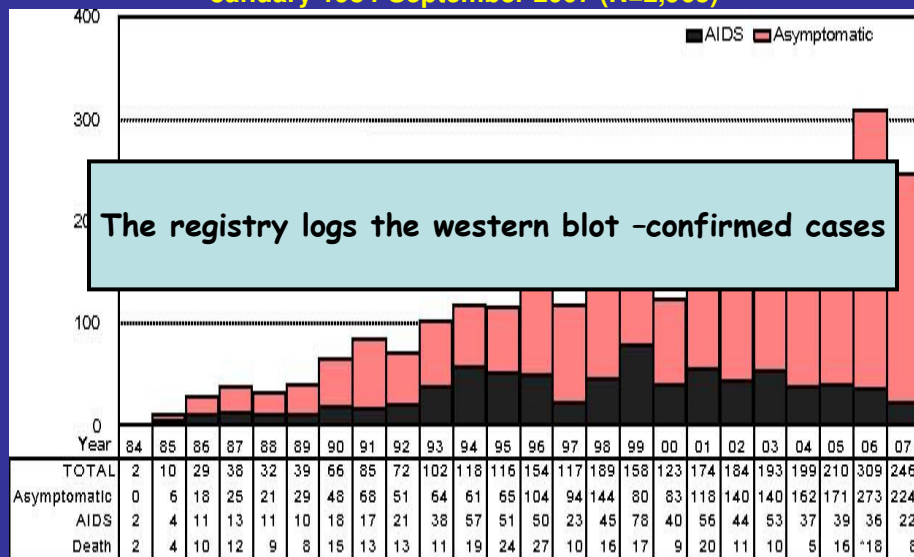


HIV/AIDS estimates, end of 2007

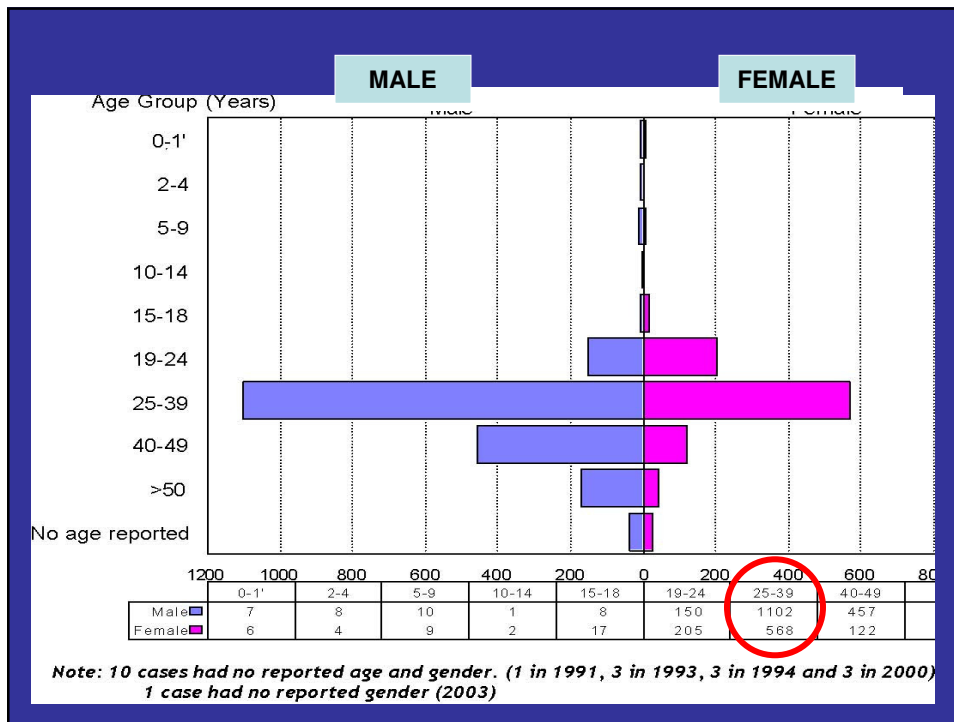
UNAIDS/WHO , November 2007

	Estimate In million	Range
People living with HIV/AIDS in 2007	33.3	30.6-36.1
Adults living with HIV/AIDS in 2007	30.8	28.2-.33.6
Women living with HIV/AIDS in 2007	15.4	13.9 -16.6
Adults newly infected with HIV	2.1	1.4 -3.6
AIDS death in 2007	2.1	1.9 -2.4
Children living with HIV/AIDS in 2007	2.5	2.2-2.5
Children newly infected with HIV in 2007	0.42	0.35 -0.54
Child AIDS death in 2007	0.33	0.31-0.38

