



Putting policy into practice: The experience of DSD guidance in Ghana

INTEREST Workshop 2019
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Background on Ghana

- Ghana's population (2018) – 29.6mill (GSS estimates, 2018) on 23Mill Ha of land
- 51% female, median age is 20yrs, TFR 4.2
- 51% urbanised
- 1 in every 24 infants die before 1 year
- 1 in every 17 children die before 5 years
- 66% of women and 82% of men are literate



HIV in GHANA

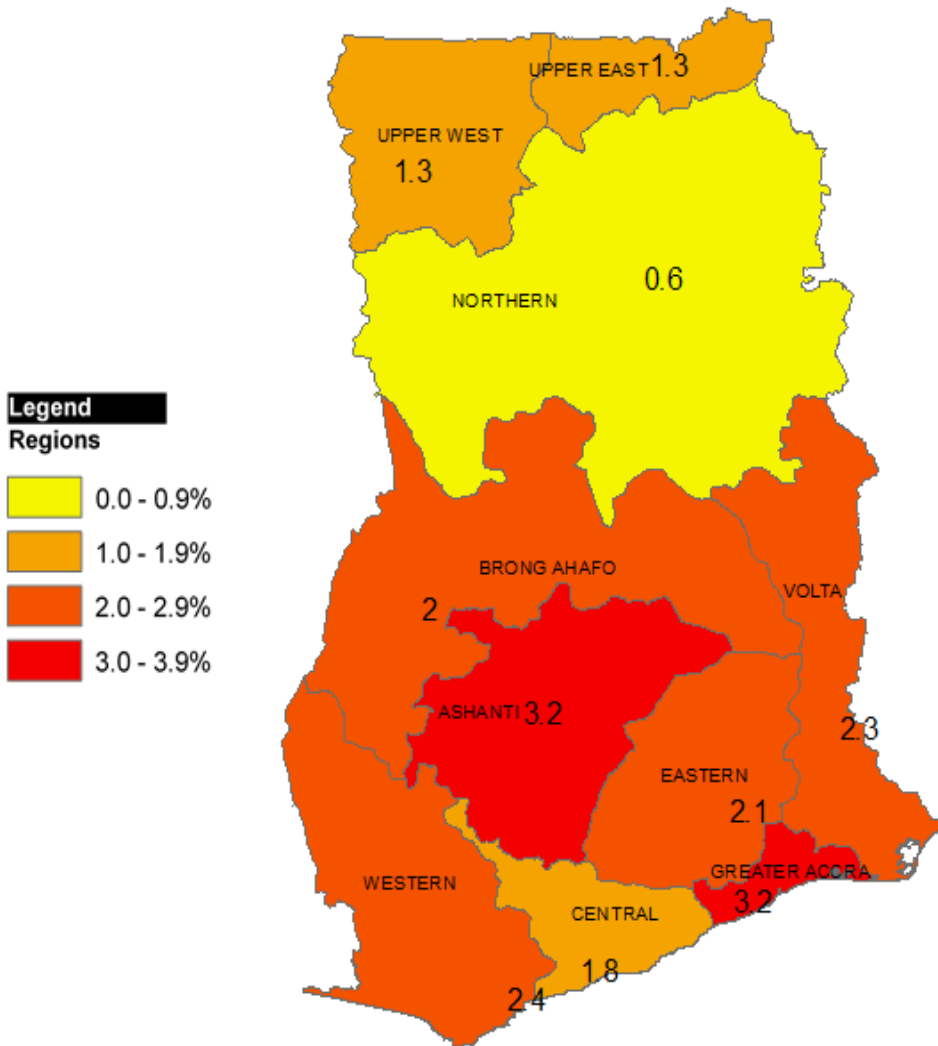
The first AIDS cases were reported in Ghana in 1986

2017 ANC Prevalence 2.1%

2018 Estimates

- National Prevalence **1.64%**
- Estimated #PLHIV **316,613**
 - Adult 289,883
 - Children 26,730
- New HIV infections is **17,649**
 - Adult 15,085
 - Children 2,564
- **11,908** annual AIDS deaths (9,435 adults & 2,473 children)

