Unlocking the power of decentralized Drug Distribution: How DDD can work for tuberculosis, noncommunicable diseases and family planning

Decentralized Drug Distribution (DDD) Learning Collaborative

February 11, 2021

PEPFAR

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EpiC
Meeting Targets and Maintaining Epidemic Control

Speakers

Anna Grimsrud, PhD

Advocate Dlamini, MD

Cuc Tran, PhD, MPH

Caitlin Corneliess, MPH

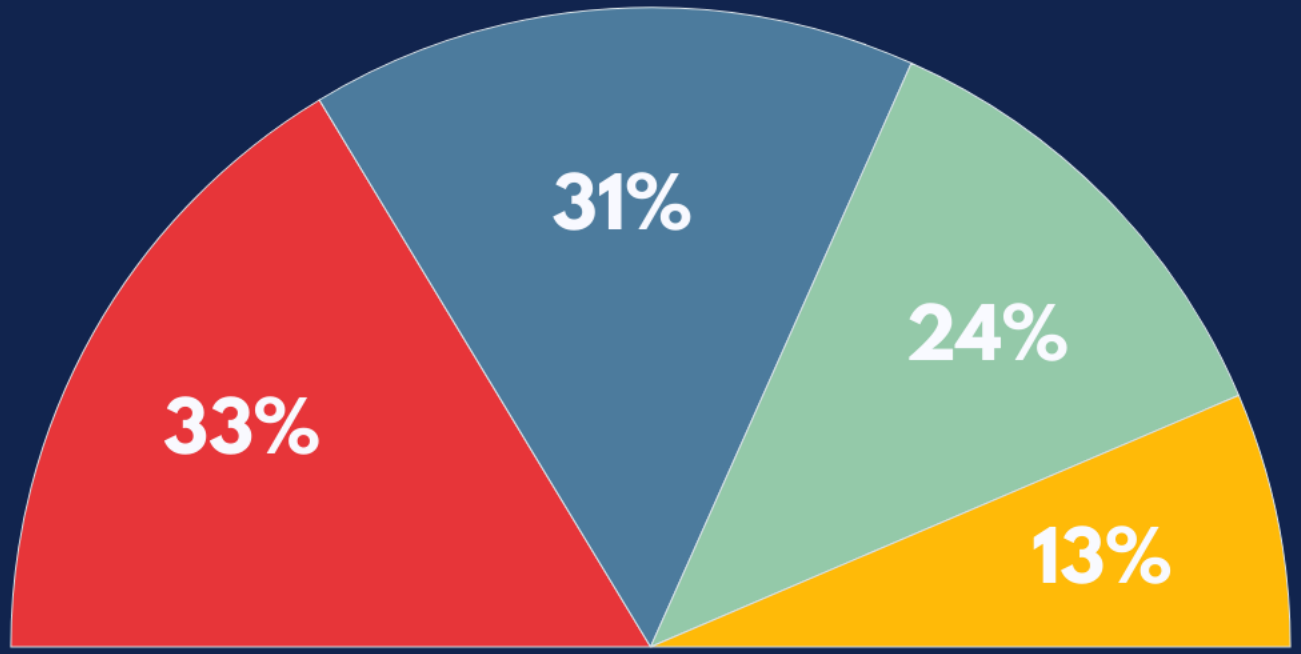
Fredrick Mubiru, MSC

Paul Pierre, MD, MPH

Session 10: Learning Collaborative Agenda (7-8:30 am EST)

- **Expanding the vision of differentiated service delivery to include additional chronic care services for people living with HIV**
  Anna Grimsrud, PhD | *International AIDS Society*
- **Integrated Services to Address Community Needs during COVID-19 and beyond**
  Advocate Dlamini, MD | *Ministry of Health, Eswatini*
- **Considerations for TB Diagnosis and Treatment within DSD Models**
  Cuc Tran, PhD, MPH | *US Centers for Disease Control & Prevention*
- **Products to people: Innovative approaches to expand family planning service delivery**
  Caitlin Corneliess, MPH | *PATH*
- **Making family planning available through innovative approaches**
  Fredrick Mubiru, MSC | *FHI 360*
- **Q&A**
  Paul Pierre, MD | *USAID*

Poll: What do you think is the biggest obstacle for the integration of HIV services with other chronic care and the achievement of universal health care?



- **Lack of funding or for other disease areas**
- **Absence of national guidance or supportive policies**
- **Fragmented supply chain systems**
- **Gaps in training of health providers**

DSD 2.0

Expanding the vision of differentiated service delivery to include additional chronic care services for people living with HIV

Dr Anna Grimsrud
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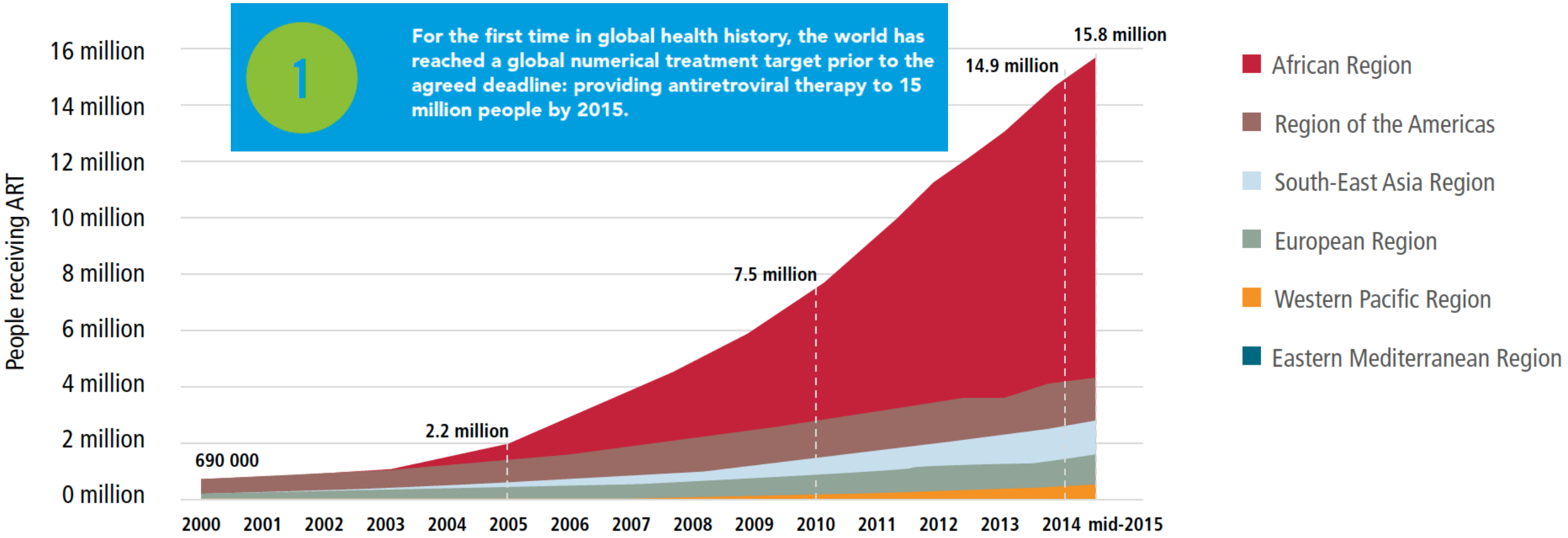
International AIDS Society

Expanding the Vision for Differentiated Service Delivery: A Call for More Inclusive and Truly Patient-Centered Care for People Living With HIV

Peter Ehrenkranz, MD, MPH,[a] Anna Grimsrud, PhD,[b] Charles B. Holmes, MD, MPH,[c] Peter Preko, MBChB, MPH,[d] and Miriam Rabkin, MD, MPH[d]



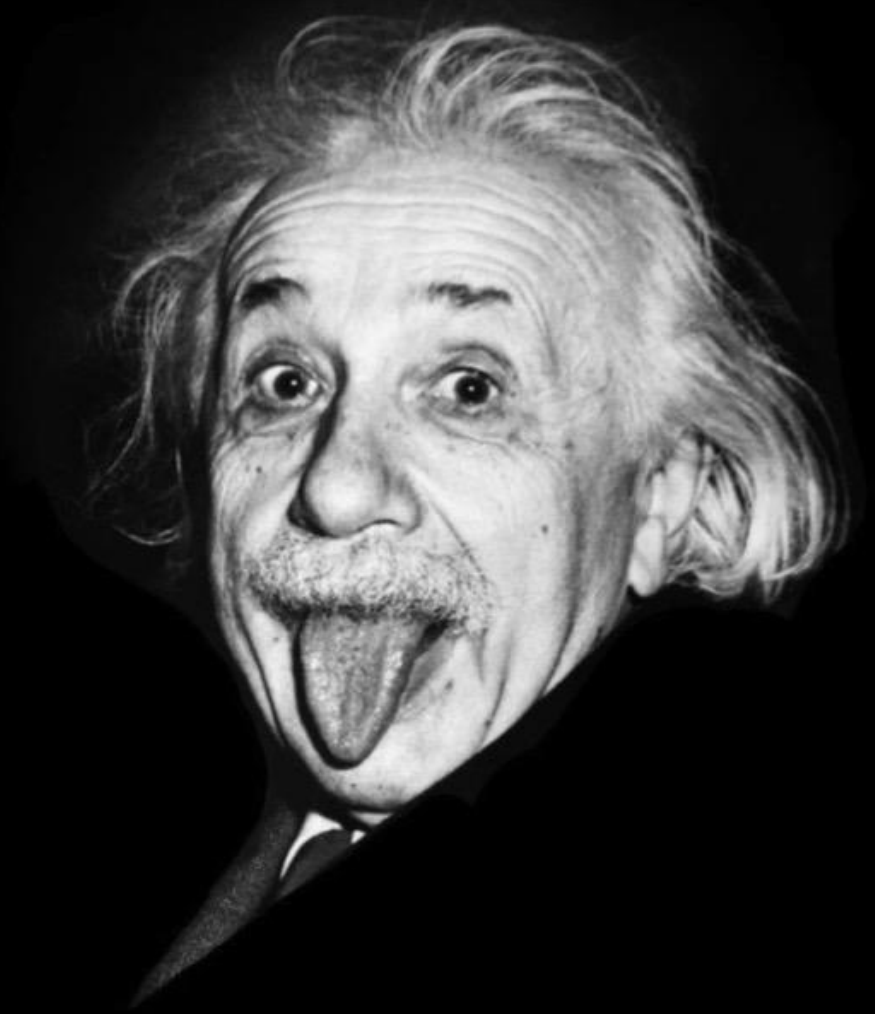

Success of antiretroviral therapy (ART) scale-up



UNAIDS

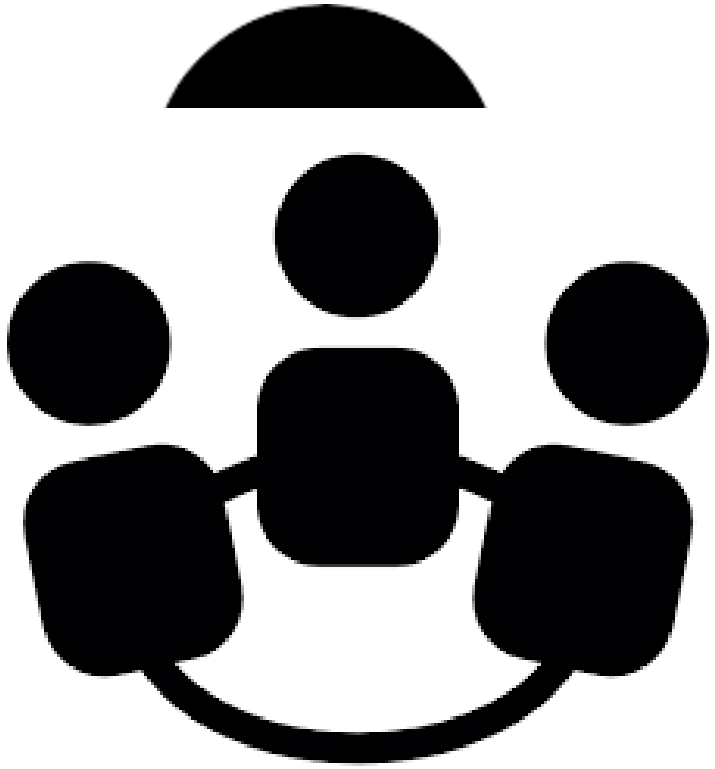
"Insanity is doing the same thing over and over again and expecting different results"

Albert Einstein



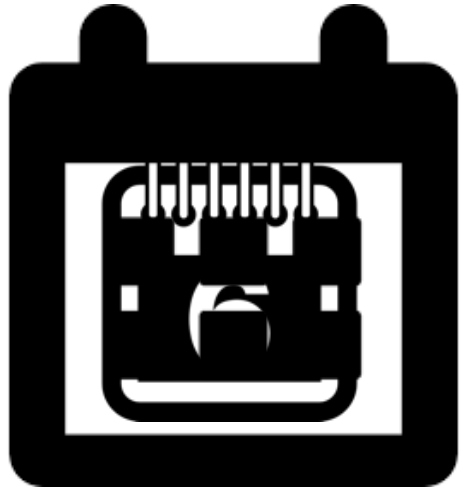
Evolution of HIV service delivery

WHO

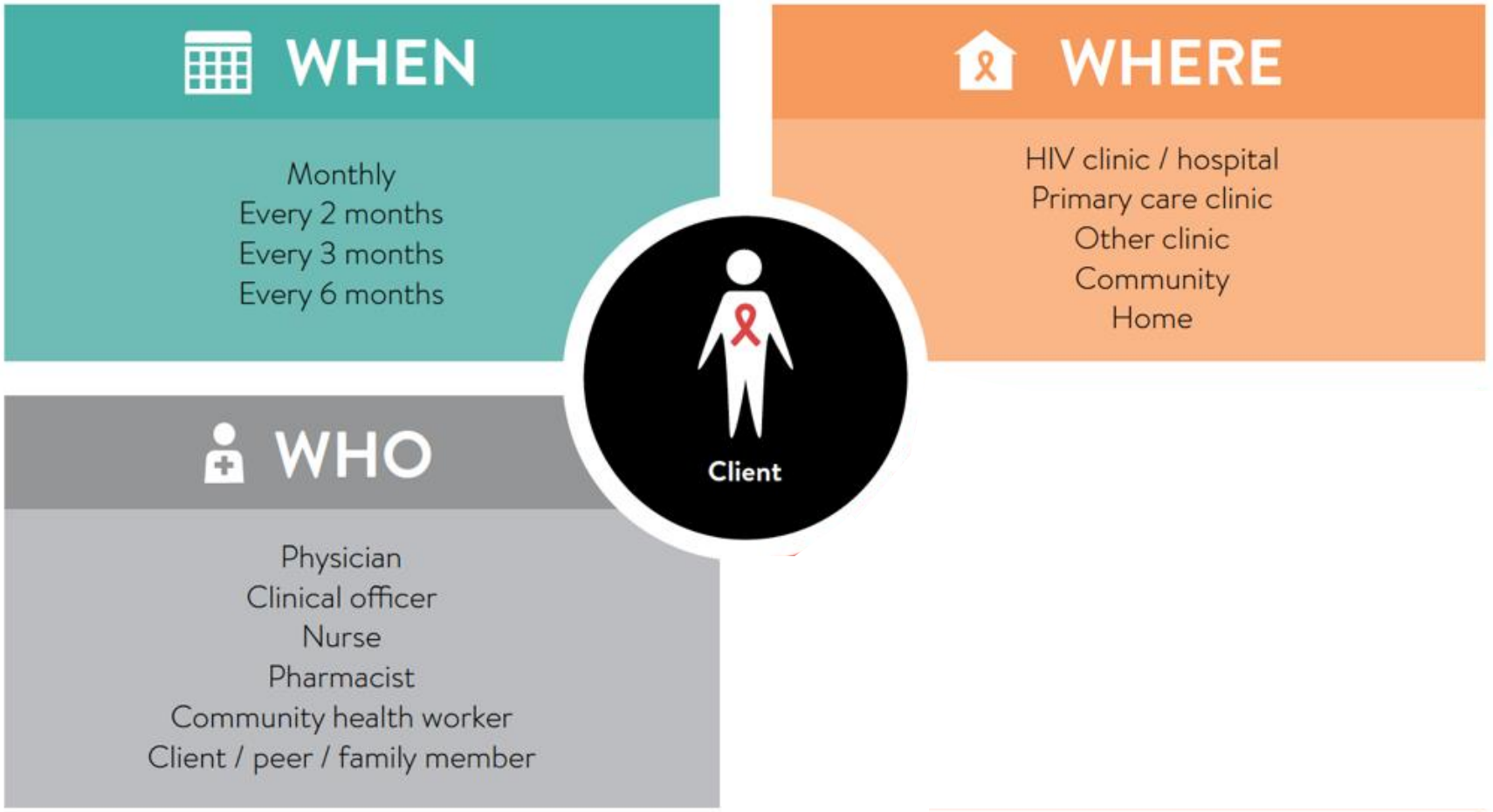


WHERE

WHEN



Building blocks of service delivery



Building blocks differ – for ART refills vs. clinical consultations vs. psychosocial support

	Clinical consultation	ART refills	Psychosocial support
WHEN	12-monthly	3-monthly	
WHERE	Health facility	Community pick-up point	
WHO	Clinician	Trained peer	
WHAT	Clinical consultation ART refill	ART refill Psychosocial support	

Four models of DSD for HIV treatment

- Multi-month dispensing is an enabler
- Clinical consultations can be considered separately to ART refills

Four models of DSD for HIV treatment

For GROUP models: Who manages the group?

