Taking Differentiated Service Delivery to Scale in Eswatini: Focusing on Quality and Coverage

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BACKGROUND

The Kingdom of Eswatini has made significant progress in curbing the HIV epidemic with 92% of people living with HIV aware of their status; 86% of people living with HIV on antiretroviral therapy (ART); and 81% viral suppression among those on ART in 2018 (UNAIDS 2019).

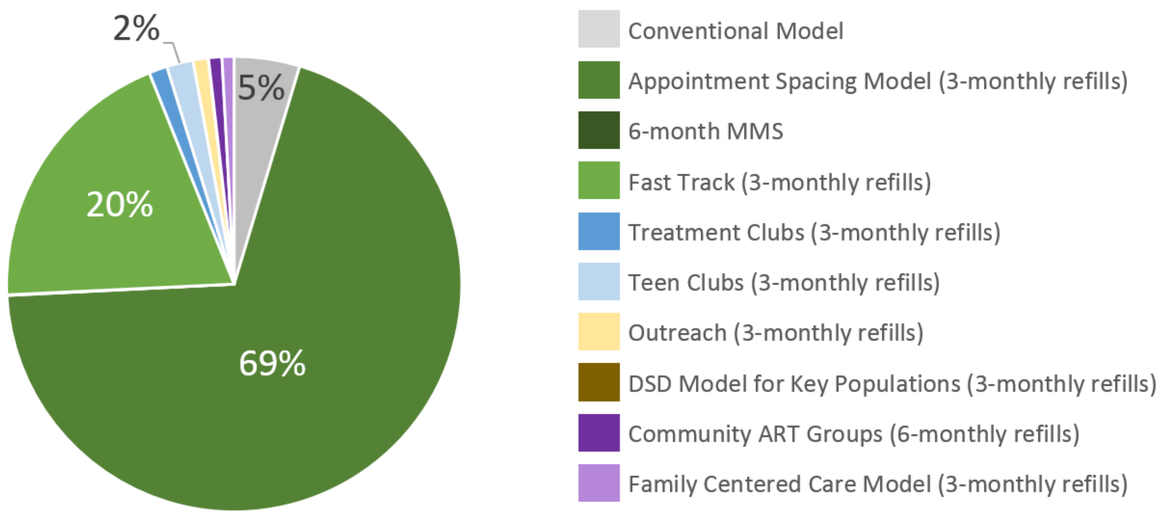
The Eswatini Ministry of Health (MOH), through the Eswatini National AIDS Programme (SNAP), has been implementing differentiated service delivery (DSD) since 2014. A DSD technical working group (TWG) was established in November 2017 to guide and oversee DSD implementation. It has now evolved to include the membership of recipients of care, who are involved in the planning, implementation, and monitoring of DSD and other HIV-related activities. DSD quality standards, which define quality services offered at the health facility, have been developed and incorporated into the National HIV Standards. Currently the quality standards assess how DSD services are generally offered at the facility. The country is working to adopt a new version of quality standards, which will have a component to assess the fidelity of DSD models.

DSD IMPLEMENTATION

Currently, eight less-intensive DSD models (DSDM) for ART are available in Eswatini, including three facility-based individual models—**Appointment Spacing** (3-month MMS), **6-Month MMS,** and **Appointment Spacing + Fast Track;** two facility-based group models—**Treatment Clubs** (for general patient populations) and **Teen Clubs;** two community-based individual models—**Outreach** and a **DSD Model for Key Populations;** and one community-based group model—**Community Adherence Group (CAG).**

Eswatini expanded Teen Club services to include ART refills after learning from Malawi on a CQUIN-supported South-to-South visit. Initially, Teen Clubs in Eswatini were focused on adherence and psychosocial support but now, following the demonstration of the Malawi model, eligible children and adolescents receive their antiretroviral (ARV) medication during the Teen Club meetings. The national DSD guidelines and standard operating protocols (SOP) have been updated accordingly.

