Ensuring 15-35 year-old Asymptomatic Clients are maintained on Treatment and are Virally Suppressed

PEPFAR MEETING 27th Jan 2019

Retaining and achieving VL Suppression 15-35 year old

- Where are we?
  - Retention
  - VL Suppression

GENERAL			
PEPFAR Approach	**Challenge Addressed**	**Intervention description**	**Working well/ Improvement Intervention**
Client Centered Care	• Supported disclosure • Stigma • Forgetfulness • Domestic/Family related stress • Fear of side effects	**Psychosocial support** • Service providers are equipped with age appropriate counseling skills, including incorporation of Stigma reduction strategies; • Pre and post test counseling Attitude of early initiators who need more counselling to understand the importance of ART adherence	More needs to be done – • Support Counsellors starting with High volume sites, • Case managers, • Build capacity for peers to fill the gap for Counselors • Expert clients who had the AIDS experience share their story with asymptomatic healthy PLHIV
	• Distance to health facility • Transport fees	**Referrals & Linkages** • Inter-facility linkages and referrals with a functional linkage directory with CBOs, SOPs on transfers and self referrals • Continuous client education on transfers and referral procedures	Working well however, self transfer is inevitable – UI will be helpful here
	Forgetting appointments for ART refills	**Appointment reminders** Pre-appointment reminders (call, SMS, or home visit), especially for new clients during first 6m on treatment, clients who are unstable or virally non-suppressed, caregivers of children, and adolescents/youth	• Improvement needed, Patients may need to be grouped so that SMS, can also be sent to a groups. • More Targeted reminders – profiling patients who are likely to miss • In areas with poor phone coverage – Peer/community system may be applicable • Nest the client who come from the same area tag them to a client with a phone

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Client Centered Care	Data use	• Use – EMR to expedite the missed appointments so that the tracking is started early enough • Paper based systems – Usually discover the clients came but were not updated in the Appointment register – usually the dispensing register has the clients as having come for refills	• Where present and used appropriately – working well • However, there is need to Profile clients who need more attention and focus
	Family centered clinic days	**Appointment scheduling** • Harmonized appointment days for Parents and children	Where present - working well, however:- • In case of a comorbidity by a child e.g. TB may be hinderance to harmonized appointments, • HCW initiated Engagement in Adolescent friendly services- may interrupt the service
	Tracking of Lost PLHIV	**Missed appointment Register** ▪ Regular tracking and update of files for clients LTFU • Recording of contacts of PLHIV	Currently being tracked by the TX-ML indicator • Implementing this with Fidelity • Scale up RCA tools in CQI work • Learn from returnees and implement solutions • Performance based contracts for HCW • Client centered appointment scheduling not being too Prescriptive • Client satisfaction survey

	Challenge Addressed	Intervention description	Working well/ Improvement Intervention
	Data Use	**Data management** • Accounting for clients lost to follow up • Weekly audits of missed appointments and update of files; quarterly audit of cohorts initiated within the most recent 6 months and update of files and registers	Working well
	Comorbidities esp NCDs, Depression	**Linkage** Linkage to other non-HIV services in Out-patient department clinics Linkage case management – walk the client through the facilities, until the clients is about 6 months old in the clinic	Clients get disappointed when they don't get the NCD services provided by the national program
	Health systems issues related to Stock outs	**Commodity management** • IP Support to HFs to Forecast and quantify commodity need to ensure regular, adequate and un-interrupted supply of ARVs	• Redistribution efforts have worked well EMR – generating numbers to feed into WAOS for appropriate orders and delieveries
Community Led services/monitoring	Lack of treatment supporters	• YAPS, expert clients, Linkage facilitators track those who are lost to follow up, and encourage them to adhere to ART	• Peer mapping and twining them to clients • Existing social groups e.g.faith community groups for mobilization
	Lack of Transport	DSDM at community level	Happening but needs to be taken to scale and is effective when there is reduction in stigma MMD needed

15-25 years			
PEPFAR Approach	**Challenge Addressed**	**Intervention description**	**Working well/ Improvement Intervention**
Client Centered Care	Transitioning from pediatric to Adult ART clinics	Adolescent and youth friendly services with adolescent/youth clinics at large volume sites	Working well in High volume faciilities
	Supported Disclosure	HCW Support AGYW people to disclose to their close relatives	Where present it is working well However, it is not robust Adolescents come alone to the HFs – more intense psychosocial support and approach – including Peer and OVC linkage for those eligible, get into the family setting – this has proved helped
	Post violence Care	Implementation of GBV screening and minimum package for post-violence care, peers support in stigma reduction, adol/youth support group meetings OVC- Clinical Linkage including provision of food GBV-Indicator working well	• Rather strong in FBO supported facilities but else where, generally weak – Trained POCs not up to it. Sometimes survivors go else where for a PE • Quarterly reporting may improve GBV – Use of GBV champions • Building CQI into GBV on top of the PEPFAR indicator • Linkage with community structures – referral for justice weak – leverage on the FCI program • Scale up OVC package of service to beef up food security especially for the eligible and GBV survivors

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	Health Care Judgmental, Disrespectful attitude toward PLHIV especially Adolescents and young people	• HCWs trained in customer care and specialized skills in handling adolescents	• Soft communication skills that are client centered • Zoom session for HCW
Community Led services/ care and monitoring	Missed appointments for adolescents in both day and boarding school	DSDM with Flexible appointment system i.e. holiday appointments, weekend, flexi hours	• Given ART refills for the school duration • Engage Nurses and school admin – happening and but not to scale – thou sometimes associated with Stigma
		Home visits by peers - YAPS	• Working well however, more facilitation needed

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25-35 years			
Client Centered Care	• Tailored services to Subpopulations e.g. those who are Busy working during Regular clinic hours	• Flexible hours especially for KP/PPs and Men, Refugees and cross boarder populations, Reduced waiting time, male friendly services • Facility DSDM for stable clients	• Working well where implemented • Needs to be taken to scale • There is need for MMD
	Supported disclosure including APN	• Supported disclosure for newly diagnosed and those on ART but not yet disclosed	Working well though Some cases of violence have been reported
	• Lack of treatment supporters, • Addressing VLNS	• PLHIV peer group formation and twining • Non-suppressed clinics	Working well and is a best practice
Community Led services/ care and monitoring	• Decongesting clinics and reducing waiting time	Community based DSDM –CLADs CDDPs	Working well – need to be scaled up
	• Lack of food	Village saving groups to improve livelihoods, get transportation to facilities, Educate affected children	Economic Strengthening activities needed to have PLHIV help themselves in their daily lives - Village talks, SACCOs etc.

Overarching Activities to Support the above Interventions

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Communication			
	Importance of retention Importance of VLS U=U messaging	Obulamu Messages around Treatment initiation, Retention and Viral suppression were done by the CHC Project	Need to modify: • Design messages around U=U for the modern generation • Campaign needed for the asymptomatic healthy PLHIV • IEC material for these groups • HCW messaging to ably communicate this to this group • Sharing of videos
			CHC or Communication partner to support the messaging
Monitoring and evaluation	• Retention - TX_CURR • DHIS 2 Quarterly reporting • TX_ML		Working Well TX_RTT for those who return to care – New Indicator
	VL Suppression – National VL Dashboard for Quarterly reporting		Working well