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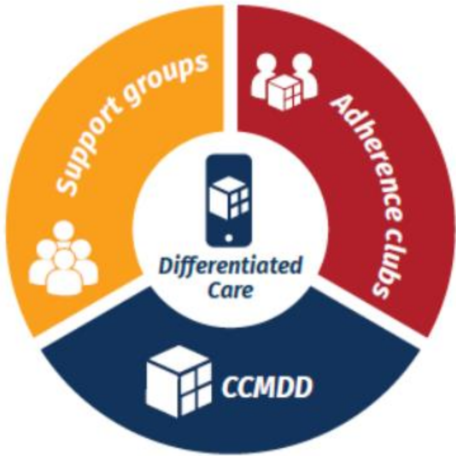
Improving retention in care (2nd 95)

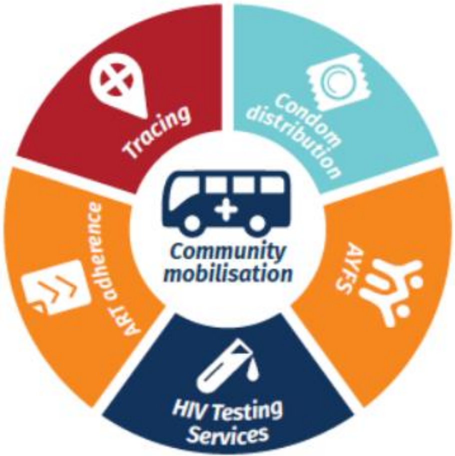
20 October 2023

Presentation outline

- HST programme support
- 95-95-95 Cascade
- Men's health strategies
- Peer-led programming
- Strategies and activities
- Hospital, CHC and community linkages
- Retention strategies
- Partnership strengthening
- Good practice
- Challenges
- Clinical governance

HST programme support





95-95-95 cascade: General population: (DoH data, June 2023)

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95-95-95 Cascade

eThekwini	uMgungundlovu	uThukela	Zululand
Total population 97-87-94	Total population 97-79-93	Total population 97-86-92	Total population 97-86-93
Paediatric 87-54-74	Paediatric 87-57-71	Paediatric 87-63-74	Paediatric 87-64-75
Males 96-79-94	Males 96-73-93	Males 96-78-93	Males 96-79-94
Females 97-92-94	Females 97-84-93	Females 97-91-93	Females 97-90-94

Strategies and related activities

First 95 – Case-finding

- HTS: targeted services
- HIVSS: OraQuick and INSTI
- Index contact testing
- Recency testing (eThekwini and uMgungundlovu)
- Hotspot mapping from Recency Testing study data
- MINA and Phila Ndoda campaigns for men
- Surge activities for paediatric and adolescent patients
- TB case-finding
- Integration of services (HTS, COVID-19 and TB screenings)

Second 95 – Continuity of care

- Case Management Model (scale-up)
- UTT
- Community referral and linkages
- Handshake referrals
- Welcome Back scripts
- Linkage Officers (active tracking and tracing)
- Community ART services
- DO ART model
- Clinician-led PuPs
- Layering of services with DREAMS, OVC and community partners
- NIMART trainings
- ACC Doctors providing TA
- Roll-out and implementation of eLABS
- TLD transitioning

Third 95 – VL suppression

- Case Managers providing EAC, disclosure support and psychosocial support
- VL blood tests done during household visits (UB team)
- Clinic Laboratory Advisors – results rejection monitoring and dashboard
- B-OK beads for U=U messaging
- Transitioning clinically stable patients to DMoC

