



What Works? Effective coordination between OVC and HIV clinical partners to improve pediatric HIV case finding, retention and viral load suppression

Presented by the OVC Task Force and Interagency PEPFAR Colleagues
Wednesday, December 13th

8-9:30 AM New York (GMT-4) | 2-3:30 PM Joburg (GMT+2) | 3-4:30 PM Nairobi (GMT+3)



Introduction

*Tanya Medrano, OVC TF Co-Chair and
Technical Advisor for Vulnerable Children
and Youth, FHI 360*

Agenda

Presenter	Title
Tanya Medrano, Technical Advisor for Vulnerable Children and Youth, FHI 360	Introduction
Janet Barry, OVC TF Co-Chair and Senior Technical Advisor, Bantwana Initiative, World Education	Opening Remarks
Belmiro Sousa the Technical Director, COVida Project, FHI 360/Mozambique	Triangulating OVC Program and Health Facility Data to Improve Pediatric Retention and Viral Suppression
Dr. Silvia Matitimmel Mikusova, Technical director, EGPAF/Mozambique	
Dr. Tania Tchissambou, Technical Director for Increase Access to Comprehensive HIV/AIDS Prevention, Care and Treatment Services project, DRC	Collaboration between OVC and clinical HIV programs in the DRC
Maggie Kuchonde, Program Manager at Lilongwe Catholic Health Commission, Malawi	Coordination between OVC and HIV Clinical Partners for the Lilongwe Catholic Health Commission OVC Activity
Viva Thorsen, Orphans and Vulnerable Children Unit Lead, CDC	Facilitated Q&A
Julie DeSoto, OVC Program Manager & Adolescent Health/Mental Health Technical Lead, World Vision	Moderator



Zoom Webinar Functionality

Audio

Q&A

Chat

Polls

Zoom Webinar

The image shows a Zoom Webinar interface. On the left, a dark panel contains two lines of orange text: "If you are unable to hear, connect your speakers by selecting 'Join Audio.'" and "Use the up arrow to change your speaker selection." Below this panel, the "Audio Settings" icon is circled in blue, with an arrow pointing to the text. In the bottom center, the "Chat" icon is circled in blue, with an arrow pointing to the right-hand chat window. The chat window on the right is white and contains two lines of blue text: "Please use the chat box to introduce yourself." and "Share thoughts and comments by sending a message to 'All panelists and attendees.'" Below the text, the "To:" dropdown menu is open, showing "All panelists" and "All panelists and attendees", with the latter option circled in blue and an arrow pointing to the text above. A "Leave" button is visible in the bottom right corner of the chat window.

If you are unable to hear, connect your speakers by selecting "Join Audio."

Use the up arrow to change your speaker selection.

Please use the chat box to introduce yourself.

Share thoughts and comments by sending a message to "All panelists and attendees."

Audio Settings ^

Chat Q&A

To: All panelists v

Your: All panelists

All panelists and attendees

Leave

Q&A and Chat

Use the Q&A box to submit questions for the panelists.

You will also be able to view questions that other attendees have asked and comment on them.

The screenshot displays a Zoom meeting interface. At the top center, a window titled "Question and Answer" is open, showing a "Welcome" message: "Welcome" and "Feel free to ask the host and panelists questions". Below the message is a text input field with the placeholder "Type your question here...". A blue arrow points to this input field, and a blue circle highlights the "Q&A" icon in the bottom navigation bar. To the right of the Q&A window, the "Chat" panel is visible, showing a dropdown menu set to "All panelists" and a message: "Your text can only be seen by panelists". At the bottom left, there is an "Audio Settings" link. At the bottom right, there is a red "Leave" button.



Opening Remarks

*Janet Barry, OVC TF Co-Chair and Senior
Technical Advisor, Bantwana Initiative,
World Education*



Poll #1

What are the key challenges faced by HIV clinical and OVC partners in their coordination efforts?

Please choose as many responses as you wish and click “submit.”



Presentation 1



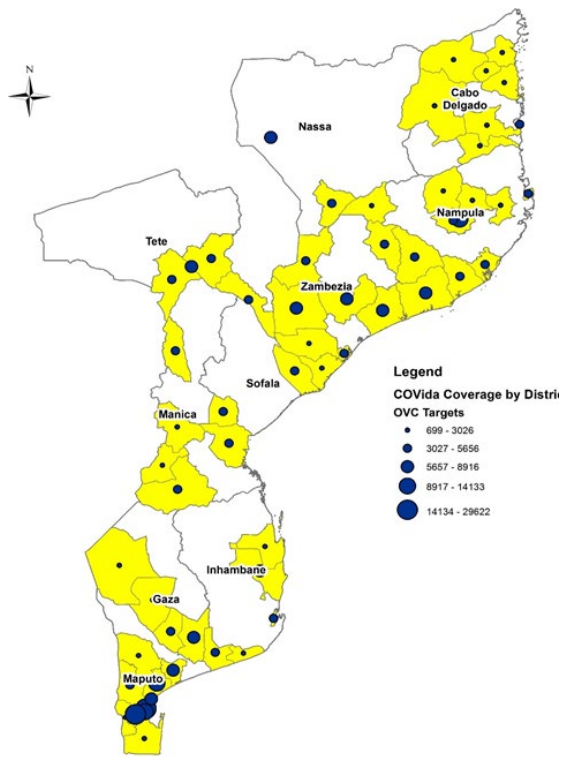
Triangulating OVC Program and Health Facility Data to Improve Pediatric Retention and Viral Suppression in Mozambique

January 13, 2021

Belmiro Sousa, Technical Director, FHI 360, COVida
Silvia Mikusova, Technical Director, EGPAF

BACKGROUND: COVida “Together for Children”

- OVC program 2016-2022
- Geographic scope: 7 provinces, 33 districts
- FY 21 target: **291,706 OVC** and caregivers
- 28 CBOs, 3000 community case workers
- Working with more than 200 health facilities
- Main interventions:
 - Comprehensive case management (household visits with direct service delivery or referrals)
 - Enrollment of C&ALHIV on ART in HFs. Intensive support to ensure adherence, retention, and VLS
 - Economic strengthening support (savings groups, emergency social support)
 - Primary prevention for boys and girls ages 9-14 years
 - DREAMS (HIV prevention) for AGYW (11 districts)



Geographic Area, Key Technical Focus, EGPAF

- **Target geographic area:**
 - **Gaza:** 10 districts, 100 HF, 155,877 patients on ART by September 2020 (9615 children)
 - **Inhambane:** 14 districts, 49 HF, 62,631 patients on ART (4134 children) by September 2020
- Focus on achieving UNAIDS' 95/95/95 goals
- **Programs/Activities:**
 - HIV counselling and testing, MCH/PMTCT, C&T, PSS, community, TB, research
 - Focus on retention activities
 - VL cascade
 - DSD expansion
 - Testing optimization strategies and care linkages
 - PMTCT
 - Quality improvement
 - CECAP
 - Pediatric mentoring program (clinical, PSS)
 - Community outreach (community index case, preventive home visits, LTFU)
 - DREAMS

