

# HATiP

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# HIV and TB in Practice for nurses: integration and decentralisation

By Theo Smart

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## Integration and decentralisation: How two words could affect your patients – and your job

“Integration” has become a buzz-word over the past few years among public health specialists, Ministers of Health and programme managers, and was a much-talked-about issue at the [IAS 2011 conference in Rome last year](#).

Most of the presentations focused on *service delivery integration* – providing services usually offered by one health department at sites run by another.

Increasingly the model for service delivery integration is TB/HIV service integration, which involves the delivery of HIV services (such as counselling and testing, cotrimoxazole preventive therapy, and ART) at TB clinics, and of TB services (the Three I's for HIV/TB) at HIV care and treatment sites.

Similarly, the *decentralisation* of HIV services involves the integration of HIV services into primary healthcare clinics and other healthcare facilities.

But what does this programme jargon have to do with nurses, or community healthcare workers?

Quite a lot, actually.

New services integrated into the health facility usually change the work that nurses are expected to do, and the training needed – anyone involved in Nurse-initiated Management of Antiretroviral Therapy (NiMART) can tell you that.

### NiMART – Nurse-initiated Management of Antiretroviral Therapy

New services may increase the nurse's workload, at least at first. But if nurses have too much work to do their jobs well, programmes need to find ways to shift some of their simpler tasks to trained community workers or expert patients, who can free up some of the nurse's time for the new services.

Indeed, the common feature of all the most successful cases of service delivery integration and HIV service decentralisation presented at the meeting was a strong partnership with community-based supporters, and peer-expert patients who provided assistance in linking patients to care and in ensuring continuity of care.

In the long run, the services may improve the patients' health, reducing the amount of time that the nurse and health system must spend caring for a sick person – and in the case of TB services, may reduce the risk of being exposed to active TB for the nurse and other patients.

## Why is there a push to integrate services and decentralise now?

### There's less money now

Donors have not been giving as much support to health programmes in resource-limited countries, and funding has dropped, especially for HIV programmes. Critics complained HIV got too much money compared to other health issues. So national programmes have been looking for ways to become more efficient and save money.

### To expand the reach and uptake of ART

Reaching all the HIV-positive people in the country, especially remote and rural areas will only be possible if treatment services, including ART, are integrated into other health services, particularly primary health care.

### To make essential services more convenient for patients

People living with HIV are at very high risk of developing active TB. Many national policies now follow the WHO recommendation that people living with HIV (PLWHIV) need to be screened for TB symptoms at every contact with the health system. If they do not have symptoms, they should be given isoniazid preventive therapy, and if they do have symptoms, sent to the facility for further diagnostic work-up.

TB screening is easy to integrate into services – one presentation described TB screening being integrated into mobile HIV counselling and testing units, screening over 26,000 people in the space of a year in the Western Cape province, South Africa (although there were problems getting those who tested HIV positive to follow through on their referral for a complete diagnostic work-up; only 64% did, and a similar percentage presented to the ART clinic).

What would happen if the HIV programme just sent every person diagnosed with HIV to the TB clinic to be screened for TB symptoms?

- Many patients would not complete the referral, even though some would have TB. These patients would go undiagnosed, and could pass on TB to other patients too.
- Sending every person with HIV to the TB site, regardless of whether they have symptoms, could strain the programme's capacity because people with HIV would need to be screened regularly (TB can develop quickly).
- It makes much more sense to provide TB screening for people living with HIV as a service at the same site where they get their care and/or antiretroviral therapy (ART).

Earlier access to diagnostic services or treatment – provided at the place where the patient already is – improves outcomes. For instance, making early ART available at the TB clinic increases survival when given as soon as possible to people on TB treatment with very low CD4 cell counts.

### The same patient needs multiple services from multiple programmes

So if a lot of patients don't complete their referrals to another clinic, how many patients do you think complete referrals to three or four different clinics? Yet, this is the experience of many PLHIV. It is also the experience of many vulnerable women in very resource-constrained turbulent settings.

