

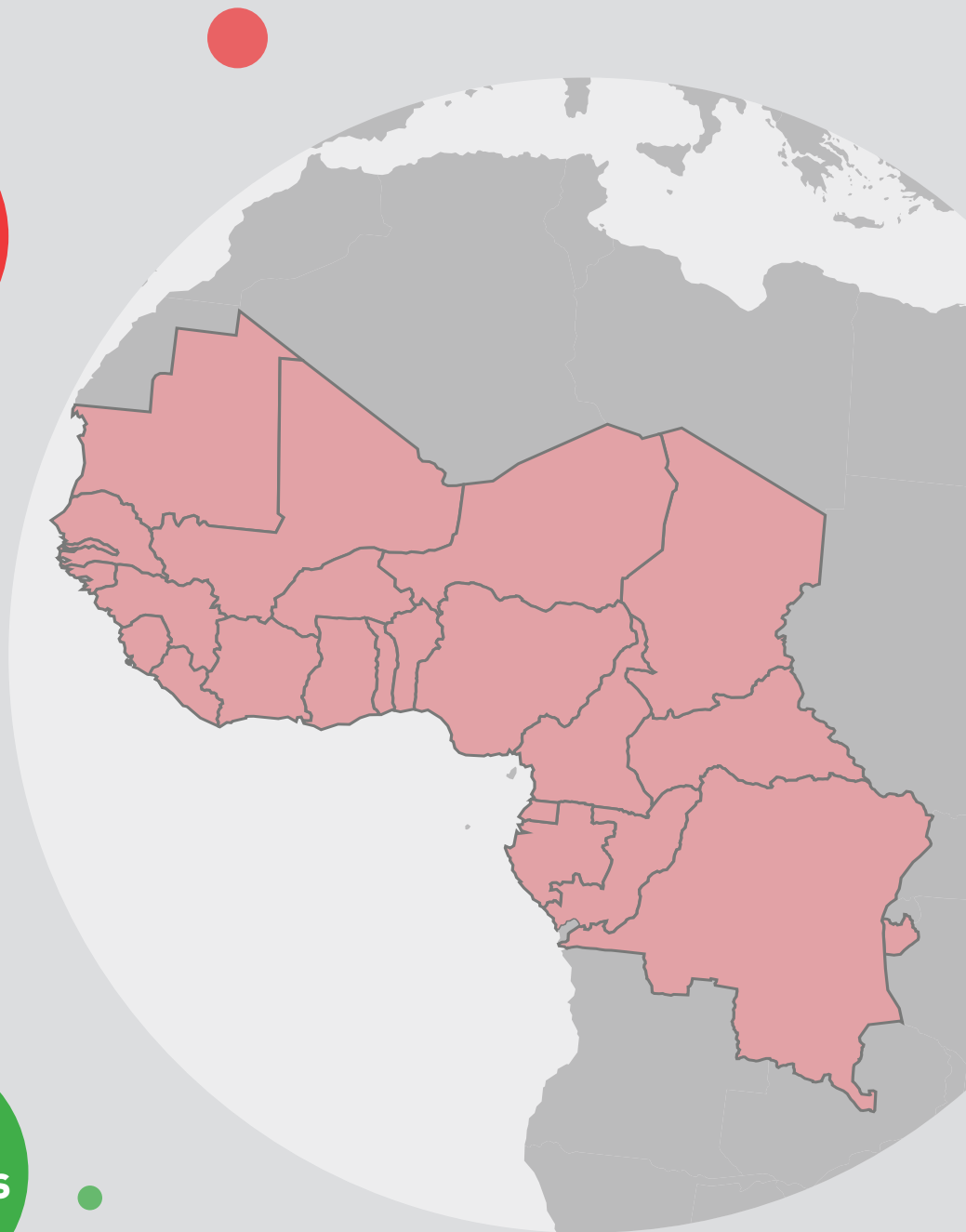
TOWARDS AN INCREASED, MORE EFFECTIVE CARE FOR PLHIV IN WEST AND CENTRAL AFRICA:

