CONSENSUS CONFERENCE TECHNICAL REPORT ON **THE ROLE OF OVC PROGRAMS SUPPORTED BY PEPFAR IN EXTENDING ACCESS TO HIV TESTING SERVICES: RATIONALE, GENERAL CONSIDERATIONS AND MOST IMMEDIATE ACTIONS**

OVC Technical Working Group in collaboration with the following TWGs:

Pediatric and Adolescent Care and Treatment,

HIV Testing Services and Pregnant and Breastfeeding Women

November, 2016

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A. Background and rationale

The essential steps in the continuum of HIV care include: Identifying which children and adolescents who need HIV testing, providing access to HIV testing, and linking infected children and adolescents to HIV treatment. Despite the great success in scaling up treatment for people living with HIV (PLHIV) in resource-limited settings (RLS), children and adolescents are easily left behind with no access to life-saving treatment. Without treatment, only 50% of children survive until their 2nd year of life and by 5 years 80% have died. Furthermore, children whose status *is* known are not always reliably linked to treatment in a timely manner, nor are they successfully retained in treatment and may not achieve virologic suppression rates comparable to those for adults. To achieve the UNAIDS 90-90-90 goals for children and adolescents by 2020 there is an urgent need to expand case finding and treatment access.

Improved HIV case finding for children and adolescents through implementation of routine, systematic linkages to HIV testing and counseling (HTC) and treatment services, is a priority for PEPFAR and key to successfully reach the UNAIDS 90-90-90 goals for epidemic control.

Like adults, children and adolescents living with HIV face a multitude of practical barriers in accessing HIV treatment and achieving viral suppression, but they are perhaps even more constrained due to a range of both household-level and societal barriers and their reliance on caregivers. Furthermore,-HIV infection in children and adolescents has specific characteristics for both diagnosis and treatment, requiring differentiated approaches to care depending on whether they acquired the infection via vertical or horizontal transmission, and if suspected at birth, during early or middle childhood, or later in life during adolescence (e.g. Long-term-non-progressors or sexually acquired infection).

Orphan and vulnerable children (OVC) programs, through their community presence and strong relationship and rapport with households (i.e., caregivers and children), are uniquely positioned to promote and facilitate successful entry and retention across the entire HIV care and treatment cascade through provision of family-centered, age-appropriate interventions and approaches**.** OVC programs have an extensive history of building HIV-competent communities[1] that protect children/adolescents through building awareness and improving self-management of child protection threats and solutions, increased male involvement in parenting and child health, eliminating stigma and discrimination and providing social support to HIV-positive children and their families. With guidance and working closely with health facilities and other partners, they can become a platform to assume an expanded role in HIV epidemic control as new models of service delivery are put in place. Working alongside other community cadres (adherence supporters, community health volunteers and others), the OVC workforce can be leveraged to ensure a focus on children and adolescents that is HIV-sensitive and engages the entire family in providing a safe, nurturing environment.

[1] Nhamo, M., Campbell, C., & Gregson, S. (2010). Obstacles to local-level AIDS competence in rural Zimbabwe: putting HIV prevention in context. AIDS Care, 22(Supp 2), 1662-1669.)

Orphans and vulnerable children are at increased risk for HIV infection. In alignment with PEPFAR's Technical Considerations for COP/ROP, all individually registered OVC beneficiaries should be screened for HIV risk by a trained provider, and if indicated linked to HIV testing services as soon as possible.

Our collective mandate is to:

a) Ensure access to testing for 100% of HIV-exposed infants, children and adolescents, and promptly link all positive children and adolescents to treatment.

b) Identify all children aged 0–17 years with known HIV infection and ensure they are linked to treatment services.

Fulfilling this mandate requires an **"all hands-on deck"** approach to building awareness about and facilitating access to HIV testing of children/adolescents, helping parents and caregivers overcome fears and resistance to testing their children, assisting with psychosocial and age-appropriate disclosure support, and facilitating access to appropriate HIV-related services. Balanced, inclusive and ethically-sound approaches that mitigate the potential for harm, stigma, and discrimination of HIV-affected children/adolescents and families that also ensure access to needed services are critical.

In the next year, OVC programs are asked to redouble their efforts to apply community-based, non-stigmatizing approaches to identify highly vulnerable children and families in need of HIV-related services. This effort will complement those put in place at facilities to identify most vulnerable children and families and help better capture the broad population of OVC in a country.

The role of OVC and Care and Treatment programs in improving the outcomes for HIV infected and affected infants, children/adolescents and their families

The multi-dimensional approach of OVC programs (integrating nutrition, education, economic strengthening, and child protection) can be used to expand the reach and effectiveness of HIV services. Household-based, family-centered approaches provide opportunities to promote and facilitate testing, support treatment retention and address adherence issues not only among children and adolescents but also for caregivers/parents and other household members, including hard-to-reach males. Scaling-up community-based testing of OVCs could potentially reduce congestion in facilities where HTS is offered while increasing the coverage of these services for specific populations. Studies and programs that have used the approach of community based testing or home-based testing have been acceptable in a variety of settings and have been successful in reaching specific groups that would be otherwise hard to reach. However, these approaches have not been systematically put in place and available data comes from pilots or special projects. Implementation of this type of approach will need to be carefully planned to make sure that community-based providers are well

trained and can appropriately provide all other OVC specific services. In the immediate term, however, OVC programs can and should identify families and children in need of HIV testing (i.e. those without a known HIV status) and ensure that they reach testing services in nearby facilities.

