STRENGTHENING UGANDA'S SYSTEMS FOR TREATING AIDS NATIONALLY

Best Practices Handbook
HIV Care and Treatment

DISCLAIMER

The USAID Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) project supports the Uganda Ministry of Health to strengthen sustainable and innovative approaches for HIV and TB service delivery at selected healthcare facilities. This project is made possible by the support of the American people through the United States Agency for International Development (USAID).

The content of this publication does not necessarily reflect views of USAID or the United States Government.

ACRONYMS

AIC	AIDS Information Centre
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
CCI	Child Chance International
EMTCT	Elimination of Mother-to-Child Transmission of HIV
FY	Fiscal Year
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
MOH	Ministry of Health
Open MRS	Open Medical Records System
RRH	Regional Referral Hospital
SUSTAIN	Strengthening Uganda's Systems for Treating AIDS Nationally
TASO	The AIDS Support Organization
TB	Tuberculosis
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UN	United Nations
UPMB	Uganda Protestant Medical Bureau
URC	University Research Co., LLC
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision

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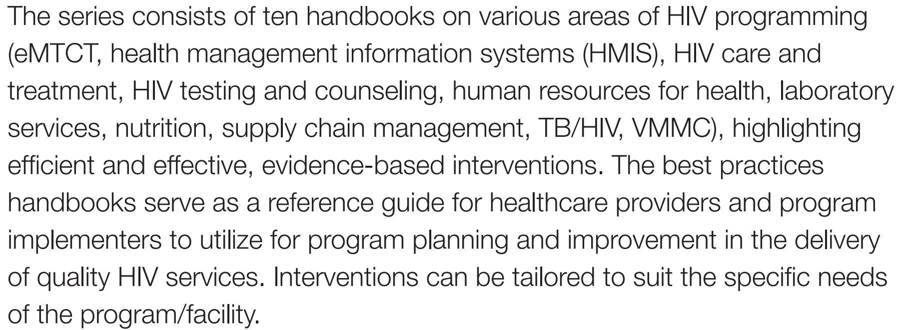
SUSTAIN BEST PRACTICES BOOKLET SERIES

The Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) project is funded by the United States Agency for International Development (USAID) and implemented by University Research Co., LLC (URC) in partnership with: The AIDS Support Organization (TASO), Integrated Community Based Initiatives (ICOBI), Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), Uganda Muslim Medical Bureau (UMMB), Child Chance International (CCI Uganda), AIDS Information Centre (AIC) and ACLAIM Africa. The original project duration was five years (2010-2015), but it received an extension of three years. USAID/SUSTAIN supports the Uganda Ministry of Health (MOH) to strengthen sustainable and innovative approaches for human immunodeficiency virus (HIV) service delivery at select regional referral and general hospitals and health centre IV's.

The project objectives are:

- Support the MOH to scale up elimination of mother-to-child transmission of HIV (EMTCT) and voluntary medical male circumcision (VMMC) as HIV biomedical interventions for infection prevention at select facilities;
- Ensure provision of HIV care and treatment, laboratory, and tuberculosis (TB/HIV) services at select facilities;
- Enhance the quality of EMTCT, VMMC, HIV care and treatment, laboratory, and TB/HIV services at select healthcare facilities; and
- Increase stewardship by the MOH to provide sustainable quality HIV prevention, care and treatment, laboratory, and TB/HIV services.

The purpose of the best practices handbook series is to document USAID/SUSTAIN's exceptional experiences over the last seven years, and to facilitate learning about what actions do and do not work by sharing those experiences with other implementers so that they might be able to replicate these best practices.


The series consists of ten handbooks on various areas of HIV programming (eMTCT, health management information systems (HMIS), HIV care and treatment, HIV testing and counseling, human resources for health, laboratory services, nutrition, supply chain management, TB/HIV, VMMC), highlighting efficient and effective, evidence-based interventions. The best practices handbooks serve as a reference guide for healthcare providers and program implementers to utilize for program planning and improvement in the delivery of quality HIV services. Interventions can be tailored to suit the specific needs of the program/facility.

Taking into consideration the definitions used by United Nations (UN) agencies and other health implementers, USAID/SUSTAIN has developed its own definition for "best practice." For the purposes of this series, a **best practice** is an innovative action or set of actions that display evidence of effectiveness and sustainability, with the ability to be replicated or adapted to different contexts or situations.