DISSEMINATION OF **THREE NOVEL APPROACHES** PILOTED BY MSF

PODI

R6M

**LAY
COUNSELLORS**



INTRODUCTION

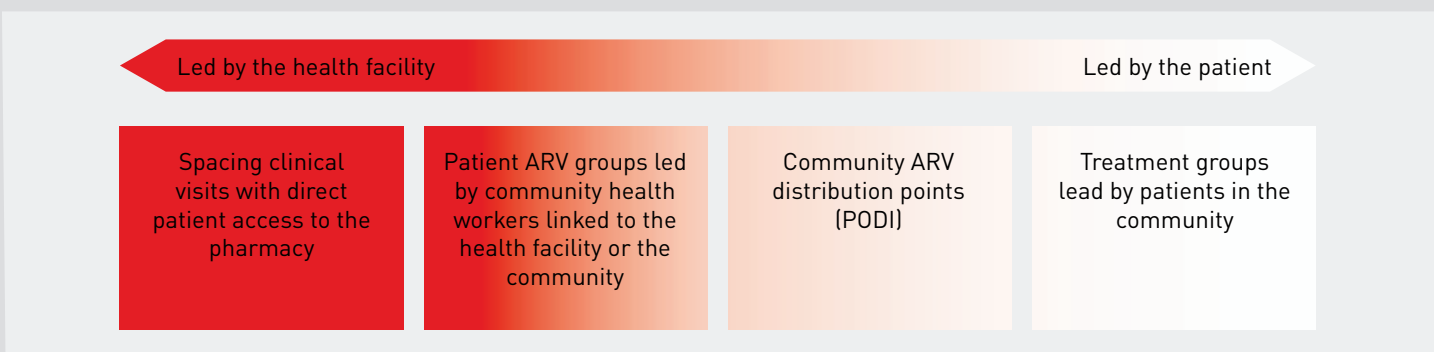
More than 17 million people living with HIV (PLHIV) are now under antiretroviral treatment (ART) globally.

Despite this remarkable progress, the region of West and Central Africa (WCA) lags behind: 72% of people requiring treatment—or 4.7 million people in total—are still awaiting treatment. This translates to excess in mortality and morbidity, and a continued spread of the epidemic.¹

To increase the effectiveness and simplify the management of the growing number of individuals on ART, to increase the size of the cohort under treatment, and most importantly to better respond to PLHIV, the World Health Organisation (WHO) has recommended the implementation of **differentiated models of access to antiretroviral therapies for stable patients**.²

These approaches to streamlining of care include, among others:

- spacing clinical visits with direct patient access to pharmacies for ARV refill
- creation of patient ARV groups led by community health workers linked to either the health facility or the community
- ARV distribution through community distribution points managed by PLHIV networks
- treatment groups led by patients.^{3,4}



These novel approaches not only reduced the burden on patients and health personnel, but also led to excellent retention in care as well as good suppression of viral load. In programmes piloted by MSF, the retention levels for individuals under differentiated models of care in South Africa reached 97% after 40 months of treatment; 94% in Malawi and 95% in Mozambique after 36 months under ARVs; and 91% in the Democratic Republic of Congo (DRC) after 24 months.⁵ Even during the Ebola crisis in Guinea, retention after 12 months was 96% thanks to the model of R6M spaced clinic visits (see point 2).

These differentiated strategies must now be replicated on a grander scale and also expanded to other categories of PLHIV, such as pregnant women, children, at-risk populations (key populations), in addition to individuals testing seropositive and directly placed in treatment within the framework of the "Treat Everyone" approach of WHO.⁶ Without this expansion, it will be a struggle to achieve the ambitious goals of the joint UN Programme on HIV/AIDS (ONUSIDA) by 2020.⁷

Three novel approaches to HIV care piloted by MSF in WCA are briefly presented in this brochure.

They are being disseminated in order to share the knowledge and experience necessary to understand and replicate strategies that will reduce the imbalance in ART coverage, notably in WCA.

