Intensive Follow-up Approach to People with Advanced HIV Disease in Lesotho

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HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

Implementation and Evaluation of AHD in Lesotho: Project Description

- Program evaluation of health service delivery strengthening for people living with HIV (PLHIV) with advanced HIV disease (AHD) who receive a package of care per the Lesotho ART guidelines
- U.S. Centers for Disease Control funded project, conducted by the Ministry of Health (MOH)
  - Implementing Partner: The Elizabeth Glaser Pediatric AIDS Foundation
- Conducted in Motebang Hospital in Leribe district and Berea Government Hospital in Berea district
- Participant recruitment: November 2018 to March 2019; follow-up ended December 2019
- Included many project objectives, such as an evaluation of intensified follow-up:
  - Proportion of participants intensively followed up through weekly phone calls for the first four weeks after enrollment (goal ≥ 90%)
  - Proportion tracked after missed visits (goal ≥ 90%)

Project Schedule of Evaluation Clinic Visits and Activities

Intensified follow-up components shown in yellow:

- Weekly patient phone calls for the first four weeks
- Two additional follow-up visits: eight weeks, 18 weeks

Time Point		Clinician Visit	ART Counselling Session	Adherence Assessment	Lab investigation
Weekly patient phone calls first **4 weeks**	Day of enrollment	X	X		CD4[#], ALT, Cr[†], HBsAg, FBC[Σ], Urine dipstick[∞], Sputum evaluation by Xpert[**], CrAg[^]
	2 weeks after enrollment/ ART initiation	X	X	X	ALT[±]
	4 weeks after enrollment/ ART initiation	X	X	X	Hb*
	8 weeks after enrollment/ ART initiation (*Additional visit added as intensive follow-up)*	X	As indicated	X	
	12 weeks after enrollment/ ART initiation	X	As indicated	X	ALT[±]
	18 weeks after enrollment/ ART initiation (*Additional visit added as intensive follow-up)*	X	As indicated	X	
	24 weeks after enrollment/ ART initiation	X	As indicated	X	VL[$], Urine dipstick[∞], ALT[±], Hb*

Intensive Follow-up, Tracking Job Aid for Patients with Missed Appointment

Patient needs advanced disease package of care

- Participant's file flagged so that they are easily identifiable as patient with AHD
- Participant's upcoming clinic appointments are recorded in the clinic appointment book system showing client has AHD

