# Community-level improvement teams address person-centered care in Uganda, Tanzania and Botswana

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## Disclosures

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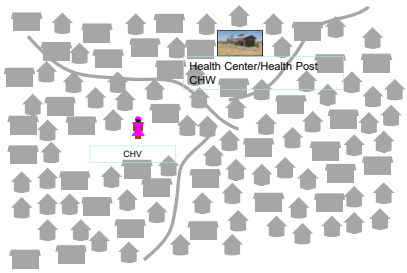
## Session overview

- **Overview presentation on improvement at the community level in Africa**
- **Botswana case study**
- **Tanzania case study**
- **Uganda case study**
- **Questions and answers**
- **Interactive discussion**

# COMMUNITY HEALTH SYSTEM



## Health care structure in communities



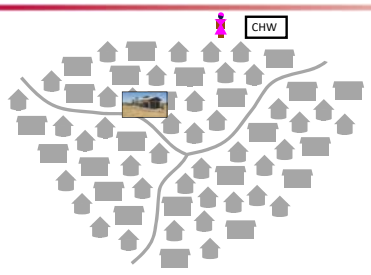

Challenges:
- Low coverage
- Low retention
- Lack of follow-up
- Low referral

Because:
- Large coverage area
- No transportation
- No support

Therefore:
- Not able to reach all households often
- Miss hard-to-reach households
- Low motivation



## No formal structure linking health facility to household



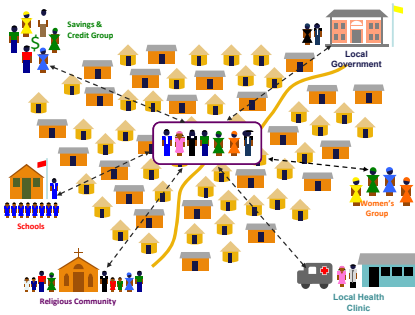

**Expensive option:**
More community health workers or volunteers

**Moderate cost:**
Increase community engagement and support

## Community health workers carry a large burden




## Organizing a community health system

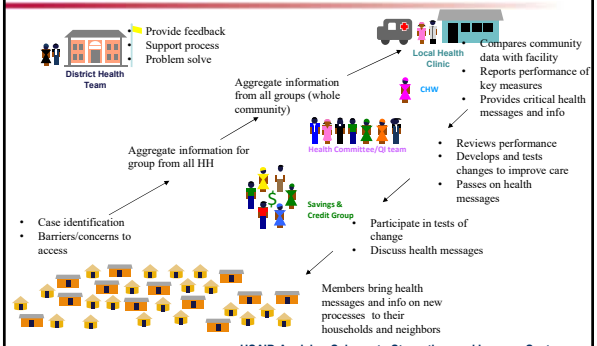



Health committee/QI Team:

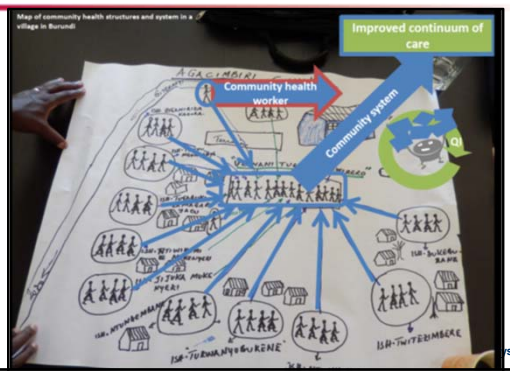
- Pulls from existing groups and networks
- Each group sends representatives
- Each group member has responsibility to follow up on health issues with their household
- Two-way information exchange



## Community health system two-way information flow process



## Example of community's map for creating the QI team





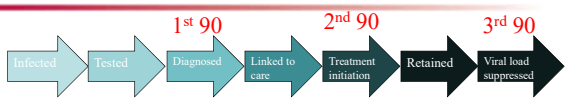

## Community health system: Adapting improvement

- **Tap into existing networks in the community to set up team**
- **Design system for community-level data collection to supplement facility data**
- **Promote locally developed solutions, tested for a short time**
- **Improve health messaging, case identification, access to services, referral, follow-up**

