LIHWANGI

Towards An HIV-Free Generation

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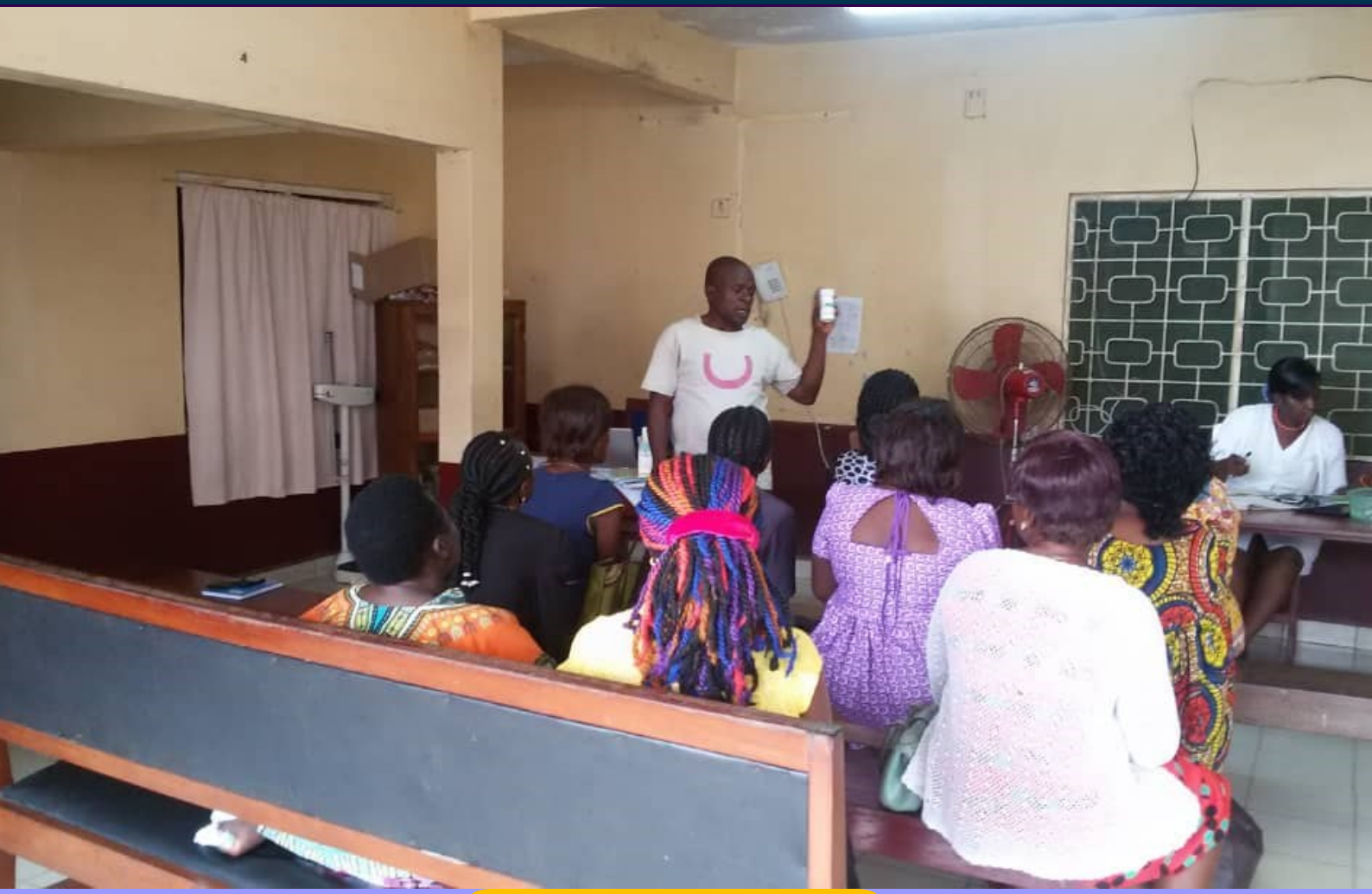
DIFFERENTIATED CARE MODEL IN HIV SERVICE DELIVERY



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HIV FREE SW II LIHWANGI NEWSLETTER

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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.

Strategy 1:
HIV Case identification & linkage

Strategy 2:
HIV Care & 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.

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

1. Increase HIV case identification to diagnose at least 90% of those living with HIV, link to care and treatment, and ensure 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.

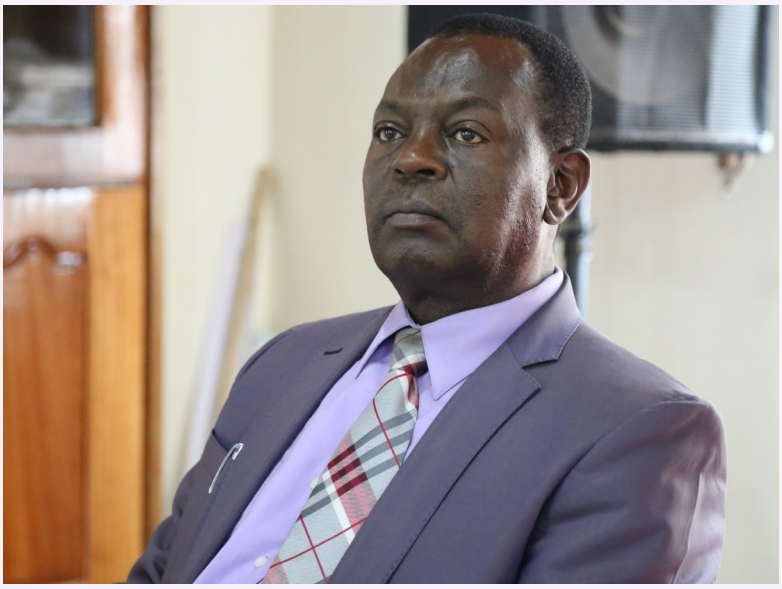
3. Improve M&E systems and promote the use of strategic information for program improvement.

