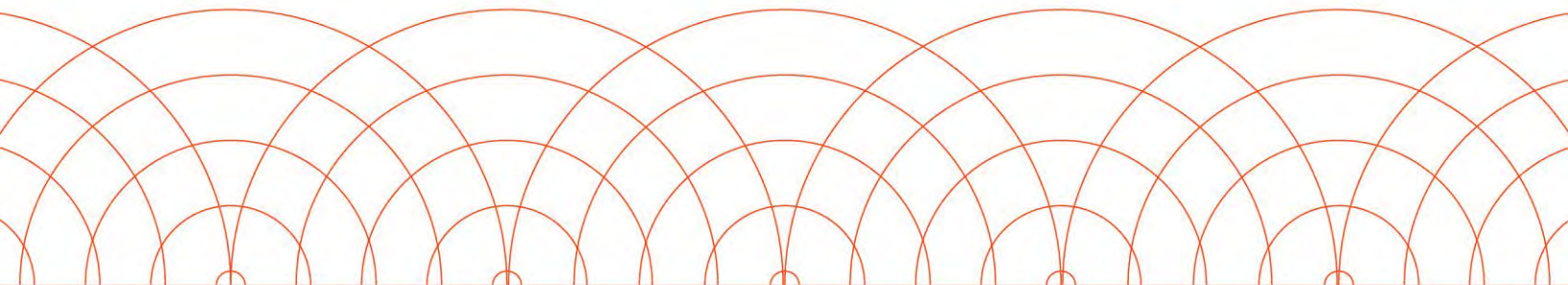


Package of Services and Interventions for Children and Adolescents Living with HIV

Guidance for Orphans and Vulnerable Children Programs

July 2023



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On the cover: Leta, with her son in a neighborhood of Maputo City, Mozambique, during a household visit by an orphans and vulnerable children case worker from the COVida—Together for Children project in March 2023. Leta shares information on her health status with the case worker. Photo credit: Mbuto Machili for FHI 360

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Introduction

For people living with HIV (PLHIV), viral load suppression (VLS) is critical for sustaining quality of life, achieving optimal treatment outcomes, preventing treatment failure, and preventing transmission of multidrug-resistant virus later in life. It is also critical for accelerating the achievement of the 95-95-95 global targets for ending AIDS among children by 2030. However, VLS among children living with HIV (CLHIV) is low globally. Joint United Nations Programme on HIV/AIDS (UNAIDS) 2021 data show that only 40% of CLHIV aged 0–14 had suppressed viral load (VL), compared to 67% of adults.¹

Adherence to antiretroviral therapy (ART) is the main determinant of VLS among PLHIV. Children and adolescents living with HIV (CALHIV) enrolled in orphans and vulnerable children (OVC) programs often face numerous barriers to ART adherence, including lack of awareness of their HIV-positive status, poor treatment literacy, lack of food to accompany their medications, and lack of money for transport to the health facility to attend medical appointments or pick up antiretrovirals. Fear of stigma and discrimination also often prevent CALHIV from taking their medications, especially while they are in school.

U.S. President's Emergency Plan for AIDS Relief (PEPFAR) guidance mandates OVC programs to support CALHIV in achieving VLS, particularly those newly diagnosed and initiated on treatment, with high VL, or with a history of treatment interruption. This technical guidance document describes the differentiated package of services that PEPFAR-funded OVC programs led or supported by FHI 360 should provide to CALHIV (and their families), and the key principles to follow in delivering services to this population. Also included are project-level coordination and advocacy activities and systems that OVC programs should implement to support improved treatment outcomes for CALHIV. Links to useful resources and tools for using or adapting are also included.

The package of services described in this document is for children and adolescents who have already been clinically diagnosed as HIV positive and have disclosed their status to the OVC program. Sometimes CALHIV and/or their caregivers refuse to disclose their status to their OVC community case worker (CW) and, in these cases, the CW is unable to provide the support appropriate to the child/adolescent's HIV status. Thus, it is extremely important for OVC programs to promote HIV status disclosure by implementing interventions to: (1) improve CWs' communication and motivational counseling skills, (2) promote trust between CWs and their clients, and (3) reduce fear of HIV-related stigma and discrimination among program participants.

¹Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS data 2021: UNAIDS 2021 reference. "Ending paediatric AIDS and eliminating vertical transmission," p. 33. Geneva: UNAIDS; 2021. Available from: [UNAIDS data 2021](#).

This document will be a helpful tool for new OVC programs in the process of establishing their package of services for CALHIV, or for ongoing OVC programs whose package of services needs to be optimized. It can help OVC programs improve and standardize the package of services offered to CALHIV across implementation sites and enhance the overall quality of care for this population. The document can be used to:

- Orient and guide OVC program staff at different levels of program implementation on service delivery to CALHIV
- Plan and budget for services and interventions for CALHIV
- Inform the supervision of service delivery activities for CALHIV to ensure they receive appropriate services and support

Principles and Considerations for Service Delivery to CALHIV and Their Families

Before describing the package of services, it is important to review some of key principles and considerations for delivering high-quality care that contributes to VLS among CALHIV:

- **Provide person-centered care.** CALHIV is not a homogenous group; subgroups include those who have been newly diagnosed and initiated on treatment, those who are stable on treatment and virally suppressed, and those with unsuppressed VL and with opportunistic infections. In addition to their different treatment-related needs, the needs may vary based on individual characteristics, such as age/developmental stage, household economic status, family dynamics, and the communities in which they live.

