

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

Implementation support: training, technical assistance, and quality improvement support

Implementation science



Increased demand from ministries of health, implementers, and communities

Increased supply of high-quality differentiated care services for HIV

Increased knowledge base

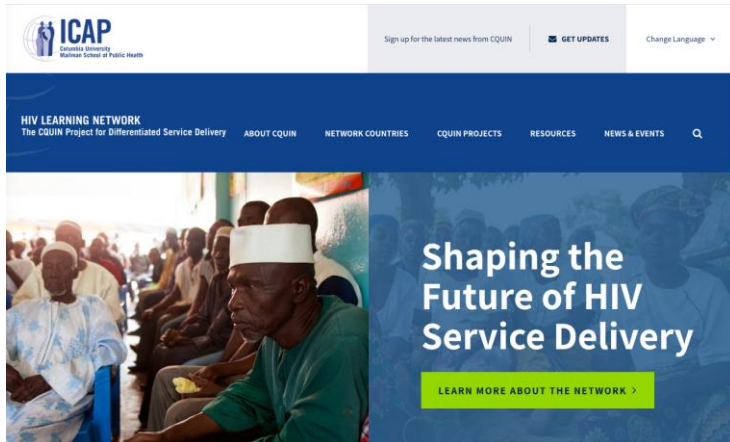


Increased coverage and quality of differentiated HIV services, leading to enhanced health outcomes and programmatic efficiencies

Exchange of Best Practices and Lessons Learned

WEBSITE, WEBINARS, JOURNAL CLUB

cquin.icap.columbia.edu



WORKSHOPS AND MEETINGS



SOUTH-TO-SOUTH EXCHANGE

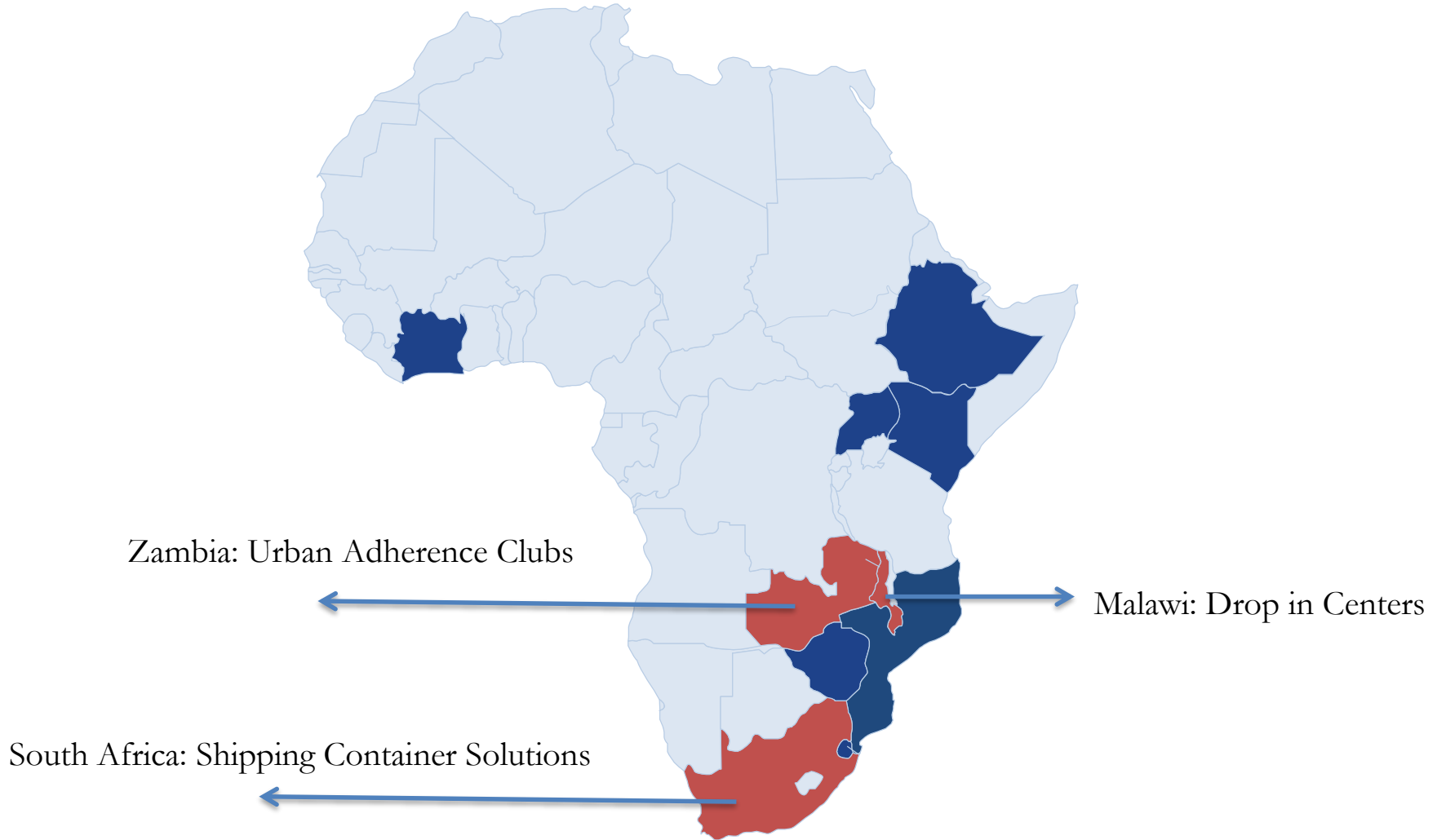
The CQUIN learning network fosters south-to-south learning – meetings, discussions, and resource-sharing – between network countries. The goal is to encourage an exchange of best practices for the scale-up and spread of DSD



VIRTUAL COMMUNITIES OF PRACTICE



Today's Case Studies



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.

