



PEPFAR



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FROM THE AMERICAN PEOPLE

# Clinical Cascade

4th Annual USAID Global Health Local Partner Meeting

**Presenters:**

Thomas Minior, USAID/HQ

Meena Srivastava, USAID/HQ

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# Clinical Cascade

Adult Care and Treatment

PMTCT

Pediatric & Adolescent Testing, Care and Treatment

HIV Testing

Key Populations



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# Adult Care & Treatment

Presenter: Thomas Minior  
Adult Clinical Branch Chief, Prevention Care & Treatment Division, GH/OHA



## Good News.....

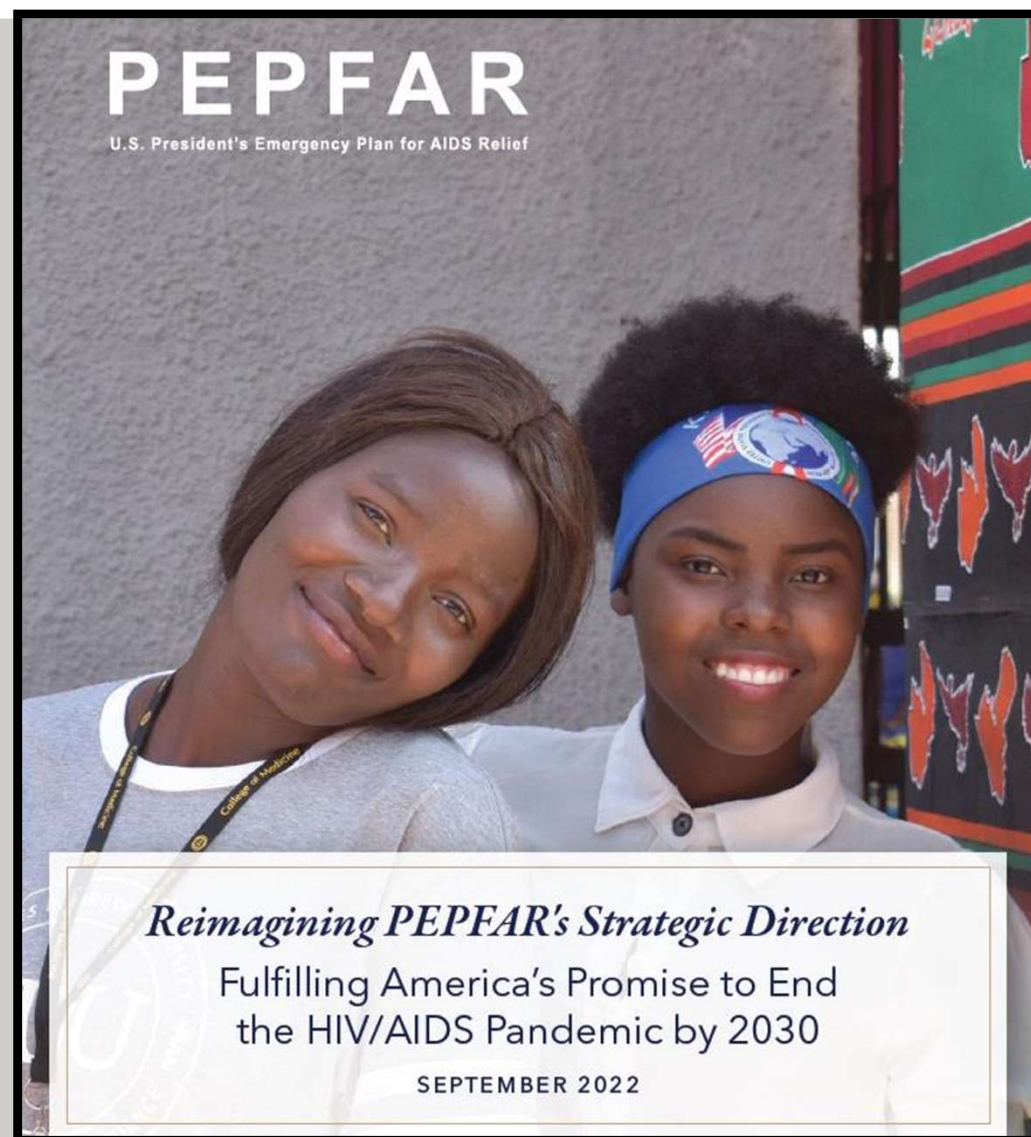
- While COVID did interrupt a lot of health service provision globally, USAID-supported HIV treatment programs were remarkably resilient.
  - TX\_CURR increased **12%** since FY20.
  - IIT has fallen to **2.5%** in FY22Q3
  - Viral suppression reached **94.7%** by FY22Q3
- This continued progress highlights the good work you have all done – in extremely challenging conditions.
- As such, there are not a lot of substantive changes upcoming in clinical service delivery in COP23 – focus on refinements, reaching gaps in priority populations, etc.  
“Do What We Do.. Just More. And Better”

## & New Opportunities.....



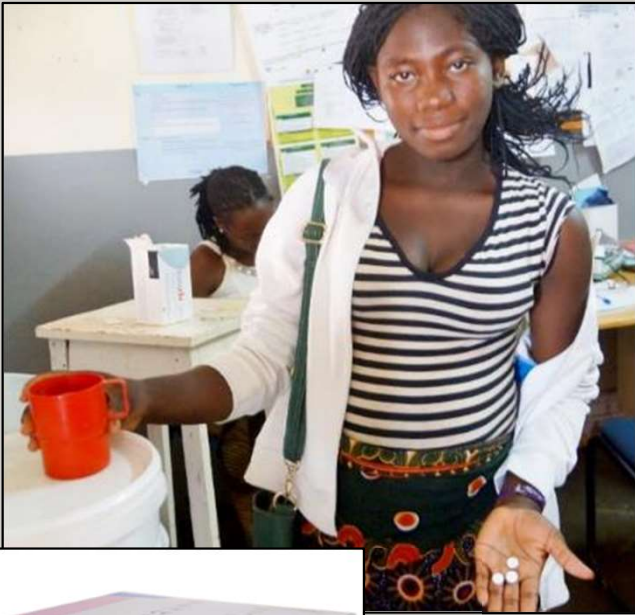
## “Re-Imagining PEPFAR”:

- PEPFAR **is** entering a new phase.
- As many of our programs mature and get close (or even surpass) 95-95-95 targets, there’s a greater focus on ensuring **long-term sustainability** while **reaching remaining programmatic gaps**, as outlined in Amb. Nkengasong’s “Reimagining PEPFAR’s Strategic Direction”
- While not ubiquitous, technology allows us to communicate with our clients and monitor progress – we can better “individualize” care.



## Advancing Advanced Disease

- PHIA surveys demonstrate that 15.4% (range 7-21%) of persons testing positive (but self-reported HIV negative) had a CD4 <200 cells/mm<sup>3</sup>.
- PEPFAR started re-investing in Advanced HIV Disease (AHD) in COP22 → *still limited scale*.
- Step 1: *CD4 testing* for all new clients, those out of care > 1 year, and those with documented virologic failure.
- *Package of services* for those with AHD:
  - Immediate ART
  - Cotrimoxazole (prevents PCP, Toxo)
  - TB Screening & Treatment (half of AHD mortality)
  - CrAg screening & treatment
  - Nutritional assessment and supplementation for SAM
- Consider supplementing with periodic “death audits” – can better understand quality of care & patterns of mortality



Death Audits??  
Sounds creepy!

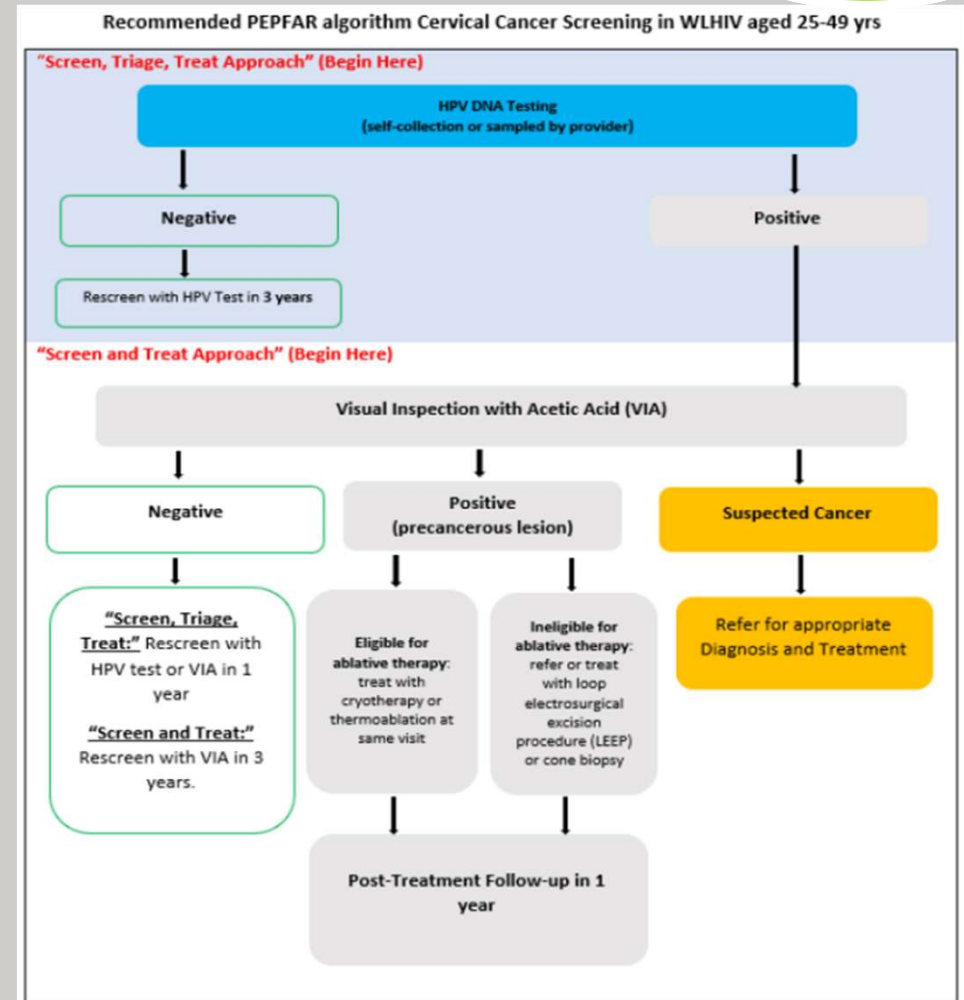




Opportunity!

## Cervical Cancer: OMG, are LPM IPs ready for HPV?

- In 2021, WHO released updated guidelines recommending an additional step in the cervical cancer approach: “Screen, *Triage*, Treat”
- PEPFAR seeking to do a phased approach to ensure:
  - Effective (>90%) linkage to treatment for those with positive lesions
  - Optimizing lab infrastructure to ensure rapid (7 day) Turn-Around Time for HPV testing
  - SOPs for quality assurance of VIA
  - Systems for providing results and tracking clients through the cascade





## Better Service Integration for Clients



- Amb. Nkengasong has highlighted service integration under his Priority Pillar #3, placing particular emphasis on NCD (non-communicable disease) and Mental Health
- Siloed HIV programming misses opportunities (such as non-communicable disease (NCD) treatment) to *reduce morbidity and mortality* for PLHIV.
  - Clients have other health needs; fractured care impedes continued adherence & suppression...
  - Less verticalized programming can encourage *sustainability*
- However, *there are risks* of service quality suffering → need to take a *thoughtful approach, tailored to the local epidemic and health system, listening to PLHIV communities and ministries of health.*

HIV into PHC?

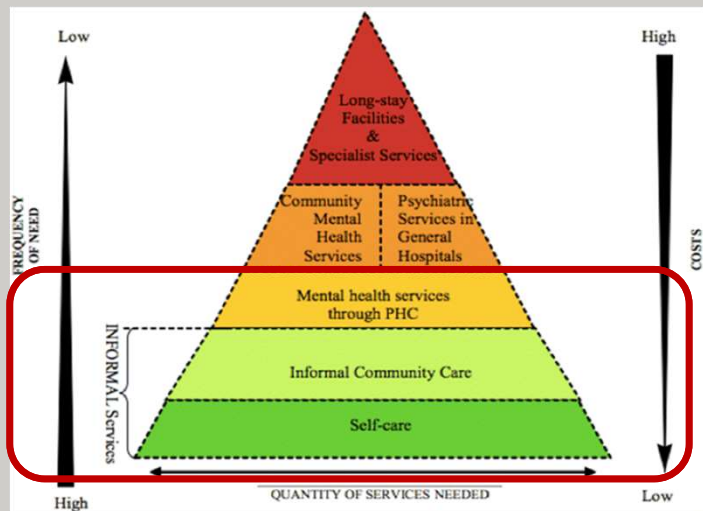


PHC into HIV?


Opportunity!

