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DIFFERENTIATED SERVICE DELIVERY MODEL FOR KEY POPULATIONS

IAS

POLICY BRIEF

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REACHING THE UNDERSERVED WITH ESSENTIAL HIV SERVICES

Differentiated service delivery (DSD) is a client-centered approach that simplifies and adapts HIV services across the HIV care cascade, to reflect the needs, and preferences of the various groups of people vulnerable to or living with HIV, while reducing unnecessary burdens on the health system. WHO released guidelines on DSD which has become a priority across HIV programs.

KP program implementation

LVCT Health, a local non-governmental organization in Kenya, has been implementing programs targeting key populations especially men who have sex with men (MSM) since 2004. Currently, services offered cover all key populations including MSM, female sex workers (FSW) and people who inject drugs (PWID) in five high HIV burden counties in Kenya. The program implements services as defined in the national guidelines for key populations.

Comprehensive services provided include HIV prevention, care and treatment, gender-based violence services in community settings known as drop-in centers (DiCEs)or prevention centers and hotspots (where KPs are found in the community).

Key Populations refer to groups of people who are at the highest risk of contracting HIV. These include men having sex with men, sex workers and people who inject drugs. Services are provided in community and facility settings with most treatment services being provided in facility settings.

KPs are enrolled in cohorts for routine (minimum quarterly) follow up for HIV prevention services such as HIV testing and counseling, health education, condom provision and STI management.

Condom distribution and health talks are provided by peer educators in hotspots while the clinical services are offered by clinical staff in DiCEs. HIV testing services (HTS) are offered in outreach/hotspot settings and DiCEs by lay counselors.

LVCT Health's prevention centre at Kawangware

Challenges in current KP programming

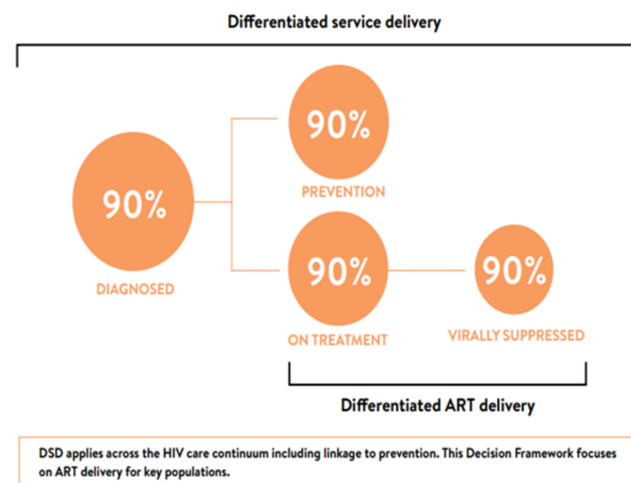
A review of program data in 2017 indicated that there was a low retesting rates (less than 20%), low retention rate in HIV prevention cohorts and low utilization of HIV prevention services at the DiCEs in spite of mobilization by peer educators. In addition, KP clients who tested HIV positive in the DiCEs or outreach and referred to nearby government health facilities for ART treatment either did not reach the facilities or defaulted from ART after a short time.

Other notable challenges were:

- Sex workers are mostly available in the late evenings and in the night and may be unable to access health services at the prevention centers or health facilities
- Available ART formulations were unfriendly to the KPs nature of work especially the sex workers as it made them drowsy thus they were not adherent to their medication
- PrEP or ART cannot be initiated within the hotspots because peers are not trained health workers
- Follow up and monitoring of KPs already initiated on either PrEP or ART requiring laboratory tests, refills and clinical assessment is difficult due their secretive nature, which inhibits them from seeking health services
- This mode of delivery of services does not allow for testing of the regular partners of the KPs who are in the general population despite the fact that it is an essential component of epidemic control, considering the high prevalence rate in this population.

Differentiated service delivery model

The program gaps identified informed the design of differentiated services delivery models for the key populations, specifically the MSM and FSW. The DSD models were developed along the HIV testing, prevention and treatment cascades. We used a systems thinking approach to develop the interventions assisted by the KPs themselves, KP peer educators and implementers who had been involved in delivery of KP services for a long time.



Source:World Health Organisation

HIV Prevention DSD

We introduced a comprehensive clinical hotspot outreach model to broaden the service delivery package beyond the basic HTS and condom distribution that was taking place before. In this new model, peer educators mobilize the KPs for a comprehensive outreach activity that takes place quarterly at a known hotspot for example a bar. The services are offered at a time that is convenient to the KPs (when the hotspot is considered active and KPs are present and this can go on as late as 2am).