***Improvement at the community level more fluid than at a facility***



## Improving the HIV Cascade: How a Community Health System can engage




| | | | | | |
|---|---|---|---|---|---|
| Prevention messages | Testing messages<br>Targeted testing<br>Access to testing | Stigma reduction<br>Disclosure support (general messaging) | Value of care messages<br>Reducing barriers (together with facility) | Adherence messaging<br>Support finding lost to follow-up<br>Support adherence (income generation; social support) | Messages on secondary prevention |

# BOTSWANA CASE STUDY

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## Botswana Country Context

**Location**: Southern Africa
**Population**: ~2.2m
**Economy**: Upper Middle income


**Health Services delivery:**

- Pluralistic, predominantly public and free
- Managed at local, sub-national and central level
- Reduced mortality but high HIV prevalence and incidence
- Predominantly clinical acute care interventions
- MoH interested in strengthened role of communities to revitalize Primary Health Care

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## ASSIST in Botswana: Scope and Scale


Coordinated PEPFAR Botswana efforts to achieve epidemic control started in October 2015

- MOHW, MLGRD at national and district level; District and Tribal Administration; other IPs under PEPFAR-B
- 7 PEPFAR priority districts with high-burden of ART and HIV
- 40+ facilities with highest volume of ART (no direct TA) and associated referral sites
- 40 communities around high-volume facilities
- 40 community-based QI teams as of 31 March 2016; 1 provider-based QI Team
- Direct and indirect beneficiaries: majority of Botswana's HIV population through improved delivery systems

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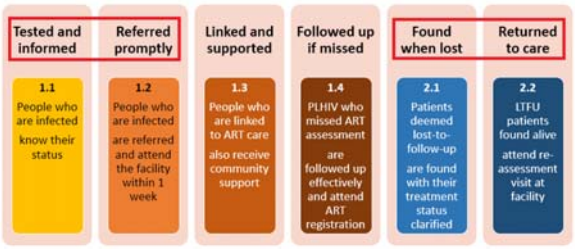
## Improvement aims along the HIV cascade

Community QI teams undertake a thorough problem analysis of local gaps and barriers to effective patient-centered HIV care, then prioritize their efforts



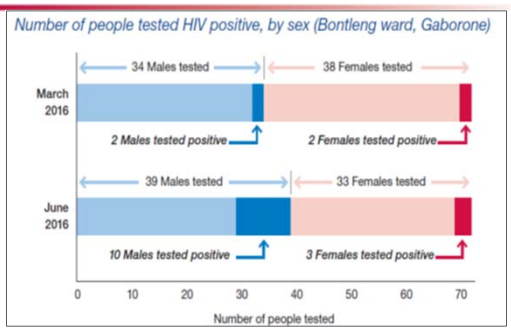



## Illustration 1: Community-directed campaign for patient centered HTC services

| Prioritised improvement aim | Improving the identification of HIV+ (increasing number of at-risk men to test) |
|---|---|
| **What is the problem?** | Low rate of men who test and know their HIV status resulting in low positivity rate among those who were tested. |
| **How did the CIT identify this as a problem?** | A BOCAIP (CBO providing community based HTC) CHW who is a member of the CIT shared that Counsellors were unable to reach weekly positivity targets of 12% despite having conducted targeted campaigns in the locality. |
| **What were the result of the problem analysis** | After discussing the challenges experienced by BOCAIP during 2-day HTC campaign around a ward covered by the CIT in March 2016; the team concluded that the root course of the problem was that community were indifferent to BOCAIP home/mobile HTC for various reasons and that BOCAIP lacked familiarity with possible hot spots for HTC demand. |
| **What change idea was prioritized?** | CIT members to use their local knowledge, legitimacy and relations with community members to direct BOCAIP around the community including to places where men are found in large numbers and to introduce the services and encourage community members to test. |



