

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

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules>).

Suggested citation. [Title]. [Place of publication]: World Health Organization; [Year].
Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Table of contents

1. Introduction	1
2. Meeting objectives	1
Figure 1: The building blocks of DSD	2
3. Key considerations for families	2
3.1. Experience to date.....	2
3.2. Outcomes from the consultation.....	3
Table 1: Building blocks for differentiated service delivery models for families.....	4
4. Key considerations for key populations	6
4.1. Experience to date.....	6
4.2. Outcomes from the consultation.....	7
Table 2: Building blocks for differentiated service delivery models for key populations.....	7
5. Monitoring & evaluation and research	8
5.1 Monitoring & evaluation.....	8
5.2 Research	8
6. Conclusion and next steps	9
Annex 1: Consultation concept note and agenda.....	10
Annex 2: List of participants.....	15

Acronyms

ANC	Antenatal care
ART	Antiretroviral therapy
DSD	Differentiated service delivery
HCW	Health care workers
HIV	Human immunodeficiency virus
KPLHIV	Key populations living with HIV
LPV/r	Lopinavir/ritonavir
MCH	Maternal and child health
MSM	Men who have sex with men
OI	Opportunistic infection
PCR	Polymerase chain reaction
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHC	Primary health clinic
PLHIV	People living with HIV
PNC	Prenatal care
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SMS	Short-messaging system
SRH	Sexual and reproductive health
STI	Sexually transmitted diseases
TB	Tuberculosis
TG	Transgender
VL	Viral load
WHO	World Health Organization

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.

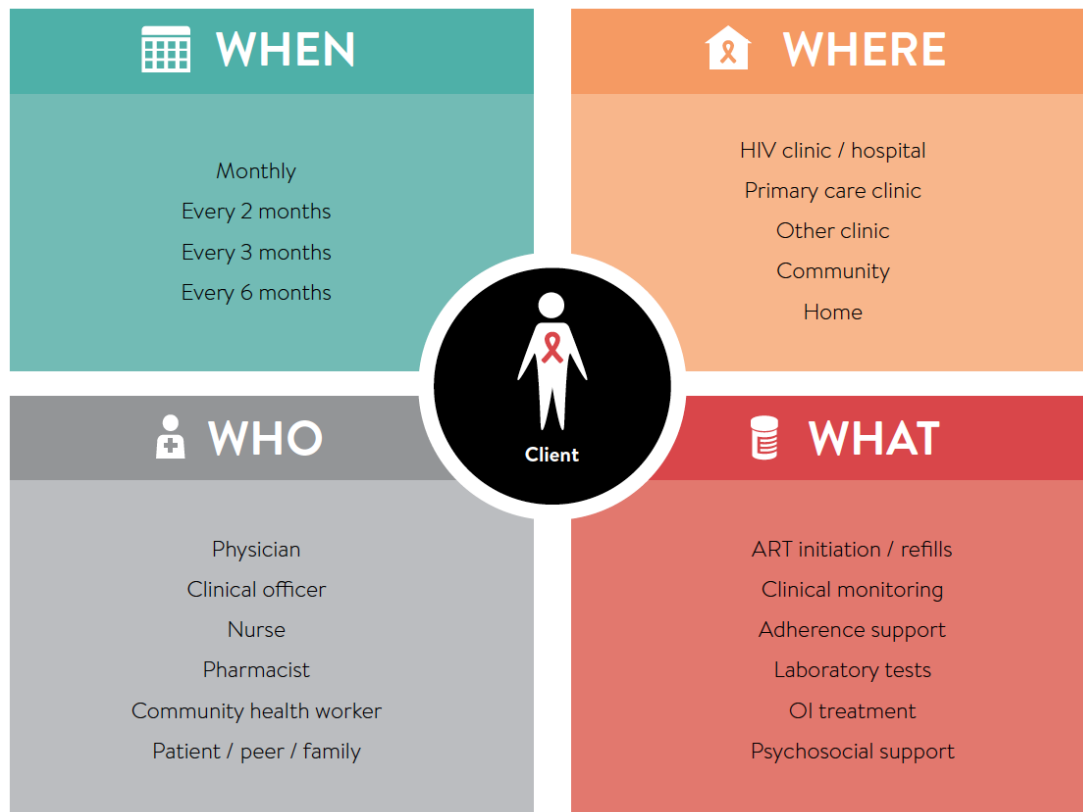
2. Meeting objectives

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

CHILDREN		
Eligibility: 2 yrs, on ART >12 months, same ART regimen >3 months, no current illnesses (incl. malnutrition), 1 VL <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		
	ART refill	Clinical consultation
When	3-6 monthly§±	6 monthly
Where	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)

