The “OVC Advocacy Tool”

Emilia (Molly) D. Rivadeneira
Pediatric and Adolescent HIV Team
MCHB, DGH/T
CDC

The Essential Role of Orphans and Vulnerable Children Programming in HIV Epidemic Control

Washington, DC

May 29 and 30, 2019

Our challenge……

- Finding/testing the Infant/child or adolescents
- Initiating treatment expeditiously with the RIGHT drugs
- Addressing the alarming virologic failure rates in the pediatric and adolescent populations
- Maintaining our focus and goals

- Supporting early disclosure and adherence
- Supporting healthy transitioning

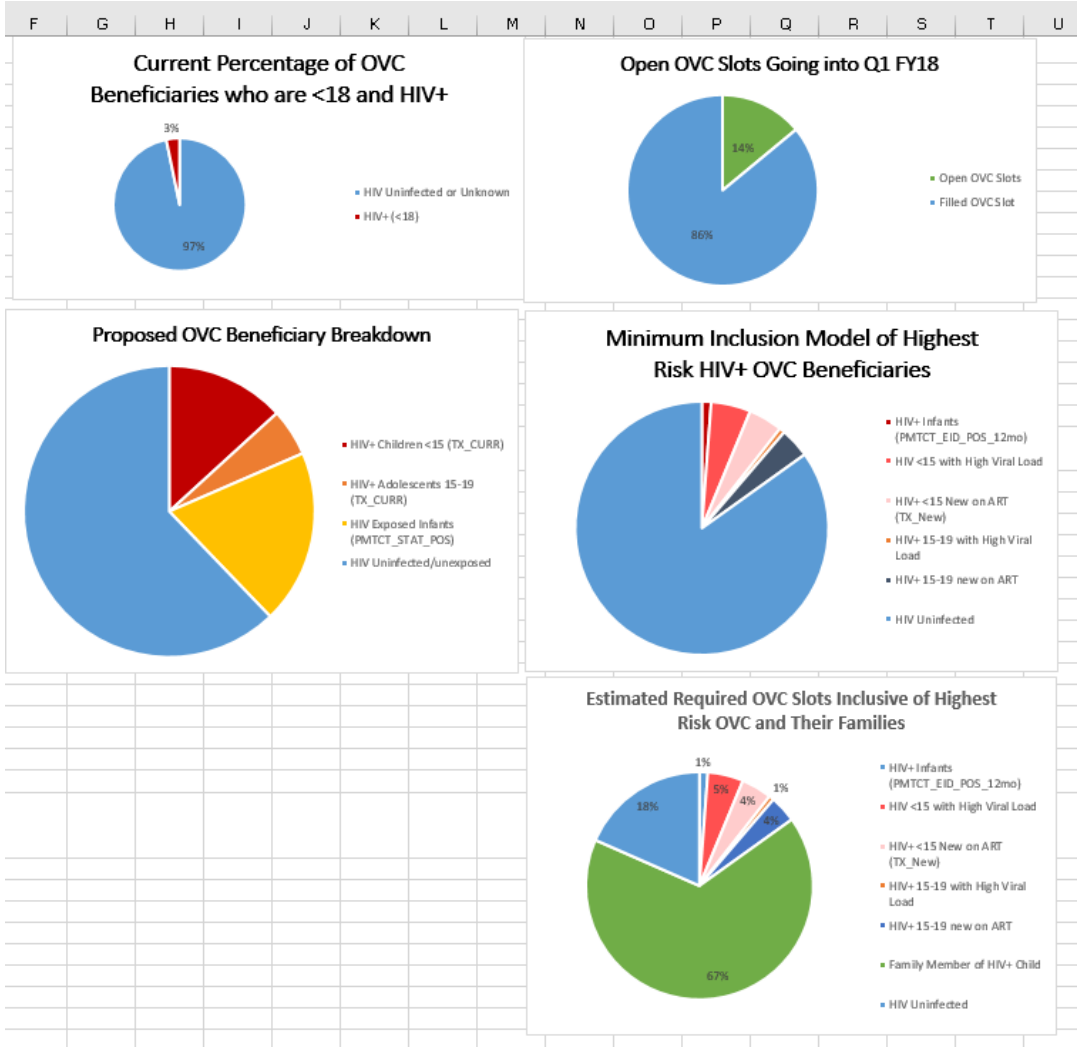
Who developed the tool?

