Entrance to FAMME, Lome, Togo

#EAWA

Making strides toward the "Second and Third 95s" in Togo

October 2019

BACKGROUND

Like all countries around the world affected by the HIV epidemic, the West African country of Togo is working hard to achieve the 95-95-95 targets set by UNAIDS. The aim of these targets is that, by 2030, 95% of all people living with HIV will know their status, 95% of those diagnosed will receive antiretroviral therapy (ART), and 95% of those on treatment will achieve viral suppression.

Since 2017, FHI 360, in collaboration with local partners, has been pursuing these targets through the Ending AIDS in West Africa (#EAWA) project. #EAWA is a five-year cooperative agreement funded by the U.S. Agency for International Development (USAID) with the goal of accelerating progress in the region toward the 95-95-95 targets by improving access to prevention, care, and treatment services, particularly among key populations (KPs).

In Togo, FHI 360 is working with local partners, Force en Action pour le Mieux etre de le Mere et de l'Enfant (FAMME) and Espoir Vie Togo (EVT), to improve access to and uptake of HIV services along the entire continuum of care, from prevention and testing to treatment and viral load suppression. FAMME is a nongovernmental organization (NGO) founded in 1990 that primarily serves female sex workers (FSWs). EVT is an NGO created in 1995 to provide services to people living with HIV (PLHIV) and has expanded its programming to include a focus on serving men who have sex with men (MSM) and FSWs.

Togo has a ways to go to meet the UNAIDS targets. As of 2018, an estimated 73% of PLHIV knew their status, and only 60% of them were on treatment (UNAIDS, 2019).[1] However, as reported elsewhere,[2] #EAWA has contributed strong progress toward the "first 95" in a short period of time, improving HIV case-finding from 6% at the beginning of the project to 25% just nine months later. The project has also made important gains related to linking those diagnosed with HIV to treatment services and helping them achieve viral suppression. This brief takes stock of the project's achievements related to the "second and third 95s" and some of the key strategies and lessons learned from progress to date.

[1] Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS data 2019. Geneva: UNAIDS.
[2] FHI 360. #EAWA: accelerating progress toward the "first 95" in Togo. Durham (NC): FHI 360; 2019.

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TREATMENT INITIATION AND RETENTION

Since the #EAWA project began in Togo, treatment initiation and retention rates have steadily improved, recently achieving a linkage to ART rate of 99% for newly diagnosed MSM, FSWs, and other priority populations reached by the project (Figure 1). This progress on the "second 95" can be attributed primarily to the introduction and scale up of two key strategies: (1) test and start and (2) peer navigation/case management. While both strategies were part of the project from the start, in FY19 the #EAWA team began providing intensive technical assistance to the local partners to fully implement both strategies with fidelity.

TEST AND START

In 2016, the World Health Organization (WHO) endorsed test-and-start strategies, which enroll newly diagnosed PLHIV on treatment as soon as possible, regardless of CD4 count. Grounded in the evidence that ART can transform HIV into a treatable chronic disease and suppress the virus to virtually eliminate the risk of ongoing transmission, test and start benefits the health and well-being of the individual living with HIV as well as reduces the risk of transmission of the virus to others.

When #EAWA started in 2017, test and start was already adopted as national policy in Togo, but was inadequately implemented, especially with KPs. #EAWA changed that, providing technical assistance to EVT and FAMME to institutionalize test and start so that someone who is newly diagnosed with HIV can start ART the same day.

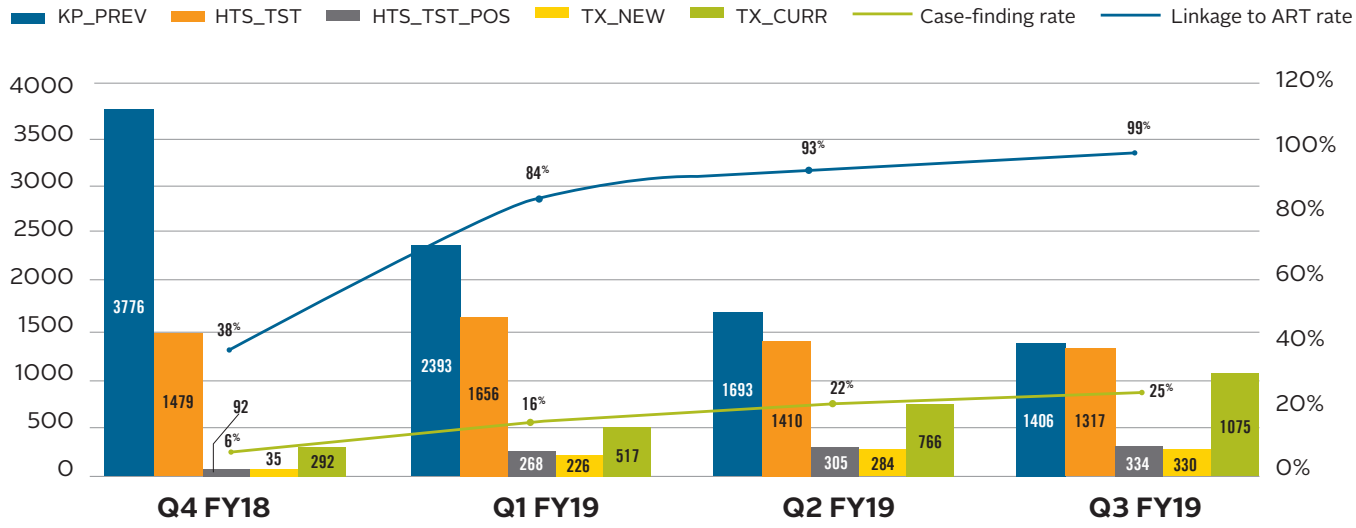
A focus of this assistance was developing the capacity of ART prescribers and psychologists at EVT and FAMME to translate the test-and-start policy into practice by counseling and motivating newly diagnosed PLHIV to engage in treatment as soon as possible, regardless of CD4 counts and pre-therapeutic literacy.

