Working Together: A discussion on index testing for children

July 29th, 2020

Agenda

- Introduction
- COP 20 Guidance
- SOP Highlights
- M&E and Reporting
- Country Presentations
- Discussion

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COP20 Guidance Highlights

Presented by Hilary Wolf, S/GAC

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COP20 Index Testing Guidance

- **Index testing = essential strategy to reach children in all settings, at all entry points**
  - No target positivity rate (can be higher than general HIV prevalence for children)
  - Priority strategy to reach biological children of key populations living with HIV
- **Essential that 100% of biological children of women living with HIV have a documented test result**
  - Children of men living with HIV are eligible for index testing services when the mothers' status is HIV-positive, unknown, or unable to be obtained
- **Programs will be expected to provide data showing that all children of women on ART have been tested**
  - Disaggregated index testing results for child and adult contacts to meaningfully assess *coverage* (percent of elicited children reached for testing) and *yield* (measure of fidelity and impact)

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COP20 Index Testing Guidance: Working Together

- **To meet these goals and ensure client-centered care, clinical and OVC programs must formalize their partnership and work together as part of multi-disciplinary teams.**
  - All women living with HIV with children should be assessed by an OVC case worker for potential OVC program enrollment (in SNUs with OVC programs)
  - OVC programs should systematically assess all beneficiaries for HIV testing needs utilizing HIV risk screening tools
  - Establish MOUs between PEPFAR-supported clinics and OVC partners
  - In high burden SNUs, assign OVC case workers to high-volume clinics and community catchment areas to ensure smooth coordination

Index testing age shift for biological children <15yo to <19yo

COP20 Minimum Program Requirements

Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.

- Case Finding: **All children under the age of 19yo** with an HIV positive biological parent must be tested for HIV.
- Prevention and OVC: Actively facilitating testing for all children at risk of HIV infection **under the age of 18yo**.
- Slight age group difference between index testing (<19yo) and OVC program (<18yo), however clinical and OVC IPs can determine their collaboration within an OU, so roles are delineated for testing and support.

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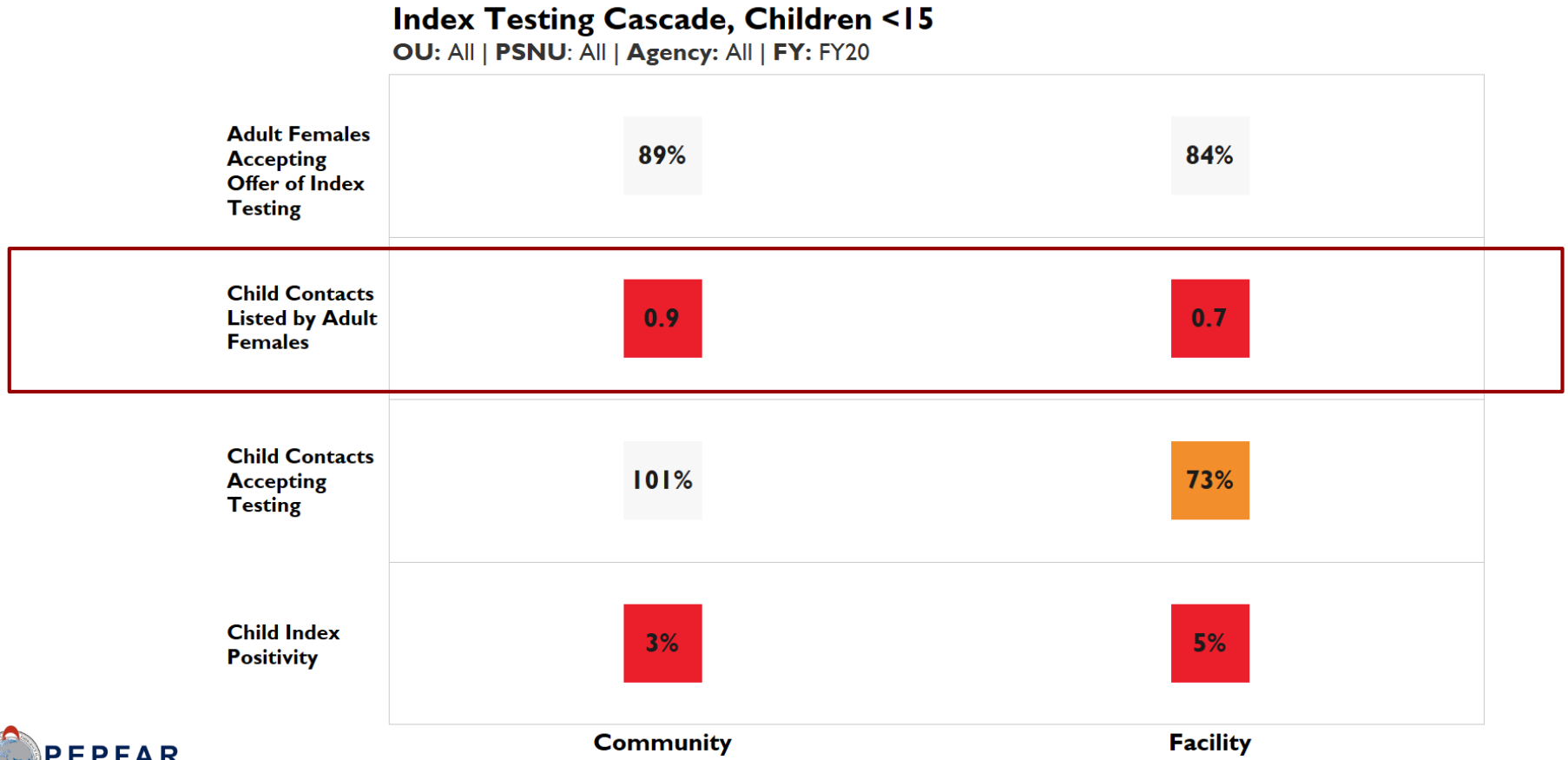
Low numbers of biological children are listed as contacts by HIV positive adult females (FY20Q2, PEPFAR data)