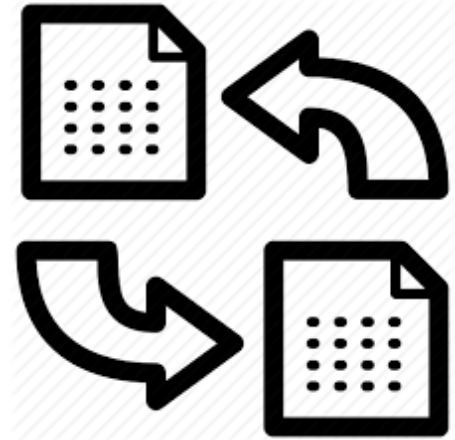


The Problems

- 99% of C&ALHIV (13,580) in COVida self-reported being on ART, while pediatric retention was below 70% across the country
- High viral load among C&ALHIV, suggesting they were not taking their medication properly or were in an ineffective treatment regimen
- Low viral load testing coverage for C&ALHIV
- Some C&ALHIV supported by COVida were in LTFU lists generated by HFs

The Data Triangulation

- Consisted of comparing data on C&ALHIV in COVida's community case management system with health facility data.
- Aimed to:
 - Correct and align C&ALHIV data in COVida and HF files and electronic patient tracking system (EPTS)
 - Confirm COVIDA C&ALHIV's enrollment in ART
 - Obtain C&ALHIV's VL data to improve VL status
 - Ensure the timely transition of children on ART to optimized pediatric regimens (DTG and LPV/r solid formulation)
- Conducted in 14 HFs in five districts in Inhambane Province where EGPAF is the PEPFAR clinical partner.



Steps for Data Triangulation in Inhambane

1. COVida met with EGPAF and its IPs in each district to discuss and coordinate the data triangulation exercise



2. COVida shared its C&ALHIV retention and adherence tracking tool with EGPAF, and it was jointly adjusted to include new fields



Data Provided by Clinical Partners (Open MRS)										
Name in EPTS	Patient ID number in EPTS	HF	Treatment Line	Start Date	Treatment Regime	ART Status	Next appointment date	Next ARVs pickup date	VL Status&Results	Comments
			ABC+3TC+DTG	1/25/2013	Dispensa Semestral	Nao Localizado	5/27/2020	6/28/2020	Indetectavel	
			AZT+3TC+LPV/r			Transferido para			Detectavel	
			AZT+3TC+LPV/r			Faltoso			Detectavel	
			ABC+3TC+DTG			Activo			A espera de resultado	
			ABC+3TC+DTG			Activo			Detectavel	
			AZT+3TC+LPV/r			Obitos			Indetectavel	

Steps for Data Triangulation in Inhambane

3. COVida's IPs generated a list of names and IDs of C&ALHIV in the OVC program and shared it with EGPAF HFs.

4. EGPAF/HF staff cross-checked the data for each child in the EPTS.

5. EGPAF/HF clinical staff provided feedback to COVida on the discrepancies identified.

6. COVida and EGPAF held weekly meetings to update and clarify information in both partners' forms and databases.

Data Discrepancies Found Through Data Triangulation, and Improvements Made

Issues Identified

- Some C&ALHIV were not registered as ART patients in a HF, suggesting they had registered using a different name.
- Some children's ages differed between the COVida and the HF databases (some registered as adults).
- Some C&ALHIV reported being on ART to COVida, but were registered as LTFU in the HF.
- Some C&ALHIV were in a different HF (that they had transferred themselves to) than was reported to COVida.



Improvements Made

- COVida cross-checked names in case management records with HF patient treatment cards and communicated findings to the EGPAF.
- COVida cross-checked children's ages and shared the correct age with EGPAF/HF. Updated case management records as needed.
- EGPAF/HF provided lists of children LTFU. COVida immediately started tracing children in the community for treatment re-initiation.
- COVida updated case management records to include the new HF.

Program Gaps Identified Through Data Triangulation, and Improvements Made

Gaps Identified

- Only 71% of C&ALHIV who self-reported being on ART to COVida were on ART.
- Of those C&ALHIV confirmed on treatment, only 52% had VL data.
- Only 60% of children with VL data were virally suppressed.
- Some children were still on nevirapine regimens (a non-optimized treatment regimen).

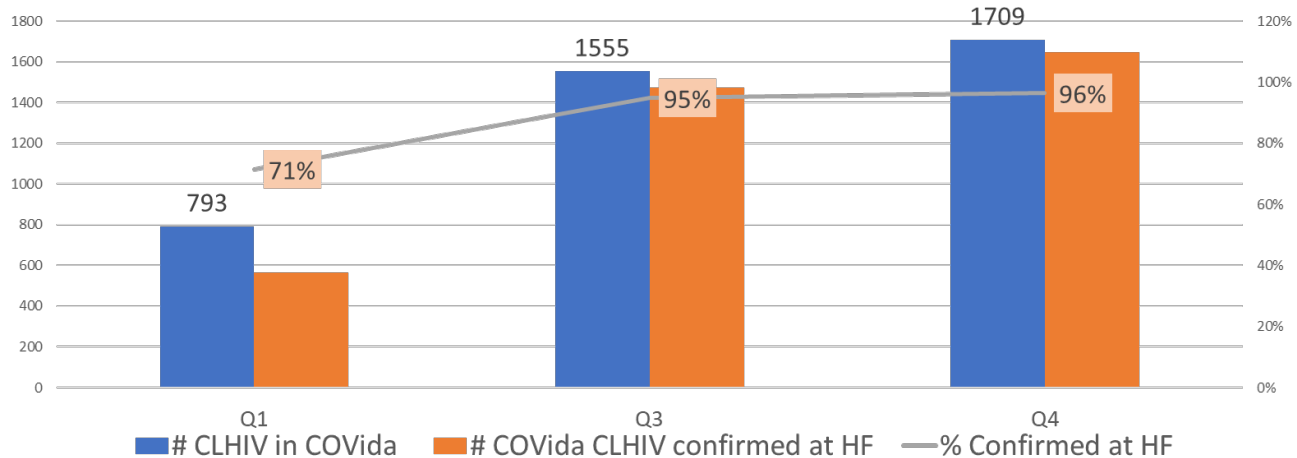


Improvements Made

- COVida escorted children to the HF for treatment initiation/re-initiation.
- COVida increased promotion of VL testing in the community and EGPAF/HFs organized sample collection in coordination with COVida.
- EGPAF trained COVida case workers on ART adherence and VL testing. COVida improved adherence monitoring during home visits.
- EGPAF/HFs provided lists of children on nevirapine to COVida, and case workers escorted these children to the HF to change their regimen.

