Service delivery models; areas of innovation

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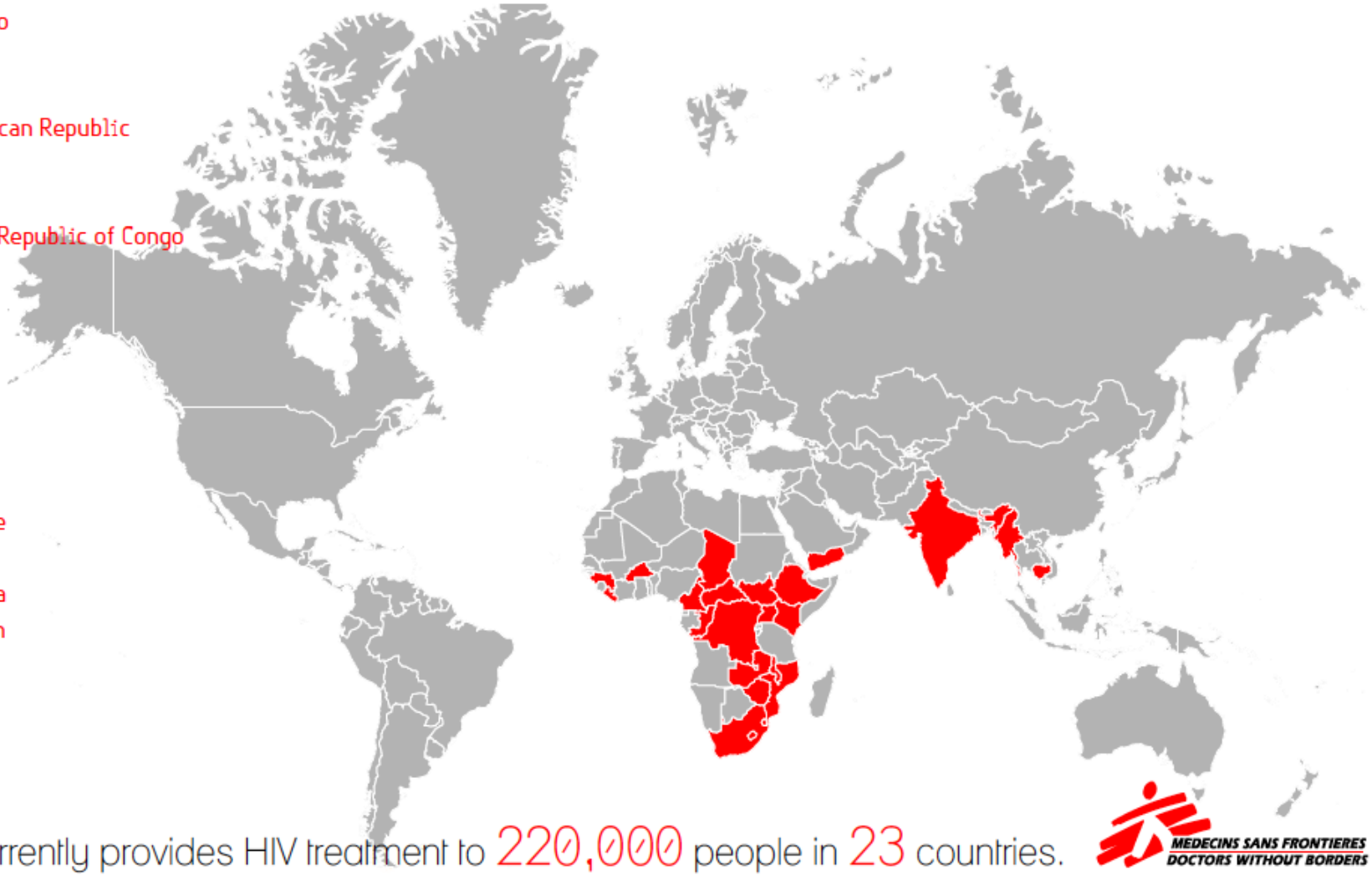
MSF HIV / AIDS TREATMENT PROGRAMMES

Burkina Faso
Cambodia
Cameroon
Central African Republic
Chad
Congo
Democratic Republic of Congo
Ethiopia
Guinea
India
Kenya
Lesotho
Liberia
Malawi
Mozambique
Myanmar
South Africa
South Sudan
Swaziland
Uganda
Yemen
Zambia
Zimbabwe



MSF currently provides HIV treatment to 220,000 people in 23 countries.

