The CQUIN Learning Network

The Science & Practice of Scale Up

Scale up and Roll out: Challenges through a systems lens

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HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

The Science & Practice of SCALE-UP

Empowering Health for 15 years ICAP
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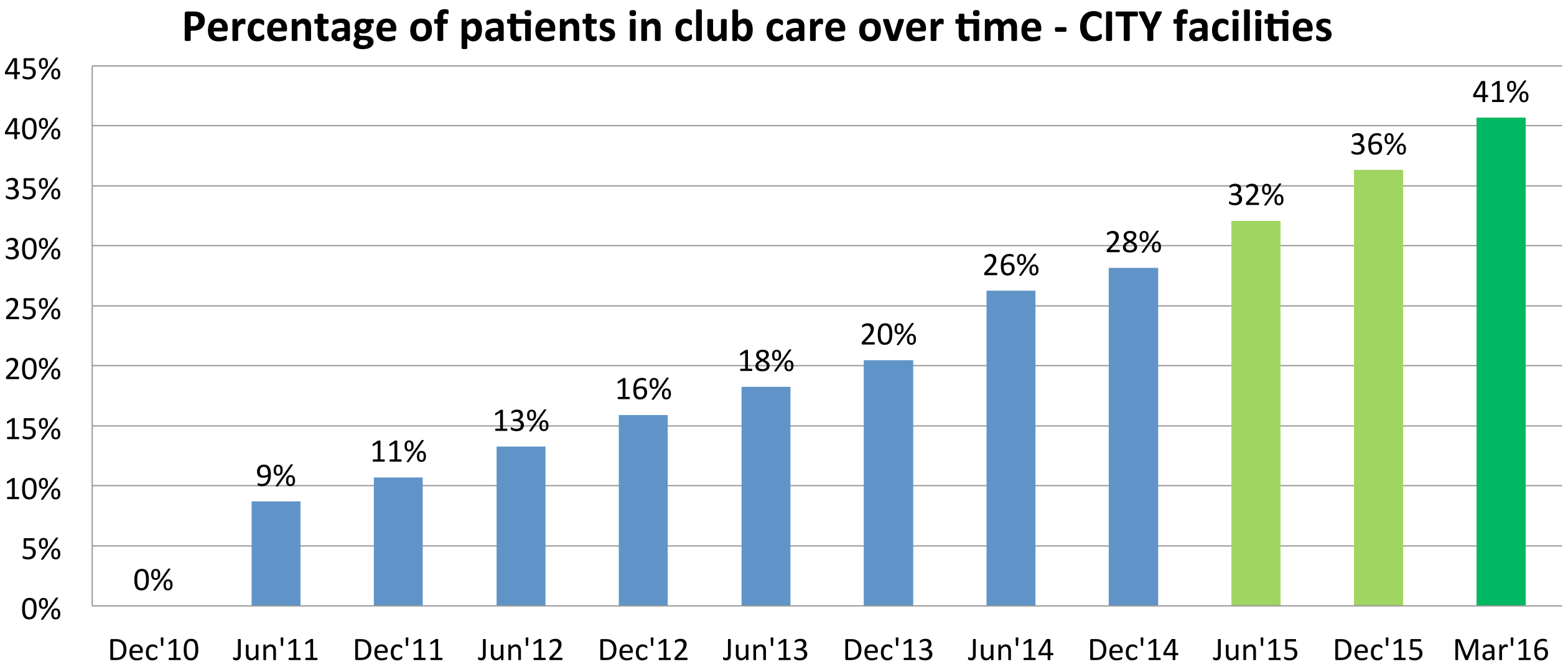
Overview

- 2001: HIV positive patients officially started on ART (Cape Town)
- Health facilities in high-prevalence areas were quickly overburdened with HIV positive patients
- Did all patients need the same level of care?
- Response: In 2007 *Médecins Sans Frontières* (MSF) piloted a model of care in Ubuntu Clinic, Khayelitsha, Cape Town to identify and support a category of 'stable' patients on ART

