

Decentralized Drug Distribution in Democratic Republic of the Congo: Final Report

Background

Democratic Republic of the Congo (DRC) has begun adopting differentiated service delivery (DSD) models to make services for people living with HIV more convenient and client centered. Stable clients are increasingly enrolled in three- to six-month multimonth dispensing (MMD), with a majority of those who are stable receiving antiretroviral therapy (ART) through the facility fast-track model, community ART groups (CAGs), and community distribution points (PODIs). However, many clients continue to get their ART at crowded government health facilities. During the COVID-19 pandemic, there was an urgent need to decongest health facilities and ensure uninterrupted ART for people living with HIV, as well as maintain a safe health care environment for clients and staff. In that context, Meeting Targets and Maintaining Epidemic Control (EpiC), a global project funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID) led by FHI 360, received Headquarters Bridge Funding (HBF) to support the rollout of decentralized drug distribution (DDD) models in several countries during FY20/FY21, including in DRC. Under the leadership of the Programme National de Lutte contre le VIH/SIDA (PNLS), and in close collaboration with PATH/Integrated HIV/AIDS Project (IHAP-HK), a USAID clinical partner, EpiC supported the distribution of ART through private pharmacies (PPs) in eight health zones in Haut-Katanga Province from June 2020 through March 2021 to complement existing models. This brief summarizes the key achievements of the EpiC project's DDD initiative in DRC.

Accomplishments

STAKEHOLDER ENGAGEMENT

Numerous stakeholders were involved in the introduction of the DDD private pharmacy model in DRC, and each played an important and specific role:

- All government units at the national and provincial level including PNLS, Direction Provinciale Santé (DPS), Inspection Provinciale Santé (IPS), and the heads of health zones provided leadership on all activities conducted and gave valuable input into the assessment designs and trainings.
- The USAID clinical partner in the covered health zones, IHAP-HK, helped with the development and execution of the implementation plan.

EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobe Group. For more information about EpiC, including the areas in which we offer technical assistance, click [here](#).

- Two associations of people living with HIV in Haut-Katanga representing the beneficiaries provided guidance on implementation.
- The Association of Pharmacies in Haut-Katanga brought together PPs to participate in the model.
- USAID DRC provided guidance on all project activities.

BASELINE ASSESSMENT

Pharmacy Assessment

Pharmacies across Haut-Katanga were assessed to identify the PPs that were willing and had the capacity to dispense antiretrovirals (ARVs) based on the criteria in Box 1. The FHI 360 team developed a pharmacy assessment questionnaire in collaboration with PNLs. Thirty data collectors received a one-day training on using the questionnaire to assess 957 PPs located in the eight health zones targeted by the DDD project in Haut-Katanga. (See Table 1 for the distribution of PPs across health zones.) Of the PPs assessed, 384 (47%) had the requisite infrastructure (security 92%, storage space for ARVs 65%, and private area for counseling 83%) and were willing to participate. However, only 200 (21%) met the selection criteria set by the project. Based on the geographic distribution of stable people living with HIV across Haut-Katanga, 30 PPs were selected for the initial rollout.

Box 1. Selection criteria for pharmacies to dispense ARVs

- Registered with a valid license
- Managed by a pharmacist or trained health professional
- Near a health facility with a medium volume of ART clients (IHAP Haut-Katanga supports facilities with a high volume of ART clients to refer cases to PPs as appropriate)
- Located in an accessible area close to many clients' homes
- In operation in the area for more than 12 months
- Operates after 5 p.m. and on weekends
- Willing to participate in DDD and agrees to sign an MOU with the health facility supported by IHAP/Bureau Centrale de la Zone
- Has adequate space to ensure confidentiality
- Agrees to collect and regularly report requested data on the services offered (ARV dispensing, co-trimoxazole, intensive phase of isoniazid, pre-exposure prophylaxis, HIV self-testing)

