HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

Improving retention for displaced / refugee clients

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CQUIN Differentiated Service Delivery Across the HIV Cascade Workshop
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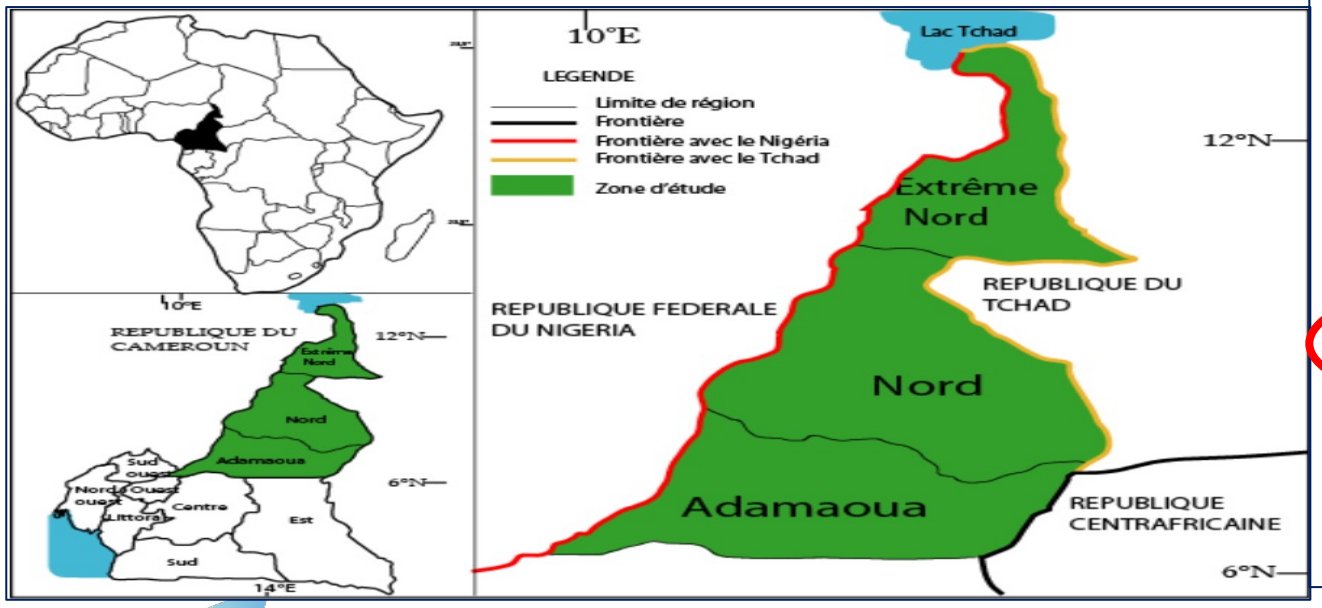
PLAN

- Context
- Challenges to HIV Treatment Continuity
- Interventions
- Results
- Next steps

Background

ICAP in Cameroon:

- ICAP is a PEPFAR implementing partner working in Northern Cameroon
- ICAP supports HIV service delivery in 46/57 health districts (80%) and at 83/1512 health facilities (5.5%) which harbors **xxx% of the total TX_CURR** in all three regions
- This area has a substantial number of refugees and displaced people



Situation of refugees and internally displaced persons in Cameroon

Persons of Concern JSON
1,948,079
Source - UNHCR, Government, IOM, OCHA
Last updated 30 Jun 2022

Population réfugiée JSON
483,869
Source - UNHCR, Government
Last updated 30 Jun 2022

Demandeurs d'asile JSON
8,590
Source - UNHCR, Government
Last updated 30 Jun 2022

Déplacés internes dans les régions du Nord-Ouest/Sud-Ouest (estimation) CSV JSON
579,136
Source - OCHA
Last updated 30 Jun 2022

Déplacés internes dans la région de l'Extrême Nord (estimation) CSV JSON
357,631
Source - IOM
Last updated 30 Jun 2022

Déplacés internes retournés (estimation) CSV JSON
518,853
Source - IOM
Last updated 30 Jun 2022

Challenges to HIV treatment continuity

Clients living in remote areas

- Far from health facilities
- Poor road conditions (especially during rainy season)

