COMMUNITY TREATMENT OBSERVATORY

PILOT REPORT

FEBRUARY 2023

JN+
Jamaican Network of Seropositives

ITPC
INTERNATIONAL TREATMENT PREPAREDNESS COALITION

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Abbreviations

ART - Antiretroviral Therapy
ARV – Antiretrovirals
CCG – Community Consultative Group
CTO – Community Treatment Observatory
FGD – Focus Group Discussions
HCW _Healthcare workers
ITPC - International Treatment Preparedness Coalition
JN+ - Jamaican Network of Seropositives
MSM – Men having Sex with Men
PLHIV – People Living with HIV
RoC – Recipients of Care
TG - Transgender

Executive Summary

The Community Treatment Observatory (CTO) was piloted by the Jamaican Network of Seropositives between August and December 2022 with the main objective of improving retention in care of People Living with HIV. It was supported both on technical and financial levels by the International Treatment Preparedness Coalition (ITPC). ITPC provided training of relevant stakeholders in the establishment of a CTO, data collection, data analysis and advocacy, as well as guidance and technical support in the various processes of the CTO such as the development of indicator frameworks, data collection tools, setting up the Community Consultative Group (CCG) and data analysis.

Between September and December 2022, 158 recipients of care were interviewed; twelve interviews with healthcare workers were done; and 17 focus group discussions were conducted. The data collection sites were Cornwall Regional Hospital, Montego Bay Type V, Savanna-la-mar General Public Hospital, Noel Holmes Hospital (Lucea), Duncan's Health Center and Jamaica AIDS Support for Life.

The resulting data was analysed to provide a baseline for the Western Region in terms of a snapshot of HIV treatment, retention in care/lost to follow up and viral load suppression. The CTO also monitored accessibility, acceptability and appropriateness of HIV services, as well as attitudes, behaviours and beliefs of recipients of care.

The key findings of the pilot phase of the CTO have been developed based on the analysis of areas which seem to present potential challenges to retaining PLHIV on quality care.

An overview of the compiled data from all six healthcare facilities shows that as of October 2022, 3,839 PLHIV were registered within these healthcare centres, and so considered to have been linked to care. There is a 21% decrease in the number of PLHIV between being linked and retained in care after 12 months or more. 93% of PLHIV still on ART after 12 months or more received a viral load test, but 43% did not receive the results within 6 months. Overall, 70% of PLHIV linked to care are virally suppressed.

Men aged between 25 and 43 years old and women aged between 18 and 24 years old appear to be the most vulnerable to being lost to follow up and having a detectable viral load. Women aged 18-24 years old, and men aged 25-34 years old have the highest lost to follow up rate, of 40% and 37% respectively. The lowest viral load suppression rates by age group are among men aged 25-34 years old (52%) and women aged 18-24 years old (51%). This could point to specific age-related challenges that they are facing to stay in care and properly take their ARVs. The CTO should follow-up on these age groups to establish if the same trend is applicable in the long term and among other data sites. Focus group discussions should further explore challenges experienced by these age groups to understand what strategies could be developed to reduce their vulnerability.

Long waiting times and challenges linked to employment and medical appointments also point to potential challenges that are negatively affecting retention in care. While 48% of recipients of care consider that a waiting time of 30 minutes to one hour is acceptable, 67% of them report an average waiting time of more than one hour (including 44% who report 2 hours or more). 29% of recipients of care that had missed a medical appointment in the last

3 months reported that it was due to work obligations. Advocacy to reduce waiting time, including addressing the lack of clinicians, limited physical infrastructure and number of clinic days should target long-term structural changes to improve retention in care. Piloting differentiated service delivery models that could support care retention should also be considered, including community-based ARV dispensation.

In all six health facilities, a large percentage of recipients of care reported no issues with confidentiality, stigma and discrimination or being refused services. This is positive feedback for all the health facilities. However, 70% of these respondents were found within Cornwall Regional Hospital, Montego Bay Type V and Savanna-la-mar General Public Hospital. It would be beneficial to further investigate these three health facilities to understand what practices, training and/or framework could be documented as a best practice and replicated in other health facilities in the future.

Methodology

The Community Treatment Observatory (CTO) was piloted by the Jamaican Network of Seropositives (JN+) between August and December 2022. This section details the steps of this pilot process and the methodology used for data analysis.

Figure 1: Summary of methodology to develop the CTO report

The development of this report was based on the following processes:

1. Data sites from the Western Region of Jamaica were selected by JN+, based on epidemiological data and the willingness of this region to participate in the pilot phase of the CTO. The selected sites were Cornwall Regional Hospital, Montego Bay Type V, Savanna-la-mar General Public Hospital, Noel Holmes Hospital (Lucea), Duncan's Health Center and Jamaica AIDS Support for Life.
2. The CTO pilot was kickstarted in August 2022 with a training delivered by ITPC on how to establish a CTO, targeting 28 participants from JN+ and relevant stakeholders from the public health sector and civil society.
3. Data collection tools, indicator frameworks, data processes and the online data base were developed by ITPC and JN+ between August and September 2022, based on the decision taken during the training to focus the CTO on improving the retainment in care of People Living with HIV (PLHIV).
4. JN+ staff followed an online training of trainers on data collection in September 2022, followed by the on-site training of data collectors delivered by JN+. Data collection tools were finalised following the training and feedback from data collectors.
5. RoCs were randomly selected based on attendance on treatment days at the respective sites. Participants for the focus group discussions were mobilized through the data collectors and their site supervisors across the region.
6. Data collection started in September 2022 and ended in December 2022. In total 158 recipients of care were interviewed; twelve interviews with healthcare workers (HCW),

were done, including the collection of patient data; and 17 focus group discussions (FGD) were conducted.

7. Data inputting into the online system was done by JN+ over November and December 2022.
8. Data quality checks were done by ITPC over November-December 2022 to ensure that there were no errors during the data collection and inputting phases.
9. In January 2023, a data analysis and advocacy training was held by ITPC with JN+ staff and during this training, additional data quality checks were.
10. The data analysis which forms the basis of this report has been done by comparing collated data from the RoC interviews, HCW interviews and statistics provided and the FGD with RoC. Where possible, cross-analysis between the three types of data collection was done.
11. The report was shared with JN+ for their input, before being shared with the Community Consultative Group (CCG) and other relevant stakeholders.

The main limitations regarding the process of this report are:

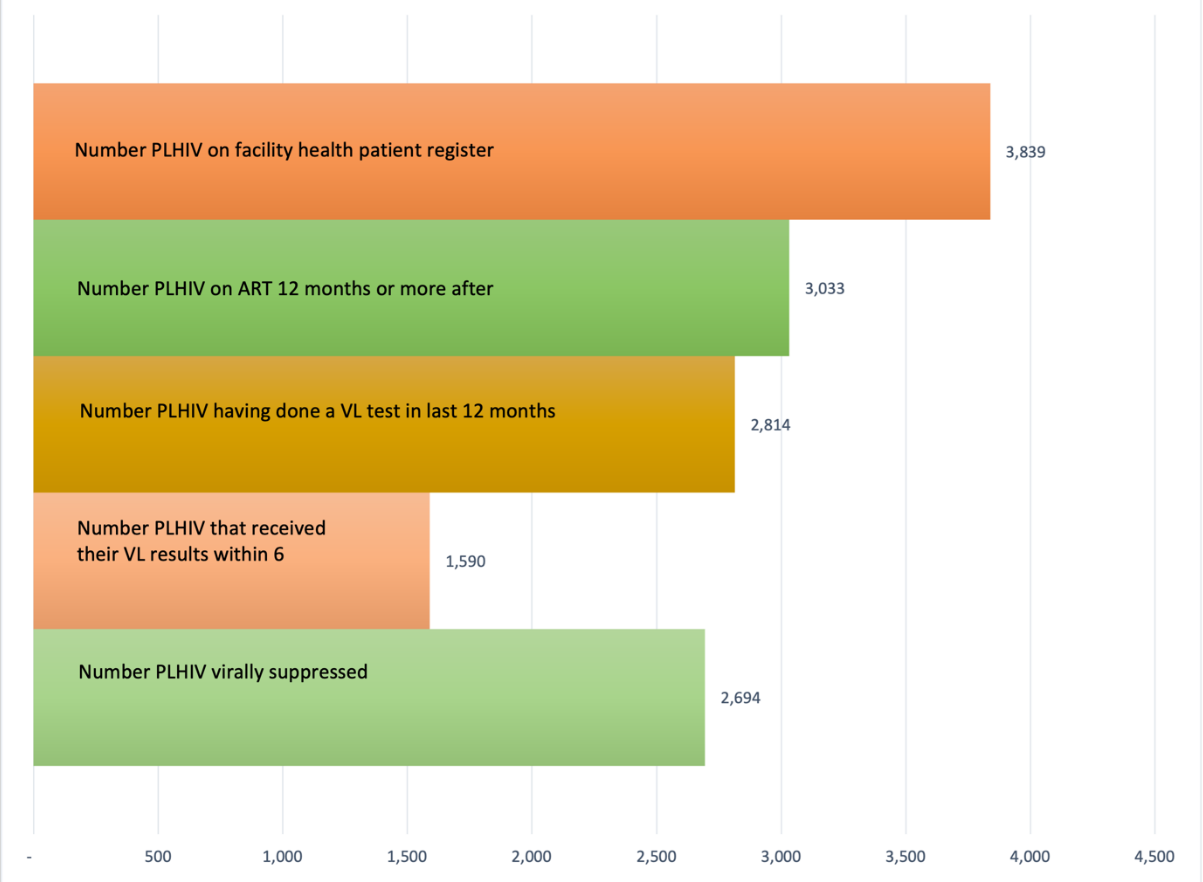
- The data obtained gives a snapshot of the current situation in the western region and with no comparison point, there cannot be conclusions derived from this data, only key findings that need further exploring or confirming.
- There were challenges in mobilising and organising focus group discussions- stemming from lack of interest among prospective participants, availability, inadequate incentives (travel stipend, etc) and location/facilities for hosting focus groups. Additionally, the capacity of the data collectors limited the depth and scope of the discussions in the FGDs. As a result, this did not bring much insight from the trends found in the quantitative data.
- The communities of Men having Sex with Men (MSM) and Transgender (TG) people were very hard to mobilise and meet for targets for the focus groups. Therefore, a few interviews and FGDs were conducted with these two communities. Since there are not enough members of these communities that have been consulted, this report does not provide sufficient data for any analysis or findings that are representative of these communities.
- Quality checks of the data inputted showed a lack of clarity on the responses ticked by some of the data collectors, introducing a small margin of error regarding the data related to RoC.

1. Snapshot of the treatment cascade in the Western Region of Jamaica

An overview of the compiled data from all six healthcare facilities shows that as of October 2022, there were 3,839 PLHIV registered within these healthcare centres, and so considered to have been linked to care. There is a 21% decrease in the number of PLHIV between being linked and retained in care after 12 months or more.

93% of PLHIV still on ART after 12 months or more received a viral load test, but 43% of these do not receive the results within 6 months. Overall, 70% of PLHIV linked to care are virally suppressed.

Figure 2 Snapshot of key data in treatment cascade of Western region, Oct 2022



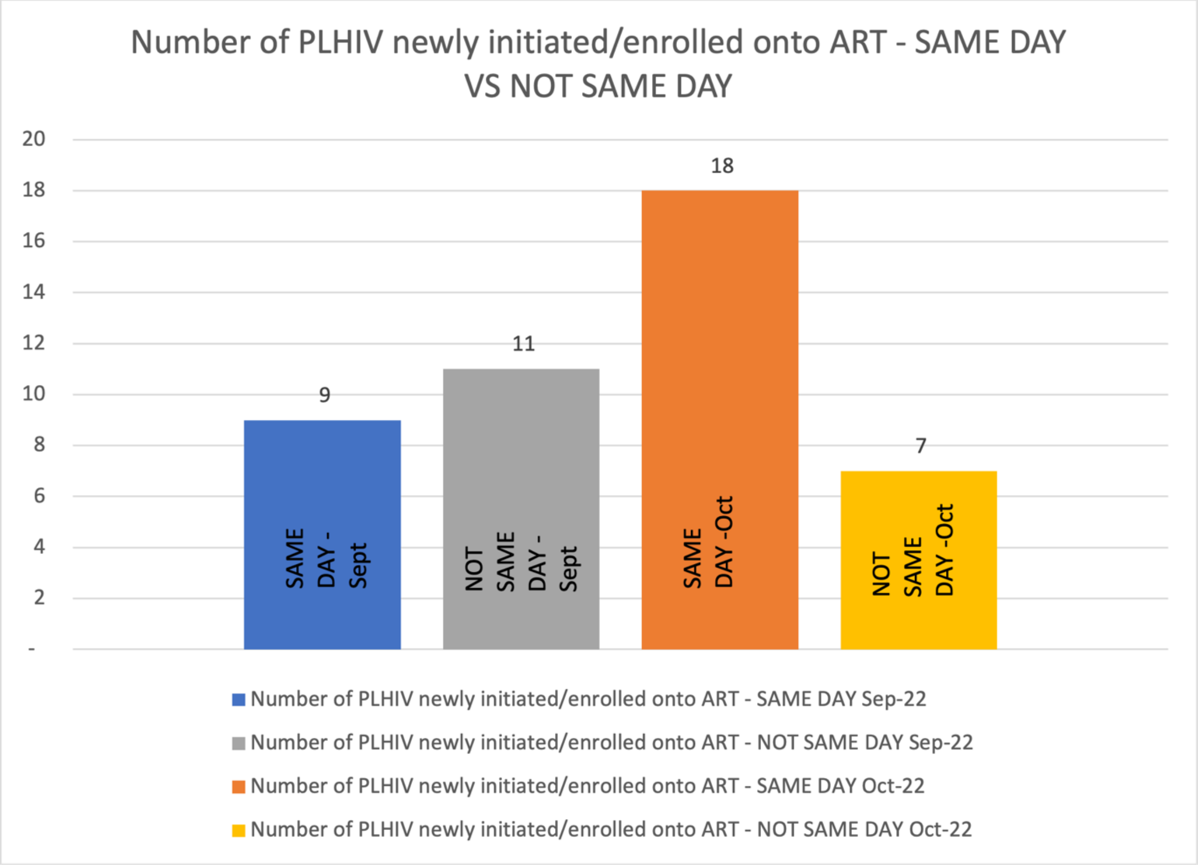
2. HIV treatment and retention in care

This section will further analyse the data from the snapshot of the treatment cascade, namely in terms of the number of PLHIV newly enrolled on ART, on the patient register/enrolled on ART, PLHIV on ART after 12 months (or more), and profiles of patients who are LFTU.

Enrolment on ART

As illustrated in figure 3, there are slight variations between people who are enrolled or initiated on ART the same day as they get their HIV test results and those who are initiated a different day. It must be highlighted that official guidelines in Jamaica require link to care within four weeks.

Figure 3 Number of PLHIV enrolled onto ART (same day v/s not same day), Sept. & Oct. 2022



This type of data is more relevant in the long-term when trends over many reporting periods are compared. However, the pilot of the CTO recorded the following reasons for non-enrolment on the same day:

- 50% of patients were diagnosed on non-clinic days, had to wait over the weekend to be linked to care or there was a delay in receiving their HIV test results.
- 30% due to refusal of patients to be linked to care, or patients are facing mental health challenges that imply they are not ready to start ART
- 12.5% due to lack of ARV

Patient register

When a patient is diagnosed with HIV, they are linked to the HIV service and registered once they are initiated on ART.

