Sustaining Adherence and Retention in Care in community level HIV and AIDS services in Swaziland

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Outline

- Introduction
- Adherence Strategy
- Key activities and components of care
- FY12 Results
- Evaluation Findings
- Challenges and opportunities
Community Linkages Project Sites

Population <1.2m

HIV prevalence 41.1%

- Hhohho: 9 Clinics
- Lubombo: 8 Clinics
Community Linkages Project (CLP): CDC-PEPFAR funded project.

- **Project Goal:** Improved quality of life of people living and affected with HIV and AIDS.

- **Objectives:**
  - Integrated community care and support for PLWHA
  - Nutritional support to PLWHA and their families

- **Two Regions:** Hhohho and Lubombo

- **Target population:** 40,065 people

- **Project duration:** 2010-2014
Adherence Strategy

- Establish Functional Links: Community → Clinic → Community using community Expert Clients

- Strengthen existing MOH & community health structures and Resource Persons

- Facilitate supportive community supervision, and mentoring of health services

- Strengthening M&E systems at community and health facility levels
**Component of Care**

**Community Level**
- Home Base Care, HIV and PMTCT services
- Establish/Strengthen Support groups
- Train/Mentor RHM, HBCs, CEC
- Support linkages between RHM/HBCs & clinics
- Patient follow up & tracking

**Health Facility Level**
- Clinical assessment and evaluation
- Laboratory workup
- Provision of ART/OIs
- Monitoring for side effects & complications
- Screening for other RH/STI
- Links with community
Referral Network-A Model of Care

- Network of community resource people committed to visiting/supporting people on treatment

- Composition: CHWs, HBCaregivers, Volunteers, Health Surveillance, Mobilizers, youth/women groups, FBOs, CBOs etc

- Enrolled, trained, mentored & supported to work at household/community level

- Facilitate referral between community and health facility
Circle of Care for PLWHA

- Patient
- Community Expert Clients
- Motivators
- Rural Health Volunteers
- Community Health Workers
- Clinical Nurses
- Doctors

Health Facility Community
FLOW OF CARE FOR COMMUNITY EXPERT CLIENTS

Community Level
- RHMS
- CEC
- CHWS
- HBC
- Volunteers

Facility Level
- PLWHA Support Groups
- Clinical Officers
- Health Centre
- Nurses
- Doctors

PLWHA Support Groups
- ID Patients
- Link patients to CHWs/Nurses
- Follow Up/Adherence Support
- Link Groups to Clinic

Community Expert Clients
Community Expert Client Role

- Identify patients who miss appointment & follow them up
- Link patients with CHWs
- Act as clinic focal person for CHWs
- Coordinate & link support groups to clinic
- Counseling of HIV patients and adherence support
Evaluation of Community Linkages Project

- 12 Month ART Client Outcomes
- Analyzed Oct-Dec 2010 Cohort (total of 2387 ART patients)
- 22 Facilities: 13 CLP sites, 9 Non CLP sites
  - 6 Manzini, 8 Hhohho, 8 Lubombo
- Evaluation Outputs:
  - Retention Rate
  - LTFU Rate
  - Death Rate
Tracking Care to beneficiaries in Community Linkages Project FY 2010-FY2012

- **Households visited and provided with HBC:**
  - FY 2010: 3,191
  - FY 2011: 6,254
  - FY 2012: 8,535

- **Defaulting patients that returned to care:**
  - FY 2010: 167
  - FY 2011: 618
  - FY 2012: 1,231

- **PLHIV provided with psychosocial support:**
  - FY 2010: 1,134
  - FY 2011: 4,892
  - FY 2012: 8,935

- **Beneficiaries linked/referred to the clinic:**
  - FY 2010: 342
  - FY 2011: 3,713
  - FY 2012: 4,935
Home Based Care FY2011- FY2012

Number of beneficiaries

FY11
FY12

Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sept
Loss to Follow Up rate FY11 - FY12

Loss to follow up: Client not to care after 90 days.
Retention and Attrition Rate at CLP and Non CLP sites

- **Non CLP**:
  - % Active#: 76.2%
  - % Attrition#: 23.8%

- **CLP**:
  - % Active#: 91.2%
  - % Attrition#: 8.8%

% Active# (After 12 mnths)
% Attrition# (After 12 mnths)
Lost To Follow Up rate at CLP and Non-CLP sites

NoN CLP: 18.3%
CLP: 6.9%
Death rate at CLP and Non-CLP sites

NoN CLP: 4.6%
CLP: 1.9%
Sustained contacts with PLHWA by various cadre of community resource persons

Effective links and follow up between community and clinics and vice versa

Engagement in adherence support groups

Regular monitoring and tracking patients in care

Use of simple and easy-to-use tools by CHWs improves adherence and retention in care for PLHWA.
Challenges:

- Late reporting especially by elderly CHWs
- Transition/Death of CHWs
- Tracking patients who relocate to South Africa
- Support groups not keen on engaging on psychosocial activities alone

Opportunity:

- Absorption of CECs by MOH
Conclusion

- CLP supported sites had higher retention rates, lower LTFU & death rates
- Sustained contacts with PLHWA by various cadre of community resource persons improves adherence
- Use of Community Expert Clients is an effective way to link clients to and from clinics and communities
- Maintaining Functional linkages from community-to-clinic-to-community is critical to adherence and retention in care for PLWHA
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