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

EDITORIAL

Prof. Tih Pius Muffih

Project Principal Investigator



The last three months have been one of the most challenging periods ever experienced by the HIV Free NW/SW II Project since its start on April 1, 2017. Our result was way below expectation which raised a lot of eyebrows vis-à-vis our project implementation. Despite these challenges, our stance "On the road to 90-90-90" has not and will not be moved. We must not lose track of the goal we are fighting to achieve, which is to eliminate HIV from the public health challenges classification table by 2030 as we for sure will attain UNAIDS Vision 95-95-95. "The Problem Child" – Retention was our major setback during the International AIDS Conference in Johannesburg South Africa. Our retention rate as was x-rayed on the presentation stood at 32% (RED); very far below expectations from the CDC because it implied that we are not on a good footing for epidemic control if we keep losing clients from treatment. We were then asked to account for the thousands of clients we have lost to follow up and those who defaulted treatment.

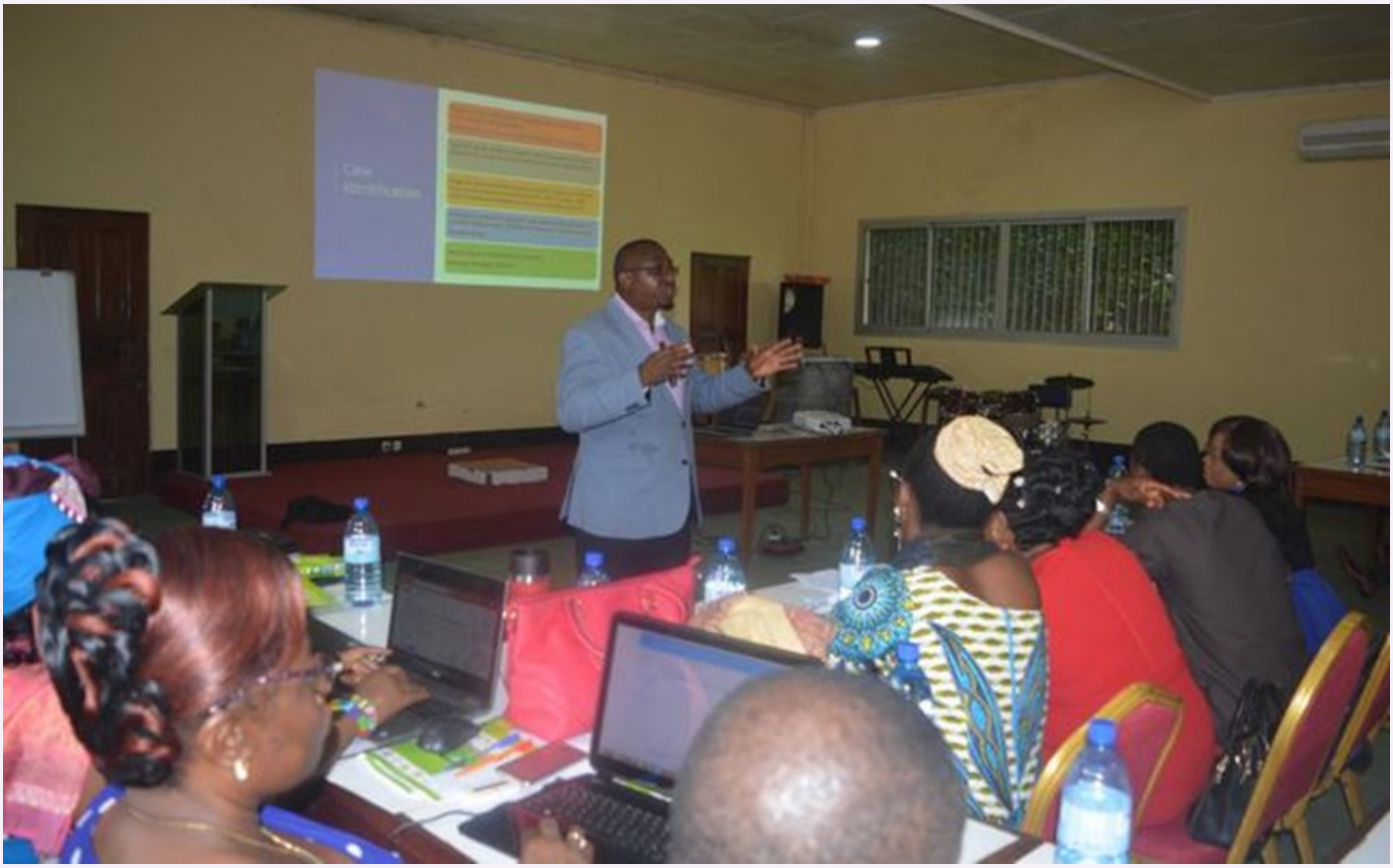
Though accounting for the lost clients was not going to be any easy, we had a limited duration of barely two weeks to attain green on the classification table. It is for this reason that we activated the "Aggressive Follow-up" as the major strategy to ensuring our ability to find and bring back to treatment with the ART Register being our major source of information. The fallouts of the Problem Child were NOT going to affect only the CBC Health Board alone, but other organizations benefitting funds from CDC/PEPFAR. To attain our goals, we spent the Easter Season at our places of work and achieved our targets with an 86% (GREEN).

