Differentiated service delivery for ART

SAMU SUMMARIES SEPTEMBER 2017
Objectives of session

• To be aware of the global guidance on differentiated service delivery for ART

• To explain the main principles of differentiated models of ART delivery for stable adult patients and specific populations

• To be able to decide what differentiated ART delivery strategies would best suit your setting
Differentiated care is a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system.

Consensus definition 2016: WHO, UNAIDS, Global Fund, CDC, USAID, OGAC, Gates Foundation, MSF
Differentiated care

Differentiated ART delivery

- Diagnosed: 90%
- On treatment: 90%
- Virally suppressed: 90%

Differentiated Testing
Differentiated Initiation
Differentiated ART delivery
Differentiated Care in International Guidance

A Toolkit for Health Facilities
Differentiated Care
For HIV and Tuberculosis

November 2015
Geneva, Switzerland

This toolkit highlights successful differentiated-care approaches implemented in a number of settings and countries in sub-Saharan Africa. The toolkit will be further updated as more experience is gained with these and similar approaches.

Dec 2015 Global Fund
Kenya, Uganda, Senegal

SERVICE DELIVERY

6.1 Introduction
6.2 Differentiated care
6.3 Models of community ARV delivery
6.4 Linkage from HIV testing to enrolment in care
6.5 Retention in care
6.6 Adherence
6.7 Frequency of clinic visits and medication pickup
6.8 Task shifting and task sharing
6.9 Decentralization
6.10 Integrating and linking services
6.11 Delivering HIV services to adolescents
6.12 Improving the quality of HIV care services
6.13 Procurement and supply management systems for HIV health products
6.14 Laboratory and diagnostic services

DIFERENTIATED CARE FOR HIV:
A DECISION FRAMEWORK FOR ANTIRETROVIRAL THERAPY DELIVERY

It's time to deliver differently.

Dec 2015 Global Fund
Kenya, Uganda, Senegal

WHO
2016

GF, WHO, OGAC, USAID, CDC, GATES, MSF 2016
Differentiated service delivery
The Three Elements

Clinical Characteristics
- Stable
- Women
- Men
- Adolescents & children
- Pregnant & breastfeeding

Context
- Urban
- Rural
- Conflict
- Epidemic type
- Prevalence: high/low

Specific Population
- High VL
- Unstable
- Other
- Urban/rural
- Stable context
- Other
Differentiated service delivery
The building blocks

Evidence for Each of these building blocks reviewed in WHO 2016 Guideline
An example of using elements and building blocks for ART delivery

Element
- Subpopulation: Adults
- Clinical characteristic: Stable
- Context: High prevalence / stable

Building Blocks for fast track model

- **When**
  - Every 3 months
  - Any time during opening hours

- **Where**
  - Direct from dispensing point

- **Who**
  - The client does not see the nurse for a consultation, only the ART dispenser

- **What**
  - ART and CTX refill only
When is ART delivered?

WHO Guidelines

Box 3: Recommendations on frequency of visits

- Less frequent clinical visits (3-6 months) are recommended for people stable on ART (strong recommendation, moderate-quality of evidence).
- Less frequent medication pickups (3-6 months) are recommended for people stable on ART (strong recommendation, low-quality of evidence) (2).

Reducing the frequency of ART refills and clinical visits

Utilizing the maximum duration of ART refills

Extending or adapting service hours
Move further towards community delivery?
Mentorship/supervision

Decentralising HIV treatment in lower- and middle-income countries.
Kredo T¹, Ford N, Adeniyi FB, Garner P. Cochrane review 2013

WHO Guidelines

Box 4: Recommendations on decentralization

Decentralization of HIV treatment and care should be considered as a way to increase access to and improve retention in care:

- Initiation of ART in hospitals with maintenance of ART in peripheral health facilities (strong recommendation, low-quality of evidence);
- Initiation and maintenance of ART in peripheral health facilities (strong recommendation, low-quality of evidence);
- Initiation of ART at peripheral health facilities with maintenance at the community level (that is, outside health facilities in such settings as outreach sites, health posts, home-based services or community-based organizations between regular clinical visits) (strong recommendation, moderate-quality of evidence).
The importance of task sharing

