NATIONAL ART RETENTION STRATEGY FOR PLHIV ON CARE

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GOVERNMENT OF THE REPUBLIC OF THE GAMBIA

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EXECUTIVE SUMMARY

Retention in HIV care is defined as continuous engagement from diagnosis, prevention, treatment, support and care services. 'However, it sometimes includes the period from diagnosis to successful linkage to care. Retention in care is required for optimal clinical outcomes in patients with HIV infection. For patients who have not initiated antiretroviral therapy (ART), retention in care enables the provision of prophylactic medications for opportunistic infections, ongoing staging, prevention of mother-to-child transmission (PMTCT) and prompt initiation of ART once the patient is ready to start.

Retention in care for all patients also provides additional benefits through ancillary services, social support, and secondary prevention messages that can help patients navigate a lifelong and complicated infection.

Failures of retention often result to default or stopping of medication. This happens once interruption occurs and the benefits of ART are rapidly reversed. Complications can occur in the form of drug resistant mutations that limit future drug options and increase mortality.

Patients in care and without retention may affect the overall effectiveness of ART programs. These has compounded the low retention rate of PLHIV in care in The Gambia and requires an urgent redress to improve adherence treatment outcomes.

Due to the above challenges, the country developed an ART retention strategy highlighting six main strategic objectives to improve the retention of PLHIV on ART. This was led by a consultant who was supported by a technical working group which was highly participatory involving all relevant stakeholders.

ACRONYMS

AGYW	-Adolescence Girl and Young women
AIDS	-Acquired immuno-deficiency syndrome
ANC	-Antenatal Care
APN	-Assisted Partner Notification
ART	-Antiretroviral Therapy
CASG	-Community Adherence Support Group
CBC	-Community Birth Companions
CHN	-Community Health Nurse
CHW	-Community Health Worker
CLF	-Community Linkage Facilitators
CMS	-Central Medical Stores
CTX	-Co-trimoxazole
DHIS	-District Health Information System
DHS	-Demographic Health Survey
DREAM	-Drug Resource Enhancement against AIDS and Malnutrition
EFSTH	-Edward Francis Small Teaching Hospital
EID	-Early Infant Diagnosis
ETS	-Electronic Tracking System
FBOs	-Faith Based Organizations
FSW	-Female Sex Workers
GBV	-Gender Based Violence
HBC	-Home Based Care
HCT	-HIV Counseling and Testing
HIV	-Human Immuno-deficiency Virus
HMIS	-Health Information Management System
HOC	-Hands on Care
HTC	-HIV Testing and Counseling
HTS	-HIV Testing Services
IBBS	-Integrated Bio-Behavioural Survey
IEC	-Information Education and Communication
INH	-Isoniazid
KPs	-Key Populations
LTIs	- Leprosy and TB Inspectors
LTFU	-Lost to Follow Up
M&E	-Monitoring and Evaluation
MDFT	-Multi-Disciplinary Facilitation Teams
MSM	-Men who have Sex with Men
NSP	-National Strategic Plan
NSS	-National Sentinel Survey
OIs	-Opportunistic Infections
OVC	-Orphans and Vulnerable Children
PEP	-Post Exposure Prophylaxis
PHC	-Primary Health Care
PICT	-Provider Initiative Counseling and Testing
PLHIV	-People Living with Human immuno-deficiency Virus
PMTCT	-Prevention of Mother-to-Child Transmission
POC	-Point-of- Care
POCT	-Point-of- Care Treatment
PPE	-Personal Protective Equipment
PrEP	-Pre exposure prophylaxis
PWID	-People Who Inject Drugs

QI	-Quality Improvement
RBF	-Results Based Financing
RMS	-Regional Medical Stores
RSSH	-Resilient and Sustainable Systems for Health
STI	-Sexual Transmissible Infections
TB	-Tuberculosis
TPT	-Tuberculosis Preventive Treatment
VDC	-Village Development Committee
YAPS	-Young People and Adolescence Peer Support
VL	-Viral Load

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The Development of the strategy was led by a national consultant Dr. Saihou T. Sabally who was supported by a technical team. We wish to thank them all for their hard work and dedication. We are also thankful to the PLHIV support groups for their meaningful participation.

We are confident that the implementation of this strategy will increase the number of PLHIV on care, reduce lost to follow up and greatly improve the retention rate of PLHIV on ART.

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INTRODUCTION

BACKGROUND

The Gambia is a low HIV prevalent country with 1.9% in the general population from the 2013 Demographic Health Survey (DHS) but concentrated in key population (35% MSM and 11% FSW) as per 2018 IBBS study. Free anti-retroviral treatment (ART) services were introduced in in 2004, piloted and three health facilities and is scaled to 14 sites as of 2016.

Survival of PLHIV for 12 months after initiation of ART is on the decline, dropping from 83% in 2015 to 75% in 2018.