Table 1. Distribution of private pharmacies across the eight health zones

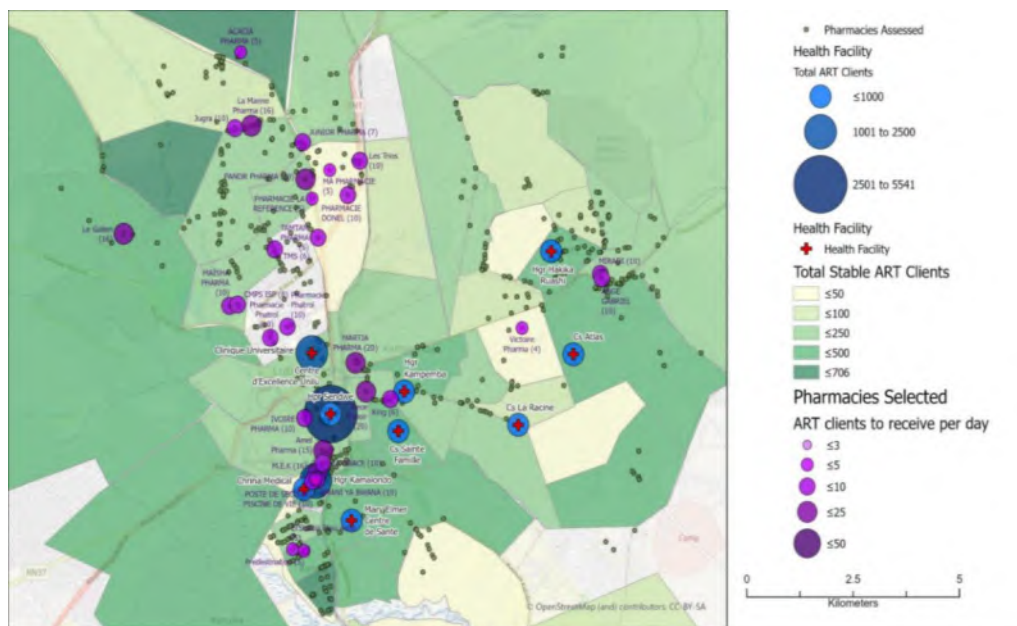
Location of PPs by Health Zone		n	%
1.	Lubumbashi	295	30.8
2.	Ruashi	158	16.5
3.	Kampemba	147	15.4
4.	Kenya	110	11.5
5.	Sakania	104	10.9
6.	Kamalondo	55	5.6
7.	Panda	51	5.3
8.	Kapolowe	37	3.9
Total		957	100

Facility Assessment

EpiC conducted a rapid assessment of 15 health facilities to document the burden of ART provision on facilities and identify priority health facilities for decongestion. The rapid assessment of facilities focused on those with a high volume of stable people living with HIV. The EpiC DRC team used registration information for clients enrolled at 15 health facilities—serving more than 16,000 stable clients—and then mapped them with selected PPs to identify the PPs in convenient locations. The goal was to identify PPs near clients’ homes to reduce travel times and associated costs. The leadership of the 15 health facilities assessed had favorable opinions of the PP model.

Using GPS coordinates of assessed PPs, health facilities, and health zones, maps were generated that allowed the identification of pharmacies that would reduce travel times for the most clients (Figure 1).

Figure 1. Map showing volume of ART clients by location



BUSINESS CASE DEVELOPMENT

Fee negotiation and signing of memoranda of understanding (MOUs)

To facilitate collaborative implementation and affirm roles, the parties involved signed an MOU. The MOU clarified the roles and responsibilities of each party and stated their agreement to adhere to the conditions listed in the MOU. For the first phase of implementation, MOUs were signed between 30 PPs, 17 health institutions, and the eight health zones under the leadership of IHAP-HK. The MOU indicated that a fee equivalent to US\$1 would be paid to each PP per refill (see Annex for MOU). This rate was negotiated with the pharmacies and matches the fee allocated within other DSD models implemented by IHAP but will be reviewed and revised periodically throughout scale-up. As the number of clients devolves and the number of participating pharmacies increases, the administrative fee per refill can be renegotiated to be decreased.



PNLS and DDD DRC team members at a ceremony to provide medical blouses, filing cabinets, and tablets to PPs. Photo credit: khan kankomba

Strengthening collaboration and partnership with PPs

Based on discussions, key stakeholders agreed that the expansion of the DDD PP model must leverage existing PPs and enhance their contribution to the country's HIV response. Therefore, in addition to capacity building, EpiC gave logistical support to PPs by providing filing cabinets with locks to ensure safe storage of drugs and confidential registers, medical blouses for staff, and tablets to support client follow-up and tracking and accurate reporting of data in real time.