Outcomes of the Data Triangulation Exercise

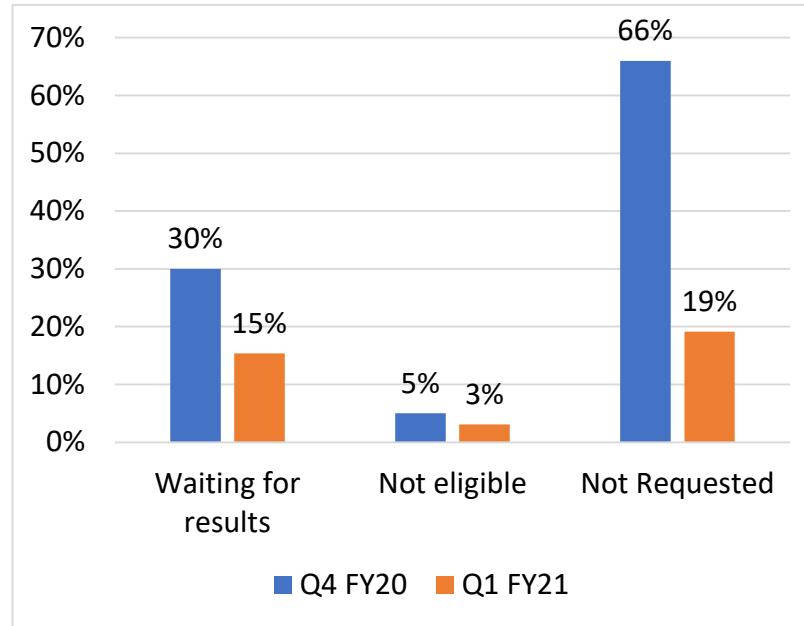
Increased Number of C&ALHIV on ART in COVIDa Inhambane Province, FY20



Note: The triangulation exercise was suspended in Q2 due to the COVID-19 lockdown, so the number of children on ART was not confirmed until Q3

Outcomes of the Data Triangulation Exercise

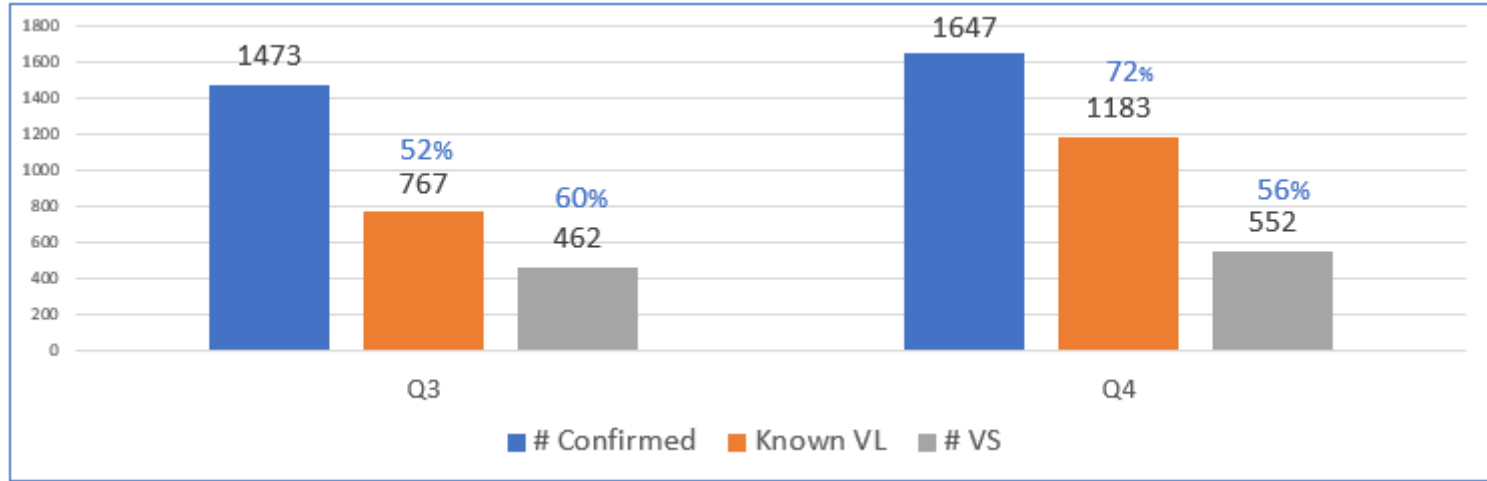
Barriers Related to VL Testing were Reduced



- The number of eligible children for whom a VL test had not been requested decreased from 66% to 19%.
- The percentage of C&ALHIV waiting for VL test results was cut in half from 30% to 15%.

Outcomes of the Data Triangulation Exercise

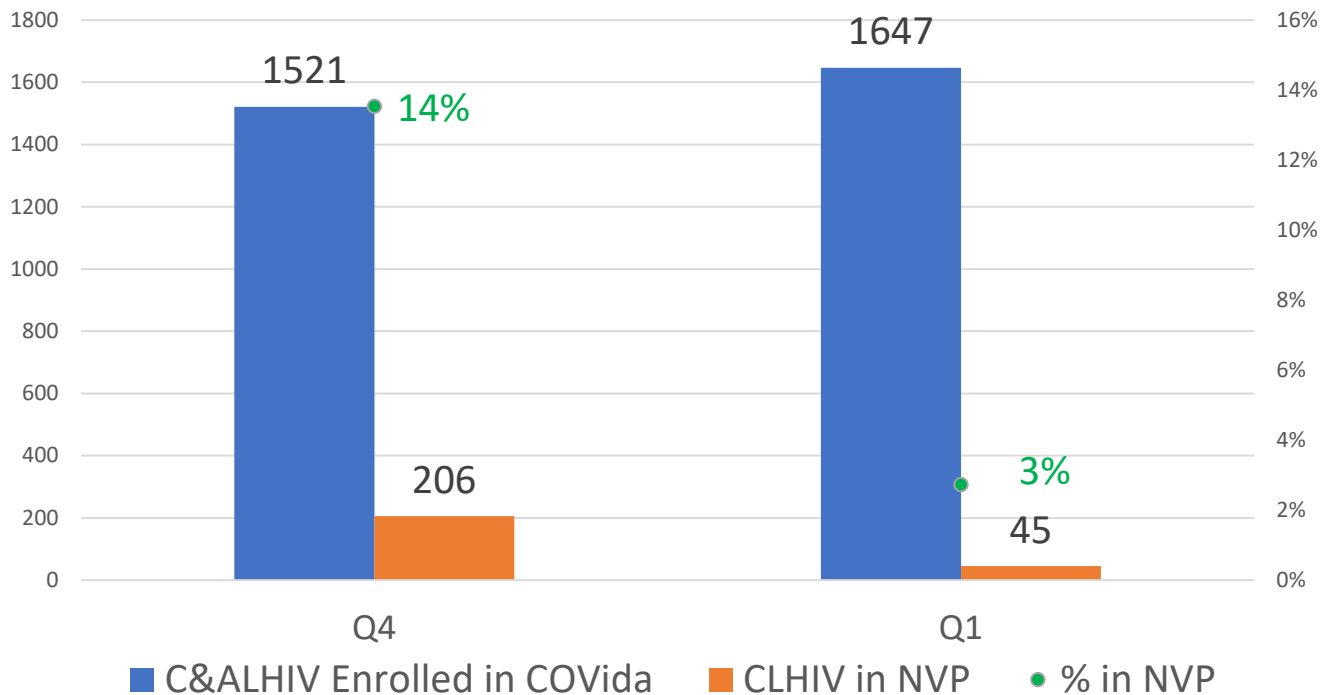
Increased Number of C&ALHIV with Known VL Inhambane, FY20, Q3-Q4



