Lazarus Momanyi, NASCOP, Kenya & Vindi Singh, The Global Fund, Switzerland

# Differentiated service delivery for HIV treatment in 2022

## Session 2: Moving into, out of and between service delivery models: Changing needs, a changing DSD model

# Conflict of interest disclosure

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# Moving into, out of and between service delivery models: Changing needs, a changing DSD model

## Session co-chairs

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# Overview of session 2

| Moving into, out of and between service delivery models: Changing needs, a changing DSD model |
|---|
| • **Enabling successful transitions within DSD for HIV treatment**, Lynne Wilkinson, IAS, South Africa |
| • **Supporting HIV care during adolescence to early adulthood**, Stanley Ngoma, Ministry of Health, Malawi |
| • **Moving between DSD models as needs change**, Cordelia Katureebe, Ministry of Health, Uganda |
| • **Managing elevated viral loads within a group DSD model**, Hélder Macul, Ministry of Health, Mozambique |
| • **DSD before, during and after pregnancy**, Lillian Mworeko, ICWEA, Uganda |
| • Q&A / Discussion |

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# Please engage

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Post your questions virtually

Lynne Wilkinson, IAS, South Africa

## DSD for HIV treatment in 2022

# Enabling successful transitions within HIV treatment

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# Where is DSD?

## Established on ART

### Adults

- Strongly endorsed in global policy – WHO, Global Fund, PEPFAR
- Widely incorporated into national policy
- Scaled implementation and accelerated in response to COVID-19 pandemic

### Specific populations

(Children, adolescents, pregnant and breastfeeding women and key populations)

- Endorsed in global policy – WHO, GFATM, PEPFAR
- Largely incorporated in national policy (except for PBFW)
- Progress towards implementation, increasing more more quickly during/after COVID-19

## Not established on ART

- Limited incorporation in global or national policy
- Increasing recognition people starting ART or struggling with adherence/ retention may benefit from less intensive DSD models

# What changes require service delivery transitions?

**Changes that require service delivery transitions**

- Age
- Pregnancy status
- Clinical stability
- Preferences or model availability

# What changes require service delivery transitions?

**Changes that require service delivery transitions**

## Age

- Child to adolescent
- Adolescent to young adult
- Young adult to adult
- Adult to older adult

## Pregnancy status

- Non-pregnant to pregnant
- Pregnant to mother-infant pair (breastfeeding)
- Mother-infant pair to mother (non-pregnant)

## Clinical stability

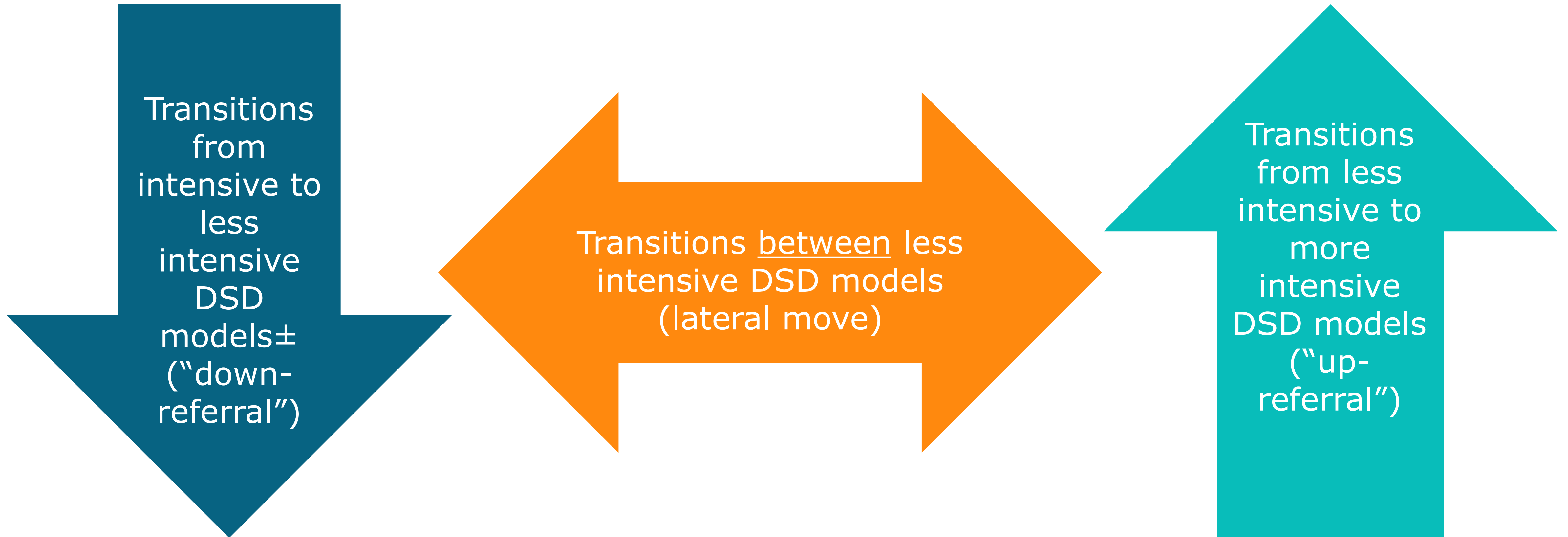
- Suppressed viral load to elevated viral load*
- Well to unwell*
- Interrupted care to re-engaged in care

## Preferences or model availability

- Migration (location change)
- Facility to community model*
- Individual to group model*

* *bi-directional*

# Types of service delivery transitions




±Includes first time and transition back following a period of increased intensity

# Transition risks

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The **person** being transitioned:

- is not ready for the transition
- has not fully understood or agreed to or accepted the transition
- loses or perceives to lose a valued service component

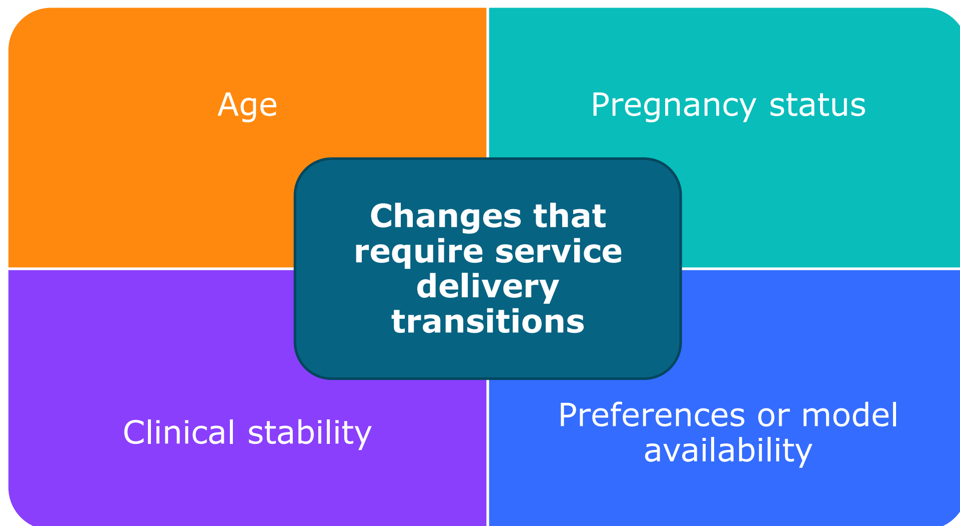
The **health system** processes may fail to support an effective transition

- no/poor transition planning
- system failures

For example

- prescription not submitted to appropriate drug supply system,
- ART refills not supplied to location for collection,
- ART stock outs, etc.

