



PEPFAR



Baby on Board: Pediatric & PMTCT Interventions to Improve HIV Outcomes for Infants, Children, and Adolescents

Moderator: Meena Srivastava, Medical Officer, Office of HIV/AIDS

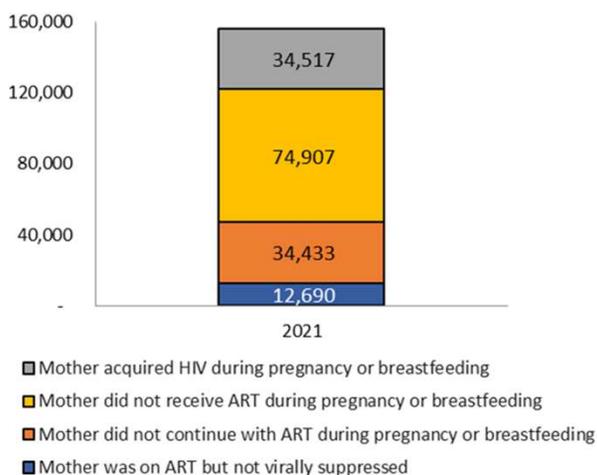
Overview

- ❖ Introductions & PEPFAR AP3 and UNAIDS Global Alliance Priorities
- ❖ Abstract presentations
- ❖ Moderated discussion

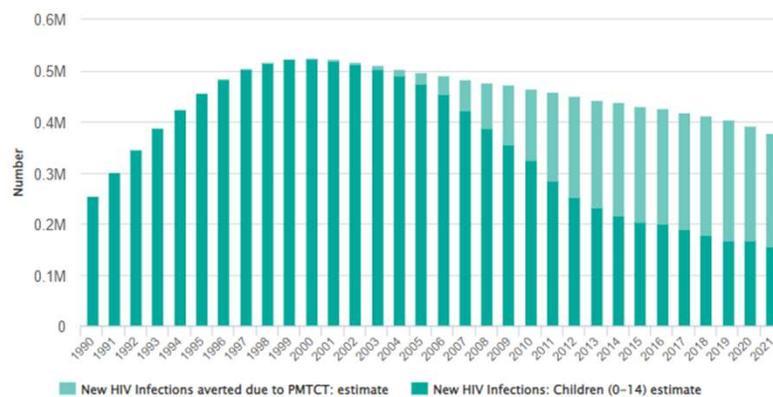


Global Progress in PMTCT and Pediatric HIV

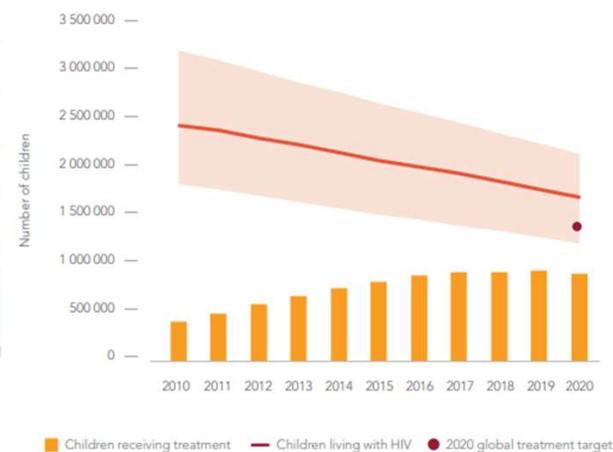
Progress made in PMTCT and Pediatric HIV programs has stagnated globally, and more effort is needed to close the gaps for mothers, infants, children, and adolescents.



Number of new HIV child infections vs number of infections averted due to PMTCT

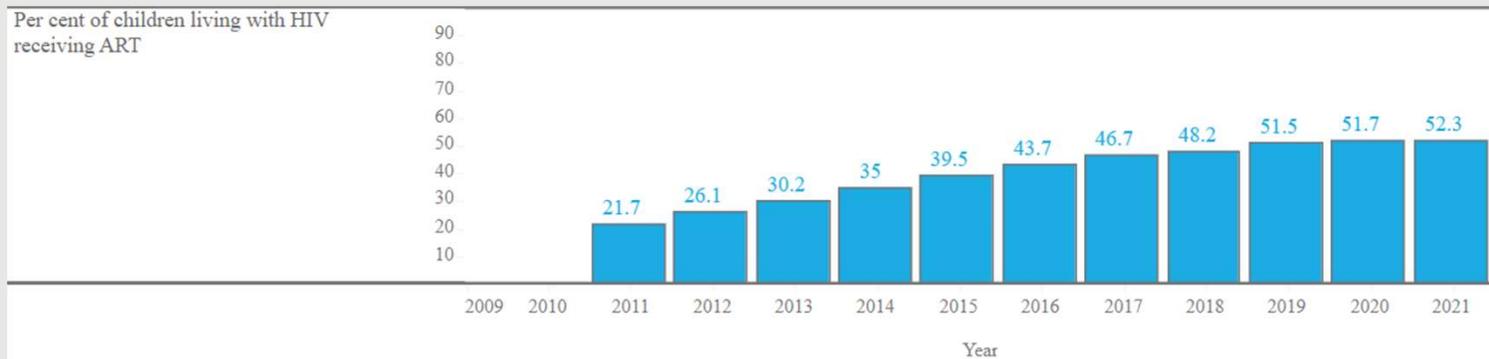
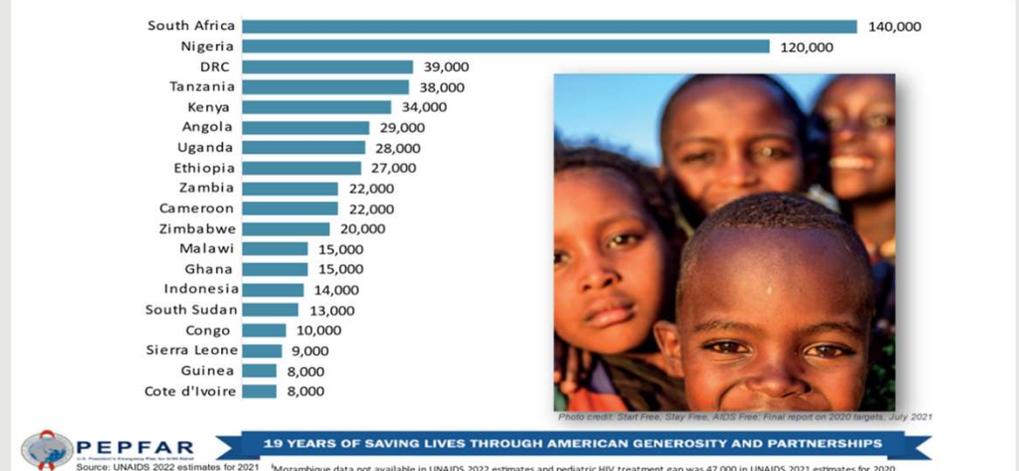
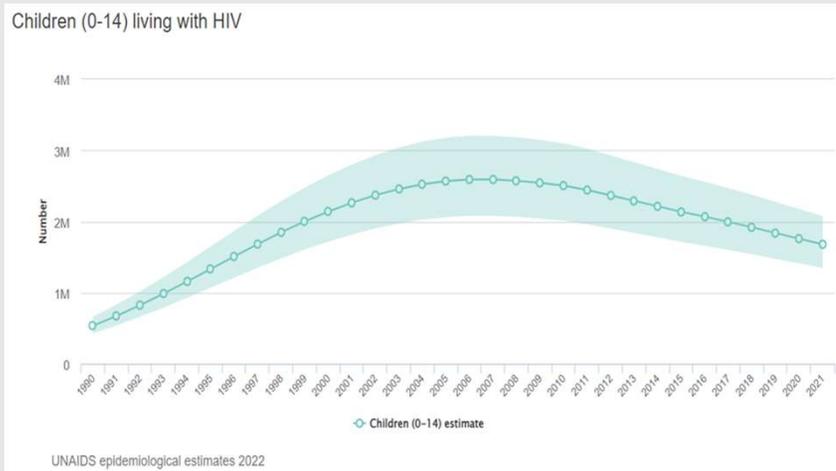