Ghana's HIV prevalence depicts a generalised epidemic





HIV in Ghana (2018)

- MSM prevalence 18.1% (Mens' Study, GAC 2017)
- FSW prevalence 6.9% (IBBSS, GAC 2015)
- 90-90-90 => 71 – 40 – 66
- Total health facilities 8,996
- HIV services availability
 - ART sites 488 (comprehensive HIV care)
 - PMTCT sites
 - HTS 4,056 out of which 1,476 provide ART as well



Process to develop DSD policy

- February, 2017, teams comprising EQUIP and NACP staff visited 20 facilities in five regions
 - Ashanti, Brong-Ahafo, Eastern, Greater Accra, Western
 - Carried out baseline assessment of these selected facilities
- Findings emphasized need for DSD across the continuum of care



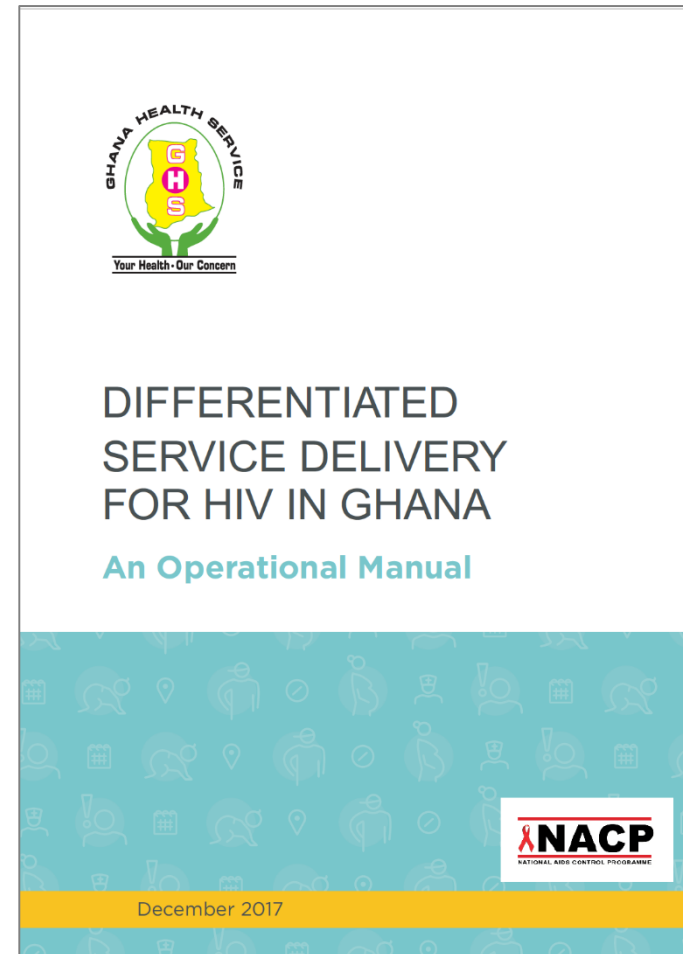
Process to develop DSD policy

- Workshop on DMoC (6th -7th April 2017) with donor partners, stakeholders and implementers from the regions
 - WHO consultant to help with development of DMoC operational guidelines and manual
- Operational manual developed, validated and print ready by Dec 2017
- Task team formed with ToR (May 2018)



Overview: Ghana DSD policy

- Covers entire continuum of care
- Differentiates between general population and considerations for specific populations
- Includes SOPs and algorithms





Policy highlights for differentiating ART delivery for stable clients

4.4 Differentiated ART delivery for stable adult clients

Definition of a stable adult (non-pregnant) client on ART

An adult client may be defined as stable when they have:

- Been on their current regimen (first or second line) for 12 months or longer
- No current opportunistic infections and stable laboratory indicators if available
- No adverse drug reactions
- A good understanding of lifelong adherence to ART and evidence of attending appointments on time
- VL <1 000 copies/ml or where VL not available, no decreasing CD4 and no persistent CD4 measurement below 100.