# Impact of poor service delivery transitions




↑ Increased treatment interruption and losses to care occur during transitioning IN/OUT/BETWEEN DSD models

↓ Reduced client satisfaction with poor transition planning and practices

**Need to pay increased attention to service delivery model transitions and their impact on outcomes.**

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# Interventions to support effective transitions

# Transitions from intensive to less intensive DSD models

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**Down referral**

- Assessed and meet eligibility for the first time
- Return of clinical stability
- Return after completing antenatal and/or post-natal care
- Return after period of re-engagement

## Increase DSD treatment literacy!

Healthcare workers to provide clear explanation of the eligibility criteria and specific DSD model options available

### Children and adolescents

- For children and families on ART - offer and support access to the same less intensive DSD model as the child's caregiver and other family members – *See Kenya's DSD policy*
- For adolescents – provide DSD model options that enable peer group interaction - *See Malawi's DSD policy*

### People re-engaging

- Clear policy guidance on accelerated access into a less intensive DSD models – *See South Africa's DSD policy*

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# Transitions from intensive to less intensive DSD models

**Down referral**

- Assessed and meet eligibility for the first time
- Return of clinical stability
- Return after completing antenatal and/or post-natal care
- Return after period of re-engagement

## Transition back into less intensive DSD models

- Clearly communicate timepoint at which re-enrolment into less intensive DSD models will be assessed and offered.
- Where a person was satisfied with their previous DSD model, re-enroll in the same model (same day/group to better leverage an established peer support network)

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# Transitions between less intensive models

**Lateral move**

- Maintain "established on ART" while aging or after post-natal period completed
- Preference for in/out of facility models changed
- Preference for individual/group models changed
- Transfer to a new health facility

## Children and adolescents

- Transition preparation - transition plan and readiness assessments

## Children adolescents and post-natal women

- Gradual transition allowing for elements of new model to be introduced into old model (for instance longer refills, new location orientation, new service provider introductions)
- Cohort transition – transition a group of individuals moving to next life stage together to retain the established supportive peer network

# Transitions between less intensive models

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**Lateral move**

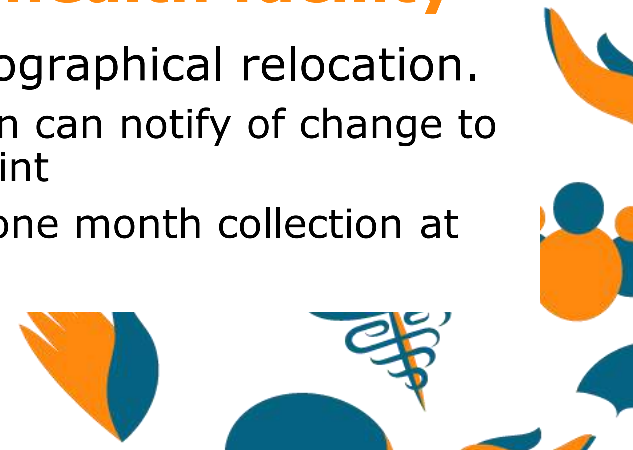
- Maintain "established on ART" while aging or after post-natal period completed
- Preference for in/out of facility models changed
- Preference for individual/group models changed
- Transfer to a new health facility

## Service preference change within a facility

- Less intensive DSD model offer not a once-off event
- DSD systems allows for model change by request and DSD model appropriateness assessed regularly (at the annual clinical visit before rescripting)

## Transfer to a new health facility

- Systems to support geographical relocation.
  - South Africa: a person can notify of change to external collection point
  - Malawi: emergency one month collection at any facility



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# Transitions from less intensive to intensive DSD models

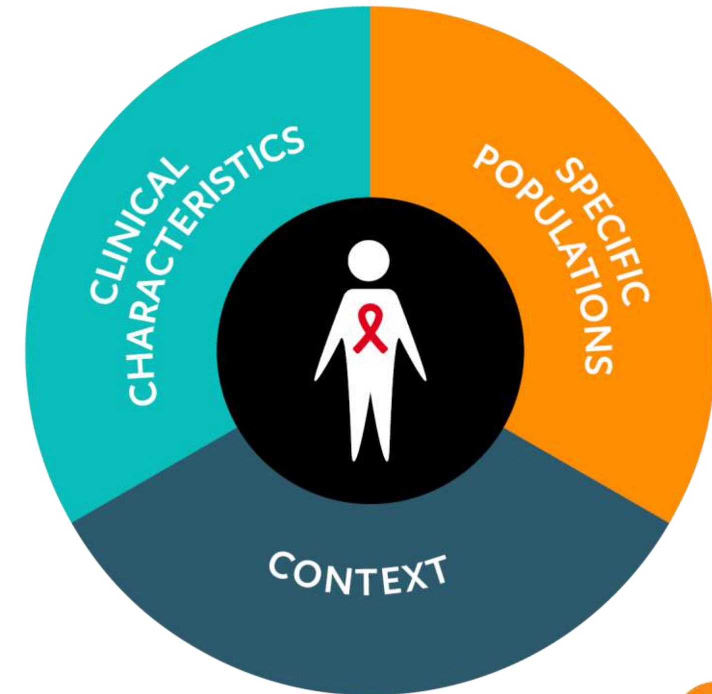
**Up referral**

- Clinical reasons (e.g., elevated viral load, unwell, interrupted treatment)
- Country DSD guidance excludes or person choses to receive integrated healthcare management (e.g., integrated ante-natal and ART management)

- Increase healthcare provider to patient communication
- Clear explanation for the transition – attribute value to increased clinical management and psychosocial support
- A clear timebound pathway back to person's less intensive model of choice

# Way forward

- Increase DSD treatment literacy
- Improve service delivery transition communication
- Consider service delivery transition facilitators/enablers when developing DSD operational guidance
- Ensure specific population DSD models include "how to" approach transitioning out of the model
- Identify the most urgent DSD model transitions to support (for example adolescence to young adulthood) and implement a "transition" support strategy




**Keeping the person in the centre requires DSD system enhancements to support service delivery transitions**

Stanley Ngoma, Ministry of Health, Malawi

## DSD for HIV treatment in 2022

# Supporting HIV care during adolescence to early adulthood

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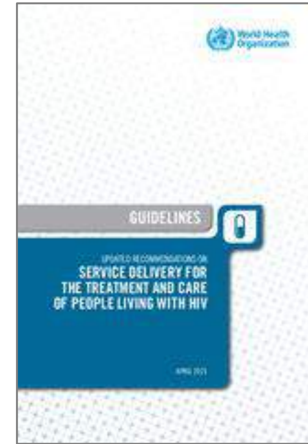
# In March 2021, WHO revised eligibility criteria for determining whether a person is established on ART




Revised

To support the implementation of these recommendations, WHO has developed criteria for determining whether a person has been successfully established on ART:

- ✓ receiving ART for at least six months;
- ✓ no cu... nditions;
- ✓ good ... provided; and
- ✓ evide... thin the past six m... ght gain, abse...

"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."

World Health Organization, *Updated recommendations on service delivery for the treatment and care of people living with HIV*. April 2021.

# DSD models for adolescents need to meet their needs and preferences

"Service delivery models beyond the facility that support adolescents in engaging in care, such as peer-based interventions and community-based services, should be considered. Young people value peer interventions highly. Adolescent-friendly health services should be implemented to improve quality…

Consider:

- providing adolescent services at specific times or in separate areas with flexible appointment systems that accommodate school hours;
- providing comprehensive services that address multiple needs, including psychosocial support and sexual and reproductive health; and
- closely monitoring adolescents' engagement in care, rapidly and proactively following up and implementing strategies for re-engagement."

World Health Organization, *Updated recommendations on service delivery for the treatment and care of people living with HIV*. April 2021.

# Different DSD models for adolescents

GROUP MODELS

*Teen/Youth clubs*

HEALTHCARE WORKER-MANAGED GROUP

*Family ART groups*

CLIENT-MANAGED GROUP

INDIVIDUAL MODELS

*Adolescent corners/Youth service days*

FACILITY-BASED INDIVIDUAL

*Outreach or youth center pick up points*

OUT-OF-FACILITY INDIVIDUAL

# Supported by Adolescent treatment supporters

- Community adolescent treatment supporters **(CATS)** – Zimbabwe
- Young People and Adolescent Peer Support model (**YAPS**) – Uganda

# Teen clubs in Malawi

- Teen club model developed by BIPAI in 2003, started in Malawi in 2007
- Teen Club offers comprehensive care (including SRH) in a confidential forum that reduces common barriers to care.
- Teen Clubs are held on weekends (usually Saturdays) at a local health facility
- Teens must satisfy eligibility criteria (10-19 years, full disclosure, guardian consent)

369 Teen clubs across Malawi

35,500 teens eligible

(95% attending teen clubs)

Retention is greater than 90% in Teen Clubs

Viral load suppression is 78% in Teen Clubs

99% of eligible children transitioned to pDTG

10+ IPs working with Teen Clubs

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# Needs change as transition though age groups

Special Needs Service

Teen Mom Clinic

Male Friendly Clinic

Nurse-led Community ART Program (NCAP)

Young Adult Service

Adolescent Service

Pre - Adolescent Service

Kindergarten ART Clinic

0 5 10 20 25 Age (Years)

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# Services offered at different age-bands

- **3-9 years**: Emphasis on disclosure and adherence
- **10-14 years**: ART adherence, nutrition and future planning
- **15-17 years**: Sexual and reproductive health
- **18-19 years**: Preparation of independence beyond adolescence
- **20-23 years**: Continued preparation (if necessary), young adult case management support, community ART

= within Teen Club

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# Model adaptations for different age groups

Teen Club activities for those 10-14 years of age

Facility based teen models for those 15—19 years of age

Graduating teens to early adulthood

# Transition challenges

## Challenges for the adolescent

- Fear of the unknown
- Discomfort with leaving known DSD model
- Lose peer support environment
- Lose known lay healthcare workers (peers) and clinician support
- Often lose integrated care – separation of SRH and ART care
- Qualitative studies have shown reduced satisfaction after transition

## Clinical outcome risks post transition

Retention

CD4 count and viral load suppression

## Health system challenges

- Adolescents transition refusal/delays
- Increased number of people to service in adolescent DSD models
- Introducing greater age disparities within "adolescent" models

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# How could we better support the transition for adolescent HIV care to adult HIV care?