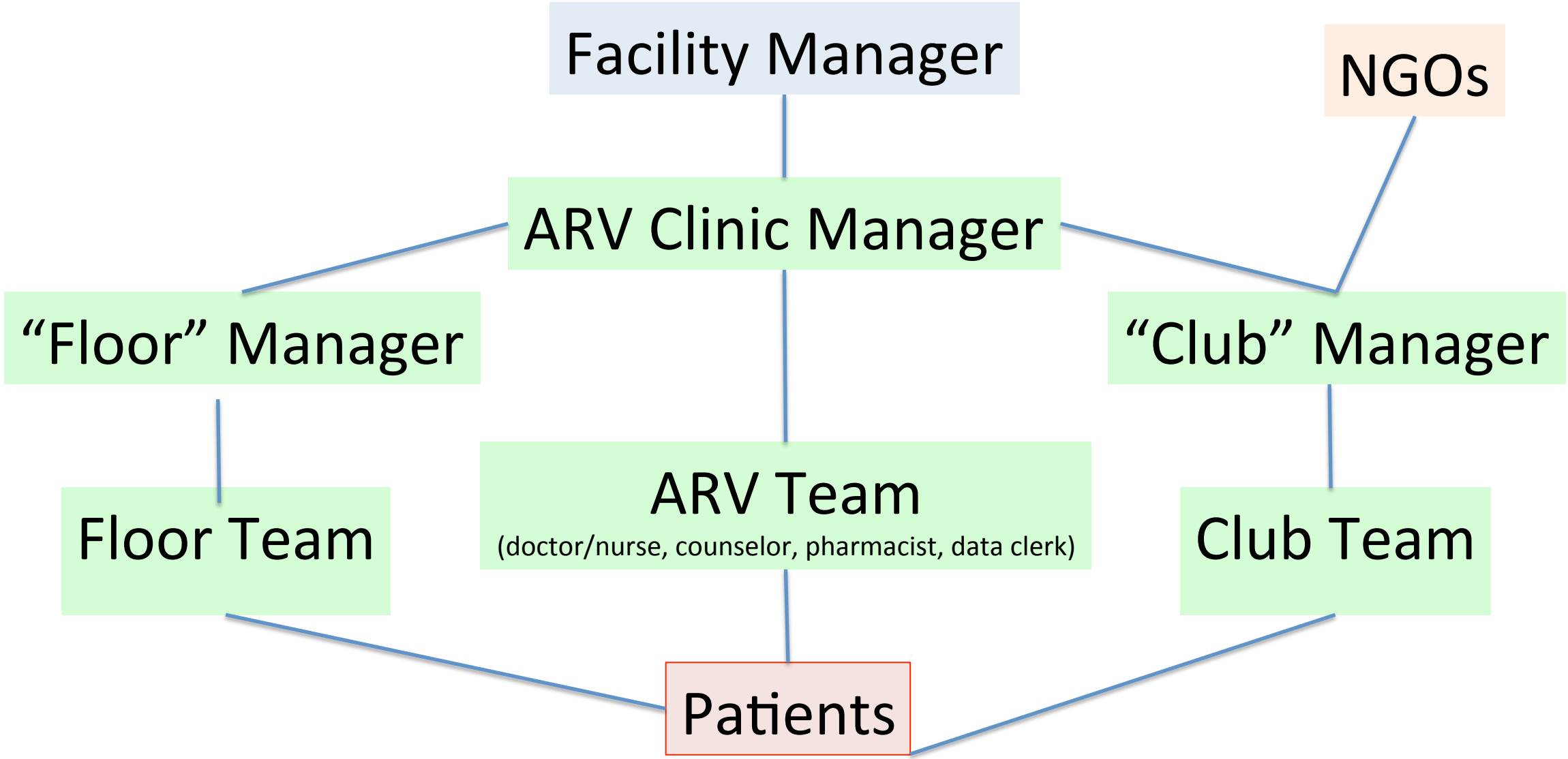
Scale up *vs.* Roll out



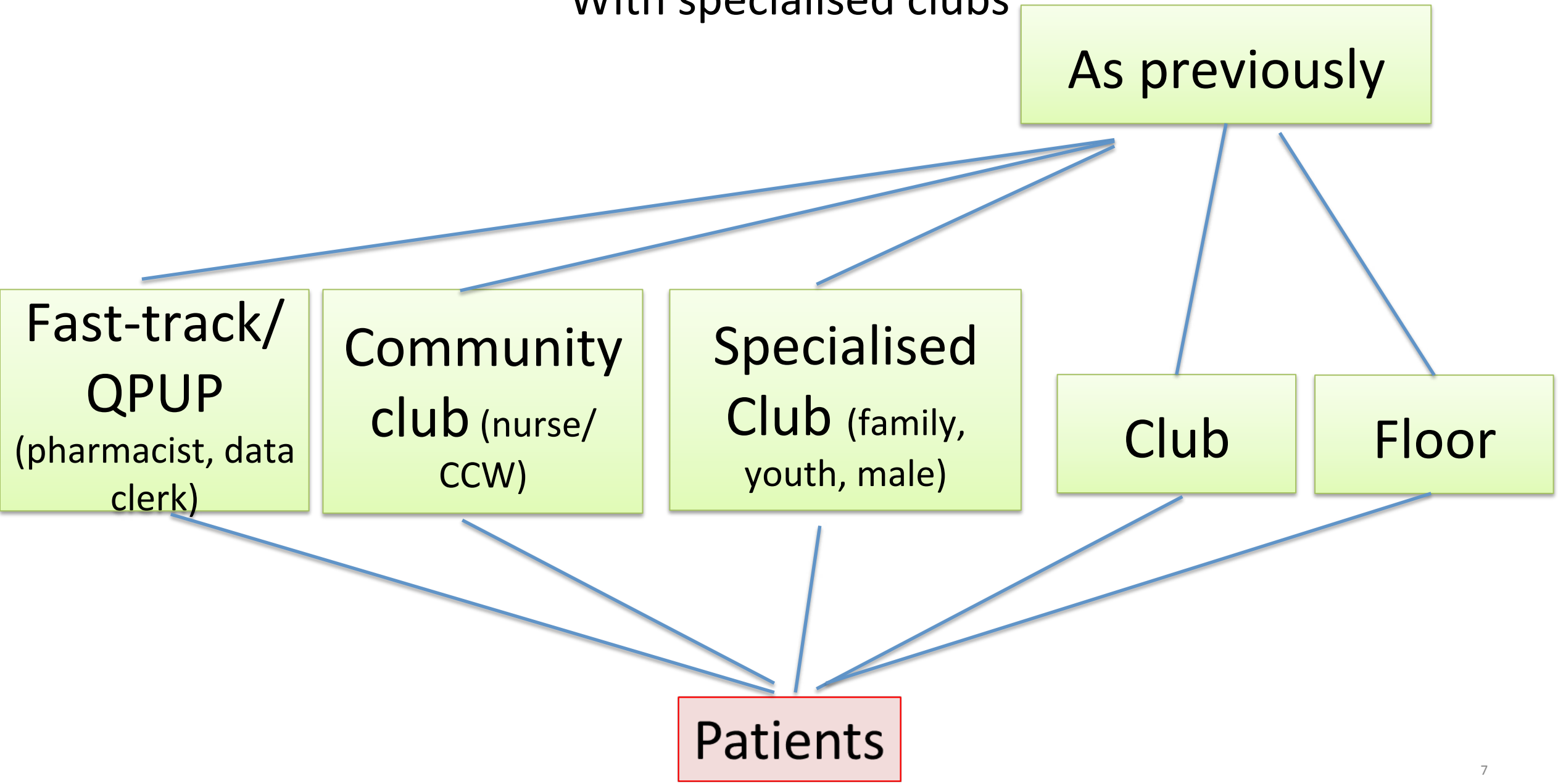
Factors affecting roll out to new facilities

- Roll out is initially easy – factors mentioned above
- Often enthusiasm, and some started on own
- But challenges (with rollout) include:
  - Different types of clubs/capacity of CHWs
  - Training and support/supervision is key
  - Numbers grow and the system becomes more complex

