STAR-EC Technical Brief

# IMPROVING REFERRAL SYSTEMS TO INCREASE ACCESS TO HIV TREATMENT, CARE, AND SUPPORT SERVICES

in East Central Uganda

## Background

To ensure an effective continuum of response to HIV and AIDS, strong links must exist between health service providers and communities to increase the ease and consistency with which people access prevention, care, and treatment services. Networked health service providers at the community and facility levels are able to collaborate more effectively and consistently provide care and treatment to individuals and families. In 2009, East Central Uganda's government health system was compromised by poor service linkage between communities and health facilities. This was especially problematic, given the region's high HIV prevalence rate of 6.5 percent; people living with HIV (PLHIV) require chronic care and treatment in order to stay healthy and reduce their risk of transmitting the virus to others.

The Uganda Health Sector Strategic Plan III (2010/11-2014/15) called for strengthening community structures so that health care providers could offer services through a networked health care delivery model which would improve access, efficiency and sustainability. In Uganda, community structures include village health teams (VHTs), networks of PLHIV, faith-based organizations (FBOs), civil society organizations (CSOs), and small businesses. Each of these structures independently offers unique value in connecting people to health services. However, an well-functioning network between them requires effort to coordinate the component parts.

In 2009, at the outset stages of STAR-EC implementation, there were many challenges to creating an interlinked health service delivery model in the East Central Region of Uganda: health workers did not routinely record and share patient information; confidentiality guidelines (what information could be shared, how, and with whom) were not well understood or routinely practiced by health workers; service delivery planning was not coordinated between communities and facilities; and record keeping varied from facility to facility, making it difficult for lay volunteers, such as VHTs, to help connect clients to the most appropriate care.

Patients were dissatisfied with the quality of care they received, which contributed to low service uptake in the region. STAR-EC studies revealed poor attitudes towards health services among community members, low community involvement in health care services, and poor health-seeking behaviors across the region's nine districts.[1] A low proportion of women (47 percent) had attended at least four antenatal visits in region, 50 percent of adults (15 years and above) had ever taken an HIV test, 37 percent of men (15-54 years) had ever been circumcised, and roughly 60 percent of patients initiated on ART were retained in treatment for 12 months. These statistics were indicative of the system's limited ability to effectively engage and follow up with patients at the community level.

[1]Data from the case study "Developing an Effective Referral System" (2013) conducted by JSI's partner on STAR-EC, Bantwana, and STAR-EC's baseline Lot Quality Assurance Sampling (LQAS) Survey (2009).

# Interventions

STAR-EC implemented patient-focused models of care, linking patients to facilities that offered a range of high-quality services, improving efficiency, and reducing out-of-pocket expenses. This approach was coupled with a service delivery model that also improved access to "wrap-around" (e.g., psychosocial, legal, income, and other support) services, resulting in an increase in service utilization. To strengthen referral networks between community structures and health facilities, STAR-EC undertook various strategies to increase the capacity for communication and knowledge sharing between community members and health practitioners at every level of the health system. The program worked to improve data collection and quality at all service delivery points to empower communities and facilities to better plan and coordinate activities.

## Relationship building and collaboration

STAR-EC worked to foster a healthy dialogue between community members and community health workers (CHWs). The project conducted routine referral coordination meetings at different levels of the health system, including at health facilities, health sub-district offices, and district offices to discuss referral experiences and strategize improvements to referral processes. Involving stakeholders from every level of the system ensured that different actors understood each other's roles and levels of collaboration.

The project also trained health workers at facilities to conduct routine supportive supervision to VHTs, PLHIV, and CSOs during community-based service provision to ensure that patient information was recorded correctly, that appropriate referrals were made to facility-based care, and that clients were being followed up with in their communities. Under the guidance of STAR-EC, community groups comprised of community members and VHTs identified by key health facility personnel were strengthened to serve as points of contact for community health workers (CHWs) that move between community structures and facilities to link clients to essential services.

## Driving demand and increasing access through the outreach service delivery model

STAR-EC helped develop an outreach service delivery model that encouraged the mobilization of community members to seek health services at nearby facilities. CHWs provided health services at the community level at regularly-conducted outreach clinics, which included HIV testing and counseling (HTC), voluntary medical male circumcision (VMMC), family planning (FP), and antiretroviral therapy (ART). These outreach clinics were conducted in tents set up in community gathering places, or adjacent to health centers III on weekends and public holidays to reach people with services at times and locations convenient to them. Community structures, including VHTs and CSOs, complemented these efforts by providing promotion for the outreach clinics, prevention messaging (via interpersonal communication and events), referrals, and follow-up. STAR-EC also selected PLHIV actively enrolled in ART to become 'expert clients,' offering advice to newly diagnosed patients based on their own experiences navigating the health system, and linking patients to various care and support services.

An expert client accompanies a woman newly diagnosed with HIV at her first consultation at a health facility.

## Using data to strengthen systems

The project also trained and provided continuous supportive supervision to VHTs and CHWs to improve their collection and use of health data. VHTs and CHWs capacity was strengthened to integrate and harmonize community health data into the national health management information system (HMIS) used at the facility and district levels. STAR-EC also worked with facility- and district-level personnel to manage and use community-level data to inform resource allocation and activity planning. District and facility personnel were also supported in logistics management, helping to ensure that enough commodities related to integrated TB and HIV services were available at the right time at each service delivery point. This data allowed facilities to better anticipate the need for HIV and TB services and commodities, thereby helping to ensure that referred patients received the required services and medicines they needed. Data collected at the community level also empowered health workers at the district and facility level to identify and follow up with patients who were referred to but never received services.

