The CQUIN Learning Network
Annual Meeting

Navigating DSD M&E in EGPAF supported programs

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Elizabeth Glaser Pediatric AIDS Foundation, Washington D.C.

February 13-15
Maputo, Mozambique

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

ICAP
GLOBAL. HEALTH. ACTION.
Columbia University
Mailman School of Public Health

EGPAF supported countries, sites & clients

EGPAF Globally

5,257 Health facilities supported

27,311,791 Pregnant women reached with PMTCT services

1,796,625 Women on ARV

923,226 Individuals receiving ART

EGPAF/Ariel has provided over 27 million women with services to prevent transmission of HIV

Choose a country:

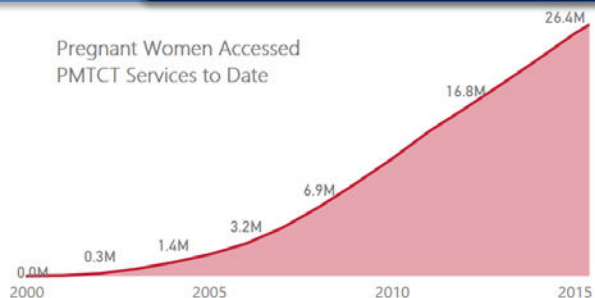Select All | Cameroon | Cote d'Ivoire | DRC | India | Kenya | Lesotho | Malawi | Mozambique | Rwanda | Swaziland | Tanzania | Uganda | Zambia | Zimbabwe

Pregnant Women Accessed PMTCT Services to Date

26.4M
16.8M
6.9M
3.2M
1.4M
0.3M
0.0M
2000 — 2005 — 2010 — 2015

Impact

301,969 Number of HIV Infections Averted

86,940 Number of Lives Saved due to ART

Activities
- Advocacy
- EGPAF Office
- Program Implementation
- Research
- Technical Assistance

Map data ©2018 Google, INEGI

Source: www.pedaids.org (Data: June, 2017)
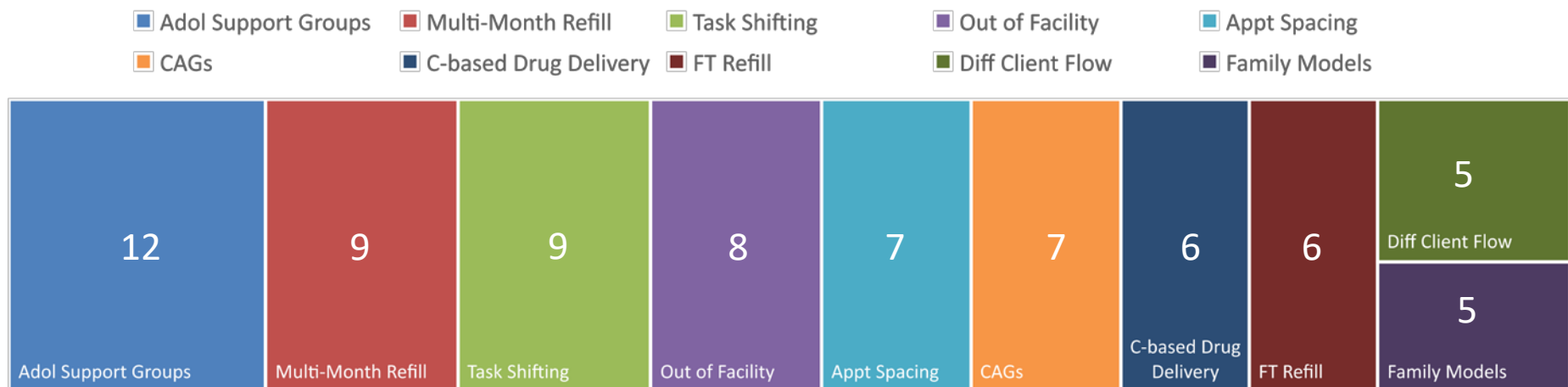
Differentiated Service Delivery at EGPAF

