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Leveraging program improvement to optimize HIV treatment and well-being for PLHIV

Jacqueline Calnan, USAID, Moderator
Tom Minior, USAID, Moderator
Anna Lawino, TASO, Uganda
Ivin Chibanda, Right to Care, Zambia
Carrie Cox, Baylor, Malawi

Accelerating Community Differentiated Service Delivery Models improves Continuity of Treatment among Persons Living with HIV in post-war ravaged Acholi sub-region, Uganda.

Presenter: Anna Lawino

Co-authors: Richard Kyakuwa Jjuuko, Angwech Agatha, Noah Kasunumba

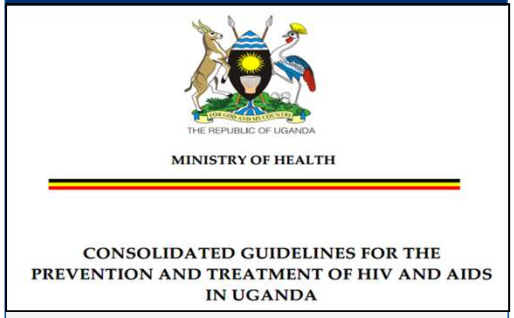
USAID Local Partner Health Services – Ankole & Acholi Activity

The AIDS Support Organization

Date: November 16, 2022

Background

MOH Guidelines



- DSD is recommended for prevention, care, & treatment to meet the needs & preferences of clients
- Core principles are client-centered care and improved clinic efficiency
- Recommended DSD models include:
  - Facility based Individual Management (FBIM)
  - Fast track drug Refills (FTDR)
  - Facility Based Groups (FBG)
  - Community Client Led ART delivery (CCLAD)
  - Community Drug Distribution Points (CDDP
  - Community retail pharmacy (CRPDDP)

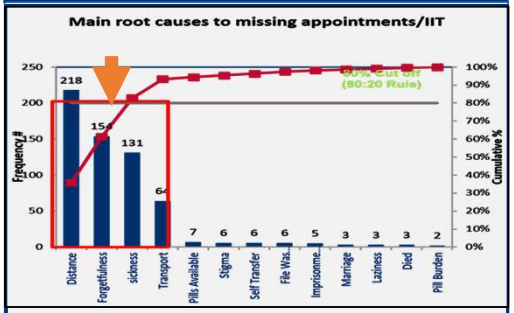
Acholi Metrics (Dec 2021)

- Acholi sub-region located in Northern Uganda
- Health system recovering from 20-year civil war
- 70 ART public health facilities serving 46,413 clients
- 2422 clients interrupting treatment within Oct-Dec 2021
- 91% virally suppressed (91% adults, 73%CALHIV)

RCA Process

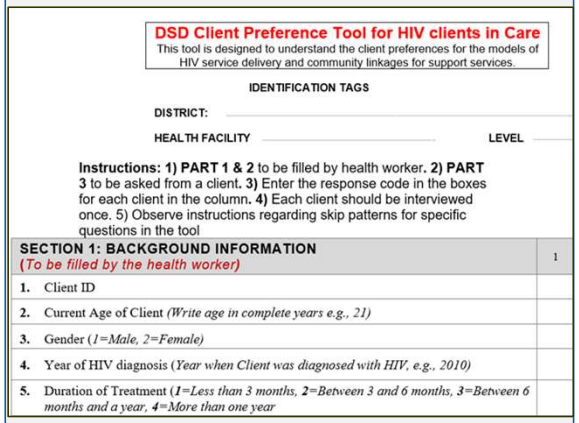
- RCA to determine barriers to continuity in treatment conducted in Feb 2022
- PLHIV on ART **who missed appointment**
- Interviewed by health providers in the community & at facility
- Using an RCA tool information was collected from eligible clients **without sampling**
- Each client interviewed only once
- The **one main reason** for missing the last appointment was recorded in verbatim
- Data analyzed using pareto-chart

Barriers/Root Causes



- **606** eligible clients interviewed
- Mostly aged **30-39 (34%)** and female (65%)
- 90% clients in f**acility-based service delivery models** (90.2%) – FTDR (41%)
- Mostly been on treatment for **at least 6 months**
- Main barriers: **distance**, forgetting appointments, sickness, **transport**

Methods



DSD Client Preference Tool for HIV clients in Care

This tool is designed to understand the client preferences for the models of HIV service delivery and community linkages for support services.

IDENTIFICATION TAGS

DISTRICT:

HEALTH FACILITY LEVEL

Instructions: 1) PART 1 & 2 to be filled by health worker. **2) PART 3** to be asked from a client. **3)** Enter the response code in the boxes for each client in the column. **4)** Each client should be interviewed once. 5) Observe instructions regarding skip patterns for specific questions in the tool

SECTION 1: BACKGROUND INFORMATION *(To be filled by the health worker)*	1
1. Client ID	
2. Current Age of Client *(Write age in complete years e.g., 21)*	
3. Gender (*1=Male, 2=Female*)	
4. Year of HIV diagnosis (*Year when Client was diagnosed with HIV, e.g., 2010*)	
5. Duration of Treatment (*1=Less than 3 months, 2=Between 3 and 6 months, 3=Between 6 months and a year, 4=More than one year*)	

DSD client preference tool scaled-up to all 70 sites upon initial roll-out in 10 sites

Improvement Aim

Mitigating attrition through optimizing client preference and client-centered care

- Accelerating enrollment of stable clients in DSD models of choice
- Using the DSD client preference tool for PLHIV

DSD client preference tool

- Aims to **understand client preferences for ART service provision,** including community linkages for support services.
- Provides an overview of the patients' preferences for antiretroviral therapy service delivery features to make ART services more responsive to patients' needs
- Targets PLHIV on ART in Facility and community-based models

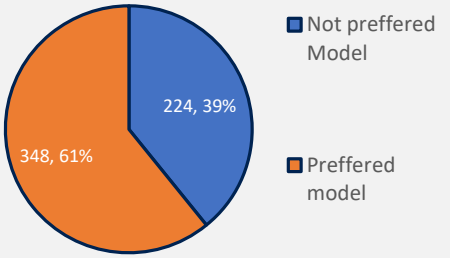
Rolling out the DSD client preference tool