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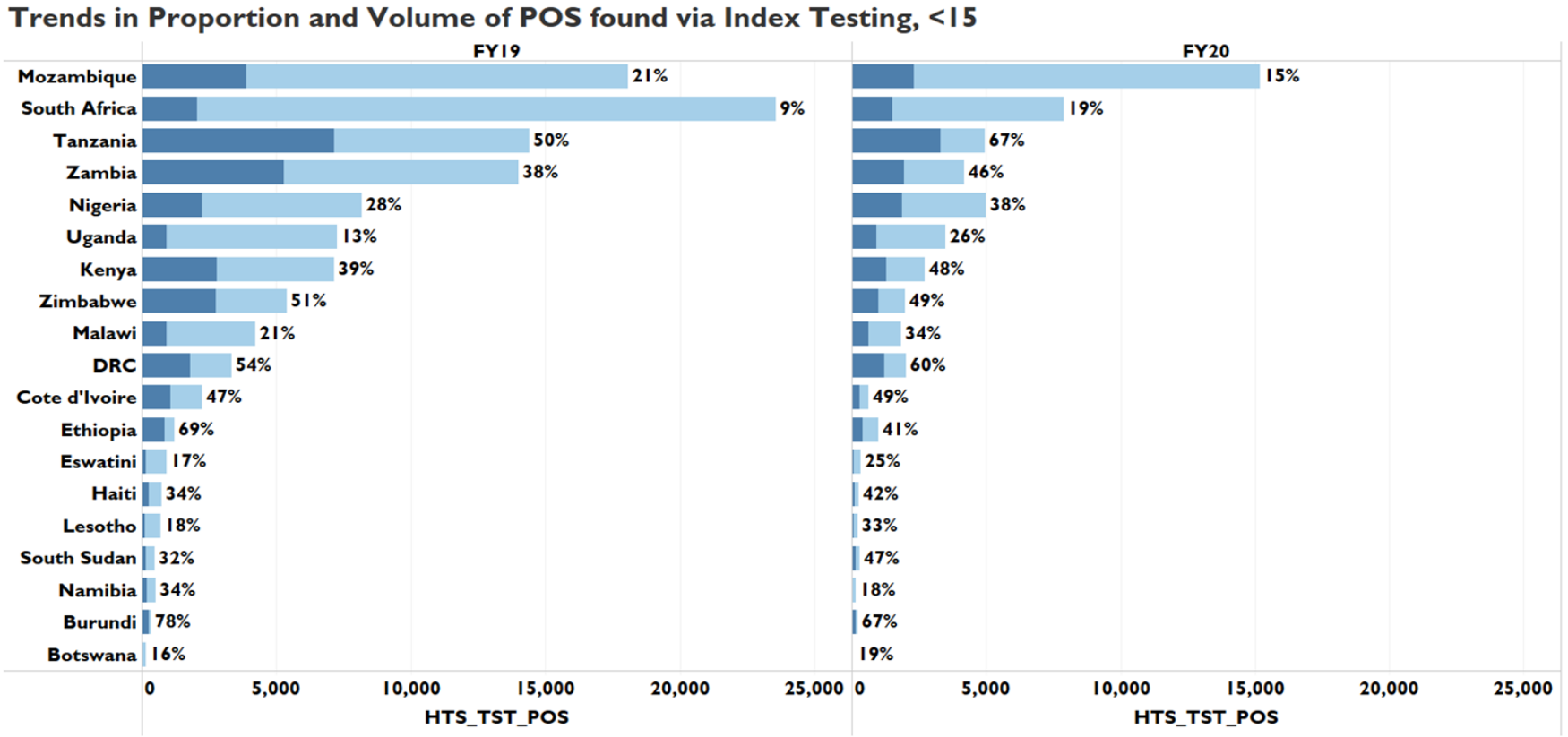
….and many countries are lagging behind with index testing



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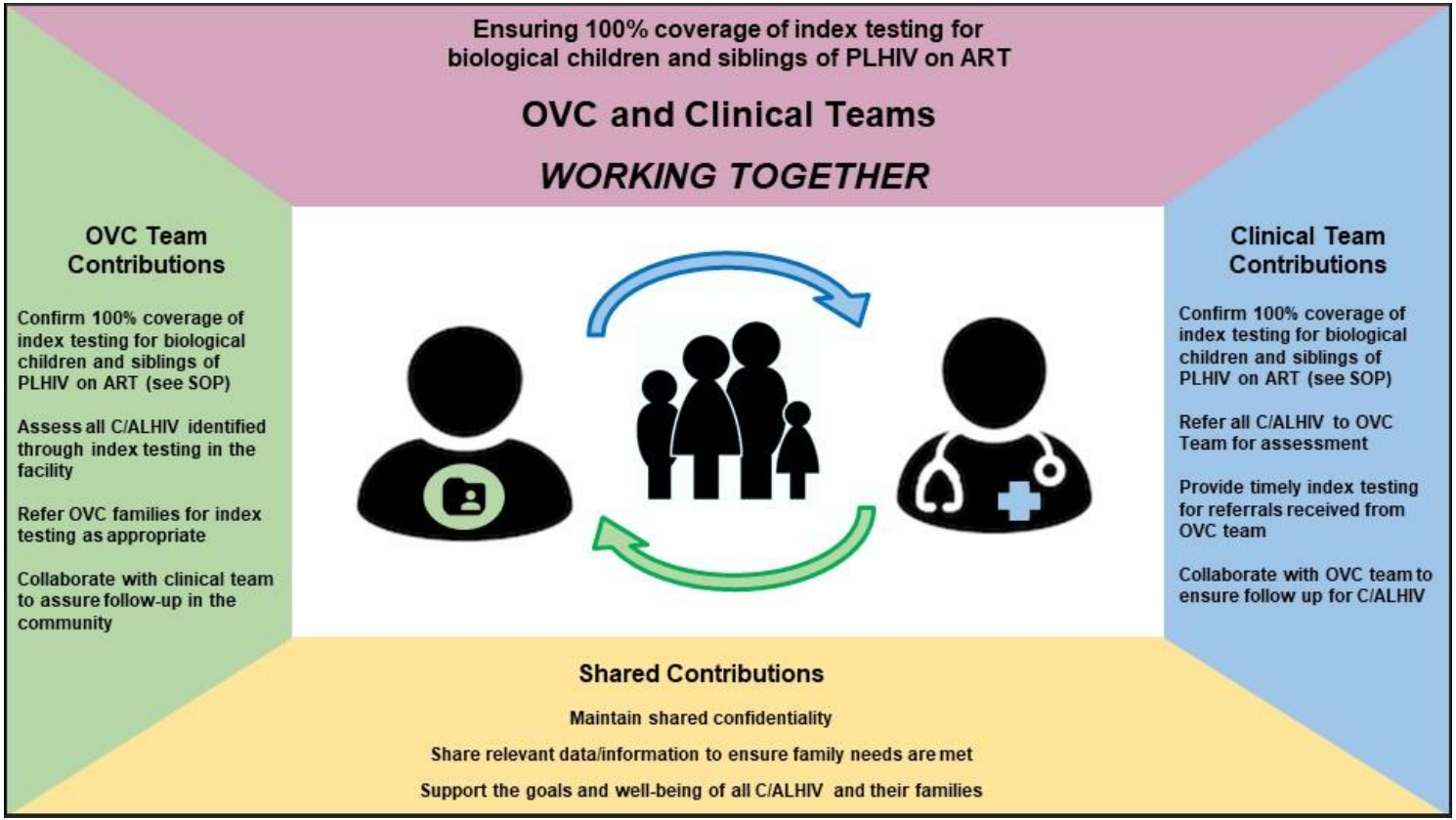
How do we improve coverage of index testing for children?