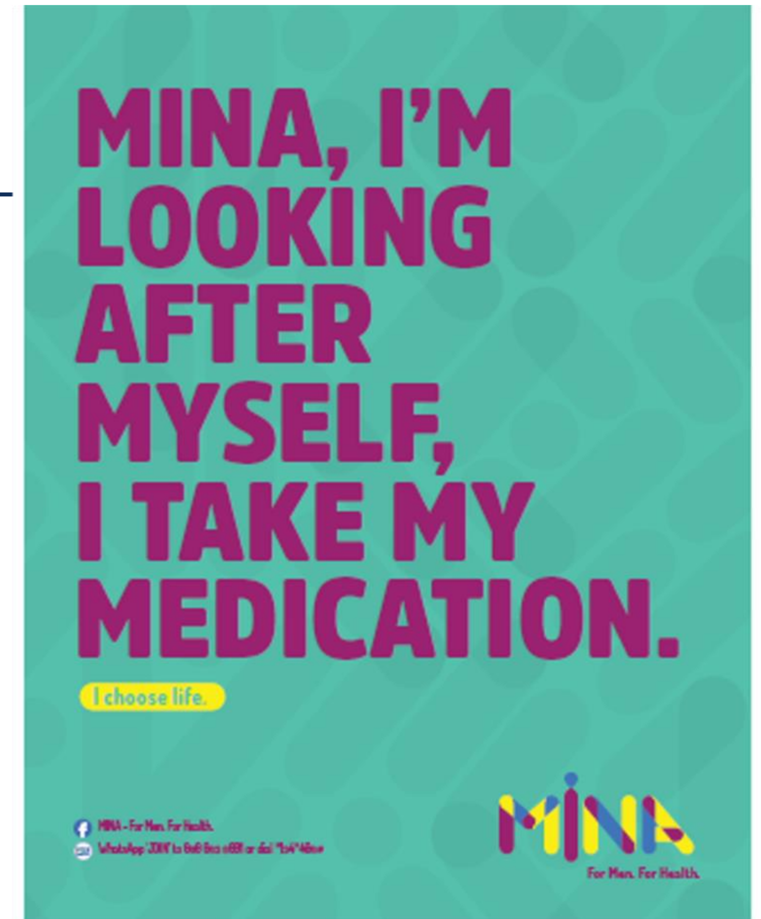
Activities targeting men: MINA Campaign

MINA Programme implemented with the support of PSI

- 128 facilities activated across the four supported districts
- Men's Corners established at some of the facilities
- Collaborations with DoH and other stakeholders
- Layering of interventions with Community Partners

Stakeholder engagement:

- Isibaya Samadoda
- Traditional Health Practitioners
- Faith-based organisations
- DREAMS implementing partners
- Local structures (Local AIDS Council, PLHIV, civil society)
- Men's Dialogues (community halls, Ward Councillors)
- Outreach activities, Wellness Days at factories and other workplaces



Challenges:

- Spaces at facilities
- HRH – not enough males

Men’s Health Services

Prevention support services

- Health promotion and education
- Gender-based violence education

Screening / treatment / continuation-of-care services

- Primary Health Care package (minor ailments; chronic conditions)
- Acute conditions
- HIV screening
- Tuberculosis screening
- Screening for sexually transmitted infections (STIs)
- Pre- and post-exposure prophylaxis (PEP and PrEP)
- Voluntary medical male circumcision (VMMC)
- Male sexual and reproductive health problems
- Mental health
- Referral services – psychosocial / neurological

Responding to a Provincial call for Men’s Clinics:

- Building on MINA lessons
- HST supporting DoH stakeholder engagements
- Facilitating collaboration between the DoH and stakeholders
- 14 Coaches supporting the Coach Mpilo programme for MLHIV

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COACH MPILO model (uMgungundlovu and uThukela)

- 14 Coaches (MLHIV) in the district.
- Coach Mpilo model implemented in collaboration with the DoH.
- Coaches mobilise all males in communities to access comprehensive health services at facilities.
- Mobilisation of clients in the communities and linking them to the outreach teams for men's health services.
- Targeting male clients in facilities, providing health education in the facility in waiting areas, and utilising the yard outside the facility.
- Promoting Family Days: men are encouraged to bring their partners and children to the community/facility.
- ***Monitoring through weekly data and narratives***