# Mental Health & Psychosocial Support: Finally!

- Screening and basic support can go a long, long way
- Will require leveraging and training community health workers and expert clients



**Common Element Treatment Approach (CETA)**



Target Populations: Unhealthy alcohol use and comorbidities among PLWH  
 Intervention delivered by: HIV peer educators and local supervisors  
 Location: PHC in Lusaka, Zambia

**Trauma-focused Cognitive Behavioral Therapy (TF-CBT)**



Target Populations: Children and adolescents  
 Intervention delivered by: Therapists  
 Location: Non-specialized healthcare settings

**WHO Mental Health Gap Action Programme (mhGAP)**



Target Populations: Adults, adolescents, and children with MNS conditions  
 Intervention delivered by: Non-specialized healthcare providers  
 Location: Non-specialized healthcare settings

**Friendship Bench (FB)**



Target Populations: Women who had been identified with depression  
 Intervention delivered by: Village health workers (VHWs)  
 Location: community/facility based in Zimbabwe

**The Zvandiri Model**



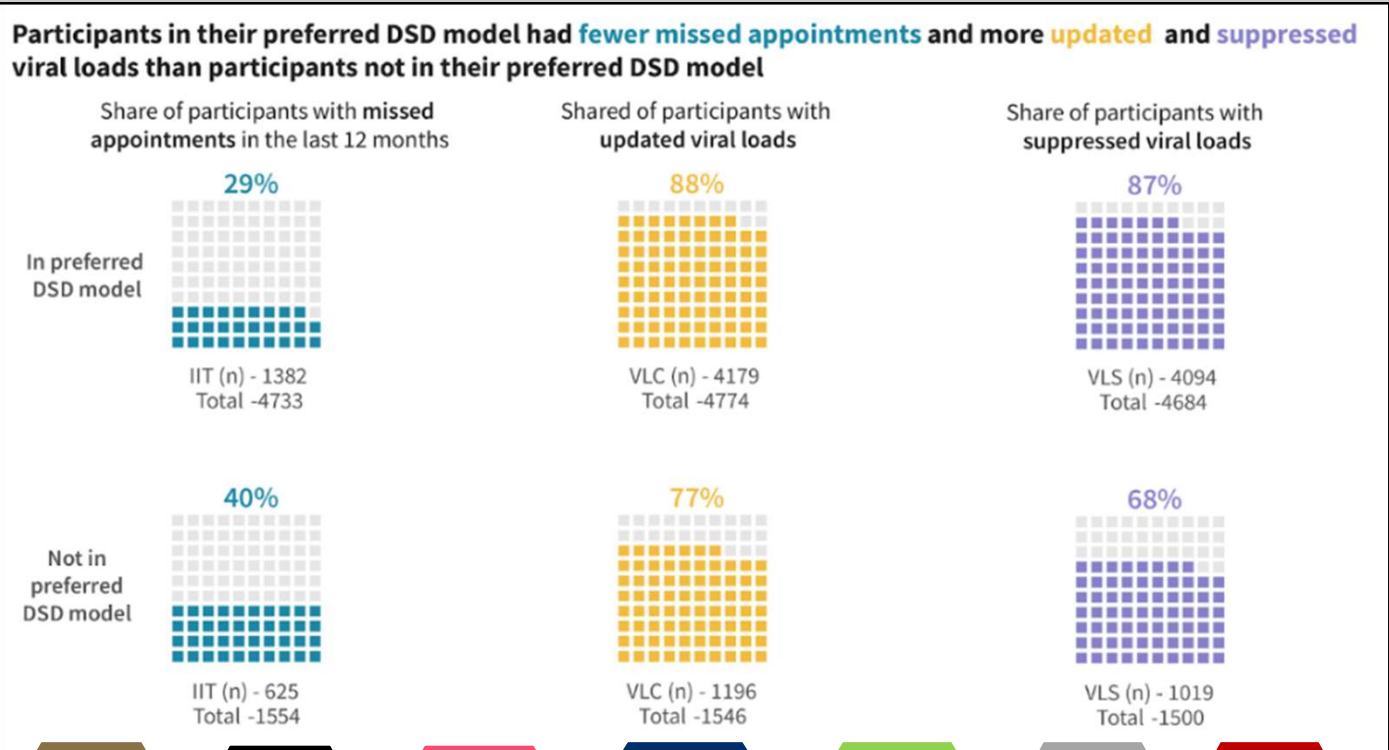
Target Populations: Adolescents living with HIV  
 Intervention delivered by: CATS, YMM, YMD  
 Location: community based in Zimbabwe

**Collaborative Care Model (CoCM)**



Target Populations: Chronic patients with co-existing depressive and alcohol use disorder (AUD)  
 Intervention delivered by: PHC nurses  
 Location: PHC in South Africa

# Optimizing DSD – Assessing Patient Preference

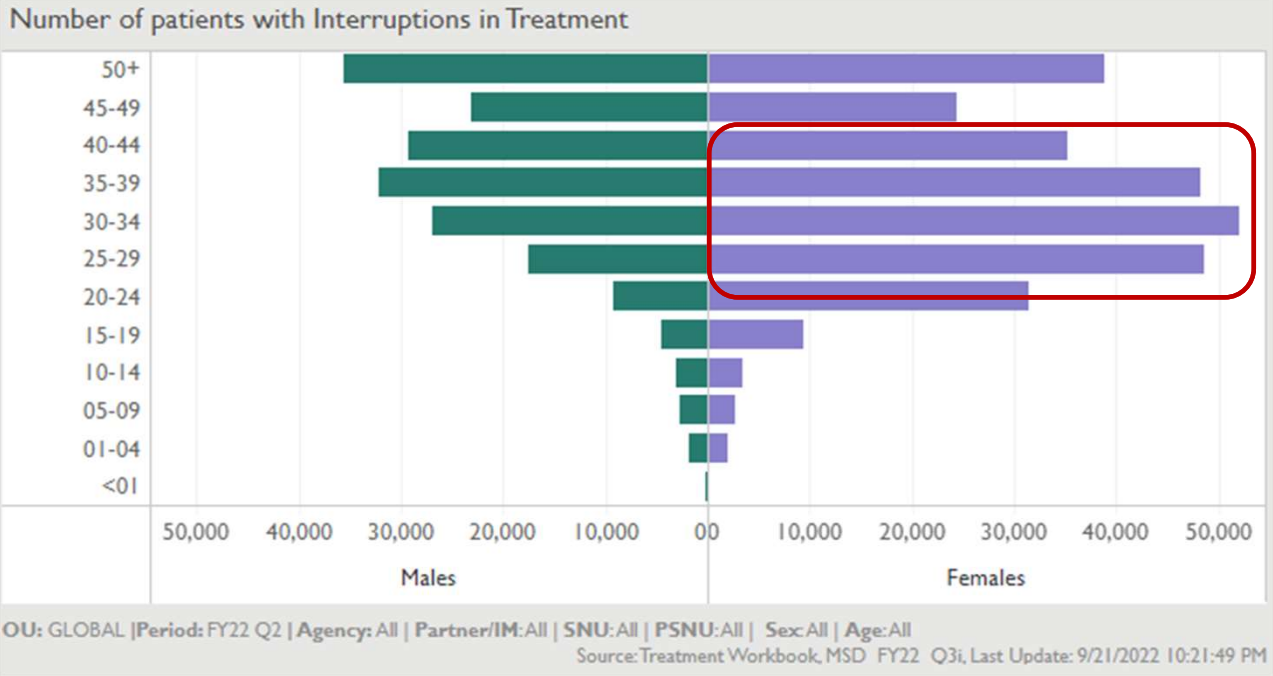


- We've made substantial progress shepherding MMD and DSD models
- Life circumstances change: Important to assess periodically
- Complement with periodic qualitative assessments and behavioral nudges

Uganda Patient-Preference Pilot 2022 courtesy of USAID/Uganda & IPs



# Don't Forget about non-pregnant WLHIV



- There were 100,00 interruptions in treatment for women just in the 30-39 year old demographic
- Most of our services for women center around pregnancy
  - *Qualitative opportunity: what are the barriers non-pregnant and older women face and how can we overcome them?*
- Services that produce even small percentage reductions in IIT can make a huge impact on the program

# Bringing it back to the basics: TLD! (Rah rah!)

- Occasionally, people will fail DTG-based regimens → but it's almost never due to resistance!
- Global Treatment Guidance is likely to change in coming years away from sequential 1<sup>st</sup>/2<sup>nd</sup> line approaches
- For now, though we need to finish the job:
  - Countries/Partners where TLD is <90% of TX\_CURR
  - pDTG
  - TLD for 2<sup>nd</sup> Line
- Be sure to monitor weight gain regularly in all clients, including those on TLD

**Prevalence of DTG resistance in ART experienced INSTI-naïve persons\*\***

Author/yr	Population	Past ART	DTG ART (q24h)	Subjects	Weeks	Percentage VF (95% CI)*	Percentage resistance (95% CI)†
About19	RCT (DAWNING)	VF on a 1st-line NNRTI regimen	DTG + 2 NRTIs (1 NRTI predicted to be fully active)	312	24	17.6 (13.7–22.4)	0 (0–1.5)
Cohn13	RCT (SAILING)	h/o resistance to ≥2 ARV classes	DTG + OI (1 to 2 ARVs predicted to be fully active)	354	48	29.1 (24.4–34.1)	0.6 (0.1–2.3)
Vavro18	trial (P1093)	heavily treated adolescents	DTG + OI	61	48	31.1 (19.9–44.3)	4.9 (1–13.7)
Lepik17	cohort	infrequent h/o NRTI resistance (<10%)	DTG + 2 NRTIs	252	48	16.7 (12.3–21.9)	0.8 (0.1–2.8)
ALL, 48 weeks‡				979	48	28.0 (18.6–37.5), I <sup>2</sup> =91	0.7 (0.2–1.2), I <sup>2</sup> =0

\*Prevalence among all on treatment (meta-analysis as of January 2019)  
 \*\*VF, confirmed viral load >50 copies/ml or treatment discontinuation for any reason. For the cohort studies, the proportion of persons with VF after the median time of follow-up was provided.  
 †Percentage of those receiving DTG ART developing an INSTI resistance mutation.  
 ‡Pooled proportions and 95% CI of VF and VF with INSTI resistance estimated using a random-effects meta-regression.

©Ihara et al. JACI 2019

Clients on ART may fail – but it's almost never DTG resistance!





**Prevalence of DTG resistance in triple ART clinical studies\***

Study	Pop	ART	Weeks	DTG, N	VL >50cps/ml ITT, n (%)	Incident DTG res in PDVF (n/N (%))
ARIA	ART naive	DTG+ABC+3TC	48	250	45 (18.0)	0/6 (0)
FLAMINGO		DTG+ (TDF/FTC or ABC/3TC)	96	242	48 (19.8)	0/2 (0)
GS 1488		DTG+ABC+3TC	144	315	50 (15.9)	0/6 (0)
GS 1490		DTG+FTC+TAF	144	325	52 (16.0)	0/7 (0)
SINGU F		DTG+ABC+3TC	144	414	118 (28.5)	0/11 (0)
SPRING-2		DTG+(TDF/FTC or ABC/3TC)	96	411	71 (17.0)	0/1 (0)
NAMBA-L		DTG+TDF+FTC	96	310	81 (26.0)	0/8 (0)
ADVANCE		DTG+ (TDF/FTC or TAF/FTC)	96	702	151 (21.5)	0/118 (0)
INSPIRING		DTG +2 NRTIs	48	69	17 (24.6)	0/2 (0)
DULPHIN-2		DTG +TDF+FTC/3TC	72	125	9 (7.2)	0/3 (0)
Siemini 1 & 2	ART experience INSTI naïve	DTG + D3+R-1C	144	717	114 (15.9)	0/9 (0)
Oddsby A***		DTG +2 NRTIs	96	151	37 (24.0)	0/15 (0)
P1093***		DTG+OI	192	142	15 (10.2)	0/36 (22.2)
EMFOT		DTG+TDF+3TC	24	1893	36 (2.0)	2/5 (40.0)
Oddsby B***		DTG +2 NRTIs	96	198	43 (21.3)	4/32 (12.5)
SAILING		DTG+OI	360	357	-	7/46 (15.2)
NALJA		DTG+2 NRTIs	96	235	46 (19.6)	0/20 (0)
ARTIST		DTG+TDF+3TC	24	60	9 (15.0)	0/1 (0)
DAWNING		DTG+2 NRTIs	150	324	-	7/16 (43.8)

\*Updated systematic review and meta-analysis ongoing  
 \*\* Data excludes case studies  
 \*\*\* Pediatric studies, the other studies included mainly adult population

Slide courtesy of Ron Shaffer, Stentor

## Bringing it back to the basics: Improving VLC

FY22 SUMMARY TABLE	
<p><b>Percent of TX_CURR on MMD at least 3m<sup>1*</sup></b></p> <p>83%</p> <p>(4,054,864/4,901,370)</p> 	<p><b>Percent of TX_CURR on MMD 6m<sup>1*</sup></b></p> <p>38%</p> <p>(1,877,745/4,901,370)</p>
<p><b>Viral Load Coverage<sup>2</sup></b></p> <p>73.2% (4,813,702)/(6,573,245)</p> <p>72.1% (4,819,525)/(6,682,783)</p> <p>73.9% (5,031,998)/(6,807,554)</p> <p><b>Meh</b></p>	<p><b>Viral Suppression<sup>1</sup></b></p> <p>95%</p> <p>(4,769,953/5,031,998)</p> 
<p><b>Continuity of Treatment<sup>2</sup></b></p> <p>99%</p> <p>(7,040,232/7,112,872)</p> 	<p><b>Interruptions in Treatment<sup>2</sup></b></p> <p>2.5%</p> <p>(179,359/7,073,794)</p> 

OU: GLOBAL | Country: All | Funding Agency: USAID Partner: <Prime Partner (group)> | Mech: All

Source: Executive Dashboard, PSNU x IM Quarterly Hyperfile, Last Updated: 12/31/2022

- We've made strides in reducing IIT, expanding MMD, increasing VL suppression → but VL coverage remains stagnant

Two key points:

- Optimize your VL system (sample delivery routes, result return)
- Take the viral load collection out of the clinic where feasible

## And of “Core”se: Don’t Forget the Core!

Rapid ART Initiation for all new and returning clients

Proactive support for retention & adherence

Providing management support to improving flow within clinics

Offering a range of service delivery models and drug pickup choices

Optimizing ART regimens (TLD!)

Checking VL annually & rapid result return

U=U Messaging and health literacy

Community-Based Support

Screening for TB and providing appropriate TPT or TB Tx

GBV screening

Instilling a culture of Continuous Quality Improvement

Periodic Data Quality Assessments

Etc...



