Taking DSD to Scale in Zimbabwe

Dr. Tsitsi Apollo
Deputy Director HIV/AIDS, STIs
Zimbabwe, MOHCC,
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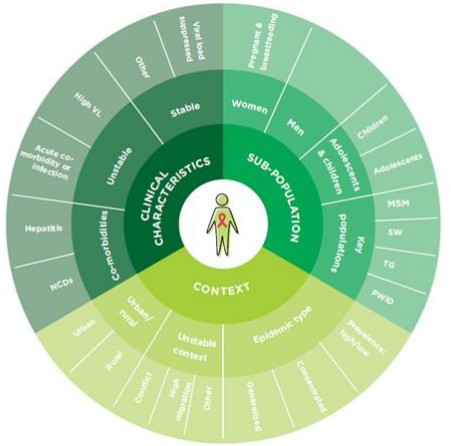
Outline:

- Country Context
- Approaches to scaling up DSDs
- Lessons Learnt

Figure 2: The three elements of differentiated service delivery



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Country Context

- Zimbabwe has a generalized HIV epidemic
- Total population: **13.5 million** (Census 2012)
- Total PLHIV: **1,32 m** (76,653 children) [2017 Estimates]
  - Males 41%
  - Females 59%
- HIV **Prevalence:** 14,6% among 15-64 year age group
  - Females: 16.7%; Males: 12.4%
- HIV **Incidence**: 0.45% in 2016
- New Infections: 40, 973 per year (2017 HIV Estimates)
- **Viral Suppression** among people on ART: 86.5% [ZIMPHIA, 2015/16]
- MTCT rate 5,2% at end of breast-feeding period
- TB/HIV co-infectivity rate 72%
- DSD Implementation success noted in 2017 with scale up earmarked for 2018-2019

Approaches to DSD Review Meetings

- Targeted HCWs leading quality improvement teams in health facilities – mainly nurses
- **140 nurses from 105 facilities reached**
- Peer platform for experience sharing, identification of bottlenecks and development for strategies for further implementation
- Sensitization done on DSDs, quick assessment made on progress

DSD Reviews Integrated with QI quarterly Review meetings, Oct 2017

National Annual Planning & Review for HIV and TB, Bulawayo- Nov, 2017

- Targeted Provincial Health Teams & partners
- A **dedicated DSD session** within a scheduled annual HIV and TB Review meeting
- Sensitization of health workers on DSDMs
- Oriented health workers on a simple DSD baseline data collecting tool
- and provincial plans developed

- Targeted provincial and district mentors
- Orientation on mentorship, DSD and QI and development of implementation plans
- **120 mentors and managers reached**
- Presentations made on provincial baseline data using the tool from the Annual Review Meeting

Combined Review Meeting for Quality Improvement, Mentorship and DSD - Feb, 2018

Provincial DSD Review Meeting, Kadoma - May, 2018

- Targeted district health teams that had been involved with implementation since the roll-out of DSD guidance in 2017
- **57 provincial HCWs from 28** health facilities reached
- Peer platform for sharing of implementation progress, best practices and identification of gaps to be addressed

