

Track B Poster Abstract Book

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General Poster Submissions

Posters selected after open call for poster concepts from CQUIN Network colleagues



HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

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B1. Client Feedback on Utilization of the Automated Medicine Dispensing System in Eswatini

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Introduction: Eswatini introduced the Automated Medication Dispensing System (AMDS) in January 2022 through collaborative stakeholder engagement. The aim was to increase access to Antiretroviral Therapy (ART) for select clients in four health facilities. Healthcare workers were trained on operationalisation of the system, demand creation activities and client enrolment and flow. Eligible clients were enrolled to access their medication from the system with a mechanism to obtain user feedback on the system.

Methods: Short survey questions in English and siSwati assessed user satisfaction and feedback on the AMDS. Client responses were obtained using tablets and transmitted to a central server for descriptive analysis.

Results: Ninety-six per cent of clients (127/132) who accessed the feedback system provided feedback; 61% were females, and 56% were aged 35–54. All clients retrieved a dolutegravir-based ART regimen. The AMDS was popular for ease of access (90%), convenience (62%), and medication retrieval in less than 10 minutes (71%). Limited support was a drawback for 38% of the clients, and 79% consented to further interviews.

Conclusion: Most clients gave positive feedback on using the AMDS to access their medications. This feedback will guide further improvement to service delivery through the AMDS.

B2. Multi-Month Antiretroviral Therapy Dispensing in Eswatini: Uptake, Challenges and the Future

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Introduction: Eswatini adopted the six-month multi-month antiretroviral therapy dispensing (6MMD) approach to respond to client needs at the peak of the COVID-19 pandemic 2020. This was scaled up afterwards to save clients time and money and to reduce congestion and workload for the healthcare workers.

Methods: We conducted stakeholder meetings to develop the criteria for 6MMD eligibility and drug quantity forecasting and introduced the 90-pill Tenofovir-lamivudine-dolutegravir. Health facilities were oriented on 6MMD, drug ordering, client eligibility criteria, enrolment and tracking in health facilities and community.

Results: Of 391,093 ART pick-ups, 65% (n=254,650) were by females, and 67% (n=262,493) were 25 – 49 years. About two-thirds (n=250,414; 65%) received 6MMD, while 87,813 (22%) received 3 – 5 months of medication and 52,774 (13%) received <3 Months medication.

Challenges: Challenges include disruption in the supply chain, misaligned clinical and laboratory visits, misclassification of 6MMD as a differentiated service delivery model, sub-optimal data capturing at health facilities and ineligible clients receiving MMD. The implementing partners drive community MMD and are not sustainable. Moreover, changing client needs results in alternating between 6MMD and shorter periods.

Conclusions/Recommendations: MMD is evolving; addressing health system support, health facility, and client-related factors can ensure optimal MMD implementations.

B3. Decentralized Drug Distribution, A Successful Patient Centered Approach among Hard to Reach Sub-Populations Across Six USAID Afya Yangu Southern Supported Regions

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Introduction: Successful ART require a life-long, patient-centered service delivery in which the health system offers' convenience and choices in the context of changing life circumstances. USAID Afya Yangu Southern Program reported 16,487 clients with treatment interruption by the end of FY21Q4, a large number being clients with ART accessibility challenges including hard-to-reach clients, clients with an experience of treatment interruption, mobile populations, cross borders and casual workers supporting big projects. The Program in collaboration with R/CHMTs in six supported regions adopted the Decentralized Drug Distribution (DDD) models as an approach to reach clients with different ART accessibility challenges.

Methods: The program mapped all clients on ART from 107 facilities and identified those who had interrupted treatment. A total of 15,497 (94%) of them were tracked and re-initiated ART, and those who consented received subsequent ART refills at conveniently selected DDD refill models (Outreach ART refills, satellite ART centers and Community ART refills). Information on the availability of DDD services was offered to all clients, including those re-engaged in treatment. The registrations, schedules and ART pick-up point were jointly agreed upon by service providers and recipients of care. Comprehensive refill services including HVL collection, short FP method, TB screening and TPT initiation were provided on a monthly basis at individual appointments. Client's data was captured using CTC2 cards and were properly and timely documented by HCPs during the services while data entries to the CTC2 database were done at the mother facilities. The programmatic data was used to access the progress of the implementation, internal data capturing system (PRODMIS Data Capturing System) and CTC2 Analytics Monthly Portal System were used to monitor the implementation every month.

Results: As of June 2023, a total of 256 ART refill sites were activated serving 14,738 (5%) of the total clients on treatment compared to 2,937 clients in September 2021. Of those 13,368 (90%) were served through outreach ART refill, 1,100 (7%) Satellite ART centers and 270 (3%) Community ART Refills. DDD models contributed significantly to reducing the number of IITs from 16,487 clients in FY21Q4 to 1,245 clients in FY23Q3. Adherence to appointment increased to 99.5% in June 2023 compared to 94% in September 2021 before scaling up ART services close to recipients of care. Retaining clients on treatment increased from 96% in September 2021 to 99.7% by June 2023 due to the provision of friendly services that reflected client's needs, preferences, and expectations. Through DDD models the program managed to support sub-populations with different challenges from high-burden regions including 409 casual workers at Mufindi tea plantation Iringa, 85 mobile clients in Kilosa Morogoro, 55 Mobile minors and 16 Cross-border clients in Ruvuma.

Conclusion: The DDD model was associated with reduced treatment interruption. The Differentiated Service Delivery (DSD) model reduce challenges in accessing ART services and promotes retention on treatment and appointment adherence. Using DDD models to refill antiretrovirals will reduce client load at care and treatment clinics, reduce client waiting times, and improve client-provider interactions, continuity of treatment and client satisfaction.

Acknowledgments: This work was made possible by the generous support by the USAID Tanzania through USAID Afya Yangu Southern Program and Regional Administrative and local government authorities in Iringa, Lindi, Morogoro, Mtwara, Njombe & Ruvuma regions.

B4. Ensuring Continuity of Health Services for Internally Displaced Populations in Meconta District, Nampula Province, Mozambique

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Background: Northern region of Mozambique has experienced armed conflicts for the last five years, resulting in almost one million internally displaced people (IDP). By November 2022, Nampula Province received 8% (73,699/946,508) of these IDP, 20,299 (28%) residing in Meconta district (16,456 with host families and 3,773 at the IDP settlement camp). Women and children, highly vulnerable populations, account for 75% of these IDP, requiring a rapid and comprehensive response to meet their basic needs.

Description: ICAP at Columbia University, in collaboration with Nampula provincial health leadership implemented mobile brigades (MB) for IDP at the Meconta IDP camp, integrating HIV prevention and care and treatment into general health services (antenatal care, family planning, outpatient consultation, tuberculosis and Gender Based Violence screening and treatment). The MB team included a clinical officer, maternal child health nurse, lay counselor, mentor mother, peer educator and immunization officer, and provided comprehensive services for one week/month at the IDP camp. This involved mapping of host family locations, supporting demand creation through community actors, leaders, and community radios, disseminating dates and times of MB presence at the camp.

Lessons learned: Between October 2021 and September 2022, 1,306 IDP, received health services through MB in Meconta, 48% (628/1306) were tested for HIV, with 65 (10%) testing positive, 84 individuals initiated antiretroviral treatment (including patients referred from community testing) and 38 initiated pre-exposure prophylaxis. Among the 1,306 IDP reached, 339 (26%) were children < 15 years old, of those 18 (1.4%) were tested for HIV and 2 (11%) were tested positive and linked to treatment. During this period, 138 women received antenatal care, all were tested for HIV, 1.4% (2/138) tested positive and all initiated treatment. In addition, two individuals screened positive for GBV and received post-GBV services and support.