CALHIV who are pregnant and/or breastfeeding, double orphans, or have disabilities, mental health, and substance-abuse problems, or are children of key population (KP) members, may have additional needs. OVC programs cannot use a one-size-fits-all approach to provide services to this population. A person-centered approach helps OVC programs provide **differentiated services** that respond to the varying needs of different subpopulations. The person-centered approach also entails providing program participants the opportunity to express their views and preferences about the care they receive and empowering them to take responsibility for their own health rather than being passive recipients of services.

- **Provide family-centered care.** CALHIV enrolled in OVC programs live within a family context, and their primary caregiver(s) play a critical role in supporting their treatment-related needs. Thus, OVC programs must facilitate access to services not just for CALHIV, but also for their caregivers, to empower them with knowledge, skills, and resources to properly care for their CALHIV and support their treatment.
- **Provide comprehensive services.** CALHIV often have multiple, concurrent health and socioeconomic needs; addressing only one or some of those needs may not lead to optimal treatment outcomes. Thus, OVC programs must offer or facilitate access to a range of health and socioeconomic services to meet the needs of CALHIV and their families. These services can be provided directly by the OVC program or by other service providers through referrals. The PEPFAR requirement that each OVC program participant receive at least one service each quarter is *only* a reporting requirement for a child to be counted as an active program participant. Receiving only one service during the quarter may not lead to improved treatment outcomes, particularly for a child or adolescent with high VL.
- **Provide age-appropriate services.** As mentioned earlier, the needs of CALHIV vary according to their age and stage of development. Thus, programs must provide services that respond to CALHIVs' age-specific needs. For instance, infants and young children depend on their caregivers to take their medications, so caregiver involvement and support is particularly critical at this stage. Adolescents, on the other hand, often have decreased caregiver oversight due their age and increased independence, so they need to be supported to develop self-care skills.

- **Provide services and support using HIV-sensitive case management.** Because the needs of CALHIV are different from other vulnerable children and adolescents in OVC programs, they must receive case management that is HIV sensitive. The primary goal of case management for CALHIV should be to:
 - ☞ Ensure treatment adherence and continuity
 - ☞ Improve treatment and viral load literacy
 - ☞ Increase uptake of critical health and socioeconomic services
 - ☞ Reinforce positive and healthy behaviors, practices, and skills
 - ☞ Prepare adolescents for transitioning to adult care and treatment

HIV-sensitive case management requires that OVC CWs supporting CALHIV be well trained in HIV care and treatment and in HIV-related stigma and discrimination. Also, standard operating procedures (SOPs) must clearly articulate how case management activities for CALHIV will be different from other groups of vulnerable children in terms of caseloads, frequency of follow-up visits, and other support activities. It is also important that key case management tools, such as the needs assessment and follow-up/monitoring tools, include questions tailored to explore and identify the unique needs of CALHIV.

- **Engage PLHIV as case workers.** Whenever possible, OVC programs should try to engage CWs who are themselves living with HIV since they are in a better position to understand the clinical, psychosocial, and socioeconomic challenges and needs of CALHIV and their families. This can also help accelerate the building of rapport and trust between CWs and CALHIV and their families.
- **Train case workers in care and treatment.** Community CWs in OVC programs should be thoroughly trained in pediatric and adolescent HIV care and treatment so they are well prepared to support CALHIV. The PEPFAR COP22 guidance encourages OVC programs to coordinate this training with HIV clinical partners. The training should cover topics such as adherence, continuity of treatment, disclosure of HIV status, antiretroviral (ARV) drug optimized regimens and drug administration, VL testing and suppression, and undetectable = untransmittable (U=U).
- **Ensure appropriate supervision of service delivery to CALHIV.** OVC programs must ensure that OVC case management and service delivery activities for CALHIV (in the community or in the health facility [HF]) are properly supervised by staff who have been thoroughly trained in both case management and pediatric HIV care and treatment. Supervision activities should ensure CWs are:
 - ☞ Following up on CALHIV with the appropriate frequency, particularly based on their risk factors, and treatment adherence and VL status.
 - ☞ Properly assessing CALHIV's adherence to ART and linking/referring those not adhering to enhanced adherence counseling.
 - ☞ Providing appropriate HIV treatment and VL literacy to CALHIV and their caregivers.
 - ☞ Making sure CALHIV are attending their clinic appointments and referring them to any missed appointments.
 - ☞ Following up on previous referrals to ensure CALHIV have received the services they were referred to, particularly for ARV refills and VL testing.

Package of Services and Interventions for CALHIV and Their Families

This section describes the package of health and socioeconomic services and interventions OVC programs should provide, or facilitate access to, for CALHIV (and their families). These services and interventions are aligned with the PEPFAR package of services for OVC programs in the monitoring, evaluation, and reporting (MER) 2.0 guidance (version 2.6), and with the PEPFAR Country Operational Plan 2022 Guidance (COP22). These services and interventions can be provided directly by the OVC program or by other service providers through referrals. The package also includes project-level interventions and activities to support improved treatment outcomes among CALHIV that entail coordination and collaboration with HIV clinical partners.

