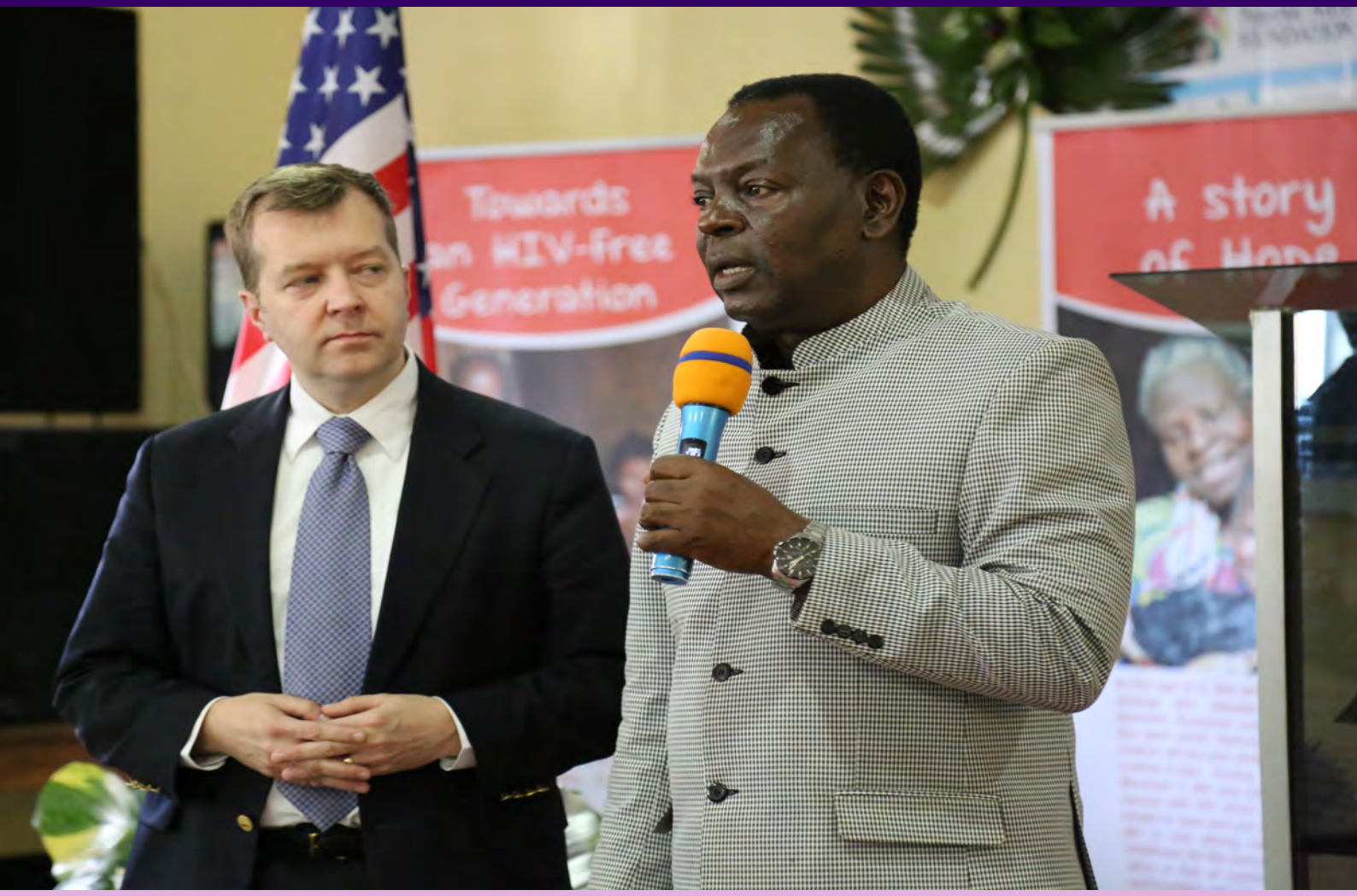
LIHWANGI

Towards An HIV-Free Generation

Vol. 002, Issue 001 July 2017

US Renews Funding for NWR and SWR!



In This Issue

CAMEROONIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS
PEPFAR

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CAMEROON BAP HEALTH 1ST BOARD CONVENTION 1975

PRODUCTION TEAM

HIV FREE II *LIHWANGI* **MAGAZINE**

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WELCOME

GOALS AND STRATEGIES OF HIV-FREE PROJECT

Project Goal: To reduce HIV-related morbidity and mortality for infected individuals through comprehensive, high-quality integrated and innovative HIV testing programs, optimized care and treatment program for adults, children, and pregnant women (Option B+), building on the successes of PEPFAR support in the HIV-Free Project in the NW and SW regions of Cameroon.

