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Pivoting the OVC Program to Improve Treatment Outcome Among Children Living with HIV across CDC Supported States in Nigeria: An Effective Differentiated Service Delivery Strategy

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BACKGROUND / INTRODUCTION

The Nigeria HIV program has made remarkable progress towards achieving the UNAIDS 95:95:95 Targets. While several innovative strategies led to the achievement of a 72% viral load suppression rate among adults living with HIV in Nigeria, the suppression rate among children remained abysmally low, hovering between 23% to 35%, with the younger children having the lower rates. With this evidence from a viral load suppression prevalence survey conducted across health facilities in Nigeria, a deliberate attempt at pivoting the OVC program to support the pediatrics treatment program was instituted with a special stream created for the enrolment of all HIV positive children into the OVC program as a differentiated approach to care.

At the beginning of FY20, the CDC Care and Treatment program was fully aligned to support the OVC program harness its inherent potential to provide targeted enrolment and innovative DSD model for CLHIV receiving treatment and HEI receiving care across the facilities. We prioritized the enrolment of CLHIV and their households with a 100% weighting and ensured that this stream was funded to meet the specific needs of CLHIV, and their household geared towards achieving VL suppression.

DESCRIPTION

The pivoting of OVC program to support epidemic control commenced in COP 2018. This adaptive innovative programming was given as the CDC strategic direction for all its implementing partners across the 19 CDC supported states in Nigeria. Viral suppression among children 0-17 years was our primary focus and we addressed critical patient level and socio-economic barriers responsible for the poorly optimized care among CLHIV. The OVC program recruited and trained specialized community case managers among the OVC community-based organizations that worked as desk officers in the facilities-community continuum. In collaboration with the clinical team, trained case managers scaled-up enrolment of CLHIV, received line lists of children eligible for drug pick-ups on a weekly basis, used various appointment reminder system to reach them, and provided wrap-around social services for such households. CLHIV from indigent households were supported with transport fares, to-and from the health facility to pick-up their ART, get their blood draws for viral load testing, and other ancillary services. Home visits were also facilitated for CLHIV, and their house holds to ensure community-based adherence assessment and counselling, family index testing, and VL sample collection by the multidisciplinary team.

LESSON LEARNED

The targeted support by the OVC program to the CLHIV and their households contributed to the improvement in viral load suppression from 23% at the end of FY19 to greater than 89% by the end of FY22. The OVC program has been pivotal using its community-based presence in supporting CLHIV and their households across the facility-community continuum using family centered approaches to keep families united and more resilient.

CONCLUSION

The geometric increase in suppression rates, from 23% to 89% among CLHIV 0-17 years demonstrated that, pivoting the OVC program to deliver focused interventions that could eliminate community level barriers to retention and support the critical needs of households will significantly shift the needle towards epidemic control among the pediatric sub-population.

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