Recognizing that the family is the primary unit of intervention,[2] OVC programs do not singularly target any child within the family without considering the needs of other siblings/children as well as the needs of primary caregivers at the household level. Expanding child-focused, family-centered service delivery approaches will ensure that high-risk family members also become aware of their status and receive subsequent support.

Similarly, facility-based HIV care and treatment programs need to identify/assess and refer HIV-affected caregivers and children in need of OVC services that ultimately may address the non-health barriers to health care and increase retention and adherence to HIV services for these families. To fully realize the potential inherent in a unified approach, mutually reinforcing relationships between facility and community-based services should be forged, mapped and mandated (through government and PEFPAR/donor support), and the contribution of OVC programs to the full cascade of services that support achievement of the UNAIDS 90-90-90 goals should be acknowledged/documented/studied.

As OVC programs embark on planning processes to support a renewed effort to address PEPFAR and UNAIDS goals for testing and treatment, field implementers expressed the need for increased clarity about their roles and priority actions. A consultation was convened in Washington, DC on February 3-4, 2016 to discuss how to build upon, strengthen and identify opportunities that can utilize OVC programming platforms and interventions to promote and facilitate HIV testing and services (HTS) efforts targeting children/adolescents and their caregivers. The meeting drew representatives from different PEPFAR technical working groups representing children and the HIV continuum as well as members of the USAID 4Children project and civil society (see Annexes 1 and 2 for agenda and list of participants).

Objectives

1. Illustrate how OVC programs, working with clinical programs can help expand HIV testing services for children and their families

2. Highlight important opportunities to ensure testing for children from birth through adolescence by:

    a) Educating families on the importance of HIV testing and treatment, the significant gains of pediatric/adolescent treatment, the role of the HIV-infected parents in securing access to life-saving services for their children.

    b) Facilitating access to HIV testing services in nearby facilities, in relevant community settings, at CBO headquarters and/or in the household;

[2] PEPFAR (2012) Guidance for OVC Programming

c) Work with clinical facilities to ensure that family members of people enrolled in care or on ART have received testing services and have been linked to needed treatment (e.g.: Complete family testing trees).

d) Document/study various HIV screening approaches, yield and effectiveness.

Audience

The intended audience for this document are PEPFAR OVC, Care and Treatment (Adult, PMTCT and Pediatric) and HTS focal points, and implementing partners. The document has been designed to support Country Operational Plan (COP) planning processes as well as provide information and practical suggestions for how OVC and clinical programming for children/adolescents can best respond to and create stronger linkages with existing HTS platforms and activities.

The following twelve operational considerations and suggested actions were put forth during the February 2016 consensus conference workshop.

TABLE 1: CONSIDERATIONS AT A GLANCE

Reduce Barriers and Build Demand for Pediatric HIV Testing and Treatment through OVC Programs
1. Ensure that OVC programs are HIV-sensitive and that staff and the community-based workforce are HIV-knowledgeable.
2. Leverage the OVC platform to create an enabling environment in communities that promotes HIV testing services (HTS), disclosure and successful linkage to care and treatment.
3. Leverage the existing rapport between the OVC worker and the household to ensure that all members of the OVC family/household are encouraged to know their HIV status.
Target & Prioritize among OVC Populations
4. OVC programs should actively facilitate HIV testing, including outside of the facility setting, when appropriate
Establishing Data-driven Plans for OVC Program Contributions to HTS
5. Prioritize children exhibiting *any* risk factors for immediate testing but plan to screen all for risk and refer for testing as appropriate
6. Develop plans for testing OVC beneficiaries in collaboration with adult, pediatrics, HTS, and Supply Chain Management (SCM) teams to ensure human resources and supply chain implications are understood. 7. Establish a confidential record keeping protocol for documenting HIV status of OVC beneficiaries and report OVC_HIVSTAT semi-annually.

Coordinate Service Provision between OVC Programs and HTS
8. Foster a coordinated "one team" approach, bringing health and social service approaches together through a clear understanding of their specific roles and responsibilities in addressing the multiple needs of the caregivers and children living with or affected by HIV.
9. Establish coordinated case management tools, structures and systems that bridge facility- and community-based care.
Protect the Best Interests of the Child
10. Ensure that all efforts to bring children to HIV testing derive from strict adherence to ethical conduct and the standards of practice that guide child protection.

B. OVC Program Operational Considerations and Suggested Actions

Reduce Barriers and Build Demand for Child Testing and Treatment through OVC Programs

1. **Ensure that OVC programs are HIV-sensitive and that staff and the community-based workforce are HIV-knowledgeable.**

   - Equip OVC program staff and community workforce with knowledge about HIV infection stressing the importance of early treatment, HIV risk factors, the HIV testing process, adherence, disclosure, support strategies and monitoring.
   - Ensure that OVC staff and community workforce are trained on all aspects of confidentiality, consent and disclosure, including relevant legal and policy frameworks (especially as they apply to children and adolescents) to support timely HIV testing, treatment initiation, adherence and progressive, age-appropriate disclosure.
   - Ensure an understanding of the stages of child development and factors that influence full or partial disclosure to the child or, in the case of adolescents testing positive, disclosure to parents and/or sexual partners.
   - Adapt OVC program tools to reflect, capture and disseminate HIV-related information at household level, including screening for HIV risks, exposure, known status, and adherence.

