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TECHNICAL REPORT SUMMARY

Private-for-Profit HIV/AIDS Care in Uganda: An Assessment

Background

Uganda has 4639 health facilities, of which 2154 (46 %) are privately owned for-profits (PFPs). The government has accredited 36 PFPs to provide care and treatment to people with HIV/AIDS, but little was known about the quality of care in these facilities. The quality of HIV care is important to patients treated in all facilities and has broader public health implications as well: Poor care can lead to the spread of resistant virus and weaken people's faith in ART if they become aware of too many poor outcomes. To learn more about the quality of HIV care in PFPs, Uganda's Ministry of Health and the United States Agency for International Development (USAID) requested that the USAID Health Care Improvement Project (HCI) assess quality of HIV and antiretroviral therapy (ART) care in Ugandan PFPs. The assessment was conducted in June and July 2008.

Objectives

The assessment had five objectives:

1. Assess the PFPs' scope of work in the area of HIV care and ART services;
2. Assess the quality of HIV and ART services provided in PFPs, including documentation practices;
3. Document ART regimens prescribed by PFP facilities and sources of such drugs;
4. Establish the opportunities and challenges PFPs face in providing HIV care and ART services; and
5. Assess PFPs' scope of work regarding tuberculosis (TB) and TB/HIV integration.

Methodology

All 36 accredited PFP sites were considered for assessment; six were disqualified for practical reasons. For the remaining 30, the study interviewed staff and reviewed the records of two cohorts at each facility. One cohort included 25 patients initiated on ART 12 months before the assessment, and the second included 25 patients registered for pre-ART care 12 months before the assessment. Records were reviewed using a standard form to gather information on demographics, adherence with selected standards, and outcomes. While the study was designed to review 1500 patient records, only 327 were found pursuant to the methodology.

Results

Availability of Services

All sites offer voluntary counseling and testing (VCT) and adult ART; 27 (90%) offer TB screening for patients with HIV; 23 (77%) offer HIV testing for patients with TB; 18 (60%) offer prevention of mother-to-child transmission of HIV (PMTCT); and 15 (50%) offer paediatric ART. Only seven (23%) offer these

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services. Twenty (67%) are open at least on all working days (Monday through Friday), while seven (33%) are open less than five days a week.

Despite the apparent accessibility offered by PFPs, they offered more clinical services than psychosocial services. Furthermore, most do not provide the services that clients may require in the community, such as income and nutrition support, insecticide-treated bed nets, and water safety supplies.

Quality of Care: Documentation

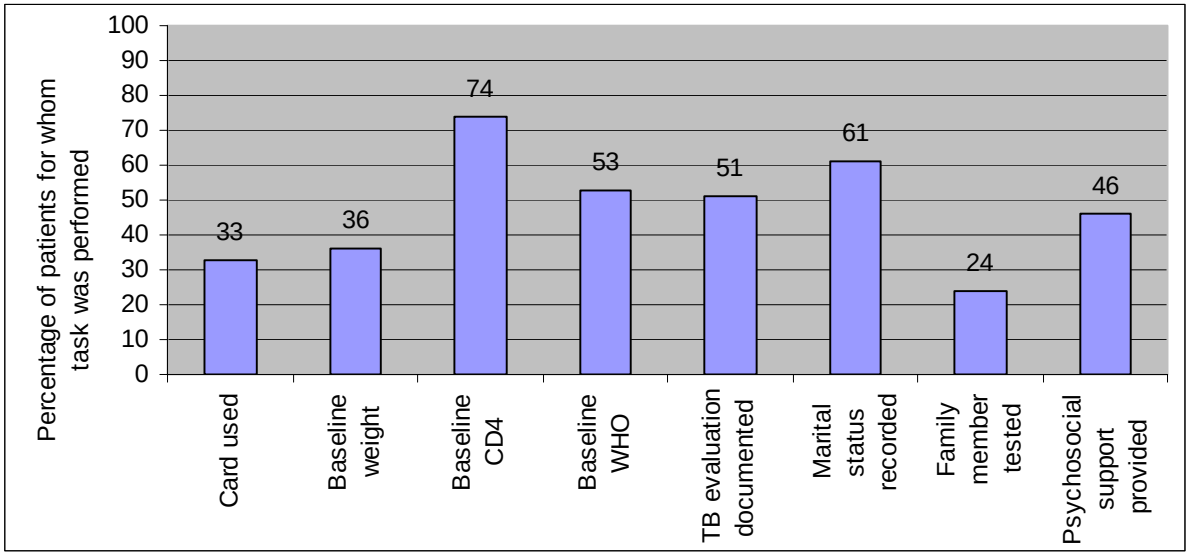
Documentation is essential for quality long-term care but was poor in most assessed facilities. The study had planned to review 750 pre-ART records but found only 117. An identical number of ART records was sought but only 210 were found. Of the records reviewed, 213 (57%) used the MoH HIV/ART care card; the remaining 43% used other formats.