- Strategy1: HIV Case identification & linkages
- Strategy 2: HIV Treatment
- Strategy 3: Adherence, and Retention
- Strategy 4: Data Management and Quality Improvement

Cross cutting approaches:

Cross-cutting Implementation Approaches: Coordination and joint supervision
Promote Task shifting and onsite mentorship.
Support MOH in Test and treat policy and community dispensation of ARVS.

With initial focus on the Northwest and Southwest, these strategies and approaches will the attainment of the following specific objectives:

1. Increase HIV case identification to identify 90% of those living with HIV, linkage to care and treatment, and 90% ART coverage of HIV infected adults, pregnant women, and children in health facilities and communities.

2. Improve adherence support, retention in care and viral load uptake to achieve 90% VL suppression for HIV infected adults, pregnant women and children.

3. Improve M&E systems and promote the use of strategic information for program improvement.

4. Strengthen the health system to support delivery of high quality and sustainable HIV related services within facilities and communities.

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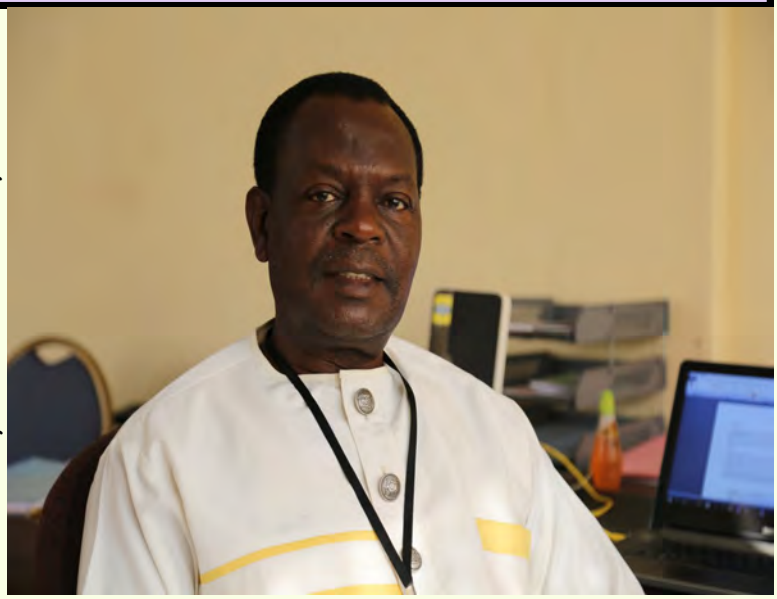
EDITORIAL

Prof. Tih Pius Muffih

Principal Investigator



CBCHS's successful implementation of HIV- Free Project phase I (from 2011-2017) was somewhat a premonition for another opportunity for CBCHS and partners to implement HIV-Free Project II which indeed is a logical flow from efforts to increase and improve access and quality of PMTCT of HIV and AIDS (phase I focus) to improving HIV Care and Treatment (phase II focus).

Yet, the transition was not as easy as every onlooker would have imagined. The Notice of Award opened the doorway for yet a series of CDC requested revisions to be made on the initial project proposal which CBCHS and partners had submitted months earlier. By the end of this revision, project activities, geographical coverage and budget were fundamentally revised to align with COP 2017/2018, PEPFAR pivoting and strategic requirements. Finally, HivF Project II came and implementation began on April 1, 2017. By signing the contract papers CBCHB indirectly committed to deliver the expected results within the five year project period. Since April 1st , the CBCHS team has been on the move; holding meetings at all levels, setting up management structure for the new Cooperative Agreement, refining strategies and allocating resources as necessary- all this to ensure a smooth take off, effective implementation and the attainment of key project targets.

On its part, the project communications team also organized itself to provide adequate support in terms of "information" to the foot soldiers (field staff) on the ground. Although the idea of a monthly project newsletter to update staff, partners and stakeholders on implementation may seem a spill over from phase 1, the content of the current eNewsletter designed for the SWR has been profoundly adjusted to align with the current project laydown and implementation strategies. At face view, the name will strike you. LIHWANGI (meaning "race" in Mopkwe- Bakweri), translates our ambition to speed up implementation in a tireless manner until the finish line (target results). In terms of content, there is a major shift from a purely news gathering and sharing approach that characterized HivF Project 1 eNewsletter. The present E-Newsletter uses strategy/result oriented reporting and is designed to have a lighter content that is informative and entertaining at same time which allows readers to go through in a "Lihwangi" manner grabbing the essentials of the project implementation and progress towards targets as the months unfold. *On the field, Practices, My story, Role Model* and *Discovery* are columns that will take you "lihwangilike" into daily project happenings, the heart of local Cameroonian communities in a way that you will feel like you were there. Our column on *Role Model* helps readers to discover some faces behind the names and to know some of those movers and shakers; those uncelebrated icons and heroes who often work behind the scenes to push the lines.

