

Catalysing Paediatric HIV Early Diagnosis and Treatment within West and Central Africa Country Catch-up Plans:

Report of the meeting at ICASA 2017 and Agenda for Action



“We need to act with more urgency to increase access to HIV testing and treatment for all children in our region. We now have better tools to make a difference. It is up to us all – governments, civil society, and technical and financial partners – to step up the pace,”
– Marie-Pierre Poirier, UNICEF Regional Director, West and Central Africa



Attending the high-level panel at the session (from left to right): Dr. Gottfried Hirnschall, WHO Director for HIV/AIDS and Global Hepatitis; Marie-Pierre Poirier, UNICEF Regional Director, West and Central Africa; Djibril Diallo, UNAIDS Regional Director, West and Central Africa; Michel Sidibé, UNAIDS Executive Director.

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Acknowledgements



Marie-Pierre Poirier, UNICEF Regional Director, West and Central Africa, making a keynote presentation at the opening of the 19th ICASA, Abidjan, Côte d'Ivoire.

UNICEF and UNAIDS jointly organized a consultation meeting with stakeholders in the West and Central Africa Catch-up Plan as an affiliated event at the 19th International Conference on HIV/AIDS and STIs in Africa (ICASA), in Abidjan, Côte d'Ivoire, on 4 December 2017. The session was co-chaired by Marie-Pierre Poirier, UNICEF Regional Director, West and Central Africa, and Djibril Diallo, UNAIDS Regional Director, West and Central Africa.

A technical task team supported the design and organization of this meeting. Members of the team included Landry Tsague (UNICEF Regional Office for West and Central Africa, Dakar), Shaffiq Essajee (UNICEF Headquarters, New York), Chewe Luo (UNICEF Headquarters, New York), Catherine Bilger (UNAIDS Secretariat, Geneva), Aliou Assani (UNAIDS Regional Support Team, West and Central Africa, Dakar), Dorothy Mbori-Ngacha (UNICEF, Nigeria), Eleanie Nyankesha (UNICEF, Regional Office for West and Central Africa, Dakar) and Amandine Bollinger (UNICEF, Regional Office for West and Central Africa, Dakar).

The co-chairs would like to thank all presenters, speakers and participants for their contributions at the meeting. Special thanks go to the government representatives, civil society representatives, implementing partners and donors who provided valuable insights during panel discussions at the meeting.

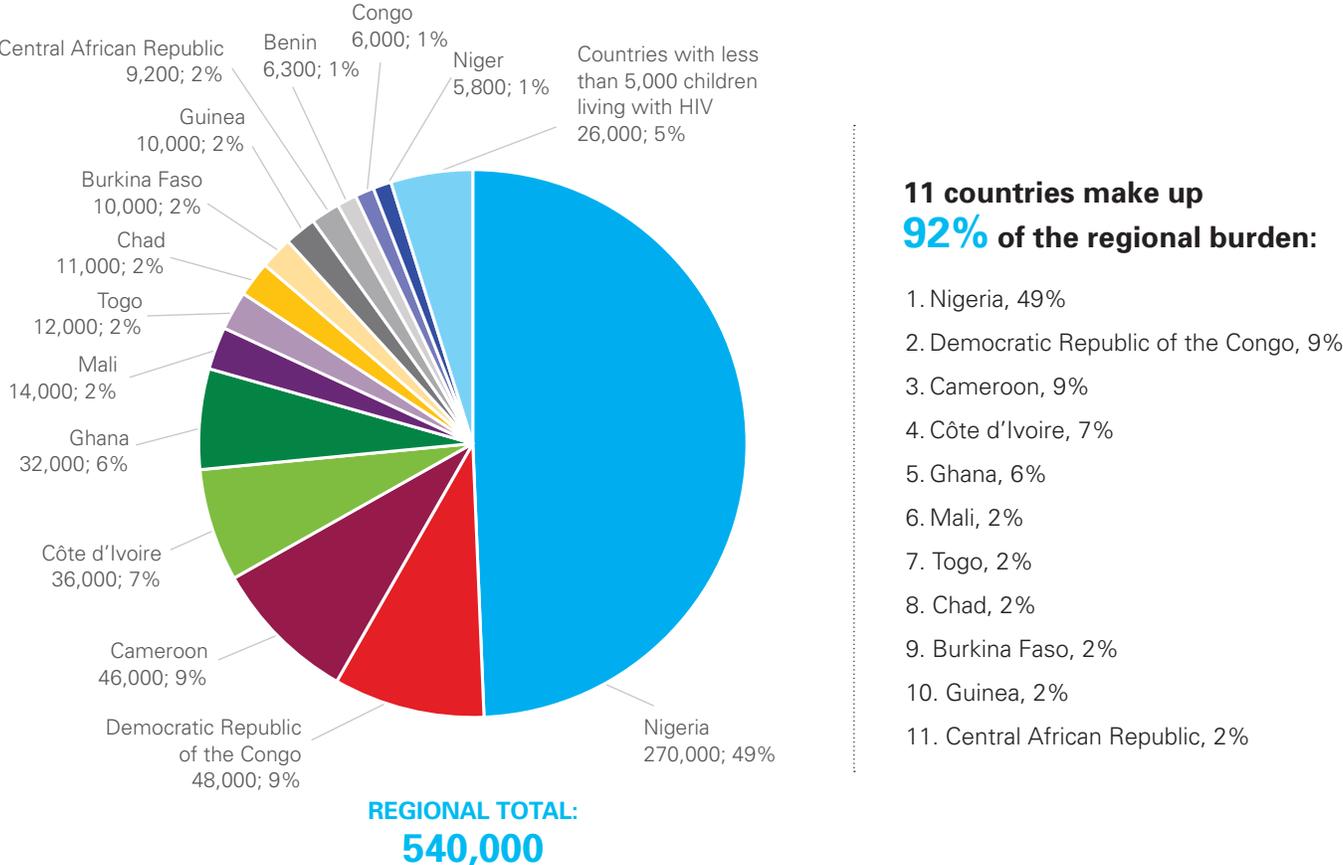
This report was prepared by Landry Tsague with support from Shaffiq Essajee and Catherine Bilger and review by members of the technical task team. Meeting notes were taken by Eleanie Nyankesha and Amandine Bollinger.

The current situation

More than four decades into the HIV epidemic, four in five children living with HIV in West and Central Africa are still not receiving life-saving antiretroviral therapy (ART) – most of them because they have not yet been tested for HIV. The coverage of ART among children living with HIV in this region is the lowest in the world. Many countries have limited capacity to conduct the tests needed for early infant diagnosis (EID) of HIV.

The 24 countries that make up the West and Central Africa region are home to 25 per cent of children aged 0–14 years living with HIV worldwide (Figure 1); this is region with the second-highest burden of children living with HIV. Of the 540,000 children living with HIV in the region, only 108,000 received ART in 2016.

FIGURE 1 Estimated number and percentage of children aged 0–14 living with HIV, West and Central Africa, 2016



11 countries make up 92% of the regional burden:

1. Nigeria, 49%
2. Democratic Republic of the Congo, 9%
3. Cameroon, 9%
4. Côte d'Ivoire, 7%
5. Ghana, 6%
6. Mali, 2%
7. Togo, 2%
8. Chad, 2%
9. Burkina Faso, 2%
10. Guinea, 2%
11. Central African Republic, 2%