One study presented at IAS reported success in integrating HIV counselling and testing, prevention of parent-to-child transmission, family planning, malaria prevention and care services to women in post-conflict Northern Uganda, where there is a high rate of maternal mortality and a low uptake of many of these services when they are offered separately. When the services were integrated and delivered at antenatal clinics, uptake of the interventions rose significantly – although there were some challenges dealing with frequent stock-outs of PMTCT drugs being supplied by the Ugandan Ministry of Health. In addition, they noted that many women were not attending the post-natal clinics.

One approach to providing some of these services is through delivery of a basic package care and prevention package (BCP) for people living with HIV.

The basic care package includes:

- Two long-lasting treated mosquito bed nets (ITBN), a safe water system (WaterGuard solution)
- Condoms and information education and communication materials on how to prevent opportunistic infections (OIs) and HIV transmission.
- Cotrimoxazole (CTX) (not included in the kit, but was distributed separately to the same population by the National AIDS Programme).

In addition to the basic care package, trained health providers and peer educators provided multiple channels of communication on the prevention of opportunistic infections, family planning, palliative care, TB/HIV and nutrition during routine HIV primary care visits, to people living with HIV.

#### **Stigma limits access to alternative sources of some services for PLHIV**

Other types of services, like sexual health and reproductive services, are best integrated into sites where people get their HIV care, because PLHIV are often denied these services at other sites where healthcare providers have not been sensitised to the fact that PLHIV have a right to sexual and reproductive health.

### **Does integration or decentralisation of services always work out for the best?**

No. Some studies suggested that while decentralisation may increase the reach of the programme, the efficiency may not increase or the quality of care can suffer. One problem is that there is much less infrastructure and diagnostic equipment which can mean delayed diagnosis for those attending remote primary care clinics. For instance, in one very large study of 663 health facilities managing over 900,000 HIV-positive patients across nine countries in sub-Saharan Africa – those who attended large tertiary hospitals had better access to the more advanced TB diagnostics.

Since it doesn't always achieve the desired effects, it is very important that clinic teams and programmes know how integration of service delivery is working for them. This means research and maintaining good records at the health facility.

#### **Sometimes there isn't good enough data to be able to know for certain.**

Because of poor data reporting it is often difficult to gauge the success of a programme. For example, there was one report at the IAS meeting about an effort to introduce intensified TB case finding into ART clinics in Lusaka, Zambia. To facilitate the service delivery, a worksheet was produced to improve the quality and consistency of symptom screening (and link it to the diagnostic work-up). They

provided nurses and clinical officers with intensive training and mentorship on TB/HIV management over three to four years.

Documentation in the patients' files suggested that staff were asking the patients about symptoms of TB. But the healthcare workers had refused to fill out the TB screening worksheet because it was seen as extra work. Yet without filling out the forms, there was no way of telling whether patients who screened positive had been sent for diagnostic work-up, and what their outcomes were.

***Take home message: when a programme integrates any new services it must make certain that the data are being recorded.***

When new services are introduced into a facility and programme, it is critically important to fill out the associated registers – otherwise, it can be very difficult to establish how implementation is going, whether the services are being performed consistently, and whether they are cost-effective. When staff do not record the data, they may just wind up dooming themselves to keep providing an unwanted or non-effective service, repeating actions that are a waste of time or worse, a distraction from more useful services that they could be providing. Having an answer to these questions is in the best interest of patients and of the people providing these services! Without reliable data, it will also be impossible for clinic teams to engage in quality improvement exercises.

In other cases, the data are contradictory, either because it takes time at first for provision of a new service to reach its stride, or there is a right way or wrong way to provide a new service or decentralise. Case in point: findings are mixed on NiMART itself, and the decentralisation of HIV care to the primary health centre.

