Launch of the Technical Brief on Paediatric HIV Case Finding: Beyond Infant Testing – Q&A

Caregiver-assisted HIVST

1. WHO's stance on assisted caregiver testing for children is that there is currently not enough evidence to make a recommendation for or against its use. More research would be needed to make a recommendation on that.
   Response: Priority action 6 in the brief highlights the need for expanded research on the use of assisted HIVST in children., including caregiver-assisted HIVST.
2. How do you plan to keep this document updated, are there any plans to revise this document in line with changing evidence and approaches?
   Response: At this time we have not developed a plan to keep the document updated as new guidelines and evidence is released. However, this is a good suggestion and will be discussed within a pediatric case finding sub-group of the Child Survival Working Group.
3. Should we take into consideration the prevalence of HIV in the countries where we want to roll out HIVST 0-14yrs?
   Response: The brief highlights considering prevalence of HIV and pediatric ART coverage for adapting all 10 priority actions to country-specific context. For the priority action on HIVST, as Jessica noted, there is evidence from high-prevalence countries (Uganda and Zambia) and low-prevalence countries (Nigeria and Ethiopia).
4. Can HIVST be used for children within 2 years?
   Response: HIVST kit is approved for different ages across manufacturers. In the US, OraQuick is approved for children down to 2 years of age and is the test with the most evidence to date for use in children. For children <2 years, virologic testing (EID) is recommended.
5. Is it used as a screening test or a diagnostic test?
   Response: A screening test.
6. At the facility level, we have had more than 100 non assisted self-tests that was done (among pediatric and adolescents 0-19) and the positivity rate was quite low. One of the major challenges that was glaring was the technical knowledge to carry out the test. I think much work has to be done on training before allowing non assisted self-test.
   Response: We agree that it is important to ensure appropriate technical knowledge of HIVST kits before use, and several countries have resources including videos, IEC materials, SOPs, and other supportive tools to ensure HCWs and caregivers have the capacity to complete the test. There is also literature that caregivers have high capacity for use of Oraquick test kits and interpretation of results. Each setting also needs to review the number needed to test (NNT) to find one positive, which varies across geographical regions even within a country, as well as across entry points. In certain settings, the NNT for children may be more than 100. It is important to monitor this type of data to build capacity of HCWs to understand the number of tests that may be required to find one positive screen in various settings.

Community-based approaches

1. I'm interested to know what community-based approaches are being recommended? I worked with UNAIDS to produce a Compendium of promising practices of faith communities re children and HIV in Africa and this included several effective interventions which improved case finding.
   https://www.unaids.org/en/resources/documents/2023/CompendiumPromisingPractices

Response: This can be used as an additional resource for countries as they identify county-specific plans based on their context.

2. What strategies can be used to engage the community LPs to optimize on HIV testing in under 15years children.
   Response: Community partners can be included in the planning process (see Figure 4 of the brief) to inform discussions on community case finding strategies.

EID

1. Dear panelists, Have we got a clear mapping of access to PCR testing as much as the time lag between DBS collection and communication of results in WCAR and finally initiation of ART? ESAR has benefitted of enormous investments to avail PCR for EID. What would be the cost in WCAR to reach similar PCR coverage as done in ESAR?
   Response: PCR mapping to support EID is beyond the scope of this technical brief. Questions on EID may be referred to the CSWG leads.
2. This is great feedback from Kenya, what other strategies have you employed in addressing the identification gap among HIV exposed infants? What criteria did you utilize to identify the children at risk for HIV transmission? and what criteria did you use to distribute HIV ST kits to children?
   - **Response:** This question was for a specific country presenter, and we encourage follow-up with the relevant panelist to answer more detailed questions on their strategies.
3. Since we know that early treatment is critical for better outcomes, what is the effort to do the post new-born testing as early as possible?
   Response: This technical brief focused on strategies for pediatric case finding beyond infant testing, which is an area that has been lagging in many countries. However, we also advocate for concurrent activities to support strengthening infant testing strategies through EID.
4. Is the recommendation of using PCR testing as EID below 18 months not by itself a limitation? Couldn't we bring this down, particularly in view of limited access to EID done by PCR?
   Response: The issue is one of biology. Certainly, you CAN use serologic tests in kids under 2, but the result may not be a reliable indication of HIV status in the child because: a. if the mother is breastfeeding the risk is ongoing so a negative Ab is not definitive
   b. because of transfer of maternal Ab across the placenta, a positive Ab may not be indicative of true HIV status. Once you get to 18 months of age, the risk of a false neg or a false pos is reduced.
5. One of the bottlenecks in diagnosing infants is the turnaround time for PCR - how does the brief address increased access to real POC testing where results are provided on the same day to the parents?
   Response: This brief focused on case finding beyond infant testing, so EID POC is not addressed. There are other resources, that discuss EID and infant testing strategies, including POC testing.

Health Systems

2. Human resources capacity appears to be a major impediment to effective HIV testing uptake among children at facility level, particularly at outpatient departments. How has this issue been addressed in the brief?

