HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

Integrating SRH services in Differentiated Care: Framing remarks

Morkor NEWMAN OWIREDU
Medical Officer
Treatment, Care and Service Delivery
WHO Geneva

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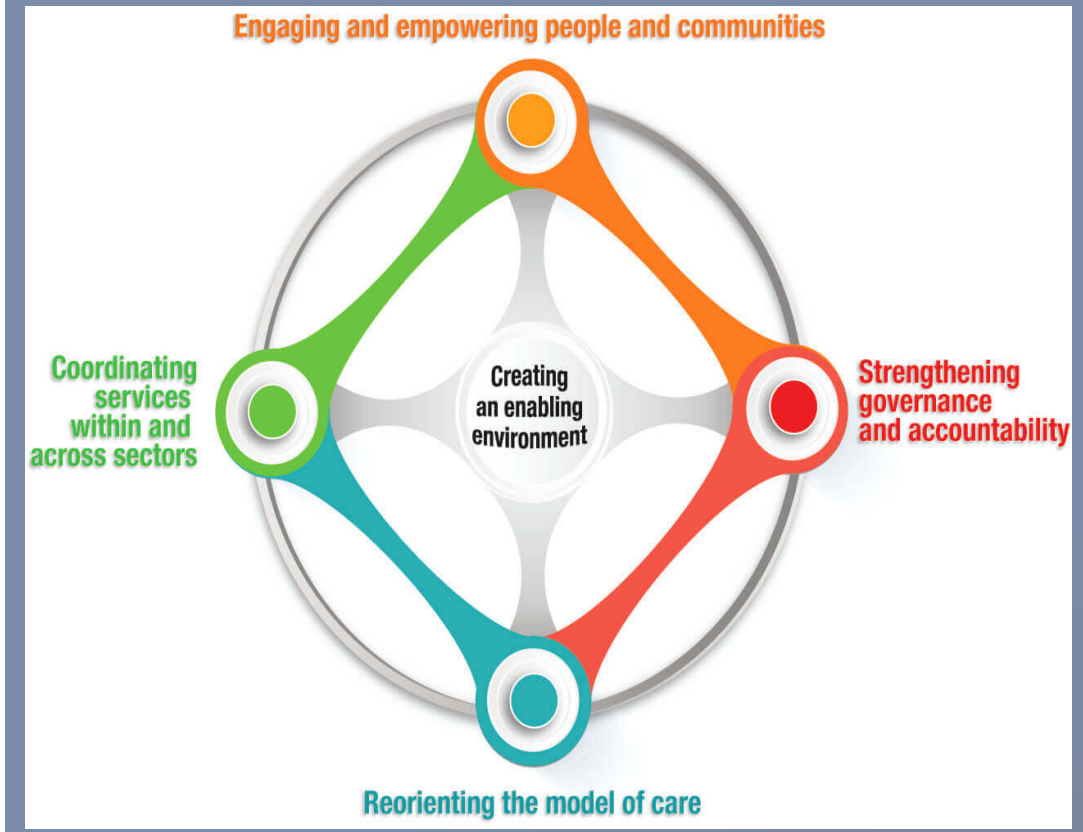
Setting the stage

Rational for DSD for MCH

- **UN's Sustainable Development Goal 3** (SDG 3) for 2030 is to "ensure healthy lives and promote well-being for all **at all ages**", a goal that crosscuts with the other SDGs
- **A life course approach** to health aims to ensure people's well-being **at all ages** by addressing people's needs, ensuring access to health services, and safeguarding the human right to health throughout their life time
- **Matching policies to the needs of people at different stages of their lives**
- Supports the **2016 Framework on Integrated people-centred health services** (IPCHS) – Resolution WHA69.24, 2016



The Framework is a call for a fundamental shift in the way health services are funded, managed and delivered.

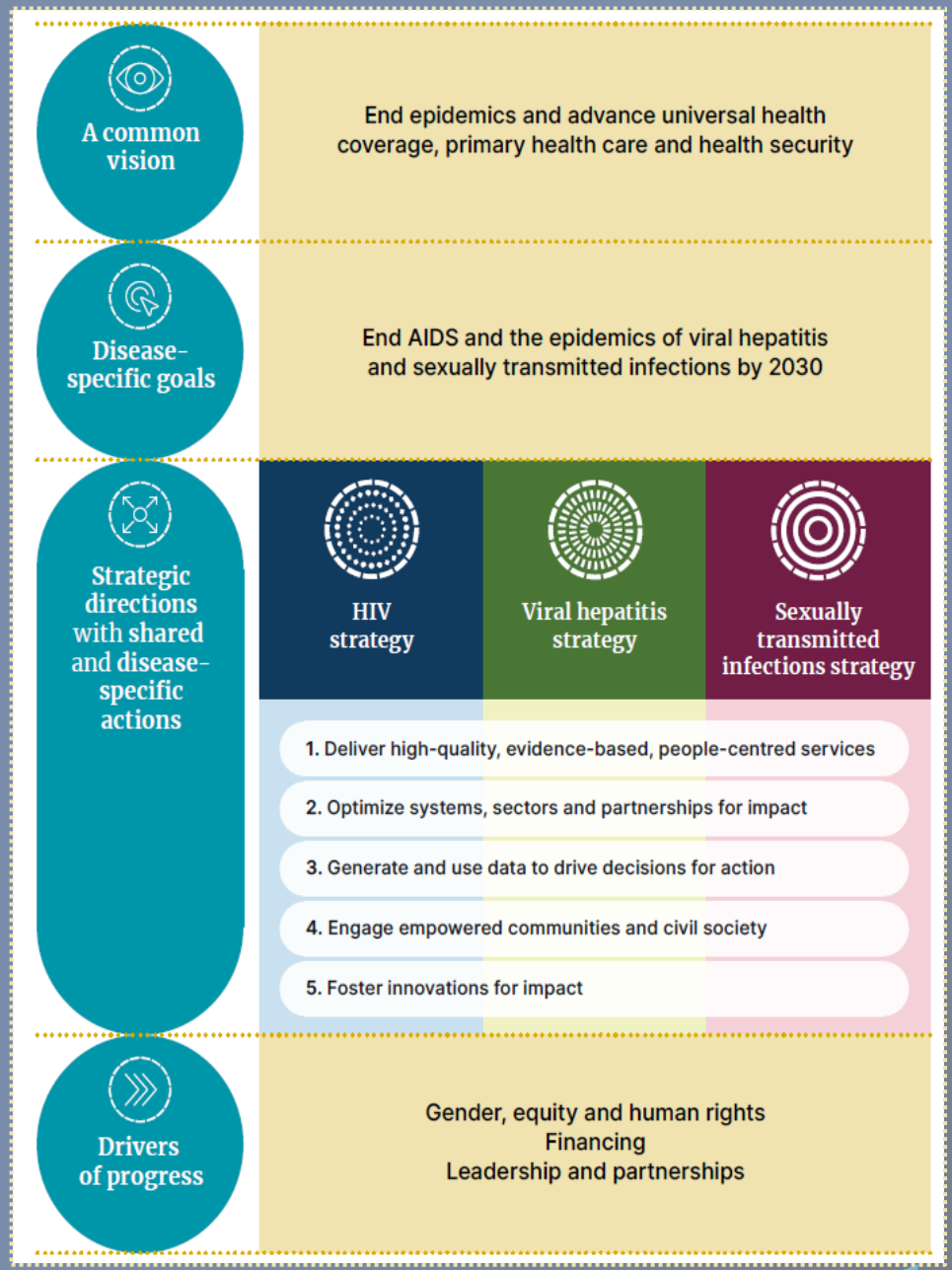
Supports countries progress towards UHC by shifting away from health systems designed around diseases and health institutions towards health systems designed for people