Virtually everyone agrees with giving nurses at the primary healthcare level the primary duty of starting and managing ART in people living with HIV.

But some people think the shift over to NiMART and decentralisation should be faster, while others advise more caution, warning that gaps and problems emerge when the transition to poorly supported nurses at poorly equipped primary health centres happens too quickly.

There were studies presented in support of each camp.

In Malawi, there are very few doctors, so ART services are delivered by clinical officers, who manage the most complicated patients, and nurses who manage the rest. An observational cohort study by MSF in Malawi found much worse outcomes among the patients managed by clinical officers, than those cared for by the nurses. But since the clinical officers took care of patients who were more ill, what is most important is that the nurses did a good job managing PLHIV.

***A strong partnership with trained patient networks improves linkages and keeps people in care***

In South Africa, the STRETCH study found a nurse-led ART service was just as effective as a doctor-led service, and even seemed to provide better quality of care in some regards. But contrary to expectations, nurse-managed care did not seem to increase access to ART. But in this study, NiMART hadn't been fully introduced to all centres in the study and nurse confidence in prescribing ART should

improve significantly with more experience. Performance may get better with time.

But there might be factors affecting access and retention other than whether a nurse or a doctor is initiating ART. In Mozambique, integrating HIV services into primary healthcare centres run by clinical officers dramatically expanded coverage compared to when ART was only available from doctor-based ART sites. But patients attending the primary healthcare sites were also much more likely to drop out of care. When the researchers asked why, the patients told them that the ART sites had dedicated pharmacies for them, but the pharmacies at the integrated clinics were of poorer quality, and importantly, offered the PLHIV no privacy. In another study in South Africa, patients refused to be down-referred to their local primary healthcare clinic because they felt that it was under-resourced and wouldn't provide the various support services available at the larger health facilities that they were used to attending.

Ongoing discussions to re-engineer primary health care must address these problems convincingly. New point-of-care lab tests may enable nurses to address some of the patient's concerns, if they are rolled out to the primary health clinic.

Other primary health clinics take the specimens onsite and send out for timely diagnosis. One study described the successful implementation of integrated TB and HIV services decentralised to a very busy primary healthcare clinic in Johannesburg. Even though the clinic has support from a doctor on three days a week, it sees more than 8500 patients per month, with 4200 people currently on ART being managed there. In addition to general HIV services, the clinic provides TB screening and treatment, pre- and post-natal care, general/chronic care, paediatric care, social services and a pharmacy. Blood for CD4 cell testing is drawn at the clinic, and sent off-site. Likewise, TB diagnostic services, such as chest X-ray, microscopy, and culture have to be performed off site.

Despite being a busy place, the clinic achieved a very high uptake of HIV testing among people diagnosed with TB attending

the clinic for treatment, and patients also eligible for ART started treatment promptly.

The clinic has community-based tracking procedures in place to make certain that TB patients get their diagnosis in a timely fashion, so that they can start treatment as quickly as possible. Another study, on an integrated one-stop shop TB/HIV clinic in Uganda, explained how an active tracing system was established and employed whenever patients missed appointments. It worked extremely well.

In fact, what seemed to often determine the success of integrating services or decentralisation to the primary health clinic, was the community, particularly the engagement of people living with HIV in the service. A strong partnership with trained patient networks improves linkage and keeps people in care. Several studies reported how the training and employing expert patients dramatically improve outcomes. In the study from Northern Uganda, the researcher concluded that having community-based peer supporters who would help follow up and provided community sensitisation of women for the antenatal services was critical.

This idea is not new. The most common model for community engagement is based on the work of Partners In Health with accompagnateurs, community members and expert patients who accompanied referrals and supported patient in Haiti and Rwanda.

Partners Health has developed [an accompagnateur training guide](#) in several languages for programmes and clinic teams who would like to train and employ their own expert patients.

## about HATiP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

For further information please visit the HATIP section of [aidsmap.com](http://aidsmap.com)