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*Applying Science to Strengthen
and Improve Systems*

CASE STUDY

Integrating quality improvement in HIV / AIDS care and treatment in the Lualaba Province of the Democratic Republic of Congo to retain PLHIV on antiretroviral therapy

Summary

In fiscal years 2015-2016, the USAID ASSIST Project funded by PEPFAR provided technical assistance to improve the retention of PLHIV on ART in 10 health facilities in the province of Lualaba. The work was executed in collaboration with two implementing partners: PATH's PROVIC Project and MSH's PROSANI Project. This intervention was guided by the results of a baseline assessment carried out by ASSIST in the care services of PLHIV from July-August 2015. This baseline assessment highlighted quality gaps in PLHIV care, especially retention and adherence to ART. Based on the baseline results, ASSIST's goal is to help improve the retention of PLHIV on ART to ensure that all patients who start antiretroviral therapy adhere to and continue to receive ART.

To achieve its objectives, ASSIST has used the collaborative approach to performance improvement, a process of mutual learning among the 10 sites in the province of Lualaba.

The results show that in November 2015 at the start of the HIV / AIDS collaborative, with a total of 2,358 PLHIV expected in the 10 collaborative sites in the province of Lualaba, only 853 PLHIV were supplied with ARVs: a gap of 1,500 people. With the progressive implementation of change ideas during the intensive phase of the collaborative, in June 2016 with 2,536 PLHIV expected to be on ARVs, 1,566 PLHIV were supplied with ARVs: a gap of 970 cases. Hence, despite the increasing number of PLHIV supported by the sites, the gap of those lost decreased. This case study allowed us to describe the experience of improving the retention of PLHIVs in ART in one province in DRC. However, like many technical assistance projects in developing countries, main challenges remain to sustainability, scaling up of good practices, and institutionalizing quality improvement.

Background

The Democratic Republic of Congo (DRC) is one of the countries most affected by HIV in the region of West and Central Africa. The HIV epidemic in the DRC has a prevalence in the general population of 1.2%.

Antiretroviral treatment (ART) was formally introduced in the DRC in 2002, but the scale up of ART across the country has been accompanied by poor quality of HIV/AIDS care and services, thus compromising its effectiveness.

The Ministry of Public Health, through the National Program for the Fight Against HIV/AIDS and Sexually Transmitted Infections (STIs) has committed in its National Health Development Plan (PNDS 2011-2015, March 2010, sectoral objective of the PNDS Page 69) to improve the quality of services offered in health facilities with the support of partners.

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From 2015 to 2016, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, funded by USAID and PEPFAR, provided technical and financial support to the DRC Ministry of Health to improve the quality of the care and treatment of HIV/AIDS in three provinces (Kinshasa, Haut Katanga and Lualaba) in collaboration with two PEPFAR implementing partners: Path's PROVIC Project and Management Sciences for Health's (MSH) PROSANI Project.

Introduction

As an expert in the science of improvement around the world, the ASSIST Project initiates processes of improvement based on data. Thus, from July to August 2015, ASSIST organized a baseline assessment in 39 sites in the three provinces of intervention in DRC to provide relevant data on the quality of HIV/AIDS services.

Analysis of the results of this baseline evaluation revealed quality gaps in some subcomponents of the cascade of care for people living with HIV (PLHIV), in the following three categories:

- 1) Counselling/testing: many screening opportunities were missed in health facilities because HIV counselling/testing is not integrated in all patient services in health facilities;
- 2) Linkage and initial assessment: the biological assessments recommended by the standards are not available or carried out in more than half of the sites surveyed;
- 3) Pre-antiretroviral treatment (ART) follow up: more than half of pre-ART patients missed at least one follow-up visit and pre-ART files were insufficiently filled out and did not allow for a sound decision;
- 4) Follow-up of ART patients: 43.6% of the sites experienced ARV stock-outs in the three months prior to the survey and 35.2% of ART patients were lost to follow-up (i.e. missed at least three consecutive visits), resulting in a low clinical and biological follow-up of ART patients, hence there is low knowledge of the well-being of PLHIVs under ART;
- 5) Partner testing: only 20% of male partners of pregnant women attending antenatal care (ANC) were counselled, tested, and obtained their results;
- 6) Tuberculosis screening: was not routine in more than half of the sites surveyed and isoniazid prophylaxis of HIV + patients, although recommended by national standards, was only applied in one site out of 39.

