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Empowering community groups to support access and retention in HIV care in Muheza, Tanzania

In early 2014, ASSIST, with support from PEPFAR, began the Community Linkages activity in five villages of Muheza District of Tanga Region in Tanzania, building on existing work at the facility level to increase retention in the HIV continuum of care. The Community Linkages component aimed to improve retention in care for people living with HIV (PLHIV) by increasing linkages between health facilities and communities.

ASSIST engaged community groups to support the work of existing Ministry of Health home-based care (HBC) volunteers to improve access to HIV/AIDS services and retention in care in their villages using the Community Health System Strengthening (CHSS) model. The CHSS model contributes to the PEPFAR 3.0 strategy by improving the performance of community-based health workers and increasing linkages between communities and health facilities to improve HIV prevention, treatment, and care, thus contributing to morbidity and mortality reduction. The CHSS model was thought to be a promising strategy in Muheza, where rural communities, though possessing limited material resources, have their own informal health and social welfare systems where community members make decisions and work together to improve the health of community members and the general welfare of the community. The basic concept of the CHSS model is to bring together representatives from all of these groups, the facilities, and local government to constitute a community improvement team that can identify local HIV and health gaps and develop and test locally feasible strategies to bridge those gaps.

As a result of incorporating health talks in their regular meetings and developing messages for community group members to discuss at home, there was an increase in the number of people tested regularly for HIV and a significant increase in the proportion of men being tested. There was an increase in the number of referrals made by the HBC volunteers in addition to strengthening the process of tracking referrals. With the community system, the HBC volunteers received and sent information to households through community groups without having to visit each one individually. Over 7 months, out of 44 individuals ever lost to follow-up, 23 clients were brought back into care, 5 were determined to have relocated, 11 had died, and only 5 were still lost to follow-up as of September 2014. While there will continue to be a small stream of clients newly lost to follow-up in these communities, there is now an active system for tracking and bringing back clients to care as soon as possible, using HBC volunteers, PLHIV groups, and client-chosen treatment supporters in order to maintain confidentiality.

This pilot project demonstrated that applying quality improvement methods at the community level through the CHSS model increased rates of HIV testing and retention in care of PLHIV by extending the reach of community-based health workers and creating efficient information flows between facilities, HBC volunteers, and community groups. The approach leveraged existing community resources by engaging a range of actors (community-based organizations, religious groups, livelihood groups, and other informal networks) to address HIV care at the community level. In this experience, increasing the frequency of open discussion of HIV issues in multiple community venues also seems to have reduced stigma and may have helped with disclosure and therefore increased uptake of HIV testing.

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