HIV Ab Seropositive Cases by Year HIV/AIDS Registry, January 1984-September 2007 (N=2,965)



National HIV/AIDS Registry, Sep 2007



Reported Mode of Transmission
HIV/AIDS Registry, January 1984-September 2007 (*N* = 2,965)

Reported Mode of Transmission	Jan 1984- Sep 2007
Sexual transmission	
Heterosexual	1,798
Homosexual contact	586
Bisexual contact	211
Blood /blood products	19
Injecting Drug use	7
Needle prick injuries	3
Perinatal	44
No exposure reported	297

Pediatric HIV



" nascent stage "

- The situation of Filipino Children Affected by HIV/AIDS : a rapid assessment

- September 2004-February 2005

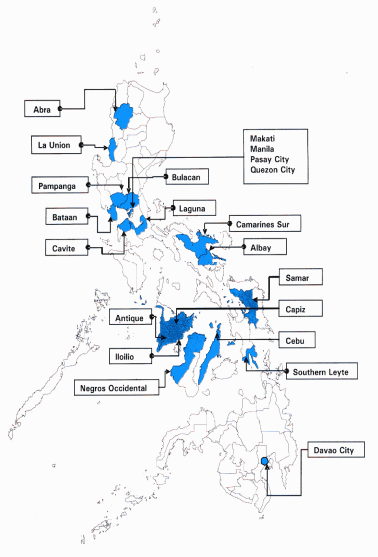
- Lunduyan



"Children affected by HIV"

- <18 years old who have close family members living with HIV
- Those who have lost close family members to HIV/AIDS
- Those who are infected with HIV

Figure 3: Areas covered by the study



- 22 of 33 initially-identified areas were covered
- 95 children were reached out of initial listings of 190

... *The Findings*

- Nationwide
- 3 children known HIV- infected
- 58% - both parents alive
- 29% - orphan (one parent)
- 15 % - orphan (both parents)

Lunduyan The situation of Filipino Children affected by HIV and AIDS: a Preliminary Assessment. 2005

Global Campaign on Children on HIV and AIDS

- 5 –year campaign launched by UNICEF and UNAIDS

• October 2005

• AIMS :

1. put children at the center of HIV agenda
2. realize measurable progress for children in areas of prevention , preventing parent-to- child transmission, pediatric treatment, and protection and support of children affected by HIV.



Crossing Borders Project

- Main objectives
 - Integration of treatment, monitoring and care
 - To develop a standardized “stand-alone guidelines” for children affected with HIV/AIDS



Precious Jewels Ministry (NGO)
DOH -
San Lazaro Hospital
Philippine General Hospital
Research Institute for Tropical Medicine

Crossing Borders Project :

- Interim Guideline (Pioneering)
 - A reference in applying multidisciplinary management of HIV & AIDS in children
- Developed for the health care provider (initially for the 3 hospitals) based on:
 - Review of literature
 - **HEAVILY DEPENDED on the WHO manuscript**
 - Result of agreements and consultations among stakeholders
 - Aligned with existing SOP's of the participating hospitals and child advocate partners.



In 2007... The Interim Guideline on the Integrated Management of Pediatric HIV and AIDS was submitted to DOH for final review.
(--personal communication with Dr Melencia Velmonte- over all chair Crossing Borders Project)

Crossing Borders Project :

- 15 children HIV positive
- <10 years old
- 3 children on ARV
 - 5 candidates to start ARV in SLH
 - 1 in RITM
- Usual presentation :
 - Failure to thrive
 - Recurrent otitis media
 - Recurrent oral thrush
- All were perinatally acquired



Most babies born to HIV-positive mothers **will not** get HIV.

A baby can get HIV from its mother:

- During pregnancy (before birth);
- During delivery (the most common)
- Breast-feeding.



Accurate diagnosis of HIV infection in children at any age requires laboratory testing