# 1. Transition readiness preparation and assessment

1. **Develop clear country level or clinic level transition plans**
   - **HOW** should teen club members be transitioned out of teen clubs
2. **Individual readiness preparation**
   - Increase knowledge, acceptance and preparation for transition
3. **Individual transition readiness assessments**
   - Reduce risk of transitioning to early

**Malawi**

- Teen mentors/peer leaders are selected and trained to work with peers in preparation for transition to early adulthood
- Transition orientation sessions as part of Teen Club from 18 years to empower with independence
- Transition orientation session for caregivers
- Skills and educational development within Teen Club environment
- Individual readiness is assessed and those not ready to transition can remain in Teen Club (more on next slide)

# 2. Gradual transition approaches

1. **New service delivery model orientation**

*For example:*

- Physical introduction to new service location/providers

2. **Introducing components of new DSD model into adolescent model**

*For example:*

- Separating refills and clinical consultation
- Longer ART refills

3. **Focused peer support pre- and post-transition**

**Malawi**

- Transition preparation starts at 18 yrs with adolescents transitioning at 19 yrs if ready – *gradual preparation*
- When young adult is not ready, can stay in Teen Club and continue with transition support up until 23 years
- Older Teen Clubs transition from monthly to quarterly to prepare for less intensive adult DSD models
- Peer leaders can provide case management for up to 12 months after transition to support transition.
- Enhanced friendly services at the clinics: fast-tracking young adults transitioned into adult services

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# 3. Cohort transition approaches

1. **Transition more than one adolescent to adult DSD model**

- Retain and leverage established peer network

2. **Identify/develop appropriate adult DSD model options**

For example:

- Identifying/enabling adult group models at the same facility
- Scheduling for individual DSD model but on same day at the same facility

**Malawi**

- Where Teen Club clinics have associated CAGs – young adult can transition into a CAG individually, with another young adult or form a new CAG with other transitioning young adults.
- Peer leaders at Teen Clubs provide support to join community support groups run by CBOs

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# Transition service delivery challenges for Malawi

- Funding gaps
- Limited partners supporting Teen Clubs
  - Low coverage
- Limited capacity to mentor and support clinics to implement Teen Clubs
- Limited number of facilities with CAGS and community support groups run by CBOS
- Challenges with buy-in among staff to reduce clinical consultations
- M&E systems to track outcomes

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# Way forward for Malawi

- Develop simplified transition approach
- Provide national guidance
- Identify partners to pilot transition package with MoH
- Engage research partner to follow outcomes after transition

- **Improved transition planning and service delivery dependent on additional funding to support development and implementation**

https://hiv.health.gov.mw

BIPAI
Baylor International
Pediatric AIDS Initiative

LIGHTHOUSE

CLINTON
HEALTH ACCESS
INITIATIVE

Dr. Cordelia Katureebe, Ministry of Health, Uganda

## DSD for HIV treatment in 2022

# Moving between DSD models as needs change

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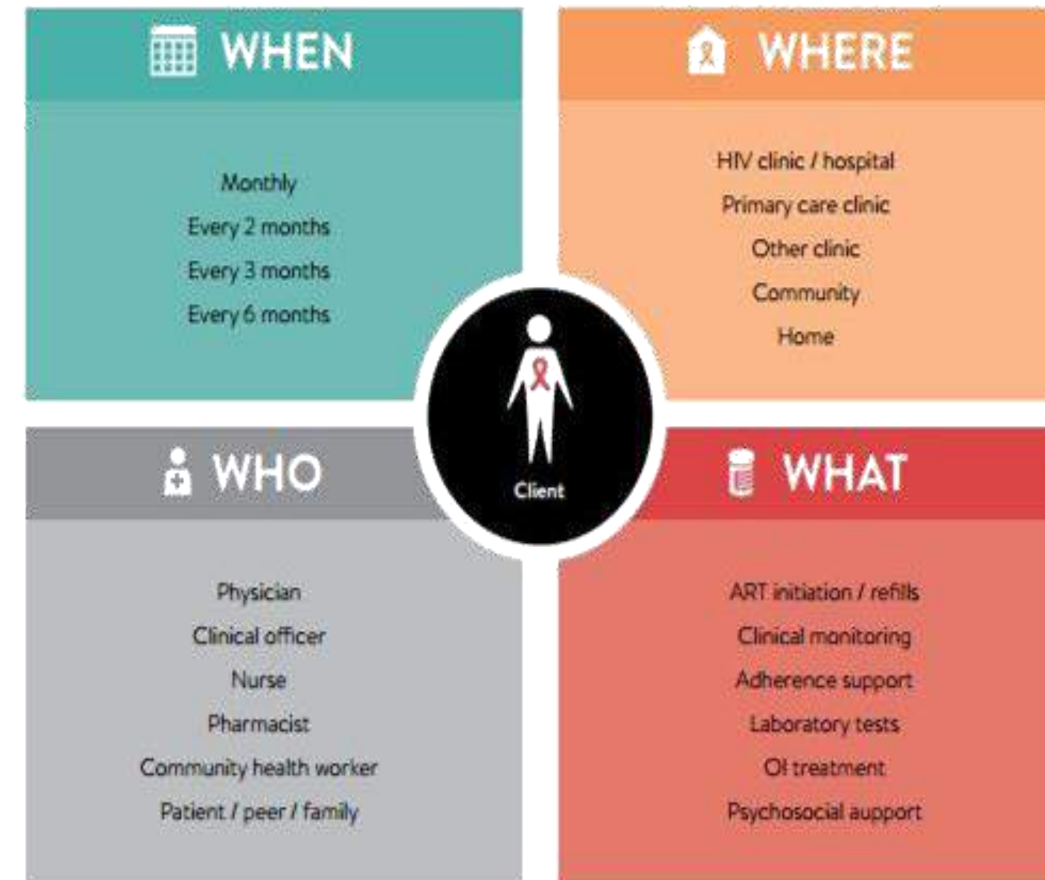
# Differentiated service delivery (DSD) implementation in Uganda, 2017-to date

- 2017: Adopted DSD following WHO guidance.
- Training curriculum developed, National, regional & facility level trainings
- 2018: Incorporated into the national guidelines
- Enrollment criteria (Stable vs. unstable)
- Fixed / inflexible models
- Currently >95% of all facilities implementing DSD
- More flexibility with 2021 updated DSD guidelines (more patient centered)

## The four building blocks of DSD



# Innovations

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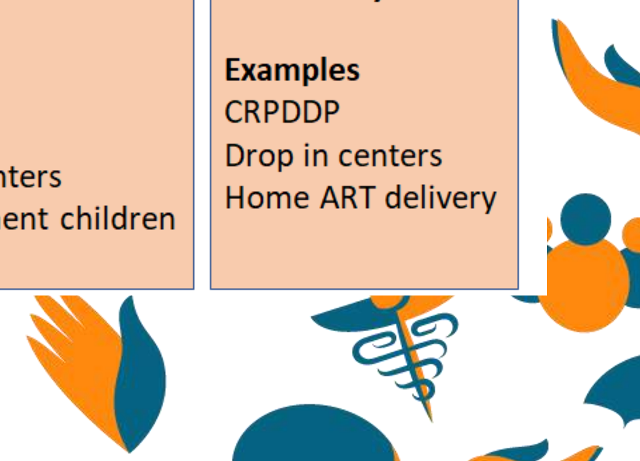
- People living with HIV dynamic in nature thus need flexible models
- Current WHO guidance- allows for flexibility of models
- Uganda incorporated this in the revised guidelines
- All recipients of care are eligible for DSD but not for all DSD models.
- As a person becomes established on ART, more DSD model choice is available.
- Allows for movement from one model to another
- Enables more community models

**Category of Recipient of Care**

- PLHIV newly identified *or re-engaging* in care with advanced HIV disease
- PLHIV newly identified or re-engaging in care when clinically well
- PLHIV established on ART and or controlled NCDs
- PLHIV with treatment failure
- PLHIV with uncontrolled chronic illness, and ART limiting toxicities

**Treatment at Facility or in Community**

| Group Model | | Individual Model | |
|---|---|---|---|
| **Group models managed by HCW**<br><br>**Examples**<br>FBG<br>CDDP<br>FSG<br>Viraemia Clinics | **Group models managed by client**<br><br>**Examples**<br>CCLAD<br>CLDDP | **Individual models based at facilities**<br>**Examples**<br>FTDR<br>FBIM<br>YAPS<br>Adolescent centers<br>Holiday treatment children | **Individual model based in community**<br><br>**Examples**<br>CRPDDP<br>Drop in centers<br>Home ART delivery |



