Implementing ART community delivery models in Resource limited settings: Lessons Learned from TASO Uganda Limited

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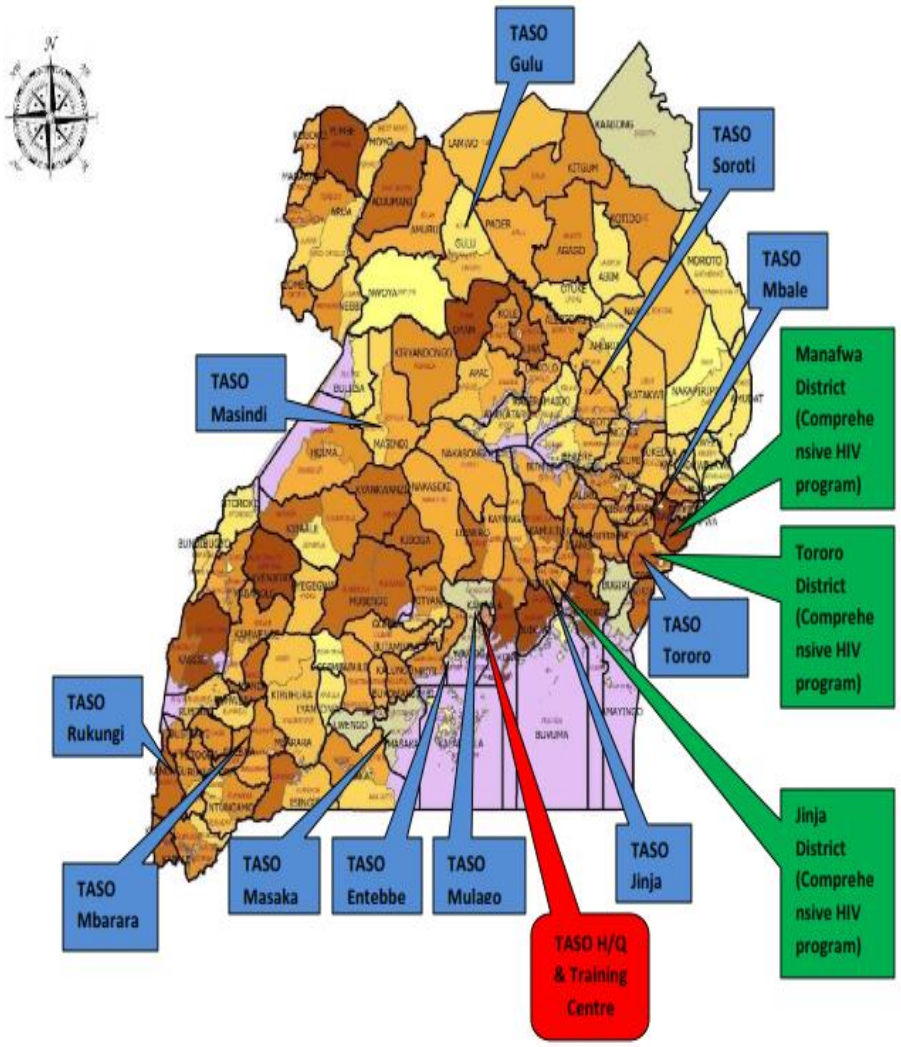
Outline

- Introduction
- TASO ART Implementation models
- Client monitoring
- Documentation and data
- Challenges
- Lessons learned
- Recommendations
- Way forward

THE AIDS SUPPORT ORGANIZATION
TASO

- **Founded in 1987** by 16 individuals personally affected by HIV and AIDS
- **Vision**: "A world without HIV and AIDS"
- **Mission**: To contribute to the process of preventing HIV, restoring hope & improving the quality of life of PLWHA & their families.
- Near 100,000 PLHIV cared for Annually; 66% on ART (TASO MIS)



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TASO ART Program

- Started in 2004; with PEPFAR support
- By March 2014, 63,360 PLHIV were on ART
  - 12% of patients on ART in Uganda (566,444)
  - 70% community ART provision; 30% facility based
- Increased enrolment of clients on ART:
  - congestion, reduced provider-patient interaction, increased LTFU, non-adherence, need for increased human resources