For INDIVIDUAL models: Where does the ART refill take place?

Different names for variations of each

"DDD – decentralized drug distribution"

DDD and DSD:

Decentralized drug distribution and differentiated service delivery

- DDD – “the delivery of antiretroviral therapy (ART) outside health facilities and can include private sector and at alternative pick-up points” *[EpiC definition]*

- DDD supports the “ART refills” building blocks (and maybe psychosocial support) of DSD for HIV treatment

- DDD – another term for “out-of-facility individual model”, but also possibly the group models (healthcare worker- and client-led)

Adaptations to DSD for HIV treatment in response to COVID-19

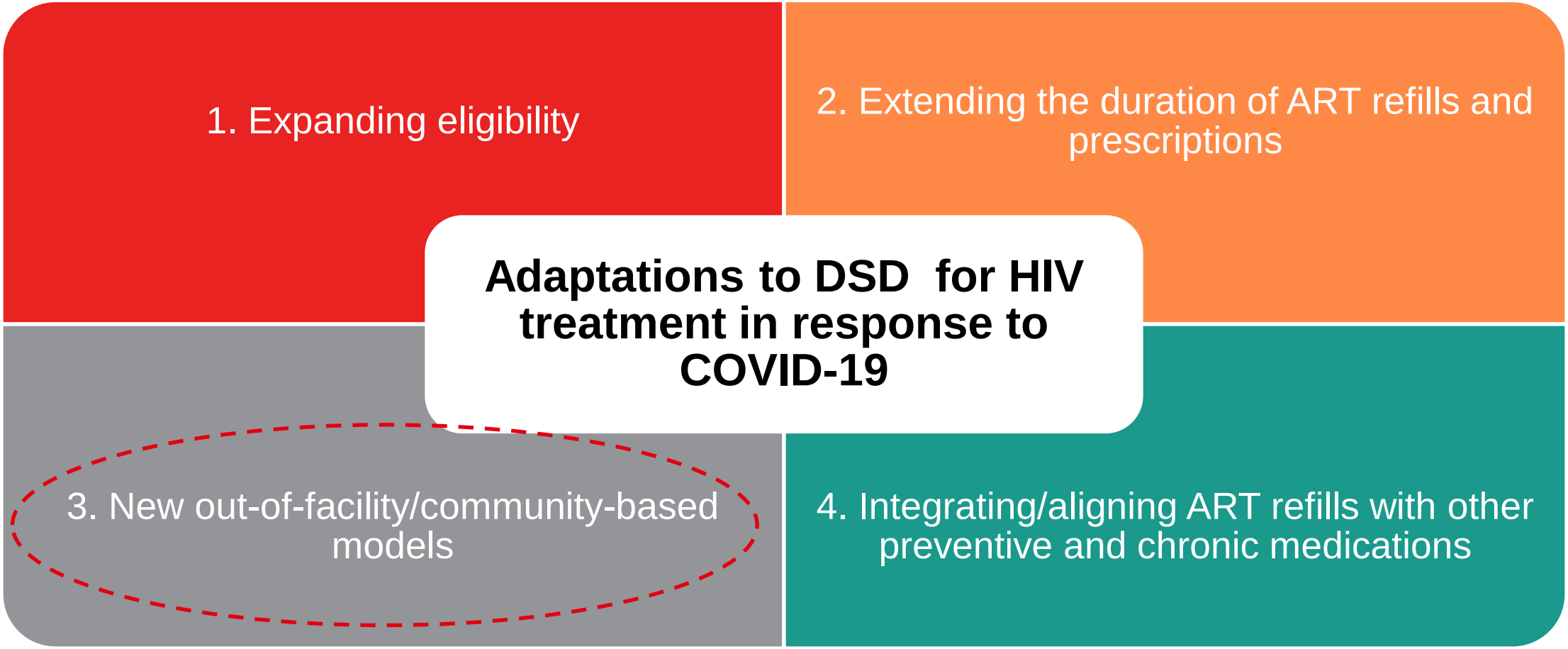
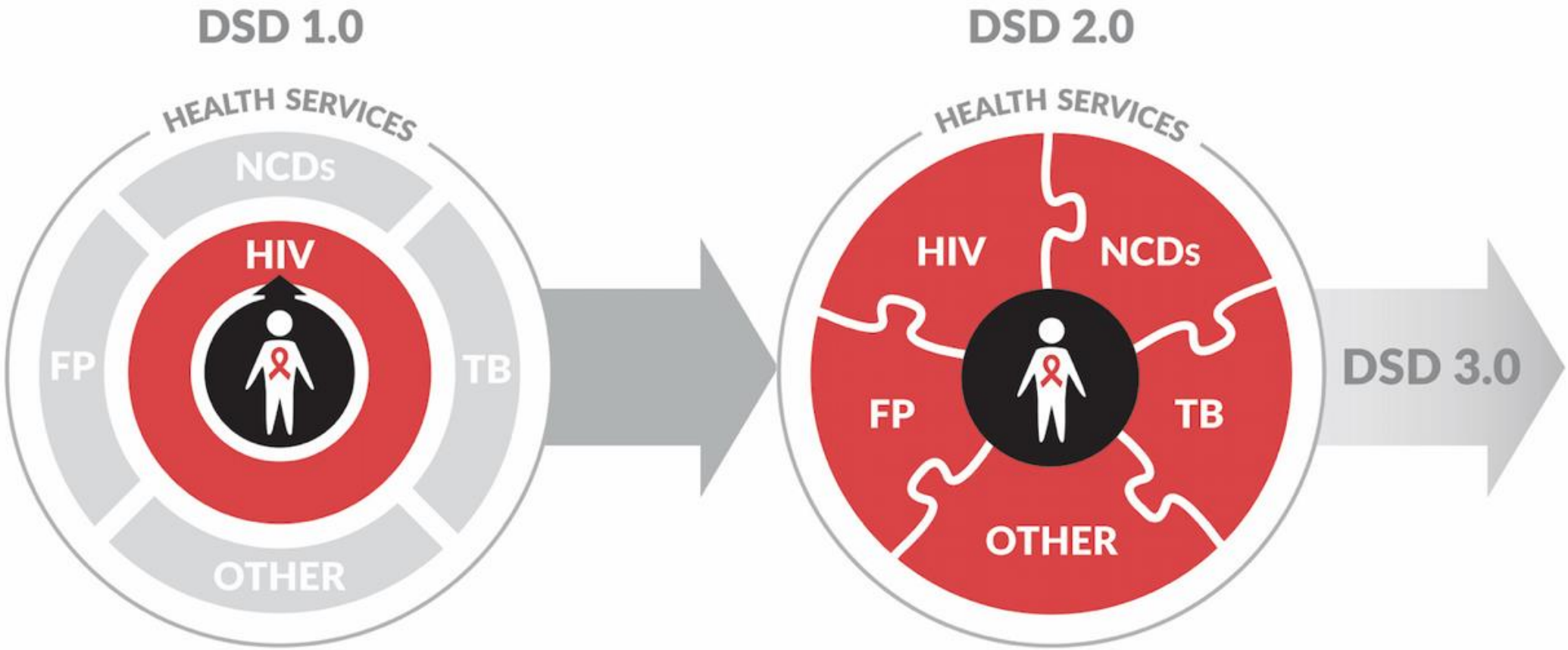


Figure 1. A description of the proposed transition from an HIV-focused "DSD 1.0" to a patient-centered "DSD 2.0." DSD 2.0 is inclusive of additional chronic care services for people living with HIV, such as tuberculosis, family planning, non-communicable diseases and others.



TPT and TB treatment within DSD for HIV treatment models

BUILDING FROM TB, FAMILY PLANNING AND NON-COMMUNICABLE DISEASES TO UNIVERSAL HEALTH CARE

Example: TPT in adherence clubs

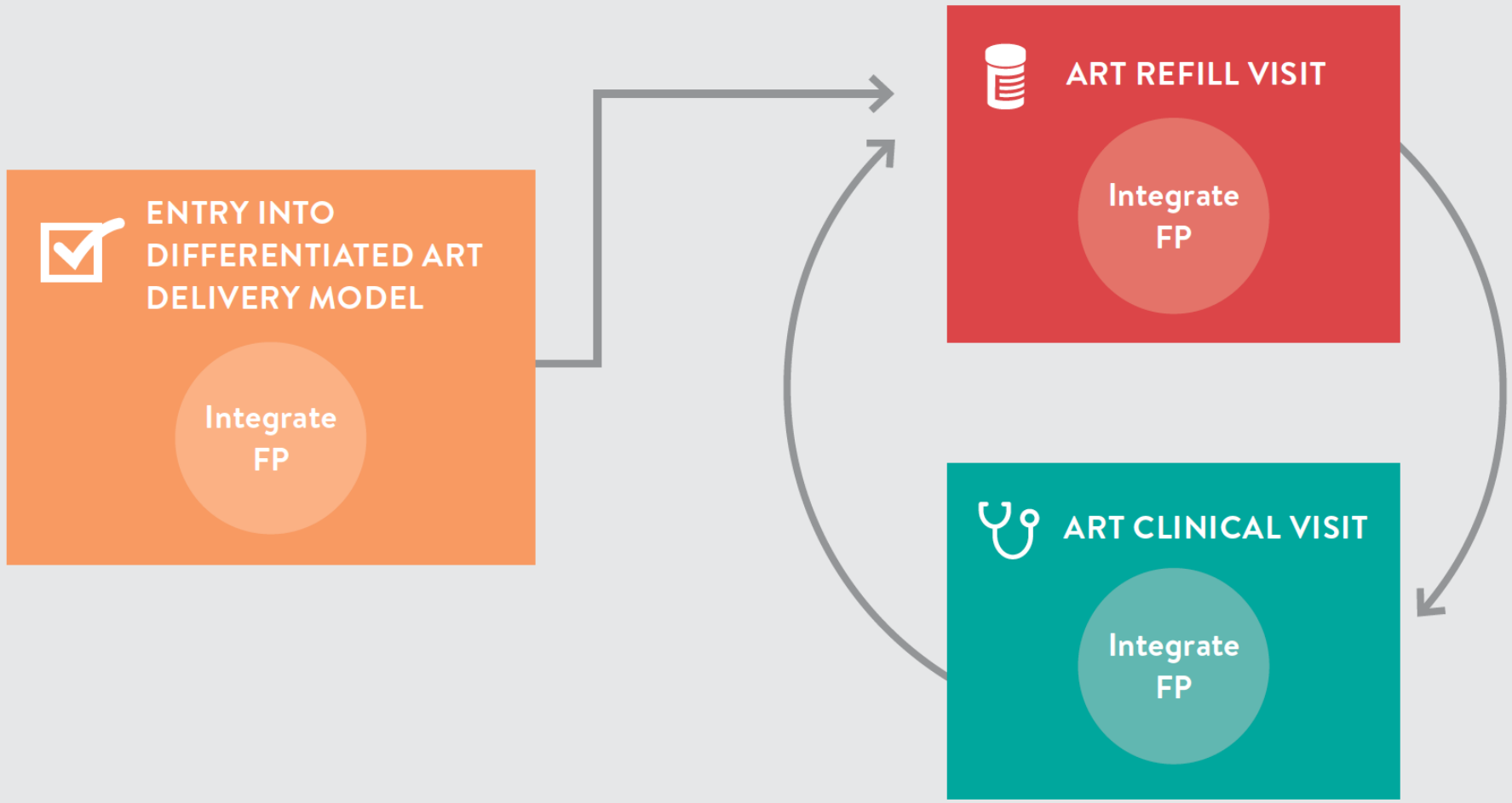
	Screening for TB	Initiation of TPT	TPT refill	Completion of TPT
WHEN	Every two months; for TPT catch up, whole group screened at one meeting for eligibility	Aligned for group	Every two months in line with ART refill (prepacked together)	After 12 months
WHERE	Club meeting space at facility	Club meeting space at facility	Club meeting space at facility	Club meeting space at facility
WHO	Lay worker who facilitates group	Nurse or doctor	Lay worker who facilitates group	Prescribing nurse or doctor
WHAT	Verbal symptom screen	TPT eligibility assessment Initiation of INH and pyridoxine Scripting INH to align with club ART refills TPT start reflected in club register TPT group treatment literacy (by lay club facilitator)	Continued TPT group literacy TPT follow-up assessment (TPT side-effects and/or TB symptoms) Refill of INH and pyridoxine Completion of TPT refill in club register (six-monthly INH and ART rescripting done by nurse or doctor)	TB symptom assessment TPT completion documented in M&E systems

TPT and TB treatment within DSD for HIV treatment models

“women living with HIV who manage their own ART may be a receptive audience for multi-month refills of oral contraceptives or longer acting self administered contraceptives, such as Sayana Press”

BUILDING FROM TB, FAMILY PLANNING AND NON-COMMUNICABLE DISEASES TO UNIVERSAL HEALTH CARE

Figure 1. Family planning care throughout differentiated service delivery of ART



Example: Integration of family planning care within Community ART Groups, Kenya

	IUDs	Implants	Oral pills	Injectables*
WHEN	Available but not taken up	At DSD entry At DSD clinical visits At facility walk in services in between visits if contraceptive need identified	Every 3 months, aligned	Every 3 months, aligned
WHERE	Available but not taken up	At same facility as ART where transition to DSD initiated/ ART collected for CAG	Collect ART and FP script from same clinic room and collect from the same pharmacy	Injection given in same room as ART assessment; group member in need nominated to collect ART for others
WHO	Available but not taken up	Implant- trained doctor, clinical officer, midwife or nurse	FP-trained clinical officer, midwife or nurse provides script	FP-trained clinical officer, midwife or nurse
WHAT	Available but not taken up	Implant information, counselling, insertion/ removal, management of side effects	Combined and progestin- only pills, information, counselling, script for pills, management of side effects	Injectable information, counselling, giving of injection, management of side effects *Self-injectable not yet available

TPT and TB treatment within DSD for HIV treatment models

"women living with HIV who manage their own ART may be a receptive audience for multi-month refills of oral contraceptives or longer acting self administered contraceptives, such as Sayana Press"

BUILDING FROM TB, FAMILY PLANNING AND NON-COMMUNICABLE DISEASES TO UNIVERSAL HEALTH CARE

"individuals who are stable on hypertension and diabetes treatment may be good candidates for appointment spacing, multi-month prescribing, and community-based services."

