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A SYNOPSIS OF DIFFERENTIATED CARE FOR ART PROGRAM MANAGERS

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FOREWORD

In 2001, before the global scale up of antiretroviral treatment (ART) for HIV infection, the FHI Foundation provided forward-looking funding for the provision of innovative ART programs in public sector settings in Ghana, Kenya and Rwanda. Following the successful implementation of the pilot phases of these ART programs, FHI 360, with funding from USAID, supported Ministries of Health in several African countries and elsewhere to initiate and expand ART programs. Countries included Ghana, Kenya, Rwanda, Tanzania, Zambia, Nigeria, Ethiopia, Eritrea, Mozambique, Malawi, Vietnam and Papua New Guinea. This rapid expansion has led to the delivery of ART services at the tertiary, secondary and primary levels of health care systems, and also included community-based programs.

Guidelines for the initiation of ART based on CD4 cell counts evolved from <200 cells/microliter up to 350 and later 500. These changes increased the number of HIV-infected clients eligible for ART. The recent 2015 World Health Organization consolidated guidelines on the use of antiretroviral drugs for treating HIV infection recommends initiation of therapy regardless of CD4 will further increase the expected client load. The treat all approach is central to reaching the UNAIDS 90-90-90 targets by 2020.

It will be important to increase efficiency at the facility level, as it is unlikely that human resources for health will increase rapidly to accommodate the increasing client load. The differentiated care model offers the opportunity to optimize the existing resources to improve quality of care, reduce patient waiting time and promote efficiency at the sites. This document will contribute to implementation of more efficient differentiated care models in FHI 360's global HIV care and treatment programs.

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IMPLEMENTING DIFFERENTIATED CARE MODELS IN AN HIV CARE AND TREATMENT PROGRAM SETTING

PEPFAR 3.0 and its associated agenda of impact, efficiency, sustainability, partnership and human rights has made it imperative to devise technical approaches that deliver desirable outcomes in a sustained and efficient manner particularly in resource constrained settings. The World Health Organization 2016 HIV consolidated guidelines further affirms that differentiated models of care are needed to address the diversity o f care and targeted interventions to different patients in the care continuum.

These desirable outcomes, which include enhanced linkages, retention and viral load suppression, require the reconfiguration of client flow systems, differential services for specific client categories including clients most in need of specific services as well as targeted interventions. FHI 360 ART programs have accumulated experience in the delivery of differentiated care to different categories of clients and or communities. The essence of differentiated care is to ensure improved efficiency within ART programs while different categories of clients and communities continue to receive care that is appropriate for them. The differentiated approaches presented here derive from national guidelines, WHO/UNAIDS guidelines, PEPFAR and Global Fund documents as well as field experience. The approaches range from community mobilization to sustained strategies for long term retention in care.

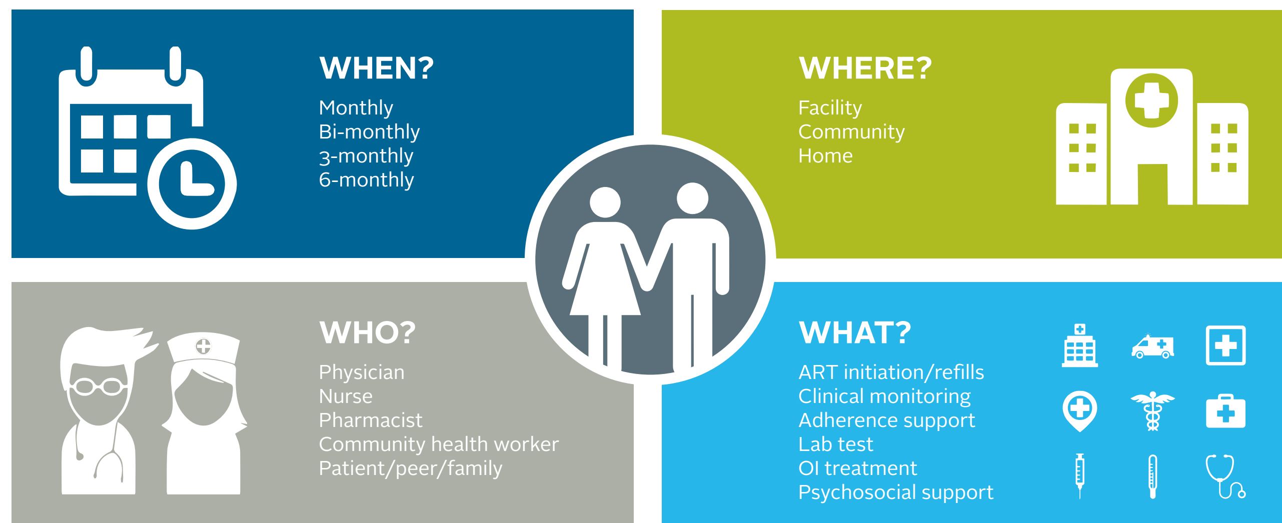
- Differentiated care refers to service-delivery models that are adapted to address the specific requirements of the continuum of prevention, care and treatment for a subgroup of clients.