Take the appointment each month, for *lihwangi* and be a part of the race towards an HIV Free Generation in the Southwest Region.

Enjoy reading! ********

ON THE FIELD

On Your Mark, Set and Go!

The official kick off of HivF II was on April 1, 2017 although effective start on the ground only began in May due to prolonged consultations with CDC. In the SW, it can be said that the race towards the targets actually took place on May 25 when the Business Official and the Program Analyst held a meeting at HSC in Mutengene to orientate all project staff on budget allocations per activity and also on requisitions, spending, purchases and reconciliation policies to be followed under the new award. This was to ensure strict respect of the budgetary allocations and that spending is consistent with EA principles and requirements.

On the same occasion, all staff engaged under HivF II in the SW were reminded of their job descriptions and their effectiveness at work. As the BO emphasized during this kick off meeting, schooling staff on available funds, how to make requisition, spend and reconcile project money and for all staff to have clear job descriptions of their assignments limits conflicts, unnecessary delays in accomplishing tasks which always contribute to poor realization of targets. Now, the race is on…….

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HivF II Determines Site Level Baselines for Better Allocation of Resources, Strategies and Performance Tracking

An effective race requires two great basic markers; the start and the endlines. In projects, these represent the baseline indicator and target respectfully. Under the HivF project, the funder-CDC sets the targets to be reached within the period of the award. At the time of this target setting only a faint idea of the real situation on the ground (i.e. all 56 sites in the SW) was known. It was thus imperative for the team to have a true picture and temperature (indicator level and challenges) of all the sites in order to determine clearly how much energy (resources) will be needed where and for what volume of target to be realized. In May, the different supervision and technical teams which were constituted earlier for this daunting task finalized their work. It should be noted that the teams used the comprehensive SIMS tool and the longitudinal site monitoring tool developed and introduced by CDC in HivF I to establish those baselines for each sites to be supported. The baseline report that was produced was then used to allocate resources including staffing, set up teams and to develop site level strategies such that specific site needs area addressed. The report is now being used to track site performance each month.

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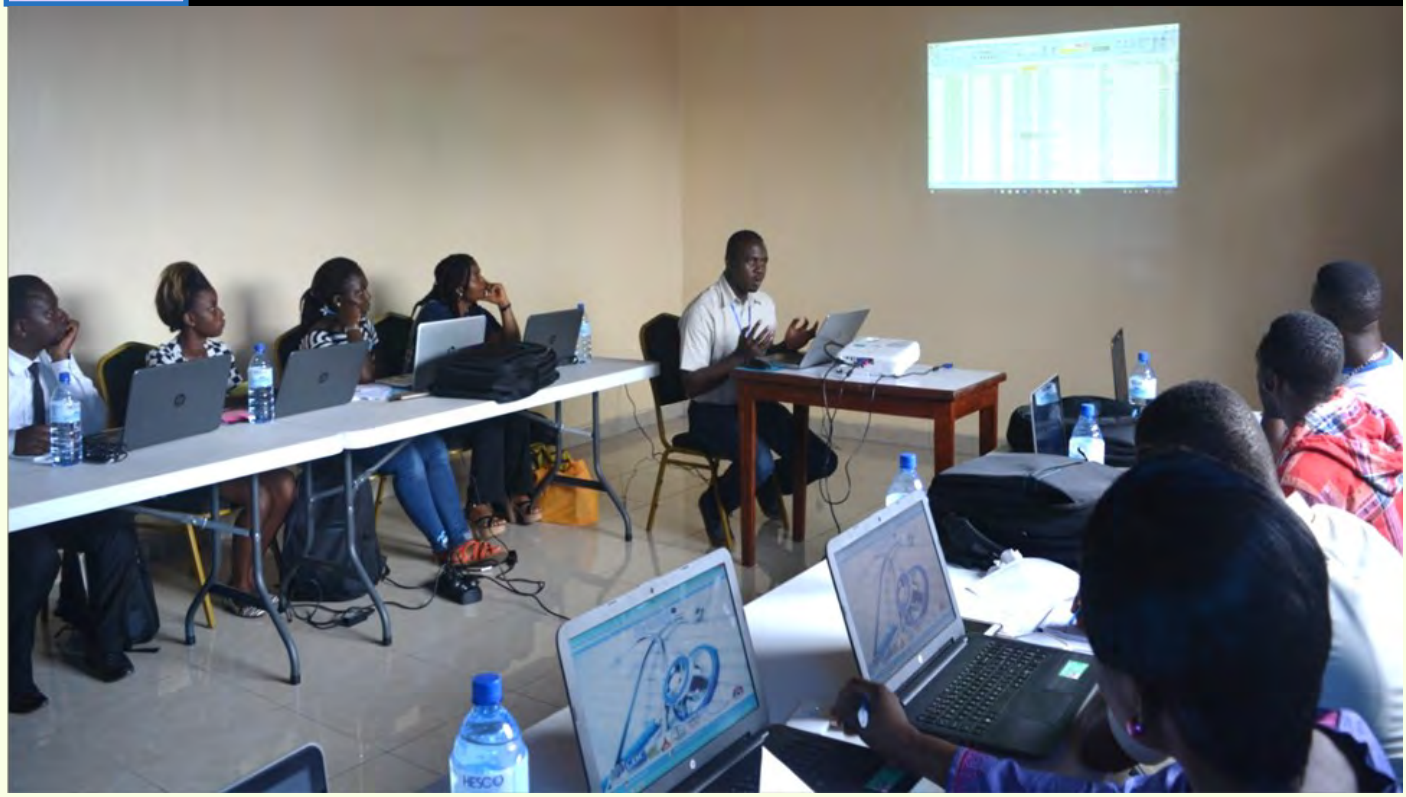
DAMA Set to Report Site Level Results

