

AWACC 2011

SYSTEMS OF CARE

Pre -ART linkage to care

- ⦿ There has been an increased awareness that many people never even make it into care after a new HIV diagnosis, and are therefore not considered in ART program outcomes.
- ⦿ in South Africa - high rates of attrition along all of the pre-ART steps in the care pathway following diagnosis
- ⦿ Obtaining a CD4 count - psychosocial assessment - ART literacy training.
- ⦿ Only 40% of ART-eligible patients were in care and on treatment one year later; 20% of them had died.

- ⦿ Barriers to engaging in pre-ART care mirror many of those that impede ART adherence:

stigma,

transport

treatment costs,

competing basic needs,

gender, education

lack of perceived need

lack of self-efficacy

social support.

- ⦿ A unique feature of pre-ART care is that often the location of the HIV test and the ART clinic are geographically separated, which creates an additional logistical barrier.
- ⦿ Only 30-40% of ART-ineligible people return for subsequent CD4 counts to establish ART-eligibility in South Africa, and are therefore not benefiting from timely ART initiation.
- ⦿ As HIV testing efforts expand outside of health care facilities, such as to mobile or home-based testing, new challenges will emerge for ensuring linkage to care for ambulatory people who may be feeling well.

Practical strategies for how to improve linkage to HIV care

- ⦿ Employing a point of care CD4 count machine has been effective for removing a step from the care pathway
- ⦿ Allowing a newly-diagnosed individual to benefit from understanding whether or not they are ART eligible. -the efficacy of a health system navigator who provides support through in person, phone and text message contacts.
- ⦿ Rigorous evaluation of other options, such as transport vouchers, conditional cash or other incentives, deployment of community health workers.
- ⦿ Structured pre-ART programs for ART-ineligible people, to ensure that they have primary HIV care and that they start ART as soon as they are eligible—provision of COTRIMOXAZOLE

NIMART

The funnel to get more people on treatment

- Political
- Conceptual- individual vs community
- PT derived –too sick and too late
- Service blockages- too few prescribers /task shifting
- Too little space in special clinics/more hours
- Too poor pt flow

Mseleni experience

- All clinicians involved
- Family centred care
- Enhanced status of clinic in the community
- 9% of adults on treatment with >90% coverage of the ART programme.
- 60% of adult population have been tested
- Deaths in the district have decreased from 20/wk to 2-3/wk
- ALL PHC structures have been improved

Caution

- ⦿ NIMART must not become a vertical programme
- ⦿ Do not discourage nurses by delaying their accreditation process
- ⦿ Doctors need to be involved in learning and supporting nurses by regular visits
- ⦿ Integrate HIV care into all sites of clinical care.

Quality assurance in care for PLHIV-focus on the social determinants of disease

- Population based planning
- Comprehensive care
- Continuity of care
- Coordination of care
- Risk stratification
- Activated patients and communities
- Outreach and support
- **TEACHING, TRAINING AND MENTORING** in a systemic and planned way
- Analysing and using information
- Quality improvement programme.

Biggest challenge

- ① FRAGMENTED AND UNCOORDINATED CARE
- ② INEFFECIENT CARE
- ③ UNCARING STAFF

PALLIATIVE CARE

- Integration of palliative care into all stages of HIV care –FROM THE POINT OF FIRST CONTACT AND THROUGHOUT LIFE
- Definition of palliative care in HIV different from other conditions
- NOT JUST HOSPICE TYPE OF TERMINAL CARE
- Increasing role in TB care –all stages including MDR/XDR patients



Guidelines for Providing Palliative Care to Patients with Tuberculosis



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