In the six healthcare facilities of the CTO pilot, the patient registers totaled 3,839 PLHIV. As illustrated in figure 4, the majority of PLHIV linked to care are men and women above 35 years old.

The number of MSM and TG people registered in health facilities seems low, but it was acknowledged that patients do not all feel comfortable disclosing sexual orientation or gender information, so this may be mis-represented. None of the MSM and TG data in this report can be considered as representative of these communities, and consequently they are not systematically referenced in the data analysis.

PLHIV on ART 12 months (or more)

Figure 5 Number of PLHIV who are on ART 12 months (or more) after initiation, Oct 2022

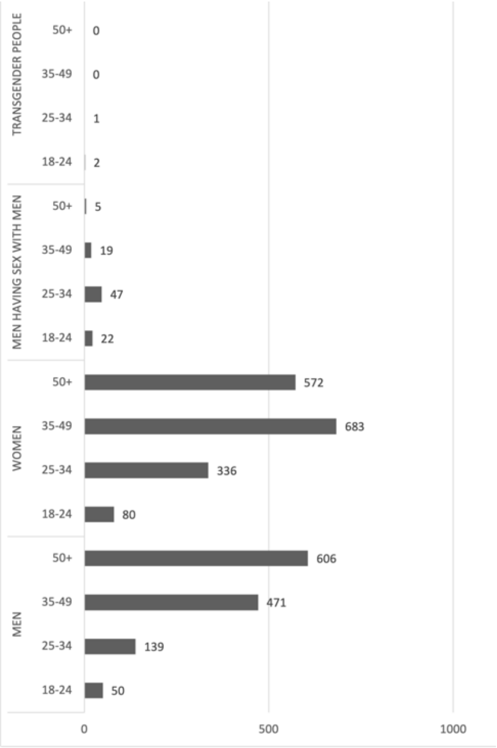
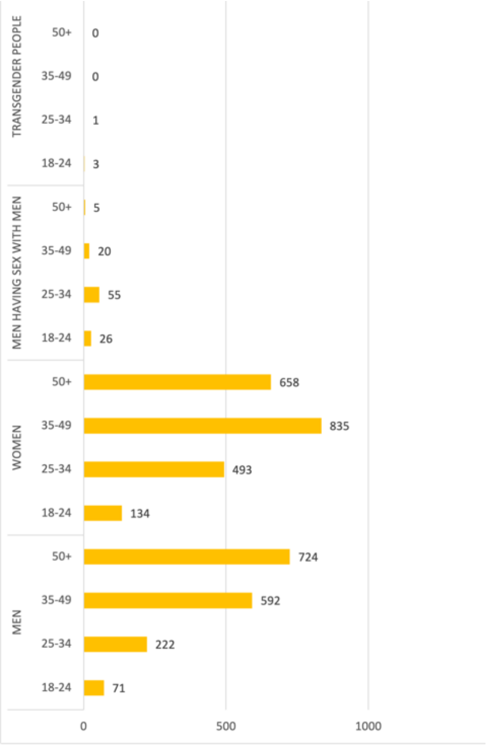


Figure 4 Number of PLHIV on the health facility's patient register, Oct 2022



The highest number of PLHIV who are not on ART after 12 months or more is as follows (figure 5):

- Men: 121 among the 35-49 years old group
- Women: 157 among the 25-34 years old group
- MSM: 8 among the 25-34 years old group
- TG: 1 among the 18-24 years old group

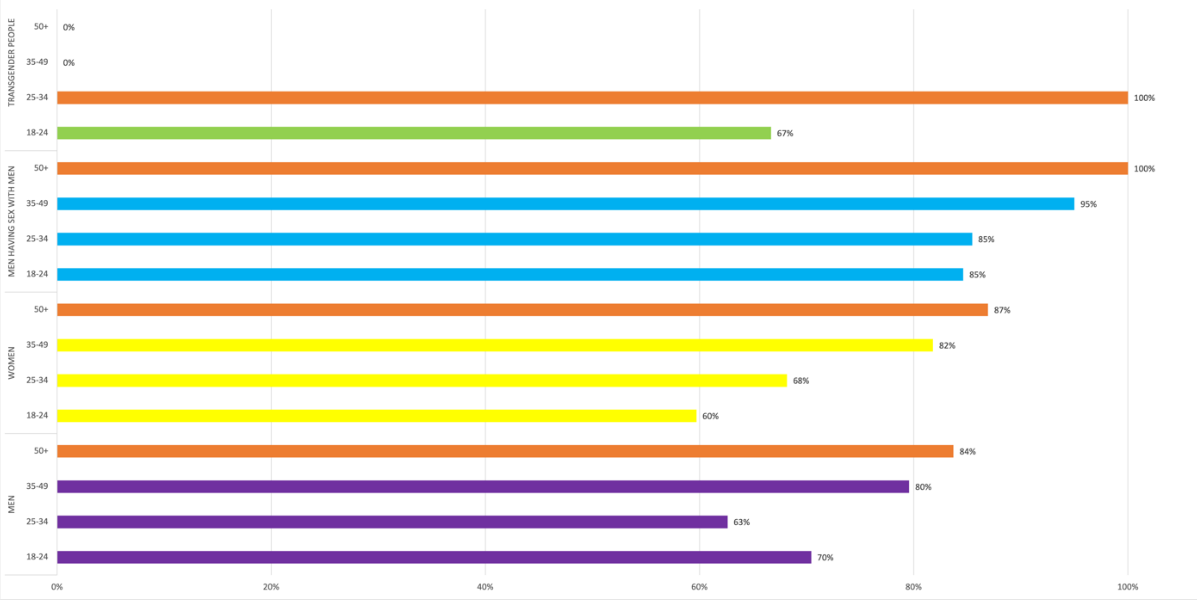
However, when the number of PLHIV on ART after twelve months is compared to the number of patients on the patient register to produce the retention rate in care after 12 months, the age groups differ.

A more detailed analysis of these numbers is provided in the next section.

The group with the highest percentage of retention in care after 12 months or more was systematically the age group 50 years or more for men (84%), women (87%), MSM (100%).

The 25-34 years old age group had a 100% retention rate among TG people (see red results in figure 6).

Figure 6 % PLHIV on ART after 12 months, Oct. 2022



Profile of PLHIV who are Lost To Follow Up

A total of 806 PLHIV were not accounted for between the moment they were initiated on ART/registered in the healthcare facility to twelve of more months after their initiation. For the purposes of this report, we consider that these PLHIV are lost to follow-up. However, we are aware that other reasons, such as the death rate and patients changing their health facilities that can affect these figures.

42% of the total number of PLHIV LTFU are men, 56% are women and 2% are MSM.

The highest number of PLHIV who are not retained on ART 12 months or more after initiation are within the 25-34 years old age group for women and within the 35-49 years old age group for men.

