Differentiated Service Delivery In HIV Treatment & Care For Pregnant and Breastfeeding Women

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General Remarks

Pregnancy and postpartum period presents significant **biological, social and economic challenges** that may affect treatment adherence and retention in care, including:

- Pregnancy-related nausea and vomiting.
- More intensive care (ANC, PNC and EPI).
- Transition between maternal, newborn and child health (MNCH) services and HIV care clinics for longer-term care may result in loss to follow-up.
- Other individual factors including lack of disclosure to the partner, family, etc. and fear of stigma & discrimination.

General Remarks (Cont'd)

- Many women living with HIV only access health services at the time of pregnancy, therefore, maternal and child health settings provide a **key opportunity to provide access to ART**.
- In 2013, WHO recommended **integration of maternal HIV care with** maternal and MNCH services.
- **PBFW** should have the **choice** to continue receiving their ART through the differentiated ART delivery model or to have their ART delivery integrated within their maternal, newborn and child health care.

Criteria For Defining Clinically Stable Clients for ART DSD Model

- Receiving ART for at least six months
- No current illness, which does not include well-controlled chronic health conditions
- Good understanding of lifelong adherence: adequate adherence counselling provided
- Evidence of treatment success: **at least one suppressed viral load result within the past six months (if viral load is not available: CD4 count >200 cells/mm3 (CD4 count >350 cells/mm3 for children 3-5 years old) or weight gain, absence of symptoms and concurrent infections)**

The definition of being established on ART (stability) should be applied to all populations:

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

Additional Eligibility Criteria for PBFW for Accessing Differentiated ART Delivery Models

Pregnant Women Clinically Stable on ART at Conception

- **Already accessing the differentiated ART delivery model *AND***
- **≥ 1 Viral Load (VL) test of <1000 copies/mL in the past three months *AND***
- **Accessing antenatal care (ANC)**

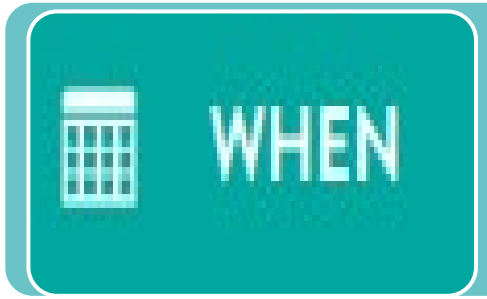
Pregnant Women Initiating ART during pregnancy

Woman initiating treatment during pregnancy will only become eligible to enter a DSD ART model postpartum.

Post-partum: Breastfeeding Women

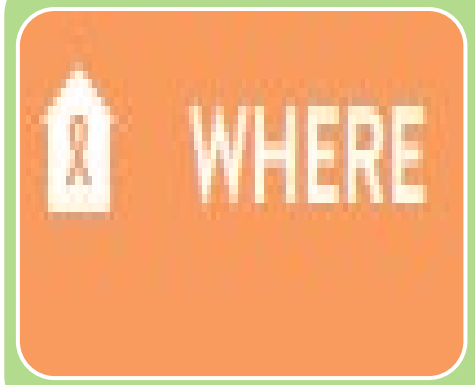
- **An HIV-negative result for her infant with a NAT at six weeks *AND***
- **Evidence of accessing infant follow-up care**

DSD for Clinical Consultation Visits



People established on ART (including PBFW) should be offered clinical visits every **3–6 months**, preferably every six months if feasible.

If possible, clinical consultations should be aligned with MNCH service visits scheduled in the same month..



Pregnant women must be given choice of where to receive ART care, but this should be carefully coordinated with the required antenatal care contacts to avoid missed opportunities to obtain both high-quality and patient-centred antenatal care and ART care.

Integrate ART treatment with ANC and PNC for PBFW and their infants within MNCH settings (2013), especially for women diagnosed and initiating ART during pregnancy.

If mobile outreach services are provided to adults receiving ART in remote areas, PBFW and their infants should also be seen and provided with integrated HIV and MNCH care.

