



# Providing community ART in a time of conflict: Pilot projects from Central African Republic

INTEREST Workshop 2019

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# Background on CAR

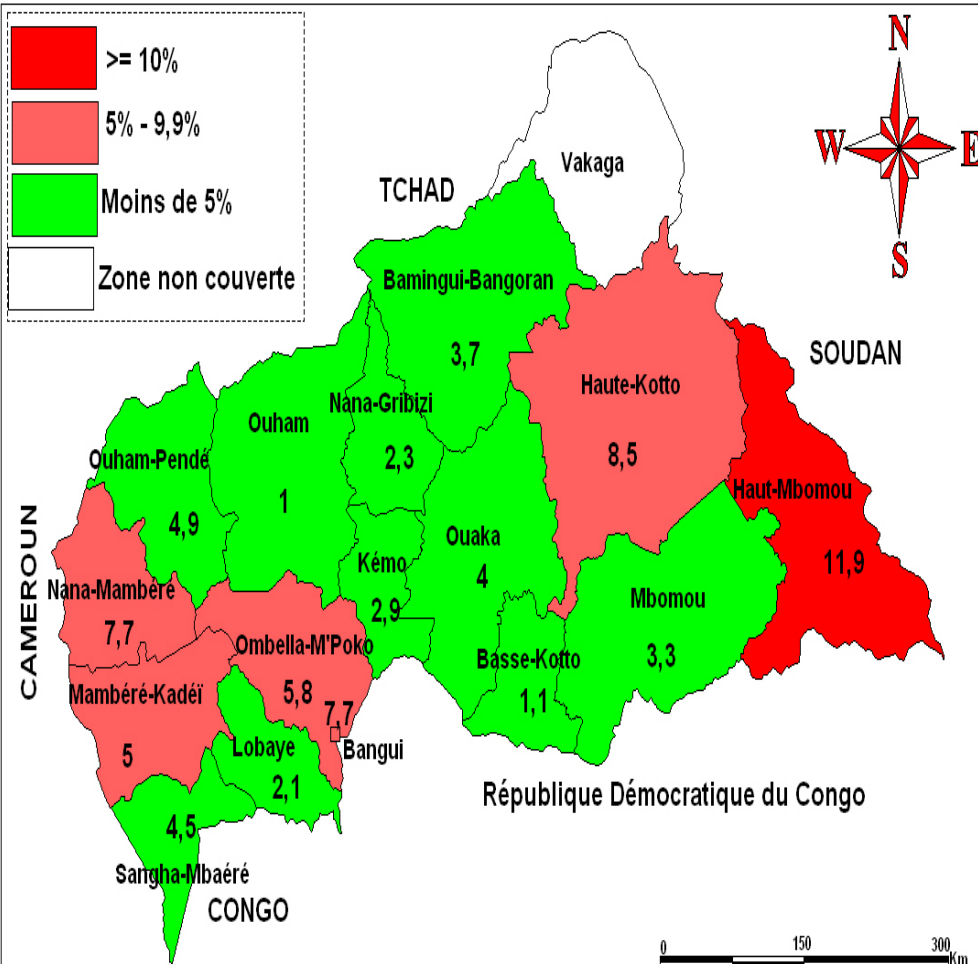
- Population 4.7 million
- Ongoing violence and continued insecurity have resulted dysfunctional state institutions, large scale population displacement & increased humanitarian needs.
- The increase in violence in 2017 resulted in the highest number of displaced (>half a million) since beginning of crisis in 2013
- Armed groups continue to hold parts of the country mobilising resources by controlling mining sites, roads and markets





# HIV in CAR

Prévalence du VIH sur l' Ensemble de la Population de 15 à 49 ans par Préfecture en 2010



- HIV prevalence in adults is 4%,
  - Higher among commercial sex workers (9.2%) and
  - Men who have sex with men (6.1%).
  - High in some rural areas e.g Haut Mbomou 11.9% (DHS 2010)
- Where with 90-90-90 targets
  - 53% of people living with HIV know their status
  - 32% accessing ART
  - Access to VL – 8%
- HIV services are centralized mainly to district hospitals
  - To PHCs where presence of NGO's