2. **Leverage the OVC platform to create an enabling environment in communities that promotes HIV testing services (HTS), disclosure and successful linkage to care and treatment.**

   - Continue to build HIV-competent communities that protect children and adolescents through awareness and management of child protection threats and solutions, increased male

involvement in parenting and child health, eliminating stigma and discrimination and improved social support to HIV-positive children and their families.

- Promote and engage the voices of children and adolescents in program planning and evaluation.
- Leverage the energy and candor of children and adolescents in the development of tools, processes and events for educating parents, caregivers, peers and the general public about the disclosure and information needs of children and adolescents.

3. Leverage the rapport between the OVC worker and household to encourage HIV testing.

- Mandate OVC community workers to actively share information about HTS and the importance of knowing one's status and the children's status, across the lifespan with OVC family/households.[3]
- The OVC community workforce should be on alert and able to identify children and adolescents (and their adult caregivers) who may have undiagnosed HIV infection. To this end, train the OVC workforce to perform HIV risk screening to generate swift, proactive mobilization of individual children and family members to be prioritized for testing (Refer to Annex 5 for a risk screening algorithm and prototype tool);
- In scale-up sub-national units (SNUs), establish a clear timeframe for achieving the goal of documenting risk status in each OVC case file and prioritizing testing for infants/children/adolescents whose screening indicates a risk for HIV.

4. OVC programs should actively facilitate HIV testing, including outside of the facility setting, when appropriate, to improve uptake.

- When possible, the OVC community workforce will escort and accompany children/adolescents and their guardians to the most appropriate HIV testing service (whether offered at home, at a community-based site or at a clinical facility) for initial testing and receipt of test results. Escorts not only provide practical guidance in an unfamiliar location, but often serve as advocates and translators, and help clients remember key advice and information gleaned during their appointments.
- Train and resource the community workforce to facilitate (through accompaniment where possible) a confirmatory test and receipt of results for clients who receive an initial positive test, regardless of where the initial test took place.

[3] Information about OVCHIV_STAT can be found in the MER 2.0 guidance. http://www.pepfar.gov/reports/guidance/

- Utilize the OVC community workforce to follow up post-partum HIV-positive mothers to ensure that HIV-exposed infants are linked to appropriate HIV care and relevant social services and that a final HIV status outcome is determined for each child.
- OVC programs should explore strategic partnering with other community or clinical implementers to deliver testing in targeted communities.
- OVC partners may pilot the training of suitable OVC program staff or volunteers to administer HIV testing and counseling, if:

  1) Such efforts are aligned with national government, policies, priorities and interests,

  2) Appropriate oversight can be provided by the partner/or lab to ensure quality HTS, and,

  3) The time spent administering HTS does not prevent staff and volunteers from completing other required OVC responsibilities.
- Regardless of where HTS are performed or which cadre provides them, test results should be reported by the relevant health facility or fixed HTS site to avoid duplication and ensure use of standard data collection tools that are approved by the MOH.
- Test results should be shared with the assigned Community Case Manager and recorded in a confidential OVC beneficiary file unless not allowed by the client/caregiver. This will help the community worker to revise the case plan, if needed, to ensure the provision of or referral to the most appropriate services and resources. All community workers handling sensitive information (test results, status) will require training in confidentiality issues and oversight.

Target and Prioritize among OVC Populations

5. Prioritize the highest risk children for immediate testing

- Ensure that OVC staff and workforce are equipped to proactively identify children/adolescents who may be at risk of undiagnosed HIV infection (Refer to Annex 5 for a risk screening algorithm and prototype tool) and that they expedite HIV testing services for children and households deemed to be at highest risk. Infants less than 2 years of age have the highest mortality rates if not treated, OVC staff and workforce should be especially diligent with identifying at-risk HIV exposed infants, and ensuring these children receive services as soon as possible.
- Ensure that OVC partners agree on a uniform strategy and harmonized data collection tools to support the integration of risk assessments in routine service delivery [4]. It is recommended that

[4] A brief (four-item) screening tool that could be used by lay cadres was validated among children 6 to 15 years of age presenting at primary care (outpatient) facilities in Zimbabwe (Bandason, et al. AIDS 2016 doi: 10.1097/QAD.0000000000000959). This tool demonstrated high sensitivity (80%) and positive predictive value (88.6%) when

OVC partners adapt risk screening tools and algorithms that are informed by the local epidemic profile and the evidence. Where possible, screening items should be rapidly piloted and evaluated in a few selected sites in order to ensure their usability and performance.