As you already know, the next six months are going to be more demanding than you have already experienced. One of the fallouts of the Problem Child on us was the division of the 10 regions of Cameroon into zones including; Zone 1 (North West, South West, and West Regions); Zone 2 (Littoral and South Regions); Zone 3 (Center and East Region); Zone 4 (Adamawa, North and Far North Regions). CBCHB remains the implementer for Zone 1 while EGPAF remains in Littoral and will be taking South Region. The implementer for Zone 3 is not yet decided while Zone 4 is going to be by some American Non-Governmental Organization. The work we do within this period is going to determine the fate of our services in the Center and East Regions. It is for this reason that I launched "Operation ALL Green (OAG)" for ALL our 6 indicators. This strategy is meant to end on September 30, 2019. To effectively track this strategy, we are going to have weekly review meetings known as "Situation Room". We are expected to reach epidemic control with the zone 1 project in 2 years; and I'm confident we will achieve this. Let me end by wishing you a very fruitful Easter Season as you take the rendezvous with me to impatiently wait for more updates on the Lihwangi E- Newsletter.

Enjoy reading …!

ON THE FIELD

Smart Strategies Prescribed in Attaining Target for Q4



Technical Director Dr. Albert Bakor highlighting on 'Smart' strategies to be implemented in Q4

The HIV Free Project Technical Director, Dr. Albert Bakor has prescribed 'Smart' strategies for the attainment of project targets in Quarter 4 of financial year 19 (FY19). Dr. Bakor was talking to HIV-Free SW project staff during Quarter 3 (Q3) coordination meeting that took place on August 2, 2019 at the CBC Health Services Complex in Mutengene. From the presentation of Q3 results there was a general improvement in the attainment of targets although not meeting the desired outcome. For instance, there were gaps noticed in HIV testing especially between the positive cases and those initiated on ARV treatment. At the end of Quarter 3 with an annual target of 149,492, the SW has so far achieved 99,171 given 66% instead of at least 75%. Still -on annual positive target of 10406, some 3,303 persons were tested positive with only 32% by Q3. Out of the 3,303 tested positive, only 2,803 persons were placed on ART giving an ART initiation rate of 85%. Meanwhile with an annual target of 9,737 to be initiated, 2,803 have been achieved being 29% achievement rate.

It is from this premise and other key indicators that the Technical Director outlined Smart strategies which centered on case identification, treatment initiation, retention, viral load suppression and performance monitoring. He noted that for project staff to be more efficient in Quarter 4, they must work hard and work smart. Some of the Smart strategies were to, focus on index testing with keen interest on sexual contacts of newly diagnosed clients, contacts of patients with unsuppressed viral load, test sexual contacts of key populations, strategize to test all contacts of index cases already elicited and notified,

