

IMPLEMENTING THE SURGE HIV RESPONSE IN AKWA IBOM

AN ACCELERATED HIV EPIDEMIC CONTROL DRIVE



Strengthening Integrated Delivery of HIV/AIDS Services



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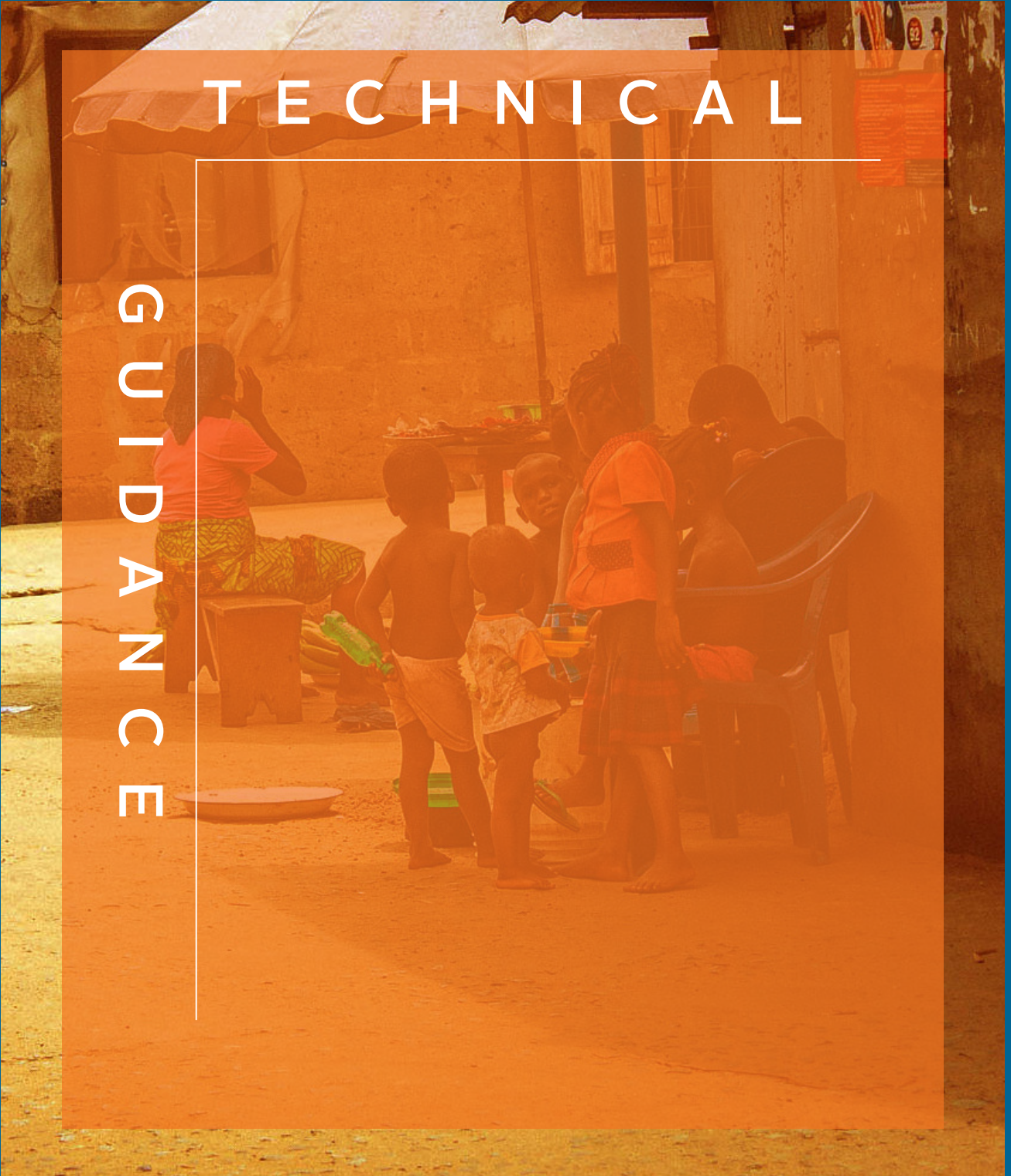