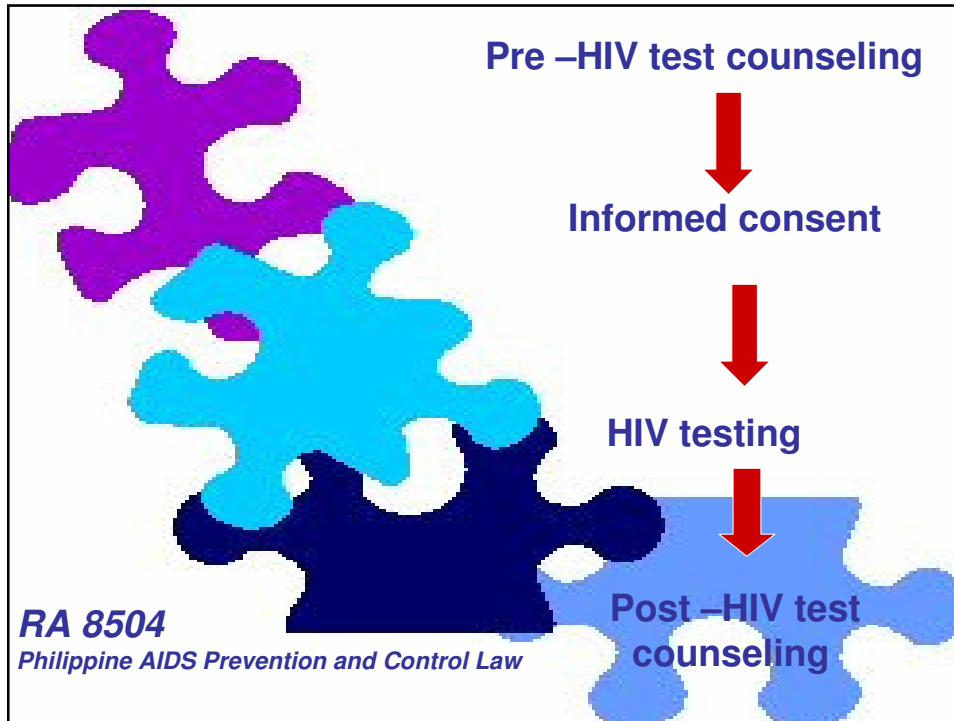


Principles for the conduct of HIV testing :

3C'S

Confidential
Counseling
Consent

UNAIDS/WHO Policy Statement on HIV Testing



Department of Health
National Reference Center for HIV Testing
 Research Institute for Tropical Medicine
 Alabang, Muntinlupa City, Philippines 1770
 Tel. Nos. : (632) 807-2626 to 32 local 226-809-7599
 Fax Nos. : (632) 842-2245-842-2628

INFORMED CONSENT TO HIV TESTING

(Before an HIV Test can be given, written informed consent is needed. If you have any questions, please feel free to ask your counsellor).

- 1. What is the HIV Antibody Test or "AIDS Test"?**
 The HIV Antibody Test is a blood test. The test shows if you have antibodies to HIV – the virus that causes AIDS. Test is not a diagnosis of AIDS.
 A sample of blood will be taken from your arm and/or fingertip. If the test shows any reaction, a different test will then be done to make sure the first test was right.
 A positive test result means you have been infected with HIV. It is not a diagnosis of AIDS.
 A negative test means you are probably not infected. It takes the body time to produce antibodies so that if you have been exposed recently, you need to be retested in several months to make sure you are not infected.
- 2. What are the benefits of taking the test?**
 If you test negative:
 You can learn how to protect yourself from getting infected with HIV in the future.
 If you test positive:
 You can learn how to avoid giving the virus to others, i.e., your partner or your baby.
 You can learn how to take care of your health, and your doctor can take care of you better.
- 3. Voluntary Testing**
 Taking an HIV antibody test is voluntary. You do not have to take the test. You can have the test without your name.
- 4. Confidentiality of Test Results**
 Your test results are confidential. It will only be given to you or to people you allow.
- 5. Risks involved with disclosure.**
 If you test positive, you should be careful about telling others what your test showed.

My questions about the HIV test have been answered. I agree to take the HIV antibody test.

Date: _____
 Signature: _____
 Name/Code: _____

I have explained the HIV antibody test, how it is done, the meaning of the results and the possible consequences of disclosure.

Name: _____
 (Signature over printed name)