Peer-led Programme (uThukela and Zululand)

- Peer Mentors provide formal and informal support to HIV-positive and HIV-negative mothers at the facility and in the community through constant communication via cellphone calls and SMSs.
- They provide health talks on HIV prevention measures using the tools such as B-OK beads, condom use demonstrations, and promotion of PrEP for mothers who test HIV-negative.
- All eligible clients are referred to the Lay Counsellor for testing, which improves the testing rate in the Antenatal Care Stream.
- They provide Family Planning health education for mothers living with HIV and those who are HIV-negative, and conduct screening for all pregnant and breastfeeding mothers to identify eligible clients for HIV testing.
- They retrieve and review the files of all booked pregnant women on ART and send SMS reminders or call them regarding their appointments.
- To support viral load suppression, Peer Mentors conduct health talks on U=U for all women with high viral loads, and support case management for all women under their care.
- They screen all children for repeat PCR testing in the facility and trace those who miss the EPI dates.

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Peer-led Programme (continued)

- In facilities where the programme is active, every HIV-positive young woman is linked to a Peer Mentor for support services related to HIV care.
- The mentors trace patients who miss appointments, targeting those aged 24 years and younger.
- They provide health education on breastfeeding for breastfeeding women.
- They follow up on HIV index contacts for testing, and offer index contact testing even to those who have tested HIV-negative to avoid mothers seroconverting through pregnancy and during breastfeeding.

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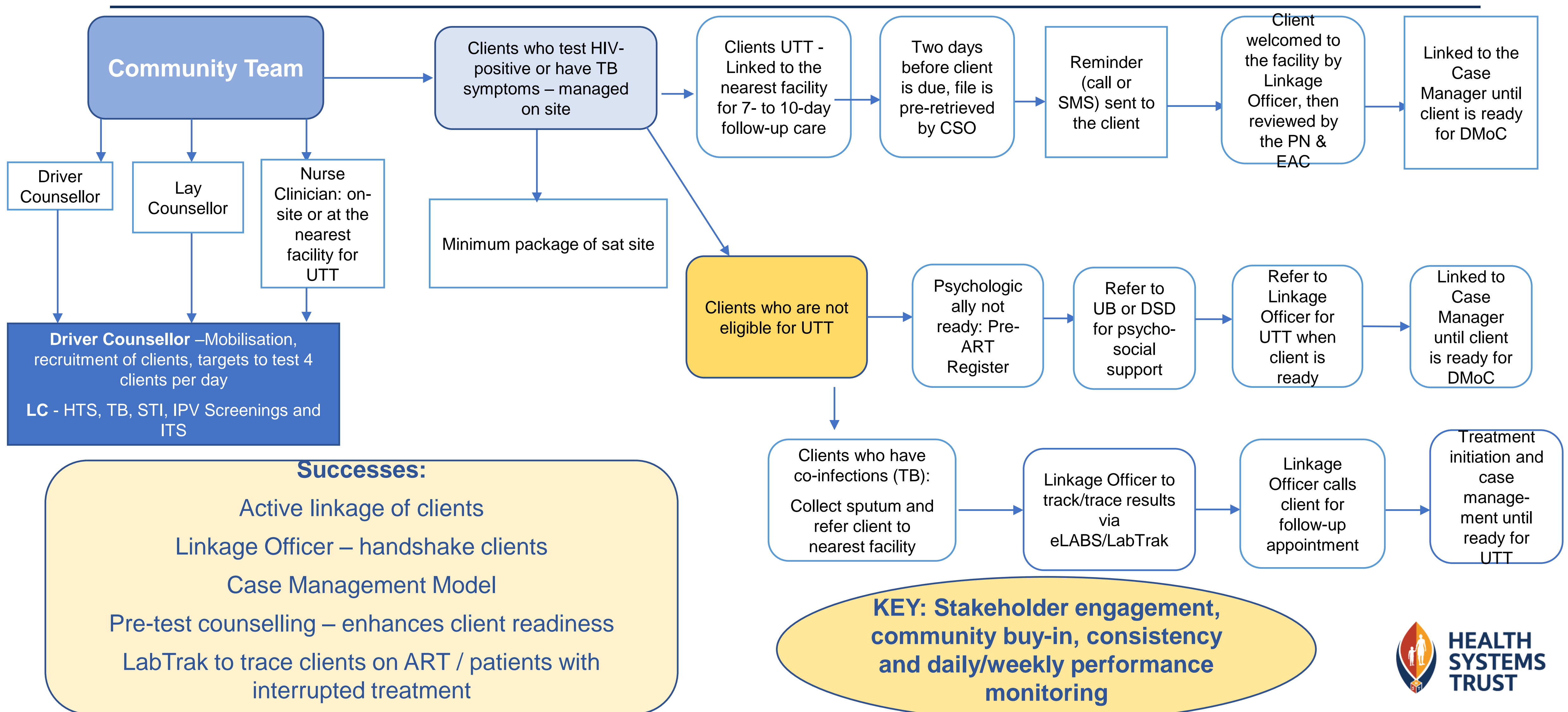
Activities focusing on paediatric retention in care