## Results 1: Improving the identification of HIV+ persons (increasing number of at-risk men to test) in Bontleng



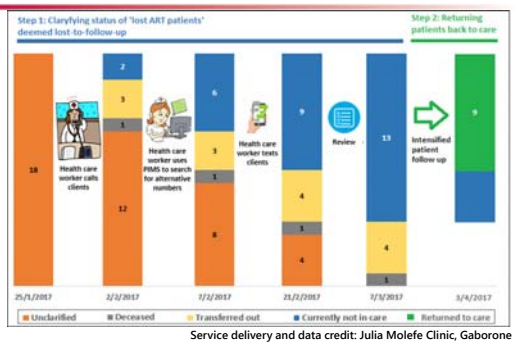

Service delivery and data credit: BOCAIP Gaborone

## Illustration 2: Reconnecting patients "lost to follow up" with care services

| Prioritised improvement aim | To recover HIV patients not currently in care |
|---|---|
| **What was the problem?** | The Health Education Assistant (HEA) from Julia Molefhe clinic who is a member of the CIT advised that the extent of HIV patient lost-to follow up (LTFU) is concerning and that it should be the focus for the CIT. |
| **Who did the problem affect?** | Men and women from wards covered by CIT who were initiated on ART at Julia Molefhe clinic but are no longer returning for care visits. |
| **What evidence substantiated problem?** | A total 18 patients have not returned to ARV clinic appointments in 2016 |
| **What was the problem attributed to?** | After discussing the challenges the team felt that patients deemed LTFU were not followed up by the clinic for various reasons attributed to capacity shortages. |
| **What Change idea was tested?** | The HEA who has access to the patients' records will re-organise her daily schedule to contact the 18 LTFUs and report back to the team without disclosing their identifiers. The contact mode will initially be telephonic. |



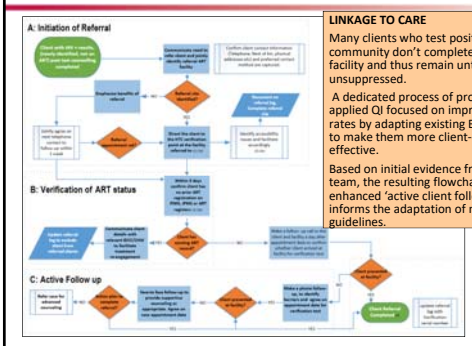
## Result 2: Patients 'lost to follow up' status clarified and returned to care at Julia Molefhe Clinic




Service delivery and data credit: Julia Molefe Clinic, Gaborone



## Institutionalized improved linkage-to-care process based on evidence generated through service provider QI




**LINKAGE TO CARE**

Many clients who test positive in the community don't complete referral at a local facility and thus remain untreated and unsuppressed.

A dedicated process of problem analysis and applied QI focused on improving low LTC rates by adapting existing BOCAIP processes to make them more client-centered and thus effective.

Based on initial evidence from the BOCAIP QI team, the resulting flowchart incorporates enhanced 'active client follow up' and informs the adaptation of national LTC guidelines.

## What have we learned?

- Community-based service delivery processes **refined with the community involvement** can enhance patient-centeredness.
- Consolidated applied QI by a team with shared concerns can improve quality of care and help to **institutionalize more effective practices** that promote patient-friendly services.
- Community-led process innovations are critical to **simplify access to care** according to patient needs.
- Active, legitimate **monitoring** and **accountability** to the community provides a platform for mutual prioritization of shared health services concerns and offers an opportunity for joint **development** of care modalities that promote **responsiveness to patient needs**.
- Adapting service modalities according to the **specific preferences and needs** of sub-populations promotes patient-orientated services.
- Continuous improvement incorporating practice experience and **patient perspective** is effective in improving efficiency and **effectiveness** of services.



