



Beyond the Clinic: Improving adherence and viral load suppression for children living with HIV through home-based Root Cause Analysis and Joint Action Planning

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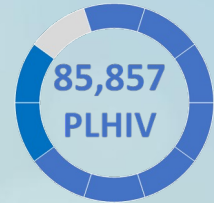
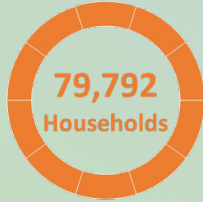


- **Uganda's HIV viral load suppression rate (VLS) for children (84.4%)** remains below adults (94.6%) due to complex clinical and socio-economic factors
- **Non clinical barriers** to treatment that present at **home, school and in the community** require support beyond the clinic
- **Joint home visits by clinic and community case managers** can rapidly improve adherence and VLS outcomes for children
- However, **unstructured and ad hoc home visits** by joint teams have limited impact



Program Description

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Under the USAID/Integrated Children and Youth Development Activity (ICYD), **community case managers** coordinate and deliver **integrated health and social protection services** with clinic counterparts to **improve HIV treatment outcomes** for **30,098** children living with HIV (C/ALHIV) across 44 districts in Uganda.



During home visits, case managers observed significant **treatment barriers** linked to **socio-economic/child protection** issues.



Holistic assessments and structured follow up was needed to effectively address barriers to non suppression in children and adolescents.



Our Response

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Developed and tested a **holistic Root Cause Analysis (RCA) and Joint Action Plan (JAP)** tool in 10 districts

Trained Case Managers (CMs) to assess **clinical and social protection barriers** with families and clinic teams during home visits

CMs developed **care plans** with families outlining the responsibilities of clinic and community actors

CMs monitored progress until children were suppressed and families confident to manage HIV treatment independently



Holistic assessments must address barriers across multiple platforms

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Health Facility



Household



Insufficient food

Unreliable or forgetful caregivers

Lack of clinic transport

Pill burden & bitter taste

Missed appointments

Wrong dose/ schedule

Regimen not optimized

Fear of stigma/discrimination

Traditional medication beliefs

Missing meals/doses when in school

Fear of stigma/discrimination

Lack of supportive teachers

Community



School



**Non suppressed
C/ALHIV**

RCA & JAP Tools include:

1. Background information
2. Viral load & regimen history
3. IAC session history
4. Household socio-economic status
5. Root Cause Assessment (RCA)
6. Joint Action Plan (JAP)

Coordinated Interventions & Results*

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Root Cause	Clinical Services	Community Services
Poor drug administration by caregivers	Intensive treatment literacy including DTG optimization	Directly Observed Treatment (DOT) by trained case managers during home visits
Poor adherence due to unstable treatment supporters	Disclosure support, adherence counseling, access to community ART	Disclosure support at home, PSS, treatment supporter attachment , child protection/abuse screening
Routine data reviews	Routine data reviews by clinic and community teams	Case file documentation support through CM clinic placements
Food insecurity	Clinical referral for severe malnutrition	Emergency food support, backyard gardens, nutrition

C/ALHIV VLS rate increased from **91% to 93%**

2% represents an increase in **VLS from 4,526 to 5,484 children**

*Between October 2021 & June 2022



Joint RCAs and JAPs enabled **rapid assessment and resolution of silent adherence barriers** that may be missed by busy health facilities (root cause based service delivery)

Joint home visits with clinic staff, and continuous upskilling of case management cadres to use the RCA and JAP tools were essential to the success

Engaging **caregivers and children in RCAs** fostered **ownership and agency to solve problems and own situation**

Children and adolescents faced different issues: adolescents struggle with **stigma and discrimination**, younger children struggle with unstable treatment supporters

Lessons Learned



Recommendations

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- **Institutionalize simple clinical practice at community level:** Scale up Directly Observed Therapy (DOT) for every unsuppressed child
- **Treatment barriers differ for children and adolescents:** Assessment tools need to be **age-sensitive** to ensure delivery of age-appropriate solutions
- **Promote family-driven solutions:** Engaging the family in problem identification and solving builds ownership, agency and confidence for sustaining children's long-term HIV management



A case manager helps a family set up a child's ART regimen schedule

Uganda Partners

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Ministry partners:

- Ministry of Gender, Labour and Social Development (MGLSD)
- Ministry of Health (MOH)

Funding partner:

- PEPFAR/USAID

HIV clinical and community implementing partners

- Bantwana Initiative/World Education
- Mildmay Uganda
- Reach Out Mbuya





Thank you “Mwebale Nyo”

For more information, please contact

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