Community health workers able to dispense ART between regular visits
Who is a stable patient?
<table>
<thead>
<tr>
<th>WHO</th>
<th>Swaziland</th>
<th>Zimbabwe</th>
<th>Kenya</th>
<th>Tanzania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time on ART</td>
<td>1 year</td>
<td>1 year</td>
<td>6 mths</td>
<td>1 year</td>
</tr>
<tr>
<td>Age</td>
<td>Not specified</td>
<td>&gt; 18</td>
<td>&gt; 20 years</td>
<td>&gt; 5 years</td>
</tr>
<tr>
<td>Current Illness</td>
<td>None</td>
<td>No other medical condition requiring frequent visits</td>
<td>No current OIs</td>
<td>No active OIs or TB in last 6 mths; completed 6 mths of IPT</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>No</td>
<td>No</td>
<td>Not mentioned</td>
<td>No</td>
</tr>
<tr>
<td>Evidence of treatment success</td>
<td>2 VL &lt; 1000</td>
<td>2 consec VL &lt; 1000 with last one within 6 mths</td>
<td>Last VL &lt; 1000 Where no VL CD4 &gt; 200</td>
<td>Most recent VL &lt; 1000</td>
</tr>
<tr>
<td>Other adherence</td>
<td>Understanding of adherence</td>
<td>Has had at least 2 ART visits at facility</td>
<td>Adhered to scheduled appts in last 6 mths</td>
<td>95% adherence Attended appointments in last 6 mths</td>
</tr>
<tr>
<td>BMI &gt; 18.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not injecting PWID</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Facility-based individual
Community based individual
Health care worker-managed group
Community based Client-managed
1. **Individual Facility ART refill - fast track**

- Chiradzulu district Malawi 3mth refills; 6 mth clinical
- 50% in fast track
- at 36 months 94% of clients in fast track retained v 83% of clients with same eligibility criteria staying in conventional care *(Mguire et al 2011)*

2. **Individual Community ART Refill (Outreach/community pharmacy)**

- Kinshasa
- Time for refill reduced 14 mins v 85 mins
- Transport costs 3x less when collection at distribution points

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**GUIDE DE MISE EN PLACE DES POSTES DE DISTRIBUTION COMMUNAUTAIRE D’ARV**

Comment rendre le traitement ARV plus accessible aux personnes vivant avec le VIH
Health care worker led group refill
“Adherence Clubs”
(20-30 clients: South Africa, Kenya)

**When?**
Every 2-3 months
Takes 30-60 minutes
After work
Saturdays

**Where?**
Most Meet At facility
Works better in urban settings

**Who?**
Facilitated by lay worker
Data as of June 2016: 
*N=53,523– 36% of the cohort*

Outcomes
12 months: 95.2% retention & 97% virally suppressed
24 months: 89.3% retention & 96% virally suppressed
When? We meet every 3 mths

Where? We Meet in each other’s houses. Generally more often in rural settings.

Who? Our group leader helps us to complete the community refill checks.

What? Every three months we meet together and check we are healthy. One of us then goes to collect all the drugs.

Once a year we go for clinical check up and viral load.

Community ART Groups
Mozambique, Zimbabwe, Malawi, SA, Lesotho, Kenya

Self forming Groups (4-12) Stable Adults Collecting ART for each other
Community ART Groups: Mozambique, Zimbabwe, Malawi, SA, Lesotho

20-45% of cohort in CAGS

Mozambique Retention in CAG 91% at 48 mths

Qualitative Income Generating Activities
Time and money saving Benefits of peer support

"The advantage of being in a CAG is that you can do other small jobs when you know that a group member will collect ART for you. This makes things easier."

