
I A
S

Defining differentiated care across the HIV continuum

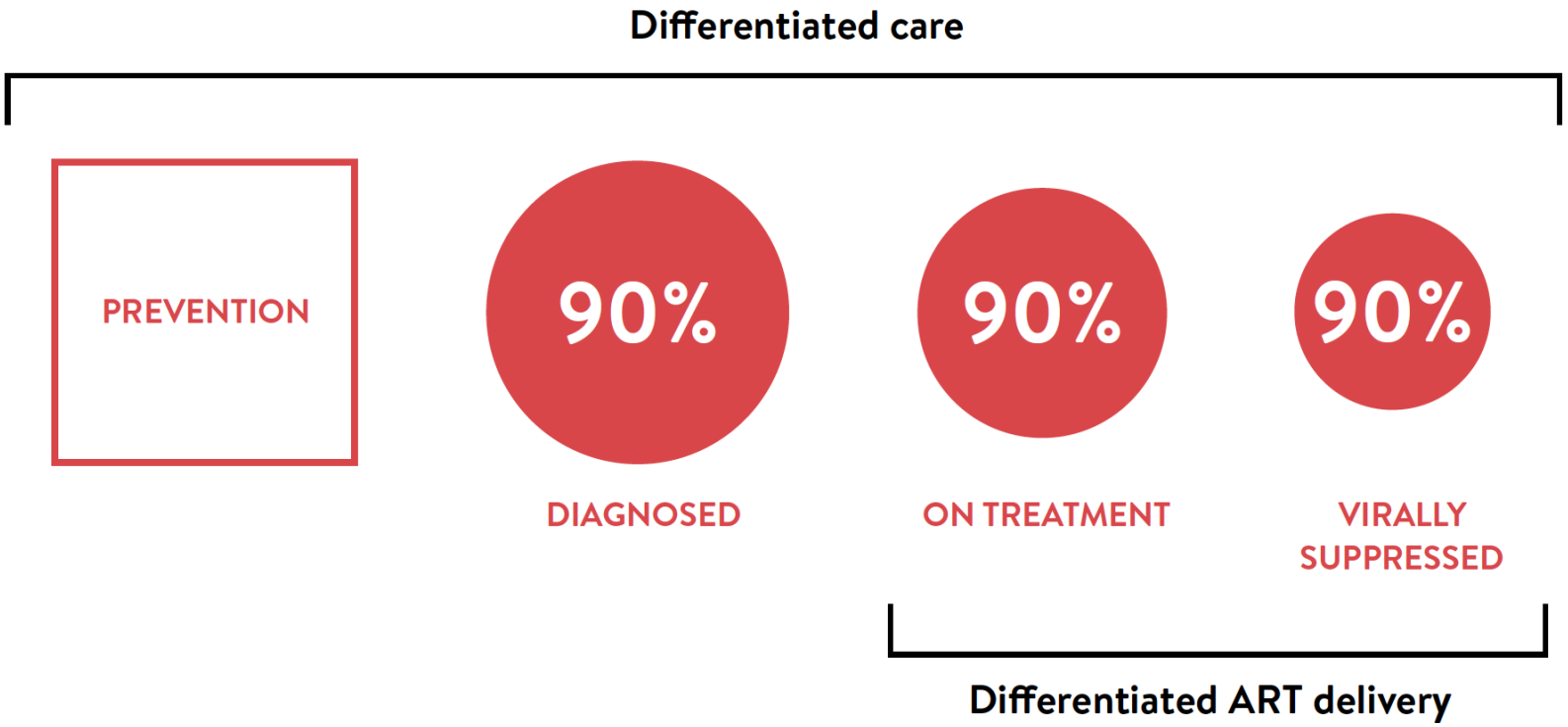
Anna Grimsrud

PATA 2017 Continental Summit
Johannesburg, South Africa
24 October 2017

Differentiated care,

or differentiated service delivery (DSD), is a **client-centred** approach that **simplifies** and adapts HIV services **across the cascade** to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while **reducing unnecessary burdens on the health system**.

Differentiated care is applicable across the HIV care continuum



Not just *what* to start and *when* to start but

SERVICE DELIVERY

6

WHO Consolidated Guidelines, 2015.

Diversity of care needs for PLHIV

"Stable individuals are defined as those who have received ART for at least one year and have no adverse drug reactions that require regular monitoring, no current illnesses or pregnancy, are not currently breastfeeding, have good understanding of lifelong adherence and evidence of treatment success (i.e. two consecutive viral load measurements below 1000 copies/mL). In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 200 cells/mm^3, an objective adherence measure, can be used to indicate treatment success." (1)