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TECHNICAL

GUIDANCE



UNDERSTANDING THE SHAPE OF THE HIV EPIDEMIC IN AKWA IBOM STATE

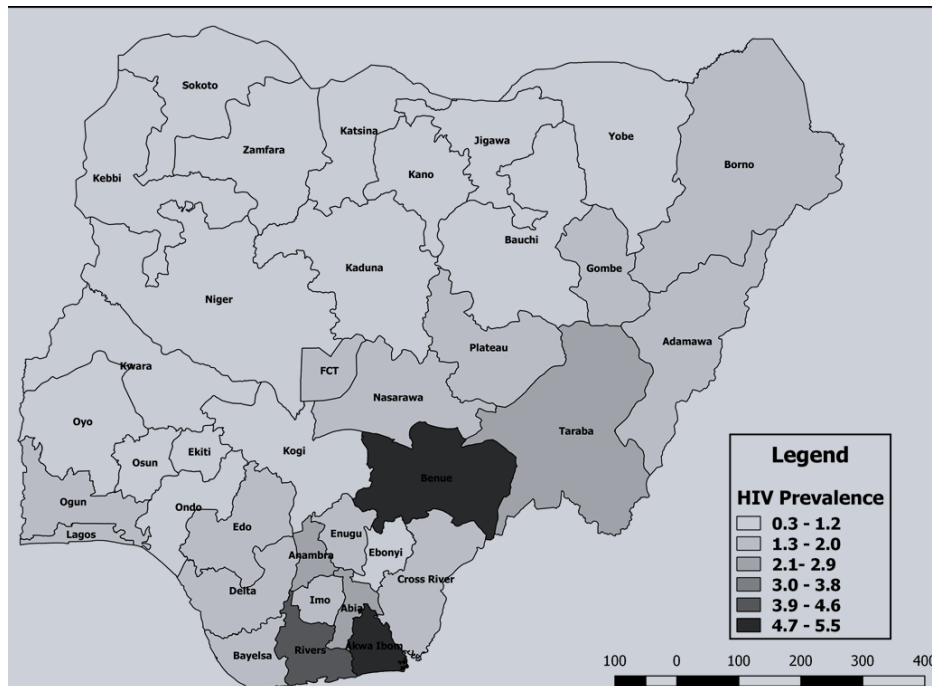
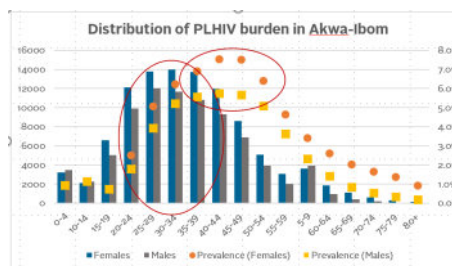
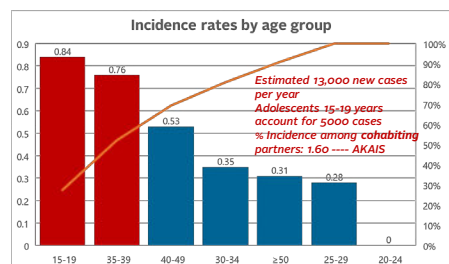


Fig 1: HIV prevalence in Nigeria (NAIIS 2018)



Nigeria has made progress in the fight against HIV/AIDS. The just concluded national AIDS indicator impact survey (NAIIS) revealed that the national prevalence of HIV is 1.4% with an estimated 1.9 million people infected with the virus. With a mixed epidemic, only 7 out of the 36 states in the country account for over 50% of this burden. The top 3 states by burden include Rivers, Benue and Akwa Ibom states.