Inadequate retention is associated with so many factors. Among them are stigma and discrimination, indirect cost to the patient, service delivery factors, patient factors and beliefs, overwhelmed and under-staffed healthcare systems. While extensive efforts have been made to create an enabling environment, work still needs to be done to address the above-mentioned challenges among PLHIV, women, young and adolescent boys and girls and key population (MSM, FSW, PWID and Prisoners).

The country's estimated thirty thousand People Living with HIV need lifelong ART. To achieve this, the country has adapted existing models of differentiated care to meet both the diverse needs of PLHIV and the capacity and constraints of the health systems. To ensure sustainability, this strategy must be supported by national policies and be adequately funded. The impact of the differentiated care models should be evaluated with clear indicators, including quality and outcomes of care, client and health care worker satisfaction, and costs to both the client and the health system. As the models are implemented and improved through analysis of programme data, other quality improvement mechanisms and implementation research, stakeholders can work together to address the priority challenges that arise. To reach differentiated care goals, Ministry of Health, Implementing Partners, Donors, Civil Society Organizations and Communities of PLHIV will first need to collaborate around a differentiated care concept that puts people at the center of services.

GOAL

To have a participatory national ART Retention Strategy with contextual factors that will enable or influence high retention of PLHIV initiated on ART

OBJECTIVES

1. Outline clear modalities in the retention of cascade of HIV care, treatment and support services among Pre-ART Patients
2. Put in place strategic measure to monitor trend of retention in care, treatment, and support programs among PLHIV at 6, 12, 24, 36, and 48 months after initiation of ART.
3. Put in place strategic initiatives to strengthen the integration of services and ensure linkages across all programme components for effective individual-level case tracking and retention.
4. Provide an explicit support system for users and community mobilization and advocacy processes that promote the rights of People Living with HIV (PLHIV) will be established as a critical means towards improving retention in Care
5. Articulate a mechanism that matches individual obligations on adherence with the health system that ensure continuous access to uninterrupted supplies of drugs, therapeutic nutrition, skilled providers (including task-shifting) and laboratory support to maximize the safety and efficacy of drugs, and a supportive environment and community norms for adherence
6. Put in place strategic measures to scale up the provision of community-based care and support services in support of the ART programmes as a means toward increasing social support, reducing stigma, discrimination, increased disclosure among PLHIVs, their partners, families and friends.

COUNTRY CONTEXT

The Gambia is a low HIV prevalent country with HIV-1 as the predominant virus driving the epidemic. Monitoring of HIV prevalence rate in the country was previously based on National Sentinel Surveillance (NSS) among pregnant women attending antenatal clinics. This is complemented by Demographic Health Survey (DHS) and Integrated Bio-Behavioural sentinel Surveillance (IBBSS) which are conducted every 5 years and every 2 years respectively. The HIV trends indicate a steady increase of HIV1 between 1993 and 2004 while HIV2 was generally decreasing. During the same period prevalence rate of HIV1 increased from 0.6% to 2.1% while HIV2 saw a decline from 1.1% to 0.8%. However, between 2004 and 2007 prevalence trends have been unpredictable since prevalence rates decreased from 2.1% to 1.1 in 2005, then sharply increased to 2.8% in 2006 and yet another sharp decrease to 1.4% in 2007.The 2008 results showed a slight increase of prevalence to 1.6% and then a slight decrease of the prevalence to 1.5% in 2014. The National Sentinel Survey (NSS) 2014 results indicate a prevalence of 1.3% for HIV1 and 0.2% for HIV2. The country for the first time conducted Demographic Health Survey (DHS) in 2013 and it showed that 1.9% of adults 15-49 among the general population are infected with HIV. This is complimented by the 2018

IBBS Final Report among Key Affected Populations (KAPs) which revealed a very high prevalence of HIV among MSM, 35% and among FSW, 11%.

With the adoption of the WHO 2015 consolidated guidelines for the prevention and treatment of HIV, The Gambia, with support from the Global Fund moved from immunological criteria to test and treat for PLHIV who need ART in 2016. This has reduced the pre ART period greatly because PLHIVs start treatment earlier but the pre ART period still exist because of personal difference in clients and co-morbidities.

Retention has been challenging as survival of PLHIV for both 12 and 24 months after initiation of ART has declined from 83% in 2015 to 75% in 2018. Factors related to provider capacities, including clinical diagnosis and management of opportunistic infections (OIs), may also be responsible. However, the Survival Study (2018) indicates that low retention on ART is attributed to:

- Lost to follow-up of ART patients
- Time and cost of transport to access ART centres
- Discontinuation of the nutritional supplement programme for PLHIV
- Stigma, leading to lack of disclosure to family members, leading to problems finding excuses to attend ART sites on a regular basis
- Lack of disclosure and personal beliefs leading to preferring traditional healers' treatments
- Difficulty in understanding the need for lifelong treatment

RATIONALE

The Gambia has never had a retention strategy plan for ART. Invariably, the strategy plan is taking cue from the NSP for the overall achievements of the UNAIDS three 90s. Further to this it is intended to decentralize services, engage all community health service sites and expand the prevention treatment and care to meet the achievement of the 90-90-90 targets. It will also provide an explicit support system for users and community mobilization and advocacy processes that promote the rights of PLHIV and established as a critical means towards improving retention in Care.
The need for this National ART Retention Strategy, is to put in place contextual factors that will enable or influence high retention of PLHIV patients-initiated on ART and come up with clear modalities to maintain them in the retention cascade of HIV care, treatment, and support services among Pre-ART and ART Patients.