Outcomes

(Decroo et al; Rasschaert, 2014; Vandendyck 2015)
Reduction in ART refill

59% reduction in refill visits in Thyolo, Malawi
Tools

samumsf.org

[Reaching Closer to Home]

Community ART Group Toolkit:
How to implement the CAG model
Bringing treatment closer to home and empowering patients

http://www.differentiatedcare.org/
Differentiated ART for stable Children and adolescents
KEY CONSIDERATIONS FOR DIFFERENTIATED ANTIRETROVIRAL THERAPY DELIVERY FOR SPECIFIC POPULATIONS:

CHILDREN, ADOLESCENTS, PREGNANT AND BREASTFEEDING WOMEN AND KEY POPULATIONS

DIFFERENTIATED CARE FOR HIV:
A DECISION FRAMEWORK FOR DIFFERENTIATED ANTIRETROVIRAL THERAPY DELIVERY

For children, adolescents and pregnant and breastfeeding women
WHO Eligibility criteria

< 2 years should be seen monthly
> 2yrs differentiated models (including family group refills) if

• On ART >12 months
• Same ART regimen > 3 months
• No current illnesses (incl. malnutrition)
• 1 VL < 1000 copies/ml in last 3 months
• No adverse drug reactions requiring regular monitoring
• Caregiver orientated on importance of engaging in age appropriate disclosure process
### WHO: criteria for clinical visit

<table>
<thead>
<tr>
<th>When:</th>
<th>6 monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aligned with family members visits</td>
</tr>
<tr>
<td></td>
<td>Consider timing to minimize school/work absences</td>
</tr>
<tr>
<td>Where (minimal):</td>
<td>PHC/mobile outreach from PHC (with drugs/scale to manage dose adjustments)*</td>
</tr>
<tr>
<td></td>
<td>*In low burden settings clinical review could be considered at higher level facility</td>
</tr>
<tr>
<td>Who (minimal):</td>
<td>Nurse</td>
</tr>
<tr>
<td>What:</td>
<td>1. Clinical review per guidelines including but not limited to: TB screen, Adherence support &amp; Disclosure support</td>
</tr>
<tr>
<td></td>
<td>2. Labs (VL annual or if not available CD4 6-monthly)</td>
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<tr>
<td></td>
<td>3. Dosage check and possible adjustment</td>
</tr>
<tr>
<td></td>
<td>• Borderline weight gain (growth) = pre-emptive dose adjusting if possible</td>
</tr>
<tr>
<td></td>
<td>4. Re-scripting (6 month script)</td>
</tr>
</tbody>
</table>
## WHO criteria for refill visits

<table>
<thead>
<tr>
<th>When:</th>
<th>3-6 monthly*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aligned with family members visits</td>
</tr>
<tr>
<td></td>
<td>Consider timing to minimize school/work absences</td>
</tr>
<tr>
<td></td>
<td>* Promote use of LPV/r pellets (syrup = 2 month shelf-life)</td>
</tr>
<tr>
<td>Where:</td>
<td>PHC or out-of-facility</td>
</tr>
<tr>
<td>Who:</td>
<td>Trained lay providers</td>
</tr>
<tr>
<td></td>
<td>Collection can be done by caregiver without child present</td>
</tr>
<tr>
<td>What:</td>
<td>ART refill</td>
</tr>
<tr>
<td></td>
<td>Adherence check (caregiver report/self-assessment)</td>
</tr>
<tr>
<td></td>
<td>Referral check - Is child well/coughing/TB in the household?</td>
</tr>
<tr>
<td></td>
<td>Disclosure support</td>
</tr>
</tbody>
</table>
Teen/ Youth Clubs

- Provision of ART refill
- Peer support
- SRH education
- Life skills
Critical enablers

- Recognition of lay workers
- Access to quality clinical management
- Reliable monitoring system
- Robust drug supply
Key Messages

• Differentiated service delivery is about putting the patient at the centre of our planning
• Differentiated service delivery spans across the cascade of care and is not just for stable adults
• Use the elements and building blocks to build the model of ART delivery
• The model chosen will be context specific to answer local challenges
• Having the key enablers in place is a foundation for providing successful differentiated ART delivery