# Facilitators for transitioning between different DSD models

- Previously we have had transitions depending on:
  - Age – Child → Adolescent → Adult
  - Viral load- stable ←→ unstable
  - Pregnancy status

- Currently:
  - People living with HIV newly identified *or re-engaging* in care with advanced HIV disease
  - People living with HIV newly identified or re-engaging in care when clinically well
  - People living with HIV established on ART and or controlled chronic illness.
  - People living with HIV with treatment failure
  - People living with HIV with uncontrolled chronic illness and drug limiting toxicities

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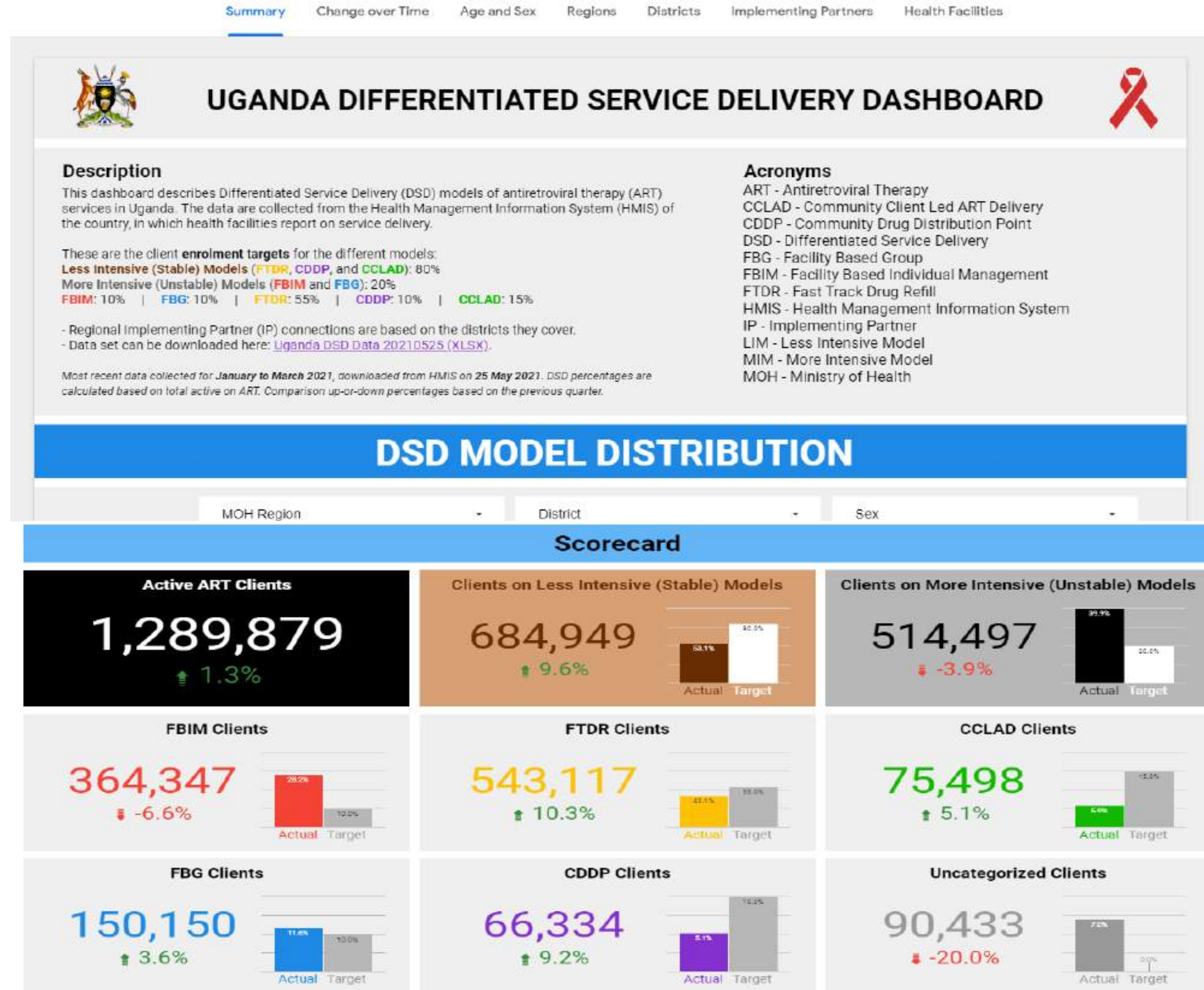
# Health Information systems

- Developed the DSD dashboard for continuous monitoring
- Screening for client preferred model using the 5 A's Approach
  - **Assess** RoC's knowledge about DSD
  - **Assist** RoC to identifying barriers
  - **Advise** RoC on appropriate models
  - **Agree** with the RoC on the DSD Model
  - **Arrange** for the RoC to receive drug under preferred model
- Paper based recording vs. online recording.
- Data indicators to be monitored



# Considerations for the data tools to facilitate DSD model transitions

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**Data capture for Care Card**

**Codes for use on the care card**

CA15

DSDM Model

Patient categorisation

Model

Approach

**DSDM Patient Categorisation CA15a**

1. PLHIV newly identified or re-engaging in care with advanced HIV disease
2. PLHIV newly identified or re-engaging in care when clinically well
3. PLHIV established on ART
4. PLHIV with treatment failure
5. PLHIV with uncontrolled chronic illness, and ART limiting toxicities

**DSDM Models CA15b**

**GMH:** Group models managed by HCW
**GMC:** Group models managed by client
**IMF:** Individual models based at facilities
**IMC:** Individual model based in community

**Approaches CA15c**

1. GMH-FBG
2. GMH-CDDP
3. GMH-FSG
4. GMH-Viraemia Clinics
5. GMH- Others (Specify)..................
6. GMC-CCLAD
7. GMC-CLDDP
8. GMC- Others (Specify).........
9. IMC-CRPDDP
10. IMC-Drop in centers
11. IMC-Home ART delivery
12. IMC-Others (Specify).........................
13. IMF- FTDR
14. IMF-FBIM
15. IMF-YAPS
16. IMF-Adolescent centers
17. IMF-Holiday treatment children
18. IMF-Others (Specify)........

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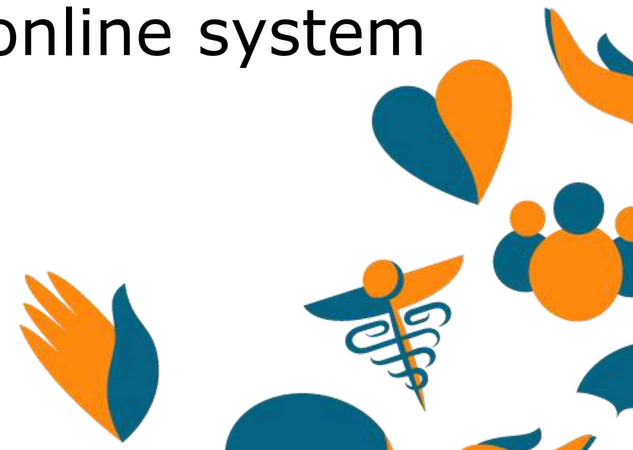
# Model transition challenges in Uganda

- Incomplete documentation on the client charts that feed into the EMR system
- Geographical scope of the different regions limiting DSD to facility-based models only.
- Stability criteria limiting the number of clients that can be enrolled in certain DSD models (for example to the community models- Community Drug Distribution points (CDDP) & Community Client Led ART Distribution (CCLADs)
- Social norms where it is believed care is at the hospital not community

# The way forward

- Modifying recommended available DSD models to fit into the scope of the region or district
- Expand eligibility criteria for certain DSD models to reduce limitations on enrolments
- Developed sensitization material in local languages to promote community models
- Optimize all data elements on the client charts to the online system (Uganda EMR)



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# ACKNOWLEDGEMENTS


- MINISTRY OF HEALTH UGANDA
- PEPFAR
- WHO
- UNICEF
- UNIAIDS
- CHAI
- EGPAF
- GLOBAL FUND


**Thank You!!!**

Hélder Macul, Ministry of Health, Mozambique

## DSD for HIV treatment in 2022

# Managing missed appointments, re-engagement and elevated viral loads within DSD

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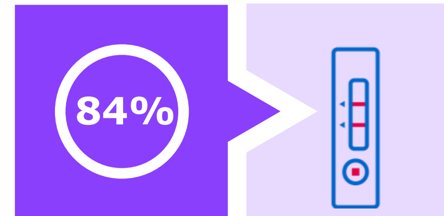
*Hélder Macul*