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Created by Megan Gleason, Nimasha Fernando, and Sally Bjornholm

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Clinical Index Testing SOP Review

Presented by: Megan Gleason and Nimasha Fernando, USAID

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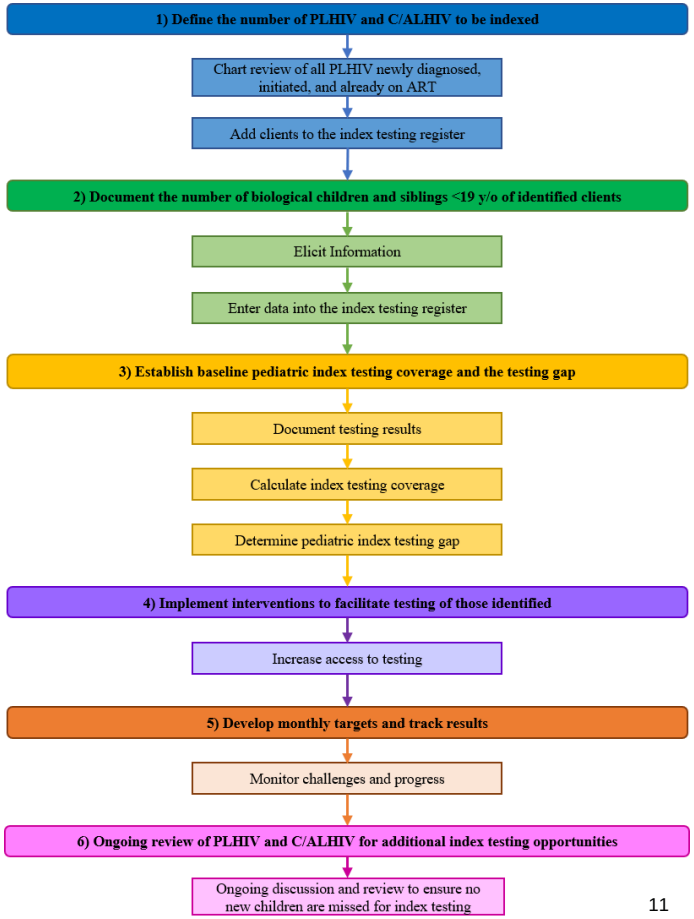
RATIONALE

- SOP Aim: Ensure that clinical partners, in close coordination with OVC, KP and community partners, **make certain that all biological children <19y/o of PLHIV and biological siblings <19y/o of C/ALHIV currently on ART know their HIV status.**

- SOP outlines the process for:
  1. Reviewing the backlog of PLHIV and C/ALHIV already on ART and not yet indexed;
  2. Ensuring that newly diagnosed and initiated PLHIV and C/ALHIV are indexed;
  3. Ensuring at-risk children and adolescents are tested in a timely manner (within 2 weeks) either through community or facility-based testing platforms; and
  4. Monitoring and documenting 100% coverage of index testing for biological children of PLHIV and biological siblings of C/ALHIV *newly diagnosed, initiated or already on ART*.
     - Ensure documentation of reasons for not reaching 100% coverage (e.g. lack of consent).



Establish baseline index testing coverage and testing gap (step 3)

- Once the charts of PLHIV on ART are reviewed and children and siblings are identified, baseline coverage and testing gap should be calculated.
- This step will help IPs collaboratively focus and target interventions to ensure follow up for these children and adolescents in need of testing services.
- Baseline index testing coverage and gap should be reported to Peds/OVC Mission POCs as soon as possible.

Index testing coverage =

Children and siblings <19 in the index register with documented HIV test results

$$\frac{\text{Number of children and siblings who know their HIV status}}{\text{All children and siblings identified in step 2}} \times 100$$

All biological children <19y/o of mothers living with HIV receiving HIV services
+ Children <19y/o of fathers living with HIV whose wives/partners have unknown status
+ All biological siblings <19y/o of C/ALHIV whose parents are not available

Index Testing Gap =

$$\left[\text{Total number of biological children and siblings <19y/o identified}\right] - \left[\text{Number of biological children and siblings <19y/o with known HIV status}\right]$$

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For more info: Access PEPFAR's index testing toolkit

For more information, resources and tools, check out PEPFAR Solutions:

- Index and Partner Notification Testing Toolkit

and

- PEPFAR Guidance on Implementing Safe and Ethical Index Testing Services

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OVC Index Testing SOP Review

Presented by: Sally Bjornholm and Joshua Volle, USAID

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RATIONALE: Role of OVC Programs

- Align with COP20 guidance to accelerate the identification of undiagnosed children and adolescents

- WORK TOGETHER with clinical, KP and community partners, to trace biological children and siblings of PLHIV

- Enroll an increased number of C/ALHIV in OVC services through the increased testing effort to find C/ALHIV not already identified