- Members of the Pediatric and Adolescent HIV team
  - Stephanie Hackett and Megumi Itoh
  - Monita Patel, Katie O'Connell and KaeAnne Parris, Susan Hrapcak, Deborah Carpenter, Jessica Gross
  - Viva Combs-Thorsen,
  - Input from country POC's

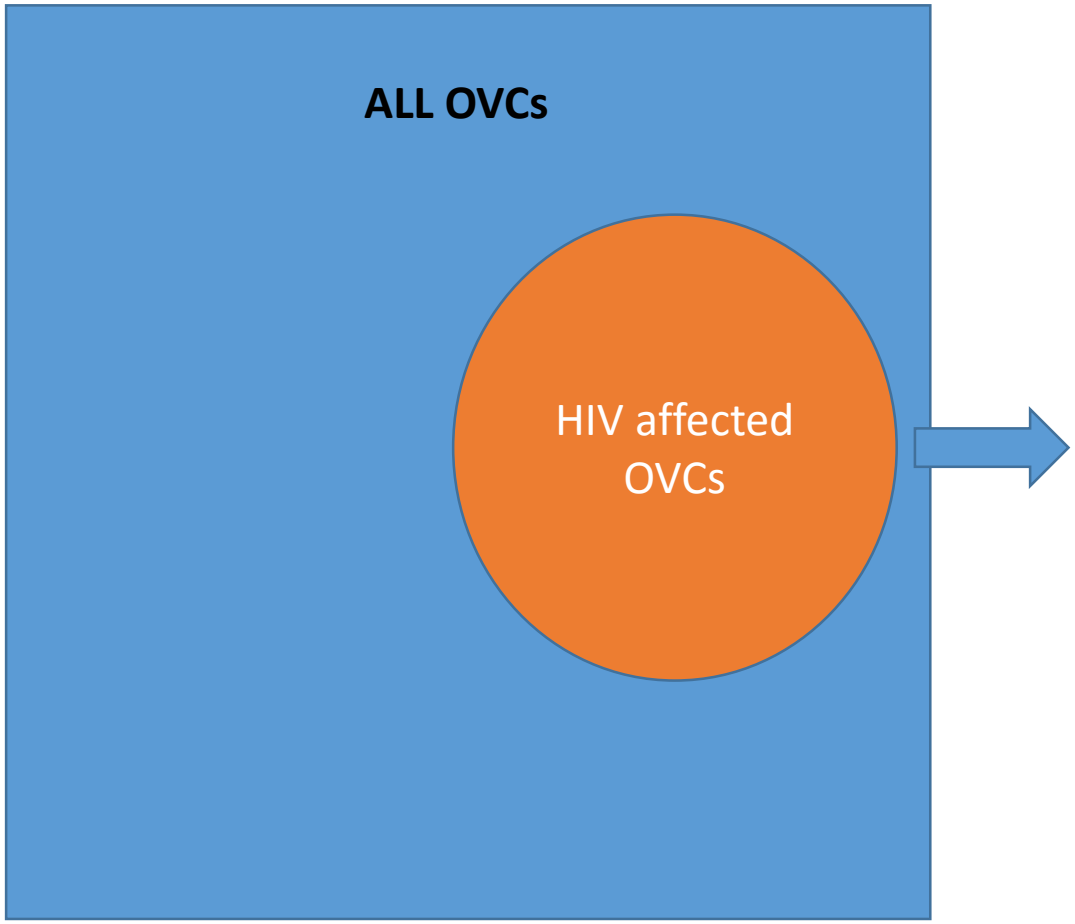
OVC Advocacy Tool

Developed to improve targeted recruitment of HIV-infected and affected children and adolescents (ages 0-17) into OVC programming

- Utilizes data on OVC demographics as well as PMTCT and Pediatric HIV populations to inform programmatic decisions
- Excel-based tool that uses accessible data (PEPFAR Panorama)
- Allows countries to determine which subpopulations are prioritized for recruitment
- Facilitates target setting for recruiting HIV-infected children into OVC programming at national and SNU levels



Orphans and vulnerable children, who are they?