# HIV in Mozambique

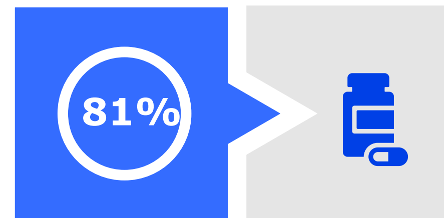
**13.2%** HIV prevalence

**1,698,486**
**People living with HIV on treatment**

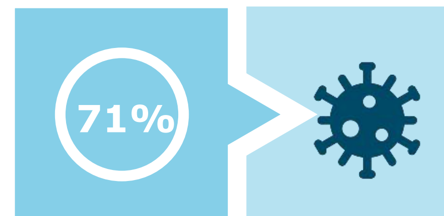
**1,706 health facilities providing ART services**




**People living with HIV know their status**




**On treatment**




**Viral load suppressed**

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# DSD guidance before COVID-19 (2018 guidelines)

| MORE INTENSIVE MODELS (MIM) | LESS INTENSIVE MODELS (LIM)* |
|---|---|
| • TB/HIV One Stop | **Facility-based** |
| • AYFS One Stop | • 3MMD (3-monthly clinicals) |
| • MCH One Stop | • Fast flow 3MMD (6-monthly clinicals) |
| • Family approach | **Community-based** |
| • Mobile brigades | • CAG |
| • Mobile clinics | • Mobile brigade – 3MMD |
| • **Adherence clubs (Viraemic/2nd line adherence clubs)**** | |

AYFS - Adolescent and Youth Friendly Services, CAG – community ART group, C&T -Care and treatment (C&T), MCH - Maternal and Child Health

*** Eligibility for less intensive models (definition of established on ART):**

- VL suppressed or CD4>200
- Have good adherence
- On ART for more than **6** months
- Without activate conditions of WHO Stage III or IV

****Viraemic/2nd line adherence clubs**

- Mix adherent and viraemic patients in these clubs to support each other – monthly at facility for everyone

# Elevated VL (2018)

- In Mozambique, to be enrolled in a less intensive model (LIM), the recipient of care (RoC) had to be VL suppressed (VL<1000) and have good adherence to the treatment
- When a patient in a LIM becomes unsuppressed in a:
- **Facility-based individual model**: temporary removed from the model, to receive enhanced counselling/drug refills and clinical consults **on a monthly basis** (until suppressed again)
- **Group models** (facility or community): can stay in their model and therefore their group but must receive additional enhanced counselling **on a monthly basis** (until suppressed again)

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# Elevated VL in group models (2018)

## Community Adherence Groups (CAGs) (a LIM)

- Guidance sets out how many people can be unsuppressed in a CAG based on the CAG size – **majority of membership must remain suppressed**
- In CAGS, a member of the CAG goes monthly for their clinical consultation and to collect ART for the remaining group members.
- On this date, the member with an unsuppressed VL **goes with each month** to receive for enhanced adherence counselling, refill and clinical consultation until resuppressed.

## Other group models (more intensive monthly models) (MIMs)

- Recipients of care enrolled on other Group Models (Adherence Clubs and Mother to Mother Groups) and who become unsuppressed
- **Continue to attend the group** to share and collect experiences about adherence
- Receive refills and clinicals in group monthly
- **Individual monthly enhanced adherence counselling (EAC)** same day as club meeting

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# COVID-19 emergency adjustments

- All group models suspended temporary
- RoC with **high VL also received 3MMD AND monthly telephone call** for enhanced counselling to avoid frequent visits to the facility
- **Implemented Care and Treatment (C&T) One Stop** – drug refill/clinical consult/lab/counselling all in one room by one provider
- **Implemented once off community refill (CDA model)** by healthcare workers:
  - **Once off** intervention where a person misses their appointment
  - HCW takes 1-3-month refill (depending on if person MIM/LIM) + clinical + prophylaxis to the patient’s home
  - Patient required to **rejoin their DSD model at their next visit date** (1-3 months later)

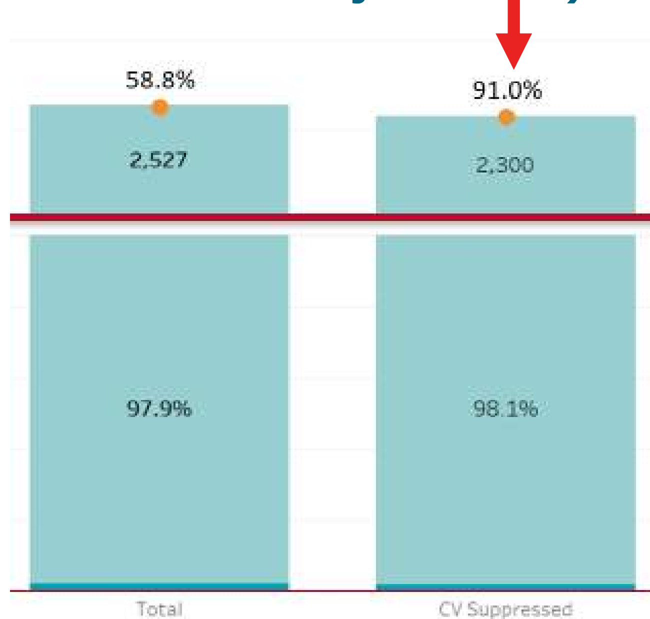
# Evidence from Mozambique's COVID-19 DSD measures

## *3MMD*

**March 2020**

**VL Suppression on patients enrolled on 3MMD with VL criteria**

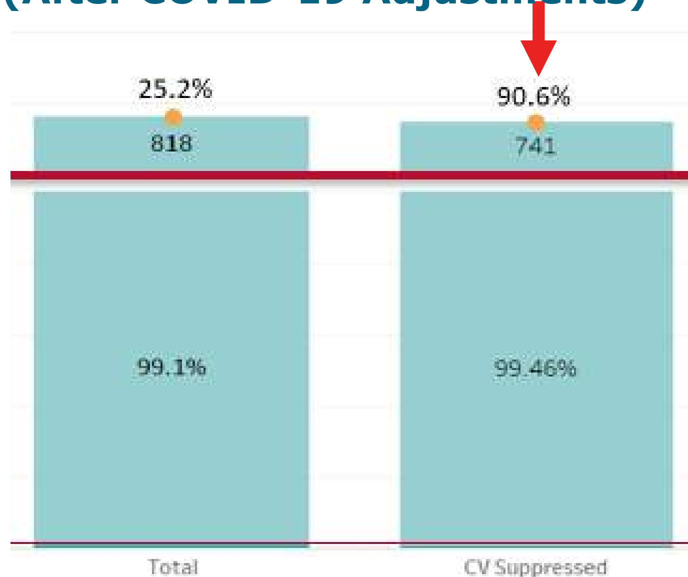
**(Before COVID-19 adjustments)**




Target

**VL Suppression on patients enrolled on 3MMD regardless of VL result**

**(After COVID-19 Adjustments)**




**There's no significant difference in VL suppression between patients enrolled on 3MMD with VL criteria and patients enrolled regardless of the VL criteria**

**ECHO 2021**

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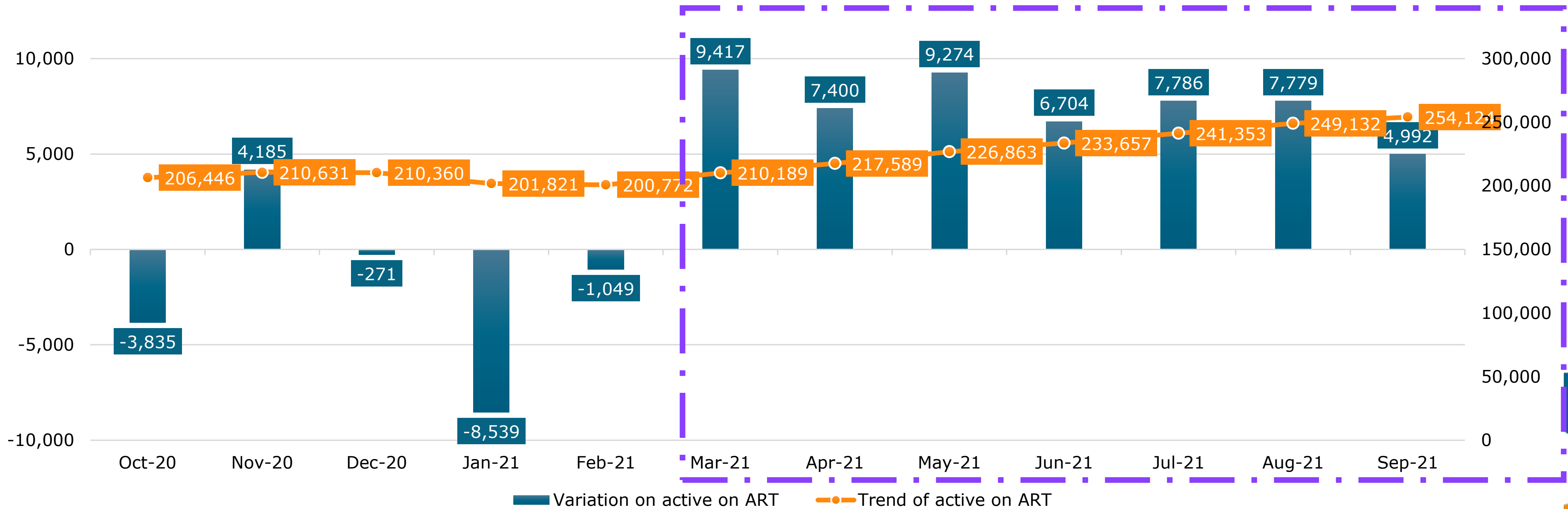
# Evidence from Mozambique's COVID-19 DSD measures

