



# Implementation of the Outreach Model in Mwenezi, Zimbabwe, 2017

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## BACKGROUND

- Piloting of implementation of differentiated service delivery has been going on in Zimbabwe since 2014
- Differentiated service delivery cuts across the whole HIV cascade, from HIV prevention to clients refills ensuring adherence and retention in care
- The Ministry of Health in partnership with MSF implemented the outreach model for differentiated service delivery in Mwenezi district, Masvingo province, Zimbabwe
- Mwenezi district is the second largest district in Masvingo province
- It has 14.9% HIV prevalence in 15 to 49 age group (ZIMPHIA 2016)
- Literacy rates are as low as 50% in some places
- Ecological farming region 4 & 5 - drought prone (poor food security) with large scale commercial farms and game parks
- The district has a highly mobile younger population who usually migrate to South Africa in search of employment
- Seventeen percent (17%) of the pop has ready access to health facilities whilst 83% travel between 15-200 Km to reach one
- This defined the role of outreach - to ensure access to care
- During land reform program of year 2000 people moved from the area with health centers into previous ranching areas (dark green areas on the map)

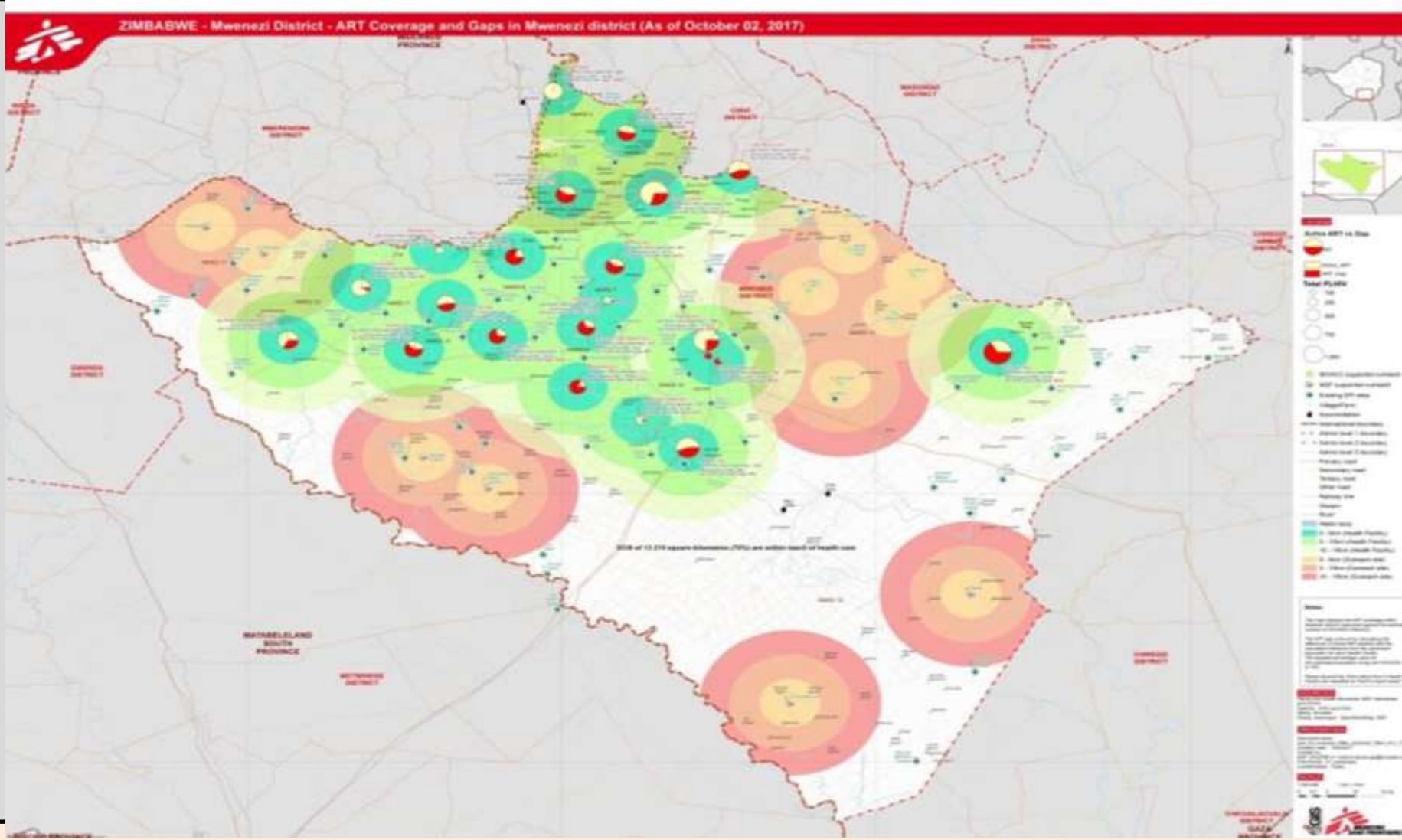
## METHODS

- District mapping was done and 5 outreach sites were done (Shown in Table 1)
- An outreach package for each outreach point included general clinical consultations, HIV testing services, ART initiation for new clients and chronic follow up of clients on ART with service differentiation in some sites, as well as TB screening and clinical monitoring using CD4 counts and viral load testing.
- Other services offered included community mobilisation for HIV services, health promotion and reproductive health services.
- New sites were visited once every two weeks and older sites once a month with plans to reduce using differentiated care models for drug pick - ups.
- Resources needed included: 4 vehicles to carry staff, tents, registers etc. Teams comprising a medical doctor, 4 nurses and 2 counsellors, data entry clerks, dispensary assistant, overnight accommodation, fuel, and allowances.

