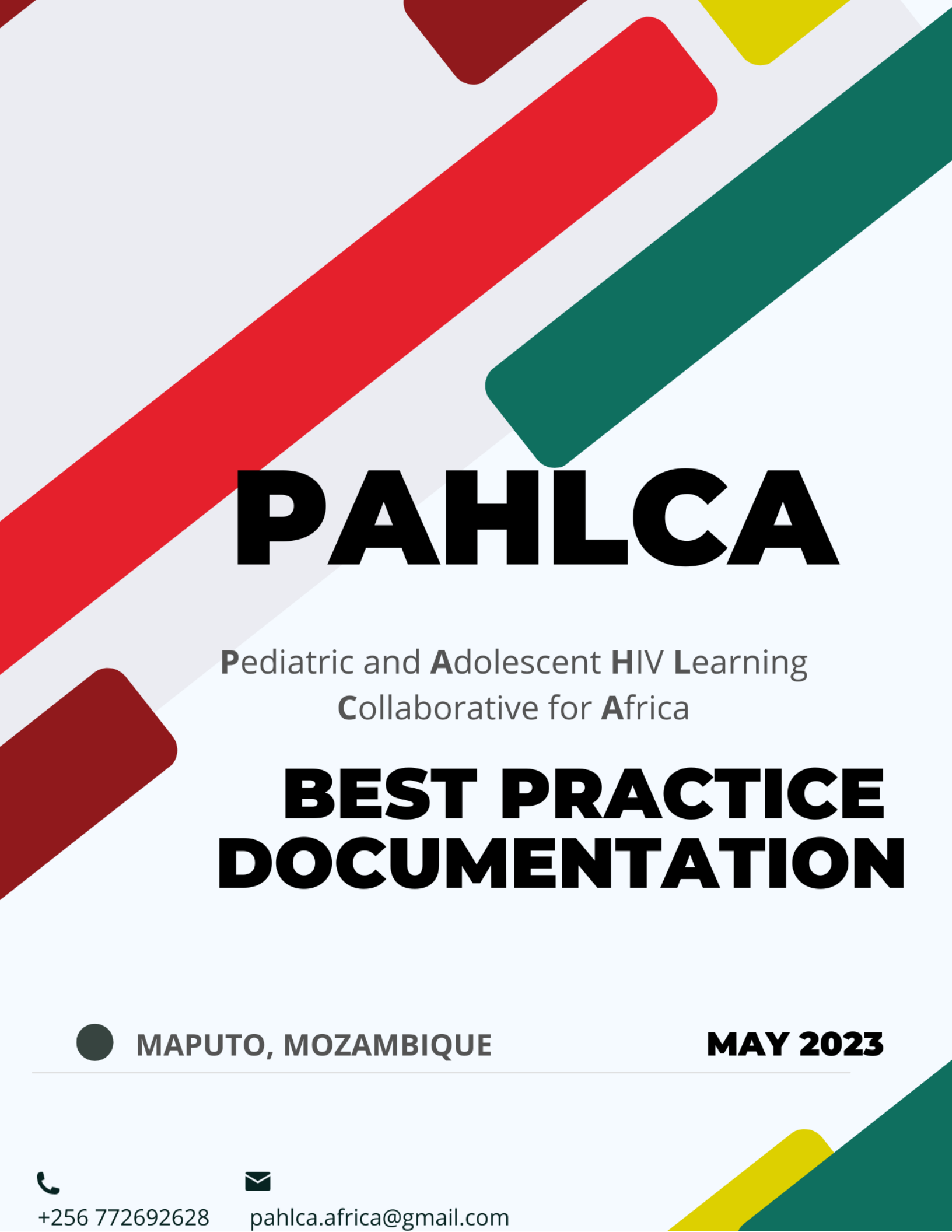




PAHLCA

Pediatric and Adolescent HIV Learning
Collaborative for Africa

BEST PRACTICE DOCUMENTATION

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MAY 2023



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May 2023

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Best Practice Documentation

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Title: Botswana's path to elimination of mother-to-child transmission of HIV and eMTCT lessons

Rationale:

- In 2012, HIV prevalence was 18.5% in Botswana, and general barriers to pediatric HIV care and treatment historically included a lack of infrastructure, lack and loss of human capacity at facilities, prohibitive expenses for healthcare, and the complexity and changing nature of pediatric regimens.
- In recognition that in high HIV burden countries, such as Botswana, the case rate is high due to high prevalence of HIV among women of childbearing age, Botswana sought to address opportunities to reduce incident infection via an effective PMTCT program, focusing on adolescent and young women, and optimizing treatment and new opportunities for prevention.
- Across the globe, reasons for new infant infections include from mothers who are newly infected with HIV during pregnancy and breastfeeding, mothers living with HIV who did not receive treatment during pregnancy or breastfeeding, mothers initiated on treatment but not retained on treatment/in care during pregnancy or breastfeeding, and mothers on treatment but not virally suppressed. The distribution of these reasons varies by country and context.