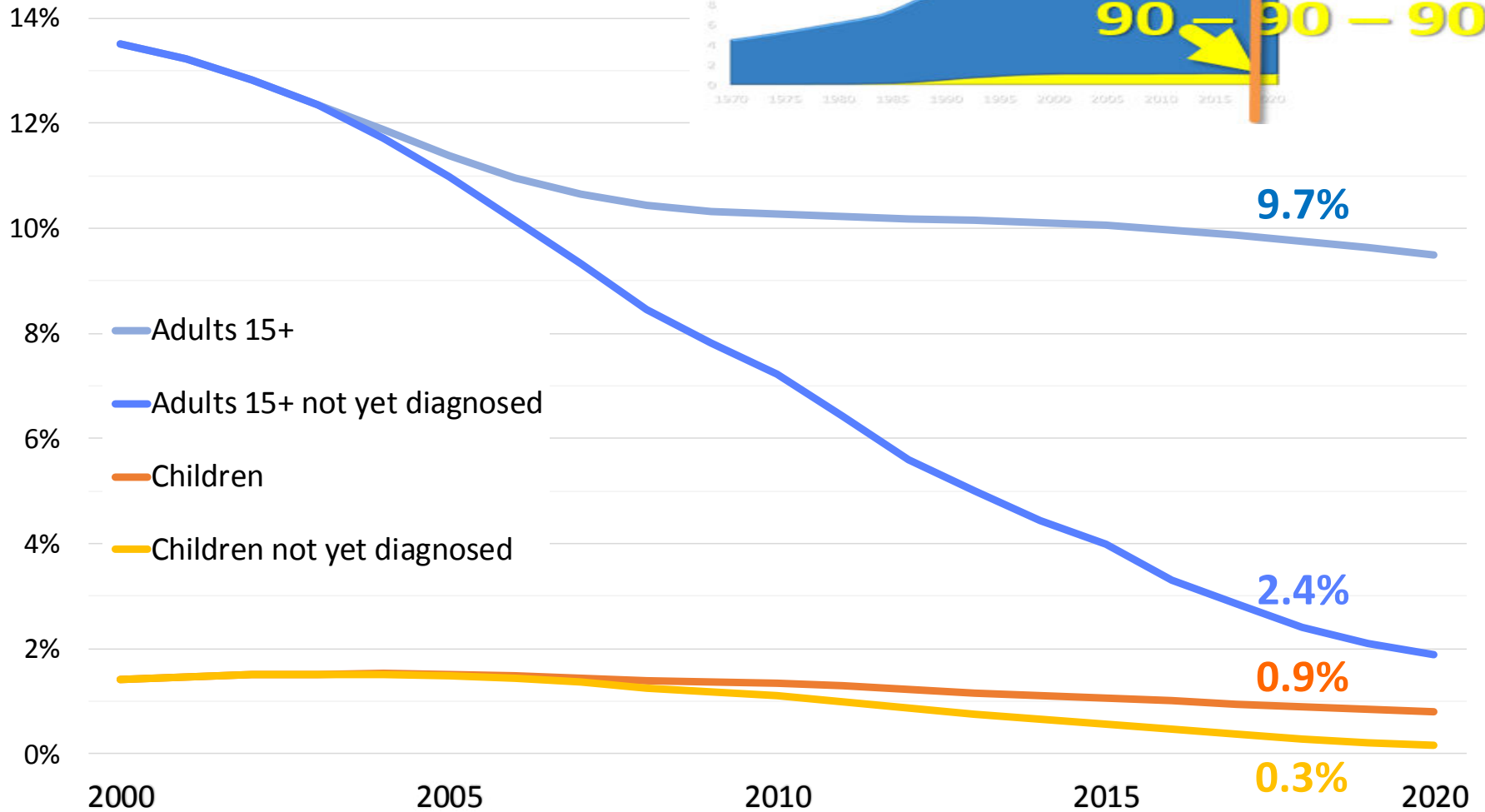
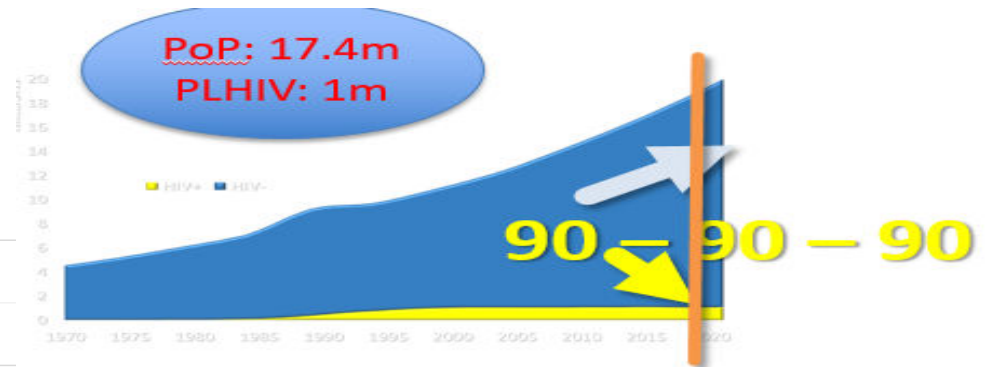


Phil Roberts, MBA, is the CCMDD project lead at Last Mile in South Africa. Mr. Roberts will present on the shipping container solution for chronic medicine pick up points in urban South Africa.