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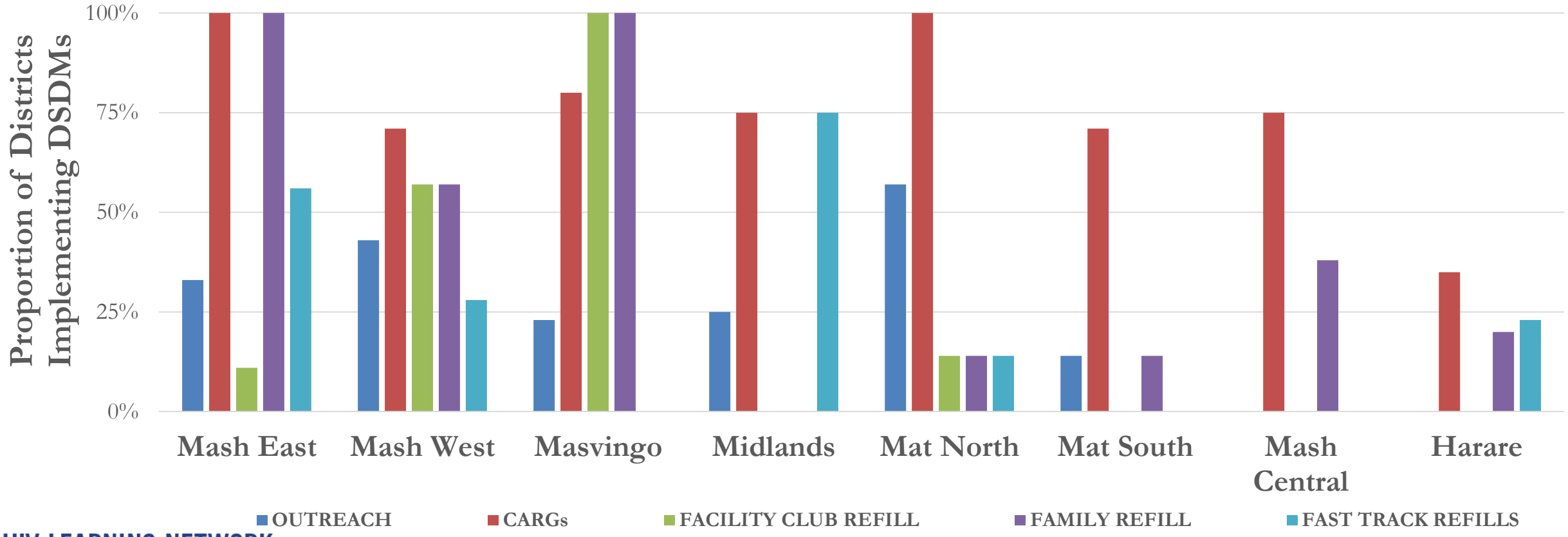
National Baseline Survey for DSDM

- Designed a **simple tool** for the baseline DSD survey in **November 2017**
- **Oriented health workers** on how to fill the template during the National Annual TB and HIV Review and Planning Meeting
- Provincial Teams provided feedback on survey data during the National Mentor's technical Update Meeting in **February, 2018**

PROVINCE:									
		MODELS BEING IMPLEMENTED (Yes/No) *(Each model is described in the OSDM pages 50 – 54)*							
		OUTREACH	CARGs	FACILITY CLUB REFILL	FAMILY REFILL	FAST TRACK REFILLS	# HCW sensitised/trained/Mentored on the OSDM	Partners assisting with Implementation
District 1	Facility 1							
	Facility 2							
	Facility 3							
	Facility X							
District 2	Facility 1							
	Facility 2							
	Facility 3							
	Facility X							
District 3	Facility 1							
* Challenges				** Recommendations				

Proportion of Districts that have at least one facility implementing any one DSD ART Models, end of 2017



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As countries scale up, some M and E systems have not yet been well adapted for DSD

Simpler ways of collecting reliable data needed**: Simple sample based method for period monitoring**

DSD Scale Up

The Missing link : Robust M and E Systems

Reliable DSD Data to Inform Programming

Mashonaland West Province

- Total Catchment Population **1,594,038**
- Total Clients on ART **131,858**
  - Adults **124,244**
  - Children **7,614**

- **6/7** Districts Currently Implementing DSDs

- **30 (16.7%)** facilities sampled from the 6 districts

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Methodology

Step 1: Identified Indicators And Data Needed

- Information needed on Coverage, Uptake and Retention
- 11 indicators identified
- 10 data elements derived for analysis

Step 2: Developed Basic Data Abstraction Form

- Data Collection Tool developed
- Simple Yes/ No responses or Options given to choose from

