Meeting report

Consultation on HIV differentiated service delivery models for specific populations and settings: Pregnant and breastfeeding women, children, adolescents and key populations

Geneva, 16-18 November 2016
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**Acronyms**

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<th>Definition</th>
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<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>DSD</td>
<td>Differentiated service delivery</td>
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<td>HCW</td>
<td>Health care workers</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>KPLHIV</td>
<td>Key populations living with HIV</td>
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<tr>
<td>LPV/r</td>
<td>Lopinavir/ritonavir</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>OI</td>
<td>Opportunistic infection</td>
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<tr>
<td>PCR</td>
<td>Polymerase chain reaction</td>
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<tr>
<td>PEPFAR</td>
<td>The U.S. President's Emergency Plan for AIDS Relief</td>
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<td>PHC</td>
<td>Primary health clinic</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PNC</td>
<td>Prenatal care</td>
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<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
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<tr>
<td>SMS</td>
<td>Short-messaging system</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>STI</td>
<td>Sexually transmitted diseases</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TG</td>
<td>Transgender</td>
</tr>
<tr>
<td>VL</td>
<td>Viral load</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1. Introduction
There is growing support for differentiated service delivery (DSD) of HIV care as a way to increase service efficiencies and impact. DSD is a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. DSD is promoted by the latest World Health Organization (WHO) guidelines for preventing and treating HIV infection [1]. In addition, a number of countries in sub-Saharan Africa have incorporated DSD into their national guidelines; these include Zimbabwe, South Africa and Swaziland. Major donors, including PEPFAR and the Global Fund, have promoted the adoption of DSD models in a number of countries, in particular through targeted support to roll out reduced frequency of clinic visits and longer ART refills (multi-month prescribing).

Most evidence in support of DSD to date comes from pilot programmes for delivering antiretroviral therapy (ART) to stable, non-pregnant adults in high-burden countries in sub-Saharan Africa. WHO guidelines do not limit recommendations relating to DSD to this group. However, experience in implementation of recommendations of task shifting and decentralization suggests that additional guidance and attention is required for specific populations and settings. Specifically, the needs of certain populations must be considered to ensure they also benefit from service adaptations; among these populations are pregnant and breastfeeding women, adolescents and children, and key populations, including men who have sex with men, sex workers, people who inject drugs, transgender people and people in prisons and other closed settings.

2. Meeting objectives
A WHO-convened consultation held in Geneva on 16-18 November was aimed at assessing current evidence, policy and practice in applying inclusive differentiated service models for ART delivery to specific populations, such as pregnant and breastfeeding women, children, adolescents and key populations. The intention was also to assess how these might be implemented in different epidemic settings, including in low-prevalence and concentrated epidemics. The consultation, which was attended by 66 people from 20 countries (see Annex 1), was aimed at achieving the following:

- Gain a shared understanding of differentiated service models for ART delivery and their application to specific populations under consideration, across a range of contexts.
- Describe the specific elements that constitute the services that should be provided in a differentiated model of care for each population and setting.
- Define the key components of a Decision Framework for DSD for these populations, building on prior work for the general adult population [2].
Before the consultation, three background papers were prepared. The first provided an overview and framing to differentiated care, the building blocks of service delivery and a summary of WHO recommendations related to the four building blocks of service delivery: When (frequency of care provision); Where (health facility vs. community); Who (delivers the care); and What (care package) (Figure 1) [2]. The second and third background papers summarized the current landscape on differentiated service delivery models for ART delivery for families [3] and key populations, respectively [4].

**Figure 1: The building blocks of DSD**

3. Key considerations for families

3.1. Experience to date
A background review identified 21 models across 15 countries (mostly in Africa) that evaluated approaches to differentiated care for children, adolescents, and/or pregnant and breastfeeding women [3]. Experience to date highlighted considerable variability in terms of the four building blocks. Eligibility for inclusion in the DSD model (notably in the definition of stable patient) also varied. Key themes emerging from this review were:

- Certain DSD elements were similar across identified models, including decentralizing care to primary health care clinics, integration of ART and maternal and child health (MCH) services, and task shifting clinical care to nurses.
For children and adolescents, ART refills every 3 months seem to be most common, with clinical visits every 6-12 month.

