PACTE-VIH's Continuum of Prevention, Care and Treatment for Key Populations in Togo and Burkina Faso

Background

The "Continuum Of Prevention, Care and Treatment" (CoPCT) as envisioned by the PACTE-VIH project, is defined as a coordinated network of prevention, treatment, care, and support activities for key populations and People Living with HIV (PLHIV). The network includes government, community-based and non-government organizations, PLHIV, key populations, their family members and others. It also spans different levels of the health system including the community. The resulting activities provide comprehensive services for adults, children, youth and families vulnerable to, living with and affected by HIV over the long-term . A critical element of the CoPCT is the establishment of a comprehensive prevention and care program that combines most effective responses to the multiple and complex needs of key populations.

It has emerged in the latter part of the fight against HIV/AIDs that only a coordinated, concerted effort as described above, will result in a lowering of new infections and bend the trajectory towards victory over the HIV pandemic. With this increasing realization, UNAIDS was tasked to establish new targets for HIV treatment scale-up beyond 2015 and this has resulted in the new narrative on HIV treatment generally referred to as the "90-90-90 targets". The targets project the following: that by 2020, 90% of all people living with HIV will know their HIV status; that by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and that by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. The effect envisioned by UNAIDS in achieving these targets in 2020 is that by 2030, the AIDS epidemic would have come to an end thus generating profound health and economic benefits.

Surveillance data indicate that most West African countries have experienced concentrated HIV epidemics. In 2012, UNAIDS estimated there were 120,000 PLHIV in Burkina Faso and a national prevalence rate of 1.6 percent (UNAIDS 2012). Female Sex Workers (FSWs) were disproportionately affected, with a national prevalence estimate of 16 percent (CNLS-IST 2005). Condom use among FSW clients in Burkina Faso was lower than in neighboring countries: 77.4 percent of clients reported consistent condom use versus over 90 percent in Ghana (CNLS-IST 2009). Although no national HIV biological and behavioral surveillance on men who have sex with men (MSM) has been conducted in Burkina Faso, a small-scale study in Ouagadougou found 19 percent of MSM to be HIV positive while another study found that 60 percent of MSM interviewed reported having sex with women (GFATM 2008). Meanwhile, figures showed that in 2001 and 2011 the rate of new HIV infections had been reduced by 60% among adults of 15-49 years (UNAIDS, World AIDS Day Report, 2012). In Togo in 2010, the national prevalence estimate was 3.2 percent and was among the highest infection rates in West Africa (UNAIDS 2010). Estimated prevalence among FSWs was more pronounced in Lomé (45.4%) than in rural areas (17.7%) (Sobela et al 2005). A similar pattern was reported in male clients of FSWs, where an estimated 8.3 percent in Lomé were infected versus 3.9 percent in rural areas. Overall, one third of the total proportion of HIV infections in Lomé was attributable to transactional sex (Sobela et al 2009). This is critically important since elevated general population HIV prevalence in mixed-epidemics is associated with a higher proportion of men having sex with FSWs (Wilson 2011). HIV however, continues to have a disproportionate impact on sex workers and MSM. Several studies have shown the central role of key population (including FSWs and MSM) in the spread of the HIV epidemic in Africa.

The development and implementation of the CoPCT is to support efforts to curb the trend of new infections among key populations, pushing towards the achievement of the 90-90-90 targets to eventually arrive at the goal envisioned to end the HIV epidemic.

