Community Based Adherence Programme

TOOLS DEVELOPMENT AND INTEGRATION WITH CLINICAL SERVICES MONITORING AND EVALUATION

Kheth’Impilo’s (KI) vision is to work towards an AIDS FREE GENERATION IN OUR TIME

Background

Kheth’Impilo’s Patient Advocate (PA) Community Adherence Model envisions PAs to straddle both health facilities and community based settings. Their primary focus is to provide adherence and psychosocial support for patients and household members on TB/HIV treatment. Research has shown that patients supported by community based PAs have improved clinical outcomes. The main challenge is developing appropriate tools that capture both clinical and psychosocial aspects of patients’ treatment history. These tools accurately capture patient and household members’ details, the PAs activities. Current systems, the paper based registers as well as the e-data tools envisaged as the backbone for Tier 1 and 2 of the NDoH M&E roll out do not encompass psychosocial aspects of care, especially elements that could impact adversely on adherence. Integration of this data with clinical outputs is not on the National NDoH agenda and yet is critical for ensuring the continuum of care. Prior to developing the tools for the KI PA model of care, there was limited information on the patient-household centred approach. Data needed included; household numbers, children <15, those needing social grants, vaccinations and other support that include food and shelter. Disclosure by the index patient is sensitively evaluated and where there has been none, this is encouraged through added counselling and support but not forced. Alcohol and drug abuse as well as domestic violence in the home is also checked. Household members are screened for TB and HIV testing is encouraged. The tools were rolled out between November 2010 and January 2011; this period constituted the pilot phase.

Methods

The tools developed highlight a data collection strategy that attempts to measure the programme process and service provision in the realm of a community based support programmes. Staff have undergone training; the tools piloted and successfully scaled-up in all the provinces where KI is operative.

Results

The tools do not only capture the patient details but interventions provided to the household members. Subsequently, all are introduced to the chain of continuum of care. The tools developed include; psychosocial screening, treatment readiness, the patient follow up plan, child and household member follow up plan; and the client summary. These tools integrate the clinical and community components of the programme. Of particular interest, the client summary tool brings together the clinical and psychosocial patient details (see insert 1). Patients are followed up in the community and are provided with services. In addition, the tools provide patient feedback on individual basis to the clinic and on overall programme performance, applied research and reporting. These tools collect data at each visit. Patients as part of treatment work up, where consent has been obtained, have an hour long detailed home assessment. Once on treatment these visits continue at decreasing frequency as patients respond to therapy and show adherence with suppressed viral load. Once stable, after 6 months, patients are check on monthly through various electronic means.

Discussion

The implementation phase of the tools was characterized by challenges. Essential data elements such as service categories like household economic strengthening (child support grants, foster care grants, disability grants, old age pension) (see insert 1), referral for services such as 6 weeks PCR and 18 months ELISA were not adequately collected. This was due to lack of programme knowledge by data and programme staff. To improve data collection using the new tools a training programme has been designed and rolled out. The training program is comprised of a series of workshops held in all districts where KI is operative. Data collection improved from 10% in second quarter (1 October 2010-31 December 2010) to approximately 55% in the second quarter (1 January 2011 to 31 March 2011). We expect further improvements in the third and fourth quarter.

Conclusion

If used correctly and consistently, the tools not only provide a good opportunity to track patients but provide outcome measures into community adherence and psychosocial support. Collected data can potentially make service providers demonstrate the needed link of patient clinical and follow up information with psychosocial components thereby holistically addressing all patient needs.

The client summary tool provides this platform for integration to create a two way loop which channels patient information from communities to the clinics and vice versa. Information gathered using these tools could set the foundation needed to measure the impact of the integrated model of care at both household and patient level. Ongoing capacity building of programme and data staff is important for the optimum utility of tools.

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