Infants and young children were commonly excluded from DSD models that call for fewer visits and services provided outside of facilities.

Peer support mechanisms were commonly integrated into adolescent DSD ART delivery models, and programmes frequently provided services on weekends.

Adolescent DSD models often included unstable and, in some cases, newly initiated clients by providing more intensified clinical care to these adolescents but allowing access to spaced ART refills and peer support.

There was utility in separately considering eligibility and appropriate DSD models for women already stable on ART prior to pregnancy and those diagnosed and initiated on treatment during pregnancy.

Only a small number of models were utilising lay health care workers (HCWs) to distribute ART refills (as already recommended by WHO) and hardly any provided ART refills out of facility.

Rural (and/or low HIV burden) contexts more commonly integrated these populations into adult DSD models, while urban (and/or high burden) contexts frequently built DSD models specific to families, i.e., adolescents and postnatal women.

Experience of implementing DSD for families was highlighted during the consultation from a range of settings. In Malawi, adolescent-only clinics, known as “teen clubs”, are held on weekends at the local health facility; they offer group peer support while teens wait to see the clinician for ART refill collection and clinical review, which includes sexual and reproductive health services. The clubs have enrolled more than 9000 adolescents to date, and report high levels of adherence and viral suppression. In Khayelitsha, South Africa, the widely implemented adult club model has been modified to cater for families, youth and, more recently, postnatal women within the MCH service. Stable family members and youth-specific clubs meet 5-6 times per year for ART refills provided by a lay health care worker, with annual clinic check-up done by a nurse.

Among other examples of differentiated care models are multi-month ART refills visits alternating with clinical review visits for stable children and adolescents in six sub-Saharan African countries, including a specific model example from Tanzania. There were also examples of lay HCW-led community-based psychosocial support mechanisms that could be leveraged to provide community ART refills.

### 3.2. Outcomes from the consultation

Meeting participants discussed DSD for children, adolescents and pregnant and breastfeeding woman in three concurrent discussion groups. For families, a key principle proposed by the consultation was to ensure, as far as possible, family-aligned ART delivery (same date, venue and provider) for male and female caregivers and/or siblings. Further, wherever possible, the eligibility for “stable” should be aligned with the adult eligibility criteria in recognition of the
need to simplify service delivery to support better uptake and further implementation.

For children, adolescents and pregnant and breastfeeding women, eligibility criteria for differentiated service delivery was essentially the same as adults. For children, in addition to time on ART, it was proposed that the child should be on the same ART regimen for at least three months. The importance of caregiver orientation on engaging in an age-appropriate disclosure process was emphasized. For adolescents and older children, there was recognition that in addition to a set of building blocks for ART refills and clinical consultations, there should also be an additional set of building blocks for psychosocial support. Peer engagement was seen as particularly beneficial for adolescents, and all models for adolescents should engage caregivers to provide a support structure while also fostering adolescent independence.

For pregnant and breastfeeding women, service delivery models were developed for: i) women who are stable on ART when they become pregnant; and ii) women who are diagnosed with HIV while pregnant. For women already stable on ART when they became pregnant, it was agreed that they should be allowed, if they choose, to remain in their DSD model if they are already accessing ART delivery in this way prior to pregnancy. Women who are newly diagnosed in pregnancy may become eligible for a stable client, less intense differentiated care model in the postpartum period. Their eligibility is the same as for stable adults and should include additional elements, such as checking that their infant had a 6-week PCR. The building blocks for differentiated service delivery models for families are summarized in Table 1.

