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Monitoring coverage of index testing for biological children and siblings of PLHIV on ART: OVC and Clinical Staff *WORKING TOGETHER*

Index Testing SOPs reviewed and improved by: OGAC Pediatric and OVC Advisors, PEPFAR Pediatric and OVC Interagency Subject Matter Experts (ISMEs), PEPFAR Pediatric and OVC Advisors from country teams, and implementing partners.

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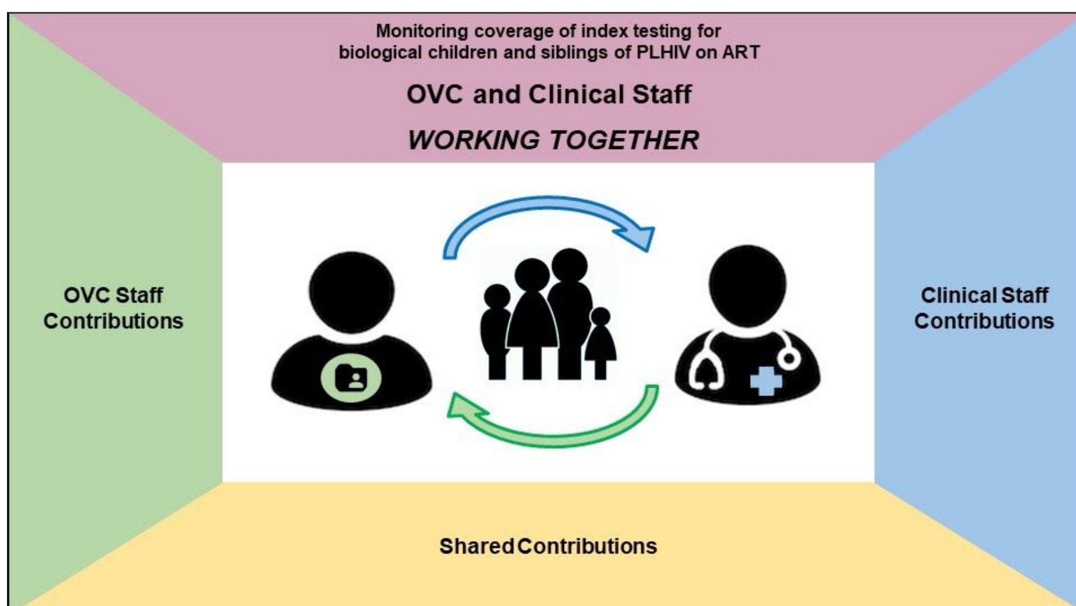
Overview

Identification of children and adolescents living with HIV (C/ALHIV) is a key priority of PEPFAR to ensure timely diagnosis and linkage to life-saving antiretroviral treatment (ART). Perinatally infected children, who were not identified during the PMTCT/EID phase, are living longer as 'well-children,' therefore finding them requires increased focus and targeted interventions. Index testing has proven to be an effective modality to identify C/ALHIV, through a biological parent or HIV-infected sibling, who would otherwise not be quickly linked to ART.

Clinical and OVC staff have unique and shared responsibilities in the on-going efforts to increase the number of C/ALHIV identified through index testing across all PEPFAR-supported countries. As required in COP20 guidance, clinical and OVC teams must work closely to ensure robust, bi-directional referral systems are in place for all C/ALHIV and their caregivers/parents/families. These efforts are key to reach 100% coverage of index testing of biological children and for the identification of C/ALHIV previously undiagnosed.

Staff must follow the host government's COVID-19 guidelines and follow all adaptations made to index case testing and OVC services due to COVID-19. The safety and protection of all workers and beneficiaries must be prioritized. For more information, see PEPFAR Technical Guidance in Context of COVID-19 (https://www.state.gov/pepfar/coronavirus/).



Two Standard Operating Procedures (SOPs) have been developed to support the joint operationalization of improving index testing coverage for children and adolescents and should be used in tandem for maximized results.

1. **Maximizing Coverage of Index Testing for Biological Children of HIV Infected Mothers: Standard Operating Procedure (SOP)** aims to provide guidance for OVC staff to assess all identified HIV infected mothers, fathers and siblings to ascertain the number of living biological children/siblings with unknown status and ensure they are referred for index testing.

2. **Monitoring Coverage of Index Testing for Biological Children and Siblings of PLHIV on ART SOP** directs clinical programs on how to determine baseline coverage rates for index testing among biological children of HIV infected parents and mothers, on-going tracking of these families to ensure index testing has been completed, and how to best collaborate with OVC partners to maximize efficiencies and results.

By implementing these SOPs in tandem with strong collaboration across programs, more C/ALHIV will be diagnosed, linked to ART, and enrolled in OVC services to support healthy living and life-long adherence.

M&E Reporting Responsibilities:

The chart below includes recommendations of how M&E reporting responsibilities can be divided between OVC and Clinical implementing partners (IPs). According to COP20 guidance, OVC and Clinical partners should have mutually agreed upon MOUs and SOPs in place with roles and responsibilities clearly defined. Joint collaboration is necessary to ensure that biological children and siblings of PLHIV newly identified, newly initiated and currently on ART are tested in a timely manner, and if positive, are rapidly linked to ART and offered enrollment into the OVC program. This framework and reporting template* are suggested, but should be reviewed and adapted by the involved providers from the facilities, and the Clinical and OVC IPs to best suit the structures and staffing at each site.

The first column describes the indicator or data point that should be reported. The partner listed in the second column identifies who should collect the data, and the partner in the third column is responsible for reporting the data. When “Clinical w/ OVC” or “OVC w/ Clinical” is suggested, the first partner is responsible for the task, and the second partner listed should collaborate and support the action.