The package includes **only** services and interventions that directly contribute to improved HIV clinical treatment outcomes among CALHIV. However, per PEPFAR guidance, CALHIV enrolled in OVC programs should receive interventions and services in four OVC PEPFAR service delivery domains: health, education, safety, and economic stability. The package can be adapted by OVC programs as needed, based on their unique mandates and local contexts.

Description of Services and Interventions

- ART adherence monitoring and counseling.** As previously indicated, adherence to ART is the most important factor for VLS, so OVC programs must monitor CALHIV to ensure treatment adherence. Adherence means they are taking their medications exactly as prescribed. Adherence monitoring should be carried out using an appropriate monitoring tool or job aid (e.g., checklist). In the event the child or adolescent living with HIV is taking other medications (e.g., tuberculosis prophylaxis), the OVC CW should assess adherence to such medications as well. Frequency of monitoring visits should vary based on each individual's VL status and risk level. During these monitoring visits CWs must assess barriers to adherence, including behavioral and socioeconomic barriers at the individual and family level. Thus, CWs should be trained to conduct a barrier analysis and equipped with the knowledge, skills, and resources to provide age-appropriate adherence counseling as well as practical support to address any barriers identified. When a child or adolescent is persistently nonadherent, they should be linked to enhanced adherence counseling (EAC), which can be provided by a qualified OVC program staff (a nurse) or by an HIV clinical provider in the HF.



Resource:

HIV Treatment Adherence Counseling and Retention Guide: A Job Aid for OVC Program Cadres Supporting Caregivers of Children Living with HIV.

- HIV treatment literacy.** Treatment literacy is key for retention in treatment, adherence to ARVs, and optimal treatment outcomes. PEPFAR defines treatment literacy as the degree to which individuals have the capacity to obtain, process, and understand HIV information to make appropriate health decisions.² Many CALHIV and caregivers have poor treatment literacy because clinical providers often do not have enough time to educate them. OVC frontline workers should be thoroughly trained on HIV treatment by clinical partners so they can contribute to improve treatment literacy among CALHIV. Caregivers' treatment literacy should also be improved since they can play a critical role in supporting their children's treatment (e.g., administering medications, taking children to clinic appointments, and providing food and emotional support). Treatment literacy activities should be carried out using age-appropriate resources and tools that are in the local language, have pictorials, and use simple language that CALHIV and their caregivers can understand.



Resources:

Children Treatment Literacy Booklet for Caregivers

[2021CaregiversGuideIEC19.pdf \(pefaids.org\)](#)



Adolescent Treatment Literacy Guide for Use in Support Group Settings

[KenyaAdoTreatmentLiteracyGuide-1.pdf \(pefaids.org\)](#)

- Monitor and support adherence to clinic appointments.** Attending clinic appointments is critical for treatment continuity. OVC programs should keep track of each child or adolescent's clinic appointments (e.g., ART consultations, ARV pickup, VL testing) and provide support to remove any barriers that may prevent them from attending these appointments. Examples of support include:
 - ☞ Provide reminders about appointments to ALHIV and caregivers (at least 48 hours prior the appointment) through phone calls, text messages, or home visits. Verify afterwards that the client attended the appointment.
 - ☞ Provide transport to the HF (based on financial need).
 - ☞ Offer navigation to the appointment site when the caregiver is unable to take the child.

OVC programs should also identify missed appointments, and counsel and refer/navigate those CALHIV to the HF for any missed services.

² PEPFAR. PEPFAR country and regional operational plan 2022 guidance for all PEPAR-supported countries (COP/ROP 2022). "treatment literacy," p. 196. Washington (DC): PEPFAR; 2022.

- **Referrals to VL testing.** VL testing helps monitor the effectiveness of ART and determine VLS status. CALHIV who are eligible for VL testing (six months after initiating ART and annually thereafter or three months after for those not virally suppressed) and are found to have unknown VL status (never tested) or have outdated VL data (last test result older than 12 months), must be referred/navigated to the HF for VL testing.
- **Counseling for disclosure of HIV status**
 - ✎ **Disclosure counseling for CALHIV caregivers.** Disclosure of their HIV status to CALHIV is a critically important component of the HIV care and treatment cascade. Studies suggest that this may support uptake of and adherence to ART. However, global prevalence of disclosure to children and adolescents remains low.³ OVC programs must equip CWs with knowledge and skills to counsel caregivers on the importance of disclosure. CWs should refer caregivers to a professional counselor in a HF where such counselors exist so they can be guided and supported by an expert during the disclosure process.
 - ✎ **Disclosure counseling for CALHIV.** Some ALHIV in OVC programs may not have acquired HIV vertically and may not have disclosed their HIV-positive status to their caregiver(s) and other family members due to fear of revealing sexual activity and being judged or rejected. Disclosure within the family, and particularly to caregivers, can create opportunities for ALHIV to access adherence support and psychosocial support within their family. Thus, it is important for OVC CWs to counsel these adolescents about the importance of disclosing within the family, particularly to their parents or caregivers. They should also refer them to professional and adolescent-friendly counseling services in a HF, where these services exist.