Table 1: Building blocks for differentiated service delivery models for families

<table>
<thead>
<tr>
<th>CHILDREN</th>
<th>Eligibility: 2 yrs, on ART &gt;12 months, same ART regimen &gt;3 months, no current illnesses (incl. malnutrition), 1 VL &lt;1000 copies/ml in past 3 months, no adverse drug reactions requiring regular monitoring, caregiver orientated on importance of engaging in age appropriate disclosure process</th>
</tr>
</thead>
</table>
| When | ART refill*  
3-6 monthly $\pm$  
6 monthly |
| Where | Clinical consultation  
PHC/mobile outreach from PHC  
PHC/mobile outreach from PHC |
| Who | Lay provider (collection can be done by caregiver without child)  
Nurse |
| What | ART refill*  
Adherence check (caregiver report/self-assessment)  
Referral check (Is child well/coughing/TB in the household?)  
Age-appropriate disclosure support |
| | Clinical review per guidelines, including but not limited to: TB screen, adherence support & disclosure support  
Labs (VL annual or if not available CD4 6 monthly)  
Dosage check and possible adjustment  
Re-scripting (6-month script) |

$\pm$ Minimize delay caused if required to wait for 2 consecutive VLs in contexts where VLs being phased in or only carried out once a year or once every two years  
§ Promote the use of LPV/r pellets (as syrup has a 2-month shelf life)  
$\pm$ Consider timing to minimize school/work absences  
*Children over 2 years of age can be weighed at 6-monthly intervals
### ADOLESCENTS

**Eligibility:** Same as WHO recommendation for adults (>12 months on ART, no current illnesses, 2 consecutive VLs <1000 copies/mL or other measure of adherence, no adverse drug reactions that require more frequent clinical monitoring)

<table>
<thead>
<tr>
<th>ART refill</th>
<th>Clinical consultation</th>
<th>Psychosocial support</th>
</tr>
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<tbody>
<tr>
<td><strong>When</strong></td>
<td>3 monthly§±</td>
<td>6 monthly±</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>PHC/mobile outreach from PHC</td>
<td>PHC/mobile outreach from PHC</td>
</tr>
<tr>
<td><strong>Who</strong></td>
<td>Lay provider (collection can be done by treatment supporter/buddy without adolescent present)</td>
<td>Nurse*</td>
</tr>
<tr>
<td><strong>What</strong></td>
<td>ART refill</td>
<td>Clinical review, including psychosocial assessment Labs (VL annual or if not available CD4 6 monthly) Re-scripting (6-month script) Mental health assessment (annual) SRH assessment</td>
</tr>
</tbody>
</table>

I Psychosocial building blocks are also applicable to older children (7-10 years)
§ Aligned with family members until ready to be managed independently
± Consider timing to minimize school/work absences
* Staff who have undergone adolescent-friendly training/orientation and have mentorship

### PREGNANT AND BREASTFEEDING WOMEN

**Stable on ART when they become pregnant**

**Eligibility:** 1 VL <1000 copies/ml in past 3 months, provided they meet the WHO adult stable criteria and in DSD model prior to pregnancy may remain in DSD model for HIV care (and will receive ANC/PNC care in MCH model)

**Initiated on ART during pregnancy**

**Eligibility:** Same as WHO recommendation for adults (>12 months on ART, no current illnesses, 2 consecutive VLs <1000 copies/mL or other measure of adherence, no adverse drug reactions that require more frequent clinical monitoring) and 6-week PCR test for their infant

<table>
<thead>
<tr>
<th>ART refill</th>
<th>Clinical consultation</th>
</tr>
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<tbody>
<tr>
<td><strong>When</strong></td>
<td>3-6 monthly±</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>PHC, ANC/MCH service at PHC, out of facility</td>
</tr>
<tr>
<td><strong>Who</strong></td>
<td>Lay provider</td>
</tr>
</tbody>
</table>
| **What**             | ART refill
Adherence check
ANC/MCH attendance check | Clinical review per guidelines including TB screen Labs (VL annual or if not available CD4 6 monthly) Re-scripting (6-month script) |

± In facility, consider aligning with ANC/MCH visit
Any child, adolescent, pregnant or breastfeeding woman receiving care through a DSD ART delivery model should be referred for intensified care if they have:

- An acute intercurrent illness requiring more frequent clinical management, including but not limited to developing a co-morbidity or co-infection, an adverse drug reaction or malnutrition in children
- VL >1000 copies/ml
- Psychosocial related issue/s requiring more intense support/management

4. Key considerations for key populations

4.1. Experience to date

A background review stressed that key populations are underrepresented in the HIV response in general, including access to ART and across settings [4]. Criminalization, violence and stigma all act as barriers to accessing prevention, testing and treatment services. There are also important additional health needs – such as drug dependence, treatment for hepatitis B & C, sexually transmitted infections (STIs) and tuberculosis (TB), mental health disorders and experience of violence – that complicate care. The review was limited to 15 models that included ART delivery through key population community-based services. While in general the building blocks were less clearly described, there were examples of ART delivery for key populations that incorporated multi-month dispensing, fast-tracking of key populations within health services, dispensing at community sites, and integration of ART delivery with other essential needs (e.g., opioid substitution therapy).

Participants identified several organizations that apply a DSD approach to prevention, testing and adherence support services to key populations, such as intensive case management and peer navigation, community-based and lay provider testing, outreach and extended and flexible operating hours.

The consultation highlighted a number of country experiences in providing ART through DSD to key populations. In South Africa, a comprehensive package of interventions, including pre-exposure prophylaxis (PrEP) and ART, are provided to female sex workers through fixed facilities, as well as mobile and outreach services. These services are also provided during evenings and weekends.

In Tanzania, the Medically Assisted Therapy programme provides methadone for opioid dependent people and offers integrated services for the treatment and screening of HIV, TB and viral hepatitis for a total of 1375 clients. The programme has achieved high rates of retention on ART (79%), and more than three-quarters (76%) of clients are consistently drug free. In Thailand, community-led health services support the provision of treatment and care for men who have sex with men (MSM) and transgender (TG) persons. Lay providers provide more than 7000 HIV tests and 600 PrEP prescriptions each year. Other examples highlighted at the meeting included community-based
multi-month prescribing (2-3 months) for men who have sex with men, sex workers and transgender people in Uganda. Models of differentiated prevention, testing and adherence support were also discussed.

4.2. Outcomes from the consultation
The priority for key populations is to address low rates of access to services, particularly ART, and to increase retention in treatment. It was emphasized that ART provision should be integrated with prevention, testing and other health services. Efforts should be made to address stigma and discrimination in facility-based health care settings alongside improving capacity of key population community-based services to provide ART; this would increase the options available for key populations to access treatment. In addition, it was stressed that engagement with key stakeholders beyond the health services (e.g., police and correctional services) is critical.

The following good practices for service delivery for key populations were identified: strategic location of services; addressing a wider range of health and social needs; ensuring confidentiality and anonymity; community involvement, including defined and paid roles for peers; extending clinic operating hours; flexibility in timing and location of service provision; non-judgmental and friendly services; offering event-driven services; and increasing mobile services.

Eligibility criteria for DSD for key populations were considered to be essentially the same as for the general population, with certain recommendations for adapting existing models. The building blocks for differentiated service delivery models for key populations are summarized in Table 2.

Table 2: Building blocks for differentiated service delivery models for key populations