Retention in care is important for positive clinical outcomes such as viral load suppression and survival. Over the past 30 years that the country is implementing the HIV and AIDS responses, a document strategy on retention of PLHIV on care has never been developed. This will enable national response to adopt a participatory approach

to improving Retention in HIV Treatment and Care for newly diagnosed patients and older patients on ART.

With evidence of decline in the survival rate from the 2018 Survival Study conducted, , this document with the National Strategic Plan (NSP) and other HIV related documents under programmatic guides will serve and support the guiding principles in the implementation of retention programme for PLHIV, reducing Lost To Follow Up (LTFU), drug resistance, enhancing viral suppression, and achieving the 90, 90, 90, targets.

STRATEGIC PRIORITIES

The strategic priorities of the 2021-2025 NSP rally around the following: Prevention (bio-medical and non-biomedical) – including HCT, PEP and PrEP; Care and Treatment; Ensuring that key or vulnerable population are not left behind; Sustainable community systems and responses; Resilient and Sustainable Systems for Health (RSSH) including Health and Community Systems; Equity; and Sustainability.

GUIDING PRINCIPLES

Focus on evidence-based interventions for maximum impact

For virtual elimination of HIV in the Gambia, it is important that all funding, interventions and activities rally around the 90-90-90 targets.

Improved targeting of critical interventions to Key and Vulnerable Populations

Although the Gambia has implemented prevention programmes for key populations, more efforts are required to reduce barriers to HIV, TB and STI services and to achieve zero transmission of HIV by 2030. These efforts must additionally be targeted at key populations most at risk of either becoming infected with HIV or infecting others, while, at the same time, focusing on vulnerable groups such as children, adolescents, youth, women, prisoners, migrants, and others, and the general population.

Quality Improvement

Quality Improvement (QI) and programme monitoring and evaluation (M&E) methods will be used to ensure that quality prevention, treatment care and support services are provided. The focus of the QI efforts will be on improving adherence to clinical practice guidelines, efficiency, lowering costs, and utilizing health information and improving care coordination.

Service Integration

Integration of sexual and reproductive health (SRH), HIV and Tuberculosis interventions will lead to several health outcomes and benefits which include among others: (1) improved access to, and uptake of critical services; (2) better access of PLHIV to services tailored to their needs; (3) reduced AIDS-related stigma and discrimination; (4) improved coverage of underserved and key populations (5) greater support for triple protection against unintended pregnancy, HIV, and STIs (6) Improved quality of care; and (7) Enhanced effectiveness and efficiency of the response.

Community Engagement

Community engagement is a key component to ensuring community participation and involvement in complementing government's effort to realize the 90-90-90 targets and keeping those who are negative HIV free. The interventions will include demand creation for services, knowledge sharing on services, mobilizing communities to access prevention services, conducting referrals of HIV positive individuals to health facilities, conducting follow-ups for ART patients to treatment adherence, and providing psychosocial support to PLHIV.

Human Rights and Gender

Human rights will be safe-guarded through promoting gender equity and equality and ensuring a stigma-free environment and protection of patients and clients rights. The strategy of protection and promotion of human rights will be essential in preventing the spread of HIV and mitigating the socio-economic impact of the pandemic.

CONTINUUM OF CARE

The continuum of care for PLHIV is a patient centered concept that extends along steps from prevention interventions, HIV testing through enrolment in HIV care, ART initiation and retention in life-long ART. The continuum does not dictate the means and models for service delivery, but provides a standardized way of analyzing the performance of different approaches to the delivery of HIV testing, care and treatment services.

Stage 1: Testing to enrollment in care

This stage covers the interval from receiving an HIV-positive diagnosis to receiving baselines results. Patients may be lost in Stage 1 between having an HIV test and

enrolling in care or, if tested at a clinic, between providing a Viral Load blood sample and returning for results. Patients must still enroll in care after diagnosis

Stage 2: Retention in pre-ART care until treatment Readiness

This covers the interval from enrollment to ART readiness, when patients who have not yet started ART are being prepared for life-long treatment. A few patients will still require a delay in initiating ART—for example, for tuberculosis treatment.

Stage 3: Readiness to treatment initiation

This lasts from determination of readiness to ART initiation. Losses in this stage relate to health system barriers, such as multiple clinic visits, delays in receiving laboratory test results, waiting time of patients or reluctance to commit to lifelong treatment.