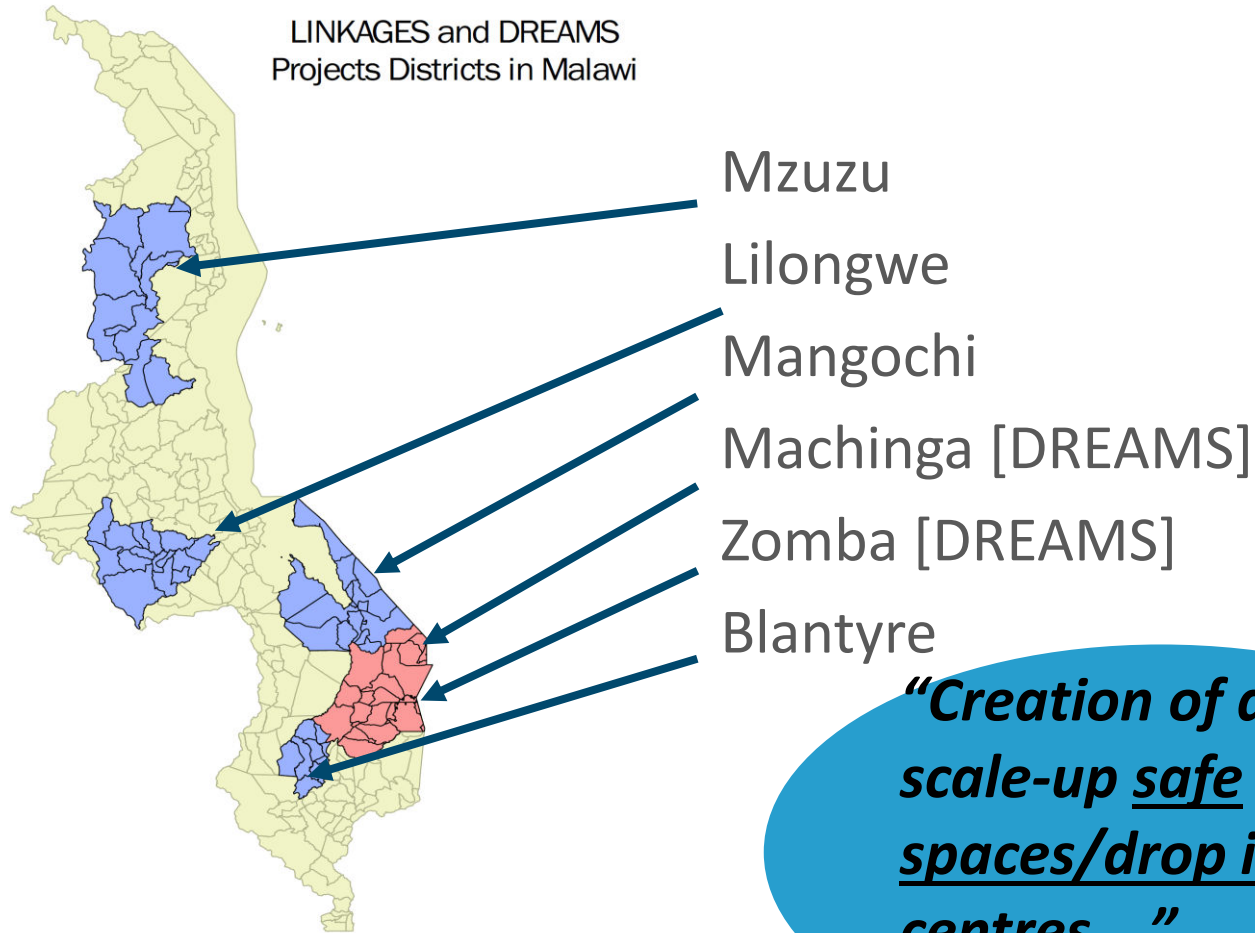
Mpande Mukumbwa-Mwenechanya, BPharm, MClinPharm, is the manager for the community ART for retention study at the Centre For Infectious Diseases Research in Zambia (CIDRZ). Ms. Mpande will present the CIDRZ urban adherence group (UAG) model.