Certain principles, such as the separation of ARV delivery from clinical care, treatment refills for longer periods, the delegation of testing tasks to non-medical personnel, and psychosocial assistance combined with ARV distribution must remain the essential foundation to differentiated models of care. Other components may vary, but will, just like these principles, be adapted to different contexts and always focused on the specific needs of the patient.

A combination of different approaches is also desirable, as is mentioned in some of the recommendations at the end of this brochure.

1

COMMUNITY ARV DISTRIBUTION POINTS (PODI)

Community ARV distribution points (*Postes de distribution communautaire d'ARV* or PODIs) in DRC are one example of a differentiated strategy of antiretroviral treatment distribution piloted by MSF.

They were launched in the capital city of Kinshasa in 2010 in partnership with a network of community-based associations (the *Réseau National des Organisations d'Assise Communautaires* or RNOAC). Their goal: to decrease demands on the MSF-supported hospital structure, improve capacity to initiate treatment and follow critical cases, and provide easier access to ARV for stable patients, notably at the community level, while simultaneously empowering patients and giving them more autonomy.

At the end of 2015, some 2300 PLHIV, including a third of MSF's active cohort in this region, obtained their ARVs directly from the 3 PODIs in Kinshasa, with notable results for the health of patients and the health system.

It is important to note that, although the PODI model has moved from a vertical to an integrated approach in the operation of the Health Zone, management at the community level is still ensured at the community level, by the RNOAC.

This model has been recognized and adopted by the National AIDS Program (PNLS) and is now financed by the Global Fund and PEPFAR. More than 30 new PODIs will be launched in the country.⁸

The PODI in DRC at a glance:

Community ARV distribution points are managed by a network of non-medical PLHIV, trained for this purpose.

They are intended for adult ARV patients who are stable and fulfil a certain eligibility profile, which includes: being over 18 years of age and under first or second line ARV treatment for at least six months; having a viral load below 1000 copies/ml or undetectable (in absence of viral load, the patient must have a CD4 count >350 or an increase of 25 to 50 cells during the first 6 months); free of opportunistic infections (OI) and not hospitalized for OIs in the previous 3 months; not pregnant or the mother of an exposed infant.

Patients come every 3 months to the PODI to collect their ARVs, monitor their weight, and receive – if necessary—adherence support from other PLHIV trained for this purpose. All services are free of charge.

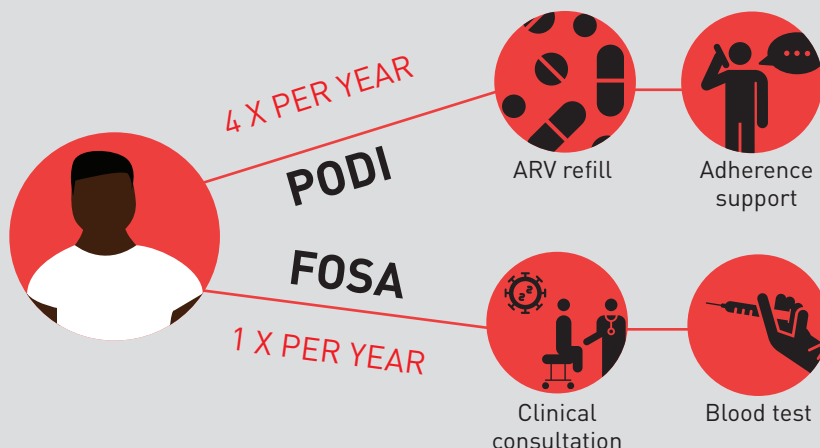
Patients who fail to appear for their appointments are followed up by telephone or house visits with the aid of a network of local volunteers.

Once a year the patient attends a health facility (formation sanitaire or FOSA) for a viral load test and an annual clinical consultation (both free of charge). In any case of medical complaints outside of annual visits, the patient can always consult the FOSA.

PODI

The PODI can also provide testing, counselling and therapeutic education services, organize support groups, and social support.

The Health Zone, the base operational level of the Minister of Health for the organization of health activities, links the FOSA and the network of PLHIV/PODI; it assures the ordering and supply of ARVs and other inputs into the PODI, incorporates the data reported by the PODIs into the data validation system and national reports, and assures the quarterly supervision of the PODIs.



