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DSD model transitions: Supporting the evolving care needs of people living with HIV

Client perspectives and the need for flexible health systems



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Conflict of interest

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





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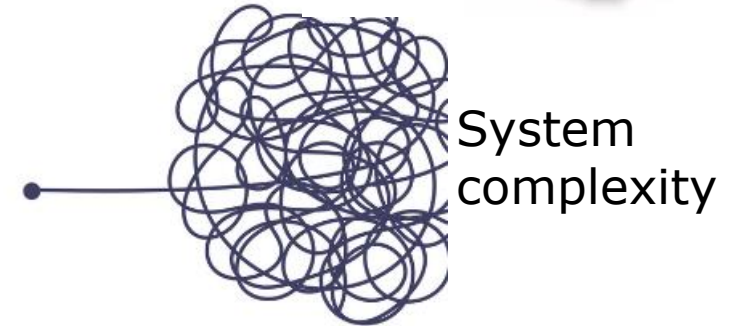
DSD is for the People

- The demand for DSD continues to grow as it puts PLHIV at the centre of their care
- BUT **differentiated** service delivery means that very few people will require the same model of care for their lifelong ART journey
- Needs and preferences will change along the way
- This means having to **MOVE – TRANSITION** between models of care
- Transitioning involves risks for the person moving and the health system managing the move



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Poor DSD transitions risk...



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1. Remove unnecessary transitions

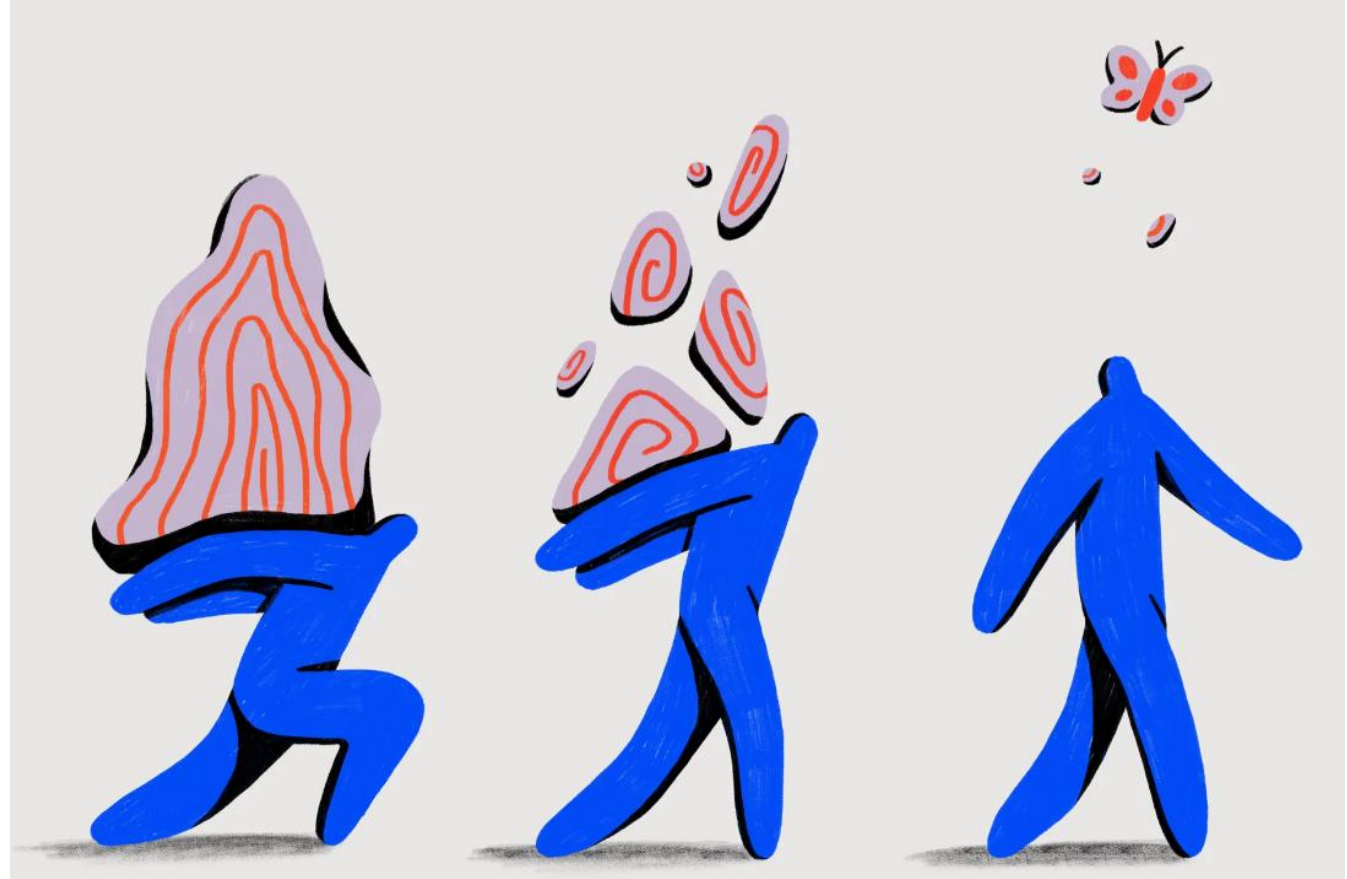
Means add more flexibility!