USAID FROM THE AMERICAN PEOPLE
PACTE-VIH
fhi360

Description

The CoPCT implemented by the PACTE-VIH project, is based on a central mechanism of local service network of community-based structures (e.g. drop-in centers (DIC) or community clinics) that offer key clinical services and a wide range of associated community-based services including health education, psychosocial support, referral to other relevant services, and community- and home-based care (CHBC). It also provides opportunities to involve key populations and PLHIV in program planning, regular data collection and analysis, and program management

Prevention	Treatment, Care & Support	Psycho-Social Support
• Condoms & lubricants • HIV testing & counseling • STI screening & treatment • Targeted BCC (through peers, internet, mobile phones, etc) • Post exposure prophylaxis in cases of rape and sexual assault	• STI treatment • Palliative care including symptom management • Home based care • Nutrition • CD4 count • **Referral for:** - Prevention, diagnosis and treatment of OIs - Antiretroviral Therapy	• Mental health diagnosis, counseling & care • Legal advice & support • Personal development and empowerment • Establishment of peer support groups and networks
Cross Cutting Elements • KP-friendly drop-in centers and clinics • Case management • Environmental mitigation actions • Service referrals • FP		

Figure 1: Package of services for key populations

Beginning the implementation process of the CoPCT, first there were discussions about the different steps in its operationalization with the governments of Togo and Burkina Faso and their partners. Similar discussions were also held at the site and facility (clinic) levels in each country. The project and its partners also provided technical assistance to relevant institutions to enhance the prevention to care continuum package. In order to increase access to services by key populations, linkages to relevant key services and referral and counter referral systems were established. Health care providers (HCP) and support-staff of identified clinics were sensitized on key populations needs and issues, and capacity-building in managing Sexually Transmitted Infections (STI) conducted. The systems networks were progressively established based on existing resources and structures, and in partnership with the national and local authorities in each country.

The following key strategies and activities were discussed and adopted with national and local authorities of the two countries of implementation through collaborative efforts and a consensus among key national and local stakeholders and PACTE-VIH's partners.

Strategy 1: Assist Burkina and Togo national and local authorities involved in the coordination of efforts for HIV prevention, care, support, and treatment services in adopting and initiating the development of the CoPCT model for key populations in both countries.

The following activities were outlined and conducted as part of this first strategy.

Activity 1.1: Advocacy was conducted among national authorities for the need to implement a CoPCT model to ensure the success of the HIV treatment cascade for key populations including Men Who Have Sex with Men (MSM) and Female Sex Workers (FSW) and their partners. Key national and local technical working groups that should be involved in the development and implementation of the CoPCT were then identified, and terms of references developed for them.

Activity 1.2: In collaboration with national and local institutions a concept note and implementation plan outlining the implementation of the CoPCT, and which identifies key services in targeted sites (based on the findings of a rapid assessment) that will be involved in the CoPCT, was developed. These services were located in areas that were easy to access by key populations and where measures to ensure the safety and security of personnel and key populations could be taken.

Activity 1.3: The Burkina Faso and Togo national and local institutions were assisted to develop the terms of references for the memorandum of understanding with the identified local services at each identified site. They were also assisted to develop tools such as guidelines, training curricula, job aids, standard operating procedures, and a monitoring and evaluation system (an example is the development of referral coupons, establishment of a unique codification system, and monitoring forms) for supporting and monitoring the implementation of the CoPCT, and its subsequent evaluation.

Activity 1.4: Technical assistance was also provided to the institutions mentioned above in monitoring and evaluating the CoPCT. This included a regular bi-annual meeting with national and local partners involved in the development of the CoPCT to provide feedback and for coordination purposes.

Strategy 2: Ensure an effective implementation of the CoPCT model for key populations in selected sites for both countries.
This strategy largely hinged on ensuring that the various components of the CoPCT were of the highest quality and delivered the best results. The following activities were therefore initiated as components of this second strategy.

Activity 2.1: Various memoranda of understanding were signed with health and other related social services for providing key populations-friendly services free of stigma and discrimination.

Activity 2.2: A local technical working group was established to ensure follow-up on the progress of the implementation of the CoPCT model, its monitoring and evaluation, capacity building and effective coordination among local services and partners.

Activity 2.3: Health care providers including HIV and psychosocial counselors, and support staff (e.g., receptionists, cleaners and security guards) were sensitized on key populations related issues and needs. Health care providers were also trained on managing STI among key populations. Also, psychosocial counselors in each identified health facility and related social services were identified and trained.