THE OF THE PODI

FOR THE PATIENT

Compared to visits to the medical facility, the transportation cost for the patient is divided in three and the waiting time to obtain ARVs by seven⁹. Thanks to free, confidential, and rapid access close to home that is non-stigmatizing because of the involvement of other PLHIV, the patients are more autonomous in the control of their illness and motivated to continue their treatment.

Good retention in care for stable patients: 98% after six months of treatment; 95% after 12 months and 91% after 24 months. This retention is in part due to the active research of drop outs. In comparison, the retention of the general cohort in the health facilities is 64% after 12 months of ART and 58% after 24 months.¹⁰

Increased access to HIV testing and screening, with patients who bring in family members and other community members. In 2015, 2054 people were tested in all of the PODIs, 19% of whom tested positive. These individuals were then referred to health facilities for medical care and initiation into treatment.

Good suppression of viral load: an analysis conducted by MSF in 2016 revealed that among patients followed at the PODI who were tested in the FOSA, 96% had an undetectable viral load (less than 1000 copies/ml).

FOR THE HEALTH SYSTEM

HIV care facilities are less overloaded. Thanks to the decrease in unnecessary consultations, these facilities can now concentrate on treatment initiation and care of instable patients under ART.

There is a favorable cost/effectiveness ratio: At the level of 2000 patients or more, the annual human resources cost per patient is around eight USD (while it is 11.27 USD in a health centre).¹¹

ESSENTIAL CONDITIONS FOR A WELL-FUNCTIONING **PODI**:

- The PLHIV network plays a key role in the running of the PODI, and should thus have good organizational capacities that are technically and financially supported, if necessary.
- A synergy with the health system is indispensable, based on a clear separation of tasks between the PODI and the FOSA but focused on continuity of care for the patient (PODI staff should be able to quickly refer patients with medical complaints to health facilities, while the FOSA should be able to refer stable patients to the PODI, etc.).
- The recognition of the work of patient-experts. This role is rarely recognized by the Ministry of Health. They should be paid, trained, and supervised to ensure quality work.
- A system of follow-up and evaluation integrated in the national health system is necessary for maintaining the quality of service and monitoring the medical supply chain. An effective management of pharmacy stock and of this supply chain are also indispensable to avoiding stock-outs.
- A national normative framework supporting differentiated ARV supply models will facilitate introduction of PODIs.

2

SPACING OF CLINICAL VISITS: APPOINTMENTS AT SIX MONTHS OR "R6M"

Since 2014 in Guinea, within the framework of an experimental pilot project, stable patients under ART have gone to the health centre every 6 months for a medical consultation, a viral load analysis, and a refill of their ARVs.

This alternative model of limited clinical consultations in combination with ARV refill, called "Appointments at 6 months" or "R6M," has already demonstrated positive effects in several pilot programs. It is now part of the WHO guidelines, which recommend less frequent ARV refill, for a period of 3 to 6 months, for stable patients.¹²

In Guinea, the R6M model was adopted in Conakry in 2013 after problems with retention of patients in treatment (in a country where the rate of detection and antiretroviral treatment are already low). In addition to this, there was a need to unplug HIV care facilities, reduce the burden of follow-up of these individuals for staff, but also reduce the burden for patients in terms of cost of transport, frequency of medical visits, and waiting time to receive ARVs.

Although health workers initially showed some resistance to this new strategy, it soon demonstrated a positive impact on retention in care, even during the 2014-2015 Ebola epidemic. This model could thus prove useful in other crises to prevent treatment interruption when access to health structures is limited or interrupted.

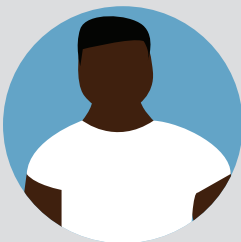
More than 55% of the active cohort of PLHIV followed by MSF in the capital—more than 3100 stable PLHIV—today benefit from this differentiated model of care. Guinean health authorities, who supported its application during the Ebola crisis, are preparing to integrate this differentiated strategy in their national plan for the care of PLHIV.

