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SPACING OF CLINICAL VISITS: APPOINTMENTS AT SIX MONTHS OR "R6M"

Since 2014 in Guinea, within the framework of an experimental pilot project, stable patients under ART have gone to the health centre every 6 months for a medical consultation, a viral load analysis, and a refill of their ARVs.

This alternative model of limited clinical consultations in combination with ARV refill, called "Appointments at 6 months" or "R6M," has already demonstrated positive effects in several pilot programs. It is now part of the WHO guidelines, which recommend less frequent ARV refill, for a period of 3 to 6 months, for stable patients.[12]

In Guinea, the R6M model was adopted in Conakry in 2013 after problems with retention of patients in treatment (in a country where the rate of detection and antiretroviral treatment are already low). In addition to this, there was a need to unclog HIV care facilities, reduce the burden of follow-up of these individuals for staff, but also reduce the burden for patients in terms of cost of transport, frequency of medical visits, and waiting time to receive ARVs.

Although health workers initially showed some resistance to this new strategy, it soon demonstrated a positive impact on retention in care, even during the 2014-2015 Ebola epidemic. This model could thus prove useful in other crises to prevent treatment interruption when access to health structures is limited or interrupted.

More than 55% of the active cohort of PLHIV followed by MSF in the capital—more than 3100 stable PLHIV—today benefit from this differentiated model of care. Guinean health authorities, who supported its application during the Ebola crisis, are preparing to integrate this differentiated strategy in their national plan for the care of PLHIV.

The R6M in Guinea at a glance:

R6M

Stable patients come every 6 months for a clinical visit, a viral load test, and refill of their ARV treatment.

The selection criteria are: patients must be over 15 years of age; under first line ART for at least 6 months; have a viral load under 1000 copies/ml; be in clinical stage 1 or 2 of the disease (according to the WHO scale); be clear of opportunistic infections; not be pregnant or the mother of an exposed infant.

2X PER YEAR

clinical visit

ARV collection

blood test

THE + OF THE R6M

FOR THE PATIENT AND THE HEALTH SYSTEM

Reduced burdens on the patients including a decrease of transportation costs, frequency of visits, and waiting time in medical facilities.

A decrease in costs to the health system.

A decrease on the workload for health staff, who can then focus on enrolling new patients on ARV and providing care to patients with complications.

Decreased stigmatization. Due to less frequent visits to health facilities, rumours that weigh on patients are reduced.

A significant increase in retention in care. A retrospective study comparing a group of patients in the R6M model demonstrated a 95.8% rate of retention for this group after 24 months in treatment. In comparison, the retention of the general cohort in the health facilities is 62% after 24 months of ART.

A reduction of loss to follow-up. The same study demonstrated a 60% reduced attrition rate over a two year period in the R6M group compared to the control group.

Within the context of the Ebola epidemic, the R6M was also resistant to the crisis by maintaining care for patients under ART (96% rate of retention in care after 12 months), and contributed to reduction of Ebola virus transmission risk by reducing contact between individuals in health facilities.

ESSENTIAL CONDITIONS FOR A WELL-FUNCTIONING R6M:

- An adequate ARV supply chain permitting distribution of six months of treatment.
- A good coverage of viral load testing. Alternatively, clinical and immunological criteria may be applied.
- A smooth and constant integration of eligible patients into R6M.

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