"The concept of DSD 2.0 provides an entry point to unlock synergies between HIV programming and a UHC-oriented service delivery redesign."

1. DSD for HIV treatment is **more than just longer ART refills** – need to support community-based and community-led delivery of services
2. DSD is **more than just HIV**
3. Let's **keep some of the changes** that were put in place because of COVID-19

Resources

- Expanding the Vision for Differentiated Service Delivery: A Call for More Inclusive and Truly Patient-Centered Care for People Living With HIV. Peter Ehrenkranz, Anna Grimsrud, Charles B Holmes, Peter Preko, Miriam Rabkin. *J Acquir Immune Defic Syndr*. 2021 Feb 1;86(2):147-152.
- Let's talk chronic disease: can differentiated service delivery address the syndemics of HIV, hypertension and diabetes? Helen Bygrave, Lina Golob, Lynne Wilkinson, Teri Roberts, Anna Grimsrud *Curr Opin HIV AIDS.* 2020 Jul;15(4):256-260.

"Leveraging differentiated ART delivery models for stable clients to scale up TB preventive therapy" available in English, French and Portuguese

"Leveraging differentiated ART delivery models to strengthen family planning" available in English, French and Portuguese

www.differentiatedservicedelivery.org

Share your work - contact us at dsd@iasociety.org

Integrated Services to Address Community Needs during COVID-19 and beyond

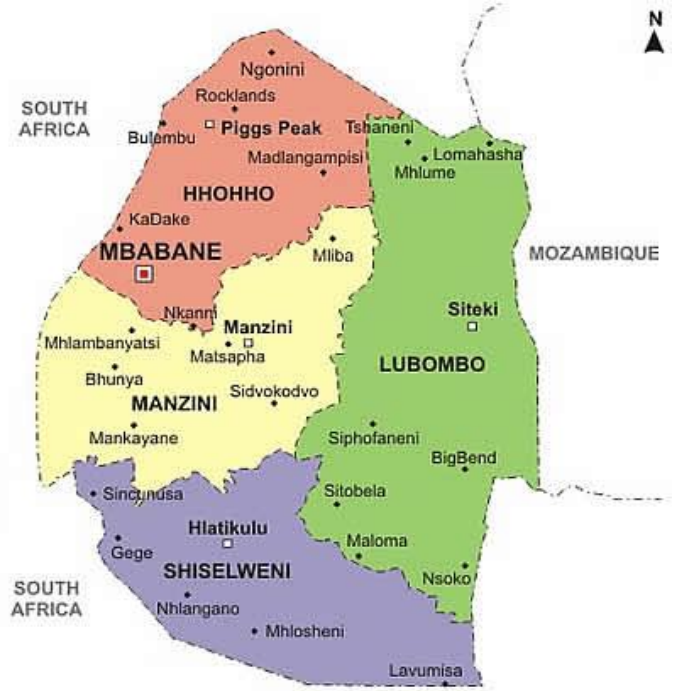
By Dr. Nkhosikhona Advocate Dlamini, National ART Coordinator-ENAP, Ministry of Health, Eswatini

Outline

- Overview DDD in Eswatini
- DDD Recruitment and Pick Up Points
- DDD Service Flow and Type of Services
- DDD Key Challenges and Lessons Learnt

Overview DDD in Eswatini

IP	Activity	Region
EGPAF	• Drugs distribution • Coordination of all IPs	Hhohho, Shiselweni
TLC & PSI	Drugs distribution	All 4 Regions
Pact	Drugs distribution	Hhohho, Shiselweni
FHI360	Drugs distribution	Hhohho Shiselweni
URC → Georgetown University	Drugs distribution	Lubombo
ICAP → Georgetown University	Drugs distribution	Manzini
HC4	Community engagement	-
FEI Systems	M&E support	-
PSM	Supply chain management	-



- DDD renamed in Eswatini as ***Community Health Commodities Distribution (CHCD)*** and launched in March 2020 as an emergency response to COVID-19

- **Eligible**: ART stable clients (VL<1,000) and patients on other selected medications

- **Venue**: community sites; private pharmacies in the pipeline to be established

- **Mapping:** community pick up points (PUP) are mapped based on distance between clients' residence and the "Mother-Baby" public health facility

- **Service delivery**: offered through IPs and dedicated DDD nurses; the DDD service is linked to a "Mother-Baby" public health facility accountable for the service

- **Type of services**: Antiretroviral (ART) and Pre-Exposure prophylaxis (PrEP), Family Planning (FP), Tuberculosis (TB), Non-Communicable Diseases (NCD); selected Lab test

Recruitment into DDD

- Virally suppressed ART patients and any patient in need for any of the medications offered through DDD, is eligible to access the service

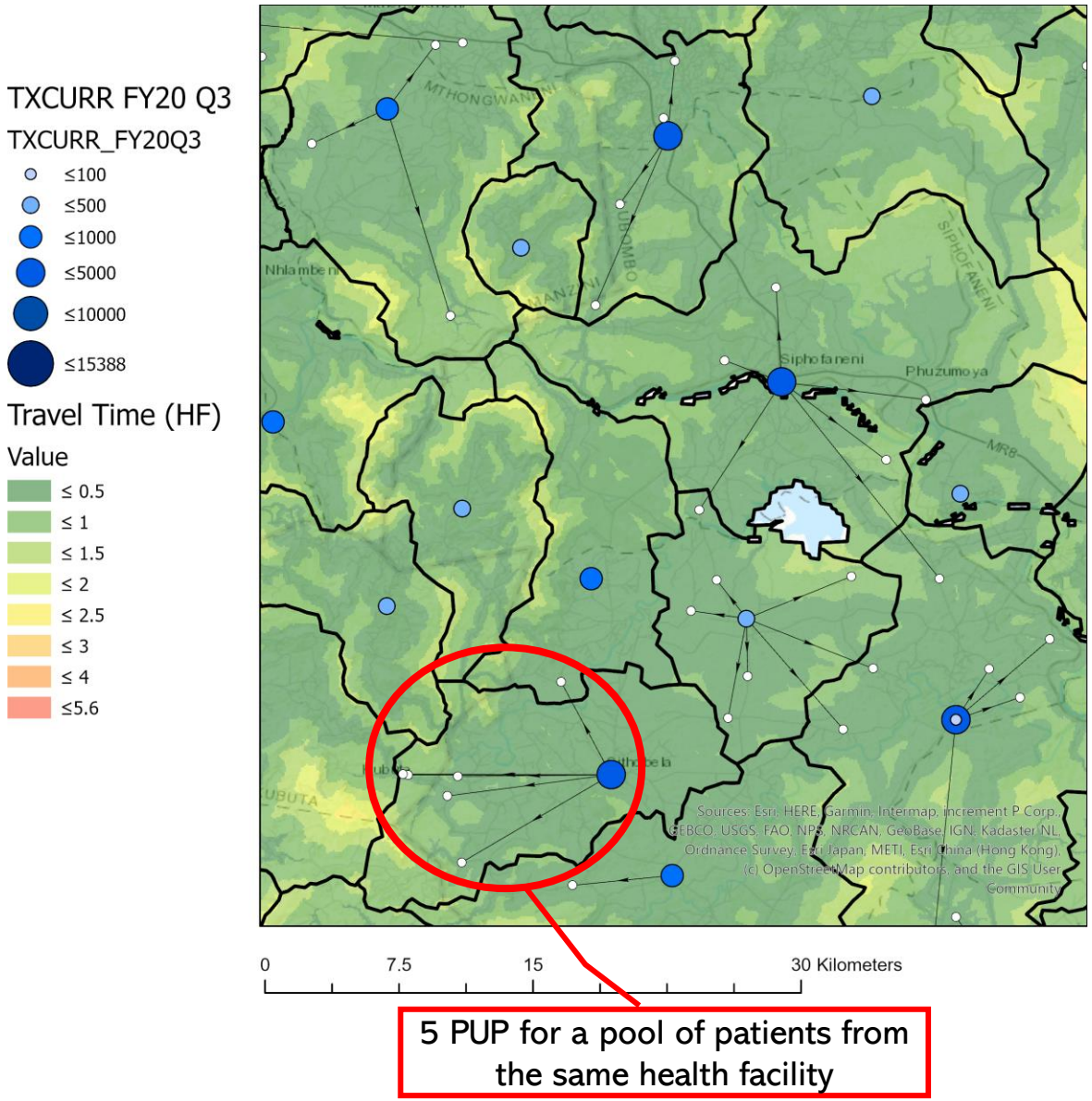
- Patients accessing the health facilities linked to the DDD service delivery model as well the communities are informed about DDD services in their catchment areas by Expert clients

- All the patients are recruited into the DDD service delivery model at the public health facility, and they are registered into a DDD Register

Figure 1. ART Nurse collecting VL sample at Mhlambanyatsi PUP

DDD Pick Up Points

- Based on an appointment plan, a day prior to service delivery, the DDD facility team (nurse, expert client and data clerk) prepare the necessary medications and commodities
- On the appointment day, the DDD nurse and the Expert Client carry all the necessary medications and commodities to the PUP
- Patients access the service and pick up the medication(s) at the designated PUP; some patients also show up without appointments and still receive the services



Services offered through DDD

ART and PrEP

TB Preventive Therapy (TPT) and TB Therapy

Family Planning (FP)

- Condom
- Pill
- Injectable

Non-communicable diseases (NCD)

- Hypertension:
- Diabetes:

- Vital signs check: Blood pressure, Temperature, Body weight
- COVID-TB screening
- STI screening
- Glucose test
- HIV test
- VL test
- Biochemistry tests and CD4
- Curative services: treatment of minor illnesses, eg. headache, skin infection, etc.
- Nutritional Support: plumpy nut
- Distribution of the medications
- Adherence assessment through pill count
- Referral to the health facility

DDD Service Flow

Mother Health Facility

Patients registered at a ***Mother public Health Facility*** are offered decentralized services at the ***Baby public Health Facility***, which is closer to the patients' residence

Baby Health Facility

Patients registered at a ***Baby public Health Facility*** are offered "further-down" decentralized services at the ***DDD PUP***

DDD Team *carries and provides the medications at the* ***DDD PUP***

DDD Site

Patients *access the medications at the* ***DDD PUP***

Patients *are* ***referred-back to the Health Facility:***

- *Deterioration of the clinical condition; development of sign/symptoms consistent with Opportunistic Infections*
- *Repeatedly poor adherence to the medication(s)*
- *Need a laboratory test that is not offered at the DDD PUP (eg. TB sputum test)*
- *Need to change FP method or medication*
- *New patient Test HIV positive and need to start ART*

Figure 1. DDD Health Facilities and PUP, as of Oct 2020

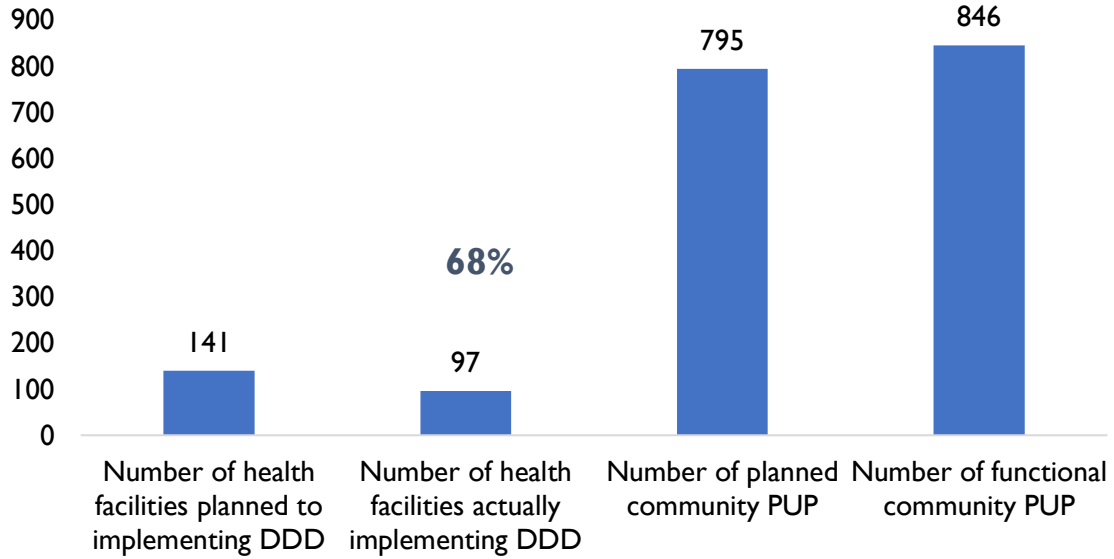


Figure 2. Type of DDD PUP, as of Oct 2020

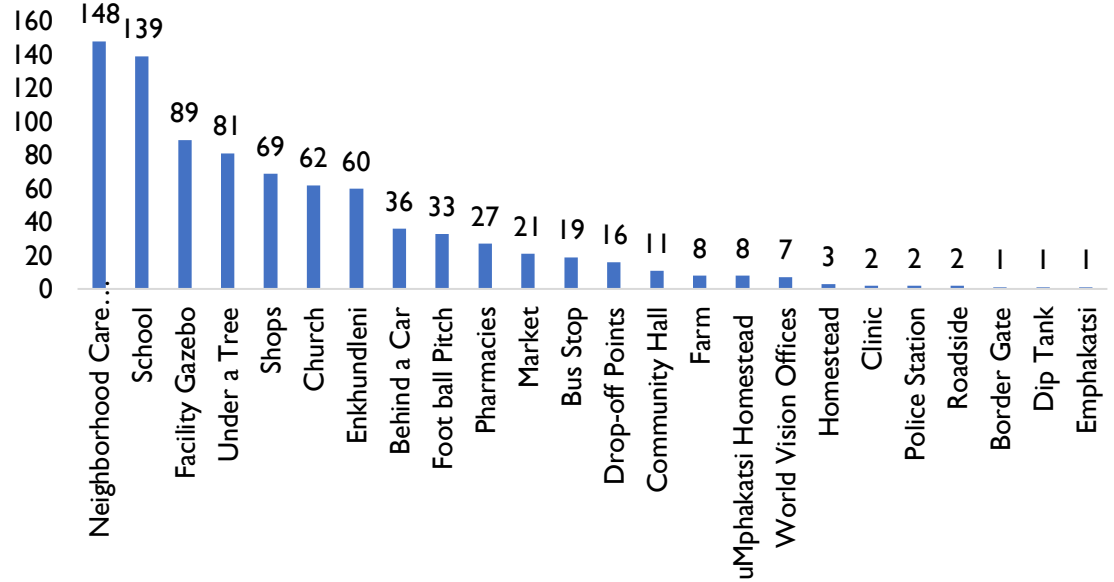
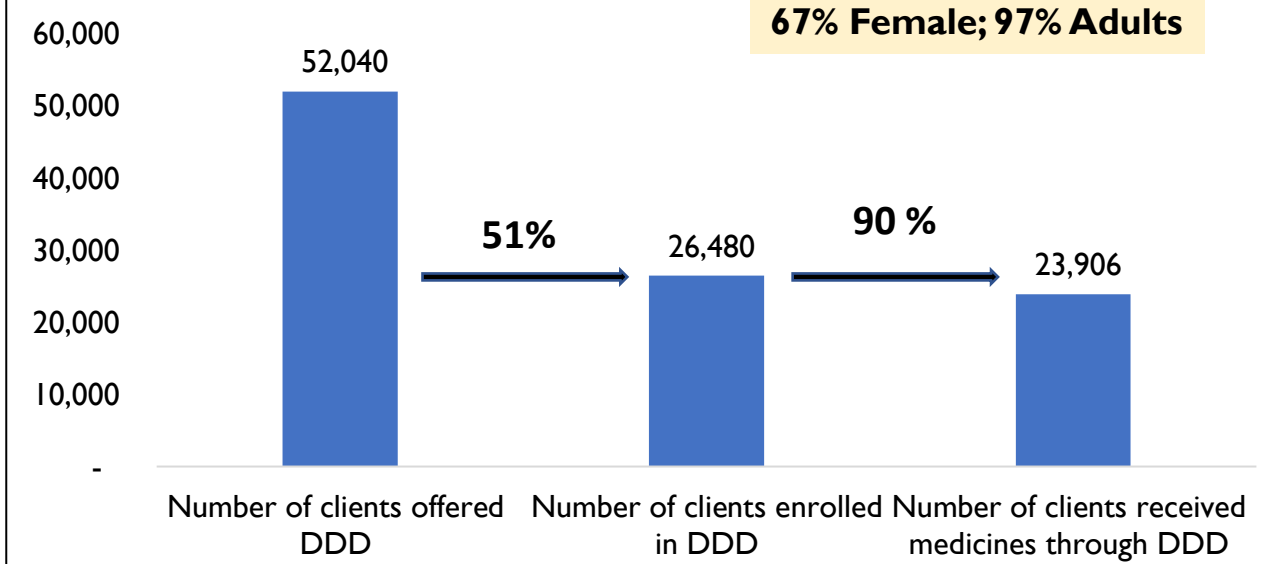