Clients extremely mobile

- Seasonal displacement punctuated by periods of ploughing and harvesting
- Some refugees choose to return to their country of origin
- Some live on the border and constantly move between 2 countries
- Frequent self-transfers between health facilities → being re-registered as a new client

Confidentiality and stigma are major issues, leading to:

- Categorical rejection of group treatment models
- Preference to access treatment far from their place of residence
- Reluctance to share personal identifiers – may give the wrong location and contact info

Contacting clients by phone is particularly challenging :

- No phone
- Poor network quality in some parts area
- Frequent changing of phone number due to mobile companies' promotions
- Only reachable on the neighboring country's network

Interventions to support retention in care – 1

Plan to obtain critical information:

Location:

Home visits to establish a narrative location map (neighborhood, area, landmark/important place near the location, neighborhood name) when client initiates care and updated regularly at every visit

Phone contacts:

- Obtain telephone number of a third party to contact and discuss what message will be delivered with the client in advance
- Take all the patient's numbers, especially those with a mobile money account, and update them at each visit
- For border areas with a neighboring country telephone network coverage, get the SIMS of this network to facilitate calls

Travel plans:

- Integrate questions about seasonal travel into pre-treatment and adherence counseling
- List all critical periods and events (rainy seasons, fishing season, religious festivals) likely to result in treatment interruption as a result of client traveling

Example of calendar used to mentor sites to anticipate seasonal events that can impact retention

Some guidelines to consider when negotiating appointments dates

October	November	December	January	February	March	April	May	June	July	August	September
		End-of-year festivities				Ramandan followed by end of Ramandan celebrations (Eid al-Fitr)			Rainy season		
		Negotiate appointments within the first 2 weeks of December. Dispense 2 months of ART to patients to cover December and January					Farming season; Traveling long distances to plough the fields				School year begins
								End of school year; Traveling for holidays			
					In the month of March; identify all Muslim clients and dispense 3 months of ART depending on the stock of ARV at the HF and number of clients expected for AVR-pick up. Negotiate next appointment dates after the 8th of May.		Identify clients with farming as their primary occupation and dispense 2 months of ART (3 months if sufficient stock of ARV)		Identify all patients living in enclave zones and dispense 2 months of ART (3 months if sufficient stock of ARV)		

NB: During the month of February (the shortest month with less than 30 days), regularize appointment dates for patients having appointments after the 24th of the month;

- If the patient is expected on the 25th or 26th of February, and ARV stock does not allow more than one month ART dispensation, negotiate a one month appointment, date = 24th of March (s/he will have 4 tabs left) if 2 months appointment, date = 2nd of May (provided the patient had 4 tabs in reserve)
- If the patient is expected on the 27th or 28th of February and the stock of ARV does not allow for more than one month ART dispensation, negotiate a one month appointment, date = 1st of March (s/he will have 0 tabs left) if 2 months appointment, date = 2nd of May

NB: In order to avoid overloading the same months for patients enrolled on multi-month ART dispensation, avoid giving the same appointment dates to these patients
(the number of months dispensed will depend on the quantity of ARVs in stock at the HF)

Interventions to support retention in care – 2

Design differentiated retention strategies with clients

- Sending SMS appointment reminders one week in advance
  - The message does not mention HIV services and is discussed with the patient in advance
- Collaboration with community health workers to trace and re-engage clients
- Multi-month dispensing, especially in advance of planned travel
- Decentralized drug delivery
  - Via post office, village letter carriers, other shipping
  - Community-based ART dispensing

- Arranging to have a third-party pick-up ART
- Harmonize appointments with dates when clients typically travel to the city (market days, end of the month for employed clients)
- Link clients with satellite site closer to their home where they can receive ART
- Design support groups to provide counseling and peer education about treatment options → these can break taboos about discussing HIV and evolve into community-based dispensing group

Interventions to support retention in care – 3

Tailoring models for refugees:

- Collaboration with local NGOs to couple ART dispensing with food distribution (packages are made in advance and added to the element to be distributed in all discretion)
- For refugees who choose to return to their country of origin:
  - Continuity of care is very challenging
  - Transfer letter with detailed summary of his medical record is provided, and the client receives multi-month dispensation to cover the time to settle in and find a care center

Tailoring models for people who frequently cross the border:

- Map and group patients by area and work with a local community health worker to locate, distribute and search for defaulters
- Educate patients on the support and benefits that psychosocial worker network can provide in the event of a self-transfer
- Active referral of patients (connecting the client with the receiving facility's psychosocial worker)

