The HIV Care Continuum and Data to Care

Using Surveillance Data for Action in the U.S. and Abroad

U.S. Conference on AIDS
September 11, 2015
NASTAD: Who we are

• National Alliance of State and Territorial AIDS Directors: Membership and representation of all U.S. states and territories. 46 Domestic staff and 50+ global staff

• Mission:
Strengthen the role and promote the success of state and territorial public health programs to reduce HIV/AIDS and viral hepatitis incidence, insure quality care and treatment and improve health outcomes

• In the US, we provide advocacy and TA to state and territorial health departments. Globally, we provide TA to ministries of health, leveraging the expertise of our US health department members.
NASTAD: Who we are

• US projects:
  o Health care access (Ryan White and ADAP)
  o Policy and legislative affairs (ACA, fed appropriations, program policy and tools)
  o HIV prevention and health equity (Gay Men’s health and health equity, engagement of Black MSM, HIV surveillance)
  o Viral Hepatitis (drug user health, policy, appropriations)
NASTAD: Who we are

• Global projects:
  o Public health systems strengthening
  o Evaluation and research
  o Monitoring and program improvement
  o Surveillance system development and implementation
Where We Work Globally

NASTAD Field Offices

- South Africa
- Uganda
- Ethiopia
- Mozambique
- Tanzania

Central American Region
- Guatemala
- Belize
- Costa Rica
- Panama

Caribbean Region
- Trinidad & Tobago
- Bahamas
- Jamaica
- Barbados

NASTAD Technical Assistance

- Haiti
- Guyana

Haiti

Guyana

Central American Region

- Guatemala
- Belize
- Costa Rica
- Panama

Caribbean Region

- Trinidad & Tobago
- Bahamas
- Jamaica
- Barbados

Ethiopia

Uganda

Tanzania

Mozambique

South Africa

NASTAD Field Offices

NASTAD Technical Assistance
Workshop learning objectives

• Review core concepts relating to the care continuum and data-to-care approach
• Learn about data needs in countries with HIV projects funded through PEPFAR
• Discuss how:
  o Lessons learned in the US can guide work in lower resource international settings
  o Working in low-resource environments allows for innovative planning and implementation
  o Structural and political barriers can be overcome to achieve success
Workshop structure

- Overview slides about care continuum, data-to-care, PEPFAR data needs
- Three case studies
  - South Carolina
  - Ethiopia
  - Haiti
- Each case study will be presented followed by small group discussion
Case-based surveillance, Care Continuum and Data to Care
What is case-based surveillance?

• Case-based surveillance (CBS) is the practice of measuring and monitoring rates of disease in a population
• Involves routine data collection, analysis and dissemination about a health-related event
• Provides a knowledge base to better understand the “who, what, when, where, and how” -- questions related to disease transmission and impact
• Much of the data required to create The HIV Care Continuum come from CBS
The HIV Care Continuum

- Also known as the “HIV Treatment Cascade”
The History of the HIV Care Continuum

2011: Gardner et al. publish article

2013: President’s "HIV Care Continuum Initiative"

2015: Updated National HIV/AIDS Strategy
U.S. HIV Care Continuum, 2011

Example 1: Prevalence-Based HIV Care Continuum, 2011

- Diagnosed: 86%
- Linked to care*: 80% of those diagnosed in 2011
- Engaged in care: 40%
- Prescribed ART: 37%
- Viral suppression: 30%

* Linkage to care measures the percentage of people diagnosed with HIV in a given calendar year who had one or more documented viral load or CD4+ test within three months of diagnosis. Because it is calculated differently from other steps in the continuum, it cannot be directly compared to other steps and is therefore shown in a different color. See Table 1 on page 4 for more details.


National HIV Care Continuum Objectives

Population-Specific Continuum

Example 2: Diagnosis-Based HIV Care Continuum, Black MSM, 2010


* Linkage to care measures the percentage of people diagnosed with HIV in a given calendar year who had one or more documented viral load or CD4+ test within three months of diagnosis. Because it is calculated differently from other steps in the continuum, it cannot be directly compared to other steps and is therefore shown in a different color. See Table 1 on page 4 for more details.

