The CQUIN Learning Network

Differentiated Service Delivery for Urban Populations

May 2, 2018

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery
CQUIN: Focusing on the “How” of Differentiated Service Delivery

**THE CQUIN FRAMEWORK**

| Demonstration of successful differentiated service delivery models | Increased demand from ministries of health, implementers, and communities | Increased coverage and quality of differentiated HIV services, leading to enhanced health outcomes and programmatic efficiencies |
| Implementation support: training, technical assistance, and quality improvement support | Increased supply of high-quality differentiated care services for HIV | |
| Implementation science | Increased knowledge base | |
Exchange of Best Practices and Lessons Learned

WEBSITE, WEBINARS, JOURNAL CLUB

cquin.icap.columbia.edu

SOUTH-TO-SOUTH EXCHANGE

The CQUIN learning network fosters south-to-south learning — meetings, discussions, and resource-sharing — between network countries. The goal is to encourage an exchange of best practices for the scale-up and spread of DSD:

- Mozambique to Swaziland
- Swaziland to Malawi
- Mozambique to Malawi
- Swaziland to Kenya
- Zimbabwe to Swaziland (2x)
- South Africa to Kenya
- Malawi to South Africa
- Zimbabwe to South Africa
- Kenya to Mozambique

VIRTUAL COMMUNITIES OF PRACTICE

In June 2017, Swaziland’s Ministry of Health observed that Malawi had successfully integrated ART refills and viral load monitoring into their teen clubs.
Today’s Case Studies

- Zambia: Urban Adherence Clubs
- South Africa: Shipping Container Solutions
- Malawi: Drop in Centers
Urban DSD
Urban Differentiated Service Delivery

Michael Odo, MBBCH, MSc, MPH, is the technical advisor for HIV care and treatment for the Department of HIV/AIDS, at the Malawi Ministry of Health. Dr. Odo will present on Drop-in Centers for female sex workers in urban Malawi.

Phil Roberts, MBA, is the CCMDD project lead at Last Mile in South Africa. Mr. Roberts will present on the shipping container solution for chronic medicine pick up points in urban South Africa.

Mpande Mukumbwa-Mwenechanya, BPharm, MClinPharm, is the manager for the community ART for retention study at the Centre For Infectious Diseases Research in Zambia (CIDRZ). Ms. Mpande will present the CIDRZ urban adherence group (UAG) model.
The CQUIN Learning Network
Differentiated Service Delivery for Urban Populations
A CQUIN Webinar

Key Population Services through Drop in Centres (DICs) in Malawi

Michael Odo; Rose Nyirenda
Ministry of Health, Lilongwe, Malawi

May 2, 2018
HIV Prevalence: Malawi

- Adults 15+: 9.7%
- Adults 15+ not yet diagnosed: 2.4%
- Children: 0.9%
- Children not yet diagnosed: 0.3%

62.7% among FSWs (2014)
17.3% among MSMs and
27% among Prisoners
Geographical Scope: Six Districts

Mzuzu
Lilongwe
Mangochi
Machinga [DREAMS]
Zomba [DREAMS]
Blantyre

“Creation of and/or scale-up safe spaces/drop in centres....”
- NSP 2015-2020
Framework for LINKAGES Cascade of services and stakeholder coordination

- Framework for LINKAGES
- Cascade of HIV Prevention, Care, and Treatment Services for Key Populations

**Enabling Environment**

- Human rights
- Gender equality
- Zero tolerance for stigma, discrimination, and violence

**Advocacy**

- Identify key populations
- Reach key populations
- HIV- HIV+
- Key populations know status
- Ongoing engagement with all KPs on prevention, including access to condoms, lubricants, needles/syringes, and psychosocial support. Regular STI screening and treatment, HTC, and PrEP for HIV negative KPs.

**Care and Treatment as Prevention**

- Enroll in care
- Initiate ART
- Sustain on ART
- Early access and adherence to ART for HIV-positive KPs in support of treatment as prevention, and regular STI screening and treatment.