<table>
<thead>
<tr>
<th>Key populations</th>
<th>Eligibility: Same as general adult population</th>
</tr>
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<tbody>
<tr>
<td>When</td>
<td>For ART refills: Same as for general adult population. For clinical visits: Frequency may depend on clinical and psychosocial needs</td>
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<tr>
<td></td>
<td>• Increase the frequency: during times of drug use, risky sexual behaviour, frequent STI symptoms, and/or violence</td>
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<td></td>
<td>• Reduce the frequency: when enrolled in adherence support groups/clubs, if client has routine contact with a peer navigator</td>
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<tr>
<td>What</td>
<td>Comprehensive package of services (as per the WHO Key Populations Guidelines and tailored to the population served and the setting): Health sector interventions:</td>
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<tr>
<td></td>
<td>• HIV prevention: condoms, PrEP, PEP, voluntary male circumcision</td>
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<td></td>
<td>• Harm reduction for people who use drugs: needle/syringe programmes, opioid substitution therapy, psychosocial interventions, community distribution of naloxone</td>
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<tr>
<td></td>
<td>• HIV testing services</td>
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<tr>
<td></td>
<td>• ART and PMTCT</td>
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<tr>
<td></td>
<td>• Prevention and management of co-infections and co-morbidities (TB, hepatitis B and C, mental health disorders)</td>
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<tr>
<td></td>
<td>• Sexual and reproductive health services</td>
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<td></td>
<td>• Mental health services</td>
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Services should include a risk/vulnerability assessment. The package of services may include both facility- and community-based services inclusive of peer-led navigation, adherence counselling and referral moderated by risk assessment.

<table>
<thead>
<tr>
<th>Where</th>
<th>General</th>
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<tbody>
<tr>
<td></td>
<td>Quality services can be provided in facilities, in the community and at home visits</td>
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<td></td>
<td>Drop-in centres, opioid substitution therapy sites, mobile units, STI clinics; needle/syringe programmes</td>
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<td></td>
<td>“One-stop shop” providing a comprehensive package of services</td>
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<td></td>
<td>Prisons</td>
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<td>Exceptions for certain groups</td>
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<tr>
<td></td>
<td>Unstable patients, high viral load</td>
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<tr>
<td></td>
<td>Those with a need for specialized adherence support</td>
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<td></td>
<td>Consideration given to patients with co-morbidities</td>
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<tr>
<th>Who</th>
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<tr>
<td></td>
<td>Trained community-based cadre: peers, community health workers, KPLHIV supporter, buddies/other treatment supporters with appropriate phasing in of skills, supervision, remuneration</td>
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<td></td>
<td>Sensitized staff at facility-based services?</td>
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5. Monitoring & evaluation and research

5.1 Monitoring & evaluation
Details of an evaluation of DSD models from 30 sites in Malawi that was completed by the Clinton Health Access Initiative were shared, as well as thoughts around potential indicators for implementation of DSD. The take-home message was that existing data and indicators should be used for the monitoring of DSD. As required, systems will have to be modified in order to accommodate non-traditional service delivery sites (e.g., in the community) and service provision by non-clinician (e.g., lay health care workers)

5.2 Research
The consultation emphasized the need to distinguish between areas where more research is needed and areas where implementation should be encouraged. For example, many lessons learnt from clinically stable adult models can inform the design and implementation of models for other populations without the need for specific research. Where research is needed, care should be taken in the choice of appropriate study design, in particular with the selection of appropriate comparison groups. Specific examples where more data is needed to inform future policy and practice are: spacing of clinic visits/refills beyond current guidance (>6 months); community ART initiation; and interventions to improve care for unstable patients.

Randomized and non-randomized approaches to adaptive implementation can be used as a way to gather information while rolling out a model. Research should go beyond the assessment of clinical outcomes to consider the potential impact of DSD models on strengthening social capital and stigma reduction, as well as client and provider acceptability and cost (including the benefits of reducing service intensity for stable clients to the broader health system). It was also noted that the “science” of scale up should be better
understood. Finally, it was recognized that dissemination of research results should take into account the multiplicity of stakeholders, including outside the health sector.

6. Conclusion and next steps
While there are many examples of DSD for families and key populations across a range of settings, the key elements of the building blocks – When, Where, Who and What – vary considerably. In reviewing experience to date, participants of the DSD consultation were able to identify a set of minimum criteria that could apply to the different groups, including instances where criteria would have to go beyond the general adult population.

For DSD to succeed for any population, key enablers include ministry ownership, the involvement of trained and supported peer providers, prioritizing approaches that build on what is already in place, and implementing new approaches selectively and strategically to support sustainable scale up.