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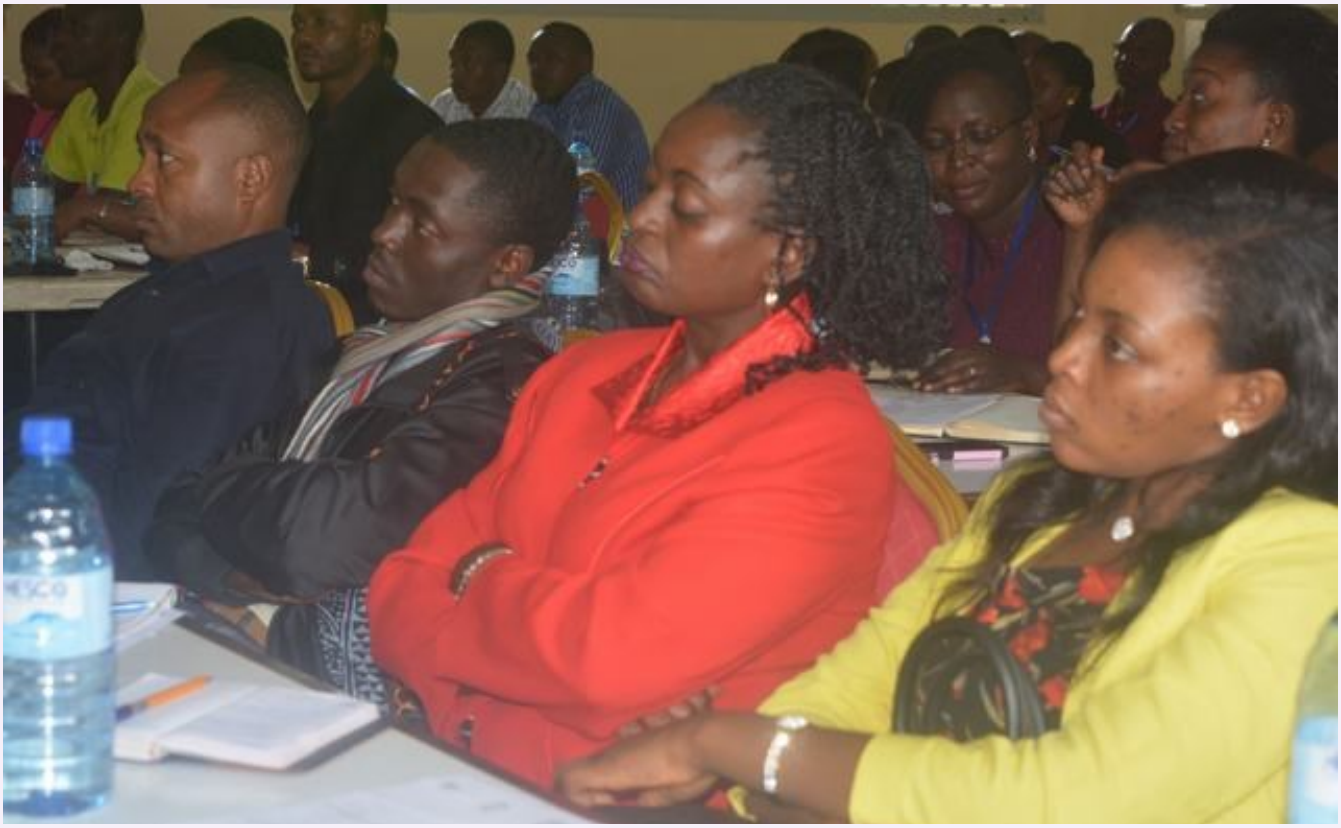


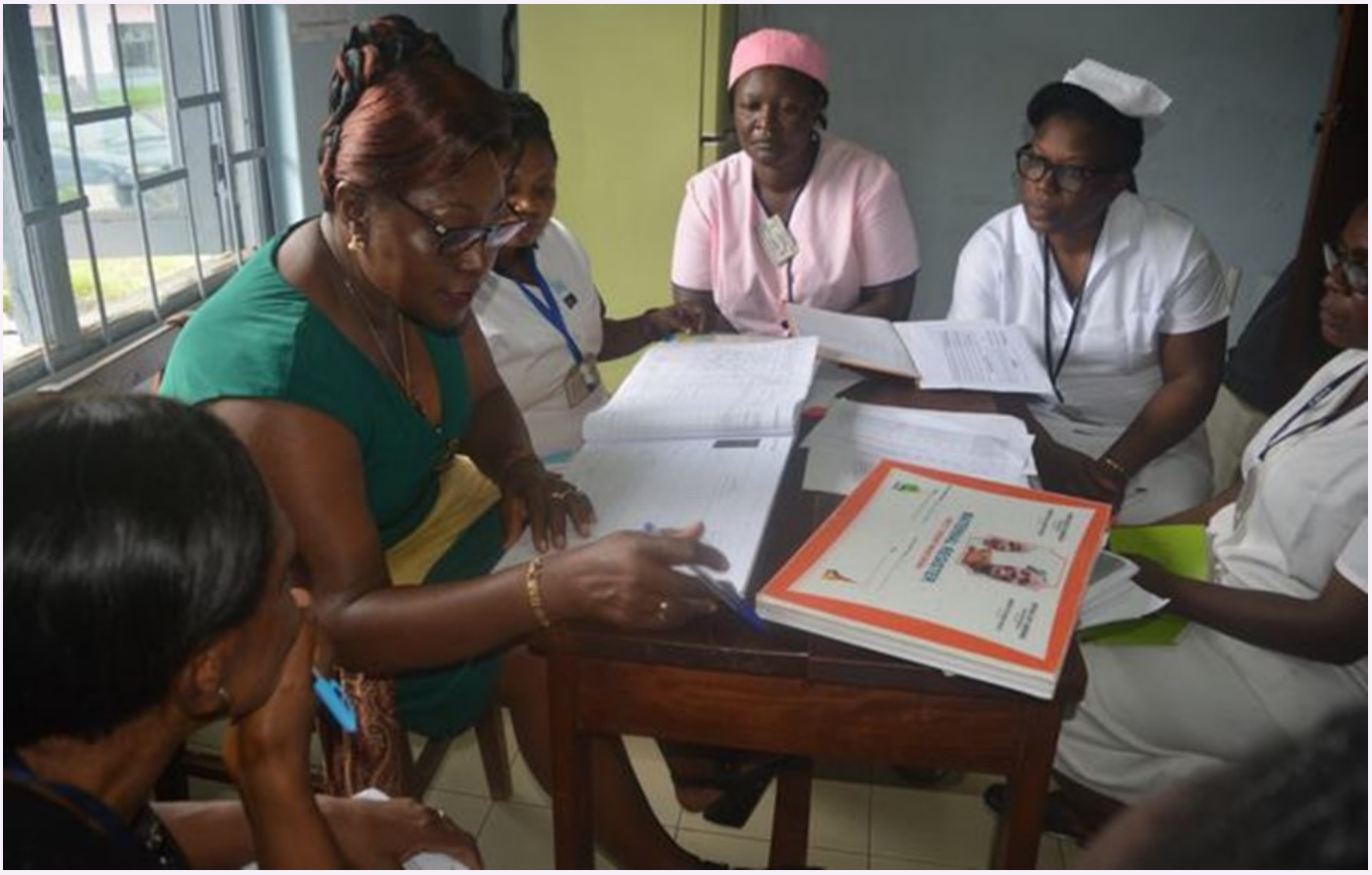
Cross Section of staff at the Q3 Coordination meeting