Conclusions: Adaptation of health service models is essential to meet the needs of IDP, with allocation of comprehensive health services and involvement of community actors for IDP in camps. However, further efforts are needed identify more cases of GBV, and as expected reach children within the displaced population for testing and re-engaging them to care. In addition, there is a need to expand this model to IDP residing among multiple host communities.

Next Steps: Based on ICAP's experience of guaranteeing access to health services and preventing gender-based violence for vulnerable populations through the differentiated service models described above, ICAP Moz intend to expand the other DSD Models and is moving forward with the creation of a DIC (Drop in Centre) which also aims to guarantee access to health services and empowerment for key populations given their vulnerability, stigma and discrimination simply because of their sexual preferences, as well as strategies for reaching children under 15y and other contacts of female sex workers in Nampula.

B5. Analysis of Advanced HIV Disease Eligibility through CD4 Test Differences in Mozambique

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Though CD4 testing initiated in Mozambique in 2003, with the approval of the National Acceleration Plan for the HIV Response in Mozambique in 2013, CD4 testing entered a usage acceleration phase, becoming widely available for HIV care initiation. This approach to HIV care was practiced until the adoption of Test and Start in late 2016 that shifted the testing importance away from CD4 and towards Viral Load. Starting in 2021 demand for CD4 increased to provide

further analysis for newly initiated beneficiaries of care and for the Advanced HIV Disease (ADH) care model implemented March in 2022.

With an HIV Program estimated 25% prevalence in newly initiating beneficiaries of HIV care, the Advanced HIV Disease (AHD) care package is critical for the successful linkage and treatment of a substantial percentage of people living with HIV in Mozambique.

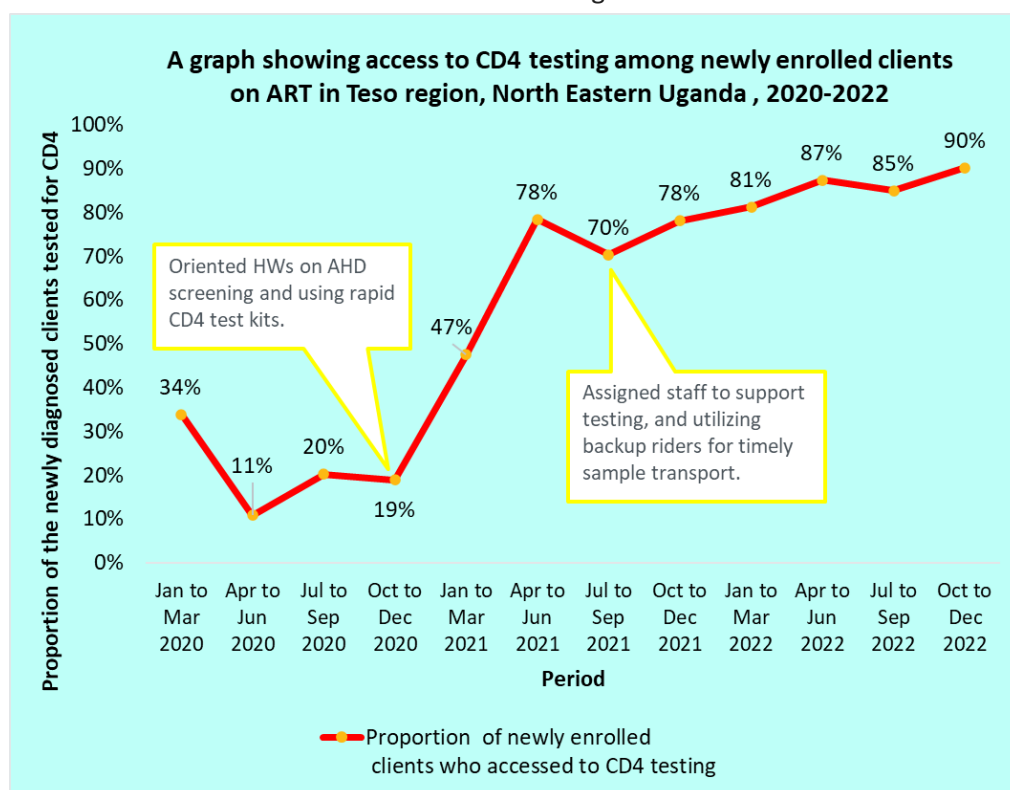
Despite the increasing numbers of CD4 tests for diagnosis of ADH, Mozambique is still a long way from reaching universal coverage for CD4 testing for ART newly initiates. New approaches are needed for increasing CD4 use, such as point of care test, that would allow a reduction in access issues to reagents as well as reducing the laboratory response time and delivery of the result.

B6. Identification of Advanced HIV Disease among Newly Enrolled Clients on ART in Teso Region, North Eastern Uganda: A Quality Improvement Intervention

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In an effort to address high HIV-related mortality in Uganda, a quality improvement (QI) intervention was implemented in the Teso region. The intervention aimed to increase access to CD4 testing and identify advanced HIV disease (AHD) among newly diagnosed people living with HIV (PLHIV). Through the intervention, 6,762 new PLHIV were identified, with 69% being tested for CD4 and 12% having a CD4 count below 200 cells. Testing for CD4 increased from 19% to 90%, and the identification of AHD increased from 7% to 15%. These QI interventions demonstrated success in improving CD4 access and AHD identification in North-Eastern Uganda.



B7. Effect of a Targeted Catalytic Strategic Initiative on the Implementation of the Advanced HIV Disease Package of Care: Case of the Global Fund DSD-SI Support to Zambia

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Background: In 2019, the WHO released the advanced HIV disease guideline, an evidence based normative guideline to systematically provide screening, prophylaxis, antiretroviral treatment and counselling, to reduced HIV related mortalities. However, the provision of the recommended package of care is complex, multidimensional, and an interprogram task requiring a background of strong health systems. Therefore, catalytic support was awarded to Zambia by the Global Fund as a strategic initiative for advanced HIV disease implementation.

Methods: We used a pre and post quasi experiment method using the CQUIN capability maturity model as a framework for the identification and monitoring of the effect of the global fund AHD-DSD SI support to Zambia.

Results: Using the CQUIN capability maturity model, support for AHD monitoring and evaluation, and laboratory and pharmaceutical logistics management were selected as the priorities for support. From the Country to Country visits to eSwatini and Nigeria, the following themes were identified: leadership and governance, operationalizing the hub and spoke model, distinguishing the in-patient and out-patient AHD, monitoring and evaluation and health products logistic management. The instituted M&E systems are functional, the supply chain is monitoring products, trainings are done, and policy documents have been developed and distributed.

Conclusion: The catalytic Global Fund strategic initiative for Advanced HIV Disease support to Zambia improved the implementation of the package of care through health systems strengthening. The CQUIN capability maturity model is an effective framework for the implementation of catalytic projects.