DSD ART refill

- Length of ART refill standardized to 3 OR 6 months
- Frequency of clinical assessment – 6 monthly
- Where can ART refills be collected – facility, CHPS, drop-in centres, community pharmacy or community health nurses deliver to homes
- Who can distribute ART refills – lay cadres



Table 6: Summary of clinical and refill visit frequency for ART follow up for stable adult clients

Refill option	Frequency of clinical visit	ART refill duration for scripting
Individual facility-based fast-track refill	Every 6 months	3 months (see SOP on page 39) See page 34 for conditions for 6-month refill
Group facility-based ART refill	Every 6 months (book as group but additionally have individual clinical assessment)	3 months (see SOP on page 42)
Health centre/CHPS/ drop-in centre/community pharmacy refill	Every 6 months at ART site	3 months (see SOP on page 46)



STANDARD OPERATING PROCEDURE FOR “FAST-TRACK” REFILL

Facility-based individual refill from pharmacy or dispensing point

WHEN

Every 3 months (see page 34 for conditions for 6-month refill)

Any time during clinic opening hours

WHERE

Accredited ART site

Direct from dispensing point



WHO

The client does not see the HCW for a clinical consultation at the refill visit; the client sees only the ART dispenser

WHAT

ART refills

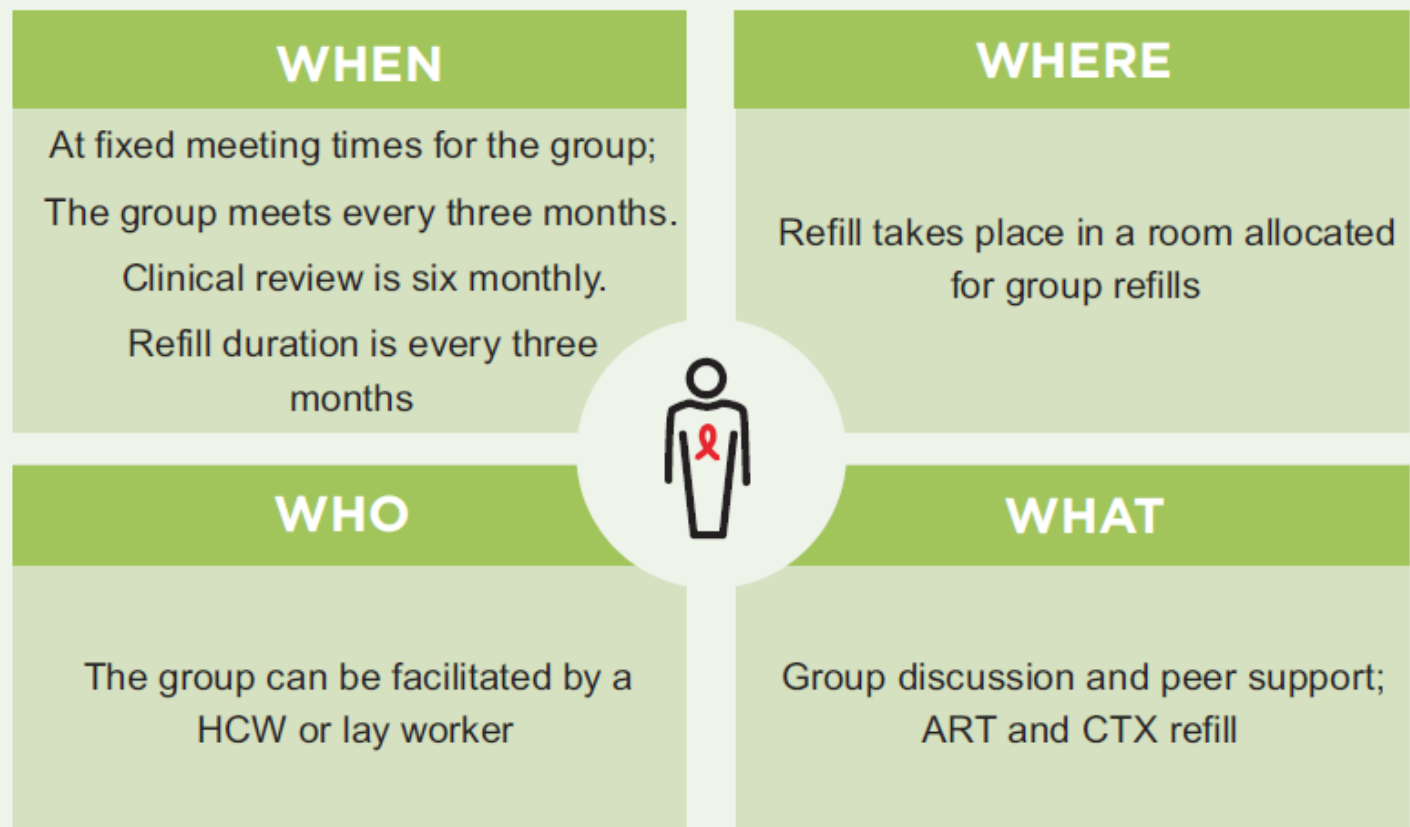
Cotrimoxazole (CTX) refills as indicated in the clinical guidelines