TABLE 2: COMPREHENSIVE LIST OF RISK FACTORS ASSOCIATED WITH HIV

Risk Factors	Setting where risk factor is likely to be identified*		
	Facility	Community	Facility and/or Community
Children/adolescents of an adult PLHIV accessing care and treatment services	X		
Sibling of a child or adolescent accessing HIV care and treatment services	X		
Children/adolescents admitted to an inpatient pediatric or malnutrition ward	X		
Children/adolescents diagnosed with TB	X		
Children/adolescents with frequent visits to an outpatient department (OPD)	X		
Children/adolescents presenting with symptoms suggesting HIV (e.g., frequent upper respiratory infections, chronic diarrhea, skin rashes, opportunistic infections)	X		
Sexually active adolescents; Adolescents accessing STI, SRH services (facility-based or through traditional healers)		X	
Children/adolescents with one (or both) parent(s) deceased.		X	
Children/adolescents living with a caregiver other than a biological parent		X	
Children/adolescents residing in a child-headed household		X	
Children/adolescents with moderate or severe malnutrition			X
Children/adolescents with chronic medical and/or psychological conditions			X
Children/adolescents with moderate to severe developmental (physical, cognitive, linguistic) delay (and/or multiple delays)			X

assessed against the actual HIV test result. A variation of this tool has been evaluated at community level (Bandason et al., forthcoming), and is undergoing evaluation in OVC programs (Zimbabwe). Further studies are warranted in different programmatic and epidemic contexts.

Children/adolescents identified as having experienced sexual and gender-based violence			X
Children/adolescents of key populations (I.e., IDUs, CSWs)			X
Children/adolescents who are below the expected school grade for age, compared with their peers			X
**Note this chart is illustrative only. The local epidemiological context should serve as the basis for development of risk factors. Also, the factors noted above may be identified by service providers across multiple settings.*			

Establish Data-driven Plans for Expanding HTS among OVC Program Beneficiaries

6. **Develop plans for HIV testing of OVC in collaboration with Pediatric/Adolescent and Adult care and treatment, HTS, and Supply Chain Management (SCM) teams to ensure human resources and supply chain implications are understood.**

   - Ensure targets for scale-up of testing services take into account supply-side challenges and supply stock-outs.
   - Work with clinical staff to design HTS models of service delivery that minimize the risk of staff overload and avoid congestion of service areas, for example, having one afternoon a week designated for testing of referrals may be useful in some settings and also help avoid service refusal.

7. **Establish a confidential record keeping protocol for documenting HIV status of OVC beneficiaries and report OVC_HIVSTAT semi-annually**[5]

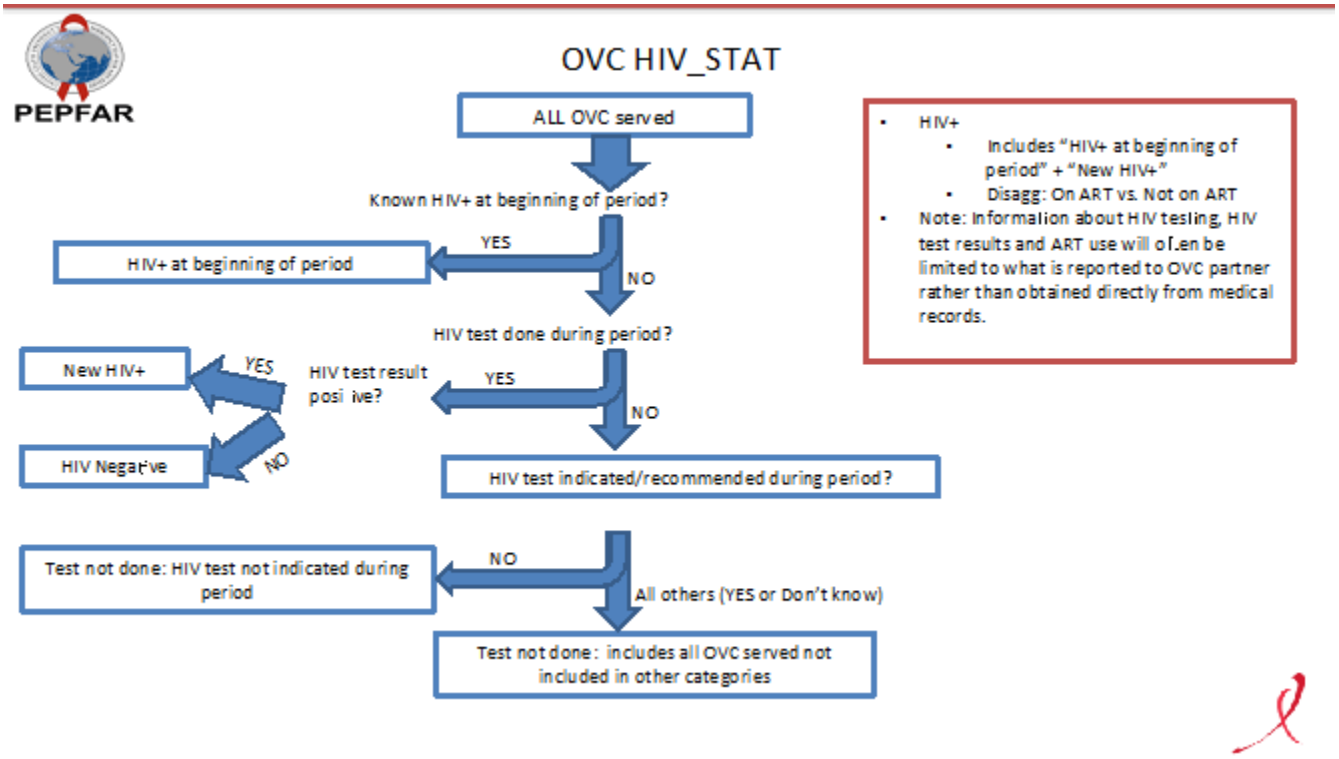
   - All OVC beneficiaries should have a unique identifier that is used to record information pertaining to HIV status, testing, care and treatment as well as risk assessment results.
   - OVC beneficiary case files, data files and databases should use client unique identifiers and not include the child's name, household head/caregiver name, or specific geographic location that could identify the child.
   - Digital OVC beneficiary case files, data files and databases should be password protected and user administration rights should be recorded and managed by the Prime partner.
   - Hard copy case files and data files/records should be securely locked and managed by the organization's data clerk/M&E Manager.