Activity 2.4: Key Populations Peer Case Managers (KPPCM) were recruited and trained at the Drop-in Centers (DIC) to ensure and follow up on referrals and counter referrals of clients within and outside of the DIC. The KPPCM ensured continuity of services provided to key populations through the following:
• Promoting counseling and testing services to their peers for early identification;

• Assisting newly-diagnosed PLHIV in accessing HIV care and treatment by accompanying them to referred services;
• Referring key populations to a broad range of facility- and community-based services to address their multi-dimensional needs and accompany them as needed;
• Establishing effective linkages between facilities and community groups, retention mechanisms, and referral systems to secure feedback on the referral and ensure that client needs are met;
• Assisting peers in attending scheduled health appointments (retention in care and treatment services), maintaining an optimal level of adherence to ART, and reducing their risk for HIV and STI transmission;
• Making home visits as appropriate for continuous follow up;
• Maintaining data for clients in a manner which respects client confidentiality;
• Developing a directory of services and service providers including caregivers, community volunteers, and service providers in the community;
• Contributing to the reduction of stigma and discrimination through community mobilization, sensitization, and dialogue organized by the partners including community-based organizations.

Activity 2.5: Regular bi-annual meetings were conducted with local partners/service providers involved in the referral networks to provide feedback and for coordination purposes.

Strategy 3: Use of mobile technology to improve delivery and strengthen access to the 4R system (**R**eferral/**R**eview/**R**eminder/**R**ecall) as well as improve linkage between Drop-In-Centers and other partner health facilities and related social services.

Mobile Technology, which includes the use of mobile phones and internet-connected computers, was used to relay 4R messages and link key populations to services offered at the DIC, partner health facilities and related social services. This innovative approach harnessed the availability of technology and equipment

already in the possession of institutions and implementing partners. The approach presented a simple, reliable, game-changing enhancement of the face-to-face referrals in current use and offered a strong foundation for ensuring the delivery and access of basic

Through the use of social media (e.g. Facebook and WhatsApp) and Short Message Services (SMS), the project was able to achieve the following:

• Actively refer key populations to relevant services of the CoPCT and confirm successful attendance;

• Send reminder and alert messages on Antiretroviral Therapy (ART) adherence and safe sexual practices.

Strategy 4: Ensure the development and implementation of the monitoring and evaluation system of the CoPCT for key populations, particularly the monitoring and evaluation of the HIV treatment cascade. To achieve this strategy, the following activities were conducted.

Activity 4.1: A referral focal person was designated at each service delivery site to ensure smooth navigation through the service delivery system. Emphasis was placed on ensuring active referrals through a feedback loop that tracked services actually utilized by referred clients. Accurate documentation of referrals was also ensured through the use of monitoring forms and other tools such as standard operating procedures, relevant job aids, and information, education and communication materials for health care workers and CBOs. A mechanism to obtain and incorporate client feedback was also established.

Activity 4.2: A directory of services and participating organizations was updated and disseminated on a regular basis.

Activity 4.3: Periodic meetings of service providers participating in the networks were organized to discuss referral-related issues and gaps in service provision for key populations.