B8. Contribution des diagnostics au points de service dans l'identification de la maladie à VIH avancée de Kinshasa, RD Congo (Contribution of Point-of-Care Diagnostics in the Identification of Advanced HIV Disease in Kinshasa, DR Congo)

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B9. 60 DAYS National Rapid Response District Level DSD Capacity Domestication for Patient-Centered Care: Domesticating Capacity for Greater Impact

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As a result of the knowledge gap in DSD models, conventional care remained the standard of care in health facilities. Sierra Leone's national technical team consulted robustly with the leadership of implementing partners and multilateral agencies (UNIAIDS, UNAIDS, UNICEF) to leverage resources to develop master trainers to orchestrate district-level DSD capacity domestication. Using evidence that cut across epidemic patterns, RoC volume, facility type and workforce category, we designed a training plan to reach 700 HCW. We trained a total of 1,040 health workforce, with 70% of the trainees female, while trainees were distributed among Nurses, Community Health Officers (CHO), and others in respective percentages of 58.7%, 13.8%, and 27.6%.

B10. Minimum DMOC Package – Key Models to Support the Recipient of Care’s Journey Along the Care Cascade

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Issues: A differentiated approach to care aims to strengthen linkage to care, adherence to treatment, and retention in care using a patient-centered approach throughout the treatment cascade. Globally known as Differentiated Service Delivery (DSD), South Africa contextualized it to Differentiated Models of Care (DMOC). With the largest HIV, TB, and NCD burden in healthcare facilities in South Africa, adherence to treatment remains a challenge and poses a strain on healthcare services, resulting in facility congestion. Over 7.9 million people are living with HIV (PLHIV) in South Africa, with 5,7 million people on ART and only 4 million virally suppressed. Thus, the country at 94-76-92 of the UNAIDS 95-95-95 targets the total population. DMOC is therefore essential in supporting the Recipient of Care (ROC) journey along the care cascade.

Description: South Africa has revised the DMOC Standard Operating Procedures (SOPs) to include the key DMOC as a package of Interventions to support the ROC journey through linkage to care, adherence to treatment, and retention in care. The minimum DMOC care package includes but is not limited to 1) Integrated care for patients with chronic conditions – A summary of all the models to strengthen an integrated approach to care. 2) Education and Counselling Sessions: which comprise (a) Fast Track Initiation Counselling (SOP1) – to support the ROC with treatment initiation, especially same-day initiation. (b) Enhanced Adherence Counselling (SOP2) - for ROC struggling with adherence. (c) Child and adolescent disclosure counselling (SOP3) – to support caregivers with disclosure to the children and adolescents. 3) The DMOC modalities for stable ROC: These are for ROC that is well established on chronic treatment – where ROC receives the Repeat Prescription Collection Strategies (RPCs), – SOP 5, facilitating facility decongestion. (a) Facility Pickup point (SOP 5.1) – ROC receiving their treatment at facility pharmacies. (b) Adherence Clubs (SOP 5.2) – these are either facility or community-based clubs – ROC in clubs or groups to support each other on the treatment journey. (c) External Pick-up point (SOP 5.3) – ROC receiving treatment outside the facility at designated external pick-up points e.g. Dischem, Clicks (Private and community pharmacies). 4) Tracing, Recall, and Reengagement in Care - to provide guidance on how to trace clients that have disengaged in care. (a)Tracing and Recall SOP (SOP 7), (b)Re-engagement in care (SOP8).

Lessons learned: The minimum DMOC package of interventions, ensures that ROC are supported in their treatment journey. DMOC is not just about the decanting models, but a comprehensive approach to support ROC with adherence. Notably, when ROC are established on chronic treatment, they are then decanted to the RPCs. The differentiated approach that enables decanting is essential to optimize reduced facility visits, medicine access, and decongesting of health facilities.

Next steps: Capacitating the clinicians who are the key implementers of the minimum DMOC Package has commenced. Conducting the DMOC Performance Reviews (DPRs) across the provinces to establish the implementation of DMOC.

The DMOC Care Package To Support Linkage To Care, Adherence To Treatment and Retention In Care

DMOC Care Package – Interventions	SOPs	Summary
<ul style="list-style-type: none"> Standardised education sessions and counselling approach for i) treatment initiation, ii) patients struggling with adherence (while in care or when re-engaging in care) and iii) supporting child and adolescent disclosure. (More Intensive / Standard Care Models) 	SOP 1 - Fast Track Initiation Counselling (FTIC)	<ul style="list-style-type: none"> including adaptation for rapid initiation and post initiation counselling aligned with treatment supply return date. for patients struggling with adherence
	SOP 2 - Enhanced adherence counselling (EAC)	
<ul style="list-style-type: none"> Longer treatment supply to reduce patient burden and support continued engagement in care (More Intensive / Standard Care Models) Differentiated models of care for stable patients on chronic treatment (Less Intensive Models) 	SOP3 - Child and adolescent disclosure counselling	<ul style="list-style-type: none"> Change in age bands: <ul style="list-style-type: none"> Non-disclosure (<5 years) Partial disclosure (5-9 years) Full disclosure (>10 years)
	SOP 4 - Multi-Month Dispensing (MMD)	<ul style="list-style-type: none"> Guides multi-month dispensing (MMD) by the facility, including 6MMD once operational capacity and stock availability is confirmed (New SOP)
<ul style="list-style-type: none"> Patient tracing and re-engagement 	SOP 5 - Repeat Prescription Collection strategies (RPCs) – DMOC for stable clients	<ul style="list-style-type: none"> Health facility-based individual RPCs Health facility or community-based group RPCs Out-of-facility individual RPCs Treatment is pre-dispensed by the Central Chronic Medicine Dispensing and Distribution program (CCMDD) or a Central Dispensing Unit (CDU) or the facility pharmacy.
	SOP 5.1 - Facility pick-up point	
	SOP 5.2 - Adherence Club	
	SOP 5.3 - External pick-up point	
	SOP 6 – Drug Switch (Switching to newly endorsed drugs for stable patients utilizing a RPCs)	
SOP 7 - Tracing and Recall	<ul style="list-style-type: none"> Tracing and recall missed appointments in order of priority. 	
SOP 8 - Re-engagement in care	<ul style="list-style-type: none"> Re-engagement in care involves assessing clinical condition and time since missed scheduled appointment and differentiating follow-up management including accelerated access to MMD and RPCs 	

B11. Assessing Community Engagement in Differentiated Service Delivery: Results from the 2022 Roll-Out of the Community Engagement Monitoring Tool

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Background: Community Engagement (CE) is central to the success of Differentiated Service Delivery (DSD). There is a need to develop useful tools to assess meaningful CE, both in general and specifically within DSD programs.

Methods: The International Treatment Preparedness Coalition (ITPC) in collaboration with the Community Advocacy Network (CAN) developed an 19-indicator Excel-based CE tracking tool focusing on three levels (policy, program, and community) and three areas (design, implementation, and monitoring and evaluation) of engagement in 2022. It included a six-colour coded scale linked to each indicator score. Between July and November 2022, 20* CAN members collected data retrospectively for the period 1 June 2021 to 31 May 2022.

Results: On average, 50% of results are in the “meaningful engagement” or “satisfactory engagement” achievement rate. Higher CE occurred during the development and implementation of DSD policy and program while lower levels of engagement occurred during most M&E related activities of the implementation cycle. 39% of CE results were in the 81-100% achievement rate (meaningful engagement) across Rwanda, Zimbabwe, DRC, Liberia, and Côte d’Ivoire. Nigeria, Kenya, Sierra Leone, and Zambia (10% of the results) scored 61-80% achievement rate (satisfactory engagement). 30% of results were in the red/grey score indicating no CE in specific areas, mainly in South Sudan, Eswatini, Burundi, Senegal, Malawi, Uganda, Cameroon, and Tanzania.

