CASE STUDY

Improving retention of clients on antiretroviral therapy through expert patients: Involving people living with HIV in Alebtong District, Northern Uganda

Summary

The World Health Organization’s (WHO) Integrated Approach to HIV Prevention, Care, and Treatment (IMAI) recommends adoption of People living with HIV (PLHIV) as community health workers (CHWs) to track patients who have not appeared at the clinic for at least three months (lost to follow-up [LTFU]) through contact tracing (home visits). Since February 2015, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) project has supported 137 health facilities in 15 northern Uganda districts to implement strategies to engage CHWs to ensure retention of HIV positive clients who are lost to follow up using a quality improvement (QI) approach. ASSIST, in collaboration with the district and health facilities in Alebtong District initiated a QI project to track and re-activate care for PLHIV who had not been seen in the clinic for at least three months at five antiretroviral therapy (ART) centers. A baseline assessment conducted in January 2016 found only 88% (2591/2921) ever enrolled clients were active in care. Facility QI teams came up with an improvement aim to return 100% of the LTFU clients within 3 months and tested changes like: reviewing the ART registers and generating lists of LTFU clients; and assigning each lost client to be followed up by community linkage facilitators (CLFs) who reside in the same or nearby village. Results received in April-June 2016 showed that of the 330 LTFU clients, 262 (79%) had been found alive and not on treatment and were brought back to care, 54 (19%) had self-transferred, and 12 (4%) had died. Involving expert clients to track LTFU from their own villages can help to bridge gaps related to retention rates and clients without additional human and financial resources.

Background

In 2014, the Joint United Nations Program on HIV/AIDS (UNAIDS) set goals to eliminate the HIV/AIDS epidemic by the year 2020 through a three-pronged approach known as the 90-90-90 strategy (Figure 1). In line with the second prong, 90% of all people identified as HIV positive must be enrolled and sustained on antiretroviral therapy (ART).

Community Linkage Facilitators (CLFs, previously referred to as HIV Expert Clients) in Uganda are HIV positive stable clients on ART that support other Positively living clients achieve better treatment outcomes through supporting them on adherence counselling, tracking lost to follow up and promote disclosure of HIV status among clients. In Alebtong District, CLFs voluntarily support ART clinics with above functions and are actively involved in clinic processes.

Figure 1: UNAIDS’ 90-90-90 strategy

90% of all living with HIV will know their HIV status
90% of all living with HIV will receive sustained antiretroviral therapy
90% of all receiving antiretroviral therapy will have durable viral suppression

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The World Health Organization's (WHO) Integrated Approach to HIV Prevention, Care, and Treatment (IMAI) recommends adoption of People living with HIV (PLHIV) as community health workers (CHWs) to track patients who have not come to the clinic for at least 3 months (lost to follow-up [LTFU]) through contact tracing (home visits) as one of the strategies to sustain ART patients on treatment (Figure 2). The Ministry of Health (MOH) in Uganda and its implementing partners including the USAID Applying Science to Strengthen and Improve Systems (ASSIST) project have adopted both strategies to reduce HIV in the entire country.

In pursuit of the 90-90-90 goals, Alebtong District, an ASSIST-supported district in northern Uganda, prioritized improving care and treatment for people living with HIV/AIDS in their HIV/AIDS strategic plan for 2015/16 with a focus on ensuring that all patients enrolled on ART are retained at five ART sites; Alebtong Health Center (HC) IV, Apala HCIII, Alo mission HCIII, Amugo HCIII, and Abako HCIII. This improvement goal was set following an ASSIST-supported baseline assessment conducted in December 2015 at these facilities that indicated a 12% gap (303/2921) of enrolled clients who were lost to follow up (LTFU) and only 88% (2591) of clients were still active in HIV care.

**Improvement process used in Alebtong District**

CLFs were identified as a success factor for achieving this improvement aim. CLFs are mostly HIV positive expert clients that voluntarily offer their time to ensuring newly identified and already existing HIV positive patients are linked and retained in care. They also perform certain assigned roles in the ART clinic including health education and counselling on positive living. Previously linkage facilitators used to follow up lost to follow up clients randomly without considering their home areas and how easy it was to access them. This would hinder tracking efforts of lost to follow up and linkage facilitators could travel long distances to trace for the clients.

At the five health facilities, health workers were allocating CLFs to the newly identified or lost to follow up clients based on when the client was tested and which CLF was at the health facility at that time. CLFs are allocated to work with these new clients because they have successfully managed the HIV disease themselves and have supported individuals and families overcome stigma and live positively in their communities. They also maintain confidentiality of the clients’ status.
The health workers and CLFs did the following:

1. Generated lists of clients LTFU and their addresses from the Pre-ART and ART registers at each of the five implementing health facilities.

2. Assigned each CLF to HIV clients who come from their areas of residence to facilitate easy access to the clients without incurring additional costs of transport.

Teams tested the additional facility and community level changes described below.

**Changes tested to ensure follow up of all lost clients**

**Facility Changes**

- Providing files with forms and referral forms to CLFs to record names of clients lost to follow up.
- CLFs together with ART clinic staff identifying clients who are lost to follow up from the ART registers.

**Community Changes**

- Creating a community tracker form (Figure 4) and CLFs using it to document feedback to the facility of LTFU client status. CLF and clinicians updated patient follow up status in the client records weekly.
- Assigned each CLF to HIV clients who come from their areas of residence to facilitate easy access to the clients without requiring additional facilitation in terms of transport fees.

**Role distribution on the ART clinics’ teams in the QI project**

<table>
<thead>
<tr>
<th>Technical ART clinic staff</th>
<th>CLFs</th>
<th>ASSIST and District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of LTFU from ART register</td>
<td>Generated a list of LTFU</td>
<td>Technical guidance to the facility teams, linkage facilitators and district HIV department</td>
</tr>
<tr>
<td>Updating of appropriate tools as per the outcomes</td>
<td>Conducting door to door tracing of clients</td>
<td>Documentation of the process of the process</td>
</tr>
<tr>
<td>Reviewed progress per month</td>
<td>Updated community trackers forms and made follow-up outcomes on a monthly basis</td>
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<tr>
<td>Updated the ART register as per the follow up outcomes</td>
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</tbody>
</table>
Results
In January 2016, 330 clients were identified as LTFU. Results of June 2016 showed that 262 (79%) were found alive but not on treatment and were brought back to care; 54 (19%) had self-transferred to other facilities; and 12 (4%) had died. As a result, the number of non-active patients on ART reduced from 330 for the entire district in the January – March 2016 period to 14 in the April – June 2016 period which reduced the LTFU gap to 0.06% (Figure 5).

Lessons Learned
1. The QI approaches lessen the tasks of follow up through assigning CLFs to track LTFU clients that are within their locality.
2. CLFs are also motivated as they could conduct the follow-up within their own means without requiring additional funds for transport because clients are near them.
3. Returning clients back into care ensures that they are retained and adhere better to HIV care and treatment which contributes to their viral load suppression, and as results shown indicate that the 2nd and 3rd 90 of the UNAIDS strategy can be attained.

Conclusion
Using the quality improvement approaches to engage CLFs to support tracking lost clients has greatly helped to improve retention rates of clients on ART in Alebtong. It is an innovation that can be implemented in other facilities and districts to improve retention in care.

DISCLAIMER: This study is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this study are the sole responsibility of University Research Co., LLC and do not necessarily reflect the views of USAID or the United States Government.