**Community engagement and capacity development**

- PLACE study
- Outreach teams

**Malawi Police Service**

- CHREA
- Other legal and advocacy partners

**Central hospitals**

- DREAM Lab
- Lighthouse

**District Health Offices (DHO)**

- Private clinics
- Baylor Children’s Foundation

**Pakachere IHDC ● YONECO ● CEDEP**

**Ministry of Health ● National AIDS Commission ● DHA**
Service Delivery Modalities for KPs

- **Drop-in Centers (DICs):** combination of services and safe space for KPs
- **Outreach Clinics**
- **Hybrid:** facilities where service provision largely depend on other stakeholders (public and private health facilities)
- **Static:** LINKAGES-supported clinics which provide services to KPs
<table>
<thead>
<tr>
<th>Package of Services</th>
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</thead>
<tbody>
<tr>
<td><strong>All Key Populations Clients of FSW</strong></td>
</tr>
<tr>
<td>• Prevention messages</td>
</tr>
<tr>
<td>• Condoms and lubricant</td>
</tr>
<tr>
<td>• HIV testing</td>
</tr>
<tr>
<td>• STI screening</td>
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<tr>
<td>• TB screening</td>
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<tr>
<td>• Reduction of stigma and discrimination</td>
</tr>
<tr>
<td>• GBV screening</td>
</tr>
<tr>
<td>• Violence/crisis response team</td>
</tr>
<tr>
<td>• Psychosocial counseling</td>
</tr>
<tr>
<td>• Clinical, legal, and psychosocial referrals</td>
</tr>
<tr>
<td>• Data collection, collation and use</td>
</tr>
<tr>
<td><strong>FSW only</strong></td>
</tr>
<tr>
<td>• Family planning services</td>
</tr>
<tr>
<td>• PMTCT</td>
</tr>
<tr>
<td><strong>HIV Positive KP</strong></td>
</tr>
<tr>
<td>• Links to ART</td>
</tr>
<tr>
<td>• Links to VL testing</td>
</tr>
<tr>
<td>• Formation and functionality of KPLHIV support groups</td>
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</tbody>
</table>
Clinical Arm and Leadership of DIC

- Clinician/Nurse (who serves as DIC Manager and in charge of catchment area of a group of hotspots)
- The DIC manager reports to District Coordinator
- HTS counselor
- Receptionist
Community arm of the DIC

- Peer educators (PE). Operate from hotspots, typical ratio, 1 PE to 40 peers. Responsible for sensitization on comprehensive package for HIV prevention care and treatment including provision of condoms, lubes, TB screening, referral for STI screening.

- Peer navigators (PN). Also operate from individual hotspots. Primarily responsible for supporting with treatment adherence and retention alongside secondary preventive package of services.
Cumulative FSW HIV Cascade – Unique FSW
Challenges and Successes

- KPs’ accessibility to health services
- High level of stigma and community harassment of KPs
- High risk behavior among KPs
- Erratic availability of HIV test kits, commodities and STI drugs

- Capacity of CBOs built
- Peer leadership established
- DICs set up
- DHOs and health facilities support to DICs and clinical outreaches
Acknowledgments
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Shipping Container Solution for Chronic Medicine
Pick up Points in South Africa

Phil Roberts
Project Last Mile

May 2, 2018
Central Chronic Medicine Dispensing & Distribution (CCMDD) Process

CCMDD improves patient access to medicine through central dispensing & distribution of medicines to patient convenient locations.
Front View of Shipping Container Solution
Internal View of Shipping Container Solution
Introduction to Shipping Container Solution for Chronic Medicine Pick up Points

- A private public partnership with a service provider, Project Last Mile (PLM) and National Department of Health (NDoH)
- A gap was identified in areas where there were a high number of Chronic patients registered on the CCMDD program but stuck in PHC facilities
- The proposed solution was placing a shipping container on a trial and validation basis
- These are self-contained semi-mobile units to issue CCMDD Patient Medicine Parcels (PMPs)
- The team will proof test the concept by implementing and monitoring eight pilot units in eThekwini District, KwaZulu-Natal
Shipping Container Features

