NATIONAL AIDS SECRETARIAT

IMPROVING ART AND PMTCT ARV INFANT SERVICES: A PRIMARY HEALTH CARE APPROACH

July, 2020

The Gambia Primary Health Care System

Following the adoption of 'Alma-Ata' Declaration in 1978, The Gambia introduced primary health care as the sole base of its national health policy. The Gambia adopted in a three-tier hierarchical health care system to implement PHC 1979/80.

In 1981, a pilot of the PHC program was started in the then Lower River Division, and the now Lower River Region, 'Mansa-Konko'. A Divisional Health Team was established to start and run the learning phase of the program. The pilot was further expanded to go national and reach different regions/districts in the country.

In early 1990s, the phase of PHC expansion started facing stumbling blocks as more funds in the budgets were being shifted from preventive to curative care. In 1994, the military change of government was not welcomed by several international donors, thereby resulting to cutting of funding (approximately, support decreased by 50%). This has reduced PHC program funding considerably, leading to limited funds for program implementation and supervision. As PHC silenced, the period was also featured by an increasing number of hospital and health center construction predominantly in urban areas.

The PHC strategy was adopted as a mechanism to reach rural communities of The Gambia through provision of essential health services. The designed program was relatively comprehensive as it dealt with prevention, promotion and curative services against major killer ailments and health problems. Maternal and child health, hygiene and sanitation and communicable diseases have been covered in the essential health service package as well. Strong community engagement and ownership characterized this strategy. The application of appropriate technologies and the provision of medicines for community services have been exemplary.

The strategy was operationalized by training of CHWs selected from the community in a village with a minimum population of 400. The villages with CHWs are named PHC villages, while those with lower populations that are not eligible for such service are named Non-PHC villages. A community with a population of four hundred was selected as it was the minimum number that was able to recover and revolve its medicines costs from user fees charged by VHWs. Any population of less than 400 was not adequate to guarantee risk pooling. VHWs and used to operate in health posts built by communities inside the villages whereas the TBA moves around to the houses to provide delivery services.

A Community Health Nurse (CHN) serves an average of 5 PHC villages with an assumption of visiting one village daily in 5 working days in a week. The main tasks of the CHN are to support, supervise, complete recording and reporting forms and distribute supplies to the CHWs. The CHN

also coordinates RCH outreach clinics conducted by the nearby Health Center. CHNs are based in a 'key village' that is usually equidistance to the rest of the villages.

The PHC strategy has been proved to pay off in improving access to several MCH and control of communicable disease services. Time series improvements of maternal and child mortality have been observed better in PHC than non-PHC villages, and indicators of service utilization including skilled birth attendance and immunization have significantly improved (Hill et al 2000).

One of the successes of PHC was the establishment of voluntary breastfeeding support groups as part of the introduction of the Global Strategy on Infant and Young Child Feeding and the Baby Friendly Hospital Initiative (BFHI). The then Nutrition Unit of the MOHSW now the National Nutrition Agency, based on the 10th Step of BFHI, worked with the VDCs of PHC villages to establish an informal voluntary group called the Village Support Group to promote optimal maternal and child nutrition and health practices. Committee of 8 people (5 women and three men) are selected and nominated by the village to lead and operate the health-related chores of the community. Two (2) of them are the VHWs and the TBA supported by other members of the VSG for community mobilization and health information dissemination.

Situational Analysis of ART and PMTCT ARV Infant Care Services

The first AIDS case was diagnosed in The Gambia in May 1986. Over the years since then, the epidemic seems to be stabilizing at less that 2 percent. HIV overall prevalence rate among ANC attendees in 2017 sentinel surveillance sites revealed a national prevalence rate of 1.82%.This suggest that almost two out of every hundred pregnant women attending ANC in the Gambia were infected with HIV. In addition, HIV1 account for 1.69% and HIV2 is 0.13% (sentinel surveillance report, 2019)

A National AIDS Control Programme (NACP) was established in 1986 and a National AIDS Committee (NAC) formed in 1987 to lead the national response to HIV/AIDS. In 2001 The Gambia acquired funding from the World Bank for the implementation of an HIV/AIDS Rapid Response Project (HARRP). This US$15 million project scaled-up the national response to HIV/AIDS. Within the framework of this project a National AIDS Council (NAC) and National AIDS Secretariat (NAS) have been established under the Office of the President with His Excellency The President of The Gambia being the chairman of the NAC.

