Facilitating effective transitions between differentiated service delivery models for HIV treatment

A supplement to *A Decision Framework for antiretroviral therapy delivery*

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This supplement to *A Decision Framework for antiretroviral therapy delivery* [1] outlines how to facilitate effective transitions between differentiated service delivery (DSD) models for HIV treatment. Ensuring effective transitions is important for treatment continuity and long-term retention and adherence.

The aim is to provide:

- **An overview of DSD**
- **An outline of what DSD model transitions are and why they are important**
- **An overview of three DSD transition types**
- **Guidance on how to facilitate effective DSD transitions**
- **Case studies of different approaches to DSD transitions**
- **An outline of priority actions to facilitate DSD transition planning and implementation**

This supplement is intended for the use of national and district antiretroviral therapy (ART) programme managers, implementing partners, community partners and donors. It should be read in conjunction with the comprehensive guidance provided in *A Decision Framework for antiretroviral therapy delivery* [1].

What is differentiated service delivery?

DSD is a person-centred approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with HIV and reduce unnecessary burdens on the health system. For clients on ART, ministries of health have scaled less intensive DSD models for HIV treatment for people established on ART.

In its 2021 guidelines update, the World Health Organization (WHO) emphasized: "The definition of being established on ART (stability) should be applied to all populations, including those receiving second- and third-line regimens, those with controlled comorbidities, children, adolescents, pregnant and breastfeeding women and key populations" [2].

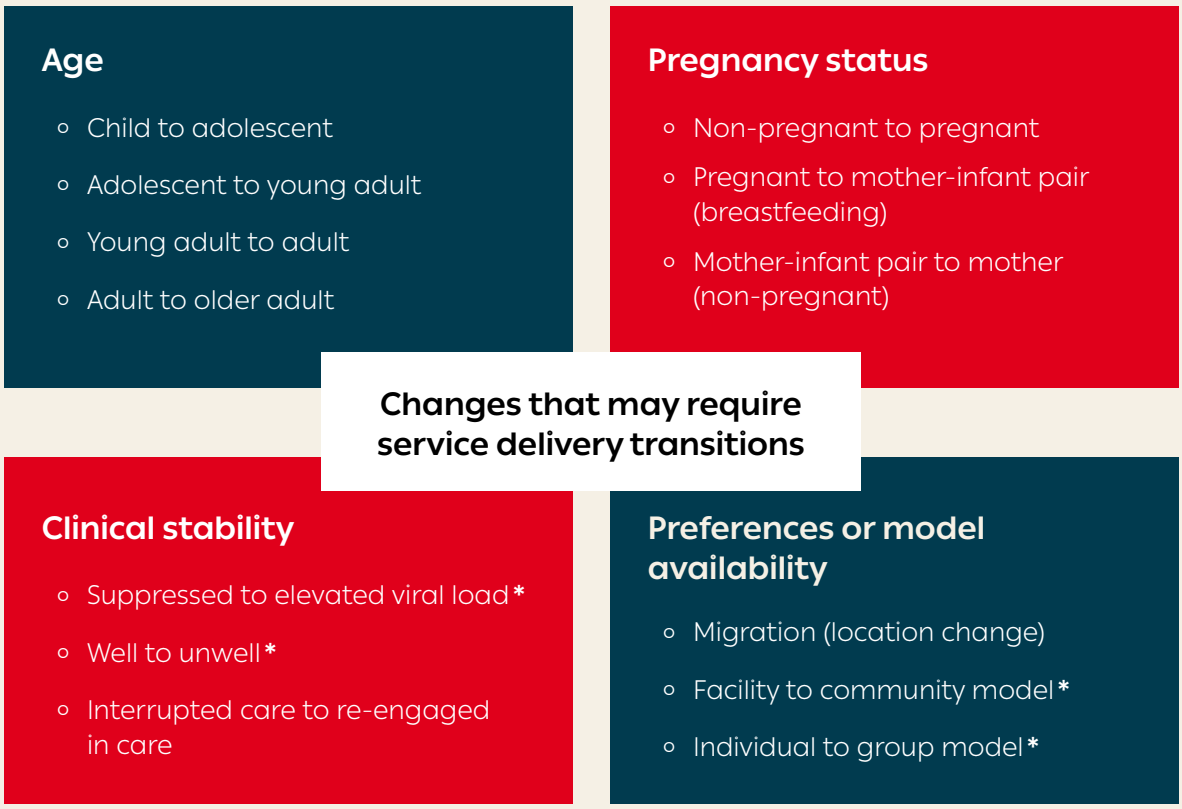
Further, the WHO guidelines outline four categories of DSD for HIV treatment models:

- Group models managed by healthcare workers, such as adherence clubs or teen clubs. A healthcare worker facilitates the group with the aim of providing education, support and distributing ART refills.
- Group models managed by clients, such as community ART groups (CAGs). Each member rotates responsibility for collecting ART refills for the group and distributing them at a group meeting in the community.
- Individual models based at facilities, such as fast-track. Individuals collect their ART refills at the health facility without queuing or seeing a clinician.
- Individual models not based at facilities. Individuals collect their ART refills from mobile or fixed community distribution points or community pharmacies.

What are DSD model transitions and why are these transitions important?

People's needs and preferences may shift during their lifelong ART journey. The changes that may require a service delivery transition can be grouped into four categories: ageing, pregnancy, clinical stability and other personal circumstances (Figure 1).
A shift in the DSD model that someone is using to access their HIV treatment and care is referred to as a DSD transition.

Figure 1. Changes that may require DSD transitions



* bi-directional

DSD transitions should be kept to a minimum to limit disruption and complexity both for the client and the health system. When transitions are necessary, clients should be supported by an enabled health system to facilitate an effective transition. When a client's DSD model transition is suboptimal, there is a risk of poor client satisfaction increasing the likelihood of treatment interruption and disengagement.

Now that DSD models for HIV treatment have been scaled in many countries with large HIV burdens, it is becoming increasingly important to pay attention not only to the eligibility assessment to access less intensive DSD models, but also to the transitions into, between and out of DSD models.

Less intensive DSD models can be defined as consisting of one of the four model categories articulated by WHO (group models managed by healthcare workers; group models managed by clients; individual models based at facilities; and individual models not based at facilities), as well as six-monthly clinical visits alongside six months of ART (known as 6MMD).