Describing the System



With specialised clubs

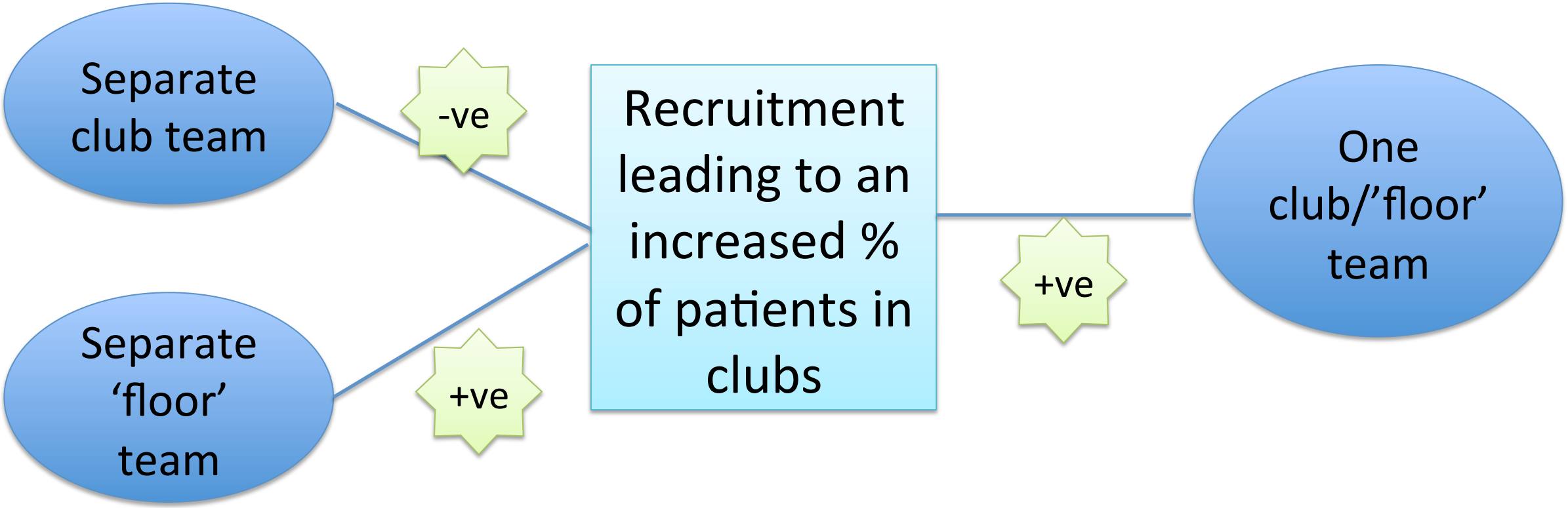


Factors affecting scale up - within facilities

Most clinics happy to start but some stutter and some don't get over a certain point. Why?

- ❑ High eligibility criteria
- ❑ Generalised recruitment strategy (no use of champions)
- ❑ Task shifting (?dumping), especially to CHWs
- ❑ Poor organisation between 'floor' and clubs –management*
- ❑ Scheduling problems because of complexity: 40 club hurdle*
- ❑ Tracking and tracing becomes more complex*
- ❑ CDU and pre-packaging drugs*