Improvement Objective

Considering these baseline results, ASSIST initiated discussions with USAID and PEPFAR implementing partners and the government programs (National Program of the Fight against HIV/AIDS and the National Multisectoral Program for the Fight against HIV/AIDS) and developed an improvement plan, based on the conceptual framework for gap analysis in HIV care, with three main objectives to reduce the quality gaps observed in HIV/AIDS care and treatment in the DRC:

1. Improve ART coverage so that all people eligible for ART can receive it;
2. Improve ART retention so that all patients who start antiretroviral therapy adhere to and continue to receive ART;
3. Improve the well-being of PLHIVs so that all ART patients continue to achieve and maintain the best possible health status.

This case study is based on the experience of improving the retention of PLHIV on ART in the 10 health centers of the HIV/AIDS collaborative of the Lualaba Province. In the DRC, retention of PLHIV under ART was a major challenge for the National Program of the Fight against HIV / AIDS (PNLS) as the effectiveness of the ART program depended on it. It was clear that to obtain and maintain a state of well-being, PLHIV must remain and adhere to ART.

The main indicator for monitoring the retention of PLHIV under ART is the retention rate of PLHIVs on ART. The monthly data collected for the calculation of this retention indicator are as follows:

- Cumulative PLHIV on ART;
- PLHIV expected to receive ARVs monthly (does not include deaths and transfers elsewhere);
- PLHIV supplied with ARVs during the month;

- The number of PLHIV on ART absent from 3 consecutive meetings (lost to follow-up).

All these data were disaggregated by sex in the collection database to identify and manage possible gaps between men and women living with HIV.

Implementation Activities by the Quality Improvement Team

To achieve its objectives, ASSIST used the performance improvement collaborative approach, a process of mutual learning between a network of teams to solve a common public health challenge. In this case, it was the retention of PLHIV on ART. In Lualaba province, for example, 10 health facilities were set up in a collaborative network in the two health zones of the province (Dilala and Manika). In the past, it was necessary to orient the system's stakeholders (governmental level, provincial and district level, and USAID and PEFAR implementing partners) to the fundamental concepts of quality improvement and the collaborative approach. After this orientation, the rest of the process consisted of developing the core documents of the collaborative, including: the change package, job aids for the national guidelines for HIV/AIDS case management, and monitoring tools. These basic documents were used to guide the provincial, district and health zone management team (known as system supervisors) in coaching techniques. Pools of external coaches were established at the health zone and provincial health team levels. These coaches then set up quality improvement teams (QITs) in the 10 health facilities with the support of ASSIST technical advisors in the province. Each QIT was comprised of providers involved in the HIV/AIDS care and treatment process, health structures managers (Zones, District, Province), community representatives, and patients. Each QIT was trained in quality improvement (QI) by the coaches and then developed their own plan to improve HIV/AIDS care and treatment according to their own context. Given the resources available in the site, existing opportunities, and local constraints, each QIT included in its improvement plan ideas for change to achieve the improvement objectives.