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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)

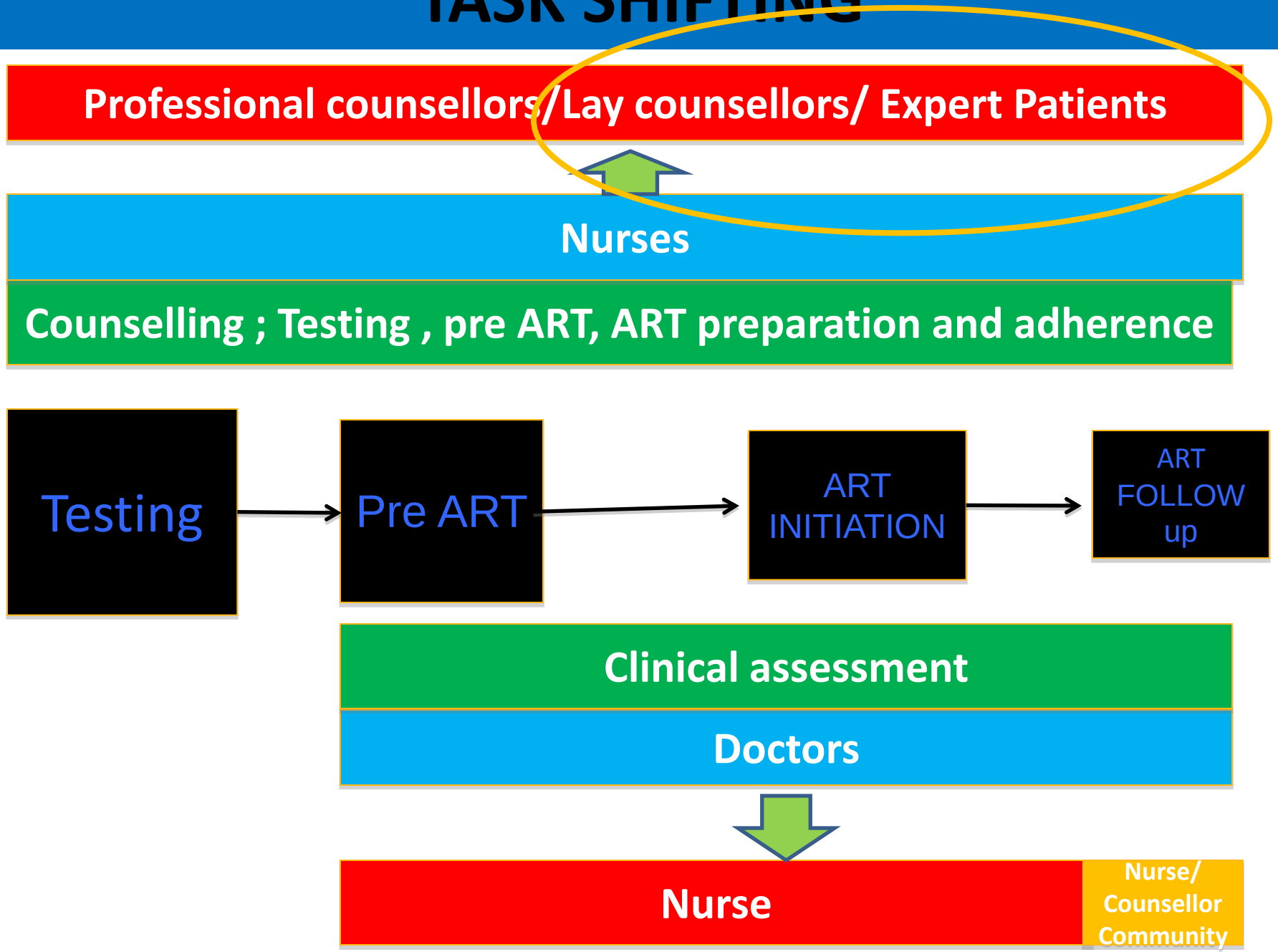
- Promote **community approaches and self-management** to enhance long term treatment retention and effectiveness.

Delivery models

What works ?

