COMMUNITY HEALTH | KACHIN STATE, MYANMAR

A PEER-LED APPROACH TO HEPATITIS C

This Médecins du Monde program uses a peer-led approach to integrate HCV care for people who inject drugs into an existing HIV and harm reduction model.

WHY DID WE ESTABLISH THIS MODEL?

1.4 million people are estimated to be living with HCV in Myanmar

84.5% prevalence of HCV antibody among people who inject drugs in Kachin State

Myanmar's national treatment program for HCV is expensive and has limited treatment places

We wanted to incorporate HCV into our existing harm reduction and HIV model

WHO ACCESSES OUR SERVICE?

150-200

CLIENTS PER WEEK

- People who use drugs and are living with HIV, with or without OAT/OST*

*OAT/OST: Opioid agonist therapy/Opioid substitution therapy

WHAT IS THE MODEL?

AWARENESS

Our peer workers provide HCV awareness, knowledge and education sessions to people living with HIV in the community. People at risk of HCV are provided with referral cards to one of our clinics.

REFERRALS

Our peer workers then support referrals to one of our three Harm Reduction and HIV Drop In Clinics or one of our Mobile Clinics.

TESTING

Each clinic offers point-of-care HCV antibody testing to people who use drugs. Testing is also offered to the client's sexual or injecting partners.

DIAGNOSIS

A laboratory technician uses the GeneXpert point-of-care testing machine on site to test all antibody positive samples for HCV RNA.

TREATMENT

HCV RNA+ patients are offered treatment. A multi-disciplinary team (primary care doctors, nurses, counsellors and a pharmacist) follow the client's journey and provide support.

SUPPORT

Peer workers support treatment adherence and help link clients to a peer-led needle and syringe program to promote safer injection, and minimise the risk of reinfection.

Essential to our model

Our peer workers

What is a peer worker?

A peer worker is a person engaged based on their unique expertise and knowledge from their lived experiences for the benefit of other people in similar situations. In this context, this refers to people who use drugs who volunteer to provide support to others with whom they share a common experience.

Our peer workers are trained on harm reduction, prevention, diagnosis and treatment of blood-borne infections including HIV, HBV and HCV.

Our peer workers are the primary point of contact with clients, providing information about HCV (including booklets), and referring them to one of our clinics for further services.

Our peer workers have a work agreement contract with MdM, and are supervised and supported by our Community Worker Mentors, who are MdM staff.

While the positions are voluntary, our peer workers are entitled to benefits such as cash incentives, health services, training & professional development, psychosocial support, and legal support services.

At least once per year, we organise a harm reduction refresher training at all three clinics for our peer workers. We also provide training on facilitation and communication skills and contact tracing.

Our top tips for engaging peer workers

- Focus on capacity building and empowerment - help your peer workers build self-esteem, resilience and communication skills
- Build awareness about the role of peer work in the community
- Advocate for peer-led models to all different levels of stakeholders

WHAT HCV SERVICES DO WE PROVIDE?

- HCV education and information
- Peer support
- HCV testing
- HCV diagnosis
- HCV treatment
- Liver disease assessment
- Genotyping for HCV

WHAT INTERVENTIONS DO WE USE?

- **Peer support**
- **Opt-out screening**
- **On-site testing**
- **Point-of-care HCV antibody testing**
- **Point-of-care HCV RNA testing**
- **Dried blood spot testing**
- **Pre-test counselling and education**
- **Patient navigation**

COMPLEMENTARY SERVICES WE PROVIDE

- Access to naloxone
- Access to a primary care provider
- Access to HIV testing and treatment
- Hepatitis B testing & vaccination
- Tuberculosis screening & treatment
- Access to OST/OAT
- Access to needles, syringes and other equipment

On average, 85-95% of clients who are given referral cards by our peer workers end up presenting to the clinic.

WHO DELIVERS OUR SERVICES?

PEER WORKER
n = 113

GENERAL PRACTITIONER
n = 10

NURSE
n = 9

COUNSELOR
n = 9

LAB TECHNICIAN
n = 4

PHARMACIST
n = 3

SPECIALIST PHYSICIAN
n = 1

HCV PROGRAM MANAGER
n = 1

SERVICE LOCATIONS

EXISTING HARM REDUCTION & HIV CLINICS IN:

- HOPIN
- MOEGAUNG
- MYITKYINA

HOW IS IT FUNDED?

- DONOR FUNDING
- ORGANISATIONAL CORE FUNDING

"Our model explores the simple notion that the HCV cascade of care can be integrated into existing harm reduction programs.

With an effective peer workforce and affordable generic treatment, every program can do this."

RENAUD BOULET
DEPUTY GENERAL COORDINATOR - MYANMAR
MÉDECINS DU MONDE

WHAT WERE THE OUTCOMES?