*But of course, with an agency-level VLS rate of 95%, you must be doing all this, so please don't...*





"Positive Living" in Tanzania. Courtesy of photostore.org

*In the End, it still boils down to understanding our recipients of care and designing effective & efficient services that empowers them and meets their individual needs.*



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# Reaching mothers, children/adolescents and families

## PMTCT and Pediatric & Adolescent Testing, Care and Treatment

Presenter: Meena Srivastava

Medical Officer, Pediatric Maternal Clinical Branch, GH/OHA



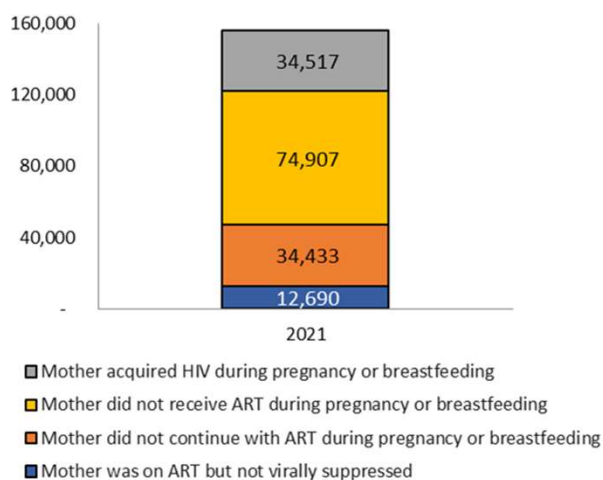
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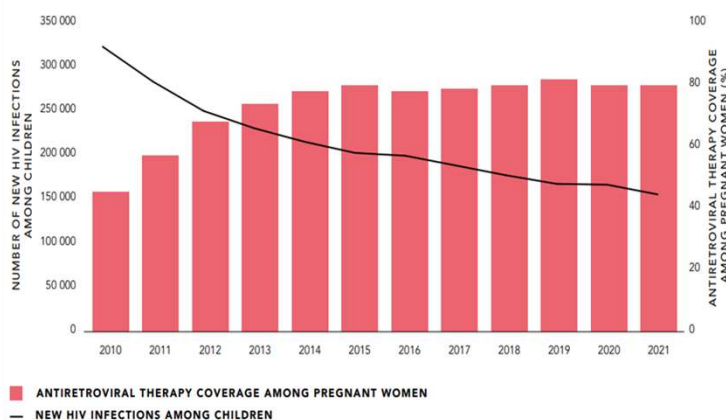
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# Global Progress in PMTCT and Reducing New Child Infections

Progress made in PMTCT has stagnated globally, and more effort is needed to close the gaps for mothers and infants

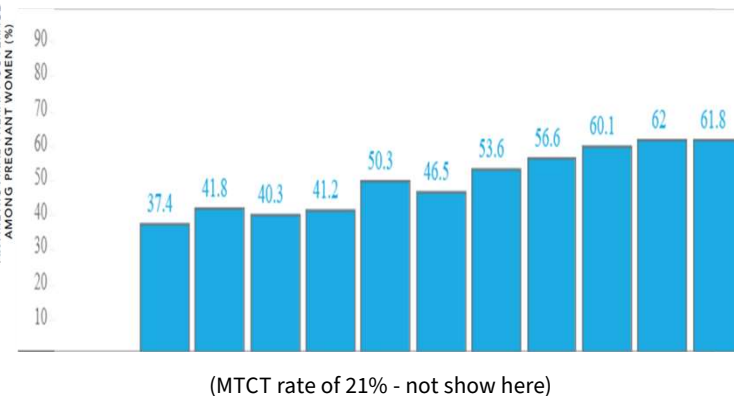


**FIGURE 1.21** New HIV infections among children (aged 0–14 years) and antiretroviral coverage among pregnant women, global, 2010–2021



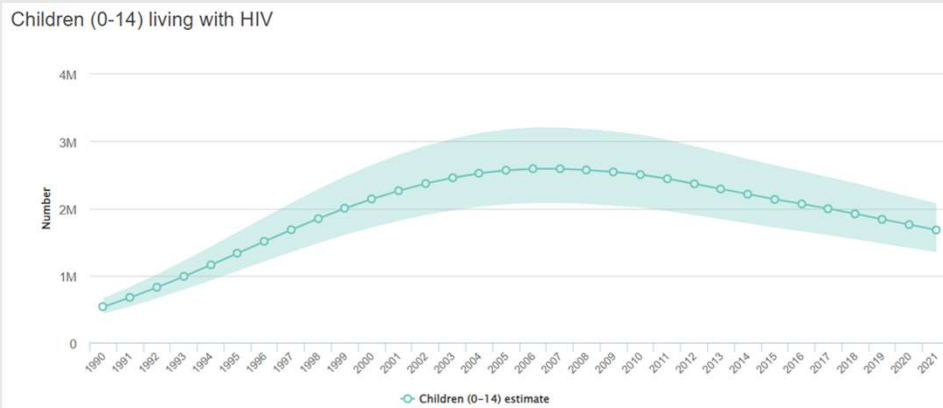
Source: UNAIDS epidemiological estimates, 2022 (<https://aidsinfo.unaids.org/>)

2mo EID coverage at 61.8% globally

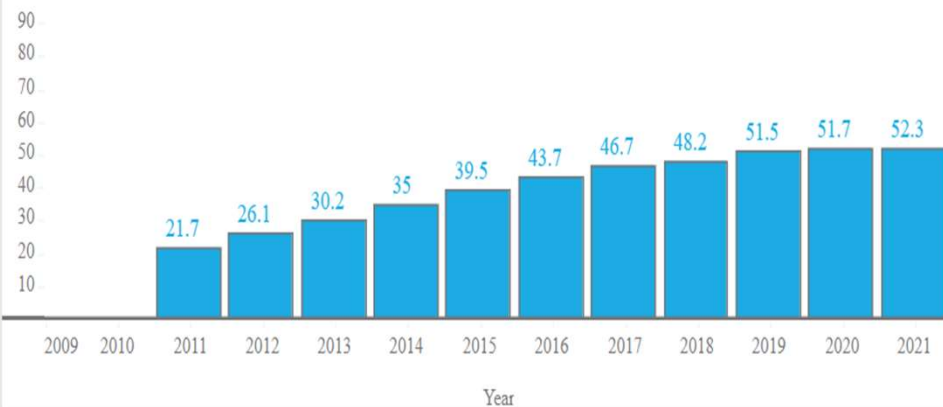


# Global Progress Towards Reaching Children Living HIV (CLHIV)

## 1.7M Children living with HIV in 2021



## 52% of CLHIV receiving ART (2021)



## 20 countries account for over 650,000 CLHIV not receiving treatment (2021)

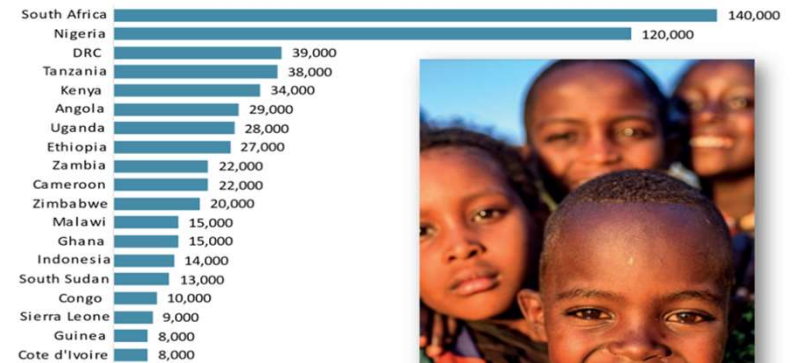


Photo credit: 'Start Free, Stay Free, AIDS Free' Final report on 2020 targets, July 2021

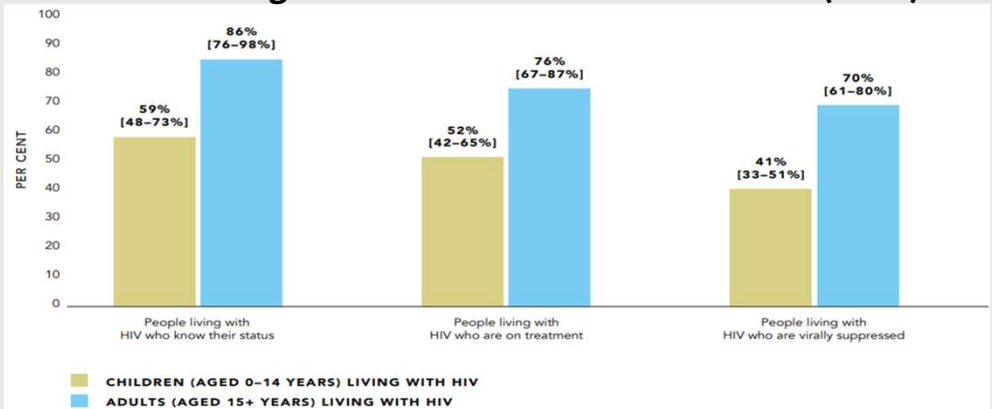


PEPFAR

19 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

Source: UNAIDS 2022 estimates for 2021. Mozambique data not available in UNAIDS 2022 estimates and pediatric HIV treatment gap was 47,000 in UNAIDS 2021 estimates for 2020

## Children lag behind adults across the cascade (2021)



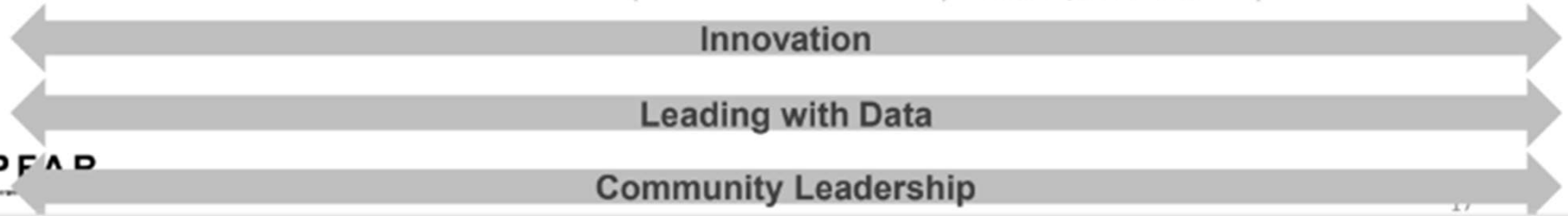
1. Global AIDS Monitoring and UNAIDS 2022 estimates 2. <https://data.unicef.org/resources/hiv-estimates-for-children-dashboard/>, 3. <https://aidsinfo.unaids.org/> 4. UNAIDS Global AIDS Update: In Danger, 2022

# Reimagined PEPFAR Centers on Health Equity for Priority Populations

## Strategic Pillars



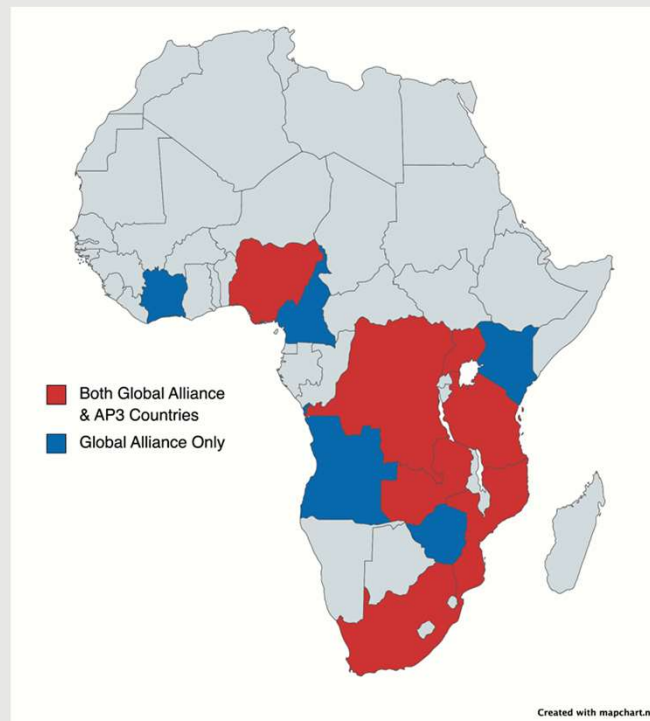
## Enablers



## ...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

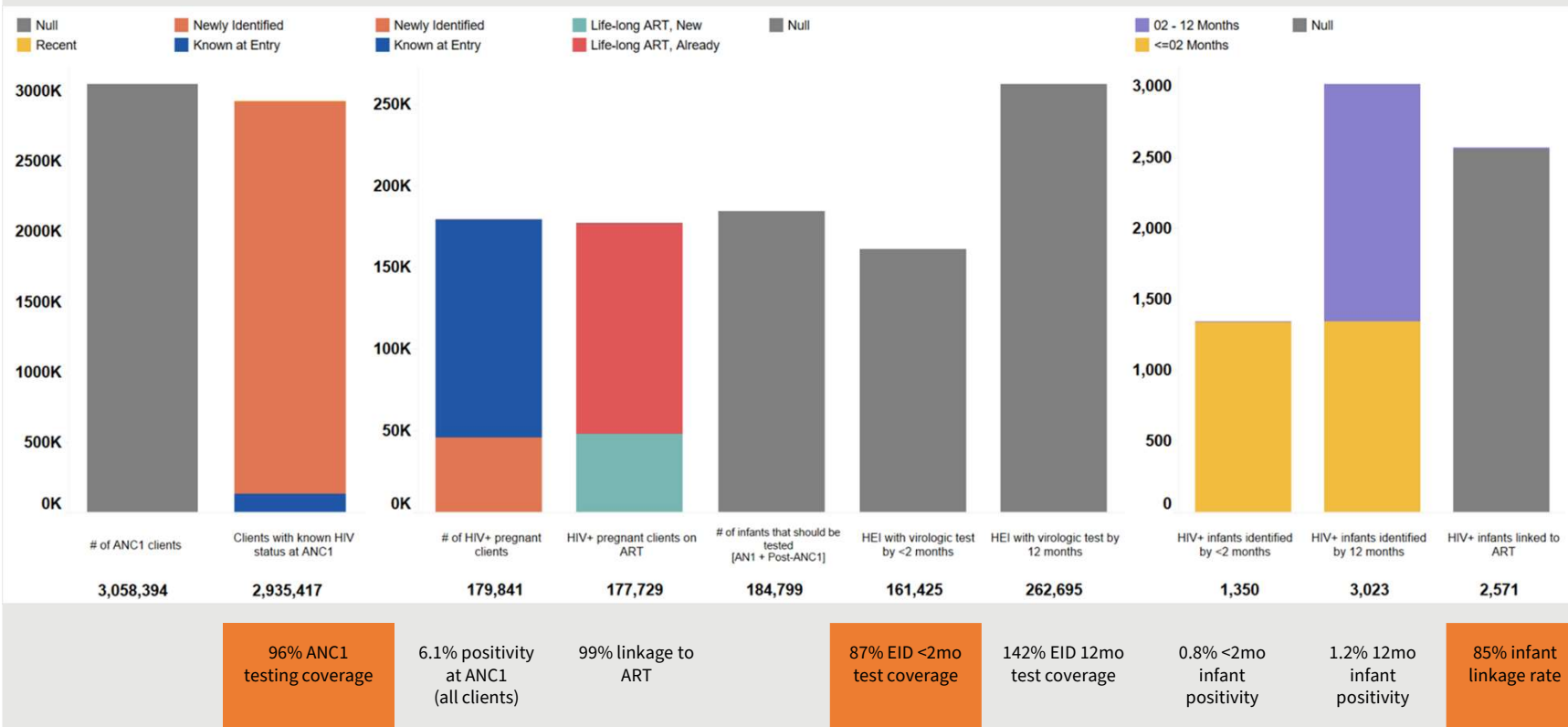


### UNAIDS Global Alliance to End AIDS In Children: Objectives

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

# FY22 cumulative (to Q3) USAID PMTCT cascade, global results

Maternal to infant cascade shows gaps in ANC1 testing, EID test by 2 mo of age, and challenges with linking all infants diagnosed with HIV to ART



## PMTCT program priorities

**Prevent / eliminate new child infections** through primary prevention, including ANC1 testing, maternal retesting and PrEP for PBFW