New Global Health Sector Strategy (GHSS) for HIV, VH and STIs

Guiding Integration of Services within the MCH continuum Towards Triple Elimination of EMTCT of HIV, syphilis & HBV

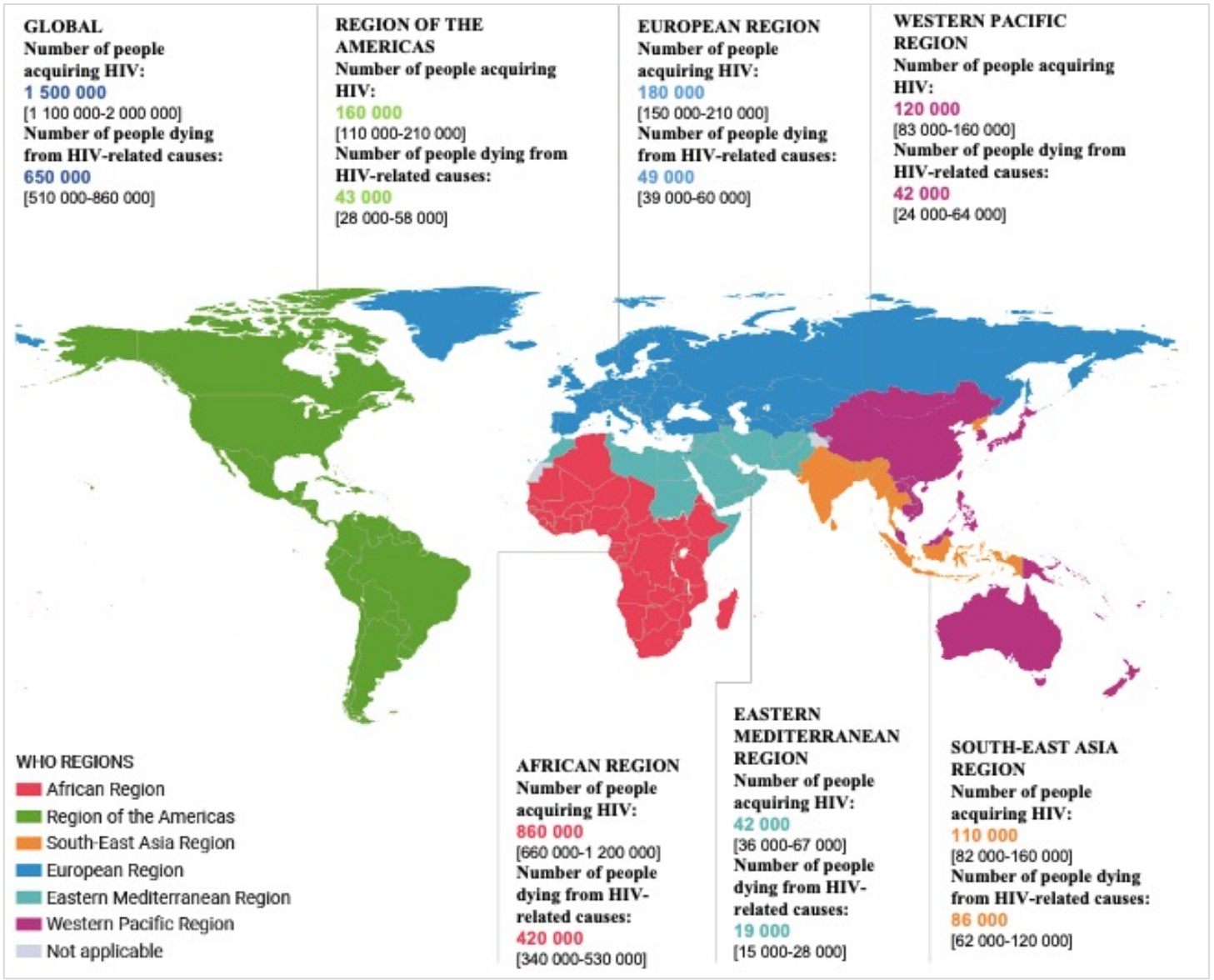
National planning efforts guided by the global shifts of GHSS 2022-2030:

- Putting people at the centre
- Addressing unique priorities for each disease area
- Taking a shared approach towards strengthening health and community systems
- Responding to a swiftly changing health and development context
- Eliminating stigma, discrimination and other structural barriers
- Related shared global 2030 targets



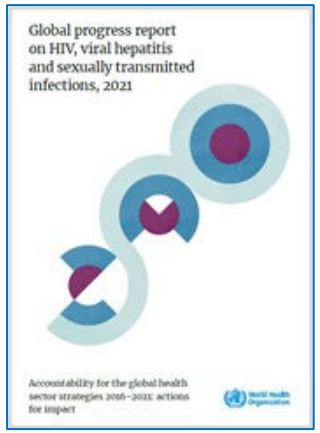
The strategies were noted with appreciation by the WHA giving WHO a clear mandate to work with Member States on the new strategic framework until 2030.