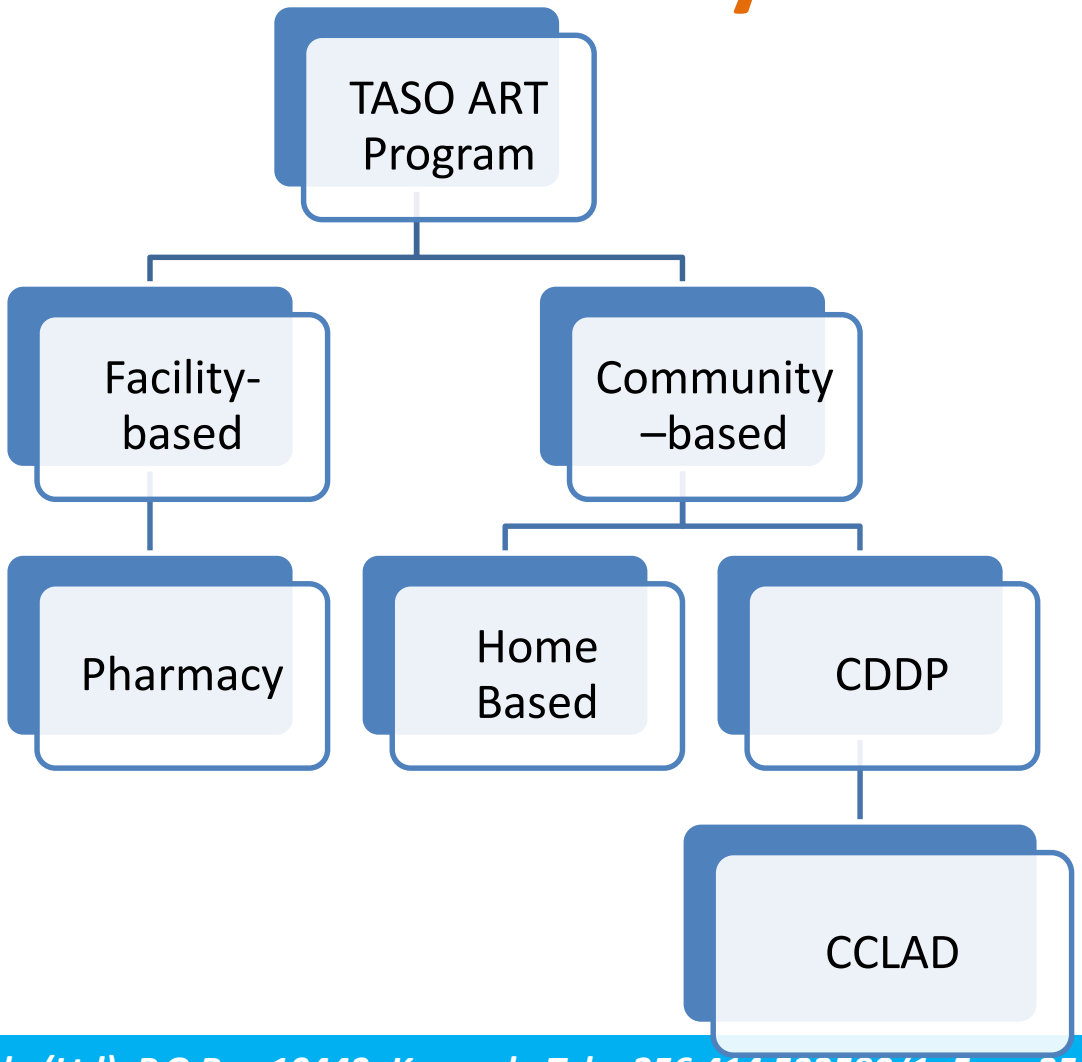
TASO ART Program

- TASO Jinja retrospective cohort study
  - Long term retention after 7 yrs at **69%,**
  - Improved clinical outcomes:
    - Loss to follow-up **16.5%** facility arm , **4.28%** at CDDP **p< 0.0001**
    - Average adherence **96.8%** for CDDP compared to ***95.6%*** of facility based, ***p>0.074*** for facility clients.
    - Fewer deaths were reported in the CDDP arm ***3.9%*** compared to facility with ***5.7%, p=0.008***
- MSF Community ART Group (CAG) in Mozambique-
  - Increased patient retention in care due to reduced costs
  - Incentive to patient involvement in own care
  - Strengthened social networks; enhancing adherence
- Similar experiences from Kitovu Mobile, Uganda