Akwa Ibom state has the highest prevalence in the country at 5.5% with an estimated burden of 178,000 people living with HIV. Of these, it is estimated that close to 120,000 have an unmet need for life-saving antiretroviral therapy and this has necessitated the need for a mix of interventions that can reduce this gap and ensure that most patients initiated on therapy, remain on therapy and achieve viral load suppression in line with the UNAIDS laid out 90-90-90 targets.

Some factors contributing to the disproportionate perpetuation of the epidemic in Akwa Ibom state have been identified. These include low HIV risk perception among the populace, difficult geographic terrain in parts of the state resulting in poor access to available ART services.

Other drivers that may also explain observed patterns include high risk sexual behaviour especially among young people and entrenched sociocultural practices. Religious and superstitious beliefs about HIV/AIDS adversely affect the health seeking behaviour of the population. These beliefs also fuel stigma and discrimination within the various communities, constituting a significant barrier in access to care.

To effectively close this treatment gap, driving the state towards epidemic control, the HIV surge activities were proposed to include a minimum package of in-facility and community based interventions. These interventions are aimed at achieving treatment saturation for people living with HIV in the state by the end of year 2020. This document attempts to outline the rationale behind these activities while providing a concise and practical guide to implementation.

WHY ARE WE EMBARKING ON A HIV SURGE RESPONSE?

In 2013, when UNAIDS laid out the 90 90 90 targets to achieve epidemic control of HIV by 2030, they appeared insurmountable. However, a cursory look at the achievements of the various states gives us cause for hope. While progress has not been uniform, the NAHS results provide the data that can help inform targeted strategies to drive performance in the states that have lagged behind.

PEPFAR through USAID and its implementing partners must realign strategies at this point to ensure that Nigeria gets on course to achieve the targets which have a deadline for the end of the year 2020. This is the why all the partners have aligned behind the surge strategy as a “catch-up” plan to ensure access to life-saving ART for all PLHIV and viral load suppression for at least 95% of all patients on treatment.

A realignment becomes necessary because a review of historical data suggests that retaining the current strategy will result in significant treatment gaps by the end of 2020 which is the deadline for the UNAIDS 90 90 90 targets. The realignment will engage a mix of community and facility interventions targeted at observed “barriers and drivers” to make ART more accessible.

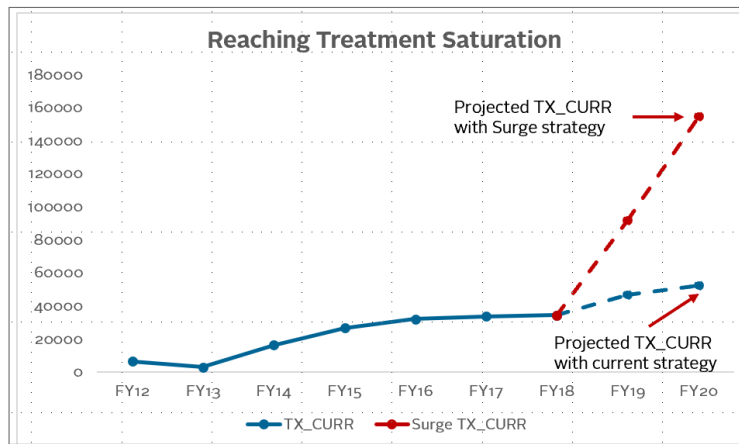
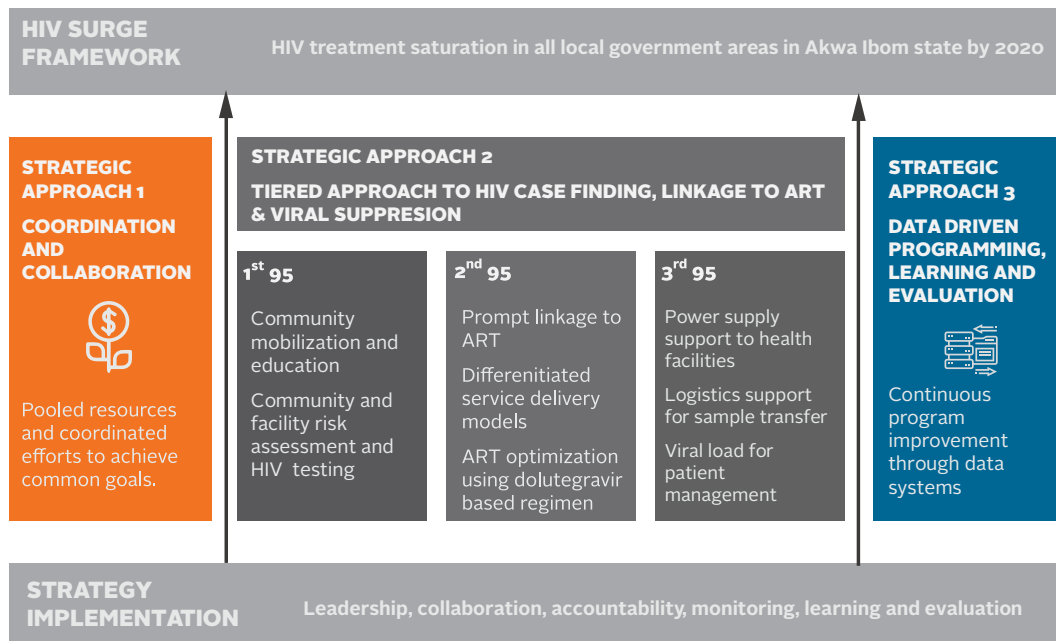