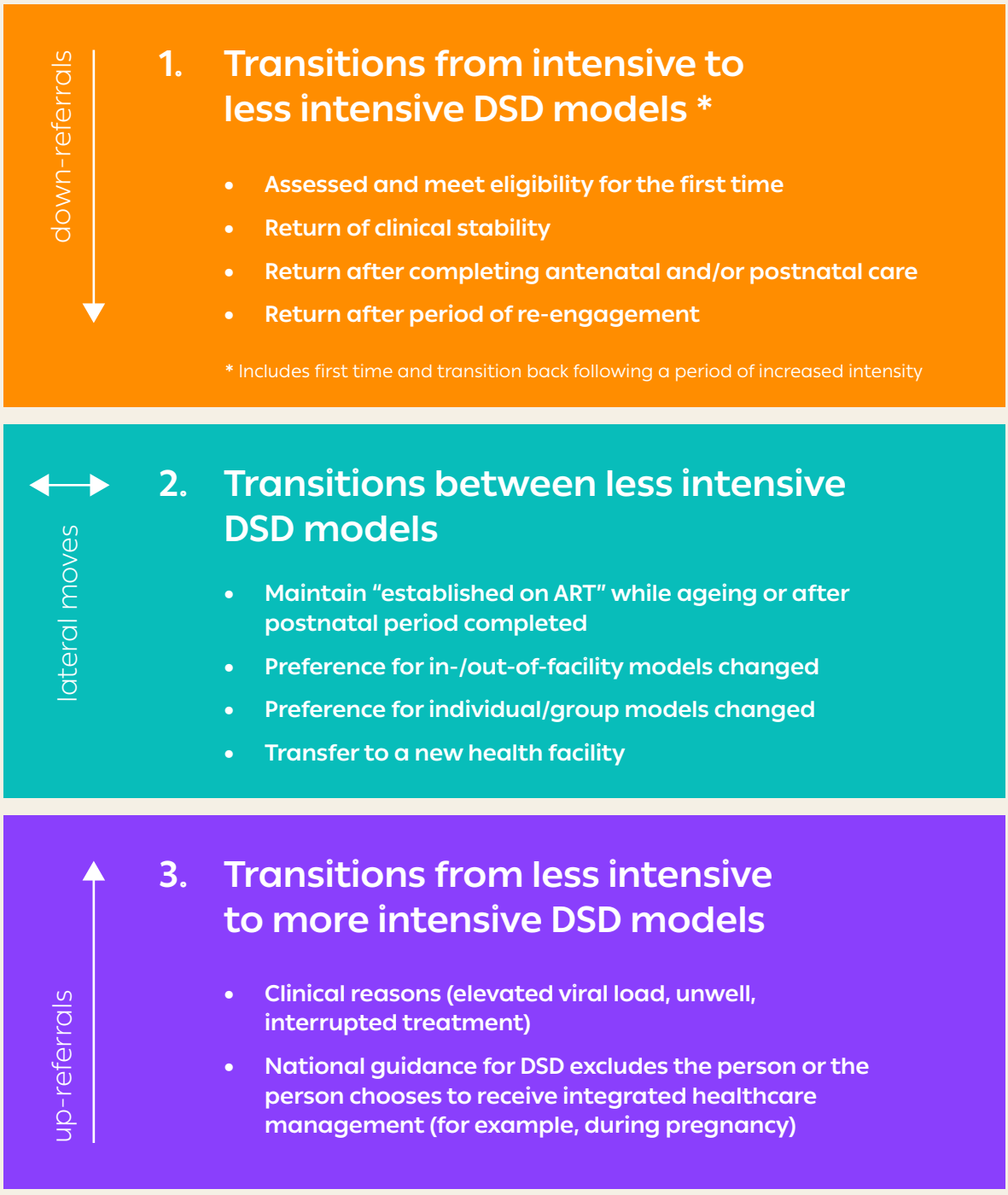
Three types of DSD transitions

There are three types of DSD transitions (Figure 2):

1. Transitions from intensive to less intensive DSD models ("down-referrals")
2. Transitions between less intensive DSD models
3. Transitions from less intensive to more intensive models ("up-referrals")

In Figure 2, the three types of DSD transitions are outlined along with common reasons for each type of transition.

Figure 2. Types of DSD model transitions and common reasons for transitions



Guidance on how to facilitate effective transitions between DSD models for HIV treatment

For each type of transition, there are interventions at a client and health system level that can be considered to facilitate effective transitions. The following tables detail these enablers for each type of transition with details for specific populations.

Table 1. Interventions to facilitate transitions from intensive to less intensive DSD models ("down-referrals")

	Across population groups	Children	Adolescents	Re-engaging	Across population groups
Reasons for transition	Assessed and qualify as established on ART for the first time				After clinical improvement or re-established on ART
Transition from (model)	Facility-based clinician-managed individual care				
Transition to (model)	Any less intensive DSD model				
Enablers at the client level	• Provide DSD literacy regarding DSD model choices available with clear explanation of: When (service frequency); Where (service location); Who (service provider); and What (service package) • Offer enrolment (not automatic) • Responsible person in DSD model informed of enrolment, possible reminder pre-visit, and follow up any missed first appointment • Timeous completion of specific DSD model enrolment processes, including notifying new service provider and script submission (if external to health facility)	+ Enable enrolment into "family-centred" models for children and their caregivers and family members (same model and building blocks). This can require a transition by all willing family members or a transition by the child into the caregiver's less intensive DSD model (see Case study 1)	+ Full HIV disclosure completed + Adolescent group DSD model/s available and prioritized for offer + Individual readiness assessment for transition + Make a timeous transition plan with adolescent + Adolescent peer in model allocated to support transition (peer-led case management for specified transition period) + Orientation: location and new peer group visit before transition	+ Healthcare provider to communicate follow-up visit schedule until less intensive DSD assessment at re-engagement visit + Adhere to timeframes communicated	• Timeous assessment for re-enrolment (adhere to timeframes communicated) • Offer re-enrolment (not automatic) • Provide DSD literacy regarding DSD model choices available • Prioritize re-enrolment in previous model or group or service provider, if preferred • Responsible person in DSD model informed of re-enrolment, possible reminder pre-visit, and follow up any missed first appointment
Enablers at the health system level	• Less intensive DSD literacy job aides to support healthcare workers (See Case study 2) • National DSD operational guidance to consider "down-referral" service delivery transition enablers • Clear specific DSD model enrolment and "up-referral" processes at facility level			+ National algorithm differentiating service delivery on re-engagement, including eligibility for accelerated access into less intensive DSD + Facility-level training and job aides to support implementation	+ Clinical ART stationary to reflect previous less intensive DSD model (to support re-enrolment offer)