# Challenges

- Insecurity
- Extremely limited financial and human resources
- Lack of simplified models of HIV care aiming at decentralizing care to the communities, close to peoples homes.
- All impact on access to:
  - Counseling and Testing
  - Treatment and Care (huge gap)
  - Quality monitoring (Viral load in the national AIDS programme)



# Intervention

- MSF piloted two DSD models
  - **Pharmacy Fast track (PFT)**
    - Appointment spacing and Fast Track Drug Refills for all stable patients on ART
  - **Community ART Groups (CAGs)**
    - Stable patients living in same geographical area (village) were invited to self-form groups
- The DSD programme is remotely supported by MSF and MOH/GF
  - Drug supplies from Bangui to Zemio by air
  - Transportation of blood samples for viral load to Bangui/Bossango
  - Simplified Data collection from registers into forms into excel database based in Bangui





# Building blocks of CAGS & PFT

**ART refills**

**Clinical consultation**

**Psychosocial support (CAGs)**

 **WHEN**

6 monthly

Once a year

Monthly

 **WHERE**

**CAGs** - Communities to client's homes  
**PFT** - Primary care clinic

Zemio- Health Centre

Communities

 **WHO**

**CAGs** - Leaders/  
Group Member  
**PFT** - Pharmacy assistant

Nurse/Nurse assistant

Group Members

 **WHAT**

ART +  
Cotrimoxazole  
refills

Weight, TB screening,  
OI screening  
Viral Load testing

Medications Checks  
Documentation of  
social problems in a  
CAG notebook



# Outcomes

	Cohort on ART before intervention* (Dec 2016) n (%)	Intervention** (Jan 2017-Dec 2018)	
		CAGs (n=77)*** n (%)	PFT n (%)
Active	1269 (79)	1132 (97.5)	108 (62)
Dead	137 (9)	35 (3)	8 (4.6)
LTFU	196 (12)	6 (0.5)	59 (34)
Total	1,602	1,173	175

\***Cohort before intervention** = overall retention from the ART start date of each client before intervention (enrolment started 2011)

\*\***Cohort after intervention** = overall retention from ART start date of each client to Dec 2018

\*\*\* **Total number of existing groups**

**LTFU slowed down after roll out of intervention**



# Viral load outcomes: Preliminary results

VL Threshold	CAGs N (%)	PFT N (%)	Total N (%)
<1000	270 (82)	16 (64)	286 (80)
>1000	61 (18)	9 (36)	70 (20)
Total	331 (28)	25 (14)	356 (26)

- VL done between Aug 18 - Jan 19)
- Limitation: small sample ; **possible** selection bias
- (Recent roll out of VL + other challenges; lack of POC; security)
- **Promising first viral suppression results** for HIV patients in CAGs
- **Sub-optimal viral suppression** for patients in PFT
- Only 19 patients are accessing 2<sup>nd</sup> line ART