Rationale for TASO Community Models of ART Delivery

- Increase accessibility to ART
- Decongest facility service points
- Task shifting- Para providers
- Enhance clients' Involvement in monitoring adherence
- Maximize retention in care
- Sustainability

TASO ART Delivery Models



TASO Facility ART Delivery Model

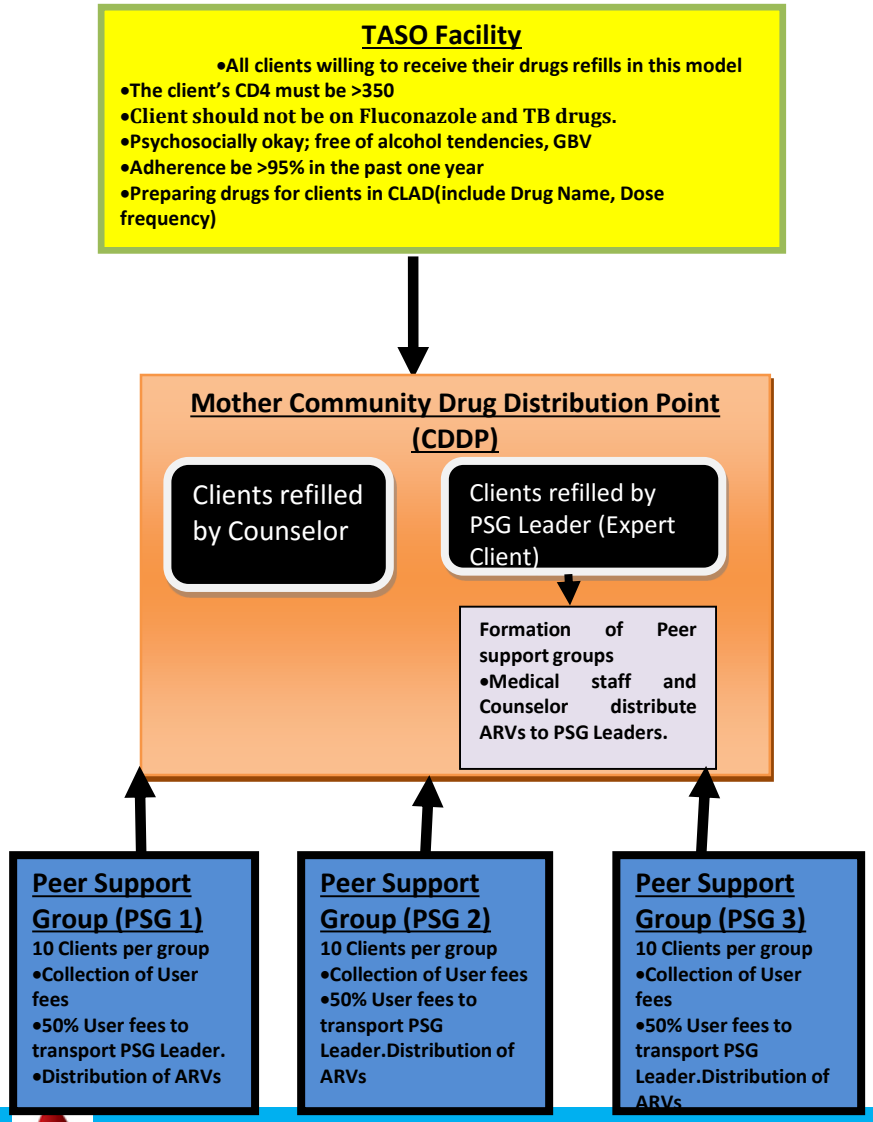
- **Pharmacy delivery model**
  - Takes care of clients
    - ≤ 10wks on ART
    - > 10wks but still require close clinical monitoring
    - Under psycho-social preparation
  - Children < 15 years
  - Adolescents
  - Clients who are not able to deal with Stigma and discrimination at community level

Community ART Delivery models

- **Community Drug Distribution Points (CDDPs)**
  - Lay worker led delivery
  - Assisted by Community ART support agents (CASAs)- Expert clients
  - Location: identified by clients served
  - Criteria for selection of clients
    - >10wks on ART
    - Clinically stable
    - Consented to community care
    - Adherence >95%