## *Once off community refill by HCW*




85 health facilities, Zambézia Province

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# DSD guidance before COVID-19 (2022 guidelines)

| MORE INTENSIVE MODELS (MIM) | LESS INTENSIVE MODELS (LIM)* |
|---|---|
| • TB/HIV One Stop | **Facility-models** |
| • C&T One Stop | • 3MMD (combined 3-monthly clinicals) |
| • AYFS One Stop | • Fast flow 3MMD (6-monthly clinicals) |
| • MCH One Stop | • **6MMD** |
| • Family approach | • **Adherence club (teen clubs)** |
| • Extended hours | **Community models** |
| • Mobile brigades | • CAG |
| • Mobile clinics | • Mobile brigade 3MMD |
| | • **3MMD Community drug dispensation by CHW (APES)** |
| • **Once off community drug refill by HCW for MIM & LIM** | |

**AT THE BEGINNING OF ART**
- All MIM models

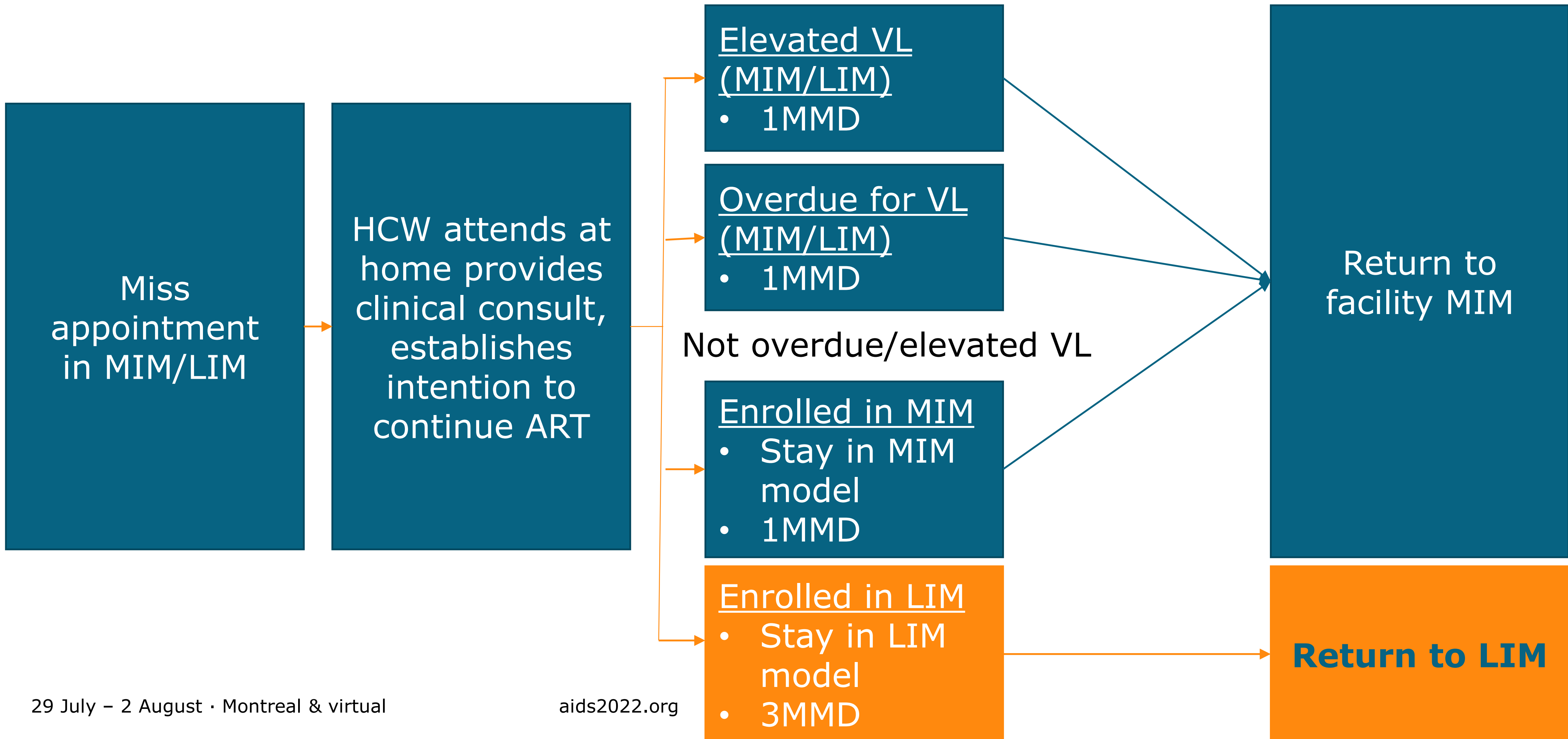
**3 MONTHS AFTER START ART**
- 3MMD only

**6 MONTHS AFTER ART START**
- All other LIM except 6MMD

**9 MONTHS AFTER ART START**
- 6MMD

AYFS - Adolescent and Youth Friendly Services, CAG – community ART group, C&T - Care and treatment (C&T), MCH - Maternal and Child Health

# Missed appointment:
## *Once off community drug refill by HCW model*



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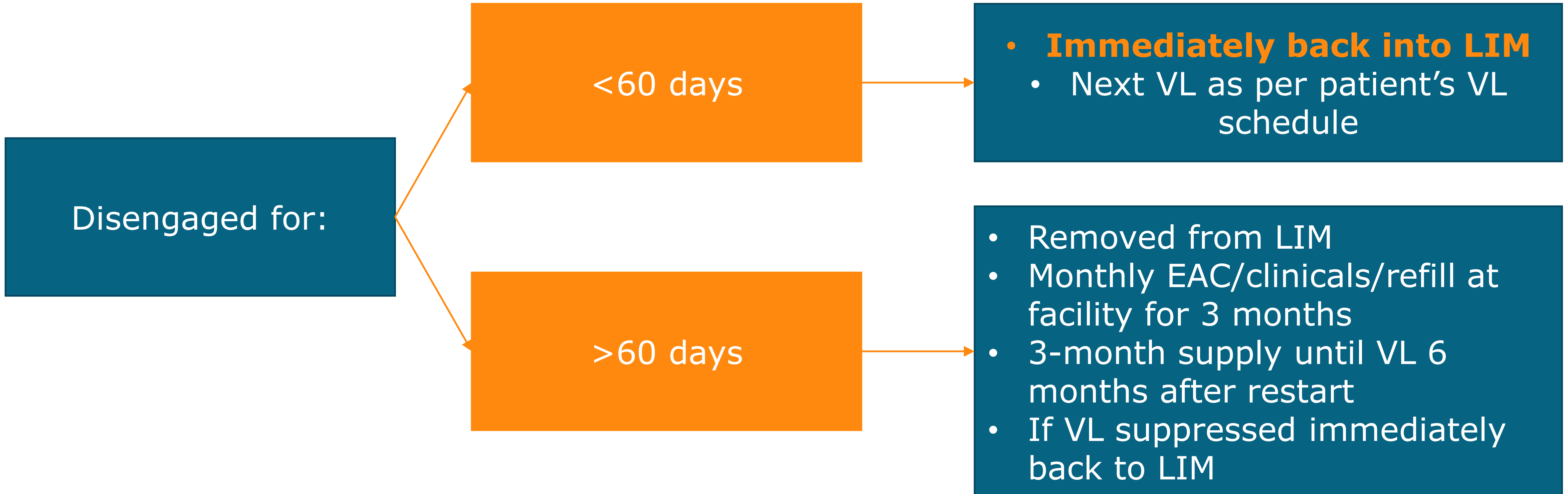
# Elevated VL

- **Remained the same as 2018:** Temporary out of individual models and stay in group models alongside monthly enhanced counselling/drug refills and clinical consults at the facility
- **New focus across models:** monthly support for 3 months→3 months later VL assessment→ if VL suppressed:
  - **Facility-individual models**: immediately back into same LIM
  - **Group models** (remained in group during VL management support)
    - **CAGs** – immediately back to attending facility once every 6 months with monthly refill in CAG in community
    - **Adherence clubs** (including teen clubs) - immediately back into club 3-monthly visit schedule (6-monthly clinical consults)

# Re-engagement



# Endorses future emergency DSD guidance

- 2022 guidance **endorses the DSD approach for future emergencies** across the country or in localized contexts
- ROC receiving ART services in an emergency context (calamities or military conflicts) become **eligible for LIM** (3MMD/6MMD or community refill by CHW), **regardless of their viral load result.**

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# Challenges

In the current visits calendar for RoC on a less intensive model, the date of collection of the follow up VL are not aligned with a clinical consultation date.