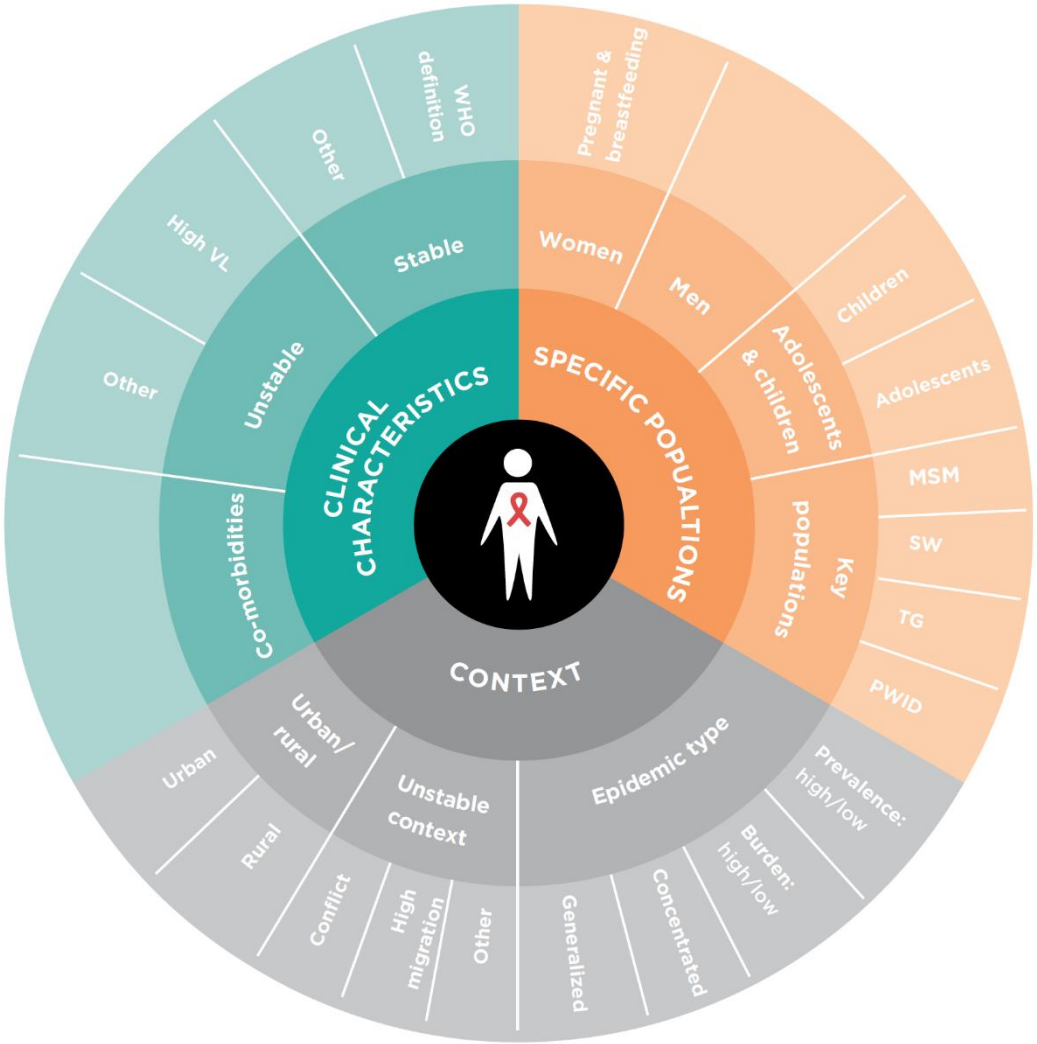
STABLE PATIENTS

- Differentiated care within the community (out of the facility)
- ARV delivery models

UNSTABLE PATIENTS

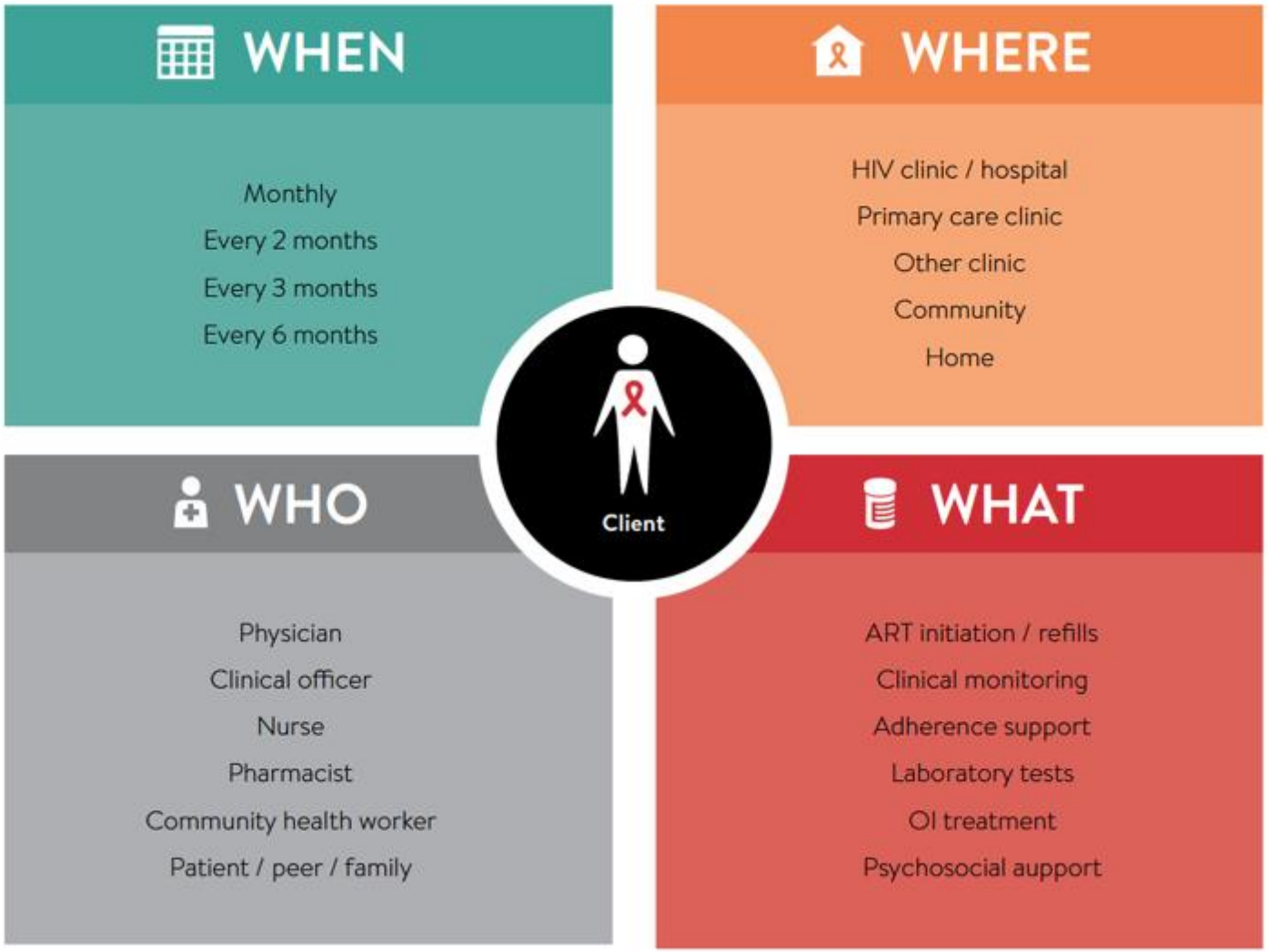
- Adherence and retention support
- Viral load testing
- Switch to second- or third-line ART if indicated
- HIV drug resistance testing
- Opportunistic infection screening and management. TB screening, diagnosis and treatment, co-trimoxazole prophylaxis and IPT[2]