The team providing the services is composed of a field officer who coordinates teams of peer educators, counsellors to provide HTS to the KPs and their clients, and clinicians to diagnose and treat STIs and any other clinical conditions. The team hire rooms from the bar owners for the night to set up clinical and counselling rooms for the KPs to access as they continue with their activities. Services provided include HTS, STI management, Pre exposure prophylaxis (PrEP) and post exposure prophylaxis, ART initiation and refills, family planning provision and referral.

A HTS counsellor distributing commodities at a hotspot during an outreach activity in Kawangware

Care and treatment DSD

From January 2017, we started offering ART services in all our DiCEs and mobilized KPs to initiate and continue receiving ART services there. This was to minimize losses of clients following referral and linkage to government health facilities as we had been doing previously. We employed clinicians trained on ART and KP sensitive services and placed them in the DiCEs. Unfortunately, not all KPs took up the model and retention and adherence to ART clinic visits and follow up was sub-optimal. Some of them complained that they lacked bus fare to get to the DiCE regularly. This informed the implementation of the hotspots-based care and treatment differentiated service delivery model.

In June 2017, LVCT Health began delivering (initiating and continuing) ART services in KP hotspots. These outreach activities are conducted on a quarterly basis and the ART delivery team consists of a counselor, clinician and peer educator (for mobilization). Besides ART, other services offered during outreach include HIV testing services (HTS), STI treatment, condoms and lubricant distribution, and support groups for those on ART. As of April 2018, 821 KPs were on ART at the DiCEs. Of these, 537 were eligible for viral load tests with a viral suppression rate of 92%. Out of the 821 KPs on ART, 147 have opted for outreach ART services and community support groups with a 82% viral suppression.

Despite this low viral suppression compared to the ones coming to the DiCEs, we noted an increased access to viral load tests for this cohort on DSD. It should also be noted that the clients on the DSD model were the difficult clients who were defaulters thus the poor viral suppression (it was worse at 63% when we began implementing the model)

James Kariuki a clinician at Sokoni DICE taking a client’s blood sample at a ‘busaa’ den (local brew) in Madiaba Kawangware slum

My work is hard and I work for long and odd hours. I sell local brew “busaa” in my community and I go for both the stock and sell the alcohol. I do not have time to do anything else including going to the clinic. It is very good when the service providers reach out to us; in my case, this is how I discovered that I was HIV positive right here at my den during their usual community visits. I am now on drugs and hopeful that I will live a good life now that I know my status.
–Godfrey Ndovu, client.*

Considerations for Success

- Providing client-centered care: The needs and preferences of clients should guide the process . For example, we responded to the needs of clients who were unable to come to the clinic during normal clinic hours as they were asleep, tired from spending the night in the hotspots
- Observation and respect for human rights should be at the core of service provision
- Recognition of the importance of the role of the communities and peers as providers
- Inclusion of psychosocial support which is an essential element for positive living

> There is minimal increase in costs as the same clinical team that would do quarterly STI screening is the same one that does this DSD model

Other benefits of DSD include:

- Drug delivery at hotspots has ensured that the clients who missed appointments due to time constraints are now able to access treatment
- Conducting phlebotomy/sample collection at hotspots has increased access to viral load testing for KPs
- Psychosocial support groups at hotspots are held in the community led by the peers and sometimes the clinical staff

From our experience, we would recommend:

1. That new implementing facilities begin with DSD facility models before community models
2. Transition of clients from facility to community DSD models is done through a client's preference and consent
3. A cost analysis/ implications evaluation for the program
4. Transition plans for individual community refills to Community ART Groups (CAGs) or facility models; as CAGs are more cost effective and self-sustaining in a resource constrained environment
5. Optimization of facility models by fast tracking the implementation of long appointment strategy for stable clients. In our differentiated service delivery models, we have found out that almost half of our clients prefer to have longer periods between clinic appointments because of the time spent in the clinics

"In addition to this, DCM has made it easier for us service providers to do our work faster, more efficiently and effectively. In the past, we often used futile methods that resulted in a lot of time and energy consuming strategies that bore very minimal results. An example of this is when we would spend hours on end on phone trying to convince a client to come to the clinic and they would still not show up; it is more efficient to go find them and link them to care immediately. I also credit DCM with creating trust between service providers and their clients especially for Key Populations who are less trusting and less open. Taking services to them makes them feel cared for and accepted. In return, they refer others especially when we are offering services at hotspots"–Cecilia Mwangi, HTS counsellor Sokoni

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Suggested reference

http://www.differentiatedcare.org/Portals/0/adam/Content/cLiSHK2JiEyOpstNl4EoXQ/File/9789241549684_eng.pdf
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