- Stakeholder meetings at district, health facility and community to disseminate RCA findings for barriers to missing appointment and orientation of health providers on DSD client preference tool
- Selection of sites for initial roll-out of the tool (**10 Public HFs** including hospitals (2), HC IV (4), HCIII (4))
- Selection of clients to be interviewed: SOP on number of clients to be interviewed per facility by **DSD model category** equally distributed in the **age bands**, and by **sex**
- Administration of tool at both facility and community with physical and virtual interviews

Results

DSDM Preference

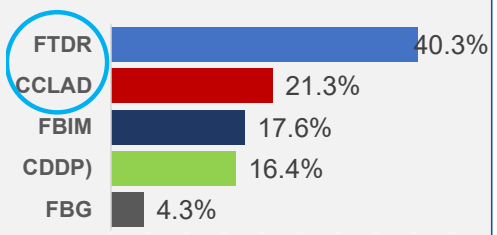
Model Preference, N = 572



61% of clients interviewed were in their preferred DSD models of care

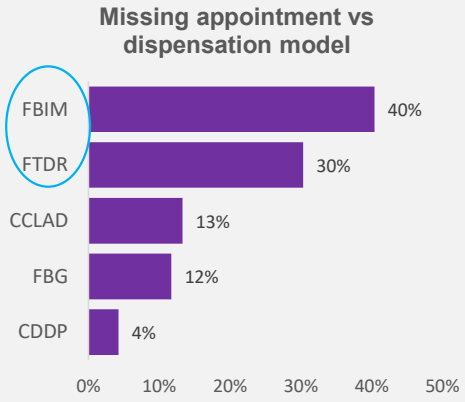
DSD model preference

Preferred model by ART distribution model



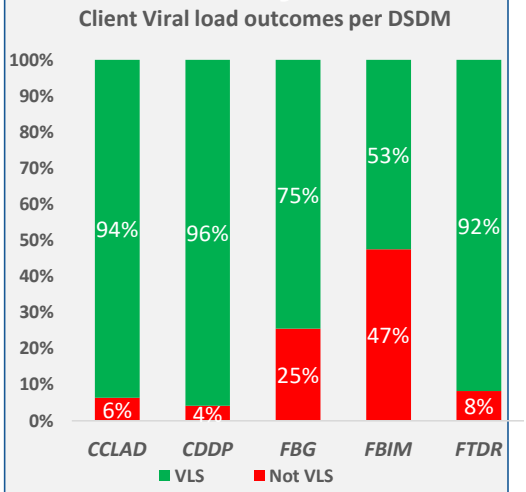
FTDR and **CCLAD** most preferred models of care

Missing appointments



40% of clients missing appointment on **FBIM** and **30%** **FTDR**

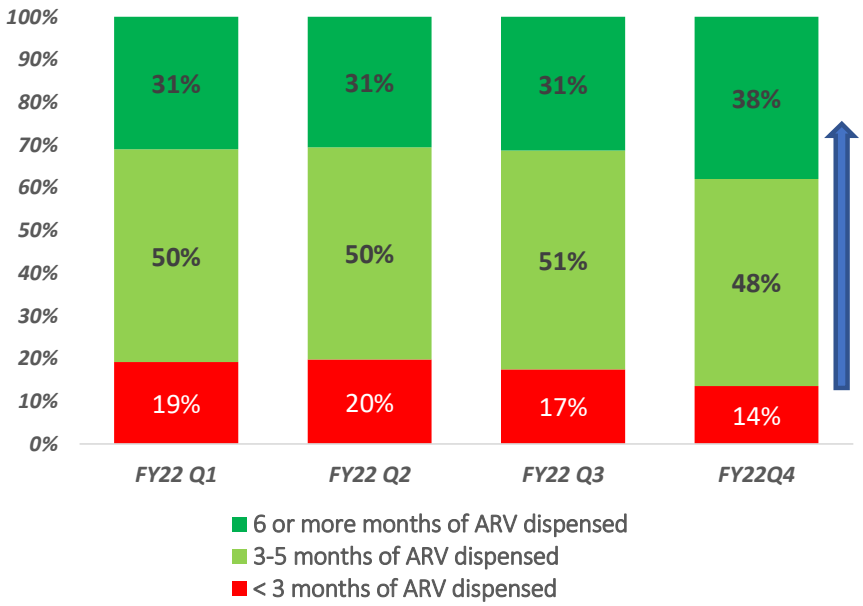
Viral load by DSDM



- Good viral suppression in Community models (CCLAD & CDDPs). **Facility- based** DSDM models had the **lowest viral suppression rates** compared to community models
- Need to scale-up community models

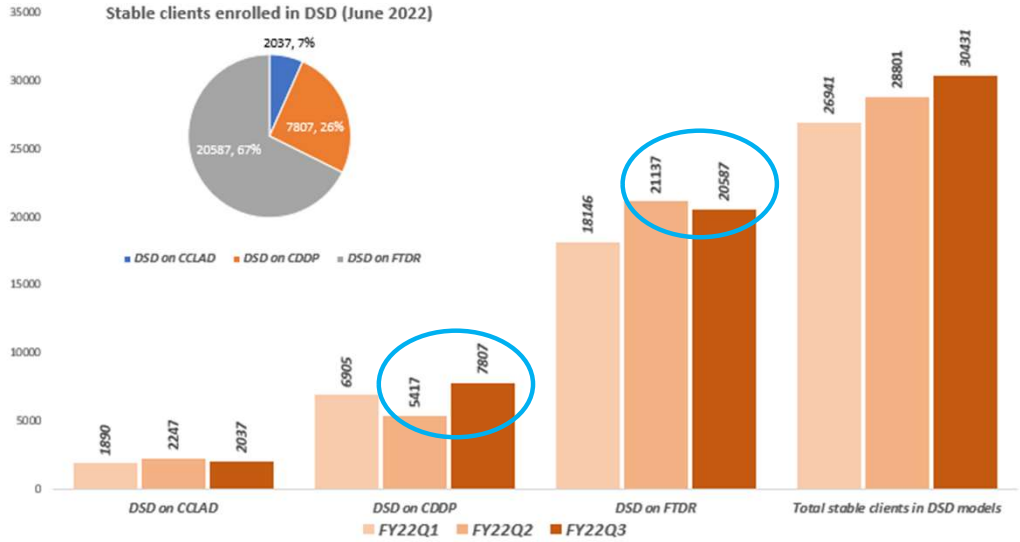
Results Cont'd

MMD trend (Q1-Q4)