[5] The indicator OVC_HIVSTAT Is fully defined in the PEPFAR Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide, October 2016

- Tools for collecting information regarding HIV status, testing, care and treatment and/or risk assessment results should use the child's unique identifier and not their personal name, the caregiver's name nor geographic information that can identify the child.

Protecting the privacy and confidentiality of the OVC beneficiary is critical throughout the duration of project implementation, monitoring and evaluation. Because partners will need to monitor caregiver knowledge of their child's HIV status, treatment status and/or risk to HIV infection, it is imperative that partners have rigorous procedures and standards for respecting and safeguarding the rights of OVC beneficiaries and protecting them from undue harm that may result from a confidentiality breach. Figure 1 below illustrates the key areas that the protocol should address in securing confidentiality, including initial assessment of HIV status, current adherence to treatment among children who are HIV positive, time last tested, recommendation for risk screening, results from the HIV risk assessment, referrals made for testing and completed, etc.

FIGURE 1. KEY STEPS IN DOCUMENTING HIV STATUS AMONG OVC



Coordinate Service Provision between OVC, Pediatric HIV, Adult HIV Programs and HTS

8. Foster a coordinated "one team" approach, bringing health and social service approaches together through a clear understanding of their specific roles and responsibilities in addressing the multiple needs of the caregivers and children living with or affected by HIV.

- Develop Memoranda of Understanding (MOUs) between OVC implementing partners, clinical TA partners, and health facilities outlining the roles and responsibilities of both programs with regard to all phases of the HIV services continuum.
- Ensure MOUs articulate clear expectations with regard to bidirectional referral process including use of standardized data collections tools and standard operating procedures (SOP) for contact tracing, family index testing, fast track testing and treatment referrals, missed appointment and defaulter follow-up.
- Schedule regular joint case conferencing and data review sessions to troubleshoot breakdowns in referral process and to identify clients requiring additional support.
- Where a community health workforce is in place, ensure that there is clear agreement about where roles are shared, linked or delineated to avoid redundancy, gaps in service and tension between different community cadres. This agreement should be captured either in the OVC/Health Facility MOU or in a separate MOU, depending on the local context.
- Support MOH and relevant ministries (social welfare, local government, etc.) to develop or adapt policies that acknowledge and define the role and responsibilities of lay workers in helping children to access testing and treatment.
- Operationalize MOUs through intentional information sharing, integrated staff meetings, joint supervisory visits and standardized tools and reporting formats and ensure that lay and health care workers are aware of the services offered by each.
- Demonstrate the "one team" approach by ensuring that (with consent and agreed upon protocols) HIV test results are released to the OVC community worker managing the specific case. This will allow the community worker to revise the case plan, if needed to ensure the provision of or referral to the most appropriate services and resources.
- Sensitize facility-based staff about existing OVC services that support the successful engagement of children/adolescents and their families across the continuum of HIV services, including psychosocial support, child protection, education, food security, and economic strengthening.
- Train facility-based staff with regard to the concrete steps clinicians should take to trigger the social service response for both statutory (for example, sexual assault) and non-statutory (for example, failure to provide for basic needs, emotional abuse) offenses.

9. Establish coordinated case management tools, structures and systems that bridge facility- and community-based care.

- Ensure that assessment tools utilized in both OVC and HIV facilities reflect the "one team" approach and include aspects related to the holistic needs of children affected by or living with HIV. For example, OVC assessments should include information related to HIV status, treatment

and disclosure, while health facility assessments should include information about non-health issues children face such as protection, education and caregiver support for use in comprehensive care planning.

- Align the case management tools used by OVC programs and health facilities to ensure they "speak to each other" insofar as possible, to enable bi-directional information-sharing, merging of relevant data sets, etc.
- Facilitate a "one team" approach to case management by holding monthly HIV Services case conferences with representatives from OVC programs, health facilities and other service providers. These conferences should address any challenges (or successes) related to specific cases, protocols or tools. Ideally these should be hosted and facilitated by (or at a minimum, include) a government body mandated with overseeing care and protection of vulnerable children.
- As children and families near graduation from the OVC program, ensure that HIV-specific information is included in the completed case file. It is strongly recommended that an indicator for graduation readiness include knowledge of HIV status. Graduation plans for children living with HIV should include specific steps, developed collaboratively with social services and clinical care providers, to ensure that graduated OVC and families continue to have access to needed HIV-specific services, including testing services.

Protect the Best Interests of the Child

10. Ensure that any efforts to bring children to HTS are derived from strict adherence to ethical conduct and existing protocols and the standards of practice that guide child protection.