Community ART Delivery models

- Number of clients per CDDP – 30-60
- 2 monthly ART refills; drugs pre-packed basing on drug pharmacy pick list
- Monitoring done
  - 2 monthly review of basic parameters e.g. weight, HCG, TB screening, etc
  - 6 monthly-comprehensive evaluation (medical and psycho-social teams)



Community Client-led ART Delivery (CCLAD)

- An off-shoot of the CDDP
- Aims to address new challenges of congestion of CDDPs
- Beneficiary participation
- Inclusion criteria
  - ART >4 yrs
  - Clinically stable
  - CD4 >350 cells/ml
  - good adherence (over 95%)
  - Client consent

CCLAD Exclusion Criteria

- Children
- Pregnant women
- Adolescents
- Poor adherence
- CD4 consistently below 350 cells/ml for more than 5 months/poor response to ART
- Currently on Anti-TB treatment or Fluconazole
- Clients with Malignancies

The CCLAD Process

- Eligible clients are
  - educated about the model;
  - organized in peer support groups (PSGs) of 7-10 members;
  - Supported to select their group leaders (using a standard selection criteria);
  - oriented leaders about their roles;
  - identified ARV drug delivery points within their localities and
  - appointments set and ARV re-fills made

- Pre-packing of each patient's drugs and labeling of pre-packed drugs by name and unique identifier.

