





### Goals and objectives of the technical brief

The specific objectives are twofold:

- To describe the current challenges to scaling-up HIV testing among children (<15 years)</li>
- 2. To provide a set of priority actions and contextspecific strategies to accelerate HIV case identification among children.

The goal of this technical brief is to address the first of the Global Alliance pillars through a focus on HIV case-finding to identify and treat undiagnosed CLHIV.

The aim is to provide strategic technical and implementation guidance to countries – especially those with substantial gaps in paediatric treatment, to improve paediatric HIV testing coverage with an expanded array of interventions that go beyond infant testing programmes.

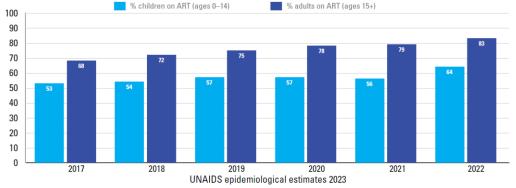


#### Why is this brief needed?

 Persistent inequities in treatment coverage for CLHIV

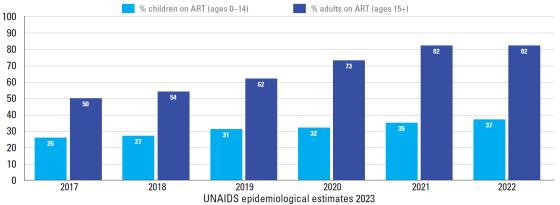
 Pediatric case finding is the gateway to effective care and treatment

FIGURE 1: Trends in treatment coverage among children and adults in Eastern and Southern African Countries\*



<sup>\*</sup> Countries https://www.unaids.org/en/regionscountries/easternandsouthernafrica

FIGURE 2: Trends in treatment coverage among children and adults in Western and Central African Countries\*



<sup>\*</sup> Countries: https://www.unaids.org/en/regionscountries/westandcentralafrica, 2022 estimates don't include data from Nigeria



#### Challenges to HIV testing and case finding among children (<15)

Disparities in progress towards HIV case finding between children and adults and between regions, with inadequate testing volumes to reach targets.

Globally, most new vertical HIV infections among children are diagnosed late (beyond 2 years of age).

Data on the status of prevention of vertical transmission and the paediatric HIV epidemic by age group is not well utilized to target the right case-finding strategies.

Stigma and misconceptions persist as a major driver of poor HIV testing uptake and there are gaps in systematic approaches to reduce structural barriers to testing access for children.

HIV testing for children has not received adequate resources to identify CLHIV not yet on treatment.



### **Action plan Framework**

FIGURE 4: Process and priorities to formulate an action plan to improve HIV testing and case finding in children

PLANNING FOR IMPROVED CASE-FINDING IN CHILDREN

- Convene national partners & funders
- Gather local data to inform gaps
- Examine priority actions to develop a contextualized plan of actions
- Case-finding approaches may differ by context, prevalence and geography
- Measure and track responses and feedback for quality improvement





### **10 Priority Actions**



Set targets for programme scale-up

1



Identify strategies to find & link adolescents living with and/ or at risk of HIV infection to integrated health services.

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2

Allocate adequate funding & resources for country plans



9

Improve data collection & use to inform HIV testing programmes



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Develop a catch-up strategy to identify undiagnosed CLHIV

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Launch community-led demand creation strategies and monitoring.

8

4

Develop a maintenance strategy for sustainability



Use epidemic context and data from programmes to define strategies

5



Address environmental determinants of health, stigma, discrimination, GBV, & barriers.



Expanded research for the use of assisted HIVST among children

3



### **Deeper dive: Priority Action 5**



- Infant Testing
- Testing in Well-child clinics
- Testing in Outpatient Sick-child or Acute Care settings
- Testing in inpatient, TB, and malnutrition wards
- Family index Testing
- Community-based models to expand access to HIV testing and case-finding for children under 15 years

FIGURE 5: Decision-making framework to guide the scale-up of paediatric HIV testing

- Provide provide-initiated testing and counseling (PITC) to all mothers presenting with children for immunization services, if the mother was not tested for HIV during ANC
- Maximize index testing services for all children <19 of PLHIV, including biological and nonbiological children living in the household (due to high HIV risk among orphans)
- Offer HIV testing to 100% of children presenting with TB or with severe acute malnutrition
- Target outpatient testing among children presenting with signs or symptoms of HIV, including opportunistic infections (e.g., signs/symptoms bf TB or TB contacts)