- The proportion of C&ALHIV with known VL increased from 52% in Q3 to 72% in Q4.
- VLS decreased from 60% to 56%. The absolute number of virally suppressed C&ALHIV increased significantly, but the proportion is diluted by new children supported to learn their VL status.

Outcomes of the Data Triangulation Exercise

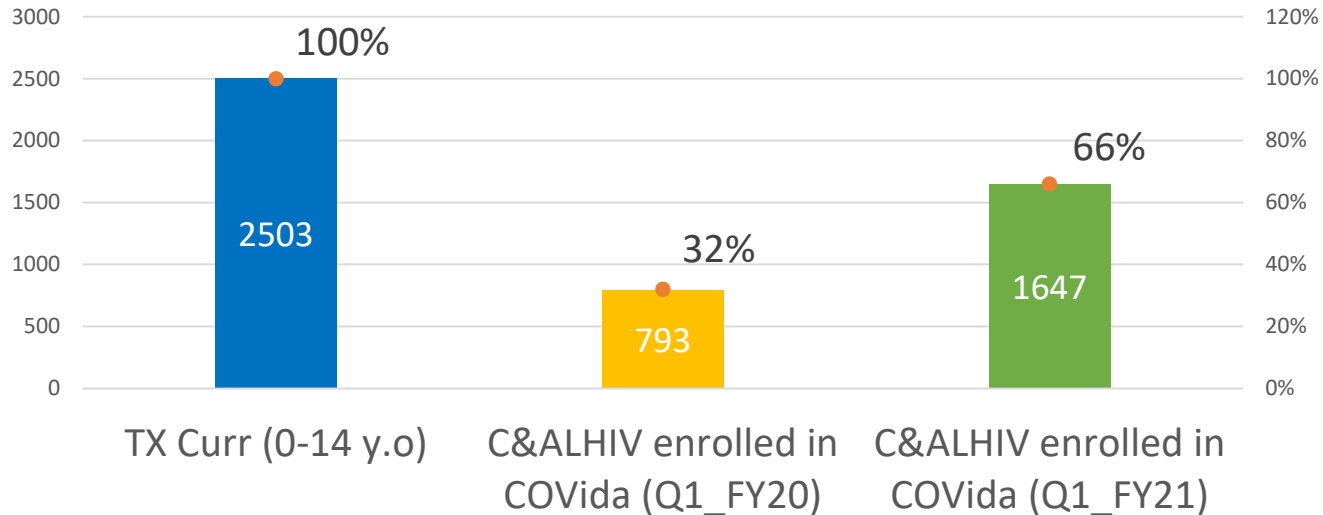
Reduced Number of Children on NVP



- More children were included in optimized regimens, reducing the # of children on NVP from 206 to 45.

Outcomes of the Data Triangulation Exercise

Increased Enrollment of COVida C&ALHIV in AJUDA Sites, Q1/FY21



Challenges and Solutions

- Some HFs did not have updated data in the EPTS
 - HF staff obtained updated information directly from patients during clinical appointments and/or from pharmacy records. Although this process was slow, it helped provide the most recent information on the treatment and VL status of C&ALHIV.
- Data verification and validation
 - Weekly coordination meetings were held between COVida and EGPAF at the HF level and monthly at the provincial level.

Lessons Learned and Recommendations


- OVC programs need to rely on HF adherence and VL data, not client self-reports. HIV knowledge, quality of services, side effects, and caregiver negligence all impact C&ALHIV's adherence.
- Data triangulation proved beneficial for both COVida and EGPAF/HFs, because it helped identify and correct discrepancies and jointly address gaps related to adherence and access to VL testing.
- Data triangulation increased EGPAF's and COVida's awareness about the importance of collaborating and exchanging data. OVC programs can capitalize on the increased collaboration to enroll more C&ALHIV from HFs in the OVC program. During the triangulation exercise, EGPAF/HF provided lists to COVida of C&ALHIV who had not been enrolled in the OVC program.
- Data triangulation proved to be an effective strategy for identifying gaps in linkage to ART, and improving retention and VL suppression among C&ALHIV. Between January and July 2020, COVida scaled up this approach to 104 additional HFs in five provinces.

A rectangular yellow sticky note is pinned to a brown corkboard. The words "Thank you" are written in a red, cursive-style font. A single red pushpin is visible at the top center of the note.

Thank you



Presentation 2



Collaboration between OVC and clinical programs:

Dr. Tania Tchissambou, Technical
Director, ICAP, DRC

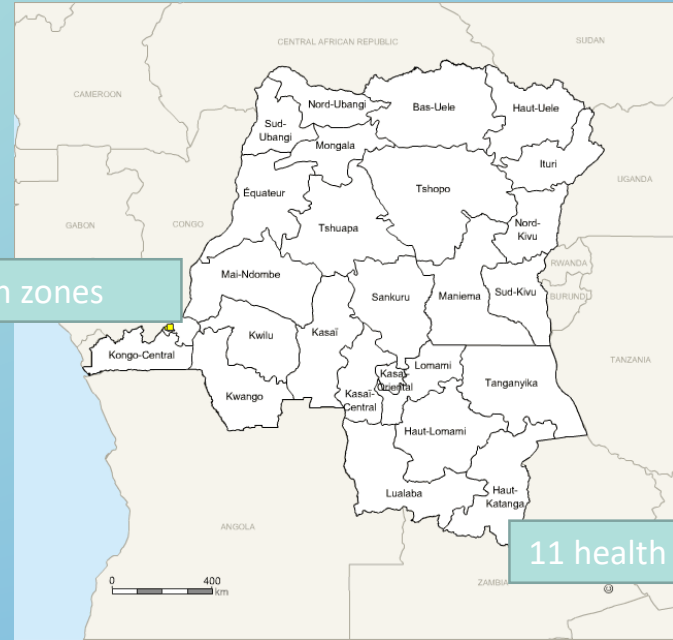
What Works to Improve HIV Outcomes for Children Living with HIV?