This synopsis is to serve as a quick reference which will help country programs situate their approaches within an overall well-defined framework.

BUILDING BLOCKS FOR DIFFERENTIATED CARE

Differentiating care requires service delivery teams and program managers to think of four building blocks all centered around the client. These include when, where, who and what services are being offered. See Figure 1.

FIGURE 1: BUILDING BLOCKS FOR DIFFERENTIATED CARE



Adapted from WHO 2016

The time block consists of timing of service delivery on the one hand and efficient use of contact time with the client on the other hand. Services can be delivered at health facilities, in communities and client homes. Task shifting and meaningful involvement of persons living with HIV are the considerations in the 'who' block – who delivers which service? Different services in the care continuum are needed by distinct categories of clients. These services are clearly spelt out upfront. At the center of differentiated care is the client. The client can be categorized using clinical and population characteristics or contextual considerations.

PATIENT CATEGORIES AND DEFINITIONS

The pool of clients in care needs to be categorized into different groups in order to introduce care that is targeted. Specific clinical ART-related characteristics should be used to categorize patients. In addition, some special populations e.g. adolescents and children, require specific considerations and tailoring of the care that they receive. The figure below shows categorization of clients using ART-related characteristics. Each of these categories, as well as considerations for adolescents and children, are described in more detail below. A summary of the approaches and specific implementation considerations for each level of care can be found in Annex 1.

FIGURE 2: CATEGORIES OF PATIENTS DEFINED USING CLINICAL CHARACTERISTICS

TRANSITION POOL	PRE-ART	NEW ON ART	STABLE	NOT STABLE
In countries implementing 'test and treat', persons who specifically require (client or provider determined) preparation before commencement of ART	By CD4 cut-off or WHO clinical staging (in countries or sub-national units not implementing 'test and treat')	Only just initiating ART and are within six months of commencing ART	Duration on ART (greater than 12 months), incidence of OI (no OI in preceding 6 months), self-reported medication adherence (>90%), adherence to clinic appointments (>90%), response to ART – CD4 criteria and or viral load (suppressed)	Clients with treatment failure, poor adherence, OIs and adverse effects. In addition, those at risk of being lost to follow up or returning after being lost to follow up also fall into this category

Transition pool
Pre-ART
New on ART
Stable
Not stable

TRANSITION POOL ('TEST AND TREAT' COUNTRIES)

If the guidelines recommend a 'test and start' approach to treatment, the transition pool would consist of persons who specifically require (client or provider determined) some preparation before commencement of ART. This group of clients can benefit from differentiated care approaches in the facility and community. The aim of care for this group is rapid transition to ART. Interventions will include counseling support to accept diagnosis and need for early start of ART, identification and development of strategies to address barriers to commencement of ART. The community and/or clinic teams care teams can arrange to have frequent contact (days to a few weeks) with clients in this category to prepare them for initiation.

PRE-ART (COUNTRIES NOT MOVING TO 'TEST AND TREAT')

In line with the national guidelines in countries not yet moving to 'test and treat', CD4 cut-off can be used to define the pre-ART pool.