Stage 4: Retention on ART

Retention after starting ART—remains a critical part of the cascade. As early retention on ART is marked by losses due to early death (largely related to late presentation) and high rates of loss to care, due to late retention on ART (after the first year) is less dramatic, with mortality stabilizing and losses diminishing.

For details of the HIV Care Continuum Model (see annex table: 1)

STRATEGIC OBJECTIVE 1

Strategy 1: Strengthen human resource capacity

Activities

- Train human resource and community structures to ensure retention
- Train health care provides on the provision of friendly client oriented services for children, adolescent and key population
- Train health care workers on the protection of children and women against abuse and GBV
- Implement stigma reduction strategies in health care facilities/communities
- Re-orientate staff on the HIV Prevention and Control Act
- Implement Task-Shifting Strategy
- Implement Results Based Financing (RBF) Approach to health system strengthening.
- Standardization of the package of basic pre-ART services
- Implement Staff Appraisal

- Coordinating movement of health care workers on service provision (reduce attrition)

Strategy 2: Strengthen Logistic arrangements for retention

Activities

- Decentralize pre-ART services at primary and secondary level facilities (POC,
- Procurement of equipment and supplies
- Provision of infrastructure at primary and secondary levels for pre-ART services
- Provision of client e-tracking system
- Use of SMS or other technologies for client reminders (for appointments or medication)

Strategy 3: Ensure availability of health commodities

Activities

- Provision of adequate medical and laboratory supplies at all times
- Provision of care and support commodities (mosquito nets, soap and other WASH commodities)
- Provision of other care and support medications (e.g. co-trimoxazole, pain medications)
- Provide transport for distribution of commodities
- Ensure adequate storage capacity and conditions at facility level

Strategy 4: Ensure client-oriented practices to retention

Activities

- Provision of income-generation activities for PLHIV
- Provision of nutrition programmes
- Provision of transport refunds
- Provision of legal and child protection programmes
- Conduct client satisfaction surveys
- Prioritization of clients at greater risk for loss to follow up

Strategy 5: Strengthen Community based practices to retention

Activities

- Use of community based volunteers or community health workers

- Education/sensitization campaigns on care and support activities in the community
- Increased involvement of PLHIV from the planning, decision making and implementation of activities in the communities
- Create community based approaches to improve retention
- Use of community base volunteers and peer educators/counselors
- Increasing male involvement in community health care activities
- Encourage linkages between communities and health facilities

Strategy 6: Tracking Lost to Follow Up (LTFU) mechanisms

Activities

- Encourage and integrate peer support groups for adolescents and children in the existing support groups
- Provide child- and adolescent- friendly clinic space and schedules
- Train healthcare workers to support adolescents through adherence, disclosure and peer influence
- Ongoing adherence counselling
- Functional tracking system to identify adolescents and children who missed appointments
- Decentralize HIV care in pediatric clinics
- Strengthen mobility for follow up at the facility level
- Provision, fueling and maintenance of motor bicycles
- Provision of telephone call allowances for contact tracing
- Training of PLHIV as peer counselors for the facilities and communities
- Training of CHNs and HBC volunteers for follow up at community level
- Use of technology for follow up and tracking of clients
- Introduce unique client identifiers to tract and follow up clients to reduce loss to follow up
- Sensitization of traditional healers to understand the need for life long treatment and support in defaulter tracing
- Sensitization of community influential leaders to understand the need for adherence and lifelong treatment

Strategy 7: Strengthen re enforcement counseling on the importance of continuum of care

Activities

- Reinforce counselling on adherence, side effects, nutrition, safer sex practices, and disclosure

- Conduct index testing
- Train/retrain peer counselors on adherence, side effects, nutrition, safer sex practices, and disclosure

Strategy 8: Redesign IEC messages on the importance of continuum of care and treatment cascade for the client, men and community

Activities

- Education campaigns/community based sensitization on care and support activities in the community
- Provision of posters and bill boards
- Mass communication and media
- Use of traditional communicators to sing songs

Strategy 9: Provision of transport cost to improve client satisfaction and quality optimal care

Activities

- Provision of reduced or free indirect cost of transportation to the clinic
- Provide logistics or means of transportation of samples collected and return of results through internal and external referral linkages

Strategy 10: Strengthening Human resources for quality ART services

Activities

- Provide additional training, incentives, data tools and job aids for health care workers.
- Provide programmatic support to ensure quality may help reduce attrition by other cadres of staff.
- Use community health workers or volunteers to conduct community outreach and client tracking efforts to reduce attrition from care programs.
- Training staff and volunteers on standards of care, follow up and improve and maintain staff relationships with clients
- Improve the work environment, motivation, appraisal, reduce work load and increase salary or other benefits.
- Conduct clinical mentoring to enhance retention to build capacity of the health care providers through on the job/step down trainings and strengthen the inter unit referral within the facility and community referral and linkages.