Using Continuum Data for Public Health Action

• *Data to Care* is a strategy that uses HIV surveillance data for individual-level action to re-link HIV-diagnosed individuals not in care, and support outcomes across the Care Continuum.
Data to Care in Practice

1. Use surveillance data to identify out-of-care individuals
2. Prioritize out-of-care list
3. Locate and conduct linkage/re-engagement outreach
4. Track and report investigation results back to health department
NASTAD’s Domestic Data to Care Work

• Community of Practice
  o Survey of 30 jurisdictions
  o Four-part webinar series in 2015 highlighting work in CO, HI, LA, MA, NY, SC, WA
  o Online learning opportunities via NASTAD OnTAP (Online Technical Assistance Platform)

• Capacity Building Assistance (CBA) provider for individual Data to Care technical assistance for health departments
Data needs under PEPFAR
PEPFAR Background

- PEPFAR = President's Emergency Plan For AIDS Relief
- USG initiative that began in 2004 to address global HIV and provide care and tx, in 15 focus countries (mostly Africa)
- Secretary Kerry on 9/2/15: “...we have made enormous progress in this fight, and PEPFAR remains the largest commitment of any nation to address a single disease...”
- http://www.pepfar.gov/funding/index.htm
Evolution of PEPFAR

• *PEPFAR 1.0* – Emergency response. Focused on getting treatment and care to individuals. (2004 – 2007)

• *PEPFAR 2.0* – Focused on country capacity, sustainability, country ownership and leadership. (2008 – 2012)

• *PEPFAR 3.0* – Focus on the “right things, in the right place, at the right time”. In line with WHO’s 90-90-90. (2013 on)
Evaluating the Success of PEPFAR

- PEPFAR 1.0
  - Measures of focus related to number of individuals testing, receiving treatment, palliative care.
  - Goal to reach 2 million with ART, prevent 7 million new infections, and provide care for 10 million people by 2010.
  - Most of the information came directly from program implementation
Evaluating the Success of PEPFAR (con’t)

• PEPFAR 2.0
  o Sustainability, country ownership, country leadership
  o Focus on strengthening human resources – training of health care workers (goal of 140,000)

• PEPFAR 3.0
  o Focused on ending the epidemic; measurement to line up with WHO’s 90-90-90 (90% of those infected diagnosed; 90% linked to care, and 90% virally suppressed)
  o SIMS – Site Improvement Monitoring System
  o More emphasis on use of clinical data and CBS
Convergence of U.S. and global data needs

• So, to connect the dots...
  
  o Adoption of the 90-90-90 goal means that the care continuum model has enormous potential for PEPFAR
  
  o HIV CBS as a model has been successful in the US, but tweaks are likely needed in international settings
  
  o The global context may offer effective strategies that could be used in the US
Case Study #1:
Data to Care in South Carolina
Monetha Gaskin, MPH, CHES

South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment
CDC Data to Care TA Project

- CDC-funded project to provide technical assistance (TA) to HDs in planning and implementing Data to Care activities
  - TA delivered from February to August 2014
  - Goal: To strengthen HD’s capacity to use surveillance data to identify PLWH not in care and link them to clinical care or re-engage them in care
Numbers and percentages of persons engaged in each step of the continuum of HIV care, 2013

- 63% of PLWHA
- 53% of PLWHA
- 49% of PLWHA

PLWHA (a) (n=14,960)
Received any care (b) (n=9,391)
Retention in continuous care (c) (n=7,907)
Viral suppression (d) (n=7,328)

Data source: South Carolina Department of Health and Environmental Control (DHEC).

a. PLWHA, Defined as persons diagnosed with HIV infection (regardless of stage of disease) through year-end 2012, who were alive at year-end 2013.
b. Percentage of persons with ≥1 CD4 or viral load test result during 2013 among PLWHA.
c. Percentage of persons who had ≥2 CD4 or viral load test results at least 3 months apart during 2013 among PLWHA.
d. Percentage of persons who had a Viral Load <=200 copies/mL at most recent test during 2013, PLWHA.
Figure 5.07: S.C. HIV/AIDS Cases NOT in Care
Diagnosed through 2013 by County

Not in Care
Percent
- 18 - 38
- 39 - 50
- 51 - 60
Historically

• Historically, our HIV prevention program, Ryan White care services, STD program, and surveillance/assessment were siloed.
• Programs did not plan, deliver, or evaluate services jointly.
• Programs reported to different federal agencies whose goals and measures were not well aligned (HRSA, CDC).
Data to Care Goals

- **Goals of Data to Care**
  - Increase the number of PLWH out of care who are linked to or re-engaged in care
  - Increase the number of PLWH with undetectable VL
- **Data to Care supports the goals of the National HIV/AIDS Strategy (NHAS)**
  - Reduce the number of new infections
  - Increase access to care
  - Improve health outcomes
Integrated Services/Collaboration

HIV Care Services

HIV Prevention

Surveillance
What needs to be done?