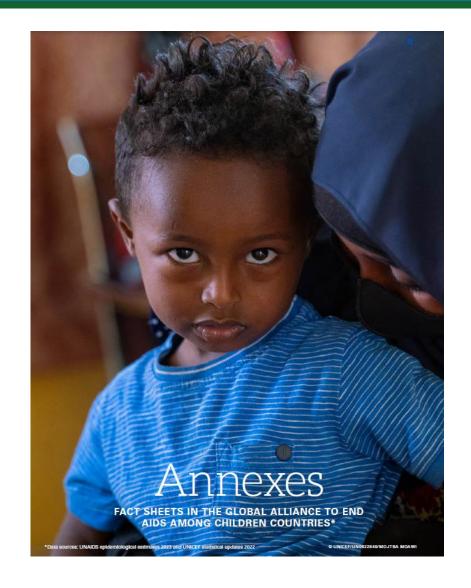
- Ensure a mix of HIV testing approaches (bulleted below) to maximize opportunities to engage with testing services
- Transition to risk screening in outpatient settings, once the 1st 95 is achieved, for all children with an unknown HIV status to screen-in children with an increased HIV risk
- Continue index testing services for all children <19 of PLHIV, including biological and nonbiological children living in the household (due to high HIV risk among orphans)
- Offer HIV testing to 100% of children presenting to inpatient wards, TB clinics (or signs/symptoms of TB or TB contacts), malnutrition (i.e., growth problems, short or light for age), STI clinics, or casualty wards or emergency departments
- Consider universal HIV testing for all mothers or children (e.g., 18 months) aligned with a routine wellness visit to decrease the age at diagnosis and <5 mortality rate</li>
- Integrate maternal HIV testing and immunization services to identify mothers not tested for HIV during pregnancy or delivery and those due for maternal retesting
- Maximize index testing services for all children <19 of PLHIV, including biological and nonbiological children living in the household (due to high HIV risk among orphans)
- Offer HIV testing to 100% of children presenting with TB or severe acute malnutrition
- Consider the use of a validated risk screening tool in outpatient settings to screen-in high-risk children for HIV testing (e.g., signs/symptoms of TB or TB contacts, growth problems, short or light for age, STIs, etc.)
- Expand operational research on caregiver or lay-staff assisted HIV self-testing (HIVST) among key populations to screen their children, to reach children living geographically distant from parents living with HIV (i.e., paediatric contacts of index clients), or for use by traditional birth attendants (TBAs) to screen mothers not receiving ANC services or testing

- Integrate maternal retesting and immunization services to identify and test mothers not tested for HIV during ANC and strengthen maternal retesting
- Continued outpatient testing for all children with an unknown HIV status until the 1st 95 is achieved for children.
- Maximize index testing services for all children <19 of PLHIV, including biological and nonbiological children living in the household (due to high HIV risk among orphans)
- Offer HIV testing to 100% of children presenting to inpatient wards, TB clinics (or signs/symptoms of TB or TB contacts), malnutrition (i.e., growth problems, short or light for age), STI clinics, or casualty wards or emergency departments
- Consider universal HIV testing for all mothers or children (e.g., 18 months) aligned with a routine wellness visit to decrease the age at diagnosis and <5 mortality rate
- Expand operational research on caregiver and/or lay-staff assisted HIVST among children, including children of KPs or those living geographically distant from parents with HIV

LOW HIV ADULT PREVALENCE (<1%)

HIGH ADULT HIV PREVALENCE (≥1%)

## **Country-specific Data Annexes**





### **Country-specific Data Visuals**



Figure 1: Estimated children living with HIV by age group, 2022

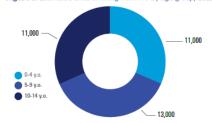


Figure 2a: FIRST 95: Estimated trends in knowledge of HIV status among adults and children, 2017-2022

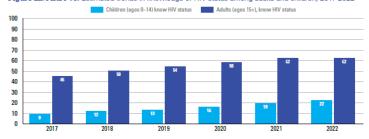


Figure 2b: SECOND 95: Estimated trends in linkage to treatment among adults and children, 2017-2022

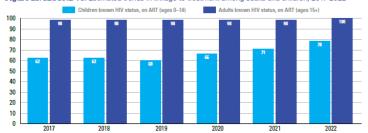


Figure 3: Estimated AIDS-related deaths among children by age group, 2022

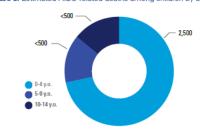


Figure 4: Trends in immunization coverage and opportunities for infant HIV testing on the MCH platform (2017-2021)

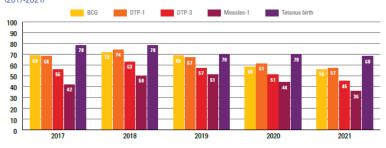


Figure 5: Trends in PMTCT and EID coverage (2017-2022)





# **Questions?**