identify entry point and linkage agents with challenges and support them to improve performance. The treatment retention improved from Q1 to Q3; in Q1, the retention was -134%, 51% in Q2 while in Q3 it experienced a sharp increase to 135%. Observing improvement in retention he urged staff to continue to implement the strategies to improve Retention and turn all the 'reds' to 'greens" for some specific sites. To ensure that clients are on treatment and current in care, it was emphasized that clients who come in the month should be refilled for at least two months if ARVs are available.

COP19 Strategic Direction Orientation come October was another highpoint of the meeting. Some issues discussed were on feedback on PMTCT Cohort Monitoring facilitative supervision in SW and integration of some AIDS Care and Presentation Programmes in HIVF, the novel approach to index testing: the anonymous index Case. Salient information and strategies were all to make work better and attainment of desired outcome. *****

ON THE FIELD

First Central Level Facilitative Supervision on PMTCT Cohort Monitoring in SW



Dr. Tumasang checking Infant Cohort Register at Regional Hospital Limbe ANC Clinic

The Senior Supervisor for Family planning and PMTCT Services Dr. Florence Tumasang has embarked on a two-day facilitative supervision on PMTCT Cohort Monitoring in some facilities in the SW region. Being the first central level supervision, some four sites; Regional Hospital Buea, Baptist Hospital Mutengene, Regional Hospital Limbe and Tiko Central Clinic/CDC Cottage were visited for the exercise from July 31-August 1, 2019. The Senior supervisor was accompanied by the HIV-Free SW PMTCT Cohort Monitoring Focal Point, and the M&E Supervisor. The objectives of the two-day facilitative supervision were to check the availability of Standard Operating Procedures (SOPs), enrolling women and children into the different cohorts, the implementation of the new viral load algorithm for pregnant women, the viral load coverage, collection of PCR samples and the availability of PCR results in the register and client's file.

Giving feedback on the supervisory visit, Dr. Tumasang said she was impressed with the fact that all trained service providers met at the facilities know the objective of the approach which is to ensure babies born of HIV positive mothers are negative for HIV at the end of at least 18 months.

Given that the risk of transmitting HIV is much more reduced when a client is virally suppressed, Dr. Tumasang stressed on the need for the mothers to do viral load test, ensure proper counselling for adherence and enhanced adherence counselling for those whose viral load are unsuppressed. Of the four sites visited Baptist Hospital Mutengene was noted to be the best in terms of performance.

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Some lapses noticed in the facilities visited called for a reminder and orientation on how to effectively implement PMTCT Cohort Monitoring. For example, viral load uptake for the pregnant women was practically empty, poor documentation and gaps in the PMTCT Cohort Monitoring register, ANC and labour and delivery registers. To improve on activities in the field, the senior supervisor recommends close supervision for all sites, enlisting and follow up of women to do viral load, reorganization to have access to EID services for all sites and peer mentoring of one site to another. For the past 7 months, 206 HIV positive women have been enrolled in PMTCT maternal cohort with 202 active and 127 in the infant cohort.