The key points identified during the consultation will serve as a basis to develop updated modules of the Decision Frameworks for Differentiated Service Delivery to support implementation and scale up of DSD models for families and key populations.

References
3. Differentiated service delivery for families - children, adolescents, and pregnant and breastfeeding women: A background review. Available at http://www.differentiatedcare.org
4. Differentiated service delivery for key populations - men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other people living in closed settings: A background review. Available at http://www.differentiatedcare.org
Annex 1: Consultation concept note and agenda

Consultation on HIV differentiated service delivery models for specific populations and settings:
Pregnant and breastfeeding women, children, adolescents and key populations
Geneva, 16-18 November 2016

Background
There is growing support for differentiated models of HIV care as a way to increase service efficiencies. Differentiated care is a client-centred approach that simplifies and adapts HIV services across the cascade in ways that both better serve the needs of people living with HIV (PLHIV) better and reduce unnecessary burdens on the health system. The most well-known differentiated care models have been for people who are stable on ART, encouraging less frequent clinic contact for people and a redirecting of health service intensity towards the management of people who are in need of clinical care. Differentiated care is promoted by the latest WHO consolidated ARV guidelines, and major donors, including PEPFAR and the Global Fund, have adopted differentiated care as policy in a number of countries.

Most evidence in support of differentiated ART delivery to date comes from pilot programmes for the stable, non-pregnant adult population in high-burden countries in sub-Saharan Africa. While WHO guidelines do not limit recommendations relating to differentiated care to this group, experience in implementation of previous recommendations of task shifting and decentralization to simplify service delivery suggests that guidance and attention is required for specific populations and settings where evidence and implementation experience are sparse. The role of differentiated care in specific settings, including in low-prevalence and concentrated epidemics, must be considered.

Further, the needs of specific populations, such as pregnant and breastfeeding women, adolescents and children, and key populations (men who have sex with men, sex workers and people who inject drugs, etc.) should be considered to ensure these groups also benefit from service adaptations. Moreover, the approach to delivering differentiated care may have to be distinct for pregnant and breastfeeding women, for children and adolescents and for key populations, taking into account specific clinical, developmental and social support needs.

Objectives
The objectives of this consultation are: to assess current evidence, policy and practice in applying inclusive differentiated service models for ART delivery to specific populations (pregnant and breastfeeding women, children, adolescents and key populations); and to assess how these might be implemented in different epidemic settings, including in low-prevalence and concentrated epidemics. The goal is to promote the application of differentiated care approaches to these groups, and to identify critical
evidence and implementation gaps in pursuit of this goal to better shape country-level guidance.