Methods/Implementation:

- To reduce the mother to child transmission rate, Botswana introduced and strengthened the PMTCT program in country focused on several key strategies:
 - o Routine HIV testing via rapid HIV tests to identify HIV infections and seroconversions via:
 - HIV testing at ANC registration
 - HIV retesting every three months during pregnancy, with catch-up testing in labor and delivery for those tested > 4 weeks previously
 - HIV retesting at 6-8 weeks postpartum, and then every 3 months for breastfeeding women
 - Note: Testing, treatment and formula provided free of charge; testing was 'opt out' with counselling for those who opted out.
 - o Scaling infant HIV testing via:
 - DNA PCR testing at 4-6 weeks
 - Immediate ART referrals for any positive tests, ahead of receiving confirmatory result
 - Retesting all previously negative babies at 6 weeks after cessation of breastfeeding
 - Ensuring a final diagnosis at 18-24 months of age
 - o Supporting infant feeding in the context of HIV, including:
 - Encouraging and supporting breastfeeding among mothers living with HIV with a VL <400 c/mL
 - Support safe replacement feeding (provided free formula for first 12 months at all public facilities) for those who cannot breastfeed
 - o Provide ongoing care and support via:

- Providing universal access to treatment for all, including task shifting to enable easy access to treatment at nearly all facilities
 - Integrating with other services to improve access
 - Linkage of all children to treatment as soon as they are identified
- Globally, potential solutions to address the drivers of new infant infections include:
 - o Preventing HIV infections among pregnant and breastfeeding women, via counseling, PrEP, HIV self-test kits for partners.
 - o HIV testing for women and girls of reproductive age and starting the ones living with HIV on treatment before pregnancy via integration of HIV services at SRH and other entry points.
 - o Ensuring continuity of treatment for pregnant and breastfeeding women, or 'keeping women in care' by reducing those drop out of care, utilizing peer support and long-acting treatment.
 - o Supporting treatment optimization for pregnant and breastfeeding women living with HIV via DTG-containing regimens to maintain viral suppression.

Results:

- In December 2021, Botswana achieved validation and certification for achieving the WHO silver tier status on the path toward elimination of mother-to-child transmission of HIV. This meant that Botswana had achieved an HIV prevalence in ANC of <9%, an HIV MTCT rate of <5.0, and an HIV case rate of <450 per 100,000 live births.
- Implementation barriers in Botswana throughout the validation process included:
 - o The decision to validate vs. conduct a self-assessment
 - o Use of hybrid paper-based and electronic systems leading to data quality issues; multiple electronic medical records systems not communicating with each other
 - o Uncertainty in inclusion of syphilis into the validation process
 - o Data quality concerns, including data discrepancies (between program, Spectrum, and GAM data)
 - o Lack of certainty/clarity of the process – needing to learn more from countries who achieved this goal
 - o Limited funding and technical support
- Lessons learned and best practices from Botswana's validation included:
 - o Establishing a representational National Validation Committee (NVC), with a comprehensive skills mix (including civil society) early on for buy-in
 - o Outsourcing the coordination and core support
 - o Routine consultations to keep leadership informed
 - o Champions to maintain momentum
 - o Staying flexible, willingness to accept findings
 - o Conducting a preassessment is key to gauge country readiness
 - o Regular technical support and guidance, along with financial support is critical
- Last Mile EMTCT frameworks include 4 connected steps: 1) a consultative process, 2) taking stock of progress and remaining gaps 3) planning and prioritizing, and 4) implementing and evaluating.
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Conclusions and Key Takeaways:

- Botswana is the first high HIV burden country to achieve the WHO silver tier validation status on the path to eliminating mother-to-child transmission, demonstrating the possibility for other countries in the region.
- Moving forward, efforts will need to be sustained to make further progress and a shift to adolescent and young women, in addition to key populations. Additionally, ensuring the most optimal treatments are adopted and available, and that new initiatives can be implemented (e.g., new opportunities for PrEP, such as CAB-LA, or long-acting ARVs) will be key.
- HIV prevalence is an important gateway to achieving elimination because it doesn't change easily.
- Key considerations for programs include identifying the main gaps, understanding the problem(s), identifying possible solutions, prioritizing interventions to address, and the need to develop a plan to prevent pediatric HIV from becoming a neglected disease with potential to reverse gains and skills over the past decade.