BURDEN: Global and regional HIV epidemic, 2021



New HIV infection every two minutes in AGYW 2021

- Scaling HIV, Hepatitis and STI responses has the potential to save 2 million lives per year by 2030
- New HIV infections are rising where they had been falling
- EECA, LAC, EMR have all seen increases in annual HIV infections over several years
- New infections dropped only 3.6% between 2020 and 2021, the smallest annual decline since 2016



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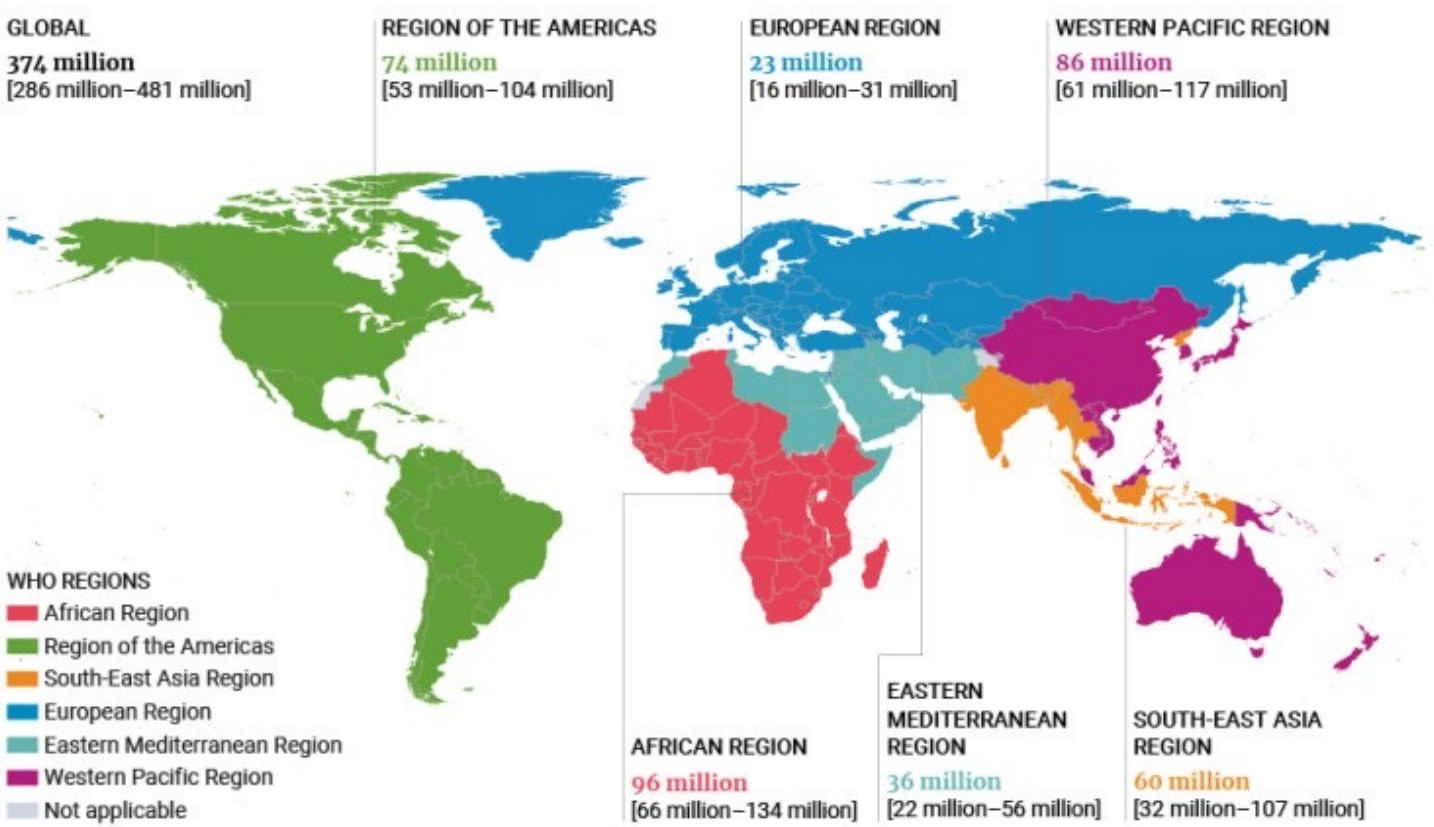
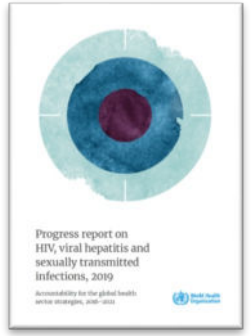
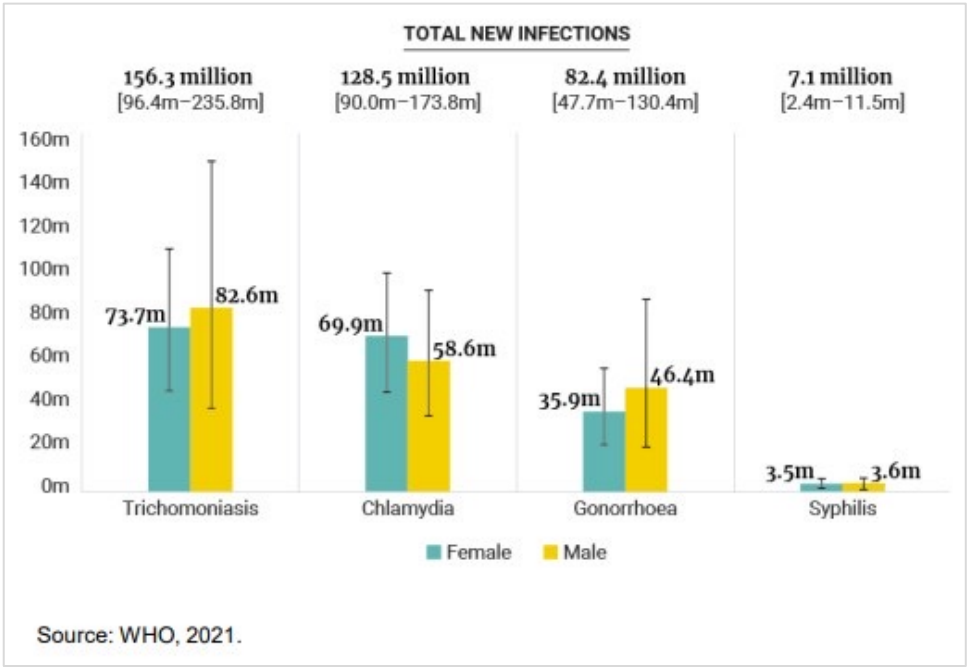
BURDEN: Incident cases of 4 curable STIs among adults (15-49 yrs old), 2020