86% of current clients on treatment receiving MMD 3+ months with **38%** on MMD for 6months

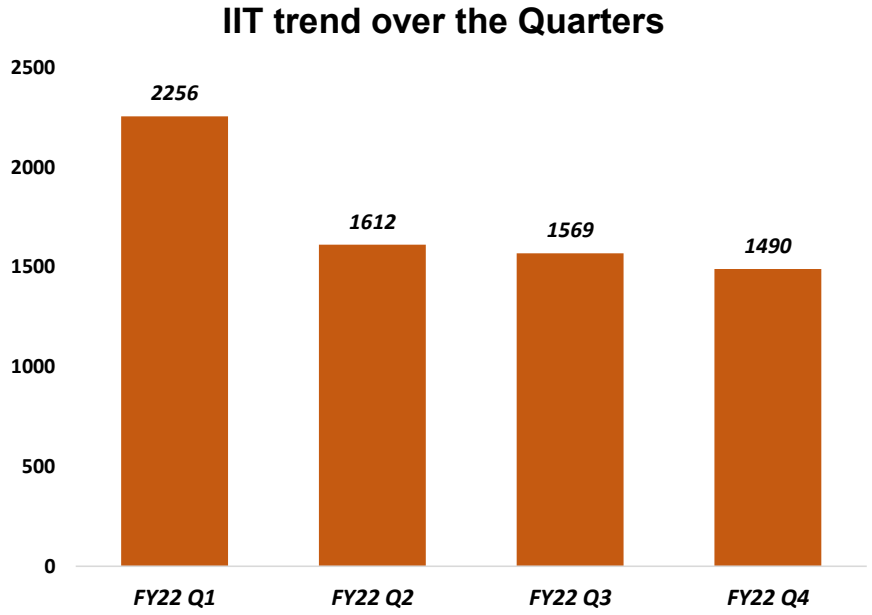
Accelerated stable client enrolment in community DSD models upon use of DSD client preference tool

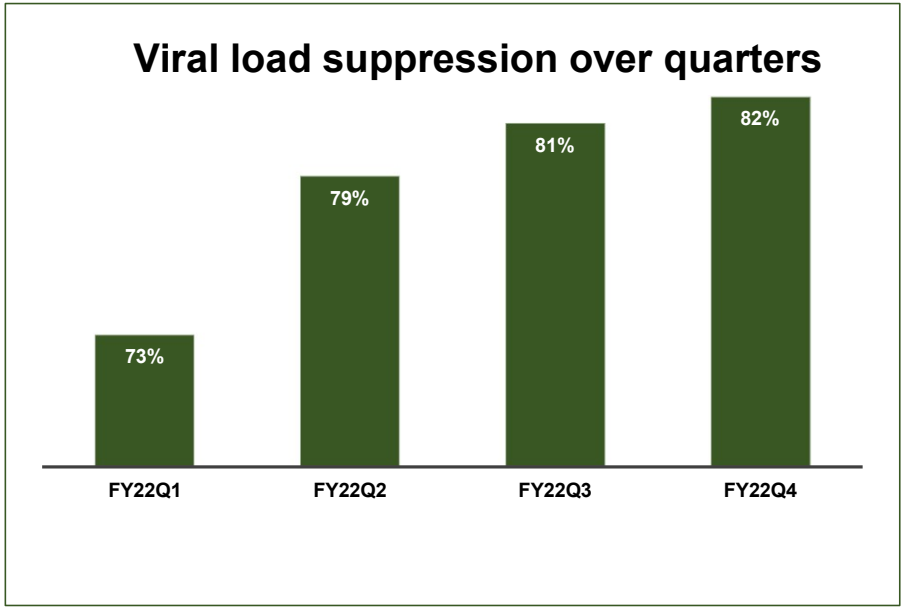


65% of clients on treatment enrolled on DSD models (CCLAD, CDDP, and FTDR).

Accelerated uptake of community-based models - ↑ enrollment in **CDDP** and ↓ in **FTDR** in Q3

Results Cont'd





Observed **reduction** in number of enrolled on treatment interrupting treatment

Improved Viral suppression rate among CALHIV

Results Cont'd

Health education session at a Community Drug Distribution Point

Photo credit:
TASO/USAID LPHS-Ankole and Acholi

Conclusion

- RCAs are simple approaches for determining structural and client-level challenges in HIV treatment
- Applying the DSD client preference tool integrates client-centered care in addressing challenges affecting treatment continuity
- Significant improvement in processes of HIV care possible with optimization of client preference of service delivery models
- Accelerated enrollment in Community DSD models improves the continuity of treatment