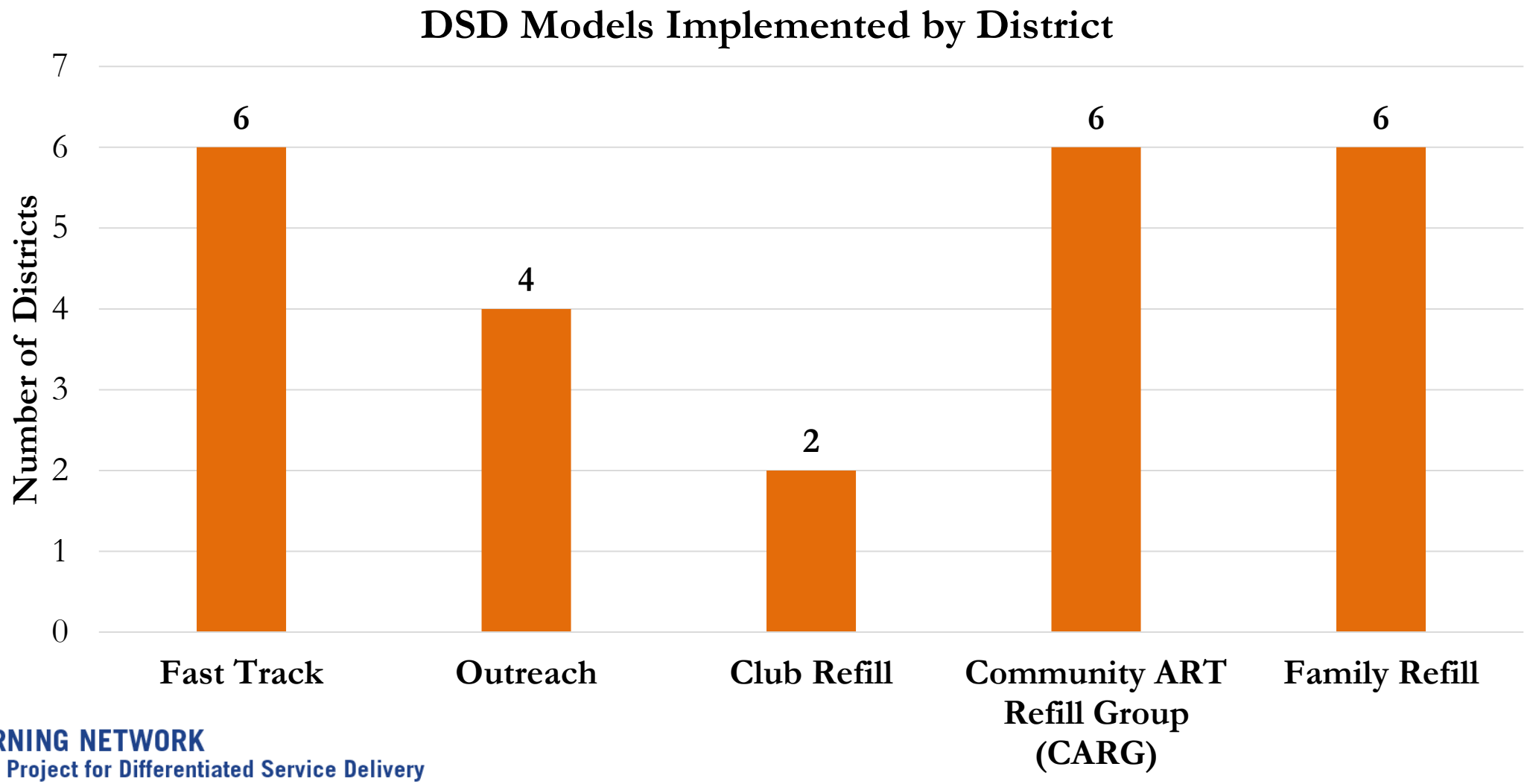
Step 3: Selected Facilities

- One province selected; All implementing districts sampled
- One district Hospital, two high volume facilities and two low volume facilities
- Random selection

Methodology

Step 4: Selected Clients	• Clients selected in 2 cohorts • 24 month cohort [initiated Feb 2016] • 12 month cohort [initiated Feb 2017]
Step 5: Abstracted Data	• Excel Data abstraction form developed • 10 questions; Simple Yes/ No, drop down option responses • 4 weeks data collection, coordinated by Provincial & District Focal Persons
Step 6 & 7: Create Simple Summaries, Share and Utilize Data	• Analysis: Frequencies and proportions for districts and facility generated using Excel • Information shared and discussed, used to inform scale up