HIV and AIDS is still one of the major public health and development challenges of The Gambia. The estimated number of PLHIV in the country according to the 2019 UNAIDS Spectrum

estimates is projected at 28, 235; the age groups 15-49 accounting for 20, 862 PLHIVs. Among the projected people living with HIV, 8, 229 (29.1%) people are currently on antiretroviral therapy.

The socio-economic burden of HIV/AIDS on individuals, families and the state is very high. Heterosexual transmission, however, continues to be the main mode of spread of HIV in the country (ART survival study, 2017). In the Gambia, more women than men have had access to HIV testing a factor that is often attributed to women's greater engagement with HIV services through the ANC services. Although HIV prevalence in The Gambia does not differ significantly between males (1.7%) and females (2.1%), over half (66.16%) of adult PLHIVs who seek treatment are females. The majority (67.79%) of ARV clients are between the 15 - 49 year age brackets (ART survival study, 2017).

Loss to follow-up (defaulters) at 24 months after initiating ART in 2014 is the major cause of attrition (23%), followed by deaths (17%). Disclosure, stigma, discrimination, lack of transport fares, patients living across the border are all contributing factors to the high defaulter rate putting individuals at high risk for disease progression. The role of the social worker to follow-up defaulter has change to providing HIV care. This has greatly affected the work of the social worker to effectively follow-up defaulters. There is the need for NAS to retrain, re-orient and provide tools to the social workers for better patient tracing procedures, better understanding of loss to follow-up if retention is to be improved (ART survival study, 2017).

Besides, the National Cohort Cleaning Report (2019) revealed a little increase of CD4 investigations in 2019 compare to 2018; (5156 vs 4585) of the 8229 PLHIV on ART. Sixty percent (N=3108) of the CD4 tests conducted in 2019 had CD4 count results less than 500. In addition, the proportion of PLHIVs in care who had a recent viral load result recorded remained relatively low over the years. Of the 7833 PLHIVs on ART at various ART Centers, 2338 (29.8%) of them had a viral load test done in 2019 with a slight increase compared to last year. The viral load suppression was documented in 1560 (66.7%).

The number infants that were supposed to be tested was 540 and 312 (58%) were tested. Two months is the age when virological test is frequently done for infants. The virological test done in 2019 was 199 (71%). Thirteen of the tests (6.5%) were positive. The serological test is done at 18 months. One hundred and thirteen serological tests were done and 8 (7%) of them tested positive (Annual monitoring Report 2019).

Strength	Weakness
✓ Technical guidance from the Senior level management ✓ Functioning M&E system to adequately monitor the strategy ✓ CHN/VHS are mobile ✓ Regional staff to coordinate activities	✓ Inadequate monitoring of indicators at regional and facility level ✓ Weak PHC System ✓ Inadequate monitoring of patients due for lab investigations (Viral load and virogical and serogical test for infants)
Opportunities	**Threats**
✓ Possible funding from NFM3 ✓ All the villages fall under a circuit ✓ Health facilities strategically located ✓ Women attend both ANC and IWC Clinics regularly ✓ CNH/VHS can collect sample for lab investigations	✓ Some circuits have n CHN/VHS circuits ✓ Inadequate funds ✓ Transport fares to clinics

Objectives

1) To increase the ART coverage from 29% to 52% by 2023
2) To increase the PMTCT ART coverage from 49% to 90% by 2023
3) To increase viral load coverage from 19% to 90% by 2023
4) To increase virogical infant testing from 15% to 90% by 2023