Discussion: The results from this assessment have provided a solid baseline from which to work to improve levels of CE and has created new perspectives to explore to strengthen CE.

*Burundi, Cameroon, Cote d’Ivoire, Democratic Republic of Congo, Eswatini, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe

B12. Mettre fin au sida pédiatrique au sein des organisations membres du RIP+

Nicolas Vako, Directeur Exécutif, RIP+; Gnanmien Goly Théodore, Directeur des programmes RIP+; Camara Ben, Zacariah chargé de programme enfants et adolescents, RIP+; ONUSIDA Côte d'Ivoire Programme National de Lutte contre le SIDA

Le projet intitulé "Mettre fin au sida pédiatrique au sein des organisations membres du RIP+" est implémenté pour réduire les inégalités observées entre adultes et enfants qui entravent l'atteinte des objectifs 95-95-95 en Côte D'Ivoire. L'objectif général est de renforcer durablement la prise en compte des cibles pédiatriques dans le cadre stratégique, le dispositif organisationnel et les actions programmatiques pour mettre fin au VIH pédiatrique. De façon spécifique, RIP+ voudrait par ce projet (i) renforcer et institutionnaliser la problématique des enfants et adolescents vivant avec le VIH dans le fonctionnement du réseau et de ses organisations membres ; (ii) coordonner le plaidoyer communautaire au niveau national et local des OSCs membres et mobiliser les ressources et (iii) intensifier l'action et renforcer la visibilité relative à la question des adolescents et enfants. En somme, le projet suscite l'engagement communautaire pour accompagner l'État dans la mise en œuvre des recommandations de l'Alliance Mondiale pour l'élimination du sida pédiatrique en Côte d'Ivoire, combler les GAPS dans les régions par les services différenciés, le plaidoyer et favoriser l'atteinte des 95-95-95. Ainsi, RIP+ s'engage à mettre la problématique du VIH pédiatrique au centre des interventions de ses OSC membres.

Putting an end to pediatric AIDS within RIP+ member organizations'

The project entitled "Putting an end to pediatric AIDS within RIP+ member organizations" is being implemented to reduce the inequalities observed between adults and children, which are hampering the achievement of the 95-95-95 targets in Côte D'Ivoire. The general objective is to reinforce the long-term consideration of pediatric targets in the strategic framework, organizational structure and programmatic actions to put an end to pediatric HIV. Specifically, through this project, RIP+ aims to (i) strengthen and institutionalize the issue of children and adolescents living with HIV in the workings of the network and its member organizations; (ii) coordinate community advocacy at national and local level by member CSOs, and mobilize resources; and (iii) intensify action and raise the profile of the issue of adolescents and children. In short, the project will encourage community involvement to support the government in implementing the recommendations of the Global Alliance for the Elimination of Pediatric AIDS in Côte d'Ivoire, to fill the GAPS in the regions through differentiated services and advocacy, and to help achieve the 95-95-95 target. In this way, RIP+ is committed to making the issue of pediatric HIV central to the work of its member CSOs.

B13. Differentiated Service Delivery Model in Zimbabwe: Transforming Community Health Systems to Improve Health Outcomes

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1. ZNNP+; 2. NAC

B14. Enhancing Community Engagement in Differentiated Service Delivery Programs: Insights from Rwanda

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1. Rwanda Network of People Living with HIV (RRP+); 2. Rwanda Biomedical Center (RBC); 3. United Nations Joint Programme on HIV/AIDS (UNAIDS)

Introduction: This abstract addresses the importance of community engagement (CE) in the success of Differentiated Service Delivery (DSD) programs for HIV control. We present the findings from the field rollout of the CE Tool between July 2021-2022, highlighting lessons learned and providing recommendations for improving CE in DSD programs in Rwanda.

Description: Recognizing the significance of CE in the success of DSD initiatives, the Rwanda Network of People Living with HIV/AIDS (RRP+) partnered with the HIV Coverage, Quality, and Impact Network (CQUIN) and other stakeholders to develop a CE framework and monitoring tool. The study employed a comprehensive methodology to collect and analyze

data at the policy, program, and community levels in the Design, Implementation, and Monitoring and Evaluation processes. Data was collected from various stakeholders involved in the HIV response, including RRP+, its constituencies, the Ministry of Health, and the Rwanda Biomedical Center.

Lessons Learned: The data collection process revealed that while CE was strong at the policy and program levels (100%), there was inadequate financial support, impeding the active participation of representatives of People Living with HIV (PLHIV) in district and sector-level activities (33%). Additionally, coordination meetings with stakeholders were minimum impeding feedback provision and discussions for enhancing DSD interventions (33%). Furthermore, the survey identified gaps in the production of communication materials, related to the establishment of community-level platforms for gathering recipients of care (RoC) views, and the organization of pieces of training for peer educators. Challenges were identified in accessing meeting reports and the importance of improving the filing system for better follow-up.

Recommendations: To enhance the effectiveness of the CE and subsequent DSD programs, the following recommendations are put forth: 1) Update the tool with qualitative information to provide a more comprehensive understanding of CE dynamics; 2) Strengthen coordination and financial support to ensure increased participation of PLHIV representatives at district and sector levels; 3) Facilitate the establishment of community-level platforms to gather RoC views on DSD models, ensuring inclusivity and representativeness; and 4) Expand the training for peer educators. Moving forward, RRP+ is conducting consultative meetings with MoH, RBC, and other partners to address the revealed gaps.

B15. Assessment Harm Reduction Coupled with Differentiated Care for Burundi's IDU's

Minani Eddy Michel¹

1. BAPUD

BAPUD is a legal Burundian organization who work with and for IDUs focuses on a client centered approach that simplifies and adapts HIV services through the cascade to reflect the IDUs living with HIV. In 2023, out of 37 hotspots identified in Burundi, 4241 IDUs were sensitized, 1398 IDUs screened, with 59 seropositive cases, 38 new cases, 16 treatment dropouts, 59.7% men and 40.3% women. A team of 65 peer educators ensuring that IDUs are cared for using the advanced differentiated care strategy, and as a result 59 IDUs HIV positive beneficiaries remain on ARV treatment and regular viral control.

B16. Home Visits and the Triple Attachment Approach for Enhancing Viral Load Suppression Rate Among Children Living with HIV in Rukwa Region, Tanzania

Angelah Msomba¹, Reginald Gervas¹, Alinuwe fungo¹, Nassoro Yahaya¹, Emmanuel Bahemana¹, Magnus Ndolichimpa¹, Sally Chalamila¹, Diana Nicholas², Boniface Nguhuni²

1. Henry Jackson Foundation Medical Research International, Tanzania; 2. Walter Reed Army Institute of Research (WRAIR)

Introduction: Medication adherence, stigma and discrimination, disclosure difficulties, access to healthcare, psychosocial supports, and transition from adolescent to adulthood are among key obstacles in achieving pediatric viral load suppression. To enhance the overall care given to pediatric clients and achieve a viral load suppression rate among pediatric clients < 15 years, HJFMRI implemented home visits and a triple attachment approach.

Methodology: 142 pediatric clients with a high viral load (> 1000 copies/mL) was attached to a: (1) Health care provider, (2) Treatment Advocates / Community healthcare workers for follow-up, (3) Client's treatment supporter. A home visit once a month was conducted at a parent/guardian pre-approved place and time. Assessment of each pediatric client's unique needs was done, proper support given with integration of different services based on needs.