At the facility, the scheduling of visits for pre-ART clients should be different from other groups. Pre-ART clients should have their laboratory monitoring visits as per national guidelines. Specific lab appointments can be given for CD4 sample collection and assay to be out of step from appointments for other groups to manage client flow and prevent over crowding. Lab appointments should be given to ensure that the results are ready before the next clinical review visit. All laboratory, clinic and refill appointments should be synchronized and must be part of an integrated appointment system.

A specific clinic day to see clients in the pre-ART pool can help provide focused attention for this group. In addition, the client flow can also be altered in order to shorten their contact time with the hospital. Emphasis should be placed on contact with the community care team and support groups. To achieve this, facility data needs to be reviewed including current clinic hours, number of staff (to assess capacity to cope with expanded clinics), and current client flows with an identification of critical bottlenecks.

Community care teams can provide CD4 estimation ahead of clinic visits using point-of-care machines, community care teams can also provide a level of clinical review in the interval between facility visits. With the licensing of GeneXpert systems for HIV-1 Viral Load and proliferation of Point Of Care (POC) viral load equipment, community care teams can also provide specific roles in community viral load.

NEW ON ART

For clients who are within six months of commencing ART, the approaches will differ slightly depending on the location of ART initiation. The key features will be more frequent appointments/contact with the caregivers in the first three months on ART, in line with national guidelines.

At the facility, the client should be seen for clinical review at 2 weeks after initiation, 4 weeks after initiation and 4-weekly for the next 3-6 months or as specified by the national guidelines. Each visit should include adherence counseling. The client flow at the facility should be adjusted for this group to make the frequent visits as non-burdensome as possible. Strategies would include integrating the HIV clinic into general outpatient care. This would increase the number of clinicians that are available to see Persons Living with HIV (PLHIV), reduce the need for

multiple separate clinic visits for PLHIV, and normalize HIV treatment in hospital settings. Family centered care is an option that can be further developed to provide care parents and children.

Early linkage to support groups and the community care teams should be a priority for clients new on ART. Case managers, generally lay providers who are mostly HIV positive, are responsible for a number of HIV positive clients providing adherence counseling, follow up services, tracking and linkage to appropriate services as needed. Case managers depending on the context may be known as adherence support workers, expert clients etc. Within the community, case managers assigned to clients should initiate early contact ensuring a phone call to the client within 24 hours of initiation and a home visit within the first 5 days of initiation. Weekly adherence and pharmaco-vigilance reviews by community teams should take place in the first 2 weeks before the first hospital visit. This is particularly important when ART is initiated in the community setting. A calendar of scheduled contact with the client by different cadres of providers can be drawn for the first four weeks. m-Health interventions such as SMS reminders, interactive SMS, and help hotlines can also be deployed to support this group of clients.

STABLE ON ART

Criteria needs to be set to determine who qualifies to be in this group. The eligibility criteria can be made of elements such as – duration on ART (greater than 12 months), incidence of OI (no OI in preceding 6 months), self-reported medication adherence (>90%), adherence to clinic appointments (>90%), response to ART – CD4 and or Viral Load (VL) suppression, etc. Once this group is defined, their clinic appointments can be spaced out, drug refills can be arranged for groups with pick-up by appointed representatives, laboratory monitoring can be arranged as drop-in visits, and client flow on clinic days can be adjusted accordingly. Members of The Chronic Care Clubs/Community Adherence Groups/Community ART group can take turns to collect drug refills on behalf of other members. Each member must, however, visit the health facility at least once in 6 months. Patients in these groups must be stable to benefit from this approach.

Clinic visits for stable clients can be spaced out to 4 - 6 monthly intervals. Drug refill visits can be scheduled to come midway between clinic visits and to coincide with clinic visits - i.e. if a 4-monthly interval is adopted, drug refill can be arranged at 2-monthly intervals. During drug refill visits, the clients should not be required to see a clinician unless requested by the client. The clinic visit can be integrated into regular General Out Patient Clinics. Laboratory monitoring can rely more on annual viral load monitoring. It is essential to set up a referral system to identify and link stable clients to the community care team and chronic care clubs.