The three elements



The building blocks

The building blocks



KEY CONSIDERATIONS FOR DIFFERENTIATED ANTIRETROVIRAL THERAPY DELIVERY FOR SPECIFIC POPULATIONS:

CHILDREN, ADOLESCENTS, PREGNANT AND BREASTFEEDING WOMEN AND KEY POPULATIONS

World Health Organization · CDC · PEPFAR · USAID · IAS

Key points

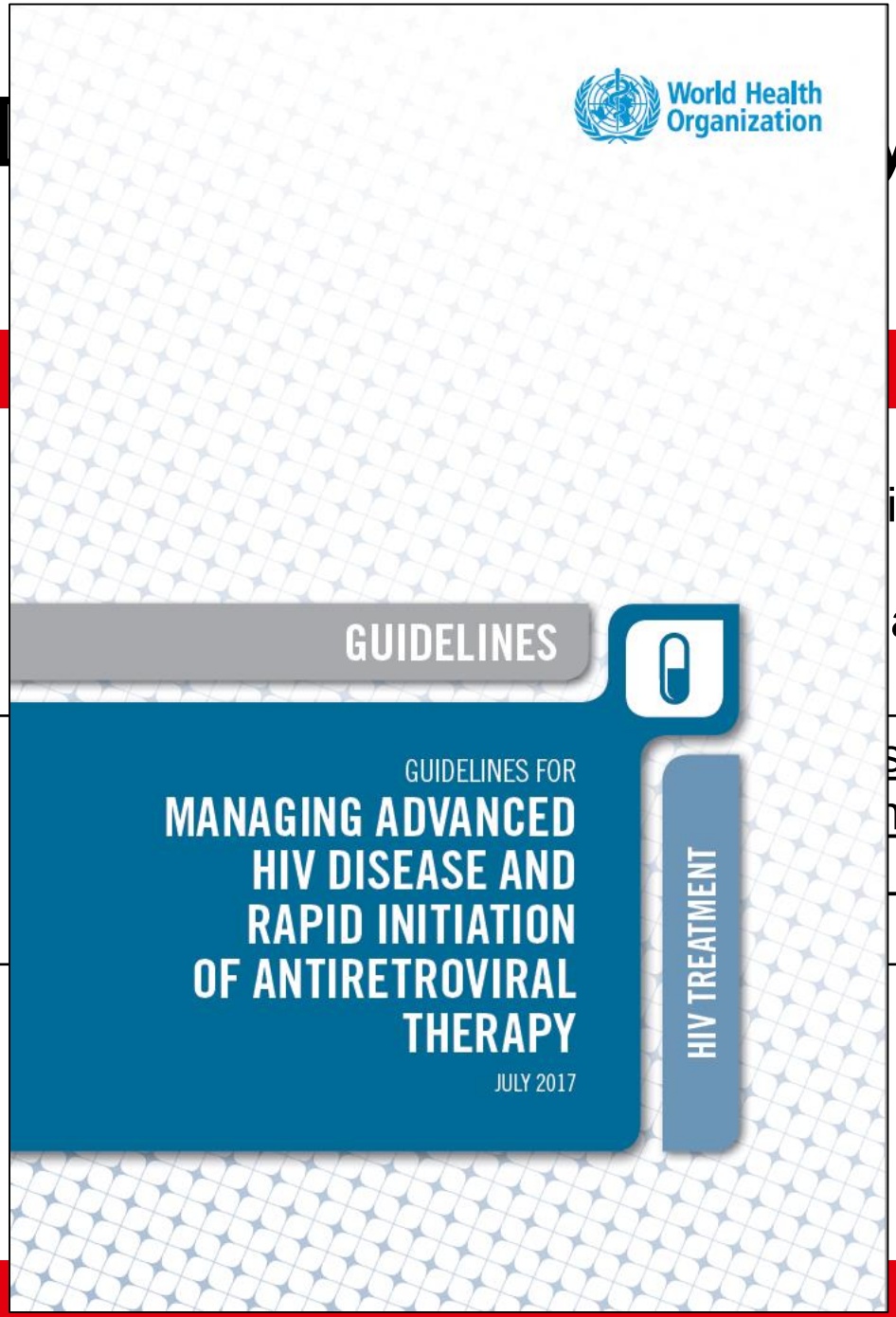
- **Clinically stable children, adolescents and pregnant and breastfeeding women** as well as members of **key populations** (people who inject drugs, sex workers, men who have sex with men, transgender people and people living in prisons and closed settings) **can benefit from access to differentiated antiretroviral therapy (ART) delivery models**

- Services should be tailored to **keep families together** as much as possible to simplify access and reduce cost