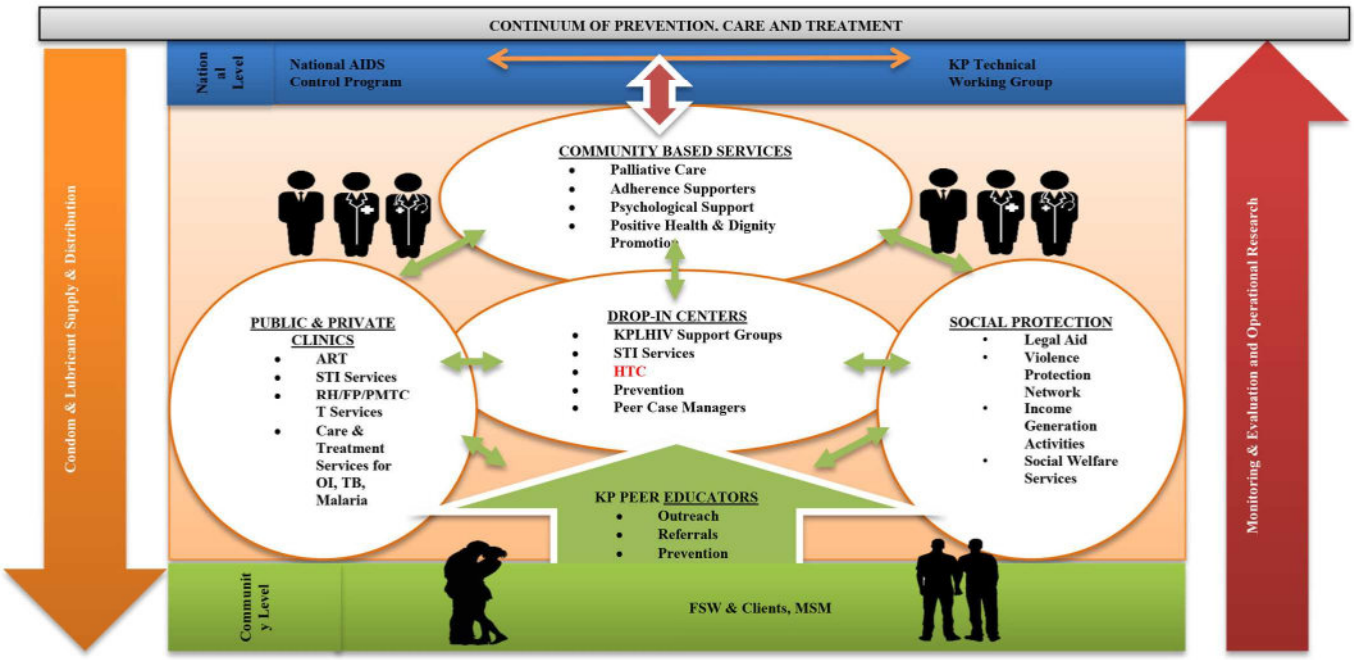


Figure 2: The CoPCT model illustrating referral networks linking key populations to a comprehensive package of service.

Outcomes

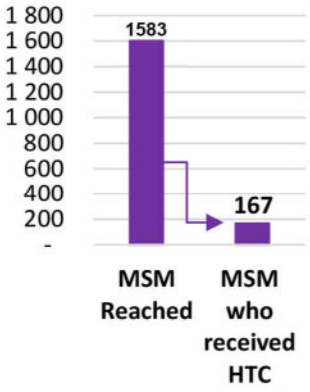
Implementing partners (IPs) at various project sites have endeavored to link people diagnosed HIV positive to care, retain them in care and place them on treatment. Extensive outreach activities conducted by these IPs, are aimed at reaching key populations with evidence-based interventions and providing HIV testing and counselling services. Mobile Clinics, Drop-In-Centers as well as "Services Adaptés" (public facilities with KP-Friendly trained medical and support staff) provide testing and other HIV-related services.
The CoPCT cascade is an innovative tool adopted by the project and used to track the continuum of prevention, care and treatment. The interpretation from the results have been used to shape and optimize program activities to achieve project aims.

