20th International Conference on HIV TREATMENT AND PREVENTION ADHERENCE

"The patient gets better and doesn't go": Healthcare providers perspectives on integrating care for HIV and non-communicable diseases in the Dominican Republic

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Background

Epidemiologic transition

Theory outlining shift from acute, infectious to noncommunicable chronic diseases (NCD)[1]

Dual burden

In practice, there is a *simultaneous* burden of HIV and NCD[2,3]

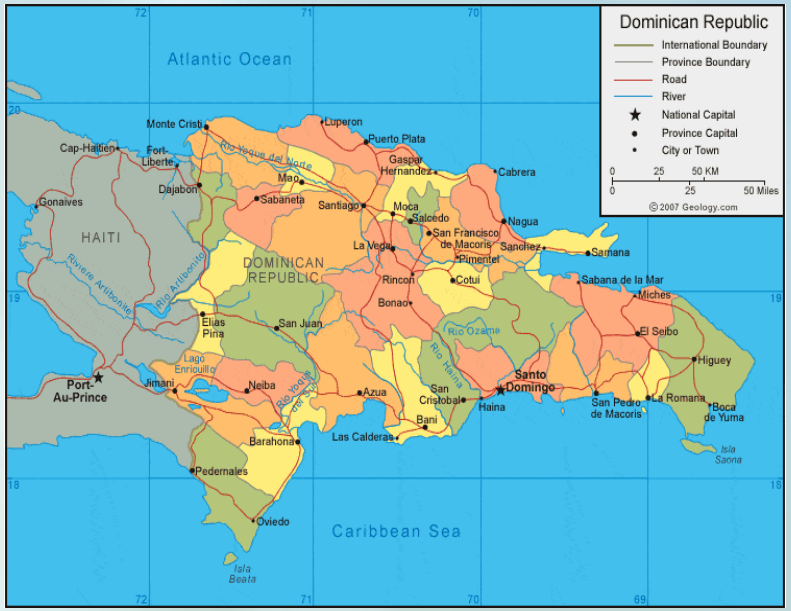
Health systems

Few models of integrated care in concentrated HIV epidemics

[1] Omran 1971; [2] Agyei-Mensah et al 2010; [3] McKeown 2009

Study Setting: Dominican Republic

- Population ~11 million
- Dual burden health profile
  - Concentrated HIV epidemic [1]
    - Adult prevalence: 1.0%
    - Female sex workers: 4.7%
  - 72% of adult deaths attributed to NCD[2]
- Decentralized HIV care system
  - *"Servicios de atención integral"* (SAI)
  - ~40 SAI clinics in Santo Domingo (~75 nationally)
  - Government and NGO



[1] UNAIDS: https://www.unaids.org/en/regionscountries/countries/dominicanrepublic; [2] WB: https://data.worldbank.org/indicator/SH.DTH.NCOM.ZS?locations=DO

Parent study

Understanding burden and lived experience of diabetes and hypertension among women living with HIV in the Dominican Republic to improve care integration (R21TW012363)

Aim 1

- Describe type 2 diabetes (T2D) and hypertension (HTN) prevalence among FSW with HIV.
- Survey and screening for T2D and HTN (n=200)

Aim 2

- Explore the lived experience of multiple chronic conditions among FSW with HIV and T2D/HTN.
- Qualitative in-depth interviews (n=25)

Aim 3

- Identify provider perspectives on integration of care for HIV and T2D/HTN.
- Key informant interviews (n=24)

Design and methods (Aim 3)

Sample

- Purposive sampling of HIV care providers from gov't and NGO SAIs and central level
- Thematic saturation

Data collection

- Semi-structured guide in Spanish
  - Experiences
  - Perspectives
  - Recommendations
- Audio-recorded
- Transcribed verbatim

Analysis

- Analyzed in Spanish
- Narrative summaries
- Thematic coding using Dedoose
- Memos and matrices

Description of sample (n=24)

Participant age:

46 years (range 32-67)

Type of provider:

Physician:	17
Psychologist:	7

Role in Facility:

Director:	7
Coordinator:	7
Provider:	10

Results

Perceived burden of HIV and NCD → Current care landscape → Perspectives on integration

Dual burden

- Increasing dual burden of HIV and NCD
  - "the norm"
- Managing multiple conditions is a challenge for patients and providers
- Limited capacity and research