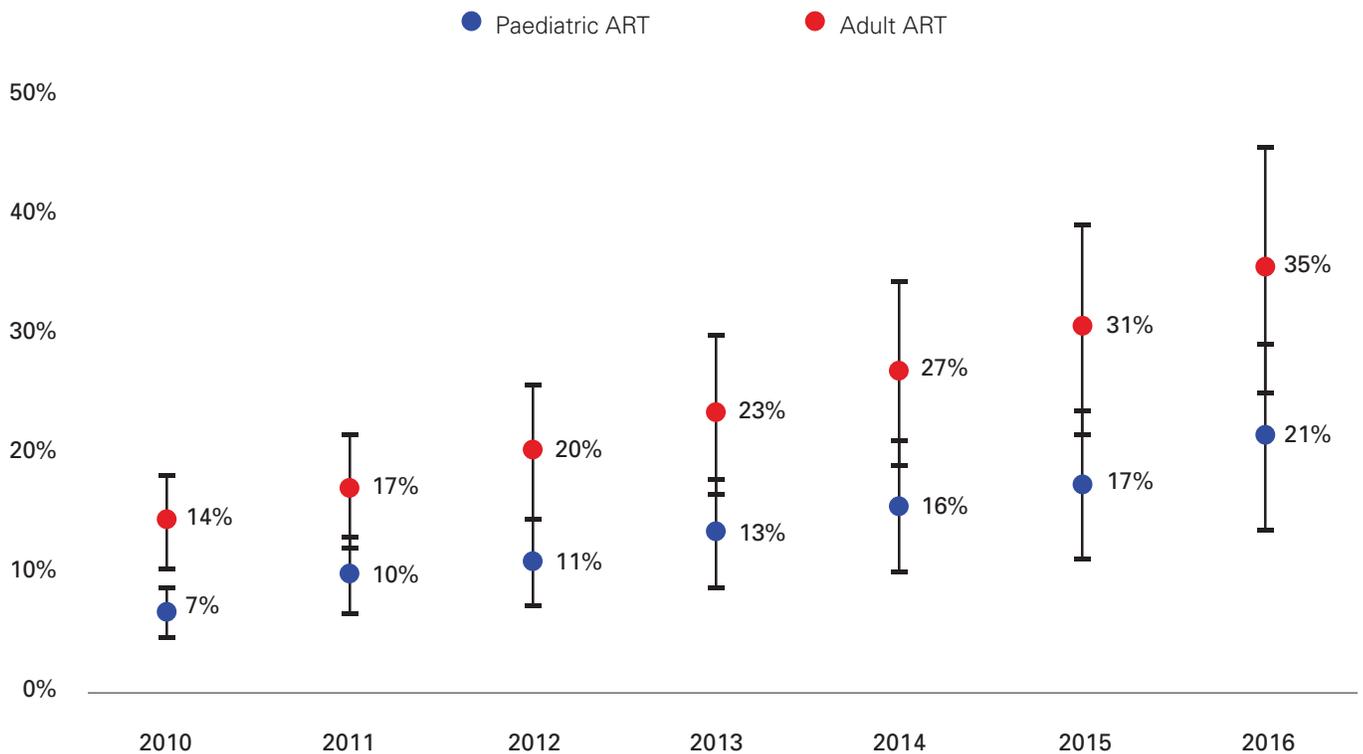
Note: Data for Sao Tome and Principe are not available.
Source: UNICEF analysis of UNAIDS 2017 estimates.

There is an urgent need to close these gaps:

- **The paediatric HIV treatment gap:** In West and Central Africa, there has not been enough progress in increasing access to ART for children (aged 0–14 years) – and the treatment gap between ART for children and ART for adults is increasing.¹ In 2016, ART coverage was 35 per cent in adults and 49 per cent in pregnant women, while in children it was 21 per cent (Figure 2).
- **The testing gap:** In West and Central Africa, nearly four out of five children aged 0–14 who are living with HIV are not accessing life-saving ART, most of them because they have not been diagnosed – even though their parents may be receiving treatment.

The ‘AIDS Free’ component of the UNAIDS Start Free Stay Free AIDS Free Framework calls on countries to accelerate action and increase treatment coverage towards the 2018 global target of reaching 1.6 million children aged 0–14 with ART. In West and Central Africa, this would translate to 400,000 children aged 0–14 receiving treatment by 2018, close to four times the current number of children receiving treatment. It is essential to capitalize on this global advocacy and urgently address the persisting inequity in access to HIV diagnosis and treatment for children in West and Central Africa.

FIGURE 2 Percentage of adults (aged 15+) and children (aged 0–14) living with HIV receiving ART, West and Central Africa, 2000–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

The Catch-up Plan for West and Central Africa: Closing the HIV treatment gap

During the 29th African Union Summit in July 2017, leaders of the African Union renewed their political commitment to combating HIV and AIDS by endorsing two landmark initiatives: The community health workers' initiative that aims to recruit, train and deploy 2 million community health workers across Africa by 2020; and a West and Central Africa Catch-up Plan to rapidly accelerate access to HIV treatment and close the gap between this region and other regions of the world.

The West and Central Africa Catch-up Plan provides a framework for political advocacy and accelerated action for countries to adapt and scale up effective approaches and innovations that will reduce inequity in access to HIV treatment. One notable goal of the Catch-up Plan is to increase the number of people on ART in the region from 1.8 million in 2015 to 2.9 million by 2018, thus initiating an additional 1.1 million people on treatment, with at least 120,000 of them children. The number of children on ART in West and Central Africa would have to double, from 108,000 in 2016 to a total of 228,000 by 2018.

Twelve countries – Benin, Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Liberia, Mali, Nigeria, Senegal and Sierra Leone² – have adapted this regional initiative to their national contexts and developed country catch-up plans, with the support of the World Health Organization (WHO), UNAIDS and UNICEF. These plans seek to address the persisting bottlenecks that hold children behind.

A recent analysis by UNICEF of 8 of the 12 country catch-up plans found that elements related to paediatric HIV testing and ART remained insufficiently articulated, and children were not sufficiently prioritized, compared with adults. Paediatric targets were not ambitious enough, and the approaches and interventions described were suboptimal.³

Meeting overview

At the 19th International Conference on AIDS and STIs in Africa (ICASA), country representatives and partners took part in a meeting convened by UNICEF and UNAIDS to reflect on the shortfalls within West and Central Africa country catch-up plans and to agree on ways to sharpen acceleration strategies and interventions that will increase access to paediatric ART. ICASA was held in Abidjan, Côte d'Ivoire, in December 2017.

The meeting at ICASA had three high-level strategic objectives:

1. Call greater attention to the gap in paediatric HIV testing, including EID, and paediatric treatment within the West and Central African country catch-up plans
2. Define the priority actions for children in country catch-up plans in 2018, with a focus on: (a) expanding access to paediatric HIV testing through improved EID and rapid testing at other entry points; (b) improving immediate linkages to care and treatment; and (c) task-shifting to enable nurses within maternal, neonatal and child health facilities to treat children
3. Galvanize partnerships in support of country catch-up plans.

Delegates from 12 WCA countries attended the meeting: Benin, Burkina Faso, Cameroon, Central Africa Republic, Cote d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Guinea, Liberia, Nigeria, Senegal, Mali. Key partners at the meeting included:

- United Nations agencies – UNAIDS, UNICEF and WHO
- Donors and foundations – The Global Fund, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and UNITAID
- Global and regional implementing partners – the Clinton Health Access Initiative (CHAI), the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Enfants et VIH en Afrique (EVA), Expertise France, the International Center for AIDS Care and Treatment Programs (ICAP), Solidarité Thérapeutique et Initiatives pour le Santé (Solthis) and Pediatric-Adolescent Treatment Africa (PATA)
- Civil society organizations and the faith-based community – Caritas, Coalition PLUS, International Community of Women Living with HIV (ICW), the International Treatment Preparedness Coalition (ITPC) and Réseau Accès aux Médicaments Essentiels (RAME).

The meeting was co-chaired by Marie-Pierre Poirier, UNICEF Regional Director for West and Central Africa, and Dr. Djibril Diallo, UNAIDS Regional Director for West and Central Africa.