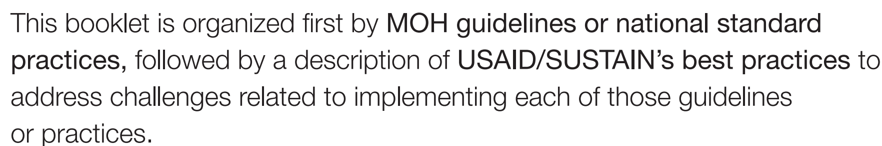
USAID/SUSTAIN acknowledges the work of the project staff, our colleagues at MoH, and counterparts at supported facilities who have been instrumental to the project's many successes throughout implementation of the documented best practices.

INTRODUCTION

Working with the Uganda Ministry of Health (MOH), the USAID/SUSTAIN project currently supports the provision of comprehensive HIV care and treatment services to over 52, 502 clients at 10 regional referral hospitals and one general hospital (60, 058 clients by March 2017 at 12 sites prior to the transition of Fort Portal Regional Referral Hospital). In 2014, the MOH adopted the UNAIDS 90-90-90 strategy in which two targets are directly related to HIV care and treatment: 90% of all people living with HIV will receive antiretroviral therapy (ART) and 90% of people receiving ART will have viral suppression. The project supports various components in HIV care to achieve these targets, including:

- Provision of co-trimoxazole preventative therapy;
- Diagnosis and management of opportunistic infections;
- Nutrition assessment, counseling and support, including the provision of ready-to-use therapeutic food and infant and young child feeding support;
- Routine clinical and laboratory (i.e., viral load and CD4) monitoring for ART and pre-ART clients;
- Counseling and psychological support for both adults and pediatric clients, including prevention support;
- Provision of a basic care package for HIV-infected clients;
- Adherence counseling and support for ART clients;
- Follow up and linkages with community-based interventions and other healthcare facilities; and
- Targeted support for special groups, e.g., children, TB/HIV co-infected clients, and clients on second-line treatment.

SUSTAIN has faced several challenges to improving access to, and implementing, quality HIV care and treatment services. These include staff attrition at the facility level, client loss-to-follow-up, and inefficient clinic and triage systems and processes.



This booklet is organized first by MOH guidelines or national standard practices, followed by a description of USAID/SUSTAIN's best practices to address challenges related to implementing each of those guidelines or practices.

BEST PRACTICES INTERVENTIONS

1 Ensuring newly-diagnosed HIV-positive clients are linked to care

According to the Uganda MOH, **every newly-diagnosed HIV-positive client should be linked to care—with evidence of complete referral.** Under this, it recommends: scheduling immediate appointments at the HIV clinic or conducting same-day enrolment, documenting referral or linkage to care, establishing loss-to-follow-up protocols, and providing post-diagnosis and post-disclosure support. Through inter-departmental and inter-facility activities—such as mentorship and meetings—SUSTAIN-supported facilities have established functional internal and external referral systems to ensure clients are linked to care.

1.1 Physically escorting newly-diagnosed HIV-positive clients to the HIV clinic for enrolment

Why is this important? Previously at SUSTAIN-supported facilities, a significant number of newly-identified HIV-positive clients from several testing points, who were referred for enrolment at the HIV Clinic did not reach the clinic and therefore did not start on ART immediately. In 2014, only 50% of newly identified HIV-positive clients who were willing to enroll at the same facility had confirmed linkage to care. Most clients were lost to follow-up between the testing point and the HIV clinic.

How is it implemented? To ensure that all newly-identified HIV-positive clients are enrolled into care, SUSTAIN-supported facilities started physically escorting clients whose preference was to be enrolled into care at the testing facility.

1. After the HIV-positive client receives test results, he or she is given immediate post-test counseling by the nurse or nursing assistant at the testing site.
2. The client then is asked if he/she wants to enroll in care at that facility or be referred to a lower-level facility. If they choose the former, then a health

volunteer physically walks with them from the testing site to the counselor at the HIV clinic for enrolment into care.

3. Triplicate referral forms are used for documentation and tracking of the referral process for clients at the enrolment point.

Who is involved? The nurse or nursing assistant conducts HIV testing and counseling (HTC) at the testing site. A health volunteer escorts the client to the HIV clinic and the counselor at the HIV clinic enrolls the client into care.