- Increase OVC workforce and clinical staff awareness of child protection issues related to HIV, across the HIV continuum of care.
- Abuse (in particular sexual abuse), neglect and abandonment not only heighten the risk of HIV infection, but can be triggered by knowledge of sero-positive status. For the sero-positive child, the family is not always a safe haven. The OVC workforce will require intervention and advocacy skills that prepare them to proactively act in the best interests of the child.

C. A call for Implementation Science Studies

The group identified several implementation science (IS) studies that could help to inform changes in program design that will lead to a greater number of OVC and their caregivers identified as HIV positive and successfully linked to care and treatment.

Suggested topics for potential IS studies include:

- Models and impact of coordinated case management, including referral mechanisms between community social services and health facilities, on testing uptake and linkage to care.
- Outcomes, pros and cons of deploying OVC service providers to provide not only HIV pre- and post- test counseling but perform the HIV test and deliver preliminary results.
- Impact of specific OVC interventions (parenting support, age-appropriate support groups, savings groups, etc.) on pediatric and adolescent testing rates, and linkage to care/treatment.
- Assessment of effective disclosure models (age appropriate and adapted to child and caregiver socioeconomic factors).
- Most effective strategies for efficient and targeted testing in different epidemic contexts and for different sub populations of OVC.
- Correlates of infection among OVC populations who test positive, to inform refinement of future targeting strategies.
- Analyze and compare effectiveness of the different testing settings utilized by OVC partners to pinpoint strategies for improving efficiency across the cascade based on the testing venue/entry point.
- Characteristics of those who opt in and those who opt out of testing, to inform refinement of messaging and tactics to improve uptake. Subtopics to explore may include whether certain factors (HIV knowledge, partner and parental status, etc.) discourage or encourage testing.

D. Annexes

Annex 1: Meeting Agenda

Considerations for OVC Programs to

Increase Access to HTC for Children and their Families

February 3 and 4, 2016

Washington, DC

Meeting Objectives:

1. Determine the role of OVC programs in bringing HIV infected and exposed children and adolescents into successful care and treatment through improved access to quality HIV testing and counseling
2. Articulate the relevant context for OVC programs engaged in this mandate
3. Develop considerations to guide COP processes, staff development and implementation at country level

Time		Topic	Purpose	Facilitator/Presenter
Day One				
8.00		Check in	*Breakfast is available*	
8.30 - 9.00	30 min	Welcome	Introductions and overview of objectives and process	Gretchen
9.00 - 10.15	75 min	Field and TWG Perspectives	Field perspectives (TBD) TWG perspectives Q&A, clarifications	Brenda; Field representatives TWG representatives from Peds, PMTCT, HTC, OVC

10.15 - 10.35	20 min	Introduction to Working Group activity	• Introduce Working Group process • Introduce Working Group leaders and form groups • Review and validate Working Group topics for clarity, gaps and redundancies	Brenda
10.35 - 11.00 Break (25 minutes)				
11.00 - 1.00	2 hrs	Working Group time	WG leaders set the stage and lead discussion of global context Create list of barriers and constraints specify to WG topic Brainstorm for solutions	Working Group leaders, Brenda
1.00 - 1.30 Lunch (30 minutes)				
1.30 - 3.00	90 min	Working Group time	• Create draft considerations list	Working Group leaders
3.00 - 3.15 Break (15 minutes)				
3.15 - 5.15	2 hrs	Reality check: Plenary discussion of initial Working Group findings	• WG presentations - 15 minutes each • Review/cross-reference considerations lists as they have been initially drafted • Check for gaps, overlap and consistency	Brenda
5,15 - 5.30	15 min	Close of Day	Brief process review and summary Reaffirm Day Two expectations	Brenda
5.30 End of Day				
Day Two				
8.30 - 8.45	15 min	Welcome back	Review of Day One	Shelby
8.45- 9.30	45 min	Review of draft considerations	Fresh look at Day One decisions to ensure consensus	Ashley
9.30 - 11.00	1.5 hrs	Working group time	• Incorporate plenary input and finalize considerations • Identify models of good practice that illustrate the implementation of each consideration • Identify outstanding evidence gaps	Working Group leaders
11.00 - 11.15 Break (15 minutes)				

11.15 - 1.00	1 3/4 hrs	Presentation of final WG products;	• Check again for gaps, overlap and consistency in approaches • Ratify draft product • Review of final document outline	Brenda and Working Group leaders
1.30 - 2.00 Lunch (30 minutes)				
1.30 - 2.30	1 hr	Learning agenda	• Create and prioritize a learning agenda that addresses evidence gaps • Identify good practice models (potential case study)	Brenda and Working Group leaders
2.30 - 3.00	30 min	Discussion of way forward	Establish protocol, timeline and persons-responsible for future consultation, case study development and dissemination of final product of consultation	Maury and Brenda
3.00 End of Meeting				

