Side Meeting - Service Delivery 2

Good health practice principles for service delivery of hepatitis B and C testing, prevention and treatment

Friday 3\textsuperscript{rd} November
7.30-9am
Chagal
Goals and session objectives

• **Goal:** To produce practical *WHO guidance on service delivery* for chronic hepatitis B and C infection for mid 2018

• **Two sessions at WHS 2017:**
  - **Session 1 (Wed 1-2pm), Matisse:** Specific populations – implementation considerations
  - **Session 2 (Friday 7.30-9am), Chagal:** Good service delivery health practice principles

• **Session Objectives:**
  - To briefly review existing WHO and other guidance
  - To seek feedback from range of Summit participants (policy makers, implementers and civil society)
  - To see good practice examples from range of settings
Simplified HCV Service Delivery for a Public Health Approach

Good service delivery health practice principles

1. **Simplified and standardized algorithms**
2. **Strengthen Linkage** from testing to care, treatment and adherence
3. **Integrated** testing, care and treatment +
4. **Decentralisation of care** where appropriate to promote access +
5. **Differentiated care** to address diverse health care needs of those with HCV/HBV
6. **Engagement with Community** and peer support

‘SLIDE’

Service delivery in specific populations

- Persons who inject drugs
- People in prisons and other closed settings
- MSM and sex workers
- Adolescents and Children
- Migrant/indigenous populations
- Pregnant women

More efficient procurement + supply management
## Agenda

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<tr>
<td>1. Overview of proposed WHO service delivery good practice principles for viral hepatitis care</td>
<td>Philippa Easterbrook (WHO HQ)</td>
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<td>2. Integrated testing with HIV and TB</td>
<td>Jean Damascene (Rwanda)</td>
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<td>3. Integrated diagnostic platforms</td>
<td>Francesco Marinucci (FIND)</td>
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<td>4. Integrated and differentiated care</td>
<td>Fumi Lesi (Nigeria)</td>
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<td>5. Decentralisation and task shifting</td>
<td>RadhaKrishan Dhiman (India)</td>
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<td>6. Community Engagement</td>
<td>Giten Khwairakpam (TreatAsia, Thailand)</td>
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1. **Simplified testing, treatment and monitoring algorithm**

**1. Single quality assured RDT**

**2. Prompt or reflex HCV RNA or core Ag**

**3. Assess and triage: Stage liver disease using NITs (APRI, FIB4, TE)**

**4. Treat All with Pan-genoptypic regimens**

**5. One-step monitoring One test of cure SVR12**
2. **Strengthen linkage**  
(From 2017 WHO testing guidelines)

Strategies to consider for increasing uptake and improving linkage

Existing recommendations based on systematic review (Lancet ID 2016)

- **Trained Peer and lay health workers in community settings (and for treatment and adherence)**
- **Clinician reminders** to prompt provider initiated, facility-based testing
- **Testing (and treatment) as part of integrated services** at a single facility, especially within mental health/drug treatment services
- **On-site or immediate RDT testing** with same day results
3. Integration

Integration with other testing services or opportunities e.g. HIV, antenatal or TB

Integrated combo serology (HIV/HCV RDTs), including self-testing

Use of integrated multi-disease platforms for HCV RNA (centralised or decentralised)

HCV care at harm reduction sites

HCV/HBV care at HIV clinics

HCV care in prisons

Build on substantial existing HIV/TB capacity

Integrated information systems
4. Decentralisation/Task-shifting

**Models:**
- Hub and spoke
- Mobile outreach
- Visiting team to site
- Others…..

**ENABLERS OF DECENTRALISATION**

- Community and peer support:
  - Awareness raising

- HCW Training and mentorship:
  - Training courses and curricula
  - Distance support - ECHO
  - Other – Whats App

- Integrated information systems
  (enhanced sample referral system, connectivity, SMS results)
### 5. **Differentiated care**
( based on evolving HIV care and treatment principles)

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<td>Persons clinically well and stable</td>
<td>Standard care package: Counselling, adherence support, treatment initiation and monitoring</td>
<td>Facility-based including primary care or community-based settings, including mobile/outreach</td>
<td>Physician or nurse</td>
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<td>Advanced liver disease or serious co-morbidities, HCC, previous treatment failure</td>
<td>Requiring more intensive clinical support and follow-up: Management of liver related complications (eg. variceal bleed, ascites, encephalopathy, HCC treatment, genotyping)</td>
<td>Facility-based - hospital</td>
<td>Physician</td>
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<td>Mental health issues, active injecting drug users, alcohol misuse, adolescents</td>
<td>Requiring more intensive psychosocial/mental health support</td>
<td>Can be Facility-based or Community-based, Harm reduction site</td>
<td>Physician and counsellor/peer support</td>
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Overall framework of service delivery approaches

– Is the SLIDE (Simplified, Linkage, Integrated, Decentralised, Differentiated, Engagement) framework the right one?
– Are there are other key elements to include?
– Is the framework of core practices (SLIDE) followed by implementation considerations in specific populations the right one?
Discussion topics

1. Simplified algorithm:
   – Can we simplify further?

2. Linkage and adherence support:
   – Other strategies for linkage and adherence support?

3. Integration
   – What are the priority areas for integration?

4. Decentralisation and Task-shifting
   – What are the best models of decentralisation to promote?

5. Differentiated care:
   – What is diversity of health care needs of persons with HBV/HCV infection
   – What are the clinical and other considerations for differentiated care eg. decompensated cirrhosis, significant co-morbidities (renal disease), treatment failure, HBV co-infection)?