Figure 7 Number of PLHIV who are Lost To Follow Up, Oct 2022

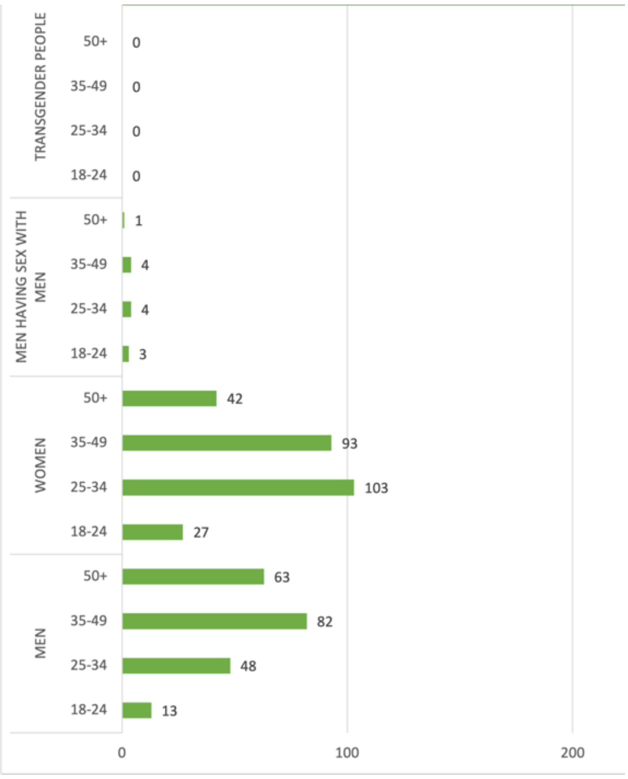
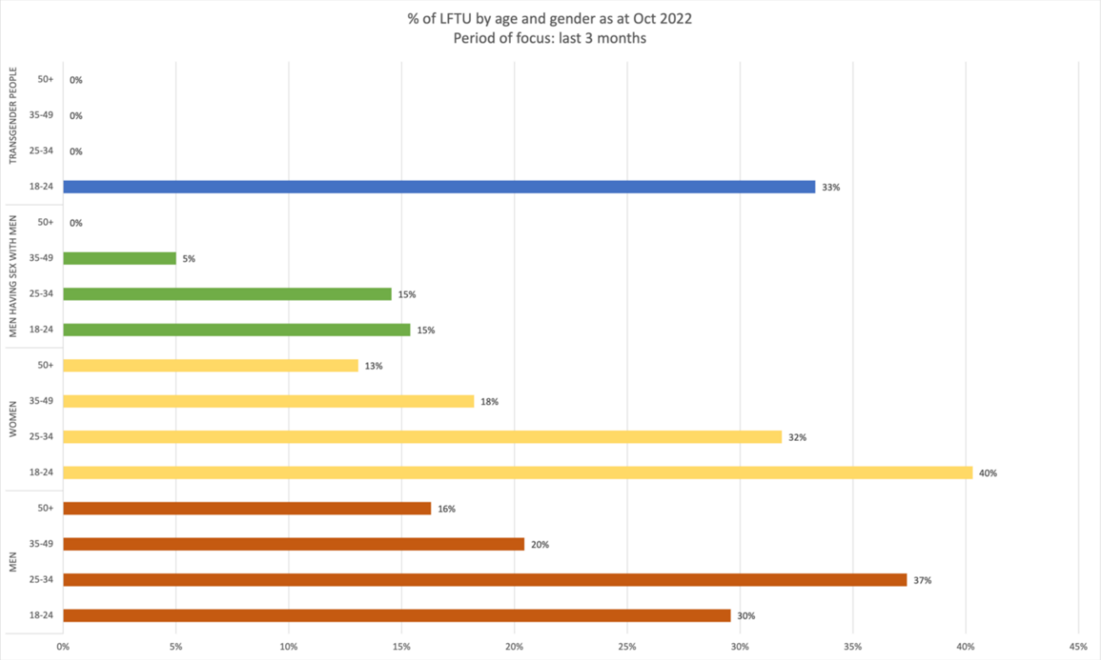


Figure 8 below illustrates the highest lost to follow up rate per age group. These percentages have been calculated by comparing the number of PLHIV LTFU per age group with the total number of PLHIV in the health register for the same age group.

Figure 8 % of LFTU by age and gender, Oct 2022



Among women, the 18-24 years old age group has the highest LFTU rate (40%). Among men, the 25-34 years old age group has the highest LFTU rate (37%).

76% of LTFU among young women aged 18-24 years old and 82% of LTFU among men aged 25-34 years old are found within Cornwall Regional Hospital, Montego Bay Type V and Savanna-la-mar General Public Hospital, that are among the largest health facilities of the Western region.

The reasons for patients being LTFU, according to HCW interviews are:

- 26% due to mental health issues such as depression, giving up ART because of being tired/hopeless, refusing treatment, denial of HIV status.
- 22% due to logistical or geographical reasons such as migration, patients changing parish, and incapacity to locate the patient (e.g.: change of phone number)
- 13% due to fear of inadvertent disclosure of HIV status in seeking treatment, fear and stigma and discrimination
- 9% due to patients claiming they have moved to the private healthcare sector
- 9% due to work-related reasons
- Other various reasons (22%) include patients feeling better, receiving non-traditional healing, competing priorities and personal challenges.

The strategies to reduce LTFU implemented by health facilities, as reported by HCW are:

- Internal organisation of the health service, with retention committees and assignment of different cohorts to the staff to retain in care

- Telephone calls to PLHIV to remind them of their appointments, follow-up and reschedule missed appointments and generally to keep in touch
- Home visits to follow-up when appointments are missed, garner family support and conduct needs assessments
- Involvement of the contact investigator to locate and bring back to care LTFU
- Referral to psychologists when relevant
- Provision of stipends and food vouchers to PLHIV who face financial challenges

Focus group discussions provided similar input, however, the main focus was on the importance of a strong support system (family/friends, peers, counselling) to reduce LTFU. Additionally, follow-up phone calls after a missed appointment and highlighting the importance of taking ART during counselling/initiation/sensitization sessions were also mentioned.

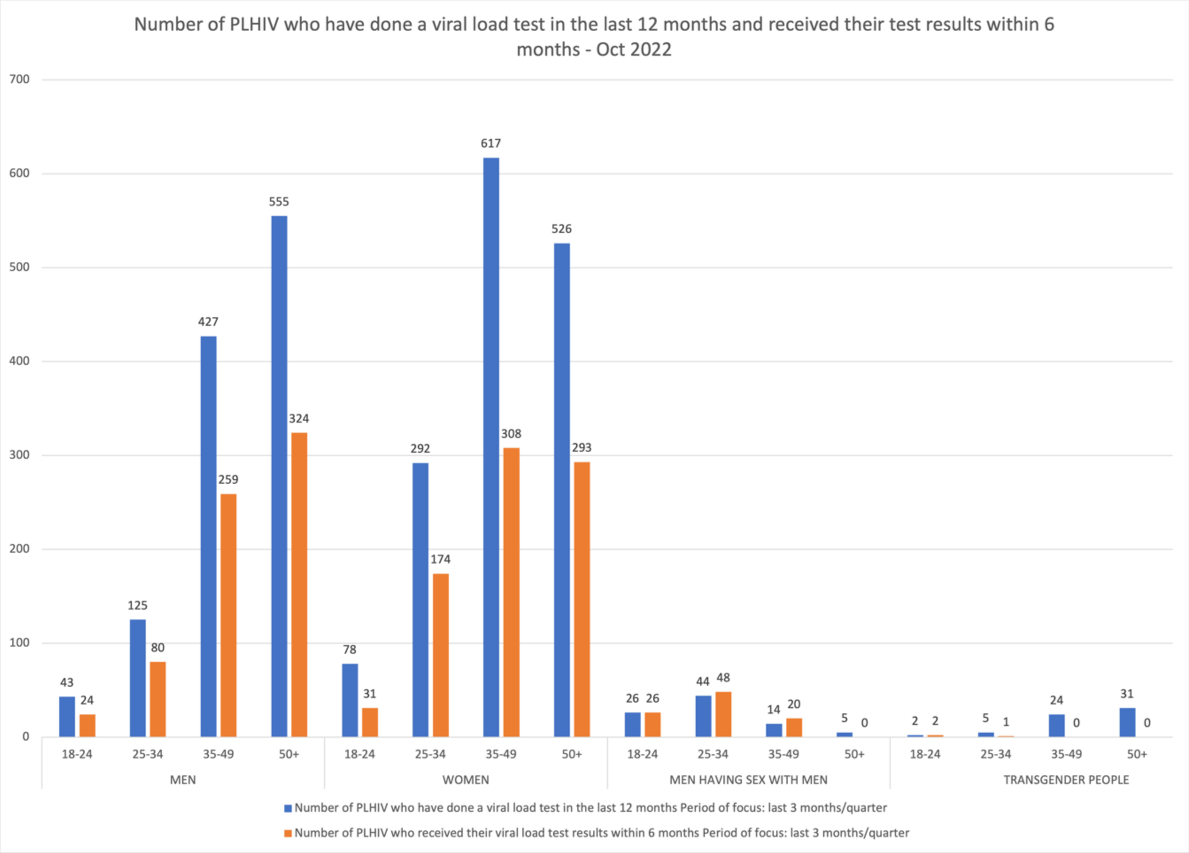
The additional resources identified by healthcare workers to retain more PLHIV in care are mainly related to physical and human resources – HIV clinicians and staff such as case managers, the possibility of opening evening clinics, and increased office space for non-clinician workers to receive more PLHIV and provide better services. More resources for support groups and for assisting patients facing financial challenges (stipends/vouchers) were also mentioned.