Annex 2: List of Participants

Name	**Title**	**Agency**	**Technical Working Group (TWG) / Affiliation**
Gretchen Bachman	Sr. Technical Advisor and Team Lead, OVC	USAID	Orphans and Vulnerable Children (OVC)
Colette Peck	OVC Technical Advisor	USAID	OVC
Maury Mendenhall	Senior Technical Advisor, OVC	USAID	OVC
Sarah Dastur	Senior Technical Advisor, OVC	USAID	OVC
Tara Reichenbach	OVC Program Advisor	USAID	OVC
Amy Aberra	Program Analyst, OVC	USAID	OVC
Marie Eve Hammink	Senior Technical Advisor, OVC	S/GAC	OVC
Jessica Tabler	OVC Program and Policy Advisor	S/GAC	OVC
Beverly Nyberg	Senior Advisor on PEPFAR	Peace Corps	OVC
Jessica Clinkscales	Monitoring and Evaluation Associate	DoD	OVC
Emilia (Molly) Rivadeneira	Team Lead, Pediatric and Adolescent HIV Team	CDC	OVC/Pediatric and Adolescent Care and Treatment (PEDS)
Mamadou Diallo	Medical Officer Pediatric HIV Care & Treatment	CDC	OVC/PEDS
Zena Belay	Program Analyst	CDC	PEDS

Tegan Callahan	Health Scientist	CDC	PEDS/PBF
Paul Young	PMTCT Technical Advisor	CDC	Pregnant & Breastfeeding Women (PBF)
Meena Srivastava	Medical Officer – PMTCT and Pediatric HIV	USAID	PEDS/PBF
Jon (Ben) Woods	Technical Advisor, Continuum of HIV/AIDS Clinical Services	USAID	PEDS/PBF
Rachel Golin	Technical Advisor, Continuum of Clinical Services	USAID	PEDS/PBF
Megan Gleason	PMTCT and Pediatric HIV Intern	USAID	PEDS/PBF
Alison Cheng	Public Health Advisor	USAID	HTC
Vincent Wong	Senior Technical Advisor – HIV Testing and Counseling	USAID	HTC
Michael P. Grillo	Director, Prevention, Education and Training	DoD	HTC
Kelley Bunkers	Child Protection and Welfare Systems Technical Director	4C/CRS	Implementing Partner (IP)
Kate Greenaway	Consultant, 4Children	4C/CRS	IP
Severine Chevrel	Technical Capacity Building Director	4C/CRS	IP
Shelby Benson	Deputy Director. Health and HIV. Resource Development and Management.	WVI	IP
Sara Bowsky	Deputy Director HIV, Health Policy Plus	Palladium	IP
Brenda Bowman	Consultant, 4Children	4C/CRS	IP

Annex 3: Suggested Terms of Reference for Coordination Roles

Suggested Terms of Reference	
Clinic-Community Case Coordinators	Community Case Managers
Receives referrals of newly tested positive individuals and their families identified by community case managers, and all facility-based services including PMTCT, HTS, Adult and Pediatric HIV, OPD, in-patient, TB and Malnutrition clinics	Receives referrals of children orphaned and made vulnerable by HIV from health facilities, social service organizations, schools, police, key and priority populations programs, and other community programs
Opens a clinic case file for the child and family	Opens a community case file for the child and family
Conducts a brief intake interview to assess eligibility for enrollment in community OVC programs or other community programs; assesses the need for further HIV testing	Conducts a thorough assessment of the needs and resources available to children and their families and develops a comprehensive case plan for meeting needs and maximizing resources. Assessments should include assessing the need for initial or confirmatory HIV testing and case plans should include plans for testing children and family members with unknown status.
Provides pre-test counseling to prepare children and families for HIV testing and makes necessary referrals to HTS	Provides pre-test counseling in coordination with Clinic-Community Case Coordinator to prepare children and families for HIV testing and makes necessary referrals to HTS Records date of HIV test and result on OVC case file
Develops and maintains service directories to support effective referral *(joint responsibility)*	Develops and maintains service directories to support effective referral *(joint responsibility)*

Uses service directories to make referrals to community OVC programs or other community programs for other critical services; notifies the HTS programs and community programs of clients referred	Makes necessary referrals to clinics for other health or HIV issues, and other community programs for services not provided by OVC programs; notifies the HTS, clinic and community programs of clients referred
Meets with Community Case Managers on a regular basis for case conferencing and improved referral/coordination between clinic and community programs	Meets with Clinic-Community Case Coordinators on a regular basis for case conferencing and improving referral/coordination between clinic and community programs Monitors progress towards achieving case plans and modifying case plans as appropriate
Explains to Community Case Managers the parameters of consent for disclosure of HIV test results and helping them to support disclosure to HIV-positive clients, management of medications, and adherence to treatment	Supports disclosure of HIV test results to clients in coordination with the Clinic-Community Case Coordinator as well as supporting management of medication and adherence to treatment for HIV-positive clients
Serves as primary case manager for HIV-positive children and caregivers that are stable and regularly adhering to treatment.	Closes case files and transfers primary responsibility for managing HIV-positive children and caregivers that are stable and regularly adhering to treatment to Clinic-Community Case Coordinators

Annex 4: Prototype Risk Screening Algorithm

Integrating Routine HTS Risk Screening into OVC Services

In as much as is possible, PEPFAR supported partners should harmonize tools and approaches across OVC service providers, in order to ensure that beneficiaries' HIV risk status is systematically assessed and documented. Missions and their implementing partners should pursue national/country level buy-in, particularly from the Ministry of Health, in order to support clinical and community linkages.