Figure 3. Clients enrolled and received DDD, Apr-Oct 2020



- Although 68% of the planned facilities implemented DDD, the number of PUP was higher than expected because additional PUPs were identified based on clients' needs (Figure 1)
- Half of the community PUP were at neighborhood care points (community structures centrally located), schools and gazebos (Figure 2)
- Half of the eligible clients enrolled into DDD, but among those enrolled, 90% received DDD (Figure 3)

Figure 1. Type of DDD Services, Apr-Oct 2020

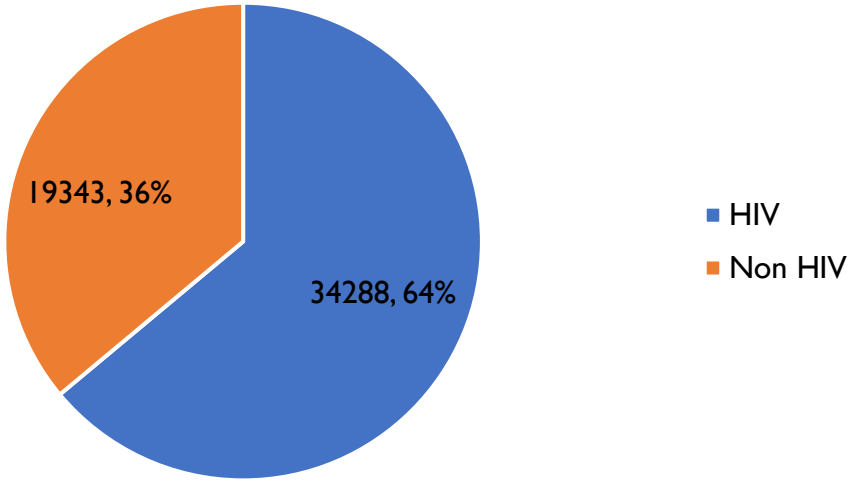


Figure 2. Types of DDD Non HIV services, Apr-Oct 2020

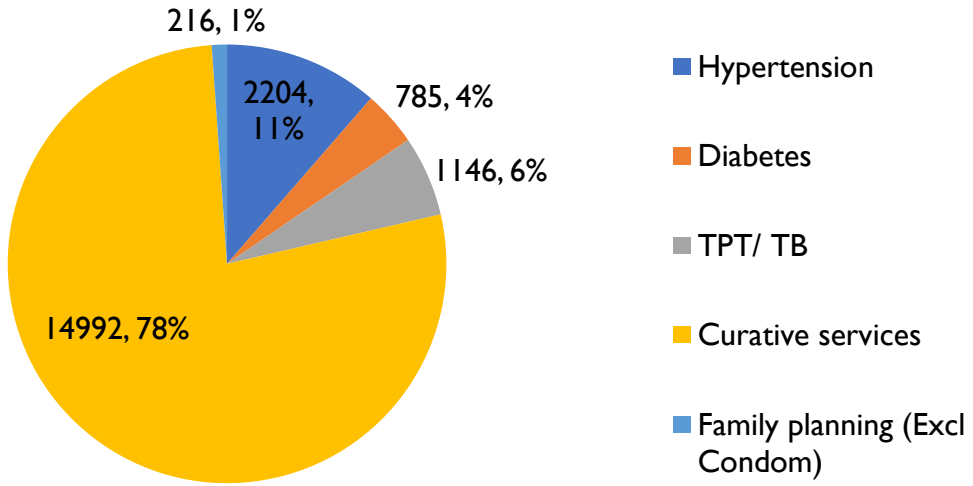
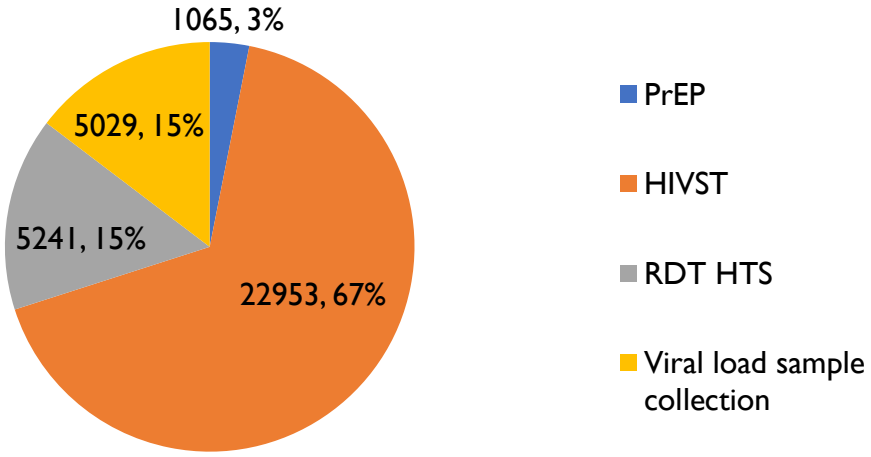


Figure 3. Types of DDD - HIV services, Apr-Oct 2020



- On average, about 70,000 medications and commodities were distributed every month at DDD PUP
- About one third of the DDD services were for non-HIV services (Figure 1)
- Curative services represented 78% of the DDD Non-HIV services (Figure 2)
- HIV Self test represented 67% of the DDD HIV services (Figure 3)
- Cumulatively, about 370K condoms were distributed (not included in the figures)

DDD Key Challenges and Lessons Learnt

- What worked
  - Rapid roll out during COVID
  - Reduce risk of COVID transmission when accessing health facilities
  - Increase access to commodities during COVID-driven lockdown
  - Decongest facilities
  - Integrated model of care
  - Increase service coverage
  - HCF added different curative and HIV related services based on client specific needs, and availability of the commodities.
  - Distribution of HIV ST during COVID-19 when HTS services were suspended

- What needs to be improved
  - Service package is not standardized; eg. some PUP do not offer glucose test or hypertension meds
  - Limited Lab coverage at PUP
  - Supply Chain management; eg. medications shortage
  - M&E system is not standardized yet

Thank you with support from:

EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium, Population Services International (PSI), and Gobee Group.

Considerations for TB Diagnosis and Treatment within DSD Models

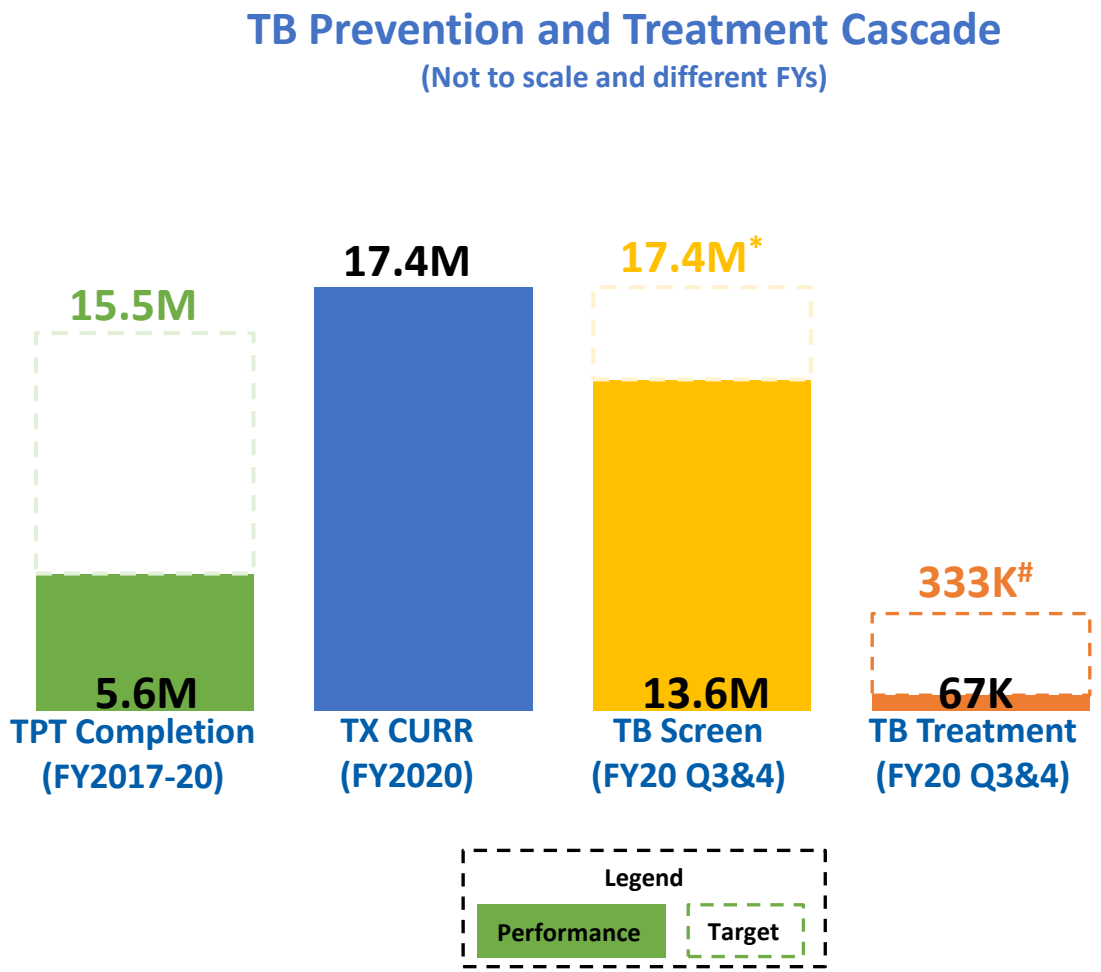
Cuc H. Tran, PhD, MPH

Epidemiologist, Global Tuberculosis Branch

U.S. Centers for Disease Control and Prevention

PEPFAR Targets and Goals

- **2017 PEPFAR target: Provide TPT to 15.5M PLHIV by end FY21**
  - **FY20 Q4: >5.6M completed TPT, ~36%**
- **COP:"TB/HIV clinical services should be fully integrated to ensure that ART and TB treatment are optimized and harmonized, including differentiated service delivery (DSD)"**
- **To reach targets, TB services *must* be expanded to PLHIV in DSD models**



*Assumption: 10% of all 100% TX CURR are screened positive for TB (literature estimates 10-15% screened positive);
#Assumptions 23% of those screened positive for TB have TB disease, based on MER

M= Million; K= Thousand

Landscape for Integrating TPT & TB Treatment into DSD

- **COVID-19 mitigation measures impacted scale-up, but encouraged TPT DSD & experimentation with TB Rx DSD**
  - **Supply chain management/commodity security remains threat to scale-up**
  - **Changes to policy/practice encouraging DSD for TB services (Table)**
  - **COVID-19 funds to CDC (IEI/CARES) have provided an opportunity to rigorously evaluate models for TPT DSD and pilot and evaluate TB services DSD**
- **Unclear scale, scope, and performance of various service packages**
  - **No standardized implementation parameters**
  - **No MER reporting metrics (only aggregate TPT initiation/completion)**
- **New research/M&E plans are critical for these TB services (e.g. adverse event and adherence monitoring) and require explicit program investment in understanding the dynamics and impacts of these models**

Country	MMD TB	MMD TPT
Botswana	Na	Na
Cameroon	**Yes**	Na
Cote d'Ivoire	Na	Na
DRC	Na	Na
Eswatini	Na	**Yes**
Ethiopia	**Yes**	No
Haiti	**Yes**	**Yes**
Kenya	**Yes**	**Yes**
Lesotho	**Yes**	**Yes**
Malawi	Na	Paused TPT
Mozambique	Na	**Yes**
Namibia	**Yes**	**Yes**
Nigeria	**Yes**	**Yes**
Rwanda	Na	**Yes**
Uganda	**Yes**	**Yes**
Tanzania	Na	**Yes**
South Africa	**Yes**	**Yes**
Vietnam	Na	Na
Zambia	**Yes**	**Yes**
Zimbabwe	**Yes**	**Yes**

Source: Al-Samarrai (OGAC), AIDS2020

PEPFAR Toolkit: DSD TPT and TB Implementation Considerations

Implementation considerations are available on PEPFAR Solutions under "TPT Implementation Tools" here (tool # 17, Oct 2019), including:

- **Alignment with ARV dispensing/clinic visits**
- **TB diagnostic evaluation**
- **TB treatment initiation**
- **Patient management and follow-up:**
  - **TB dispensing**
  - **Evaluating treatment effectiveness**
  - **Screening for adverse events**
  - **Monitoring adherence and completion**
- **Recording and reporting**

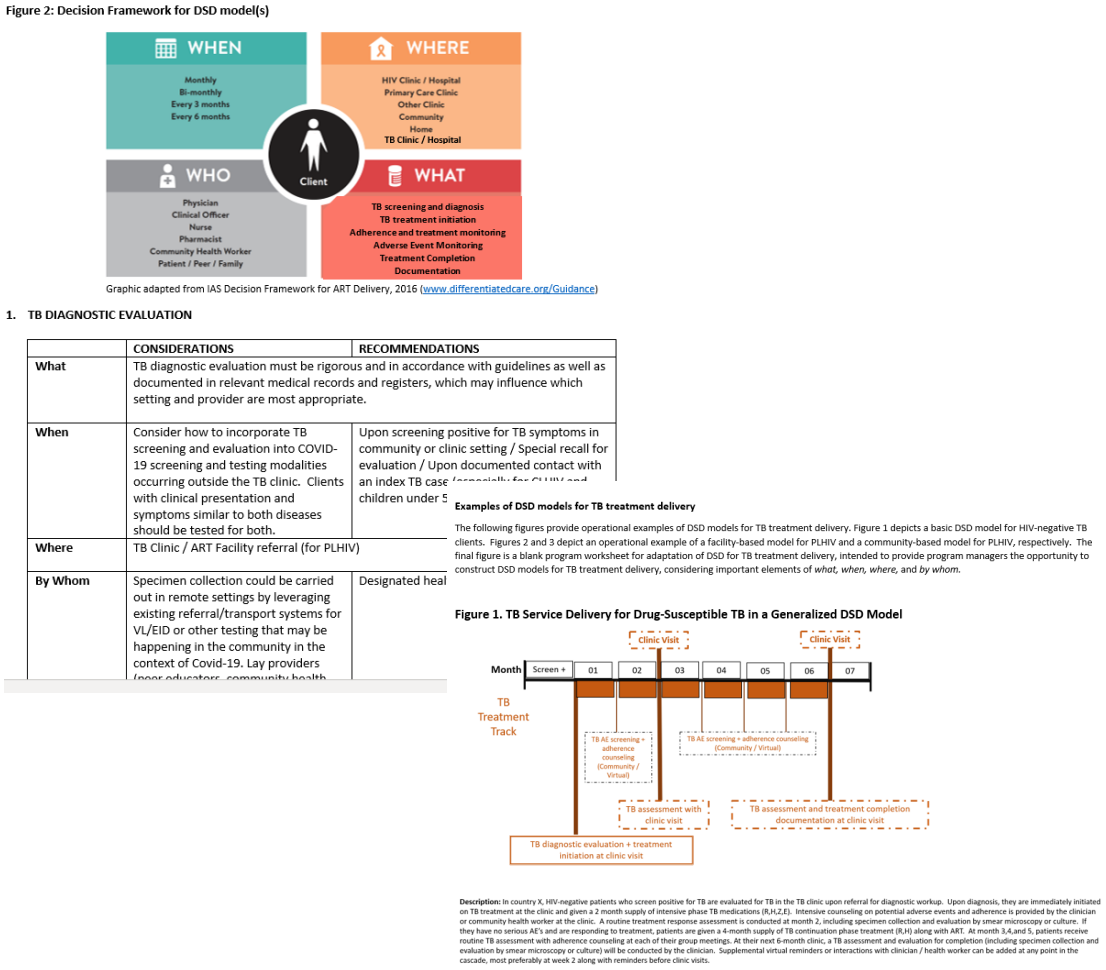


Figure 2: Decision Framework for DSD model(s)