- **Integration**
- **Simplification**
- **Task-shifting**
- **Involvement of lay people**
- **Decentralization**

TASK SHIFTING

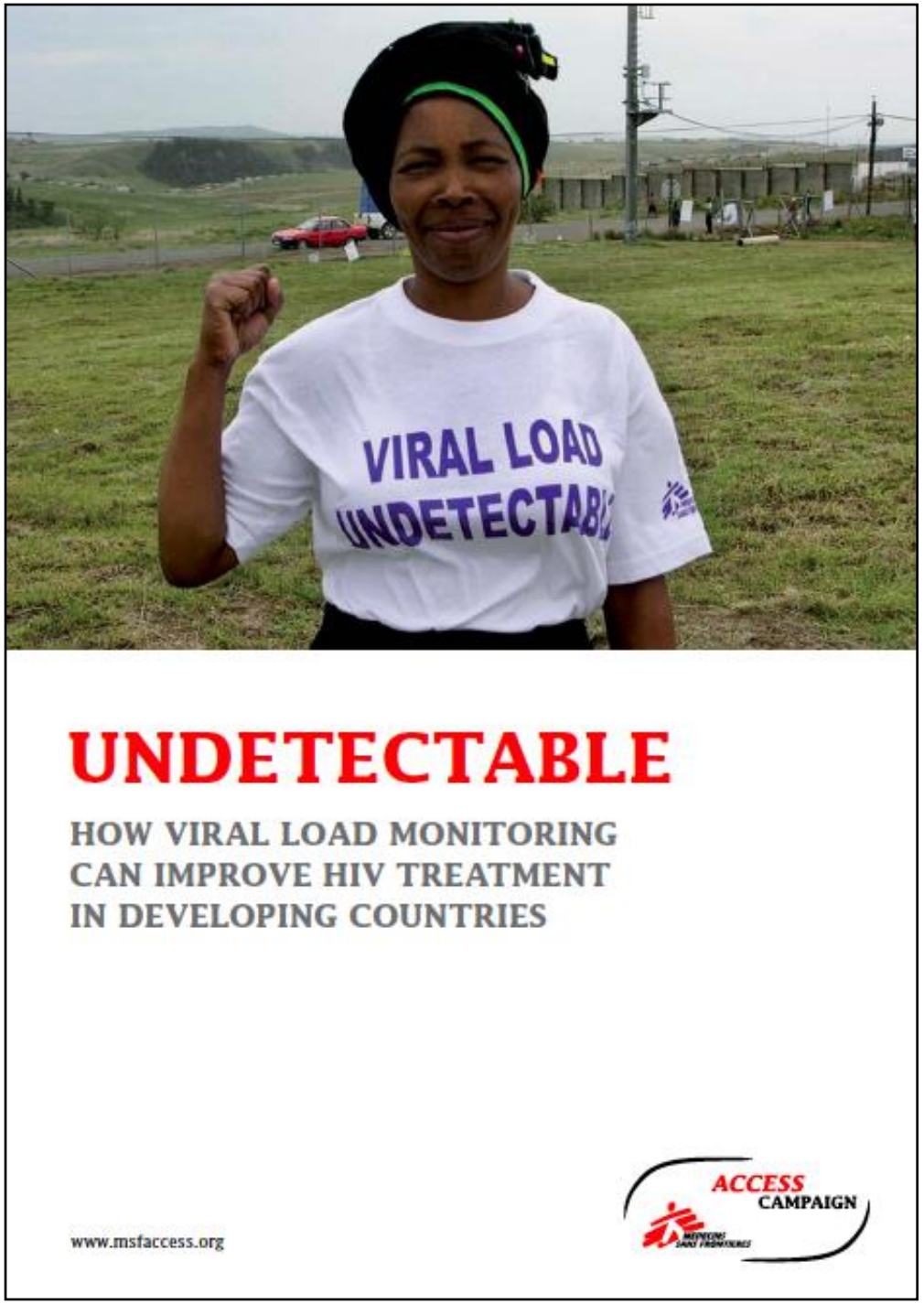


Delivery models:
Current areas of innovation

- **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.



