



MINISTRY of HEALTH
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Applying Science to Strengthen
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CASE STUDY

Strengthening HIV linkage and retention through improved community/facility collaboration in Palla Road, Botswana

Summary

In Palla Road village, an improvement team of community members and health post personnel identified retention in anti-retroviral treatment as a major challenge affecting their community. Facilitated by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, the *Pusetso* community improvement team (CIT) brainstormed how existing community platforms and resources could collaborate with local facility personnel in locating and returning patients for re-assessment. Taking into account sensitivities around confidentiality, the CIT developed change ideas involving team members to guide health care workers visiting patients who were lost to follow-up (LTFU), while others held health education talks throughout the village. On February 2, 2016, 23 patients were identified as LTFU at the facility. By March 29, 2016, 14 of those had been found: One had died and 13 returned to care. The number of traced patients increased further even after active CIT facilitation was concluded, resulting in a clarified and up-to-date status of all patients originally deemed lost. This experience was shared with partners at district level who supported the institutionalization of this innovation to improve community/facility collaboration.

Background

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and USAID, through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, are supporting the Government of Botswana (GoB) to strengthen the community health system response to HIV/AIDS. ASSIST Botswana is working closely with other partners, including the global USAID Advancing Partners and Communities (APC) Project under a joint PEPFAR Botswana strategy toward achieving epidemic control in Botswana by 2018. Through dialogue with government, ASSIST was able to identify shared interests around quality and align its project design with GoB plans for decentralization and stronger roles of communities. Working with district officials and community leaders, ASSIST oriented community groups on the formation of community improvement teams (CITs). They also invited health facility staff and other service providers operating in the community. CITs were supported in the step-by-step application of rapid change (Plan-Do-Study-Act, PDSA) cycles, and in monitoring progress on selected basic indicators. ASSIST Community Improvement Coordinators provide the teams with bimonthly coaching, with remote support as needed, to undertake focused improvement work and to assist in data management for the monitoring of relevant indicators.

Palla Road village in Mahalapye Sub-District is one of a growing number of communities where ASSIST has been invited to work with existing community mechanisms. With a small population of only around 500, the village was identified by district officials as a community in urgent need of improved care and system support. The local facility is a health post with 2 nurses and 1 health education assistant (HEA). One nurse and the HEA became founding members of the 18-member CIT, alongside other members representing various village committees, social and other groups. The team chose the name *Pusetso*, (Setswana for *restoration*). Beginning in January 2016, the *Pusetso* CIT started exploring the



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potential roles of community structures in improving the linkage, retention and adherence of HIV patients to treatment.

After jointly analyzing the broader problems the village faced, the CIT felt strongly about the need to ensure the well-being of sick community members, and committed to the challenge of getting lost to follow-up (LTFU) patients back to care, focusing on utilizing the role and resources of the community to help the facility personnel to find and reconnect with patients.

Improvement Strategy

The ASSIST team supported the Palla Road community improvement team with hands-on facilitation, beginning with an in-depth analysis of problems faced by the community. The CIT paid special attention to identifying gaps and barriers to existing health services in the community, including but not limited to HIV testing, linkage, and retention. *Pusetso* was formed as a microcosm of the broader community, representing both formal and informal structures existing in the village. The enthusiasm and willingness of community members to be actively involved in improving services, combined with the resources of facility staff and other service providers, opened up new opportunities to capitalize on the community's local knowledge and networks. ASSIST's facilitation focused on guiding the team to focus their deliberations on finding simple but effective change ideas to experiment with and improve patient-centred processes across community and facility platforms.

From the beginning of their analysis, CIT members recognized that confidentiality and disclosure of HIV status were tricky and very sensitive issues requiring creative 'work-arounds' to maintain and reinforce the trust of patients. They explored reasons for why people stopped seeking services and treatment and how many members in their community might be affected. Following lively discussions, the team agreed that in order to preserve confidentiality, they would source only overall numbers of LTFU (rather than names) from the facility, and only for the purpose of monitoring progress and effect of the change ideas.

The facility nurse, a *Pusetso* team member, provided baseline numbers, updated the team weekly, and with the team's secretary plotted the graph on the basis of facility data (see photo). Even though facility follow-up of patients should be routine, it typically is not a priority because of facility workload and other challenges at the facility. On the basis of its dedicated problem analysis, the CIT developed a change idea with 2 elements that would represent a promising innovation within existing MOH guidelines.

