostic tests to confirm TB as applicable:[c]
  - Rapid molecular diagnostic (Xpert® MTB/RIF or Ultra) on (induced) sputum, stool, gastric aspirate or nasopharyngeal aspirate or other extrapulmonary samples if relevant
  - Lateral flow urine lipoarabinomannan (LF-LAM) assay[d]

Cryptococcal infection among adolescents
- Serum or plasma or blood cryptococcal antigen screening followed by lumbar puncture if positive or symptomatic

Malnutrition
- Weight-for-height
- Height-for-age
- Mid-upper arm circumference among children 2–5 years old

Treat

TB, severe pneumonia, severe bacterial infections, cryptococcal meningitis and **severe acute malnutrition** according to WHO guidelines

Optimize

Rapid antiretroviral therapy start – within seven days with optimal regimens*

Antiretroviral therapy counselling

Prevent

Bacterial infections and *Pneumocystis* pneumonia
- Co-trimoxazole prophylaxis

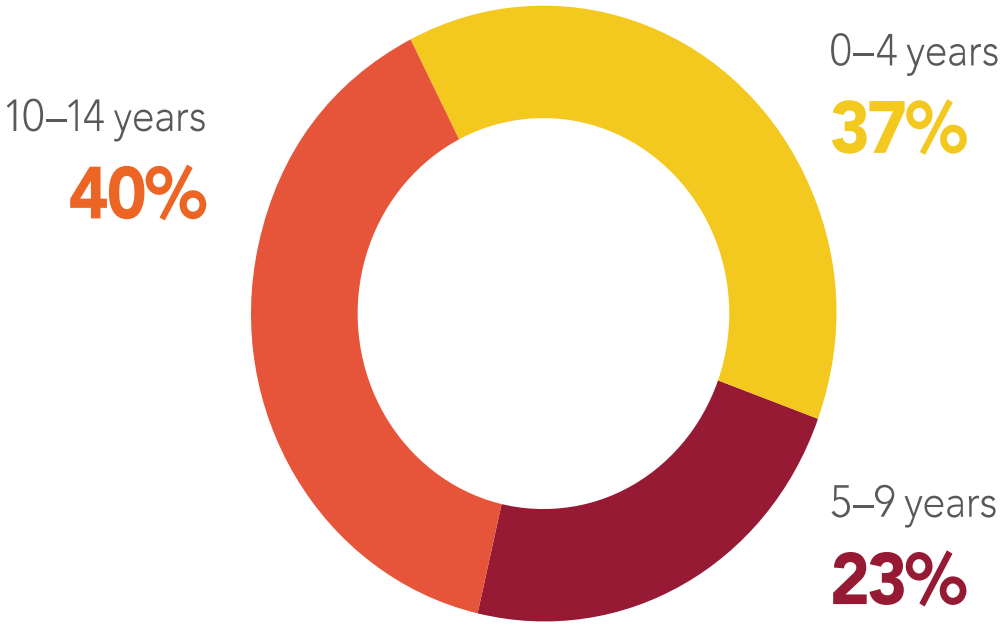
TB
- TB preventive treatment

Cryptococcal meningitis among adolescents
- Fluconazole pre-emptive therapy

Vaccinations
- Pneumococcal vaccine
- Human papillomavirus
- Measles
- BCG

* Screening refers to screening and diagnostics throughout this publication.
[b] See Fig. 3 in *Guidance for national tuberculosis programmes on the management of tuberculosis in children* (9).
[c] A negative test result does not exclude TB in children living with HIV in whom there is a strong clinical suspicion of TB.
[d] See Table 2 and the text for recommendations.
* Unless TB or cryptococcal disease is diagnosed (10).