Fig 2: HIV surge response projections

OVERARCHING THEMES OF THE HIV SURGE RESPONSE



“*The targets are ambitious and require intensive implementation of a mix of both in-facility and community services.*

A guiding principle for all interventions is that they must focus on efficiency and convenience in a way that optimizes patient outcomes”

PRE-IMPLEMENTATION ACTIVITIES

Strategy Development & Community Engagement

The surge plan required careful deliberations and strategic planning to assure us of successful implementation. This process has involved all relevant stakeholders in the HIV/AIDS prevention, care and treatment cascade across the state. The various USAID/PEPFAR implementing agencies within the Akwa Ibom state committed to a coordinated effort for the treatment saturation strategy across the state.

In addition, target communities were visited to engage with gate keepers and community leaders with the aim of gaining their support for the surge activities. These visits also provided a learning opportunity to identify key drivers of the epidemic, potential hotspots based on social and behavioural patterns. Community-facility interoperability issues were also clarified and roles assigned between the USAID implementing partners to ensure seamless coordination of synergistic activities towards attaining an overall goal of treatment saturation in Akwa Ibom state.

Advocacy

We recognise that such a herculean effort requires the support and program ownership of the leadership of the state. To this end, high level advocacy visits were made to the Executive Governor and the State Executive Council to discuss recent NAHS results, and proposed interventions to saturate the state through the budgeting and appropriation of additional funding for HIV response in the state using the recent NAHS position as a change agent from the executive.

Further meetings were held with the head of the legislative arm of the state in the person of the Speaker of House of Assembly in Akwa Ibom state to drum up support for the intervention of the government in the HIV treatment saturation in the state.

COMPOSITION OF THE COMMUNITY ART MANAGEMENT TEAMS

Engagement with GoN at both state and local council levels were conducted to enable them take the lead for the surge and provide support including provision of RTKs, community interventions and additional staff to support the surge as well as waiving of facility card fees for HIV positive clients identified during community HIV service provision and linked to facilities.

Sensitization and engagement with all traditional rulers and chiefs in each local government area in the state to take the lead for community interventions. Further engagement with relevant religious leaders and associations as well as influential persons at the state level to identify Christian leaders as change agents to improve public perception regarding the acceptance and management of HIV services were conducted.

Health workers at supported health facilities were also engaged to garner their support for the surge activities. This was important to position these health facilities as hubs to cater to the needs of the community ART patients upon stabilization and referral.

