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STANDARD OPERATING PROCEDURE FOR MANAGEMENT OF CHILDREN WITH HIGH VIRAL LOAD – JUA MTOTO WAKO INITIATIVE	
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Signed by COP	

Definition-JUA MTOTO WAKO INNITIATIVE

An initiative to improve viral suppression rates among children 19 years and below through individualized approach to identifying and managing their barriers to ART adherence. This requires that the clinic gets to know the child in-depth hence the name.

Standard Operating Procedure for JMW

1. Flagging of the high viral load by the assigned person (s)

2. Facility clinical officer in charge or an assigned person enters the child's socio-demographic and clinical biodata into the **Jua Mtoto Wako register**.

3. Clinical officer in charge assigns a **case manager**. Case managers should be clinic staff including clinical officers, nurses, nutritionist, social workers, and outreach /retention officers.

4. Case manager identifies the barriers to adherence using the **Case manager tool**. The case manager reviews the patients file for previously identified barriers to adherence within the same week of the first high viral load and documents in the case manager tool. He /she calls the caregiver or the adolescent and books a clinic appointment for the next week. He/she also informs the social worker/CHV assigned to the child. The social worker/CHV should do a home visit within the same week. The home visit to have a **Home visit checklist filled**.

5. The clinic conducts an **MDT** in the same week to discuss what is currently known about the child. The case manager documents the key points. Use the **MDT reporting tool**.

6. On the clinic day, an MDT is conducted with the **first EAC session**. In attendance should be the case manager, the program officer/STO/ county team representative e.g. Sub CASCO, Social worker/ CHV, peer, caregiver and child. This can take different shapes depending on the clinic. The main aim of the meeting is to identify the barriers to adherence, and agree on some interventions. The case manager should document adherence (**MMS4 and MMS8**), **PHQ9 scores**, **CRAFT/CAGE** scores, conduct a **HEADSS assessment** etc.

7. Make a re- suppression plan and implement them between EAC session 2-5 (OVC enrolment, EAC, HIV literacy to caregiver and to child, family therapy, support group and OTZ enrollment, engagement of children's department or legal office, rehabilitation for alcoholic parents, DOT (DOT tool) etc.). The interventions should as much as possible be multi-disciplinary with involvement of community stakeholders where necessary. These include the children's department, school staff, chiefs or administrative officers among others. These are documented in the case manager's tool.

8. Repeating VL 6 months after process has started

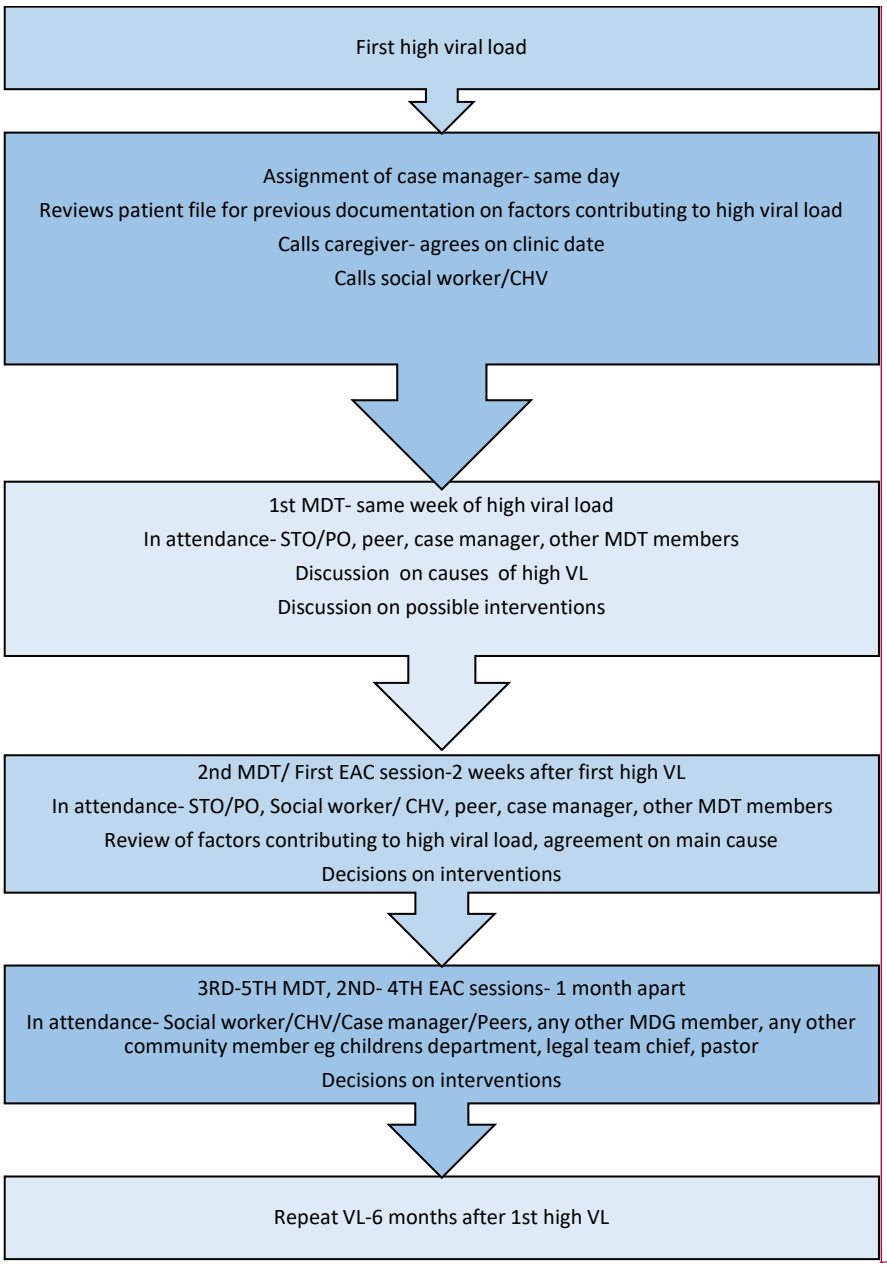
9. Action based on VL result- continued support/ drug switch

10. Continued support after re-suppression/ drug switch

11. Fill the **JMW register** and monthly reporting of data based on monthly cohort (Longitudinal register).

Commented [BJ1]: Is it not expected that these interventions should be completed within three months and a repeat VL done immediately thereafter, i.e. within month 4?

Commented [BJ2]: Repeat VL is not to be done after 3 months of intervention?



Commented [BJ3]:

Commented [BJ4]:

Commented [BJ5R4]: A bit hesitant about saying repeat VL testing after 6 months. Would leave it at 3 months of assured adherence