As a first step, service providers should explain in simple and clear terms, the purpose and intention of the risk screening process, using a standard script. This can also serve as an opportunity to educate caregivers on the link between health and child wellbeing.

Previously tested?

- Inquire if a child's HIV status is known, positive or negative, or unknown; this will help avoid service duplication and enable partners to refer children/adolescents to the appropriate services.
- Children who have received an HIV test in the past, and were confirmed HIV negative should not require additional HTS services, unless there is a history of abuse or rape that occurred after that test was conducted.
- Clients who enrolled as children and had a negative HIV test in the past but are now sexually active adolescents should be offered HIV testing as per national guidance.

HIV positive parent or sibling?

- Service providers should also systematically document parental and sibling HIV status, and:
  Facilitate HTS services for children of unknown HIV status who have an HIV positive sibling or parent. Fast-track infants less than 24 months of age, sick children, and adolescents.
- Children who do not have an HIV positive parent or sibling can reasonably be assumed to have low- to no- HIV risk, and should be documented as such.
- OVC with unknown parental HIV status who have not previously or recently received an HIV test should be assessed for social and health factors indicative of HIV risk.

Once the initial assessment has been completed, repeated risk screening is not indicated or recommended for a child/adolescent, unless there is reason to believe that the initial responses provided by the parent/caregiver were inaccurate. Programs should carefully weigh the risks, benefits, and obligations of screening for GBV, and for assessing adolescents for HIV infection based on high-risk sexual activity**.**

Prototype Risk Screening Algorithm

1. Question: How old is the child?

- If ≥18 years of age, refer to VCT as per national guidelines.
- If <18 years of age, go to next question.

2. Question: Has the child previously been tested for HIV?

- If **YES**, please determine whether the test results were positive, negative, or unknown.

  If the result was:
  Positive: STOP screening. Ensure that the child is enrolled in a care and treatment program and has good adherence and retention.
  Negative: HIV test not needed. STOP screening. If possible, confirm documentation of the test results.
  Unknown: Go to the next question.

- If **NO**: Go to the next question.

3. Question: Did/Does the child have an HIV positive parent or sibling?

- If **NO**: **STOP** screening.
- If **YES**: HIV TEST is recommended. Fast-track infants less than 24 months of age and sick children/adolescents. (Note: ensure positive parents/siblings are linked to HIV care.)
- If **Unknown**: **Go to next question**.

4. Offer or facilitate HIV testing for mother to determine her status.

- If mother tests **HIV negative: STOP screening.**
- If mother **tests HIV positive: HIV TEST is recommended.** Fast-track infants less than 24 months of age and sick children/adolescents. (Note: ensure mother is linked to HIV care.)
- If mother can or will not be tested for HIV: Go to next question.

5. Question: Is the child 0-2 or older than 2 years of age?

- **Children 0-2 years of age**: Prioritized HIV testing recommended.
- **Children >2-17 years of age**: Use screening tool below.

All Children/Adolescents

1. Has the child been admitted to hospital before?
2. Does the child have recurring skin problems?
3. Are one or both parents of the child deceased?
4. Are one or more siblings of the child deceased?
5. Has the child had poor health in the last 3 months?
6. Does the child have a chronically ill parent and/or family member?
7. Is the child below his/her expected school grade relative to his/her peers?

For Adolescents Only

(Screen all adolescents in private and refer systematically for HIV testing if sexually active)

8. Does the adolescent report genital discharge or sores?

6. Question: Does the caregiver/child report YES to at least one risk factor above?

- If **NO,** document results of screen and arrange testing at a convenient time.
- If **YES** to any question, escort or refer for HIV testing services. Document referred service point, and whether caregiver accepted referral or offer to escort for HIV testing services.

7. Question: If caregiver/child was referred for services, was referral completed?

- If **NO,** investigate reason and document.
- If **YES**, request HIV status, or document caregiver's refusal to disclose.

Annex 5: Prototype HIV Risk Screening Log

PROTOTYPE HIV RISK SCREENING LOG																		
Date	**ID of the Child** AND **ID of Parent/ Caregiver, or Household**	**Age**	**Sex**	**Current HIV status (Known Pos., Known Neg., Unknown)**			**Parental or Sibling HIV status**		**HIV Risk Screening Questions (Perinatal Exposure)** **ASK:** Does the child have…/Has the child had…						**Sexual Risk**	Child Eligible for HIV test if at least one YES for screening items	Caregiver accepted to test the child for HIV (YES, NO, Not Eligible)	Test for HIV? (Yes, No)	**HIV test result** POS, NEG, Did not disclose
				KNOWN POS (If YES, indicate status and STOP screen, confirm care)	**KNOWN NEG** (If YES for AFTER BF ends, indicate status and STOP screen)	**HIV STATUS NOT KNOWN:** If child's HIV status is unknown PROCEED	IF **YES,** SKIP the screening items and **OFFER HIV** Test	IF **NO**, Document below and **ASK** screening questions	Hospital admission (EVER)?	One or both parents are DEAD	One or more siblings DEAD	Poor health in the last 3 months (Fever, diarrhea, cough, sudden weight loss, recurrent skin problems)?	An adult or child with HIV or TB in this House hold?	Is the child below his/her expected school grade (when compared to his/her peers)?	**FOR TEENS ONLY (Ask in private)**: Genital discharge or sores?				