- Engage with clients/families in the community and within the health facility, to assist in tracking clients in the community

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Operational Considerations for maximizing coverage of index testing for children/adolescents

- ***Who are we looking for?***
- ***How should children in need of an HIV test be identified?***
- ***How should an HIV test be offered to a child or adolescent?***
  - *Record/Client File review*
  - *Clinic or community visit with family (should be done by both clinical and OVC staff)*
- ***Types of HIV testing to consider when creating a plan for the child/adolescent***
- ***Next steps after HIV referral for testing or HIV results***

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Considerations for discussing index testing with parents and/or children/adolescents

- Comply with the country's national HTS guidelines for testing children and adolescents.
- If a home visit is to be made, ensure that you have the index parent's permission and agreement to the visit the home.
- Gather as much information as you can prior to engaging the family through review of client files and engaging with service providers for the family.
    - Allows CM to be prepared with history on the family/child and create a strategy to address index testing for the child and adolescent (mother refuses testing for child, history of GBV, history of missed appointments, etc.).
- Index testing should be discussed each time an HIV-infected parent(s) accesses the health facility, especially clients returning after a period of being LTFU
- All information gleaned from the records review is to be kept in the strictest of confidence, this includes personally identifiable information, health status and KP status (e.g. sex worker)

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Monitoring and Evaluation

Presented by Joshua Volle

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Monitoring and Tracking the Process

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.

A system may need to be developed so that we can:

- Register identified children/families
- Track children through the process
- Answer analytic questions and report on associated indicators

System will:

- Need to be either an augmentation of current electronic system or an excel spreadsheet. (see appendix for examples of data collection forms to build from)
- Need coordination between OVC program and all PEPFAR supported health facilities
- Require additional training of OVC staff in health facility
- Require increased confidentiality

The Framework the steps

1. Identify PLHIV and C/ALHIV that have contacts <19 yo and should be indexed
2. Identify how many biological children and siblings <19 yo of these identified clients
3. Establish baseline pediatric index testing coverage and identify pediatric index testing gap

$$\text{Index testing coverage by health facility} = \left(\frac{\#\ \textit{biological children and siblings with known HIV status}}{\textit{All biological children and siblings identified in step 2}}\right) \times 100$$

4. Facilitate testing for those in need of testing to close index testing coverage gap

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Monitoring and Tracking the process

1. 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
2. How many of the # biological children and siblings contacted in Step 4a with unknown HIV status were reached? ❑ By clinical staff ❑ By OVC staff
3. How many of the biological children and siblings contacted in Step 4b, received parental consent or gave consent to get tested for HIV?
4. 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)
5. How many of the biological children and siblings receiving an HIV test in Step #4d were positive, negative and indeterminate (by age and sex)?
6. How many of the biological children and siblings identified with HIV in Step #4e were linked to ART.
7. 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

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Suggested Reporting Template

- Tab 1: Brief data dictionary
- Tab 2: First 3 steps of the Monitoring Framework
  - How many records were reviewed?
  - How many people met the inclusion criteria?
  - How many children were identified?
  - How many have a known status vs. unknown status?
  - What is the baseline child index rate?
- Tab 3: Step 4 of the Framework
- Tab 4: Summary sheet for indicators (auto-calculations)

Link to reporting template

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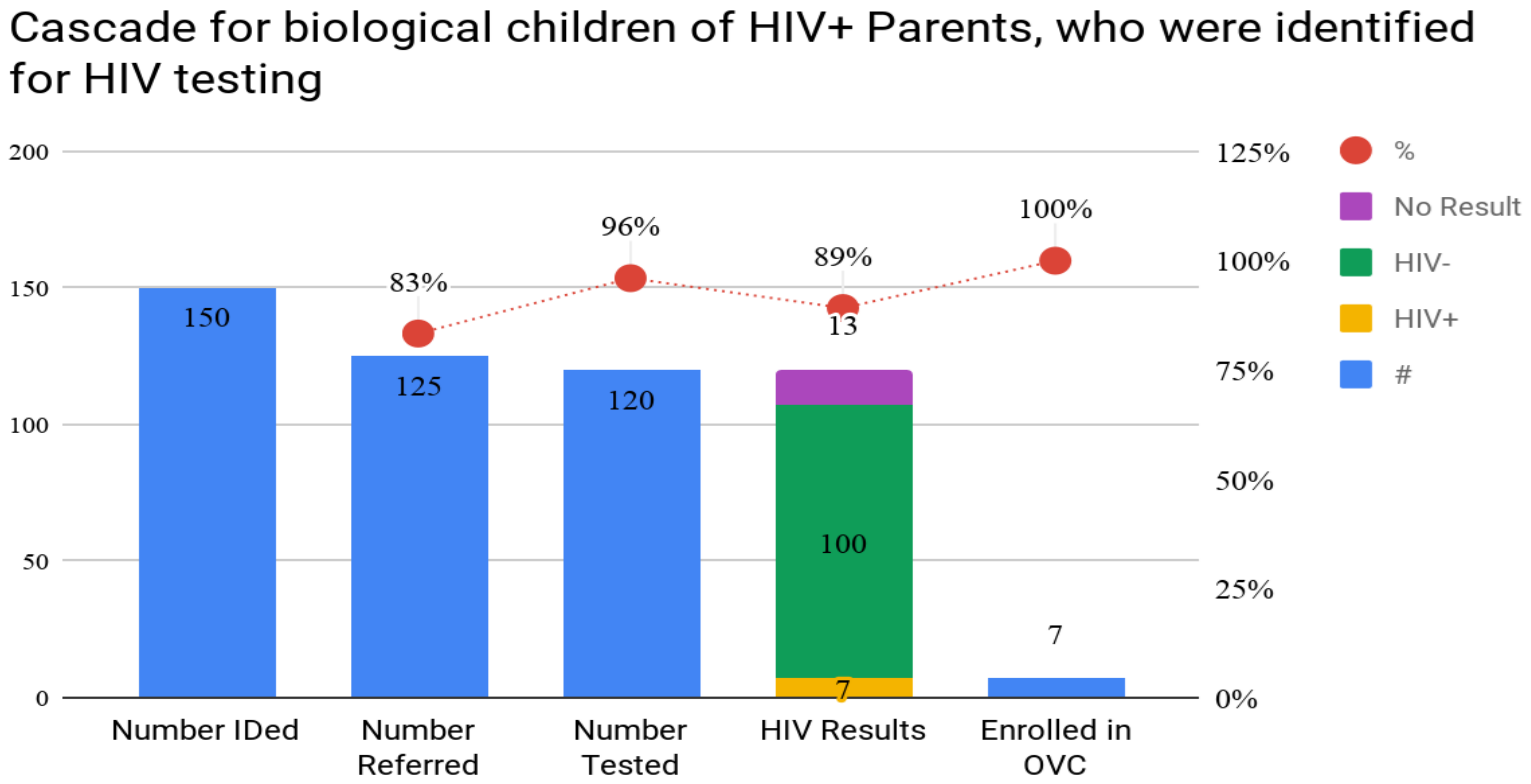
Indicators