HIV Prevalence: Malawi



62.7% among FSWs (2014)
17.3% among MSMs and
27% among Prisoners

Geographical Scope: Six Districts



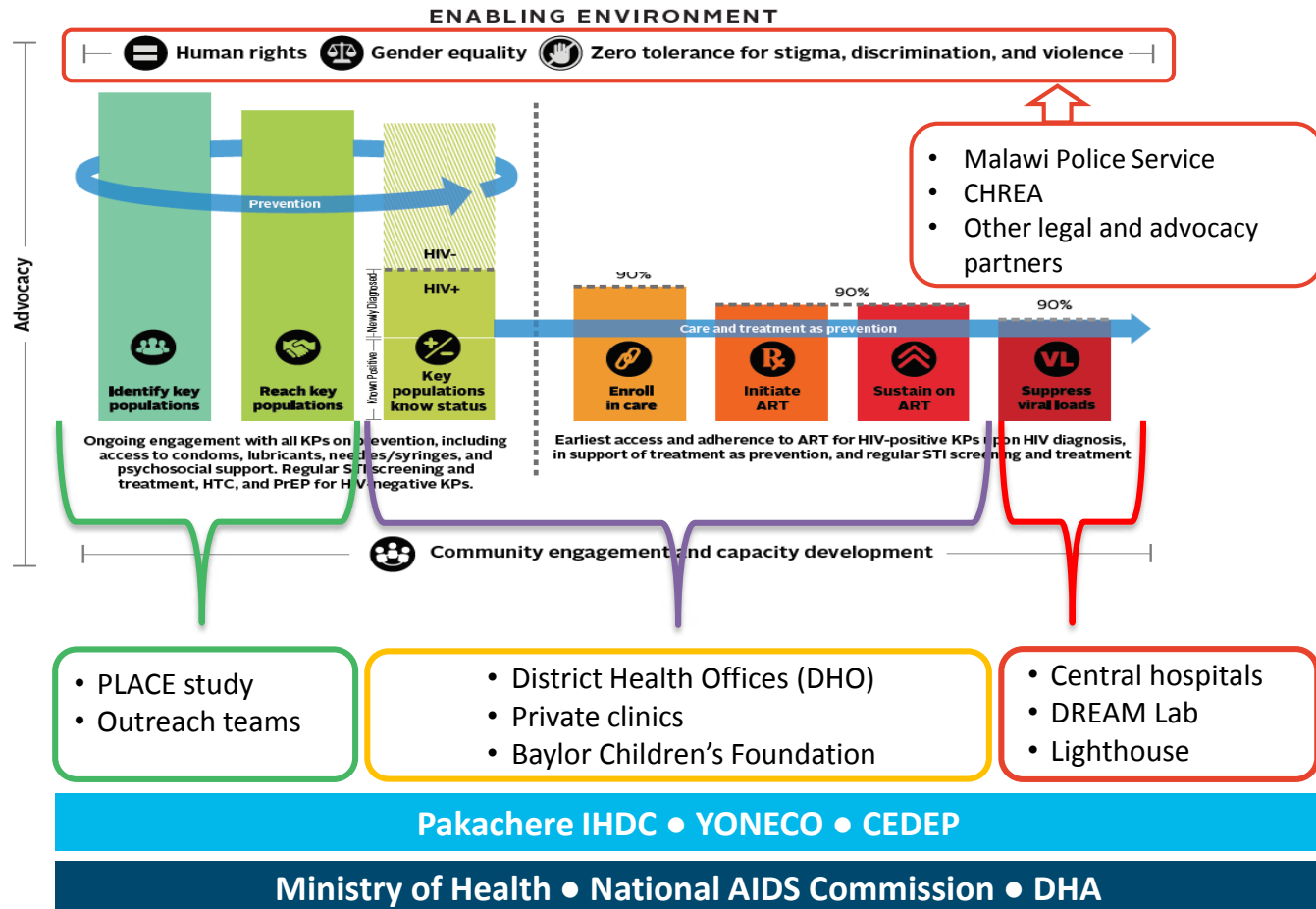
***“Creation of and/or
scale-up safe
spaces/drop in
centres....”***

- NSP 2015-2020

Framework for LINKAGES Cascade of services and stakeholder coordination




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



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



	Package of Services
<p data-bbox="214 137 571 229">All Key Populations Clients of FSW</p> 	<ul data-bbox="703 137 1541 762" style="list-style-type: none"> • Prevention messages • Condoms and lubricant • HIV testing • STI screening • TB screening • Reduction of stigma and discrimination • GBV screening • Violence/crisis response team • Psychosocial counseling • Clinical, legal, and psychosocial referrals • Data collection, collation and use
<p data-bbox="214 903 394 943">FSW only</p>	<ul data-bbox="703 903 1251 1008" style="list-style-type: none"> • Family planning services • PMTCT
<p data-bbox="214 1075 498 1115">HIV Positive KP</p>	<ul data-bbox="703 1075 1682 1243" style="list-style-type: none"> • Links to ART • Links to VL testing • Formation and functionality of KPLHIV support groups