All these steps were taken to enable a holistic approach towards HIV treatment saturation in Akwa Ibom state with the full involvement of every stakeholder in Akwa Ibom. The attainment of treatment saturation across the Akwa Ibom state will involve a mix of both facility optimization and community ART Management to ensure that the unmet need for antiretroviral therapy across the state is closed.

The Community ART Management team is formulated as an entire medical management team that provides the comprehensive ART services to the community through a client centered approach. Efforts have been made to identify and include health service providers from the LGAs where the community interventions are being implemented. This is to ensure the service providers can be embedded within the communities where they work. This can further improve community buy – in of the various interventions.

This is to ensure that every identified barrier to clients accessing antiretroviral therapy is addressed and overcome towards ensuring that every person that needs the ART services receives it. The community ART management team is composed of the following cadre of staff:

Personnel	Roles & responsibilities
Clinician	<ul style="list-style-type: none"> Provides technical and operational leadership to the community ART management team Provides HIV treatment services for HIV positive clients identified in the community
Pharmacist	<ul style="list-style-type: none"> Provides pharmaceutical care for the identified clients and manages ARV and drug logistics for the team
Laboratory Specialist	<ul style="list-style-type: none"> Provides the laboratory support to the team Ensures logistics support & documentation for RTKs and lab commodities for the team
HIC Counsellor – testers	<ul style="list-style-type: none"> Conducts HIV counselling and testing activities within the community teams
Case Managers	<ul style="list-style-type: none"> Provides adherence and treatment support to clients. Supports client retention activities
Community Mobilizers	<ul style="list-style-type: none"> Facilitates community entry for the various community surge activities
LGA Treatment Support Officer	<ul style="list-style-type: none"> Coordinates the various community activities at the LGA level with the various healthcare facilities and service delivery points
Data Entry Clerks	<ul style="list-style-type: none"> Ensures the proper documentation of the various community surge activities and performance

ENGAGEMENT OF THE COMMUNITY ART MANAGEMENT TEAMS

The engagement process of the various cadre of service providers for the community ART management teams was done in line with full involvement of the GoN partners to ensure the transparency of the entire process. Notices of the engagement process was widely disseminated, and interviews were conducted towards determining the suitability of the staff for the positions being applied for.

The successful candidates were notified, and an orientation was conducted for the service providers to ensure the proper implementation of the various services within the community ART management services.

MICRO-PLANNING & CONTEXT SPECIFIC IMPLEMENTATION

Utilizing lessons learnt from the community scoping activities, strategies are being deployed towards ensuring the success of the community ART management services.

In ensuring that these plans were context specific, micro-planning within the communities for efficient service provision by utilizing the minimal utilization of resources is being embarked upon. Ongoing iteration of ideas and strategies will ensure that the teams make the best use of the available resources to progressively improve program outcomes.

EMBEDDED SERVICES & CLUSTERED TECHNICAL SUPPORT

The community ART management approach requires intensive community presence and support. To this end, health service providers are expected to be embedded in the communities in which they provide Community ART services.

A streamlined technical support structure has been designed, clustering the state into 3 technical and operational units. Each cluster is to have an operational hub which will serve as the base for coordination across the LGAs. The operational hub locations are accordingly:

- North East Cluster: Uyo
- North West Cluster: Ikot Ekpene
- South Cluster: Eket

SIDHAS staff and personnel involved in the community ART management as well as consultants providing facility optimization will operate within the various communities/LGAs and clusters where they are deployed.

CLUSTER 1: UYO

Etinan
Ibesikpo Asutan
Ibiono Ibom
Itu
Nsit Atai
Nsit Ibom
Nsit Ubium
Uruan
Uyo

CLUSTER 2: IKOT EKPENE

Abak
Essien Udim
Etim Ekpo
Ika
Ikono
Ikot Ekpene
Ini
Obot Akara
Oruk Anam
Ukanafun

CLUSTER 3: EKET

Eastern Obolo
Eket
Esit Eket
Ibena
Ikot Abasi
Mbo
Mkpat Enin
Okobo
Onna
Oron
Udung Uko
Urue Offong/Oruko



HIV CASE FINDING

While the surge emphasizes intensive HIV case finding to cover the existing treatment gaps, it is important to note that the strategy is guided by the need to ensure testing efficiencies across all HIV testing modalities.