**Expected outcomes**
The following outcomes are anticipated:
- Shared understanding of differentiated service models for ART delivery and their application to specific populations: pregnant and breastfeeding women, children, adolescents and key populations
- Shared understanding of differentiated service models for ART delivery and their application to specific contexts, including in countries of low prevalence
- For each population and setting, define the specific elements that constitute the services that must be provided in a differentiated model of care
- Review the current *Decision Framework for ART delivery* and propose modifications of the elements to address the needs of children, pregnant and breastfeeding women, adolescents and key populations.
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<th>Time</th>
<th>Session</th>
<th>Chair/Presenter</th>
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<td>08.30-09.00</td>
<td>SESSION 1: Welcome and Introductions</td>
<td>Meg Doherty (WHO)</td>
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<td>09.00-10:00</td>
<td>SESSION 2: Background and Objectives</td>
<td>Anna Grimsrud (IAS) and Meg Doherty (WHO)</td>
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<tr>
<td></td>
<td>What is Differentiated Care?</td>
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<tr>
<td></td>
<td>What are the Objectives of this meeting</td>
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<td></td>
<td>Moderated discussion</td>
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<td>10.00-10.45</td>
<td>SESSION 3: Global Perspectives</td>
<td>Meg Doherty (WHO) &amp; Bob Ferris (USAID), Jeffry Acaba (Youth LEAD), Juliana Odindo (ICW), Ade Fakoya (GF), Peter Ehrenkranz (BMGF)</td>
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<tr>
<td></td>
<td>Moderator: Kevin Osborne</td>
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<td></td>
<td>- Policy Adoption and uptake</td>
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<td>- Client perspectives and expectations</td>
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<td>- Funders</td>
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<td>11:00-12:00</td>
<td>SESSION 4: Differentiated care for pregnant and breastfeeding women, children, and adolescents —what we know from the literature and country learning</td>
<td>Shaffiq Essajee &amp; Lynne Wilkinson</td>
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<td>Presentation of the background paper followed by moderated discussion</td>
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<td>12:00-13:00</td>
<td>SESSION 5: Differentiated care for key populations —what we know from the literature and country learning</td>
<td>Virginia MacDonald</td>
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<tr>
<td></td>
<td>Presentation of the background paper followed by moderated discussion</td>
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<tr>
<td>14:00-14:15</td>
<td>Overview of afternoon sessions</td>
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<tr>
<td></td>
<td>Group A: Malawi, Kenya, Zimbabwe, Brazil, Rwanda, Ukraine, Ethiopia, Indonesia, India, Botswana</td>
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<td>Group B: South Africa, Tanzania, Thailand, Cameroon, Mozambique, Malaysia, Uganda, Pakistan, Kazakhstan, Swaziland</td>
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<td></td>
<td>Chair: Frances Cowan</td>
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<td>Rapporteur: Shaffiq Essajee</td>
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<td>14:15-15:45</td>
<td>SESSION 6B: Group B – Part 1: Differentiated care for key populations</td>
<td>Hasina Subedar, South Africa Yusuf Mzitto, Tanzania Praphan Phanuphak, Thailand Bithia Keseh, Cameroon Joselyn Pang, Malaysia</td>
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<td>Chair: Aleny Couto</td>
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<td>Rapporteur: Cameron Wolf and Tisha Wheeler</td>
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<td>15:45-16:00</td>
<td>Tea Break</td>
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<tr>
<td>16:00-17:30</td>
<td>SESSION 7A: Group A - Part 2: Differentiated care for key populations</td>
<td>Bernardo Montessanti, Brazil Pavlov Smyrnov, Ukraine Frances Cowan, Zimbabwe Chris Akolo, Malawi</td>
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<td>Chair: Juliana Odindo</td>
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<td>Rapporteur: Virginia MacDonald</td>
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<tr>
<td>16:00-</td>
<td>SESSION 7B: Group B – Part 2:</td>
<td>Lynne Wilkinson, South Africa</td>
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<td>17:30-17:45</td>
<td><strong>Differentiated care for families</strong>&lt;br&gt;Chair: Hasina Subedar&lt;br&gt;Rapporteur: Anna Grimsrud</td>
<td>Mercy Minde, Tanzania&lt;br&gt;Aleny Couto, Mozambique&lt;br&gt;Anita Bt Suleiman, Malaysia</td>
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<tr>
<td>18:00-19:30</td>
<td><strong>Regroup and instructions for day 2</strong>&lt;br&gt;Nathan Ford</td>
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**DAY 2 : CHAIRS Laura Broyles and Gift Trapence**

