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

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

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USAID Local Partner Health Services – Ankole & Acholi Activity
The AIDS Support Organization
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### 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 facility-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**

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

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

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

**Results**

**DSDM Preference**

Model Preference, N = 572

- 348 (61%)
- 224 (39%)

**DSD model preference**

Preferred model by ART distribution model

- FTDR: 40.3%
- CCLAD: 21.3%
- FBIM: 17.6%
- CDDP: 16.4%
- FBG: 4.3%

**Missing appointments**

Missing appointment vs dispensation model

- FBIM: 40%
- FTDR: 30%
- CCLAD: 13%
- FBG: 12%
- CDDP: 4%

**Viral load by DSDM**

Client Viral load outcomes per DSDM

- CCLAD: 94%
- CDDP: 96%
- FBG: 75%
- FBIM: 53%
- FTDR: 92%

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

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

**Improved** Viral suppression rate among CALHIV
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

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• 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
• 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.
0-2 weeks old

- AZT / 3TC + NVP

Current Scenario:

- 4 weeks - 5 years old
  - Newly diagnosed
  - On NNRTI-based regimen

Transition:

- 4 weeks to 7 years old
  - Newly diagnosed
  - On PI-based regimen
  - On NNRTI-based regimen

- Contraindication to DTG
  - No Contraindication to DTG

- 2NRTI + LPV/r granules

- 2NRTI + LPV/r granule

- 2NRTI + pDTG

Note: AZT/3TC+NVP should be given from birth until the child is 4 weeks old, then switch to pDTG.
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 1,696 (96%) clients were transitioned in four months from April 2022 to July 2022.
• 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

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RTCZ Supply Chain and facility teams
Phone based psychosocial counseling expands access to psychosocial counseling services

November 2022

Tingathe CORE Program
Baylor College of Medicine Children’s Foundation Malawi
• No conflicts of interest to disclose
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

Psychosocial counselors physically based at 10 high volume facilities provided in person counseling to clients

Clients were referred for counseling services and had to travel for in-person counseling at referral facilities
Methods

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

120 health facilities

12 months
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

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (overall)</td>
<td>10504</td>
<td>31642</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Per month</td>
<td>553</td>
<td>2254</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Per counsellor</td>
<td>70</td>
<td>307</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Per day (average)*</td>
<td>18</td>
<td>88</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Females per month*</td>
<td>347</td>
<td>1414</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Males per month*</td>
<td>206</td>
<td>840</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*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
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.
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