The viral load flow (*Health facility –> Referral lab –> Health facility*) often do not support timely availability of VL results for decision making.

Paper-based tools do not capture all the DSD data for a right and timely decision making.

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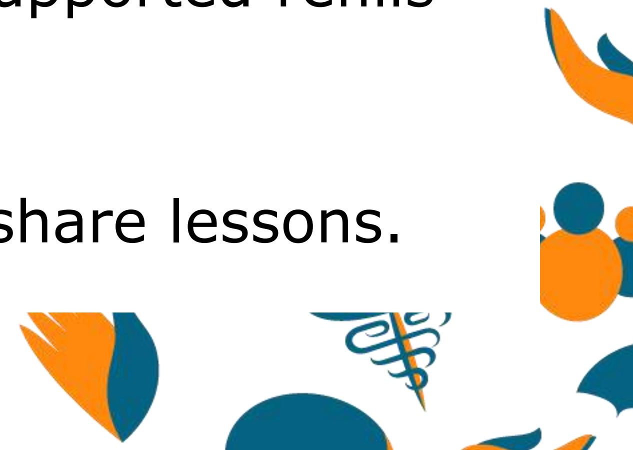
# Summary

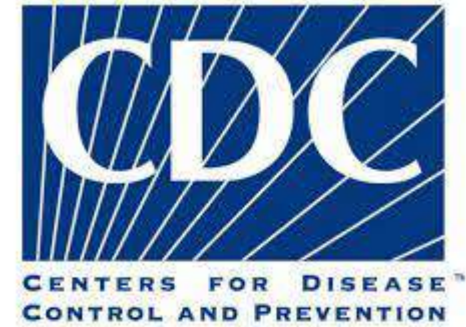
- In 2018, Mozambique started supporting ROC with elevated VLs to **stay in their group models** with increased clinical and adherence support alongside.
- COVID-19 DSD measures showed
  - Possible to **make it easier for people missing appointments and re-engaging in care** to remain engaged by **staying in their LIM**
  - endorsing **DSD measures for future emergencies** will facilitate a quicker response to ensure resilience of treatment program
- 2022 guidance revisions took into consideration COVID-19 DSD lessons
- Mozambique will remain focused on supporting people with:
  - elevated VLs on a monthly basis for 3-months towards **immediately returning them to their individual DSD models or their group DSD model visit schedule**
  - missed appointments or re-engaging to remain engaged by **staying in their LIM**

# Way forward

- **Elevated VL in LIM**:
  - Consider outcomes of telephonic monthly EAC with 3-month refill to see whether reducing visit frequency with EAC support supports VL suppression in era of DTG
  - Awaiting evidence on benefits of 1 versus 3 EAC sessions – can 1 EAC session be provided with a 3-month refill until the next VL.
  - Evaluate outcomes of CAG members with unsuppressed VLs.
- **Missed appointments in LIM**:
  - Continue to evaluate outcomes of once-off community supported refills towards sustaining retention.
- **Re-engagement in LIM:**
  - Evaluate outcomes of Mozambique's new approach and share lessons.



# Acknowledgments



Lillian Mworeko, ICWEA, Uganda

## DSD for HIV treatment in 2022

# DSD before, during and after pregnancy

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*I have no relevant financial relationships with ineligible companies to disclose*

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# Demands during pregnancy and as a new mother

- Individual/personal
- Child-care
- Work related
- Societal
- Health care and related increased needs and priorities

**YET a time that healthcare visit burden increases significantly!**

# VOICES OF WOMEN LIVING WITH HIV

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*It has been our hard work as women living with HIV to reach this level of DSDM; we worked hard to let the world know we can relieve the health care system. What is the difference now that I am pregnant? Has my commitment to a better health changed?*

*Pregnant women must participate in decision making about how, when and where they get services. We cannot do business as if we are back to the beginning of the pandemic. When will our service providers enable us to manage our health and pregnancies?*

*Remember we demanded choice during the ECHO Trial, the Dolutegravir saga, and now we must advocate for pregnant women's choice. Where there is choice - access, uptake and retention is high. That is what a pregnant woman who is struggling with so many things wants*

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# In 2021, WHO updated guidance to include pregnant women as eligible for DSD

| | 2016 | 2021 |
|---|---|---|
| **Term** | Stable | Established on ART |
| **Time on ART** | 12 months on ART | 6 month on ART |
| **Inclusion of pregnant women** | Pregnant women excluded | Pregnant women included |
| **Inclusion of children and adolescents** | Children and adolescents included | Children and adolescents included |
| **Regimen** | Second and third line not explicitly stated | Any ART line included |
| **Viral load / evidence of treatment success** | Two consecutive viral loads <1000 copies/ml | At least one viral load <1000 copies/ml in last 6 months |

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- **Inclusion of pregnant and breastfeeding women in DSD models**
- Recognition of the transition with associated characteristics
- Most women living with HIV who get pregnant are already in DSD models
- Make sure there are options and choices

"The **period of transition** from maternal, new-born and child health services to HIV care clinics is often a critical point in which many women and their infants discontinue care…

…An increasing number of women living with HIV who become pregnant are clinically stable on ART and access their care through a differentiated ART delivery model. While they are pregnant and during the early postpartum period, these women require additional health-care visits. **They should have the choice** to continue receiving their ART through the differentiated ART delivery model or to have their ART delivery integrated within their maternal, newborn and child health care…"

- WHO, 2021 Consolidated guidance

# But still…

**Countries remain hesitant to support pregnant and breastfeeding women in DSD for HIV treatment models**

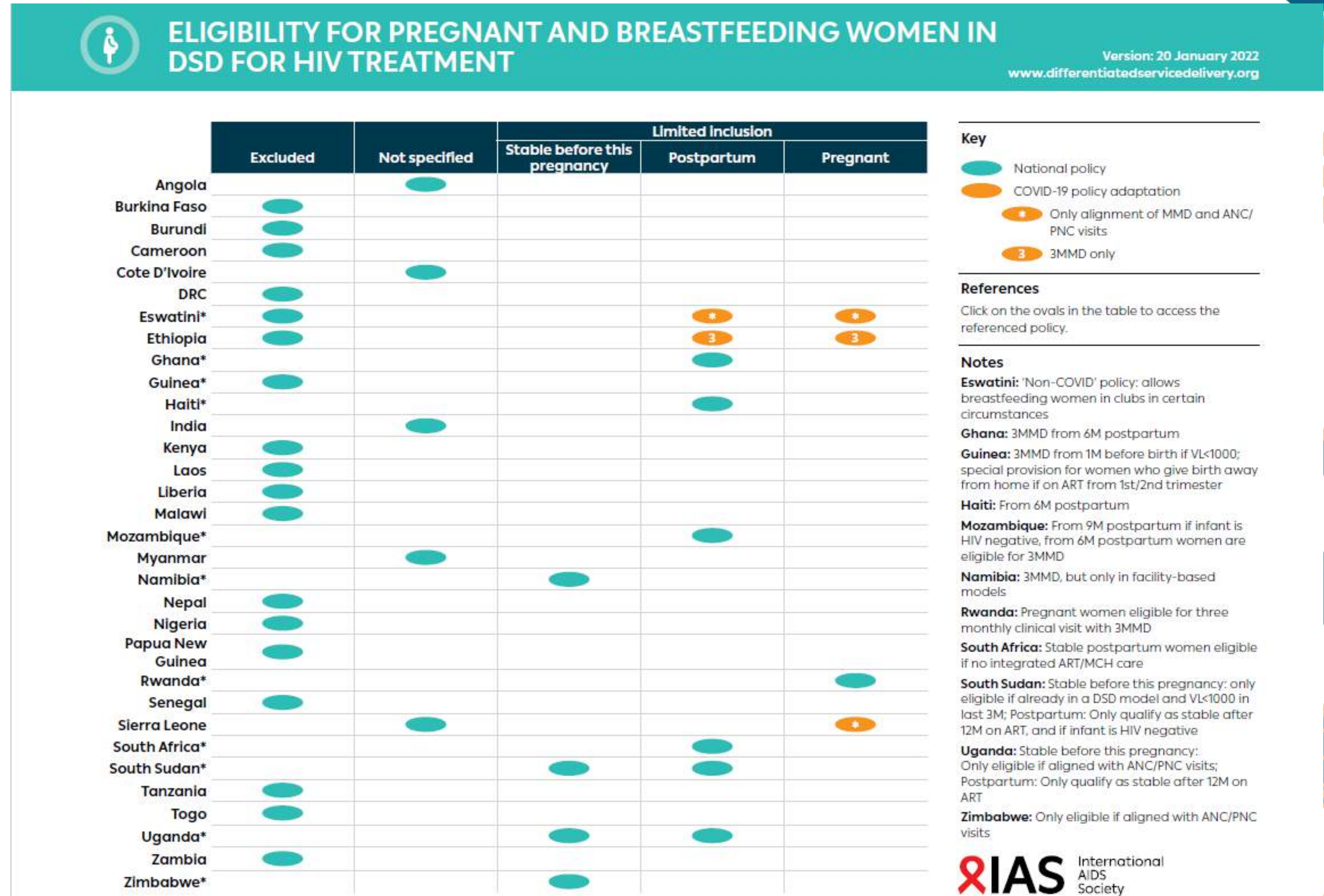
**Limiting the duration of ART refills to ensure they attend ante-natal care (ANC) and maternal and child health (MCH) services**