Developing a change idea

At the center of the CIT idea to reconnect with lost patients was the recognition that actual patient follow-up needed to remain in the hands of formal health facility staff, specifically the HEA as the public service cadre meant to strengthen the link between communities and facilities. As HEAs are subject to regular transfer policies, however, they often lack in-depth knowledge of the communities they serve. *Pusetso's* idea therefore was to support the HEA in her mandate by providing general geographic guidance to Palla Road's wards and areas that allowed her to locate and connect with patients. This approach thus provided sufficient local knowledge of the community, while preserving existing public service guidelines and avoiding sensitive implications around confidentiality. Alongside these elements of a novel joint approach, the rest of the team organized groups to embark on health education messaging in the community to prevent future LTFU, including by encouraging communication with the facility. Messages included the importance of adhering to treatment, reporting family deaths, and informing the facility when moving away from the village or transferring to a different facility. These messages, in the eyes of the CIT, would help ensure that facility records could be kept up-to-date in future, and thus maintain confirmed numbers of LTFU. The messages were delivered at different community venues, including football and netball sporting grounds, *shebeens* (home-based bars



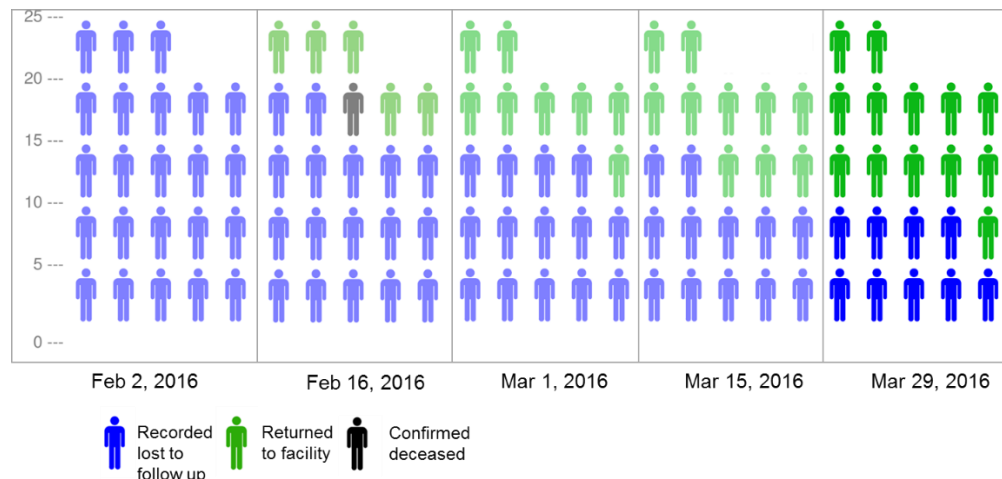
Pusetso members presenting the final outcomes of the LTFU improvement change idea at the Palla Road *Kgotla*.
Photo credit: Kabo Thankane, URC.

and 'drinking holes'), the health facility, and central *Kgotla* (community assembly) meetings. In addition, CIT members took these messages to their own committee and club meetings.

Results

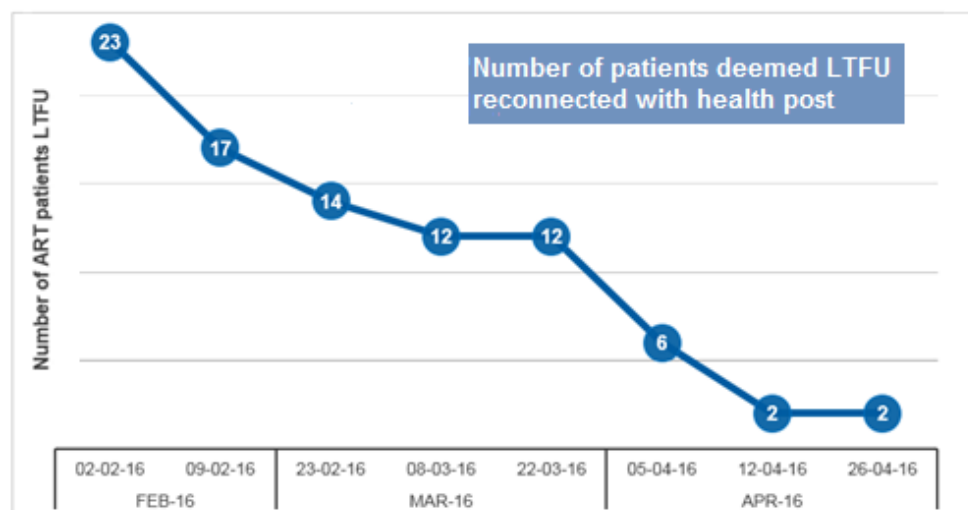
When the CIT began reviewing health facility data in February, the facility staff identified a total of 23 patients who were considered 'lost' at that time (a significant number for a village with a total population of 500). At their next meeting two weeks later, the location and status of six of these 23 LTFU patients was confirmed: one had died, the other five had returned to care. By March 29, two months into the Team's joint efforts with the facility staff, the number of patients returned to care had increased to 13 (see **Figure 1**), representing a reduction of 60%.

Figure 1: Reduction of LTFU patients at Palla Road, February 2, 2016 – March 29, 2016



This already reflected a significant achievement for the CIT's primary objective to return patients to care. Another month later (by the end of April) during which the CIT did not conduct dedicated support or community messaging, facility personnel confirmed that all of the 23 patients originally deemed as LTFU had been traced by and engaged with the facility, either directly or with next of kin for those deceased or unavailable. Of these, two cases had been located in remote areas but required more efforts to be returned to care (see **Figure 2**). This clarification of status regarding all patients in question represented an important secondary objective of the community. This development was welcomed by facility staff, allowing them to focus on the remaining actual two cases of 'lost' patients as well as on the prevention of new LTFUs.

Figure 2: Reduction of patients with unclear status deemed LTFU, February 2, 2016–April 26, 2016



The experience of Palla Road has shown that innovation in how facilities relate to and collaborate with the community is possible, practical, and potentially very powerful. In fact, just as members of the CIT subsequently expressed a sense of excitement and increased motivation, facility staff also reported to have intensified their efforts to improve follow-up to other patients, with HIV and other conditions.

Key Factors of Success

From the perspective of the ASSIST team that supported the community improvement team in Palla Road on the ground, a number of important factors contributed to the positive outcomes.

- *Pusetso* is a dedicated team of community volunteers, led by a *Kgosi* (chief) who from the beginning bought into the idea of improving the collaboration with the health facility for better health services and outcomes, and invited ASSIST to help apply simple QI methods to do so.
- Community members were visibly thrilled by the bottom-up approach to local problem-solving and expressed their conviction that this had been missing in the past. This is reflected in their unwavering support, but also in the jostling for seats on the *Pusetso* team.
- Local health facility staff welcomed the new improvement initiative endorsed by the village leadership, and recognized the opportunities presented by a functioning, well-organized platform to help address some of the most pressing problems around community health. This was in contrast to common experiences by facility managers that community platforms where they exist were often limited in their capacity or entirely dysfunctional.
- Facility staff recognized that the CIT engagement was genuinely coming from within the community and driven by the village leadership, which legitimized joint efforts to collaborate on taking services to the people, rather than waiting for them to show up at the facility.
- ASSIST's community engagement model was designed for 'best fit' in the relevant local context with a respect for existing traditional structures, local gatekeepers and timelines. As a result of this approach and focused consultations of the project, CITs feel genuinely accountable to their own community and the *Kgosi* – rather than to an outside project.

The example of Palla Road seems to illustrate the potential of applied improvement work in Botswana: communities and facilities alike are not only eager and ready to collaborate around patient care based on existing structures; given the right tools, they can actually work together in a focused way to improve services and patient outcomes, in HIV but also with a view to other chronic conditions.

Limitations

All communities are different, and while principles are valid across contexts, the details of collaborative models need to be adapted locally. What works in a small village like Palla Road might not apply to or work in a larger peri-urban and inner-city context. Understanding and operating within different contexts therefore requires communities to be in the lead in any adaptation and the generation of change ideas. Providing outside support and start-up facilitation to existing community platforms depends on dedicated, reliable support and frequent consultations.

While the intention and expectation of the project is that community improvement teams will gradually need less outside facilitation as they become more familiar and proficient with improvement methodology, there is also a possibility that this would not be the case. To be effective, PDSA cycles are meant to be rapid and focused and they depend on reliable service numbers and progress data. Often this information is difficult to obtain for a number of reasons, including misunderstandings but also active resistance. In addition, backlog and poor management practices often require considerable investments of time and effort to review and clean data for the purpose of improvement work.

Next Steps

The *Pusetso* team concluded the testing of their prioritized change ideas to address the loss of Palla Road patients along the HIV treatment cascade. Jointly reviewing the data and progress over three months, the team (including the facility personnel members on the CIT) concluded that these change ideas were successful and encouraging – but also limited in scope. Once a facility such as theirs had managed to address the backlog in ART patient management, the challenge shifted to one of continuous

and systematic follow-up practices and the prevention of new LTFU. In addition to the immediate effects of their effort, the facility begun to reorganize their filing system for better continuous monitoring of all patients, in particular HIV but also other chronic care patients.

Overall, the experience in Palla Road suggests that their model of improved community/facility collaboration around the challenge of LTFU be reviewed, adapted, and institutionalized by others. This was also the conclusion of district officials at the Mahalapye learning session on community improvement that ASSIST organized on 2-3 August 2016 where the *Pusetso* and other CITs presented their improvement work and data. Specifically, senior managers from the District Health Management Team (DHMT) indicated their interest in potentially integrating and scale-up of both the collaborative improvement approaches and the change ideas they generate.

Practical innovations such as this one from Palla Road are important inputs to the development of new models for an improved community-based delivery of differentiated care in Botswana. As part of the dialogue with district officials in Mahalapye, ASSIST was invited to enter a strategic partnership with the DHMT to review and improve district system processes, including to bring local innovations to scale and institutionalize improved community/facility collaboration across the entire district.

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