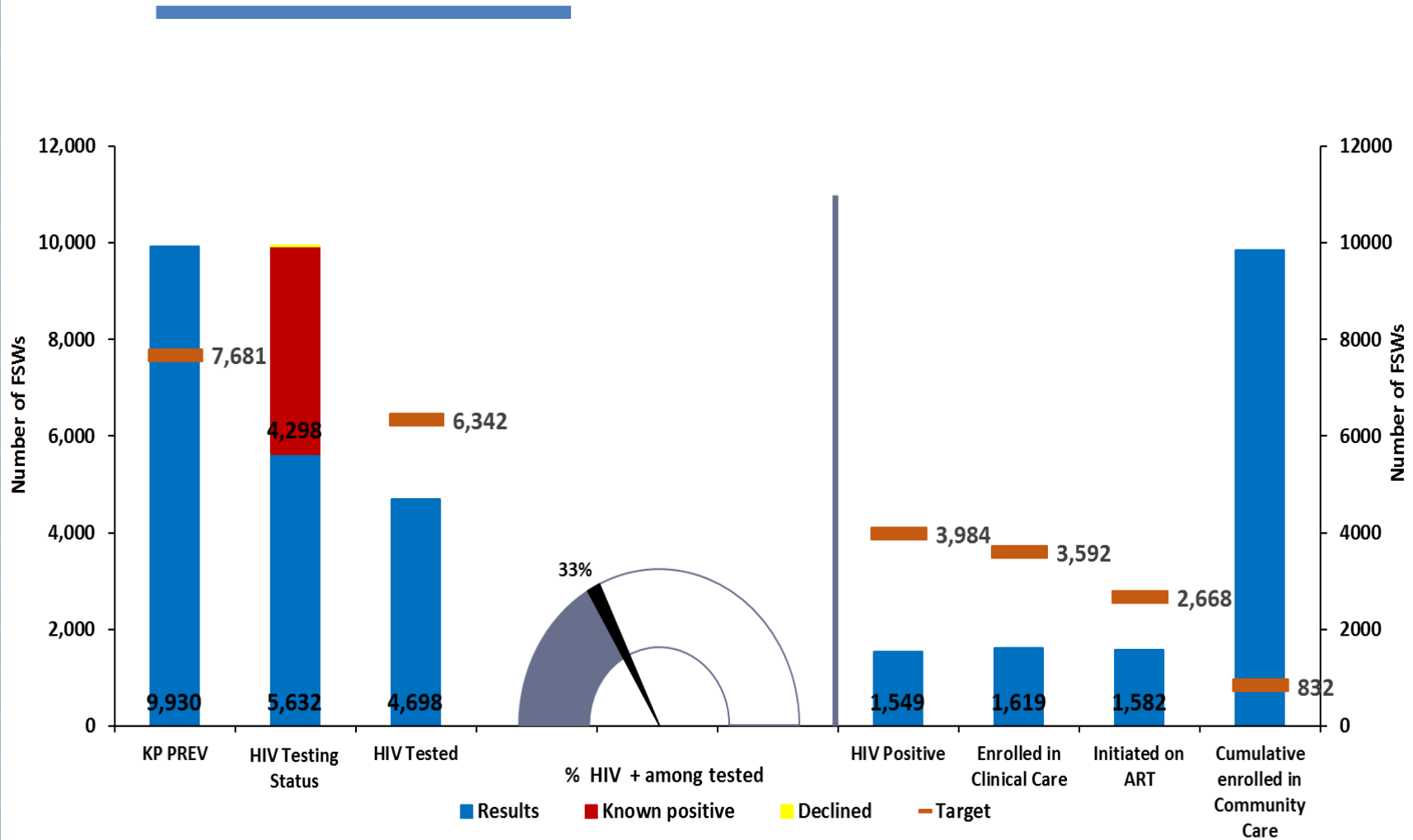
Clinical Arm and Leadership of DIC

- 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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Differentiated Service Delivery for Urban Populations

A CQUIN Webinar

Shipping Container Solution for Chronic Medicine Pick up Points in South Africa

Phil Roberts
Project Last Mile

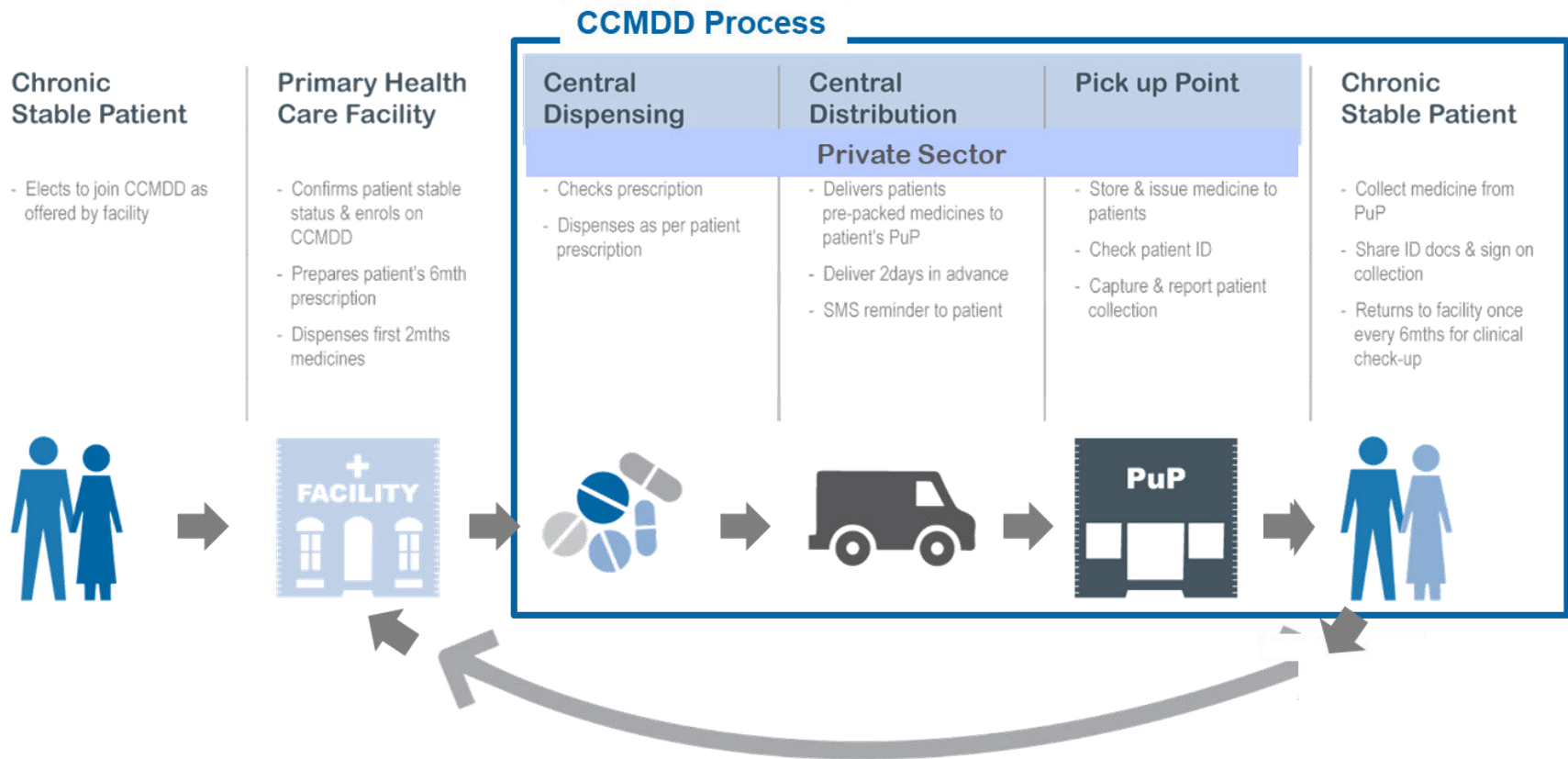
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Central Chronic Medicine Dispensing & Distribution (CCMDD) Process

