HIV TESTING AMONG CHILDREN AND ADOLESCENTS

KPA CONFERENCE
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OUTLINE

- Background information.
- Principles of testing.
- Testing algorithm.
- HIV prevention in children
- Linkage to care.
UNAIDs facts on HIV in children

- 1.8 million [1.5 million–2.0 million] children were living with HIV
- 150 000 [110 000–190 000] children became newly infected with HIV
- 110 000 [84 000–130 000] children died of AIDS-related illnesses, 400 children became newly infected with HIV every day, 290 children died of AIDS-related illnesses every day
- 49% [42–55%] of children living with HIV accessed antiretroviral therapy Children (<15 years)
- ½ Of children living with HIV will die before their second birthday if they don’t have access to antiretroviral therapy

UNAIDS- Fact sheet July 2016
HIV prevalence among children aged 18 months to 14 years was 0.9% in 2012.

- Among children of HIV-infected parents, only 45.4% had ever been tested for HIV.
- Eighty-nine percent of children aged 10-14 years had heard of HIV. However, only 17.4% had correct knowledge about HIV prevention and treatment.
- Seven in 100 children aged 12-14 years had ever had sex. Of those, 22.8% had used a condom at first sex.
- Among all children aged 0-17 years, 14.4% were orphans or vulnerable children (OVC). Both parents had died among 10.8% of OVC, one parent had died among 60.4% of OVC, and 28.9% of OVC were vulnerable children.

Source KAIS 2012, Pg 235
New HIV infections in children aged 0-14 years old.

Number of new infections globally (thousands)

- 2 million HIV infections in children were prevented between 2000 and 2017.
- To reach UNAIDS targets, we need to reduce annual new infections to 20,000 by 2020.

Access to Treatment (90–90–90 Targets)

90% of those who are HIV positive identified

90% of those identified are on ART

90% of those on ART are virally suppressed

Total 1,121,938 [75%] PLHIV on ART

86,323 [84%] Children on ART

322,104 [62%] Male on ART

713,511 [83%] Female on ART

Increase in retention rates:
90% Overall Retention Rates at 12 Months

90% Overall Viral Load Suppression Rates

86,323 [84%] Children on ART

322,104 [62%] Male on ART

713,511 [83%] Female on ART

93% among Children

89% among Male

91% among Female

79% Overall Viral Load Suppression Rates

97% Viral Load Testing Coverage

A Kenya free of HIV Infections, Stigma and AIDS related deaths
## HIV Burden, 2018

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td># of PLHIV (all ages)</td>
<td>1,493,400</td>
</tr>
<tr>
<td>Adults (15+)</td>
<td>1,388,200 (F=864,600 M=523,600)</td>
</tr>
<tr>
<td>Children (0-14)</td>
<td>105,200</td>
</tr>
<tr>
<td>Adolescents (10-19)</td>
<td>105,200</td>
</tr>
<tr>
<td>Young Adults (15-24)</td>
<td>184,700</td>
</tr>
<tr>
<td>Prevalence (15-49)</td>
<td>4.9% (F=6.2% ; M=3.5%)</td>
</tr>
</tbody>
</table>

- Prevalence remains **higher** among women at 6.2% compared to men at 3.5%.
- Women account for **62%** of all adults (15+) PLHIV.
- **Children (<15) account for 6%** of all PLHIV.
- Adolescents (10-19) accounts for **7%** of all PLHIV.
- Young adults (15-24) accounts for **12%** of all PLHIV.
## Annual new HIV Infections, 2018

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td># of new HIV infections (all ages)</td>
<td>52,800</td>
</tr>
<tr>
<td>Adults (15+)</td>
<td>44,800</td>
</tr>
<tr>
<td>Children (0-14)</td>
<td>8,000</td>
</tr>
<tr>
<td>Adolescents (10-19)</td>
<td>8,200</td>
</tr>
<tr>
<td>Young Adults (15-24)</td>
<td>17,700</td>
</tr>
<tr>
<td>Incidence rate</td>
<td>0.19%</td>
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</table>

- The estimates depicts a **gradually declining incidence** in the country.
- Adults (15+) account for **85%** of all new infections.
- *Adolescents (10-19) accounts for **16%** of all new infections.
- *About **2 in every 5** adults new HIV infections occurred among youth 15-24 years (40%).

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Global Records AIDS

**A Kenya free of HIV Infections, Stigma and AIDS related deaths**
Principles and settings for HTS

- HIV testing should be voluntary and conducted ethically in an environment where there is assured:
  - Consent
  - Confidentiality
  - Counselling
  - Correct results
  - Connection (linkage)

- To optimize access to testing services, HIV testing can be conducted in 3 different settings:
  - Facility-based
  - Community-based
  - Self-testing :For adolescents
# HIV consent requirements

<table>
<thead>
<tr>
<th>AGE</th>
<th>CONSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;7 YRS</td>
<td>Parent to consent</td>
</tr>
<tr>
<td>7-15 YRS</td>
<td>Parent consent and child assent</td>
</tr>
<tr>
<td>&gt;15</td>
<td>Consent from client</td>
</tr>
</tbody>
</table>
Package of HIV Testing Services

A HIV testing and counselling session consists of

- A pre-test session
- HIV test
- A post-test session

Note: Referral and linkage to other appropriate health services All PLHIV now qualify for ART irrespective of WHO Clinical Stage CD4 count, age, gender, pregnancy status, co-infection status
HIV Testing Services Algorithm