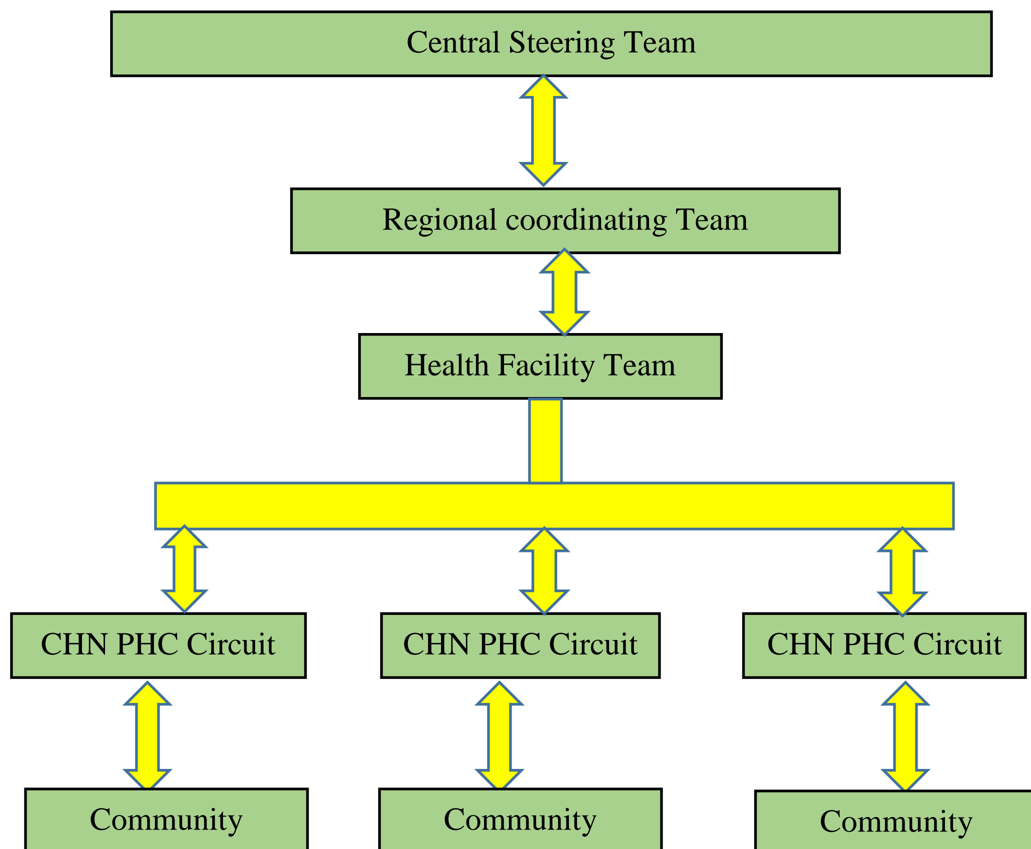
Implementation Strategy

This concept will use the existing Primary Health Care System (primary care services). All the health facilities providing ART and Prevention of Mother-To Child-Transmission services will be included.

Clustering

In this model, the regions will be divided into clusters (PHC Circuits). Each cluster will contain health facilities (Public and Private) which provide ART and PMTCT ARV Infants Services.

The figure below showed the proposed outlook of clustering model



There are 14 ART and 58 centers in the seven regions of the country. Western 1 Health Region (6 ART and 18 PMTCT centers), Western 2 (3 ART and 7 PMTCT center) Lower River Region (1 ART and 6 PMTCT centers), Central River Region (1 ART and 9 PMTCT centers), Upper River Region (1 ART and 8 PMTCT centers), North Bank East (1 ART and 6 PMTCT centers) and North Bank West (1 ART and 4 PMTCT centers)

Each health region will be broken down into a number of clusters based on the number of PHC Circuits in the region as in the table below

No	Region	Number of Circuits	Activated	Vacant
1	Western 1	8	3	5
2	Western 2	14	14	0
3	Lower River	15	14	1
4	Central River	34	26	8
5	Upper River	18	18	0
6	North Bank East	14	11	3
7	North Bank West	16	15	1
	Total	119	101	18

The Primary Health Care Unit of the Ministry of Health has also developed a concept note on Urban PHC. The document is yet to be validated. The unit also need to conduct an assessment and demarcate the urban area into circuits. As most of the PLHIV clients lives in the urban area, assisting the unit in this endeavor will enhanced complete circuit demarcation of the whole country. Thus the cluster modeling strategy cover the whole country.