***Figure 3**: Mobile clinic in Lomé, Togo*

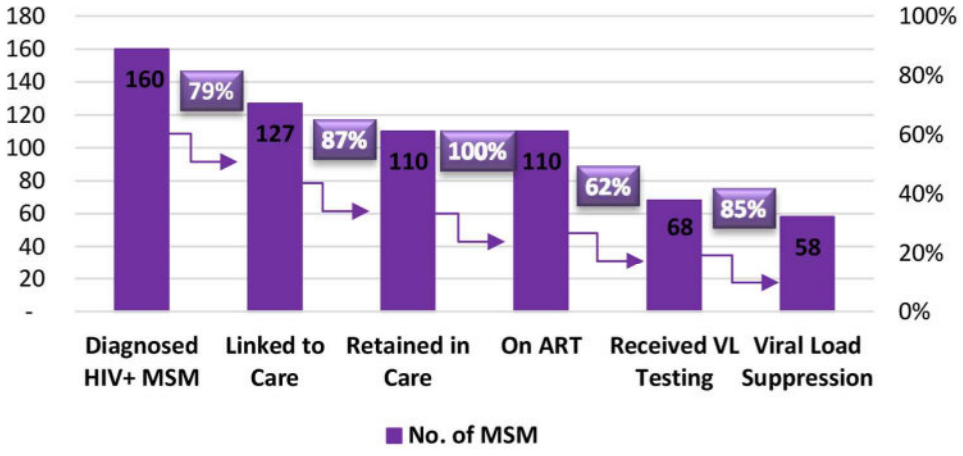
MSM Cascade, Togo

EVT's efforts are targeted at MSM in Togo. Results for activities in Lomé, presented below in graphs 1a and 1b shows that during the first two quarters of Year 5 of the project, EVT's efforts in providing HIV Testing and Counselling (HTC) services to MSM in Lomé, Togo yielded 167 MSM receiving services. So far, 160 have tested HIV positive and linked to care for subsequent treatment. Reviewing the CoPCT cascade, 79% of MSM diagnosed HIV positive have been linked to care. Furthermore, 87% of those linked to care have been retained in care and a 100% of those retained are currently receiving treatment. Efforts made to provide viral load testing in Togo reported 68 MSM being tested of which 58 (85%) recorded undetectable viral loads. This represents 52% of those on ART attaining viral suppression.

Graph 1a: MSM Cascade, EVT, Lome (Oct. 2016-Mar. 2017)



Graph 2b: MSM Cascade, EVT, Lome (Project Lifetime)

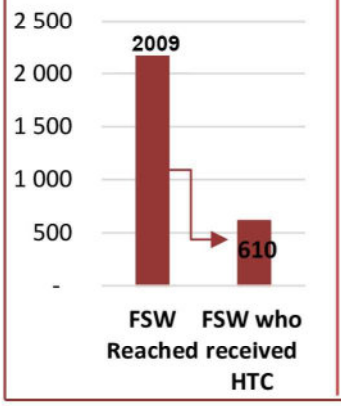


FSW Cascade, Togo

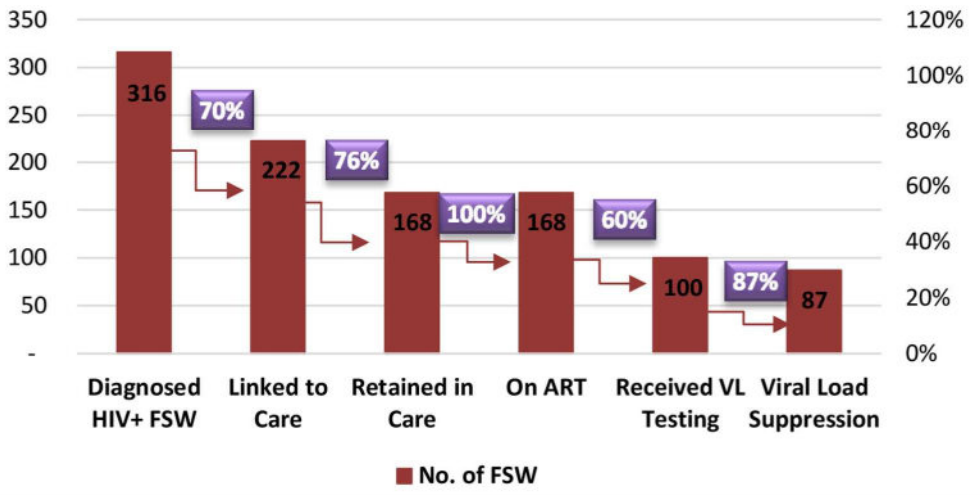
FAMME's efforts targeted at FSW in the first two quarters of Year 5 of the project resulted in 610 FSW receiving HTC in Lomé as reflected in graphs 2a and 2b. Of the 316 FSW ever diagnosed positive, 70% have been linked to care. Also, 76% of those linked have been retained in care and currently receiving treatment. A total of 100 FSW tested for viral load suppression of which 87 (87%) have attained viral suppression. This represents 52% of those on ART attaining viral suppression.