Speakers at the meeting presented on a range of topics:

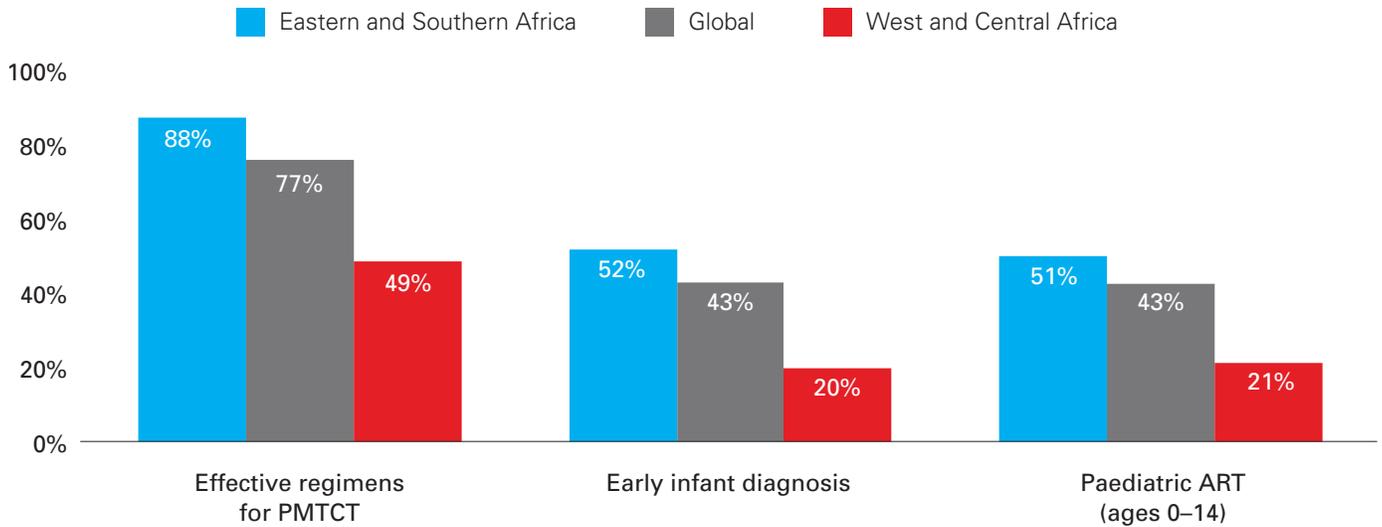
- Current coverage for effective antiretrovirals (ARVs) for the prevention of mother-to-child transmission (PMTCT), EID and paediatric ART in West and Central Africa
- Regional momentum around scaling up paediatric ART, and specific deficiencies within country catch-up plans
- Key challenges for an effective response
- Priority actions to rapidly scale up access to paediatric HIV testing and treatment.

Current coverage for effective ARVs for PMTCT, EID and paediatric ART

The coverage of core services for paediatric HIV prevention and treatment remains low in West and Central Africa. Recent data reported through the Global AIDS Monitoring system highlight the problem. Across three key interventions – PMTCT, EID and paediatric ART – West and Central Africa lags significantly behind the global average and even further behind Eastern and Southern Africa (Figure 3).

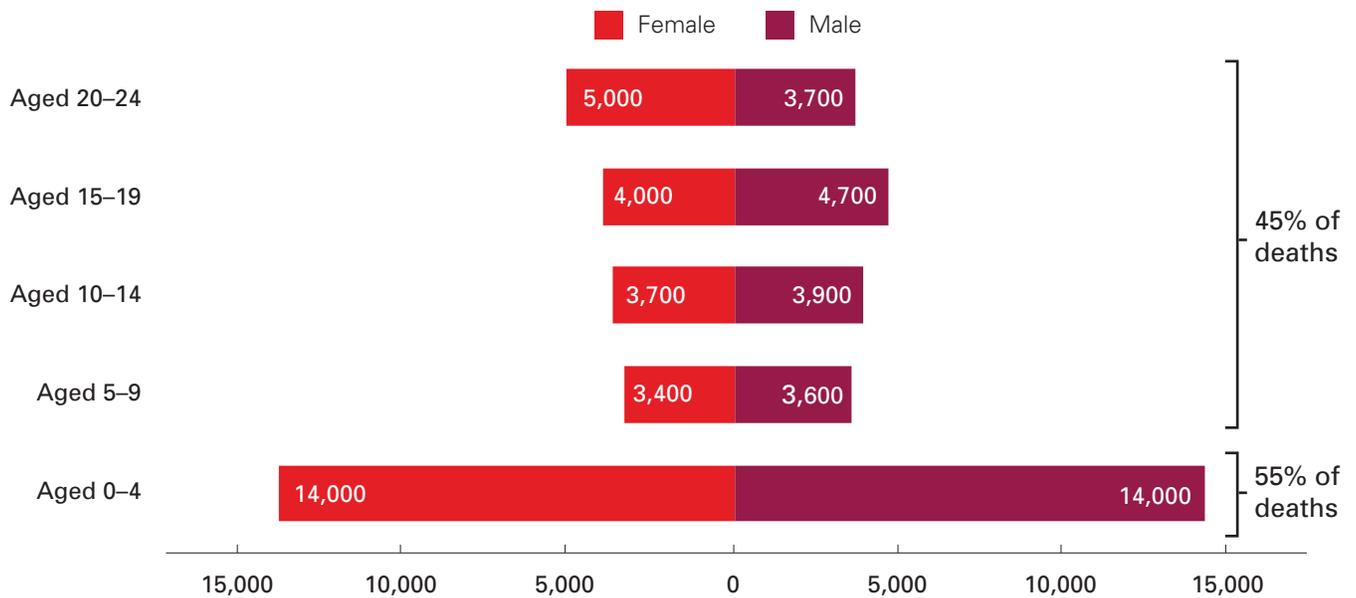
It was noted that Nigeria is home to almost half of the children living with HIV (270,000), but only 21 per cent of children in Nigeria are accessing treatment. Data from West and Central Africa suggest that most deaths in children and youths (0-24) occurs before the age of 5 (55 per cent) (Figure 4).

FIGURE 3 Coverage of key interventions for preventing mother-to-child transmission of HIV and for paediatric care and treatment globally and in African regions, 2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

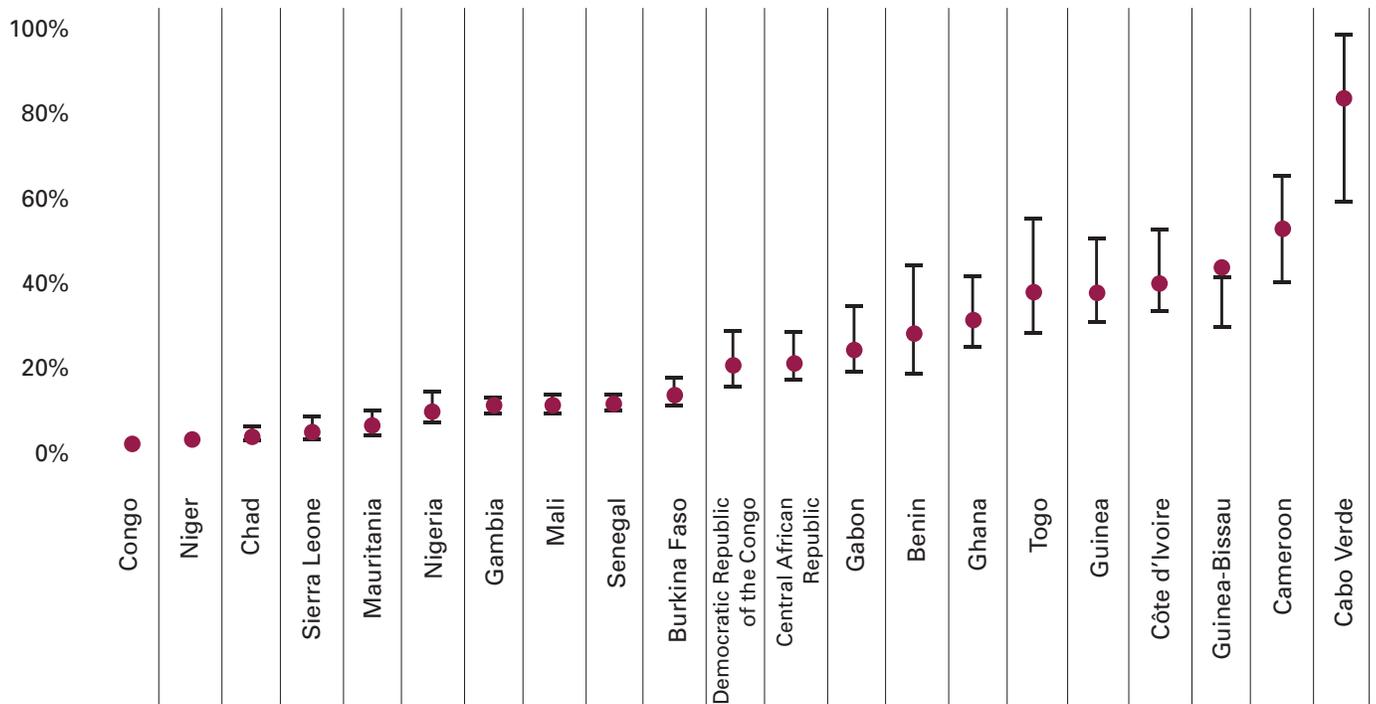
FIGURE 4 Estimated number of AIDS-related deaths, by five-year age groups, West and Central Africa, 2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

This high mortality in children under 5 years old could be prevented with early treatment, but early treatment requires early testing – and in West and Central Africa, access to early testing is low. The majority of children living with HIV in West and Central Africa are not tested within their first two months of life; early infant diagnosis coverage ranges from 3 per cent in Congo to 81 per cent in Cabo Verde. Globally, 43 per cent of all HIV-exposed infants are tested for HIV at or before 2 months of age. West and Central Africa, with a regional average of only 20 per cent of infants tested, is well below this global average – and only three countries of the region have averages that are above the global average (Figure 5).