- Air-conditioning for the temperature control of medication
- Refrigerators for the storage of thermo-labile medication
- Wash basins with running water via a reservoir if no plumbed water available
- Impermeable work surfaces
- Lockable cupboards
- Adequate shelving for systematic storage of medication
- All openings are secured with security gates or burglar guards
- Design of the unit streamlines patient and flow
- The unit is wheelchair friendly
Benefits

• The shipping container solution for chronic medicine pick up points is a turn key, self-sufficient, model easily adapted to urban areas.
• The shipping container solution reduces over head costs, i.e. rent or lease.
• In high burden areas where there is great demand for suitable building spaces the shipping container solution is ideal.
• Any open space can be leveraged.
• It is scalable and relocatable.
• Low initial capital outlay.
• Complies with Good Pharmacy Practice.
• Employs staff from local communities thereby creating jobs in the community.
Process

• Project Last Mile’s CCMDD geo-mapping and data sets provided a baseline for the project
• Based on the data analysis the following were deduced:
  o high burden of disease
  o high volume of CCMDD patients
• Site visits conducted in targeted areas
• Potential sites were listed and an individual pilot site was identified
• Negotiations with stakeholders included the Local Ward Councillor, eThekwini Metro Health Unit and property owner
• All parties were in agreement and eager to embark on this project
• The site was prepared, the pre-fabricated structure was installed and interior fitted
• Assessment of qualifying criteria to be a PuP was conducted and the PuP was contracted by South African National Department of Health
• Health facilities enrolling patients onto the CCMDD programme in the surrounding areas were informed of the availability and location this new PuP
Geographic Location of PHC Facilities

Shipping Container Solution
Growth

Number of Patient Medicine Parcels (PMPs) Issued to Patients

- **Nov-17**: 53
- **Dec-17**: 252
- **Jan-18**: 977
- **Feb-18**: 900
- **Mar-18**: 1784
Thank You

Phil Roberts
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Urban Adherence Groups in Zambia: Findings from model implementation
Mpande-Mukumbwa-Mwenechanya
BPharm, MClinPharm
Centre For Infectious Disease Research In Zambia

May 2, 2018
Overview of Presentation

• Background of the Community ART Study
  – Aims
• UAG Model
  – Emerging Findings
  – Lessons Learnt
  – Recommendations
• Questions
Motivations for Differentiating Care in Zambia

• In 2013/2014, HIV care delivery in Zambia had reached stasis as a decentralized and task-shifted system
  – Practice norm: facility-based, ”one size fits all” approach
  – Increasing numbers in care led to clinic congestion
• Individuals with diverse needs received similar services and encountered substantial health systems barriers
• Continuous retention 2 years after ART initiation suboptimal (58%\(^1\))
• Limited experimentation with community-based delivery and differentiated care models

\(^1\)CIDRZ, unpublished data, Better Info for Health In Zambia study
BMGF-funded CIDRZ Differentiated Care Study: Community ART (March 2015-March 2018)

**Aim 1:** To rapidly assess local preferences for various elements and attributes of differentiated models and create an evaluation toolkit for use in other settings

**GOVERNMENT AND COMMUNITY LEADERS**

- **In-depth interviews**
  - Examine policy environment & attitudes/perceptions of policy makers to differentiated care approaches

**PROGRAMMERS & PROVIDERS**

- **Focus group discussions**
  - Examine beliefs about and needs for differentiated care models among direct users of healthcare system

**ART & PRE-ART PATIENTS & FAMILY**

**Surveys**

- Focus groups discussions
- Discrete choice experiments

- Evaluation of acceptability of & preferences for differentiated care models & assessment of clinical, psychosocial, access needs
Aim 2: Rigorous evaluations of feasibility, effectiveness & cost-effectiveness of four differentiated care models, implemented with attention to scalability within the public sector ART program

CLIENT MANAGED GROUPS
Community Adherence Groups (CAGs)

Stable rural patients rotate ARV pickup and labs in groups of 6
(n= 1,073)

RCT

HEALTH CARE WORKER MANAGED GROUPS
Urban Adherence Groups (UAGs)

Lay counselor distributes ARVs to groups of ~30
(n= 1,097 )

RCT

IN FACILITY MANAGED MODEL
FAST-TRACK

Lay counselor rapid distribution of ARVs at clinics in Lusaka
(n= 408)