Strategy11: Strengthen advocacy to dispel stigma and discrimination against PLHIV

Activities

- Sensitize/train staff on anti- stigma and discriminatory measures in health care facilities
- Conduct community sensitization on stigma and discrimination
- Create a more supportive environment and encourage PLHIV to seek care.
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- Create and strengthen support for HIV care services among community/traditional leaders
- Use the right based approach in children, girls, women and key population to enable the reduction of gender inequality and improve retention

STRATEGIC OBJECTIVE 2

Strategy 1: Ensure loss to follow-up of ART patients are brought back

Activities

- Provide community service manual for support societies
- Provide community service manual for community health nurses and leprosy and TB inspectors (LTIs)
- Engage support societies to follow up PLHIV who defaulted in the community
- Engage the Community Health Nurses and Leprosy and TB Inspectors (LTIs)to follow and administer ARVs to defaulted PLHIV in the communities

Strategy 2: Ensure time and cost of transport to access ART centres is reduced

Activities

- Establish more ART sites across the country and upgrade all PMTCT sites to act as refilling centers for ART
- Train more health care workers in line with task shifting protocol (working document) to prescribe ART and monitor PLHIV at the newly established sites
- Create transport refunds and nutrition support for PLHIV on follow up visit to the health facilities.

- Provide and administer ART to LTFU in the communities through the VHS/CHN
- Provide access to ART services for Prisoners or those incarcerated and key population

Strategy 3: Ensure continuation of the nutritional supplement programme for PLHIV

Activities

- Provide nutrition support for PLHIV during follow up visit to the health facilities (3 monthly visits for regular checkup)

Strategy 4: Strengthen differentiated care at all levels

Activities:

- Formation of individuals or groups of support group as adherence clubs
- Incorporate enhanced adherence counseling for all PLHIV every three months
- Train PLHIV ad service providers on right based approaches with links to legal services

STRATEGIC OBJECTIVE 3

Strategy 1: Reduce stigma and discrimination

Activities

- Raising awareness through community-led HIV education and sensitization activities using social and behavioral change communication strategy
- Raising awareness through community-led HIV education and sensitization activities using social and behavioral change communication strategy to address and end gender-based violence in PLHIV and other special groups

Strategy 2: Address the issue of difficulty in understanding the need for lifelong treatment

- Raising awareness through community-led HIV education and sensitization activities using social and behavioral change communication strategy

- Treatment literacy and education for children, adolescents, women and men on the need for life long treatment

Strategy 3: Addressing Rights and legal services

Activities

- Conduct training for health-care personnel
- Conduct sensitization for health-care personnel
- Conduct sensitization Community structures,
- Conduct sensitization for PLHIV
- Conduct sensitization for key population
- Conduct sensitization for lawmakers
- Train and sensitize law enforcement officials

Strategy 4: Task-shifting and task-sharing

- Train/orient health care workers on client care, education and SOPs on HIV care
- Orient and train community health workers and community structures on HIV community-based services

STRATEGIC OBJECTIVE 4

Strategy 1: Ensure uninterrupted supply of drugs, laboratory supplies and therapeutic nutrition

Activities

- Train/retrain pharmacy staff on supply chain management (consumption data, quantification of drugs and laboratory reagents)
- Train/retrain pharmacy staff on inventory control and management.
- Maintain a minimum stock level of two months for RMS and one month for health facilities
- Redistribute supplies from slow moving facilities to fast moving facilities to avoid stock out

Strategy 2: Ensure the availability of skilled service providers for an uninterrupted service delivery

Activities

- Introduction of Result Based Financing (RBF) in HIV care and treatment
- Re introduce the use of PLHIV as peer counselors at the facility and community
- Capacity building and skills transfer
- Train PLHIV and other specific groups on counseling and advocacy
- Train PLHIV and other specific groups on positive living and treatment literacy

STRATEGIC OBJECTIVE 5

Strategy 1: Strengthen Capacity of community-based volunteers and/or community health workers, community home based volunteers, family carers and lay counselors for social support and tracing of LTFU

Activities

- Training/retraining of community health workers, home based care volunteers, family carers and lay counselors on psycho-social support and tracing of LTFU
- Training/retraining of community health workers, home based care volunteers, family carers and lay counselors on adherence counseling, treatment literacy, and tracking of LTFU

Strategy Strengthen community-based approaches to improve retention in care

Activities

- Train and sensitize the PHC structures on continuum of care and stigma reduction
- Train and sensitize community and traditional leaders on continuum of care and stigma reduction
- Identify community moderators or champions to support community linkages and referral
- Train and sensitize community influential leaders on male involvement
- Sensitize and promote positive parenting and communication between girls, boys and their parents/caregivers to reduce or avoid risk STIs and GBV
- Sensitize the community on the use of the free hot line to report child protection and GBV issues
- Provide support and care services and safety net to protect Orphans and Vulnerable Children in collaboration with Ministry of Women, Children and Social Services

- Provide care and support for key populations

Strategy 3: Ensure client satisfaction and feedback mechanism

Activities

- Conduct quarterly feedback meetings with clients on service delivery/waiting time
- Provide transportation support during feedback meetings
- Provide food and refreshment