Title: SRH-HIV Integration for Adolescents

Rationale:

- In Malawi, 2/3 of the population is <25 years and 43% of girls begin childbearing by the age of 18. Further, HIV/AIDS is the leading cause of death among girls and boys aged 10-19 years.
- Globally, SRH for adolescent girls and young women (AGYW) is a key lever to successful PMTCT programs.
 - o In Malawi, implementation gaps are due to stigma in seeking SRH services, poor ART adherence among AGYW, limited HCW capacity to provide SRH services, socioeconomic challenges, lack of coordinated efforts in the delivery of SRH services for AGYW, and geographic challenges.

Methods/Implementation:

- To address SRH and HIV gaps for AGYW in Malawi, the Ministry of Health operationalized multiple key strategies and interventions including:
 - o Constructing health posts for integrated HIV/SRH and mother-infant-pair packages
 - o Training and recruiting necessary human resources including community midwife assistants, psychosocial workers, teen mother clubs, and peer providers
 - o Capacity building for healthcare workers at facility
 - o Provision of direct service delivery of HIV testing and counselling, ART, and ANC
 - o Advocacy for HIV testing, family planning, and other health services for pregnant women and adolescent girls
 - o Providing economic empowerment opportunities through linkages and referrals (e.g., social cash transfer to OVCs)

- Systems strengthening through facility service delivery and referral systems – including decentralizing services to the community
 - Provision of youth friendly health services
- The INGUSSA Project in Mozambique aimed to improve adolescent SRH services through health system strengthening. This was via a client-centered approach to quality SRH care and by mobilizing adolescents and youth at school and in communities. Specific key interventions included:
 - Mobile adolescent-friendly SRH clinic
 - Integrating SRH components within school by training teachers and students
 - Facilitating peer and community-leader led community dialogues
 - Evidence generation of effective approaches to address adolescent SRH needs

Results:

- In Malawi, the highest volume of ANC attendance was seen in 2022. HIV status ascertainment was high at just below 98%, and there was a steep decline in HIV prevalence at 5.4% compared to 8.8% in 2012. Further, viral load suppression among AGYW was 88% and 85% among adolescent boys. ART coverage among children 0-14 years was 68.5% and the MTCT rate dropped to 7.8%, while 35,142 new infant infections were averted between 2020 and 2023, and early infant diagnosis reached 87% (above the 85% target).
- Facilitating factors for the intervention in Malawi included good collaboration and partnership to deliver SRH services to AGYW, contributing to reduced MTCT. Integration of HIV and SRH was key to sustainability of both services, and strong monitoring contributes to cocreation of interventions.
- In Mozambique, the adolescent friendly mobile SRH clinics reached 53,000 adolescents and provided HIV testing to 15,000 adolescents; there was a significant increase in utilization of adolescent SRH services by males 10-19 years ($p=0.01$) and females 10-19 years ($p=0.31$), along with positive trends in STI screening among these males ($p=0.009$) and females ($p=0.34$).

Conclusions and Key Takeaways:

- In Malawi, key facilitators to successful implementation included taking a multisectoral, evidence-based, and collaborative/consultative approach, in addition to engaging community and peers, and implementing task shifting.
- Moving forward, Malawi recommends focus on children and older young women who are undiagnosed, implementing interventions to reduce ART drop-off for AGYW and pregnant or breastfeeding women, further strengthening of HIV-SRH integration, coordination with AGYW on interventions, and investing in demand creation for SRH services among AGYW.
- In Mozambique, the mobile adolescent friendly clinics reached adolescents in their communities that would not otherwise access adolescent-friendly services at health facilities. It was a well-accepted form of service provision. Further, SRH education is highly demanded by students and teachers. Involving community leaders is crucial to mobilizing adolescents' access to SRH care.
 - Mobile adolescent-friendly clinics should be considered a differentiated service delivery model, and can help to engage both adolescent girls and boys in HIV and STI screening and linkage to care or prevention.