No communications between ICAP and implementing partners across the border in other countries

Interventions to support retention in care – 4

Additional DSD models and strategies include:

- Fast track dispensing circuit
- Differentiated schedules
- Family Dispensing Model
- ARV dispensing is also integrated into all community outreach activities
- Community-based distribution of ARVs by psychosocial workers
- Dispensation through CBOs

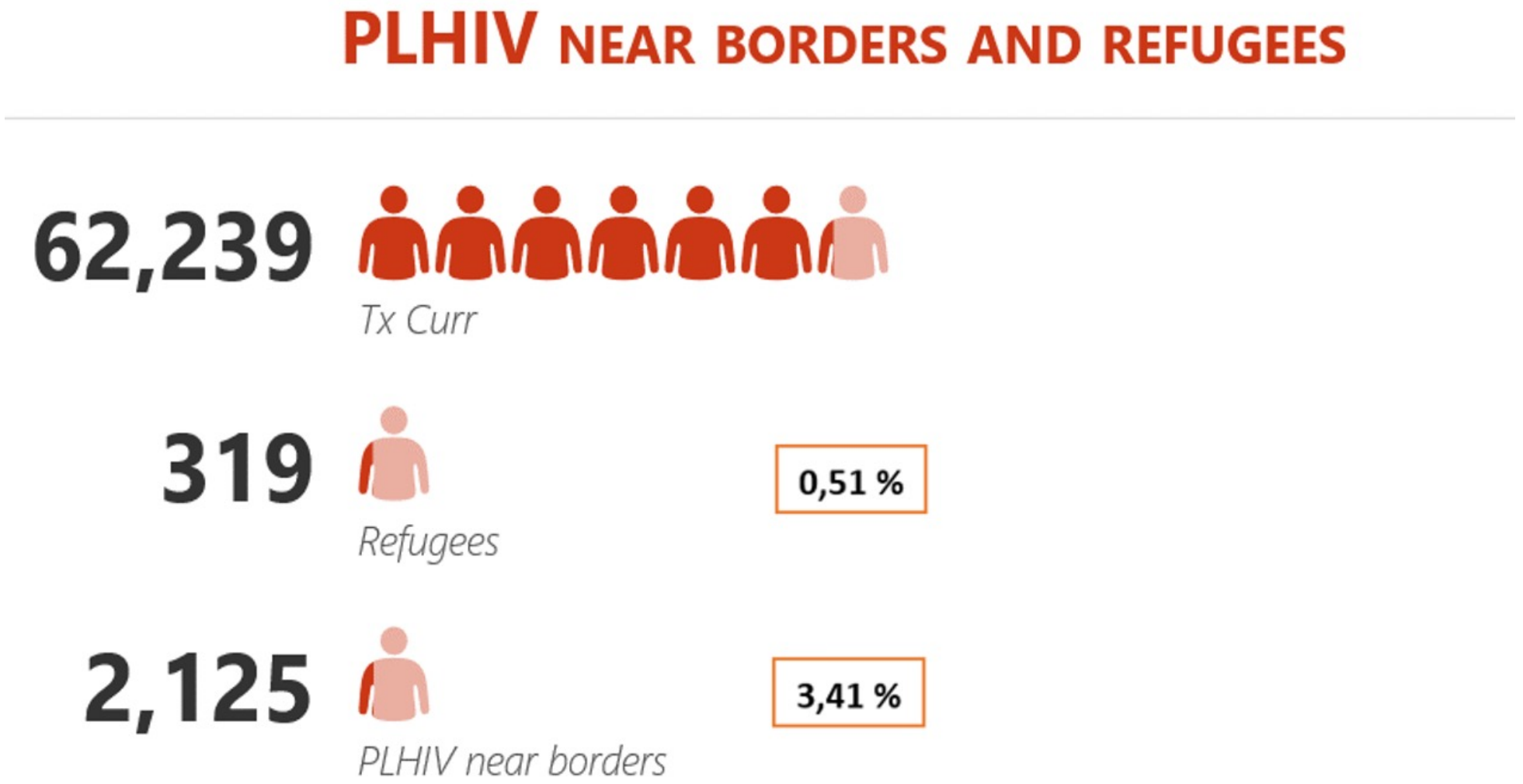
Counseling and Education are Critical

- All interventions seek to empower clients through high-quality counseling
- Much emphasis is laid on staff training, SOPs, job aides, mentorship including role-playing sessions