<table>
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<tr>
<th>Time</th>
<th>Session</th>
<th>Chair/Contact Person</th>
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<tr>
<td>09:00-10:00</td>
<td><strong>Readout from Day #1 breakout sessions</strong>&lt;br&gt;• DSD models discussed&lt;br&gt;• Common themes emerging&lt;br&gt;• Areas where there are gaps&lt;br&gt;• Discussion</td>
<td>Rapporteurs from Day 1 breakout sessions&lt;br&gt;Tisha Wheeler, Shaffiq Essajee, Anna Grimsrud</td>
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<tr>
<td>10:00-11:20</td>
<td><strong>SESSION 8: Plenary Session 1</strong>&lt;br&gt;Perspectives from implementing partners on differentiated care as applied to specific populations and settings&lt;br&gt;Moderated by Anouk Amzel and Laura Broyles</td>
<td>Jen Cohn, EGPAF&lt;br&gt;Miriam Rabkin, ICAP&lt;br&gt;Maria Kim, Baylor&lt;br&gt;Bernard Etukoit, TASO&lt;br&gt;Stephanie Thomas, Zoe Life&lt;br&gt;Tom Ellman, MSF</td>
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<td>11:20-11:35</td>
<td><strong>Coffee Break</strong></td>
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<td>11:35-12:55</td>
<td><strong>SESSION 9: Plenary Session 2 – Perspectives on differentiated care from clients who use services</strong>&lt;br&gt;Moderated by: Cameron Wolf and Hally Mahler</td>
<td>Hally Mahler, LINKAGES&lt;br&gt;Surang Janyam, SWING&lt;br&gt;Abhina Aher, HIV/AIDS Alliance&lt;br&gt;Gift Trapence, CEDEP&lt;br&gt;Judy Chang, INPUD&lt;br&gt;Dorothy Ogutu ASWA</td>
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<td>12:55-13:00</td>
<td><strong>Overview of how the afternoon sessions will work</strong>&lt;br&gt;Anna Grimsrud</td>
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<td>13:00-14:00</td>
<td><strong>Lunch</strong></td>
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<td>14:00-15:30</td>
<td><strong>SESSION 10A: Group 1 Key considerations in applying a differentiated care approach for key populations</strong>&lt;br&gt;• MSM&lt;br&gt;• SW&lt;br&gt;• PWID&lt;br&gt;• TG&lt;br&gt;• Prisoners</td>
<td>Chair: Trista Bingham&lt;br&gt;Rapporteurs: Cameron Wolf, Tisha Wheeler and Virginia MacDonald</td>
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<td>14:00-15:30</td>
<td><strong>SESSION 10B: Group 2 Key considerations in applying a differentiated care approach for women, children and adolescents</strong>&lt;br&gt;• CLHIV&lt;br&gt;• ALHIV&lt;br&gt;• HIV+ pregnant &amp; breastfeeding women</td>
<td>Chair: Nathan Ford&lt;br&gt;Rapporteurs: Shaffiq Essajee, Anna Grimsrud, Lynne Wilkinson</td>
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<tr>
<td>15:30-15:45</td>
<td><strong>Break</strong></td>
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<td>15:30-17:00</td>
<td><strong>Report back from groups</strong>&lt;br&gt;Rapporteurs from both day 2 breakout sessions</td>
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<tr>
<td>17:30-17:45</td>
<td>Regroup and instructions for Day 3</td>
<td>Anna Grimsrud</td>
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<tr>
<td>9:00-10:30</td>
<td>SESSION 11: Report back from Day 2 afternoon discussions</td>
<td>Dan Levitt, Stefanie Kandasami, Chris Akolo, Hasina Subedar, Lynne Wilkinson</td>
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<td>10:30-11:00</td>
<td>Break</td>
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<tr>
<td>11:00-12:45</td>
<td>SESSION 12: Next steps and future discussions</td>
<td>Herb Harwell, David Sullivan, Jen Cohn, Nathan Ford, Kevin Osborne</td>
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<td>- Monitoring &amp; evaluation of Differentiated Service Delivery</td>
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<td>- Research agenda for differentiated service delivery</td>
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<td>- Future modules of the Decision Framework</td>
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<tr>
<td>12:45-13:00</td>
<td>SESSION 13: Closing remarks</td>
<td>Abhina Aher, Shannine Mushonga, Gottfried Hirnschall</td>
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<tr>
<td>13:00</td>
<td>Lunch</td>
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# Annex 2: List of participants

**Consultation on HIV differentiated service delivery models for specific populations and settings: Pregnant and breastfeeding women, children, adolescents, and key populations and epidemic settings**  
16-18 November 2016  
Geneva, Switzerland

**LIST OF PARTICIPANTS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization and Location</th>
<th>Email Address</th>
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<tbody>
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