- **HIV-exposed infants** (babies born to positive mothers)
- **HIV infected** infants, children and adolescents
- **HIV negative** infants, children and adolescents of **positive adults**

All **have or had a positive person in their immediate household**, all are at risk for STIGMA & DISCRIMINATION

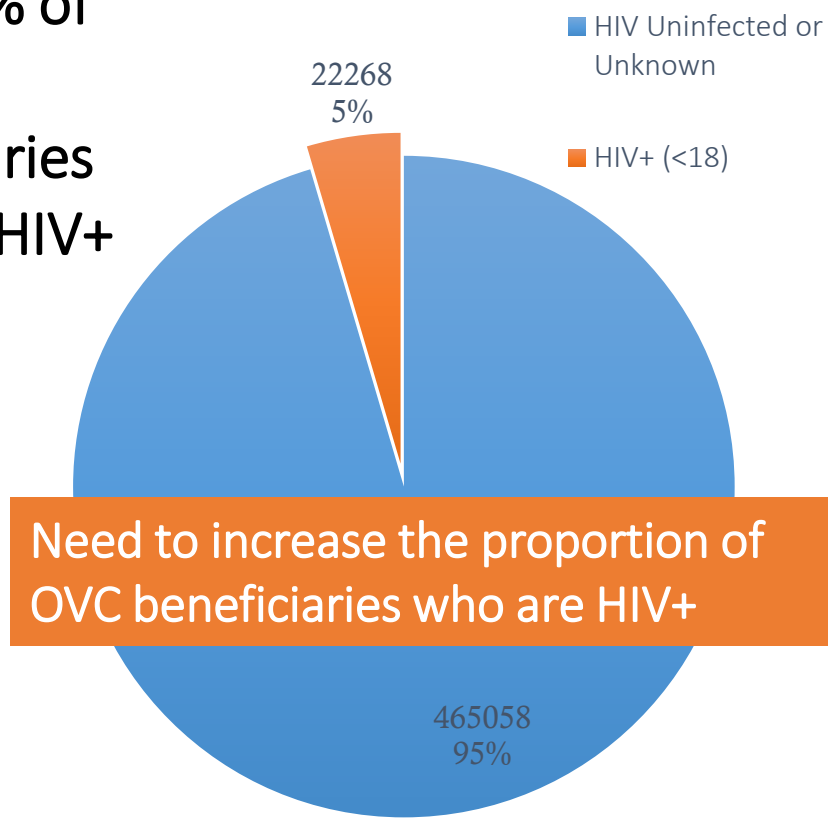
Tool sections: OVC program overview

This section of the tool allows for calculation of the # of potential open OVC slots

OVC Overview			
OVC_SERV APRR17 target	493294		
OVC_SERV APRR17 result	471003	OVC_SERV target achievement	95%
OVC_SERV <01	6017	% OVC beneficiaries	1%
OVC_SERV 1-9	147151	% OVC beneficiaries	31%
OVC_SERV 10-14	142158	% OVC beneficiaries	30%
OVC_SERV 15-17	96550	% OVC beneficiaries	20%
OVC_SERV 18-24	29403	% OVC beneficiaries	6%
OVC_SERV 25+	49724	% OVC beneficiaries	11%
# Exited without graduation	11170	% beneficiaries	2.4%
# Transferred	81	% beneficiaries	0.02%
# Graduated	190213	% beneficiaries	40.4%
# Active	302673	% beneficiaries	64.3%
OVC_HIVSTAT APR17 <18yo	257590	HIVSTAT/SERV	55%
OVC_HIVSTAT_POS APR17 <18yo	25342	HIVSTAT_POS/HIVSTAT	10%
OVC_HIVSTAT_POS on ART <18yo	22490	On ART/HIVSTAT_POS	89%
#of <20 yo on ART	60248	Sum of 0-19 age TX_CURR agebands	
# of potential open OVC slots (OVC_SERV target-#active)	**190621**		