In the community, the reduced frequency of visits by stable patients in the facilities in spacing out clinic appointments can be enhanced by support from the community care team. Reviews in the interval between clinic appointments would be provided by the community care team with symptom screening, adherence reinforcement, request for viral load assays, viral load literacy, being some of the services that can be delivered. Drug refill visits could also be eased out by membership of a community-based chronic care club/community adherence group. These groups will have community-based meetings and appoint a representative who picks up drugs for the group on schedule . Variants include drug refills by community care teams or community pharmacists (also known as Accredited Drug Dispensing Outlets in some settings).

UNSTABLE PATIENTS ON ART

Patients who are categorized as unstable on ART require more than the routine monitoring offered to a typical patient. Patients in this category include those with treatment failure, poor adherence, opportunistic infections and adverse effects. In addition, those at risk of being lost to follow or returning after being lost to follow up will require intensive adherence counseling. Additional monitoring will include clinical and lab review and investigations. Clinical visits would be more frequent, depending on the condition, until a time when the identified issues are fully resolved or the patient is no more at risk. For example, management of mild or moderate adverse effects will require a few more clinical visits before complete resolution.

Treatment failure is associated with poor adherence. The patients are usually not virally suppressed. For this group, once identified using viral load estimations, clinic appointments will need to be scheduled in the immediate period to be frequent and focusing mainly on adherence support and management of opportunistic infections if any.

At the facility, once a client is found to have viral load above the guidelines stipulated cut-off (usually >1000 copies/ml for plasma assays) or using immunological or clinical criteria, adherence reinforcement sessions are scheduled monthly for 3 months. Drug refill and clinical review are also done monthly in the 3 months. A reassessment of the viral load after this period is done. A lab appointment should therefore be given at the last adherence reinforcement session. A switch committee, responsible for changing regimen in cases of treatment failure, where available (role preferably played by drug and therapeutic committees or equivalent), should meet ahead of the next clinical review appointment of the client. This will ensure a reduced waiting time for the client. If the client was identified and admitted as an in-patient, the adherence sessions and switch decision can be made during in-patient care depending on duration and status of the client.

Community level support should include adherence support, viral load literacy, viral load testing, and linkage to the treatment and care continuum. During the period of adherence reinforcement, bi-weekly contact should be made by the community care team. This level of support may be important as patients at risk of being lost to follow up or clients who missed appointments but have been tracked and brought back into care require closer monitoring.

Viral load testing can be simplified by triaging patients during clinic visits. Through a color coding system, patients' due for viral load enumeration are readily identified based on the color of the sticker on their folder. The lab staff can collect the samples at the outpatient/clinic to further simplify the patient flow.

ADOLESCENTS

This group comprises of young (10-15 years) and old (15-19 years) adolescents with specific characteristics and needs including the need for adolescent-friendly services. A survey to identify their particular needs in each locale should serve as the starting point. Set questions with precoded responses or open ended type questions can be used. Information from this survey should then be used to set up adolescent-friendly services in either the facility or community and should include the adolescents in its design.

At the facility, making clinics adolescent friendly entails an initial assessment of clinic characteristics, what may serve as barriers to adolescent care and what resources and adjustments are needed. Specific steps may include – training

of clinic staff in adolescent care, differentiating the physical location of the clinic from adult clinics, scheduling a different clinic day or time for adolescent clinics, allowing unscheduled visits, ensuring privacy, engaging peers in clinic activities, etc. Services should be integrated, and a visit to the clinic should meet most clinical needs of the adolescent. A warm reception and short waiting time are essential. For the older adolescent, special considerations should be given to transition to adult care - including periodic familiarization visits to the adult ART clinic. It is important to set up an appointment system and to ensure linkage to community care teams and integrated adolescent spaces. Regular meetings of peer educators in the community and facilities can also help to raise awareness for available services and improve coordination. A community resource directory placed at the adolescent friendly clinic or prepared as pamphlets can also help.

At the community level or in the clinic, integrated adolescent spaces can be established. The aim is to have a space where adolescents of all ages feel free to engage, and interact, ensuring psychosocial wellbeing, retention, adherence, sexual and reproductive health, and prepares the adolescent for eventual transition to adult HIV services. Peer-led support groups should be setup to cater for different adolescent age groups and categories. Integrated adolescent spaces will need to regularly reappraise supported activities to keep them relevant to evolving client needs. Managers of the integrated adolescent spaces should engage with hospitals in the community and ensure proper referral and linkages.