Additional Key Considerations:

- Have clear guidelines on service integration like in the case of AGYW program
- Have a robust health workforce that has capacity to offer SRH-HIV services
- Engage multisectoral stakeholders to facilitate service delivery at all angles

Title: EID program success in Eswatini

Rationale:

- Implementation gaps in the PMTCT/EID program in Eswatini included late initial ANC booking, poor follow-up and retention of mother-baby pairs (~30% of infants miss final EID test), suboptimal EID coverage, late ART initiation for infants, and inconsistent stock for EID commodities.
- To address these challenges, Eswatini implemented birth testing (0-3 days) via point-of-care (POC) EID, with catch-up testing for infants who missed this test between 4 days - <6 weeks. This was coupled with strong follow-up for mother-baby pairs to strengthen complete EID (6-8 weeks, 9 months, 12 months, and 18-24 months).

Methods/Implementation:

- Birth testing for all HIV-exposed infants (HEI) was implemented via POC machines in 11 public delivery sites to ensure short turnaround time for results and rapid ART initiation
 - o The national EID algorithm was reviewed to include birth testing as the first virological EID test
 - o Midwives in maternity and postpartum were capacitated to provide birth testing
 - o Any HEI that missed their birth test (e.g., born outside of facility) was tested on their first facility encounter during PNC
- Mother-baby pair (MBP) follow-up was implemented to ensure mother and infant receive services together at 6 weeks, 9 months, 12 months, and 18 months
 - o Mentor mothers capacitated at facility to follow-up and support women at facilities
 - o Community mentor mothers provided psychosocial support and proactive follow-up to pregnant women living with HIV
 - o Community-service organizations provided follow up for MBPs for EID

Results:

- POC currently comprised 50% of all EID tests in country
- Birth testing coverage was 90%, with 95% results received; EID coverage at 6-8 weeks is 96%; EID final outcome coverage was 90% in 2022
- MTCT rate at 6-8 weeks dropped to <1%
- MTCT during the breastfeeding period dropped to 50% of all cases
- Enabling factors included a strong peer-to-peer model

Conclusions and Key Takeaways:

- Recommendations for further improvements for this program include:

- o Strengthening supply chain issues for Conventional and POC EID commodities.
- o Provide PrEP using opt out approach for HIV-negative pregnant and breastfeeding persons.
- o Strengthen VL monitoring schedule for pregnant and breastfeeding women, including introducing POC VL for this population.
- o Provide routine mentorship for HCWs to ensure mother-baby pairing and continue to strengthen for final EID test.
- o Collaborate more broadly to fill gaps not covered by these strategies.
- With extra support, programming would include:
 - o Expanding POC EID through multiplexing on existing GeneXpert platforms
 - o Utilize trained non-laboratory HCWs to operate POC and near-POC platforms to expand access
 - o Implementing the HIV/syphilis dual testing and hepatitis B testing
 - o Implement POC VL testing for pregnant and lactating women on ART
 - o Implementing cohort tracking and testing
 - o Facilitating cross-country learnings

Additional Key Considerations:

- o Strong MoH commitment for eMTCT - demonstrated through establishment of TWG, development of an eMTCT strategy, structured and functional PMTCT program
- o Efficient supply chain management of EID commodities to mitigate stock ruptures
- o Enrollment of all HIV-negative pregnant and breastfeeding women on PrEP to avoid maternal seroconversion
- o Same-day initiation of identified HIV positive pregnant and breastfeeding women
- o Routine VL monitoring for pregnant and breastfeeding women on ART with timing aligned to maternal visits during ANC and PNC
- o Conduct regular MTCT audits to identify maternal factors associated with MTCT for HIV
- o Sustainable funding commitment for strategy implementation from domestic and external sources
- o Implementation of community mentor-mother initiative to follow-up the mother-baby-pair and ensure adherence to scheduled ANC and PNC visits including EID.
- o Development of a standardized eMTCT training curriculum
- o Consider task-sharing for EID to expand access
- o Introducing birth testing and improving EID coverage through expanding POC and near-POC testing
- o Development of robust a PMTCT reporting framework to ensure consistent monitoring and evaluation of PMTCT indicators