Resource:

Disclosure of HIV Status Toolkit for Pediatric and Adolescent Populations
[NewHorizonsDisclosureToolkit_FINAL.pdf \(pedaids.org\)](https://pedaids.org/NewHorizonsDisclosureToolkit_FINAL.pdf)

- **Linkage to a peer support group.** Peer support groups (or teen clubs) have proven to be an effective intervention to ensure treatment continuity, improve adherence to ART, and achieve VLS among ALHIV.⁴ For adolescents, peers can be an important source of empathy and social acceptance. Many ALHIV experience stigma and peer violence, so peer support groups can have a protective effect, buffering the negative effects of stigma, providing positive role models, and positively influencing behaviors. OVC programs should link ALHIV to age-appropriate peer support groups in the HF or in the community (where these groups exist), and support and monitor their participation in the meetings.

³ Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). Disclosure of pediatric and adolescent HIV status toolkit. Washington (DC):EGPAF; 2018. Available from: [New-Horizons_HIV-Status-Disclosure-Toolkit.pdf \(childrenandaids.org\)](https://childrenandaids.org/New-Horizons_HIV-Status-Disclosure-Toolkit.pdf).

⁴ Mark D, Hrapcak S, Ameyan W, Loyich R, Ronan A, Schmitz K. [Peer support for adolescents and young people living with HIV in sub-Saharan Africa: emerging insights and a methodological agenda. Curr HIV/AIDS Rep. 2019;16\(6\):467-74.](https://doi.org/10.1186/s12916-019-1467-4)


Resources:

Positive Connections: Leading Information and Support Groups for Adolescents Living with HIV. [Positive Connections: Leading Information and Support Groups for Adolescents Living with HIV |FHI 360](#)

Vhutshilo 3. [Vhutshilo 3 | VHUTSHILO](#)

- **Support for transitioning to adult care.** Inadequate preparation for the transition from pediatric/adolescent care to adult HIV care and treatment can be a critical barrier to treatment continuity for ALHIV.⁵ OVC programs should support HIV clinical partners' efforts to prepare ALHIV for this transition by implementing the following activities:
 - ☞ Support disclosure to the adolescents to ensure they know their HIV status.
 - ☞ Discuss the transition process with adolescents so they can be emotionally and mentally prepared for the transition and address any fears or concerns they may have.
 - ☞ Develop adolescents' self-care skills.

Many settings do not have a separate pediatric HIV provider; care is given by the same providers to all populations. In these cases, OVC programs should continue to focus on developing self-care skills in adolescents to increase their knowledge and ability to take care of themselves over time.⁶



Resource:

Toolkit for Transition of Care and Other Services for Adolescents Living with HIV

[Toolkit for Transition of Care and Other Services for Adolescents Living with HIV \(usa.gov\)](#)

Screening for and referral of CALHIV with advanced HIV disease (AHD). Children and adolescents with AHD often experience HIV-associated infections such as pneumonia, tuberculosis, diarrhea, and severe acute malnutrition. In addition, ALHIV experience adult-type opportunistic infections (OIs), including meningitis. These infections are the major causes of disease and death among CALHIV, particularly in low- and middle-income countries. Children under 5 years old are at much higher risk of death than older PLHIV and disproportionately die

⁵ PEPFAR COP/ROP; 2022, p. 206.

⁶ Duffy MH, Bergmann H, Sharer M. Toolkit for transition of care and other services for adolescents living with HIV. Arlington (VA): USAID's AIDS Support and Technical Assistance Resources (AIDSTAR-One); 2014. p. 10.

from AIDS-related causes compared to older PLHIV. Disparities in case finding and linkage to ART may explain this higher risk. According to UNAIDS 2021 data, only 59% of CLHIV less than age 15 had known HIV status (compared to 82% of PLHIV older than age 15), and among these only 54% were on treatment, compared to 74% of adults.⁷ Treatment coverage among children 0–4 years was even lower at 37%.

Children and adolescents considered to have advanced HIV disease are:

- All CLHIV less than 5 years old at time of HIV diagnosis.
- All CLHIV less than 5 years old who are not adhering to ART and are not clinically stable.
- CALHIV older than 5 years with either a CD4 cell count <200 or WHO stage 3 or 4 illness.

Improving the identification and management of pediatric and adolescent AHD is critical to prevent deaths among CALHIV. All CALHIV with AHD should be identified and managed according to the World Health Organization (WHO) Screen, Treat, Optimize and Prevent (STOP) AIDS Package, which includes the following interventions:

- Screen for TB and malnutrition
- Treat TB, severe pneumonia, severe bacterial infections, cryptococcal meningitis, and severe acute malnutrition
- Optimize ART: rapid start of ART (within seven days with optimal regimens) and ART counseling
- Prevent bacterial infections, pneumonia, TB, cryptococcal meningitis among adolescents, and provide vaccinations (pneumococcal vaccine, human papillomavirus, measles, BCG)

OVC programs can contribute to preventing, identifying, and addressing AHD among CALHIV under age 18 by:


- ☞ **Supporting early case finding and linkage to ART.** All children and adolescents enrolled in the OVC program must be supported to know their HIV status and to rapidly initiate ART if they test positive. Those with unknown HIV status under 5 years should be prioritized for expedited HIV risk screening and testing.
- ☞ **Monitoring and supporting adherence to ART and the overall health.** Closely monitor and support children and adolescents to ensure they are adhering to ART and are in overall good health, particularly those less than 5 years.
- ☞ **Supporting those who are ill to access health care.** Children who show signs of illness (e.g., fever, coughing, difficulty breathing, diarrhea, vomiting--especially young babies less than 12 months), or have rapid weight loss (not gaining weight) should be immediately referred to and supported to go to a HF for urgent care, diagnosis, and treatment. During household visits, OVC cadres can also monitor adherence to any other medications prescribed by clinical providers to treat illnesses and infections, such as for OIs and/or prophylaxis (isoniazid/3HP, cotrimoxazole, fluconazole, nevirapine, etc.).
- ☞ **Screening for TB, malnutrition, and vaccination status.** Screen all CALHIV for TB, and screen children under 5 years for malnutrition and vaccination status. These screenings are part of the standard service package for all CALHIV recommended in this document (regardless of AHD status), so they are described in more detail below.

⁷UNAIDS. UNAIDS data 2021: UNAIDS 2021 reference. “Ending paediatric AIDS,” p. 33.

- **Screening for and referral of TB presumptive cases and support adherence for TB treatment.** CALHIV have increased risk of TB exposure, infection, progression to disease, and TB-related morbidity and mortality. At least one in five pediatric AIDS-related deaths are due to TB globally, and the largest TB case-finding gaps are among children. Optimizing the screening, prevention, diagnosis, and treatment of TB can help improve the health of CALHIV. All CALHIV in OVC programs should be screened for TB using a standardized TB screening questionnaire, at least monthly. Those found at risk should be referred to a HF for evaluation, diagnosis, and prophylaxis or treatment. OVC CWs should support CALHIV diagnosed with TB to correctly take the prescribed ART and OI medication (co-trimoxazole and fluconazole pre-emptive therapy), as appropriate.
- **Primary health care for infants and young children.** OVC programs should refer and support children under 5 years to receive all standard primary health care services to prevent morbidity and mortality. These services include vaccination per national guidelines, weight and growth monitoring, deworming, vitamin A and iron supplementation, and malaria prophylaxis.
- **Screening for malnutrition and referral to nutritional supplementation and counseling services.** Malnutrition has been associated with morbidity and unsuppressed VL, particularly among children under 5 years. OVC programs should screen all CLHIV less than age 5 for malnutrition using the mid-upper arm circumference (MUAC) measurement method. Nutritional supplementation (when paired with ART and other HIV services) can augment growth and improve outcomes among CLHIV, so children found to be malnourished should be referred to a HF for nutritional supplementation and counseling. HIV clinical programs often offer nutritional support to HIV-positive clients with malnutrition, so OVC programs should coordinate with ART clinics, through their facility-based staff, to ensure malnourished children receive this support.
- **Food support.** Food plays a major role in promoting adherence to ART. However, many CALHIV live in destitute households and lack sufficient food to take their medications. Therefore, OVC programs should also identify sources of food support in their target communities and in the faith-based and private sectors, so they can link destitute households to this support.
- **Food security interventions.** These interventions aim to ensure that households always have access to sufficient, safe, and nutritious food to satisfy their nutritional and dietary needs. An example of this type of intervention is household gardens where families are equipped with the knowledge, skills, and resources (e.g., seeds) to plant small gardens at their home. OVC programs should assess the food security situation of each CALHIV household and provide interventions to insecure ones. If program mandate or budget limitations do not allow an OVC program to implement this type of intervention, they should refer families to other service providers who offer it.
- **Monitoring of developmental milestones.** Studies have shown that exposure to the HIV virus, ART, and parental and environmental factors (e.g., lack of early stimulation, stigma) contribute to cognitive and other developmental delays in children.⁸ It is important for OVC programs to monitor CLHIV, particularly infants and those under age 5, using a

⁸ Sherr L, Croome N, Castaneda KP, Bradshaw K, Romero RH. [Developmental challenges in HIV infected children— an updated systematic review. Child Youth Serv Rev. 2014;45:74–89.](#)

developmental milestone monitoring checklist to identify those at risk of developmental delays and refer them for professional screening and support services. See the CDC developmental monitoring checklists (listed in resources box), which can be adapted by OVC programs.



Resources:
 Developmental [Milestone Checklists \(cdc.gov\)](https://www.cdc.gov/ncbddd/developmental-monitoring/checklists/) (checklists only)
[CDC's Developmental Milestones | CDC](https://www.cdc.gov/ncbddd/developmental-monitoring/) (more developmental milestones resources)