3. HIV viral load testing and suppression

The following section analyses data related to viral load testing. It compares the number and rate of PLHIV on ARV for 12 months or more who have received a viral load test in the last 12 months, as well as the timeframe for receiving results and the viral load suppression rate.

PLHIV who received a viral load test in the last 12 months and received the results within 6 months

Figure 9 PLHIV who received a viral load test in the last 12 months and received the results within 6 months - Oct 2022



Statistics provided by healthcare workers indicated that 2,814 PLHIV received a viral load test in the twelve months preceding October 2022. This represents 93% of PLHIV on ART 12 months or more after initiation and 73% of PLHIV initiated on ART.

The breakdown of PLHIV on ART after 12 months or more and having received a viral load test in the last 12 months is as follows:

Gender	Highest viral load testing rate	Lowest viral load testing rate
Men living with HIV	Age group: 50 years old + (84%)	Age group: 25-34 years old (63%)
Women living with HIV	Age group: 50 years old + (87%)	Age group: 18-24 years old (60%)

From the PLHIV who have done a viral load test in the last 12 months, 43% did not receive their test results within 6 months.

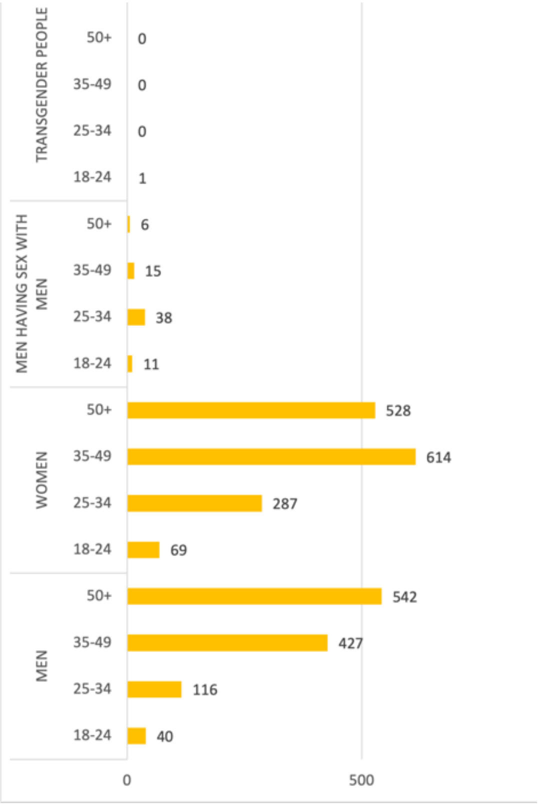
The 18-24 years old age group among men and women had highest rates of not receiving their test results within 6 months, respectively 44% and 60%. The 25-34 years old age group among men and women had the highest rate of receiving test results within 6 months, respectively 64% and 60%.

The most common reasons given by healthcare workers for both viral load testing not being in the last 12 months and test results taking longer than 6 months to be received are that the patient is LTFU or has missed their appointment (either for the blood sample or to collect results). It also happens, but rarely, that the blood sample is lost at the level of the national laboratory and the test must be re-done.

Feedback from focus group discussions confirm that there is a long wait for viral load testing results, and this causes disappointment in some patients. However most feedback reports that there is no issue at this level and so the consequences of the waiting time have to be further explored to identify if this is a factor that negatively affects retention in care.

PLHIV on ART who are virally suppressed

Figure 10 Number of PLHIV on ART who are virally supressed - Oct 2022



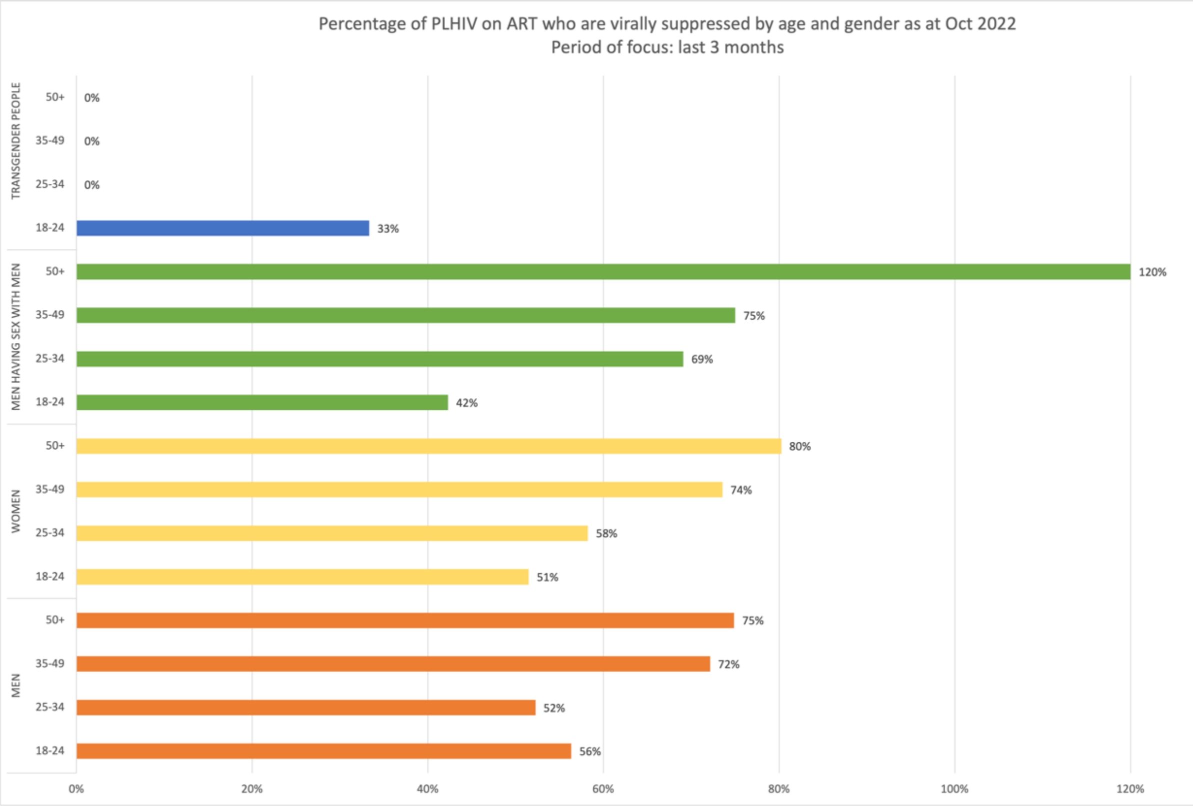
In total 2,694 PLHIV were reported as virally supressed as of October 2022. Most of these were women living with HIV aged 35-49 years old and men living with HIV aged 50 years or more.