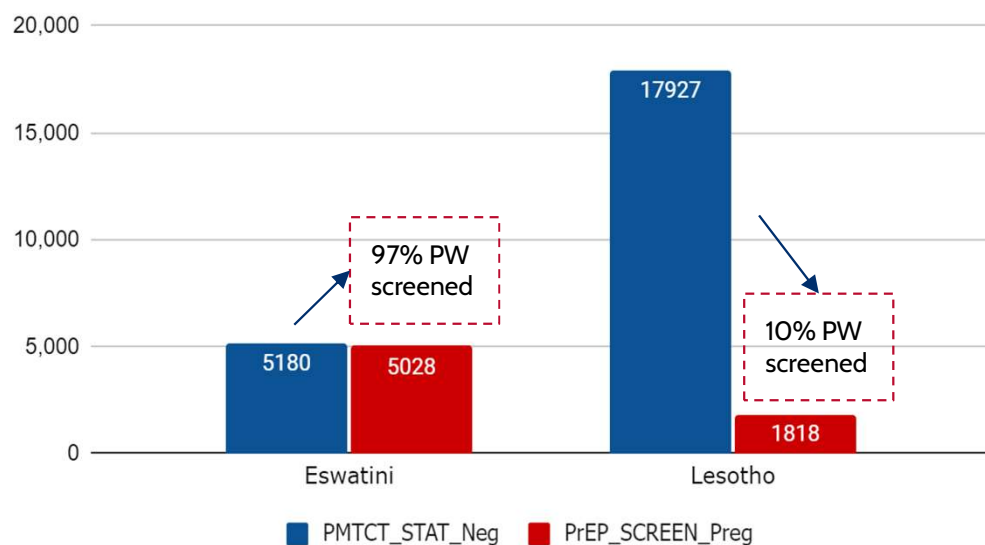
**Attaining VLS for PBFW** through differentiated models, adherence support and U=U

**Leveraging OVC/KP platforms** to improve CoT / final outcome for mother-infant pairs, especially AGYW

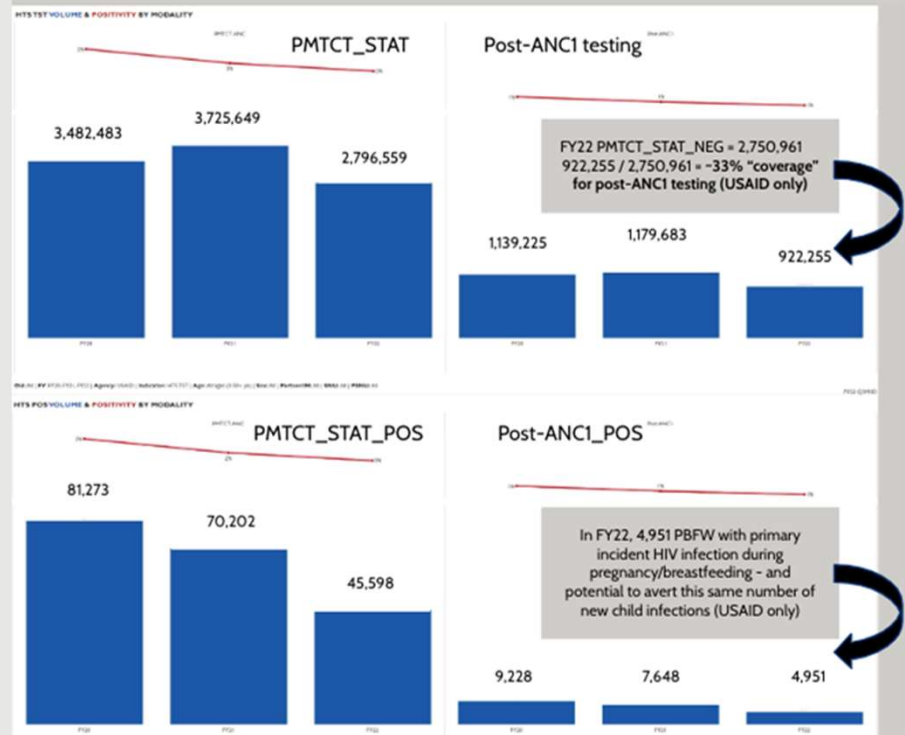
## Improving access to maternal retesting and PrEP for PBFW can reduce maternal incident infections. For newly identified PBFW, maternal retesting can promote earlier treatment and help them attain VLS to reduce MTCT.

USAID Custom indicator (CI) data shows high % screening of HIV negative pregnant women for PrEP in Eswatini and a large pool of HIV negative pregnant women in Lesotho in ANC who can be screened for PrEP services

% of all ANC1 HIV Negative Pregnant Women Screened for PrEP, Eswatini and Lesotho (FY22 Cumulative)



High number of negative women at ANC1 who can potentially be offered maternal retesting later in pregnancy/breastfeeding.



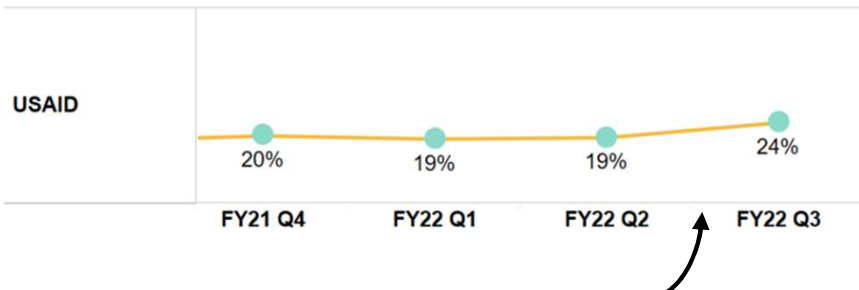
USAID Global Results, FY22 cumulative (up to Q3)

# Ensuring PBFW access VL testing and attain suppression

Many PBFW are now on TLD, but issues with understanding treatment, adherence support, and stigma remain. Important to ensure VL access through POC where possible, emphasize early ART start, U=U messaging and DSD models



Viral Load Coverage among Pregnant Clients



## VL access and data Use:

- VLC for PW may be underreported - triangulate MER data with program data to improve accuracy.
- Ensuring access to timely VL testing and POC VL (where available)

## Supporting Adherence and CoT:

- Supporting PBFW to remain in DSD model of their choice, including MMD
- Providing disclosure support and peer support in the community (e.g. mentor mothers, OVC case managers...)

## Early ART and Optimal ARVs:

- Testing and starting WLHIV on ART prior to conception
- Supporting TLD treatment literacy
- Expanding U=U messaging to PBFW
- Enrollment on TLD without prior VL requirement



# OVC & KP Programs Supporting Mother-Infant Pairs

**OVC and KP programs are uniquely positioned to support continuity of treatment for mother-infant pairs and to ensure the infant's final status is known. OVC activities and interventions should support the unique needs of mothers-infants pairs (priority on AGYW) across all four domains.**

**Healthy**

Referrals and support to ensure timely EID, Linkage to ART, family planning, food and nutrition support, Adherence support for mothers, PSS and MH services, appointment reminders

**Safe**

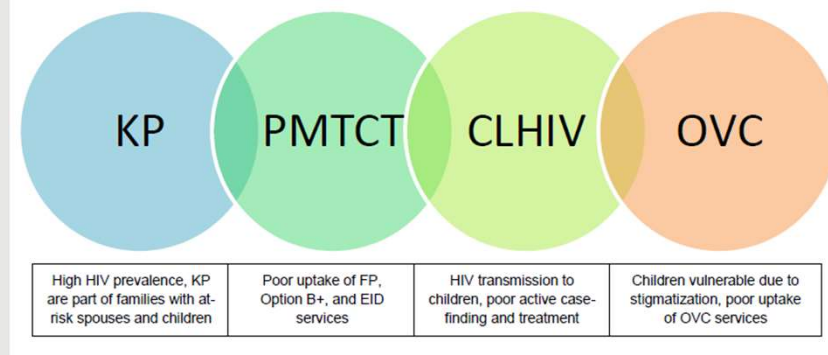
GBV referrals, Disclosure support, Positive Parenting

**Stable**

Economic strengthening opportunities such as savings groups financial literacy

**Schooled**

Support siblings to enroll in school, Keep AGYW mothers in school or re-enroll after delivery, Early stimulation and development



- FSW living with HIV and their HEI / children should be assessed and offered enrollment in the OVC program
- Requires strong coordination with KP, Clinical and OVC programs, partners and staff

# OU Example: Tanzania OVC Program Prioritizing Mother-Infant Pairs

Kizai Kipya (Pact) collaborates with Clinical IPs to identify high volume facilities for HIV-exposed infant (HEI) enrollment:

## Enrollment criteria

- Enrollment focuses on councils with EID 2mo coverage < 60%.

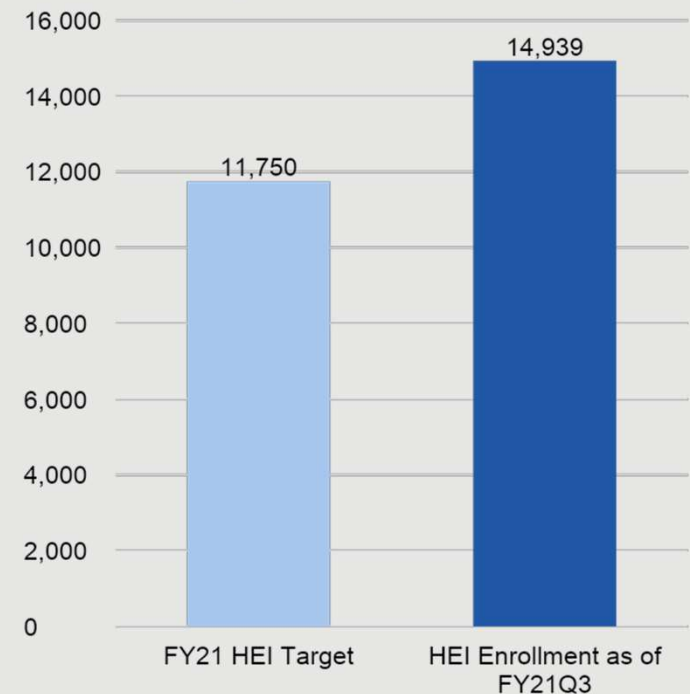
## Priority

- HIV+ positive pregnant adolescent <18y/o
- HIV+ breastfeeding adolescent mothers
- HIV+ positive breastfeeding women

## Focusing on

- HIV+ breastfeeding women with late first postnatal care attendance.
- HIV+ breastfeeding women with at least one missed appointment.
- Caregiver of HEI attending PMTCT/RCH site (can be aunt, grandmother etc. who cares for HEI)

HEI Target versus Enrollment



**FY22Q3 update:** 27,265 HEI enrolled in OVC program and 30,141 HIV+ PW reported in FY22 (cumulative, PMTCT\_STAT\_POS)

# 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

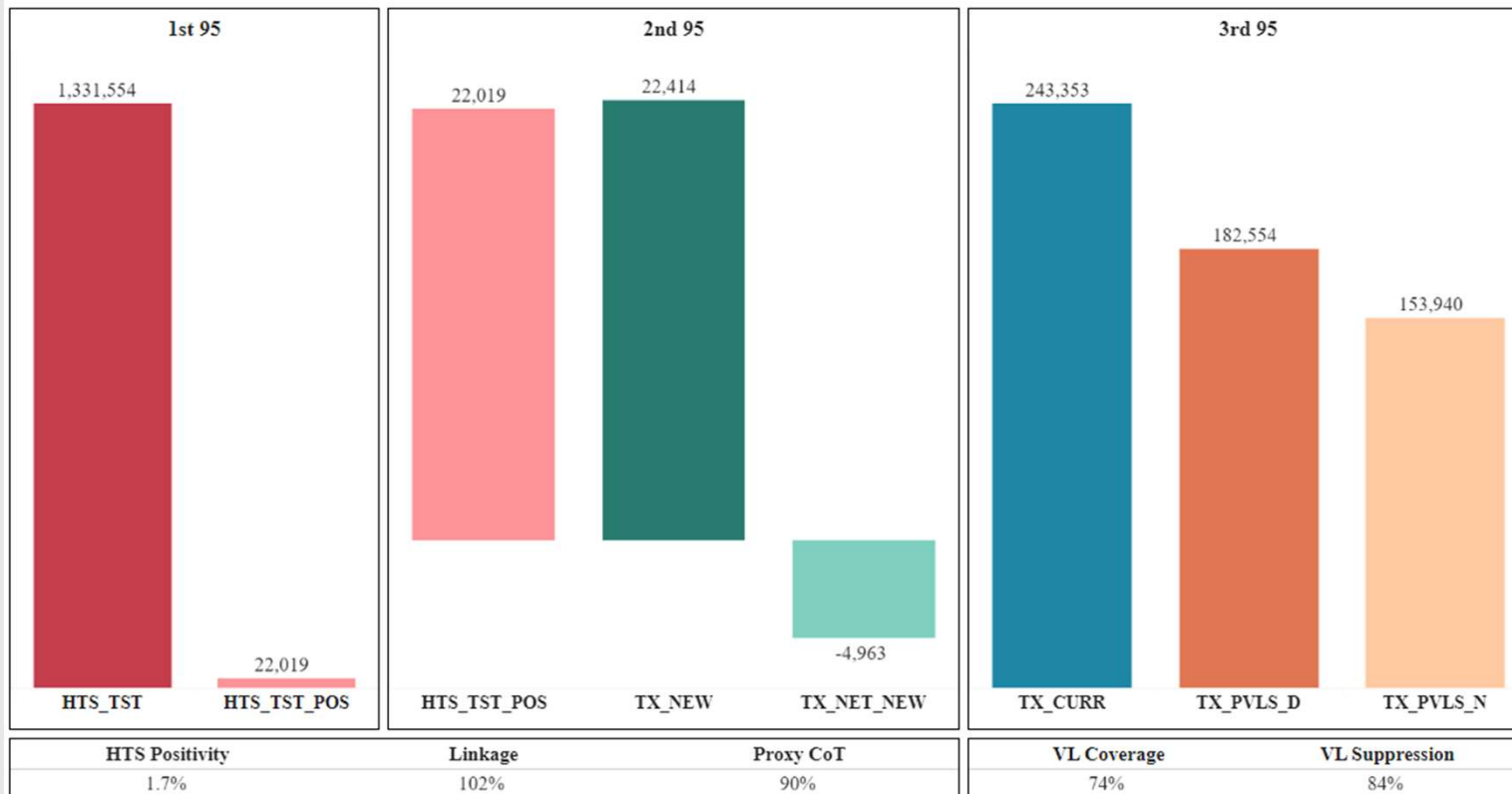
## Care and testing for HIV-exposed infants