NUMBER OF CHILDREN LIVING WITH HIV AND THOSE RECEIVING ANTIRETROVIRAL THERAPY, GLOBAL, 2010-2020



Global Progress towards reaching CLHIV with ART

20 countries account for over 650,000 CLHIV not receiving treatment



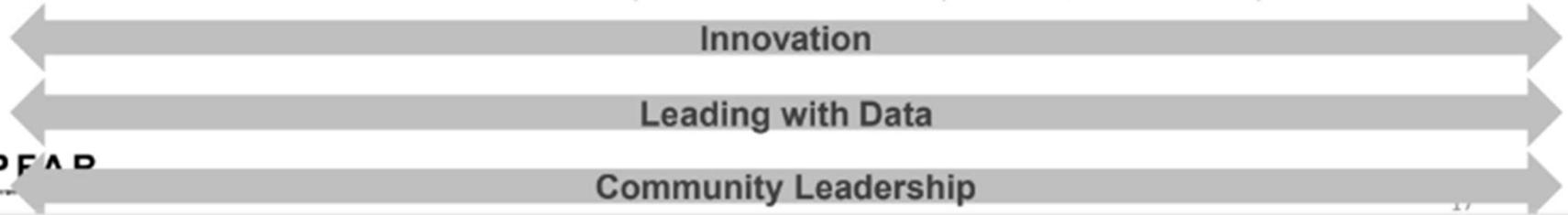
Global AIDS Monitoring and UNAIDS 2022 estimates 1. <https://data.unicef.org/resources/hiv-estimates-for-children-dashboard/>, 2. <https://aidsinfo.unaids.org/>

Reimagined PEPFAR centers Health Equity for Priority Populations

Strategic Pillars



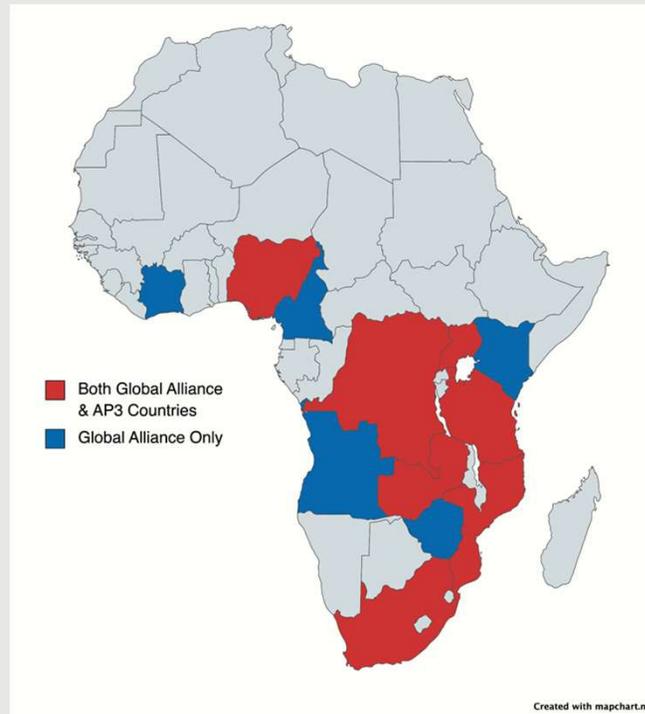
Enablers



...and aligns with PEPFAR's AP3 Initiative and UNAIDS Global Alliance

PEPFAR Accelerating Progress in PMTCT and Pediatric HIV (AP3): Objectives

1. Reduce new child infections in children <10 years through addressing **gaps in the PMTCT** program
2. Rapid **identification, linkage, and treatment of children/adolescents** not yet on ART to increase coverage.
3. **Increase rates of pediatric viral load suppression** to 95% and reduce mortality.



UNAIDS Global Alliance to End AIDS In Children: Objectives

1. Early **testing** and optimized **treatment** for infants, children, and adolescents living with HIV
2. Closing the **treatment gap for pregnant/breastfeeding women** living with HIV and improving continuity of treatment
3. **Preventing new HIV infections** among pregnant/breastfeeding adolescents and women.
4. **Addressing rights, gender equality** and the **social and structural barriers** to access services and promote participation

Summary of Key PMTCT Activities

Prevent and identify incident infections

- **Maternal retesting** at recommended time points; ensure HTS counselor is assigned to MCH
- **HIV self-testing** for maternal retesting
- **Improve M&E** for maternal retesting
- **PrEP for PBFW**
- Link HIV-negative pregnant AGYW to **DREAMS**
- **Male partner testing**
- **Integrate GBV services** into ANC/PMTCT

Ensure uptake of ART among PBFW

- Ensure **all ANC facilities** are **testing for HIV** and reporting data accurately
- In countries with low facility attendance, look for **case finding opportunities** in private facilities and community birth attendance settings
- Engage **faith-based institutions** and other community structures for demand creation
- Intensify **transition to TLD** for PBFW

Continuity in treatment for PBFW

- **AGYW-friendly PMTCT services** and **DSD/MMD**, e.g. group ANC models and new mother programs for AGYW, weekend appointments
- **Peer-based support**, e.g. mentor mothers and peer support groups
- Align **OVC support to facilities** with high rates of AGYW pregnancies
- **QI for VL coverage and suppression in PBFW**; improving disaggregated VL data for PBFW

Care and testing for HIV-exposed infants

- Improve **infant testing uptake** and **reduce missed tests** at all recommended time points, including through community support
- **Provide POC EID** as part of an optimized lab network
- **Track infants** until final outcome; e.g. longitudinal cohort monitoring, inclusion in EMRs, continuity coordinators at sites
- **OVC support to at-risk HEI** and their families

Summary of Key Activities for Children and Adolescents

- Promote family-based index testing
- Utilize community testers
- Establish efficient HTS streams and sick entry points
- Use validated HIV screen-in tool (OPD)
- Allow HIV self-testing for CALHIV
- EID and HTS (within community PMTCT)
- Integration of OVC, KP and TB for HIV case finding
- Testing through other modalities
- M&E and CQI

2nd 95



- Prevention of IIT/CoT
- AHD diagnosis and treatment
- DSD scale up & MMD for all eligible C/ALHIV
- Service integration (OVC, KP & TB)/TPT
- ART optimization
- Improve linkage to ART
- Consultation rooms for peds (one-stop-shop family approach)
- pDTG roll-out
- Improve ICT implementation for C/ALHIV
- Strengthen patient tracking system

- POC testing for VL
- Family centered approach
- Case management to strengthen ART adherence
- Caregiver education
- One team approach (OVC platform to improve VL)
- Community demand creation strategy
- Secure commodity supply chain

3rd 95



1st 95





PMTCT and Pediatric/Adolescent Treatment Overview

Meena Srivastava

Slide 9

1

Meena to drop in a few intro slides from this deck that we are using for the technical session (slides 15-23).

https://docs.google.com/presentation/d/1yOaCn6WeckOicaM_e1y-6PWBjRVXG9DDtOnIVdCOH0w/edit#slide=id.g12bba0c3e00_0_166