Timely reporting is important in that it makes available critical information which is used for timely decision. Under HivF I, the project struggled to improve PMTCT reporting by working with government to strengthen the reporting system and tools. A major breakthrough in CBCHB's effort to improve reporting was the introduction of the CBCHB developed Data Manager (DAMA) software for timely reporting of site level results. In the SW, the training and installation of DAMA was done at five pilot sites namely; Limbe Regional Hospital, Baptist Hospital Mutengne, Regional Hospital Buea, District Hospital Kumba and Presbyterian General Hospital Kumba.

With the need to increase reporting under HivF II,

ON THE FIELD



DAMA Designer Presenting on New Software Features

DAMA clerks from the 10 pilot sites met on June 9, 2017 at HSC in Mutengene to review the effectiveness of DAMA by comparing the data as reported on DAMA with the data from the site statisticians' reports. The team also reviewed DATIM indicators and reporting tools.

To further make DAMA effective for timely reporting of site level results, some new features were added. These include Excel export functions, management of differences in reporting calendars, and the offline version of DAMA, and HTC reporting by entry point.

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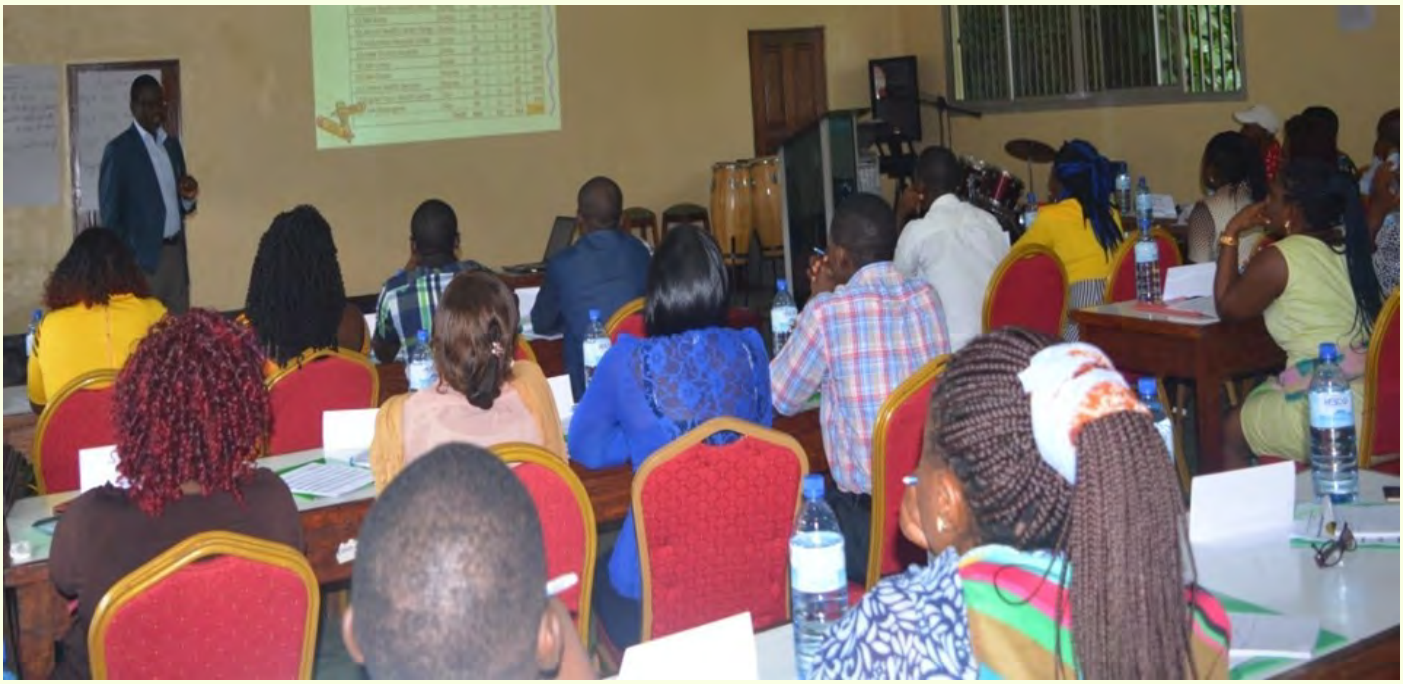
PRACTICES