Below, we summarize the promising changes initiated and tested by QITs to retain PLHIV on ART in the 10 health facilities in the province of Lualaba. These changes, considered effective and replicable in the DRC context, have been documented in a [package of best practices](#) and made available to the Ministry of Health for large-scale improvement of HIV/AIDS care and treatment. Among the ideas tested, those that had a positive impact on retention of PLHIVs under ART include:

- **Active search for patients who do not attend appointments through:**
 - Setting up a follow-up agenda for PLHIV;
 - The list of PLHIV expected during the week including their first and last name, telephone number, their PLHIV code, and their confidant's contact number;
 - The granting of cards with telephone credits to prescribers by the management committee for calls from absent clients to the appointment;
 - Calling clients or their confidants after 48 or 72 hours of absence;
 - Use of community relays (volunteers from the community who work closely with providers to involve and promote community participation in health activities. They represent the link between health facilities and communities) or self-help groups depending on location for home visits after phone calls failed.
- **Reorganization of service to reduce stigma through:**
 - Patient pathway analysis in the team care structure;
 - Identification of stigma points in the care setting;
 - Review of the circuit to integrate benefits for chronic diseases. (Example: PLHIV move to the same location where people with hypertension, diabetes, tuberculosis, etc. go);
 - The avoidance of specific days reserved for PLHIV (discriminatory);
 - Accountability of officers in all positions for respectful care for all patients.
- **Gender integration in performance monitoring through:**
 - Disaggregation of indicator data by sex;
 - Meeting of the QITs to analyze sex-disaggregated data for gender-related gaps and identify socio-cultural and context-specific factors;
 - Use of mentor mothers as links between the health center and women living with HIV (mentor mothers are women living with HIV on ART who work voluntarily with the QIT to mentor patients);

- Supply of ARVs for two to three months for men living with HIV who claim they cannot return within one month (for example, miners and truck drivers) after checking their clinical status, per the national protocol to keep them on ART.

Results

The different change ideas tested by the QITs to improve the retention of PLHIV on ART resulted in the following:

Figure 1 shows the retention rate of PLHIV on ART by health zone and for the province of Lualaba. This rate improved with the start-up of HIV/AIDS improvement collaborative activities in November 2015 until June 2016, after which there was a slight decline in performance related to the devolution of ASSIST activities in the DRC.

Figure 2 shows the gradual reduction of the ART retention gap (difference between PLHIV expected to replenish ARVs and those who did replenish their ARVs) between November 2015 to June 2016 (from 1,500 at the beginning of collaborative to 970 at the devolution of ASSIST activities in the DRC). Thus, we can say that the collaborative in its intensive phase had a positive and progressive effect on the improvement of the retention gap of PLHIV on ART. However, with the announcement of the end of project activities, performance did not follow the same rate of reduction.

Figure 1: % of PLHIV retained on ART, Lualaba, by Health Zone, 10 sites (Aug 2015 - Sept 2016)