Quality of Care: Pre-ART

Adherence with standards at initial visit

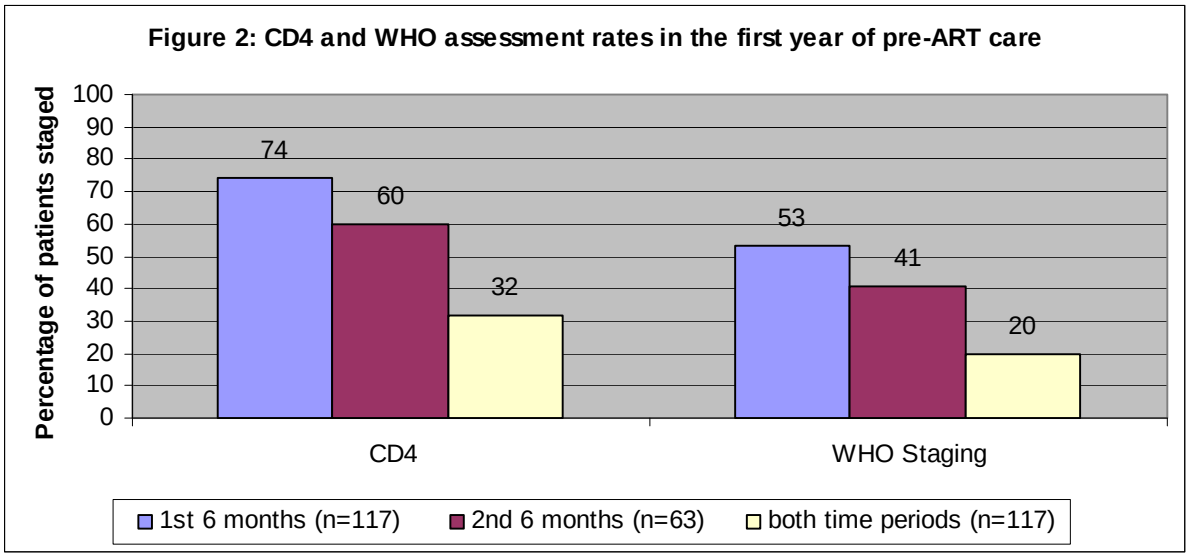
Adherence with selected standards at the initial visit tended to be better for clinical than psychosocial care. The review of 117 pre-ART records found that only 42 patients (36%) had their baseline weight measured; 86 (74%) had their baseline CD4 count measured; 62 (53%) had their WHO stage recorded; and 60 (51%) had documented evidence of screening for TB. Standard psychosocial care documentation tended to be less frequent: 71 (61%) patients had their marital status recorded; 28 (24%) had their partners or family members tested for HIV; and 54 (46%) received psychosocial support at some point in the year following registration (Figure 1).