PEER NAVIGATION/CASE MANAGEMENT

Peer navigators and case managers work full-time as part of a case management team to assist HIV-positive KP members in enrolling in and accessing care and treatment services, while supporting them to identify and overcome barriers that interfere with achieving personal health-related goals. Peer navigators are typically people who are living with HIV and members of a specific KP community, so that they have an intimate understanding of the lived experience of the peers they support. Case managers, on the other hand, are not necessarily living with HIV or from a KP community but are accepted by KP members living with HIV to assist them in accessing care and treatment services.

#EAWA implements peer navigation with MSM, but case management with FSWs. While the project's peer navigators are MSM and living with HIV, the case managers (also called "mediateurs" in Togo) are not FSWs themselves and were recruited regardless of their HIV status. Case management was determined to be a more acceptable and appropriate approach for FSWs due to concerns around breaches of confidentiality and stigma within the FSW community. Many FSWs do not want peer navigators who are from the community

Figure 1. Case-finding and linkage to ART rates by quarter for all populations



because they worry if other FSWs know their HIV status that they may not be able to attract as many clients.

With support from #EAWA, EVT and FAMME have nine peer navigators and case managers working to link KP members living with HIV to treatment and help them remain adherent. #EAWA's approach to peer navigation and case management was adapted from the Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project, supported by USAID and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which has implemented peer navigation successfully in several countries, specifically with KPs.[3] Now, every individual diagnosed with HIV through #EAWA is assigned a peer navigator or a case manager.

#EAWA's peer navigators and case managers are connectors, a bridge between the community and KP-friendly health care facilities and providers. Once clients are initiated on ART, they are the lynchpin in a set of strategies that the project deploys to support adherence to ART, including (1) monthly in person follow-up and home visits; (2) individual and/or group counseling on treatment adherence; and (3) appointment reminders through phone calls and text messages.

[3] For more information on peer navigation, please see LINKAGES Peer Navigation Implementation Guide.

In addition, when a client misses an appointment, the facility notifies the peer navigator/case manager, who follows up immediately. For clients who were adherent but missed an appointment, the navigator will take the treatment to them. While there, they will explain the benefits of being adherent, counsel on viral load (VL) testing, and accompany them to services. If lack of transportation was the reason for missing an appointment, as is often the case, the peer navigator or case manager will escort them to the facility or provide funds for transportation.

The support a peer navigator and case manager provide each client is highly personalized. They get to know their clients and understand their social situation, which informs their counseling. For some clients, they provide support on a daily basis. They also link them to support groups they run, addressing topics relevant to their communities, such as gender-based violence, stigma and discrimination, and — for MSM — empowerment education related to living in a homophobic environment.

The ways in which peer navigators and case managers work to ensure KP community members living with HIV get the health care services they need are best described by the people at the intersection of this work:

LAMBONI'S STORY

Lamboni is a sex worker who lives in an FSW hot spot. Six years ago, a peer educator came to her hot spot to provide educational talks and encourage HIV testing. When Lamboni showed up at the FAMME clinic for testing, she was diagnosed with HIV. She received a lot of empowerment counseling at the time of her diagnosis and was assigned a case manager. She started ART one month later and even joined a support group for people living with HIV. However, she wasn't adherent to her treatment initially and quickly became very sick. FAMME staff, including her case manager, immediately stepped up their support for Lamboni. The case manager gave her a referral to the main hospital, and FAMME staff brought her food and gave her a small stipend to cover transportation to appointments and most of the costs of the treatment. Since then, Lamboni has been very adherent. Her case manager now calls her every day to make sure she has taken her ART. If she reports any obstacles to obtaining her treatment, the case manager will bring it to her or provide transportation for her to the clinic. Lamboni also now comes to FAMME every six months to get her viral load tested. The virus in her body is currently undetectable. Knowing she has achieved an undetectable viral load has been extraordinarily empowering and reinforced her motivation to be adherent to her treatment:

> "It's proof that I'm not doing all of this for nothing. When I got my viral load test results, I felt proud of myself. Everyday I feel happy to take my pills. I go to the support groups, and I share my experience on viral load. I don't hide. I don't feel ashamed when I take the ART now. I have a virus in my blood, but I'm not sick. I am alive because of these drugs, and I should not be ashamed of it. I'm very proud when I take my ART."

Lamboni describes the support she has received from FAMME since her diagnosis in 2013 as "more than important." She explained, "I wouldn't be alive without FAMME."

- "Most of the time when we refer people to a facility, they are scared and ask what will happen to them at the facility. That's why we connect them to a peer navigator. When they get to the facility, the peer navigator accompanies them through the services." EVT program manager

- "Peer navigators link our beneficiaries to facility-based services. We visit them at home to support their adherence to treatment. We run adherence support groups. And, if someone misses an appointment, we pay him a visit, ask him why he missed his appointment, and encourage him to return." MSM peer navigator

- "When I came for testing and found out I was positive, the peer navigator took my number and followed up with me. From day one, he was sending me supportive messages, reminders to take my drugs. With the help of that peer navigator, I don't miss my treatment." MSM program beneficiary

As a result of peer navigation/case management, the project has not only seen steady increases in the number of people newly initiated on treatment, but also decreases in loss to follow-up among those already on treatment (Figure 2).

Despite the critical role that peer navigators and case managers play in helping KPs living with HIV initiate and stay on treatment, the current peer navigator/case manager-to-client ratio is about 1:141, which is too large to ensure quality control. In FY20, #EAWA will expand the number of peer navigators and case managers the project supports and strive to reduce the caseload for each one. The project will also improve quality of care by developing the capacity of peer navigators and case managers to provide differentiated support to clients based on characteristics such as whether they are newly diagnosed or established patients, and stable or unstable on treatment.

VIRAL LOAD TESTING

A fundamental component of achieving the "third 95" — widespread community viral suppression — is expanding access to VL testing. Since 2013, VL monitoring has been recommended by the WHO as the preferred method for monitoring people on ART. VL monitoring is a more sensitive, timely, and reliable method of identifying treatment failure compared to clinical monitoring or use of CD4 count. Based on WHO guidelines, routine VL testing should be conducted at six and 12 months after ART initiation and every 12 months thereafter.

Prior to #EAWA, access to VL testing services, especially at KP-friendly health facilities, was extremely limited in Togo. VL testing has also been hampered by the need to manually review client records to identify those eligible for VL testing, as well as by delays in documenting and returning test results — sometimes as long as three to six months. These delays were problematic not only for clients, but also for providers, some of whom were becoming so discouraged they were reluctant to even recommend VL testing to clients.

To resolve some of these challenges, #EAWA staff have been providing technical assistance to strengthen

Figure 2. Trends in treatment initiation and retention by quarter for all populations