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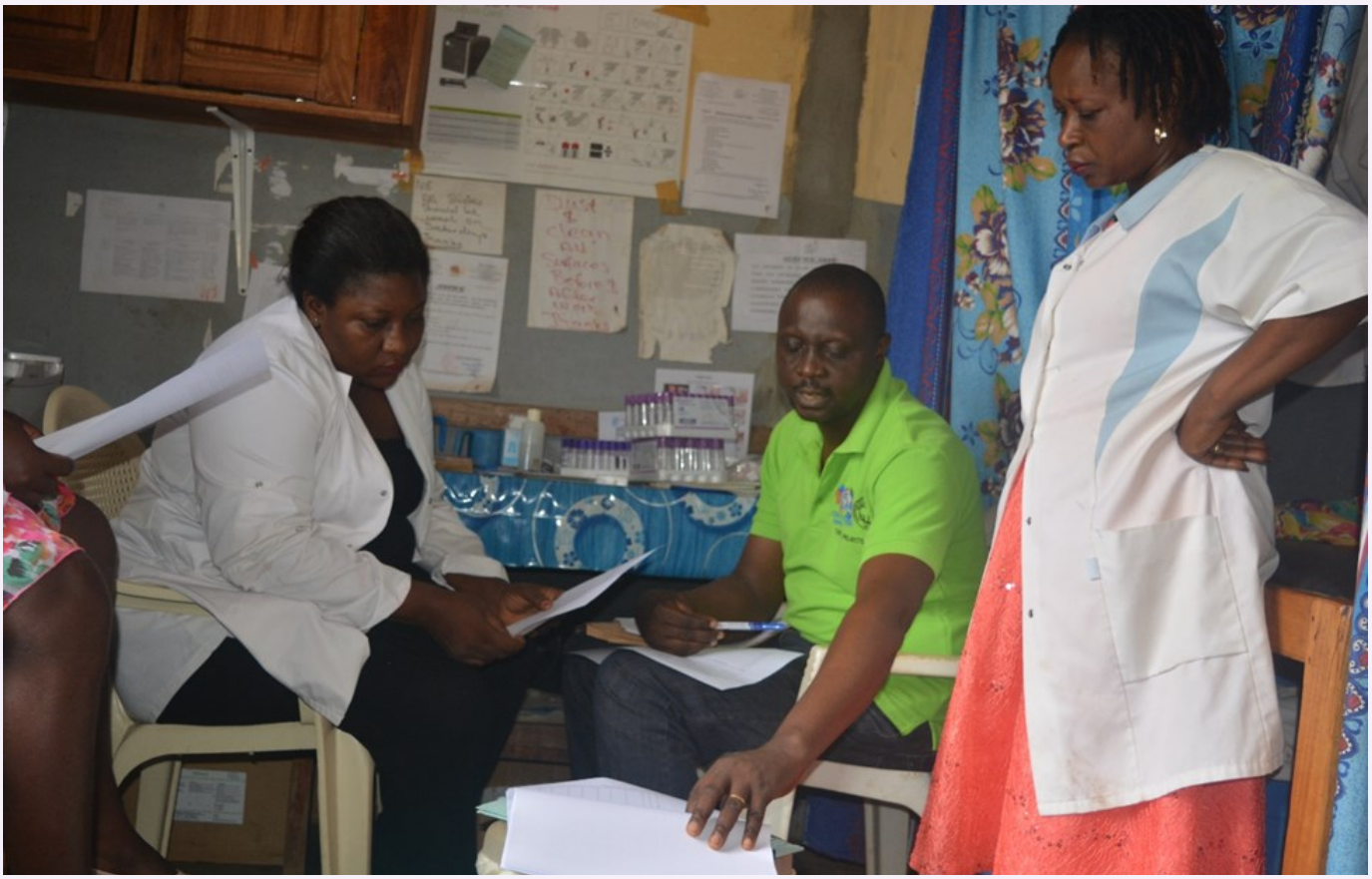
New Care and Treatment Sites Orientated on VL Documentation



HIVF EID Focal Point orientating Laboratory staff at CMA Holforth Tiko on filling the Sample collection form

New Care and Treatment sites as well as Option B+ sites are supposed to monitor the treatment of their clients through the viral load test. Very few samples have been sent from these facilities. The EID focal point recently visited the Option B+ sites and newly upgraded treatment centres in Tiko, Buea, Limbe and Kumba Health Districts to orientate the staff. They were orientated on the collection of VL plasma samples, proper labelling of the cryo-tube, proper filling of the viral load registers and the request form. The reclassification of clients' files and update of contact information was hinged on. Some working tools such as the temporal viral load register, cryotubes from the National Early Infant Diagnosis laboratory were given to the facilities. ****

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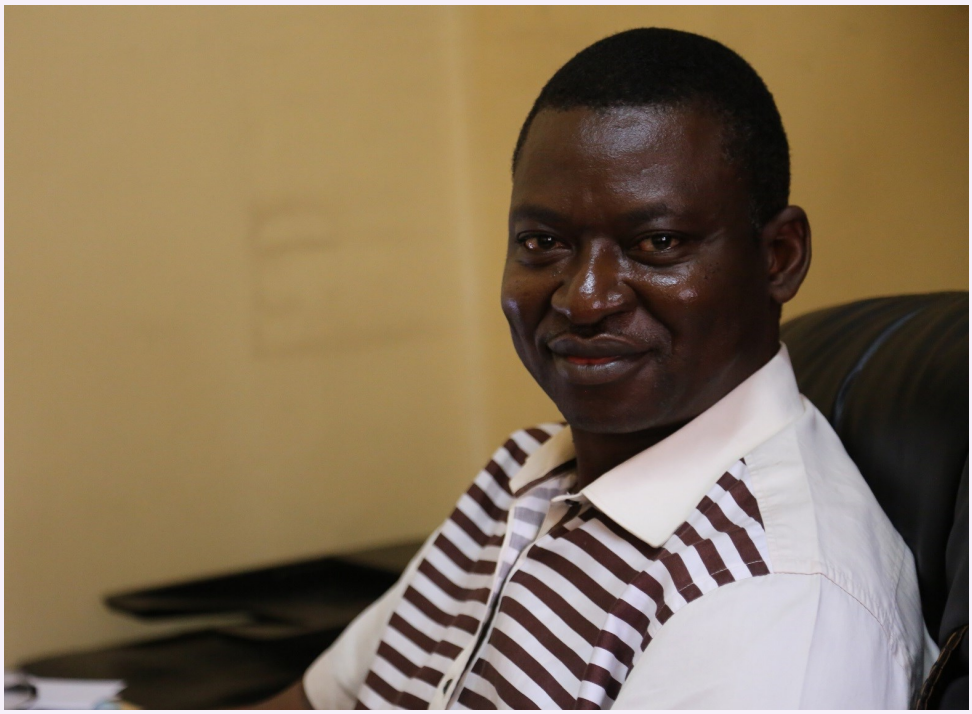
Differentiated Care Models Gaining Root in Health Facilities Offering HIV Services

This interview which generally sort to know the various packages of the differentiated care model and how beneficial it is to the HIVF project was done with Dr. Pascal Atanga Nji, the Senior Technical Advisor for Care and Treatment.