ICAP in DRC

- 2010 to present : HIV and AIDS prevention, care, support, and treatment interventions in 16 health zones in 2 provinces: Kinshasa and Haut-Katanga
- 2016: OVC programming in 11 health zones: 6 health zones in Kinshasa and 5 in Haut-Katanga
- 2020 (FY 21): Scale-up of the socio-economic interventions for OVCs in all supported health zones in FY21

Program name : Increase Access to Comprehensive HIV/AIDS Prevention, Care and Treatment Services in the Democratic Republic of Congo under the President's Emergency Plan for AIDS Relief



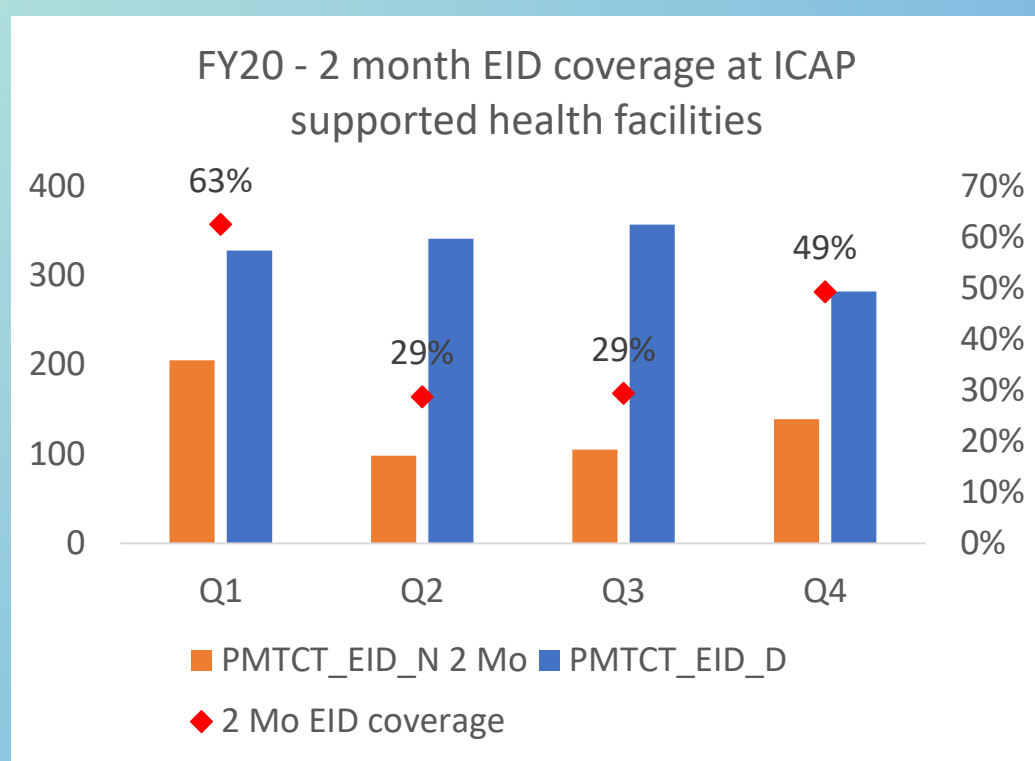
CDC-funded comprehensive program targeting the general population, KPs and OVCs

Gaps in the HIV pediatric cascade

1st 95: low testing coverage and low proportion of HEI who receive DNA-PCR

2nd 95: weak adherence to ART, low rate of continuity of treatment

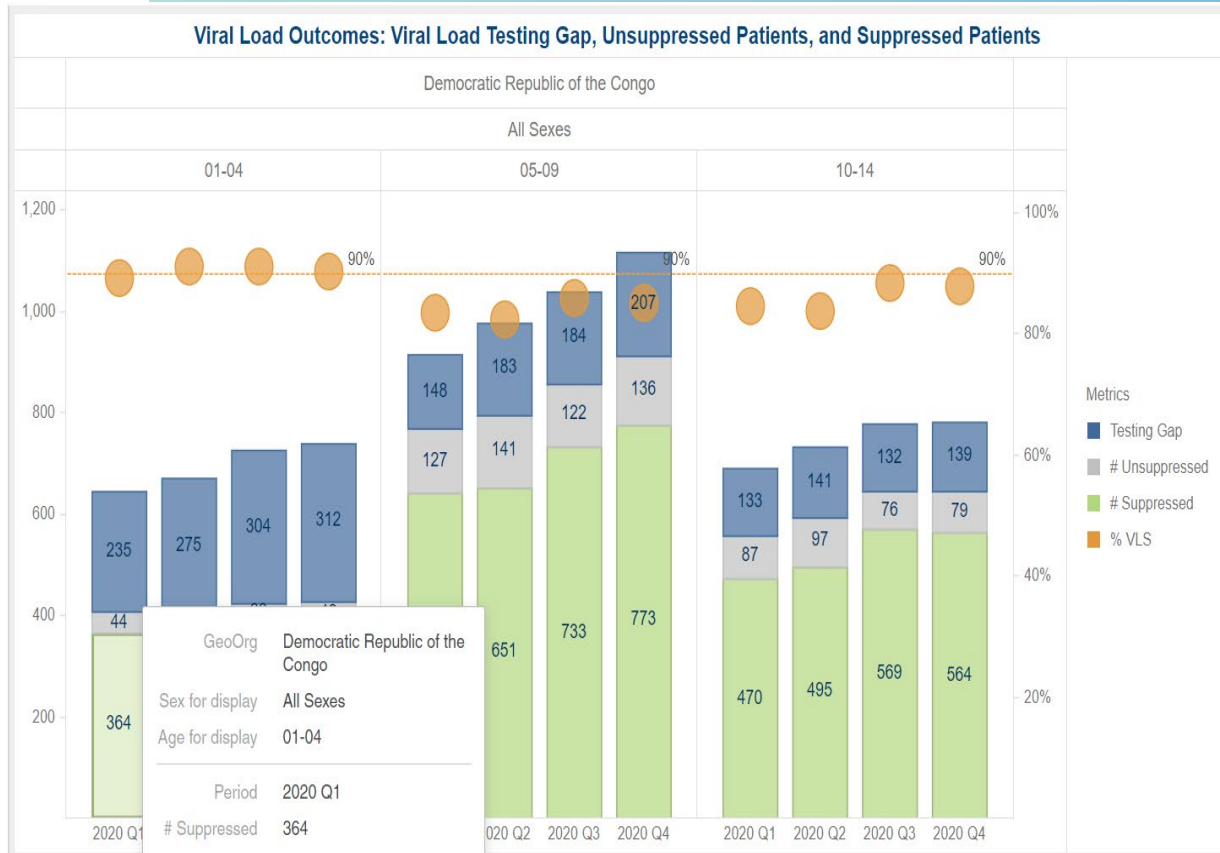
3rd 95: low proportion of children whom blood was drawn for VL and low proportion of children/adolescents with a suppressed VL