Results: 138 pediatric clients achieved viral load suppression. The suppression rate for pediatric clients remarkably improved from 88% in September 2022 to 95% by June 2023.

Conclusion: Home visits and triple attachment showed a very positive impact in pediatrics care and treatment. Every pediatric client is unique with different needs and challenges related to the care and treatment of HIV. Differentiated and person-centered care is mandatory for improving viral load suppression among pediatrics.

B17. Impact of Provider Led Community ART Distribution on Retention in Baylor Foundation Malawi Supported Health Facilities

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Introduction: Expansion of ART programs in sub-Saharan Africa have increased access to life-saving HIV treatment among people living with HIV (PLHIV). However, retention in care, adherence to ART and viral suppression remain key challenges to success of these programs. In Malawi, long distances from the community to the health facility represent a key barrier to adherence and retention in care. Community ART distribution (CAD) is an innovative differentiated care model designed to provide ART services closer to the community to address retention barriers due to distance.

Methods: Routine deidentified program data from January 2021 to September 2022 on retention in care, treatment interruption and viral suppression from 21 CAD sites affiliated to 15 hub facilities was compared. Retention in care was defined as number of clients alive in care at the end of the reporting period. Interruption rate was defined as missing appointment for more than 28 days. Viral suppression was defined as viral suppression of <1000 copies per ml. Chi-square test was performed to compare proportions of those retained in care, viral suppression, and treatment interruption between CAD sites and affiliated hub facilities.

Results: Cumulatively, 168,080 active clients enrolled in 15 affiliated hub facilities and 12,870 clients enrolled in 21 CAD sites after excluding 52,086 and 195 transfer outs respectively. Clients in CAD sites had significantly better retention rates at 96% (12319/12870) compared to 61% (102723/168080) at hub facilities ($p<0.001$). Similarly, CAD sites had a lower rate of interruption at 4% (478/12870) as compared to 29% (48153/168080) at hub facilities ($p<0.001$). Viral load coverage at hub sites was 51% (range: 33-71%) and 80% (range: 51-100%) CAD sites. Hub facilities reported higher viral suppression at 92% (49478/53896) as compared to 86% (4179/4850) at CAD sites ($p<0.001$).

Conclusion: We found that clients receiving care in CADs had higher retention and lower interruption rates than clients at the affiliated hubs. Clients at HUB sites achieved higher rates of viral suppression compared with those receiving care at CAD sites; we are looking into this further to understand the differences.

B18. Factors Associated with Viral Non-Suppression in People Living with HIV Initiated on Antiretroviral Therapy During the Test & Start Era in Eswatini

Fezokuhle Khumalo¹, Arnold Mafukidze¹, Victor Williams¹, Clara Nyapokoto², Normusa Musarapasi¹, Thokozani Maseko¹, Jilly Motsa-Dlamini¹, Setsabile Gulwako², Magnus Beneus¹, Pido Bongomin¹, Sindy Matse², Samson Haumba^{1,3}, Sylvia Ojoo³

1. Center for Global Health Practice and Impact, Georgetown University, Mbabane Eswatini; 2. Eswatini National AIDS Program, Mbabane, Eswatini; 3. Center for Global Health Practice and Impact, Georgetown University Medical Center, Washington DC, USA

Introduction: Eswatini achieved HIV Epidemic Control (95-95-95) in 2021, but some sub-populations lag on the 3rd 95. We identify and present sociodemographic and clinical predictors of viral nonsuppression.

Methods: Sociodemographic and clinical data were extracted from the Client Management Information System (CMIS) for analysis. The outcome was an "unsuppressed" viral load ($VL \geq 1000$ copies/ml). Logistic regression analyses estimated odds ratio (OR) for independent predictors of viral suppression at $p<0.05$.

Results: Of 30,274 clients, 61% ($n=18,350$) were females, 68% ($n=19,358$) were aged 25-44, 99% ($n=28,124$) were on a Dolutegravir-based regimen, and 2.9% ($n=827$) had an un-suppressed VL. 6.8% (16/235) not on DTG vs 2.9% (811/28120) on DTG were not suppressed ($p=0.0004$). 2.3% ($n=255$) males and 3.3% ($n=572$) females were unsuppressed ($p<0.001$). Older age 20-29 (OR 0.5, $p<0.0001$), 30-39 (OR 0.46, $p<0.0001$), 40-49 (OR 0.33, $p<0.0001$), ≥ 50 (OR 0.16, $p<0.0001$) had

lower odds of non-suppression vs those aged <20 years while duration on ART 1-3 years (OR 0.46, p<0.001) & 3-5 years (OR 0.33, p<0.001) had lower odds of nonsuppression vs <1 year.

Conclusions: Females, younger clients on ART, and a shorter duration on ART were predictors of nonsuppression. Context-specific ART adherence interventions should target females and young people <20 years.

B19. Implementing PrEP for HIV Prevention in Liberia: Sharing Best Practices and Programmatic Data

Berline M.F. Gibson, D. Amos Mulbah, Micheal Odo, Jonathan Flomo, Claudius Paye, G. Moses Jackson, Diah Nyanplu, M. Janjay Jones, Mary G. H. Jackson, Gift Kamanga, Julia Toomey

Introduction: Key populations (KPs) in Liberia, with HIV prevalence rates of 37.9% among MSMs, 16.7% among FSWs, and 27.6% among TGs, are key drivers of the HIV epidemic (Liberia IBBSS 2018). With an estimated population of 74,634 MSMs, 163,033 FSWs, and 1,741 TGs, the country's progress toward the UNAIDS 95-95-95 targets have been hampered by stigma and poor access to HIV services. The National AIDS Control Program, supported by USAID and the PEPFAR-funded EpiC project, introduced Oral PrEP to prevent HIV transmission and enhance HIV case finding among KPs.

Methods: Advocacy and sensitization with policy leaders led to the establishment of a multi-stakeholder group of technocrats, civil society, and IPs, and the development of a PrEP national road map. Guidelines and job aids were developed to support the training, coordination of a hub of KP-friendly facilities and a spoke of multiple KP-focused CBOs for demand creation and safe service delivery corridor for Oral PrEP. A monitoring team of technical and strategic information visits the CBOs and facilities for quality assurance and compliance on the use for the guidelines. A quarterly technical working group meeting collates the experiences and discuss approaches to improve on the program.

Results: From April 2022 to September 2023, 9,966 clients were screened for Oral PrEP. 7,531 were eligible and started on Oral PrEP in the facility, including 286 TG, 1,777 MSM, 1,611 FSW and 3,857 general population. 2912 (38.6% were PrEP_Continue by September 2023). In the community, between June and September 2023, 1,906 people were screened for PrEP, 41 tested HIV positive (2.1%), and 950 eligible persons were started on PrEP out which 269(28% PrEP_CT at 3-months)

Conclusion: Oral PrEP is a feasible and acceptable HIV prevention intervention in Liberia at facility and community levels. It is also an opportunity to finding new HIV cases among the key and general populations. Use of peers as community support is facilitates PrEP continuation. There is need to scale up the intervention for country wide impact.