Mashonaland West Province as of April, 2018



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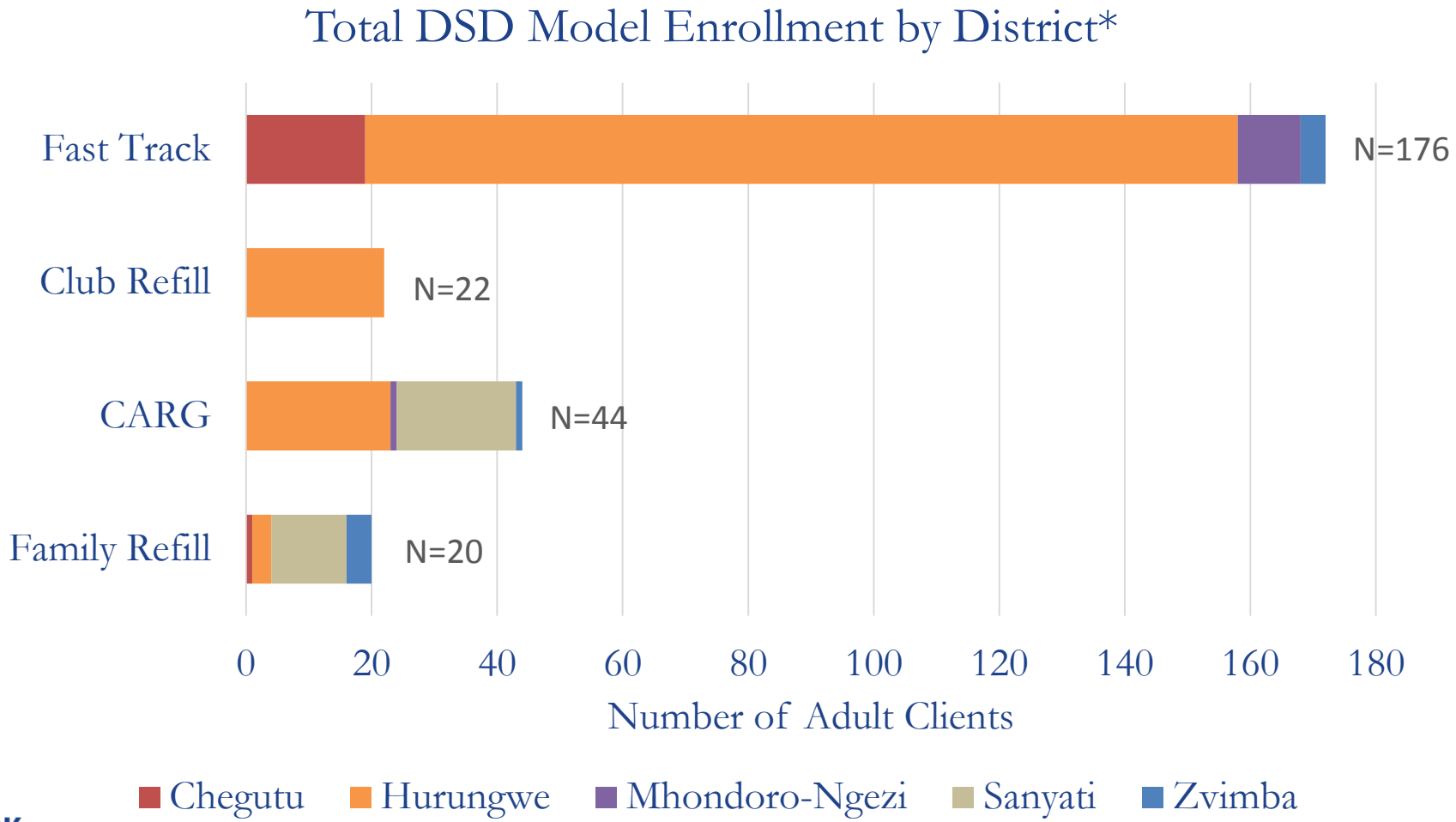
Mashonaland West
Provincial DSD Data Summary as of April, 2018



*For adult clients active on ART (not controlled for stability criteria)