- 374 million new infections in 2020
- Over one million new infections a day





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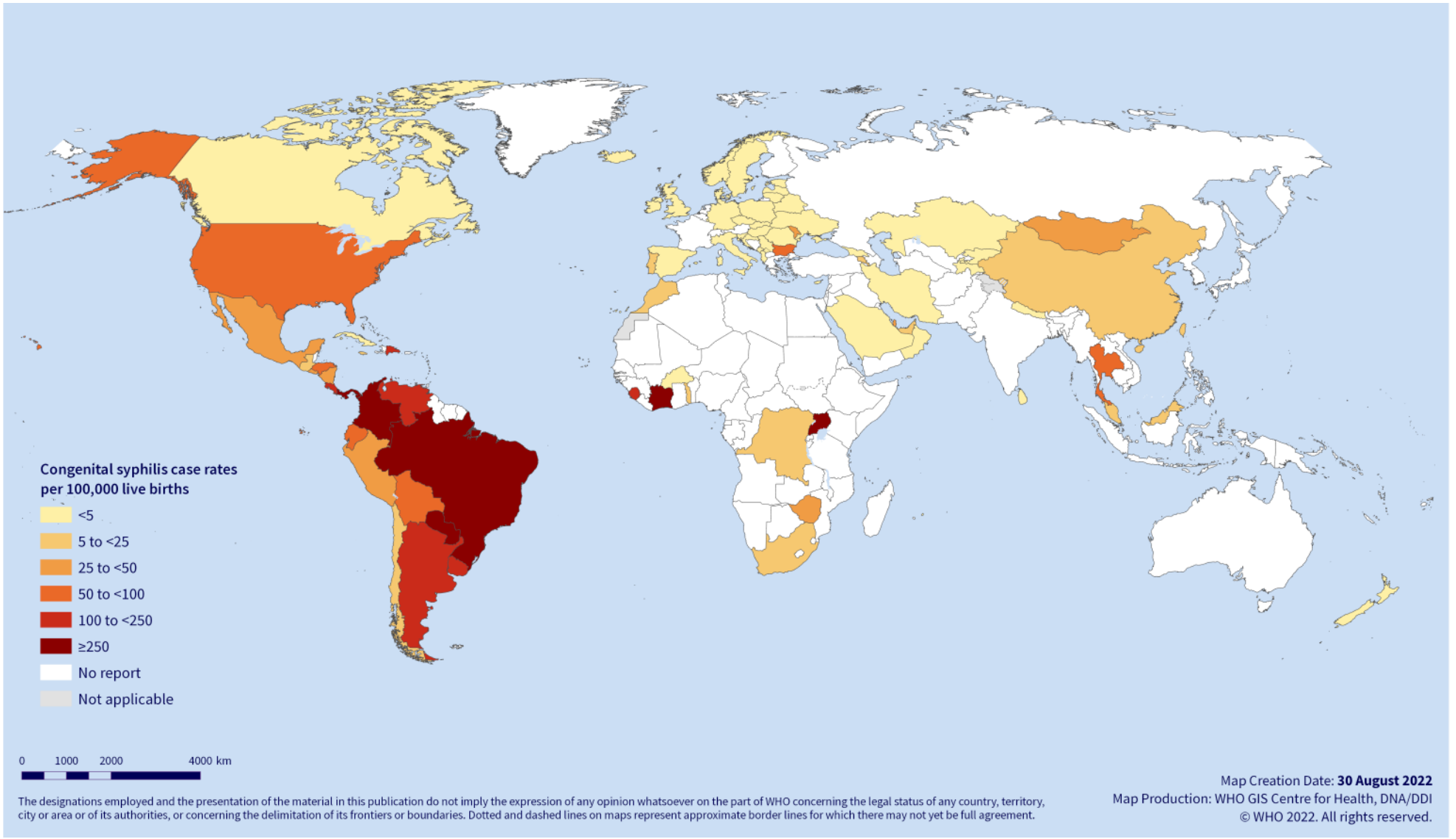
Congenital syphilis case rates per 100,000 live births, as of 30 Aug 2022