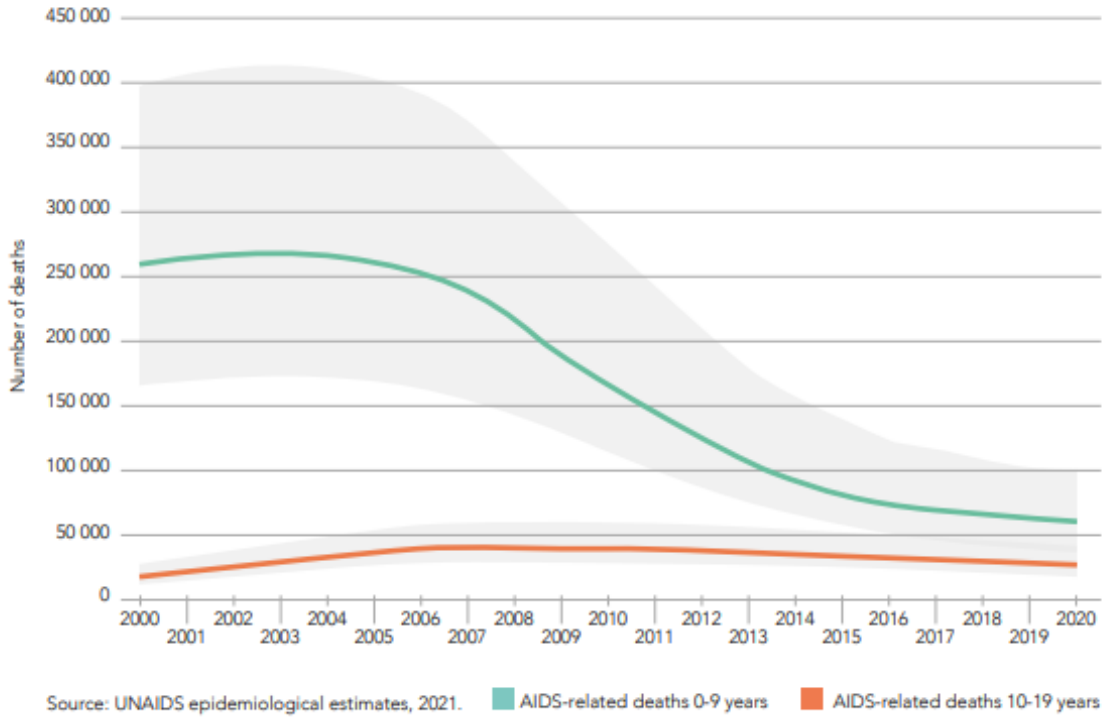
Gaps Remain: Children living with HIV Not Receiving Treatment by Age Group, 2020



Almost two thirds of children living with HIV not on treatment were aged 5 years or older.

Global Progress in Reducing AIDS-Related Deaths in Children

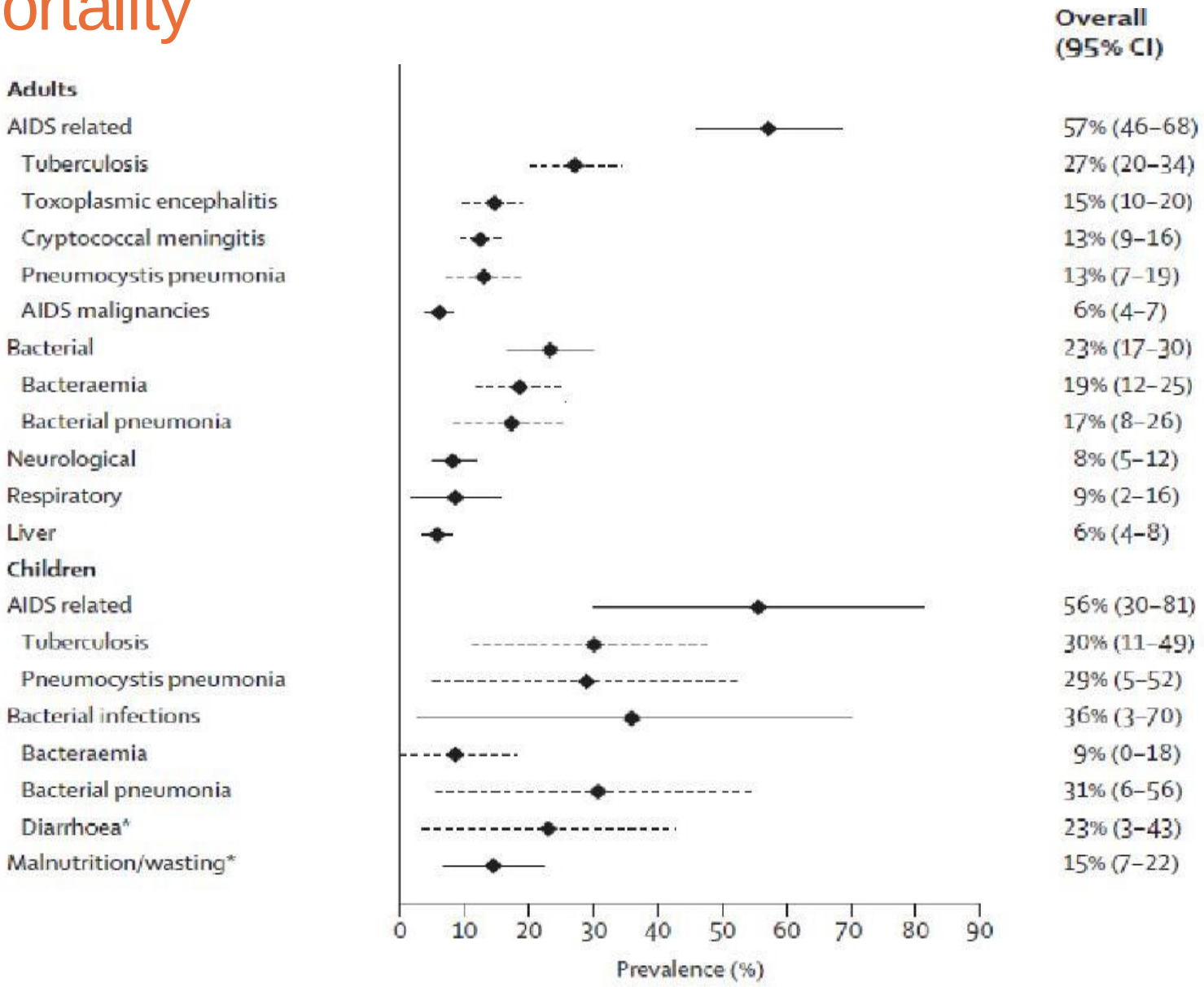
Figure 16. Children aged 0–9 years and adolescents aged 10–19 years dying from AIDS-related causes, focus countries, 2000–2020



