

Influencing and Monitoring PEPFAR COP23

Pediatric HIV: Diagnosis, Treatment and Care



International Community
of Women Living with HIV
Eastern Africa



Refresher: What is the Country Operational Plan?

The Country Operational Plan (COP) is an annual plan created jointly by USAID and CDC that outlines how the billions of dollars in HIV funding from the U.S. government will be spent.

What is in the COP?

- The goals and priorities for the country
- What strategies and interventions will be used by the IPs
- “Where” and “who” will be prioritised
- The targets
- A detailed budget

Activist Tips for COP23

- **Watch out!** The COP23 planning cycle will have major changes compared with COP22. We are concerned that some of these changes will dilute our ability to advocate and hold PEPFAR accountable to communities, including children with HIV (**[see PEPFAR Watch COP23 Introduction Webinar](#)**)
- **Visit the [resource portal at PEPFAR Watch](#) for webinar recordings and slides from our COP2023 training series, which started Jan 19 2023**
- Share the names of your country representatives so we can coordinate, info@pepfarwatch.org

Pediatrics and COP23

What we will cover today

- Linking HIV exposed infants (HEI) with point of care HIV diagnosis, and HIV positive children with quality, lifelong HIV treatment;
- Accelerating pediatric DTG roll out
- Strategies to combat chronically high rates of loss to follow up among HIV positive children as well as breastfeeding women with HIV indeterminate children;
- Access to family-friendly service delivery models for HIV positive children and their caregivers
- Securing viral load suppression and AHD treatment for HIV positive children

What we won't cover today

- HIV testing and retesting strategies for pregnant and breastfeeding women and finding missing children living with HIV ([join PEPFAR Watch HIV testing strategies webinar, Feb 6](#))
- PrEP access for pregnant and breastfeeding women, including AGYW ([PEPFAR Watch PrEP webinar](#))



Pediatrics: Service Quality

There has been inadequate investment in improving retention of HIV+ kids and caregivers; exacerbated by COVID-19. Key interventions must be universally adopted, at scale:

- CHWs who are HIV-positive mothers, paid a living wage, trained and supported (“mentor mother” approach); treating patients with dignity and respect; particularly women who are KPs and AGYW

- Treatment literacy!

- One-stop care provision for PBFW

- MMD for children and PBFW

- Continuum of prevention, PMTCT services must be strengthened

 - AGYW access to PrEP/ring, testing and retesting, self testing
 - stock outs of NVP prophylaxis, access to POC VL

Pediatrics Emergency

Programs are **STILL** failing children with HIV

- Only 52% of HIV positive kids on treatment vs. 76% of all adults and 85% of pregnant women (2019);
 - 66% of the HIV+ kids without treatment access are more than 5 years old
- Without treatment, about [50% of kids will die before their second birthday](#)
- Only 37% of HIV positive kids are virally suppressed, compared to 60% of adults
- About 160,000 new HIV infections per year and ~100,000 deaths per year (13.7% of deaths but children are only 4.7% of all HIV+ people)
 - Missed global 2020 goal of only 20,000 new perinatal infections
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- Only 60% of HIV-exposed infants are tested by two months of age
- Game changing treatment and diagnostics (POC EID, PrEP for HIV negative PBFW, pediatric DTG based combinations) are *still* out of reach, not at scale

