Differentiated Care to Simplify HIV Services and Reduce Unnecessary Loss-To-Follow-Up

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Differentiated Service Delivery (DSD)

“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” [1]

1. IAS, https://www.iasociety.org/Differentiated-Service-Delivery
Guiding Principles

• Patient-centeredness
  – Delivery of different care packages based on patient’s needs, preferences and expectations

• Health systems efficiency
Rational of DSD in Zambia

Current Situation

- 22% of patients are lost to follow-up
- Patients must travel long distances to access care and may lose an entire day of productivity
- Human resources are limited and clinics are over-burdened with patient numbers

Source: BetterInfo Study, CIDRZ
Findings:

- Substantial inefficiencies for both patients and HCWs

- Workloads heavily concentrated in the first few hours of clinic opening, limiting HCW and patient interaction time

- DSD may help to redistribute workloads more evenly and prevent patients queuing for hours before clinic opening
‘BENEFITS’ OF DSD

- Improve:
  - Access
  - Adherence
  - Retention in care
- Reduce costs and burdens on health systems
- Care more patient-centered
- Increase sustainability
- Maximize impact
- Reduce morbidity/mortality

What are the benefits of differentiated service delivery?
DSD Model Categories

- **Client-managed groups** (known as community adherence groups or CAGs)
- **Healthcare worker-managed groups** (known as adherence clubs)
- **Facility-based individual models** (known as the six-monthly appointment or SMA programme)
- **Out-of-facility individual models** (known as points de distribution communautaires or PODIs)
Gaps in knowledge

• Which DSD elements do patients prefer?
• How do preferences vary?
• What model should we choose for which setting?
• Asked patients to choose from different combinations of DSD attributes and attribute levels

• Conclusions:
  – Overall preferences vary
    • Reducing frequency of visits most valued
  – Urban participants
    • Want to receive ART at the Clinic
  – Rural participants
    • Want to receive ART in the community

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Better Retention on DSD (CommART)

Assessed 3 DSD Model Effectiveness in cRCT;
Cumulative incidence of first late drug pickup at 12 months, 28 days late

UAG Model

Control: 0.46 (95% CI: 0.41 – 0.50)
Intervention: 0.20 (95% CI: 0.17 - 0.24)

CAG Model

Control: 0.38 (95% CI: 0.34 - 0.42)
Intervention: 0.10 (95% CI: 0.07 - 0.12)

Log-rank test: p < 0.0001
Better Retention on DSD (CommART), Cont’d

FT Model

- Significant benefit in intervention at 180 and 365 days of follow-up time
Evidence Limitations

• Beyond stable adults: impact for key and vulnerable populations
• What services to integrate in DSD?
• Very few RCTs to support evidence
• There is little evidence on scale-up
• Retention past 24 months
• The effect on the health system not well documented
• Viral suppression
• Cost effectiveness of DSD not known
Future directions for DSD

• Cost – to the health system and clients/families
• DSD from prevention to viral suppression
• Client choice, satisfaction and quality
• Integration of co-interventions within HIV DSD to care for co-morbidities and co-infections
• Strengthening of health information systems to track patients between service delivery points to monitor, evaluate and report HIV care as a continuum instead of a silo approach
Conclusion

• Minimizing the burden of frequent appointments improves retention – a lesson that may have broad implications for innovative health services outside of HIV as well as within HIV.
  – **Business cannot continue as usual!**

• The choice of effective DSD options will depend on the context and clinic population
Thank You

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http://www.cidrz.org/toolkits/commart-toolkit/