As per the 2016 guidelines, **trained non-physician clinicians, midwives and nurses** can initiate and maintain ART (including for PBFW).

HIV Impact Network for Vertical Transmission Elimination

DSD for Clinical Consultation Visits (Cont'd)

WHAT	**Clinical consultation for PMTCT**	**Follow country guidelines on clinical assessment for PMTCT,** including but not limited to TB screening and post-delivery mental health and SRH assessment.
	Laboratory Tests	***For pregnant women receiving ART before conception***: conduct a **VL test at the first ANC visit** (or when first presenting) to identify women at increased risk of in utero transmission. ***For pregnant women starting ART during pregnancy***: conduct a **VL by three months after ART initiation** to ensure that there has been rapid viral suppression. ***For all pregnant women, regardless of ART initiation timing***: **conduct VL testing at 34–36 weeks of gestation (or at the latest at delivery**) to identify women who may be at risk of treatment failure and/or may deliver infants at higher risk of perinatal transmission. ***For all breastfeeding women, regardless of when ART was initiated***: conduct **VL test three months after delivery and every six months thereafter** to detect viraemic episodes during the postnatal period.
	Rescript	The ART and family planning (post-delivery) scripting period should cover the period until the next clinical consultation
	MNCH check (if not integrated)	If clinical care is not integrated, HIV clinical consultations should include a check that the person is attending maternal, newborn and child health-care visits.

DSD for ART Refill visits

People established on ART (including PBFW) should be offered refills of ART lasting **3–6 months**, preferably six months if feasible. ART refills can either be provided at each clinical consultation visit or can be dispensed between clinical visits.

If ART refills take place at primary health care, they should be aligned with the scheduled maternal, newborn and child health visits in the same month.

ART refills should be provided as close to PBFW's homes as possible. Consideration could be given to delinking refill collection from maternal, newborn and child health care.

ART refills can be collected by individuals, including PBFW, (at facilities or at other distribution points) or by groups of clients (in a community ART distribution model).

DSD for ART Refill visits

WHO

As per the 2016 guidelines, trained and supervised lay providers and community healthcare workers can be able to distribute and dispense ART between clinical visits, to all adults (including PBFW).

Consideration can be given to using lay providers equivalent to mentor mothers for task shifting ART refill distribution.

WHAT

1. ART refill: If possible, family planning repeat visits should be aligned with ART refill visits. If oral contraception is provided, refills could be distributed along with ART refills.

2. Referral check: clear referral pathways should be put in place. Lay providers should always check whether there are any health or psychosocial concerns, requiring a referral to clinician

3. Adherence check including pill counts, pharmacy refill records and self-report.

4. MNCH check-in: Consideration could be given to lay providers checking to determine whether the woman is attending MNCH visits.

DSD for Psychosocial Support

WHEN

Every **1–6 months,** the frequency and duration of psychosocial support as appropriate for the pregnant or breastfeeding woman's needs**.**

Needs to both be available and accessible either as a package of support at ART refill visits or provided separately.

WHERE

Psychosocial support is ideally provided as close to PBFW's home. May be facility or out-of-facility based and either individual or group-based including peer support programmes such as mothers-to-mothers programmes and peer adolescent support groups for adolescent pregnant women living with HIV.

DSD for Psychosocial Support

WHO

Lay providers and peers

WHAT

1. Peer support: PBFW benefit from individual and/or group peer support, especially when integrating delivery, infant feeding and early childhood development support and guidance.

2. Referral check: clear referral pathways should be put in place. Every contact with a PBFW should be used for any health or psychosocial concerns, requiring a referral to clinician.

3. Onward disclosure support: Psychosocial support packages should consider supporting partner disclosure and involving the partner in ongoing care.

