Service delivery models; areas of innovation

Roger Teck, MD - MPH
Medecins Sans Frontieres
MSF currently provides HIV treatment to 220,000 people in 23 countries.
Priorities for MSF in support to HIV care and treatment

• Supporting **access to ART** in low-coverage countries and responding to **care and treatment gaps** in high-coverage countries

• Pilot **early treatment initiation** (Treatment as Prevention)

• Promote **community approaches and self-management** to enhance long term treatment retention and effectiveness.
Delivery models

What works?

• Integration

• Simplification

• Task-shifting

• Involvement of lay people

• Decentralization
TASK SHIFTING

Professional counsellors/Lay counsellors/ Expert Patients

Nurses

Counselling; Testing, pre ART, ART preparation and adherence

Testing → Pre ART → ART INITIATION → ART FOLLOW up

Clinical assessment

Doctors

Nurse/Counsellor Community
Delivery models:
Current areas of innovation

• Community based HIV testing

• **Linkage and retention** (referral, sampling techniques & transportation, POC, mhealth,..)

• VL treatment monitoring

• Community based models for treatment support and self management
VL monitoring

- **Motivation tool** ("get and stay undetectable")

- Early detection of **adherence problems** triggering target adherence support

- Early detection of **treatment failure**

- **Program monitoring**: community viral load, treatment response.
Community based models: Treatment support and self-management
Community Based Models of Care

- CAGS
- Adherence Clubs
- PODI
- Fast track once a year appt
Why community based models?

Patient perspective

- Difficult to continue ART while carrying on with the activities of life
- Fatigue with ART collection system
Why community-based models

Health system perspective

- Number of ART patients growing..........
- Limited staff to manage...
- Need capacity to initiate new & manage pts unstable and/or at risk of failing treatment
Not one size fits all....
Different contexts and different people

• Health posts run by community health workers Thyolo/Malawi

• Reducing appointment frequency with support to patient self-management: Chiradzulu/Malawi

• Community ART groups: Tete/Mozambique, Thyolo/Malawi, Zimbabwe

• Community adherence clubs: Khayelitsha/SA, Maputo,...

• Patient managed ART distribution: Kinshasa/DRC
Common Elements

• Focus on stable patients

• ART delivery

• Health checks and referral based on self-management & peer support
<table>
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<th>Criteria</th>
<th>Malawi, Thyolo</th>
<th>Malawi, Chiradzulu</th>
<th>Mozambique</th>
<th>South Africa</th>
<th>Democratic Republic of the Congo</th>
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<td>Voluntary participation</td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
<td>Strongly recommended for those meeting referral criteria</td>
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<td>Adults only</td>
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<td>Duration on ART</td>
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<td>Eligibility according to CD4</td>
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<td>Eligibility according to adherence check</td>
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<td>No</td>
<td>No</td>
<td>Yes (no missed previous visits)</td>
<td>No (active opportunistic infections)</td>
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<td>Location</td>
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<td>Adherence checks</td>
<td>Frequency of ART dispensing</td>
<td>Frequency of clinic visits</td>
<td>Referral mechanism</td>
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<td>Mozambique, Tete</td>
<td>6 monthly in Health Facility Monthly in CAG</td>
<td>6 monthly in health facility Monthly in CAG</td>
<td>1 monthly</td>
<td>6 monthly</td>
<td>Self referral/referral by CAG from community to health facility</td>
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Community ART groups: Distribution of antiretroviral therapy through self-forming groups, in Tete Province, Mozambique

Tom Decroo1, Barbara Telfer1, Jacob Maïkéré1, Sergio Dezembro1, Carla das Dores Pereira Mosse2, Nathan Ford3 and Marc Biot1

1 Médecins sans Frontières, Mozambique.
2 Provincial Health Department, Tete, Mozambique
3 South African Medical Unit, Médecins Sans Frontières, Johannesburg, South Africa
Monthly, each CASG indicates 1 member to go to the HF for a routine clinic visit and to collect refill for the other 5 members.

Whenever sick, any member can go to the HF for an unplanned consultation.

Next month the CASG meet and indicate another member to go to the HF.

Rotation wise, all members will go to the HF for routine clinic visit and collection of refill for the group.

Member 1 returns to the community to distribute ARV to the other 5 CASG members.
March on 1 May
Adherence clubs

Counselor / peer educator run
Nurse supported

Every 2 months:

✓ Quick clinical assessment
✓ Collection of 2 month ART supply
✓ Quick optimized group support

Once a year:

✓ Blood taken for CD4 and viral load
✓ Clinical consultation with clinician
Key challenges

- Balancing **options** according to context
- Defining **inclusion criteria**
- Monitoring & evaluation - Supervision
- **Drug supply**
- Community participation
- **Specific groups:** pregnant women, children and adolescents
- Patient choice
Acknowledgement

- Teams and patients groups of Thyolo, Chiradzulu, Tete, Khayelitsha & Kinshasa.
- MSF AIDS Working Group
- Southern Africa Medical Unit, Cape Town
- Analysis and Advocacy Unit, Brussels.

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