



OPTIMIZING HIV, TB & NCD TREATMENT IN FIVE SUB-SAHARAN AFRICA COUNTRIES

EVALUATION OF DGD-FUNDED PROJECTS: GUINEA, KENYA, MOZAMBIQUE, SOUTH AFRICA AND ZIMBABWE (2014-2016)

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SHORT VERSION

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of **Médecins sans Frontières** or the Stockholm Evaluation Unit.

EXECUTIVE SUMMARY

INTRODUCTION

Médecins Sans Frontières Belgium (MSF OCB) has been providing HIV care and supporting ministry of health HIV programs across Southern, Eastern and Western Africa since 1999. Their programs aim to increase the number of patients receiving care and improve adherence.

MSF's long-term objective for these projects is to achieve policy and health system change at national and international level to optimize prevention, diagnosis & long-term care of HIV, tuberculosis (TB) & and non-communicable diseases (NCD). The short-term objective is to deliver quality and affordable care and treatment to a large number of people living with HIV, TB and/or NCDs, while controlling the attrition along the treatment cascade. Routine viral load monitoring combined with differentiated and community models of care have been at the heart of MSF's HIV strategy to achieve these objectives.

This evaluation was commissioned by the Belgian General Directorate for Development (DGD) who has been funding MSF'S HIV work since 2008. It covers the HIV, TB and NCD projects in Guinea, Kenya, Mozambique, South Africa and Zimbabwe from 2014-2016, and focuses on assessing the treatment cascade, viral load monitoring and differentiated models of care, alongside the question of whether MSF's advocacy efforts have resulted in long-term policy change to optimize prevention, diagnosis and care of the diseases at stake.

METHODOLOGY

This evaluation has used a mixed-method methodology: review of internal (project) and public documents, including an analysis of quantitative data at the disposal of the evaluators, and a qualitative analysis based on key informant interviews and focus group discussions. Participants for interviews and focus group discussions were purposefully selected based on their availability and knowledge of the project. In making the selection, a diversity of perspectives has been ensured to be able to triangulate the findings, by selecting staff from various layers in the organisation, as well as external stakeholders, partners, and patients.

KEY FINDINGS

Routine viral load monitoring

MSF has been able to introduce routine viral load (VL) monitoring for people living with HIV (PLHIV) in all of the missions evaluated. This is an important step in monitoring adherence and improving antiretroviral treatment (ART), particularly when resistance develops and a switch to second line ART is needed.

The main challenge in routine VL monitoring is precisely this switch to second line treatment. Patients who have two consecutive detectable VL results should switch to second line ART, but the proportion who are actually switched at the appropriate in time remains low, ranging from 29%-75% across projects. The reasons for this are rather complex:

- All of the countries, with the exception of South Africa, have faced challenges with long turnaround time for results (TAT). This is due to a mix of problems, often linked to sample transport and equipment maintenance and change in VL protocols.
- Unclear protocols for switching patients to second line treatment.
- Patients and healthcare providers who are reluctant to switch.
- Centralized switch committees.
- Health staff not feeling sufficiently empowered to change.

MSF has responded to the delays in switch decisions by advocating for decentralised switch committees (either at provincial or facility level), and by introducing nurse-led switching, mostly with success.

To address TAT, projects have outsourced sample transport to other organisations and introduced mobile Health (mHealth) solutions to report VL results.

The main lesson learned with regards to VL monitoring is that VL is a necessary but insufficient step in improving treatment outcomes for patients. When setting up routine VL monitoring, it is necessary to ensure that VL results will

be used to manage treatment, and switch patients to second line treatment in a timely manner. Constant training, mentoring and support of healthcare professionals is essential to increase uptake of VL monitoring and use of the test results to manage patient care in HIV.

Differentiated Models of Care (DMoC)

MSF, often in cooperation with MoH, introduced various differentiated models of care (DMoC) in all its projects, adapted to the context. All modalities have convenience and patient-centeredness in common, which are aimed at improving adherence and retention in care, while simultaneously reducing the workload of overburdened healthcare providers. The uptake of the different DMoC modalities varies within projects, e.g. between urban and rural settings. Across projects, uptake of DMoC varies from 18%-37%. Notable successes include Community Adherence Groups (CAGs), ART Clubs, medication Fast-track and Pick-Up Points. CAGs and Clubs include peer-support and reduce travel and/or waiting time. Fast-tracks and Pick-Up Points are a fast and often decentralised way to pick up medication. All of these DMoC have been adopted by the health authorities in the countries involved. Patients appreciate the DMoC as they reduce disruption of daily activities; members of the group modalities of DMoC like the peer support from their fellow group members.