SCREENING

NON REACTIVE

- REPORT NEGATIVE

REACTIVE

- CONFIRMATORY TEST

  NON REACTIVE

  INCONCLUSIVE

  REFER TO THE COMPREHENSIVE CARE CLINIC

  SCREENING TEST

  NON REACTIVE

  REPORT NEGATIVE

  Collect DBS and send to laboratory for DNA PCR

  Report Inconclusive

  Report Positive

  Enroll to care and treatment

  Inconclusive

  Request for retest after 2 weeks at CCC

NB: The use of TIE BREAKER is no longer recommended
Approved HIVST kits for use in Kenya

Oraquick HIV Self-Test
(Oral fluid based)

Insti HIV Self-Test
(Blood based)
Evidence for HIVST in Kenya

HIVST has been studied extensively in Kenya, over 25 studies have been completed between 2006-2017 among:

- Adolescent females 15-24
- FSWs
- MSMs
- General population
- PLHIVs
- Discordant couples on PrEP
- PrEP users
- ANC and PNC mothers; their partners
- Truck drivers
- Healthcare workers

Summary of Findings

- HIVST is acceptable and feasible among various groups
- Testers are capable of using both blood and oral self-test kits
- HIVST kit distribution to partners of ANC & PNC mothers and FSWs is an effective way of promoting testing and for negotiating safer sex
- There are minimal cases of IPV as a result of HIVST kit use or distribution to partners
- There is willingness to pay for HIV self-tests

For detailed information on all the studies done please visit www.hivst.org
WHY- HIV testing and counselling for infants and children?

- Early identification of HIV for prompt management
- Identification of HIV-exposed infants for follow-up and care
- Testing of Orphan and Vulnerable Children/family testing
Who requires HIV testing among children?

- Infants, children and adolescents should be tested in the following circumstances:
  - At first contact as possible for infants known to be exposed to HIV
  - A child who is ill e.g. presenting with an HIV-associated illness such as TB or malnutrition
  - Orphans e.g. parents have died as a result of AIDS or other undiagnosed debilitating illness.
  - Sick children who present with HIV related signs and symptoms
  - In cases where a child has been exposed or potentially exposed to HIV – through sexual abuse /rape cases.
  - As precondition prior to initiation of post-exposure prophylaxis (PEP) and Pre-exposure prophylaxis (PREP).
Where should testing take place?

- Maternal health services: In PMTCT setting.
- Child health services: Immunization and malnutrition clinics, inpatient units and special clinics.
- Adult treatment and testing services: infants and children of HIV positive adults.
- Home-based testing initiatives: targeting whole families
- Programs for vulnerable children.
- Private clinics / children seeking services from pediatricians and other specialists.

NB: Avoid all missed opportunities for testing in all these settings.
Linkage To Care and Treatment

HTS providers should adopt the 6 approaches which are known to improve linkage to Treatment and prevention:

- Information
- Disclosure
- Address barriers to linkage
- Establishing systems to facilitate linkage
- Care coordination and integration
- Documentation (using linkage registers)

NB: The HTS provider has the responsibility to link HIV positive clients from testing points to enrolment into HIV care.
HTS link services for children

- HIV exposed infant linked to PMTCT services so that early diagnosis can be made and follow up made
- Infected infants and children should be linked to care and treatment services
- Vulnerable child’s situation may have put them at high risk of HIV infection, such as from sexual abuse, hence need medical, psychological and legal support.
- Children presenting within 72 hours of an alleged sexual assault/rape should be offered post exposure prophylaxis (PEP), and national medico-legal policies and procedures should be followed.
Refusal of testing for a young child

- Parents or caregivers may feel that they have their child’s best interest in mind when refusing an HIV test, but this refusal may mean the child is unable to access life-saving interventions.

- Providers need to understand both what is in the best interests of the child and when it is their duty to provide testing for children. Caregivers may need to be supported in making the decision to test their children.

- If a parent refuses to consent HIV testing for his/her child, referral to and follow up at a center experienced in child HIV management may be required.

Children's rights= Right to life, Right to health, right to access health services
What the law says about reporting offences against children

- Section 110(2) says that any person who believes on reasonable grounds that a child is in need of care and protection may report the matter to the provincial Department of Social Development, a designated child protection organization or a police official.
- Additionally, currently, section 54(1)(a) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 says that any person who has knowledge that a sexual offence has been committed against a child must report this to a police official immediately.
HIV prevention among children

Every day more than 650 children become infected with HIV

- Steps to stopping new HIV infections among children
  - Strengthen PMTCT interventions-If a woman is living with HIV, the virus can pass to her baby during pregnancy, labor, birth or when breastfeeding. But if she has access to antiretroviral therapy, the risk of transmission drops to less than 5%.
  - Universal ART to all infected children and adolescents
  - HIV education in schools, community emphasizing prevention.
  - Voluntary Medical Male Circumcision
Early testing, diagnosis and treatment in HIV infected infants and young children reduces their morbidity and mortality

Antibody testing may not be diagnostic for children under the age of 18 months. Virological testing for this age group is recommended

Age-appropriate algorithms should be available at all testing centers, supported by well-defined standard

Testing young children is more straight forward than many healthcare workers imagine; Healthcare providers should not hesitate to initiate child HIV testing and counselling

Policy and guidelines may need to be revised to, clarify age-appropriate consent and disclosure procedures, and to account for the special circumstances of children without parents or guardians
References

Global Records AIDS Monitoring: Kenya 2018 report
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UNAIDS- Fact sheet July 2016
Universal Declaration of Human Rights
NASCOP, HIV setting Guidelines 2016
NASCOP, self testing guidelines
WHO Policy Requirements for HIV Testing and Counselling of Infants and Young Children in Health Facilities
World Bank, UNICEF analysis of UNAIDs 2017 data
Appreciations

MOH
NASCOP
CDC
CHS
Thank you!

Centre for Health Solutions – Kenya

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