FIGURE 5 Percentage of infants born to pregnant women living with HIV receiving a virological test for HIV within 2 months of birth, West and Central Africa, 2016



Note: Data for Equatorial Guinea, Liberia, and Sao Tome and Principe are not available.

Source: UNAIDS/UNICEF/WHO Global AIDS Monitoring and UNICEF analysis of UNAIDS 2017 estimates.

Building momentum to fast-track paediatric ART in West and Central Africa

The catch-up plans for countries of West and Central Africa draw on a legacy of other commitments and plans in the region, dating back to the Dakar Call to Action in 2015 and the drawing up of national paediatric acceleration plans in 2016 (Figure 6). The catch-up plans should incorporate elements of previous paediatric initiatives. Yet, a recent UNICEF review of the paediatric elements in 10 country catch-up plans found that while almost all noted the importance of closing the access gap between children and adults, only half of the plans set ambitious treatment targets for children and none had defined targets for virologic suppression among paediatric patients.⁴ Other elements of paediatric care, such as task-shifting for children, developing strong monitoring and evaluation systems and promoting community engagement, were noted in only 20 per cent of the catch-up plans reviewed.

Priority actions to scale up paediatric HIV testing and treatment in West and Central Africa

Meeting participants identified three “game changers” that if adopted into catch-up plans will accelerate the pace of paediatric HIV programme scale-up: enhanced infant HIV diagnosis; expanded entry points for testing children outside PMTCT programmes; and task-shifting for paediatric HIV care and treatment.

Enhanced infant HIV diagnosis

Low rates of HIV diagnosis in infants below the age of 2 months is largely due to three factors at facility level: few laboratory sites where HIV virological testing can be performed; inefficient systems to collect dried blood spots from lower-level health facilities and channel them to central laboratories; and weak mechanisms for the timely reporting of HIV test results from the central laboratory to lower-level health facilities. A 2016 multi-country assessment in 11 West and Central African countries found the average time between sample collection and receipt of HIV results was 1.4 months in Nigeria, 1.7 months in Cameroon, 2.2 months in Togo, 2.3 months in the Democratic Republic of the Congo and 3.5 months in Ghana.⁵ Such lags are a major concern because late detection leads to delays in treatment initiation, which increases the likelihood of death in HIV-infected infants.

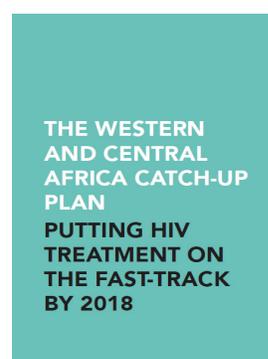
FIGURE 6 Momentum to fast-track paediatric ART in West and Central Africa (2015-2017)



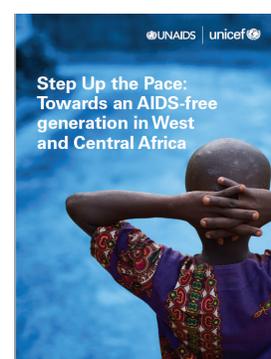
2015
Dakar Call to Action
 Endorsed by delegates from 19 countries, the West African Health Organization (WAHO) and the Economic Community of Central African States (ECCAS)



2016
National Paediatric HIV Acceleration plans
 Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Gabon, Guinea, Liberia, Nigeria, Sierra Leone, Togo (12 countries)



2016–2017
WCA catch-up plans (by 2018)
 Benin, Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Liberia, Mali, Nigeria, Senegal, Sierra Leone (12 countries)



2017
Step Up the Pace report
 At 19th ICASA, Abidjan, Dec. 2017:

- Launch of the first report on children and AIDS in West and Central Africa
- Satellite on Catalysing Paediatrics in West and Central Africa Catch-up Plans

Novel approaches to infant HIV testing offer great promise, specifically through the use of point-of-care (POC) diagnostic technology, which eliminates the need to send samples to a central laboratory and wait too long for the results. With the support of UNITAID, POC platforms are being implemented in pilot projects in 15 countries, including in Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo and Senegal in West and Central Africa. Early results from this work suggest that POC technologies can be deployed using a variety of different service delivery approaches (such as onsite testing, mobile testing or centralized testing in a hub-and-spoke model) (Figure 7) and in a variety of different settings, including at the primary health care level. POC testing technologies for EID are promising, but it is essential to expand in-country conventional laboratory capacity for EID at the same time. POC EID should be strategically placed within the national HIV testing services for children using available tools for diagnostic prioritization and site selection.⁶

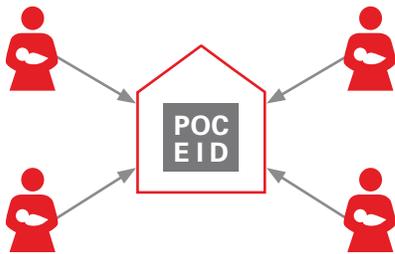
Expanded entry points for testing children outside PMTCT programmes

In many countries in West and Central Africa, coverage of PMTCT programmes remains low – close to half of pregnant women and their exposed children are unreached. As a result, most HIV-exposed and infected infants and children will not be identified within the context of PMTCT services. Data from other countries have shown that testing children in a variety of child health settings has relatively high yield, especially when those children are sick, admitted to inpatient wards or being treated for malnutrition and tuberculosis (Figure 8).

FIGURE 7 Models for optimal placement and use of POC EID technology

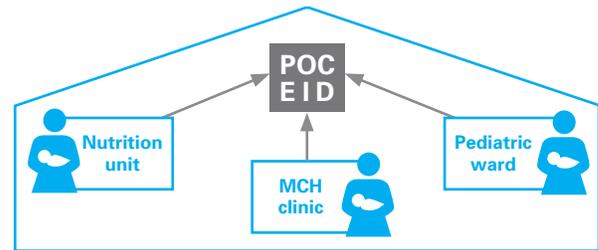
Model 1: Standalone sites

Receive samples directly from clients and perform POC EID tests on site



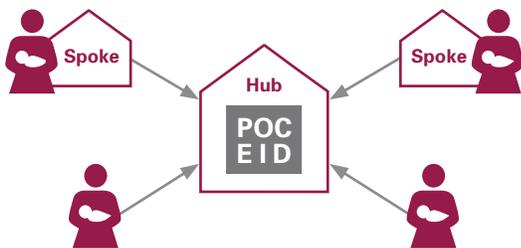
Model 3: Multiple-entry-point sites

Stand-alone or hub testing sites receive samples from different units or wards within the same health facility



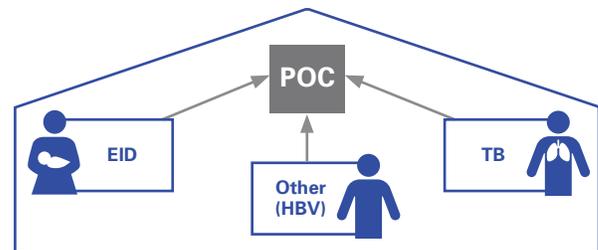
Model 2: Hub and spoke networks

Hub sites provide testing for patients at that site and for spoke sites. Nearby spoke sites send samples to the hub sites for testing