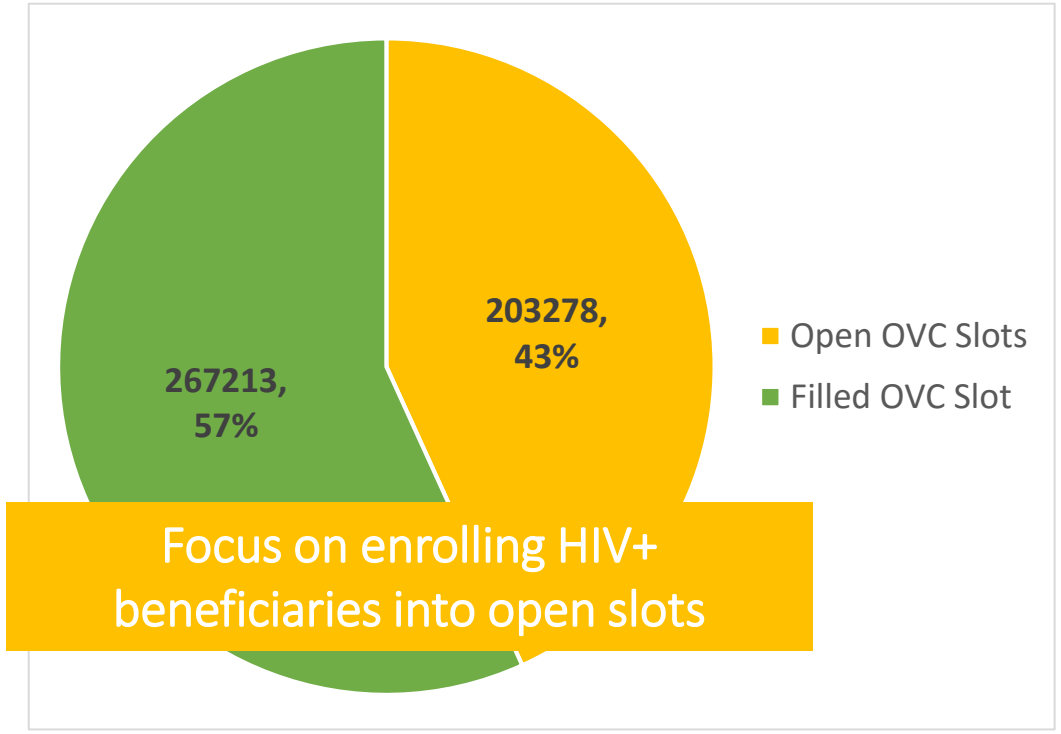
Goal: Focus OVC Programming on HIV-Infected Children and Adolescents

