IMPROVING THE QUALITY OF HIV SERVICES TO INCREASE RETENTION IN CARE AND TREATMENT
INTRODUCTION

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) began supporting HIV and AIDS care and treatment programs in Côte d’Ivoire in 2004 and prevention of mother-to-child HIV transmission (PMTCT) services in 2005. EGPAF is working to end the country’s HIV epidemic by increasing access to comprehensive, high-quality and well-integrated HIV prevention, care and treatment services for women, children and families.

Launched in 2011 with funding from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Centers for Disease Control and Prevention (CDC), Project Djidja enables EGPAF-Côte d’Ivoire to support 126 health facilities in the south eastern and central parts of the country. Through Djidja, EGPAF works to strengthen health systems, including increasing health care workers’ capacity in the provision of high-quality HIV prevention, care, and treatment services. EGPAF provides direct service delivery support to these sites in the areas of PMTCT, provider-initiated HIV testing and counseling, and HIV care and treatment, as well as diagnosis and treatment of tuberculosis (TB). EGPAF also ensures local ownership of HIV service delivery improvements. We work with 11 community-based organizations (CBOs), enabling them to expand comprehensive HIV programs. We also work hand-in-hand with EGPAF’s own local affiliate organization, Fondation Ariel Glaser, to improve access to quality HIV and AIDS programs in other regions of the country.

Maintaining patients in care and treatment is critical to ensuring that people living with HIV receive the necessary care to live long and healthy lives. Project Djidia, over its course, has worked to scale-up retention in treatment among clients throughout all of its supported sites. Creative interventions designed to increase retention, involving better use of data and standardization of follow-up activities were scaled up in 16 districts within four regions (Abidjan 2, Bélier, Indenie-Djuaiblin, and Nzi-Iffou).
The Government of Côte d’Ivoire and EGPAF-Côte d’Ivoire (EGPAF-CDI) are committed to achieving the Joint United Nations Programme on HIV and AIDS’ (UNAIDS) 90-90-90 targets*. Retaining people living with HIV in care and treatment services is essential to achieving the third target. However, retention continues to be a major obstacle for HIV programs across sub-Saharan Africa.

UNAIDS estimates that in 2010, 18% of patients initiated on treatment were lost to follow-up (LTFU)† within the first year of treatment in developing countries. Multiple studies demonstrate that about 25% of HIV patients who started antiretroviral therapy (ART) do not remain in treatment 12 months after initiation.7-6

“In Côte d’Ivoire, LTFU (defined as patients who have not received ART in more than 90 days) rates surpass those of other developing countries; according to the Ministry of Health and Public Hygiene, in 2007, 2008, and 2009, the rates of LTFU at 12 months after ART initiation were 35%, 40%, and 38.8%, respectively.”7,8

Since the start of Project Djidja in October 2011, retention of HIV patients in care and treatment has been a consistent challenge. During the first year of the project, retention of adults and children in care and treatment was 70% at six months after ART initiation and 57% at 12 months. During the second project year, these rates increased to 72% at six months and 63% at 12 months. The overall weak retention rates were due in part to elevated LTFU and mortality rates in the program, both of which were influenced by systemic social, financial, clinical, and health system factors.

EGPAF and PEPFAR have identified retention as a common and key obstacle for implementing partners in Côte d’Ivoire, as well as a barrier to achieving the 90-90-90 targets. In 2013, following the release of an evaluation of the country’s care and treatment program, PEPFAR recommended that implementing partners aim to reach an 85% retention rate at 12 months after ART initiation.9

* 90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving treatment, and 90% of people on HIV treatment experiencing suppressed viral load by 2020.

† Patients are considered LTFU if they have not attended appointments to receive ARVs in more than 90 days.
EGPAF-Côte d’Ivoire strategized on various ways to confront low retention rates within its service delivery catchment areas under Project Djidja. This included determining how best to use available site level data to target clients LTFU and to focus on strengthening key components within the package of services available to improve quality of HIV services and strengthen retention rates of HIV-positive patients in care and treatment services. This resulted in the development of three strategies:

- suivi-actif du cohort (SAC),
- constat-action-resultat (CAR), and
- suivi-actif de la femme et enfant (SAFE)

These strategies were implemented within 109 health centers supported by Project Djidja. Their implementation was guided by several principles including use of data; standardization of procedures; and regular and standardized follow-up of activities.

**SUIVI-ACTIF DU COHORT (SAC) STRATEGY**

The SAC strategy, also known as “actively monitoring the cohort,” targets retention of patients on ART in their first 12 months post-treatment initiation. The strategy began in 2014 in 76 sites and has since been scaled up to 84 (as of September 2016). The objective of SAC is to increase retention rates and reduce LTFU and mortality rates. Through the SAC strategy, program officers and lay counselors (community health workers or social workers) analyzed patient level data for all patients living with HIV (adults, children, and pregnant women) attending these supported care and treatment facilities on a weekly basis in order to ensure all appointments...
were scheduled and attended. When patients on ART missed appointments, community health workers or
social workers proactively contacted these patients to urge them (via phone calls, and/or home visits) to return
to the facility for continued care and treatment. Since October 2015, the SAC strategy evolved to allow health
care workers to conduct this weekly analysis on a monthly basis for patients, with follow-up action taken, as
necessary, upon monthly review. After a patient’s first year on treatment, EGPAF-supported sites were urged
to track patients using the CAR strategy (see below). The SAC strategy entailed the following steps:

• Program officers and lay counsellors collect essential information on patients (phone number and clinical
  status of patients) at patient enrolment on ART

• Program officers generate a list per month of patients on ART and their status (on treatment, stopped
  treatment, without treatment, LTFU, transferred, or deceased), grouped by status based on the month they
  initiated treatment

• Program officers and lay counsellors identify patients who are out of treatment or LTFU

• Lay counsellors contact the patients out of treatment or LTFU by telephone

• After two unsuccessful attempts of contacting the patient by telephone, lay counselors visit all patients LTFU
  and provide ART to patients at their homes during these visits

• Program officers ensure that patients out of treatment or LTFU are reintegrated into care and treatment
  services

SAC IMPACT

Following the implementation of the data-driven SAC strategy beginning in January-March 2014, ART
retention rates at 12 months increased to 71% during the third project year and 79% during the fourth (75% and
81% at six months, respectively) in supported sites. In spite of this growth, the retention rates at six and 12
months still remained below PEPFAR’s goals of 95% at six months and 85% at 12 months (see Figures 1 and 2).