Cascade for biological children of HIV+ Parents, who were identified for HIV testing
200
150
100
50
0
125%
100%
75%
50%
25%
0%
%
No Result
HIV-
HIV+
#
150
125
120
100
7
7
83%
96%
89%
100%
13
Number IDed
Number Referred
Number Tested
HIV Results
Enrolled in OVC

Set annual targets

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%

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Country Presentations

Moderated by Caroline Cooney, S/GAC

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July
2020

USAID Caring for Vulnerable Children (CVC)

Finding Children and Adolescents Living with HIV in Addis Ababa/Ethiopia through Index Testing

Dr. Kesetebirhan Yirdaw, HIV/Health Director

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Operation Triple A (OTA) – Addis Ababa Acceleration

Treatment Gap:

- Pediatric ART coverage in PEPFAR supported sites in Ethiopia only 41% (Ethiopia COP20)

OTA Objectives:

- Improve new HIV case finding among children and adolescents <18 in Addis Ababa.

- Support C&ALHIV to achieve the “three zeroes” (zero missed appointments, zero missed medications, and zero viral load).

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Strategies for Finding Undiagnosed HIV-positive Children of Index Cases

- Identify untested children of HIV+ mothers in ART clinics through patient chart reviews

- Identify children of newly diagnosed HIV+ mothers in VCT clinics, particularly children of women who are divorced, separated or widowed (DSW)

Working Together: Activities for Finding Undiagnosed HIV-positive Children of Index Cases

Orientation of Health Facility staff on the role of the OVC program in supporting index testing

Updating of MOUs between IPs and HFs to allow:

- shared confidentiality between IPs and Health Facilities
- weekly meeting of IPs and HFs staff to discuss performance on index testing

Orientation of OVC Linkage Coordinators stationed in Health Facilities by the IPS on index testing and patient chart reviews

Provision of scripts to OVC Linkage Coordinators for counseling mothers on index testing

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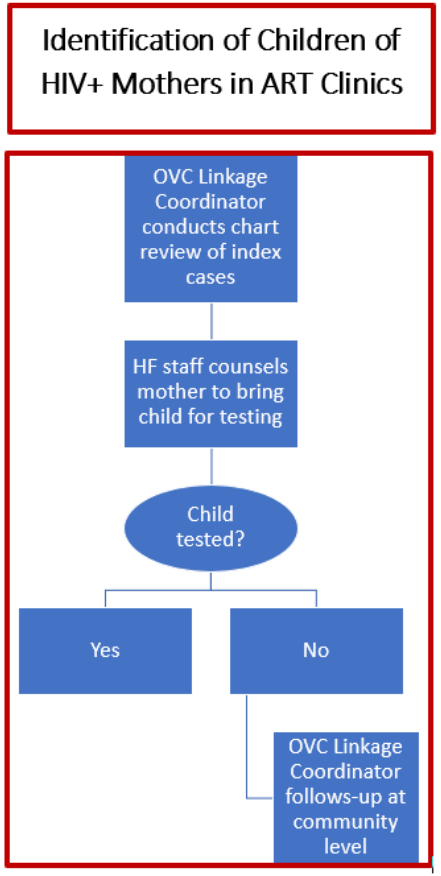
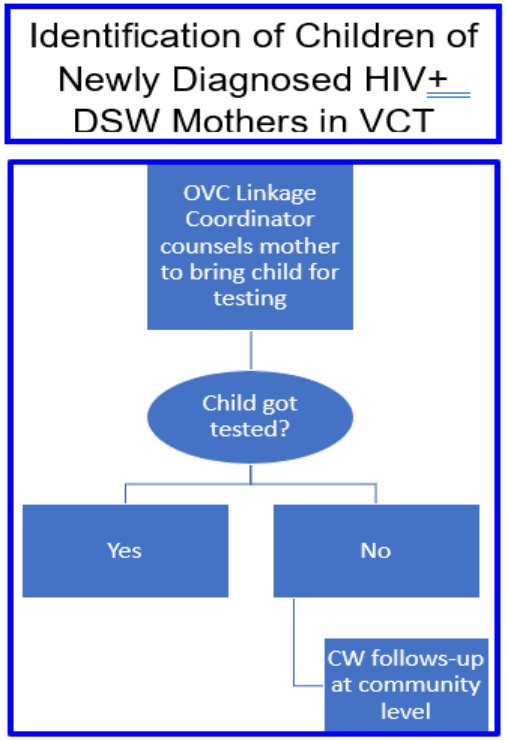
Child Case Finding Process





Working Together: Clear Roles and Responsibilities in Index Testing

Clinical Partners/Health Facilities

- Share information on index cases
- Test children referred by IPs and provide feedback on testing results, and treatment initiation for HIV positive clients
- Use existing platforms like MDT and catchment area meetings to coordinate index testing efforts with OVC Linkage Coordinators

OVC Program

- Work with health facilities to identify children eligible for index testing through chart reviews
- Conduct HIV risk assessment at community level for children of index HIV cases with unknown HIV status and refer for testing
- Follow-up on all referrals to ensure testing and linkage to ART (if HIV+)

Approaches to Ensure Index Testing

- Accompanied clients to HF (accompanied referrals)
- Provided allowance to facilitate transport to HF
- Facilitated weekend testing in HF for children attending school
- Facilitated home-based HIV self-testing (occasionally used with adolescents)