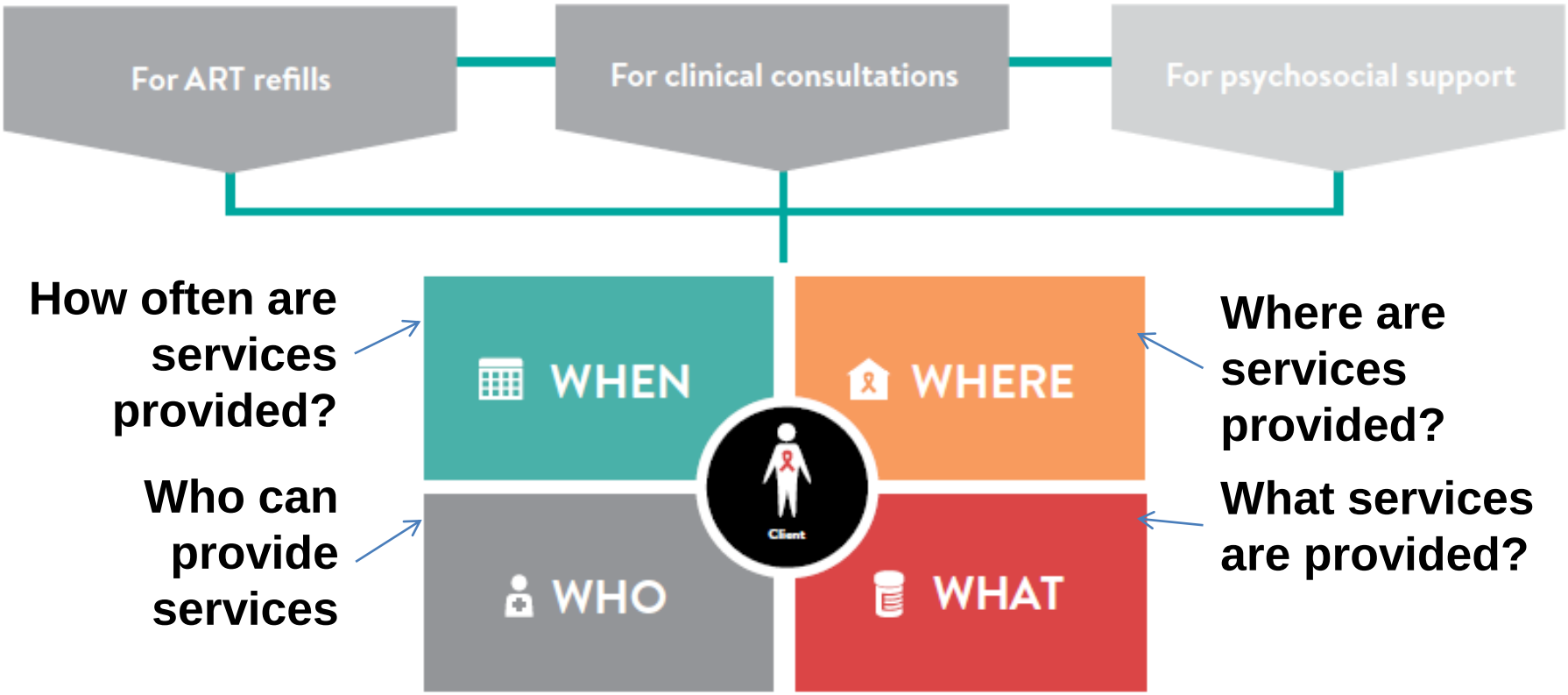
- Differentiated ART delivery **can address inequities** in the access to HIV treatment services and **enable key population communities to be more involved in HIV treatment and care**

- **Extension of differentiated care** to adolescents and pregnant and breastfeeding women as well as members of key populations has **highlighted the importance of psychosocial support** and the need to better define **how a differentiated ART delivery model can provide psychosocial support components**

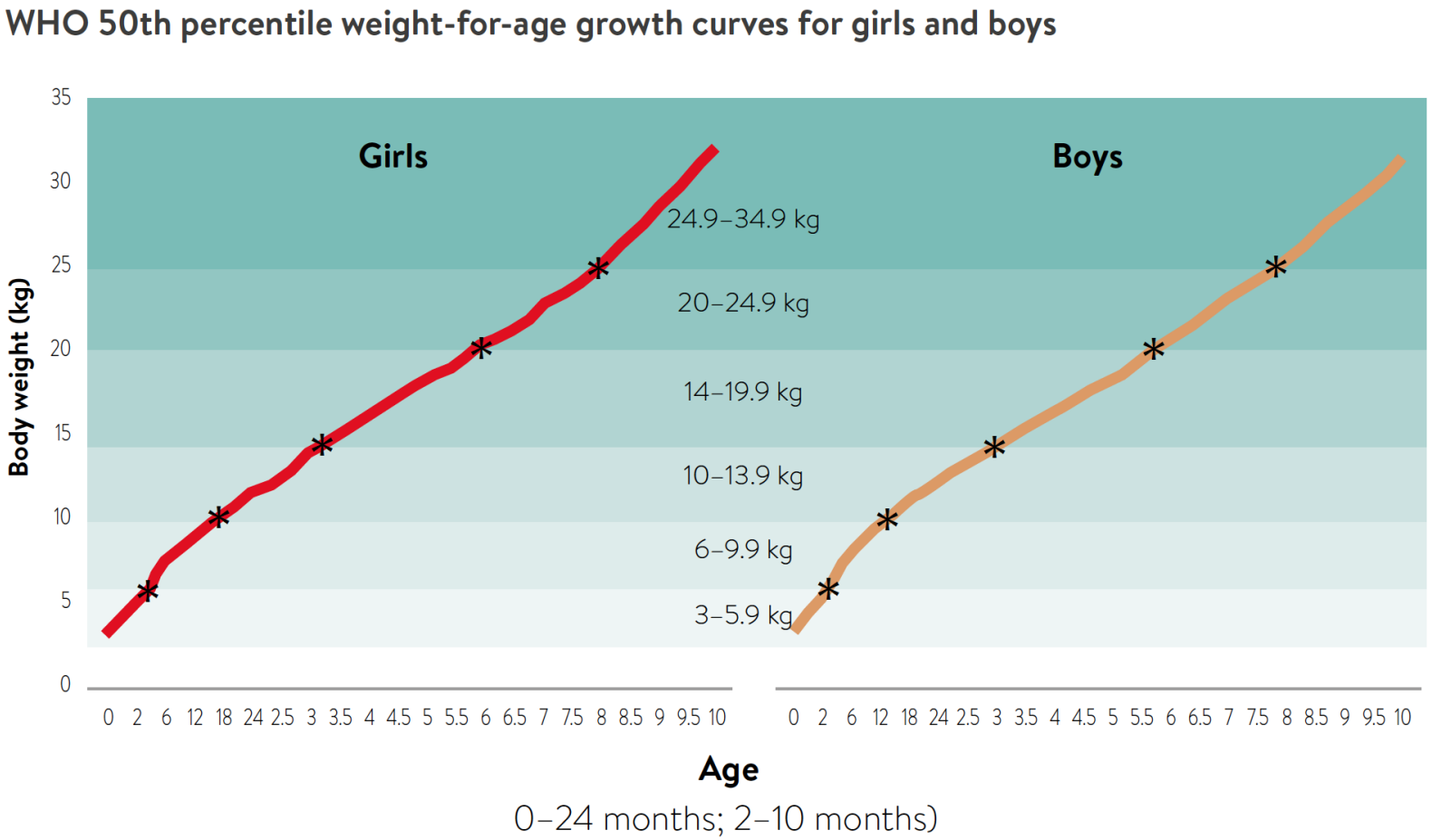
POPULATION	
ADULTS	itoring adherence
CHILDREN	should be at least n for >3m and on the disclosure
ADOLESCENTS	