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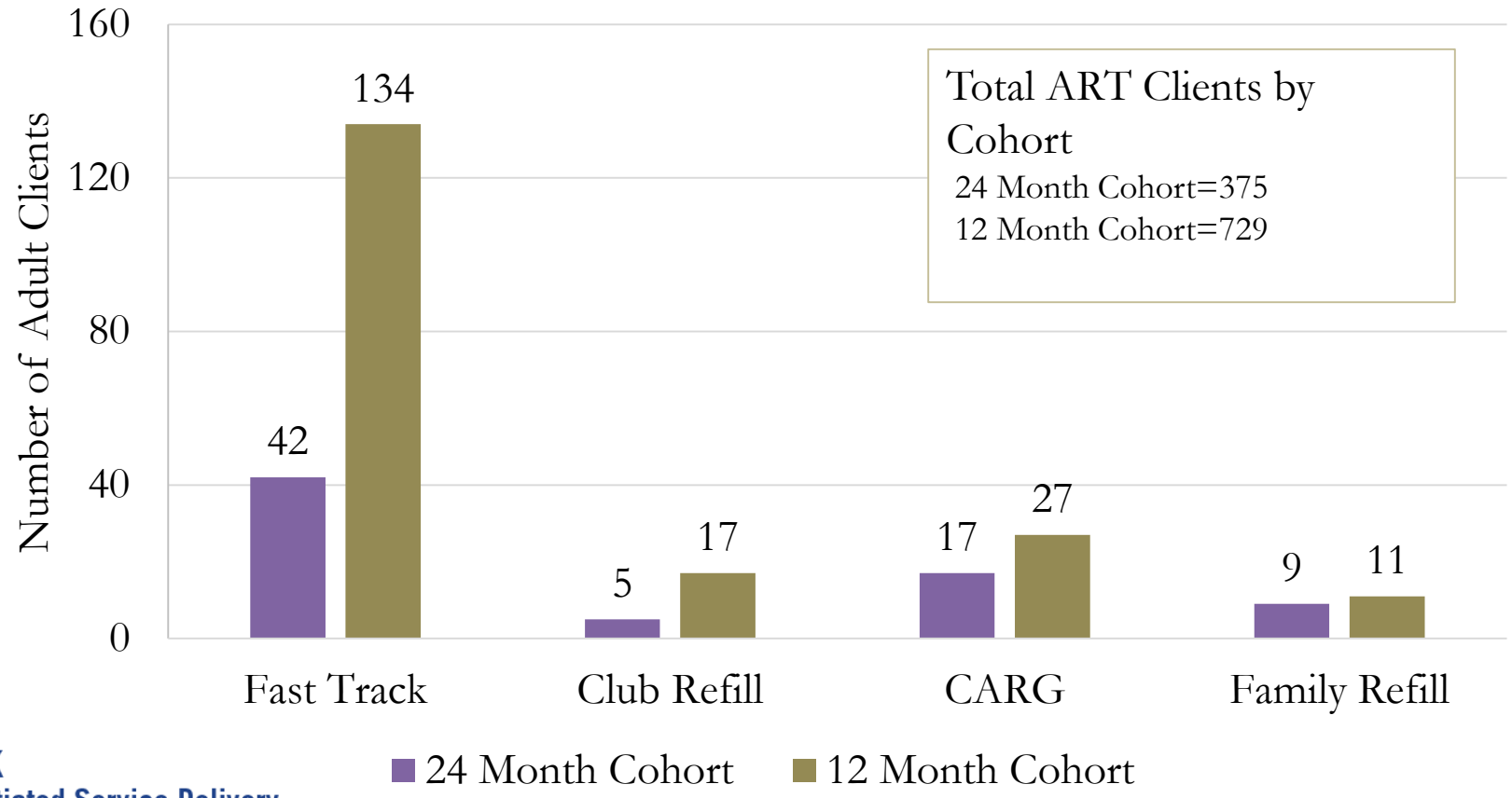
Mashonaland West
Provincial DSD Data Summary as of April, 2018