What was the result? Linkage to care for newly identified HIV-positive clients improved, from 50% in 2014 to 94.2% by March 2017 for 12 facilities (11 Regional Referral Hospitals (RRHs) and 1 General Hospital (GH)) to 94.3% by June 2017 (10 RRH and 1 GH, following transition of Fort Portal Regional Referral).

What else to keep in mind?

- The use of health volunteers/peers as escorts is essential. Health service providers—especially those in human-resource-constrained facilities—may not have the time.
- Linkage by escorting requires prior agreement for the referral process by all staff which enhances seamless enrollment into care.

1.2 Conducting secondary post-test counseling sessions for newly diagnosed HIV-positive clients

Why is this important? A few, newly-identified HIV-positive clients at supported facilities were taking longer to enroll in care due to difficulty deciding after receiving their test results.

How is it implemented?

1. After a newly-diagnosed HIV-positive client is escorted, they receive a second post-test counselling session—conducted by a counselor at the HIV clinic. This serves to guide informed decision making by the client on enrolment into care, either at the same or another facility of their choice.
2. Information provided during this session includes: reinforcing positive living, decision on site enrolment, the need for baseline ART assessment,

disclosure, and a discussion of the client's family members' HIV status, highlighting the need for testing.

3. During this visit, the counselor also conducts a psychosocial assessment and uses talking points drafted by the psychosocial team to guide the session.
4. The clinician also assesses the client for TB and their nutritional status. This visit is key because it sets the client up for effective care and treatment.

Who is involved? The HIV counselor and clinician conduct the second counseling session.

A nurse counsels a newly identified HIV positive couple before enrolment, Fort Portal RRH

What was the result?

- Prompt, informed decision making by clients to enroll in care at the facility of their choice.
- For those opting to go to other facilities, referrals are made early and enrollment is followed up.

What else to keep in mind?

- Talking points are vital tools for ensuring that the counseling sessions cover all relevant topics and are conducted in a manner that is sensitive to the client.

1.3 Engaging hub riders to deliver referral information to lower-level facilities

Why is this important? When a newly identified HIV-positive client chooses to be referred to a lower-level facility for care, they do not always follow through and it is difficult for staff at SUSTAIN-supported facilities to ensure they are properly linked to care. Before the use of hub riders was implemented, facility staff lacked mechanisms to confirm facility and community linkages for newly identified HIV-positive clients whose preference was to be enrolled somewhere other than the testing facility.

A hub rider in Fort Portal picks up laboratory samples from the post office for delivery to lower facilities, Fort Portal RRH

How is it implemented? To effectively follow-up on referrals to lower level facilities for HIV-positive clients, SUSTAIN-supported facilities utilize hub riders to deliver referral information. Hub riders are normally used to transport HIV tests and results between lower-level facilities and the laboratories at RRH, which act as regional laboratory hubs. The linkages coordinator provides hub riders with the list of clients who chose to enroll in care at other facilities, which is delivered to the respective facilities. The contact person at the lower-level health facility, usually the in-charge of the facility, reviews the list and verifies those clients who are enrolled in care at that facility. The hub rider is given back the list, with those who are successfully enrolled into care highlighted, and he returns it to the RRH on his next trip. Upon receiving the list of those successfully linked, the community linkage coordinator completes the successful referral in the triplicate form booklet. On the subsequent visit, the hub rider takes the second copy of the triplicate referral form to lower facilities to document successful referral.

Who is involved? The community linkages coordinator shares the referral list and forms with the hub rider who then delivers the list and forms to the lower-level facility. The lower-level facility In-charge reviews the list and forms and sends updated information back to the RRH with the hub rider.

What was the result? Information on confirmed linkages for newly identified HIV positive clients enrolled at other facilities is now available.

What else to keep in mind?

- The documentation of referral facilities and client details must be complete and accurate to ensure linkages are maintained
- Both the hub rider and facility In-charge that receives the referral list and forms should be oriented on this process to ensure it is done correctly.3.1