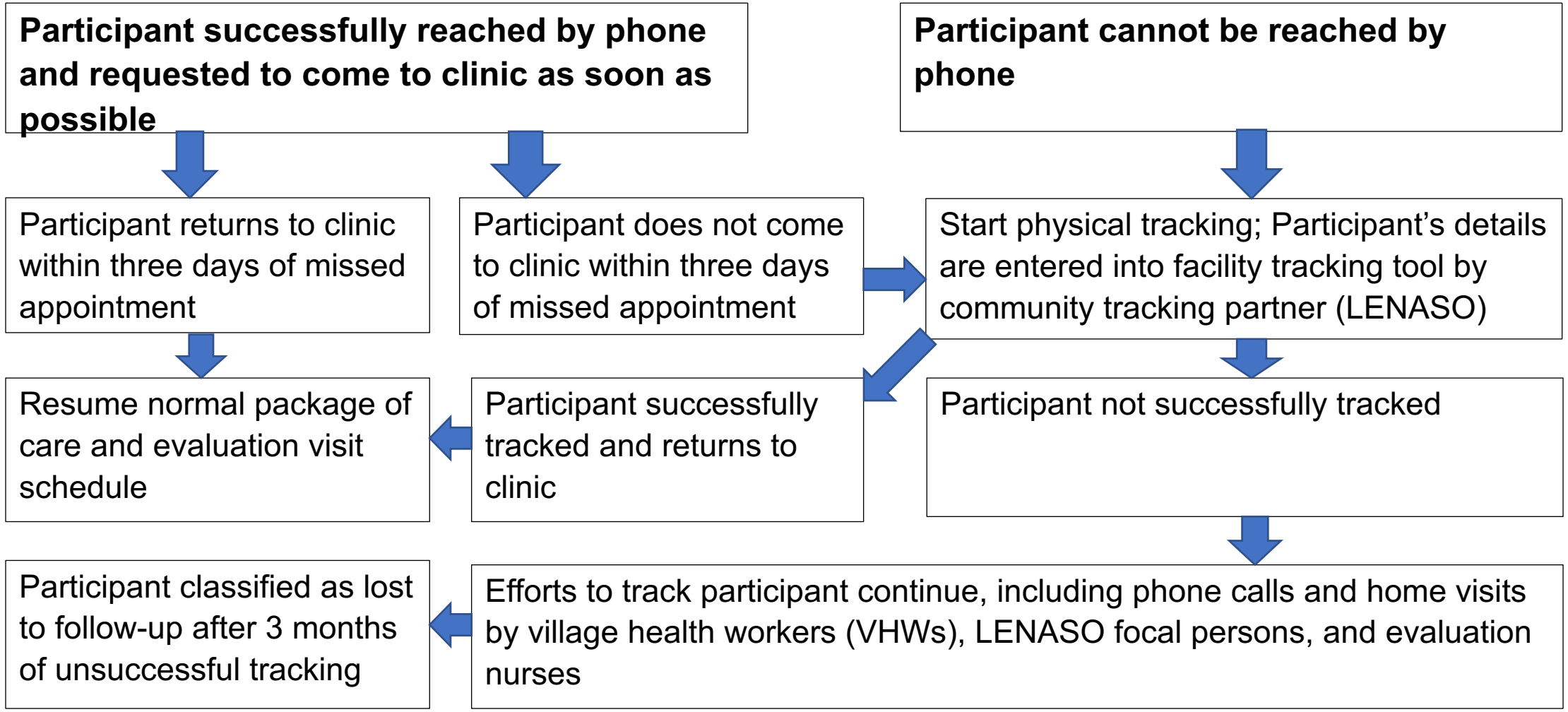
Appointment book is reviewed at the end of every clinic day and participants who have missed their clinic appointment are flagged for follow-up

Facility staff verifies that participant has consented to active tracking. Then, facility staff call participant the day after their missed clinic appointment to assess reason for not attending their scheduled visit

Participant is successfully reached by phone and requested to come to clinic as soon as possible

Participant cannot be reached by phone

Intensive Follow-up, Tracking Job Aid for Patients with Missed Appointment (continued)



Follow-up Information for Enrolled Participants

Follow-up Visit Type	Period after enrolment	# Expected at facility visit	# Seen at facility (%)	Died before follow-up visit	# Missed Visits
#1	2 Weeks	107	92 (86%)	2	15
#2	4 Weeks	104	89 (86%)	3	13
#3-Additional	8 Weeks	101	85 (84%)	3	13
#4	12 Weeks	100	69 (69%)	1	30
#5-Additional	18 Weeks	99	62 (63%)	1	36
#6	24 Weeks	98	68 (69%)	1	29

Overall, the intensified follow-up with extra visits at eight and 18 weeks were well-attended. **Attendance was 84% at the 8-week visit and 69% at the 18-week visit.**

Summary of Weekly Phone Calls Made in First Four Weeks of Follow-up

Call	Week-1	Week-2	Week-3	Week-4
Patient Called	**90 (83%)**	**82 (75%)**	**82 (75%)**	**82 (75%)**
Call outcome:				
Available	79	77	75	77
Not available	11	5	7	4
Patient Not Called	**19 (17%)**	**27 (25%)**	**27 (25%)**	**27 (25%)**
Reason?				
Has no Phone	4	4	4	4
Came to clinic on day of call	4	9	9	8
Admitted to hospital	5	5	2	2
Transferred out	0	0	0	2
Dead	2	2	4	5
Call not placed	4	7	8	6

Overall, intensified follow-up with phone calls was carried out in at least 75% of patients. Phone call follow-up was considered unnecessary for patients who came to the clinic on the day of the scheduled call or were in hospital or had earlier died.