Elements of care are for ART refills, clinical consultations and psychosocial support



Weight-for-age growth curves (Annex 2)



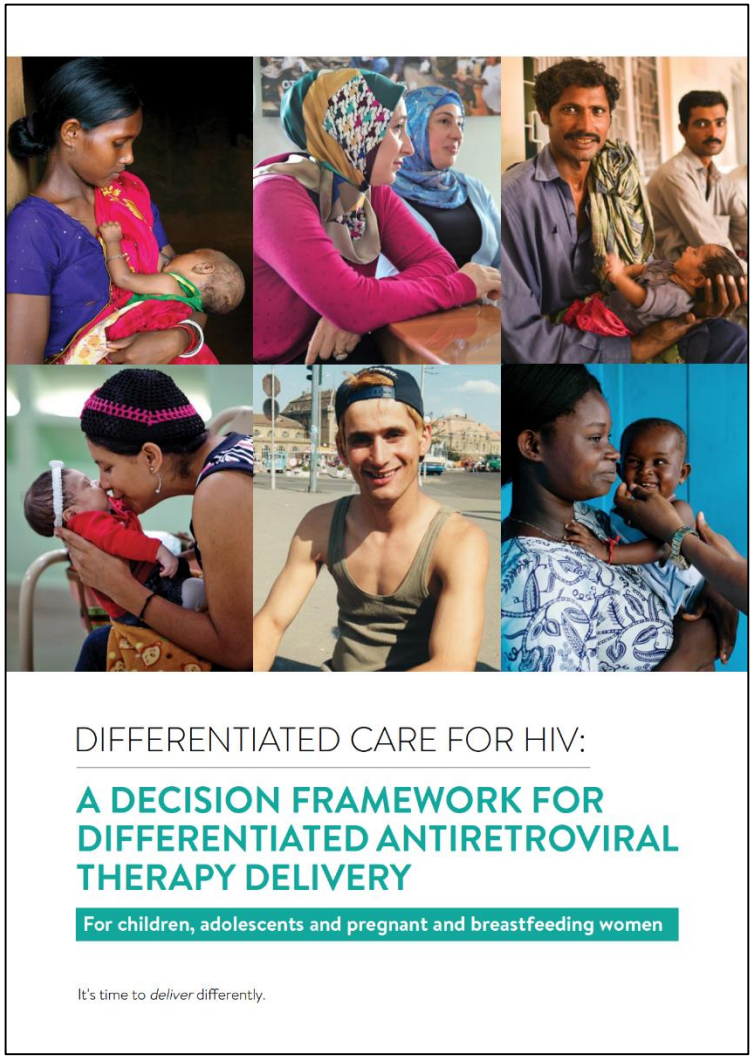
Building blocks for children (2-9 years) (Annex 3)

	Clinical consultations	ART refills	Psycosocial support
WHEN	Every 3-6 months	Every 3-6 months	1-6 months
WHERE	Primary care Outreach from primary health care	Primary care Out of facility	Primary care Out of facility Virtual
WHO	Nurses Midwives Clinical officers Doctors	Lay providers	Lay providers Peers and outreach worker
WHAT	Clinical consultation of children Dosage checks and possible adjustments Laboratory tests Rescript	ART and co-trimoxizole refills Referral check Adherence check Disclosure process check-in	Peer group environment Referral check Disclosure support

Building blocks for adolescents (10-19 years) (Annex 4)