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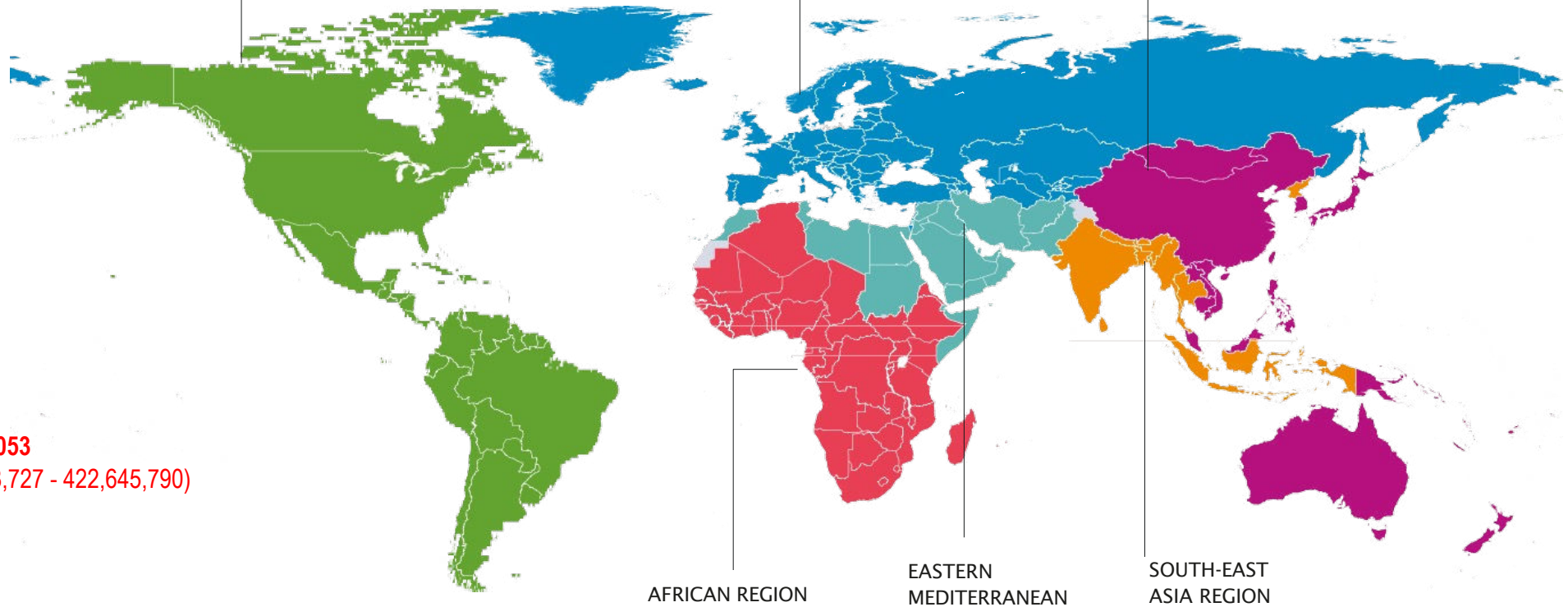
BURDEN: Prevalence of HBV infection by WHO Region, 2019



Addressing the Burden:
Rationale for Triple Elimination of EMTCT of HIV, syphilis & HBV

All 3 infections…

Are transmitted sexually and vertically (from mother to infant)

Are often silent with long latency period and infected mothers may be unaware and have no symptoms

Can cause significant maternal and child morbidity and mortality

Can be identified during ANC and treated to prevent vertical transmission

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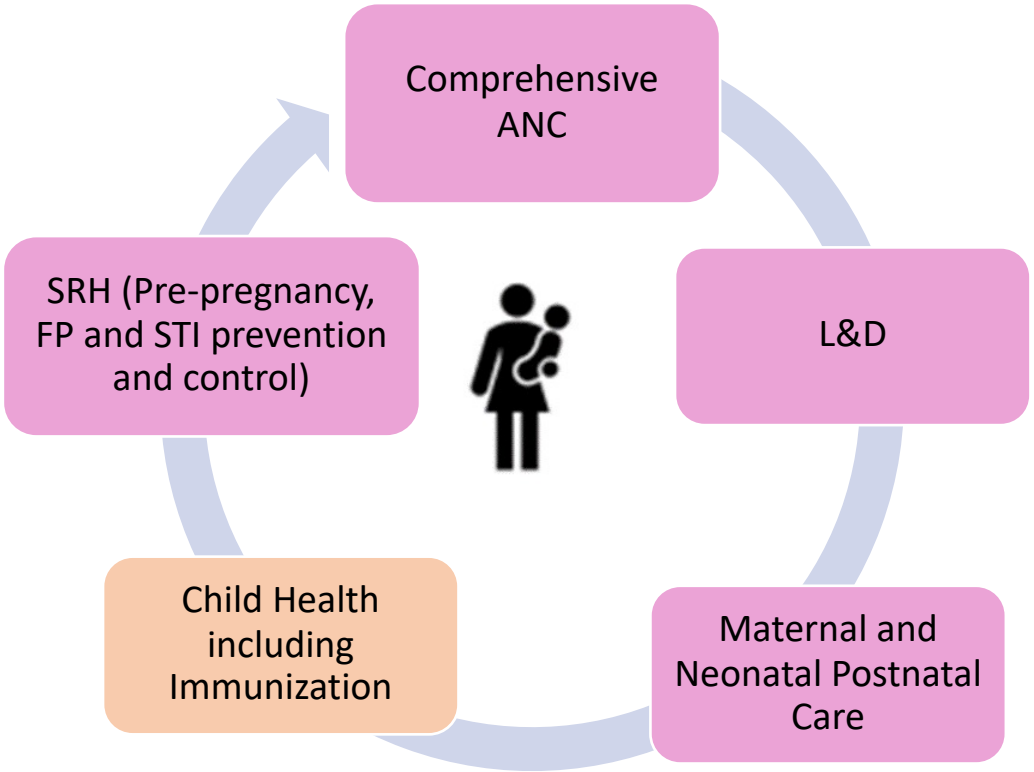
Targets for Elimination