# TANZANIA CASE STUDY



## USAID ASSIST Project Tanzania Coverage


Divided into 31 Regions and 169 districts
HIV prevalence at 5.1%
ART coverage at 37%

MOHCDGEC, 18 IPs

84 PEPFAR scale-up and 98 sustained Councils

618 facilities

260 communities

878 QI teams

23,289,864 out of 50 million

## Goal of the community patient-centered initiative

- To contribute to the attainment of the 90:90:90 UNAIDS goals through detection of PLHIV, ART initiation, retention in care as well as promotion of linkages

### Objectives

1. To build capacity of communities to implement community-based mechanisms for promotion of HIV testing, ARV pick-up for stable patients, ART adherence and retention
2. To strengthen bidirectional community-facility referral systems and linkages for PLHIV

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## Support to community teams to identify gaps, analyze, test changes that address patient preferences, needs and values

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## PLHIV concerns discussed and addressed by the community QI teams

- Too much time spent in long queues at clinic
- Long walking distances to the clinic
- Transport cost
- Forgetting to take prescribed ARVs at home
- Stigma
- Lack of someone trustworthy to share concerns
- Adherence to ARV and coping with side effects
- Income generation activities
- Care of orphans and most vulnerable children
- Disclosure of status to relatives and partners

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## Key interventions

- Community sensitization on HIV testing to all family members of the community QI team
- Engaging religious leaders to routinely promote HIV testing, ARV pick up, adherence and stigma reduction during mass and other religious gatherings
- PLHIV support group members in each village motivating fellow PLHIV clients on keeping their scheduled ARV appointments, adherence to medication, allaying anxiety related to toxicity of ARV and side effects
- Treatment supporters and fellow PLHIV picking ARV for their colleagues who cannot show up to clinics due to lack of bus fares and other reasons
- CHBC providers sharing reports on progress made in tracking LTFU, missed appointment clients (without exposing clients' identities) during community QI team meetings
- CHBC sending mobile SMS messages reminding PLHIV clients on their scheduled appointment

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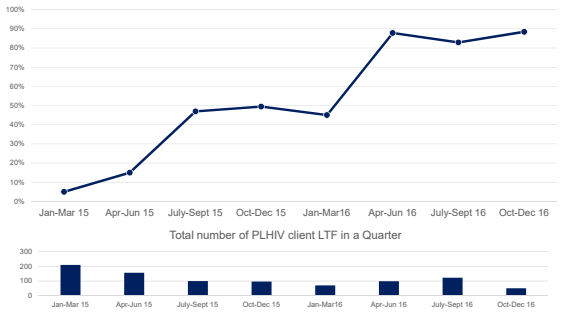
## Tracking lost to HIV care: % of PLHIV tracked back to HIV care at Muheza District Hospital Jan 2015 – Dec 2016 (USAID ASSIST & LEAD)

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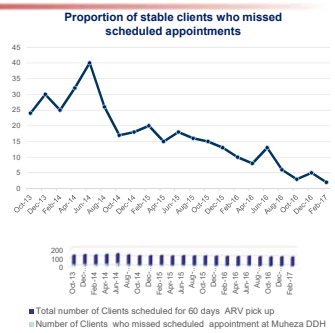
## Improved ARV pick up among stable patients at Muheza District Hospital

*"She [the patient] would come and talk to me because she felt comfortable. We would talk about daily life, and she told me what was going on. She was moving from place to place and didn't want to people to know she was HIV+ and taking ARVS, knew she was in denial stage. So I encouraged her that I went through the same experience …and I was able to take her ARVs refills for about 5 months; now she has accepted and even goes to take my ARVs" (Expert patient in Tanga)*

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# Thank you!



## UGANDA



## Uganda at a Glance

**Health & Demographics:**

- Population – 35 million (1.3m in 3 districts)
- 37.8% live on < $ 1.25/day
- 84% live in rural areas
- 93% of households live within 10km of a health facility
- HIV prevalence 7.4% (5.8% in 3 districts)

**Health system:**

- Referral basis – HC I, HC II, HC III, HC IV, District Hospital, Regional Referral Hospital
- Village Health teams constitute HC I
- HC I services - Health promotion and community participation

## Problems addressed

- Poor retention in care for clients on ART <85% (HCI, 2011)
  - clients loss to follow up
  - Missed visits
- Minimal interaction/feedback between health facilities and communities
- Inadequate patient tracking systems in the community
- Low involvement of volunteer village health teams in HIV/AIDS activities (HCI, 2012)
- Long term support for PLHIV in the community almost non-existent (HCI, 2012).