- The introduction of **Paediatric Case Managers and Linkage Officers in facilities** has improved retention and linkage.
- **Caregiver support groups** for ART treatment literacy were established to improve retention among children.
- Conducted a skills audit to identify gaps in knowledge of child and adolescent disclosure guidelines.
- Rolled out **KidzAlive training** for HST and DoH staff to improve support for disclosure and treatment literacy education – identifying a KidzAlive Champion at facilities.
- Strengthened **partnerships with CINDI and PACT** in relevant districts to improve access to psychosocial support and layered support for other services.
- Implementation of the **Unfinished Business project** to support high-yield facilities.
- Implementation of **Family Days** during weekends, focusing on the 0–19 years age group, served by a multidisciplinary team.
- Offered **extended hours and weekend visits** in key facilities to improve access for children and caregivers.
- Worked with **school-based outreach teams** to improve case-finding and treatment options.
- Conducted **facility mapping** to identify poorly performing facilities, guided by the data provided, and developed **QIPs** customised to identified bottlenecks.

Linkage and retention: Outreach Team tracing



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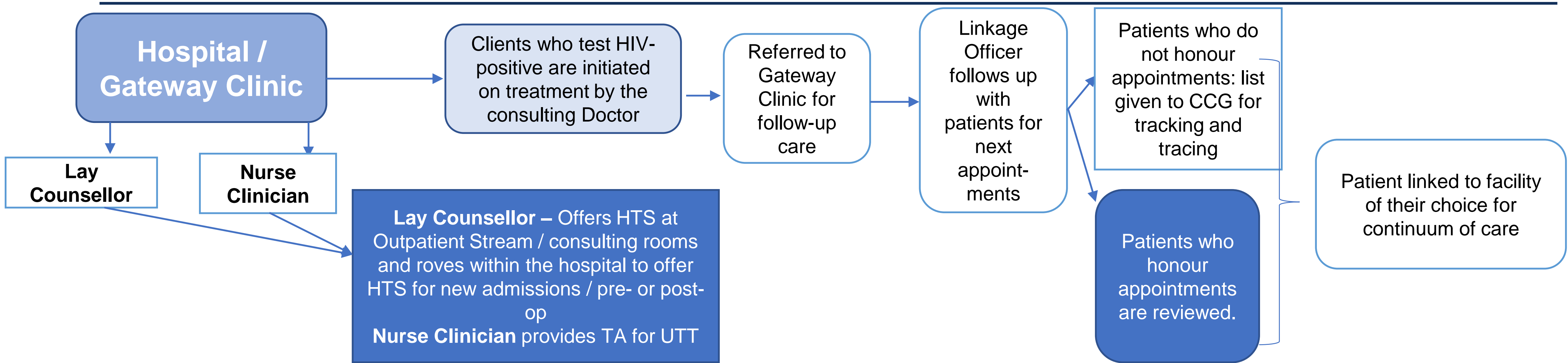
Community ART: Lessons learnt