Meena Srivastava, 11/8/2022



PEPFAR



Improving EID Uptake at 6 weeks and Preventing New infections among HEI at Final Outcome through Effective Mother-Baby Pair Tracking: Experience from the USAID Funded ARFH-ICHSSA 2 Project in Lagos State

Presenter: Jimin Sontyo, Association for Reproductive & Family Health (ARFH)

Authors: Jimin Sontyo¹, Iwuala Felix¹, Doreen Magaji², Oke Olufemi¹, Biola Asekun, Mobereade Ayotunde¹, Olabisi Mapaderun³, Amina Mbaya³

Affiliations: ARFH, USAID Nigeria, FHI360

Slide 10

2 @ifaturiyele@usaid.gov
@llee@usaid.gov
@eaberra@usaid.gov

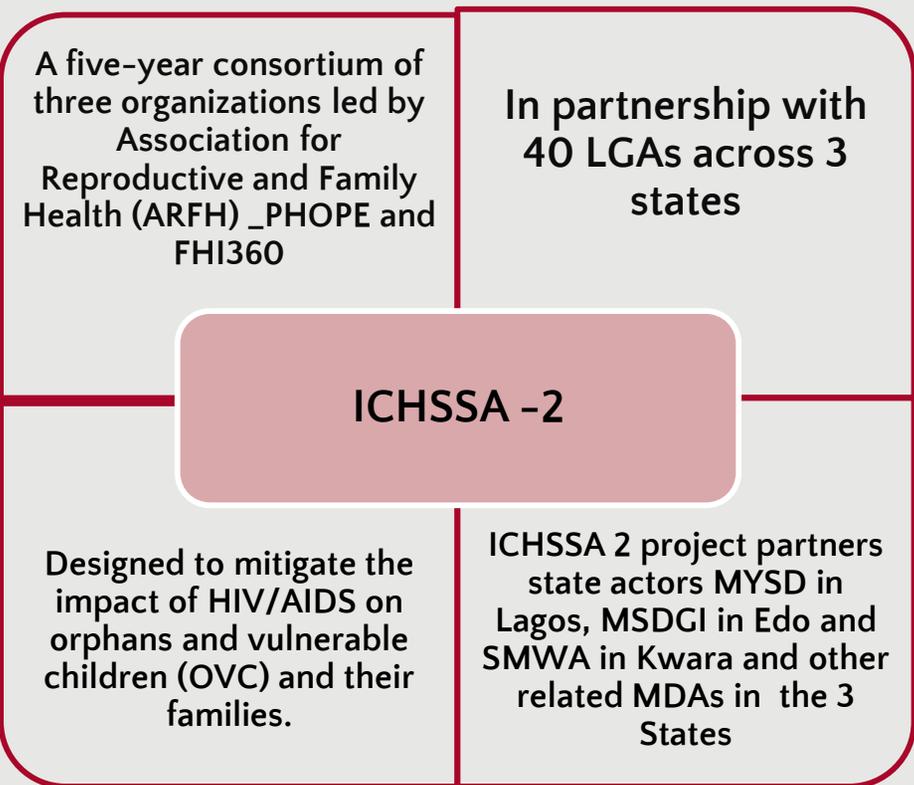
Hi Ola, Lana and Amy - FYI that Nigeria will be submitting slides later today for this LP abstract session. Feel free to review and let us know if any feedback if you have time. I'll update you all when slides are in. Thanks!

Meena Srivastava, 11/8/2022

3 Hi all - Nigeria slides were submitted starting on slide 4. Thanks!
Meena Srivastava, 11/8/2022

Background

- Nigeria continues to experience challenges with Prevention of Mother to Child Transmission of HIV (PMTCT) and tracking of HIV Exposed Infants (HEI), due to increased cycles of interruptions in treatment.
- The USAID funded Integrated Child Health and Social Services Award (ICHSSA-2), implemented by Association for Reproductive and Family Health (ARFH) and Partners, adopted an effective **mentor mother tracking model**, to increase EID uptake at 6 weeks and prevention of new MTCT of HIV after the receipt of EID results.



Methods

To prevent missed opportunities and ensure mother-baby pairs are tracked until final outcomes, ICHSSA-2 adopted a two-prong approach of tracking mother-baby pairs through mentor mothers, engaged Case Managers.

Using a tracking register,

- Facility based: case managers
- Community based: mentor mothers on the project track the infants until results are received and expected outcomes are achieved.

The mentor mothers track the mother-baby pairs to ensure the uptake of EID at 6 weeks and to ensure that they receive a rapid test at 18months, including comprehensive services.

Quarterly review meetings were held for learning and sharing of best practices on Adherence, retention and care for HEI/CLHIV.

**Mother baby
Tracking across
community
structures**



ARFH

Working Together, Building a Healthier Future

Mentor Mothers



**Quarterly review
meetings with
mentor mothers**



Partnership



Results

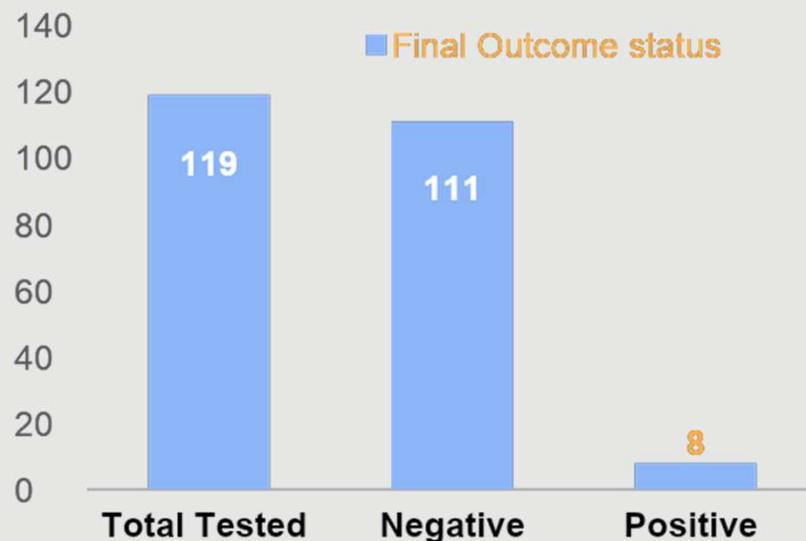


*RR: Result returned



Out of the 949 (477M, 472 F) being tracked, a total of 765 (378M, 387F) HEI were due at least 6 weeks for EID, sampling rate of 99.6% was achieved {762 (376M, 386F) following tracking supports.

Result returned rate was 90% {754 (371M, 383F)} with 8 cases found (5M, 3F). Positivity yield= 1.1%



Of the 119 (53M, 66F) who had HIV rapid test done at final outcome, 111 had negative and 8(3M, 5F) had positive results respectively.

Positivity yield= 6.7%

Replicating this model/intervention in other countries



Opportunities

- Increased pediatric case finding
- Preventing missed opportunities
- Increased identification and linkage of pregnant women

4

Challenges

- Perception of competition among TBAs
- Client follow up related issues
- Delayed DBS results

Slide 14

- 1 Could this be clarified? Competition could be a good thing, but here its listed as a negative
Jacqueline Firth, 11/8/2022
- 4 Hi Jimin - Could you clarify this bullet on competition between TBAs? Perhaps on the slide or in your talking points, you can expand further...

@sontyo.j@arfh-ng.org
Meena Srivastava, 11/8/2022

Conclusion



Effective tracking of mother baby pairs in a community-based approach, with support from the mentor mothers engaged as Case Managers could improve the uptake of EID at 6weeks (99.6%).