The R6M in Guinea at a glance:

R6M

Stable patients come every 6 months for a clinical visit, a viral load test, and refill of their ARV treatment.

The selection criteria are: patients must be over 15 years of age; under first line ART for at least 6 months; have a viral load under 1000 copies/ml; be in clinical stage 1 or 2 of the disease (according to the WHO scale); be clear of opportunistic infections; not be pregnant or the mother of an exposed infant.



2X PER YEAR



clinical visit



ARV collection



blood test

THE OF THE R6M

FOR THE PATIENT AND THE HEALTH SYSTEM

Reduced burdens on the patients including a decrease of transportation costs, frequency of visits, and waiting time in medical facilities.

A decrease in costs to the health system.

A decrease on the workload for health staff, who can then focus on enrolling new patients on ARV and providing care to patients with complications.

Decreased stigmatization. Due to less frequent visits to health facilities, rumours that weigh on patients are reduced.

A significant increase in retention in care. A retrospective study comparing a group of patients in the R6M model demonstrated a 95.8% rate of retention for this group after 24 months in treatment. In comparison, the retention of the general cohort in the health facilities is 62% after 24 months of ART.

A reduction of loss to follow-up. The same study demonstrated a 60% reduced attrition rate over a two year period in the R6M group compared to the control group.

Within the context of the Ebola epidemic, the R6M was also resistant to the crisis by maintaining care for patients under ART (96% rate of retention in care after 12 months), and contributed to reduction of Ebola virus transmission risk by reducing contact between individuals in health facilities.

ESSENTIAL CONDITIONS FOR A WELL-FUNCTIONING R6M:

- An adequate ARV supply chain permitting distribution of six months of treatment.
- A good coverage of viral load testing. Alternatively, clinical and immunological criteria may be applied.
- A smooth and constant integration of eligible patients into R6M.