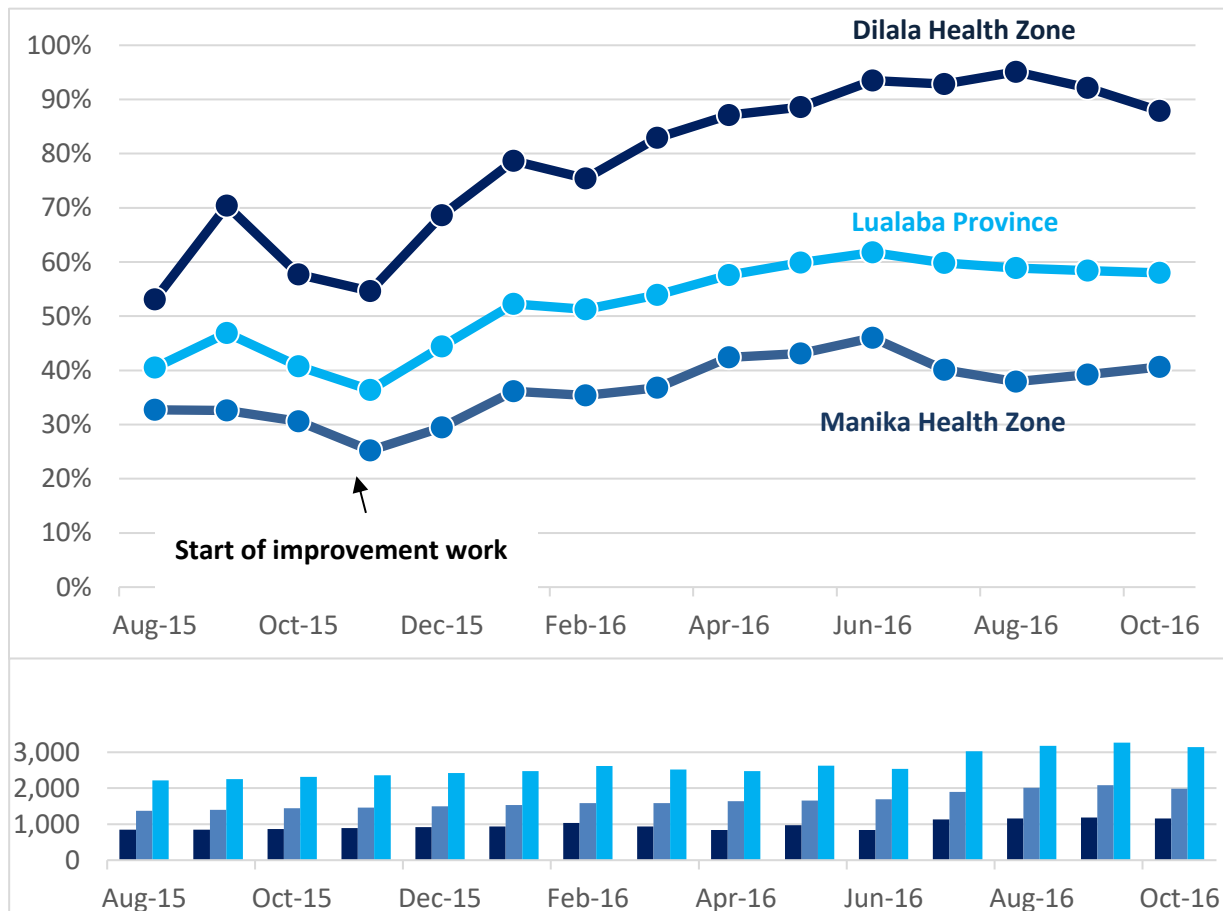


Figure 2: Evolution of the retention gap for ART clients, 10 sites, Lualaba Province (Aug 2015–Oct 2016)