- Low proportion of HIV exposed infants who received EID at 2 months in Q2 and Q3, FY20
- The management of the mother-baby pairs by OVC case managers has led to an increased coverage

Gaps in the HIV pediatric cascade

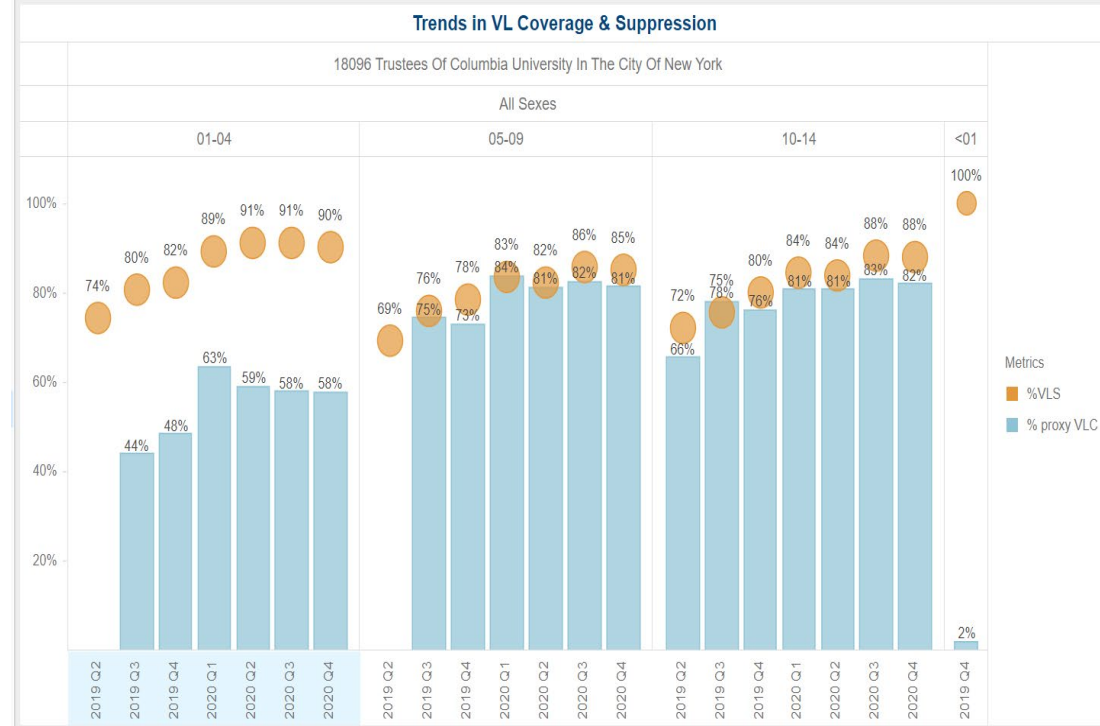
- Viral load testing coverage** - the proportion of children/adolescents who benefit from VL monitoring - was low among all age categories
 - Weak retention on antiretroviral treatment
 - Inconsistent attendance to planned clinical appointments



- Many missed opportunities for VL testing among children/adolescents mainly in the 1-4 age band
- Need of strategies to strengthen patient adherence and retention on treatment

Gaps in the HIV pediatric cascade

- **Viral load suppression** - *the proportion of children/adolescents VL result <1000* - was below 90% among all age categories
 - Poor adherence to antiretroviral treatment
 - Low number of children/adolescents with HIV serostatus disclosed to them
 - Inconsistent attendance to planned clinical appointment



- **Viral load suppression increased over time but remained below 95% in all age groups**
- **Need of strategies to strengthen patient adherence and retention on treatment to improve viral load suppression**

Roles of facility peer educators to improve VL coverage and VL suppression

- Identification of children/adolescents living with HIV who meet eligibility criteria for enrollment in the socioeconomic program targeting OVCs in health facilities
- Provide critical information regarding children/adolescent health to OVC case managers for them to provide home-based service
- OVC case managers participate in case conferencing



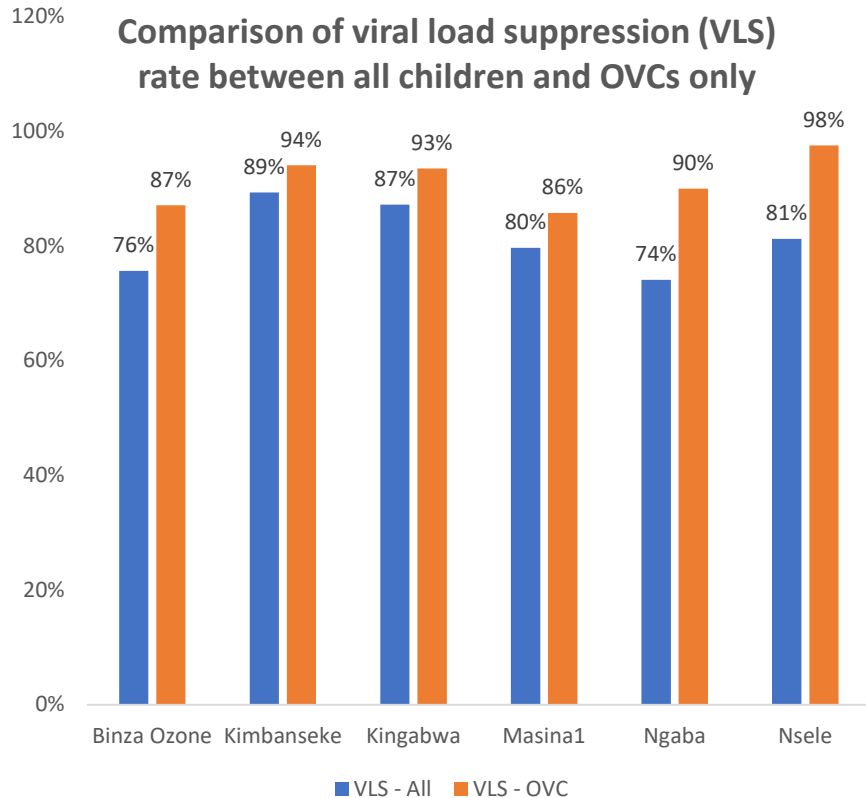
Roles of OVC case managers to improve case finding and, VL coverage and VL suppression

- Provide adherence counseling and adherence support
- Support disclosure of HIV serostatus for children and adolescents
- Send out appointment reminders
- Escort to facilities for clinical visits where needed
- Organize home-based VL sample collection
- Participate in case conferencing

Case managers

- People living with HIV/AIDS
- Former peer educators in ICAP program
- Completed secondary school
- Trained on HIV testing and counseling services
- Trained on case management
- Monthly stipend of \$160 - 180 per month