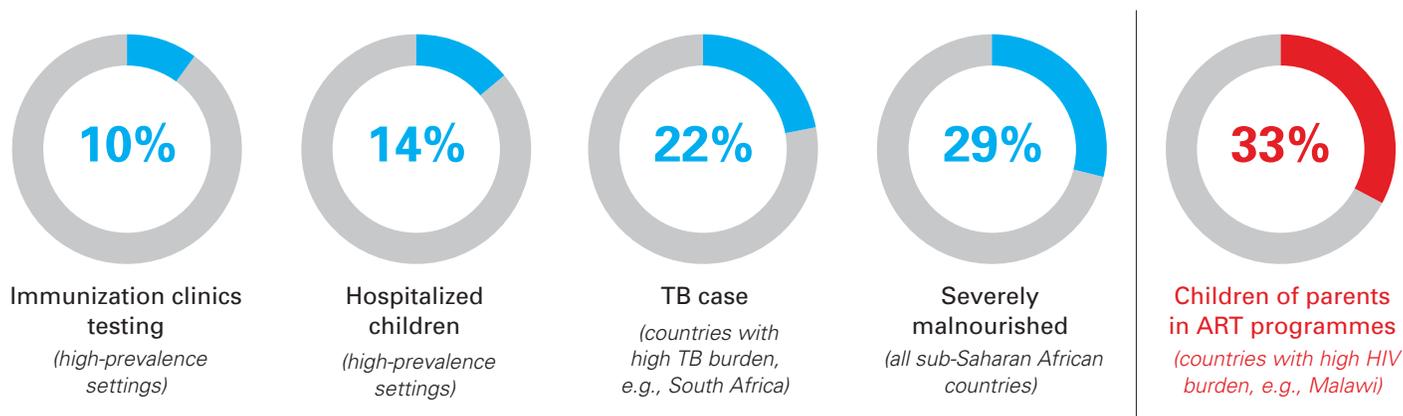
Model 4: Integrated testing sites

Process different types of POC tests (e.g., EID, TB, other)



Source: Preliminary results from UNITAID/EGPAF POC EID implementation across nine countries.

FIGURE 8 Percentage of children who tested HIV-positive, where testing took place at different entry points in high-prevalence settings



Source: Fergusson P, Tomkins A, "HIV prevalence and mortality among children undergoing treatment for severe acute malnutrition in sub-Saharan Africa: a systematic review," *Trans R Soc Trop Med Hyg*, 2008, doi:10.1016/j.trstmh.2008.10.029. Hesseling AC et al., "High incidence of tuberculosis among HIV-infected infants: Evidence from a South African population-based study highlights the need for improved tuberculosis control strategies," *Clin Infect Dis*, 2009, 48:108-114. Ferrand RA, Bandason T, Musvaire P, Larke N, Nathoo K, Mujuru H, et al., "Causes of acute hospitalization in adolescence: burden and spectrum of HIV related morbidity in a country with an early-onset and severe HIV epidemic: a prospective survey." *PLoS Med*. 2010;7(2):e1000178. Cohen D et al., "HIV testing coverage family members of adult antiretroviral therapy patients in Malawi." *AIDS Care*, 2010, 22:1346-1349.

Recent reports from the West and Central Africa region suggest that some of these approaches – including routine testing of children whose parents are on ART and testing of children in inpatient wards and malnutrition centres – could be highly efficient. In one large study conducted in one tertiary hospital facility in Cameroon, 3,439 children were enrolled during a period of four months (January–April 2016) and 2,104 were offered testing. The median age was 2.1 years, and the acceptance rate was close to 100 per cent. Overall HIV prevalence was 2.1 per cent, and of all children newly identified, 95 per cent were successfully enrolled on ART. Among the different approaches evaluated, family testing – which targets children whose parents were already enrolled into ART programmes (index case) – had the greatest yield, at 22.2 per cent (Figure 9). This is actually higher than the yield reported in other countries where HIV programmes are better established,⁷ suggesting that this type of index case-finding could be especially important in West and Central Africa.

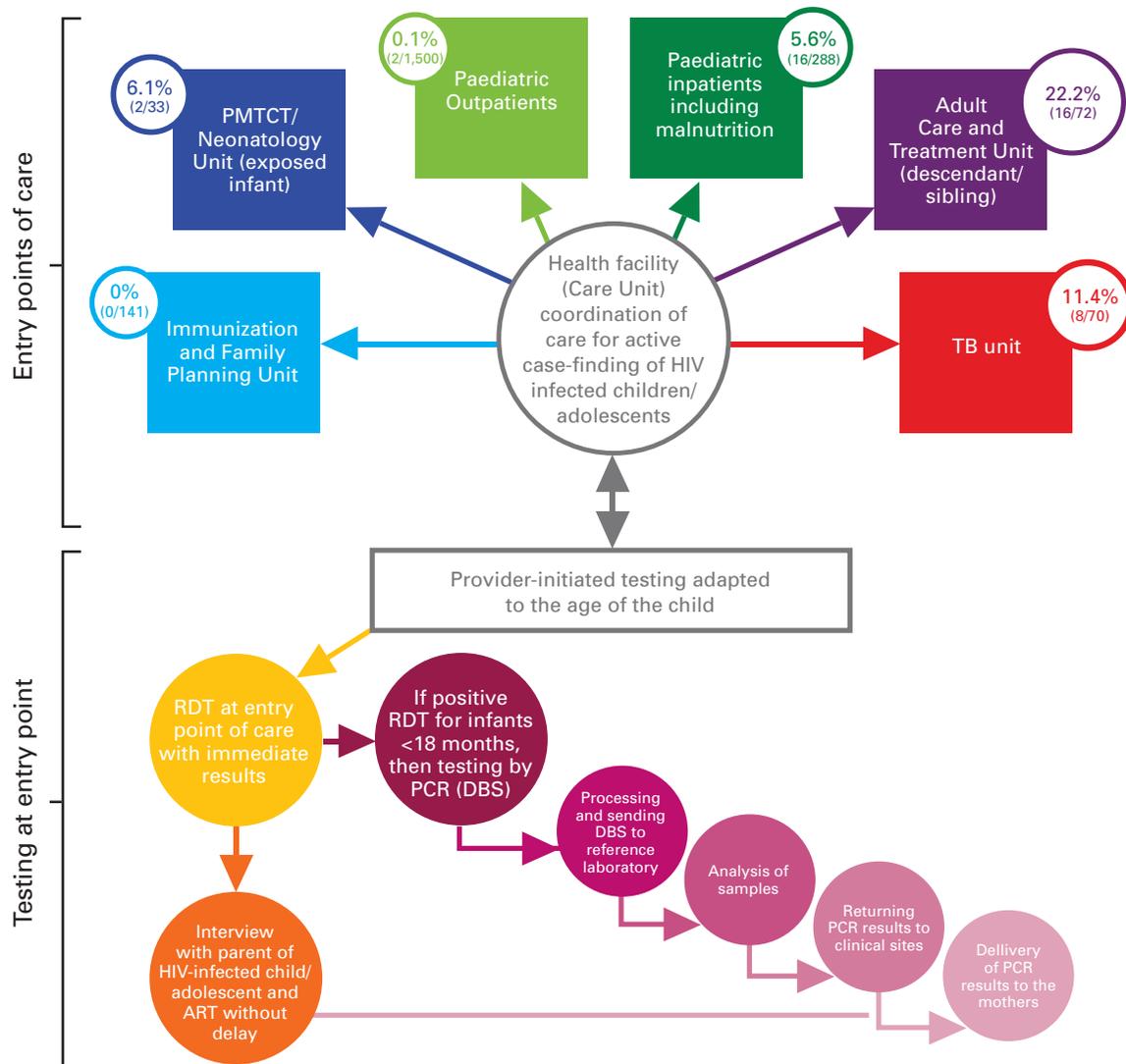
The Cameroon study also highlighted the fact that while testing sick children admitted to hospitals can be useful and is relatively easy to implement, in some cases it may be too late to improve outcomes. Despite high rates of ART initiation, 16 per cent of identified children died during the period of follow up – mainly due to tuberculosis and malnutrition.⁸ The study also found that adult ART clients were willing for their children to be tested, but preferred home-based testing (during the weekend) rather than bringing children to the facility. At the meeting, participants noted that testing children of adults on ART not only produces high yield but makes it easier to link newly identified children to care, since their parents are already engaged and on treatment.

