Swaziland Country Presentation:
M&E of DSD

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Swaziland National AIDS Programme
19th October 2017
When systems get overloaded......
Swaziland Health profile

- Population: 1.2 million
- HIV incidence
- HIV prevalence
- Four administrative regions
  - Regional management teams
- TB/HIV co-infection 70%
- MTCT 3% at 6 weeks
- ~290 health facilities
- 170 ART sites

- ART roll-out began in 2003
- 3 month refilling started in 2008
- Refilling-in-absentia started in 2008
- Test & Start started in Oct 2016
- RVLM started in 2012 but limited to 1 region
- RVLM expanded to all regions in Apr 2017
- Systems in place:
  - Paper system
  - APMR
  - RxSolution (pharmacy)
  - CMIS in place
Swaziland adopted the word **CommART** for DSD

CommART =

Community/Client Centred model of ART Service Delivery

- Does not mean giving ARVs in the community at will
- CommART identifies the Swaziland approach

**Synonyms:** DSD, DC, CCC
Guideline and SOP development process

- Feasibility informed by pilot projects
- Extensive consultation
- Lessons from 3 month refills
- A little patience to stakeholders is priceless
- Documents approved by the Directorate- MoH
# Swaziland CommART Roadmap

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## PHASE 1: Pilot/Trial phase

- **01/12:** Pilots across SWZ

## PHASE 2: Situational Analysis / Design

- **05/15:** Pilot Report

## PHASE 3: Implementation

- **2015-16:** CommART Steering Committee
- **Consultative meetings**
  - Mentors, Nurses
  - Doctors
  - Pharmacists
  - IAS
- **06/16:** Adoption of CommART care
- **09/16:** Printed copies released
- **11/16:** Trainings

## PHASE 4: MERL of DSD

- **2/17:** Guidelines distribution
- **3/17:** Progress monitoring

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**PHASE 1:** Pilot/Trial phase

**PHASE 2:** Situational Analysis / Design

**PHASE 3:** Implementation

**PHASE 4:** MERL of DSD
Why CommART?
Drivers…

- Increasing number of new ART patients e.g. from 16000 in 2013 to 25000 in 2016
- New ART guidelines, more well clients with economic commitments enrolling on ART
- HIV care HCWF has not significantly increased
- No significant change in capacity of healthcare facilities’ for chronic care demand

Saturation at ART service delivery points

Getting to Zero (Time to act now) ……. 
Why CommART? Let’s….

- Deliver services that best suits different needs of clients (*improve allocative efficiency*)
- Use resources in the least costly manner (*more cost-effective*)
  - **Resources?**: Time, money, human, infrastructural
- Configure health service resources in a way that release some of the resources to those that need them most without sacrificing any current quality standards (*more technically efficient*)
- Decongest in one way or the other [BUT does not necessarily mean less work]
- Decrease waiting time
- Improve psychosocial support and adherence
  - Reduce stigma & discrimination
Guiding principles for all models

1. Quality Services
2. Fully Informed and engaged client (co-responsibility)
3. Trust relationships (provider-client)
4. Flexibility
   - Customer focused approach
   - Super market Approach
   - Clients free to move between desired models
5. Confidentiality
6. Valid and Reliable Data
7. Reliable ART and laboratory supplies
Models of service delivery

- Mainstream ART delivery Model
- Outreach Model
- Facility ART Fast Track Model
- Community ART group Model
- Facility-based Treatment Club Model
Guidelines, Procedures and Trainings

- A policy document for CommART is available
- SOPs to facilitate implementation have been developed
- Training materials were developed containing:
  - Overview folder: guidelines
  - SOPs folder
    1. Fast Track
    2. CAGs
    3. Treatment clubs
    4. Outreach
Training materials

- 2.5 day training content
- Content guided by:
  - Guiding documents: guidelines and SOPs
  - Topical questions during consultative meetings
  - Lessons from CommART pilots
- A fully fledged **CommART curriculum** is not yet in place
- Content designed to target specific groups
  - doctors
  - pharmacists
  - mentors, TOTs
  - Stakeholders for sensitization purposes
## Facility Trainings: Hhohho, Lubombo