3

DELEGATION OF TASKS TO LAY COUNSELLORS

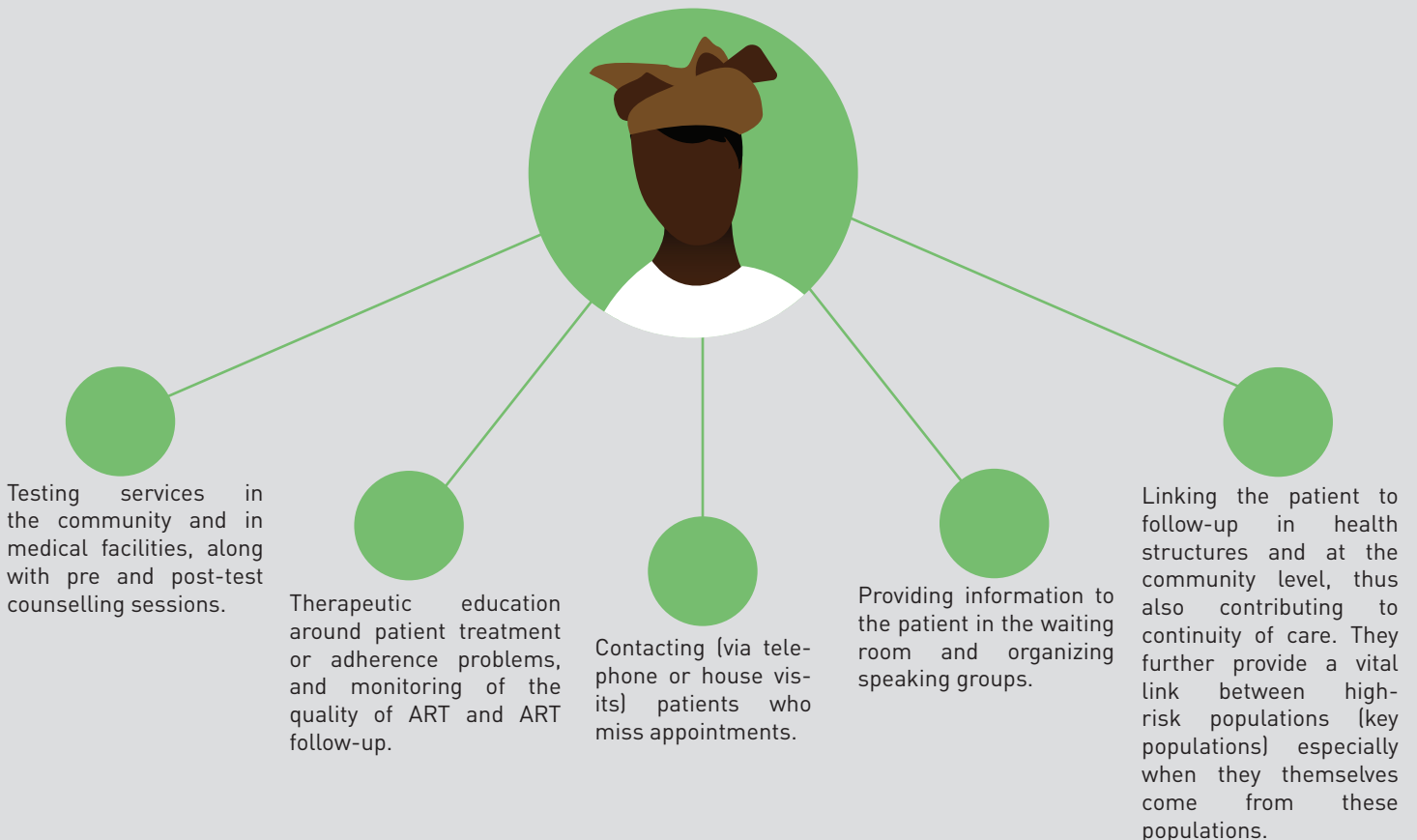
In order to respond in part to the lack of qualified health staff in many countries affected by HIV and improve care offered to PLHIV, the WHO recommends the transfer of tasks linked to HIV testing to community health workers or to lay counsellors (sometimes also called psychosocial counsellors, expert patients or peer counsellors when referring to PLHIV in this role). These lay counsellors are trained in the use of rapid diagnostic tests to offer reliable and effective screening services in an independent manner. Since they already provide many counselling and support services for individuals who are going to be or already are under treatment, the WHO also recommends that these lay counsellors be permitted to dispense ARVs between regular clinic visits, both in the health structures and the community.¹³

In southern Africa, the delegation and shifting of tasks from doctors to nurses as well as lay counsellors has contributed to the rapid expansion of HIV-related services, resulting in increased adherence to treatment and improved follow-up of patients (and inversely, when lay counsellors are removed, the number of tests is reduced).^{14, 15, 16}

Many WCA countries have not yet fully implemented or formalized this task shifting strategy, but various initiatives are beginning to emerge, such as the involvement of lay counsellors and patient associations in the PODIs described above, or in the psychosocial support of patients in Guinea. There, 12 associative agents (two per centre), themselves HIV-positive, participate actively and effectively in the care of PLHIV in six health centres in the capital Conakry. Unlike health workers, these lay counsellors (médiateurs associatifs), who are members of patient associations, are much more sensitive to the psycho-emotional difficulties encountered by patients. This approach, developed by MSF, is attracting increasing interest from the Guinean authorities (and donors), who have adopted it to build their national policy of psychosocial support for PLHIV.¹⁷

The role of lay counsellors in Guinea and elsewhere

The lay counsellors, once they are trained in their assigned tasks, can provide psychosocial support to PLHIV, consisting of:



THE OF TASK SHIFTING TO LAY COUNSELLORS

At the level of pre and post-testing counselling:

● They increase HIV testing and counselling services. This reduces the workload to healthcare workers, permitting earlier case detection at the community level and referrals of PLHIV toward medical care.

● They increase and strengthen entry points for HIV screening.

At the level of ARV treatment initiation

A counselling structured around ● treatment initiation can reduce the number of patients lost between the time of testing and treatment initiation, and also ensures retention in care and adherence once the treatment is initiated.