The wider testing of children in West and Central Africa will require careful consideration of issues of supply chain and human resources to conduct the tests. In the Cameroon study, nurses and other cadres were trained in HIV testing in order to facilitate testing at multiple entry points, including at home, without the need to refer children to the laboratory.

Task-shifting for paediatric HIV care and treatment

In most West and Central African countries, the adoption of task-shifting policies for ART initiation by nurses in the context of PMTCT has not translated into more nurses equipped to manage paediatric ART. Task-shifting policies for paediatric HIV treatment are not explicitly included in task-shifting policies for HIV treatment (they were mostly limited to adults and pregnant women), and services remain largely limited to urban settings, in the hand of few paediatricians. A UNICEF situation analysis of paediatric HIV services in 11 high-burden countries⁹ found that when available, paediatric ART services were mostly concentrated in urban health facilities (73 per cent of the 399 health facilities surveyed). There were not enough physicians trained to manage paediatric HIV, and nurses were not always equipped and empowered to manage children living with HIV.¹⁰

FIGURE 9 Model for identifying children and adolescents and screening them for HIV at various entry points of care in a tertiary hospital in Douala (Cameroon)



Note: HIV positivity rate is provided for each entry-point and the yield of HIV positive children during a period of 4 months (January-April 2016), Data are from Hopital Laquitini, Douala (Cameroon).

Source: Penda, C., et al. *Feasibility and Utility of active case finding of HIV-infected children and adolescents by provider-initiated testing and counselling at entry points in a resource limited setting: Evidence from Laquitine hospital, Douala, Cameroon*. BMC-HRSP, 2017.

Roundtable discussion

Ministry of Health partners, key donors and implementing partners at the meeting engaged in a forthright and enthusiastic discussions on the issues and priority actions, and outlined their respective commitments.

The Ministry of Health representative from the Democratic Republic of the Congo acknowledged the lack of progress to date. Out of the three “game changers” described above, task-shifting is a centrepiece of this country’s paediatric ART acceleration strategy. It intends to add 30,000 new health personnel (lower cadres) and implement task-shifting, in order to close the paediatric testing and treatment gap.

Several experts noted that changing the mindset of providers is a real challenge for task-shifting. It is hard for doctors to relinquish control of “medical” tasks such as prescribing drugs or ordering tests, and it is difficult for nursing staff to accept this new role unless they have been well trained and empowered.

The civil society representative from Burkina Faso noted that there are community workers who can take on the task of dispensing ART for adults, but expanding this role to also treat children can be challenging. Training and capacity-building are needed, as well as the sharing of best practices from throughout the region and elsewhere.

The Global Fund representative noted the slow utilization rates of country allocation and the need to be ambitious around paediatric testing and treatment targets. He also informed participants that there is flexibility to reprogramme budgets in response to higher target-setting for paediatric testing and treatment.

The UNITAID representative emphasized the need to strengthen the health system and leverage innovations in HIV diagnostic technology (e.g., point of care for early HIV diagnosis and viral load monitoring) and in paediatric treatment (e.g., Lopinavir/r pellet for younger children).

PEPFAR is committed to advancing the paediatric testing and treatment agenda, particularly in West and Central Africa. In the context of the ongoing country planning process, PEPFAR will push for more ambitious paediatric target-setting and allocate resources to help achieve results. Three elements will be key:

1. Identifying children who are HIV-positive through a multipronged approach, with each country evaluating how well the entry points for HIV testing are working and modifying their approaches accordingly
2. Improving treatment referrals and linkage mechanisms, especially when testing and treatment are not offered at the same location
3. Breaking down treatment data by age to demonstrate how well infants and young children are being served by national programmes, in consideration of the especially high mortality in this age group.

The EGPAF representative echoed the importance of closing the treatment gap between children and adults and between West and Central Africa and the rest of the world, and called for improving management at the national level, establishing “dedicated, reliable, consistent and determined” staff or focal points for paediatric HIV treatment within Ministries of Health, increasing advocacy and engaging in South-South learning, with focused exchanges within the region and with countries in Eastern and Southern Africa.

The African Union representative reiterated this institution’s commitment to the Catch-up Plan and announced the launch of a new campaign by the African First Ladies – called “Free to Shine” – to end paediatric AIDS by 2030. She called for country delegates and partners to leverage the political momentum from the campaign and advance paediatric coverage in West and Central Africa.

Key takeaways

There was widespread recognition of the low paediatric HIV treatment access in West and Central Africa. All stakeholders were determined to address the underlying issues, building on the momentum of the West and Central Africa catch-up plans. The immediate challenge is to address the lack of testing of infants known to be HIV-exposed and the testing of older children outside of PMTCT programmes.

Priority actions include scaling up EID with the strategic use of POC, and intensifying family testing and the testing of sick children (for example, with tuberculosis or malnutrition) or in hospitals. Family and community engagement will be critical to support initiatives such as family testing and testing of orphans and vulnerable children, and to retain children and other family members in care. Task-shifting paediatric HIV treatment to trained non-physicians should be a priority focus. The progress in treatment access for adults and pregnant women needs to be the foundation for addressing gaps in treatment access for children.

Stigma and discrimination remain key barriers to improving access in some West and Central African countries. There is need to address stigma and discrimination in health facilities and communities in order to improve the attitudes of health providers and to mobilize families to demand services.

Meeting participants identified three innovative interventions as critical. These interventions have yielded results in other settings and been shown to be feasible in the West and Central Africa region:

1. Improving systems for infant diagnosis, including laboratory
2. Expanding entry points for paediatric HIV rapid testing and referral to care, including at community level
3. Adopting task-shifting policies for the prescribing of paediatric ART.

Momentum is building among donors and partners to close the gaps in access to paediatric HIV treatment in West and Central Africa. The Global Fund allocation to HIV/AIDS, including for paediatric ART, across the 22 countries of the region is estimated at US \$1 billion for 2017–2019. Priority countries for accelerated support through the AIDS Free global partnership include six high-burden countries in West and Central Africa: Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ghana and Nigeria.

Moving forward, three concrete steps were identified for action:

1. Revise country catch-up plans to redefine targets for paediatric HIV testing and treatment and integrate high-impact priority interventions and approaches
2. Develop and implement a plan of support for technical assistance around four main areas: (a) strategic use of POC to scale up EID; (b) effective approaches for family HIV testing; (c) paediatric ART task-shifting; and (d) community systems for paediatric testing and treatment
3. Re-engage national stakeholders through joint technical missions focused on addressing the priority policy and programmatic bottlenecks to the scale-up of paediatric testing and treatment.

UNITAID, CHAI, EGPAF and UNICEF are supporting the introduction of point-of-care technologies to improve access to infant diagnosis in Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo and Senegal. PEPFAR's new strategy for accelerating HIV/AIDS epidemic control (2017–2020) will sustain support for treatment while intensifying effort in 13 priority countries, including Côte d'Ivoire in West and Central Africa. Civil society organizations and the faith-based community have recently committed to supporting paediatric ART scale-up in Cameroon, the Democratic Republic of the Congo and Nigeria.

The AIDS Free global partnership is providing the necessary framework to annually monitor the implementation of priority actions in West and Central Africa. There is strong commitment by the United Nations family to mobilize political will and a recognition that UNICEF has a central role to play around communication, advocacy and service delivery. We need to leverage these joint efforts to push for greater commitment from government and partners and change the situation for children living with HIV in West and Central Africa.

An agenda for action

Policy and advocacy agenda

1. Redefine paediatric HIV targets in line with the AIDS Free super-fast track targets by 2018 and 2020
2. Engage high-level political and community leadership for paediatric treatment catch-up (e.g., Ministers of Health, First Ladies, Religious Leaders)
3. Advocate for adoption/extension of ART task-shifting policy to paediatric treatment
4. Advocate for the adoption of policy to boost early infant diagnosis (EID) and family testing
5. Advocate for reprogramming Global Fund country envelopes towards redefined targets for paediatric ART
6. Leverage other resources and initiatives (e.g. PEPFAR, UNITAID, Initiative 5%, etc.)
7. Mobilize domestic resources for national scaling up of paediatric testing and treatment (government and private sector)
8. Reinforce national and regional coordination to catalyse action and monitor progress in paediatric HIV acceleration.