Graphic adapted from IAS Decision Framework for ART Delivery, 2016 (www.differentiatedcare.org/Guidance)

1. **TB DIAGNOSTIC EVALUATION**

	CONSIDERATIONS	RECOMMENDATIONS
What	TB diagnostic evaluation must be rigorous and in accordance with guidelines as well as documented in relevant medical records and registers, which may influence which setting and provider are most appropriate.	
When	Consider how to incorporate TB screening and evaluation into COVID-19 screening and testing modalities occurring outside the TB clinic. Clients with clinical presentation and symptoms similar to both diseases should be tested for both.	Upon screening positive for TB symptoms in community or clinic setting / Special recall for evaluation / Upon documented contact with an index TB case children under 5
Where	TB Clinic / ART Facility referral (for PLHIV)	
By Whom	Specimen collection could be carried out in remote settings by leveraging existing referral/transport systems for VL/EID or other testing that may be happening in the community in the context of Covid-19. Lay providers	Designated heal

Examples of DSD models for TB treatment delivery

The following figures provide operational examples of DSD models for TB treatment delivery. Figure 1 depicts a basic DSD model for HIV-negative TB clients. Figures 2 and 3 depict an operational example of a facility-based model for PLHIV and a community-based model for PLHIV, respectively. The final figure is a blank program worksheet for adaptation of DSD for TB treatment delivery, intended to provide program managers the opportunity to construct DSD models for TB treatment delivery, considering important elements of *what, when, where,* and *by whom.*

Figure 1. TB Service Delivery for Drug-Susceptible TB in a Generalized DSD Model

Description: In country X, HIV-negative patients who screen positive for TB are evaluated for TB in the TB clinic upon referral for diagnostic workup. Upon diagnosis, they are immediately initiated on TB treatment at the clinic and given a 2 month supply of intensive phase TB medications (R,H,Z,E). Intensive counseling on potential adverse events and adherence is provided by the clinician or community health worker at the clinic. A routine treatment response assessment is conducted at month 2, including specimen collection and evaluation by smear microscopy or culture. If they have no serious AE's and are responding to treatment, patients are given a 4-month supply of TB continuation phase treatment (R,H) along with ART. At month 3,4,and 5, patients receive routine TB assessment with adherence counseling at each of their group meetings. At their next 6-month clinic, a TB assessment and evaluation for completion (including specimen collection and evaluation by smear microscopy or culture) will be conducted by the clinician. Supplemental virtual reminders or interactions with clinician / health worker can be added at any point in the cascade, most preferably at week 2 along with reminders before clinic visits.

Related Resources:

- IAS supplement on Leveraging Differentiated ART Delivery Models for Stable
- Clients to Scale-Up TPT (2019)
- CQUIN Framework for Implementation

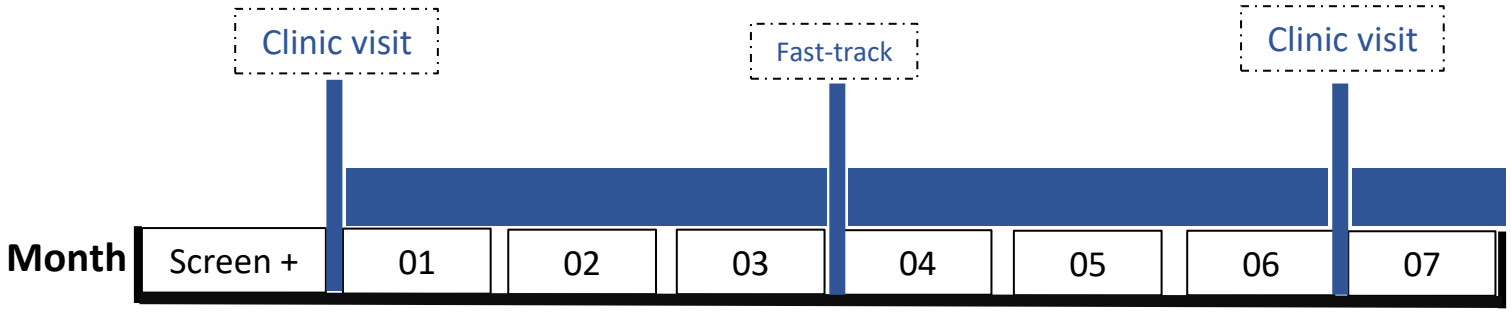
Critical Considerations

- **Standardized comprehensive education and counseling**
  - **Foundation by provider, reinforced by treatment supporter**
- **Adherence and AE monitoring**
  - **Daily or weekly monitoring during the intensive phase and monthly monitoring during continuation phase**
  - **Must find lost clients and identify reasons for noncompliance**
- **Treatment effectiveness**
  - **Evaluated at month 2, 5 and/or 6**
- **Recording and reporting of treatment**