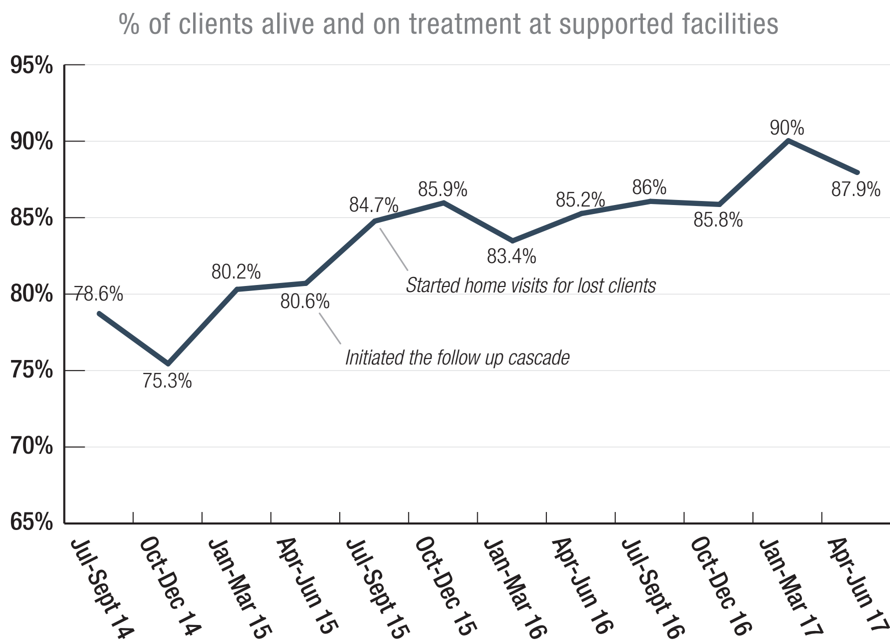
2 Improving Antiretroviral (ARV) treatment adherence and retention

Ensuring ART adherence and retention is important for achieving the third of the UNAIDS 90-90-90 targets: 90% of all people on ART will have viral suppression. To ensure adherence and retention, facility staff must consider

a client's ability and motivation to adhere to treatment and remain engaged in care for ongoing monitoring and support. According to the MOH, **HIV-positive clients on ART should visit the clinic at least once every quarter** in order to monitor their treatment adherence. In addition, MoH recommends: ensuring a continuous supply of ARVs, providing programs for psychosocial support and adherence, instituting family clinic days and health education sessions, and sensitizing staff on the importance of external factors that affect adherence and retention. SUSTAIN has worked with supported facilities to maintain adequate ART stock, establish systems for client follow-up, and increase accessibility of HIV services at the hospitals and at lower-level facilities.

Staff at Kabale regional referral Hospital attending a performance review meeting

Project's Performance on Retention



Graph showing the retention on treatment rates from FY 14 to FY 17 (Oct-Jun)

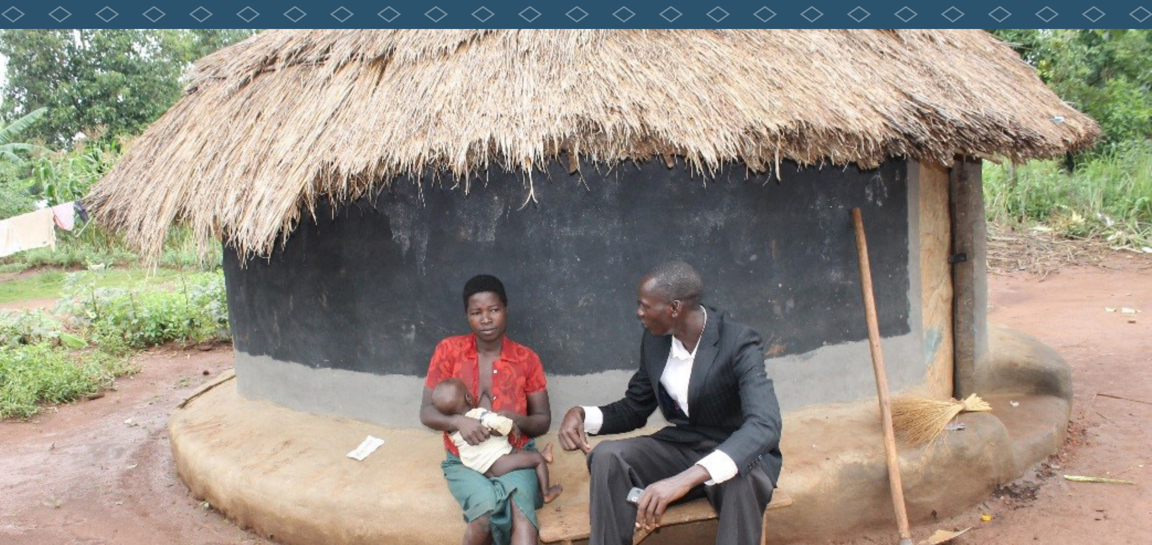
2.1 Conducting regular, systematic follow-up with HIV Clients who miss appointments

Why is this important? Before SUSTAIN-supported facilities implemented best practices to maintain clients in care, 16% of clients, on average, were lost to follow up annually. This was due, in part, to a lack of mechanisms in place to systematically follow up with HIV-positive clients in care, especially those who missed appointments.