# Results

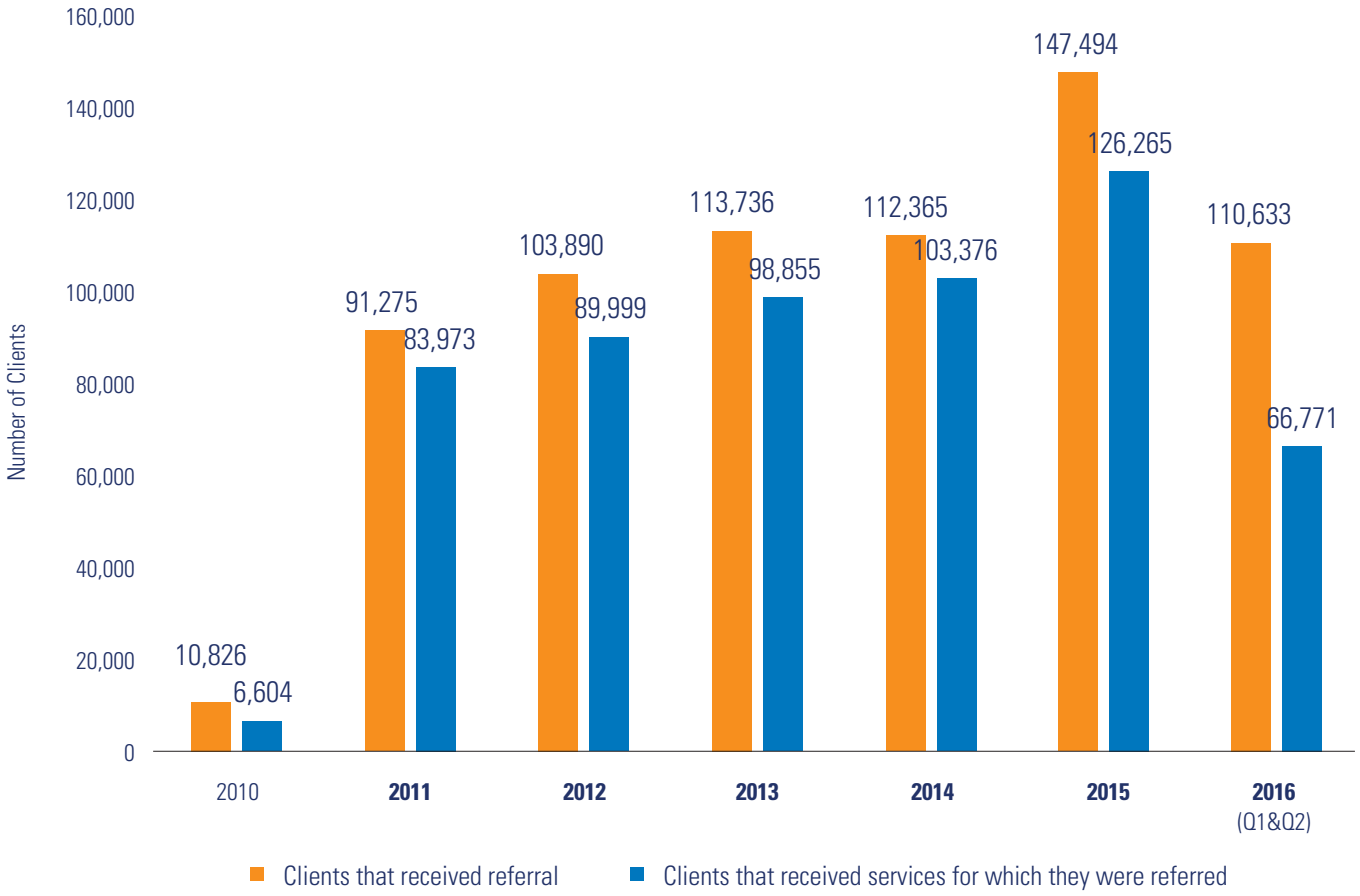
The number of clients accessing a range of services grew progressively over the course of project implementation. HTC was the entry point for most clients to access other services, including voluntary medical male circumcision (VMMC), TB screening and treatment, family planning, antenatal care (ANC), prevention of mother-to-child transmission (PMTCT) or HIV, treatment for other medical illnesses, and other wrap-around services. As shown in Figure 1, both the number of clients who were referred to services and the proportion of those clients who received services increased between 2009 and 2016. The proportion of those who received services for which they were referred increased from 61 percent (2009) to 86 percent (2015).

# Conclusion

STAR-EC's efforts to improve referral and network systems in the region have increased access to and utilization of comprehensive services in the East Central Region of Uganda. These efforts have improved the lives of many individuals and families affected by HIV. At the district level, increased coordination and communication between health facilities, CSOs, and volunteers encouraged knowledge sharing and improved the ability of personnel at all levels to link patients to appropriate care. Increased capacity at the facility level to use data to anticipate patient needs and follow up with referred clients helped improve the percentage of patients retained in treatment. VHTs and expert clients were critical to increasing awareness of treatment and care services at the community level and linking patients to services at facilities. Through sustained effort to strengthen the referral and linkage system in the East Central Region, those living with and affected by HIV will have access to a range of treatment and support services that help them lead healthy and productive lives.

A health worker records the health information of a mother and her baby during an outreach clinic in Namayingo District.

**Figure 1:** Proportion of clients who received services for which they were referred

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