Figure 1: Adherence to MoH pre-ART guidelines



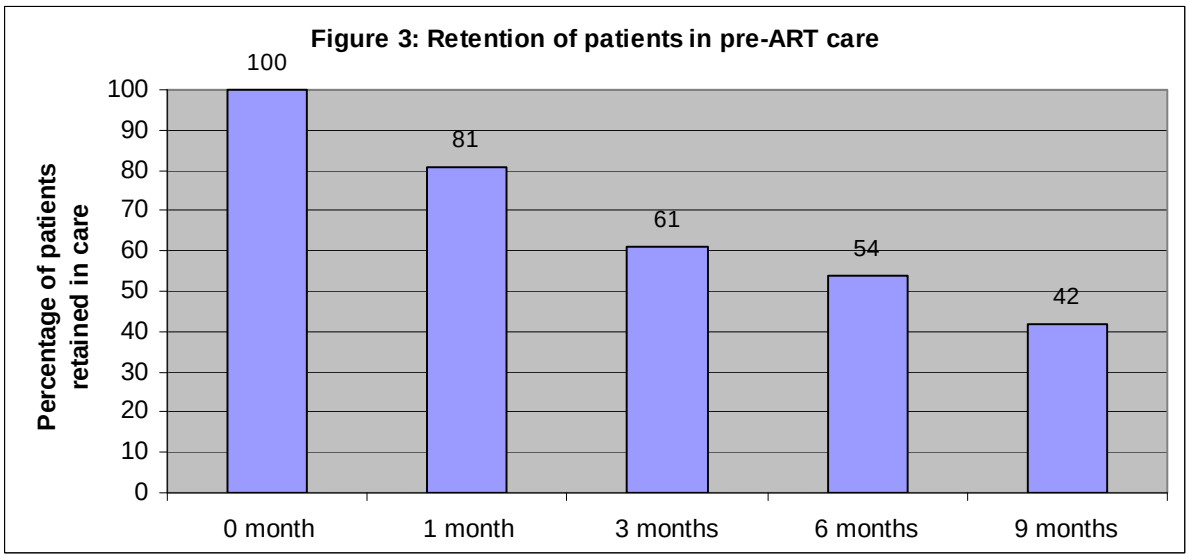
Adherence with standards in the second six-month period of care

The Ministry recommends that a patient be clinically staged at every visit and have a CD4 done at least once every six months. Of the 117 patients represented by the pre-ART records, only 63 (54%) had a visit 6–12 months after registration. Of them, 38 (60%) had a CD4 count and 26 (41%) had their WHO stage recorded. Figure 2 shows these declines from the initial visit. Only 37 patients (32% of those registered for care) had CD4 counts recorded, and only 23 (20%) had WHO staging done in both time periods (Figure 2).



Retention in care

After the initial visit, patients returned to the PFP a median of four times in the next 12 months, well short of the Ministry's recommendation that a patient return monthly. After the first month, 81% of patients were still in care; this fell to 61% after three months, 54% after six months, and 42% after nine months (Figure 3).



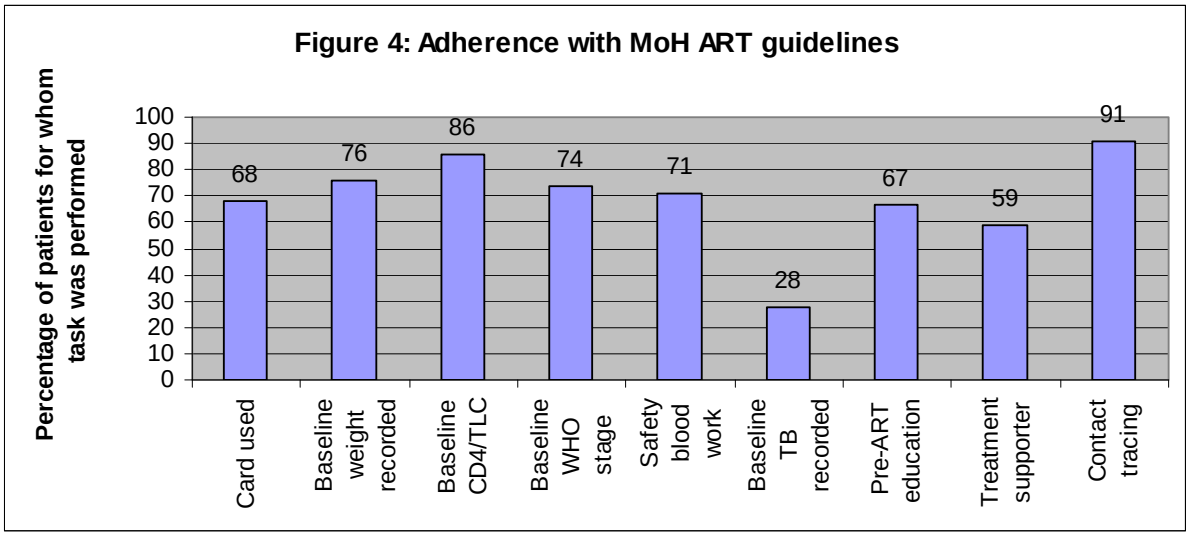
Outcomes

Based on CD4 counts, 24 patients (21%) became eligible for ART in the second six months after registration, but of those eligible, only five (20%) started ART. Based on WHO staging, 13 patients (11%) became eligible for ART in second six months, but of those, only four (31%) started ART. This means that even when found eligible for ART, a significant proportion of PFP patients may not start therapy.