How is it implemented? To improve retention of HIV-positive clients in care, follow up is key. The project developed a systematic cascade of processes to aid in the follow up of HIV-positive clients who miss their appointments.

1. First, the facility **compiles a list of clients who have missed their appointments** using the Open MRS database that is confirmed using client files and refill dispensing logs. Missed appointments are defined as missed clinic visits—they have not come to the clinic within seven days from their appointment date.

2. Second, facility staff **telephone (call) these clients** to see why they missed their appointments and to encourage them to return to the facility. The outcomes of these phone calls are logged in the client register. Project standard practice is that clients must be called at least three times within two weeks before they are considered "not found" by phone call.
3. Third, facility staff conduct weekly meetings to develop a secondary list for those patients who are considered "not found" by phone call. This list is used to **conduct follow-up home visits,** which should all be completed by the end of the month. Home visit clients are clustered by location. A small group of facility staff, either nurses, clinicians or expert clients, conduct the home visits in one area and document outcomes on a customized form. During the visit, clients undergo clinical, psychosocial and adherence assessment and support.
4. The client most often agrees to return to the facility within the month or is referred to a lower-level health facility. If a client has not disclosed to their families, expert clients conduct the home visit to maintain discretion. Expert Clients are individuals living positively with HIV who have exemplified excellent adherence skills and who wish to take on a voluntary role to help motivate others living with HIV.



A breastfeeding mother is physically followed up in the community after the she had been declared lost from care at Gulu RRH, Northern Uganda

Who is involved? The community linkages coordinator oversees the follow-up process with support from a selected volunteer. The data officer develops the missed appointment list; phone calls and home visits are conducted by counselors, expert clients and the Community Linkage Coordinator. Clinicians conduct review meetings to monitor client loss-to-follow-up and discuss interventions to mitigate client loss.

What was the result? Now, 30-40% of loss-to-follow-up clients return to the facility within the month. Previously, the number lost-to-follow up was 2,000-3,000 every three months; and it was 1,041 as of March 2017 (for 12 supported facilities) and is now 859 as of June 2017 (For 11 supported facilities; following transition of Fort Portal RRH)

What else to keep in mind?

- Documentation is key for enrollment—not just the initial information, but the outcomes along the whole process.
- Systematic follow-up of clients is a resource-intensive process.; Facilities must account and plan for resources to accomplish follow-up and find areas to reduce costs.
- Geographical clustering of lost clients, coupled with involvement of peers within the same area, reduces operational costs of home visits

2.2 Organizing inter-facility meetings for client tracking

Why is this important? Supported facilities experienced challenges in confirming complete client referrals and tracking client self-referrals. This was a result of weak inter-facility linkage networks for information sharing.

How is it implemented? To monitor client retention, the project organizes monthly inter-facility meetings to provide a platform for harmonizing client referrals between facilities in the same catchment area and strengthen linkage networks. During these meetings, eight ART-accredited facilities and stakeholders from the region share notes on self-referrals. Receiving facilities provide details on self-referred clients and their clinics of origin to enable facilities to confirm and document client referrals. Select facilities are making attempts to transition this harmonization activity into a district-led

process. Because communication streams are more open among facilities, these meetings now only occur every three months. The meetings have now evolved to include other technical areas, such as EMTCT and TB. However, the facility HIV focal persons are always included on the agenda to discuss client tracking and it is one of the main deliverables of the meeting.

Who is involved? The attendees of the meeting include the facility teams (hospital director or administrator, clinician, counselor, in-charges from lab, TB, and mother-baby care points, data officer, and community linkage coordinator) and sometimes district personnel (TB, lab, and HIV focal persons).

What was the result? The cohort of clients on ART completing 12 months on treatment, who self-transferred out as of March 2017 was 243 and 223 as of June 2017 (following transition of Fort Portal RRH) Information about self-transferring clients is actively shared between facilities by phone prior to the inter-facility meeting.

