

# A Framing of Differentiated Service Delivery

*In preparation for the Consultation on Differentiated Service Delivery for Specific Populations and Settings, 16-18 November 2016, Geneva*

## Introduction to differentiated care

Differentiated care is aimed at providing a framework for the re-examination of service delivery. It is a client-centred approach that simplifies and adapts HIV services across the treatment cascade in order to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. By providing differentiated care, the health system can refocus resources to clients most in need.

Differentiated care will become even more relevant as countries face additional health system burdens. More and more PLHIV will interact with the health system in line with the World Health Organization (WHO) recommendation to treat everyone diagnosed with HIV (1) and in the drive to achieve the 90-90-90 targets (90% of people living with HIV should know their status; 90% who know their status should be on ART; 90% of those on ART should be virologically suppressed) (2).

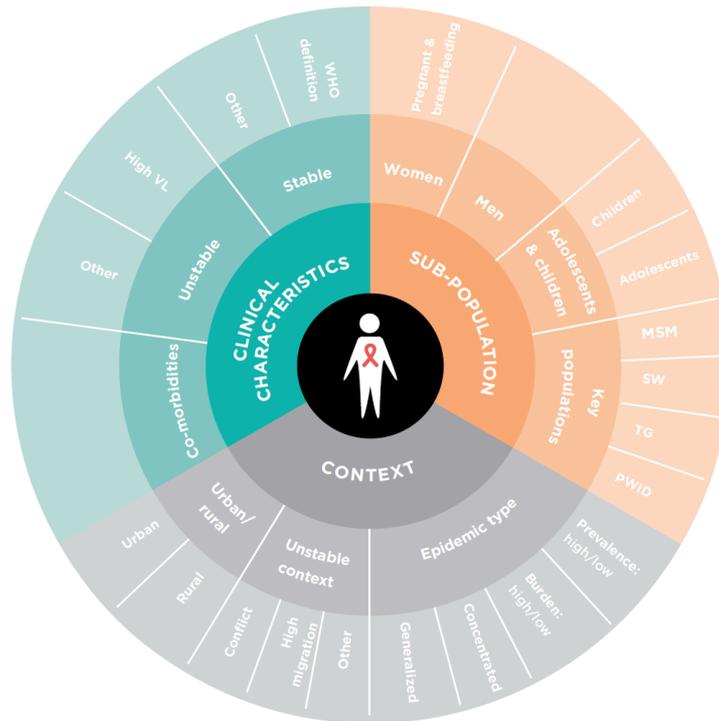
The best-known differentiated service delivery (DSD) models for HIV to date are for *differentiated ART delivery for clinically stable patients*, which focus on the second and third 90-90-90 targets although it is recognized that DSD could be applied across the HIV cascade. Key results that have been achieved through DSD so far include reduction of the burden for clients and health systems, and high retention rates (3).

As much of the DSD work to date has focused on ART delivery for clinically stable adults in high-prevalence settings, the upcoming consultation on DSD (16-18 November 2016, Geneva) is aimed at looking beyond this group of clients to assess what is known of models of specific populations and settings. Therefore, two reviews have been developed to better understand DSD models for families (children, adolescents, pregnant and breastfeeding women) and key populations (people who inject drugs, men who have sex with men, sex workers, transgender people, prisoners and other people living in closed settings). For families, the review focused on differentiated models of ART delivery and on adherence support models that could be leveraged to also support ART delivery. For key populations, the paucity of examples of differentiated ART delivery models led to the scope being expanded across the care cascade to review models for ART testing, linkage and initiation. This document sets out the framing for the reviews through outlining the elements, general models of differentiated care and the building blocks for DSD.

## Differentiation elements

According to the DSD framework, differentiating service delivery for PLHIV requires consideration of three key elements: the sub-population; the context; and the clinical characteristics of clients (Figure 1) (4). Models for service delivery should be differentiated according to these elements.

**Figure 1: The three elements**



*Acronyms: men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG), viral load (VL), World Health Organization (WHO)*

Differentiation must also go beyond clinical characteristics to the context and the sub-population. With regards to context, consideration of the epidemic type that the client is part of in is important, as well as whether they are in an urban or rural area, or in an unstable context. Differentiation by sub-population requires consideration of the varying needs of women (pregnant and breastfeeding), adolescents and children, men and key populations.

WHO has defined four types of PLHIV to illustrate the diversity of needs: patients presenting well; patients presenting with advanced disease; stable patients; and unstable patients (2) (Table 1). Each of these client types will require different care packages to support their clinical needs. It is expected that clients will move between these categories.

**Table 1: Diversity of care needs for people living with HIV\***

People living with HIV	Appropriate package of care
<b>People presenting well</b>	Adherence and retention support
<b>People with advanced disease</b>	Clinical package to reduce morbidity and mortality
<b>Stable individuals</b>	Reduced frequency of clinic visit and community ART delivery models
<b>Unstable individuals</b>	Adherence support, viral load testing, switch to second- or third-line ART if indicated, monitoring for HIV drug resistance

*\*Adapted from the 2016 WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*

## General models of differentiated care

Service delivery models can be grouped into the following four categories:

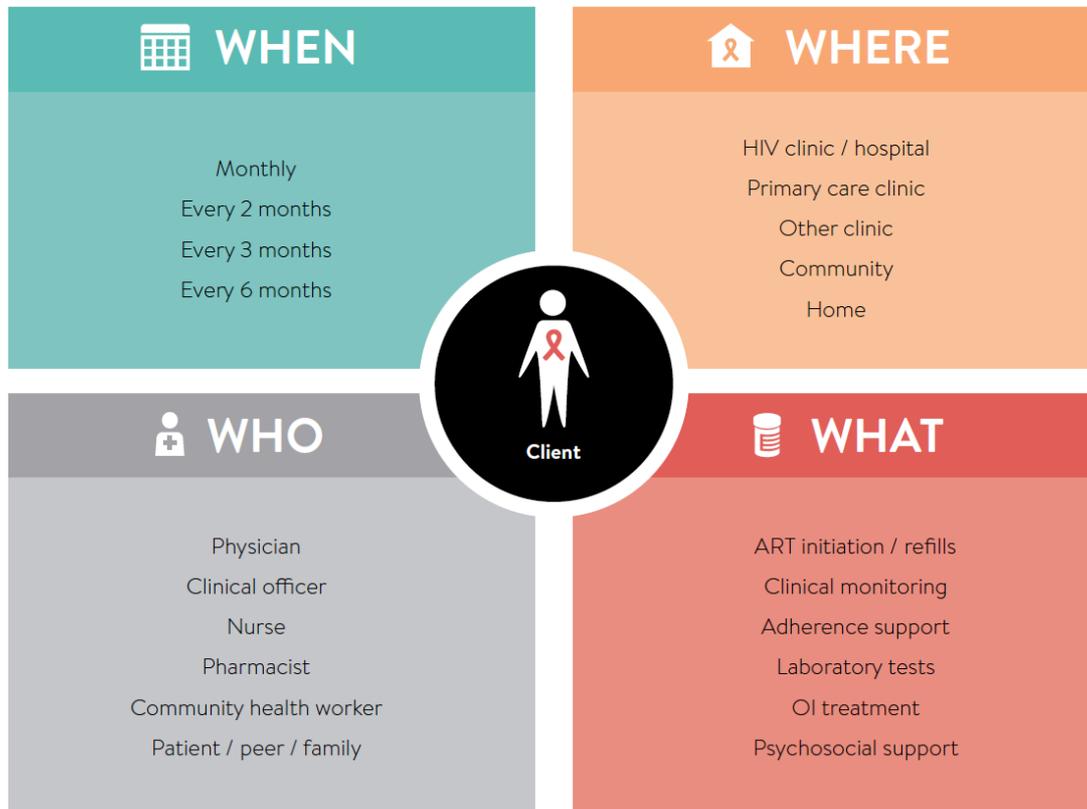
1. Facility-based individual models, where clients are seen individually within health care facilities;
2. Out-of-facility individual models, where clients are seen individually outside of health care facilities;
3. Health care worker-managed group models, where clients are seen in a group managed by a health care worker, either a professional or law health care provider, within and/or outside of health care facilities;
4. Client-managed group models, where clients meet in a group, generally outside of health care facilities.

These categories have been used previously to describe models of ART delivery (4), but can be applied to service delivery models for testing, linkage or initiation.

## The building blocks of DSD

The building blocks are the key components for building a differentiated model of service delivery, previously described as the “key factors in differentiated approaches to HIV care” (3, 5) (Figure 2). They centre on four questions (4): When is care provided? Where is care provided? Who is providing care? What care or services are provided?

**Figure 2: The building blocks of DSD**



The client is at the centre of all models of differentiated care. Models of differentiated ART delivery should consider the building blocks for ART refills separately from those for clinical consultations.

When considering the building blocks needed for families and key populations during the consultation, the focus will be to add to or modify the current recommendations for stable adults based on an understanding of the preferences and expectations of the aforementioned specific populations and their needs. The recommendations by building block for stable adults are outlined below (Table 2).

**Table 2: Recommendations for ART delivery to stable adults by building block**

Building block	Recommendations for ART delivery to stable adults
“When” is ART delivered?	<ul style="list-style-type: none"> <li>• Reducing the frequency of ART refills and clinical visits</li> <li>• Utilizing the maximum duration of ART refills</li> <li>• Extending or adapting service hours</li> </ul>
“Where” is ART provided?	<ul style="list-style-type: none"> <li>• Decentralising services closer to home</li> </ul>
“Who” is providing differentiated ART delivery?	<ul style="list-style-type: none"> <li>• The importance of task shifting</li> <li>• Dispensing versus distribution of ART</li> <li>• The vital role of lay cadres</li> </ul>
“What” services should be offered?	<ul style="list-style-type: none"> <li>• Stable clients still need regular clinical consultations</li> <li>• Considerations with expanded access to routine viral load</li> </ul>

Key questions for consideration in reviewing DSD for families and key populations include:

- Do the above recommendations still apply within the discussion for specific populations? If yes, how? If no, what recommendations?
- What additional recommendations, if any, are needed for each specific population?
- Are additional building blocks necessary? If yes, what building blocks and for which specific populations?

### **In summary**

The two reviews that will be presented summarize differentiated service delivery for families and key populations in order to bring everyone to a shared understanding of the current evidence and practices for DSD in families and key populations. They are also aimed at highlighting potential lessons for scale up and where there are other differentiated care models for other components of the cascade that could be leveraged and expanded to include ART delivery. Each model is outlined utilizing the three elements to describe who the model is for, which general model is being utilized, and what is included in the building blocks. Gaps and key areas for discussion will also be included to help provide the starting point for in-depth discussions at the consultation.

## References

1. World Health Organization. Policy brief: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: what's new. Geneva, Switzerland: World Health Organization, 2015 November 2015.
2. UNAIDS. 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Geneva, Switzerland UNAIDS, 2014 October 2014.
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4. International AIDS Society (IAS). Differentiated Care for HIV: A decision framework for antiretroviral therapy delivery. July 2016.
5. Duncombe C, Rosenblum S, Hellmann N, Holmes C, Wilkinson L, Biot M, et al. Reframing HIV care: putting people at the centre of antiretroviral delivery. *Trop Med Int Health*. 2015;20(4):430-47.