† 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)

± 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)			
	ART refill	Clinical consultation	Psychosocial support†
When	3 monthly§±	6 monthly±	Monthly
Where	PHC/mobile outreach from PHC	PHC/mobile outreach from PHC	PHC or out of facility (community or home) or virtual environment
Who	Lay provider (collection can be done by treatment supporter/buddy without adolescent present)	Nurse*	Young person/adolescents PLHIV (preferably)
What	ART refill	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	Peer/peer group supportive environment (e.g., support group or virtual chat group or SMS support) Red flag screening for referral to facility

† 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		
	ART refill	Clinical consultation
When	3-6 monthly±	6 monthly±
Where	PHC, ANC/MCH service at PHC, out of facility	PHC/mobile outreach from PHC
Who	Lay provider	Nurse/midwife
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

Key populations	
Eligibility: Same as general adult population	
When	For ART refills: Same as for general adult population. For clinical visits: Frequency may depend on clinical and psychosocial needs <ul style="list-style-type: none"> • Increase the frequency: during times of drug use, risky sexual behaviour, frequent STI symptoms, and/or violence • Reduce the frequency: when enrolled in adherence support groups/clubs, if client has routine contact with a peer navigator
What	Comprehensive package of services (as per the WHO Key Populations Guidelines and tailored to the population served and the setting): Health sector interventions: <ul style="list-style-type: none"> • HIV prevention: condoms, PrEP, PEP, voluntary male circumcision • Harm reduction for people who use drugs: needle/syringe programmes, opioid substitution therapy, psychosocial interventions, community distribution of naloxone • HIV testing services • ART and PMTCT • Prevention and management of co-infections and co-morbidities (TB, hepatitis B and C, mental health disorders) • Sexual and reproductive health services • Mental health services

	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.
Where	<p>General</p> <ul style="list-style-type: none"> • Quality services can be provided in facilities, in the community and at home visits • Drop-in centres, opioid substitution therapy sites, mobile units, STI clinics; needle/syringe programmes • “One-stop shop” providing a comprehensive package of services • Prisons <p>Exceptions for certain groups</p> <ul style="list-style-type: none"> • Unstable patients, high viral load • Those with a need for specialized adherence support • Consideration given to patients with co-morbidities
Who	<ul style="list-style-type: none"> • Trained community-based cadre: peers, community health workers, KPLHIV supporter, buddies/other treatment supporters with appropriate phasing in of skills, supervision, remuneration • Sensitized staff at facility-based services?

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

1. World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach. WHO, Geneva: 2nd Edition. 2016.
2. Differentiated care for HIV. A Decision Framework for antiretroviral therapy delivery. Available at <http://www.differentiatedcare.org>
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.