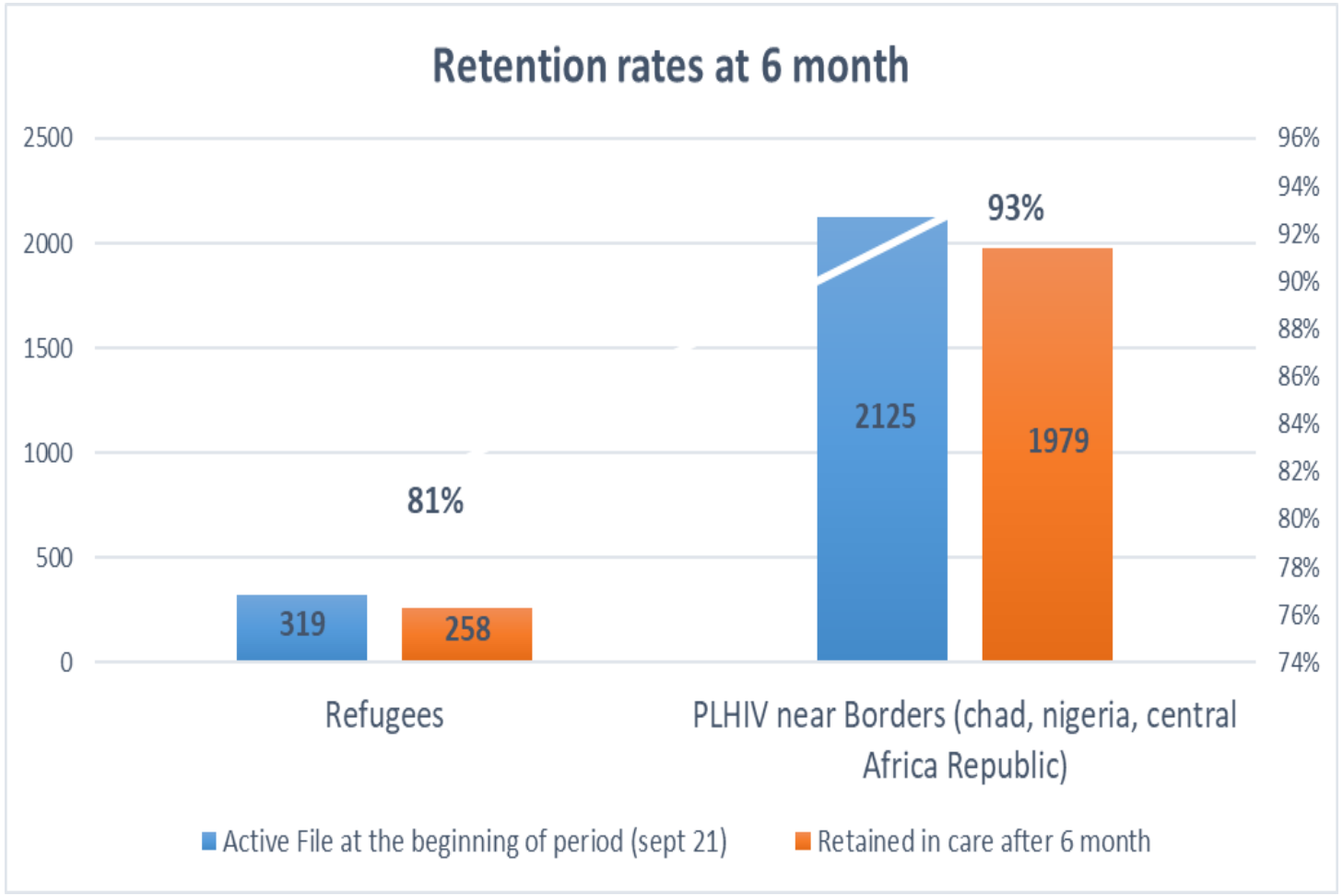
icap Global Health

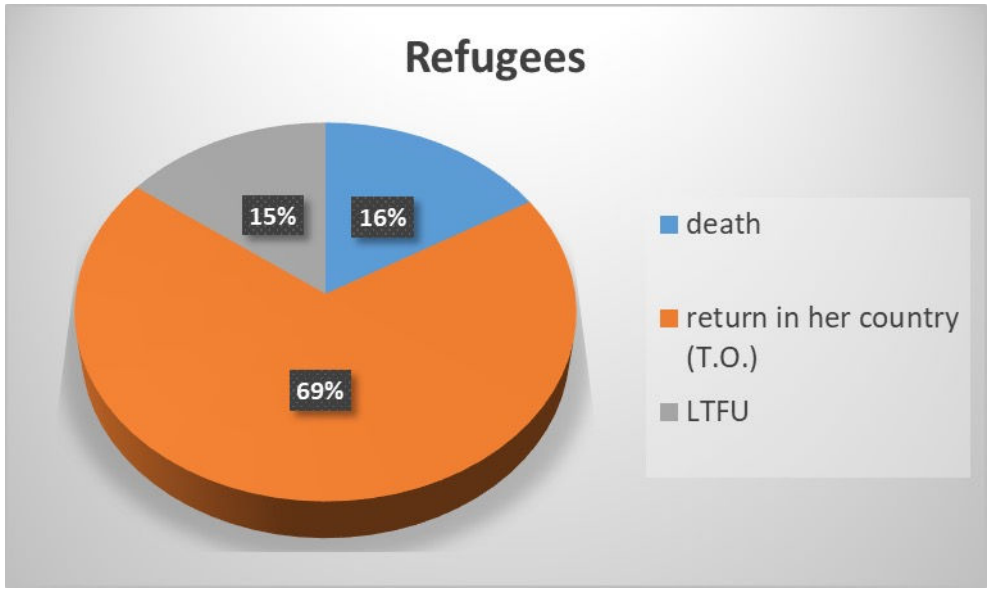