	EMTCT of HIV	EMTCT of Syphilis	EMTCT of HBV
2030 Global Health Sector Strategy (GHSS) direct and related targets	'Zero' new infections among infants	≤50 cases of congenital syphilis per 100 000 live births in 80% of countries	95% reduction in incidence of chronic viral hepatitis B infections
IMPACT TARGETS Impact criteria must have been met for one year	New paediatric HIV infections **population case rate ≤50 cases per 100 000 live births**	A **case rate of congenital syphilis** of **≤50 per 100 000 live births**	**<0.1%** prevalence* HBsAg in ≤5-year-olds
	MTCT rate of HIV of **<2%** in non-breastfeeding populations OR **<5%** in breastfeeding populations		In countries using targeted birth dose, an additional impact target of **MTCT rate** of **≤2%**
PROGRAMMATIC TARGETS Process criteria must have been met for two years	ANC **coverage** (at least one visit) (ANC-1) of **≥95%** **Coverage** of HIV testing (pregnant women) of **≥95%** ART **coverage** (HIV-positive pregnant women) of **≥95%**	ANC **coverage** (at least one visit) (ANC-1) of **≥95%** **Coverage** of syphilis testing of pregnant women of **≥95%** (attended at least one ANC visit) Adequate treatment (syphilis - seropositive pregnant women) of **≥95%**	With universal birth dose (BD) **≥90%** HepB3 vaccine coverage **≥90%** HepB BD coverage With targeted BD or without universal BD **≥90%** HepB3 vaccine coverage **>90%** HepB BD coverage **>90%** coverage of maternal HBsAg testing **>90%** coverage with antivirals for eligible

Using a woman and child-centred model of care, how can we work together to ensure that all health needs are being met?

- DSD offers a person-centered approach to HIV Care and Treatment
- Women have their own SRH needs that must be met
- Some, but not all HIV services have successfully been integrated into the MCH cascade
- Challenges for integration include fragmentation of health service records



Triple Elimination: 'protégé' for integration

- Ensuring **routine maternal** HIV Syphilis and HBV **testing services**: essential for triple elimination agenda
- **Primary prevention** of incident infections

Pregnant, Breastfeeding and women need **differentiated models of care** that **respect their evolving needs** over their sexual and reproductive health span

- Prioritizing **integration of Family Planning** / Contraception into DSD: critical to EMTCT (choice, pregnancy intentions)
- Opportunity for **increasing access to and uptake** of other SRH services
  - STI prevention and control including ECS
  - Addressing AGYW: adolescent health
  - Addressing RMNCAH in key and vulnerable populations
  - Civil society engagement
- Opportunity for scaling up **high-quality differentiated treatment and care** for all population groups
  - Maternal HIV and syphilis treatment
  - Maternal HBV treatment for the eligible

Proposed Pillars for addressing the Burden

1. Provision of HIV, syphilis, and HBV testing services for women and girls
2. Primary prevention of incident HIV, syphilis, and HBV infection in women and girls
3. Linkages and integration with sexual and reproductive health services including prevention of unintended pregnancy, and prevention and control of STIs
4. Provision of appropriate maternal HIV and syphilis treatment; and maternal HBV treatment where eligible
5. Provision of relevant prevention or treatment services for exposed infant(s), partner (s) and family(ies)

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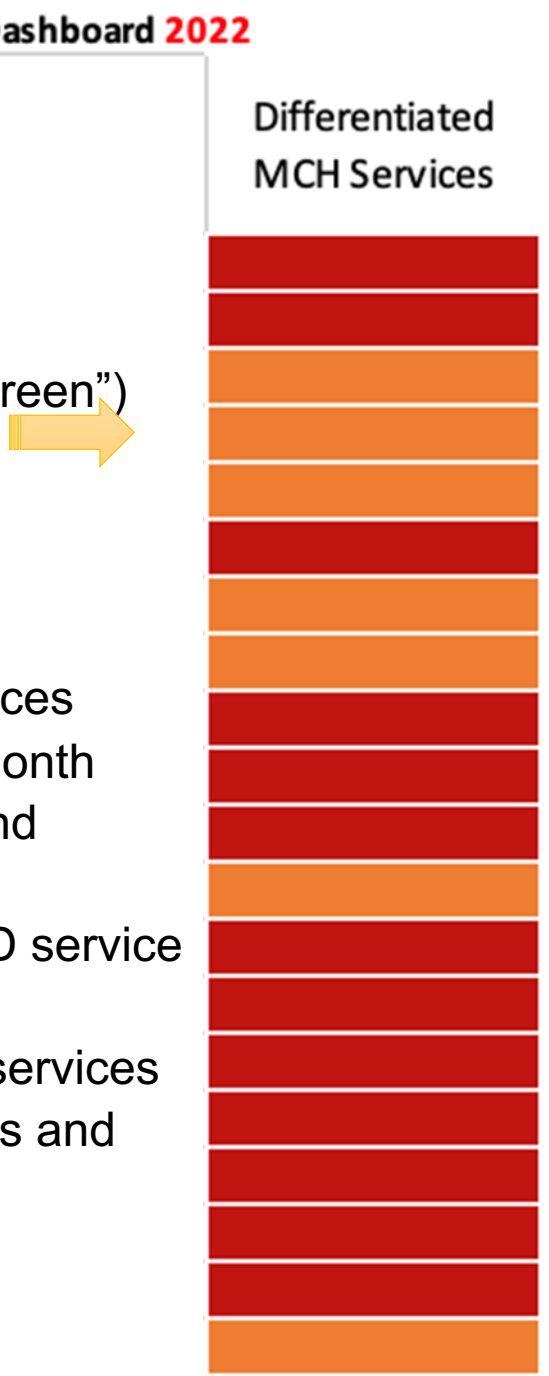
Overview of the MCH Community of Practice

MCH CoP Objectives:

- Tracking country progress in the MCH/FP domains of the CQUIN treatment dashboard, reviewing shared challenges, and best practices to enable progress towards mature ("green") staging over time
- Supporting the inclusion of differentiated MCH activities in CQUIN country workplans
- Centering the voices of recipients of care to guide differentiated MCH service delivery
- Convening webinars and virtual community of practice meetings
- Coordinating country-led virtual learning exchange series - case studies and best practices related to integration of maternal child health and HIV service delivery including multi-month dispensing (MMD) for FP and ART, and integrated models of HIV and syphilis testing and treatment
- Exploring priority areas and missed opportunities for integrating/linking FP into HIV DSD service delivery models
- Working with the Quality Improvement CoP to define standards for differentiated MCH services
- Reviewing programmatic data related to pregnancy and FP to understand potential gaps and opportunities for program integration