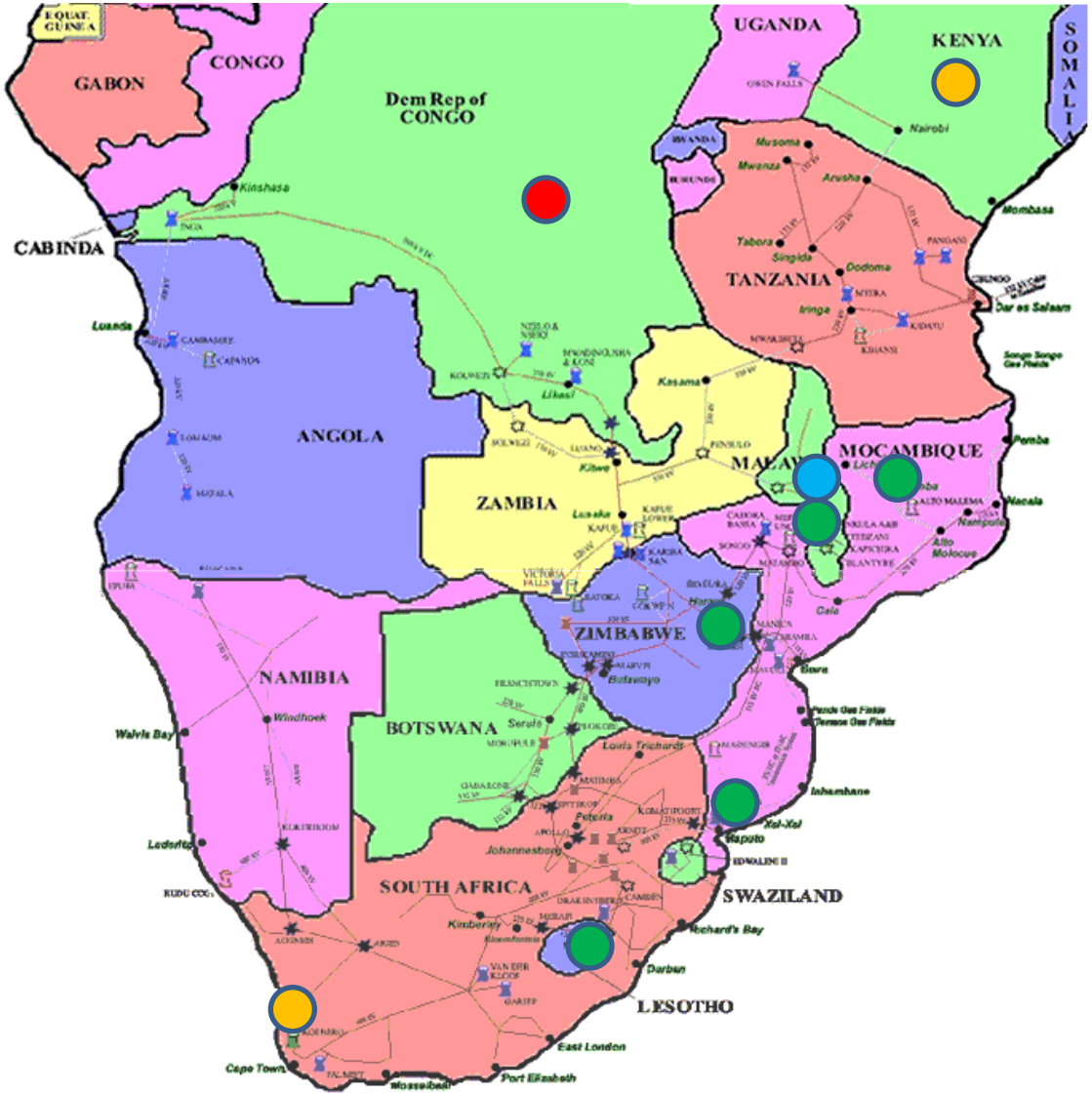
Community based models:

Treatment support

and

self-management

Community Based Models of Care



- CAGS
- Adherence Clubs
- PODI
- Fast track once a year appt

Why community based models ?