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 eThekweni 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 wheel chair 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
- Its 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

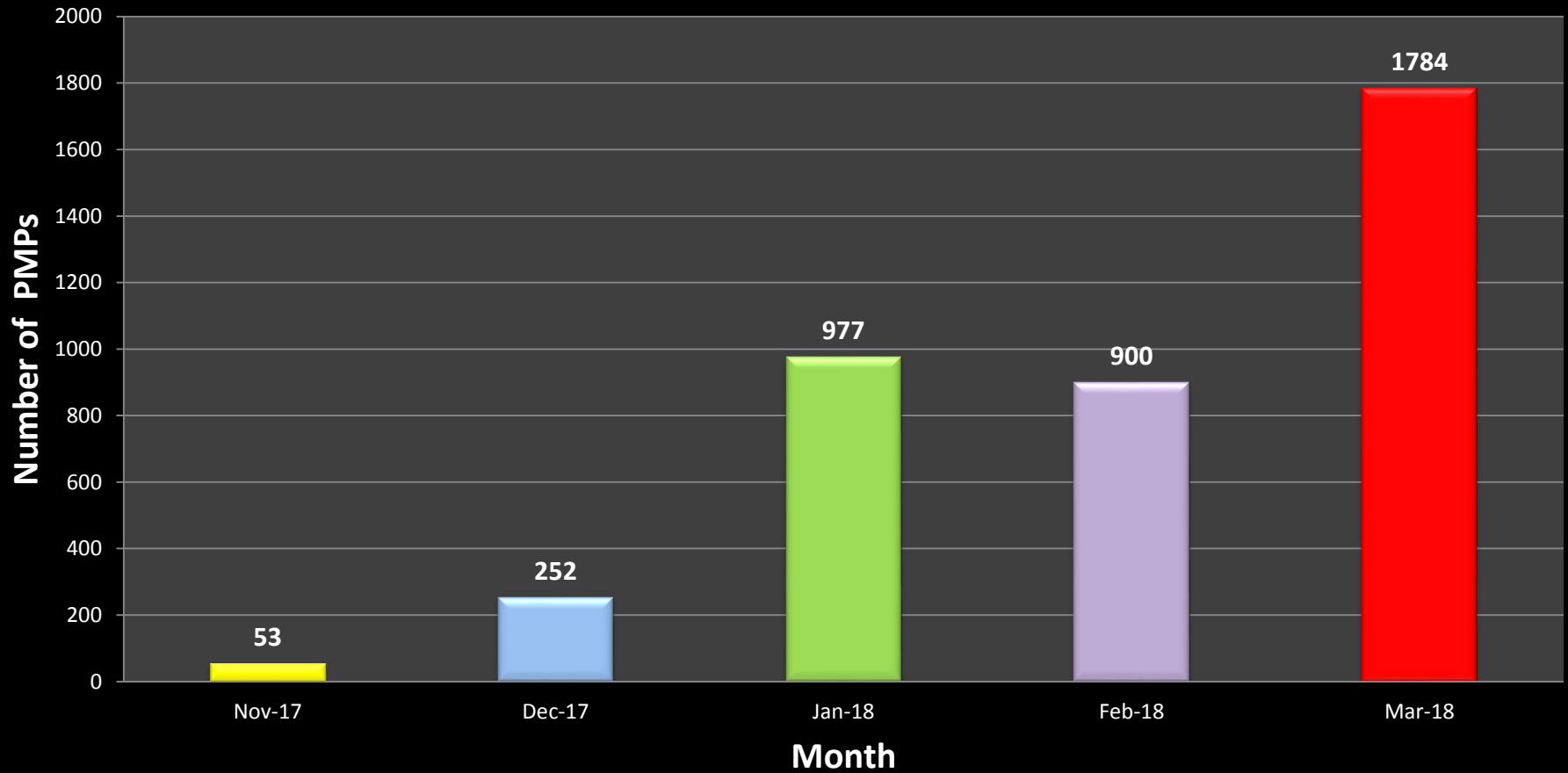
- Project Last Mile's CCMDD geo-mapping and data sets provided a baseline for the project
- Based on the data analysis the following were deduced:
 - high burden of disease
 - high volume of CCMDD patients
- Site visits conducted in targeted areas
- Potential sites were listed and an individual pilot site was identified
- Negotiations with stakeholders included the Local Ward Councillor, eThekweni 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