Agenda

DAY 1 : CHAIRS Tsitsi Apollo and Peter Ehrenkranz		
08.30-09.00	SESSION 1: Welcome and Introductions	Meg Doherty (WHO)
09.00-10:00	SESSION 2: Background and Objectives – What is Differentiated Care? – What are the Objectives of this meeting – Moderated discussion	Anna Grimsrud (IAS) Meg Doherty (WHO)
10.00-10.45	SESSION 3: Global Perspectives Moderator: Kevin Osborne - Policy Adoption and uptake - Client perspectives and expectations - Funders	Meg Doherty (WHO) & Bob Ferris (USAID), Jeffry Acaba (Youth LEAD), Juliana Odindo (ICW) Ade Fakoya (GF), Peter Ehrenkranz (BMGF)
10:45-11:00	Coffee Break	
11:00-12:00	SESSION 4: Differentiated care for pregnant and breastfeeding women, children, and adolescents —what we know from the literature and country learning Presentation of the background paper followed by moderated discussion	Shaffiq Essajee & Lynne Wilkinson
12:00-13:00	SESSION 5: Differentiated care for key populations —what we know from the literature and country learning Presentation of the background paper followed by moderated discussion	Virginia MacDonald
13:00-14:00	Lunch	
14:00-14:15	Overview of afternoon sessions Group A: <i>Malawi, Kenya, Zimbabwe, Brazil, Rwanda, Ukraine, Ethiopia, Indonesia, India, Botswana</i> Group B: <i>South Africa, Tanzania, Thailand, Cameroon, Mozambique, Malaysia, Uganda, Pakistan, Kazakhstan, Swaziland</i>	
14:15-15:45	SESSION 6A: Group A – Part 1: Differentiated care for families Chair: Frances Cowan Rapporteur: Shaffiq Essajee	Stanley Ngoma, Malawi Tsitsi Apollo, Zimbabwe Shannie Mushonga & Nicola Willis, Zimbabwe Sabin Nsanzimana, Rwanda
14:15-15:45	SESSION 6B: Group B – Part 1: Differentiated care for key populations Chair: Aleny Couto Rapporteur: Cameron Wolf and Tisha Wheeler	Hasina Subedar, South Africa Yusuf Mzitto, Tanzania Praphan Phanuphak, Thailand Bithia Keseh, Cameroon Joselyn Pang, Malaysia
15:45-16:00	Tea Break	
16:00-17:30	SESSION 7A: Group A - Part 2: Differentiated care for key populations Chair: Juliana Odindo Rapporteur: Virginia MacDonald	Bernardo Montessanti, Brazil Pavlov Smyrnov, Ukraine Frances Cowan, Zimbabwe Chris Akolo, Malawi
16:00-	SESSION 7B: Group B – Part 2:	Lynne Wilkinson, South Africa

17:30	Differentiated care for families Chair: Hasina Subedar Rapporteur: Anna Grimsrud	Mercy Minde, Tanzania Aleny Couto, Mozambique Anita Bt Suleiman, Malaysia
17:30-17:45	Regroup and instructions for day 2	Nathan Ford
18:00-19:30	Reception	

DAY 2 : CHAIRS Laura Broyles and Gift Trapence

09:00-10:00	Readout from Day #1 breakout sessions <ul style="list-style-type: none"> • DSD models discussed • Common themes emerging • Areas where there are gaps • Discussion 	Rapporteurs from Day 1 breakout sessions Tisha Wheeler, Shaffiq Essajee, Anna Grimsrud
10:00-11:20	SESSION 8: Plenary Session 1 Perspectives from implementing partners on differentiated care as applied to specific populations and settings Moderated by Anouk Amzel and Laura Broyles	Jen Cohn, EGPAF Miriam Rabkin, ICAP Maria Kim, Baylor Bernard Etukoit, TASO Stephanie Thomas, Zoe Life Tom Ellman, MSF
11:20-11:35	Coffee Break	
11:35-12:55	SESSION 9: Plenary Session 2 – Perspectives on differentiated care from clients who use services Moderated by: Cameron Wolf and Hally Mahler	Hally Mahler, LINKAGES Surang Janyam, SWING Abhina Aher, HIV/AIDS Alliance Gift Trapence , CEDEP Judy Chang, INPUD Dorothy Ogutu ASWA
12:55-13:00	Overview of how the afternoon sessions will work	Anna Grimsrud
13:00-14:00	Lunch	
14:00-15:30	SESSION 10A: Group 1 Key considerations in applying a differentiated care approach for key populations <ul style="list-style-type: none"> • MSM • SW • PWID • TG • Prisoners 	Chair: Trista Bingham Rapporteurs: Cameron Wolf, Tisha Wheeler and Virginia MacDonald
14:00-15:30	SESSION 10B: Group 2 Key considerations in applying a differentiated care approach for women, children and adolescents <ul style="list-style-type: none"> • CLHIV • ALHIV • HIV+ pregnant & breastfeeding women 	Chair: Nathan Ford Rapporteurs: Shaffiq Essajee, Anna Grimsrud, Lynne Wilkinson
15:30-15:45	Break	
15:30-17:00	Report back from groups	Rapporteurs from both day 2 breakout sessions

17:30-17:45	Regroup and instructions for Day 3	Anna Grimsrud
-------------	------------------------------------	---------------

