Community consultation

Differentiated service models for ART delivery to PLHIV and key population communities in India

August 3rd, 2017, New Delhi
National Coalition Of People Living With HIV in INDIA (NCPI+)

NCPI+ convened a one day consultation on August 3rd 2017 aimed at deliberating at applying differentiated service models for ART delivery to PLHIV and key population communities in India. Discussions were undertaken to assess how these might be implemented at national, as well as state level in India. Main objectives of the consultation were to:

- Understand differentiated service models for ART delivery and their application in India.
- Elaborate on recent developments in treatment, while reflecting on differentiated service delivery model
- Dwell on areas highlighted during NACO led national consultation on differentiated service delivery model
- Draw a 'community perspective' on specific elements that constitute the services that should be provided in a differentiated model of care for.
- Define the key components for recommendations from PLHIV and key population community on differentiated service delivery model.

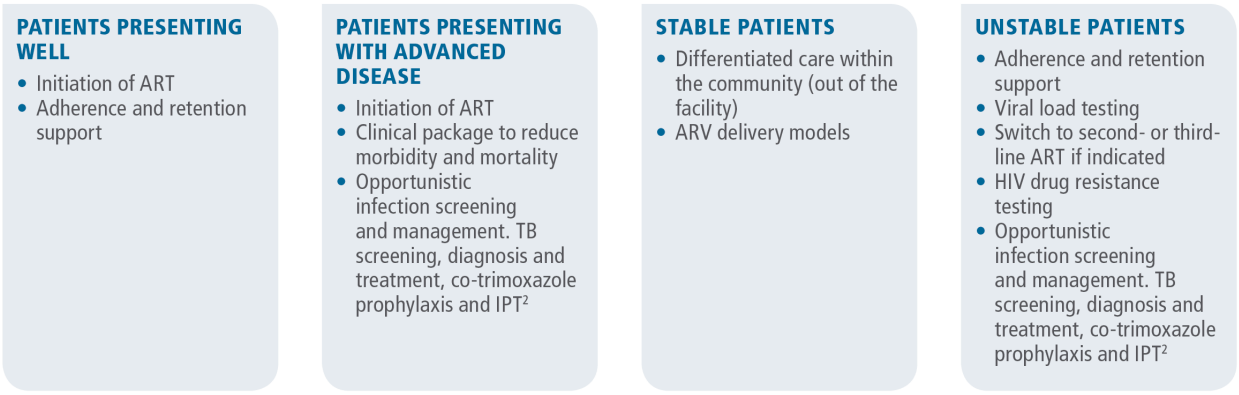
Discussions were initiated by highlighting on the need to have models of differentiated care. Considering vast landscape and economic disparities in India, we need to acknowledge the range of needs in the current ART client population. By categorizing clients by clinical condition, the frequency, cadre, intensity and location of services can be tailored to the needs of patients. Patient –centered differential care service delivery is ardently required in India.

Thus, let us focus on '**treatment for the people and by the people'**; and adherence can only be assured by 100% treatment literacy.

What is differentiated care?

Differentiated care 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. By providing differentiated care, the health system can refocus resources to those most in need.

Discussions were centered around clarifying that DSD is a client-centred approach that simplifies and adapts HIV services across the cascade, in ways that both serve the needs of PLHIV better and reduce unnecessary burdens on the health system. Further diversity of care needs for PLHIV was discussed in detail.



Differentiated models of ART delivery for stable clients, were discussed in detail. Thus, following four models were highlighted:

- **In facility-based individual models** ART refill visits have been separated from clinical consultations. When clients have an ART refill visit, they bypass any clinical staff or adherence support and proceed directly to receive their medication (e.g., appointment spacing and "fast-track" ART refill model from Malawi).
- **Out-of-facility individual models** describe those where ART refills and, in some cases, clinical consultations are provided to individuals outside of health care facilities (e.g., PODI model in DRC). These models are inclusive of community pharmacies, outreach models and home delivery.
- **In health care worker-managed group models**, clients receive their ART refills in a group and either a professional or a lay health care staff member manages this group (e.g., adherence clubs in South Africa). Health care worker-managed groups meet within and/or outside of health care facilities.
- **In client-managed group models**, clients receive their ART refills in a group but this group is managed and run by clients themselves (e.g., CARGs in Zimbabwe and CAGs

in Mozambique,). Generally, client managed groups meet outside of health care facilities.