30% of children and adolescents still present with severe immunosuppression

Tuberculosis, severe bacterial infections remain leading causes of mortality

•Ford et al, Lancet HIV 2016



Definition of advanced disease in children: further articulated in 2020 technical brief

- Children > 5 years:
- WHO stage 3 or 4 or a CD4 cell count <200
- cells/mm3
- Children < 5 years:
- Considered to have advanced HIV disease

- "Although children younger than five years are
- defined as having advanced disease at presentation,
- those who have been receiving ART > 1 year and
- who are clinically stable should not be considered to
- have advanced disease and should be eligible for
- multi-month dispensing"

Addressing advanced HIV disease: The difficult part we always forget

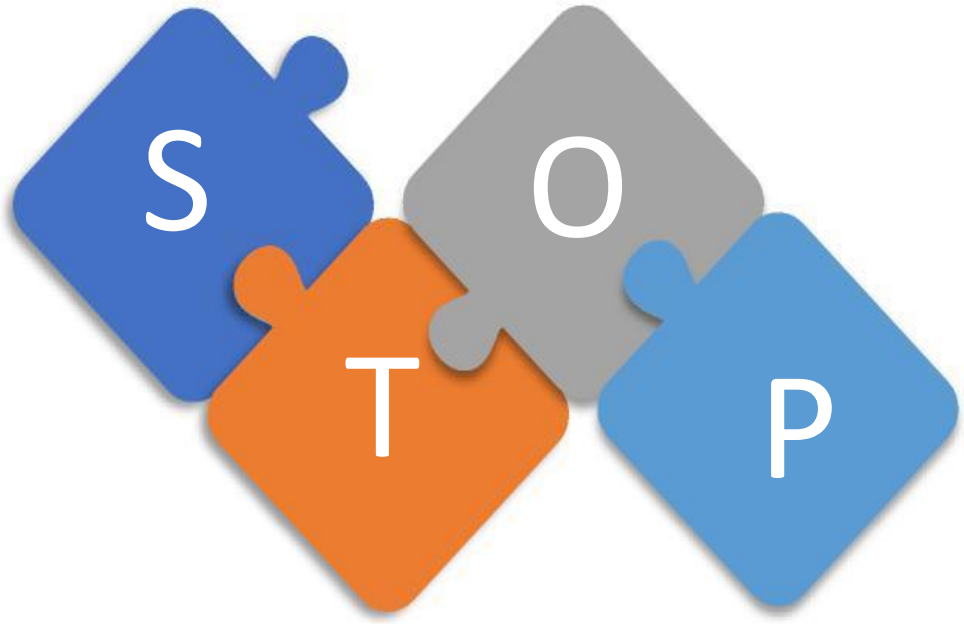
- 30% of children and adolescents still present with severe immunosuppression