B20. Creating a Learning Exchange and Measure to Promote Scale-up of Quality Differentiated Model of Care (DMOC) platform through DMOC Performance Reviews (DPRs) in Mpumalanga and Eastern Cape Provinces, South Africa

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1. Department of Health –South Africa (NDOH); 2. Department of Health; 3. Eastern Cape Department of Health

Issues: Over the years, performance on the total remaining on ART (TROA) in South Africa (SA) regressed. Exacerbated this were numerous factors including lack of implementation of Differentiated Model of Care (DMOC) strategies, lack of harmonization and integration of monitoring & evaluation systems, and high loss to follow up. SA has since aligned its ART programs putting the Differentiated Model of Care (DMOC) as an epitome of supporting the quality services and DMOC scale-up. DMOC Performance Reviews (DPRs) were conducted to determine the performance and identify the missed opportunities to inform the scale-up of DMOC in the Provinces.

Description: The DPR was conducted in 3 districts and 12 health facilities in Mpumalanga, 4 districts and 16 in Eastern Cape provinces between April and May 2023. The DPR phased process involved primary data collection from clients' records at 28 sampled health facilities in both provinces using SurveyCTO from the designed tool. 4 cohorts (6 months, 12 months, 24- and 36-month cohorts) were sampled. Analysis of these data, and development of data visualizations,

were done through the Power BI. Dissemination of the results was done at an in-person workshop where stakeholders discussed the findings and developed action plans.

Lessons learned: A total of 1914 for the number of ART client files were abstracted across 28 learning sites. As the clients progress in their respective cohorts, the retention in care declines, whilst the LTFU increases respectively. The declining TROA may be exacerbated by several reasons. E.g., Missing, or duplicate client folders, sub-optimal documentation on client folders. High proportions (51%) of clients were well established on ART but were not decanted. Attributing to a missed opportunity for ensuring retention in care. Relatively comparable unstable clients on the Conventional Care model when mixed with established clients in the same modality leading to possible facility congestion. About 5% of Clients were decanted even when not established, attributing to missed opportunity, risking treatment failure, and possible Advanced HIV Diseases or Opportunistic Infections. Clients don't remain in one DMOC Model. There is marginal decanting from the Conventional Model to other DMOC modalities. However, there is a predominant proportion that remains in the Conventional model constituting a missed opportunity to decant.

Next steps: The findings suggest that the existing M&E systems need to be harmonized and ongoing triangulation will be necessary for routine monitoring of DMOC programs to be possible. Capacity building in the revised ART guidelines and DMOC SOPs will enhance DMOC upscale.

Description of the gap/issues identified during the DPR

- As the clients' progress in their respective cohorts, the retention in care declines, whilst the Lost to Follow-up (LTFU) increases. A higher LTFU has been observed ranging from 25% to 40% across the 12-, 24-, and 36-months cohort respectively.
- Declining of Total Remaining on ART (TROA) – which is a retention indicator: The decline may be attributed to a myriad of reasons which include but are not limited to Missing, or duplicate client folders, and sub-optimal documentation on client folders.
- Clients established on ART (between 50% - 89%) due for decanting to DMOC for stable clients, were not decanted, thus, a missed opportunity for ensuring and strengthening retention in care.
- Gaps in the filing system due to space challenges, leading to duplication of patient folders.
- Gaps in the utilization of the Adherence Plan, which is a tool guiding through the patient treatment journey

Actions/Activities planned and implemented to address the gap/issues identified

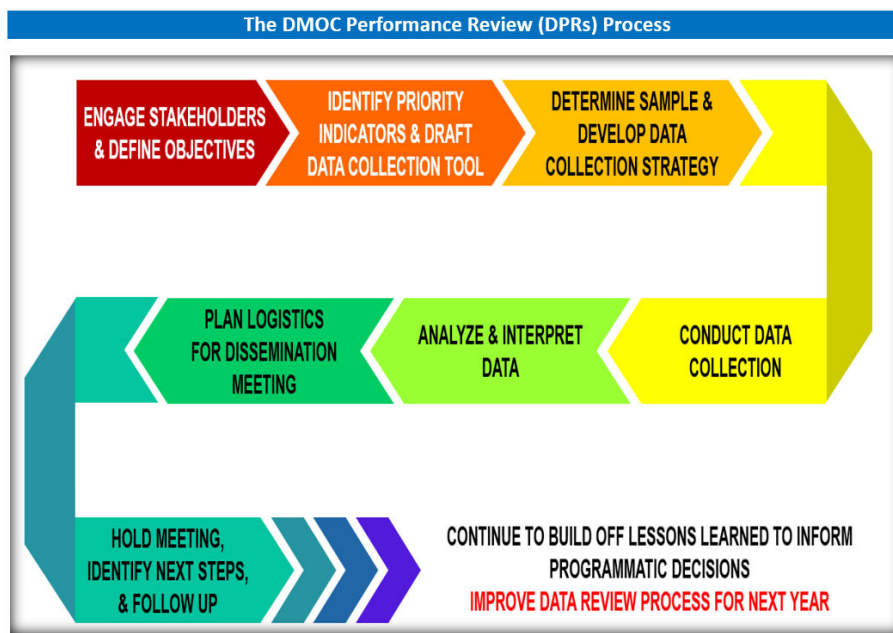
- Implementation of tracing and recall for patients as soon as they miss an appointment
- Capacity building on DMOC including capturing the DMOC according to each of the three modalities (Facility Pick up point, Adherence Clubs and External Pick up Point)
- Capacity building on data capturing of DMOC indicators on TIER.net and on DHIS
- Provinces mobilizing resources from the District Support Partners to assist with the Cabinets for clients' folders as well as data mop-up to deal with the duplication of folders

Impact of these actions/activities in terms of improvement with regard to the gap/issues identified

- The activities will help in increasing the Total remaining on ART (TROA) - retention
- Will also help with finding missed appointments as soon as possible
- Capturing on the clients medical records appropriately

What was decisive in the implementation of the activities to obtain the improvements

- Districts were able to draw their action plan regarding the gaps



B21. Strengthening Reporting of Differentiated Service Delivery Models through Electronic Medical Record (EMR) Systems in Nigeria

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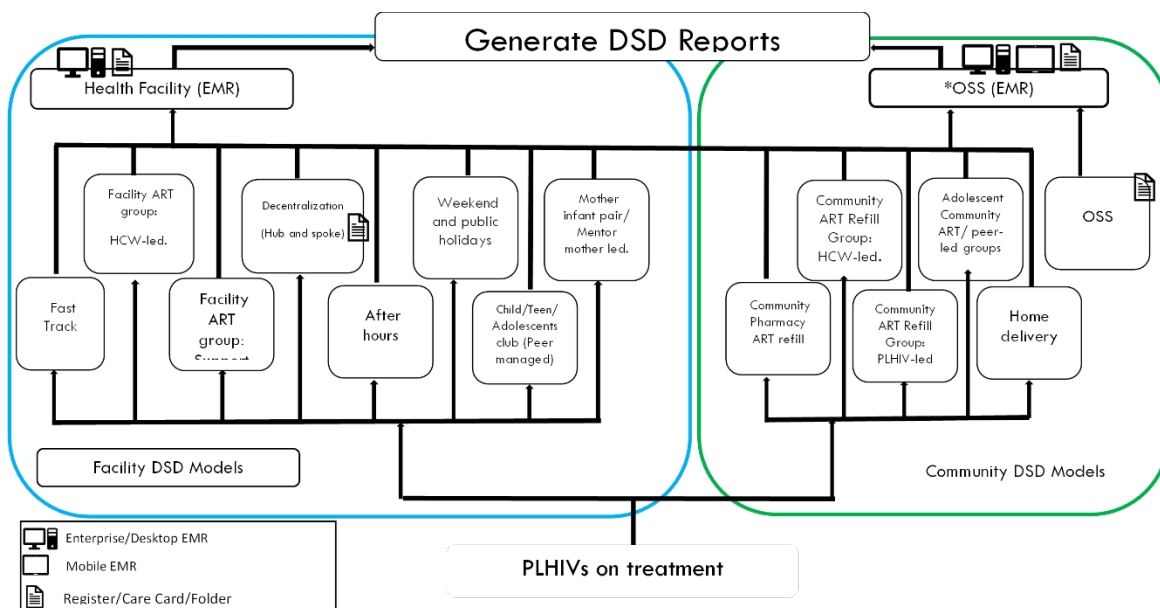
1. US Centers for Disease Control and Prevention, Division of Global HIV and TB; 2. US Centers for Disease Control and Prevention; 3. National AIDS and STDs Control Program, FMOH, Abuja Nigeria

