

Universal access and upholding adherence in rural Malawi:

the contribution of task shifting to more effective ART delivery at Health Centres

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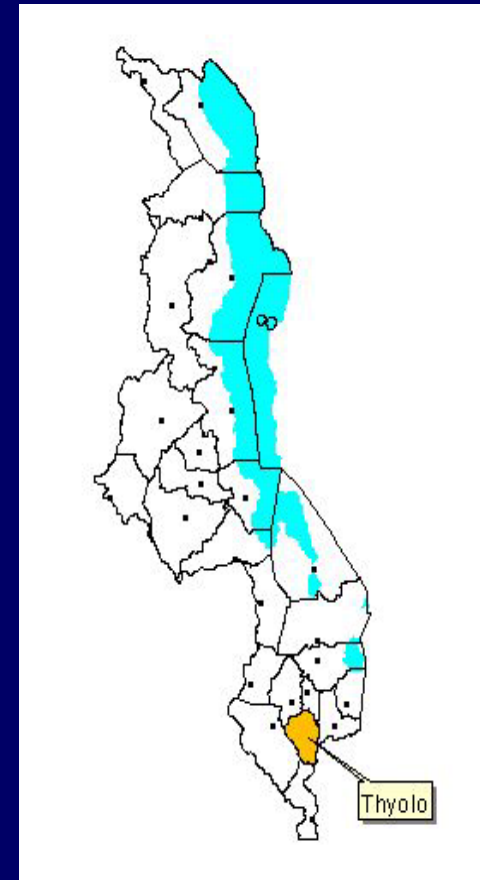
Background

Malawi

Population	± 12 m
HIV infected	± 900,000
Needing ART	290,000
Started ART	141,449 <i>Dec 2007</i>

Thyolo District

Population	± 600,000
HIV infected	± 60,000 (10%)
Needing ART	± 9-12,000
ART	13,702 <i>June 2008</i> <i>“Universal Access”</i>



HR Shortages in Malawi

- **Vacancies:** Nurses: 55%,
Doctors: 45% (*MoH, 2007*)
- Main cause of attrition (44%): HIV/AIDS related illness/death
(*MoH, 2005*)
- Uneven distribution of staff (20% of doctors in rural areas)
- High workload (150-200 consultations/day for MA in Thyolo)

	Malawi	Thyolo District	WHO <i>recommendation</i>
Doctors	1.2	1.3 (1.6)	20
Nurses	28	17 (25)	100

Doctors/nurses p/100,000 population (in brackets, MSF staff added)

Thyolo HIV/AIDS project

- National Universal Access goals in Thyolo, but ± 7000 new patients/yr
- If MD based model used in Thyolo from start of scale-up \rightarrow need for **9.7 FTE MD**
 - 50 MD graduates per year in Malawi (2007): 20% of these
 - Calculation scale up to 10,000 pts \rightarrow need 27 nurses (25% graduates 06)

\rightarrow Less HRH-intensive approach was needed

- **Problems for programs and patients:**
 - Overcrowded ART clinics
 - Decentralisation to Health Centres: less staff & less qualified
 - High staff turnover

*Task shifting **as part of** overall strategy to continue pace of ART scale up and maintain UA with good outcomes.*

Approach in Health Centres

Task shifting	Other measures
<p><u>VCT</u> by lay counsellors (# tests increased from 15,000 in 2003 to nearly 78,338 in 2007)</p>	<p>Increase # of testing sites Opt-out testing strategy</p>
<p><u>ART</u></p> <ul style="list-style-type: none">•Initiation by Medical Assistant•FU by lay counsellors (adherence support + ARV refill)•Dispensing to be shifted to pt attendant	<ul style="list-style-type: none">•Decentralisation of ART initiation & FU to health centres•Simplify & standardize protocols•Reduce # visits for stable pts•Reduce steps pre-ART initiation•“Track system”