## Community Improvement Approach

**What was done:**

Community support for HIV continuum of care

+

**How it was done:**

- Dialogue with clients
- Client self-care
- Community follow up care & support

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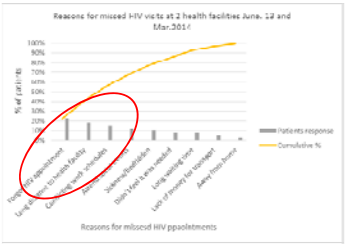
**Output/ outcome**

- Retention in care
- Clinical wellness



## Understanding barriers patients face in HIV care




Steps:

- Use facility records to identify communities where fewer patients attend HIV cares visits
- Discuss with patients to identify barriers and solutions
- Prioritize barriers
- Communicate with health team
- Integrate solutions into patient routine care

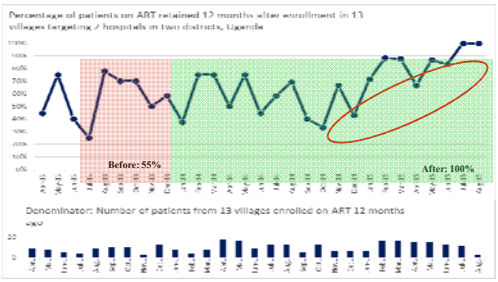
## Activity I: Using Client Feedback to Improve HIV care appointments in 18 villages


**Steps:**

- Clients identify supportive community personnel
- Mobilise community support teams
- Develop trust & confidence for community support
- Link clients to community personnel
- Map client locations
- Pre-appointment visits
- Discuss barriers and develop plans
- Follow up

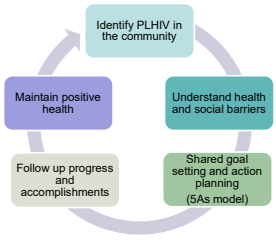


## Result I: Maximum Retention on ART at 12 months

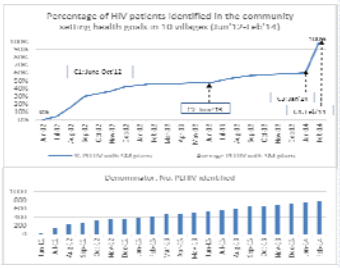





## Activity II: Empowering HIV clients to manage their care in the community




## Result: Goal setting to address individual barriers to HIV care




**Client-community goal setting ideas:**

**C1:** Target clients with poor clinical status (Medical complaint, weight loss, basic routines)

**C2:** Individual goal setting action plan.

**C3:** Phase long term goals into short, achievable and realistic targets.

**C4:** all clients irrespective of clinical status set goals to maintain good health



## Result II: Clients with good clinical outcomes improved from 61% to 91% at Buikwe Hospital

*"There is something different about the patients I receive at the HIV clinic that come from Kulingo village. They are happier and I notice more openness and reduced stigma. They attribute this to their strong community support system, and they feel more empowered because they can now access basic needs and are able to pick their drugs from the hospital on time".*

**Joweriah Kasiir, In-charge, HIV Clinic**

**Kamuli General Hospital**

*"The clients have improved from their bad state of living, their health has improved gradually due to having a personal life plan"*

**Male VHT, Kisimba Village**



## Lessons

- **Client centered solutions improve experiences with care and sustains positive health.**
- **Community resources fill gaps in services that are not provided by the health system.**
- **Patient self care saves time for community providers to provide focused visits to patients.**
- **Constant interaction between the patients and their community-based providers promotes continuity of care.**

## CONCLUSIONS



## Community health system promotes patient-centeredness

- Engages patients and community members in finding ways to improve care
- Provides venue for collecting and sharing information about patient needs and wants with facility
- Supports patient responsibility by reaching into households



## AUDIENCE DISCUSSION

## Acknowledgement

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