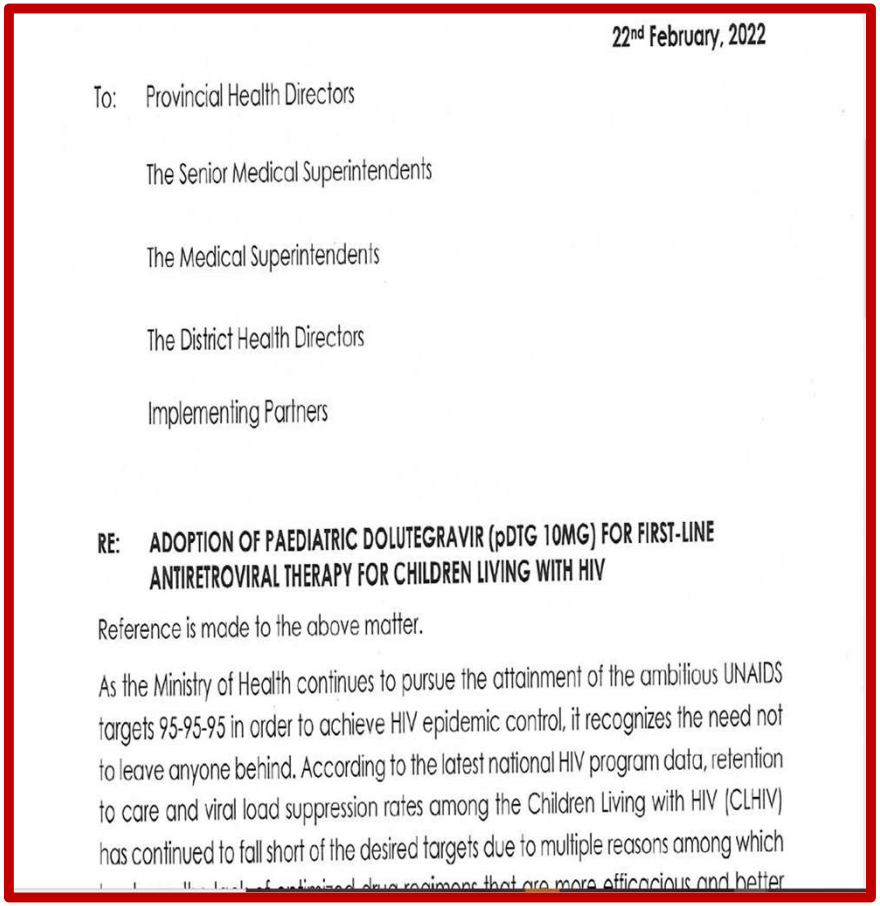
Acknowledgement

- USAID
- Ministry of Health, Uganda
- Districts and health facilities in Acholi sub-region
- TASO/USAID LPHS-Ankole and Acholi Activity
- URC/USAID RHITES-North Acholi Activity

ART treatment optimization using pDTG in CLHIV: Transition of eligible pediatrics clients to pDTG in Muchinga, Luapula and Northern provinces of Zambia.

Ivin Chibanda
Pharmaceutical Supply Chain Advisor
USAID Action HIV

BACKGROUND



22nd February, 2022

To: Provincial Health Directors

The Senior Medical Superintendents

The Medical Superintendents

The District Health Directors

Implementing Partners

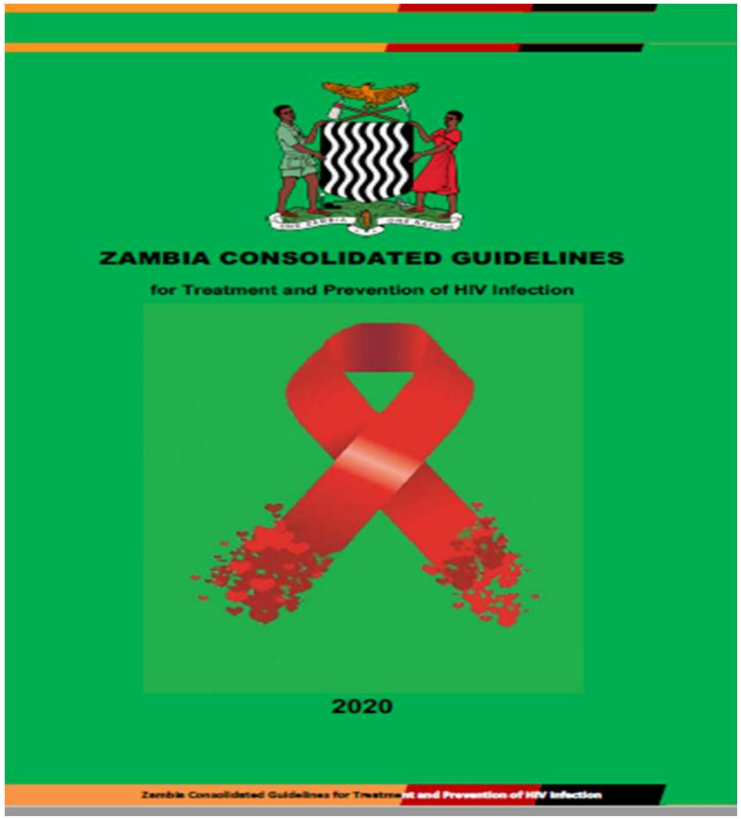
RE: ADOPTION OF PAEDIATRIC DOLUTEGRAVIR (pDTG 10MG) FOR FIRST-LINE ANTIRETROVIRAL THERAPY FOR CHILDREN LIVING WITH HIV