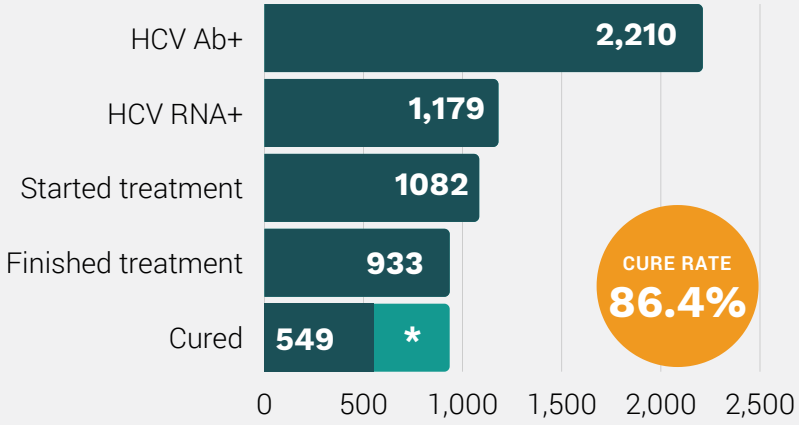
JUNE 2019 - APRIL 2021

HOPIN
MOGAUNG
MYITKYINA

3 CLINICS

3,183

CLIENTS SCREENED FOR HCV



* 298 awaiting SVR12 testing
86 treatment failed
25 lost to follow up

Among clients who started HCV treatment:

99%
MALE

AVERAGE AGE = 35 YRS*

100%
HIV CO-INFECTED

58%
ON OAT/OST

34%
PEOPLE WHO INJECT DRUGS

66%
PEOPLE WHO USED TO INJECT DRUGS

*Min = 16, Max = 60

Partnerships

Our model was built on strong collaborations between multiple organisations.

Our model is a collaboration between:

- Médecins du Monde (MdM)
- Medecins Sans Frontieres – Swiss (MSF-CH)
- Save the Children

Medecins du Monde (MdM)
MdM is the implementing partner, and runs the three existing clinics that were utilised in this model.

Save the Children
Save the Children contributed financial support via the Global Fund.

Medecins Sans Frontieres – Swiss (MSF-CH)
MSF-CH provided capacity building and training to MdM. MSF-CH have experience implementing a HCV project in another region of Myanmar, so they were able to share their expertise with the MdM team.

From May 2021, MSF-CH also contributed technical reference, DAAs, GeneXpert cartridges and financial support for blood tests.

Our project is run under the general guidance of the National Hepatitis Control Program (NHCP), Ministry of Health and Sports, Myanmar. Reports have been regularly submitted to NHCP, following the standard practice implemented countrywide.

WHAT WERE THE BARRIERS?

BARRIERS	SOLUTIONS
 Disruption in supply chain. Sometimes there is a shortage of DAA supply, which halts treatment initiation for eligible clients.	Regular follow up and reminders with drug providers, and coordination with other agencies to receive a loan of treatments.
 The COVID-19 pandemic made in-person training for our medical team challenging.	We adapted quickly and designed a training program that could be delivered entirely online.
 The COVID-19 pandemic has also posed a huge barrier for in-person peer support through the HCV care cascade.	We made sure our peers were equipped to comply with infection control measures (e.g. masks, handwashing items) and used it as an opportunity to disseminate COVID-19 prevention education among the clients.
 The price of DAAs has made it difficult for the national government to scale up our model, and access to generics isn't yet possible.	Access to generics in future will make it affordable for the national health system, contribute to the sustainability of the program and allow it to be government-led.
 When we set up the model, we didn't consider a plan for re-treating clients for whom treatment was unsuccessful. There are also no other service providers in Kachin who we can refer clients to for re-treatment.	We provide counselling and education on risk factors to minimise transmission in these clients. Next time, we will include a plan for re-treatment in our proposal.

LOOKING TO IMPLEMENT A SIMILAR MODEL?

OUR TOP 5 KEY CONSIDERATIONS

1

ENGAGE KEY STAKEHOLDERS EARLY.

Involve national authorities from the beginning to ensure engagement and sustainability. Emphasise the need to involve necessary resources to treat at large scale.

2

ENGAGE YOUR COMMUNITY.

Organise awareness sessions on the benefits of HCV treatments. Include clients who have already been treated, and promote the establishment of peer support groups. We engaged peers and community groups to help provide counselling, health literacy and feedback to improve uptake of treatment and adherence.

3

MAKE USE OF EXISTING INFRASTRUCTURE.

Consider integrating your model within existing programs. We integrated our model with an existing harm reduction and HIV program, which meant we already had a good understanding of our clients, and our clients were already familiar with us.

4

TASK SHIFT.

Instead of specialist physicians, consider whether there are other providers (e.g. GPs, nurses) who could do the work. For example, due to the lack of specialists in Kachin State, we asked for permission to test and treat HCV co-infected clients using our public health doctors.

5

SIMPLIFY AND BE FLEXIBLE.

Simplify your testing and treatment algorithm to make it more accessible to your population. Comprehensive services available at one location makes it easier for clients. Be flexible - during the COVID-19 pandemic, we quickly adapted to adversities by identifying partnerships and using technology.

INHSU
International Network on Health and Hepatitis in Substance Users

MÉDECINS DU MONDE

MEDECINS SANS FRONTIERES

Save the Children

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