Current % of <18 OVC beneficiaries who are HIV+



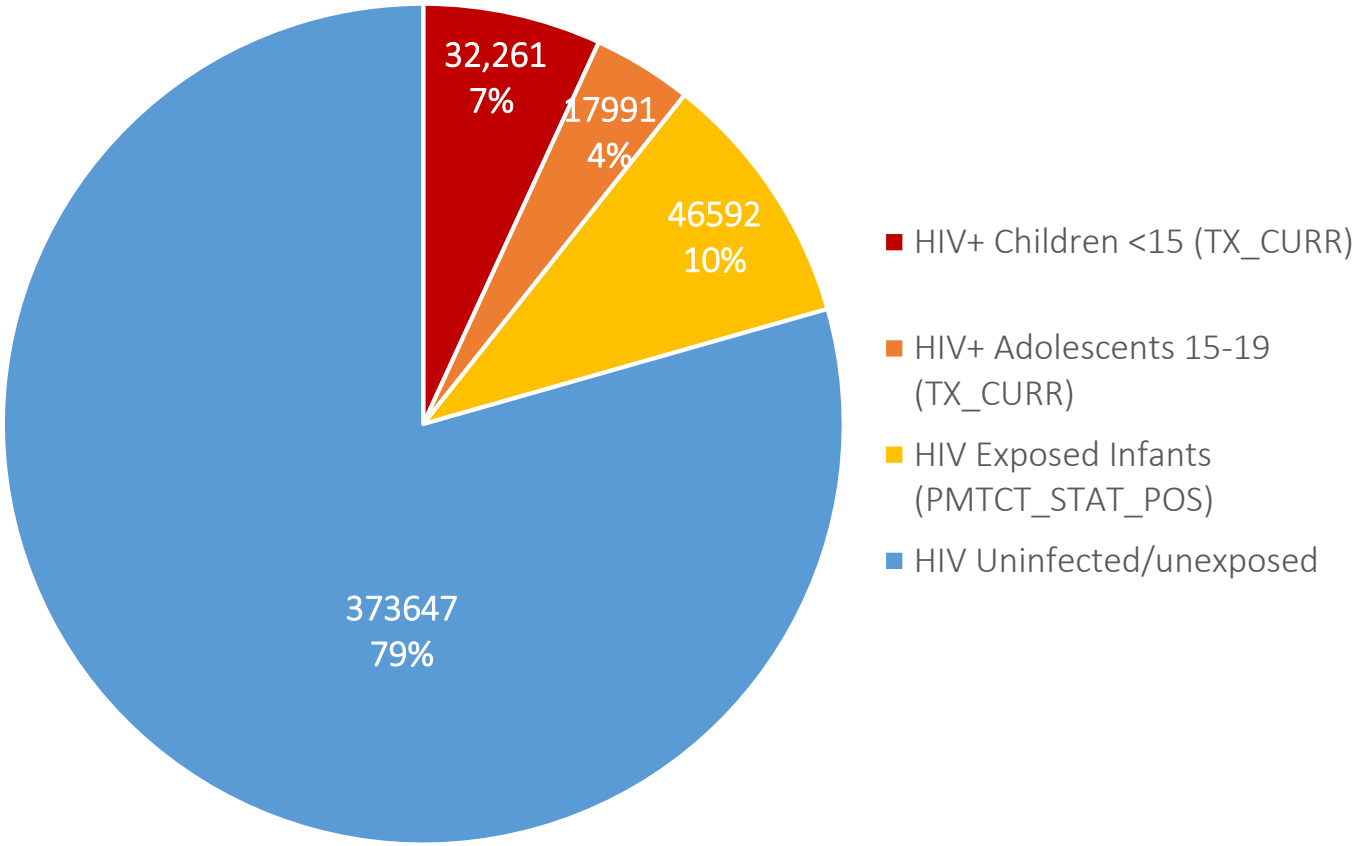
Need to increase the proportion of OVC beneficiaries who are HIV+

Potential open OVC slots for FY18



Focus on enrolling HIV+ beneficiaries into open slots

Maximum inclusion: What if all TX_CURR <19 *and* HIV-Exposed Infants were enrolled into OVC?



Pie-in-the-sky scenario:
All TX_CURR <15 and 15-19 and every HIV-exposed infant would take up 21% of the OVC slots

BUT we would need to multiply by average household size (5.1) so would take up more than the total # of available slots

Prioritization

- Given the limited number of available beneficiary ‘slots’, certain populations need to be prioritized for enrollment.
- In our model, the “highest priority” populations are all HIV-infected infants <1 and HIV+ children and adolescents with high viral load or who are newly initiated on ART.

Risk within risk….

- **HIV-exposed infants**
  - **Mom is positive**
  - **Mom is a new positive**
  - **Mom is positive <24 years of age**
  - **Mom is new positive < 24 years of age**
  - **Mom is < 19 years of age**
  - **Mom is failing treatment**
- **HIV infected infants, children and adolescents**
  - **On treatment doing well**
  - **On treatment failing**
  - **On 3rd line treatment**
  - **On treatment, failing and 14 y/o male**
  - **New on treatment adolescent**