- When is it in a person's best interest to be removed from their less intensive DSD model?
- When does requiring a transition INCREASE rather than DECREASE risk for a person's short and long-term outcomes?
- When is the health system requiring a transition only because it is not set up to manage a person's change in circumstances without a transition?
- How often should a person be assessed for possible transition?



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2. Better facilitate necessary DSD transitions

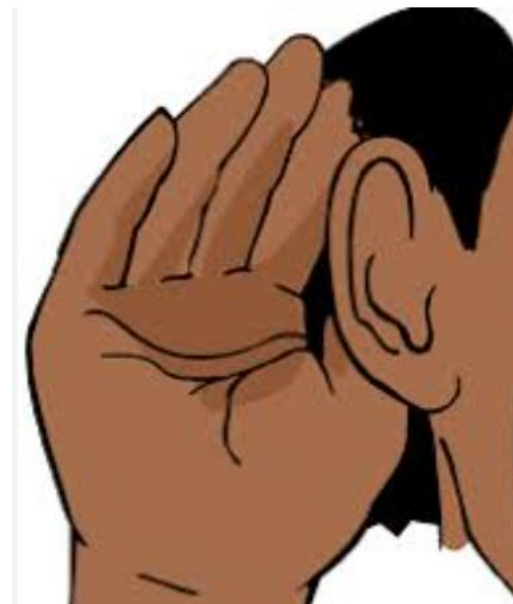


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i. Engage with PLHIV experiencing transitions

1. Which transitions are the most difficult to navigate?
2. What intervention/s could better support:
 - Mobility
 - Pregnancy
 - Motherhood
 - Transition into adolescence
 - Transition into adulthood
 - Re-engagement in care
 - Co-morbidities





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ii. Recognise the importance of DSD literacy

- **What is DSD literacy?**
 - What is DSD
 - How DSD models work – building blocks
 - When a model works for you and when it may no longer work for you
- **Improve communication** between healthcare workers and clients
 - Open feedback channels
 - Measure and track satisfaction
- **Invest** in DSD literacy and quality of healthcare worker-client communication



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iii. Provide value when burden on people living with HIV is increased

- Is the reason for up-referral being actively addressed at each required additional visit?
 - Providing an increased level of care?
 - Providing quality clinical care?
 - Providing integrated care?
 - Attaining better satisfaction?





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iv. Enable the power of peers

1. **Changes don't only happen to me** – many people are simultaneously experiencing the same aging, pregnancy, motherhood, struggles with treatment adherence, illness
2. Remember the **mutual support lessons** HIV has taught us over the years
3. How can we better **leverage peer support mechanisms**:
 - a. Orientation by peers
e.g. from post-natal back into general adult services
 - b. Group DSD models with peers
e.g. from family to adolescent DSD models
 - c. Group transitions
e.g. young people transitioning to same adult model
 - d. Future social networks to lean on during and after the life/circumstance change
minimise disruption of social networks



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Where to from here....



→ **Engage with us**



→ **Invest in DSD literacy**



→ **Provide quality care**



→ **Leverage peer support mechanisms**

- **Be more flexible** – don't lose us while a change occurs in our lives. *Keep all the doors to care open for us during challenging times.*
- Identify the most **critical transitions** in the specific context that need to be better facilitated **with us**
- We now live in a DSD world – transitions are an integral part of that world.
- We need:
 - **Patient-level enablers**
How can my healthcare workers and clinic support me during a necessary transition?
 - **Broader health system enablers**
How can the health system support me to continue in my less intensive DSD model when I move?



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Thank you

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Please engage

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Post your questions and comments virtually

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