Strategy 4: Re introduce income generating activities for PLHIV social protection

Activities

- Provide training in business management
- Provide soft loans to PLHIV support groups/members
- Train PLHIV on leadership and group dynamics
- Train/retrain PLHIV on livelihood skills and income generation activities

Strategy 5: Provision of nutritional supplement and food security

Activities

- Support back yard gardening
- Support poultry and small ruminant farming
- Training in food preparation and preservation
- Train/retrain PLHIV in communal farming

Strategy 6: Capacity building of children, adolescents and young women

Activities

- Train boys, girls, adolescents and young women on livelihood protective skills to reduce or avoid risk of STIs/HIV and gender based violence
- Training on communication skills to engage their parents/guardian in the event of risk or occurrence

STRATEGIC OBJECTIVE 6

MONITORING AND EVALUATION

Monitoring and evaluation (M&E) frameworks and systems will need to collect and analyze information to support the implementation and maximize the impact and measure the trend of retention in care for PLHV at 6, 12, 24, 36 and 48 months following initiation of ART.

M&E will assess the effectiveness of interventions and linkages between services along the cascade of testing, treatment and care for HIV and associated conditions. Such information is essential to detect and respond to bottlenecks or gaps in programme performance and to adequately characterize and respond to patient attrition.

Patient monitoring systems are also important to support people receiving treatment over time and as they move between clinics. As programmes mature, monitoring is also essential for individual- and population-level outcomes to optimize the impact of country programmes. Involving civil society in M&E activities is also critical to better understand successes and failures, especially in assessing the determinants, perceptions, values and experiences of people living with HIV, key populations and the broader community in accessing and using services.

A limited number of studies reflecting HIV care and ART retention have been done in the Gambia. Studies on retention conducted focused on retention for 12 and 24 months but those for the other periods have not been done. The other studies done are the PMTCT Impact Study and National Sentinel Studies

Strategy 1: Review, update and strengthen Monitoring and Evaluation systems

Activities

- Indicator selection and standardization
- Periodic review and update of data tools
- Transition to electronic data collection tools
- Data analysis
- Capacity strengthening for data managers and users

Strategy 2: Conduct Research

Activities

- Survival Studies
- PMTCT Impact Assessment

- Integrated Bio-Behavioral Sentinel Surveys
- Cohort Analysis
- Incidence, Prevalence and Mortality studies
- Viral Suppression
- Drug adverse effects, toxicity and resistance studies
- Client satisfaction studies
- Sentinel studies
- Impact and programme performance studies
- Surveillance

Strategy 3: Establish and maintain simple and standardized monitoring system at health facility and community levels

Activities

- Use of electronic pharmacy based records
- Use of electronic based HIV registers
- Facility based ART reporting
- Data review and feedback meetings including community structures
- Device tools to collect health commodity consumption data
- Monitor ARV stock out
- Capacity strengthening of health personnel and community structure on monitoring

Strategy 4: Strengthen laboratory systems

Activities

- Monitor laboratory consumable and stockouts
- Use of electronic based recording system
- Capacity strengthening for staff
- Provision of laboratory equipment
- Providing reliable electricity
- Expand and refurbish laboratory infrastructure
- Provide more Gene-Xpert machines

INDICATORS FOR HIV CARE

- Number of PLHIV who tested positive to HIV and know their status this month
- Number of PLHIV enrolled into care this month

INDICATORS FOR ART

- Number of PLHIV on ART for the first time this month
- Number of PLHV currently on ART this month
- Number of PLHIV who restarted ART this month
- Number of PLHIV on ART transferred in this month
- Number of PLHIV on ART transferred out this month
- Number of PLHIV on ART who defaulted
- Number of PLHIV on ART who died
- Number of PLHIV on treatment for 6 months after initiation of ART
- Number of PLHIV on treatment for 12 months after initiation of ART
- Number of PLHIV on treatment for 36 months after initiation of ART
- Number of PLHIV on treatment for 48 months after initiation of ART
- Median baseline CD4 count for persons who started ARV in the last month

INDICATORS FOR CARE AND SUPPORT SERVICES

- Number of Orphans and Vulnerable Children who received educational support
- Number of Orphans and Vulnerable Children who received nutritional support
- Number of PLHIV on appointment who received transport refunds

INDICATOR FOR VIRAL SUPPRESSION

- Number of PLHIV on ART who had viral load test done
- Percentage/Number of PLHIV on ART who are virally suppressed

INDICATORS FOR STOCKOUTS

- Number of health facilities that reported stock outs of HIV test kits this month
- Number of health facilities that reported stock outs of ARVs this month.
- Number of health facilities that reported stock out of laboratory reagents this month

INDICATORS FOR HIV AND TB COINFECTION

- Number of PLHIV screened for TB monthly
- Number of PLHIV assessed for TB monthly

APPENDIX:

GLOSSARY OF TERMS

- Consistency of terminology is especially important for monitoring and evaluating HIV services which in turn is critical to improving HIV service quality and delivery.
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1. **Adherence:** Compliance with a prescribed medication or treatment regimen.