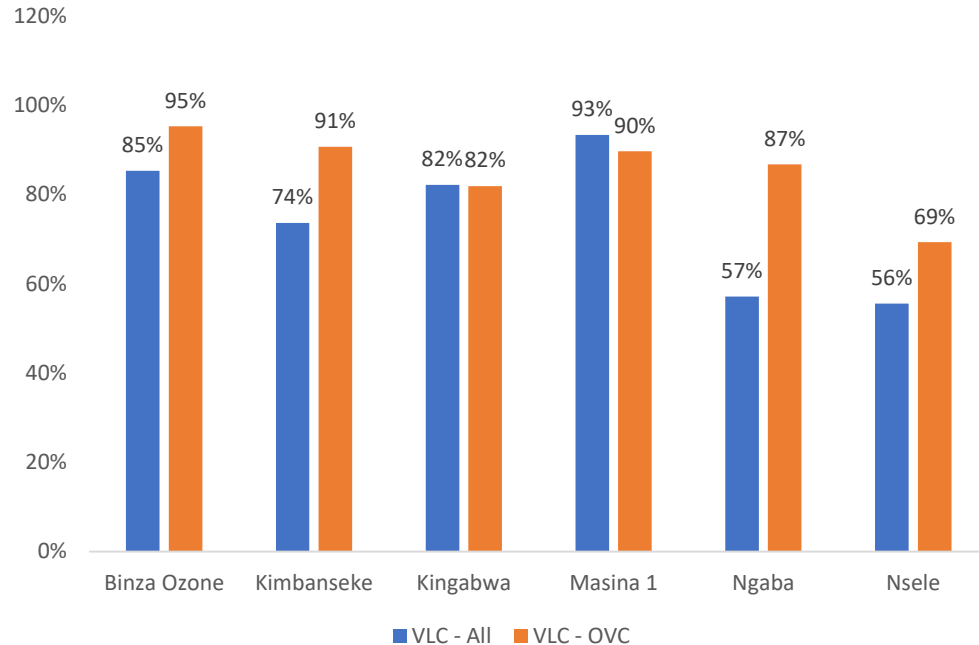
Challenges in the pediatric HIV cascade - VL suppression



- VL suppression below 95% in all supported health zones for all children and adolescents
- Increased VL suppression among OVC beneficiaries due to home-based visits to support HIV serostatus disclosure, retention on ART and adherence to ART

Challenges in the pediatric HIV cascade - VL coverage

Comparison of viral load coverage (VLC) rate between all children and OVCs only



- VL coverage below 90% among children in all supported health zones in Kinshasa
- The involvement of OVC case managers in appointment reminders and escorting defaulter clients to health facilities for clinical visits has improved VL coverage

Challenges encountered & solutions

- Gaps in communication between health care workers, peer educators and OVC case managers
 - Development of SOPs on the flow of communication between the clinical and the OVC teams by ICAP staff in collaboration with case managers and health facility staff
 - Organization of monthly case conferencing at the health zone level involving facility HCWs, peer educators and OVC case managers
 - Implementation of a WhatsApp group to rapidly share information on clients
- Reluctance of health care workers to send their “VIP” patients to the socio-economic program for OVCs
 - Experience sharing on the benefit between patients during peer support group meetings organized in the health facilities
 - Data review meeting on the effect of the SE program for OVCs organized by ICAP staff for HCWs

Lessons learned

- The close collaboration between healthcare workers, peer educators and case managers is key to improve children outcomes in HIV treatment program
- Monthly meetings for data sharing and activity planning allow facility staff and OVC case managers to have common objectives on improving children outcomes
- Building OVC case managers' capacities on counseling for adherence and retention on ART, and disclosure facilitated the continuum of care in the community
- The involvement of OVC case managers to provide adherence counseling, to support the HIV serostatus disclosure to children and adolescents, to track defaulter clients in the community has increase VL coverage and VL suppression for children enrolled in the SE program for OVCs



Presentation 3



COORDINATION BETWEEN OVC AND HIV CLINICAL PARTNERS

**MAGGIE KUCHONDE, PROGRAM MANAGER, CATHOLIC HEALTH
COMMISSION,
LILONGWE, MALAWI**

WEDNESDAY 13TH JANUARY 2021

LILONGWE CATHOLIC HEALTH COMMISSION OVC ACTIVITY

- The Lilongwe Catholic Health Commission OVC Activity (LLOVC) is a 5-year project targeting children (aged 0-17 years) and their caregivers with a known risk factor (HIV+ children, HIV exposed infants, children of HIV+ female sex workers, survivors of violence, abuse, exploitation and neglect (VAEN), child-headed households, HIV+ caregivers)
- LLOVC implemented in 21 health facilities identified by PEPFAR as high HIV burden priority sites
- The goal of the project is to mitigate the impact of HIV and prevent new infections among targeted Malawian priority populations to enable them to achieve their maximum potential as individuals and citizens.

LLOVC COORDINATION WITH 3 CLINICAL PARTNERS

Signed MOUs with three clinical partners:

- Lighthouse (5 Health Facilities (HF) **CDC Partner**
- Partners in Hope (13HF) – **USAID Partner**
- Baylor (3 HF) **USAID Partner**

- This coordination was initially highlighted in the proposal, but it was not effective due to absence of MOU's. Once the donor directed development of MOU's, coordination was enhanced.

COORDINATION PATHWAYS

I. MOUs

- Aimed at providing a cooperative framework for mutual engagement in delivering improved quality HIV services
- Guided by principles including open communication; confidentiality; use of local existing structures; mutual consent for decisions
- Specified roles and responsibilities for each partner and areas of coordination

COORDINATION PATHWAYS

2. LLOVC Referral and Linkage Facilitators coordinate with Patient Supporters from treatment partners

- Clinical partners, through Patient Supporters, refer eligible beneficiaries for enrollment to LLOVC Referral and Linkage Facilitators
- Clinical partners share the list of defaulters and LTFU with LLOVC Case Care Workers (CCW's) for tracing back in to care
- LLOVC CCW's create demand for HIV testing through home visits and clinical partners conduct both community and facility-based HIV testing
- Referral and Linkage Facilitators, in collaboration with Patient Supporters and ART Coordinators, identify new possible beneficiaries through ART registers and link them with CCW's for regular home visits

COORDINATION PATHWAYS

3. Case conferences

- LLOVC CCW's initiate case conferences with treatment partners and other key stakeholders for CLHIV with complex cases (like high viral loads (VL) or showing other signs of treatment failure), resulting in switching regimens in some cases or in the provision of emergency assistance in the form of food.
- LLOVC CCW's and Patient Supporters conduct joint know-your-child sessions to identify specific needs for individualized support services