- 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

# Q3)

## FY22 Cumulative Clinical Cascade, Peds (<15 yo)

OU: All | PSNU: All | SNU: All

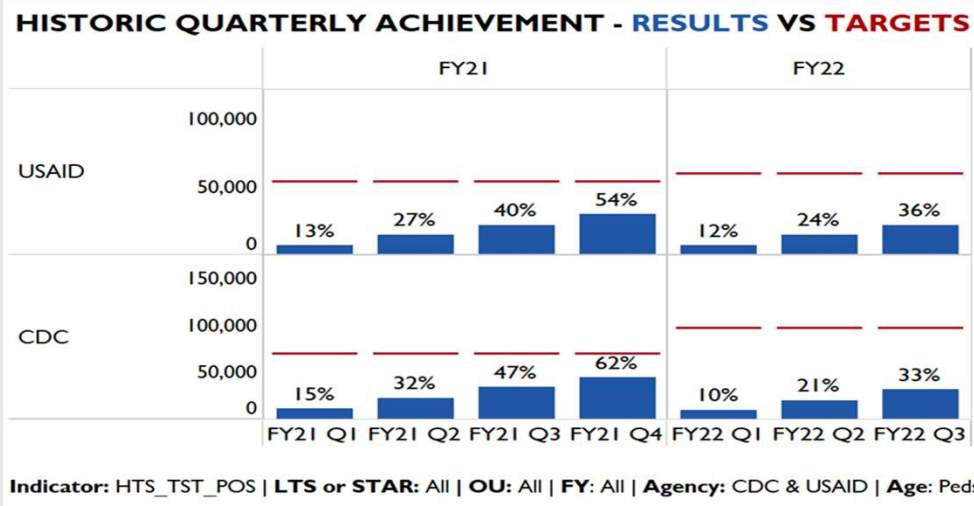


Source: PSNU x IM Quarterly Hyperfile  
 Country: All | Aesacv: USAID | IP: All | IM: All | Aes band: All | Ser: All

# Looking back, Moving forward to identify C/ALHIV

**Refocus to strategically find and diagnose C/ALHIV that might have been missed during PMTCT programs - important to optimize a multi-modality approach.**

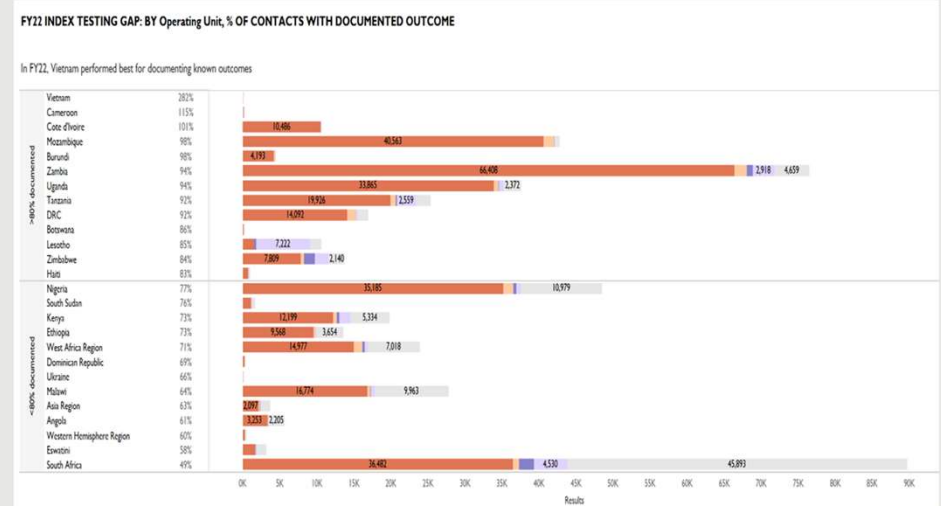
Underachievement on pediatric case-finding (<15yo) in PEPFAR programs



## Moving forward to identify C/ALHIV

1. Adapting national programs
2. Systematically increasing outpatient testing for at-risk children
3. Scaling pediatric index testing
4. Monitoring testing coverage at all entry points
5. Expanding access to HIVST

Index Testing “gap” for children <15y/o, USAID



PEPFAR solutions page:  
<https://www.pepfarsolutions.org/resources-andtools-2/tag/index+testing>

Contact your OHA Peds and HTS Advisor if interested in pediatric index testing training

## Opportunities to utilize Caregiver / Provider-assisted Oral HIV Screening to identify hard-to-reach biological children while leveraging KP and OVC Programs

### Leaving No Child Behind: Burundi Data

Metric	#	%
Offered Index Testing Services (Female 15+ y/o)	19,179	-
Offered to Accepted (Female 15+ y/o)	17,182	90%
Accepted to Contacts Ratio (Female 15+ y/o to Children <15 y/o)	40,482	2.4 (ratio)
Contacts Eligible for Testing (Children <15 y/o)	28,698	71%
Eligible Children <15 y/o Tested	26,952	94%
Eligible Children <15 y/o Not Yet Tested	1,746	6%
Index Positivity Children <15 y/o	1,663	6.2%
Linkage to ART	1,634	98%

Index testing data from Burundi presented at the International Workshop on HIV & Pediatrics (IWHP 2022, Montreal, abstract [here](#)) revealed a gap of 1,746 eligible children not tested because they do not live with parents.



**Action:** Prioritize and operationalize the introduction of an assisted HIVST screening demonstration in Burundi to address existing pediatric index testing gap.

### Supporting the introduction of caregiver and provider-assisted oral HIV screening in children:

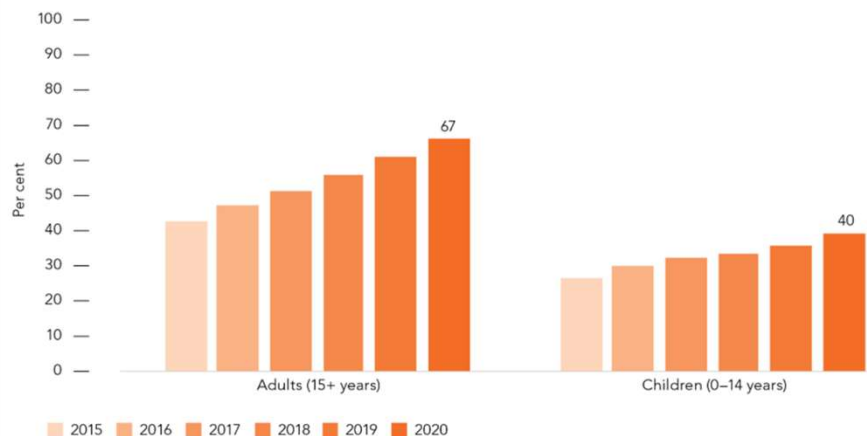
- Index testing gap review by OU, IP and geography to characterize biological children we are not reaching with index testing (similar to Burundi example)
- Supply Chain planning, engagement and assessment early on to ensure availability of oral test kits to align with demonstration project
- Follow-up on pricing of Orasure kits by country and where costs are being incurred.
- Country engagement with OHA Peds, HTS, KP, and OVC Advisors

# Improve VLC and VLS to ensure C/ALHIV Survive and remain Healthy and Thrive

Ensure that C/ALHIV are prioritized for viral load collection and remain virally suppressed

*VLS continues to lag behind globally for children <15yo*

Proportion of adults (aged 15+ years) and children (aged 0–14 years) with suppressed viral load among people living with HIV, global, 2015–2020

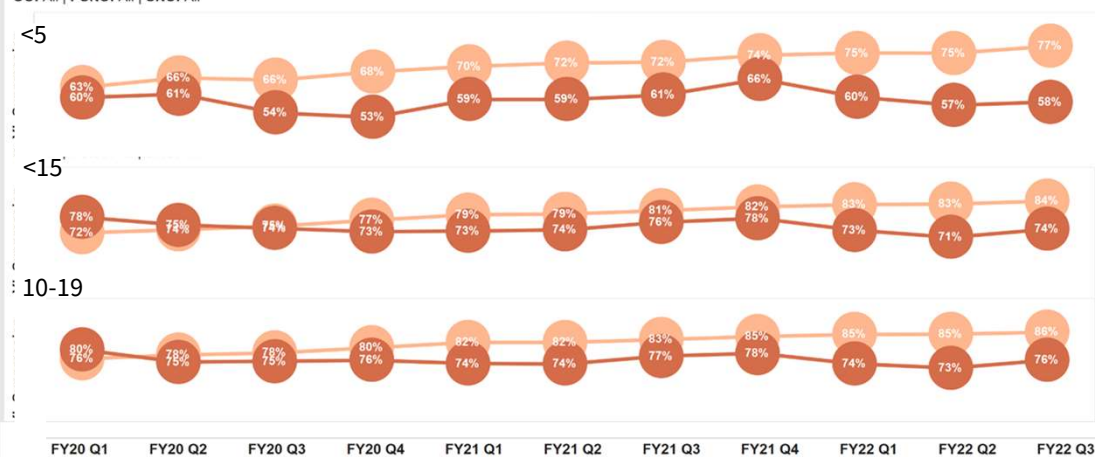


Source: UNAIDS epidemiological estimates, 2021 (<https://aidsinfo.unaids.org/>).

Consider using pediatric VL blood draw commodities for plasma samples from young children (<5yo)

## Trends in Viral Load Coverage & Suppression, Children (<5)

OU: All | PSNU: All | SNU: All

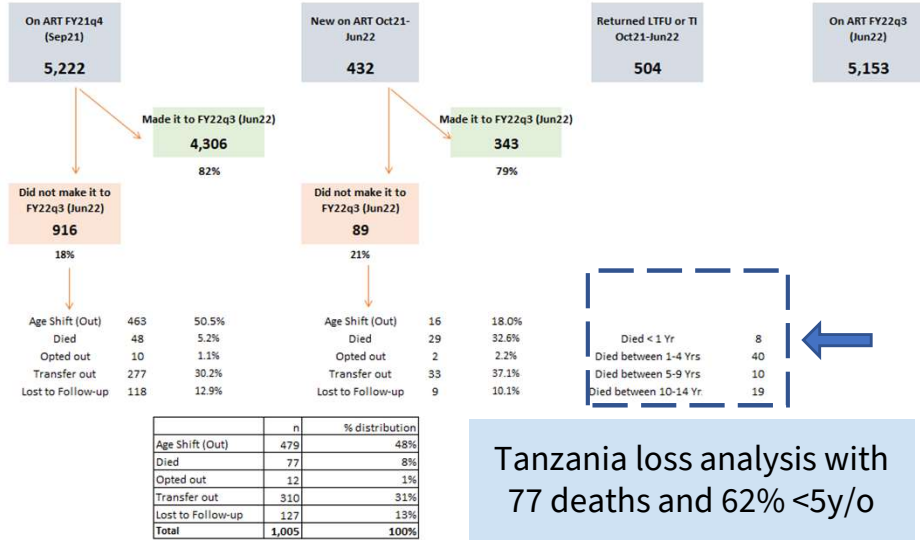


## Strategies to improve pediatric and adolescent VLC and VLS:

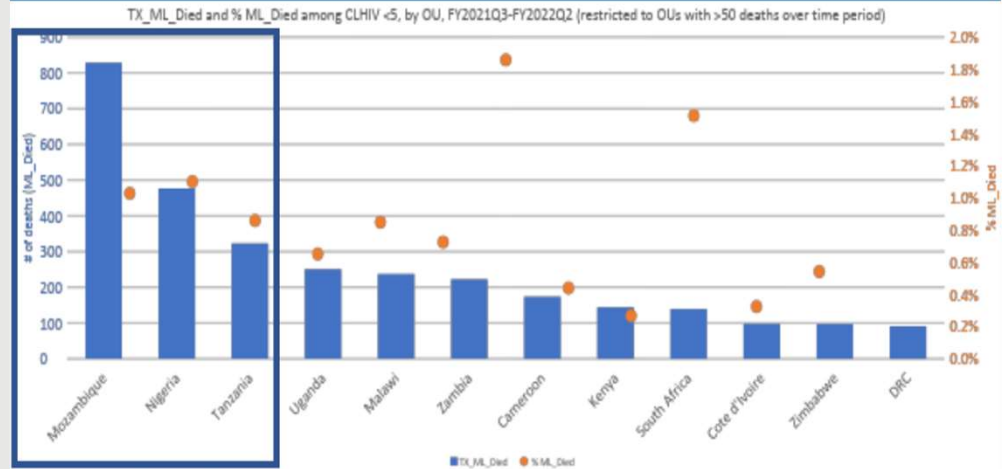
1. Complete ART optimization to DTG-based regimens
2. Use VL blood draw commodities for children (e.g. butterfly needles)
3. Consider decentralization of VL collection to community
4. Ensure rapid TAT for VL results and communicate to client
5. Scale MMD to all eligible C/ALHIV
6. Promote family-centered care and joint appointments
7. Increase treatment literacy and promote demand for VL testing
8. Utilize POC testing where feasible and practical

# Advanced HIV Disease Management for the youngest CLHIV (<5y/o)

Children <15y On ART by FY21Q4 (txcurr by September 21) or TXNEW from Oct21-June 22 (FY22Q3; JUN)  
DB sites in 5 regions (n=437 of 437 total DBs)



## Mozambique, Nigeria, and Tanzania account for the highest # of deaths

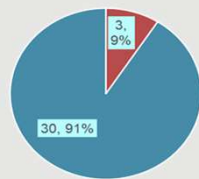


\*among countries with >50 deaths among CLHIV<5 years old in past 4 quarters.  
Sources: PEPFAR MER Indicator data, ML\_death and %ML\_death+TX\_ML\_died/TX\_Curr\_previous+TX\_New current)

**33 pediatric deaths audited (Tanzania):** 82% <5y/o, 70% CLHIV died at home, >50% CLHIV <3 mo on ART, 76% CLHIV with no VL sample

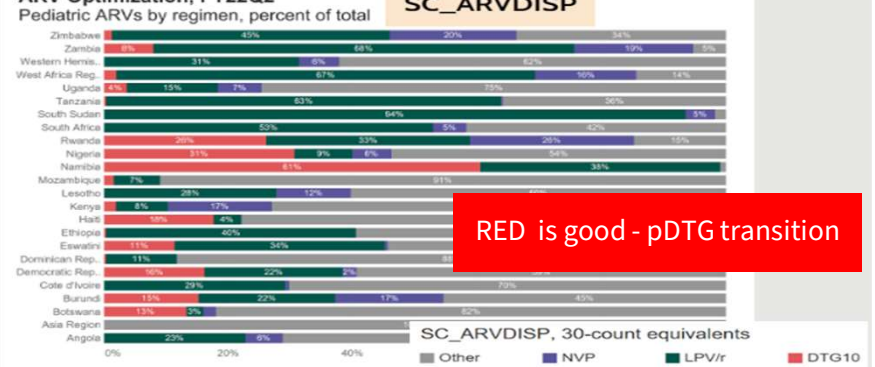
**Main causes of death:** 42% severe acute malnutrition, 21% TB, 15% stopped, 3% AIDS defining illness