Stigma remains a challenge to higher participation in group models, as disclosure of status is implied with participation. A notable exception to this is the NCD / HIV club model in Kenya, which includes patients with NCDs who are not HIV-positive, and participants are not automatically assumed to be HIV-positive.

The suitability of each form of DMoC is patient and context dependent. CAGs generally function well in rural contexts with limited stigma like Mozambique and Zimbabwe, but failed in Guinea, where discrimination against HIV patients is extreme, and patients are fearful of their status being disclosed. Clubs were selected in Nairobi where distance to the clinic was not a factor. Pick-Up Points were preferred by patients in Eshowe, an urban setting. It is an open question whether there is enough uptake of DMoC among patients, and what the optimal coverage of these DMoC is. In general MSF has expanded the DMoC it has on offer to patients, including those models that do not require disclosure.

The key lesson learned is that the role of stigma and fear of disclosure remains an important barrier to uptake for some of the DMoC. Offering a selection of DMoC will allow patients to choose the option that suits them best.

Treatment Cascade

In line with the UNAIDS 90-90-90 target, MSF uses the treatment cascade to monitor its HIV programs. The 90-90-90 refers to targets for three important steps in the treatment cascade: step 1 (the first 90): 90% people living with HIV actually know their status; step 2: 90% of PLHIV who know their status are on ART (and remain in care); step 3: 90% of people on ART are adherent to treatment as shown by an undetectable viral load. All programs collectively managed to bring 55,867 PLHIV into care. Determining the percentage of PLHIV who know their status was challenging

All five of the projects have higher percentages of patients on ART than the national figures, and all of the MSF-supported projects have achieved or are close to achieving the target of having 90% of eligible PLHIV on ARV. Kenya, Zimbabwe and South Africa are also close to achieving 90% viral load suppression (87%, 83%, 86%, respectively), while Tete, Mozambique (66%) and Conakry, Guinea (63%) still struggle to increase VL suppression among their ART patients,

Main challenges include the poor results of the cascade among children, especially with respect to their retention in care. Another challenge is that men are not coming forward for testing and care, and treatment adherence in men/boys tends to be poorer than adherence in women. Poor cascade results in children are linked to difficulties that parents or guardians have in disclosing to children that they have HIV. In men, poor cascade results are linked to men being mobile to find a job, and therefore not regularly accessing care. It is also costly for men to visit a clinic or go for a test, as they must leave work to do so, and thus lose income.

MSF has responded to these challenges by introducing special adherence groups and clinics for children and adolescents, and by developing testing services that cater specifically for men and other groups that are hard to link into care, such as sex workers. These services include door-to-door testing in the communities, mobile and outreach testing strategies, and special clinics. Defaulter tracing has also been stepped up to reduce loss-to-follow-up. Finally, the earlier-mentioned DMoC are expected to have a positive influence on adherence and retention in care. These initiatives have led to progress in retention for children, while some of the initiatives targeted at men will require further monitoring to determine their effectiveness.

Aside from its focus on the last two 90s, MSF has also made impressive strides in activities which aim to prevent HIV and to achieve the first 90 with activities, like male medical circumcision, condom distribution, community HIV counselling and testing, prevention of mother to child transmission (PMTCT), post-exposure prophylaxis for survivors of sexual violence, and outreach activities to specific populations including youth in schools, sex workers and (migrant) workers in mines and on farms. All these activities show impressive volumes of activities and as such have prevented HIV, provided information on HIV, screened for TB, STIs and/or pregnancy, and provided a link to care for individuals who tested positive.

National policy change

MSF has contributed to national-level policy change in all five countries evaluated. It is regarded as a technical expert in HIV care, and its experience 'on the frontlines' is highly valued as are its financial independence and its capacity to innovate and challenge existing policies.

MSF's influence can be broken down four ways: influence on high level policies, influence on technical guidelines, influence on practice, and influence on major donors. MSF's advocacy strategy relies predominantly on participation in technical working groups, conducting and disseminating results from operational research, sharing monitoring data, and collaboration with other advocates.

Tuberculosis

In addition to HIV, MSF has introduced new approaches to tuberculosis screening and treatment in various projects, particularly with respect to drug-resistant tuberculosis. MSF has also integrated tuberculosis case finding in its HIV projects.

The integration of isoniazid preventive therapy (IPT) in HIV and TB services remain challenging, as well as achieving sufficient coverage of IPT. Other challenges include achieving high quality screening and hence improving case detection rates. This is partly due to poor record keeping, as well as insufficient attention to sensitization of staff and patients. Improving treatment outcomes is also a challenge.

MSF has responded to paying extra attention to the aforementioned issues in staff training and mentoring. Treatment has also been decentralised, especially for drug-resistant TB.