More C&T Sites To Increase Treatment Access And Adherence



Dr. Atanga Pascal showing the treatment gap in the Option B+ sites

A major impediment for C&T uptake and adherence has always been the huge distances between the clients and the points of dispensation. Until the close of HivF I, C&T centers were few across the SW region thereby compounding the challenge of access treatment and adherence for many especially those clients in far off communities who needed to incur huge cost in transportation to and from the dispensation point each month. And because fewer C&T centers existed, referral became a common practice and this increased rates of clients being Loss to Follow up (LTFU).

CBCHB's continued advocacy for more C&T sites led to government upgrading some sites in SW to full C&T sites where all those who test HIV positive can be initiated in line with the new country guideline that prioritizes PITC and *"Test and Start"*. Of the 13 sites that were upgraded to full C&T sites were hitherto option B+ sites. To ensure quick start, quality and consistency in

New Care and Treatment Centers in SW

S/N	Facility	District
1	Buea Road Integrated Health Centre	Buea
2	CMA Muea	Buea
3	Mount Mary Catholic Hospital Buea	Buea
4	Baptist Health Centre Kumba	Kumba
5	CMA Ntam	Kumba
6	Catholic Health Centre Fiango	Kumba
7	Presbyterian Hospital Limbe	Limbe
8	Presbyterian Hospital Limbe	Limbe
9	CMA Limbe	Limbe
10	CMA Ekona	Muyuka
11	Calvary Health Services Muyuka	Muyuka
12	Regina Pacis Health Center Tiko	Tiko
13	CMA Mutengene	Tiko

practice across all 13 new C&T sites, HivF II conducted a four day training for the key site staff. This was an opportunity for the staff to be drilled on the use of tools and learn how to properly document for reporting. These additional HIV Management Units are expected to significantly increase treatment uptake and improve adherence.

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HivF SW II Uses Supervision and Technical Team Approaches to Improve Implementation

In HivF I, CBCHB adopted an approach which consisted in breaking the regions into coordination area and stationing coordinators to ensure the day-to-day activity implementation including supervision and follow up. This approach was favorable for the PMTCT improvement and scale up which was the focus of HivF I. With the CDC/PEPFAR pivoting to care and treatment and with some sites being Direct Service Delivery (DSD) sites while others are merely Technical Assistance (TA) sites, it became necessary to put in place an implementation approach that meets current expectations. Under HivF II, supervisory teams have been set up in lieu of the coordination teams to ensure the day-to-day implementation and follow up of activities at all sites including TA sites. To further boost the teams, three technical teams (teams 1, 2 and 3) have also been put in place made up of clinical mentors (leader and assistant), linkage nurses and an M&E staff. The clinical mentors provide information and assist with service delivery, onsite training etc. On their part linkage nurses ensure that all those that test positive at all entry points are linked to/initiated on treatment/ and remain in care. In collaboration with C&T staff, they also follow and bring back to care all clients who are loss to follow up or who have missed appointment. They thus have a daunting task to the achievement of project targets. The technical teams meet regularly to think and rethink strategies for the supervision teams to implement.