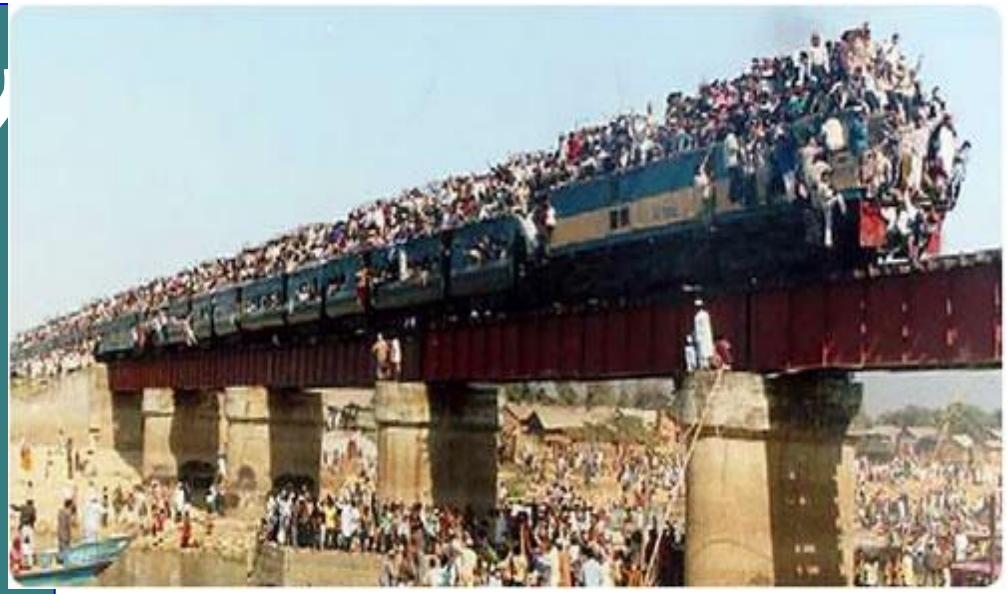
Patient perspective

- 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 2: ELIGIBILITY CRITERIA FOR COMMUNITY ART DISTRIBUTION

Criteria	Malawi, Thyolo	Malawi, Chiradzulu	Mozambique	South Africa	Democratic Republic of the Congo
Voluntary participation	Yes	Yes	Yes	Yes	Strongly recommended for those meeting referral criteria
Adults only	Yes	Yes	No	No	Yes
Duration on ART	6 months	12 months	6 months	12 months (will likely be reduced)	Yes
Eligibility according to CD4	Yes (CD4 > 300)	Yes (CD4 > 300)	Yes	No	Yes (CD4 > 350)
Clinical criteria		No active OI	WHO Stage I/II		
Eligibility according to adherence check	Yes	No	No	Yes (no missed previous visits)	No
Pregnant		No	Yes	Yes	No active opportunistic infections

Location	Health checks	Adherence checks	Frequency of ART dispensing	Frequency of clinic visits	Referral mechanism	Cumulative Retention*
Mozambique, Tete	6 monthly in Health Facility Monthly in CAG	6 monthly in health facility Monthly in CAG	1 monthly	6 monthly	Self referral/referral by CAG from community to health facility	97% after average FU time of 16 months
Malawi, Thyolo	3 monthly	Peer counsellor	3 monthly	3 monthly	Self referral	98% after 15 months
Malawi, Chiradzulu	6 monthly in Health Facility	6 monthly in health facility 3 monthly in CAG	3 monthly	6 monthly	Self referral	97% after 1 yr and 93% after 2 years*
Malawi, Chiradzulu	--	--	3 monthly	6 monthly	--	97% after 2 years
South Africa, Khayelitsha	Nurse	Viral load	2 monthly	6 monthly	Nurse	90% at 2 years
Kinshasa, DRC	Peer counselor	Peer counselor	--	--	--	--

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DE SAÚDE TETE

DIRECÇÃO PROVINCIAL DE
SAÚDE TETE

Community ART groups:
Distribution of antiretroviral therapy through self-forming groups,
in Tete Province, Mozambique

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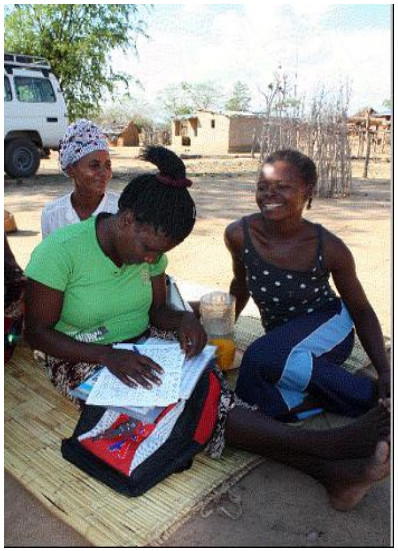