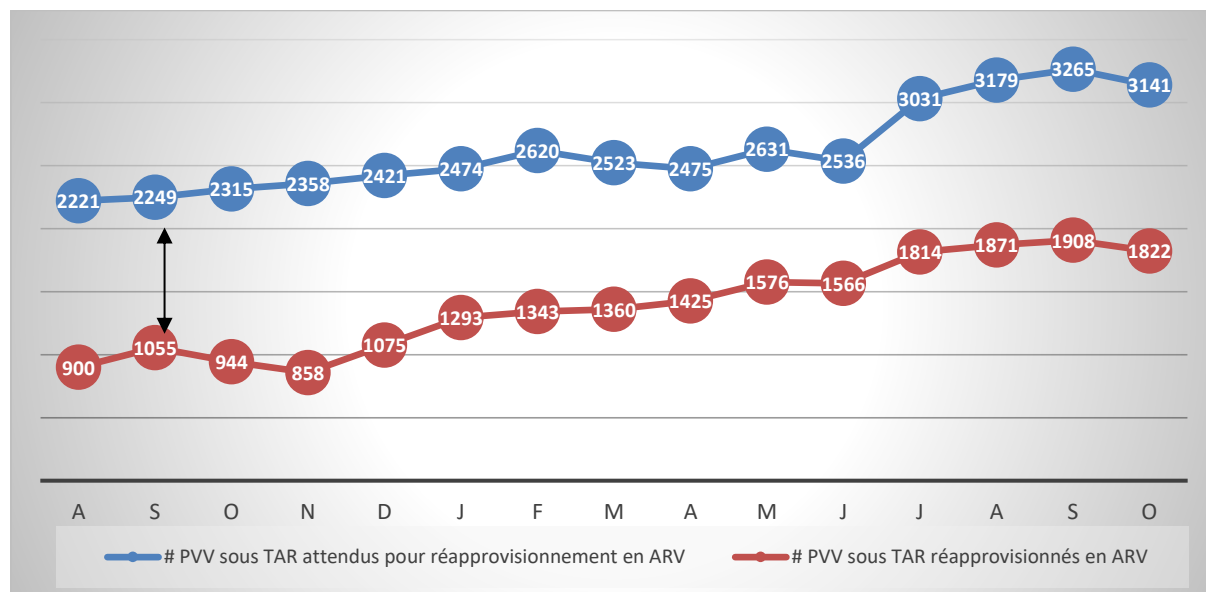
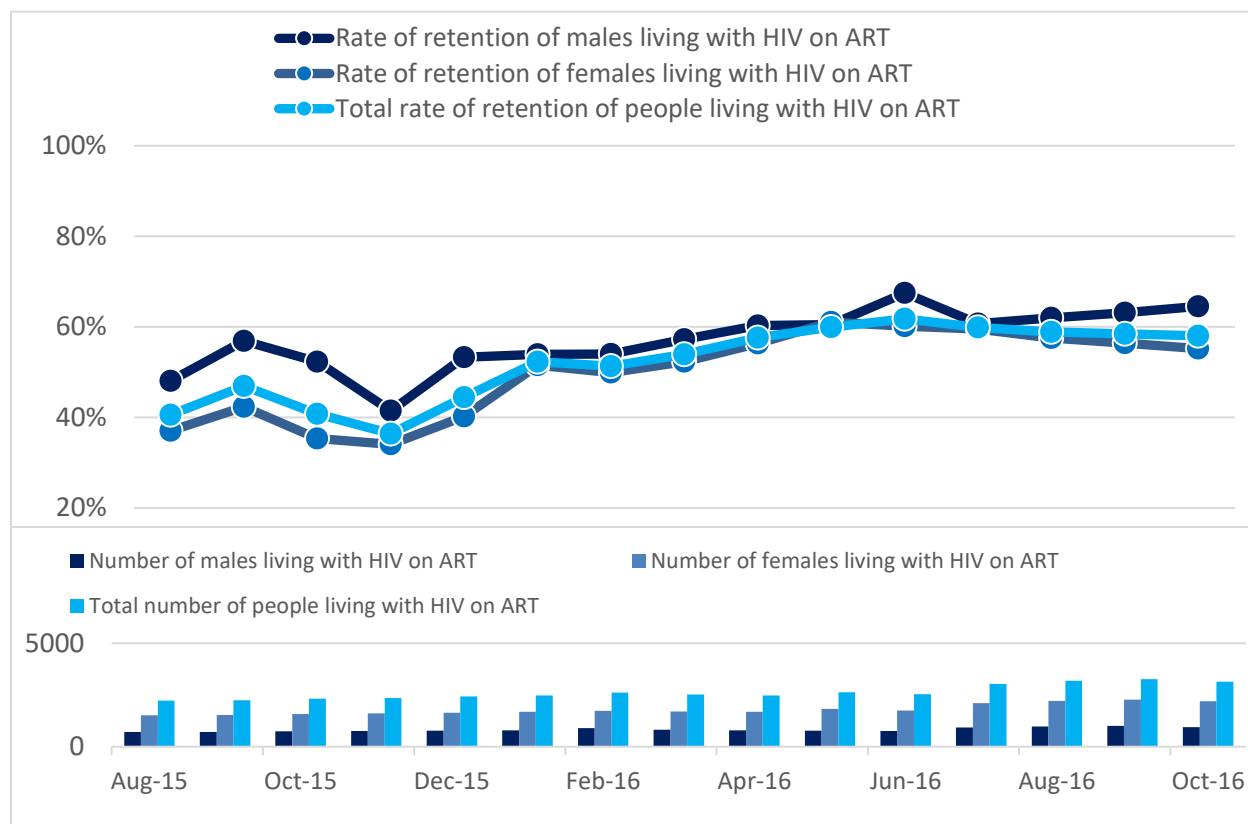


Figure 3 shows the increase in the PLHIV retention rate of male and female patients on ART exposed to the gender-related changes initiated and tested by the QITs at the 10 HIV/AIDS collaborative sites in Lualaba province. It should be noted that this work was facilitated by disaggregating data by sex from the outset of the project. The baseline analysis, also sex-disaggregated, showed that before the collaborative started (November 2015), there were differences in retention to ART by sex.

Figure 3: Percentage of PLHIV retained on ART by sex, Lualaba, 10 sites (Aug 2015 - Oct 2016)



The change ideas included the development of an appointment schedule for all PLHIV; Telephone calls to those absent or their confidants after 48 hours or 72 hours of absence; Analysis of sex-disaggregated retention data to identify gaps between female and male PLHIV, and the decision of specific strategies targeting issues affecting female and male PLHIV; Home visits to female PLHIV by mentor mothers; Two to three months of ARVs for PLHIV miners or truck drivers who often do not return monthly for ARVs, to avoid interruption to their ART.

Next steps

Based on the DRC experience, there are four main areas of learning:

1. ASSIST status as a technical assistance project limited its scope to the needs of the field (training in HIV care, supply of basic inputs, harmonization of data collection with the Ministry of Health);
2. Full collaboration with the central government on the level of provision of care at the provincial and district levels led to the involvement of actors at all levels;
3. Collaboration with the PEPFAR implementing partners, demonstrated through joint planning and coaching visits of the quality improvement teams;
4. Low-cost local strategies used by QITs to retain PLHIV on ART with the effective involvement of the health center management committees and beneficiaries (mentor mothers), are replicable.

As an assistance project, integrating quality improvement in HIV/AIDS care and treatment requires the creation of minimum conditions to promote good adherence to standards. This includes the continuous availability of ARV medicines and appropriate supports and qualified staff, which ASSIST has little or no influence on in healthcare facilities, as they are entirely the responsibility of the PEPFAR implementing partners. Sites experiencing stock outs of ARVs found it very difficult to retain PLHIV on ART.

Also, although ASSIST disaggregated data by sex, gender integration was not taught to QITs or staff at the beginning of the intervention. Only one orientation session on gender integration took place towards the end of the ASSIST activities in the DRC, which would explain a lack of ownership of gender integration in improvement activities, which explains the persistence of gaps between men and women in ART retention, although the indicator improved over time.

We also learned that leadership at all levels of the system and gender integration are critical to the success of quality improvement interventions. The orientation of all actors involved to obtain consensus, the training of pools of coaches by zone of health, the implementation of the QITs in the sites of the collaborative and their responsibility in monitoring the data, and the organization of the learning sessions promoted stakeholder engagement at all levels. However, the process ownership by the system after one year of the HIV/AIDS collaborative seemed to be slow despite the goodwill displayed by the health authorities of the province of Lualaba.

We note that the lack in communication between partners is a factor that halted the implementation of the improvement activities and that it would be very useful to define at the outset of the project a partnership framework between all the players with roles and responsibilities well clarified.

The changes ideas developed, tested, and implemented by QITs to improve the retention of PLHIV on ART certainly had a positive effect, but the main challenge for the Lualaba province remains the sustainability and the scale-up of good practices in the DRC context. It is a very large country with several pockets of insecurity that entirely is dependent on the outside world for the availability of ARVs.

The institutionalization of quality improvement in the health system will be the only guarantee of sustainability, and ASSIST was only able to organize one orientation session for the Ministry of Health. The technical and financial assistance of USAID and PEPFAR through its various partners is more than ever necessary to support the DRC Ministry of Health to continue the process of institutionalizing quality in the system.

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