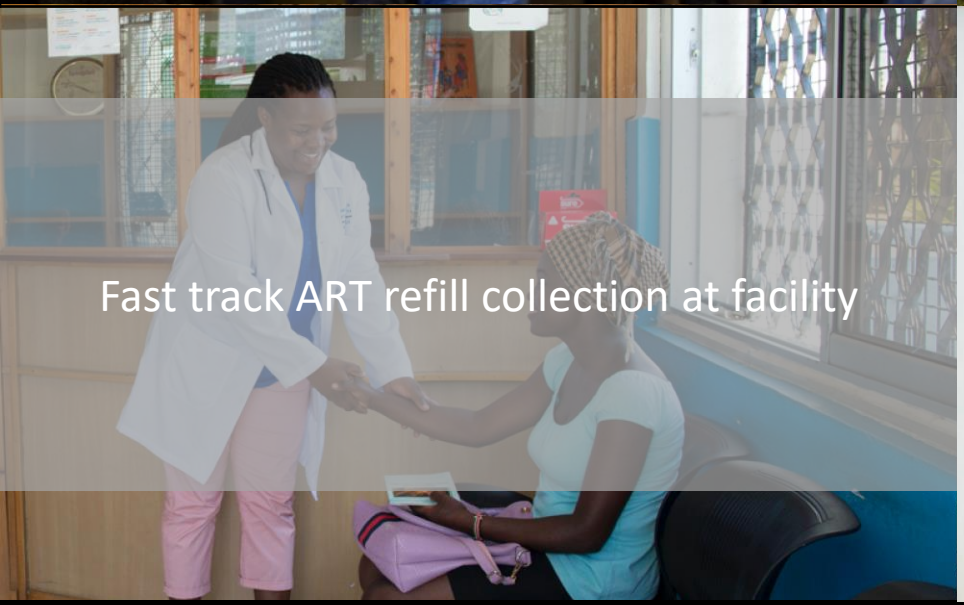
	Clinical consultations	ART refills	Psycosocial support
WHEN	Every 3-6 months	Every 3-6 months	1-6 months
WHERE	Primary care Outreach from primary health care	Primary care Out of facility	Primary care Out of facility Virtual environment
WHO	Nurses Midwives Clinical officers Doctors	Lay providers	Lay providers Peers
WHAT	Adolescent clinical consultation Mental health assessment Laboratory tests Rescript	ART Referral check Adherence check Disclosure process check-in	Peer group environment Referral check Onward disclosure support

