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PITC in Pediatric Settings: A Gateway to Enrolling Families into HIV Care and Treatment

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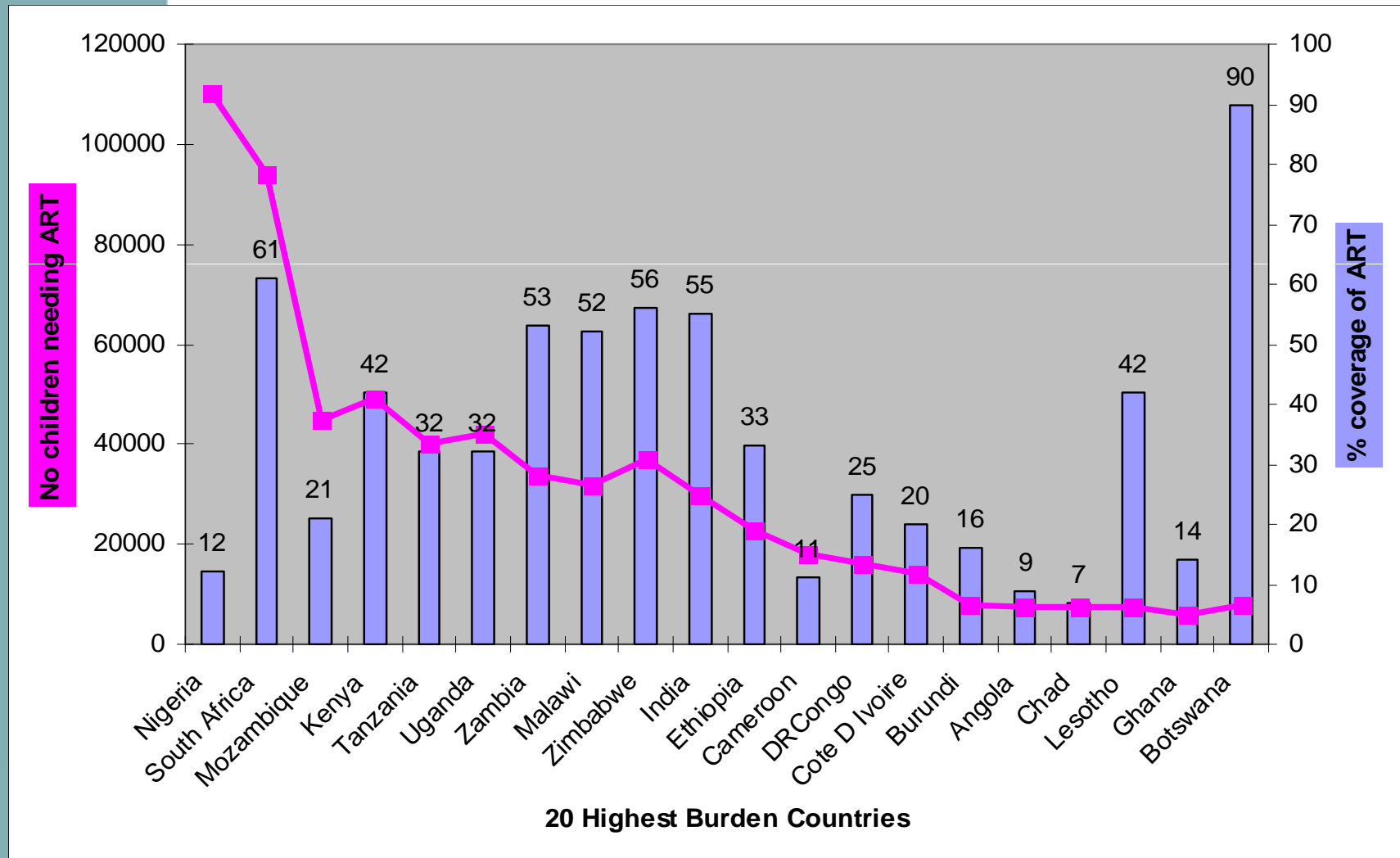
Why Provider Initiated Testing and Counseling (PITC)?

- Access to care for HIV infected children and their families still low
- Majority of children in care and treatment are initiated late on ART and/or are older age group (>5 years)
- PMTCT coverage is still low and testing of family members of tested pregnant women is very low

PITC in Pediatric Settings = MCH/HIV Linkages and Integration

- Offering PITC in pediatric settings (e.g. OPD, routine child health services) is one example of *MCH/HIV linkages and integration*
 - Identify children **and** family members and enroll them into HIV care and treatment
 - Different models providing HIV care and treatment to these children and families (integrate vs link/refer)

Estimated Number of Children on ART: 20 Countries with Highest HIV Burden



WHO 2007 Guidelines on PITC

“In generalized epidemics... HIV testing & counseling ... as part of the normal standard of care

...regardless of whether the patient shows signs & symptoms of underlying HIV infection or the patient's reason for presenting to the health facility”

PITC in Pediatric Settings

- Prenatal Care
- Intrapartum Care
- Postnatal Care
- Early and Late Childhood Care

PITC as a Gateway for Family Testing: Study from Uganda*

- Tested 8990 (92.8%) of 9687 children
- 89.8% caretakers accepted testing
- Only 41.3% caretakers had previously tested for HIV
- Of the 313 parents that had previously tested, only 36.3% had tested their children prior to hospitalization

DBS/PCR Results by PMTCT Access

Entry point	Number of infants tested	Number of infants tested positive	%
<i>PMTCT</i>	3324	340	10,23%
<i>non PMTCT</i>	532	256	48,12%
Total	3856	596	15,46%

Routine HIV Testing for Children

- Acceptable
- Feasible
- Cost effective

Facilitators for Routine HIV Testing for Children

- Policy
- Training
- Practice – “Routinize”
- Staffing – Task shifting* / task sharing
- Others – Leadership, supplies, space

*McCollum ED et al (2010) PLoS ONE 5 (3) e9626.

Task Shifting Improves Pediatric HIV Testing: Study from Malawi*

- Model 1 used lay counselors, Model 2 used “patient escorts”
- Increased pts offered testing
 - 43.1 vs 19.9% ($p < 0.001$)
- Pts younger
 - 17.3 vs 26.7mo ($p < 0.001$)
- Tested sooner after admission
 - 1.77 vs 2.44 days ($p < 0.001$)
- Overall 68.3% of children enrolled in care

Facilitators for Effective Routine HIV Testing for Children

- Integration into existing services, especially care and treatment
- Strong, effective linkages with care and treatment (if not integrated)
- Strong M&E
 - Good recording and use of data

Integration of PITC: EGPAF Swaziland Experience

- 3 months of program data
- 1,299 children were tested
 - Average age: 43 months (range 18 mo - to 15yrs)
- Tested 336 of their siblings as well as 250 of their parents
- Of 86 children who tested positive
 - 100% were initiated on CTX
 - 91% had blood drawn for CD4 testing
 - 63 (73%) of the children referred for care and treatment & reached the referral site

Conclusion

- PITC is acceptable and feasible, and should be provided on a routine basis in pediatric settings
 - Can lead to increased uptake of HIV care and treatment, and reduced morbidity and mortality
- Important elements for success:
 - Adequate planning and resource allocation
 - Task shifting/sharing
 - Strong M&E

Thank you