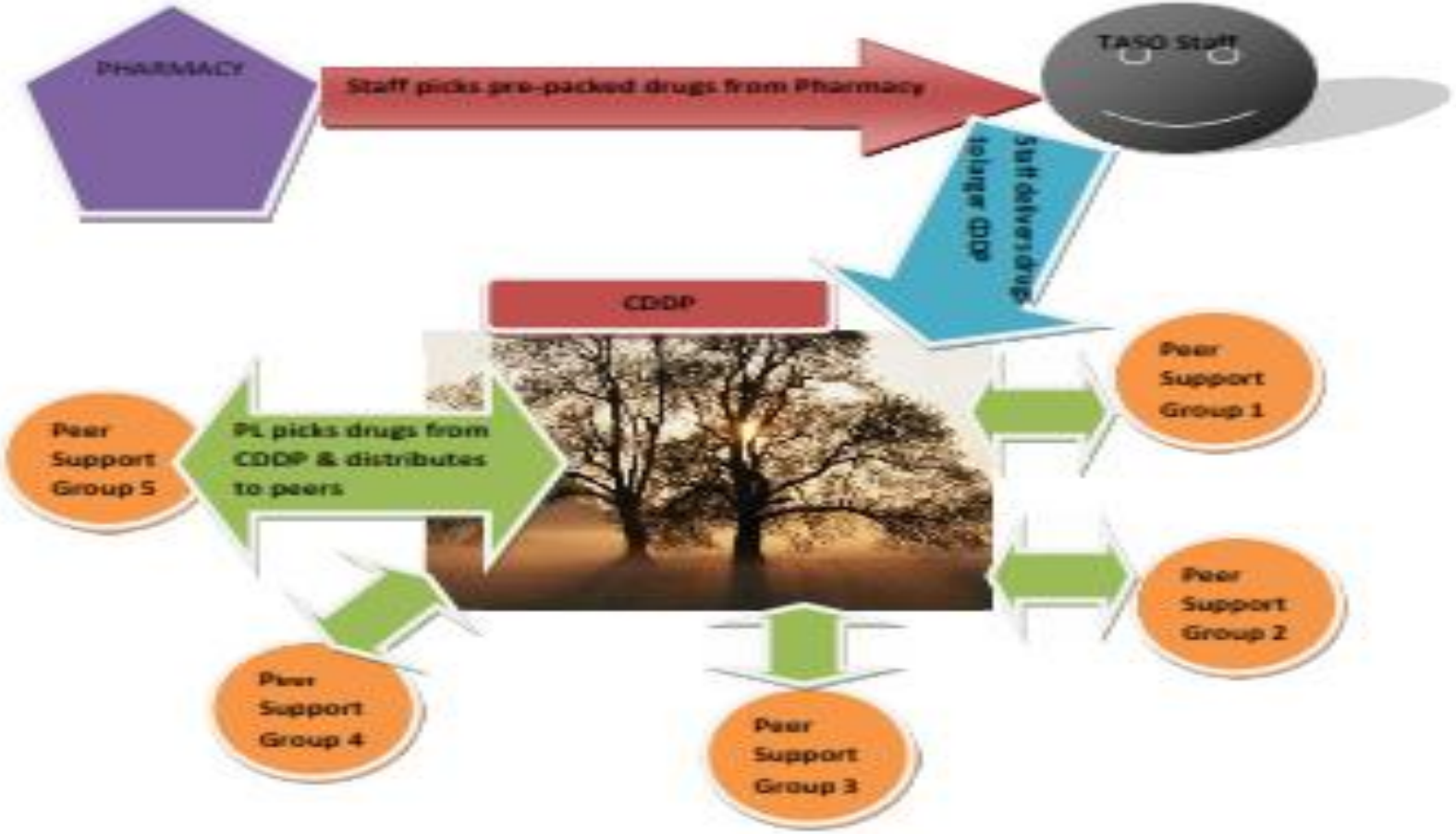
Figure . *A sample of pre-packed drugs*

The Process ……

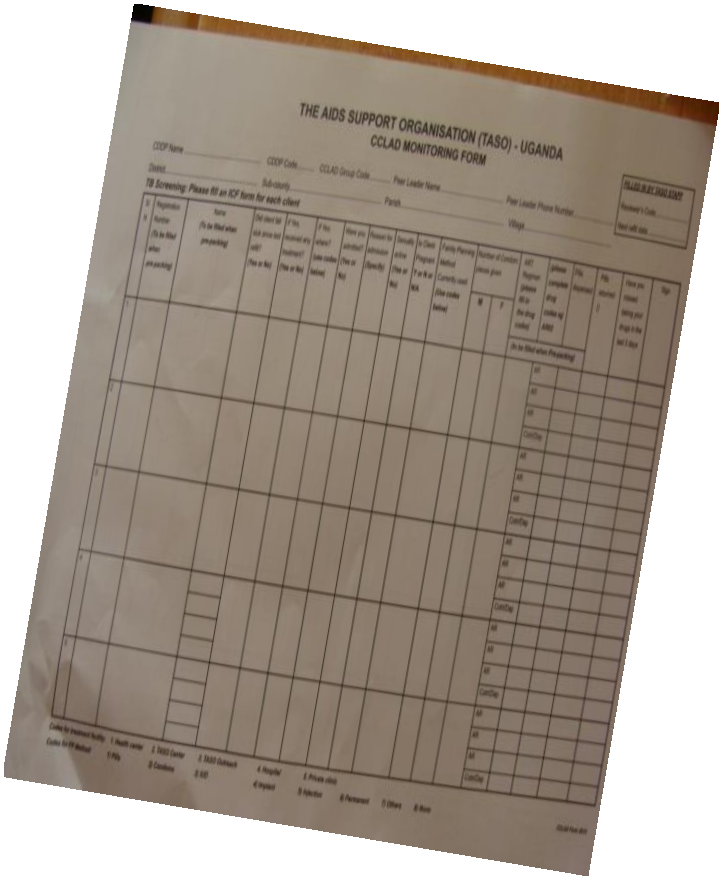
Figure . Juliet, a counselor in charge of Amungura 2 Community Drug Distribution Point (CDDP) in Tororo, Eastern Uganda giving a health education talk to clients before they divided up in their small peer support groups

- The leader picks and acknowledges receipt of the members' drugs from the health provider and ensures all the members acknowledge receipt on delivery.
- Patient monitoring is conducted monthly by Expert patients and counselors.
- 2 monthly re-fills
- 6 monthly clinical reviews
- Clients free to visit service delivery points

Process


PHARMACY
Staff picks pre-packed drugs from Pharmacy
TASO Staff
Staff delivers CDDP
CDDP
Peer Support Group 1
Peer Support Group 2
Peer Support Group 3
Peer Support Group 4
Peer Support Group 5
PL picks drugs from CDDP & distributes to peers