Introduction: Nigeria continues to deliver quality HIV/AIDS care and treatment services that is appropriate and convenient to people living with HIV/AIDS through facility and community -based differentiated service delivery (DSD) models. Poor documentation and attribution of clients in the different models led to under reporting of DSD services across 19 states supported by the United States Centers for Disease Control and Prevention (CDC). This abstract describes efforts at improving reporting of DSD models using an electronic medical records (EMR) system across service delivery points.

Description: CDC supported the deployment of the Nigerian Medical Records System (NMRS)- An enterprise version used within supported facilities and a mobile version for phones and tablets for out of facility service delivery – to streamline data review and collection for facility and community-based DSD models in line with the country’s guidelines. This innovation strengthened the data flow from paper-based patient management and monitoring tools into the NMRS for reporting quality metrics of clients within DSD models including viral load coverage, suppression, and retention in care. A schema of the data flow is represented in Fig 1 below.

Lessons learned: The scale up, optimization and use of the NMRS for collation, reporting, and analysis of key performance indicators for DSD across supported facilities was crucial to curb under reporting of efforts and improve model attribution for services rendered across supported facilities and community-based system. The adaptation of a mobile NMRS proved a game changer for effective service delivery and reporting from distant and hard to reach communities using mobile devices and tablets.

Conclusion: The improvements in DSD reporting, data availability, and use for decision making in Nigeria was hugely influenced by the availability and use of the NMRS at critical points of service provision especially the mobile NMRS within the communities. Onboarding and optimization of EMR system to support DSD programs are instrumental in achieving retention and quality indicators while driving client-centric service delivery for achieving epidemic control of HIV/AIDS in Nigeria.



B22. DSD Performance Review Process: A Case Study of Implementation in Uganda

Ivan Arinaitwe¹, Geoffrey Taasi¹, Moses Luwunzu¹, Hudson Baliddawa¹, Cordelia Katureebe¹

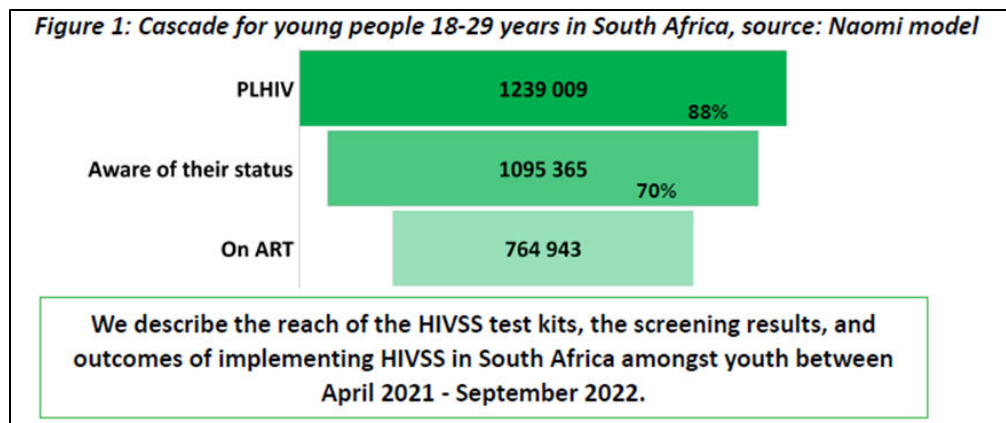
1. Ministry of Health Uganda

B23. Uptake of the HIV Self-Screening Modality Amongst the Youth 18-29 Years in South Africa

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1. The National Department of Health, Pretoria, South Africa; 2. Clinton Health Access, Pretoria, South Africa,

South Africa (SA) has the highest number of people infected with HIV globally, with the fourth-highest adult HIV prevalence rate of 13%. South Africa committed to the United Nations 95:95:95 strategy to end AIDS as a public health threat by 2030 which involves scaling up a combination HIV prevention interventions. The National Department of Health (NDOH) introduced HIV self-screening (HIVSS) as an additional testing modality to close the testing gap for hard-to-reach populations including key populations, men and youth. HIVSS has proven to be a critical modality to increase the adoption of HIV prevention and treatment. NDOH had initially targeted to implement the modality in 222 health care facilities within the country based on resources. However, at the end of 2022, approximately 900 health care facilities were implementing the modality due to the increased demand and partner support from communities, especially amongst youth.



The results show that HIVSS is a modality that is reaching the youth aged 18-29 years. However, more young people living with HIV could be reached if distribution models are expanded out of facilities, such as into schools, higher health institutions, and workplaces. Social media and social mobilization campaigns should be strengthened. Continuous capacitation and mentorship should be provided to the Health Care Workers (CHWs), peer educators and CHWs on HIVSS to ensure the stability of the modality.

B24. Secondary Distribution Pilot of Self Testing through Community Interventions OVC and DREAMS (Mozambique)

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1. MOH; 2. USAID; 3. ECHO; 4. ANDA

Mozambique has adopted the UNAIDS goals of 95-95-95 by 2025, which will allow the country to achieve control of the second largest HIV epidemic in the world. One of the persistent challenges to the achievement of this goal is the first 95, PLHIV that know their status. According to the latest population bases survey, only 71.6% of the estimated 2.4 million PLHIV living in the country know their status. Over the last 2 years, a new strategy for self-testing for reaching hard to test populations has been expanded nationally and is available in all of Mozambique 11 provinces. This approach is orientated to fill the traditional HIV testing gaps, which include key and high risk populations as well as populations that don't frequent health services such as young people and rural areas.

The Ministry of Health piloted a secondary distribution of HIVST, carried out by Community Peers from DREAMS and OVC projects, to reach and achieve Adolescents and Young People.

In both of the approaches, OVC and DREAMS, the distribution of HIVST using community peers allowed to reach adolescents and young people, which are population with high-risk and vulnerable. And most them had been tested for more than 12 months and other's had never been tested for HIV in their life.

B25. Besides Same Day ART Initiation: A Follow Up Analysis of Clients Deferring ART and Their Linkage to Care

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Introduction: Eswatini adopted the test-and-start strategy in 2016. This strategy has resulted in high linkage rates to antiretroviral therapy (ART). Despite these high linkage rates, some clients do not initiate ART on the same day of diagnosis. We describe reasons for non-initiation on the day of HIV diagnosis.

Methods: A cross-sectional analysis of clients who tested HIV positive from October 2020 until September 2023 was done. Data was obtained from the client management information system (CMIS), and descriptive analysis was used to identify reasons for non-initiation on the day of diagnosis and non-initiation on ART.