HIV Testing Results

Fig 1

OTA HIV Case Finding among Children and Adolescents <18 in Addis Ababa, August 2019-March 2020

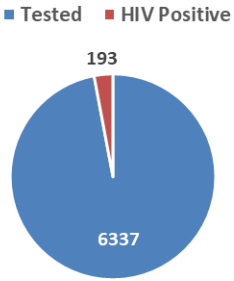


Fig 2

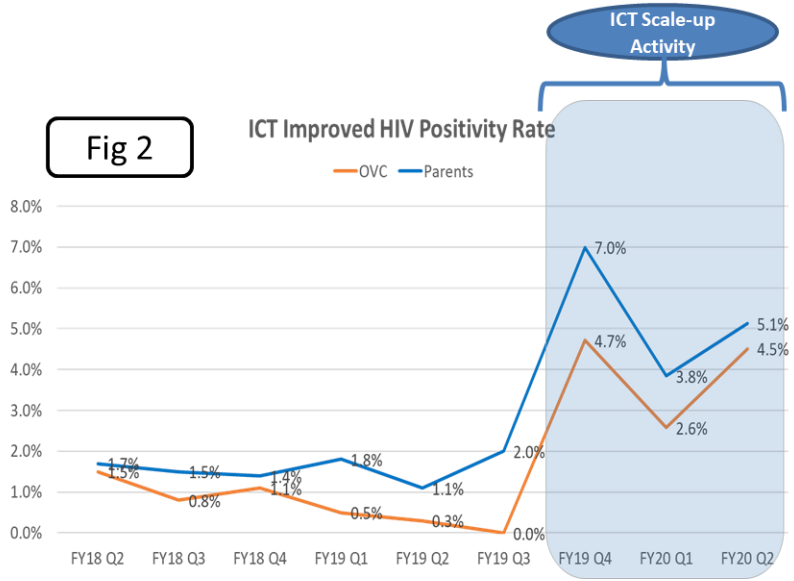


Fig 3

% share of Risk Factors for newly diagnosed HIV+ children/adolescents

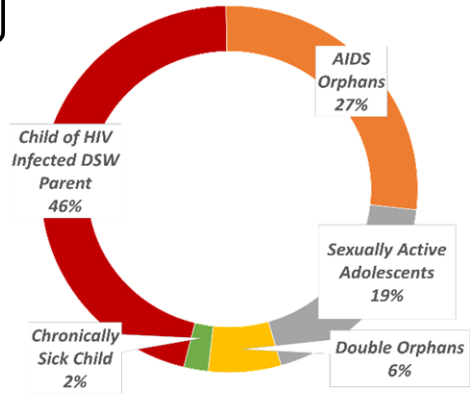
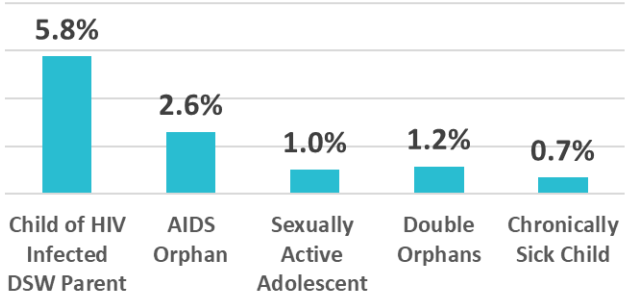


Fig 4

HIV Testing Positivity for Children and Adolescents by Risk Factor



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Challenges at Health Facility Level and Actions Taken by the OVC Program

- Lack of understanding of the role of the OVC program in supporting index testing among HF staff
  - Orientation and re-engagement during progress review meetings
- Chart reviews difficult due to HF staff workloads
  - Low work-load hours used for chart reviews
- Incorrect addresses in index patient records
  - HF staff updated addresses during routine visits of index clients
- Weekly progress review meetings often difficult due to HF staff workloads
  - Integrated performance review meetings with multidisciplinary team meetings

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Challenges at Community Level and Actions Taken by the OVC Program

- High turnover among community volunteers (case workers)
  - → Ongoing recruitment, training, and deployment
- Refusal by some parents to get their children tested
  - → Ongoing counseling

Key Lessons Learnt

The weekly progress review meetings contributed to the "one team" approach and to increase mutual accountability between the OVC program and HFs

Prioritizing children of newly diagnosed mothers, (those who haven't gone through PMTCT) is an effective case finding approach

Thank You!

For more information, please contact:

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Paediatric/OVC Index Testing in Kenya

CDC Kenya Paediatrics and Adolescent Treatment Program

CDC Kenya OVC Program

July 29, 2020

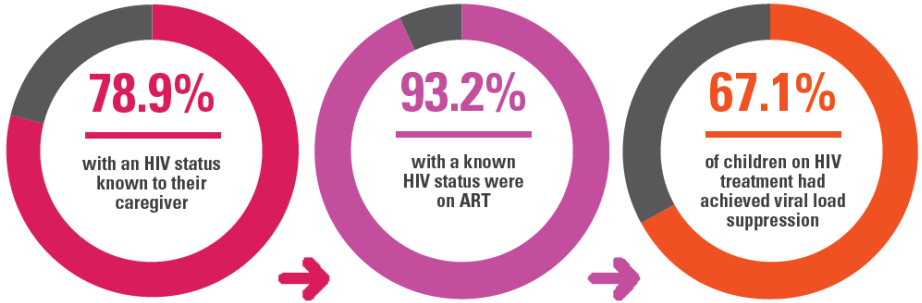
Background

- Estimated CLHIV – 139,000 (KENPHIA 2018)
- **Testing gap for children – 21%**
- Current on ART – 91,406 (66%)

COP 20 Target

- **Enroll at least 90% TX_CURR<18 years (in OVC SNUs) in the OVC program**
- Clinical and OVC supported by **different IPs** in most regions

Ages 0-14 years



Introduction

Modalities for identification of children
SAPR 20

Modality	No.POS	% contribution
Facility - Index	785	56.3%
Facility - Other PITC	442	31.7%
Facility - VCT	63	4.5%
Facility - TB Clinic	35	2.5%
Facility - Inpatient	26	1.9%
Facility - Pediatric	22	1.6%
Facility - PMTCT ANC1 Only	4	0.3%
Facility - Malnutrition	3	0.2%
Facility - PMTCT Post ANC1	2	0.1%
Facility - VMMC	1	0.1%
Community - Mobile	11	0.8%
Community - Index	1	0.1%
Total	**1395**	**100%**