Internal meetings

What would we like our model to be and do?
Where and how do we start?

Contact and meet others doing Data to Care
Join in and listen to multiple webinars

What works for our state and what doesn’t
Key Stakeholders

Community Engagement meetings

- Data Sharing Agreements
- Policy and Procedure manual
- Job Descriptions
- Contact Script
- Notice of Privacy

Health Department
- Surveillance, prevention, care, Partner Services, linkage/retention projects

Community
- PLWH, HIV planning groups, advocates, community advisory boards, etc.

Providers
- Medical providers, community-based organizations
<table>
<thead>
<tr>
<th><strong>SCDHEC eHARS</strong></th>
<th><strong>Internal Investigation</strong></th>
<th><strong>Local Investigation</strong></th>
<th><strong>OOC Assessment</strong></th>
<th><strong>Action &amp; Referral</strong></th>
<th><strong>Retention</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who:</strong> SCDHEC epidemiologist</td>
<td><strong>Who:</strong> SCDHEC Surveillance Manager and prevention Data Coordinator</td>
<td><strong>Who:</strong> Provider Staff</td>
<td><strong>Who:</strong> Regional Service Coordinators/Provider Staff</td>
<td><strong>Who:</strong> Regional Service Coordinators</td>
<td><strong>Who:</strong> SCDHEC Data Coordinator/Surveillance</td>
</tr>
<tr>
<td><strong>What:</strong> Query statewide HIV surveillance data to identify PLWHA who haven’t had labs during 9-month period.</td>
<td><strong>What:</strong> Use available resources to investigate and document patient whereabouts and HIV care status (internal Databases).</td>
<td><strong>What:</strong> Use locally-available resources to investigate, verify, document patient whereabouts, HIV care status.</td>
<td><strong>What:</strong> Contact and discuss HIV care status directly with patient; initiate barriers survey and ARTAS intervention if applicable.</td>
<td><strong>What:</strong> Attempt to provide direct assistance or refer patient to re-engagement services</td>
<td><strong>What:</strong> Document patient retention rates every 3 months for 24 months</td>
</tr>
<tr>
<td><strong>Why:</strong> Identify potentially OOC cases and make baseline data available for investigation.</td>
<td><strong>Why:</strong> Reduce investigation burden on local public health, take advantage of SCDHEC specific data resources, and ensure consistency and efficiency of investigation methods.</td>
<td><strong>Why:</strong> Take advantage of local data resources; leverage familiarity with local landscape and existing provider relationships.</td>
<td><strong>Why:</strong> Take advantage of direct patient contact and ARTAS assessment data to help patients link or reengage in care.</td>
<td><strong>Why:</strong> Identify early signs of potential out of care status.</td>
<td><strong>Why:</strong> Identify early signs of potential out of care status.</td>
</tr>
</tbody>
</table>
Take aways!

• Working together internally is key
• Listening to key stakeholders (provider/community)
• Let the community see that their suggestions have been implemented or not
• Keep everyone involved when there is change
• It CAN be done
• This process is not a sprint but a marathon
Proof of Concept for HIV Surveillance in Ethiopia: Strategic Partnership Development

Case Study #2
Background

HIV Prevalence Among Adult Population, 2011

- Tigray: 1.8%
- Afar: 1.8%
- Somali: 1.1%
- Oromia: 1.0%
- SNNPR: 0.9%
- Gambella: 6.5%
- Benishangul G.: 1.3%
- Addis Ababa: 5.2%
- Dire Dawa: 4.0%
- Harari: 2.8%
- Ethiopia Total: 1.5%

Source: Ethiopia Demographic and Health Survey, 2011.
Barriers

• Encountered concerns about data requirements
  o No national identifier in use, like social security number
  o Patient name, DOB, address, and clinical health information required
  o Personally identifying data to be shared