The surge utilizes a mix of targeted community and facility testing as opposed to generalized HIV testing especially in high burden communities and in congregate settings. The targeted testing leverages on operational knowledge of the “drivers” of the epidemic to identify potential hotspots for targeted HIV testing.

In addition, an added layer of HIV risk stratification in select service delivery points within the facility and at all community outreaches will provide improved efficiencies across the testing streams.

However, the tool will not be used in high-yield testing streams like the TB-DOTS & STI clinic. It will also not be used in the context of prevention of mother to child

HIV testing algorithm

The standard National HIV testing algorithm remains deployed across the supported health facilities and communities where HIV testing services are implemented.

For patients with HIV positive results, retesting according to laid down protocols have been instituted to ensure the integrity of the results before ART initiation is considered for patients.

HIV testing modalities

In keeping with the need for context specific approaches, different modalities for HIV testing have been deployed to maximize HIV case detection efficiencies across Akwa Ibom state. The most important strategies include:

- **Targeted Community Testing:** HIV testing is offered in the communities to individuals that are identified to be at a higher risk of HIV infection during HIV risk stratification. Further targeting can be done through various community mapping activities to ensure further improvement in HIV case detection efficiency.
- **Partner Notification Services (PNS)** forms the fulcrum of case identification and should be offered to newly identified clients and virally unsuppressed patients in the community to further improve HIV case detection in the various testing streams.

- **Genealogy testing** as an arm of index case testing has also been deployed across the state to identify HIV infected spouses and children of PLHIV.
- **Moonlight testing:** This is HIV testing being done in the evenings/nights. This is predicated upon the idea that most individuals in the communities are at work during the daytime when HIV testing is usually offered in the communities. Offering HIV testing in the evening will increase the chances of meeting more people who can then be offered HIV testing in the evenings.
- **Marine community testing:** HIV testing services specific to the various marine communities was set up. This is to accommodate the peculiarities of providing HTS in the riverine/marine communities. These communities are relatively poorly accessed because the only way to access these communities is through the waterways. This approach explores the engagement of residents of these marine communities to provide HIV testing services in their communities with linkages to ART.
- **Third party testing and referrals in private labs:** many persons patronize the various private laboratories across the state for HIV testing services. This approach leverages on the existing HIV testing being done in these labs by ensuring the proper linkage of the HIV positive clients to community ART services.
- **PMVs (patent medicine vendor) testing & referrals:** patent medicine vendors are usually patronized by the members of public and they are the first point of call for many members of the communities once they are feeling unwell. This provides an opportunity to offer HIV testing at these points. Onsite training for the PMVs equips them to offer HIV testing and referrals made to the community ART Management team that is providing support where the PMV is located.
- **HIV risk screening and PITC** at services delivery points except STI, TB clinics (100% testing).
- **Liaise with blood banks** to identify and link infected donors to care.

HTS documentation

Documentation for HTS is done using conventional paper-based data capture tools in addition to the use of software like LAMIS-lite and daily DHIS uploads to ensure that the proper documentation of the HIV testing services and availability of data for decision making.



LINKAGE TO ANTIRETROVIRAL THERAPY

A client-centered approach to ART

The end-point of ART on such a scale is to ensure virologic suppression for at least 95% of patients placed on treatment. To achieve this, we are guided by the client-centered approach that seeks to provide ART services in the most convenient and non-intrusive manner possible.

An important indicator that can assure programs that they are on the way to good viral suppression in the population of concern is retention on ART. This is the reason why client-centered approaches to community and facility ART services have been employed.

ART linkage options in community ART management

In line with the client-centered approach for the provision of community ART services, various options are available link HIV positive clients to antiretroviral therapy. The cardinal focus of the preference of the client is ensured while providing the client with the options.

