

Ensuring the difference between life and death: MSF's experience with differentiated models of HIV care during conflict, Zemio, Central African Republic

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Introduction

MSF has been providing HIV care in Zemio, Central African Republic (CAR) since 2010; in November 2016, two differentiated service delivery (DSD) models for HIV care were initiated with the Ministry of Health (MoH). DSD models involved patients attending community antiretroviral therapy groups (CAG's) and pharmacy fast-track models (PFT's). For both models, patients visited health facilities less often, and managed their health more autonomously in groups (CAGs) or alone (PFT). In June 2017, violence displaced much of the population and MSF started providing remote support. We aimed to document outcomes and patient perceptions within DSD models.

Methods

We retrospectively analysed quantitative routine patient data within the programme from November 2016 to December 2019, conducting descriptive analyses of treatment outcome and viral load test (VLT) results. Additionally, we did semi-structured interviews with patients selected using convenience sampling, to monitor programme implementation from April-December 2018. Data were collected using a short interview form completed by MoH staff, and a content analysis approach was used to code, categorise and interpret text data.

Ethics

Quantitative data collection fulfilled the exemption criteria set by the MSF Ethics Review Board (ERB) for a posteriori analyses of routinely collected clinical data, and thus did not require MSF ERB review. Qualitative data collection was conducted with permission from Sidney Wong, Medical Director, Operational Centre Amsterdam, MSF.

Results

DSD models enrolled 1511 patients; 1,180 within 77 CAG's; 331 within PFT. For CAG's, by December 2019, 1,070 (90.7%) patients were labelled active, 47 (4.0%) were lost to follow-up (LFU), 61 (5.2%) had died, and 2 (0.2%) had been transferred. In PFT, 137 (41.4%) patients were labelled active, 167 (50.5%) were LFU, 25 (7.6%) had died, and 2 (0.6%) had been transferred. Between 2017 and 2019, among patients in CAG's, 56.9% (672/1,180) received VLT, and 76.3% (513/672) were suppressed. Among patients in PFT's, 23.3% (77/331) received

VLT, and 53.2% (41/77) were suppressed. 79 interviews were conducted with CAG patients and leaders. Reported challenges for CAG leaders included travel difficulties hampering drug collection; dispersal of CAG members; payment of armed groups during travel; and insecurity fears. Issues for CAG members included drug stock-outs; organisational issues; ill-health or opportunistic infections, and lack of healthcare and food. Reported advantages of CAG's included continued medication supply, reduced travel burdens, solidarity and support, and survival.

Conclusion

Retention in DSD's, and virological outcomes within CAG's were encouraging, with suppression rate of 76%; higher than the regional average, around 39%. PFT patients did less well. However, VLT was not conducted systematically, and patients who were tested might have been more adherent because they were better followed up. While patients faced substantial challenges, CAG's mostly continued to function, many perceiving this as ensuring the difference between life and death. Our analysis is limited by difficulties accessing patients and collecting data during acute conflict but provides unique data from CAG programmes operating during active conflict.

Conflicts of Interest

None declared.

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