Some Results

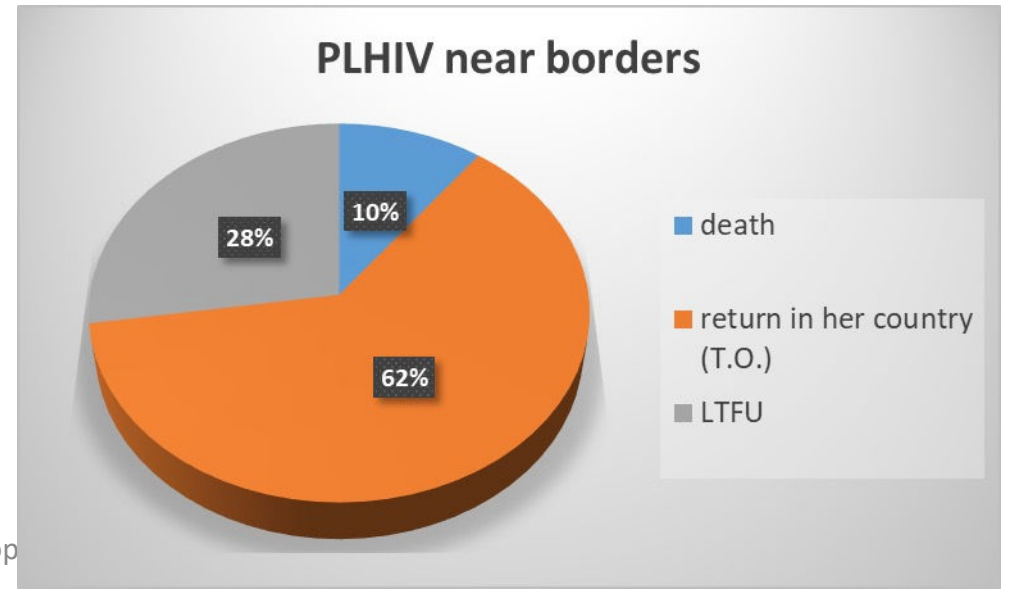
PLVIH near borders and refugees overview