2. **Care continuum:** The continuum between identification of PLHIV, initiation and maintenance of treatment. This is defined by 4 Steps starting from a positive HIV test to enrolment in care as follows; enrolment in care to assessment for ART readiness, ART readiness to initiation of ART, and finally continuation of lifelong ART

3. **Contact:** A patient's contact with the healthcare facility/ programme. This can be a clinic visit, medication pick-up, attendance at laboratory services, or telephone review

4. **Decentralization:** usually refers to a political reform, designed to reduce the extent of central influence and promote local autonomy. Consists of two forms;
    - **Deconcentration:** transfers authority and responsibility from a central Ministry of Health to field offices of the Ministry at a variety of levels (regional, provincial, and/or local)
    - **Delegation:** This form of decentralization transfers authority and responsibility from the Ministry of Health to organizations not directly under its control (i.e. non-governmental agencies)
5. **Defaulter:** A PLHIV who had been on ART and missed two or more monthly clinical appointments
6. **Disengagement:** is to separate or release someone or something from something they are attached to or connected
7. **Follow-up:** An intended contact. This includes a formal appointment, telephone contact, or referral.
8. **Integration:** The provision of related healthcare services together to facilitate continuity of care and may improve convenience for the patient. Integration may be functional or structural
9. **Linkage:** When a patient or client is moved to another unit within the same facility or another facility to commence or continue receipt of service or care
10. **Loss to follow up:** is when 180 days or more has elapsed since the last clinic visit by a PLHIV and after three unsuccessful tracking attempts

11. **Minimum Stock Level:** Is the level of an item, below which the actual stock should not normally be allowed to fall, to avoid stock-out
12. **Missed appointment:** A scheduled clinical appointment for which a PLHIV does not show up
13. **Pre-ART period:** refer to the period between enrolment at an ART clinic and initiation of ART and will include prevention, care and support services
14. **Referral**: This is when a client is sent to another service delivery centre to get a service that is not available where the client was
15. **Retention in care:** Ensuring that the client continues to receive appropriate services throughout the continuum of HIV care and support.
16. **Visit:** Contact with care
17. **Viral suppression:** This is when a client's viral load is less than 1000 copies per milliliter of blood or is undetectable