Laboratory Diagnosis of HIV among children



Depends on the age of the child

In adults and children **more than 18 months**
antibody testing → ELISA

→ Western Blot

In children **less than 18 months**

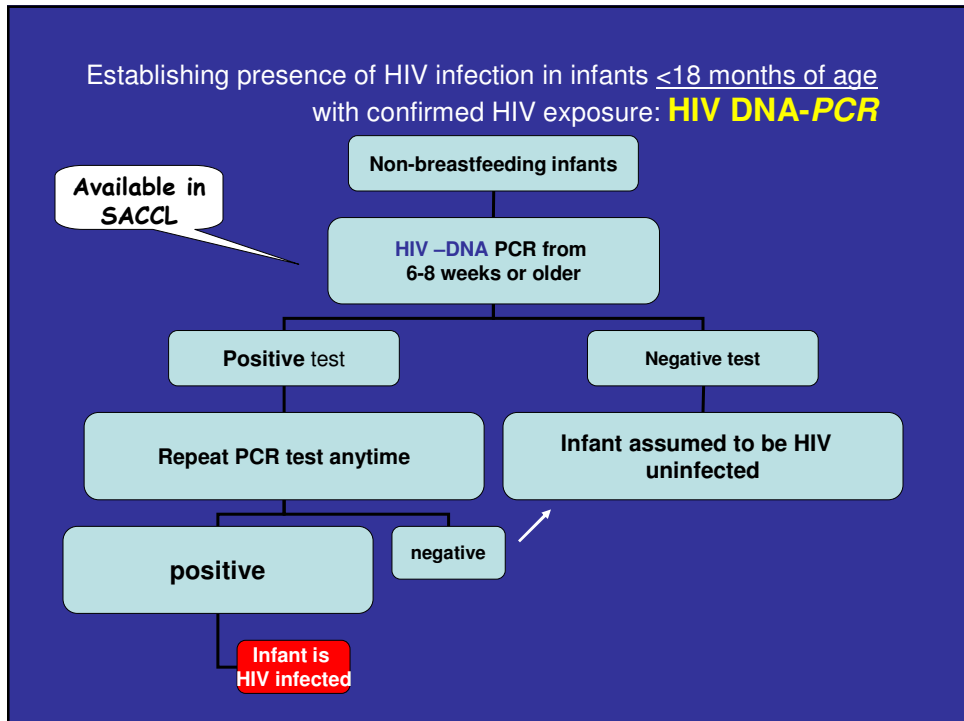
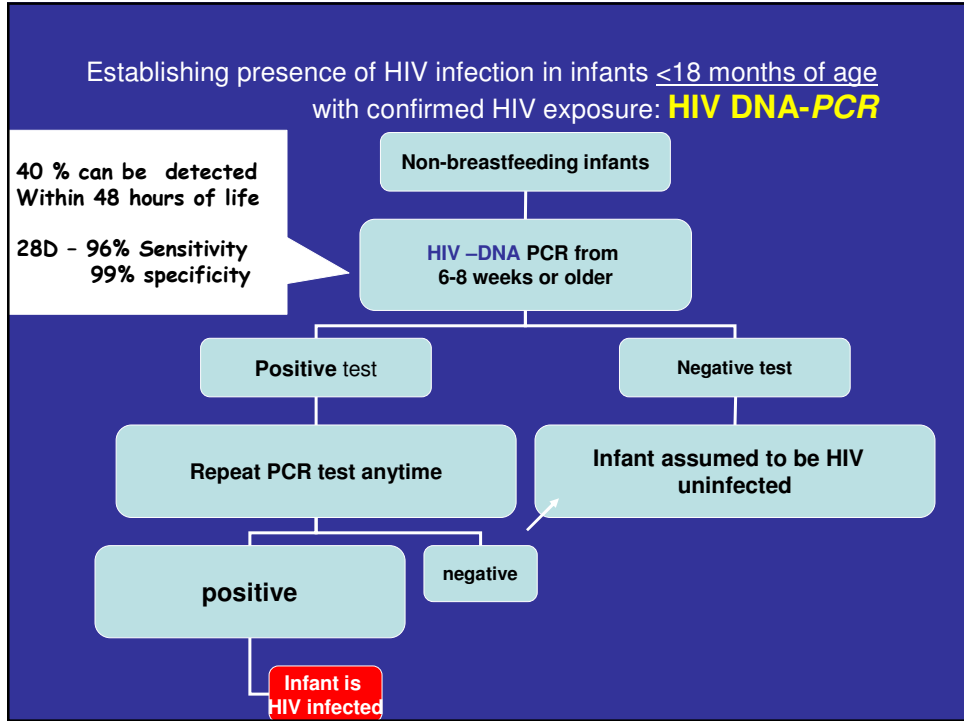
Virologic testing HIV DNA PCR – available at
SACCL in SLH

HIV DNA PCR :

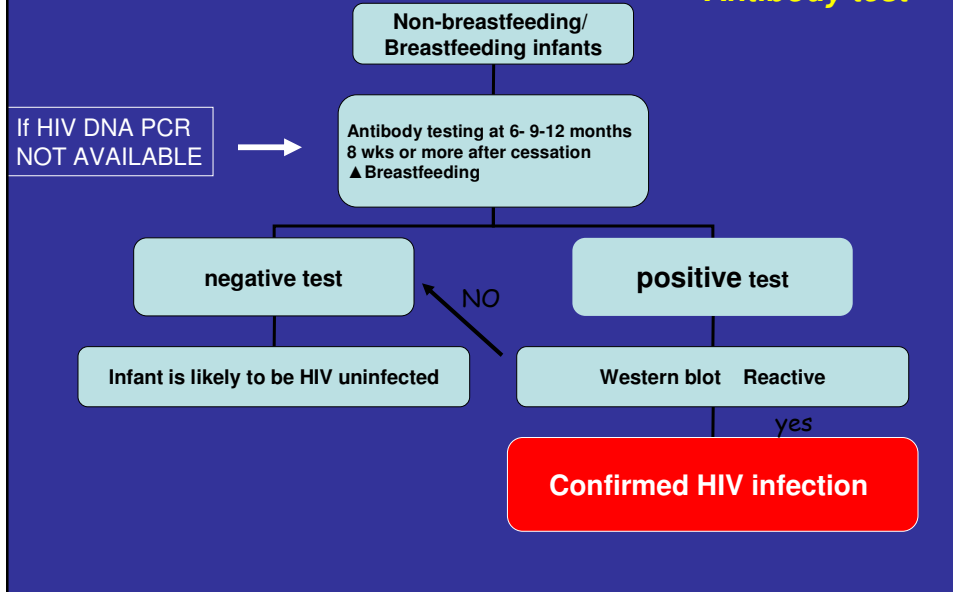
preferred virologic method in infant < 18 months

- HIV DNA PCR - detects pieces of the viral gene that are incorporated in the human blood cell

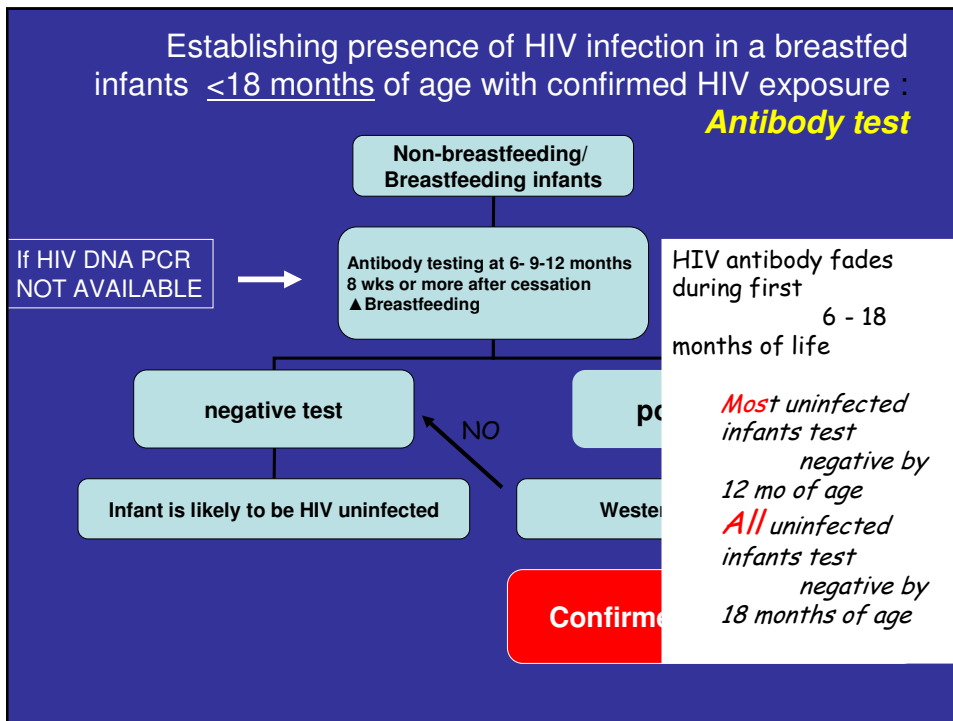
HIV Antibody testing detects the antibody that the body makes in response to the HIV virus



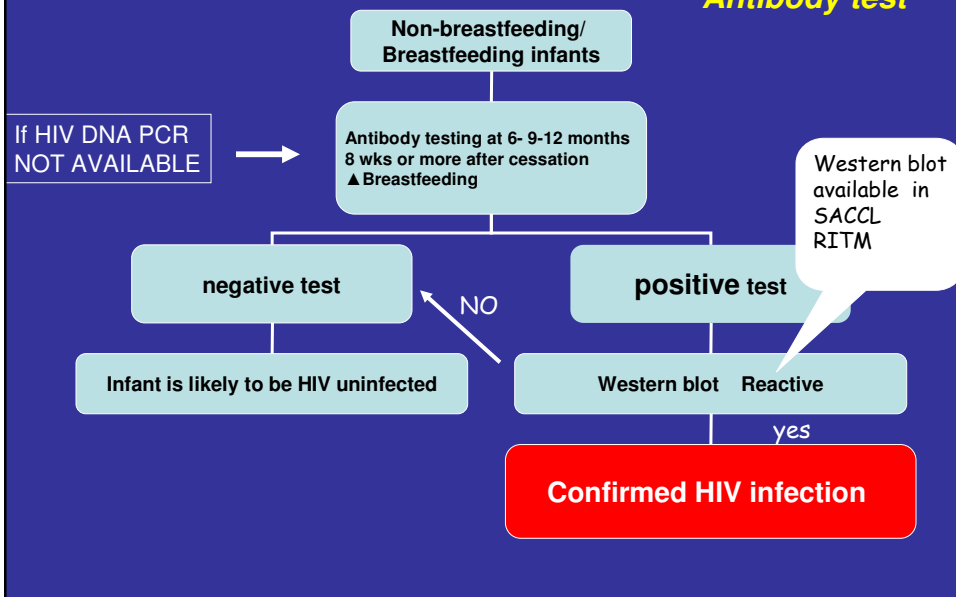
Establishing presence of HIV infection in a breastfed infants <18 months of age with confirmed HIV exposure : **Antibody test**



Establishing presence of HIV infection in a breastfed infants <18 months of age with confirmed HIV exposure : **Antibody test**



Establishing presence of HIV infection in a breastfed infants <18 months of age with confirmed HIV exposure : **Antibody test**



Chemoprophylactic Regimens for Infants Exposed to HIV-positive mothers



- Start AZT within 8-12 hours after delivery
- Dose : 2mg/kg/dose every 6 hours for 6 weeks



- Start Cotrimoxazole on the 4-6th week :
- Dose : 6-8 mg once daily

Cotrimoxazole-prophylaxis

Age	Status	Start	Discontinue
< 18 mo	HIV exposed	4-6 weeks or when 1 st seen	Only if HIV excluded by negative virologic test and mother not breastfeeding >6 months
≥18 mo	HIV infected	with any clinical signs or symptoms suggestive of HIV, regardless of age or CD4 count.	indefinitely where ARV treatment is not yet available. If ARV treatment is being given- stopped once clinical or immunological indicators confirm restoration of the immune system for 6 months or more

Joint WHO/UNAIDS/UNICEF statement

WHEN TO START Antiretroviral Therapy?

1. Age of the child
2. WHO Pediatric Clinical Guidelines
3. Immunologic MARKERS
 - CD4
 - Total Lymphocytes count
4. Psychosocial assessment
5. Co-morbidity



WHO Pediatric Clinical Staging

- For use in those 12 years or under with confirmed laboratory evidence of HIV infection

Clinical Stage	HIV- Associated Clinical Disease Classification
I	Asymptomatic
II	Mild
III	Advanced
IV	Severe

WHO clinical Staging of HIV/AIDS for Children

- Clinical staging 1:
 - Asymptomatic
 - Persistent generalized lymphadenopathy
- Clinical Staging 2: **MILD**
 - Unexplained persistent hepatosplenomegaly
 - Papular pruritic eruptions
 - Extensive warts
 - Extensive molluscum contagiosum
 - Fungal nail infections
 - Recurrent oral ulcerations
 - Unexplained persistent parotid enlargement
 - Linear gingival erythema
 - Herpes zoster
 - Recurrent or chronic upper respiratory tract infection

WHO clinical Staging of HIV/AIDS for Children

•Clinical Staging 3 : **ADVANCED**

- unexplained moderate malnutrition not adequately responding to standard treatment
- Unexplained persistent diarrhea (>14 days)
- Unexplained persistent fever (>37.5 >1 month)
- Persistent oral candidiasis
- Oral hairy leukoplakia
- Acute necrotizing ulcerative gingivitis or periodontitis
- Pulmonary tuberculosis
- Severe recurrent bacterial pneumonia
- Symptomatic lymphoid interstitial pneumonitis
- Chronic HIV- associated disease including bronchiectasis
- Unexplained anemia (<8g/dL), neutropenia (<500/cmm) and thrombocytopenia (<50000/cmm)

WHO clinical Staging of HIV/AIDS for Children

•Clinical Staging 4 :

- unexplained severe wasting, stunting or severe malnutrition not adequately responding to treatment
- Pneumocystis pneumonia
- Recurrent severe bacterial infections
- Chronic herpes simplex infection
- Extrapulmonary tuberculosis
- Kaposi sarcoma
- Esophageal candidiasis
- Central nervous system toxoplasmosis
- HIV encephalopathy