Decision Framework

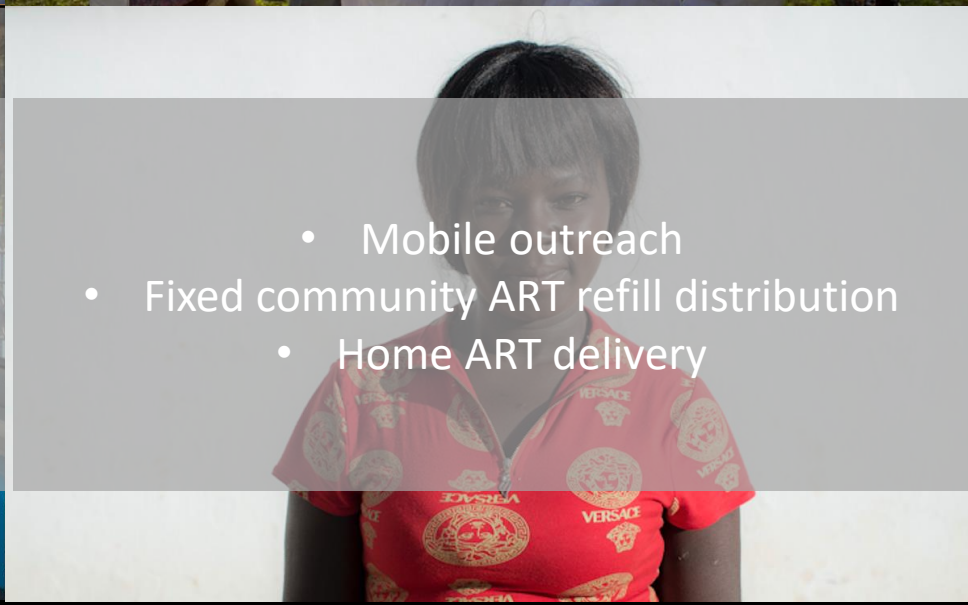


Health care worker-managed group

Client-managed group

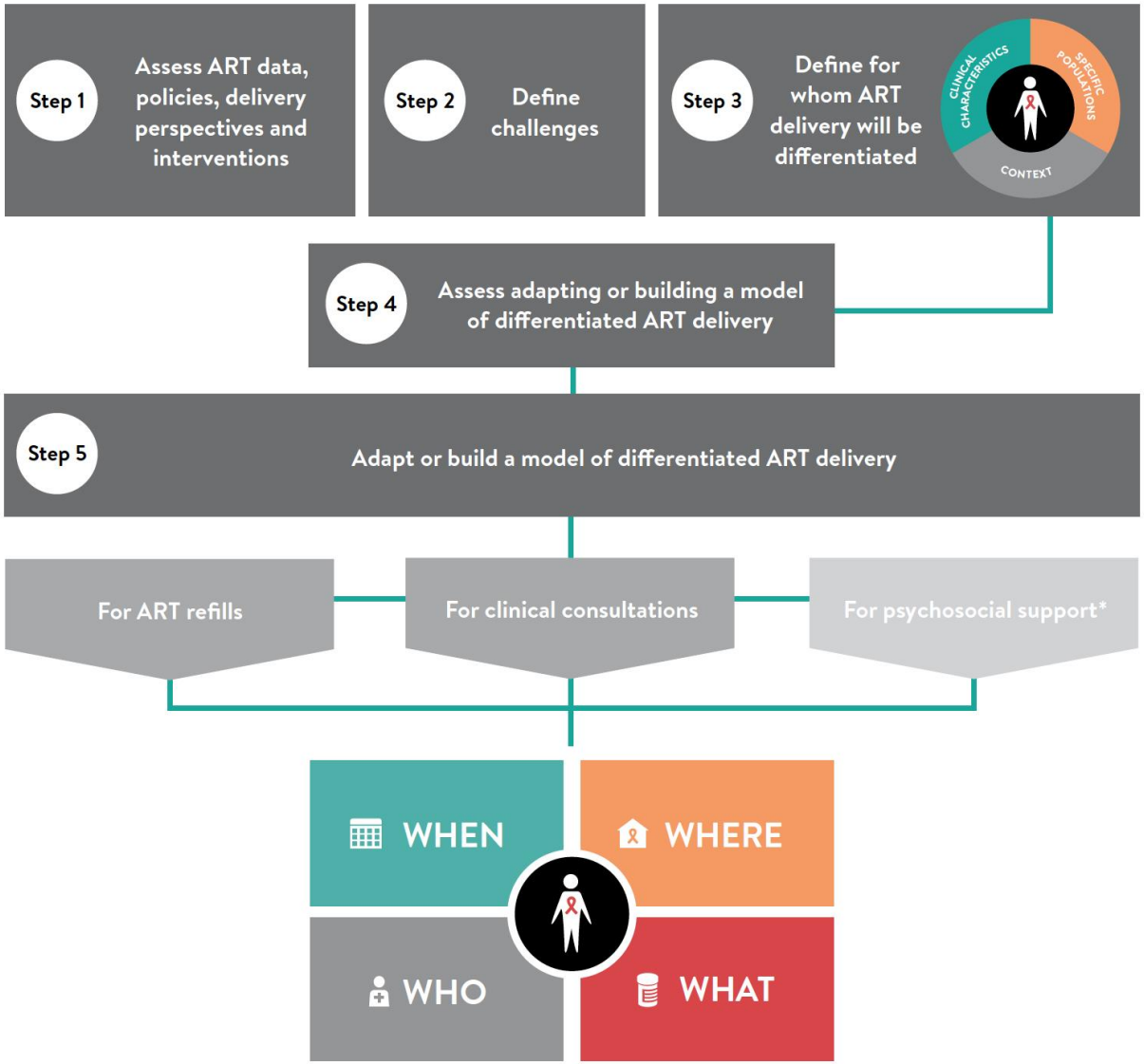


Facility-based individual



Out-of-facility individual

5-step approach to differentiated ART delivery



Adaption case studies:
South Africa adult adherence club model

POSTNATAL CLUBS

YOUTH CLUBS

FAMILY CLUBS (CHILDREN & CAREGIVERS)

ADULT CLUBS

An example – Adolescent groups in Zimbabwe

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	3 monthly	6 monthly	3 monthly*
WHERE	PHC	PHC	PHC with additional visits in the community, outside the health facility
WHO	Primary counsellor/CATS	Nurse	CATS
WHAT	ART and Cotrimoxazole refills Referral check	Clinical consultation SRH services Blood draw (annual if VL)	Peer support SRH education Adherence check Referral check

- An example of a health care worker-managed group
- Leverages existing model of psychosocial support

*More frequent psychosocial support provided as required

Example: When building block

1. 2017 WHO Key Considerations:

WHEN: Key Considerations: **Frequency of visits**

	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT
WHEN	3-6 monthly	6 monthly (Children 2-5 years old: 3 monthly)	1-6 monthly

2. What to plan:

- Alignment of ART delivery among family members on ART
- Reducing the frequency of ART refills and clinical visits
- Utilizing the maximum duration of ART refills
- Extending or adapting service hours
- Frequency of psychosocial support in peer support environments

3. Specific considerations for each population

CHILDREN

WHEN

Frequency of drug dosage adjustments

Reducing visit frequency can seem complicated because of drug dosage adjustments required as children grow, but these happen infrequently after 2 years of age (see Annex 2 in the Key Considerations [3]). A clinician seeing a child every 6 months would be sufficient frequency to detect changes to weight that require dosage adjustments.

Paediatric drug formulations

For stable children to receive longer supplies of drugs, they should ideally be taking pellets or tablets rather than syrups, which often have shorter shelf lives and are more bulky for transporting to and from collection points by health care workers and clients. However, clinical visit infrequency could still be maximized, even if the limitations of liquid formulations mean that more frequent but expedited drug pick-ups are still necessary.

ADOLESCENTS

WHEN

Fluctuating mental health and SRH needs

Adolescence is a period of fluctuating mental and SRH needs. A clinician seeing an adolescent every 6 months would provide sufficient opportunity to identify these needs. Adolescents can also choose to see a clinician in between, if required.

Aligning visit schedule to school calendar

Reducing visit frequency enables visits to be scheduled during school holidays. Malawi and Zimbabwe specifically allow longer ART supplies (6-12 months) for clients who attend school or university far from home. Rwanda provides 3-month refills, but aligns adolescent appointments with the school breaks.

Description

Building blocks

Elements

Example 4:

Family member ART refill, Zimbabwe [29]

Overview

In Zimbabwe, children on ART were required to attend monthly clinical visits, despite differentiated ART delivery being offered to adults. Recognizing a family-centred approach, the family member ART refill model was developed from the community ART refill group model that was already being implemented.

Children older than 2 years with no opportunistic infections, a viral load of less than 1,000 copies/ml and on the same ART regimen for at least 6 months can now join their family group. Every 3 months, one family representative collects ART refills for all ART-stable family members and distributes these at home. Children between 2 and 5 years are required to attend every time with their family representative for a clinical consultation. When the child is at least 5 years and on adult dosages, he/she can attend only every second visit (i.e., 6 monthly) for clinical consultation.

This continues through adolescence until 19 years of age, when the family member is required to attend only an annual clinical consultation. Viral loads are taken annually for all family members. Where a family member is already part of this model and becomes pregnant, she can remain a member of the family ART refill group provided she attends MNCH care separately.

The family member ART refill model is an example of a stable adult differentiated ART delivery model already endorsed by national guidelines adapted for specific populations. More information on this model is available at www.differentiatedcare.org.