Distribution of Clients in DSD Models, by Cohort and Model Type*



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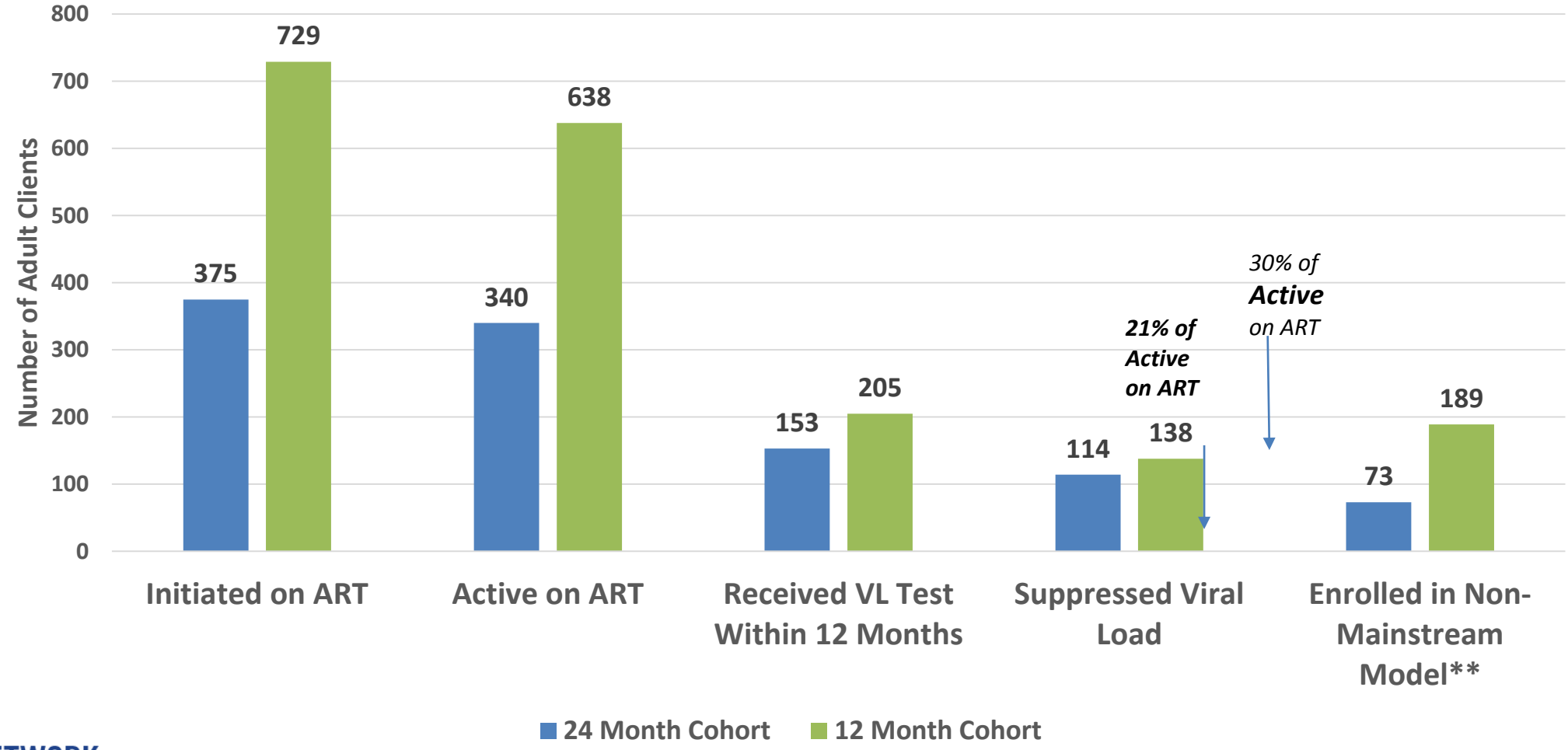
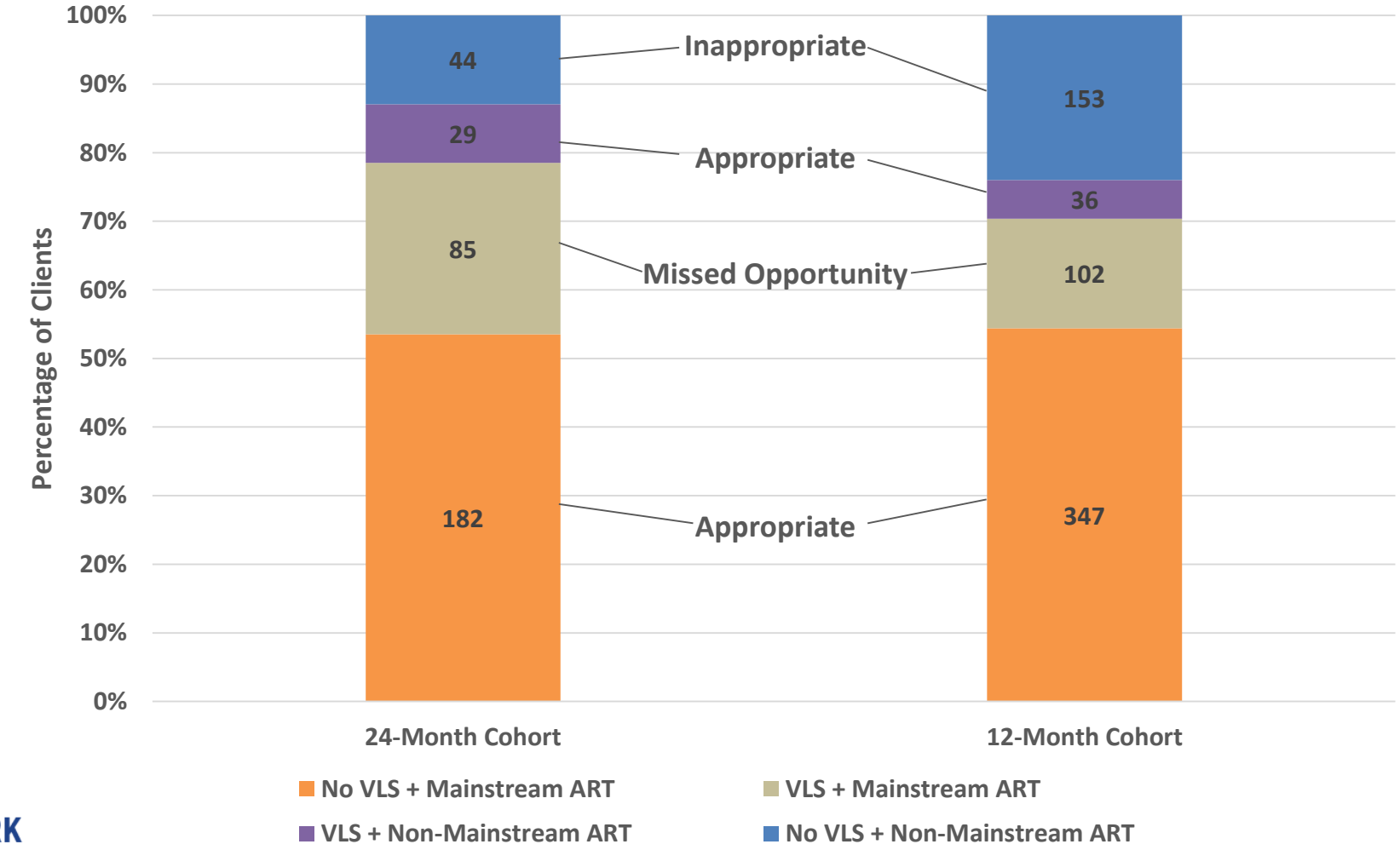
Modified DSD Cascade by Cohort*†



*For adult clients
†Excludes Makonde District due to ongoing data validation activities
**For all clients active on ART (not controlled for stability criteria)

Appropriateness of Model by Cohort and VLS*†



*For adult clients active on ART, where VLS is defined as a VL test ≤12 months ago and a result of <1000 copies
†Excludes Makonde District due to ongoing data validation activities

Lessons learnt

Integrated review meetings helped to leverage in-country resources; reaching wider audiences; helped to enhance program ownership; and fostered integrated DSD activities within broader HIV work plans

Sharing of practical implementation strategies and challenges among peers from similar settings helped to stimulate action towards scale up of DSDMs

Stand-alone provincial review meeting provided more focused discussions and ample time for review of DSD implementation by district; however, may not be sustainable for scale up

Simple data collection tools and analyses can be used to develop capacity and interest for data utilization and track progress on DSD implementation while robust M and E systems are being set up

Acknowledgements

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