• Standards for security of data and maintenance of confidentiality less defined
  o Facility based procedures for collecting and handling paper and electronic records
  o Institution based procedures for receiving, sharing and using primary health data
Partnership Development

- **Primary partners**
  - Ethiopian Public Health Institute
  - Addis Ababa City Health Bureau
  - Centers for Disease Control and Prevention – Ethiopia

- **Formal memorandum of agreement**
  - Designated responsibilities
  - Defined data sharing standards including security of personally identifying data

- **Data security and confidentiality review added to Proof of Concept protocol**
  - Referenced UNAIDS Guidelines on Protecting the Confidentiality and Security of HIV Information: Proceedings from a workshop
Methods

• Goal: Assess a subset of existing patient-level data and data collection processes to define whether criteria were in place that would support Ethiopia to implement case-based surveillance of HIV
  o Assess quality and completeness of HIV surveillance related variables
  o Identify a method to link patient data using a pseudo unique identifier (PUID)
  o Identify a method to capture select case report variables
  o Demonstrate patient-level data analyses useful to document patient linkages, disease progression and clinical outcomes

• Population:
  o Individuals diagnosed with HIV, including adult (aged 15 years and older) and pediatric (birth through 14 years) HIV case-patients receiving services
  o Health facilities in Addis Ababa, selected by convenience

• Data Sources: Existing HIV-related service data in paper and electronic format

• Time Period: Data collected during May – December 2015
### Table: Count of health facilities and health records included in Proof of Concept for HIV Case Based Surveillance – Addis Ababa City Health Bureau, Ethiopia, June 2015

<table>
<thead>
<tr>
<th></th>
<th>Quality Assessment</th>
<th>Data Linkage thru PUID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paper</td>
<td>Electronic</td>
</tr>
<tr>
<td>Facilities</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Records</td>
<td>1,500</td>
<td>52,817</td>
</tr>
</tbody>
</table>
Variable Quality and Completeness – Paper Records, Preliminary Results

Table: HIV surveillance related variables from paper based health records by percentage complete and valid – 24 health facilities, Addis Ababa, Ethiopia, June 2015

<table>
<thead>
<tr>
<th>High (&gt;90%)</th>
<th>Medium (26-89%)</th>
<th>Low (&lt;25%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient age</td>
<td>CD4 value</td>
<td>Unique ART number</td>
</tr>
<tr>
<td>CD4 test</td>
<td></td>
<td>Year ART regime change</td>
</tr>
<tr>
<td>Month HIV care medical visit</td>
<td>Name diagnosing institution</td>
<td>Partner tested</td>
</tr>
<tr>
<td>Year HIV care medical visit</td>
<td>Patient Kebele residence</td>
<td>Patient mother's code (for exposed infant)</td>
</tr>
<tr>
<td>Patient sex</td>
<td>Patient grandfather name</td>
<td>Day delivery</td>
</tr>
<tr>
<td>Month Patient last Visit</td>
<td>Patient cell phone number</td>
<td>Month delivery</td>
</tr>
<tr>
<td>Year Patient last Visit</td>
<td>Syphilis test result</td>
<td>Year delivery</td>
</tr>
<tr>
<td>WHO clinical staging</td>
<td>Year referral treatment &amp; care</td>
<td>Infant treated at delivery</td>
</tr>
<tr>
<td>Day Patient last Visit</td>
<td>Month referral treatment &amp; care</td>
<td>Patient pregnancy status (if female)</td>
</tr>
<tr>
<td>Month HIV diagnosis</td>
<td>Medical Record Number</td>
<td>Day infant PCR</td>
</tr>
<tr>
<td>ART regime</td>
<td>Month first ART prescription</td>
<td>Month infant PCR</td>
</tr>
<tr>
<td>Patient name</td>
<td>Year first ART prescription</td>
<td>Year infant PCR</td>
</tr>
<tr>
<td>Why eligible for ART</td>
<td>Name institution referred to</td>
<td>Day postnatal ART prophylaxis given</td>
</tr>
<tr>
<td>Year HIV diagnosis</td>
<td>Month cotrimoxazole prescribed</td>
<td>Year postnatal ART prophylaxis given</td>
</tr>
<tr>
<td>Patient father name</td>
<td>Patient Woreda residence</td>
<td>Month ART regime change</td>
</tr>
<tr>
<td>Month CD4 test</td>
<td>Year cotrimoxazole prescribed</td>
<td>Month postnatal ART prophylaxis given</td>
</tr>
<tr>
<td>Year of CD4 test</td>
<td>Patient mother's name (for exposed infant)</td>
<td>Mother treated at delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient expected delivery year (if pregnant)</td>
</tr>
</tbody>
</table>
Variable Quality and Completeness – Electronic Records, Preliminary Results