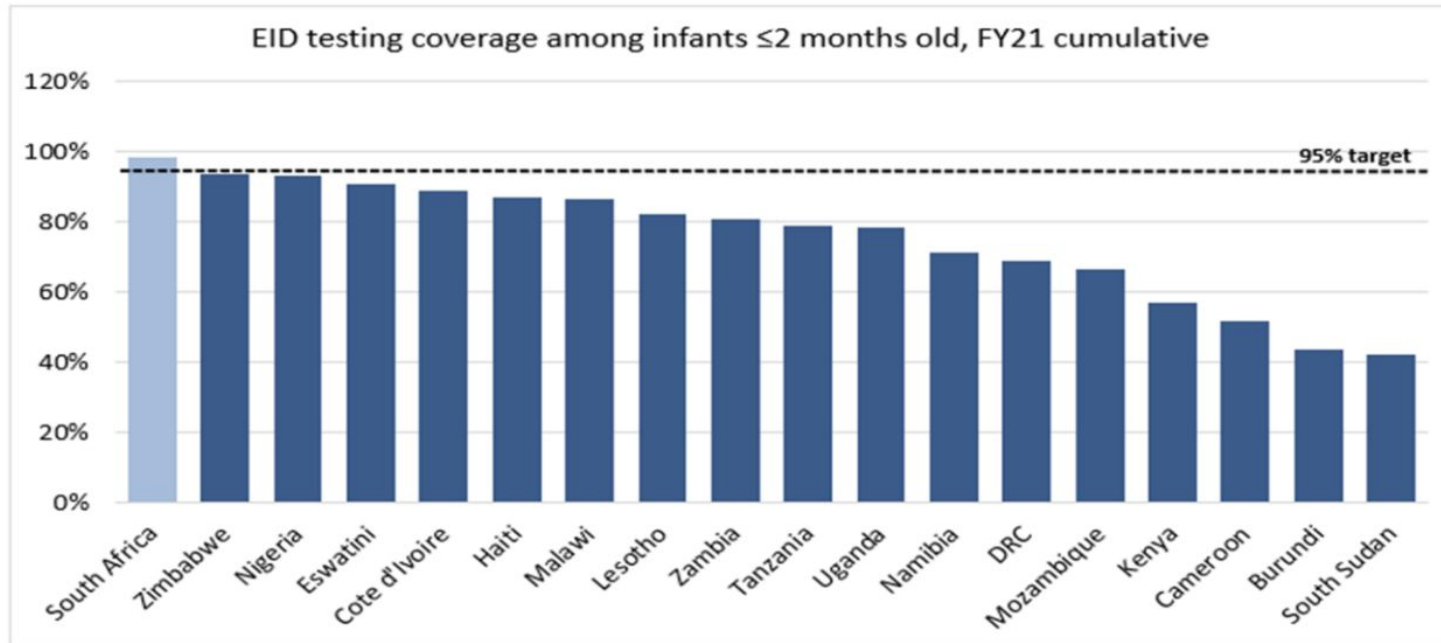
Pediatrics Emergency

Deadly inequities: continued

- Only 50% of HIV-exposed infants were tested within two months of birth and of those tested, only 15% had results returned to a caregiver within 30 days ([2018 assessment in 9 sub-Saharan African countries](#))
- Increasing treatment coverage for pregnant women but perinatal transmission persists: 49% of all new pediatric infections
- Adolescent and young women are 42% of all pregnant and breastfeeding women who acquired HIV but they are only 26% of all pregnant and breastfeeding women
- High rates of treatment interruptions among pregnant and breastfeeding women (PBFW) as well as high risk of acute HIV acquisition during PBF (PrEP access too low) and HEI testing barriers
 - 51% new pediatric infections are postpartum
- Quality, peer-led treatment and prevention services provided with dignity targeting PBF women of all ages—especially AGYW and sex workers—must be universally funded and available

Pediatrics Emergency

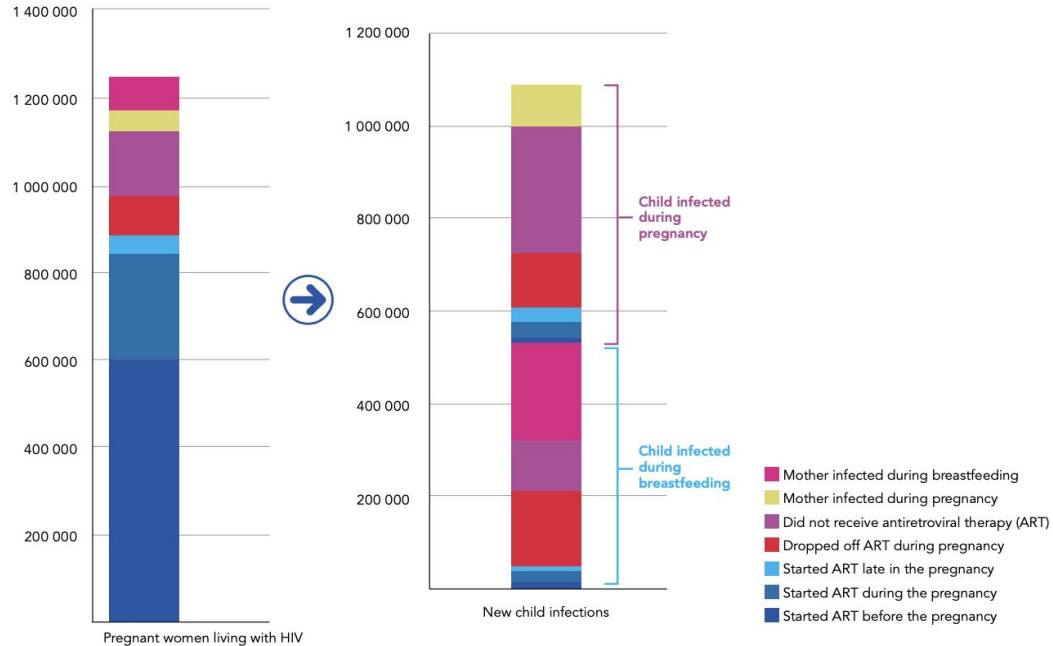
Almost all PEPFAR countries are still failing to reach kids with tests by 2 months of age (draft COP23 technical considerations, p 151)



HIV transmission happens throughout pregnancy and BF

Figure 4. New child infections can occur at any time during pregnancy and breastfeeding and for various reasons.

Number of pregnant women living with HIV and new child infections and the reason for transmission, 21 focus countries, 2019



Without prevention and treatment programs that are responsive to the needs of PBF women, especially AGYW and KPs, pediatric inequities will continue

see: [UNAIDS, Ending Inequalities](#), p. 56

2025 global goals for kids

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95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding

**75% OF ALL CHILDREN
LIVING WITH HIV HAVE
SUPPRESSED VIRAL LOADS
BY 2023 (INTERIM TARGET)**

Pediatrics: Lifesaving regimens

The good news: WHO treatment guidelines shifted—in COP21!

- New regimens for < 20kg infants: [10mg dispersible, taste-masked dolutegravir](#): \$120/year for regimen
 - “Transition all CLHIV onto a DTG-based regimen as quickly as possible” old [PEPFAR COP21 Guidance, p 340](#)
 - **Many country COP22 Planning Level Letters committed to DTG transition by September 2022.**
- **What about your country? Read PLL, to be released Feb 15**

Pediatrics

WHO 2021 Guidelines on first-line pediatric regimens



Chapter 4: ART for people living with HIV (continued)

4.6 What to start

4.6.1 First-line ART

Preferred regimen

1. DTG in combination with an NRTI backbone is recommended as the preferred first-line regimen for people living with HIV initiating ART.^a

- Adults and adolescents (*strong recommendation, moderate-certainty evidence*)
- Infants and children with approved DTG dosing^b (*conditional recommendation, low-certainty evidence*)

^aIn settings or populations in which DTG is not accessible or unsuitable because of toxicity and national levels of pretreatment HIV drug resistance are $\geq 10\%$, PI/r-based ARV drugs should be used in first-line ART. The choice of PI/r will depend on the programmatic characteristics. Alternatively, and if feasible, HIV drug resistance testing can be considered to guide the selection of first-line ART regimen (see Section 4.9 and Table 4.3).