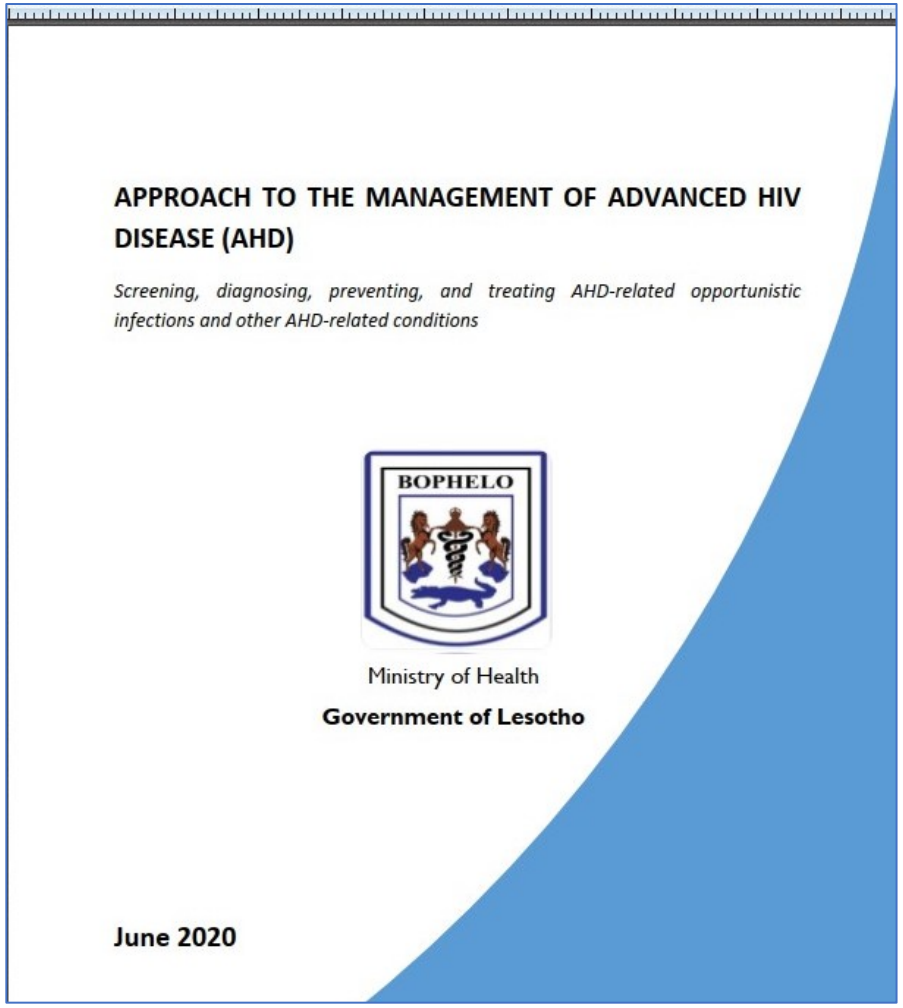
Challenges During Follow-up

- Follow-up appointments not given according to protocol
  - Some patients given three months ART (MMD)
- Patients did not follow scheduled appointments, returned to clinic at other times – but overall attendance was good
- Phone numbers incorrect or unavailable – a general problem not unique to patients with AHD
- Calls answered by relatives, patients away for work
- A few patients had no phones and could not be tracked
- Clinicians sometimes unavailable or forgot to call patients

National Scalability of AHD Model

- The Lesotho Ministry of Health has developed a manual for management of advanced HIV disease

- The manual includes guidance on intensified follow-up for people living with AHD



National Approach for Intensive Follow-up of Patients with AHD

- Patients with signs of AHD should be prioritized for admission
- When necessary and feasible, appropriate referrals should be made with clear documentation and provision of adequate patient information to facilities or departments receiving the patient
- Clinic follow-up schedule to involve at least five visits in the first six months
  - Week-2, week-4, **week-8**, week-12 and week-24 to assess OIs, ART adherence, and toxicity.
- Weekly patient phone calls for the first four weeks is an additional intervention that clinicians can consider using
- Assessment at six months to determine whether patient is stable enough for differentiated ART refill models with reduced visits that suit their lifestyles

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  - Baylor College of Medicine Children's Foundation Lesotho
  - Lesotho Network of People Living with HIV/AIDS (LENEPWHA)
- Motebang and Berea Hospital Staff
- Project Participants