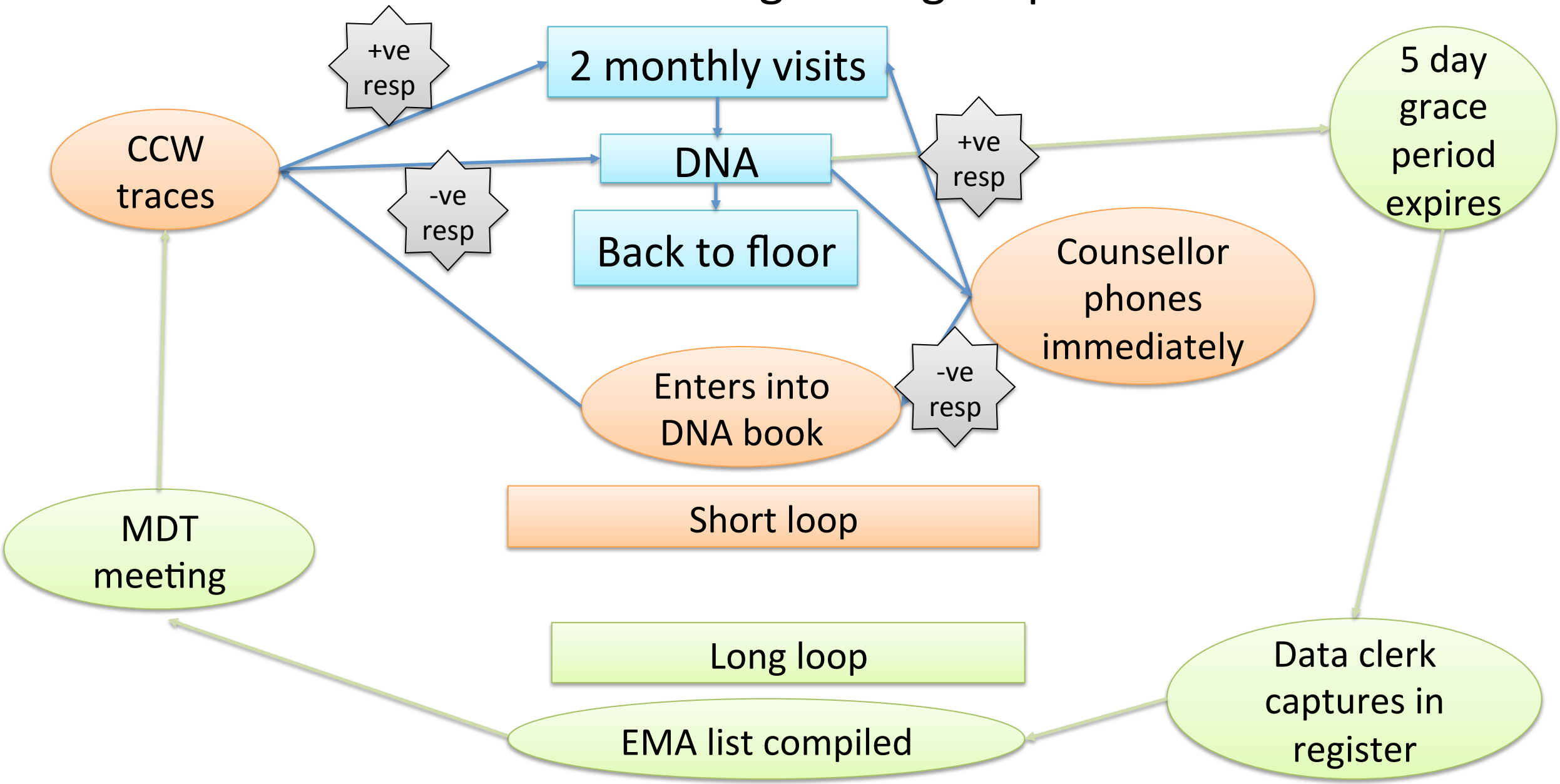
Poor organisation between ‘floor’ and clubs – management