DSD Focus:

- Programming, Research and Advocacy
- Pediatrics, pregnant women and family models
- Scale up evidence-based models

DSD MER Focus:

- Access, linkage, retention, suppression
- Acceptability, satisfaction, efficiency/productivity, quality, cost, outcomes

Coverage of select DSD Models in EGPAF-supported countries (n = 12)

- Adol Support Groups
- Multi-Month Refill
- Task Shifting
- Out of Facility
- Appt Spacing
- CAGs
- C-based Drug Delivery
- FT Refill
- Diff Client Flow
- Family Models

Adol Support Groups	Multi-Month Refill	Task Shifting	Out of Facility	Appt Spacing	CAGs	C-based Drug Delivery	FT Refill	Diff Client Flow / Family Models
12	9	9	8	7	7	6	6	5 / 5

M&E Strategy – Data Collection and Reporting

M&E in national **guidelines** and DSD **training** curricula

Existing data collection tools (cards, files, registers) with DSD codes

New collection & reporting tools

SOPs to guide data capture

DSD Cohort in **Open MRS** - Uganda

Aligned to **national HMIS reporting cycle**

Facility

Community

FBIM   FBG   FTDR   CDDP   CCLAD

CCLAD Form

Clinician

Triage Nurse

Clinician

HIV Care/ART Card

HIV Care/ART Card

EMRS

ART Register

Reporting
(HMIS 105, 106a)

DHIS2
(HF or District)

SOP for records and data management of DCM patient files

Client paper based file

1. Introduce a code "DCM" to the patient clinic number on the file folder. For example if the patient clinic number is 105 then the patient new ID is "105 - DCM". This will work for as long as the client has is on the DCM program.

   NOTE: Don't change patient clinic number in the Pre-ART and ART registers for smartness issues.

2. The same code "DCM" should be introduced in the filing system on the file suspenders (on the clear tabs). **NOTE:** The HIV care cards **MUST** be kept in the filing shelves.

1034   1034 - DCM

Electronic data management - OpenMRS

1. Introduce the code "DCM" to the OpenMRS, by doing the following steps:

Source: EGPAF & MoH Uganda, 2016

FBIM – facility based individual management
FBG – facility based groups
FTDR – fast track drug refills
CDDP – community Drug Distribution Points
CCLAD – community Client Led ART delivery

"There's a tool for that"

Community Drug Distribution Points

Community Art Groups

Community Client-led ART Delivery

DSD Quarterly Report

M&E Job Aids

DSD Registers; Family Model Register

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Source: EGPAF Uganda, Kenya, Lesotho

5

Adapting M&E tools and systems to a CAG model - Kenya

- **5** Health Facilities (3.7% of 134 sites) with at least 1 Community ART Group (6 total)
- **Implemented 3 groups in Lwanda Gwasi targeting Fisher Folk** - "very well received by the groups"

Lwanda Gwasi Fisher Folk – Homabay, Kenya (EGPAF TIMIZA-90 Project)

6-member CAGs formed at facility

One member collects drugs monthly; receives care

CAG meeting; drug delivery to group members

Quarterly CAG meeting attended by EGPAF Staff

DMOC Register

Appointment Card
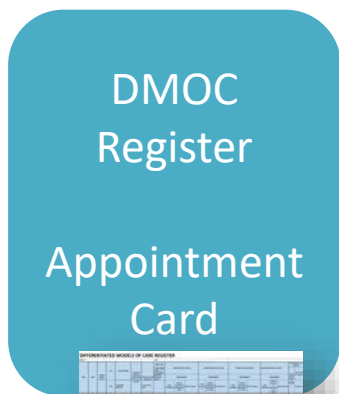
ART Register

Dispensing Log

CAG Meeting Minutes

Peer educator reports to EGPAF

OCT TO SEP 2017

Results

64,108

52% of Total on ART

33,178

24% of Stable PLHIV

8,007

Total Tx Current — Total No of Stable PLHIV — Total Number of Stable patients on DC