Conclusion

- **Pregnant women must be given choice of where to receive ART care, but this should be carefully coordinated with the required antenatal care contacts to avoid missed opportunities to obtain both high-quality and patient-centred antenatal care and ART care.**
- **Issues to consider in the assessment of choice may include the capacity and quality of HIV care in the maternal and child health-care setting, acceptability and proximity of alternative HIV care settings and the burden of HIV infection.**
- **When considering community- based DSD models, important to consider the need for clinical visits as there is the increased risk of other conditions (complications) from pregnancy and therefore consider special care to prevent or treat pregnancy-related risks, illnesses and death.**
- **Capacity building for management of pregnancy in DSD particularly identification of pregnancy related danger signs.**
- **Strengthening of management of transitioning between the maternal and child health (MCH) and routine ART care services.**

References

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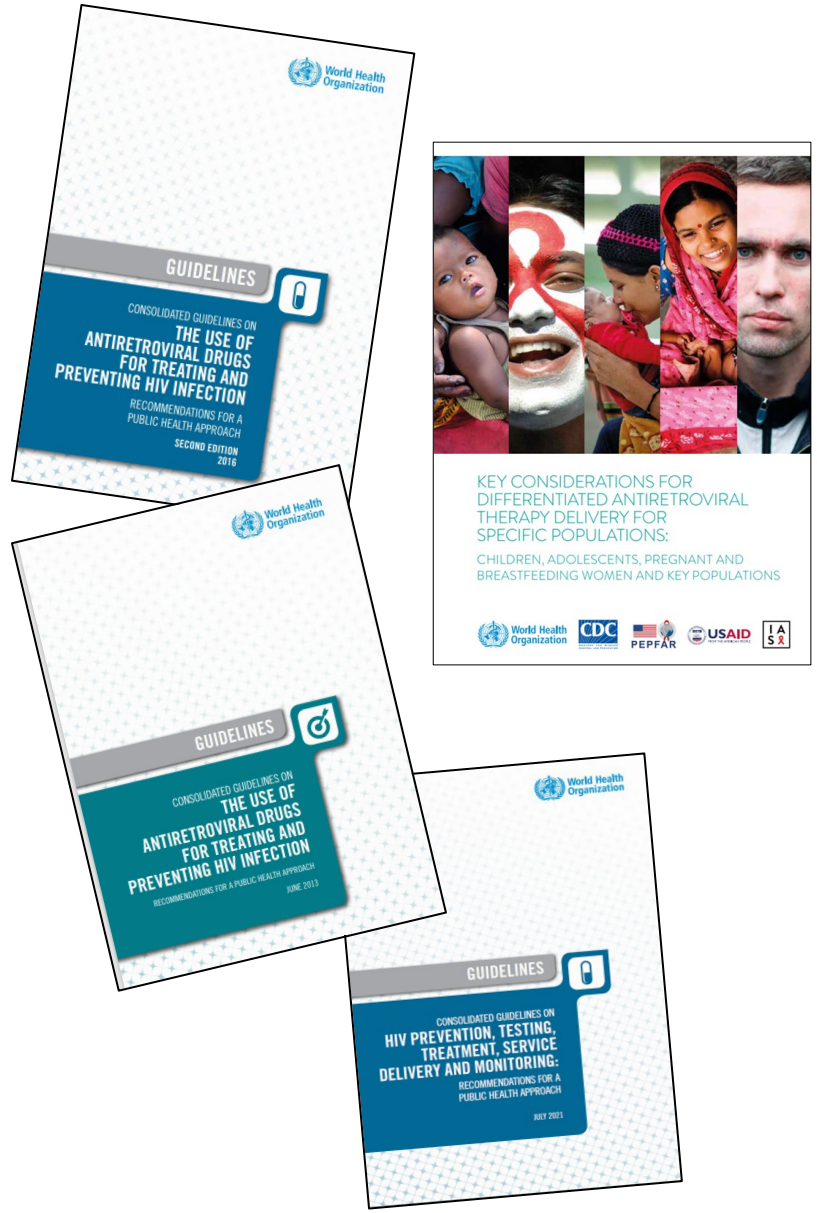

Thank You!

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