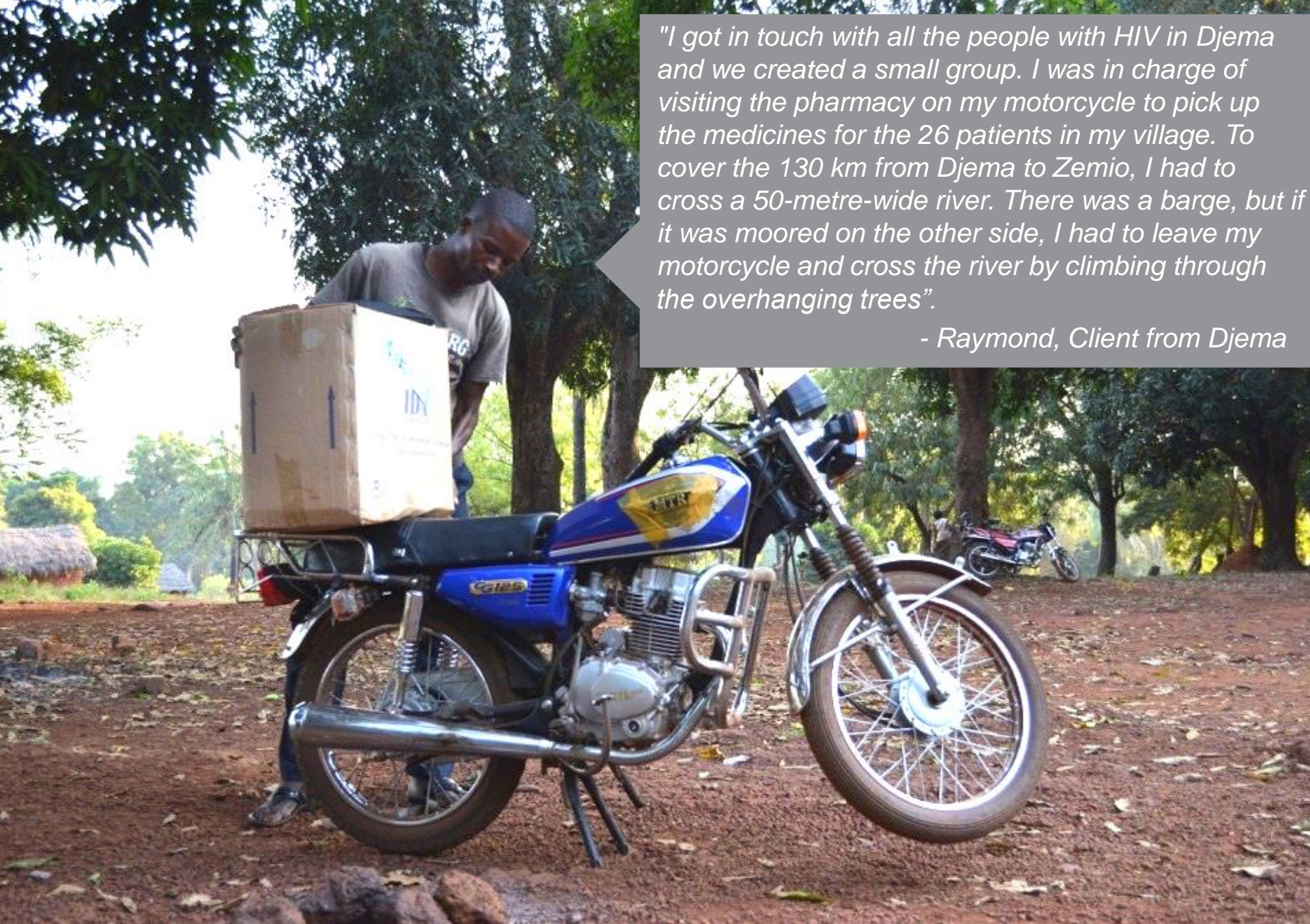


*There are many advantages of being in a CAG: in the CAG I work without thinking of going to Zemio town; in the CAG I spend less on transport; in the CAG I know my brothers who are like me; in the CAG I'm not scared."*

Female CAG member, RDC

*"We are together to share ideas and tips to motivate members of my CAG group, and if there is a problem, together we try to find the solution - even if one member is sick."*

CAG leader, Zemio



*"I got in touch with all the people with HIV in Djema and we created a small group. I was in charge of visiting the pharmacy on my motorcycle to pick up the medicines for the 26 patients in my village. To cover the 130 km from Djema to Zemio, I had to cross a 50-metre-wide river. There was a barge, but if it was moored on the other side, I had to leave my motorcycle and cross the river by climbing through the overhanging trees".*

*- Raymond, Client from Djema*



# Scale up/Sustainability

- MSF support to MOH to rollout DSDs to at least three new areas (Boguila, Bossangoa and Bambari).
- Boguila: 360 on ART, 183 enrolled in 18 CAGs and three in PFT
- Integration of DSD M&E into SANTIAs the national (MOH) electronic database.
- National DSD guidelines in process



# Challenges

## **ART programme challenges**

- Ongoing conflict & insecurity, threatens ART programme sustainability
- Continued displacements– has resulted in cohort from Zemio to spread to many different places such as Obo, Bangui, Djemmah & Bangassou)
- Viral load monitoring at national scale needs to be established and likely to be challenging
- Staffing and remuneration is key to sustain the models

## **DSD programme challenges**

- Ensuring 6 months uninterrupted drug supplies to maintain the DSD models
- Simplified national data collection tools to monitor DSDs



# Lessons learned

- DSD models (CAGs and PFT) are feasible and acceptable in a conflict/unstable setting in CAR
- Feasible through minimal supervision (remote setup) in conflict/unstable setting
- Possible that model could be replicated in other parts of the CAR and other countries with similar challenges