The lowest number of PLHIV who were virally suppressed were among the 18-24 years old age group among men and women.

However the actual numbers are not very revealing, so a further analysis of rates of viral load suppression, calculated based on the proportion of PLHIV on ART after 12 months or more who are also virally supressed was conducted.

As illustrated below in the figure 11, the lowest viral load suppression rates are among men aged 25-34 years old (52%) and women aged 18-24 years old (51%). The highest viral load suppression rates are among the age group 50 years old or more for both men and women.

Figure 11 Percentage of PLHIV on ART who are virally suppressed by age and gender - Oct 2022



4. Accessibility of HIV services

Waiting time and convenience of operating hours

As illustrated in figures 12, 13 and 14, 49% of Recipients of Care interviewed consider the waiting time in health facilities as too long. While 48% of RoC consider that a waiting time of 30 minutes to one hour is acceptable, 67% of RoC report an average waiting time of more than one hour (including 44% who report 2 hours or more).

Figure 12 Average waiting time of recipients of care from registration to seeing a member of the health team - Oct 2022

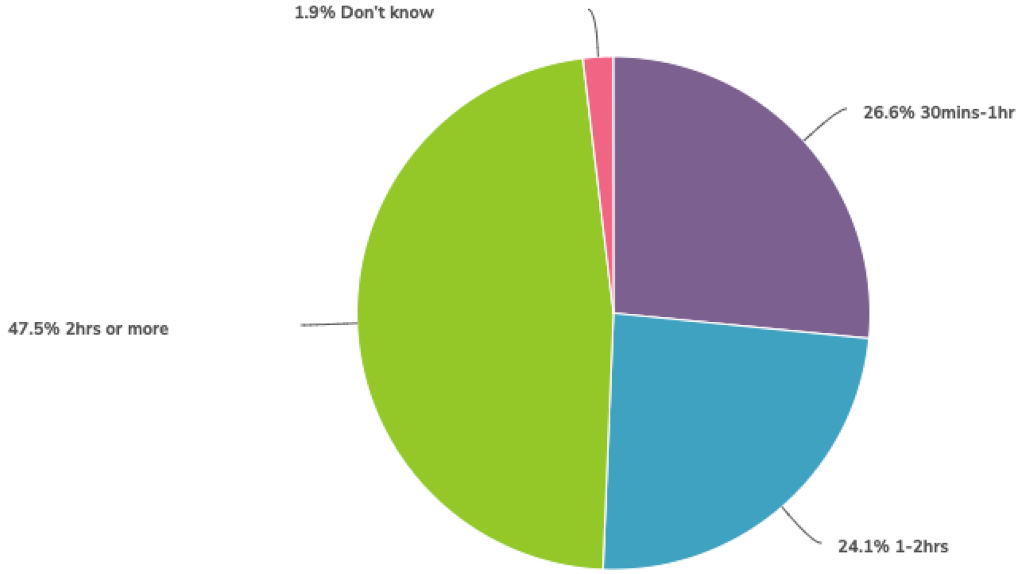


Figure 13 Opinion of recipients of care on whether the waiting time at the facility is too long or not, Oct 2022

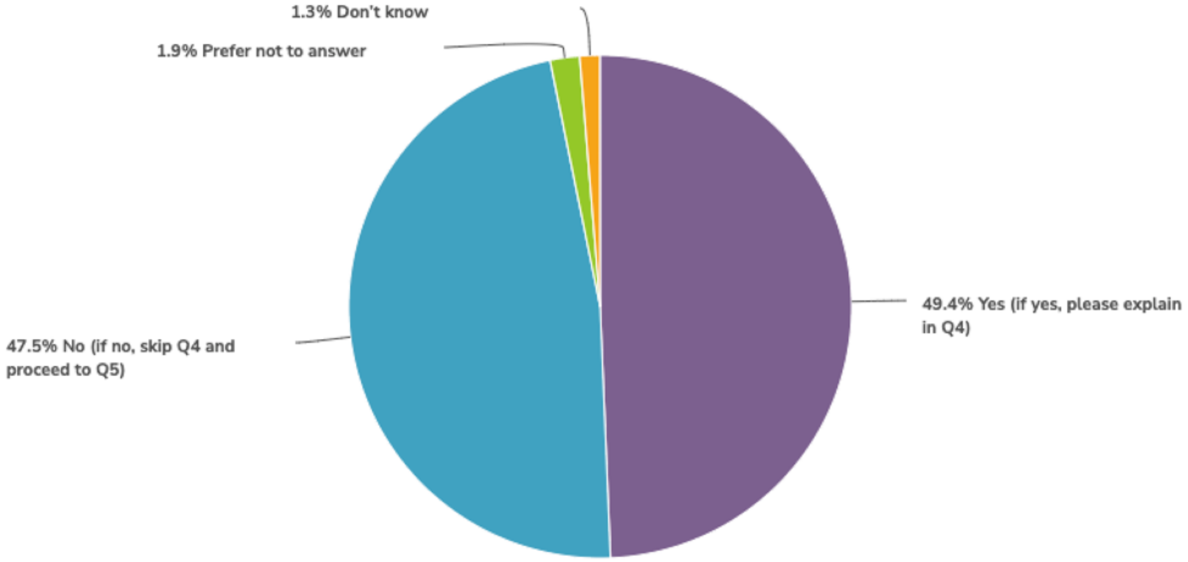
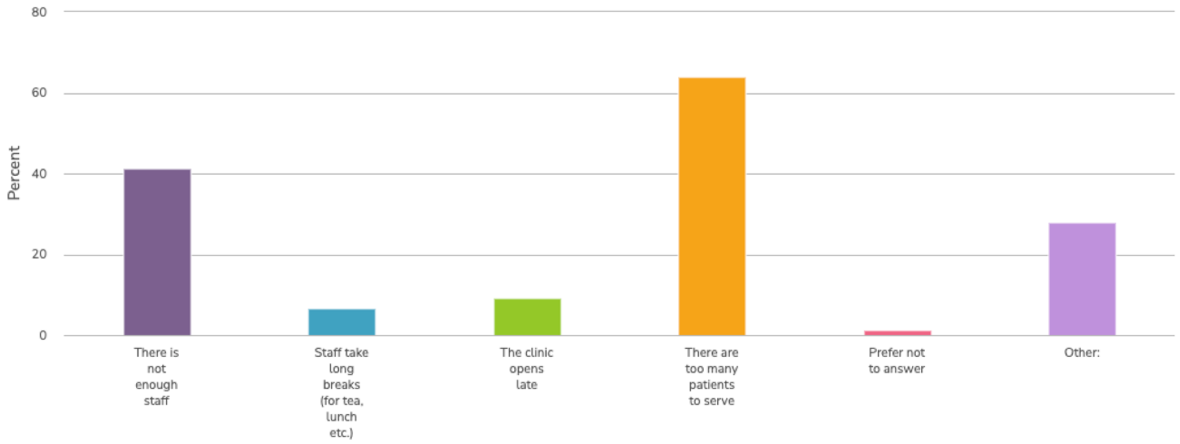