What else to keep in mind?

- Be strategic in who you invite to inter-facility meetings to ensure maximum involvement and impact.
- Once alternative phone networks are established, the frequency of inter-facility meetings can be reduced.

2.3 Providing "SUSTAIN" telephones at each supported facility for client follow-up and communication

Why is this important? Clients sometimes give out the wrong contact information or their contact information changes. This can make client follow up difficult. Supported facilities also lacked clinic telephones and airtime to follow up with lost clients.

How is it implemented? The project provided clinic-specific telephones (TB, HIV and EMTCT) and associated phone numbers at each supported facility for follow-up and communication. Clinic-specific contacts are displayed for clients to see and use to get in contact with the facility, if necessary. When the client provides their contact, the client enrolment health worker—with

consent—calls the provided number. This serves to share the clinic number with the client and confirm the contact information is accurate. The clients can then use the phone number to call the facility to make them aware of conflicts with appointments or other areas of concern.

Who is involved? The client enrolment officer receives, records and confirms client contacts.

What was the result? Clients are now able to contact the clinic in case of emergencies, change of appointments, etc. The clinical team can reach clients to reschedule and follow-up on missed appointments.

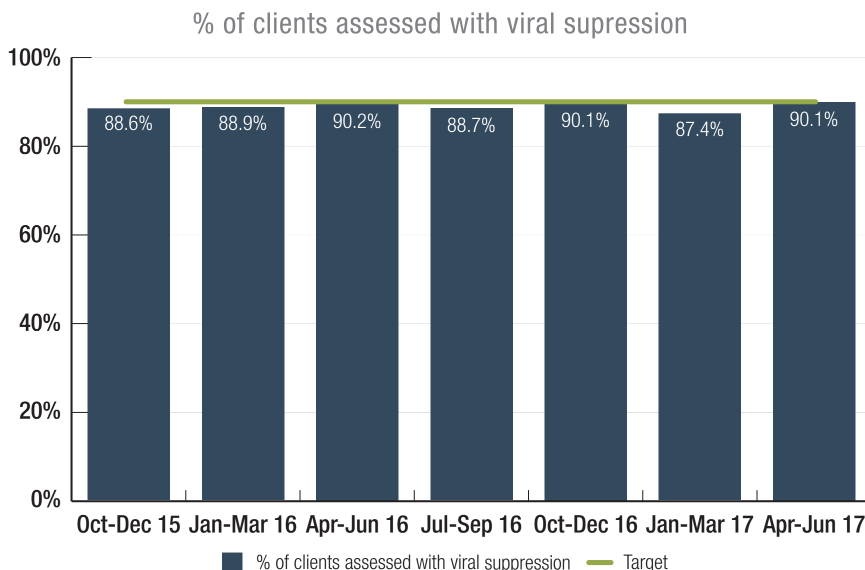
What else to keep in mind?

- This process is important for ensuring that the correct contact information is available and reduces the errors made when contact information is recorded.

3 Conducting laboratory monitoring for viral suppression

Improving laboratory monitoring is also important for achieving the third 90-90-90 target which aims at having 90% of all people receiving antiretroviral therapy achieving viral suppression. Clinical and laboratory tests play a key role in assessing clients before ART is initiated and in monitoring their treatment response and possible adverse effects of ART. Viral load is recommended as the preferred monitoring approach to monitor response to ART and to diagnose ART failure. According to the MOH, **HIV-positive clients on ART should receive their first viral load test at six months after treatment initiation and every 12 months thereafter, and every 6 months for children and adolescents.** SUSTAIN-supported facilities conduct viral load testing for clients using these guidelines to monitor for viral suppression. To improve viral load monitoring, facilities have developed the following best practices.

Project's Performance on Viral Suppression



3.1 Organizing weekly data reviews of viral load results

Why is this important? Despite the significant scale up and access for viral load, most of the results remained undocumented in patient files and under-utilized by the facilities to make decisions regarding client care. Clients who were not suppressing would go unnoticed.

How is it implemented?

1. When viral load results come back to the facility from the Central Public Health Laboratory, a lab officer is assigned to document the results in the lab register and review results to identify which clients have high viral loads (above 1,000 copies).
2. The lab officer then requests a data officer to gather the files of these clients to be presented to the head of the clinical review team, who assigns roles to counselors and clinicians to make notes in preparation for the review meeting.
3. This information is discussed in clinical review meetings and appropriate decisions made. Results for clients with viral suppression are inserted in the respective files and reviewed by clinicians.