DAY 3 : CHAIRS Tom Ellman and Joslyn Pang

9:00-10:30	SESSION 11: Report back from Day 2 afternoon discussions	Dan Levitt, Stefanie Kandasami, Chris Akolo, Hasina Subedar, Lynne Wilkinson
10:30-11:00	Break	
11:00-12:45	SESSION 12: Next steps and future discussions <ul style="list-style-type: none"> • Monitoring & evaluation of Differentiated Service Delivery • Research agenda for differentiated service delivery • Future modules of the Decision Framework 	Herb Harwell, David Sullivan, Jen Cohn Nathan Ford Kevin Osborne
12:45-13:00	SESSION 13: Closing remarks	Abhina Aher, Shannine Mushonga, Gottfried Hirschall
13:00	Lunch	

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

Bernardo Montessanti
Municipal Health Secretariat in Curitiba
Brazil
Email:
bernalmeida@sms.curitiba.pr.gov.br

Dan Levitt
CARE
Cameroon
Email: daniel_levitt@me.com

Raoul Fransen dos Santos
Global Network for and by People Living
with HIV (GNP+)
Netherlands
Email: rf@icssupport.org

Gloria Anyalechi
Centers for Diseases Control and
Prevention
USA
Email: iyo8@cdc.gov

Juliana Odindo
International Community of Women with
HIV/AIDS (ICW)
Kenya
Email: julianaodindo@yahoo.com

Stanley Ngoma
Ministry of Health
Malawi
Email: ngomastanley4@gmail.com

Melchiade Ruberintwari
FHI 360, Linkages Across the Continuum
of HIV Services for Key Populations
(LINKAGES)
Malawi
Email: Mruberintwari@fhi360.org

Maria Kim
Baylor College of Medicine
Malawi
Email: mariakim77@gmail.com

Gift Trapence
Centre for the Development of People
(CEDEP)
Malawi
Email: gtrapence@yahoo.co.uk

Aleny Couto
Ministry of Health
Mozambique
Email: gtrapence@yahoo.co.uk

Sabin Nsanzimana
Ministry of Health
Rwanda
Email: nsabinco@gmail.com

Anna Grimsrud
International AIDS Society (IAS)
South Africa
Email: anna.grimsrud@iasociety.org

Tom Ellman
Médecins San Frontières (MSF)



World Health Organization

South Africa
Email: Tom.Ellman@joburg.msf.org

Hasina Subedar
Department of Health
South Africa
Email: hasinasubedar@outlook.com

Lynne Wilkinson
Médecins Sans Frontières (MSF)
South Africa
Email: lynne.susan.wilkinson@gmail.com

Pumeza Runeyi
Médecins Sans Frontières (MSF)
South Africa
Email: msfocb-khayelitsha
youth@brussels.msf.org

Stephanie Thomas
Zoe Life
South Africa
Email: stephanie@zoe-life.co.za

Tara Mansell
International AIDS Society (IAS)
Switzerland
Email: tara.mansell@iasociety.org

Ade Fakoya
Global Fund to Fight AIDS, TB and
Malaria
(GFATM)
Switzerland
Email: Ade.Fakoya@theglobalfund.org

Jen Cohn
Elizabeth Glaser Pediatric AIDS
Foundation (EGPAF)
USA
Email: jcohn@pedaids.org

Yusuf Mzitto

MEFADA
Tanzania
Email: yusufmzitto@gmail.com

Elizabeth Ndakidemi
Tanzania Youth Alliance (TAYOA)
Tanzania
Email: ndakidemi@tayoa.org

Albert Komba
Sauti
Tanzania
Email: albert.komba@jhpiego.org

Mercy Minde
Baylor College of Medicine Children's
Foundation
Tanzania
Email: mminde@baylortanzania.or.tz

Jeffrey Acaba
Youth LEAD
Thailand
Email: jeff@youth-lead.org

Praphan Phanuphak
Thai Red Cross
Thailand
Email: Praphan.P@chula.ac.th

James Kisambu
Uganda Prison Service
Uganda
Email: drkisambu@gmail.com

Pablo Smyrnov
Alliance for Public Health
Ukraine
Email: Smyrnov@aph.org.ua

Anouk Amzel
USAID
USA
Email: aamzel@usaid.gov

Cameron Wolf



World Health Organization

USAID
USA

Email: cwolf@usaid.gov

Judite Langa
Centers for Diseases Control and
Prevention
Mozambique
Email: hoo2@cdc.gov

Robert Ferris
USAID
USA
Email: rferris@usaid.gov

Laura Broyles
Centers for Diseases Control and
Prevention
USA
Email: zjt5@cdc.gov

