

**ICAP Collaborative PMTCT and Pediatric HIV Strategic Planning Workshop
In Partnership with Tygerberg Children's Hospital, South Africa and S2S**

Title:	Where there are no/few doctors to care for the HIV-infected child
Country:	Mozambique
Host Name and Title:	Maria Grazia Lain, Pediatric Advisor
Session Goal:	To appraise and review ways to deliver quality clinical services to HIV-infected children where there are limited or no skilled health-workers available.
Learning Objectives:	<ol style="list-style-type: none"> 1. To describe and compare different approaches of attending to pediatric patients in various clinic settings (country examples) 2. To examine which approaches are more successful in providing quality clinical care 3. To identify feasible approaches to delivering quality of care when there are no trained doctors/medical assistants 4. To share experience in applying the Pediatric SOC in our setting: process, findings 5. To examine ways of “transferring knowledge” to nurses/medical assistant (clinical mentoring as an approach)
Instructional Method(s):	<ul style="list-style-type: none"> • Structured overview • Group discussion • Debate between the 2 groups
Session Description:	<p>0-30 minutes:</p> <ul style="list-style-type: none"> • The host will describe/present the situation of pediatric care in Mozambique (2-3 slides and poster) • Each participant will describe his/her experience in delivering pediatric care, starting with the Mozambique experience. The following questions to be considered in describing country examples: <ol style="list-style-type: none"> 1. Where is the HIV positive child followed in care? <ol style="list-style-type: none"> a. Is there a specific Pediatric HIV clinic? b. Is the follow up integrated in other Child Health services (such as PMTCT or IMCI)? 2. Who is attending/taking care of them? <ol style="list-style-type: none"> a. Is it a “one person follow up” or is a MDT involved? 3. What tools-job aids is the staff using during their job? 4. What is the routine of care for an infected child? <ol style="list-style-type: none"> a. Describe the algorithm at the HIV clinic (triage-consultation-lab test-pharmacy-counseling sessions) 5. Is there any staff supervision at sites? <ol style="list-style-type: none"> a. Is clinical mentoring an integral component of the pediatric program? b. How is it working? 6. Pediatric SOC: Have you done any quality of care evaluation? <p>The host will keep record of the different experiences in a flipchart that will be used to guide the group discussion and the debate.</p> <p>31-50 minutes: GROUP DISCUSSION (preparing for the debate)</p> <ul style="list-style-type: none"> • Participants will break into 2 groups and each group will be assigned a specific scenario. <ul style="list-style-type: none"> ○ Scenario 1: “Pediatric care is best when care is provided by doctors

	<p>only”</p> <ul style="list-style-type: none"> ○ Scenario 2: “Pediatric care is best when care is provided by nurses/medical assistants” ○ In order to debate the proposed scenarios, each group will be asked to discuss the assigned scenario and produce a list of 5 reasons in support of the assigned scenario ○ Each group will choose a speaker to represent the group in the debate, at least in the initial phase. <ul style="list-style-type: none"> ● The host will provide questions to guide the group-discussion <p>51-80 minutes: DEBATE</p> <ul style="list-style-type: none"> ● The speaker of each group will present the list produced in the group discussion (5 minutes for each group) ● The 2 groups will debate: all participants will be asked to participate in the discussion supporting their assigned scenario ● The aim of the debate is to provide arguments to convince the constituents of the other group that their scenario is best. ● During the debate, those who change their opinion based on the justifications presented by the other group will move from the initial assigned group to the other group ● At the end of the time assigned for the debate the group with more participants will win the debate. ● The host will moderate the debate between the 2 groups following the questions given: <ul style="list-style-type: none"> ○ Why does your group think that pediatric care is best if offered by docs/nurses/med assistant only? ○ Who can offer the best care? ○ Are there specific elements of care that can only be provided by a specific cadre? Which ones, and by whom? Why? ○ If MDs are not enough, who should be trained? ○ Do MDs/nurses/med assistants need supervision? Does one cadre need more supervision over another? ○ How should supervision be done? Is clinical mentoring an effective approach? ○ Are in-service re-fresher/updates necessary for docs/nurses/med ass? ○ Is there a way to integrate the 2 approaches? <p>81-90 minutes:</p> <ul style="list-style-type: none"> ● Host will summarize the outcome of the debate comparing the conclusions of each group, the elements of quality care, possible providers of each elements and what is need to obtain that. ● The plenary will decide, on the base of the debate outcome which approach in which context is better to offer HIV care to pediatric patients explaining the rationale of the conclusion
Pre-session Activities:	<ul style="list-style-type: none"> ● Review and prepare answers to questions that will be asked about country experience <ol style="list-style-type: none"> 1. Where is the HIV positive child followed in care?