CHILDREN

For this group facility approaches should include family-centered appointment scheduling that ties parents' appointments with their children's appointment. Clinical review, lab monitoring, and drug refills should be made to align. The clinic space should also see 'the family as one visitor' and not make the family attend separate clinics even when appointments are given for the same day. Disclosure plans for older children should be put in place.

In the community, integrated MNCH outreaches in identified hotspot communities should integrate HIV testing with immunization, deworming campaigns, mosquito nets distribution, etc. Community care teams should support adherence to clinic appointments including the week-6 visit for HIV Exposed Infants (HEI) Community care teams can play an active role in getting Early Infant Diagnosis (EID) results to families by serving as a link between PCR labs, facilities and clients. Results can be delivered from the PCR lab to a care team mapped to a community. It is essential to equip community care teams for disclosure support, and information on pediatric and adolescent ART.

CONCLUSION

Differentiated care holds the promise of improving efficiency of service delivery while increasing client satisfaction. Engagement of stakeholders including frontline health workers in making required system changes will be critical to success. The context also needs to be carefully appraised.

CASE STUDY 1: SUPPORTING NEW CLIENTS ON ART IN A DIFFERENTIATED CARE SETTING IN NIGERIA

In Ikot Ekpene Local Government Area (LGA) of Akwa Ibom State, Nigeria, a robust community ART program has been implemented since June 2015 linked to facility-based ART clinics. The LGA in 2015 was estimated to have a population size of 193,201 and an estimated 14,324 PLHIV. Clients identified on the community ART program often have better health indices than persons identified in the facility. In addition, clients are more likely to experience side effects in the first few weeks of commencement of ART and are likely to discontinue ART during this period. This peculiarity and additional socio-cultural perspectives mean that clients are more likely to be lost from the program immediately after enrolment into care - which happens on the same day as diagnosis. This is further compounded when patients have to be transitioned into the health facility. In order to mitigate these effects and provide support that will ensure that clients are retained on ART within the first month of ART commencement, a 'support calendar' was introduced. This schedule ensures that there is supportive contact between the ART program and the client at least twice every week in the first month on ART. The supportive contact is provided by a multidisciplinary team including case managers (motivated ART-experienced PLHIV with basic training), pharmacists and clinicians. The contact comprises of phone calls, home visits, a clinic visit, and short messaging system (SMS).

Before implementation of this approach, retention after the first month on ART was as poor as 32%. Providing close support in the first month on ART improved this figure to 97% after 3 months of implementation.

CONTACT SCHEDULE FOR NEW CLIENTS IN THE FIRST MONTH ON ART IN IKOT EKPENE LGA, AKWA IBOM STATE

ONGOING ADHERENCE SUPPORT SCHEDULE FOR ALL NEW ART AND PMTCT CLIENTS - MONTH 1							
	1	2	3	4	5	6	7
Week 1	Treatment initiation - receives appointment for day 14	Phone call/ home visit by expert clients		Phone call by pharmacist to asses for ADR			Phone call/ home visit by expert clients
	8	9	10	11	12	13	14
Week 2	SMS messaging for adherence reinforcement			Phone call/ home visit by expert clients		Day 14 appointment reminder by expert client	Follow up clinic visit
	15	16	17	18	19	20	21
Week 3	SMS messaging for adherence reinforcement					Phone call/ home visit by expert clients	
	22	23	24	25	26	27	28
Week 4	SMS messaging for adherence reinforcement						Month 2 appointment reminder by Expert clients

CASE STUDY 2: A CASE STUDY FOR SIX MONTHS' PRESCRIPTION FOR STABLE PATIENTS ON ART IN MOZAMBIQUE

The Moatize Health Center is located in Tete Province in Mozambique. Moatize has a population size of 52.205 inhabitants. Moatize health facility (HF) has been providing ART since May 2007, with more than 6.000 patients enrolled in ART.