^bAs of July 2021, the United States Food and Drug Administration and the European Medicines Agency have approved DTG for

The AP3 in COP23 - how do we use it?

- Expanding “Accelerating Progress in Pediatrics and PMTCT,”
 - AP3, started COP22
 - 7 countries (DRC, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia)
- “Just trying to do the same things we are doing now but ‘better’ won’t get us to our goal of ending pediatric AIDS by 2030” - p 580
- “To expand on COP22 groundwork, in COP/ROP23 we expect all OUs with a PMTCT/pediatric program to address these 6 elements in their approach to closing gaps for women and children—and for prior AP3 countries to expand upon the groundwork laid 598 in COP22” - p 587



The AP3 in COP23 - how do we use it?

- “PEPFAR data reveal that children under 5 years of age who are living with HIV experience 655 disproportionately high mortality compared to all other age groups. Even when children under 5 years old who are living with HIV are on ART, they still appear to have an increased risk of death compared to all other people living with HIV who are on ART (PEPFAR program data)”
- OUs address this by:
 - mortality surveillance systems and continuous quality improvement (CQI) death audits that include cause of death
 - Improving longitudinal monitoring of mother-baby pairs through individual level data simultaneously ensuring infants are clinically managed individually
 - Ensuring malnourished children, especially in the first 6 months of ART initiation, receive nutritional supplements
 - De-stigmatizing HIV in primary pediatric health care settings.
 - Ensuring advanced HIV disease (AHD) commodities, especially cotrimoxazole for all children living with AHD, are available and free of cost.
 - Improving TB screening, diagnosis, and treatment for children.
 - Providing intensive case-management services for all children living with HIV and their families who are newly initiating ART until viral suppression is achieved.”

The AP3 in COP23 - how do we use it?

“Adolescent girls and young women are also less likely to engage in antenatal care (ANC) for a variety of reasons, including the lack of adolescent-friendly clinical staff and services.

This represents missed opportunities to receive HIV combination prevention, treatment, or sexual and reproductive health services.

In addition, data show that adolescent and young mothers have lower ANC retention rates as well as delayed and reduced treatment adherence.”

Pediatrics: Treatment

10 mg DTG roll out: Priority Issues

- Push for countries to plan and budget now (using all available funding sources) for pediatric optimization transition costs
 - Community and professional health worker training, counseling
 - Viral load to switch regimens safely
 - Treatment literacy led by and for pregnant women and caregivers
 - Resources: EGPAF/UNITAID [Quantification and Budgeting Tool](#)
 - PEPFAR, WHO, Global Fund: “Committed to support national governments as they develop rapid transition plans from existing suboptimal HIV treatment to DTG-based treatment for infants and children” ([Joint Statement Dec 22 2020](#))

Pediatrics: Diagnosis

- **POC EID is a game changing technology for linking the youngest HIV exposed kids to testing and immediate treatment**

- **The good news: POC EID WHO recommendation, 2021**

Urgent need to scale up POC EID for infants

Rates of timely access by caregivers to EID results unacceptably low using conventional means .

Point-of-care nucleic acid testing should be used to diagnose HIV among infants and children younger than 18 months of age (*strong recommendation, high-certainty evidence*).

Rapid diagnostic tests for HIV serology can be used to assess HIV exposure among infants younger than four months

Clearly outline key recommendations & demands for pediatrics

- **What is the priority intervention?** Identify the area or intervention of concern (e.g. *Pediatric HIV treatment*,) – focus on a short, strategic list.
- **What is PEPFAR doing on this now?** Take a look at the 2020 COP for the current language on what they're doing. Dive into the Q3 and Q4 data — what does it tell us about progress, and why we need our interventions?
- **What should PEPFAR be doing on this in 2023?** What specific language should PEPFAR include in the COP? What should the target be? Be clear and specific! Do we know what budget is needed?