Also, this approach has the potential to prevent vertical transmission from mother to child at the 6 weeks timeline based on ongoing support through regular home visits and provision of care and support services for the mother-baby pair by community based Case Managers.

The sustained technical assistance provided by USAID/Nigeria and informed guidance provided during routine weekly meetings have continued to strengthen program implementation for optimal outcome of interventions. This is a golden practice that should be replicated.

—

Thank you





Child, Adolescent and Family Care Days provide a mix of interventions that support retention and virological suppression in children living with HIV

Presenter: Jackie Dunlop, Anova Health Institute

Authors:

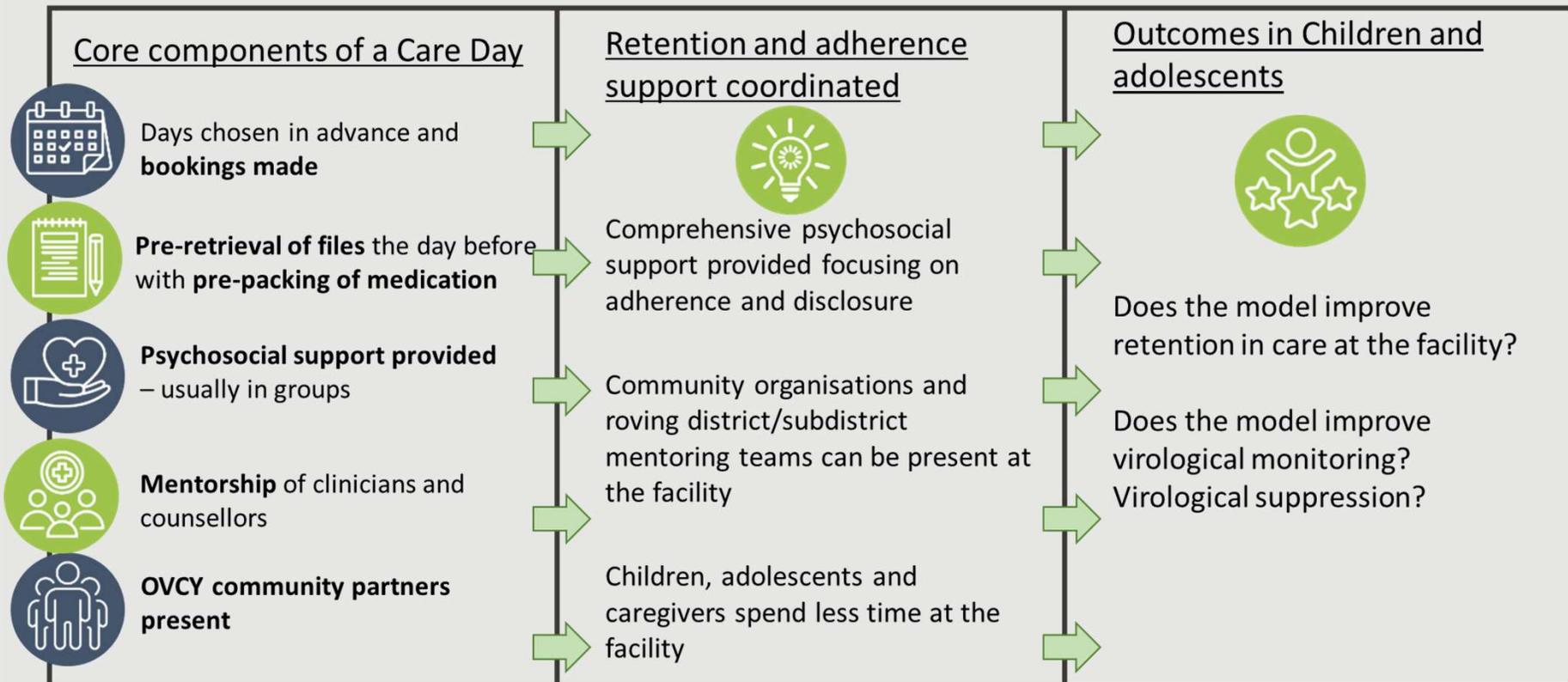
Affiliations:

Slide 17

- 1 Thanks, Meena. I welcome Sarah's input on if it's appropriate to ask how OVC IPs can be included in this important work.
Rachel Golin, 11/8/2022
- 1 Hi all, OVC partners are noted as participants on Slide 10 which is good. Note that our OVC IP (HIVSA) has an MOU with Anova that lays out collaboration/roles/responsibilities.
- It could be useful for Anova to highlight how they work with OVC on this activity (and more broadly), especially the role of the Child and Youth Care Workers (CYCWs) in ensuring holistic care for C/ALHIV, family disclosure support, etc.
Sarah Dastur, 11/8/2022
- 2 Yes, thank you, Sarah > yes, I was thinking of more granularity as the mention on slide 10 is broad.
Rachel Golin, 11/8/2022
- 6 Agree with you both. I'll ping Jackie Dunlop from ANOVA to see if she can incorporate this feedback.
Meena Srivastava, 11/8/2022
- 1 Thanks for the comments. This was indeed a gap in the presentation. I have added a new slide fourteen
Jackie Dunlop, 11/9/2022
- 5 @rgolin@usaid.gov
@jfirth@usaid.gov
@sdastur@usaid.gov
- Hi all - FYI that these are slides submitted by the Anova team for the LP PMTCT/peds abstract session. In case you have any feedback, let me know.
Thanks!
Meena Srivastava, 11/10/2022
- 7 Thank you Jackie!
Meena Srivastava, 11/10/2022

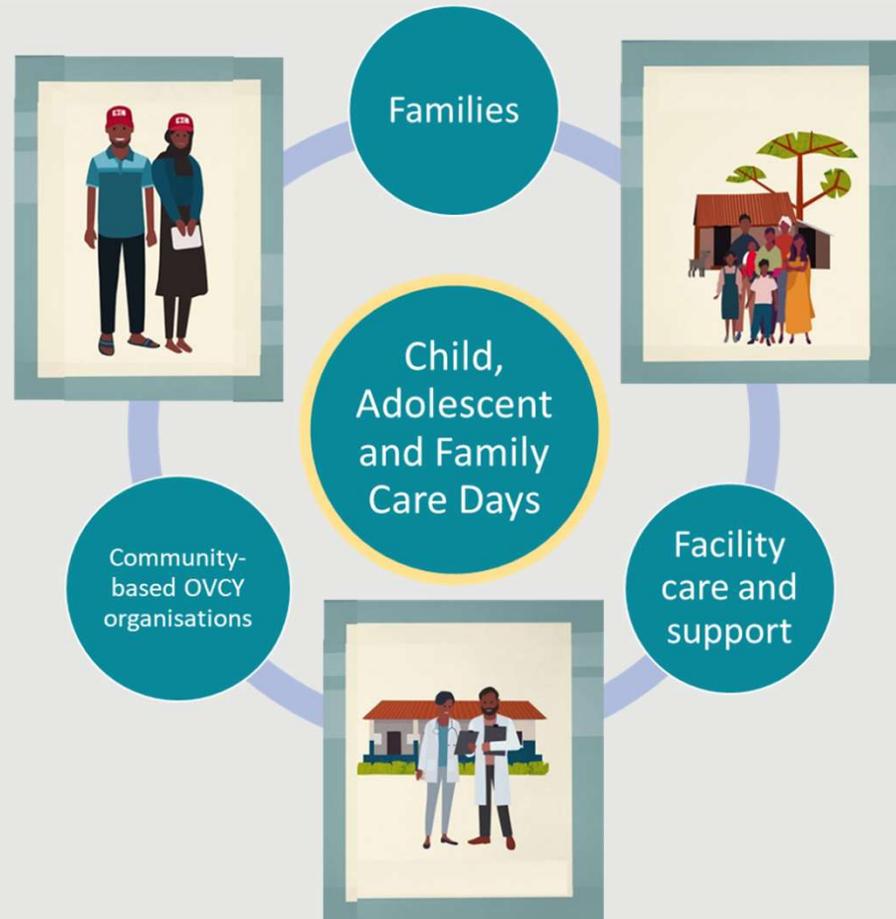
Background

- A family-centred model of care for HIV services
- Care Day's support this by grouping children and adolescents
- Part of the National Department of Health's Paediatric and Adolescent Matrix of Interventions