Now HIV patients don't die (from HIV). Now they have different conditions including diabetes, hypertension…. This is what we are seeing every day. We are entering the era of aging with HIV, but no one is talking about it. (40, psychologist)

Current care landscape

- NCDs among FSW with HIV are frequently diagnosed in the SAI
- FSW patients prefer to receive all healthcare at the SAI
- Patients speak more openly about missing doses of NCD meds than ART

…remember, the HIV patient is a patient who sometimes self-stigmatizes…and they don't want to go to other sub-specialties. We tell them, "Look, we can manage part of this. If you are hypertensive, we can care for you at the beginning and you can then go to your specialist.", such as a cardiologist. But, the patient gets better and doesn't go. (55, ID physician)

Barriers to referrals

- Intersectional stigma related to HIV, sex work, race, ethnicity, poverty

…intentionally or not, health professionals included, end up stigmatizing, rejecting, discriminating patients with HIV…. (33, ID physician)

If a woman is a sex worker who is used to exposing her body and this is the only clothing she has, how are you going to say that she can't go to a health facility in a short skirt? ….She will not go. So, there are many forms of discrimination in our services. (67, psychologist)

Barriers to referrals

- Cost
- Lack of health insurance
- Lack of information and support for patients
- Gaps in coordination and communications between providers

The patients don't have insurance. You refer them to a place, and they come back and tell you, "Doctor, I went but the consult was $50, I didn't have that kind of money, so I am going to see if I can go next month". Or, there are some who have insurance but they tell you they went to the endocrinologist or diabetes specialist consult and the insurance doesn't cover it. And they end up going two, three, even fourth months without any follow-up and the patient keeps getting worse.
(32, general physician)

Perspectives on integration

- Health system is siloed and has weak primary care and congested secondary and tertiary care that is not patient friendly

The problem is, look, HIV has been individualized, it has not been integrated. We talk a lot about integration but we struggle to actually integrate. Our health system is not an integrated system. …I mean, we still have a major deficiency in our primary care system and when the HIV care system was established, it was made outside of the system. So, here we are, 20 and some odd years later and bringing HIV into the system creates challenges. (55, ID physician)

Perspectives on integration: two models of care

Treat HIV in primary care

Strengthen NCD capacity in HIV clinics

Treat HIV in primary care

- Small pilot effort underway with stable HIV patients
- Low uptake but positive results
  - Lack of confidence in primary care system and providers who are not “specialists”
- Still requires strengthening referrals to specialists

…those who have accepted the option have felt really good because the doctor is not exclusively focused on HIV. It is the facility doctor who provides HIV care, but it is not a doctor exclusively focused on patients with HIV. This doctor also cares for all patients who go to the primary care clinic and this is the advantage with the issue of stigma. (National Health Services division)

Strengthen NCD capacity in HIV clinics

- Some HIV providers already provide care for NCD in the SAI
- Limited capacity among HIV providers to provide care for NCD
- Still requires strengthening referrals to specialists

What integration are we going to see if we continue to manage these processes separately?...You know about HIV, but you don't know about anything else. (67, psychologist)

Conclusions

- FSW with HIV face multilevel barriers to holistic healthcare
- HIV providers recognize the need, but lack training and a functional referral system
- Intersectional stigma is a cross-cutting barrier to integration and referrals
- Need to balance patient preferences with provider and health system capacity to determine the most effective response
- Multilevel challenges to integration require multilevel interventions

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Current care practices

ATTEND	REFER
• *….our patients have HIV, but we also see a lot of patients with diseases like diabetes and hypertension. Here, we also provide support, we give them their medications, and we make sure that they don't only take their anti-retrovirales but also that they attend to the (other) conditions." (DHIC016: 40, medico proveedor)*	• *The doctor who works in the HIV clinic usually just learns how to manage HIV and the other co-morbidities you handle based on your prior experience and what you are able to learn….Even though the HIV care guide tells you that you have to do routine analyses, I have seen that what a lot of HIV clinics do is refer. (KI 8)*

Adherence

- HIV medication is provided for free
- Physical symptoms of not taking meds can aid with NCD treatment adherence BUT there is more support for ART adherence.

It is not the same to be adherent to one medication as it is to be adherence to three medications. And your health is more complex, more compromised. (64, psychologist)