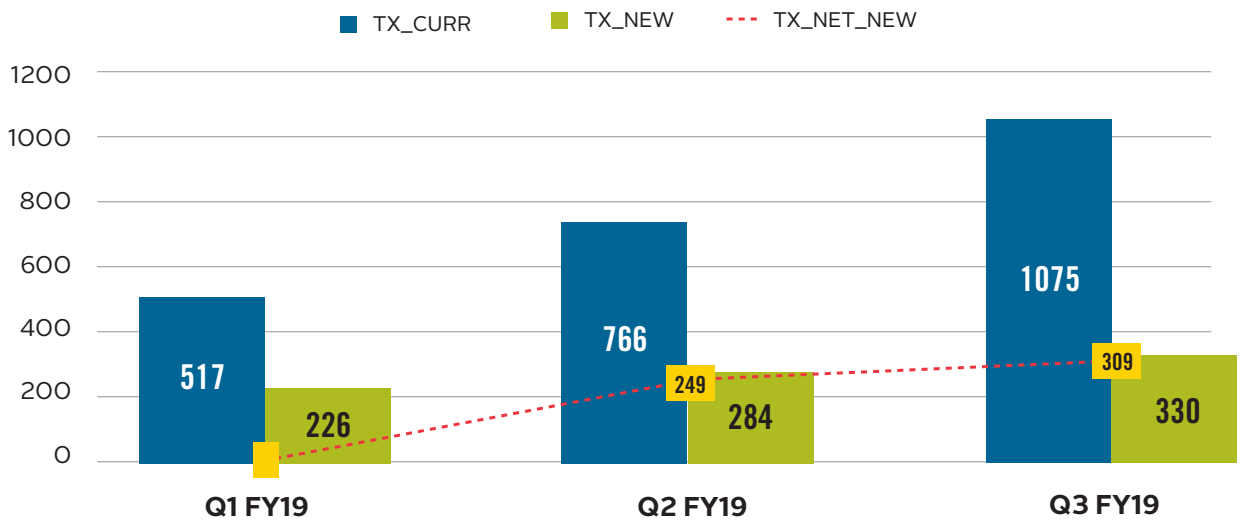
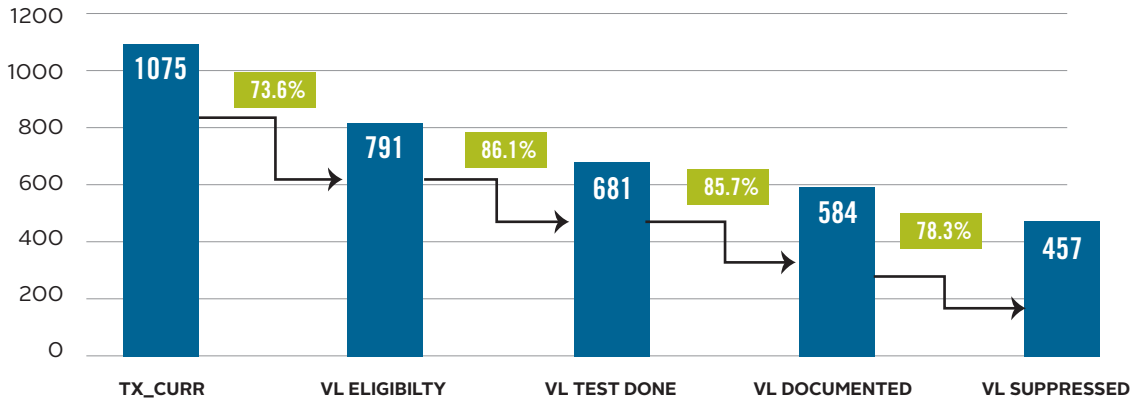


Figure 3. Viral load cascade, all populations, Q3 FY19



laboratory services for VL testing and create a functional lab referral network for transferring samples and returning results. They forged a unique partnership with the laboratory of Lomé Commune region and seconded a staff person from FAMME to the lab who is responsible for processing and returning KP VL test results more efficiently.

Another aspect of #EAWA's VL technical assistance has been supporting local partners to better document the number of those who complete a VL test, receive VL test results, and attain viral suppression. And, recent data suggest the increased attention to VL testing is starting to pay off. Among all population members who were eligible for VL testing (N=791), 86.1% were tested and 85.7% had their results documented (Figure 3). The overall viral suppression rate was 78.3%, but the rates were higher among KPs. Compared to the viral suppression rate of 67.9% among other priority populations, the rates for MSM and FSWs were 83.7% and 83.0%, respectively.

For patients who are virally suppressed, receiving and understanding their VL test results can be a powerful motivator to remain adherent to treatment. One EVT client who has been on ART for five years described how he felt when he received his VL test result and learned he was undetectable: "I wasn't surprised because I was adherent. But I was proud."

For those who are not virally suppressed, their VL test result can help programs differentiate services and prioritize treatment support for individuals who need it most. Indeed, this will be a priority for #EAWA going forward. In FY20, #EAWA will continue to develop the capacity of providers to use VL test results to improve clinical decision-making and management of suspected treatment failure, ensuring that those who are unsuppressed receive enhanced adherence counseling and more intensive follow-up from peer navigators.

FY20 will also bring increased investments in expanding coverage of VL testing services, including point-of-care sample collection, transportation and results delivery, and demand generation for VL testing through use of community "VL Champions" who implement VL education campaigns and link clients to testing sites. The #EAWA team is also developing an electronic system that will allow EVT and FAMME to more easily identify and keep track of PLHIV eligible for VL testing.

LOOKING AHEAD

As the #EAWA project approaches the end of its second year, it is gaining critical momentum toward all three 95 targets. Indeed, the progress made in such a short period has sparked excitement about the potential to achieve epidemic control in Togo. To that end, beginning in October 2019 (FY20), #EAWA will receive additional funds from PEPFAR to expand its impact. Taking the successful programmatic strategies and lessons learned to date and delivering them at scale — while continuing to innovate — will be challenging. But the project is poised to deliver.

For more information about the #EAWA project, please contact Jean Paul Tchupo at jtchupo@fhi360.org
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