Growth

Number of Patient Medicine Parcels (PMPs) Issued to Patients

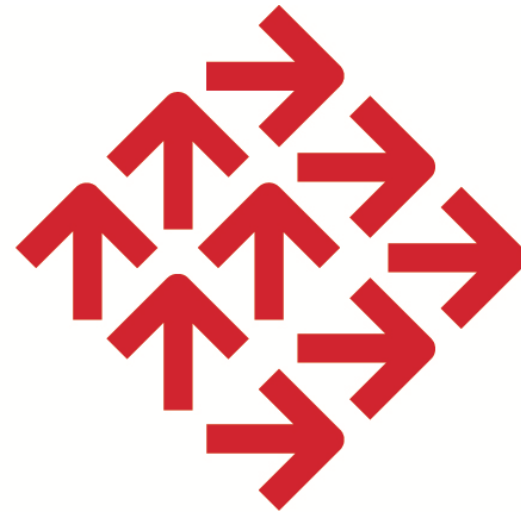


Thank You

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Project Last Mile

The CQUIN Learning Network

Differentiated Service Delivery for Urban Populations

A CQUIN Webinar

Urban Adherence Groups in Zambia: Findings from model implementation

Mpande-Mukumbwa-Mwenechanya
BPharm, MClinPharm

Centre For Infectious Disease Research In Zambia

May 2, 2018



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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