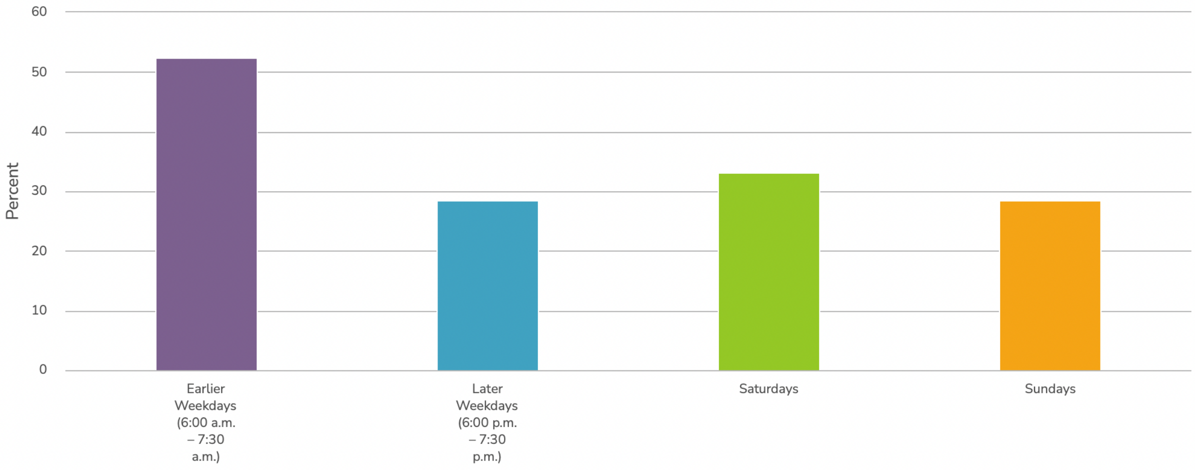
Figure 14 Reasons for long waiting time as per recipients of care feedback, Oct 2022



The most common reason reported for the waiting time is that there are too many patients and not enough staff. The health facilities with the longest waiting times (2 hours or more) are predominantly Cornwall Regional Hospital and Noel Holmes Hospital (Lucea), two facilities that only have one day per week where the clinic is open to People Living with HIV.

89% of recipients of care consider that the operating hours of health facilities are convenient. Among the 10% who do not find the operating hours convenient, 52% would prefer earlier operating hours (6am to 7:30am) and 33% prefer Saturdays.

Figure 15 Feedback from recipients of care on more convenient operating hours, Oct 2022



Referral processes with other in-house services

90% of recipients of care interviewed consider transition to other in-clinic services at this facility to be smooth. From the 8% that declare the referral processes are not smooth, 70% link this to long waiting time, and related factors such as long administrative processes, understaffing and consequently consultations are too short.

5. Acceptability of HIV services

This section analyses the perception of recipient of care towards how much their health facility keep their HIV status private and confidential, if they've ever experience stigma or discrimination in the facility or been refused services due to discrimination. The results from the interviews of recipients of care are summarised below and additional insights from the focus group discussions with them are included.

Refusal of services, experience of stigma or discrimination and level of confidentiality of facility

87.8% of recipients of care consider that the health facility keeps their HIV status private and confidential. 4% of respondents found issues such as disclosure of HIV status to third parties without consent and inadvertent disclosure of status when heath care workers conduct home visits.

93% of recipients of care have not experienced stigma or discrimination from anyone in their health facility. The most common example given from the 6% that report stigma and discrimination and participants of focus group discussions was from "nurses being disrespectful or breaching confidentiality".

0% of recipients of care have been refused services due to discrimination based on HIV status, gender or sexual orientation. As there were very few recipients of care interviews of non-binary/transgender people, and men who have sex with men, the result is not representative of refusal of services based on gender or sexual orientation.

Complaint system in health facility

85% of recipients of care know who to contact if they have a complaint to make. Most respondents listed a variety of healthcare workers they could contact, but the three most common ones were the social worker, the adherence counsellor, and the community facilitator.

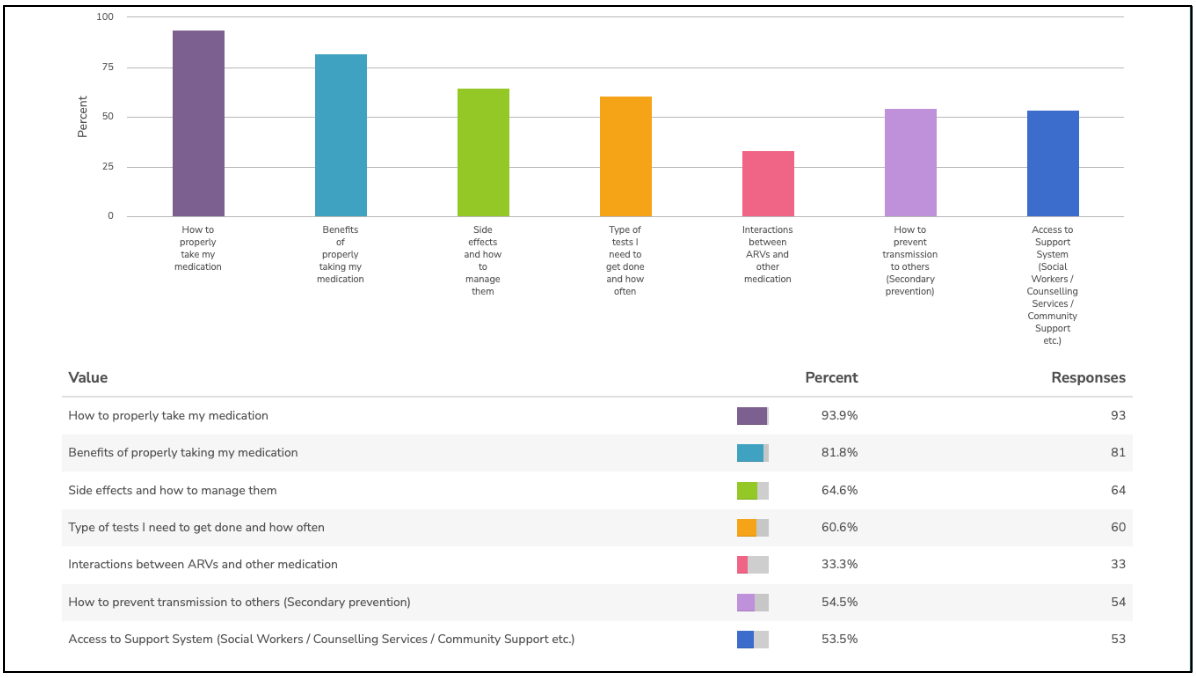
6. Appropriateness of HIV services

The following section will look into the appropriateness of HIV services focusing on the type of information received during ART initiation. Originally this section also included sensitivity of health facilities to the needs of men who have sex with men and transgender people, but due to lack of enough respondents, this is excluded from the report.

Level of information during treatment initiation

Figure 16 illustrates how the focus of ART initiation is on how to properly take ARVs including why it is important to take them and what are the side effects. The areas that can be reinforced during initiation on ART are more information on interaction between ARVs and other medication, access to support systems and how to prevent transmission to others (secondary prevention).