	<ul style="list-style-type: none"> a. Is there a specific Pediatric HIV clinic? b. Is the follow up integrated in other Child Health services (such as PMTCT or IMCI)? <ol style="list-style-type: none"> 2. Who is attending/taking care of them? <ul style="list-style-type: none"> a. Is it a “one person follow up” or is a MDT involved? 3. What tools-job aids is the staff using during their job? 4. What is the routine of care for an infected child? <ul style="list-style-type: none"> a. Describe the algorithm at the HIV clinic (triage-consultation-lab test-pharmacy-counseling sessions) 5. Is there any staff supervision at sites? <ul style="list-style-type: none"> a. Is clinical mentoring an integral component of the pediatric program? b. How is it working? 6. Pediatric SOC: Have you done any quality of care evaluation?
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Session Notes and Summary

Session name: Where there are no/few doctors to care for HIV infected children

Note taker name: Stephen Arpadi

Major Discussion Points and/or Conclusions:

1. Experiences for ICAP projects in delivering care to HIV infected children were described and compared (summarized in table below). Virtually all country projects reported that pediatric care services were delivered in adult ART settings. Few had dedicated pediatric clinical areas. Doctors and nurses provided majority of care some reported additional cadres such as nutritionists or Clinical officers. The constellation of services varied somewhat, in some places patients saw MD at every visit while in others triaging was performed and only those with problems or concerns had a visit with an MD. Few sites have established regular on-going monitoring of Standards of Care though many have some experience.

2. Debate Summary of group opening arguments

A. Nurses are better able to care for HIV infected children

1. Nurses typically more abundant cadre of trained HCW
2. Positive experience (thought limited) with respect to being able to care for HIV infected children
3. Often a more stable constant member of the health care team-less mobility
4. Probably better suited for chronic care activities
5. Often of the same culture background even locale as families and patients that are enrolled in care –thus greater acceptance
6. In settings where medical doctors are few using nurses is wiser allocation of limited resources-doctors can be freed up to provide more specialized care for complicated cases etc.

B. Doctors are better able to treat HIV infected children

1. Better training thus better able to provide care
2. Would perform better with better outcomes
3. In many places they are the only legally authorized prescriber
4. Can also provide the leadership that is necessary in site implementation

3. Debate Discussion summary

- Agreed that nurses more abundant and many cases more stable and possibly acceptable HCW (in some settings) for providing chronic care
- Training and systems of supervision and consultation and support are pre-requisite for nurses to provide of care for HIV infected children where there are no or few MD.
- Using multidisciplinary approaches many different types of cadres could be involved in providing leadership and supervision of sites by ICAP staff should provide mentoring on leadership.
- Integration support, training of all available HCW cadre is essential undertaking at facility where no or few doctors are available to treat HIV infected children

Several counter points were argued:

- Medical legal concerns were a matter of policy and not insolvable obstacle to using nurses
- A challenge was made to all that measuring outcomes by monitoring SOC was essential regardless of who is delivering care to HIV infected children

	MZB	Lesotho	Kenya	Rwanda	ETH	RSA	Swazi	Nigeria	TNZ
Where	Adult HIV clinic U5Clinic Peds HIV clinic	Adult HIV clinic Few peds clinics	Adult HIV clinic “peds days”	Adult HIV clinic “family day”	Adult Some peds	Adult Peds	Adult Baylor Peds	Adult Peds sites	Adult Peds sites
Who	MD	MD Nurse	Nurses Clinical Officer Some MD	MD	MD start Nurse FU	MD	Nurses MD	MD	CO MD
What	Reception Triage MD consult Psychosoc Pharm	Yes Yes If prob Yes yes	Yes Yes Clinical Officer Nutrition Yes	As for Lesotho	As for Lesotho	As for Lesotho	As for Lesotho	As for Lesotho	As for Lesotho
Supervision/mentoring	ICAPstaff	ICAP Baylor	ICAP	ICAP	ICAP	ICAP	ICAP Site super	ICAP MOH Staff	ICAP Site mentors
Performed SOC review	Yes	No	Started	some	yes	Yes	No	No	No