Who is involved? The lab officer documents results in the register and generates the list of clients with high viral loads and the data officer collects the client files and enters them into the electronic data system. The head of clinical review meetings distributes the select files to counselors and other clinicians.

What was the result? Documentation of viral load results improved, both in the register and in client files. From Oct-June of FY 17, all (100%) viral load results were documented in the lab registers and client files, and all client viral load results were reviewed by clinicians.

What else to keep in mind?

- This process is most effective when roles for documentation and review of results are appropriately assigned.
- Knowledge in viral load monitoring is important for interpretation and utilization of results.

Lab team during a data review meeting at Kabale RRH, south western Uganda

3.2 Conducting clinical review (switch) meetings to determine clients who have failed on treatment

Why is this important? During clinical mentorships, it was noted that decisions made individually to switch client ART regimens may not consider other factors causing non-suppression, and therefore may lead to inappropriate regimen switch.

How is it implemented?

1. First, facility staff identify clients with high viral loads. Select members of the clinical review team are assigned the files of non-suppressing clients in preparation for the meeting. The team confirms treatment failure using the national guidelines. The counselor and expert peer review clients' adherence and psychosocial history. At the meeting, members are reminded of the criteria and factors leading to treatment failure. Feedback is given on the clients being reviewed.
2. Each member of the clinical team presents on a client, including regimen and adherence history, whether the client has been exposed to regimens that may have caused them to fail, what psychosocial issues may be preventing them from taking their medicine appropriately, and the trend in laboratory results are given before reaching a professional conclusion regarding why this client may or may not have failed on treatment.
3. Then the other attendees give their opinion on the client and the group concludes as to whether the client has failed on treatment.
4. If the client is deemed to have failed on treatment, their treatment regimen is changed. If the facts do not support a conclusive decision, the clinical team will recommend that the client comes into the facility for additional tests and psychosocial review. When the team decides that the client regimen be changed, roles are assigned to members to support the regimen switch process (including client notification, counseling and regimen switch).

Meetings are conducted weekly, depending on availability of clients to discuss.

Who is involved? The clinic team includes the clinician, the counselor for psychosocial issues, the lab personnel for the test results, and an expert client for social issues that might influence the client's treatment.

What was the result? This process supports systematic review and ownership of decisions by a multi-disciplinary team to switch clients. Knowledge and skills are built for staff through peer to peer learning..

What else to keep in mind?

- Involvement of other stakeholders (counselors, peers, lab staff, nurses, and dispensers) in this process will highlight other factors that might affect viral suppression and not necessitate change of regimen.

4 Improving the Quality of HIV Care and Treatment

To ensure all eligible HIV-positive clients are on treatment and that ART is working effectively, it is vital that **HIV services are accessible and high-quality.** SUSTAIN has supported facilities to build the capacity of staff to continually analyze HIV service delivery systems and processes—focusing on increasing efficiency, reducing waste, and improving client outcomes. Facilities continuously change these systems and processes to ensure quality HIV service delivery.