Moving ahead it was concluded that 'we need an evaluation focused on three models of differentiated care that may improve ART delivery by streamlining services for stable patients. Discussions provided participants an overview of differentiated care and a summary of WHO recommendations related to the four building blocks of service delivery:

- When (frequency of care provision)
- Where (health facility vs community)
- Who (delivers the care)
- What (care package)

Further discussions were maneuvered on emerging issues that adversely affect available treatment options for community.

Unavailability of Dolutegravir (DTG) drug in India was highlighted, despite being manufactured in India. It was further highlighted that it is Integrase Inhibitor and wad approved by US, FDA in 2013 and European Commission in 2014. It is manufactured by Viiv Healthcare (**GSK**, **Pfizer** and **Shionogi**). It can be used in combination with other ARV for adult, adolesent and older children. In 2015, WHO Treatment Guidelines included DTG as an alternative for 1st line regimen.

Routine Viral Load testing should happen on regular basis. Though NACO initiated a dialogue on purchasing viral load tests in 2015, with support from The Global Fund; it has still not moved ahead. Now it is proposed that CBNAAT machines will be used to undertake hepatitis C and viral load testing along with TB screening.

Since 2004 India is struggling with unmanaged drug stock out of ARVs. Supply chain management need to be strengthened. Community led monitoring needs to be taken up.

Questions from participants:

When we talk about different needs for different people. How do we measure the frequency of visits by an individual? Will it impact on management of Lost to Follow-up among the PLHIV community?

Discussions further led to the conclusion that, community led differential care will benefit the community. Indicators will can be adapted as per the need of program. However,

- Prioritizing and community intervention will aid in reducing LFU.
- It will also aid is reducing stigma and discrimination inflicted on key population community.
- However, there is a challenge in identifying stable clients, considering immense footfall at ART center. Thus, differential care model should be a two way approach. A consensus drawn in-between government and community! It should be based on willingness from community and segregation of stable clients from government data.
- We need to study government data and draw conclusion on increase of load at ART because of new 'test and treat/start policy'.

- Second and third 90 fits in our country's model. Thus community can engage in last two 90's and strengthen the differential care model. So, we as community need to come up with a robust model to strengthen this approach.
- It should be choice of a patient to fall in this model.

Further discussions were centered on following aspects:

- Challenges in accessing ART services
- Challenges in accessing services through link ART
- Challenges in accessing PPTCT
- Challenges in accessing diagnosis/ testing facilities

It was concluded that uninterrupted ART and diagnostics should be our goal for differential care!

A group work was also undertaken to understand DSD: Imagine a poor woman having an infant, living 20 kilometers away from ART center. Participants discussed and prepared a differential care plan for her. It was deliberated that the woman is facing lot of challenges in pursuit of receiving regular ART, such as low resources, different visit dates for mother and child, different ART centers (if there is a pediatric unit), distance / travel, wage loss, school day loss/ hampered confidentiality at child's school, no social security etc. Thus, participants proposed following interventions for the woman to mitigate challenges faced by her, such as drugs should reach her, engaging/ through NGO/CBO support, flexible timings, suitable date/ day, saving on distance, better adherence, increase of resources by linking her to various social protection schemes, better knowledge of available services like, nutrition, OI management, Referral for a consultation, availability of multi month drugs, viral/CD4 facilities etc. However, some disadvantage of differential care were also discussed as control on quality of services, delivery of drugs, management of adherence, we find a problem too late (detection of TB) etc.

Participants also discussed that in India we already have some examples of differential models, like link ART centers and care and support centers (CSC). Thus, while planning for DSD model for India we must plan a combination of treatment and care and support.

We need to strengthen our community support systems also. We need to take a staggered approach. Community groups should be empowered and strengthened in a phased manner, so that we are competent enough to manage the load. To get more clarity on DSD, consensus were drawn that:

NCPI+ and ITPC India will plan a two days community consultation. Recommendations from it will be shared with NACO and other stakeholders, as they will be engaged at the end of consultation. It will be planned during the first week of September.

Participants also drew consensuses on planning for next steps. It was concluded that pilot sites should be prioritized for DSD, considering high or low load at an ART center and with both stable and unstable clients. Meanwhile, we need to propose different strategies for pre-ART and on ART clients. We need to strike a balance between community, as well as government perspectives, however it should be peer led, based on patient centric approach. Community strengthening needs to be undertaken for effective management of treatment adherence, while moving into the DSD model.