“Track System”-

more efficient patient flow by categorizing patients

**Screening & track allocation
by HSA**

Opp.infections,
side effects,
ART initiation
& early ART FU

Stable patients:
counselling
& drug refills

Slow track

*Medical assistant
(nurse?)*

Fast track

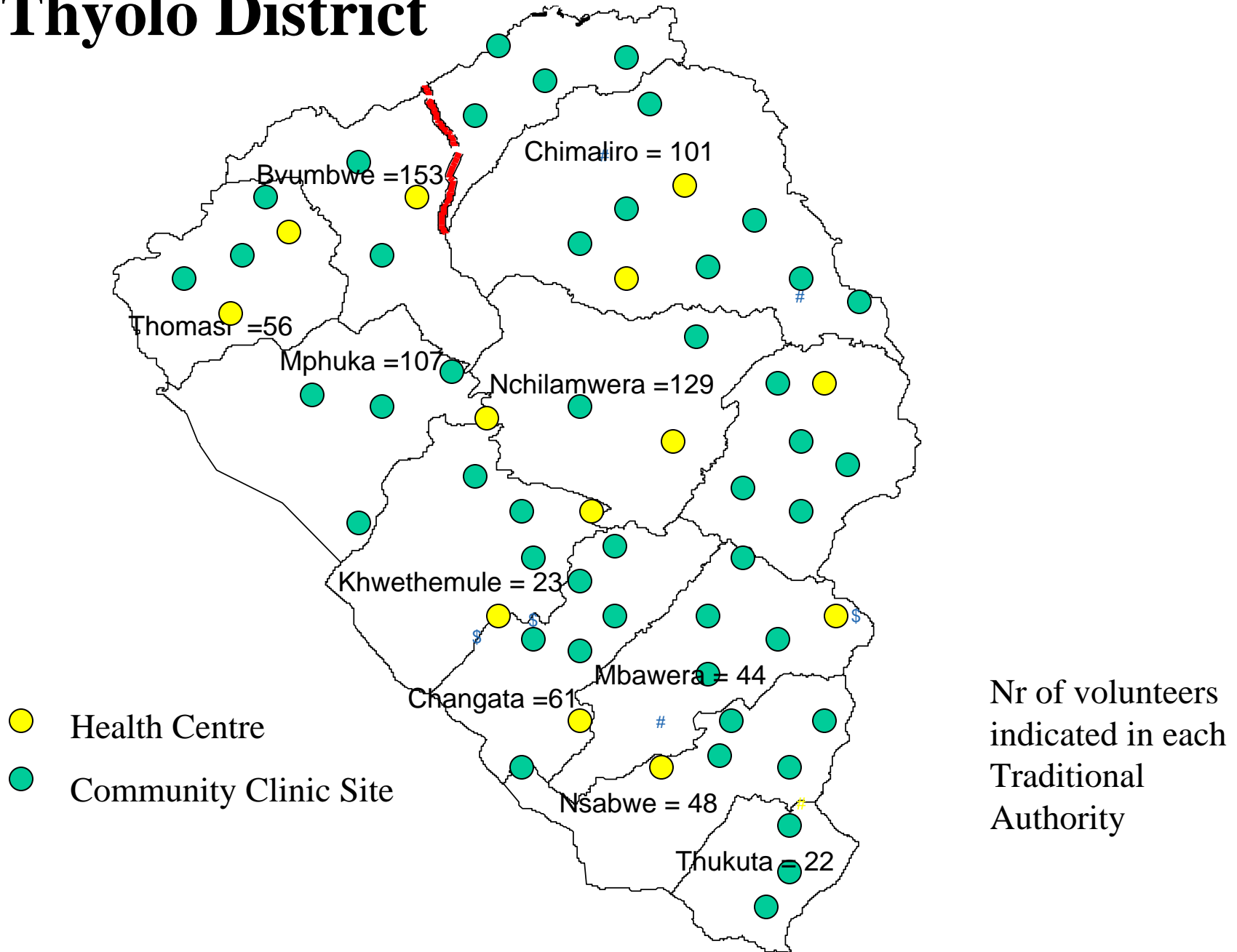
*Lay counsellor
PLWHA
HSA*

*Supervision and support
by Doctor/Clinical officer*

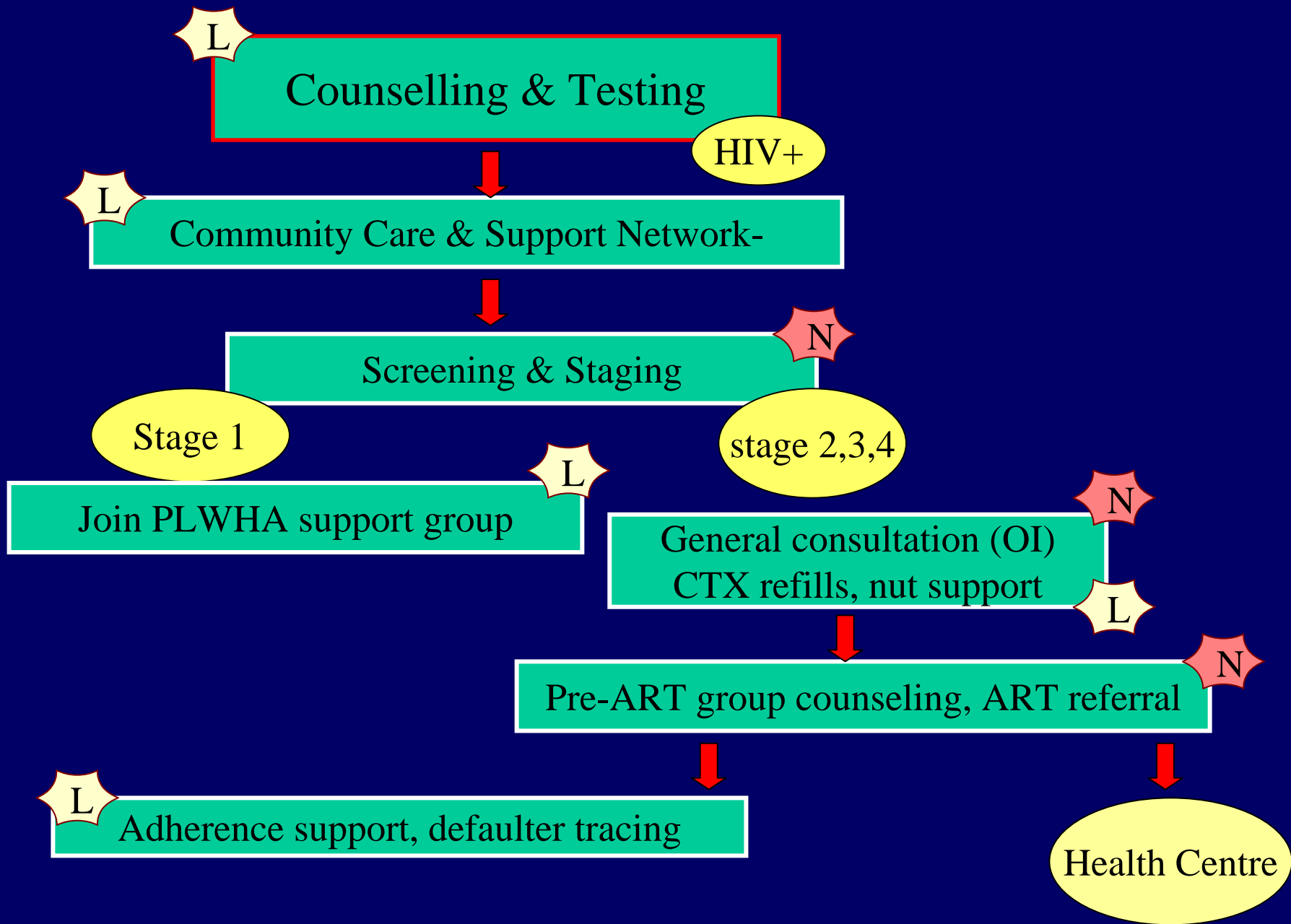
Approach in Community

Task shifting	Other measures
<u>Community nurses:</u> Screening/clinical staging, pre-ART group counseling, OI's, CTX, nut care	Reduce # of visits to HCs
<u>Volunteers/PLWHA:</u> Pre-packing of drugs, registration, pt mobilization, pt referrals	Community empowerment in ART
<u>Volunteers/PLWHA/Support Groups</u> Defaulter tracing, adherence support	Support long term adherence