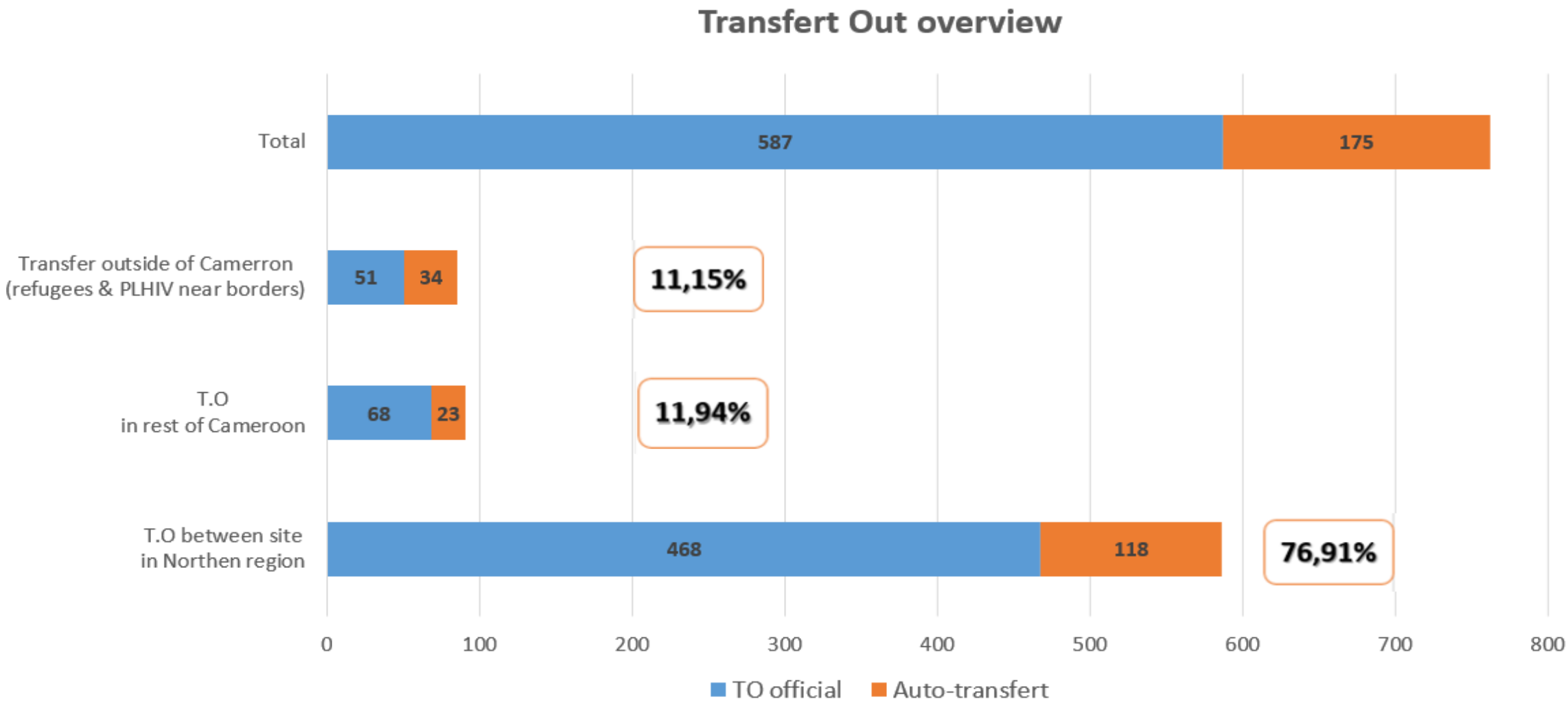
Retention rates at 6 month and reason of lost







Return in her Country of refugees and PLHIV near borders



Key Challenges

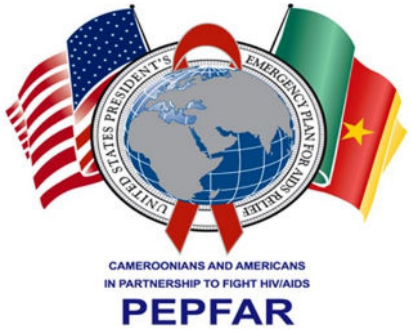
- The quantity of ARVs available in the health facilities often do not allow for multi-month dispensation [pediatric ARVs and TDF/3TC/DTG (300/300/50)]
- Some sites are in insecure areas (red zone)
- High mobility of clients leads to difficulties in respecting the timing of viral load sample collection and testing
- Decentralization strategies have created more HIV centers, increasing the geographic coverage … but the new sites are often not equipped or staffed to provide high-quality HIV services

Recommendations

Setting up a network of collaboration with health facilities in neighboring countries

Better planning of return to home country (especially for refugees)

Acknowledgement



PLHIV

Thank you!