WHO clinical Staging of HIV/AIDS for Children

•Clinical Staging 4 :

- CMV infection
- Extrapulmonary cryptococcosis
- Disseminated non-tuberculous mycobacterial infection
- B-cell non-hodgkins lymphoma
- Progressive multifocal leukoencephalopathy
- Symptomatic HIV associated nephropathy or HIV associated cardiomyopathy

1994 Revised Human Immunodeficiency Virus Pediatric Classification System:
Immune Categories Based on Age-Specific CD4+ T Cell Count and Percentage

Immune category (CD4)	<12 months		1-5 months		6-12 yrs	
	No/mm ³	CD4 (%)	No/mm ³	CD4(%)	No/mm ³	CD4(%)
Category 1: No Clinical suppression	≥ 1,500	(≥25%)	≥ 1,000	(≥ 25)	≥ 500	≥ 25%
Category 2: Moderate suppression	750-1,499	(15%-24%)	500-999	(15%-24%)	200-499	(15%-24%)
Category 3: Severe suppression	<750	(<15%)	<500	(<15%)	<200	(<15%)

•Consider AGE as variable when interpreting CD4 count
 •CD4 absolute count changes with age while the CD4% does not
 •CD4% is a better marker of disease progression up to the 6 years of age

Immunological Criteria in Initiating ART

Recommendations According to Age- related Immunological Makers

Immunological Marker	Age-specific recommendation to initiate ART			
	≤ 11 months	12-35 months	36-59 months	≥ 5 years
CD4 %	25%	20%	15%	15%
CD4 count	1500 cells/mm ³	750 cells/mm ³	350 cells/mm ³	200 cells/mm ³
To be used only in absence of CD4 assays:				
TLC	4000 cells/mm ³	3000 cells/mm ³	2500 cells/mm ³	1500 cells/mm ³

Notes:

- Immunological markers supplement clinical staging
- ART should be initiated by these cut-off levels, regardless of clinical stage; a drop of CD4/TLC below these levels significantly increases the risk of mortality

Recommendations for initiating ART in infants and children according to clinical stage and availability of immunological markers

WHO Pediatric Stage	Availability of CD4 cell measurement	Age specific treatment recommendation	
		<12 months	>12 months
4(a)	CD4	Treat All	
	No CD4		
3(a)	CD4	Treat all	Treat all, CD4 guided in those with TB ^(b) , LIP, OHL, thrombocytopenia
	No CD4		Treat all ^(b)
2	CD4	Close to or below CD4 threshold*	
	No CD4	At or below TLC threshold*	
1	CD4	Only where at or below CD4 threshold*	
	No CD4	Do not treat	

*For CD4 and TLC values refer to table

(a) stabilize any opportunistic infection prior to initiation of ARV therapy

(b) In children with pulmonary tuberculosis, the CD4 level and clinical status should be used to determine the need for and timing of initiation of ART in relation to TB treatment

What to start with Summary antiretroviral drugs



NRTI	NNRTI	PI
Zidovudine (AZT)	Nevirapine (NVP)	Nelfinavir (NFV)
Stavudine (d4T)	Efavirenz (EFV)	Saquinavir (SQV)
Lamivudine (3TC)	Delavirdine (DLV)	Lopinavir (LPV)
Abacavir (ABC)		Indinavir (IDV)
Didanosine (ddl)		Ritonavir (RTV)
Emtricitabine (FTC)		Amprenavir (APV)
Tenofovir * (TDF)		Atazanavir (ATV)

Backbone of management

2 NRTI + 1 NNRTI (or 1PI)



ZIDOVDINE (AZT)
syrup:10 mg/ml
8-15 mg/kdose BID
Or (180-300 mg/m2) BID



LAMIVUDINE (3TC)
Syrup: 10 mg/ml
4 mg/kg /dose BID



NVP(syrup :10 mg/ml)
Induction dose (14 days): 4 mg/kg/day
or (200 mg/m2)
Maintenance dose <8 years: 7 mg/kg 2x/day
≥8 years: 4 mg/kg 2x/day

Backbone of management

2 NRTI + 1 NNRTI (or ~~1~~PI)



ZIDOVUDINE (AZT)
syrup:10 mg/ml
8-15 mg/kg/dose BID
Or (180-300 mg/m²) BID



LAMIVUDINE (3TC)
Syrup: 10 mg/ml
4 mg/kg /dose BID



EFAVIRENZ (EFV)
Capsule: 200 mg Tablet: 600 mg
~15 (10-20) mg/kg/day OD



Currently Available Drugs in the Crossing Borders Project

First line Regimens

Normal Hemoglobin

AZT+3TC+EFV for child more than 3 years old
AZT+ 3TC+NVP for a child 3 years old and below

