M&E of DSD: Zimbabwe

M and E Community of Practice

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Country HIV Perspective

- Zimbabwe remain one of the countries in the world heavily burdened by HIV/AIDS & TB
  - ***1.33M PLHIV*** (7% are children)
  - ***HIV Prevalence: 13.8%*** among 15-49 yr age group
    - Female 16.7%
    - Male 10.5%
  - ***HIV Incidence: 0.48*** in 2016 (down from 1.42 in 2011, 0.98 in 2013)
  - Need for PMTCT 65,158
  - **MTCT rate 5.24%**
  - TB/HIV co-infectivity rate 72%

Total Popn ~ 13 million (2012 Census)

Current Status of DSD Model Implementation

- **Models being implemented, or planned for implementation, as described in the OSDM**
  - Fast-track, outreach, family clubs, CARGs
- **DSD programmatically is still in its infancy**
  - Variations across facilities/country: implementing partners use their own guidelines so facilities that have been using DSD for some time are different from those newly rolling out models (using the OSDM as a guide)
  - OSDM and Job Aide only give minimum standards, national guidelines are in development
- **Models being implemented**
  - Community ART Refill groups
  - Club Refill Groups (CATS model for Adolescents)
  - Fast Track Refill
  - Family Refill Model
  - Outreach Refill
- **Why these models?**
  - Decongesting health facilities in anticipation of increased numbers with Treat All
  - To sustain long term retention of stable ART patients by easing their access related burdens(time, cost, distance...)
  - They allow/tape into community based peer patient support and patient self care, thus promoting active participation of clients in service delivery
  - To simply the follow up of stable patient by allowing flexibilities in term of lengthy supplies
  - Optimize community based patient tracing capacity through use established social networks of patients

- Models planned for implementation (if applicable)
  - All models are being implemented to some extend
    - CARGs implementation more than others as this was being piloted in the last 2 years
    - Outreach was also being done but affected by resource constraints
    - Club refills and Fast track to be actively implemented as they were not widespread
  - What drives decision to implement new models
    - Facility problem identification – provider challenges and client challenges e.g. congestion at facilities, distance to the facilities, costs incurred by clients in travel, need for psychosocial support etc

- Number of sites implementing DSD
  - All 10 provinces are in various stages of DSD implementation
  - Recent trainings and sensitisations done for DSD models in the OSDM
  - Currently data collected shows that CARGs have been widely implemented since pilot
  - As at end of June 2017, there were 36 districts (of 64 districts) that were formally implementing CARGs with approximately 191 facilities in these districts implementing CARGS
- Number of patients enrolled in DSD Models
  - CARGs - in the implementing facilities, proportions of clients enrolled in CARGs vs those enrolled in Care ranged for 5.7%-48.6%

Procedures and Trainings

- SOPs recently developed and packaged in the OSDM and Job Aid
- National and provincial (10) trainings done by 1st week of July
- Five (5) provinces further cascaded trainings to district facilities. The other 5 are still planning and resource mobilising
- Parties involved in designing tools
  - Stakeholder consultations between MoHCC, partners, CSOs and PLHIV were done to define the scope of DSD and also the challenges seen in health provision
  - Consultation was sought for the development and design of the tools. Tools for CARGs were adopted from MSF and adapted to suit Ministry needs.
  - Consultation was also sought for the national trainings and the set up of learning sites for DSD models. Trainings to be done in a cascade i.e. from national level, provincial then district level on all available platforms and largely through mentorship
- Results in the field/Reception by HCW
  - Reception was good, anticipated challenges were quickly highlighted and discussions were done around how to address the challenges
  - 50% of provinces are done with lower level trainings are have started implementation.

Elements of M&E System

- Strengths and weaknesses of the system
  - **A number of adaptations were made and with lessons already drawn from the pilot, there are plans to review the system to ensure it captures other additional DSD variables**
  - There currently is community ART Initiation in selected districts supported by MOHCC partners using a mix of MOHCC and partner staff
  - Traditional M&E focuses at facility-held medical records, needs to adapt to community activities
  - Need for demo projects: outreach for HIV testing, ART initiation with strong retention through linking clients to local facilities.
  - M&E systems need to be strengthen to be able to capture ART and HTS community transactions and patient flow from community to facilities. Data elements will mostly be the same as those currently being collected in facilities.
  - Electronising data collection and management systems remains a top priority for the country.