CAPACITY BUILDING AND DEMAND CREATION

Training of staff on the PP model and data reporting

Under the leadership of PNLS, and in collaboration with EpiC DRC and IHAP-HK staff, 65 individuals representing key stakeholders were trained in the PP model (Table 2). Because of the COVID-19 pandemic, the training was broken into three sessions held on three separate days to minimize the number of participants in one room and adhere to social distancing

guidelines. The training covered basic HIV knowledge, ART dispensation, the monitoring and evaluation (M&E) system, and how all parties would work together to implement the PP model.

An additional three-day training was conducted for participating PPs on the use of DHIS2 e-Tracker for DDD data reporting and follow-up of clients using the provided tablets. Afterward, M&E project staff provided individual coaching. All service providers were asked to submit the collected data by email or short message service (SMS). Communication fees were paid to facilitate data reporting.

Table 2. Staff trained in the PP model of DDD

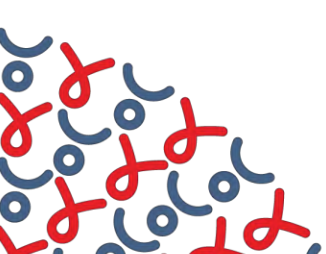
Staff Trained in DDD PP Model	n
PP staff	40
Health facility staff	17
PLHIV association staff	4
Private pharmacy associations of diplomaed pharmacists	4
Total	65



Training session on DDD with key stakeholders Photo credit: khan kankomba

Develop information, education, and communication (IEC) materials on ART DDD models

Under the direction of a team led by the head of the PNLS communication unit, and in collaboration with IHAP-HK, the EpiC DRC team conducted a five-day workshop to inform development of IEC materials to promote the PP model. As part of the workshop, the team conducted three focus groups—one each with health providers, people living with HIV, and community staff—then synthesized findings and identified key messages and overarching communication objectives. At the end of the process, attendees agreed on the template for



posters and flyers. EpiC supported the finalization of the IEC materials, translated them into four local languages, and distributed them in collaboration with IHAP-HK.

Figure 2. IEC poster (left) and flyer with the PP list (right)



Sensitization sessions of health providers on DDD PP model

A three-hour orientation session was organized for 207 health providers working with various health facility entry points (e.g., tuberculosis section, antenatal clinics) in the 17 health facilities involved in the pilot exercise. During the orientation session, the existing DDD models already in place in DRC were reviewed, and detailed information was provided on the new PP model and its advantages for clients. This session provided an opportunity to distribute the new IEC materials to help with the promotion of PP services and to guide key messages for the health providers.

Key Results

Enrollment in the PP model of people living with HIV started in late December 2020. By the end of March 2021, 368 clients had signed up for the PP model (Figures 3 and 4).

Two months into implementation of the DDD PP model in DRC, a survey was conducted to collect feedback from clients. More than 180 participants completed the survey, which assessed the following:

- The impact of DDD on the people living with HIV enrolled in the PP model in terms of time savings, transport costs, and other experiences
- The results of demand-creation activities/IEC materials, how people living with HIV learned about the PP model, and how and when they enrolled
- The quality of ART dispensation at the PPs, client suggestions to improve performance, and their opinions on the PP where they received ART
- The satisfaction level of clients enrolled in the PP model and whether they would recommend or had recommended the PP model to their peers

Figure 3. Number of ART clients receiving services through PPs by health zone, December 2020–March 2021

