Table 3: Factors influencing retention in care

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| **Policy Indicator** | **WHO** | **Malawi policy** | **Practice: (i) Karonga HDSS facilities implementation, N=5, and (ii) insights from KIs** |
| **Service coverage and access factors** |
| ART clinic does not have to include doctor or clinical officer |  | Minimum staff requirement includes 1 clinician (2006)([Ministry of Health Malawi, 2006a](#_ENREF_11)) | **PARTIAL:** All 5 sites had at least one clinical officer or medical assistant |
| **Quality of care factors** |
| Periodic refresher training for ART staff required | 2010 | 1-day ART classroom refresher training course to be taken once a year, followed by 1-day knowledge dissemination & best practice. To be organized at regional/zonal level (2006)([Ministry of Health Malawi, 2006b](#_ENREF_12))  | **NOT IMPLEMENTED:** Out of a total of 43 staff, 15 had received formal medical/nursing training in HIV care and treatment in the past 2 years.  |
| Periodic quality control checks at ART clinics required | 2010 | Team of experienced clinicians to go to every ART site every quarter, as supervision. They create a list of action points to be followed up. The form has a trigger to call a mentoring team, in case of problems. A certificate of excellence – motivation system – is awarded to “good” sites. \*  | **COMPLIES:** 4 out of 4 facilities said quality of care reviews / audits of HIV treatment services were conducted every 3 months. However, the nature of “quality of care review” is not known, nor whether it is as comprehensive as policy demands. |
| **Coordination of care and patient tracking factors** |
| Routine 6 monthly CD4 count monitoring on ART | Not a requisite | Routine scheduled CD4 monitoring of patients on ART is not supported by the national program (2011), to prioritize pre-ART follow up([Ministry of Health Malawi, 2011](#_ENREF_17)). Previously, it was recommended if capacity was there. But this led to limited capacity being used by a handful of sites with no tangible impact.  | **PARTIAL:** Two facilities conduct no CD4 tests once stabilized on ART. Two facilities report conducting them every 6 months. One facility does not do CD4 test routinely, but “done if requested”. |
| 3 monthly drug supplies once stable on ART |  | Patients initiating 1st line ART reviewed after 2 weeks, then every month for first 6 months. Thereafter, stable and adherent patients can be given up to 3 months. In exceptional cases, up to 12 months of ARVs can be dispensed. Patients starting 2nd line ART must be seen every 4 weeks for first 6 months, thereafter, up to 2-month appointments. (2011)([Ministry of Health Malawi, 2011](#_ENREF_17)) | **PARTIAL:** All 5 facilities said patients must return for refills every 2 months max, once they stabilize on ART |
| Pill counts at every visit |  | The emphasis was previously on the pill count([Ministry of Health Malawi, 2003](#_ENREF_10)). Now, the focus is on a formal active dialogue (including an assessment and counseling). Ask “Have you had any problems taking your ARVs? Were there any days when you did not manage to take all your tablets at the right time?” Check “Next appointment date” on patient card to confirm patient is not late.([Ministry of Health Malawi, 2011](#_ENREF_17)) | **NOT IMPLEMENTED:** All facilities check and count patients’ pillbox. Only two facilities also ask patients about pill-taking. |
| Home visits following signs of poor adherence |  | No policy regarding home-visits. However, conduct follow-up group counseling and individual counseling if any sign of poor adherence. Give practical advice: a) build ARVs into daily routine, b) ask family or friends for reminders, c) set a daily alarm on cell phones d) keep a “drug diary” and mark every tablet taken.([Ministry of Health Malawi, 2011](#_ENREF_17)) | **COMPLIES:** For patients who present with low drug adherence, 1 facility insists on participation in support groups, and all 5 facilities provide psycho-social counseling. |
| Home visit or telephone contact for missed visits | 2013 | Patients late for ART appointment to be actively followed from the clinic (home visit, phone, guardian). Patients asked for consent for active follow-up at time of initiating ART (can withdraw consent any time). Prioritize patients on ART & HCC patients eligible to start ART. (2011)([Ministry of Health Malawi, 2011](#_ENREF_17)) | **PARTIAL:** For patients that default, one facility does nothing, 3 facilities try to reach the patient by phone and 4 report to do home visits. For patients that are lost to follow up, 2 facilities do nothing, 2 facilities visit at home (1 missing).  |
| **Medical management factors** |
| IPT for all HIV+ patients without active TB | 2010 | Give IPT to all HIV infected who are not on ART, regardless of clinical stage/CD4 count, who don’t have active TB. Start at enrolment for pre-ART follow-up and continue for as long as patient is in pre-ART follow-up. Stop IPT when ART is started (2011)([Ministry of Health Malawi, 2011](#_ENREF_17)). | **COMPLIES:** All facilities offered IPT in pre-ART phase, and all currently had IPT in stock. |
| TB screening at every pre-ART & ART visit | 2010 | Yes. Screen all patients at every visit (pre-ART and ART) for signs of active TB using 4 standard questions (cough, fever, night sweats, weight loss/failure to thrive). If 1+ signs, thoroughly investigate further (2011)([Ministry of Health Malawi, 2011](#_ENREF_17)) | **PARTIAL:** 3 out of 5 facilities screen for TB for all patients *initiating* ART. For those that don’t they would screen based on clinical symptoms of TB. Patients *on* ART are screened for TB in 4 out of 5 facilities. |
| WHO 1st line ART (2010) as standard | 2010 | D4T/3TC/NVP([Ministry of Health Malawi, 2011](#_ENREF_17)). But plans to switch. | **EXCEEDS:** All facilities providing TDF+3TC+EFV  |
| At least four 1st line regimens choices in national programs | 2006 | There are 6 different 1st line regimens. 3 are used for initiating ART. All are fixed-dose combinations (only 1 type of tablet). Move patients with significant side-effects to an alternative 1st line regimen. (2011)([Ministry of Health Malawi, 2011](#_ENREF_17)) | **PARTIAL:** Variable.Number of different regimens in 4 of the facilities: 2, 2, 4, 6. Missing data for 5th.  |
| **Support to PLHIV factors** |
| At least one adherence counseling conducted individually |  | All patients must receive individual counseling at ART initiation. In addition, patients should attend an ART group counseling session between 1-5 days before the day of ART initiation, or on same day as ART initiation. Patients must attend group counseling with named guardian (or treatment supporter). (2011)([Ministry of Health Malawi, 2011](#_ENREF_17)). | **COMPLIES:** 4/5 fully adhere to Malawi policy. One facility just does individual counseling only. |
| All patients on ART referred to peer support groups |  | No MoH policy. It has not been proactive in pushing this. Left to the site, and their HSAs. | **EXCEEDS:** No question asked about referrals, but 3 facilities said there were support-groups for PLWH in the community: 1 at another facility, 1 ran the support-group at the facility itself  |
| Nutritional supplements for malnourished patients | 2006 | None. There used to be an HIV unit attempt at providing adult food interventions (plumpy-nut), but it was found to be expensive and it didn’t show a measureable impact. It was decided to treat the underlying condition (HIV) and this should address the malnutrition. So adult food supplementation was taken out of clinical guidelines. \* | **UNCLEAR:** 3 facilities provide food-packages/nutritional support to patients. 2 facilities say that food-packages/nutritional support is available at another facility. But these were child nutrition programs.  |
| All patients on ART referred to home based care |  | Very little on home-based care, and not handled by HIV department. If anything, it is self-organized by individual sites, or NGOs. \* | **EXCEEDS:** All 5 facilities claim home-based care is provided either by them (2), another facility in the area (2), or at the community level (1) |

\*Source: Key informant interview