Trista Bingham
Centers for Diseases Control and
Prevention
USA
Email: tub9@cdc.gov

Peter Ehrenkranz
Bill and Melinda Gates Foundation
USA
Email:
Peter.Ehrenkranz@gatesfoundation.org

Herb Harwell
Clinton Health Access Initiative (CHAI)
USA
Email: Joseph_Harwell_MD@brown.edu

Gina Dallabetta
Bill and Melinda Gates Foundation
USA
Email:
gina.dallabetta@gatesfoundation.org

Tsitsilina Apollo
Ministry of Health and Child Care
Zimbabwe
Email: tsitsiapollo1@gmail.com

Frances Cowan
Centre for Sexual Health HIV and AIDS
Research (CeSHHAR)
Zimbabwe
Email: francesmcowan@yahoo.co.uk

Nicola Willis
Africaid Zvandiri
Zimbabwe
Email: nicola@zvandiri.org

Shanine Mushonga
Africaid Zvandiri
Zimbabwe
Email: xaa9med@gmail.com

Chris Akolo
FHI 360, Linkages Across the Continuum
of HIV Services for Key Populations
(LINKAGES)
USA
Email: cakolo@fhi360.org

Miriam Rabkin
ICAP at Columbia Univeristy
USA
Email: mr84@cumc.columbia.edu

Hally Mahler
FHI 360, Linkages Across the Continuum of
HIV Services for Key Populations
(LINKAGES)
USA
Email: hmahler@fhi360.org

Alice Armstrong
Consultant
South Africa
Email: armstronga@who.int

Anna Deryabina
ICAP at Columbia University
Kazakhstan
Email: annaderyabina@icap.kz

Joselyn Pang
Malaysia AIDS Council
Malaysia
Email: joselyn@mac.org.my

Qasim Iqbal Khawaja
Naz Male Health Alliance
Pakistan
Email: qasim.iqbal@nmha.org.pk

Carlo Andre Oliveras Rodriques
International AIDS Society (IAS)
Puerto Rico
Email: carlo.oliveras@iasociety.org

Bernard Michael Etukoit
The AIDS Support Organization (TASO)
Kenya
Email: Etukoitm@TASOUGANDA.ORG

Kevin Osborne
International AIDS Society (IAS)
Switzerland
Email: kevin.osborne@iasociety.org

HIV/AIDS Alliance
India
Email: aaher@allianceindia.org

Bithia Keseh
Cameroon Medical Women Association
(CMWA)
Cameroon
Email: c/o ndonko.carecameroun@gmail.com

Annette Reinisch
Global Fund to Fight AIDS, TB and Malaria
(GFATM)
Switzerland
Email: Annette.Reinisch@theglobalfund.org

Surang Janyam
Service Workers IN Group Foundation
(SWING)
Thailand
Email: surangjanyam@yahoo.com

Peter Preko
ICAP at Columbia University
Swaziland
Email: prekopo@gmail.com

Wame Dikobe
FHI 360, Linkages Across the Continuum of
HIV Services for Key Populations
(LINKAGES)
Botswana
Email: wdikobe@fhi360.org

Caspian Chouraya
Elizabeth Glaser Pediatric AIDS Foundation
(EGPAF)
Email: cchouraya@pedaids.org;

Yaroslava Lopatina
AIDS Healthcare Foundation
Ukraine
Email: Yaroslava.Lopatina@aidhealth.org

Steve Wignall
FHI 360
Indonesia
Email: SWignall@fhi360.org

Stephanie Kandasami
Global Fund to Fight AIDS, TB and Malaria
(GFATM)
Switzerland
Email: Stephanie.Kandasami@theglobalfund.org

WHO Secretariat

Rachel Baggaley
Coordinator, Key Populations & Innovative Prevention
Department of HIV/AIDS
Email: rbaggaley@who.int

Meg Doherty
Coordinator, Treatment and Care
Department of HIV/AIDS
Email: dohertym@who.int

Shaffiq Essajee
Treatment and Care
Department of HIV/AIDS
Email: essajees@who.int

Nathan Ford
Treatment and Care
Department of HIV/AIDS
Email: fordn@who.int

Virginia MacDonald
Key Populations & Innovative Prevention
Department of HIV/AIDS
Email: macdonaldv@who.int

Annette Verster
Key Populations & Innovative Prevention
Department of HIV/AIDS
Email: verstera@who.int