Hemoglobin Below 12 gm/dl
AZT → Stavudine

Baseline and Monitoring Pediatric ARV

Baseline	On ARV
Confirm dx	-
Clinical stage	Clinical stage
Readiness	Adherence
Concom conditions/meds	Concom conditions/meds
Wt, ht, develop	Wt, Ht, growth, development
Nutritional status	Nutritional status
CD4 (desirable not required)	CD4 q 6-12 mos (or clinical indic)
Hb (esp if on AZT)	Hb (WBC) 1-3 mos post start ARV,
Other lab	<u>Then Sx-directed</u> , eg ALT, lipid, glucose
VL if available	VL if indicated (to confirm CD4 drop?)

Referral



- If facilities are not available in your hospital, consider referring a child suspected to have HIV infection :
 1. For pre and post test counseling
 2. For HIV testing
 3. To access free antiretroviral drugs and free medicines for opportunistic infections
 4. For community based social support program
 5. For further counseling and continuing psychosocial support
- ... coordination through HIV/AIDS Core Team (HACT)

Treatment hubs in the Philippines

- Metro Manila
 - Research Institute for Tropical Medicine
 - San Lazaro Hospital
 - Philippine General Hospital
- La Union (Ilocos Training and Regional Medical Center)
- Cebu (Vicente Sotto Memorial Medical Center)
- Davao (Davao Medical Center)

* Needs coordination with the HACT Team

GFATSI Project Philippines

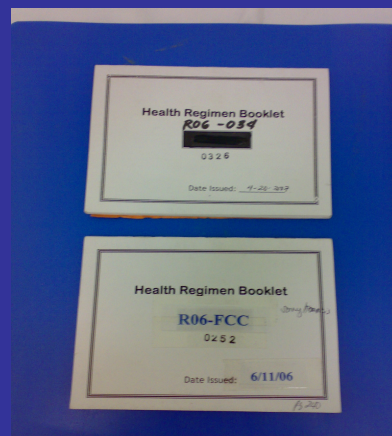
Care and Support Component
GF CS Form 1
ARY ENROLLMENT FORM

Date of Registration: _____

Patient's Hospital Code(s) <small>(Name of Hospital/Department and/or Specialist)</small>		Patient's Hospital Code
1.		
2.		
3.		
4.		
5.		
6.		

Health Regimen Booklet Number: _____

Name:	Identification Number:	
Alias:		
Sex:	Age:	Marital Status:
Place of Residence <small>(Municipality/City/Township)</small>	Birth Date:	Birth Place:
Citizenship:	Referred by:	
	Name of Physician <small>(M.D. Number)</small>	Name of Hospital/DO
	Name and signature <small>of Physician/Health Officer</small>	Name of Hospital
		Contact Number



NASPCP Role in Health Sector: HIV and Children

National AIDS/STD Prevention and Control Program

- Governance
 - Technical leadership
 - Policy development on Pediatric HIV Guideline and PMTCT in 2008
 - Operations of Pilot Implementation of PMTCT (on-going)
 - Trainings for Service Providers
 - Operational Research on the Vulnerability of Children
 - Engagement of Private Sectors
- Regulation
 - Coordination with Reference Labs for HIV testing laboratories

NASPCP Role in Health Sector: HIV and Children

- Financing
 - PhilHealth OPD Package for HIV
- Service Delivery
 - Free ARV and drugs for OI (adult and pedia)
 - Fund allocation for PCR at the NRL-SACCL
 - Diagnostic Services
 - Care and Support Services for PLWH and significant others

Challenges and opportunities

- Challenges
 1. Sustaining the interest
 2. Reaching the children
- Opportunities
 1. Access to treatments
 2. Network and advocates
 3. Valuing family



Lunduyan The situation of Filipino Children affected by HIV and AIDS: a Preliminary Assessment. 2005

The Child's name is

TODAY

**We are guilty of many errors and faults,
But the worst crime is abandoning the children.
Neglecting the fountain of life
Many of the things we need can wait....
The children cannot.
Right now is the time their bones are being formed,
Their blood is being made and
Their senses are being developed.
To them, we cannot answer "Tomorrow"
The child's name is "TODAY"**

Adapted in the Interim Guideline on the management of Pediatric HIV and aids

Acknowledgements

- Drs Dizon and Tactacan – SLH
- Drs. Velmonte, Gonzales, - PGH
- Dr. Ditanco - RITM
- Dr. Gerard Belimac – NASPCP, DOH

... And to all the children , who are our best teachers