ARV Regimen



91% of CLHIV on a LPV/r-based regimen

## ARV Optimization, FY22Q2

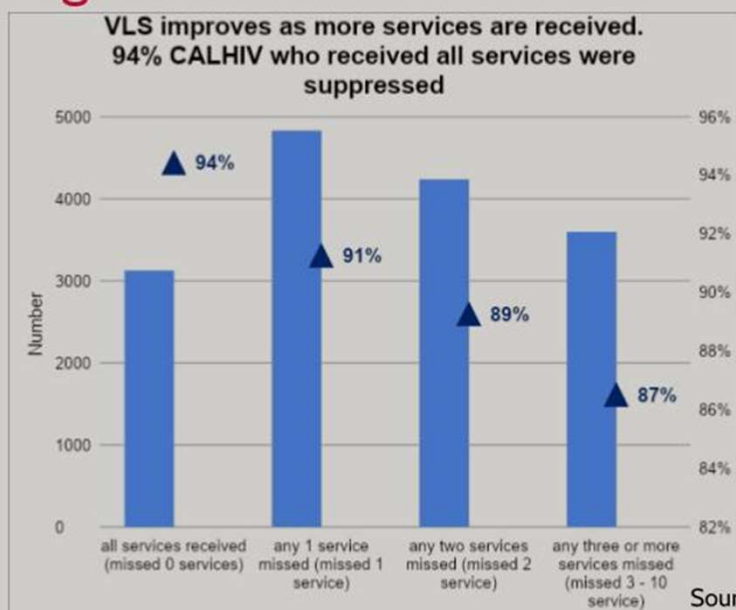




# Improve VLC and VLS to ensure C/ALHIV are Healthy and Thrive

Ensure that C/ALHIV are prioritized for viral load collection and remain virally suppressed

## OU Example: Uganda Service Package Associated with higher Viral Load



Uganda Layered Services Monitored:

- On time Viral Load
- DTG regimen
- IAC initiation
- TPT initiation
- TB Assessment
- MMD
- Appointment kept
- OVC screening assessment
- CHW attachment
- Community visit

**\*OU Best Practice\***

Source: Q3 Audit Data analyzed by USAID/U with IP SITES

# Leveraging the OVC program to support C/ALHIV and families for improved outcomes and impact

**Continue strengthening strategies that support CoT for C/ALHIV and their families, ensure enrollment of the most vulnerable, and monitor 95-95-95 outcomes through the use of custom indicators**

## Indicators: Tracking progress in Tanzania's OVC program

### i. Number of beneficiaries enrolled in the OVC program by subpopulation

### ii. Among CLHIV enrolled in the OVC program

- % on ART
- % on MMD (3MMD/6MMD)
- % with a suppressed viral load
- % who reached <=28 days past their expected clinical contact or drug pick-up at the end of the reporting period (ITT)

### iii. Among HEI enrolled in the OVC program:

- 2mo EID coverage
- 12mo EID coverage
- % HIV positive (at any point)
- % HIV+ initiated on ART

### iv. Among Caregivers enrolled in the OVC program

- % HIV+
- % of HIV+ on ART
- % on MMD (3MMD/6MMD)
- % with a suppressed viral load
- % who reached >=28 days past their expected clinical contact or drug pick-up at the end of the reporting period (IIT)

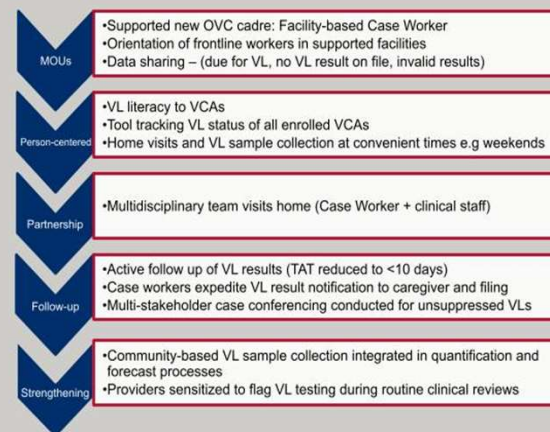
### V. Local ownership and sustainability of the OVC program

- # of OVC beneficiaries supported by economic empowerment activities (e.g., saving & lending groups, income generating activities, vocational training and support)
- % of OVC portfolio implemented by local partners (USD value and # of children served)
- Value (USD) of savings and lending among WORTH/VSLG groups
- Approximate value of additional resources leveraged through GOT or private partners
- # of CCWs and other social welfare structures supporting OVC

Tanzania OVC Program Metrics as agreed by Interagency team

## Improving Peds VLS through OVC/Clinical partnerships

OVC Case Workers in Zambia are facilitating VL testing in homes through joint visits with clinical providers through:

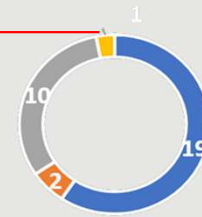
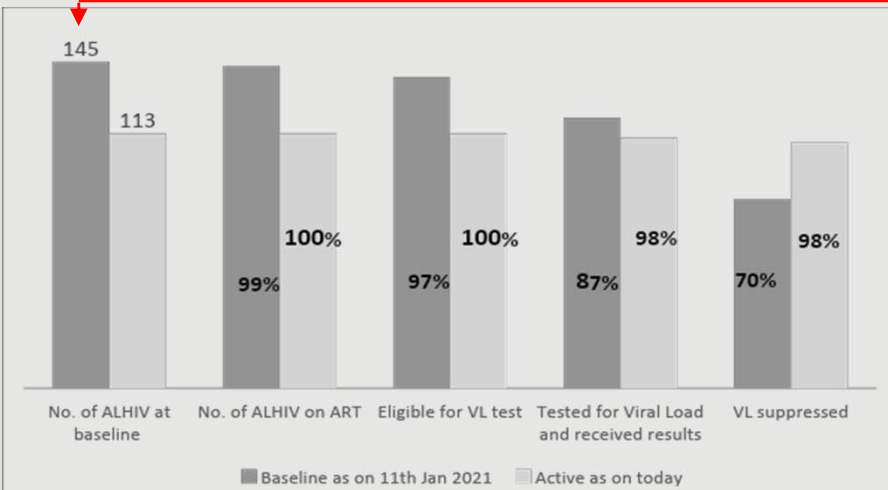


## Results:

- Since FY21, the ECAP program facilitated 3,371 viral load tests
- VLC for OVC living with HIV in the ECAP program increased from 55% to 90%

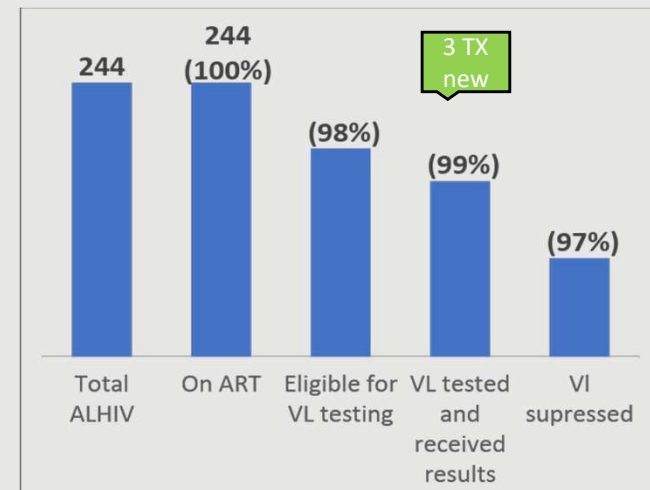
# Adolescent-friendly Health Centers (AFHCs) promote improved viral suppression for ALHIV through comprehensive service delivery in India

Baseline Cohort and follow-up HIV Treatment Results for ALHIV



32 ALHIV from the baseline cohort dropped out, 19 graduated, 10 migrated, 2 opted out and 1 passed away

Treatment outcomes among ALHIV



1. Case profiling
2. Categorization and prioritization
3. Intensive care services
4. ART adherence barrier assessment
5. Developing individualized ART adherence barrier interventional plan
6. Developing assisted action plan

5. Implementation support and follow up
6. Tx literacy, support group, Tx champions
7. Skill building and cultural activities
8. 104 ALHIV on MMD, 15 ALHIV on CARG, 181 eligible for FCA, 101 completed FCA



# Summary of Key Activities for C/ALHIV

- 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 C/ALHIV
- 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



# Pediatric Maternal Clinical Branch Technical PoCs

Technical Area	POC	Email
PBFW & Peds Virologic Suppression and HIVDR	Nicole Buono (PAC) & Alex Vrazo (MIhC)	<a href="mailto:nbuono@usaid.gov">nbuono@usaid.gov</a> ; <a href="mailto:avrazo@usaid.gov">avrazo@usaid.gov</a>
Adolescent Care and Treatment	Tishina Okegbe & Kate Plourde	<a href="mailto:tokegbe@usaid.gov">tokegbe@usaid.gov</a>
Peds MMD	Lauren Bailey	<a href="mailto:lbailey@usaid.gov">lbailey@usaid.gov</a>
EMTCT & Comprehensive Care for HEI	Alex Vrazo	<a href="mailto:avrazo@usaid.gov">avrazo@usaid.gov</a>
Peds/OVC TU	Megan Gleason	<a href="mailto:mgleason@usaid.gov">mgleason@usaid.gov</a>
PBFW & Peds Retention/DSD	Ola Faturiyele	<a href="mailto:ifaturiyele@usaid.gov">ifaturiyele@usaid.gov</a>
PBFW & Peds HIV Case Finding/HIVST	Meena Srivastava Ronnie Lovich	<a href="mailto:msrivastava@usaid.gov">msrivastava@usaid.gov</a> <a href="mailto:rlovich@usaid.gov">rlovich@usaid.gov</a>
Peds ART	Anouk Amzel	<a href="mailto:aamzel@usaid.gov">aamzel@usaid.gov</a>

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# HIV Testing

Presenter: Kristina Bishop  
Senior HIV Testing Services Advisor, GH/OHA



## REMINDERS- changes to current COP22 guidance

1  
2  
3

- Positivity targets for OtherPITC have been removed from COP22 guidance
- ALL index metric minimum standards (except 100 percent offer) have been removed from COP22 guidance
- Programs should determine for themselves how to target testing for their own epidemics

## Slide 39

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- 1 this is min positivity targets - but positivity targets will still be derived in the DATA PACK..  
Vincent Wong, 11/12/2022
- 2 added it's the min stds that have been removed. can we reference the table and page from COP22 guidance  
Vincent Wong, 11/12/2022
- 3 is this true..and it means Agencies correct? (vs pgms)  
  
also include an HIVST bullet on multiple kits being available and expanded use.  
Vincent Wong, 11/12/2022



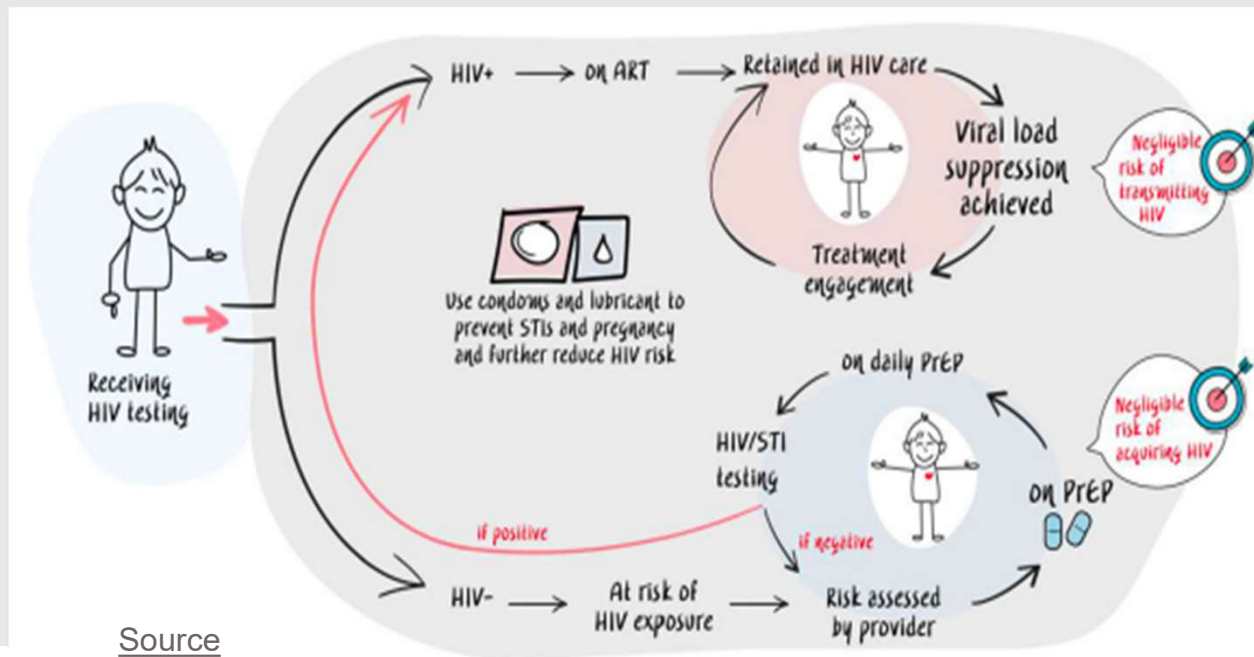
# HTS Should Be Status Neutral

From the PEPFAR Strategic Direction 2022

## FOCUS AREA 4: HIV TESTING SERVICES

Support approaches for status neutral HIV testing services, including testing for HIV prevention (e.g., in context for PrEP interventions), access to HIV self-testing, and strategic case finding to achieve the first 95, while investing in new approaches such as multiplex testing and re-engagement strategies.