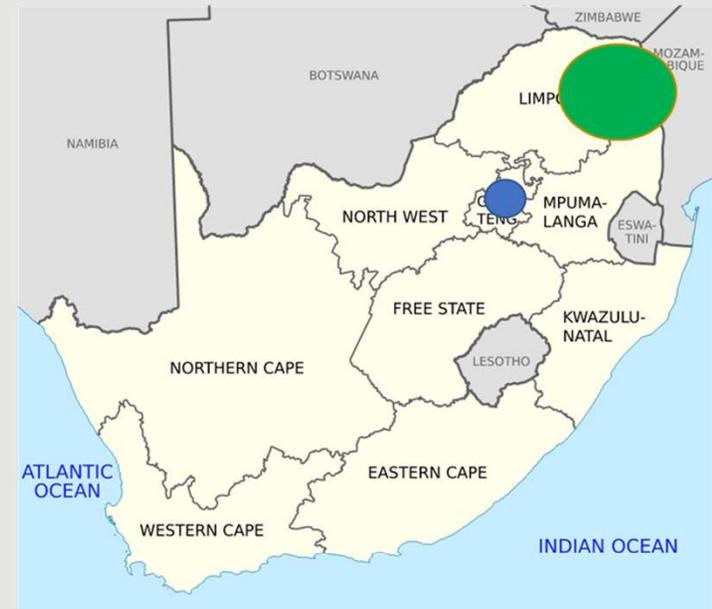
Linking HIV-affected families to OVCY Community-based partners through Care Days

- OVCY community-based partners are key to providing children, adolescents and families living with HIV with comprehensive psychosocial support
- Coordination through Care Days allows for:
 - Community and Facility Teams to collaborate and build relationships
 - Community Team to meet and engage families while they await care
 - Consent to be signed for support and home visits
 - Healthcare workers to refer for specific support where need is identified during clinical consultation (e.g. disclosure)
 - Case conferencing of difficult cases by facility and community team members



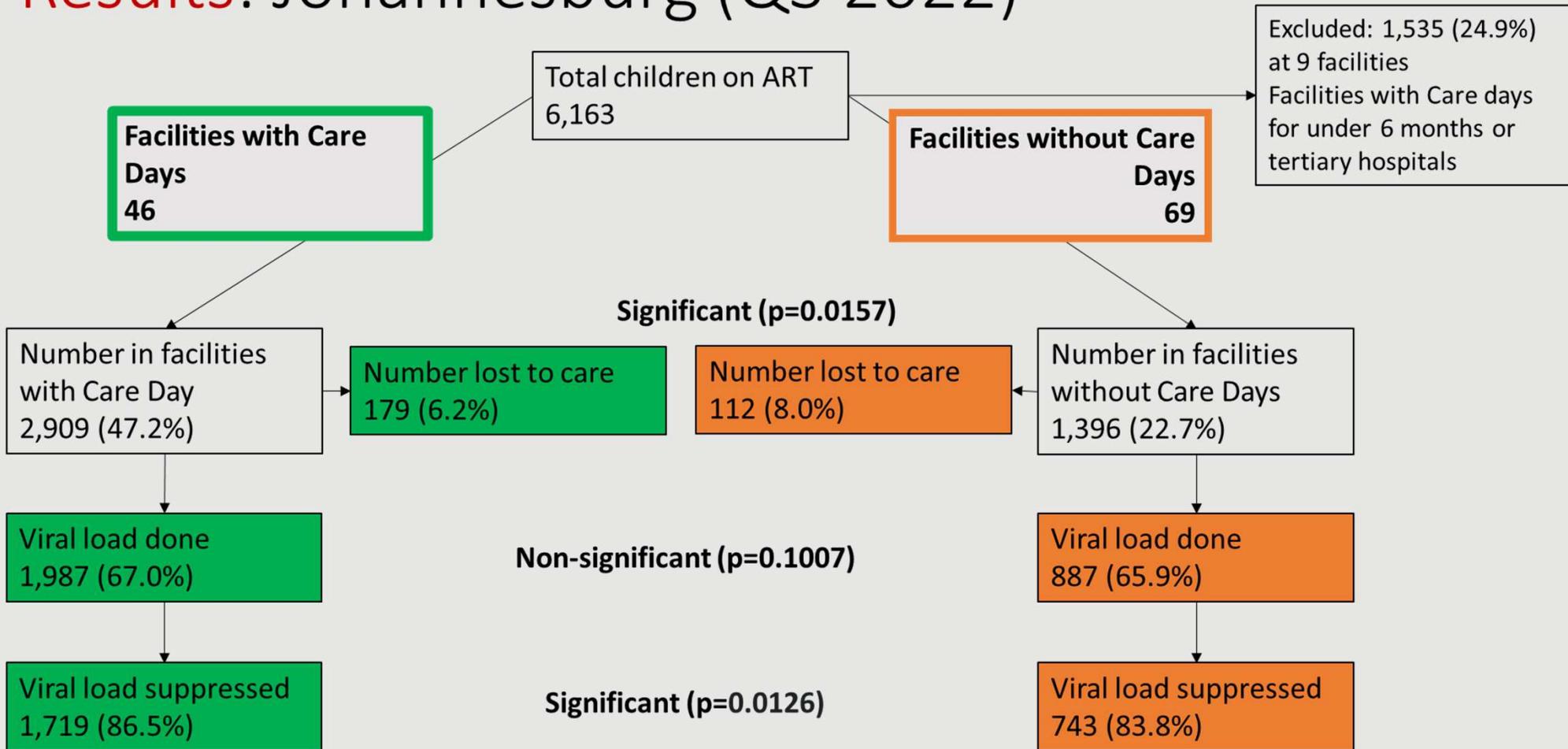
Methods

- Care Days were formed at priority facilities
- At the time of analysis, Care Days had taken place for more than 6 months in:
 - 46 facilities in Johannesburg; and
 - 31 facilities in Mopani
 - Facilities with care days less than 6 months old and tertiary hospitals were excluded
- We measured retention, viral load (VL) done and virological suppression (<1000 copies) for clients under 15 years old
- Compared facilities with Care Days to those without in the same district
- National Department of Health Reports (Original source TIER.Net for April to June 2022)
- Retention was measured by the number and percentage of children who left care in the quarter, because they had disengaged, transferred out or died.