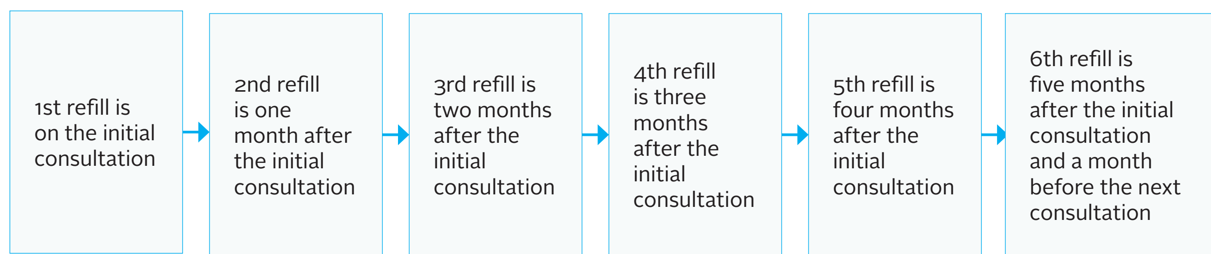
According to Mozambican HIV care and treatment guidelines, a stable patient on ART has clinical consultations twice a year. However, drug refill for ARV is monthly.

During the initial phases of ART provision, the process for drug refill for stable patients was time consuming because they had to see clinicians to access the prescription and then go to pharmacy to collect the drugs.

In 2013, when patients on ART started to rapidly increase, the health facility implemented the national policy from the Ministry of Health called "rapid flow" for stable patients on ART. The concept for rapid flow was that every stable patient on ART receive a 6 month refills prescription. They go directly to the pharmacy to collect ARVs without seeing the clinician.

The eligibility criteria for rapid flow include being on first line ART for at least six months, age at least 15 years, CD4 over 200 or viral load less than 1000copies/ml, no active opportunistic infection and patient willingness.

In the clinical consultation, a stable patient receives a prescription for 6 refills and the first refill is on that consultation day for 30 days and from then they have to return to the health facility pharmacy every month to collect the ARV's until they finish all the refills in the prescription, and that is the time for the next clinical consultation and they get another prescription for 6 refills.



The Moatize Health Center has about 2000 patients on rapid flow, constituting about a third of patients on ART. This approach has reduced patient waiting time and client load. Revision of the existing guidelines will allow clients to receive three-month drug supply instead of monthly.

CASE STUDY 3: DIFFERENTIATED APPROACH FOR PATIENTS IN NEED OF VIRAL LOAD UNDER THE APHIA PLUS RIFT VALLEY PROGRAM, KENYA.

Molo Sub-county Hospital has been providing ART since 2005 with support from PEPFAR through the United States Agency for International Development. It has 1551 currently on treatment (June 2016). Following the release of the Kenyan ART rapid advice in June 2014 that recommended use of viral load for monitoring of clients on ART, Molo sub-county hospital continued to experience low viral load uptake. It was observed that it took one and half hours to see the clinician and another two hours for a blood sample to be taken at the laboratory. This led to long waiting times and many patients leaving the hospital without viral load testing.

Using a color coding (white sticker) to identify all patients eligible for viral load and a red sticker for repeat viral load due to suspected treatment failure, a triage nurse rapidly identified eligible patients and could easily categorize clients for differentiated client flow. Sample (DBS) of the patient were taken at the outpatient before seeing the clinician;

Triaging for viral load and the color coding to identify patients in need of viral load was initiated in September 2015. Viral load uptake prior to this had been 151 samples for July-Dec'14 and 187 samples for the Jan-June'15 period. Following the initiation of the differentiated model for patients in need of viral load, the uptake increased to 481 samples in the July-Dec' 15 period and 1608 samples including repeats in Jan-June '16.

A similar approach is being implemented in 59 of the 138 ART sites supported by APHIA Plus Rift Valley.

Picture below shows patient categorization in Mau Narok Health Centre in Narok.

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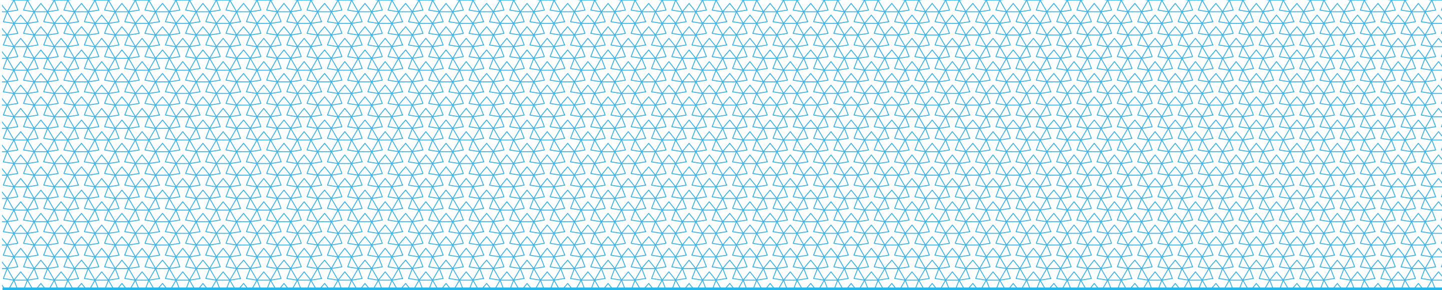
ANNEX 1: DIFFERENTIATED CARE AND IMPLEMENTATION CONSIDERATIONS

LEVEL OF CARE	APPROACHES	SPECIFIC IMPLEMENTATION CONSIDERATIONS
Enrolment into care	Differentiate the pool of patients in care into sub-groups	• On enrolment into care, if the national guidelines stipulate a CD4 cut off, this should be used. If not, use readiness for ART and other criteria as below. • Beyond the broad CD4 cut-off, define criteria for differentiating clients into specific care pools. Who goes into pre-ART pool? Who qualifies to be called stable on ART? Examples of elements that can go into the criteria include – duration on ART, incidence of OI, self-reported adherence, response to ART – CD4 or VL, etc
Transition pool	Facility-based • Differentiated schedules – frequent clinic visits • Differentiated client flow	Facility • Monthly adherence counselor visits, monthly cotrimoxazole refill, yearly VL assay • Review and chart facility client flows for each group • Put in place synchronized appointment scheduling system that considers total hospital visit needs of the client • Ensure linkage to community care team
	Community-based • Differentiated schedules – frequent clinic visits	Community • Calls by case managers in the first few days after diagnosis • Home visit • Link to support group.
Pre-ART	Facility-based • Differentiated schedules – give pre-ART • Differentiated client flow – allow pre-ART clients skip certain clinic processes to make their stay shorter	Facility • 3-monthly clinical review, 3-monthly CD4 estimation, 3-monthly cotrimoxazole refill, yearly VL assay • Review and chart facility client flows for each group • Decide what steps can be skipped in the flow for each group • Support each Service Delivery Point to know what role to play in ensuring smooth client flow for each group • Put in place synchronized appointment scheduling system that considers total hospital visit needs of the client • Ensure linkage to community care team
	Community-based • Differentiated schedules • Differentiated client flow	Community • Align care pools with facility categories • Facility based groups and community register to specifically keep a record of which care pool individual clients fall into. • Put in place a mechanism for moving and keeping track of clients as they graduate between different pools. • Linkage to support group

LEVEL OF CARE	APPROACHES	SPECIFIC IMPLEMENTATION CONSIDERATIONS
New on ART – defined as the first six months on ART	Facility-based • Differentiated schedules – more frequent contact in the early period on ART • Differentiated client flow	Facility • If initiated in the facility, give more frequent appointments in the first six months on ART - Week 2, Week 4 and then 4 -weekly thereafter. • Set up a client flow to make these frequent visits as non-burdensome as possible • Consider integration of clinical reviews into general outpatient care • Link clients to support group and community care team • Ensure a mechanism in place to transfer client appointments to community team
	Community-based • More frequent contact (home visits, phone calls and SMS alerts) by case manager	Community • If initiated in the community, ensure phone call to the client within 24 hours of initiation. Ensure home visit within first 5 days of initiation. • If initiated at the facility, ensure home visit in the first 2 weeks before the first return visit to the facility is due. • Weekly adherence and pharmaco-vigilance reviews by community teams in the first 4 weeks • During home visits by case manager, review need for clinical review, provide adherence support
Stable on ART	Facility-based • Differentiated schedules including appointment spacing • Differentiated client flow	Facility • Facility appointments for clinical review spaced out to 4-6 monthly • Drug refill appointments can be given at 2-3 month's intervals • Lab monitoring appointments - annual viral load estimation, annual CD4 estimation arranged to be 6 months out of step • Facility appointment diary to be kept to provide estimate of clinic volume, track defaulters, link with community teams
	Community-based • Community-based clinical review • Community-based ART refill • Community-based viral load • Reinforcement of adherence	Community • Between extended facility clinic visits, clients are linked to community-based clinical reviews • This can be documented on client-held health cards • Linked to the facility, ART refill groups can be organized with group representatives picking up drugs on behalf of the team. • The community-based clinical team could also dispense ART refills for this group. • All stable clients could get VL requests through their community care teams with documentation linked to facilities