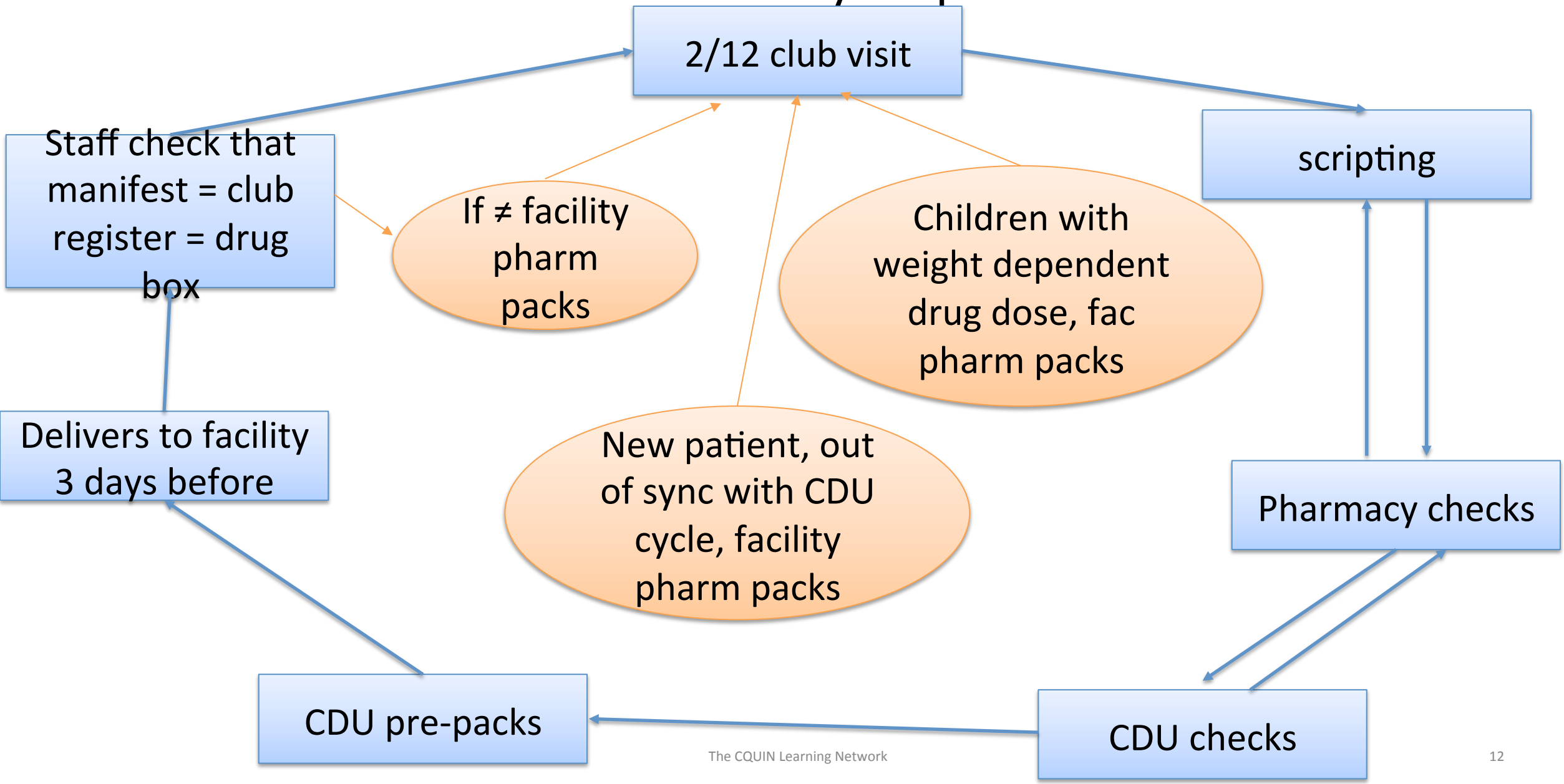
Understanding the 40 club hurdle

- Forty club hurdle as a tipping point
- One club per day over a 8 week cycle = 40 clubs
- Requires seamless logistical preparation and functioning - an error in one component was likely to have a domino effect across the whole club system:
  - ❑ Drug supply problems
  - ❑ Quality of care
  - ❑ Scheduling problems
- One holistic management system worked best

Short and long tracing loops



Pharmacy loop



Summary of challenges to scale up (and roll out)

- Motivation/drive diminished
- Reduction of external support, less mentoring, fewer meetings
- Changing role of the steering committee
- Push for managers to focus on integrated NCDs
- Decongestion slow to appear
- Clubs ‘added’ to the workload
- Holistic view or separate
- Burn out of counsellors, especially
- Focus on starting clubs but not scale up within a facility

  → 40 club hurdle
- More complex pharmaceutical system – more breakdowns

Thoughts on scale up and providing DSD

- ***Appropriate clinical care as a right or a privilege***
- ***Task shifting, clinical governance and quality of care***

Discussion: points on providing differentiated quality care

- ***Integration, co-morbidity and other NCDs***

  It is important to realise that there has to be some 'sharing' and thus it is important for clinicians and managers to focus on core aspects and the principles of the model, ensure that the benefits are available and utilised for other NCDs and thus craft a win-win situation.

- ***Simplifying systems***

Discussion - managerial responsibilities

- ***Innovation/institutionalisation***

Conclusion

- Our analysis reveals how a programme initially representing a simple, unitary system in terms of management and clinical governance had evolved into a complex, differentiated care system.
- However, as scaling up progressed, challenges have emerged at the same time as support has waned.
- We argue that innovation in largescale, complex programmes in health systems is a continuous process that requires ongoing support and attention to new innovation as challenges emerge

Thank you