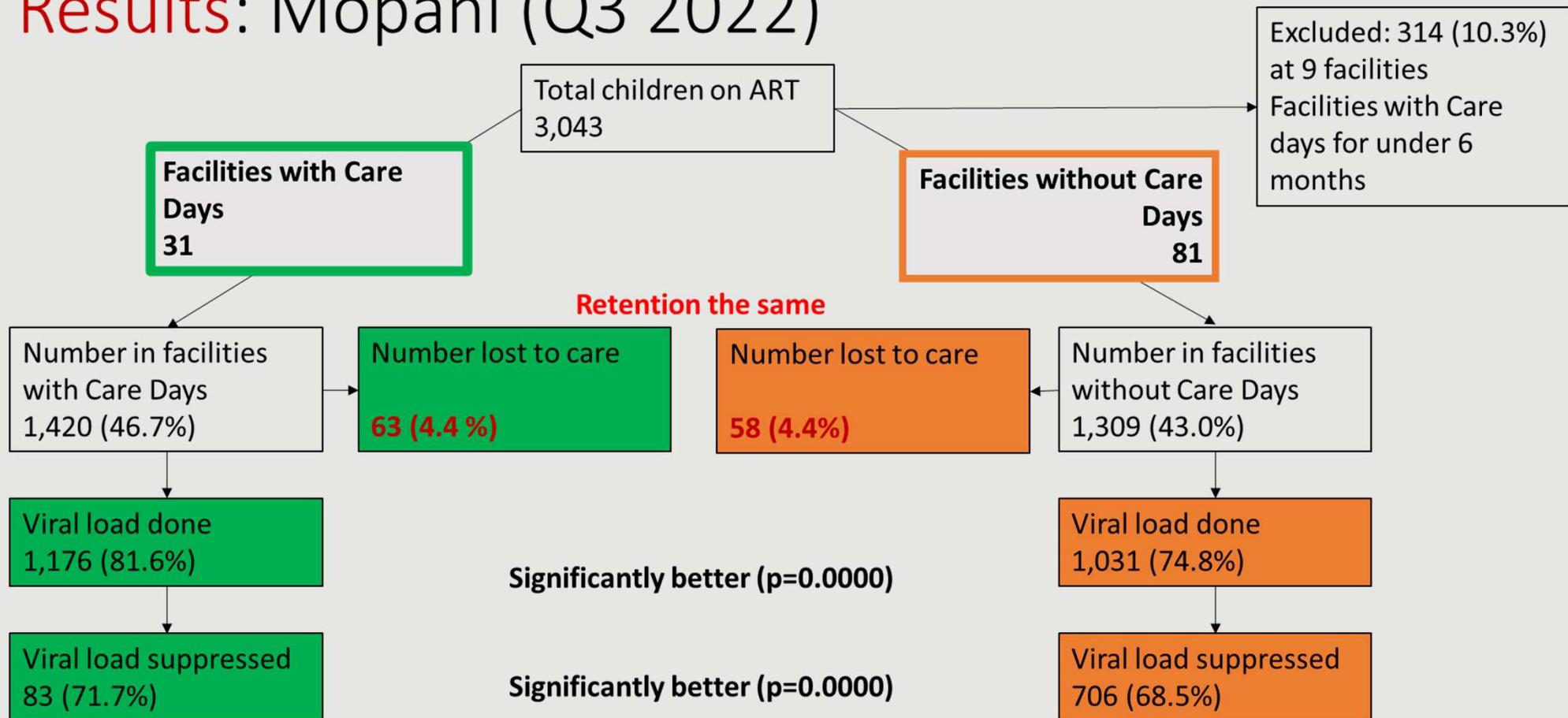


- Johannesburg
- Mopani

Results: Johannesburg (Q3 2022)



Results: Mopani (Q3 2022)



Conclusion

- The number of children not retained in facilities without Care Days is disproportionately higher when compared with facilities with Care Days in Johannesburg but not in Mopani.
 - Smaller numbers in Mopani make this indicator less reliable
- Both VL done and suppressed were better in Care Day facilities in Johannesburg and Mopani, suggesting the core components of Care Days strengthen quality of care provided to children.

Replicating this model/intervention in other countries

- Care days are part of the South African National Department of Health's (DoH) Paediatric HIV Matrix of Interventions
- This is a standardised list of interventions to help SA achieve the UNAIDS 95-95-95 targets for children with HIV
- The Matrix allows for DoH and Implementing Partners to work toward implementing common activities and shares accountability
- Ensuring strategies are aligned allows for an integrated approach to implementation
- In-country strategies focussing specifically on the child HIV programme are necessary to direct efforts towards this underserved group

Thank you:

- To our Funders who made this work possible
- To the Clinic and Community Staff who work tirelessly
- To the Children and Families who worked with us to make Care Days a success



Accelerated and Comprehensive HIV Care for Epidemic Control in Zimbabwe (ACCE) Project

Innovative and sustainable health solutions



Outcomes of Children Living with HIV Transitioned to Dolutegravir based Antiretroviral Therapy Regimen in Midlands and Manicaland Provinces, 2022

Authors: Sibanda T. P.¹, Ganje N.², Tachiwenyika E.¹, Hlungwani E.¹, Tapera T.¹, Nyamundaya T.¹, Muzondo M.¹, Chingombe B.¹, Mucchekeza M.², Mukuzunga M.², Mushavi A.², Nyafesa T.², Hlupeni A.², Andifasi P.², Nyagura T.³, Mhangara M.³, Mukungunugwa S.³, Dhodho M.¹

Affiliations:

¹Zimbabwe Health Interventions

²Ministry of Health and Childcare

³United States Agency for International Development - Zimbabwe



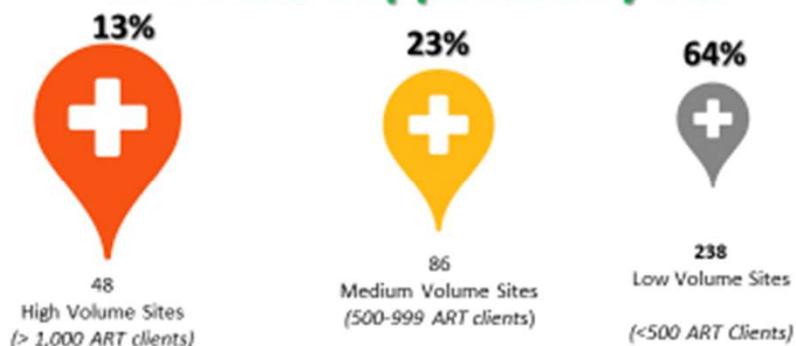
ACCE is a Five-year USAID funded PEPFAR HIV Prevention, Care & Treatment Project



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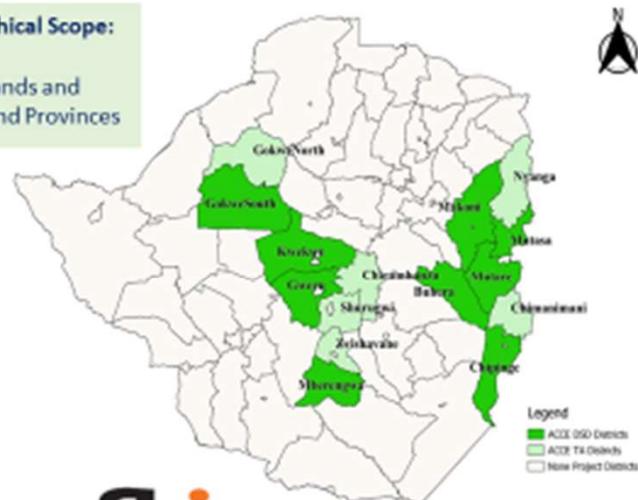


372 Sites Supported by ZHI



Geographical Scope:

Midlands and Manicaland Provinces



ACCE Consortium



Introduction

- Dolutegravir (DTG) is a highly potent antiretroviral medicine and significantly reduces viral load (VL) among people living with HIV (PLHIV)
- In 2021, Zimbabwe introduced the child-friendly dispersible pediatric DTG (pDTG) 10mg tablet in addition to 50mg tablet
 - Phased approach
 - Full scale up with effect from July 2022
- ZHI is supporting roll out and transition to DTG based regimens
 - Capacity building of health care workers
 - Supporting the quantification, ordering and distribution of the drugs to site level
- Routine program data showed suboptimal viral load suppression among children
 - Poor adherence
 - Pill burden / unfriendly regimens