Results: Of 5262 clients with positive results, 606 (11.5%) did not initiate on the day of diagnosis, while 127 (2.4%) were not initiated (Figure 1). The most common reason for not starting ART on the day of diagnosis was comorbidities/opportunistic infections, while the most common reason for those delaying ART beyond a month was being unprepared. No-disclosure is still a significant barrier among females to early ART.

Conclusions: Strategic investment in ongoing client engagement, follow-up and psychosocial support is required to address barriers to ART initiation. This can increase linkage rates for clients who do not start ART on the day of diagnosis.

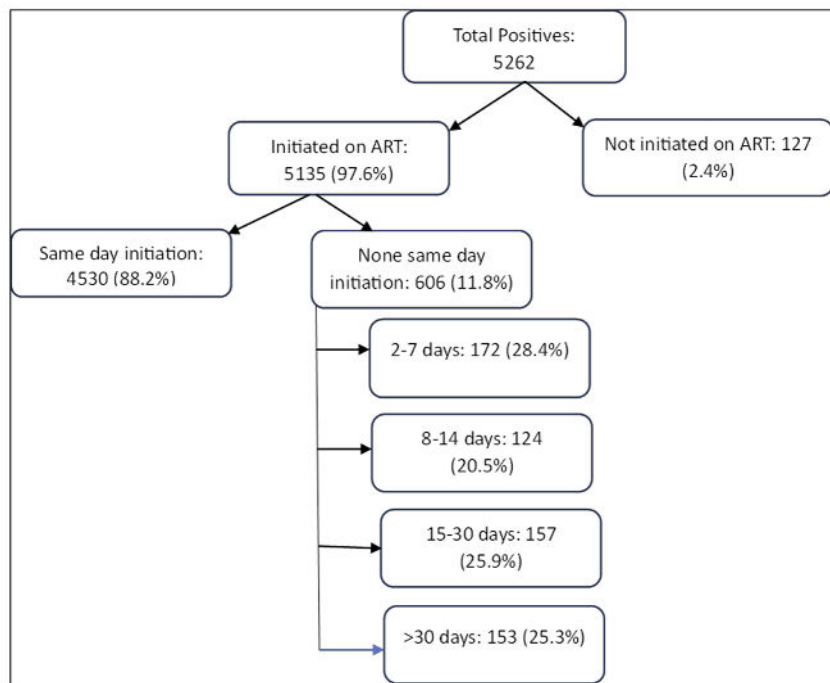


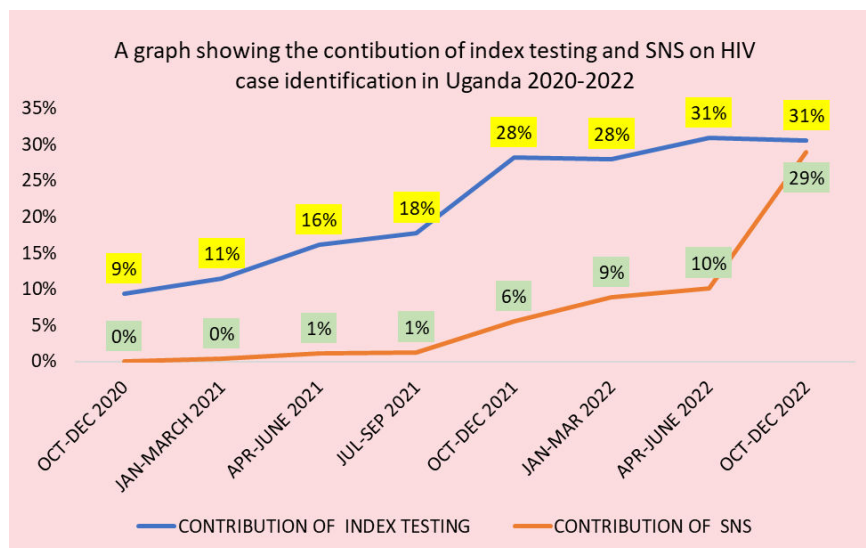
Figure 1: ART Linkage status and timelines for clients who tested HIV positive between October 2020-September 2023

B26. Improving HIV Case Finding through Differentiated HIV Testing using HTS Mentors in Uganda

Bakashaba Baker¹, Ssentongo Saadick¹, Muzaaya Godfrey¹, Olweny Denis¹, BukenyaLameck¹

1. Soroti Region project The AIDs support organization (TASO), Uganda

This study conducted in North-Eastern Uganda aimed to address the challenge of low HIV awareness among individuals. By leveraging HIV Testing Services (HTS) mentors, the study implemented index testing and Social Network Testing (SNS) strategies. From January 2021 to December 2022, a total of 56,293 individuals received HTS services, with 7055 testing positive. Index testing and SNS contribution to identifying positive clients, increased from 9% to 31% and 0% to 29%, respectively. Trained HTS mentors played a crucial role in improving the yield from both SNS and index testing, improving the identification of individuals living with HIV in North-Eastern Uganda.



B27. Progress on Differentiated HIV Testing Services Post-meeting action plans: Uganda Case Study

Geoffrey Taasi¹, Ivan Arinaitwe¹, Moses Luwunzu¹, Hudson Baliddawa¹, Cordelia Katureebe¹

1. Ministry of Health Uganda

B28. Integration of Screening and Management of Hypertension and Diabetes Services: Experiences from a USAID client-centered program

Juma Songoro¹, Christopher Genge¹, Revocatus Shigi¹, Frederick Haraka¹, Cosima Lenz², Roland Van de Ven¹, Sajida Kimambo¹

1. Elizabeth Glaser Pediatric AIDS Foundation Tanzania; 2. Elizabeth Glaser Pediatric AIDS Foundation Global

Introduction: This abstract describes the experience of integrating hypertension and diabetes screening within HIV care services in 103 selected high-volume care and treatment clinics supported by USAID Afya Yangu Northern project in five regions of Tanzania namely Arusha, Kilimanjaro, Manyara, Dodoma and Singida.

Methods: HIV clinic healthcare providers were trained on the provision of integration services, screening for diabetes and hypertension among people living with HIV (PLHIV). PLHIV attending clinic screened for risk factors (such as smoking, obesity, physical inactivity, and unhealthy diet for HTN and those with family history of DM or presented with polyuria, polydipsia and polyphagia screened for DM). PLHIV receive BP measurements at triage as part of routine vital signs checks, those screened with risk factors are further evaluated for HTN disease. Fasting or random blood glucose test provided to PLHIV presented with risk factors. Both HIV and NCD services were provided under one roof by same clinicians and nurses at CTC. Management of newly identified clients with HTN and DM was provided at CTC including prescription of medicines, and for already known PLHIV with HTN or DM, monitoring of their treatment adherence and control of the disease were done at CTC clinics. PLHIV presenting with complicated HTN or DM conditions and those needing further specialized care were referred to specialized clinics accordingly.

Results: Amongst the 4,222 people screened for HTN, prevalence was 12%. 5.8% were newly diagnosed and 6.2% had known HTN. 49.9% were adults aged 30-44 years, 30% were between 45-59 year, and 9% were >60 years old. Among the 2,500 individuals screened for DM, there was a prevalence of 7.7%. 39% of these were newly identified and 6% had known DM.

Discussion: Provision of integrated NCD screening and HIV care services can be done under one roof at care and treatment services by the same healthcare providers.