MSF could use successful elements of its own approach in HIV in its TB program to achieve improved results. For instance, the attention to monitoring and high-quality data present in the HIV project may pay off in TB as well. Differentiated care models and community involvement will also be important to adapt and transfer to TB programming.

Sustainability and replicability

Sustainability is a high priority in each of the countries evaluated. The three main strategies to improve sustainability are: 1) advocating for policy change, in order to transfer and integrate innovative interventions and models of care in the MoH models, protocols and guidelines; 2) providing extensive training, supervision and support to MoH staff (the mentoring and coaching approach) as well as to local CBOs; 3) building the capacity of civil society.

A notable sustainability success is the invention of DMOc by MSF and the subsequent inclusion of DMOc such as CAGs and Clubs the national government in all five of the countries with DGD funded projects.

MSF has not been able to secure the incorporation of lay counsellors into national human resource for health frameworks despite advocacy work since 2002 in some countries. As a result, lay counsellors in most countries are not MoH employees, and their role relies on the availability of funding by external donors.

An important finding is that a formal program of developing a mentoring and coaching approach among MoH facility staff by helping to establish a cadre of trainers is not part of the handover strategy in all projects, whereas its inclusion has the potential to amplify the sustainability of MSF's projects.

There is a tension between MSF's desire to provide a high level of quality of care and its desire to have its activities sustained beyond the life of the project. Often, interventions that are essential to improving health outcomes for PLHIV (e.g. outreach services) require resources such as fuel, vehicles and personnel – including lay counsellors as mentioned above – that the MoH often does not have the funding to sustain after MSF's departure.

RECOMMENDATIONS

- ⇒ **Recommendation 1: Address the high HIV prevalence in adolescent girls and young women** by implementing, scaling up and adapting approaches that work in the other projects
 - Consider girls-only programming that addresses the unique vulnerabilities that girls face with respect to HIV. Alternatively, look for partner organizations implementing girls-centred programming and support these with modules on HIV and sexual and reproductive health.
 - Adolescent girls and young women in school can be addressed through school programs like the one in KZN that includes HIV testing and counselling, access to condoms and links to care.
 - Include adolescent girls and young women out-of-school in interventions based on a good needs assessment.
 - Programs for adolescent girls and young women need to be accompanied by programs aimed at changing attitudes and practices with regards to safe sex among older men.
- ⇒ **Recommendation 2: Increase uptake of services in men** throughout the treatment cascade
 - Get a better understanding of barriers for men to testing, treatment, disclosure and adherence through focus groups, survey or other suitable operational research methodologies.
 - Consider adapting services to cater for men: changing working hours of clinics to be more convenient for men who work; adherence clubs or other differentiated models of care with social activities adapted to the situation of working men; training of male counsellors and male nurses; sensitise men to seek care before they fall ill.
- ⇒ **Recommendation 3: Address weaknesses in the VL cascade**
 - Decrease turnaround time, where applicable, by setting a mutually-agreed goal with all stakeholders and work towards it by selecting a series of measures tailored to agreed problem analysis of long TAT and appropriate to the context e.g.: improving transport efficiency through contracting of commercial courier companies when possible and feasible; by limiting patients coming for VL checks on Fridays or other days on which transport of the samples may not be timely; by improving recording of results e.g. through electronic data recording systems or more stringent procedures; move towards (further) decentralised or point-of-care VL tests using existing decentralised platforms like XPERT; develop SOPs and train nurses such that task shifting to nurses for operating a VL test becomes a reality; reduce maintenance problems and problems replacing broken equipment by leasing machines rather than purchasing them.
 - Speed up decision to switch to second line antiretroviral therapy by using best practices like decentralised switch committees; advocating for and improving guidelines, protocols and standard operating procedures about switch decisions; ensure decision support for nurses by having a hotline with a doctor from a switch committee who can authorise to switch; involving patients / peer support regarding increased pill burden and potential new side-effects for those who need to switch.
- ⇒ **Recommendation 4: Scale-up utilisation of differentiated models of care**
 - Pilot a variety of modalities such that patients can choose a modality that fits them and their lifestyle;
 - Consider more flexible eligibility criteria for enrolment in DMoC; especially unstable patients with adherence problems potentially benefit from the peer support that the group modalities offer;
 - Operational research to demonstrate the positive effect of DMoC on outcomes like VL detectability or retention in care
- ⇒ **Recommendation 5: Strengthen TB case finding and treatment of DS-TB along DR-TB** with the same level of effort as has been exercised on improving the HIV treatment cascade in order achieve better treatment outcomes for DS-TB and thus have a positive impact on the most important cause of death in PLHIV.
- ⇒ **Recommendation 6: Continue advocating for formal recognition of lay counsellors** and their incorporation into national human resources for health frameworks.

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