Objectives

Broad Objective

- To assess outcomes of children transitioned to Dolutegravir (DTG)-based ART regimen in Midlands and Manicaland Provinces of Zimbabwe, 2022

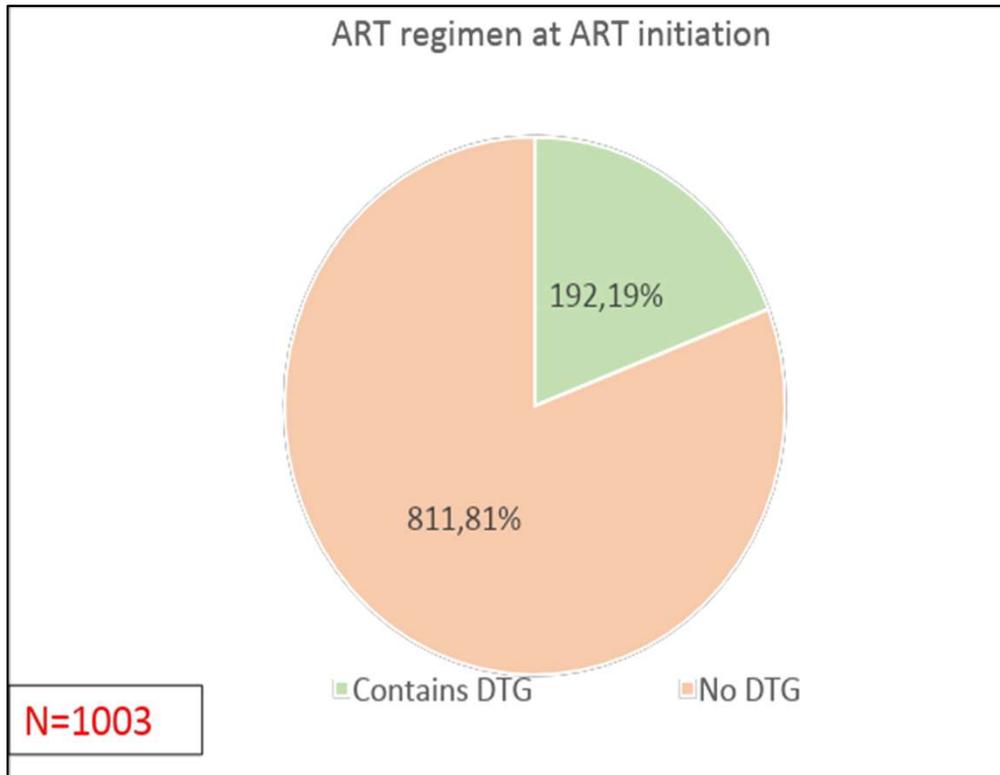
Specific Objectives

- To assess DTG transition rates among eligible children
- To assess viral load suppression rates in children before and after transition to DTG-based ART regimen

Methods

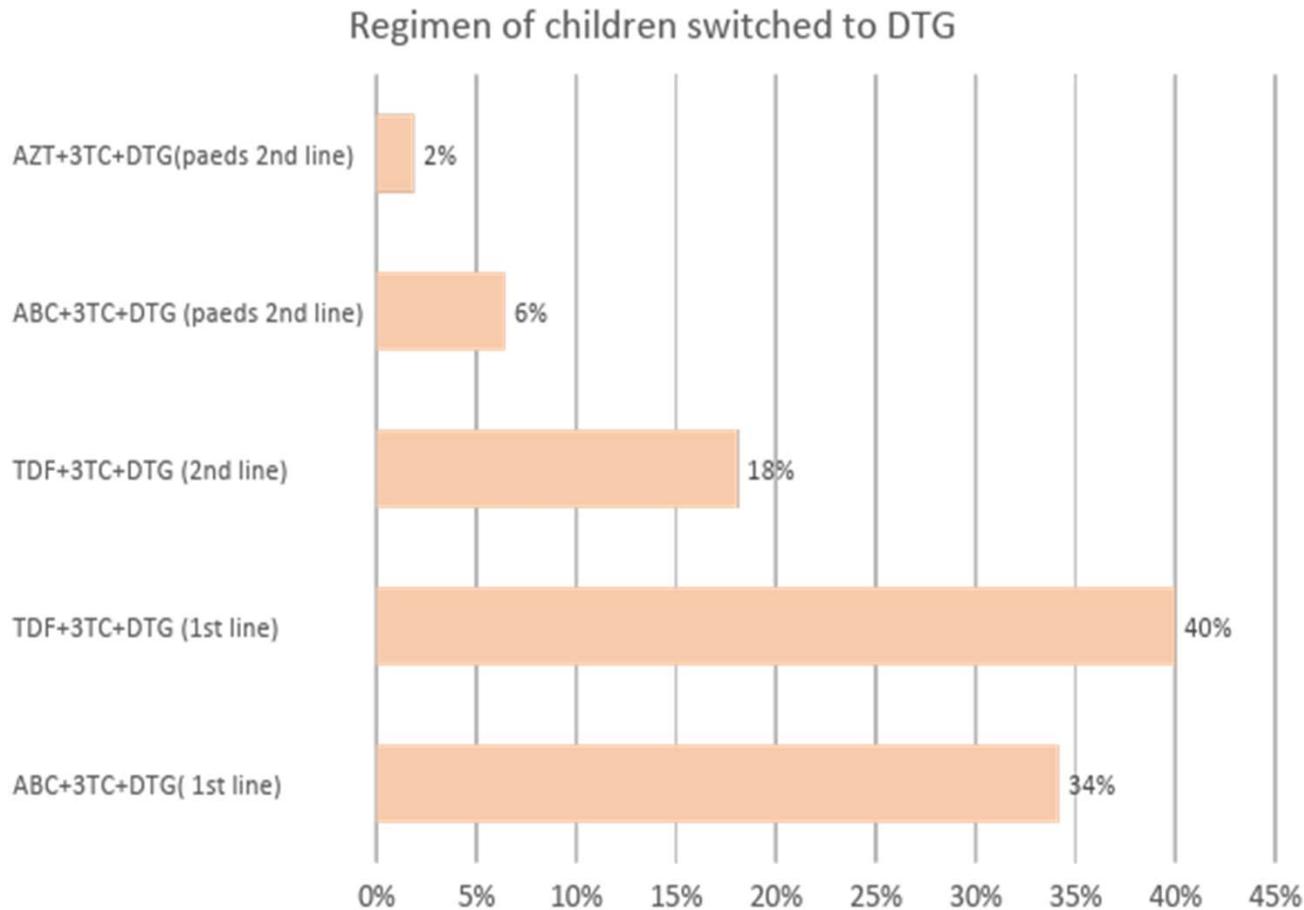
- Analytic cross-sectional study focusing on client outcomes before and after DTG transition across 34 high-volume sites
 - The facilities were purposively selected → ZHI supported staff at those facilities
 - All children on ART in these facilities were included
 - All children 14 years and below at time of ART start were included
- The primary outcomes were viral load suppression and transition to a DTG based regimen
- Ethical approval obtained → Non-research determination
- Client folders were reviewed, and routinely collected data were abstracted and captured into a Kobo electronic data collection tool
- Data were analyzed using Stata 15