+ denotes additional enablers specific to certain populations groups

Case study 1 (client level)

Family-centred DSD for children, their caregivers and family members in South Africa

In South Africa, national DSD guidelines support a family-centred approach to DSD. Children older than five years and their caregivers and/or family members are encouraged to join the same DSD model. Family-centred DSD options include facility or community adherence clubs (group models managed by healthcare workers), fast-track ART refill collection at the facility (an individual model based at facilities), and external pick-up points (individual model not based at facilities). Eligibility criteria for less intensive DSD models specify that **"stable family members should be encouraged to join the same repeat prescription collection strategy (DSD model) option with the same treatment supply, collection location and appointment date to support family adherence"** [3].

Case study 2 (health system level)

DSD treatment literacy job aides in Zimbabwe

In 2022, the Zimbabwe Ministry of Health and Child Care updated its national DSD guidance and job aides to support DSD treatment literacy provision by healthcare workers [4-5]. The job aide sets out model choice by specific population and includes the "building blocks" of each model: When (the frequency of services); Where (the location of the services); Who (the cadre of healthcare workers providing the services); and What (the packages of services provided). These job aides support healthcare workers to provide clear explanations of the eligibility criteria for less intensive DSD models, what DSD models are available, and how each model functions.

Table 2. Interventions to facilitate transitions between less intensive DSD models ("lateral moves")

	Across population groups		Children	Adolescents	Postnatal
Reasons for transition	Change of DSD model preference	Transfer to new health facility	Ageing into adolescence	Ageing into adulthood	Infant >18 months old
Transition from (model)	Any less intensive DSD model	Any less intensive DSD model at previous health facility	Family-orientated DSD model	Adolescent-specific DSD model	Postnatal DSD model
Transition to (model)	Any other less intensive DSD model	Any less intensive DSD model available at new health facility	Unaccompanied adolescent less intensive DSD model	General adult less intensive DSD model	
Enablers at the client level	• Check on DSD model appropriateness and satisfaction at every annual clinical review (Case study 4) • Where change in service delivery need or preference indicated, provide DSD literacy regarding DSD model choices available • Offer enrolment (not automatic) • Responsible person in new DSD model informed of enrolment, possible reminder pre-visit, and follow up any missed first appointment • Timeous completion of specific DSD model enrolment processes, including notifying new service provider and script submission (if external to health facility)	• Provide information to people enrolled in a less intensive DSD model on how to change location of ART refill collection (where this is enabled) • Any transfer documentation completed to include DSD model utilized prior to transfer • Include assessment for less intensive DSD model at transfer-in visit and offer immediately if eligible	• Full HIV disclosure completed • Individual readiness assessment for transition • Make a timeous transition plan with child/adolescent • Peer (in new age group) allocated to support transition (peer-led case management for specified transition period) • Group DSD model/s available in new age group and prioritized for offer • Gradual transition: introducing new DSD model building blocks into current DSD model (for example, increasing refills or contraceptive care assessment into service package) • New DSD model orientation: location and new peer group visit before transition • Cohort transition: where possible, more than one child/adolescent from previous model transitioned together (Case study 3)		• Make a timeous transition plan with postnatal woman (ensure she knows when to expect transition and has chosen her preferred service delivery option) • Mentor mother navigation/ accompaniment to new service location with orientation visit before transition date • Cohort transition: where possible, transition more than one postnatal woman from previous model together • Where not possible to transition directly into less intensive DSD model in general ART service, carry out assessment and, at first clinical consultation, offer less intensive DSD model options
Enablers at the health system level	• Same as Table 1 with national DSD operational guidance to consider "lateral move" service delivery transition enablers	• Enable simplified processes for geographical change to ART refill collection elsewhere in the country	• Facility-level transition planning for readiness assessments, suitable DSD model availability, enabling gradual transitioning, cohort transitioning and new model orientation package		

