Successes in linkage to care of HIV positive clients: Lessons from a community-based HIV collaborative programme

[1,2]S.Shamu, [1]J. Slabbert, [1]G. Guloba, [1]D. Blom, [1]S. Khupakonke, [3]N. Masihleho,[3]J.Kamera, [1]S. Johnson, [1]T. Farirai, [1]N.Nkhwashu
[1]Foundation for Professional Development, [2]University of the Witwatersrand, School of Public Health, [3]USAID, Pretoria, South Africa

INTRODUCTION

Linkage of HIV-positive clients to HIV treatment and care continues to be a huge challenge in many settings in Sub-Saharan Africa including South Africa. This leads to failure to meet the UN's second 90 goal to link 90% of those tested HIV positive. The aim of this paper is to report on the outcome of an innovative collaborative intervention involving two non-governmental organisations to increase linkage to care between 2016 and 2017 in high HIV prevalence districts in South Africa.

METHODS

A mixed methods study was conducted to quantify the linkage to care (LTC) rate between 2016 and 2017 and explain contributing successes in program implementation using in-depth interviews and boardroom discussions. Five programme managers, four implementers, five HIV positive clients were interviewed on the perceived factors contributing to program success/failure. Two feedback consultative meetings were conducted to present draft findings to programme managers (n=7) and implementers (n=10) for results verification and data confirmation. Thematic content analysis was used to analyse qualitative data and descriptive analyses used to establish LTC rates.

RESULTS

A baseline cumulative LTC rate of 27% was reported in 2015. After implementing a collaborative programme with NGOs to facilitate linkage to HIV services, the LTC rate rose to 85% in 2017. In the qualitative data analysis, five themes emerged as success factors at the health system and structural levels. The themes include client escort service provision, human resource capacity strengthening at health facilities, employing onsite LTC strategy, inter and intra-organisational teamwork, facilitated and expedited jumping of queuing of clients, and task shifting administrative duties to non-clinical staff. The program thus witnessed a decrease in LTC related expenditure, swift ART initiation of clients and increased client support which all resulted from the implemented strategies.

CONCLUSION

A holistic target driven approach involving commitment from various stakeholders can significantly improve client linkage and retention in care.

Factors contributing to the increase in LTC rates between 2016-2017 in the CBCT program

THEMES	IDENTIFIED CHALLENGES	MITIGATING STRATEGIES	QUOTES FROM THE INTERACTIONS WITH PROGRAM STAFF
Provision of client escort services	• High transport cost for linkage tracer to escort client to referral clinic • Time intensive client escort services • Ineffective transport money claiming system • Backlog in client linkage	• Establishing synergy in activities for the HIV counsellor and the linkage tracer • Making program resources such as vehicles, be available for client tracing and subsequent linkage • Abolishing the money claiming system	"The children (1–14) were always red, so we turned them green through home visits and transportation to the clinics". **Program Manager, CBCT program**
Facilitated jumping of queues	• TiHigh amount of time spent at the clinic for client ART initiation • High loss to follow up among clients who could not spend a full day at the clinic for initiation due to work and other commitments	• Established relationship with the BroadReach, a district support partner providing ART initiation services in relevant clinics • Linkage tracers provided administrative duties to assist nurses speed up the ART initiation process thereby shortening the total time spent	". . .without fast-tracking, clients used to spend 3–4 hours waiting for consultation with the DoH (Department of Health) nurse. Sometimes (just) before your (client's) turn, the nurse would go for lunch or tea break, what would you do? . . . so I approached our District Service Provider and said: is it possible not to keep our clients waiting? Instead open a clinical chart (patient record) for them then the District Service Provider nurse will initiate because we can't expect the Department of Health nurse to stop consulting other people..." **District CBCT Coordinator.**
Task shifting of administrative duties to linkage tracers	• Facing resistance from clinic staff when going through clinic files to confirm patients	• Provision of administrative duties to facilitate the acceptance of linkage tracers as part of clinic staff while expediting linkage of escorted clients	"Without a District Service Provider, you find that someone was linked to care but not captured [onto the system]. So with the District Service Provider nurse who has quick access to the information database
at ART initiation	• confirmed as linked to care • When clients were escorted for ART initiation		you have real time data on who is linked to care or not and this information helps to speed up LTC". **HIV counsellor, CBCT program.**
On-site linkage to care	• Lack of resources for clients to get linkage to care decreased LTC rates and increase lost-to-follow up rates • High patient loses in the system due to population movements	• Requesting a DSP nurse to travel with the mobile teams and ensure that all clients testing HIV positive are linkage on site immediately	"Linkage is a joint activity. . .we jointly own the positivity and link the positive clients together" …**Program Manager, CBCT program** ". . .even after church the District Service Provider nurse calls us and checks 'is there a person for me to link today'". **Linkage tracer, CBCT program**
Intra-and-inter NGO teamwork	• Uncoordinated provision of HTS services • Lack of integration in systems initiated for the same project	• Promotion of teamwork in all project staff • Instituting daily and weekly meeting for reporting progress from all teams • Creating project dashboards displaying progress in all areas	". . .our coordinator told us that LTC is everyone's business and that if patients are not linked to care then it means CBCT is failing. So even the HTC counsellor sometimes links patients to care. . .everyone is involved." **Linkage tracer, CBCT program**
Challenges encountered during implementation	• Incorrect capturing of client details resulting in high loss-to-follow up rates	• Buzzing client phones after receiving contact details to confirm the recorded contact details	"I did not visit the clinic or start treatment immediately because I needed to discuss this [HIV positive status] with my family before rushing to the clinic". **Female, CBCT client** "Home visits for linkage was strengthened after realising that some clients did not respond to their mobile phones, so we visited them to get them to the clinic to link them". **Linkage nurse, DSP**


Dr Simukai Shamu
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
simukais@foundation.co.za


Mr Jean Slabbert
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
jeans@foundation.co.za


Mr Geoffrey Guloba
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
geoffreyg@foundation.co.za


Ms Dalene Blom
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
daleneb@foundation.co.za


Ms Sikhulile Khupakonke
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
sikhulilek@foundation.co.za

Nomea Masihleho

Julius Kamera


Ms Suzanne Mabaso
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
suzannem@foundation.co.za


Dr Nkhensani Nkhwashu
FPD
PO Box 75324,
Lynnwood Ridge,
0040, South Africa,
nkhensanin@foundation.co.za