Characteristics of included participants



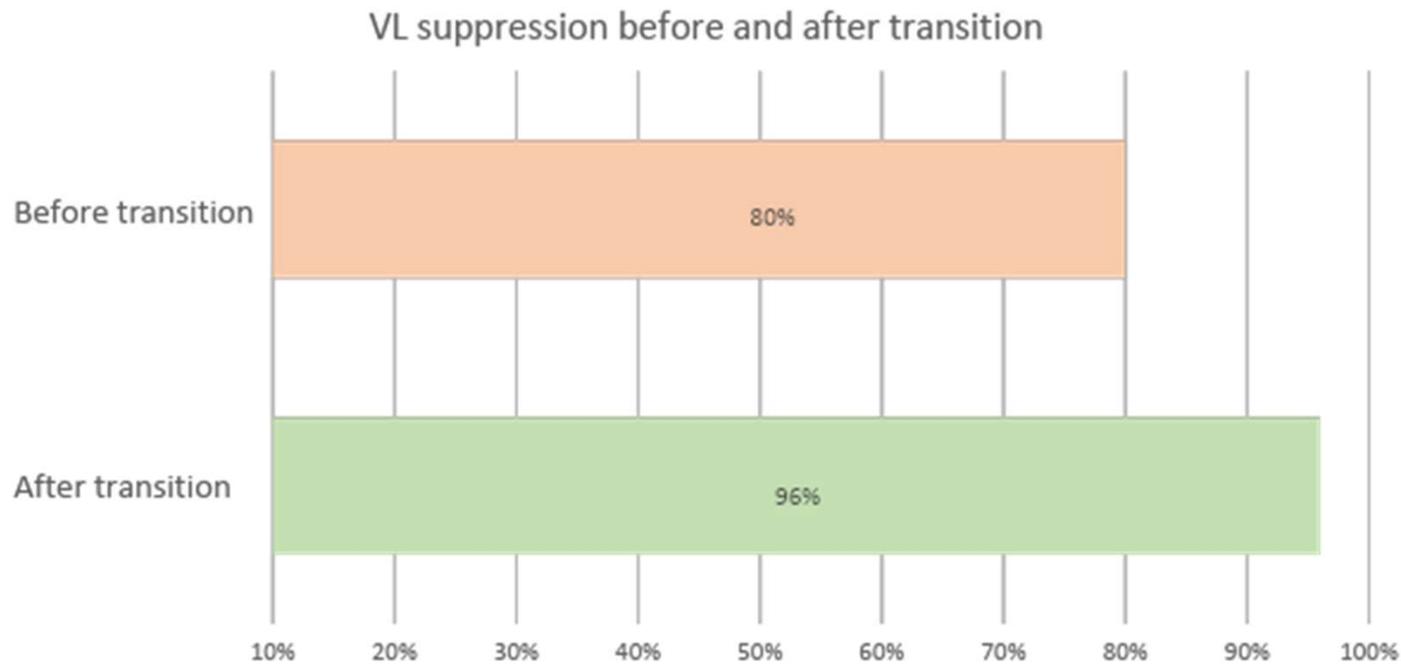
- 1,003 children included
- Median age 11 years (IQR 7-13)
- At ART start 811 (81%) were on a non-DTG based regimen
 - NNRTI-based regimens – 56%
 - LPV/r based regimens – 25%

Proportion of children switched DTG based regimen



- 811 children on non-DTG based regimen
- 635 (78%) were switched to a DTG based regimen between October 2021 to June 2022
 - Before full scale –up

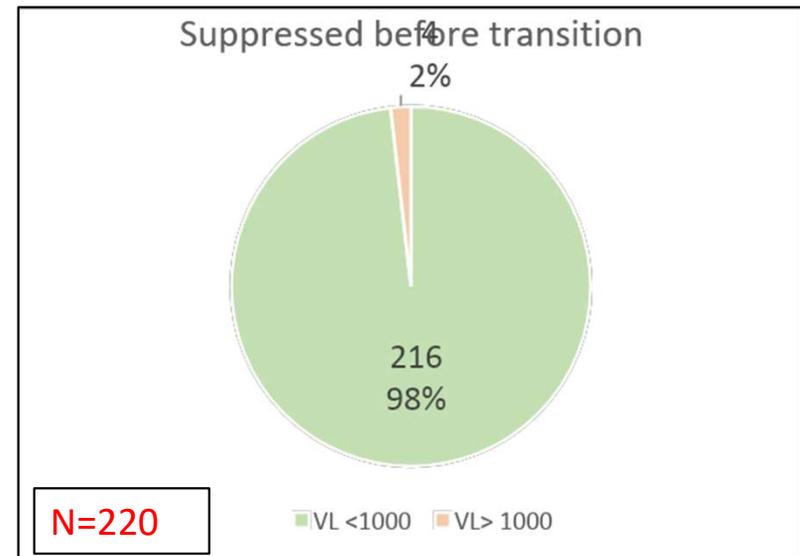
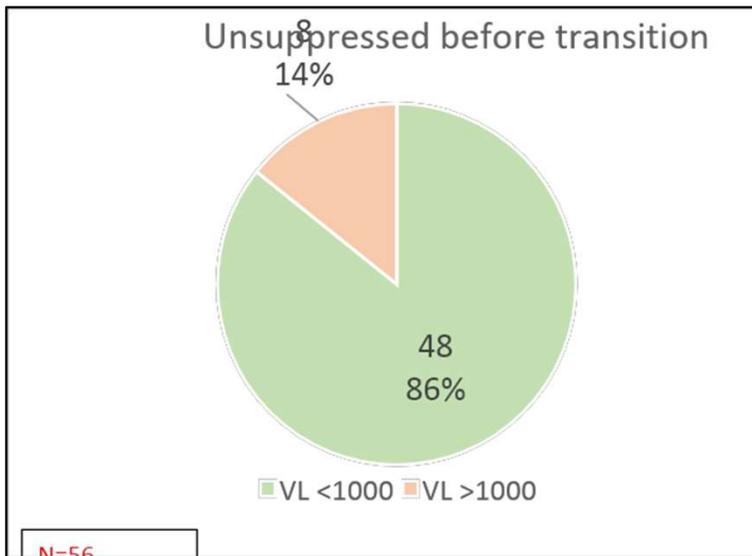
Viral Load suppression before and after transition



N=276

- Results for both groups was available for 276 children
- +16% change in suppression

Viral Load suppression before and after transition



- Subgroup analysis
 - 56 children had unsuppressed viral load before transition and of these 86% (48) were suppressed after transitioning to DTG
 - 220 had suppressed VL before transition and 98%(216) remained with a suppressed VL after transition
- Children who remained on a non-DTG containing regimen were **8 times more likely to have unsuppressed VL** compared than those who switched to DTG (RR 7.86, 95% CI 2.4-25.2)

Discussion

- A significant proportion of children were transitioned to a DTG containing regimen
- Those on a DTG regimen had better VL suppression compared to those on a non-DTG regimen
- Following these observations;
 - 93% of CAYPLHIV in the ZHI supported sites are on DTG – based regimens as at September 30 , 2022
 - VL suppression rates among CAYPLHIV on DTG – based regimens have increased to 93% as at September 30 , 2022 compared to VL suppression rates of 87% as at March 31, 2022 for the same cohort

Conclusion and Recommendation

- Recommend programs to develop guidance to expedite transition of children to DTG-based regimens.



Thank You !



- This report was made possible by the support of the U.S. Government and American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)
- MOHCC staff at all levels
- ZHI program staff
- Program beneficiaries

The contents of this report are the responsibility of Zimbabwe Health Interventions and do not necessarily reflect the views of USAID or the United States Government



Moderated Discussion and Q&A

Thank you!



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