Figure 16 Type of information received during ART initiation reported by recipients of care, Oct 2022



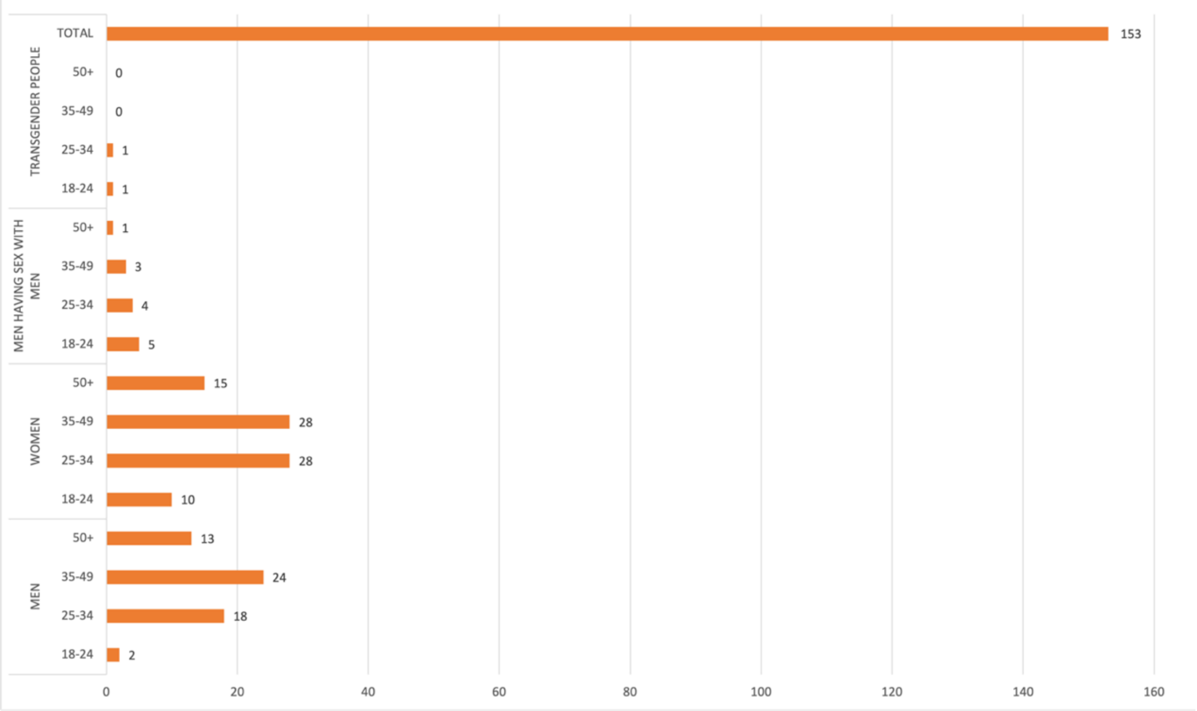
Value		Percent	Responses
How to properly take my medication	🟪	93.9%	93
Benefits of properly taking my medication	🟦	81.8%	81
Side effects and how to manage them	🟩	64.6%	64
Type of tests I need to get done and how often	🟧	60.6%	60
Interactions between ARVs and other medication	🟥	33.3%	33
How to prevent transmission to others (Secondary prevention)	🟪	54.5%	54
Access to Support System (Social Workers / Counselling Services / Community Support etc.)	🟦	53.5%	53

7. Attitudes, beliefs, and behaviours of recipients of care

Appointments and ARV intakes missed

The total number of missed appointment reported by healthcare workers during the last 3 months before the reporting period was 153. 53% of these were accounted for by women, 37% by men, 8% by MSM and 1% by TG. Appointments missed by women were highest in the 25-49 years old age group and by men within the 35-49 years old age group.

Figure 17 Number of PLHIV who have missed their appointments in the last 3 months, reported by healthcare workers, Oct 2022



Interviews of recipients of care reported 22% of respondents having missed a medical appointment in the last 6 months. From these, nearly one third (29%) indicated it was due to work obligations and 19% indicated it was due to forgetting their appointment and/or not receiving a reminder call from the health facility.

The two most common challenges causing missed appointment that were mentioned in focus group discussions are related to financial constraints and working hours (lack of flexibility of working hours).
The following were also mentioned:

- geographical or logistical constraints such as the long distance to the facility meant they arrived too late for the appointment, and inadequate transport systems
- fear of being recognised at the facility

41% of recipients of care reported having missed an ARV intake in the last month. 33% of these missed 2 days intake and 29% missed 1 day of treatment. The reasons given were:

- 35% reported having forgotten to take their medication
- 25% reported running out of ARVs
- 20% were travelling and did not bring medication with them.

During the focus group discussions among recipients of care the following were other reasons commonly mentioned for missing ARVs:

- Not having a safe space at home (partner not knowing status) or family support
- Lack of food when medication was due to be taken

8. Conclusions

Key findings of CTO pilot phase

The key findings of the pilot phase of the CTO have been developed based on the analysis of areas which seem to present potential challenges to retaining PLHIV on quality care. However, the analysis is limited by the fact that this baseline data can only point to areas of concern and does not draw any conclusions.

The following key findings were derived from the analysis:

- Men aged between 25 and 43 years old and women aged between 18 and 24 years old appear to be the most vulnerable to being lost to follow up and not virally suppressed.
- Women aged 18-24 years old, and men aged 25-34 years old have the highest lost to follow up rate, 40% and 37% respectively.
- The lowest viral load suppression rates by age group are among men aged 25-34 years old (52%) and women aged 18-24 years old (51%). This could point to specific age-related challenges that they are facing to stay in care and properly take their ARVs.
- The data also indicates that long waiting times and challenges linked to employment and medical appointments also present potential challenges that affect retention in care.
- While 48% of recipients of care consider that a waiting time of 30 minutes to one hour is acceptable, 67% of them report an average waiting time of more than one hour (including 44% who report 2 hours or more). 29% of recipients of care that had missed a medical appointment in the last 3 months reported that it was due to work obligations. In all six health facilities a certain number of recipients of care reported no issues with confidentiality, stigma and discrimination or bring refused services. This is positive feedback for all the health facilities. However, 70% of these respondents were found within Cornwall Regional Hospital, Montego Bay Type V and Savanna-la-mar General Public Hospital

Key considerations for the upscaling of CTO

The recommendations for the upscaling of the CTO by JN+ is based on lessons learnt from the pilot phase. The CTO will be upscaled to all four health regions in the country, with nine data sites and 16 data collectors.

The following recommendations are technical considerations for the upscaling of the CTO:

- Consider developing an identity/brand or name for the CTO so that all stakeholders are familiar and can identify with the activity.
- Review the data collection tools to simplify the language, clarify misinterpreted questions, especially related to the focus group.
- Standardize the period of focus on data collection for healthcare worker interviews.

- Strengthen the training of data collectors by providing more time for troubleshooting of tools, with special focus on building capacity in the use of tablets and facilitating focus group discussions (including correct use of recording devices).
- Use both tablets and paper versions of the questionnaires for at least the first round of data collection to ensure quality control and correct use of tablets.
- Consider building capacity for program staff in data analysis techniques for faster and more efficient data analysis of large volumes of quantitative and qualitative data, especially as, the CTO matriculates across the island.
- Consider alternatives to ensure input of MSM and TG communities are statistically represented in future data collection.

The following recommendations are related to more in-depth analysis of trends identified during the CTO pilot:

- Given the data on viral suppression rates among men aged 25-34 years old and women aged 18-24 years old, it is recommended that the CTO should follow-up on these age groups to establish if the same trend is applicable in the long term and among other data sites. This could point to specific age-related challenges that are impacting PLHIV staying on treatment and in care. Focus group discussions should further explore challenges experienced by these age groups to understand what strategies could be developed to reduce their vulnerability.
- Advocacy to reduce waiting time, including addressing the lack of clinicians, limited physical infrastructure and number of clinic days should target long-term operational changes to improve retention in care. Piloting differentiated service delivery models that could support retainment in care should also be considered, including community-based ARV dispensation.
- It would be beneficial to further investigate practices, training and/or framework at Cornwall Regional Hospital, Montego Bay Type V and Savanna-la-mar General Public Hospital because 70% of their respondents had no issue with confidentiality, stigma and discrimination or being refused services.

Technical needs for way forward

The following technical needs have been identified by JN+ to support the upscaling of the CTO:

- Introduce and build internal capacity on using a data analysis software to facilitate data analysis of large volumes of quantitative and qualitative data (for example SPSS or MAXQDA).
- Online guidance and technical support on launching the upscaled CTO through check ins and advice via email or Zoom.
- Technical support mainly on data analysis and data quality audit of data collection of the upscaled CTO, to include guidance on how to use quantitative data analysis to inform FGD guide.