- Implemented through the DO ART Project
- Designed to demonstrate how community ART can improve treatment outcomes
- Aligned with the DoH Community ART SOP
- Used the following strategies to improve retention:
    - Community ART initiation
    - Community follow-up
    - Client-centred case management approach
- Project had 95% retention rate and this is attributed to:
    - Convenient for clients, as it is community-based.
    - Flexi-time availability allows people to be tested and attended to at their preferred time.
    - Shorter waiting times, as patients are attended to in small clusters.

Linkage: Hospital / Gateway Clinic – technical assistance



Challenges:

- Down-referrals remain a challenge as patients do not reach the referral point.
- Tracking and tracing of patients post discharge (location and cellphone number change)

Actions:

- Trained newly appointed CEOs
- Medical officers conducted training with all CEOs and Medical Managers
- Medical Officers engaged in case management workshops
- Case Manager provides ongoing counselling and manages the newly initiated/virally unsuppressed patient for at least 6 months post testing positive.

Successes:

- Active tracking and tracing of patients by Case Manager / Linkage Officer develops a relationship with the patient
- Providing TA to hospitals for referral to mobile units
- Conducting file audits to identify EMA
- QIPs developed jointly with DoH
- Health education sessions at OPD regarding referrals

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Activities that contributed to improved retention

- **Handshake model** – proper implementation, whereby patients tested by Lay Counsellors are directly linked with a Nurse Clinician through a physical introduction and handover
- **Linkage Officers –** All HST Linkage Officers are clinically trained Enrolled Nurses
- **Case Management –** Ongoing case management beyond treatment initiation led by Linkage Officers
- **Pre-ART monitoring** – allocation of HAST Champion for daily review of the pre-ART list and follow-up with all patients on the list, including adolescents
- **Physical tracing** – Outreach Teams trace all waiting-for-ART clients not reached by phone and initiate contact
- **Collaboration** – layering of services with men's activities such as Isibaya samadoda and ikhosomba lamajita, utilising MINA campaign activities for male-friendly services
- **Community** – Outreach Nurse Clinicians initiate all positive cases identified in the community while roving between testing sites
- **Training –** ACC / District Trainer / CLI teams

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Retention activities

ACTIVITY	How is it implemented	Good practices
File management	• Using SOP approach to folder number allocation • Files left at last consultation point • Collection of files by Filling Clerk and Data Capturers every two hours	• Pre-retrieval of patient files in a few facilities • Active collection of files in consulting rooms
Data-capturing	• Files are collected in the consulting rooms every two hours. • Capturing is done by all Data Capturers.	• Data Capturers removed in 2 facilities and DoH is holding the fort.
Tracking and tracing	• Lists are extracted from TIER.Net weekly by Data Capturers and shared with Linkage Officers. • Tracing activities start and if the patient s not found, the case is referred for community tracing. • Tracing team reports back to the Linkage Officer and outcomes are recorded.	• Collaboration with CHWs • Support reporting and Capturing
Prevention of missed appointments	• Patient appointment reminders • Supporting scale-up of DMoC – collaborated efforts between SyNCH and Area Pairs to re-orientate the Clinician on DMoC SOP • Proper management of file flow to prevent false missed visits	• Collaboration with CHWs • Data clean-up activities