Programmatic agenda

1. Build capacity for the introduction and rollout of new HIV POC diagnostic technologies in national health systems to scale-up access to EID and viral load monitoring
2. Develop and disseminate guidance note and job aids on testing outside of PMTCT programmes
3. Disseminate job aids to support task-shifting of paediatric ART prescribing using simplified paediatric ARV formulations
4. Organize high-level technical missions (e.g., in Burkina Faso, Chad, Mali, Nigeria) to support paediatric testing and ART strategic planning sessions, engage partners and consolidate partner commitments
5. Build capacity of health care workers and community actors to play a role in paediatric HIV testing and treatment, adherence support and retention in care
6. Conduct a consultation with community actors and people living with HIV to define their roles in addressing the paediatric HIV testing and treatment gaps
7. Strengthen systems for family HIV testing (campaigns) and testing of vulnerable children such as orphans and children of key populations
8. Annually monitor country and regional progress and document lessons learned and best practices
9. Assess the effectiveness of facility/community approaches to optimize the HIV cascade for children in West and Central Africa

Endnotes

1. United Nations Children's Fund and Joint United Nations Programme on HIV/AIDS, *Step Up the Pace: Towards an AIDS-free generation in West and Central Africa*, UNICEF West and Central Africa Regional Office and UNAIDS Regional Support Team for West and Central Africa, Dakar, 2017. Web link: https://www.unicef.org/publications/files/Step_Up_the_Pace_West_and_Central_Africa.pdf.
2. Catch-up plans for Senegal and Mali are still being finalized.
3. Desk review of country catch-up plans by UNICEF West and Central Africa Regional Office, 2017.
4. Desk review by UNICEF West and Central Africa Regional Office, 2017. Catch-up plans in Benin, Burkina Faso, Cameroon, the Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Liberia, Nigeria and Sierra Leone were part of this review.
5. United Nations Children's Fund, 'Synthèse de l'analyse situationnelle de la prise en charge du VIH pédiatrique en Afrique de l'Ouest et Centrale', UNICEF West and Central Africa Regional Office, Dakar, February 2016, p. 12. Cited in UNICEF and UNAIDS, *Step Up the Pace: Towards an AIDS-free generation in West and Central Africa*, p. 16.
6. UNICEF, *Key Considerations for Introducing New HIV Point-of-Care Diagnostic Technologies in National Health Systems* (forthcoming in 2018).
7. Ahmed, S., et al. *Index case finding facilitates identification and linkage to care of children and young persons living with HIV/AIDS in Malawi*. *Trop Med Int Health*. 2017 Aug; 22(8):1021-1029.
8. Penda, C., et al. *Feasibility and Utility of active case finding of HIV-infected children and adolescents by provider-initiated testing and counselling at entry points in a resource limited setting: Evidence from Laquiline hospital, Douala, Cameroon*. *BMC-HRSP*, 2017.
9. United Nations Children's Fund, 'Synthèse de l'analyse situationnelle'.
10. United Nations Children's Fund, 'Synthèse de l'analyse situationnelle'.

Annex 1: Meeting agenda

Time	Session	Detail	Speaker/Presenter
Session 1: SETTING THE STAGE Facilitator: Shaffiq Essajee (UNICEF), Rapporteurs: Eleanie Nyankesha (UNICEF)			
15.00 – 15.15	Introduction and welcome remarks	Opening remarks by Marie-Pierre Poirier and Michel Sidibe (15 min)	Marie Pierre Poirier (UNICEF RD-WCARO) Djibril Diallo (UNAIDS-RD-WCA-RST)
15.15 – 15.45	SETTING THE STAGE What do we know about the global challenges and solutions? Where are we on paediatrics in the catch-up plans?	Global situation on paediatric HIV and the AIDS-free agenda. What are the main bottlenecks and what works? (10 min)	Martina Penazzato /Gottfried Hirschall (WHO)
		Snapshot of paediatric HIV in West and Central Africa country catch-up plans and progress in 2017. (10 min) Q&A (10 min)	Landry Tsague (UNICEF WCARO) and Aliou Assani (UNAIDS WCA-RST)
Session 2: PRIORITY ACTIONS FOR PAEDIATRICS IN WEST AND CENTRAL AFRICA REGION Facilitator: Landry Tsague (UNICEF), Rapporteurs: Dorothy Mbori-Ngacha (UNICEF)			
15.45 – 16.20	WHAT DO WE NEED TO DO TO CLOSE THE GAP? Perspectives and priority actions	Diagnosis in Infants and children: 15 mins Decentralizing HIV testing for children and strengthening the lab-clinic interface	Valery Nzima Nzima (EGPAF) - 7 min
		Differentiated HIV testing for children Integration: Testing children at multiple entry points (outside PMTCT)/Community: Family/Community testing including supply chain management of HIV testing commodities.	Dr. Ida Penda (EVA, Pediatrician) – 7 min
		Linkage to Treatment and Retention in Care: 7 mins Task-shifting for paediatric treatment, tools to improve linkage to care and mentorship for paediatric ART scale-up.	Dr. Alain Azondekon (EVA, Paediatrician) – 7 min
		Q & A with Countries MoH, implementers and CSO reacting to priority actions – 10 min <i>Panel facilitator summarizes key priority actions - 3 min</i>	
Session 3: ROUNDTABLE DISCUSSION – Ministry of Health and key donors react to the priority actions and outline commitments Facilitator: Catherine Bilger (UNAIDS), Rapporteurs: Amandine Bollinger (UNICEF)			
16.20 – 16.50	ROUNDTABLE Mobilizing for 2018 - reaching more children with testing and life-saving treatment in West and Central Africa	Ministry of Health partners and key donors respond to a series of questions	Ministry of Health representatives Global Fund PEPFAR UNITAID RAME AU EGPAF
16.50 – 17.00	CLOSING	Summary of way forwards and key actions	Marie-Pierre Poirier (UNICEF RD-WCARO) Luiz Loures (UNAIDS DED)

Annex 2: Key meeting slides

Strategies to test more children

- In ANC settings we offer HIV testing to all mothers as a matter of routine...why not do the same for children?
- Testing all children in outpatient settings is being piloted in some settings, but HIV prevalence in children is lower than adults
- And in low prevalence settings this may not be an efficient use of resources
- Evidence suggests that testing children of HIV positive adults may be a more efficient approach¹
- In addition, home based testing for this approach may be more acceptable than clinic based testing²

1 Ahmed, AIDS 2013
2 Lugada, JAIDS 2010, Pyllesee Trop Med Int Health 2004, Ware, JAIDS 2006, Weeman, AIDS 2010

Game Changers for the Region

The plan to accelerate pediatric HIV treatment access in West and Central Africa starts with a game changing approach to testing

Two critical components

- Intensification of active case finding among children whose mothers missed the opportunity to do PMTCT
- Task shifting of testing

This strategy has a two fold effect: that of systematically proposing HIV screening at the entry point of care potentially providing more HIV-infected children and offering care to parents who are unaware of their HIV status.

What is best way to identify these children?

We have recently concluded a large study to evaluate different entry points for pediatric testing

- Focused on hospital facilities
- Tested 3,439 children at 6 entry-points, 61.3% had not been been previously tested and 99.9% accepted testing
- Mean age: 2.1 years (Sd=2.96)
- Overall HIV prevalence (2.1% (44))
- 42/44 children (95%) were initiated on ART
- 7/44 died (15.9%) mainly due to tuberculosis and malnutrition.