The three elements of family ART refill

The building blocks of family ART refill in Zimbabwe

	ART REFILLS	CLINICAL CONSULTATIONS*			PSYCHOSOCIAL SUPPORT
	All family members	Children 2-5 years	Children >5 yrs + adolescents on adult doses	Adult family members	Accessible for adolescents
WHEN	3 monthly	3 monthly	6 monthly	Annual	1-3 monthly*
WHERE	At home	Primary care clinics			In community
WHO	Family member	Nurse			Lay provider
WHAT	ART and cotrimoxazole refill	Clinical consultation Blood draw (VL annual)			Peer support group

Differentiated Care Youth Champions

5 YOUTH CHAMPIONS

(Two males and three females from Kenya, South Africa, Malawi, Tanzania and Zimbabwe)

32 FOCUS GROUP DISCUSSIONS

393 YOUNG PEOPLE CONSULTED

"I LIKE GETTING MY MEDICATION THROUGH THE YOUTH CARE CLUBS. BEFORE, I HAD TO WAIT A LONG TIME IN A QUEUE JUST TO GET MY MEDICATION."

(YPLHIV, South Africa)

THE BUILDING BLOCKS: HOW YPLHIV WANT TO RECEIVE THEIR HIV CARE

WHEN

YPLHIV who are stable on treatment want to see clinicians less often, e.g., two clinical consultations per year. However, those newly diagnosed or experiencing clinical complications prefer more frequent clinical monitoring and peer support on a monthly or weekly basis. Young people also want operating hours outside of school time.

WHERE

YPLHIV want services that are easily accessible and located close to their schools and homes. HIV clinics should not be identifiable as HIV-only services because many young people fear loss of confidentiality and unintentional disclosure, resulting in stigma and discrimination in their community.

WHO

YPLHIV want to receive their care from both clinicians and peers through peer mentoring in group models. It is important for YPLHIV to receive services from peers with the same status as them. They fear being stigmatized in their communities if they receive services from HIV-negative peers.

WHAT

YPLHIV want a comprehensive and integrated approach to HIV care, including services for sexual and reproductive health. Young people value having clinical consultations and would like to see opportunities for more frequent psychosocial support, including from communities and peers.


DIFFERENTIATED
CARE
Online knowledge repository
www.differentiatedcare.org
Global and country guidance
• ART delivery model examples & tools
• Published evidence & resources

It's not about everybody getting the same thing, It's about everybody getting what they need in order to improve the quality of their situation." C.Parker

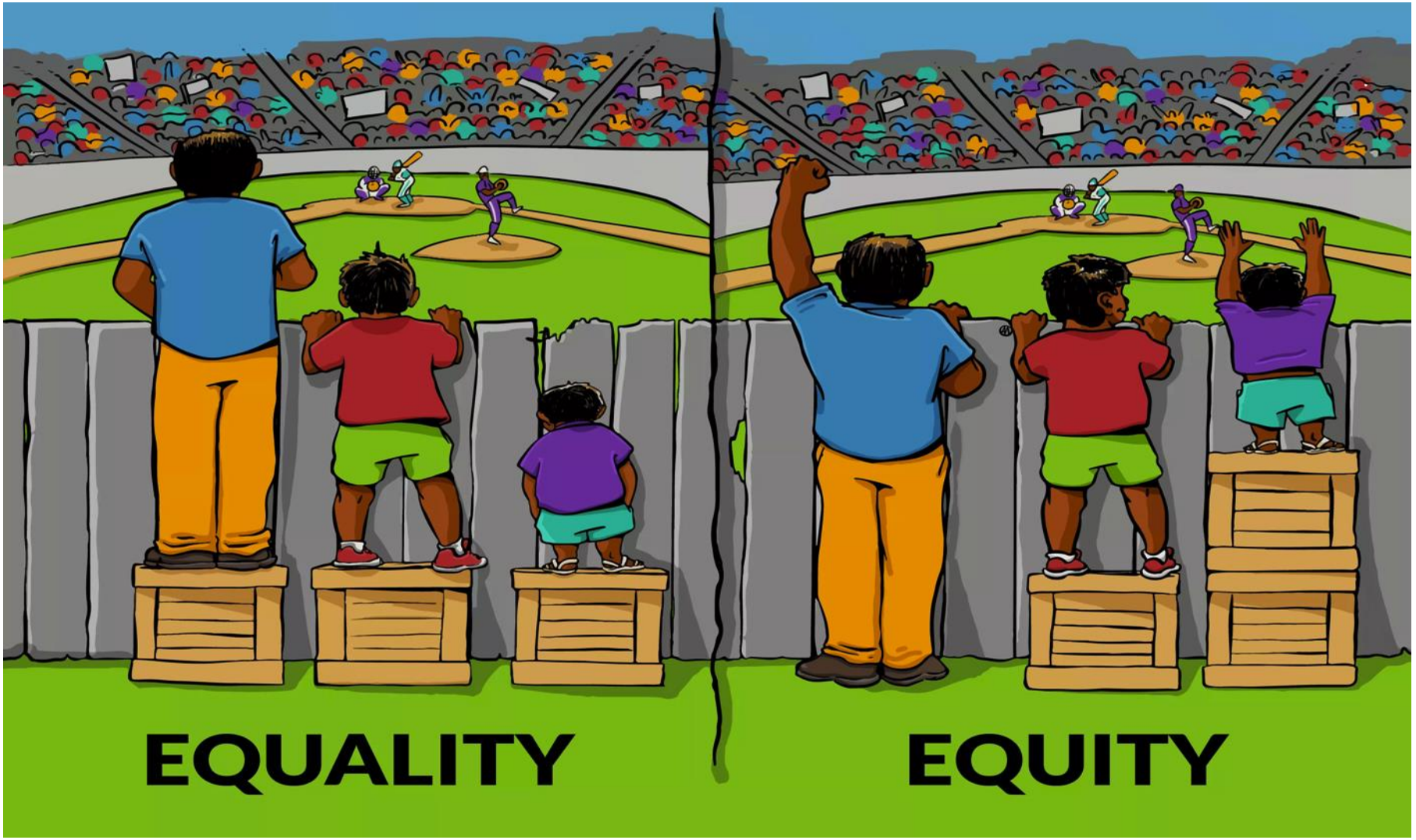


Image : "Interaction Institute for Social Change | Artist: Angus Maguire."

DIFFERENTIATED
CARE