The default ART linkage option for the Community ART management is essentially community initiation with community refills for the first three months of ART. At the end of this period, the client is referred to a facility for ongoing refills or other community DMOC platforms to ensure that the client is retained on therapy.

This is to ensure that intensive adherence support and follow up for ART refill is done in a way that ensures retention on ART. This model also leverages on this close support to identify and provide support for all barriers to ongoing ART management.

Initiation of clients on ART in the community

Identified clients during community ART services should be ART initiation after assessing their readiness to commence ART using client readiness determination checklist. This is in line with the same-day “test and start” strategy to ART management.

Unless otherwise indicated, the preferred first line regime appropriate for the age/sex of the client is prescribed for the client in line with the National Guidelines on ART Treatment.

TB preventive therapy (TPT) Implementation in CAM services

All newly initiated clients on ART should also be screened for Tuberculosis. Those who are eligible for Tuberculosis Preventive Therapy (TPT) must be commenced by the community teams on Isoniazid 300mg daily for 6 months to ensure proper protection against Tuberculosis.

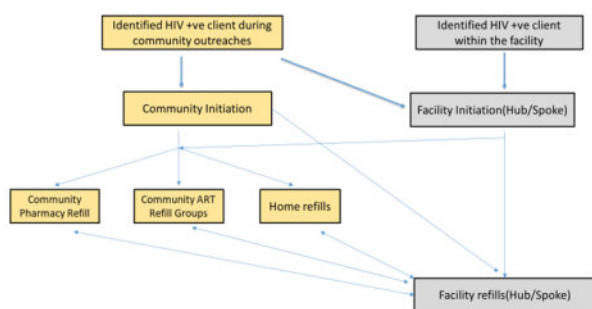


Fig 4: Models for community ART services



RETAINING CLIENT ON ART THROUGH CAM SERVICES

Retaining patients on antiretroviral therapy has been challenging in Akwa Ibom state. In addition to already identified drivers of the epidemic which also affect retention, historical data shows that the largest losses for clients occur immediately after ART initiation and in border communities where cross border mobility into areas outside the program's jurisdiction often occurs. These factors have been closely considered in designing retention interventions that utilize community structures. They include:

- Utilization of the readiness to start checklist and employing a multidisciplinary approach to treatment preparation
- Case management to ensure close follow up within the first month of ART which is critical to long term retention. This makes use of the 30 - day adherence schedule. The first month is critical because approximately 30% of patients do not return after ART initiation
- Close client support including home visits within 72 hours of being initiated on ART. As an alternative, clients can be transported home after ART initiation upon obtaining consent, to ensure clients place of abode is identified.
- Cross program biometric systems to document client's ART initiation towards preventing "silent transfers" that results in client's being lost to follow up.
- Implementing the various models of DSD for both stable and unstable clients towards ensuring ongoing client retention.
- Family centered appointment schedules including coinciding appointments with holidays and ensuring same day appointments for the caregiver-child pair.
- Support for adolescent friendly clinics, disclosure and transition to adult care
- Peer support and champions to support adherence counseling and linkage to support groups
- Peer led CARC in fishing communities with documentation support using mobile EMRs
- Male friendly clinics with flexible times
- Peer led community ART support groups to improve male linkage and retention in care



VIRAL LOAD SERVICES IN THE SURGE

Pre-analytic phase

It is the mandate of the program to optimize demand for viral load services during the surge. This is because the endpoint of the surge from a public health perspective is the achievement of viral load suppression in at least 95% of all patients on ART.

This begins with ensuring viral load coverage for all patients on treatment. Through EMRs and routine line listing of patients, all eligible patients will be enumerated for phlebotomy appointments.

In addition, patients will be targeted with client literacy materials to ensure that they demand for their viral load tests according to the national guidelines. Healthworkers on the other hand, will continue to receive technical support to ensure that they optimize viral load services.

Clients are to be provided viral load service within the communities/facility as required. Eligible clients for viral load investigation will have their samples taken and linked to the treatment hub for transport by the NISRN for transportation to the reference labs. Whole blood samples will be taken, prepared and logged where available. As an alternative, DBS for viral load will be offered where available in hard to reach areas.