Figure1: Stable Client Model

Source: Grimsrud A Et al. Journal of the International AIDS Society 2016

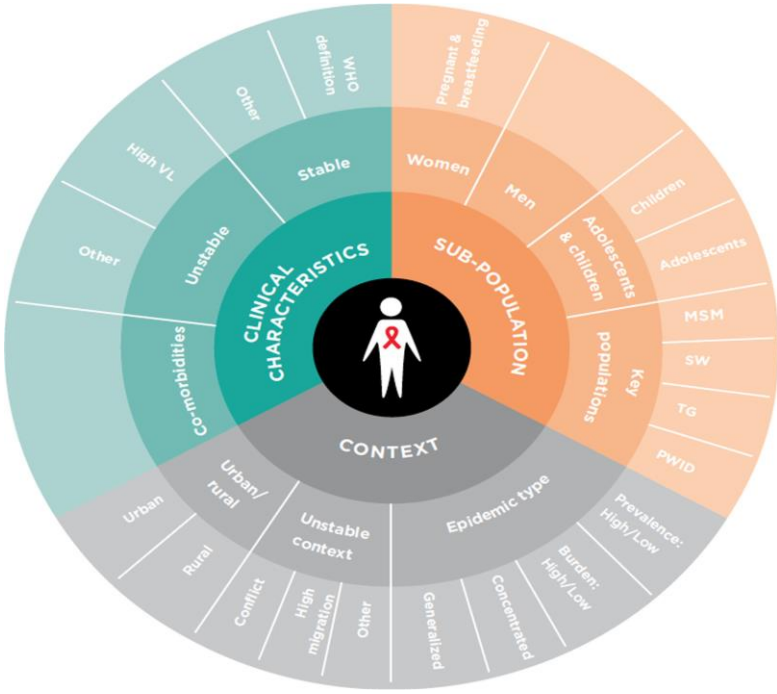

Table 1: HIV Care Continuum Model

Stage 1: From a Positive HIV Test to Enrollment in Care	
Recommendation	Additional Considerations
Develop guidelines and improve strategies to successfully link HIV-positive clients into care.	Policies could support the provision of services that are demonstrating effectiveness in improving linkage to and retention in care, such as POC CD4 testing.
Standardize the definitions of LTFU and pre-ART care.	Developing a universal definition of LTFU in the pre-ART stage may help focus efforts to track clients before they default. Additionally, pre-ART care could be more systematic and a comprehensive package of services could be available to clients in this stage.
Improve counseling services for newly-diagnosed HIV-positive clients to offer comprehensive psychosocial support, utilizing peer counselors or community health workers.	Offering disclosure support and peer counseling to clients following diagnosis may provide a cost-effective mechanism to help HIV-positive clients to accept their diagnosis and access care.
Stage 2: From Enrollment in Care to ART Readiness	
Recommendation	Additional Considerations
Minimize stockouts of commodities an equipment needed for assessing clients' eligibility for ART, and scale up co-trimoxazole.	Since co-trimoxazole improves client retention and initiation of ART when clients are eligible, ensuring adequate stock is necessary for improving Pre-ART care.
Employ active monitoring (tracking) strategies for pre-ART clients ineligible for ART both at the facility and in the communities.	Many programs lacked patient-tracking systems for pre-ART clients and only monitored patients who had been initiated on ART. With the high attrition and LTFU rates among pre-ART clients, improving these strategies may be critical to retention in care.
Ensure timely CD4 testing at the facility level and in the community, if feasible.	As a structural strategy, ensuring timely access to CD4 testing and monitoring may help improve clients' retention in care and linkage to ART when eligible.
Implement community-based interventions, e.g.	Mobile CD4 testing, counseling or client-tracking
Mobile HIV services to mitigate client-related distance or transportation issues.	Strategies may improve LTFU rates. Men, younger clients and clients who live in rural settings should be targeted, as findings suggest that these sub-populations are commonly LTFU. Home-based care should be considered.

Improve counseling services for pre-ART clients to offer comprehensive psychosocial support, including adherence support.	Some programs achieved improved retention levels by implementing adherence counseling prior to ART care. Counseling may also include education, family planning, and nutritional support; and may be facilitated at the facility or community levels.
Stage 3: From ART Readiness to Initiation on ART	
Recommendation	Additional Considerations
Utilize client tracking systems, including adapting registers for pre-ART patients transitioning to ART.	Many current programs lack tracking systems for pre-ART clients altogether, or their tracking systems are not systematized. Developing client tracking systems to monitor patients, particularly those Transitioning into ART, will help improve continuity in patient care and data monitoring. Standardizing referral forms designed specifically for Pre-ART services could help monitor referrals that were followed, and track bidirectional referrals between facilities and communities.
Stage 4: Continuation of Lifelong ART	
Recommendation	Additional Considerations
Establish electronic tracking systems (ETS) for all clients in HIV care.	ETS may help improve accurate and complete data collection and quality of care.
Strengthen human resources, recognize new cadres of health workers, and address current infrastructure.	Providing additional training, incentives, data tools and job aids for health care workers may help improve retention in HIV care. Providing programmatic support to ensure quality may help reduce attrition by other cadres of staff. Using community health workers or volunteers in community outreach and client tracking efforts may reduce attrition from care programs. Staff and volunteers should receive formal training on the new tasks they assume, and be compensated accordingly.
Build on achievements in integration.	Integrating TB testing and treatment, SRH, and other services could provide more of the “one-stop shop” approach often preferred by clients. The opportunity to review systems can emerge when exploring ways to integrate services and strengthen systems. Sharing equipment and commodities as a result of integration may help address the shortages experienced by HIV care programs, but improved

	commodities and logistics management is needed to prevent the problem from expanding.

Reference

1. Guidelines for Antiretroviral Therapy and Prevention of HIV in The Gambia, 2020
2. Improving retention of clients on antiretroviral therapy through expert patients: Involving people living with HIV in Alebtong District, Northern Uganda
3. NUMART study on the retention of PLHIV on ART, USAID, Uganda, May 2009
4. PEPFAR Uganda Country Operational Plan (COP) 2019 Strategic Direction Summary April 12, 2019
5. Reimagining HIV service delivery: the role of differentiated care from prevention to suppression, Journal of International AIDS Society, 2016
6. Strategic Considerations for Mitigating the Impact of COVID-19 on Key-Population-Focused HIV Programs, May 2020
7. Survival/Retention Study of People Living with HIV (PLHIV) Initiated on Anti-Retroviral, Treatment (ART) in -The Gambia (2016) Cohort
8. The Gambia Integrated Biological Behavioural Surveillance Survey 2018
9. The Gambia Key Population Needs Assessment Study 2019
10. The Gambia National AIDS Secretariat, 2018 PMTCT Impact Study
11. The Gambia National AIDS Secretariat, 2019 ART Survival Study
12. The Gambia National AIDS Secretariat, 2019 Cohort Cleaning Report
13. The Gambia National Strategic Plan for HIV 2021 – 2025
14. USAID, 2013, Linkage and Retention in Pre-ART Care-Best practices and Experiences from 14 Countries
15. WHO and Pan-American Health Organization, 2014, HIV Continuum of Care Monitoring Framework
16. WHO, UNAIDS, USAID, Patient Monitoring Guidelines For HIV Care and Antiretroviral Therapy (ART), 2006
17. WHO-RETENTION IN HIV PROGRAMMES-Defining the challenges and identifying solutions MEETING REPORT, 13–15 SEPTEMBER 2011, GENEVA