- **Sexual and reproductive health (SRH) services.** Many ALHIV, like their peers who are not HIV positive, initiate sexual activity during adolescence. Adolescents tend to have low levels of sexual health knowledge and limited access to SRH services; two factors that are linked to higher engagement in risky sexual behaviors (e.g., having multiple sexual partners), unplanned pregnancies, and higher rates of sexually transmitted infections (STIs).⁹ While these outcomes are concerning for all adolescents, they are more concerning for ALHIV, who can transmit the virus to their sexual partners and experience worse health outcomes due to STI co-infection. Pregnant or breastfeeding adolescent girls and young women can also transmit HIV to their HIV-exposed infants. ALHIV face the additional challenge of living with a stigmatized chronic condition that can impact their ability to access SRH services and contraceptives needed for protection. Structural and social barriers such as poverty, limited access to health services, and laws on age of consent for accessing SRH services further contribute to negative outcomes for adolescents and young people in low- and middle-income countries.^{10,11} To support the SRH of ALHIV, OVC programs should train their community CWs to ensure they understand the SRH needs of ALHIV, SRH services, and barriers ALHIV face in accessing these services. To facilitate referrals to youth-friendly SRH services and age-appropriate SRH education, OVC programs should map these services and include them in the service provider directories used by CWs.
- **Screening and referrals for mental health services.** HIV exacerbates psychological distress, particularly among adolescents. Studies have shown that ALHIV experience greater emotional, behavioral, and conduct problems than other adolescents. ALHIV with mental health difficulties are less likely to achieve viral suppression, have lower odds of retention in care, and have an increased risk of AIDS-related mortality than their peers in

⁹Alawode OA, Ogunwemimo H, Bolorunduro M-E, Awoleye AF. Age at sexual debut and multiple sexual partnerships among adolescents in Nigeria: an assessment of the mediating role of the knowledge of sexually transmitted infections. *Adolescents*. 2021;1(4):421–32. Available from: doi: [10.3390/adolescents1040032](https://doi.org/10.3390/adolescents1040032).

¹⁰ Mkumba LS, Nassali M, Benner J, Ritchwood TD. Sexual and reproductive health needs of young people living with HIV in low-and middle-income countries: a scoping review. *Reprod Health*. 2021;18: 219. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8570025/>.

¹¹ Alawode OA, Ogunwemimo H, Bolorunduro M-E, Awoleye AF. Age at sexual debut and multiple sexual partnerships among adolescents in Nigeria: an assessment of the mediating role of the knowledge of sexually transmitted infections. *Adolescents*. 2021;1(4):421–32. Available from: <https://www.mdpi.com/2673-7051/1/4/32>.

other high-risk groups.¹² OVC programs should screen ALHIV for mental health issues on a regular basis, by using a simple validated mental health screening tool. Those found at risk should be referred to adolescent-friendly mental health services in the HF. To facilitate these referrals, OVC programs should map the mental health services available within their target geographic areas and include them in service provider directories.

- **Screening and referrals for substance use services.** The relationship between substance abuse disorders and HIV disease is complex and bidirectional. Substance abuse disorders are common in individuals living with HIV and have been associated with poor ART use, and lower likelihood of VLS. Because of this linkage, ALHIV should be screened for and provided treatment if a substance abuse disorder is found.¹³ Those identified to be at risk should be referred to professional counseling services in the HF. To facilitate referrals, OVC programs should identify HFs with professional counselors and incorporate them in service provider directories.
- **Social protection and economic strengthening interventions.** Economic factors play a key role in ART adherence and VLS. Competing demands for food, school fees, and transport to HFs create barriers for CALHIV to receive the care they need. OVC programs must assess the level of poverty of CALHIV households so they can provide or link them to appropriate services and interventions. Depending on each family's economic situation, these interventions will aim to either stabilize them and meet basic needs (e.g., social protection) or promote their economic growth (economic strengthening). Both interventions are described below.
- **Social protection**
 - ☞ **Linkage to government social protection programs.** These programs—cash transfers or other types of social grants—play an important role in meeting the basic needs of children in destitute households and reducing their vulnerability. OVC programs need to identify and establish referral relationships with existing programs in their local context so they can refer households with CALHIV.
 - ☞ **Short-term emergency cash support.** In countries with weak or no social protection programs, OVC programs should budget for and provide a small cash *transfer to CALHIV in destitute households to meet urgent needs relevant to their treatment*, such as food, medicines, and transport to the HF. This cash transfer should be temporary and provided only until the family is able to generate sufficient resources through economic strengthening efforts, or until they can be linked to more sustainable sources of support.
- **Economic strengthening (ES) interventions.** These interventions help OVC households generate money so they can meet their children's basic needs, including those related to treatment. They can also help create a financial cushion for vulnerable households to survive shocks due to unexpected expenses. Programs should facilitate access to a range of ES interventions that can help improve the economic capacity of families at different levels of vulnerability. Examples include:

¹² Bhana A, Abas MA, Kelly J, van Pinxteren M, Mudekunya LA, Pantelic. Mental health interventions for adolescents living with HIV or affected by HIV in low- and middle-income countries: systematic review. *BJ Psych Open*. 2020;6(5):e104. doi: [10.1192/bio.2020.67](https://doi.org/10.1192/bio.2020.67).

¹³ PEPFAR COP/ROP; 2022, p. 515.

- ☞ Asset transfers
- ☞ Savings groups
- ☞ Financial literacy training
- ☞ Entrepreneurship training
- ☞ Provision of start-up kits for small businesses
- ☞ Agribusiness training
- ☞ Linkages to formal financial institutions (banks, credit unions, microfinance institutions (MFIs), etc.)

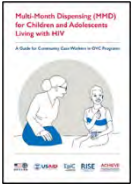
ES interventions can be implemented by the OVC program or by other programs or service providers.

Project-Level Interventions and Activities

This section describes project-level interventions and activities OVC programs should implement in support of CALHIV. Most of these interventions entail coordination and collaboration with clinical partners and HFs and/or setting up OVC project-level systems.


- **Strengthen coordination and collaboration with PEPFAR HIV clinical partners.** PEPFAR OVC and HIV clinical partners need to work closely together to improve treatment outcomes for CALHIV. OVC programs must implement the following activities to enhance coordination and collaboration with HIV clinical partners
 - ☞ **Develop memoranda of understanding (MOU):** MOUs should delineate roles and responsibilities for the following key activities: (1) shared confidentiality agreements, (2) placement of OVC staff in the HFs, (3) training of OVC cadres in HIV care and treatment, (4) routine joint data review and triangulation, and (5) joint case conferencing.
 - ☞ **Establish shared confidentiality agreements.** OVC and clinical partners must agree on the joint responsibility of all parties working with CALHIV personal information to guarantee the information remains confidential and is shared only with appropriate care team members.
 - ☞ **Place OVC staff in each HF.** OVC programs should station a linkage coordinator/facilitator in each HF within their target geographic, particularly in high-volume HFs. This person will support coordination and bidirectional referrals between the OVC program and each HF, among other tasks. Ideally, this person will have a clinical background (e.g., nurse) so they can easily interact with the community and clinical providers.
 - ☞ **Training of OVC cadres and clinical staff.** OVC and clinical programs are expected to support one another in building their capacity to support CALHIV. OVC implementing partners (IPs) can train clinic staff to help them understand the family, cultural, and socioeconomic factors that may impact health-seeking behaviors and ART adherence among CALHIV. They can also help clinical staff understand which children or adolescents would benefit the most from OVC program support. Clinical partners, on the other hand, are expected to train community (OVC) cadres in pediatric HIV care and treatment.

- ✎ **Conduct regular routine data review and triangulation.** OVC programs and clinical partners should hold regular information sessions to share programmatic updates, discuss challenges, and find joint solutions. OVC IPs should also regularly review and triangulate self-reported CALHIV program data with data on CALHIV on ART in the HF's electronic patient information system. This will help the OVC program and clinical providers identify and address data discrepancies and programming gaps.
- ✎ **Participate in case conferencing meetings for CALHIV.** A case conference is a formal multidisciplinary meeting involving service providers from different fields involved in the care of a child.¹⁴ Pediatric HIV clinical providers often organize these meetings to discuss difficult cases (e.g., a child with persistently high VL) and find solutions. Where these meetings are taking place, a representative from the OVC program (e.g., the linkage facilitator stationed in the HF) should participate to provide the community perspective on factors that may be contributing to nonadherence and nonsuppression (e.g., lack of caregiver support, family cultural or religious beliefs and practices, household poverty, food insecurity). These meetings also help OVC program staff stay abreast of clinical providers' concerns and actions to support specific CALHIV.
- **Coordinate and support access to multimonth dispensing (MMD) of antiretroviral drugs (ARVs).** MMD is an aspect of differentiated service delivery that provides clients with either three or six months of medication, which eliminates the need for monthly clinic visits. MMD has been shown to reduce the cost of travel, number of work or school hours lost, and client burden. More importantly, MMD improves adherence and VLS.¹⁵ OVC programs should advocate and coordinate with HIV clinical providers for CALHIV who are stable to be placed on MMD.



Resources:

Multi-Month Dispensing for Children and Adolescents Living with HIV: A Guide for Community Case Workers in OVC Programs.
https://ovcsupport.org/wp-content/uploads/2021/06/Pact_ACHIEVE_RoleofCCW_20210504.pdf



Using Multimonth Dispensing to Improve Outcomes for Children and Adolescents Living with HIV in Nigeria: A Technical Brief.
[epic-mmd-tech-brief.pdf](https://www.epic-mmd-tech-brief.pdf) ([fhi360.org](https://www.fhi360.org))

¹⁴ Coordinating Comprehensive Care for Children (4Children). Standard operating procedures for case management. Harlan (IA): Catholic Relief Services; 2019. Available from: [4Children-SOP-for-Case-Management-v2.5.pdf](https://www.4children.org/sites/default/files/4Children-SOP-for-Case-Management-v2.5.pdf) ([ovcsupport.org](https://www.ovcsupport.org)).

¹⁵ Traud AM, Ifafore-Calfee T, Phelps BR. Multimonth dispensing of antiretroviral therapy protects the most vulnerable from 2 pandemics at once. Glob Health Sci Pract. 2020;8(2):176–77. Available from: <https://www.ghspjournal.org/content/8/2/176>.

- **Coordinate and support access to community-based ARV refills/delivery.** Community-based models for ARV refill/delivery (e.g., adherence clubs, community ART distribution points, community ART groups) have proven successful in reducing burdens for clients and their retention in care.¹⁶ OVC programs should advocate and coordinate with HIV clinical providers for CALHIV on treatment to be linked to community-based or home-based ARV refill/delivery. This will help eliminate many of the barriers faced by CALHIV to access ARVs, such as long distance to HFs, lack of money for transportation, and long waiting times in the HF.

Resource:

FHI 360 and EpiC. Decentralized Drug Distribution package of documents.

<https://www.fhi360.org/resource/meeting-targets-and-maintaining-epidemic-control-epic-decentralized-drug-distribution>

- **Advocate for and support family-centered HIV care and treatment models.** Family-centered HIV care and treatment models aim to deliver comprehensive HIV care to all HIV-positive family members as a unit in the same clinic visit, as opposed to separate pediatric and adult HIV clinics. For example, in Kenya where the HIV program is designed around the family unit, family members are booked for joint appointments, their files are kept together, couples and family counseling are provided, and family treatment buddies and partner involvement are encouraged.¹⁷ The aim of family-centered HIV care is to improve access and efficiency in the delivery of HIV services to promote better ART initiation and retention in families. These models have been found beneficial in strengthening relationships within the family, and in improving health information sharing within the family and between family members and health care workers, as well as promoting HIV status disclosure among family members.¹⁸

In settings where family-centered care models already exist, OVC programs must aim to understand how they work, so they can provide information and support to OVC households to access services through these models of care. Where these models of care do not yet exist, OVC program implementers should take advantage of their working relationship with health officials and with HIV clinical providers to advocate for their establishment. Clients should

¹⁶ Joint United Nations Programme on HIV/AIDS (UNAIDS). Community-based antiretroviral therapy delivery: experiences of Médecins Sans Frontières. Geneva: UNAIDS; 2015. Available from: [20150420_MS_F_UAIDS_JC2707.pdf](https://www.unaids.org/en/resources/other/20150420_MS_F_UAIDS_JC2707.pdf).

¹⁷ Grimsrud A, Bygrave H, Wilkinson L. [The case for family-centered differentiated service delivery for HIV. J Acquir Immune Defic Syndr. 2018;78\(Suppl 2\):s124–27. Available from: doi: 10.1097/QAI.0000000000001733.](https://doi.org/10.1097/QAI.0000000000001733)

¹⁸ Khumalo PH, Katirayi L, Ashburn K, Chouraya C, Mpango L, Mthethwa N, et al. 'There are no more secrets': acceptability of a family-centered model of care for HIV positive children in Eswatini. BMC Health Serv Res. 2020;20, 951. Available from: doi: [10.1186/s12913-020-05810-5](https://doi.org/10.1186/s12913-020-05810-5).

always be offered the choice to receive ART through either a family- or individual-focused model, respecting their wish to disclose or not to disclose, to family or nonfamily members.

- **Support HIV clinical providers in transitioning CLHIV to optimized treatment regimens.** In line with WHO guidance and in coordination with clinical partners and HF staff, OVC programs must support children to transition to more effective and child-friendly pediatric ARV regimens (lopinavir, ritonavir-based, or dolutegravir-based). This support may entail coordination with HIV clinical providers as well as training community cadres and educating caregivers of children on the new regimens. The box at right provides an illustrative example of how an FHI 360 OVC program supported this process.
- **Coordinate decentralized VL testing with HFs.** Accessing facility-based services is sometimes difficult for CALHIV due to the distance from their home to the closest HF, lack of money for transportation, illness, and other barriers. Thus, OVC programs should coordinate with clinical partners and HF staff to support differentiated VL testing services, such as community or home-based VL testing.
- **Monitor the VL of CALHIV.** OVC programs must monitor the VL of CALHIV to determine whether they are adhering to treatment and progressing toward VLS, or if they have high VL and need additional support. To monitor VL OVC programs need to obtain VL test results from the HF on a regular basis and establish an individual child and adolescent VL tracking system.

Supporting Children in Mozambique to Transition to Optimized Treatment Regimen

In Q2 FY22, the Ministry of Health in Mozambique introduced pediatric dolutegravir (pDTG) 10 mg as the new treatment regimen for infants and young CLHIV older than 4 weeks of age and between 3 and 20 kgs in weight. To ensure all eligible children in the COVida OVC project were transitioned to this new regimen, the project:

- Trained its OVC case workers on the new regimen with support from its clinical partners.
- Generated lists of all eligible children and provided these lists to OVC case workers.
- Case workers conducted home visits to sensitize and support caregivers to take their children to the health facility for the change of treatment regimen.

By end of Q3 FY22, the project had identified 6,000 eligible children and 99.5% of them had been transitioned to pDTG.

Conclusion

During the last few years countries have made progress in reaching HIV epidemic control among the adult population. However, data shows that children (ages 0–14) and adolescents (ages 10–19) living with HIV continue to lag behind adults in the HIV clinical cascade.

PEPFAR-funded OVC programs are in a unique position to contribute to improved HIV treatment outcomes among CALHIV. These programs work in partnership with HIV clinical providers and have community-based CWs who have been trained to provide services, support, and close follow-up to CALHIV and their families using an HIV-sensitive case management approach. However, to achieve improved treatment outcomes, OVC programs must provide the right services to CALHIV and their families. They must provide or facilitate access to comprehensive health and socioeconomic services that are age appropriate and address the unique and complex risks, challenges, and needs of this population. This technical guidance document aims to inform and guide OVC programs to ensure they structure an appropriate package of interventions and services for the CALHIV they serve and their families. This will contribute to the provision of more effective care and support and, ultimately, to improved treatment outcomes and well-being for CALHIV.

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