FAMME's extensive outreach screenings in remote areas necessitates referrals to health facilities that may not be project partners. These referrals may therefore not be adequately captured in the cascade thus reflecting the loss between diagnosis and retention.

Graph 2a: FSW Cascade, FAMME, Lome (Oct. 2016-Mar. 2017)



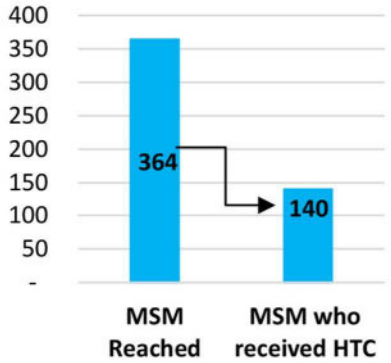
Graph 2b: FSW Cascade, FAMME, Lome (Project Lifetime)



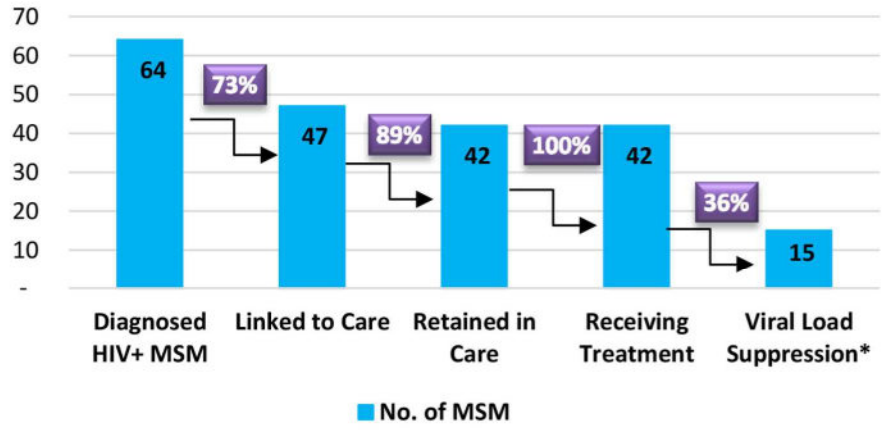
MSM Cascade, Burkina Faso

The MSM cascade for Burkina Faso, shows progressive efforts to link hard to reach MSM to care and retain them on treatment. Graph 3b shows that of the 64 MSM ever diagnosed, 73% have been linked to care of which 89% have been retained and are receiving treatment. Of those on treatment, 36% have attained viral suppression.

Graph 3a: MSM Cascade, Burkina Faso (Oct. 2016-Mar. 2017)