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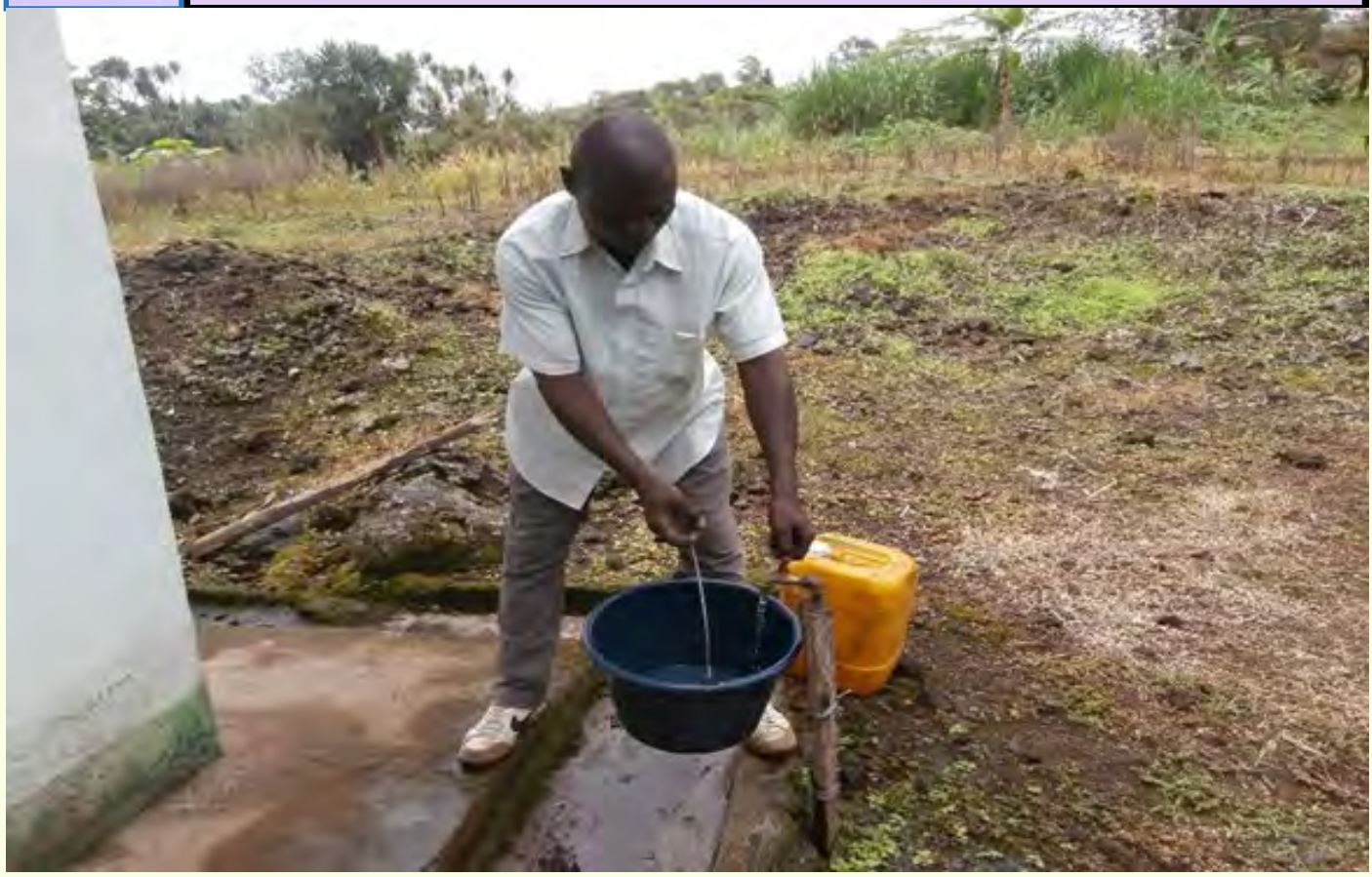
Activities Improve Health Facility Situations: The Case of Muabi Integrated Health Centre

It is estimated that over 60% of Cameroon's healthcare is provided by the state. Thus, government is expected to create, construct, equip, man and manages its health facilities in a manner consistent with standards. Unfortunately, due to limited resources many government health facilities often fall below the required standards be it in terms of infrastructure, staffing, equipment/input, service delivery or management.

Through the Local Capacity Initiative (LCI) sub component of HivF I, CBCHB has been capacitating local communities to take ownership and leadership in the running of their health facilities as a way to close critical health facility gaps. Using 5 health districts in the region, CBCHB successfully piloted the LCI. This led to the revitalization of the health dialogue structures (provided by policy), development of tools and other aids to enable them to better perform. Most importantly, the health dialogue structures were capacitated to mobilize resources locally in multiple ways to improve the functioning of their health facilities. This led to the LCI providing capital for the dialogue structures to carryout Income Generating Activities (IGAs) to raise resources to support health activities. The case of Muabi Integrated Health Centre is just one in point which shows how communities can use little to improve healthcare delivery.

