Decentralization, Scaling out Antiretroviral Treatment to Health Centres in a Rural District in Malawi: Process, progress and lessons learnt after two years

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MSF-Belgium HIV/AIDS Programme

The Setting - Thyolo District, Malawi

Mainly rural population: > 575,000
Prevalence HIV at ANC: 20-22%
No. living with HIV/AIDS: 57,500
No. of advanced HIV/AIDS: 162,11,200
No. of Deliveries per year: 27,000
Main income: Employed by the Tea Estates

Health Services in Thyolo District

2 Hospitals (one district and one missionary)
10 health centres
5 missionary facilities
5 tea estate clinics
16 HIV testing sites (health-centre-based)
Strong network of community home-based care (CHBC)

Decentralisation of ARV treatment follow-up & ARV initiation at HC Level - Timeline

End of 2002: gradual introduction of "Pure" ARV HIV services in most of the health centres/clinics.
July 2004 – June 2005: "piloting" of ARV treatment follow-up in 7 health centres and later added 2 more health centres
- Mobile health services support team
- Formal and on-the-job training of health centre staff on OI management and ARV patient follow-up
June 2005 – July 2005: Re-design of decentralisation strategy and opted for accelerated to meet demand of national ART scale up
August 2005 – June 2006: Acceleration of decentralisation and started patient initiation on ARVs in three health centres

Rationale for decentralisation

- Follow-up of stabilised patients on HAART in health facilities closer to patients
- Support the scale-up of ARV by decenestralisation of hospitals thereby providing capacity for new patients initiation
- To reduce travel distance to hospitals and reduce financial burden for follow-up visit (cost & time)
- To support patients’ long-term adherence to ART
- To integrate patients on HAART into the community “Continuum of Care Model”

Process

- 9 health centres selected based on set criteria
- Train staff (Medic. Assist. & Nurses) on OI management and follow-up of patients on first-line ART (certified by MoH)
- Health Surveillance Assistants (HSAs) trained to manage patient registration, adherence counselling and patient follow-up

Set criteria agreed between District Health Officer (DHO) and MSF on health centres selection:

- Available staff (Medical Assistant/Nurse)
- Counselling and Testing service available
- Selected HCs must be far distance away from main ART clinics (Thyolo & Malawila Hospitals)
- At least 2 rooms: 1 for consultation and 1 for counselling and ARV drug dispensing
- Safe storage for drugs: ARVs & essential OI drugs
- Site can follow simple monitoring and evaluation tools (eg: master card)

Selection Criteria of Patients for Decentralisation

1) Must be adult or older child (>25 kg on 1st line ART regime (Tenofovir 3 x 12.25 mg)
2) No OI drug intolerance
3) Counsellors have confidence that patients can adhere
4) Patient coming from faraway place not close to the two mother hospitals

Preparation:
- One week beforehand MSF HC support team get patient names from main ART clinic booking diary
- Special ART diary needed for each HC
- Patients book in advance

Records:
- MSF team keeps copy of MoH master card (original kept in Thyolo Hospital)
- Data is transferred to Thyolo master Card
- MSF Fuchsia follow-up form filled in during HIV ART clinic and entered in database at Thyolo Hospital, and

CD4 Count* Profile for Decentralised Patients

<table>
<thead>
<tr>
<th>CD4 Counts</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 250</td>
<td>778</td>
<td>83%</td>
</tr>
<tr>
<td>250-350</td>
<td>144</td>
<td>15.4%</td>
</tr>
<tr>
<td>&gt; 350</td>
<td>51</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Total Number: 937

Acceptability

<table>
<thead>
<tr>
<th>Reason</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have not shown up yet at HC for follow up</td>
<td>69</td>
</tr>
<tr>
<td>Defaulted</td>
<td>11</td>
</tr>
<tr>
<td>Died</td>
<td>44</td>
</tr>
<tr>
<td>Accepted to be decentralised but continue follow up at Hospital</td>
<td>129</td>
</tr>
</tbody>
</table>

Out of 937 patients decentralised by ARV counsellors at TDIH, 608 visited the HCs leaving 129 who did not visit. Five of these died due to severe complications.

Lessons learnt: Observations and Challenges

- 4 patients with side effects
  - Hypnotic unpleasant effects (2 cases)
- 4 deaths
  - 1 defaulters, 1 x transfer out
  - Positive patients' staff feedback but slow pace in 1st year (long time in need to time)
- No storage of ARV drugs allowed in HC
- Retaining trained MoH staff in HC
- Lack MoH drugs for OIs in HC
- Access to health passbooks of dead patients

Conclusions and Recommendations

ART decentralisation is necessary, feasible and convenient to patients (preliminary outcomes positive).
Slow response first year but better uptake in second year.
Needs simple, supportive monitoring, supervision.
Well-prepared HC can become initiation site.
ART and follow up should be one of an integrated full HIV-care package including community care.

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