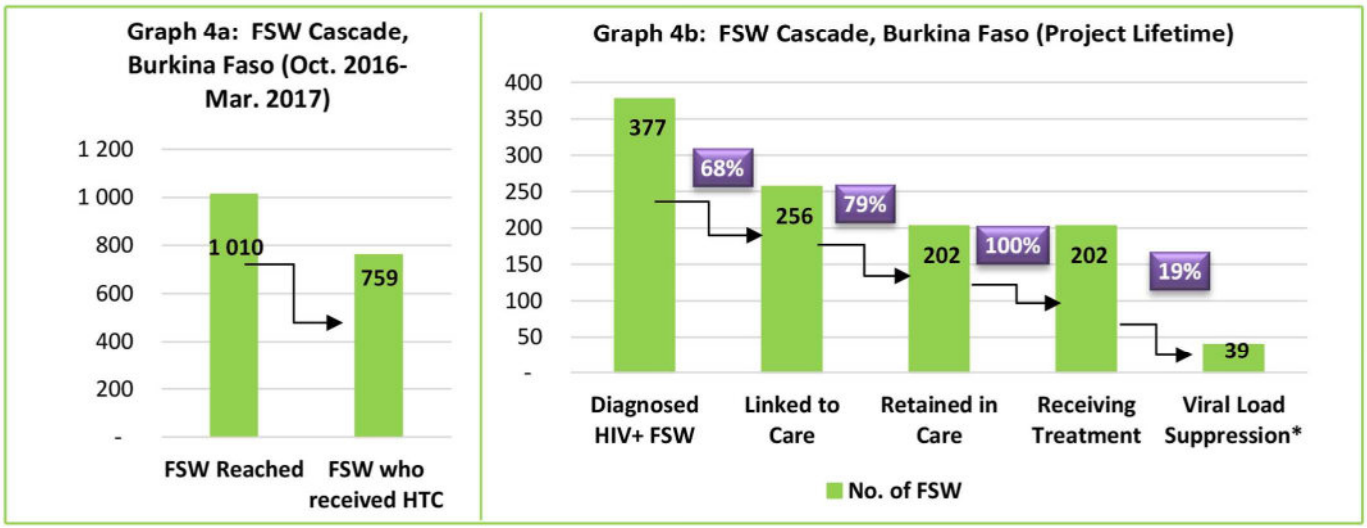


Graph 3b: MSM Cascade, Burkina Faso (Project Lifetime)



FSW Cascade, Burkina Faso

Combining the various CoPCT cascades for Ouagadougou and Bobo Dioulasso reflects the total efforts made by IPs to retain FSW in the continuum. In Burkina Faso, unlike Togo which has two main IPs, the project engages various partners in the operationalization of the CoPCT. Reviewing graph 4b, it is observed that of the 377 FSW ever diagnosed, 68% have been linked to care of which 79% have been retained and receiving treatment. Of those on treatment, 39 (19%) have attained viral suppression



Barriers experienced in attaining each goal of the 90-90-90 target

The challenges associated with the CoPCT can be broadly categorized by each step of the cascade. Beginning with the first 90 of the 90-90-90 goals set by UNAIDS, it is vital to test as many as possible and provide them with their results so they know their status. Some challenges associated with KP not getting tested include the following:

a. Hard to reach KP: some KP especially MSM are hard to reach due to stigma and discrimination. It is therefore difficult to reach them with traditional face to face interventions.

b. High mobility of KP: FSW and MSM are a highly mobile group. FSW tend to travel to locations away from their home locations in order to transact business and avoid detection, stigma and discrimination. Others also seasonally travel to areas where business has picked. MSM frequently relocate to avoid stigma and discrimination.

c. Transportation: Once reached, the issue arises of lack of funds to travel to testing sites to get tested. Some also site the distance required to travel to get the testing done as these outreaches may have occurred several miles away from testing sites.

d. Perceptions: Some KP generally do not feel that they are sick hence see no need for testing. The notion of prevention is difficult to grasp. Others also feel that the outreach testing strategy is not “scientific” enough, citing doubt that a small equipment with the subsequent issuing of a small green slip of paper is enough to determine whether one has this deadly virus or not.

e. Loss of enthusiasm: Enthusiasm diminishes after a PE has provided sensitization and moved on to the next geographical area. In other instances, KP are saturated with HIV sensitization and have lost interest in the subject.

f. Fear of stigma and discrimination has also been cited for KP not getting tested.