- What tools are currently in use?
  - Tools currently in use are a mix of paper and electronic. Various initiatives are underway to pilot other e-records before integration into ePMS.
  - A very consultative process which included HCWs from facility, district, provincial and national levels, MOHCC, UN Flagship, PEPFAR-supported organizations.
  - The process always builds on existing tools

Elements of M&E System

- **M&E tools (patient card, EPMS database) were updated with data elements specific to DSD:** *Visit type*.
- **Gaps: monitoring at community level**
  - Traditional M&E focuses at facility-held medical records, needs to adapt to community activities
  - Demo projects: outreach for testing, initiation, retained on community model for 4 mo., then transitioned to local facilities, but always flagged as Pts coming from community interventions
  - Community ART Initiation: supported by NGOs, one using MOH staff and one that hired own staff
  - Data collected will be same as that collected in facility, may be rearranged/different format--plan to move to electronic collection
  - Hope to integrate clinic and community-based data elements into one reporting tool

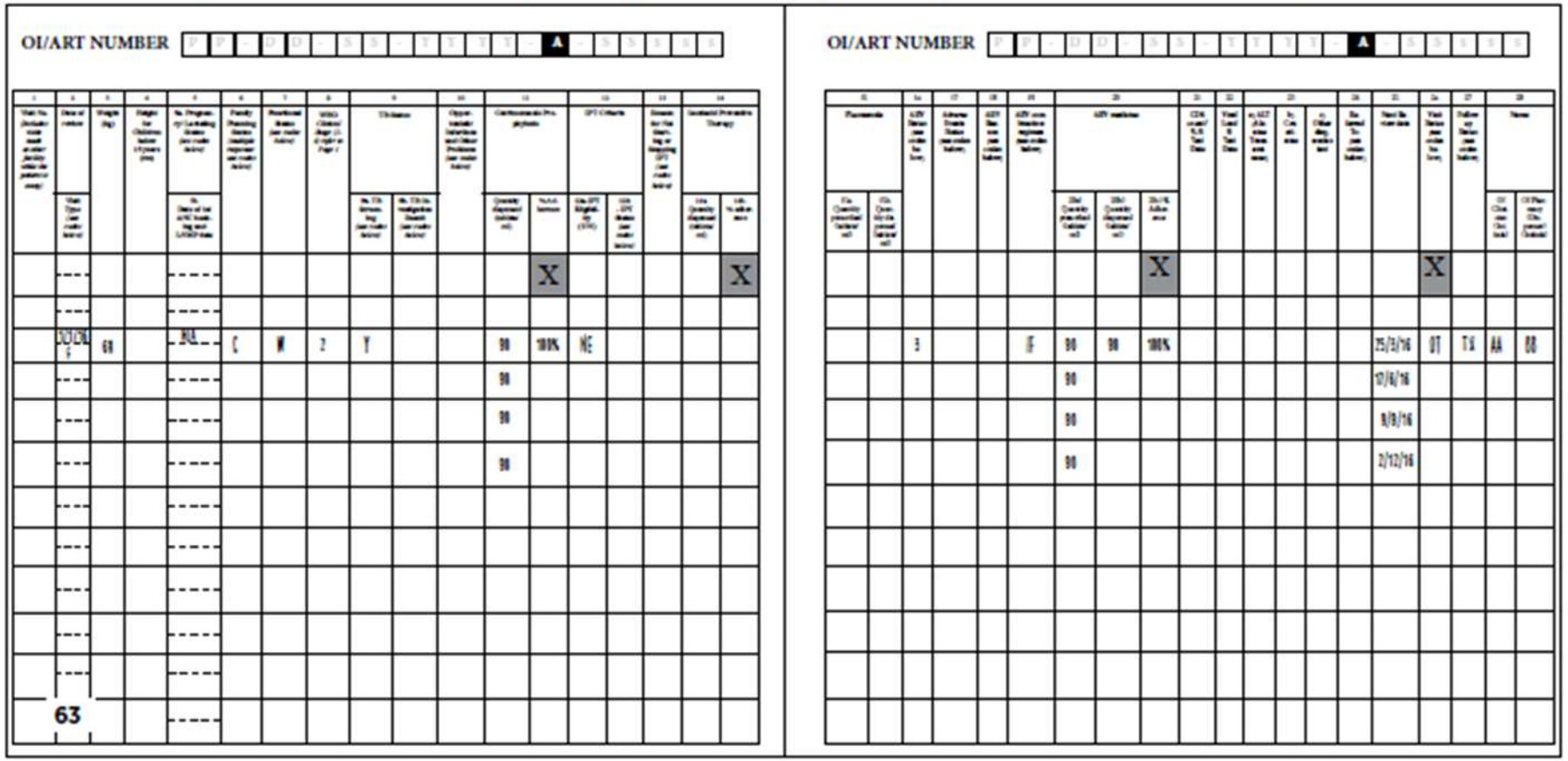
- **Patient card: visit type field coded for models**
  - Unclear how visit field is filled out for absent members during CARG ART pickup, or for fast track patient at 6-monthly clinic visit

- **Electronic system, EPMS, has same data elements as patient ART card (including visit type)**
  - EPMS: 700,000 cases in system out of 1M Pts, not used in all facilities, prioritized high-volume sites;
  - A target of 1,000 sites out of 1,600 sites by December 2017

Elements of M&E System

Documentation in patient care and treatment booklet

- Column 2 now indicates the code for the type of ART refill model the client has selected.
- For today's clinical visit, complete all columns.
- To prescribe medication for subsequent one (if no VL monitoring) or three (where VL monitoring) refills, complete columns 11, 20a and 25