Example

TB Treatment & Alignment with HIV Care

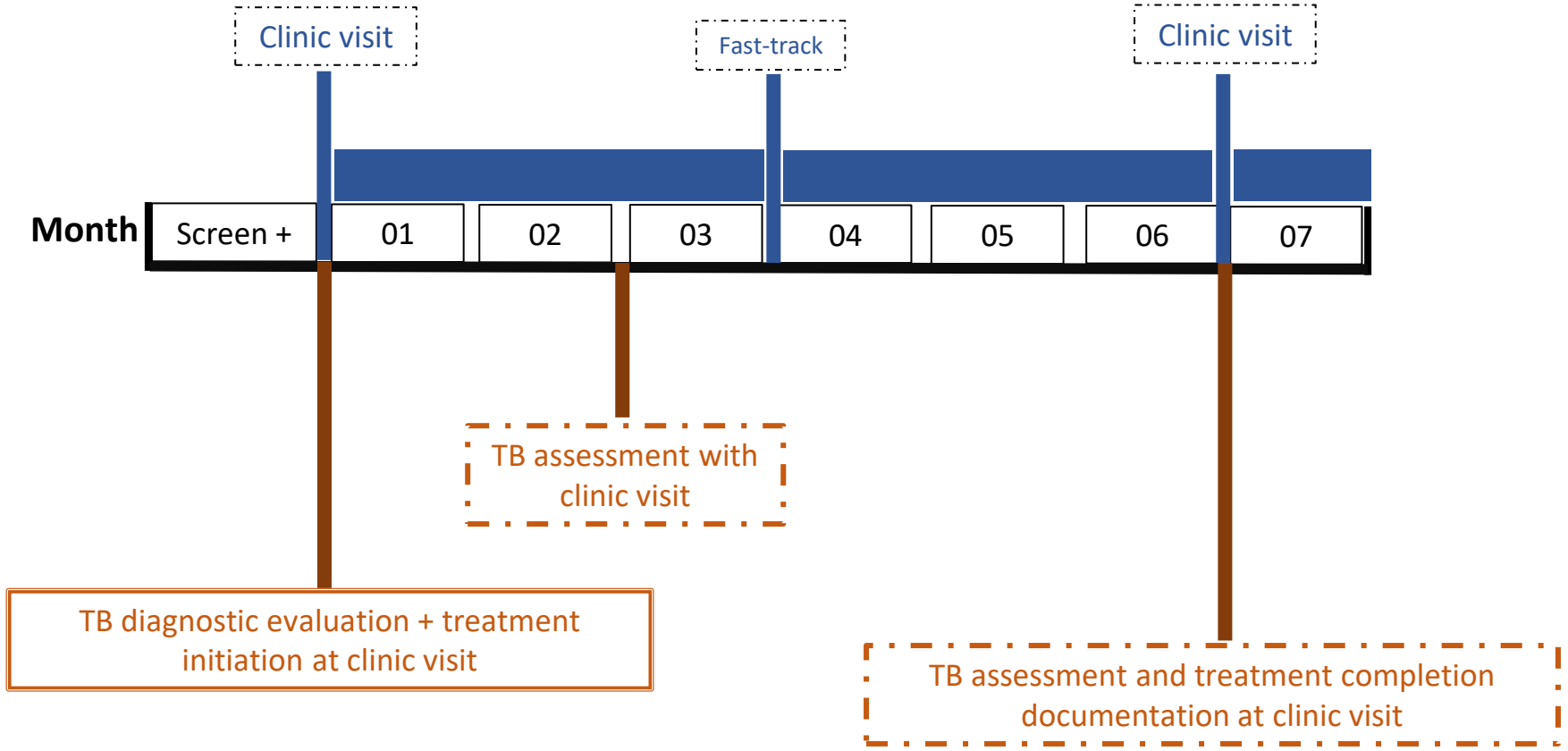
ART Track



TB Treatment & Alignment with HIV Care

ART Track

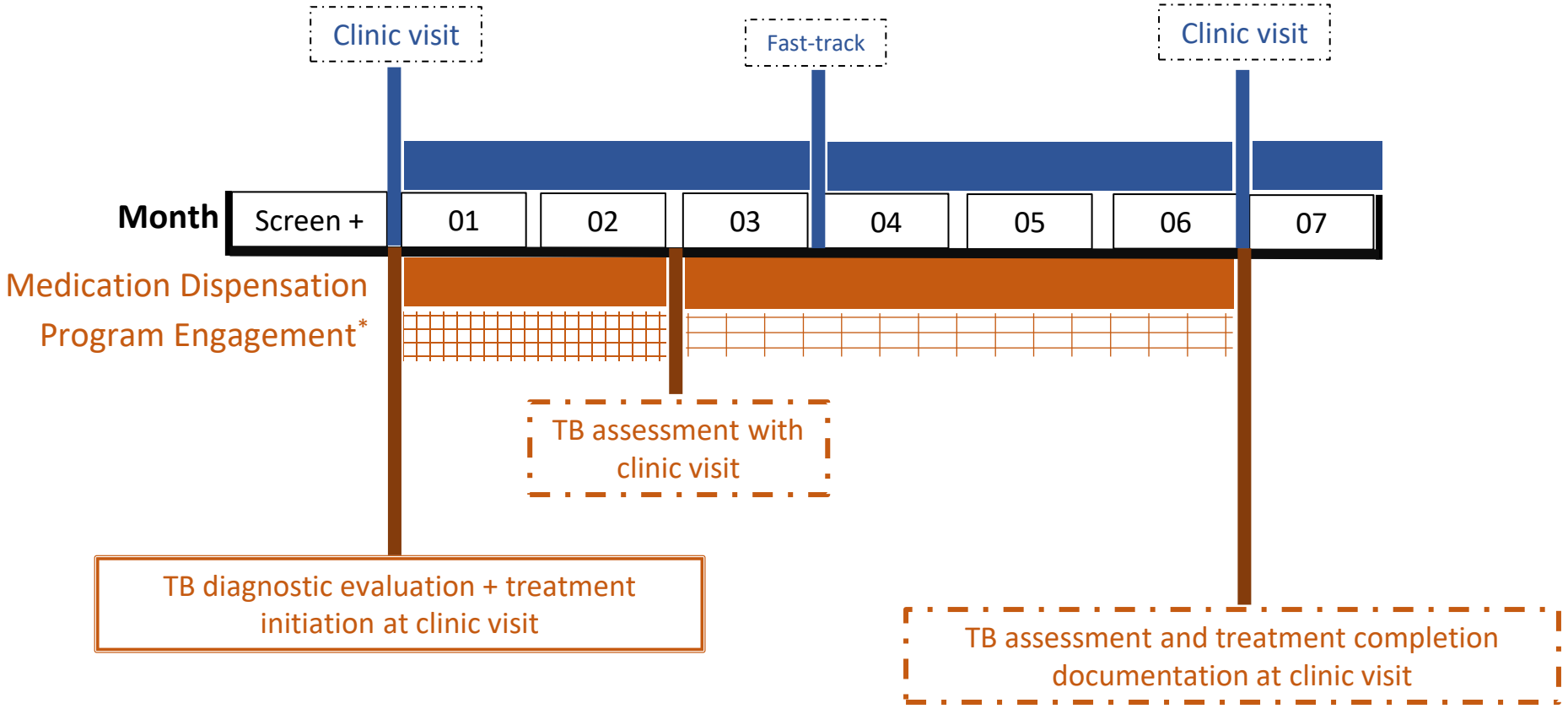
TB Treatment Track

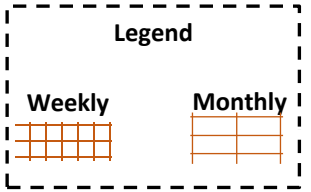


TB Treatment & Alignment with HIV Care

ART Track

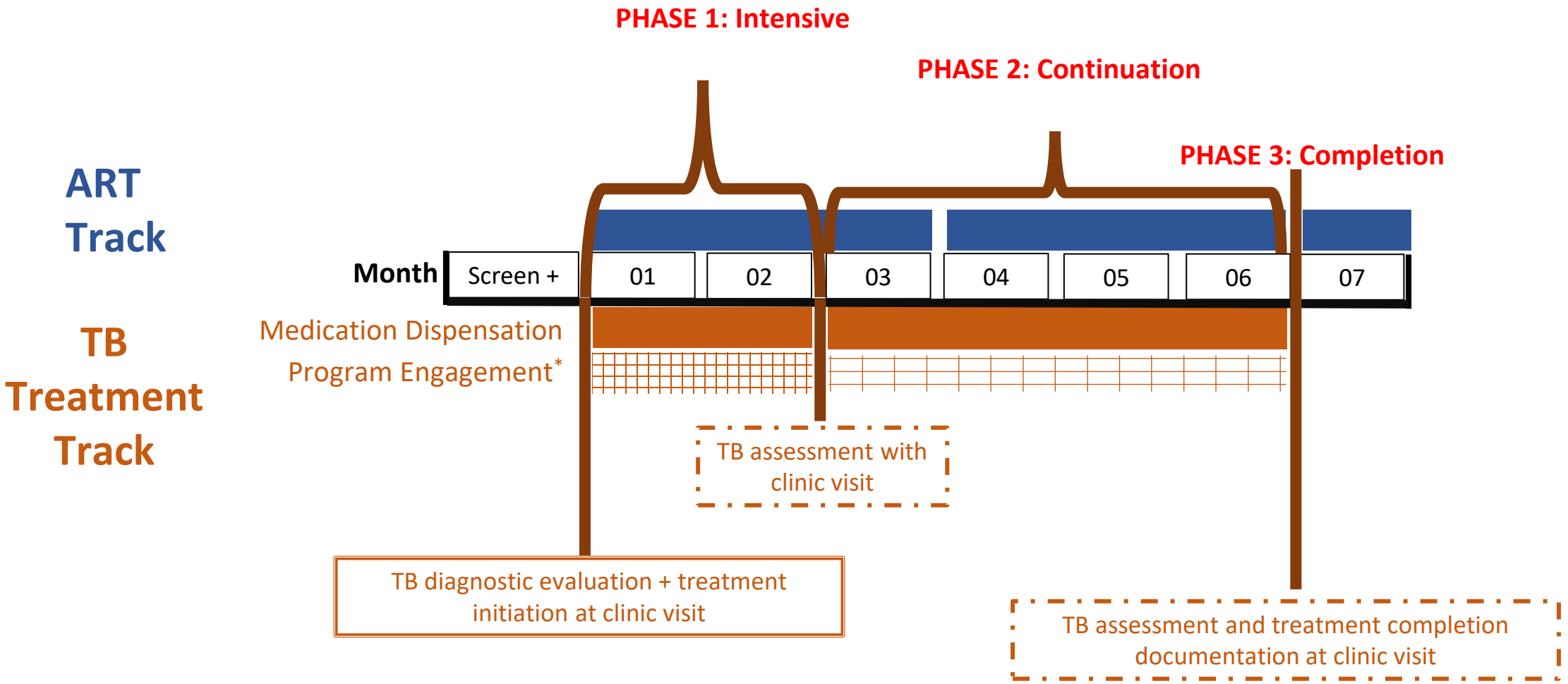
TB Treatment Track





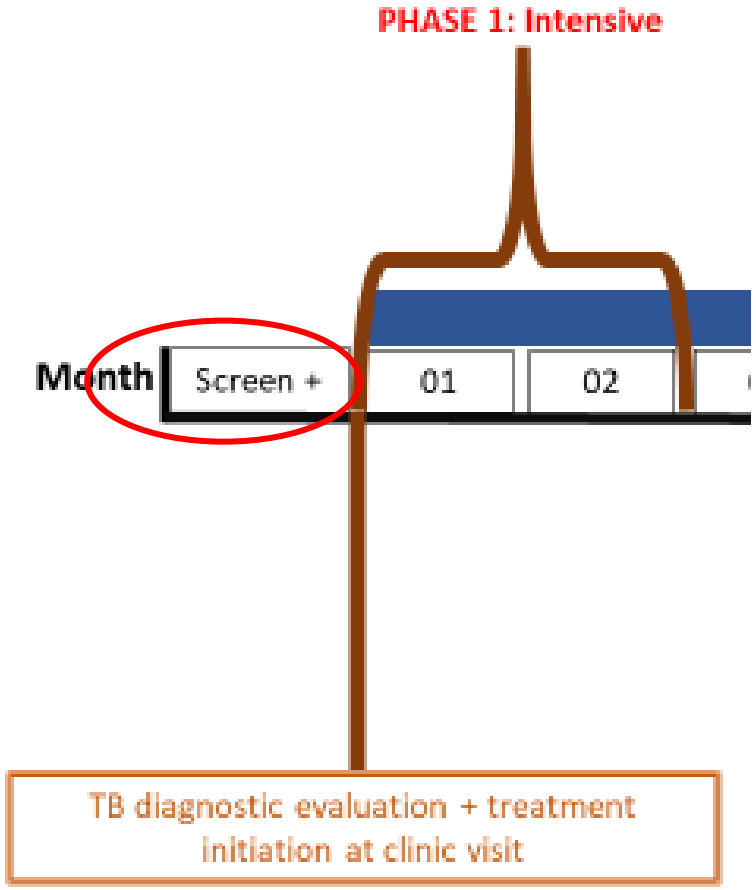
* Virtual/community engagement with client (e.g., monitoring for adherence and AEs, counseling)

TB Treatment & Alignment with HIV Care



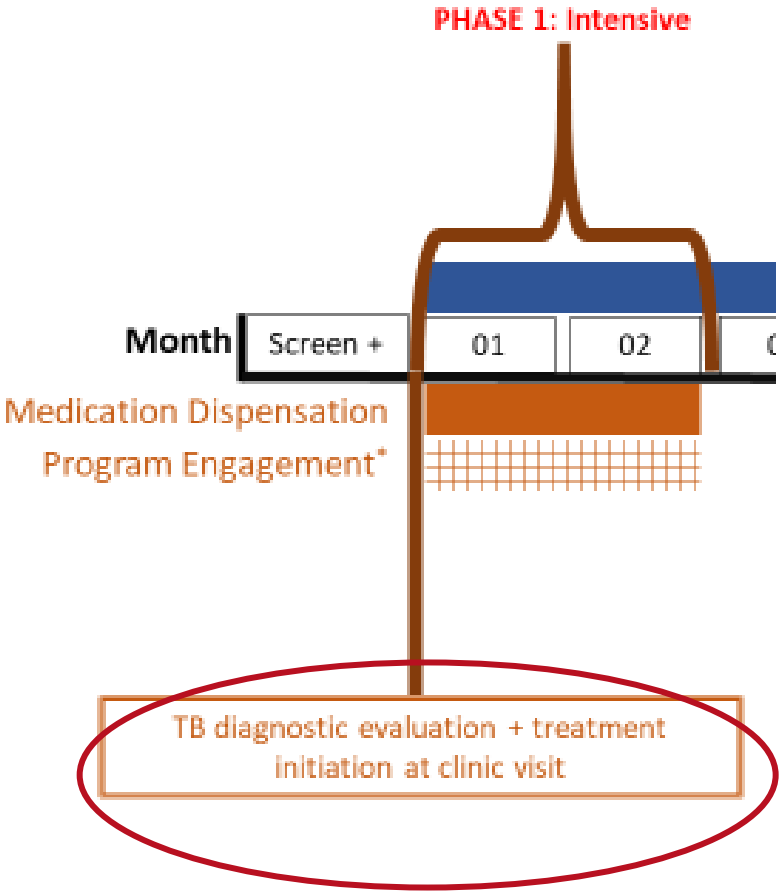
* Virtual/community engagement with client (e.g., monitoring for adherence and AEs, counseling)

Phase 0: TB Diagnostic



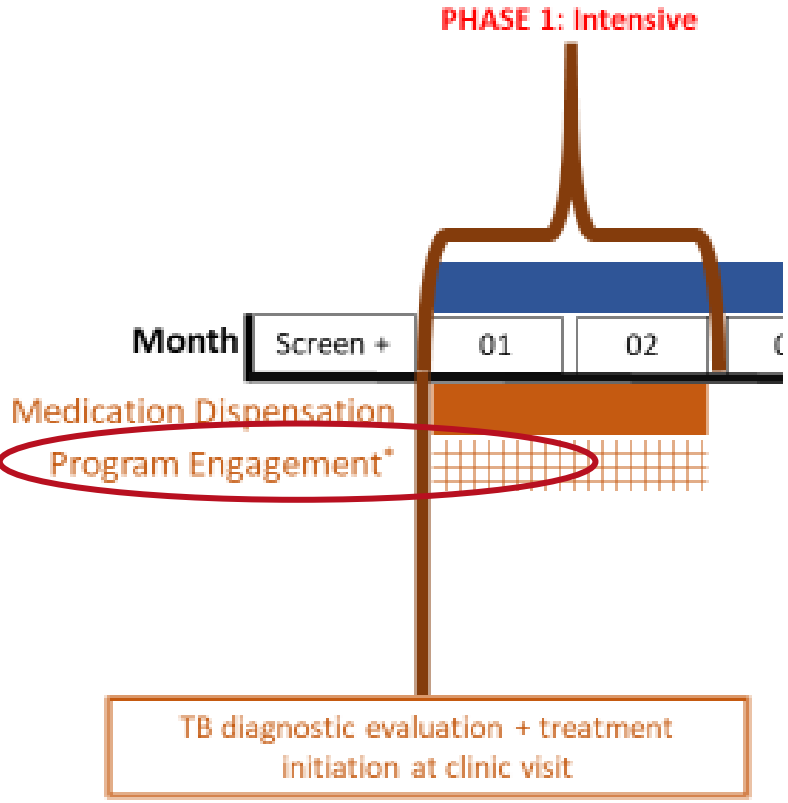
What	TB Screening	Sample Collection
When	Screening at every encounter	At time of positive screen or closely after
Where	Health facilities, drug distribution points, community (all contact points, e.g., COVID screening)	Health facility, community (leverage existing systems, e.g., COVID testing sites)
By Whom	Client, peer educators, community health workers, health providers	Health provider, community health workers

Phase 1: Intensive Phase – Initial Clinic Visit After Dx



What	TB Diagnosis	Client education & counseling	Recording & reporting	Medication dispensing
When	Initial clinic visit after diagnosis	Initial clinic visit after diagnosis	Initial clinic visit after diagnosis	Dependent on stock, aligned with ART (2 months)
Where	Health facility	Health facility	Health facility, pharmacy	Health facility, pharmacy, community (drug distribution points)
By Whom	Health provider	Health provider	Health provider, pharmacist	Health provider, pharmacy, peer educators, community health workers

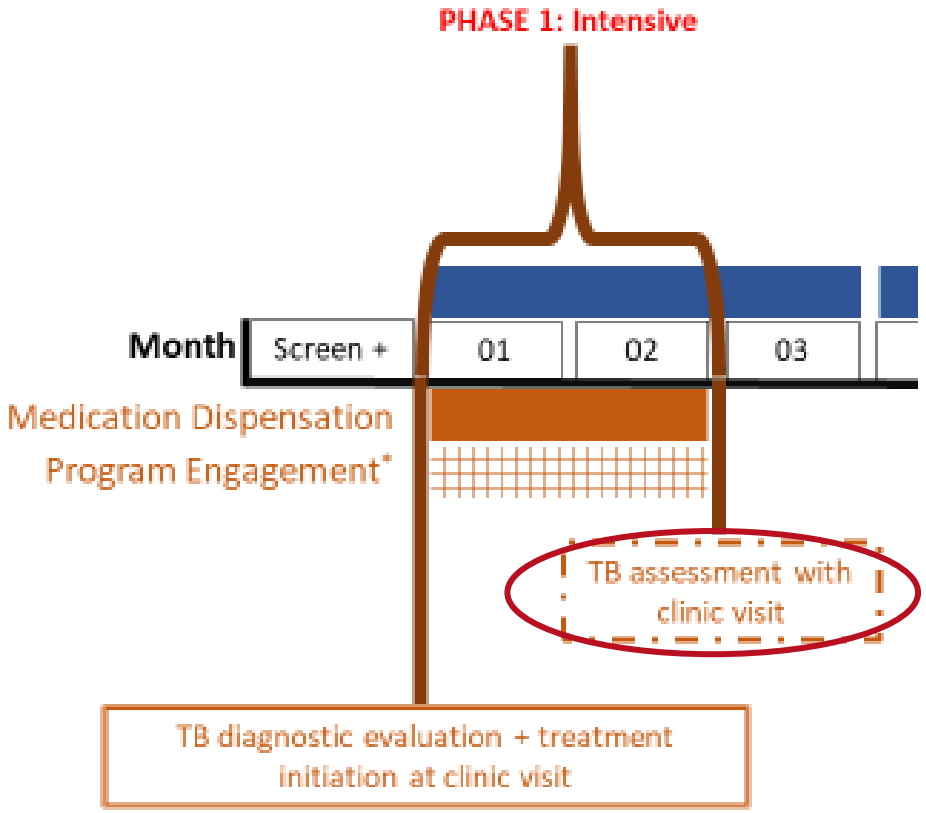
Phase 1: Intensive Phase – Program Engagement



What	Monitoring adherence and AEs	Client education & counseling	Recording and reporting
When	Weekly		At each interaction and at dispensing
Where	Community or virtually using digital technology (SMS, phone)		Health facility, pharmacy
By Whom	Peer educators, community health workers		Health provider, pharmacist, Peer educators, community health workers

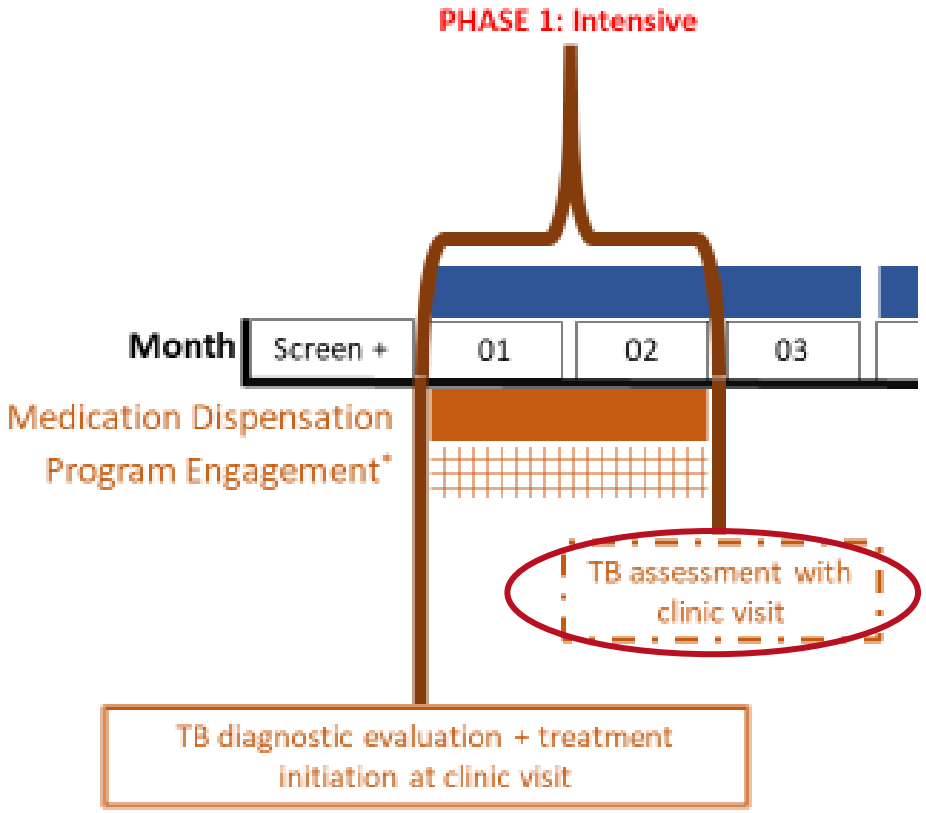
* Virtual/community engagement with client (e.g., monitoring for adherence and AEs, counseling)

Phase 1: Intensive Phase – 2nd Clinic Visit



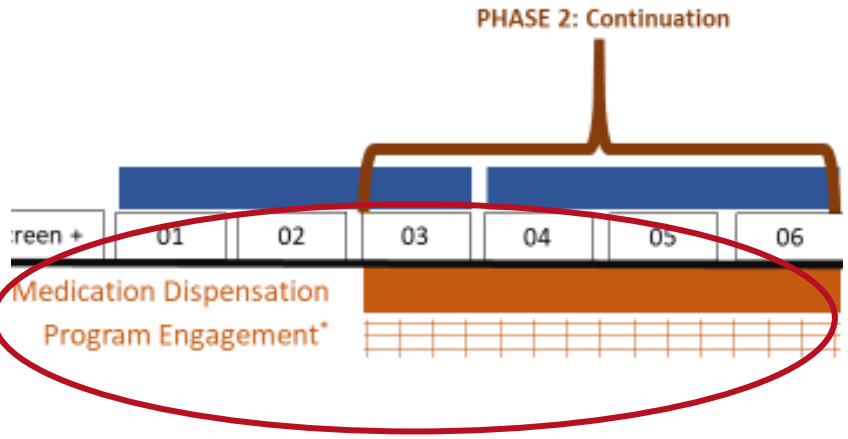
What	Sample Collection	TB Assessment	Client education & counseling
When	Before visit	Clinic	Clinic
Where	Health facility, community	Health facility	Health facility
By Whom	Health provider, community health workers	Health provider	Health provider