Some challenges associated with the second 90, which involves linking HIV positive KP to care and subsequently placing them on ART are as follows:

a. Fear of disclosing HIV status: once they test positive some KP are unwilling to disclose their status to the PE or case managers who would facilitate the linkage to care and treatment. KP would sometimes deliberately provide wrong phone numbers or relocate thus making it difficult for the PE or case manager to follow up to link them to care. Lack of trust and confidence in these mediators then become a barrier to the KP. Beyond this, there is also fear of disclosure to spouses, parents and relatives which would generate stigma and discrimination.

b. Stigmatization at having to go to a DIC and the fear of stigma should they attend other health facilities was also cited as a challenge. To some, the DIC which was

established to promote stigma-free access to health services has itself become subject to stigma.

c. Some KP cited hearing rumors that ART's had debilitating side-effects.

d. Nutrition: lack of food to eat serves as a barrier to the uptake and retention on ART. Coupled with the fear of the side-effects of the medicines, some KP would tend not to take them.

e. Other cross-cutting challenges such as lack of transportation and frequent relocation, were cited as barriers to linkage and uptake of ART.

There are two main barriers associated with attaining viral load suppression with those on ART (third 90). The first is unavailability of the viral load tests which is attributable to lack of laboratory equipment to support viral load testing. The second challenge is related to inaccessibility of these tests. Where these tests are available, they come at a cost to the beneficiary thus creating a barrier.

Lessons Learned and Recommendations

To mitigate the barriers described above, the PACTE-VIH project devised a set of innovations to improve the cascade as a result of lessons learned during implementation. Key innovations in response to targeting hard to reach MSM was the setup of the mHealth and Social Media campaigns. The mHealth uses SMS messages delivered to a beneficiary's mobile phone on a daily basis to serve as reminders to get tested and also take ARTs. The Social Media campaign employs tech savvy MSM as "social media animators" to target hard to reach MSM in networks with HIV prevention and care messages including HIV testing messages and subsequently linking them to PEs and case managers in their geographical areas.

Additionally, KPLHIV were employed as case managers to foster trust and confidence in KP who have been diagnosed. Early linkage and retention occurs when KP disclose their status after testing to these mediators who then help them to navigate the care and treatment continuum.

Recommendation to reducing or eliminating barriers associated with the first 90 include self-testing and Peer testing. These steps can be introduced to improve the uptake of testing. Additional recommendations include performance-based remuneration to PEs. Also, to break the cycle of monotonous testing, other tests like Hepatitis B could be added to the package to make HIV testing more attractive to those who are already saturated with HIV sensitization.

To mitigate challenges associated with placing KP on ART, transportation incentives can be provided to support those to be initiated and those already on ART. Other mechanisms can also include community-based ART initiation and support. Provision of nutritional kits to all KPLHIV and children of FSW living with HIV is also recommended. The project provides nutritional kits to HIV positive MSM to support their nutrition needs whiles on ART. The project also provides nutritional counselling to HIV positive FSW to promote a proper balanced diet whiles on ART.

Equipping laboratories with machines such as the GeneXpert to conduct viral load testing would be a major step in mitigating the challenges associated with the third 90. Adequate training of laboratory staff as well as sensitization of KPLHIV about the purpose and use of the viral load tests is also recommended.

One key thing to note is that HIV counsellors may not necessarily be psychologists. Deep seated issues of depression, fear, suicide and other related psychological issues are best addressed by psychologists. This is particularly true in the case of MSM and FSWs. It is therefore important to re-inforce the role of the psychologists at health facilities or DICs to attend to these needs that an HIV counsellor may not be able to address.

Finally, attention should be paid to fostering better interactions between staff involved in the cascade of prevention, care and treatment in order to facilitate better tracking of those diagnosed with HIV. Better information flow between different departments facilitates faster initiation on ART and better monitoring of progress for KP to attain viral suppression.

Contact us

FHI360 Ghana Office
2nd Floor, Marvel House 148A
Giffard Road, Accra, Ghana
P. O. Box CT 4033, Accra, Ghana

www.pactevih.org
jtchupo@fhi360.org

The HIV & AIDS prevention and care project in West Africa (PACTE-VIH) is a five-year cooperative agreement (2012-2017) between USAID/West Africa and FHI360.

This document was made possible by the generous support of the American people through the United States of International Development (USAID). The contents are the responsability of FHI360 and do not necessarily reflect the views of USAID or the United States Government.