The role of the health facility staff

The health facility staff will line list all the patients receiving ART at both ART and PMTCT centers by their address (villages). These names will be regrouped by circuits in the region. When the month ends the facility staff will prepare a list of those clients that missed their routine appointments ART mediation, viral load and EID investigation by village and circuit and submit to the CHN/VHS concern for necessary follow-up. The facility staff will conduct periodic review meeting with the CHN/VHS to discuss the progress of strategy implementation and way forward. During this meeting the head of HIV services at the facility will brief the meeting on the progress made during the period under review. The meeting will enhance the development of a work plan to improve the services. Such meetings will be attended by the regional AIDS coordinator.

The role of CHN/VHS

All the community health nurses at village health services in the country will be trained on counseling and testing services, General ART and PMTCT services. Each CHN/VHS will be tasked to ensure that all missed appointments of ART, PMTCT ARV Infant other services are follow-up in the community. The community health workers (VHWs and CBCs) can help in the EID follow-up if the need arise. In addition, to minimize defaulters rate, CHN/VHS can also be given at least a month or two's medications supply for stable patients to be administered at home. During the visit, the CHN/VHS can also collect samples for both viral load and EID when they are

due and submit them to the laboratory through the care nurse or PMTCT focal person. They can also encourage all clients to go for their routine lab investigations at due date. The CHN/VHS will require to fill the follow-up form and submit to the head of ART/PMTCT services at the facility.

The CHN/VHS will be remunerated **(D2, 000)** for this services in addition to monthly fuel allocation per month.

Structures

Three teams shall be formed; the central steering, regional and facility teams. The former will be an oversight committee that oversees the general implementation of the program while the other two provide technical guidance to the successful implementation of the strategy. The teams shall meet periodically to discuss the status of program implementation. Breakfast shall be provided.

The team composition and roles and functions are described below

Central Team

Team Composition

- NACP ART Supervisor (secretary)
- Care and Support Officer NAS (Chair)
- Primary Health Care Unit MOH – 1
- Monitoring and Evaluation Specialist NAS
- Coordinator RSSH NAS
- Laboratory staff NPHL – 1
- PSM Officer NAS

Role and Functions

- Planning and coordination of the strategy
- Mobilization of resources for the successful implementation of the strategy.
- Monitoring the implementation of the strategy.
- Conduct on the job supportive supervision during which performance review meetings are held with regional and facility teams

Regional team

Team composition

- Regional AIDS Coordinator (secretary)

- Regional Principal Nursing Officer (chair)
- Regional CHN Trainer
- The Care nurse at ART Center
- Regional Drug Store Keeper

Role and Functions

- Monitor progress of implementation of the strategy in the region
- Report regularly to the central team on the status of the implementation
- Obtain reports from the facility teams
- Analyse data received from the facility teams and provide feedback on trends observed;
- Conduct periodic review meetings with the facility teams on the strategy
- Provide technical support and advice (mentorship) to facility teams on how to strengthen the strategy

Facility Team

Team Composition

- Principal Nursing Officer at the hospital/Facility In-Charge (chair)
- The Care Nurse/PMTCT Focal person (secretary)
- The social worker
- The CHN/VHS
- Laboratory staff – 1
- Pharmacy staff – 1

Role and Functions

- Periodic review of the registers to identify missed appointments, those due for viral load and EID
- Monitoring the monthly data trend from the monthly summary reports.
- Collaborate with the Community Health Nurse Village Health Services on defaulter tracing (ART and EID) and refilling of medications for stable patients
- Sending regular monthly /quarterly report to the regional team
- Provide on the job mentorship for health facility staff and Community Health Nurses Village Health Service.

CLIENT FOLLOW-UP FORM

Name:

Address:

Circuit:

Contact number:

Reason/s for follow-up:

Client traced: YES NO

Reason advanced by client for missing the service:

Service/s provided during the follow-up visit:

Name of health worker:

Title:

Signature:

Date: