CHANGE PACKAGE

Improving Access to HIV Testing and Treatment Services for Vulnerable Children and their Caregivers in Uganda

JULY 2018

This change package on improving access to HIV testing and treatment services for vulnerable children and their caregivers was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Esther Nassali, Juliana Nabwire, and Esther Karamagi of URC. It was developed as part of the Orphans and Vulnerable Children work in Uganda funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and carried out under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is made possible by the generous support of the American people through USAID.
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For more information on the work of the USAID ASSIST project, please visit www.usaidassist.org or write to assist-info@urc-chs.com

Recommended citation

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Acronyms

ART  Antiretroviral Treatment
ASSIST  Applying Science to Strengthen and Improve Systems
CSO  Civil Society Organisation
HCT  HIV Counselling and Testing
IP  Implementing Partner
MGLSD  Ministry of Gender Labour and Social Development
OVC  Orphans and Other Vulnerable Children
QI  Quality Improvement
PEPFAR  Presidential Emergency Fund for AIDS Relief
PIASCY  The Presidential Initiative on AIDS Strategy for Communication to Youth
PLHIV  People living with HIV
VSLA  Village Savings and Loan Association

Glossary of Terms

Change idea: an actionable specific solution for changing process which may be tested by a CSO or community quality improvement team to determine if it results into anticipated outcomes.

Change concept: a category of changes ideas or solutions that are similar and have a common underlying thought.

Change package: an organized summary of changes which have been tested and proven to improve access to HIV testing and treatment services among vulnerable households.

Collaborative: multiple quality improvement teams brought together to work and learn together to rapidly achieve significant improvement towards a common goal with the intention of scaling these up to other sites.

Community resource persons: are people in the community who provide time and expertise to participate in assigned tasks to support their communities do better.
Introduction

The HIV epidemic has significantly affected the wellbeing of children in Uganda, as evidenced in the National Household Survey 2010 (UBOS, 2010) that shows that 14% of children are orphaned and about 45.6% of this orphanhood is attributed to HIV/AIDS, and 105,000 children between 0-14 years of age are HIV positive. Despite progress in reaching people living with HIV/AIDS (PLHIV) and delivering high antiretroviral therapy (ART), children still lag behind in terms of access to HIV care and treatment compared to the adults. The 2016 Uganda HIV Population Based Impact Survey (UPHIA) reported the following: HIV prevalence among children below 15 account for 7.4% of HIV-infected persons; only 73% have a known HIV status; 67% have been enrolled in HIV care; and 67% are virally suppressed. To achieve the UNAIDS epidemic control goals of 90-90-90, more effort is needed to ensure that gaps along the HIV prevention and treatment cascade are closed.

Complementary efforts have been undertaken by the social services sector to ensure that vulnerable children and their caregivers are identified and supported to build resilience and reduce risk through different interventions of Orphans and Vulnerable Children’s (OVC) programs. Implementation of these programs however are not integrated with existing HIV programs, creating missed opportunities of providing care to children in need. OVC programs are mainly community-based and are best suited to recognize the community needs and appropriately address them by acting as a link between the community and the health system, as well as providing continuous care and support through their existing community structures.

Why focus on Improving Access to HIV Testing and treatment services for vulnerable children and their caregivers?

In October 2015, following the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) guidance to improve integration of HIV and OVC care programs for improved outcomes for children and their caregivers, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) project set out to support OVC implementing partners (IPs) to strengthen community-facility linkages. In collaboration with the Ministry of Gender Labour and Social Development (MGLSD) and OVC IPs, ASSIST conducted a baseline assessment to obtain information on key indicators for targeted processes of care for the HIV positive child and their caregivers at selected four civil society organizations (CSOs) with results as shown in Table 1.

Table 1: Baseline data on vulnerable children along the HIV continuum, 4 CSOs (October 2015)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Vulnerable children (0-14 years) with a known HIV status</td>
<td>37% (894/2406)</td>
</tr>
<tr>
<td>2 Beneficiaries and caregivers 15+ years with a known HIV status</td>
<td>33% (834/2480)</td>
</tr>
<tr>
<td>3 HIV positive OVC (0-14 years) enrolled in HIV care</td>
<td>81% (40/49)</td>
</tr>
<tr>
<td>4 HIV positive beneficiaries 15+ yrs enrolled in HIV care</td>
<td>80% (237/294)</td>
</tr>
<tr>
<td>5 HIV positive OVC (0-14 yrs) active in HIV care</td>
<td>82% (33/40)</td>
</tr>
<tr>
<td>6 HIV positive beneficiaries 15+ yrs active in HIV care</td>
<td>87% (210/240)</td>
</tr>
</tbody>
</table>

The baseline data showed that only 37% and 33% supported vulnerable children (0-14) years and adolescents 15 and above and caregivers respectively had a known HIV status. However, most of those with known status were enrolled and active in HIV care. Similarly, tools used by CSOs to identify beneficiaries of OVC programs did not consider one’s HIV status but their vulnerability to other factors. Consequentially, there were HIV positive children who would otherwise benefit from the OVC program who were not reached. With this background information, ASSIST set out to use quality improvement (QI)
methods to strengthen community-facility linkages and ensure that HIV positive children in the community are identified, linked to care and support for improved clinical outcomes with the support of the OVC program.

Methodology

To commence this work, ASSIST worked with 10 CSOs that were selected by the IPs. A total of 38 villages were selected in 6 districts which were identified with high number of HIV positive OVC. These include: Masaka, Luweero, Iganga, Jinja, Kibaale, and Bushenyi.

ASSIST supported the setup of QI teams at the parish and CSO levels. See Tables 2 and 3 for the 10 CSO and 38 community improvement teams that we worked with from October 2015 to July 2017. ASSIST also built the capacity of these CSOs to conduct quality supervision and they carried out two capacity building sessions including a QI training held in July/August 2016 for the CSOs, and the second a sharing meeting held in February/March 2017 to get the CSOs to share changes, successes, and challenges in implementing improvement work.

ASSIST used a collaborative approach where we set QI teams at the different levels: CSO and community given that they were both working on different processes of the community-facility linkages. The work started with the CSOs focusing on increasing the proportion of supported beneficiaries (vulnerable children and caregivers) with a known HIV status, then they began identifying HIV positive children in the supported communities who had not yet been reached by their programs. Subsequently, their efforts targeted closing gaps in the processes along the HIV care and treatment cascade ensuring identification, linkage, retention, and viral suppression.

Table 2: List of Participating CSO improvement teams and districts

<table>
<thead>
<tr>
<th>No.</th>
<th>CSO/Community</th>
<th>Partner supporting</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bantwana</td>
<td>BOCY</td>
<td>Jinja</td>
</tr>
<tr>
<td>2</td>
<td>KIFAD</td>
<td>UPHS</td>
<td>Wakiso</td>
</tr>
<tr>
<td>3</td>
<td>Kimwanyi Muslim Support Initiative (KIMOSI)</td>
<td>UPHS</td>
<td>Iganga</td>
</tr>
<tr>
<td>4</td>
<td>Fishing Community Health Initiative (FICHI)</td>
<td>UPHS</td>
<td>Masaka</td>
</tr>
<tr>
<td>5</td>
<td>Community Vision</td>
<td>BOCY</td>
<td>Kamuli</td>
</tr>
<tr>
<td>6</td>
<td>Kibaale Community Society Network</td>
<td>SOCY</td>
<td>Kibaale</td>
</tr>
<tr>
<td>7</td>
<td>Kareera Ecumerical</td>
<td>UPHS</td>
<td>Sheema</td>
</tr>
<tr>
<td>8</td>
<td>Concerned Parents Association</td>
<td>BOCY</td>
<td>Apac</td>
</tr>
<tr>
<td>9</td>
<td>Integrated Community Based Initiative (ICOBI)</td>
<td>SOCY</td>
<td>Bushenyi</td>
</tr>
<tr>
<td>10</td>
<td>FORCREV</td>
<td>SOCY</td>
<td>Luweero</td>
</tr>
</tbody>
</table>

Table 3: List of participating community improvement teams

<table>
<thead>
<tr>
<th>Improvement teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushenyi</td>
</tr>
<tr>
<td>Ibaare</td>
</tr>
<tr>
<td>Kainamo</td>
</tr>
</tbody>
</table>
Improving Access to HIV Testing and Treatment Services for Vulnerable Children and their Caregivers

Objective of the OVC QI collaborative

To improve access to HIV testing and treatment services for OVC and caregivers at both CSO and community level.

QI support mechanisms

a. QI training

The CSOs received QI training from ASSIST. The first QI training was conducted in March 2016 with two to three representatives from each CSO. The participants were equipped with basic QI knowledge including; set up of QI teams, development of improvement aims, testing and implementing changes, and updating the documentation journals.

b. Coaching and Mentoring

Monthly coaching and mentorship was conducted by a team of coaches from MGLSD, IP staff, ASSIST, and district local government. The CSO staff were supported to form QI teams and roles were assigned to the team members. The teams started off their work with the action plans developed during the QI training.

The coaching sessions at the CSO level focused on building capacity of the team to use data to make decisions and testing changes to improve the process of care. They were supported to update the documentation journals with information on the changes tested and results obtained. Teams were also supported to work through other challenges as identified that hindered progress of the set improvement objectives.

At the community, QI teams were set up at parish level. The teams constituted an average of 5 to 7 members of the community including peer educators, para-social workers, and village health team (VHT) members. The community improvement teams were provided basic training on what they were to work on, oriented on their roles through coaching meetings on the specific areas for improvement and tools.

c. Collaborative Learning meetings

At CSO level. CSO teams in the collaborative would meet once a year to share results and tested changes that worked on improving access to HIV testing and treatment services in selected sub-counties. The changes that worked were scaled up to new sub-counties where the CSOs operate. The changes that worked were spread to CSOs that were not implementing them. The teams developed action plans with those new tested changes. ASSIST conducted monthly coaching visits to support CSO staff implement the changes that worked in new sub counties and new CSOs.

At community level. Annual joint sub-county sharing meetings were held for members of the parish QI teams to share results and tested changes on improving access to HIV testing and treatment services.
The tested changes that worked were documented and spread to new communities. Through monthly coaching visits, CSO staff supported spread of changes that worked to new communities.

d. Strengthen partnerships with service providers

To improve community facility linkages for HIV testing services, CSO team leaders liaise with District Health Officers to supply HIV test kits to health facilities. This enables vulnerable children and caregivers who are referred to access HIV testing services both in the targeted community HIV counseling and testing (HCT) outreaches and at facility level.

Results

Following implementation of the changes, the percentage of vulnerable children (0-14 years) with a known HIV status increased from 37% (894/2406) in October 2016 to 78% (14195/17710) in July 2017 at 10 CSOs. And OVC 15+years with caregivers improved from 35% (915/2545) to 81% (14874/17773) (Figure 1). Changes tested include: targeted home visits to provide counseling on benefits of HIV testing and targeted community HCT outreaches.

Similarly, the percentage of persons eligible for HIV testing who tested HIV positive reached an average of 54% for children (0-14), adolescent 15+ years, and caregivers by July 2017 (Figure 2).

Those eligible were identified through use of a screening tool (Appendix I) with children 0-14 as an entry point to the household. On identification of eligible persons for HIV testing, 5 community resource persons made referrals to the nearest health facility, outreach testing points, and, in some cases, home-based HCT. Referrals were done with the MGLSD referral form (Appendix II).

For full results, see Appendix III.

Figure 1: Increase in percentage of vulnerable children (0-14 years) and beneficiaries 15 years and above with known HIV status, 4 demonstration and 6 spread CSOs (October 2016-July 2017)
Intended use of this change package

This change package illustrates how to improve processes of care for HIV-positive children (including identification, linkage to care, and viral suppression) in the community. It serves as a learning tool for organisations, CSOs, or local government Community Development Officers and any other entities working in the community that can adapt or adopt these suggested solutions to their own settings. The change package includes a “how to” section with detailed explanation of the implementation of the change ideas. Teams may select what they deem as relevant changes, adapt or adjust them as necessary, then test them on a small scale and use data to determine whether implementing those ideas has led to improvement or not. The team should continue testing or adding ideas until the desired level of performance is reached. It is important to note that the improvement teams need to understand the root cause of the challenge they are trying to address to be able to identify an effective change that will close the gaps.
Detailed change package for improving access to HIV testing and treatment services for vulnerable children and their caregivers

(i) Changes tested at CSO level

### 1. Change ideas to increase vulnerable children and caregivers with a known HIV status

#### Concept 1: Use of community resource persons (village health teams [VHTs]/para-social workers) to provide home-based counseling on the benefits of HCT

<table>
<thead>
<tr>
<th>Change Idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Results</th>
</tr>
</thead>
</table>
| Use trained community resource persons to provide home-based counseling | Fear associated with HIV positive results hindered vulnerable children and caregivers from accessing HIV testing services | • CSOs identified community resource persons with support from community development officers and trained them in HIV counseling skills.  
  • The CSO provided community resource persons with a list of supported vulnerable children and caregivers with unknown HIV status.  
  • VHTs/para-social workers conducted home visits to these vulnerable households and provided counseling on the benefits of HIV testing.  
  • Referrals to the nearest health facility were documented for the children and caregivers. | Number of children and caregivers identified and referred for HCT  
  Bantwana – 1,196/2,559  
  COMVIS – 2,082/3,244  
  CPA APAC – 360/1,426  
  ICOBI – 1,158/2,593  
  Caring Hands – 673/1,008 |

#### Concept 2: Bring HIV testing services to the community with vulnerable populations

<table>
<thead>
<tr>
<th>Change Idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Results</th>
</tr>
</thead>
</table>
| Conduct home-based HCT | Long distances to health centres made it difficult for vulnerable children and caregivers to access HIV testing services | • Project team leaders planned with health workers on targeted community HCT outreaches’ schedules, venues, logistics required, among others.  
  • VHTs conducted targeted mobilization and informed the vulnerable children and caregivers with unknown HIV status of the venue where HCT services would be provided. | KAREERA – 0-14 years improved from 17% (97/557) to 77% (435/558) and 15+ years from 7% (49/668) to 67%(453/670)  
  KIMOSI – 0-14 years improved from 25% (207/824 to 100% (824/824) and 15+ years from 30% (347/1149) to 100% (1149/1149)  
  FICHI – 0-14 years improved from 67% (404/603 to 80% (806/1000) |
| Conduct targeted community HCT outreaches | | | |
### Concept 3: Integrate HCT in other OVC programs

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Results</th>
</tr>
</thead>
</table>
| Conduct HCT during school holidays | Children were not reached with HIV testing services because they were at school | • Liaised with health facility in charges to provide HCT services during school holidays.  
• Social workers and VHTs conducted targeted mobilization for OVC with unknown HIV status and informed them about the need to test for HIV.  
• Identified a venue to conduct HCT. | **ABC Tororo** – Vulnerable children (0-14 years) increased from 5.6% (50/890) to 21% (189/890) tested |
| Use The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) school days to provide information on benefits of HIV testing | Children would never come for HIV testing with their caregivers | • The social worker visited schools on PIASCY days and provide information on benefits of HIV testing.  
• For children above 12 years who accepted to test they were requested to sign consent forms and would proceed to be tested for HIV.  
• For children below 12 years who wanted to test for HIV, invitation letters were sent to their parents to come and receive the children’s results. | **Caring Hands** – 31/191 children (0-14 years) tested of those who had unknown HIV status. |
| Organise HCT with village savings and loan association (VSLA) meetings | Caregivers complained that they had no time to go for HIV testing at a health facility | • Sensitization on benefits of HIV testing was done during the VSLA meetings.  
• Projects facilitated health workers who conducted HIV testing during VSLA meetings. | **FXB** – 8/100 caregivers with unknown HIV status were tested |

### 2. Change ideas to improve retention of HIV positive beneficiaries identified out of HIV care

#### Change 1: Use community resource persons to follow up HIV positives identified out of HIV care

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Results</th>
</tr>
</thead>
</table>
| Community resource persons conduct home visits to | HIV positive caregivers would take alcohol and would forget their clinic | • VHTs collaborated with health facilities and knew which caregivers had dropped out of HIV care.  
• VHTs conducted home visits to provide counseling, for example on the dangers of taking | **FICHI** – from 0/37 to 30/37 HIV positives were enrolled back into HIV care |
Provide counseling on benefits of re-enrolment into HIV care

<table>
<thead>
<tr>
<th>Concept 2: Improve wellbeing of HIV positives re-enrolled in HIV care</th>
</tr>
</thead>
</table>
| Train PLHIV to set up small gardens to grow vegetables and legumes that can supplement their meals | HIV positives do not have enough food to enable them to have 3 meals a day | • PLHIV were trained to set up backyard gardens and grow vegetables in sacks.  
  • The vegetables were for their own consumption and for selling to generate income. | Caring hands – HIV positives (children and beneficiaries 15+ years) enrolled back improved from 0/9 to 9/9  
  FICHI – HIV positives (children and beneficiaries 15+ years) enrolled back improved from 0/37 to 30/37 |
| Provide transport to critically vulnerable HIV-positive children to pick up drugs on their clinic appointments | HIV-positive children and caregivers failed to keep their clinic appointments because of the long distances to health centres that provide ART | • Social workers conducted home visits to the critically vulnerable HIV positives and would provide them transport to health centres to enable them keep their clinic appointments.  
  • The HIV positives were supported to request for extended clinic appointments. | KIFAD – HIV positive children enrolled back into care improved from 0/12 to 10/12 |

**Concept 3: Bring ART services closer to the community through the health facility and VHTs**

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Results</th>
</tr>
</thead>
</table>
| Give HIV positives extended clinic appointments for two or three months | Caregivers would find it hard to access ART services because of the long distance to health facilities | • Health facilities gave extended monthly appointments to HIV positives from distant places such that caregivers are able to organise transport.  
  • HIV experts were attached for follow up to ensure good adherence. | FICHI – PLHIV retained improved from 39% (50/128) to 93% (120/128) |
| VHTs take drugs for some HIV positive vulnerable children | | • VHTs take drugs for HIV positive children living with elderly caregivers.  
  • HIV expert clients follow up the children to provide adherence support.  
  • Children have scheduled appointment for clinic visit that coincide with obtaining tests such as viral load. | FICHI – PLHIV retained improved from 0/30 to 30/30*  
  *This represents the 30 children with whom the intervention was implemented |

(ii) Identifying new HIV positive OVC at community level
### 3. Change ideas to improve identification of new HIV positive children in the community

#### Concept 1: Efficiency in finding the new HIV positives

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Data</th>
</tr>
</thead>
</table>
| Use of a case finding tool to identify new HIV positive suspects | Need for criteria to target new positives | • Community resource persons were trained on QI approaches in the community, were organised into QI teams, allocated villages to work in and set indicators to improve upon.  
• Supported CSOs such as Karera, FICHI, etc. to train community resource persons on criteria such as: sickly or malnourished children, children who lost parents to HIV/AIDS, children living under care of an HIV positive caregiver. | 59% (326/557) new HIV positives identified and enrolled in HIV care in 38 communities |

#### Concept 2: Train community resource persons to provide home based counseling to identified HIV suspects on benefits of HIV testing

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community resource persons provide home based counseling to HIV suspects and make referrals for HIV testing</td>
<td>Stigma and discrimination associated with HIV positive results</td>
<td>• During home visits, community resource persons provided counseling on the benefits of HIV testing and the referral form (<a href="#">Appendix II</a>) was given to those that accepted to test.</td>
<td>0-14yrs - 74% (658/879) and 15+yrs - 81%(1024/1260).</td>
</tr>
</tbody>
</table>

### 4. Change ideas to improve re-enrollment of HIV positives identified out of HIV care

#### Concept 1: Follow up visits by HIV expert clients to provide counseling on benefits of re-enrolment

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Reason for the change</th>
<th>How the change was implemented</th>
<th>Data</th>
</tr>
</thead>
</table>
| Use HIV expert clients to provide counseling on benefits of re-enrolment into care to HIV positives identified out of care in the community | HIV positives identified out of HIV care feared to be stigmatized because of their results | • Through home visits to the HIV positives identified out of care, HIV expert clients shared their experience on remaining active in HIV care.  
• HIV positives provided counseling on the benefits of enrolment back into care. | HIV positives (0-14 years) 74% (40/54) and individuals 15+ years 71% (48/68) in 16 communities were re-enrolled into care |
Lessons learned

During the implementation of this work, we learned that:

- The use of the screening tool to identify HIV positive children in the community is effective and efficient. Based on the findings in the 38 communities from the community, an average yield of over 50% HIV positive children was achieved among all children who were identified as eligible by the screening process. This process was efficient as most of those identified as eligible received HIV testing services.

- Build capacity of existing community structures to improve service delivery for efficiency. Implementation of this work based on existing community resource persons who were provided basic training and supported on a regular basis to conduct planned activities. The community resource persons had people skills and were familiar with the community, integration of these activities enabled a smooth take off.

Recommendations

- To improve coordination of service delivery at the community level, it is important that you leverage on existing community structures to support vulnerable households. The community structures may be both informal and formal – what is important is to build their capacity to implement the activities effectively.

- Simple documentation tools are required at the community level to track related activities including needs, service delivery, referral, and feedback.

- There is need to build partnership with existing service providers to leverage on existing resources and improve access to a wide range of services for vulnerable children and their households.
Appendix I: Community-based HIV screening tool for children

**HIV positive case identification tool**

**Purpose:**
This tool is used for identifying HIV positive children in the community who have not been previously reached and link them to HIV testing services. The tool was designed to target children however, caregivers are also provided an opportunity to get linked to HIV testing services when a child is referred.

**Who administers the tool:**
Trained community resource person such as a para-social worker or VHT

**When is the tool administered:**
The community resource person administers the tool during a home visit. It is incorporated with other services to be provided during the household visit.

**Identification criteria:**
If a child is of unknown HIV status (no evidence of HIV testing) and has either of the characteristics below the should be referred for HIV testing services:

- Sickly child
- Malnourished child
- Child who lost parents to HIV/AIDS
- Child living under care of an HIV positive caregiver
### Appendix II: MGLSD referral form for vulnerable children

#### MINISTRY OF GENDER, LABOUR AND SOCIAL DEVELOPMENT

### REFERRAL FORM FOR ORPHANS AND OTHER VULNERABLE CHILDREN
(REVIS ED DECEMBER 2014)

1. **DETAILS OF THE SERVICE PROVIDER**

   - Name of the agency: 
   - Name of the person referring the child: __________________________ Title: __________________________
   - Telephone: __________________________ Email: __________________________
   - Signature & Stamp: __________________________ Date: __________________________

2. **CASE DETAILS**

   - Name of Child: __________________________ Age: __________________________ Sex: __________________________ Case No: __________________________
   - Village: __________________________ Parish/Ward: __________________________ Sub County / Division: __________________________ District: __________________________
   - Nature of the case: __________________________
   - Date of occurance: __________________________ Other risks / vulnerabilities / needs: __________________________
   - Name of Parent / Guardian / next of kin: __________________________ Tel: __________________________
   - Email: __________________________ Relationship with Child: __________________________
   - Village/cell: __________________________ Parish/ward: __________________________ Subcounty/Division: __________________________ District: __________________________

3. **SERVICES TO THE CHILD**

   - Services provided before referral: __________________________
   - Services being sought: __________________________
   - Have you spoken to the child or their parent/guardian about the referral? Yes/No. If No, provide details: __________________________

4. **RECEIVING ANGENCY DETAILS**

   - Name of Agency: __________________________
   - Location: __________________________
   - Name of the contact person (where known): __________________________
   - Telephone: __________________________ Email: __________________________

5. **FEEDBACK TO THE REFERING SERVICE PROVIDER**

   - Name of the Agency: __________________________
   - Name of person providing feedback: __________________________ Title: __________________________
   - Telephone: __________________________ Email: __________________________ Date: __________________________
   - Signature & Stamp: __________________________ ID No: __________________________ Case No: __________________________
   - Service provided by the referral Agency: __________________________
Appendix III. Results

(i) At CSO level
Results for both demonstrations at 4 CSOs and the spread 6 CSOs by February 2017 include:

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Baseline data</th>
<th>Follow on by July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vulnerable children (0-14 years) with a known HIV status</td>
<td>37% (894/2406)</td>
<td>76% (12649/16579)</td>
</tr>
<tr>
<td>2</td>
<td>Beneficiaries 15+ years with a known HIV status</td>
<td>33% (834/2480)</td>
<td>77% (13600/16811)</td>
</tr>
<tr>
<td>3</td>
<td>HIV positive vulnerable children (0-14 years) enrolled in HIV care</td>
<td>81% (40/49)</td>
<td>96% (435/445)</td>
</tr>
<tr>
<td>4</td>
<td>HIV positive beneficiaries 15+ years enrolled in HIV care</td>
<td>80% (237/294)</td>
<td>96% (1860//1883)</td>
</tr>
<tr>
<td>5</td>
<td>HIV positive vulnerable children (0-14 years) active in HIV care</td>
<td>82% (33/40)</td>
<td>90% (147/162)</td>
</tr>
<tr>
<td>6</td>
<td>HIV positive beneficiaries 15+ years active in HIV care</td>
<td>87% (210/240)</td>
<td>97% (388/398)</td>
</tr>
<tr>
<td>7</td>
<td>HIV positive vulnerable children (0-14 years) with undetectable viral load test results</td>
<td>0</td>
<td>82% (64/78)</td>
</tr>
<tr>
<td>8</td>
<td>HIV positive beneficiaries 15+ years with undetected viral load test results</td>
<td>0</td>
<td>96% (134/139)</td>
</tr>
</tbody>
</table>

(ii) At Community level
Results at community level include:

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Values by July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Children (0-14 years) who received HIV testing services through community health facility referrals</td>
<td>74% (658/879)</td>
</tr>
<tr>
<td>2</td>
<td>Beneficiaries 15+ years who received HIV testing services through community health facility referrals</td>
<td>81% (1024/1260)</td>
</tr>
<tr>
<td>3</td>
<td>HIV positive children (0-14 years) who had dropped out of HIV care who were enrolled back into HIV care</td>
<td>74% (40/54)</td>
</tr>
<tr>
<td>4</td>
<td>HIV positive beneficiaries 15+ years who had dropped out of HIV care who were enrolled back into HIV care</td>
<td>71% (48/68)</td>
</tr>
<tr>
<td>5</td>
<td>Children (0-14 years) identified as suspects and referred who tested HIV positive</td>
<td>54% (197/366)</td>
</tr>
<tr>
<td>6</td>
<td>Individuals 15+ years identified as suspects and referred who tested HIV positive</td>
<td>53% (280/530)</td>
</tr>
</tbody>
</table>
Appendix IV: PLHIV home visit form

### Monthly Home visit form for PLHIV

<table>
<thead>
<tr>
<th>Visit date:</th>
<th>HH unique ID:</th>
<th>HH head:</th>
</tr>
</thead>
<tbody>
<tr>
<td>District:</td>
<td>S/county:</td>
<td>Parish:</td>
</tr>
<tr>
<td>Village:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Name of Health facility providing care</th>
<th>Patient ID number</th>
<th>Age</th>
<th>Sex (M/F)</th>
<th>Enrolled on ART (Y/N)</th>
<th>Active in HIV clinic (Y/N)</th>
<th>Kept last appointment (Y/N)</th>
<th>Adherence to ARVs (G/F/P)</th>
<th>Have an up to date VL test (Y/N)</th>
<th>VL test undetectable (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Retention in HIV care

**When were you enrolled in HIV care?**

**When did you last receive your treatment?**

### Gaps identified and plan to address gaps

<table>
<thead>
<tr>
<th>Gap</th>
<th>What has been done today?</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did not keep last appt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Fair/Poor adherence to ARVs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. No viral load result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Others (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Codes**

*Active in HIV clinic:* Made a physical visit to the HIV clinic in the last 3 months

*Update Viral Load:* At least 1 VL in one year; *Undetectable VL:* less than 1,000 copies/ml

**Adherence codes:**

<table>
<thead>
<tr>
<th>Adherence</th>
<th>Missed doses per month</th>
<th>1x daily dosing</th>
<th>2x daily dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>G (good)</td>
<td>≥ 95</td>
<td>≤ 2 dose</td>
<td>≤ 3 doses</td>
</tr>
<tr>
<td>F (fair)</td>
<td>85-94%</td>
<td>2-4 doses</td>
<td>4-8 doses</td>
</tr>
<tr>
<td>P (poor)</td>
<td>&lt; 85%</td>
<td>≥ 5 doses</td>
<td>≥ 9 doses</td>
</tr>
</tbody>
</table>

Are you currently saving with a VSLA group- for caregiver? (Yes/No)

Please mention the name of the VSLA group where you are saving

How often do you save in the mentioned saving group?

*Adapted by USAID ASSIST*
USAID APPLYING SCIENCE TO STRENGTHEN AND IMPROVE SYSTEMS PROJECT

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