Clients who are on Dolutegravir – based treatment regimen will be offered viral load investigation 3 months after the commencement of treatment. Clients on non-DTG based regimen will have their samples taken 6 months after treatment initiation.

Analytic phase

To handle the increased demand for viral load services during the surge, PEPFAR has supported the deployment of high throughput PCR machines at the Uyo mega-lab.

The community ART Management service delivery will leverage on these services to ensure that the turn – around time of the viral load investigation is reduced to recommended standards.

Also, the project has committed to provide support (where necessary) for extended work hours to deliver results efficiently.

Post-analytic phase

EMR integration with LIMS to facilitate seamless results delivery is underway and when complete, will shorten the time from blood draws to availability of results for clinical decision making.

Clients with unsuppressed viral load results will be provided with enhanced adherence counselling and treatment support towards attaining eventual viral suppression. Clients that require regimen switch to 2nd line management will be referred to the health facilities for ART management.

Supporting virologic suppression in CAM

Enrolment of clients with VL > 1,000 in “Viremia Suppression Services” with enhanced adherence support, management of OIs and repeat VL investigation. This can be managed by the treatment team in the community ART services or referred to supported facilities for EAC and repeat viral load collection.

There will be an ongoing treatment support by case managers to assist client in navigating the process of EAC and follow up actions in the community. Historically, the pediatric and adolescent age groups have poorer viral suppression than the older age groups. To address this:

- Intense monitoring of the dose – adjustments for the children.
- Ensuring the placement on age – appropriate regimen for the pediatric and adolescent age groups through ongoing folder audits and mentoring.
- Case Managers to support client – caregiver pair to ensure disclosure.
- For clients in hard to reach areas, Peer – led adherence support services with linkage to follow on services for viral suppression to be implemented.



COORDINATING FACILITY-COMMUNITY INTERVENTIONS

Through USAID, a state wide collaborative has been established to ensure efficient coordination and utilization of resources particularly between the facility and community interventions across the state. All the partners supporting OVC and key population services as well as Global Fund partners have committed to coordinated efforts to ensure proper implementation of activities. The collaborating IPs include: HIFASS, ARFH and Save the Children Initiative: OVC services. Heartland Alliance is providing services for the Key Population while KNCV will be driving TB services across the state.

The bi-directional linkage of children/adolescents from the SIDHAS treatment services to OVC services and vice versa is to be implemented across the state. The role of the state and local government is central towards ensuring that the various interventions have the buy in of health workers at the facility level and will be involved in joint supervision and monitoring of the surge response.

Monitoring Services

The high intensity intervention of the surge is such that every aspect of the surge will be reviewed for optimization. Attention will be paid to the following:

- HIV positivity volume
- HIV testing efficiency
- Linkage to ART
- Retention of clients (using the 28 – day PEPFAR bench mark)
- Viral suppression among clients on ART

Regular deep-dive analysis will be conducted to monitor performance. Performance will be constantly reviewed across the various community teams. Daily reporting of performance will be ensured through the reporting on the daily DHIS updates. Facility level data is also expected to be uploaded daily in all supported facilities. Biometric systems for client identity management is being deployed and is expected to be taken to scale.

Enhanced site management (ESM) services

As part of the overall enhanced site management structure, impromptu supervisory visits will be conducted by both USAID, SIDHAS and GoN supervisory teams. Community ART management teams are to maintain the highest standards of service delivery and documentation at every point of the surge within the facility and community services.

A supervisory checklist will be administered on each community team's activity to ensure an objective review process as well as facilitate feedback to the teams on performance improvement.

CONCLUSION

The Attaining treatment saturation through the various surge activities is attainable with the full involvement of the government in partnership with the various stakeholders and implementing partners to drive the state response. The need to sustain the intensity of intervention to ensure ongoing drive towards attaining the goal of controlling the HIV epidemic in Akwa Ibom by Q4 2020

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