Case study 3 (client level)

Transitioning clubs for adolescents and young adults in Eswatini

For several years, Eswatini has supported and implemented teen clubs for adolescents. To support adolescents who are ageing into adulthood, Eswatini expanded guidance in its 2022 update to include guidance on "transitioning clubs" [6]. Transitioning clubs are for adolescents and young adults aged 16-24 years and have the same ART refill and clinical review frequency as adult clubs. Transitioning clubs introduce sexual and reproductive health components and assist adolescents to set and achieve goals for independence and self-management of care. A specific checklist is provided to assess readiness for service transition into individual adult DSD models of care.

Case study 4 (health system level)

Revisiting DSD model preference at each clinical review visit in Uganda

Uganda uses clinical consultations as an opportunity to check in and discuss the model preference of the client. In its clinical stationery, it is required that at each clinical consultation, an assessment of DSD-related categorization is completed along with the preferred DSD model [7]. Training for healthcare workers supporting DSD in Uganda emphasizes a "5As approach":

- Assess the person's knowledge of DSD.
- Assist the person to identify barriers to continued care.
- Advise the person on appropriate DSD models.
- Agree with the person on their DSD model of choice.
- Arrange for the person to receive ART drug refills and clinical management in their preferred DSD model.

Table 3. Interventions to facilitate effective transitions from less intensive to intensive DSD models ("up-referrals")

	Across population groups
Reasons for transition	Clinical reasons or preference to integrate care or ineligible for less intensive DSD in terms of DSD policy
Transition from (model)	Any "established on ART" DSD model
Transition to (model)	Facility-based clinician-managed care (possibly integrated care)
Enablers at the client level	• Clearly explain the purpose of increased clinical management, when the stipulated postnatal period will be complete, and when the next assessment for re-enrolment in less intensive DSD will take place (clear timeframes). • If the person was receiving care in a group or an individual community model with an established peer support network, provide the choice to stay in a DSD model alongside additional clinical care. • If the person is clinically well, continue to provide longer treatment refills and consider minimum necessary clinical consultations and/or counselling sessions (Case study 5). • Provide quality comprehensive clinical management (not only rescript and drug refill) to ensure that service delivery change has added value. • Track and trace if the person missed a follow-up clinical appointment.
Enablers at the health system level	• Implement quality assurance processes to support the provision of quality comprehensive care to people requiring more intensive clinical management. • Audit processes to review quality of clinical management and appropriate timing for assessment and offer the chance for re-enrolment into intensive DSD models.

Case study 5 (client level)

Supporting multi-month dispensing clinically well people with an elevated viral load in Côte d'Ivoire, South Africa and Mozambique

Clients who are clinically well with an elevated viral load can benefit from both enhanced adherence counselling and extended ART refills to support treatment continuity. In Côte d'Ivoire [8], national DSD policy for this population supports continued three-month ART refills alongside enhanced adherence counselling. In South Africa, those who are clinically well with an elevated viral load receive a single enhanced adherence counselling session and a three-month ART supply until the follow-up clinical review where a viral load is retaken [9]. The Mozambique policy enables people with elevated viral loads to continue in their facility-based three- or six-monthly refill model when logistical barriers to access the clinic have contributed to their elevated viral load [10].

Priority actions to facilitate effective DSD transitions

- Minimize unnecessary transitions between DSD models to reduce disruption and complexity for the client and health system.
- Increase DSD literacy and service delivery-related communication among and between healthcare workers and clients.
- Identify and include approaches to enable effective DSD transitions in national DSD guidance. Where such guidance supports population-specific models, the approach to transitioning out of the specific DSD model should be outlined.
- Identify DSD transitions that make the largest contributions to treatment interruptions or disengagement in specific contexts, implement transition support strategies and evaluate quality of implementation.

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