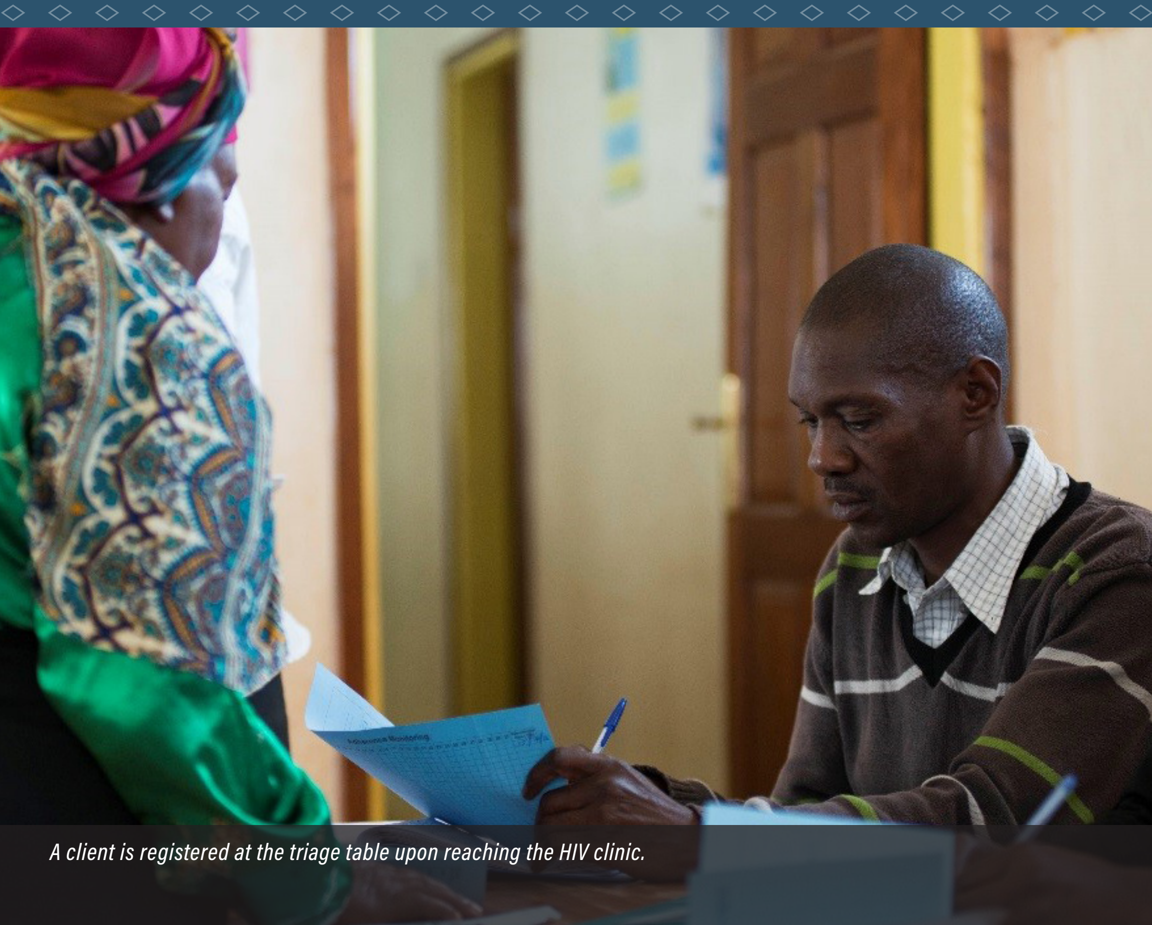
4.1 Establishing a multi-disciplinary triage system for HIV clinics

Why is this important? Triage, a high-coverage area, offers little space for clients to wait. This congestion makes it difficult to refer clients to the appropriate area. As a result, supported clinics experienced irregular client loads, which affected planning processes and led to human resource constraints and failures to hold planning meetings and data reviews.

How is it implemented? To reduce congestion in the triage area, the project conducted an analysis of daily client attendance. The results were inconsistent, but the facilities would see as many as 500-600 patients per day.

1. First, the facilities established a daily attendance limit for appointment giving to regulate the number of patients seen to less than 300 per day. Appointments for children were given only on Thursdays to specialize their care.

2. Second, the facilities reorganized the triage. The clients are separated between those who are stable and just need to obtain medicine and those who require clinical services. A nurse is assigned to triage to determine who falls into each of the two groups. Over time, a clinical officer was also added to the triage team to write prescriptions. Nurse visits are established for those who require no clinical services to reduce client waiting time.
3. Eventually, a third category of triage—critical clients—was added, who are now seen before stable clients and clients who require clinical services. Because of this new process, most clients who come for medications are finished by midday and those receiving clinical services are finished by the afternoon. This gives the facility staff the time to review and update files, do other necessary tasks, and prepare for the next day, leading to overall improved performance.



A client is registered at the triage table upon reaching the HIV clinic.

Who is involved? The nurses and clinical officer conduct the triage.

What was the result? At Gulu, Fort Portal, and Lira RRH, this led to reduced waiting time, decreased number of clients per day, improved number of client assessments, and reduced loss to care.

What else to keep in mind?

- A volunteer is not sufficient to conduct the triage; more experienced staff is needed to properly identify clients.
- Everyone in the hospital needs to be organized and “in the know” about the new client flow.
- It can take up to three months to re-organize client appointments and have the triage area working effectively.

Supporting Sustainable and Innovative Approaches for HIV & AIDS Prevention, Care and Treatment in Uganda

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