



IMPROVING ACCESS TO HIV/AIDS CARE AND PATIENT RETENTION IN RUSSIA

Background

The USAID-funded Quality Assurance Project (QAP) began work in the Russian Federation in 1998, initially supporting the piloting and scale-up of improved systems of care for maternal and child and primary health care. In 2003, USAID asked QAP to apply quality improvement methods to improve treatment, care, and support for HIV-infected and AIDS patients. From 2004-2006, QAP supported a demonstration collaborative on HIV/AIDS treatment, care and support involving sites in four cities in the oblasts of Samara, Saratov, and Orenburg, and St. Petersburg. The aim of the demonstration collaborative was to develop a municipal model for delivery of treatment, care and support services to persons living with HIV/AIDS (PLWHA).

Problem Analysis

- Over 400,000 HIV-infected individuals are officially registered in Russia; almost 80% of them are substance users, and only half are in HIV care and treatment
- Tuberculosis (TB) is a major co-infection; 30% of people with late stages of HIV present TB, yet only 10,000 people have been identified as TB-HIV co-infected
- Although the availability of antiretroviral therapy (ART) has expanded since 2005, the number of HIV patients on treatment remains low
- Reliance on specialized AIDS centers has limited the Russian health system's ability to respond to the needs of a growing number of patients; moreover, HIV, TB and substance abuse treatment services are weakly integrated and have little coordination with the general health care system

Strategies for Change

Improvement teams were formed from representatives of AIDS centers, polyclinics, TB and narcological dispensaries, social service organizations, NGOs, and patient advocacy groups. Each team included 12-15

people. The improvement collaborative methodology was applied to organize mutual learning and sharing of ideas among team members and teams. QAP staff provided coaching to teams through field visits and frequent communication.

Illustrative Changes Introduced in the HIV/AIDS Treatment, Care and Support Collaborative

Area of Care	Changes Introduced by Teams
Access to counseling and testing	<ul style="list-style-type: none"> • Reduction in turnaround time from 2 weeks to 72-96 hours • Patient materials developed and information stands on HIV/AIDS and ART installed at all health care facilities • Care providers trained in voluntary counseling and testing (VCT) • Algorithm for access to ART developed and institutionalized by official order (<i>prikaz</i>) • Information exchange mechanisms established between care providers
Screening of HIV patients for TB and counseling on TB-HIV co-infection	<ul style="list-style-type: none"> • Orders issued regulating HIV-TB counseling, TB screening and information exchange between services • Initiated systematic X-ray screening of HIV patients at primary care settings and routine tuberculin testing at the AIDS Center • Staff of TB facilities, AIDS Centers and primary care settings were trained in HIV, HIV-TB and VCT • AIDS Center specialists were deployed to TB facilities to provide TB-HIV counseling • Information exchange established between primary care, TB services and AIDS Center • Cooperation established with NGOs to refer patients for TB screening • Outreach workers and hot-line staff trained in HIV-TB
Coordination and continuity of care	<ul style="list-style-type: none"> • Follow-up of HIV clients at polyclinics organized • Data on HIV patients exchanged between the AIDS Center and polyclinics to inform primary care providers about patients in their catchment area • Primary care infectious disease specialists asked to actively encourage patients who have not been in the health care system to visit the polyclinic for a check-up • System of referrals and communication re-organized between primary care settings, AIDS Centers and specialty facilities
Social support	<ul style="list-style-type: none"> • Social worker/case manager position created at the AIDS Center • Social workers trained in case management • Referral mechanisms developed • Cooperation established with NGOs and peer support groups • Communication established between specialty services, primary care settings and social services

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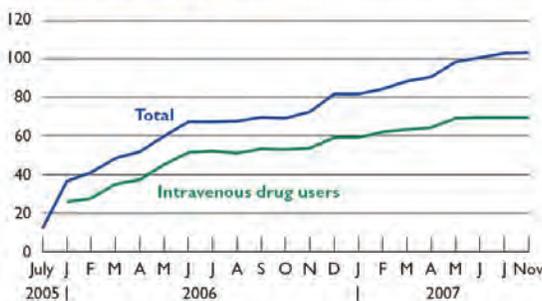
To ensure that the work of teams was authorized and constantly monitored, coordinating committees were formed in each city and were chaired by health authorities with active involvement of the heads of the participating institutions. Regional and interregional learning sessions were organized by QAP with the participation of national and international experts.

Results

Teams in all four cities have made gains in HIV case detection and access to ART. Innovations developed by teams to make TB screening more accessible for HIV-positive clients, increase counseling on HIV-TB co-infection, and increase TB preventive treatment among HIV clients have also spread to additional facilities in St. Petersburg, Orenburg Oblast, Saratov Oblast, and Samara Oblast. In Orenburg, the successes of the original TB-HIV team resulted in the Orenburg Oblast Ministry of Health issuing an order in May 2007 to mandate cooperation and the exchange of information on HIV patients between the AIDS Center, TB services, and polyclinics; introduce a TB-screening algorithm for use with HIV patients; and institute TB preventive therapy among HIV patients.

In 2006, QAP began planning, together with local authorities, for spread activities to extend the improvements and innovations developed in the demonstration sites. New spread collaboratives were developed with authorities in St. Petersburg City and Leningrad Oblast and Orenburg Oblast to scale up improved systems for detection, referral, and follow-up of HIV-positive persons to increase access to ART and for the management of TB-HIV co-infection. The USAID Health Care Improvement Project, the successor to QAP, is now supporting these spread collaboratives.

Number of HIV-positive Individuals Receiving ART in Krasnogvardeisky District of St. Petersburg 2005-2007

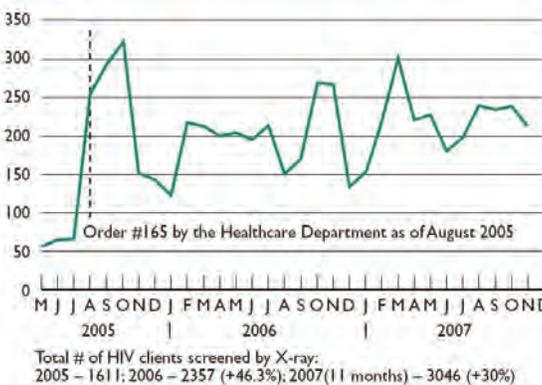


Value of QI for Local Authorities

“Improved data collection and presentation as well as clear workplans with clear targets help us at the Ministry better justify the regional target HIV program budget when developing the entire health sector budget. This year we got 100% funding.”

Dr. Komarov, Minister of Health,
Orenburg Oblast, 2007

Number of HIV Patients Screened for TB by X-ray with the Results Submitted to the AIDS Center Togliatti, Samara Oblast, 2005-2007



Lessons

- The collaborative facilitates building a shared vision among providers, generates commitment for improvement and ownership for successes, thus ensuring long-term sustainability of new practices
- Interdisciplinary teams need to be constantly supported to keep them focused on their improvement objectives, encourage regular meetings, and assist them with using data for analysis of improvements during action periods. Support of the institution's leadership for the quality improvement activities is important, as well as having time allocated during the work schedules to participate in team meetings.
- Communication of results by team members to other staff of their institutions and to the leadership was very important to maintain the momentum of improvements. Our project facilitated this by providing phone cards, facilities to conduct conference calls, and access to the internet.
- **Key Message:** Where HIV/AIDS services are fragmented and systems are vertical, improvement efforts need to foster interdisciplinary collaboration between various sectors such as health, social services, education, and nongovernmental sectors. Having health authorities on board and bringing different types providers together to work out operational issues in care integration yields solutions which then can be rapidly taken to scale.