What is the Differentiated Care Model?

Differentiated care is a new framework of delivering HIV care and treatment that involves varying the intensity of care to meet the needs of different clients. I think if you get to understand it, now treatment is given to every patient who is diagnosed early. Therefore, we have patients who come into treatment looking excellently well, healthy, not having any condition that is putting them down, then there are clients who are discovered with HIV when they are sick. there are others who have been living with HIV and their health is stable. And as such, providing care to these clients you don't need a standard approach. So, client's treatment can be tailored according to their specific needs and specific time. This is what we call differentiated care; that is varying the care according to their specific needs.

Why was this approach adopted?

When you look at the HIV care package, you will realize that the number of patients that we have in care, if we were to adopt a standard package of care like it used to be in the past, then thousands of patients we see in our clinics needed to visit on a regular basis. This meant a lot of pressure on the health services and on the health care staff. So, it became necessary to look at how to vary patients care depending on their needs and how to move patients who don't really need hospital care to even be managed in the community and to be managed by non-health care workers. This became important in the new context of 'test and treat' when the patient load was growing at a very significant rate.

What are the different packages adopted by the HIVF Project? Are the packages different from what other countries like Kenya is doing?

The HIVF might not be doing anything different from the Kenyan model. We are all working under that the same umbrella which is WHO guidelines and the guidelines made it clear and came with specific models that can be applied and these models have been adopted depending on the available evidence, models that have

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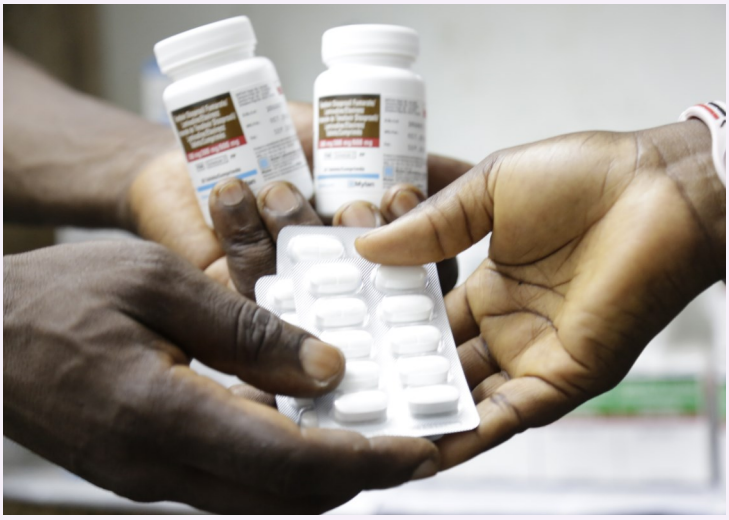
proven to work in context. The models are;

1.**Multi-month scripting:** this is a model that has been applied in our programme, across the national and world wide. It means patients who are already stable in care does not need to visit the clinic regularly. In this case the patient can



receive 3 to 6 months of medications depending on the availability of stock. In our context we have been able to give 3months for clients who are stable. Such a client might just see the consulting physician once or twice a year for regular checkup.

2. **Community Model** is another model which has a lot of aspects. In the Community ART Dispensation (CAD) model, the idea here is that HIV treatment can actually be delivered out of the facility and by a non-specialized service provider. We have several approaches with the community model. The approaches here are;

- Support group of persons living with HIV who have constituted themselves into an organized community group in view of sharing their experiences and overcoming their difficulties. They can use that same structure to deliver ARVs to their members when they are having their monthly or quarterly meetings. The facility can also provide them with medication through a service provider during their meeting.
- Community based organization that are already providing a lot of other services like in sanitation or malaria prevention services, so when such a CBO is identified they can also be provided with ARVs so that in their setting with the community they can also serve ARVs to the community as part of their community activities.
- Another aspect of CAD is the Community ART Group (CAG). This model is very interesting and has quite some advantages. One of the advantages it has is that the community members get to share their challenges and opportunity to interact. Secondly, they don't have to go the clinic all of them at a time. They might put their resources together and just one member goes to the facility to pick their drugs for all other members of the group. So, we are advised to have community groups not more than 12 persons. Each member take turns to go to the clinic where they can have clinical and biological follow up. This is really for clients who are stable. It reduces cost of transportation which the HIVF project is also taken care of. We are encouraging more of these groups to be formed especially in the conditions of the crisis in which we find ourselves.

3. One decentralized care model which is still part of differentiated care is that not all health facilities are accredited to deliver HIV care and treatment. So, health centres that don't deliver care can be affiliated to major centres who deliver care and the health centre will function as an outreach centre. By so doing Staff can leave the treatment centre and visit the health centre ones in a month to deliver HIV care and treatment services to clients who are registered in the centre, hence progressively build the capacity of the staff on

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ground to be able to take care of the client. This helps by reducing the workload of the main treatment centre and the cost of transportation for clients and so taking treatment closers to the client.