Phase 1: Intensive Phase – 2nd Clinic Visit



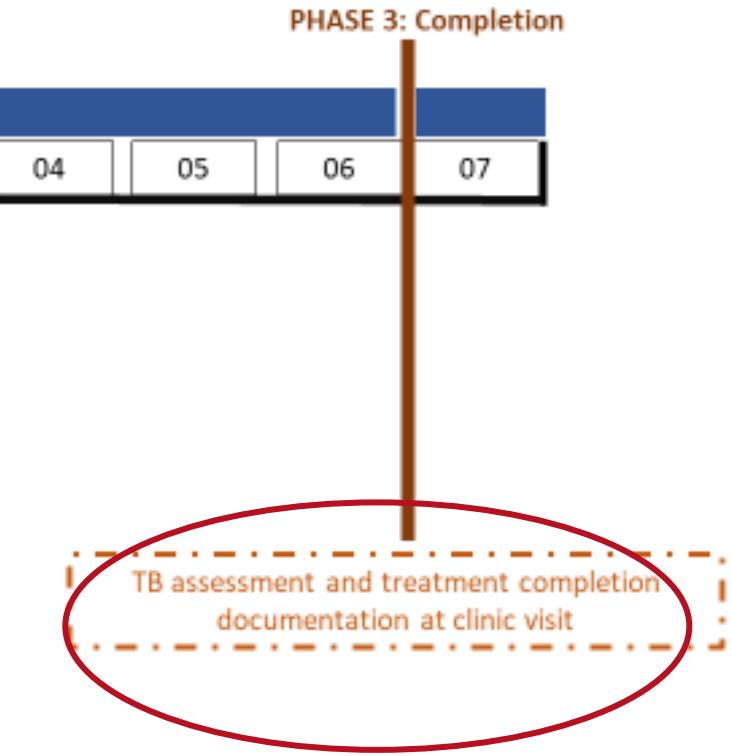
What	Medication dispensing	Recording and reporting
When	Dependent on stock, aligned with ART (4 months)	At clinic and/or pharmacy
Where	Health facilities, community drug distribution points, home	Health facility, pharmacy
By Whom	Peer educators, community health workers	Health provider, pharmacist, Peer educators, community health workers

Phase 2: Continuation Phase



What	Monitoring adherence and AEs	Client education & counseling	Recording and reporting	*Medication dispensing* *(if needed)*
When	Monthly		Each interaction and at dispensing	*Dependent on stock, aligned with ART optimal (4 months)*
Where	Community or virtually (SMS, phone)		Health facility, pharmacies	*Health facilities, community drug distribution points, home*
By Whom	Peer educators, community health workers		Health provider, pharmacist, Peer educators, community health workers	*Peer educators, community health workers*

Phase 3: Completion



What	Sample Collection	TB Assessment	Client education & counseling	Recording and reporting
When	Before visit	Clinic	Clinic	Clinic
Where	Health facility, community	Health facility	Health facility	Health facility, pharmacies
By Whom	Health provider, community health workers	Health provider	Health provider	Health provider, pharmacist, Peer educators, community health workers

Zambia TB Service Delivery Structure

- **Zambia NTP began offering MMD for TB treatment in response to COVID-19 in May**
  - Monthly dispensation for first two months with in-clinic evaluation for treatment monitoring, adherence counseling, adverse event monitoring and other follow-up
  - Followed by 4-month dispensation for continuation phase with digital/sms/phone follow-up for adherence counseling and AE monitoring
  - 6-month return clinic visit for treatment monitoring and treatment completion documentation

- **Limited implementation mostly in urban areas with 10-15% interim LTFU/inability to connect by phone/sms (similar to TPT scale-up)**
  - Digital adherence technologies need to be buttressed by community or household engagement to reduce LTFU/increase ability to reconnect with clients

- **Assessment and adaptation of this plan is ongoing and run through NTP**

Looking Forward: Scaling Up & Evaluating DSD for TB

- **CDC is launching a targeted, intensified effort in eight countries (Ethiopia, Haiti, India, Kenya, Nigeria, Uganda, Vietnam, Zambia) over 18–24 month period to scale-up and evaluate innovations in TB/HIV service delivery to mitigate impact of COVID-19**
- **Includes focus on:**
  - Bi-directional TB and COVID testing among symptomatic clients
  - Utilization of Xpert networks for decentralized Covid-19 testing (optional, dependent upon commodity)
  - Systematic implementation and evaluation of TPT and TB care in DSD models including facility and community multi-month dispensing, community-based and/or digital adherence support and AE monitoring
    - Exploring digital adherence technologies with Stop TB Partnership
    - Comparing different approaches and model designs for interim and treatment outcomes
    - Developing R&R approaches to supplement MER indicators
- **Prep and protocol development underway with implementation in early 2021**

Questions?

For more information, please contact:

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Andy Boyd (ipo2@cdc.gov)

Ishani Pathmanathan (ydi6@cdc.gov)

February 11, 2021

DMPA-SC ACCESS COLLABORATIVE

Products to people:
Innovative approaches to expand family planning service delivery

Photo: PATH/Will Boase

Caitlin Corneliess, Director, DMPA-SC Access Collaborative

PATH

JSI

The Access Collaborative

Purpose: The AC aims to ensure **sustainable availability of DMPA-SC self-injection as part of an expanded range of contraceptive methods.**

Vision: The AC's work will increase women's and girls' contraceptive choices and empowerment.

Functions: The AC is a *coordination and technical assistance* effort which

- Supports ministries of health in close collaboration with country partners to introduce and scale-up self-injection.
- Informs data-driven decisions on self-injection, family planning, and self-care by global and country level stakeholders.

1 DMPA-SC and Self-Injection Background

2 Progress in making DMPA-SC and Self-Injection accessible through a total market approach

3 Moving forward: promising approaches and lessons learned

Expanding family planning service delivery relies on a total market approach

Photo credits: Family Planning NSW (row 2, left); all other photos PATH

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The transformative potential of DMPA-SC and self-injection

Features/Benefits

- Shorter needle
- Lower dose
- All-in-one presentation
- Easier to transport, inject, store, and less waste to dispose

Opportunities

- Increased acceptability
- Well suited for community-based distribution, drug shops/pharmacies
- Uniquely suited to self-injection

Value

- Expanded access
- More new users
- Higher continuation
- An additional self-care option

More information: www.rhsupplies.org/activities-resources/tools/advocacy-pack-for-subcutaneous-dmpa

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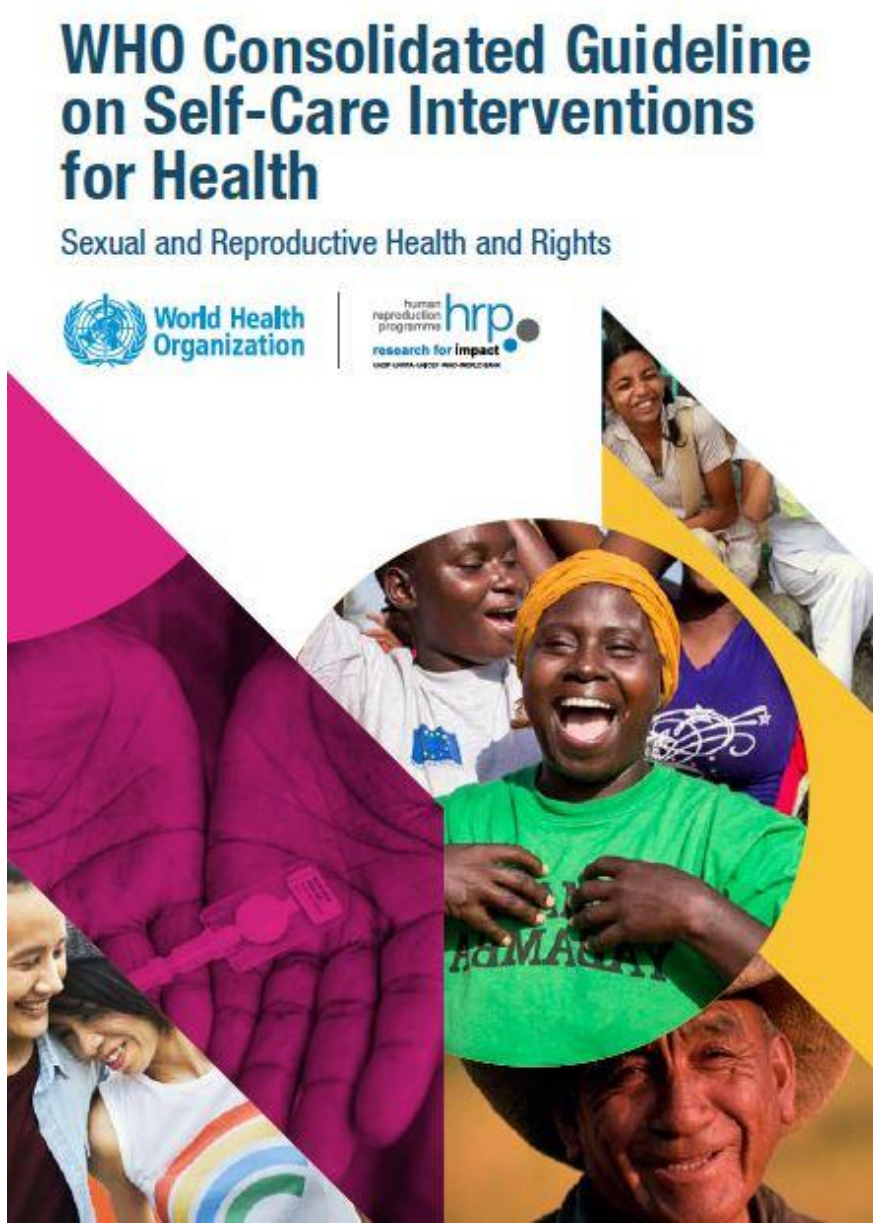
WHO's strong recommendation in favor of self-injection issued in 2019

Background

Injectable contraception is widely, used globally and a new subcutaneous form (DMPA-SC) is available that can be injected relatively easily and is safe and efficacious.

Recommendation 10:

Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age.



Self-care has similar goals to Decentralized Drug Distribution

- **Client-centered** initiatives that empower clients and save them time and resources
- Aim to **decongest** overburdened health facilities
- **Reduce interruption**/improve continuation of medications
- Have **clinical and supply chain implications**
- Use (some) similar **distribution models** (CHWs, private facilities)
- Require supportive **policy environment**

WHO Definition:

"Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health-care provider"

Increasing global commitment to introducing DMPA-SC, including self-injection, as part of an expanded method mix

31
countries introducing **DMPA-SC**

12 countries with self-injection scale up underway or complete

8 countries introducing or planning to introduce self-injection

Self-injection journey

Color legend

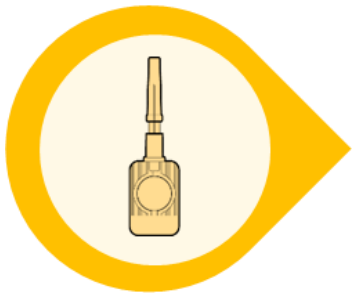
- Outreach and intake
- Client engagement with provider on self-injection
- At home
- At home and with provider

Provider training

Demand generation

Client intake

Client training



1st self-injection

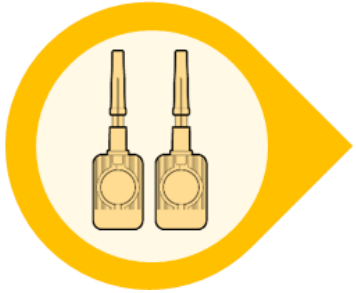
Collect and submit data

Storage

Reinjection

Disposal

Follow-up



Resupply

Four priority areas for policy action on self-care that could also inform DDD efforts

	Policy Categories	Illustrative Guidelines
1	**Task-shifting to increase access through pharmacies, drug shops & CHWs**	Task shifting to pharmacists/CHWs
		PrEP initiation via pharmacies
2	**Promoting home-based & user-controlled access**	Opt out self-injection counselling
		Self managed/home-based MA
		Multi-month dispensation
3	**Telemedicine & remote counseling**	Online/telemedicine service provision
4	**Enabling OTC access to ease dispensation restrictions**	3rd party/age of consent removal
		OTC access/prescription removal

Source: Salient Policy Assessment for Self-Care

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3 Moving forward: promising approaches and lessons learned

DMPA-SC and SI **policies and plans**: SI policies are strong; private-sector SI policies need attention

Key: Yes 🟢 No 🔴 In process 🟡

Country	Total market approach planned (**bold** = DMPA-SC is actively offered)	SI policy	CHWs authorized to initiate SI	Pharmacies/drug shops authorized to initiate SI	SI in COVID plans	Examples of current SI advocacy opportunities
Benin	🟢 Public: **facility**, **community** Private: **facility**, drug shop; **SMOs**	🟢	🔴 CHWs can administer, but not initiate SI	🔴 Pharm/DS can neither administer nor initiate SI	🔴	Approval for CHWs to initiate SI; approval for pharmacies to administer
Burkina Faso	🟢 Public: **facility**, **community** Private: **facility**, **comm**, drug shop, pharmacy; **SMOs**	🟢	🔴 CHWs can administer, but not initiate SI	🔴 Policy for pharm/DS to administer in process, but cannot initiate SI	🔴	Approval for CHWs to initiate SI; approval for pharmacies to administer + initiate SI
Cote d'Ivoire	🟢 Public: **facility**, **community** Private: facility, comm, drug shop, pharmacy; SMOs	🟢	🟢 CHWs can administer and initiate SI	🟢 Pharm/DS can administer and initiate SI	🔴	Reinforce CHWs approval to initiate SI through other guidelines; COVID integration
DRC	🟢 Public: **facility**, **community** Private: **facility**, **comm**, **drug shop**, **pharmacy**; **SMOs**	🟡	🟢 CHWs can administer and initiate SI	🔴 Pharm/DS can neither administer nor initiate SI	🟢 Includes SI	Finalize policy approval of SI; build champions in new PNSR leadership
Ghana	🟢 Public: **facility**, **community** Private: **facility**; **SMOs**	🔴	🟢 Comm health nurses (not vols) can admin and initiate	🔴 Pharm/DS can neither administer nor initiate SI	🔴 Includes FP	Approval for pharmacy distribution & refills (esp. to minimize fac visits during COVID)
Guinea	🟢 Public: **facility**, **community** Private: **facility**, drug shop, pharmacy; **SMOs**	🟢	🔴 CHWs can administer, but not initiate SI	🔴 Pharm/DS can neither administer nor initiate SI	🔴	Approval for CHWs to initiate SI; integration of SI in COVID-19 guidelines
Kenya	🟢 Public: **facility**, community Private: **facility**, community, **pharmacy**; **SMOs**	🟡	🔴 CHWs can admin in limited settings, but cannot initiate	🟢 Pharmacists can administer and initiate SI	🔴 Includes FP	Develop SI implementation guidelines; sub-national advocacy for DMPA-SC in FP plans
Madagascar	🟢 Public: **facility**, **community** Private: **facility**, pharmacy; **SMOs**	🟢	🟢 CHWs can administer and initiate SI	🔴 Pharmacists can neither administer nor initiate SI	🟢 Informal guidance	Approval for pharmacies to administer and initiate SI
Malawi	🟢 Public: **facility**, **community** Private: **facility**, pharmacy; **SMOs**	🟢	🟢 HSAs can admin & initiate; CBDAs (volunteers) cannot	🔴 Policy for pharm/DS to administer in process, but cannot initiate SI	🟢 Includes SI	Approval of OTC status
Mali	🟢 Public: **facility**, **community** Private: **facility**, **comm**, drug shop, **pharmacy**; **SMOs**	🟢	🟢 CHWs can administer and initiate SI	🔴 Some pharm admin informally, but no authorization to admin/initiate SI	🔴	Reinforce CHWs approval to initiate SI through other guidelines; COVID integration
Mauritania	🟢 Public: **facility**, **community** Private: **facility**, **community**; **SMOs**	🟡	🔴 Policy to admin in process, but cannot initiate SI	🔴 Policy for pharm to administer in process, but cannot initiate SI	🔴	Approval of SI; integration of SI in COVID-19 guidelines
Mozambique	🟢 Public: **facility**, **community** Private: **facility**, **community**; **SMOs**	🔴	*Information not available*	*Information not available*	*Info not available*	*Information not available*
Myanmar	🟢 Public: **facility**, **community** Private: **community**; **SMOs**	🔴	🔴 CHWs can administer, but not initiate SI	🔴 Pharm/DS can neither administer nor initiate SI	🔴	Accelerate acceptability studies, required by MOH before SI is approved
Niger	🟢 Public: **facility**, **community** Private: drug shop, pharmacy; **SMOs**	🟡	🔴 CHWs can administer, but not initiate SI	🟡 Policy for pharm/DS to administer and initiate SI in process	🟢 Includes SI	Approval of SI; approval for CHWs to administer and initiate SI