Figure 1. Trends in Retention and LTFU Rates in 6 Month Cohort of SAC Implementation
**CONSTAT-ACTION-RÉSULTAT (CAR) STRATEGY**

In early 2014, EGPAF began implementing the CAR strategy, or “using evidence to inform action” at all 109 care and treatment sites supported by Project Djidja. The CAR strategy aims to increase access to high-quality care and support services, thereby ensuring greater involvement in care and treatment, and retention. The strategy monitored a package of services provided to persons living with HIV (e.g., enrollment in care, cotrimoxazole [CTX] prophylaxis, TB screening, HIV testing among individuals with TB, nutritional assessments, positive health, dignity, and prevention) and to ensure that patients accessing these services remained in care.

Under this strategy, EGPAF program staff conducted weekly site visits to assess whether patients had received the package of services and if the services were well documented. If program staff found patients had not returned to the facility to get the necessary follow up services (test results, initiation of prophylaxis or treatment), lay counselors would place phone calls to patients to bring them back in the facility. If the patients were not reachable by phone, lay counselors conducted home visits and provide home-based care, such as counseling, prophylaxis and treatment (similar to SAC).

**CAR IMPACT**

Since beginning implementation of the CAR strategy in early 2014, improvements in use of provider-initiated testing and counseling, adult and pediatric care and treatment, TB/HIV co-infection, and care and support (i.e., prophylaxis and nutrition services) have been seen. Figures 4, 5, and 6 demonstrate trends over the course of Project Djidja for key indicators of quality: number of patients enrolled in clinical HIV care, nutritional assessments, and TB screening among people living with HIV.
Figure 3. Percentage of People Living with HIV Receiving CTX Prophylaxis and Patients in Clinical Care

Figure 4. Percentage of People Living with HIV Nutritionally Assessed and Patients in Clinical Care
The SAFE strategy, or “active follow-up of the mother-baby pair” began in 2015 and has been implemented in 60 high-volume, PMTCT sites. Through this strategy, EGPAF program officers monitor delivery of a minimum package of services to HIV-positive pregnant or breastfeeding women and their HIV-exposed infants (including ANC visits, ART provision to HIV-positive women, CD4 count diagnostics, TB screening, and nutritional assessment for women and children, early infant HIV diagnosis (EID), prophylaxis, and treatment among HIV-infected infants) through appointment reminders, phone calls, and home visits for all missed appointments.

SAFE entails the following steps:

- Identification of all HIV-positive pregnant women in ANC and labor and delivery by health workers
- Monitoring of all ANC visits of HIV-positive pregnant women by EGPAF program officers
- Monitoring of deliveries at health centers among HIV-positive pregnant women by EGPAF officers
- Phone calls and home visits (by lay counselors and social workers) to HIV-positive pregnant women who missed at least one service (ANC or prophylaxis pick-up) or who are LTFU
- Weekly monitoring (by EGPAF program staff) of CTX distribution to HIV-exposed infants at six weeks
- Weekly monitoring (by EGPAF program staff) of EID at two months and 12 months of age
EGPAF program officers realized several changes were needed to improve site and infrastructure functions. Documentation of PMTCT and care and treatment services was poor at the beginning of Project Djidja. EGPAF developed user-friendly tools to record PMTCT and care and treatment support to clients, training health workers on their use. PCR testing is recommended among all HIV-exposed infants. However, only three laboratories in the country were capable of performing PCR exams (all located in Abidjan). Early in the implementation of SAFE, Djidja established a blood transportation system from PMTCT site to the referral laboratories and further improved this system to ensure that PCR results were available at the facilities in a timely manner.

**SAFE IMPACT**

SAC and SAFE employed similar approaches and saw similar results. Overall, the SAC and SAFE strategies have contributed to fewer missed appointments among HIV-positive pregnant women in those supported sites, with staff using reminders, phone calls, or home visits to keep those who have missed appointments in care.

**CHALLENGES**

The availability of human resources has been an obstacle in the implementation of all of these strategies. At some facilities, there was a shortage of data monitoring assistants, who allow for the rapid identification of missed appointments. There was also sometimes an insufficient number of social workers and community counselors to bring patients LTFU back into care through phone calls and home visits. Some facilities also did not have a database available to allow for the longitudinal management of clinic data. Lastly, sustained financial resources for phone credits for calling patients and travel costs for home visits by social workers and community counselors is lacking and will need to be established to ensure continued gains of this program.

**NEXT STEPS**

Through continued CDC support, EGPAF will work with the heads of facilities and districts to strengthen human resources and ensure the functions of CAR, SAFE and SAC are well-supported. Identified site level providers will be trained in 2017 by EGPAF program officers on standard operating procedures for the continued implementation of the SAC, CAR, and SAFE strategies to enable further progress towards the 90-90-90 goals. EGPAF will also expand focus within SAC to 24 and 36 month retention after ART initiation to monitor long-term retention rates.
REFERENCES


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