Moreover, in Vihaan program one support group meeting (SGM) will be undertaken on DSD at CSC level and six monthly advocacy meetings will focus on DSD and HIV bill.

Participants also discussed that differential care strategy should be planned, considering:

- Clinical barriers need to be understood for stable/unstable clients.
- Sub –groups needs to be focused. A specific strategy for key populations, women and children, migrants etc.
- Geographical perspectives should be drawn for rural, urban, hilly terrains etc.
- Innovations needs to be drawn, e.g. ART vending machines, OST based ART dispensing units and other options can be having ART dispensed hospitals, NGO, SLN/DLN, targeted interventions, care and support centers (CSC) etc.
- Outreach based service delivery could be the model for CSCs and TIs. It can be popularized by adding suitable add-on services to it.
- Adherence buddy groups needs to be created. Intensive monthly sessions will be undertaken for 5-6 months. Social package will be created to strengthen peer led adherence. Co-infection management will be prioritized, along with family testing.

Consultation concluded on the note that national level advocacy initiatives needs to be undertaken. It will be an outcome of collaboration among KP and PLHIV communities. Thus, a strategic advocacy plan needs to be developed in the proposed two days consultation. Resource generation will also be prioritized to manage smooth implementation of this advocacy plan.

Annexure-A:

Programme Schedule

"Community Consultation on Differentiated Service Delivery "

Date	3rd August 2017			
Venue	Alliance India, Delhi office			
Time	Title of session	Session Objective	Methodology	Name of Facilitator
10:30	Registration			NCPI+
10:45 am	Introduction of consultation	Set the objective	Participatory	NCPI+
11:00 am to 1:00	Recent development in treatment Summery of Differentiated Service Delivery	Participant can get latest updates about treatment. Get knowledge about other country about service delivery model based on ITPC toolkit	PPT	Loon Gante, ITPC
	Discussion			
Lunch Break 1:00 pm to 2:00 pm				
2:00 pm to 2:30 PM	Overview of NACO consultation	Participant get update about NACO consultation discussion		Mona Balani
2:30 PM to 3:30 PM	VIHAAN category A,B,C vise expectation on Differentiated Service Delivery	Category wise recommendation for Differentiated Service Delivery	Group Exercise	Rose, India HIV/AIDS Alliance
Tea Break 3:30 pm to 3:45 pm				
3:45 to 5:00 PM	Summery recommendation for NACO			Sonal, India HIV/AIDS Alliance and team NCPI+

Annexure-B: List of Participants

S. No	Name of the Participant	Gender	Organization
1.	Manish	TG	Love Life Society
2.	Paramjeet Kaur	Female	OPNP+
3.	Jagdish Gupta	Male	DNP+
4.	Vijay Singh	Male	Love Life society
5.	Loon	Male	ITPC
6.	Naresh Yadav	Male	UPNP+
7.	Rajpal	Male	MPNP+
8.	Purushottam Jatt	Male	RNP+
9.	Lakshmi	Female	Delhi positive women networks
10.	Daxa Patel	Female	NCPI+
11.	Manoj pardeshi	Male	NCPI+
12.	H. Rosenara	Female	India HIV/AIDS Alliance
13.	Maitri Lakra	Female	DNP+
14.	Hari Shankar	Female	DNP+
15.	Pradeep Dutta	Male	Nai Umang
16.	Aditi Sharma	Female	
17.	Surirtha dutta		India HIV/AIDS Alliance
18.	Kusum	Female	All India Sex worker network
19.	Sahil	Male	OPNP+
20.	Umesh Chawla	Male	India HIV/AIDS Alliance
21.	Gautam Yadav	Male	Humsafar trust
22.	Mona balani	Female	NCPI+
23.	Harjyot Khosa	Female	India HIV/AIDS Alliance
24.	Paul	Male	DNP+
25.	Simon	Male	India HIV/AIDS Alliance/IDUF
26.	Manilal	Male	India HIV/AIDS Alliance
27.	Deepak	Male	NCPI+
28.	Rajrani	Female	Jagriti
29.	Soumya	TG	Humsafar trust
30.	Sonal Mehta	Female	India HIV/AIDS Alliance
31.	Firoz Khan	Male	NCPI+
32.	Gaurav	Male	NCPI+
33.	Abhina Aher	TG	India HIV/AIDS Alliance