Quality of Care: ART

Adherence with standards at initial visit

The record review found that provider adherence to selected standards was generally higher in the ART cohort than the pre-ART cohort. Of 210 ART records, ART cards recommended by the Ministry were used in 143 (68%). For the clinical standards, weight was recorded for 159 (76%), CD4 for 181 (86%), and WHO stage for 156 (74%). Safety blood work (for haemoglobin and liver and renal function) were performed for 150 (71%) of these patients before initiating ART. Surprisingly, only 60 (28%) had their TB status recorded at the first visit. For the selected psychosocial standards, 140 patients (67%) received pre-ART education, 124 (59%) had a treatment supporter named in the medical record, and 192 (91%) had contact-tracing information recorded. However, only 42 (20%) were linked to home-based care (Figure 4).

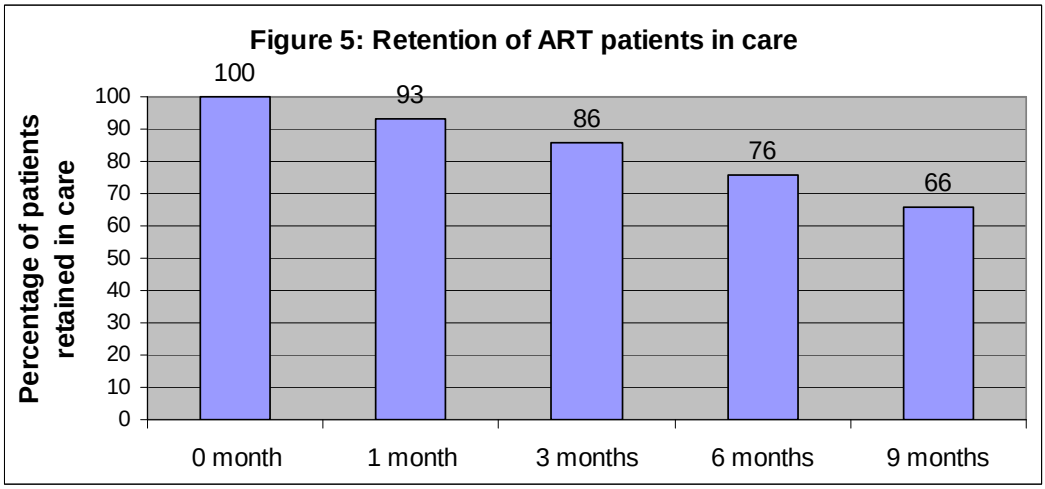


Adherence with standards in the second six-month period of care

After six months, 159 (76%) ART patients were still in care. Of those, 84 (53%) had a CD4 count taken in the second six-month period; 75 (36%) had a CD4 test in both time periods.

Retention

Of the 210 ART patients, 93% were still in care after one month, 86% after three months, 76% after six months, and 66% after nine months (Figure 5), further indicating that retention over time, even the relatively brief period of a year, is a concern.