# COVID-19 pushed countries to be pragmatic and provide 3MMD to many pregnant and breastfeeding women

## But now, these policies are being reversed

# Limited country progress

- Most countries continue to completely exclude pregnant and breastfeeding women from DSD.
- Uganda one of the few countries that have revised their DSD guidance but more can still be done…



ELIGIBILITY FOR PREGNANT AND BREASTFEEDING WOMEN IN DSD FOR HIV TREATMENT

Version: 20 January 2022
www.differentiatedservicedelivery.org

| | Excluded | Not specified | Limited inclusion: Stable before this pregnancy | Limited inclusion: Postpartum | Limited inclusion: Pregnant |
|---|---|---|---|---|---|
| Angola | | ● | | | |
| Burkina Faso | ● | | | | |
| Burundi | ● | | | | |
| Cameroon | ● | | | | |
| Cote D'Ivoire | | ● | | | |
| DRC | ● | | | | |
| Eswatini* | ● | | | * | * |
| Ethiopia | ● | | | 3 | 3 |
| Ghana* | | | | ● | |
| Guinea* | ● | | | | |
| Haiti* | | | | ● | |
| India | | ● | | | |
| Kenya | ● | | | | |
| Laos | ● | | | | |
| Liberia | ● | | | | |
| Malawi | ● | | | | |
| Mozambique* | | | | ● | |
| Myanmar | | ● | | | |
| Namibia* | | | ● | | |
| Nepal | ● | | | | |
| Nigeria | ● | | | | |
| Papua New Guinea | ● | | | | |
| Rwanda* | | | | | ● |
| Senegal | ● | | | | |
| Sierra Leone | | ● | | | * |
| South Africa* | | | | ● | |
| South Sudan* | | | ● | ● | |
| Tanzania | ● | | | | |
| Togo | ● | | | | |
| Uganda* | | | ● | ● | |
| Zambia | ● | | | | |
| Zimbabwe* | | | ● | | |

Key
● National policy
COVID-19 policy adaptation
* Only alignment of MMD and ANC/PNC visits
3 3MMD only

References
Click on the ovals in the table to access the referenced policy.

Notes
**Eswatini:** 'Non-COVID' policy: allows breastfeeding women in clubs in certain circumstances
**Ghana:** 3MMD from 6M postpartum
**Guinea:** 3MMD from 1M before birth if VL<1000; special provision for women who give birth away from home if on ART from 1st/2nd trimester
**Haiti:** From 6M postpartum
**Mozambique:** From 9M postpartum if infant is HIV negative, from 6M postpartum women are eligible for 3MMD
**Namibia:** 3MMD, but only in facility-based models
**Rwanda:** Pregnant women eligible for three monthly clinical visit with 3MMD
**South Africa:** Stable postpartum women eligible if no integrated ART/MCH care
**South Sudan:** Stable before this pregnancy: only eligible if already in a DSD model and VL<1000 in last 3M; Postpartum: Only qualify as stable after 12M on ART, and if infant is HIV negative
**Uganda:** Stable before this pregnancy: Only eligible if aligned with ANC/PNC visits; Postpartum: Only qualify as stable after 12M on ART
**Zimbabwe:** Only eligible if aligned with ANC/PNC visits

IAS International AIDS Society

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# DSD for pregnant and breastfeeding women in Uganda

<u>March 2020</u>
Stable for pregnant/ post-natal = 12 months on ART (not 6 months)

| Categories | Qualifying Clients | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Stable* Client | Complex Unstable**/ New/ Transfers in | Children | | Adolescents | | PMTCT (ANC→3 months postpartum) | PMTCT (Mother-Baby Pair 3-18 months) | Key Populations |
| | | | <2 years | 2 - <10 years | 10-14years | 15-19years | | | |
| Facility Based Individual Management (Comprehensive clinical evaluation) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Facility Based Group | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Fast track drug pick-up | ✓ | | | ✓ 1 | ✓ | ✓ | | | ✓ |
| Community Client Led ART Distribution (CCLAD) | ✓ | | | | ✓ 3 | ✓ 5 | | | ✓ |
| Community Drug Distribution Points (CDDPs) | ✓ | | | ✓ 2 | ✓ 4 | ✓ 6 | | | ✓ |

Stable and become pregnant WLHIV can stay in their DSD model (aligned with ANC visits)
Also eligible for DSD post delivery (clinical visits aligned with immunization schedule - 6wks/10 wks/14wks/6m/9m/12m/15m/18m/24m)

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# Not only excluded from DSD but also

## Complex service delivery transitions increase risk of disengagement

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# Transition from "established on ART" model to facility-based clinician managed care (within ANC/MCH)

**Up Referral**

Pregnant and post—natal women

- Clinical reasons (e.g., elevated viral load, unwell, interrupted treatment)

or

- Woman chooses to combine her ART care into ANC/MCH care

## Facilitators

- Clear explanation for and purpose of increased clinical management and limited time period
- **Provide choice to stay in DSD model if prefer alongside additional clinical care**
- Mentor mother/lay provider supports follow-up if missed follow-up clinical appointment

# Transitions from post-natal club to non-MCH facility-based clinical managed care (back to ART clinic)

**Up**
**Referral**
After post-natal
Period

- Infant is now > 18 months old

## Facilitators

- Clear communication after 18m infant HIV test result
- Mentor mother/peer navigation/accompaniment
- **Where possible, transition more than one mother from post-natal group together**
- Assessment at first clinical consultation at non-MCH facility for DSD model enrolment

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**Down Referral**
Pregnant, post—natal women and after post-natal period

- Assessed and qualify as established on ART

# Transition from facility-based clinical managed care (within ANC/MCH service) to any "established on ART" DSD model

## Facilitators

- Clear explanation for and purpose of possible transition
- Offer not forced transition
- DSD model preference provided with clear explanation of WHEN/WHERE/WHO and WHAT of model choice available
- Clear explanation of where clinical consultations will take place (ART service or elsewhere)
- ART refill responsible person informed of enrolment, possible reminder pre-visit and to follow-up any missed first appointment

# Transition from any "established on ART" DSD model to a NEW DSD model (specific to pregnant or post—natal women)

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**Lateral move**

- Change of DSD model preference, including if specific DSD model specific for pregnant or post-natal women is available

## Facilitators

- Clear explanation for offer to change DSD models to meet current needs
- Clear communication regarding DSD model schedule date and venue for first visit
- For post-natal women only: Where possible more than one mother transitioned together
- ART refill responsible person informed of enrolment, possible reminder pre-visit and to follow-up any missed first appointment

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# Way forward

- Meaningful engagement of women living with HIV in decision making about their options and choices
- DSD models are meant to serve the unique needs and priorities of individuals and pregnant and breastfeeding women should not be excluded
- Countries to follow WHO guidance in DSD policy guidance updates
- **AND** consider how to best facilitate service delivery transitions to avoid women becoming disengaged from care during pregnancy or post-natally

Lazarus Momanyi, NASCOP, Kenya & Vindi Singh, The Global Fund, Switzerland

**Differentiated service delivery for HIV treatment in 2022**

# Q&A

# Discussion

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# Up next...

## Session 3: DSD to support sustained re-engagement: It shouldn't be one-size-fits all

### Session co-chairs

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