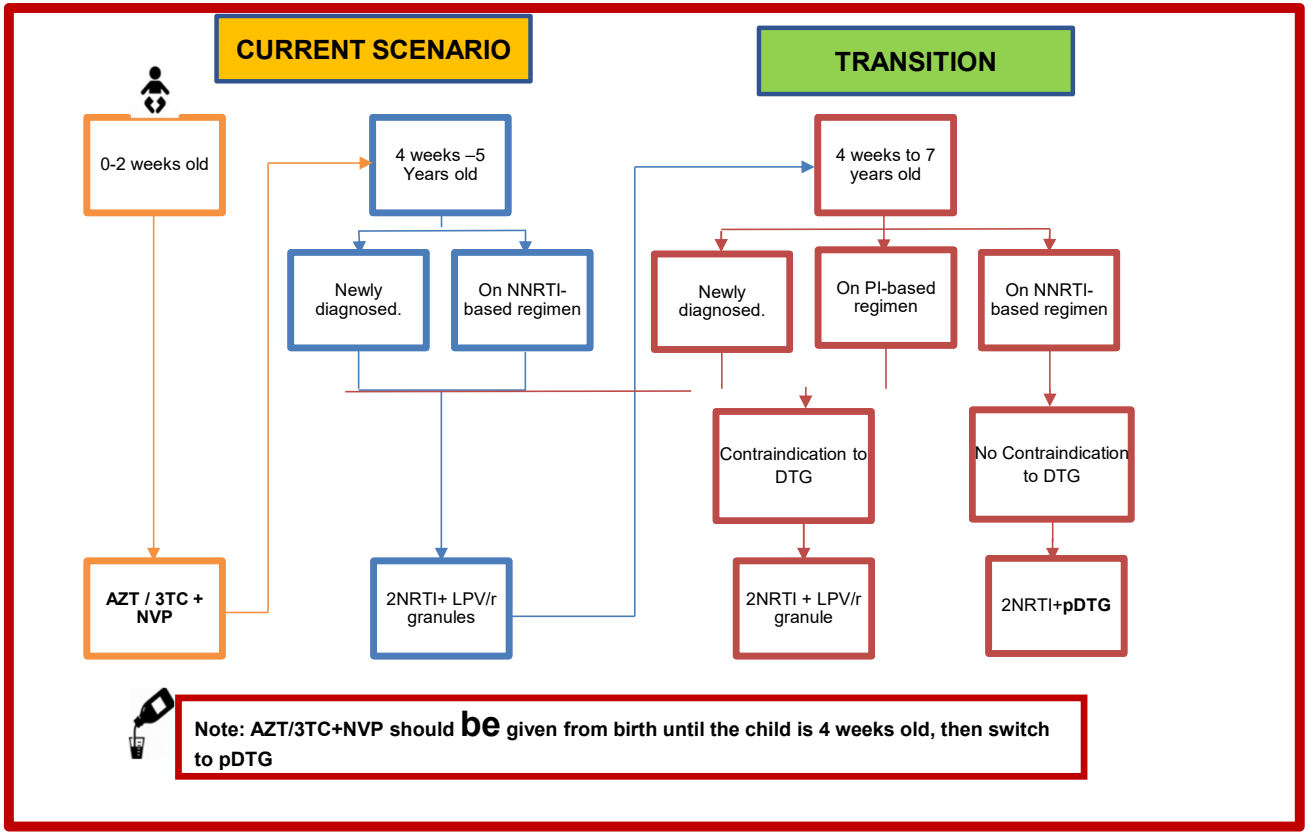
Reference is made to the above matter.

As the Ministry of Health continues to pursue the attainment of the ambitious UNAIDS targets 95-95-95 in order to achieve HIV epidemic control, it recognizes the need not to leave anyone behind. According to the latest national HIV program data, retention to care and viral load suppression rates among the Children Living with HIV (CLHIV) has continued to fall short of the desired targets due to multiple reasons among which

- Following WHO guidance to transition all stable patients under 20 kg to pDTG in 2019,
- In February 2022, the Ministry of Health issued a memorandum to adopt pDTG as the first line of antiretroviral treatment for children living with HIV.
- MOH recommends all children over 4 weeks and between 3-20 kg be transitioned to pDTG 10 mg given its clinical superiority and improved adherence over other ARVs.

pDTG10 transition flow chart

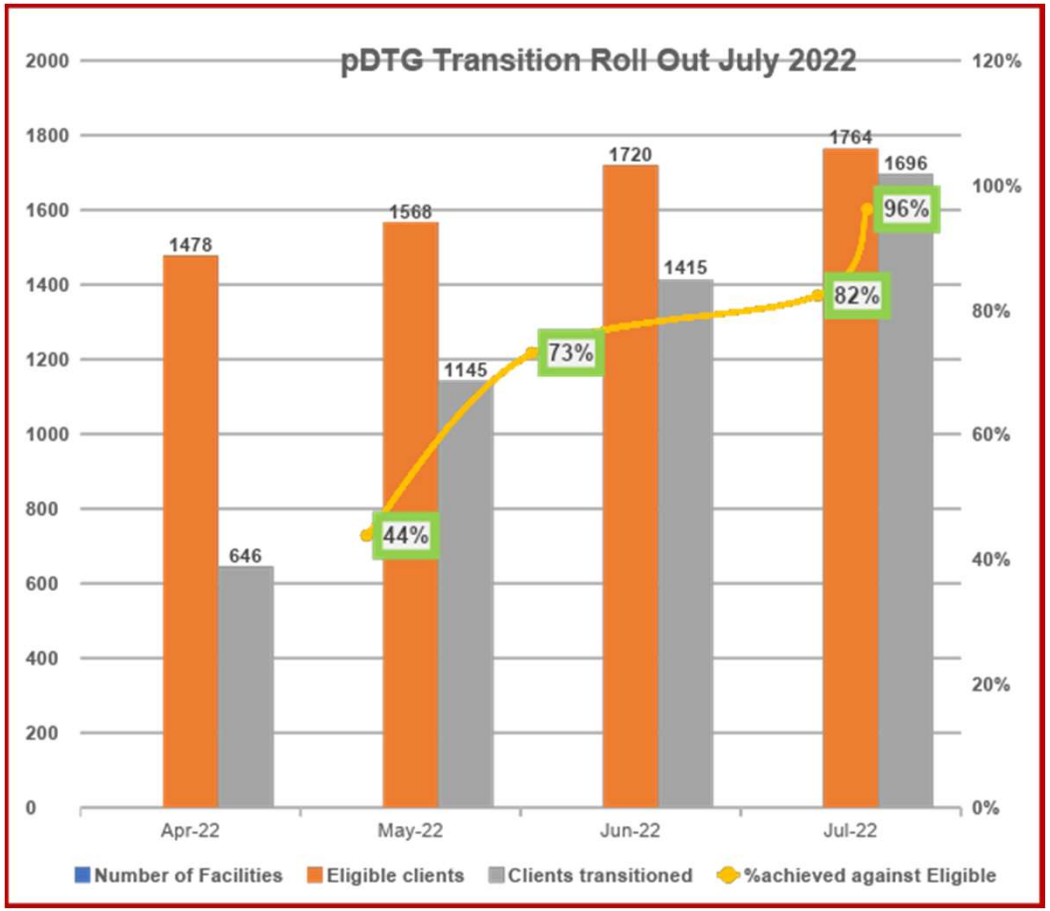




Best practices

- Capacity building of health facility staff was conducted across 256 health facilities conducted by Pharmacy Staff- Pharmacist and Pharmacy Technologists
- Orientation of ART providers ART optimization using pDTG through:
  - virtual training with clinical staff across all sites
  - Onsite mentorship for facilities with poor connectivity and not covered during virtual training
- Identification of eligible children through file audits, calling and Tracking them for transitioning those due and appointment rescheduling for children with future appointments
- Community sensitization and health education for caregivers- use of IECs.
- Provision of Job Aids, dosing charts, wheels, Demand creation IECs and weighing scales to ensure optimization of all eligible pediatrics.
- Quantification based on eligible children and stock distribution to the 256 facilities
- Mentorship of facility staff in Stock Management procedures