Source - DATIM

Index testing contributed 56% of HIV pos children identified

- Index testing of children
  - Contributes more than half of HIV pos children
  - Index testing is **comprehensive** for all children including OVCs
  - Settings: community and **facility** settings
  - Use of existing tools, processes, SOPs and staff **Reduces provider confusion and documentation tools overload**
- OVC testing processes
  - OVC assessment form to check HIV status
  - Testing is **integrated** and conducted by HTS providers as part of overall HIV testing services
  - **Coordination** between OVC and clinical services partners already initiated
    - OVC referred/escorted to facilities for testing

Process of Paediatric Testing

Stepwise approach to index testing – OGAC guidance followed

Sources of index clients

- New positive biological parents especially mother
- Newly identified HIV positive sibling
- Biological parent or sibling already on Treatment – from CCC (green card – family table)
- **New positive from OVC** referred to facilities for testing

↓

Fill family table

↓

Use index testing tracking tool to ensure all family members are tested

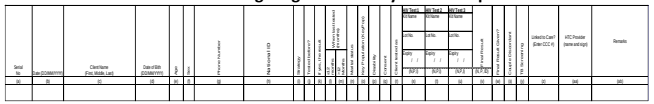
↓

Update client record (Family table) with testing results

Collaborate with OVC Programs to facilitate index testing for HIV positive index OVC clients and harmonize tools

TOOLS – data capture and source of patients

MoH 362 – HTS and linkage register – Newly identified positives

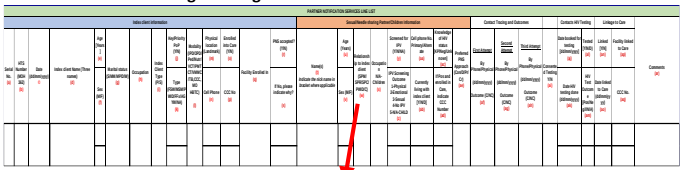


HEI register – Newly identified positives from PMTCT and HEI F/U

MoH 257 – Clinical encounter green card (Family table)

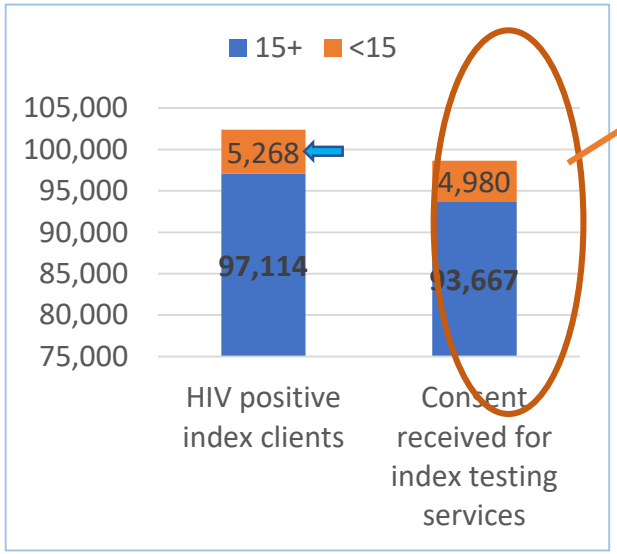
Family Testing	Relationship to Index client	Baseline HIV status	HIV testing date	CCC Referral
Name		Date	Results	CCC Number

Index testing tracking tool



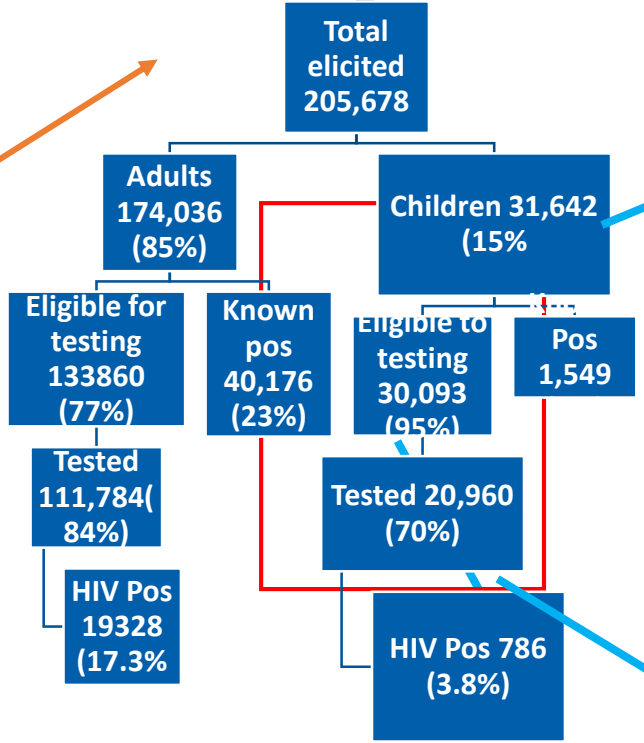
Relationship to index client (SPM/ SPR/SPC/ PWID/C) – C is child

Overall Index Testing for Children (OVC included)



Children constitute 5% of HIV pos index clients

Index testing cascade: Oct 2019 – March 2020_CDC



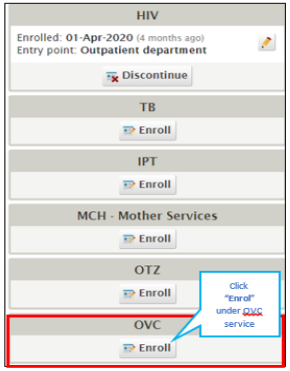
- Gaps in documentation of HIV Pos children enrolled in OVC at facilities
- Introduced OVC EMR module to facilitate identification of enrolled OVC
- Started documentation of OVC CPIMS No. in client records