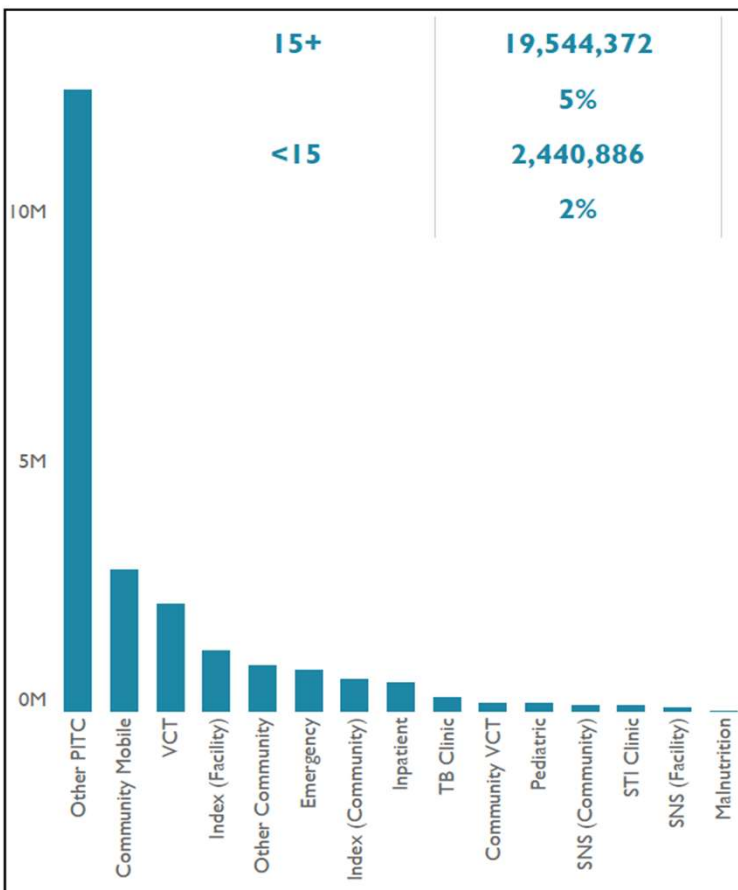
- “The status-neutral approach begins with an HIV test which is followed by active engagement of that person regardless of their HIV status. Those who tested HIV-positive are engaged in treatment right away while those who tested HIV-negative are also immediately engaged in PrEP or post-exposure prophylaxis (PEP), visualizing that the clinical, programmatic, or social “HIV” divide is nonexistent.”
- “Both HIV-positive and HIV-negative individuals end at a common final stage of being continuously engaged in clinical care with negligible risk of either transmitting or acquiring HIV.”



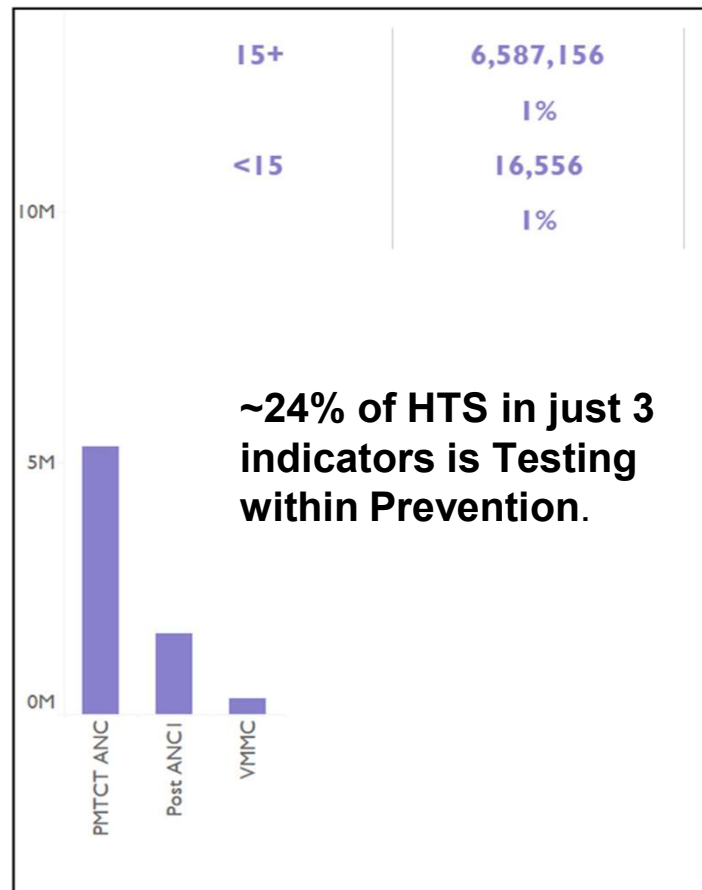
# Testing Within Prevention as a Part of Status Neutral Testing

Status neutral testing has a broader scope than just testing for case finding and actively supports linkage to and engagement in prevention programs.

TESTING FOR CASE FINDING



TESTING FOR PREVENTION MONITORING



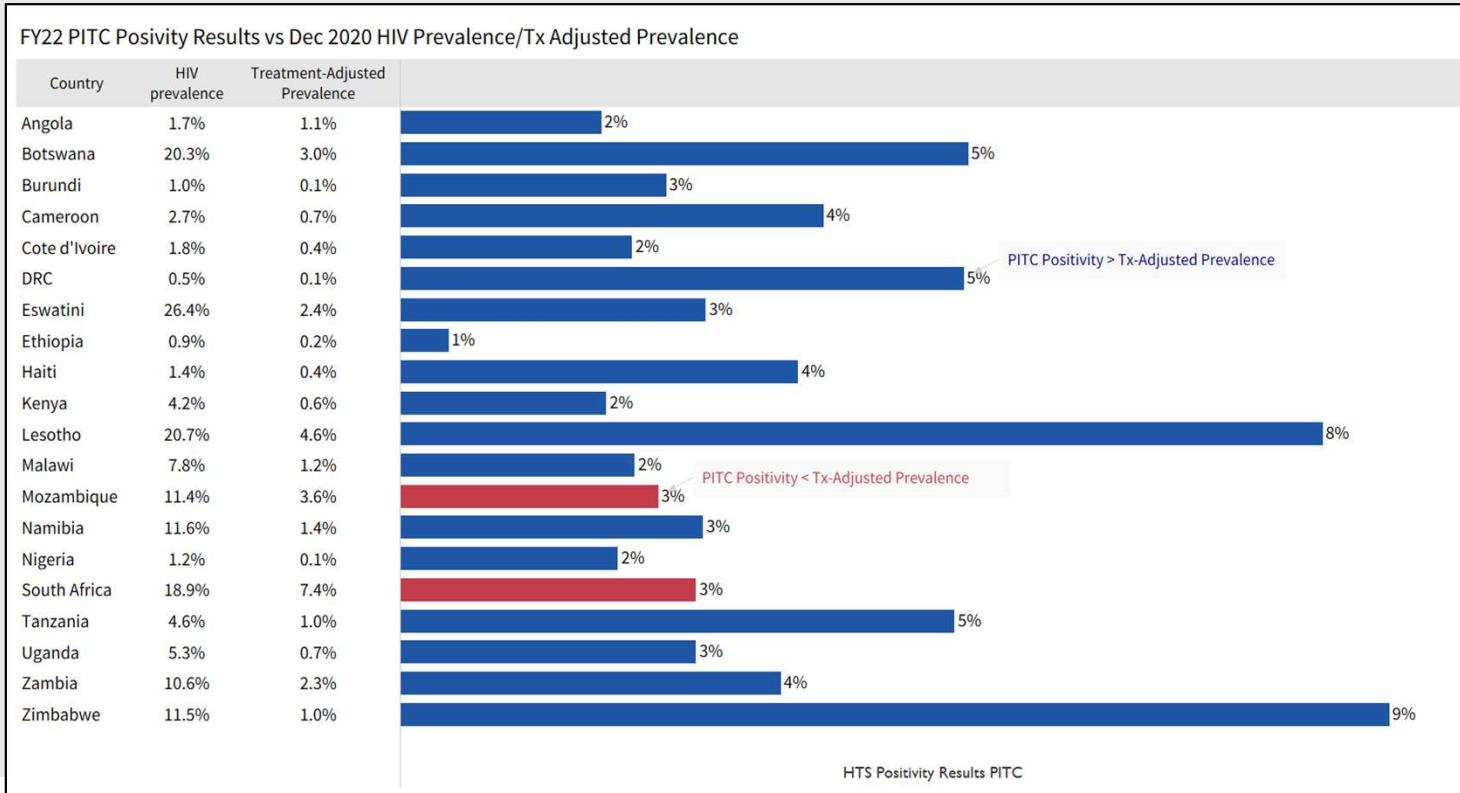
# TxAP Expected to be Standard. PITC Already Widely Optimized

Estimated Number of Adult PLHIV - Number of Adult PLHIV on ART

Treatment Adjusted Prevalence =

Total Adult Population - Number of Adult PLHIV on ART

Treatment adjusted prevalence estimates the expected positivity in a testing program by accounting for both national HIV prevalence and ART coverage. The treatment adjusted prevalence is calculated to account for individuals with HIV who are a) diagnosed, b) previously diagnosed and treatment naive, or c) previously diagnosed with an interruption in treatment. To account for second 95 achievements, individuals who are on ART are excluded from the calculation.

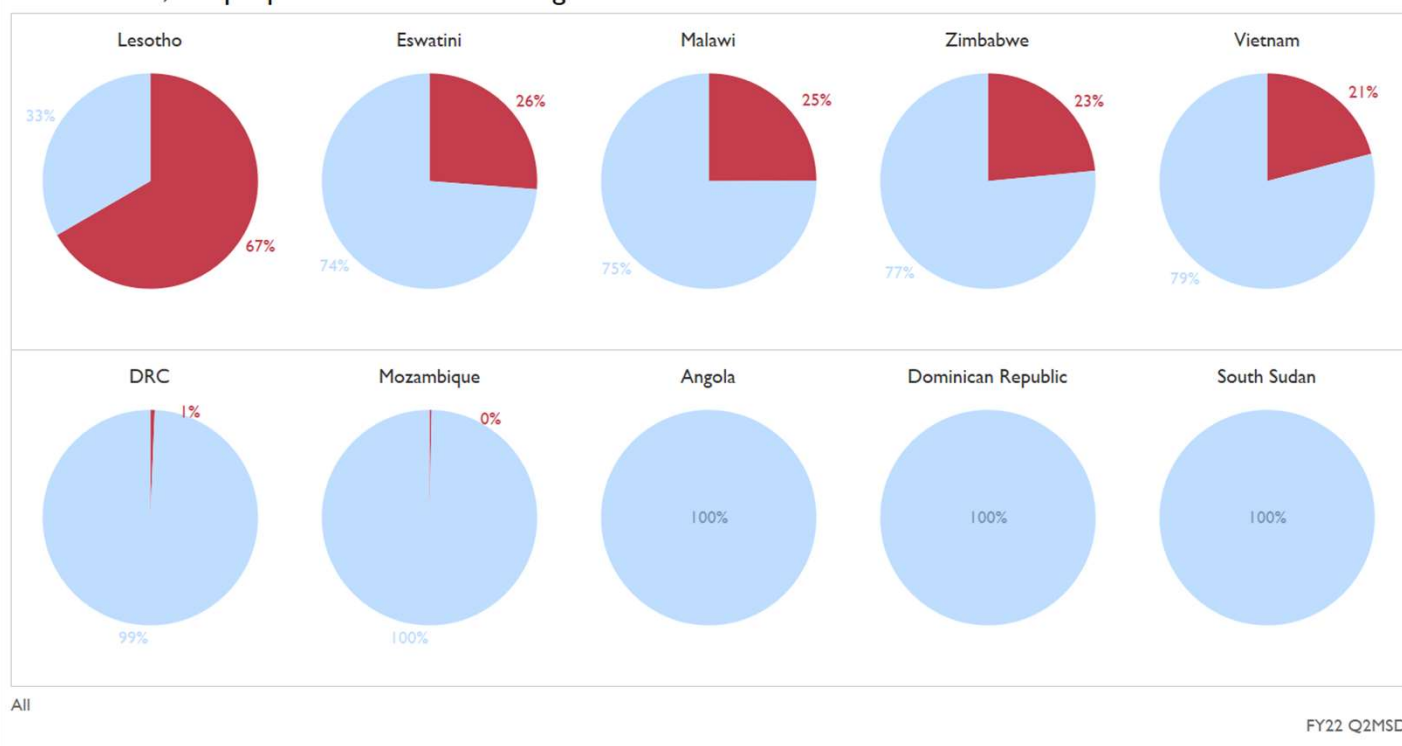




# HIVST Should Continue to be Scaled. Decrease Data Push.

- HIVST means an individual performs a test on themselves in private or under observation of a professional if they so desire. It should be voluntary and not forced or coerced. **People who use a self-test should not be forced or coerced to disclose the result of that test to anyone, and should only do so voluntarily.**
- Data shows that **HIVST linkage rates are comparable to conventional testing**

Across OUs, the proportion of overall testing that is **SELF** vs **HTS** varies



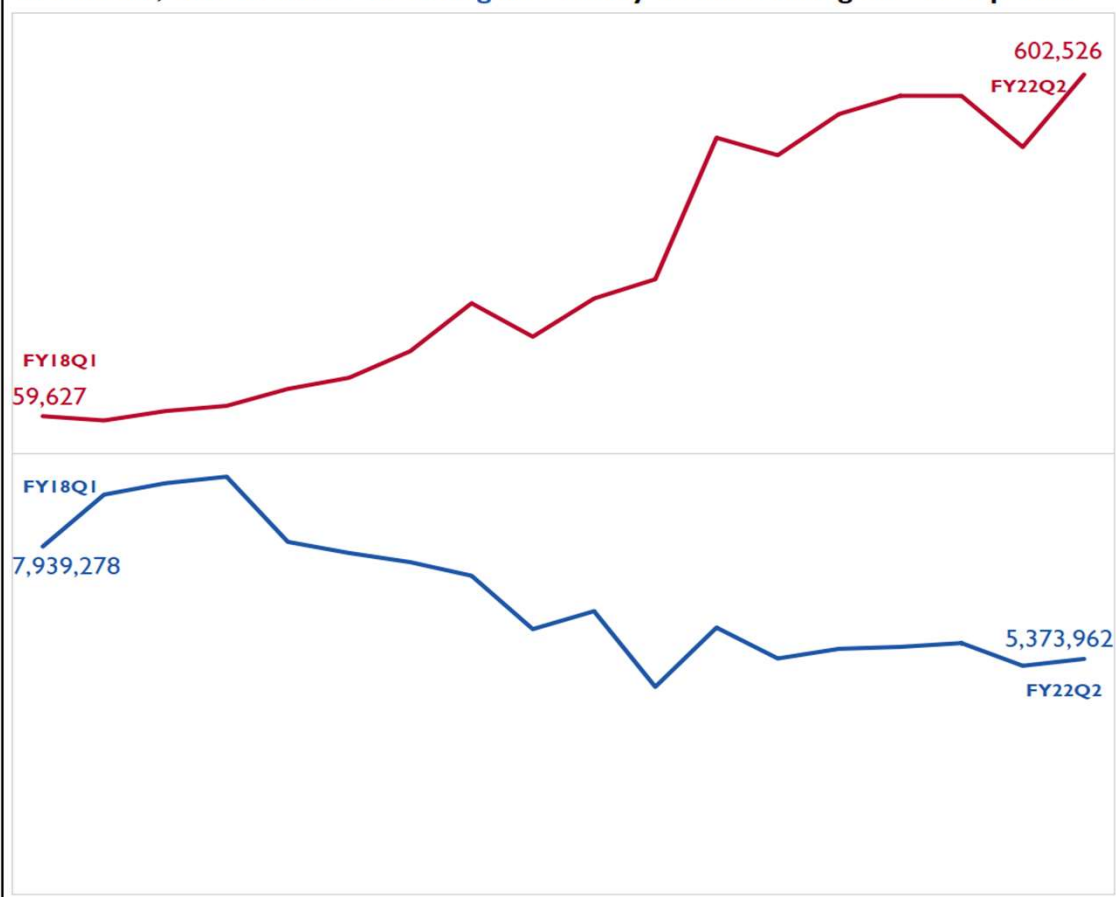
The majority of OU's have not yet optimized the use of HIVST as a component of testing services.