Coming back to the clinic again we have other models of care which are meant to take care of particular needs of certain patients. We have some patients that might not be able to go to the facility, not because they don't want to go but because they are either bed ridden or too old and in such cases these patients have to receive some sort of home-based care. The facility staff (APS) have to organize ones in a while to provide care to these patients. There are some patients who depending on their societal status and nature of job might not keep up their drugs on a regular basis such patients can be provided with fast track services. This depends on the facility and such clients are expected to pay to the facility. They need to also explain to them what it takes to obtain a standard package of care like coming for viral load. In some facilities we have included some Extended Service delivery hours between 3 -6pm and on weekends to careter for the needs of clients who could not make it in a regular basis. These models are on going and has yielded a lot of fruits.

Worth noting is that if you look at what we have described, is standard of differentiated care but unfortunately, we have not looked at context. Because we can have a situation that the context can come in play just as in the NW and SW Regions where we have a conflict with clients displaced. So, we need to be thinking how to adopt some of our models to take care of these clients. So, the standard care we were providing only for very stable patients might now need to be provided for patients who are even starting treatment because of instability. You may find a patient who is just entry into care, and we are forced to give multi months because of the situation in which we find ourselves.

When did we start the implementation of the Differentiated care model?

Differentiated care was introduced by WHO in the 2016 guideline and it was the main topic of discussion in the last World AIDS Conference in 2016. We didn't start immediately but we started thinking of how to integrate that into our services. As early as 2017, we started with some of the models like Multi- month Scripting and effectively in 2018 we brought in the other aspects of differentiated care. Most of the treatment centres might not implement all the model but implement what suits their contest. Multi-month dispensation is one of those models practice in all care and treatment. Almost all the models are applied in our major facilities.

What has been the outcomes of implementing the DCM since 2017? Is it worth continuing?

I think we have actually seen a lot of improvement and advances in the care of patients since the implementation of DCM. The first advantage is that, it has reduced the workload at the treatment centre. We use to have treatment centre which usually receive about 4-5000 clients a month at least. Our clinical staff have more time to focus on patients who need clinical care. We have also seen an improvement in our retention on the patients, it has reduced the time spent in the facility and transport to the facilities and some other opportunity cost. Patient can just come twice or thrice a year depending on their state. On how it is helping the project specifically; one of the major things the HIV Free has benefited from DCM is that it is actually helping to improve on our treatment current. In quarter 3, about 10% of clients who were current on treatment received the ARVs though DCM. It has been helpful in reducing the amount of client on a regular basis

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has also made it possible for us to manage other activities at the sites rather than focusing on the patient. We have time to look at other service delivery procedures that has help to improve on the quality of services we are offering.

What are the challenges experienced so far and how has the project intervened to handle the issue?

The multi month dispensation has its challenges. When you provide the patients with many drugs at the same time. We might be worried about conditions of storage, how well they are taken their drugs. But that notwithstanding, once in a while the psychosocial staff check on their treatment. The context now imposes on us and at times even patients who are initiating treatment very recently might still receive multi month and the risk you run there is that if these clients have not understood the importance of treatment then you are not very sure that they will take the drugs received but again that comes back to remote follow up. You need to work with them to understand you will be regularly checking on them to find out how they are doing with their treatment, knowing their motivation and answering questions to some of the challenges they might be having while away with their treatment.

The support group does not really have a lot of challenges. They do fairly well because they are usually people who are experienced patients and committed in supporting each other. Only challenges we have experienced with the Support groups is that some of the members have been displaced and some group even ended up rounding up. So, if you are given drugs to such a group, then you will not be able to account for the stocks.

For the CBOs, the only challenge is that their staff needs to be trained. Most them where involve in other health care activities and sensitization but just newly introduced into care and treatment of HIV they needed to be properly trained on managing the drugs and generally to properly deliver ARVs. I think this has been on going and the HIVF NW and SW project have been helping the RTG to organized training and supervised the activities with CBOs.

Outreach activities have been affected by the crisis and some are not functioning. Some of the outreach were redefined to actually constitute the community ART groups.

One of the challenges is about supplies. We have witnessed stock out from the national level. Clients might not have as much as we would have wanted to give. For instance, some second line drugs as well as Bactrim are out of stock.

The HIVF has always worked closely with the regional as well as the national level to make sure that issues of stock are properly managed. Once ever we witness any stock problem with the region, we immediately communicate the national level to understand where they stock problem might be coming from. Our management has always been very available and supportive and in some cases has even had to transport medication from the central to the regional or site level to reduce some issues up with some stock situation. The other we always do is to make sure that the sites communicate effectively and timely on stock situations. We follow up with our mentors on the ground to make sure we have the exact situation of stock sites and getting sites to request on time. I think that information is very necessary for the national level to maintain stock levels. That is already on going but just with the other challenges like need for capacity building and supervision we are doing that and will continue to go that because they are elements necessary to run and maintain the differentiated care model. *****

On the Road to 90-90-90

CBC HEALTH BOARD

"HIV is just like any other disease; get tested and get treated"

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