•Screen

- For TB, cryptococcal disease,
- developmental delay

•Treat

- For TB, cryptococcal disease, severe pneumonia



•Optimize

- Early ART initiation within 7 days, optimal regimen (LPV/R or DTG), counselling

•Prevent

- TB, PJP, cryptococcus, pneumonia and catch-up immunizations

We need to **Stop AIDS!**

Sources: WHO (2020), Package of CARE for Children and Adolescents with Advanced HIV Disease (AHD): "STOP-AIDS"

STOP AIDS: Key Messages for Paed AHD	
Screen	Critical and supportive diagnostics exist to support children with advanced HIV disease LF-LAM (using urine) is a key diagnostic to identify TB in children Molecular TB testing can now use non-sputum specimens for diagnosis Rapid and simple cryptococcal antigen testing is now available for diagnosis in adolescents
Treat	Treatment of TB requires ARVs dose adjustment Treatment of severe bacterial infections (Streptococcus, Staphylococcus, Salmonella) and severe pneumonia (including PCP for infants) should follow WHO guidelines Malnutrition, main driver of mortality; start ART as soon as possible after stabilization of metabolic complications and sepsis
Optimize	Enable rapid ART initiation with appropriate counselling and support Co-morbidities might required stabilization before ART is started ART initiation to happen during admission to reduce LTFU Ensure linkage to the facility providing routine care after discharge
Prevent	CTX for CLHIV remains a core intervention despite scale up of ART Effective and available TPT in use; suitable to all children living with HIV, Fluconazole for adolescents with CrAg positive Vaccinations: catch up pneumococcal ; vaccine but also remember BCG, measles, HPV

STOP AIDS: Implementation considerations for Paeds AHD - 1

National	• Critical to harmonize and align various recommendations adopted by the country
	• Registration and procurement of commodities essential step for implementation
	  • Leveraging on the fair pricing initiatives to avail commodities
	  • Early market access initiatives – e.g. for Visitect CD4 Testing
	• Policies and protocols to enable catch up vaccinations outside of EPI
	• Translating policies and guidelines into practice

Facility	• Hub-and-spoke model central to current implementation • Important to enable and support task-shifting for some components of the AHD package • Ensuring right mix of commodities, screening tools and child-friendly environment at the facility level • Protocols for bi-directional referrals • Structured patient flow, service Navigation between OPD and In-Patient departments and structured Appointments management
Commodities (Lab, Pharms & Non-Pharms)	• Ensuring SOPs for commodities' management are in place as well as training, capacity building activities • Lab – Staffing, Structured sample collection & Networking e.g. CD4 Testing, Gene Xpert, POC tests (Visitect, TB LAM etc); Explore capacity for AMR surveillance. • Addressing Pharmaceutical and Non- Pharmaceutical needs

STOP AIDS: Implementation considerations for Paeds AHD - 2

Health care provider	• Training, capacity building and supported supervision
	  • inclusion of AHD package in HIV training curriculums
	  • Advanced trainings for district MOH mentorship teams
	• Multi-disciplinary Team approach to management of patients with AHD

Patient Monitoring	• Drug toxicity monitoring & reporting • Ensuring development of tools to track clinical implementation of the AHD package • Longitudinal Follow-up/Case management approach • Documentation of interval and final clinical outcomes (6, 12, 24, 36 mons etc) • Routine Mortality audits
Program Monitoring & Evaluation	• Developing AHD M&E Frameworks • Adopt disaggregated data for pediatric cohorts • Developing and adopting M&E Tools (Patient chart tools, Register and summary reports) • Preferably integrated into national EMRs/EHRs • Routine reporting to MOH
Patient Centered Approach	• Caregiver literacy & involvement in Care • involvement of the adolescents in their care • Flexi-hours, Child/Adolescent-friendly clinics/corners • Community based support/interventions to compliment Clinical interventions (REMSTART Study showed better outcomes with home/community visits)

Q&A

Take Away Messages

Elizabeth Glaser Pediatric AIDS Foundation

Fighting for an AIDS-free generation