Muabi IHC in Bangem Health District created in 2011 operated from a temporal a 'calaboot' (wood) building until 2013 when services were moved into the newly government constructed building after

PRACTICES



Community Member Making Use of the Clean Tap Water in Muabi Health Center

handing over to the community. The facility lacked essentials such as electricity and water since the work areas had mainly wash hand basins some of which stopped flowing.

"Lack of water at the new premise was a real night-mare. Staff and caregivers had to trek long distances to get water especially in the dry season when most water sources run dry." Mr. Ekane Felix, The Chief of Center.

When the health dialogue structure received a financial support of Fcfa 40000 to embark on the cultivation of maize as their IGA, few could believe that such meagre amount would bring any meaningful change to a health facility so desperate. Against all expectation, the dialogue structure was able to organize itself to cultivate and three months later harvested, marketed the maize and made profit. Part of this profit (FCFA 34 000) was used to purchase pipes and pay labor for water to be extended to their new facility.

"This is a great breakthrough. Work is now safer, faster and easier ever since we have a running tap at the Health Centre. The tap also serves the community;" Chief of Centre.

This singular act has improved quality of service delivery in Muabi IHC as well as quality of life of the population around the facility. This former can be evidence from the increased ANC uptake in the facility which moved from an average of 1 ANC client to 4 ANC clients per month in corresponding periods. The case of Muabi is only one of the many positive changes that are now being reported across LCI districts where profit from IGAs are helping to improve quality of infrastructure, staffing, equipment/input, service delivery and facility management situations.

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MY STORY

The High Cost of Ignorance

"Growing up, I knew child birth could take place anywhere even in the house. That it depended more about where labour started. This is what I saw my mother do".

Sarah stated firmly while luring her 4 year old to sleep. At 33 and mother of 3, Sarah only learned about the virtues of ANC on February 28, 2013 and at a very high cost.

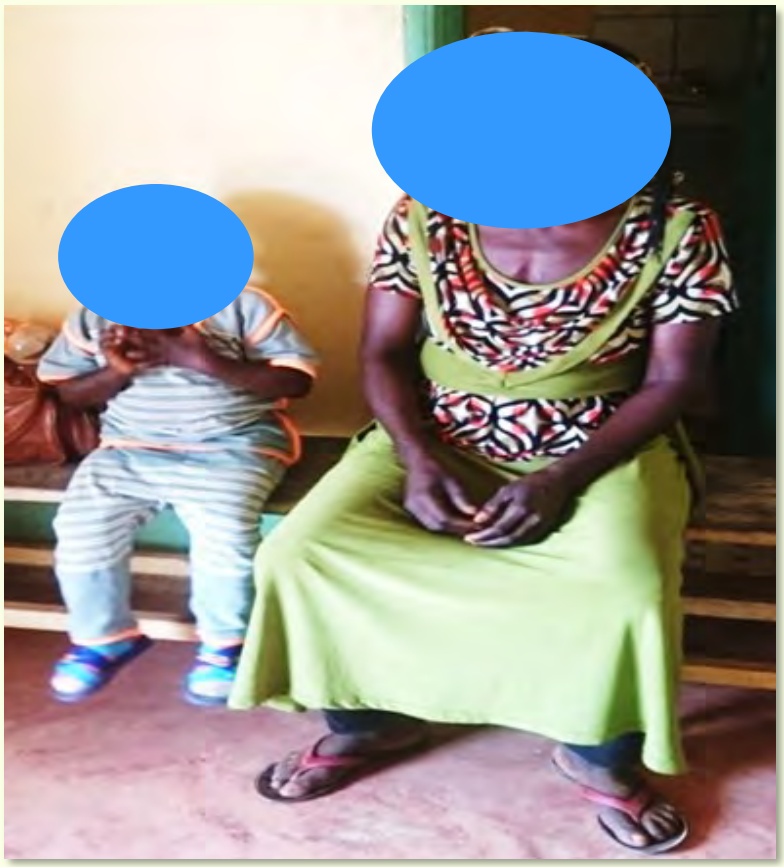
The setting was the far off remote community of Kumbe Balue while the occasion was an outreach jointly conducted by CBCHB and the Kumbe Balue IHC. Met on this occasion, Sarah confessed never hearing about HIV and AIDS before in her 33 years of life and also never attending any ANC during any of her pregnancies since she did not know about it after all.