Partnership strengthening efforts

Partner	Agreed points of contact	Scale-up and sustainability
Government Departments: DSD	• Project performance and activities presented at DSD Child Protection Forum (first meeting: 16 February 2023) • Training of Home-based Care Social Workers and child/youth care workers on the adherence guidelines, focusing on psychosocial interventions. • HIV testing campaigns will be conducted at Youth Care Centres – Centre Managers will be in contact re arrangements • Temporary Emergency Units and having mobile units visit these centres • Participation in the Teenage Pregnancy Dialogues – Outreach Teams will also offer testing and linkage services during dialogues • Facility-based teams (Lay Counsellors and Case Managers) will also be trained by DSD on the Ambassadors Against Drug Abuse programme and other behaviour change interventions such as CHOMI, YOLO, KEMOJA, etc. DSD will confirm the dates when training can be offered – trying to have training completed by mid-March • Align the data elements and reporting lines, especially for community-based tracing and joint community-based case management activities	Activities can be replicated in non-UB supported facilities DSD Social Workers and Youth Care Workers: trained on adherence guidelines and data elements, and reporting lines are being clarified
Guiding policy for paediatric and adolescent ART: Matrix of Interventions (MoI) SOP	• Technical support of MoI implementation and implementation of psychosocial support interventions: HST Technical Advisors and DSD staff • Training on MoI for selected facility staff in the district	KZN-DoH planning for district wide MoI orientation and training Orientation and training of Technical Advisors on MoI