Response: Priority action 2 focuses on Allocating adequate funding and resources for country plans, and includes discussion of human resource allocation.

3. Are your unique identifiers at only identification or throughout the care journey? Is it facility specific or across the program and one is able to identify the PLHIV irrespective of which region or Health facility they are found?
    - **Response**: This question was for a specific country presenter, and we encourage follow-up with the relevant panelist to answer more detailed questions on their strategies.
4.

Risk screening tools

1. Anything to update us regarding the pediatric risk screening tool use at OPDs and Inpatient level universal testing?
   Response: The current recommendation is universal testing at inpatient and OPD. However, we know that volume at entry points such as OPD that resources may not support universal testing. Approaches to screen children presenting to OPD to systematically identify children at higher risk for having undiagnosed HIV is one strategy to overcome resource constraints in OPD entry points. As inpatient volume is usually much smaller, in general resources are often available to support implementation of universal testing. It is important to understand current coverage of testing at both of these entry points to determine any adjustments needed to optimize testing in children.

CLHIV estimates and surveys

1. What's the guidance on population based impact assessment surveys to have more accurate estimate of undiagnosed children instead of statistical models?
   Response: Because of the lower HIV prevalence in children, the resources needed to include children may be prohibitive in many countries. There are currently ongoing discussions to identify other approaches to inform inputs into the child SPECTRUM model, as well as efforts to validate the outputs of the model, that are less resource intensive than PHIA surveys for children.

Country experience

1. CDC project in Ethiopia we implemented pediatric acceleration plan /PHPI tremendous improvement case finding but need consider this approach?
   Response: Priority action 3 in the brief recommends developing a catch-up strategy to identify undiagnosed CLHIV, and the Pediatric Acceleration Plan in Ethiopia is a great example of this. It would be great in future forums to be able to share this experience and lessons learned more widely.

Age-specific strategies

1. Does the technical brief stratify case finding strategies by age band - for example are there specific strategies for 10-14 year old versus young children?
   Response: Priority action 10 does discuss specific considerations for 10-14 year olds. The brief also encourages use of data on estimates and coverage by 5-year age band to adapt testing

strategies to make sure you are reaching the age bands with the largest gaps, including 10-14 year olds.

2. I was thinking of the 4-8 yrs age range and possibly involving the educational network/infrastructure as a point of contact.
   Response: UNAIDS estimates and other data sources utilize 5-year age bands, 0-4, 5-9, and 10-14, so we often frame our strategies using these age bands. We recognize that many 5-9 and 10-14 year olds attend school, and there may be opportunities to collaborate with Ministry of Education to identify strategies appropriate for that country's context, including HIV prevalence and other considerations.

<u>10 Priority Actions</u>

1. What do you think could be the game changers in the proposed actions of the brief?
   Response: The brief recommends a combination of strategies that could be adapted to each country's context. The strategies are a combination of addressing barriers to optimal implementation of evidence-based strategies that we know work but are not well implemented, as well as innovation to reach children and families to overcome persistent barriers.

<u>Case Study</u>

Response to all questions: To protect the privacy of the patient and family, we are unable to provide any additional information about the child at this time.

1. Can we have any previous history of the child. Any prior admissions, blood transfusions or any invasive procedures done on the child before? What might be the source of the infection to this child?
2. Good afternoon, the Ugandan couple reported that their 9-year-old child was infected with HIV while the parents were seronegative. Is it possible to know how this child contracted HIV? Under what circumstances?
3. This is great feedback from Kenya, what other strategies have you employed in addressing the identification gap among HIV exposed infants? What criteria did you utilize to identify the children at risk for HIV transmission? and what criteria did you use to distribute HIV ST kits to children?
4. What can be the possible exposure to the child? especially a 9 year old?
   a. The possible exposure of this child still unclear as the child was delivered in the hospital, was circumcised from the hospital.
5. Curious to know whether they lived with their son or he lived elsewhere? Also any other family members at that time with health illnesses.
   a. By the time of diagnosis the child was in boarding school. No other family members had similar illness. He is the only member of the family who is positive with HIV.
6. Good afternoon, the Ugandan couple testifies that their 9-year-old child was infected with HIV while the parents were sero-negative. Is it possible to find out how this child contracted HIV? Under what circumstances?
   a. We don't know the details but maybe it was due to a transfusion or a traditional procedure. In my country (Kenya) it's very common to cut the uvula, for example.

- Bon apres midi, le couple ougandais temoigne que leur enfant de 9 ans etait infectes au VIH alors que les parents etaient sero negatifs, est il possible de savoir comment cet enfant a contracte le VIH? Quelles circonstances?
- Shaffiq Essajee: Felicite, merci pour la question. nous ne savons pas les details malhereseuemnt mais peut etre c'etait a cause d'un transfusion ou bien un procedure traditionel. Dans mon pais (kenya) c'est tres comun de couper le uvula par exemple

Resources

1. Can you share the country profile for Paed care & gaps in Uganda?
   Response: The annex at the end of the brief has dashboards for all the Global Alliance countries including Uganda https://www.childrenandaids.org/paediatric-case-finding-technical-brief