DMPA-SC and SI **policies and plans**: SI policies are strong; private-sector SI policies need attention

Key: Yes 🟢 No 🔴 In process 🟡

Country	Total market approach planned (**bold** = DMPA-SC is actively offered)	SI policy	CHWs authorized to initiate SI	Pharmacies/drug shops authorized to initiate SI	SI in COVID plans	Examples of current SI advocacy opportunities
Nigeria	🟢 Public: **facility, community** Private: **facility, comm, drug shop, pharmacy; SMOs**	🟢	🟢 CHWs can administer and initiate SI	🟢 Pharm can admin & initiate; DS can refill prescriptions but not initiate SI	🟡 Includes SI in draft	Private sector engagement strategy; development of national self-care guidelines
Senegal	🟢 Public: **facility, community** Private: **facility, pharmacy; SMOs**	🟢	🟢 CHWs can administer and initiate SI	🔴 Pharmacists can neither administer nor initiate SI	🔴 Includes FP	Development of national self-care guidelines
Togo	🟢 Public: **facility, community** Private: **facility,** pharmacy; SMOs	🟢	🔴 CHWs can administer, but not initiate SI	🔴 Pharmacists can neither administer nor initiate SI	🔴	Approval for CHWs to initiate SI; integration of SI in COVID-19 guidelines
Uganda	🟢 Public: **facility, community** Private: **facility, comm, drug shop, pharmacy; SMOs**	🟢	🟢 CHWs can administer and initiate SI	🟡 Policy for pharm/DS to administer and initiate SI in process	🟢 Includes SI	Approval for Pharm/DSs to administer and initiate SI; CIP updates; self-care guidelines
Zambia	🟢 Public: **facility, community** Private: facility, pharmacy; SMOs	🟢	🔴 CHWs can administer, but not initiate SI	🟢 Pharmacists can administer and initiate SI	🔴 Includes FP	Dissemination and implementation new pharm policy; advancing self-care

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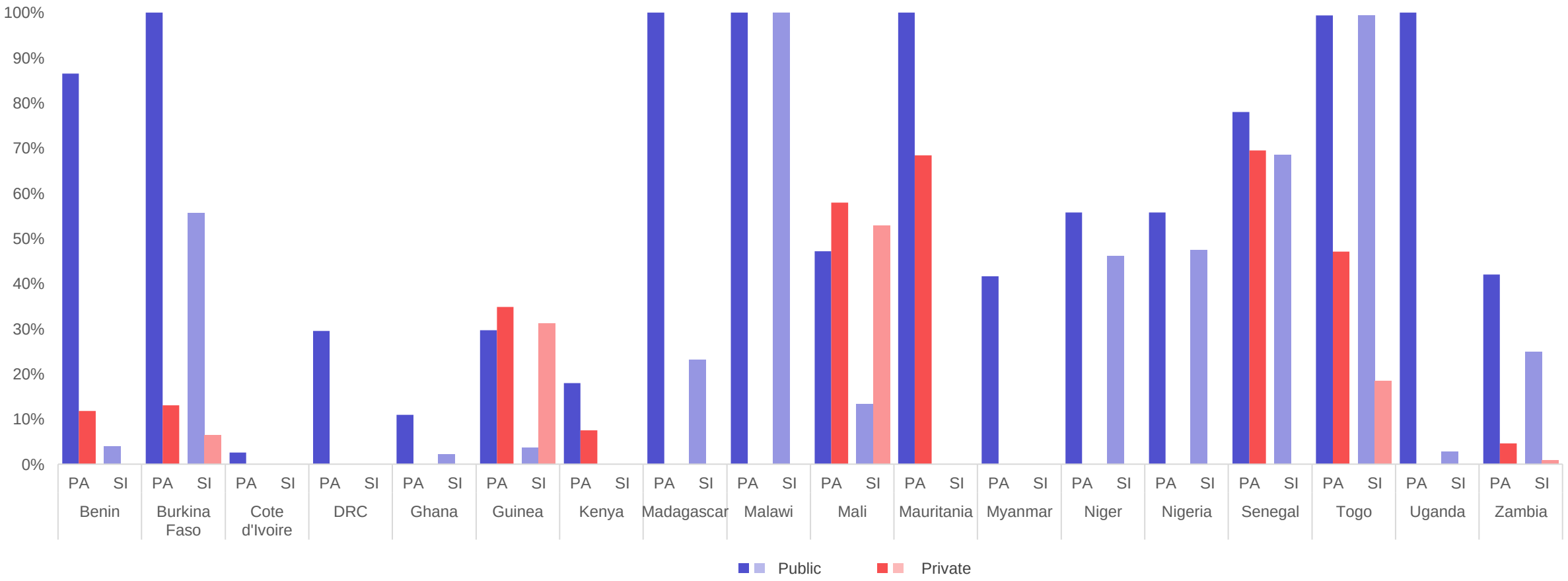
DMPA-SC in private sector **service delivery channels**

Significant progress to date opening new private sector channels for DMPA-SC and SI, but more needed.

Public-sector **service delivery points** offering DMPA-SC injections; progress needed on self-injection, and in private sector



*Data through December 2020; data from the private sector may be incomplete

1 DMPA-SC and Self-Injection Background

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3 Moving forward: promising approaches and lessons learned

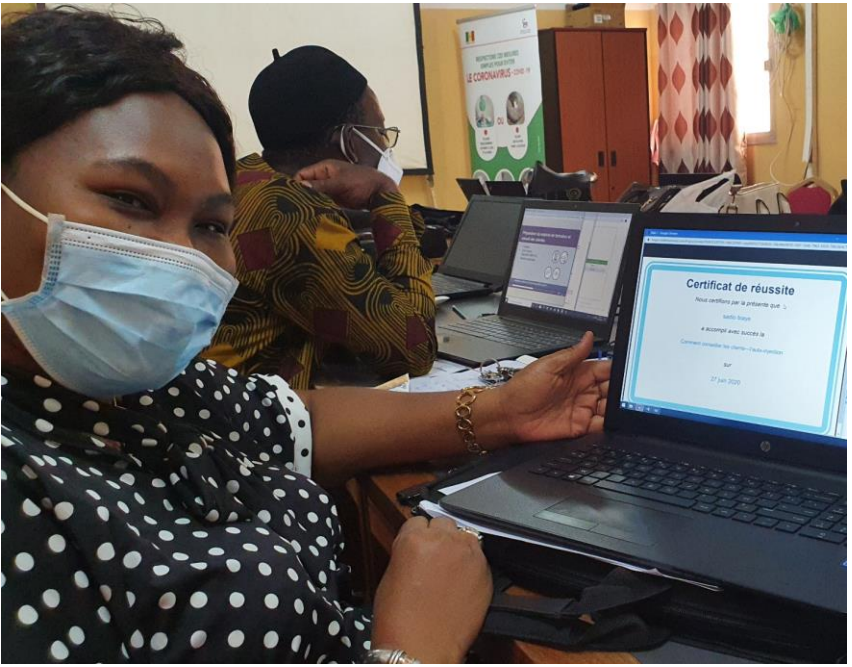
High-potential, innovative DMPA-SC distribution models in pilot stages in the FP space

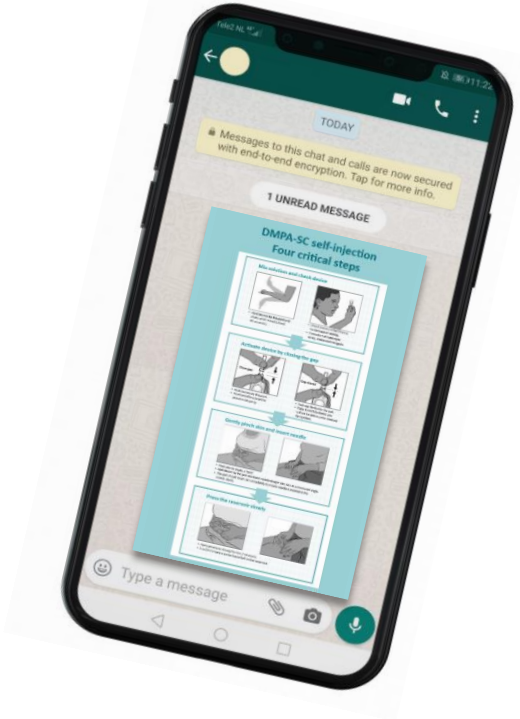
	 Hair salons counselling, distribution and referral	 Online pharmacies with telemedicine prescriptions	 Fixed point community-based distribution
Model	Jhpiego piloted distribution in hair salons in urban areas in Guinea under supervision of local NGOs. **Apprentices provided counselling and distributed pills, condoms, cycle beads and provided referrals to health facilities for implants, IUDs and DMPA-SC.**	Women in Kenya and Rwanda can **order FP products (OCs, EC, condoms, patch, implants, IUDs) confidentially online, by phone, or via a Kasha agent**, and have the product delivered to their home or a local pickup point via delivery agents. OCs and patch required prescription, IUDs and implants required referral to provider; rolling out DMPA-SC.	PSI piloted CHWs selling OCs door-to-door in Mozambique. Learned that providers did not want to walk door to door due to heat and women wanted privacy. Changed model to have **women seeking methods to come to CHWs' homes** instead by putting a sign in front of the provider's house.
Key Learnings	• Hair salons can reach new users as new clients visit daily • Pilot observed frequent stockouts due to lack of incentives and motivation for hair salons to refill products • Required supervision; in order to be sustainable, requires formal linkage to health system which was a key challenge as MoH does not see this as a viable channel and has concerns with quality of counselling • May be better suited as a demand generation model	• Work with on-ground partners that can connect customers to providers for counselling, prescriptions through telemedicine, referrals for LARCs • Implementation challenges include: increased scrutiny of online platforms' compliance with OTC sales due to visibility compared with physical pharmacies, lack of guidance from MoH around online pharmacies (Lack of guidance in Kenya; Rwanda is developing guidelines in response to more pharmacies moving online due to COVID-19)	• Decongested public sector health facilities • Women were counselled and initiated onto FP methods by nurses and refilled products at CHWs' homes in their neighbourhoods • Pilot also had some CHWs administer OCs and injectables out of homes but insufficient mandate to continue • Side effect of women going to CHWs instead of nurses was lack of counselling and therefore cannibalization of longer-term methods

Source: Clinton Health Access Initiative

Innovations in self-guided learning

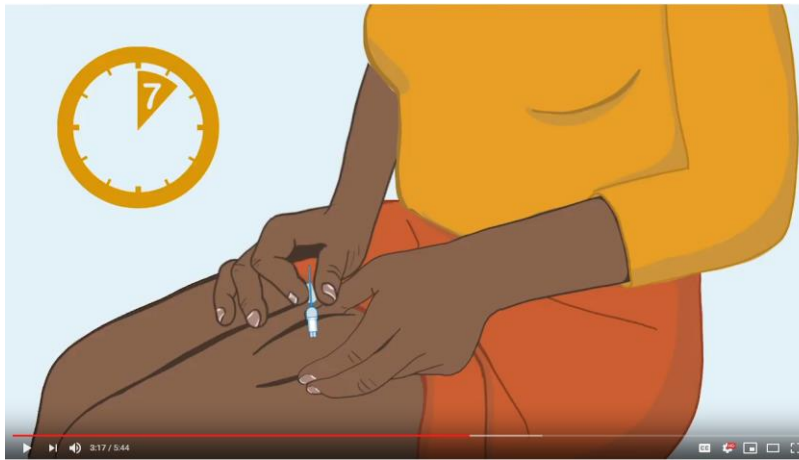
Self-care interventions also prompt the expansion of options for self-guided learning/training, for both providers and clients.






SI group training in Uganda

SI instructional video



Insights and next steps from piloting self-injection in the private sector in Uganda, 2019

- Most providers find it **feasible and acceptable** to offer self-injection services in the private sector.
- **Training** in the private sector looks slightly different than the public sector. In the private sector, most women were trained one-on-one and fewer women practiced injections, watched a demonstration, or used a job aid.
- **Uptake** of self-injection was fairly low, with most women receiving their injection from the provider; **those who self-injected had good competency**.
- **Obstacles** for self-injection in the private sector include the up-front cost of multiple units; fear of needles and self-injection; and a desire for more training.
- Uganda MOH and the DMPA-SC scale-up task force are **updating plans for self-injection scale-up**; these findings are being integrated in that process, along with drug shop/pharmacy initiatives.


Photo: PATH/Will Boase

The potential of self-injection and self-care for women

“I don't need to travel long distance. It is easy, safe, and gives me the freedom to manage it myself.”

-Self-injection research participant, Uganda

PATH/Dave Simpson

For more information contact:

Caitlin Corneliess

ccorneliess@path.org

Website

www.path.org/dmpa-sc

DMPA-SC Resource Library:
https://fpoptions.org/

Making family planning available through innovative approaches:

Community-based distribution for self-injection in Uganda

Fred Mubiru, Technical Advisor
Research for Scalable Solutions (R4S) Project, FHI 360

fhi360
THE SCIENCE OF IMPROVING LIVES

Drug Shops Provision of Family Planning

*"*Private pharmacies and drug shops constitute a major source of modern family planning services and products in low- and middle-income countries*."*

– Riley et al., 2017

Ugandan Context

Evidence shows that with training and support, pharmacy and drug shop staff can facilitate the use of modern contraception

Photo Credit: Nana Kofi Acquah

Implementation Challenge: Supply Chain

Implementation Challenge: Training Costs

District-based trainings using local family planning trainers reduced costs by nearly 50% compared to regional trainings

Implementation Challenge: Lack of Trust

Programmatic Modifications to Facilitate DDD

- Integrate drug shops into health systems
- Standardized stakeholder involvement through scale up
- DSOs teach women to self-injection
- Innovative supervision models for DSOs
- Secure supply chain

Key Research Questions

- What kinds of supportive supervision work best to improve knowledge and skills to provide family planning methods and counseling?
- What are the best ways to facilitate effective referrals?
- What is the best engagement approach for collaborating with drug shops to improve family planning access?

Thank you!

Q&A

Upcoming Session

"Nothing for us without us" the experience of people living with HIV: Creating demand and optimizing DDD

Thursday, March 11, 2021

7:00 AM-8:30 AM EST | 13:00-14:30 CAT | 14:00-15:30 EAT

Register here