Outcomes

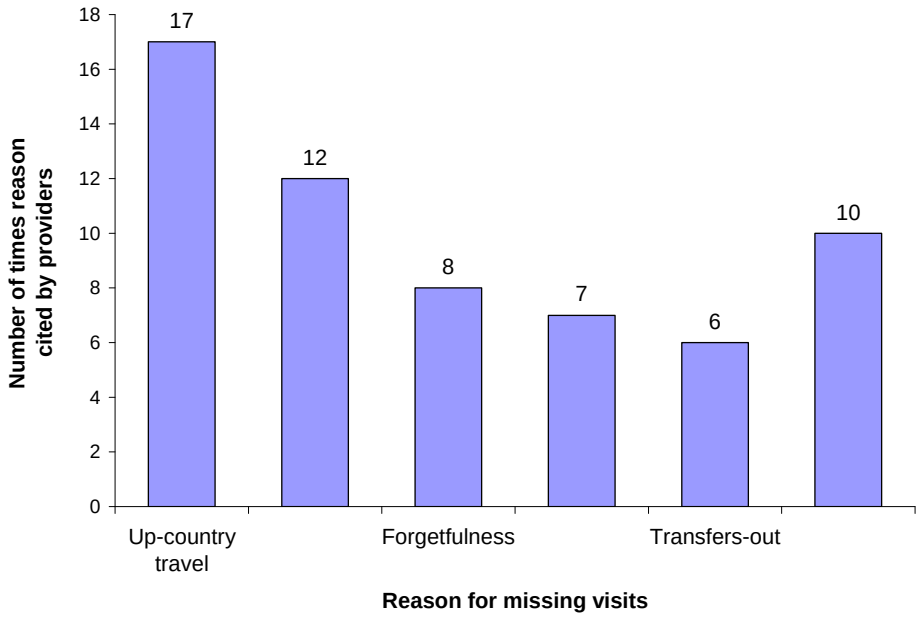
The median CD4 count increase in the 99 patients who had CD4 tests in both six-month periods was 114 cells/mm^3; the median increase in weight was four kilograms. Nine patients (4%) had single drug substitutions to their ART, and no patient changed to a second line regimen. Single drug changes were made in response to adverse events or the Ministry's new policy phasing out D4T-containing regimens.

Opportunities and Barriers Identified during Interviews

The provider interviews revealed the most common challenges facilities faced when providing ART services: inadequate drug supply, stock-outs, and high drug costs (reported by 22 sites [73%]); inadequate knowledge of ART (15 sites [50%]); and limited human resource capacity to deliver the ART programme effectively (14 sites [47%]). Lack of commitment from management, lack of follow-up mechanisms, a high rate of patient loss to follow-up, and inaccessibility of laboratory services were the other challenges reported.

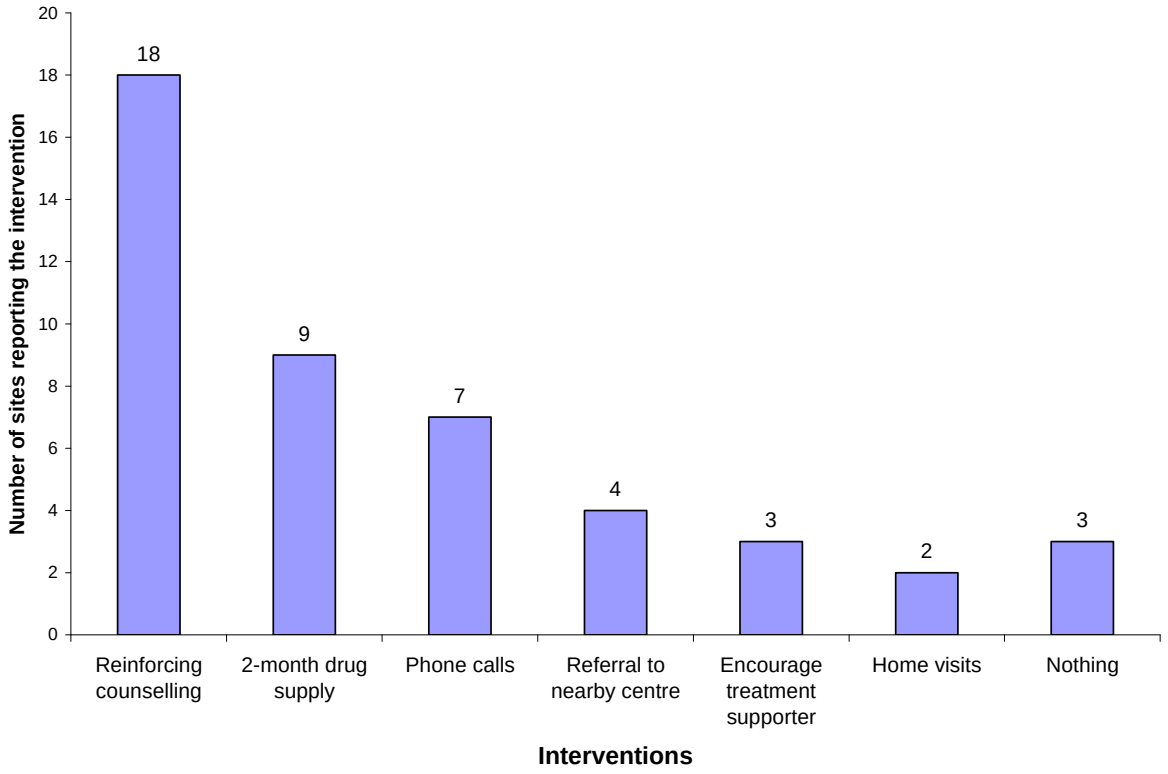
We asked providers for their opinions of the causes of poor retention. The five most commonly mentioned reasons why providers believed patients missed their appointments were: patients travelling, being transferred, and being deployed (mentioned at 57% of sites); transport difficulties and cost (40%); forgetfulness or busy schedule (27%); sickness/illness and being too weak for the hospital journey (23%); and attending other clinics or transfers-out (21%). The other reasons were side effects of antiretrovirals, expensive drugs, drop-outs, and insecurity on the roads (Figure 6).