Table: HIV surveillance related variables from electronic medical records by percentage complete and valid – 21 health facilities, Addis Ababa, Ethiopia, June 2015

<table>
<thead>
<tr>
<th><strong>High (&gt;90%)</strong></th>
<th><strong>Medium (26-89%)</strong></th>
<th><strong>Low (&lt;25%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CRDID</td>
<td>Referral Information</td>
<td>Date of Birth (DOB)</td>
</tr>
<tr>
<td>Chronic Date</td>
<td>Estimated Delivery Date</td>
<td>Height Adult</td>
</tr>
<tr>
<td>Age</td>
<td>Status</td>
<td>Address Region</td>
</tr>
<tr>
<td>Gender</td>
<td>WHOSTage1Date</td>
<td>Address Woreda</td>
</tr>
<tr>
<td>Address Kilfe Ketema</td>
<td>WHOSTage3Date</td>
<td>ANC Register Number</td>
</tr>
<tr>
<td>HIV Test Day</td>
<td>Med Eligible Date</td>
<td>Status Date</td>
</tr>
<tr>
<td>Pregnant</td>
<td>Eligible Ready Date</td>
<td>WHOSTage2Date</td>
</tr>
<tr>
<td>Reason Medically Eligible</td>
<td>ART Start Date</td>
<td>WHOSTage4Date</td>
</tr>
<tr>
<td></td>
<td>Functional Status</td>
<td>Devtal Milestone</td>
</tr>
<tr>
<td></td>
<td>Weight</td>
<td>Height</td>
</tr>
<tr>
<td></td>
<td>WHO Stage</td>
<td>TIF from Where</td>
</tr>
<tr>
<td></td>
<td>CD4CountAdult</td>
<td>Last Visit CTX Adherence</td>
</tr>
<tr>
<td></td>
<td>CD4PercentChild</td>
<td>Last Visit Weight</td>
</tr>
<tr>
<td></td>
<td>Original Regimen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appoint Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last Visit Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last Visit TB Screen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last Visit Weight</td>
<td></td>
</tr>
</tbody>
</table>
**Data Linkage through Use of PUID Preliminary Results**

Table: Application of the Pseudo Unique Identifier (PUID) and Metaphone (m) PUID to identify unique HIV patients among electronic medical records – 33 health facilities, Addis Ababa, Ethiopia, June 2015

<table>
<thead>
<tr>
<th>Match Procedure</th>
<th>Records</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Exact</td>
<td>7,220</td>
<td>6.7</td>
</tr>
<tr>
<td>mExact</td>
<td>2,688</td>
<td>2.5</td>
</tr>
<tr>
<td>PUID</td>
<td>6,846</td>
<td>6.3</td>
</tr>
<tr>
<td>mPUID</td>
<td>7,053</td>
<td>6.5</td>
</tr>
<tr>
<td>Subtotal - Matched</td>
<td>23,807</td>
<td>22.0</td>
</tr>
<tr>
<td>Record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal - Unmatched</td>
<td>84,328</td>
<td>78.0</td>
</tr>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>108,135</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Next Steps

• Goal: Assess a subset of existing patient-level data and data collection processes to define whether criteria were in place that would support Ethiopia to implement case-based surveillance of HIV
  ✓ Assess quality and completeness of HIV surveillance related variables
  ✓ Identify a method to link patient data using a pseudo unique identifier (PUID)
    ☐ Review ‘matched’ records to confirm unique patient
    ☐ Identify a method to capture select case report variables
    ☐ Demonstrate patient-level data analyses useful to document patient linkages, disease progression and clinical outcomes
The SAFE initiative:
Preventing mother-to-child HIV transmission in Haiti

Case Study # 3
HIV in Haiti

• 1982: first HIV reported in Haiti
• In the general adult population, the prevalence was estimated to be:
  o 5% in the mid 1990s
  o 2% over the past 5 years
• Almost 3% of pregnant women and approximately 12,000 children under age 14 are HIV-infected.
Service scale up