Results



- Action HIV Pediatric TxCurr in April 2022 was 4,807 out of which 1,764 children were identified to be eligible for DTG in 256 facilities in Muchinga, Northern and Luapula provinces
- Results showed a quick transitioning pace of 1696 (96%) clients were transitioned in four months from April 2022 to July 2022

CONCLUSION

- Tracking for the pending pediatrics to be transitioned to pDTG all eligible pediatrics and the new on treatment.
- The achievement of 96% transition of the eligible clients will result in improved treatment adherence and viral suppression in CLHIV
- Clinical reviews, monitoring Viral Load suppression of pediatrics on pDTG and ensuring stock availability in all facilities to avoid interruptions in treatment will be key activities going forward

Acknowledgements

USAID

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RTCZ Supply Chain and facility teams






USAID Local Partners Meeting

Phone based psychosocial counseling expands access to psychosocial counseling services

November 2022

Tingathe CORE Program
Baylor College of Medicine Children's Foundation Malawi

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TINGATHE

- No conflicts of interest to disclose

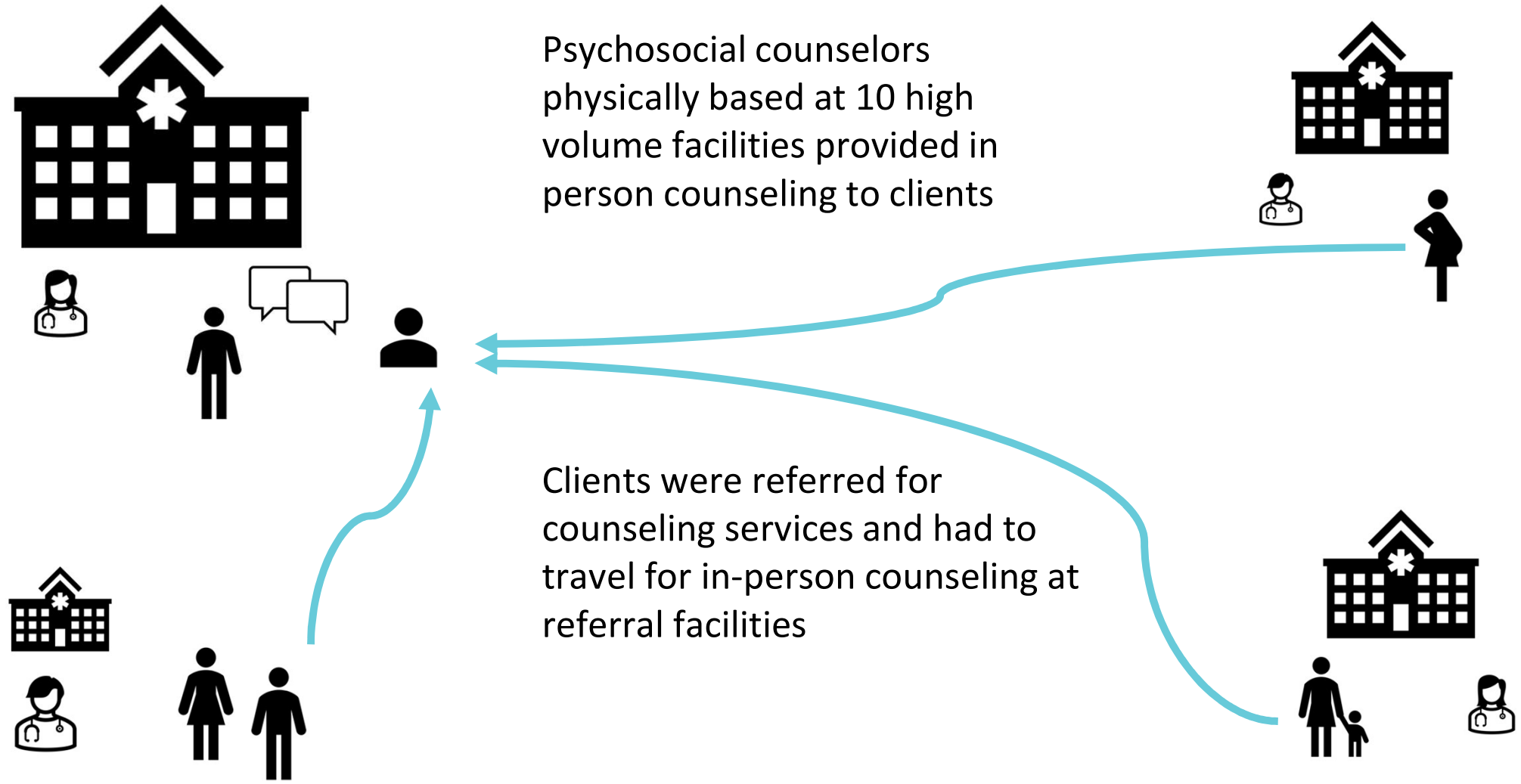
PLHIV have psychosocial health needs

- Many PLHIV have complex psychosocial health needs due to experiences with
  - Coping with diagnosis of chronic illness
  - Stigma and discrimination
  - Intimate Partner violence
  - Depression
  - Adherence and retention challenges

- Counseling helps address many of these psychosocial health needs with additional benefit on medical outcomes

