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
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<tr>
<th>PEPFAR Approach</th>
<th>Challenge Addressed</th>
<th>Intervention description</th>
<th>Working well/ Improvement Intervention</th>
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| 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  

| Referrals & Linkages | • 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 |
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<td>Data Use</td>
<td><strong>Data management</strong>&lt;br&gt;• Accounting for clients lost to follow up&lt;br&gt;• 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</td>
<td>Working well</td>
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<td>Comorbidities esp NCDs, Depression</td>
<td><strong>Linkage</strong>&lt;br&gt;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</td>
<td>Clients get disappointed when they don’t get the NCD services provided by the national program</td>
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<td>Health systems issues related to Stock outs</td>
<td><strong>Commodity management</strong>&lt;br&gt;• IP Support to HFs to Forecast and quantify commodity need to ensure regular, adequate and un-interrupted supply of ARVs</td>
<td>• Redistribution efforts have worked well&lt;br&gt;EMR – generating numbers to feed into WAOS for appropriate orders and deliveries</td>
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<td>Community Led services/monitoring</td>
<td>Lack of treatment supporters&lt;br&gt;• YAPS, expert clients, Linkage facilitators track those who are lost to follow up, and encourage them to adhere to ART</td>
<td>• Peer mapping and twining them to clients&lt;br&gt;• Existing social groups e.g. faith community groups for mobilization</td>
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<td>Lack of Transport</td>
<td>DSDM at community level</td>
<td>Happening but needs to be taken to scale and is effective when there is reduction in stigma MMD needed</td>
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<td>Client Centered Care</td>
<td>Transitioning from pediatric to Adult ART clinics</td>
<td>Adolescent and youth friendly services with adolescent/youth clinics at large volume sites</td>
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<td>Supported Disclosure</td>
<td>HCW Support AGYW people to disclose to their close relatives</td>
<td>Where present it is working well Though, it is not robust</td>
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| Post violence Care        | Implementation of GBV screening and minimum package for post-violence care, peers support in stigma reduction,adol/youth support group meetings  | • Rather strong in FBO supported facilities but elsewhere, generally weak – Trained POCs not up to it. Sometimes survivors go elsewhere 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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<td>Health Care Judgmental, Disrespectful attitude toward PLHIV especially Adolescents and young people</td>
<td>• HCWs trained in customer care and specialized skills in handling adolescents</td>
<td>• Soft communication skills that are client centered</td>
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<td>• Zoom session for HCW</td>
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<td>Community Led services/ care and monitoring</td>
<td>Missed appointments for adolescents in both day and boarding school</td>
<td>DSDM with Flexible appointment system i.e. holiday appointments, weekend, flexi hours</td>
<td>• Given ART refills for the school duration</td>
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<td>• Engage Nurses and school admin – happening and but not to scale – thou sometimes associated with Stigma</td>
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<td>Home visits by peers - YAPS</td>
<td>• Working well however, more facilitation needed</td>
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<td>25-35 years</td>
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| 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 borderer 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                                           |
| Community Led services/ care and monitoring | • Lack of treatment supporters,  
  • Addressing VLNS                                                                                   | • PLHIV peer group formation and twining  
  • Non-suppressed clinics                                                                  | Working well and is a best practice                                                                    |
| • 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                                  | 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 |
|                 | Importance of VLS U=U messaging                          |                                                                                          | 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                                                                 |

**Importance of retention**

- Importance of VLS
- U=U messaging

**Importance of VLS**

- U=U messaging

**U=U messaging**

- 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
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**CHC or Communication partner to support the messaging**

**Working Well**

- TX_RTT for those who return to care – New Indicator

**Working well**

- VL Suppression – National VL Dashboard for Quarterly reporting