TREATMENT

Criteria for determining whether a person is "established on ART"

⚠ **INCLUDES all populations established on ART:**

- Individuals receiving **second- and third-line regimens**
- People living with HIV and **controlled comorbidities**
- **Children and adolescents**
- **Pregnant** and **breastfeeding** women
- **Key populations**

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TREATMENT
Specific criteria for pregnant and breastfeeding women

Box 7.4 Additional eligibility criteria specific to pregnant and breastfeeding women for accessing differentiated ART delivery models outside clinic care

- **Women clinically established on ART when conceiving:** already accessing the differentiated ART delivery model plus at least one viral load test of <1000 copies/mL in the past three months and accessing antenatal care.

- **Women initiating ART during pregnancy:** since a woman initiating treatment during pregnancy will only become eligible to enter a differentiated ART delivery model in the postpartum period, an HIV-negative result for her infant with a NAT at six weeks and evidence of accessing infant follow-up care are additional requirements.

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ELIGIBILITY FOR PREGNANT AND BREASTFEEDING WOMEN IN DSD FOR HIV TREATMENT

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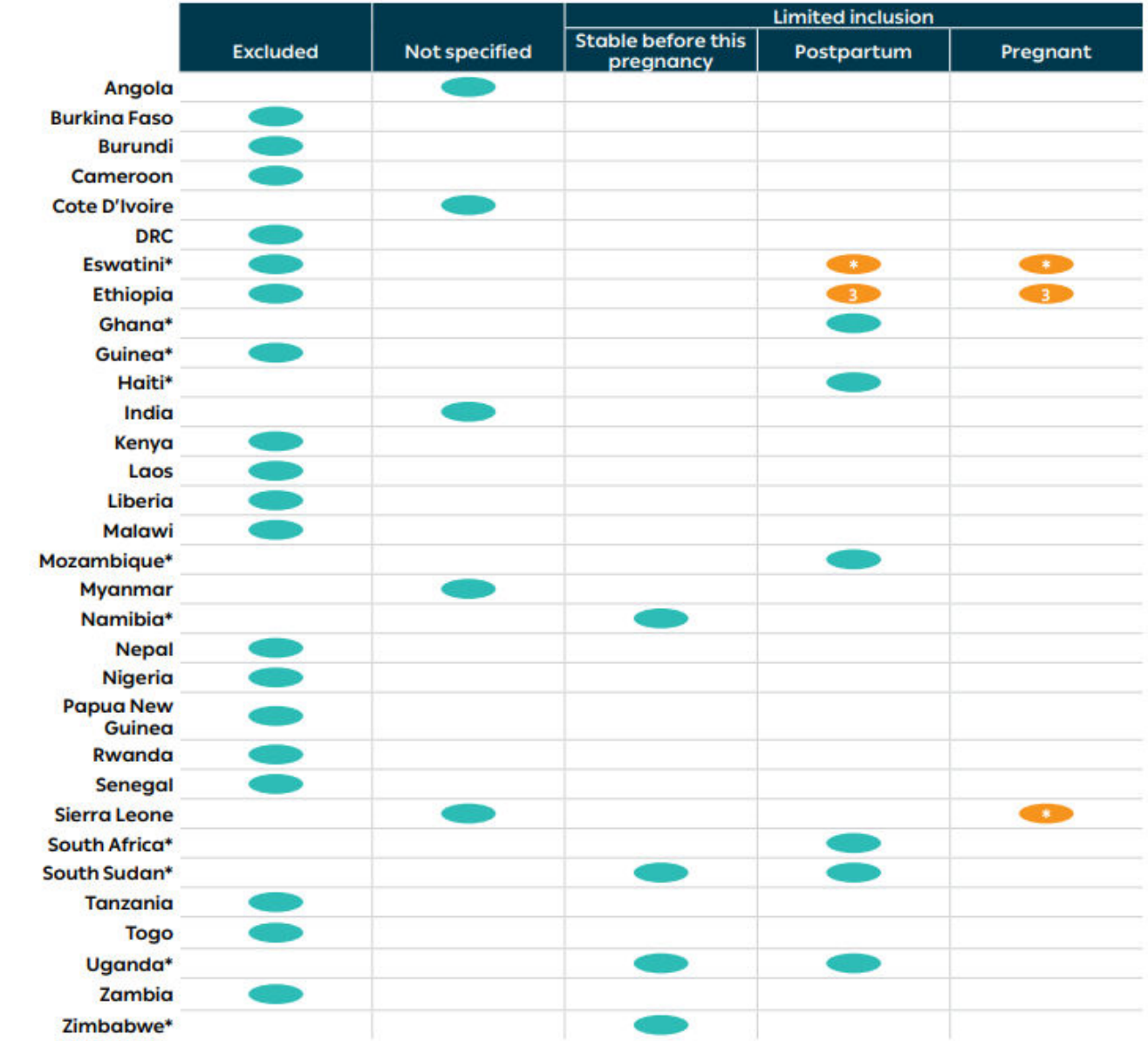

Key

- National policy
- COVID-19 policy adaptation
- * Only alignment of MMD and ANC/PNC visits
- 3 3MMD only

References

Click on the ovals in the table to access the referenced policy.