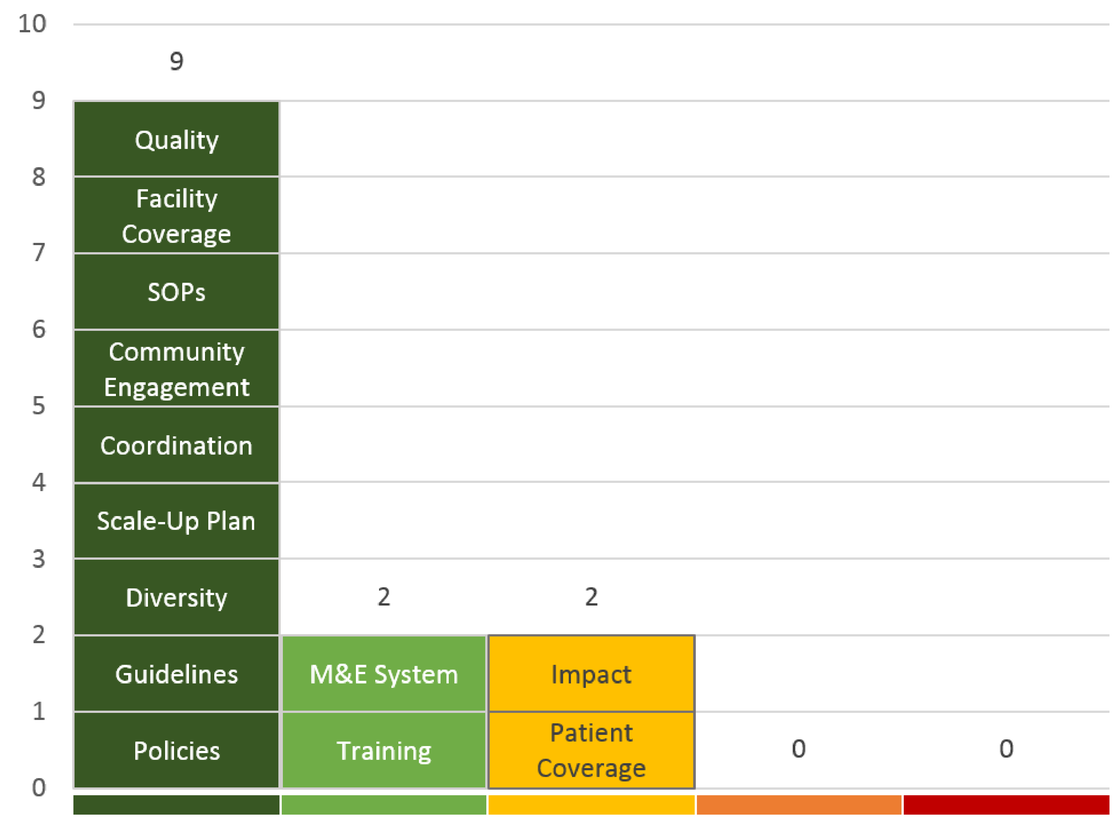
Figure 1: DSD Model Mix, June 2019



As of October 2019, there were 153 ART sites in Eswatini that were eligible to offer DSD models, of those, 123 (80%) offer at least one DSDM. Figure 1 describes patient coverage of different models of ART services, including the more-intensive conventional model ("standard of care") and the eight less-intensive models. Other than the 6-month MMS model (which, as the name implies, features 6-month ART refills), all less-intensive models include 3-month ART refills as part of the model guidelines. Based on data from the national health management information system and implementing partner reporting from June 2019, it is estimated that 95% of people on ART were enrolled in a less-intensive model (95%) vs. only 5% in the conventional model. The majority of all those current on ART (69%) were enrolled in the appointment spacing model. A further 20% were enrolled in the Fast Track model, and enrollment in all other models accounted for 2% or less of those on ART.

DSD DASHBOARD

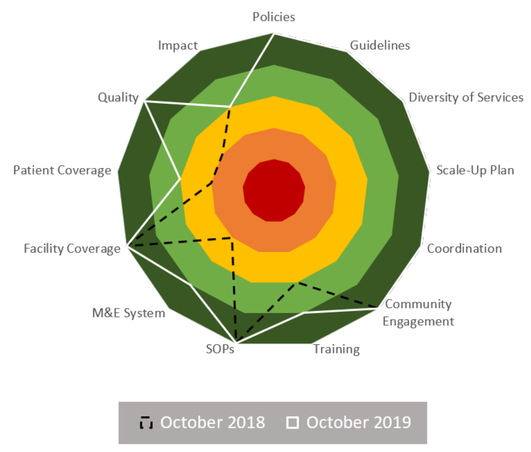
Figure 2: Dashboard Results 2019



The CQUIN DSD Dashboard (Figure 2) assesses the maturity of national DSD programs. In October 2019, Eswatini ranked nine domains at the highest possible level.

Figure 3 describes the progress Eswatini has achieved between October 2018 and October of 2019, with advancements in the Training domain which moved from yellow to light green.

Figure 3: Dashboard Results 2018 *vs.* 2019



CASE STUDY/BEST PRACTICE

In 2018-2019, Eswatini initiated a Quality Improvement project in three high-volume health facilities motivated by the low enrollment of clients in DSD, which was attributed to poor utilization of viral load (VL) results and inconsistent provider knowledge of DSD. Health facilities were selected for inclusion in the project based on having more than 1,000 patients on ART, regional variation, and receipt of support from implementing partners (IPs). A representative from each health facility attended a workshop, and MOH staff shared feedback from the workshop with each health facility, conducted mentorship and supervision visits, and convened two experience sharing meetings. Throughout the process DSD quality assessment tools were used for the first time to assess the quality of DSD services offered at the three health facilities. The Quality Improvement Project improved uptake of DSD. Lessons learned from the project motivated the MOH to extend the initiative to 23 health facilities to improve utilization of VL results.

NEXT STEPS/WAY FORWARD

- The Eswatini MOH and IPs are conducting a study at 39 health facilities to assess client and healthcare worker satisfaction with DSD services.
- The national M&E system is not yet able to efficiently report DSD-specific data from health facilities to the central level. DSD data will be routinely reported when the updated version of CMIS is fully functional and deployed to all health facilities.
- A representative from M&E will fully join the DSD Sub-TWG to provide updates on M&E facilitate the design of a system with routinely-reported DSD indicators.
- The TB/HIV sub-unit at SNAP and the National TB program are collaborating to improve a data collection tool used in the community by clients enrolled in CAGs.