¹CIDRZ, 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

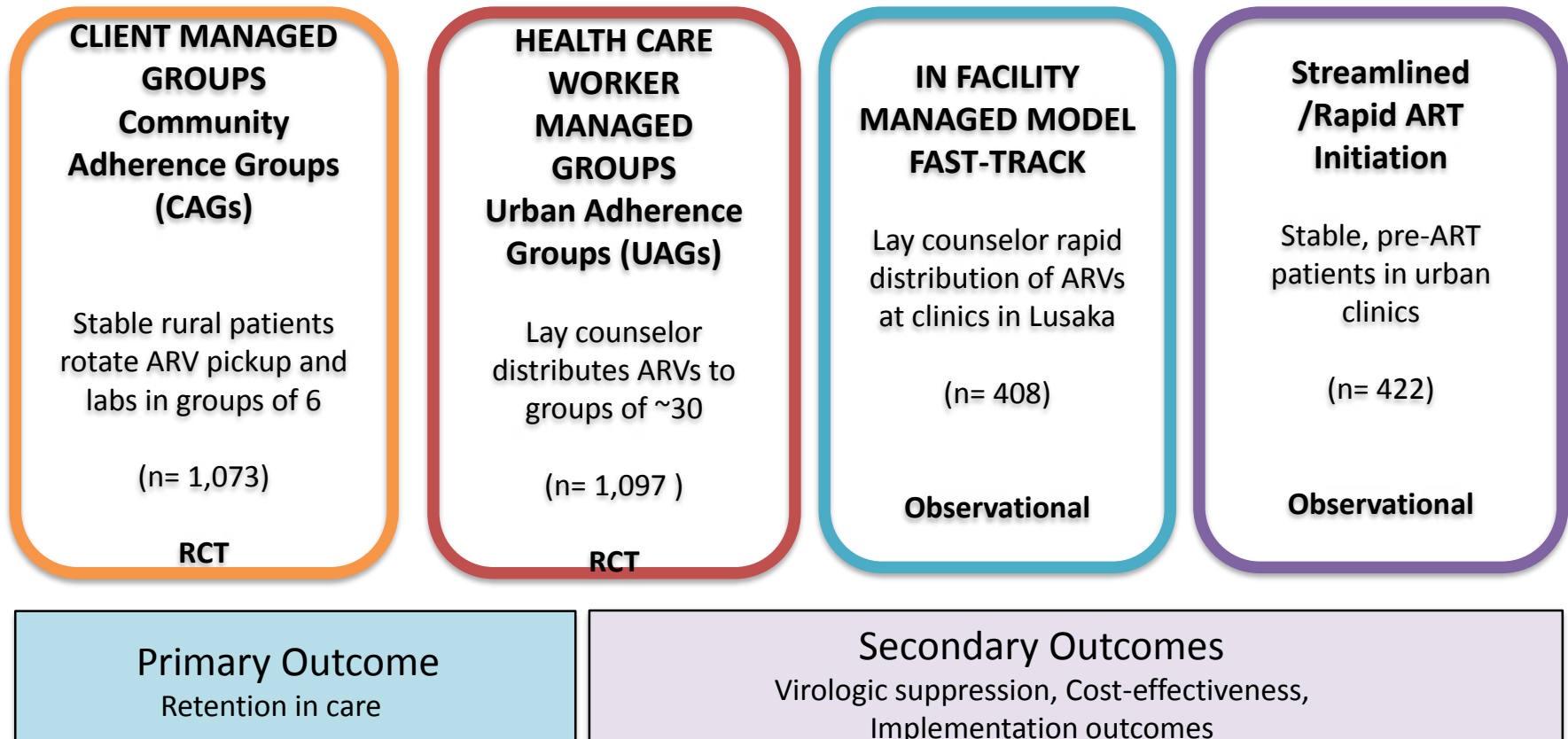
ART & PRE-ART PATIENTS &
FAMILY

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



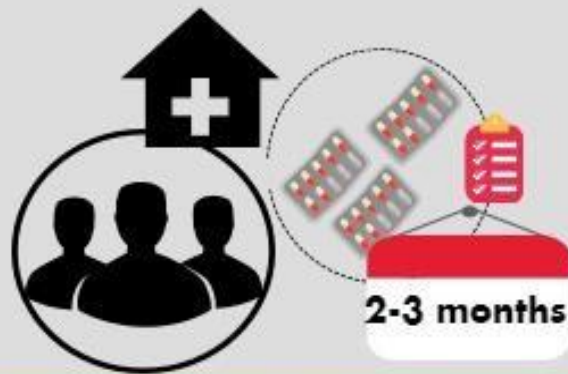
Eligibility Criteria for Enrolment into DSD model

- 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

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

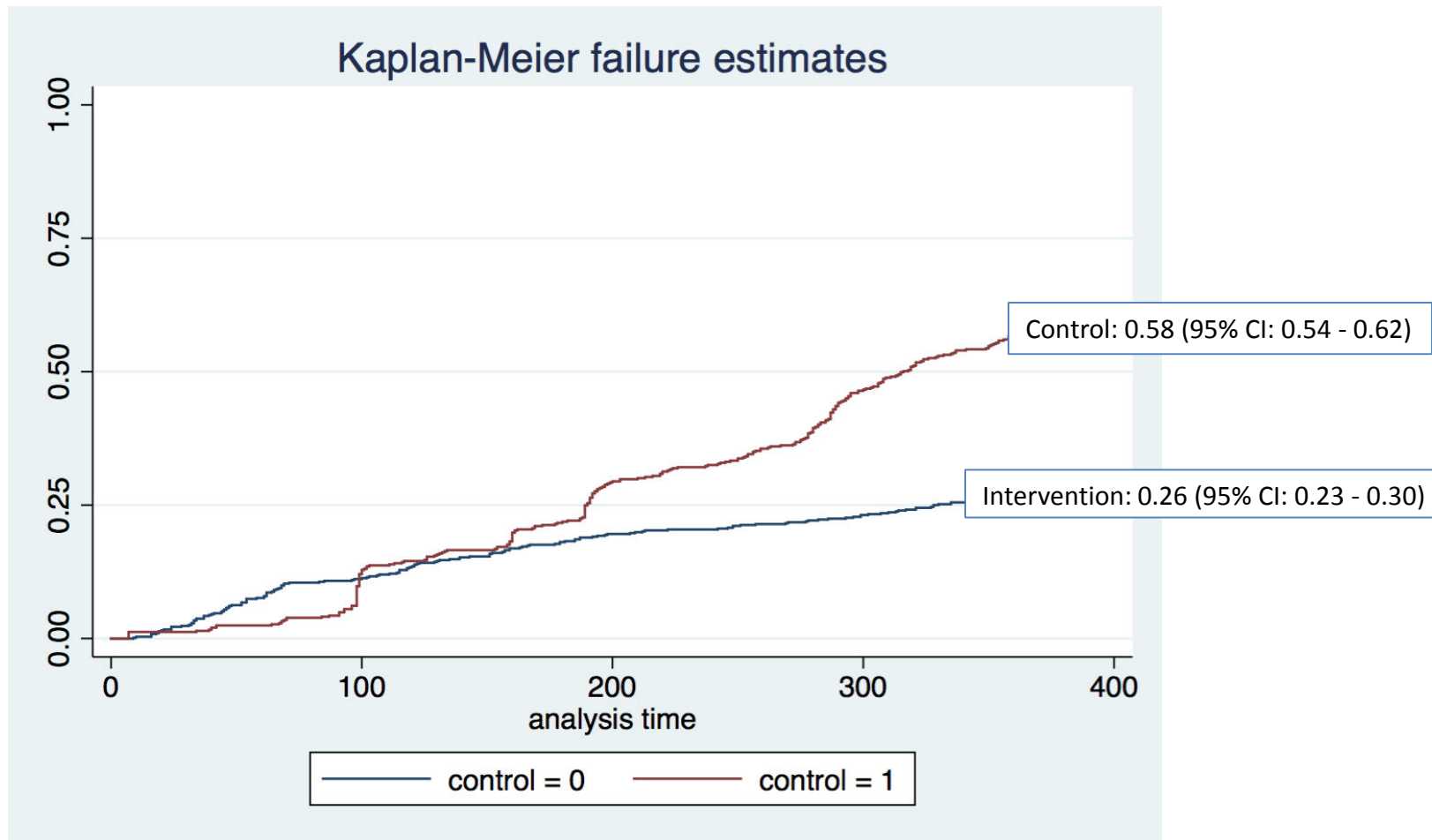
“... I can be very happy if [UAG] continue. If it comes to an end and we get back to the old system, it will be a very difficult thing. Like we have already said, the kind of jobs that we are doing, it is difficult to ask for permission. This month you have asked, then the following month you ask again, 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 means¹
- 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]



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