• Haitian Ministry of Health (MSPP) has prioritized the elimination of mother-to-child HIV transmission:
  o promote HIV screening among pregnant women
  o ensure availability of treatment and support services

• 145 prevention of mother-to-child transmission (PMTCT) sites in place throughout Haiti

• During 2014: >75% of estimated total of 300,000 pregnant women were tested for HIV
Development of SAFE

- In 2012, NASTAD, MSPP and U.S. CDC started piloting enhanced perinatal HIV case-based surveillance in order to:
  - improve public health surveillance of HIV among mothers and infants,
  - promote linkage and adherence to HIV care, treatment and prophylaxis.

- “SAFE” (Surveillance Active de Femmes Enceintes Seropositives), was implemented nationally early 2014 and is currently in use at 143 PMTCT sites.
SAFE Initiative PMTCT Clinic

POPULATION / AREA KM
- 12 - 160
- 161 - 200
- 201 - 350
- 351 - 1000
- 1001 - 5000
- 5001 - 23010

[Map showing distribution of clinics in Haiti with population/area legend]
SAFE System

• Designed to leverage existing PMTCT case management and data collection processes (patient registers).

• MSPP requires that 10 “sentinel events” be reported related to HIV infection among pregnant women
  - epidemic tracking
  - assure appropriate care
MSPP Sentinel Events

Pre-Natal and Pediatric Surveillance

- Pregnancy+ HIV+ Test (date)
- Entry to PMTCT/ART initiation (date)
- Delivery (date)
- Post-delivery visit (ART maintained)
- Care and treatment
- Infant Prophylaxis within 72 hours (date)
- PCR test between 4 weeks and 1 year of age (date)
- If PCR-, retest again after 6 weeks (date)
- If PCR+, confirmation test (date)
- If positive, entry into care (date)
SAFE Process

- Case Manager obtains demographic and clinical information
- On ANC registry and paper-based HIV Case notification Form: patient data (name, address, national ID code, demographic and clinical data)
- CM logs onto SAFE system by using an unique ID and confidential password
- SAFE paper form is entered on the interface and the case becomes active.
Ministère de la Santé Publique et de la Population
Fiche de notification de l'infection par le VIH pour les adultes (âge ≥15 ans)

1. Identification

Nom : ____________________________
Prénom : _________________________
Nom de Tél. : ______________________
A.K.A. : __________________________
Adresse : _________________________
Lieu de résidence : ________________
Prénom de la mère : ________________

Code VCT : ________________
Code d'identification du patient : ________________

Si la date de naissance est inconnue,
Ape (en années) : _______ ans

Si F, est-ce que le patient est enceinte ?
Oui  ❑  Non ❑

2. Mode possible de transmission

Rapports sexuels avec un mâle : Oui ❑  Non ❑
Rapports sexuels avec une femelle : Oui ❑  Non ❑
Injection de drogues : Oui ❑  Non ❑
Bénéfice de sang/services de sang : Oui ❑  Non ❑
Transmission Maternelle : Oui ❑  Non ❑
Accident d'exposition au sang : Oui ❑  Non ❑

3. Autres facteurs de risque

Histoire ou présence de Syphilis : Oui ❑  Non ❑
Histoire ou présence d'autre IST : Oui ❑  Non ❑
Vicime d'agression sexuelle : Oui ❑  Non ❑
Autre risque spécifié : ____________

4. Diagnostic du VIH

Date du diagnostic VIH+ : ____________________________
Nom de l'établissement : ____________________________

Date de la référence au centre de prise en charge :
Mes / Année
Nom de l'établissement de référence :

NOUVEAU FORMULAIRE DE NOTIFICATION ADULTE
Notification de cas de VIH/SIDA pour les adultes (≥ 15 ans)

Rempli par :
Nom du conseiller :
Prénom du conseiller :
Date de remplissage :
Jour / Mois / Année

Etablissement :

1. Identification

Nom :
Prénom :
Code VCT :

Code d'identification du patient :

Si la date de naissance est inconnue,
Ape (en années) :

Si F, est-ce que le patient est enceinte ?
Oui  ❑  Non ❑

2. Mode probable de transmission

Rapports sexuels avec un homme :