Observational

Streamlined /Rapid ART Initiation

Stable, pre-ART patients in urban clinics
(n= 422)

Observational

Primary Outcome
Retention in care

Secondary Outcomes
Virologic suppression, Cost-effectiveness, Implementation outcomes
Eligibility Criteria for Enrolment into DSD model

- HIV-positive adolescents and adults (>14 years old)
- Last 6 month CD4 count > 200
  *if last 6 month CD4 count not available, clinician at facility determined whether patient was stable
- Not acutely ill
- For ART patients, on ART for at least 6 months
What is an Urban Adherence Group (UAG)?

A UAG is a group of 30 stable HIV+ patients from the same community.

Every 2-3 months the members meet at the clinic for adherence, support, a symptom screen, and drug dispensation during after clinic hours.

Every 6 months patients go the clinic for a full clinical visit. However, continue to collect drugs in their UAG.
Acceptability, Appropriateness & Feasibility

• Acceptance high (99%) albeit with continuing concerns about additional human resources needed to support the meetings outside clinic hours

• Model- and audience-specific communication perceived as important for successful implementation.¹

• Anticipated difficulties of involuntary disclosure and stigma due to large group size and off-hours ART provision not reported after implementation.²

• Needs design ‘templates’ accompanied by local-level authority for iterative adaptation for UAGs to remain responsive, effective and sustainable.³

¹Effronson ICASA 2017  ²Mwamba IAS 2018  ³Topp ICASA 2018
UAG valued for social support and convenience

“... This group surely should continue because it is helping us; it is easy for us to collect drugs and encourage one another”

- FGD George Female Participant

“... I can be very happy if [UAG] continue. If it comes to an end and we get back to the old system, it will be a very difficult thing. Like we have already said, the kind of jobs that we are doing, it is difficult to ask for permission. This month you have asked, then the following month you ask again, then in the end they will chase you from employment ... Let it just continue because we don’t ask for permission now. Like today Sunday, we are from church, to come here, from here we will go home. Tomorrow we will be at work.”

- FGD George Female Participant
Preliminary Results on Effectiveness

• Group meetings were generally well-attended and in nearly 1/3 of missed meetings, patients picked ARVs in time using other means\(^1\)

• Twelve month cumulative incidence of >7 days late pharmacy visit was lower in intervention arm (26% vs 58%; 95% CI: 23%-30% vs 54%-62%).

• Further adjusted analyses and mixed effects regression will be conducted for twelve month cumulative incidence of missed pharmacy visits (defined as >7, >14, and >28 days late)
Cumulative incidence of > 7 days late ARV pick-up at 12 months UAG intervention (intention to treat analysis) [Preliminary Data]

Control: 0.58 (95% CI: 0.54 - 0.62)
Intervention: 0.26 (95% CI: 0.23 - 0.30)
Lessons Learnt while Implementing UAGs

Overall:

• Patients miss clinical visit because it is not part of UAG meeting
• Short expiry drugs affected meeting schedule
• Slow transitioning from standard of care to UAG (e.g., missing visit)

Enrolment:

• Weekends more popular than weekday off hours

Meeting logistics:

• Difficulty acquiring meeting space to accommodate group size
• Difficulty acquiring secure drug storage space
• Meetings take longer than planned

Attendance:

• Rains posed a challenge to attendance and thereby drug collection
Recommendations

Patient-centeredness:
• Be flexible regarding meeting day/time and group composition (couples, adolescents, women only)
• Encourage a buddy system among group members
• Set up system for appointment reminders for patients
• Have a nurse or clinician present at UAG meeting
• Integrate dispensation of other chronic care medication

Sensitization and engagement:
• Sensitization of all key stakeholders (especially community)

Human Resources:
• HRH task-shifting
• Investment in staff training and development
• Appropriate staff scheduling or compensation arrangements for staff working over weekends or off-hours

Drug Supply:
• Adequate supply with long expiry

Lab:
• Essential labs are key to patient management

Monitoring and evaluation:
• Create appropriate community and facility tools with staff trained
Thank You