**Table 1: Distances Covered to Outreach Points, Mwenezi, 2016 - 2017**

Outreach Site (MSF –Supported)	Distance
Chovelele	171 km
Velkom(BubyeRange)	40 km
Chipangayi	60 km
Makugwe	158 km
Turf	100 km
Mateke	120 km

**Figure 2: GIS Map showing Facility and Community ART services, Mwenezi District, 2016 - 2017**



## RESULTS

**Table 2: Differentiated HIV Testing in Mwenezi District, 2016 - 2017**

Testing Strategy	Number Tested	First time tested	HIV positive	Men Tested	STIs treated
1.Facility based	41562	23142	2924	21806	2931
2.Community based (at our outreaches)	737	321	52	293	30
3.Night Clinics	264	104	11	165	60
4.Hot spots Day testing done at points that had high rate of STIs	415	193	21	199	50
5.HTS campaigns e.g. those done during an activity such as market place or sporting activity	321	180	22	143	46

A high proportion of men were tested in night clinics (62.5%), followed by facility based HIV testing which contributed 52.5%. Higher yields of HIV positivity were seen in community testing (7.1%) compared to other testing areas.

**Table 3: Profile for Patients Receiving ART at Mobile Outreach Sites, Mwenezi, 2016 - 2017**

Indicator	Number
Number of active outreach cohort	1014
Number of patients on second line	15
Number of males	327 (32.3%)
Number of females	687 (67.7%)
Mean age	35.9
Age of 0-14	115 (11.3%)
Age 15-29	167 (16.5%)
Age 30-44	474 (46.8%)
Age 45-59	200 (19.7%)
Age >60	58 (5.7%)

## RESULTS, continued

The total cohort had 1014 clients on ART and the majority were female (67.7%). Approximately a third (29.8%) of the cohort being managed were children, adolescents and young adults. Adults greater the 60 years old accounted for the least proportion of 5.7%.

**Table 4: Client Profile – Baseline CD4 Count, Mwenezi, 2016 - 2017**

Indicator	
# of patients with baseline CD4	371
Median baseline CD4 (cell/mm <sup>3</sup> )	289
Min baseline CD4 (cell/mm <sup>3</sup> )	14
# of patients with <200 baseline CD4 (%)	139 (37.5%)
45.5% of all the males and 34.5% of all females with a documented CD4 count had a CD< 200	

Table 4 shows the CD profile of clients in the outreach model who had a documented baseline CD count, 371 in total and 37.5% of these were late presenters with a CD4 count <200cells/mm<sup>3</sup>. Median baseline CD4 count was 289cells/mm<sup>3</sup>

**Table 5: Clients Profile – Baseline WHO Stage, Mwenezi 2016 - 2017**

Indicator	
Number of patients with documented WHO stage	902
# of patients with WHO stage 3-4 at baseline (%)	388(43%)
45.9% of all the males and 41.7% of all females with a documented WHO stage had WHO staging 3 - 4	

Both Table 4 and 5 show the characteristics of the clients in care and more than a third of the clients presented late either with a CD < 200 (27.5%) or WHO stage 3 or 4 (43%). Forty – five percent of all the males with a documented WHO stage were late presenters. Of the cohort identified and initiated in outreach with CD < 200, 83.7% were male.

## DISCUSSION

- The results show that differentiation of HIV services through the outreach model is essential in serving populations that would otherwise fail to have access to critical services.
- Differentiated HIV testing revealed the high yields activities that the ministry can focus on. Reaching a high proportion of men is a main highlight as more and more strategies are being developed on how to reach and engage men in HIV services (Hensen et al, 2014). Repeating these regularly will lead to further identification of clients who should be identified as the last mile as the country works towards achieving the 90 – 90 -90 targets
- Higher positivity rate in outreach testing compared to facility based testing clearly supports the importance of differentiating HIV testing services
- Identification of patients of patients classified as lost to follow up who had previously received services at the facilities further showed the importance of outreach services in addressing access issues
- The results showed that there was a high number (37.5%) of late presenters were linked to care. This is a critical group of people that are at high risk of getting advanced disease.
- Their identification in the community also shows us that there are gaps to be addressed in routine service provision which is necessary as we work on epidemic control.
- The possibility of clinical and VL monitoring for clients in hard to reach areas was demonstrated in the implementation of this model and further supports the guidance of integrating it into routine service delivery
- Team visits improved TAT of specimens results and follow up
- Though this is a very effective model in areas such as Mwenezi, it is limited in terms in terms of efficiency e.g. fuel, transport. The lack of resources has the potential to compromise sustainability and quality of services provided.

## NEXT STEPS/WAY FORWARD

- The approach has been shown to be feasible and can be considered for use in areas with access issues in regards to HIV service provision
- There is a need for innovative adaptation for the model in order to allow sustainability in the long run as this models are resource intense
- Enrolling clients into different DSD models (e.g. CARGs, Family refills, ART community dispensing points, etc) while maintaining patient monitoring as demonstrated will increase coverage, quality and Retention in Care.
- There is need for a committed logistics capability to get the medicines, POC diagnostics and personnel to outreach. This will be greatly made possible by the buy - in from partners and other funding agencies

## ACKNOWLEDGEMENT

- We would like to thanks the Health staff commitment toward increasing access to HIV and TB management for hard to reach areas.