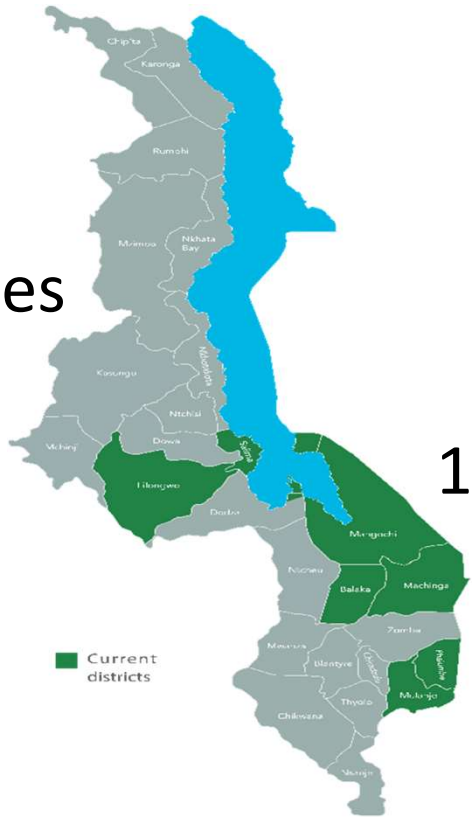
- Unfortunately access to these counseling services are limited
  - Reasons are multifactorial including:
    - lack of skilled human resource,
    - lack of awareness about mental illness and psychological distress, and
    - stigma surrounding mental illness

Before P-PSC implementation



Methods

120 health facilities

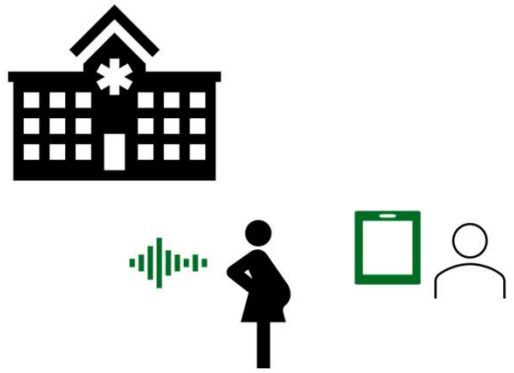


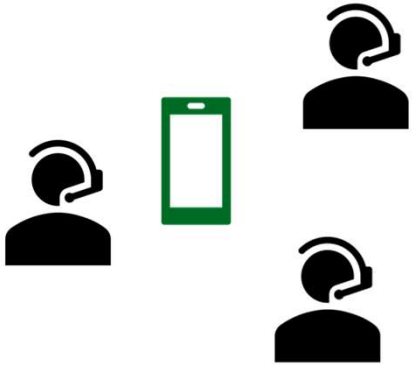
12 months

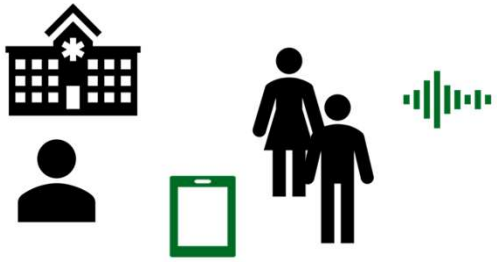
COVID-19 mitigation strategies limited movement and aimed to decongest health facilities

P-PSC implementation

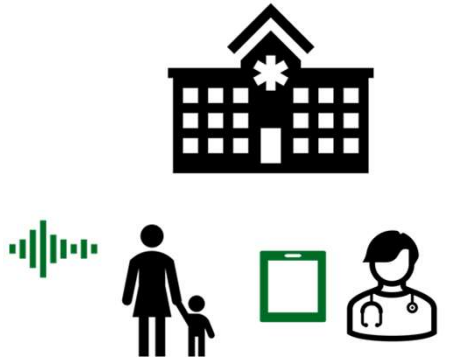
Psychosocial counselors delivered phone-based counseling to clients from all 120 supported HF







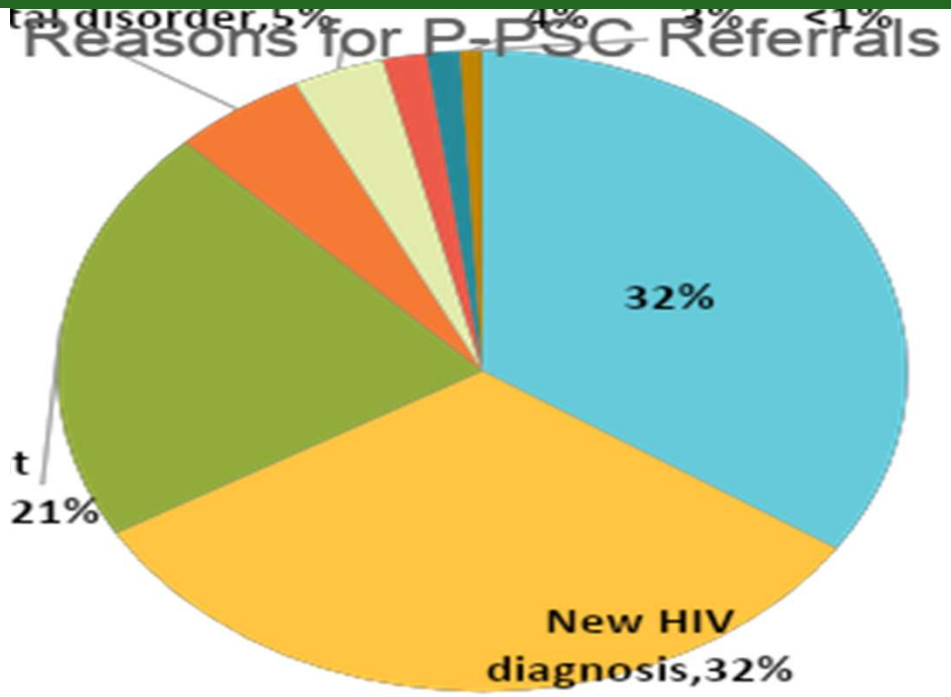
Counseling was same day and no client travel required