<table>
<thead>
<tr>
<th>Cluster</th>
<th>No. of ART sites</th>
<th>No. of sites received onsite training</th>
<th>No. of sites providing CommART</th>
<th>No. of HCWs trained offsite</th>
<th>Models implemented</th>
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## Facility Trainings: Manzini & Shiselweni

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<td>FT, CAG &amp; OM</td>
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# CommART M&E Roadmap

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<th>SEPT 2016</th>
<th>OCT 2016</th>
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<th>DEC 2016</th>
<th>JAN 2017</th>
<th>FEB-MAR</th>
<th>APR-MAY</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUG</th>
<th>SEP 2017</th>
<th>OCT 2017</th>
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## Milestones

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<th>Development of tools for CommART</th>
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<td>Pilot testing of tools to HMIS</td>
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<td>Revision of tools and consultations</td>
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<td>Consultative Field Visits - CQUIN</td>
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<td>Presentation of revised tools to HMIS</td>
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<td>CommART indicators &amp; data fields captured in JAD sessions</td>
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*NB: CommART indicators are expected in the next version of CMIS*
ART OUTREACH

Mobile teams from your facility bring ARVs to the community closer to you. You will have a schedule for their visits and you will be appointed accordingly, usually every 3 months. You may be required to go to the clinic for specific procedures as advised by the Health care worker.

To join you just have to ask your nurse or counsellor to help you register.
It is a group of clients who meet with other patients every 3 months at the facility for ART collection and group counselling. If you join a Treatment Club, you only need clinical consultation and counselling twice a year and blood collection when due.
Who can join TREATMENT CLUBS?

- Are you 18 years or older?
- Is your viral load undetectable?
- Have you been taking ARVs for more than 1 year?

TREATMENT CLUB

Reduces your time in the facility and helps you build up a support system in your community and within your peers.

To join you just have to ask your nurse or counsellor to help you register.
Early lessons

- Initially CommART was misunderstood
- Perceived to reduce quality of care
  - Dispensing and distribution outside pharmacies
  - Use of patients to distribute meds. in communities
  - Handling of bulk medicines at clubs meeting points
  - Possible mix up of medicines
- Emphasised on wellness
- Capitalised on previous care approach which closely linked to DSD
- Monitoring, Evaluation & Reporting of CommART?
Demystifying the subject

- Clients only choose FT and CAG
  - Not a problem, As long we give them all choices
- CommART is led by counsellors, ECs
  - Incorrect- CommART is a service approach within the existing facility structures
- Pharmacists not oriented on CommART
- No guidelines and SOPs to facilitate implementation
- No M&E plan
Status of implementation
Current Status of DSD Model Implementation

- Number of sites implementing DSD = 95
- Number of patients enrolled in DSD Models = ??
## Implementation across 4 regions

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<tr>
<th>Model</th>
<th>Hhohho</th>
<th>Lubombo</th>
<th>Manzini</th>
<th>Shiselweni</th>
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<td>No. of sites</td>
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<td>Treatment Clubs</td>
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<tr>
<td>- Family centred approach</td>
<td>4 clubs</td>
<td>418 ART clients</td>
<td>4 30 U-Tech</td>
<td>20 SOS</td>
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<tr>
<td>Treatment Clubs</td>
<td>16</td>
<td>700</td>
<td>2 500</td>
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<tr>
<td>Community ART Groups (CAGs)</td>
<td>2 20 CAGs</td>
<td>1 10 CAGs 50</td>
<td>3 609 clients</td>
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<tr>
<td>Outreach</td>
<td>2</td>
<td>4 31 outr. sites</td>
<td>1 1110 clients</td>
<td>1 2 99 clients</td>
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<tr>
<td>Fast Track</td>
<td>3 422 clients</td>
<td>1 115 clients</td>
<td>8</td>
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M&E
M&E structure and systems