On the same occasion, Sarah decided to attend her first ever ANC session in life and opted for an HIV test also for the first time perhaps; more for curiosity sake. Behold, Sarah tested positive and weeks later her 11 month old baby was also found to be living with the virus- acquired from the mother.

*"I asked the doctor if I will die and She told me that I will not die if I take my drugs and do everything as I am told to do ."*Sarah asked in a trembling voice.

At first, Sarah was hesitant to be on any medication partly because of the cost involved as she needed transportation to go to the nearest C&T in Ekondo Titi where she was referred. Today, Sarah and her son are both on treatment thanks to the follow up for initiation by HivF project staff. Sarah's son is now 4 years old and will have to leave with the virus all his life. At the moment, the child has been enrolled in the child Play corner in Ekondo titi District Hospital for better quality pediatric C&T services.

Sarah's story speaks volumes about our local communities. In as much as in towns we may have



the impression that a lot of education and sensitization is being done on HIV and AIDS and related topics such as ANC, many in our remote backyards still die in ignorance. We must keep on with the race!

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ROLE MODEL

Dr. Mbome Njie Victor

South West Regional Delegate of Public Health

He is an exemplary husband, father, a well experienced public health fellow and frontline HIV and AIDS fighter. We are proud to present to you the one man behind the health wheel in the SWR. Welcome our icon of the month Dr. Mbome Njie Victor, present Southwest Regional Delegate For Public Health.

Dr. Mbome Njie Victor is quickly remembered by many for championing the creation of the first ever and lone HIV C&T center in the South West Region; while serving as Director at Limbe Regional Hospital before his appointment as SW Regional Delegate for Public Health. This son of Bokwai village was born in August 1959 and attended primary education at Cameroon Baptist Mission (CBM) Primary School. Upon completion, he schooled at CPC Bali, and CCAST Bambili from where he proceeded to Nigeria for further education and graduated as a Dental Surgeon in 1986. In 2007, he obtained a Master of Science in Public Health from the University of Leeds in the UK among other Diplomas in different health domains.

Our Icon started his medical career in 1986 at Bafia District Hospital in the Centre Region before proceeding to Bamenda and Limbe Regional Hospitals where he continued to serve as a Dental surgeon prior to his appointment as the Medical Adviser to the Limbe Regional Hospital. Between 2003 and 2012, he served as Inspector of Health Services at MOH; and the Director of the Regional Hospital Buea prior to ascending to his current position. His passion, humility and great leadership qualities have earned him other calls to serve and several recognitions at home and abroad. Dr. Mbome is a crowned Knight of the Cameroon Order of Value; an elitist state distinction reserved for a select few who have demonstrated outstanding service to the nation.

As Regional Delegate, Dr. Mbome has continued to impress by his soft leadership approach to drive a health system made up of 18 health districts marked by so much diversity and complexity. History will have it that it is under his leadership as Regional delegate that the region witnessed one of the most significant drops in HIV prevalence from 8% to 5.7% (until 2011 demographic assessment) . When quizzed on his secret for all his successes, Dr. Mbome- in his characteristic humility attributes all his professional prioress to his immediate collaborators, colleagues and the huge support from his family; especially his prayerful wife.

Dr. Mbome is a committed Christian who believes that all he is and has comes from God. He is an elder and current Church Chairman of Emmanuel Baptist, Bota in Limbe. Quizzed on his secret to good health, He indicates that he avoids excesses and spends most of his leisure time at home with family or alternatively in church. As concerns out of job time, Dr. Mbome is particularly passionate about his hobby which is sports especially football and table tennis. No doubt therefore why in his house each person has their own champions' league team they support and endless debates are held each day especially on game days on which team is stronger to fun-fill family time.

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DISCOVERIES

The Hanging Bridge

Hanging Bridge Over River Mungo in Konye Health District

Movement in most rural communities in the SW is not easy due to lack of access roads. For instance in the health districts of Wabane, Bangem, Konye, Ekondo Titi and Mundemba, hanging bridges are 'en-vogue'. Hanging bridges are initiatives from the riverine populations to bring solution to their movement challenges. They are built using local materials usually above high tide water bodies. Crossing on a hanging bridge requires extradose of courage and so good for lovers of breath taking sports and adventures given their dangling nature. Paradoxically, hanging bridges remain the "safest" and often the only route by which population and health staff access health care units in some communities of the SW. This has made feeble hearted community members who cannot brave the odds to stay away from health facilities thereby forging unorthodox health practices in their respective communities.

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SET FOR THE 90 90 90 AGENDA—VISION 2020

CBC HEALTH BOARD

"We are improving on services but only you can improve on your health"

Prof Tih, Project Principal Investigator.

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