Notes

Eswatini: 'Non-COVID' policy: allows breastfeeding women in clubs in certain circumstances

Ghana: 3MMD from 6M postpartum

Guinea: 3MMD from 1M before birth if VL<1000; special provision for women who give birth away from home if on ART from 1st/2nd trimester

Haiti: From 6M postpartum

Mozambique: From 9M postpartum if infant is HIV , from 6M postpartum women are eligible for 3MMD

Namibia: 3MMD, but only in facility-based models

South Africa: Stable postpartum women eligible if no integrated ART/MCH care

South Sudan: Stable before this pregnancy: only eligible if already in a DSD model and VL<1000 in last 3M; Postpartum: Only qualify as stable after 12M on ART, and if infant is HIV negative

Uganda: Stable before this pregnancy: Only eligible if aligned with ANC/PNC visits; Postpartum: Only qualify as stable after 12M on ART

Zimbabwe: Only eligible if aligned with ANC/PNC visits

The importance of choice for HIV care during pregnancy and post-partum period

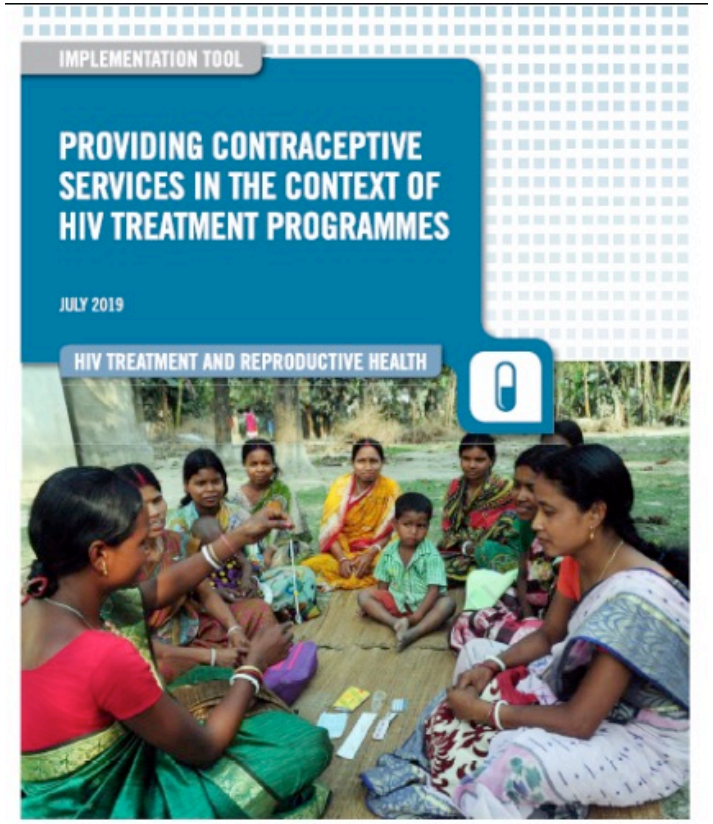

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Table 29: Building blocks for the common family planning methods provided

	IUD	IMPLANT	ORAL PILLS	SUB-CUTANEOUS 3-MONTHLY INJECTABLE	INTRA-MUSCULAR 3-MONTHLY INJECTABLE	CONDOMS
WHEN	At DSD entry At DSD clinical visits At facility walk-in services in between visits	At DSD entry At DSD clinical visits At facility walk-in services in between visits	At same clinical and refill visit as ART Every 3 months	Not yet available	At DSD entry At DSD clinical visits At facility walk-in service Every 3 months	At same clinical and refill visit as ART Every 3 months
WHERE	Offer at ART clinic or through referral Primary care clinics Hospitals	Offer at ART clinic or through referral Primary care clinics Hospitals	Primary care clinics Hospitals	Not yet available	Primary care clinics Hospitals	Primary care clinics Hospitals
WHO	IUD-trained doctor, midwife or nurse	Implant-trained doctor, midwife or nurse	FP-trained doctor, midwife, nurse, clinical officer, community-based distributor	Not yet available	FP-trained doctor, midwife, nurse, clinical officer	Doctor, clinical officer, midwife, nurse, community distributor, VHW, CATS and key population peer supporters
WHAT	IUD information, counselling, insertion/ removal, management of side-effects	Impact information, counselling, insertion/ removal, management of side-effects	Combined and progestin-only pills, information, dispensing of pills, management of side-effects	Not yet available	Injectable information, counselling, giving of injections, management of side-effects	Male and female; information, counselling, dispensing of condoms

DSD for Family Planning/Contraception

WHEN:

- A quality FP consultation should be carried out at entry into a DSD model and at each clinical visit.
- Those methods requiring ongoing commodities should be given on the same day and time as ART.
- Align pill refills and depot with ART refills.
- Women should always be still offered a six-month ART refill.
- For pills, if the supply chain cannot match 6MMD, provide a multi-month script that can be collected directly from the pharmacy, community distributor or via a refill model.
- Injections should be booked for the same date as ART refills or clinical visits. Women on three-monthly injectables should still be able to receive 6MMD of ART, and the additional visits should be offered at the site they receive their ART.

WHERE:

- Same location as ART
- In some settings, referral may be needed for insertion of IUDs and implants, but the goal should be for other methods to be available where ART is delivered.
- Contraceptive pills and condoms can be distributed in community locations.

WHO:

- The same HCW as providing ART
- Referral may be needed for IUDs and implants.
- In high-volume sites, the goal should be for one HCW to be trained to insert IUDs and implants.
- Community distribution of pills may also be performed by family planning community distributors.
- Condoms may be distributed by community distributors, VHWs, CATS and key population peer supporters.

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INTEGRATION OF FAMILY PLANNING WITHIN DSD FOR HIV TREATMENT MODELS

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Key

- National policy
- Interim COVID-19 policy

References

Click on the ovals in the table to access the referenced policy.

Notes

Eswatini: FP included in clinical consultation for all models; oral contraceptive refills provided for same duration as ART refills in COVID policy

Ethiopia: Oral contraceptive refills provided for same duration as ART refills in COVID policy

Ghana: Injectable contraceptive aligned with ART refills

Kenya: FP commodities provided within facility-based and healthcare workers led community-based HIV treatment models

Mozambique: In the one-stop-shop models (maternal and child health and youth-friendly services) some family planning commodities are integrated into DSD for HIV treatment.

Uganda: FP commodities provided within community-based HIV treatment models (CDDPs and CCLADs)

Zimbabwe: FP commodities provided within facility-based adolescent HIV treatment models

Thank you!