Among high risk patients

● Additional interventions for those at higher risk of discontinuing treatment may also be provided by lay counsellors. These include psychosocial support for patients with adherence difficulties and pregnant women included in the B + program of prevention of transmission of the virus from mother to child; disclosure of the result of diagnosis to children; or support to patients under treatment for drug-resistant tuberculosis.

At the level of retention in care

● Lay counsellors have an impact on patient adherence and retention, especially if the lay counsellor is a PLHIV, since the patient sees one of their peers living positively with the disease. Community participation is strengthened, and cost for patients is decreased.

● They help achieve positive results by empowering patients in their treatment, improving health outcomes, and reducing workloads for caregivers.

At the level of viral suppression

● Advice for better adherence to ART provided by lay counsellors allows for better virological suppression. In case of problematic viral load results, lay counsellors also intervene with the patient to better understand the problem and propose concrete solutions.

ESSENTIAL CONDITIONS FOR THE EFFECTIVE FUNCTIONING OF THIS APPROACH:

- Clarification of guidelines for psychosocial support for the purpose of supporting adherence and retention for all patients (including positive pregnant women and tuberculosis patients), as well as the definition of the patient circuit in relation to the lay counsellors and the role of health personnel in this circuit (such as a midwife for prenatal screening, for example).
- Recognition of the role of the lay counsellors; harmonisation of their remuneration, training curriculum, and job description; and technical and financial support.
- Training and supervision of these lay counsellors by professionals.
- Development of a long term strategy for the health workforce which includes psychosocial support by the lay counsellors, with donor support for their planning, integration in health policy, and financing.

AND TOMORROW? SOME SUGGESTIONS FOR THE FUTURE

This document describes the benefits of three innovative approaches for PLHIV and patient care programs. In order to optimize the associated benefits, a series of suggestions and amendments follow:

A combination of the various elements of the different strategies and models is desirable:

- A synergy of several strategies makes it possible to increase the range of choices for the patient and allow them to organize their treatment around their family, social and professional life.
- These approaches should be combined with measures to facilitate access to care, such as free patient care, reduction in wait times for follow-up, subsidized transportation costs, therapeutic education, and support from other PLHIV.

Current differentiated care models are based on fairly strict eligibility criteria in terms of the types of patients included and their simplified access to ARV refills closer to their place of residence. In view of the excellent retention in the care rates of these models, **a revision of the eligibility criteria** in order to increase the proportion of patients who could benefit from these approaches is desirable. More specifically, the following changes are advised:

- Travel times, waiting times in health facilities, stigmatization, and patient fees for medical consultations are all obstacles to retention in health care. The inclusion of children and adolescents, pregnant women, co-infected patients, migrants and mobile populations in alternative, less burdensome models may prove productive.
- As part of the WHO criteria to extend ART to all people living with HIV, positive test subjects with a CD4 count > 500 are now expected to be initiated into ART directly. The majority of these people do not show clinical signs and do not require the same type of care as patients at a later stage of the disease. Consequently, an adapted program for this type of patient, with less frequent medical visits, simplified ARV refill and integration into community models, would lead to increased empowerment of these PLHIV (and likely lead to improved retention).
- In contexts where viral load testing is still limited, the use of clinical and immunological criteria to evaluate the eligibility of patients in differentiated models is a possible alternative in order not to delay the treatment of patients in need.

The probability of service disruptions is higher in crisis-linked contexts than in stable environments. **Models of care focused on patient autonomy and increased flexibility in ARV distribution are therefore more suited to this type of context.** During peaks of violence, political tensions or other crises, the initiation of contingency measures such as the provision of ARVs for longer periods and the accessibility of stocks within the community (and accessible to all patients, stable or not) are part of appropriate anticipatory measures. Alternative ARV distribution models may also mitigate the effects of fragile health systems, for example in cases where barriers to access to HIV care are coupled with a limited offer of health services (stock-outs of ARVs and other medical supplies, etc.).

The WHO recommendations now offer longer ARV refills for stable patients for periods ranging from 3 to 6 months. Biannual refills have proven their effectiveness. **Extension of refills to the annual level is being evaluated, as is research on alternative ARV supply mechanisms at the community level.** These include automated distribution points, delivery by mail, relay points in local pharmacies, mobile distributions, etc. **Not only should these initiatives be supported and strengthened, but other strategies also need to be evaluated** to continue improving and simplifying the care and lives of PLHIV in WCA and the rest of the world.