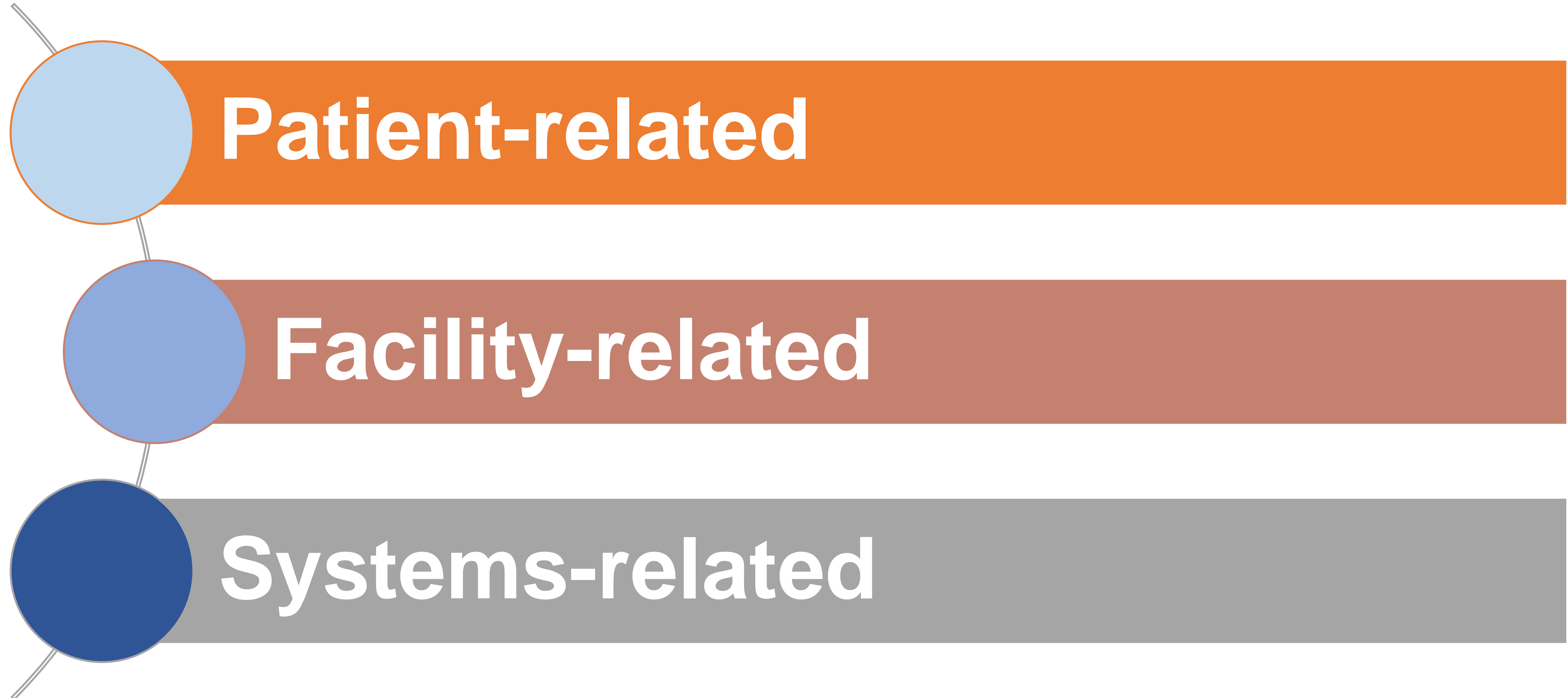
Partnership strengthening efforts

Partner	Agreed points of contact	Scale-up and sustainability
OVC: CINDI Network	• Electronic tracing of all categories of virally unsuppressed CINDI Network patients using the Results for Action Dashboard (RfAD) • Sharing of household lists containing contact details of HIV-positive caregivers with UB Outreach Team and provision of household testing and linkage-to-care services by the UB Outreach Team – OVC partners will mobilise households in preparation for outreach visits, and YCWs will also be available to accompany teams when needed. • Community partners will verify and correct where possible the contact details of patients identified as untraceable by the UB Outreach Team – once verified by the community partners, the team will trace missing or lost patients again. • eThekwini Youth Care Workers have been trained on adherence guidelines by the UB roving team – this training will be extended to uMgungundlovu and Zululand Districts: 72 YCWs and other staff attended the eThekwini training from CCP and NACCW.	Activities can be replicated in non-UB-supported facilities. CINDI Network Youth Care Workers will continue implementing adherence guidelines. Clarification of data elements and reporting lines in process.
DSP: TB/HIV Care	• Clinical mentorship of AYFS Champions by the roving team with a particular focus on latest developments in the field such as changes in formulations, regimen switching and viral load monitoring • Identifying AYFS Champions and Peer Educators in health facilities and linking them with the UB facility-based staff (Lay Counsellors and Case Managers) • Referral of patients traced back to care by the Outreach Team to AYFS clinics for resumption of ART • Referral of patients enrolled in UB-supported interventions who are in need of a Clinical Psychologist • Referral of patients enrolled in UB-supported interventions for economic empowerment The AYFS-supported facilities are: KwaMashu B, Inanda Seminary, Halley Stott, Sivananda, Tongaat, Isipingo, Marriannridge, Inanda C, Redhill, Lamontville, Umzamo, Cato Manor, Mpola and Chesterville.	Activities can be replicated in non-UB-supported facilities.

Good practice: Case Management Model II (CMM2) – benefits

Benefits to patients	Benefits to provider	Benefits to system
• Reduced waiting times • Holistic care reduces unmet needs – through improved integrity of consultations • Enhanced positive experience of health care and understanding of importance of life long ART adherence • Builds and sustains long-term relationships – enhances advocacy for individual patients • Enhanced provider and patient goal-setting – promotes involvement of patients in their care plans • Replicable across all facilities – large and small – thus promoting equity in care	• Fulfilling to the provider • Fair distribution of work • Contributes to EPMDS source data • Individual workplans are better organised • Improves staff competency through easier identification of competency gaps among Clinicians • Assignment of patients to named providers enhances pride and restores passion in care provision • Easier monitoring of patient care milestones • Enhances ethical practice	• No additional staff required • Uses already available resources • Enhances full utilisation of staff and is sustainable • Enhances accuracy in data-capturing and reporting • Accountability for patients is shared by named Clinicians and then the OM as overall supervisor • Enables faster and more focused intervention to improve provider skills and competence • Improves outcomes for chronic illnesses

Remaining challenges



In conclusion

Thank you

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