## HIVST Should Continue to be Scaled. Decrease Data Push. (pt 2)

- HIVST can **increase testing coverage w/ out HRH burden** of conventional testing
- **HIVST has uses for both case-finding** (e.g. increased coverage in high burden facility settings, replace screening tools in OPDs, community outreach for KPs & high burden areas, secondary distribution through index & SNS) **and prevention** (e.g. PrEP initiation & continuation, secondary distribution to partners, AGYW distribution, SRH distribution)
- Virtual platforms w/ **private sector distribution should be scaled** (eg pharmacies & retail vendors)
- Advocacy for **regionalization of HIVST storage and/or manufacturing**

**HIVST GREW 9-FOLD FROM FY18Q1 TO FY22Q2**

In contrast, **conventional HIV testing** has steadily declined during this same period



# HIVST Use Expanded for PrEP - But Not For Initiation

Main points from the recent WHO guidance:

- HIVST can complement existing HIV testing strategies for PrEP to support differentiated service delivery approaches for oral PrEP and the DVR to reduce clinic visits, and it may increase PrEP use and frequency of HIV testing.
- HIVST provides an additional testing choice to PrEP users when starting, restarting or continuing PrEP, which may be preferred for convenience, privacy and self-managed care.

PEPFAR supports the revised WHO guidelines on the use of HIV self-testing to facilitate easier access to and use of PrEP for prevention clients, **including PrEP continuation, re-initiation, and effective use**

- Note that unlike the WHO guidance, **PEPFAR is NOT recommending HIVST use for PrEP initiation**



July 2022 WHO Guidance

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# Key Populations

Presenter: Patrick Hazelton  
Sr. Key Populations Technical Advisor, GH/OHA





# KP Local Partner performance rivals KP Central Mechanisms!

FY22 KP Target Achievement Comparison of Local Partner and Central KP Mechanisms, USAID

Share of Results		Local Partner KP Mechanisms			Central KP Mechanisms		
		Q1-Q3 Results	Targets	Target Achievement	Q1-Q3 Results	Targets	Target Achievement
	KP_PREV (Q2)	564,906	537,227	105%	309,344	365,997	85%
	PrEP_NEW	94,534	63,532	149%	43,013	48,205	89%
	HTS_SELF	131,588	192,122	68%	86,189	59,966	144%
	HTS_TST	666,052	379,782	175%	321,968	226,188	142%
	HTS_TST_POS	35,100	31,337	112%	21,023	20,625	102%
	TX_NEW	30,598	26,707	115%	17,754	12,685	140%
	TX_CURR	128,289	122,603	105%	87,606	53,094	165%
	TX_PVLS (D)*	87,282	82,763	105%	26,973	50,591	53%
	TX_PVLS (N)*	84,421	78,515	108%	25,857	48,086	54%

\*5 central mechanisms are unable to report KP disaggregated TX\_PVLS results which decreases KP TX\_PVLS achievement. Total achievement is somewhat higher than shown here for Central KP mechanisms, but results still fall below targets.

**Note:** This is not a comprehensive view of USAID KP performance. It intentionally excludes bilateral, international partners implementing KP programs.

# Vast majority of global HIV burden lies with Key Populations

- 70% of new HIV infections in 2021 were among **key populations** and their sexual partners
  - KPs account for **less than 5%** of the global population
- **What does this mean for the focus of PEPFAR programs in the future?**

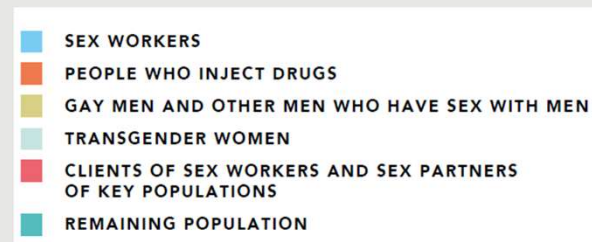
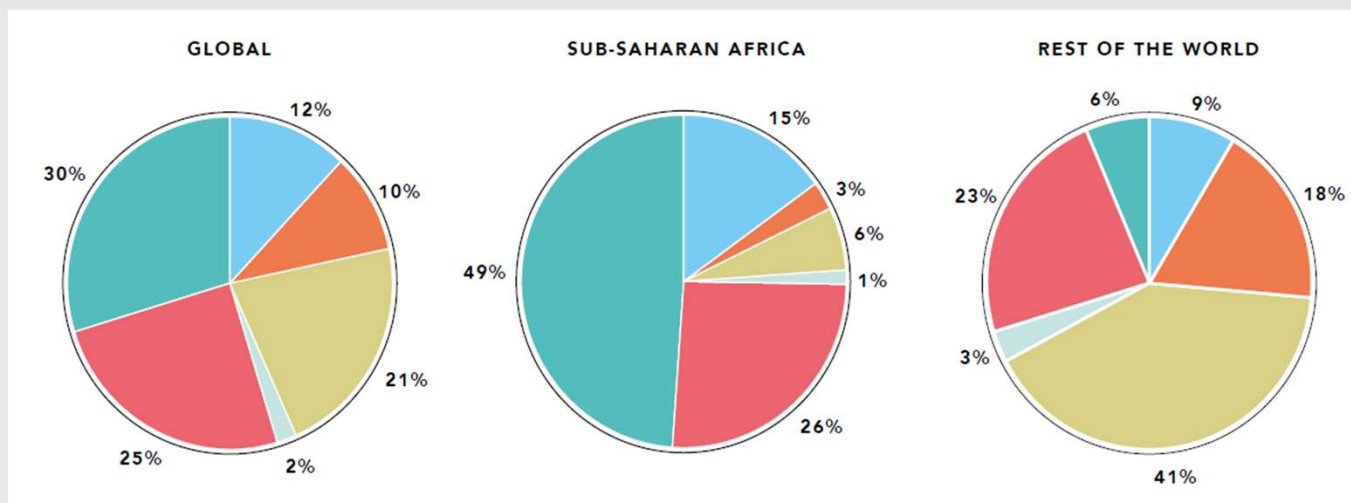
## Relative risk of HIV acquisition, global (2021)



Source:  
UNAIDS  
special  
analysis  
2022

# Every region has a substantial population of vulnerable KPs

- In **Sub-Saharan Africa** KPs and their partners represent **51%** of those infected while in **the rest of the world** they represent **94%**
- How is PEPFAR addressing the unique needs of KPs in all regions and countries?



Source:  
UNAIDS  
special  
analysis  
2022

# Key Populations are central to equity in the HIV response

1

There is a **public health imperative** to differentiate services

- Missed 2020 targets
- Equity lens includes renewed focus on structural issues, human rights
- Epi lens can focus on heterogeneity of risk + prevention impact (coverage to halt transmission over time)

2

UNAIDS, WHO, and PEPFAR underscore the **importance of vulnerable populations** in global strategies and guidance

- 95–95–95 testing and treatment targets are achieved within *all subpopulations, age groups and geographic settings*, including CLHIV
- 10-10-10s
- PEPFAR Pillar 1: Health Equity

3

“Know and close your gaps” by scaling up **evidence-based programs with differentiated services**

- DSD scaled nationally, institutionalized within sustainable health systems
- Robust commitment to primary HIV prevention (invest in understanding onward transmission)
- Integrate services
- Embrace innovation

**IN DANGER**

**END INEQUALITIES.  
END AIDS. GLOBAL AIDS  
STRATEGY 2021-2026**



# Key Populations are central to equity in the HIV response



## INTEGRATE SERVICES

Integrate services for HIV, sexual and reproductive health, family planning, NCDs, and emerging infectious disease threats to advance health equity and sustainability.



## DSD FOR ALL SERVICES

Institutionalize differentiated approaches in the context of integrated services, for all services and all populations, to close gaps and strengthen primary care.



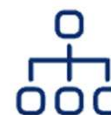
## ADDRESS S&D

Prioritize and allocate resources to eliminate ongoing stigma and discrimination as the basis of human rights-based programming.



## FOCUS ON INDIVIDUAL AND GAPS

Focus on individual needs and gaps, tailoring interventions and linking activities across sites, systems, and individuals to improve prevention and retention in care.



## COMMUNITY-LED SERVICES + CLM

Increase systems sustainability by reaching into community sites and focusing on populations' unmet needs, not just more funding for each siloed population.

# Structural Interventions are essential to KP Programming

## A Fostering Enabling Policy Environments:

- Supporting decriminalization/ anti-discrimination advocacy
- Engaging law enforcement and legal services
- Providing minimum set of human rights policies

## D: Meeting KP community needs

- Human Rights (HR) Violation Response & Reporting System
- KP-specific health services linked to HIV outcome
- Social protections linked to services
- KP socio-economic empowerment



## B: Mitigating Stigma, Discrimination and Violence

- Mitigating SDV in family, community, government services
- Scaling KP competency training in community and facility health services
- Assess/Support emergency response mechanisms

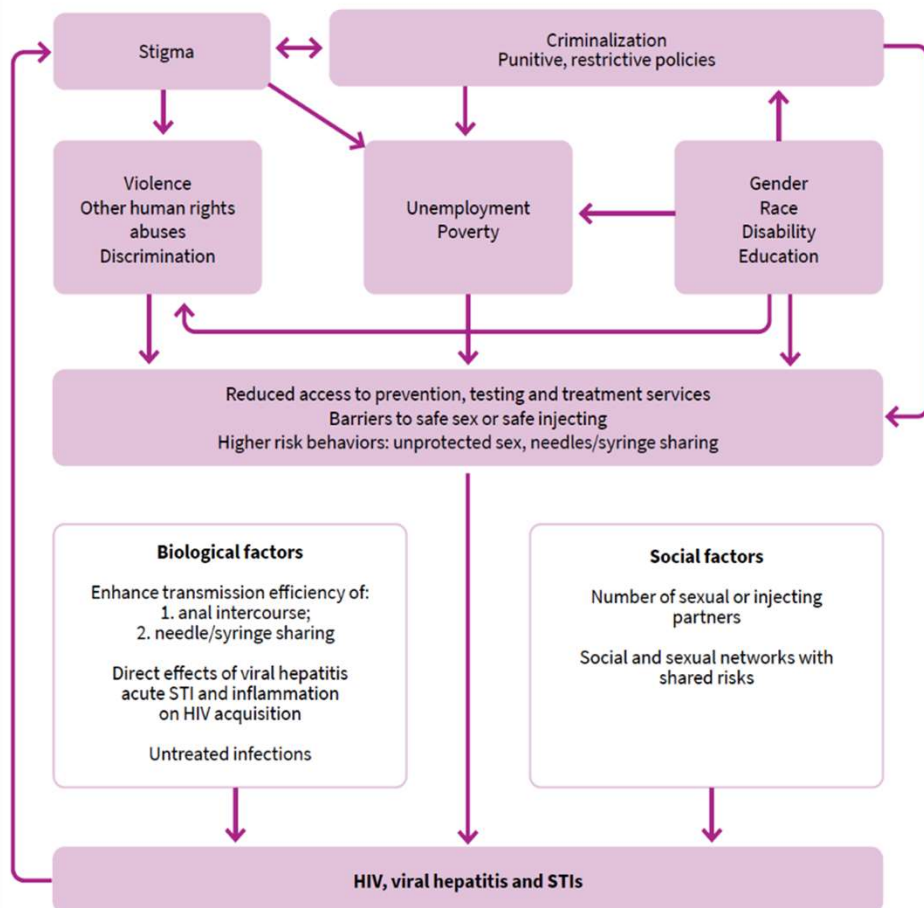
## C: Engaging KP-led CSOs

- Social Contracting/ Social Enterprise
- KP-led CSO capacity strengthening
- Community centered KP programming
- KP leadership development

# What's new in WHO's consolidated KP guidelines



Why we must **prioritize** key populations in the response to HIV, viral hepatitis and STIs



# What's new in WHO's consolidated KP guidelines



## Prioritizing interventions

### Essential for impact: enabling interventions

interventions recommended to address structural barriers to health services access for key populations.

### Essential for impact: health interventions

interventions which have a demonstrated direct impact on HIV, viral hepatitis and STIs in key populations.

### Essential for broader health

health sector interventions to which access for key populations should be ensured, but which do not have direct impact on HIV, viral hepatitis or STIs.

### Supportive

other interventions which support the delivery of health sector interventions, such as creating demand, providing information and education.

ESSENTIAL IN ALL SETTINGS



# What's new in WHO consolidated KP guidelines

World Health  
Organization

## Behavioural interventions



### New good practice statement

When planning and implementing a response for HIV, viral hepatitis and STIs, policy-makers and providers should be aware that counselling behavioural interventions that aim to change behaviours to reduce risks associated with these infections for key populations have not been shown to have an effect on HIV, viral hepatitis and STI incidence nor on risk behaviour such as condom use and needle sharing. Counselling and information-sharing, not aimed at changing behaviours, can be a key component of engagement with key populations, and when provided it should be in a non-judgmental manner, alongside other prevention interventions and with involvement of peers.

#### Remarks:

- Behavioural interventions, counselling, demand creation, information and education can all support the recommended interventions. In the development of this guideline, we did not find evidence for the effectiveness of counselling behavioural interventions that aim to change risk behaviours;
- While we did not review evidence related to other types of behavioural or supportive interventions, information and education support key populations to understand their health, health risks, available services and legal rights;
- Counselling interventions which promote abstinence from drug use, rehabilitation or cessation of sex work or drug use, or a so-called cure for homosexuality or gender incongruence (for example, so-called conversion therapy)\* are not recommended, and create barriers to key population service access.

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# Discussion and Questions



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Thank you!