- Total Tx Current
- Total No of Stable PLHIV
- Total Number of Stable patients on DC
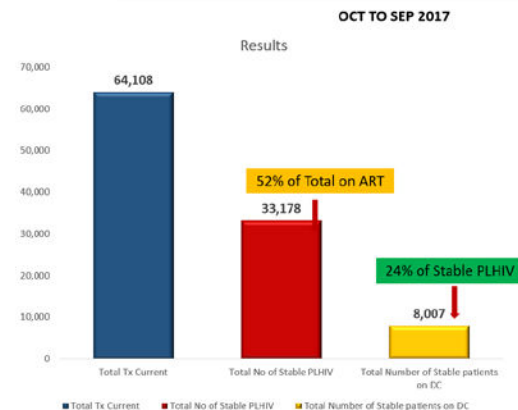
Source: USAID TIMIZA 90 Project, Kenya (Feb 2018)

Adapting M&E tools and systems to a CAG model - Lesotho

Good practices

- Separate **filing system** for CAGS
- **CAG registers** provide data on group progress: growth, red flags (retention)
  - Gender disaggregation; status of CAG membership
- CAG clinical **monitoring teams** to support updating of patients files
- **Index testing tool** for family members (+ children) and partners

Challenges

- Red flag monitoring or resolution challenging due to **timing of CAG meetings** (often in the evenings); can lead to group collapse
- Data collection **tools not updated** by the health facility personnel (dependency on CSOs or trained community members)

What do health care providers think?

- 10% (5) respondents unsatisfied with **organization of medical records**. *(Dispenser, medical, clinical and nursing officers)*
- 4 (8%) dissatisfied with **efficiency of drug pick-ups** *(1 Dispenser, 2 medical officers, 1 Nursing officer)*
- 15% (7) do not believe they have **adequate time with clients** under DSD
- 17% (8) do not think they have **sufficient equipment and tools** to perform what is expected of them under DSD *(3 nurses, 3 medical officers)*

Cadre	Number
Dispenser	1
Clinical Officer	4
Medical Officer	8
Clinician	3
Counselor	4
Nursing Officer	13
Enrolled Nurse	1
Data Clerk	13
Vector Control Officer	1

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Source: USAID RHITTES Project, Uganda (Dec, 2016)

M&E Challenges

- Human Resources:
  - *Capacity, absenteeism and turnover*
  - Intensive **data collection** (physical file counts)
  - Inconsistent documentation of **DSD codes** or **multi-month dispensing**
- Limited **time** between data collection and reporting
- Monitoring @ **community level** e.g. filing system for CAG ill defined
- Limited capacity of **lab system** to process VL (affects attendance, documentation of results, client misclassification)
- Breakdown and/or inconsistent use of **EMR systems**
- Monitoring **key and priority populations**

Recommendations

- **Coding** specific to DSDM key to tracking outcomes

- Increase **lab capacity** since VL adopted as standard of care

- Functional and up to date (electronic) **medical records systems** would improve categorization, monitoring, reporting and tracking of outcomes

- The points of data capture within the **client flow** system should be known, have the appropriate tools and responsible persons in place

- **Evaluations** are critical in assessing impact of DSD on **quality** of patient care

Outcomes of DM of ART delivery (multi-months dispensing and community ART distribution for stable clients) - *Lesotho*

Uptake of key interventions for patients with **advanced HIV disease** in DSD model - *Lesotho*

Feasibility, acceptability and cost-effectiveness of differentiated community ART delivery - *Zambia*

Effect of **home-based family index testing** on yield, linkage and enrollment and retention - *Tanzania*

Effect of **male friendly services** on uptake of HIV testing - *Malawi*

Assessing CAGs and FP uptake among stable HIV infected women of reproductive age

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