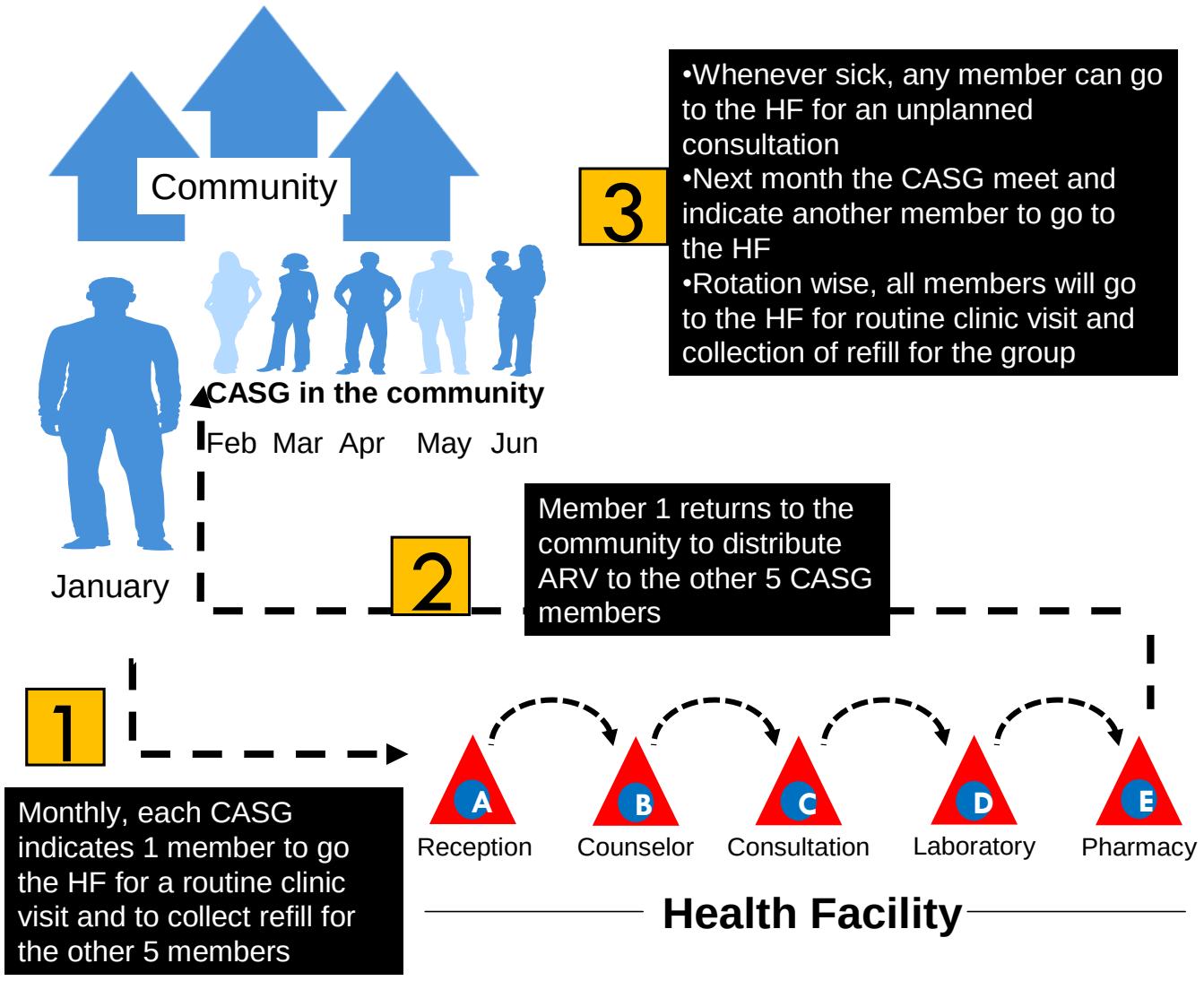
Community
CASG in the community
Feb Mar Apr May Jun
January
3
•Whenever sick, any member can go to the HF for an unplanned consultation
•Next month the CASG meet and indicate another member to go to the HF
•Rotation wise, all members will go to the HF for routine clinic visit and collection of refill for the group
2
Member 1 returns to the community to distribute ARV to the other 5 CASG members
1
Monthly, each CASG indicates 1 member to go the HF for a routine clinic visit and to collect refill for the other 5 members
A
B
C
D
E
Reception
Counselor
Consultation
Laboratory
Pharmacy
Health Facility

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.
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