Results

~75% of clients were referred for

- Adherence support
- New HIV diagnosis support
- Retention support after interruption in treatment



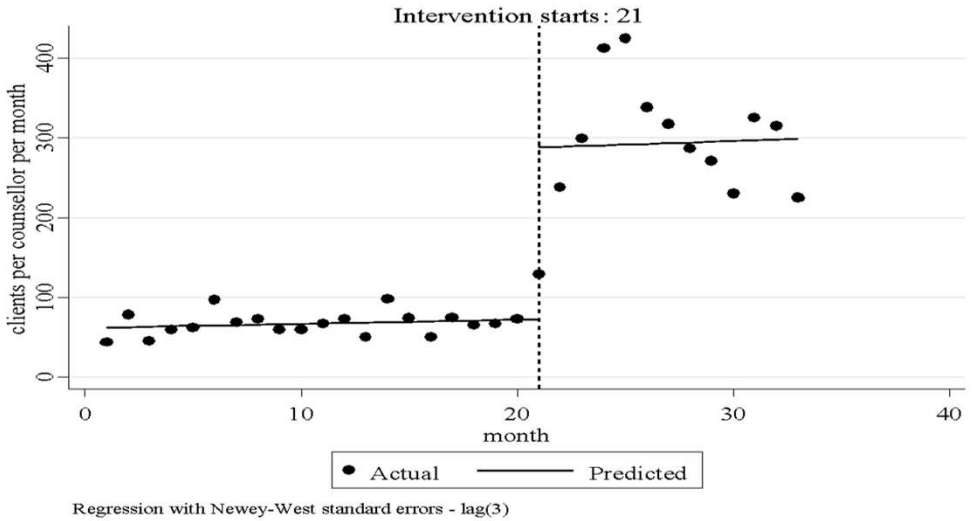
Referrals to P-PSC were from: lay health care workers (91%), clinical staff (5%), and clients themselves (3%)

99.4% of referred clients were counseled

96% visits were <30 minutes

- 46% <15min; 46% 16-30min; 8% 31+min

Results



- Over 30,000 p-psc encounters in year 1
- Statistically significant increase from pre- to post-intervention period
  - From 77 to 216 encounters/ counselor/ month
  - From 18 to 88 per day (avg)

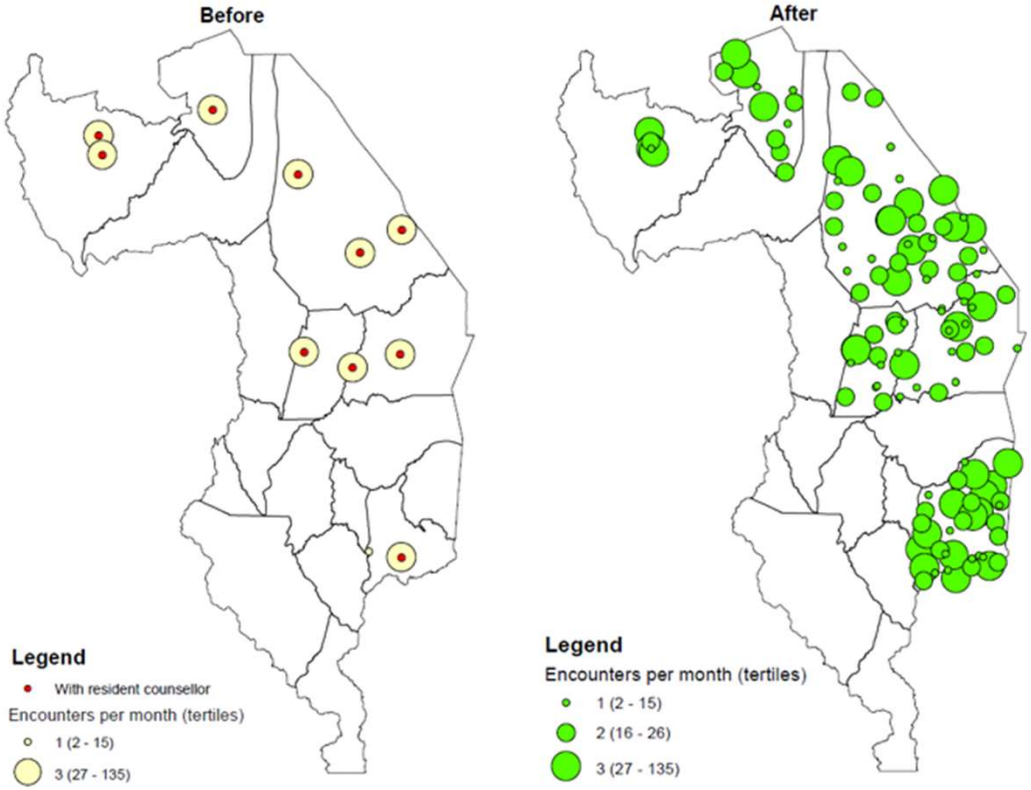
Table 2: Number of psychosocial counseling encounters pre- and post-intervention

Variable	Pre-intervention	Post-intervention	p-value
Total (overall)	10504	31642	
Per month	553	2254	<0.001
Per counsellor	70	307	<0.001
Per day (average)*	18	88	<0.001
Females per month*	347	1414	<0.001
Males per month*	206	840	<0.001

*The single-sample t-test was used. This compared whether the sample average during the intervention period was equal to the average (single value) in the pre-intervention period

Geographic reach of PSC counseling services increased exponentially with P-PSC

Figure 1: Average number of encounters per month at each site before and after phone-based psychosocial counselling



Conclusions

- Implementation of P-PSC to scale was rapidly done and immediately successful with over 30,000 P-PSC encounters during year 1
- This new P-PSC model helps many people access services
- We are still looking at impact on medical outcomes from these services
- We continue to deliver both P-PSC and in person counseling to all clients

ACKNOWLEDGEMENTS

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- USAID
- 2022 Local Partner Meeting Organizing Committee
- Baylor College of Medicine Children's Foundation Malawi staff

Zikomo