Thyolo District



Patient Flow in Community Care Programme

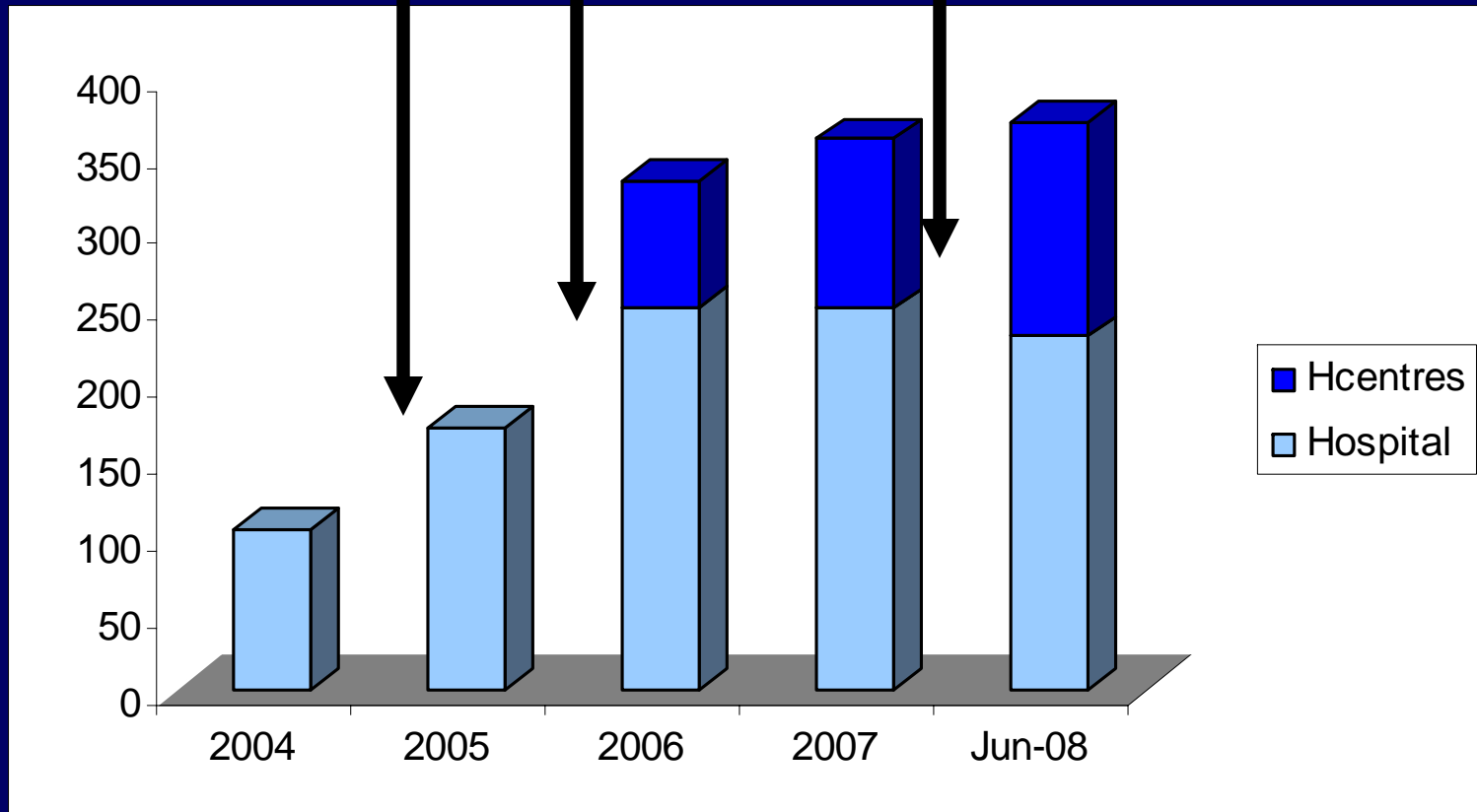


RESULTS Clinical care: ART: New inclusions/Month (2 hospitals, HCs)

“Partial” task shifting
to medical assistants

Task shifting to medical assistants, nurses & PLWA’s in HCs

7 health centres ++



Thyolo District

Overall 13,702 ever started on ART, of which 10,360 (77%) retained on treatment

Comparative analysis hospital / health centers

	Hospital <i>(June 06-June 07)</i>	Health Centre <i>(June 06-June 07)</i>	P-value
Ever started on ART	2,904	1,170	
Retained	2,463 (84.9%)	999 (85.4%)	<0.001
<i>Alive & Active</i>	82.1%	85%	<0.001
<i>Transferred out</i>	2.7%	0.4%	<0.001
Attrition	439 (15.1%)	171 (14.6%)	0.5
<i>Died</i>	7%	12.8%	<0.001
<i>Defaulted</i>	7.8%	1.5%	< 0.001
<i>Stopped</i>	<0.4%	<0.3	0.6

ART outcomes (Dec 2004)

	Community care <u>YES</u>	Community care <u>NO</u>	
Placed on ART (n-1634)	895	739	
• Alive & on ART	856 (96%)	560 (76%)	<i>P<0.001</i>
• Died	31 (3.5%)	115 (15.5%)	<i>P<0.001</i>
• Loss to follow up	1 (0.1%)	39 (5.2%)	<i>P<0.001</i>
• Stopped	7 (0.8%)	25 (3.3%)	<i>P<0.001</i>

Better standardized outcomes among pts on ART receiving community support, than those without

Results

Increased access and reducing workload for HC/hospital:

- UA objective achieved in 2007
- Contribution community network:
 - Pts counselled (stage 3,4) & referred for ART initiation: **±250 p/m** (2007)
 - Number of consultations p/month: 1400-2000 (2007)
 - **71%** of pts on ART under community care:
Coverage allows enhancing adherence

Human Resources needs

- with re-organisation/task shifting approach: 7 nurses extra
- **For 1000 patients on ART: 4 FTE** (*in hospital*)
- **Volunteers used p/community clinic day – 5-8**
- **±3 community nurses needed for referrals of 1000 pts to be initiated on ART (per yr) (further task shifting possible).**

Opportunities

- Feasibility UA for ART in a resource poor, high prevalence country
 - without adding too many HRH
 - without losing quality
- Task shifting within facility and to community to volunteers & HSA:
 - relieved workload from clinic staff,
 - eases access and adherence
- Involvement of motivated PLWHAs /volunteers/ community in HIV/AIDS activities is **key**

Challenges

- Public health services vs Community burden:
 - Not replacing clinical work but complement and expand it
- Next step: nurses initiating ART- but what about overload nurses?
- Who will provide support package & close supervision? (start up & continued)

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