SCIENCE AND COMMUNITY IN THE RESPONSE TO HIV IN WESTERN AFRICA

AIDS 2018 POST-CONFERENCE WORKSHOP

Ghana, 12-13 May 2019
Differentiated Service Delivery Models: How can they be implemented?

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Introduction

• By 2020, 90% of all people living with HIV (PLHIV) should know their HIV status, 90% of all people diagnosed with HIV infection will receive antiretroviral therapy, and 90% of all people receiving antiretroviral therapy should achieve virological suppression 12 months after starting treatment.
In 2015, WHO also recommended the “treat all” policy, where all clients diagnosed with HIV are eligible for ART regardless of CD4 count or clinical stage.
Rationale for DSD Models

• Targets set for 2020
  – demand that twice as many people are tested for HIV as were tested in 2018
  – three times as many clients are initiated on ART compared with the achievements documented in the 2018 NACP service data.

• In order to achieve these ambitious goals, in a context where
  – healthcare workers are overburdened
  – clients face financial and practical barriers to access care,
    • including high levels of stigma
    • long waiting times for clients
    • Travel distance to centralised sites

• The DSD approach to HIV service delivery will have to be adapted
Rationale for DSD Models

- DSD provides an opportunity to adapt health services to the needs of clients while reducing the burden on health care workers
  - Improve adherence to treatment
  - Increase the rate of viral suppression for patients on treatment
DSD definition

Differentiated care is a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system.
How is DSD implemented

- There is a 5-step implementation process
- **STEP 1**: Conduct situation analysis using assessment tool
- **STEP 2**: Define facility specific challenges
  - General challenges
  - Facility specific challenges
- **STEP 3**: Decision making process for DSD
  - Define which populations
  - Identify what to implement immediately & in the longer term
- **STEP 4**: Design DSD model
  - For HIV testing
  - For ART delivery
- **STEP 5**: Implement & monitor
  - Mentoring
  - Lessons learned
Ghana’s experience with DSD implementation
Process to develop DSD policy

• February, 2017, teams comprising EQUIP and NACP staff visited 20 facilities in 5 regions - A, B, A, E, G, A and W

• The purpose - a baseline assessment of these selected facilities

• Findings emphasized need for DSD across cascade of care
Process to develop DSD policy

• Workshop on DMoC (6th - 7th April, 2017) with donor partners, stakeholders and implementers from the regions
  – WHO consultant to help with development of DMoC operational guidelines and manual

• Operational manual developed, validated and print ready by Dec. 2017
Overview: Ghana DSD policy

- Covers entire continuum of care
- Differentiates between general population and considerations for specific populations
- Includes SOPs and algorithms
DSD policy development to implementation

• Task team formed with ToR (May 2018)
• Task team developed dissemination plan with National ToT and Regional ToT in June, 2018.
• Sub-regional orientation was started in Dec., 2018 in 10 facilities in GAR
  – 20 more facilities were oriented in AR, BAR, ER, GAR, WR
  – All 20 EQUIP supported sites were oriented by EQUIP
How Ghana prioritized implementation

• Key priorities in implementation plan
  – High client load facilities with at least 200 clients
    • Not EQUIP-supported
  – Onsite orientation
    • Deal with site specific challenges
    • Get a lot more staff involved
• Orientate facilities with Regional teams while National officers supervise
Implementation to date

• PITC, testing at high yield entry points – 40% of all facilities
  – DOTS corners
  – STI clinic
  – IPD/Ward
  – Emergency room
  – ANC
  – Nutrition rehab centres
  – OPD

• Linkage to care – improved by 20 to 50% within DSD-oriented facilities
Implementation to date

- Treat All
- Up to 60% of facilities do MMSD
  - From about 20%
- About 60% of facilities provide 6 month clinic visit appointments
- Facility-based care
- Community-based care
  - 30% provide Community-based individual ART delivery at PHC level
- Trained facilities contact clients with VL >100copies/ml ASAP once results are received
Challenges in implementation of DSD

• Time lapse between development of Manual and implementation
• Time lapse between Regional ToTs and facility trainings
• Funding is partial
  • CDC has supported onsite orientation in 30 facilities so far
  • GF supported EQUIP in 10 sites
• Onsite strategy is time consuming
Challenges in implementation of DSD

- Availability of commodities – test kits, ARVs at units other than ART and pharmacy, communication for LTFU tracing
  - Implementation of sample referral in some regions
- Inability to trace LTFU clients
- M&E tools not part of national
- Need to carve out time for Supportive supervision
Lessons learned from policy to practice

• Wide stakeholder engagement to accept model - especially implementers
• Implementation strategy – **onsite** or ‘classroom’
  – Engaging as many as possible during orientation
  – Reduces effects of attrition as a lot more staff are engaged
• **FUNDING**
  – A costed plan and dedicated funding should be secured to ensure smooth operationalization
  – Periodic assessment of impact to be undertaken beyond the baseline to justify further investment
• Availability of resources/commodities
• **M & E tools & activities** - most indicators are process indicators so better monitored during supportive supervisory visits
• Supportive supervisory visits- A MUST
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