COORDINATION PATHWAYS

4. Coordinated support services for CLHIV

- Clinical partners refer CLHIV with high VL to LLOVC to conduct home visits to identify the causes and provide the necessary support depending on the need (e.g. emergency support, counselling, adherence support)
- LLOVC CCWs through case management processes monitor VL and refer beneficiaries due for VL testing to clinical partners and assist in following up on VL results
- Clinical partners put eligible CLHIV on optimized ART regimens according to national treatment guidelines
- LLOVC CCW's refer CLHIV to teen clubs for drug refills, psychosocial support, disclosure support, stigma and discrimination reduction, nutritional education
- Joint planning and supportive site visits by LLOVC Caseworker Supervisors, management team and team leads from clinical partners ensure that benchmarks are met

LLOVC PROMOTING ART RETENTION SERVICES WITH CLINICAL PARTNER, PARTNERS IN HEALTH



IMPROVEMENTS DUE TO COORDINATION

LLOVC has observed the following key successes due to improved coordination with clinical partners:

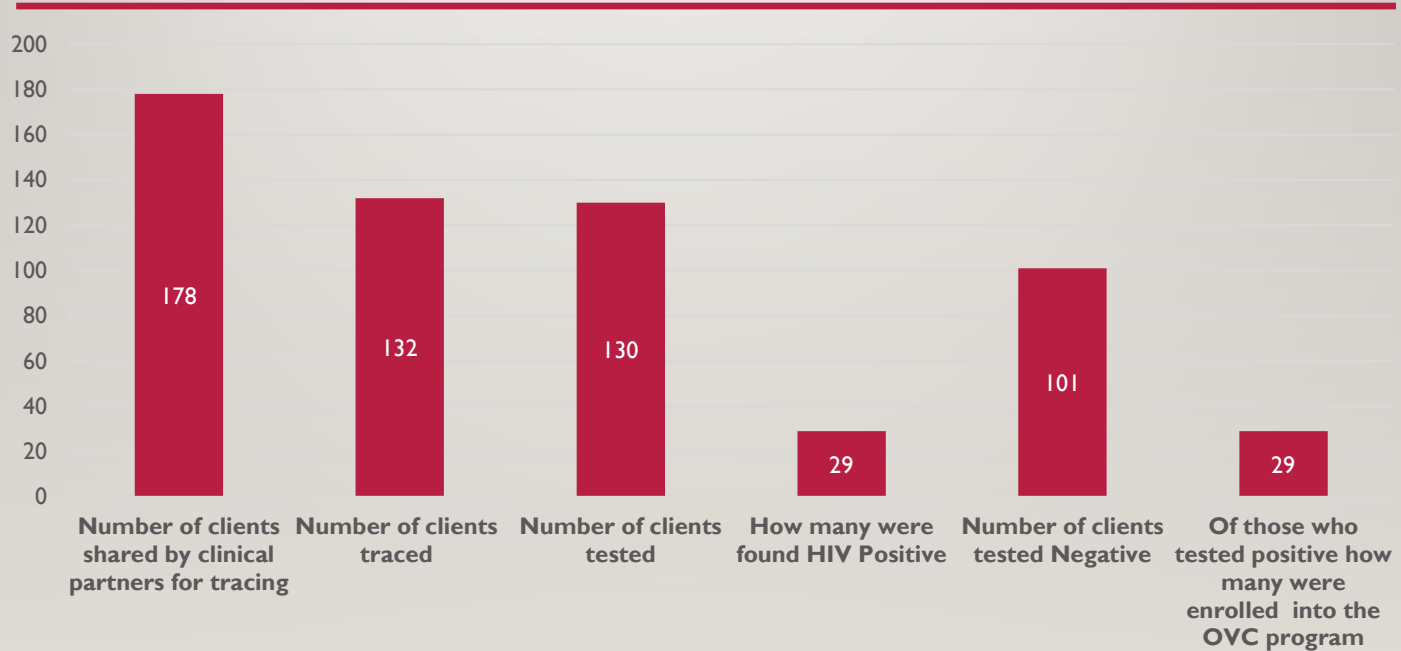
- Improved CLHIV enrollment (1531 in FYI-Q3 to 1714 in FYI-Q4)
- Reduced number of CLHIV with high VL from 234 in FYI-Q3 to 206 in FYI-Q4
- Well documented data on Index Case Testing (ICT) for tracing and HIV testing services

IMPROVEMENTS DUE TO COORDINATION

- Data sharing has improved identification of CLHIVs (as partners , can share list of CLHIVs, list of HIV+ caregivers, and ably use the same list to support index testing this has improved identification of other A/CLHIV who were not initially enrolled into the program
- Improved outcomes for CLHIV, including swift regimen change and emergency nutritional support for those A/CLHIV with high viral load due to lack of food
- The collaboration has resulted in better understanding for LLOVC on how to work with CLHIV resulting in improved services. Through on job orientation, supervision, training and planning meetings, LLOVC CCWs are oriented by team leads (clinical partners) on necessary support services required for CLHIV and how to improve their health

COORDINATION WITH PIH AND LIGHTHOUSE ON INDEX CASE TESTING

SAMPLE ICT -PIH/LIGHTHOUSE-FY2Q1



CHALLENGES AND SOLUTIONS

Challenges	Solutions
Lack of data on CLHIV/PLHIV to facilitate index case testing (ICT)	MOU's enables sharing of data for household visits and risk assessments
No initial referrals for ICT	Well documented data for ICT referrals from all partners
Absence of OVC community front line workers at the facility to coordinate community and clinical HIV interventions	21 dedicated referral and linkage facilitators coordinate with Patient Supporters from clinical partners to enhance partnership
Ineffective coordination of OVC community Y+(Youth HIV+) sessions and clinical partner's teen clubs	With clinical partners, standardization of service provision for Y+ and teen clubs
No initial guidelines for OVC and clinical partnership	Development and operationalization of MOU's for OVC and clinical partnerships. Donor support of partnerships and meetings between OVC and clinical partners

IMPROVEMENTS DUE TO COORDINATION

- Orienting each other on the program interventions and implementation strategies being deployed at both facility and community levels ensures that all partners are responsible for collaborative efforts
- Agreeing to MOU's strengthens working in a spirit of openness, transparency and consultation
- Placement of Referral and Linkage Facilitators at facilities enhances the coordination at facility level
- Conducting joint review meetings to track progress of interventions and share experience improves outcomes
- Case conferencing which incorporates clinical partners is important given the multisectoral nature of HIV programming
- Joint planning helps build common goals towards HIV care and treatment



THANK YOU





Poll #2

What are the top 2 strategies (in your experience, or from presentations) that you can apply to your program?

Please type answers in the chat box to “all panelists and attendees”. Continue submitting throughout Q&A session.



Question & Answer

Please type questions in the Q&A box



MURAL Canvas

Your responses shown here will be sent to all attendees after the webinar.



Closing Remarks

Amy Aberra, Integrated Children's Health & Social Services Technical Advisor, USAID



Thank you!