¹ Data from UNAIDS 2015, available on: <http://aidsinfo.unaids.org/>. For more information on the WCA region, see also the MSF report "Out of Focus: How Millions of People in West and Central Africa are being Left Out of the Global HIV Response," April 2016. http://www.msf.org/sites/msf.org/files/2016_04_hiv_report_eng.pdf

² For further information on differentiated care for HIV, see <http://www.differentiatedcare.org/>

³ WHO, "Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach" - Second edition, June 2016. <http://www.who.int/hiv/pub/arv/arv-2016/en/#>

⁴ Bemelmans M. et al., "Community-supported models of care for people on HIV treatment in sub-Saharan Africa," *Tropical Med Int Health*. August 2014;19(8):968-977

<https://www.msfaccess.org/sites/default/files/2014%20comm%20supported%20models%20tmih.pdf>

⁵ MSF, "Adapted models of ARV refill: The experience of Médecins Sans Frontières," round table presentation at the AFRAVIH conference, Brussels 2016.

⁶ WHO, "Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV," September 2015. <http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/>

⁷ Known under the name "Target 90-90-90," they aim that 90% of PLHIV will know their HIV status; 90% of all HIV seropositive individuals receive continuous ARTs, and 90% of people under treatment are virally suppressed. For more information, see UNAIDS, "Fast-track: Ending the AIDS epidemic by 2030," 2014, available from: http://www.unaids.org/en/resources/documents/2014_fast_track as well as: UNAIDS, "2016-2021 Strategy. On the Fast-Track to End AIDS," October 2015, available from: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

⁸ For more information on the establishment of PODIs in DRC, consult the "Guide de mise en place des postes de distribution communautaire d'ARV" published by MSF and RNOAC at the end of 2016, and available on: <http://samumsf.org>

⁹ Jouquet Gu. and Engels Th., "Economic Evaluation of HIV/AIDS Primary/Community Care in Four Selected MSF Project Settings: Patient and Health Care Provider Perspective." Unpublished report, Médecins Sans Frontières, Brussels, July 2011.

¹⁰ MSF, "Le traitement antirétroviral au niveau communautaire pour une meilleure rétention: Expériences des points de distribution (PODI) communautaires à Kinshasa, RDC." Presentation at the AFRAVIH conference, Brussels, April 2016.

¹¹ Jouquet Gu. et Engels Th., *Op.Cit.*

¹² WHO, "Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach," *Op.Cit.*

¹³ *Ibid.*

¹⁴ According to an MSF study conducted in the province of Kwazulu Natal, South Africa, the loss of each counsellor led to at least 28 fewer tests per month. See the MSF presentation, "Getting to 90-90-90: What will it take? Perspectives and Realities from the Field," International HIV conference in Durban July 2016, available at <https://www.msf.org.za/about-us/publications/briefing-documents/getting-90-90-90-what-will-it-take>.

¹⁵ MSF, "HIV/TB counselling: Who is doing the job? Time for recognition of lay counsellors," August 2015. Available at http://www.msf.org/sites/msf.org/files/final_web_counsellor_report_one_page.pdf

¹⁶ The position of lay counsellors remains poorly recognized and/or supported in national policies. See Bemelmans M et al., "Sustaining the future of HIV counselling to reach 90-90-90: A regional country analysis," *Journal of the International AIDS Society*, 2016, 19:20751 <http://www.jiasociety.org/index.php/jias/article/view/20751>

¹⁷ A guide containing the standards and procedures for the psychosocial support of PLHIV was developed by the national program for health care and prevention of STIs/HIV/AIDS (PNPCSP) in Guinea in 2016.



Contact: aaub@brussels.msf.org

Twitter: [@MSF_HIV](https://twitter.com/MSF_HIV)

For more information about MSF and HIV/AIDS, go to:

www.samumsf.org

www.fieldresearch.msf.org

www.msf.org