Figure 6: Providers' beliefs of why patients miss their appointments



Comparing providers' beliefs of the causes of missed appointments and the interventions PFPs had devised to reduce those misses resulted in an important finding: Little relationship exists between the causes and the interventions/solutions. Of the 30 facilities, 90% had established at least one intervention in their ART programme aimed at reducing missed visits and patient loss to follow-up (Figure 7): 18 sites emphasised counselling to encourage patients to keep their appointments; nine gave two months' worth of drugs, and seven called patients to remind them of their appointments. Other interventions were to encourage patients to send a treatment supporter to pick up drugs, transferring patients to health centres closer to the patient to save transport costs, and organising home visits by service providers. Because the most common barriers were related to distance and transport (as seen in Figure 6), it is doubtful that additional counselling and reminders would be effective.

Figure 7: Interventions for reducing missed visits and lost to follow-up



Summary of Findings

The major findings of this assessment of Ugandan PFPs were: 1) adherence with standards was good in the first visit, particularly for clinical activities, but weakened over time; 2) poor patient retention is the main cause of poor quality care; and 3) sites are making changes to improve quality, but, at least in efforts to improve retention, the changes do not always effectively address the problems.

Study Limitations

One limitation of the study is its reliance on medical records. Poor results for adherence to standards and retention could be due to either poor documentation (failure to take notes during patient visits or not recording all information) or care not being provided. This study did not determine the extent of these problems. Care not being provided is obviously more serious, but documentation is essential to providing good quality care over time. HCI is planning studies to assess documentation quality.

Recommendations

As in most health systems, care in privately owned for-profit facilities in Uganda has been designed to provide care to the acutely ill. They are fairly good at adhering to clinical standards at the first visit, suggesting that the PFP system does well at what it has traditionally done: care for patients in the clinic. However, PFPs are not prepared to manage patients with chronic diseases, as is reflected in poor patient retention, declining adherence with standards as a patient is in care longer, and weak links with the community.

We have three recommendations to improve the quality of HIV/AIDS care in PFP facilities:

Regularly measure quality: Facilities should be supported to regularly measure and report on indicators of patient retention, adherence with standards, and patient outcomes.

Adapt and incorporate elements of the chronic care model: A major challenge to health systems globally is adapting to the increased prevalence of chronic disease. With the arrival of ART, HIV became a chronic disease requiring emphasis on retaining patients in care over the long term and supporting them at home and in their community. The chronic care model developed by the (United States) University of Washington for chronic disease care could be adapted for Uganda. The model has five components: patient self-management, use of multi-disciplinary teams to provide health care and to support patients, support for less trained members of the team, information systems for long-term care, and links with the community. Improvements in each of these components would be expected to improve the quality of care.

Establish and support quality improvement teams at the site level to make these changes: Making changes to improve chronic care will not be easy. Based on years of experience in improving the quality of care in developing country health systems and the findings reported here, we recommend that the Ministry of Health and its partners establish mechanisms to ensure that PFP health workers are trained in using data to improve care and in quality improvement techniques. The design should incorporate supportive supervision visits that stress adherence to the MoH guidelines and use of the chronic care model so that PFPs can redesign their care systems to be better adapted to the unique challenges of chronic diseases such as HIV.

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Further information, including study instruments, may be found in: Kyayise AM, R Kyeyagalire, N Livesley, I Kirunda, B Tumwesigye, S Kinoti and D Katungu. 2008. Private-for-profit HIV/AIDS Care in Uganda: An Assessment. *Technical Report*. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

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