Data Management/Reporting



- One national M&E system (use of National data recording & reporting tools) maintained
- A simple data collection tool with key variables for Peer Leaders used
- Data is transcribed to the National ART register by Providers
- Group Leader fills the ICF form for TB Screening & brought to the mother CDDP for review by Clinicians & appropriate intervention

Successes to-date

- Willingness of PLHIV to participate- 60% of PLHIV were eligible for transition into CCLAD; 100% eligible were willing to receive their drugs through this model
- Patient waiting time for ART refills reduced averaging 30-45 minutes as opposed to 2 to 3 Hrs previously due to reduction in provider-patient ratio;
- Less transport challenges in collecting the drugs because of resources pooling
- Improved Adherence to treatment

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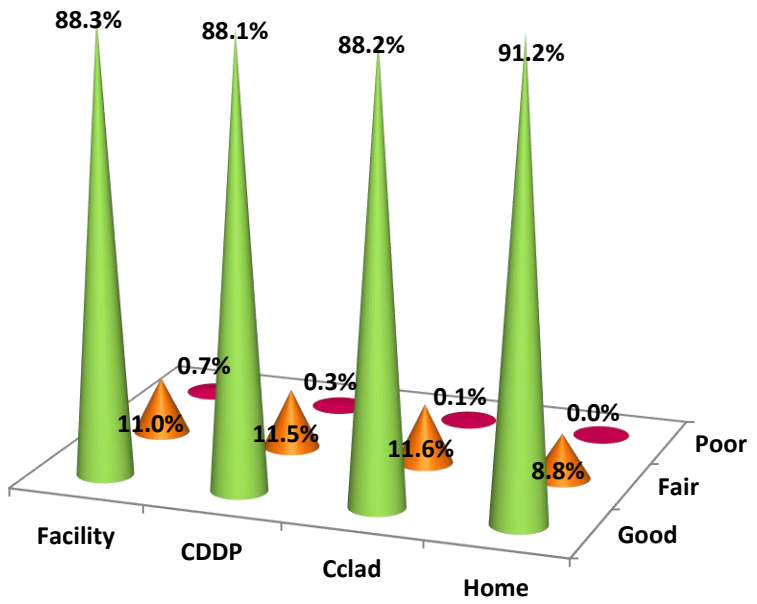
Adherence Level assessed at Last Encounter- Jan to Mar 2014

Adherence Level (3day recall)	Mode of ART delivery				
	CDDP	Facility	Home	CCLAD	TOTAL
Good (>=95%)	32405	20416	62	2470	55,353
Fair (85-94%)	4244	2531	6	325	7,106
Poor(<85 %)	128	166	0	4	298
TOTAL	36,777	23,113	68	2,799	62,757



$$Adherence = \frac{\text{no.of pills taken}}{\text{Total no.of pills expected to have been taken}} x100$$

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Successes…..

- Stronger networks – social safety net works through PSGs which provide peer psychosocial support;
- Efficiency gains- fewer fulltime health workers needed to distribute drugs
- Improved service quality considering client load; enhanced patient follow up and better care for new naïve patients
- Decongested drug distribution points
- More incentive for patients to manage own health

Challenges

- Not yet national policy so largely informal
- Overwhelming demand from patients
- Illiteracy of Peer Leaders
- Volunteering
- Inadequate data management and reporting for community health systems

Figure 4. *The Peer support group leader being coached on how to fill the data collection tool correctly*

Lessons Learnt

- Use of expert patients increases community involvement in ART- workload reduction on health workers, quality improvement, participatory M&E

- Patient participation improves adherence, retention in care & general improvements in health outcomes

- Patients can voluntarily contribute to costs related to their own health

- Use of community own resources ensures a robust health system with ability to deliver quality ART services in a sustainable manner

Recommendations/ Way forward

- Conduct cost-benefit Analysis for the community models – ongoing study with Population council

- As an emerging strategy, need to manage the new knowledge through strengthening community M&E systems, Research, knowledge sharing/dissemination

- Treatment programmes should harness the synergy of involving beneficiaries in delivery of ARV drugs especially in planning, implementation and M&E

Recommendations/ Way forward

- Clearly define expectations, roles and tasks to be performed by willing patients
- Governments need to provide guidance on working with patients in delivering ART in chronic care programmes
- Community Health Systems Strengthening should be an integral component of Health systems strengthening

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