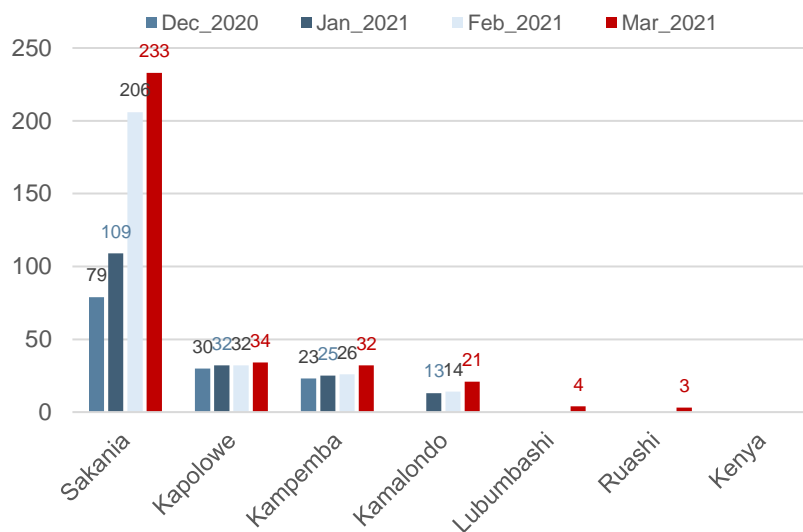
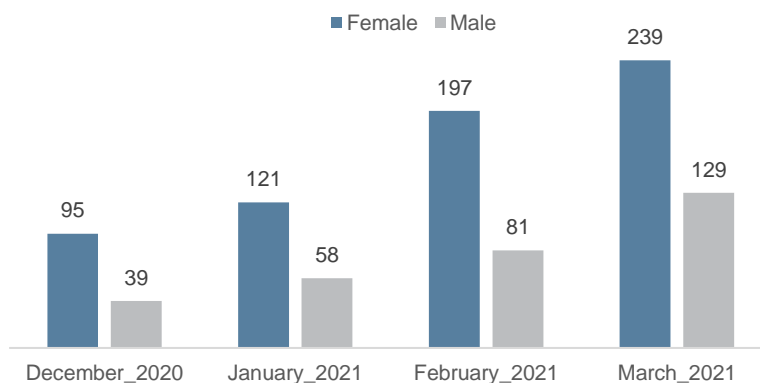


Figure 4. TX_CURR_DDD* by sex, December 2020–March 2021



* TX_CURR_DDD: Number of adults and children currently accessing ARVs through DDD pick-up points (PuP) or other DDD modalities

All PP model enrollees who were interviewed reported being satisfied with the model. Key findings included:

- Of the interviewed clients, 76 percent reported a shorter distance to the PP where they picked up their ARVs compared to their previous pick-up point.
- The majority (65%) reported learning about the PP model from health providers in facilities, while 15 percent were informed by other clients, 13 percent via the IEC materials, and 6 percent via associations for people living with HIV.
- Clients perceived the PP model as associated with greater confidentiality (25% of clients), better counseling (21%), and reduced refill time (10%).
- Clients reported that the PP model had reduced or eliminated transport costs, especially for those from rural areas, saved time, and reduced the perceived risk of exposure to COVID-19.

Lessons Learned

Several challenges were encountered during the introduction of the PP model in DRC, including the reluctance of health providers to offer the PP model to stable clients, compensation to be provided to the PPs, which have a for-profit business model, and the management of start-up activities among key stakeholders. However, several strategies helped mitigate these challenges:

- Stakeholder engagement at the beginning of the project, including establishment of the MOU, facilitated acceptability and success during implementation of the PP model.
- Having the PNLS lead all activities improved the quality of the implementation process.
- All actors, especially health institution providers, were sensitized that (1) the PP model does not compete with other ARV distribution models and (2) clients continue to be enrolled in the health facilities even if served by a PP.
- Health providers at the facility level and the beneficiaries of the PP model played key roles in promoting and creating demand for the model

Next Steps

Ongoing implementation and scale-up of the DDD PP model will be transitioned to IHAP. A plan for transitioning the management of this effort to IHAP has been developed and includes:

- The transfer of all project databases
- Key recommendations regarding the need to:
 - Conduct regular supervision of health facilities and PPs
 - Ensure adequate data collection and reporting
 - Conduct active and continuous demand-creation activities with a key role for users of the PP model
 - Guarantee a functional supply chain and improve data quality assurance by adding questions to monitor the quality of services at the PP pick-up points
- EpiC DRC will continue to advocate for the expansion of the PP model in Kinshasa Province and work with the PNLs to revise the national guidelines to include the PP model as an additional differentiated model to increase access to ART among people living with HIV in DRC.

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