Rapports sexuels avec une femme :

Injection de drogues :

Bénéfice de sang/services de sang :

Transmission Maternelle :

Accident d'exposition au sang :

3. Autres facteurs de risque

Histoire ou présence de Syphilis :

Histoire ou présence d'autre IST :

Vicime d'agression sexuelle :

Autre risque spécifié :

4. Diagnostic du VIH

Date du diagnostic VIH+ :

Date de la référence au centre de prise en charge :

Sélectionnez une institution :

Sélectionnez une institution :

Paper-Based  Web-Based
### Identification de la Gestante (Notification de VIH)

<table>
<thead>
<tr>
<th>Nom: ______________________________</th>
<th>Prénom: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Num. de Tél: ______________________</td>
<td>Pseudo: ____________________________</td>
</tr>
<tr>
<td>Adresse domiciliaire: __________________</td>
<td>Commune: ___________________</td>
</tr>
<tr>
<td>Lieu de résidence: __________________</td>
<td>Commune: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date de Naissance: __________________</th>
<th>Age: ________ ans (année)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Statut VIH + du conjoint: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

| Occupation: __________________ |
|------------------------------|---|

### Suivi en Clinique Prénatale

| Code de service prénatal: __________________ |
|------------------------------|---|

<table>
<thead>
<tr>
<th>Date de Dernière Règle: ________</th>
<th>Si oui, Suivi communautaire: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Probable d'accouchement: ________</th>
<th>Si oui, Suivi communautaire: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diagnostic VIH +: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Num du site: ________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fëtus viable: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date de Décès: ________</th>
</tr>
</thead>
</table>

### Suivi PTME

| Code entitément PTME: __________________ |
|------------------------------|---|

<table>
<thead>
<tr>
<th>Test CD4: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Première dose de prophylaxie: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

| Age gestationnel en semaine de grossesse à la première dose: ________ |
|--------------------------|---|

### Suivi à la Maternité

| Code service Maternité: __________________ |
|------------------------------|---|

<table>
<thead>
<tr>
<th>Accouchement Institution: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Référence de l'enfant en service pédiatrique: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Enfant Monté: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

### Suivi en Pédriatrie

| Code service Pédiatrique: __________________ |
|------------------------------|---|

<table>
<thead>
<tr>
<th>Prophylaxie du Nouveau-né à 72h: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

| Si oui, Age à la prophylaxie en semaine: ________ |
|--------------------------|---|

### Suivi en ARV

| Code entéitment ST: __________________ |
|------------------------------|---|

<table>
<thead>
<tr>
<th>Accouchement domicile: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Prophylaxie à Domicile: Oui</th>
<th>Non</th>
</tr>
</thead>
</table>

| Date: ________ |
|--------------|---|
SAFE process

• During antenatal and postnatal care, key benchmarks are tracked and record
  o Ensuring that mothers and infants receive appropriate care, prophylaxis and treatment

• CM initiate outreach efforts as needed for the lost to follow-up
SAFE process

- SAFE data are automatically uploaded to the National MSPP HIV Case Surveillance Registry

- Data are just becoming available after 1 year of implementation. In the future, data will be routinely analyzed to:
  - to track epidemic progress
  - To monitor use and effectiveness of Haiti’s PMTCT system
**Bolded case management reminders appear in this column for key patient events.**

(patient data obscured)
Challenges and next steps

- **Challenges:**
  - Lack of infrastructure (internet, computers)
  - Staffing (understaffing, turnover)
  - Lack of accountability and “data culture”

- **Goals for next 12 months:**
  - Integrate data with core surveillance
  - Continue to evaluate process and outcomes
  - Develop and publish a pediatric cascade
  - Validate data for completeness and accuracy
Sample PMTCT care continuum

- Est # of pregnant women: 100,000
- Pregnant women who attend ANC1: 90,000
- Pregnant women with known HIV status: 80,000
- HIV+ pregnant women identified in reporting period: 20,000
- HIV+ pregnant women initiating ART: 17,000
- HEI tested: 10,000
- HIV infected infants: 1,000
- HIV infected infants new on ART: 750

- 90% of pregnant women attend ANC1
- 89% of pregnant women with known HIV status are identified
- 85% of HIV+ pregnant women are tested
- 50% of HEI tested are initiated on ART
- 75% of HIV infected infants are on ART