STANDARD OPERATING PROCEDURE FOR GROUP FACILITY-BASED ART REFILL

This model may be offered at ART sites or health centre or CHPS refill sites.

Implementation experience to date shows that it is most effective at high-volume sites in urban settings.





STANDARD OPERATING PROCEDURE FOR HEALTH CENTRE/CHPS/DROP- IN CENTRE/COMMUNITY PHARMACY REFILL

WHEN

Refill every three months
Clinical visit every six months

WHERE

Refill at health centre, CHPS refill
site, drop-in centre or community
pharmacy
Clinical visit at ART site



WHO

The healthcare worker or lay
worker at refill site

WHAT

ARVs and CTX refills



How Ghana prioritized implementation

- Key priorities in implementation plan
 - High client load facilities with at least 200 clients (Not EQUIP-supported)
 - Onsite orientation
 - Deal with site specific challenges
 - Get a lot more staff involved
- Orientate facilities with Regional teams while National officers supervise



Implementation to date on ART delivery for stable clients

- Task team developed dissemination plan with National ToT and Regional ToT in June 2018.
- Sub-regional orientation was started in Dec 2018
 - 10 facilities in GAR
 - 20 more facilities were oriented in AR, BAR, ER, GAR, WR
 - All 20 EQUIP supported sites were oriented by EQUIP



Implementation to date on ART delivery for stable clients

- Increase from 20 to 60% (300/488) of facilities implementing 3m ART refills
- Approx. 60% of facilities provide 6 month clinical consultation visit appointments
- 30% of facilities provide community-based individual ART delivery at PHC level



Implementation challenges/barriers to DSD ART delivery

- Time lapse between development of manual and implementation
- Time lapse between Regional ToTs and facility trainings
- Funding issues contributed
 - CDC supported onsite orientation in 30 facilities so far
 - GF supported EQUIP in 10 sites
 - PEPFAR supported EQUIP in 10 sites
- Onsite strategy is time consuming



Implementation challenges/barriers

- Availability of commodities – ARVs at units other than ART clinics and pharmacy
- Communication for LTFU tracing and poor implementation of tracing
- M&E tools not part of national
- Need to carve out time for supportive supervision



Lessons learned from policy to practice

- Wide stakeholder engagement to accept model especially implementers
- Implementation strategy – onsite or ‘classroom’
- FUNDING related:
 - A costed plan and dedicated funding should be secured to ensure smooth operationalization
 - Periodic assessment of impact to be undertaken beyond the baseline to justify further investment
- Procurement planning to ensure drug supply available
- Most indicators are process indicators so better monitored during supportive supervisory visits
- Supportive supervisory visits - A MUST



Thank you