- Opportunity in collaborating with OVC programs to address testing gap

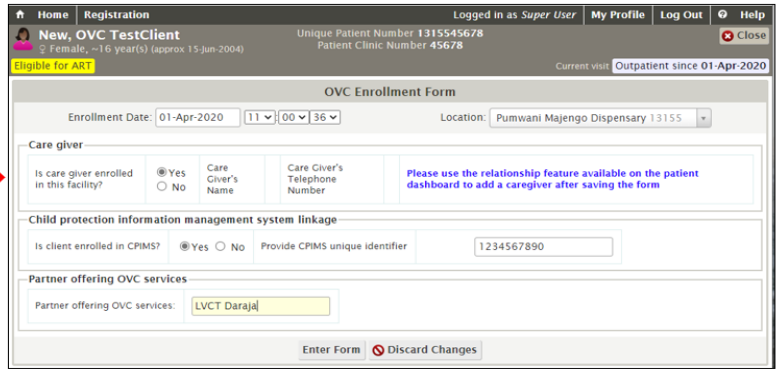
EMR Module: Client Enrolment into and Exit from OVC Service

1

Client Enrolment into OVC Service

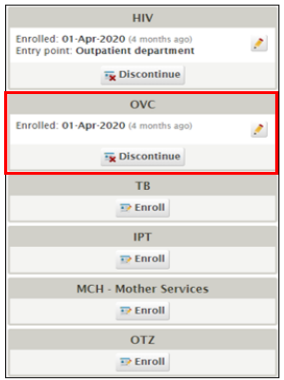


Capturing OVC enrolment details in KenyaEMR

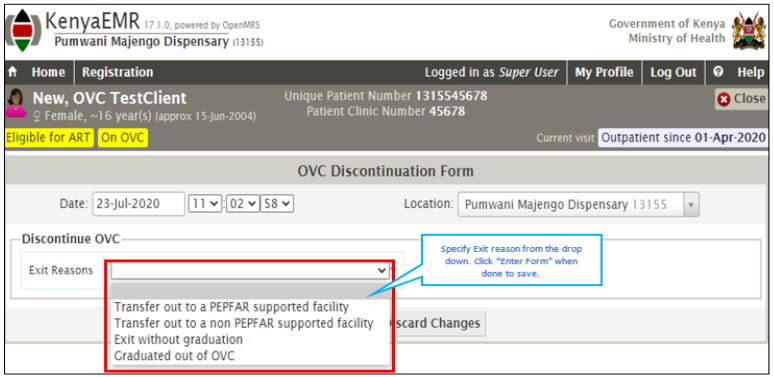


2

Client Discontinuation from OVC service



Capturing OVC discontinuation details in KenyaEMR



Registration of OVCs in KenyaEMR

- *Kenya's OVC program uses CPMIS to monitor OVCS & EMR for HIV treatment*
- *In KenyaEMR clinical teams can register OVCs in EMR using the CPMIS number and link them with their registered care-givers*
- *OVC registration in EMR is done at any time during HIV diagnosis or treatment*

Discontinuation from OVC program in EMR

- *KenyaEMR allows ART teams to discontinue a child from the OVC program*
- *The reason for discontinuation is recorded in the EMR*

HIV Testing and Linkage to Treatment in OVC settings

HIV Status of OVC Known. All HIV pos OVC are Linked to Care (PEPFAR/CDC funded OVC Programs: March 2020)

Implementing Partner	Total Number of Households	Total Number of Beneficiaries/OVC	Total OVC <18 years	Total OVC_HIVSTAT (Known HIV status)	Total HIV Positive OVC	Total CLHIV linked to care	Total caregiver with known HIV Status	Total HIV positive caregivers	Total HIV positive caregivers linked to care
Bomu	3,033	6,057	5,159	5,159	2,196	2,196	3,033	1,408	1,408
EGPAF Timiza	5,728	16,987	15,915	15,915	1,562	1,561	5,728	3,320	3,320
CHAK CHAP	2,465	6,430	5,950	5,941	781	781	2,150	2,012	2,012
Total	**11,226**	**29,474**	**27,024**	**27,024**	**4,539**	**4,538**	**10,911**	**6,740**	**6,740**

EGPAF Timiza OVC index-siblings mapping and HIV status as at March 2020

	CLHIV (index)	SIBLING HIV+	SIBLING HIV -VE	TOTAL SIBLINGS
GGHA	184	16	295	311
SOS	375	4	602	606
DEVLINK	102	26	372	398
TMT	439	92	282	374
OLPS	300	23	282	305
TOTAL	1400	161	1833	1994

Data Source – Implementing Partner Level Data, March 2020

- Data analysis at partner level is possible using existing tools
- Documentation of HIV status for all OVC is key
- Index sibling mapping to ensure index testing coverage

Challenges and Lessons Learnt

- **Working collaborations between clinical and OVC IPs is key including OVC index testing as part of overall paediatric HIV case identification**

- **Leverage on existing tools to reduce documentation overload**

Thank you!

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Questions?

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Q&A and Discussion

Moderated by Viva Thorsen, CDC and Jessica Tabler Mullis, Save the Children

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FAQs

Question	Answer
1) Will additional funding or resources be provided?	No. These activities should have been in place per COP20 guidance.
2) What is the timeline for the SOPs?	OVC SOP to be implemented by start of COP20/FY21 to support clinic index testing and enrollment of C/ALHIV in OVC. If feasible, obtain/submit baseline coverage during FY20 Q4 to inform COP20/FY21 implementation. Agencies may be in touch with specific requests for Q3.
3) What ages are included in the SOP?	All biological children and siblings **<19 y/o** of PLHIV on ART.
4) Do the SOPs have interagency, OGAC, and Chair support?	Yes. DoD, CDC, O/GAC, Peace Corps, and USAID are all coordinating implementation.
5) What if the SOPs conflict with my country's national policies (e.g. MOH guidance)?	Work with your Peds and OVC advisors to adapt the SOPs to your country context.

Discussion Questions

1. What challenges are your IPs facing in implementing index testing for children and adolescents?

2. What engagement has there been w/MoH?

3. Are clinical and OVC IPs working together to implement index testing for children and adolescents?

4. What solutions do your IPs have for increasing index testing? (e.g. strategies for increasing clinical and OVC collaboration)

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Contact Information

Thank you for your participation!

For questions related to this webinar, please contact Caroline Cooney (CooneyCA@state.gov), S/GAC OVC Policy Advisor

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