- SID provide support to the program on all data collection, analysis and reporting needs
  - **HMIS**: data tools, data systems, data collection & indicator protocols
  - **M&E**: Data analysis and generation of reports
  - **HISCC**: Committee guiding introduction of new tools and indicators
- Facilities reports to the Regional SID. Regional data is aggregated at national level
- ART facilities operate in a mother baby pairing system
  - APMR systems is only at mother sites, baby sites’ data is send to mother sites for entry and reporting
  - Other systems: Paper-based (manual), CMIS
- APMR is currently be replaced
Client Management Information System (CMIS)

- Real time, web based,
- Installation at all sites, currently 72 live sites
- Linked to HA database using the national ID as the unique identifier
- Currently being revised and updated to version 2
CommART/ DSD M&E

- Registers developed in 2016
- 1st discussed at HISCC in Nov 2016
- Received technical support from CQUIN in June 2017
- Worked together with HMIS, M&E and DSD implementing sites to finalise required data elements, indicators and adjustments necessary to CMIS
- Paper elements approved in August 2017 and are in use at selected sites
- Conducted a CMIS Joint Application Development (JAD) workshop in Sept 2017
- JAD incorporated the new data fields for DSD and will be available once version 2 goes live.
# CAG Register

## Community ART Group Registration

### Group Details

<table>
<thead>
<tr>
<th>Client No.</th>
<th>Client Name</th>
<th>Grade</th>
<th>Age</th>
<th>Group members</th>
<th>ART Regimen at Enrollment</th>
<th>Date of Enrollment (dd/mm/yyyy)</th>
<th>Date of V.L. Test Done (dd/mm/yyyy)</th>
<th>Changed to other care model (Case ID)</th>
<th>Outcome</th>
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### Group Members' Enrollment Data

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### Outcome

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*Getting to Zero (Time to act now) .....*
# Club register

## Treatment Clubs

<table>
<thead>
<tr>
<th>Treatment Club Name</th>
<th>Treatment Club start date</th>
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</table>

## Clinical data at enrolment

<table>
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<tr>
<th>Gender</th>
<th>Age</th>
<th>ART number</th>
<th>ART start date</th>
<th>Date joined club</th>
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<td>1. Real time</td>
<td>1. Teething challenges</td>
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<td>2. Links sites</td>
<td>2. Requires HiTech infrastructure</td>
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<td>3. Centrally managed</td>
<td>3. Speed: not user friendly</td>
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<td>4. Allows for flexibility in light of ever changing indicators</td>
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<td>5. Links data well from different service points using ID as unique identifier</td>
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How services are differentiated

Five models

1. Mainstream care (existing) - HCW led
2. Fast track - HCW led
3. Treatment club - HCW plus group distribution of medicines
4. Community ART group - client distribution of medicines
5. Outreach - HCW led
Proposed indicators for M&E of non-mainstream models under CommART

1. Number of patients enrolled in non-mainstream ART models at the beginning of the period
2. Number/percentage of newly-eligible ART patients initiating ART model
3. Number/percentage of all eligible patients receiving care under non-mainstream ART models
4. Number/percentage of patients with a clinical assessment at the health facility 12 months after initiating ART model
5. Number/percentage of patients receiving DSD who received a VL test 12 months after initiating ART model
6. Number/percentage of patients receiving DSD who are virally suppressed 12 months after initiating ART model
7. Number/percentage of patients receiving DSD model with the following outcomes 12 months after initiating ART model:
   a. Lost to follow-up or stopped ART
   b. Dead
Goals of participation in CoP

- To learn from from other countries their experiences regarding:
  - Acceptability
  - Implementation
  - Monitoring
  - Outcome: effectiveness,

- To share our own experiences and lessons with other countries:
  - guideline development process
  - Indicators
  - Reporting
Acknowledgement

- MoH Directorate
- RHMT
- RAC
- HCWs
- PEPFAR & EGPAF
- SID
- SNAP, NTCP & SRHU
- SWANNEPHA
THANK YOU