Facility ART Club Register

Facility "club" group register									
Facility name:					Meeting time:				
Club number:									
Club member number	ART number	Full name	Sex	Date of birth	Mobile number	Date ART initiation	Date joined club	Date permanently left club	Reason left club*
1				../../....		../../....	../../....	../../....	
2				../../....		../../....	../../....	../../....	
3				../../....		../../....	../../....	../../....	
4				../../....		../../....	../../....	../../....	
5				../../....		../../....	../../....	../../....	
6				../../....		../../....	../../....	../../....	
7				../../....		../../....	../../....	../../....	
8				../../....		../../....	../../....	../../....	
9				../../....		../../....	../../....	../../....	
10				../../....		../../....	../../....	../../....	
11				../../....		../../....	../../....	../../....	
12				../../....		../../....	../../....	../../....	
13				../../....		../../....	../../....	../../....	
14				../../....		../../....	../../....	../../....	
15				../../....		../../....	../../....	../../....	
16				../../....		../../....	../../....	../../....	
17				../../....		../../....	../../....	../../....	
18				../../....		../../....	../../....	../../....	
19				../../....		../../....	../../....	../../....	
20				../../....		../../....	../../....	../../....	
*Reason for leaving club: 1. TFO 2. Moved to another club 3. Permanently returned to clinic care 4. LTFU 5. Died 6. Other									
Club appointment dates									
../../....		../../....		../../....		../../....			
../../....		../../....		../../....		../../....			
../../....		../../....		../../....		../../....			
../../....		../../....		../../....		../../....			

CARG Group Register

CARG group register									
Facility name:			Group leader name:				Meeting area:		
CARG number:			Group leader contact number:						
CARG member number	ART number	Full name	Sex	DOB	Mobile number	Date ART initiation	Date joined CARG	Date perma-nently left CARG	Reason left CARG*
1				../../....		../../....	../../....	../../....	
2				../../....		../../....	../../....	../../....	
3				../../....		../../....	../../....	../../....	
4				../../....		../../....	../../....	../../....	
5				../../....		../../....	../../....	../../....	
6				../../....		../../....	../../....	../../....	
7				../../....		../../....	../../....	../../....	
8				../../....		../../....	../../....	../../....	
9				../../....		../../....	../../....	../../....	
10				../../....		../../....	../../....	../../....	
11				../../....		../../....	../../....	../../....	
12				../../....		../../....	../../....	../../....	
*Reason for leaving CARG: 1. TFO 2. Moved to other CARG 3. Permanently returned to clinic care 4. LTFU 5. Died 6. Other									
CARG appointment dates									
../../....		../../....		../../....		../../....			
../../....		../../....		../../....		../../....			
../../....		../../....		../../....		../../....			
../../....		../../....		../../....		../../....			

Community ART group register

CARG Refill Form

Community ART group refill monitoring form														
Facility name:							CARG number:							
Date group meeting before refill ../../...							Signature of group leader:							
Date ART prescribed by nurse ../../...							Signature of nurse:							
Date ARVs distributed ../../...														
	To be completed By Group Leader						To be completed by nurse				To be completed By CAG member			
CARG member number	Full name	Pregnant (P) or on family planning (FP)	TB symptoms* Y/N	Other "alert" problems**	ARV tablets remaining	CTX tablets remaining	ARV regimen prescribed / quantity	CTX quantity prescribed	VL result (CD4 if not available)	Date VL	Full name	Signature of recipient	Date drugs received	Comments (include any reason for temporary clinic follow up)
1										../../...			../../...	
2										../../...			../../...	
3										../../...			../../...	
4										../../...			../../...	
5										../../...			../../...	
6										../../...			../../...	
7										../../...			../../...	
8										../../...			../../...	
9										../../...			../../...	
10										../../...			../../...	
11										../../...			../../...	
12										../../...			../../...	
*TB symptoms: Ask if the member has a current cough of any duration, is losing weight, has night sweats or has had contact with TB patient in last month														
**Alert problems: Ask if the member has any ankle swelling, puffiness of the face, breathlessness, diarrhea for more than 2 weeks, severe headache														

Elements of M&E System

- Data elements and indicators
  - A series of workshops at national, provincial and district levels leading to consolidation of indicators.
  - There is urgent need to strengthen DSD data systems by re-engaging stakeholders.
  -

- How is data collected and used
  - Data are collected at facilities on every client's visit and at community-level for monitoring activities at that level.
  - Currently available data may not be enough to fully evaluate or assess programme performance
  - Data are used at all levels of the health system and there exists more opportunities to promote data utilization.

Goals for participation in this CoP

- What parts of your country's experience do you think could help other countries?
  - Engagement of key stakeholders including PLHIV in indicator selection and data management.
  - HIV Case-based Surveillance and patient monitoring initiative at all facilities
  - Use of electronic systems in patient management

- What is your team most interested in learning from other countries about M&E of DSD?

  - Guidance on selection of key DSDM indicators
  - Review of existing M&E tools
  - Guidance on integrating DSD M&E with traditional M&E, avoiding parallel systems
  - Guidance on eligibility criteria (adherence, psychosocial elements) for data element