LEVEL OF CARE	APPROACHES	SPECIFIC IMPLEMENTATION CONSIDERATIONS
Unstable on ART	Facility-based • Differentiated schedules • Differentiated client flow	Facility • Appointments to follow algorithm as per national guidelines. This would entail frequent adherence reinforcement visits (usually monthly for 3 months), OI management visits, lab monitoring visits. If being cared for on an in-patient basis, institute adherence measures once client is stable • Set up facility 'drug therapeutic committee' or its equivalent to review clinical decisions for this group of clients ahead of clinic appointments. This will shorten the time required during clinic visit.
	Community-based • Early identification • Support for clinical decision making	Community-based • Early identification of persons who might not be suppressed on their current regimens should involve viral load literacy, scheduling of viral load lab appointments • Collection of viral load samples, transportation to the PCR lab, documenting results and making it available to support clinical decision making could all be instituted by the community care team.
Adolescents on ART	Facility-based • Differentiated clinic schedules • Differentiated client flow • Integrated services • Transition planning	Facility • First, conduct an assessment of how adolescent friendly the HIV service in the hospital is. This should help to identify current gaps and action and resources needed to fill the gap. • Services must be tailored to be age-appropriate and integrated to meet all the clinical needs as much as possible. • Making clinics adolescent friendly would entail – training of clinic staff, differentiating the physical location of the clinic from adult clinics, scheduling a different clinic day or time for adolescent clinics, engaging peers in clinic activities, providing disclosure support, etc • For older adolescents, special considerations to be given to transition to adult care - transition counseling, transition planning, including periodic familiarization visits to adult ART clinic • Linkage to community care teams and integrated adolescent spaces - hold regular meetings, compile a resource directory, prepare IEC materials, work with peers

LEVEL OF CARE	APPROACHES	SPECIFIC IMPLEMENTATION CONSIDERATIONS
Adolescents on ART *(continued)*	Community-based • Integrated adolescent spaces • Peer-led support groups	Community • A survey (preferably qualitative) to understand adolescent needs should precede the differentiated approach. • Set up integrated adolescent spaces with an adolescent health clinic. This should be done in a participatory manner with selected adolescents. The aim is to have a space where the adolescent feels free to engage, and interact, ensuring psychosocial wellbeing, retention, adherence, sexual and reproductive health, and prepares the adolescent for eventual transition to adult HIV services. • Integrated adolescent spaces will need to regularly reappraise supported activities to keep them relevant to evolving client needs.
Children	Facility-based • Family centered approach • Differentiated client flow	Facility • Increasing the identification of HIV positive children should happen at post-natal clinics, immunization clinics, malnutrition clinics, under-5 clinics, pediatric in-patient wards, pediatric out-patient clinics, etc • The facility should institute family centered care with appointment scheduling that ties parents' appointments with their children's appointment. • Where possible, the clinic space should also see the 'family as one visitor' and not make the family attend separate clinics even when appointments are given for the same day. • Disclosure plans for older children should be put in place.
	Community-based • Early identification • Home visits • Disclosure, ART literacy	Community • Integrated MNCH outreaches in identified hotspot communities should integrate HIV testing with immunization, deworming campaigns, mosquito nets distribution, etc • Community care teams should support adherence to clinic appointments including the week-6 visit for HEIs • Community care teams can play an active role in getting EID results to families by serving as a link between PCR labs, facilities and clients. Results can be delivered from the PCR lab to a care team mapped to a community. • Equip community care teams for disclosure support, pediatric and adolescent ART literacy



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