Note: If there is no OVC program currently active at the site, the Clinical Team is responsible for all of the M&E reporting responsibilities to ensure all biological children of PLHIV are identified, initiated, and linked to ART.

*Reporting Template: https://drive.google.com/file/d/1wnW2ffy41WRIqp24enpT-qh38m4Wvln0/view?usp=sharing

<table>
<tr><th>Indicator/Data Point</th><th>Who collects the data?</th><th>Who reports the data?</th></tr>
<tr><td colspan="3">1. Identify PLHIV and C/ALHIV that have contacts <19 yo and should be indexed:</td></tr>
<tr><td>Total # of PLHIV that have biological children and C/ALHIV that have biological siblings
❑ Newly identified PLHIV (HTS_POS)
❑ Newly initiated PLHIV (TX_NEW)
❑ PLHIV currently on ART (TX_CURR)</td><td>Clinical w/ OVC</td><td>Clinical</td></tr>
<tr><td>Total # of records reviewed for each of the target criteria</td><td>OVC</td><td>OVC</td></tr>
<tr><td colspan="3">2. Identify how many biological children and siblings <19 yo of these identified clients</td></tr>
<tr><td>Total # of biological children and siblings <19 yo of these identified clients
❑ Known status (by age and sex)
❑ Unknown status (by age and sex)</td><td>Clinical w/ OVC</td><td>Clinical</td></tr>
<tr><td colspan="3">3. Establish baseline pediatric index testing coverage and identify pediatric index testing gap</td></tr>
<tr><td>Index testing coverage by health facility =
$\left(\frac{\#\ biological\ children\ and\ siblings\ with\ known\ HIV\ \ status}{All\ biological\ children\ and\ siblings\ identified\ in\ step\ 2}\right) \times 100$</td><td>Clinical w/ OVC</td><td>Clinical</td></tr>
<tr><td colspan="3">4. Facilitate testing for those in need of testing to close index testing coverage gap</td></tr>
<tr><td>4a. How many of the biological children and siblings <19 identified in Step #2 with unknown HIV status were contacted?

❑ By clinical staff
❑ By OVC staff</td><td colspan="2">For these indicators, the responsibilities between OVC and Clinical Staff will vary and should be mutually agreed upon by all staff involved.

Tips for monitoring include:
● Define detailed roles and responsibilities for OVC and Clinical Staff (use MOUs/SOPs whenever possible)</td></tr>
</table>

<table>
<tr><td>4b. How many of the # biological children and siblings contacted in Step 4a with unknown HIV status were reached?

❏ By clinical staff
❏ By OVC staff</td><td colspan="2" rowspan="3">● Engage with Community Testing IP to align efforts and ensure all C/ALHIV identified are referred to OVC and linked to ART

● Every effort should be made to reach all contacts and on-going tracing should be prioritized. (Do not accept “unable to trace” outcomes for these children and adolescents in need of testing)</td></tr>
<tr><td>4c. How many of the biological children and siblings contacted in Step 4b, received parental consent or gave consent to get tested for HIV?</td></tr>
<tr><td>4d. How many of the biological children and siblings receiving parental consent or providing their own consent (if old enough) in Step #4c were tested for HIV?

❏ By clinical staff (facility or community-based testing)
❏ By OVC staff (if OVC staff facilitated testing to a community site)</td></tr>
<tr><td>4e. How many of the biological children and siblings receiving an HIV test in Step #4d were positive, negative and indeterminate (by age and sex)? If tested positive through a community site, please ensure confirmatory testing in the health facility.</td><td>Clinical w/ OVC</td><td>Clinical</td></tr>
<tr><td>4f. How many of the biological children and siblings identified with HIV in Step #4e were linked to ART.</td><td>Clinical w/ OVC</td><td>Clinical</td></tr>
<tr><td>4g. How many of the biological children and siblings identified with HIV in Step #4e were:

● Assessed for enrollment into the OVC program
● Offered enrollment into the OVC program
● Agreed to enroll into the OVC program
● Refused enrollment into the OVC Program</td><td>OVC w/ Clinical</td><td>OVC</td></tr>
</table>

Develop program targets and tracking:

Clinical and OVC Staff are encouraged to set targets and monitor progress to maximize performance and best meet the needs of the children and adolescents in need of testing. When setting these targets it is important to consider country by country and context-specific considerations. Below are several suggested targets that can be modified accordingly.

Proposed target:	Target benchmark:
% of children and adolescents with unknown HIV status contacted/reached	>95%
% of children and adolescents contact/reached who are referred for HIV testing	>80%
% of children and adolescents referred who obtained an HIV test result	>95%
% of children and adolescents testing HIV+ who are linked to care and treatment services and initiated on ART	100%
% of children and adolescents testing HIV+ who are assessed for enrollment into the OVC program	100%
% of children and adolescents assessed who are offered enrollment into the OVC program	90%
% of children and adolescents offered enrollment into the OVC program who enroll	90%

Ongoing Review:

Once the full cohort of PLHIV are indexed (in Step #1), Clinical and OVC staff must ensure that on-going index testing efforts for children continue and are standard of care with routine monitoring. Newly identified and initiated PLHIV must also be indexed as they are identified and linked to ART, adding those contacts to the denominator and following Steps #2-5.

Any challenges or barriers with implementation, as well as steps taken to address those challenges (e.g. meetings, TA requested, index testing register revised) should be well-documented to ensure qualitative data can support any gaps in quantitative data.