REF: Feasibility and Utility of active case finding of HIV-infected children and adolescents by provider-initiated testing and counselling at entry points in a resource-limited setting: Evidence from the Laquintinie hospital in Douala, Cameroon. Calais (in) PENEZ et al BMC-PIDS in press, 2017

Key considerations for implementing Testing of children of adults in HIV care

- Develop identification models according to the health pyramid level and taking into account the community
- Effective implementation of HIV screening requires Task shifting for testing and their coordination
- Demand creation
- Reinforce supply chain
- Integration of HIV testing in malnutrition and tuberculosis clinics
- Linkage to care is key
- BUT testing children of adults in ART clinics is the best way to institute test and treat strategies for children, because their parents are already on treatment and aware and those children are being identified within ART programs

Annex 3: List of participants

African Union and Regional Economic Communities	African Union/Social Affairs	Dr. Marie-Goretti Harakeye Ndayisaba – Chief HIV/TB and Malaria, Ethiopia (Harakeyem@africa-union.org)
National Ministries of Health, Governments and National AIDS Control Programmes	Benin	Prof. Armande Flore Gangbo – Coordinatrice du PSLS (armandegangbo@yahoo.fr)
	Burkina-Faso	Dr. Bapougouni Philippe Christian YONLI MD, MPH – Coordonnateur du Programme Sectoriel, Santé de Lutte contre le Sida et les IST (PSSLS-IST) (yonlichristian@yahoo.fr)
	Cameroon	Dr. Tjek Biyaga Paul Théodore – Chef de service PTME, Direction de la Santé Familiale du MINSANTE (tjekpaul@yahoo.fr) Dr. Jean Bosco ELAT NFETAM – Secrétaire Permanent du CNLS (jeanbosco.elat@cnls.cm)
	Central African Republic	Dr. Mbeko Marcel – DG de la sante (simaleko@yahoo.fr) Dr. Diemer Henry Saint Calvaire – Directeur de la DES (diemerhenri@yahoo.fr) Dr. Wilfried Sylvain Nambei – CN/CNLS coordinator (wilfrid.nambei@gmail.com) Edwige Opportune – CNLS (onguelebe@gmail.com)
	Côte d’Ivoire	Dr. Abo Kouame – Head of PNLS (Kwagny@gmail.com) Dr. Kouadjale Mahouri Mathurin – Responsable de la prise en charge pédiatrique au PNLS (drkouadjale@yahoo.fr)
	Democratic Republic of the Congo	Dr. Placide Wello – Directeur PNLS RDC Dr. Theodore Assani – Directeur Adjoint PNLS RDC Dr. Faustin Kitetele – Médecin Chef d’Unité Hôpital Pédiatrique de Kalembe-Lembe
	Equatorial Guinea	Dr. Justino Obama – Presidential Adviser HIV/AIDS Programme & Ex Minister of Health (nve008@yahoo.es)
	Guinea	Dr. Kade NDIAYE – Chef Unité PTME au PNPSP (kadendiaye@gmail.com) Dr. Abasse DIAKITE – Secrétaire exécutif du CNLS (abasse.diakite@gmail.com)
	Liberia	Mr. Janjay Jones – Deputy Programme Manager/M&E and Surveillance (mjanjay@yahoo.com) Dr. Julia Toomey-Garbo – Programme Manager/NACP (hnadetoomey@yahoo.com)
	Mali	Dr. Nia Kone – Responsable de la prise en charge pediatrique, Cellule Sectorielle de la Lutte contre le Sida, Ministere de la Sante, Mali (niaboula@yahoo.fr)
Nigeria	Nwakageo (ART Coordinator, Nigeria)	
Senegal	Prof. Cheikh Tidiane Ndour – Chef de la Division Lutte Contre Sida / IST (Cheikh.t.ndour3@gmail.com)	

List of participants

Civil society organizations and faith-based community	RAME	Simon Kabore – Executive Director (simonkabore@gmail.com)
	ICW	Florence Anam – Advocacy and Communication Manager (advocacy@iamicw.org)
	ITPC	Alain Manouan – Community Treatment Monitoring Project Director (AManouan@itpcglobal.com)
	CARITAS	Dr. Olawale Felix Fadare – Senior Technical Advisor (HIV/AIDS), Nigeria (ofadare@ccfng.org)
HIV implementers	EGPAF	Chip Lyons – Chief Executive Officer (clyons@pedaids.org) Dr. Nzima Nzima Valery – Cameroon Implementation Manager for UNITAID (vnzima@pedaids.org)
	ICAP	Dr. Ruby Fayorsey – Deputy Director for Clinical & Training Unit and Peds Lead, New York (rf2190@cumc.columbia.edu) Nathalie Elong Ntsama – Littoral PMTCT/ART Regional Coordinator (en2367@cumc.columbia.edu)
	EVA	Cheick Tidiane Tall – Directeur Exécutif, Réseau EVA (Enfants et VIH en Afrique) (cttall@reseaeuva.net) Dr. Calixte Ida Penda – Paediatrician, Réseau EVA (idapenda@yahoo.fr) Dr. Alain Azondekon – Paediatrician, Réseau EVA (alainazon@yahoo.fr)
	Solthis	Roubanatou Abdoulaye-Mamadou – Coordinatrice médicale (coordinateurmedical.niger@solthis.org)
	PATA	Agnes Ronan – Head of Programmes (agnes@teampata.org)
	United Nations agencies (HQ, Regional Offices and Country Offices)	UNAIDS
UNICEF		Marie-Pierre Poirier – Regional Director, WCARO (mppoirier@unicef.org) Chewe Luo – Associate Director HIV/AIDS, New York HQ (cluo@unicef.org) Catherine Langevin-Falcon – Senior Adviser HIV/AIDS, New York HQ (clangevin@unicef.org) Shaffiq Essajee – HIV/AIDS Senior Adviser, New York HQ (sessajee@unicef.org) Landry Dongmo Tsague – Regional Adviser, HIV/AIDS, WCARO (Itsague@unicef.org)

List of participants

United Nations agencies (HQ, Regional Offices and Country Offices)	UNICEF	<p>Amandine Bollinger – HIV/AIDS Specialist, WCARO (Airbollinger@unicef.org)</p> <p>Elevanie Nyankesha – HIV/AIDS PMCT Specialist, WCARO (enyankesha@unicef.org)</p> <p>Nathalie Daries – Chief HIV/AIDS, Côte d’Ivoire (ndaries@unicef.org)</p> <p>Dorothy Mbori-Ngacha – Senior Health Specialist (HIV/AIDS), Nigeria (dmboringacha@unicef.org)</p> <p>Abdelkader Bacha – Adolescent and HIV/AIDS Specialist, WCARO (abacha@unicef.org)</p> <p>Ana Paula Maximiano, Health Specialist, UNICEF Cabo Verde (paula.maximiano@cv.jo.un.org)</p> <p>Aboudou Karimou Andele, Chief Health, UNICEF Mali (kandele@unicef.org)</p> <p>Fanta Siby, HIV Specialist, UNICEF Mali (fsiby@unicef.org)</p> <p>Ibrahim Ahmat Manoufi, HIV Specialist, UNICEF Chad (iamanoufi@unicef.org)</p> <p>Arlette Diane Ajavon, Program Associate, UNICEF Wcaro (aajavon@unicef.org)</p> <p>Kouame Jean Konan, HIV Specialist, UNICEF Cote d’Ivoire (kkonan@unicef.org)</p> <p>Victorine Dilolo, HIV Specialist, UNICEF Cote d’Ivoire (vdilolo@unicef.org)</p>
	WHO	<p>Dr. Gottfried Hirsenschall – Director HIV/AIDS and Global Hepatitis, HQ (hirsenschallg@who.int)</p> <p>Dr. Martina Penazzato – Paediatric technical lead (Treatment and Care unit), HQ (penazzatom@who.int)</p> <p>Dr. Frank John Lule – Treatment and Care Unit, AFRO (lulef@who.int)</p>
Donors and foundations	The Global Fund	<p>Dr. Jean-Thomas Nouboussi – Gestionnaire de portefeuille Senior, West Africa Team, Grant Management, Suisse (jean.nouboussi@theglobalfund.org)</p>
	PEPFAR	<p>Dr. George Siberry – Director for HIV Treatment, Care & TB; Senior Pediatric Technical Advisor, Office of the U.S. Global AIDS Coordinator (S/GAC) (SiberryGK@state.gov)</p>
	UNITAID	<p>Dr. Philippe Duneton – Deputy Executive Director (dunetonp@who.int)</p> <p>Gelise McCullough – Programme Officer (mcculloughg@unitaid.who.int)</p>

