Improving Retention of Patients in HIV Care in Uganda

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Context

Financial constraints, travel difficulties and stigma in general can all prevent HIV patients who start treatment and care from continuing it. As many are still lost to follow-up, there is a need for interventions at all levels to ensure patients do and are able to return for the treatment they begin.

For this reason, the USAID Health Care Improvement (HCI) Project is supporting Uganda’s Ministry of Health (MoH) to improve the coverage, retention and outcome gaps in HIV care through a series of related improvement collaboratives. Fourteen sites currently are addressing the retention gap to ensure patients lost to follow-up remain in care and those started on therapy continue it.

Strategy for change

The intervention used multi-disciplinary QI teams formed at facilities to identify problems, collect data, discuss progress and suggest areas of improvement.

Teams also participated in learning sessions to share experiences, identify best practices and define a retention change package.

Patients gave feedback about care delivery and changes for improvement.

Coaching visits supported facilities’ teamwork, reviewed indicators’ progress, gave clinical updates, and trained on QI methods.

Teams also coordinated specific interventions to improve HIV care through the following methods:

- **ART support groups**: Patients with similar appointment dates living in the same location collect ART on a rotational basis. Members are collectively responsible for each other’s well-being. Group size varies at each facility.

- **More than one month supply of ART**: Applies to stable patients with an adherence level to treatment of 95% and above. Appropriate drug stock and assigning staff to monitor stock is essential.

- **Treatment supporters**: Friends or family members collect treatment on behalf of patients up to a maximum of 2 months. This method is applicable to stable patients with an adherence to treatment level of 95% and above.

Measurement of improvement

Facilities used multiple approaches to improve and measure patient retention:

- Collecting baseline data and making monthly comparisons
- Using a standard documentation journal to monitor progress
- Creating simple run charts and teams sharing at learning sessions held showed the changes and effects of these approaches. Clients also were randomly selected during clinic visits to give feedback about how care was provided.

Effects of changes

Since the collaborative’s launch in November 2009, 7 out of the 14 participating sites had a retention problem. By 2010:

- Bwera Hospital improved from 54% to 93% in July 2010 after implementing a more than one month supply of ART and giving ART to patient groups.
- 5 sites that had no retention gaps worked to maintain or increase performance.
- One site worked on reducing time spent at the clinic from 360 to 120 minutes, which affected retention (shown in Figure 1).

Involving patients in care improved their ability to discuss problems with health workers. However, patients’ changing needs require facilities to be flexible and meet these needs in a timely fashion.

Lessons learnt

Previously, facilities’ retention data was poor, but interventions can help through:

- Updating records about each patient’s status (e.g., removing those who died, transferred or were lost to follow-up) helps facilities track and take actions to improve retention in care.
- Health workers assisting patients in identifying problems and suggesting changes in care delivery.
- Maintaining retention data that can improve other systems, including logistics management.

Message for others

Addressing the retention issue requires facilities that are responsive to patients’ changing needs, which can be achieved through productive interactions between patients and health workers.