HIV negative infants, children and adolescents of positive adults

One parent positive on treatment doing well,

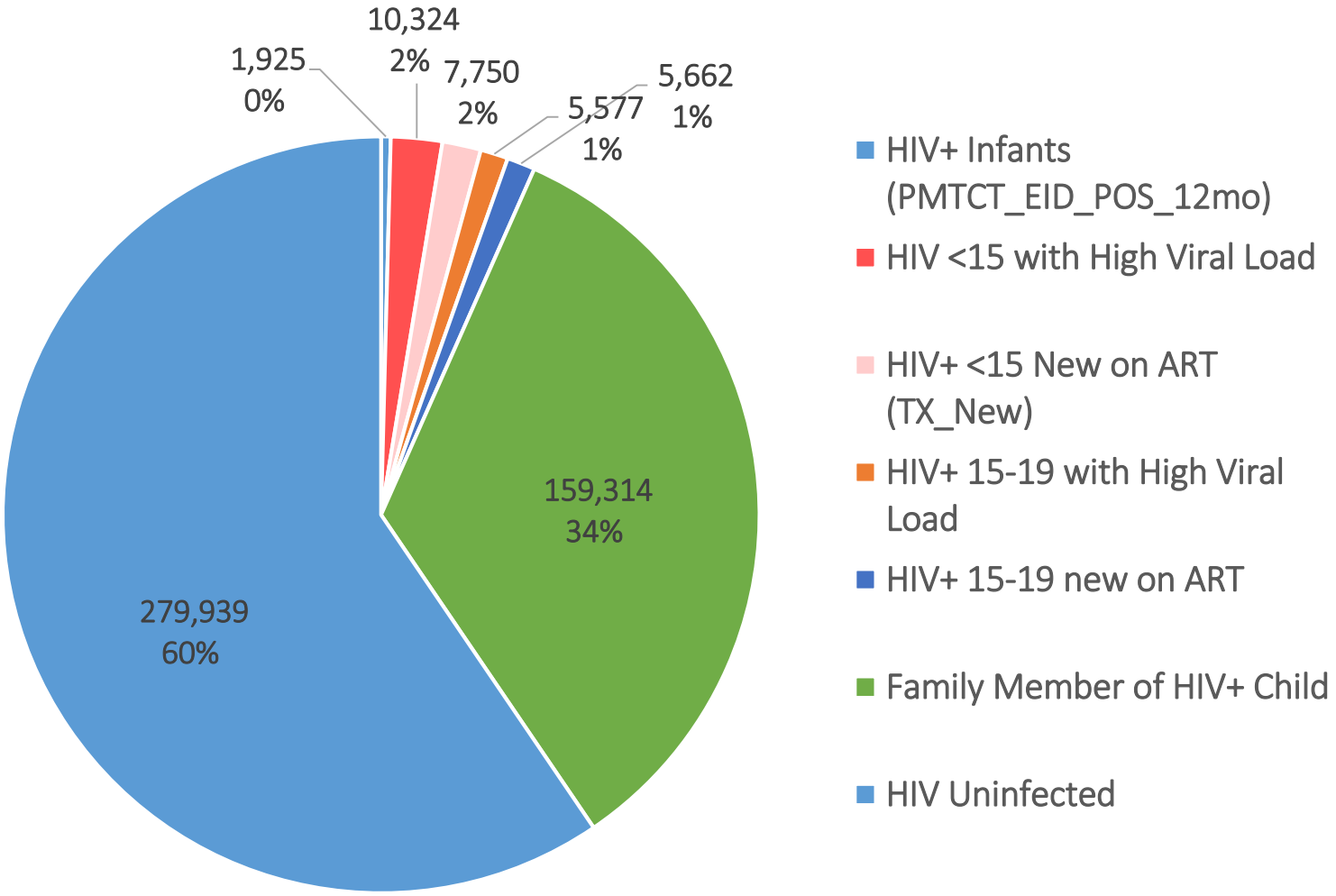
Both parents positive on treatment doing well

One parent positive failing treatment, with advance disease and low CD4

Both parents with advanced disease

ANY of the above + AGYW

Minimum inclusion:
Highest risk HIV+ Children and Adolescents



If we prioritize only the "highest risk" HIV+ children and adolescents (HIV+ infants, those with high VL, newly on ART), they would only take up about 6% of the slots

Including the family members (average household size 5.1) would still be feasible within the open OVC slots (~40%)

Other considerations

- Can tailor this tool to enroll additional priority populations depending on your country's needs and strategic priorities:

  - Children with OIs, children on 2nd and 3rd line regimens, children of adults with detectable viral loads, on 2nd and 3rd line regimens, children who are not retained, high-risk pregnant women

  - Children of KPs, children not in school, adolescent boys, etc.
  - Lack quality data measures for some subpopulations, also with extensive overlap among risk groups